

BUILDING AN EFFECTIVE BEHAVIORAL HEALTH ENGAGEMENT MODEL

STRATEGIES FOR COMMERCIAL, MEDICAID, AND MEDICARE
POPULATIONS

September 27, 2019



ARCADIA

BREAKFAST AGENDA

- 1 Welcome from Arcadia
- 2 Why build a chronic and complex patient management program for behavioral health?
- 3 Setting appropriate goals and measures
- 4 Population identification strategies
- 5 Approaches, staffing, and trigger opportunities for patient engagement
- 6 Engaging and supporting primary care providers
- 7 Q&A



BUILDING AN EFFECTIVE BEHAVIORAL HEALTH ENGAGEMENT MODEL

HEATHER TRAFTON, MBA, PA-C



**CHIEF OPERATING OFFICER
ARCADIA**

Before joining Arcadia.io as Chief Operating Officer this year, Heather Trafton, MBA, PA-C was the Senior Vice President and COO of National Operations at Steward Health Care Network (SHCN). SHCN remains one of the largest ACOs in the country, operating in 11 states with 5,500 contracted physicians serving 2.1 million paneled lives. SCHN also operates a Health Plan for 400K lives covered by four products in two states.

Heather led networkwide performance at SHCN to high value in risk-based contracts, driving operations across six states for both the ACO and Health Plan with a team of 500+ employees. She was responsible for provider engagement and field operations, clinical programs for both physical and behavioral health, population health programs, performance improvement in quality, risk adjustment and patient experience.

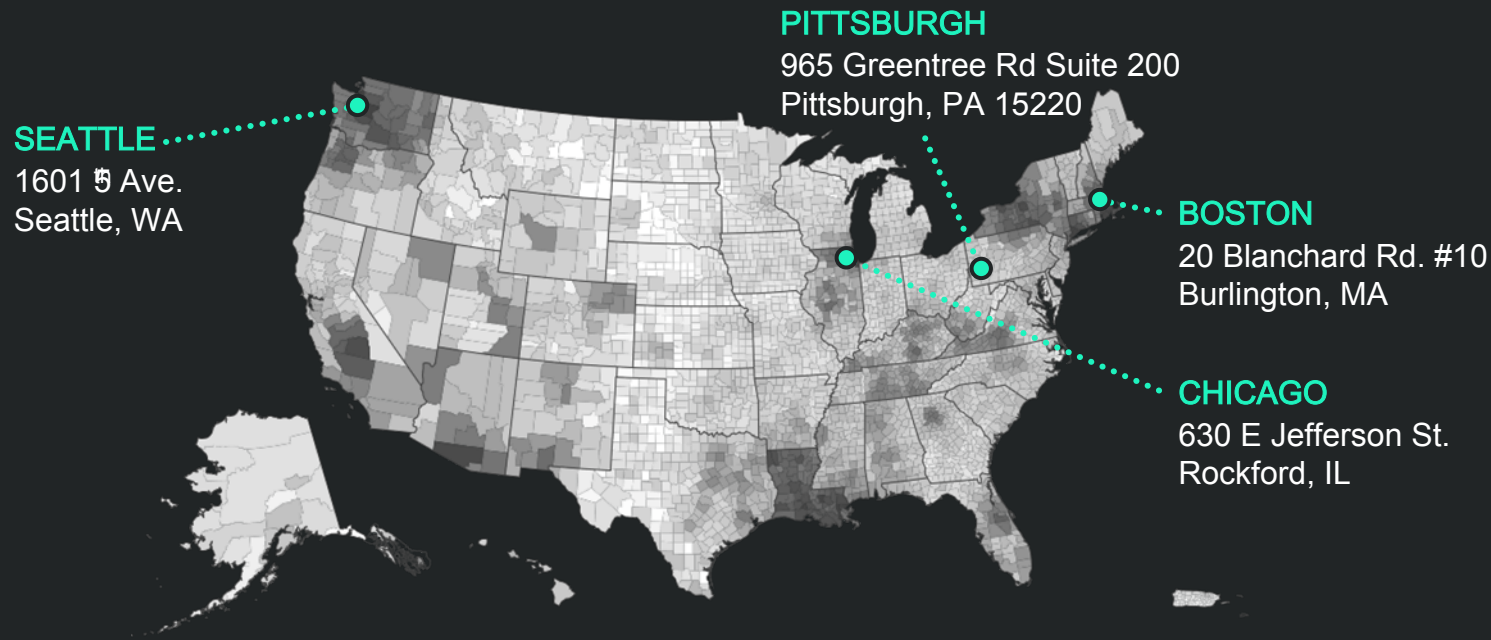
Heather guided operational performance improvement for pay-for-performance risk contracts, driving the critical linkage between budget drivers and organizational efforts to improve quality, reduce risk and reduce unnecessary and preventable resource expenditures for both the ACO and Health Plan.

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ABOUT ARCADIA

ARCADIA IS A **POPULATION HEALTH MANAGEMENT** COMPANY, SPECIALIZING IN DELIVERING VALUE-BASED CARE ANALYTICS AND CARE MANAGEMENT TO THE ENTERPRISE. WE CULTIVATE HIGH-QUALITY DATA ASSETS, ENABLING OUR CUSTOMERS TO EFFECTIVELY MANAGE RISK.

ARCADIA HAS ANALYZED OVER **50 MILLION** PATIENTS NATIONALLY



50M

PATIENTS
MEASURED



2.5x

HIGHER ACO
PERFORMANCE



\$8.9M

AVG SAVINGS
IN MSSP



40+

EHR
VENDORS
CONNECTED



2002

YEAR
FOUNDED



No.1

VALUE-BASED
SERVICES

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WHY BUILD A PROGRAM FOR BEHAVIORAL HEALTH PATIENTS?



BROADLY-AFFECTED POPULATION

On average, 46% of the adult population is struggling with mental health issues, 60% of them never seek treatment from a provider. 70% of adults who suffer from a behavioral health condition have comorbid medical conditions.



SIGNIFICANT IMPACT ON OUTCOMES, UTILIZATION

Patients with primary or secondary behavioral and mental health conditions typically have poorer physical health outcomes and higher medical utilization. Up to 30% of Diabetes patients also suffer from depression.



PRIMARY CARE ACCOUNTABLE BUT NOT WEL-EQUIPPED

In the current health system today, PCPs are responsible for patient outcomes and total cost of care of these patients, but typically need support to care for chronic and complex behavioral or mental health conditions.



ACCESS CHALLENGES

Referring patients to BH providers can be challenging for PCPs, due to a fragmented market of small practices and decentralized information. To date, the behavioral health space has not undergone the evolution and consolidation we have seen in the medical community.

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SETTING APPROPRIATE GOALS AND MEASURES

CONTRACT PERFORMANCE OUTCOMES

- ▶ Better chronic disease outcomes (better control and less acute utilization)
- ▶ Decrease inpatient admissions and ED visits
- ▶ HEDIS measures specific to BH

ACO OPERATIONAL GOALS

- ▶ Increase ambulatory access to BH providers with contracted Network
- ▶ Make referrals to appropriate services before escalating risk patients are in crisis
- ▶ Provide for telephonic and face-to-face outreach in support of care plans
- ▶ Establish behavioral health clinical programs to support high need patients

PROVIDER SUPPORT GOALS

- ▶ Connect members to community resources and supports
- ▶ Surface high risk patients for development of outreach and care plan
- ▶ Improve coordination between providers

PATIENT SUPPORT GOALS

- ▶ Increase timely access to behavioral health providers
- ▶ Improve adherence with treatment recommendations
- ▶ Provide ongoing in the community and telephonic support
- ▶ Develop safety/crisis plans

Measurement Considerations

Example

Understanding of risk contract TCOC/TME calculations as it relates to BH/SUD

BH and SUD are included in TCOC/TME calculation but certain information stripped in claims

Risk stratification of patient population to identify patients with opportunity (quality improvement, improve TME), total potential value to the contract impact

BH patients who have had 3 inpatient admissions, 3 ED admissions, or met other criteria in the past year

Can you identify them early enough to make an impact, what are potential ways to identify these patients

Claims, emergency rooms, group homes, transitions of care

Based on assumptions of identification opportunities to total opportunity, is there enough potential value to establish a program

Yes, an estimated 4,500/10,000 patients meet the criteria and assumption identifiable

Determine the impact assumptions of building a program around this population both quality measure impact + value from TME reduction

% reduction in IP, % reduction in ED, % improvement in 3 BH quality measures = X\$

ROI target of 2.5:1 meaning Value/expense

5% reduction in total cost of care from baseline = \$2.5 million, expense 8 staff at \$1 million; 2.5:1

What staffing will you need, multidisciplinary staffing models, social works and community health workers

8.0 FTE: 4.0 social workers, 3 CHW and 1 supervisory position



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BEHAVIORAL HEALTH ENGAGEMENT MODELS...

Different patients, different needs, different programs

FIT WITHIN A
BROADER
PORTFOLIO OF
SERVICES

- ▶ Post-acute transitions of care
- ▶ Complex/chronic medical care management
- ▶ **BH complex care management**
- ▶ Post-acute care strategy
- ▶ **Embedded in practice care coordination**
- ▶ Disease specific (CHF) management initiatives
- ▶ **Community-based services partnerships**
- ▶ **Social Services (SDOH focus)**

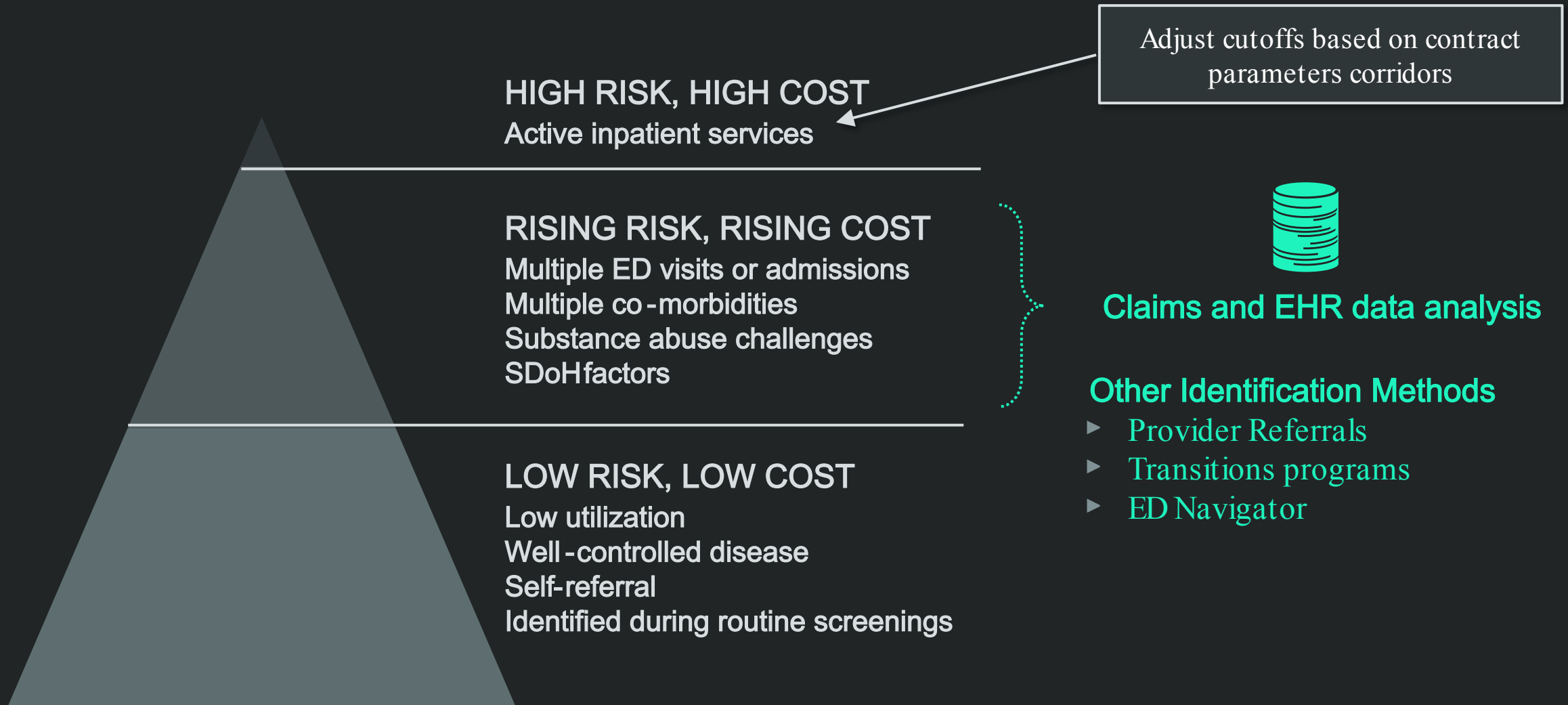
High-risk members who need 3-6 months of intensive support

Meeting patients in places they are in the community

Additive to patients in other programs that need help with SDOH resources

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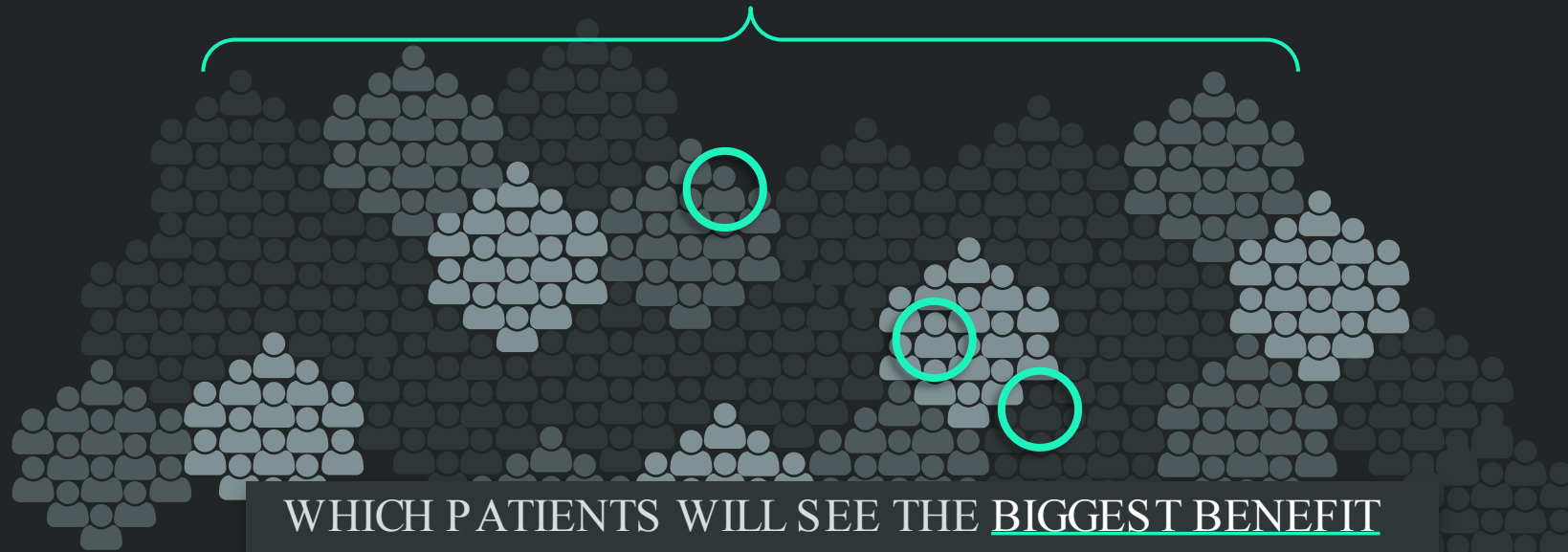
POPULATION IDENTIFICATION



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POPULATION IDENTIFICATION

5-10 SOCIAL WORKERS
TARGET 5000 MANAGED PATIENTS



WHICH PATIENTS WILL SEE THE BIGGEST BENEFIT
FROM ENGAGEMENT/MANAGEMENT? And, which
patients are the best fits for a specific program?

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CHALLENGES WITH TRADITIONAL APPROACHES

1

HIGHEST RISK/COST PATIENTS ARE
NOT GENERALLY IMPACTABLE
WITH CARE MANAGEMENT
(CANCER, ACCIDENTS)

3

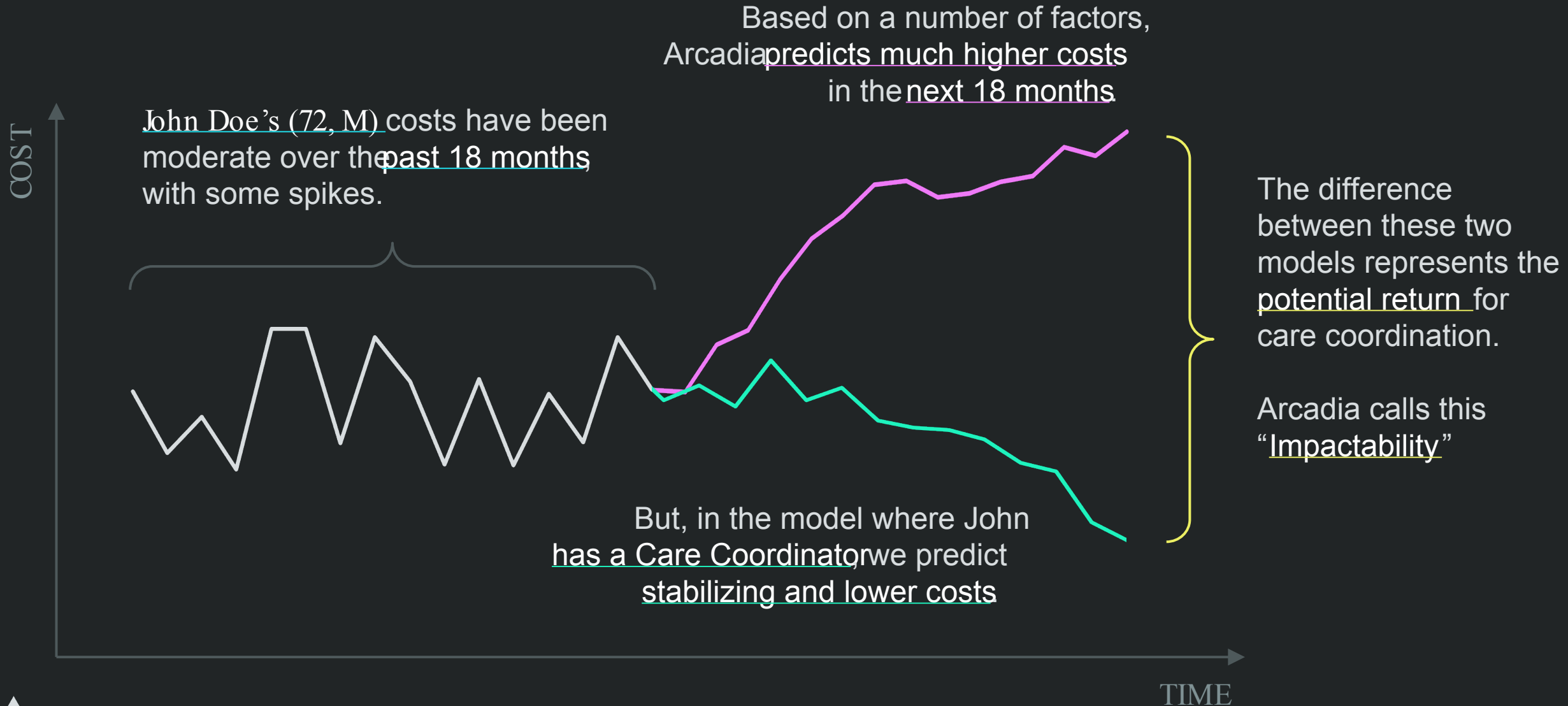
TRADITIONAL RISK ALGORITHMS
DO NOT CONSIDER ALL THE DATA
NEEDED TO PREDICT WHO WILL
BENEFIT FROM CARE
MANAGEMENT, BH AND SDOH
HAVE TRADITIONALLY NOT BEEN
INCLUDED

2

TRADITIONAL RISK ALGORITHMS
ARE DESIGNED FOR RISK
ADJUSTMENT AND MEDICAL MORE
THAN POPULATION
STRATIFICATION AND BH/SDOH
SPECIFIC IDENTIFICATION

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MEASURING IMPACTABILITY



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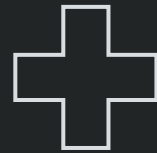
PREDICTIVE ANALYTICS FOR PATIENT IDENTIFICATION

- ▶ **Predictive modeling:** Using data and clinical insights to try to find patients who are most likely to benefit from clinical and support programs.



Clinical Insights

Research, best practices, and expert clinical experience



Data Insights

Machine learning over a sufficiently large data set

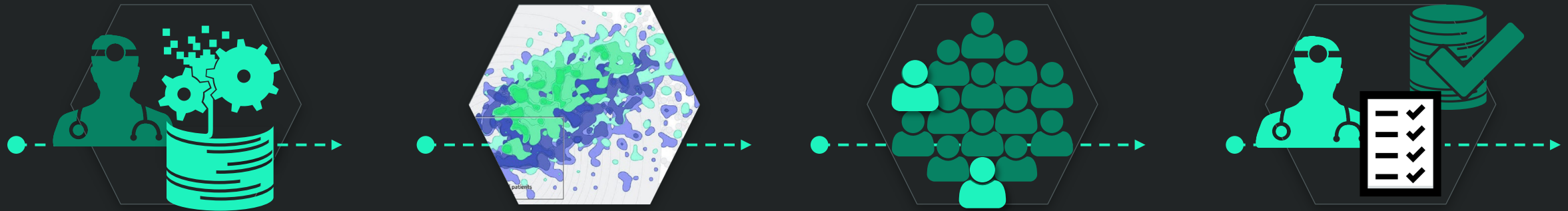


Predictive Model

Which patients are most likely to benefit from interventions?

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PREDICTIVE ANALYTICS FOR PATIENT IDENTIFICATION



- ▶ **Predictive algorithm** developed over massive data set using machine learning, clinical insights

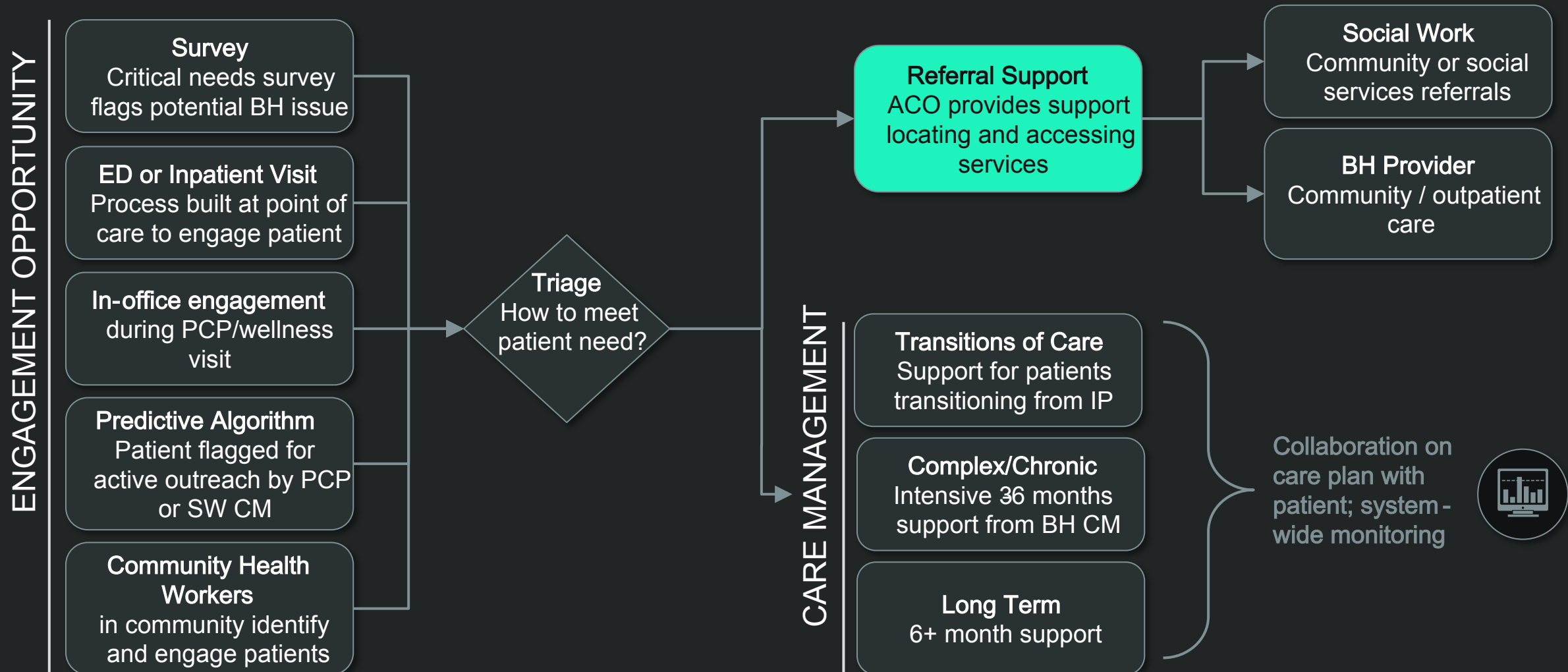
- ▶ Predictive algorithm used to stratify patient population and score individual patients

- ▶ Scoring used to identify patients for programs – based on profile fit

- ▶ **Clinical review** of algorithm-identified population opportunity for provider referral

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PATIENT ENGAGEMENT



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PATIENT ENGAGEMENT CONSIDERATIONS

STAFFING CONSIDERATIONS

- ▶ Have community workers or licensed **staff in the right places** to find patients: ED, group homes, community centers, etc.
- ▶ Social worker expertise in available services by region
- ▶ For **pediatric patients**, embed support within the practice to engage patients at wellness visits
- ▶ Develop **community partnerships** for expedited access to services

OUTREACH CONSIDERATIONS

- ▶ Patients **less likely to have valid contact information** on file – develop processes across care settings to engage patients when they present
- ▶ **SDoH factors** impact Medicare patients as well as Medicaid patients – be sure to ask early and **have clear pathways for referrals** to social services

TRIGGER OPPORTUNITIES

- ▶ **Care Needs Screening** – if patient completes survey tool, much more likely to engage
- ▶ **ED and inpatient visits** offer strong opportunities, if a process is in place to engage and follow up with patients

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PROVIDER SUPPORT

CHALLENGES

- ▶ Held to quality and TCOC performance standards for BH patients and SUD
- ▶ These patients are often difficult to identify
- ▶ Practices not generally staffed to meet the needs of patients with chronic or complex BH and SUD conditions
- ▶ Referrals to BH providers and social services can be challenging to navigate and time intensive



ACO SUPPORT GOAL

Reassure PCPs that if they ask about BH issues during encounter, they have access to a team

SUPPORT STRATEGIES

- ▶ **Centralized ACO support for referrals** to help PCPs and patients access appropriate BH and SUD services
- ▶ **Trained ED and inpatient navigators** to engage and support patients in crisis
- ▶ **ACO-provided social work care managers** for chronic and complex patients

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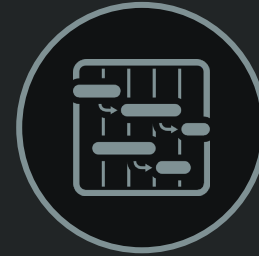
OPERATIONAL AND TECHNICAL INFRASTRUCTURE



DATA & TECHNOLOGY

FOUNDATION

- ▶ **Comprehensive data asset**
- ▶ **Population stratification**
- ▶ **Real-time insights** into process and outcome measures



ACO RESOURCE

CONSIDERATIONS

- ▶ **Analysts and medical economists** extremely helpful in making use of the data
- ▶ **Project management capabilities** are critical to execute across a portfolio of initiatives



OPERATIONAL

EXECUTION


- ▶ Ensure process **well-communicated** at every care setting, from PCP office, hospitals and community settings

BUILDING AN EFFECTIVE BEHAVIORAL HEALTH ENGAGEMENT MODEL QUESTIONS?



HEATHER TRAFTON, MBA, CPA

 heather.trafton@arcadia.io

 <https://www.linkedin.com/in/heathertrafton-43961914/>