Utilizing Emerging Virtual Care Methods and Population Health Platforms to Redefine Access to Behavioral Health Services within the Ambulatory Care Setting

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Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

OR

The presenters of this session currently have or have had the following relevant financial relationships (in any amount) during the past 12 months.
Conference Resources

Slides and handouts shared by our conference presenters are available on the CFHA website at https://www.cfha.net/page/Resources_2019 and on the conference mobile app.
Learning Objectives

At the conclusion of this session, the participant will be able to:

- Understand how care delivery systems focused on telehealth, virtual care, and skill optimization are driving access to behavioral health services in a financially sustainable model targeting population health.
- Articulate the business reasons for integrating behavioral health into primary care and identify the appropriate measurements to evaluate effectiveness.
- Design quantifiable metrics relative to program impact on health outcomes, symptom improvement, resource utilization and overall cost of care.
Learning Assessment

- A learning assessment is required for CE credit.
- A question and answer period will be conducted at the end of this presentation.
OUR MISSION:

TO IMPROVE

ELEVATE

AND ADVANCE

HEALTH

HOPE

HEALING

- FOR ALL

VISION:

TO BE THE FIRST AND BEST CHOICE FOR CARE
The State of Behavioral Health

- One in five adults suffers from a diagnosable mental disorder.
- 43.8 million adults experience mental illness in a given year.
- Untreated mental health and substance abuse disorders cost the US $250-$500 billion per year.
- $193 billion per year in lost workplace earnings due to untreated mental illness.
- Even beyond the United States, mental illness is the #1 cause of disability life years worldwide, vastly outnumbering those caused by cardiovascular disease and cancer.
- With proposer diagnosis and effective treatment, the recovery rate for patients with mental illness is 60-80%.
- But in today's environment, the effective recovery rate is only 5-10% due to such limited resources and infrastructure.
Atrium Health will develop a transformative, clinically integrated, and sustainable system of high-quality, patient- and family-centered care to serve the Behavioral Health needs of patients, their families and the community.
Population Health Management (Customized Coordinated Care)

![Wellness/Illness Burden Pyramid](image)

- **Continuing Care**
  - Catastrophic Conditions
  - Multiple Chronic Conditions

- **Medical Home**
  - Uncontrolled CDM
  - Mod complex CDM
  - Early/Mild/Pre CDM
  - Wellness & Prevention
  - Episodic Illness

- **Health & Wellness**
  - Stable
  - At Risk for Multiple Chronic Conditions
  - Healthy

- **Illness Burden**:
  - Bands 1, 2, 3, 4, 5

- **Percent of Population**:
  - 2%
  - 8%
  - 20%
  - 20%
  - 50%

- **Percent of Cost**:
  - 32%
  - 28%
  - 24%
  - 10%
  - 6%

Adapted from BCBC MD CareFirst
Emphasis on Reducing Low Value Care

Low Value Care
- Overutilization of Services
- Inappropriate Care
- Anecdotal care as opposed to evidence based care

Patient Impact
- Inconsistent Care
- Inability to Afford Out of Pocket expenses for high-cost services
- Access Problems

“Bigger than higher prices, administrative expenses and fraud, however, was the amount spent on unnecessary healthcare services.”

“In just a single year, up to 42% of patients received “low-value care”

-Atul Gawande, Harvard University
Virtual Care... Not just Technology
Care is Care

Core Competencies

- Virtual Care Clinical Teams
- Clinical Culture & Workflow
- Telemedicine Platform
- Data, Algorithms & Reporting

Benefits

- Evidence Based
- Timely Access
- Scalability
- Industry Alignment
- Sustainability

CFHA - COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION
Why Primary Care?

Stigma is Lower
Greater than 50% of all psychotropics prescribed by PCPs
70% of PCP visits involve a behavioral concern
50% of patients referred to psychiatry do not attend appointment
2/3 of PCPs report limited access to BH services

Patient Centered

- Improve early detection
- Timely access to services
- Identify patients that require a psychiatric referral
- Drive cost-effective & clinically effective treatment
- Support the primary care provider

“The key to making team-based medical care work...is helping the patient feel that his or her relationship with the primary-care provider is at its center.”
vBHI Model

The Collaborative Care Model

- PCP
- BHP/Care Manager
- Consulting Psychiatrist
- Other Behavioral Health Clinicians

Additional Clinic Resources
- Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources

Outside Resources

The Team

Behavioral Health Professional
- LCSW/LPC, Psych RN

Health Coach
- Bachelor level with two years' experience
- Obtain Health Coach Certification within 1 year of hire date

Provider
- Adult Psychiatrist
- Child and Adolescent Psychiatrist
- Nurse Practitioner

Pharmacy
- Board Certified Psychiatric Pharmacist (BCPP)
Screening is the Driver, Standardization makes it scalable and sustainable

**Standardized tools in the PCP setting enhance screening, diagnosis, and treatment planning**
Process

PCP consults BH Provider for curb side chart review

Elevated PHQ-9 Scores Captured in BH Patient Registry

PCP Office

PCP Office Administers PHQ-9

PCP Appointment

PCP initiates in office video visit if needed

Post Appointment Call Back Protocol

BH Patient

Virtual BH Support Team

PCP Office
2018 Outcomes

Entry Point

Access to vBHI

vBHI by the Numbers (2018)

15,601 Unique Patients
86,303 Patient Encounters
1,006 Patients Active Patients
25 Primary Care Practices
7 Pediatric Practices
70+ Care Management Clinics

TEAMMATE INTERVENTIONS

Total Encounters 86,303
## Outcomes

<table>
<thead>
<tr>
<th>Disease Severity</th>
<th>Clinical Outcomes</th>
<th>Healthcare Utilization</th>
<th>Cost of Care</th>
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<tbody>
<tr>
<td>▼ Depression symptoms</td>
<td>▶ Weight/BMI</td>
<td>▼ Inpatient Visits</td>
<td>▼ Overall</td>
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<td>▼ Anxiety symptoms</td>
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<td>▼ Inpatient Days</td>
<td>▼ Inpatient</td>
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<td>▼ Suicide ideations</td>
<td>▼ Cholesterol (Total, triglycerides, LDL, HDL)</td>
<td>▲ Ambulatory Visits (Primary/Specialty)</td>
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<td>▼ Avoidable ED/IP Visits</td>
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Symptom Improvement

**Depression**
- 60.2% of patients receiving BHI services demonstrated 50% reduction in PHQ-9 score

**Anxiety**
- 65.9% of patients receiving BHI services demonstrated 50% reduction in GAD-7 score

**Remission**
- 44.1% of patients receiving BHI services achieved remission

**Suicidal Ideations**
- 88.0% of patients receiving BHI services endorsed absence of suicidal ideations upon completion of Health Coaching
Clinical Outcomes

**Weight**

- Mean weight in kilograms:
  - 24-month PRE: 88 kg
  - 24-month POST: 88 kg

- Sample size: n=430

**Hgb A1C**

- Patients in each Hgb A1C category:
  - Normal: 57 patients
  - Elevated/poorly controlled: 7.1%
  - Severely elevated with risk of complications: 7.2%

- Sample size: n=50

**Lipids: Total Cholesterol**

- Patients in each total cholesterol category:
  - Optimal: 100
  - Intermediate: 105
  - High: 106

- Mean total cholesterol:
  - 24-month PRE: Optimal: 185.6, Intermediate: 100.8

- Sample size: n=151
Avoidable Inpatient Care and ED Utilization

- There was **27%** reduction in avoidable inpatient visits (from 33 visits pre- to 24 visits post-intervention). Inpatient visits were classified as avoidable using AHRQ Prevention Quality Indicator (PQI) methodology.

- There was **7%** reduction in avoidable ED visits (from 621 visits pre- to 578 visits post-intervention, \( p = .883 \)).

- Visits were classified as avoidable using NYU ED Algorithm (types of avoidable visits included: NonEmergent, Emergent but PCP Treatable and Emergent but preventable).
Key Takeaways...

This work puts the **patient first always** – integrated into the **full continuum**, including prevention and community health.

**Standardized work** in development and being refined (incl. teammate expectations and tools that need to be followed).

Utilize **data analytics** to drive focus and improve outcomes. **Coordination is essential**; expectation that as a team... we make sure this happens 100% of the time.

Efforts to **scale** will be **critical for success** – we will prioritize to ensure this happens.
Session Survey

Use the CFHA mobile app to complete the survey/evaluation for this session.
Join us next year in Philadelphia, Pennsylvania! Thank you!