Improving Behavioral Health Outcomes for HUSKY Members

The Connecticut Behavioral Health Partnership

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Agenda

- Overview
- Member Engagement
- Provider Access
- Provider Education and Support
- Local Call Center and Contract Standards Supporting Members and Providers
- Utilization and Quality Integration
  - Impact
- Quality Management
  - Provider Tools and Support to Drive Practice Change
- It Starts With the Data: Identifying Members Most at Risk and Designing Programs to Meet Their Needs
- Challenges and Opportunities
- Questions

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Connecticut Behavioral Health Partnership (CT BHP)

A contract structure that is unique in the country, allowing for a multi-agency approach to problem solving and to address seemingly intractable system concerns, resulting in significant positive outcomes. Examples include:

- The Department of Children and Families (DCF), the Department of Mental Health and Addiction Services (DMHAS), and the Department of Social Services (DSS), contracting with Beacon Health Options as the Administrative Services Organization (ASO)
- Behavioral Health Oversight Council and subcommittees created in statute as an advisory body
- True provider partnerships developed over the years
- Alignment of contract and contract incentives designed to increase access and improve member outcomes

Recovery Model

- As CT BHP administrator, Beacon ascribes to a Recovery Model in developing and delivering its programs, services, member engagement, provider relations, and performance goals. These standards are based on the Substance Abuse and Mental Health Services Administration (SAMHSA) Eight Dimensions of Wellness to maintain Recovery over time, as well as other Industry Standards:

  - Engagement-focused
  - Person-centered
  - Trauma-informed
  - Solution-focused
  - Culturally competent
  - Recovery-oriented
  - Relationship-focused
  - Strength-based
  - Whole-person focused
  - Affiliation/community focused

Member Engagement

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Member Engagement

- Beacon, as the ASO, uses Peers with “lived experience” with a mental health and/or substance use disorder or who have cared for a family member who has. Because of this, the Peer can teach, offer support, and help members to work with the health care system. They provide hope that recovery is possible and keep us honest and appropriately focused. The largest Peer department at Beacon is located in the CT BHP
- The Consumer and Family Advocacy Council (CFAC) is a consumer- and family-driven group of over 60 members, tasked with improving communication among statewide providers, individuals, families, and agencies to develop more positive service delivery outcomes. CFAC also develops advocacy and educational programs in the community
- CFAC and the CT BHP co-sponsor the annual consumer-driven iCAN Conference to ensure Connecticut communities are aware of behavioral health programs, services, and resources, and to encourage partnership in system change. 225 attendees in 2017. The fourth conference will take place in September, 2018

Member Engagement (Con.)

- Our on line education and support library, Achieve Solutions, offers members access to numerous articles, tutorials, and other resources
- Beacon, as the CT BHP ASO, is fully engaged in the Zero Suicide initiative on both the national and local basis
- CT BHP continues to offer Community Meetings throughout the state since 2006 on a variety of topics, including Autism Spectrum Disorder, Substance Use Disorder, and Resiliency
- Beacon complies with National Standards for Culturally and Linguistically Appropriate Services (CLAS), intended to advance health equity, and improve quality and cultural competency

Member Engagement

Consumer & Family

Advisory Council

Where Consumers Are True Partners

Beacon Health Options

CONNECTICUT COMMUNITY
CCAR
FOR ADDICTION RECOVERY

iCAN
CONFERENCE
Keys to Success – The Power of Partnership

NAMI Connecticut
National Alliance on Mental Illness

Provider Access

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Behavioral Health Access in Connecticut Medicaid

- A general goal of CT BHP is to expand access to community based outpatient services, and manage access to more restrictive and costly inpatient services.
- **Based on the following considerations, access to Behavioral Health (BH) services in Connecticut is excellent:**
- The US Department of Health and Health Services reports[1] that BH penetration in Medicaid, defined as the **percentage of those in need of BH services <u>that actually use it,</u>** was 32.6% in 2014
- In CT the access rate, defined as **the <u>% of the population of</u> Medicaid members that utilizes any BH service in a year**, was 27% in 2016 (33.3% Adult; 17.5% Youth (excluding ages 0-2)

[1] Behavioral Health Performance Measures. Mancuso, D. DSHS Research and Data Analytics Division, January 14, 2016.

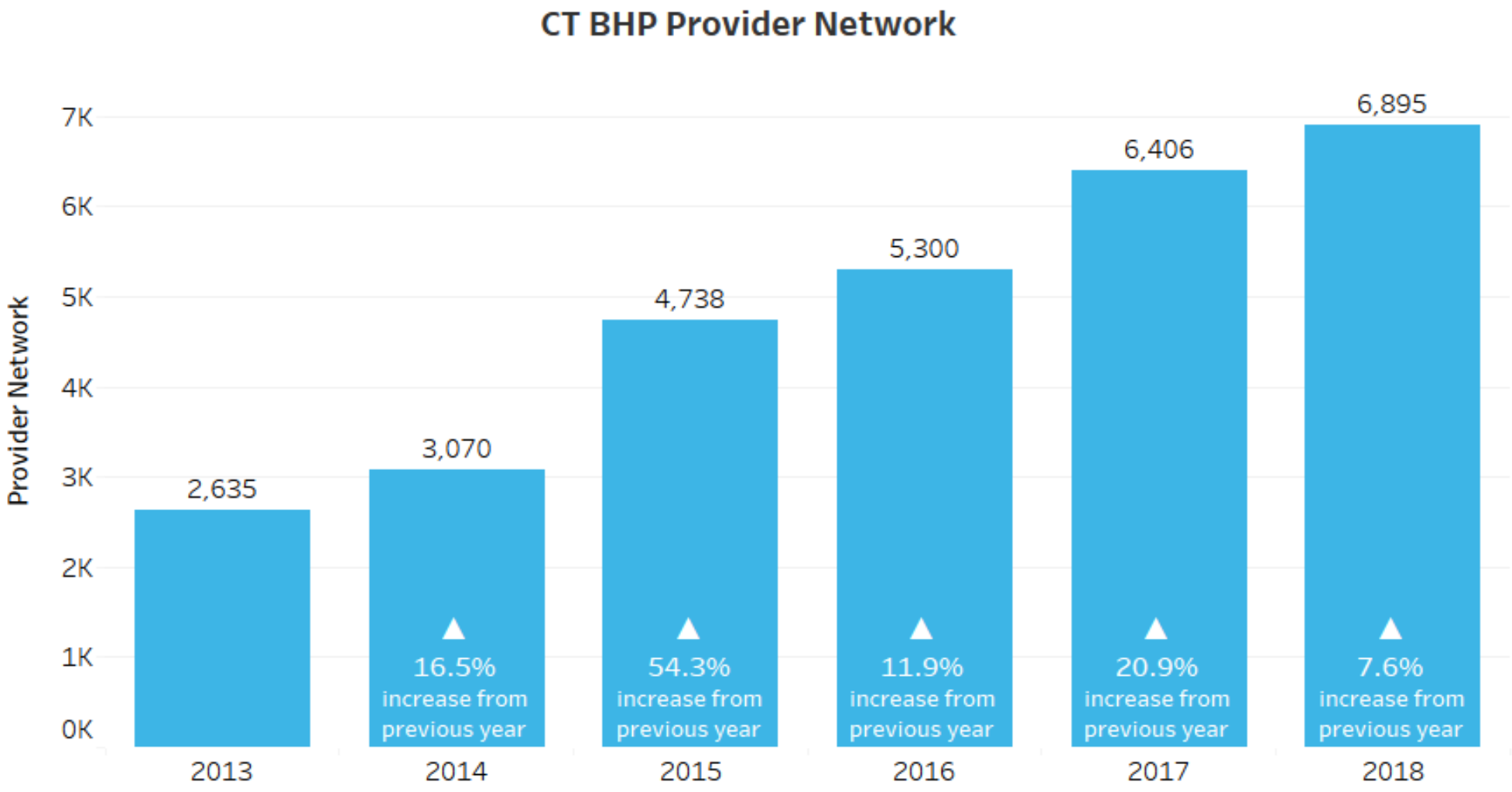
Provider Types and Specialties

- **345+ Facilities / 1150+ Practice Locations**
  - Hospitals
  - Mental Health / Medical Clinics
  - Alcohol & Drug Abuse Centers (Detox, Methadone Maintenance, Outpatient)
  - Methadone Maintenance Clinics
  - Home Health Agencies
  - Adult Group Homes
  - DCF Residential and Congregate Care
  - Psychiatric Residential Treatment Facilities (PRTF)
- **6,800+ Individual Practitioners/Group Practices**
  - Psychiatrists, Psychologists, APRN, LCSW, LMFT, LPC, LADC, BCBA

CT BHP Network Growth

Individual Practitioners/Group Practices/Performing Providers

Growth primarily attributed to addition of ASD Network, Hospital Outpatient Reform - Professional Service/Group Practice enrollment and increase in Individual Practitioners enrolling as LLC Group Practices.



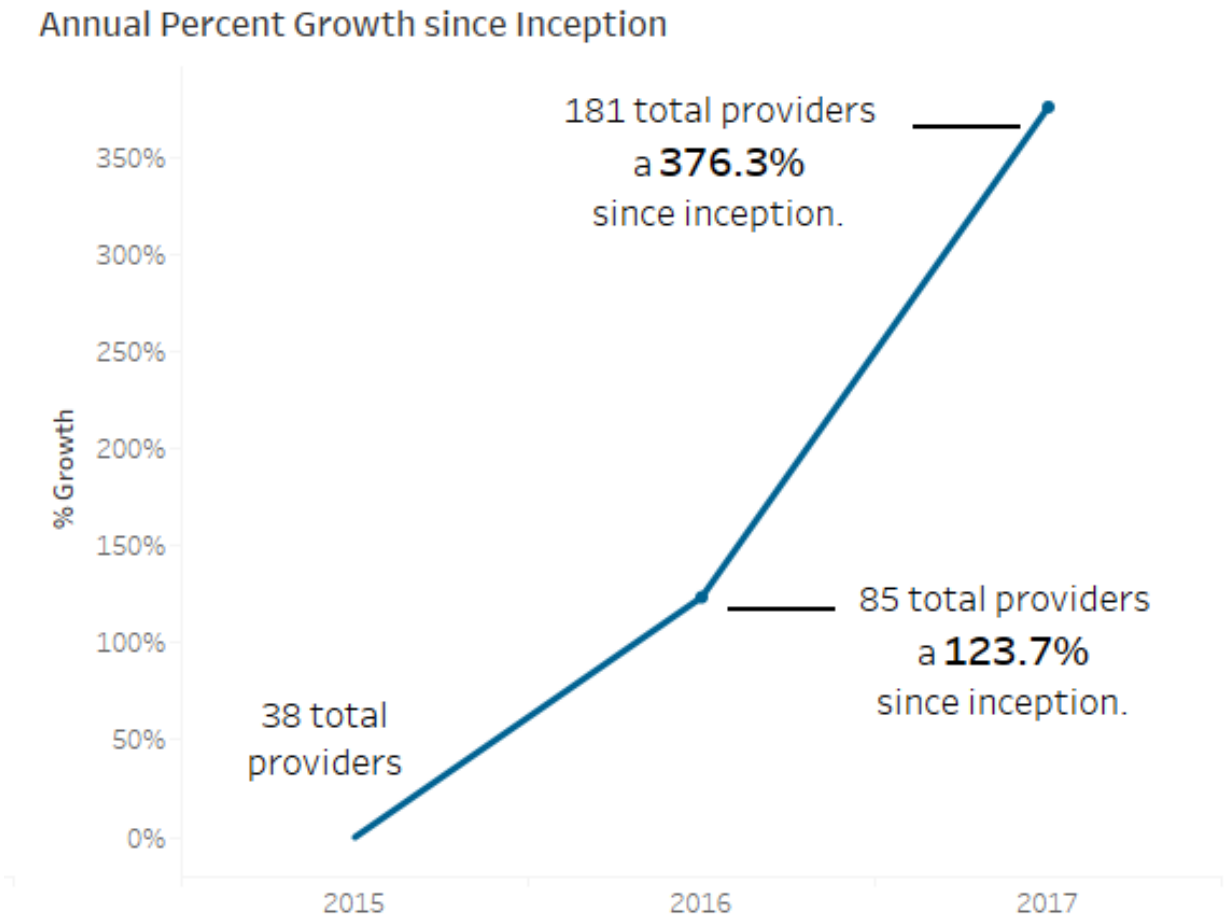
Growth for Behavioral Health Facilities remained unchanged

Provider Enrollment for Autism Spectrum Disorder Services

As of the end of 2017, there were

181

total ASD providers.



Independent Validation of Performance Change and Access Within Connecticut

- In a 2016 study completed by Connecticut Voices for Children, the evaluators found that:
  - "The number and the percentages of children and adults who received behavioral health services were far greater in the study period (2012, 2013) than the baseline period (2004, 2005)."
  - "The increase in utilization was evident in all age, racial/ethnic, primary language, and residential groupings."
- According to a yet-to-be published study by Washington State University, using a national Medicaid data base, Connecticut has seen a higher growth in access to care coordination and Intensive In-home Services compared to other state child mental health systems.[1]

[1] According to a personal communication with Eric Bruns, PhD, on June 29, 2018

Challenges in Access to Care

- Autism Spectrum Disorder (ASD) - Despite significant increases in the ASD provider network, there remains a shortage of qualified providers of treatment services that contribute to delays in accessing care
- Medication-Assisted Treatment (MAT) – MAT is the most efficacious treatment for opioid use disorders, yet it remains underutilized due in part to a lack of qualified providers and regulatory restrictions
- Psychiatric Residential Treatment Facilities (PRTF) – Shortage of beds and long lengths of stay at this level of care results in longer inpatient stays
- Respite and Short-Term Crisis Stabilization – Issues with timely access to crisis stabilization and respite beds impacts the rate and length of children and youth “stuck” in the Emergency Department

Provider Education and Support

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Provider Education and Support

- Weekly updates to CT BHP website (www.ctbhp.com). Includes Provider, Member handbooks, and other materials. Full content review on annual basis
- Access to ECHO® Trainings to support Medication Assisted Treatment (MAT). MAT Provider Locator map.
- Daily telephonic and electronic assistance to provider network
- 525+ trainings, webinars, focus groups and on-site visits with the Connecticut Medical Assistance Program (CMAP) provider network, assisting over 9200+ attendees.
- 5,300+ ProviderConnect user ID's created
- Triannual provider newsletter published
- Qualification process for ASD providers

Local Call Center and Contract Standards Supporting Members and Providers

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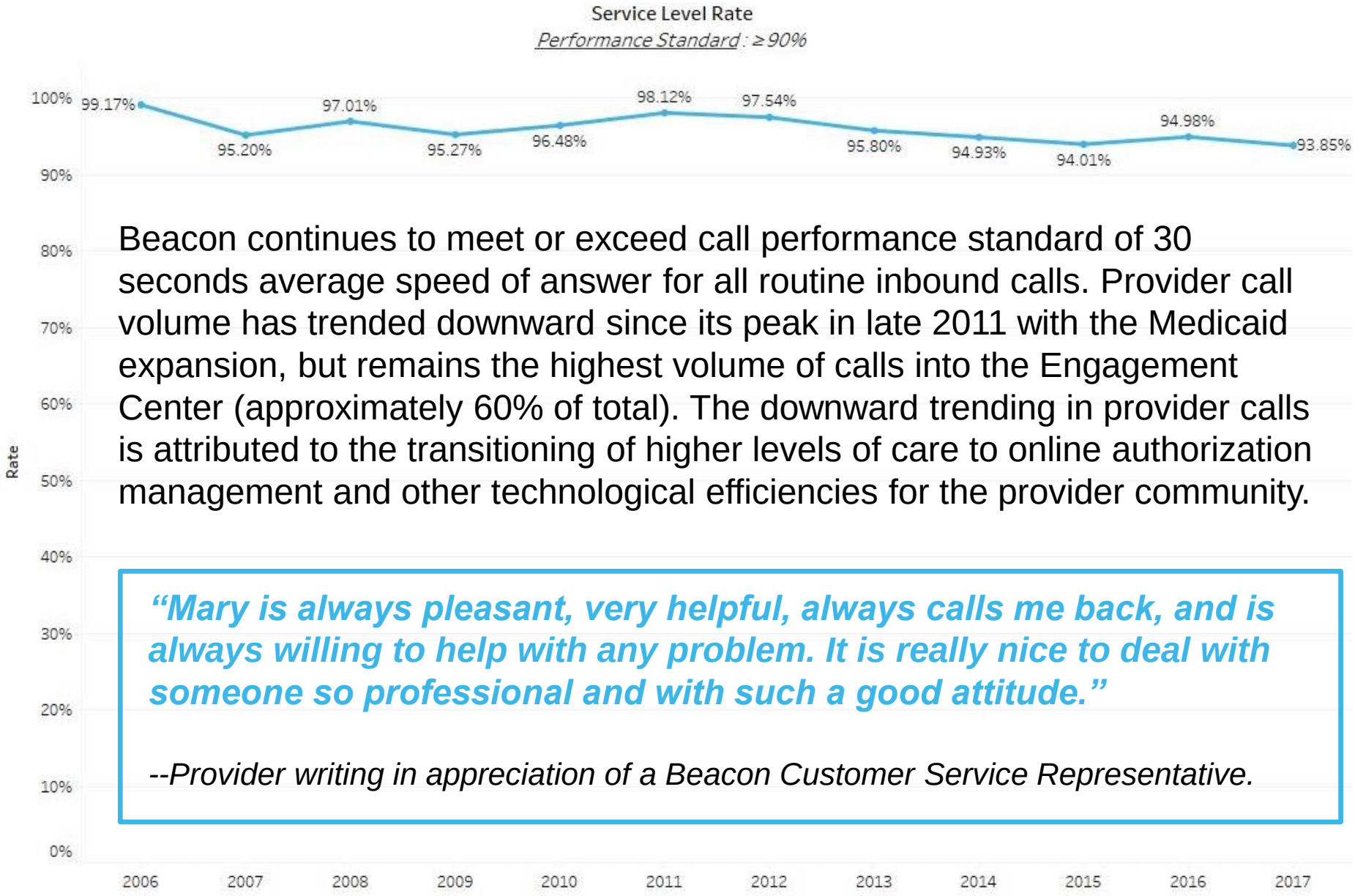
CT BHP Call Management (CY 2006-2017)



Beacon continues to meet or exceed call performance standard of 30 seconds average speed of answer for all routine inbound calls. Provider call volume has trended downward since its peak in late 2011 with the Medicaid expansion, but remains the highest volume of calls into the Engagement Center (approximately 60% of total). The downward trending in provider calls is attributed to the transitioning of higher levels of care to online authorization management and other technological efficiencies for the provider community.

"Mary is always pleasant, very helpful, always calls me back, and is always willing to help with any problem. It is really nice to deal with someone so professional and with such a good attitude."

--Provider writing in appreciation of a Beacon Customer Service Representative.

Administrative Performance - Standards

Standards

- Since Contract Inception (12 years) – 15 Performance Standards
- Covering call management, timeliness of authorization processes, denials, complaints, and appeals, etc.
- Assessed quarterly and reported semi-annually

Performance

- 97.5% compliance with standards since contract inception

Utilization & Quality Integration

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Utilization Management (UM)

- Utilization Management (UM) is the program whereby Beacon, as the Behavioral Health ASO, ensures the right level of care at the right time for the right amount of time
- Through collaboration with the individual served, family, and care team, UM promotes a strengths-based, person-centered approach focused on member success and recovery
- Currently leverages data and technology to ease the administrative burden of the process on the providers (e.g. by-pass and registration)
- >70% of requested authorizations are processed via the web by licensed clinicians, minimizing administrative burden to providers
- Clinicians works in step with Quality Department to utilize data and the analytic program to inform care at the provider and member level
- Level-of-Care Guidelines developed in collaboration with providers and state agencies, and approved by the Behavioral Health Oversight Council

Impact

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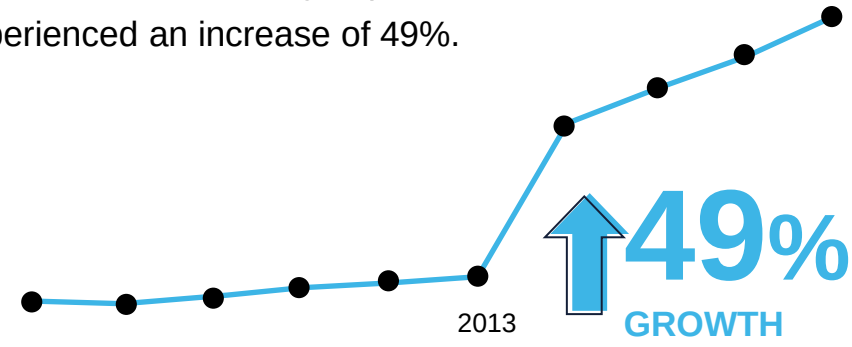
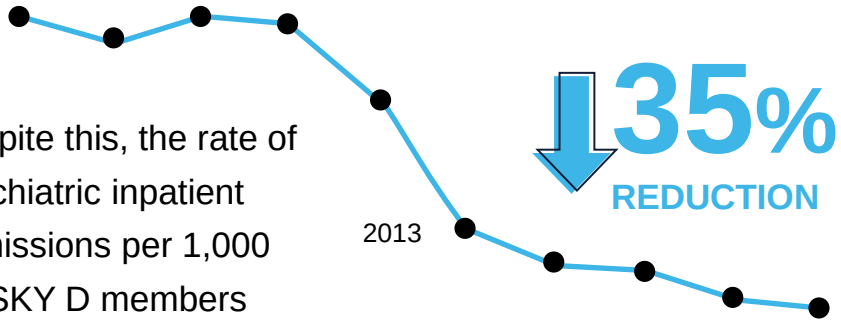
Medicaid Membership Growth/Use of Inpatient Services

As Adult Medicaid Membership has increased, use of Inpatient Behavioral Health Services remains steady.

Between 2013 until the end of 2017, The HUSKY D benefit group experienced an increase of 49%.

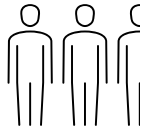


Despite this, the rate of psychiatric inpatient admissions per 1,000 HUSKY D members reduced by 35%.



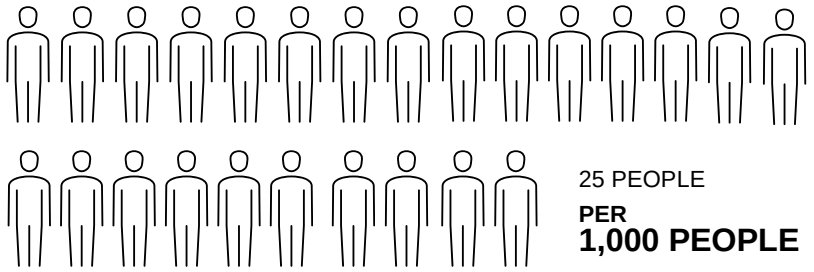
In addition, inpatient behavioral health admissions for this group are significantly lower than outpatient admissions (Q4 2017). Outpatient behavioral health services remain the most highly used intervention for the entire Medicaid population.

HUSKY D Inpatient Admits



2.4 PEOPLE
PER
1,000 PEOPLE

HUSKY D Outpatient Admits



25 PEOPLE
PER
1,000 PEOPLE

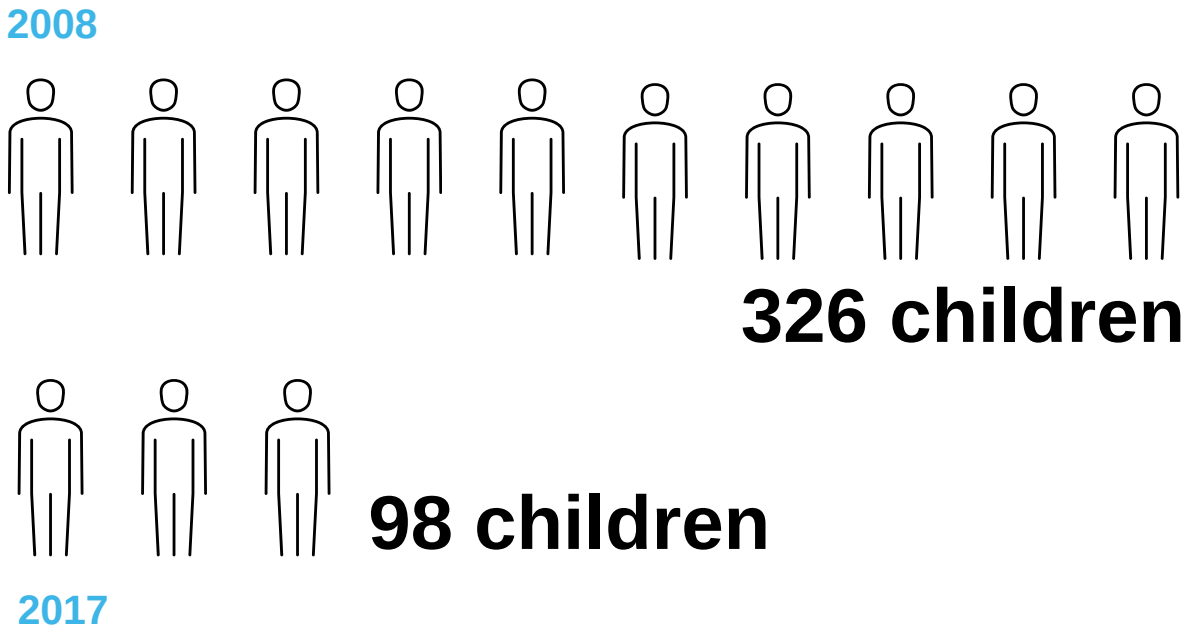
Discharge Delay

Reduced Discharge Delay

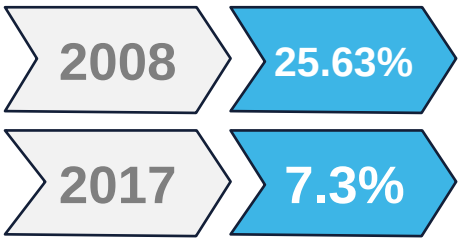
When a child is ready to leave a psychiatric hospital, but a needed service is not immediately available, the child's discharge is delayed.

Beacon, DCF and DSS staff, and providers work together to identify available services while removing barriers to accessing treatment. As a result, the time children wait unnecessarily in hospitals has been greatly reduced as seen below.

Fewer Youth Waiting to Discharge from the Hospital

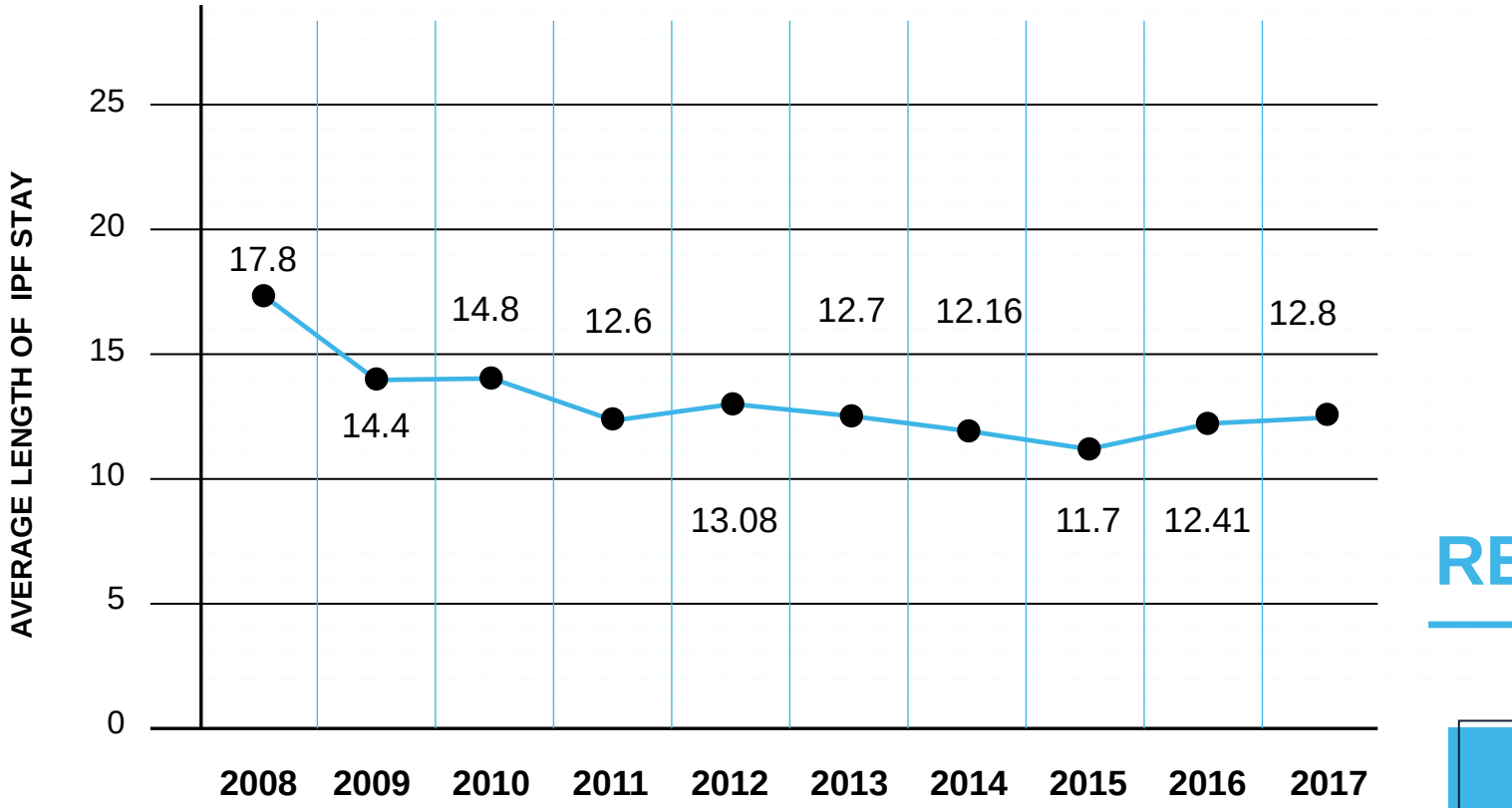


Reduction From



70% REDUCTION

Child Inpatient
Average Length of Stay

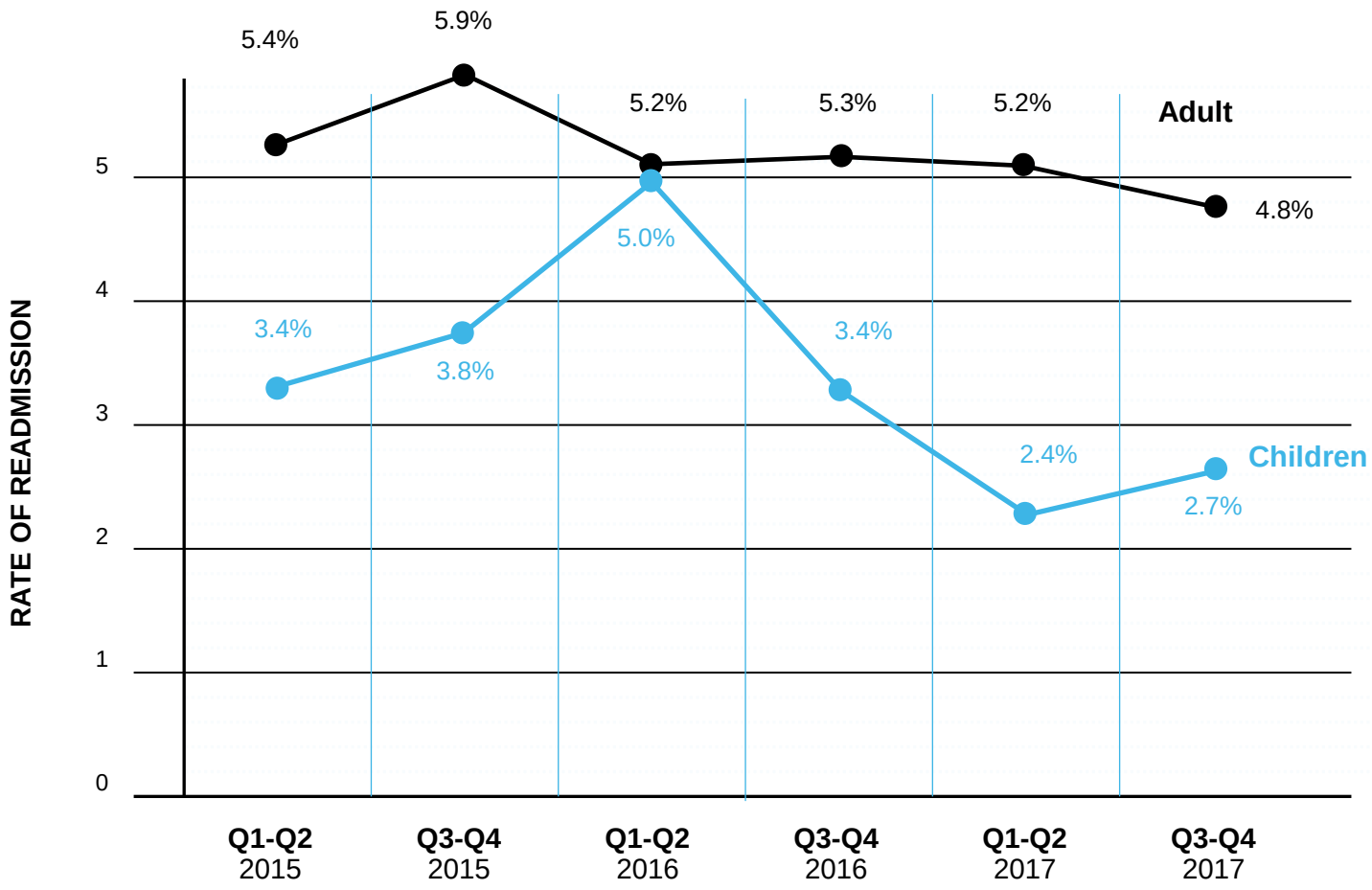


Child Inpatient ALOS reduced by 29% between 2008 and 2017

RESULTS

29%
REDUCTION

Adult & Child 7-Day Readmission Rate



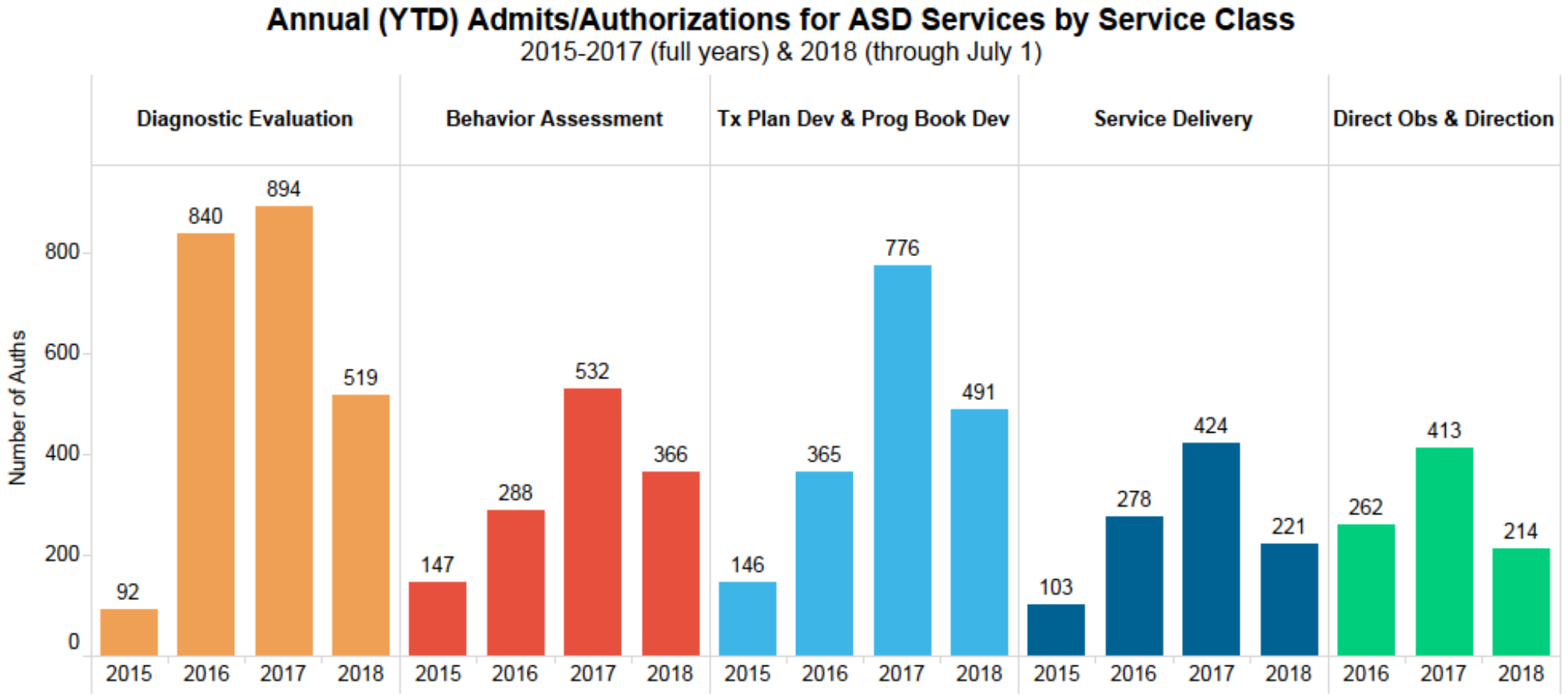
RESULTS

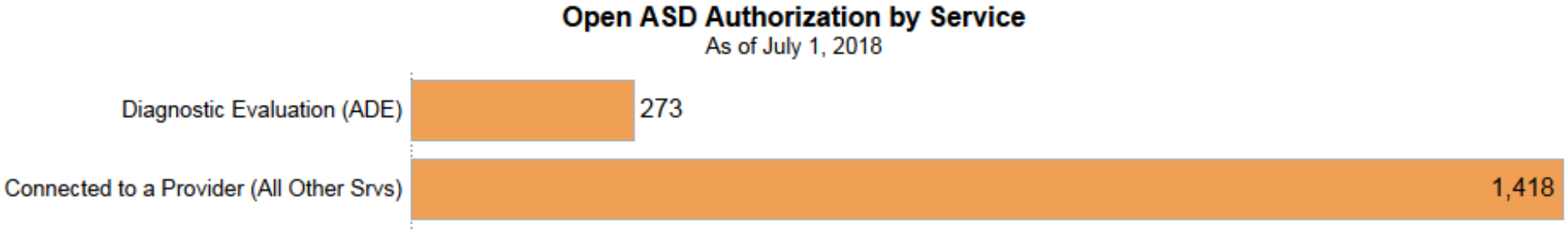
11% REDUCTION

20% REDUCTION

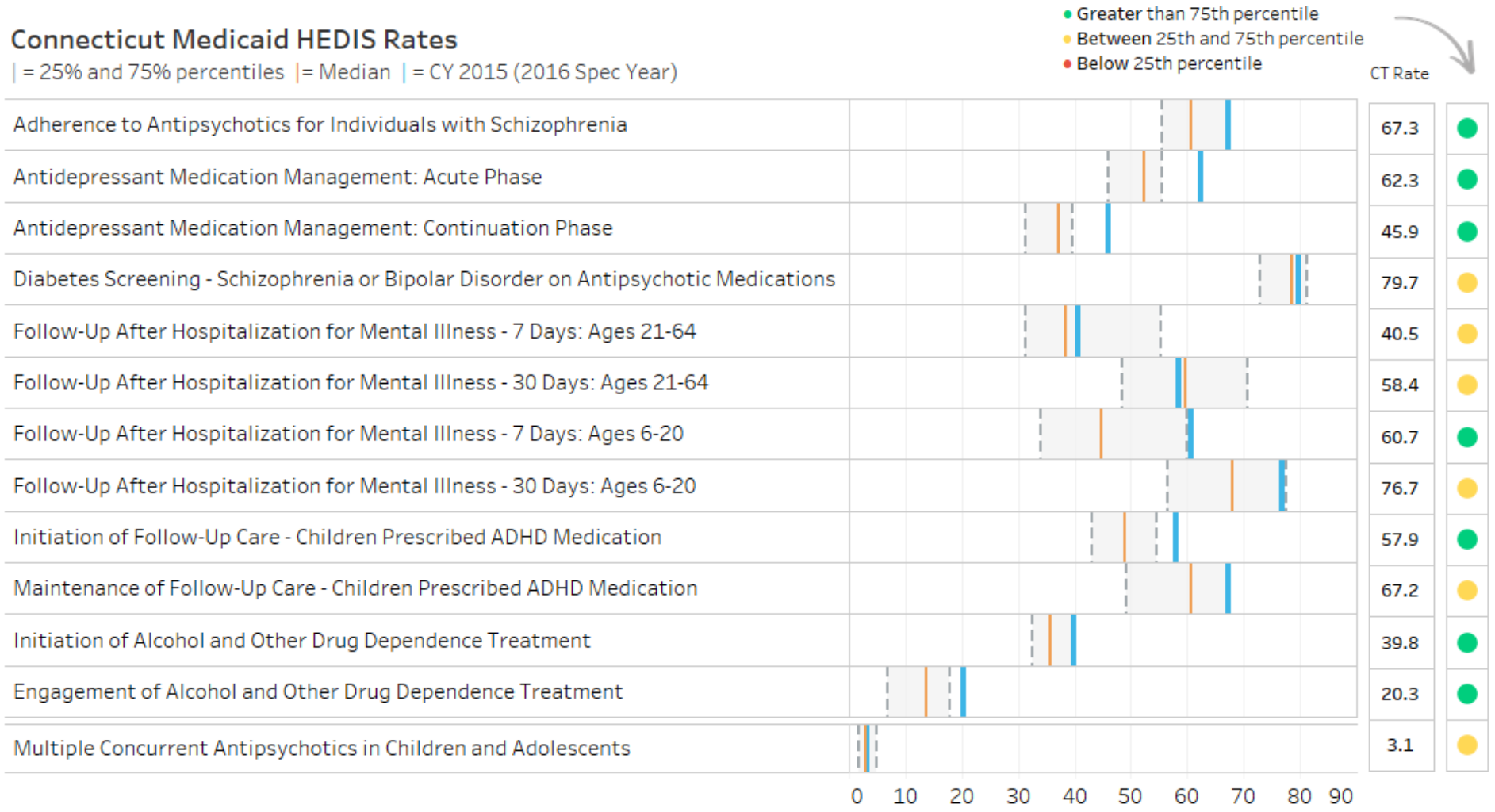
Adult and Child 7-Day Readmission Rate reduced 11% and 20%, respectively, between 2015 and 2017.

Autism Spectrum Disorder (ASD) Annual Authorizations and Open Authorizations by Service





Behavioral Health Healthcare Effectiveness Data and Information Set (HEDIS) Measures



Dashboard created by Lindsay Betzendahl at the request of Bert Plant on June 25, 2018 at Beacon Health Options - CT. Data sourced from Medicaid.gov and is not data from Beacon: https://data.medicaid.gov/Quality/2016-Child-and-Adult-Health-Care-Quality-Measures/vncf-b8xx

Quality Management

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Quality Management – Core Functions

- **Improvement** –Provider Analysis & Reporting (PAR), Regional Network Management, HEDIS and Hybrid Quality Metrics

- **Analytics** – Financial Mapping, Per Member Per Month (PMPM) by LOC, & use of advanced statistical techniques such as survival, multiple regression, predictive modeling, propensity score matching analyses, support for multiple contracts

- **Innovation** – Tableau, SAS Miner (machine learning), Spectrum, Growing capacity to import additional data sets

- **Quality Assurance** – Monitoring and measuring Inter-rater Reliability (IRR), Performance Standards, Quality of Care Concerns, Grievances & Appeals, Telephone Metrics, etc.

When UM and QM Intersect

- Provider and member level experience contextualize data
- Increasing sophisticated analytics drives us beyond basic utilization metrics, to more complicated analysis of provider performance and population health assessment and intervention
- We are able to leverage data from Medicaid, the Department of Children and Families, the Department of Mental Health and Addiction Services, and Project Notify for a more full picture of performance and health status

Business Intelligence & Engagement Tools

ADVANCED ANALYTICS

- Predictive Modelling
- Machine Learning
- Clinical Program Evaluations

QUALITY MANAGEMENT REPORTING

- HEDIS and Custom Measures
- Special Population Registries
- Provider Analysis & Reporting Programs
- Dashboards – Provider, Key Performance Indicator (KPI), Encounter, & Performance Standards

QUALITY MANAGEMENT RESOURCES

- Oracle SQL
- Full Claims Set
- Integrated DSS, DMHAS & DCF data
- Statistical Analysis System (SAS)

DATA VISUALIZATION TOOLS

- Tableau Publishing Platform
- Provider Locator Maps

CTBHP MEMBER & PROVIDER WEBSITES

- Training & Educational Resources
- Clinical Guidelines/Criteria
- Level of Care Guidelines
- Bed Tracking Tools

COMMUNICATION PLATFORMS

- Health Alerts
- Mass Mailing
- Automated Calls
- Public & Conference Presentations

CARE MANAGEMENT REPORTING

- Project Notify
- Spectrum Treatment History

Provider Tools and Support to Drive Practice Change

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Provider Analysis and Reporting (PAR) Program

The PAR Program is intended to inform and shape practice by identifying and positively impacting variation in performance within a specific level of care

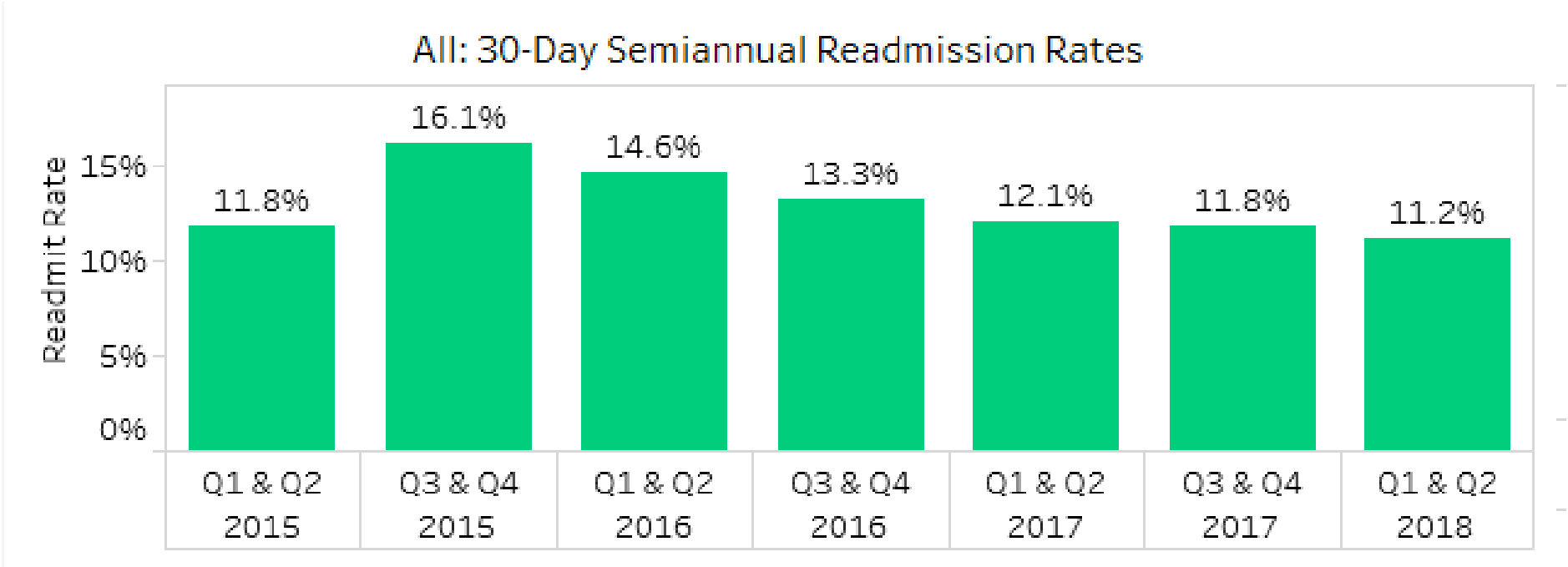
- Inpatient Psychiatric Hospitals, Adult and Children
- Withdrawal Management Programs (ASAM 3.7)
- Enhanced Care Clinics
- Psychiatric Residential Treatment Facilities
- Emergency Departments
- Intensive In-Home Child and Adolescent Services (IICAPS)
- Home Health

Implementing PAR: Network Collaboration and Technical Assistance

Regional Network Managers

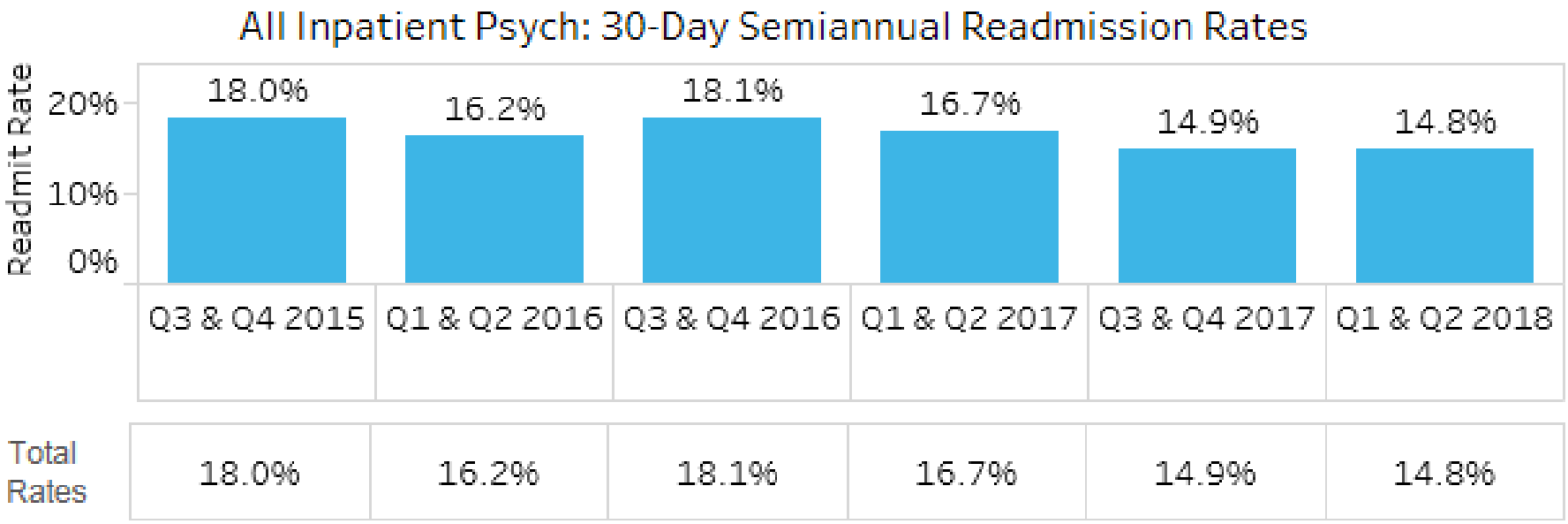
- Facilitate system improvement and provider performance via the PAR program, informed by and in conjunction with Medical Affairs and the Clinical Department
- Use data to inform performance improvement and work with providers and stakeholders to identify and address needs within regional networks and the statewide system of care
- Promote the dissemination of best practices

PAR: Pediatric Inpatient Psychiatric Hospital 30 Day Readmission Rates



Pediatric Inpatient Psychiatric Hospital 30-Day Readmission Rates decreased 30.4% from 16.1% in Q3 & Q4 ’15 to 11.2% in Q1 & Q2 ‘18.

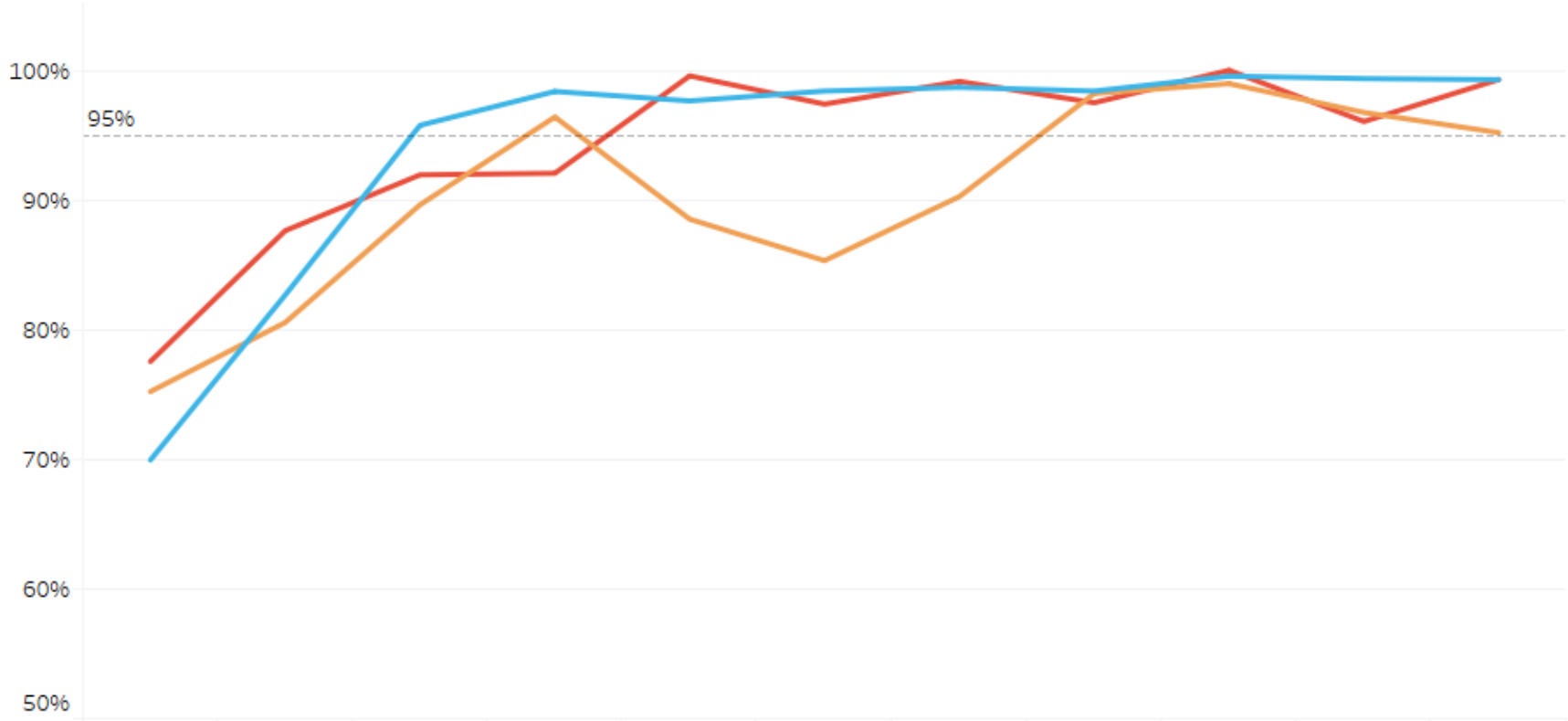
PAR: Adult Inpatient Psychiatric Hospital 30 Day Readmission Rates



Adult Inpatient Psychiatric Hospital 30-Day Readmission Rates decreased 17.9% from 18.0% in Q3 & Q4 ’15 to 14.8% in Q1 & Q2 ‘18.

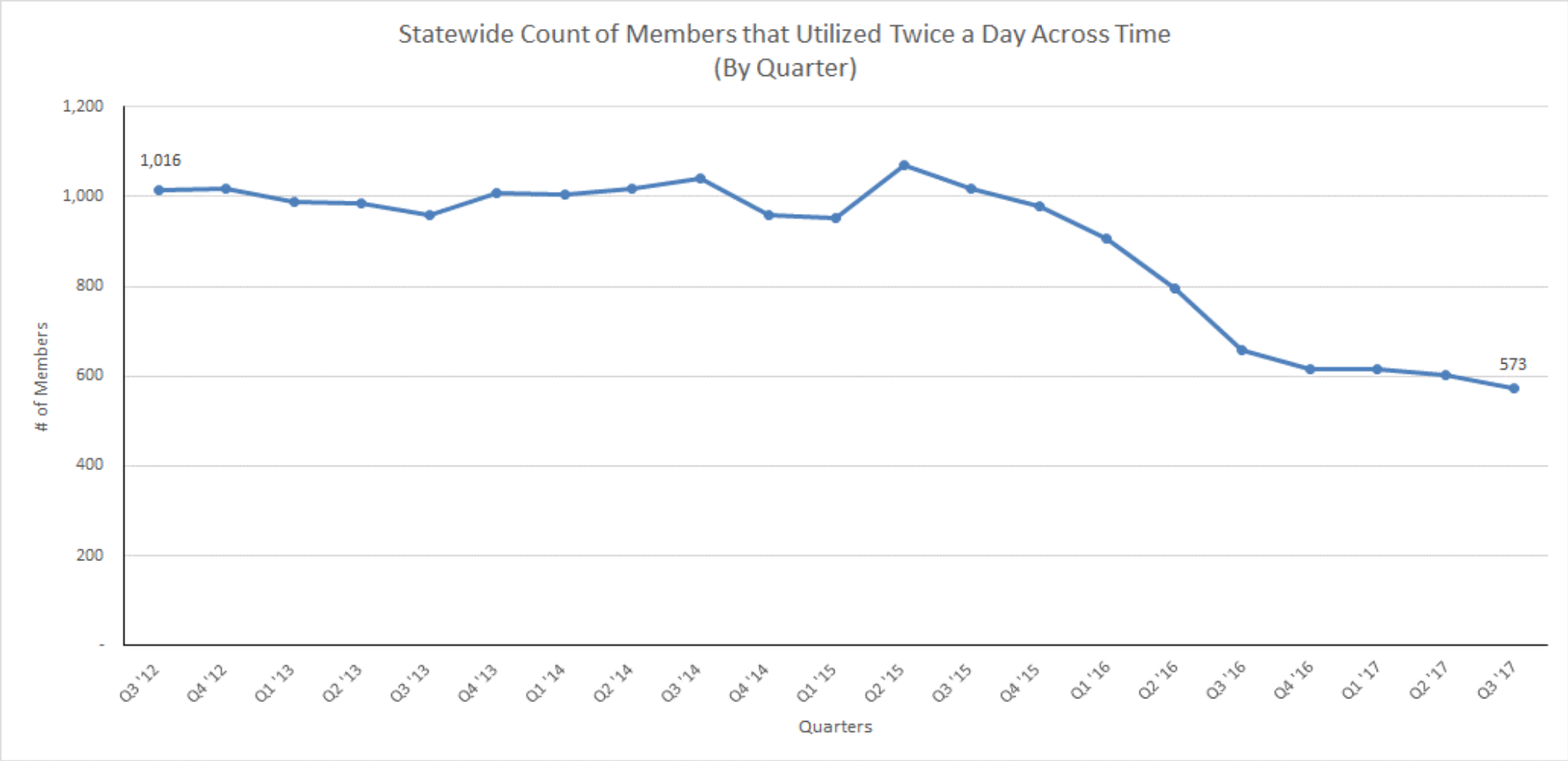
PAR: Enhanced Care Clinic Access Standards

Adult & Youth ECC Outpatient Annual Access Standards



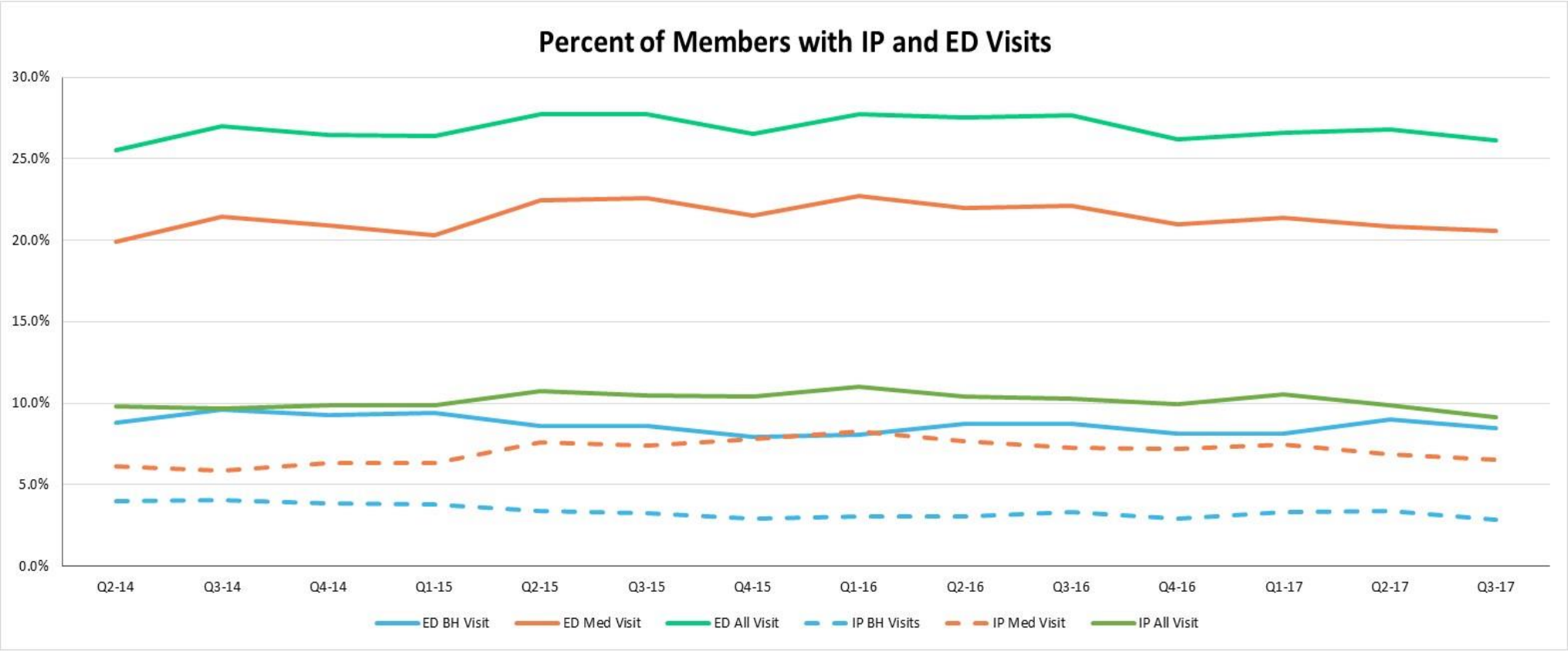
	CY '07	CY '08	CY '09	CY '10	CY '11	CY '12	CY '13	CY '14	CY '15	CY '16	CY '17
Routine	69.94%	82.67%	95.76%	98.37%	97.64%	98.40%	98.69%	98.40%	99.55%	99.36%	99.28%
Urgent	75.22%	80.55%	89.63%	96.40%	88.52%	85.32%	90.26%	98.21%	98.97%	96.75%	95.19%
Emergent	77.54%	87.63%	91.94%	92.06%	99.57%	97.39%	99.14%	97.50%	100.00%	96.05%	99.29%

PAR: Home Health - Increased Autonomy by Moving to Recovery Model



- Based on the Twice a Day – Daily Grid; includes Behavioral Health claims only
- There has been a 43.6% decrease in Statewide Members that utilized twice a day from Q3'12 to Q3'17

PAR: Home Health - Increased Autonomy DOES NOT lead to Increased Utilization



Additional Technical Assistance to Expand Network Capacity

- Project ECHO® is an **Evidenced and Community Based Public Healthcare National initiative** that facilitates treatment of common yet complex diseases in under-served and rural areas.

- The **goals of Project ECHO** are two-fold:
  - Develop capacity to **safely and effectively treat complex diseases** in rural and underserved locations
  - **Monitor outcomes centrally** to assess effectiveness of the program

Participation in Project ECHO Offers Many Potential Benefits

Provider Benefits:

- Professional interaction with providers who share similar interests
  - **Diminishes professional isolation**
- Provides access to **specialty consultation and mentorship** with addictionologist, psychiatrist, pharmacist, and patient specialists
  - Develops clinical expertise
  - Enables providers to become a local expert for their clinic or group
- Establishes a **good mix of work and learning**
- Improves **Professional Satisfaction**/retention
- Introduction of **Continuing Medical Education** credits

Participation in Project ECHO Offers Many Potential Benefits

System Benefits:

- Improves Quality and Safety
- **Reduces variations in care** across settings
- Improves **access for rural and underserved patients**
- **Spreads specialty medical knowledge, enhanced via CHN's participation**
- Supports the **Medical Home Model**
- **Cost-effective care –** prevents excessive testing and travel
- Addresses the **impact of untreated disease** (e.g. overdose deaths, comorbid physical health complications)

It Starts With the Data: Identifying Members Most at Risk and Designing Programs to Meet Their Needs

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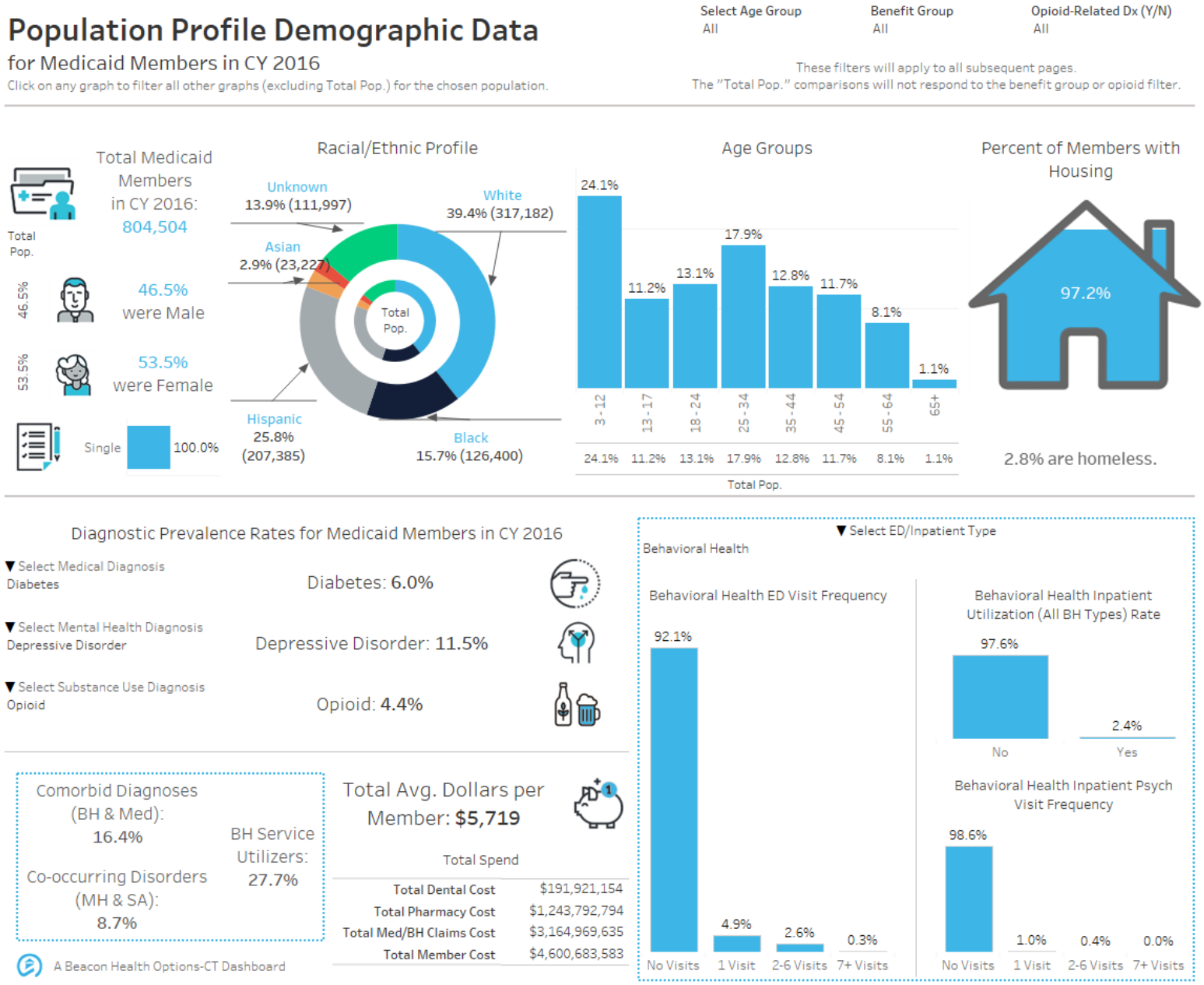
Population Profile Demographic Data



Specialty Programs for Special Populations

- With providers, ensure a person/family-centered, strength-based approach, focused on member success and recovery, prominently factoring social determinants of health
- Consistent use of evidence-based recovery, clinical and operational protocols
- Experienced clinicians, care coordinators, peers, and administrative staff with expertise in behavioral health
- Access to specialty Behavioral Health providers and facilities
- Integrated care coordination with primary care and social supports, inclusive of regular clinical dialogue with Community Health Network (CHN) nurses and physicians
- Outcomes monitoring, comprehensive reporting, and informed data analytics to support and improve individual outcomes

CT BHP Intensive Care Management (ICM) & Peer Models

- All of our Care Coordination Programs are inclusive of Peer Specialists
- Beacon Connecticut has the largest staff of Peer employees within the national Beacon organization
- Peers have been an integral part of the program since its inception in 2006

Face-to-Face	Telephonic
• Adult ICM Program	• Child ICM Program
• DCF Intensive Care Coordination Model	• First Episode Psychosis Model
• Autism Spectrum Disorder Peer and Care Coordinators • Expansion (serving Emergency Departments)	• Autism Spectrum Disorder Clinical

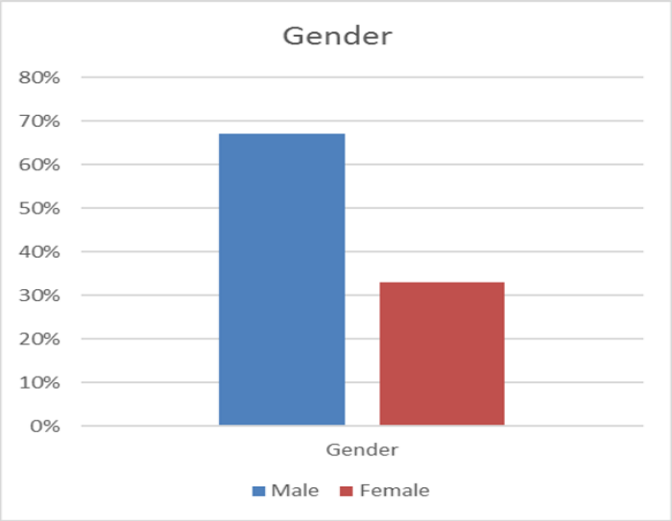
Co-Management Programs with Veyo, Benecare and CHN-CT

- Beacon has collaborated with CHN on over 1,800 high-risk members since January 2018, averaging approximately 3,000 referrals per year
- Beacon participates in Complex Care Rounds which have representation from all ASOs designed to ensure a holistic approach to care coordination
- Beacon has provided consultation and support to Veyo related to the transportation needs of 185 Medicaid members since January 2018 resulting in more efficient access to service, closer to home
- The Intensive Case Managers and Peer specialists refer members to Connecticut Dental Health Partnership and coordinate care soon after initial contact as most often this is the first need identified by the member

High Need/High Cost Individuals: National Governors Association (NGA)

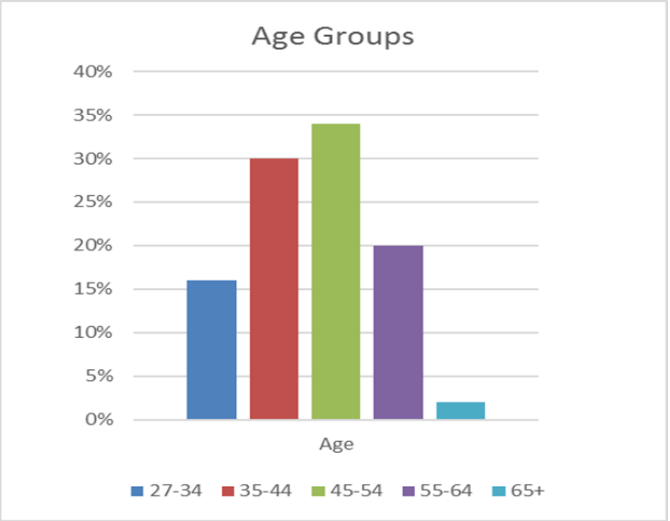
- **Background**
  - The NGA developed an initiative for identified Medicaid members to improve coordination of care among care managers, peers, families/supports and community providers. In CT, this involves state agencies, ASOs, and NGA Team.
  - Identified members with minimum of three Emergency Department visits and two Inpatient admissions within three consecutive six months. Members with highest costs associated w/ Behavioral Health (BH) diagnoses identified.
  - High Need/High cost cohort is divided into intervention and control group
- **Intervention**
  - Peer/ team outreaches and engages eligible members
  - Peer/ICM team addresses social, medical, and BH needs via a person-centered care planning process
- **Monitoring/Outcomes**
  - Analysis of characteristics of the population, acuity scores, etc.
  - Track self-reported outcomes (SF-12s)
  - Outcomes October 2018

Who Are the High Need Members?



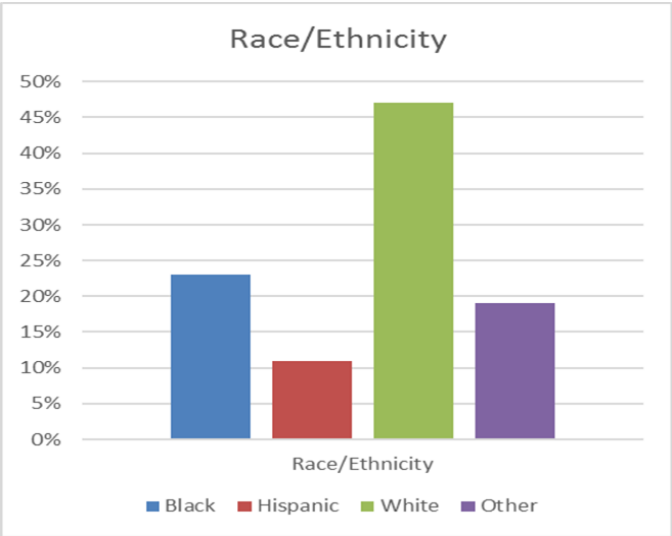
Gender

- Males are over-represented



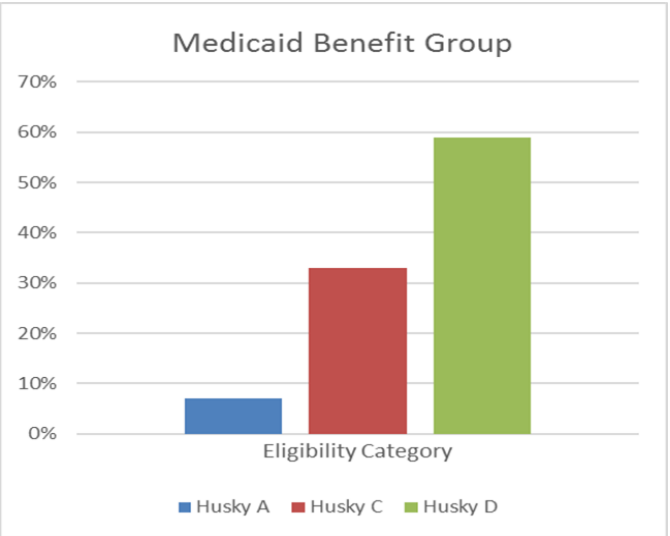
Age

- 45-54 largest group and over-represented
- 27-34 smallest group and under-represented



Race/Ethnicity

- Whites and Blacks are over-represented
- Hispanics under-represented



Benefit Group

- C & D are largest groups
- A is under-represented

Preliminary Findings

Preliminary analyses based on the first wave of program participants indicates the following results for those that received the intervention vs. those that did not:

- Rate of ED utilization shows a trend towards a greater decline for intervention group
- The rate of outpatient service utilization shows a larger increase
- Inpatient utilization is higher in the first three months post enrollment
- Inpatient utilization is lower in the second three months post enrollment

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Emerging Adults

- **Background**
  - Emerging adults (ages 15–26) face many challenges
  - Particularly challenging for those with behavioral health needs
  - Strides have been made in understanding vulnerable population
  - Still large gaps in our knowledge base; few evidence-based interventions
- **Connecticut Emerging Adults Performance Target**
  - Identify characteristics and service utilization patterns
  - Conduct predictive analytics to strengthen identification of risk and need
  - Inform, develop, and implement intervention to support Medicaid emerging adults
  - Produce enhanced monthly report to identify high-risk emerging adults

First Episode Psychosis (FEP)

- **Background**
  - Evidence supports effectiveness of early intervention for FEP
  - The Substance Abuse and Mental Health Services Administration (SAMHSA) directive to set aside 10% of Mental Health Block Grant for Serious Mental Illness (SMI)
  - CT DCF contracted with Beacon to identify, refer, & follow-up
- **Connecticut FEP Program**
  - Utilize claims data to identify potential FEP Medicaid members
  - Produce a monthly 'triage report' that is used internally
  - Utilize internal identification methods (e.g., real-time referrals)
  - FEP ICM (1) outreach to identified members, offer referrals and support
  - Refer to evidence-based programs, when possible, or to other appropriate treatment and services
  - Utilize predictive modeling to better identify members
  - Assess readiness of provider network to adopt best and evidence-based FEP practices

Challenges and Opportunities

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Challenges and Opportunities

- **Public Health**
  - **Opioid Crisis** – Opioid prescribing is declining but rates of fatal overdose continued to rise from 2016 to 2017
  - **Disparities in Behavioral Health Care** – Metrics to identify and track disparities, but capacity to meaningfully address is in early stages
  - **Suicide** - Connecticut performs well in comparison to most other states but rates here have also increased between 6-18% from 2000 to 2016 (Center for Disease Control)
- **Behavioral Health System**
  - **Inpatient** – Although current rates are within industry standards, adult inpatient psychiatric length of stay is trending up
  - **ED Volume and Youth Awaiting Services** – Volume of BH ED visits is trending up particularly for youth

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Questions

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