CHCS Center for Health Care Strategies, Inc.

Advancing access, quality, and cost-effectiveness in publicly financed health care

Medical Care Meets Behavioral Health

Cal MediConnect Providers Summit
January 21, 2015

Moderator: Michelle Herman Soper, Senior Program Officer, CHCS

Medical-Behavioral Integration: More Talk, or Real Action?

Jerry Vaccaro, M.D.
President, Ingenuity Health
CEO, RightPath HC

Today's Conclusions: Change Finally May Be Here

- Interesting confluence of events and initiatives
  - Continued discordance between rising costs and clinical outcomes
  - ACA, ACOs, CMS Innovation Center, initiatives for dually eligible individuals, payer ACO-like programs accelerating
  - Diminished interest in the carve-out
  - BH impact on cost being felt among providers for dually eligible and SPD populations
  - SMI PCMHs gaining support
- Culture shifts
  - Evolved and evolving concepts: beyond separate fiefdoms, co-location → unified models aided by technology

The Problem of Non-Integration

- Poor clinical outcomes among medical *and* BH patients
  - Prevalent and under-treated BH conditions drive increased medical morbidity
  - Untreated medical conditions among SMI drive high morbidity and mortality rates
  - Longstanding schism between sectors → entrenched programs that are poorly understood
- Inefficiencies, frustration

California-Specific (and not-so-California-Specific) Challenges

- Highly evolved, capitated medical delivery system
- Highly evolved, complex BH system, especially for the severe end of the BH spectrum
- Existing system promotes separation, redundancy, confusion → overwrought workflows
- Multiple payer initiatives, dizzying array of models and offerings

Early and Mid-Term Solutions: Themes

- Plethora of models and programs being advocated
- States and other payers interested in aligning financial and clinical → Triple Aim
- SMI Medical Homes gaining momentum
  - "Reverse" integration gaining?
- Fewer settings fixated on coordination or co-location alone

Early and Mid-Term Initiatives: Lessons from Other States

- PR: All Medical Groups mandated to include BH providers in their settings
- Multiple States: SMI PCMHs
- OR, NC: Proliferation of ACO-Like organizations, many with strong BH focus
- FL, AZ: Alignment of BH and medical finances

Early and Mid-Term Solutions: SynerMed Los Angeles

- Culture endorses integration, sees it as a long-term effort
  - Plan(s), Hospital(s), Group(s) integration
  - Application of lessons learned from Hot Spotting CMS Innovation Project
  - Application of lessons learned from CareMore model but specifically designed for Medicaid SPD and dually eligible populations
  - Treatment of the “Whole” patient
- Model articulates workflows that address current complicated array of payers, constituents
- “Ambulatory ICU” meets hot-spotting
  - Targets the 1%/ 22% group; vast majority have severe BH co-morbidities
  - Full integration of care and planning
  - Pragmatic, do-what-it-takes, community-based population health management

Early and Mid-Term Solutions: SynerMed Los Angeles

- Early results very encouraging
  - Over 1,600 patients through the program with an active patient load of 500
  - Decreased ER, IP, readmission rates
  - Increased clinic and ancillary services use
  - Significant cost reductions
  - Expansion under way
- Expand and evolve current suite of assessment tools → increased automation and workflow drivers
- Greater use of technology to spur integration efforts and expand access

Today's Conclusions: Change Is Here

- Opportunity created by confluence of events
- Pragmatism, transparency, openness/ willingness to change will drive success
- Better care, treatment and service will cost less

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HEALTH PLAN®

For a Healthy Life

L.A. Care Cal MediConnect Behavioral Health Integration

Clayton Chau, MD, PhD
Medical Director, L.A. Care
Assistant Clinical Professor, UCI Medical School
cchau@lacare.org

Celebrating 15 Years
of Providing Health Care in Los Angeles County
1997-2012

The Cal MediConnect Population

- Members of Cal MediConnect are adults (age 18 or older) who are eligible for both Medicare and Medicaid. This population has a high prevalence of medical and mental health conditions or disabilities, substance use disorders, social isolation, and poverty

- Behavioral health services integration and care coordination are an important care component of Cal MediConnect

- Outpatient and emergency behavioral health services *do not require referrals*

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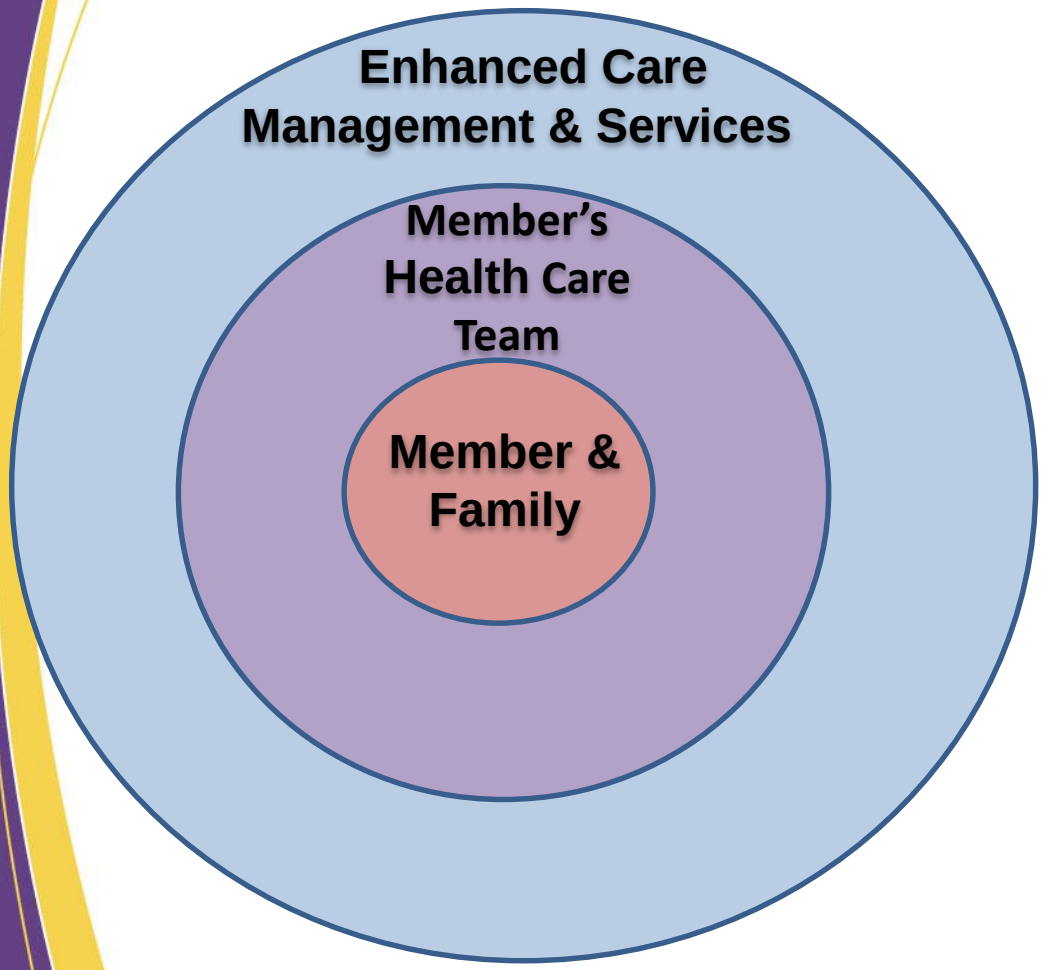
Cal MediConnect Model of Care



Member & Family

- Member
- Family and Caregivers

Each member's needs will dictate who is on his/her health care team and his/her care management and services.

Member's Interdisciplinary Care Team (ICT)

- Primary Care Provider
- Care Manager
- Social Worker
- Therapists (OT, PT, etc.)
- Medical Specialists
- Pharmacist
- Managed Long-term Services and Supports Specialist
- Behavioral Health Specialist
- Health Educator

Enhanced Care Management & Services

- Health Risk Assessment
- Care Planning and Service Coordination
- Transitional Care
- Home-based Care
- Medication Management
- Disease Management
- 24/7 Nurse Advice Line
- Integration of Medical, Behavioral and Long-term Care

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Behavioral Health Strategies

- L.A. Care has partnered with Beacon Health Strategies/College Health IPA (CHIPA) for behavioral health services for Cal MediConnect

- Behavioral Health services include inpatient and outpatient care:
  - Mental health crisis prevention and treatment
  - Substance use diagnosis and treatment
  - Integrated with medical care and services

- For access to carved out specialty services, L.A. Care partners with LA County Department of Mental Health (LAC DMH) for specialty mental health services and Department of Public Health/Substance Abuse Prevention & Control (LAC DPH) for Drug Medi-Cal services

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Behavioral Health Case Management

- Beacon provides
  - A network of psychiatrists, other licensed mental health professionals, and certified substance abuse specialists from private practice and community care settings
  - Expertise in case management such as care planning, multi-services coordination and navigation
  - Individualized Care Plan (ICP) is developed by the behavioral health case managers for identified members
  - The behavioral health case managers participate on Interdisciplinary Care Teams (ICT) to address whole person needs

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Care Coordination – Specialized Behavioral Health Services

- Members meeting criteria for Specialty Mental Health Services are linked to LAC DMH
- Members needing specialized Drug Medi-Cal services will be linked to LAC DPH
- “No wrong door” approach to access to care
- Coordinate care between PCP, behavioral health providers, and other ancillary providers
- Formalized and timely level-of-care transition is assured

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Data Sharing Requirements

- The state is implementing a “strategy for shared accountability” to ensure health plans and counties have aligned incentives to coordinate services that are in beneficiaries’ best interest
- Health plans and county’s mental health and substance use agencies are required to expand existing or develop detailed written agreements (MOUs) where data sharing for care coordination and integration for beneficiaries who meet the medical necessity criteria for specialty mental health and substance use services is one of the important elements
- Data to be shared:
  - Medication reconciliation
  - Treatment plan
  - Core measures

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Successes

- Members receive services at the right place and the right time
- Weekly case conferences between all entities
- Bi-weekly meetings to address dispute resolutions as it relates to clinical or administrative issues; thus far, none is required
- Roles identification
- Universal consent form
- Transition of care form

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Barriers

- Role confusion
- Telephonic case management style
- Complex members
- Homelessness
- Other community resources
- Confidentiality/data sharing
- Gap in service areas
- Drug Medi-Cal

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Interventions

- Constant communication
- Members and clinicians are shielded from administrative issues
- Simple screening form to evaluate members for appropriate level of care assignment

- Rutgers' University Collaborative

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Key Concepts

PERSON-CENTERED PLANNING

- The Member "drives" the process
- The Person-Centered Team

SOCIAL MODEL OF DISABILITY

- Moving from a "medical model" only to a "systems" approach
- Identify and impact social barriers and assumptions
- “Functional impairment" vs. "Disability”

INDEPENDENT LIVING PHILOSOPHY

- Solutions-focused and self-determination
- Identifying and reducing physical and attitudinal barriers
- Community integration

RECOVERY MODEL

- Building upon a person's assets and strengths
- Empowering the individual

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James S. Pratty MD

Psychiatrist

Senior Medical Officer – Behavioral Health

CareMore Medical Group

James S. Pratty MD

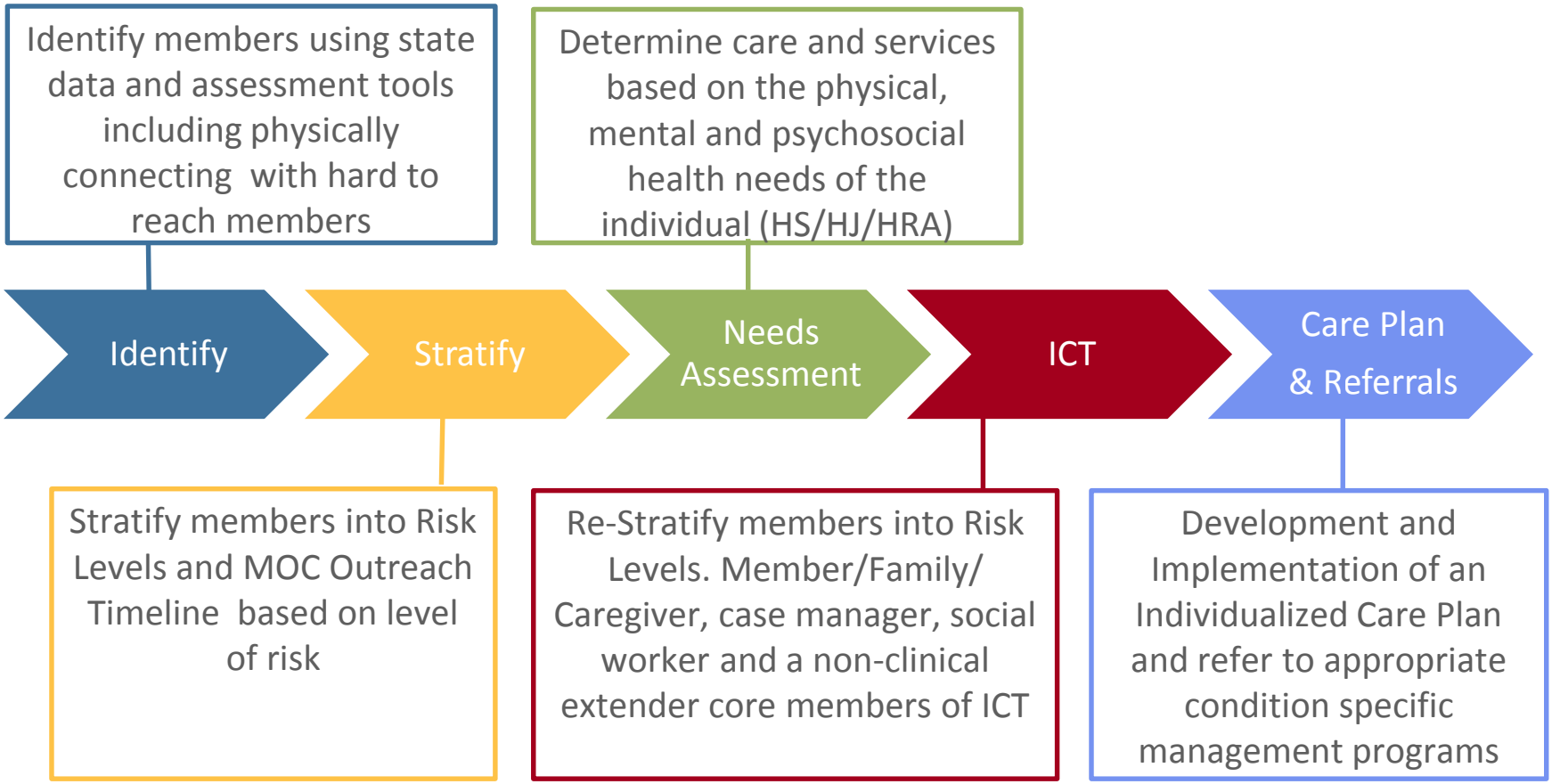
Bilingual Psychiatrist specializing in adolescent, adult and geriatric psychiatry with sub-specialties in Treatment Resistant Depression, Dementia, Schizophrenia, Affective Disorders and is a Board Certified Addictionologist

Senior Medical Officer - Behavioral Health for CareMore Medical Group

One of the principal designers of CareMore's Duals MOC

Oversees clinics throughout California, Arizona, Nevada, Richmond, Virginia, Memphis, Tennessee, Ohio, and now associated with Emory Healthcare in Georgia

Care Management Process



The CareMore CMC framework ensures appropriate services are available and offered to each member.

Care Management Process

The CareMore duals program is structured around a framework that ensures appropriate services are available and offered to members. Our approach addresses:

Identification of members using state data, assessment tools, and deployment of "feet-on-the street" to physically connect with hard-to-reach members

Stratification of members into

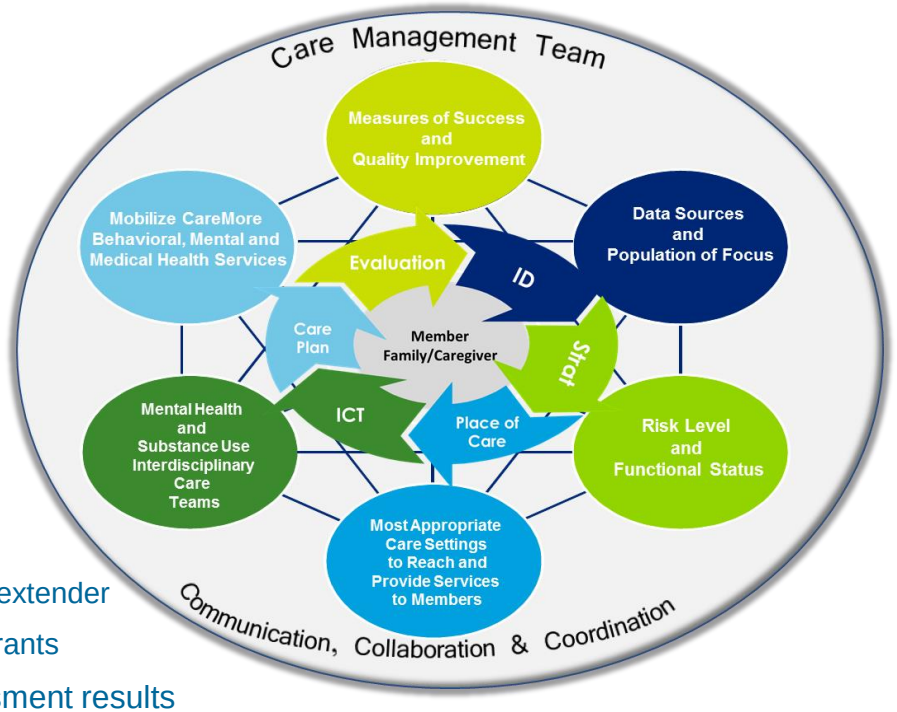
- High, Moderate, Low and No risk levels to determine
  - Provider needs, level of touch & urgency of care delivery

Determination of best place of care and services will be determined based on the following:

- Stratification level,
- Member's Needs (social, medical, mental health and LTC)
- Culture, Safety and input from providers

Interdisciplinary care team will include:

- Core care management team w/ CareMore NP oversight
  - Member/Family/Caregiver, case manager, social worker &, extender
- PCP plus additional practitioners as the member's condition warrants



Care Plan Development and Deployment based upon assessment results

- The care management team facilitates the development and execution of a individualized care plan, referral to the appropriate condition-specific management programs, optimization of benefits and identification of supplemental services

Evaluation – The effectiveness of the member's care plan and services provided will be evaluated by measures specific to the program, the core care team and provider services delivered. The outcomes will be evaluated to continually improve the member's health outcomes and functional capacity, as well as the ICTs management.

First Visit Strategy

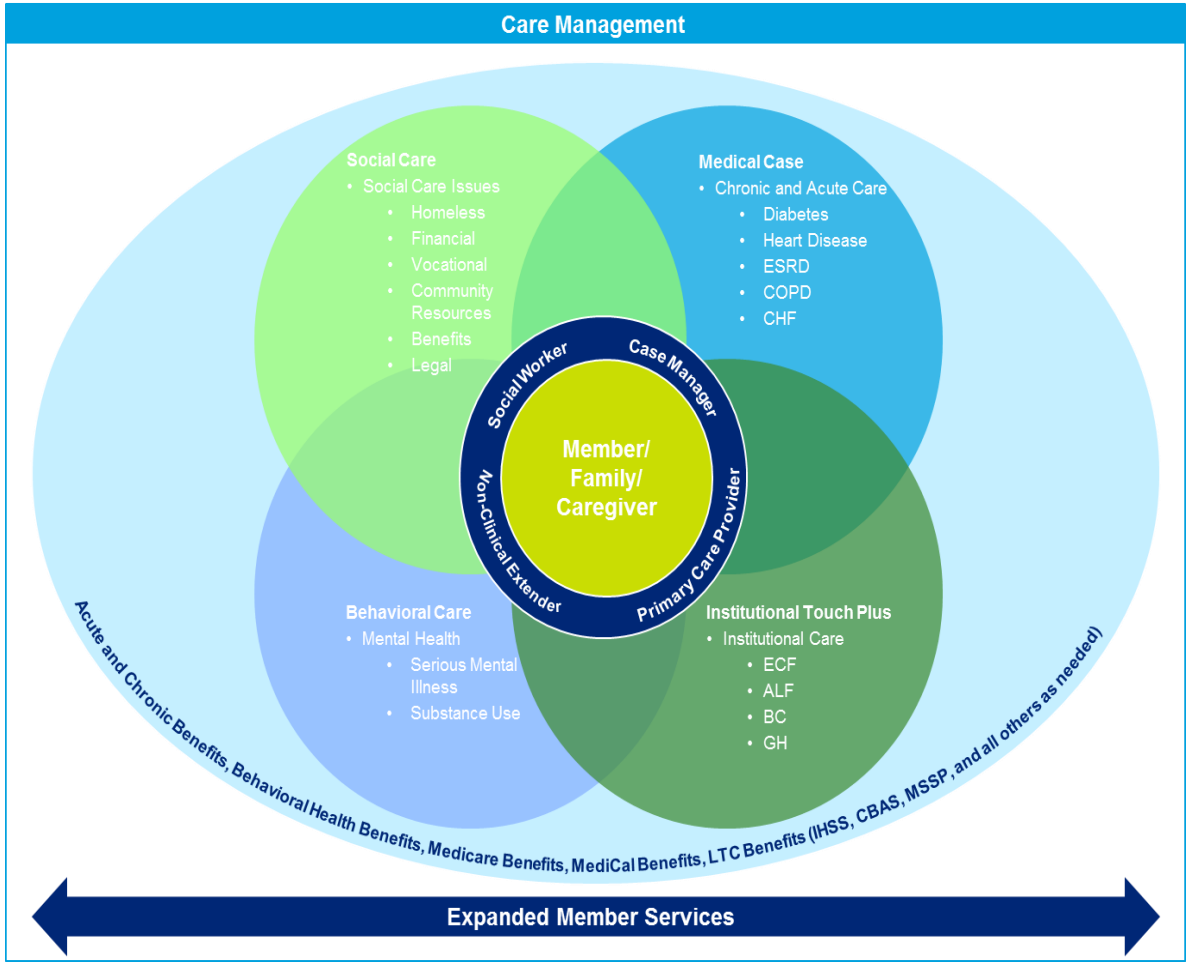
- Identify specific concerns of the patient
- Answer the question “Why now?”
- Obtain collateral information from family and caregiver
- Obtain old records including past pharmacy records
- Coordinate care with the Primary Care MD
- Review old labs and tests if they are available
- Avoid addictive and high copay medications
- Complete objective testing: MADRAS, PHQ9, MMSE, MDQ
- Complete Treatment Planning including Caregiver
- Complete all documentation by the end of visit

Care Management

CareMore develops and implements health service strategies and interventions that address the medical, social, long term care, and mental health/substance use needs and concerns of members through collaboration, coordination, and integration of CareMore and community-based infrastructure and resources.

The CareMore Model of Care is a comprehensive approach to the holistic management of members and patients. This approach is composed of:

- Social Care ensures that members are safely cared for at home or their place of residence including homeless
- Medical Care provides aggressive clinical management of acute, skilled and high-risk patients, including those w/co-morbid conditions e.g., several chronic diagnosis, SMIs, Substance Abuse
- Behavioral Care addresses the mental health and substance use needs and concerns of members
- Institutional Touch Plus provides aggressive clinical management of facilities-based patients



Decompensation and the 8 Myths of In-Patient Psychiatric Hospitalization

- The Psychiatrist will review the old chart
- The Psychiatrist will review old medical records including obtaining a copy of out-pt. Rx recs
- The treatment team will coordinate with the outpatient treatment team
- Family will be contacted within 24 hours of admit
- Substance abuse will be identified & treated
- The stepdown in care will be realistic
- Utilize Formulary Medications that patient can afford
- Consider use of LAI's

And, So The Challenge

- Take advantage of unique CA assets
  - Legacy of aligning financial and clinical risk
  - Highly evolved systems
  - New payer initiatives
- Debate: open, honest, direct
- Make the next leap
  - Fully align medical and financial risk?
  - Experiment with partial risk arrangements?
  - Test clinical delivery models

Questions and Discussion