All Provider Meeting
January 25, 2017
1:00pm – 3:00pm
4600 Emperor
Boulevard, Durham, NC
Rooms 104-105
Welcome and Introductions

Alliance Provider Advisory Council (APAC) Updates (Mark Germann)........

Alliance Updates

- MCO Leadership Updates (Beth Melcher)
- Legislative and Health Reform updates (Carol Hammett)
- DOJ Update (Ann Oshel)
- Outcome measures inclusion in FY18 Contracts (Kathy Niblock and Beth Melcher)
- Clinical Practice Guidelines (ADHD & Schizophrenia) update (Dr. Anderson Brown and Vera Reinstein)
- Access and Referral- Discussion on using slot scheduler (Kate Neely)
- Therapeutic Foster Care database and referrals- (Kate Peterson)
- Health Information Exchange overview (Cathy Estes)

NEXT MEETING MARCH 15, 2017 1-3 PM
Overview of DOJ Settlement: Transitions to Community Living Initiative
Olmstead V. L.C. and E.W.

- Filed on May 11, 1995 on behalf of Lois Curtis (L.C.) age 31 and Elaine Watson (E.W.) age 47 was added in 1996
- June 22, 1999 Supreme Court on a 6-3 vote rejected the state of Georgia’s appeal to enforce institutionalization of individuals with disabilities
- Justice Ruth Ginsberg
  - “States are required to place persons with mental disabilities in community settings rather than in institutions when the state’s treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.”
- Olmstead named after the Defendant, Tommy Olmstead, Commissioner of the Georgia Dept. of Human Resources
Impact of Olmstead

• In 2009 US Dept. of Justice made Olmstead a priority of its Civil Rights Division
• Courts expanded Olmstead beyond psychiatric hospitals to include:
  – All State and Medicaid funded institutions including nursing facilities
  – Individuals living in the community who were at risk of institutionalization
  – Sheltered workshops (2014 Olmstead violation Rhode Island)
  – Forensic hospitals (Georgia)
United States Vs. the State of North Carolina: “The Agreement”

• Agreement signed August 23, 2012 between the United States and the State of North Carolina

• Not an admission by the State that corrective measures are necessary to meet the requirements of the ADA, the Rehab Act or the Olmstead decision

• OR that any citizen or resident of the State is entitled to housing or a housing subsidy under the United States or NC Constitutions, the ADA, the Rehab Act, the Olmstead decision or any other federal or State law or regulation

• The agreement is intended to ensure that the State will willingly meet the requirements of the ADA, the Rehab Act and the Olmstead decision and that the goals of community integration and self-determination will be achieved

• The State disputed many of the findings and conclusions but it was in their best interest to avoid litigation

• Total of 103 requirements
Substantive Provisions: Community Based Supportive Housing

• “The State agrees to develop and implement effective measures to prevent inappropriate institutionalization and to provide adequate and appropriate public services and supports identified through person centered planning in the most integrated settings appropriate to meet the needs of individuals with SMI, who are in or at risk of entry to an adult care home”

• Community-based Supported Housing Slots
  – Will provide access to 3,000 housing slots by July 1, 2020
    • Alliance target approximately 320
  – By July 1, 2016 the State will provide housing slots to at least 1,166 individuals
    • Alliance target 128 housing slots
  – Scattered site housing with no more than 20% of the units occupied by someone with a known disability
Priority populations for housing slots

- Individuals with SMI who reside in an adult care home determined by the State to be an Institution of Mental Disease (IMD)
- Individuals with SPMI who are residing in adult care homes licensed for at least 50 beds and in which 25% or more of the resident population has a mental illness
- Individuals with SPMI who are residing in adult care homes licensed for between 20 and 49 beds and in which 40% or more of the resident population has a mental illness
- Individuals with SPMI who are or will be discharged from a State psychiatric population and who are homeless or have unstable housing
- Individuals diverted from entry into adult care homes

- 2000 housing slots provided to individuals residing in an adult care home
- 1000 housing slots provided to individuals for diversion
Substantive Provisions: Community Based Mental Health Services

- “The State shall provide access to the array and intensity of services and supports necessary to enable individuals with SMI in or at risk of entry in adult care homes to successfully transition to and live in community-based settings. The State shall provide each individual receiving a housing slot under this Agreement with access to services...”
- ACTT, CST, case management, peer support, psychosocial rehab and any other services outlined in the agreement
- “The State will hold the PIHP and/or LME’s accountable for providing access to community based mental health services in accordance with 42 C.F.R Part 438, but the State remains ultimately responsible for fulfilling its obligations under the Agreement”
Substantive Provisions: Community Based Mental Health Services

- By July 1, 2019, the State will increase the number of individuals served by ACT teams to 50 teams serving 5,000 individuals at any one time.
- By July 1, 2016, the State will increase the number of individuals served by ACT teams to 40 teams serving 4,006 individuals.
Substantive Provisions: Supported Employment

- The State will develop and implement measures to provide Supported Employment Services to individuals with SMI, who are in or at risk of entry to an adult care home, that meet their individualized needs.
- Defined as services that will assist individuals in preparing for, identifying, and maintaining integrated, paid, competitive employment.
- Services offered may include job coaching, transportation, assistive technology assistance, specialized job training and individually tailored supervision.
- By July 1, 2019 the State will provide Supported Employment Services to a total of 2500 individuals.
- By July 1, 2016 the State will provide Supported Employment Services to a total of 1,166 individuals.
Substantive Provisions: Discharge and Transition Process

• The State will implement procedures for ensuring that individuals with SMI in, or later admitted to, an adult care home of State psychiatric hospital will be accurately and fully informed about all community-based options, including the option of transitioning to supported housing, its benefits, the array of services and supports available to those in supported housing, and the rental subsidy and other assistance they will receive while in supported housing

• In-Reach and Discharge Planning
  – Transition and discharge planning will be completed within 90 days of assignment to a transition team. Discharge will occur within 90 days provided that a Housing Slot is available
Substantive Provisions: Pre-admission Screening and Diversion

• The State will refine and implement tools and training to ensure that when any individual is being considered for admission to an adult care home, the State will arrange for a determination, by an independent screener, of whether the individual has SMI.

• Once an individual is determined to be eligible for mental health services, the State and/or the PIHP and/or the LME will work with the individual to develop and implement a community integration plan.
Substantive Provisions: Quality Assurance and Performance Improvement

• The goal of the State’s system will be that all mental health and other services and supports funded by the State are of good quality and are sufficient to help individuals achieve increased independence, gain greater integration into the community, obtain and maintain stable housing, avoid harms and decrease the incidence of hospital contacts and institutionalization.

• Quality of Life Surveys
  – Implemented prior to transitioning out of the facility
  – Eleven months after transitioning
  – Twenty four months after transitioning
PROVIDER NETWORK EVALUATION

Proposed Process and Outcomes

Clinical Service Evaluation Team
Alliance Behavioral Healthcare
Overview

• DMA Requirement to include outcomes in provider contracts
• Identify outcomes associated with national or state standards
• Promote population and health outcomes
• Identify outcomes with data elements that Alliance can produce and analyze
• Use outcomes to work collaboratively with our providers to develop capacity use outcomes to improve quality of care
Proposed Reporting Structure

• Service, provider or catchment area-specific data provided by Alliance (2-3 measures)

• Providers submit Annual report that responds to data

• Report Review by ABH

• Outcomes, lessons learned, technical assistance to prepare for next set of data and annual report
GROUP TYPES

• **INTENSIVE**  IIH, MST, CST, and ACTT

• **DAY**  Day Treatment, PSR, Peer Supports, SAIOP, and SACOT

• **CRISIS**  Inpatient, Mobile Crisis, Rapid Response and FBC/CEO

• **RESIDENTIAL**  PRTF and Residential Levels I-IV
## Proposed Schedule

<table>
<thead>
<tr>
<th>Intensive</th>
<th>Day</th>
<th>Crisis</th>
<th>Residential</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2017</td>
<td>Data /baseline collection</td>
<td>Data /baseline collection</td>
<td>Data /baseline collection</td>
</tr>
<tr>
<td>July 2017</td>
<td>TA and collaboratives</td>
<td>TA and collaboratives</td>
<td>Data /baseline collection</td>
</tr>
<tr>
<td>October 2017</td>
<td>ABH provides data to provider</td>
<td>TA and collaboratives</td>
<td>TA and collaboratives</td>
</tr>
<tr>
<td>January 2018</td>
<td>Provider submits annual report</td>
<td>ABH provides data to provider</td>
<td>TA and collaboratives</td>
</tr>
<tr>
<td>April 2018</td>
<td>Annual reports reviewed</td>
<td>Provider submits annual report</td>
<td>ABH provides data to provider</td>
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<tr>
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<td>Outcomes, lessons learned, TA, next steps via collaboratives</td>
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</tbody>
</table>


Potential Outcome Measures

1. HEDIS Measures

- Adherence to Antipsychotic Medications for Adults with Schizophrenia
- Follow Up Care for Children Prescribed ADHD Medications
- Diabetes Screening for Adults with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- Integrated Care: Percentage of Adults and Children who had a primary care or preventative care visit during the measurement year
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment for Adults and Adolescents
- Follow-Up After Emergency Department Visit for Mental Illness
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence
HEDIS Example: Adherence to Metabolic Screens for Adults with Schizophrenia

Adults (age 18+) who were dispensed an antipsychotic med and had a MBS in past 12 months [n=1583]

- 29% MBS
- 71% No MBS

Reporting period: 1 year look-back from September 30, 2016
2. DMA measures (current and proposed)

- 30 Day Readmission Rates for Adult and Child Psychiatric Patients

- The Percentage of MH/SA Child and Adult Consumers Who Received At Least One Primary Care or Preventative Doctor’s Visit in the Measurement Year (Integrated Care).

- NC Topps Compliance and/or NC Topps Clinical Measures

- Timely Incident Reporting and Follow Up
### DMA Outcome Measure Example:
Alliance’s DMH Quarterly Performance Measure  Apr-June 2016

<table>
<thead>
<tr>
<th>County</th>
<th>Total Number of Readmissions within 30 days</th>
<th>Total Number of Discharges</th>
<th>Percent Readmitted Within 30 Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland</td>
<td>7</td>
<td>83</td>
<td>8.43%</td>
</tr>
<tr>
<td>Durham</td>
<td>7</td>
<td>95</td>
<td>7.37%</td>
</tr>
<tr>
<td>Johnston</td>
<td>13</td>
<td>91</td>
<td>14.29%</td>
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<tr>
<td>Wake</td>
<td>25</td>
<td>265</td>
<td>9.43%</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td>0.00%</td>
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<tr>
<td>Total</td>
<td>52</td>
<td>534</td>
<td>9.74%</td>
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</table>
3. Other Administrative Outcome Measures

- Clinical and Administrative Denial Rates
- Denied billing rates
- Cost analyses
Administrative Example:
IIH Claims Denied Rate

Alliance would provide:

➢ the top 3 denial reasons for claim denials for IIH and

➢ average denial rate for IIH.

Providers could answer the following questions:

➢ What is your analysis of the root cause of this rate?

➢ Explain any barriers related to denied claims?

➢ Does your agency routinely analyze denied claims data?

➢ What’s working or not working?

<table>
<thead>
<tr>
<th>Provider</th>
<th>Number of Claims</th>
<th>Number of Denied Claims</th>
<th>Claims Denied Rate</th>
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<tbody>
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<td>1</td>
<td>3</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>2</td>
<td>13</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>3</td>
<td>4514</td>
<td>30</td>
<td>0.66%</td>
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<tr>
<td>4</td>
<td>1405</td>
<td>19</td>
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<td>4241</td>
<td>70</td>
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<td>6</td>
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<td>15</td>
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<td>1</td>
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<td>24</td>
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<td>25</td>
<td>993</td>
<td>246</td>
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<tr>
<td>26</td>
<td>612</td>
<td>319</td>
<td>52.12%</td>
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<tr>
<td>Totals</td>
<td>52439</td>
<td>2961</td>
<td>5.65%</td>
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</table>
Next Steps

• Get feedback from key Alliance departments

• Get feedback from providers through APAC

• Identify Elements and begin to create reports to review/validate

• January-February begin to roll out to broader provider community

• Outcomes added to Medicaid contracts for FY 18
Clinical Practice Guidelines
ADHD and Schizophrenia

All Provider Meeting
1/25/2017

Tedra Anderson-Brown, M.D.
Shruti Mehta, M.A.
Vera Reinstein, Pharm.D.
What are clinical practice guidelines and what purpose do they serve?

- Systematically developed statements to assist practitioners and patients in making decisions about appropriate health care for specific circumstances.

- Not intended to be a substitute for clinical judgment

- Institute of Medicine

- Provide a more rational basis for referral
- Promote efficient use of resources
- Act as focus for quality control
- Reduce inappropriate variation in practice
- Describe appropriate care based on the best available scientific evidence and broad consensus
- Highlight shortcomings of existing literature & suggest future research
Clinical Guideline Requirements

- NCQA and URAC require the MCO to have Clinical Practice Guidelines.
- URAC requires the Medical Director of the MCO to chair a group of experts from the provider network to produce them.
- Experts from the field who have expertise in Mental Health, IDD or Substance Use Disorders, Adult, Child and Geriatric, or any combination.
Alliance Clinical Guidelines

Disclaimer: Clinical Practice Guidelines have been developed nationally by a variety of expert sources including the American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), American Society of Addiction Medicine (ASAM), Substance Abuse and Mental Health Services Administration (SAMHSA) and other national and international societies, government/VA/DoD, and other care delivery systems such as Magellan and Managed Care organizations (MCOs). When national guidelines are unavailable, work groups comprised of Alliance staff, providers and consultants who are experts in their fields have developed clinical guidelines. All of these guidelines have been reviewed and adopted by the Alliance Clinical Advisory Committee to assist providers and consumers alike in the clinical decision making process for a variety of mental health and substance use disorders with the goal of improved patient management and enhanced quality of care. As a result of this explosion of knowledge, concerns about the quality of care, access and cost and to determine “appropriate” or “reimbursable” care, it is necessary to describe the range of treatments available for patients with Mental Illness, Behavioral Disorders and/or Substance Use Disorders.

Clinical Practice Guidelines clearly and concisely document what is known and what is not known about a condition or disorder for the treatment of patients with the ultimate goal of improving care. These guidelines reflect evidence based treatment, but are not intended to be service definitions, or medical necessity criteria, though they may overlap. Additionally, guidelines should enhance individualized care, sound clinical practice and good judgment. Guidelines also do not supersede federal and/or state regulations. Alliance will continue to review, revise and update its approved clinical practice guidelines. Your comments and suggestions are welcome.
## Alliance Behavioral Healthcare Website

http://www.alliancebhc.org/providers/alliance-clinical-guidelines/

<table>
<thead>
<tr>
<th>Condition</th>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>Obsessive-Compulsive Disorders in Children and Adolescents</td>
<td>300.3</td>
<td>[AAM Practice Parameters for the Assessment and Treatment of Children and Adolescents with Anxiety Disorders](<a href="http://www.alliancebhc.org/providers/alliance-clinical-guidelines/clinical-guidelines/">http://www.alliancebhc.org/providers/alliance-clinical-guidelines/clinical-guidelines/</a> obsessive-compulsive-disorders)</td>
</tr>
<tr>
<td>Obsessive-Compulsive Disorders in Adults</td>
<td>300.3</td>
<td>[APA Practice Guideline for the Treatment of Patients with Obsessive-Compulsive Disorder](<a href="http://www.alliancebhc.org/providers/alliance-clinical-guidelines/clinical-guidelines/">http://www.alliancebhc.org/providers/alliance-clinical-guidelines/clinical-guidelines/</a> obsessive-compulsive-disorders)</td>
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<tr>
<td>Opioid Treatment for Adults</td>
<td>304.00, 306.50</td>
<td><a href="http://www.alliancebhc.org/providers/alliance-clinical-guidelines/clinical-guidelines/opioid-treatment">SAMH National Practice Guidelines for the Use of Medications in the Treatment of Addiction Involving Opioid Use</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.cdc.gov">CDC Guideline for Prescribing Opioids for Chronic Pain</a></td>
</tr>
<tr>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.alliancebhc.org/providers/alliance-clinical-guidelines/clinical-guidelines/opioid-treatment">Prescribing Resources</a></td>
</tr>
<tr>
<td>Oppositional Defiant Disorder</td>
<td>313.81</td>
<td><a href="http://www.alliancebhc.org/providers/alliance-clinical-guidelines/clinical-guidelines/oppositional-defiant-disorder">AAM Practice Parameters for the Assessment and Treatment of Children and Adolescents with Oppositional Defiant Disorder</a></td>
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<tr>
<td>Panic Disorder in Children and Adolescents</td>
<td>300.01, 300.21</td>
<td><a href="http://www.alliancebhc.org/providers/alliance-clinical-guidelines/clinical-guidelines/panic-disorder">AAM Practice Parameters for the Assessment and Treatment of Children and Adolescents with Anxiety Disorders</a></td>
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<td>Panic Disorder in Adults</td>
<td>300.01, 300.21</td>
<td><a href="http://www.alliancebhc.org/providers/alliance-clinical-guidelines/clinical-guidelines/panic-disorder">Practice Guideline for the Treatment of Patients with Panic Disorder</a></td>
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<tr>
<td>Post-Traumatic Stress Disorder in Children and Adolescents</td>
<td>309.81, 309.81</td>
<td><a href="http://www.alliancebhc.org/providers/alliance-clinical-guidelines/clinical-guidelines/post-traumatic-stress-disorder">AAM Practice Parameter for the Assessment and Treatment of Children and Adolescents with Post-Traumatic Stress Disorder</a></td>
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<td>Post-Traumatic Stress Disorder in Adults</td>
<td>309.81, 309.81</td>
<td><a href="http://www.alliancebhc.org/providers/alliance-clinical-guidelines/clinical-guidelines/post-traumatic-stress-disorder">APA Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Post-Traumatic Stress Disorder</a></td>
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</table>
QUALITY REVIEWS FOR GUIDELINE ADHERENCE

Alliance QM department conducted quality reviews focusing on pharmaceutical data elements.
CPGs apply approximately 75% of time (i.e. in most cases)

Children in treatment for ADHD:
Use of approved meds
Participation in psychosocial interventions

Adults in treatment for Schizophrenia:
Use of approved meds
Regular medical monitoring (metabolic screens)
Methodology

1. CMT* custom reports to obtain data:

   **ADHD:**
   - Children ages 3-17 with an ADHD dx code;
   - Behavioral health services claims within the past 90 days;
   - List of medications filled in past 90 days.

   **Schizophrenia:**
   - Adults 18+ with a Schizophrenia or Schizoaffective dx code;
   - Metabolic screenings within the past 12 months: hemoglobin A1c; Fasting glucose; HDL; triglycerides; comprehensive panels;
   - List of medications filled in past 12 months.

2. Link with AlphaMCS claims data

3. Analyze to determine adherence, type of BH services, identify target group for interventions.

* Care Management Technologies’ ProAct Analytics reports on general Medicaid population
Findings

ADHD:

➢ Of the children who had received a behavioral health service from an Alliance network provider, 74% had an ADHD-approved medication prescription filled during the reporting period.
Next Steps:

ADHD:

- Provider feedback to address quality care consideration.
  - Those children receiving therapy from an Alliance network provider, who may not be receiving ADHD-approved medications (i.e. did not have ADHD medication utilization data within CMT).
- Provider education on clinical practice guidelines.
- Global outreach to pediatric and family practices within our catchment area to promote integrated care and provide resources on child behavioral health services.
Findings

Schizophrenia:

- Medicaid + Private: 1%
- Medicaid + Medicare: 45%
- Medicaid only: 54%

Antipsychotic Meds Dispensed:
- Atleast 1 Rx Fill: 80%
- No Rx Fills: 20%
Findings

Schizophrenia:

- Of the adults who had received a behavioral health service from an Alliance network provider, and had at least one antipsychotic prescription filled in past 12 months, 71% had MBS screens.

![Pie chart showing 71% MBS and 29% No MBS]
NEXT STEPS

SCHIZOPHRENIA:

- Provider feedback to address quality care consideration.
  - Those adults receiving BH services from Alliance network provider, who may not be receiving Schizophrenia approved medications or not adhering to best practices to monitor metabolic functioning.

- Provider education on clinical practice guidelines and general medication adherence.

- Expand report parameters to include additional MBS and dive deeper into the data so that we can determine adherence rates.
For every 100 prescriptions written...

- 66-48 are picked up
- 30-25 are taken properly
- 20-15 are refilled as prescribed

70-50 go to a pharmacy


AllianceBHC.org
Medication Taking “Lingo”

<table>
<thead>
<tr>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>The extent to which a patient conforms to healthcare provider recommendations regarding timing, dosage and frequency of taking medication. 1 Patient agreement with the recommendations is not required. 2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adherence</th>
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</thead>
<tbody>
<tr>
<td>The extent to which a patient’s behavior—taking medications, and/or executing lifestyle changes—corresponds with healthcare provider recommendations agreed upon by the patient. Patient agreement with the recommendations is required. 2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Persistence</th>
</tr>
</thead>
<tbody>
<tr>
<td>The act of continuing to take medication for the prescribed duration of time from initiation to discontinuation of therapy. The patient may continue to take any amount of medication and be considered persistent. 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Concordance</th>
</tr>
</thead>
<tbody>
<tr>
<td>The process of reaching a consensus about medication taking which focuses on adequate communication and the clinician-patient relationship as the cornerstones of the medication-taking process and addresses whether recommendations are “right or wrong”. 3</td>
</tr>
</tbody>
</table>

ADHD: Adherence and Persistence

• ½ patients DC Rx stimulants after 3 months

• Only one-fifth fill prescriptions continuously
  Can J Psychiatry, Vol 49, No 11, November 2004

• Adolescence: adherence rates decrease
  72% (age 11 years) → 32% at age 15 years
  Dev Behav Pediatr. 2006 Feb;27(1):1-10

• Prospective COMPLY: 504 pts/1 year –
  atomoxetine 67.5%, psychostim 74.2% adherence
  Atten Def Hyp Disord (2015) 7:165.doi:10.1007/s12404-014-0156-8
Stimulants: Half Stop within 3 months

Survival distribution of methylphenidate hydrochloride treatment for attention-deficit/hyperactivity disorder. ER-MPH indicates extended-release methylphenidate; IR-MPH, immediate-release methylphenidate.

ADHD: Adherence and Persistence

• Prospective studies (adults & children): non-adherence 15-83% tend to have inflated results; clinical trial populations
• Retrospective claims analysis: 27-85% tx dc rates/180 dys more real world; Rx fills indicate possession not ingestion
• LA formulations better adherence & persistence
  – 22% adherence
  – 73.5% DC rate within 180 day period
• Inconsistent definitions & measures across studies
• Non-adherence: parent report 3% → 24.8% saliva sampling

ADHD: Treatment Dropout Reasons

• Lack of understanding
  – why they were taking the medication
  – tx could prevent severe consequences later in life
• Expect treatment cured ADHD
Schizophrenia and Medication Non-adherence

- The norm > 60%
  - Estimated to impact > 1/3 of patients with SCZ every year
  - At least 50% of patients DX w/ SCZ became partially adherent or non-adherent within 1 year and 75% within 2 years of discharge
    - 1975-1996 Adherence - Antipsychotics at 58% (CW 65% AD, 75% for physical disorders)
- Clinically underestimated
- Not a stable trait
  - VA study of 34K SCZ/4 years *MPR* (overestimates); 36% poor adherence Q year; 36% consistently good; 18% consistently poor adherence; 43% inconsistently adherent;
- NOT one-time NOR one-size-fits-all solution: crucial to assess each persons reasons on an ONGOING basis and tailor strategies to address med adherence
- Single largest predictor of SCZ relapse risk is patient’s DC their medication
- Non adherence to meds linked with inc hospital, emergency psych care, > 2X arrest/violence/crime victim, substance misuse 3 yr prospective OBS US study
Adherence Measures: Sources of Error

- Plasma concentration
- Pharmacy record
- Pill count
- MEMS
- Samples, old prescription bottles
- Removing multiple doses
- Behavior in the days immediately preceding assessment

MEMS, electronic monitoring.
Hospitalization Rates Associated With Degree of Adherence

Hospitalization Rates by Measures of Adherence in Patients With Schizophrenia

<table>
<thead>
<tr>
<th>Measure</th>
<th>Hospitalization Rate</th>
<th>Statistical Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>MPR ≥70</td>
<td>4.0%</td>
<td>P &lt; 0.001</td>
</tr>
<tr>
<td>MPR &lt;70</td>
<td>10.4%</td>
<td>P &lt; 0.001</td>
</tr>
<tr>
<td>Consistency ≥70</td>
<td>4.0%</td>
<td>P &lt; 0.001</td>
</tr>
<tr>
<td>Consistency &lt;70</td>
<td>9.6%</td>
<td>P &lt; 0.001</td>
</tr>
<tr>
<td>Persistence ≥90</td>
<td>5.5%</td>
<td>P = 0.1096</td>
</tr>
<tr>
<td>Persistence &lt;90</td>
<td>8.2%</td>
<td></td>
</tr>
<tr>
<td>Medication gaps 1-10 days</td>
<td>2.3%</td>
<td></td>
</tr>
<tr>
<td>Medication gaps &gt;30 days</td>
<td>10.1%</td>
<td>P &lt; 0.001</td>
</tr>
</tbody>
</table>

Mean cost for a hospital stay for schizophrenia: $7,500

Cost for schizophrenia-related hospital stay is higher than the average hospital stay without a major operating room procedure.

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Medication Gaps Associated With Hospitalization Rates

Study population: patients with schizophrenia.

Non-Adherence is Underestimated

Rates of Nonadherence Assessed in Patients Diagnosed With Schizophrenia by Various Assessment Methods

<table>
<thead>
<tr>
<th>Adherence assessment method</th>
<th>Nonadherence (%) in a 12-week study (N = 52)</th>
<th>Nonadherence (%) in a 6-month study (N = 61)</th>
<th>Nonadherence (%) in a 12-month study (N = 44)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipsychotic plasma level</td>
<td>51</td>
<td>57</td>
<td>39</td>
</tr>
<tr>
<td>Electronic monitoring</td>
<td>37</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Physician impression</td>
<td>34</td>
<td>Physician impression</td>
<td>Claims data (MPR)</td>
</tr>
<tr>
<td>Pill count</td>
<td>25</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Patient self-report</td>
<td>14</td>
<td>Patient self-report</td>
<td>Physician impression</td>
</tr>
</tbody>
</table>

Methods to Improve Adherence

• Expect and plan for non-adherence/non-persistence
  – assess patient attitude/beliefs toward medication
  – identify root cause of non-adherence
    69% behaviors, 16% cost, 15% SE
  – combined psychosocial interventions
• Enlist community pharmacy support cpesn.com locator
• Consider LA meds – LA-S/LAI earlier in appropriate candidates
• Technology: electronic reminders
Schizophrenia adherence tool
https://www.psychu.org/brief-adherence-rating-scale/

**BRIEF ADHERENCE RATING SCALE**

_The following information is obtained by the clinician:_

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How many pills of ____________ (name of antipsychotic) did the doctor tell you to take each day?</td>
<td>Few, if any (&lt;7)</td>
</tr>
<tr>
<td></td>
<td>7-13</td>
</tr>
<tr>
<td></td>
<td>14-20</td>
</tr>
<tr>
<td></td>
<td>Most (&gt;20)</td>
</tr>
<tr>
<td>2. Over the month since your last visit with me, on how many days did you NOT TAKE your ____________ (name of antipsychotic)?</td>
<td>Always/Almost Always (76-100% of the time) = 1</td>
</tr>
<tr>
<td></td>
<td>Usually (51-75% of the time) = 2</td>
</tr>
<tr>
<td></td>
<td>Sometimes (26-50% of the time) = 3</td>
</tr>
<tr>
<td></td>
<td>Never/Almost never (0-25% of the time) = 4</td>
</tr>
<tr>
<td>3. Over the month since your last visit with me, how many days did you TAKE LESS THAN the prescribed number of pills of your ____________ (name of antipsychotic)?</td>
<td>Note: 1 = poor adherence</td>
</tr>
<tr>
<td></td>
<td>4 = good adherence</td>
</tr>
</tbody>
</table>

*Please place a single vertical line on the dotted line below that you believe best describes, out of the prescribed antipsychotic medication ____________ doses, the proportion of doses taken by the patient in the past month.*

Response struck on above line (%) = ____________

Rater’s Initials: ____________________________

September 2015    MRC2.CORP.X.00461
Medication Adherence

Next Steps

• Alliance
  – Improve data accuracy - NEED PROVIDER FEEDBACK!
  – texting platform with care coordinators
  – failure to fill project
  – deeper data analysis - NEED PROVIDER FEEDBACK!
  – Clozapine support
  – LAI

• Providers
  – Feedback
  – Identify non-adherence and incorporate strategies in clinic flow to assess and improve adherence
Referrals

Communicating with Call Center
Purpose

• Call Center is responsible for screening, triage and referral in 4 counties.

• Call Center manages close to 6000 calls each month.

• Call Center is open 24/7/365.

• Alliance Behavioral Healthcare (Alliance) has contracts with more than 1000 agencies – providing a range of services, across multiple settings, to various demographics.
Communication

• Communication is critical to ensure members are connected to the most appropriate providers.
• Communication improves providers’ ability to document benchmarks met.
• Communication improves the experience for members, provider staff and call center staff.
How?

Using Alpha and the Slot Scheduler

1. Providers alert Call Center to availability and populations served.
2. Call Center staff alert providers to clinical information for referrals.
Alpha: Provider Scheduler

Access instructions by logging into Alpha.

From Menu (dropdown) select University.
Alpha: Provider Slot Scheduler

The Provider Scheduler module is utilized to handle consumer referrals. Many agencies have regularly scheduled times that they can handle referrals. You are able to set these up in the Provider Scheduler so that the MCO knows your availability and can schedule appointments appropriately.

To launch the Provider Scheduler, click Menu > Provider Scheduler

Module View
Creating Slots
Slots on the Calendar

Managing the Appointment
Consulting the Referral
Notifications and Rescheduling

Creating Slots

Create available slots for the MCO to refer consumers to your agency. Find the time you want to create the slot for and double click.

NOTE: If your company is set up as an Open Access provider, you won’t be able to create open slots in the Provider Scheduler. You can check to see if your company is one of these providers by going to the Provider Details module, Provider Base site. Refer to the Provider Details document.

NOTE: You are not allowed to schedule walk-ins to slots, these are reserved for the MCO. However, you can reschedule MCO referrals to other slots.
Alpha: Provider Slot Scheduler

**Slots on the Calendar**

Now that I've created my open slots, I can view them for the month by clicking the Month calendar view:

After a Consumer is Referred

Once a consumer is referred, everyone at your agency with a partial user account will receive an email alerting so. You can confirm and record the results of the appointment from the scheduler:

**Managing the Appointment**

To manage the appointment, you want to first locate it on your schedule then double click the slot. After double clicking the slot, the below window will open for you to manage the appointment.
Alpha: Provider Slot Scheduler

Completing the Referral

Since this is an Enrollment Request, and once the appointment is in session, you can go to your Enrollment Module and use the filter to search for enrollments that were placed into your client's record.

Results

Once you have completed the task at hand, in this case an enrollment and assessment, you can now go back to your provider scheduler, open the appointment and choose Attended, then SAVE to complete.

By now you have noticed block changes colors as the MCO begins to reserve slots:

- If a block is GREEN, that means all the slots in it are still available. For example, if you have three slots and all three are still available, the block will be green.
- If a block is YELLOW, some of the slots have been reserved but not all. If you have one or two of these slots still available, the block will be yellow.
- If a block is RED, all the blocks have been reserved. All these slots have been reserved and nothing else can be scheduled here.

NOTE: You can go to the appointment and double click on it to check the Acknowledgment checkboxes so the MCO knows you're aware of the appointment. Once the appointment has/had not happened, you can go back into the appointment and enter a Status. This information appears on the MCO side once saved.

What if the Consumer Cancels, then Reschedules?

If a consumer is a No Show, cannot be reached or reschedules then you can always ask the consumer when their initial appointment was, or you can refer back to the consumer's enrollment form that was handed over to you by the MCO and review the Provider Attempts section on the bottom of the Clinical Page of the Enrollment (if you do not know off hand).

Updating original Appointment then rescheduling

New Appointment View on 12/5/13 after clicking SAVE
Alpha: Provider Referral Search

In the Referral Search module, Portal Users will be able to search appointments made by the MCO for the Provider.

Menu > Referral Search

Menu options include:
- Notes: Will bring up any ‘notes’ associated with the referral with other information from the MCO.
- Scheduler: By clicking on this, the user will be brought to the Scheduler.
- View Docs: This will show you any documents attached to the referral for the provider to be aware of.
- Update: Clicking update will save any changes made to the Status, New Date, New Start Time, New End Time, and Acknowledgement.
- View Screening Report: This is a report of Screening Tools and Questions from the MCOs call with the consumer.

** Please note that the only information included in the report will be what is input into the system. If the MCO does not use the Screening Tools then no information will populate. **
www.Alliancebhc.org

• http://www.alliancebhc.org/providers/alpha-provider-portal/
• http://www.alliancebhc.org/using-the-provider-slot-scheduler/
Sample of Best Practice: Open Access
Sample of Best Practice cont’d:
Walk-In
Sample of Best Practice cont’d:
Traditional

[Image of a software interface showing an appointment entry form with fields for Subject, Description, Start Time, End Time, Number of Available Slots, Disability, Age Range, and Funding Source.]
Sample of what to avoid

![Edit Appointment – AlphaMCS](image)

<table>
<thead>
<tr>
<th>Appt ID</th>
<th>Patient Name</th>
<th>Start Time</th>
<th>End Time</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>850795</td>
<td></td>
<td>09:30AM</td>
<td>11:00AM</td>
<td></td>
</tr>
</tbody>
</table>
More of what to avoid
Things to Consider

• Your Business Model
  – In-home assessments vs. Office Based
  – Access to language line
  – Access to a prescriber
  – Special services (populations served)
  – One staff managing the calendar for multiple therapists or multiple therapist managing their own appointments
  – Office Hours (Evenings, Weekends, Holidays)
  – State Funds vs. Medicaid Funds

• Make sure your appointments clearly identify the type of referral you want and how you plan to meet with referrals for at least the 1st visit.
More things to consider

• We schedule appointments 24 hrs a day.
• We schedule discharge appointments for hospitals, crisis centers and prisons in our catchment area.
• We schedule for initial assessments (We do not schedule for outpatient therapy, medication management, or enhanced services – these all require a referral based on an assessment).
• We schedule for individuals without insurance (State, Uninsured, IPRS)
• We schedule for individuals with Medicaid from our catchment area regardless of where they live.
THERAPEUTIC FOSTER CARE INFORMATION

Did you know that anyone can make a referral for Therapeutic Foster Care by going to www.ncrapidresource.org? Referrals go to all Alliance Network providers. Instructions are found here:


All referrals for TFC to Alliance Network Providers must be entered into the RRFF Database. By doing this our providers are able to match placements for best geographic location and treatment program and give choices to referrers. Moves are also tracked. In order to have optimal consideration for an open bed, please enter as much information as you possibly can. Therapeutic Foster Care unlike other residential options requires a “matching process”. This process entails cross referencing a list of youth and family treatment needs with the demographics and strengths of the treatment family. Our goal is to have one treatment placement for a youth as multiple TFC placements can contribute to cumulative trauma.

Questions about making a referral? contact@ncrapidresource.org
Questions about Alliance TFC: kpeterson@alliancebhc.org

Thank you for helping us get the best outcomes for youth and families!
Any referral entered by a provider agency: consult your internal policies and procedures regarding ROI’s. You can have a release to Rapid Resource for Families/Alliance Network if your policies and procedures allow. If your agency wants a list of Network providers, please email Kate Peterson and she will be happy to provide one.
Referral into the database

• www.ncrapidresource.org

Alert goes to Alliance Network TFC Approved Users

• Alliance TFC Provider Staff

Provider Staff view and determine Yes, No, Maybe-if maybe,

• Disposition maybe or yes, provider works the referral, disposition no, the referral disappears from provider’s screen.

Provider gets more information from the referrer to determine appropriate match

Placement date set with legal custodian and TFC agency
NC Health Information Exchange Authority
Overview
ARE YOU PREPARED?
https://hiea.nc.gov/

• The information contained in this overview comes from https://hiea.nc.gov/

• Source: NCHICA Update October 2016
General Background

What is a health information exchange and who is the NC HIEA?

A health information exchange is a secure and electronic network that gives authorized health care providers the ability to access and share health-related information across a statewide information highway. It exists to improve health care quality, enhance patient safety, improve health outcomes, and reduce overall health care costs by enabling health information to be available securely whenever doctors, nurses and patients need it.

The North Carolina Health Information Exchange Authority (NC HIEA) was created by the North Carolina General Assembly to oversee and administer the state-designated HIE (NCGS 90-414.7). They will receive input and advice from an Advisory Board consisting of patients, hospital systems, physicians, technology experts, public health officials and other key stakeholders to continuously improve the HIE Network, now called NC HealthConnex, and move towards more efficient and effective care.
Who is “required” to use NC HealthConnex?

The new law requires that as of February 1, 2018, all Medicaid providers must be connected and submitting data to NC HealthConnex in order to continue to receive payments for Medicaid services provided. By June 1, 2018, all other entities that receive state funds for the provision of health services, including local management entities/managed care organizations, also must be connected. (NCGS 90-414.4)
What does connected mean?

To meet the state’s mandate, a Medicaid provider is “connected” when its clinical and demographic information pertaining to services paid for by Medicaid and other State-funded health care funds are being sent to the NC HealthConnex at least twice daily – either through a direct connection to NC HealthConnex or via a hub (i.e. a larger system with which it participates, another HIE with which it participates, or EHR vendor). Participation agreements signed with the designated entity would need to list all affiliate connections.
I am a behavioral health or substance abuse treatment provider in North Carolina. Am I required to connect to NC HealthConnex?

If you are a behavioral health provider that bills NC Medicaid for reimbursement for behavioral or mental health services, you are required to connect to the HIE Network, now called NC HealthConnex, by February 1, 2018.

How do I connect to NC HealthConnex?

1) The first step in connection is reviewing and signing the Participation Agreement. If you have questions regarding this process, please contact Alice Miller via email alice.miller@nc.gov or by phone 919-754-6912.
2) The second step is to have an ONC-certified EMR product that can send HL7 version 2.0 and higher.
3) The third step is to identify three points of contact within your medical practice that will collaborate with the NC HIEA and the technology partner, SAS, to complete a successful connection.
Do you have a list of EMR systems that support connection to NC HealthConnex?

Any ONC-ATB certified EMR product that can send HL7 version 2.0 and higher will support the connection to NC HealthConnex. Following is a list of EMR vendors that are connected to NC HealthConnex currently (October 2016) or that they have experience with building the connection:

Allscripts Professional
Allscripts Touchworks
Amazing Charts
Aprima
AthenaHealth
Centricity
CureMD
eClinicalWorks
Epic
Greenway Primesuite
McKesson Practice Partners
Medinformatix
MicroMD
NextGen
Patagonia
**EHR Integrations** - The NC HIEA continues to work with a list of EHR vendors (Allscripts, AthenaHealth, eClinical Works, Cure MD) to build multi-tenant connections that will enable participants to access patient records in NC HealthConnex via an EHR integration. They hope to have these agreements in place in the near term so that those healthcare providers who have signed Participation Agreements with the NC HIEA can begin utilizing NC HealthConnex for the secure exchange of patient information. They recommend that healthcare providers contact your EHR vendor and request their timeframe for connection so you can begin your planning and preparations.
What happens if my practice doesn’t want to connect to NC HealthConnex?
Recently passed legislation requires that as of February 1, 2018, all Medicaid providers must be connected to the HIE in order to continue to receive payments for Medicaid services provided. By June 1, 2018, all other entities that receive state funds for the provision of health services, including local management entities/managed care organizations, must be connected.
General Inquiries
Email: hiea@nc.gov
Phone: 919-754-6912
The NC HIEA Business Office regular hours are Monday through Friday 9 a.m. to 5 p.m.

Mailing Address:
NC Health Information Exchange Authority
Mail Service Center 4101
Raleigh, NC 27699-4101
Other News
Last Year to Get Started in the NC Medicaid EHR Incentive Program - If you haven’t already heard, the NC Medicaid EHR Incentive Program gives eligible providers the chance to earn $63,750 over six years if they are using their certified EHR to meet Meaningful Use. Program Year 2016 is the last year to start participating and the last year to receive a first year payment of $21,250. If you’re an eligible provider type with a certified EHR and you see 30% Medicaid patients, now is the time to get started. There are resources available to help you attest for a payment. The NC Medicaid EHR Incentive Program has attestation guides to walk you through the process step by step, a library of FAQs, webinars to bring it all to life and a dedicated help desk to answer your questions. Visit [https://www2.ncdhhs.gov/dma/provider/ehr.htm](https://www2.ncdhhs.gov/dma/provider/ehr.htm) for more information and attest today!