Concepts for Physical Health, Mental Health & SUD Services Integration

Presentation before
Workforce Development Expert Workgroup
Section 1115 Medicaid Waiver Renewal
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MHSUDS Integration Task Force Meeting (11/10/14)

- Purpose: Input on short- and long-term strategies to transform California's BH programs into a high-performing, fully integrated system
- Convened CA thought leaders in relevant fields
- Participants asked to think broadly and strategically

Programmatic Concepts for Consideration

Input was received for:

a. Data system infrastructure

b. Comprehensive care coordination services

c. Multidisciplinary teaming

d. Psychiatric/PCP consultations

e. Peer providers

f. SBIRT expansion and training sustainability

g. Cross systems training

h. Measurements to enhance accountability

The Concepts Support Overall Vision for Medi-Cal and 1115 Waiver Renewal

The programatic concepts fit at least one of the goals defined by DHCS for workforce development

The programatic concepts are consistent with the criteria DHCS developed for the Waiver renewal

Workforce Development Goals

Goal 1 : Increase number of health workers to provide health care services in medically underserved areas or to serve a high number of Medicaid beneficiaries

Goal 2: Develop innovative ways to address whole person care to meet the unique yet interrelated needs of physical and behavioral health

Goal 3: Create financial and other incentives to encourage greater commitment to serve Medicaid beneficiaries and practice in underserved areas

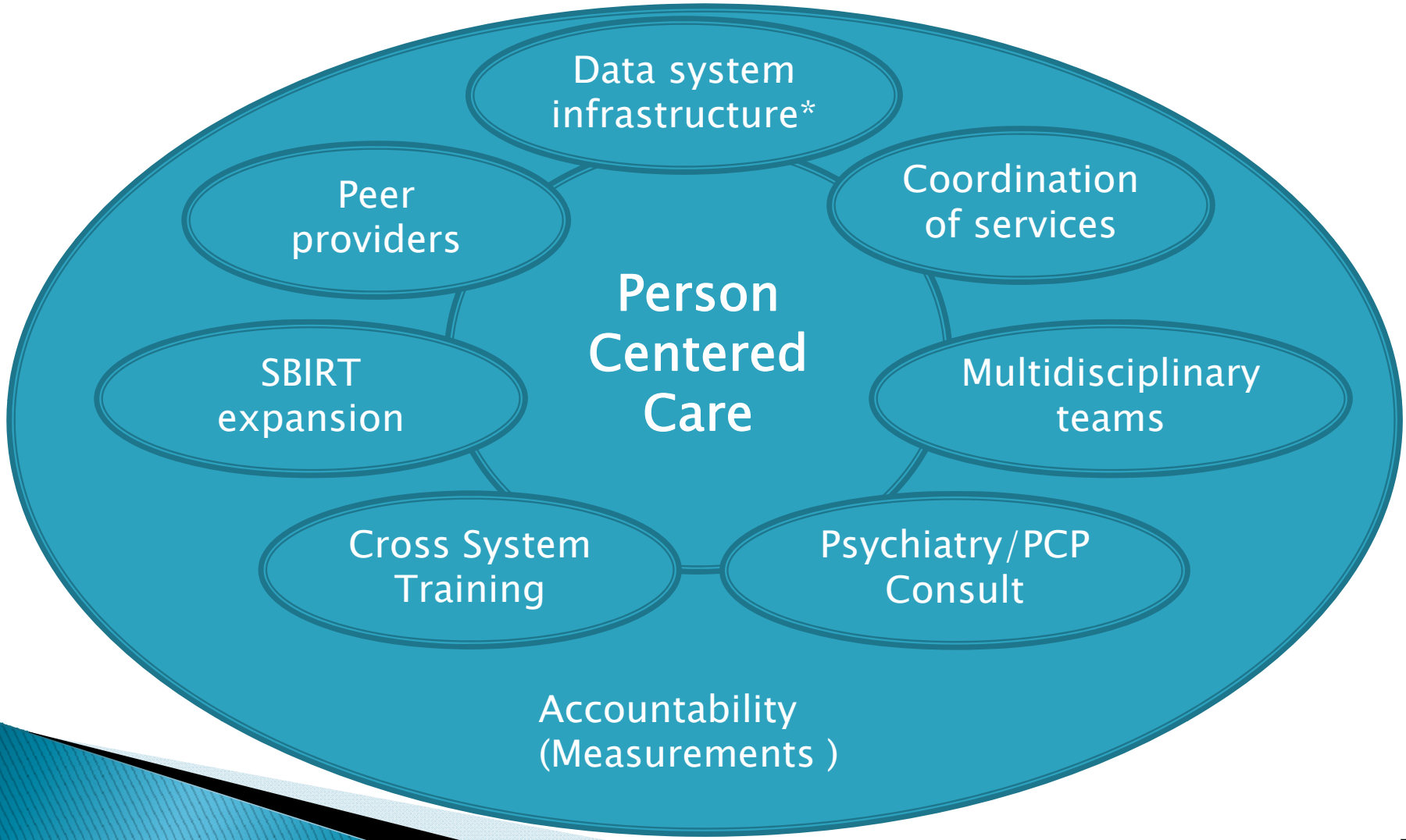
Taken from Dodson, December 2014

Workforce Development Workgroup: Criteria for Consideration

- Addresses Workforce Goals
- Fits shared CMS 1115 Waiver Renewal Goals
  - To further delivery of high quality and cost efficient care for our beneficiaries
  - To ensure long-term viability of the delivery system post-ACA expansion
  - To continue California's momentum and successes in innovation achieved under the "Bridge to Reform" Waiver
- Feasible
  - Medicaid laws and regulations and CMS financial participation requirements
  - State law
  - Stakeholder support
- Measurable for Evaluation

Taken from Dodson, December 2014

Building blocks for Integration



Care Coordinators who offer Comprehensive Care Coordination Services

Behavioral Health Integration Strategies for consideration:

1) Coordination of care across payer and provider organizations for individuals with complex behavioral and physical health conditions

2) The Care Coordinator "intentionally ensures the necessary degree of screening, referrals, tracking, outcome measurement, and care coordination needed to assure good health outcomes." (Avery, 2014)

Options:

a) Hire Care Coordinators to serve as the single point of contact

b) Ensure Care Coordination processes tailored to population served

Multidisciplinary Teaming

Behavioral Health Integration Strategies for Consideration:

1) Collaboration between providers, which can include care coordinators, clinical social workers, community health workers, psychiatrists, pharmacists, counselors
2) Practices informed by evidence

Option:

a) Enable plans/providers to finance and implement a collaboration model that works for their circumstances while encouraging use of core evidence based practices

Psychiatric / PCP Consult

Behavioral Health Integration Strategies for consideration :

1) Primary care access to psychiatric services
2) Coordination/Integration with primary care

Options:

a) Increase access to psychiatric consultation using sustainable financing and tele-health where appropriate
b) Facilitate evidence-based practices such as systematic psychiatric caseload reviews and tele-mentoring

Peer Providers: Certification and Reimbursement

Behavioral Health Integration Strategies for consideration:

1) Common definition of Peer Providers
2) Framework for the services/supports they provide
3) Certification
4) Reimbursement Strategy

Options:

a) Adopt a common definition for California
b) Design and implement a services/supports framework
c) Certify and make services reimbursable

SBIRT Expansion and Sustaining Training

Behavioral Health Integration Strategies for Consideration:

1) Screening patients for SUDs at all points of care
2) Training for providers in appropriate screening practices

Options:

a) Expand SBIRT Locations
b) Expand Screening services to include other populations
c) Expand professionals who can supervise SBIRT services
d) Expand training effort to include learning collaboratives and technical assistance. Emphasize sustainability

Cross Systems Training

Behavioral Health Integration Strategies for Consideration:

1) **Partnerships across systems of care**: primary care, BH, MCP, peer providers, social service providers

Options:

a) Offer cross system, multi-county learning collaboratives
b) Provide an overview of evidence-based practices: motivational interviewing, self-help, medication assisted treatment
c) Offer implementation learning collaboratives to sites
d) Offer intensive coaching to systems partners in individual counties that need more support than can be offered in a learning collaborative

Accountability – Example BH Int. Measures

Condition/Area	Performance Measure *
Utilization and Access	• Sensitive Condition Admission (1. Grand Mal and other Epileptic Convulsions, 2. COPD, 3. Asthma, 4. Diabetes, 5. Heart failure and Pulmonary Edema, 6. Hypertension, 7. Angina)* • ED Utilization rates • ED Utilization rates – mental health and SUD • Inpatient Utilization rates • Inpatient Utilization rates – mental health and SUD • Follow-up after MH hospitalization* • Successful Linkages to Integrated Care
Access to Preventive/Ambulatory Health Visits	• All-cause readmission (number of acute 30-day readmissions for any diagnosis)

- * CMS measures. (Still under development and review.)
- Most other measures are national measures taken from NQF/NCQA. A few are taken from other states (e.g., Ohio) or CA specific.

Accountability – cont.

Condition/Area	Performance Measure
Care Coordination	• Timely Transmission of Transition Record (transition record sent to health home within 24 hours of discharge)* • Medication Reconciliation Post-Discharge • Release of Information for sharing protected health information (PHI) across providers • Care Coordinator Assignment: Percentage of clients in the target population with an assigned care coordinator • Common Care Plan: Percentage of clients in the target population with a physical and behavioral health care plan accessible by all providers and payers

Accountability – cont.

Condition/Area	Performance Measure
Substance Use/Prevention	• Screening • SBIRT • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*
Patient Experience	• Client experience with care • Client confidence • Satisfaction with coordination of care
Recovery	• Milestones of Recovery Scale (Improved mental health outcomes) • Housing stability • Employment • Food Access

Thank you!