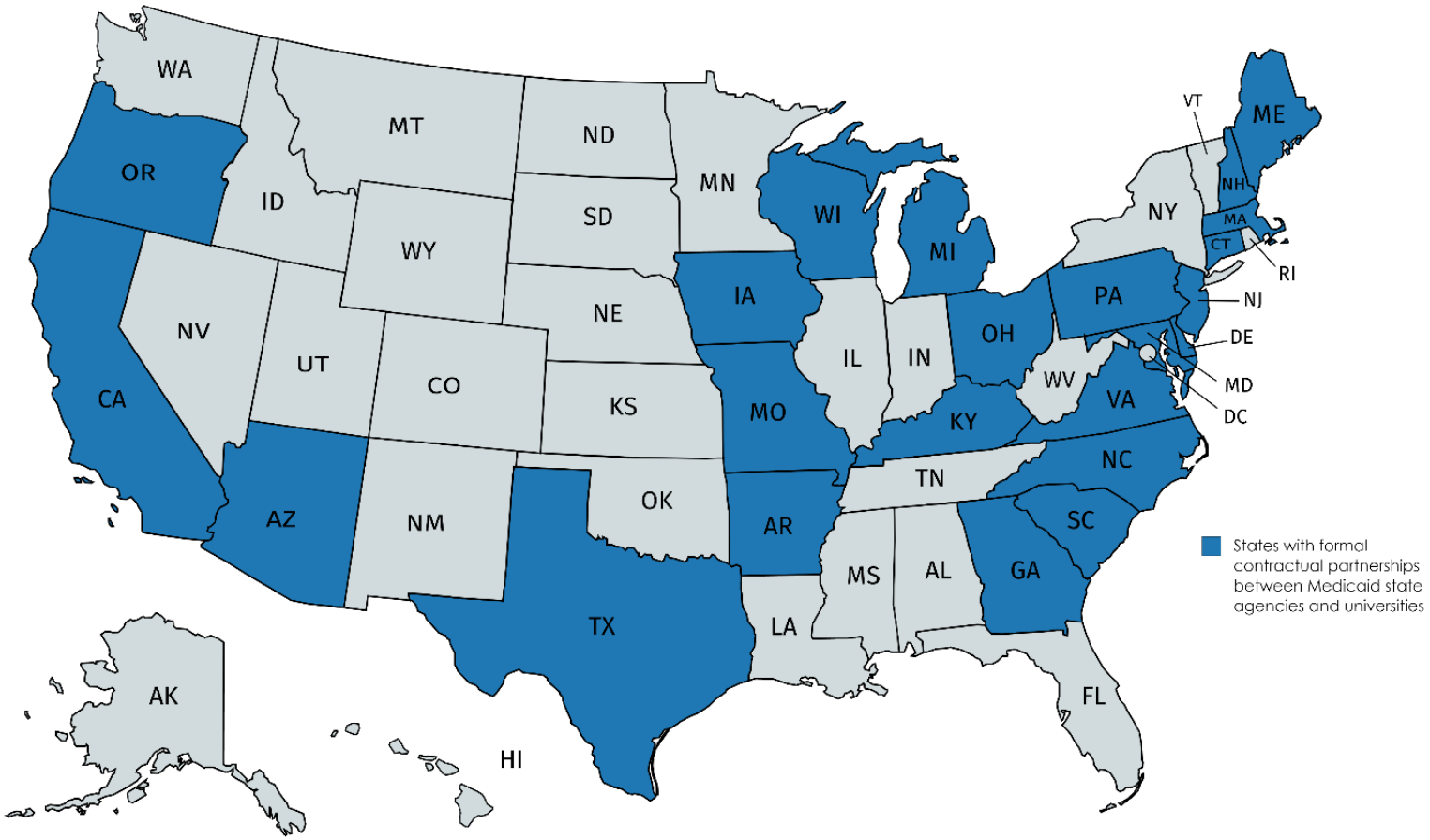
BHECON
Behavioral Health + Economics Network

ABHA CELEBRATING 20 YEARS
ALASKA BEHAVIORAL HEALTH ASSOCIATION

Behavioral Health Data Collaborative

Dr. Joe Parks
Medical Director, National Council for Behavioral Health



ABHA CELEBRATING 20 YEARS ALASKA BEHAVIORAL HEALTH ASSOCIATION

BHECON Behavioral Health + Economics Network

Types of Data Shared for Analysis

- Over half of the partnerships had access to the following datasets on an On-Going basis:
    - Medicaid Claims data
    - Medicaid Enrollment data; and
    - Dental data.
- The majority of partnerships had access to the following datasets on a Project-by-Project basis:
    - CHIP data (i.e., Claims, Encounter and Enrollment data);
    - Birth records;
    - Death records; and
    - Hospital discharges

Obtaining Federal Match For Partnership Activities

1. the state Medicaid agency fully funds the partner to conduct the analyses, invoices CMS for the FFP, and then retains the 50% at the Medicaid agency as partial compensation for the Medicaid agency's costs; and/or
2. the partner incurs costs for conducting the analyses, invoices the state Medicaid agency, and then receives the 50% FFP funds from the Medicaid that acts as a fiscal pass-through once the Medicaid agency receives the funds from CMS based on the agency's having invoiced CMS for the costs the partner incurred.

Administrative expenditures eligible for FFP reimbursement must meet be necessary for the "proper and efficient" operation of the medical assistance program

- Eligibility determinations and provider payment functions;
- Operational or clinical quality control, ensuring access to services;
- Ensuring that Medicaid is "payer of last resort";
- Managing clinical quality, utilization, and cost effectiveness of services;
- Program integrity monitoring, analysis, and evaluation;
- Program and policy development, planning, research, and analysis;
- Federal reporting, FFP claiming costs, responses to federal inquiries;

Georgia

- Supports four full-time FTEs at Medicaid at 20 FTEs at Department of Behavioral Health

- Paid claims analysis for:
  - 1115 waiver compliance
  - Children's Mental Health System of Care Grant
  - CHIP Quality Metrics
  - Long-Term Services and Supports analysis

BHECON
Behavioral Health + Economics Network

ABHA CELEBRATING 20 YEARS ALASKA BEHAVIORAL HEALTH ASSOCIATION

Missouri Data-Driven Care Management Partnership

Dr. Joe Parks
Medical Director, National Council for Behavioral Health

Why Share Data?

What gets measured gets done

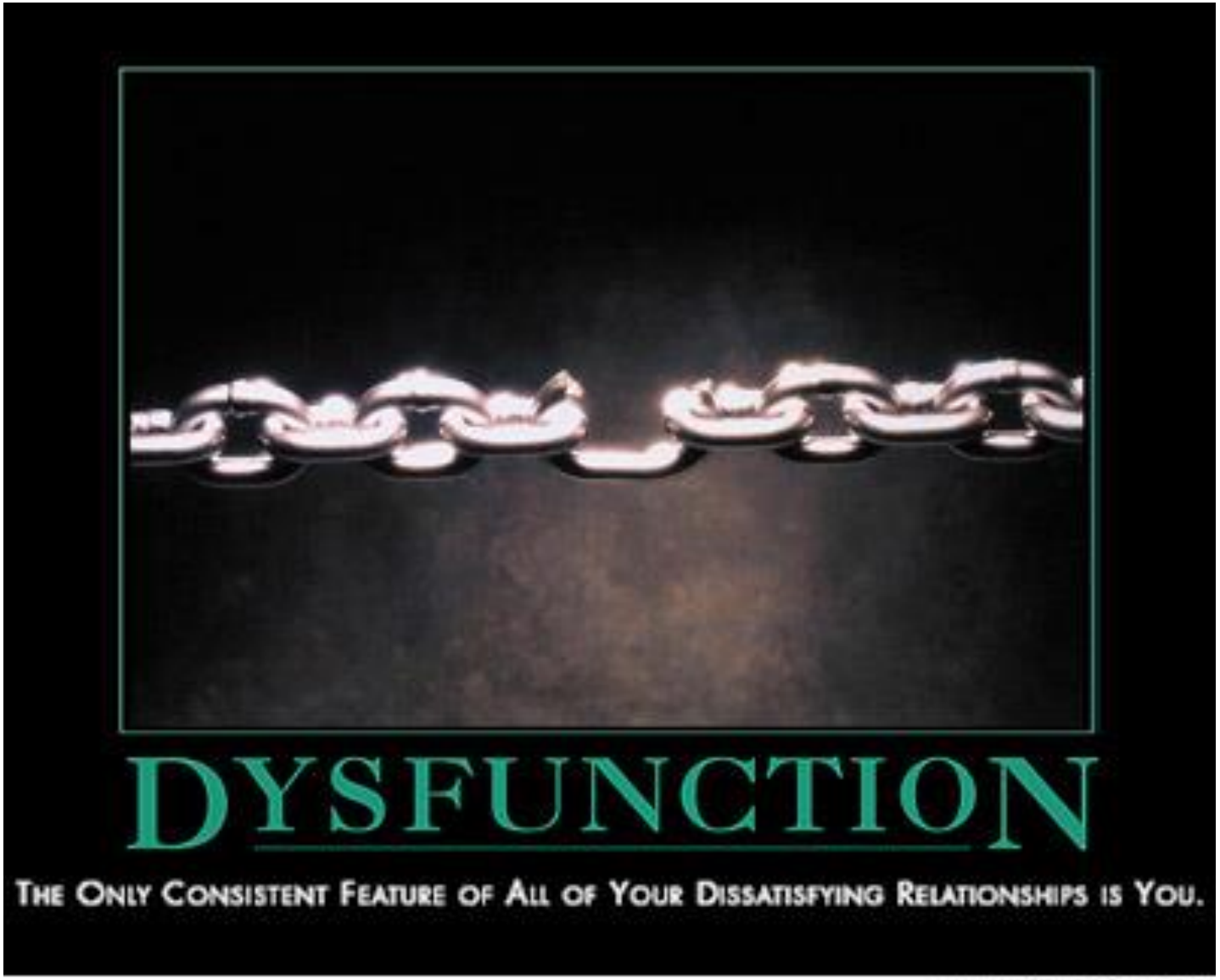
Missouri Partners

A collaborative effort involving:

- Dept. of Social Services (MO HealthNet/Medicaid)
- Dept. of Mental Health
- Coalition for Community Behavioral Healthcare
- Missouri Primary Care Association
- Missouri Institute for Mental Health

What Made it Possible? **Relationships**

- The Missouri Coalition of CMHCs
  - Stability
  - Trust
- The State Medicaid Authority and State Budget Office
  - Transparency
  - Common Agenda
- University of Missouri St Louis – Missouri Institute of Mental Health
- The Missouri Primary Care Association
  - CMHC/FQHC Integration Initiative


DYSFUNCTION
THE ONLY CONSISTENT FEATURE OF ALL OF YOUR DISSATISFYING RELATIONSHIPS IS YOU.

Partnership Principles

DON'T	DO
• Talk about your need first	• Ask about their needs first
• Expect to get something	• Give something
• Limit assistance to a project	• Assist wherever you can
• Make it about this deal	• Make it about the next 10
• Push a specific position	• Pursue common interest
• Withhold information	• Reveal anything helpful
• Let them take their lumps	• Take one for the team

S.M.R. Covey, The Speed of Trust

Behaviors that Promote Trust

- Character
  - Talk Straight
  - Demonstrate Respect
  - Create Transparency
  - Right Wrongs
  - Show Loyalty
- Competence
  - Deliver Results
  - Get Better
  - Confront Reality
  - Clarify Expectations
  - Practice Accountability
- Character & Competence
  - Listen First
  - Keep Commitments
  - Extend Trust

State Perspective

- Under Staffed
- Vulnerable to Public Opinion
- Stalked by Predatory Reporters
- Pushed around by Politics
- Constantly Criticized
- Damned if they Do and Damned if they Don't
- Can't tell who/what will hit us next

Data Uses

- Aggregate Reporting – performance benchmarking
- Individual drill down – care coordination
- Disease Registry – care management
  - Identify Care Gaps
  - Generate to-do lists for action
- Enrollment Registry – deploying data and payments
- Understanding – planning and operations
- Telling your story – presentation like this

Principles

- Use the Data you have before collecting more

- Show as much data as you can to as many partners as you can as often as you can
  - Sunshine improves data quality
  - They may use it to make better decisions
  - It's better to debate data than speculative anecdotes

- When showing data ask partners what they think it means

- Treat all criticisms that results are inaccurate or mis-leading as testable hypotheses

More Principles

- Tell your data people that you want the quick easy data runs first. Getting 80% of your request in 1 week is better than 100% in 6 weeks
- Treat all data runs as initial rough results
- Important questions should use more than one analytic approach
- Several medium Data Analytic vendors/sources is better than on big one
- Transparent Bench Marking improves attention and increases involvement

Most Important Principle

- Perfect is the Enemy of Good
- Use an Incremental Strategy
- If you try figure out a comprehensive plan first you will never get started
- Apologizing for a failed prompt attempt is better than is better than apologizing for missed opportunity


PLANNING
MUCH WORK REMAINS TO BE DONE BEFORE WE CAN ANNOUNCE
OUR TOTAL FAILURE TO MAKE ANY PROGRESS.

Data You Need to Manage

- Eligibility/Enrollment Registry
- Payment System
- Work Process Tracking
  - Data reporting
  - Use of HIT Care management tools
  - Staffing as required and turnover
  - Attending training and Conference calls
- Aggregate Outcomes
- Individual Patient Look-Up/Drill down

Data Sources

- Claims – Broad but not Deep, already aggregated
  - Diagnosis
  - Procedures including Hospital and ER
  - Medications
  - Costs
- EMR Data Extracts – Deep but not Broad, need aggregating
- Practice Reported – Administrative Burden
  - Metabolic Values – Ht, Wt, BP, HbA1c, LDL, HDC
  - Satisfaction and community function – MHSIP
  - Staffing and Practice Improvement
- Hospital Stay Authorization – Hospital Admissions

Provide Information to Other Healthcare Providers

- HIPAA permits sharing information for coordination of care
- Nationally consent not necessary
- Exceptions:
  - HIV
  - Substance abuse treatment – not abuse itself
  - Stricter local laws

Some Successful Approaches

- Convert some services funding into an ASO contract to help the state manage
- Use peer pressure to help the state manage your underperforming peers
- Write your BAAs very broadly
  - Many parties, not just two
  - Broad functions, not just one project
- Don’t confuse legal advice with court orders

Health Home Target Populations

Primary Care Health Homes

- Patients with diabetes
  - At risk for cardiovascular disease and a BMI > 25
- Patients who have two of the following:
  - COPD/Asthma
  - Diabetes (also as single condition)
  - Cardiovascular disease
  - BMI>25
  - Developmental disabilities
  - Use tobacco

CMHC Healthcare Homes

- Individuals with a serious mental illness; or with other behavioral health problems who also have:
  - Diabetes
  - COPD/asthma
  - Cardiovascular disease
  - BMI > 25
  - Developmental disabilities
  - Use tobacco

Missouri's Health Homes

Primary Care Health Homes

- Providers
  - 18 FQHCs
    67 clinics
  - 6 hospitals
    - 22 clinics
    - 14 rural health clinics
- Enrollment 17,253
- Passive Auto-Enrollment of High Utilizers - over $10,000 prior year and not terminally ill

CMHC Healthcare Homes

- Providers
  - 28 CMHCs
    - 120 clinics/outreach offices
- Enrollment – 21,893
- Passive Auto-Enrollment of Medium Utilizers – over $3000 prior year and not terminally ill

Missouri Health Home PMPM

Staff	Amount	Cost	PMPM
Nurse Care Manager	1 FTE/250 enrolled	$105,000/year	$35.00
Primary Care Consultant	1hr/enrollee/year	$150/hour	$12.50
Health Home Director	1 FTE/500 enrolled	$115,000/year	$19.17
Administrative Support	1 FTE/500 enrolled	includes other stuff	$12.07
Total			$78.74

Administrative PMPM

- CMHC on-site Admin staff
  - for Referral tracking, Data collection and reporting, Scheduling, Chart audits, reminders for appointments & filling prescriptions, Requesting and sending Medical Records for care coordination
  - $37,200/FTE/year divided by 500 patients divided by 12 months/year = $6.20 PMPM

- Physician time to attend mandatory Learning Collaborative
  - not covered by PMPM @ 2 physicians, 6 days/year each
  - $150/hr physician cost X 8 hours/day X 6 days/year X 2 physicians divided by 500 patients divided by 12 months/year = $2.40 PMPM

- Contracted Data Analytics
  - Training and Technical Assistance for aggregating and reporting performance and monitoring measures, maintaining patient disease registry, and risk predictive analysis to select high risk patients for intervention.
  - $750,000/year divided by 18,000 members divided by 12 months/year = $3.47 PMPM

- Total = $12.47 PMPM

Funding Flows

- PMPM includes $3.47 for Administrative Support, Training, and Data analytics
- Individual Health Homes pay Coalition of CMHCs the $3.47 for Administrative Support, Training, and Data analytics
- Coalition keeps $1 PMPM to hire staff to assist state in implementation, training and data
- Coalition sub-contracts $2.47 PMPM to University MIMH for Administrative Support, Training, and Data analytics
- MIMH under state agency direction:
  - Hires staff who work in state agency offices – project managers and data analysts
  - Executes external data analytic contracts as needed
  - Pays training and travel costs

Compliance and Monitoring Tools

- Staffing Reports
- Time logs for staff not completely funded by PMPM
- Use of IT tools – PROACT and CyberAccess
- Completion of Metabolic Screening
- Site visits with chart reviews
- Practice Coaches

Compliance Actions

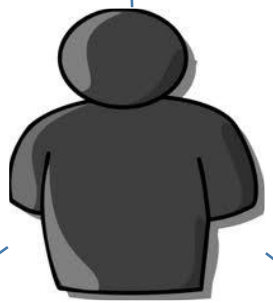
- Transparent Benchmarking
- Plans of Correction for Low Outliers
- Recognition awards for High Outliers
- PMPM Recoupment for Under Staffing
- Suspension of HH status for Global non-performance

Important Provider Competencies

Characteristics:

- **Outcomes-oriented**
- **Enabled by technology**
- **Patient-centered**
- **Use of data and analytics**
- **Performance transparency**
- **Ability to partner across organizations**

Care Coordination



Care Management

Clinical Integration

Population-Based Care

- Don't rely solely on patients to know when they need care and what care to ask for and from whom - use data analytics for outreach to high need/utilizer patients
- Don't focus on fixing all care gaps one patient at a time - choose selected high prevalence and highly actionable individual care gaps for intervention across the whole population
- The population-based health care provider is the public health agency for their clinic population

Step 1 – Create Disease Registry

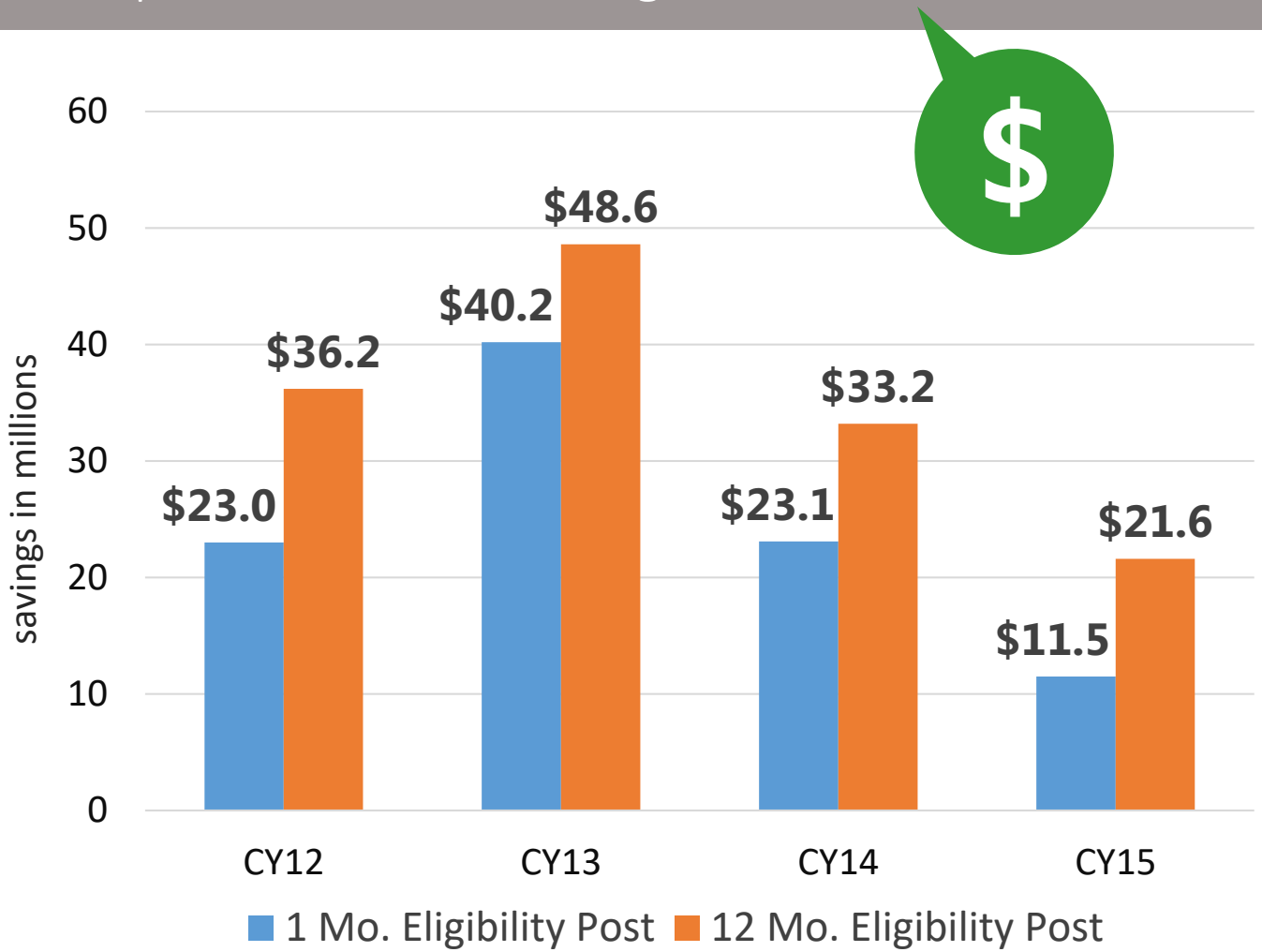
- Get Historic diagnosis from administrative claims
- Get clinical values from metabolic screening, clinical evaluation and management, care plans
- Combine into EHR Disease Registry
  - CMT's PROACT
  - Azara's DRV
- Online access available to all providers

Step 2 – Identify Care Gaps and ACT!

- Compare combined disease registry data to accepted clinical quality indicators
- Identify care gaps
- Sort patients groups with care gaps into agency specific to-do lists
- Nurse care manager helps team decide who will act
- Set up indicated visits and pass on info with request to treat

Cost Savings

Over the first 4 years, CMHC Healthcare Homes produced a net savings of **$98 million!**



Cost Savings (2012-2015)

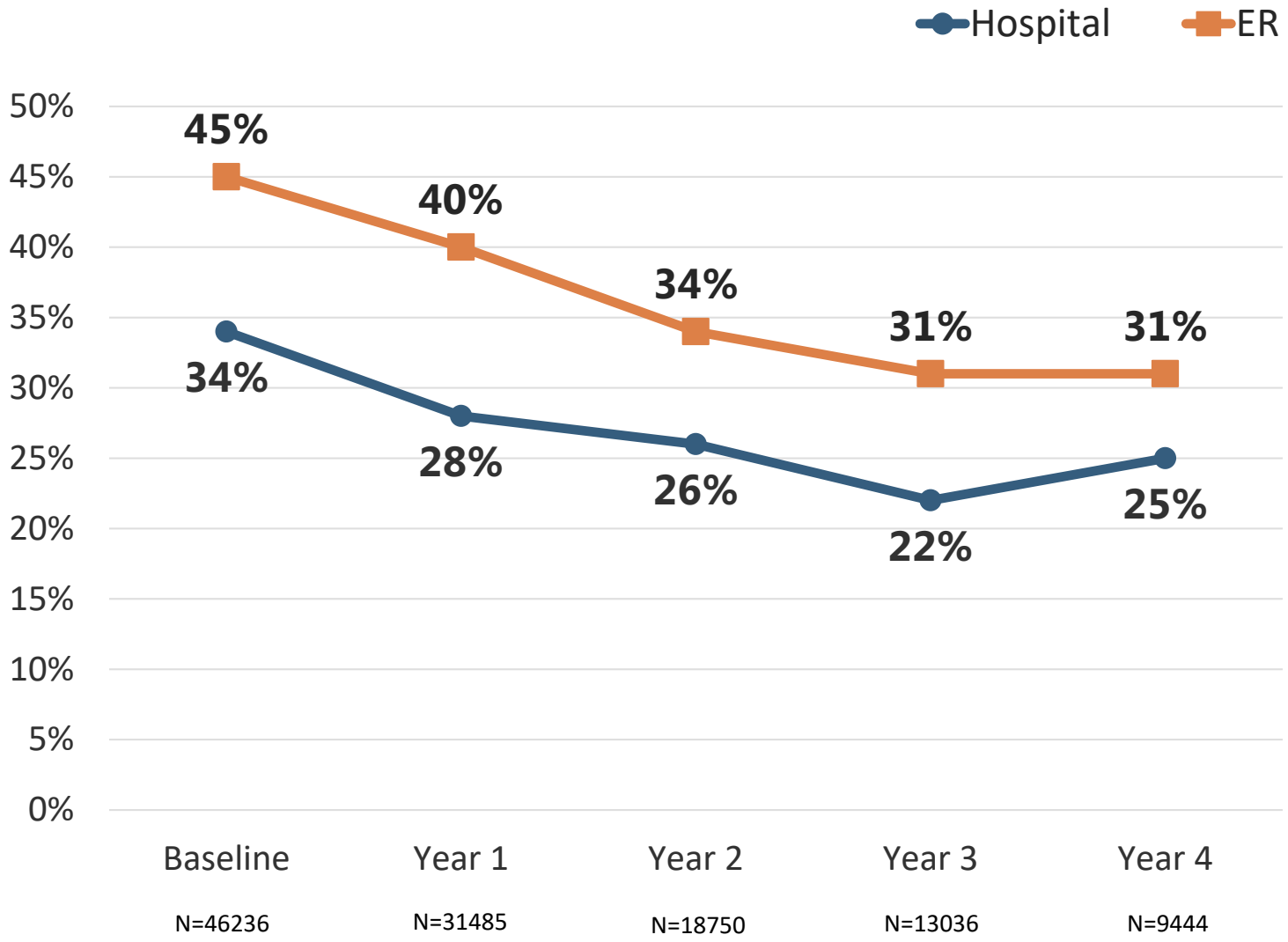
Current per member per month (PMPM) rate for CMHC Health Homes is $85.23 (Jan 2016)

ABHA CELEBRATING 20 YEARS ALASKA BEHAVIORAL HEALTH ASSOCIATION

BHECON Behavioral Health + Economics Network

Hospital & ER

% of clients with 1+ Hospitalizations

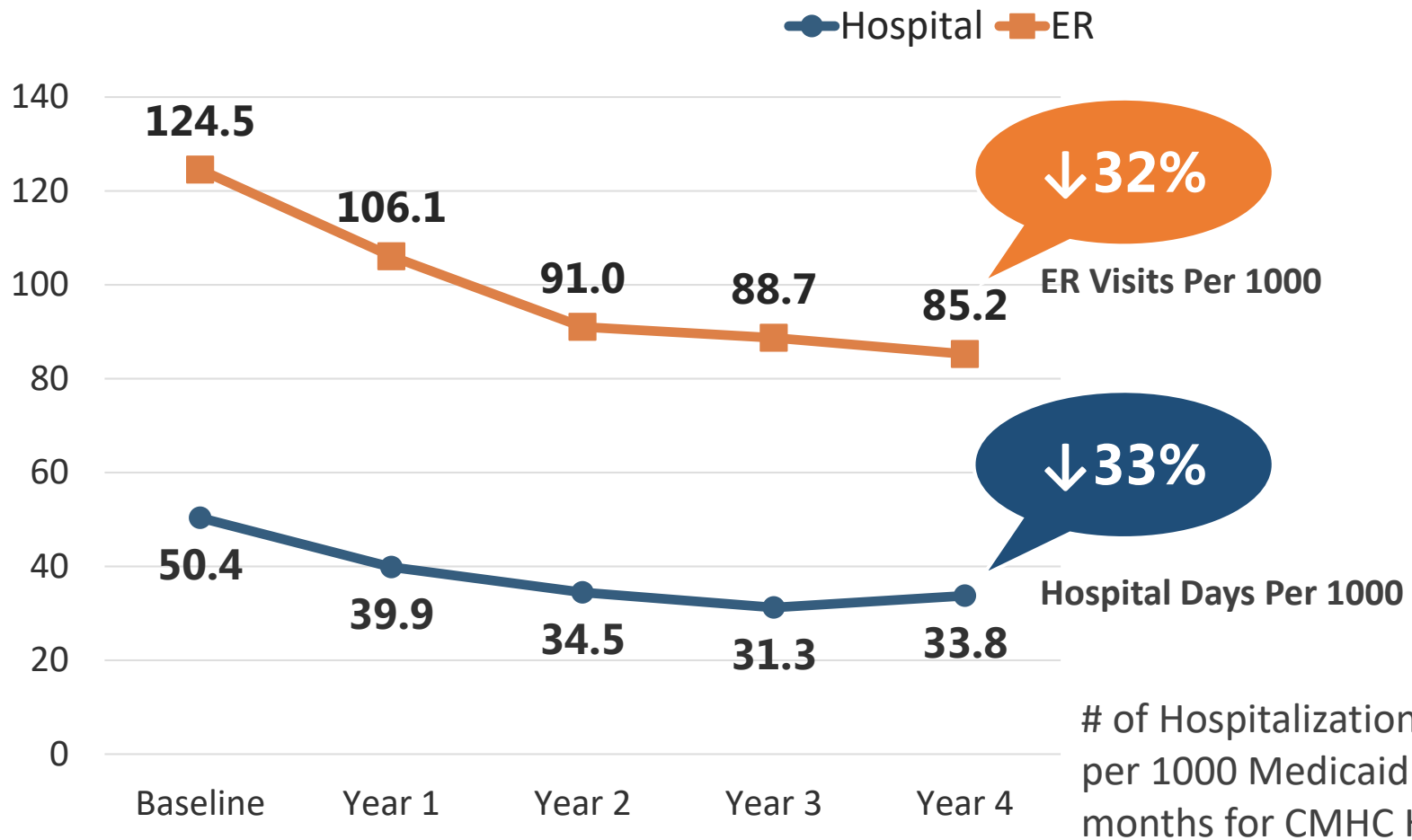


Includes all CMHC Health Home participants who had at least 12 months Medicaid in the measurement year

ABHA CELEBRATING 20 YEARS ALASKA BEHAVIORAL HEALTH ASSOCIATION

BHECON Behavioral Health + Economics Network

Hospital & ER Days per 1,000



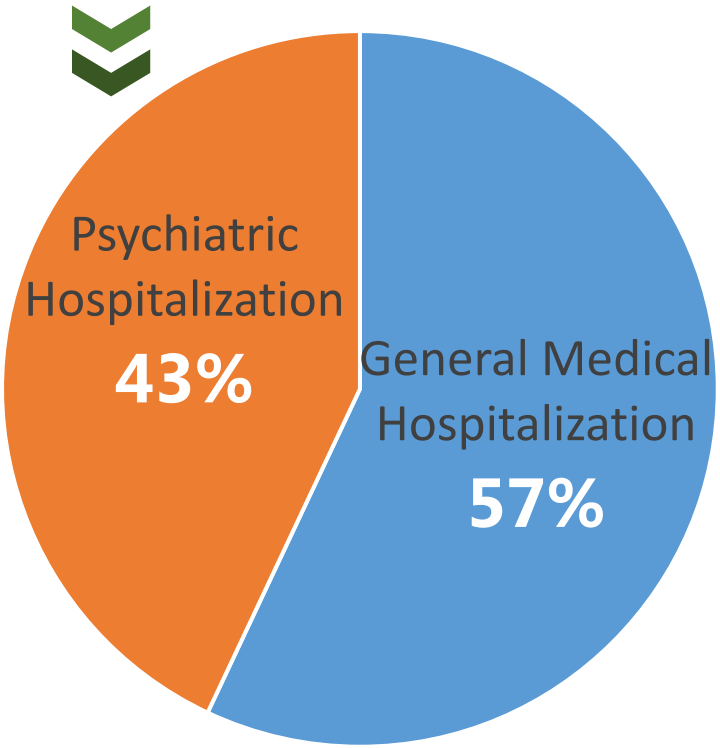
# of Hospitalizations and ER visits per 1000 Medicaid member months for CMHC Health Home participants as of 1.1.17 with at least 12 months HCH services

ABHA CELEBRATING 20 YEARS ALASKA BEHAVIORAL HEALTH ASSOCIATION

BHECON Behavioral Health + Economics Network

2015 CMHC Health Home **Hospital** Encounters

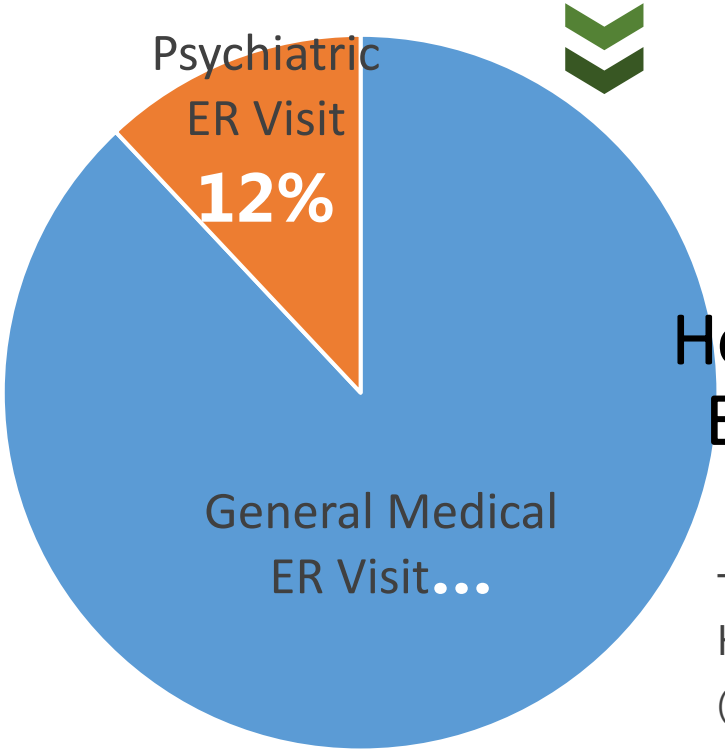
Total N = 7,777



N = # of hospital encounters during CY2015

2015 CMHC Health Home **ER Visit** Encounters

Total N = 44,531



N = # of ER encounters during CY2015

Hospital & ER Encounters

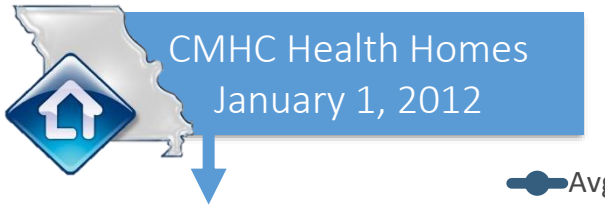
Total CMHC Health Home participants:

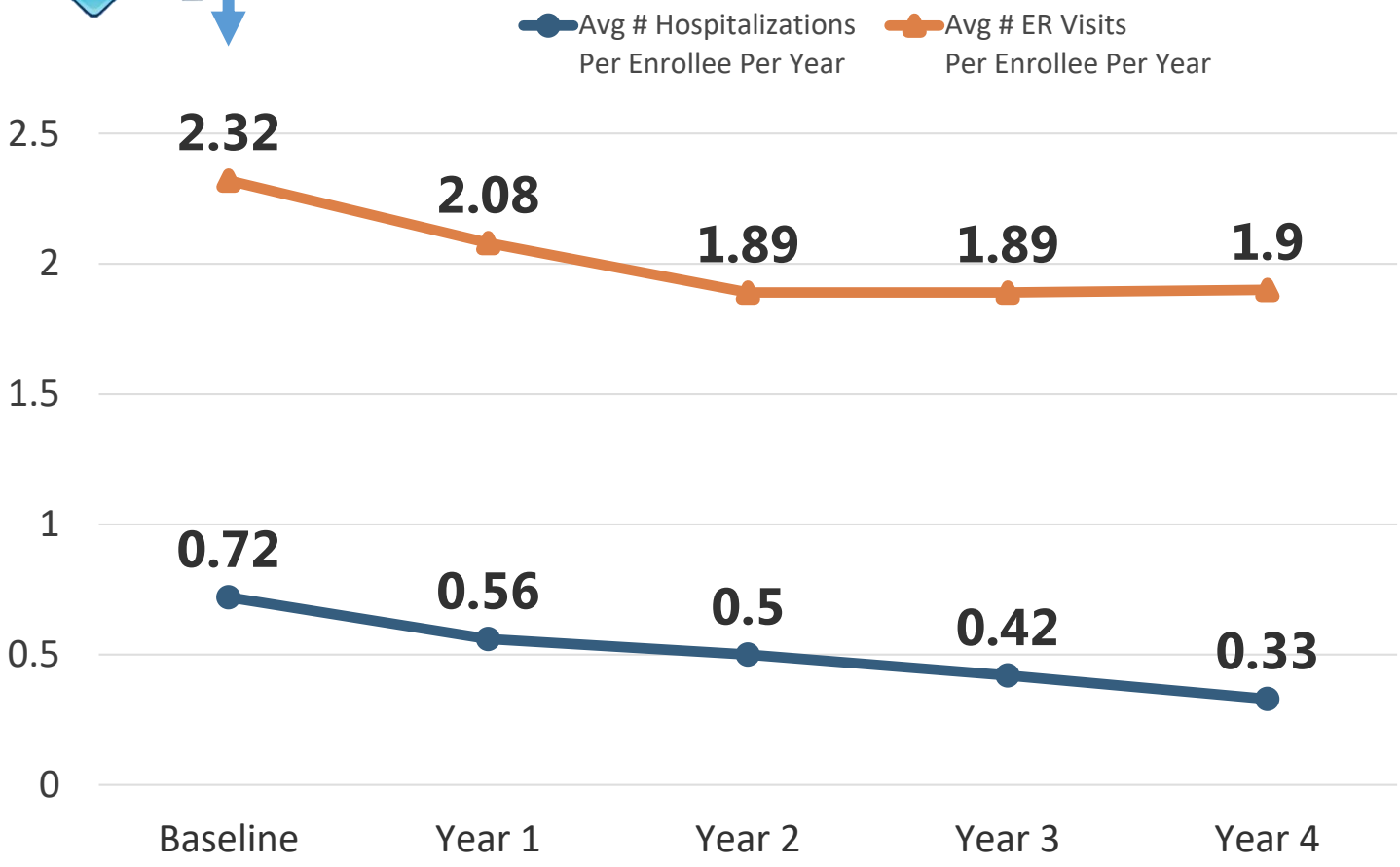
(2015) = 23,326

ABHA CELEBRATING 20 YEARS ALASKA BEHAVIORAL HEALTH ASSOCIATION

BHECON Behavioral Health + Economics Network

Average # Hospital & ER Encounters





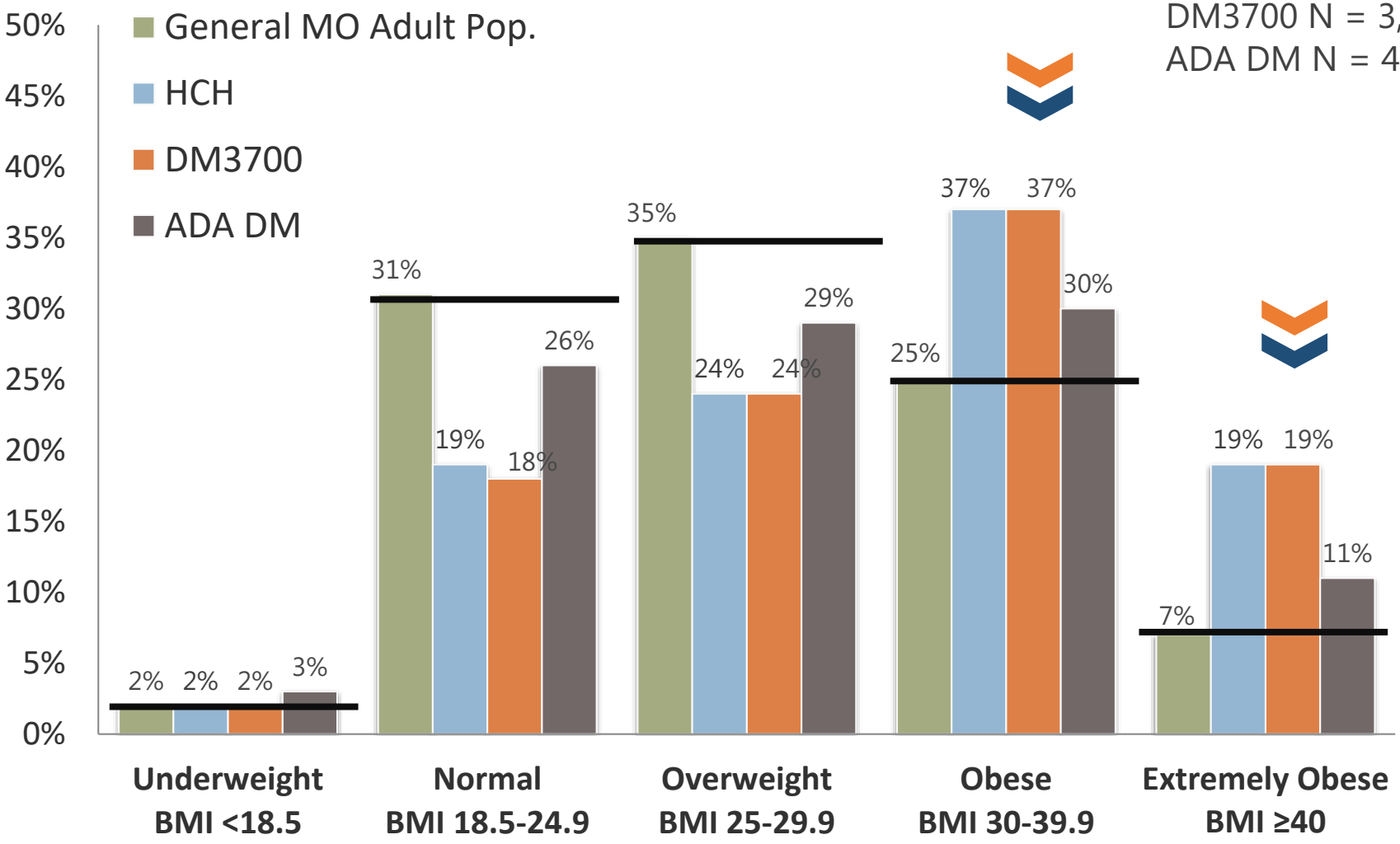
Total CMHC Health Home participants:
(2011) = 17,975
(2012) = 18,034
(2013) = 18,476
(2014) = 20,343
(2015) = 23,326

ABHA CELEBRATING 20 YEARS ALASKA BEHAVIORAL HEALTH ASSOCIATION

BHECON Behavioral Health + Economics Network

Body Mass Index (BMI) & Obesity

CMHC Health Home participants Jan 2017
HCH Adults N = 25,290
DM3700 N = 3,163
ADA DM N = 485



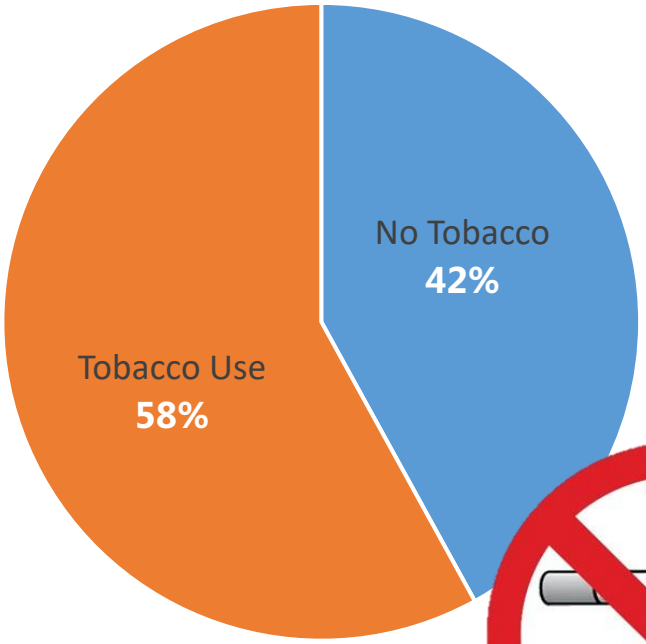
ABHA CELEBRATING 20 YEARS ALASKA BEHAVIORAL HEALTH ASSOCIATION

BHECON Behavioral Health + Economics Network

Tobacco Use

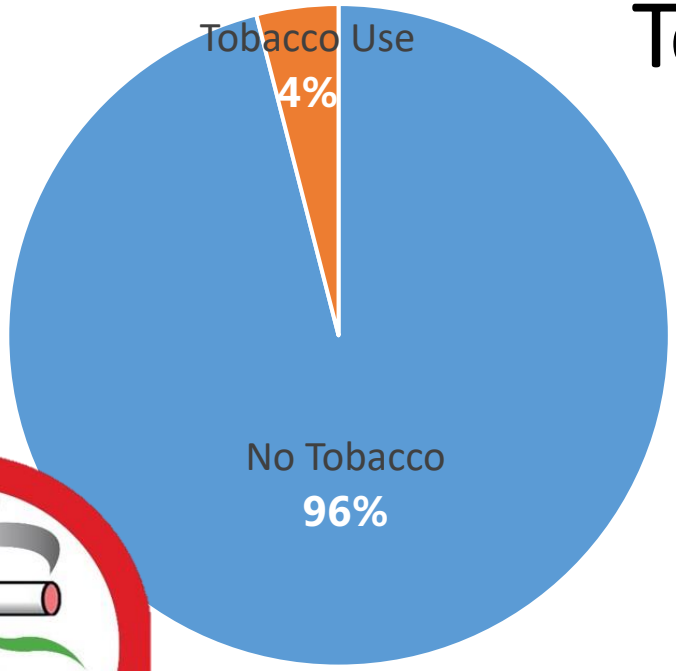
Adult Tobacco Use

Total N = 23,768



Youth Tobacco Use

Total N = 5,156



Total CMHC Health Home participants as of Jan 2017

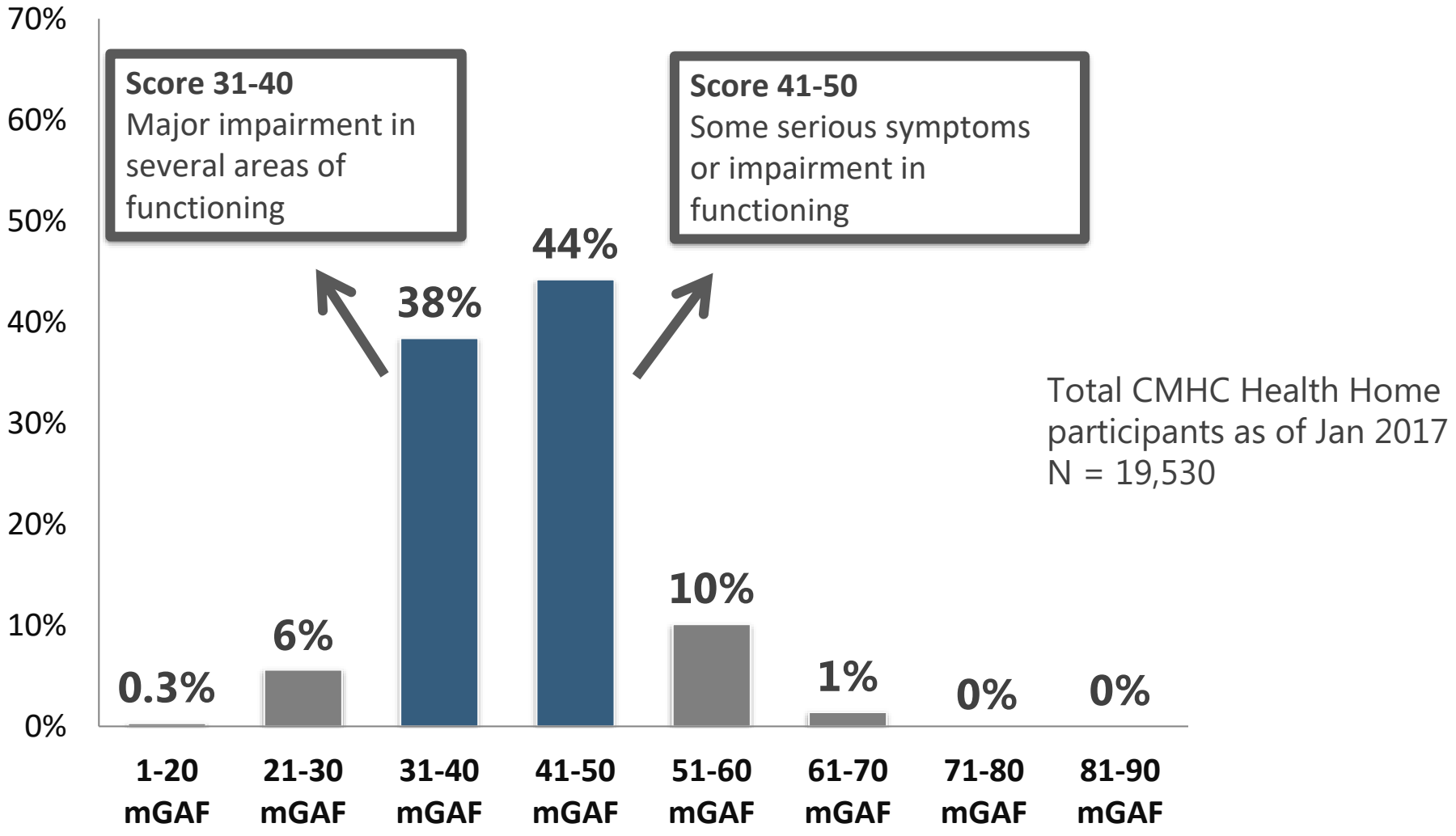
Adult N = 23,768

Youth N = 5,156

ABHA CELEBRATING 20 YEARS ALASKA BEHAVIORAL HEALTH ASSOCIATION

BHECON Behavioral Health + Economics Network

Daily Living Activities (DLA-20) Assessment



Total CMHC Health Home participants as of Jan 2017
N = 19,530

ABHA CELEBRATING 20 YEARS ALASKA BEHAVIORAL HEALTH ASSOCIATION

BHECON Behavioral Health + Economics Network

Disease Management

Performance Measures & Outcomes

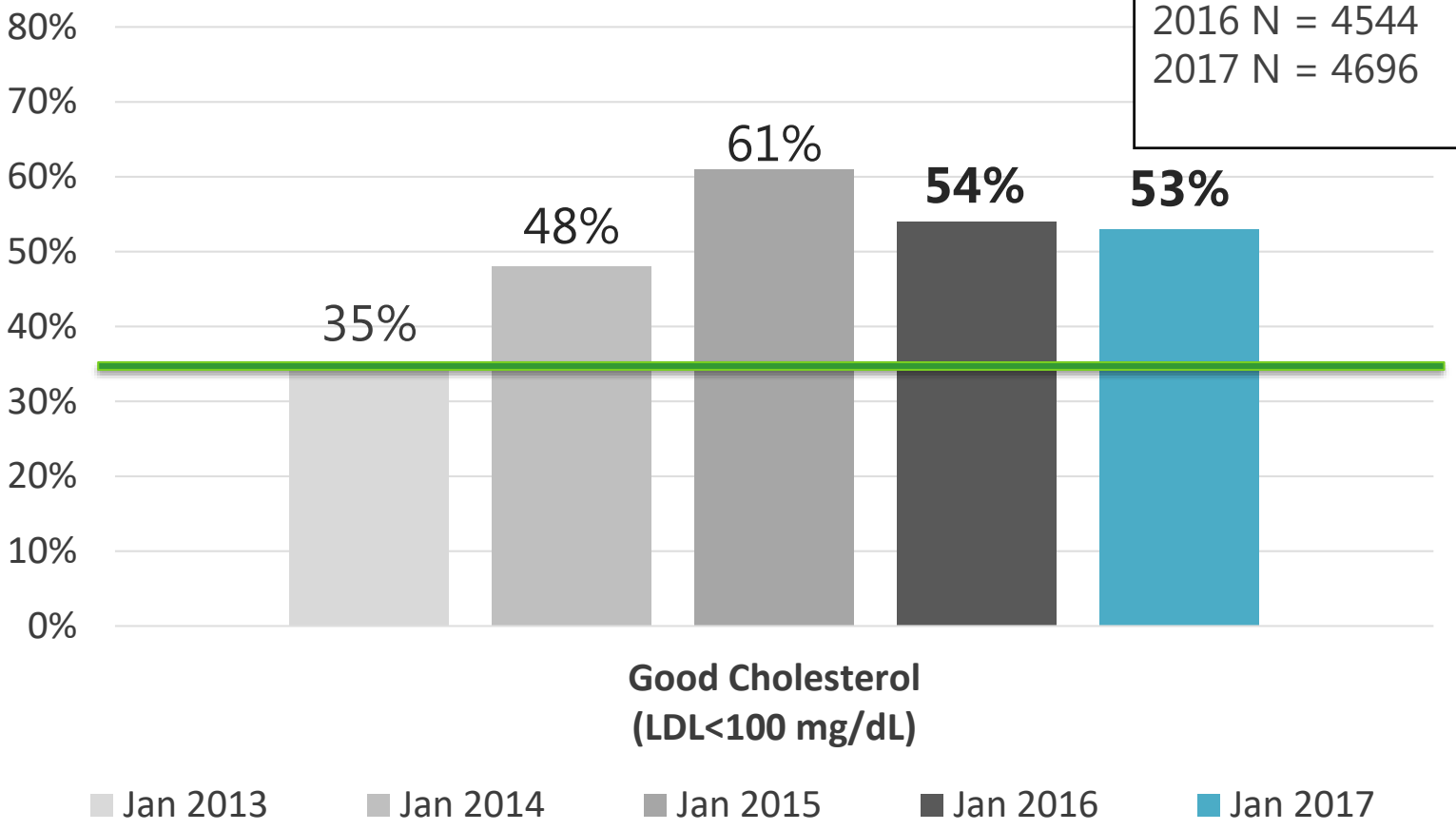
ABHA CELEBRATING 20 YEARS ALASKA BEHAVIORAL HEALTH ASSOCIATION

BHECON Behavioral Health + Economics Network

Diabetes

Good Cholesterol

CMHC Health Home participants enrolled as of Jan 1st
2013 N = 4362
2014 N =4139
2015 N =4354
2016 N = 4544
2017 N = 4696

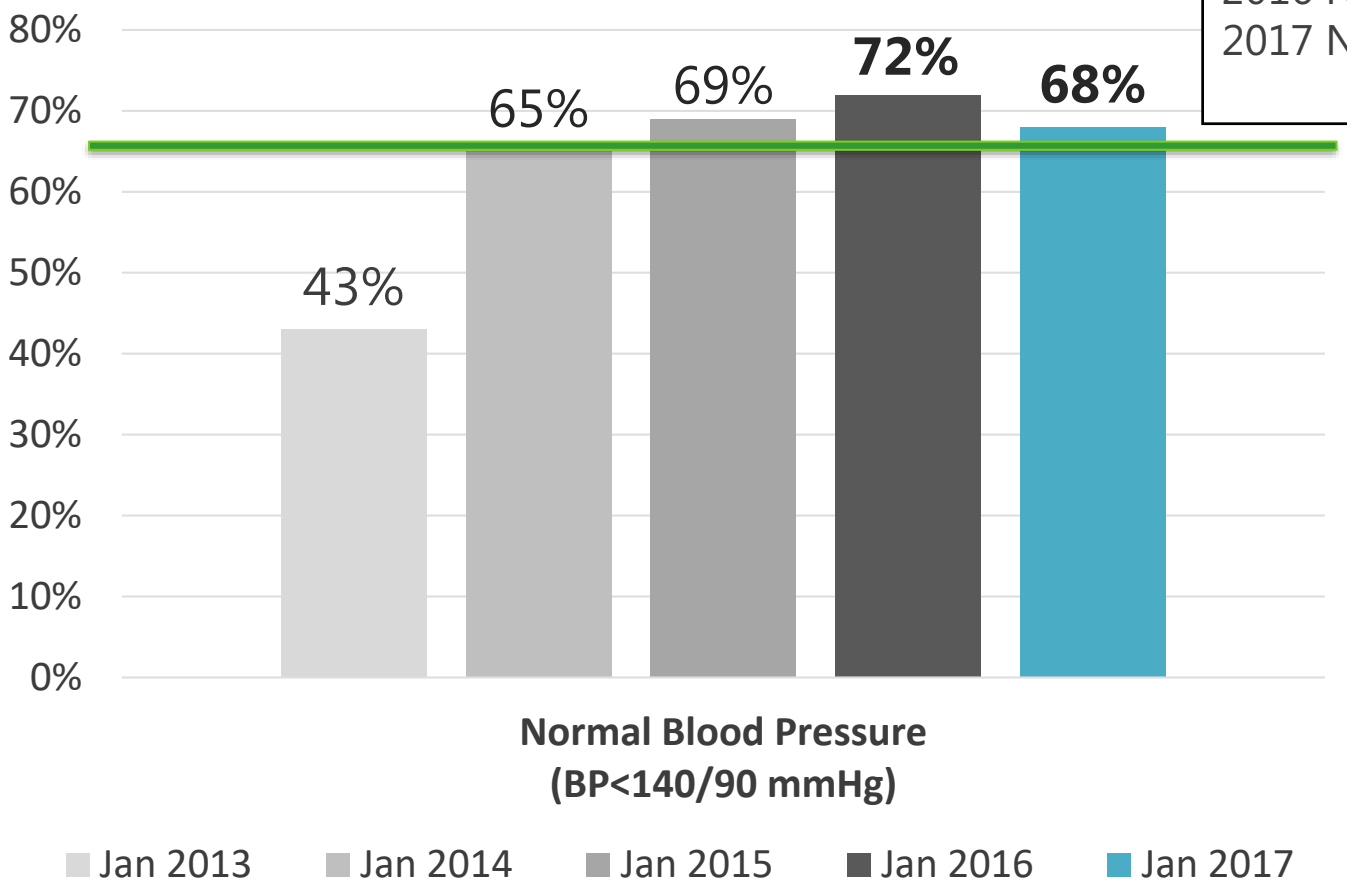


Diabetes

Blood Pressure

Adult HCH

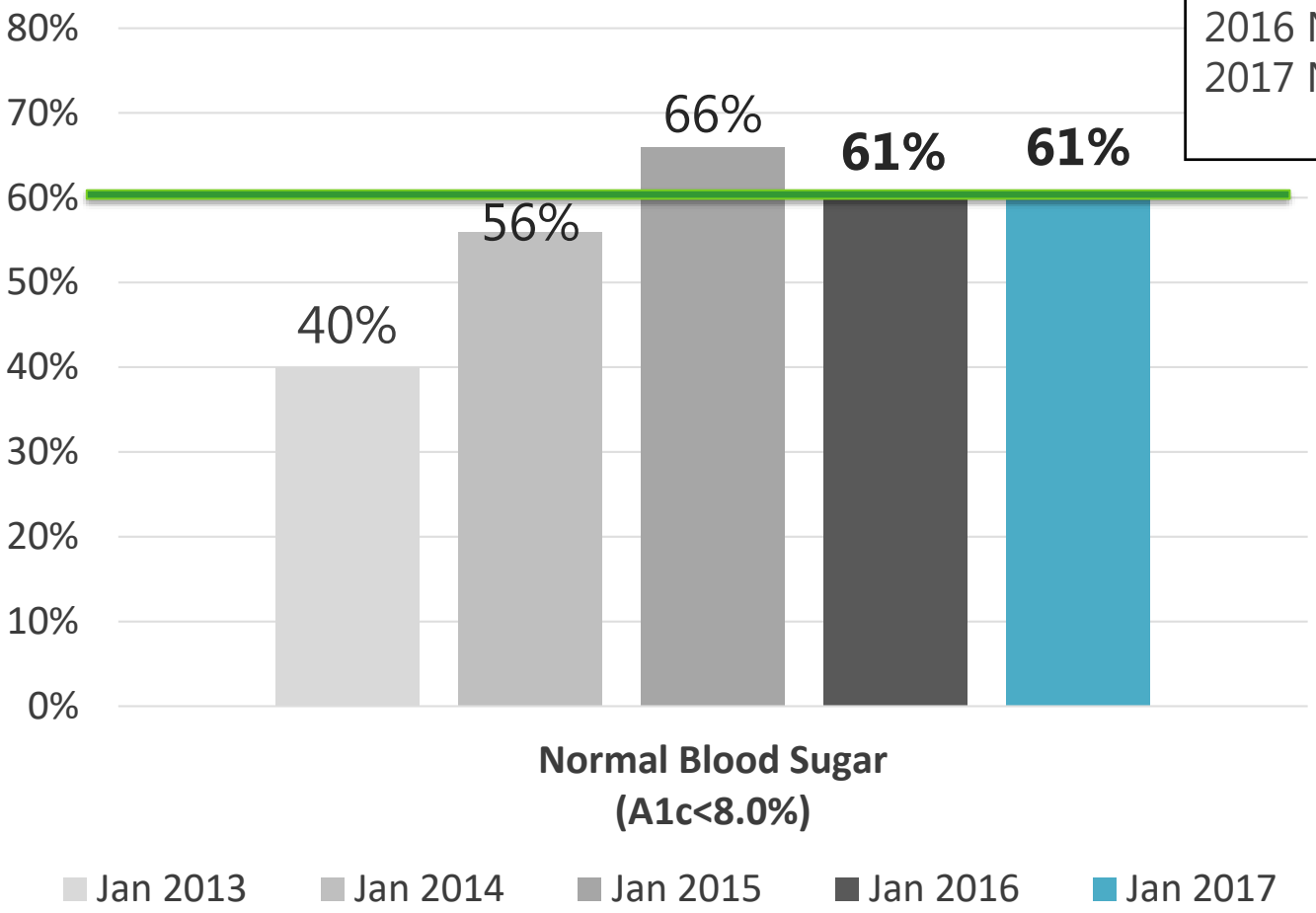
CMHC Health Home participants enrolled as of Jan 1st
2013 N = 4362
2014 N =4139
2015 N =4354
2016 N = 4544
2017 N = 4696



Diabetes

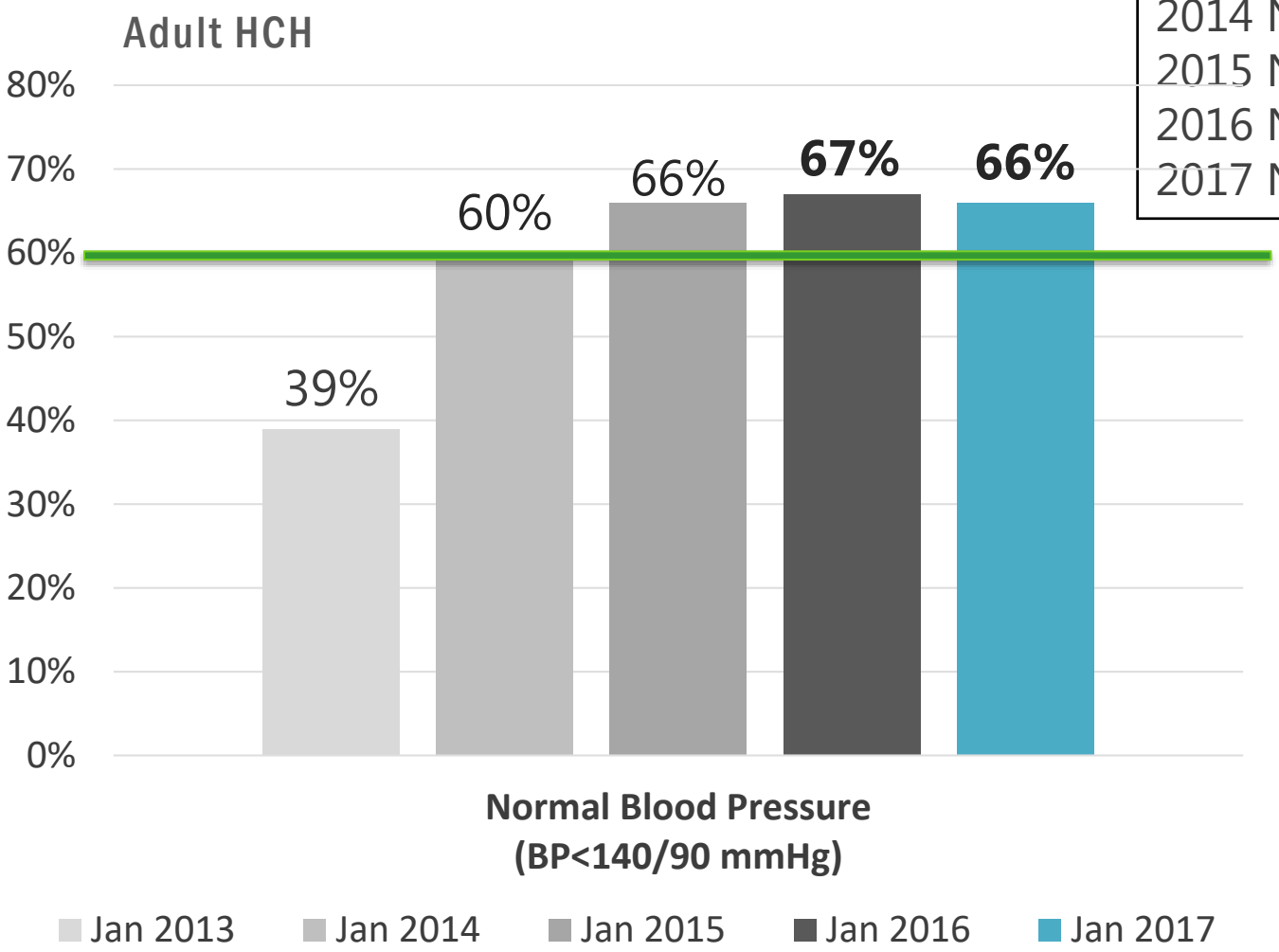
A1c

CMHC Health Home participants enrolled as of Jan 1st
2013 N = 4362
2014 N =4139
2015 N =4354
2016 N = 4544
2017 N = 4696



Hypertension

Blood Pressure

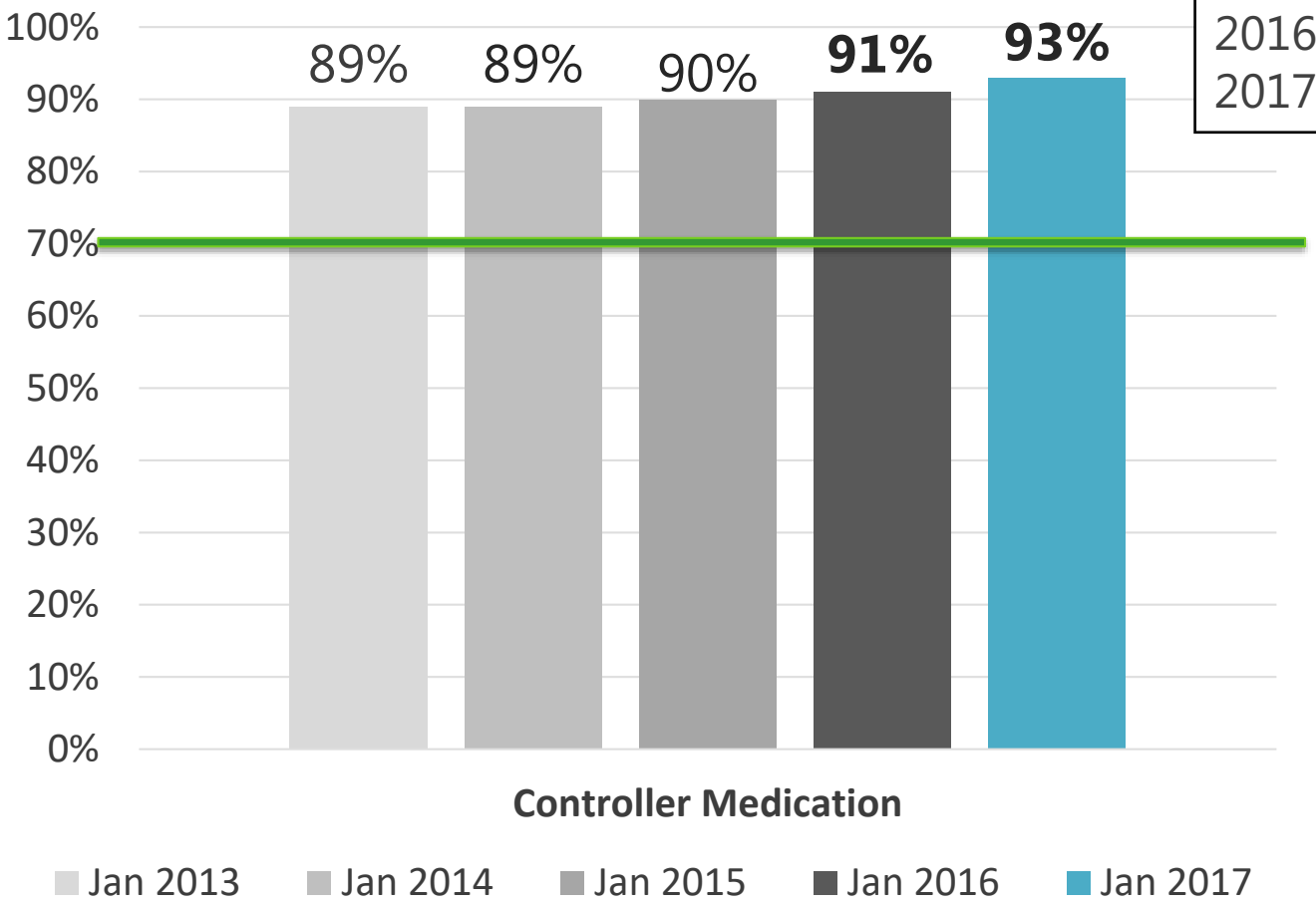


CMHC Health Home participants enrolled as of Jan 1st
2013 N = 5813
2014 N =5481
2015 N =5841
2016 N = 6170
2017 N = 6621

Asthma

Medication

Adult HCH



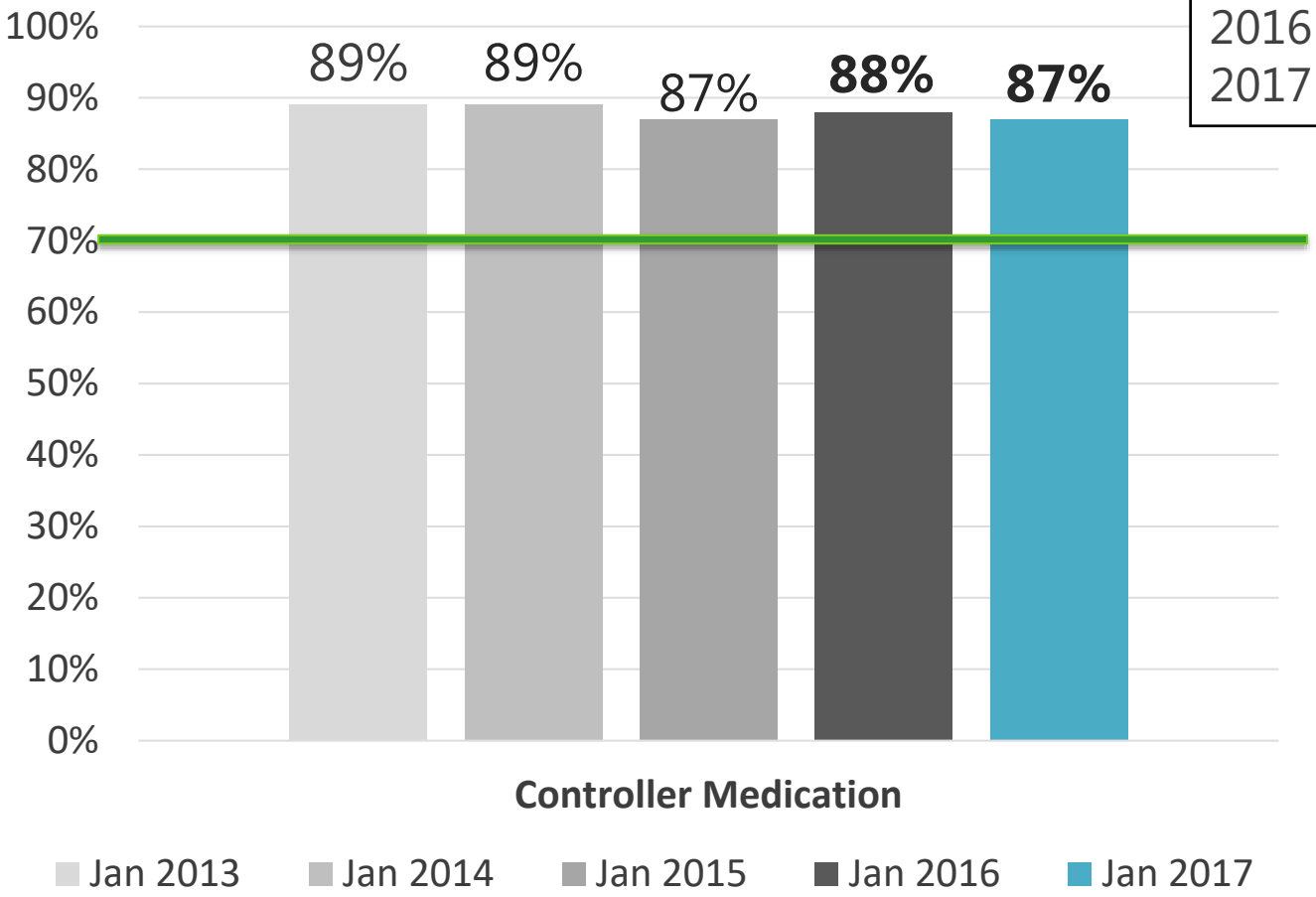
CMHC Health Home participants enrolled as of Jan 1st
2013 N = 3839
2014 N =3623
2015 N =3691
2016 N = 4244
2017 N = 6582

Asthma

Medication

Youth HCH

CMHC Health Home participants enrolled as of Jan 1st
2013 N = 533
2014 N =402
2015 N =426
2016 N = 530
2017 N = 680



ABHA CELEBRATING 20 YEARS ALASKA BEHAVIORAL HEALTH ASSOCIATION

BHECON Behavioral Health + Economics Network

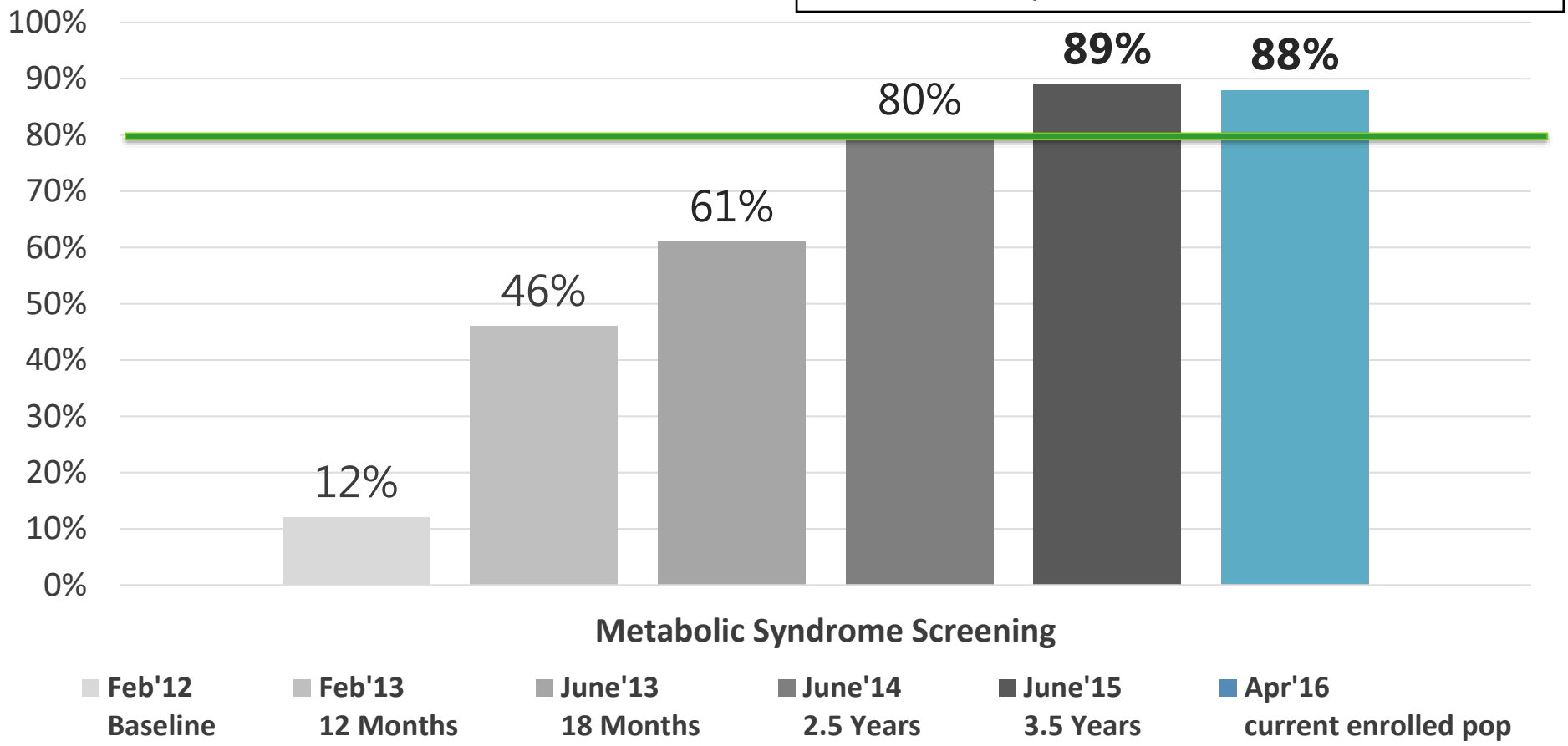
Metabolic Syndrome Screening

All CMHC Health Homes have attained a completion rate above 80%!

State Performance Rate at 90%!

N = 6,553 (3.5 yr. enrollment)

N = 21,407 (Apr 2016)

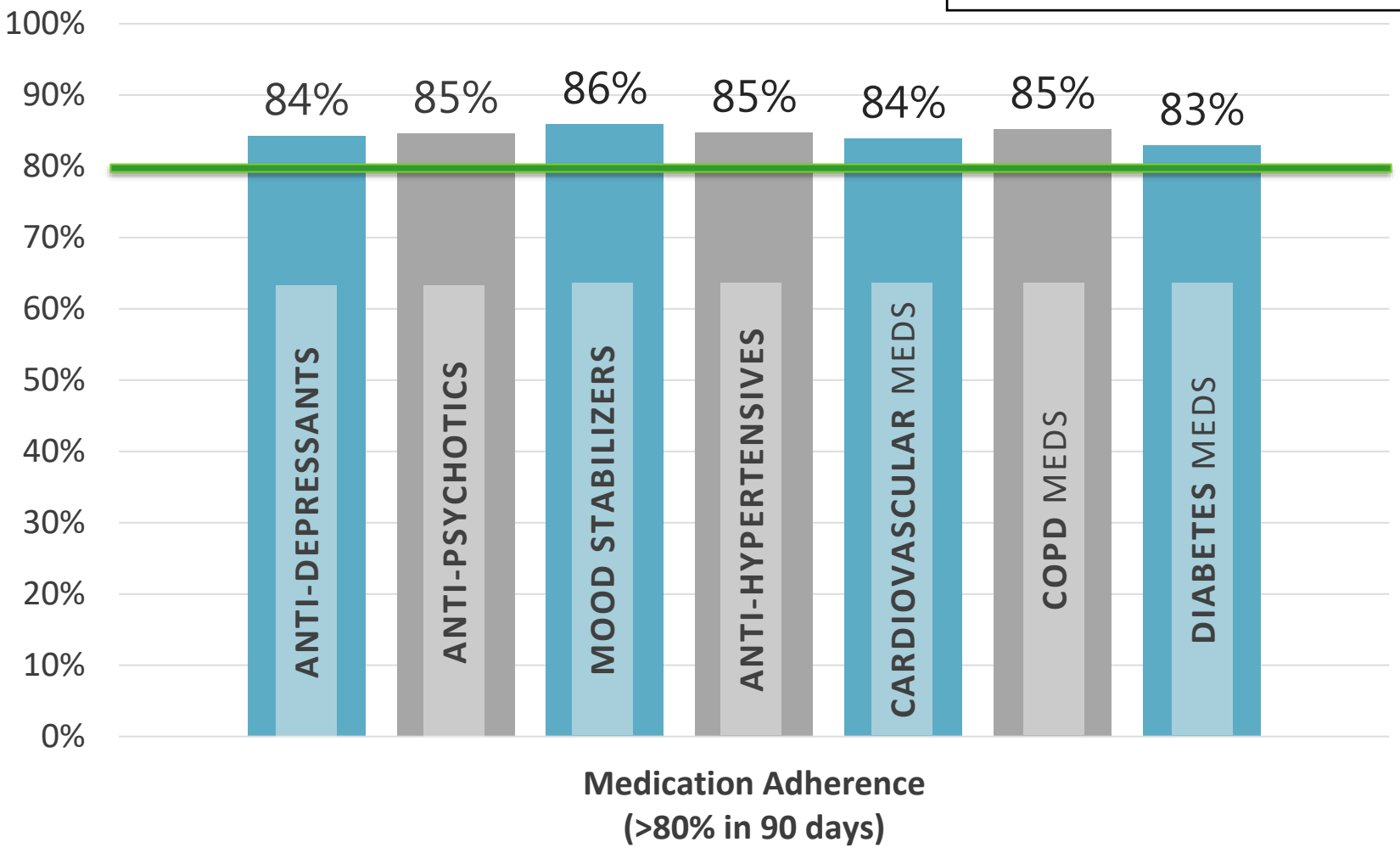


ABHA CELEBRATING 20 YEARS ALASKA BEHAVIORAL HEALTH ASSOCIATION

BHECON Behavioral Health + Economics Network

Medication Adherence

CMHC Health Home participants enrolled as of April 2016
N = 16,900



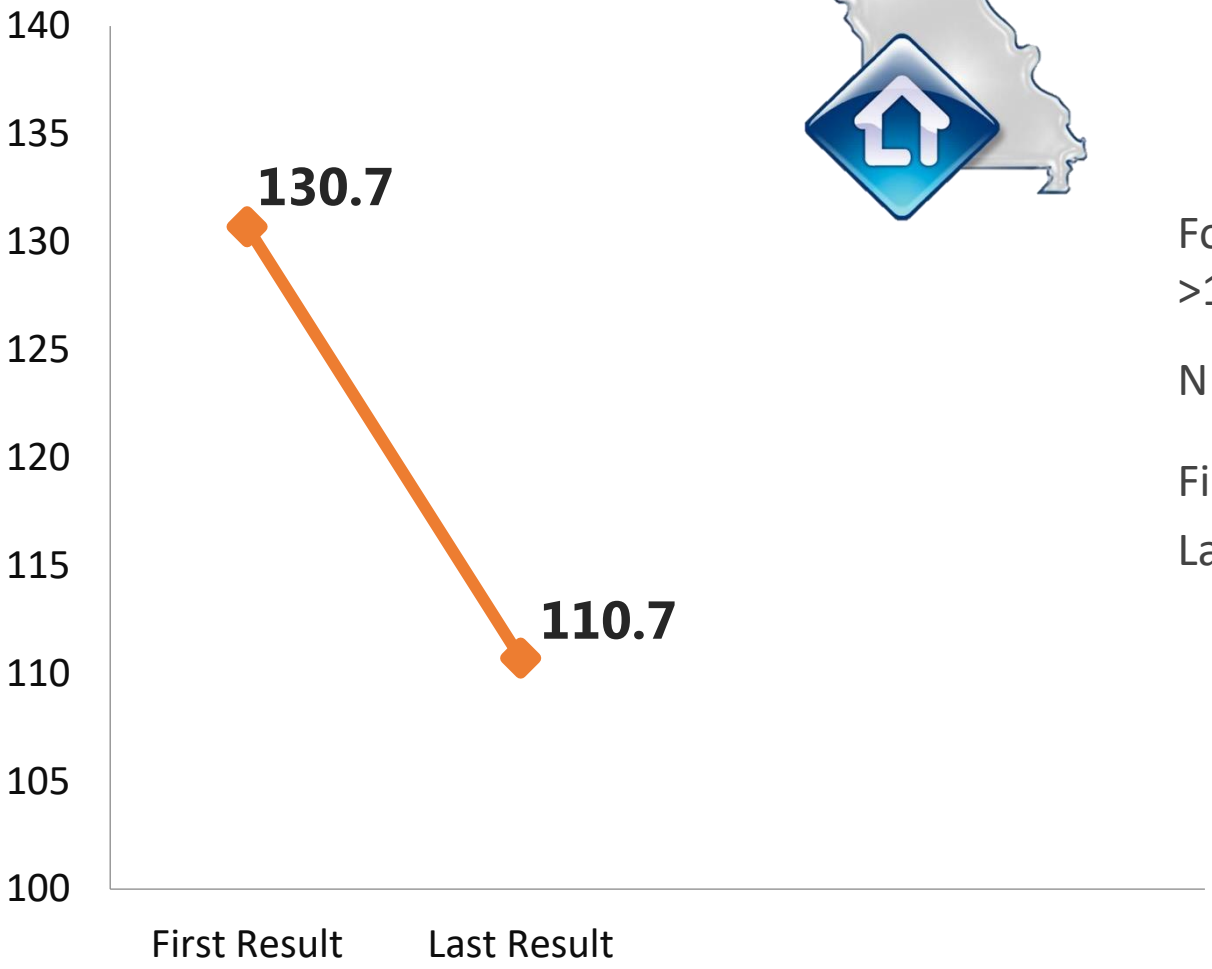
small changes make a

BIG DIFFERENCE

Small Changes » Big Difference

Cholesterol ↓10%	**10% ↓ in cardiovascular disease**
Blood pressure ↓ 6mm/Hg	**16% ↓ in cardiovascular disease** **42% ↓ in stroke**
Triglycerides ↓10 mm/L	**5% ↓ in cardiovascular disease**
HbA1c ↓ 1 pt	**21% ↓ in diabetes related deaths** **14% ↓ in heart attacks** **37% ↓ in microvascular complications**

Improving uncontrolled cholesterol



For individuals with LDL >100 at initial test result

N = 6,721

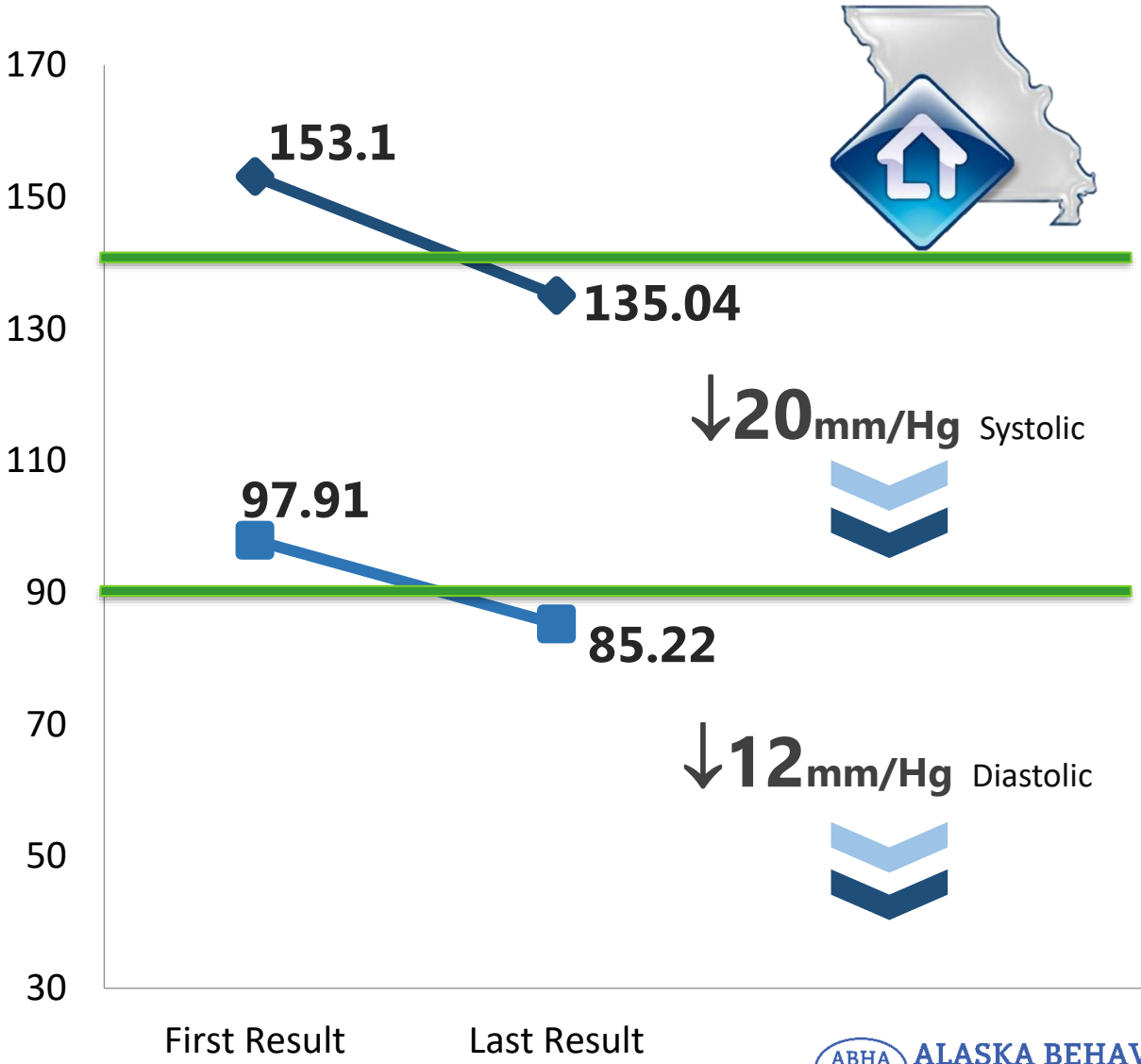
First Result: **130.7**

Last Result: **110.7**

ABHA CELEBRATING 20 YEARS ALASKA BEHAVIORAL HEALTH ASSOCIATION

BHECON Behavioral Health + Economics Network

Improving uncontrolled blood pressure



For individuals with SBP >140 and DBP > 90 at initial test result

SBP N = 2,659
DBP N = 2,326

SBP First Result: **153.1**

SBP Last Result: **135.04**

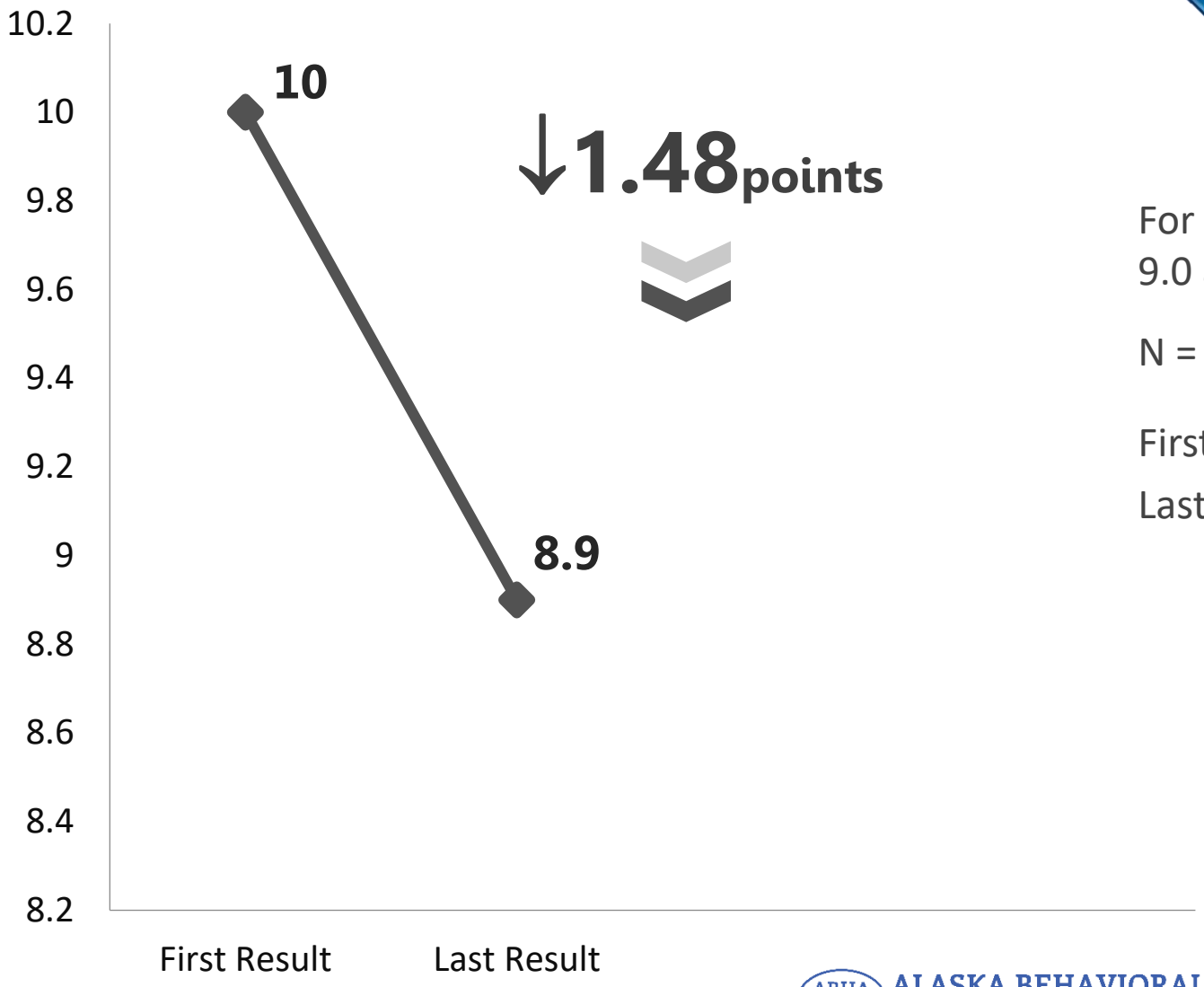
DBP First Result: **97.91**

DBP Last Result: **85.22**

ABHA CELEBRATING 20 YEARS ALASKA BEHAVIORAL HEALTH ASSOCIATION

BHECON Behavioral Health + Economics Network

Improving uncontrolled A1c



For individuals with A1c > 9.0 at initial test result

N = 909

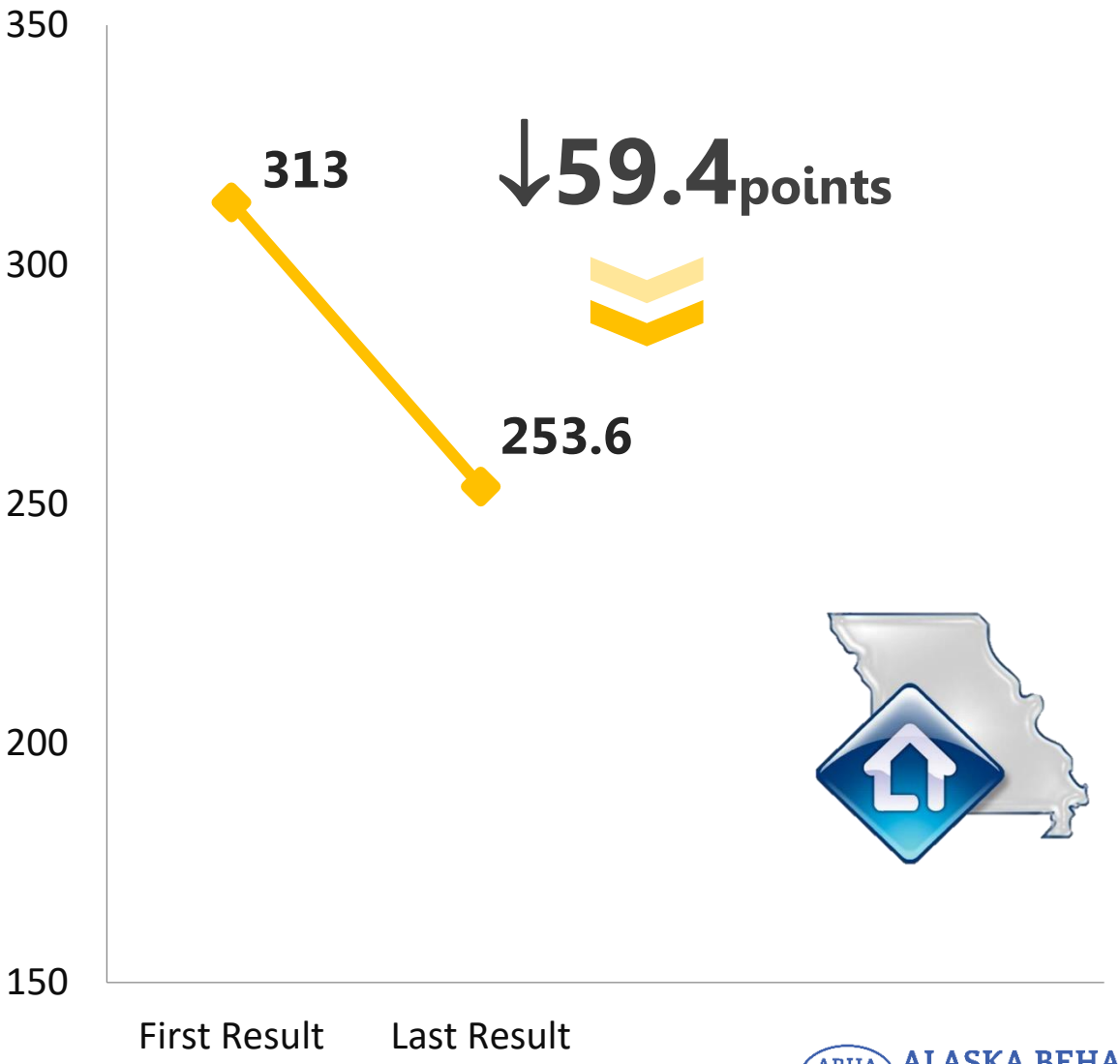
First Result: **10**

Last Result: **8.9**

ABHA CELEBRATING 20 YEARS ALASKA BEHAVIORAL HEALTH ASSOCIATION

BHECON Behavioral Health + Economics Network

Improving uncontrolled Triglycerides



For individuals with A1c > 9.0 at initial test result

N = 4,718

First Result: **313**

Last Result: **253.6**

ABHA CELEBRATING 20 YEARS ALASKA BEHAVIORAL HEALTH ASSOCIATION

BHECON Behavioral Health + Economics Network

The Behavioral Health + Economics Network, known as BHECON (pronounced “beacon”) unites diverse stakeholders in a series of forums to examine and advance policy reforms to strengthen states’ behavioral health delivery systems.

Led by the National Council for Behavioral Health with our state partners, BHECON participants include individuals and organizations recognized for their commitment to improving lives of people living with serious mental illness and incorporates representatives from the behavioral health, criminal justice, and public safety sectors, along with individuals working in the greater medical field.

BHECON has partnered with academic research institutions to provide data and analysis specific to the topics presented at the forums and has curated national data in support of this effort.

BHECON is made possible by generous grants from Alkermes, Genoa Healthcare and the New York Community Trust.