Panel II: Clinical Practice in the Era of Integrated Care and Population

Moderator: Arthur Evans, Ph.D.

Commissioner, Department of Behavioral Health and Disability Services, City of Philadelphia

Clinical Practice in the Era of Integrated Care and Population Health

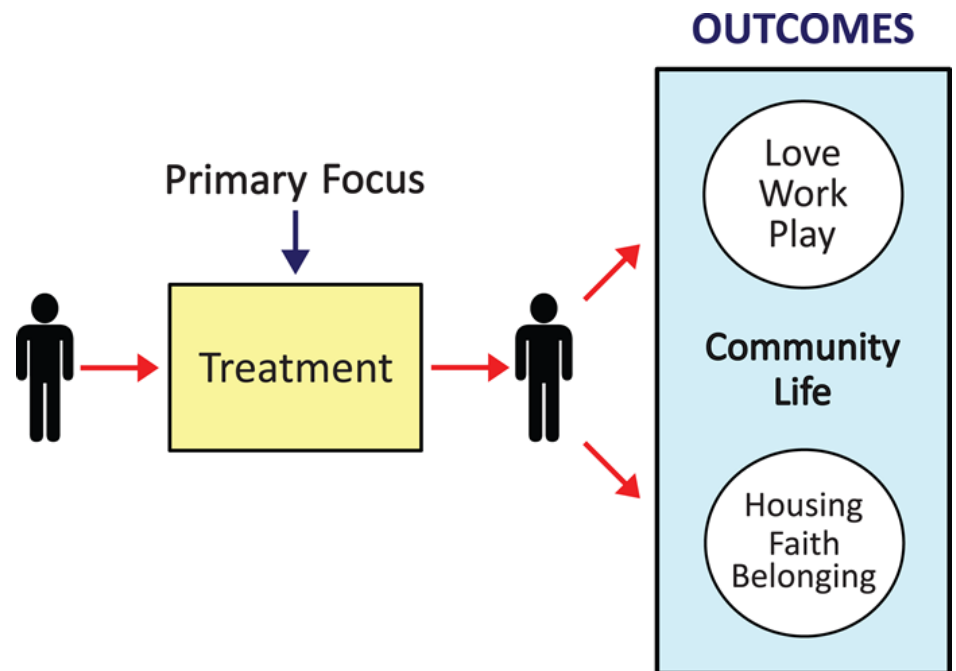
31st Annual Rosalynn Carter Symposium on Mental Health Policy
November 13, 2015

Arthur Evans, Ph.D., Commissioner

Behavioral Health System Challenges

- **Untreated behavioral health conditions major cost driver**
- **Retention**
- **Engagement**
- **Dose**
- **Transitions**

TRADITIONAL TREATMENT MODEL



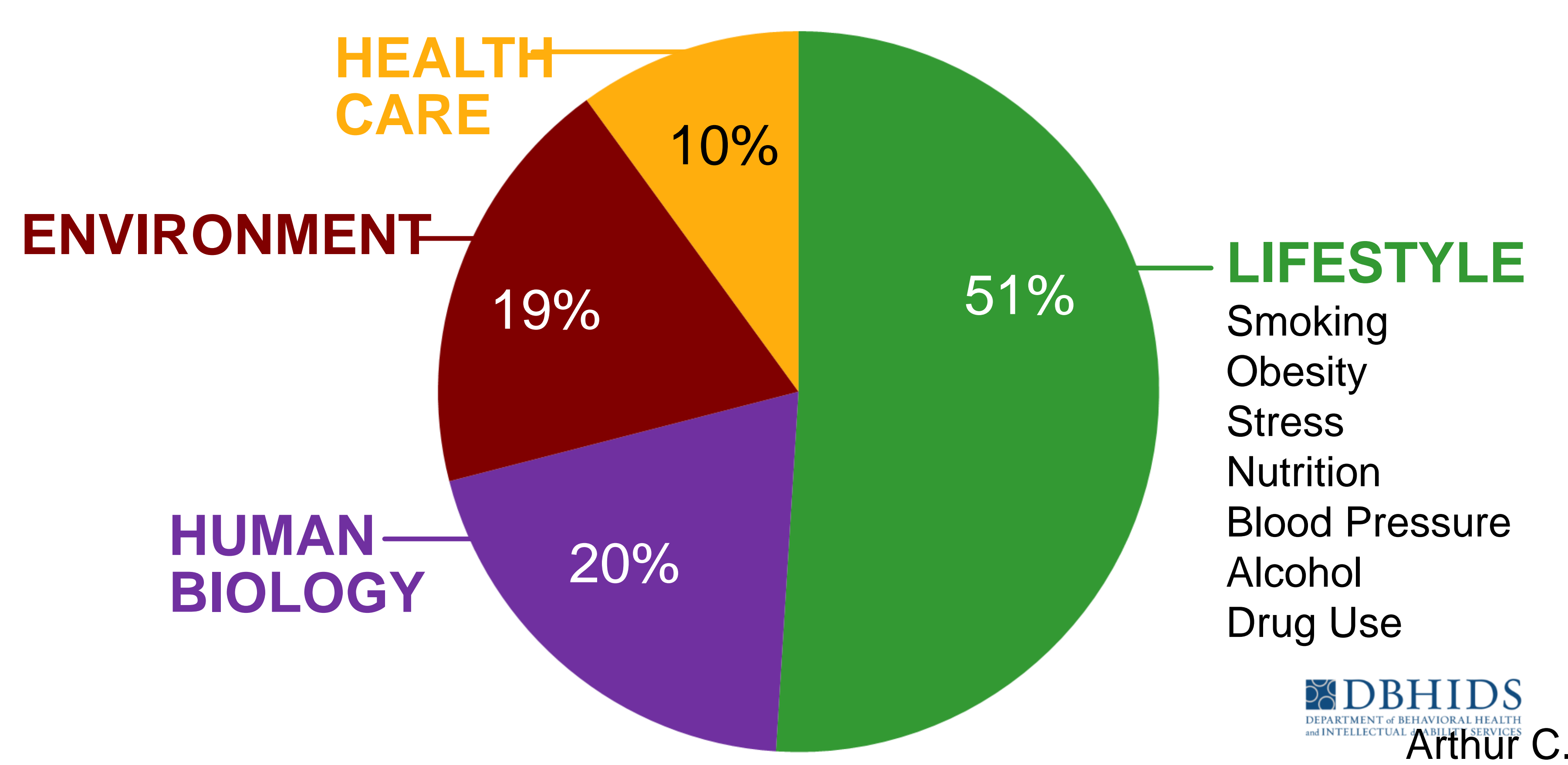
and Environmental Factors
Living and Working Conditions
Family and Community Networks
Personal Behavior
Individual Traits

$100 BILLION
Our Current✓ Treatment System

5%	Severe Mental Illness
20%	Diagnosable Mental Disorder
75%	Everyone Else

Arthur C.

Factors that Influence Health Status



Arthur C.

Population Health: Kindig, 2003 (IHI)

the health outcomes of a group of individuals, including the distribution of such outcomes within the group. *These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group.*

Arthur C.

Elements of a Population Management Approach

- Addresses **social determinants** of health
- Is focused on **long-term outcomes**
- Has **health as the goal** (not symptom reduction)
- Requires **partnership**
- Requires **creativity and innovation**
- Utilizes a **data driven approach**
- Involves **systemic strategies**
- Can use **managed care approaches**

Public Health Approach to Population Health

EFFECTIVE TREATMENT & SYSTEMS

+

COMMUNITY HEALTH STRATEGIES

7 Competencies Needed for Population Health Management

1. Working at the community and group level
2. Working upstream
3. Broad set of strategies
4. Working with non-diagnosed populations
5. Deliver health promotion interventions
6. Working in community and other non-clinical settings
7. Health activation approaches and empowering others

DBHIDS
DEPARTMENT of BEHAVIORAL HEALTH and INTELLECTUAL disABILITY SERVICES

Community Screenings

Community Screenings

Screenings

HealthyMindsPhilly.org

Mental Health First Aid On Our Minds Calendar Behavioral Health Screening

Get Help Now.

Help Yourself, Help Others

Mental Health First Aid »

Learn to identify, understand, and respond to signs of behavioral health challenges or crises.

On Our Minds »

Thoughts and updates from Dr. Arthur C. Evans, Jr., Commissioner of DBHIDS and staff.

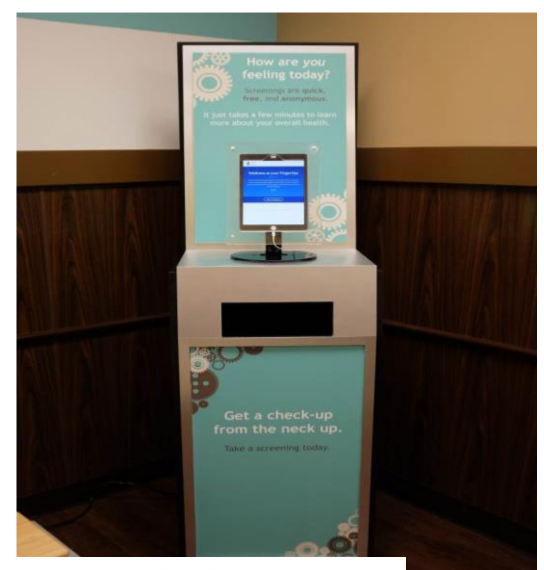
Calendar »

Find awareness events, screenings, or trainings from DBHIDS.

Behavioral Health Screening »

If you feel sad, anxious or stressed, this screening tool can help you decide if you need further help.

Mental Health Kiosk



philly.com READERS' CHOICE 2·0·1·5

VOTED "PHILADELPHIA'S BEST GYM"
-THE PHILADELPHIA INQUIRER

ShopRite®

Screening for Mental Health®

Early Intervention

Trauma Response Teams

Arthur C.

Arthur C.

“When the community starts getting together around this process, other good things start happening too."

Betsy – Porch Light Participant

Arthur C.

Arthur C.

Finding the Light Within

© 2012 City of Philadelphia Mural Arts Program / James Burns.
Horizon House, 119 S. 31st Street. Photo by Steve Weinik

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and INTELLECTUAL disABILITY SERVICES

Thank You

Arthur C. Evans, Ph.D.

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Healthymindsphilly.com

Panel II: Clinical Practice in the Era of Integrated Care and Population

Panelists:

Lisa Goodale, M.S.W., *Vice President of Training, Depression and Bipolar Support Alliance*

Frank de Gruy III, M.D., M.S.F.M., *Woodward Chisholm Professor and Chair, Department of Family Medicine, University of Colorado School of Medicine*

Benjamin Miller, Psy.D., *Assistant Professor, Director, Office of Integrated Healthcare Research and Policy, Department of Family Medicine, University of Colorado School of Medicine*

Naakesh Dewan, M.D., *Medical Director for Behavioral Health, BayCare Medical Group*

PEER SUPPORT SERVICES
IN THE ERA
OF POPULATION HEALTH
AND INTEGRATED CARE

2015

Led by and created for individuals living with mental health conditions, and that experience informs everything that we do

National leader in training people with mental health conditions to use their experiences to work with others as Peer Specialists.

First-ever national contractor for training/certification of VA peer support staff members

What are we integrating?

- ➔ Care and services
- ➔ The patient’s perspective and desires

1. **Need for recognized, accessible training and certification**

2. **Salary inequities and limited career path**

2015 National Web Survey of Peer Support Specialist Wages and Salaries

Daniels et al, 2015

3. Effective utilization of peer support services

4. Lack of recognized legitimacy and worth

VA Consumer Provider Study

Provider comments:

- CP would be “not completely stable all of the time”, “too fragile”, or “inconsistent”
- CPs “may fall apart” or would have “difficulty in all the paperwork”
- “Given that CPs are not professionals, who will be responsible when something bad happens?”

Chinman, Young, Hassell, Davidson (2006). Toward the implementation of mental health consumer providers services. Journal of Behavioral Health Services & Research, 33, 2, 176-195

Do not work *on* me.

Work *with* me.

- Kunc & Van der Klift

DBSAlliance.org/Training

Enablers of Integrated Care

Frank deGruy
Carter Center
November 12, 2015

Culture & Conventions

- PC
  - Fast, loud, interrupted
  - Lots of live problems
  - Shifting lead clinician
- BH
  - Longer visits
  - Wraparound services
  - PCC needs rooms, stuff

Physical Space

- Proximity
- Interruptibility
- Bumpability

Staffing & Scheduling

- PC
  - Psychologist: 4:1 adults, 3:1 kids
  - Psychiatrist: .2 FTE per 10,000 pts
- BH
  - 1 PCC/500-800 pts
- Flex schedule : available, but not idle

Communication

- Shared EHR (including on phone)
- Phone
- Huddles
- Telehealth
- Common clinical workspace

Teamwork

- Consultation
- Coordination
- Collaboration

Complete Integration

- One clinic, no wrong door
- All patients have a PCC
- All have access to BH clinicians
- Deep end covered

Leadership

- Complex adaptive system
- Complex adaptive leadership
- Administrative leadership
- Enabling leadership

Barriers to Integrated Care

Benjamin F. Miller (@miller7)
Carter Center
November 12, 2015

The barriers

- Payment
- Policy
- Workforce

Action items for better behavioral health

- Behavioral health is a critical facet of comprehensive primary care — no different than investments in practice-based care management, measurement and other data use competencies, technology and practice transformation support.
- Global payment based upon defined practice budgets for personnel, interventions and related infrastructure – to create team-based, whole-person care (e.g. CoACH)
- Changing payment allows behavioral health providers to not be trapped in a workflow designed to maximize volume-based payments, or pigeon holed into distinct "physical" and "mental health" coding categories
- Primary care practices "own" their own behavioral health resources and are fully accountable for measured outcomes

http://sustainingintegratedcare.net/
http://farleyhealthpolicycenter.org/cost-assessment-of-collaborative-healthcare/

Cost Outcomes

- Substantial, independently evaluated TCOC differentials
- Normalized for differences in population, demographics, risk and price

Medicaid	Medicare	Medicare-Medicaid Beneficiaries
- 5.5%	- 3.0%	- 5.4%

- TCOC = total cost of care.

http://sustainingintegratedcare.net/

Payment recommendations

- Make sure the practice is getting paid by keeping the patient healthy, not per patient visit
- If the practice is not getting one payment per patient, make sure there are incentives in place to encourage primary care clinicians to work with behavioral health (e.g. hold them accountable for certain behavioral health conditions)
- Make sure behavioral health providers share in gains, when appropriate

Consider your policy

- Consider what impact carving out behavioral health in all forms and permutations does at all levels and all policy processes
- End legacy "home grown" assessment and reporting processes that drain resources and often lack any basis in evidence
- See the mental health "system" clearly for what it is now (a 'safety net' and a source of 'specialty care') -- and what it CAN be (a very useful vehicle for community based interventions, a much wider array of social determinant supports and population campaigns)
- Dispel any and all myths that "one size fits all" for behavioral health

Workforce

- The current
- The future
- The community
- Generalist vs. specialist
- Rethink the who and where
- Behavioral health in all contacts

In closing

Legacy systems and often antiquated payment policies limit primary care practices ability to provide integrated behavioral health

There should be "no wrong door" for patients in our community when it comes to receiving behavioral health care

All health policies should be measured against the question, "Will this limit my patients' choice in receiving behavioral health where they want?"

Resources

One stop: http://integrationacademy.ahrq.gov/

Implementation guide: http://www.safetynetmedicalhome.org/change-concepts/organized-evidence-based-care/behavioral-health

Policy: http://farleyhealthpolicycenter.org

Case study: http://www.advancingcaretogether.org/

Webinars: http://www.youtube.com/CUDFMPolicyChannel

State example: http://coloradosim.org/

National organization: http://www.cfha.net/

More: http://www.pcpcc.org/behavioral-health

Email: Benjamin.miller@ucdenver.edu

Integrated Care in a Digital World

N.A. Dewan,M.D.
Medical Director for Behavioral Health,
BayCare Medical Group, BayCare Health System
Nick.Dewan@baycare.org
Editor : Mental Health Practice in a Digital World: A Clinicians Guide, Springer 2015

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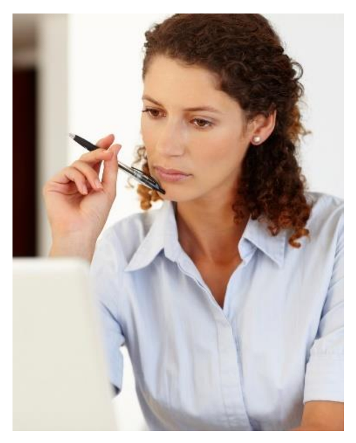
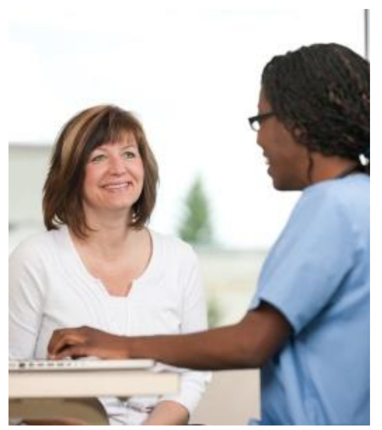
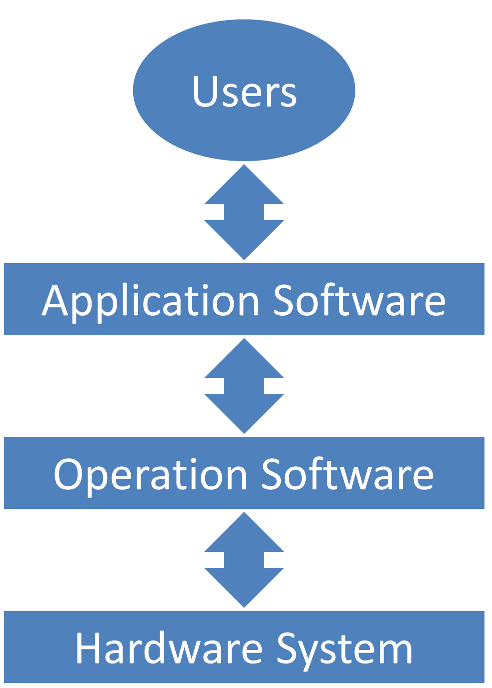
BayCare Applications

BayCare utilizes over 500 different applications for its customers.



Source: Greg Hindahl, CMIO BayCare

BayCare Technology Strategy

Digitization (-'12)	Integration ('12-'16)	Collection ('13-'15)	Analytics & Predictive Modeling ('14-'16)	Act ('14-)
Pharmacy	BEACON	EDW	Scorecards	Predictive Outcomes
Financial	HIE	DG	Analytics	Population Management
Labs	Soarian		KPI	Financial Sustainability
Clinical			Dashboard	

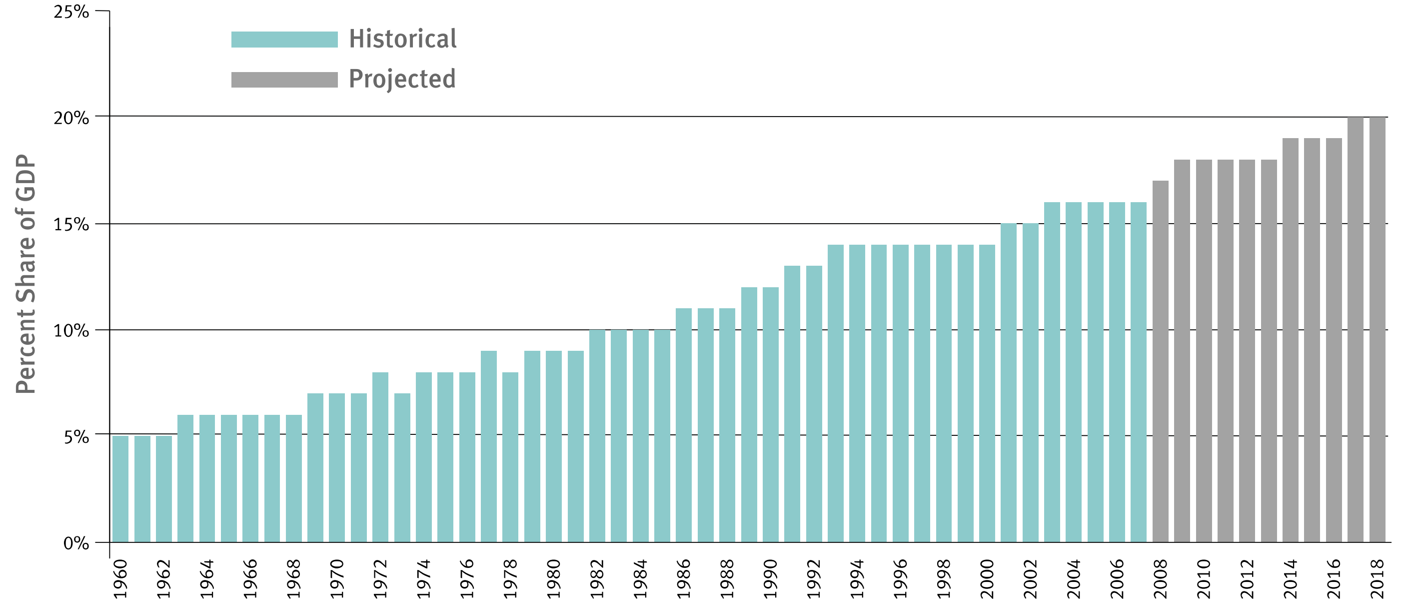
DG: DM&A Capabilities — Retirement, Creation, Storage, Movement, Usage

Analytics: 10010110 10111010

Source : Greg Hindahl , CMIO BayCare

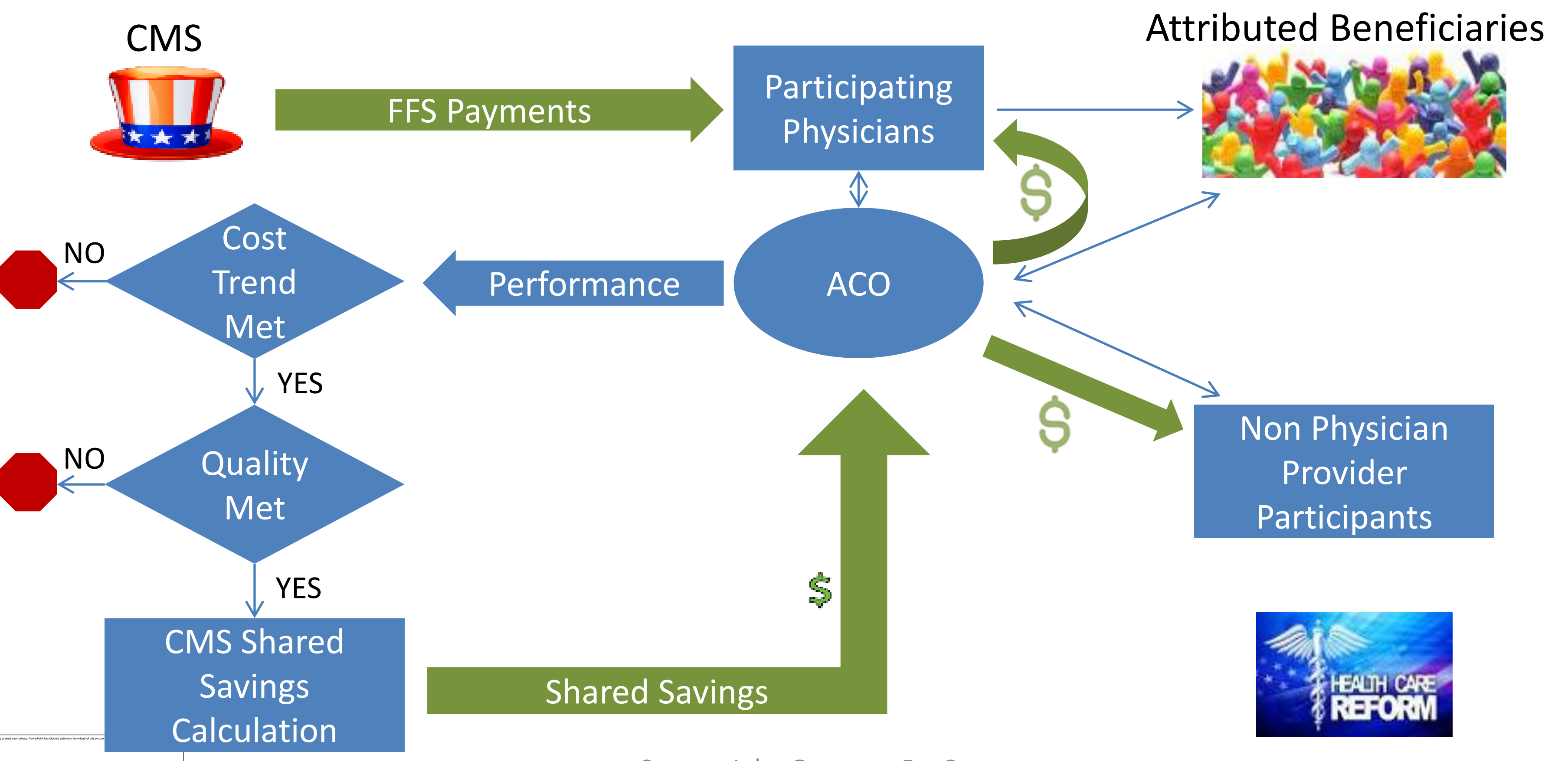
© marketoonist.com

Figure 2: Health care spending as a percent of GDP: United States, 1960-2007 and projected for 2008-2018

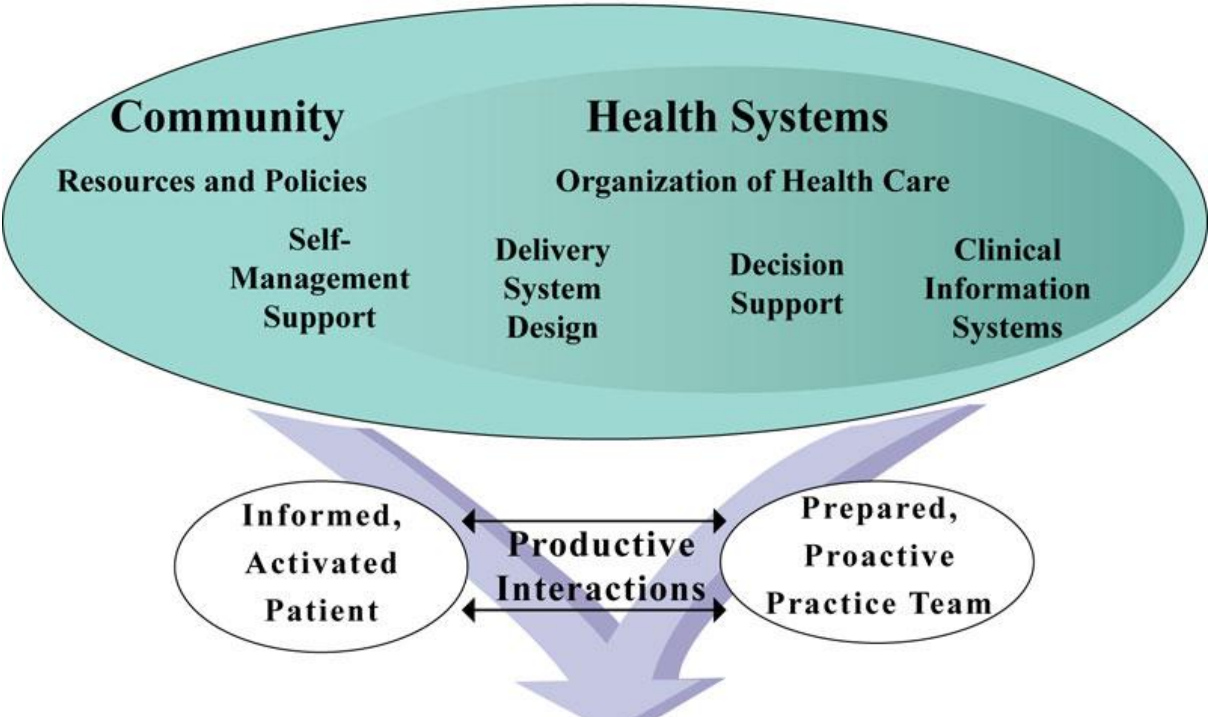


Source: Office of the Actuary, Centers for Medicare and Medicaid Services, 2008

ACO Overview Physician Compensation



Source: John Gantner , BayCare


The Chronic Care Model
Community
Resources and Policies
Health Systems
Organization of Health Care
Self-Management Support
Delivery System Design
Decision Support
Clinical Information Systems
Informed, Activated Patient
Productive Interactions
Prepared, Proactive Practice Team
Improved Outcomes
Developed by The MacColl Institute
® ACP-ASIM Journals and Books

Our Changing Technology Landscape

Valuations and Investments

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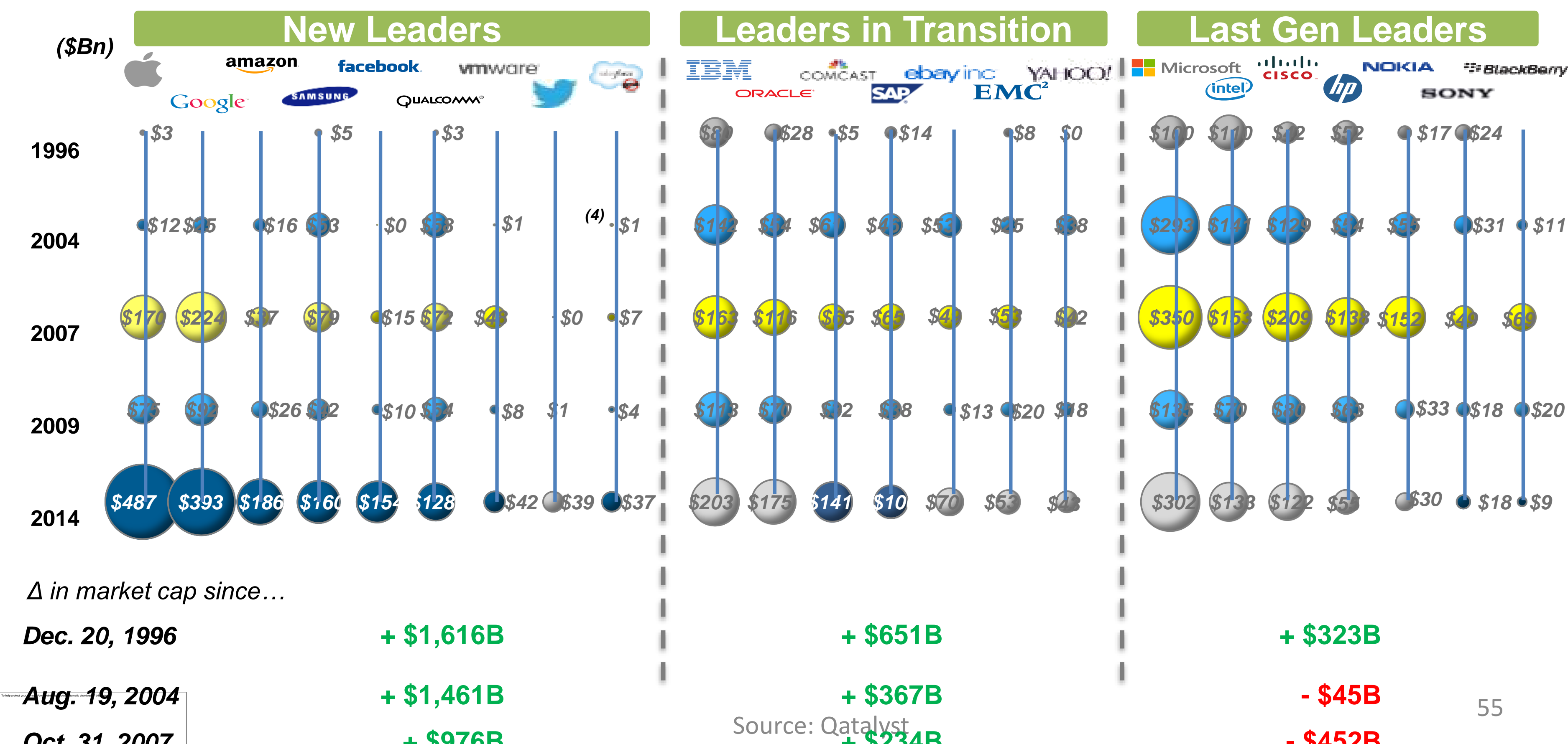
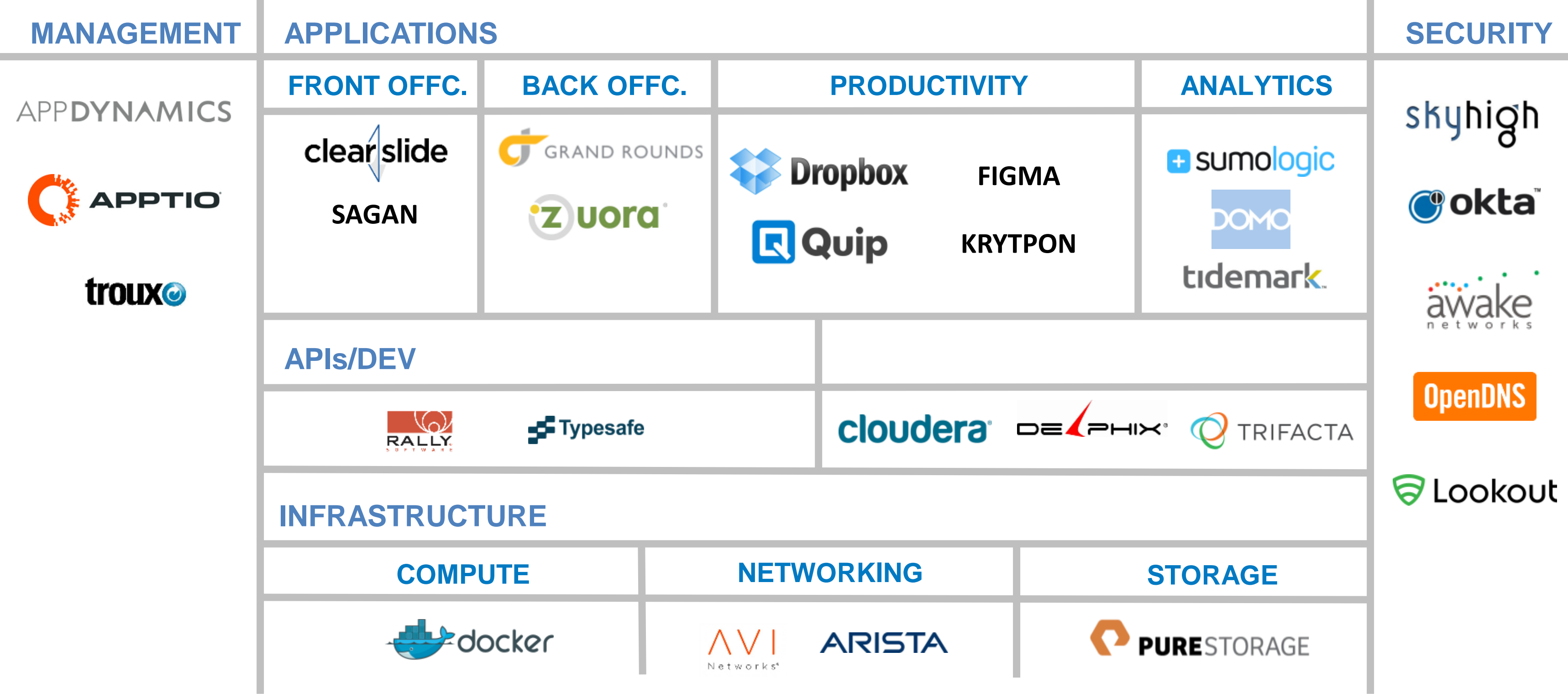
Evolution

- Apple's Acquisition of NeXT (Dec. 20, 1996)
- Google's IPO (Aug. 19, 2004)
- Prior NASDAQ Peak (Oct. 31 2007)
- Recent NASDAQ Trough (Mar. 9, 2009)
- Current (January 13, 2014)



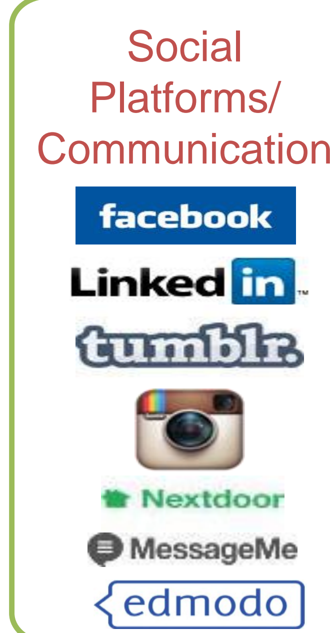
Source: Qatalyst

Greylock Enterprise Portfolio



Source: Asheem Chandna

Greylock Consumer Portfolio



Source: Asheem Chandna

Enterprise Investment Themes

HOT

Cloud, Mobility
Big Analytics
Security
Storage
Software Center
SDN
Internet of Things
Vertical SaaS
Healthcare IT

NOT

– Semiconductor
– Cleantech
– Hardware-centric

???

Bitcoin
3D Printers
Robotics
Drones ☺

To help protect your privacy, PowerPoint has blocked automatic download of this picture.

Source: Asheem Chandna

Healthcare Technology Trends – Big Data , Big Cloud, Big Social, Big Mobile

Investments

- 2013: $3.0B
- 2014: $6.8B
- 2015: $6.0B

Themes

- Wearables, Ingestibles
- Data Analytics
- Precision-Personalized Medicine

mHealth app count

- 2013: 44k iOS
- 2015: 90k iOS, 165k all platforms
- 29% are now mental health
  - Autism: 33%, Depression/Anxiety: 36%

1/3 of MDs recommend apps

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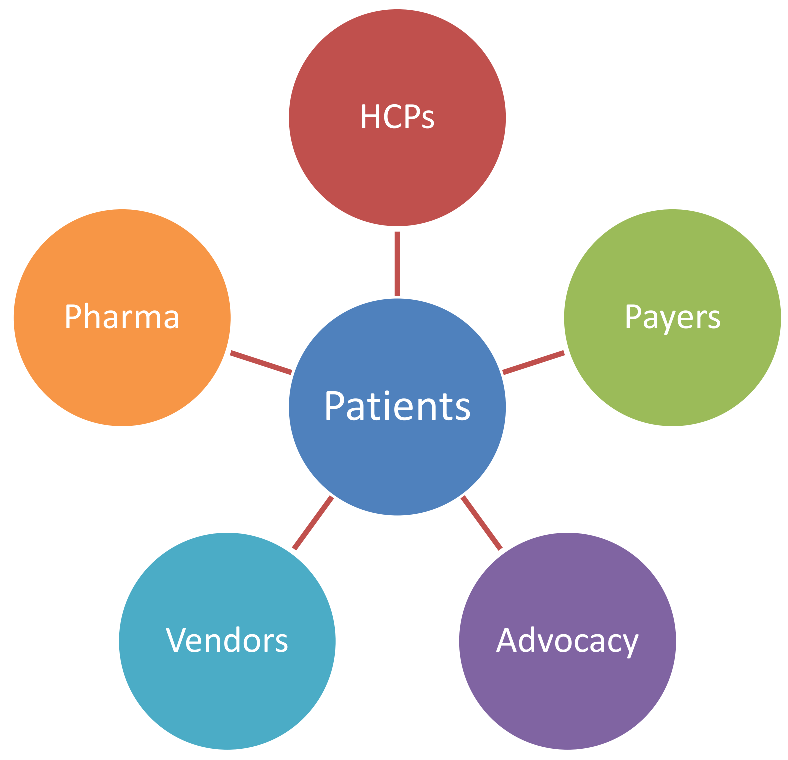
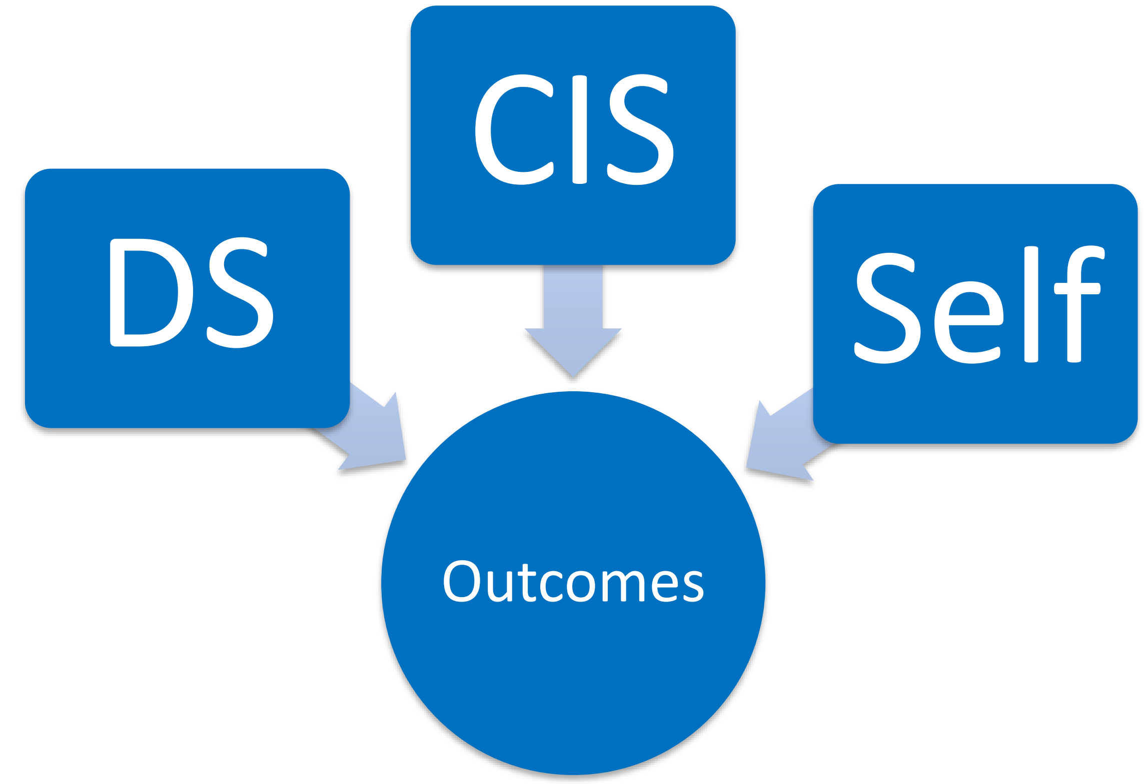
Source: Startup Health, IMS Institute Sept 2015

Crowded landscape, many players creating resources and touching the patient, disconnected and confusing, and problems persist

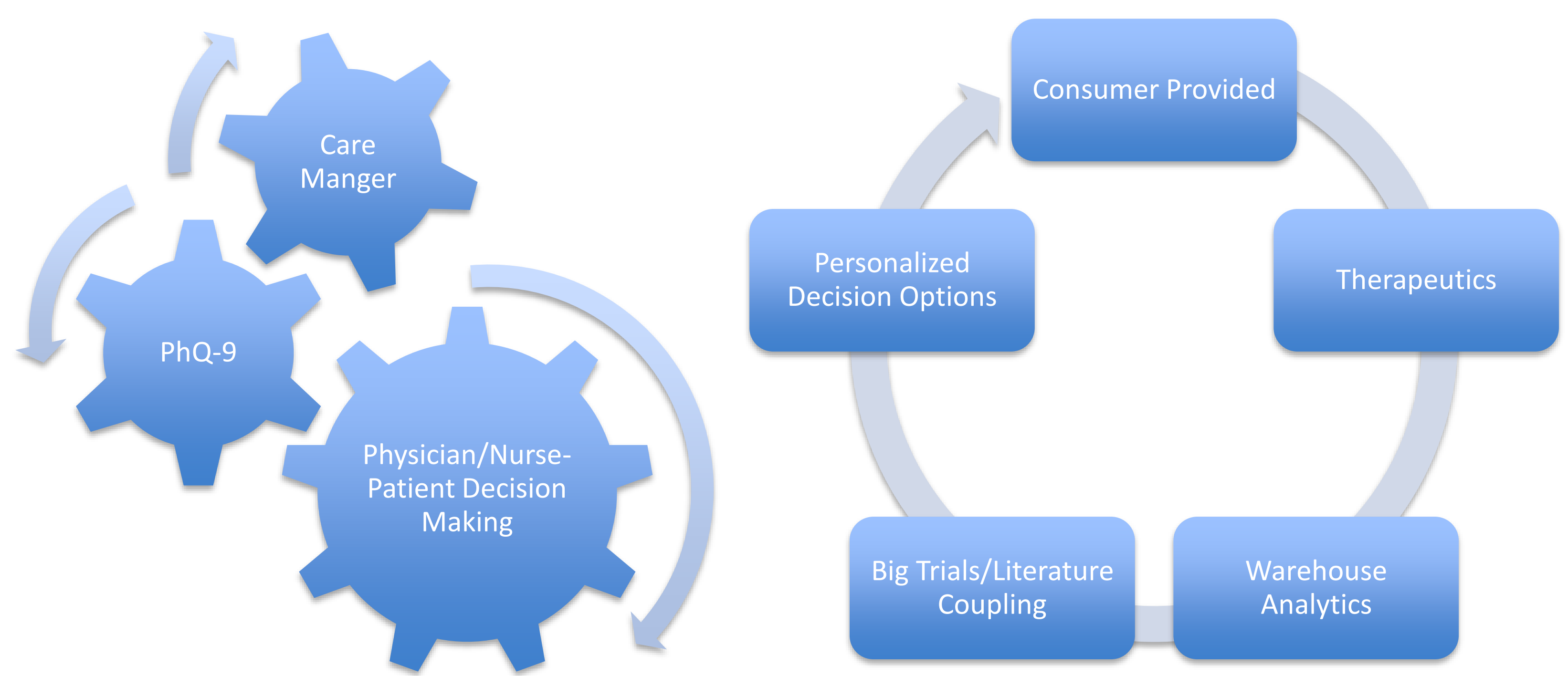


Source: Charles Peipher, Rajas Consulting

Our Concept of Integrated Care Technologies



Future of Decision Support in a Measurement Based Care World



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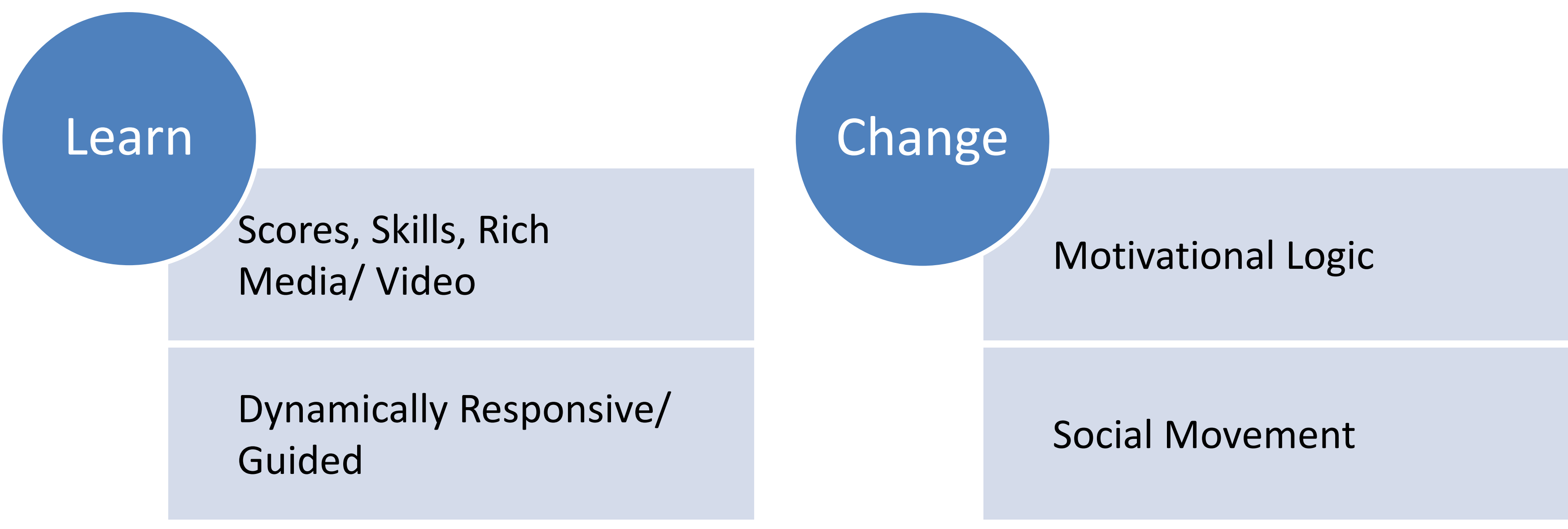
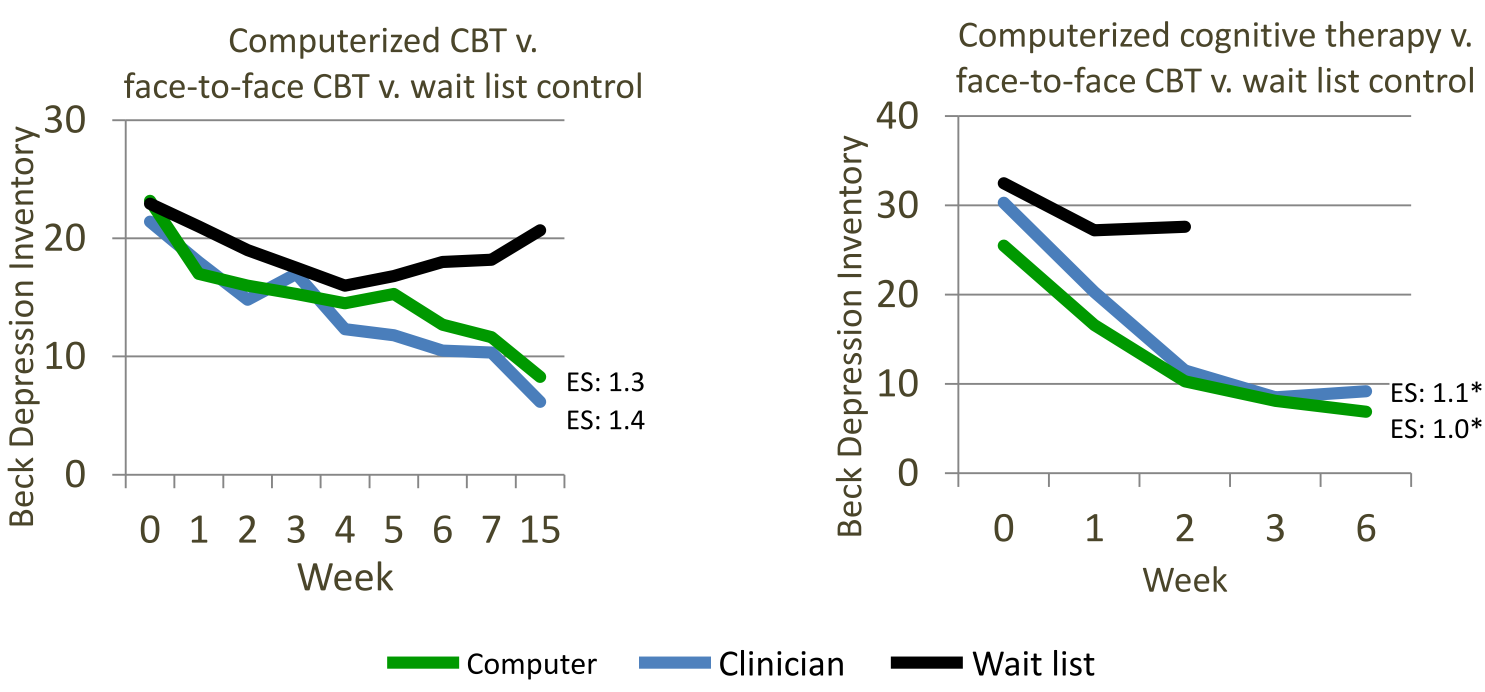
Future of Self-Management On-Demand -CCBT Support = Finally!!



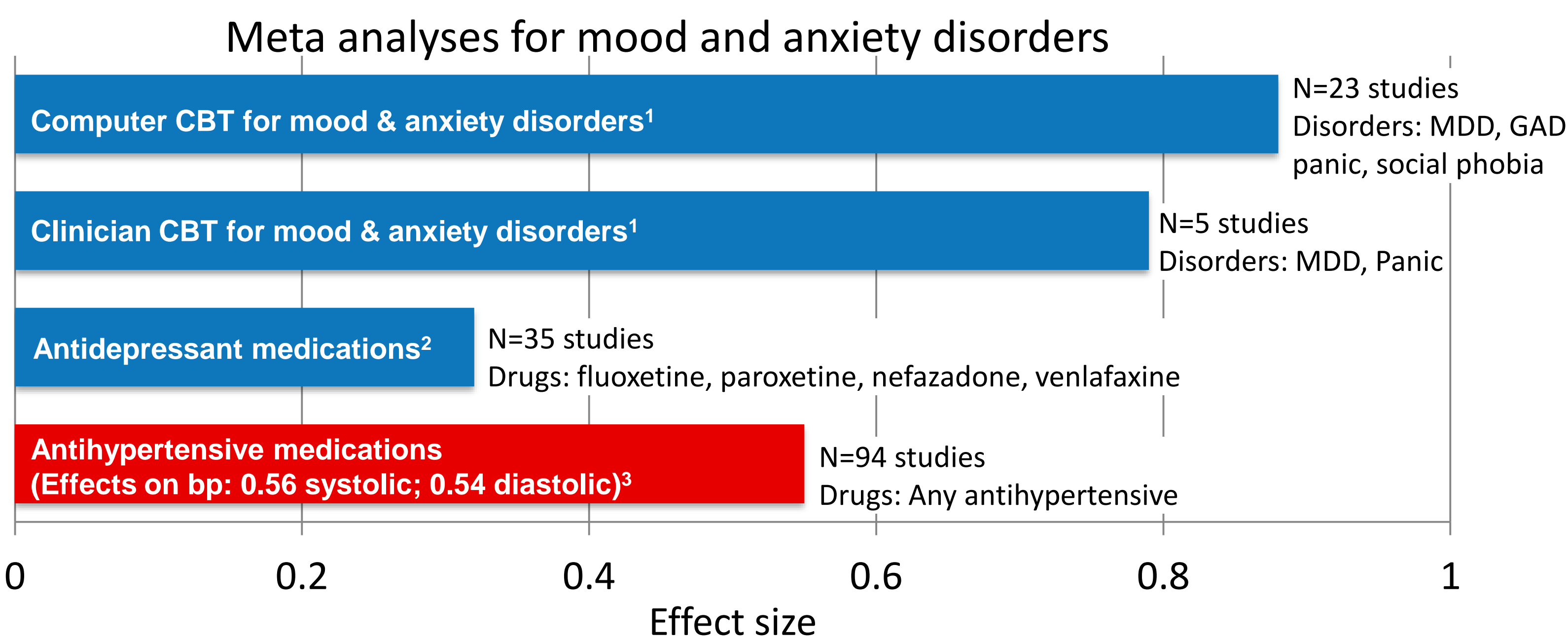
CBT: computers and humans clinically equivalent



Selmi PM, et al.: AJP, 1990;147:51-56

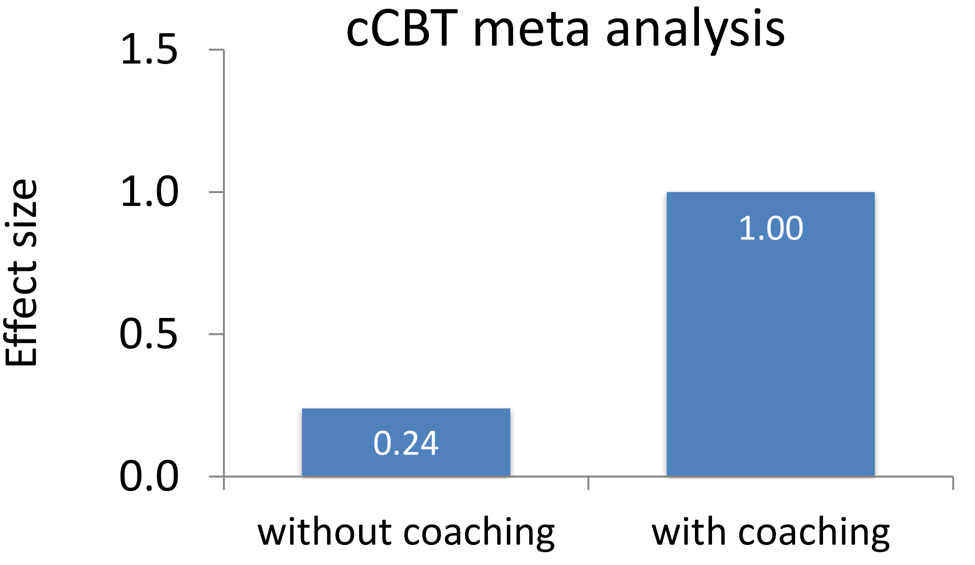
Wright JH et al, Am J Psychiatry 2005; 162: 1158-1164
*Mean effect size for BDI and Ham-D

Computerized CBT effect size compares favorably



1. Andrews et al. *PLoS ONE*, www.plosone.org 2010;5:e13196
2. Otto et al. *AJP* 2001;158:1989-1992.
3. Leucht et. al., *BJP* 2012: 97-106

Historically, coaching increases cCBT effectiveness



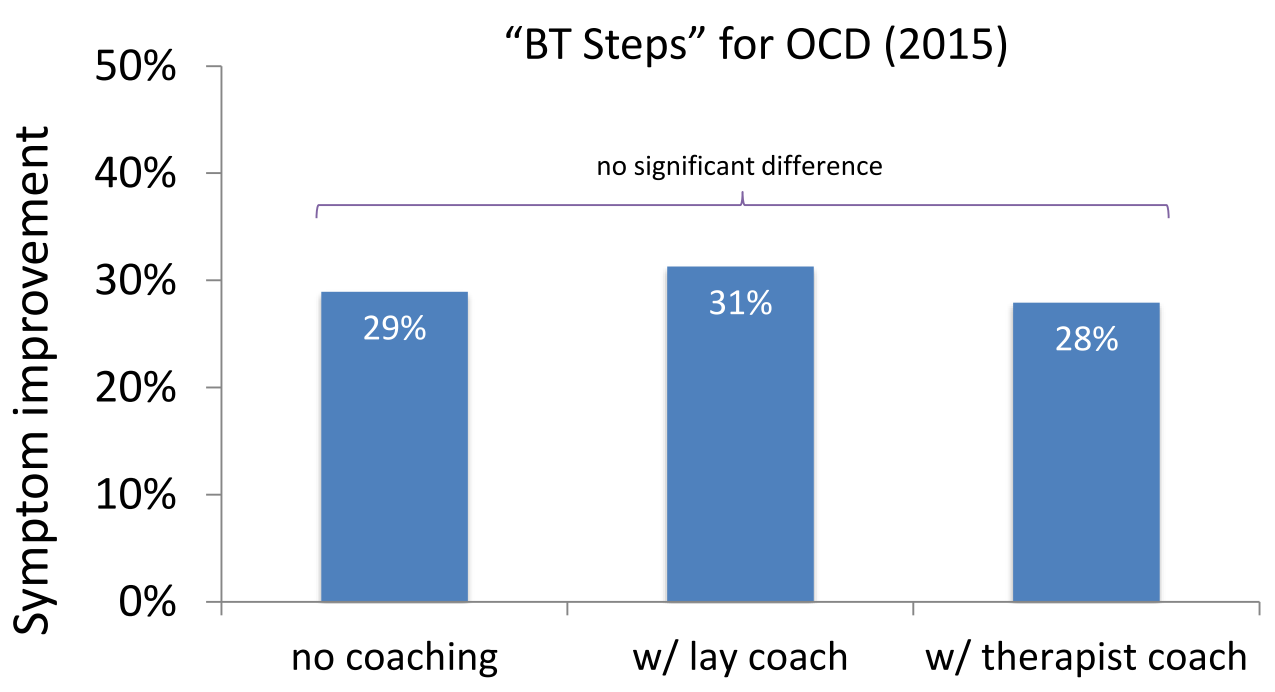
Meta analysis of 11 studies of computerized CBT programs for depression and anxiety (n = 2,157)

Support only in working through standardized course material; no “therapeutic alliance”

Therapist support increased effect size *four-fold*

Spek et al. Psychological Medicine 2007:37:319-328

But is coaching still necessary?



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Kobak et. al. Ann Gen Psychiatry. 2015 Feb 22;14:10.

Future Workforce Optimization
Usual Productivity vs Tech Driven Care

Usual Care Therapists

1500 hrs serving 250 individuals x (6) 60 minute visits = 1500 visits

Tech Driven Therapists

1500 hrs serving 750 individuals x 1 60 min visits and (2) .5 hr visits = 2250 visits + unlimited computer visits

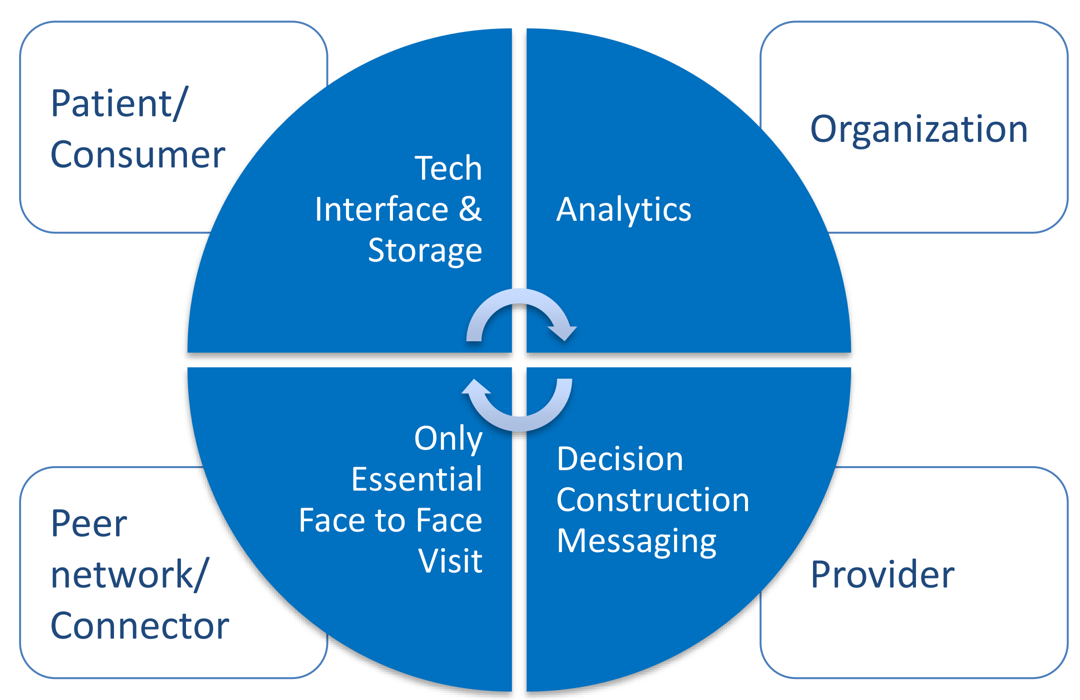
Usual Care ARNP or MD

1500 hrs serving 1000 individuals x (1) 45 min visit and (3) 15 min visits = 4000 visits

Tech Driven ARNP or MD

1500 hrs serving 1500 individuals x (1) 30 min visit and (3) 10 min visits = 6000

Technology Based Asynchronous Care Needs Organizational, Policy, and Reimbursement Innovations



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Q & A

Panel III: Innovations in Education and Training

Moderator: Ben Druss, M.D.

Rosalynn Carter Chair in Mental Health, Rollins School of Public Health, Emory University

MEDICAL EDUCATION AND TRAINING: WHERE WE'VE BEEN AND WHERE WE NEED TO GO

Benjamin Druss MD, MPH

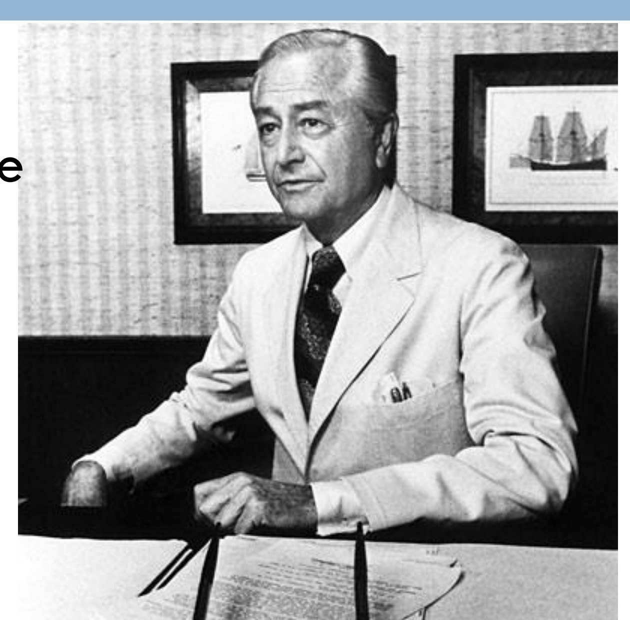
Carter Center Symposium

November 13, 2015

The Old Model of Care Delivery

- Physicians largely in solo practice
- Treatment about providing the best care possible for individual patients
- Skills needed: clinical knowledge,

good listening skills



The New Model of Care Delivery

- Physicians increasingly working as part of large organizations
- Skills needed: understand principles of population-based care, work as part of teams; leadership

The Old Model of Learning

- Knowledge relatively static
- Goal is to memorize body of medical knowledge during medical school and residency

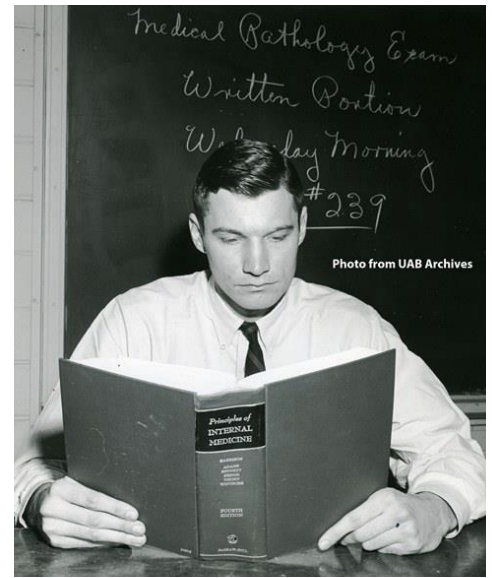


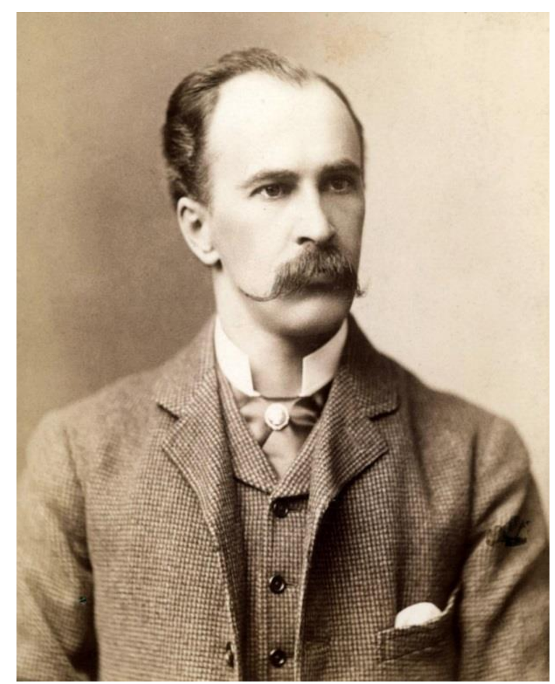
Photo from UAB Archives

The New Model of Learning

- Knowledge base constantly changing
- Learning occurs throughout career

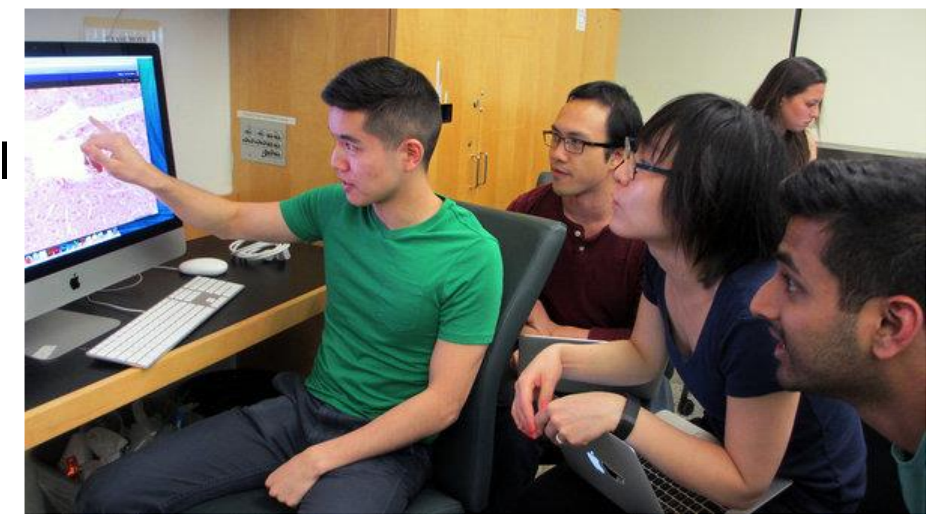
The Old Model of Training

- Problem: not enough information
- Training model: memorization and apprenticeship



The New Model of Training

- Problem: too much information
- Training model: learn to isolate signal from noise



Summary

- Can't understand workforce without considering how they are trained
- Training needs to embody skills in interpreting data and continues across a lifetime