NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH

Leveraging Behavioral Health Data to Inform Population Health Management Strategies

Thursday, January 28, 2021

2:00-3:00pm EST

CoE

Center of Excellence for Integrated Health Solutions

Funded by Substance Abuse and Mental Health Services Administration
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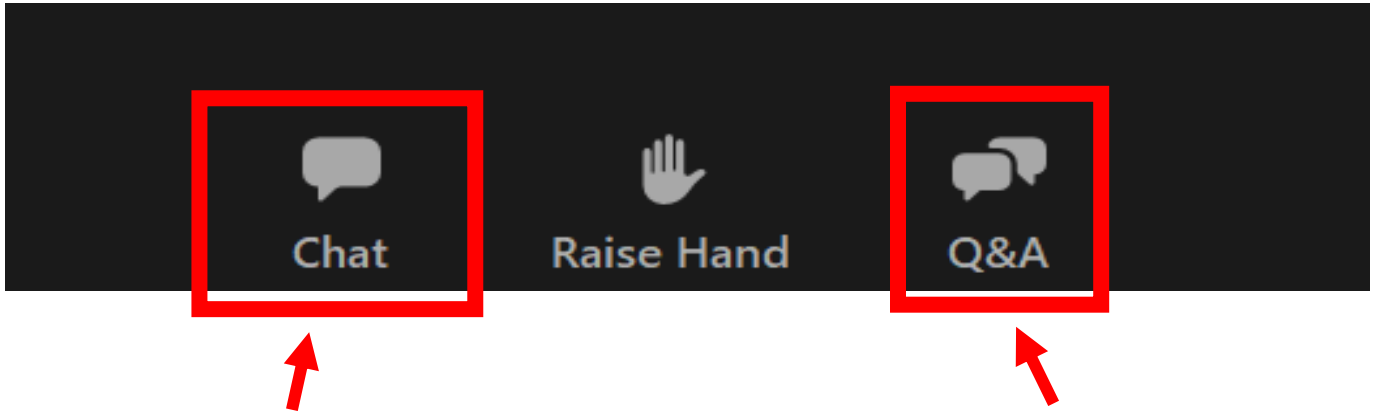
How to Ask a Question/Make a Comment



Type in a **comment** in the **chat box**

Type in a **question** in the **Q&A box**

Both are located at the bottom of your screen.

We'll answer as many questions as we can at the end of the presentation.

Disclaimer

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).

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www.samhsa.gov

Poll #1: What best describes your role?

- Clinician
- Administrator
- Policy Maker
- Payer
- Other (specify in chat box)

Poll #2: What best describes your organization? (check all that apply)

- Behavioral Health Provider
- Primary Care Provider
- Mental Health Provider
- Substance Use Disorder Provider
- Other (specify in chat box)

Poll #3: Where is your organization in the process of integration?

- Learning/Exploring
- Beginning Implementation
- Advanced/Full Implementation
- Ongoing Quality Improvement
- Other (specify in chat box)

Introductions

Jeff Capobianco, PhD, LLP
Integrated Health Senior Consultant, Practice Improvement & Consulting, National Council for Behavioral Health

Dianne Shaffer, LMSW
Director of Systems Development, Integrated Services of Kalamazoo

Beth Ann Meints
Senior Executive – Services for Adults with a Mental Illness/Substance Use Disorder, Integrated Services of Kalamazoo

Learning Objectives

In this webinar participants will learn about:

- Common tools for mental health and substance use screening, level of care determination, and risk stratification.
- How teams can leverage data to best manage populations from the perspective of health disparities, early identification of needs, and effective care coordination within and outside of the healthcare organization.
- The importance of population stratification by different cultural identities, race, and sexual orientation to best mobilize services.

How we'll spend our time together

1. Framing our discussion through the lens of Health Equity
2. Defining Population Health Management (PHM) and Risk Stratification (RS)
3. Executing on PHM & RS using the Collaborative Care Pathways as examples

Defining Health Equity

"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.....For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups."

Source: A New Definition Of Health Equity To Guide Future Efforts And Measure Progress, Health Affairs Blog 2017

Health Inequity Root Causes:

1. Intrapersonal, interpersonal, institutional, and systemic mechanisms (also referred to as structural inequities) that organize the distribution of power and resources differentially across lines of race, gender, class, sexual orientation, gender expression, and other dimensions of individual and group identity.
2. The unequal allocation of power and resources—including goods, services, and societal attention—which manifests itself in unequal social, economic, and environmental conditions, also called the determinants of health.

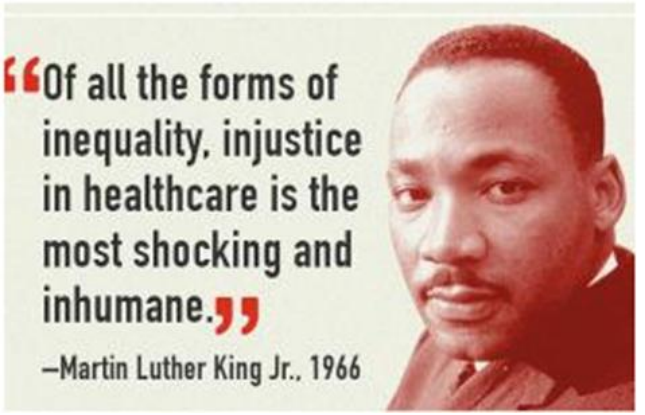
Source: National Academies of Sciences, Engineering, and Medicine. 2017. Communities in action: Pathways to health equity. Washington, DC: The National Academies Press. doi: 10.17226/24624.

Healthcare Inequity & the Integration of Behavioral and Primary Healthcare Have Some Things in Common…

Centuries of being a work in progress..

17th century pamphlet depicting the effects of the plague on different social classes in London

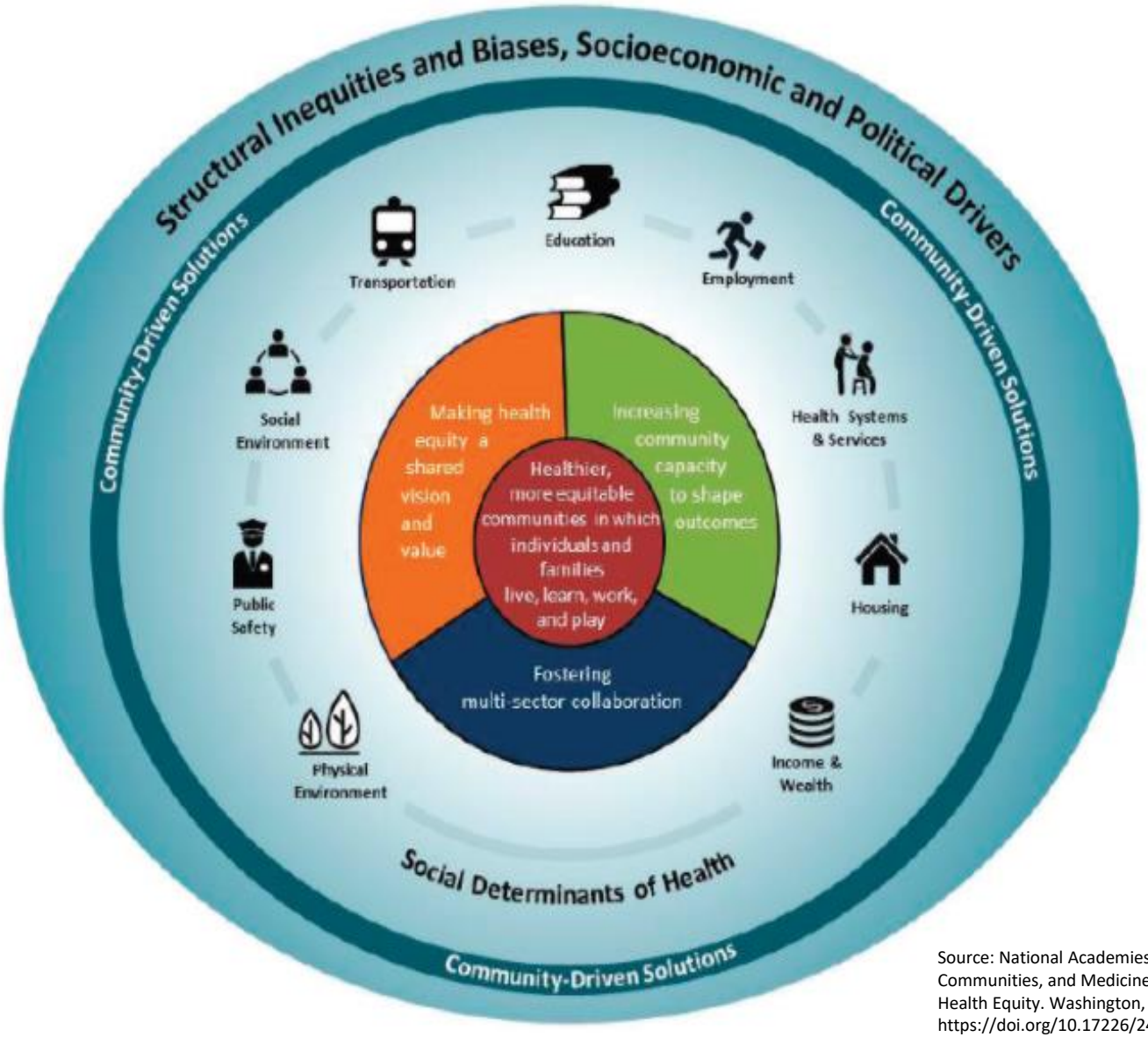
Source: The Lancet



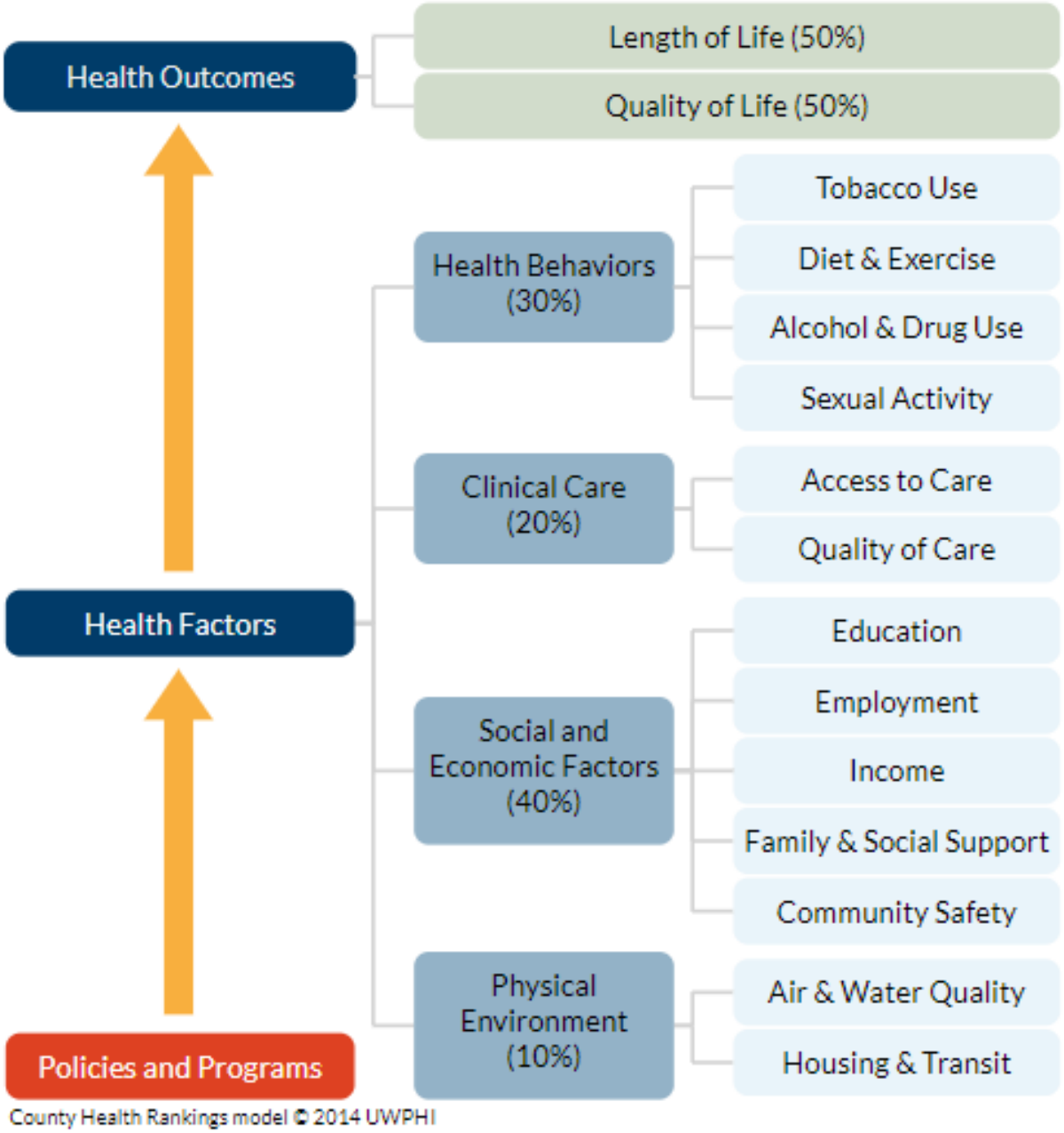
"The Body must be treated as a whole and not just a series of parts."

Hippocrates 300 BC

Healthcare Providers, Policy Makers, Funders, Advocates and People Receiving Care All Have A Role In Understanding the Landscape and Improving It



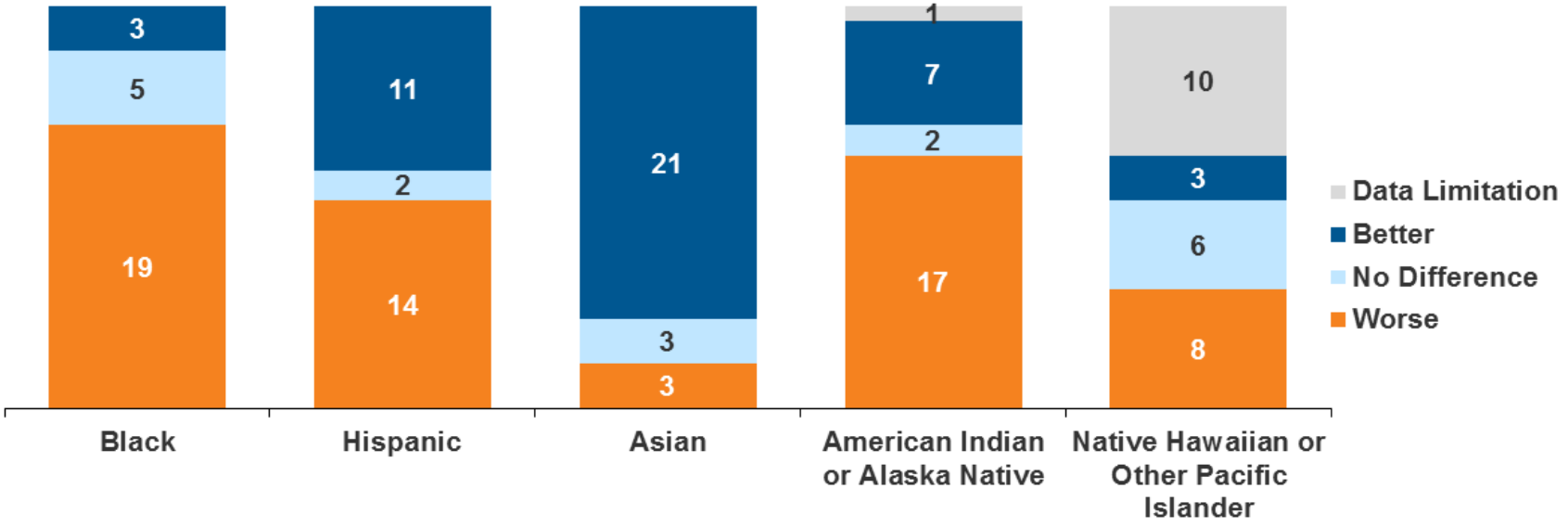
Source: National Academies of Sciences, Engineering Communities, and Medicine 2017. in Action: Pathways to Health Equity. Washington, DC: The National Academies Press. https://doi.org/10.17226/24624.



Source: County Health Rankings. (2017). Retrieved from http://www.countyhealthrankings.org/our-approach

Disparity in Health Status by Race & Ethnicity

Number of Measures for which Group Fared Better, the Same or Worse Compared to Whites



Note: Measures are for 2018 or the most recent year for which data are available. "Better" or "Worse" indicates a statistically significant difference from Whites at the p<0.05 level. No difference indicates no statistically significant difference. "Data limitation" indicates data are no separate data for a racial/ethnic group, insufficient data for a reliable estimate, or comparisons not possible due to overlapping samples. AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic.

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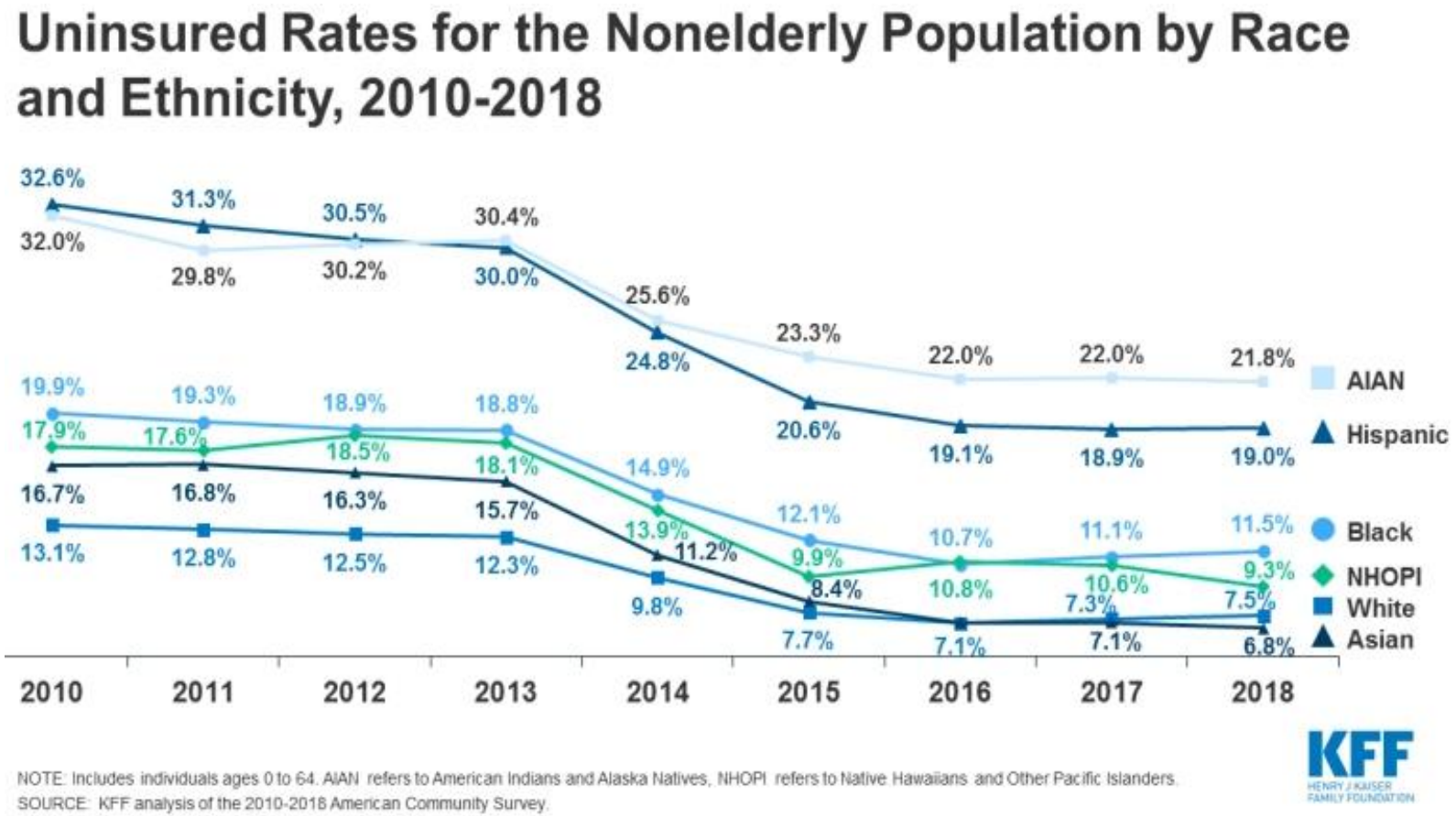
Access to Health Insurance



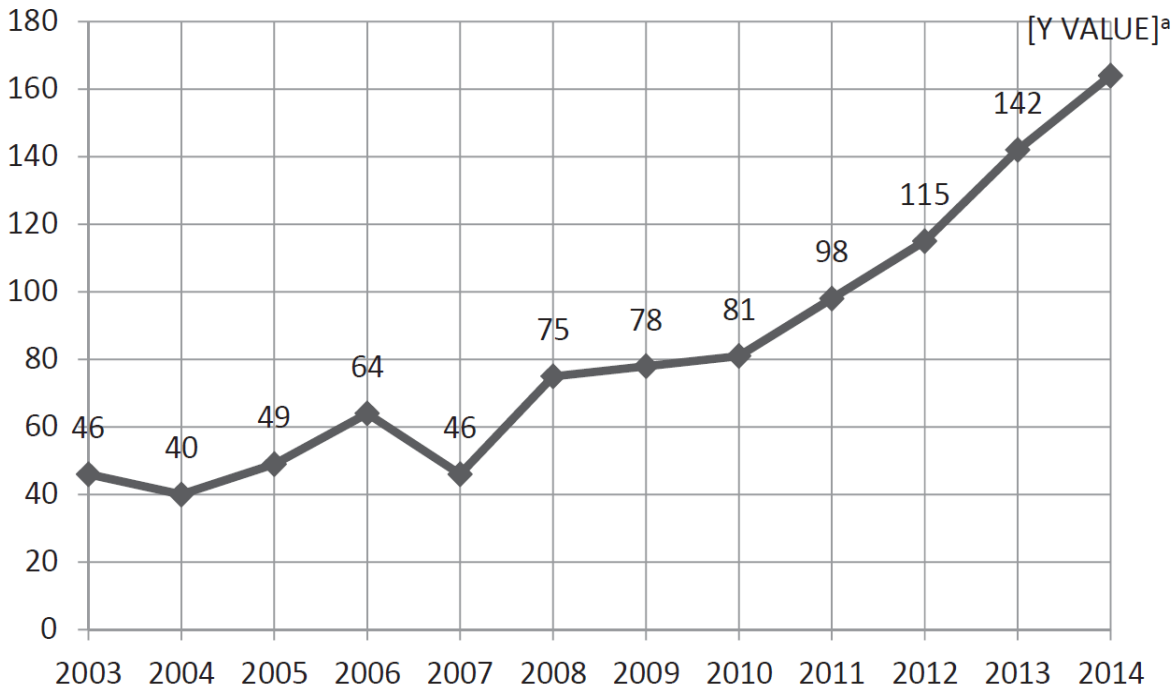
NOTE: Includes individuals ages 0 to 64. AIAN refers to American Indians and Alaska Natives, NHOPI refers to Native Hawaiians and Other Pacific Islanders.
SOURCE: KFF analysis of the 2010-2018 American Community Survey.

Looking at Health Equity & Services Integration through the Lens of Effective Data Capture & Use?

- Without Robust Population Health Management, it is difficulty to understand where your organization stands regarding health equity…
- Population Health Management uses data to tell the story of who (i.e., people of different sexual orientations, races, ethnicities, etc.) is/isn't accessing and using services and how effective the services are in meeting their needs.
- Team-based Integrated Care Pathways are the means through which populations are engaged in effective care

The Rise of Population Health Management (PHM)

Figure 1. English-Language PubMed Titles With "Population Health"



[a]Projected based on first 6 months of 2014.

Source: Sharfstein, The Milbank Quarterly (2014)

Defining Population Health Management

- A **set of interventions** designed to maintain and improve people's health **across the full continuum of care**—from low-risk, healthy individuals to high-risk individuals with one or more chronic conditions.

- Population management requires providers to develop the capacity to **utilize data** to choose which patients to select for specific evidence-based interventions and treatments.

- Strategies for optimizing the health of an entire client population by **systematically assessing tracking** and **managing the group's health conditions and treatment response.**

- It also entails approaches to **engaging the entire target group**, rather than just responding to the clients that actively seek care.

(source: Felt-Lisk & Higgins, 2011; Parks, 2014)

Risk Stratification

- Risk Stratification is the process of assigning a health risk status classification and using it to direct and improve care.
- A consumer is ***at risk*** when he/she reaches an established threshold or cutoff that triggers a step-in care (i.e., up or down).
- High utilizers are most familiar example of a risk group.
- The goal of **Risk Stratification** is to help patients achieve the best health and quality of life possible by preventing chronic disease, stabilizing current chronic conditions, and preventing the acceleration to higher-risk categories and higher associated costs.

(Source: American Academy of Family Physicians High Impact Changes for Practice Transformation, July 2017)

Key Aspects

1. Knowing what to ask about your population
2. Data registry with reliable and valid measures describing your population needs
3. Effective CQI Process with your Teams to improve Care Pathway Processes to address the needs
4. Use of Dashboards for monitoring care pathway efficiency and effectiveness

Care Pathway

Standardized set of processes or care management guidelines developed by a clinic team to screen, assess, and treat patients with a specific health condition or social determinant need.

Care pathways include both clinical (e.g., prescribing, therapy), financial (e.g., documenting and billing), and administrative (e.g., reviewing data, team meetings) workflow behaviors which staff engage in when delivering care.

Steps for Designing and Implementing a Care Pathway

1. **IDENTIFY** a client population.

2. **ASSIGN** an interdisciplinary quality improvement team.

3. **RESEARCH** the evidence-based or best practice guidelines associated with identified need(s) of the population.

4. **MAP** the current state of services provision and identify areas for improvement.

5. **DEVELOP** the revised care pathway protocol(s).

6. **TEST** the new protocol(s) using Plan-Do-Study-Act.

7. **IMPLEMENT** the new care pathway and monitor using continuous quality improvement.

Care Management: Care Pathway

Conduct Screening & Assessment

Conduct Biopsychosocial Assessment using Social Determinant, Physical Health, & Behavioral Health Screening Data

Assess Patient's Readiness for Change for each Clinical & Social Determinant Need

Develop Treatment Plan

Based on the Screening& Assessment Develop Treatment Plan based on the Patient's Readiness for Change with Treatment Targets to address each Health Condition & Social Determinant need

Provide Services Using Team-based Care: Conduct Regular Population Health Management to Stratify Risk & Adjust Care

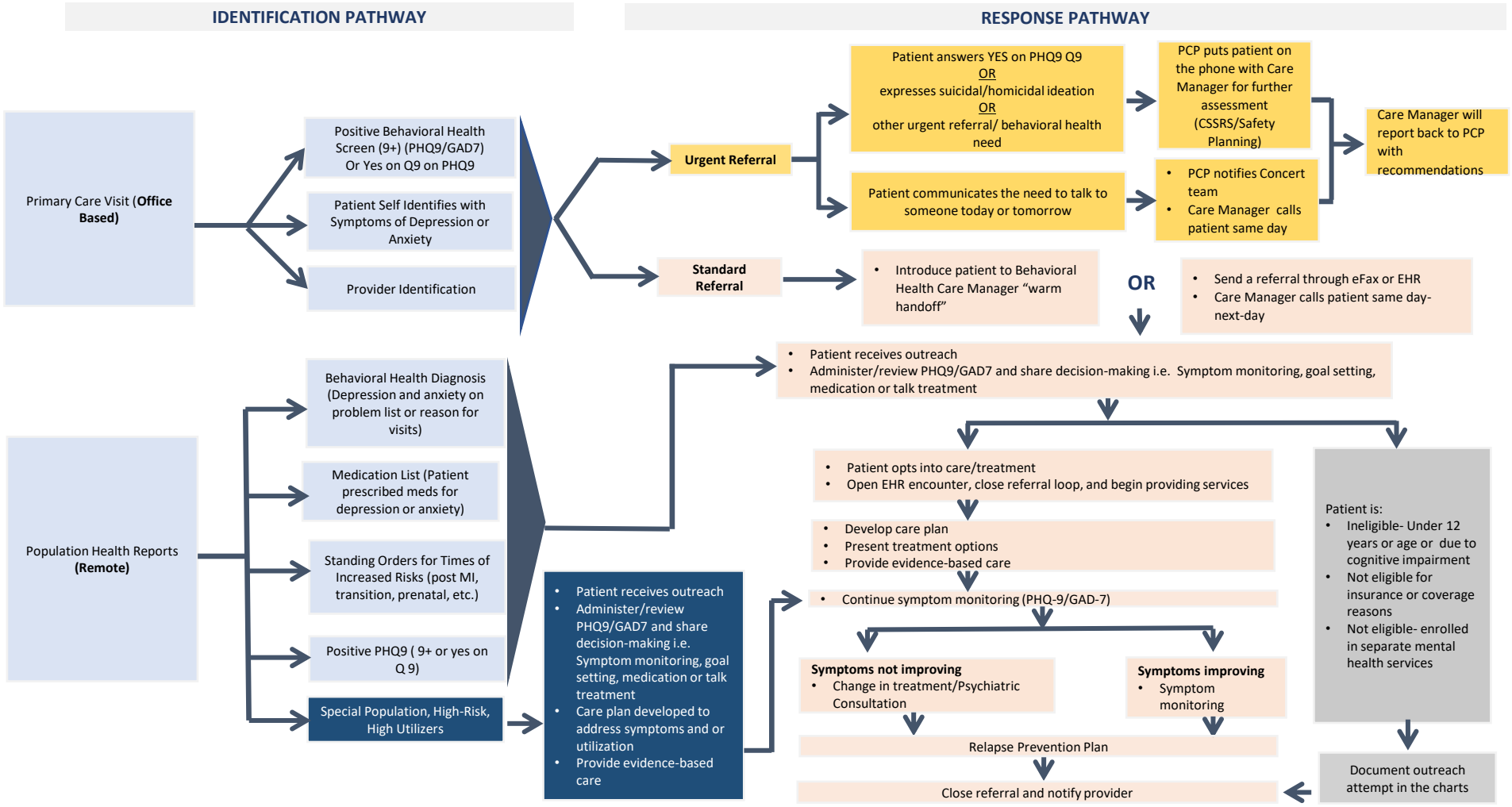
Assess Risk &Stratify Care Based on Goal Progress

Based on Risk Strat. Findings Step Care Up or Down

Achieve Treatment Targets

Achieve the Target Goals for each Health Condition & Social Determinant Need

Depression & Anxiety Collaborative Care Pathway



*The Collaborative Care model is an evidence-based model for patients 12 years and above. Patients under the age of 12 are ineligible to receive Collaborative Care services.
Source: Virna Little, ConcertHealth

[Depression & Anxiety Collaborative Care Pathway PDF]

Team Collaborative Care Pathway Dashboard

TRACKING PROGRESS AND ADJUSTING TREATMENT APPROACH

			Treatment Status				PHQ-9				GAD-7				Psychiatric Consultation	
			! Indicates that the most recent contact was over 2 months (60 days) ago				✓ Indicates that the last available PHQ-9 score is at target (less than 5 or 50% decrease from initial score) ! Indicates that the last available PHQ-9 score is more than 30 days old				✓ Indicates that the last available GAD-7 score is at target (less than 10 or 50% decrease from initial score) ! Indicates that the last available GAD-7 score is more than 30 days old					
View Record	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Consultant Note
View	Active	Susan Test	9/5/2015	2/23/2016	10	26	22	14	-36%	2/23/2016	18	17	-6%	! 1/23/2016	Flag for discussion & safety risk	1/27/2016
View	Active	Albert Smith	8/13/2015	! 12/2/2015	7	29	18	17	-6%	! 12/2/2015	14	10	-29%	! 12/2/2015	Flag for discussion	
View	Active	Joe Smith	11/30/2015	2/28/2016	6	14	14	10	-29%	2/28/2016	10	✓ 6	-40%	2/28/2016	Flag for discussion	/2016
View	Active	Bob Dolittle	1/5/2016	3/1/2016	3	9	21	19	-10%	3/1/2016	12	10	-17%	3/1/2016	Flag as safety risk	2/18/2016
View	Active	Nancy Fake	2/4/2016	2/4/2016	0	4	.	No Sc			.	No Score				
View	RP	John Doe	9/15/2015	3/6/2016	10	25	20	✓ 2	✓ -90%	3/6/2016	14	✓ 3	✓ -79%	3/6/2016		2/20/2016

FREE UW AIMS Excel® Registry (https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data)

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Dashboard Metrics to track for Impacting Disparities in Care and Social Determinants

Social and Economic Factors Drive Health Outcomes

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Racism and Discrimination					
Employment Income Expenses Debt Medical bills Support	Housing Transportation Safety Parks Playgrounds Walkability Zip code / geography	Literacy Language Early childhood education Vocational training Higher education	Food security Access to healthy options	Social integration Support systems Community engagement Stress Exposure to violence/trauma	Health coverage Provider availability Provider linguistic and cultural competency Quality of care

Health Outcomes: Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

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ICD 10 Coding for Disparity & Social Determinants

Problems related to education and literacy

Code	Social Determinant
Z55.0	Low level of Literacy
Z55.1	Unavailable schooling
Z55.2	Failed Examinations
Z55.3	Underachievement in School
Z55.4	Educational maladjustment and discordwith classmates and/or teachers
Z55.8	Other problems related to education and literacy

Problems related to employment and unemployment

Code	Social Determinant
Z56.0	Unemployment, unspecified
Z56.2	Threat of job loss
Z56.3	Stressful work schedule

Problems related to housing and economic circumstance

Code	Social Determinant
Z59.0	Homelesss
Z59.1	Inadequate housing
Z59.4	Lack of adequate food
Z59.5	Extreme Poverty
Z59.6	Low income
Z59.7	Insufficient social insurance and welfare support
Z59.8	Other problems related to housing and economic circumstances

Problems related to social environment

Code	Social Determinant
Z60.0	Problems of adjustment to life-cycle transitions
Z60.1	Atypical parenting situation - problems related to a parenting situation
Z60.2	Living Alone
Z60.3	Acculturation Difficulty
Z60.4	Social exclusion and rejection/ Isolation
Z60.8	Other problems related to social environment

Problems related to negative life events in childhood

Code	Social Determinant
Z61.1	Removal from home in childhood
Z61.4	Problems related to alleged sexual abuse of child by a person within primary support group
Z61.5	Problems related to alleged sexual abuse of child by a person outside primary support group
Z61.6	Problems related to alleged physical abuse of child
Z61.8	Other negative life events in childhood
Z62.0	Inadequate parental supervision and control
Z62.2	Institutional upbringing
Z62.4	Emotional neglect of child
Z62.5	Other problems related to neglect in upbrining

Other problems related to primary support group, including family circumstances

Code	Social Determinant
Z63.0	Problems in relationship with spouse or partner
Z63.2	Inadequate family support
Z63.4	Disppearance/death of a family member
Z63.5	Disruption of family by separation and divorce
Z63.6	Dependent relative needing care at home
Z63.7	Other stressful life events affecting family and household
Z63.72	Alcoholism and drug abuse in family

Problems related to psychosocial circumstances

Code	Social Determinant
Z64.0	Problems related to unwanted pregnancy
Z65.0	Conviction in civil and crimminal proceedings without imprisonment
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to relase from prison
Z65.3	Problems related to other legal circumstances

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Questions?

Resources

[Addressing Health Equity and Racial Justice Webpage]

Webinars and Upcoming Events

- RECORDINGS AND PRESENTATIONS

Resources and Tools

- ASSESSMENT TOOLS
- STAFF TRAININGS
- STIGMA REDUCTION
- EDUCATIONAL TOOLKITS

Resources (cont'd)

- Depression & Anxiety Collaborative Care Pathway PDF
- Toolkit for Designing and Implementing Care Pathways
- Communities in Action: Pathways to Health Equity
- County Health Rankings
- Exploring the Promise of Population Health Management Programs to Improve Health (Felt-Lisk & Higgins 2011)
- Disparities in Health and Health Care: Five Key Questions and Answers (Kaiser Family Foundation)
- Centers for Medicare and Medicaid Services – Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH)
- DLA20 Alcohol-Drug Assessment of Functioning
- AIMS Center (Advancing Integrated Mental Health Solutions) Caseload Tracker tool
- AIMS Center Patient Tracking Spreadsheet Resources

Upcoming CoE Events:

Improving Client Outcomes with Care Coordination and Population Health Management Strategies

Register here for webinar on Feb. 4, 2-3pm ET

Health Equity ECHO – APPLY NOW until Feb. 5

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Thank You

Questions?

Email integration@thenationalcouncil.org

SAMHSA's Mission is to reduce the impact of substance abuse and mental illness on America's communities.

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