Association for the Chronically Mentally Ill (ACMI)

March 10th, 2021

Thewebinar will start @ 6:00 PM

ACMI Educational Webinar:

Population Health- Who we are treating (and not treating) and why?

- Information presented is not medical advice
- Please mute all lines except presenters
- Submit questions in chat window
- Those requesting a Certificate of Attendance need to send an email to contact@acmionline.com with following information:
  - First name
  - Last name
  - Email address
- Copa Education will be sending the certificate

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POPULATION HEALTH

Dr. Michael Franczak

COPA HEALTH
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POPULATION HEALTH

COPA HEALTH
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- ❑ Tracking outcomes
- ❑ Track the entire population for key indicators
- ❑ Identifying individuals with Emerging Risks
- ❑ Alert clinical teams, BHMP's and PCP's of issues
- ❑ Work with outside providers, hospitals, emergency room, crisis services.

Population Health – Turning Data Into Action

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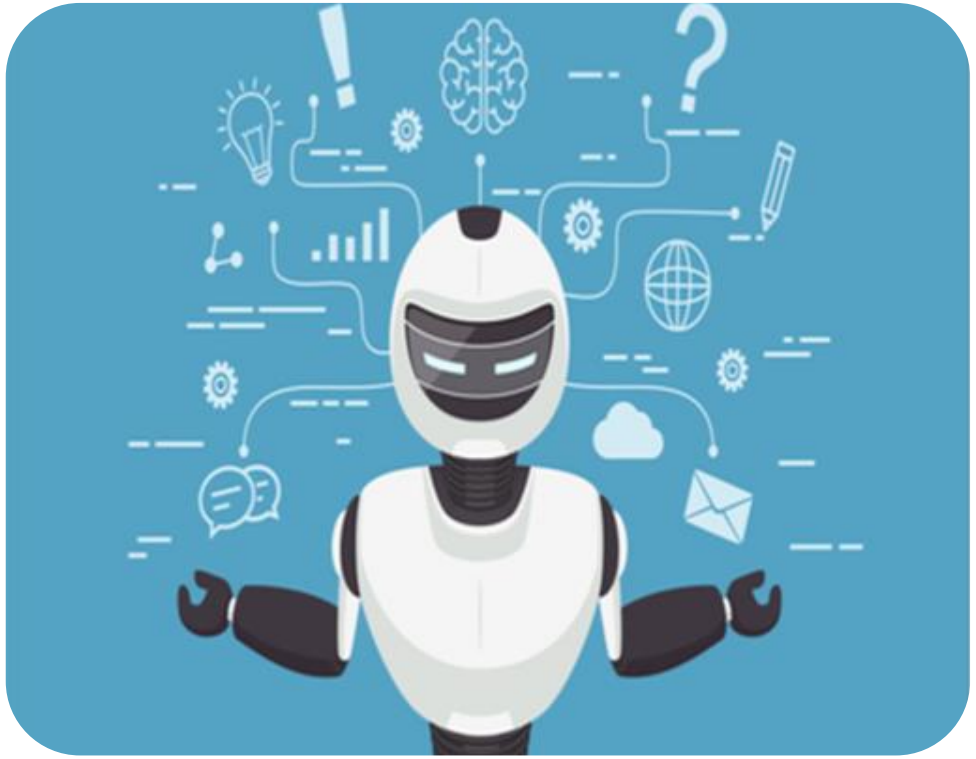
- Using data to focus interventions
  - Interesting Data vs Actionable Data

- Designing Population wide and Individual interventions addressing:
  - High utilization of ED, Inpatient settings
  - High Cost/High Need
  - Care gaps – prevention
  - SDOH Factors
  - Improving BH/PH outcomes – Care Management

POPULATION HEALTH

- Social Determinants of Health (SDOH)
- Co-Morbidities
- Risk Stratification
- Numbers to Action
- Functional Risk Analysis
- Teamwork w/ Skillful Adaptation

Data Sources



- ❑ Health Current– ADT & Batch Alerts
- ❑ Single EMR (Primary/Behavioral Health)
- ❑ Discharge/Transition Planners and Care Manager staff
- ❑ Data from MCO Care Managers
- ❑ MCO Claims Files & Population Health Reports
- ❑ Data from AHCCCS TIP Program

Decoding the Data- Risk Factors for High Utilization

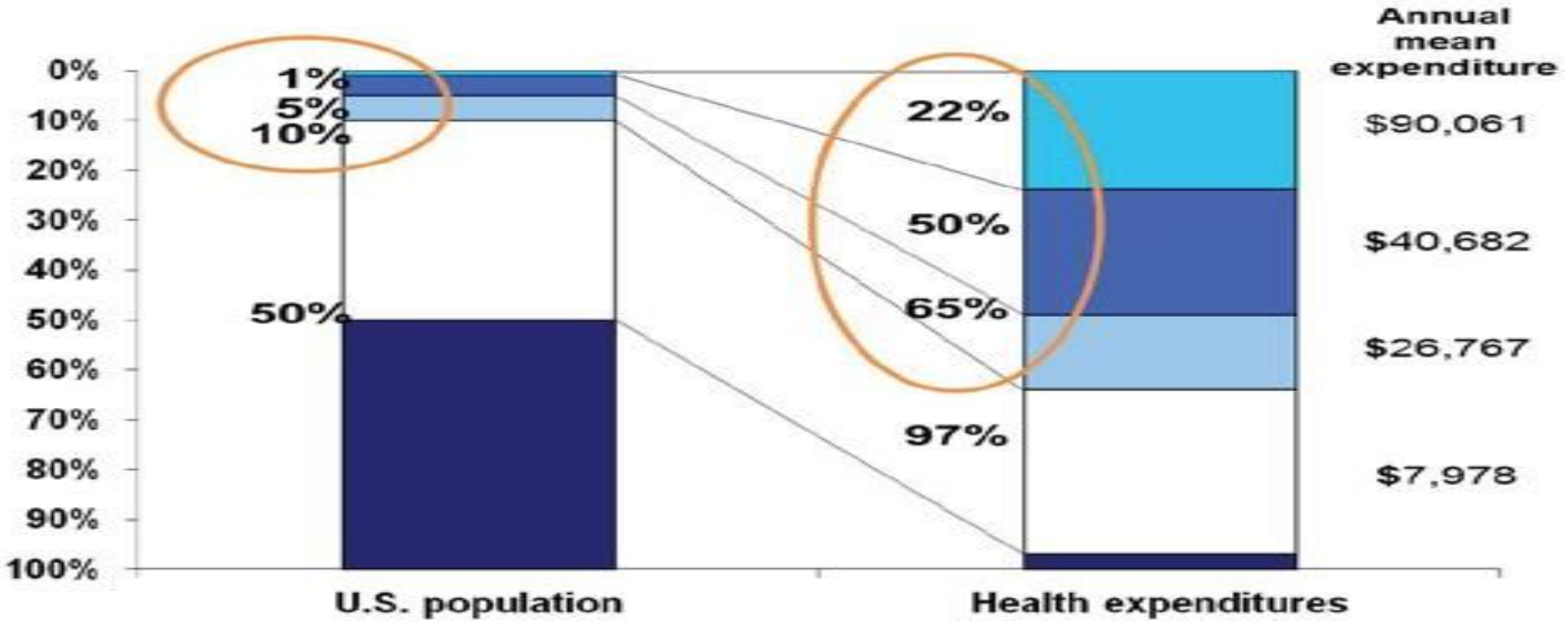
- ❑ **Undiagnosed and/or untreated chronic medical conditions**
- ❑ **Opioids/deception**
- ❑ **Location/Proximity**
- ❑ **ER or Hospital is their "Health Home"**
- ❑ **Health literacy**
- ❑ **SDOH- Social Determinants of Health**
  - ➢ **Housing (Getting warm, getting cool)**
  - ➢ **Food Insecurity**
  - ➢ **Social Isolation**
  - ➢ **Family/Relationship Stressors**
  - ➢ **Finances**

High Risk Population Interventions – Reducing Unnecessary Utilization

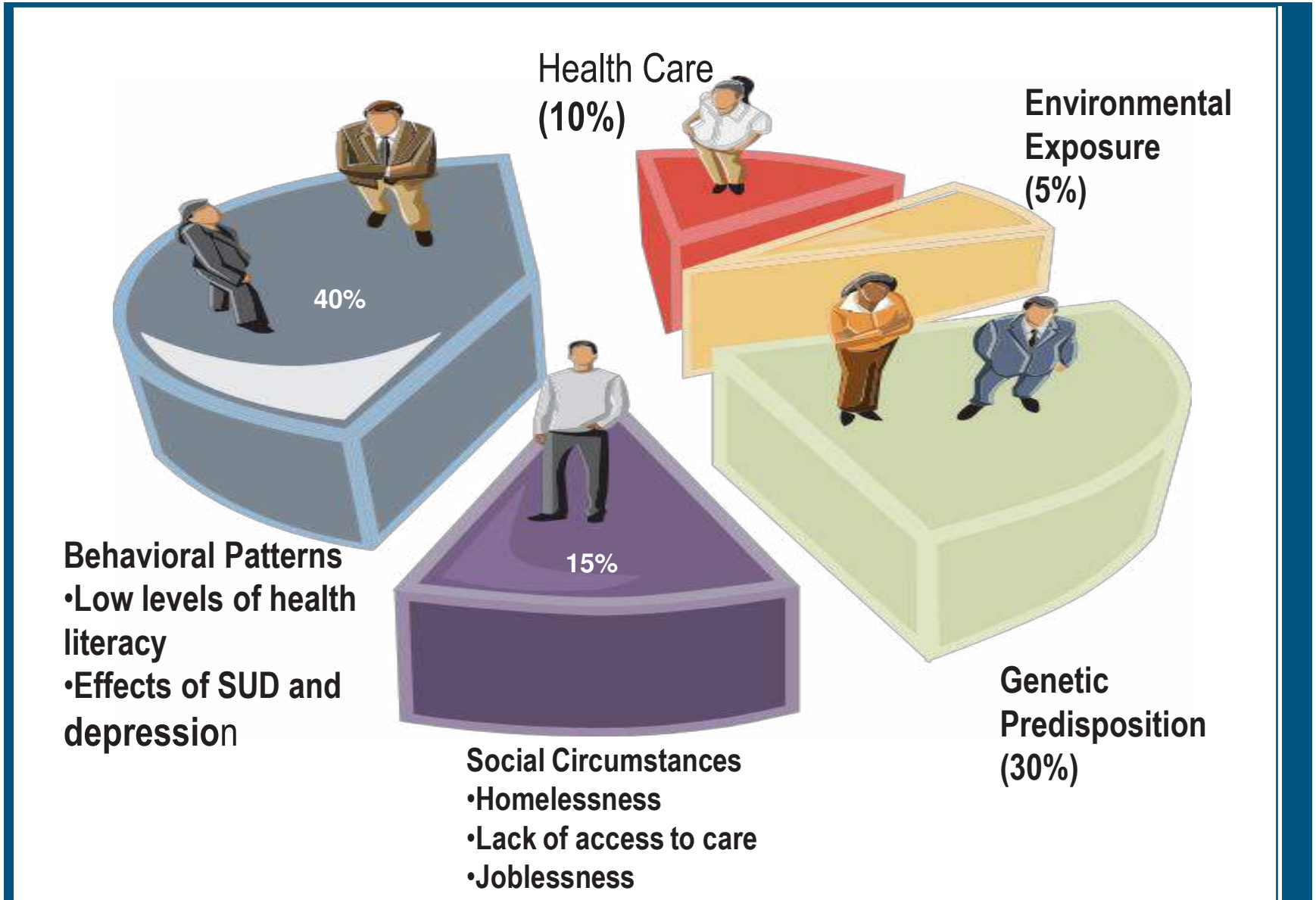
- ❑ High Risk Registry
- ❑ Establish clinic-based teams to focus specifically on these individuals
- ❑ Functional Risk Analysis – an individualized assessment & strategy
  - ➢ Medications, Dx, baseline
  - ➢ PCP visits (or lack thereof)
  - ➢ Health literacy
  - ➢ Reason for visit (stomach ache, headache)
  - ➢ SDOH review
  - ➢ Support network

Goal is to provide effective treatment in the community as an alternative to high cost settings when they are unnecessary

Distribution of health expenditures for the US. population by magnitude of expenditure, 2009



Source: Agency for Healthcare Research and Quality analysis of 2009 Medical Expenditure Panel Survey.


Health Care
(10%)
Environmental
Exposure
(5%)
40%
Behavioral Patterns
•Low levels of health literacy
•Effects of SUD and depression
15%
Social Circumstances
•Homelessness
•Lack of access to care
•Joblessness
Genetic
Predisposition
(30%)

Social Determinants of Health (SDOH)

Many of these supports are outside the scope of MEDICARE, MEDICAID OR Commercial Health Plans

Many health care organizations are trying to find a way to build relationships with community resources

Most community support organizations are Non-Profit Charitable Organizations- Many are run by Religious Organizations

Many behavioral health providers have been doing this all along. Helping participants obtain food boxes, finding housing, preventing evictions and organizing transportation.

Most PCP sites do not have the staff to address these issues.

The Good News:

AHCCCS and Health Current are trying to address this issue

The Interplay between Behavioral/Mental Health Conditions & Physical Illnesses

Although the clinical course of multi-morbidity is not well understood, the relation between mental and physical problems seems to be bidirectional.

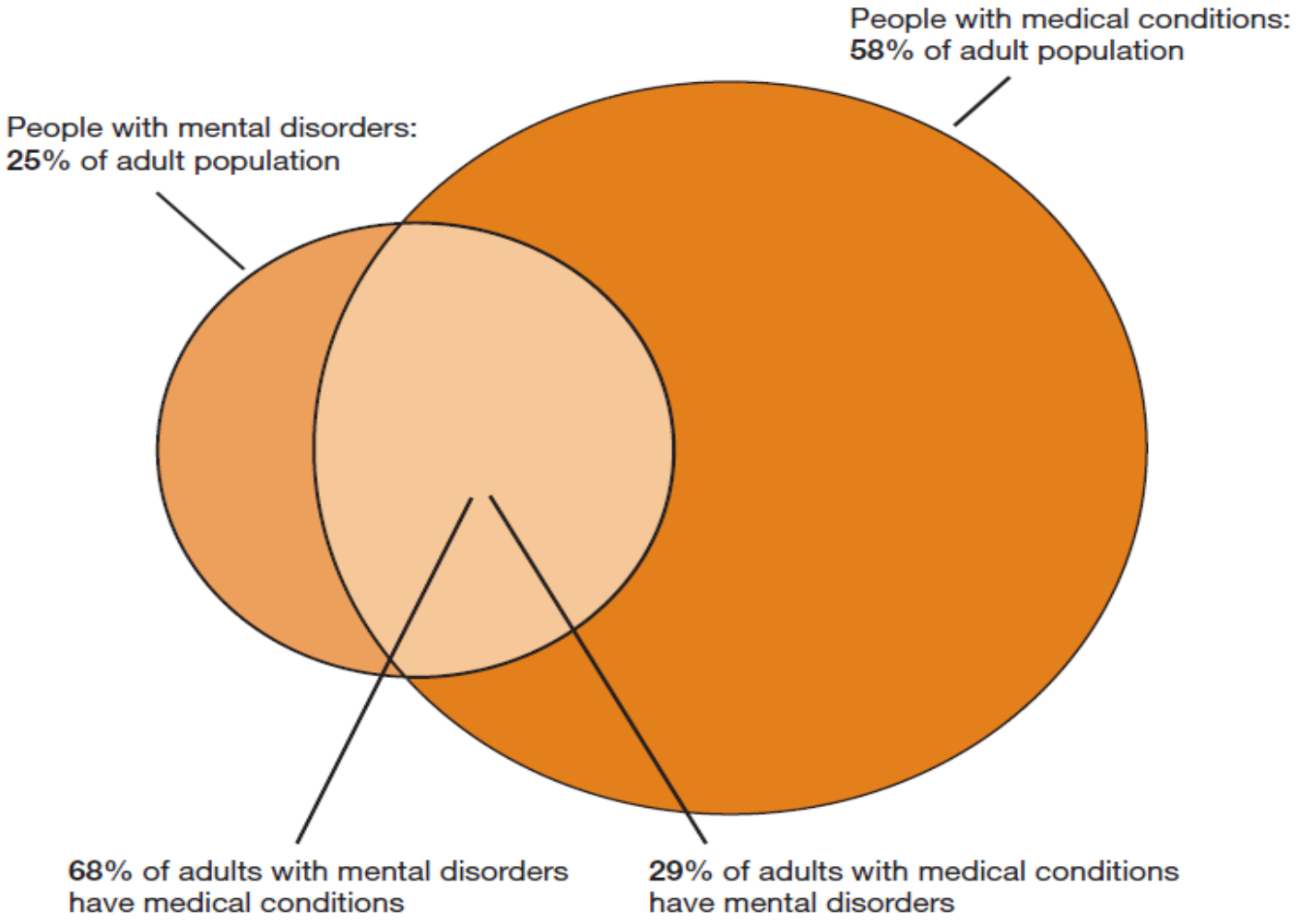
Patients with severe and enduring mental health problems such as chronic depression, dementia, or psychotic disorder are at high risk of developing long term physical conditions, and the risk of mental health problems increases substantially in those with long term physical conditions.

Rates of mental health problems also increase noticeably as the number of long term physical conditions increases and as socioeconomic deprivation worsens.

BH PROBLEMS COMMON & OFTEN CO-OCCUR w/ PHYSICAL HEALTH PROBLEMS

- **1/4 of Americans will meet criteria for mental illness at some point in their lives**
- **A large % of the adult population (34 million people), have co-morbid mental and physical conditions within a given year**

Figure 1: Percentages of people with mental disorders and/or medical conditions, 2001–2003



Source: Adapted from the National Comorbidity Survey Replication, 2001–2003 (3, 83)

CO-MORBIDITY CHALLENGES

Co-Morbid Conditions

- Adults who had any mental illness, serious mental illness, or major depressive episodes in the past year had increased rates of hypertension, asthma, diabetes, heart disease, and stroke (NSDUH analysis, 2008-2009)

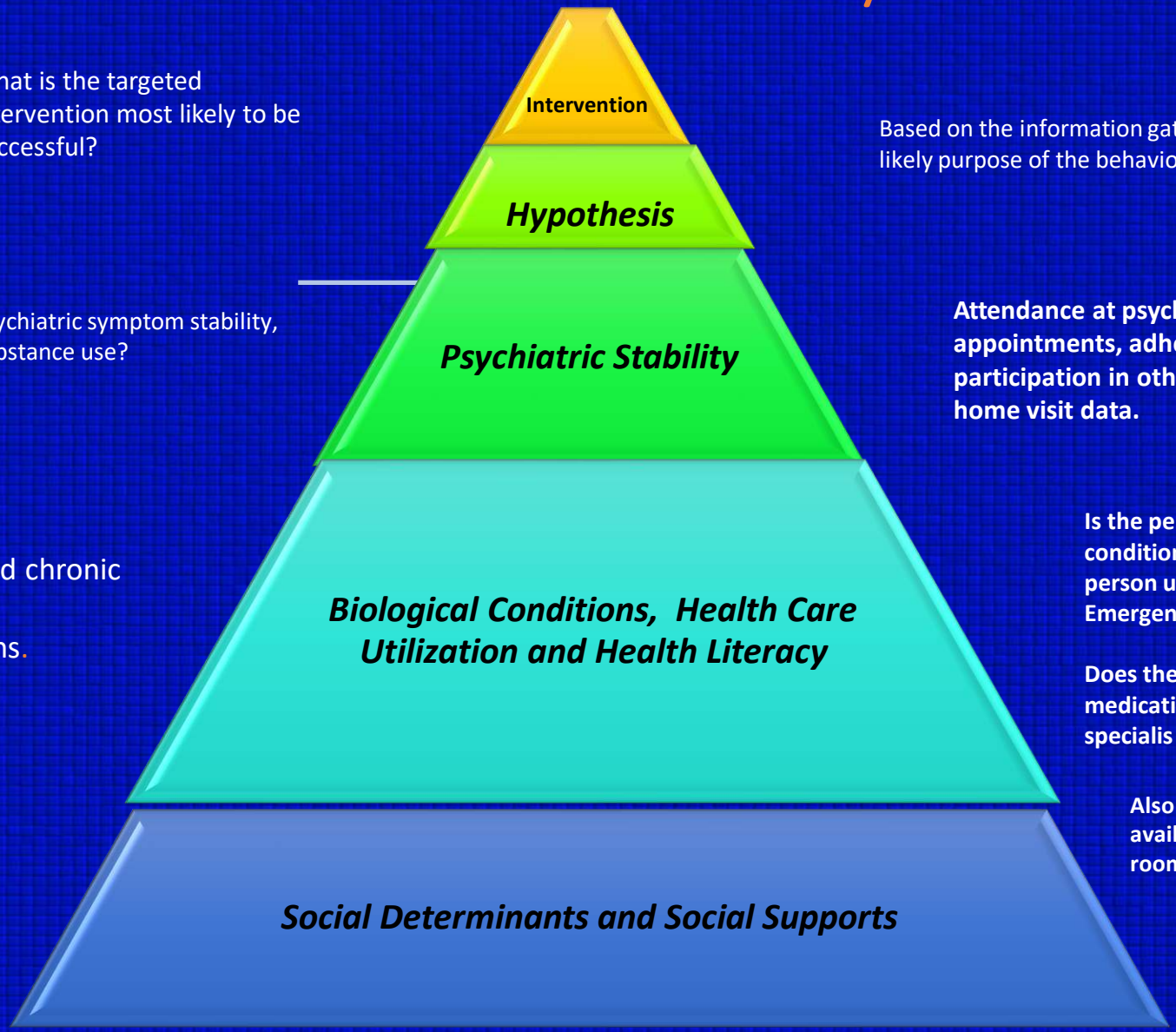
Medication Issues

- Most psychiatric medications, particularly anti-psychotic medications, can cause weight gain, obesity and Type 2 diabetes, all of which impact mental conditions such as major depression

Functional Risk Analysis

What is the targeted intervention most likely to be successful?

Based on the information gathered what is the most likely purpose of the behavior?



Psychiatric symptom stability, substance use?

Attendance at psychiatric and other clinic appointments, adherence to medications, participation in other therapeutic interventions, home visit data.

Acute and chronic medical conditions.

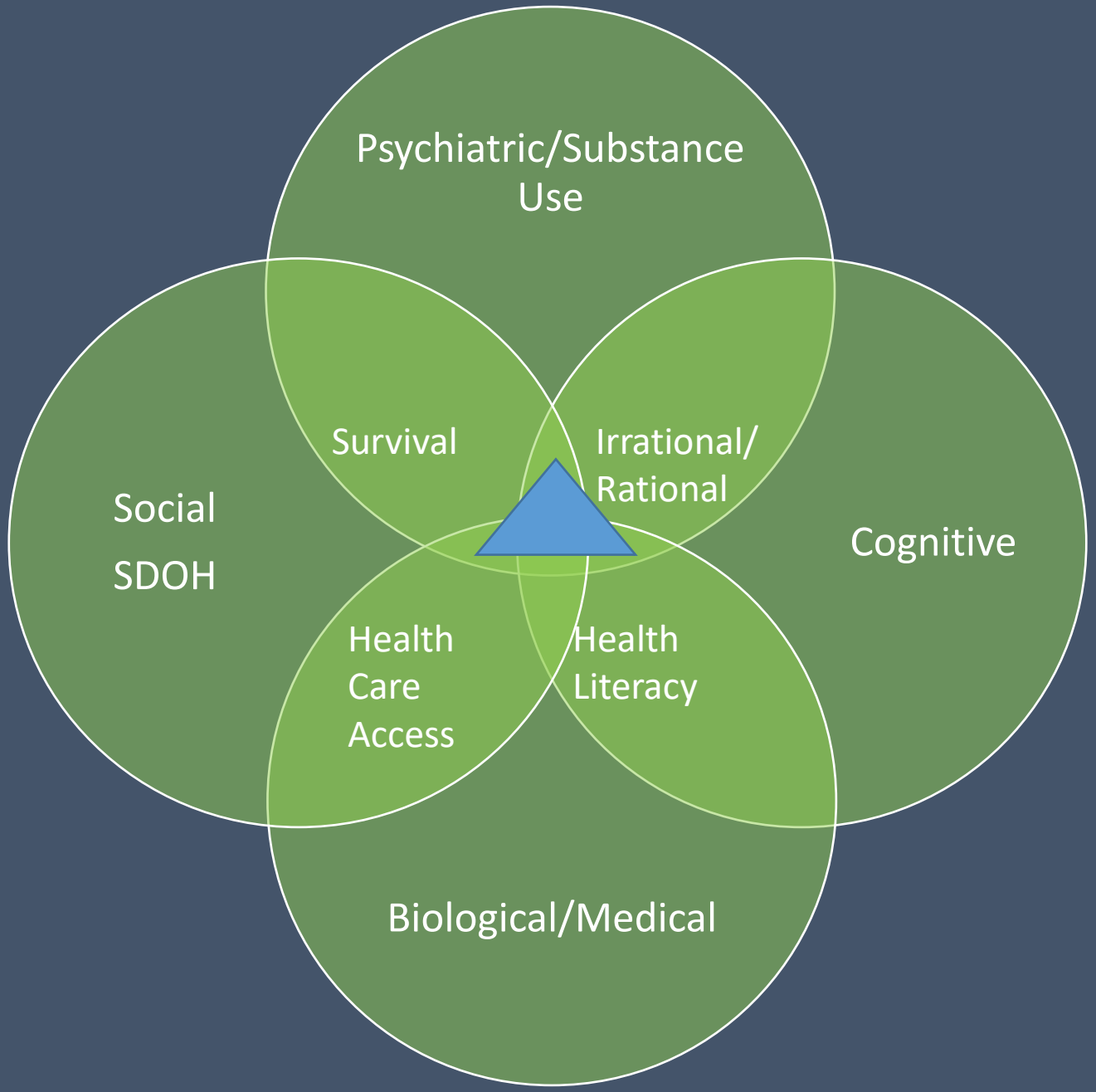
Is the person attending to these conditions. Which services does the person use (PCP, Pain Management Clinic, Emergency rooms, etc.)

Does the person follow thru with medications, attend appointments, go to specialis

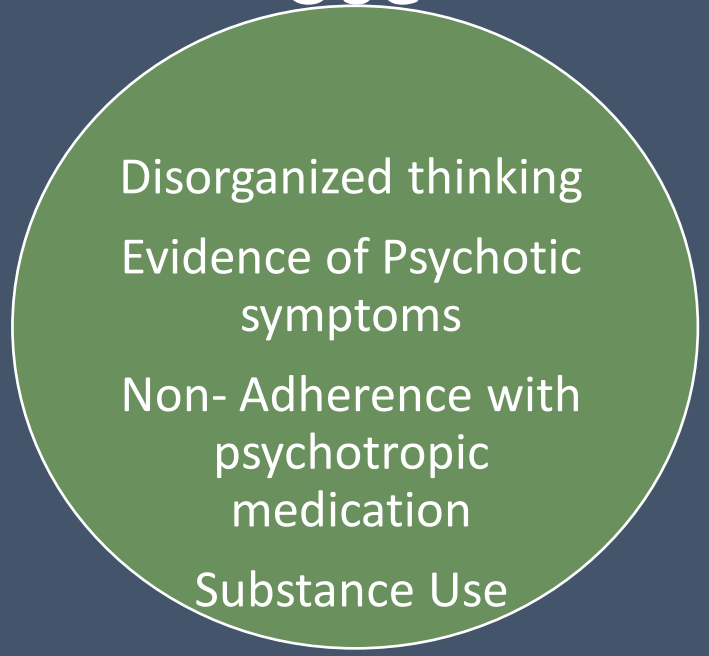
Also identify the social supports available to the person (family, friends, roommates, etc.)

Identify housing stability, food, transportation, etc.

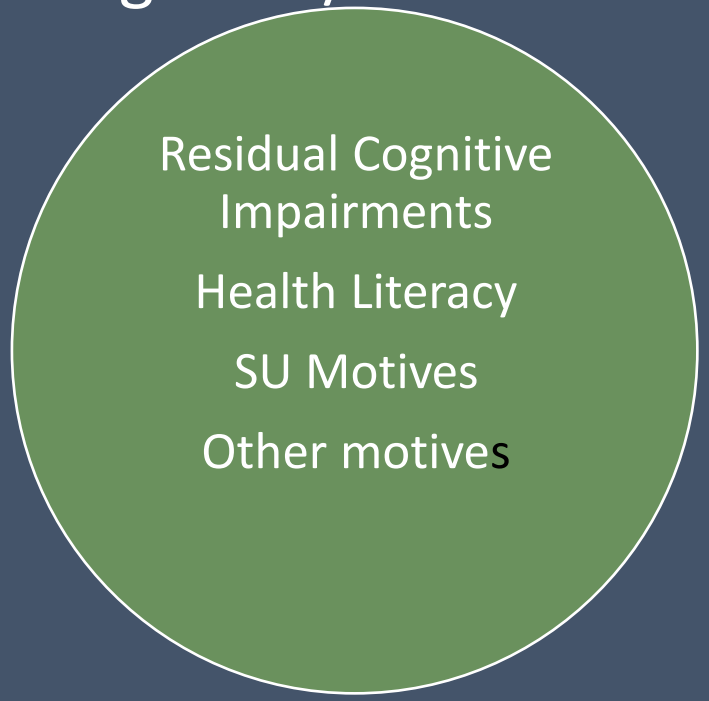
Decision Analysis



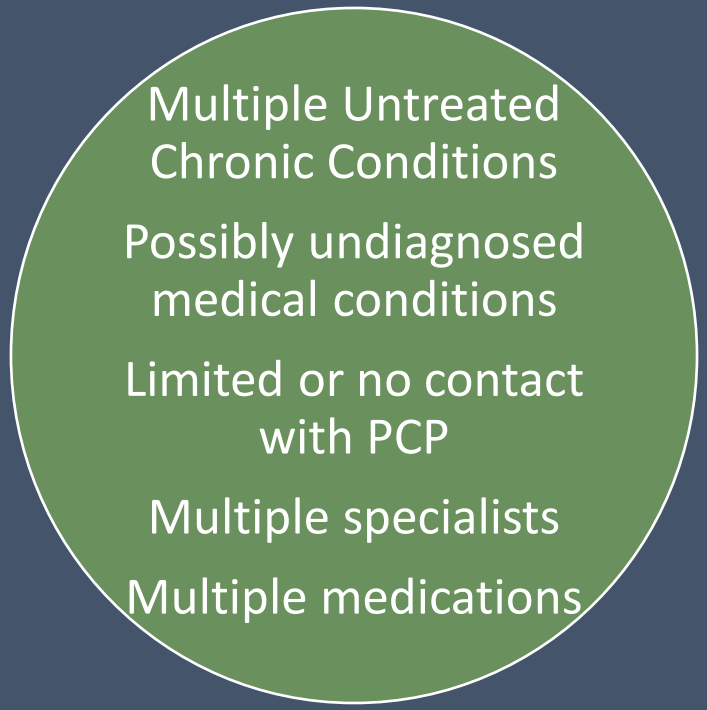
Psychiatric/ Substance Use



Cognitive/Behavioral



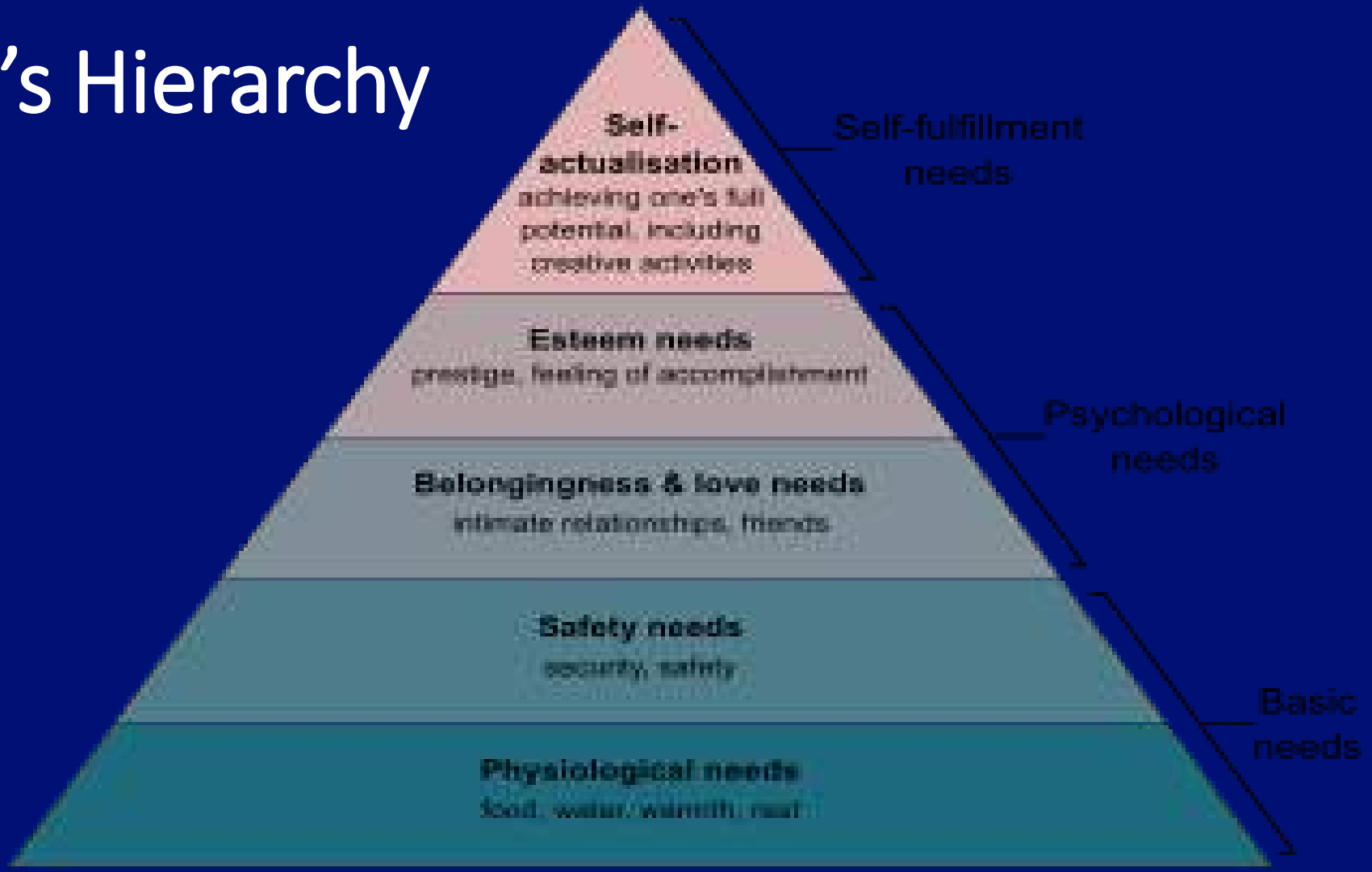
Biological/Medical



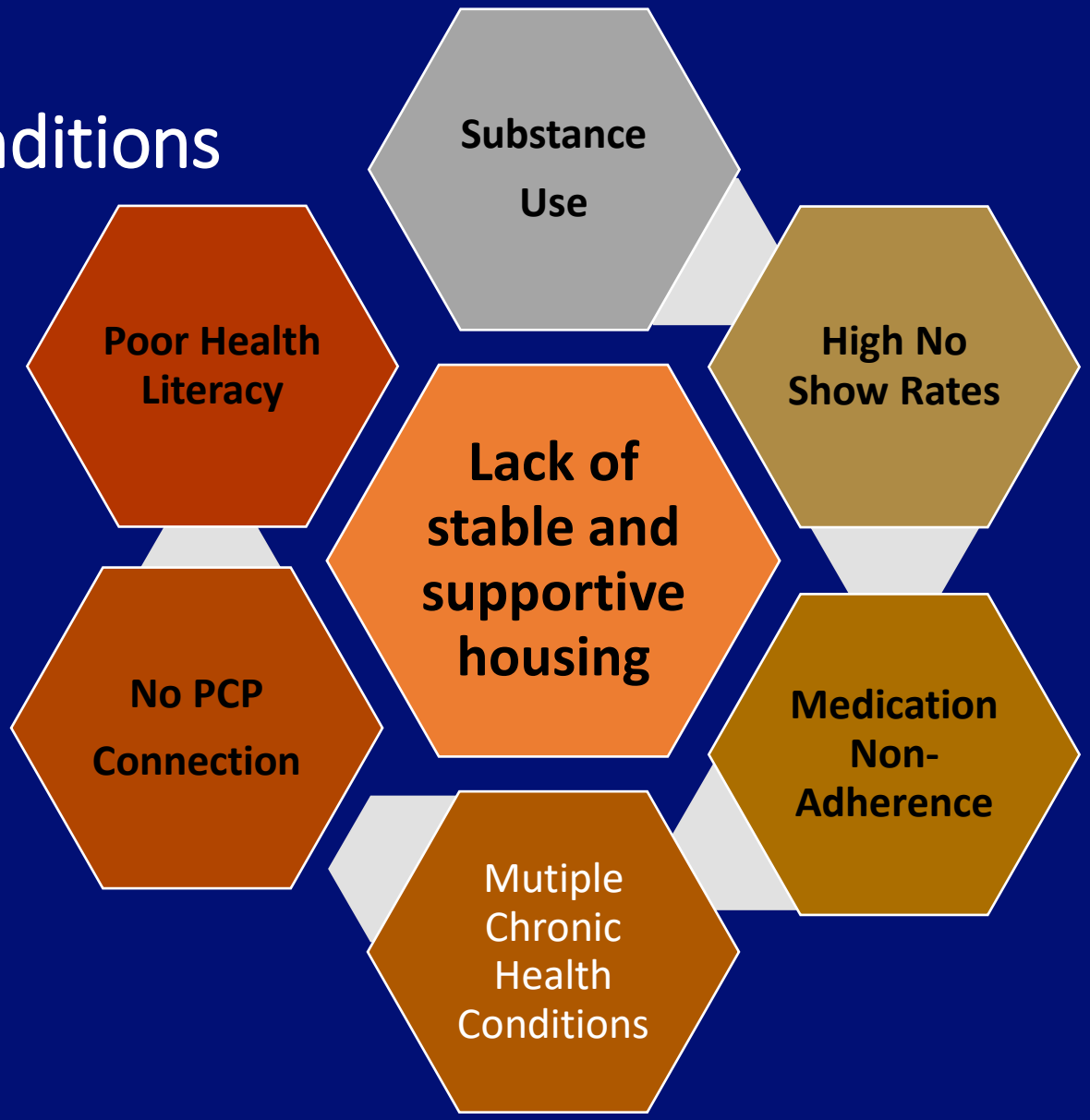
Social


SDOH Factors
Housing situation
Social supports
Finances
Transportation

Maslow's Hierarchy



Challenging Conditions



DropOut and Now Shows

- In general psychiatric clinics, 20%-57% of the patients fail to return after the first visit (Blenkner, 1984; Dodd, 1971; Gallagher & Ranter, 1961; Katz & Solomon, 1958; Overall & Aronson, 1963; Rosenthal & Frank, 1958; Weiss & Schaie, 1958).
- 31%-56% attend no more than four times (Frank et al., 1957; Gallagher & Kanter, 1961; Garfield & Kurz, 1952; Lindsay, 1965).
- Mean or median number of visits ranges from only 3 to 13 (Affleck & Garfield, 1961; Affleck- & Mednick, 1959; Bahn & Norman, 1959).

Other Conditions for which it is difficult to obtain services

- Individuals who are aged and need assistive living services
- Young individuals who need housing with supports
- Individuals who ignore or refuse care for life threatening Illnesses
- Societal and self Stigma

Protective Factors

AHCCCS Whole Person Care Initiative (WPCI)

- Officially launched the Whole Person Health Initiative in November 2019.
- Focused on role social risk factors play in influencing individual health outcomes.
- Exploring options for advancing WPCI through maximization of AHCCCS's current benefit package.

Arizona Health Current SDOH Referral System Features

Service Requestors

- Identify preferred network.
- Register patients.
- Data-driven approach to screen and tailor referral to individual needs.
- View screening, referral and service history.
- Search for service providers.
- Set communication preferences.

Service Providers

- Receive complete referrals.
- View screening, referral and service history.
- Determine eligibility.
- Communicate with patients, referring agencies and other providers.
- Patient reminders and alerts.
- Provide referral feedback (close the loop).

The Family Guide to Mental Health Care

Advice on Helping Your Loved Ones, from the medical director of the country's largest state mental health system and the mental health editor of the Huffington Post

Lloyd I. Sederer, MD
Forward by Glenn Close

W.W. Norton & Company 2013
New York • London

Introduction

- **The impact of mental illness doesn't stop with the person who is ill. It places great demands on families, stoking tensions and often pitting parents against each other.**
- **Sucking parents, siblings, and other family members into its maelstrom, mental illness is the visitor no one wants.**

Introduction

- **In fact, people with mental illnesses can improve and build satisfying lives, just like other people with common physical illnesses such as diabetes or heart disease.**
- **With both physical and mental disorders, the earlier the treatment is received, the better.**
- **When medications and therapy are combined, and there is an informed, engaged, and supportive family, each element builds on the other and optimizes the chances of recovery.**

Introduction

- **The problem is that many people in the grip of mental illness are not getting the quality care they need. In fact, an astonishing 80% of Americans with treatable mental disorders do not receive proper diagnosis and effective treatment.**
- **Can you imagine patients with heart disease ever tolerating similar odds – a 20% chance of receiving what they need to get them well?**