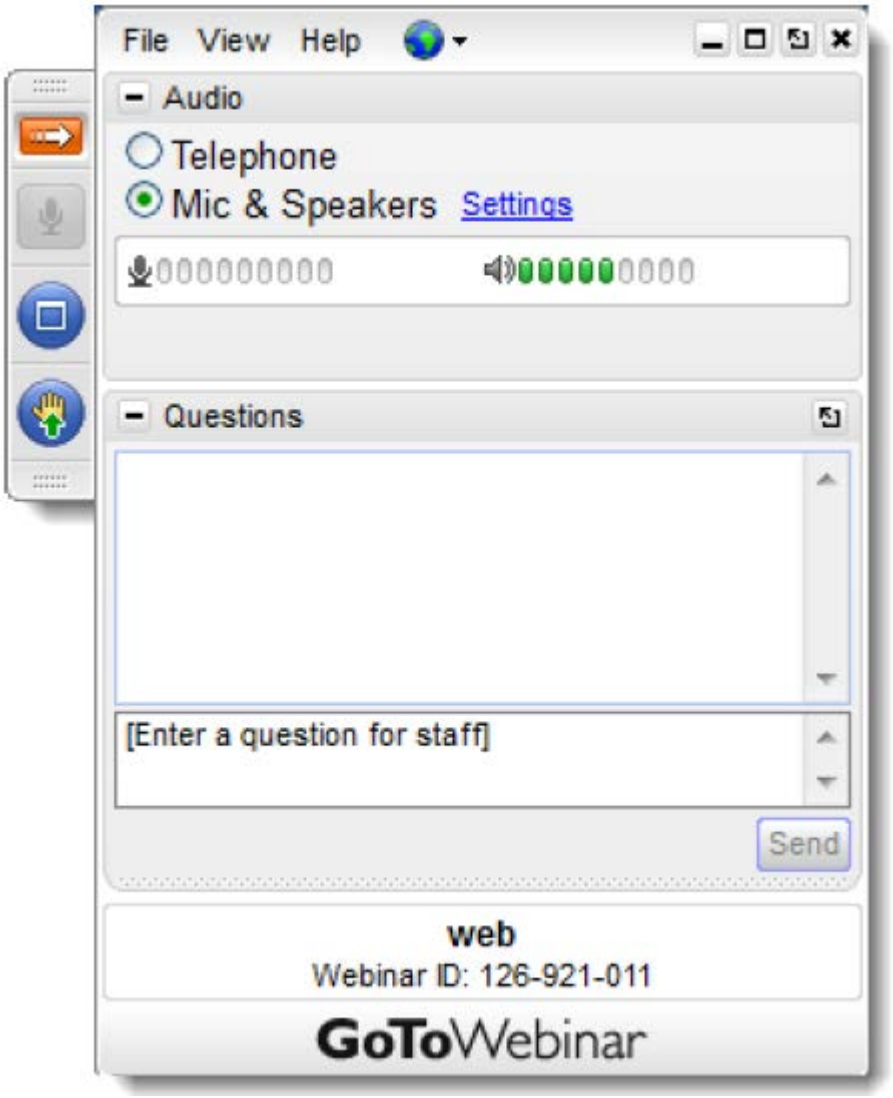
Mental Health & Substance Abuse Integration: Strategies and Lessons Learned from Around the Nation

September 2016

VHCIP Webinar Series

Before we get started…



- By default, webinar audio is through your computer speakers.
- If you prefer to call-in via telephone, click "Telephone" in the Audio pane of your control panel for dial-in information.

Before we get started…

- **We've reserved time for Q&A at the end of this event.** Submit questions via Questions pane in webinar control panel.
- **This webinar is being recorded.** Slides and recording will be posted to the VHCIP website following the event: http://healthcareinnovation.vermont.gov/
- **Please complete our brief evaluation survey** at the end of the event. We value your feedback!

Vermont Health Care Innovation Project

Speakers

- Moderator: Georgia Maheras, Director, Vermont Health Care Innovation Project (VHCIP), and Deputy Director of Health Care Reform for Payment and Delivery System Reform, Agency of Administration
- Speaker: Allison Hamblin, Vice President for Strategic Planning, Center for Health Care Strategies (CHCS)
- Speaker: Ginger Cloud, Screening in the Medical Home Project Manager, Central Vermont Medical Center (CVMC)

Agenda

- Medicaid Trends in Mental Health and Substance Abuse Integration
- Case Study: CVMC Screening, Brief Intervention, and Referral to Treatment (SBIRT) in the Medical Home Project
- Q&A

CHCS Center for Health Care Strategies, Inc.

Advancing innovations in health care delivery for low-income Americans

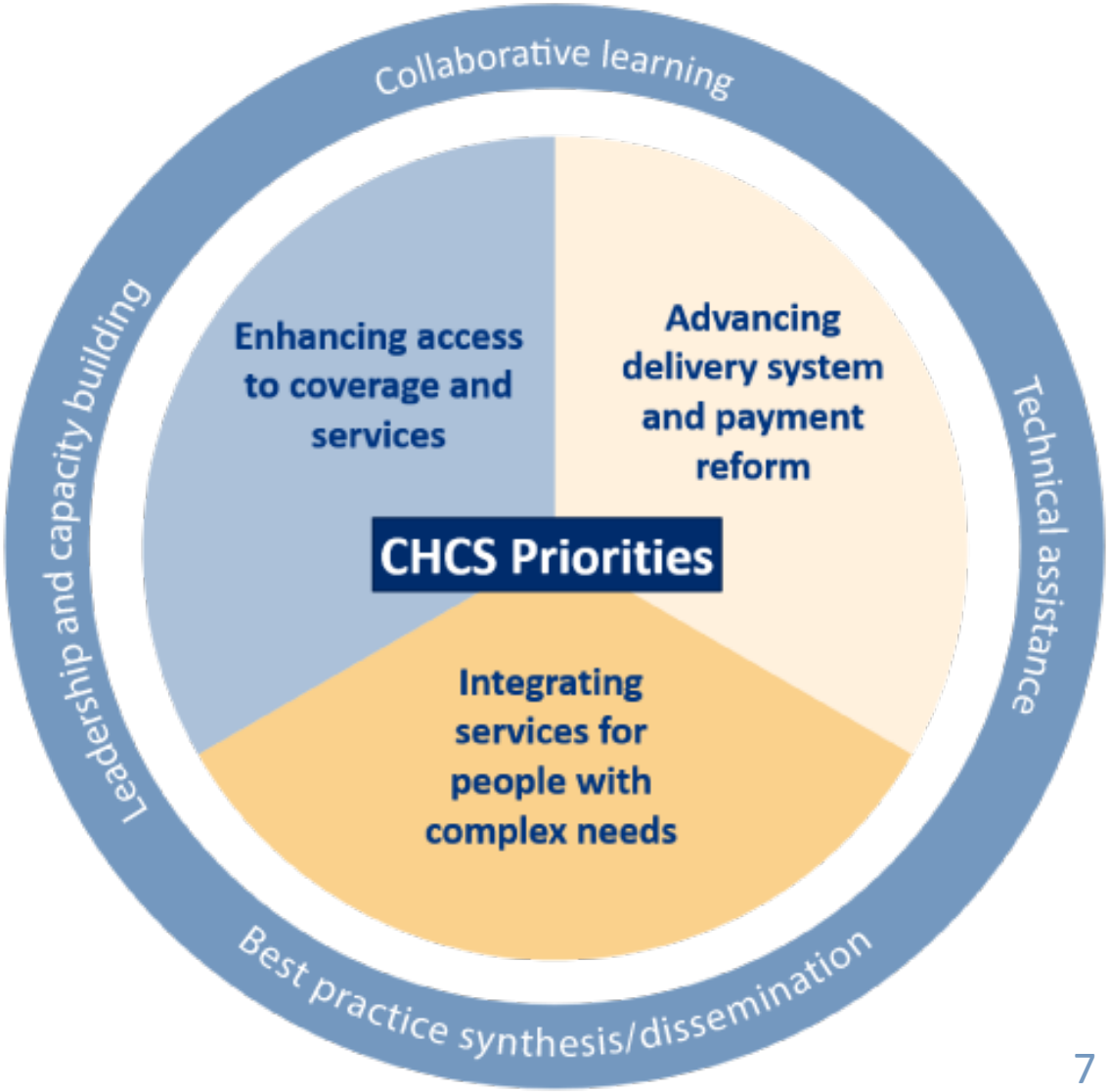
Medicaid Trends in Mental Health and Substance Abuse Integration

September 14, 2016

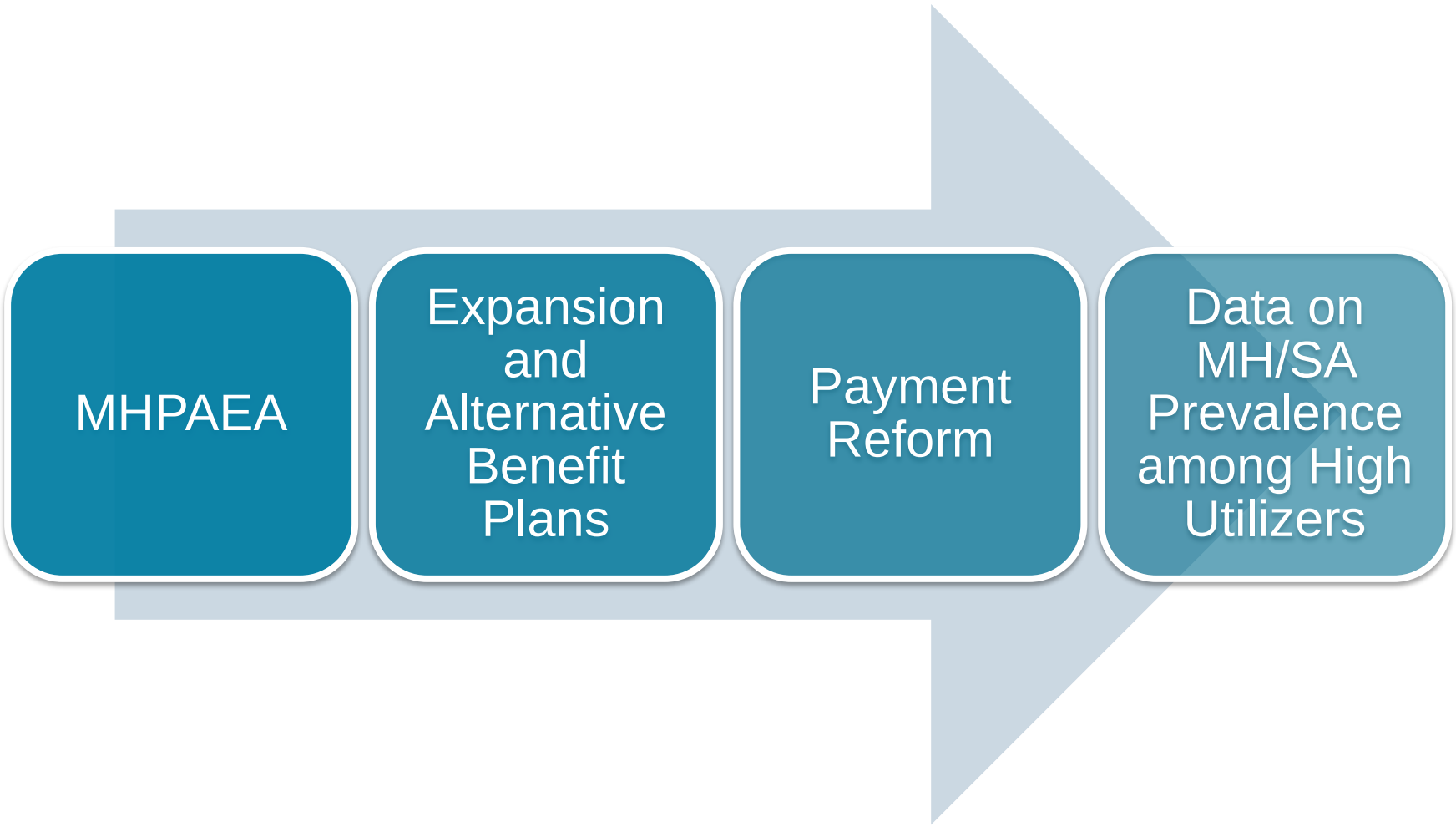
Allison Hamblin, Vice President
Center for Health Care Strategies

About the Center for Health Care Strategies

A non-profit health policy center dedicated to improving the health of low-income Americans

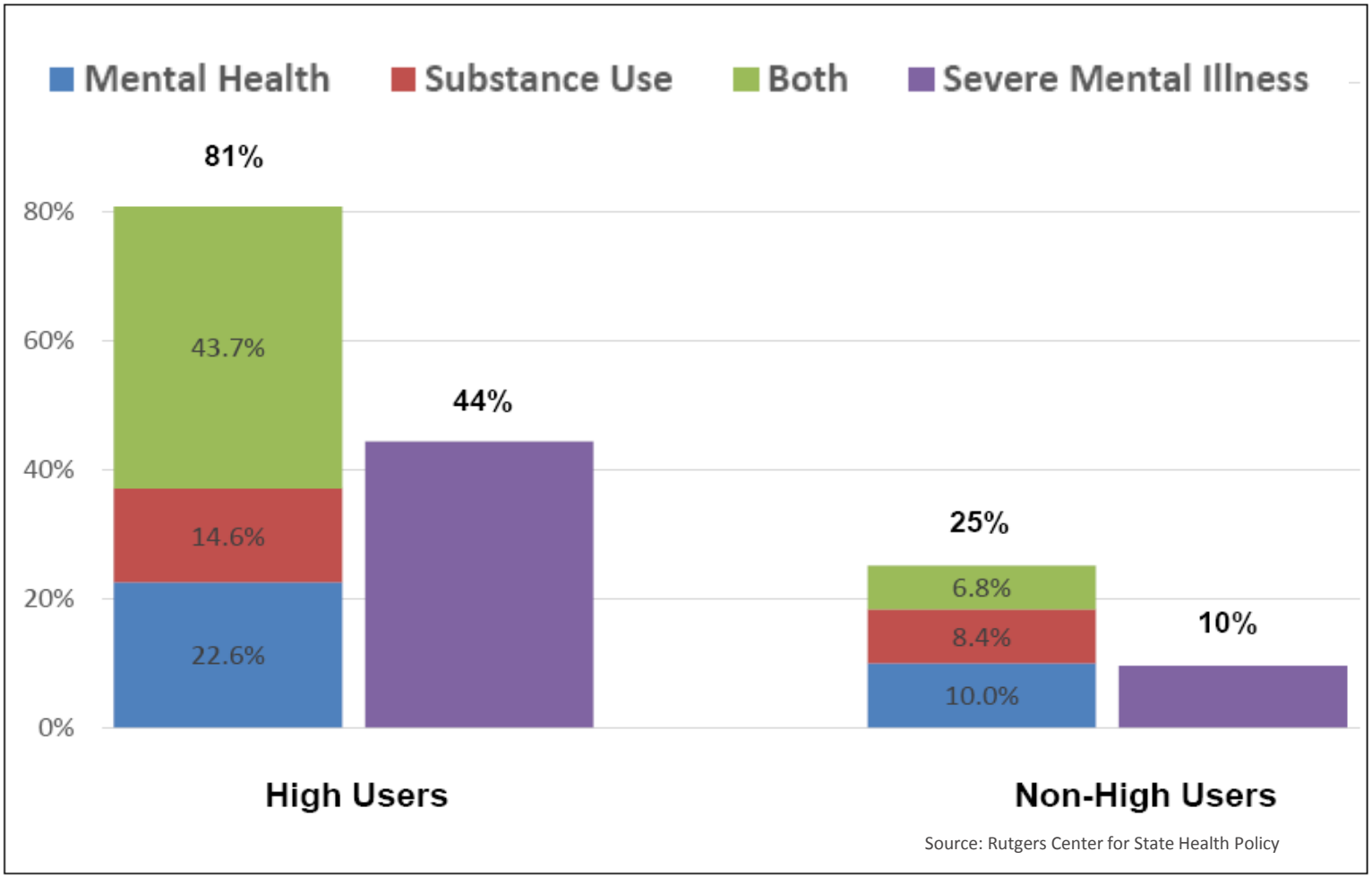


Drivers of State MH/SA Integration Activity



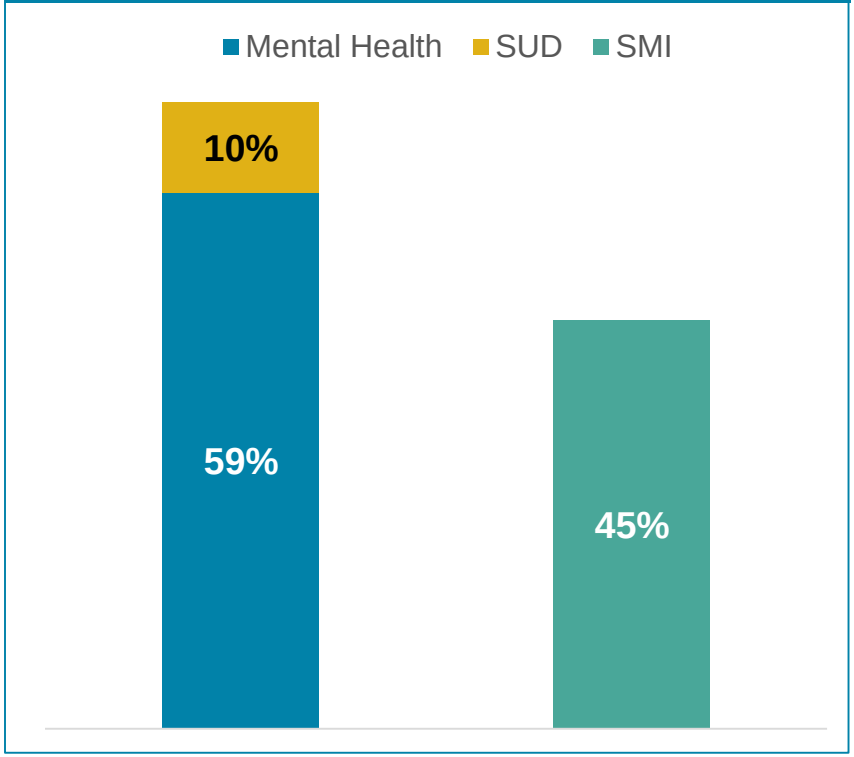
NJ Medicaid Beneficiary MH/SA Prevalence by Inpatient High User Status

13 Low-Income NJ Areas, 2008-2011

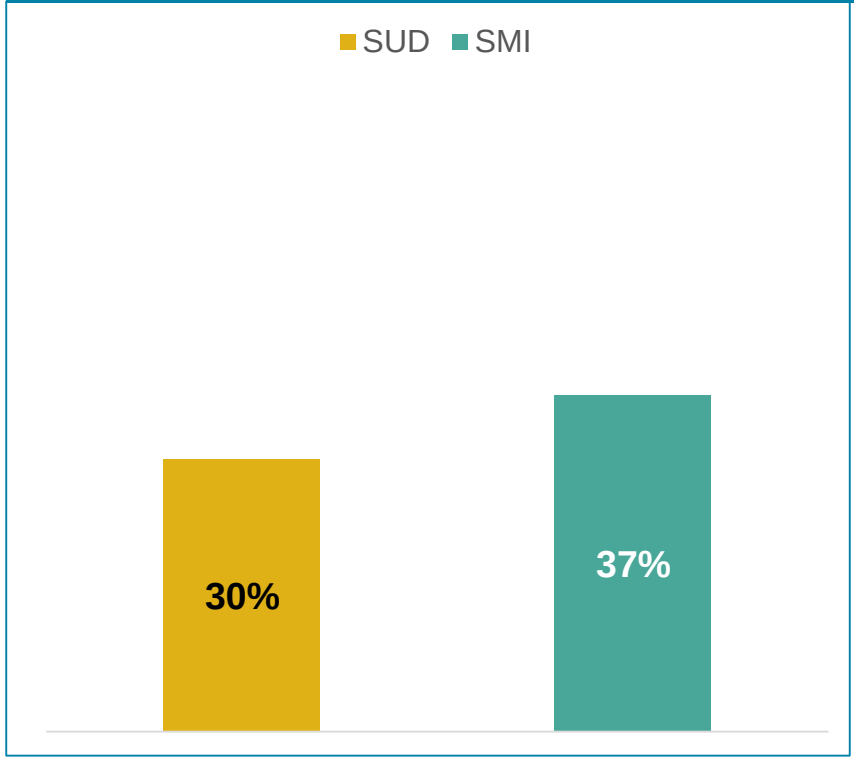


How Do Other States Compare?

California: Top 5% High Cost Medicaid



Washington: Top 5% High Risk Medicaid

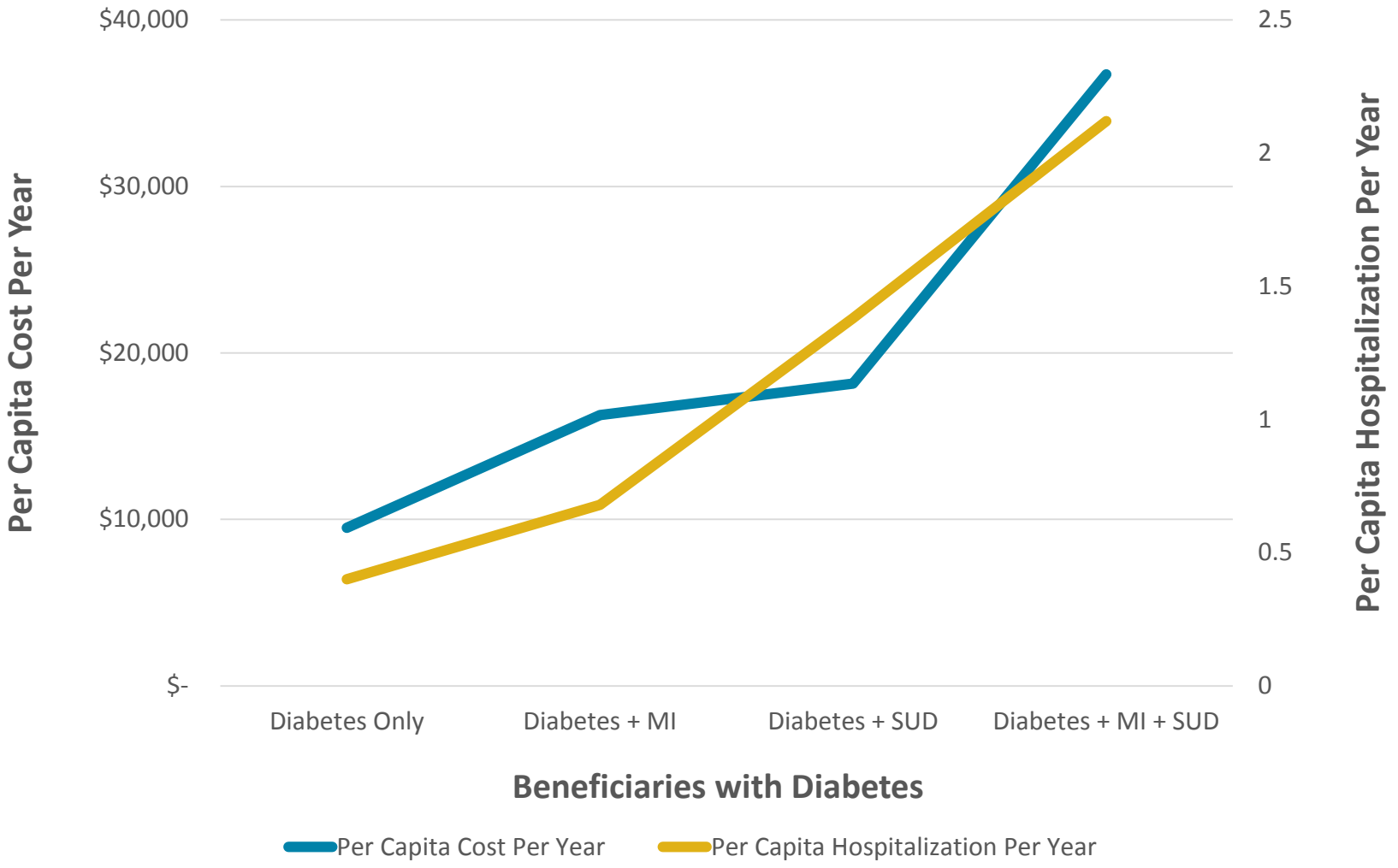


Pennsylvania: All Payer High Inpatient Users

Mental health disorders among top three reasons for admission among super-utilizers

Sources: CA: DHCS Research and Analytic Studies Division. *Understanding Medi-Cal's High Cost Populations.* March 2015. WA: DSHS Research and Data Analysis Division, Integrated Client Database, January 2012. Data from SFY 2009; PA: Health Care Cost Containment Council. Data from FY 2014.

Impact of Mental Health and Substance Use Disorders on Cost and Hospitalization for Diabetics



Source: C. Boyd et al. *Faces of Medicaid: Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services*. Center for Health Care Strategies, December 2010.

How Are States Attempting to Integrate Care for Complex Populations?

Managed Care Integration

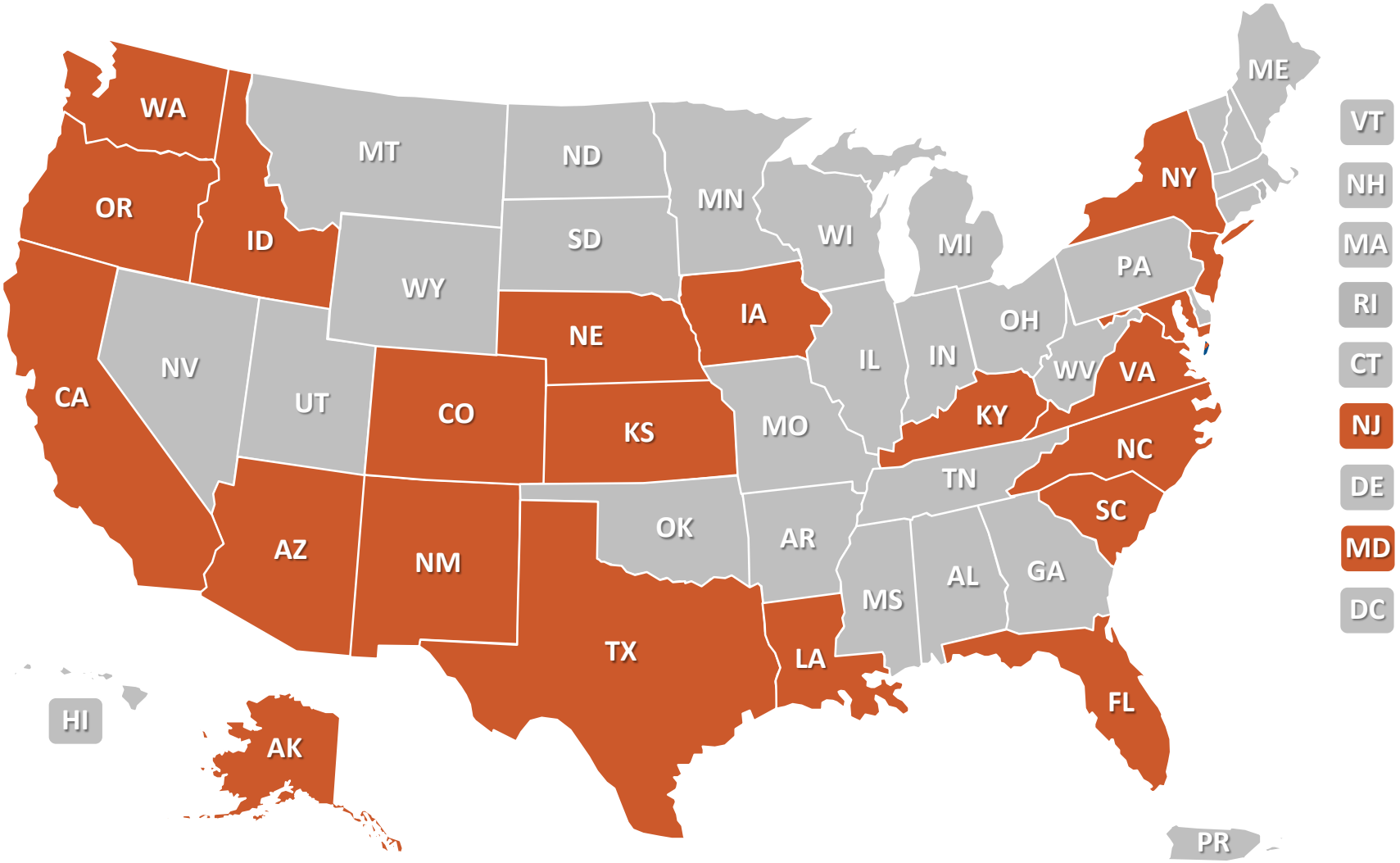
Care Coordination

Delivery system and payment reform

Peer Supports

Criminal Justice Collaboration

Hot Spots for MH/SA System-Level Reforms



Source: Internal CHCS analysis.

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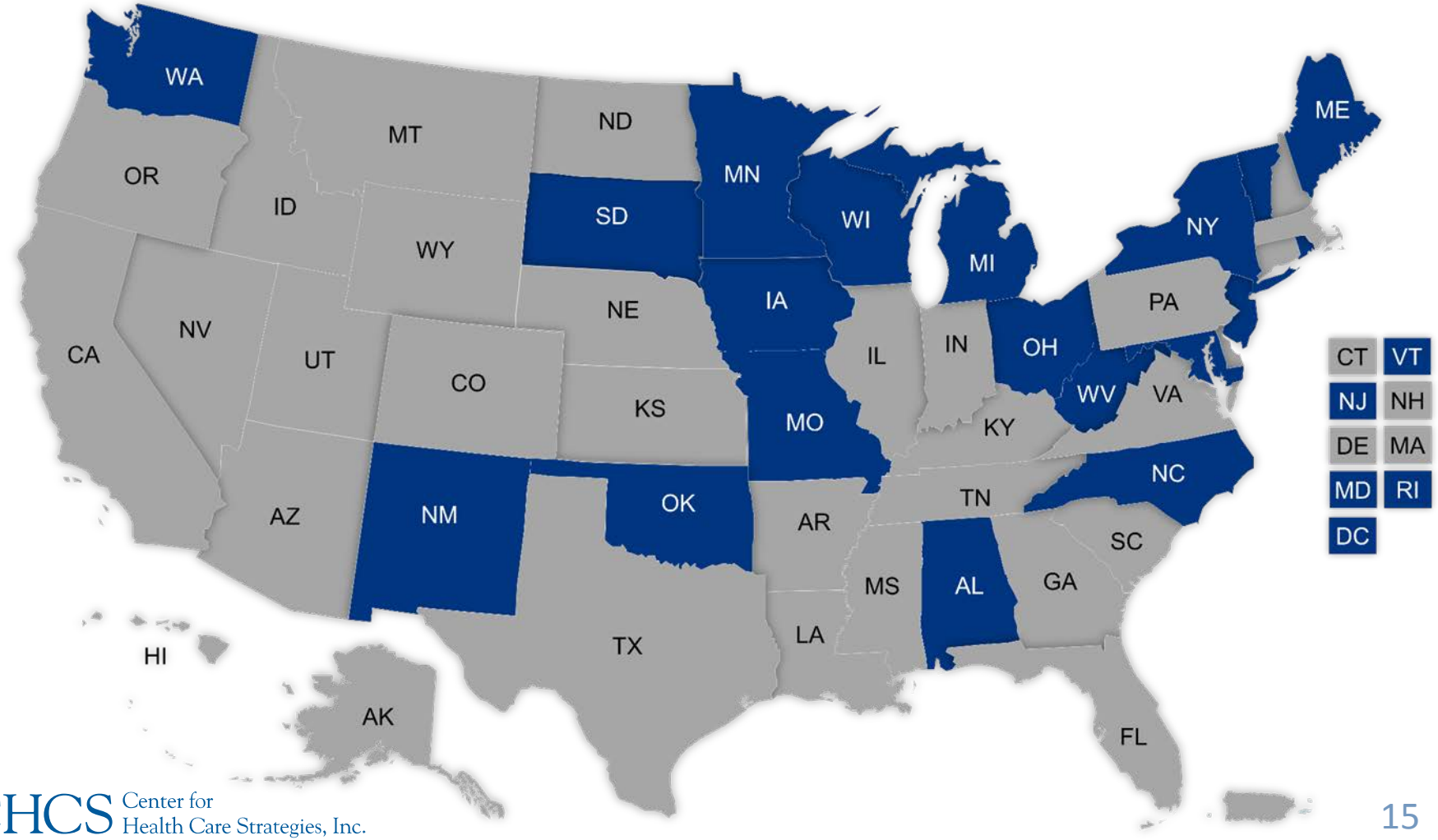
State Health Home Activity

As of September 2016, 19 states and the District of Columbia have a total of 28 approved Medicaid health home models: Alabama, District of Columbia, Iowa (2), Maine (2), Maryland, Michigan (2), Minnesota, Missouri (2), New Jersey (2), New Mexico, New York, North Carolina, Ohio, Oklahoma (2), Rhode Island (3), South Dakota, Vermont, Washington, West Virginia, Wisconsin.



Approved Health Home Models

Chronic Medical Focus

Iowa
Maine
Michigan
Missouri
North Carolina
Wisconsin

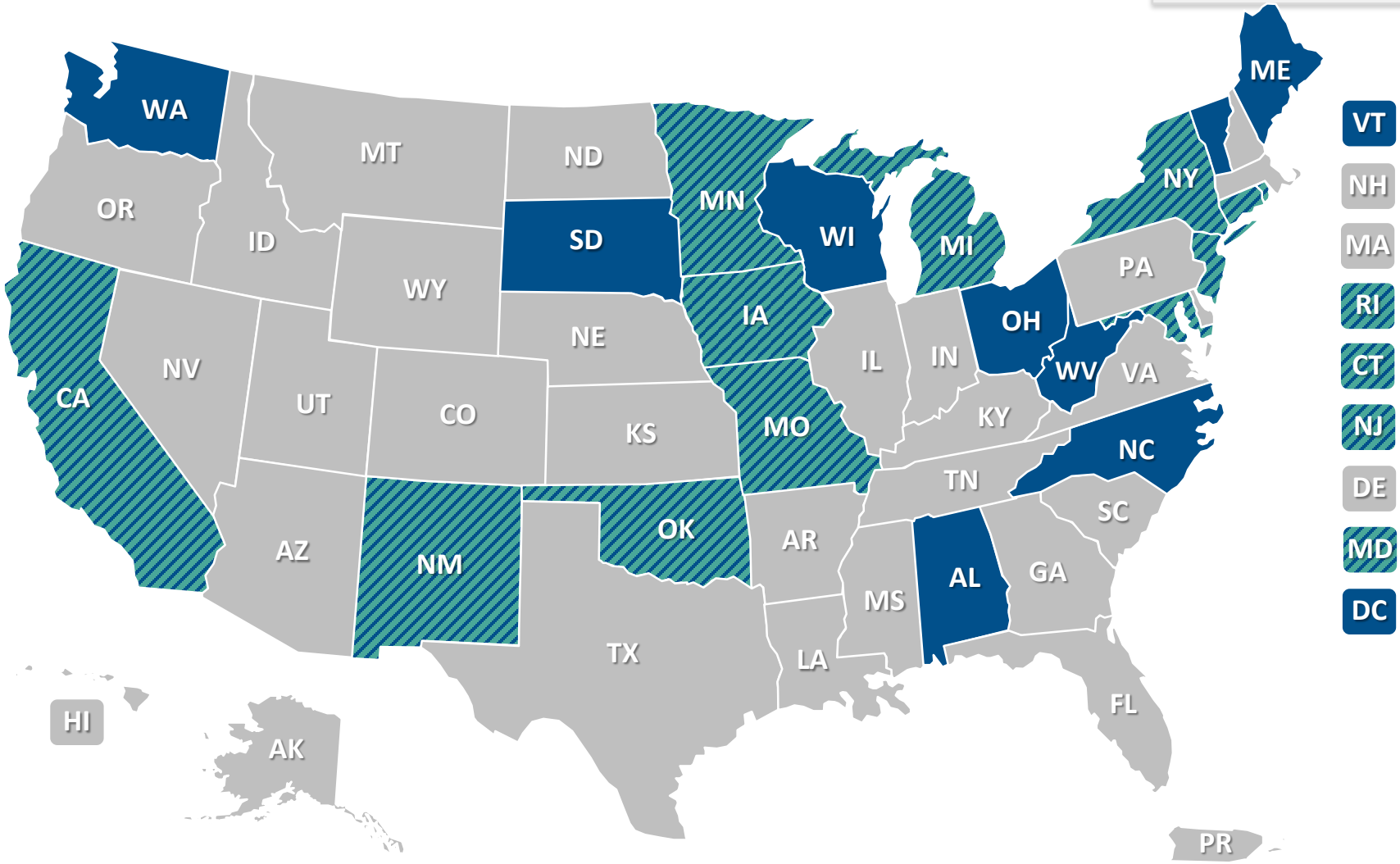
SMI/SED/SUD Focus

- District of Columbia
- Iowa
- Kansas
- Maine
- Maryland
- Michigan
- Minnesota
- Missouri
- New Jersey
- New Mexico
- Ohio
- Oklahoma
- Rhode Island
- Vermont
- West Virginia

Broad: Chronic Medical and SMI/SED

- Alabama
- Idaho
- New York
- South Dakota
- Washington

Behavioral Health Homes States* with CCBHC Planning Grants



*States with BHH models planned or implemented

CCBHC Integration Requirements

- Outpatient primary care screening and monitoring
- Care plans addressing medical, behavioral, and social needs
- Care coordination with physical health providers through:
  - health information technology systems
  - monitoring health behaviors and indicators
  - tracking of acute care utilization
- Medical Director who can prescribe medications
- Staff trainings on integration

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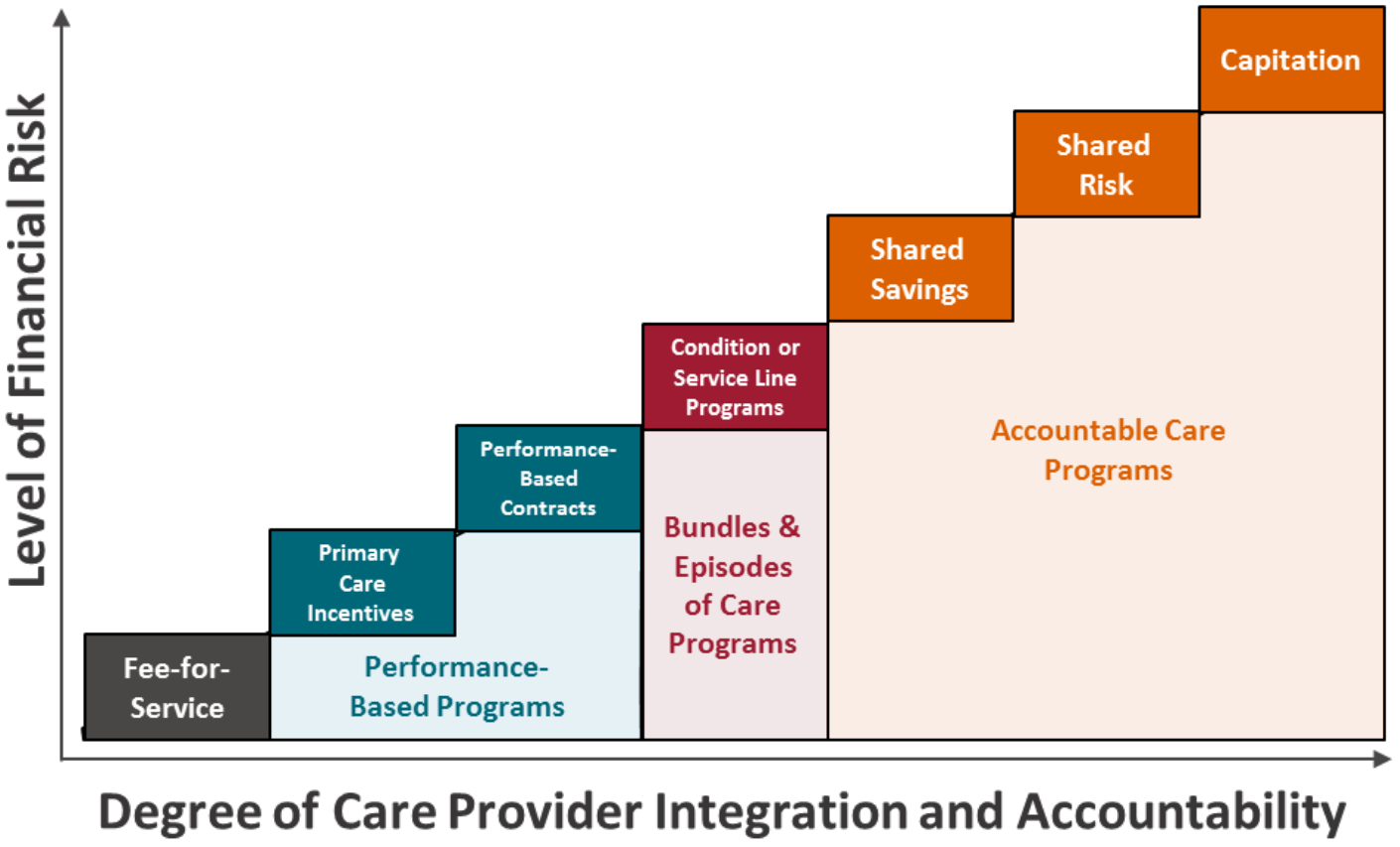
Continuum of VBP Strategies



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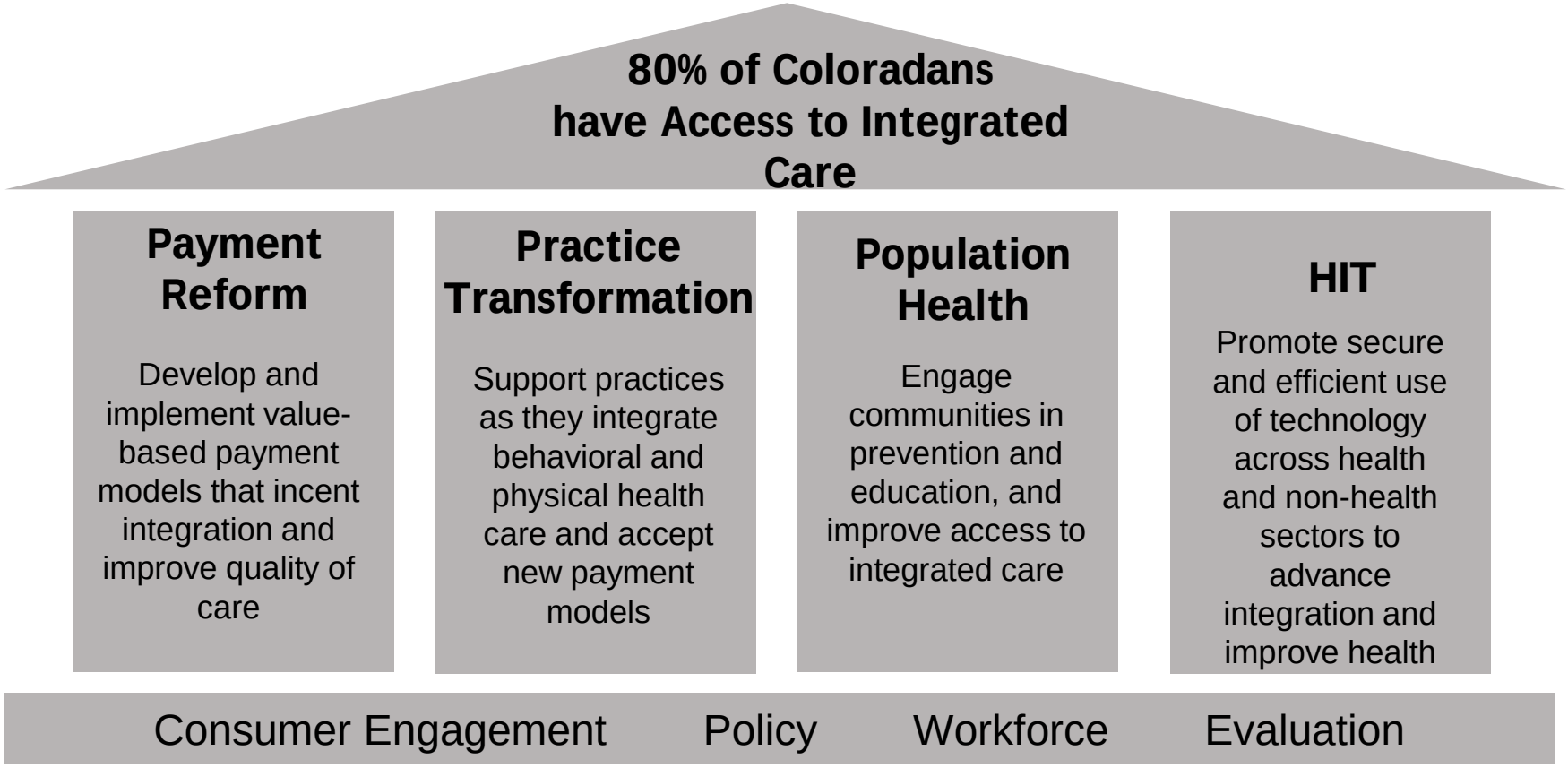
Complex Care Payment Models Currently in Use

	Care Coordination Reimbursement	Shared Savings/Risk Payments	Global Payment
Methods	Prospective monthly fee structured to cover extensive set of care management and coordination services only	Retrospective payment based upon savings achieved, relative to projected total cost of care	Prospective monthly fee structured to cover health services, care management, and other supportive services
Organizational Models	Health Homes	ACOs	MCO/ACO
States	NY, WA	ME, MN, VT	MN (Hennepin), OR

Comparison of Payment Models

	Benefits	Challenges
Care management PMPM	• Directly funds services critical to preventing avoidable acute care utilization among SU patients • More effective in covering upfront staff costs • Targeted to SU patients with clear expectations	• Unclear whether incentives align with cost reduction, social determinants • Difficult to incentivize engagement effectively • Sustainability • Prescriptiveness
Shared savings/risk	• Incentivizes cost reduction • Flexibility to cover supportive services	• Does not cover upfront staff/investments • Requires targeted metrics to ensure quality • Minimum patient requirements • Not specific to SU patients
Global payment	• Covers upfront costs and has backend cost savings incentives • Flexibility to cover supportive services	• Financial reserves needed—only feasible for large orgs. • Provider financial sophistication • Targeted metrics to ensure quality • Not specific to SU patients

Colorado Model



Colorado Behavioral Health Integration

- Integration of physical and behavioral health in 400 practices over 4 years.
- Bi-directional health homes: integration of behavioral health in 4 community mental health centers with a focus on treating individuals with severe mental illness.
- Payment will move from additional care coordination payments to shared savings & risk to fully capitated payments for total cost of care.

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Innovative Peer Models

Wilmington, DE: Project Engage	• Embeds peer specialists in hospitals to engage high utilizers with untreated SUD
Pittsburgh, PA: CCISUD Project	• Replicating Project Engage in 4 hospitals; supported by Medicaid MCOs
Providence, RI: AnchorED	• Deploys peers to emergency rooms statewide to engage patients following opioid overdose

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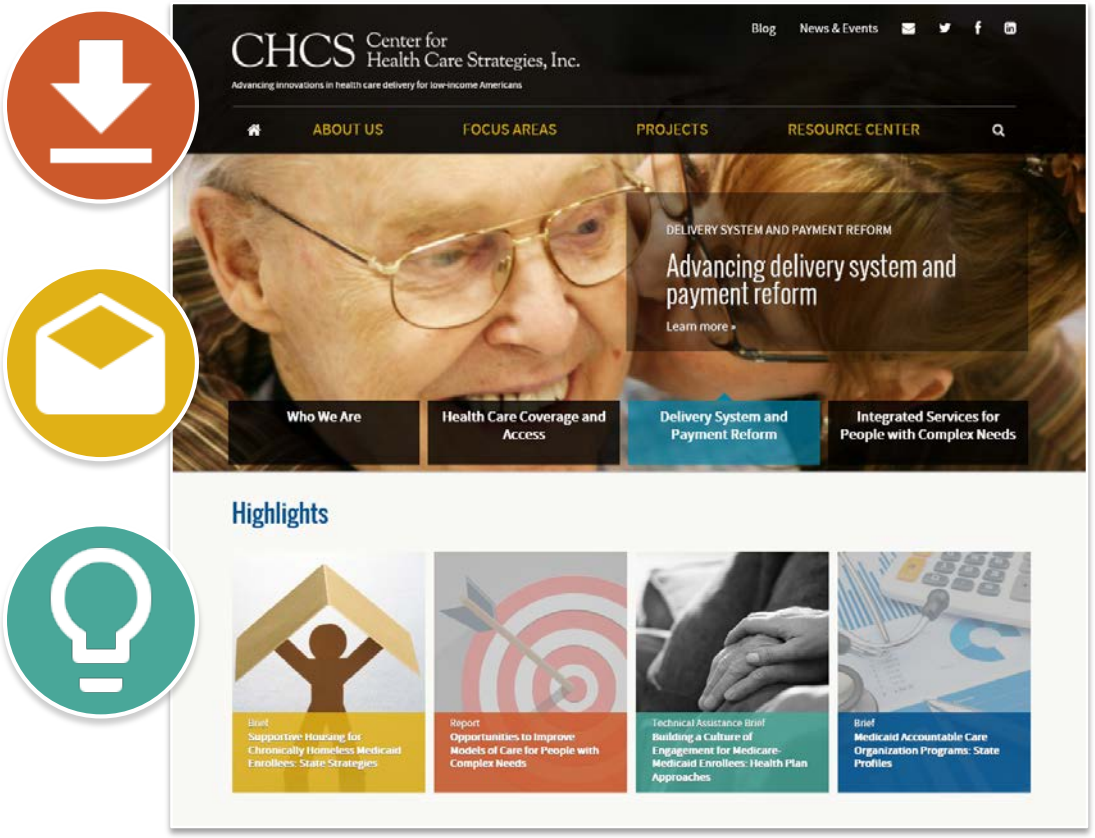
Innovations in Criminal Justice Collaborations

Albuquerque, NM	• MCO partnerships facilitating immediate enrollment upon release along with care coordination/case management
Maryland	• Waiver application submitted in early May to allow presumptive eligibility for inmates upon release for up to 60 days of initial coverage
New Jersey	• Forthcoming waiver application will include continuous eligibility for inmates upon release for 18-24 months, as well as new requirements for MCO-led care coordination
Illinois	• Waiver application submitted in August would allow care coordination 30 days prior to release, as well as naltrexone for targeted subpopulations

Visit CHCS.org to…

- **Download** practical resources to improve the quality and cost-effectiveness of Medicaid services
- **Subscribe** to CHCS e-mail, blog and social media updates to learn about new programs and resources
- **Learn** about cutting-edge efforts to improve care for Medicaid's highest-need, highest-cost beneficiaries



The heart and science of medicine.

UVMHealth.org/CVMC

Screening, Brief Intervention, and Referral to Treatment in the Medical Home

Ginger Cloud, Screening in the Medical Home Project Manager, Central Vermont Medical Center (CVMC)

September 14, 2016

THE University of Vermont HEALTH NETWORK

Central Vermont Medical Center

- Over the past three years Central Vermont Medical Center has been awarded two SBIRT grants. Currently the SBIRT model is integrated into six medical homes, the emergency department, the women's health clinic, and in the inpatient hospitalist service.
- The ability to screen and intervene through these multiple points of entry have allowed the CVMC SBIRT project a unique opportunity to identify service gaps, increase patient care coordination, and provide many of central Vermont's residents with quality substance abuse interventions and care.

Reducing Patient Barriers

- Inherent in the medical home SBIRT project is tobacco treatment, providing patients with access to individual counseling and free nicotine replacement therapy.
- Through the SIM grant we have been able to provide treatment for free, at the patient's medical home, and with the ability to schedule an appointment immediately. These qualities decrease the patient costs (financial, time, and burden of external referral) traditionally associated with seeking treatment.
- Our program has incorporated Feedback Informed Treatment (FIT) tools measuring patient's level of functioning in important life areas and the patient's perceived therapeutic alliance at each session. Using FIT has been shown to improve the effectiveness of psychotherapy.

Identifying System Barriers

- Internal system barriers - medical culture dynamics
  - Increased pressure to screen and intervene for numerous conditions during 15-20 minute routine visit.
  - Varied documentation standards, EMR complications, and complex coding structures
  - Medical staff (secretary, nurse, provider) bias toward substance abuse patient population
  - High levels of provider burnout and retirement – impacting integration/incorporation of new skills/increased workload
  - Constant cycling of grants, initiatives and short funded programs
  - Shortage of quality trained substance abuse counselors

External Barriers

- A struggling system of care for people with substance abuse issues
  - Lack of local detox, residential, and intensive outpatient services
  - Substance abuse counselors are overburdened (often responsible for providing counseling, case management, care coordination, insurance authorizations and course of treatment for large number of patients) and underpaid – contributing to high turnover and inconsistent care
  - Short term (detox 5 days, residential 1-3 weeks, intensive outpatient 8-16 weeks) treatment split between multiple settings often with gaps in service and inconsistent care coordination
  - Two way releases, complex patient issues (lack of phone, housing, transportation, funding to engage in tx), lack of communication identifying solutions to problems between organizations providing care

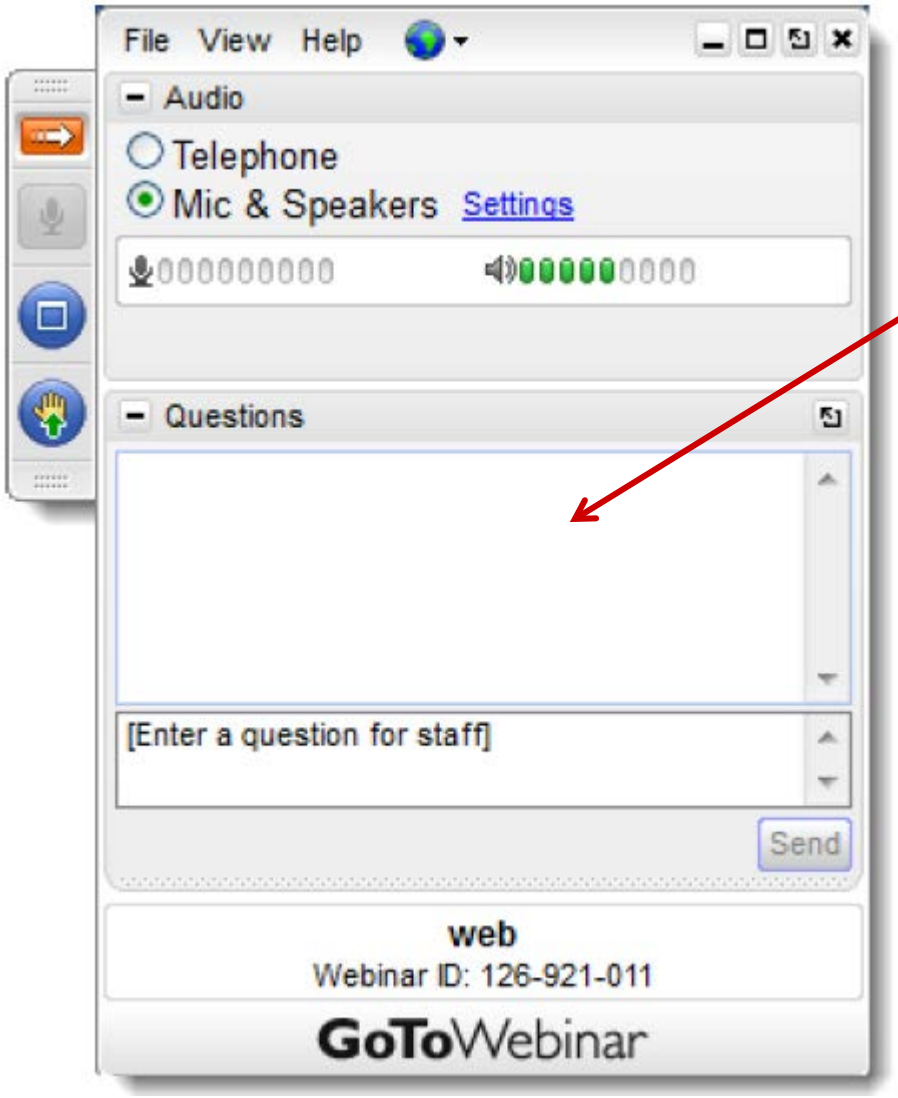
Reducing Barriers

- The CVMC SBIRT project has all the screening tools and interventions set up as templates in our EMR.
- Clinicians are available to offer brief interventions when not engaged in a patient therapy visit.
- Incorporating mental health/substance abuse clinicians into the practice flow gives an opportunity for conversations and coordinated treatment plans with medical staff. This appears to support the decrease in misperceptions and stigma associated with patients seeking mental health and substance abuse treatment.
- Our work has brought additional attention to the shortage of substance abuse therapist and the need for greater treatment options for patients looking to make change in their lives.
- A regional substance abuse committee consisting of CVMC care providers, statewide substance abuse treatment provider and community resources have been meeting monthly to discuss service barriers and cultivate solutions.

Highlights – Advancing Care

- At CVMC over past three years of SBIRT implementation nearly 24,000 patients have been screened for alcohol and drug use.
  - More than 1,600 patients have received a brief intervention regarding their use.
  - Approximately 680 patients have engaged in brief treatment with one of our SBIRT clinicians.
  - 150 of those patients engaged in tobacco treatment counseling.
  - There are currently 120 patients currently engage in brief treatment or follow up from a referral for either tobacco, alcohol or drug counseling throughout CVMC.
  - Approximately 49% of the medical home patients seeking SBIRT services have commercial insurance, 33% have Medicaid, 16% have Medicare, and 2% self pay.

Questions?



- Enter questions in Questions pane of GoToWebinar control panel.

Vermont Health Care Innovation Project

Thank you!