The CMHC Value Proposition

How Our Dog Caught the Car

My Background

- Medical Director for National Council for Behavioral Health
- Previously
  - Missouri Medicaid Director – 3 years
  - DMH Medical Director – 20 years
- Practicing Psychiatrist -
- Distinguished Professor, Missouri Institute of Mental Health, University of Missouri –St. Louis
- Adjunct Professor of Psychiatry – University of Missouri Columbia

Where are we today? The good news

- **There is growing awareness of our issues.**
  - Understanding that behavioral health is essential to whole health
  - Sustained media attention, growing numbers of people talking openly about their or their loved one's experience

- **More Americans have coverage than ever before.**
  - Coverage includes parity for most Americans
  - Full parity implementation has proven difficult, many consumers still lack access to key services

Good news: growing recognition that…

- **Behavioral health is essential to whole health**
  - Higher costs, poorer overall outcomes associated with co-occurring BH and physical health conditions
- **Treatment works**
- **Recovery** and a fully functioning life in the community are possible

Public Attention to Mental Health and Addiction is Growing

A First-Aid Class for Mental Health

Most people know how to help someone with a cut or a scrape. But what about a panic attack?

The New York Times

"Elsewhere, groups or networks have formed to spread the knowledge…They include the National Council on Behavioral Health's Trauma-Informed Care Learning Community…"

The Washington Post

Trying to make mental health first aid as familiar as CPR

npr

Shortage Of Addiction Counselors Further Strained By Opioid Epidemic

February 24, 2016 · 4:57 AM ET
Heard on Morning Edition

CNBC

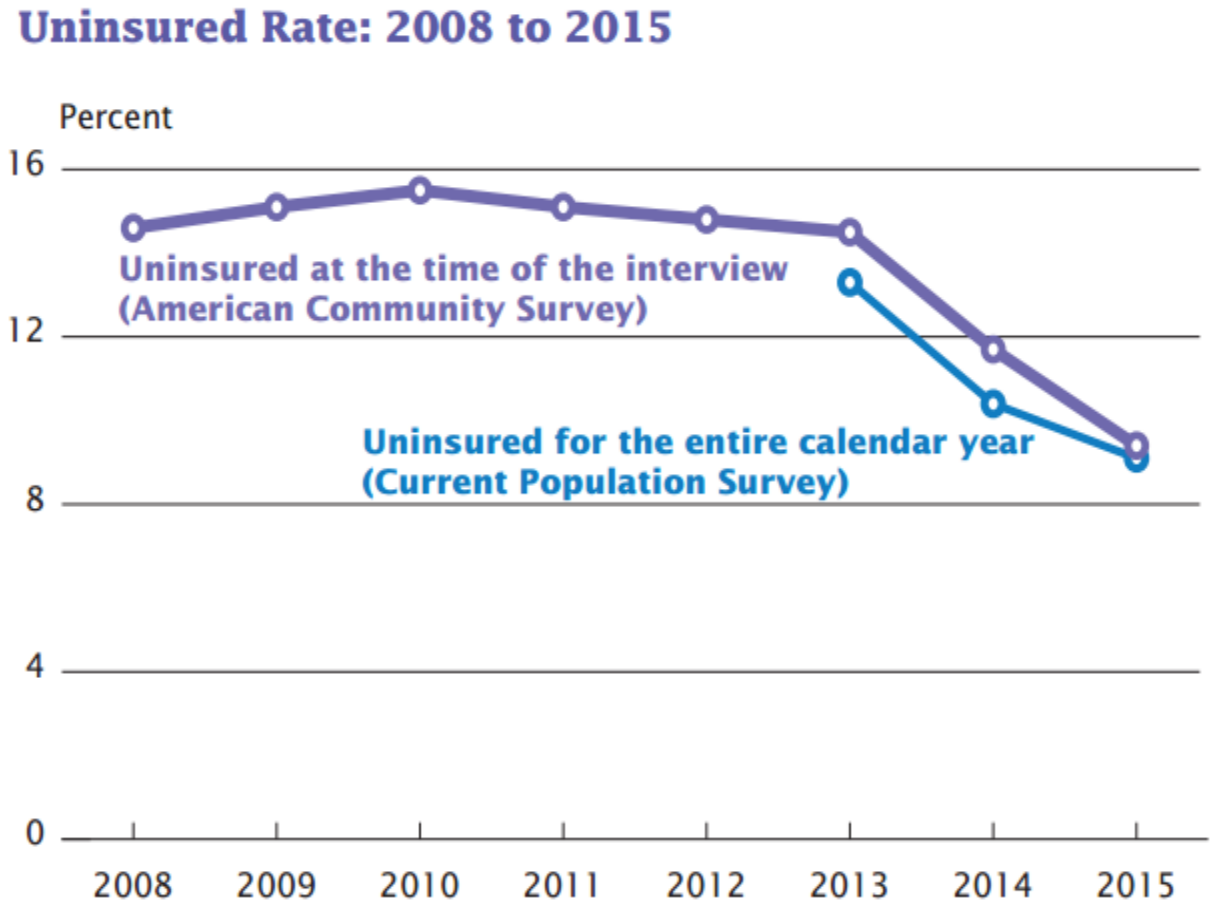
Can treating past trauma lead to big US health savings?

Dan Mangan | @_DanMangan
Thursday, 21 Jan 2016 | 2:00 PM ET

CNBC

C-SPAN

More Americans gaining coverage (that includes parity)



Yet, lack of access, disparities persist

- Mental illness is the leading source of disease burden in the US
- Addiction has become a public health crisis
- Suicide rates are climbing
- Continued high levels of unmet need for care
- Little access to care even among working people with health coverage
- Lack of access to care has a critical impact on special populations: children, people of color, justice-involved

Fact: Addictions – public health crisis

Addictions as chronic diseases … medications … inpatient … residential and outpatient treatments … and recovery supports including **housing**

Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century

Anne Case[1] and Angus Deaton[1]

Woodrow Wilson School of Public and International Affairs and Department of Economics, Princeton University, Princeton, NJ 08544

Contributed by Angus Deaton, September 17, 2015 (sent for review August 22, 2015; reviewed by David Cutler, Jon Skinner, and David Weir)

This paper documents a marked increase in the all-cause mortality of middle-aged white non-Hispanic men and women in the United States between 1999 and 2013. This change reversed decades of progress in mortality and was unique to the United States; no other rich country saw a similar turnaround. The midlife mortality reversal was confined to white non-Hispanics; black non-Hispanics and Hispanics at midlife, and those aged 65 and above in every racial and ethnic group, continued to see mortality rates fall. This increase for whites was largely accounted for by increasing death rates from drug and alcohol poisonings, suicide, and chronic liver diseases and cirrhosis. Although all

the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE). The comparison is similar for other Organisation for Economic Co-operation and Development countries.

Fig. 1 shows a cessation and reversal of the decline in midlife mortality for US white non-Hispanics after 1998. From 1978 to 1998, the mortality rate for US whites aged 45–54 fell by 2% per year on average, which matched the average rate of decline in the six countries shown, and the average over all other industrialized countries. After 1998, other rich countries' mortality rates continued to decline by 2% a year. In contrast, US white non-Hispanic mortality rose by

SOURCE: ***Proceedings of the National Academy of Sciences*****, vol. 112 no. 49: 15078–15083**
http://www.pnas.org/content/112/49/15078.full

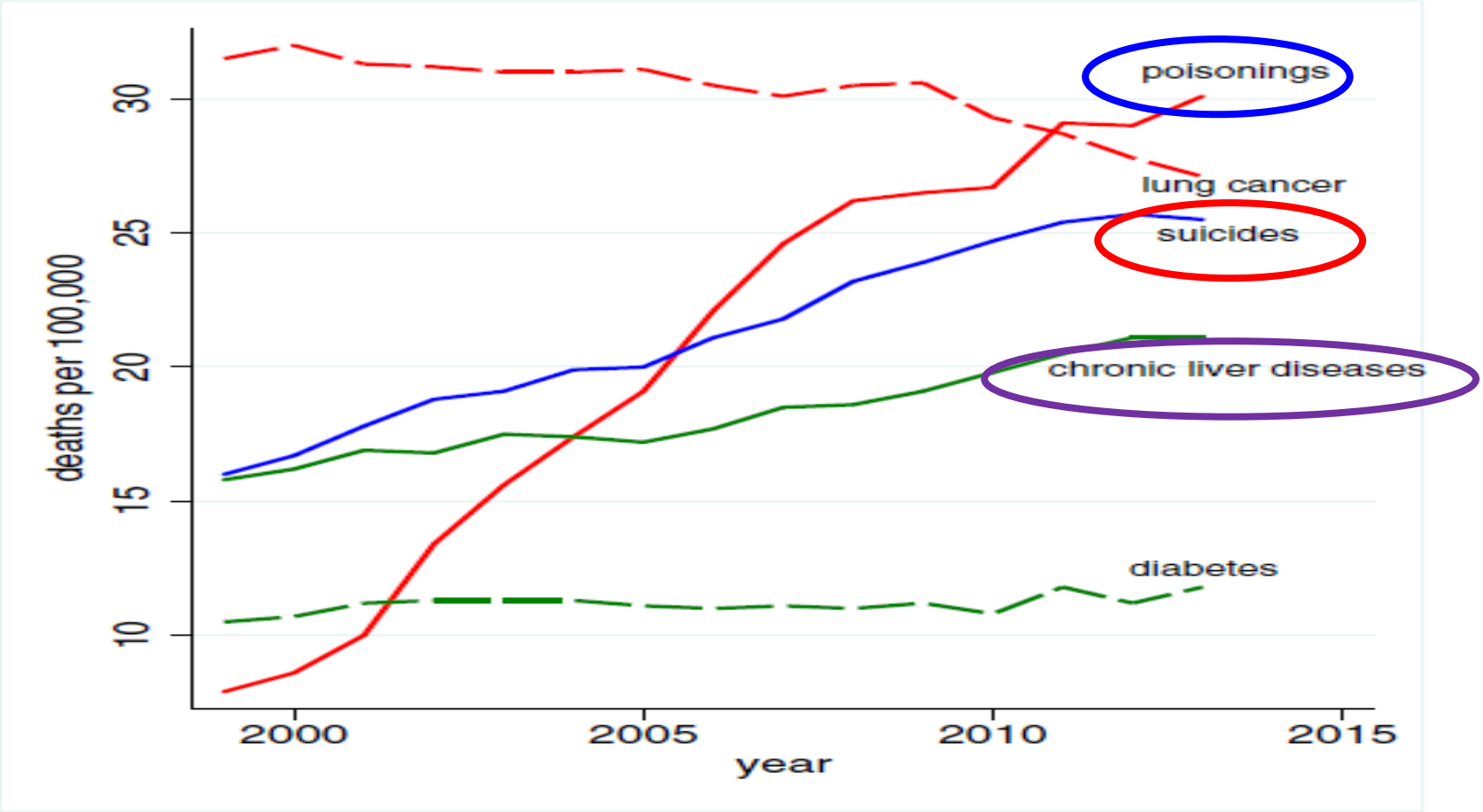


Fig. 2. Mortality by cause, white non-Hispanics ages 45–54.

Mortality by Poising, Suicide, Chronic Liver Disease and Cirrhosis

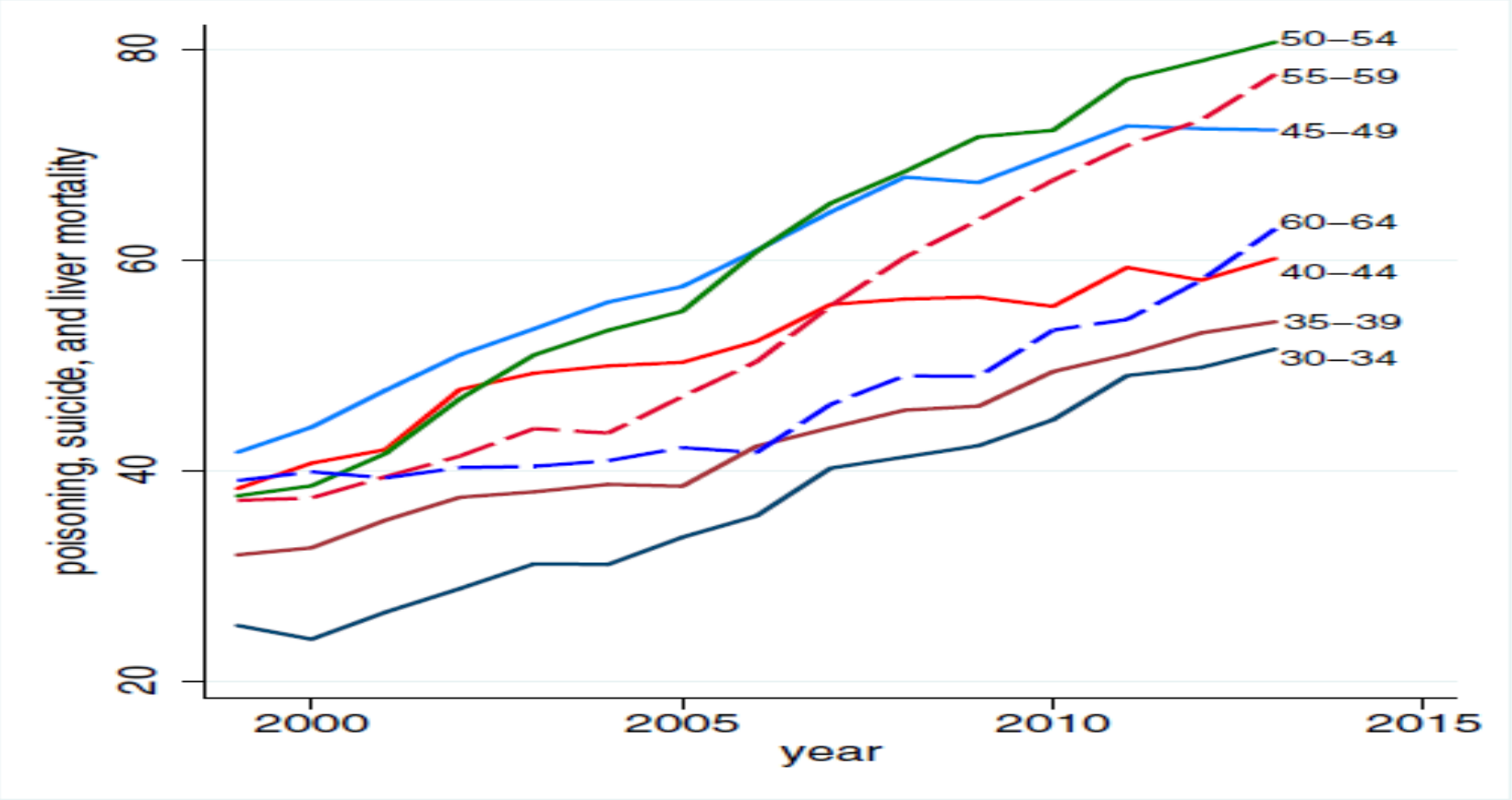
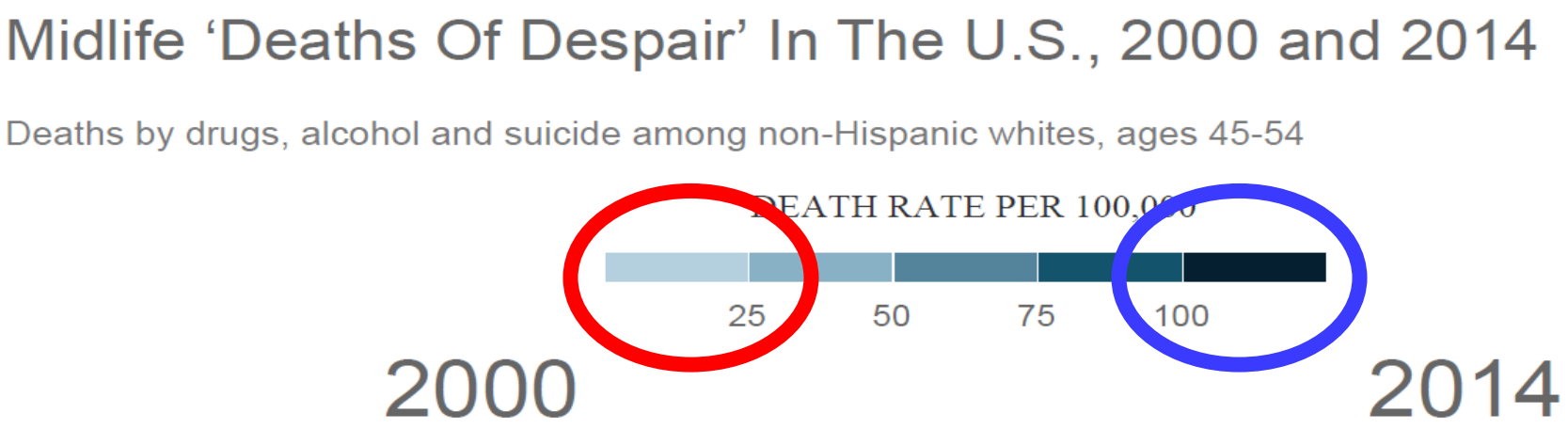


Fig. 4. Mortality by poisoning, suicide, chronic liver disease, and cirrhosis, white non-Hispanics by 5-y age group.

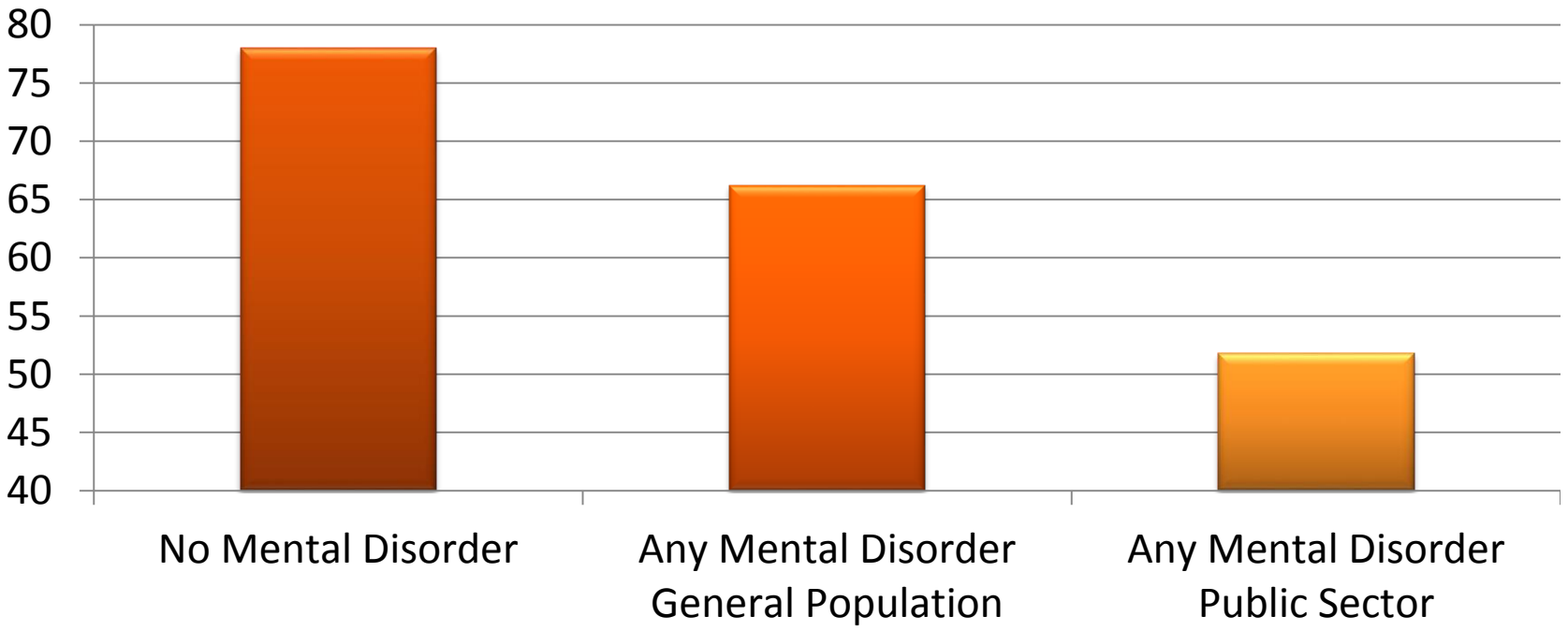
SOURCE: Angus Deaton and Anne Case, "Rising morbidity and mortality in mid-life among white non-Hispanic Americans in the 21st century," http://www.pnas.org/content/112/49/15078.full

“Deaths of Despair” among Middle-Class Whites



SOURCE: Jessica Browdy, “The Forces Driving Middle-Aged White People’s ‘Deaths of Despair’”. Health news from NPR. March 23, 2017. http://www.npr.org/sections/health-shots/2017/03/23/521083335/the-forces-driving-middle-aged-white-peoples-deaths-of-despair citing Brookings paper by Angus Deaton and Anne Case https://www.brookings.edu/bpea-articles/mortality-and-morbidity-in-the-21st-century/

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

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.

The CATIE Study

At baseline investigators found that:

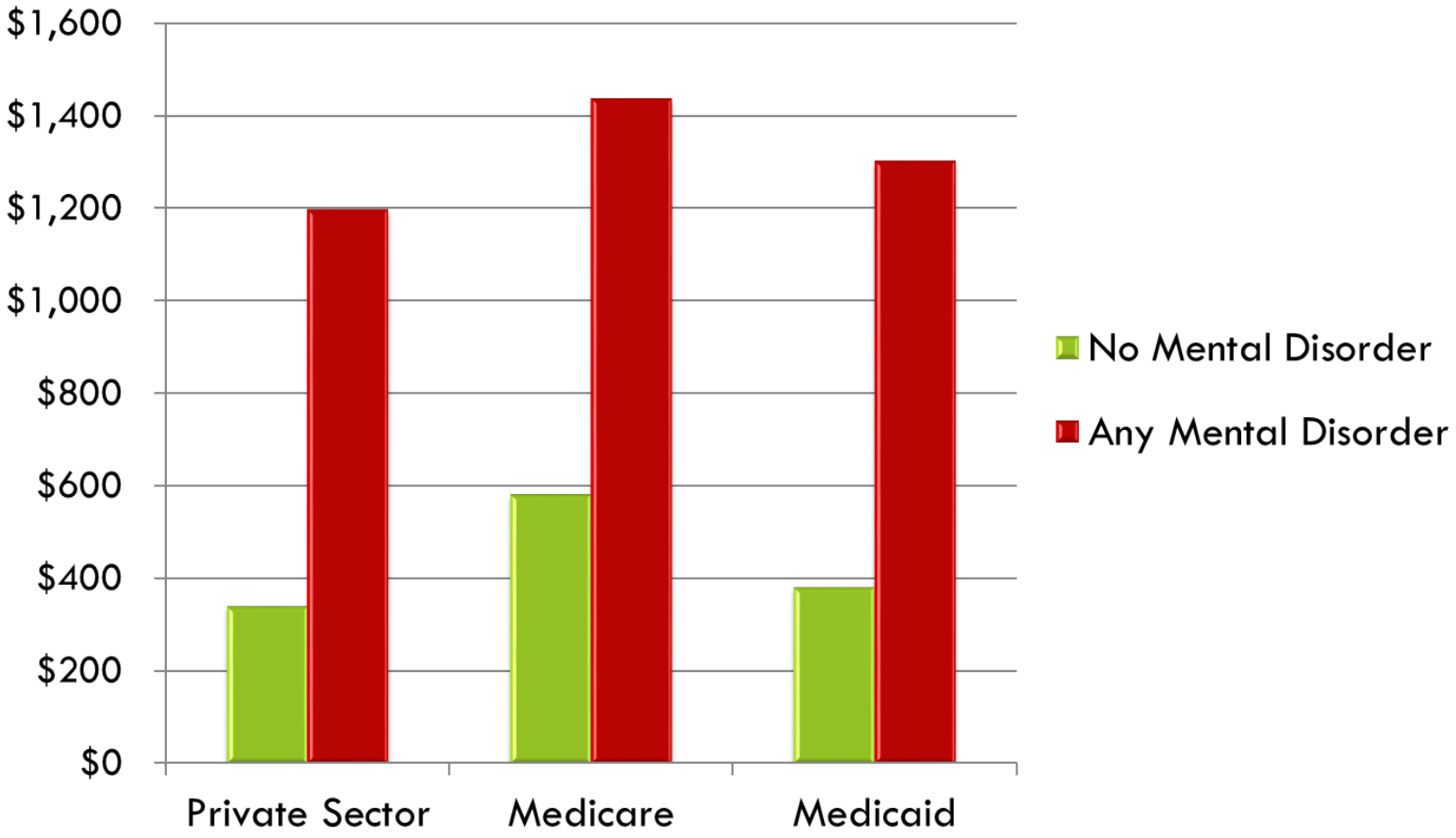
- **88.0%** of subjects who had dyslipidemia
- **62.4%** of subjects who had hypertension
- **30.2%** of subjects who had diabetes **were NOT receiving treatment.**

CATIE
Clinical Antipsychotic Trials of Intervention Effectiveness

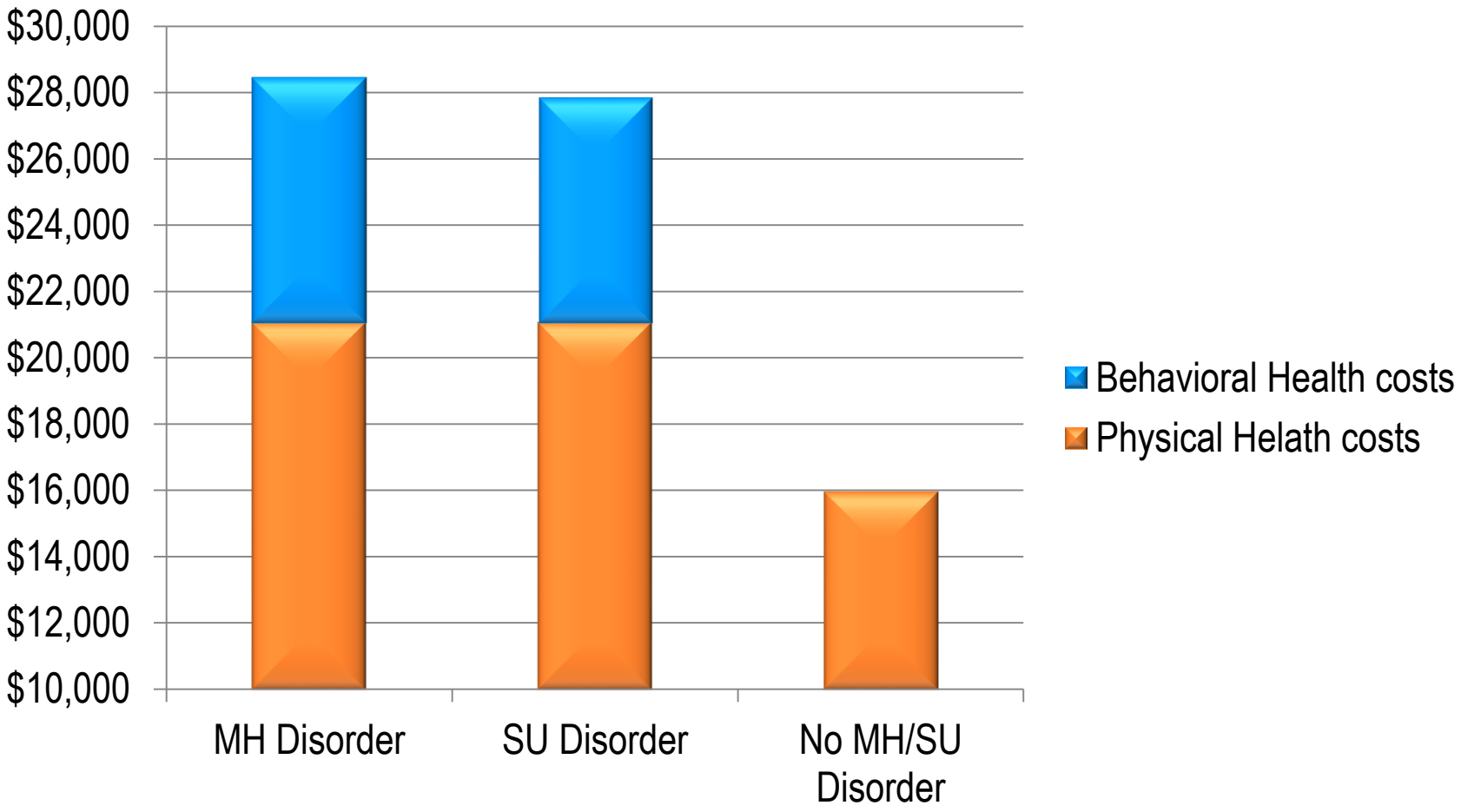
Causes of Excess Mortality

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

Per Member Per Month Costs

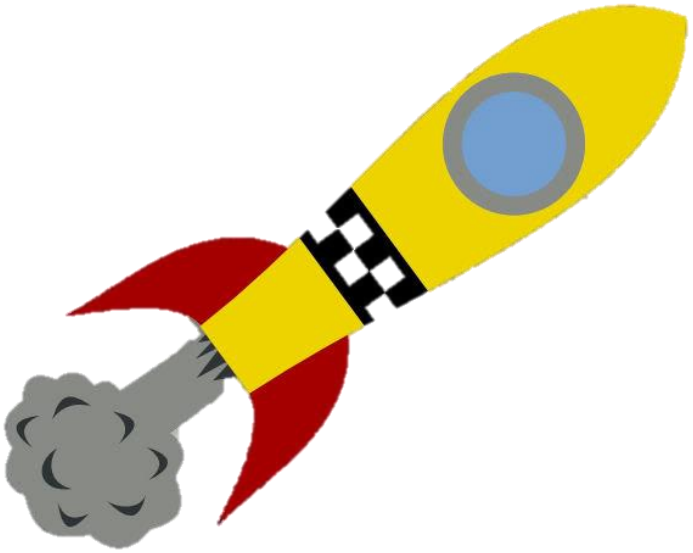


MH/SU costs in NY State's Medicaid Program



Rocket Science

DOES THE BROADER HEALTHCARE INDUSTRY NEED BEHAVIORAL HEALTH TO SUCEED?



Drivers of Increased Demand for Behavioral Health Care

- ACA Insurance reforms and Medicaid expansion substantially increases behavioral health coverage for adults
- ACA requires newly covered populations meet the parity requirements of Wellstone Domenici Parity Act
- Multiple parts of ACA require or incentivize integration of Behavioral Health and general medical care
- Stigma continues to drop releasing pent up demand
- In responding to recent press coverage of mass shootings increasing mental health services is more popular than gun control

New Drivers of BH Demand

- Medicaid Access Rule
  - Went into effect October 2016
  - Requires that MHD monitor and report on Access to 5 essential provider types – one is BH
- Medicaid Managed Care Rule
  - Extends Wellstone-Domenici BH parity to Medicaid Managed Care
  - Requires very detailed parity analysis for every eligibility group/benefit plan – approx. 100 in MO!
- Medicare MACRA P4P

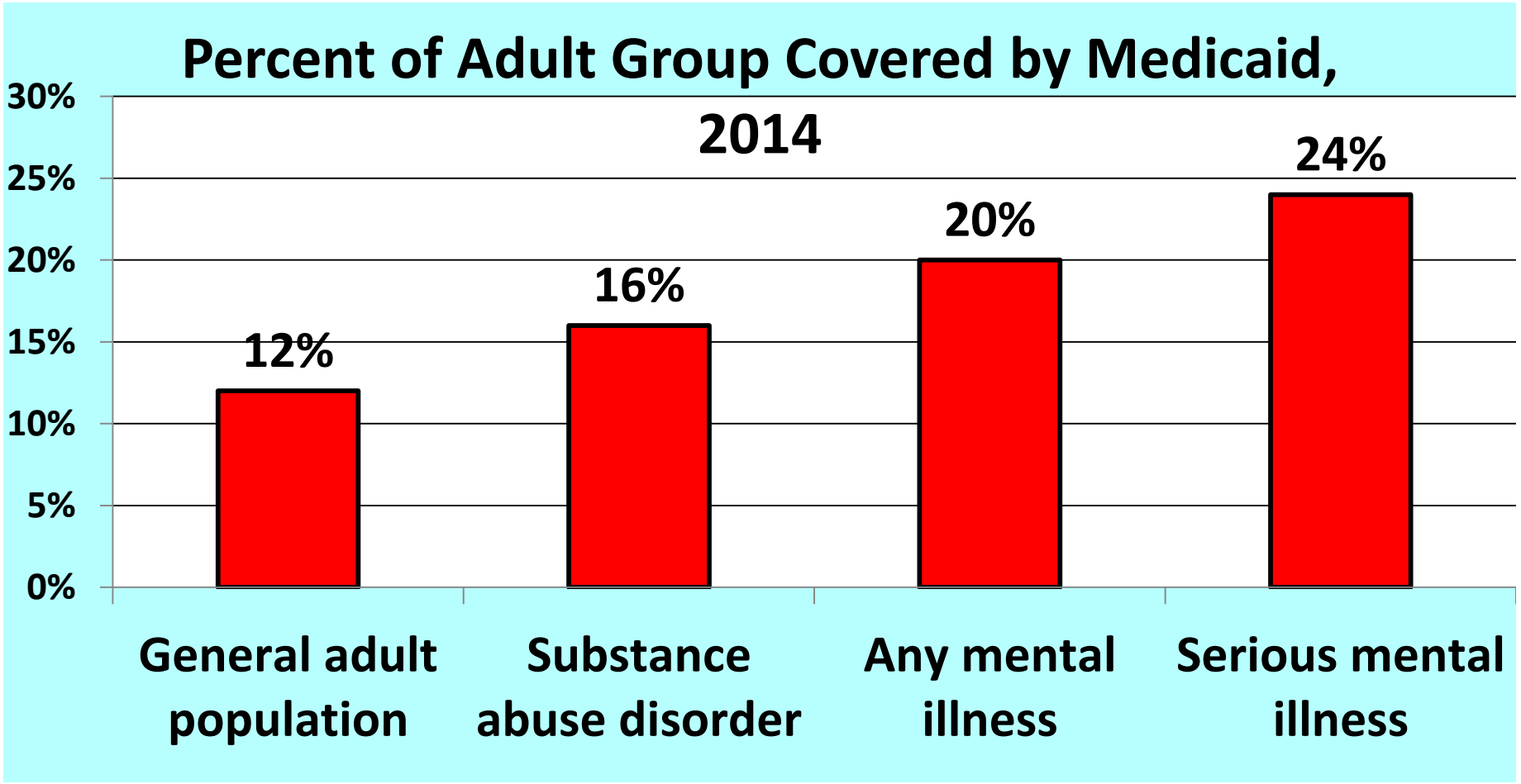
Fact: Working people have little access to care

- Escalating deductibles/copays make treatment for mental illness (OCD, anxiety, depression - conditions highly responsive to medication and cognitive interventions) out of reach.

- Equally destructive are stagnant insurance reimbursement rates that make behavioral health cash only businesses.

Medicaid is Largely a BH Funding Program

- Single largest payer for BH services accounting for 26% of all behavioral health spending in 2009.
- The 20% of Medicaid beneficiaries with a BH diagnosis account for 48% of all Medicaid expenditures.
- Total Average Medicaid Expenditures
  - With BH diagnosis $13,303
  - Without BH diagnosis $3564
- About half of the non-dually eligible, under age 65 (including children) with disability have a behavioral health diagnosis.
- Total Medicaid expenditures for this group accounts for two thirds of total Medicaid spending.



SOURCE: Adapted from Rachel Garfield and Julia Zur, Kaiser Family Foundation, http://kff.org/medicaid/issue-brief/medicaid-restructuring-under-the-american-health-care-act-and-implications-for-behavioral-health-care-in-the-us/

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Medicaid is radically different from commercial or Medicare coverage

- Targets high need populations left out of other insurance programs
- Negligible co-pays and no deductibles
- Coverage available nowhere else
  - Long term services and supports – NH, Personal care, Home health
  - Specialized support programs for specialized populations – SMI, DD, Foster care children, HIV,
  - Transportation to and from treatment
- Innovation

Innovative Medicaid programs For Behavioral Health Populations

- Community support services and case management
- Crisis Services and hotlines
- ACT Teams
- Peer Services
- ER diversion programs
- Partial Hospital
- Residential Treatment
- Psychosocial Rehabilitation
- CMHC Health Homes
- Family Support

Problem Statement

Exhibit 7: Frequency of Diagnostic Dyads by Cost among Medicaid-only Beneficiaries with Disabilities, 2002, CDPS + Rx Data*

Diagnosis 1	Diagnosis 2	Frequency among all beneficiaries	Frequency among most expensive 5%
Psychiatric	Cardiovascular	24.5%	40.4%
Psychiatric	Central Nervous System	18.9%	39.8%
Cardiovascular	Pulmonary	12.5%	34.3%
Cardiovascular	Central Nervous System	13.1%	32.9%
Psychiatric	Pulmonary	11.2%	28.6%
Cardiovascular	Gastrointestinal	10.2%	27.8%
Central Nervous System	Pulmonary	7.0%	26.2%
Cardiovascular	Renal	7.1%	24.6%
Pulmonary	Gastrointestinal	5.9%	24.2%
Psychiatric	Gastrointestinal	9.5%	24.0%

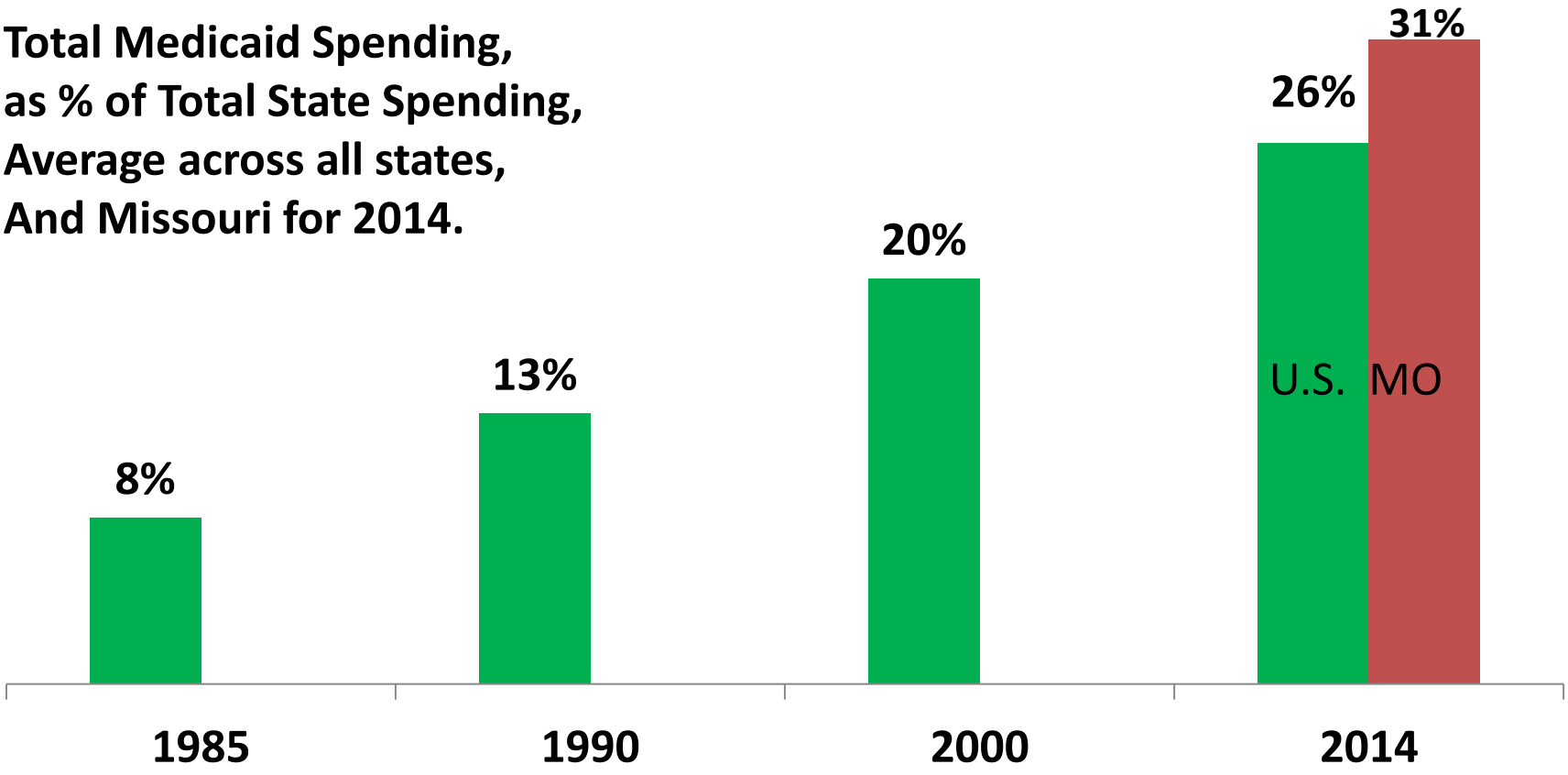
The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions Center for Health Care Strategies, Inc., October 2009

- **49% of Medicaid beneficiaries with disabilities have a psychiatric illness.**
- **52% of those who have both Medicare and Medicaid have a psychiatric illness.**

Medicaid Spending Now Averages 26% of Total State Budgets

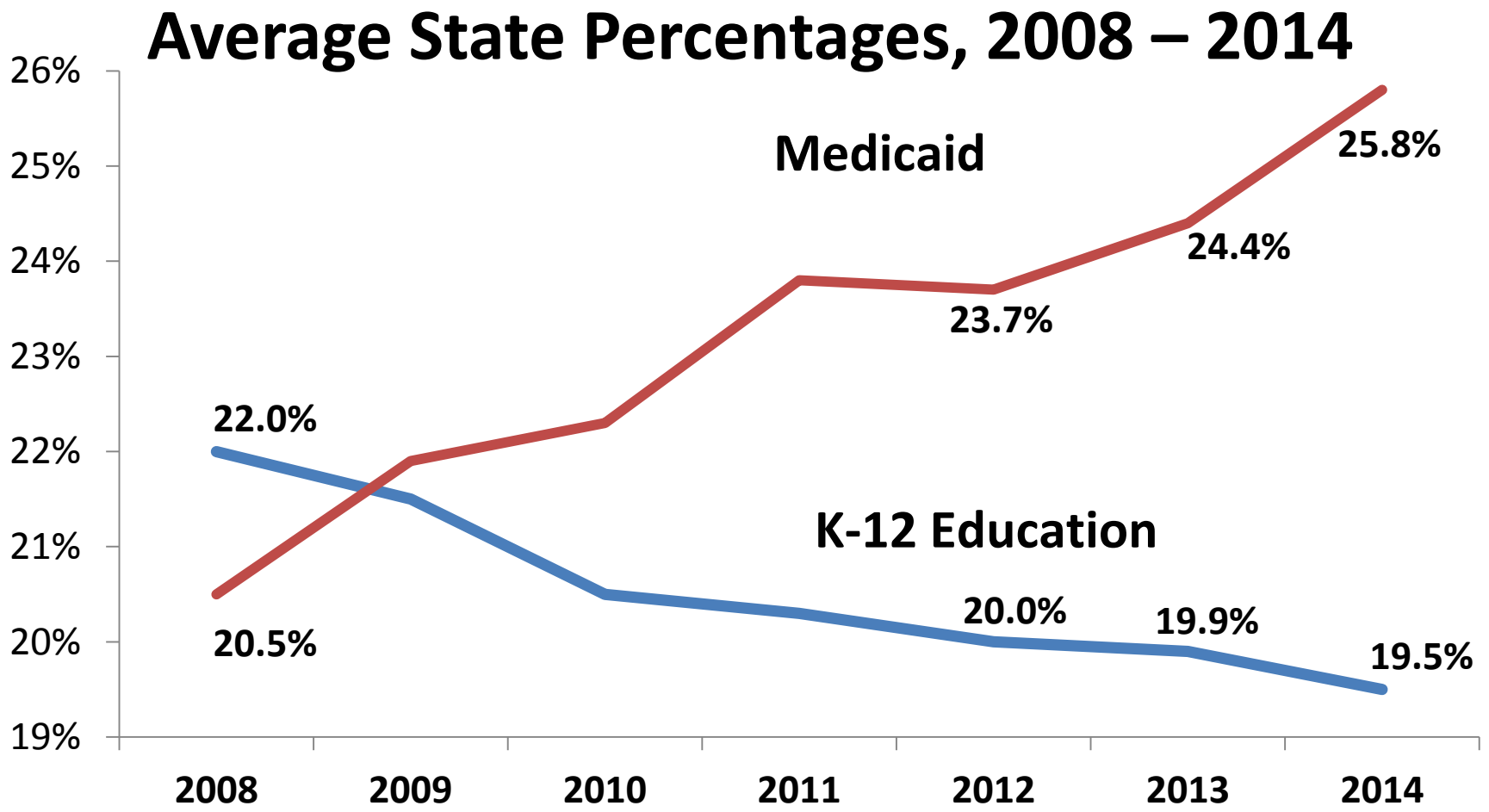
1985 - 2013

Total Medicaid Spending, as % of Total State Spending, Average across all states, And Missouri for 2014.



Source: HMA, based on NASBO, *State Expenditure Report*, 2014 and earlier years.

Total Spending on Medicaid and K–12 Education as % of Total State Spending



Source: HMA, based on data in: NASBO, *State Expenditure Report*, 2014 and Earlier Years.

Big Trends

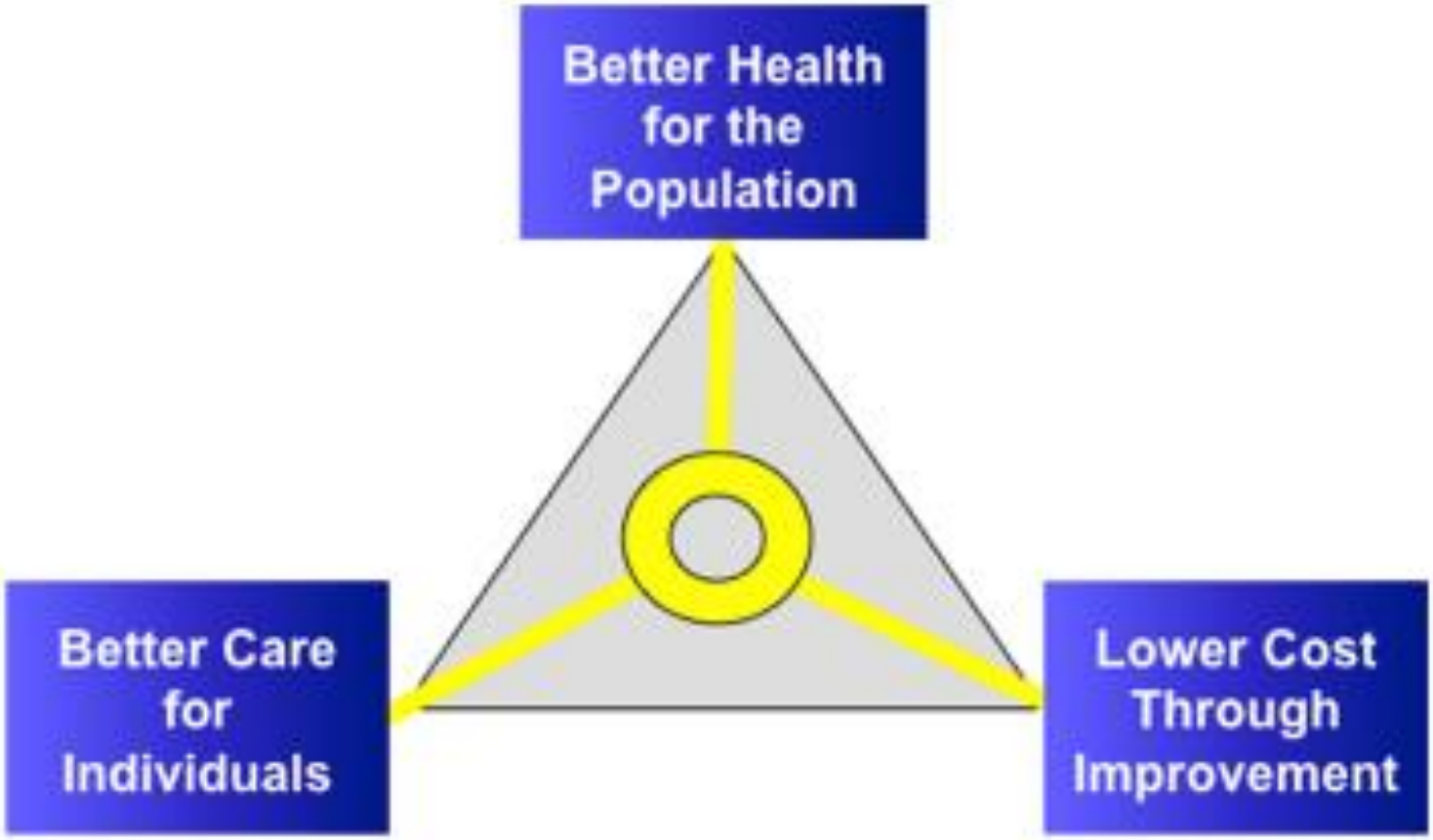
- Increased Coverage
- Increased Demand
- Focus of High Utilizers
- Increased desire for integration by payers
- Provider Consolidation
- Performance Based Payments
- Shrinking Psychiatric Workforce

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).

The IHI Triple Aim

Better Care for Individuals, Better Health for Populations, and Lower Per Capita Costs



Population-Based Care

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

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

Principles

- Use the data you have before collecting more
- Show as much data as you can to as many partners as you can as often as you can
  - Sunshine improves data quality
  - They 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

Most Important Principle

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

Six Population Health Management Services

- Care Management
- Care Coordination
- Managing 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 administrative claims
- Get clinical values from metabolic screening, clinical evaluation and management, care plans
- Combine into EHR Disease Registry
  - CMT's PROACT
  - Azara's DRV
- Online access available to all providers

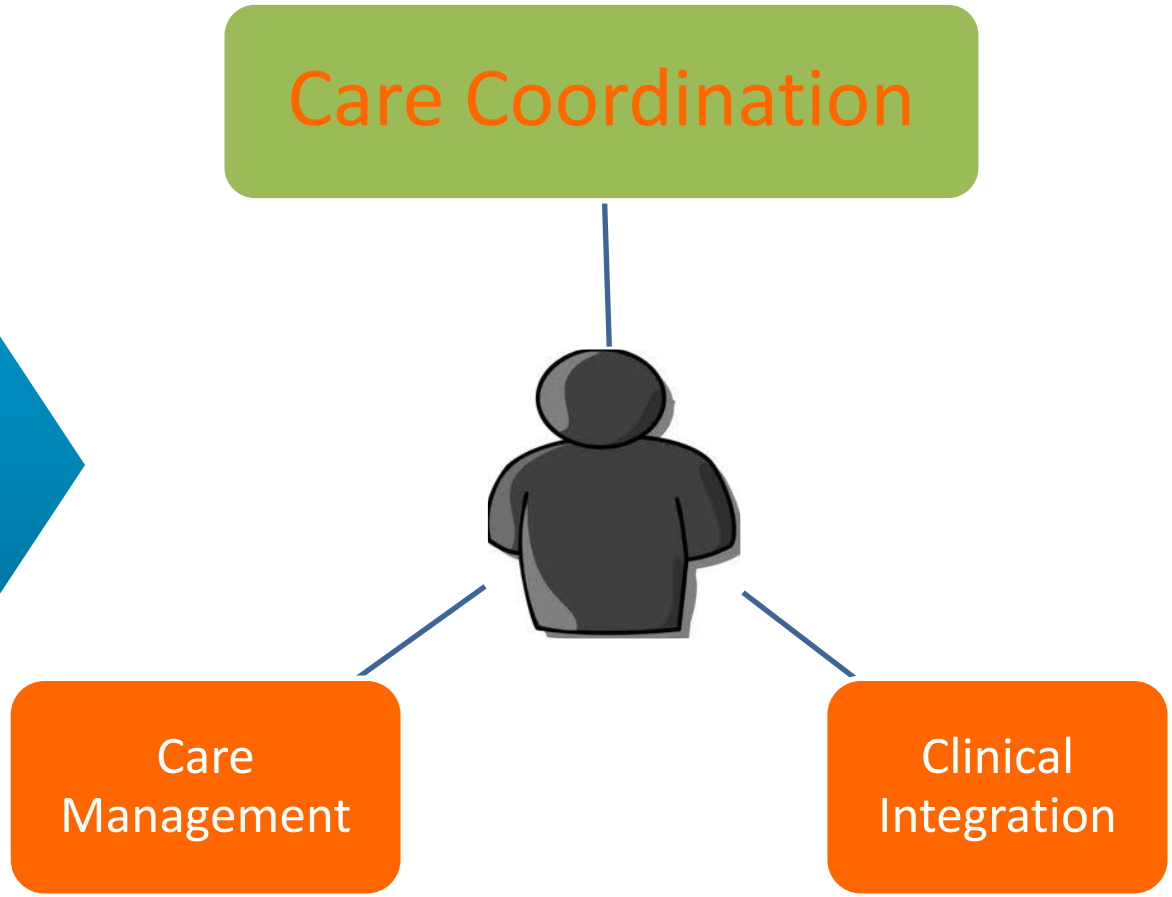
Step 2 – Identify Care Gaps and ACT!

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

Important Provider Competencies

Characteristics:

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



What is a Health Home?

- Not just a Medicaid benefit
- Not just a program or a team
- It's a system and an organizational transformation

Health Home Target Populations

Primary Care Health Homes

- Patients with Diabetes
  - At risk for cardiovascular disease and a BMI > 25
- Patients who have two of the following
  - COPD/Asthma
  - Diabetes (also as single condition)
  - Cardiovascular Disease
  - BMI>25
  - Developmental Disabilities
  - Use Tobacco

CMHC Healthcare Homes

- Individuals with a serious mental illness; or with other behavioral health problems who also have
  - Diabetes
  - COPD/Asthma
  - Cardiovascular Disease
  - BMI>25
  - Developmental Disabilities
  - Use Tobacco

Providers and Enrollment

Primary Care Health Homes

- Providers
  - 21 FQHCs
    - 61 Clinics
  - 9 Hospitals
    - 36 clinics
  - 3 Independent Practices
    - 3 Clinics
- Enrollment
  - 17,823 adults
  - 1,168 children
  - 18,991 total

CMHC Healthcare Homes

- Providers
  - 26 CMHCs
    - 120 Clinics/Outreach offices
- Enrollment
  - 20,877 adults
  - 3,359 children
  - 24,236 total

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)
- Learning collaborative training
- Next day notification of hospital admissions

Six CMS Required Health Home Functions

- Care Management
- Care Coordination
- Managing Transitions of Care
- Health Promotion
- Individual and Family Support
- Referral to Community Services

Training Initiatives

- “Paving the Way” – required for CEO to deliver
- Leadership and team “HCH 101”
- Access to Care – open access scheduling
- Population Health technology training (CMT’s PROACT)
- Physician Institutes
- NCQA and CARF

Facilitating Healthcare Kit

The FH kit contains 8 modules:

- Overview of Chronic Diseases and Risk Factors
- Issues Associated with Medication Non-Adherence
- Asthma and COPD: The Role of the Case Manager
- Hypertension in Clients with Mental Illness
- Diabetes and Mental Health
- Dyslipidemia and Mental Illness
- Obesity
- Smoking Cessation

All titles include:

- A 3-8 page Monograph
- A 35-40 minute lecture
- On-line post-test and CEU application online.

More info at: http://www.mimhtraining.com

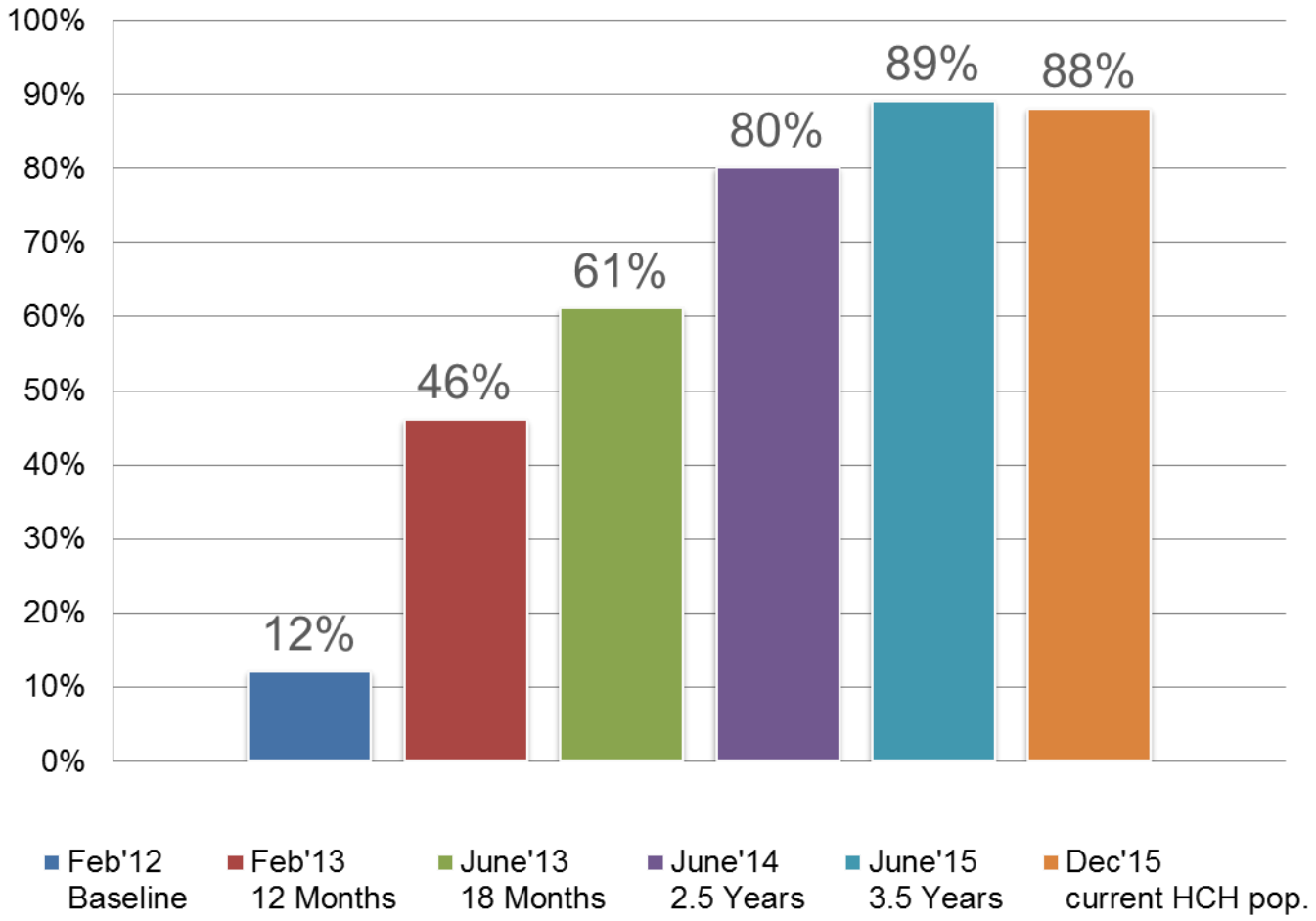
More Training Initiatives

- Chronic illness and Disease Management
- Motivational Interviewing
- TEAMcare
- Wellness Coaching
- CARF
- Tobacco cessation
- Obesity interventions

CMHC Health Home Performance Progress

LDL, A1C, and Blood Pressure

METABOLIC SYNDROME SCREENING



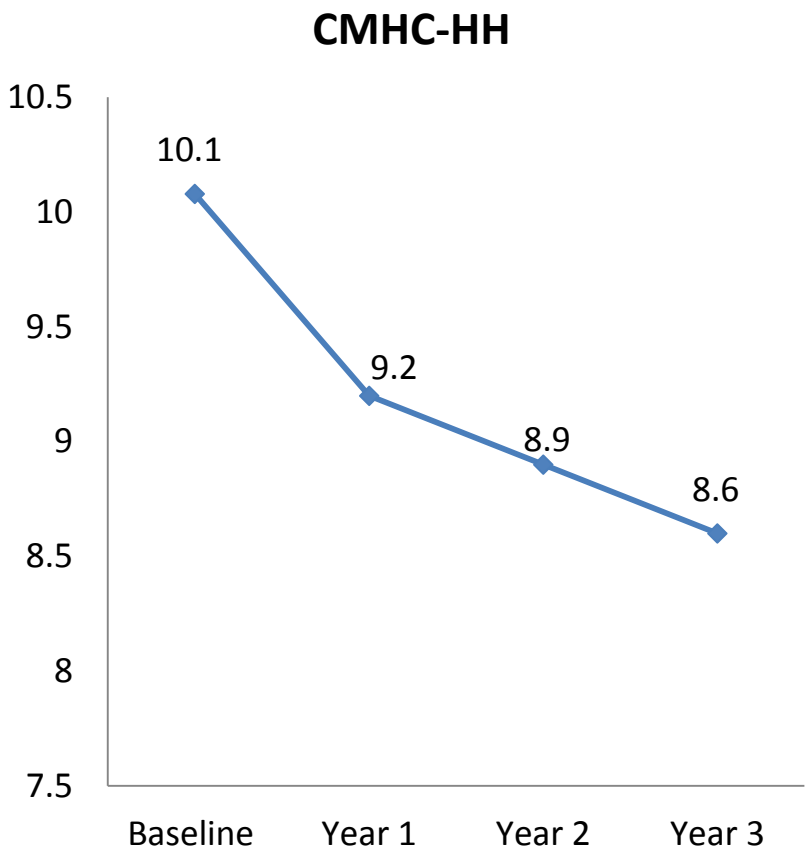
All CMHC Health Homes have attained a completion rate above 80%!

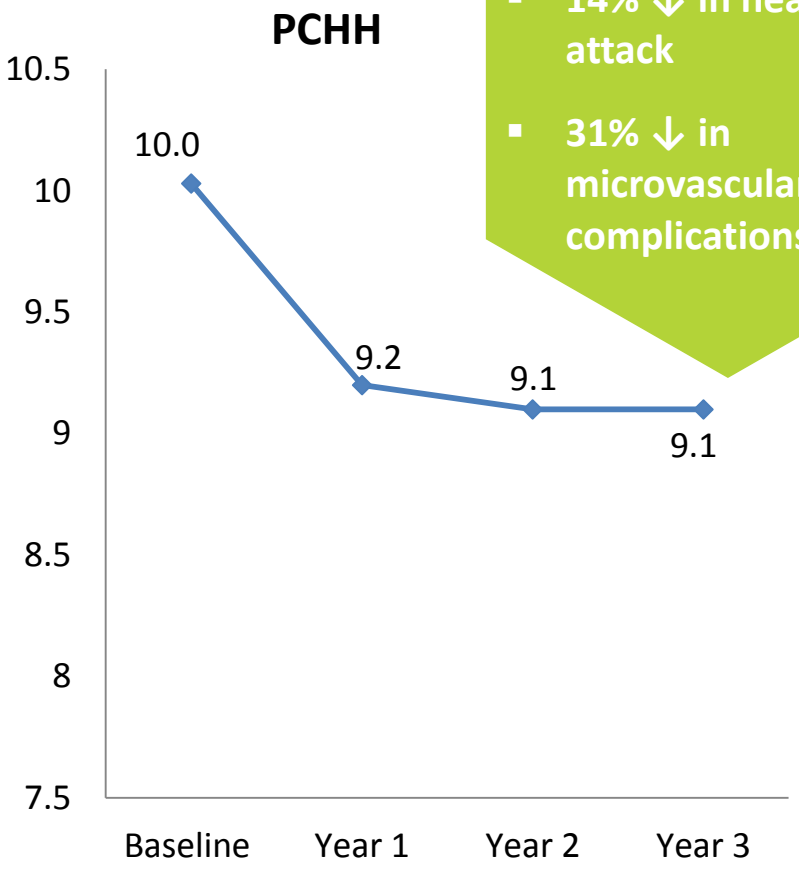
N= 6,553
(at 3.5 years)

N= 20,648
(Dec 2015)

A1C Levels Over Time

About 7% had uncontrolled A1c levels





1 POINT DROP IN A1C

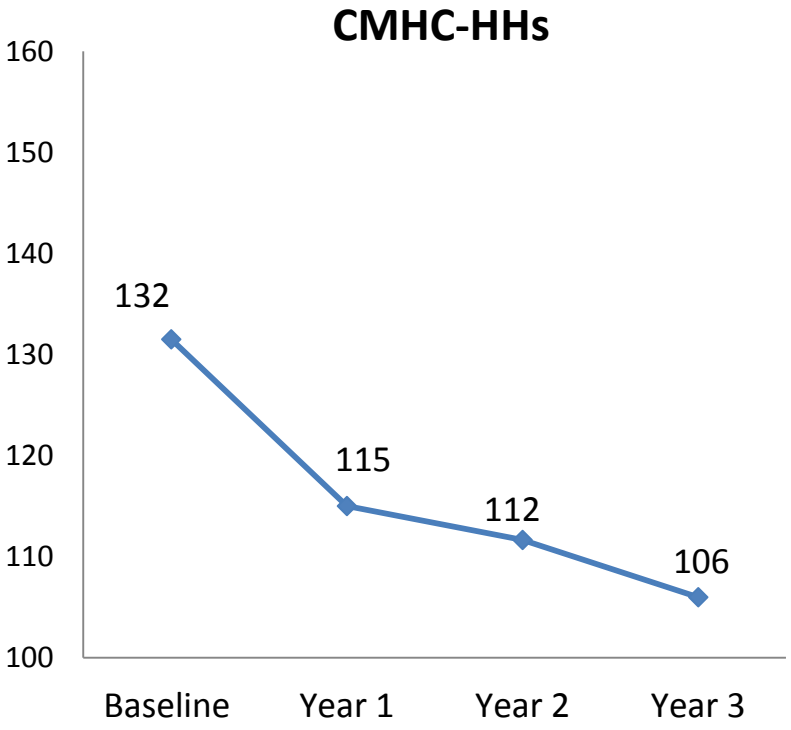
- 21% ↓ in diabetes related deaths
- 14% ↓ in heart attack
- 31% ↓ in microvascular complications

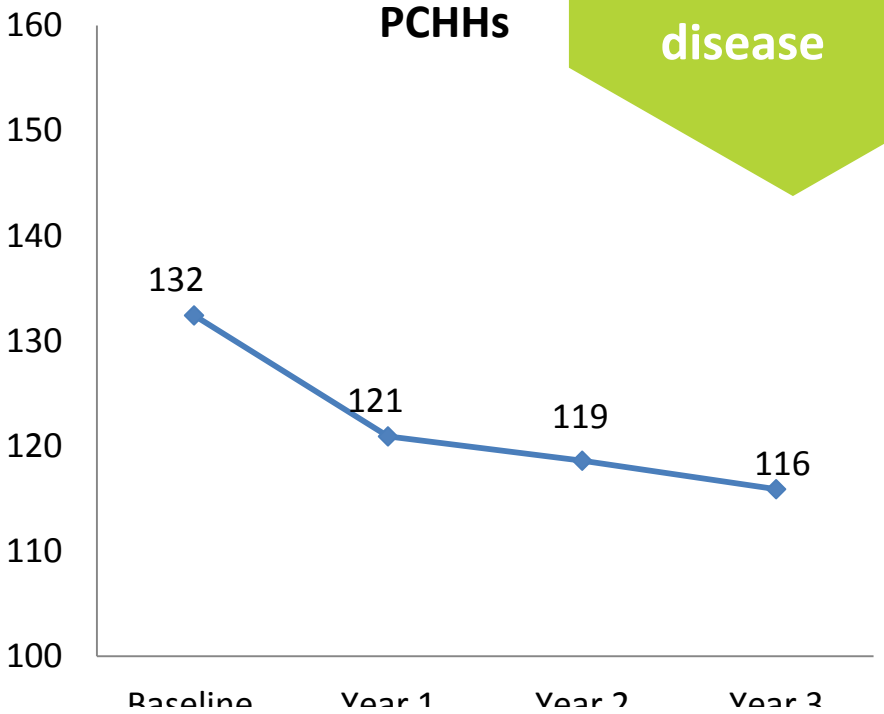
LDL Levels Over Time

About 45% had uncontrolled LDL levels

10% DROP IN LDL LEVEL

- **30% ↓ in cardiovascular disease**



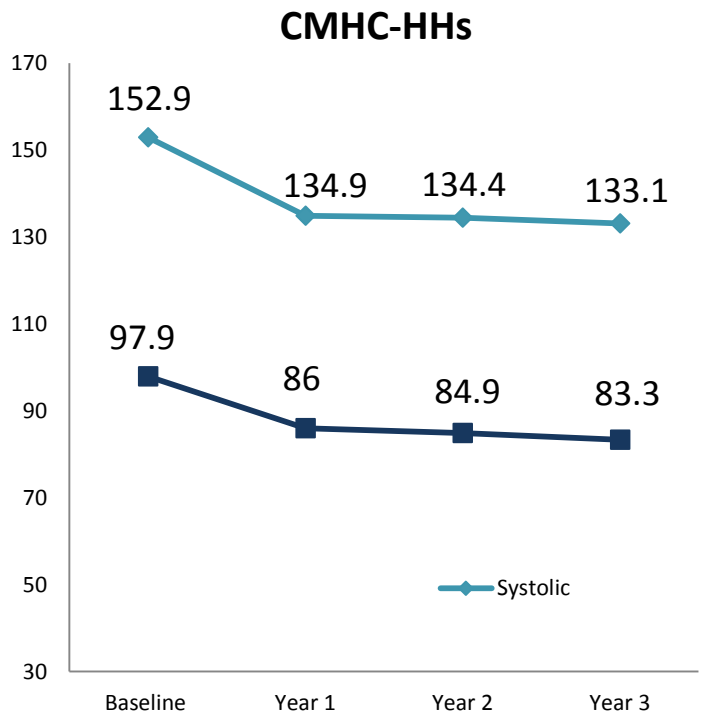


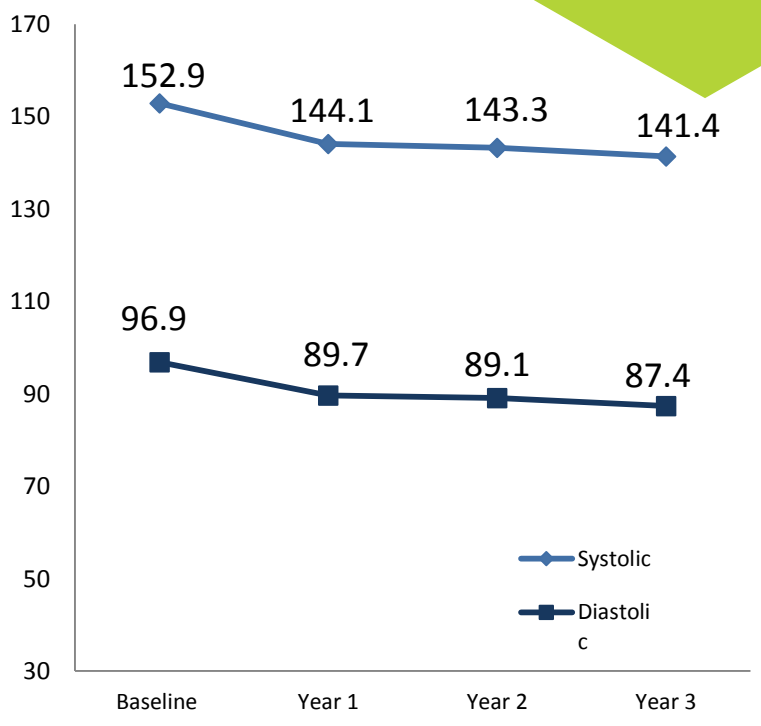
Blood Pressure Changes Over Time

20-24% had uncontrolled BP levels

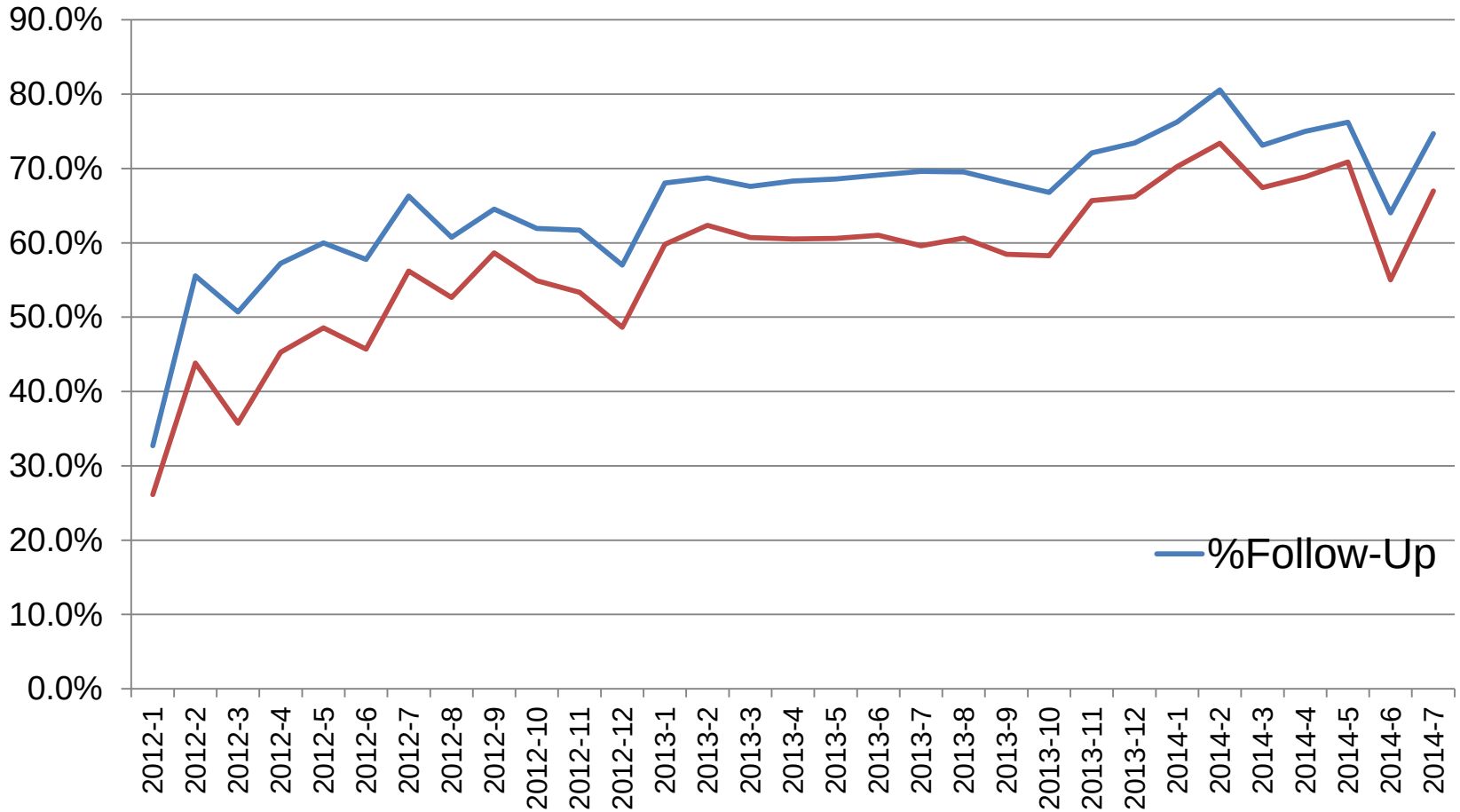
6 POINT DROP IN BLOOD PRESSURE

- **16% ↓ in CD**
- **42% ↓ in stroke**

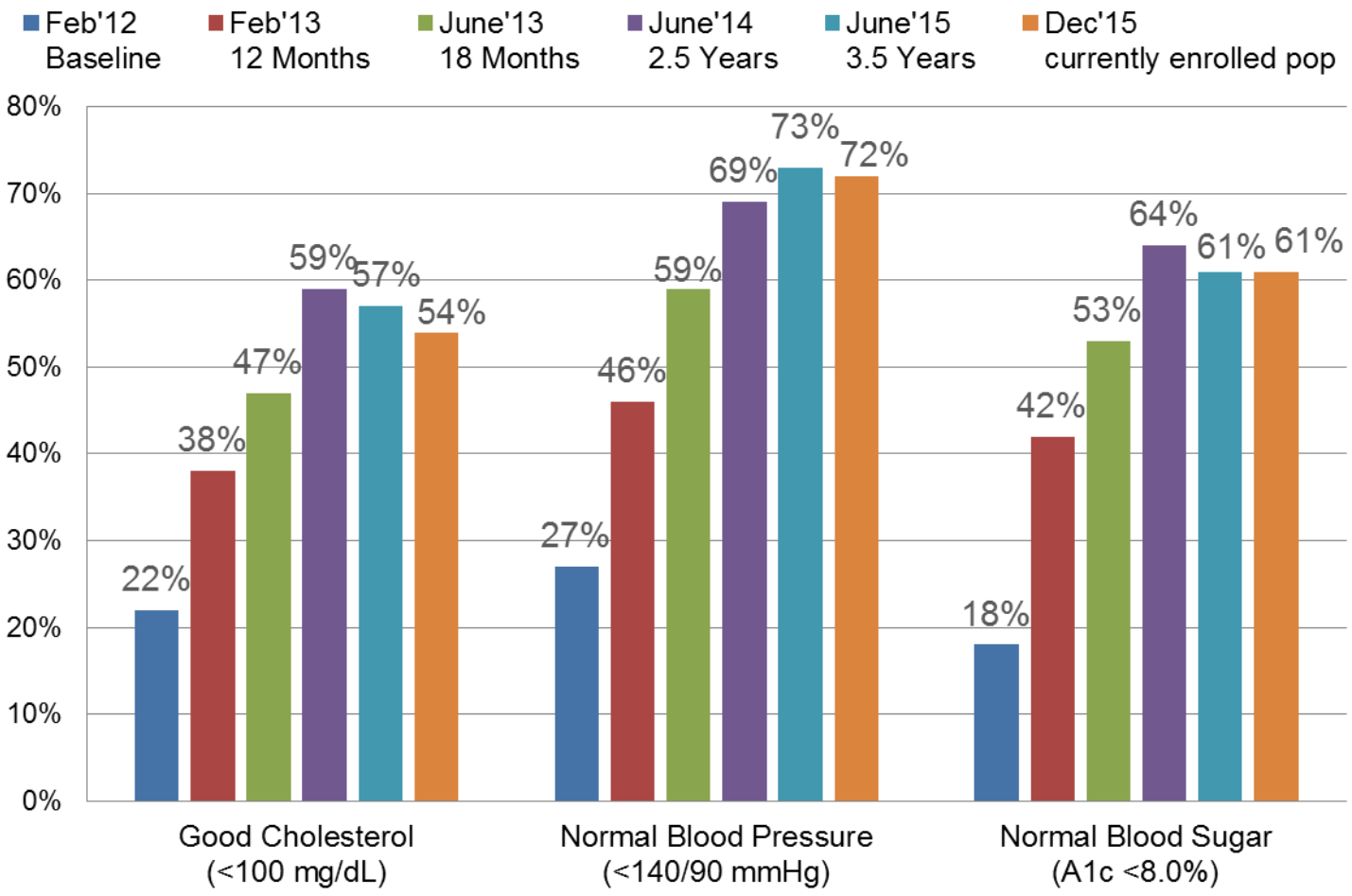




Hospital Follow-up Jan 2012 through July 2014



DIABETES



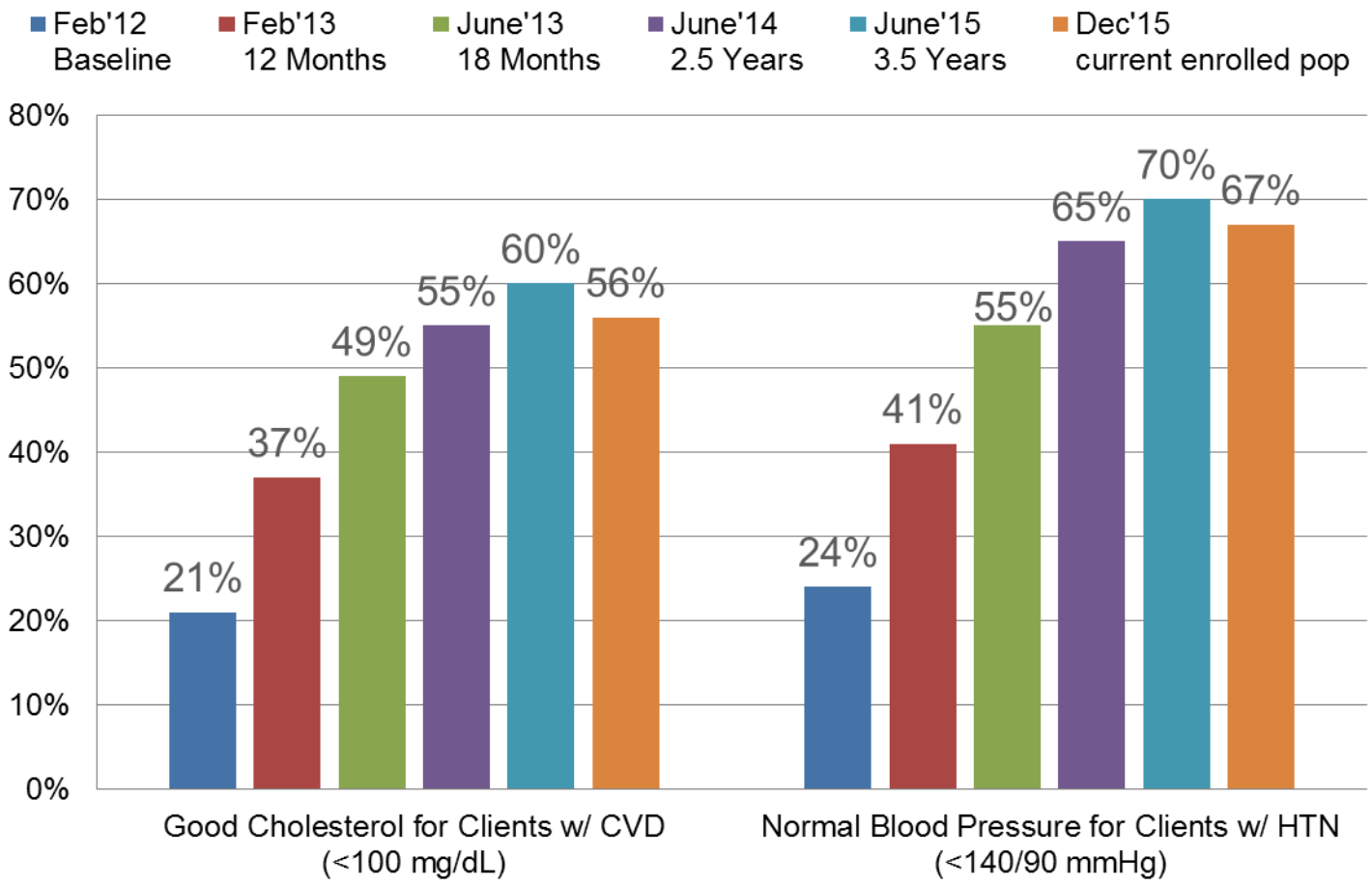
Adults continuously enrolled

N= 1,889 (at 3.5 years)

N= 4,526 (Dec 2015)

Data source: CMT

HYPERTENSION & CARDIOVASCULAR DISEASE



Adults continuously enrolled

CVD N= 232 (at 3.5 years)

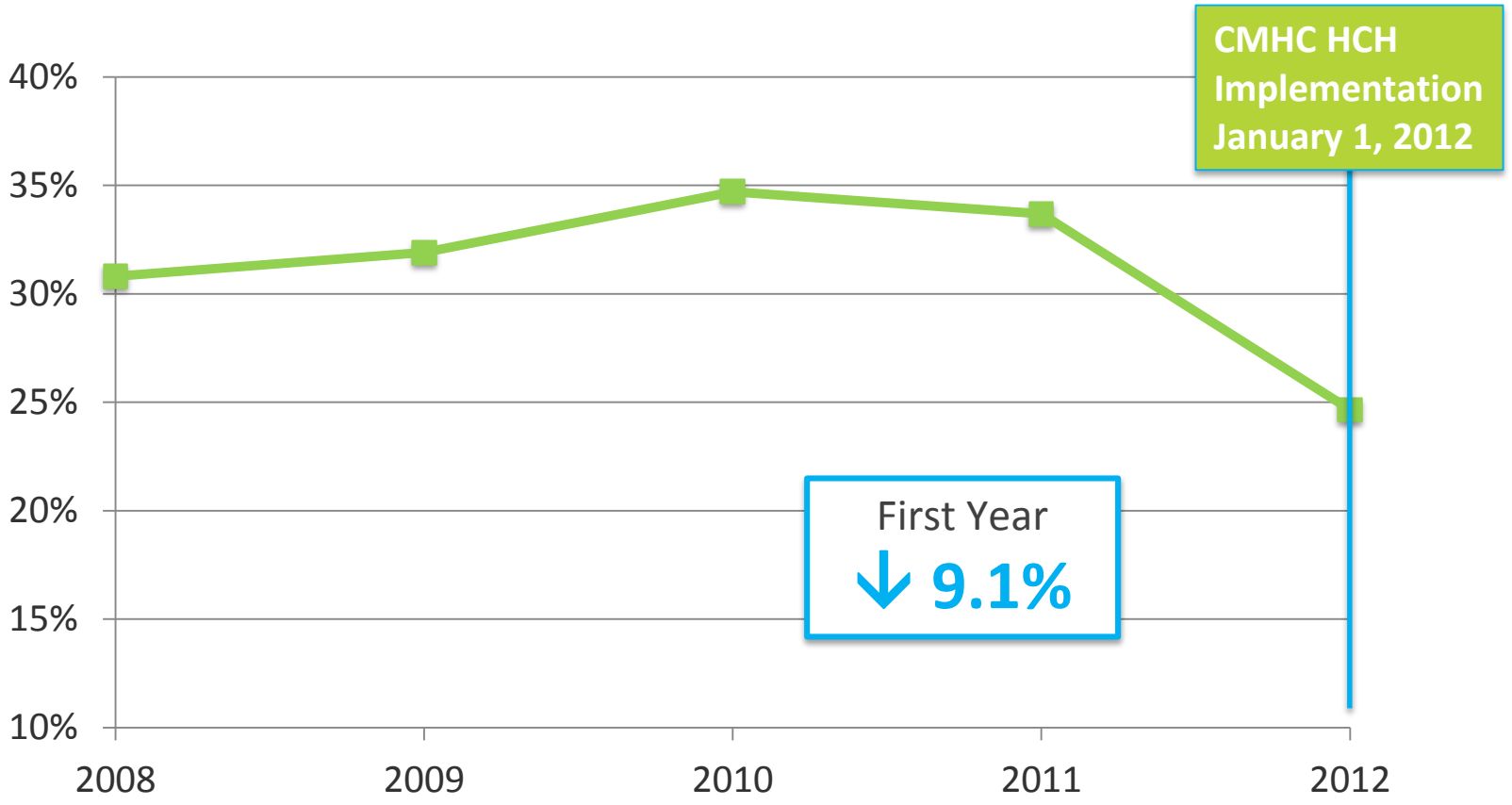
CVD N= 564 (Dec 2015)

HTN N= 2,401 (at 3.5 years)

HTN N= 6,111 (Dec 2015)

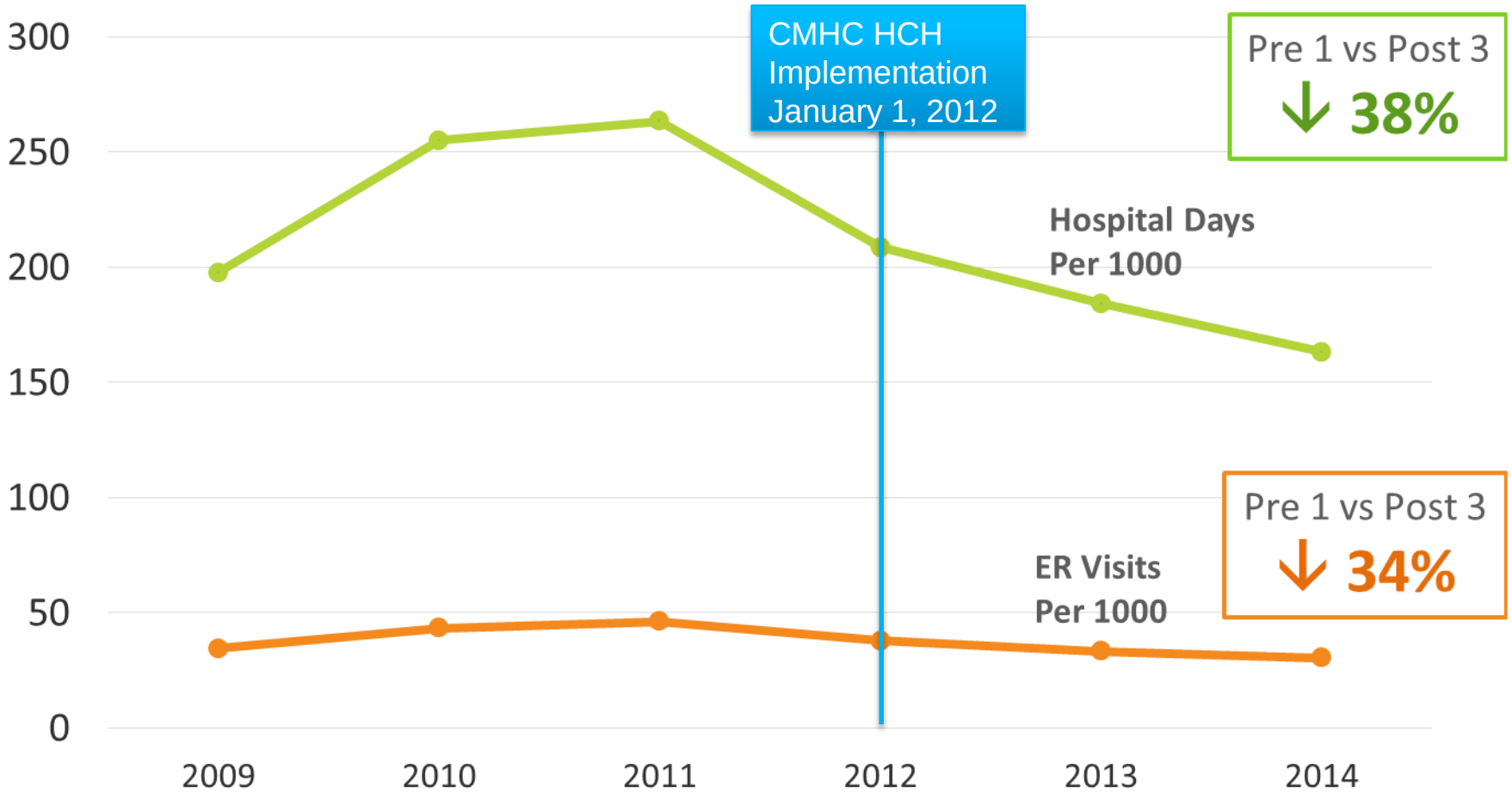
Data source: CMT

% OF CLIENTS WITH 1+ HOSPITALIZATION

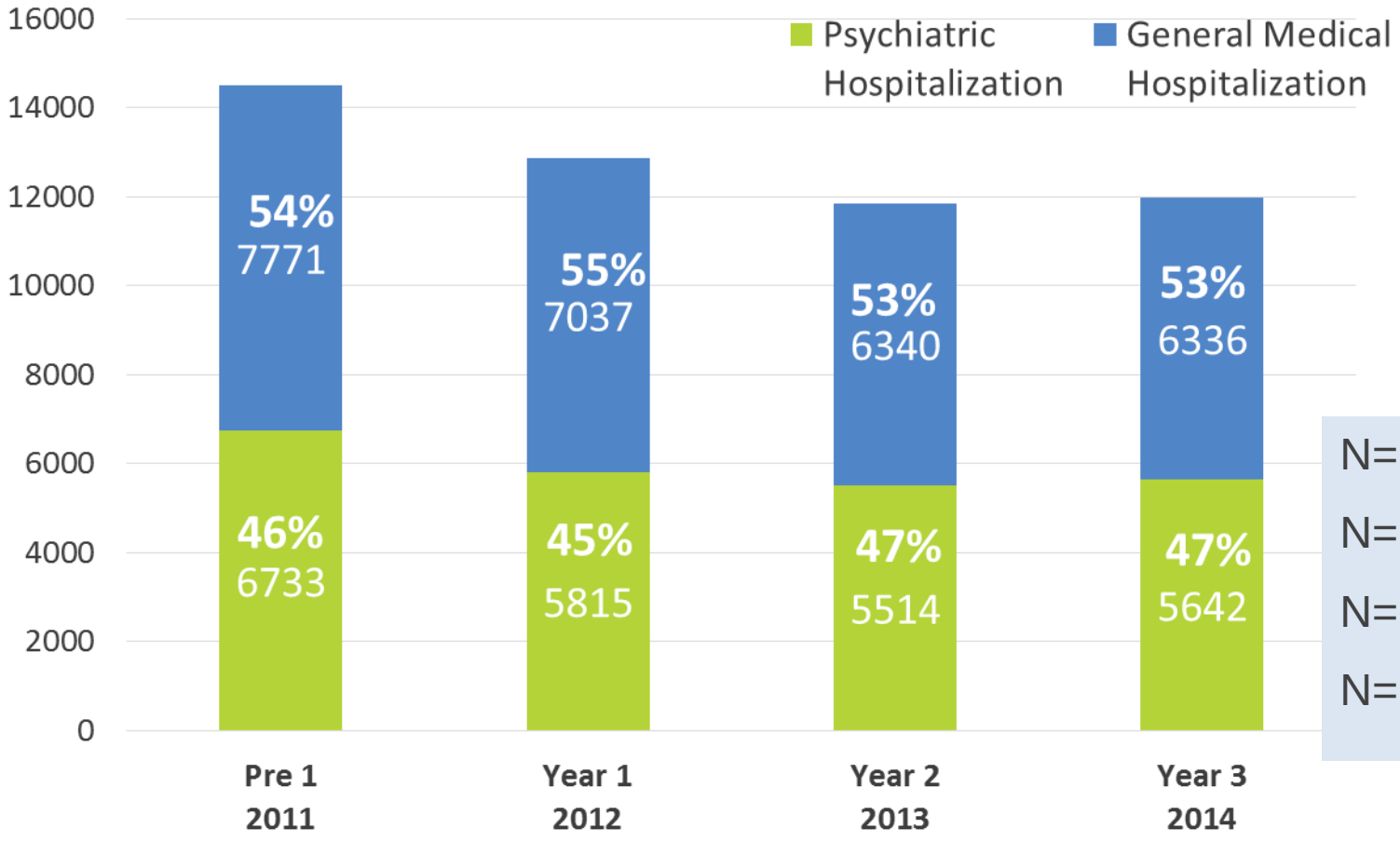


Data source: MIMH

ER & HOSPITAL DAYS PER 1,000



HOSPITAL ENCOUNTERS



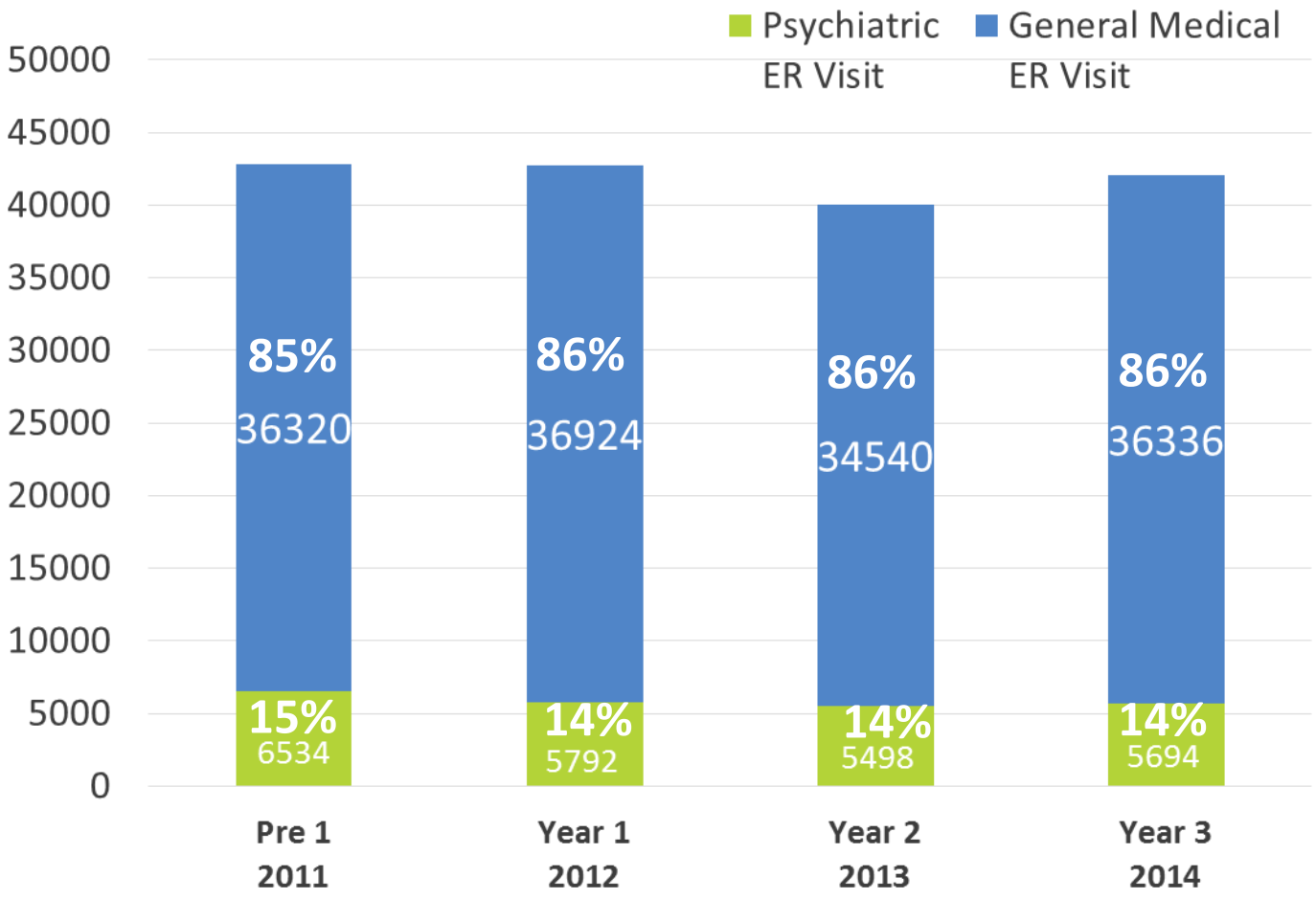
N= 17,084 (2011)

N= 18,776 (2012)

N= 19,103 (2013)

N= 20,345 (2014)

ER ENCOUNTERS



N= 17,084 (2011)

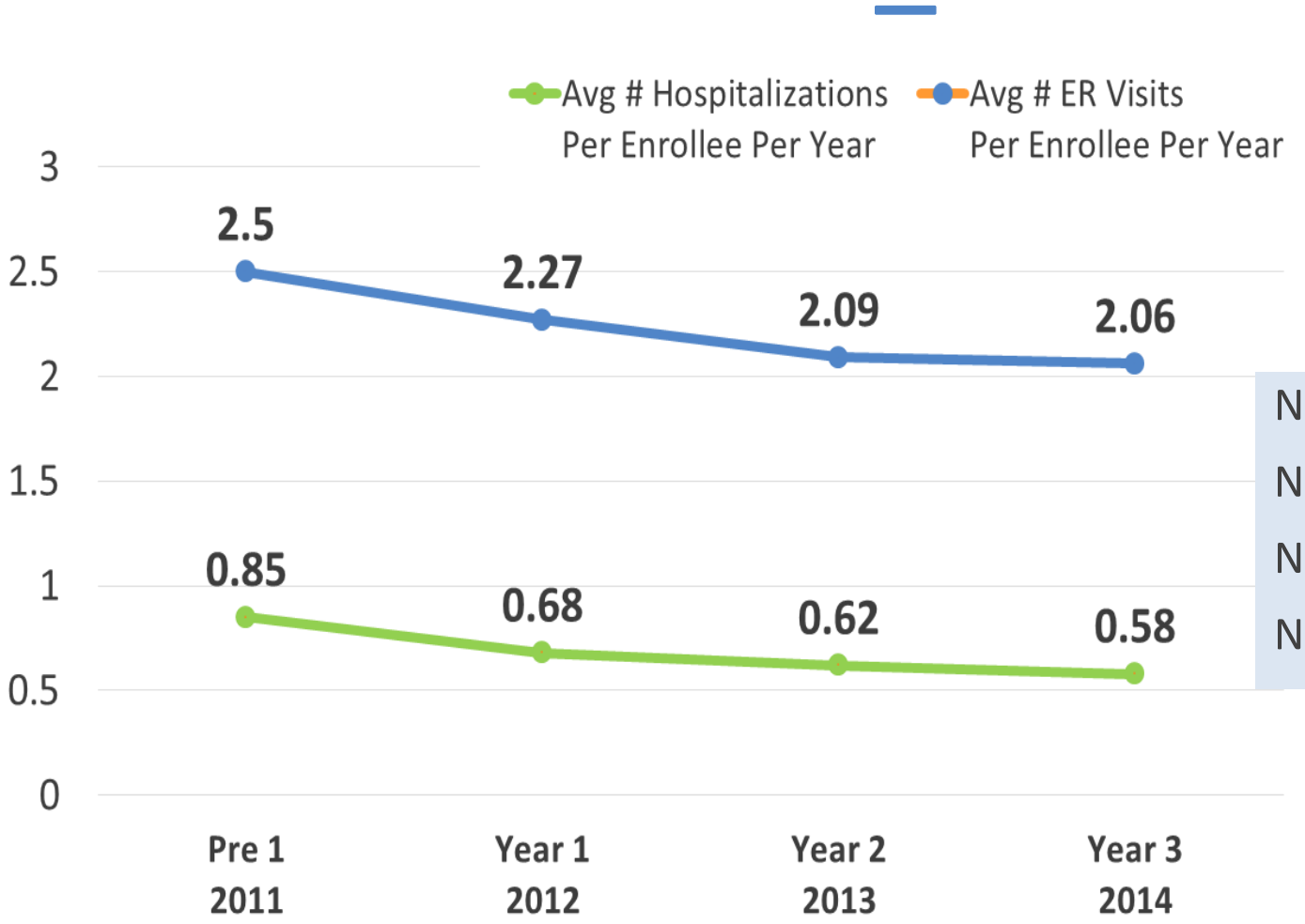
N= 18,776 (2012)

N= 19,103 (2013)

N= 20,345 (2014)

Data source: CMT

AVERAGE # OF ER & HOSPITAL ENCOUNTERS



N= 17,084 (2011)

N= 18,776 (2012)

N= 19,103 (2013)

N= 20,345 (2014)

Cost Savings Year 1 (2012)

Health Homes have saved Missouri an estimated

$36.3 million

SAVINGS = $60 PMPM

Community Mental Health Center Healthcare Homes have saved Missouri

$31 million

SAVINGS = $98 PMPM

DM3700 subset saved

$22.8 million

SAVINGS = $395 PMPM
(4,800 lives)

CHANGE

WHEN THE WINDS OF CHANGE BLOW HARD ENOUGH,
THE MOST TRIVIAL OF THINGS CAN TURN INTO DEADLY PROJECTILES.

NASMHPD Technical Reports

http://www.nasmhpd.org/publications/NASMHPDPublications.aspx

Healthcare Home Source documents page

http://dmh.mo.gov/mentalillness/introcmhchch.html

Missouri CMHC Healthcare Homes

http://dmh.mo.gov/mentalillness/mohealthhomes.html