Speakers

Tammy Floyd has served as NCMMHCs Healthcare Home Director since community mental health agencies started healthcare home program in 2011. Tammy started as a community support specialist with the agency in 2001. She also served as the agencies nurse liaison. Tammy is a 1994 graduate of North Central Missouri College in Trenton, Missouri.

Dr. Carol Clayton is a licensed, practicing psychologist with 30 years of healthcare experience in the public and private sector, including non-profit and private practice work. She currently works as the Translational Neuroscientist for Relias, specializing in online workforce development and training. Before joining Relias, Dr. Clayton was the CEO of Care Management Technologies, a health IT data analytics company.
What do we want to do today?

Build our Foundation

• Definition of Population Health
• Why should you Care?
Steps to Success

• Where to Start
• Identifying the Primary Population
  • A bit About Risk Modelling
• Identifying What to Do
  • A bit about Change
• Who’s Going to do it
  • The Importance of Leadership
  • The Importance of Clinician Buy In
  • The Importance of Training
• How Do we Know we are Achieving Our Goals
  • Performance Tracking and Reporting
  • A Bit About Technology
Putting It All Together

North Central Missouri’s Story
Who is Relias?
Why Are We Talking About Population Health?

Health System Evolution

<table>
<thead>
<tr>
<th>20th Century</th>
<th>21st Century</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Benefit restriction</td>
<td>• Mental Health Parity</td>
</tr>
<tr>
<td>• Prior authorization/edits</td>
<td>• Focus on outcomes and quality</td>
</tr>
<tr>
<td>• Medical services only</td>
<td>• High Volume/Low Quality</td>
</tr>
<tr>
<td>• Limit provider rates</td>
<td>• Care is a Killer</td>
</tr>
<tr>
<td>• Pay based on utilization</td>
<td>• Self Directed Care</td>
</tr>
<tr>
<td>• Provider focus on volume</td>
<td>• Complex needs population</td>
</tr>
<tr>
<td>• 1-800 #</td>
<td>• Integrated Care</td>
</tr>
<tr>
<td>• Healthy population</td>
<td>• Pay for performance</td>
</tr>
</tbody>
</table>
What is Pay for Value or Value Based Purchasing (VBP)?

- A system that rewards incentive payments based on a population’s size and characteristics and the calculated value of a provider’s care.
  - Incentive payments tied to the quality of care, not the quantity of services.
  - Requires outcomes demonstration and reporting

- Examples of metrics and quality domains:
  - Reducing the total cost of care
  - Reducing clinical variation
  - Improving access to care
  - Improving health outcomes
  - Increasing consumer satisfaction
  - Reducing hospital readmissions
The Infrastructure for Success: Not Success Itself

- New payment models (VBP) do not reduce costs or improve care
- New technology supports but does not execute a change process

*Need for adjustments in staff skills, technology, processes and care delivery*
What Gets in the Way: Top Three Biggest Pain Points

Where to Start

• Different Payer Expectations
• What Measures?
• Which Consumers?

Inefficiency in changing processes and workflow

• Lack of Implementation Science Know How
• Knowledge to Practice Needs
• Work Force Training Needs
• Aging Workforce
• Staff Burnout and Turnover

• Insufficient Tools for Tracking and Reporting on Value

• E HR and Billing System is not enough
• Population Health Requires Newer Technology
• Evolution Requires Multiple Tools
How to You Get From Here to There?

The “Knowledge to Practice” Gap
What is Your Starting Point: (1) Financial Drivers

Compensation Continuum By Level Of Financial Risk

Small % of financial risk | Moderate % of financial risk | Large % of financial risk

Fee-for-service | Performance-Based Contracting | Bundled & Episodic Payments | Shared Savings | Shared Risk | Capitation | Capitation + Performance-Based Contracting

No financial accountability | Moderate financial accountability | Full financial accountability

Passive involvement accountability | Provider engaged | Provider active in management | Providers assumes

(2) Government Priorities

- Managing the Budget
  - Must be balanced
  - Work within means

- Political Agendas
  - ACA—to stay or not to stay?
  - National Opioid Epidemic

- Taxpayer Stewards
  - Is money well spent?
  - Value for the dollar?

- Health of State/Communities
  - Healthy Community 20/20
  - Opioid Risk Reduction
(3) Mission Driven Priorities

Relias strives to measurably improve the lives of the most vulnerable members of society and those who care for them.
(4) Who is Affected: Who and What to Give Attention?

Identifying and analyzing the population
(5) Risk Stratification Based on Priorities
Starting Point Example:

Members of Missouri Behavioral Health Home (approx. 17,000)

SMI + 1 or more chronic health conditions (3700 not currently enrolled)

No Metabolic Syndrome Screen (~15,000 members)

FINANCIAL DRIVER: PMPM payment
Government Driver: HH Model
Mission Model: Local Care Value
Staff Model: HH Director for each CMHC
Technology Model: Population Health Tool
CH CH CH Changes. . .

• Questions to Ask and Answer:
  • *When should we create positive incentives versus negative ones?*
  • *How can we best engage staff to change?*
  • *Who can best purvey information about innovation?*
  • *When do we need changes in policies and procedures?*
  • *Who is the transactional leader?*
  • *Who is the transformational leader?*
• Understanding Change: Implementation Science Resources
  • Health Affairs May, 2017 and February, 2018
  • National Center for Translation Sciences
    • Translating what we know from other disciplines to promote rapid adoption of change process to ultimately affect health outcomes/patient care

• Three Types
  • Diffusion—broad/passive distribution of information
  • Dissemination—planned and targeted distribution of information
  • Adoption—integrated and implemented within the practice and culture; active

• Keys to Success
  • Must have leadership buy in
  • Behavior of professionals is key
  • Must have different strategies for different subgroups
Leadership Buy-In

Open Minds Leadership Institute 2017:

• Complicated vs Complex Leadership is Like Comparing Building of a Jet to Making Mayonnaise

  • **Complicated processes** are those that have a lot of moving parts but the end result is the same (small jet to bigger jet)
  
  • **Complex Processes** are those that when parts are added the end result is a new product (creating mayonnaise from eggs, oil, and sugar)
  
  • Depending on the process, different leadership is required:
    
    • **Transactional Leadership**: show me each step; take me there one step at a time.
    
    • **Transformational Leadership**: inspire, nurture, take risks, handle the unknown, manage conflict
  
  • **Change Processes require both**. Show me the steps to take and give me the boost, encouragement to innovate/take risks/work in the unknown
Clinician Burnout

More than the Triple Aim:

- Healthcare organizations must be able to deliver a high-quality experience of care for the patient and provider, that results in a healthier population, at optimized costs.

Confident, Satisfied, Engaged Workforce = Lower Turnover and Higher Patient Satisfaction.

- Need to Support New Skills/Processes
- Beware of Burden of measurement and reporting being pushed to physician/clinician ranks—40% burnout rate reported

What’s In It for the Clinician? Bonuses are not enough.
Relias Analytics: Easing the Burden of the Clinical Work Force

How we do it:

1.) A web-based data-driven patient registry supporting population health.
2.) Works in the background to aggregate, analyze, and interpret data (no data entry!)
3.) Tracks and reports 350+ evidence and standards-based clinical quality measures.
4.) Prebuilt care coordination and actionable desktop measurable intervention supports.
## Targeted Measures

| Presence of a diabetes screening test during the measurement year for a patient diagnosed with schizophrenia or bipolar disorder who was dispensed an antipsychotic medication. | A First Look Into Integrated Care for Primary Care Staff |
| Presence of a HbA1c and LDL-C tests during the measurement year for a patient diagnosed with schizophrenia and diabetes. | Managing Medicaid Members with Chronic Behavioral and Physical Health Conditions |
| Presence of a follow-up visit within 30 days after hospitalization for mental illness. | Building Care Teams and Establishing Check Points: Diabetes |
| Presence of a follow-up visit during the 30 day initiation phase for 6-12 year old prescribed ADHD medication. | Payer Perspective: Diabetes Management |

### Training Hours: 8.75

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing Unnecessary Hospital Admissions and Readmissions</td>
<td>1.00</td>
</tr>
<tr>
<td>Psychotropic Medications: Antipsychotics and Beyond</td>
<td>1.00</td>
</tr>
<tr>
<td>Medications Related to Schizophrenia and Other Psychotic Disorders</td>
<td>1.00</td>
</tr>
<tr>
<td>ADHD: Diagnosis and Treatment</td>
<td>2.00</td>
</tr>
</tbody>
</table>
How Do You Go From Here to There? Tools for Measurement to Reporting
Translating Evidence and Standards to Measurable Rules

Examples of General Preventive Care Rules

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Flu shot</td>
</tr>
<tr>
<td>No evidence of annual <strong>comprehensive preventive care assessment including physical examination</strong>.</td>
</tr>
<tr>
<td>On psychotropic medication with <strong>no evidence of psychiatric evaluation</strong> in the past year.</td>
</tr>
<tr>
<td>Dx of COPD/asthma and no record of annual pneumovax</td>
</tr>
</tbody>
</table>

Behavioral Pharmacy Rules

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of an antipsychotic at a higher than recommended dose for 45 or more days</td>
</tr>
<tr>
<td>Multiple prescribers of any antipsychotic for 45 or more days</td>
</tr>
<tr>
<td>Failure to refill/fill a medication in a patient with multiple recent emergency department (ED) visits</td>
</tr>
<tr>
<td>Use of benzodiazepines at a higher than recommended dose for 60 or more days</td>
</tr>
<tr>
<td>No evidence of follow-up appointment or psychosocial intervention in a patient who has failed to refill/fill medication</td>
</tr>
</tbody>
</table>

Chronic Disease Management Rules

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic with no evidence of annual foot exam</td>
</tr>
<tr>
<td>Diabetic with no evidence of annual urine test for protein/creatinine</td>
</tr>
<tr>
<td>Diabetic with no evidence of lipid monitoring</td>
</tr>
<tr>
<td>Diabetic with no evidence of HbA1c level in the last 6 months.</td>
</tr>
<tr>
<td>Diabetic with no evidence of statin if patient &gt; age 40</td>
</tr>
<tr>
<td>Diabetic with no evidence of annual eye exam</td>
</tr>
<tr>
<td>On atypical antipsychotic medication with no evidence of metabolic monitoring.</td>
</tr>
<tr>
<td>Dx of Cardiovascular Disease and no evidence of statin</td>
</tr>
<tr>
<td>Diabetic with use of high risk antipsychotics (clozapine, olanzapine, quetiapine)</td>
</tr>
</tbody>
</table>

RELIAS LEARNING
Relias Smart Tech Tool: Beyond the EHR

Information technology is a “must” in the new world

Technical Blueprint For IT Functionality in Practice Changes

1. Electronic Medical Record
   - Collect the data generated within a provider practice
     - Clinical symptoms
     - Confounding factors
     - Measures of progress/response
     - Resource utilization
     - Build patient centered longitudinal clinical database
   - The Need: Case Tracking Systems

2. Health Information Exchange
   - Aggregation of data generated across the healthcare community
     - Augment the single provider’s EMR with patient data from other sources
     - Transmission of data to other sources
   - The Need: IT Systems Integration

3. Clinical Analytics
   - Convert aggregated data into actionable information
     - Identify, stratify and synthesize data to identify
       - At risk patients
       - Provider performance
       - Registries
       - Cost profile
       - Benchmarks
   - The Need: Smart system supports
     - Analytics and Evidence-based reviews

4. Population Health Management
   - From information to action
     - Systems designed to mitigate identified risk
       - Info for provider at point-of-care
       - Integrated info management system
       - Patient-centered records
   - The Need: Practice redesign
     - Workflow
     - Skill set

Using an interactive Dashboard is one way to evaluate the population to look for areas of focus.

Drill in by:
- Geography
- Age Band
- Diagnosis
- Spend Category
- And more….
## Case Study: Behavioral Health Data Report

### OUTCOME IP ADMITS / 1000 (AUTH) BED DAYS / 1000 (AUTH) ED VISITS / 1000

<table>
<thead>
<tr>
<th></th>
<th>PRE</th>
<th>POST</th>
<th>DIFFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP ADMITS</td>
<td>4,531</td>
<td>1,942</td>
<td>2,589</td>
</tr>
<tr>
<td>BED DAYS</td>
<td>18,301</td>
<td>7,288</td>
<td>11,013</td>
</tr>
<tr>
<td>ED VISITS</td>
<td>12,106</td>
<td>8,385</td>
<td>3,721 reduction</td>
</tr>
<tr>
<td>% DIFFERENCE</td>
<td>57%</td>
<td>60%</td>
<td>31%</td>
</tr>
</tbody>
</table>

### OUTCOME MED PMPM RX PMPM TOTAL PMPM

<table>
<thead>
<tr>
<th></th>
<th>PRE</th>
<th>POST</th>
<th>DIFFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>MED PMPM</td>
<td>$2,375</td>
<td>$1,217</td>
<td>1,158</td>
</tr>
<tr>
<td>RX PMPM</td>
<td>$324</td>
<td>$411</td>
<td>-87</td>
</tr>
<tr>
<td>TOTAL PMPM</td>
<td>$2,699</td>
<td>$1,629</td>
<td>1,070 savings</td>
</tr>
<tr>
<td>% DIFFERENCE</td>
<td>49%</td>
<td>-27%</td>
<td>40%</td>
</tr>
</tbody>
</table>

6 Month Data: 53% increase in rx PMPM • 51% decrease in IP admits • 58% decrease in bed days • 25% decrease in ED visits • 30% decrease in total PMPM
Putting It All Together

Learning from North Central Missouri
Where North Central Missouri Mental Health HCH Started

**Staffing: Nurse Liaison**

NCMMHC had a nurse liaison for 3 years prior to the start of HCH. This enabled us to have baseline metabolic readings for some clients prior to enrollment into the program. The nurse liaison had also been working on clients’ medication adherence.

**Population Identified: DM 3700 program**

**Training: Preparation for the big start date of January 1, 2012**

DMH required the agency to fill out an application to become a healthcare home. We attended DMH and Missouri Coalition sponsored trainings to prepare. In November of 2011 we received a list of possible eligible HCH clients and started talking with these clients about the HCH program.
The Right Staff

Nurses who work well with clients that have a mental illness and enjoy the educational side of the job is the type of nurse you want.

The Right Tools

*Relias ProAct*
Electronic records
Cyber Access
Mo Health Net
My Strength
*Relias Training*
Cyber Access

Cyber access is used on a daily basis.

All clinical staff are trained on how to access and use it.

MO Health Net

High Utilizer

Hospital – ER Reports
**ProAct (Relias Analytic Tool)**

Used to identify clients with abnormal metabolic readings
- Adherence report
- Metabolic screens due
- Missing attribute report

**Electronic Tools**

- MyStrength
- Carelogic

LDX and A1C Monitors
Buy In and Trainings

Doesn’t happen over night

HCH 101 Trainings

All clinic directors, CPRC directors, and team leaders are required to attend a Healthcare Home 101 training taught by the Department of Mental Health and the MO Coalition staff. All other staff get the training at the agency from the HCH director when they are hired. Additionally ongoing trainings are held each year at the agency by the HCH director and nurse care managers.

It is important to let clinicians see the numbers and acknowledge them for how they are improving the lives of their clients.
Challenges

Physical and mental health go hand in hand

The biggest challenge would be getting all staff to see why the HCH program would be beneficial to the client. Clinicians need to understand how physical and mental health work together. Another challenge is getting the primary care physicians and hospitals to work with the mental health agency to coordinate the client’s care.

Challenges are ongoing

Clinicians can get discouraged when clients are not ready to work on improving their physical health conditions or when they don’t see improvement in a client.
### Success Stories

#### 61 year old female

<table>
<thead>
<tr>
<th></th>
<th>2010 Prior to HCH</th>
<th>Today</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>158</td>
<td>165</td>
</tr>
<tr>
<td>Total Cholesterol</td>
<td>156</td>
<td>147</td>
</tr>
<tr>
<td>LDL</td>
<td>68</td>
<td>64</td>
</tr>
<tr>
<td>HDL</td>
<td>29</td>
<td>40</td>
</tr>
<tr>
<td>Triglycerides</td>
<td>296</td>
<td>215</td>
</tr>
</tbody>
</table>
Success Stories

61 year old male unaware he was diabetic

2010 prior to HCH
Weight 193.2
Hgl A1c 14.0

Today
Weight 155
Hgl A1c 5.0
### Success Stories

#### 41 year old female

<table>
<thead>
<tr>
<th>2012 first year in HCH</th>
<th>Today</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>210</td>
</tr>
<tr>
<td>glucose</td>
<td>103</td>
</tr>
<tr>
<td>Total Cholesterol</td>
<td>179</td>
</tr>
<tr>
<td>LDL</td>
<td>117</td>
</tr>
<tr>
<td>HDL</td>
<td>23</td>
</tr>
<tr>
<td>Triglycerides</td>
<td>192</td>
</tr>
</tbody>
</table>
Success Stories

Hospital Admissions Per Client

<table>
<thead>
<tr>
<th>Year</th>
<th># clients</th>
<th># admissions</th>
<th># per client</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>235</td>
<td>103</td>
<td>.44</td>
</tr>
<tr>
<td>2013</td>
<td>309</td>
<td>102</td>
<td>.33</td>
</tr>
<tr>
<td>2014</td>
<td>363</td>
<td>125</td>
<td>.34</td>
</tr>
<tr>
<td>2015</td>
<td>519</td>
<td>164</td>
<td>.32</td>
</tr>
<tr>
<td>2016</td>
<td>617</td>
<td>210</td>
<td>.32</td>
</tr>
</tbody>
</table>
Success Stories

In 2016 we had 51 clients who had cardiovascular disease and or diabetes. They had been in the HCH program for two years or longer. Of those clients 33 averaged a 41 point decrease in their LDL readings, 13 had LDL readings below 100 and readings continued to stay below 100.

Of those 51 clients-------

only 5 had an increase in their LDL readings.
Where do you want to go from here?

For further information:

Attend our session at the Open Minds Technology Institute
November 7\(^{th}\)-8\(^{th}\)
Loews Philadelphia Hotel

Reach out to me at:
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Translational Neuroscientist
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www.reliaslearning.com