Behavioral Health Homes: Optimizing Health & Wellness

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Agenda

• Behavioral Health Homes Background and Study Overview: Optimizing Behavioral Health Homes by Focusing on Outcomes that Matter Most to Adults with SMI

• Study findings and interpretation

• Program cost evaluation

• Discussion and next steps
Behavioral Health Homes
Behavioral Health and Wellness

- Adults with SMI are one of the most medically vulnerable populations
  - 68% of adults with mental health disorders also have medical conditions
  - High rates of undiagnosed, untreated, or poorly treated medical illnesses and difficulty accessing medical care
  - High rates of premature death; dying as much as 15 to 25 years younger than the general population
  - Modifiable lifestyle choices and behaviors may contribute (alcohol & tobacco use, poor nutrition)
Community Care’s BHH Plus

• Community Care’s commitment to overall health & recovery-based programs

• Behavioral & physical health systems have historically failed to systematically address and support prevention and wellness, especially the most vulnerable populations such as adults with SMI

• Belief that BH providers are uniquely positioned to assist adults with SMI in addressing whole health and wellness
Community Care’s BHH Plus

• Successful early collaboration with Community Care & BH providers in North Central region of PA to address wellness through BHH model in 2010 with a focus on:
  – Enhancing capacity of behavioral health providers to serve as health homes
  – Comprehensive care management
  – Care coordination and health promotion
  – Linkage of service users to community resources
Study Overview: Optimal Health

• A multi-stakeholder collaboration to study the key components of the BHHP model

• Main partners include:
  – Community Care
  – UPMC Center for High-Value Health Care
  – University of Pittsburgh
  – Stakeholder Advisory Board
  – BHARP, NC and Chester Counties and Providers

• Principal investigators:
  – James Schuster, MD, MBA, Community Care
  – Charles (Chip) Reynolds III, MD, University of Pittsburgh
  – Tracy Carney, CPRP, CSP, Community Care

• Supported by the Patient-Centered Outcomes Research Institute (PCORI)
**Study Overview: What is PCORI?**

- **Patient-Centered Outcomes Research Institute**

- **Established in 2011 by Congress through the Affordable Care Act to support comparative effectiveness research to provide information about the best available evidence to help patients and their health care providers make more informed decisions about their care**

- **Focused on studying outcomes that matter to patients in real world settings; robust stakeholder involvement a hallmark**
Study Overview: Interventions

Comparative effectiveness study of two behavioral health home model approaches to **improve the health status of individuals with serious mental illness**, increase patient activation in care, and improve engagement with primary/specialty physical health care.

**Provider-Supported Care**
- Wellness nurses focused on PH & wellness (5 providers)

**Self-Directed Care**
- Self-management toolkits & resources (6 providers)

**Enhancing patient & BH provider capacity to address PH & wellness**
Study Overview: Interventions

• Both approaches:
  – Train case managers and peer specialists as wellness coaches/health navigators
  – Establish an agency culture of wellness
  – Utilize a high-risk disease registry with key indicators of PH and BH needs
Study Overview: Data Sources

Primary Data Sources

Self-Report Measures
(Patient activation,** health status,** hope, quality of life, functional status, satisfaction with care, social support)

Qualitative Data
(Service user & provider interviews)

Learning Collaborative (LC) Data
(Implementation information)

Secondary Data Sources

HealthChoices Eligibility Data
(Medicaid eligibility)

Administrative Data
(Demographic info)

Behavioral Health Claims
(BH diagnosis, utilization)

Physical Health Claims
(Engagement in primary/specialty care**)

Pharmacy Claims
(Medication utilization)

**Primary outcome

PCORI Optimal Health Participants

1229 participants
## Study Overview: Demographics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Provider-Supported</th>
<th>Self-Directed</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
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<tr>
<td>Total</td>
<td>713</td>
<td>58.0%</td>
<td>516</td>
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<td>Age (mean/range)</td>
<td>43.47</td>
<td>19-72</td>
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<td>Gender</td>
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<tr>
<td>Female</td>
<td>428</td>
<td>60.0%</td>
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<tr>
<td>Male</td>
<td>285</td>
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<tr>
<td>Race</td>
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<td>White</td>
<td>622</td>
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<tr>
<td>Hispanic</td>
<td>3</td>
<td>0.4%</td>
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<td>Diagnosis</td>
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<tr>
<td>MDD</td>
<td>227</td>
<td>31.8%</td>
<td>234</td>
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<tr>
<td>Bipolar</td>
<td>193</td>
<td>27.1%</td>
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<td>Schizoaffective</td>
<td>131</td>
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<td>Schizophrenia</td>
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<td>12.1%</td>
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<tr>
<td>Other</td>
<td>67</td>
<td>9.4%</td>
<td>31</td>
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<tr>
<td>None</td>
<td>9</td>
<td>1.3%</td>
<td>10</td>
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Study Findings and Interpretation
Findings Executive Summary

• Learning Collaborative/Implementation Findings:
  – Performance on all process/outcome goals improved over time
  – Provider-supported arm reported higher degree of achievement on all process goals after one year of implementation

• Qualitative Interview Findings:
  – Little difference in findings between intervention arms
  – Overall positive experiences participating in (service users) or implementing (providers) interventions

• Quantitative Findings:
  – Intervention type (Provider-Supported vs. Self-Directed) has a differential impact on some patient-centered outcomes (treatment X time interaction effect)
  – Both interventions positively impact several of our outcomes over time (change over time)

• Financial Findings:
  – Indicative of long-term cost reductions in Provider-Supported (Wellness Nurse) sites, with some evidence of long-term decreases in Self-Directed (self-management navigator) sites
  – Suggestive of increased short-term PH use at both sites, but more ambulatory and lower inpatient
Structured approach for change

Adopt best practices in multiple settings

Uses adult learning principles & techniques

Time-limited learning process

Shared learning and collaboration

- Learning Sessions
- Training Manuals

Apply Skills Test Changes
- Action Periods

- Collaborative Meetings
- Ongoing TA & Support

Share Progress
- Measure Outcomes

• Learning Sessions
• Training Manuals
• Apply Skills Test Changes
• Action Periods
• Collaborative Meetings
• Ongoing TA & Support
• Share Progress

LC to Support Implementation

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Findings: LC/Implementation Data

Provider-Supported (Wellness Nurse)
Year 1: Process Goals

Self-Directed (Self-Management Tools)
Year 1: Process Goals
## Findings: LC/Implementation Data

### Provider-Supported Year 1: Outcome Goals

<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
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<tr>
<td>Respect</td>
<td>30%</td>
<td>71%</td>
<td>67%</td>
<td>86%</td>
<td>90%</td>
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<tr>
<td>Involvement</td>
<td>45%</td>
<td>40%</td>
<td>40%</td>
<td>70%</td>
<td>67%</td>
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<tr>
<td>Confidence</td>
<td>24%</td>
<td>32%</td>
<td>50%</td>
<td>60%</td>
<td>73%</td>
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### Self-Directed Year 1: Outcome Goals

<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respect</td>
<td>27%</td>
<td>27%</td>
<td>43%</td>
<td>58%</td>
<td>72%</td>
</tr>
<tr>
<td>Involvement</td>
<td>42%</td>
<td>44%</td>
<td>44%</td>
<td>50%</td>
<td>57%</td>
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<tr>
<td>Confidence</td>
<td>0</td>
<td>40%</td>
<td>78%</td>
<td>98%</td>
<td>96%</td>
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### Year 2: Sustained Implementation

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<th>August 2015</th>
<th>January 2016</th>
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<tbody>
<tr>
<td>Respect</td>
<td>83% (5/5 Reporting)</td>
<td>86% (4/5 Reporting)</td>
</tr>
<tr>
<td>Involvement</td>
<td>72% (6/6 Reporting)</td>
<td>78% (5/6 Reporting)</td>
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</table>

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Qualitative Interview Data: Svc. Users

- Shift in definition of health and wellness, away from vague/impersonal towards more personalized
- Increased awareness of interconnectedness of mental and physical health
- Overall favorable intervention experiences
- No major distinctions between arms — no evident differences in engagement in or satisfaction with interventions
- Most important factor leading to intervention participation was relationship with wellness coach

<table>
<thead>
<tr>
<th>Code Name</th>
<th>Round 3 # of Participants</th>
<th>Round 2 # of Participants</th>
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<tbody>
<tr>
<td>Goal Exercise</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>Goal Eating</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Goal Weight Loss</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Goal Relationships</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Goal Tobacco</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Goal Medication</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Goal Mental/Emotional Health</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Goal Other</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Goal Unsure</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Goal None</td>
<td>6</td>
<td>17</td>
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<tr>
<td>Goal General Activity</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Goal Independence</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Goal Physical/Dental Health Appointments</td>
<td>3</td>
<td>6</td>
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<tr>
<td>Goal Starting</td>
<td>3</td>
<td>3</td>
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<tr>
<td>Goal Sobriety</td>
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<td>1</td>
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<tr>
<td>Goal Social Services</td>
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<td>9</td>
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<tr>
<td>Goal Sleep</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Goal Cleaning</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>
Qualitative Interview Data: Svc. Users

“We made a goal [for walking] a half mile. I go and sometimes I go a mile. So we start from the mile and then we go up. If I didn’t make it and went back, then I told her I’d make it up. So I go and instead of doing the mile, I do a mile and a half. That way I keep myself ahead.”

“...Going to the doctor and asking him about the Chantix...I was afraid to take it because it straight says on there, ‘if you have depression, talk to your doctor first.’...It didn’t seem to have any bad effect on that...Overall, it really helped me quit. It took away that urge to want the cigarette smoke.”

“I'm eating a lot more fruits and vegetables. Cutting down what I'm eating. Trying to watch my calories. She [the case manager] knows that I just started watching my calories and she’ll ask me how the calorie counting is going...she’ll encourage me.”

“I've actually exceeded my goal...the weight I'm at now, I haven't been since I was a young teenager...I lost 25 pounds in the beginning and I've actually lost more close to 45. I feel like I have more energy.”
Qualitative Interview Data: Providers

• Agency response:
  – High degree of agency support for wellness coaching
  – Establishment of culture of wellness
  – Continued use of model post study implementation period
  – Staff turnover problematic for maintaining wellness coaching continuity
  – Worry about service user “relapse” when discharged from CMHC

• Provider response:
  – Providers simplified/casualized wellness coaching to increase service user engagement
  – Nurses often mentioned as most beneficial component of the model
  – Providers often established their own wellness goal(s)
Qualitative Interview Data: Providers

• Service user response (provider perception):
  – Robustly positive impact on service user’s health/wellness
  – Some service users resistant to wellness coaching due to mental illness severity or age (e.g., being set in their ways)
  – Structural barriers (e.g., lack of access to health care, community resources, transportation) limits success

• Physician response:
  – Several providers indicated difficulties engaging with primary care providers (especially at interview time point three)
“We really need to find a way to keep this program going for them because we finally got them doctors. We can’t just say, ‘Oh, we’re sorry’ now. It’s done so much for them...We know how important this is for the consumers...A gentleman in his late 50s, he has some intellectual disabilities, and he was very anxious about getting testing for us. We wanted his to get an echo and a stress test...labs, x-rays...he is now going to get these tests...and on top of all that, he has lost about 36 pounds.”

“We had better coordination of care and her hospital visits decreased. Before I met her, she said she was going [to the hospital] once or twice a month; now she might go once every three months when her bronchitis flares up a little bit, but she’s able to come home the next day or the day after that so it’s not as traumatic...She sees the wellness nurse and she gets all of the information she needs regarding each specialist. And there was a time when she was here and monitored by the wellness nurse, and the nurse said, ‘You need to go to the ER because you’re not well, you’re coughing, and your blood pressure is sky high.’ If she wouldn’t have come in and had those things done...A regular visit from back in the day, she would have come in and she would say, ‘I’m fine,’ and I don’t know that she would have made it.”

“He went from three packs a week to one pack a month, and he did that within six months...His goal within the next six months is to quit smoking all together & not use the e-cigarette.”
## Quantitative Data: Brief Summary

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Significant Treatment X Time Interaction</th>
<th>Significant Change Over Time</th>
<th>Gender as a Moderator</th>
<th>No Significant Findings</th>
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<tr>
<td><strong>Primary Outcomes</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Patient Activation</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Health Status – Mental</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Health Status – Physical</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
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<tr>
<td>Engagement in Primary/ Specialty Care</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
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<tr>
<td><strong>Secondary Outcomes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hope</td>
<td></td>
<td>X</td>
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<td></td>
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<tr>
<td>Quality of Life</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Emergent Care Use</td>
<td></td>
<td>X</td>
<td></td>
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<tr>
<td>Lab Monitoring*</td>
<td>X (total services; glucose)</td>
<td>X (lipids)</td>
<td></td>
<td>X (EKG)</td>
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<td>Medication Adherence*</td>
<td>X (antidepressants; hypertension; diabetes)</td>
<td></td>
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<td>X (antipsychotics)</td>
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<tr>
<td>Satisfaction with Care</td>
<td></td>
<td>X</td>
<td></td>
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<tr>
<td>Functional Status</td>
<td></td>
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<td>X</td>
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</table>
Quantitative: Patient Activation

• What is patient activation?
  – Measures an individual’s level of engagement in their own health care; measured via the Patient Activation Measure (PAM)
  – Past research suggests even a small increase in patient activation is associated with reductions in health care utilization and improved medication adherence

• Our finding: provider-supported (treatment A) led to more immediate and stable improvement in patient activation (significant treatment X time interaction effect)
Quantitative: Patient Activation
Quantitative: Patient Activation

• Our finding: Female gender is associated with quicker improvement in patient activation in the Provider-Supported (Treatment A) arm (significant treatment X time X gender effect)
Quantitative: Patient Activation

Least Squares Mean Estimates of PAM by Treatment over Time:
Male

Least Squares Mean Estimates of PAM by Treatment over Time:
Female
Quantitative: Health Status

• What is health status?
  – Health status measured with the SF-12, which measures both *perceived physical and mental health*
  – The national mean score for SF-12 is 50; our participants scored much lower than the national average
  – Research shows that even a small score change can impact mortality rates and other health-related factors

• Our findings:
  – Mental health status score increased, particularly at month 6 (significant change over time)
  – Physical health status score decreased over time, particularly after month 12 (significant change over time)
Quantitative: Mental Health Status

Month at 0: 39.30
Month at 6: 40.30
Month at 12: 40.00
Month at 18: 39.92
Month at 24: 39.90

Least Squares Mean Estimates of SF12_Mental by Treatment over Time
Quantitative: Physical Health Status

Least Squares Mean Estimates of SF12_Physical by Treatment over Time

Month at 0: 42.28
Month at 6: 41.86
Month at 12: 41.18
Month at 18: 41.02
Month at 24: 41.04
Quantitative: Health Care Utilization

Engagement in Primary/ Specialty Care

• Our finding: while the two interventions did not differ significantly in their impact on this outcome, both showed improvement over time (significant change over time)

Emergent Care Use

• Our finding: two interventions were significantly different with regard to their impact on ED use; Self-Directed started off with higher utilization and decreased more drastically, Provider-Supported remained fairly stable over time (significant treatment X time interaction effect)
Engagement - Primary/Specialty Care

Engagement in primary/specialty care

<table>
<thead>
<tr>
<th>Month from the baseline</th>
<th>Treatment A</th>
<th>Treatment B</th>
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<tbody>
<tr>
<td>Month at 0</td>
<td>6.64</td>
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<td>Month at 12</td>
<td>9.34</td>
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<tr>
<td>Month at 24</td>
<td>9.09</td>
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## Emergent Care Use

![Least Squares Mean Estimates of Emergent care by Treatment over Time](image)

<table>
<thead>
<tr>
<th>Month</th>
<th>Treatment: A (PS)</th>
<th>[Lower, Upper]</th>
<th>Treatment: B (SD)</th>
<th>[Lower, Upper]</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>2.88 (2.10, 3.66)</td>
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<td>3.61 (2.89, 4.32)</td>
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</tr>
<tr>
<td>12</td>
<td>2.95 (2.10, 3.80)</td>
<td></td>
<td>3.00 (2.29, 3.72)</td>
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</tr>
<tr>
<td>24</td>
<td>2.60 (1.86, 3.33)</td>
<td></td>
<td>2.85 (2.10, 3.60)</td>
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</tbody>
</table>
Quantitative: Quality of Life

• What is quality of life?
  – Measured using the Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (Q-LES-Q-SF) which assesses physical health, mood, relationships, and well-being, among other variables

• Our finding: Provider-Supported (Treatment A) started off with a higher score and the score peaked at 6 months. Quality of life score for Self-Directed (Treatment B) peaked at 12 months (significant treatment X time interaction effect)
Quantitative: Quality of Life

Least Squares Mean Estimates of QSF_percent by Treatment over Time

![Graph showing the least squares mean estimates of QSF_percent by treatment over time.](image-url)
Program Cost Evaluation*

*These analyses were conducted independent of PCORI-funded contract
Program Cost Evaluation

- Background and goals
- Trial data methodology and results
- Post-trial comparison group methodology and results
- Follow-up questions and answers
- Conclusions and caveats
Background and Goals

- Community Care has rolled out several waves of behavioral health home (BHH) initiatives
  - Programs seek to integrate BH and PH care with goals of better health outcomes and lower costs

PCORI – November 2013

859 patients enrolled in study*

5 On-site Provider Supported Wellness Nurse practices (Intervention)

6 Self-Directed Health Navigator practices (Control)

* 1,229 patients originally identified with SMI diagnosis in demonstration agencies. Those included in study only received TCM from the agency with which they enrolled and had at least one month of Community Care HealthChoices eligibility in each of the three years of the study.
Background and Goals

• Comparison of utilization and spending

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<th>Total</th>
<th>IP</th>
<th>Rx</th>
<th>TCM</th>
<th>ER</th>
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<tr>
<td>Overall</td>
<td>Overall</td>
<td>Overall</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PH</td>
<td>PH</td>
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</tr>
<tr>
<td>BH</td>
<td>BH</td>
<td></td>
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</table>

PMPM
(spending per SMI patients enrolled in the study per month)

Use
(measured by monthly penetration rate)
Trial Data: Methodology

- PCORI sites were randomized
- DHS provides full, historical encounter extract for initial patients
- PCORI groups are best source for evaluation of BHH initiative
- Evaluating cost using cluster randomized trial design focusing on intervention (nurse + navigator training) vs. control (navigator training only) in each of first two measurement years for which there is complete runout
- Costs are based on a publicly available standardized pricing algorithm (TCRRV) calibrated against Medicaid prices and applied to DHS-supplied encounter data as well as Community Care BH data
Trial Data Only: Results

Nurse vs. Navigator

**Total**
- Year 2: PMPM 9% lower
- Years 1 and 2: PH use 5% higher
- Year 2: BH 16% PMPM lower

**IP**
- Year 2: Overall use 23% lower
- Years 1 and 2: PH use and PMPM 25% lower
- Year 2: BH use

**Rx**
- Year 1: PMPM 24% higher
- Year 2: Psychotropic use and PMPM 15% higher

**TCM**
- Year 1: PMPM 19% lower
- Year 2: PMPM 33% lower

**ER**
- Year 1: Use 17% lower
- Years 1 and 2: PMPM lower (19%, 33%)

- Total spending lower with nurse practices in longer term
- Nurse practices engaging patients more with PH services while decreasing PH IP
- BH service use lower with nurse practices, including IP, psychotropics and TCM

*Controlled for baseline demographics and PMPM

† Statistically significant (<0.05)
‡ Suggestive; not quite statistically significant (<0.2)
Trial Data Only: Results

**Total PMPM change vs. Year 0**

![Graph showing total PMPM change](image1)

**BH PMPM change vs. Year 0**

![Graph showing BH PMPM change](image2)

**PH penetration change vs. Year 0**

![Graph showing PH penetration change](image3)

**TCM PMPM change vs. Year 0**

![Graph showing TCM PMPM change](image4)
Post-Trial Comp. Group: Methodology

859 PCORI-enrolled patients
- 11 agencies
- SMI diagnosis
- TCM only from enrollment agency
- Eligibility in at least one month in each of three years

859 PCORI-match patients
- 18 agencies
- No TCM from PCORI agencies or roll-out agencies
- Mix of counties, including Allegheny, may impact results

Age
Gender
SMI diagnosis
Continuous eligibility and attribution
Baseline total cost
Other total costs
Post-Trial Comparison Group: Results

<table>
<thead>
<tr>
<th>Nurse + Nav</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td><strong>IP</strong></td>
</tr>
<tr>
<td>Year 2: PMPM 15% lower♦</td>
<td>Year 2: Use 30-40% lower♦ and cost 20-25% lower♦</td>
</tr>
<tr>
<td>Years 1 and 2: PH use (40-50%) higher♦</td>
<td>Year 2: PH Use 30-35% lower♦</td>
</tr>
<tr>
<td>Year 2: BH PMPM 20-30% lower♦</td>
<td></td>
</tr>
</tbody>
</table>

- Nurse sites have lower long-term spending driven largely by decreases in BH
- Nurse sites have increased PH use but similar PH cost and less PH IP use
- Nurse sites have less RX use but higher RX costs
- Nurse sites have long-term decreases in TCM costs
Findings Recap

**BEHAVIORAL HEALTH HOME MODELS**

- **PATIENT SELF-DIRECTED CARE**
  - N=516 Enrolled
  - (6 participating CMHCs)
  - Unique Components:
    - Self-Directed
    - Later improvement in Patient Activation (18 months)
    - Improvement in activation more significant in men
    - More immediate decrease in ED utilization

- **PROVIDER-SUPPORTED INTEGRATED CARE**
  - N=713 Enrolled
  - (5 participating CMHCs)
  - Unique Components:
    - Provider-Supported
    - Earlier improvement in Patient Activation (6 months)
    - Improvement in activation more significant in women
    - More immediate increase in quality of life

**Common Components**

- WELLNESS COACHING & HEALTH NAVIGATION
- PROVIDER COLLABORATION
- CULTURE OF WELLNESS

**Significant Findings**

- Improvement in engagement in primary/specialty care (approx. 40% increase in number of visits)
- Improvement in perceived mental health status and decline in physical health status
Discussion and Next Steps
Discussion

• Lessons learned

• Applicability to behavioral health providers

• Key takeaways
Next Steps

• Complete interpretation of study findings and develop final research report

• Dissemination
  – PCORI
  – Clinical trials
  – Manuscripts
  – Conference presentations
  – Stakeholder forums and results materials
  – Optimal Health dissemination website
  – PCORI dissemination funding opportunity

• Behavioral health home expansion
Behavioral Health Home Expansion

- Additional populations served: adolescents, opioid treatment programs
- Population Health LC for mature providers focused on hypertension & smoking cessation: 19 BHHs participating in first cohort, second cohort began July 2017
Thank You