Getting it Right the First Time: The Essentials of Integrating Behavioral Health and Social Services with Population Health Management

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Advocates for Human Potential, Inc. (AHP)
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About AHP

- Our mission:
  - *AHP improves health and human services systems of care and business operations to help organizations and individuals reach their full potential.*
- Subject matter experts in specialty subpopulations: behavioral health, addictions, criminal justice, workforce, veterans, and more
- Three major product/service areas: technical assistance/training, research and evaluation, and professional consultation
- Headquartered in Massachusetts with offices in New York, Maryland, Illinois, and California

Population Health Management: What Does it Mean to Get it Right?

Getting it Right Means…

- that we have the best opportunity ever to design a system of care and services that works for every American.
- that our most vexing and seemingly intractable challenges can be resolved with enough collaboration, intelligence, and determination.
- that we can ensure behavioral health, social services, and IDD are properly included in the design of the new world and make sure everyone is welcome to their seat at the table.

Integrating Behavioral Health and Social Services with Population Health

- Integrating ***complex populations*** into population health management is essential to achieving the Triple Aim.
- Successful integration takes:
  - Careful assessment
  - Knowing the community and forming effective partnerships
  - A strategic plan for integration
  - Implementation that supports ***all*** the moving parts

Understanding the Challenge

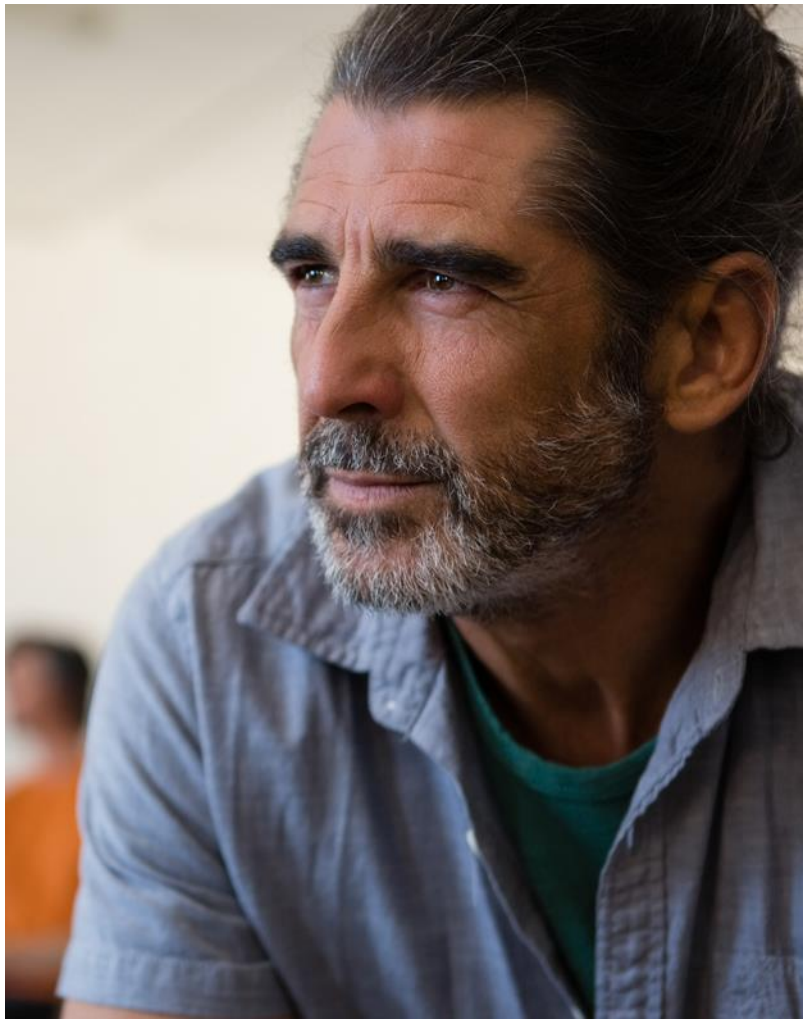
Complex Populations

Complex populations are subpopulations that share particular vulnerabilities, as well as multiple chronic conditions, including mental health and substance use disorders.

Definition

- Common characteristics
  - Disparities and stigma
  - Household income challenges
  - Housing instability
  - Unique needs
  - Lack of independence
  - Lack of social cohesion

Complex Populations, Cont'd



- Not easily or readily treated in mainstream clinics
- Often stigmatized by providers
- Can be:
  - Enrolled in or eligible for multiple benefits/programs
  - Served by multiple public agencies
  - Treated by many different and disparate providers

Other Risk Factors

- Previous admissions to mental health (MH)/substance use disorder (SUD) facilities
- Previous admissions to a medical hospital with an MH diagnosis
- Criminal justice system involvement
- Lack of health insurance
- Adverse childhood experiences
- Higher rates of single-parent families
- Higher rates of unemployment
- Higher rates of illicit drug and alcohol use/abuse
- Higher rates of homelessness

Provider Barriers: Stigma and Preconceptions

- **Persistent beliefs** among Emergency Department (ED) personnel that drug use and overdose reflect a moral failing.
- **Pessimism** that people with co-morbid serious mental illness (SMI) can make significant improvements.
- **The overshadowing effect** that MH and SUD have on chronic medical conditions and how they are screened and treated.

Staff burnout and a "revolving door"

Inordinate focus on behavioral health conditions at the expense of medical conditions

Continuum of Care – All Play a Vital Role

1. Education and orientation for all providers
2. Care coordination along the continuum
3. Operationalizing of the relationships among providers
4. Maintenance of respect for culture across the continuum

Time for a poll!
Please vote on your screen below.

Data is Essential and Must Be Comprehensive

Federal data

Claims data

Reengineering Systems Must Reflect Complexities

- One-size-fits-all solutions to address all subpopulations at once ***simply do not work.***
- Complex social, economic, cultural, and medical conditions require some degree of complexity in solution engineering.

Solutions Must Include Strategies at the Level of Subpopulations

- Care coordination focused on complex comorbid conditions ***and*** social determinants of health (SDOH)
- Partnerships between managed care plans, public agencies, and providers
- Home and community-based services that are relevant to the subpopulation
- Tolerant of providers and agencies that do not yet have the business acumen and technological savvy of most providers

Framing the Solution

Guiding Principles

- Establish social, economic, cultural, and medical/behavioral nuances.
- Establish benefit eligibility.
- Consider the widest range of providers.
- Reflect the unique needs of the subpopulation in the benefits.
- Do not sacrifice specialization for integration.
- Know provider business operations before implementing programs.

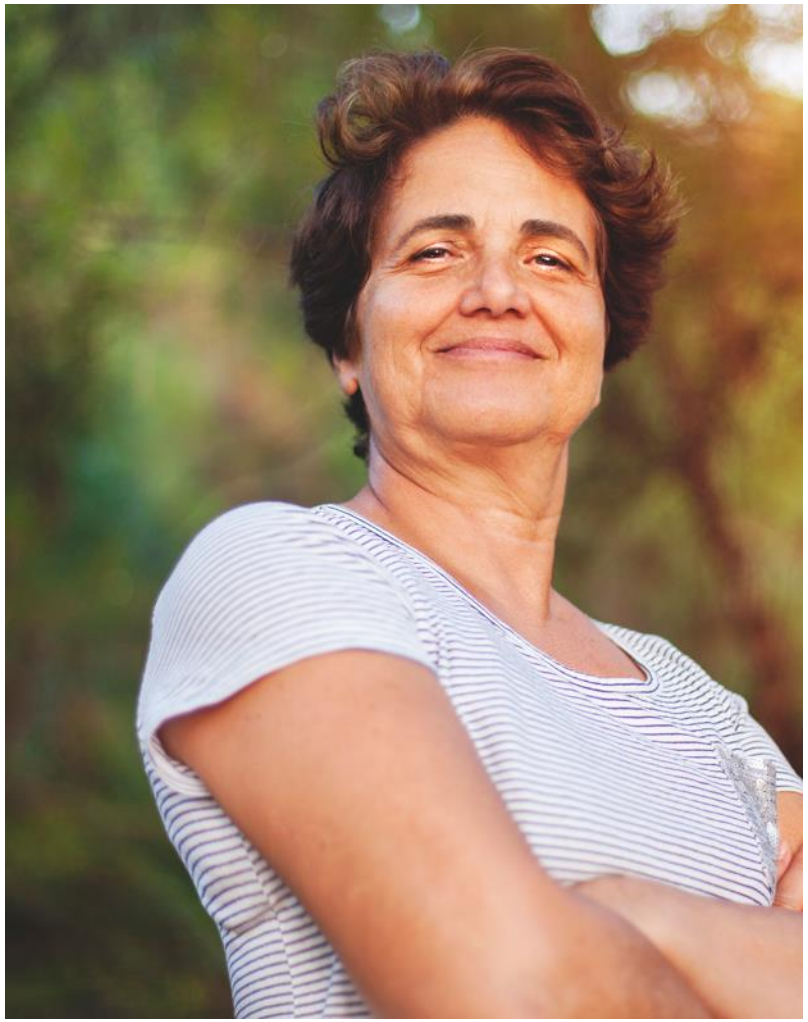
Goals for System Reengineering

- Gather data from as many sources as possible.
- Gather input from as many stakeholders as possible, harvesting their mission and values and respecting their culture and heritage.
- Analyze system of care strengths and weaknesses.
- Recommend practical process enhancements that support business, clinical, and cultural aims.
- Establish resource requirements and secure resources before making changes.

Objectives for System Reengineering

- Engage the community.
- Collect data from the widest range of sources.
- Understand how race, age, and gender will manifest.
- Identify the barriers to treatment plan and clinical pathway adherence.
- Understand gaps in provider network access, capacity, and competencies.
- Determine the continuum of care (CoC) based on evidence-based practices and subpopulation preferences (often rooted in culture).
- Map community assets that correspond with desired CoC.

Objectives for System Reengineering, Cont'd



- Develop comprehensive system reengineering plan(s).
- Develop agreements.
- Develop subpopulation-specific measures of outcomes, quality, and budgets.
- Identify where and how various players will interact.

Provider Networks

- Analysis to identify the most appropriate points of care and service mix
- Comparison of the current network capacity and identification of gaps
- Identification of population-specific improvements and critical success factors
- Recommendations for overcoming cultural impediments
- Action plans for overcoming infrastructure and operational barriers
- Recommendations for overcoming reimbursement obstacles

Alignment

- Alignment with policies, rules, laws, and expectations (contracts, certifications)
- Business process redesign
- Redesign and alignment of organizational structures
- Alignment of any changes due to the implementation of evidence-based practices
- Risk identification and risk management
- Facilities impact assessment and planning
- IT infrastructure assessment and planning
- Staffing assessment, planning, and training
- Project and timeline management
- Quality assurance planning and deployment

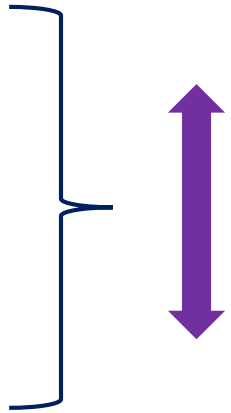
Subpopulation System Reengineering Guide

Subpopulation System Reengineering

1. Identify the goals and objectives.
2. Analyze the data, engage the community, revisit the goals and objectives, and design the solutions.
3. Develop the infrastructure and align the players.
4. Develop the contracts and rates.
5. Develop the policies, procedures, and workflow.
6. Measure the results and improve the program.

What Will Reengineering Require?

- Ample time for planning
  - Two years is not out of the ordinary
- Consumer and family engagement
  - Outreach, meetings, surveys



- Policies
- Goals
- Challenges
- System Design
- Implementation
- Outcomes
- Quality
- Satisfaction
- Costs
- Evaluation

Start with the PBSNA

The PBSNA sets the stage for effective population health planning and administration.

Population Behavioral & Social Needs Assessment

- Assess your community's social determinants of health

Community Partnerships & Network Development

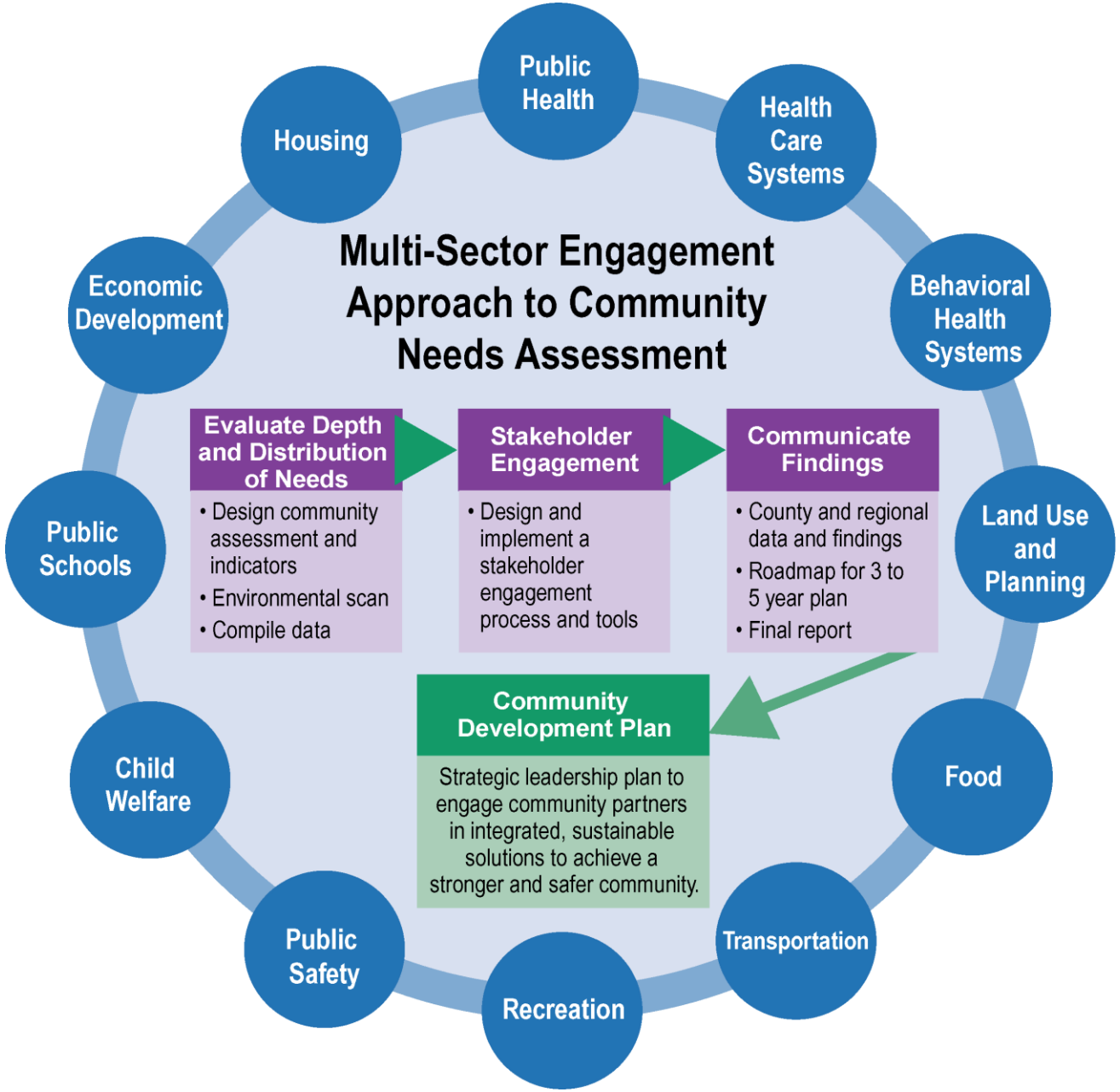
- Create effective partnerships to integrate delivery systems

Population Health Strategic Planning

- Leverage PBSNA findings to plan inclusive, multi-stakeholder solutions

Population Health Implementation

- Operationalize an integrated delivery system that ensures better health for more populations, saves cost, and improves quality


Public Health
Health Care Systems
Behavioral Health Systems
Land Use and Planning
Food
Transportation
Recreation
Public Safety
Child Welfare
Public Schools
Economic Development
Housing
Multi-Sector Engagement Approach to Community Needs Assessment
Evaluate Depth and Distribution of Needs
• Design community assessment and indicators
• Environmental scan
• Compile data
Stakeholder Engagement
• Design and implement a stakeholder engagement process and tools
Communicate Findings
• County and regional data and findings
• Roadmap for 3 to 5 year plan
• Final report
Community Development Plan
Strategic leadership plan to engage community partners in integrated, sustainable solutions to achieve a stronger and safer community.

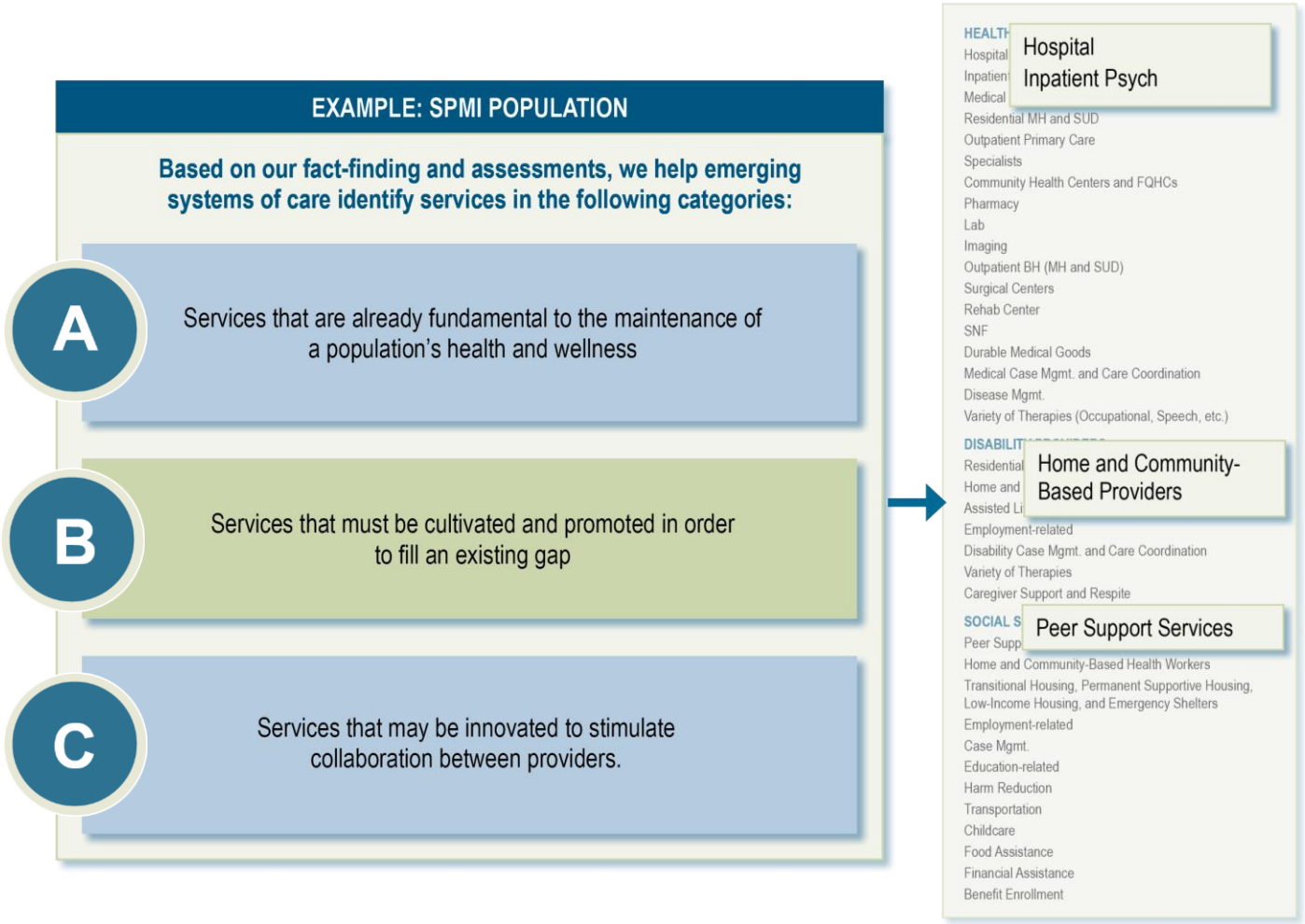
PBSNA Includes Assessment of…

- adequate infrastructure
- populations to be served
- services to be offered
- geographic area
- enrollment inclusion of self-direction, if applicable

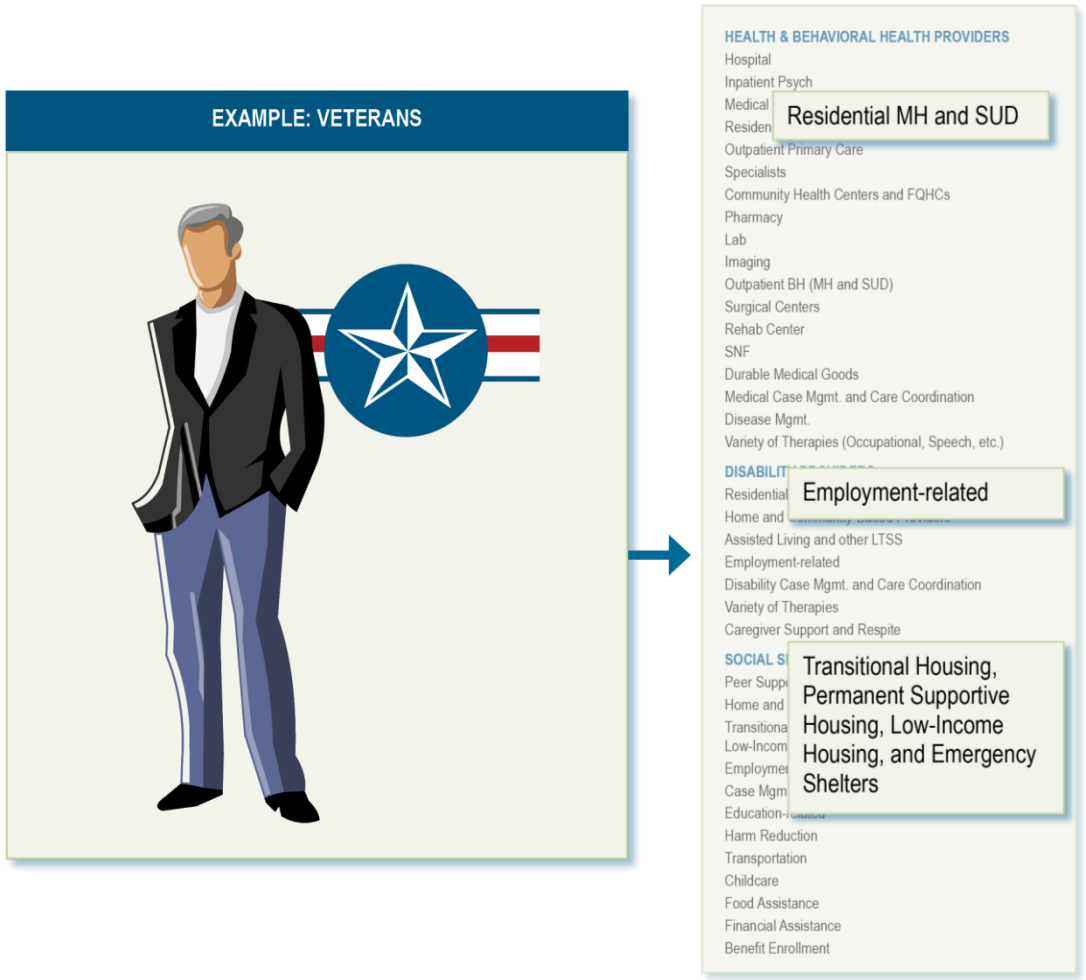
What Very Few Are Doing: Stratify Subpopulations by Risk Factors

- Incidence and prevalence of SUD
- Incidence and prevalence of SMI/SPMI
- Housing instability and homelessness
- Prior incarceration, probation, and parole
- Violent crime (exposure to)
- Unemployment
- % of single-parent households
- No access to an automobile

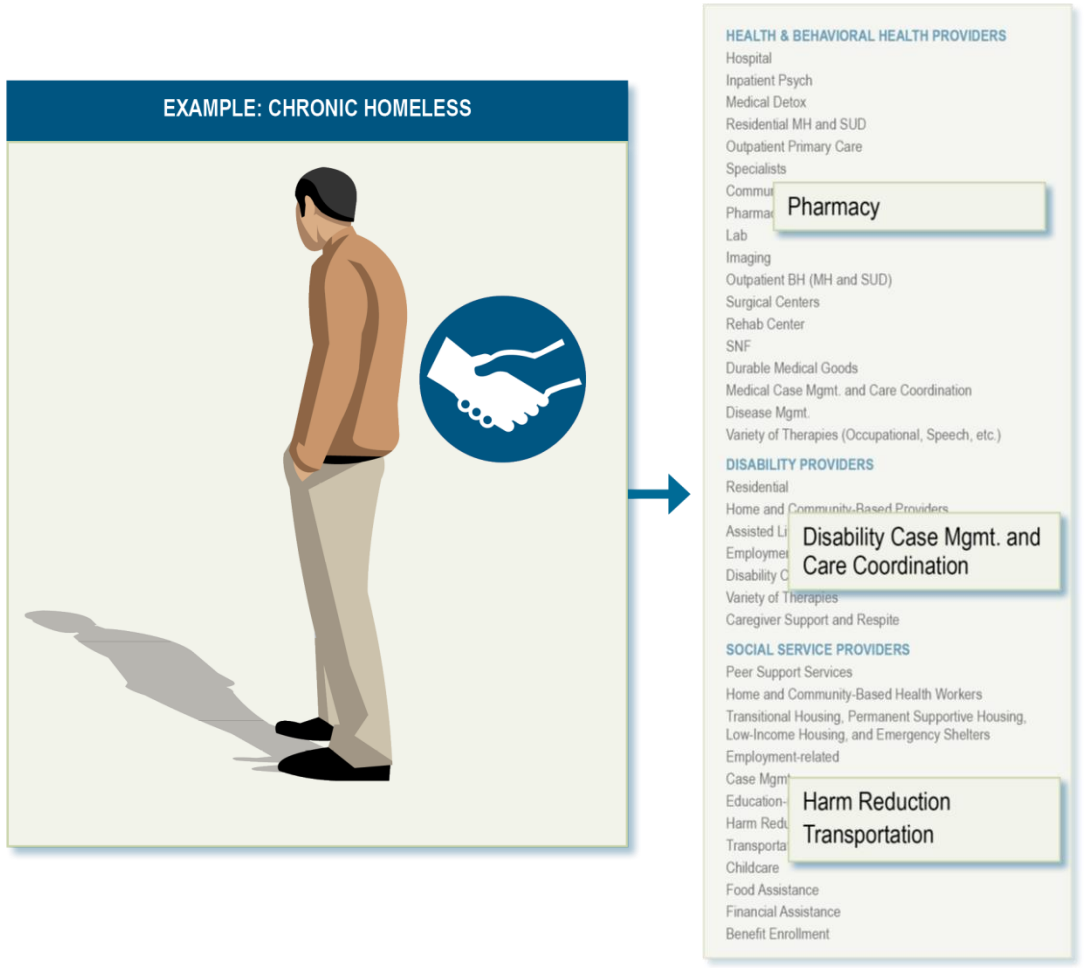
PBSNA Example: SPMI



PBSNA Example: Veterans



PBSNA Example: Chronic Homeless



Checklist: Ensuring Sustainable Change

Prepare	Engage	Collaborate
Funding ❑ Develop initial budget for community engagement in the initiative, identifying source funding ❑ Identify long-term funding support for initiative ❑ Develop funding plan for the long-term ❑ Track and measure performance of funds **Policies** ❑ Identify and understand rationale of catalysts for change. Ask questions! ❑ Assess performance and needs of current system, identifying specific challenges ❑ Assess readiness and capabilities of unique elements within system ❑ Forecast measurable impact of changes ❑ Identify community assets and measure gaps in system ❑ Identify preliminary goals and objectives ❑ Identify policies, standards and rules that require change ❑ Develop informational and educational materials accordingly for variety of audiences, addressing cultural nuance and language	**Policymakers** ❑ Engage policymakers in definition of the problem, solutions, resource requirements, and budget estimates ❑ Identify policies and rules that will support long-term success of the initiative, taking cultural variables into consideration ❑ Ensure the policy, standards, and rule changes are thoroughly implemented ❑ Normalize new policies, standards and rules, disseminating them widely and training stakeholders where necessary **Community** ❑ Identify entire range of stakeholders impacted by initiative and changes as well as those whose involvement will enhance the initiative ❑ Develop marketing and communications plans ❑ Develop media/marketing campaign addressing cultural relevance and language ❑ Reach out, engage and invite to orientation and education sessions in the community ❑ Share results of performance and needs assessment, assets and gap analysis ❑ Identify culturally-relevant issues and needs as well as language needs ❑ Include all voices in refinement of goals and objectives ❑ Enhance community's capacity to maintain policies and objectives over long-term ❑ Create ongoing opportunities for participation, feedback, input and concerns and harvest all actionable ideas	**Implementation** ❑ Create working groups and committees to include consumers/patients, advocacy groups, families, and providers working in collaboration with policymakers and administrators ❑ Working groups identify critical paths to full implementation (timeline, milestones, tasks, dependencies, roles and responsibilities), identifying barriers and obstacles and the strategies to overcome them ❑ Develop comprehensive implementation project plans, identifying resource requirements ❑ Secure the resources required ❑ Manage and monitor plans and projects and report progress regularly ❑ Implement communications channels ❑ Allocate resources rationally, benefitting all working groups based on their needs ❑ Stimulate affiliation, partnerships and joint ventures ❑ Develop contracts and MOUs accordingly ❑ Develop technical assistance toolkits ❑ Provide ongoing technical assistance ❑ Measure and report progress of system change ❑ Evaluate entire effort and allow regularly published results to shape continuous improvement ❑ Celebrate the victories! Provide recognition where it is due.

Start with These Tools

Download before you leave:

- Today's presentation slides
- Sustainable Change Checklist
- Population Behavioral and Social Needs Assessment (PBSNA) Service Brief
- White paper: *Achieving Population Health: Behavioral Health Systems as the Link to Success*

Next steps:

- Contact Patrick Gauthier for a free preliminary consultation – no charge or obligation
- Follow AHP for future events and new resources
  - Watch the AHP PBSNA page
  - LinkedIn
  - Facebook
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Real World Solutions for Systems Change

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Visit the PBSNA page on AHP's website for more info and resources!

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