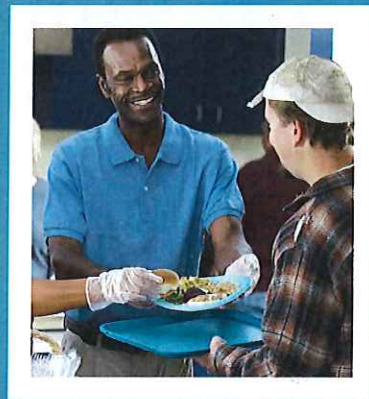
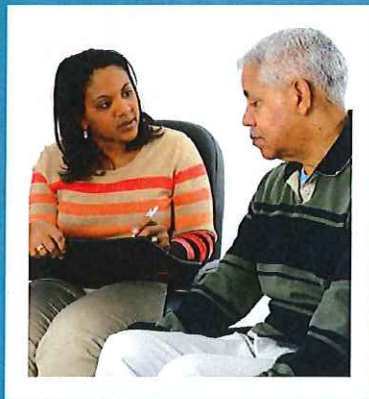
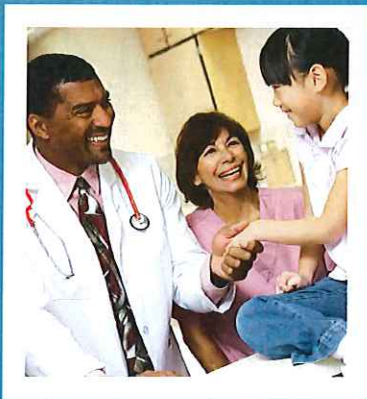




ACHIEVING POPULATION HEALTH:

BEHAVIORAL HEALTH SYSTEMS AS THE LINK TO SUCCESS



Advocates for
Human Potential, Inc.

The right people with the right ideas at the right time.



Advocates for Human Potential, Inc. (AHP) offers cutting-edge solutions that address the issue of integrating health and behavioral health systems, particularly in today's health care reform and population health environment. These strategies and tactics are having significant impacts on systems of care around the country and can be customized to address unique needs and values in your community.

Powered by a team of national behavioral health and health reform experts with health insurance backgrounds, AHP is the architect of a growing number of integrated specialty provider network solutions operating across wide geographies, serving behavioral health, HIV/AIDS, and developmental disability populations, and many other healthcare organizations. As a company with research, technical assistance, training, and policy consulting capabilities, AHP serves federal, state, and county clients; managed care organizations; and health care providers, their systems of care, and related services.

INTRODUCTION

Health care in America is changing rapidly. The Affordable Care Act (ACA) extends mental health and substance abuse treatment benefits and parity protections to 62 million Americans (Beronio, Po, Slopes, & Giled, 2013), ushering in the most sweeping changes in health care financing and delivery in more than 40 years. 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 increasingly is touted as a way to accomplish these goals.

As a behavioral health provider, you may wonder, “What is population health and how and why should I manage it?” This white paper puts population health in perspective. It helps you prepare to participate on a level playing field as health care becomes increasingly integrated across physical health, behavioral health, and social services. Advocates for Human Potential, Inc. (AHP), works at the intersection of these systems and understands that behavioral health providers have a critical role to play in the success of population health management. The ultimate goal of managing population health is to achieve the “triple aim” of health reform—better health, better care, and lower costs. The time to begin is now.

WHAT IS POPULATION HEALTH?

Population health refers to “the health outcomes of a group of individuals, including the distribution of such outcomes within the group” (Kindig & Stoddart, 2003).

Population health is both simple and profound. In a narrow sense, it refers to the health of a defined population, such as that served in a health system (Kassier, Tomoyasu, & Conway, 2015). More broadly, population health focuses on the health of entire populations. It encompasses not only health outcomes, but also the health determinants that influence these outcomes and the interventions that impact the determinants (Kindig & Stoddart, 2003).

Population health recognizes that “our ZIP code may be more important than our genetic code” in determining overall health status (Marks, 2009). At best, medical care accounts for only 10 to 15 percent of preventable deaths (Robert Wood Johnson Foundation, 2009). Other factors exert a powerful influence on our 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, among others. Behavioral patterns and social circumstances confer 55 percent of the risk for health outcomes (Schroeder, 2007; see Figure 1). Ultimately, there is no health without behavioral health.

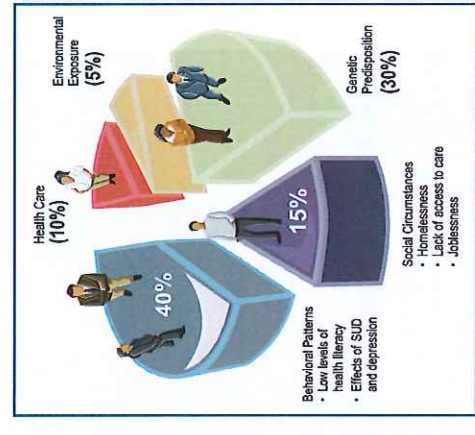


FIGURE 1. Behavioral Health and Social Conditions Significantly Impact Population Health

¹ Throughout this document, the term “behavioral health” refers to both mental and substance use disorders.

WHY IS POPULATION HEALTH IMPORTANT?

Many Americans have multiple, complex conditions, and their care is costly. Population health acknowledges that we cannot hope to improve health outcomes and rein in costs without paying attention to all of the factors that impact a person's health. The scope of the challenge is significant. The Agency for Healthcare Research and Quality (AHRQ) reports that the sickest 10 percent of individuals account for 65 percent of health care expenses (AHRQ, 2012; see Figure 2).

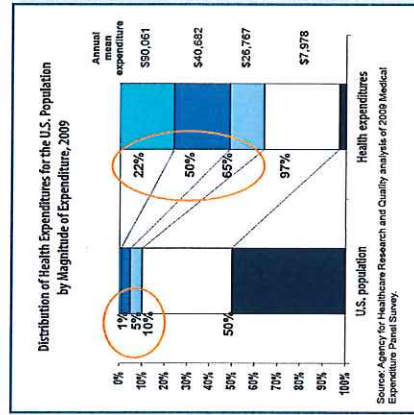


FIGURE 2. Health Care Costs Are Concentrated in a Sick Few

More recently, the federal Centers for Medicare and Medicaid Services (CMS) released an analysis of claims from 5.3 million individuals who were dually eligible for Medicare and Medicaid in 2008. Among the study population, 60 percent had at least three chronic conditions, and a full quarter had five or more chronic conditions (CMS, 2014). Three quarters of the population had at least one heart-related diagnosis, and nearly half—41 percent—had one or more mental health conditions (excluding substance use disorders).

Individuals with multiple health conditions were expensive to serve. Those with no physical or mental health condition incurred \$875 per member per month on average. Average monthly costs for members with two comorbid conditions were \$1,628; those with five or more conditions incurred an average monthly cost of \$3,940 (CMS, 2014).

In many cases, these are the very individuals that behavioral health providers serve. Individuals with the most serious mental illnesses die, on average, 25 years earlier than the general population (Parks, Svendsen, Singer, & Forti, 2006). Moreover, they die from treatable medical conditions, such as cardiovascular disease, which are caused by modifiable risk factors—including smoking, obesity, the side effects of psychotropic medication, and lack of access to preventive care. The rate of Americans who are uninsured has dropped to 12.9 percent, the lowest rate since Gallup began tracking this statistic in 2008 (Levy, 2015). However, significant gaps remain for those with comorbid behavioral and physical health conditions, many of whom are served by safety net providers.

WHAT IS POPULATION HEALTH MANAGEMENT?

At its most basic, population health management is about paying for value rather than volume, and for quality rather than episodes of care. It moves care upstream—from treating people when they become sick to helping them stay well. In turn, managing the health of populations with multiple, comorbid conditions should reduce waste and inefficiencies and cut costs. However, as Nash (2012) points out, “Much of the emphasis of health reform is on new payments, rather than explicit new methods to deliver care.” Successful health care leaders “must not simply follow the tenets of reform, but fully understand and follow the tenets of population-based care” (p. 5).

Population health management focuses on high-risk individuals, who generate most of the health care costs. At the same time, it addresses comprehensively the preventive and chronic care needs of every patient. The goal 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).

Key Components of Population Health Management

Multiple observers have outlined the elements of population health management. At a minimum, they include the following key components (see Figure 3).

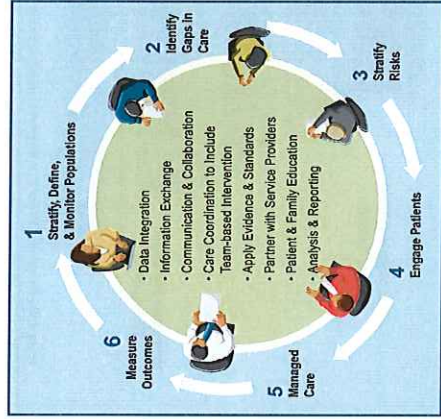


FIGURE 3. Key Components of Population Health Management

Define the Population

Population health management is successful when directed at those who need it most. Many individuals, especially those served by behavioral health safety net providers, have comorbid, complex, costly conditions. Providers can help identify patients whose behavior puts them at risk of poor outcomes. These might include individuals who need reminders for preventive care or tests, are overdue for care or not meeting goals, have failed to receive follow-up care after being reminded, or who could benefit from discussion of risk reduction (Cusack, Knudson, Kronstadt, Singer, & Brown, 2010). Behavioral health providers may identify individuals who can benefit from a dedicated care coordinator or peer support.

Identify Gaps in Care

Fragmented service systems lead to gaps in care that result in poorer health outcomes and higher health care costs. Just 55 percent of American adults receive recommended preventive care, acute care, or care for chronic conditions (McGlynn et al., 2003). Only 11 percent of Americans who need treatment for an illicit drug or alcohol problem receive it (Substance Abuse and Mental Health Services Administration, 2014). Few individuals receive evidence-based behavioral health interventions (McGlynn et al., 2003).

Stratify Risks

Patient populations can be stratified based on such characteristics as geography, health status, resource use, and demographics (Institute for Health Technology Transformation, 2012). Providers can engage and intervene with those populations identified as being at high risk for poor health outcomes and high costs based on any or all of these characteristics; this is the *sine qua non* of population health management.

Engage Patients

As Schroeder (2007) points out, “The single greatest opportunity to improve health and reduce premature deaths lies in personal behavior.” Patient self-management is a key tenet of both health reform and population health management, and the more activated patients are, the more likely they are to manage their health. Individuals with higher levels of activation have better health outcomes and lower costs than those with lower levels of activation (Greene & Hibbard, 2012; Hibbard, Green, & Overton, 2013). The Chronic Care Model (Wagner, 1998; see Figure 4) emphasizes the importance of the relationship among informed, activated patients and prepared, proactive practice teams in improving health outcomes. In a behavioral health setting, persons with lived experience (e.g., peers or persons in recovery) may be important allies in engaging patients.

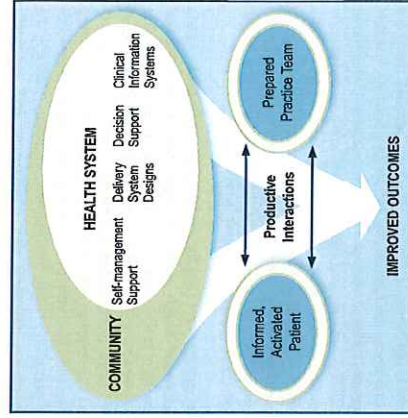


FIGURE 4. The Chronic Care Model

Manage Care

Managing patient care increasingly is done as part of an interdisciplinary practice team that understands the totality of the patient's health care needs, engages the patient in decision-making and self-care, provides or makes referrals for the full range of health and social services the patient requires, and guides and follows the patient through the continuum of care and across the lifespan. Because health is a function of multiple factors that may change throughout a person's life, intervening at specific points in the life course can help reduce risk factors and promote health (Healthy People 2020, n.d.).

Primary care providers increasingly are relied on to participate in multidisciplinary treatment teams and to coordinate treatment planning for individuals with multiple, complex conditions. Care coordination is one of the key pillars of programs that have demonstrated improved outcomes and lowered costs (Meyers et al., 2010). Lack of coordination is unsafe and can be deadly, if abnormal test results are not communicated correctly, prescriptions from multiple doctors conflict with each other, or primary care physicians do not receive hospital discharge plans for their patients (Nielsen, Langner, Zema, Hacker, & Grundy, 2012). Uncoordinated care may lead to increased costs due to preventable hospital readmissions, duplicated services, or overuse of more intensive procedures.

Measure Outcomes

The success of population health management hinges on the use of proper data and technology to identify and then track the outcomes of the groups being served. Health care systems must be able to develop, stratify, deploy, and monitor data. Among other functions, data can:

- Target patients in greatest need of services by narrowing subpopulations;
 - Make data on patients actionable by generating alerts to patients to seek appointments with their providers and by generating alerts to providers about patient care needs; and
 - Facilitate exchange of information with other providers on the treatment team (Institute for Health Technology Transformation, 2012)
- Developing and implementing meaningful interoperable systems and data warehouses supports population health interventions across multiple health care settings (Nash, 2012). As Figure 5 makes clear, data must be captured, stored, and deployed for a variety of users. These include:
- The patients, who can access personal health records, build self-care plans, and communicate with providers
 - The researchers, who will use "big data" to analyze and communicate population trends

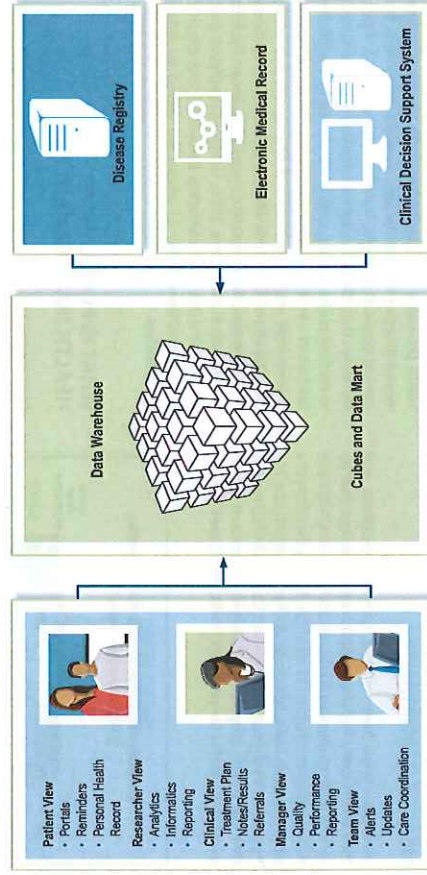


FIGURE 5. Population Health Data Management

- The clinicians, who will manage clinical and electronic medical record data
- The program managers, who are responsible for quality, outcomes, and accountability
- The care teams, which will coordinate care across time and systems

WHAT DOES POPULATION HEALTH MANAGEMENT MEAN FOR BEHAVIORAL HEALTH?

The concept of population health is simple—it is inherently more humane and less costly to help people stay well than to wait to treat them when they become sick. However, the implementation can be complex. *No single organization or sector alone can successfully pursue the improved health of a population* (see Figure 6).

As Stoto (2013) points out, population health management recognizes that the responsibility for population health outcomes is shared. However, because there are many upstream factors that influence population health, accountability is diffuse. This necessitates broad-based coalitions specific to the populations being served and the communities in which they live. "Interactions among the health care, business, and political communities are rarely considered in the current illness-focused model for health care delivery; yet they are the drivers of population health outcomes," notes Nash (2012, p. 3).

To participate in caring for an individual's whole health needs, behavioral health providers must partner with medical providers in their community; they will be expected to have the capacity to do so. But many behavioral health providers are small, grant-funded organizations with limited experience contracting with managed care organizations or billing insurance. Their infrastructure is ill-suited to meet the demands of population health management, including stratifying the population, providing care coordination, and, eventually, assuming risk for the health of a defined population.

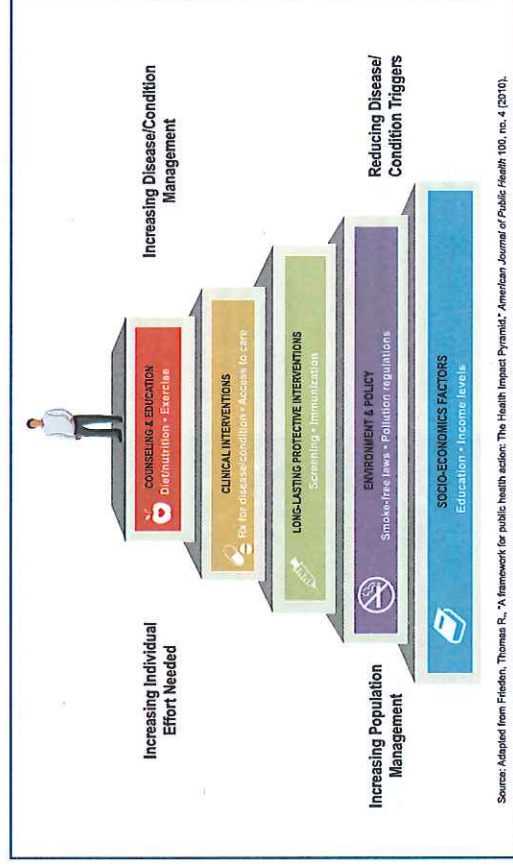


FIGURE 6. Population Health Management Framework for Improving Health

However, such collaboration is essential for the health of your business and for the health of the individuals you serve. By some estimates, primary care practitioners provide more than half the mental health treatment in this country (World Health Organization, 2008; Regier et al., 1993), and they prescribe the majority of antidepressants, increasingly to individuals without a psychiatric diagnosis (Mojtabai & Olsson, 2011). Psychotropic medications increasingly are being prescribed to children, especially those in foster care, and to elderly individuals in nursing homes.

Yet behavioral health conditions frequently are under-recognized and undertreated by primary care providers, many of whom have little training in mental health or substance abuse diagnosis or treatment (Kohn, Saxena, Levay, & Saraceno, 2004). Primary care providers may find it difficult to make appropriate referrals for behavioral health in a fragmented service system. Further, certain ethnic minorities may prefer to be treated for behavioral health conditions in primary care settings. Interdisciplinary, collaborative care is essential to improve health outcomes and reduce costs for individuals with multiple, chronic conditions—the very individuals served by behavioral health and community providers.

POPULATION-LINKED SERVICE SYSTEMS (PLSS)

As noted, health care is only a small fraction of what helps people stay well. Individuals who have experienced early childhood trauma and those who lack safe, affordable housing, adequate income, and social support will struggle to maintain their physical and behavioral health. Health and behavioral health providers alike must attend to what the Institute of Medicine (IOM) calls “psychosocial vital signs” (IOM, 2014). These include such factors as race, ethnicity, education, financial resources, physical activity, social isolation, exposure to violence, and neighborhood median household income, among others.

Behavioral health providers sit at the crossroads of the health and social service systems that are critical to supporting treatment and recovery from behavioral and physical health conditions and addressing the social determinants of health. As behavioral health providers, you are uniquely positioned to:

1. **Understand** the needs of the populations most at risk for poor health outcomes and the stakeholders that interact with, support, and serve them in the medical, psychological, and public health communities
2. **Recognize** the importance of creating linkages and cooperation between behavioral health and social service providers
3. **Develop** the business structures and processes to ensure that these collaborative ventures succeed

When these key elements are implemented, they lead to a concept that AHP calls population-linked service systems (PLSS), the connection of social services, behavioral health treatment, and primary care necessary to improve population health. PLSS focuses on and addresses the needs of people who live on the margins—individuals whose lives are most at risk and who, without proper care and attention, end up costing the health care system the most. The most vulnerable populations are those most in need of PLSS approaches—individuals with mental, substance use, and co-occurring disorders; those with intellectual and development disabilities; older adults; veterans; and people who experience chronic homelessness. These are the populations AHP serves. PLSS addresses the behavioral health, housing, employment, and income support needs of these vulnerable populations. Until recently, these safety net providers have been only tangentially involved in mainstream health care service delivery and financing. However, that is changing rapidly. As previously uninsured individuals gain access to mainstream health care through private insurance and health exchanges, providers are responding to the clinical and financial imperative to serve their complex needs. Integrating these vulnerable populations and the providers that serve them into a population health framework is one of the most significant health care reform challenges.

For behavioral health providers, efficient, streamlined business operations fine-tuned to satisfy the triple aim are critical for the success of PLSS. Behavioral health providers can take advantage of these new opportunities to improve internal operations and to consider leveraging partnerships, potential networks, and other integration options that advance business opportunities while supporting population health and the triple aim.

HOW IS POPULATION HEALTH MANAGEMENT BEING IMPLEMENTED?

There are a number of new business and clinical arrangements designed to deliver on the promise of population health. They include those noted below.

The Patient-centered Medical Home

The patient-centered medical home (PCMH) is a model of primary care that is comprehensive, patient-centered, coordinated, accessible, and focused on quality and safety (AHRQ, n.d.). A PCMH features multidisciplinary, team-based care that emphasizes whole health, patient self-management, shared decision-making, health information technology, provider payment reform focused on patient outcomes and health system efficiencies, and team-based education and training support its success. The PCMH model has grown exponentially and is proving effective. Research reveals that a PCMH improves patients' access to care, reduces disparities, and lowers costs (National Committee for Quality Assurance, 2013).

Medicaid Health Homes

Medicaid health home models authorized by the ACA and funded by CMS are similar to a PCMH. However, health homes are designed specifically for individuals with chronic conditions, including comorbid physical and behavioral health disorders. In keeping with population health goals and objectives, health homes models must include:

- Comprehensive care management, care coordination, and health promotion;
- Coordinated transitions in care, including appropriate follow-up, from inpatient to other settings;

- Patient and family support (including authorized representatives);
- Referral to community and social support services; and
- Use of health information technology to link services, as feasible and appropriate (CMS, 2010).

Accountable Care Organizations

An accountable care organization (ACO) is a network of doctors and hospitals that shares financial and medical responsibility for providing coordinated care to Medicare beneficiaries (Gold, 2014). ACOs, authorized by the ACA, make providers jointly responsible for their patients' health. If they deliver high-quality care and save money for the Medicare program, they may share in some of the savings (CMS, 2015). Although an ACO is essentially a shared savings model, it achieves its goals by focusing on providing comprehensive, coordinated care, similar to a PCMH or health home.

Management Service Organizations

A management service organization (MSO) allows providers—especially those in the behavioral health and social service sectors—to straddle the two worlds of emerging health care systems: highly integrated service delivery and new business structures. A PCMH focuses on comprehensive care for a defined population, while a business arrangement such as an independent practice association (IPA) joins groups of physicians in private practice to negotiate with insurance companies. An MSO provides the backend business operations for groups of providers, enabling them to focus on patient care.

For many small organizations that lack the staff and infrastructure to compete successfully in the new health care marketplace, an MSO may be the first rung on the ladder toward a fully integrated, population health approach. MSOs that join behavioral health and social service providers—which historically have offered separate services to the same group of vulnerable individuals—are in an even stronger position to join forces with the medical community in a population health approach.

NEXT STEPS FOR BEHAVIORAL HEALTH PROVIDERS—WHAT YOU CAN DO NOW

Improve Business Operations

The first priority is to ensure that your organization is financially sound and operationally efficient to establish a strong market position and present an attractive opportunity to potential partners for integration activities. Figure 7 outlines core and supportive processes that are necessary for an organization to position itself effectively to support health care reform and integration and, ultimately, to contribute to population health management.

To meet these operational goals, organizations may pursue the following strategic activities (see Figure 8):

- **Market Research**—conducting environmental scans, internal analyses, competitive analyses to better position the organization in the marketplace
- **Financial Assessments**—performing billing, claims, and revenue evaluations and improvements
- **Gap Analyses**—identifying the missing elements to streamline business operations
- **Strategic Business Planning**—determining organization goals, vision, and direction
- **Product Development/Expansion**—planning for growth in areas of strength

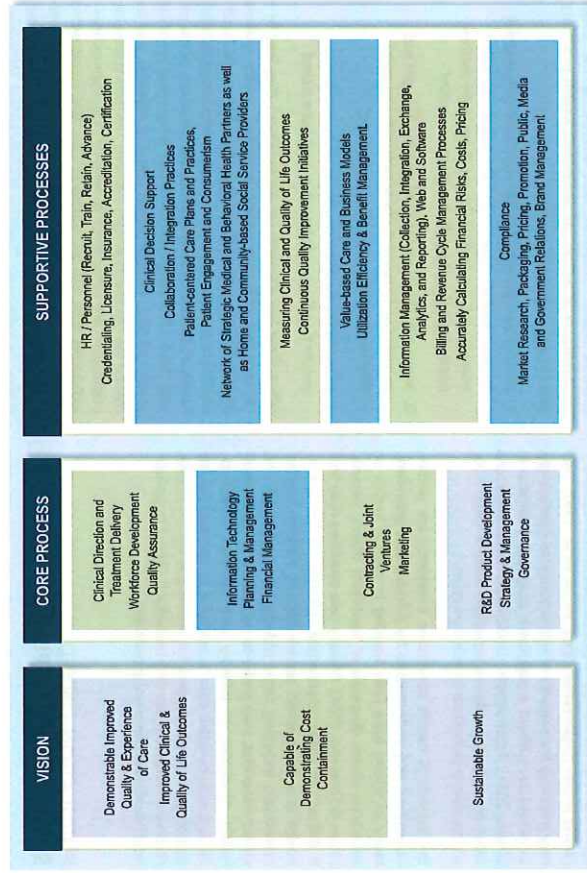


FIGURE 7. Key Internal Operations Necessary for Success in Health Care Reform

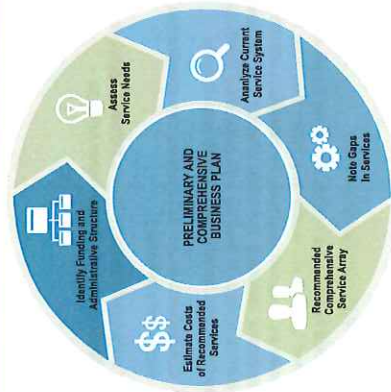


FIGURE 8. Developing a Business Plan to Support Integration

Consider Networks for Integration

By virtue of the fact that they serve special populations at the intersection of primary health and social services, behavioral health providers are well positioned to serve a critical role in integration. There are several options for networks to consider, including integration with a local hospital system, an MSO (as described in the section above), or an IPA, which has the capabilities of an MSO, plus the ability to assume financial risk (see Figure 9).

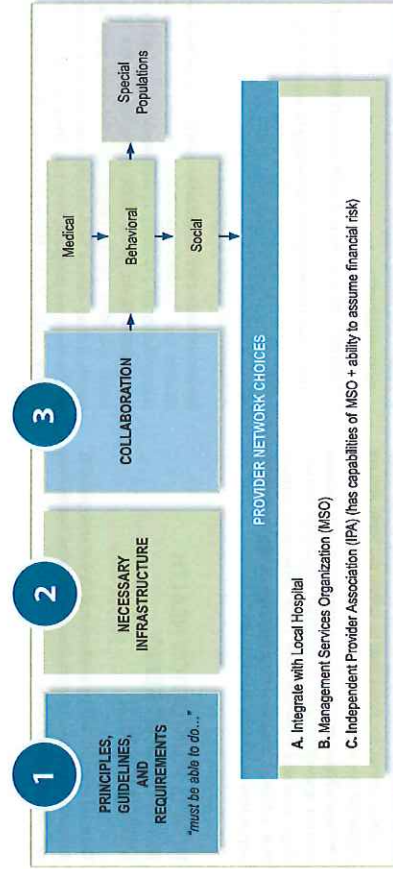


FIGURE 9. Models for Behavioral Health Integration through Network Formation

An IPA is an integrative organizational umbrella that has been a viable form for physician practices for over 30 years. Almost 700 IPAs representing 300,000 physicians operate today, and IPAs are attracting renewed interest as essential components of ACOs. The IPA form of enterprise modeling offers members the ability to achieve efficiency, enhance capacity, and realize growth that individual organizations cannot accomplish on their own.

There are many reasons for behavioral health providers to consider forming or joining a network; for example, if your organization is seeking to:

1. Integrate fragmented systems
2. Consolidate and simplify administration
3. Consolidate revenue management and position for reimbursement reforms and new methodologies
4. Standardize, collect, and measure outcomes
5. Decrease operating costs
6. Improve access to care and services
7. Enhance continuity of care
8. Standardize and optimize quality
9. Develop the workforce

Organizations considering network formation must consider the many opportunities and challenges and have a systematic approach to evaluating opportunities (see Figure 10).

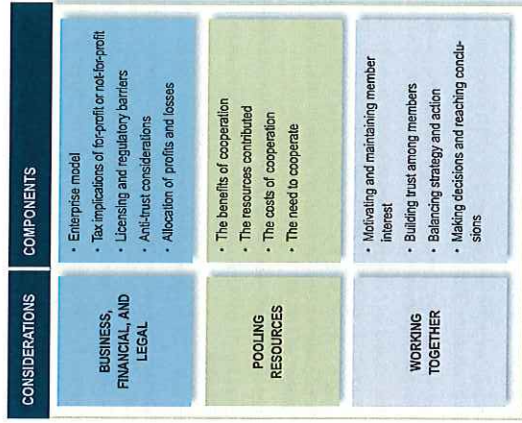


FIGURE 10. Considerations and Components of Network Formation

The network development process is composed of a six-step process that can be applied across any number of organizations considering participation.

1. **Visioning**—a facilitated process wherein providers decide what type of business entity (MSO or IPA) they would prefer to build and what kinds of services they would prefer to offer.
2. **Forming**—a facilitated process wherein participating providers form the entity, name it, form a board of directors and various committees, and make decisions as to for-profit or not-for-profit status. For-profit entities begin to incorporate and make decisions regarding shares and pricing.

CONCLUSION

Population health management is not the latest buzzword in health care—it is the best and only way to ensure better health, better care, and lower costs for vulnerable populations, including the individuals with multiple, comorbid conditions that behavioral health providers serve. AHP and the behavioral health and social service providers with which it works are uniquely positioned to improve population health. Focusing on key agency enterprises, such as improved business operations and health care integration through forming provider networks, behavioral health organizations can take advantage of exciting emerging business opportunities. Together, behavioral health and social service providers, collaborating with their primary care partners, can address health in its broadest sense—including all of the factors that determine why people become sick and how they can become and stay well. There isn't a moment to lose.

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AHP is available to discuss population health and population-linked service systems. AHP has the necessary behavioral health subject matter expertise, cutting edge information on policy and practice, and historic context to provide a rapid start and lasting value. AHP supports its clients with assessments, design and redesign, strategic and tactical planning, detailed implementation planning, research and evaluation, and technical assistance.

Thank you for the opportunity to share these ideas. We look forward to discussing them further with you.

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