CHCS Center for Health Care Strategies, Inc.

Improving the quality and cost-effectiveness of publicly financed health care

Best Practices for Care Coordination

Cal MediConnect Providers Summit

June 23, 2015

Moderator: Alexandra Kruse, Senior Program Officer, CHCS

INTEGRATING BEHAVIORAL & PHYSICAL HEALTH: "WHOLE PERSON" CARE COORDINATION

PETER CURRIE, PH.D

INLAND EMPIRE HEALTH PLAN

- Today IEHP serves 1,100,000 members in government-sponsored programs compared to 400,000 in 2009
- With Health Care Reform & Cal MediConnect, IEHP is projected to grow to over 1,300,000 members by 2016: 1 in 4 IE Residents

Empowering Minds
IEHP
Behavioral Health

Carve Out Of Behavioral Health: Unintended Consequences

- Behavioral and social determinants of health are major drivers of health outcomes
- Separate funding streams for behavioral health created silos
- Health plans and PCPs have not had much responsibility for BH
- Medicaid benefits created “excluded diagnoses”

  E.g., autism and other developmental disabilities
- County mental health programs were limited to serve only those with severe mental health conditions – “Specialty Mental Health”
- Substance abuse was further segregated from mental health at the state level and in most counties until recently -“Drug Medi Cal”

Riverside County Mortality Report *(Provided Courtesy of RCDMH)*

- 206 adverse incidents reported
  - January 2007 – May 2010
  - 145 Deaths
  - US average life expectancy: 77.7 years
  - RCDMH average age at death:
    - 41.8 years
    - 36 years less than the general population
  - Natural causes: 46.8 years
  - Unnatural/unexpected causes: 38.8 years
    - Deaths in older adults may be under-reported

Why IEHP Integrated BH

- Physical health and behavioral health (BH) care were separate and disconnected
- Outpatient mental health services underutilized & substance abuse treatment was nil
- IEHP had no influence over the BH network
- Coordination of care – PCPs describe referring into the "Black Hole"
- High cost of BH administrative services:
  - 50% of BH dollars reached the MBHO's providers (2009)
  - Context – 95% of tax payer dollars paid to IEHP reach IEHP Medical Providers

The BH Integration Plan

- Fully integrated BH program – “In House”
- Streamline the coordination of physical and mental health benefits
- Redirect MBHO admin/profit (50%)to fund expanded BH services
- Directly contracted BH network – identify and support best practices
- Eliminate reliance on vendors (MBHOs) for all BH expertise including NCQA compliance

Preparation for Integration

- Infusing BH competency in all IEHP departments
- In-house clinical expertise – clinical director, consulting psychiatrist & BH care managers (LCSWs)
- Directly contract the BH network to ensure access
- Leveraging web-based technology
  - Online compiled EHR available to all BH providers
  - Required BH assessment/treatment plan sent securely to IEHP BH care manager and the PCP

PCP Referral to Behavioral Health Specialist

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Welcome to the PCP Referral to Behavioral Health Specialist preliminary form. Access to the complete form will be granted upon completion of this preliminary form.

* denotes a required field.

Member/Provider Identification

*Step 1: Member ID	
*Step 2: Date Of Service	
*Step 3: Provider of Service	

Member Information

Name	Gender	DOB	Age
Address	City	State-Zip	Phone
IEHP ID	CIN	MediCare	Medi-Cal
LOB	County	Aid Code	Group

Risk Assessment: Active and Current Status

*Suicidal Ideation	No Yes
*Suicidal Ideation with Plans	No Yes
*Suicidal Ideation with Means	No Yes
*Homicidal Ideation	No Yes
*Homicidal Ideation with Plans	No Yes
*Homicidal Ideation with Identifiable Victim	No Yes
*Gravely Disabled	No Yes
*Member is at Risk of Severe Withdrawals, Evaluate for Detoxification	No Yes

County Mental Health Clinic or Provider

*Is Member currently being treated by a County Mental Health Clinic?	No Yes
*Is Member currently being treated by a County Mental Health Provider?	No Yes

Additional Risk Factors

*Non-Suicidal Self Injury	No Yes
*History of Psychiatric hospitalization in the last 3 months	No Yes
*History of Running Away	No Yes

Behavioral Health Initial Evaluation Coordination of Care Report

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Welcome to the Behavioral Health Initial Evaluation Coordination of Care Report. **Access to the complete form will be granted upon completion of the Authorization Information section. Please Enter a valid authorization number, date of service, and then select a Behavioral Health Service Provider.**

*** denotes a required field.**

Authorization Information

***Step 1: Authorization Number**	
***Step 2: Date Of Service**	
***Step 3: Provider Of Service**	

Continue

Member Form History

Member Information

Name	**Gender**	**DOB**	**Age**
Address	**City**	**State-Zip**	**Phone**
IEHP ID	**CIN**	**MediCare**	**Medi-Cal**
LOB	**County**	**Aid Code**	**Group**

Member PCP Information

Name	**ID**	**NPI #**	**Phone**
Address	**City**	**State-Zip**	**Fax #**

Provider Information

Name	**ID**	**Auth #**	**Report Date**

Visit Information

*Verified Member signed the required Release of Information Form allowing IEHP to release medical and behavioral health information to your PCP and potential treating Providers.

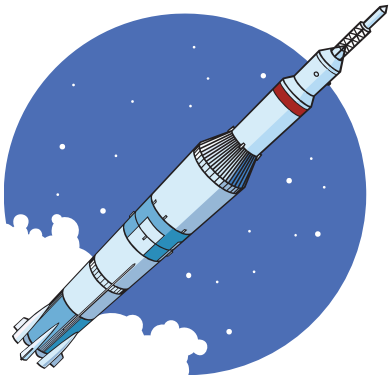
It is the responsibility of the referring Provider to inform the Member that IEHP will be sharing information with their PCP and potential treating Providers, which may include Member's respective County Mental Health System. Please have the Member sign the release. **Click here to print the release.**

○ Yes ○ No

*Last known Member phone #:	e.g. 9091234567
*Co Treating BH Provider Other Than Self:	Search Available BH Providers
*Initial Visit	Select Initial Visit Date
*Next Scheduled Visit:	Select Next Scheduled Date

BH Integration at IEHP for Medicare: The Launch – Feb 1, 2010

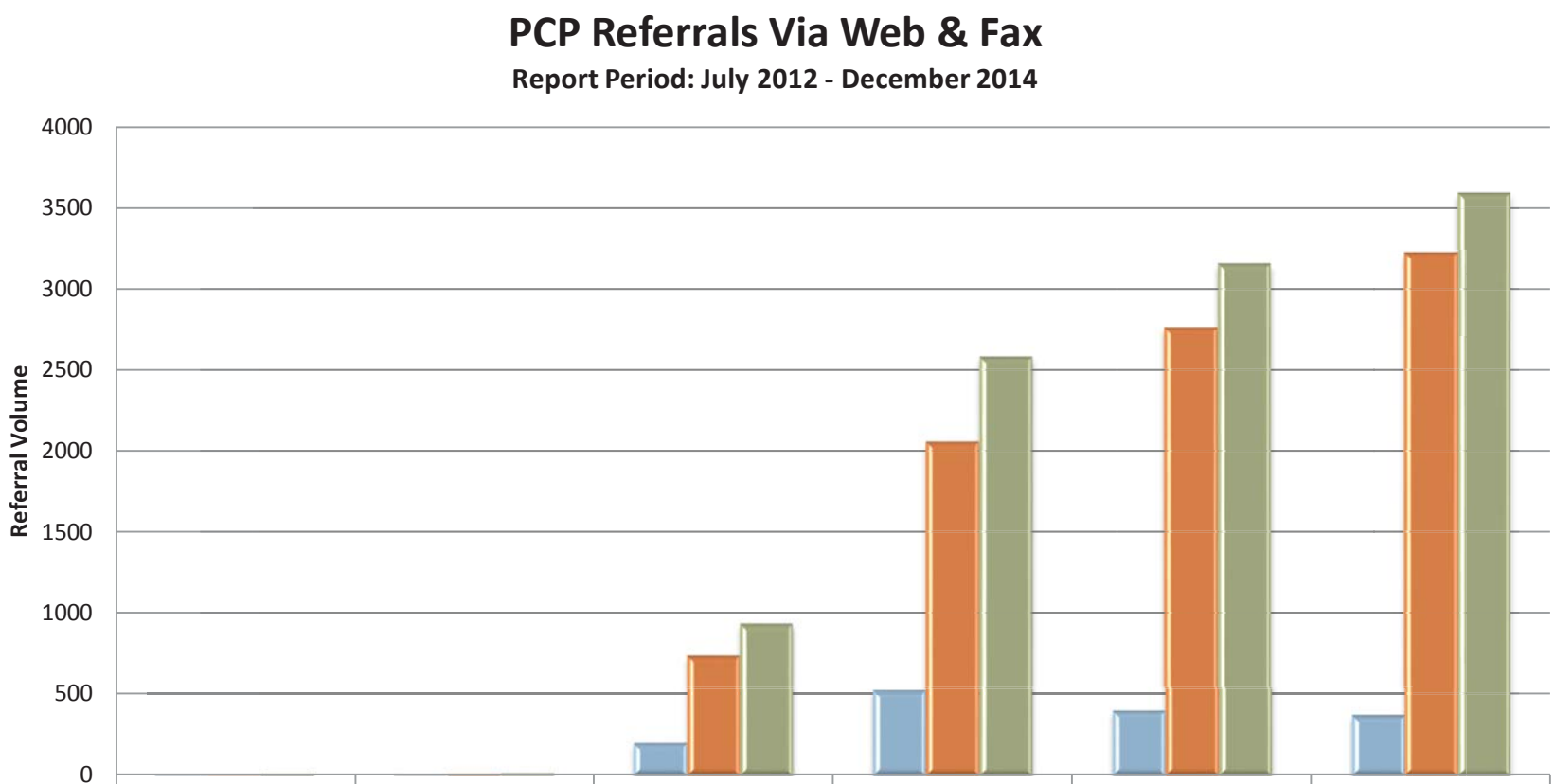
- IEHP "Dual Choice" (Medi Medi) – foundation for CMC
- One phone # access at IEHP for physical & mental health
- BH call center: Triage & referral by BH care managers
- Higher than average rate of pay for the initial evaluation:
  - Incentivize prompt access
  - Payment triggered by coordination of care TX report web form – eliminating the "Black Hole"
- Added intensive outpatient programs (IOP)



BH Integration Results Applied to Cal MediConnect (CMC)Expansion

- Increase access to BH services – **Cost neutral to plan**
- Medical cost-offsets for high-risk/high-cost populations
- Improve coordination of physical & behavioral healthcare through web: access to health record for BH providers & BH treatment reports through IEHP portal for PCPs
- IEHP's BH network (private sector, FQHCs, county mental health & CBOs): Access delays due to capacity is a concern
- Infusing BH services within primary care for complex populations: e.g. pain/narcotic misuse
- Moving toward BH consultation for primary care where co-location is not feasible

Massive Demand for BH Services: PCP Referrals Increase Dramatically in 2014/15



	July-Sept 2013	Oct-Dec 2013	Jan-Mar 2014	Apr-June 2014	July-Sept 2014	Oct-Dec 2014
Fax	5	4	198	519	394	368
Web	6	11	740	2057	2756	3219
Total	11	15	938	2576	3150	3587

Pressure on Health Plans to Integrate Physical & Behavioral Health

- Download of BH benefits into the health plans
  - January 1, 2014 Medicaid expansion of mental health
  - April 1, 2014 dual eligible pilot
  - September 15, 2014 EPSDT benefit for autism
- State direction & lessons from IEHP's recent CMS audit
  - Expectation that health plans have a care plan for members that includes BH provider treatment plans
  - Expectation that BH providers participate in interdisciplinary care teams

Lessons from Riverside County Co-Location Pilot Applied to CMC

- Patients arrive to health care providers "fully integrated" with physical and BH needs intertwined
- Health care providers in the IE operate mostly in silos that limits their impact on overall health status
- Blaine Street County Mental Health and Rubidoux Public Health Clinic bi-directional co-location pilot Learning
  - People seek care where they are welcomed and comfortable
  - Rather than refer out to the "black hole" bring the missing/needed care to where the population is
- IEHP's "all in" investment: Behavioral Health Integration Initiative (BHI-I)

What is the IEHP Behavioral Health Integration Initiative?

1. A strategy for **practice transformation**
2. Investment in **infrastructure development and practice coaching** to support integrated practice in partnership with key health care partners in San Bernardino & Riverside Counties
3. **The Pilots will impact 12 key Inland Empire health care providers and 33 clinics,** including the public hospitals, county primary care, county behavioral health, private & non-profit primary care and behavioral health sites, a children's clinic, a substance use treatment clinic, and a board and care center
4. The intent: IEHP members receive **integrated care from a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide whole person care**

Behavioral Health Integration Initiative (BHI-I) Framework

5 KEY AREAS OF CHANGE & IMPROVEMENT

1. Screening & assessment processes
2. Care planning
3. Service delivery practices
4. Population health management and data infrastructure
5. Health promotion & patient experience of care

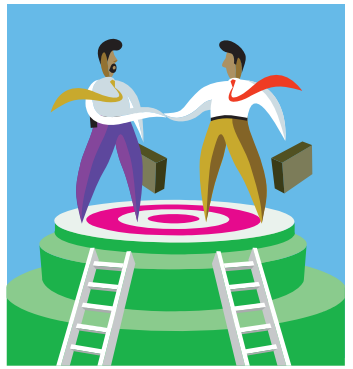
BHI-I Framework

Achieving Improvement in Those Key Areas Requires Competency Development

- Team Based Care
- Comprehensive Care Management and Coordination
- Health Information Technology
- Health Promotion and Self Management

Behavioral Health Integration: Platform for Population Healthcare

- Build & support health home array with "BH Inside"
  - Supporting provider partners who are already integrating care to build out & refine what they have already begun
  - Linking best integration practices to achieve shared care plans that live and breath and reflect the whole person
- Support new trans-disciplinary treatment models for complex populations:
  - E.g., combining pain management, mental health and substance abuse (SUD) to create a new pain/narcotic misuse treatment center

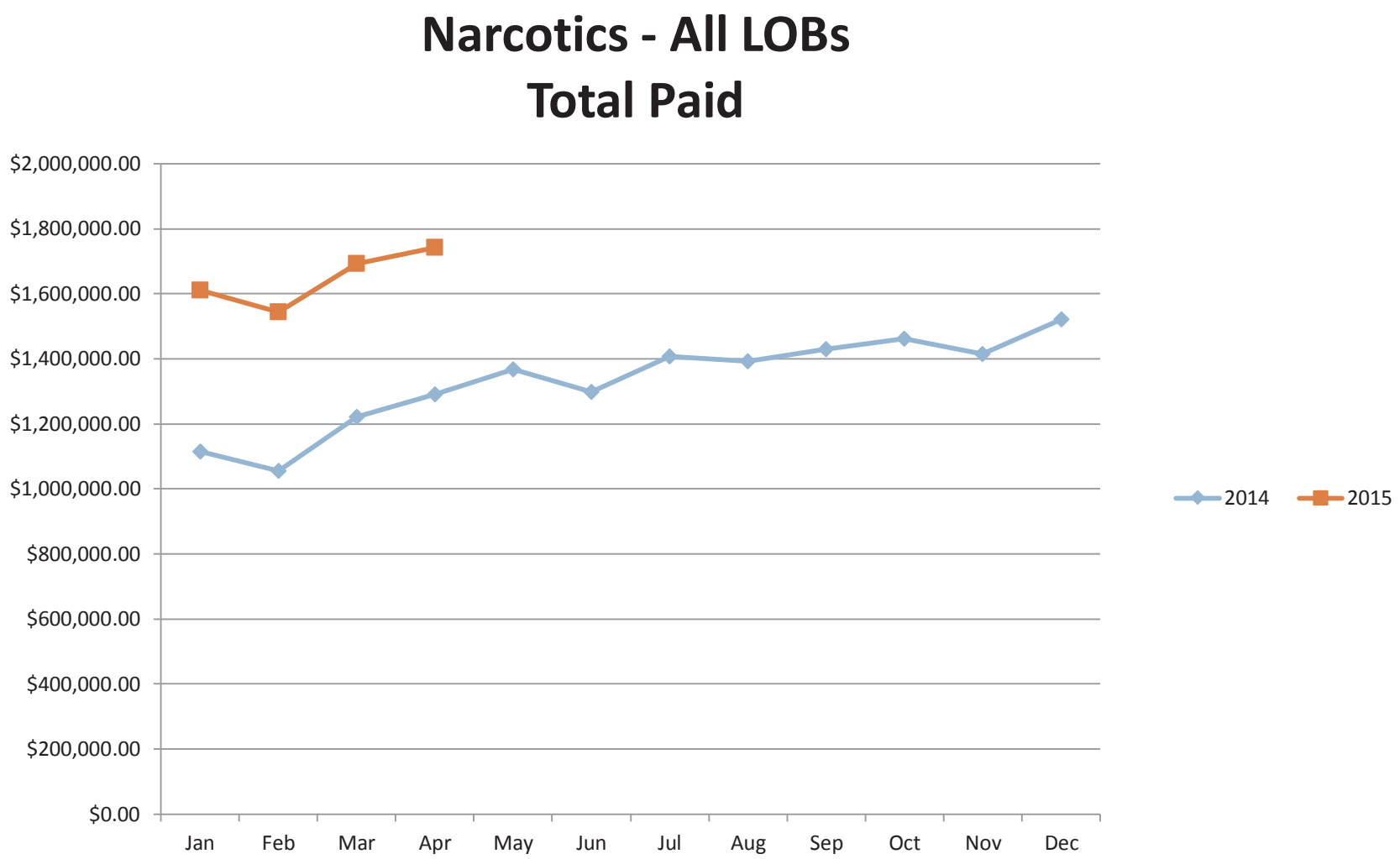


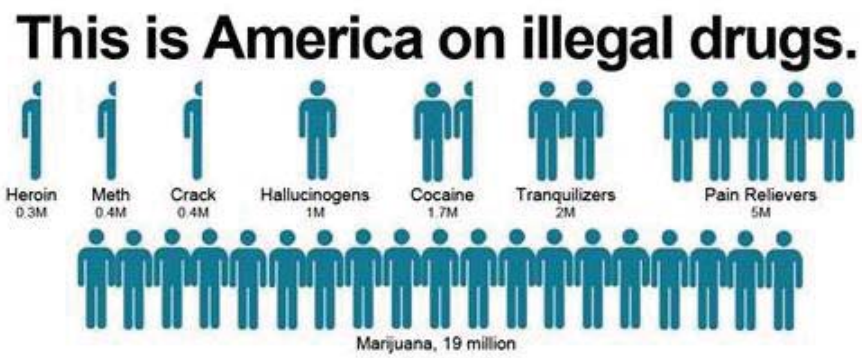
Example: Complex CMC Population - BH Integration to Address Two Public Health Crises:

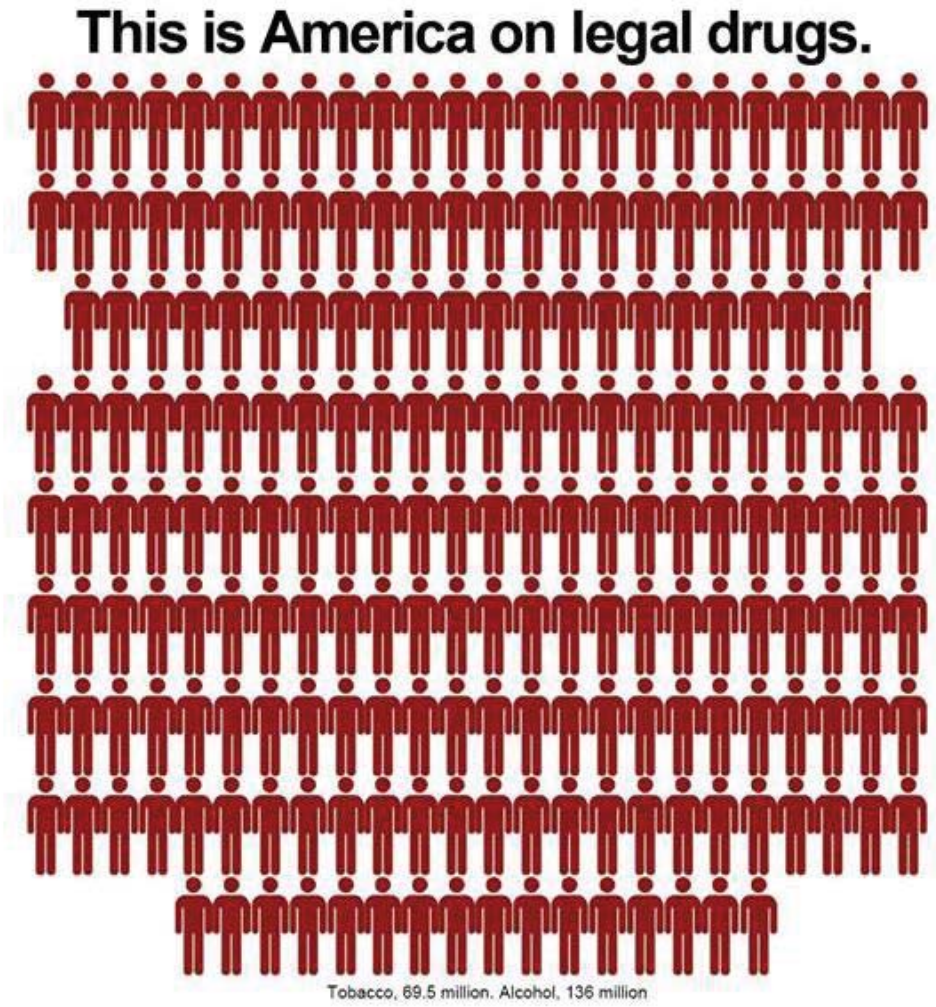
1) Poorly treated chronic pain

2) Prescription drug abuse

IEHP Narcotics Claims Costs







- Heroin 0.3M
- Meth 0.4M
- Crack 0.4M
- Hallucinogens 1.0M
- Cocaine 1.7M
- Tranquilizers 2.0M
- Pain Relievers 5.0M
- Marijuana 19.0M

- Tobacco 69.5M
- Alcohol 136M

Poorly Treated Chronic Pain

Empowering Minds Behavioral Health

More than 116 million American adults suffer from pain, more than those affected by heart disease, cancer and diabetes combined

(Relieving Pain in America, Washington,DC: National Academies;2011)

Total related annual costs: $635 billion (Relieving Pain in America, Washington,DC: National Academies;2011)

Poorly treated pain affecting approximately 75 million Americans

(American Pain Foundation. Annual report. 2006)

Poorly treated chronic pain negatively affects physical, psychological and social well being frequently leading to sleep disturbance, depression and anxiety (Argoff CE. The coexistence of neuropathic pain, sleep and psychiatric disorders: a novel treatment approach. Colin J Pain. 2007;23(1):15-22)

Prescription Drug Abuse: Fastest Growing Substance Use Disorder (SUD)

Empowering Minds
Behavioral Health

Opioids have been used for thousands of years for analgesic properties (Deer ed. American Academy of Pain Medicine, Textbook 2013)

90% of patients being treated in pain management settings are receiving opioid therapy (Paulozzi et al. Increasing deaths from opioid analgesics in the United States. Pharmacoepidemiol Drug Saf 2006;15:(618-27)

In patients being treated for a chronic pain condition: 15% are concomitantly abusing prescription drugs and 35% are using illicit drugs (Manchikanti L. Prescription drug abuse: what is being done to address this new drug epidemic? Pain Physician 2006;9(4): 287-321)

Prescription Drug Abuse

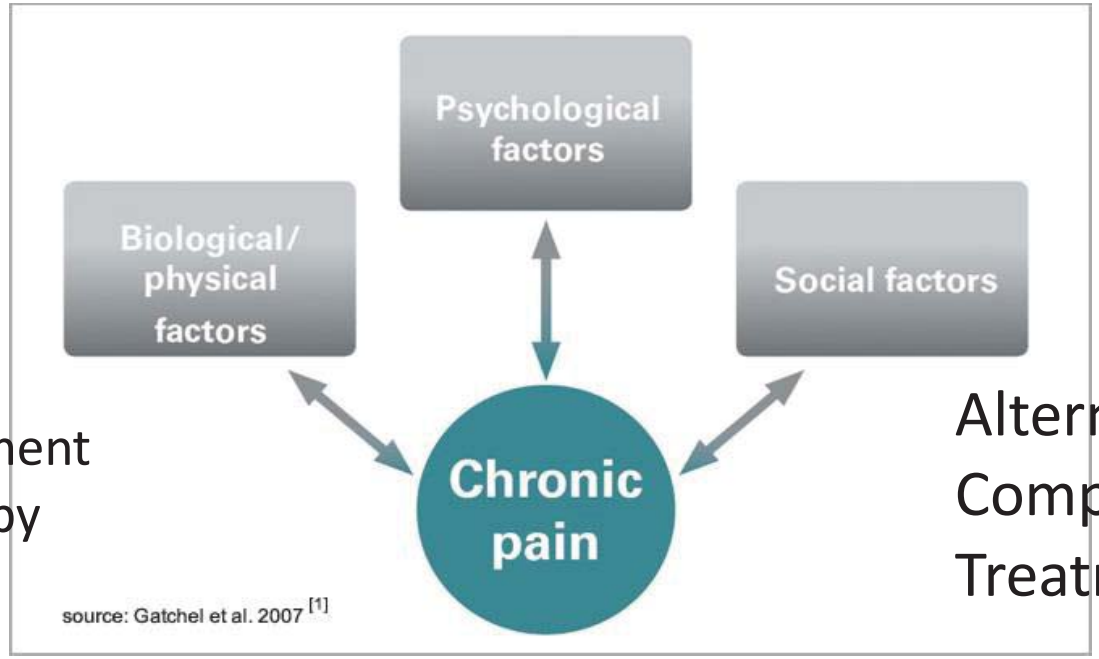
More than 6 million Americans are abusing prescription drugs, more than the number abusing cocaine, heroin, hallucinogens and inhalants combined. About 75% are in the opioid analgesic class (Deer ed. American Academy of Pain Medicine, Textbook 2013)

The number of overdoses due to prescription opioids now surpasses both cocaine and heroin overdoses combined (Paulozzi et al. Increasing deaths from opioid analgesics in the United States. Pharmacoepidemiol Drug Saf 2006;15:(618-27)

Cost related to prescription drug abuse: nearly $200 billion from medical costs, crimes involved and loss of productivity (Paulozzi et al. Increasing deaths from opioid analgesics in the United States. Pharmacoepidemiol Drug Saf 2006;15:(618-27)

Multidisciplinary Treatment

Psychiatry
Psychology
SUD Treatment



Medical Treatment
Physical Therapy

Alternative/
Complementary
Treatments

Integrated Pain/Behavioral Health Treatment Pilot: Multidisciplinary Team

- Medical/Pain Specialists
  - Medication management and opioid taper
  - Interventional treatments, i.e. injections
- Psychologists and SUD specialists
- Physical reconditioning Osteopathic manipulative treatment (OMT)
  - Physical (PT) and Occupational (OT) Therapies
  - Passive modalities (e.g., ultrasound, electrical, stimulation, massage)
  - Neurophysiology education
- Alternative/Complimentary
  - Chiropractic care
  - Naturopathic/Homeopathic treatments, hydrotherapy
  - Diet coaching
  - Mindfulness/Meditation

Integration In California: Agenda for 2015/16

- The Impact of the ACA on California
  - From silos to accountable organizations
  - New benefits require changes in responsibility
  - Expect movement from “carve-out” to “carve-in” funding
- Health Home Array to add Behavioral Health Homes
  - Promoting innovation county by county
  - Piloting new BH integration models in primary care
  - New behavioral health home models for SMI population served by county mental health and innovative wrap around programs (e.g. telecare)

Empowering Minds
IE HP
Behavioral Health

Achieving the Triple Aim
by integrating the social and behavioral determinants of health into health care payment and delivery systems

Cal-MediConnect Provider Summit

Best Practices For Care Coordination

Deborah Miller
Vice President, Healthcare Services
Molina Healthcare of California

June 23, 2015

MOLINA® HEALTHCARE

Your Extended Family.

Molina Care Coordination

- Helping members/families **access medical benefits and services** (LTSS, LTC)
- At the **right time, place and cost**
- Based on **assessed needs**: behavioral health, medical, psychosocial, functional status
- Based on **member's preferences** and willingness to participate
- **In concert with PCPs, specialists, LTSS providers and other interdisciplinary participants and providers**

Care Coordination-Other Provider Types

- Hospitals
- Home health, hospice, palliative care
- SNF and LTC, board and care facilities
- Urgent care providers
- Behavioral health providers, county agencies
- IHSS, MSSP, CBAS
- Dialysis center staff
- Independent living centers

Care Coordination

Most effective with provider involvement

Common reasons to contact physician:

- Invite to the interdisciplinary care team meeting
- Obtain PCP involvement in care coordination
- Share medication concerns, pharmacist input
- Giving/getting information - change in health status
- Share assessment information - care plan development, psychosocial issues, LTSS, plan care coordination
- Work with physician extender when physician unable to participate directly in ICT

IPAs and Medical Groups

- Those with MSO or care management departments - very receptive to participating in care coordination
- Will often send their case manager to the ICT
- Will often invite plan's CM to their ICT
- Receptive to contributing to care plan, sharing member address/phone number, other relevant information
- Appreciate our field work with member, care transitions, follow up with member, LTSS service coordination
- JOMs - focus on what can be improved
- Plans want more access to group/IPA EMR

Interdisciplinary Care Team

PCP/Specialist involvement:

- Becoming more common
- Now more receptive to ICT recommendations
- IPA medical assistant is often the path to access the physician
- PCP more likely to accept brief phone call for consult than attend a formal ICT
- Physician ICT involvement is brief, can be formal or informal
- Respect PCP's time

Frank's Story

Frank's Interdisciplinary Team

- Frank (member centric)
- RN care manager - Molina
- Community Connector - Molina
- PCP - medical group, IPA, direct
- Physician specialists
- Medical director(s) - Molina
- Director of LTSS-Molina
- Dentist
- Frank's wife
- ILS - independent living center representative
- Ramp builder
- IHSS liaison

What did Frank need/want?

- Access to care - Physician that can manage complex care
- Independent transfers - in and out of bed
- Fewer UTIs
- Healed skin wounds, no more pressure sores
- Transportation to medical appointments
- To go back to school
- Safe access to his apartment-ramp

What did Frank need/want?

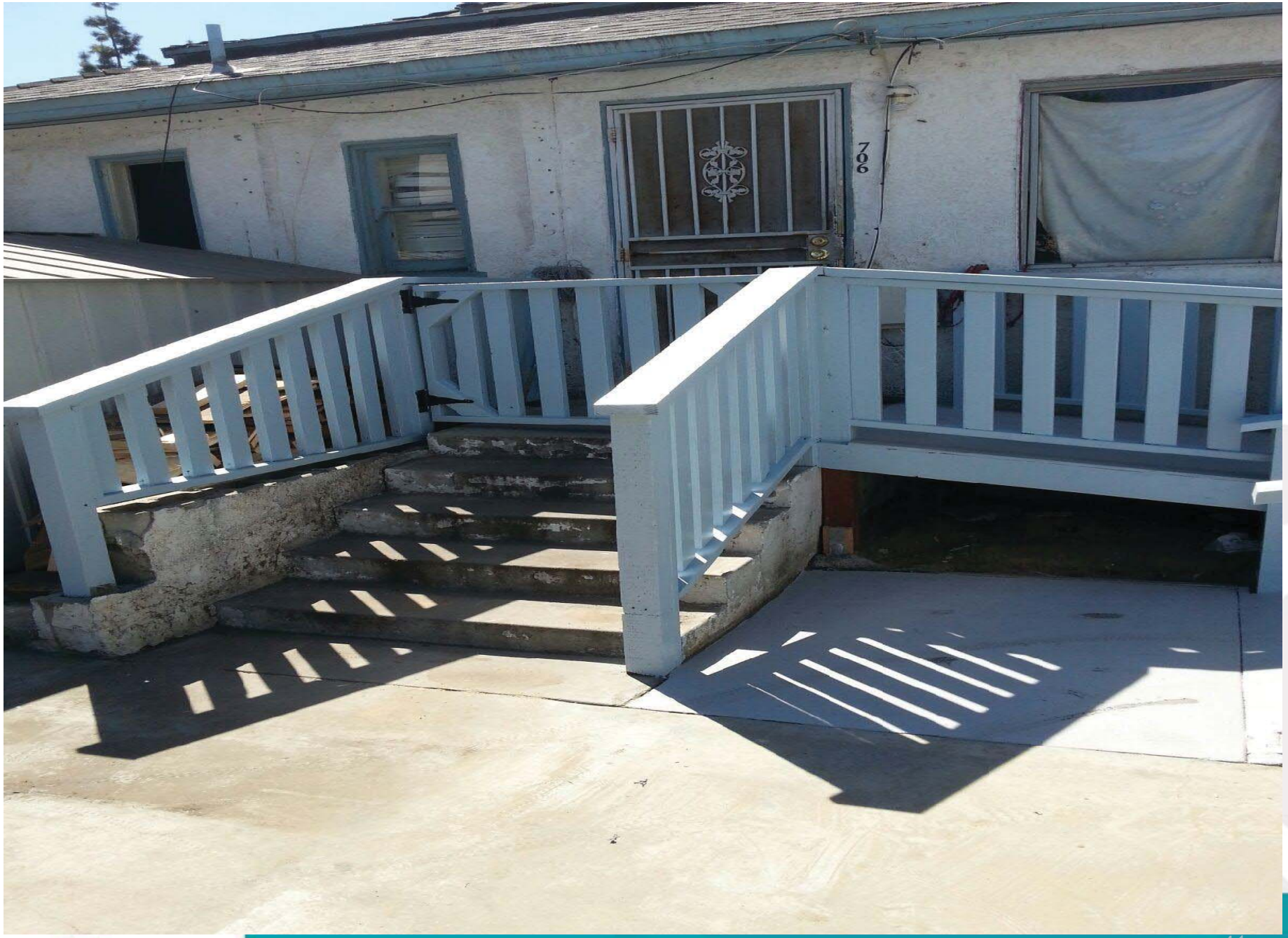
- To link family with services (dental, medical)
- To take a shower safely, regularly
- Dentures
- To give up
- To die
- A transplant
- To live

What did Frank Get? (so far)

- **A caring involved PCP, access to specialists**
- A bed, trapeze - Independence
- Dental care - access
- Incontinence supplies - fewer UTIs
- Functional wheelchair - Independence
- On waiting list for better housing
- Assessment for transplant - access to care

What Else Did Frank Get?

- Interdisciplinary **team expertise**
- Advocacy- **psychological support**
- New perspective - **motivation**
- The **will to live**
- **Hope** for a better future
- Better **Quality of Life** through interdisciplinary care coordination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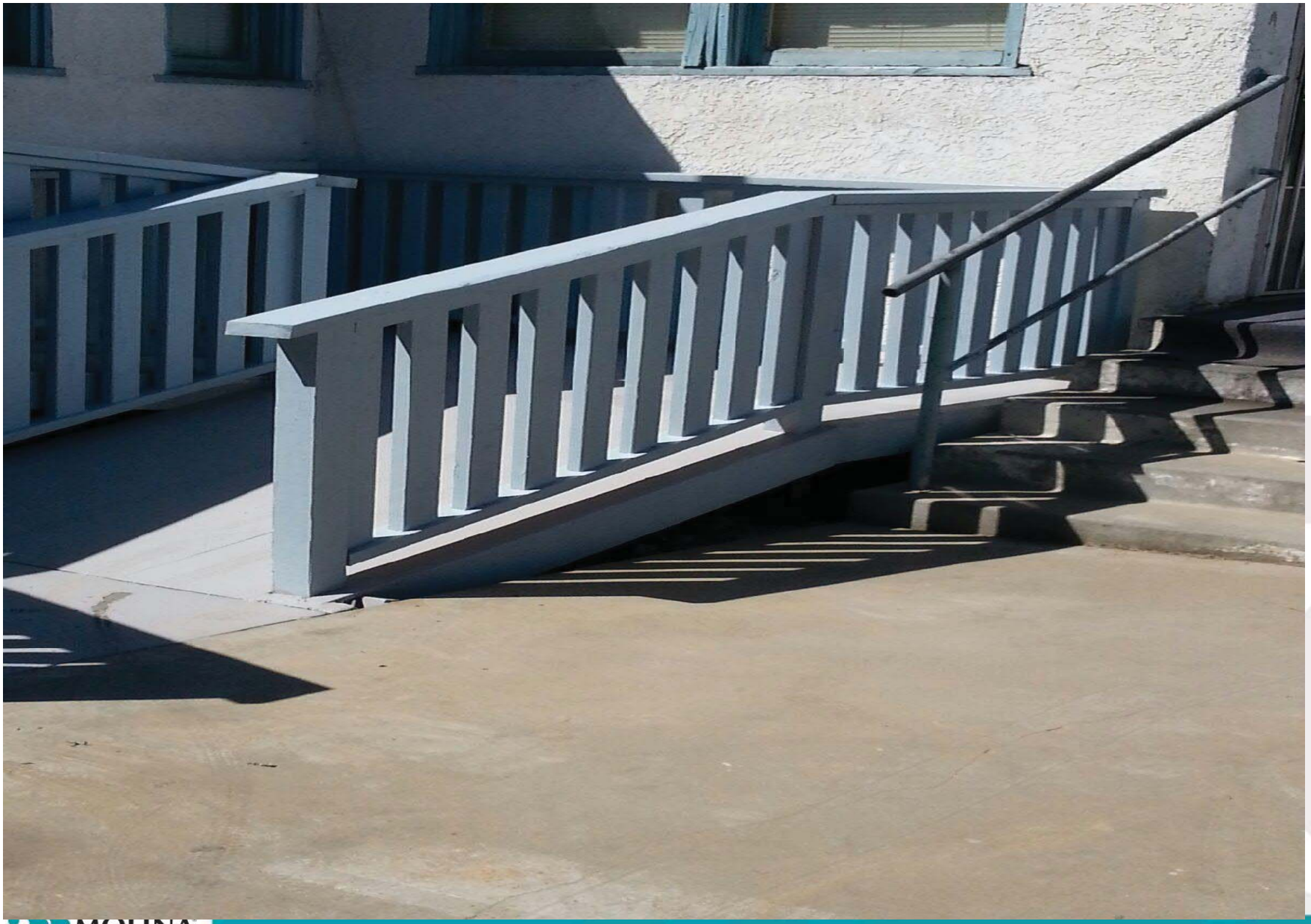

Best Practices for Care Coordination

Demara Nuzum, RN

Vice President of Medical Management

NAMM California
North American Medical Management

PRIME Care
Medical Network, Inc.

Network Integrity

NAMM CA Overview	
MA & Duals	67,000
Commercial	160,000
Exchange	12,000
Insurance License	Limited Knox-Keene
Network Statistics	15 IPAs, 575 PCPs
IPA Relationships	1 Managed, 14 Owned
Key Relationships	Aetna, Blue Shield, United, Cigna, Humana, Anthem, SCAN, Health Net, Care 1st, IEHP, Sharp

- Breadth and Depth of Network
  - Largest non-Kaiser provider of managed care services in S.B. and Riverside counties ~22%
  - Exclusive PCPs represent over 87% of enrollment
  - 3-5 year exclusivity terms with 11 year average tenure
- Strong Payer Relationships
  - Global risk with 8/9 senior and 3/7 commercial plans
  - Private label PPO/HMO commercial ACO product
  - Covered California HMO provider
  - Other Commercial ACO products pending

Cities/Towns with NAMM Physician Presence
NAMM Primary Admitting Hospitals
Represents Area with Negligible Population Density

PRIME Care
Medical Network, Inc.

NAMM California Structure

North American Medical Management, California, Inc.

MSO Services

PrimeCare Medical Network, Inc Knox-Keene

Owned IPAs:

- Coachella Valley Physicians of PrimeCare, Inc.
- PrimeCare of Citrus Valley, Inc. (80%)
- PrimeCare of Corona, Inc.
- PrimeCare of Hemet Valley, Inc.
- PrimeCare of Inland Valley, Inc.
- PrimeCare of Moreno Valley, Inc.
- PrimeCare of Redlands, Inc.
- PrimeCare of Riverside, Inc.
- PrimeCare of San Bernardino, Inc.
- PrimeCare of Sun City, Inc.
- PrimeCare of Temecula, Inc.
- Valley Physicians Network, Inc. (80%)
- Premier Choice ACO, Inc.

Your Health Options Insurance Services, Inc.

Other NAMM Managed/Owned Entities

IPAs:

- PrimeCare Medical Group of Chino Valley, Inc (50%)
- Primary Care Assoc. Medical Group, Inc
- Mercy Physicians Medical Group, Inc (Managed)

Owned Groups:

- Redlands Family Practice Medical Group, Inc.
- Physician Partners Medical Group

Scripps IDN Management, LLC (JV)

MDOps, Inc.

PrimeCare Medical Network, Inc.

Dr. Tarek Mahdi
President
Riverside Family Physicians

Questions and Discussion