MAINE QUALITY COUNTS

Maine Behavioral Health Home Learning Session

Integrated Care and Behavioral Health Home Pilots: RI and Beyond

Augusta, Maine
February 27, 2015

Michael S. Varadian, JD, MBA
RECOGNIZE THE HEALTH HOME OPPORTUNITY!

- An innovative initiative to provide services to individuals to address both Behavioral Health and Primary Care conditions
- Aligns with State’s effort to implement a recovery oriented system of care
- Offers states the opportunity to provide Medicaid coverage, at an enhanced Federal Medicaid Participation Rate of 90-10 (FMAP)
- Win-Win result on improving access, use and coordination of appropriate care
RI’S MEDICAID HEALTH HOMES

- RI has implemented three statewide HH programs:

  - Community Mental Health Organizations (CMHOs)
    - 7 CMHOs and 2 Specialty MH Centers
    - Approximately 5,200 SMI enrollees

  - Comprehensive Evaluation Diagnosis Assessment Referral Re-evaluation Family Centers (CEDARRs)
    - 4 CEDARR centers
    - Approximately 2,700 Children and Youth enrollees

  - Opiate Treatment Program Providers
    - 5 OTP providers - 12 sites
    - 2,588 opioid dependent adults with chronic conditions
    - CARF Accredited
RI CMHO HEALTH HOME SPA TEAM

- CMHO/Agency Representative
- Trade Organization Representative
- State Medicaid Agency Representative
- BHDDH Program and Fiscal Staff
- Managed Care Organizations
- Transformation Advisory Group
DEFINE THE POPULATION

- CMS Requires that the Health Home Populations meet one of the following criteria:
  - Have two chronic conditions
  - Have one chronic condition and be at risk for a second
  - Have one Serious Mental Illness (SMI)

- RI CMHO Population include individuals who have SMI, with most having other chronic conditions as well
DEFINE THE POPULATION

- RI CMHOs serve approximately 7,600 persons with SMI:
  - 35.5% - Medicaid eligible
  - 33.9% - Dually eligible (Medicaid/Medicare)
  - 14.4% - Medicare only
  - 5.5% - Other insurance
  - 10.7% - Uninsured

- In RI, all Medicaid-only individuals are enrolled in Managed Care, with BH-carve out for persons with SMI. All Medicaid SMI individuals were auto assigned to a Health Home provider. This option no longer exists as CMS now requires opt-in or opt-out choices.
CORE CMS HEALTH HOME SERVICES

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Support Services
THE CMHO HEALTH HOME TEAM

- A Master’s Level Team Coordinator (1 FTE)
- A Psychiatrist (0.5 FTE)
- A Registered Nurse (2.5 FTE) *(Key role, CNA could help)*
- A Licensed and Master’s prepared mental health professional (1 FTE)
- A Community Support Professional – Hospital Liaison (1 FTE) *(Key role, consider expanding)*
- Community Support Professionals (5.5 FTE) *(keep caseload<30)*
- A Peer Specialist (0.25 FTE) As the resource becomes available
- **Total of 11.25 FTEs per 200 clients**
THE CMHO HEALTH HOME TEAM

- Other health team members may include, but are not limited to:
  - primary care physicians
  - pharmacists
  - substance abuse specialists
  - vocational/employment specialists
  - community integration specialists
  - affordable housing resources
RI Children’s Health Home Program: CEDARR
(Comprehensive Evaluation, Diagnosis, Assessment, Referral and Reevaluation)

- Changed existing provider communication and information sharing process to comply with Health Home data sharing definitions and integration with multiple provider systems

- Pediatrician buy-in essential to help expand coverage to complex population for a more holistic treatment approach

- Health Home provided additional resources to encourage participation in areas traditionally outside traditional practice (i.e., linking obesity or low healthy weight to depression or other mental health issues)
RI Children’s Health Home Program: CEDARR
(Comprehensive Evaluation, Diagnosis, Assessment, Referral and Reevaluation)

- New data collection requirements include tracking of outcome measures such as: family information on stress levels; knowledge of the patient’s condition; ability to advocate for their child; and level of normalcy (activities)

- Facilitates transition into adult CMHO Health Home
RI QUALITY MEASURES

- Goal Based Quality Measures:
  - Improve Care Coordination
  - Reduce Preventable Emergency Department (ED) Visits
  - Increase Use of Preventive Services
  - Improve Management of Chronic Conditions
  - Improve Transitions to CMHO Services
  - Reduce Hospital Readmissions

- Within each domain, are measures for:
  - Clinical care
  - Experience of Care
  - Quality of Care
RI HEALTH HOME SERVICE
DEVELOPMENT PRINCIPLES

1. Person/Family Centered Care Coordination
2. Comprehensive Whole Person Care
3. Evidenced-Based (Self Management Goal)
4. Accountable (HH fixed point of responsibility)
5. Continuity and Transition Management
6. Proactive Outreach/Engagement
7. Data-Driven Outcome-based Approach (to customize ongoing treatment plans)
8. Community Provider Engagement/Collaboration Strategy
MAINE BEHAVIORAL HEALTH HOME SPA GOALS

1. Reduce Inefficient Healthcare Spending
2. Improve Chronic Disease Management
3. Promotion of Wellness and Prevention
4. Recovery and Effective Management of Behavioral Health Conditions
5. Promote Improved Experience of Care for Consumers/Families
VARIED STATE APPROACHES TO HEALTH HOMES

- **Iowa**: opportunity to strengthen primary care practices and PCMH certification for system transformation

- **New York**: align diverse care management initiatives and integrate siloed programs to promote accountability

- **Missouri**: improve coordination and transition of care, and integrate BH/PC to reduce hospitalizations

- **Oregon**: increase access to PCMH and allow Medicaid to be a key PCMH player in multi-payer strategy

- **RI**: coordinate siloed children’s program and improve care management and integration of adult programs
NATIONAL COMMON THEMES AND BEST PRACTICES

1. Comprehensive Care Management
   - Track care plan goals, MH/SA screenings and reassessment

2. Care Coordination
   - Face to face contacts, case conferences and improve notification of admissions

3. Health Promotion
   - Focus on patient engagement and address non-clinical needs

4. Comprehensive Transitional Care
   - Pharmacy coordination, hospital liaisons and home visits

5. Individual and Family Supports
   - Assist to develop social networks, advance directives

6. Referral to Community Resources
   - Develop resource manual, identify policies, procedures and accountabilities with community based groups
EVALUATION OVERVIEW

- States must describe how to collect information from CMHOs, MCOs, Medicaid and Medicare for purposes of providing data for the 2017 Congressional Health Home report, which will ultimately influence the value, extent and use of this program, as it pertains to the following:
  - Hospital Admission rates
  - Chronic Disease Management
  - Coordination of care for individuals with chronic conditions
  - Assessment of program implementation
  - Processes and lessons learned
  - Assessment of quality improvements and clinical outcomes
  - Estimates of cost savings
RI HEALTH HOME PROGRAM
AUDIT

- Audit Tool/Certification Report
  - Based on Person Centered Health Home Best Practice Standards issued in September 2012
  - Covers all six key Health Home categories
  - Uses multiple sources of information:
    - Chart reviews
    - Interviews with staff
    - Observation of team meetings
    - Agency’s own self rating scores compared to BHDDH results
    - Discuss pathways to goals and outcomes
Audits of 9 Health Home provider agencies conducted from January-March, 2013

Three-step audit process developed with Person Centered Health Home Audit Tool

1. Provider Agency Self Audit
2. Department Site Visit Audit
3. Comparison of results and discussion of Audit findings/plans of correction

Many components of the Health Home program performed very well; Thus, I highlight identified areas of caution and components needing improvement
RI HEALTH HOME PROGRAM
AUDIT FINDINGS

Comprehensive Care Management

- Focus on key areas of medical discharge and urgent care follow-up
- Management of prescriptions and compliance
- Develop system to stratify client needs/supports
- Refine team communication process
RI HEALTH HOME PROGRAM 
AUDIT FINDINGS

Comprehensive Care Management

- Strengthen liaison with primary care provider staff (education, data, collaboration, care coordination)

- Develop comprehensive and culturally appropriate health assessment - nurses are critical team members

- Develop training on key areas of medical interface, standardized assessment, medication management, data collection
RI HEALTH HOME PROGRAM AUDIT FINDINGS

Care Coordination and Health Promotion

- Caseload size (<30) and turnover key factors of effectiveness

- Training needs (stage of client’s health, motivational interviewing, health coaching, knowledge of chronic disease management)

- Lack of evidenced based guidelines (integrated assessment/screening, interface with primary care, medical discharge planning, medication reconciliation)
RI HEALTH HOME PROGRAM
AUDIT FINDINGS

Care Coordination and Health Promotion

- MIS capacity needed for team data sharing (medical data, comprehensive assessment, lab results, treatment regimen, appointments, tracking, etc.)

- *Currentcare* statewide HIE participation and challenges

- MOUs needed beyond behavioral/primary care to include secondary level care providers and local institutions (schools, police, churches, community agencies and recreational programs, support groups, etc.)
Comprehensive Transitional Care

- Health Home client medical hospital admission notification to agencies is still a challenge because of privacy, HIPAA rules, hospital regulations and medical clinical territorial issues.

- Transitions (discharge planning, post discharge care, follow-up tracking, medication reconciliation) worked more effectively with psychiatric hospital admissions based on past practices > role of hospital liaisons.

- Current process involves notification from insurers vs. providers: (Insurers have financial incentives.)
Comprehensive Transitional Care

- Hospital liaisons and pharmacy are critical to this area
- Transitions to/from other facilities (LTC, rehab, day treatment, corrections, community services) better networked and managed
- Identify and address consumer’s barriers to self management and understanding of post hospital care
RI HEALTH HOME PROGRAM
AUDIT FINDINGS

Individual and Family Support Services

- Plans of care need improvement related to consumer and family preferences, education, support for self-management, coping skills and resources to understand health risks and implement health action goals.

- Transportation and accompanying to appointment.

- Improve involvement of family—may need engagement and negotiation.

- Consider ethnic, language, literacy and cultural issues.

- Need to further develop role and relationship with FQHCs.
Referral to/Mobilizing Community and Social Support Services

- Variable effectiveness in focus on self-management and addressing risk factors of heart disease, obesity, diabetes, hypertension, and circulatory conditions (training, consumer desire)

- Key areas to emphasize: support skills/techniques to deal with frustration, fatigue, pain and isolation

- Appropriate use of medication (filling prescriptions and compliance, etc.)
RI HEALTH HOME PROGRAM
AUDIT FINDINGS

Referral to/Mobilizing Community and Social Support Services

- Nutrition and decision making regarding new self-management goals
- Need to address functional impairment (thinking and planning, sociability/emotional expression, activity/interest and anxiety management)
- Re-evaluate composition and effectiveness of network
Use of Health Information Technology to Link Services

- The barrier of information sharing will be the major factor limiting the effectiveness of care coordination.

- Agency MIS systems are challenged to incorporate medical disorders, screenings, health risks, expanded medications, etc., into behavioral health software programs.

- Health Home field needs technical support to aid standardization of integrated care data collection and reporting components.

- Need process to interface medical records with hospitals, primary care, laboratories, pharmacies, etc., and data sharing features.
RI HEALTH HOME PROGRAM
AUDIT FINDINGS

Use of Health Information Technology to Link Services

- Meaningful Use HITECH Act stage two provisions for sharing data

- MCOs need to share claims data and reporting with CMHOs for Health Home clients (set timelines, reporting requirement, etc.)

- Tracking, follow-up, notifications, and client and team communication must be features of MIS system

- Currentcare statewide HIE slowly serving Health Homes (Maine’s HealthInfoNet may be more advanced...status?)
HEALTH INFORMATION TECHNOLOGY

- CMHOs still attempting to implement, integrate and standardize EHRs

- Medicaid MCOs providing CMHOs with quarterly claims data for the 35% of Medicaid Health Home recipients enrolled in MCOs, including health utilization profiles:
  - Hospital admissions
  - # Emergency Room Visits
  - Last ER Visit Date
  - Last ER Visit Primary Diagnosis
  - # Urgent Care Visits
  - PCP site and date of last PCP visit, etc.
The state has still not been able to obtain Medicare utilization and cost data (hospitalization, primary care services, ER visits, etc.) for 33% of Health Home population that is dual eligible.

*Try to develop system to track “appropriate” inpatient and ER admissions and “avoidable” readmissions.
The state currently collects a great deal of self report data on the state RIBHOLD (RI Behavioral Healthcare On-Line Database) system including commonly co-occurring conditions such as:

- MH/SA, Developmental Disabilities, Pregnancy, Smoking, Hypertension, Hepatitis, Life Threatening Viral Illness, Hypercholesterolemia, Obesity, Diabetes, Asthma and Chronic Obstructive Pulmonary Disease

An outside consultant is assisting the state to access and analyze claims data to measure Health Homes outcomes.
HEALTH INFORMATION TECHNOLOGY

- Agencies report monthly on, for example: # of HH clients served, # newly admitted HH clients, # of clients receiving face to face services within 10 days of hospital discharge, # of psychiatric admissions and other encounter data detailing type of contact and duration

- Agencies also report HH FTE team composition and vacancies
A number of states have experienced changes to service delivery and payment systems as a result of Health Homes, including:

- Increase in PCMH
- Integrated care demonstrations
- Managed care redesigns
- Medicaid Accountable Care Organizations
- State Innovative Model Design Grants
- Coverage Expansion
REPORTED OUTCOMES FROM STATES

- New York
  - 14% increase in PC visits
  - 23% decrease in hospital admissions and ER visits
  - 30% decrease in inpatient spending for enrollees

- Missouri
  - 8% decrease in ER visits
  - 13% decrease in ambulatory-sensitive hospitalizations
  - Average savings to state of $52 PMPM

- Rhode Island (one agency)
  - 13% decrease in medical admissions
  - 15% decrease in psychiatric admissions
  - PCP identified for 85% of clients
IMPLEMENTATION EXPERIENCE

- Communication is Key
  - Ongoing Provider Association and Consumer/Family Involvement is critical to address cultural issues
  - Provider Certification Agreement
    - State and Agency roles and responsibilities
    - Care coordination agreement templates with hospitals and MCOs
  - Health Homes Resource Manual
    - Program goals
    - Team functions
    - CMS outcomes
    - Event databases
    - Fee schedules
    - Auditing tool
IMPLEMENTATION EXPERIENCE

- Almost 70% of RI SPMI Health Home clients have substance abuse, homelessness or unemployment issues affecting clinical outcomes.

- It is challenging to separate care coordination from treatment when (necessarily) occurring in the same time period to address all of these issues.

- It is also challenging to separate populations between Health Home and non-Health Home clients who must be treated (differently) by the same staff.
IMPLEMENTATION EXPERIENCE

- Need a less intensive level of care to support recovery

- 10-20% of Health Home clients lose their Medicaid eligibility (spend down/flex off) at some point and it may take 3-6 months to re-enroll, disrupting clinical outcomes (lose access to primary care and medications because of no coverage or unaffordable deductibles/co-pays)

- *Need a state Health Home program coordinator to manage resources, data collection and outcome reporting
IMPLEMENTATION EXPERIENCE

- Change Is Always A Challenge (and Opportunity)
  - New rules and systems need to be clarified

- However, client clinical needs do not pause for change

- Broad variation in provider capacities and organization

- Low operating margins- training, reimbursement, etc.
IMPLEMENTATION EXPERIENCE

- Change Is Always A Challenge (and Opportunity)
  - Role change from case manager to care coordinator
  - Data changes take forever and always involve other areas
  - Reporting systems needed for outcomes as well as payment
  - Be aware of impact of outside issues- transportation, housing, vocational issues, substance abuse
  - Overall, anticipate and include enough ramp-up time in program to minimize disruption and foster compliance
IMPLEMENTATION EXPERIENCE

Financial Challenges

- Transition from blended fee for service and per diem rate to case rates were both favorable to some and unfavorable to other agencies

- Changes in rules and reporting (minimums) negatively affected revenue streams in most agencies

- New payment methodology provided reimbursement for care coordination activities that were not funded or provided uniformly (i.e., new encounter reporting), however, treatment funding reduced
IMPLEMENTATION EXPERIENCE

Financial Challenges

- Enrollees were going in and out of Medicaid eligibility, which created vacuums in reimbursement, coverage and treatment plan effectiveness.

- Staff report that there should be a group home facility for more intensive SPMI clients that don’t do well in a nursing home care as a more cost and clinically effective setting.

- Some (medical) admissions may increase with coordinated access to needed care and better educated/empowered consumers.
IMPLEMENTATION EXPERIENCE

- What Are the Clients Saying, so far..?

  - I never had these clinicians, specialists, coordinators and transportation services
  - More attentive to interventions
  - Better grasp of treatment compliance issues
  - Higher self esteem in primary care settings
IMPLEMENTATION EXPERIENCE

What Are the Clients Saying, so far..?

- Less medication errors and omissions (unintentional and intentional!)- Prescription Monitoring Program

- Hospital liaisons and peer specialists very helpful

- Positive response from their PCPs (welcoming help with difficult patient population)

- Major life improvement- physical ailments have inhibited behavioral health recovery, and vice versa
THANK YOU!

QUESTIONS AND CONTACT:

Michael S. Varadian: 617-462-4668
msvaradian@gmail.com