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Can Population Health Management Interventions Help State Medicaid Plan Offerings?

December 18, 2014

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Attorney Advertising

Upcoming Webinar!

How Health Information Exchanges Are Supporting Population Health Management

This session will examine a Health Information Exchange's (HIEs) support for population health management and coordinated care efforts for lessons learned and utilize the panelists' national perspective to explore the range of additional potential. The webinar also will review current issues associated with sustainability, privacy and security, data integrity.

- January 29, 2015 at 12:00 p.m. ET
- Featured Speakers:
  - Lee Barrett, Executive Director, Electronic Healthcare Network Accreditation Committee
  - Irene Koch, Executive Vice President and General Counsel, Healthix, Inc.

Keep an eye out for the webinar invitation!

Webinar Presenters

- **Joe Parks, MD**

  Director, Missouri HealthNet Division of the Missouri Department of Social Services

- **Cliff Barnes: Moderator**

  Member

  Epstein Becker Green

Presentation Overview

- This session will focus on how state Medicaid programs are utilizing case management and other population health management interventions to improve clinical and financial outcomes.
  - One major issue concerns ongoing budgeting issues, along with how to bend the cost curve and generally “fix” the Medicaid system.

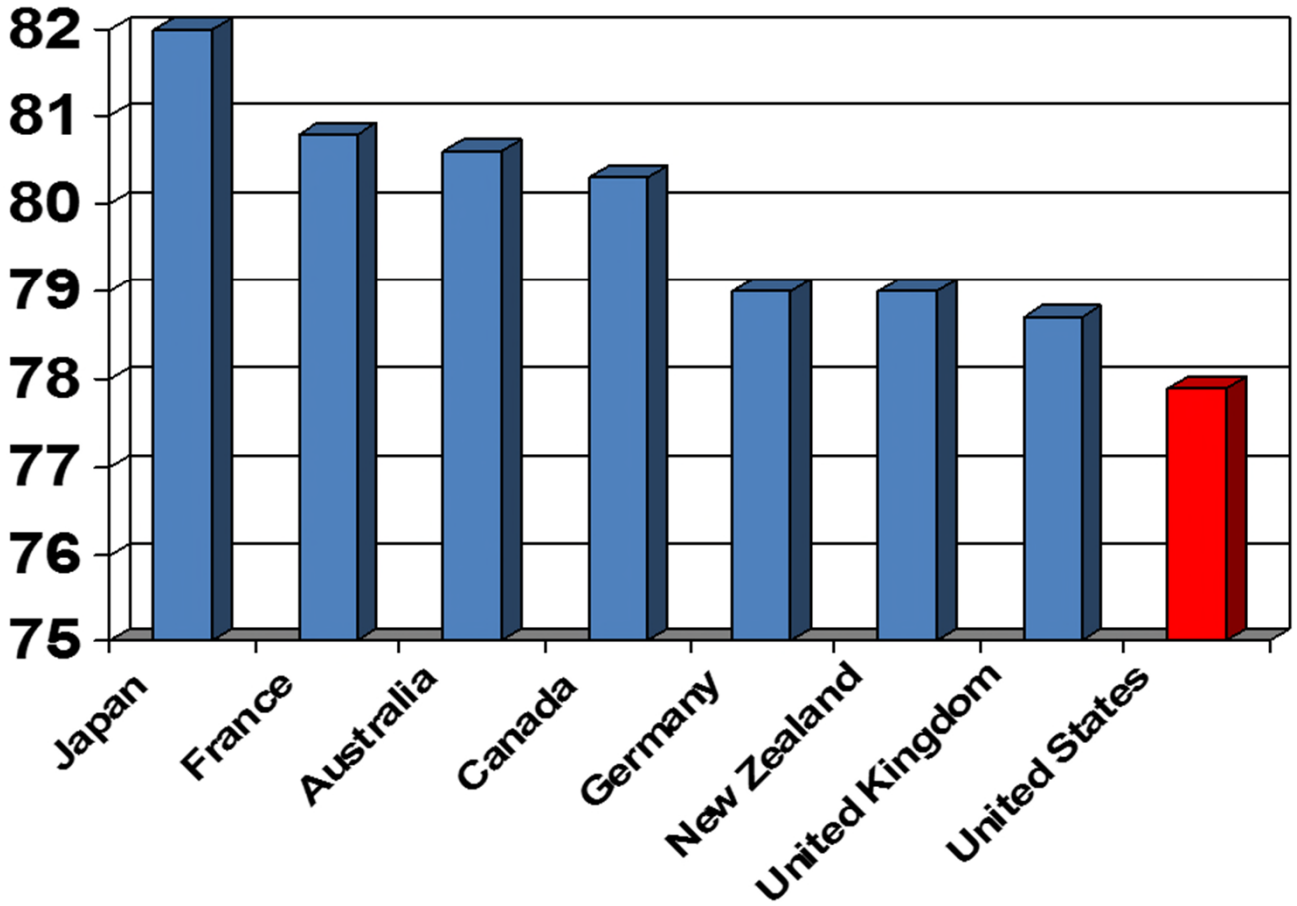
- The session also will touch base on how to best implement meaningful population health programs where federal, state and local agencies often need to fund, pay for and coordinate care together.

Population Health Definitions

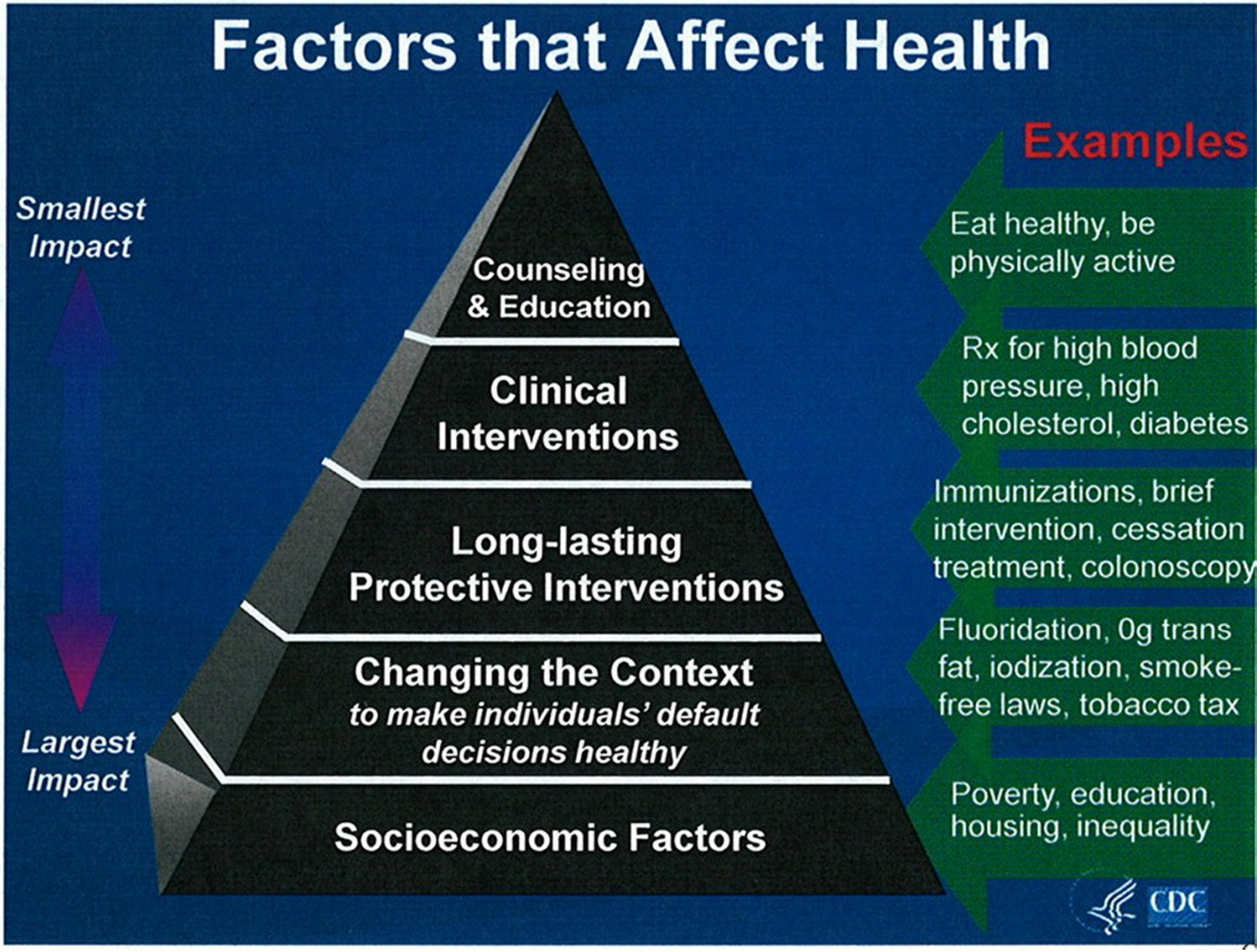
- The health of the population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services (Dunn and Hayes, 1999)

- A conceptual framework for thinking about why some populations are healthier than others as well as the policy development, research agenda, and resource allocation that flow from it (Young 2005)

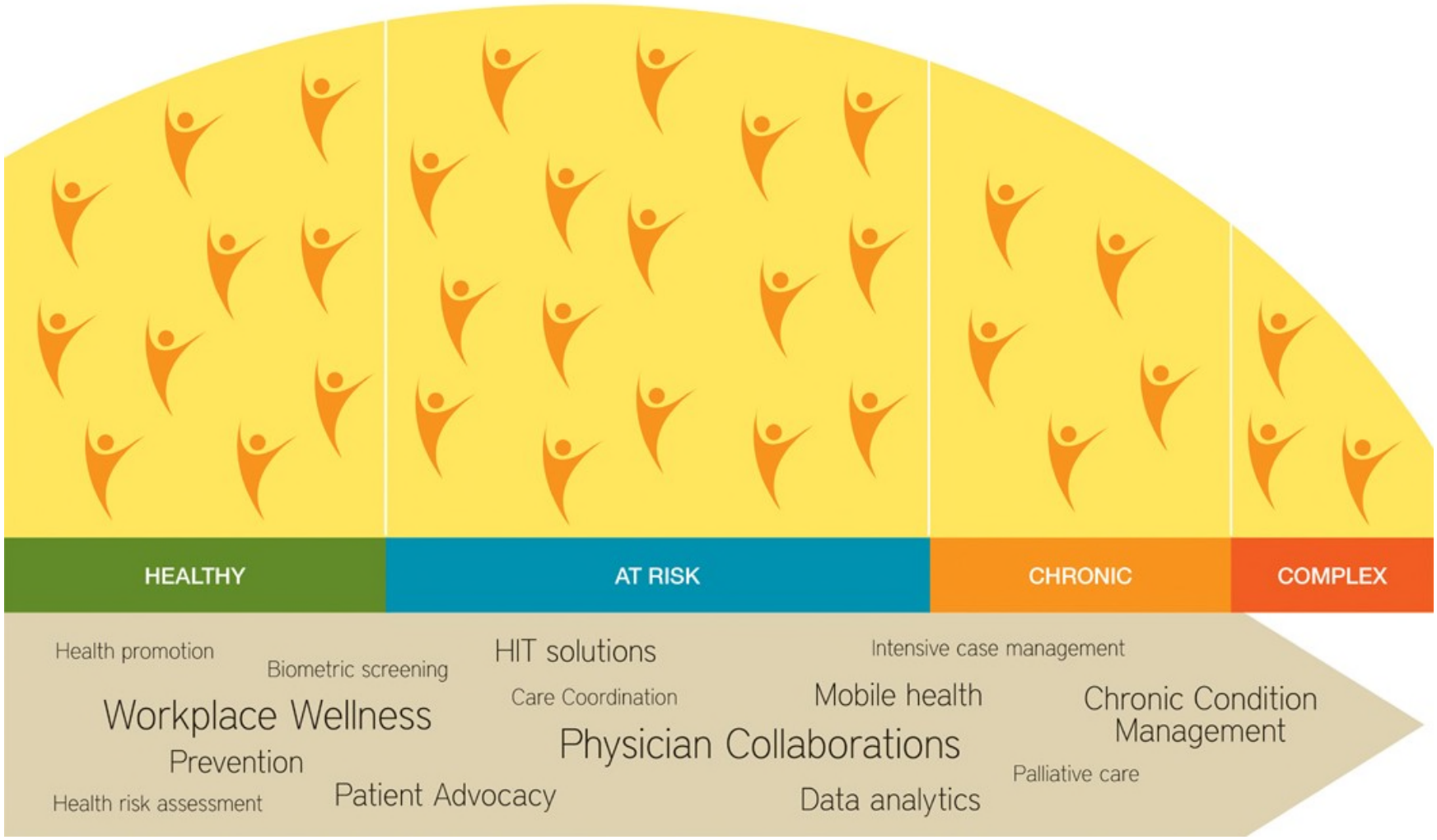
Health Rankings



America's Health Rankings: A Call to Action for People & Their Communities
United Health Foundation, 2007


Factors that Affect Health
Smallest Impact
Largest Impact
Counseling & Education
Clinical Interventions
Long-lasting Protective Interventions
Changing the Context
to make individuals' default decisions healthy
Socioeconomic Factors
Examples
Eat healthy, be physically active
Rx for high blood pressure, high cholesterol, diabetes
Immunizations, brief intervention, cessation treatment, colonoscopy
Fluoridation, 0g trans fat, iodization, smoke-free laws, tobacco tax
Poverty, education, housing, inequality
CDC

The Continuum of Care



How do you deliver PHM in any care setting?

Assess

Stratify

Implement Solutions

Measure & Report

Population Management Principles

- Population-based care
- Data-driven care
- Evidence-based care
- Patient centered care
- Addressing social determinates of health
- Team care
- Integration of behavioral and primary care

Population-Based Care

- Don't rely solely on patients to know when they need care and what care to ask for from whom
  - Use data analytics to outreach to high need/high 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

Data-Driven Care & Data Sources

- Patient Registries
- Risk Stratification
- Predictive Analytics
- Performance Benchmarking
- Data Sharing

- 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

Population Management

- Selects those from whole population:
  - Most immediate risk
  - Most actionable improvement opportunities

- Aids in planning:
  - Care for whole population
  - New interventions and programs
  - Early identification and prevention
  - Choosing and targeting health education

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 – presentations like this

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

Principles

- Use the data you have before collecting more
- Show as much data as you can to as many partners as often as you can
  - Sunshine improves data quality
  - Partners 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 misleading as testable hypotheses
- Tell your data people that you want the quick, easy data first
  - Getting 80% of your requests in one week is better than 100% in six 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 one big source
- Transparent bench marking improves attention and increases involvement

The Most Important Principles

- Perfect is the enemy of good
- Use an increment strategy
- If you try to figure out a comprehensive plan first, you will never get started
- Apologizing for a failed prompt is better than apologizing for a missed opportunity

Six Population Health Management Services

- Care management
- Care coordination
- Manage transitions of care
- Health promotion
- Individual and family support
- Referral to community services

Comprehensive Care Management

- Identification and targeting of high-risk individuals
- Monitoring of health status and adherence
- Identification and targeting care gaps
- Individualized planning with the patient

Step 1

Create Disease Registry

- Get historic diagnosis from admin claims
- Get clinical values from metabolic screening, clinical evaluation and management, care plans
- Combine into EHR disease registry (central data registry, PROACT)
- Provide online access to all providers

Step 2

Identify Care Gaps and ACT!

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

Care Coordination

- Coordinating with the patients, caregivers and providers
- Implementing plan of care with treatment team
- Planning hospital discharge
- Scheduling
- Communicating with collaterals

Best Practices	Care Transitions
Telephonic model	Home visits for some high utilizers or hard-of-hearing members
Empower members to make follow-up MD appointments	Conference call with MD office to make follow-up appointment
Assessment asks if members understand meds & DC instructions	More comprehensive probing and medication reconciliation
Care transitions coaches struggling with complex end of life issues	Referrals to advanced illness management program

Why Behavioral Health Needs Population Management

- ACA requires it
- SMIs are sicker
- Population management needs behavioral health
- Psychiatry shortage

Health Care Reform: Moving Toward an Accountable Health Care System

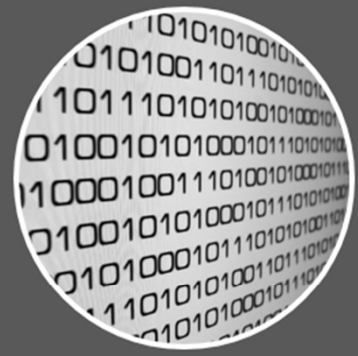
Coverage for All

Payment Reform

Align incentives

Pay for Value

Strengthen Primary Care



Improve Quality and Support Innovation

Tools to Rebuild and Restructure Health Care

Population Health Management in the ACA

- Community health needs assessment requirements
- Expansion of prevention and wellness services
- Hospital readmissions reduction programs
- Community-based care transitions programs
- Accountable care organizations
- Patient centered medical homes
- Health homes for chronic conditions
- Increased funding for health centers

Turning the Ship

Drivers:

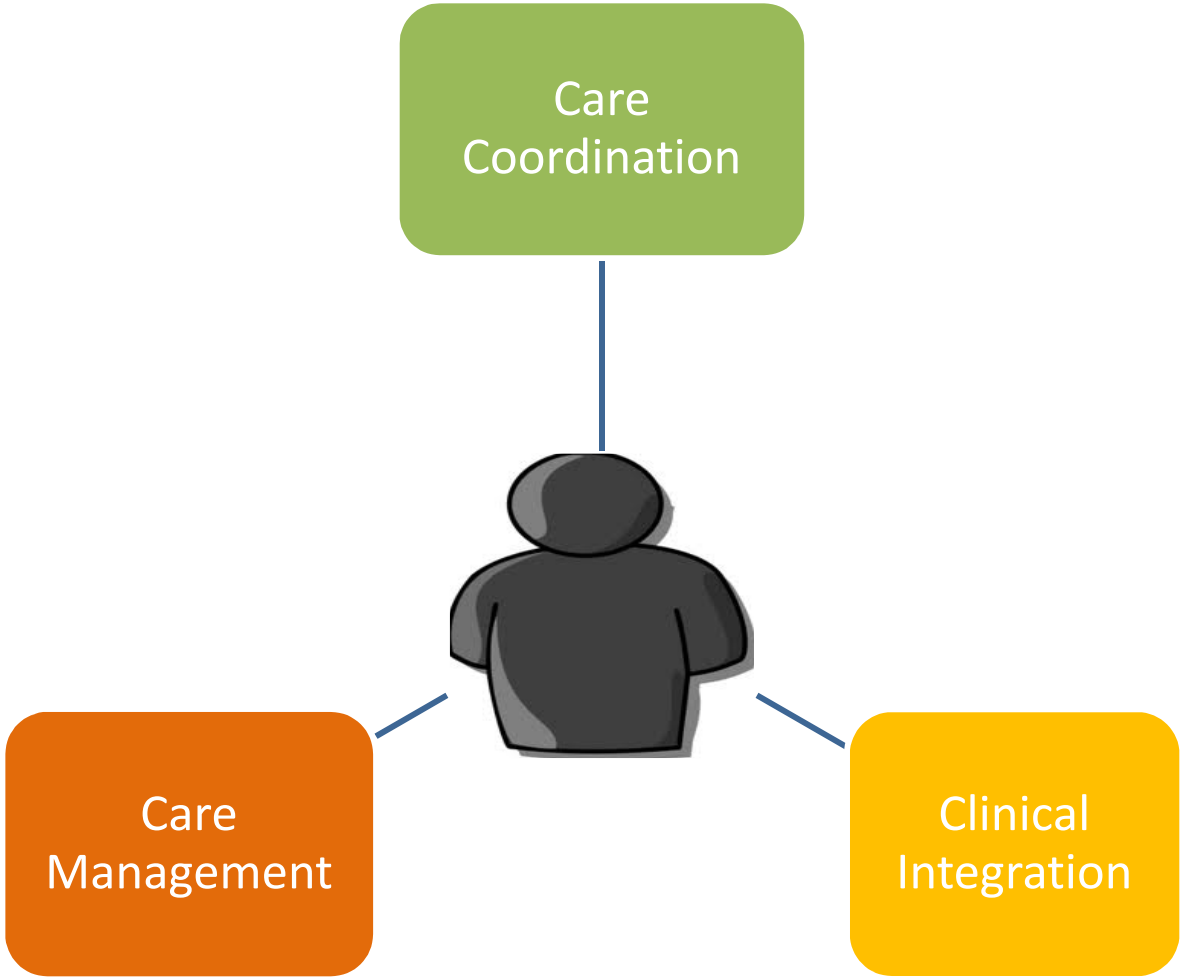
- Health care cost crisis
- Health reform
- Improved HIT
- Greater stake-holder alignment

Provider-managed health rather than health plan managed care

Creating need for new skill sets, policy, tools and competencies

- New models of care delivery and coordination
- Payment aligns with goals
- New tools for clinical alignment
- Better PHM capabilities
- Experience in performance management/data reporting
- Experience in population risk adjustment/risk mitigation
- Increased awareness of prevention and wellness value
- Educated, empowered patients

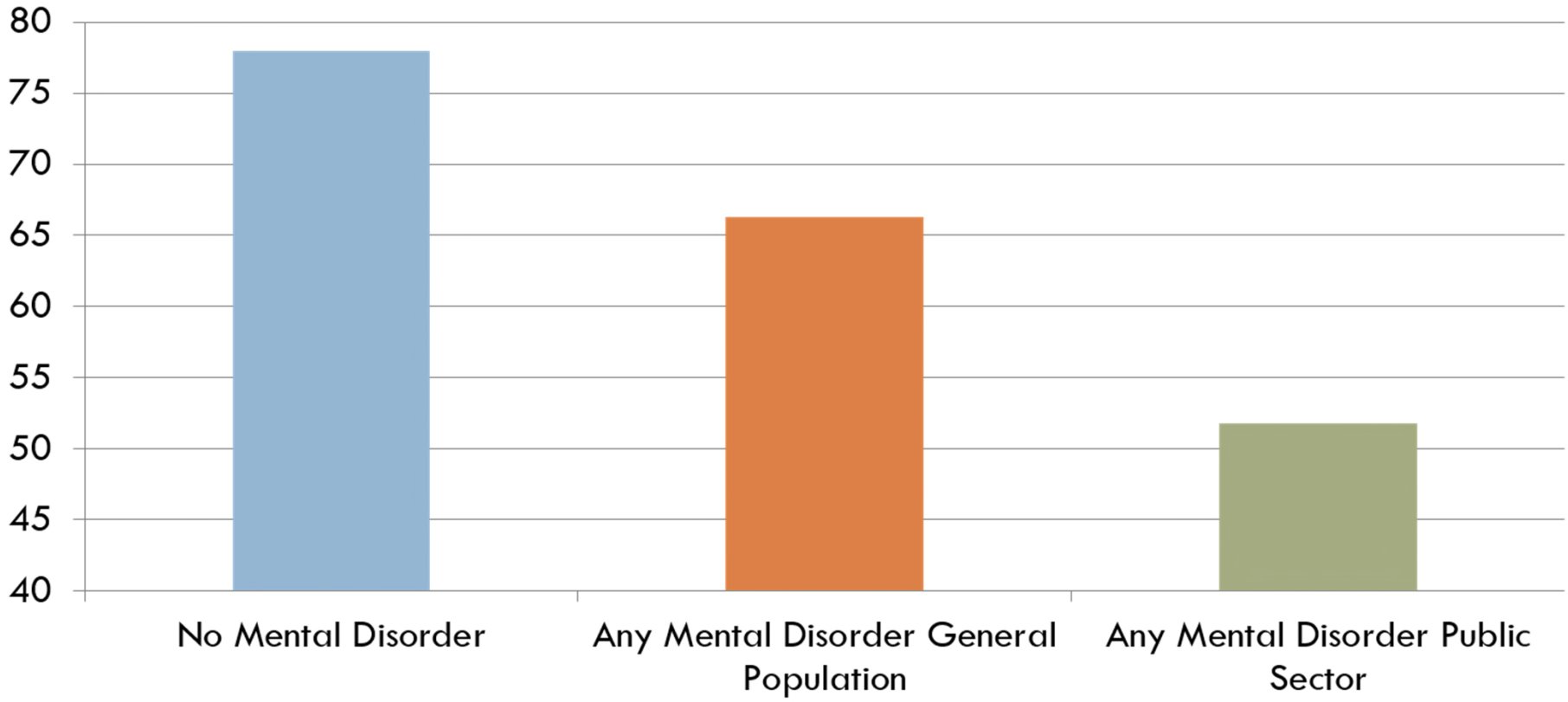
Important Provider Competencies



Characteristics:

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

Life Expectancy



Bar 1 & 2: Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 June;49(6):599-604

Bar 3: Daumit GL, Anthony CB, Ford DE, Fahey M, Skinner EA, Lehman AF, Hwang W, Steinwachs DM. Pattern of mortality in a sample of Maryland residents with severe mental illness. Psychiatry Res. 2010 Apr 30;176(2-3):242-5

The CATIE Study

- At baseline, investigators found that…
  - 88.0% of subjects had dyslipidemia
  - 62.4% of subjects had hypertension
  - 30.2% of subjects had diabetes
- …and were NOT receiving treatment

Comparison of Metabolic Syndrome Prevalence in Fasting CATIE Subjects and Matched NHANES III Subjects

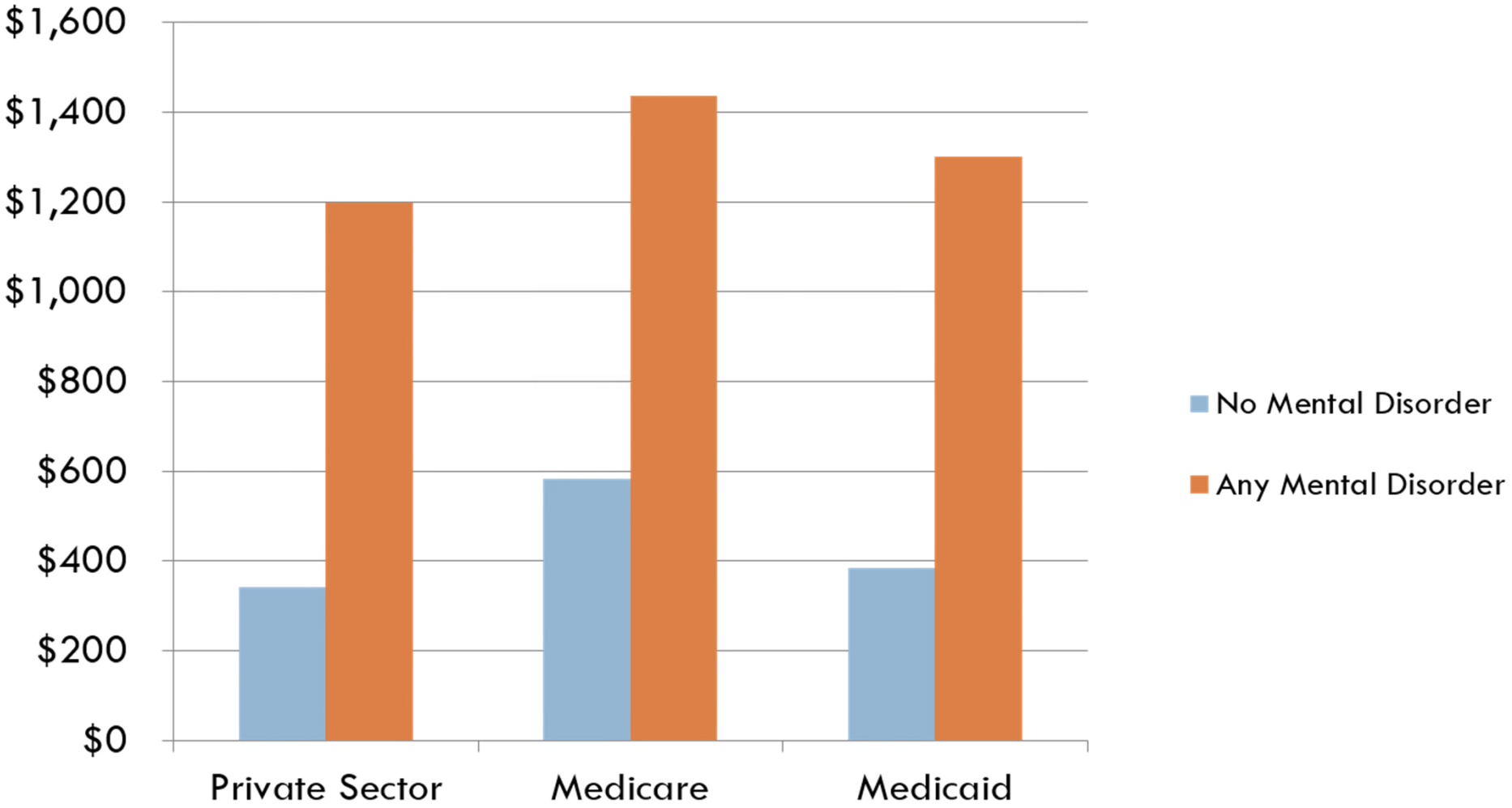
	Males			Females		
	CATIE N=509	NHANES N=509	*p*	CATIE N=180	NHANES N=180	*p*
Metabolic Syndrome Prevalence	36.0%	19.7%	.0001	51.6%	25.1%	.0001
Waist Circumference Criterion	35.5%	24.8%	.0001	76.3%	57.0%	.0001
Triglyceride Criterion	50.7%	32.1%	.0001	42.3%	19.6%	.0001
HDL Criterion	48.9%	31.9%	.0001	63.3%	36.3%	.0001
BP Criterion	47.2%	31.1%	.0001	46.9%	26.8%	.0001
Glucose Criterion	14.1%	14.2%	.9635	21.7%	11.2%	.0075

Meyer et al., Presented at APA annual meeting, May 21-26, 2005.
McEvoy JP et al. Schizophr Res. 2005;80:19-32.

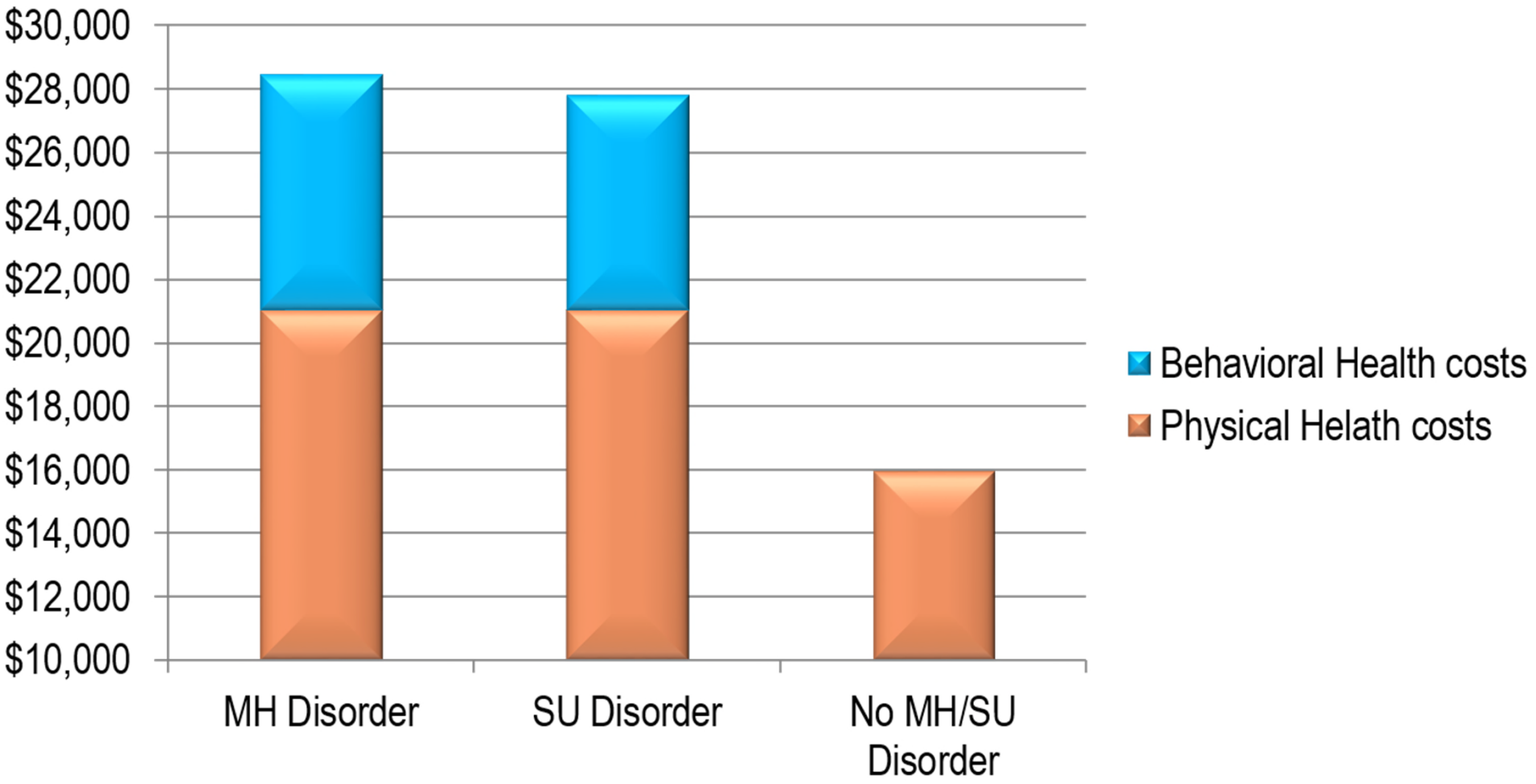
Causes of Excess Mortality

- Smoking
- Obesity
- Inactivity
- Polypharmacy
- Under diagnosis of medical conditions
- Inadequate treatment of medical conditions

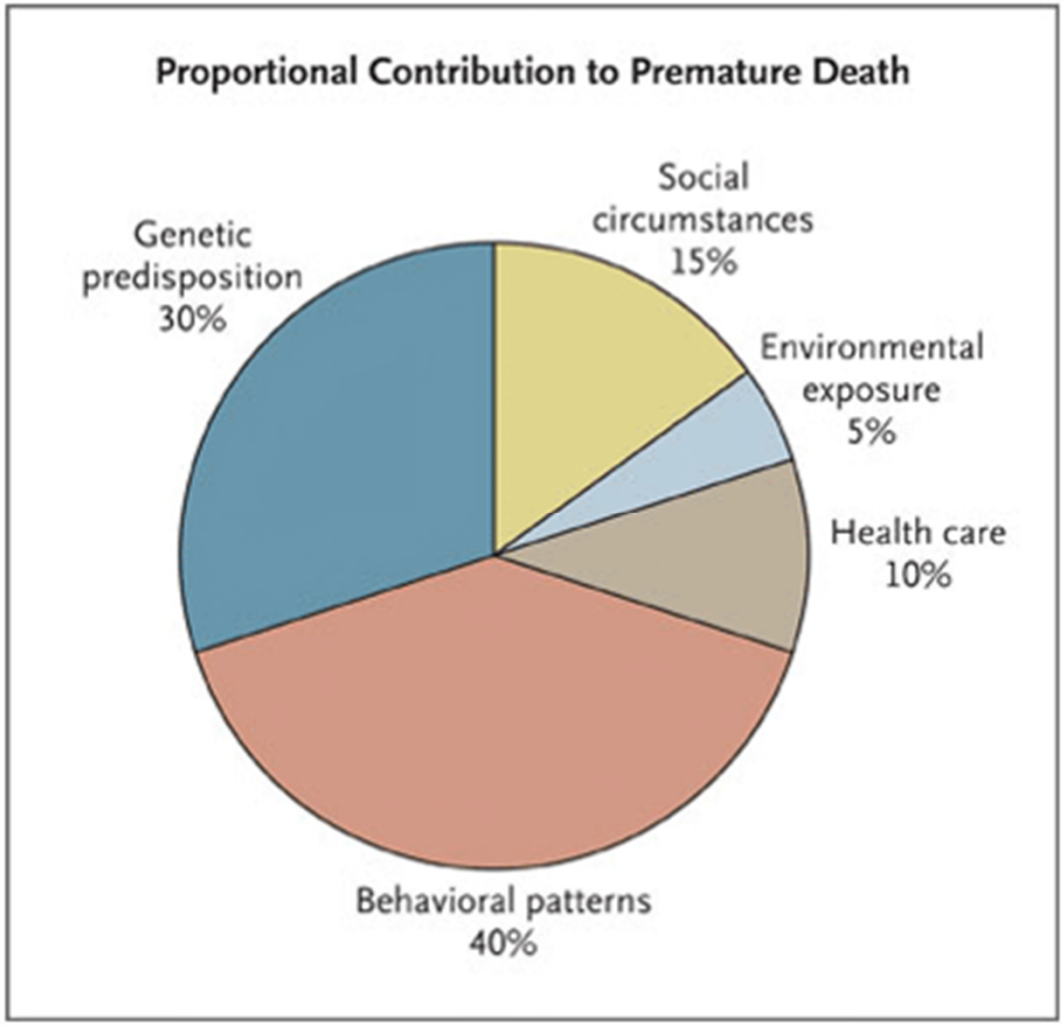
Per Member Per Month Costs



MH/SU Costs in NY State's Medicaid Program



Determinants of Health



Determinants of Health and their Contribution to Premature Death, Adapted from McGinnis, et al., 2002

Psychiatrist Shortage Overview

- Currently, the demand for psychiatrists exceeds the supply
- The demand for a psychiatric workforce is increasing
- The psychiatric workforce is projected to shrink
- The current psychiatric care delivery model is not sustainable
- So what can be done differently?

Current Shortage

- Best data: study by University of North Carolina commissioned by Health Resources and Services Administration (HRSA)
- The study demonstrated shortages for all MH professionals, especially "prescribers"
  - 77% of U.S. counties have "a severe shortage of prescribers, with over half their need unmet"
  - 96% of US counties have "some unmet need"

Konrad et al, Psych Services, 60: 1307-14, 2009

Drivers of Increased Demand

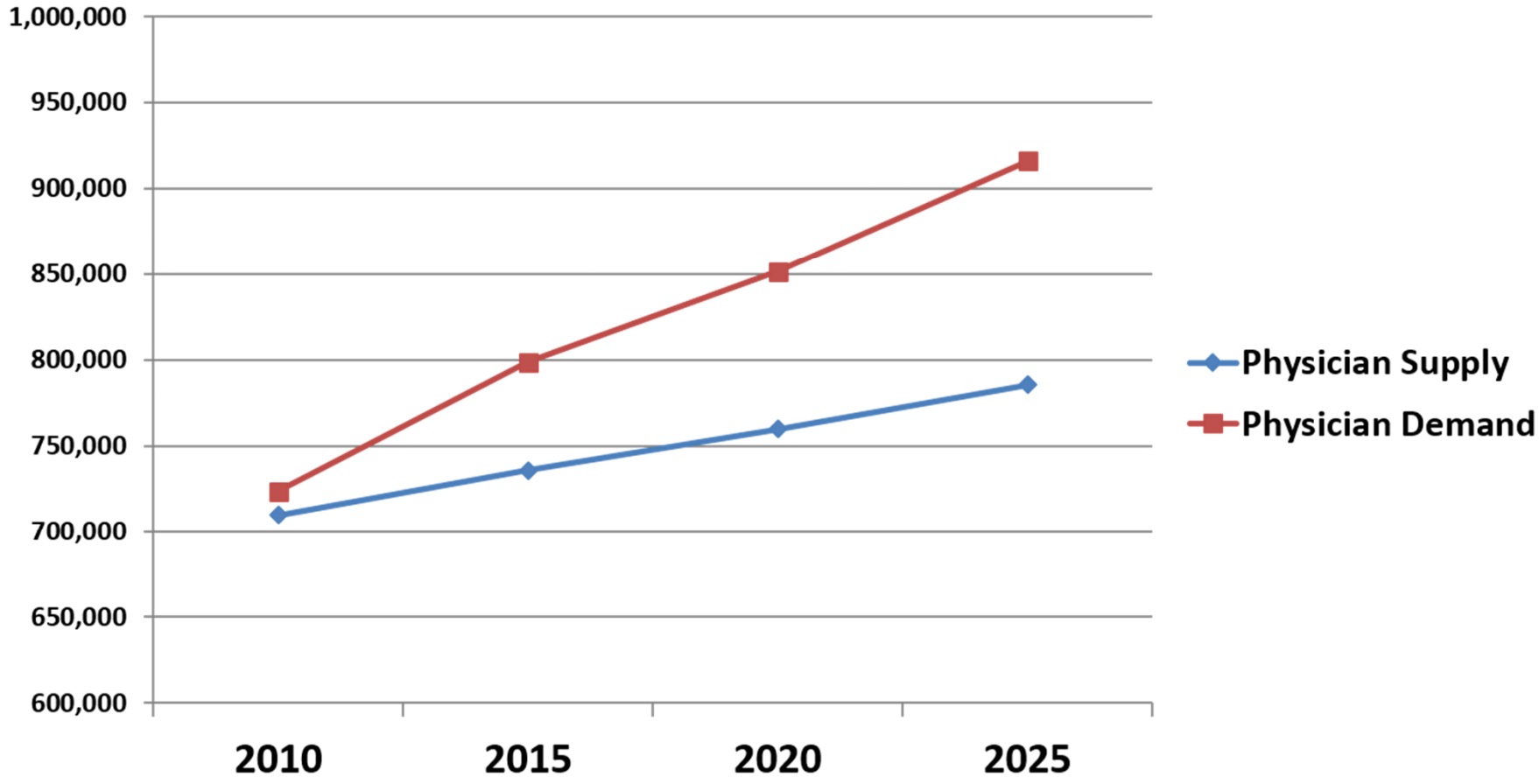
- Increased Coverage
  - Wellstone Domenici Parity Act
  - ACA
- Increased Demand
  - Stigma continues to drop, releasing pent up demand
  - Press coverage of mass shootings: increasing mental health services is more popular than gun control
- Focus on high utilizers
- Increased desire for integration by payers
- Shrinking psychiatric workforce

Current Supply and Need for Psychiatrists

- Estimated need of 25.9 psychiatrists/100,000 population
  - With current population of 300,000,000, this is 78,000
- Current supply is ~ 48,000 (~ 16/100,000)
- Current gap = at least 30,000
- Much greater supply vs. need gap for child and adolescent psychiatry (~ 7,500 total)
- Current psychiatrists are aging out fast
  - Off all sub-specialties (35), psychiatry is second oldest (second only to preventive medicine)
  - 55% of current psychiatrist are > age 55

Sources: Konrad et al, Psych Services, 60: 1307-14, 2009

Projected Supply and Demand of All Physicians 2010-2025



Source: AAMC Center for Workforce Studies, June 2010 Analysis

What is a Health Home?

- Not just a Medicaid benefit
- Not just a program or a team
- A system and organizational transformation
- Payments for HH services will be paid PMPM, not unit by unit
- Service needs will be identified by patient health history and status
- Outcomes will be measured by groups of clients (i.e. by organization, region, medication used, co-morbid conditions)

Health Care Home Strategy

- Case management coordination and facilitation of health care
- Primary care nurse care managers
- Disease management for persons with complex chronic medical conditions, SMI or both
- Behavioral health management and behavior modification as related to chronic disease management for persons with medical illness
- Preventive health care screening and monitoring by MH providers
- Integrated primary care and behavioral health care
- Health technology is utilized to support the service system
- "Care coordination" is best provided by a local community-based provider
- MH Community Support Workers who are most familiar with the consumer provide care coordination at the local level
- Primary Care Nurse Care Managers working within each Health Home provide system support
- Behavioral Health Consultants in each Primary Care Health Home
- Statewide coordination and training support the network of Health Homes

What is Different About Health Homes?

Treatment as Usual

- Individual practitioner
- Episodic care
- Focus on presenting problem
- Referral to meet other needs
- Managed care
  - Manage access to care
  - Dose not change clinical practice

Health Homes

- Integrated primary/behavioral health care team
- Continuous care
- Comprehensive care management
  - Coordinates care across the health care system
  - Data driven population management
  - Transforms clinical practice
  - Emphasizes healthy lifestyles and self-management of chronic health problems

Health Home Target Populations

Primary Care Health Homes

- Patients with diabetes
  - At risk for cardiovascular disease and a BMI of > 25
- Patients who have two of the following:
  - COPD/Asthma
  - Diabetes
  - Cardiovascular disease
  - BMI > 25
  - Developmental disabilities
  - Tobacco use

CMHC Healthcare Homes

- Individuals with a serious mental illness
- Individuals with behavioral health problems and who also have:
  - Diabetes
  - COPD/Asthma
  - Cardiovascular disease
  - BMI > 25
  - Developmental disabilities
  - Tobacco use

Missouri's Health Homes

Primary Care Health Homes

- Providers
  - 18 FQHCs
    - 67 clinics
  - 6 hospitals
    - 22 clinics
    - 14 rural health clinics
- Enrollment
  - 15,526 adults
  - 428 children
  - 15,954 total

CMHC Healthcare Homes

- Providers
  - 28 CMHCs
    - 120 clinics/outreach offices
- Enrollment
  - 16,611 adults
  - 2,387 children
  - 18,998 total

Principles

- One Team
  - CMHCs composed of pre-2012 CPRC staff plus NCM and PC consultants
  - PCHHs composed of new infrastructure and team members
- One Treatment Plan for the Whole Person
  - Rehab goals
  - Medical goals
  - Healthy lifestyle goals
- Some goals and outcomes reference Health Home performance measures
- Wrap-around approach to outside treating PCP, mental health providers, community supports, etc.

Health Home Team

- Nurse care managers (1FTE/250pts)
- Care coordinators (1FTE/500pts)
- Health Home director
- Behavioral health consultants (primary care)
- Primary care physician consultant (behavioral health)
- All must learn collaborative training
- Perform next day notification of hospital admissions

Performance Progress

- Small Changes Make a Big Difference
- Blood cholesterol
  - 10% ↓ = 30% ↓ in CVD (120-100)
- High blood pressure (> 140 SBP or 90 DBP)
  - ~ 6 mm Hg ↓ = 16% ↓ in CVD and 42% ↓ in stroke
- Diabetes (HbA1c > 7)
  - 1% point ↓ HbA1c = 21% decrease in DM related deaths, 14% increase in MI and 37% decrease in microvascular complications

Stratton, et al, BMJ 2000
Hennekens CH. *Circulation* 1998;97:1095-1102.
Rich-Edwards JW, et al. *N Engl J Med* 1995;332:1758-1766.
Bassuk SS, Manson JE. *J Appl Physiol* 2005;99:1193-1204

Conclusions

A1c Control

- About 7% had uncontrolled A1c levels
- Cohorts with elevated A1c levels showed at least an 1 point reduction
- Cohorts with normal A1c levels increased by 0.1 point or less

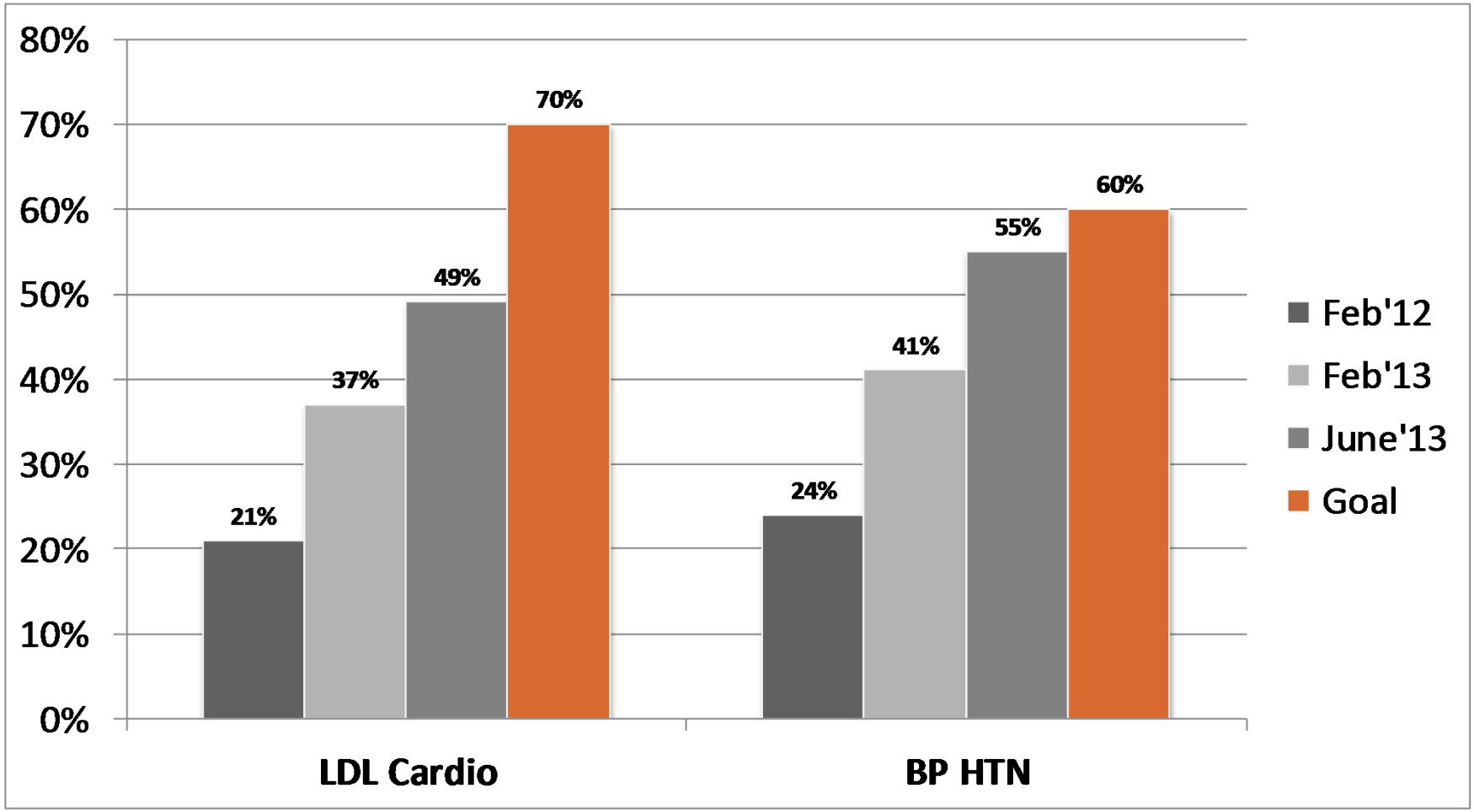
LDL Control

- About 45% had uncontrolled LDL levels
- Cohorts with elevated LDL levels showed more than a 10% reduction
- Cohorts with normal LDL levels increased by 7 to 8 points, but remained in the low 80s

Conclusions: Blood Pressure Control

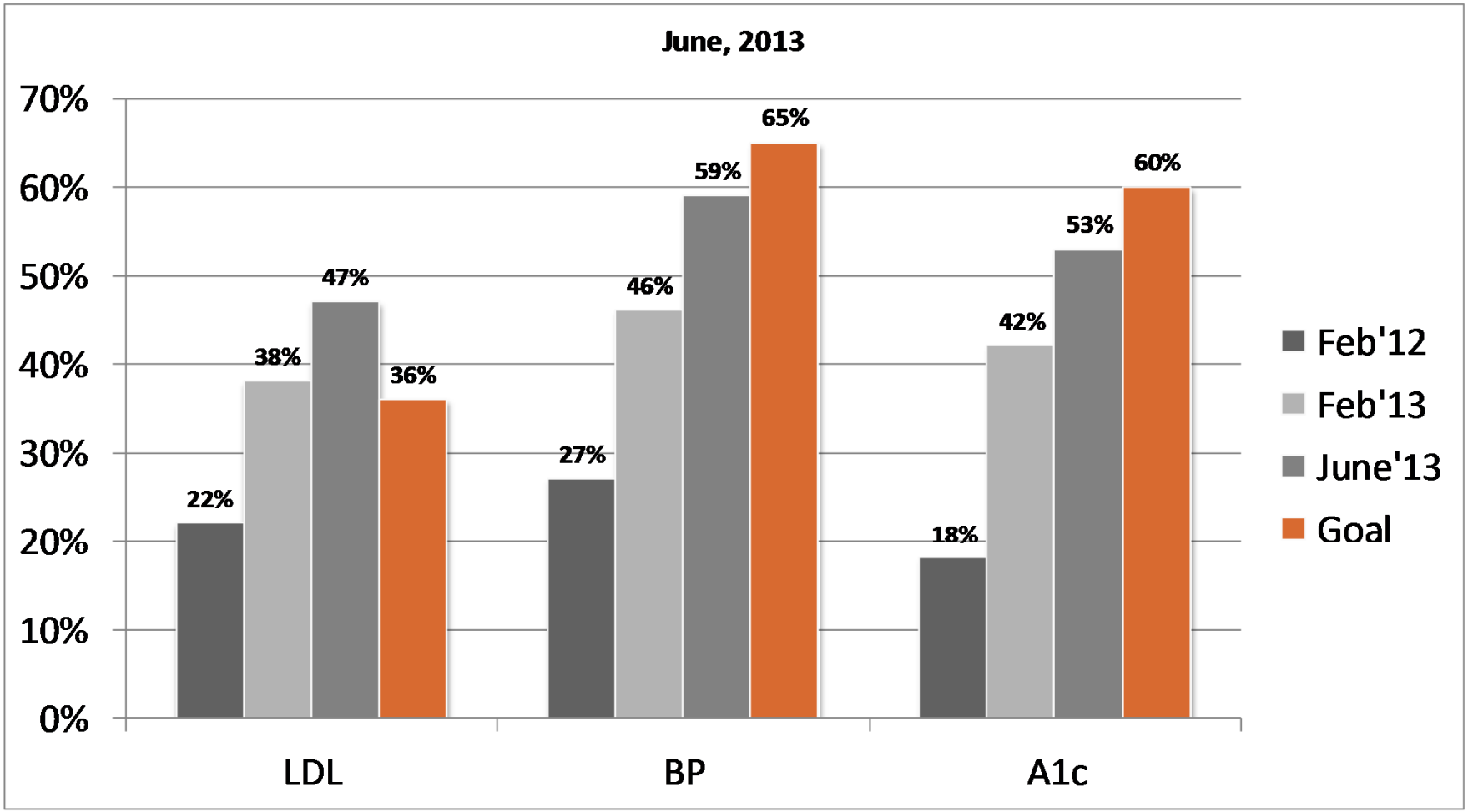
- 20%-24% had uncontrolled blood pressure levels
- Cohorts with elevated blood pressure levels showed more than a 6 point drop in both systolic and diastolic pressure
- In every cohort, on average, systolic pressure dropped below 140 and diastolic pressure dropped below 90
- Systolic and diastolic pressure increased by 1 to 5 points in cohorts with normal blood pressure levels, with Systolic pressure averaging in the low 120s and Diastolic pressure averaging in the mid 70s

Hypertension and Cardiovascular Disease



Disease Management: Diabetes

2822 Continuously Enrolled Adults*



*29% of continuously enrolled adults

Initial Estimated Cost Savings after 18 Months

- **CMHC Health Homes**
  - 20,031 persons total served (includes dual eligibles)
  - Cost decreased by $76.33 PMPM
  - Total cost reduction $15.7 M
- **Health Homes**
  - 43,385 persons total served (includes dual eligibles)
  - Cost decreased by $51.75 PMPM
  - Total cost reduction $23.1M
- **PC Health Homes**
  - 23,354 persons total served (includes dual eligibles)
  - Cost decreased by $30.79 PMPM
  - Total cost reduction $7.4 M
- **DM3700**
  - 3560 persons total served (includes dual eligibles)
  - Cost decreased by $614.80 PMPM
  - Total cost reduction $22.3M

Planning

- Requires a significant change in the way of thinking and practice patterns of providers
- Care for an entire population, not just for the individual patients who actively seek care
- Adopt a new way of doing business
- "Health information technology is absolutely 'necessary but not sufficient' for creating practice-based population health management; committed executive and clinical leadership, care team development, and care coordination processes are also critical success factors"[1]

[1] Population Health Management: A Roadmap for Provider-Based Automation in a New Era of Healthcare, Institute for Health Technology Transformation, Chase, Alide, et.al.

What Makes it Possible?

- A relationship of basic trust between:
  - Department of Mental Health
  - MO HealthNet (Medicaid)
  - State Budget Office
  - MO Coalition of CMHCs
  - MO Primary Care Association
- Transparent use of data instead of anecdotes to explore and discuss issues
- Willingness of all partners to tolerate and share risk
- Principled negotiation and motivational interviewing

Partnership Principles

DON'T

- Talk about your need first
- Expect to get something
- Limit assistance to a project
- Make it about this deal
- Push a specific position
- Withhold information
- Let them take their lumps

DO

- Ask about their needs first
- Give something
- Assist wherever you can
- Make it about the next 10
- Pursue common interests
- Reveal anything helpful
- Take one for the team

Questions?

Upcoming Webinar!

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