

# Behavioral Health Sub Committee

July 2012

# Group Membership

- ▶ Legislative
  - Senator Christensen, Rep. Chavez–Houck, Rep. Menlove, Rep. Sanpei
- ▶ Community & State Agencies
  - Weber Human Services
  - Department of Health
  - Utah Health Policy Project
  - Assn for Utah Community Health (AUCH)
  - SL County Div. of Behavioral Health
  - Utah Hospital Association
  - NAMI Utah
  - Midtown Community Health Clinic
  - UT Division of Substance Abuse & MH
  - U of U Neuropsychiatric Institute
  - Wasatch Mental Health
  - Utah Association of Counties
  - Utah Medical Association
  - Various private providers and payers

# Progress Update

- ▶ 2 Hour Weekly Meetings
  - ▶ Major Topics Covered
    - Background / Rationale
    - Vision / Objectives
    - Current System of Care
    - Alternative Systems of Care
    - Current Utah Pilots
  - ▶ Next Steps
    - Measurements
    - Recommendations
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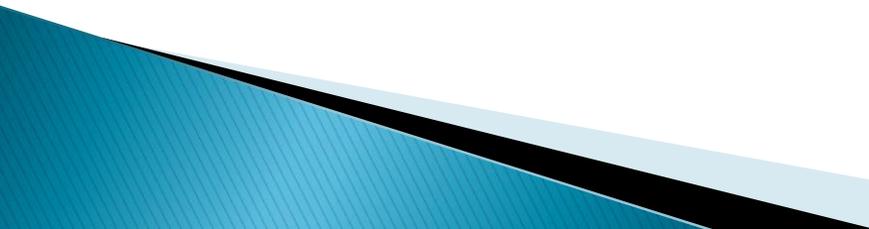
# Background / Rationale

- ▶ State Medicaid Reform
- ▶ First focus was medical w/geographic focus along Wasatch Front
- ▶ Next need to address medical overlaps and access issues for behavioral health
  - Severely and persistently mentally ill (SPMI) clients die approximately 25 yrs earlier than the rest of the population
  - Preventable medical conditions are the leading cause of premature death among the SPMI population
  - Behavioral health clients have higher rates of co-occurring conditions including: hypertension, diabetes, obesity, and asthma.
  - Behavioral health clients are less likely to receive care that meets clinical guidelines.

# Background / Rationale

- ▶ Payment and incentive mechanisms not always aligned (e.g. fee for service emergency room use versus capitated mental health payments)
  - ▶ Impacts from inefficient continuity of care on community are profound (e.g. jail use, emergency room overuse, homelessness, etc.)
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# Guiding Principles / Objectives

- ▶ **“First do no harm”**
  - ▶ Recognize there are **different segments of need** / solution will require some complexity
  - ▶ Need to be **inclusive with process** (various perspectives need to be represented including those of: rural, urban, community members, children, etc.)
  - ▶ Focus on both **costs and quality**
  - ▶ Encourage **innovations** (e.g. telehealth)
  - ▶ Plan for **long term** solutions
  - ▶ Evaluate all **financing sources**
  - ▶ Strive to **improve amount and appropriateness of access**
  - ▶ Need to have preferred approaches be **patient and family centered**
  - ▶ **Set aside self interests** for the sake of finding the best overall policy
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# Current System of Care

Area	Financing Type	Financing Sources	Organization
Behavioral Health	Capitation	State, Federal, Counties	Mix of contracting w/private providers and county owned services
Medical	Fee for service	State, Federal	Mix of private hospitals, physicians, community health clinics, and health department services
Substance Use Disorder	Mixed	State, Federal, Counties,	Mix of contracting w/private providers and county owned services

# Current System of Care

- ▶ Widely varying levels of integration exist
  - Lifestyle of behavioral health clients does not always fit into standard primary care practices
  - Many behavioral health clients view their psychiatrist as a primary care physicians
  - Behavioral health population needs vary greatly, but also have many overlaps (i.e. seriously and persistently mentally ill versus “simple” anxiety and depression versus substance use disorder versus chronic medical condition versus acute medical condition, etc.)
  - Multiple settings for clients to “enter” system
    - Hospitals and emergency departments
    - Community physicians in private practice
    - Community health centers
    - Volunteer medical centers
    - County run facilities
    - Public safety system

# Alternative Systems of Care

- ▶ Changing Flow of Funds
  - “Carve in”
  - “Carve out”
  - Hybrids (carve in for inpatient / carve out for outpatient)
  - Health home based (Primary care versus community mental health) – both embrace “whole person”
  - Shared Savings

# Alternative Systems of Care

- ▶ Behavioral and Physical Health Integration (components with or without flow of fund changes)
  - Advanced primary care
  - Regional leadership teams
  - Specialized and targeted services (can be associated with “hot spotting”)
  - Data – tracking across continuum and various providers
  - Nurse care managers
  - Co-location of services
  - Physician consultants
  - Progressive disease management initiatives

# Key Current Utah “Pilots”

- ▶ Midtown / Weber Human Service – “Co-location program”
  - Mental and physician health co-located with single entrance
  - Grant funded
- ▶ Intermountain Healthcare – “Mental Health Integration Program”
  - Mental and physician health resources not co-located, but highly coordinated
  - Substantial cost savings demonstrated
- ▶ University of Utah – “Medical Home Program”
  - Limited availability to developmentally disabled with a mental health concern
  - Medicaid funded w/a single premium payment for both medical and behavioral elements

# Key Current Utah “Pilots”

- ▶ Different populations
  - ▶ Different mechanisms for funding
  - ▶ All are demonstrating higher levels of satisfaction and engagement
  - ▶ Two have shown significant outcome and cost improvements with the 3<sup>rd</sup> having promising early results
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# Next Steps

- ▶ **Measurements**
  - Assess currently available measures and comparisons
  - Determine gaps and methodologies for filling
- ▶ **Recommendation Development**
  - Identify initiatives most consistent with guiding principles
  - Recommend changes to Health Reform Task force

**Questions...**

**...Thank you!!**