QI Collaborative’s 4th Annual Medicaid Payment Reform Summit

“Towards a more patient-centered, data-driven Medicaid health system”

October 9, 2015
See, they aren’t unicorns! (Building an ACO)

Jeffrey Brenner, MD
Executive Director
“The accountable care organization is like a unicorn, a fantastic creature that is vested with mythical powers. But no one has actually seen one.”

Mark Smith, M.D., M.B.A.,
Former President and CEO of the California Healthcare Foundation
SENATE, No. 2443

STATE OF NEW JERSEY

214th LEGISLATURE

INTRODUCED DECEMBER 6, 2010

Sponsored by:
Senator JOSEPH F. VITALE
District 19 (Middlesex)

SYNOPSIS
Establishes Medicaid Accountable Care Organization Demonstration Project in DHS.

CURRENT VERSION OF TEXT
As introduced.
Clinical Redesign Activities

Seven Day Pledge

ASK YOUR DOCTOR FOR A 7 DAY APPOINTMENT.

CAMDEN COALITION OF HEALTHCARE PROVIDERS
AND NICHOLSON FOUNDATION COLLABORATION

7 DAY PLEDGE

Seeing your primary care provider within 7 days of hospital discharge can help with:

- Answering any questions about your new medications or health conditions
- Getting additional services you need to stay healthy
  AND
- Preventing you from going back to the hospital!

Seeing your doctor is an important part of recovery! The next time you leave the hospital, make sure to ask your primary care provider for an appointment within 7 days.

ASK YOUR DOCTOR ABOUT THE 7 DAY PLEDGE.
Clinical Redesign Activities
Seven Day Pledge

An initiative to reduce hospital readmissions.
ACO Provider Dinners
Clinical Redesign Activities
Seven Day Pledge
Clinical Redesign Activities

ACO Incentive Plan

• **Practice incentive**
  - **$150** payment for each 30 minute post-hospital follow-up PCP visit within 7 days of discharge
  - **$100** payment for each 30 minute post-hospital follow-up PCP visit within 14 days of discharge

• **Patient incentive**
  - **Cab voucher** to and from post-hospital follow-up PCP visits for patients (given at hospital bedside)
  - **$20 Visa gift card** for patients upon completion of post-hospital follow-up PCP visit (if within 14 days)

• **Other incentives**
  - Patient satisfaction surveys $500
  - 2 practice work sessions $1,000
  - 4 quality improvement dinners (provider/staff incentivized)
  - Approved QI plan $2,500
January Inpatients by Practice

The 7-Day Pledge
February Inpatients by Practice
March Inpatients by Practice

The 7-Day Pledge
The 7-Day Pledge

April Inpatients by Practice

The chart shows the distribution of April inpatients by practice, with different percentages for each practice.
May Inpatients by Practice

The 7-Day Pledge
June Inpatients by Practice

The 7-Day Pledge
August Inpatients by Practice

The 7-Day Pledge
Camden Coalition ACO Dollars Earned: all 7-14 day visits

![Bar graph showing the amount of dollars earned in 2015 for 7-14 day visits, with the highest amount in April 2015 at $21,800 and the lowest in November 2014 at $4,950.]

The 7-Day Pledge
Additional Minutes Spent with Patients

The 7-Day Pledge

- January 2015: 810 minutes
- February 2015: 840 minutes
- March 2015: 2,235 minutes
- April 2015: 2,385 minutes
- May 2015: 2,310 minutes
- June 2015: 2,160 minutes
- July 2015: 2,250 minutes
- August 2015: 2,475 minutes

Total additional time spent with patients in 2015: 10,620 minutes
Triage
Bedside Engagement
Initial Care Planning

Questions for My Care Team...
- Birth Certificate
- Social Security Card
- Non-drivers N.J. I.D.
- Housing
- Schooling
- Employment
- Addictions Support
- Medication Support
- Transportation
- Phone Communication
- Clothing
- Food - Welfare
Accompaniment
Navigation
Monthly Care Management Meetings
From book by Elizabeth Bradley and Lauren Taylor- *The American Health Care Paradox: Why Spending More is Getting Us Less*
Housing is the best pill...
Staff Training in Behavioral Health
Camden Coalition of Healthcare Providers

Mental Disorder
n = 53

Mental Disorder + Substance Abuse
n = 36

Substance Abuse Only
N = 3

Mental Health Only
n = 17

68%
205 individuals were identified to be cross sector high utilizers (10+ ED visits & 6+ police encounters).
Who are Cross Sector High Utilizers?

205 individuals
Median Age: 38

- **Gender**: 70% Male
- **Violent**: 39%
- **Disorderly**: 89%
- **Drug**: 61%
- **Substance Abuse**: 77%
- **Behavioral Health**: 54%
- **Homelessness**: 41%

Types of Police Charges

Socio-behavioral destabilizers
Median Age: 44

- Averaged 11 police encounters, 27 ED visits, 2 inpatient admissions
- Average hospital charges 2010-2012: $144,930
- 66% had at least one assault-related hospital visit over 2010-2012
Typologies

Predominately drug involved with some history of violent crime n=23 (11%)

- Median Age: 38
- Averaged 8 police encounters, 21 ED visits, 1 inpatient admission
- Average hospital charges 2010-2012: $122,064
- 70% had at least one assault-related hospital visit over 2010-2012
Median Age: 34

- Averaged 12 police encounters, 24 ED visits, 2 inpatient admissions
- Average hospital charges 2010-2012: $103,218
- 50% had at least one assault-related hospital visit over 2010-2012
Men with a history of violent crime
n=43 (21%)

Median Age: 32

- Average 11 police encounters, 17 ED visits, 1 inpatient admission
- Average hospital charges 2010-2012: $83,551
- 72% had at least one assault-related hospital visit over 2010-2012
Typologies

Homeless (n=37)

- Average 18 police encounters, 34 ED visits, 3 inpatient admissions
- Average hospital charges 2010-2012: $225,980
- 64% had at least one assault-related hospital visit over 2010-2012
Camden Coalition

- Health Information Exchange
- High Utilizer Outreach Team
- Primary Care Redesign
- Citywide Membership Non-profit
- Cross-Site Learning and Workforce Development
- Advocacy and Policy Change
- Research and Performance Improvement
Population Health

Better care at lower cost for everyone everyday
Standardization

**EARLY AUTO WORKSHOP**
• non-standard product
• high cost, poor quality

**EARLY ASSEMBLY LINE**
• standardized work
• lower costs & higher quality

**MODERN ASSEMBLY LINE**
• team-based work
• automation
• delegation
• standardization
• lower cost & high quality
The most important problem to address...

Research Article

Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults
The Adverse Childhood Experiences (ACE) Study

Vincent J. Felitti, MD, FACP, Robert F. Anda, MD, MS, Dale Nordenberg, MD, David F. Williamson, MS, PhD, Alison M. Spitz, MS, MPH, Valerie Edwards, BA, Mary P. Koss, PhD, James S. Marks, MD, MPH
2015 Student Hotspotters

- 20 different communities with teams of 5 students
- 100 + health professions students in medical, social work, public health, nursing, business, dental school
- Caring for 3-5 outlier patients
- Collaboration with American Assoc. of Medical Colleges and Primary Care Progress
QI Collaborative’s 4th Annual Medicaid Payment Reform Summit
“Towards a more patient-centered, data-driven Medicaid health system”
October 9, 2015
Integrated Behavioral Health Care

Jürgen Unützer, MD, MPH, MA
Chair, Psychiatry & Behavioral Sciences
Director, AIMS Center
University of Washington
October 9, 2015
Jürgen Unützer, MD, MPH, MA

Professor & Chair, University of Washington Department of Psychiatry and Behavioral Sciences
Director, AIMS Center: Advancing Integrated Mental Health Solutions
Adjunct Professor, School of Public Health: Departments of Health Services and Global Health

Grant funding

- National Institute of Health (NIMH, NIDA, AHRQ, NLM)
- National Corporation for Community Service (Social Innovation Fund)
- Center for Medicare and Medicaid Innovation Department of Defense (Henry M. Jackson Foundation)
- American Federation for Aging Research (AFAR)
- John A. Hartford Foundation
- Alaska Mental Health Trust Authority
- George Foundation
- PCORI (Patient Centered Outcomes Research Institute)
- American Red Cross (RAND)
- California HealthCare Foundation
- Robert Wood Johnson Foundation
- Hogg Foundation for Mental Health

Contracts

- Community Health Plan of Washington, Public Health -- Seattle & King County
- Washington State Healthcare Authority
- California Institute of Behavioral Health
- Los Angeles County, Santa Clara County, Ventura County, Alameda County
- New York State Department of Health
- Institute for Clinical Systems Improvement

Consultant & Advisor

- Group Health Research Institute
- World Health Organization
- SAMHSA (CMHS)
Key points

• Mental illness and substance use (behavioral health problems) are major drivers of disability & costs.
• Fewer than half of those in need have access to effective specialty behavioral health care.

• Effective integration of behavioral health care with primary care has several advantages:
  • Better access to care
  • Better health outcomes
  • Lower costs

= the Triple Aim of health care reform
Burden of Mental Illness

1 in 4 Americans struggle with a mental health or substance use problem at some point in their lives. No family goes untouched.

Behavioral health disorders cause nearly **25% of all disability worldwide**
Depression alone accounts for 10% of health related disability.

Years Lost to Disability (YLD) from depression =
3x diabetes; 8x heart disease; 40x cancer
(Murray C et al; Global Burden of Disease ; Lancet, 2012)

For governments: high health care costs, high rates of unemployment, homelessness, and involvement in the criminal justice system.

For employers, mental health & substance use problems are
- Major drivers of absenteeism and presenteeism.
- Major drivers of health care costs
Suicide

• One suicide every 15 minutes
• More suicides than homicides or motor vehicle fatalities

Tragedies can be prevented by better access to the right care at the right time!
# High Health Care Costs

<table>
<thead>
<tr>
<th>Population</th>
<th>% with behavioral health diagnosis</th>
<th>PMPM without BH diagnosis</th>
<th>PMPM with BH diagnosis</th>
<th>Increase in total PMPM with BH diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>14%</td>
<td>$ 340</td>
<td>$ 941</td>
<td>276 %</td>
</tr>
<tr>
<td>Medicare</td>
<td>9%</td>
<td>$ 583</td>
<td>$ 1429</td>
<td>245 %</td>
</tr>
<tr>
<td>Medicaid</td>
<td>21%</td>
<td>$ 381</td>
<td>$ 1301</td>
<td>341 %</td>
</tr>
<tr>
<td>All insurers</td>
<td>15%</td>
<td>$ 397</td>
<td>$ 1085</td>
<td>273 %</td>
</tr>
</tbody>
</table>

Mental health specialty care accounts for only 3 % of overall costs. More effectively integrated mental health care could save billions.

* APA Milliman report; Melek et al; 2013
Mental and Medical Disorders are Tightly Linked
e.g., Depression & Diabetes

- Smoking
- Sedentary lifestyle
- Obesity
- Lack of adherence to medical regimens
- Psychophysiologic:
  - ↓ Insulin sensitivity
  - ↑ Autonomic nervous system
  - ↑ Inflammatory markers
  - ↑ Cortisol

- Diabetes and CHD at earlier age
- Poor symptom control
- ↑ Functional impairment
- ↑ Complications of medical illness
- ↑ Mortality

Katon et al. Biol Psychiatry 2003
Access to Care

• Even with insurance, the average wait time is **25 days** to see a mental health specialist.

• **2/3** of primary care providers report poor access to mental health care for their patients.

• Only **1/10** Americans with a substance use disorder receives specialty care.

“We couldn’t get a psychiatrist, but perhaps you’d like to talk about your skin. Dr. Perry here is a dermatologist.”
Of all people living with mental disorders
12% see a psychiatrist
20% see any mental health specialist
40 % get mental health treatment in primary care
Most get no formal treatment.
Mental Health Workforce

- Mental health professionals are concentrated in urban areas.
- More than half of counties in US don’t have a single practicing mental health professional.
“The 50 minute hour”

• Ideal

50 minutes

• Urban US

6 minutes

• Rural US

1.5 minutes

Assuming that 3% of population could benefit from psychiatric care.

Talk fast!
Poor Quality of Care

• ~ 30 million people receive a prescription for a psychiatric medication in primary care each year; only 25% improve.

• Patients with serious mental illness die 10 – 20 years earlier due to poor medical care.

“Of course you feel great. These things are loaded with antidepressants.”
How do we close the gap?

- Train and retain more mental health professionals
- Work smarter: leverage mental health professionals through
  - Partnerships (e.g., primary care)
  - Technology
Task sharing.

“You have no idea how much lunch there is.”
Collaborative Care

Primary Care Practice
- Primary Care Provider
- Patient
  + Mental Health Care Manager
  + Psychiatric Consultant

Outcome Measures

Treatment Protocols

Population Registry

Psychiatric Consultation
Evidence Base

More than 80 randomized controlled trials have shown Collaborative Care to be more effective than usual care for common mental health conditions such as depression and anxiety.

First demonstrated in the IMPACT Trial
Collaborative Care doubles effectiveness of depression care

50% or greater improvement in depression at 12 months

Unützer et al., JAMA 2002; Psych Clin NA 2004
Collaborative care improves physical function

SF-12 Physical Function Component Summary Score (PCS-12)

Callahan et al., *JAGS* 2005; 53:367-373
Collaborative care reduces health care costs
ROI: $ 6.5 saved / $ 1 invested

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>4-year costs in $</th>
<th>Intervention group cost in $</th>
<th>Usual care group cost in $</th>
<th>Difference in $</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPACT program cost</td>
<td></td>
<td>522</td>
<td>0</td>
<td>522</td>
</tr>
<tr>
<td>Outpatient mental health costs</td>
<td>661</td>
<td>558</td>
<td>767</td>
<td>-210</td>
</tr>
<tr>
<td>Pharmacy costs</td>
<td>7,284</td>
<td>6,942</td>
<td>7,636</td>
<td>-694</td>
</tr>
<tr>
<td>Other outpatient costs</td>
<td>14,306</td>
<td>14,160</td>
<td>14,456</td>
<td>-296</td>
</tr>
<tr>
<td>Inpatient medical costs</td>
<td>8,452</td>
<td>7,179</td>
<td>9,757</td>
<td>-2578</td>
</tr>
<tr>
<td>Inpatient mental health / substance abuse costs</td>
<td>114</td>
<td>61</td>
<td>169</td>
<td>-108</td>
</tr>
<tr>
<td>Total health care cost</td>
<td><strong>31,082</strong></td>
<td><strong>29,422</strong></td>
<td><strong>32,785</strong></td>
<td><strong>-$3363</strong></td>
</tr>
</tbody>
</table>

Unützer et al., *Am J Managed Care* 2008
Collaborative Care achieves
The Triple Aim of health care reform

- Better care experience
  - Access to care
  - Satisfaction

- Better clinical outcomes
  - Less depression
  - Less physical pain
  - Better functioning

- Lower health care costs

"I got my life back"
Replication studies show: the model is ‘robust’

<table>
<thead>
<tr>
<th>Clinical Setting</th>
<th>Target Clinical Conditions</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care for Adolescents</td>
<td>Adolescent Depression</td>
<td>Richardson 2009, 2014</td>
</tr>
<tr>
<td>Adult primary care</td>
<td>Depression &amp; Diabetes Depression, Diabetes, Heart Disease</td>
<td>Katon et al., 2004, Katon et al, 2010</td>
</tr>
<tr>
<td>Latino patients in safety net clinics</td>
<td>Diabetes and depression</td>
<td>Gilmer et al., 2008, Ell et al, 2010</td>
</tr>
<tr>
<td>Public sector oncology clinic</td>
<td>Cancer and depression</td>
<td>Ell et al, 2010</td>
</tr>
<tr>
<td>Women’s health care clinics (IDAWN)</td>
<td>Depression, PTSD</td>
<td>Melville 2014, Katon 2014</td>
</tr>
<tr>
<td>Adult primary care</td>
<td>Anxiety Disorders including PTSD</td>
<td>Roy-Byrne et al 2012</td>
</tr>
<tr>
<td>Older adults in primary care</td>
<td>Arthritis and depression</td>
<td>Unützer et al., 2008</td>
</tr>
<tr>
<td>Primary Care / Cardiology (COPES)</td>
<td>Heart disease and depression</td>
<td>Davidson et al., 2010</td>
</tr>
</tbody>
</table>
But not all integration efforts are effective

- **Approaches that don’t work:**
  - Screening without adequate treatment
  - Referral to specialty care without close coordination: 50% fall through the cracks
  - Co-located behavioral health specialists without effective oversight or evidence-based treatments

Patients ‘fall through the cracks’ or stay on ineffective treatment for too long.
**Principles of Collaborative Care**

**Patient-Centered Collaboration.** Primary care and mental health providers collaborate effectively using shared care plans.

**Population-Based Care.** A defined group of patients is tracked in a registry so that no one falls through the cracks.

**Treatment to Target.** Progress is measured regularly and treatments are actively changed until clinical goals are achieved.

**Evidence-Based Care.** Providers use treatments that have research evidence for effectiveness.

**Accountable Care.** Providers are accountable and reimbursed for quality of care and clinical outcomes, not just volume of care.
Effective integration requires practice change.

everyone wants **better**. no one wants **change**.
Trained over 5,000 providers

AIMS CENTER
Advancing Integrated Mental Health Solutions
Behavioral Health Integration Program (BHIP) at UW Medicine

20% of UW Medicine Primary Care Patients have at least one visit with a mental health diagnosis

15 Participating Clinic Sites
- Harborview Medical Center (HMC):
- University of Washington Medical Center (UWMC)
- University of Washington Neighborhood Clinics (UWNC)

2014 APA Award of Distinction for Model Program
“You have no idea how helpful it is for a provider to have a resource like you in the clinic. I practiced for 16 years without it and I will never go back! You are such a great support for all of us.”
Mental-Health Care at the Doctor’s Office

Providers Take Integrated Approach, With Patient Numbers Set to Jump Under New Law and Psychiatrists in Short Supply

By MELINDA BECK

Seattle psychiatrist Anna Ratliff oversees mental-health care for nearly 500 patients—most of whom she will never meet.

As the consulting psychiatrist for four primary-care practices, Dr. Ratliff consults weekly with 10 care managers who follow the patients closely, provide counseling and chart their progress in electronic registries, she helps devise treatment plans and suggests changes for those who aren’t improving.

“I get to touch so many more lives than I would if I were seeing these patients in person,” she said.

Dr. Ratliff’s practice is part of a burgeoning effort to integrate psychiatric care into primary care.
• Washington State
• Community Health Plan of Washington
• Public Health Seattle & King County

http://integratedcare-nw.org
Mental Health Integration Program

> 50,000 clients served in over 150 primary care clinics
Care Management Tracking System (CMTS©)

- Access from anywhere.
- Population-based.
- Supports effective care
- Keeps track of ‘caseloads’.
- Facilitates consultation.
- Allows research on highly representative populations

Licensed in 14 US states & Alberta
Supporting care of over 100,000
## MHIP Common Client Diagnoses

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>71%</td>
</tr>
<tr>
<td>Anxiety (GAD, Panic)</td>
<td>48%</td>
</tr>
<tr>
<td>Posttraumatic Stress Disorder (PTSD)</td>
<td>17%</td>
</tr>
<tr>
<td>Alcohol / Substance Abuse</td>
<td>17%*</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>15%</td>
</tr>
</tbody>
</table>

**Thoughts of Suicide**

… plus acute and chronic medical problems, chronic pain, substance use, prescription narcotic misuse, homelessness, unemployment, poverty.
MHIP: Pay for Performance initiative cuts median time to depression treatment response in half

Particularly effective in high risk moms

Kaplan-Meier Survival Curve by Enrolled After 2009
Time to 50% PHQ improvement

Log-rank test for equality of survivor functions, p<0.001

Among Mom Population (African American, Asian, Latino & White) with baseline PHQ9>=10 (n=653)
Leverage

Psychiatrists reach many more patients:

“I am helping so many more people than I used to see in traditional office practice.”

“The greatest benefit of the MHIP consultation program may be in the diagnosis and treatment of patients that aren’t even in the program.”
Leverage through Technology
Task sharing with technology

Data streams
- Multimodal
- Ecologically valid
- Continuous

Cloud-based analytics

Mental Health Indicator
- Personalized
- Portable
- Convenient
- Discrete

Clinical Algorithms
- Evidence-based

Novel interventions
- Automated, or initiated by self, provider, or family
- Just-in-time
- Mobile
- Context-sensitive

Provider Dashboard
- Decision support
- Population-based management

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In 2015

ACA & Medicaid expansion
  • Up to 60 million Americans eligible for new or better MH coverage.
  • Strain on existing specialty mental health provider network
  • Primary care practices not sufficiently resourced to provide behavioral health care
    => patients are falling through the cracks.

Accountable Care (ACOs)
  • Patients with BH conditions have 2-3 times higher health care costs

Patient Centered Medical Homes (PCMH)
  • NCQA: measurement of depression screening and remission rates.

State Medicaid Programs are working towards integrated care:
  • WA State
    • Fully Integrate Purchasing & Delivery of Behavioral Health and Medical Services by 2020
    • Integrated Care Psychiatry Training Program
    • Funding for Telemedicine / Telepsychiatry

  • Missouri: Behavioral Health Care Homes
  • New York: Integrated Depression Care
FIXING BEHAVIORAL HEALTH CARE IN AMERICA

First in a series, this policy brief calls for integrating and coordinating specialty behavioral health care with the medical system in America.

LEARN MORE ABOUT THE POLICY BRIEF

OUR VISION

The Kennedy Forum is working toward lasting change in the way mental health and addictions are treated in our healthcare system, through:

PAYER ACCOUNTABILITY

PROVIDER ACCOUNTABILITY

INTEGRATION & COORDINATION
Thank you

unutzer@uw.edu
http://uw.aims.edu
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