Overview

- What is driving healthcare re-engineering?
- Healthcare delivery system re-engineering
- How are behavioral health providers responding?
Impact of Behavioral Health Co-Morbidities on Medicaid Costs

- Asthma and/or COPD: $24,598
- Congestive Heart Failure: $24,927
- Coronary Heart Disease: $24,443
- Diabetes: $36,730
- Hypertension: $35,840

Source: OECD
State of the (Care Coordination) Union

- 10% of Medicare beneficiaries enrolled in an ACO
- > 500 hospitals participating in a Medicare bundled-payment initiative
- > 235 health systems in accountable care arrangements with payers
- 29 States participating in ACA Health Home Program
- 75% of Medicaid population is in managed care
- Reduction in health care spending correlated with slower employment growth in the health care field
A Policy Maker’s Two Choices

• Cost containment strategy Options:
  ✓ Ration services
  ✓ Reduce insurance benefits
  ✓ Increasing cost sharing by users of care
  ✓ Restrict eligibility for programs
  ✓ Cut payments to providers

• Re-engineer health services to make them more efficient:
  ✓ Focus on 1/3 of spending that is estimated to be wasted
  ✓ Reform the delivery system
  ✓ Reform the system of payments to providers
  ✓ Engage consumers in making better health care choices
  ✓ Make health care data more available
  ✓ Reduce administrative expenses

Research Studies Recommend:

• Discard the current fee-for-service payment system

• Have providers share risk for the cost and quality of services
  ✓ Capitation or partial capitation
  ✓ Global budgeting
  ✓ Risk-sharing arrangements such as ACOs, PSNs

• Strengthen three elements of current health care systems:
  ✓ Availability and usefulness of health information
  ✓ Coordination of care
  ✓ Primary care services
What Does This Mean for Medicaid?

• Like ACOs, capitated MCOs have a financial incentive to contain costs

• Incentives are stronger for capitated MCOs than for ACOs
  ✓ MCOs keep 100 percent of all savings
  ✓ MCOs are at risk for all expenditures

ACOs in Medicaid?

• Most states establish more rigorous benchmarks and/or performance incentives for Medicaid MCOs
  ✓ MCOs pass these standards/performance incentives on to their participating providers

• Not clear what advantages ACOs would offer to Medicaid programs, compared with what capitated MCOs already offer
Where Could ACOs Fit in Medicaid?

- ACOs could be a provider/sub-contractor in an MCO network
  - Paid through shared savings, performance-based payments, or sub-capitation payments

- Integrated delivery systems could have the same range of clinical and financial integration as ACOs using different organizational and regulatory structures
  - IPAs, PSNs.....
Population Health Focus

• Targeted approaches for pockets of health care need
  ✓ Communities with high rates of potentially avoidable hospital admissions
  ✓ People with chronic disease

• Intervention in these “hot spots” will require a combination:
  ✓ Enhanced primary care
  ✓ Collaboration with community, social, and public health resources
  ✓ Collaboration with behavioral health resources
  ✓ Combatting higher state rates of smoking, obesity, infant mortality, and premature death in vulnerable populations.

Potential Savings from these Models

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<tr>
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<td>Payment reforms to pay for value to accelerate delivery system innovation</td>
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WHAT DOES THIS MEAN FOR YOU?

• Shifting socio-economics
• Push-pull on volume
• Decreasing reimbursement?
Driving Health Care System Transformation

Healthcare Delivery System 1.0
- Episodic Non-Integrated Care
- Fee for Service

Healthcare Delivery System 2.0
- Accountable Care
- Volume-based payments to performance-based Payments
- Continuous quality improvement and measurement
- Transparency

Healthcare Delivery System 3.0
- Integrated Health
- Full risk or capitated payments
- Bundled payments across levels of care
- Population health focus

Risk & Accountability Continuum

Small financial risk
- Fee-for-service

Medium financial risk
- Performance-based Contracting
- Bundled and Episodic Payments
- Shared Savings
- Shared Risk

Large financial risk
- Full Capitation

No Accountability
- Moderate Accountability
- Full Accountability

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Innovations Designed To Improve Care & Reduce Costs

- Health Homes
- Integrated Care Organizations
- Dual Eligibles
  - BH
  - Elderly
  - Physically disabled
- I/DD Care Coordination
- Managed Foster Care

Form
ACO/PCMH/Health Home/DISC O

Care Delivered to Consumer

Revenue Cycle Mgmt.

Value = \frac{Outcomes}{Cost}

Insurers
Public Health
Behavioral Health
Substance Abuse
Primary Care

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Implications

- Care management a major core competency
- Care and services will be fully integrated
- Coordination will be essential with hospital networks and provider networks
- Increased emphasis on population data analytics
- Sharing of health information through HIE
- Capitated payments

Health Homes

- Created by Section 2703 of ACA
- Eligibility:
  - Medicaid eligible
  - Two or more chronic conditions, or
  - One chronic condition and at risk for another, or
  - A serious and persistent mental health condition
Eligible Conditions

- Mental health disorders
- Substance use disorders
- Asthma
- Diabetes
- Heart disease and overweight (BMI>25)

Health Home Services

- Defined by Section 1945(h)(4) of ACA:
  - Comprehensive care management
  - Care coordination and health promotion
  - Comprehensive transitional between LOC
  - Individual and family support
  - Referral to community/social support services
  - Use of HIT to link services
What Is A Health Home?

- Not a residence or building, but a care management model
- A formal integrated network of providers
- Provider network is linked by IT
- Takes primary responsibility for a client for health and social needs
- Care coordination is the one Medicaid Funded Service

Fundamental Change in Orientation

Needs of the patient → Needs of the population
Support of the individual provider at the point of care → All providers across the spectrum of care
Treatment of chronic disease → Management of chronic disease
Islands of automation → Integrated information access across providers, settings & activities
Steps to Driving Accountable Care

CARE COORDINATION APPROACHES
Content Required to support multiple Populations

- Management of Multiple Chronic Conditions
- Management of the Seriously Mental Ill (SMI) Population
- Integration of Child and Family Services
- Behavioral Health Integration with an ACO
Coordinated Behavioral Care
- Emergency Services and Shelter
- Implementing Netsmart CareRecord (EHR)
- Health Home for Children (Magellan)
Sending and Receiving a Care Plan

**Behavioral Health Home (Beth Israel)**
- Care Coordination
- Care Management Agency
- Care Coordination Plan

**Physical Health Home (St. Luke)**
- Care Coordination
- Care Management Agency
- Care Coordination Plan

Problems | Objectives | Interventions
---|---|---

Healthix
Health Information Exchange

**Technology To Support New Models**

**Behavioral Health, CFS, SA, I/DD**

**Netsmart**

**Acute Care Hospitals and Ambulatory Practices**
- Epic
- Allscripts
- Cerner

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Henderson Primary Care Integration

Primary and Acute Care Use Cases
The Problem – Why Connect to Acute Care Hospitals?

• Current healthcare systems are often disjointed, and processes vary among and between behavioral health and physical health sites

• Specialists do not consistently receive clear reasons for the referral or adequate information on completed tests

• Primary care physicians do not often receive information about what happened in a referral visit

• Referral staff deals with many different processes and lost information, which means care is less efficient

The Goal

• Improve patient safety by reducing medication and medical errors

• Increase efficiency by eliminating unnecessary paperwork and handling

• Provide caregivers with clinical decision support tools for more effective care and treatment

• Eliminate redundant or unnecessary testing

• Improve public health reporting and monitoring

• Engage healthcare consumers regarding their own personal health information

• Improve healthcare quality and outcomes

• Reduce health related costs
Henderson Behavioral Health Strategy for Integration with Primary Care

- The HILL Project (Helping Individuals live longer) provides primary medical care and wellness services to persons who receive behavioral health service at HBH

- Strategy involves on-site medical exams, lab tests, coordination of follow-up services, and onsite wellness activities

- Adheres to principles of informed choice, recovery-focused and person-centered care and incorporation of evidence based practices in routine care.

HBH Current Primary Care Goals and Objectives

- Increase delivery of a coordinated array of medical, self-help, social, supportive, and rehabilitative services designed around the needs and desires of the individual

- To improve the physical health of individuals with serious mental illness who are at-risk for co-occurring behavioral health and primary care conditions

- To assist persons in taking an active role in their health and well-being

- To assist in the coordination of primary, specialty, and behavioral health services

- To increase individual and family input thereby enhancing their experience of care

- To reduce/control the per capita cost of care.
Notable Outcomes Year-to-date

- Over 450 individuals enrolled to date
- 22% have improvement in combined blood pressure from baseline to six-month assessment
- 46% of individuals served demonstrated improvement in BMI from baseline to six-month assessment
- 60% of individuals served demonstrated an improvement in Breath CO Measurements from baseline to six month assessment. (a metric used to assess, motivate and educate individuals for smoking cessation)
- 50% of individuals served demonstrated an improvement in plasma glucose readings
- 25% of individuals serves demonstrated an improvement in tryglycerides from six-month reassessment.

HBH Integration with Memorial Health System

- Initial project focused on improving consumer satisfaction and coordination of care between Memorial Health System & Henderson:
  - Reduce average 18 hour stay in MHS ED
  - Move consumer to more appropriate site of care for BH issues
  - Open ED bed for more appropriate use
  - Reduce cost to county and state
- Why a direct connect? Simple two-way information exchange that eliminates major roadblocks encountered due to 42CFR. Releases are obtained between just two systems
- Memorial Healthcare System and Henderson Behavioral Health are the largest Healthcare and Behavioral Healthcare Systems in the Greater Fort Lauderdale region
- Strong leadership and staff relationships between the two systems that support the initiative.
Integration Use Case

• MHS ED determines that the patient would be appropriate for Henderson CSU Inpatient facility based on the Florida Baker Act
• MHS determines that appropriate consents have been obtained
• If applicable, a copy of legal paperwork faxed to Henderson
• Staff at MHS send the referral C-CDA CCD (elements listed below) from the Epic system to Henderson Avatar system:
  - Labs or studies that have been completed for the medical diagnosis while in the emergency room/hospital to support medical clearance
  - Demographic Information
  - Medical Summary
  - Medication List
  - Vital Signs
• Henderson CSU receives the C-CDA CCD
• When the C-CDA CCD is received at the Henderson server a notification is generated to staff on duty that a referral from MHS has been sent
• Henderson staff review the information received to determine accuracy and appropriateness for Nurse review
• If accurate, a MHS Nurse to Henderson Nurse exchange is performed for questions and acceptance or denial

HBH Expected Clinical and Financial ROI

• Much more accurate information
• Much less time involved
• Data entry reduced in Avatar by importing the CCD directly into MyAvatar
• Huge time savings over faxing
• Increased client satisfaction scores and process will feel smoother and more organized for clients—focus on the “client experience”
• When shifts change referral process will create an easier process from one clinician to another if the referral is still in a pending status, it will save time transitioning these referrals
Opportunity or Chaos? It all depends on your

PLAYING OFFENSE