Behavioral Health Partnership Oversight Council

Adult Quality, Access & Policy Committee

Legislative Office Building Room 3000, Hartford, CT 06106

(860) 240-0346 Info Line (860) 240-8329 FAX (860) 240-5306

www.cga.ct.gov/ph/BHPOC

Co-Chairs: Howard Drescher, Heather Gates, Alicia Woodsby

Meeting Summary
Tuesday April 3, 2012
2:30 – 4:30 p.m.
Value Options
500 Enterprise Drive, 4th Floor Huntington Conference Room
Rocky Hill, CT

Next Meeting: Tuesday May 1, 2012 @ 2:30 PM at Value Options, Rocky Hill

Attendees: Co-Chair Howard Drescher, Co-Chair Heather Gates, Co-Chair Alicia Woodsby, Teodoro Anderson-Diaz, Jill Benson, Kim Beauregard, Alyse Chin, Elizabeth Collins, Terri DiPietro, Erin Donahue, Rauld Fleming, Sara Frankel, Bill Halsey, Colleen Harrington, Charles Herrick, Colleen Kearney, Steven Moore, Margaret O'Hagan-Lynch, Ann Phelan, Kelly Phenix, James Pisciotta, Debra Polun, Javier Salabarria, Barry Simon, Debra Struzinski, Hillary Teed, Laurie Van Der Heide, Kathy Ulm

Opening Remarks and Introductions

Co-Chair Heather Gates commenced the meeting by welcoming everyone and introductions were made.

Value Options McKesson Update Presentation

Dr. Steve Moore and Dr. Laurie Van Der Heide from ValueOption BHP presented related data for the Wellness Care Coordination Program, a pilot project which started on September 1, 2011. The source of this information was gathered by McKesson Member Program Data Set.

There are **Five (5) Member Identification** classifications:

1. Members with Behavioral Health (Mental Health or Substance Abuse) as primary driver in claims data who also have physical health conditions
2. Members with at least one "tier one" or "tier two" physical health condition AND one or more inpatient or ED psychiatric events in past 12 months
3. Gaps in treatment will contribute to the overall risk rating
4. Overall risk ratings are 1 low, 2 medium, 3 High and
5. Belong to a prioritized eligibility group
   - 70% HUSKY C
   - 20% HUSKY D
   - 5% HUSKY B & HUSKY A
   - 5% HUSKY A & Charter Oak

Tier one physical conditions include: Heart failure, COPD, Diabetes, Asthma, and Coronary Heart Disease
Tier two physical conditions include: Stroke, TIA, Chronic Kidney Disease, Cystic Fibrosis, Hepatitis B and C, Inflammatory Bowel Disease, Peripheral Vascular Disease, Sickle Cell, Migraine, Back Pain, High Cholesterol, Hypertension, Lupus, Rheumatoid Arthritis, Seizure d/o, Gastroesophageal Reflux Disease, Multiple Sclerosis, and Peptic Ulcer Disease

Definitions
Enrolled Membership is a count of Actively Engaged Members and Passive Participants

Actively engaged member is a member who has been contacted and agreed to participate. They receive proactive outbound calls on a schedule that varies by severity level.

Passive engagement is a member participating in "on demand" services. No proactive outbound calls are scheduled, though members may call in and access nurse services.

These are members who have been actively enrolled at one time but are no longer reachable or only wish to receive mailings.

Demographic Information of Enrolled Members

- 287 total enrolled (300 maximum)
  - 227 (79%) Actively Engaged
  - 60 (21%) Passive Participants
- 24 of the 287 (8.4%) members have a primary, secondary or tertiary S. A. condition (22 have active enrollment)
- 54.7 years is the average age of all enrolled members
- 75% of all enrolled members are Caucasian, 24% are African-American, and 1% are Asian
- 64% of all enrolled members are female

- Cities with 10 or more enrolled members include Bridgeport (15), Hartford (30), Meriden (15), New Britain (13), New Haven 924), New London (10), Waterbury (15). These members represent 42.5% of all members enrolled
- All enrolled members have been enrolled in the program an average of 91.5 days
- The average risk rating for all enrolled members is 2.5 (Risk scale is 1-3, Low-Moderate-High)

Bill Halsey (DSS) asked if Spanish speaking nurses were available. Dr. Moore replied no but one nurse does speak some Spanish. Co-Chair Alicia Woodsby asked how long is the pilot program. Dr. Moore said it was for one year and that it will end on August 31, 2012.

Care Management Contacts

- **Unscheduled** contact attempts are unplanned call that can either be outbound or inbound. Unscheduled calls consist of enrollment calls
- **Scheduled** contact attempts are planned call to a member based on a previously set appointment time. Scheduled calls consist of *Initial Assessment, Monitoring, 6-Month review, and Annual Reviews*
- **Monitoring calls** are scheduled cal made by the nurse. The primary objective of these calls is to educate the member and address concerns on the member care plan. This would also be the definition of a coaching call
- **Completed calls** are calls during which all objectives of a given call type were achieved with the members. This advances the intervention plan to the next recommended call type
- **Unscheduled calls** in December decreased as **monitoring calls** increased, i.e., the majority of cases moved from enrollment phase to monitoring phase
- The number of **completed** monitoring calls have increased more than 15x when comparing September to December

Program Referrals to Date (as of 12/31/11)
Resource referrals are directed towards linking members and caregivers to community resources. Interventions are used to facilitate skill building, provide education and valuable resources to members.

Resource Referrals	**# Referrals**
Care Support Services (incl. companion, homecare, disability services)	6

Durable Medical Equipment	6
Disease specific (incl. aging, Cancer, MH, Diabetes, Preventative Health…)	17
Financial (incl. food, housing, other)	20
General Health (incl. Tobacco, Vision, Nutrition, Dental and other)	32
Total Resource Referrals	81

Post Assessment Letters
Communications are sent to a member and his or her provider at various points during the program. These communications may be used to summarize information reviewed on a call with (our) nurses, provide member health status updates to providers, or to engage a member as significant program milestones are achieved.
As of 12/31/11:

- 211 post-assessment letters have been mailed to enrollees
- 58 post-assessment letters have been mailed to providers

Outcomes

- An average Length of Stay in this program model is approximately 6 months
- Outcomes are assessed at program "graduation" (including if member withdraws him/herself from the program)
- First run of outcome data by McKesson is expected in March/April 2012, however, these numbers are expected to be extremely low as enrollment has been gradually ramping up over the months
- Outcome data will be more meaningful once the graduation "N" is more significant
- VO will run authorization and claims based outcome reports in the future to look at utilization patterns pre-and post- program involvement


Microsoft PowerPoint Presentation

Bill Halsey asked if any referrals were made by providers. Dr. Moore replied that he was not aware of any. Bill then asked about the coordination of care. Co-Chair Howard Drescher asked what has VO learned so far from the pilot program. Kelly Phenix said that when it come time to re-determine her eligibility for DSS benefits, the Department is not up-to-date on their information even though she is very diligent to provide her information to DSS every it comes up for review and renewal. Bill replied that the system that DSS has is archaic.

Adult Population Utilization Data

Dr. Laurie Van Der Heide of VO gave the Power Point Presentation. She explained the following: Membership is Adult (19+)

Microsoft PowerPoint Presentation

Adult eligibility Categories- *How they tie to HUSKY designations*

- HUSKY A: Includes Family Single and Family Dual
- HUSKY B: Only HUSKY B
- HUSKY C: Aged, Blind and Disabled Single and Dual Long Term Care Single and Dual
- HUSKY D: Medicaid Low Income Adults (MLIA)
    - The total Adult Membership from Q2 ’11 through Q4 ’11 was 416,822
    - Membership was stable within the benefits groups

Inpatient Admits/1000 adult (19+)

- Admits/1000 rates were highly stable across benefit groups throughout the three quarters reviewed
- Three (3) of the four (4) groups with the highest volume of admissions decreased from Q2 ’11 through Q4 ‘11
    - ABD Single 7.37% decrease
    - ABD Dual 14.7% decrease
    - MLIA 6.9% decrease

Inpatient ALOS (Average Length of Stay) Adult (19+)

- The ALOS for all benefit groups increased across the three quarters, despite efforts to mange utilization for LOC
- The highest ALOS was found in the LTC Single (17.46 days) and LTC Dual (12.59 days) benefit groups.

Inpatient Days/1000 Adult (19+)

- Results on this measure were consistent with expectations for the benefit groups
- The rate of Days/1000 for ABD Single & MLIA members remained consistent from Q2 ’11 through Q4 ‘11
- Members in the LTC Single group appear to have a higher Days/1000 due to extended length of stay which peaked in Q2 ’11 (68.49 Days)

Inpatient Detox Hospital Admits/1000 Adult (19+)

- Admits/1000 members remained relatively stable from Q2 ’11 through Q4 ‘11
- Both MLIA and ABD Single groups, decreased over 25% from Q@ ’11 to Q4 ‘11
- The other benefit groups had low rates of admissions and/or very small numbers of admissions.

Inpatient Detox Hospital ALOS (Adult (19+)

- The ALOS for this level of care was essentially unchanged across the three quarters
- This result likely relates to providers use of pre-determined protocols for detox, a factor that is difficult to address via utilization management
- Utilization management efforts for the coming year may focus on addressing the initial treatment plan and emphasizing individualized treatment, rather than pre-designed protocols

Inpatient Detox Hospital Days/1000 Adult (19+)

- Hospital Day/1000 decreased overall from Q2 ’11 through Q4 ‘11
- MLIA and ABD Single recorded the highest average number of inpatient days
  - Suggesting that they also had the most complicated clinical presentations, warranting longer hospital stays.
- No other benefit groups reached even one day per 1000 members.

Inpatient Detox Free Standing Facility Admits/1000 Adult (19+)

- These results show that the Admits/1000 are from 2 to 25 times higher for freestanding programs than in hospitals, depending on the benefit group
- MLIA and ABD Single were the two benefits groups with the highest utilization
- Although these groups represented the highest utilization, the volume of Admits/1000 decreased by 12.6% (MLIA) and 23.9% (ABD single) respectively

Inpatient Detox Free Standing Facility ALOS Adult (19+)

- ALOS in freestanding detox program was highly consistent across all benefits groups, and as with hospital-based programs, may reflect utilization of pre-determined treatment protocols by providers

Inpatient Detox Free Standing Facility Days/1000 Adult (19+)

- MLIA members averaged 8.4% fewer days/1000 in Quarter 4 than in Quarter 2
- The ABD Single group averaged 24.1% fewer days

Partial Hospital Program Admits/1000 Adult (19+)

- Results for 2011 reflect very little change across quarters for any benefit group
  - The greatest changes occurred in benefit groups with low levels of utilization
  - MLIA rate of Admits/1000 was almost double that of members in the ABD benefit group

Intensive Outpatient Admits/1000 Adult (19+)

- Due to the initial registration of members for the April 1 start date, Q2 ’11 numbers are inflated. Q3 & Q4 ’11 more accurately represent this LOC
  - The MLIA group had the highest utilization
  - From Q3 ’11 to Q4 ’11 there was a 7.5% decrease
  - That represents nearly 200 fewer admissions in Q4 vs. Q3

Home Health (Total) Admits/1000 Adult (19+)

- The ABD population accounts for the significant majority of admissions
- Family Dual members had the third highest rate for Admits/1000
- Admits/1000 decreased during the fourth quarter
  - By Quarter 4, more of the authorization volume was focused on concurrent reviews rather than new admissions

Ambulatory Detox Admits/1000 Adult (19+)

The MLIA population represented the largest number of admissions and the highest rate of admissions

- Over five times as high as the next highest group, Family Single

The ABD benefit group had very few admissions for Ambulatory Detox

- The ABD group tends to have multiple and complex needs that are not well served in this type of ambulatory care

GeoAccess Report Update

Dr. Laurie Van Der Heide also gave this report which is how many members have access to a provider in a certain geographic area. The average provider reported they treated four (4) patients within these geographic areas for the 2010 calendar year. Member access by region will be studied and analyzed and then VO will report back at a later date.

Grant and Health and Housing Integration Update

Co-Chair Alicia Woodsby gave a brief overview of the Social Innovation Fund (SIF) grant that Connecticut received from the Corporation from Supportive Housing (CSH) to implement Connecticut Integrated Healthcare and Housing Neighborhoods, which will build upon Connecticut’s success with supportive

housing as a statewide approach to ending chronic homelessness, and will create a health home outreach model linking primary care, behavioral health care and supportive housing. Individuals identified through a data match between the State's Medicaid administrative data and Homeless Management Information Systems will be provided with supportive housing linked to health services through a coordinated delivery system involving Federally Qualified Health Centers, local mental health agencies and other providers. Care coordination will be achieved through newly created Patient Navigator positions serving as boundary spanners across housing and health providers.

Alicia also reported that the committee will meet with DSS and DMHAS for a report on Health Homes for the next meeting. They are waiting for the agencies to complete their data analysis to determine what the target population should be and whether children/adolescents should be included in the model development. They are also waiting to meet with the agencies to establish the smaller stakeholder workgroup that will work directly with the agencies to design the plan and report back to the Committee.

Provider Analysis and Reporting Program (PARS)

Dr. Laurie Van Der Heide gave the report that deals with the former HUSKY population which is now combined with the Adult population and is concerned with different levels of care, utilization of care, and comparisons. One aspect of this program is to find out what is impacting the differences between hospitals and to find out what is working for hospitals and to find out why there are differences between hospitals. This is tracked by profiling and sharing information. The set goals are to know how to change things, i.e., admissions, lengths of stay, etc. Performance initiatives attach many incentives for efficiency, i.e., quality measures, family engagements, if communication plans were implemented, number of adult patients in hospitals, utilization and readmission rates. How often is a follow- up visit after seven (7) days discharge? Questions like: If Local Mental Health Agencies have strong relationships with hospitals and what type of collaboration do they offer each other. Laurie will give the committee ongoing feedback at a later meeting.

New Business and Announcements

Hearing no new policy items, Co-Chair Howard Drescher adjourned the meeting at 4:25 PM.

Next Meeting: Tuesday May 1, 2012 @ 2:30 PM at Value Options, Rocky Hill