

IHC Mental Health Integration

Primary Care Clinical Programs
IHC Community Team



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Vicky Cattrell, Executive Director NAMI, Consumer Leader

Community Health Plan Partners: IHC, DMBA, Medicaid, PEHP, UHC

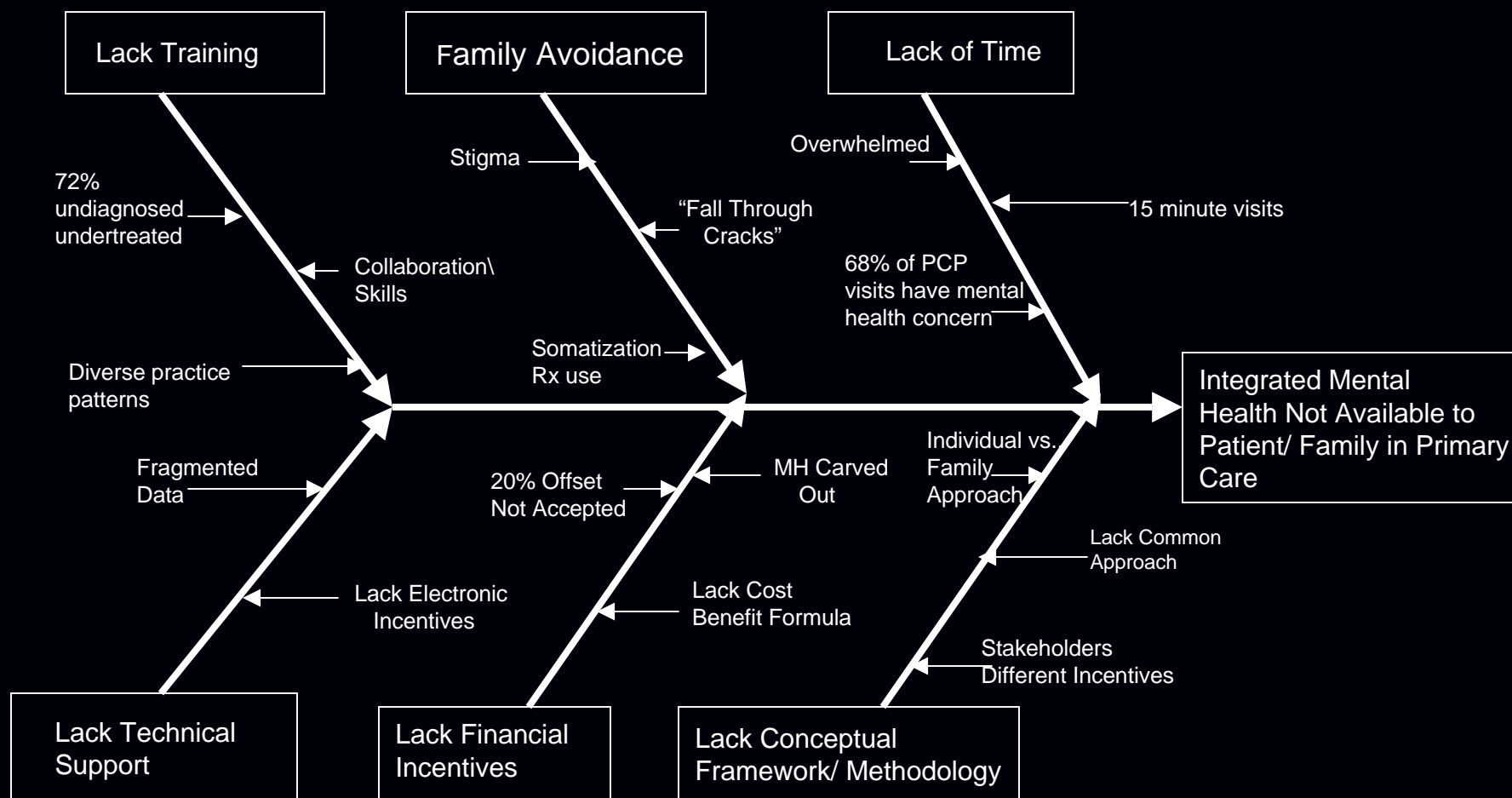
**National Partners: RWJ, Dartmouth/MacArthur, Columbia, Hartford,
SAMHSA**

Problem Statement



- 300% increase MH treatment in PC 1990-2000
- Hospital ER 20% increase
- Depression/MH conditions second to Cardiovascular disabilities by 2020
- Evidence based treatment available
- Delivery models inefficient and ineffective
- WHO 2001 Report: integration/reform

Cause and Effect Diagram



IOM Study Quality Service Gaps



- Care Coordination
- Patient Self Management
- Financing the Business Case
- Information Technology
- Community Activation /Coalition Building
- Measurement

Depression: Key Levers to Overcome Barriers to High Quality Care



1. Team approach to comprehensive care should be emphasized, incentivized and drive “pay for performance”.
2. Uniform electronic medical record that is easily accessible, increases efficient communication among team and for patient and family self-management.
3. Understand what people with depression, and those at risk for , or families living with depression want and need to improve their care and quality of life.
4. Require financial alignment/support to accomplish integration goals.
5. Facilitate sharing of best practices including economic cost modeling.

“A quality investigation of the impact of mental health integration on primary care delivery outcomes: detection, functional improvement, cost and satisfaction”



Hypotheses

Implementation of Mental Health Integration would:

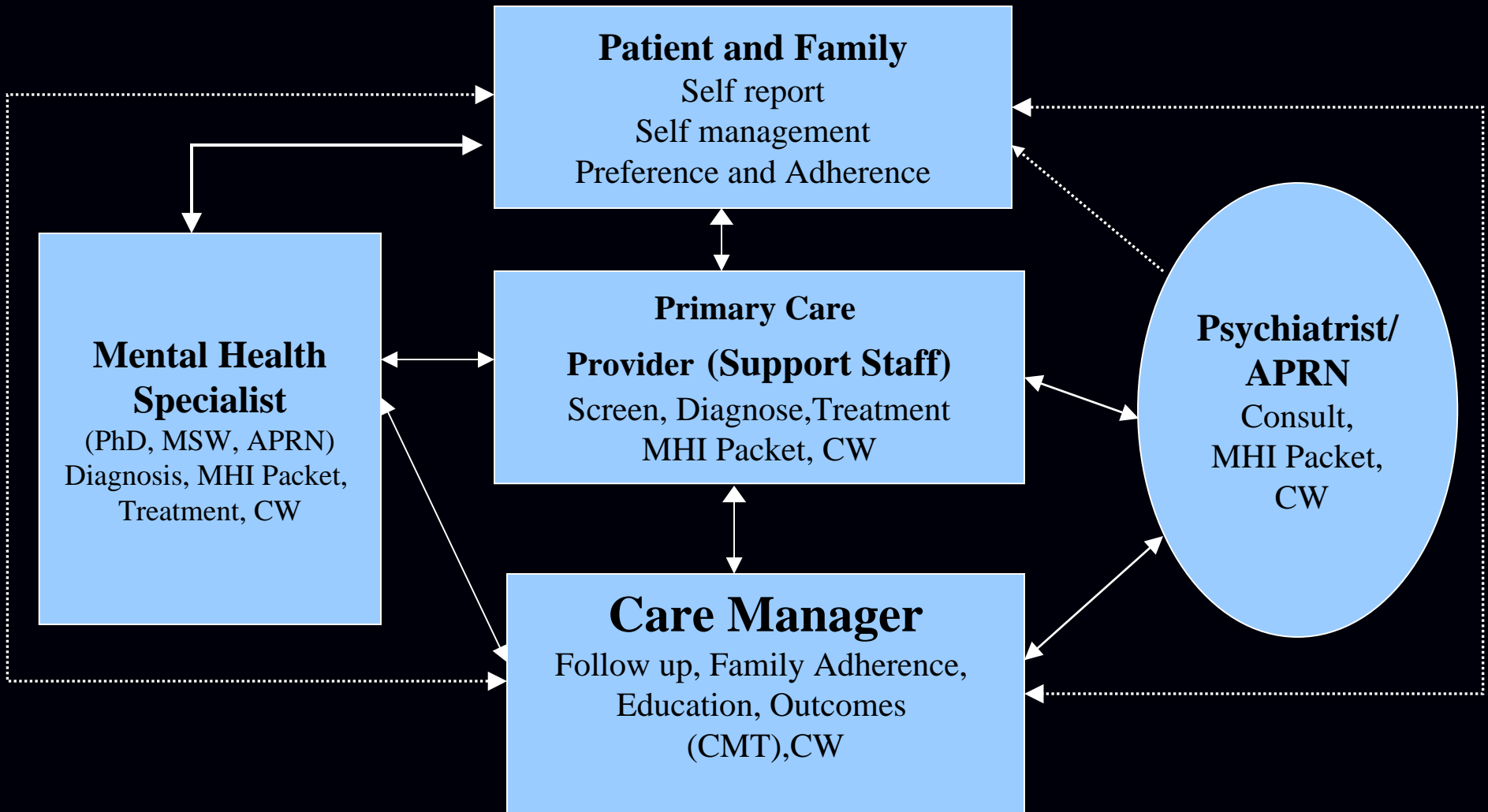
1. Improve PCP ability to identify and confidently treat mental health conditions.
2. Improve detection rate.
3. Improve patient functional status and satisfaction with care.
4. Minimize burden of costs and access barriers.

Method



- Develop MHI quality work teams (Onsite/offsite integrated teams)
- Redesigned delivery: collocation to integration
“Quality Principles”
- Built family health mission
- Developed health clinic accountability: **PD
Regional Proforma**
- Analyzed intervention and comparison clinics
- Link cost value to point of recovery

The Clinical Model : “Patient Walk Through”



Evaluation of Cost Outcomes



➤ Payer Costs

- Analysis of claims data
- Trend & cohort (system/region/clinic)
- Individual & Family

➤ Employer Costs

- Analysis of productivity impact results
- Individual & Family

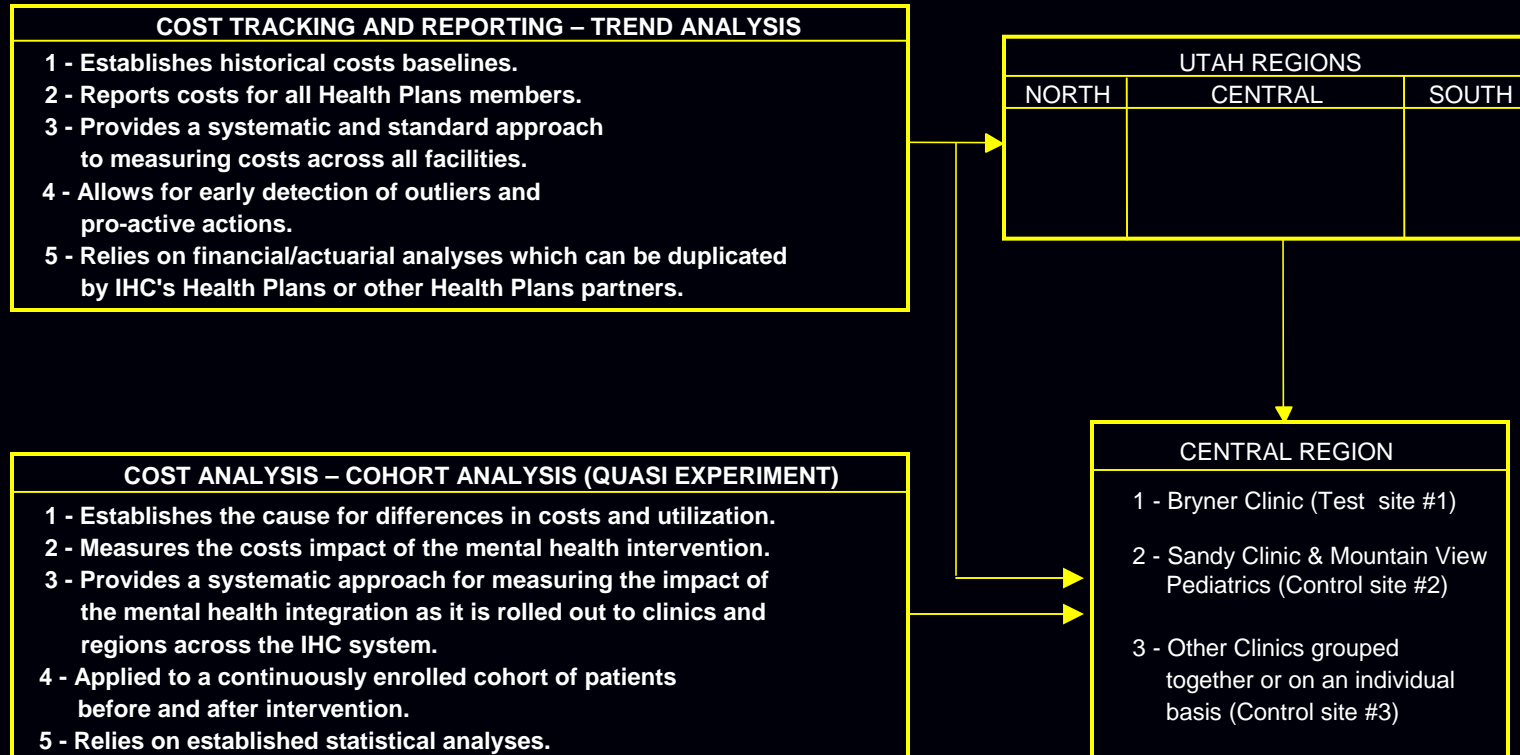
➤ Operational Costs

- Efficiency of care, productivity of care managers, physicians and MH Specialists

Cost Analysis Framework



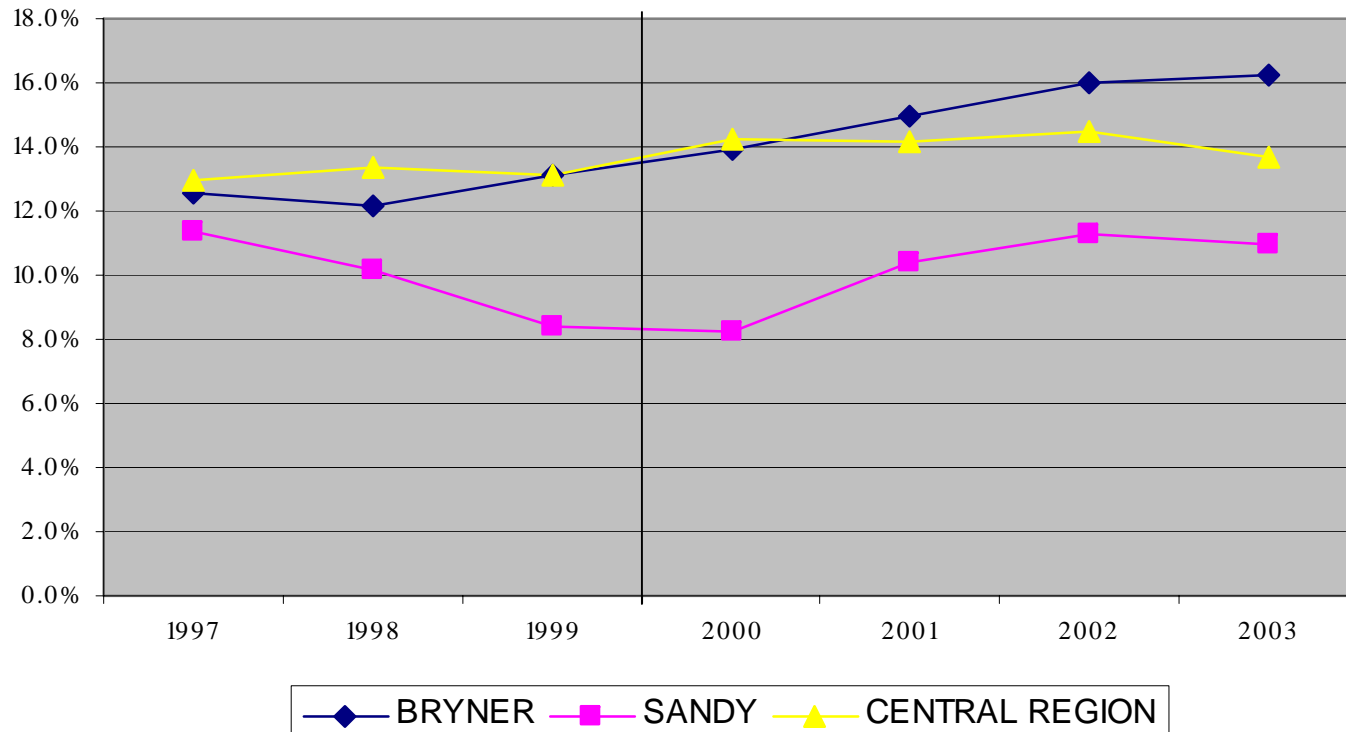
MENTAL HEALTH ANALYSIS FRAMEWORK FOR ADULT AND PEDIATRIC PATIENTS, AND THEIR FAMILIES



Trend Analysis For Adult Patients with DX of Depression

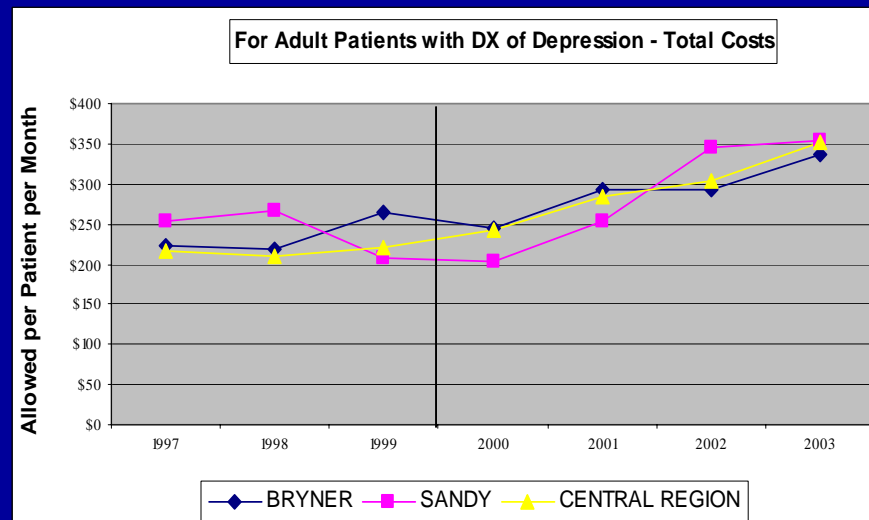
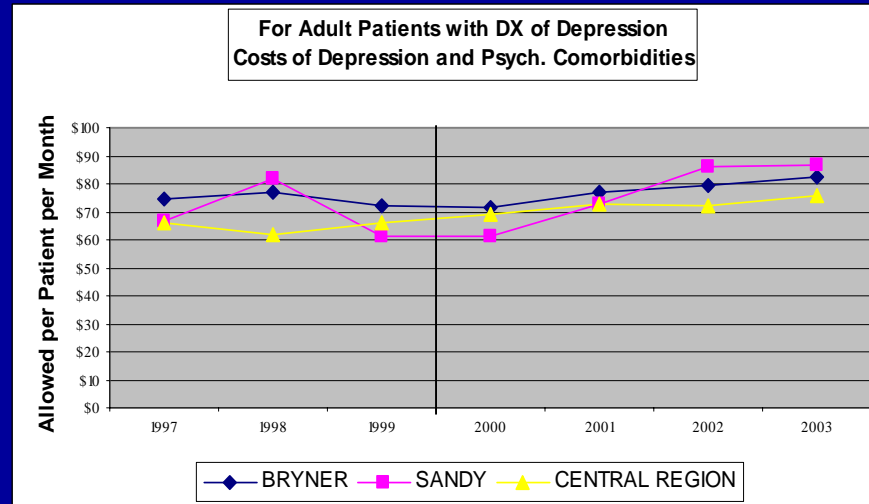


For Adult Patients with DX of Depression - Rate of Detection



Trend Analysis

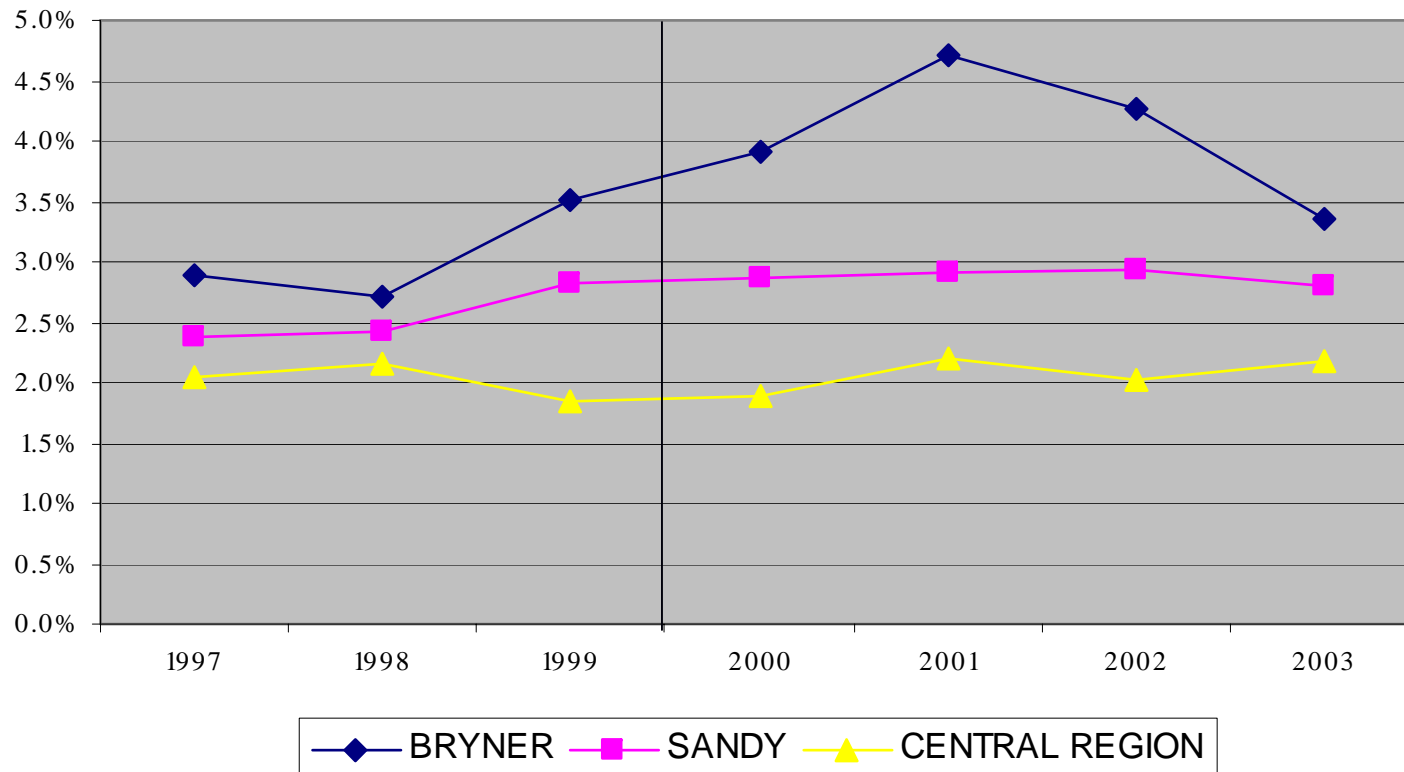
For Adult Patients with DX of Depression



Trend Analysis For Pediatric Patients with DX of Depression



For Ped Patients with DX of Depression - Rate of Detection

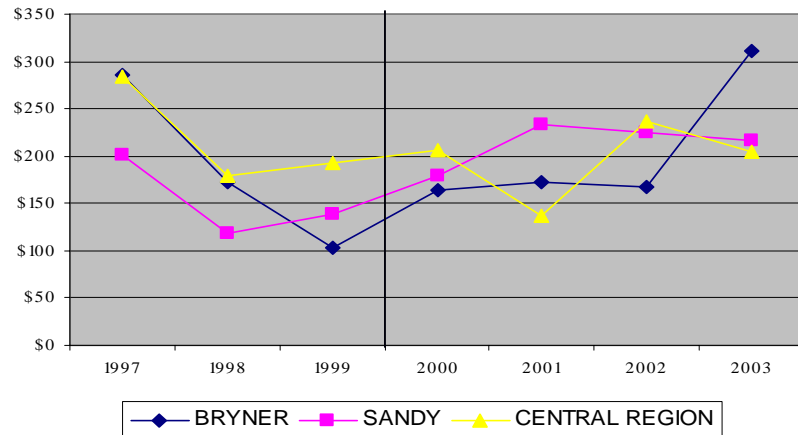


Trend Analysis

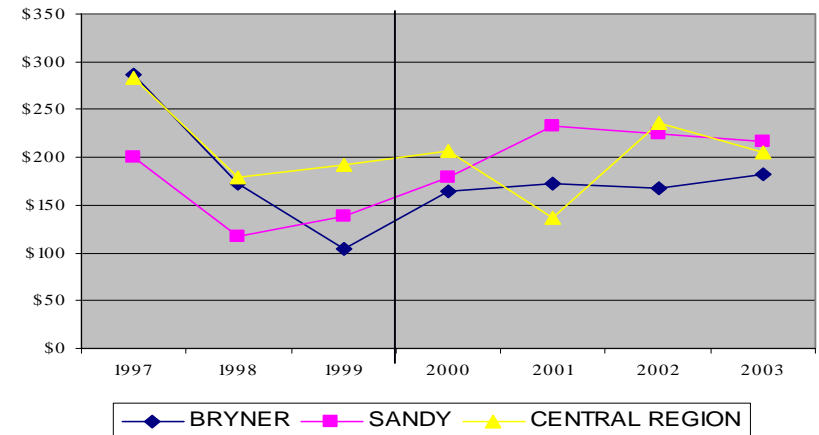
For Pediatric Patients with DX of Depression



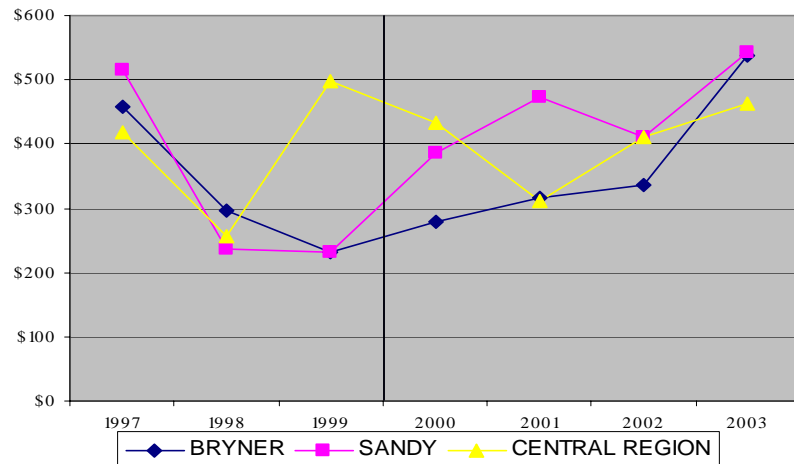
For Patients with DX of Depression - Costs for Depression and Psych. Comorbidities



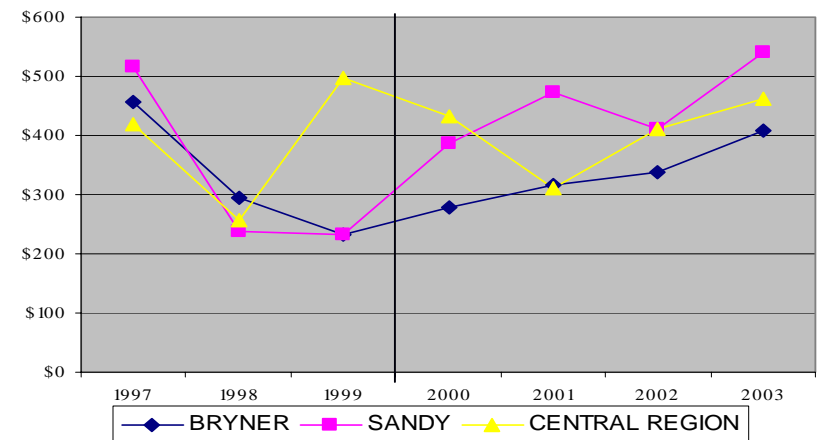
For Patients with DX of Depression - Costs for Depression and Psych. Comorbidities - No Outliers for Bryner in 2003



For Patients with DX of Depression - Total Costs



For Patients with DX of Depression - Total Costs No Outliers for Bryner in 2003

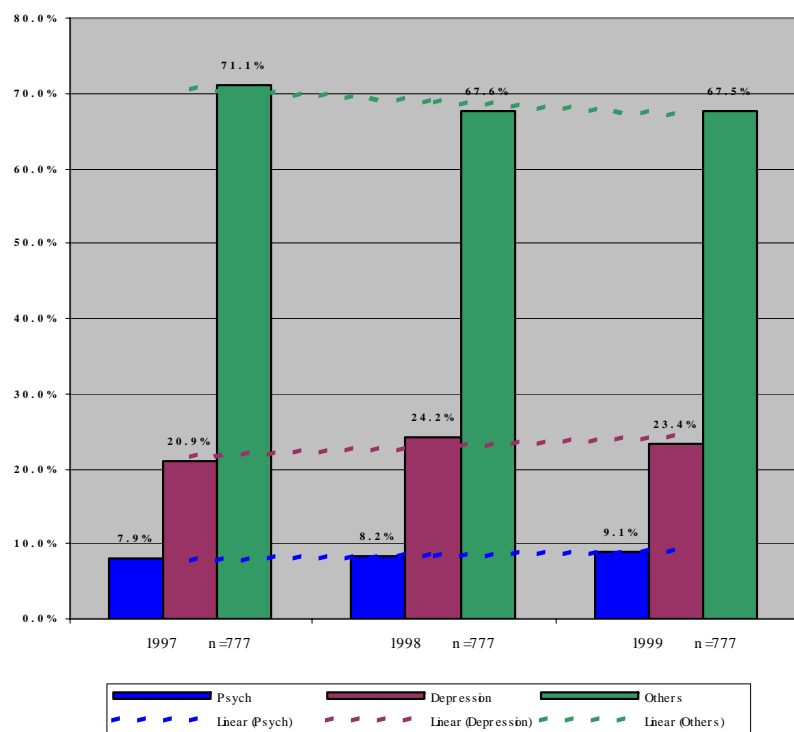


Cohort Analysis

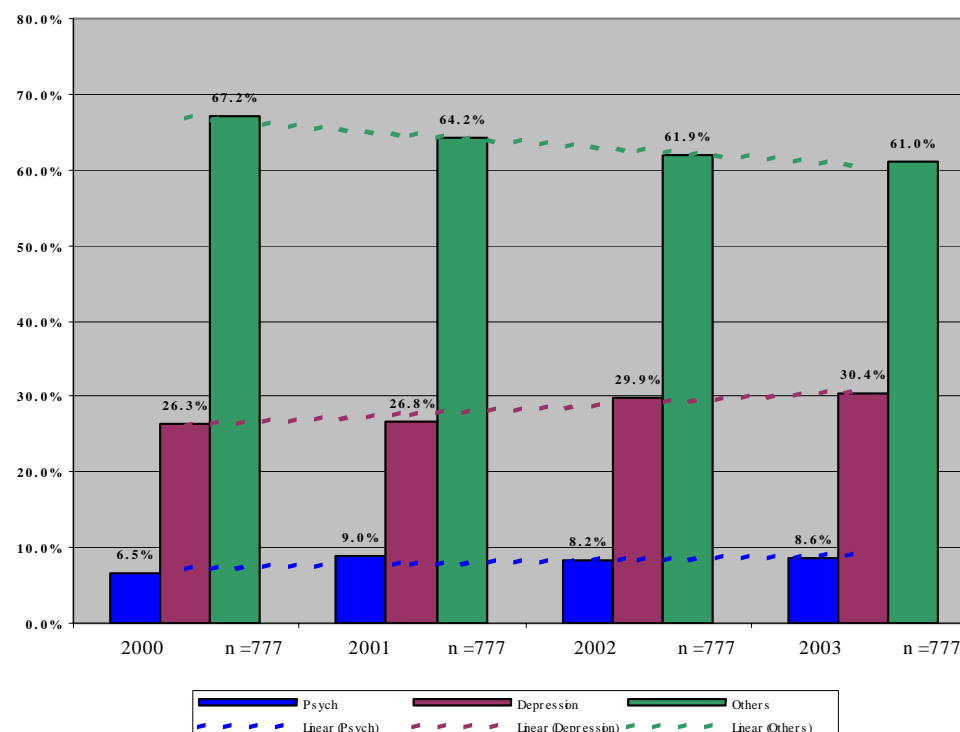
For Adult Patients at BRYNER



Patients Distribution per Comorbidity
FOR BRYNER - PRE INTERVENTION



Patients Distribution per Comorbidity
FOR BRYNER - POST INTERVENTION

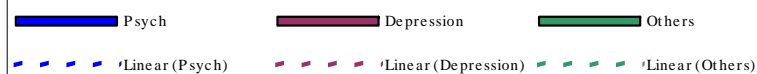
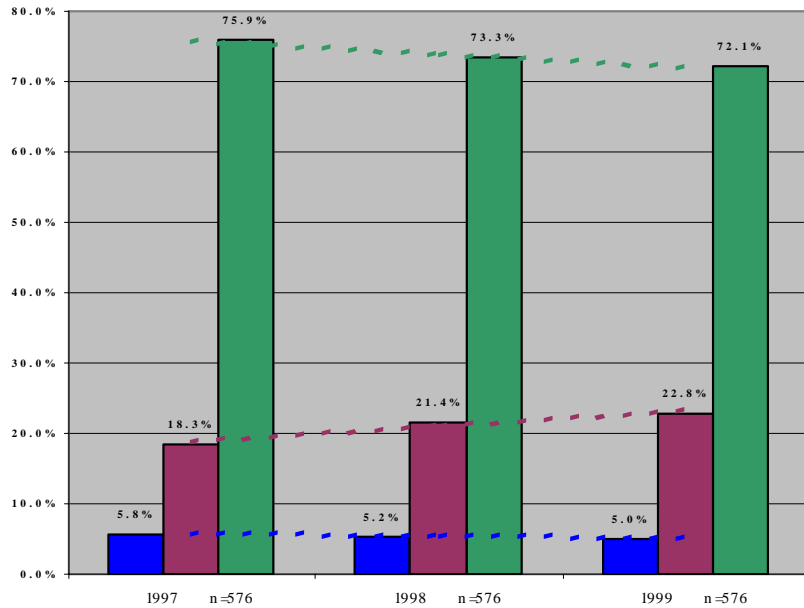


Cohort Analysis

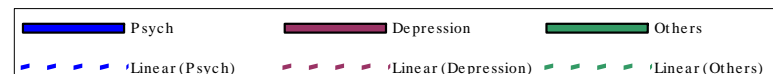
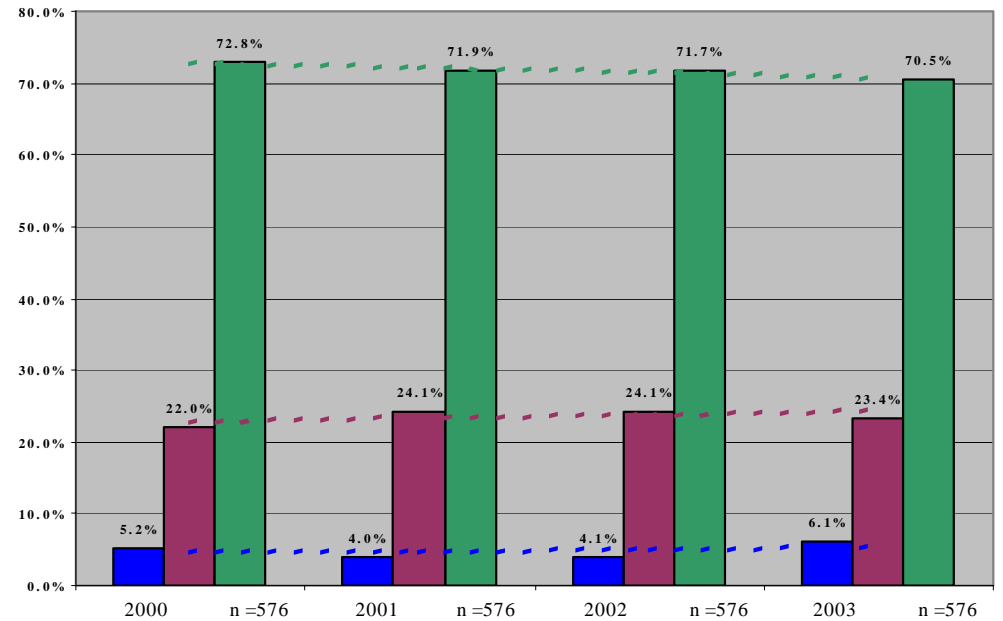
For Adult Patients at SANDY



Patients Distribution per Comorbidity
FOR SANDY - PRE INTERVENTION



Patients Distribution per Comorbidity
FOR SANDY - POST INTERVENTION

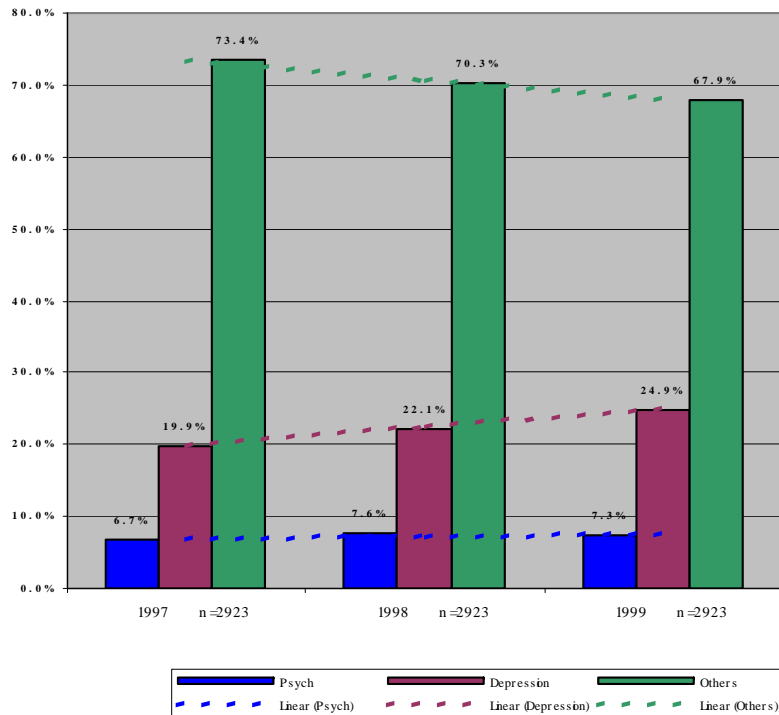


Cohort Analysis

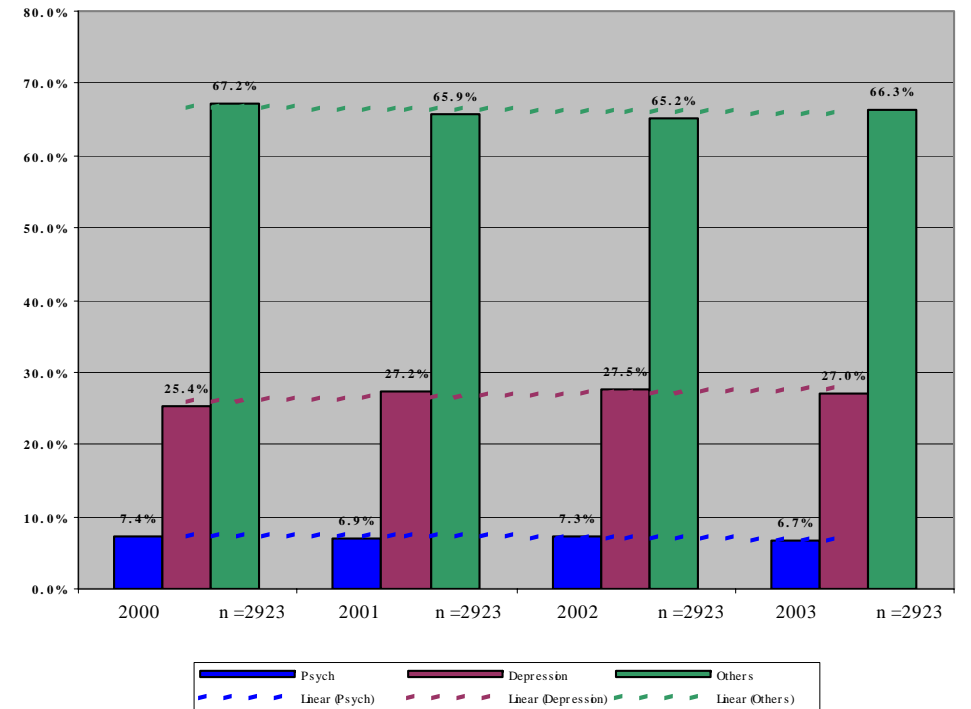
For Adult Patients at CENTRAL REGION



Patients Distribution per Comorbidity
FOR CENTRAL REGION - PRE INTERVENTION



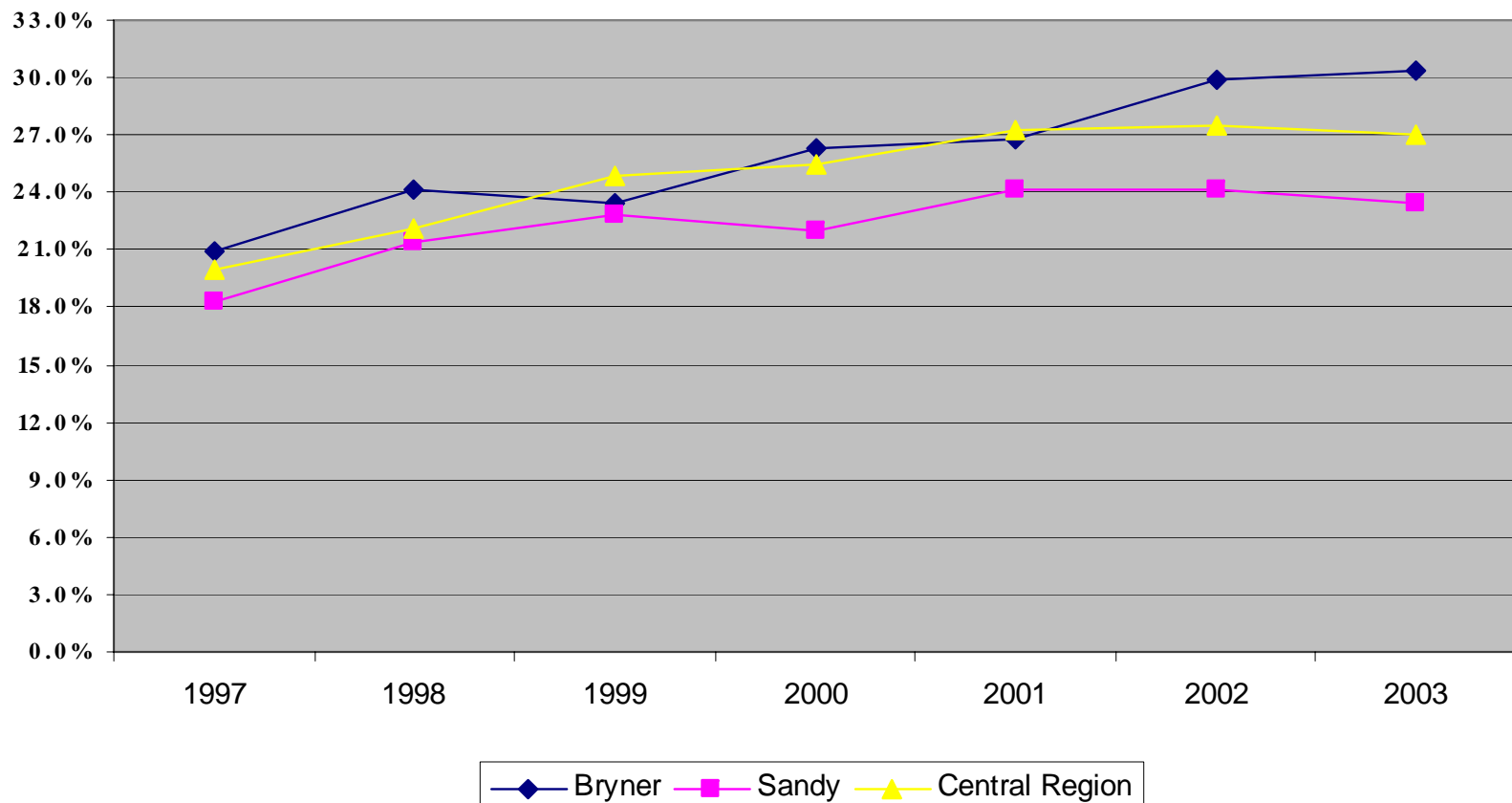
Patients Distribution per Comorbidity
FOR CENTRAL REGION - POST INTERVENTION



Cohort Analysis For Adult Patients



For Adult Patients with DX of Depression - Rate of Detection

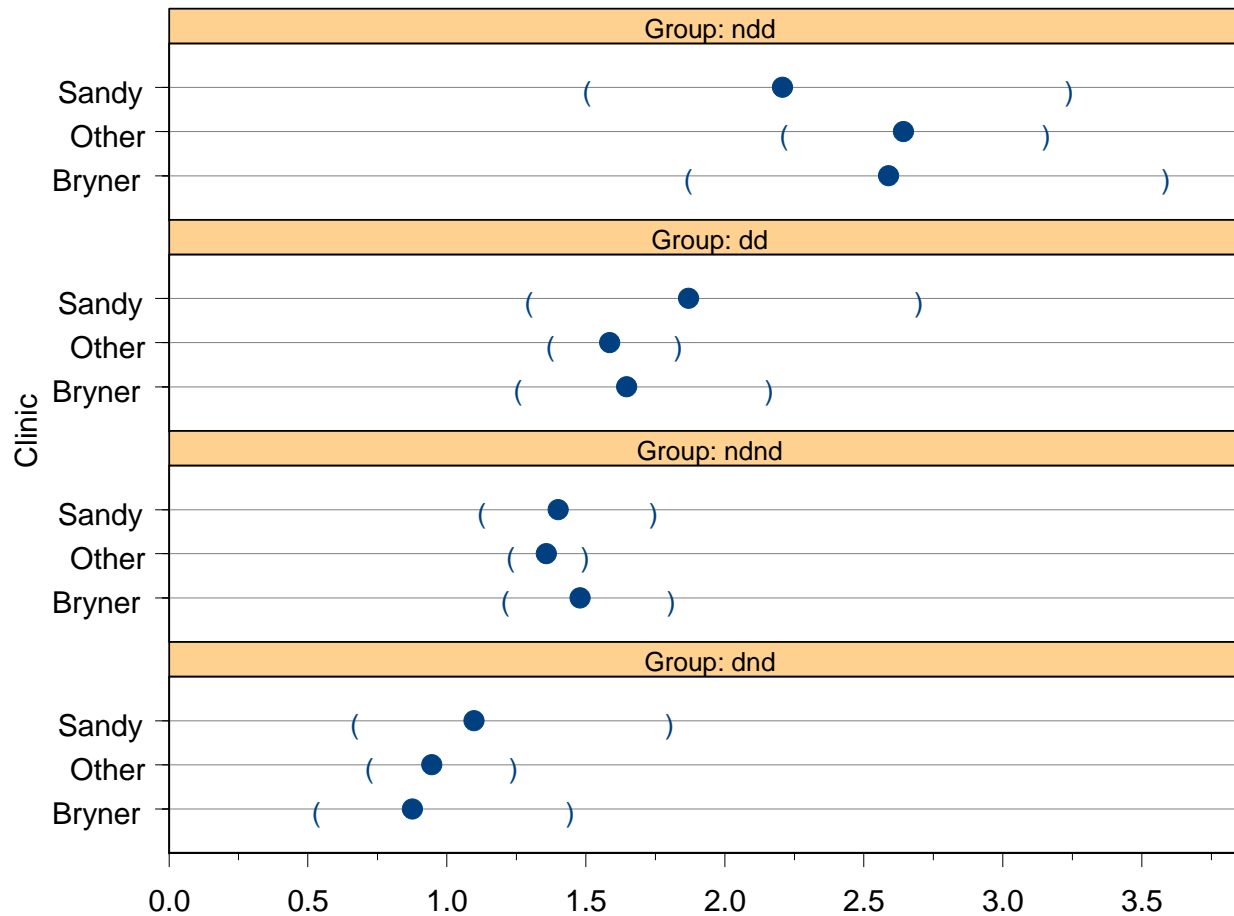


Cohort Analysis

For Adult Patients – Comparison of Total Costs



Adults



ndnd = Not Depressed Pre-Intervention
Not Depressed Post-Intervention
nnd = Not Depressed Pre-Intervention
Depressed Post-Intervention

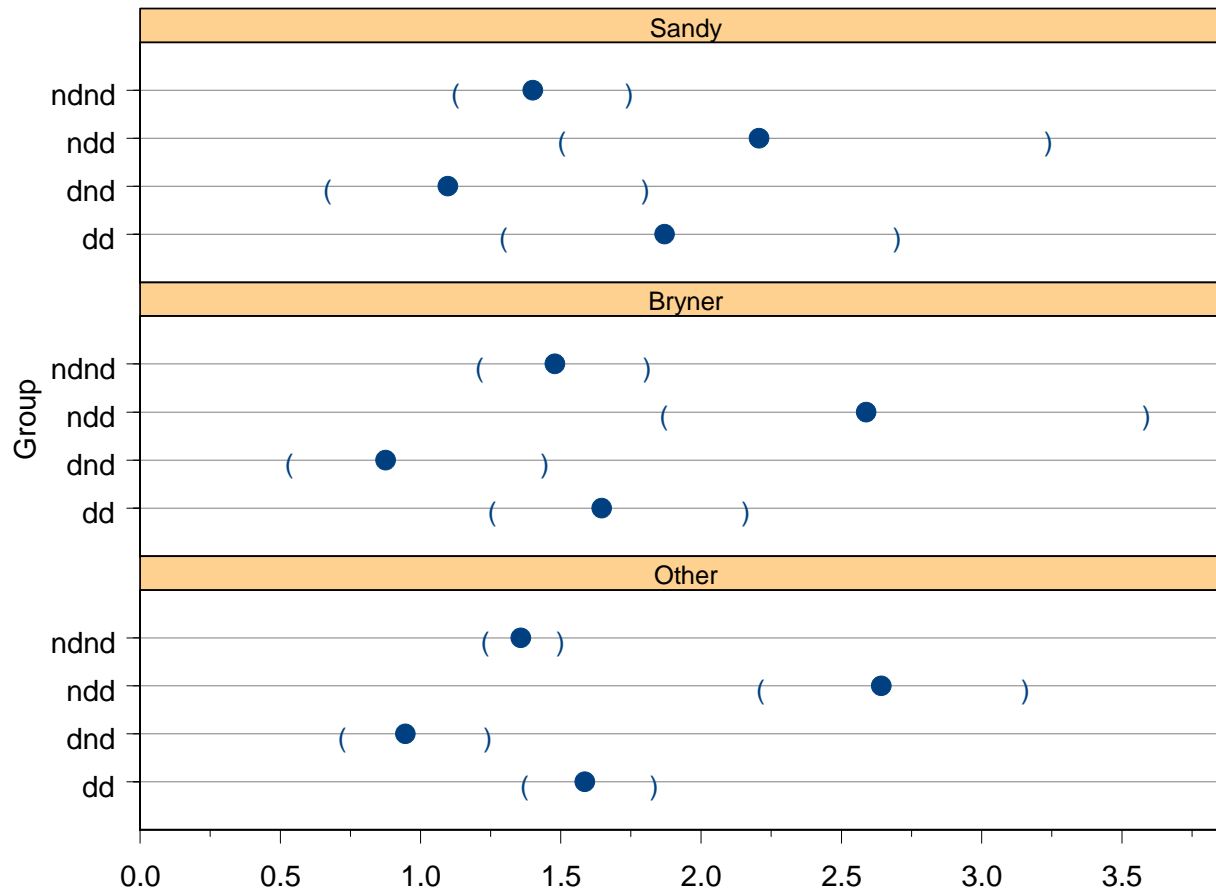
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Depressed Post-Intervention

Cohort Analysis

For Adult Patients – Comparison of Total Costs

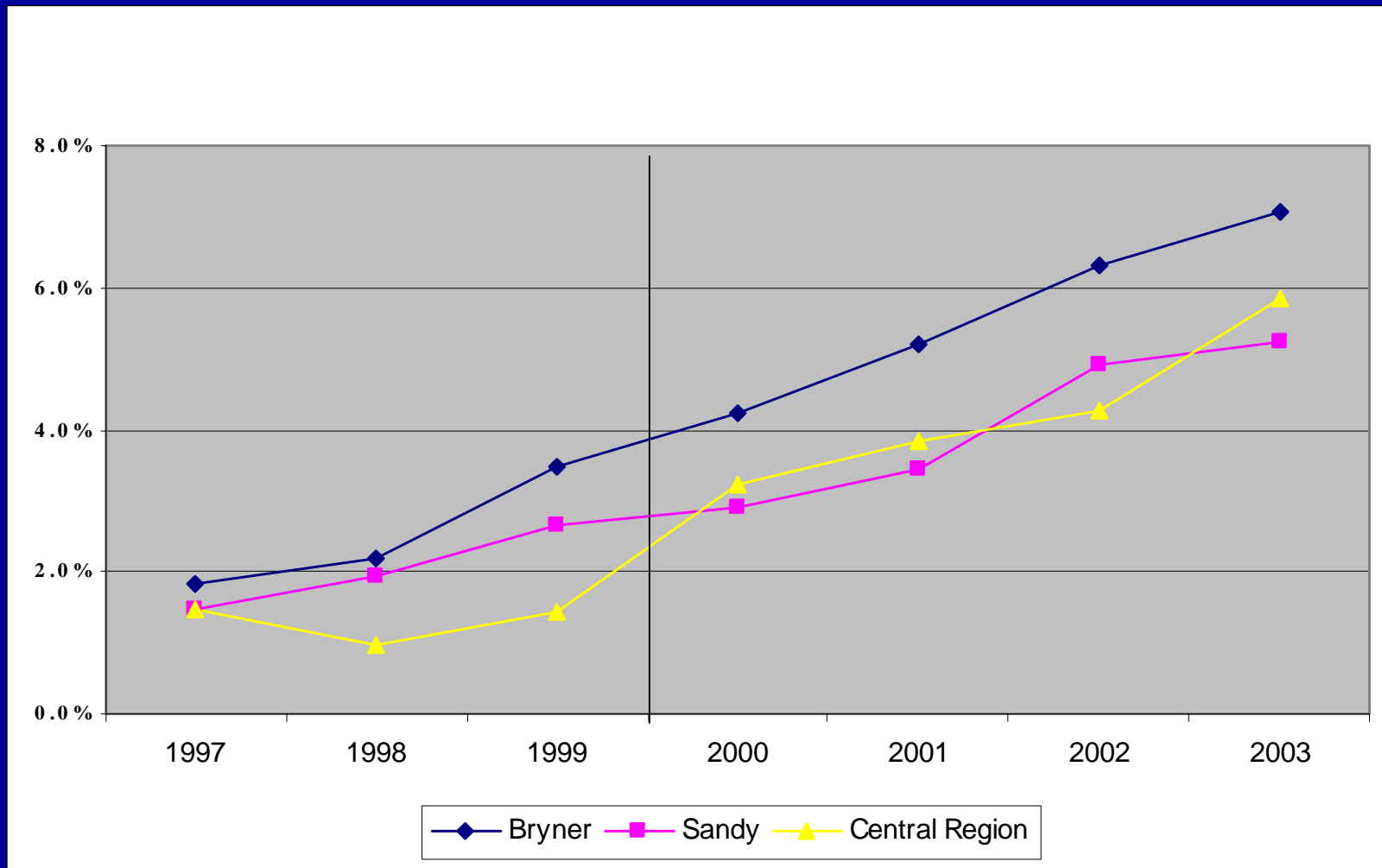


Adults



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Cohort Analysis For Pediatric Patients

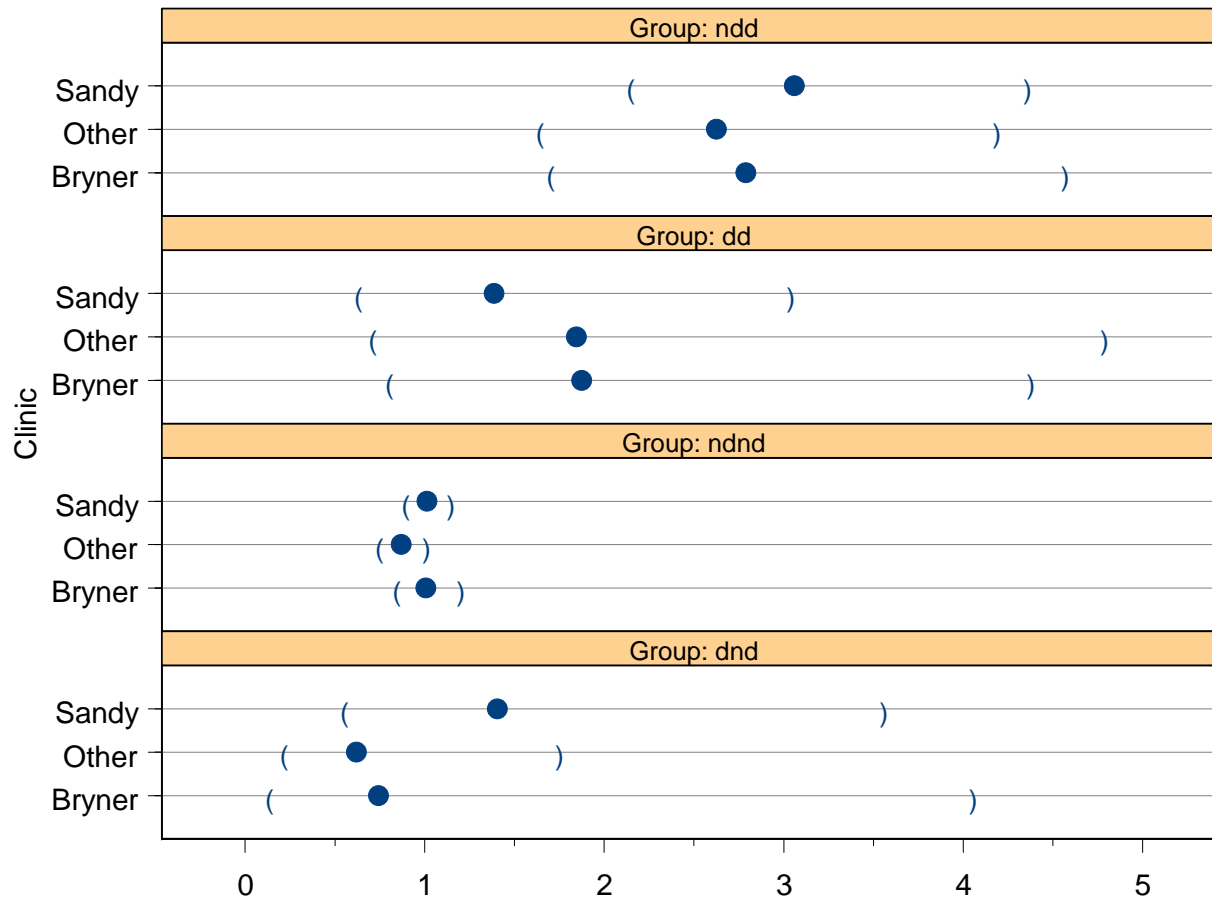


Cohort Analysis

For Pediatric Patients – Comparison of Total Costs



Pediatric



ndnd = Not Depressed Pre-Intervention
 Not Depressed Post-Intervention
 ndd = Not Depressed Pre-Intervention
 Depressed Post-Intervention

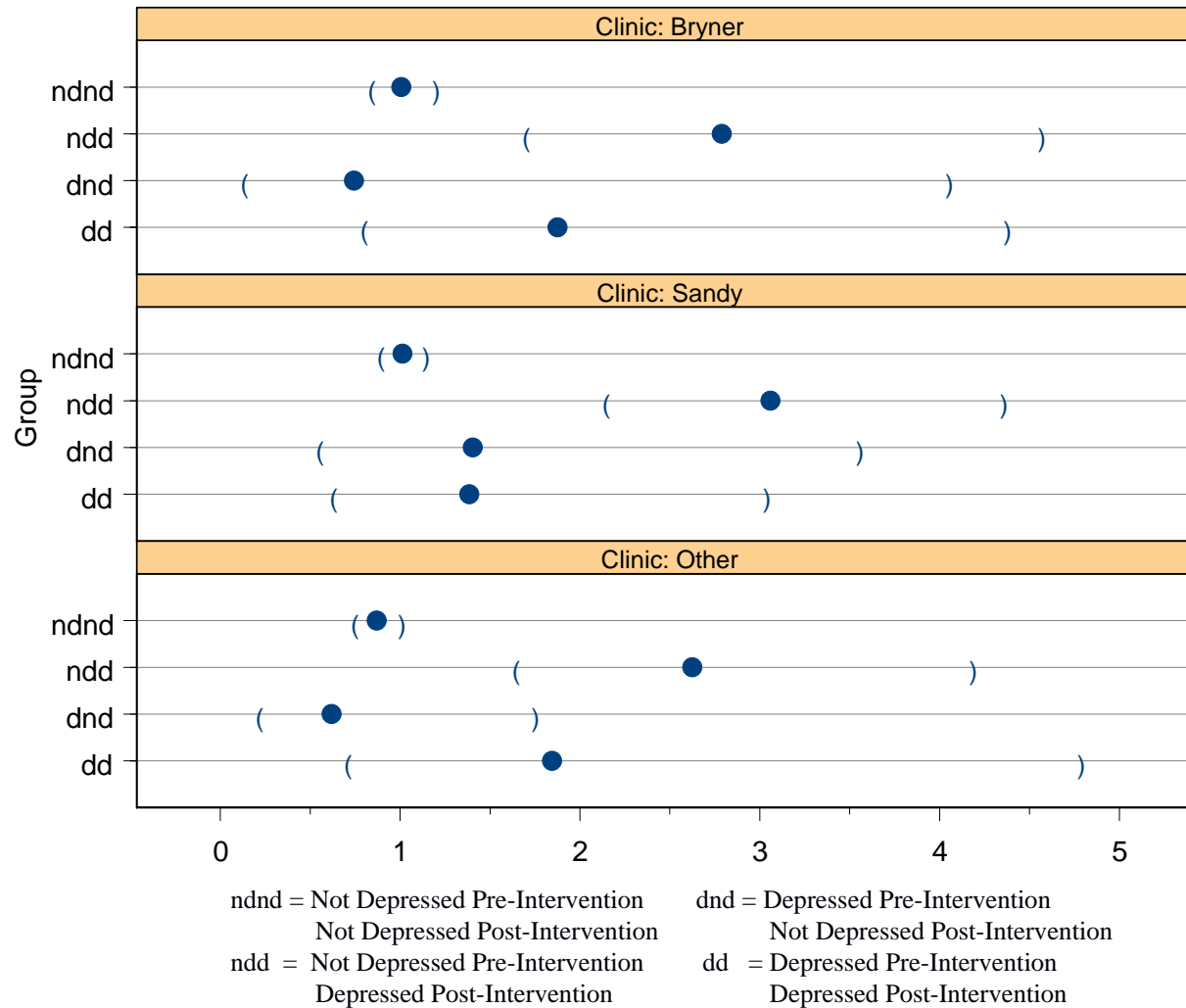
dnd = Depressed Pre-Intervention
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 Depressed Post-Intervention

Cohort Analysis

For Pediatric Patients – Comparison of Total Costs



Pediatric



Cost Analysis Framework

Further Analysis – Holding the Gains



- More detailed analyses remained to be done using trend and cohort data (control charts per month).
- Additional studies will look at how the intervention has affected the medical costs for the families of patients with depression both using trend and cohort data.
- Further studies will look at how the intervention has affected the medical costs for patients with other chronic comorbidities (diabetes, asthma) when these patients are known to suffer from depression.
- These trend and cohort studies will be repeated for different population of patients at different clinic sites as the depression model is rolled out to the entire state.

Drilldown Analysis Based upon Risk Stratification



DETAIL ANALYSIS FRAMEWORK FOR ADULT AND PEDIATRIC PATIENTS, AND THEIR FAMILIES

GOAL: TO PUT A COST AND QUALITY MEASURE ON THE MH INTEGRATION

- 1 – The overall analysis established that the MH integration does not add overall cost to the care of the patient.
- 2 – This drilldown analysis quantifies what the MH integration “buys” the customers.
- 3 - For its customers (patients and family, providers, health plans, employers), what is the MH integration offering both in terms of financial and clinical outcomes?
How can these be measured and reported?

MHI CARE MANAGEMENT LEVELS			
PCP		COLLABORATIVE MHI TEAM	MHS
ONLY	+ CM		
1 - No Comorbidity		1 – Complex Comorbidity	1 - Psych
2 - Responsive family support		2 – Family/Relational isolated chaotic	2 – Family/Relational Support Burden
3 - GS scores: 1 – 3		3 – GS scores: 5 – 6	3 – GS scores: 6 - 7
4 - PHQ9: Mild		4 – PHQ9: Mild-Moderate	4 – PHQ9: Severe

MEASURE CLINICAL AND COST OUTCOMES PER LEVEL OF MHI MANAGEMENT

HYPOTHESES:

- 1 – Costs difference between different levels of MHI management.
- 2 – Clinical outcomes difference between different levels of MHI management.
- 3 – Patients with multiple complex and severe comorbidity not receiving adequate level of MHI management.

FOR PATIENT POPULATION ANALYZED BY TREND METHOD

FOR PATIENT POPULATION ANALYZED BY COHORT METHOD