



POPULATION HEALTH AND INTEGRATION

Shaping the Future of Treatment for Mental and Addictive Disorders

NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS

Highlights from a 2014 NAPHS Leadership Forum

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INTRODUCTION

Highlights of the
2014 NAPHS LEADERSHIP FORUM
of the
**NAPHS COMMITTEE ON BEHAVIORAL HEALTH SERVICES
WITHIN GENERAL HEALTHCARE SYSTEMS**

St. Louis, MO
November 6–7, 2014

*Our thanks to the team at SSM Health-SSM Behavioral Health Services
for hosting the committee's 2014 event.*

POPULATION HEALTH: SHAPING THE FUTURE

There are changing expectations and demands on all of health care to improve outcomes and reduce costs. General healthcare system CEOs are increasingly looking to behavioral health leaders for ideas on the role of behavioral health within a population health model.

Health systems are interested in lowering readmissions, cutting unnecessary emergency department use, and improving outcomes and patient satisfaction. Systems are now looking to better understand the role that behavioral health can play in impacting overall health. They are working to identify ways that behavioral health can reduce costs and improve outcomes for medical patients (e.g., helping cardiac patients with depression) as well as new ways to better serve psychiatric and substance use patients (who often also have complex and costly medical needs).

Opportunities for and interest in integration are great, but the challenge is in the details. There is much to consider in terms of clinical programming, workforce competencies and recruitment, information technology, and financing.

In November 2014, the National Association of Psychiatric Health Systems (NAPHS) held an NAPHS Leadership Forum with members of the NAPHS Committee on Behavioral Health Services within General Healthcare Systems. This event, hosted by SSM Health-SSM Behavioral Health Services in St. Louis, provided an opportunity for our committee members—as the behavioral health leaders within their general healthcare organizations—to come together to share their experiences and learn from each other.

Below are selected highlights from the discussion held in St. Louis, along with concepts and trends that may be of interest to all NAPHS member organizations as well as to others interested in understanding forces of change—and local solutions—in the delivery of services to individuals with mental and addictive disorders.

KEY THEMES FROM NAPHS LEADERSHIP FORUM DISCUSSIONS

The NAPHS Leadership Forum participants held wide-ranging discussions and shared case examples of members' involvement in projects now underway in various states to address key trends. Discussions were held around four themes:

- 1) Redefining behavioral health;
- 2) Moving from a disease model to a population health model;
- 3) Workforce; and
- 4) Financing/access/coverage.

Key trends are highlighted below.

PRACTICE:

Observations on strategies / changes that may be needed to achieve organizational goals:

- **Technology “is the ticket” for the future.**
 - “Disruptive innovation” is coming.
 - NAPHS members are now beginning work to find digital solutions
 - To decrease psychiatric crisis episodes, which may lead to predictive analytics;
 - To create patient portals (specialized education tools);
 - To develop self-management tools (to increase adherence) using tools such as smart-phone technology.
- **Telepsychiatry can be a valuable tool.**
 - Telepsychiatry is being used in various ways by NAPHS-member systems. Some are offering consults to primary care practices. Others are using telepsychiatry to reach rural populations. Some are using telepsychiatry in the ED.
- **Data (analytics) strengthen support for behavioral health...and are critical for population health.**
 - In one large system, analytics helped to show that over time, the system was able to drive down the age at which children's mental health issues were being uncovered from age 11 down to age 7½. The system also demonstrated that sick-child visits went down 40%.
 - Members described the importance of partnering with payors to build trust and relationships. These relationships can result in valuable information (such as where patients had been before admission and where they go after discharge).
- **New strategies are helping to reduce readmissions and improve patient satisfaction.**
 - In one system, RNs do follow-up calls within 72 hours (to inquire on prescriptions, etc.).
 - Health homes are helping some states to reduce unnecessary ED use.
 - The concept of “honored guest” is being used in one system to better serve high-utilizers.

- **Rethink job competencies and definitions.**
 - Key competencies for the future include:
 - The ability to tolerate risk;
 - Systems thinking;
 - The ability to leverage clinical knowledge across systems.
 - Challenges remain as more people seek behavioral health care at a time when there are fewer licensed professionals.
 - It was suggested that it may be helpful to view the role of the psychiatrist as more of a “consultant” in charge of a medical model (where other professionals—such as RNs, etc.) handle what is in their scope of practice.
 - With a population health model, house primary care physicians may be able to handle anxiety/depression—unless it is refractory to care (and requires specialty intervention).
 - Greater use of advanced practice registered nurses (APRNs) is proving helpful in many systems.
 - Systems have created physician-APRN partnerships, an APRN fellowship, and instituted the use of both psychiatric and medical APRNs. Some are using APRNs in the hospital; others are using them more in outpatient.
 - Health educators, peers, and other new types of positions can be effective.
 - One system is using health educators to supplement the Delivery System Reform Incentive Pools (DSRIP) model. Although not reimbursed, the health educators support the system in its commitment to ensuring that underlying needs are met (with the help of a care coordinator with social work, licensed peers, and community health workers).
 - Systems are working to reeducate and retrain staff.
 - As systems increasingly work to support the concept of population health, systems are beginning to look for ways to retrain the existing workforce beyond traditional inpatient “mental illness care” so that they are also prepared to deliver “mental health care” in the community (where you may also be working to help individuals get on an inhaled steroid or stop smoking).
 - Look for “early adopters” who can help bring along the rest of the team in new ways of thinking.
 - One system is doing a pilot test that will move social work under nursing as a way to decrease silos and cross-pollinate skill sets.
 - Systems are working around cultural issues to help primary care.
 - For example, primary care may demand a psychiatrist in situations where other team members could be more appropriate. One system is working to help primary care understand when a masters-prepared person is needed (vs. a psychiatrist).
 - Risk is a key concern for primary care, as they see an increasingly disabled and higher risk population (with suicide now a problem in outpatient settings). Because managing risk is what behavioral health leaders are trained to do, they can play a key role in helping primary care physicians address safety.
- **Prepare for a new, younger workforce.**
 - To be able to recruit, it’s important to look at what makes a job attractive to younger generations. Work-life balance is often highly valued, so looking at satisfaction, contribution, and flexibility may be more important than dollars.

- Some facilities are looking at creative ways to do this. One system is exploring the changing role of the social worker in a hospital (with an opportunity to see the social worker as more of a “life coach” than a case manager).
- One system had a hospital in the 99th percentile in Press Ganey employee engagement surveys. They block out Fridays to have no meetings at all for leaders. Instead there are town meetings on Fridays that are run by employees. This allows the sharing of successes as leaders spend the day with employees. Twice a year employees shadow executives, and 15 times/year they spend the whole day with the executive, working the schedule for the day with the executive.
- To address inpatient worker burnout (which can occur when people don’t see the patient progress), one system is holding “recovery celebrations” and encouraging staff to attend.
- **Leadership—(“ways of saying ‘yes’ even when payment is not immediately available”)—is a role that hospitals are playing in their communities. As one said, “Give something to get something.”**
 - In one state members are offering a patient portal (access to the medical record) to the community mental health center as a way to “give”....before being asked.
 - One hospital system is looking at how they can divert operational funds to support housing as a way of addressing emergency department overcrowding.
 - To reduce the stigma between medical health and behavioral health, one system has developed a series of videos (on topics such as aggression, depression, suicide) to help their medical/surgical nurses better understand and manage mental health.
- **Partnerships are essential.**
 - To improve transitions of care, hospitals need to find ways to better partner with community mental health centers (CMHCs) and other community providers. Organizations are doing this in various ways (e.g., in one case through a joint workforce training grant).
 - Recognizing there was not enough outpatient capacity, one system built a relationship with a Hispanic family collaborative and Catholic family organization. Starting such projects can begin with a simple Memorandum of Understanding.
- **Find financial resources wherever you can. Various strategies have been helpful in kick-starting collaborations and projects. For example,**
 - Uninsured patients in one system are covered by a state grant.
 - Private and church funds provide a completely free service of transitional rehabilitation. This Bridge to Recovery, staffed by a coordinator with AA and church groups, will take people post-discharge from detox and “bridge” until they can get into a treatment center (providing transportation).
- **Privacy issues need to be better addressed as part of a broader look at improving communication between psychiatry and medicine.**
 - Organizations are using various approaches.
 - One system chose to opt all behavioral health patients out of open access by other providers to their behavioral health records. But in the next visit, patients are asked whether they want to opt-in to give access to their record to all their providers. About 90% are opting in.
- **There is no magic.**
 - “We are flying an airplane and changing the engine in flight,” it was said.
 - Find what people are looking for....and just do it.

POLICY:

The following observations were made about policy changes needed.

- **“Mental health is not a partisan issue,”** noted Missouri Medicaid Director Joe Parks, M.D., who was a guest speaker at the NAPHS Leadership Forum. There is strong interest in understanding and addressing behavioral health issues (among Medicaid directors, for example) regardless of party. Behavioral health leaders need to continue to reach out to both Democrats and Republicans.
- **There needs to be a continuing push for behavioral health IT incentives** (equal to those for medicine). “Separate (e.g. different payment incentives for electronic health records) is never equal and is discriminatory,” noted guest speaker Joe Parks.
- **IT vendors need to hear from behavioral health providers about specific challenges (and solutions) to interoperability between medicine and psychiatry.**
- **Payment must be changed to drive the practice of population management.**
- **Telepsychiatry should be supported.** There is currently little funding available, and more could be done if this were more widely available.
- **Support improved community resources...and improved partnerships between health systems and those community resources.**

MISSOURI MEDICAID DIRECTOR:

“If you don’t like your partnership, you need to change.”



Mental health is not a partisan issue.

Joe Parks, M.D.

Medicaid directors are increasingly taking notice of behavioral health, psychiatrist and Missouri Medicaid Director Joseph Parks, M.D., told the NAPHS Leadership Forum. At a May Medicaid directors’ meeting (five months after the Exchanges began), two-thirds of Medicaid directors wanted to talk about behavioral health. “We have opportunities, but we need to execute now...to do things differently than before.”

“The people we serve [with behavioral health disorders] are burdened with a lot of medical illness,” he noted, and “we [behavioral health] see them the most.” Per member/per month (PMPM) costs for those with mental illnesses are greater than \$1,200, where the PMPM for those without mental illnesses is less than \$600 (Milliman, 2013).

MISSOURI’S BI-DIRECTIONAL INTEGRATION WITH HEALTH HOMES

In Missouri, they have created health homes as a “system and organizational transformation.”

[Read more about the Missouri Community Mental Health Center (CMHC) Healthcare Homes at <http://dmh.mo.gov/mentalillness/MOHealthHomes.htm> and more about the Primary Care Health Homes at [http://dss.mo.gov/mhd/cs/health-homes/.](http://dss.mo.gov/mhd/cs/health-homes/)]

Over time, these models have had significant impact. Primary Care Health Homes have served 23,354 people (including dual eligibles), decreased costs by \$30.79 PMPM, and resulted in a total cost reduction of \$7.4 million. CMHC Health Homes have served 20,031 people, decreased cost by \$76.33 PMPM, and resulted in total cost reduction or \$15.7 million.

OTHER TRENDS

There is increased sharing of medical risk (as in the Accountable Care Organization model), as well as consolidation, Dr. Parks said.

Seven states (CA, KA, MA, NJ, NM, NY, and TX) are using Delivery System Reform Incentive Pools (DSRIP), where they get a Medicaid 1115 waiver for meeting specific planned milestones in building system reforms. Mostly hospital-based, these are slated to run three to five years. [For background on DSRIP, see a Center for Health Care Strategies report at <http://www.chcs.org/delivery-system-reform-incentive-payment-program-model-reforming-medicaid/>.]

In concluding, Dr. Parks drew on his psychiatric expertise to encourage behavioral health leaders to play a greater role in encouraging change. “We need to be better partners,” he said, and to do that there must be trust. “If you don’t like your partnerships,” he said, “you need to change” and use a strategy that you will “help them until they’re helpless without you.”