Mental Health & Substance Use Integration Work Group: Local Collaboration

Meeting 2

May 16, 2012

Healthy San Diego Behavioral Health Work Team

Analysis of Current Collaborative Landscape

Existing Local Collaboration (MOUs, Contracts, etc)

- MOU between BHS and San Diego Plans have existed since 1998.
- Healthy San Diego Behavioral Health Work Team.
- LTCIP Dual Demonstration Project Advisory Committee.
- Support from San Diego HHSA.
- Large network of FQHC's with behavioral health programs.
- Solid public behavioral system.

Future Opportunities

- Expand current MOU to address issues specific to the Dual population and include Substance Abuse.
- Integrated care plan for medical and behavioral health.
- Better access to specialists.
- Improved coordination.
- Improved satisfaction with health care.

Top Perceived Barriers to Integration

(clinical, administrative, financial, and other)

- Clear delineation of benefits and financial responsibility.
- Sharing of information & privacy issues.
- Accurate, timely and actionable data from DHCS and CMS.
- Community buy in.
- Stigma in the primary care setting.
- Multiple formularies in geographic managed care.
- Limited connection between plans and substance use system.

Early Ideas and Examples of Useful Performance Measures for Tracking Accountability and Collaboration *(clinical, fiscal, administrative and other)*

- Reducing psychiatric bed days.
- Reducing readmissions
- Reducing ER visits.
- Selected HEDIS measures.
  - Follow up after hospitalization.
  - Anti-depressant medication management.
  - Use of high risk medication in the elderly.
- Selected CAHPS measures.
- Medication adherence.
- Access to care standards.

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Orange County

Analysis of Current Collaborative Landscape

Existing Local Collaboration

- MOU – 1998
- Tri-Agency Meetings – 1998
- MH/PCP Communication tool – 2002
- CalMEND Collaborative Pilot for Integrated Care (CPIC) – 2010
- CalOptima contract as ASO for OCMHP – 2010
- MEDNET - 2011
- SBIRT Pilot- 2011
- Integrated Community Services (ICS) - 2011
- Care Integration Collaborative (CIC) – 2012

- Collaboration with OneCare community BH provider - 2005
- County (HCA)contract as OneCare provider - 2012

Future Opportunities

- Revise current Medi-Cal MOU
- Create/expand MOU for Duals
- Substance Use Services contracting/expansion
- Use of MHP Access line for Duals BH inquiries
- System Navigators
  - Peer
  - Licensed

Early Ideas and Examples of Useful Performance Measures for Tracking Accountability and Collaboration

Structural Measures:

- Screening, assessment and initial referral process in place
- Risk stratification using SPMI/SUD indicators
- Comprehensive provider network
- Comprehensive transitional care

Process Measures:

- Days from discharge to first MH/PCP OP visit *(build on OneCare work using HEDIS)*
- Cardiometabolic testing for members on antipsychotics *(build on MEDNET work)*
- Shared care planning *(build on CalMEND/CIC work)*
- Alcohol/substance use/depression and anxiety screenings *(build on SBIRT work)*
- Screening for physical health conditions in behavioral health care
- Increase appropriate referrals
- Increase appropriate health home visits

Outcome Measures:

- Decrease in rate of ED (medical and psychiatric) use for members with SPMI
- Decrease in rate of hospital admission (medical and psychiatric) for members with SPMI
- Improved member experience
- Financial measurement (Measure and methodology TBD with Technical Assistance)

Top Success Factors For Integration

Clear data sharing policy
- System-level
- Provider to provider
- Possible additional clarification for SUD data

Provider capacity/buy-in
- Adequate resources
- Increased familiarity with person-centered approach and benefits of integration
- Consistency across multiple payors

Funding flexibility
- Allowable benefits, provider types and places of service
- Incentives (care coordination, consultation)

Engaged members
- Understanding of how "system" works
- Feeling empowered
- Readiness to change

Cultural differences addressed
- Primary care v. behavioral health

Consistent communication mechanisms
- New HIT adoption
- Shared care planning

Los Angeles County

Analysis of Current Collaborative Landscape

Existing Local Collaboration (MOUs, Contracts, etc)

- Item 1: MOUs exist between DMH, LA Care and Health Net for Specialty Mental Health Services to Manage Care Medi-Cal beneficiaries.
- Item 2: New MOU between DMH and LA Care that allows for the exchange of information for SPD population.
- DMH has experience with integrating mental health services in primary care settings, MOU between DMH and DHS

Future Opportunities

- Item 1: Further expand partnerships between DMH, LA Care, and Health Net to improve care coordination.
- Item 2: Establish mental health telepsychiatry and E consult services.
- Item 3: Early Intervention and Prevention opportunities
- Data Sharing
- Grant writing
- Interagency care coordination team
- Shared accountability

Top Perceived Barriers to Integration

(clinical, administrative, financial, and other)

- Role of LMHP needs to be clearly defined and agreed upon by DMH, LA Care, Health Net. DMH strongly advocates for MCOs to contract directly with DMH to access its network of providers
- Clarification re: minimum mental health benefit required
- Payment process for Specialty Mental Health Services
- Prioritization of projects: Identify model, screening tool, development of MOU/ contract, payment process, determine outcomes and measurement tools, infrastructure needed, processes and protocol for referral and tracking of referrals, staff training etc.
- Information sharing restrictions
- Shared accountability

Early Ideas and Examples of Useful Performance Measures for Tracking Accountability and Collaboration *(clinical, fiscal, administrative and other)*

- Behavioral Health Screening tool to identify dual eligible beneficiaries that may need mental health services (PHQ 9)
- Use current DMH and LA Care MOU as a template for data exchange to identify beneficiaries seen by DMH and MCO to assist with care coordination
- Update existing MOUs between DMH, LA Care and Health Net to include referral, care coordination and administrative processes for Dual Eligible beneficiaries
- Establish interagency care coordination teams

SAN MATEO COUNTY

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Analysis of Current Collaborative Landscape

- As a COHS, most beneficiaries already enrolled in Health Plan of San Mateo (HPSM)
- Contracts and MOUs exist between County Health System and HPSM
- Duals and long-term care integration planning has been underway for years including:
  - HPSM
  - SMC Health System- Aging and Adult Services (AAS)
  - SMC Health System- Behavioral Health and Recovery Services (BHRS)
  - SMC Medical Center and Clinics
- Planning subcommittees and work plan in place
- Now moving from structure and planning to implementation

Data Integration

- Challenge: take data from various systems, present data in an integrated way, make it easy to use and cost-effective
- Result: Data Mart
  - Integrated picture of individual member
  - Ability to develop standardized and ad-hoc aggregate reports
- Built external to each program's system to decrease IT system and workflow disruptions
- Examples of data points:
  - Demographics
  - Claims (Medical and Mental Health)
  - LOCUS (Level of Care Utilization System tool)
  - Services / Hours

Top Perceived Barriers to Integration

(clinical, administrative, financial, and other)

- Sharing substance use data and information

  Federal CFR 42 – narrower than HIPAA

- Difficulty tracking changing eligibility status; constraints on use of MEDS system for checking eligibility and follow-up
  - DHCS intends to take MEDS access away from COHS Plans which will limit availability of SSA/BENDEX Medicare information that is crucial to Duals eligibility

Examples of Performance Measures for Tracking Accountability and Collaboration
(clinical, fiscal, administrative and other)

- Approach – Look at existing measures but take out of siloes and look at the intersection of medical and behavioral health

- HPSM current measures:
  - CMS Star Ratings, e.g. Adult BMI, Cholesterol Screening
  - ED and hospital admissions and readmissions

- BHRS current measures:
  - Initiation (2nd visit) within 14 days of 1st contact
  - Engagement (3rd and 4th visits) with 30 days of 2nd contact
  - Percent of clients meeting goals

- Integrated Approach to Risk Stratification will now be possible