Is Mental Health the Missing Link in Your Hospital's Population Health Strategy?

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Hospitals and health systems are rapidly going on a journey from volume to value. By the end of 2017, 50 percent of Medicare payments will be in an alternative payment model.

But the vast majority of healthcare organizations are unprepared to truly shift care in the ways that are needed to achieve success in these models. Nowhere is this more apparent than in their approach to behavioral health, which has historically been seen as a low-reimbursement service leading to disinvestment. As hospitals and health systems shift toward population health, however, they are realizing that they may need to flip their strategy to invest proactively in outpatient and inpatient behavioral health services. To understand why, it's important to understand mental health from a population health perspective. This article looks at the scope of the problem and how to apply a population health lens to this challenge.

The Scope of the Problem from a Population Health Perspective

In this era of value-based payments, we are asked to improve health outcomes and experience at a lower or sustainable cost. There are five key facts every board member and executive should know about how mental health may be invisibly driving health outcomes and cost in their patient population:

1. One in four Americans are experiencing difficulty with mental health at any given point, according to the Substance Abuse and Mental Health Services Administration (SAMHSA).[1]
2. Mental health and substance use disorders are among the leading causes of years lived with disability (YLD) and associated cost.[2]
3. Coexisting mental health disorders substantially reduce both length of life (25-year drop in life expectancy if you have a physical and mental health disorder) and increase cost of physical health conditions (up to twofold). It's estimated that 50 percent of people suffering from a chronic physical disease like diabetes or heart disease have a co-occurring mental health disorder they are struggling with (e.g., depression). Mental health and well-being as well as social well-being are well-known predictors of hospital readmissions.[3]
4. For the top 10 percent of high-risk, high-cost patients for whom you may be receiving value-based payments, mental health and social determinants together are likely to drive 60–85 percent of cost depending on your patient population, with Medicaid patients predictably bearing a higher burden of poor health outcomes and cost.[4]
5. The rising epidemic of substance use, in particular the skyrocketing opioid epidemic, is leading to a substantial increase in poor outcomes and healthcare cost. There has been a twofold increase in deaths from prescription pain medicines between 2002–2011.[5]

For a hospital or health system, this means that it will be very difficult to make headway in the world of population health and value-based care if your strategy doesn't address mental and behavioral health. The good news is that healthcare leaders can take a stepwise approach and substantially innovate to improve outcomes and costs.

Approaching Mental Health from a Population Perspective

Most healthcare organizations begin to address this by trying to gain an additional supply of mental health practitioners and quickly find that the demand far outstrips the supply. When the math just doesn't work we keep delivering care the way we currently are; in fact, we would likely need a 22:1 ratio of mental health clinicians to primary care providers.[6] We need to address the 25 percent of people who need mental health support as a *population* and make mental health everybody's job**.** Below are three ways to approach mental health from a population perspective.

1. For those who have chronic, severe, persistent mental illness, integrate medical care into mental health. Develop an integrated health system with the mental health team as the lead, with primary care support incorporated into mental health. These may be some of the same people who are ending up on the list of high-risk, high-cost patients, especially if they have a co-occurring social need or substance use disorder. We recommend that all care management teams be multidisciplinary with a combination of a licensed social worker/other paraprofessional who can address the mental health needs of the patient and a community health worker/case manager who can address social needs combined with a medical professional such as an RN

Key Board Takeaways

As boards of all types of healthcare organizations invest in behavioral health services to achieve their population health strategies, they should consider the following:

- There are various ways mental health may be invisibly driving health outcomes and cost in your patient population.
- You cannot address population health without addressing mental health.
- There are simple, powerful approaches to improving mental health with better experience at a lower cost. These approaches will require us to innovate and redesign our mental health delivery system in a community-based way.

1 "What Is Mental Health?" HHS, MentalHealth.gov.

2 Christopher Murray, et al., "The State of U.S. Health, 1990–2010: Burden of Diseases, Injuries, and Risk Factors," *JAMA,* August 14, 2013.

3 Fernando Rodríguez-Artalejo, et al., "Health-Related Quality of Life as a Predictor of Hospital Readmission and Death among Patients with Heart Failure," *Archives of Internal Medicine,* June 2005.

4 Internal data from Cambridge Health Alliance ACO.

5 "Overdose Death Rates," National Institute on Drug Abuse, Revised on January 2017; *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health,* U.S. Department of Health and Human Services, 2016.

6 A primary care clinician with 2,000 patients a year, assuming they are identifying the one in four patients with mental illness, could identify up to 500 patients a year using universal screening (would require 1,000 hours of care). If each person received a monthly psychiatry visit and a weekly therapy visit for a year, it would generate 250 hours of psychiatry care and 22,000 hours of therapy care—a 22:1 ratio of mental health clinician: primary care clinician time.

or NP who can manage the medical aspects of a person's illness.

2. Develop a stepped model of care for people with active mental illness. For those who are experiencing mental illness, we recommend an escalating set of supports that begins in the community where people live, work, and play and seamlessly transitions into primary care, where the vast majority of mental illness can be treated, with long-term co-management by mental health specialists for those with persistent mental illness. There is an opportunity to apply the same rigorous chronic care model as we would any medical condition such as diabetes (screening, team-based care, proactive management with registries, use of PHQ-9 and other scores to manage the high prevalent mental health disorders, self-management support, etc.). This can help to destigmatize mental illness and integrate "the head back with the body."

There is also a huge opportunity to innovate on outcomes and cost through the use of non-traditional health workers—community residents trained in mental health first aid or naloxone use, non-licensed social workers or care partners who have been trained in screening and early life coaching, or peers with lived experience of mental illness who can facilitate support groups. Technology has been used in fascinating ways to support self-management and access to specialty care. These have all been shown to be successful at improving outcomes at a much lower cost than simply investing in personnel. Cambridge Health Alliance has made both these approaches central to their model.

3. Consider investing in upstream prevention efforts, like addressing violence and drugs in partnership with others in the community. Not only does violence have a direct health impact on the victim, but the secondary impacts of violence and trauma on those around the victim and the perpetrator are well documented. Destigmatize mental illness and create social spaces for people to share experiences with those who don't have it—remember, nearly everyone has been affected or has a loved one who has been. We have a special prevention role to play in the opioid epidemic in particular.[7] We don't have to do this alone—we can join with partners across the community to address these critical needs together.

The Governance Institute thanks Somava Saha Stout, M.D., M.S., Executive Lead, 100 Million Healthier Lives and Vice President, Institute for Healthcare Improvement, for contributing this article. She can be reached at sstout@IHI.org.

7 To find out more, go to www.100mlives.org/opioid.