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Serious Mental Illness: Data Use to Improve Health Outcomes

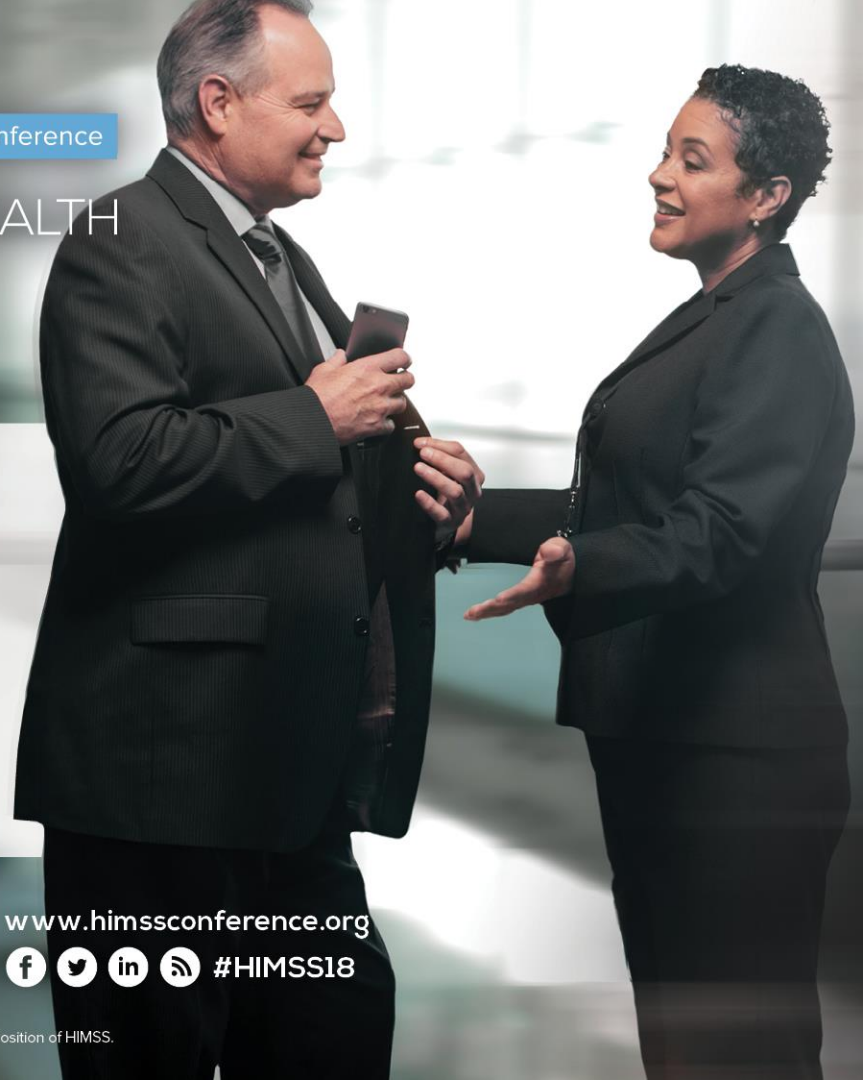
Session #74, March 6, 2018

Presenters: Nina Marshall, MSW; Samantha Holcombe, MPH

Care Transitions Network:

National Council for Behavioral Health
Montefiore Medical Center
Northwell Health
New York State Office of Mental Health
Netsmart

COMMITMENT



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Conflict of Interest

Samantha Holcombe, MPH
Has no real or apparent conflicts of interest to report.

Nina Marshall, MSW
Has no real or apparent conflicts of interest to report.

Agenda

- Review of Objectives
- Setting the Context
  - Background and overview of Care Transitions Network, value-based payments and behavioral health populations
- Objective 1
  - Care Transitions Network support for organizational quality improvement approaches; challenges and opportunities in technology
- Objective 2
  - Care Transitions Network care transitions interventions and outcomes; challenges and opportunities in technology
- Objective 3
  - Population health management as a best practice; challenges and opportunities in technology

Learning Objectives

- Examine the infrastructure, governance and technology required to employ an organization-wide quality improvement approach that drives clinical decision making
- Describe strategies for supporting short-term care transitions, including outpatient practices and health homes, for patients with serious mental illness after discharge from hospitalization, with the ultimate goal of preventing visits to the emergency department and/or re-hospitalization
- Identify best practices in technology and training to help implement evidence-based practices and transition to value-based payments

Care Transitions Network in New York State

Who We Are

- CMS Transforming Clinical Practice Initiative: One of 29 “Practice Transformation Networks”
- Helping clinicians achieve large-scale health transformation

Who We Work With

- Over 80 healthcare provider organizations across New York State
- 97% of participating organizations are behavioral health or substance use providers

Project Goals

- Decrease re-hospitalization rates
- Improve adoption of evidence-based practices for behavioral health population

Fee For Service

Incentive for Volume

Service → Payment

Service → Payment

Service → Payment

Metrics to track:

- Unit of care
- Volume

Value-Based Payments

Incentive for Results

Metrics to track:

- Clinical outcomes/best practices
- Population
- Total cost

Realities for Behavioral Health Populations

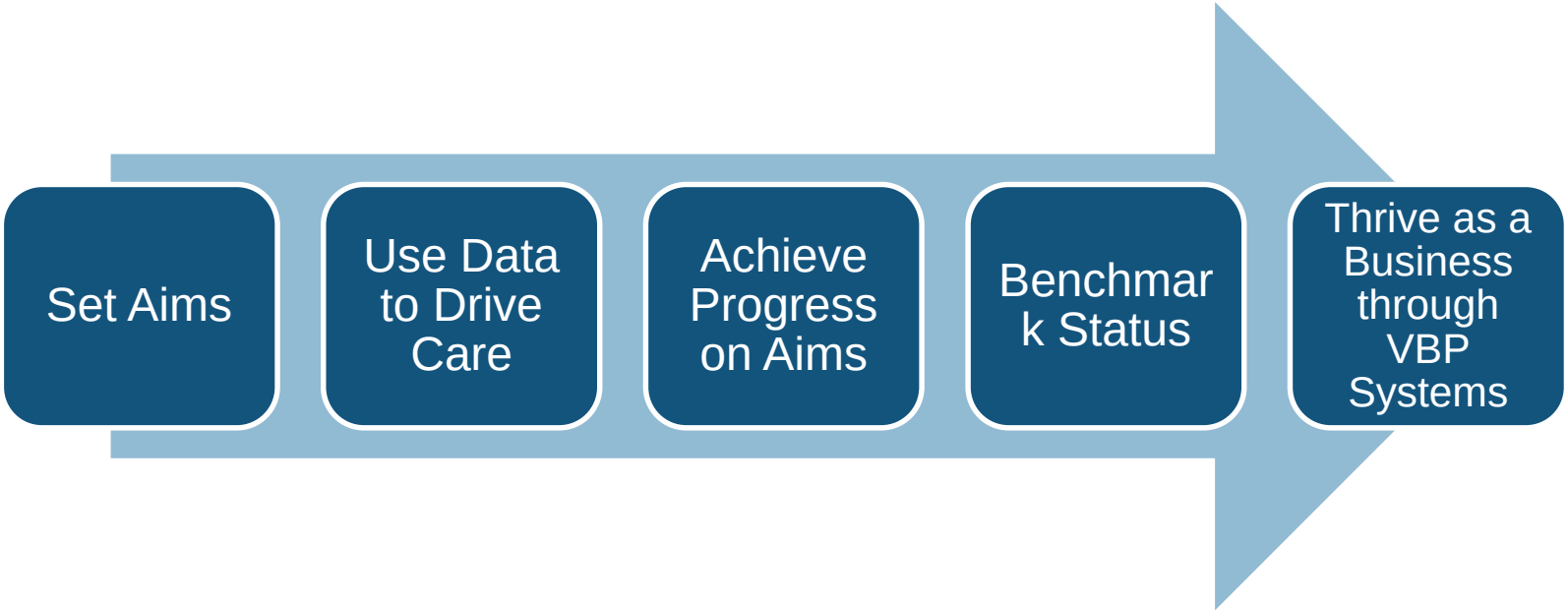
- **Total spending** per person for individuals with a behavioral health diagnosis is nearly **four times higher** than for those without.
- **20 percent** of Medicaid enrollees who have a behavioral health diagnosis **account for almost half of total Medicaid expenditures**.
- Many people with serious behavioral health disorders have a substantial number of comorbid acute or chronic medical conditions.

*Medicaid and CHIP Payment and Access Commission. “Chapter 4: Behavioral Health in the Medicaid Program — People, Use, and Expenditures. Report to Congress on the Medicaid and CHIP.” June 2015.

Value-Based Payment Readiness: A Data-Dependent Enterprise

- Patient- and Family-Centered Care Design
- Data-driven Quality Improvement
- Sustainable Business Operations

Readiness for Value-based Payments

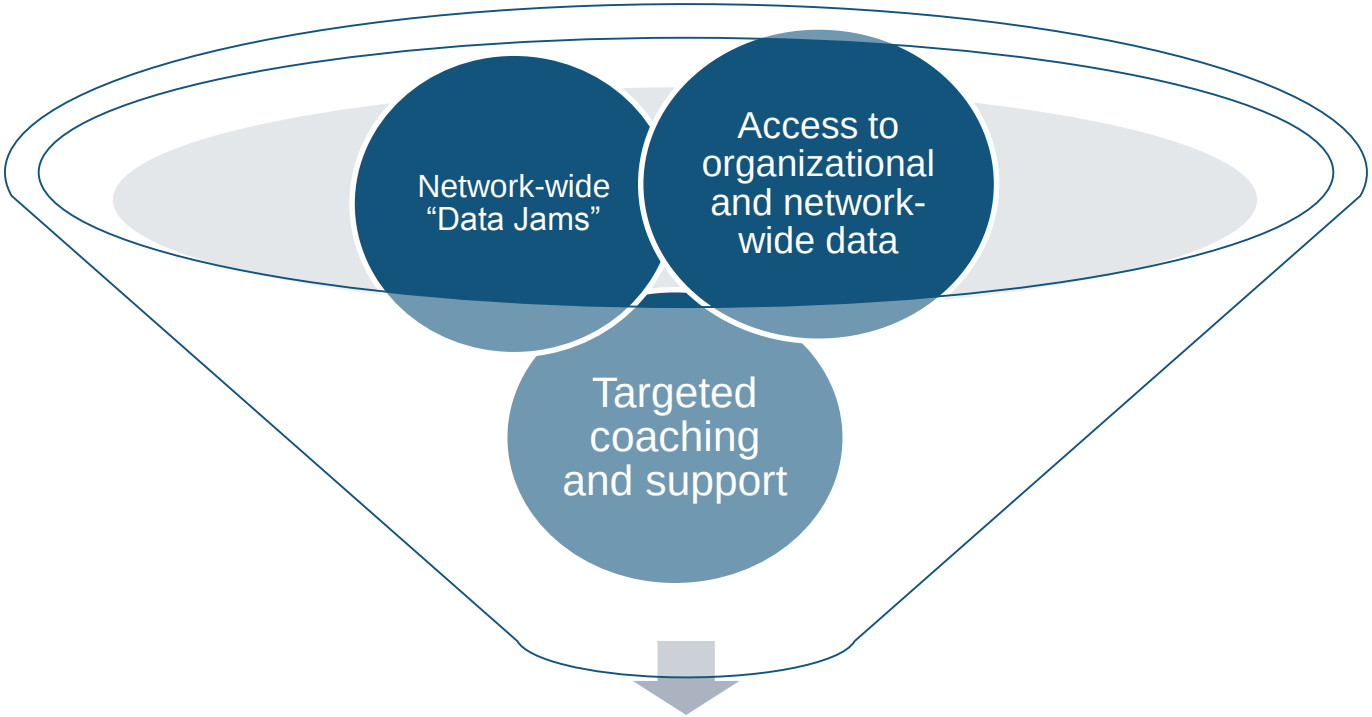


Objective 1

Examine the infrastructure, governance and technology required to employ an organization-wide quality improvement approach that drives clinical decision making

Establishing a Data-Driven QI Approach

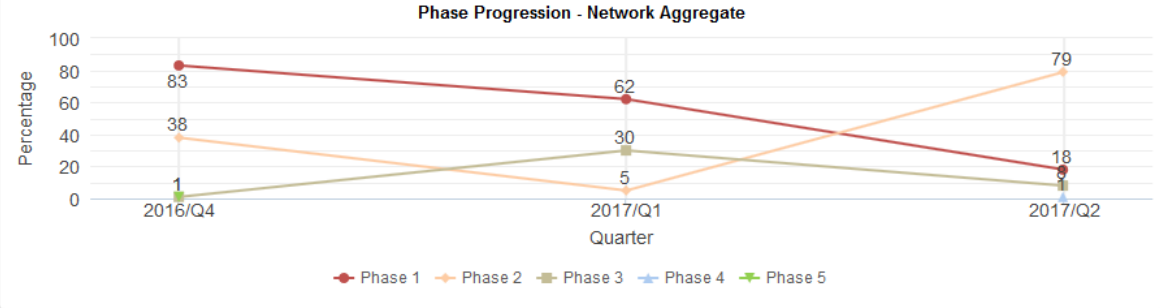
Care Transitions Network Approach



Use of data to inform clinical decision making

Dashboards to Track and Benchmark Progress

Measure	Indicator	Standard	+/-	Current Quarter Percentage	Network Average
1	All-cause 30-day readmission rate following MH inpatient discharge.	NYS	-	25%	25%
2	30-day MH re-admission.	NYS	-	20%	20%
3	Follow-Up After Hospitalization for Mental Illness, 7 Days.	NQF 0576 PQRS 391 HEDIS FUH-A	+	51%	51%
4	Follow-Up After Hospitalization for Mental Illness, 30 Days.	NQF 0576 PQRS 391 HEDIS FUH-B	+	70%	70%



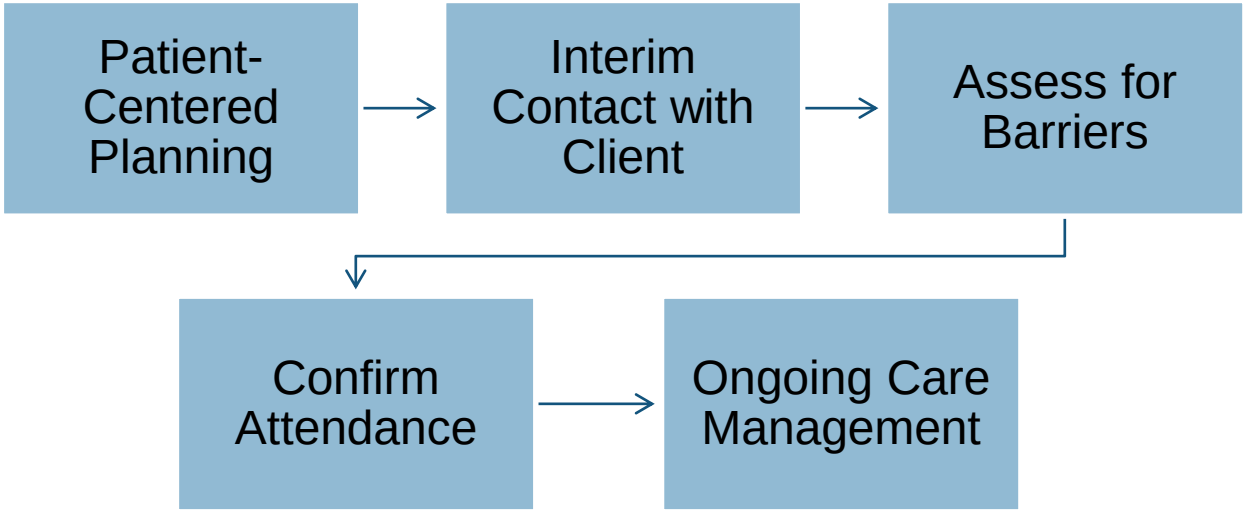
Challenges and Opportunities

- Challenges
  - Use of claims data to populate dashboards requires time lag of approximately 9 months
  - Providers will only have access to claims data through life of project
- Opportunities
  - Incorporation of clinical decision making tools or algorithms into EHRs that would support increased implementation of evidence-based practices
  - Use of EHR for more real time data capturing

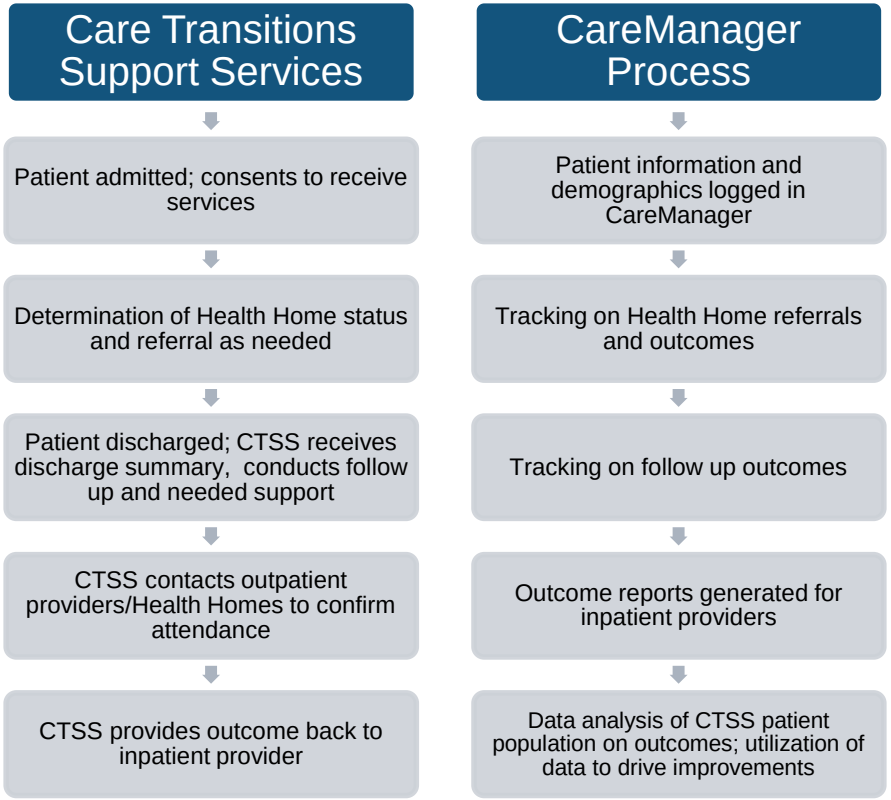
Objective 2

Describe strategies for supporting short-term care transitions, including outpatient practices and health homes, for patients with serious mental illness after discharge from hospitalization, with the ultimate goal of preventing visits to the emergency department and/or re-hospitalization

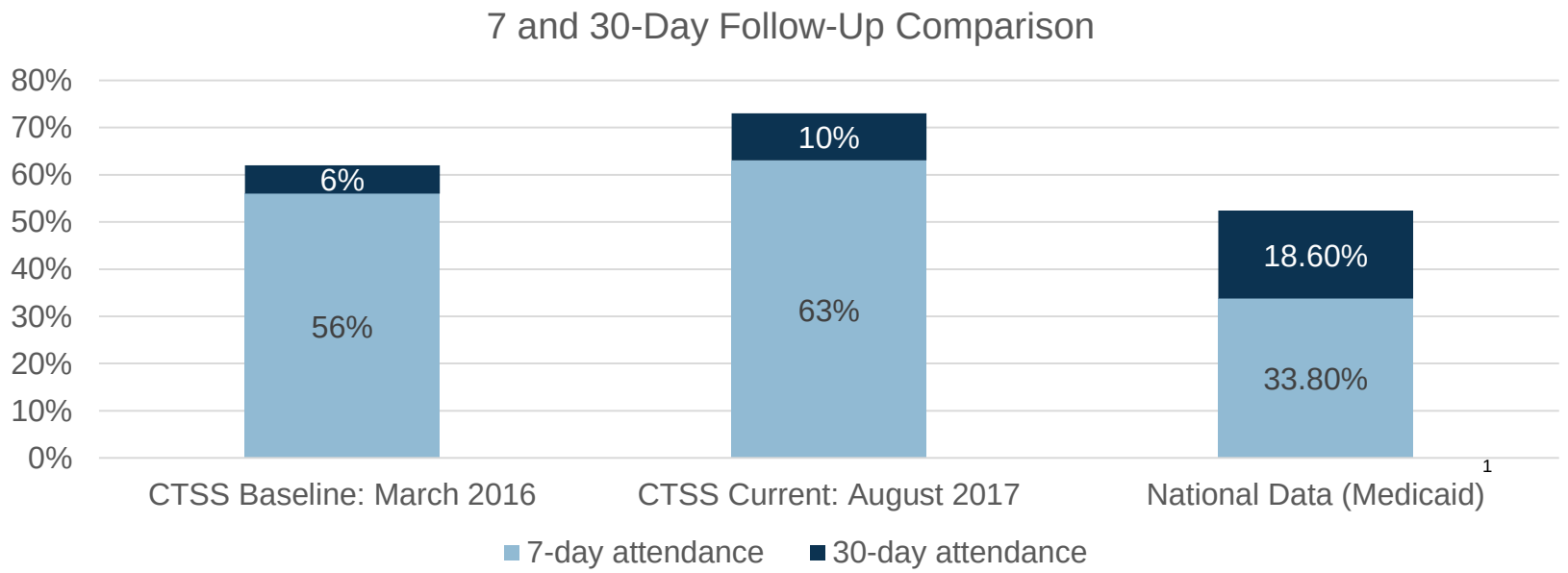
Care Transitions Core Elements



Utilization of Technology to Support Transitions of Care



Care Transitions Clinical Outcomes



[1] http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality/2016-table-of-contents/follow-up

Cost Savings to Date

March 2016-December 2016
455 Clients

Pre/Post-Intervention Claims Analysis:
$808 PMPM

Savings for 455 Clients:
$4.41 million

March 2016-August 2017
1,590 Clients

Using same PMPM

Estimated Savings for 1,590 Clients:
$15.42 million

Challenges/Opportunities

- Challenges
  - Timely tracking on patient outcomes outside of direct network
  - Patient consent for follow on coordinating activities
  - Understanding history for people who experience rapid re-hospitalization
- Opportunities
  - Utilization of RHIOs/HIEs for alerts and notifications outside their network
  - Consolidating patient consents and incorporating into pre-existing workflows
  - Case conferencing with previous care team

Objective 3

Identify best practices in technology and training to help implement evidence-based practices and transition to value-based payments

Principles of Population Health Management

Population Based Care

- Focus on caring for whole population you are serving, not just the individuals actively seeking care

Data-Driven Care

- Utilize data and analytics in order to make informed decisions to serve those in your population who most need care.

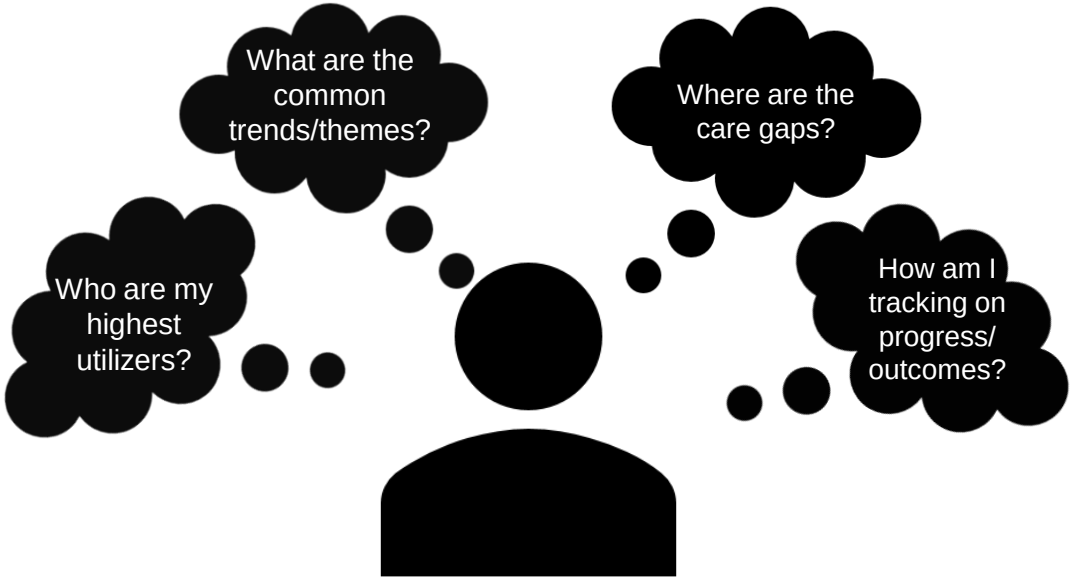
Evidence-Based Care

- Make use of best available evidence to guide treatment decisions and delivery of care

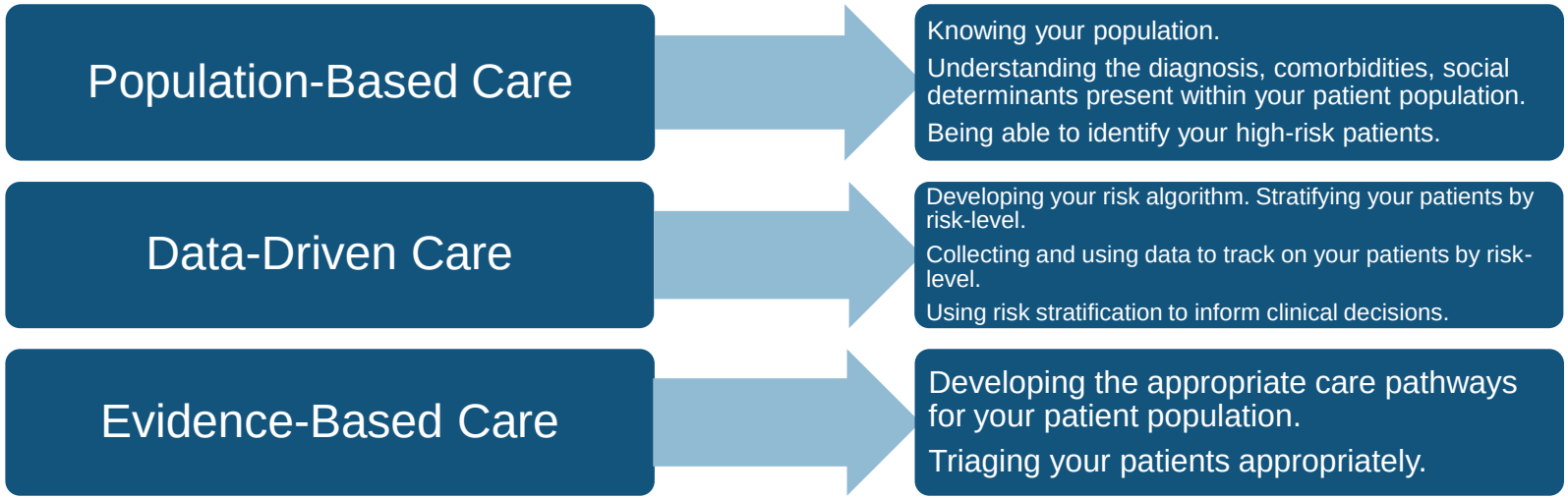
Care Management

- Engage in actionable care management for the population you serve

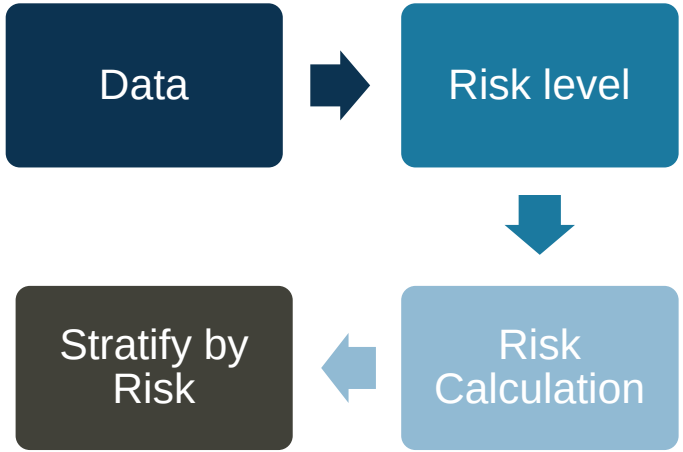
A shift in thinking…



Population Health Operationalized



Care Transitions Network Interventions



- Risk Identification
  - Using population data, defining risk levels
- Risk Calculation
  - Developing risk algorithm
- Risk Stratification
  - Analyzing data and stratifying population by risk
  - Using CTN's Risk Stratification Tool
  - Mapping to EHRs

Challenges and Opportunities

- Challenges
  - Capture of data aligned with risk algorithm
  - Real time data on outcomes
- Opportunities
  - Addition of social determinant-related data fields
  - Incorporation of risk algorithms into EHRs to automate processes and improve clinical decision-making

Questions?

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Thank you!

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