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Lower Shore Clinic

Indiana Council

Data Driven Outcomes

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Introductions

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Dimitri Cavathas, LCSW-C

- CEO, Lower Shore Clinic, Inc. (November 2015 - present)
- Awarded CCBHC Planning & Development Grant
- Responsible for all operations
  - integrated outpatient mental health
  - addictions
  - primary care clinic
  - psychosocial and residential rehabilitation
  - supported employment
  - health home services

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Melanie Elliott, PhD

- Vice President, Analytics Strategy, Afia, Inc.
- Over 2 decades of experience in Behavioral Health
- Building standardized, flexible multi-source data warehouses
- Measuring outcomes & evaluating progress
- Answering critical industry questions with data

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The Lower Shore Clinic Integrated Care Model

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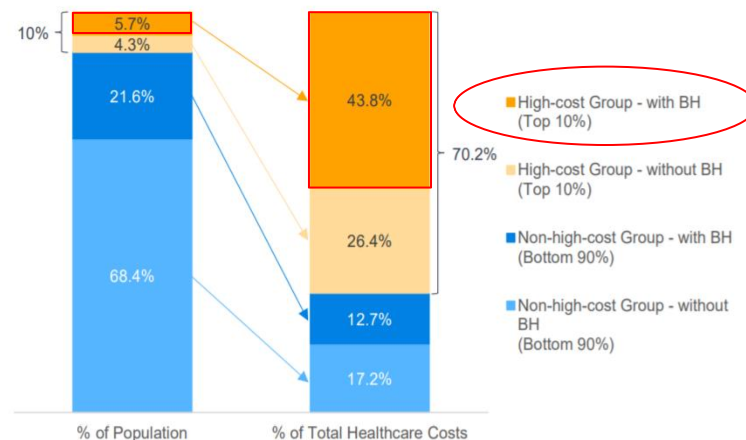
The High Cost of Healthcare

- A Milliman study of 21 million insured lives (Davenport, Gray, & Melek, 2020) pointed out:
  - **10% of the population accounts for 70% of the healthcare spend**
  - **57% of this *high-cost group* has both physical and behavioral health conditions**



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Integrated Care that Prioritizes SDoH

Primary Care

Mental Health Care

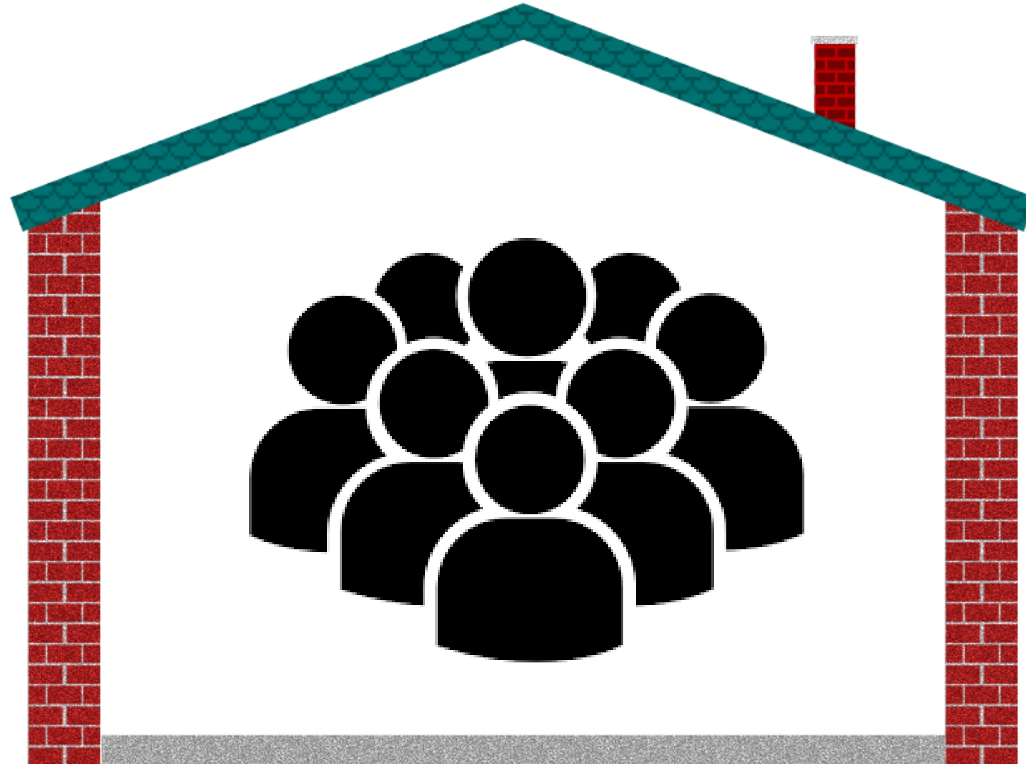
Substance Use Care

Population Health Management

Crisis Stabilization

Community Integration

Medication Adherence



Housing

Transportation

Food Security

Employment/Education

Financial Security

Flexible Funding

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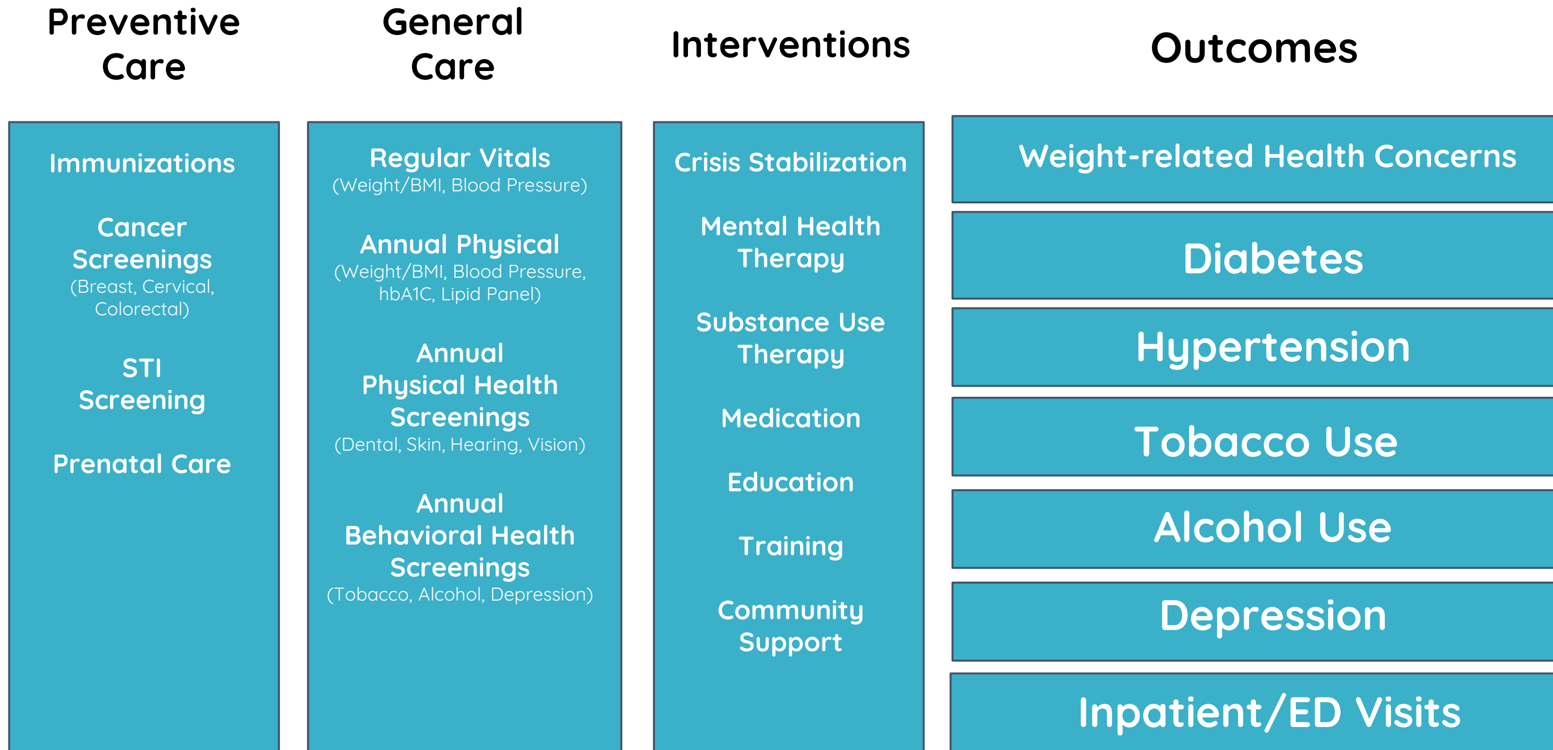
Population Health Standards of Care



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Population Health Standards of Care

Preventive Care	General Care	SDoH Supports	Interventions	Outcomes
Immunizations	Regular Vitals (Weight/BMI, Blood Pressure)	Food Security	Crisis Stabilization	Weight-related Health Concerns
Cancer Screenings (Breast, Cervical, Colorectal)	Annual Physical (Weight/BMI, Blood Pressure, hbA1C, Lipid Panel)	Stable Housing	MH Therapy	Diabetes
STI Screening	Annual Physical Health Screenings (Dental, Skin, Hearing, Vision)	Safe Neighborhood	Substance Use Therapy	Hypertension
Prenatal Care	Annual Behavioral Health Screenings (Tobacco, Alcohol, Depression)	Employment	Medication	Tobacco Use
		Financial Security	Education/ Training	Alcohol Use
		Transportation	Community Support	Depression
		Social Support		Inpatient/ED Visits

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Goals of the Lower Shore Integrated Care Model

- 95% of agency **housing will be occupied**
- 100% of housing will **pass safety & occupancy inspections**
- 95% of supportive housing clients will have a **positive home inspection**
- 100% of clients will have **potable water** in their home
- 25% reduction in **preventable ER visits**
- 30% **reduction in Inpatient admissions**
- 100% **reduction in suicide attempts**
- 80% of members **enrolled in medication adherence services**
- 15 or **fewer medication errors** in RRP & RCS
- 40% or more **graduation rate from Substance Use treatment programs**
- **0 overdoses**
- 75% **adherence to Vivitrol injections**
- 25% of tobacco users will participate in **cessation interventions**
- 35% of Supportive Employment clients are **employed**
- 90% of clients have **increased income**
- 15% of clients will use agency **financial management services** (rep payee)
- 40% of clients participate in **group activities**
- **90% of clients have reliable transportation**
- 2% or **fewer incident reports** due to violence
- 100,000 **nutritionally balanced meals** provided annually
- 50% of Diabetic clients have an **hbA1C reduction** of at least 2 points
- 35% of Obese clients have a **decreased BMI**
- 10% of **STI screenings** will be positive
- 50% of clients have **blood pressure below 140/90**

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Using Business Intelligence To Guide Clinical Decision Making

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Putting the Data To Work To Improve Outcomes

- Monitoring of data collection
  - Who needs to be assessed?
  - When are they coming in next?
  - Did we get the assessment when they came in?

- Monitoring progress by Service Providers, not just Program Directors
  - What is the client's current status?
  - How is that compared to Baseline
  - How is that compared to last visit?
  - Are they getting better?

- What needs to be done to improve/maintain client's well-being?
  - Data-informed clinical decision making
  - Person-centered intervention effectiveness

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Progress & Lessons Learned At Lower Shore Clinic

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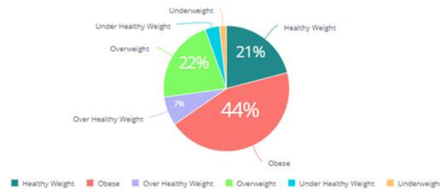
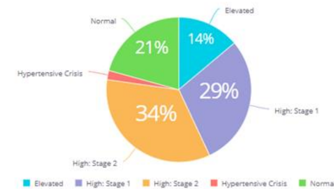
Monitoring the Most In Need Populations

- Residential Rehabilitation (RRP)
- Psychiatric Rehabilitation (PRP)
- Assertive Community Treatment (ACT)
- Health Homes (HH)

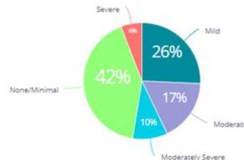
BMI Status
@ Latest Checkpoint



Hypertension Status
@ Latest Checkpoint



Depression Score Category
@ Latest Checkpoint



Percent of Clients Who Use Tobacco
@ Latest Checkpoint

48.19%

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Hypertension/Diabetes/BMI Interventions

- Monitoring vitals & hbA1C since 2017

- 2017 - 2020:
  - Saw improvement by 2nd post-Baseline checkpoint
  - But, also saw rebounding by 4th post-baseline checkpoint

- 2021-2022
  - Same findings
  - Better compliance with checkpoint data due to in house A1C machine

- Hard to evidence stable outcomes over time

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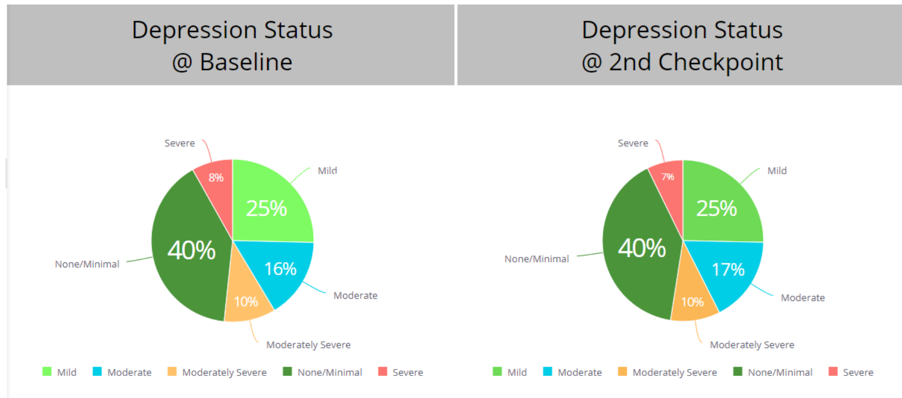
Depression Intervention

- Monitoring Depression since 2017

Treatment as Usual
2017 - 2020



Little to No Change by 2nd Post-Baseline Checkpoint

No Meaningful Results until 4th Checkpoint

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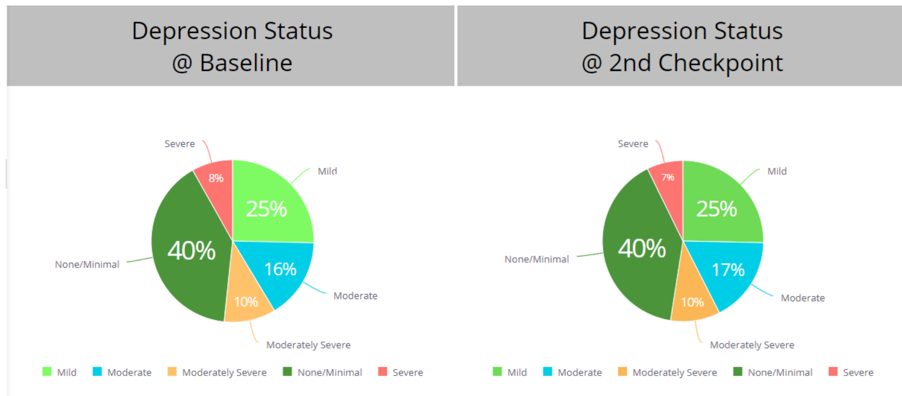
Depression Intervention

- Monitoring Depression since 2017

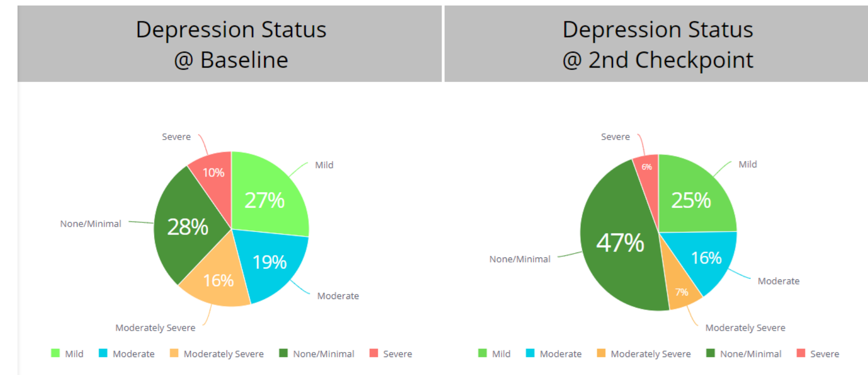
Treatment as Usual 2017 - 2020



Little to No Change by 2nd Post-Baseline Checkpoint

No Meaningful Results until 4th Checkpoint

Integrated Care with SDoH 2021 - 2022



By 2nd Checkpoint:
30% Increase in Mild/No Depression
50% Decrease in Severe/Mod. Severe Depression

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Behavioral & Physical Health are Inextricably Linked

- **SDoH improvements needed** to make early & meaningful change
- Expect to see **follow on improvements in Physical Health** now that Depression has been reduced

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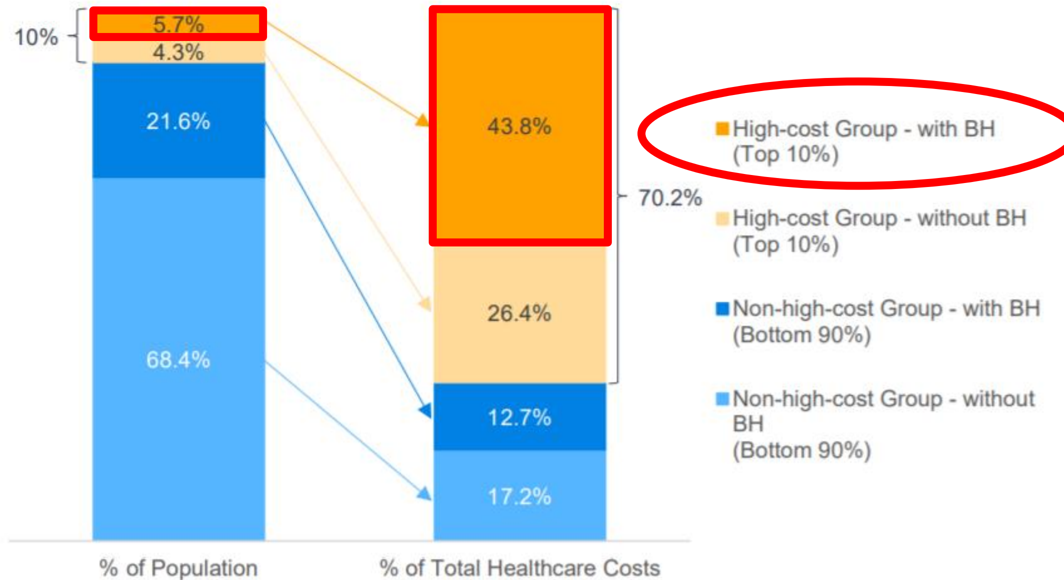
Behavioral & Physical Health Care Issues Drive Cost



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SDoH Lessons Learned

- **Housing First**
  - Permanent supported housing (affordable housing)
- **Employment**
  - Reduce poverty & increase social connectedness
- **Healthy Food**
  - Must be easy and quick to prepare
- **Clinic-administered labs**
  - hbA1C machine & program-administered blood draws with processing by local lab
- **Transportation**
  - 91 vehicles & bus passes
- **Flex Funding**
  - Copays, first month rent, utilities, furniture, clothing, etc.
- **Harm Reduction**
  - Stagewise approach to Substance Use & other unhealthy habits
- **Rapid Access to Primary Care**
  - Primary Care practitioners employed by the agency
- **On-site Pharmacy Integration**
  - Pre-packaging to increase self management & improve adherence

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Measuring Progress

CCBHC Measures

- Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)
- Weight Assessment for Children/Adolescents: Body Mass Index for Children/Adolescents (WCC-BH)
- Controlling High Blood Pressure (CBP-BH)
- Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)
- Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)
- Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)
- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)
- Screening for Clinical Depression and Follow-Up Plan (CDF-BH)
- Depression Remission at Twelve Months (DEP-REM-12)
- Follow-up after Hospitalization for Mental Illness (FUH)
- Follow-up after Emergency Department Visit for Mental Illness (FUM)
- Follow-up after Emergency Department Visit for Substance or Alcohol Use (FUA)

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Statewide Monitoring

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State Data Aggregation

Provider 1

Smart Connectors

Daily Data Flow

Provider 2

Provider 3

External Data
(e.g., HIE, Claims data, etc.)

Aggregated and De-Identified Client Data

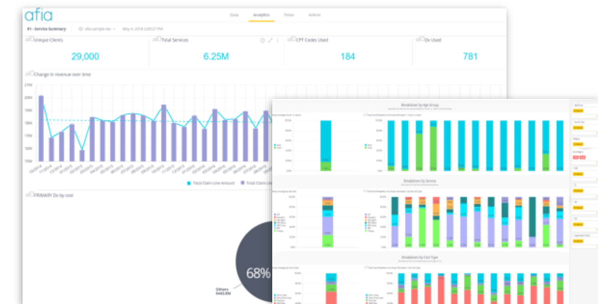
Aggregation Engine

#1 #2 #x

Member Databases

Aggregate Dashboards

Direct-Access Provider Dashboards



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ED Follow-up Monitored at the State Level

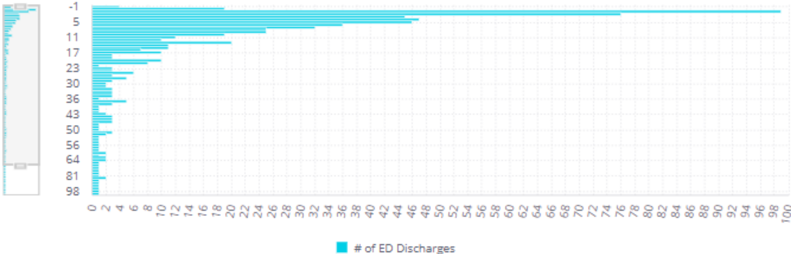
Maryland Aggregate Dashboard
MH/SUD ED Discharge Follow-up

The goal of the measure is to calculate the percent of ED Discharges with a MH/SUD diagnosis that receive a subsequent follow-up service.
Note: A MH/SUD ED Discharge Follow-up pathway episode is created for a client if the client has a qualifying ED discharge.

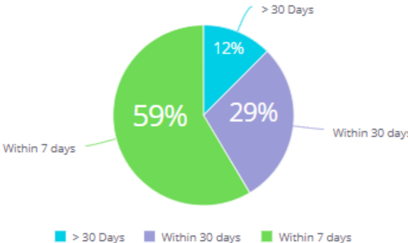
Clients with a MH/SUD ED Discharge

525

Number of Days Between MH/SUD ED Discharge & Follow-up



Number of Days Between MH/SUD ED Discharge & Follow-up



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Inpatient Follow-up Monitored at the State Level

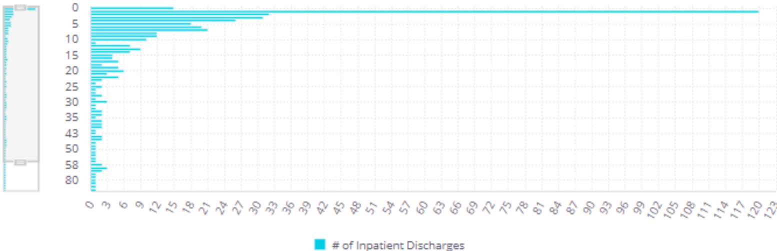
Maryland Aggregate Dashboard
MH/SUD Inpatient Discharge Follow-up

The goal of the measure is to calculate the percent of Inpatient Discharges with a MH/SUD diagnosis that receive a subsequent follow-up service
Note: A MH/SUD ED Discharge Follow-up pathway episode is created for a client if the client has a qualifying inpatient discharge.

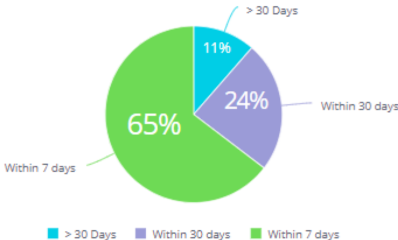
Clients with a MH/SUD Inpatient Discharge

381

Number of Days Between MH/SUD ED Discharge & Follow-up



Number of Days Between MH/SUD ED Discharge & Follow-up



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Inpatient Readmission Monitored at the State Level

Maryland Aggregate Dashboard
MH/SUD Readmission

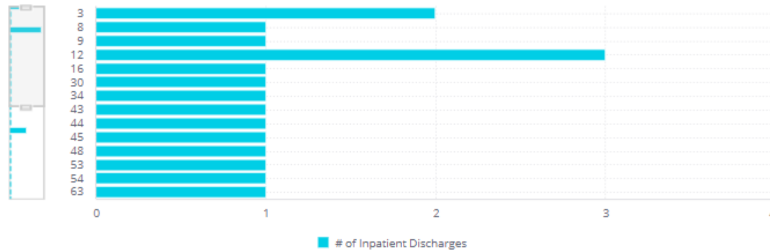
The goal of the measure is to calculate the percent of Inpatient Admissions with a MH/SUD diagnosis that occur after previous MH/SUD Inpatient Discharge (i.e., the client was readmitted to an Inpatient stay).
Note: A MH/SUD ED Discharge Follow-up pathway episode is created for a client if the client has a qualifying inpatient discharge.

Clients with a MH/SUD Inpatient Discharge
250

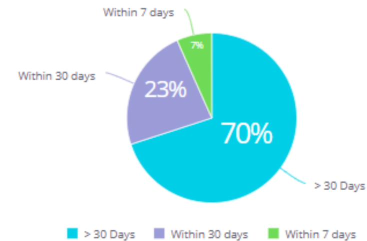
Clients with at least one MD/SUD Inpatient Readmission
12

Percent of Clients with at least one MH/SUD Readmission 4.80%

Number of Days Between MH/SUD Inpatient Discharge & Subsequent MH/SUD Inpatient Admission



Number of Days Between MH/SUD Inpatient Discharge & Subsequent MH/SUD Inpatient Admission



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Value-Based Care

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Widely Varied Value-based Payment Definitions

- Agencies should take control of the definition
- Negotiate reasonable rates & payment structures
- Lack of a model for SMI & high Cost/high utilization populations

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Value-based Care =

X Care

Over **Y** Timeline

To Produce **Z** Outcome

For **A** Population

At **B** Cost

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Q & A

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Thank you!

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