Health and Human Services Transformation

Illinois HHS Medicaid Waiver Advisory Committee Discussion 2

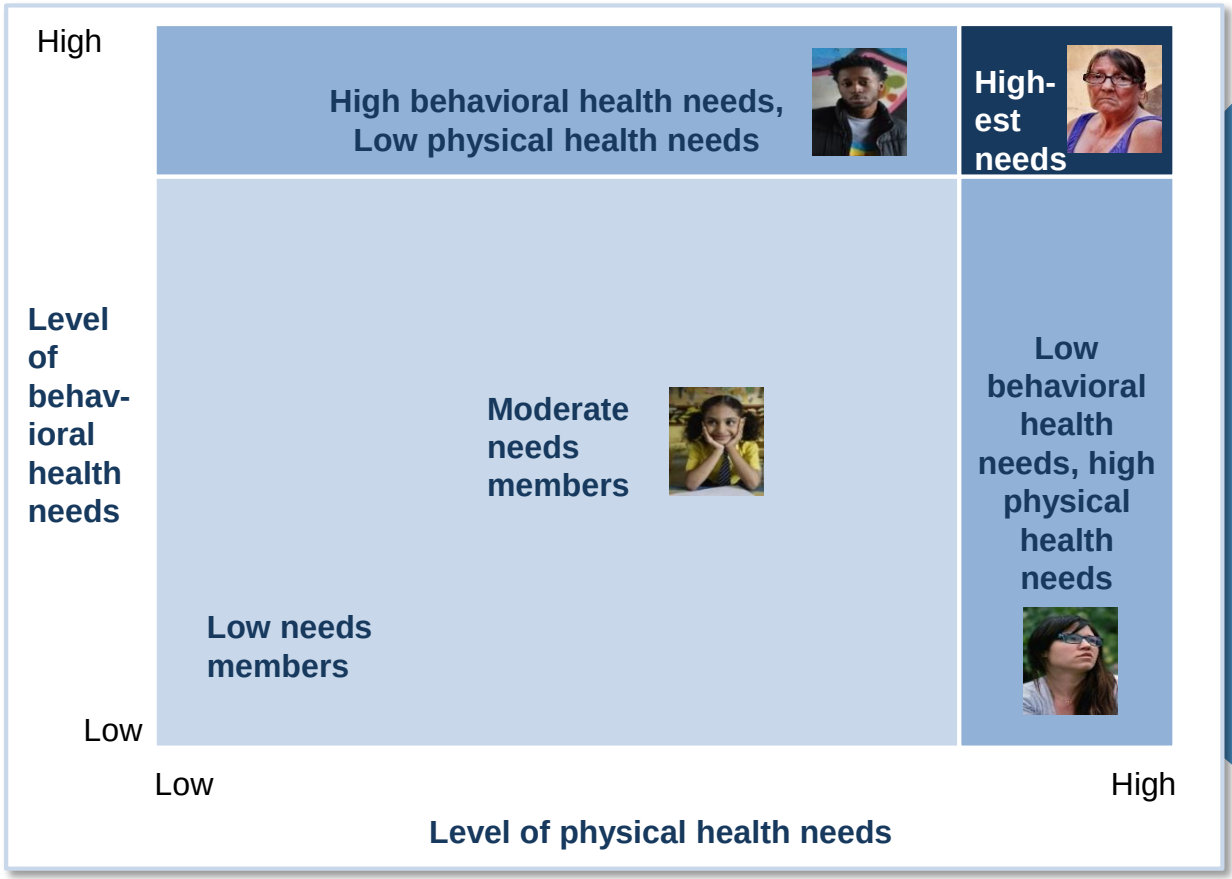
Pre-read document

February 2, 2017

Contents

1 Potential expectations for providers in coordinating care for high need members

ILLUSTRATIVE



For high need members, IHHs:

- **Provide multi-faceted care co-ordination** (e.g., develop integrated care plan, engage member caregivers)
- **Address acute events** with referrals to specialists (e.g., crisis pregnancies with OB-GYNs) and demarcate respective care coordination responsibilities for duration
- **Collaborate with MCO care co-ordinator** as needed
- Co-ordinate care on long term basis for **their significant chronic conditions**
- May be able to directly provide **more of the needed services**

- **All high need members to be attributed to provider equipped to address their needs**
- **Any provider serving high need members should be capable of serving members with low of moderate needs**
- **Additional requirements are expected of IHHs serving members with high needs**

1 Guiding principles for determining eligibility of provider types for high need members

- Include provider types already capable of **providing fully-integrated physical and behavioral health care**
- Ensure other provider types can **demonstrate capability to collaborate effectively with other providers** whose abilities complement their own
- Select provider types whose institutional character ensures ability to **maintain long-term relationship with members**
- Avoid excluding provider types where significant numbers of members have shown **preference for establishing therapeutic and/or coordination relationships**
- Exclude provider types catering exclusively to specific age-groups, in order to **ensure providers will be able to coordinate care for whole families**

What other principles should be considered?

1 States may choose from among a set of provider types in the Health Home SPA, and may add additional provider types beyond this set

	Physical Health Providers	Behavioral Health Providers
Provider types offered by default in Health Home SPA	▪ Primary care physicians ▪ Clinical practices or clinical group practices ▪ Rural health clinics ▪ Community health centers ▪ Case management agencies ▪ Home health agencies ▪ Federally Qualified Health Centers	▪ Community mental health centers ▪ Community/behavioral health agencies
Select provider types observed in other Health Homes	▪ Physicians/physician groups employed by hospitals (e.g., Missouri) ▪ Tribal health centers (e.g., Michigan)	▪ Substance abuse providers (e.g., Vermont) ▪ Mental health providers employed by hospitals ▪ Psychiatric rehabilitation programs ▪ Mobile treatment service providers (e.g., Maryland)

1 Also permissible to use teams of select healthcare specialist types (with one designated as lead entity) and entities with state-specific accreditation (e.g., Maine's Enhanced Primary Care Practice)

SOURCE: CMS SPA guidelines; State Health Home SPAs

1 Provider types under consideration for inclusion in the program for members with high needs

	Scenario 1: Behavioral health provider is lead entity[1]	Scenario 2: Physical health provider is lead entity[1]
Eligible physical health provider types	▪ Any physical health provider type in accordance with the Health Home SPA default list ▪ Any other State-approved physical health provider type	▪ Primary care physicians ▪ Clinical practices or clinical group practices ▪ Rural health clinics ▪ Physicians and physician groups employed by hospitals ▪ Community health centers ▪ Federally qualified Health centers
Eligible behav-ioral health provider types	▪ Community mental health centers ▪ Other eligible specialty behavioral health provider types as approved by the State[2] (e.g., community/behavioral health agencies, clinics within hospitals)	▪ Community mental health centers ▪ Other eligible specialty behavioral health provider types as approved by the State[2] (e.g., community/behavioral health agencies, clinics within hospitals)

Are there additional provider types that should be explicitly included or excluded from consideration here?

1 With collaborative agreement in place with corresponding entity 2 Excludes e.g., psychiatric rehabilitation programs

1 Staffing and technical requirements suggested to deliver effective care coordination and to reflect current provider capabilities

	Description
Staffing requirements	▪ **Health coordinators:** Lead nurse care manager; nurse care manager; clinical care coordinator, with expectation of training to ensure compliance with High Fidelity Wraparound approach and comparable approaches for adults ▪ **Clinical experts:** Physician and psychiatrist or similar behavioral health specialist; substance use disorder specialist; psychologist ▪ **Social supports:** Social worker; recovery support specialist
Software requirements	▪ State-mandated screening tools and functional assessments, with use of Admission, Discharge, Transfer feeds as rolled out, **and progression toward Electronic Health Record use encouraged**
Collaborative agreements	▪ **Collaborative agreement** with: – A physical health provider if the lead entity is a specialist behavioral health provider – A behavioral health provider capable of treating members with high behavioral health needs if the lead entity is a physical health provider

- **What challenges might there be in different parts of Illinois to meet these requirements?**
- **How can collaborative agreements be written to ensure true collaboration among providers?**
- **At what point should EHR usage become mandatory for providers?**

1 Potential approaches to supporting IHHs serving high need members

Type	Approach	Description
Capability building	Learning collab-orative	▪ Entity that supports regular discussions, exchanges of best practice, conversations on working effectively with Medicaid/MCOs, and networking/mentoring among IHH providers
	Coaching	▪ Training and technical support on workforce development, care coordination/ integration, and other topics central to IHH performance
	Pilots	▪ Disease-specific integration pilots to build a foundation for behavioral and physical health collaboration among relevant providers (e.g., diabetes and depression; non-opioid collaborative therapy etc.)
Infra-Struc-ture	Grant support	▪ Support grant applications to enhance provider infrastructure or capabilities (e.g., workflow or member data analysis software, telemedicine systems)
Program eligibility support	Readiness assessment	▪ Development of an IHH readiness assessment tool to evaluate processes that providers have in place and ability to perform integrated activities, permitting providers to baseline their capabilities and learn from best practice
	Outreach, support, & technical guidance	▪ Efforts spanning initial attempts to alert providers to existence of program and its benefits, through to targeted support and guidance through application process, e.g., through supplying draft text of collaborative agreement

What other forms of support should be offered to providers – and when?
What capabilities will providers require greatest help in developing?

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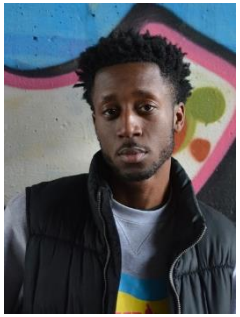
2 Meet Brice, a teenager with depression and multiple suicide attempts

ILLUSTRATIVE

How the system is set up for Brice today



- Brice is **16 years old**, lives at home, and is **Medicaid-eligible**
- Brice has major depressive disorder and has had **multiple suicide attempts**

- Brice is linked in to a **community mental health** center who manages his behavioral health treatment and **coordinates his care** with his school psychologist and his primary care physician
- When Brice is actively suicidal he receives **crisis stabilization services from his CMHC** and, when necessary, they admit him for inpatient psychiatric care
- When Brice gets older, the agencies and providers involved in his care help him **transition into the adult system**

Health care pain points

- **Value**
  - Brice's physician does not adhere to a preferred drug list and **prescribes expensive**, non-generic anti-depressants
  - Brice's **utilization of inpatient treatment is not optimal**; he is often admitted unnecessarily or not admitted when it is necessary. When he is admitted, his length of stay is sometimes longer or shorter than necessary
- **Quality**
  - Brice is prescribed anti-depressants, but d**oes not receive evidence-based psychotherapy services** for his depression
  - His psychiatrist is not aware that Bryce uses alcohol and marijuana on weekends due to difficulty coordinating lab testing
- **Continuity**
  - Brice's inpatient psychiatrists **do not effectively communicate** with his CMHC to optimize his care during his inpatient stays
  - **Data is siloed**, so the prescribing CMHC physician is blind to other prescribers who may be providing care to Brice
  - Brice's school and church notice when he is more depressed, but are **not linked with his CMHC** to inform them of the change
- **Access**
  - When Brice turns 19 he loses his Medicaid eligibility and **does not sign up for health insurance**

2 For consideration: How should Brice's IHH deploy resources to help manage his changing level of need over time?

Level of need

- Brice is a 16 year old from Chicago with **major depression and suicidal ideation**
- Before joining an IHH, **Brice's conditions were not managed effectively or holistically**
- Since joining an IHH with the right capabilities to meet his changing needs, his care has been **better integrated, leading to improved outcomes for him**

1 Brice is admitted to an ED after expressing a strong desire to harm himself. The hospital alerts his MCO and IHH via ADT feeds. **Brice, his IHH, and the hospital create a discharge plan together**

2 On discharge, **the IHH updates Brice's care plan** (including his medication regimen), with input from him and clinical specialists. The IHH involves his Child and Family Team in **finding him a psychotherapist to help manage his depression**, with extended hours to reduce Brice's reliance on EDs

3 The IHH **secures Brice's parents' consent to share and gather medical data** from his social supports, like his pastor. Soon after, his pastor alerts the IHH that Brice may be experiencing a spike in his suicidal ideation. Brice's IHH immediately connects him with **crisis stabilization services**

4 Brice's IHH ensures he is **regularly screened for substance use**. On testing positive for marijuana, his nurse care coordinator provides education on substance abuse. As Brice approaches adulthood, **the IHH begins working with his family and social worker to make sure he retains Medicaid eligibility** and is able to continue his membership at the IHH

5 Brice's IHH is alerted that he has broken his leg. It begins preparation for a new discharge plan, and **seeks out physical therapists to help Brice recover from his injury**

Day 1 | Week 1 | Month 1 | Month 6 | Month 9

Which other clinical or supportive services should Brice's IHH prioritize connecting him with?

2 Meet Tom, an adult with alcohol and opioid use disorders, who has spent time in the correctional system

ILLUSTRATIVE

How the system is set up for Tom today

- Tom is 36 years old, **newly Medicaid eligible,** and lives in a friend's home
- Tom has **alcoholism and opioid use disorder as well as early signs of diabetes**
- Tom receives level **II substance use disorder treatment** from a local outpatient substance use disorder provider

- Tom gets **primary care services intermittently** from a local PCP; with more regular the PCP would screen him diseases common in alcoholics and **coordinates his care** with his substance use disorder provider
- If Tom suffers an opioid overdose, EMS brings him to the **emergency room** where he is stabilized and discharged to a **detoxification treatment center**
- Tom's outpatient substance use disorder provider (level II) works with Tom's residential treatment providers to plan for a **safe discharge and transition**
- Tom may be eligible for Medication Assisted Treatment and may be evaluated by a trained physician/methadone provider
- Tom **may be eligible for Level III.5** care if he has difficulty staying sober; however he must be detoxed from both alcohol and drugs before he will be allowed admission
- Tom has potential access to a variety of services to support him including **recovery homes and alcoholics anonymous**

Heath care pain points

- **Value**
  - Tom is at risk for losing his housing (his friend has given him one week to get off the couch); living on the street will likely exacerbate Tom's addictions eventually leading to **need for high intensity care**
  - Tom's alcoholism puts him **at risk for serious medical illnesses**, but he does not see his PCP so is not provided counseling or screening for these diseases; when they finally manifest they are severe and expensive
  - There is a shortage of detoxification programs for opiate addiction so **Tom must detox in the expensive ED/acute care hospital**
- **Quality**
  - When Tom is drunk on the street and brought to the ED the providers discharge him when he is sober without offering him any substance use disorder recovery services
  - Tom **requires but does not receive testing for diabetes** and education on the disease and its treatment
- **Continuity**
  - Tom finally does go to an inpatient substance use disorder treatment facility, but is **discharged without a holistic array of recovery services like case management and job training,** leading to a quick relapse
- **Access**
  - Tom's addictions lead him to **avoid doctors** and so he does not seek medical treatment for his feet which he notices are slowly becoming numb; an early sign of diabetes
  - Tom sometimes stays in homeless shelters; **but he does not receive substance use disorder referrals** while there
  - Tom does not have access to transportation, causing him to frequently miss appointments
  - There is a **shortage of detoxification programs for opiate addiction** and Tom has trouble finding a place to detox so that he can become eligible for Level III.5 services

2 For consideration: After joining, Tom's IHH uses screenings to identify his unmet needs and engages social supports extensively

Level of need

- Tom is a 36 year old with **opioid use disorder, alcoholism, and early signs of diabetes** who is currently **staying on his friend's couch**
- He has **intermittent relationships with several providers** and was **not previously recognized as Medicaid eligible**
- He has been **admitted to an ED before** for substance use but has **continued to use and no one has followed-up**

1 Tom is **brought to an ED after being apprehended by the police for public intoxication** and is admitted for inpatient detox. The hospital and an MCO **recognize his eligibility for Medicaid and connect him with an Integrated Health Home** that is capable of serving his needs

2 Tom's Integrated Health Home immediately connects him to a **provider specializing in substance use disorders** and introduces him to **alcohol and opioid recovery support groups**. Additionally, his care coordinator orders a **series of screenings** for Tom, including ANSA, SBIRT, and tests for physical conditions commonly observed in alcoholics and opioid addicts, **resulting in a diagnosis of diabetes for which he is referred to an endocrinologist**

3 Tom's friend will no longer allow him to sleep on his couch. Tom has no other friends to turn to and is **suddenly homeless**. Feeling helpless, he considers turning to drugs. He calls his **sponsor from his addiction recovery support group, who relays his housing difficulties to his care coordinator**. His care coordinator finds a **homeless shelter** for Tom to spend the night in, and puts him in touch with **supportive housing services**

4 Tom continues attending support group meetings and **begins to stabilize**. He expresses his desire to **return to the workforce**, and his care coordinator puts him in touch with **employment training and placement services**

5 Tom begins to notice **signs of hyperglycemia**. Rather than heading directly to the ED, he **contacts his care coordinator**, who is able to schedule him to see his PCP for immediate treatment. He is then scheduled for a **follow-up appointment with his endocrinologist** and is given **coaching on how to avoid future episodes**

Day 1 Week 1 | Month 1 | Month 6 | Month 9

2 Activities supporting 6 main care delivery goals for members with high needs and their families

Activity requirements for Integrated Health Home providers

Integrated care planning and monitoring	**Create and update integrated care plan** working in conjunction with other providers, social supports, and patients **Prepare and implement transitional care plan** to smoothly move patients between settings of care as needed
Physical / maternal health provider engagement	**Improve access to clinical care** via partnering with other providers to address gaps, and broadening the channels of care delivery
Behavioral health provider engagement	**Implement integrated care plan** through follow-up and communication with other providers and partner entities
Supportive service coordination	**Increase awareness and access to social supports** where possible by educating members of available supports and facilitating interaction **Engage social supports in care planning and delivery process/meeting member needs** where possible through pursuit of bi-directional communication
Member engagement & education	**Reduce barriers affecting adherence to care regimens** by offering ongoing access and support from care coordination team **Educate members and families on health maintenance, improvement, and ownership** with increasingly aspirational goals
Population health management	**Engage in continuous improvement to meet members' needs** by participation in ongoing education and tracking key performance data **Identify disparate levels of member need across whole panel** through usage of stratification tools

- **What other core activities should IHHs be responsible for?**
- **Which activities should occur at regular intervals for any given member?**

2 What activities should IHHs be expected to perform to support members?

This page may be used to list down activities you feel IHHs should perform to achieve improvement against each goal for their members, particularly those with high needs (e.g., Tom and Brice)

Contents

Medicaid Waiver Advisory Committee members (1/2)

Meeting Chair

- Howard A. Peters (Vice-Chairman, Medicaid Advisory Committee)

Committee members

Name	Role and location
Jennifer Craig	COO, Centerstones Illinois (Alton, Marion, Carbondale)
Regina Crider	Youth and Family Peer Support Alliance (Champaign County)
Victor Dickson	Safer Foundation (Chicago)
Kathy Donahue	SVP, Catholic Charities (Chicago)
Dennis Duke	President, Robert Young Center/Unity Point Health (Quad Cities)
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Doug Elwell	EVP, Cook County Health and Hospital System (Chicago)
Raul Garza	President/CEO, Aunt Martha's (Chicago Heights)
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Arlene Happach	EVP/COO, Children's Home and Aid (Chicago)
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Sara Howe	CEO, IL Association of Behavioral Health (Springfield)

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Marvin Lindsey	CEO, CBHA (Chicago)
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Heather O'Donnell	Thresholds (Chicago)
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TBD	Illinois State Medical Society
TBD	Illinois Mental Health Partnership

Integrated Health Homes working team

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