



All Provider Meeting
January 15, 2019
1-3:00 pm

Agenda

Welcome and Introductions: Kate Peterson

Alliance Provider Advisory Council (APAC) Updates -Ali Swiller

Discussion of local PAC's and importance of involvement

Alliance Updates

Legislative and Medicaid Transformation Updates and Discussion-Sara Wilson

Group Living Plan Overview- Rob Bell and Amy Johndro

IDD Care Team overview and implementation discussion Walter Linney

Review of implementation, experiences and roles

Care Management- Sean Schreiber

Whole Person Health- Damali Alston

Questions

Powerpoint will be posted on the Alliance Website by January 24

<https://www.alliancebhc.org/providers/provider-resources/all-provider-meetings/>

Next All Providers Meeting is March 11, 2020 1-:30 pm

Legislative Updates

Sara Wilson

Group Living Update

**Creating a Recovery Oriented System of Care:
Repurposing Residential Care for Person with
Mental Illness**

Starting in 2015...

- Alliance contracted with the Technical Assistance Collaborative (TAC) to assess three primary areas of the residential continuum:
 - Residential capacity in terms of quality and availability of residential housing and service options
 - How these options are accessed/utilized
 - Associated costs
- Conducted assessment between March and June 2015
 - Meetings with leadership and key internal positions
 - In-person focus groups and telephone interviews
 - Review of documents and claims data over an 18 month period (Sept 2013-March 2015)

Overview of TAC Report

- Report organized by three distinct target populations
 - Adults with mental illness and/or substance use disorders
 - Individuals with IDD
 - Children/Youth with mental illness and/or substance use disorders
- Each section of the report includes:
 - Related needs and challenges
 - Recommendations to expand community based housing and services
 - Cross cutting recommendations to enhance best practice and outcomes
- Recommendations point to an overreliance on group living settings

Common Themes Across All Groups

- Assess individual and housing needs/preferences and facilitate more informed choice of housing and service options
- Establish and reinforce service standards/expectations to encourage movement toward more independent settings
- Support the financing and effective delivery of appropriate wraparound services which promote housing stability, community integration and recovery

Common Themes Across All Groups

- Provide capacity building and training to assist providers in delivering best practice housing and service interventions
- Develop and implement outcome/performance measures to monitor provider and program performance and improve individual and system level outcomes
- Reprogram some existing funding sources and develop relationships with the affordable housing system to create more desirable housing options

Since 2015...

- Administer four Permanent Supportive Housing (PSH) Programs
- Invested almost \$4.5 million dollars in affordable housing creating 57 set aside units
- Continually meet and exceed the TCLI housing goals
- Developed a Bridge Housing Program in Wake Co

Since 2015...

- Partnered with three large housing authorities to access specialized permanent vouchers for people with disabilities
- Created a successful Landlord Leasing Incentive Program
- Contracted with two national housing consultants: Enterprise and Corporation for Supportive Housing
- Contracted with Community Inclusion Center at Temple University

Since 2015...

- Contracted with two national housing consultants: Enterprise and Corporation for Supportive Housing
- Contracted with Community Inclusion Center at Temple University
- Assumed Subsidy Administration role with TCL vouchers
- Continue to expend over \$700,000 annually in financial assistance to address eviction prevention and rapid re-housing

And Now...

- Current focus on persons with primary mental illness residing in group living settings
- Goal is to implement a comprehensive Recovery Oriented System of Care built on:
 - Housing choice and access to safe and affordable housing
 - Wraparound services and supports that promote community inclusion and quality of life
 - Creating and funding alternative models to long term congregate living
 - Building provider competency for tenancy supports that are integrated with treatment interventions

Getting There from Here...

- Built micro-strategy report based on paid claims that show:
 - Level of residential care
 - Primary diagnosis
 - Length of stay
 - Service utilization and type
 - Accumulated cost by level of care and individual
- Conducted further analysis of key clinical data
 - Number of crisis days within past year
 - Crisis episodes by level of care
 - Crisis episodes by age
 - Crisis episodes by length of stay

Getting There from Here...

- Developed cross departmental workgroup
 - Meets every 2 weeks
 - Thorough clinical review of current state funded group living census for persons with mental illness
 - Develop policy and best practice recommendations
 - Develop procedures for housing choice and community living
- Developed in-reach process for current residents
- Developed Community Inclusion Planning Team for persons expressing a desire to transition to community living
- Developing model to repurpose select group living settings into acute transitional program

Getting There from Here...

- As of Dec. 1 new benefit plan for Group Living High
 - 90 day authorization with no more than 30 extension
- As of Jan. 1 all 5600A facilities must be located in the catchment area or within 30 miles
- As of Jan. 1 begin in-reach process (notification to guardians prior to in-reach)
- Starting in January begin active transition planning for those desiring to move
- July 1 Alliance will cease to be the payor of state funded group living for persons with mental illness

Why This Change and Why Now?

- Over the last several years have developed supportive housing expertise and partnerships
- Have permanent housing inventory and vouchers in our high needs counties
- Honoring the intention of the Olmstead Act of 1999
- Redirecting funds to bolster and build other parts of the ROSC
 - Supportive Living
 - Subsidies for longer term financial assistance
- New Care Management model that can support the intensity of community transitions
- Able to incorporate new thinking and emerging best practices
 - Community Inclusion

Focusing on Community Inclusion and Recovery

- What is Community Inclusion?
 - “The opportunity to live in the community and to be valued for one’s uniqueness and abilities like everyone else.” (Salzer, 2006)
 - Fully integrated and contributing member of the community
 - Unpaid supports, social connections, recreational pursuits, gainful employment, etc...

Focusing on Community Inclusion and Recovery

- What Community Inclusion is not...
 - Clustering people with severe mental illness into one home, classroom, workplace, or social center
 - Giving "special privileges" to people with severe mental illness
 - Feeling sorry for people with severe mental illness

The Importance of Community Inclusion

- Why Community Inclusion is so important
 - “Research findings clarifying that people with mental illnesses ‘would, should, and could’ participate in the mainstream of their community’s life” (Baron, 2018)
 - Members are more likely to stay engaged in all aspects of life: housing, treatment, employment, social networks, etc.

The Importance of Community Inclusion

- Community Inclusion is a necessary component of the recovery model
- Enriches overall quality of life: mentally, physically, spiritually, etc.
- Strengthens and enriches the whole community
- Community Inclusion is a human right, not a privilege

Care Team Overview and Discussion

Walter Linney, MA

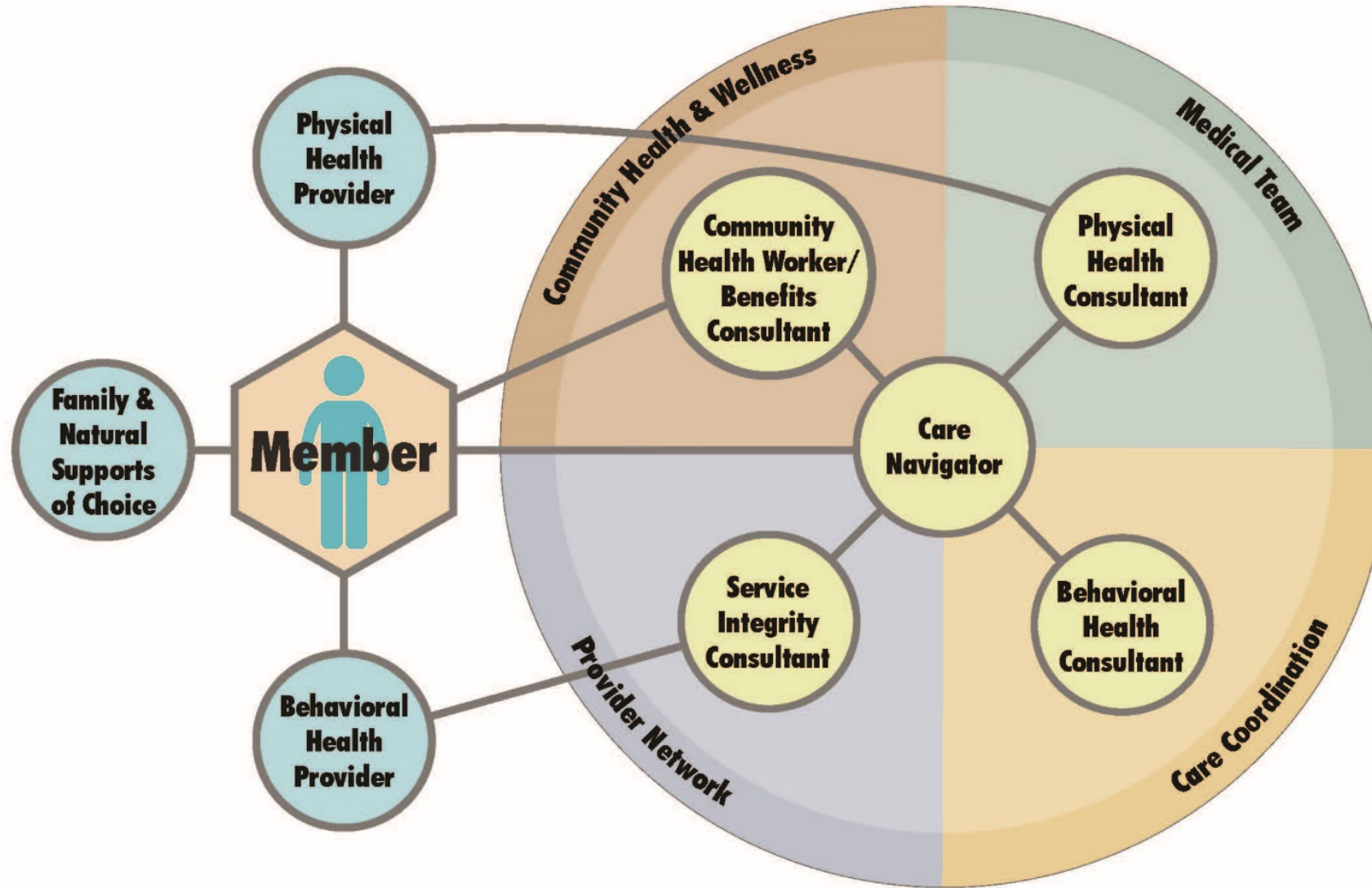
Director of Operational Integrity

Care Management

What Changed and Why?

- Preparation for tailored plan management of whole health needs
- Transitioned from one Care Coordinator providing BH case management to interdisciplinary Care Team providing whole-person care management (BH, PH, Pharmacy, and SDOH)
- Preparing to support the whole-health needs of an estimated 20,000 patients under the Tailored Plan (current census receiving CC is 6000)

Care Team Model



What Can We Expect?

- Major shift in how case management is provided
- Evolution to full implementation over a two-year learning period
- Completing modifications inclusive of stakeholder feedback
- An effective model of care management to support the unique needs of the TP population

Implementation Timeline

- 1/1/19 – 6/30/19 – IDD CC position reassignment, case reassignment, and public information sessions
- 7/1/19 – Start of LTS (IDD) Care Teams
- 10/1/19 – 6/30/20 –MHSUD CC position reassignment/case reassignment and if needed, hold additional public information sessions
- 7/1/20 – Estimated Start of MHSUD Care Teams

Assistance Needed!

- IDD Providers – we need your help to schedule monitoring visits (required in CCP 8P)
- Each member's assigned Service Consultant will be contacting you in the very near future to schedule regular monitoring visits
- Please work with the Service Consultant to get this done!



Submit additional questions to
careteam@AllianceHealthPlan.org

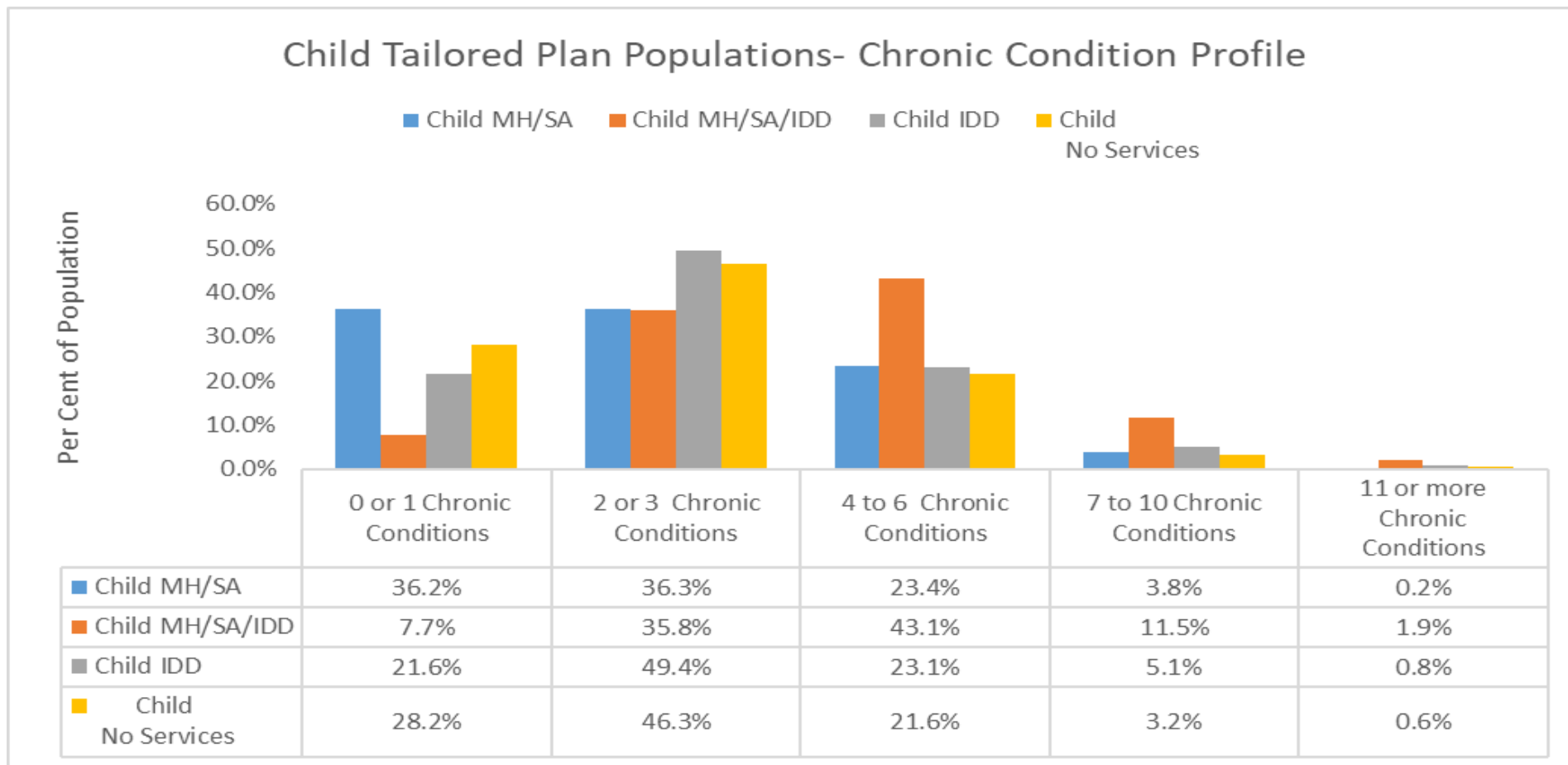
Provider-Led Care Management

Characteristics of TP Population

- Individuals eligible for a TP will:
 - Represent a complex population with multiple co-occurring behavioral and physical health conditions made more complex by issues of housing, food insecurity, economic insecurity, isolation, etc. (social determinants of health)
 - Need to access enhanced services, integrated care settings, and community supports
 - Need care management to ensure member doesn't "fall through the cracks" and during transitions

Child Tailored Plan Population

Disease Burden – in terms of chronic conditions

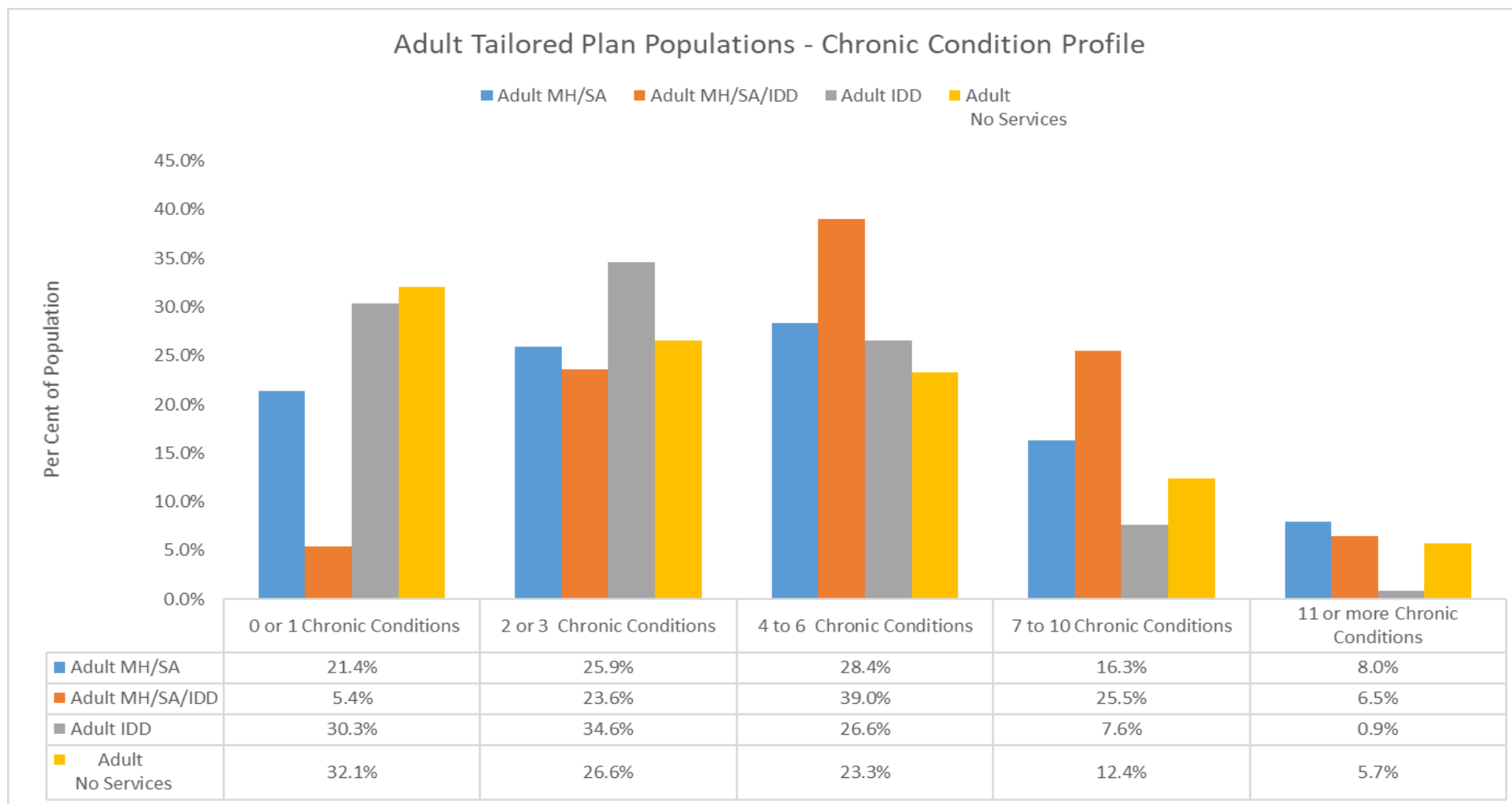


Child Tailored Plan Population Physical Health Description

Child Tailored Plan Population Description - Common Physical Health EDC Categories				
	MH/SA Population	MH/SA with I/DD	I/DD only	No Services in 2018 or 2019
Obesity	13.2%	16.6%	12.2%	12.5%
Asthma	13.0%	18.0%	6.5%	15.7%
General Neurologic Concerns	15.6% +	39.8% +	45.7%+	47.3%+
Seizure	3.9%	8.9%	13.5%	13.5%
Gastrointestinal Symptoms	1.5%	4.7%	7.2%	14.2%
Constipation	9.3%	11.1%	11.8%	10.1%

Adult Tailored Plan Population

Disease Burden – in terms of chronic conditions



Adult Tailored Plan Population

Physical Health Description

Adult Tailored Plan Population Description - Common Physical Health EDC Categories				
	MH/SA Population	MH/SA with I/DD	I/DD only	No Services in 2018 or 2019
Tobacco Use	42.2%	8.8%	1.3%	6.20%
Obesity	17.0%	24.4%	12.7%	17.60%
Respiratory Disorders	16.6% +	15.1%+	10% +	13.7% +
Hypertension	35.7%	25.8%	15.0%	27.90%
Diabetes	10.7%	6.9%	1.8%	10.40%
Renal Disease	4.4%+	2.9% +	1.7% +	7.6% +
General Neurologic Concerns	32.3%+	33.4% +	17.3% +	28.3% +
Seizure	4.6%	20.7%	24.0%	20%
Gastrointestinal Disorders	16.5%+	16.6% +	10.2% +	16.1% +
Musculoskeletal Concerns	23.3%+	15.1% +	10.8%+	16.3% +
Hepatitis C	4.6%	0.2%	0.0%	0.80%
Hypothyroidism	5.0%	12.4%	5.5%	11.80%

DHHS Goals for Care Management

- Broad Access with choice
- Single Care Manager taking integrated whole person approach
- Person/Family Centered
- Provider and Community-based
- Greater consistency across the state

Comprehensive Care Management

Complex care management is a person-centered process for providing care and support to individuals with complex needs. The care management is provided by a multi-disciplinary comprehensive care team comprised of members of the primary care team and additional members, the need for which is determined by means of a person centered needs assessment.

The comprehensive care team will focus on further assessing the individual's clinical and social needs, developing a plan to address those needs, and creating action steps so that the individual is both directing and involved in managing their care.

Overview of Tailored Care Management Approach

Department of Health and Human Services

Establishes care management standards for BH I/DD Tailored Plans aligning with federal Health Home requirements



The BH I/DD Tailored Plan will act as the Health Home and will be responsible for meeting federal Health Home requirements

BH I/DD Tailored Plan Health Home



Care Management Approaches

BH I/DD Tailored Plan beneficiaries will have the opportunity to choose among the care management approaches; all must meet the Department's standards and be provided in the community to the maximum extent possible.

Approach 1:

"AMH+" Primary Care Practice
Practices must be certified by the Department to provide Tailored Care Management.

Approach 2:

Care Management Agency (CMA)
Organizations eligible for certification by the Department as CMAs include those that provide BH or I/DD services.

Approach 3:

**BH I/DD Tailored Plan-
Employed Care Manager**

The Department anticipates allowing—but not requiring—CMAs and AMH+ practices to work with a **CIN or other partner** to assist with the requirements of the Tailored Care Management model, within the Department's guidelines.

Health Home Requirements

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care/follow-up
5. Individual and family support
6. Referral to community and social support services

* Providers must be able to use health information technology (HIT) to facilitate the health home's work and establish quality improvement efforts

Quality Measure	Measure Description
Adult Body Mass Index (BMI) Assessment	Percentage of members ages 18–74 who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year
Prevention Quality Indicator (PQI) 92: Chronic Condition Composite	The total number of hospital admissions for chronic conditions per 100,000 Health Home beneficiaries age 18 and older
Care Transition – Transition Record Transmitted to Health Care Professional	Care transitions: percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, for whom a transition record was transmitted to the facility, primary physician or other healthcare professional designated for follow-up care within 24 hours of discharge
Follow-Up After Hospitalization for Mental Illness	Percentage of discharges for members age 6 and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge
Plan All-Cause Readmission Rate	For members age 18 and older, the number of acute inpatient stays during the measurement year that were followed by both an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission

Screening for Clinical Depression and Follow-Up Plan	Percentage of patients age 18 and older screened for clinical depression using a standardized tool <i>and</i> follow-up documented
Initiation and Engagement of Alcohol or Other Drug (AOD) Dependence Treatment	Percentage of adolescent and adult members with a new episode of AOD dependence who received the following: Initiation of AOD treatment Engagement of AOD treatment
Controlling High Blood Pressure	The percentage of patients ages 18–85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year

Tailored Plan Care Management

- Everyone under the tailored plan gets care management
- Needs to be team-based with one care manager per member
- Members receive care management for as long as they are in the tailored plan
- Provider remains responsible for care management even if member is not using their behavioral health services

Tailored Plan Care Management

- Alliance has developed a support plan for providers who have capacity to offer comprehensive care management
- State will initially certify providers interested in being designated as a Care Management Agency (CMA)
- Providers either must have capacity to perform care management or a credible plan to develop capacity by July 2021 in order to be certified.
 - Clinical, administrative and IT infrastructure
 - Member volume and ability to scale

Tailored Plan Care Management

- Ability to receive and share data is critical as care management is data driven
- IT platform that supports care management workflows and activities is required
- Alliance will certify CMAs after go-live
- Application dates:
 - February 7, 2020
 - April 2020
 - September 2020
 - December 2020

Supporting Provider-Led Care Management

- Established a learning collaborative and will provide onsite support for providers interested in becoming a CMA
 - Contracted with McSilver Institute of NYU to assist in model development, create technical assistance plan, facilitate learning collaborative and conduct agency trainings
- Timely transmission of required data
- Provide access to MCO resources,
- Practice Transformation Teams

Care Team Structure

Structure: Each team serves all 3 acuity levels

Reasoning: People move from level to level, to promote better continuity of care management with individuals

Team Caseload: ~85-110 individuals

Care Team Composition

Team comprised of the following individuals:

CMA or AMH+

- 2 Care Managers: predominantly field & community-based work
- 1 Peer: engagement work

Alliance Health

- Assigned Practice Transformation Specialist (not an actual care team member) Support overall CM delivery
- Specialist consultants to care team, i.e. clinical pharmacist, housing specialist

Provider

- Physical health, behavioral health, LTSS

Overview of Associated Care Team Tasks

CMA or AMH+

- Predominantly field & community-based
- Telephonic engagement for low acuity clients
- Engagement with members lost to care
- Initiates person-centered Plan of Care

Alliance Health

- Data analysis & information sharing with CMA/AMH+
- Practice support, identify gaps and assist with QI efforts, and performance reporting
- Specialized support utilized when member's care team lacks an area of expertise

Provider

- Support and consultation for individuals engaged in care
- Provide services and accept referrals from Care Team
- When possible, participate in treatment plan development for individuals engaged in care

Integrated Health Measures

APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics

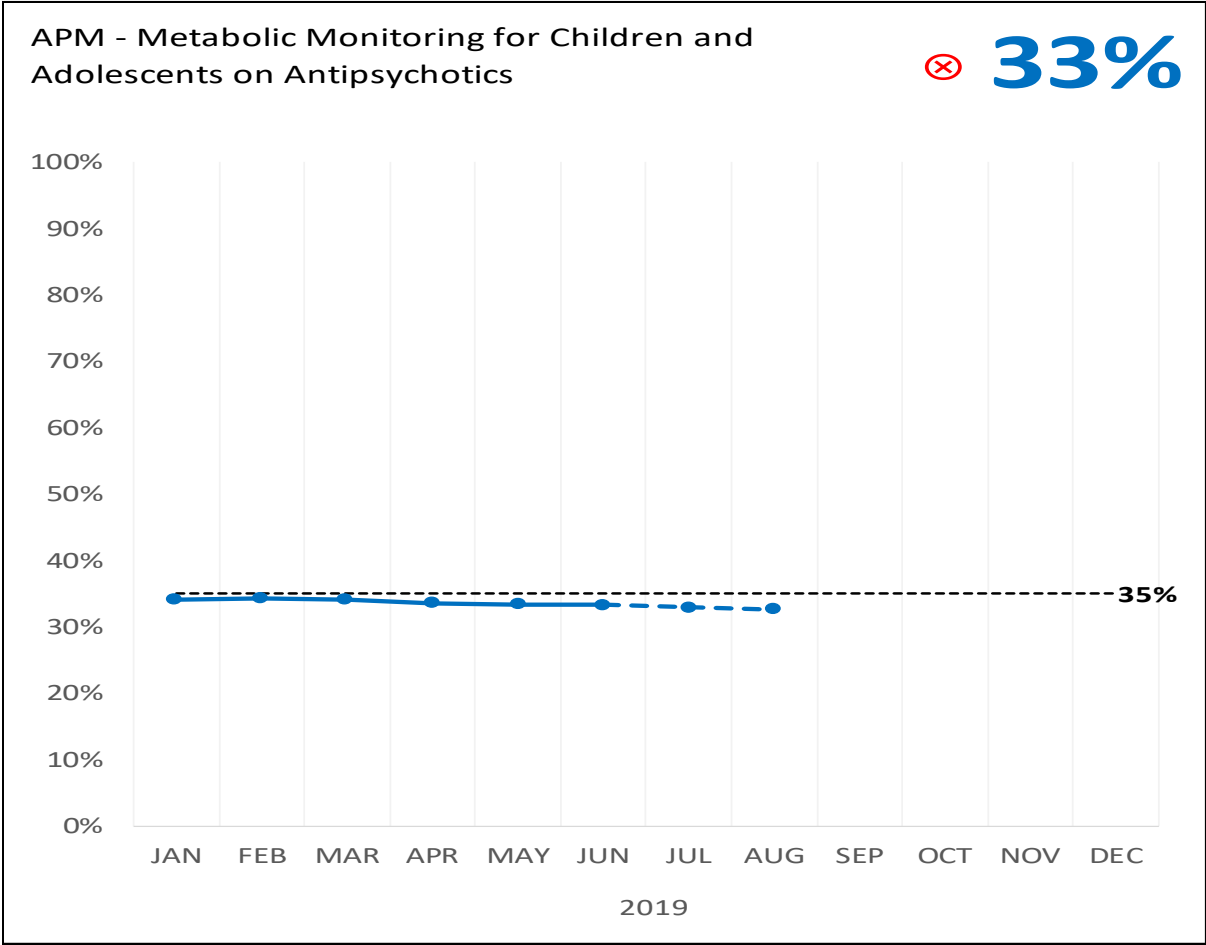
----- 2017 National Average - Alliance Target

— Performance

--- Projected Performance

⊗ Target Not Met

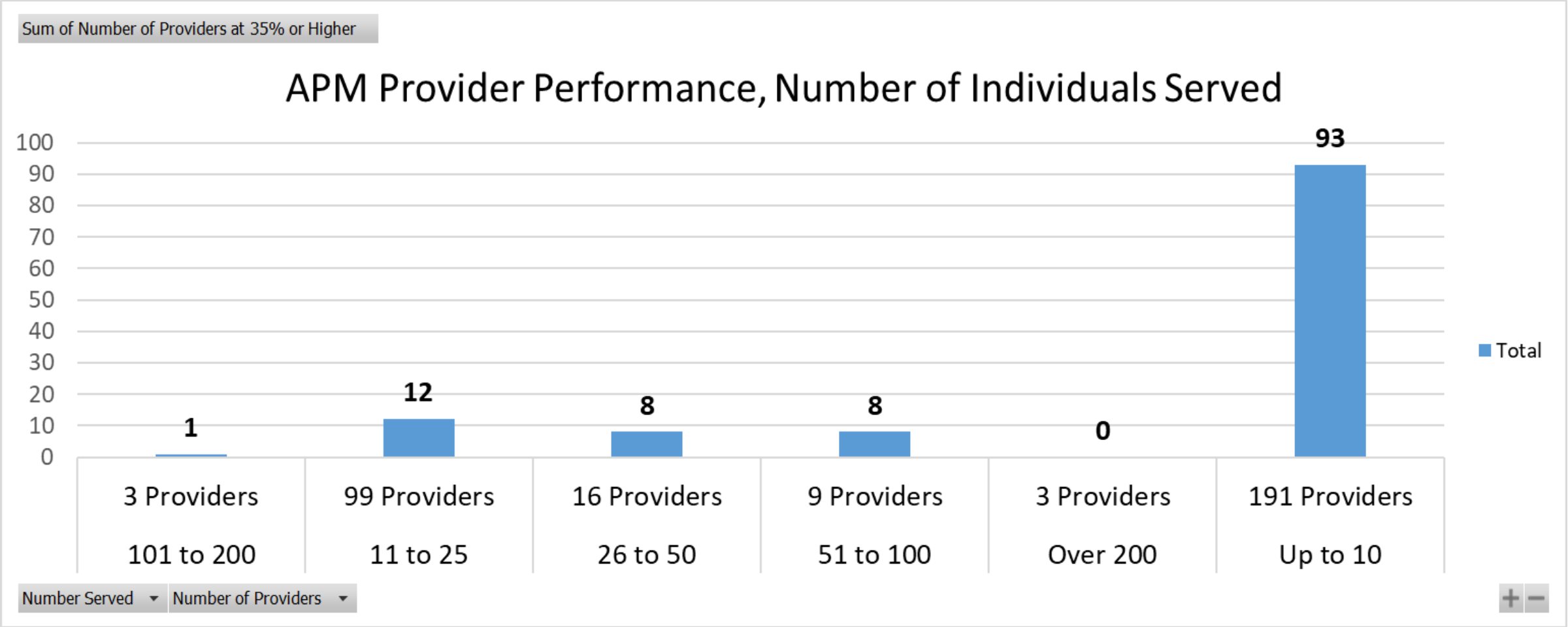
Updated: October 28, 2019



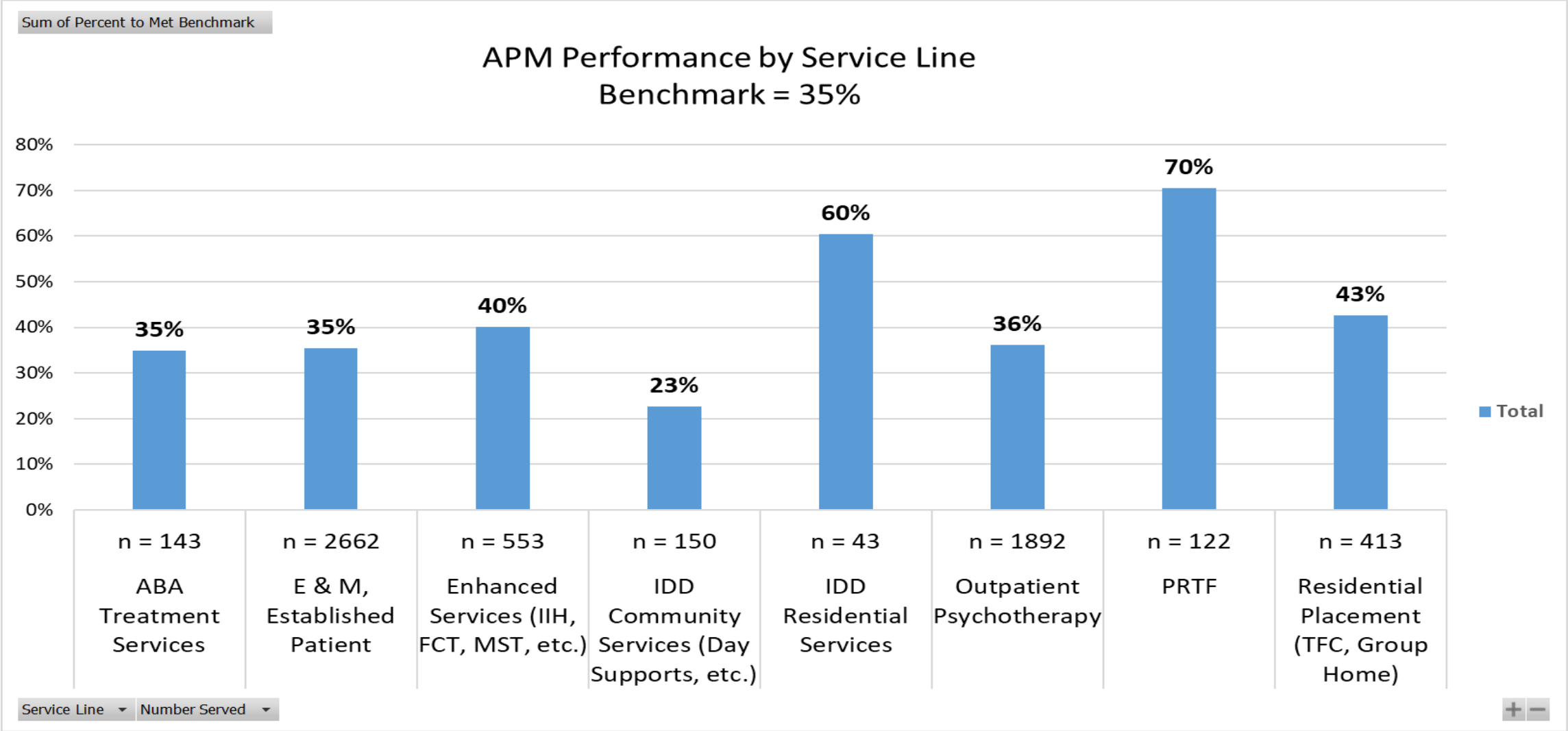
The percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Members in hospice are excluded from the eligible population. At least two antipsychotic medication dispensing events of the same or different medications, on different dates of service during the measurement year are required.

BENCHMARK = 35%

APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics



APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics



SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia

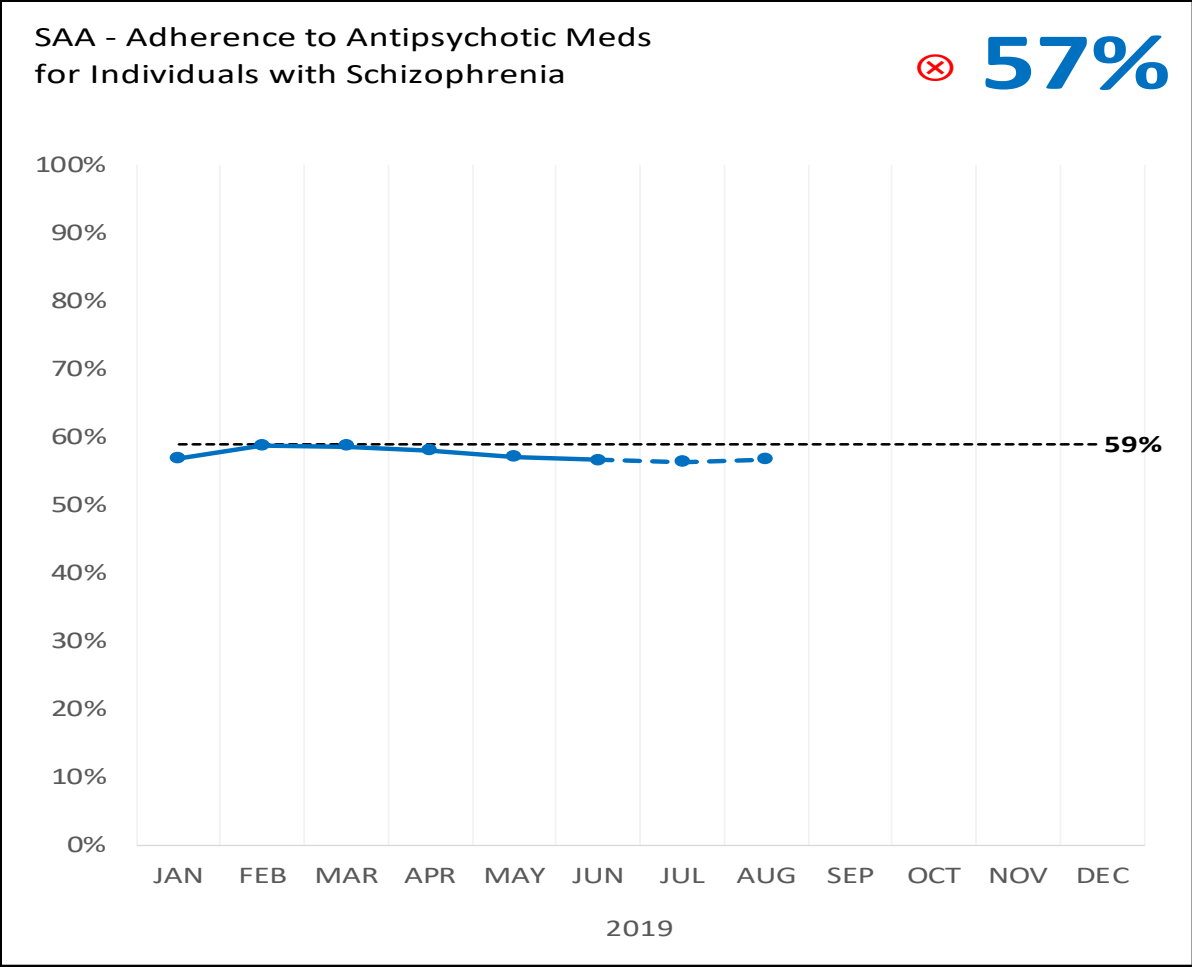
----- 2017 National Average - Alliance Target

— Performance

--- Projected Performance

⊗ Target Not Met

Updated: October 28, 2019

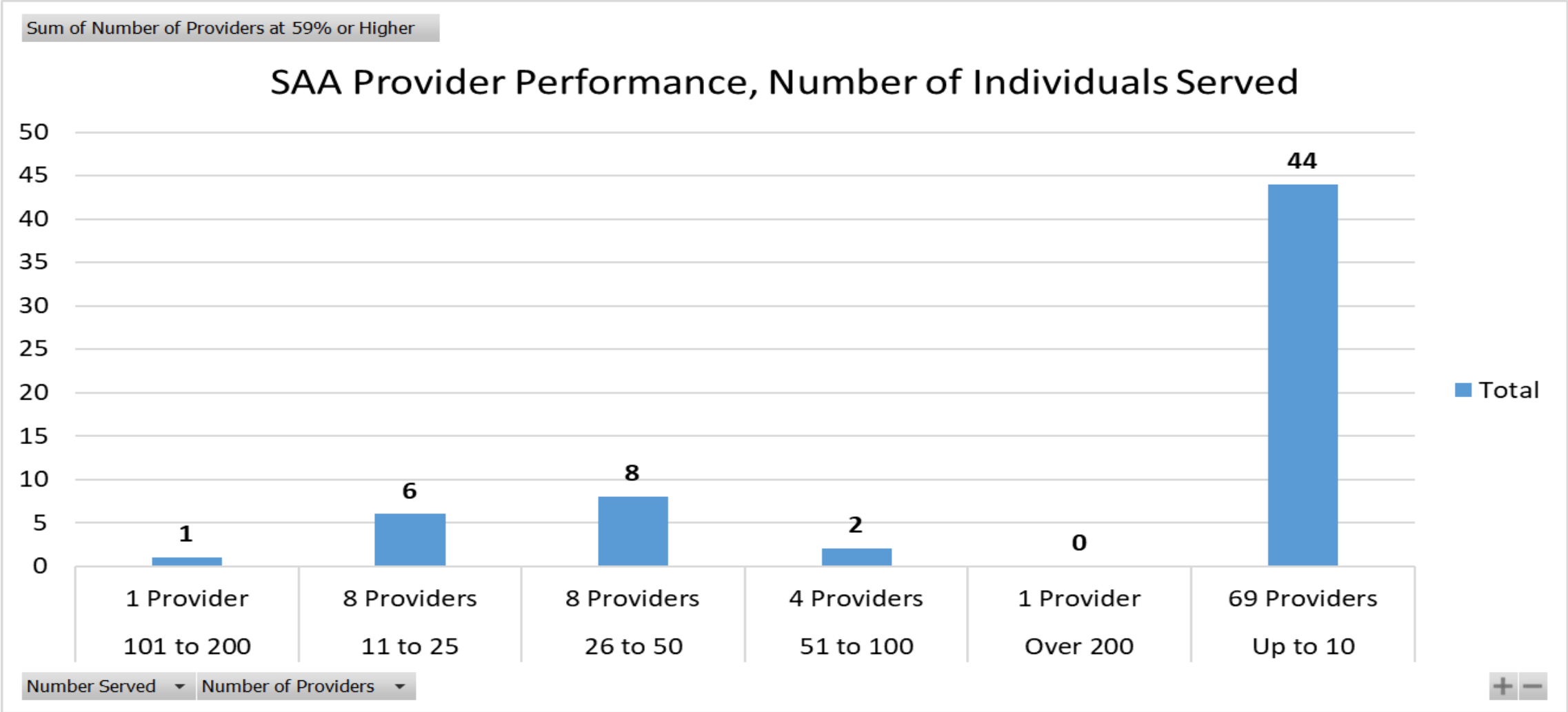


The percentage of members 19-64 years of age during the measurement period with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of there treatment period.

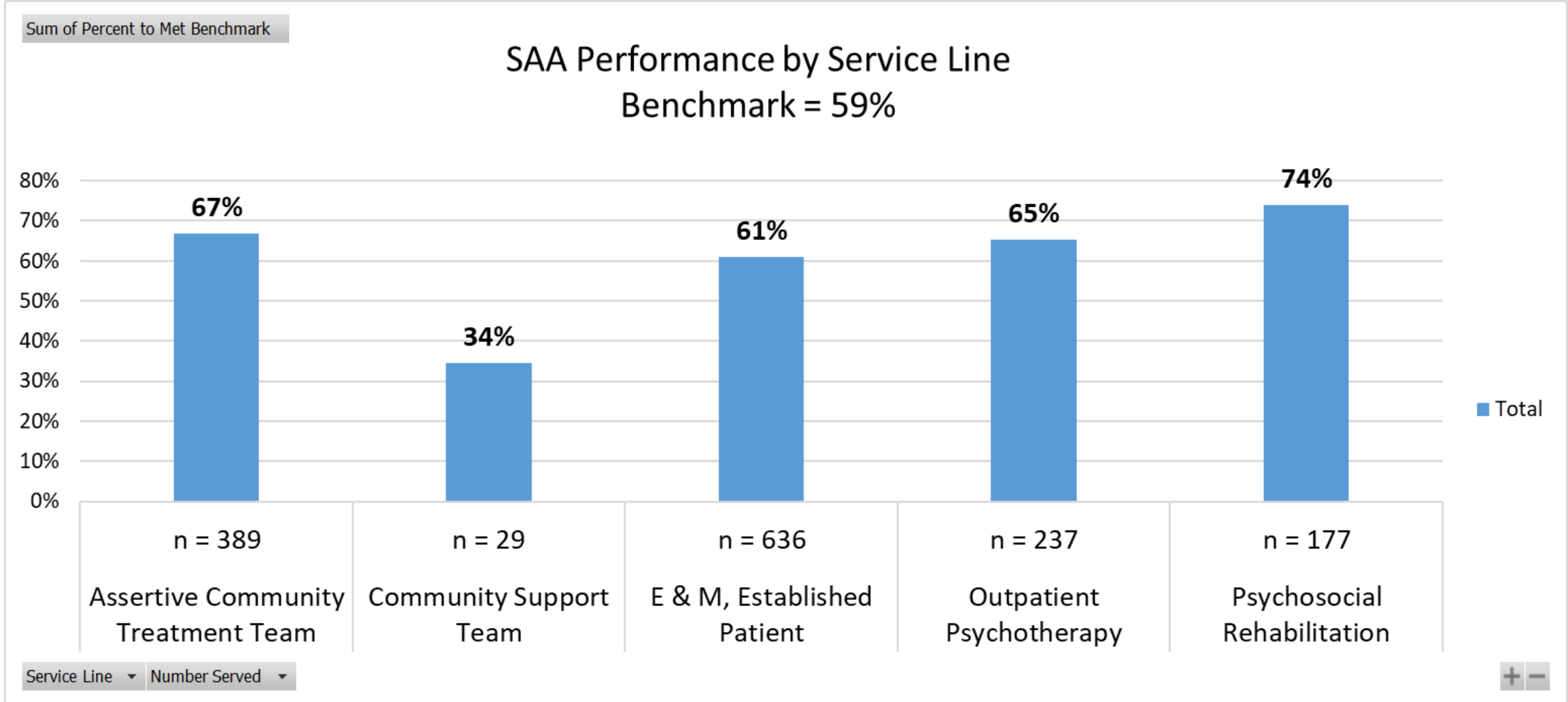
BENCHMARK = 59%

*Performance is pulled monthly, with a 12-month lookback period

SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia



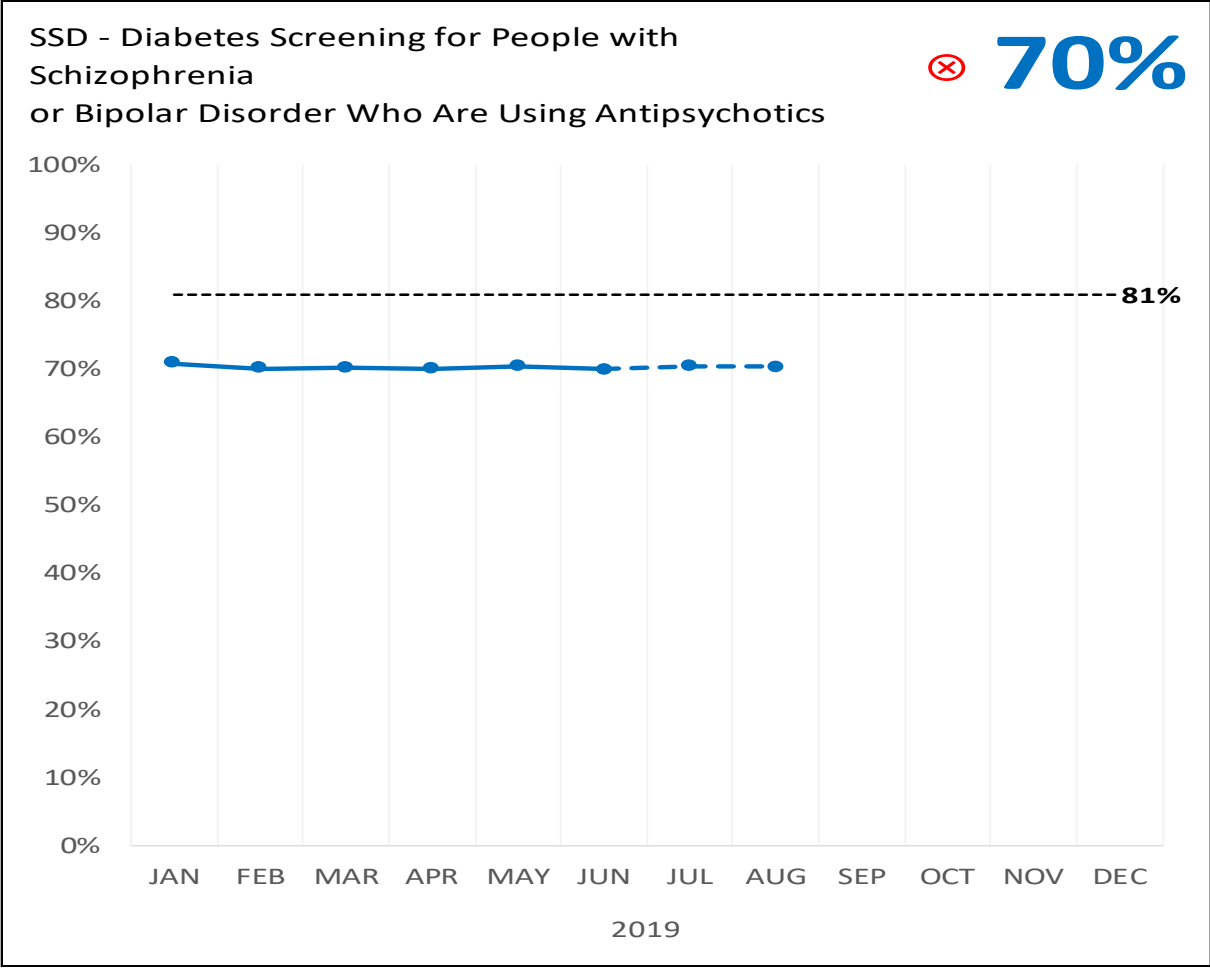
SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia



SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

----- 2017 National Average - Alliance Target — Performance - - - - - Projected Performance ⊗ Target Not Met

Updated: October 28, 2019

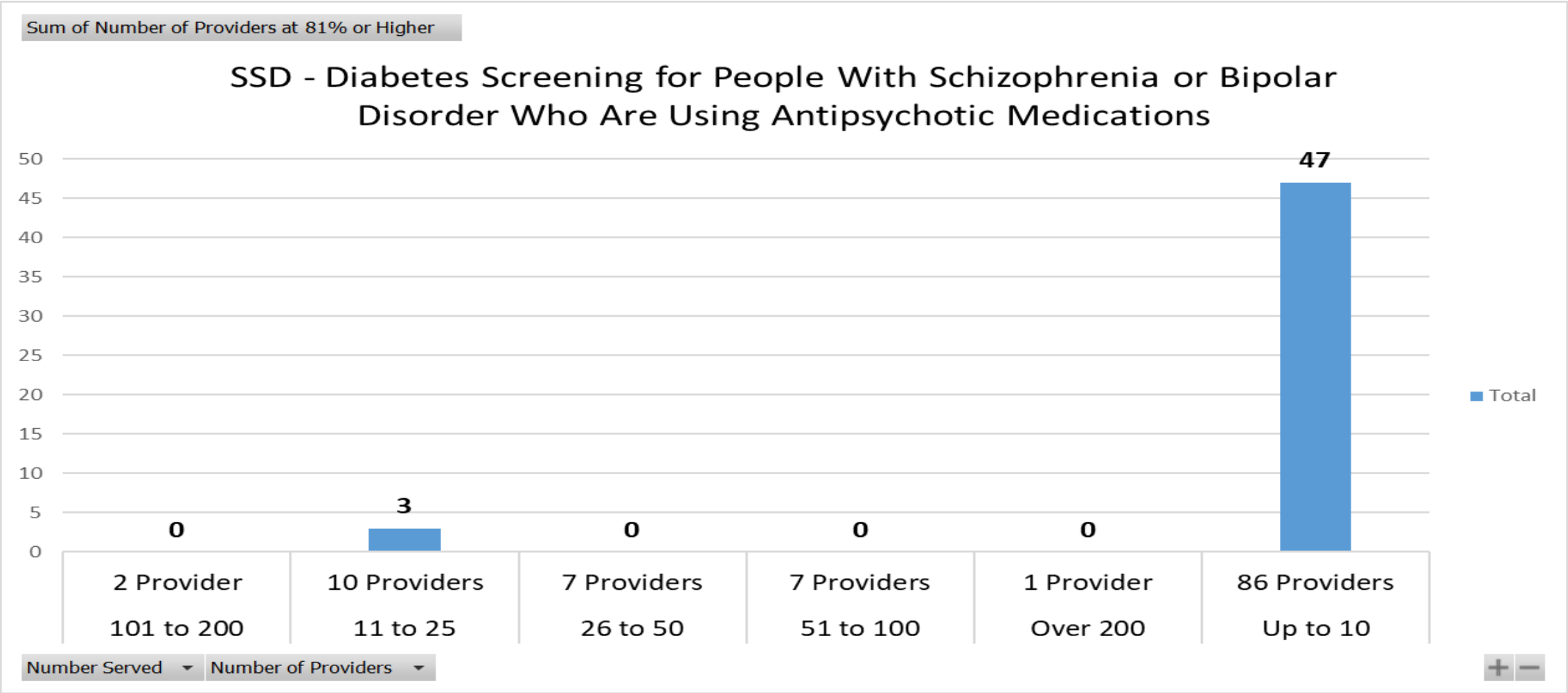


The percentage of members 18-64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement period.

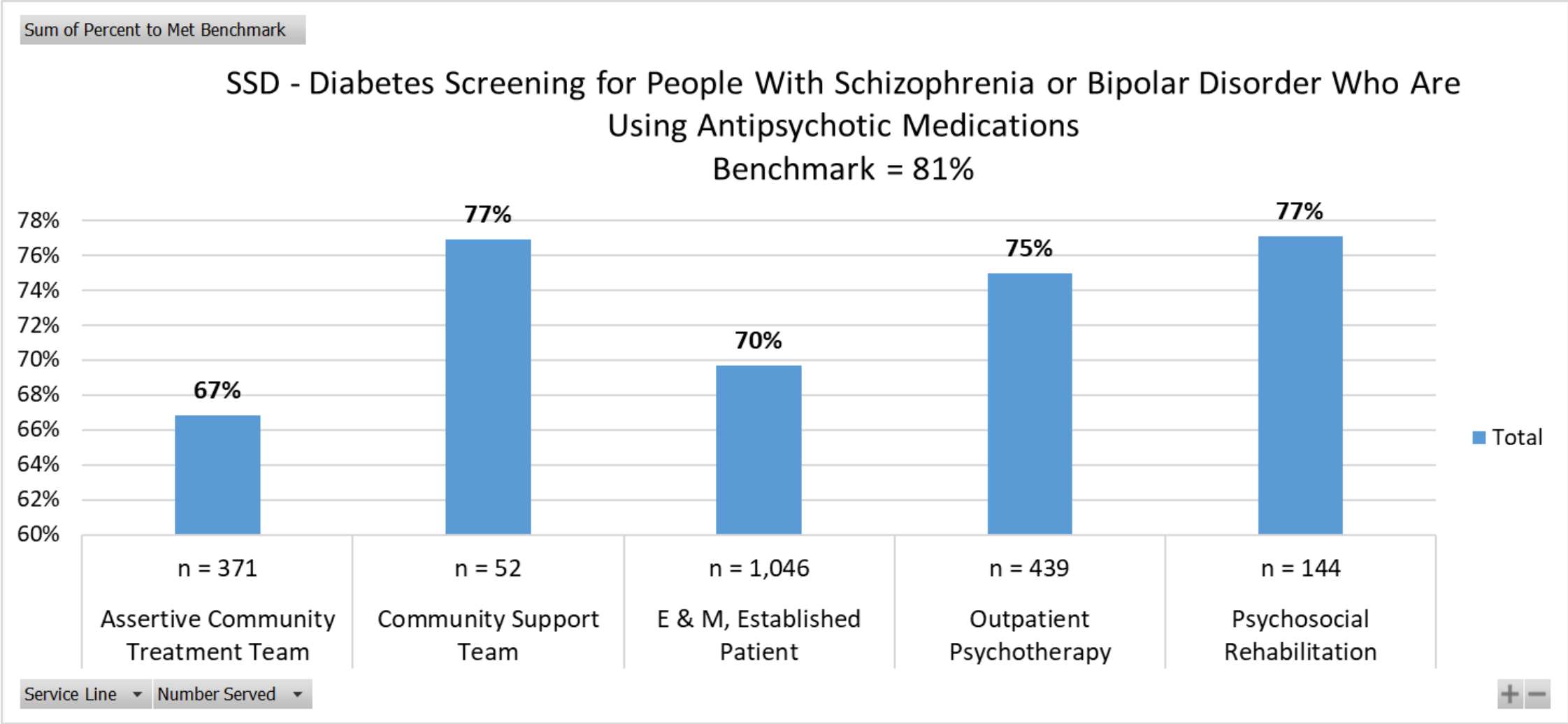
BENCHMARK = 81%

*Performance is pulled monthly, with a 12-month lookback period

SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications



SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications



Any Questions?

Thank you for coming.

Next All Providers meeting is March 11, 2020- please work with your local PAC to identify any future topics you would like to see covered in the next meeting.