Central East (HHS Region 3)
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Addressing Behavioral HEALTH Inequities Part 1

Business advice from the edge of the emerging future of health care

The coronavirus pandemic continues to expose inequities in America. While every community is experiencing harm, certain groups are suffering disproportionately: people of color, workers with low incomes, and people living in places that were already struggling financially before the economic downturn.

Introduction

The conditions, in which people live, learn, work and play contribute to their health and wellness. These conditions known as social determinants of health can lead to different levels of needs, risks and health outcomes for racial and ethnic minority groups.[1] In fact, medical care drives 20% of population health outcomes, while 80% are attributable to social determinants. [2] According to a recent Kaiser Family Foundation Report, 86% of adults say their physical heath is about the same as before the pandemic. However, it has taken a toll on people's mental health (e.g., stress, unemployment, social isolation, and other social inequities.) [3]

A person's overall health is dependent on good mental health as well. Health and mental health are associated with social determinants. It is of major importance to take action to improve the quality of places where we live, learn, work and play. Reducing social inequities will provide opportunities for improving population mental health.

This two-part series will provide information on how the behavioral health system can employ the tools of population health management for planning and redesigning. Part 1 will describe and provide strategies on how to implement population management and Part 2 will discuss value-based reimbursement.

Issue 1: Population Health Management

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[1] https://www.who.int/social_determinants/sdh_definition/en/
[2] https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/
[3] https://www.kff.org/report-section/kff-health-tracking-poll-may-2020-health-and-economic-impacts/?utm_campaign=KFF-2020-polling-surveys&utm_medium=email&_hsmi=2&_hsenc=p2ANqtz-_46YhF4lO275JYRjHo3fXal_3Ef7uLgPftDVra-29wl_3qCARrB3tkAJhUvE87mzOgi6y9IYV5y3fzcovPTOEFtRZwDA&utm_content=2&utm_source=hs_email

Health care in America is changing rapidly. The drive toward integrated care, evidence-based practices, and self-management of long-term conditions—coupled with performance-based incentives—puts increasing pressure on the health and behavioral health care systems to provide interdisciplinary care, build recovery competencies, and adopt new reimbursement models.

Population health management (PHM) increasingly is touted to accomplish these goals. As a behavioral health provider, you may wonder, "What is population health, what does it have to do with my work, and how do I 'do' it?"

PHM helps you participate on a level playing field as health care becomes increasingly integrated across physical health, behavioral health, and social services. Population health approaches are critically important in providing coordinated and comprehensive care to people with serious mental illness (SMI), substance use disorders, and complex co-occurring physical and behavioral health conditions.

Ultimately, managing population health helps providers achieve the "quadruple aim" of modern health care—better health, better care, lower costs, and improved provider experience.

Read on to learn how you can integrate PHM into the work you do every day.

Alignment with SAMHSA Strategic Goals:

PHM is closely aligned with achieving SAMHSA's goal to reduce the impact of SMI and serious emotional disturbance and improve treatment and recovery support services … by facilitating access to quality care through services expansion, outreach, and engagement.

Substance Abuse and Mental Health Services Administration Strategic Plan FY2019-2023

The Fundamentals of Population Health Management

Population health is simple and profound. In a narrow sense, it refers to the health of a defined population, such as those served in a health system[4] or in a community. More broadly, population health focuses on the health of entire populations. It encompasses not only health outcomes, but also the health determinants influencing these outcomes and the interventions affecting the determinants.[5]

Population health recognizes that factors outside of physical conditions exert a powerful influence on people's health. These factors include

- The social, economic, and physical environments in which we live, work, learn, and play;
- Our personal health practices and coping skills; and
- Our early childhood experiences.

The goal of population health is to keep individuals as healthy as possible—thereby minimizing expensive interventions—by modifying the risk factors that make them sick or worsen their conditions.

Institute for Health Technology Transformation, 2012

[4] Kassler, W. J., Tomoyasu, N., & Conway, P. H. (2015). Beyond a traditional payer—CMS's role in improving population health. *The New England Journal of Medicine*, *372*(2), 109–111.

[5] Kindig, D., & Stoddart, G. (2003). What is population health? *American Journal of Public Health*, *93*(3), 380–383.

What is population health management?

PHM moves care from treating people when they become sick to helping them stay well. In turn, managing the health of populations with multiple, comorbid conditions reduces waste and inefficiencies and cuts costs.

A small, but vulnerable, proportion of Americans are so expensive to treat that they drive prices up for the remainder of the population. These increasing costs lead to stricter policies, more managed care, decreased rates of reimbursement, and tighter networks of providers. This, in turn, decreases access to preventative, routine, and recovery-support service—leading to exacerbated conditions, deteriorating overall health and comorbid conditions, and the need for higher acuity care. And this harmful cycle continues.

PHM focuses on these high-risk individuals while also addressing the preventive and chronic care needs of everyone.

Population health

- Acknowledges that low-cost, high-quality care is dependent on paying attention to vulnerable and complex populations and all of the factors that impact people's health;
- Reins in costs and improves outcomes by engaging patients in their own care earlier and more often; and
- Aims to reinforce highly integrated delivery systems and reimburse them based on the value they produce.

Why should PHM matter to me?

- People deserve good care.
- The most vulnerable and complex people in your community deserve the best treatment available, regardless of their ability to pay.
- Science and data show that evidence-based treatment delivered on a platform of deeply integrated care teams is best.
- People with multiple chronic and interrelated conditions require communication and collaboration between providers who invest in their ability to work together.
- Medicare, Medicaid, and commercial health plans are all driving toward value-based reimbursement and investing heavily in social service innovations for these targeted populations.

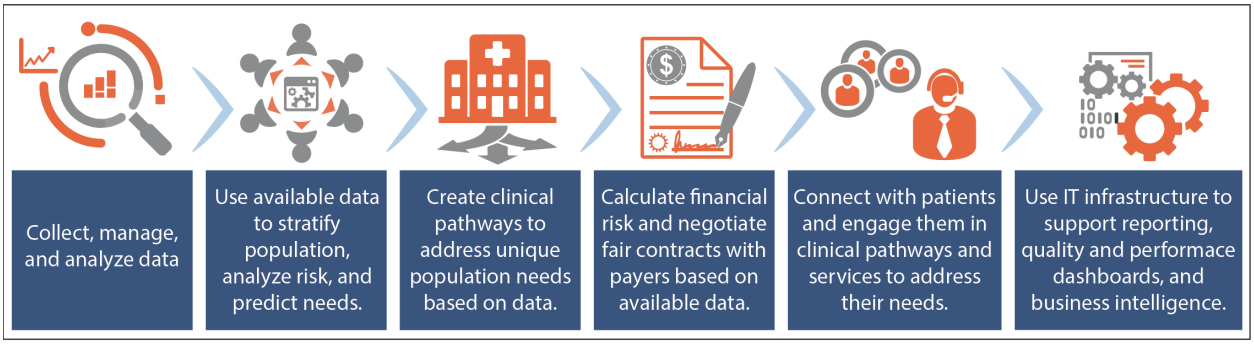
A transformation in physical and behavioral health care has begun. Hospitals and health systems, managed care companies, and communities are joining forces to design and develop entirely new systems of whole person care that include early screening of adverse childhood experiences (ACEs), building low-income housing options, transportation, nutritious food pantries, exercise and recreation, social inclusion and interaction, and more.

How to Succeed in the Era of Population Health Management

Behavioral health providers have a lot to offer and a lot to gain from getting on board with population health management (PHM).

The following is the PHM Framework and Process. This is a step-by-step set of concrete strategies for success in PHM. Many of these strategies can be accomplished with existing staff. Others may require adding new, expert staff or hiring consultants in areas unfamiliar to you and your organization.

Title: PHM Framework and Process



1. Commit to Data Management, Health Informatics, Predictive Modeling, and Health Information Exchange

PHM is only possible with robust and modern technology, as well as the staff with the expertise to make it all happen.

Successful data management allows you to:

- Integrate and aggregate population-specific data from different systems into a data repository;
- Stratify the population based on costs, diagnoses, utilization patterns, and other factors;
- Understand what all the data means both clinically and financially;
- Detect and correct data quality issues;
- Develop the tools to analyze and report the data meaningfully; and
- Apply well researched and reasoned benchmarks to model how the population behaves now in comparison to how it might behave with strategies like care coordination and new clinical pathways.

The same infrastructure supporting health informatics should also support health information exchanges (HIE), enabling behavioral health providers to communicate readily with their partners in a HIPAA-compliant way. PHM and HIE are inseparable.

Strategies:

1. Give executives and managers the opportunity to learn more about PHM and develop your organization's vision and goals for PHM.
2. Based on the vision and goals, dedicate the time to create an Information Technology (IT) strategic plan and budget.
3. Start now. Significant health IT changes require months to years to implement.
4. Visit the U.S. Office of the National Coordinator for Health Information Technology's (ONC's) HealthIT.gov website to learn more.

2. Build Your Understanding of Population Characteristics and Develop a Risk Profile

Fully understanding your population's characteristics contributing to physical and behavioral health morbidity, utilization, and costs allows you to better manage their associated risks and improve care quality, outcomes, and spending. This population analysis helps you identify clinical, social, and cultural risks unique to your community.

You will need to understand, anticipate, and prepare to address issues around the following:

- Whole person care for people with multiple chronic conditions;
- Challenges associated with collaborating and integrating with primary care, hospitals, and specialists in your unique community;
- Transportation issues;
- Age-related challenges like access to child or geriatric psychiatrists;
- Housing availability and stability;
- Language barriers;
- Access to nutritious foods in the community; and
- Challenges associated with individuals who have co-morbidities (e.g., attempting to treat a person with a substance use disorder, a physical condition or combination thereof)

Strategy:

1. See the strategies in the previous item to help you stratify and understand your population health data.
2. Create Clinical Pathways and Systems of Care Addressing SDOH with Community Partners

A data-driven understanding of your population's needs tells you about its demands on your system of care. Next, you need to compare these factors to the existing and dominant practices of providers in the system.

Here is how it works: A review of claims data will show the most common and likely clinical pathways in your system of care. With enough data, these pathways can illuminate new possibilities and opportunities for better care. Identifying, for example, that the population relies too heavily on the emergency department (ED), the system of care can develop new pathways to divert people to outpatient crisis centers.

PHM data give you and your health system the opportunity to look for efficiencies, a better patient experience, greater provider satisfaction (less burnout and turnover) and proof that evidence-based practices are being used the way they were intended. It also provides the opportunity to validate that care is well integrated and care coordination efforts are working.

Lastly, this is the opportunity to ask the system of care: "What are we missing?" This is where the data will help you determine how you might enhance and expand recovery support services to your networks of care. For instance, service extenders like childcare agencies or Veteran employment training providers can be woven into the mix of services for people who most likely need them.

Strategies:

1. Use publicly available data (e.g., census and demographic information, public health datasets) and your organizational data (e.g., claims data) to get a clearer picture of your population and their greatest risks and barriers.
2. Review your findings with hospital, health system, managed care, state, and other stakeholders to check your understanding against theirs and get them on board with finding solutions.
3. Contextualize your data in terms of what you know about your service area and its strengths (assets) and weaknesses.
4. Compare your data to what the evidence-based practice calls for in terms of clinical pathways through treatment.
5. Convene with potential partners in the community and imagine or co-create solutions to vexing problems.
6. Develop a value proposition for your solution set, i.e., the differentiator that makes your organization attractive to your customers. What is the estimated impact on utilization, costs, and outcomes? How might you propose this value to a payer or partner?
7. Think about where you can add or redesign services to address an unmet need or improve a substandard process or practice.
8. Take your solutions to stakeholders, payers, and funders to tell them about your value proposition.

3. Determine Your Financial Risk and Work on Rate Setting

Providers must be able to calculate their costs and their financial risks. Value-based reimbursement (VBR) and other alternative payment methods (APMs) rely first on well-functioning traditional billing operations.

It is necessary to enter this step with an understanding of, and experience with, the dynamics of clinical documentation, diagnosis codes, procedure codes, contracted rates of reimbursement, and the various laws, rules, and policies governing conventional billing. If you are not there yet, work on it first. This is an area where you may benefit from some outside help if the competency does not exist within your staff.

Remember, one of the key ingredients in PHM is data, especially financial data. Calculating your costs and risks will require

- Access to accurate and timely data from within your provider organization and across electronic health record (HER), financial, and payroll platforms and from among your payers;
- An understanding of the financial models and principles used to formulate VBR and calculate risk;
- Financial modeling, and
- Financial management

All of these are essential to arriving at rates that are attractive to payors and partners.

Strategies: The following strategies assume you have electronic health record and claims data to use.

1. Adopt a cost of service calculation model and calculate your cost of delivering discrete units of service. If you do not know what your true costs are, you cannot calculate all your risks. VBR assumes incremental increases in risk, so this is crucial to your future.
2. Make all your current rates of reimbursement available to those working on this project.
3. Report your billing operations (i.e., revenue cycle management) performance measures over time. Two to three years performance reporting on billing and receivables is ideal.
4. Recognize where your organization is weak. What would you need to do to perform at a higher level, assuming you were shouldering additional financial risk?
5. Research, compare, and contrast the various models of APM and VBR on a continuum of increasing financial risk. Choose a model or two that make the most sense in your unique situation.
6. Discuss a data-sharing agreement with your potential business partner(s)/payer(s). For example, if you are considering assuming some risk in a VBR arrangement for 5,000 Medicaid managed care plan members, you will need a minimum 3 years' claims data from this plan.
7. Develop analytical models enabling you to see clearly current and projected utilization patterns and total cost of care (TCOC), and project how changes in practice might adjust the cost curve your population represents.
8. Apply your costs of doing business. Develop models projecting or forecasting your true future costs. Do your cost estimates align with pricing or with proposals from partners and payers? Do you stand to break even, make money, or lose money?

4. Make Patient Engagement a Priority

What makes PHM really stick is the ability to mobilize and connect with consumers and family members both those engaged in services *and* those not yet engaged. Motivate new behaviors, and get people interested in their own well-being. This usually requires

- Engagement, education, incentives, and self-management strategies for consumers and families;
- System navigators, peers, and other outreach workers; and
- Comprehensive and creative care coordination, such as text message reminders, telehealth to accommodate remote locations or peer support.

Strategies:

1. Focus on consumer and family engagement activities and individuals to help support their self-care such as peer staff, patient navigators, or recovery coaches.
2. Develop your message. What is it you want to tell consumers and families? What wording will ensure the greatest engagement, activation, and fidelity?
3. Develop a marketing and media approach. Will you use printed materials? An app for smart phones? Text messages and telephone call reminders? Video-enabled telehealth?

5. Focus on Outcomes, Quality and Cost Reporting

Lastly, the same technology infrastructure supporting health informatics and HIE will now support regular reporting, performance dashboards, and the business intelligence (BI) required to succeed. Success rests on differentiation, and the differences will only be evident in the data.

Strategy:

1. Create performance dashboards and outcomes reports to focus on continuous quality improvement in your services and programs to best meet the needs of the people you serve.

What You Can Do *Now* to Get on Board with PHM

Now that you know, what PHM is and what it requires for success, the next question is: *How do I get started?* A provider cannot do PHM alone. You need partners who can help you meet the full spectrum of needs of the special population(s) you serve.

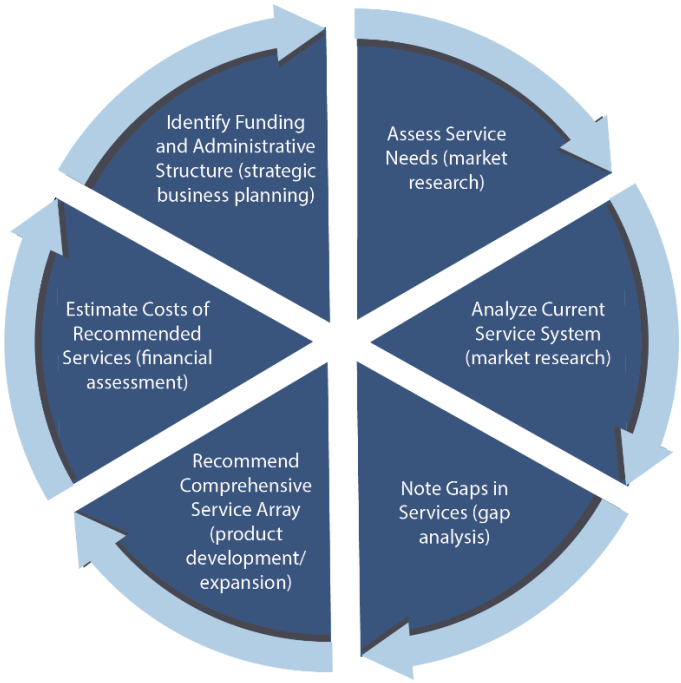
There are three key areas to focus on if you want to make PHM happen for you: involving research and development (R&D), improving business operations, and joining networks of other providers.

1. Research and Development

R&D is essential to PHM. This is an era of *Big Data* and data-driven business planning. Your research homework has been outlined throughout this document, and there is much more you can do in your community. Most of all, find out:

- What are your payers doing?
- What do they want to do?
- How can you position yourselves to deliver what they want?

You should plan to meet with your payers and partners in-person as soon as you can. There is no substitute for face-to-face conversations and fact-finding. The familiarity these meetings foster and the trust they instill are essential to your success. The graphic below depicts how the information you gather can be developed into viable solutions.



2. Improve Business Operations

A financially sound and operationally efficient organization can establish a strong market position and present an attractive opportunity to potential partners. At the very least, you need:

- A mission and vision for quality, costs, and growth
- Core processes that include
  - clinical and treatment delivery
  - workforce development
  - quality assurance
  - information technology
  - financial management
  - contracting and joint ventures
  - marketing and product development
  - strategy, management, and governance
- Supportive processes such as human resources and compliance.

How to Improve Business Operations

To get started on improving your business operations, focus on the tasks listed below:

- **Baseline Performance Assessment**—Capture and evaluate the performance of your revenue cycle (addressing the entire cycle!).
- **Gap Analysis**—Compare your current state of performance against the benchmark or your desired future state. What is missing? How might you begin to fill this gap in performance?
- **Implementation Planning and Execution**—Assign a team and provide them with enough financial and human resources to get the job done on time and on budget.

3. Consider Joining or Forming Networks

There are several types of network relationships you may want to consider when expanding your services and reach, such as integration/collaboration with primary care providers and other stakeholders.

You may want to join a provider network already in existence. However, if you decide to get together with some other local organization and form your own provider network to meet the population health needs in your community, the following steps can guide your way.

Why Join or Form a Provider Network?

There are many reasons for behavioral health providers to consider forming or joining a network, including:

- Integrate fragmented systems
- Consolidate and simplify administration
- Consolidate revenue management and position for APM and VBR
- Standardize, collect, and measure outcomes
- Decrease operating costs
- Improve access to care and services
- Enhance continuity of care
- Standardize and optimize quality
- Grow the workforce

1. **Vision.** Decide what type of business entity you and your partners would prefer to build and what kinds of services you want to offer.
2. **Form**. Form the entity and name it. Build a board of directors and various committees and make decisions as to for-profit or not-for-profit status.
3. **Readiness and Capabilities Assessment.** Evaluate your people and your operations'/infrastructure's ability to make this change.
4. **Gap Analysis and Solution Alternative Analysis.** Determine how to get from where you are to where you want to be.
5. **Business Planning.** Develop a business plan and *pro forma* set of cost and revenue financial projections and indications of probable return on investment.
6. **Implementation Planning.** Create a comprehensive project plan with milestones, calendar time, tasks and activities, and roles and responsibilities to get your network up and running.

To learn more, see these resources

- The Office of the National Coordinator of Health Information Technology Health IT Playbook: https://www.healthit.gov/playbook/population-public-health/
    - Centers for Disease Control and Prevention (CDC) Population Health Training: https://www.cdc.gov/pophealthtraining/whatis.html

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