Panel II: Clinical Practice in the Era of Integrated Care and Population

Moderator: Arthur Evans, Ph.D.
Commissioner, Department of Behavioral Health and Disability Services,
City of Philadelphia
Clinical Practice in the Era of Integrated Care and Population Health

31st Annual Rosalynn Carter Symposium on Mental Health Policy
November 13, 2015

Arthur Evans, Ph.D., Commissioner
Untreated behavioral health conditions major cost driver

- Retention
- Engagement
- Dose
- Transitions
TRADITIONAL TREATMENT MODEL
Severe Mental Illness: 5%
Diagnosable Mental Disorder: 20%
Everyone Else: 75%

$100 BILLION
Our Current Treatment System

Arthur C.
Factors that Influence Health Status

- **Health Care**: 10%
- **Environment**: 19%
- **Human Biology**: 20%
- **Lifestyle**: 51%
  - Smoking
  - Obesity
  - Stress
  - Nutrition
  - Blood Pressure
  - Alcohol
  - Drug Use

Arthur C.
the health outcomes of a group of individuals, including the distribution of such outcomes within the group. These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group.
Elements of a Population Management Approach

- Addresses **social determinants** of health
- Is focused on **long-term outcomes**
- Has **health as the goal** (not symptom reduction)
- Requires **partnership**
- Requires **creativity and innovation**
- Utilizes a **data driven approach**
- Involves **systemic strategies**
- Can use **managed care approaches**
Public Health Approach to Population Health

Effective Treatment & Systems + Community Health Strategies
7 Competencies Needed for Population Health Management

1. Working at the community and group level
2. Working upstream
3. Broad set of strategies
4. Working with non-diagnosed populations
5. Deliver health promotion interventions
6. Working in community and other non-clinical settings
7. Health activation approaches and empowering others
Community Screenings

Screenings
HealthyMindsPhilly.org
Help Yourself, Help Others

Mental Health First Aid
Learn to identify, understand, and respond to signs of behavioral health challenges or crises.

On Our Minds
Thoughts and updates from Dr. Arthur C. Evans, Jr., Commissioner of DBHIDS and staff.

Calendar
Find awareness events, screenings, or trainings from DBHIDS.

Behavioral Health Screening
If you feel sad, anxious or stressed, this screening tool can help you decide if you need further help.
Mental Health Kiosk

VOTED “PHILADELPHIA'S BEST GYM“
-THE PHILADELPHIA INQUIRER
Early Intervention

Trauma Response Teams
“When the community starts getting together around this process, other good things start happening too.”

Betsy – Porch Light Participant
Finding the Light Within

© 2012 City of Philadelphia Mural Arts Program / James Burns.
Horizon House, 119 S. 31st Street. Photo by Steve Weinik
Thank You

Arthur C. Evans, Ph.D.

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@ArthurCEvans
DBHIDS.org
Healthymindsphilly.com
Panel II: Clinical Practice in the Era of Integrated Care and Population

Panelists:

Lisa Goodale, M.S.W., Vice President of Training, Depression and Bipolar Support Alliance

Frank de Gruy III, M.D., M.S.F.M., Woodward Chisholm Professor and Chair, Department of Family Medicine, University of Colorado School of Medicine

Benjamin Miller, Psy.D., Assistant Professor, Director, Office of Integrated Healthcare Research and Policy, Department of Family Medicine, University of Colorado School of Medicine

Naakesh Dewan, M.D., Medical Director for Behavioral Health, BayCare Medical Group
PEER SUPPORT SERVICES
IN THE ERA
OF POPULATION HEALTH
AND INTEGRATED CARE

2015
Led by and created for individuals living with mental health conditions, and that experience informs everything that we do.

National leader in training people with mental health conditions to use their experiences to work with others as Peer Specialists.

First-ever national contractor for training/certification of VA peer support staff members.
What are we integrating?

- Care and services
- The patient’s perspective and desires
1. Need for recognized, accessible training and certification

2. Salary inequities and limited career path

2015 National Web Survey of Peer Support Specialist Wages and Salaries

Daniels et al, 2015
3. Effective utilization of peer support services

4. Lack of recognized legitimacy and worth

VA Consumer Provider Study

Provider comments:

– CP would be “not completely stable all of the time”, “too fragile”, or “inconsistent”
– CPs “may fall apart” or would have “difficulty in all the paperwork”
– “Given that CPs are not professionals, who will be responsible when something bad happens?”

Do not work *on* me.

Work *with* me.

- Kunc & Van der Klift

DBSAlliance.org/Training
Enablers of Integrated Care

Frank deGruy
Carter Center
November 12, 2015
Culture & Conventions

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<th>PC</th>
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<td>Fast, loud, interrupted</td>
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<td>Lots of live problems</td>
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<td>Shifting lead clinician</td>
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<table>
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<th>BH</th>
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<td>Longer visits</td>
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<td>Wraparound services</td>
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<tr>
<td>PCC needs rooms, stuff</td>
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</table>
Physical Space

- Proximity
- Interruptibility
- Bumpability
Staffing & Scheduling

- **PC**
  - Psychologist: 4:1 adults, 3:1 kids
  - Psychiatrist: .2 FTE per 10,000 pts

- **BH**
  - 1 PCC/500-800 pts

- Flex schedule: available, but not idle
Communication

- Shared EHR (including on phone)
- Phone
- Huddles
- Telehealth
- Common clinical workspace
Teamwork

- Consultation
- Coordination
- Collaboration
Complete Integration

- One clinic, no wrong door
- All patients have a PCC
- All have access to BH clinicians
- Deep end covered
Leadership

- Complex adaptive system
- Complex adaptive leadership
- Administrative leadership
- Enabling leadership
Barriers to Integrated Care

Benjamin F. Miller (@miller7)
Carter Center
November 12, 2015
The barriers

- Payment
- Policy
- Workforce
Action items for better behavioral health

- Behavioral health is a critical facet of comprehensive primary care — no different than investments in practice-based care management, measurement and other data use competencies, technology and practice transformation support.

- Global payment based upon defined practice budgets for personnel, interventions and related infrastructure – to create team-based, whole-person care (e.g. CoACH)

- Changing payment allows behavioral health providers to not be trapped in a workflow designed to maximize volume-based payments, or pigeon holed into distinct “physical” and “mental health” coding categories

- Primary care practices “own” their own behavioral health resources and are fully accountable for measured outcomes

http://sustainingintegratedcare.net/
Cost Outcomes

- Substantial, independently evaluated TCOC differentials
- Normalized for differences in population, demographics, risk and price

<table>
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<th>Medicaid</th>
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<th>Medicare-Medicaid Beneficiaries</th>
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<td>- 5.5%</td>
<td>- 3.0%</td>
<td>- 5.4%</td>
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TCOC = total cost of care.

http://sustainingintegratedcare.net/
Payment recommendations

- Make sure the practice is getting paid by keeping the patient healthy, not per patient visit.

- If the practice is not getting one payment per patient, make sure there are incentives in place to encourage primary care clinicians to work with behavioral health (e.g. hold them accountable for certain behavioral health conditions).

- Make sure behavioral health providers share in gains, when appropriate.
Consider your policy

★ Consider what impact carving out behavioral health in all forms and permutations does at all levels and all policy processes

★ End legacy "home grown" assessment and reporting processes that drain resources and often lack any basis in evidence

★ See the mental health “system” clearly for what it is now (a 'safety net' and a source of 'specialty care') -- and what it CAN be (a very useful vehicle for community based interventions, a much wider array of social determinant supports and population campaigns)

★ Dispel any and all myths that “one size fits all” for behavioral health
Workforce

- The current
- The future
- The community
- Generalist vs. specialist
- Rethink the who and where
- Behavioral health in all contacts
In closing

Legacy systems and often antiquated payment policies limit primary care practices ability to provide integrated behavioral health

There should be “no wrong door” for patients in our community when it comes to receiving behavioral health care

All health policies should be measured against the question, “Will this limit my patients’ choice in receiving behavioral health where they want?”
Resources

One stop: http://integrationacademy.ahrq.gov/


Policy: http://farleyhealthpolicycenter.org

Case study: http://www.advancingcaretogether.org/

Webinars: http://www.youtube.com/CUDFMPolicyChannel

State example: http://coloradosim.org/

National organization: http://www.cfha.net/

More: http://www.pcpcc.org/behavioral-health

Email: Benjamin.miller@ucdenver.edu
Integrated Care in a Digital World

N.A. Dewan, M.D.
Medical Director for Behavioral Health,
BayCare Medical Group, BayCare Health System
Nick.Dewan@baycare.org
BayCare Applications
BayCare utilizes over 500 different applications for its customers.

Source: Greg Hindahl, CMIO BayCare
BayCare Technology Strategy

- **Digitization** (’12)
- **Integration** (’12-’16)
- **Collection** (’13-’15)
- **Analytics & Predictive Modeling** (’14-’16)
- **Act** (’14-)

**Pharmacy**
- BEACON
- EDW
- Scorecards
- Predictive Outcomes

**Financial**
- HIE
- DG
- Analytics
- Population Management

**Labs**
- Soarian
- Usage
- KPI
- Financial Sustainability

**Clinical**
- Scorecards
- DG
- KPI
- Dashboard

Source: Greg Hindahl, CMIO BayCare
INSTEAD OF RISKING ANYTHING NEW, LET’S PLAY IT SAFE BY CONTINUING OUR SLOW DECLINE INTO OBSOLESCENCE.
Figure 2: Health care spending as a percent of GDP: United States, 1960-2007 and projected for 2008-2018

Source: Office of the Actuary, Centers for Medicare and Medicaid Services, 2008
ACO Overview Physician Compensation

CMS

Cost Trend Met

YES

NO

Quality Met

YES

NO

CMS Shared Savings Calculation

FFS Payments

Participating Physicians

Performance

ACO

Attributed Beneficiaries

Shared Savings

Non Physician Provider Participants

Source: John Gantner, BayCare
Our Changing Technology Landscape

Valuations and Investments
## Greylock Enterprise Enterprise Portfolio

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Source: Asheem Chandna
Greylock Consumer Portfolio

Social Platforms/Communication
- facebook
- LinkedIn
- tumblr
- Nextdoor
- MessageMe
- edmodo

Marketplaces/Commerce
- Airbnb
- One Kings Lane
- Redfin

Media Convergence
- Pandora
- WildTangent
- creativeLIVE

Monetization
- Coupons.com
- TellApart
- richrelevance

Search
- Jackmoble
- SmartThings
- cardspring

Internet of Things

Payments

Productivity
- Dropbox

Source: Asheem Chandna
Enterprise Investment Themes

**HOT**
- Cloud, Mobility
- Big Analytics
- Security
- Storage
- Software Center
- SDN
- Internet of Things
- Vertical SaaS
- Healthcare IT

**NOT**
- Semiconductor
- Cleantech
- Hardware-centric

**???
- Bitcoin
- 3D Printers
- Robotics
- Drones 😊

Source: Asheem Chandna
Healthcare Technology Trends – Big Data, Big Cloud, Big Social, Big Mobile

Investments
- 2013: $3.0B
- 2014: $6.8B
- 2015: $6.0B

Themes
- Wearables, Ingestibles
- Data Analytics
- Precision-Personalized Medicine

mHealth app count
- 2013: 44k iOS
- 2015: 90k iOS, 165k all platforms
- 29% are now mental health
  - Autism: 33%, Depression/Anxiety: 36%
- 1/3 of MDs recommend apps

Source: Startup Health, IMS Institute Sept 2015
Crowded landscape, many players creating resources and touching the patient, disconnected and confusing, and problems persist.

Source: Charles Peipher, Rajas Consulting
Our Concept of Integrated Care Technologies

- DS
- CIS
- Self

Outcomes
Future of Decision Support in a Measurement Based Care World

- PhQ-9
- Care Manager
- Physician/Nurse-Patient Decision Making

- Consumer Provided
- Personalized Decision Options
- Big Trials/Literature Coupling
- Warehouse Analytics
- Therapeutics
Future of Self-Management On-Demand - CCBT Support = Finally!!

Learn
Scores, Skills, Rich Media/ Video
Dynamically Responsive/ Guided

Change
Motivational Logic
Social Movement
CBT: computers and humans clinically equivalent

Computerized CBT v. face-to-face CBT v. wait list control

Beck Depression Inventory

Week

Computerized cognitive therapy v. face-to-face CBT v. wait list control

Beck Depression Inventory

Week

ES: 1.3
ES: 1.4

ES: 1.1*
ES: 1.0*

Computer
Clinician
Wait list

Selmi PM, et al.: AJP, 1990;147:51-56


*Mean effect size for BDI and Ham-D
Computerized CBT effect size compares favorably

Meta analyses for mood and anxiety disorders

- **Computer CBT for mood & anxiety disorders**¹
  - N=23 studies
  - Disorders: MDD, GAD
  - Panic, social phobia

- **Clinician CBT for mood & anxiety disorders**¹
  - N=5 studies
  - Disorders: MDD, Panic

- **Antidepressant medications**²
  - N=35 studies
  - Drugs: fluoxetine, paroxetine, nefazadone, venlafaxine

- **Antihypertensive medications**³
  - N=94 studies
  - Drugs: Any antihypertensive
  - Effects on bp: 0.56 systolic; 0.54 diastolic

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3. Leucht et. al., *BJP* 2012: 97-106
Historically, coaching increases cCBT effectiveness

Meta analysis of 11 studies of computerized CBT programs for depression and anxiety (n = 2,157)

Support only in working through standardized course material; no “therapeutic alliance”

Therapist support increased effect size four-fold

Spek et al. Psychological Medicine 2007:37:319-328
But is coaching still necessary?

“BT Steps” for OCD (2015)

Symptom improvement

- No coaching: 29%
- With lay coach: 31%
- With therapist coach: 28%

No significant difference

Future Workforce Optimization
Usual Productivity vs Tech Driven Care

Usual Care Therapists
1500 hrs serving 250 individuals x (6) 60 minute visits = 1500 visits

Tech Driven Therapists
1500 hrs serving 750 individuals x 1 60 min visits and (2) .5 hr visits = 2250 visits + unlimited computer visits

Usual Care ARNP or MD
1500 hrs serving 1000 individuals x (1) 45 min visit and (3) 15 min visits = 4000 visits

Tech Driven ARNP or MD
1500 hrs serving 1500 individuals x (1) 30 min visit and (3) 10 min visits = 6000
Technology Based Asynchronous Care Needs Organizational, Policy, and Reimbursement Innovations
Q & A
Panel III: Innovations in Education and Training

Moderator: Ben Druss, M.D.
Rosalynn Carter Chair in Mental Health, Rollins School of Public Health, Emory University
MEDICAL EDUCATION AND TRAINING: WHERE WE’VE BEEN AND WHERE WE NEED TO GO

Benjamin Druss MD, MPH
Carter Center Symposium
November 13, 2015
The Old Model of Care Delivery

- Physicians largely in solo practice
- Treatment about providing the best care possible for individual patients
- Skills needed: clinical knowledge, good listening skills
The New Model of Care Delivery

- Physicians increasingly working as part of large organizations
- Skills needed: understand principles of population-based care, work as part of teams; leadership
The Old Model of Learning

- Knowledge relatively static
- Goal is to memorize body of medical knowledge during medical school and residency
The New Model of Learning

- Knowledge base constantly changing
- Learning occurs throughout career
The Old Model of Training

- Problem: not enough information
- Training model: memorization and apprenticeship
The New Model of Training

- Problem: too much information
- Training model: learn to isolate signal from noise
Can't understand workforce without considering how they are trained

Training needs to embody skills in interpreting data and continues across a lifetime