Connecticut's Behavioral Health Homes: Outcomes, Lessons Learned & What's Next

Presentation to the Adult Quality, Access & Policy Subcommittee

June 12, 2018

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Project Partners

- State Partner Agencies
  - Department of Mental Health and Addiction Services
  - Department of Social Services
  - Department of Children and Families
- 14 BHH Providers
- ASO Partners
  - Advanced Behavioral Health
  - Beacon Health Options

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Origin & Background

- Section 2703 of the Patient Protection and Affordable Care Act allows states to establish a “health home” option under Medicaid to serve enrollees with specified chronic condition(s)

BHH Eligibility

- SPMI Diagnosis:
  - Schizophrenia and Psychotic Disorders;
  - Mood Disorders;
  - Anxiety Disorders;
  - Obsessive Compulsive Disorder;
  - Post-Traumatic Stress Disorder; and
  - Borderline Personality Disorder.
- Medicaid Eligibility
- Medicaid claims > $10k/year

Decision to Create BHH

- Individuals with SMI are:
  - Dying 25 years earlier than non-SMI individuals
  - Largely underserved by primary care
  - Experiencing barriers in accessing medical/specialty care
  - Using behavioral health as their primary source of care

BHH Model Development

2012: Oversight by the Adult Quality, Access and Policy sub-committee of the Behavioral Health Partnership Oversight Council in conjunction with DMHAS, DCF, and DSS. Tasks included:

- Establishing eligibility criteria
- Designating provider standards
- Outlining CT-specific outcome measures

BHH Services

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Patient and Family Support
- Comprehensive Transitional Care
- Referral to Community Support Services

Affordable Care Act: Triple Aim

The Goals of Health Homes align with the Triple Aim of the Affordable Care Act (ACA)

- Improved experience in care
- Improved health outcomes
- Reduced health care costs

BHH Vision and Values

BHH Vision

- *Health Homes change the standard of care in behavioral health.*

BHH Values

- Whole person, whole health approach
- Seeking partnership, collaboration and alignment
- Data-driven decision-making
- Blazing trails
- Maintaining transparency
- High-touch customer service
- Blending recovery and medical models
- Using technology

Major Milestones

- 8/2014 Providers Receive 1st List of Eligible Clients
- 11/2014 Missouri Facilitating Healthcare & Nursing Asmnt Training
- 7/2016 1st Provider Mgmt Report Delivered Through Secure Sites
- 9/28/2016 State Plan Amendment Approved, Retro to 10/15
- 10/2017 Beacon's ProviderConnect Enhanced to Collect Health Assessment Data
- 4/2018 Through Collaboration with CHN – Medical Data Begins to Flow to Providers
- 5/2018 Core, Utilization, and CT Specific Outcome Measures Submitted to CMS for CY 2016

BHH Enrollee Demographics

	2015		2016	
	BHH	BH POP	BHH	BH POP
Age Span	7-89	3-97	9-90	3-99
M/F	47%/53%	47%/53%	47%/53%	46.5%/53.5%
Race/Ethnicity				
African American	19%	17%	18%	16%
Hispanic	18%	29%	19%	26%
Caucasian	61%	49%	57%	39%
Other	2%	5%	6%	5%
Unknown	-	-	-	14%

Source: Beacon's 2015 and 2016 Population Health Reports

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BHH Enrollee Diagnostic Data

	2015	2016	+/-
Co-occurring MH/SUD:	64% (3,165)	64% (5,136)	
Co-morbid BH/Medical:	82% (4,078)	79% (6,335)	↓ 3%
Highest Prevalence- Medical Diagnoses			
Hypertension	45.9% (2,283)	45.1% (3,608)	↓ 0.8%
Hyperlipidemia	38.5% (1,913)	36.7% (2,932)	↓ 1.8%
Diabetes	35.3% (1,755)	28.7% (2,293)	↓ 6.6%
Highest Prevalence- Substance Use Disorders			
Nicotine	39.7% (1,973)	38.9% (3,114)	↓ 0.8%
Alcohol Use	30.4% (1,512)	31.8% (2,544)	↑ 1.4%
Cannabis	18.4% (917)	22.3% (1,780)	↑ 3.9%
Opioid	14.8% (736)	17.3% (1,383)	↑ 2.5%

Source: Beacon's 2015 and 2016 Population Health Reports

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Enrollment/Service Data

Enrollment:

- 10/1/2015: **3917**
- 12/31/2016: **7185**
- 12/31/2017: **7072**

Services Billed:

- Through 9/30/2017 (1st 8 quarters): **103,529**
- Through 3/31/2018: **132,746**

Children Served:

- 2016: **23**
- 2017 **55**

Source: DMHAS Billing Data

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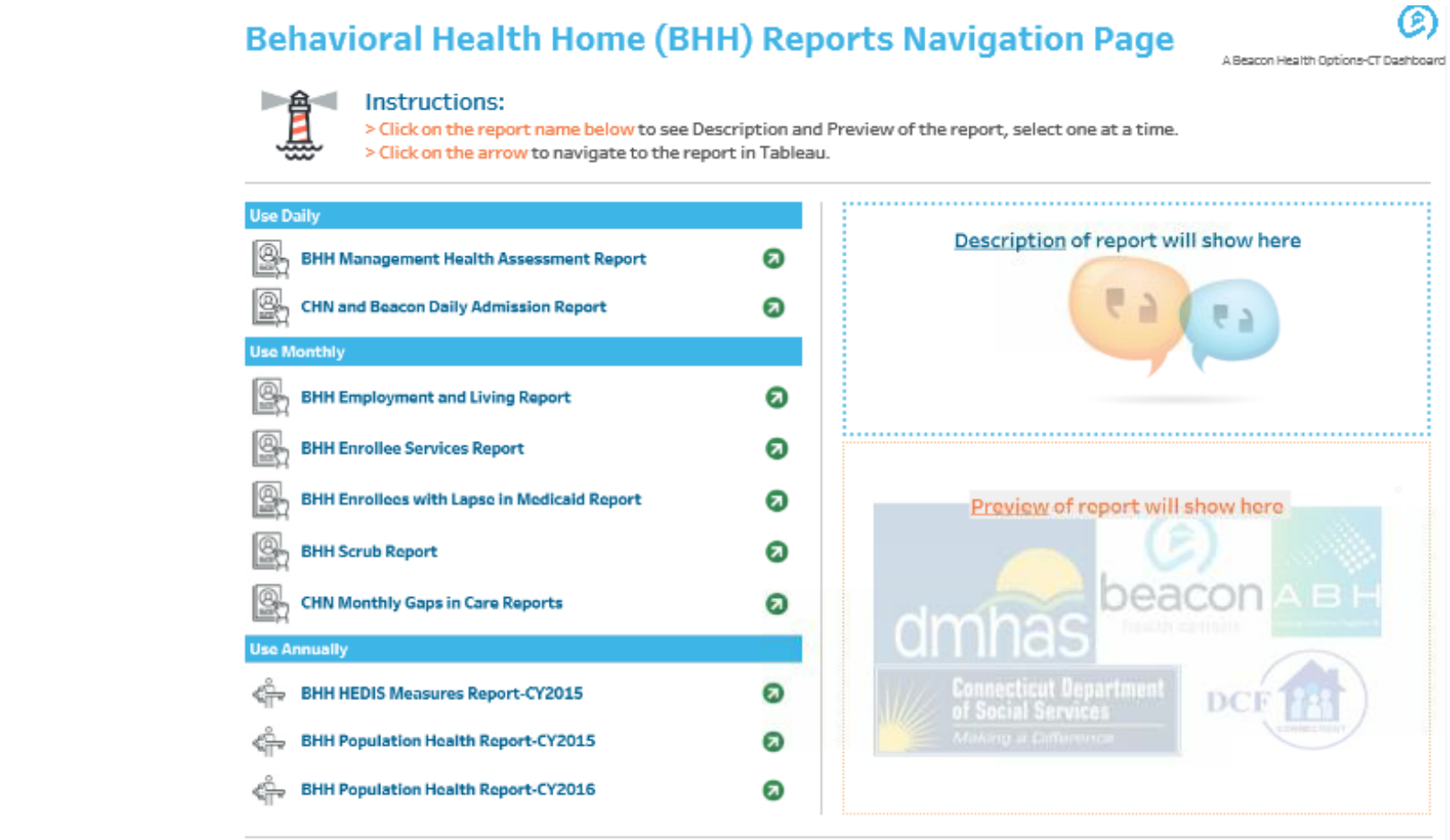
Culture Change

- People
  - New staff and/or new roles
  - Intra and inter agency collaborative work
- Partnerships
  - Physicians, hospitals and other specialty providers in the community
- Procedures
  - Workflow changes
  - New or updated protocols
- Data and Systems
  - Spectrum, ProviderConnect, Tableau
  - Health Assessments
  - Medical Data

Data Management

- Management Reports
- Medical Data
- Outcome Reports

Tableau Dashboards



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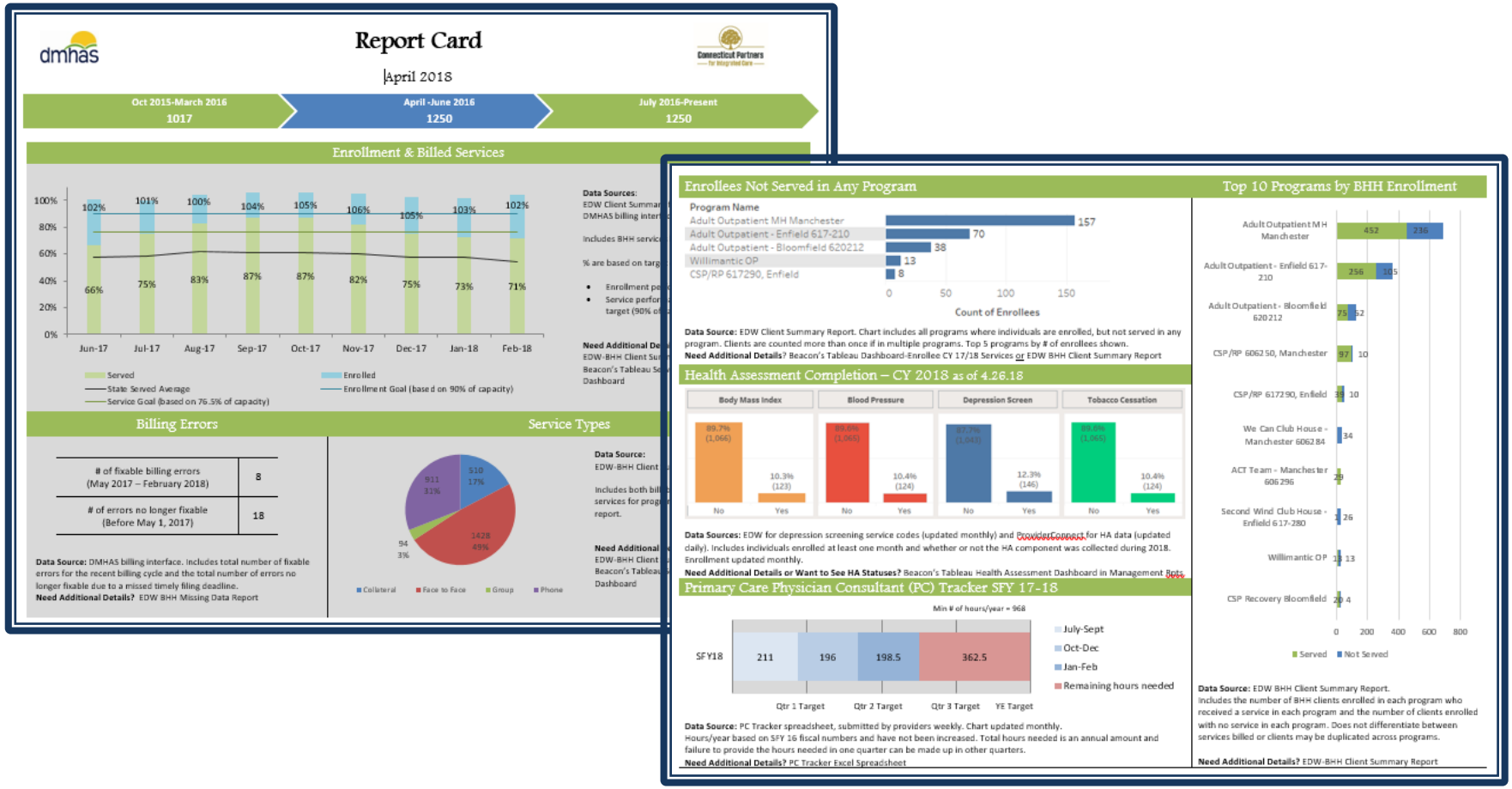
Report Cards



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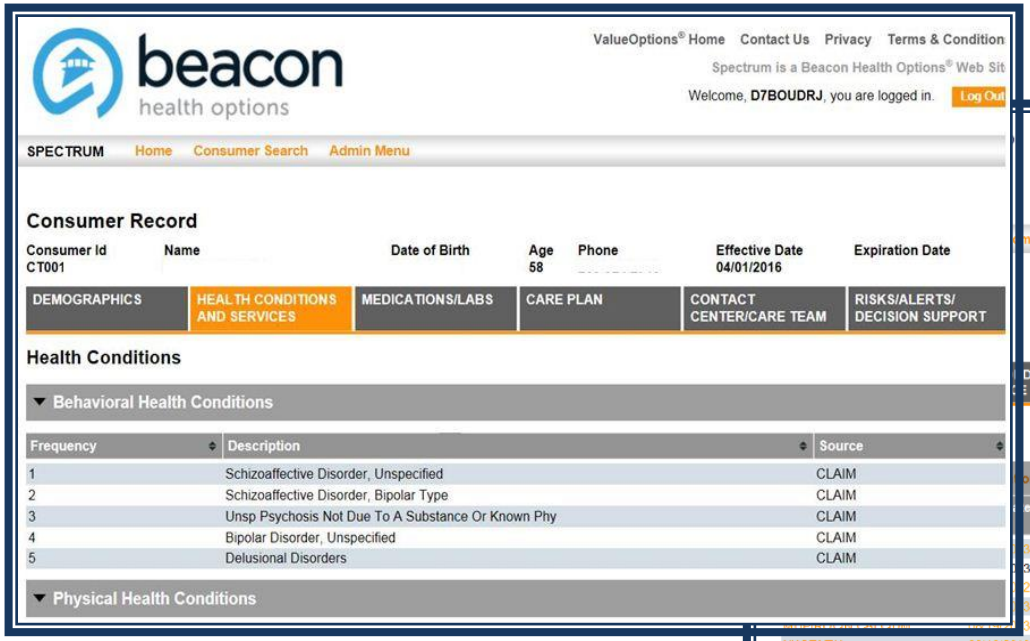
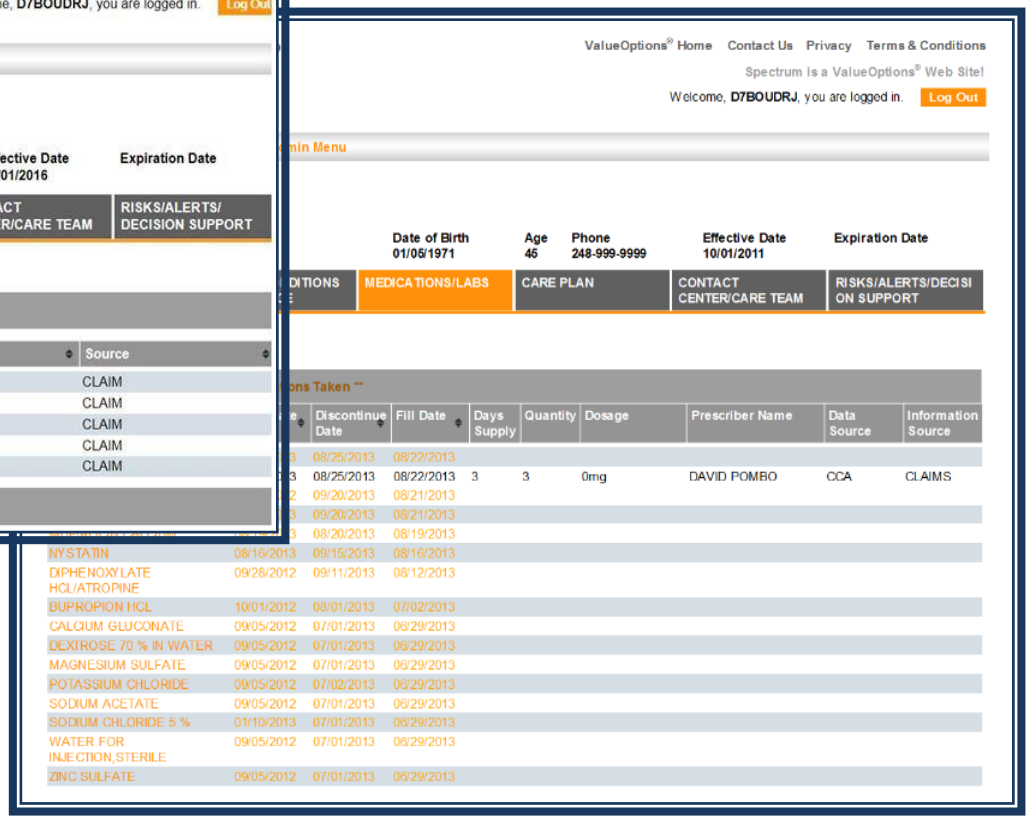
Spectrum





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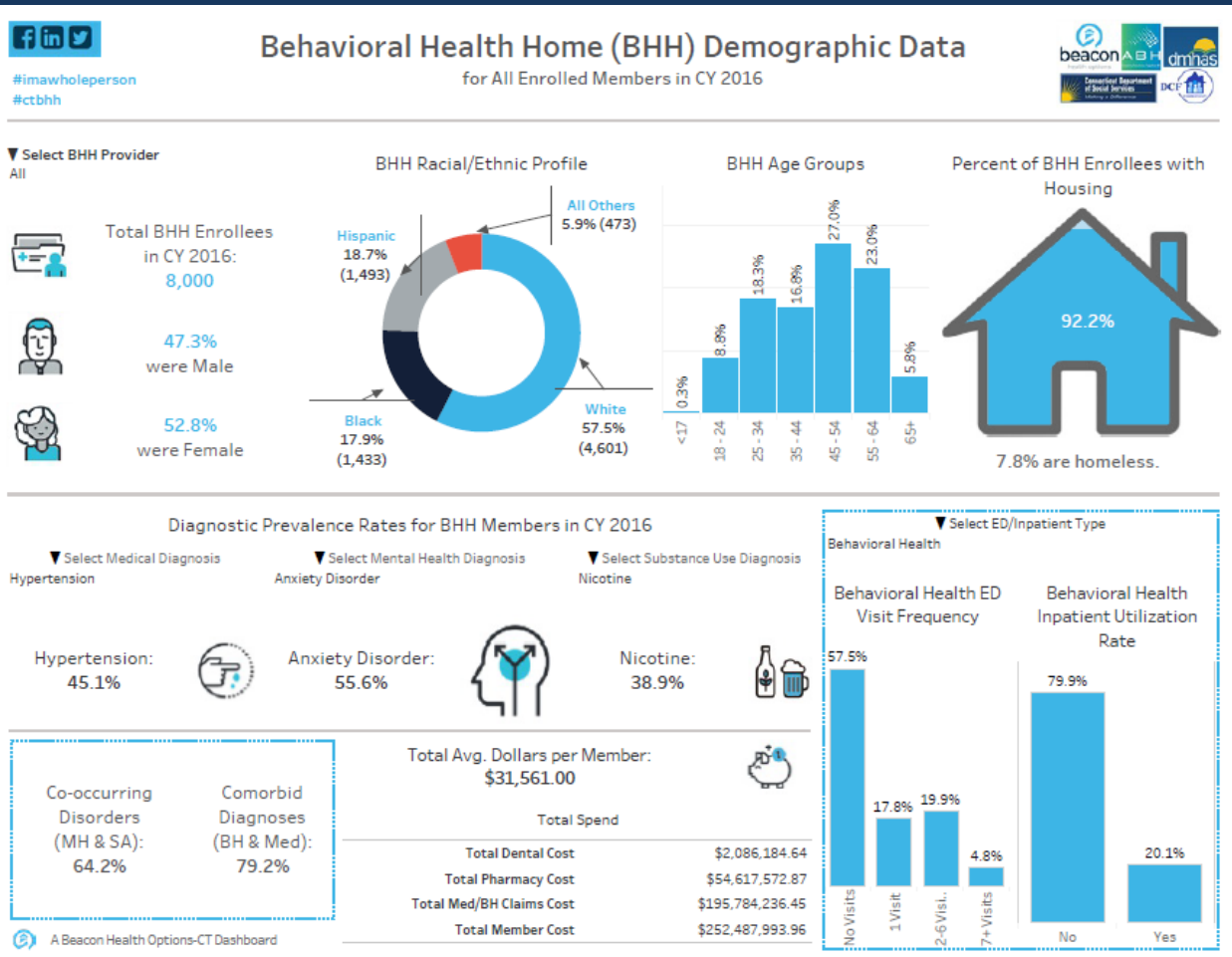
Population Health Profiles



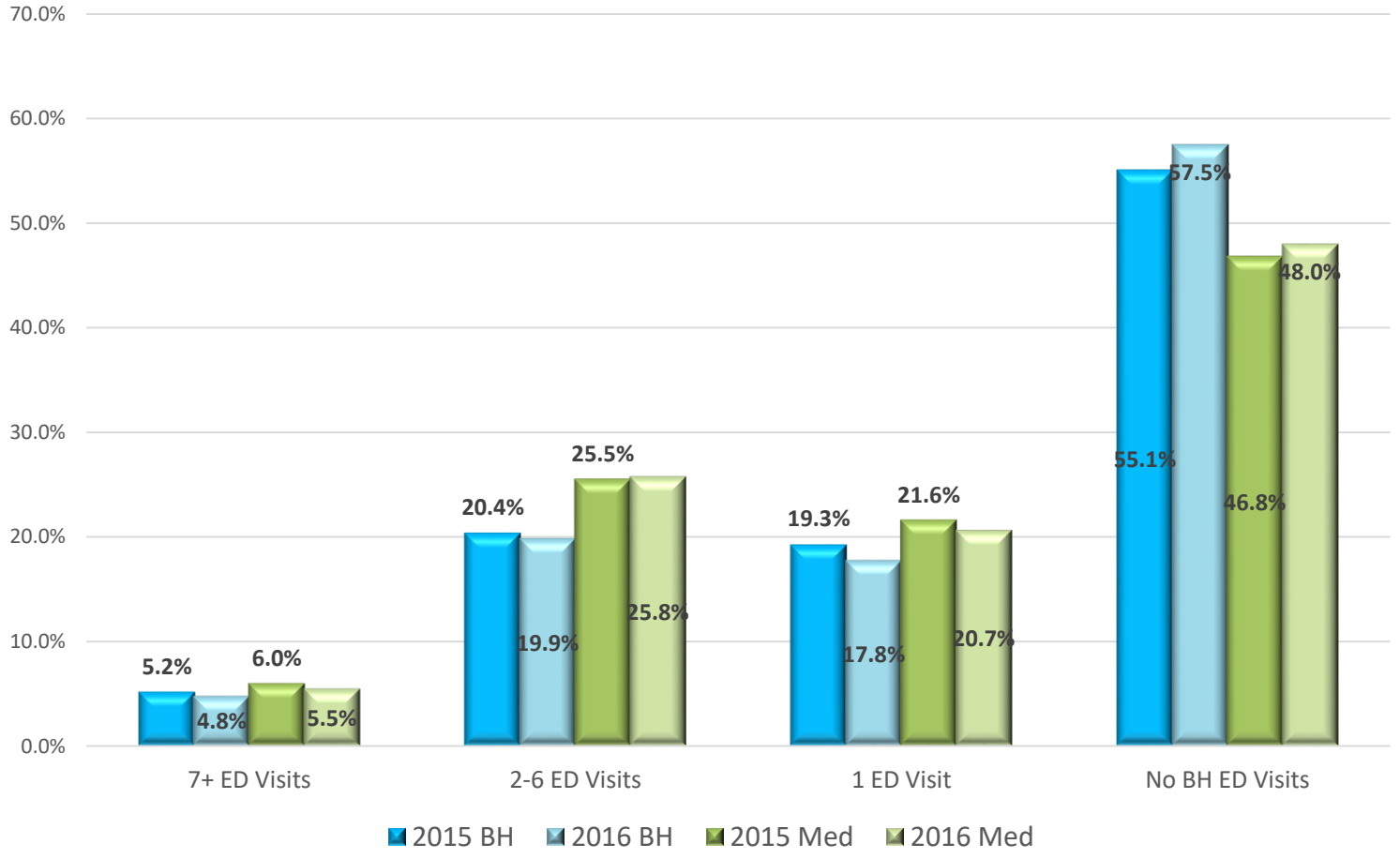
Outcome Reporting

- Data Limitations and Report Specifications
  - Impact numerators, denominators, and rates in some cases

- CMS/PQRS/HEDIS Measures:
  - The measures require continuous enrollment, for both BHH and Medicaid, to be included in the denominator,
  - Duals (enrollees eligible for Medicaid and Medicare) are not included,
  - Clients are assigned to providers based on where they are enrolled and not where they received the service(s) being measured,
  - Only claims data is used so DMHAS funded services are not captured, and
  - Some measures were modified due to the lack of access to medical records or other data sets needed to program these according to CMS specifications.

- CT Specific Measures:
  - Data sources are included on each slide

1. Emergency Department Visits



Source: 2015 and 2016 Population Health Reports

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1. Average ED Visits PM/PY

Source: CY2016 CMS Inpatient Utilization Report

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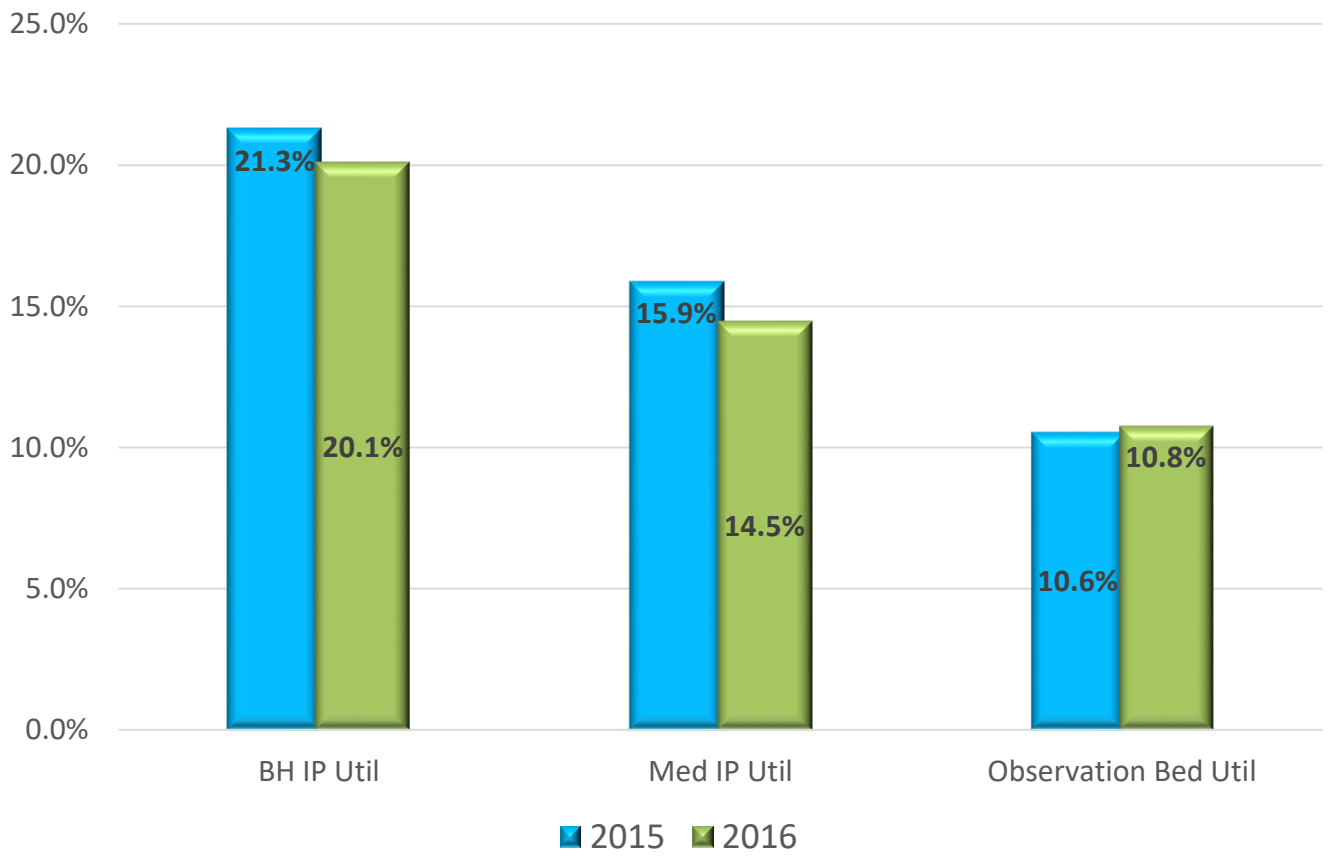
1. Inpatient Utilization Rates



Source: 2015 and 2016 Population Health Reports

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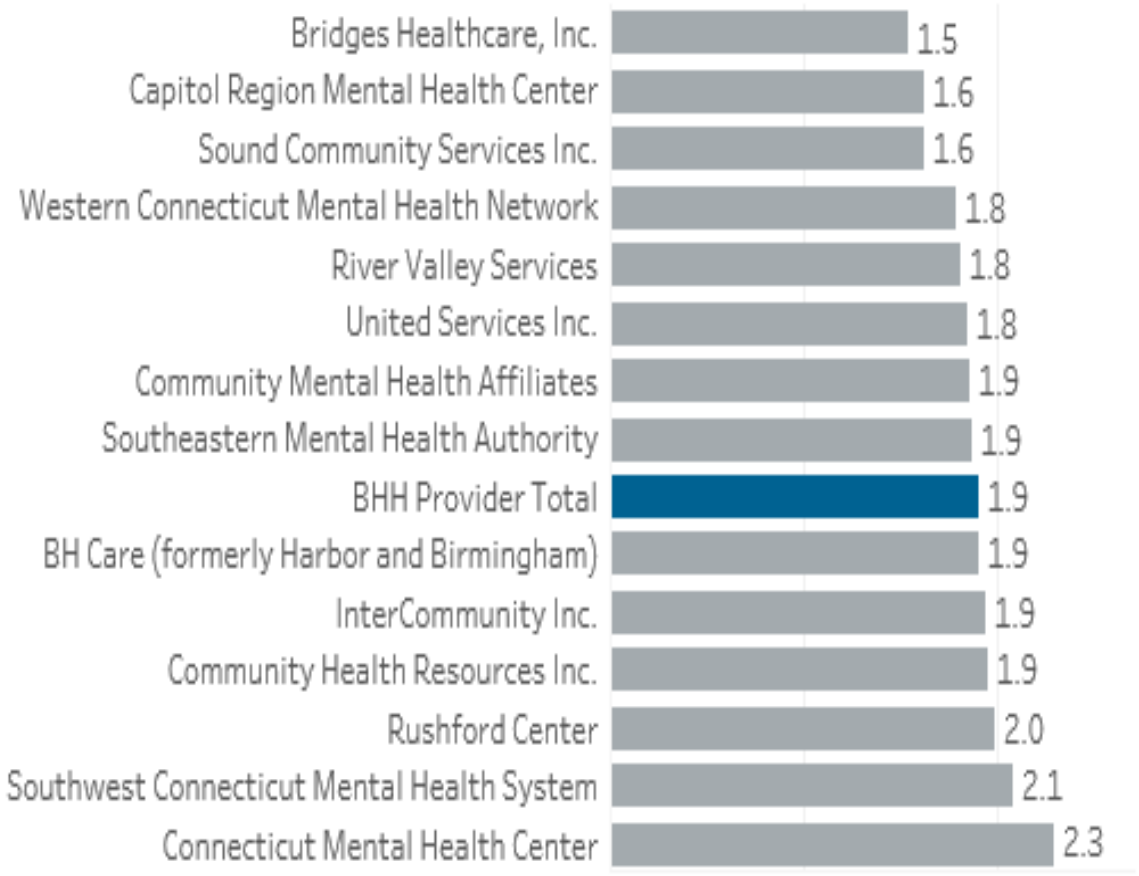
1. Average IP Visits PM/PY



Source: CY2016 CMS Inpatient Utilization Report

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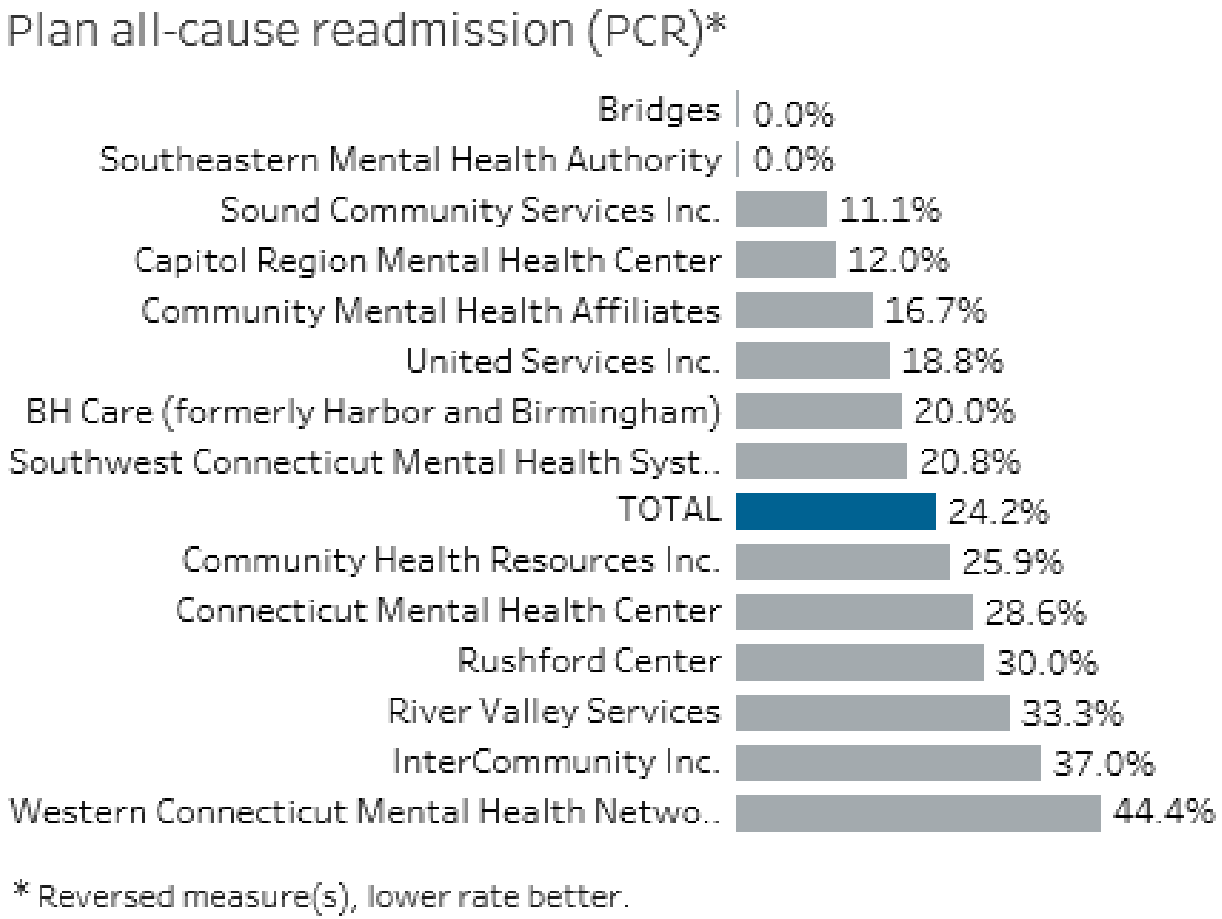
1. Plan All Cause Readmission (PCR)*



Source: CY2016 CMS PCR Report

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2. Tobacco Cessation (TC)

Tobacco Assessment	2016	2017	2018 through May
Not a Smoker	**1,685**	**1,990**	**1,177**
Tobacco Cessation Offered	1,061	1,543	995
Tobacco Cessation Not Offered	199	435	53
% offered TC	**84%**	**78%**	**95%**
No Assessment Data Entered	5,148	4,449	4,716

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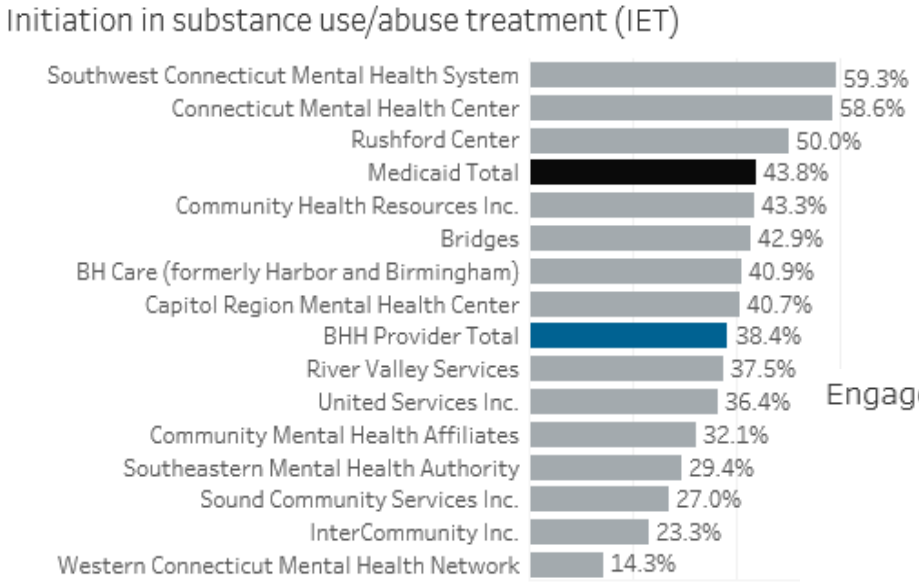
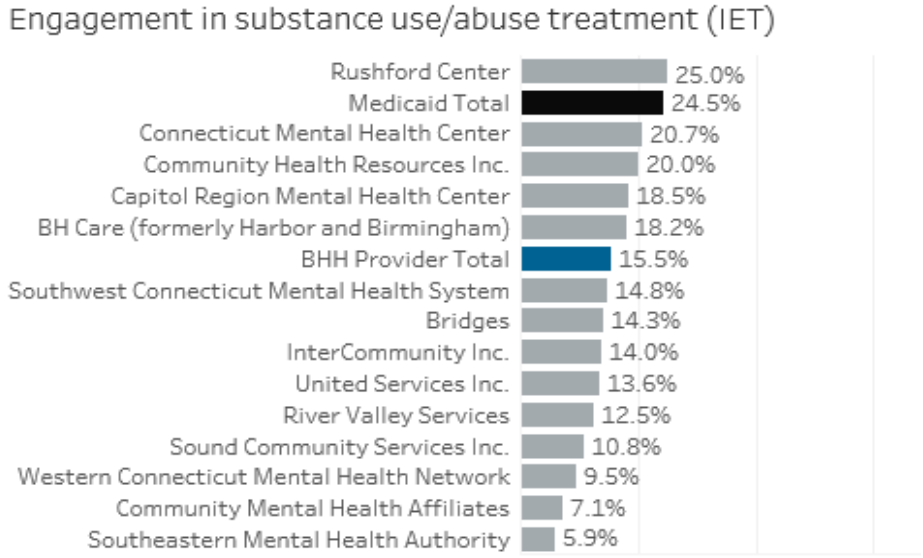
2. Initiation and Engagement in Treatment (IET)*





*Treatment is not always with listed providers. DMHAS funded services not included.

Source: CY2016 CMS IET Report

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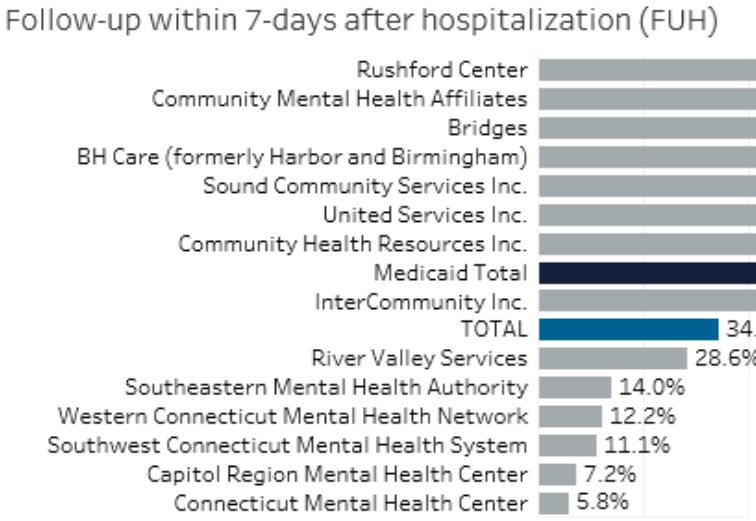
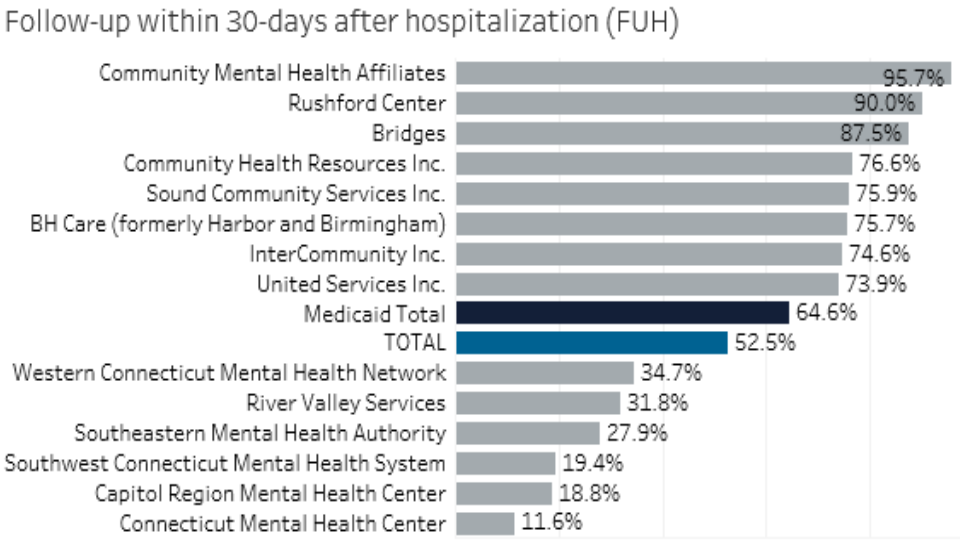
3. Follow-up After Hospitalization (FUH) 7 and 30 days





Source: CY2016 CMS FUH Report

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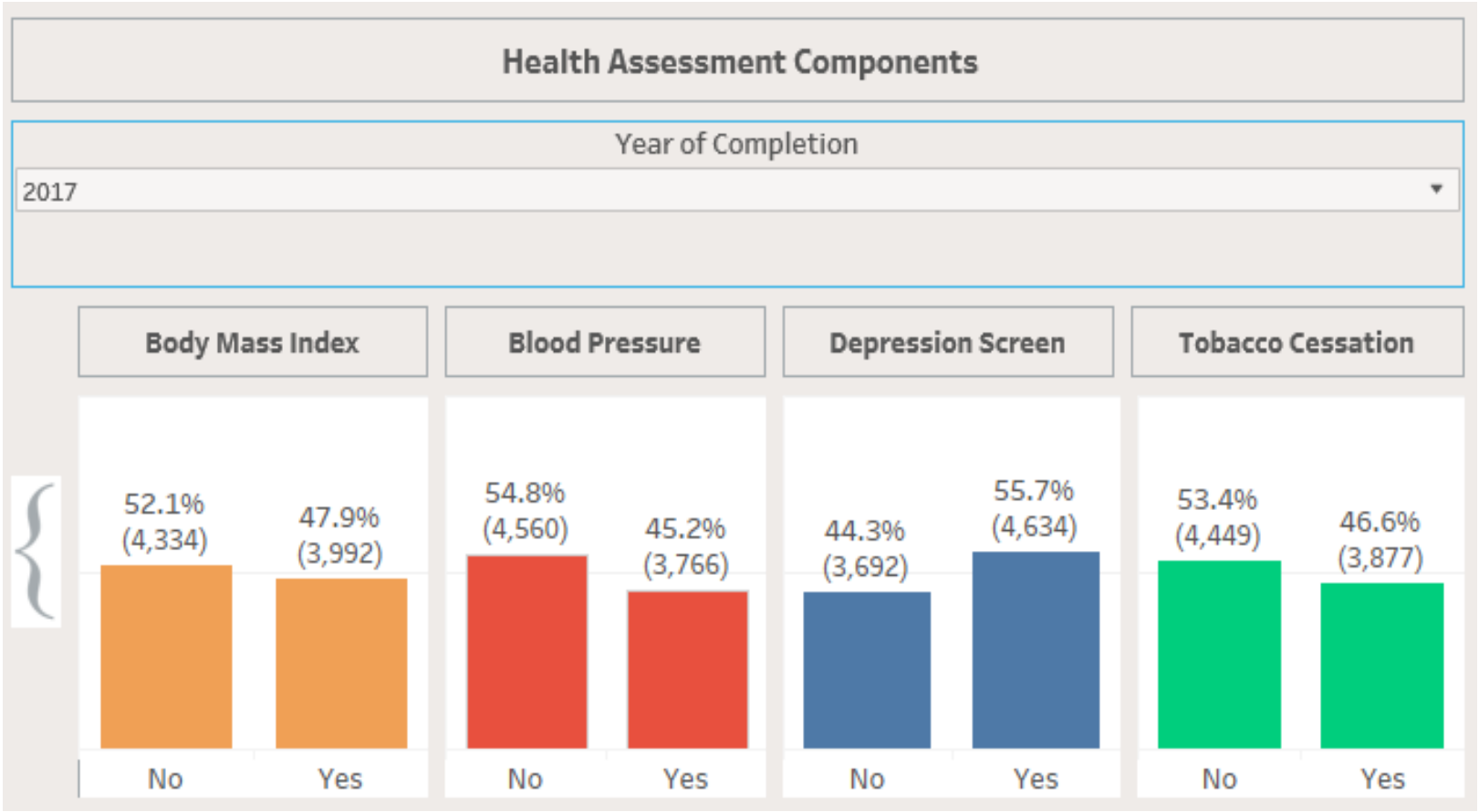
4. Health Assessment Tracking



4. Health Assessment Statuses

Blood Pressure Range	2015	2016	2017
SBP (<120) AND DBP (<80)	33.5%	33.4%	30.9%
SBP (120-129) AND DBP (< 80)	12.8%	13.0%	13.7%
SBP (130-139) OR DBP (80-89)	40.7%	41.3%	42.8%
SBP (>=140) OR DBP (>=90)	13.0%	12.2%	12.5%
SBP (>180) AND/OR DBP (>120)	0.1%	0.1%	0.1%

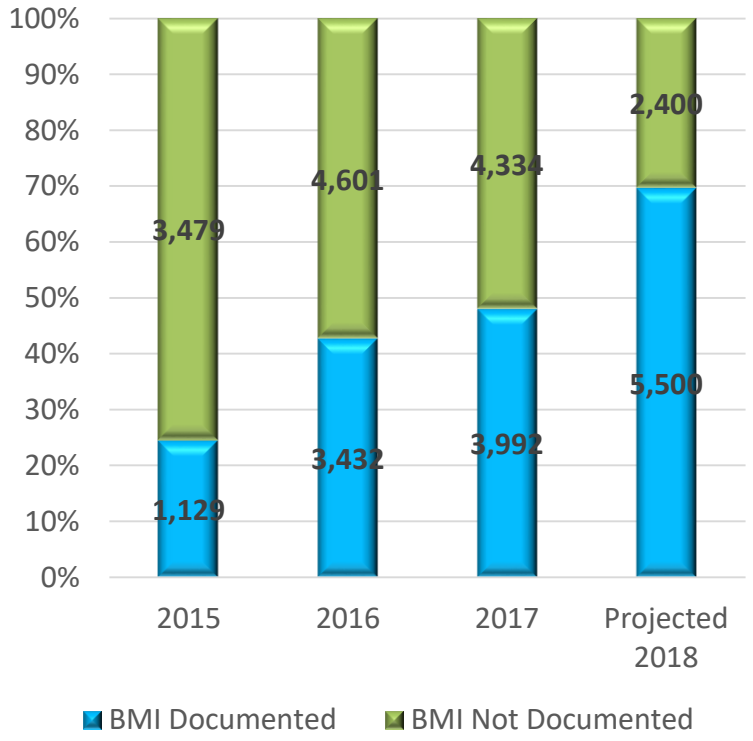
BMI Adult Status	2015	2016	2017
Underweight	0.8%	1.3%	1.7%
Normal	15.0%	17.9%	18.2%
Overweight	22.8%	24.6%	25.1%
Obese	43.6%	39.5%	38.8%
Morbidly Obese	17.8%	16.7%	16.2%

Tobacco Assessment	2015	2016	2017
Cessation Intervention Not Offered	5.5%	6.8%	11.0%
Cessation Intervention Offered	43.2%	36.0%	38.9%
Not a Smoker or Tobacco Users	51.4%	57.2%	50.2%

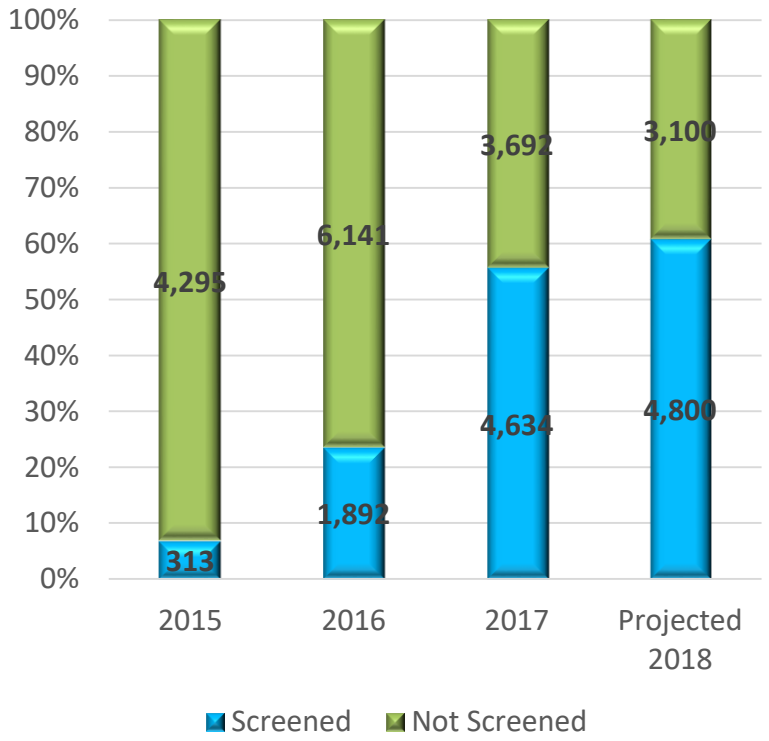
Depression Assessment	2015	2016	2017
(-) Screen	54.5%	54.3%	54.2%
(+) Screen	45.7%	44.4%	37.4%
EX_DP_INCR			0.0%
EX: Current Functional Capicity May E..			0.1%
EX: Existing DX of Depression or Bipol..		1.4%	8.0%
EX:Enrollee Refused		0.1%	0.4%

4. Health Assessment Data

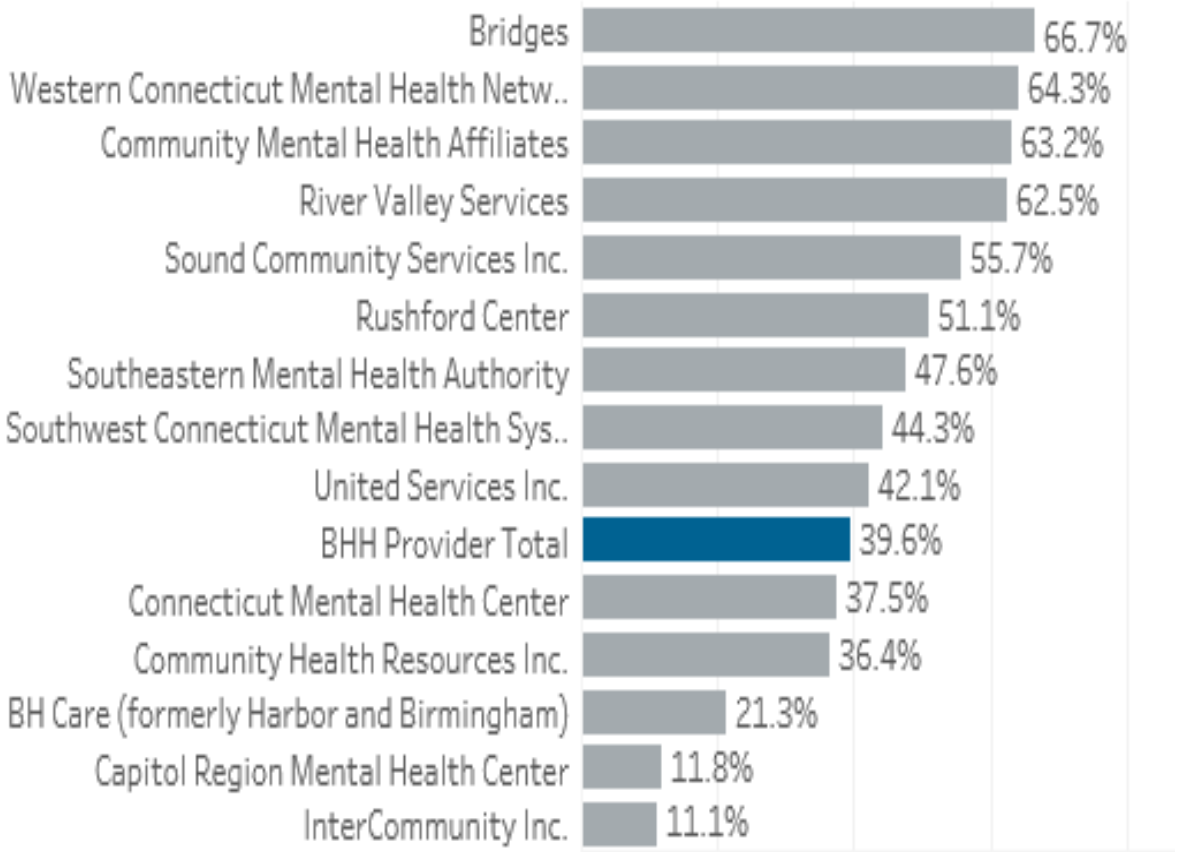
Body Mass Index (BMI)



Depression Screening



5. Controlling Blood Pressure (CBP)



Notes:

There were many deviations to this measure due to not having access to medical records.

If you remove members who didn't have BP collected by provider in 2016, the overall rate increases to 74%.

Source: CY2016 CMS CBP Report with CT Deviations

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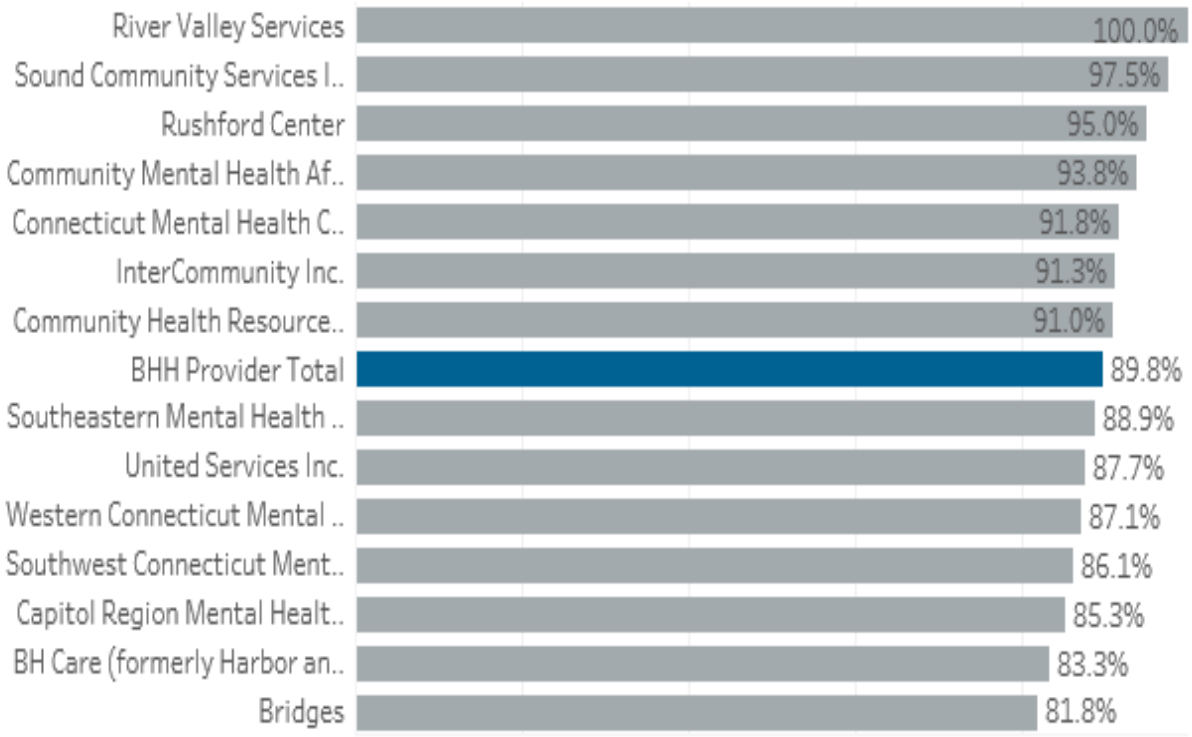
5. Diabetes Care-HbA1c



State Medicaid Rates:

- Husky A/B: 83.58%
- Husky C: 88.56%
- Husky D: 86.31%

Source: CY2016 CMS CDC-A1C Report

Source: Community Health Network of CT

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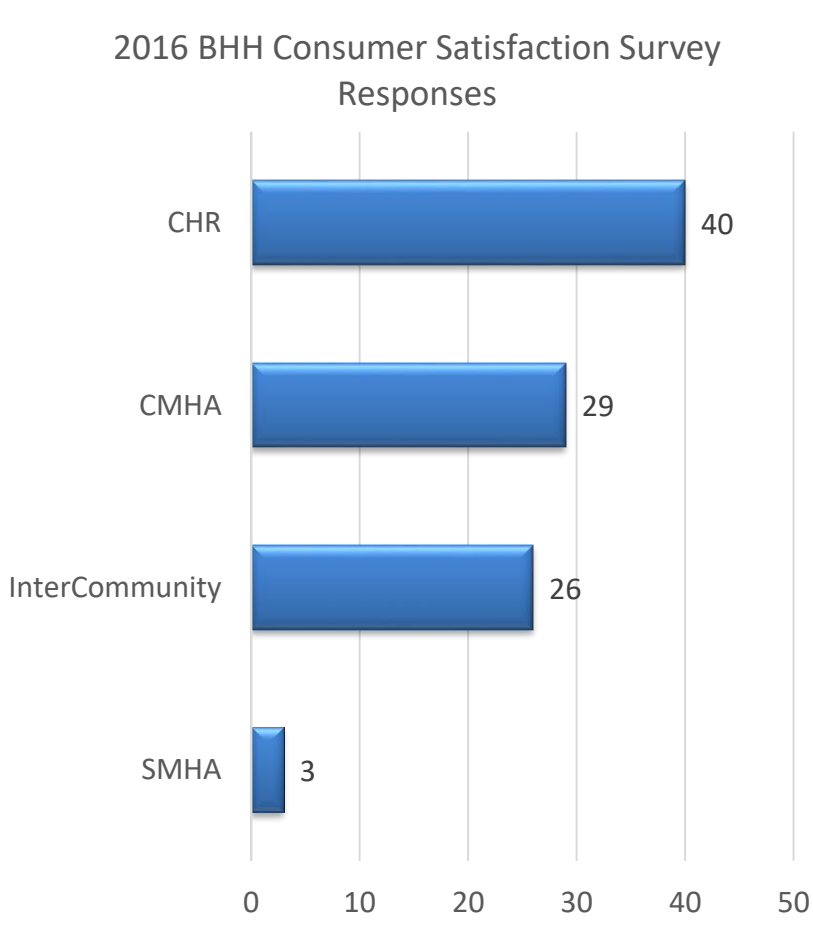
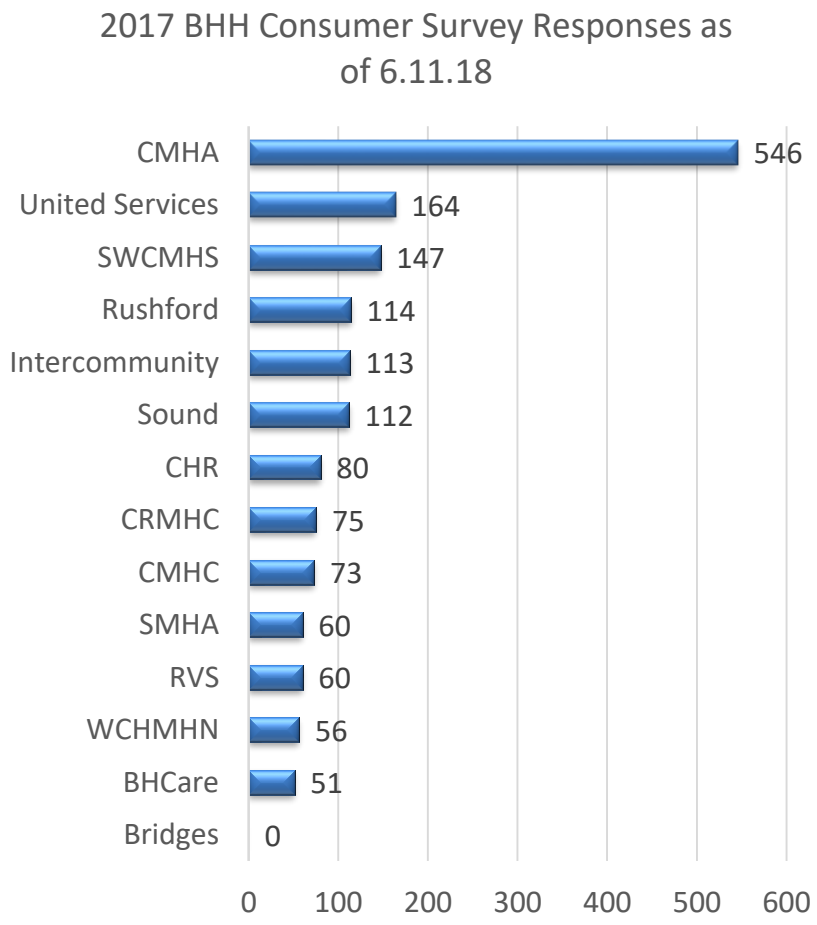
5. CHN Gaps in Care Reports

- Adult Diabetes Screening Tests
- Child Diabetes Screening Tests
- Adult Preventative Visits Age 21-49
- Adult Preventative Visits Age 50-64
- Asthma Controller Medications
- BEH and Developmental Screenings
- Breast Cancer Screenings
- Cervical Cancer Screenings
- Colorectal Cancer Screenings

6. Consumer Satisfaction





7. Stable Living and Employment/School

Measure	2016	2017
Stable Living	93.6%	93.6%
Employed or in School	11.5%	13%

BHH Cost Savings

Costs	12 months pre-BHH	12 months post-BHH	Difference
PMPM Costs	$33,811	$33,628	($183)
Annualized Costs	$405,732	$403,536	($2,196)
Total savings for 4,925 enrollees in the cost analysis			**$10,815,300**

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What We've Heard…

From Enrollees:

- "Before I went to [diabetes] group, I didn't know that I felt bad every day because I wasn't eating enough food at the right times, and wasn't taking my insulin at the same time every day. I feel much better now that I've been doing the things at the same time each day."

- "Takes a little off of me. A lot of appointments hard to keep track. Help schedule outside appointments. Making sure I am eating good healthier foods. I have learned more about my medications."

- Staff provides several opportunities for clients to better understand their medications.

What We've Heard…

From Providers:

- PC Consultant developed blood pressure protocols & staff trainings
- Host pop-up blood pressure clinics
- Transitional care staff imbedded in the hospital
- Nurses huddle with case management teams
- Offer Health and wellness groups
- Lives literally saved by BHH
- Having nurses available has been extremely helpful-would be devastated without them
- Nurses have facilitated speaking with doctors, explaining tests, medications, and health information to clients; and help with getting appointments for clients
- Doctors are taking clients seriously because BHH staff have intervened

Challenges Experienced

- Communication and coordination - lack of integrated health information exchange
- Documentation and reporting – No EHR for some BHHs, and managing new data and reports difficult for some
- Data Integration – data comes from multiples sources, creating challenges for entry, integration and utilization
- Staff - high reliance on in-kind, staff changes have large ripple effect on training, expectations, and support for BHH
- Culture shift – made great strides, but integration continues to be a challenge in some areas

What's Next

- Increasing Report Utilization
- Data Informed Care to Improve Outcomes
- Showcasing Promising Practices
- CY2017 CMS Outcome Measures and Population Health File
- Member Level Dashboard

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