Behavioral Health Partnership Oversight Council

Adult Quality, Access & Policy Committee

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

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

Next Meeting: Tuesday, August 7, 2012 @ 2:30 PM at Value Options, Rocky Hill

Attendees: Co-Chair Heather Gates, Co-Chair Alicia Woodsby, Sheila Amdur, Teodoro Anderson-Diaz, Jill Benson, Kim Beauregard, Alyse Chin, Elizabeth Collins, Susan Coogan, Marilyn Cormack, Lawrence Daskal, Chantal DeArmitt, Robert Draka, Ronald Fleming, Sara Frankel, Bill Halsey, Colleen Harrington, Kim Haugabook, Robin Hawley, Kate Maldonado, Jennifer Hutchinson, Steven Moore, James Pisciotta, Nic Scobelli, Henrietta Small, Debra Struzinski, Hillary Teed, Kathy Ulm, Laurie Van Der Heide, and Rose Yu-Chin

Opening Remarks and Introductions

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

Presentation on the Health and Housing Integration Pilot from Theory to Practice by Co-Chair Alicia Woodsby, Deputy Executive Director, Partnership for Stong Communities

Adobe Acrobat Document

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What We Know So Far…

- A significant portion of people who are chronically homeless with chronic health challenges are also Medicaid's high-need, high-cost population
- Supportive housing has evidence of improving health and reducing Medicaid costs
- Supportive housing's services match services the Medicaid benefits have covered

CT Preliminary Medicaid/HMIS Data Match

- CT cohort of adult Medicaid beneficiaries who are homeless, high-cost utilizers of health services
- Average annual Medicaid payments of $67,992 per person
- **9 times more expensive than the average Medicaid beneficiary**

Top 3 most costly service categories:

- Acute Inpatient
- Emergency Department Visits
- Medications

The top 10% accounted for more than 44% of Medicaid spending of those who matched

Average Annual Medicaid Payments per Enrollee by Cohort

o 10% High Utilizers	$67,987
o 20% High Utilizers	$47,796
o Aged	$22,074
o Disabled	$24,628
o Adults	$2,234
o Total	$7,437

SH's Impact on Use and Health Costs

- Research shows the Supportive Housing is able to reduce Medicaid costs by 41% for this population
- Review of the literature for service model:
  - 40% reductions in Acute Inpatient
  - 60% reductions in Inpatient Behavioral Health
  - 50% reductions in emergency Department Visits

Impact on Cost Per Beneficiary

	Top 10%	**Top 20%**
Per person Medicaid costs for homeless, High-cost utilzers	$67,987	$47,796
Potential % Medicaid cost offsets from Supportive housing	41%	41%
Potential per person Medicaid cost		

Reductions from supportive housing	$27,875	$19,596
Annual average per person cost Of supportive housing	$19,500	$19,500
Potential annual per person savings	$8,374.67	$96.36
Potential annual savings for 200 high Utilizers	**$1,674,934**	**$19,272**
% reductions needed to break-even with cost of supportive housing	*28.7%*	*40.8%*

Overview

- **CIHHN is a**
  - Targeted
  - Data driven
  - Assertive outreach
  - Care coordination model
  - Utilizing local multidisciplinary teams to connect health care and housing
- Establishes local partnerships between FQHCs, LMHAs, supportive housing and shelter providers, and the state's Medicaid Administrative services organizations

Health team staff includes:

- Nurse care managers
- Patient navigators (a new healthcare workforce role)
- Homeless outreach
- Benefits specialists
- Systems coordination

Care coordination will be achieved through newly created <u>Patient Navigator</u> positions serving as boundary spanners across housing and health providers.

Patient Navigation
Leveling the Playing Field

Fragmented Healthcare System

- Remove barriers to care
- Improve the coordination of care
- Bridge access to community supports, appropriate treatment and services
- Provide information and practical assistance
- Give emotional support
- Facilitate decision making

- Create linkages to resources
- Identify gaps in transitions in a care continuum, delays in care continuum, barriers in or out of the system

- Assertive outreach, engagement and individualized support necessary to effectively serve those with complex health care needs who are experiencing homeless/housing instability and extreme poverty.
- Demonstrate the role of permanent supportive housing and housing stability as critical healthcare interventions.

A pilot to test the model is currently being funded by CSH social Innovation Fund:

- 160 tenants
- Targeted- data match between the state's Medicaid data and Homeless Management Information Systems
- Individuals who are currently homeless
- Multiple state and local partnerships

Goals

- Improve Health Outcomes
- Reduce Costs
- Create Sustainability

Goals: Improve Health Outcomes

- Reduce inpatient admits/ED visits
- Housing retention and stability
- Health coverage and benefits
- Assertive engagement by a health professional around receiving health/behavioral health services
- Connection to primary care
- Increase participation in routine recommended health maintenance visits and screenings
- Patient satisfaction survey- self report on health and access improvements

Capacity

Target numbers by geographic area:

- New London 10
- New Haven 40
- Hartford 25
- Bridgeport/Stamford 55
- Waterbury 20

Local Partners

- Permanent Supportive Housing Provider(s)
- Local mental Health Authority
- Federally Qualified Health Center

- Intensive Care Management (Medicaid ASOs)
- "Regional Coordinating Agency" operates and serves as the fiduciary
- Other community members may be invited to participate, as appropriate

Memorandum of Agreements (MOUs) will be signed to clarify roles and responsibilities

Data Match

- **Statewide Data Match-** Data from the state's Homeless Information Management system (HMIS) is matched with CT Medicaid cost and claims data to identify a cohort of adults who are the most high cost utilizers of Medicaid services.

o **400 people; 100 removed for control group, lists broken out by geographic areas**

Data Match Implemented

- List of individuals flagged as meeting the "high cost utilizer" criteria are returned to the HMIS agency
- **Release of Information-** lists created for local teams that breakout whether the Release of Information (ROI) was signed or not
- Signed go to the Patient Navigator; not signed go to the shelters
- Shelters work to get the ROI from client and the contact Patient Navigators (Patient Navigators check in regularly with shelters)
- There are 12 shelters involved with project geographical areas

The Process

- Patient Navigator works with an experienced homeless outreach worker to conduct outreach and identify individuals on the list
- Assertive outreach- multiple attempts to engage clients and initiate (Streets, Soup Kitchens, Courts, Hospitals, ERs, Jails/Prison Staff, Ambulance)
- An Intake will be completed by the Patient Navigator
- Housing placement is initiated immediately
- An assessment is conducted by the Intensive Care Manager (ICM)
- A PAP Voucher application is completed and sent to D'Amelia and Associates
- Temporary Housing Strategies are employed by Supportive Housing Providers and the Team, including DMHAS Housing Assistance Fund (HAF)
- The client formulates a Wellness Plan with the ICM and Patient Navigator with input from the Team
- On-going Patient Navigation and Housing Stability services are provided
- Documentation, Documentation, Documentation

Reduce Costs

- Reduction in preventable hospital admissions

- Reduction in hospital discharge planning
- Return to productive community activity, including employment
- Successful self-management of personal health conditions

Sustainability

- Integrate the core Health/Housing staff as part of a Health Home team
- Coordinate with the state's HCBS waiver for people with SMI at risk of or in nursing homes to provide services to most complex and/or seriously ill participants
- Explore the expansion of eligibility and service package for the state's HCBS waiver or a 1915(i) state plan option as we document needs of population and outcomes of the model
- Document the extent of savings of Medicaid expenditures and design a process for state set asides for supportive housing
- Strong cost effectiveness justification

Final Outcomes

- Individuals are housed and connected to services
- The model is tested, refined and brought to scale

Discussion

Housing first is a core strategy of this program, which engages and works with the client to secure permanent, affordable housing and offers voluntary services ***without*** the requirement that they follow program rules (i.e. maintaining sobriety) or agree to accept certain services/supports. The housing will be scattered site, which was made available by the Administration through rental subsidies. The program is exploring potential sustainability under Medicaid.

Presentation on the On-Going Work on the Health Neighborhoods and Health Home by Jennifer Hutchinson and Colleen Harrington of DMHAS. A Health Home is a smaller version of a Health neighborhood but is for individuals who are single eligible as well dual eligible. This presentation is an overview of what is currently going on in some parts of the country.

Microsoft PowerPoint Presentation

Health Homes: A State Comparison

Federal Criteria for HH Recipient Inclusion

- Has 2 chronic health conditions or has 1 chronic health condition and is at risk for another
- Commonly included chronic health conditions:

- Mental Health, Asthma, Diabetes, Cardio-Vascular Disease, BMI>25, Substance Abuse

Key Design Features

- Provider Credentials/Qualifications
- Payment Methodology
- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual/family Support Services
- Quality Measures

States working on SPA for Implementing Health Homes

- Arizona
- California
- Illinois
- Massachusetts
- Michigan
- Washington
- West Virginia

States with State Plan Amendment (SPA) Approval by CMS

- Iowa
- Missouri*
- New York
- North Carolina
- Oregon
- Rhode Island*

  - *Both Missouri and Rhode Island are specifically Behavioral Health Homes

HH Enrollment

Opt In	Opt Out
Iowa	Missouri
North Carolina	New York
	Oregon
	Rhode Island

Provider Credentials/Qualifications

- NCQA, Joint Commission or other national PCMH accreditation
- Enhanced patient access
  - Including the development of alternatives to face – to – face visits, such as telephone or email. 24 hours per day 7 days per week
- Must develop contract or MOU with:

- Regional hospitals or systems for transitional care planning
- Specialists for care not available on site

- Conduct wellness interventions based on level of risk
- Develop qualitative improvement plans
- Either directly provide, or subcontract for the provision of, HH services
  - HH provider remains responsible for all program requirements, **including services performed by subcontractors**

Payment Methodology Examples

- **Iowa**
  - Patient management PMPM
  - Performance payment based on quality beginning in 2013

- **North Carolina**
  - Tiered PMPM reimbursement based on ABD (aged, blind, disabled) or non-ABD status
  - Plus add-on payments that support specialized care management for individuals with special health needs

- **Missouri**
  - Clinical care PMPM payment in addition to existing FFS or managed care organization (MCO) payments for direct services
  - Administrative payment is included in the rate to support transforming traditional CMHCs into health homes
  - Minimum health home service required for PMPM payment is documentation by a health home director or nurse care manager on a monthly health home activity report that the enrolled individual has received care management monitoring for treatment gaps or another health home service

Care Management

- Comprehensive care management services, conducted by the health home director with the participation of other team members, include:
  - Identification of high –risk individuals and use of client information to determine level of participation in care management services
  - Assessment of preliminary service needs
  - Treatment plan development, which will include client goals, preferences and optimal clinical outcomes
  - Assignment of health teams roles and responsibilities
  - Development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions
  - Monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines and
  - Development and dissemination of records that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs

Care Coordination

- Care coordination is the implementation of the individualized treatment plan (with active client involvement) through appropriate linkages, referrals, coordination, and follow-up to needed service and supports

- The primary responsibility of the care manager is to ensure implementation of the treatment plan for achievement of clinical outcomes consistent with the needs and preferences of the client
- Specific activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes, and communicating with other providers and clients/family members
- Care managers with assistance from health home administrative support staff will be responsible for conducting care coordination activities across the health team

Health Promotion

- Promotes the use of evidence based, culturally sensitive wellness and prevention by linking the enrollee with resources for smoking cessation, diabetes, asthma, self-help resources and other services based on individual needs and preferences
- Encourages and supports healthy ideas and concepts to motivate individuals to adopt healthy behaviors

Comprehensive Transitional Care

- Reduce hospital admissions
- Ease the transition to long-term services and supports
- Interrupt patterns of frequent hospital emergency department use
- Ensure proper and timely follow up care post discharge
- Ensure notification and coordinated, safe transitions

Individual/Family Support Services

- Providing assistance in accessing needed self-help and peer support services
- Advocacy for individuals and families
- Assisting individuals identify and develop social support networks
- Assistance with medication and treatment management and adherence
- Identifying resources that will help individuals and their families reduce barriers to their highest level of health and success

Quality Measures Examples

- Documentation of physical and behavioral health needs
- Follow up visit post discharge/contact by hospital liaison post discharge
- Decrease ED visits (including for mental health condition)
- Satisfaction with services; accessibility of care;
- Prevention, such as: pap test, mammogram, colonoscopy, depression screening and follow up
- Initiation of Alcohol or Other Drug (AOD) treatment and encouragement of AOD treatment for adults with new episode of AOD dependence
- Diabetes under control
- Appropriately prescribed asthma medication
- Hypertension under control
- Lipid levels under control

- Adherence to asthma/COPD medication
- Adherence to CVD/anti-hypertension medication
- Use of statin medication for history of CAD
- Appropriate ambulatory care prevents/reduces admissions/readmissions

Next Steps

- Behavioral Health Home Models
- Convene a BHH work group
- Identify potential model design options
- Convene focus Groups
- Health Policy Matters

Discussion

This program will bring homelessness to the forefront as a healthcare issue. It is also about management versus long term coordination and about the macro and micro. Case managers will become the care coordinators. Co-Chair Heather Gates and Jennifer Hutchinson asked committee members to volunteer to form a small workgroup to assist in the design of the Health Home for adults only and to answer and identify key features of HHs and to define them so that they will be workable. This group will be convened before the next meeting of the Adult Quality, Access & Policy meeting on August 7, 2012. If there are more volunteers than needed, a select representation will be pared to achieve a good balance of providers, consumers and family members. To help make a decision about whether or not you would like to participate, there are some parameters to help with the decision making:

Timeframe – now through March 2013

Number – ten to twelve, not including the co-chairs, DMHAS and DSS staff

Representation – consumer, family member, LMHA both state and private non-profit, home health agency, housing provider, small affiliate of an LMHA, mental health and addiction treatment providers, advocates etc.

Commitment – need to commit to the entire process not just one or two meetings.

Attendance at committee meetings – need to have attended enough committee meetings to be versed in what we are talking about, including the work to date on the Health Neighborhood design.

The first meeting will take place on Wednesday July 25 from 12:30 – 2:30 and will be held at DMHAS's office in Hartford. Heather will let you know the room number.

A schedule of meetings will be worked out at that time.

The Department of Social services will put out an RFP in late August to early October for public comment.

New Business and Announcements

Hearing no new policy items, Co-Chair Heather Gates adjourned the meeting at 3:50 PM.

Next Meeting: Tuesday August 7, 2012 @ 2:30 PM at Value Options, Rocky Hill