Nine Competencies for High Performing Behavioral Health Organizations in the New Healthcare Reform Environment

Alameda County

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Agenda

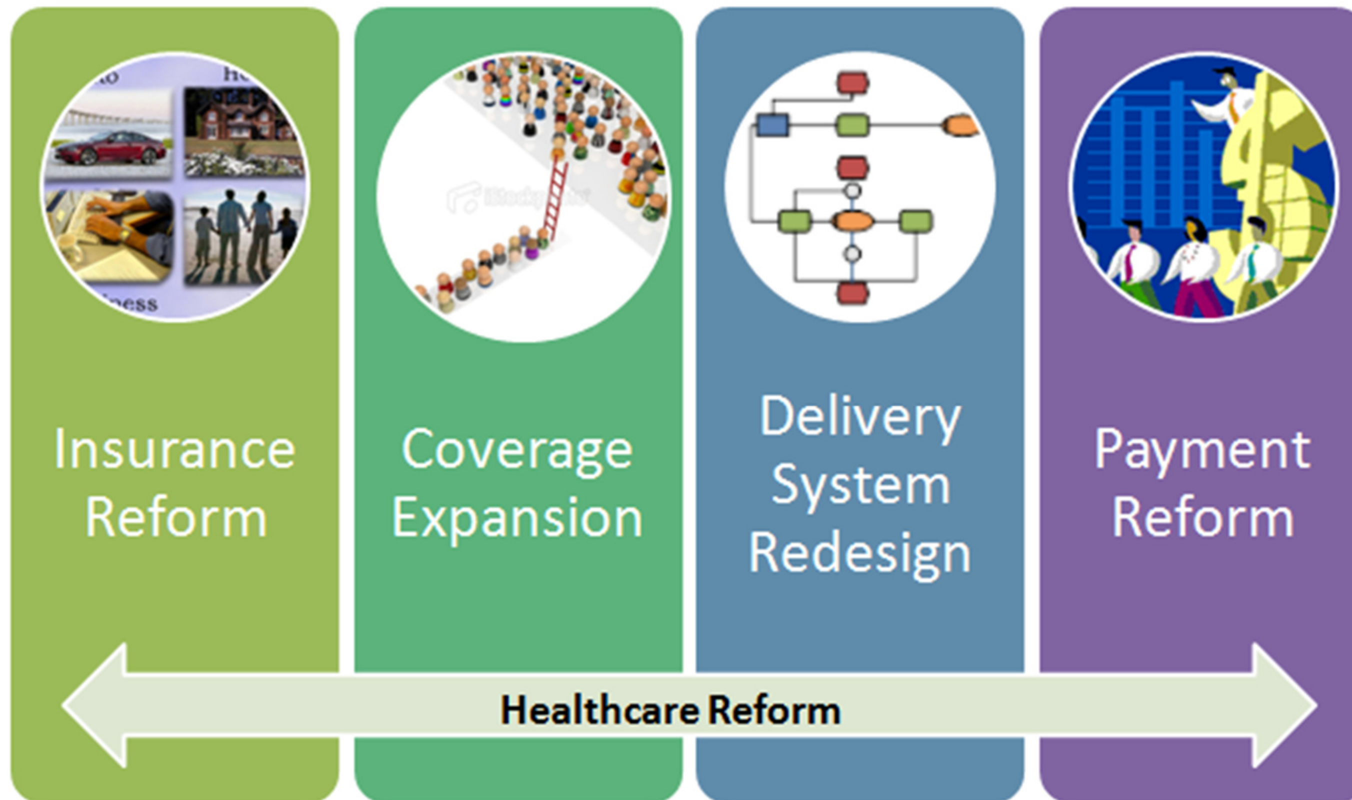
- Basics of Healthcare Reform and Parity
- Bi-Directional Integration Using the Four Quadrant Model
- Nine Competencies of High Performing Behavioral Health Organizations

The Basics of Healthcare
Reform and Parity

Healthcare Reform & Parity Changes Everything…..

- The Affordable Care Act (ACA) triggers dramatic changes in how health and MH/SU services are ***organized***
- These changes create a tipping point in how the ***healthcare needs of persons with serious mental illness*** and the ***MH/SU healthcare needs of all Americans*** are addressed
- Which will change the way MH/SU services are ***funded and fit into the new healthcare ecosystem***
- ***But state economic crises forces reduction in services while the future requires expanded access to better integrated services to improve quality and flatten the cost curve***
- Can we plan for a very different future while trying to hold the safety net together?

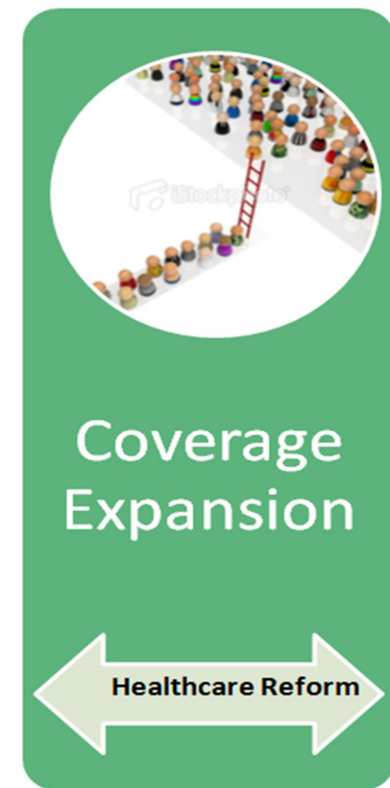
National Healthcare Reform
Four Key Strategies



U.S. health care reform is moving forward to address key issues
- Charles Ingoglia, National Council

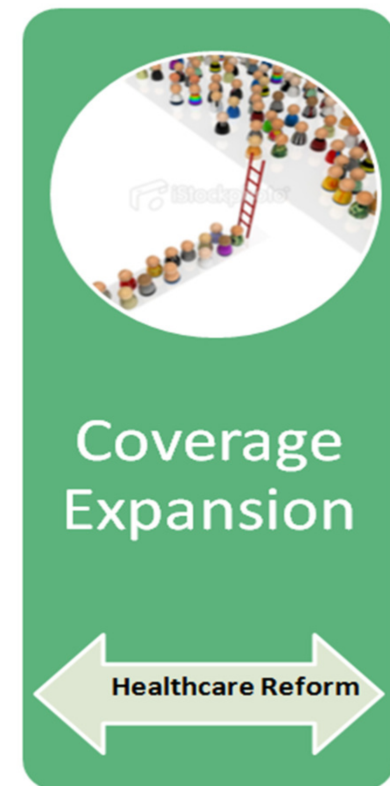
Coverage Expansion: Federal Healthcare

- The New Health Care Reform Law:
  - Requires most individuals to have Coverage
    - Insurance Mandate being challenged as “unconstitutional”
  - Creates State Health Insurance Exchange
    - CA first state to pass legislation: currently being established
  - Employer Coverage Requirements (>50 employees)
  - Small Business Tax Credits



Coverage Expansion: Federal Healthcare

- The New Health Care Reform Law:
  - Provides Credits & Subsidies up to 400% Poverty (FPL)
    - CA 1115 Waiver designed to move to 200 % FPL (Healthcare Coverage Initiative HCCI)
  - Expands Medicaid to 133% of fed poverty level
    - CA 1115 Waiver designed to move to this benchmark (MediCal Expansion – MCE)



Parity – General Information on Interim Final Regulations

- Apply for plan years beginning July 1, 2010
- General rule – parity applies if a plan offers medical/ surgical and MH/SUD benefits (> 50 employees)
  - Applies to Medicaid Managed Care
  - Will apply to Medicaid benchmark plans beginning in 2014
- A plan may not apply any **financial requirement** or **treatment limitation** to MH/SUD benefits in any classification that is **more restrictive** than the **predominant** requirement or limitation for **substantially all** medical/surgical benefits in the same classification

Coverage Expansion – Parity Legislation

- HCR builds on parity, and includes:
  - Large Employers (Parity Act)
  - Managed Medicaid Plans (Parity Act & Reform Legislation)
  - Health Insurance Exchanges for Individual and Small Group Policies (Health Reform Legislation)
  - Medicare: more to do (Medicare Improvements Act – MIPPA)
  - A mandate that the mental health and substance use benefits that are required of plans offered through the Exchanges will apply to those newly eligible for Medicaid through the expansion.

Key Question: will Insurance companies provide adequate "scope of services" needed for persons with SMI/SED?

Parity Requirements/Limitations

- **Financial requirements** – e.g., deductibles, copayments, coinsurance, out-of-pocket maximums
- **Treatment limitation requirements** – cannot limit benefits based on frequency of treatment, number of visits, days of coverage, days in a waiting period, and "**other similar limits on the scope and duration of treatment" unless same limits on other benefits**
  - **Quantitative treatment limitation** – expressed numerically, e.g., annual limit of 50 outpatient visits
  - **Nonquantitative treatment limitation** – not expressed numerically but otherwise limits the scope or duration of benefits

Coverage Expansion: Most Members of the Safety Net will have Coverage including MH/SU

- 15 M increase in Medicaid enrollees (43%)
- 16 M increase in privately insured (8%)

Impact of U.S. Health Reform on Coverage for Non-Elderly
Senate Finance Committee Reform Bill

	Current Law 2019 (Millions)	Reform Impact (Millions)	Reform Total (Millions)	Reform Impact %
Medicaid/CHIP	**35**	**15**	**50**	**43%**
Private/Other Insured	**193**	**16**	**209**	**8%**
Covered Non-Elderly	**228**	**31**	**259**	

Coverage Expansion: Most Members of the Safety Net will have Coverage including MH/SU

- $15 to $23 billion in added spending for MH/SU from insurance expansion
- No credible info yet on $ impact of Parity Act

Senate Healthcare Reform Bill	2019
Medicaid & SCHIP Expansion	$87,000,000,000
Healthcare Exchange Subsidies	$106,000,000,000
Total Expansion Funding	$193,000,000,000
Behavioral Health Spending @ 8%	$15,440,000,000
Behavioral Health Spending @ 10%	$19,300,000,000
Behavioral Health Spending @ 12%	$23,160,000,000

Insurance Reform

- The New Healthcare Reform Law:
  - Requires guaranteed issue and renewal
  - Prohibits all annual and lifetime limits
  - Bans pre-existing condition exclusions
  - Will create an essential health benefits package that provides comprehensive services *including MH/SU at Parity*
  - Requires health plans to spend 80%/85% of premiums on clinical services
  - Creates a new Health Insurance Rate Authority to provide oversight at the Federal level and help States determine how rate review will be enforced

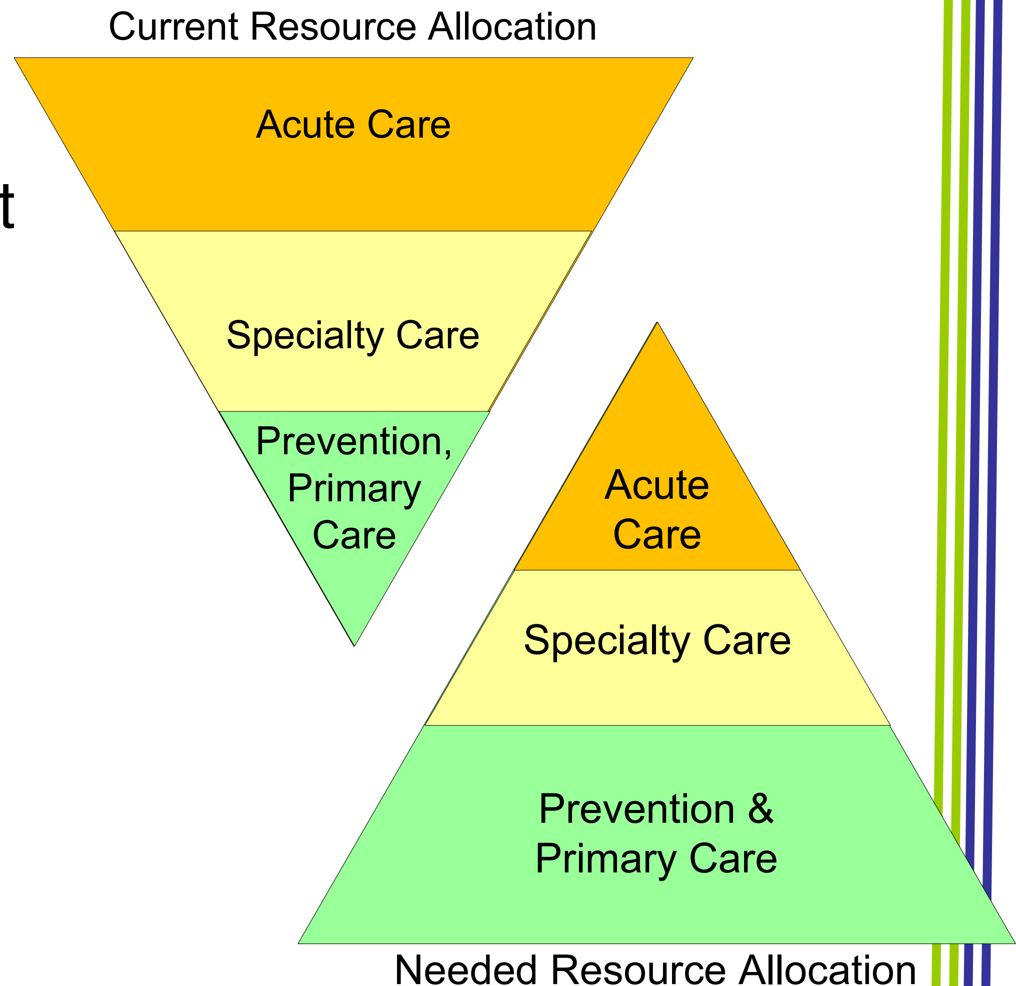
Service Delivery Redesign

- Institute for Healthcare Improvement's Triple Aim*
  - Improve the health of the population
  - Enhance the patient experience of care (including quality, access, and reliability)
  - Reduce, or at least control, the per capita cost of total healthcare

*Donald Burwick, MD, IHI Founder and current CMS Administrator

Achieving the Triple Aim

- Need to invert the Resource Allocation Triangle
- Prevention activities must be funded and widely deployed
- Primary Care must become a desirable occupation and…
- Services for MH/SU disorders must be integrated and robust
- Decrease demand in the specialty and acute care systems
- These are dramatic shifts that will not magically take place



CA Integrated Policy Initiative

- Conclusion:

ALL HEALTH CARE IS LOCAL

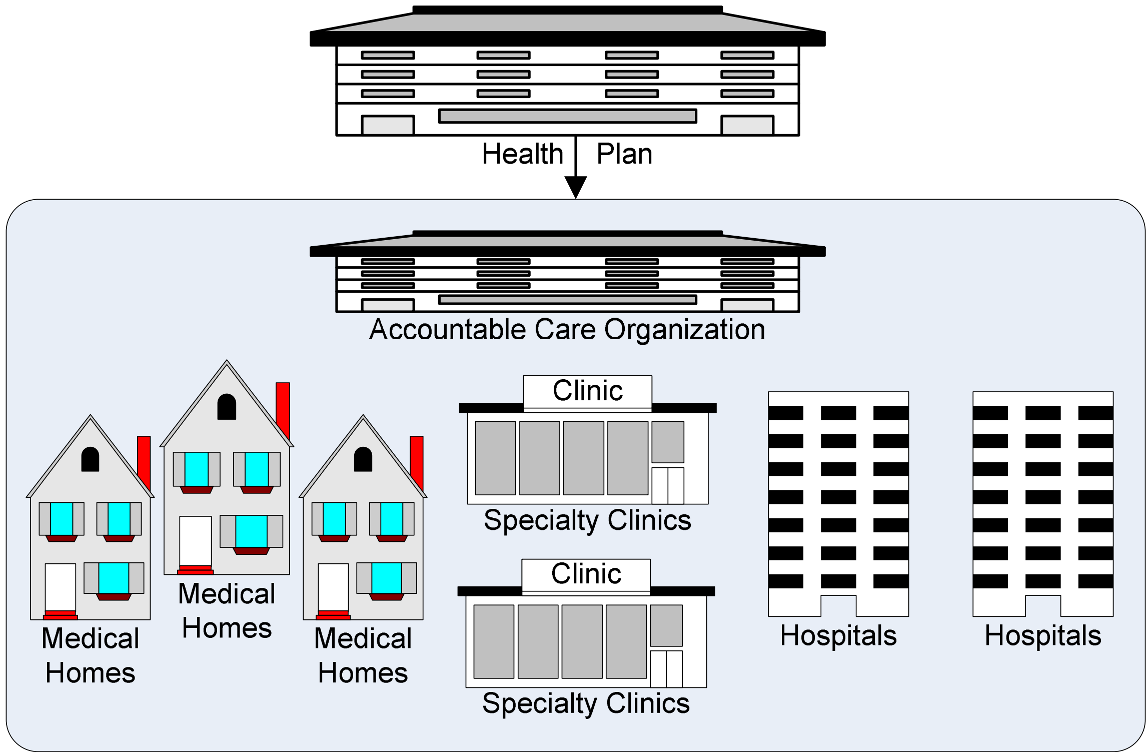
- The IPI project was a nine month process and consisted of MH, SU, and PC Leaders
- http://www.cimh.org/Initiatives/Primary-Care-BH-Integration.aspx

California PC, MH, SU Integration

Vision: Overall health and wellness is embraced as a shared community responsibility

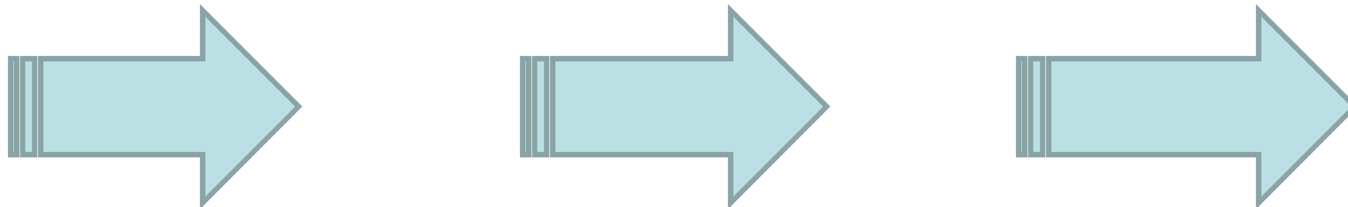
– To achieve individual & population health & wellness (physical, mental, social/emotional/ developmental and spiritual health), healthcare services for the whole person (physical, mental and substance use healthcare) must be:
  - seamlessly integrated
  - planned for and provided through collaboration at every level of the healthcare system, as well as coordinated with the supportive capacities within each community

Healthcare Reform Model



New Healthcare System & New Payment Models=ACOs

- **Accountable Care Organizations; Person Centered Medical Homes; Person Centered Medical Home Neighborhood**



- **They are all about *Improving Quality* and managing *Total Healthcare Expenditures*!**

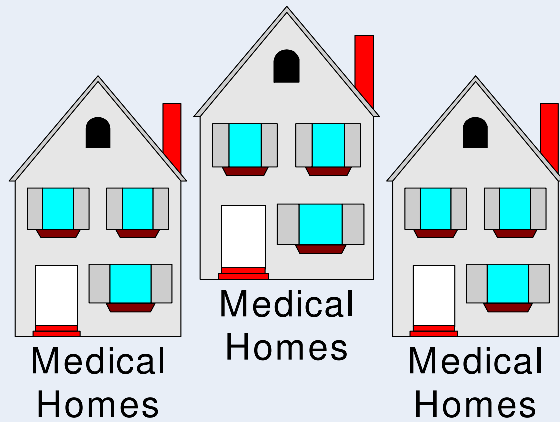
Local Accountable Care Organization (ACO) Development

- **Congress and CMS**: an ACO would have at least one hospital, a minimum of 50 physicians (primary care and specialists), commit to be in business for at least 3-5 years, and serve at least 5,000 patients
  - If the ACO met pre-established quality goals, it would receive an incentive payment
  - Penalties would be assessed if care did not meet the quality goals established
  - Incentive payments and penalties would be split between the members of the ACO
  - The providers in the ACO would follow best practices, be patient-centered and contribute to the development of best clinical practices to build standards of evidenced-based medicine

Local Accountable Care Organization (ACO) Development

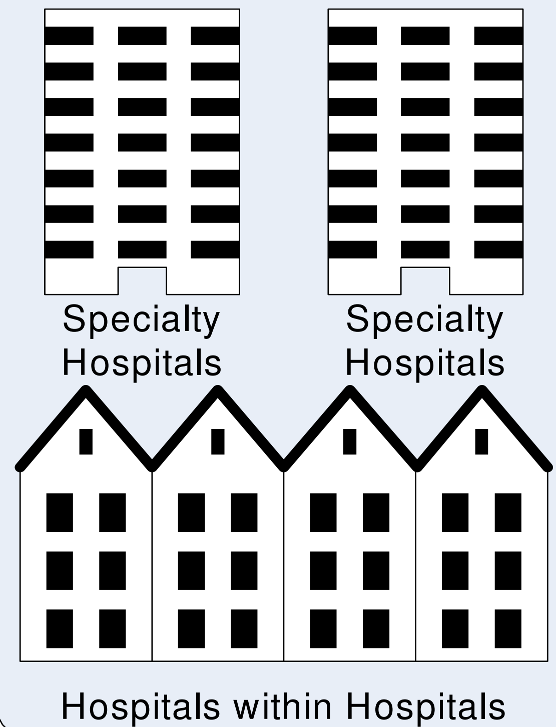
- **Medicare**: Allow providers organized as ACOs that voluntarily meet quality thresholds to share in the cost savings they achieve (2012)
- **Medicaid** demonstration projects:
  - Pay bundled payments for episodes of care that include hospitalizations (2010-2016);
  - Make global capitated payments to safety net hospital systems (FY2010-2012);
  - Allow pediatric medical providers organized as ACOs to share in cost-savings (2012-2016)
- **NCQA:** Has developed & published standards
- **http://www.iha.org/pdfs_documents/home/ACO_whitepaper_final.pdf**

Payment Model to cover Prevention, Primary Care and Chronic Disease Management; Bonus Structure for managing Total Health Expenditures



Linkages to High Performing Specialists that can support the management of Total Health Expenditures and minimize Defect Rates

Bundled Case Rates that pay a Percentage of PACs and Non-Payment for Never Events



Patient Centered Medical Homes: Foundations of the ACO

- An ACO focus on insurance design will not ensure delivery system design—the PCMH needs a supportive infrastructure!
- Don’t mistake insurance functions for delivery system functions or assume that the former will create the latter
- Don’t establish policy, regulatory or financing models at cross-purposes with the intended PCMH model
- In the future, ACOs can mediate these spheres of activity

Person Centered Healthcare Home

- Patient Centered Medical Home
  - each patient has a personal physician who provides first contact, continuous and comprehensive care.
  - physician leads a team who take responsibility for the ongoing care of patients.
  - the physician provides for all care needs or arranges care including all stages of life; acute care; chronic care; preventive services; and end of life care.
  - Care is coordinated and/or integrated across all health (e.g., subspecialty care, hosps, home health agencies, nursing homes) and the pt’s community (e.g., family, public and private community-based services)..

Person Centered Healthcare Home

- Care is facilitated by registries, IT, HIE, & other means to assure that patients get care when & where needed and wanted, in a culturally & linguistically appropriate manner
- Quality and safety are hallmarks
  - Practices support patient-centered outcomes defined by care planning driven by a partnership between physicians, patients, and the patient's family.
  - Evidence-based medicine and clinical decision-support tools guide decision making
  - Physicians accept accountability for CQI thru performance measurement and improvement.
- NCQA recently published standards emphasizing behavioral health

Person Centered Healthcare Home

- Quality and safety are hallmarks
  - Patients participate in decision-making & feedback is sought to ensure patients' expectations are met
  - IT supports optimal patient care, performance measurement, patient ed, enhanced communication
  - Practices go thru a voluntary process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model. Patients and families participate in quality improvement activities at the practice level.
  - http://www.acponline.org/advocacy/where_we_stand/medical_home/

The PCMH-Neighbor

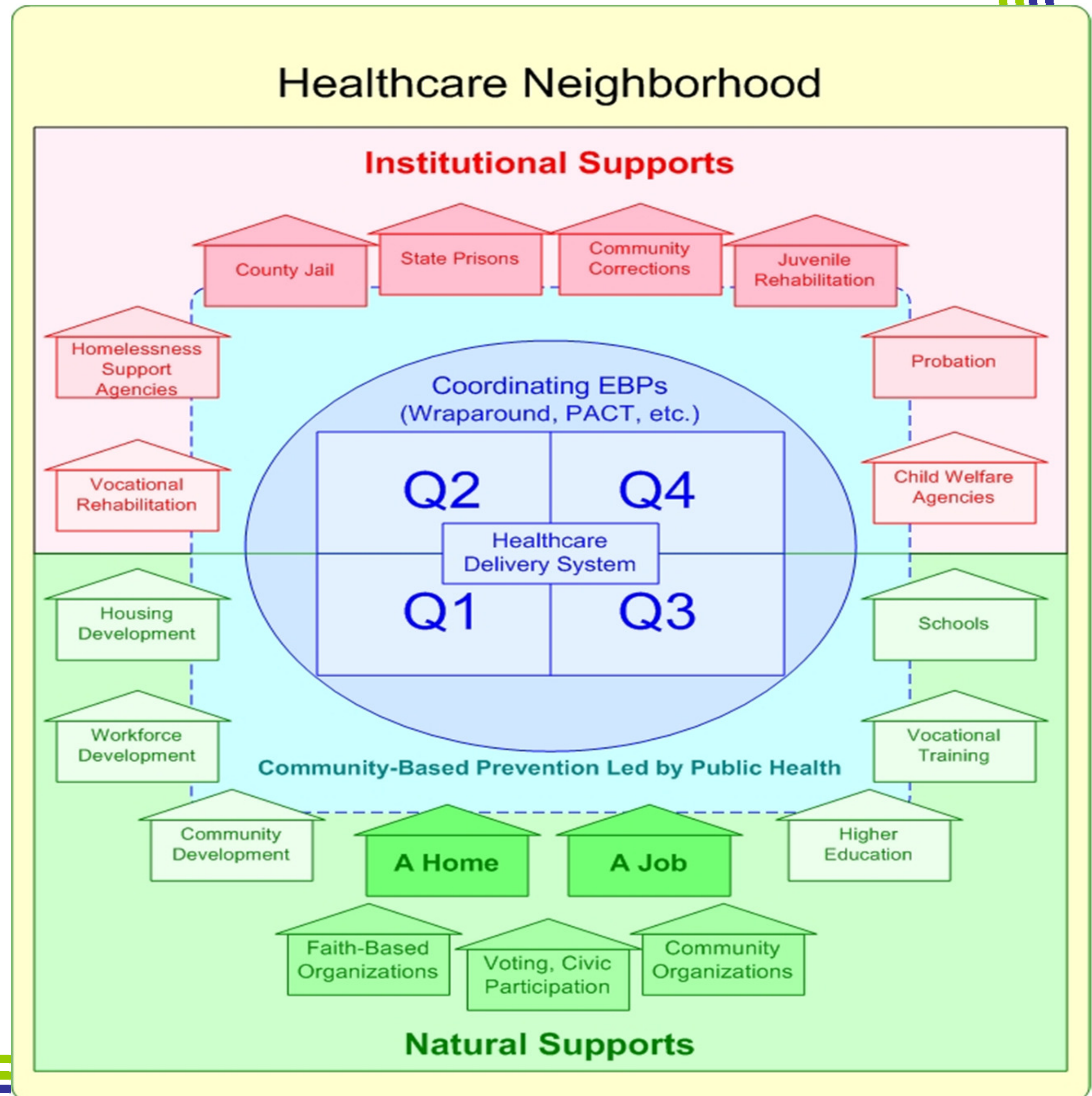
- **A specialty/subspecialty practice recognized as a Patient-Centered Medical Home Neighbor (PCMH-N) engages in processes that:**
  - Ensure effective communication, coordination, and integration with PCMH practices in a bidirectional manner to provide high-quality and efficient care
  - Ensure appropriate and timely consultations and referrals that complement the aims of the PCMH practice
  - Ensure the efficient, appropriate, and effective flow of necessary patient and care information

The PCMH-Neighbor

– Effectively guide determination of responsibility in co-management situations
– Support patient-centered care, enhanced care access and high levels of care quality and safety
– Support the PCMH practice as the provider of whole-person primary care to the patient and as having overall responsibility for ensuring the coordination and integration of the care provided by all involved physicians and other health care professionals.
– http://www.acponline.org/advocacy/where_we_stand/policy/pcmh_neighbors.pdf

Vision for the Next Generation Safety Net

- Healthcare Homes are critical for Safety Net/Vulnerable Populations…
- But they must also be connected to Public Health and the Community

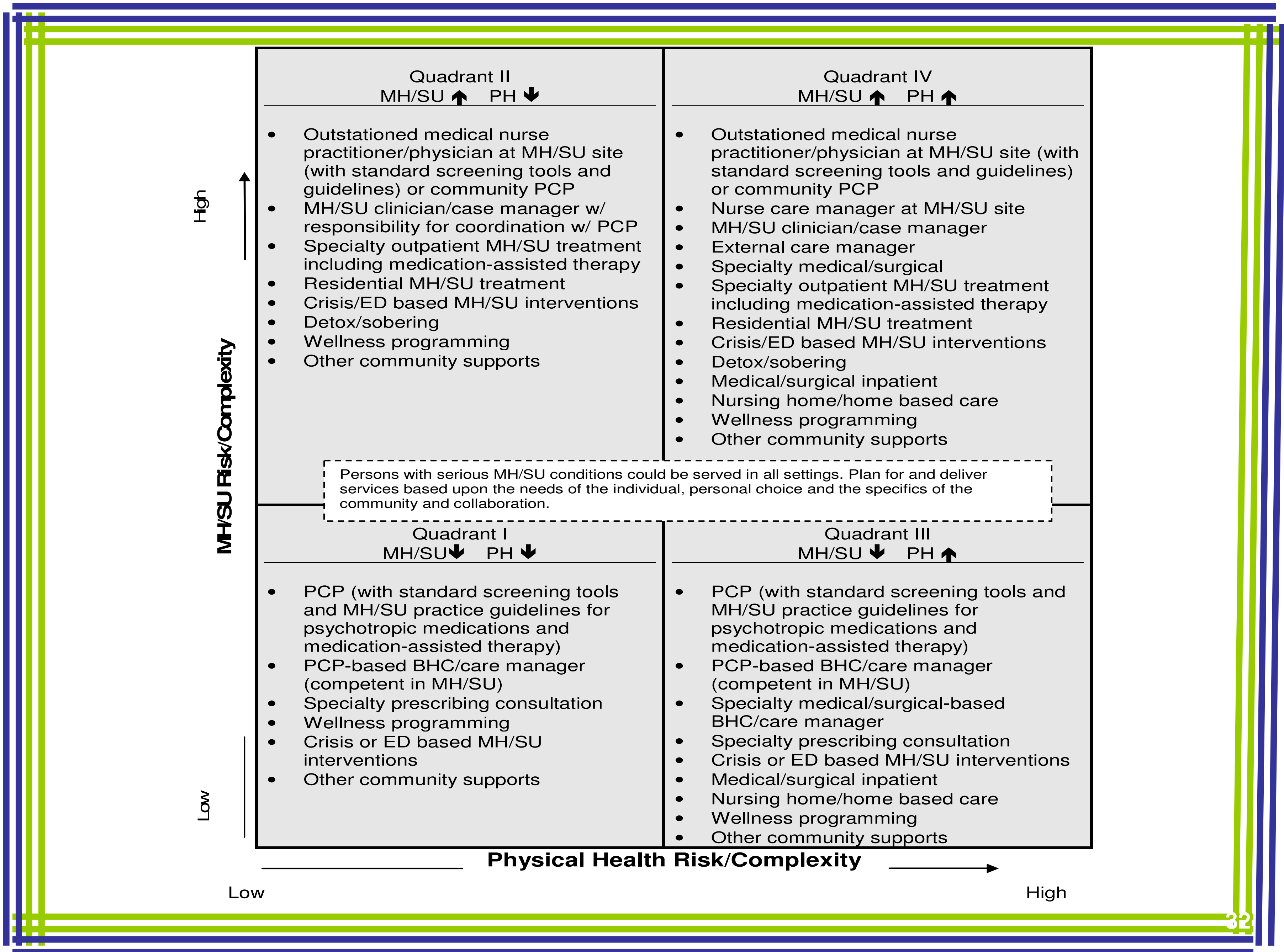


Payment Reform: from Volume to Value, Paying Based on Quality

- Shared savings
- “Episode-of-care payment”
- “Comprehensive care payment” (condition-adjusted capitation)
- Bundled payment
- Pay for performance
- Non-payment for: services required to treat complications, infections, etc.; for services that fail to meet minimum quality standards
- Quality-based tiering

Planning for Bi-Directional Integration Using the Four Quadrant Model:

Behavioral Health Integrated into Primary Care Services and Primary Care Integrated into Behavioral Health Services



Quadrant II
MH/SU ↑ PH ↓
Outstationed medical nurse practitioner/physician at MH/SU site (with standard screening tools and guidelines) or community PCP
MH/SU clinician/case manager w/ responsibility for coordination w/ PCP
Specialty outpatient MH/SU treatment including medication-assisted therapy
Residential MH/SU treatment
Crisis/ED based MH/SU interventions
Detox/sobering
Wellness programming
Other community supports
Quadrant IV
MH/SU ↑ PH ↑
Outstationed medical nurse practitioner/physician at MH/SU site (with standard screening tools and guidelines) or community PCP
Nurse care manager at MH/SU site
MH/SU clinician/case manager
External care manager
Specialty medical/surgical
Specialty outpatient MH/SU treatment including medication-assisted therapy
Residential MH/SU treatment
Crisis/ED based MH/SU interventions
Detox/sobering
Medical/surgical inpatient
Nursing home/home based care
Wellness programming
Other community supports
Persons with serious MH/SU conditions could be served in all settings. Plan for and deliver services based upon the needs of the individual, personal choice and the specifics of the community and collaboration.
Quadrant I
MH/SU ↓ PH ↓
PCP (with standard screening tools and MH/SU practice guidelines for psychotropic medications and medication-assisted therapy)
PCP-based BHC/care manager (competent in MH/SU)
Specialty prescribing consultation
Wellness programming
Crisis or ED based MH/SU interventions
Other community supports
Quadrant III
MH/SU ↓ PH ↑
PCP (with standard screening tools and MH/SU practice guidelines for psychotropic medications and medication-assisted therapy)
PCP-based BHC/care manager (competent in MH/SU)
Specialty medical/surgical-based BHC/care manager
Specialty prescribing consultation
Crisis or ED based MH/SU interventions
Medical/surgical inpatient
Nursing home/home based care
Wellness programming
Other community supports
MH/SU Risk/Complexity
High
Low
Physical Health Risk/Complexity
Low
High

California: IPI Continuum

The IPI Continuum:

A Collaborative MH/SU/Primary Care Continuum for the Safety Net Population[1]

(This Continuum details the vertical MH/SU axis of the 4Q Model and does not attempt to span the horizontal axis, which considers the range of general healthcare services from prevention/health promotion to specialty medical/surgical and inpatient services. The supportive services and systems in the community are also not detailed here, however it is anticipated that development of a locally specific IPI Continuum would describe these as a part of defining seamless services.)

	Mild MH/SU Complexity	Moderate MH/SU Complexity	Serious MH/SU Complexity	Severe MH/SU Complexity
Characteristics of the population with MH/SU needs to be served in each level—for all ages (children, youth, adults, older adults)	• No comorbidities • Family/community supports OR • Need for health behavior change related to medical presentation (e.g., sleep disorder, pain), chronic medical conditions (e.g., cardiovascular, diabetes), developmental/parenting concern	• Medical comorbidity, including pain, or MH/SU comorbidity, and/or • Isolated or chaotic family/ community environment	• Multiple, complex medical, MH/SU comorbidities, and/or • Isolated or chaotic family/ community environment, and/or • Previous treatment ineffective	• Adults 18 years and over, with a severe and/or persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment, but for whom long-term 24-hour care in a hospital, nursing home, or protective facility is unnecessary or inappropriate (NIMH). *(In CA, referred to as Serious and Persistent)*
	• Standardized assessment tool[12] indicates mild to moderate symptoms or developmental concern	• Standardized assessment tool[12] indicates moderate to severe symptoms and their impact on functioning	• Standardized assessment tool[12] indicates severe symptoms and their impact on functioning	• Individuals with SU disorders that require ASAM Level III or IV services
	• Diagnostic examples include V-codes, mild depression, mild anxiety, sleep disorder, somatic disorder, SU disorder	• Diagnostic examples include moderate depression, moderate anxiety (including PTSD), sleep disorder, somatic disorder, SU disorder (abuse)	• Diagnostic examples include severe depression, severe anxiety (including PTSD), schizophrenia, bipolar disorder, schizoaffective disorder, personality disorders, SU disorder (abuse/dependence)	• Diagnostic examples include schizophrenia, schizoaffective disorder, bipolar disorder, SU disorder (abuse/dependence)

The Person-Centered Healthcare Home: Q I and III

Q I

- PCP (with standard screening tools and SU practice guidelines for medication-assisted therapy)
- PCP-based BHC/care manager (MH and SU competent)
- Specialty prescribing consultation
- Wellness programming
- Crisis/ED based SU interventions
- Other community supports

Q III

- PCP (with screening tools/guidelines)
- PCP-based BHC/care manager (MH and SU competent)
- Specialty medical/surgical-based BHC/care manager
- Specialty prescribing consultation
- ED based SU interventions
- Medical/surgical inpatient
- Nursing home/home based care
- Wellness programming
- Other community supports

The Person-Centered Healthcare Home-Neighbor

Q II

- Outstationed medical NP/PCP
- SU clinician/case manager w/ responsibility for coordination w/ PCP
- Specialty outpatient SU treatment including medication-assisted therapy
- Residential SU treatment
- Crisis/ED based SU interventions
- Detox/sobering
- Wellness programming
- Other community supports

Q IV

- Outstationed medical NP/PCP
- Nurse care manager/SU site
- SU clinician/case manager
- External care manager
- Specialty medical/surgical
- Specialty outpatient SU treatment
- Residential SU treatment
- Detox/sobering
- Crisis/ED based SU interventions
- Medical/surgical inpatient
- Nursing home/home based care
- Wellness programming
- Other community supports

Nine Competencies of High
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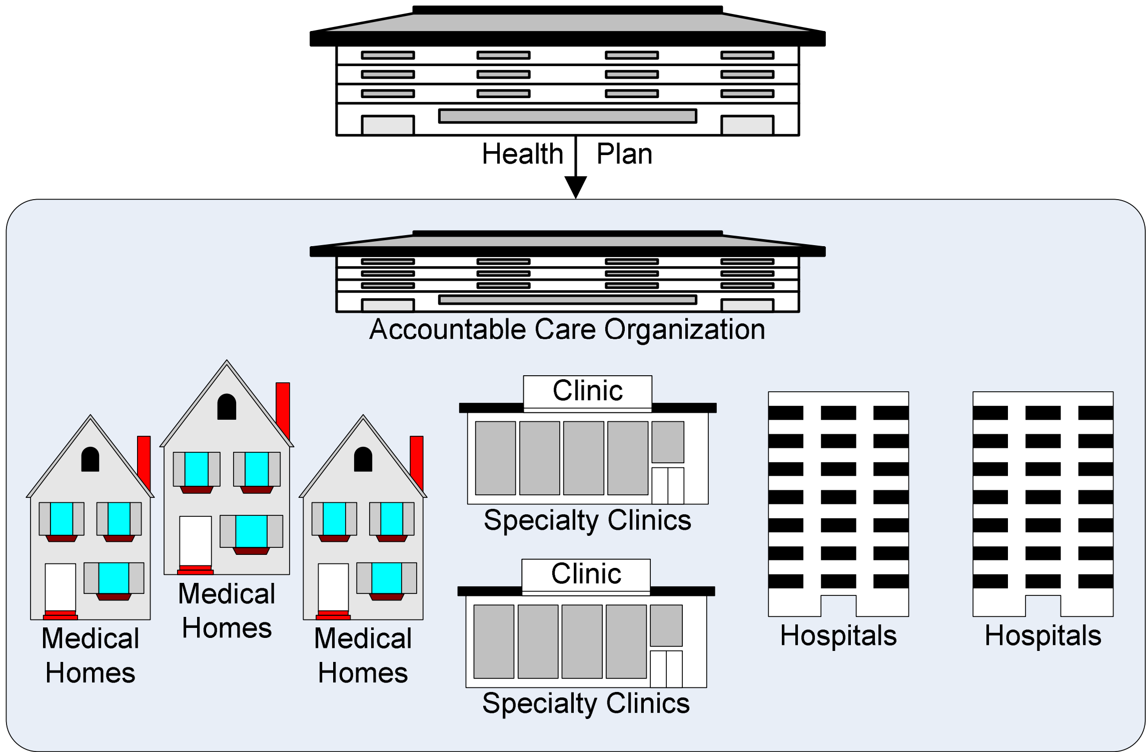
Healthcare Reform Model



SAMHSA’S “Description of a Good and Modern Addictions and Mental Health Services System”

Healthcare Home/ Physical Health	Prevention and Wellness	Engagement Services	Outpatient and Medication Services
• Screening, brief intervention and referral • Acute primary care • General health screens, tests and immunization • Comprehensive Care management	• Screening, brief intervention & referral to tx Brief motivational interviews • Wellness Programs* • Tobacco Cessation • Parent Training • Facilitated Referrals • Health Promotion • Relapse Prevention • Wellness Recovery Support • Warm line	• Assessment • Specialized Evaluations (psychological, Neurological) • Service planning (including crisis planning) • Consumer/Family education • Outreach	• Individual Evidenced Based Therapies * • Group therapy • Family therapy • Multi-family counseling • Medication management • Pharmacotherapy (including Opiod Maineenance Therapies) • Laboratory services • Consultation with staff and caregivers

Community and Recovery Support (Rehabilitative)	Other Supports (Habilitative)	Intensive Support Services	Out-of-Home Residential Services	Acute Intensive Services
• Peer supports • Recovery Support Coaching • Parent Caregiver Support • Skill building (social, daily living, cognitive) • Case Management • Continuing Care • Behavioral management • Supported employment • Permanent Supportive housing • Recovery housing • Therapeutic mentoring • Traditional healing services	• Personal Care • Homemaker • Respite • Educational Services • Transportation • Assisted Living Services • Recreational Services • Trained behavioral health interpreters	• Substance abuse intensive outpatient services • Partial hospital • Assertive community treatment • Intensive home based treatment/ • Multi-systemic therapy	• Crisis residential/stabilization • Residential services* • Supports for children in foster care	• Mobile crisis services • Urgent care Services • 23 hour crisis stabilization service • Psychiatric inpatient and medical detoxification services • 24/7 Crisis Hotline Services

1. Competency: A Full Array of Specialty Behavioral Health Services

- Work w SAMHSA on "Description of a Modern Addictions and Mental Health Service System"
  - Disseminate information
  - Review for TA needs
- Continue work on implementation of evidence based practices
- Continue work on transformational care planning (person centered care planning)
- Increase work on co-occurring disorders, clinical and system
- IPI Continuum
- FSP Survey Project; FSP Implementation Tool Kits

2.Competency: A Well Defined Assessment Process and Level of Care System

- <u>Definition</u>: Patient-centered behavioral health providers must deliver full behavioral health person-centered assessments and physical health screening that will identify the level of care needed by the person seeking services.
  - Includes appraisal of emotional, cognitive, mood, expressiveness and interpersonal functioning
  - Includes appraisal of alcohol and drug use, misuse, and addiction
  - Includes screening of overall physical health

2.Competency: A Well Defined Assessment Process and Level of Care System

- High priority for CiMH
- CalMEND ICSC; CPCI
- Important to bring together partners for Workgroup to address comprehensively. Proposed members include:
  - SAMHSA's National Training and T.A. Center for PCBH Integration (National Council); CPCA; IHI; CA SOC Chairs; Medical Directors Association (MH & Med) CADPAAC; Agencies well-versed in LOC assessment measures (e.g., Stanislaus, MHA/Los Angeles, Telecare), Members (and lessons learned) from CIMH BTS Learning Collaborative PIPs (CPCI, SCERP, LA ICSC)
- Foundation sponsored

3.Competency: Measurement Systems and Tools to Measure Consumer Improvement

- Definition: Provider organizations need to be “learning organizations” that measure their performance, experiment with ways to improve their processes based on their experience.
- Competencies:
  - Capacity to monitor achievement of individual client progress, including use of registries and frequent monitoring of treatment targets
  - Capacity to support small-scale, rapid cycle, testing (e.g. PDSA)
  - Capacity to monitor program level performance and insure adherence to program standards including measures of program quality, client outcomes, and costs.
  - Capacity to implement and test program improvement strategies and to incorporate and sustain improvements.

3.Competency: Measurement Systems and Tools to Measure Consumer Improvement

- Rationale: Growing demand that evidence of improvement be made public and transparent.
  - Accountable care systems expected to be accountable for the care of the population of which they are responsible.
  - Need to provide reliable and valid information on quality and cost of care for:
    - public reporting to inform choice
    - basis for differential payment based on performance

3.Competency: Measurement Systems and Tools to Measure Consumer Improvement

- Keep counties/CBOs informed regarding healthcare reform changes/environment (MADM; Policy Forums)
- Help counties/CBOs understand and use CQI processes (CPCI; ICSC; SCERP PIP)
- Measure outcomes of all continuum Prevention, Early Intervention, Treatment, Recovery, Community integration (MORS; CIOM; LOCUS)
- Measure and target services to specific populations
- TA to analyze existing data access/timelines etc. – to inform practice (FSP Dashboards)
- Interpret recovery to Primary Care (IPI Policy Paper; Policy Forums)
- Brief health care measures (CPCI LC)
- IDEA

4. Competency: Demonstrated use of Clinical Guidelines and Evidence Based Practices

- Definition: Provider organizations need to incorporate and insure use of clinical models and interventions that have the best available evidence for effectiveness, and managerial and organizational structures and practices that have the best available evidence for improving overall quality and cost performance.
- Competencies
  - Capacity to monitor and remain current on advances in clinical and organizational practice
  - Capacity to incorporate, apply and sustain innovate practices at the clinical and organizational levels.

4. Competency: Demonstrated use of Clinical Guidelines and Evidence Based Practices

- Rationale: As the effectiveness research base on clinical interventions and organizational practices grow, Accountable Care Systems must:
  - be knowledgeable of advances
  - incorporate improvements in clinical and organizational practices

4. Competency: Demonstrated use of Clinical Guidelines and Evidence Based Practices

- Continued support of EBP implementation
  - Use the CDT model to support the sustainable implementation of EBPs in the adult service syste
  - Build off of Transformational (Person Centered) Care Planning
  - Build off counties who have experience implementing EBPs with children & families
- Regional Workforce activities
  - Create opportunities for cross-discipline training
- E-Learning and webinars

4. Competency: Demonstrated use of Clinical Guidelines and Evidence Based Practices

- Develop a repository/clearinghouse of information on clinical guidelines and evidence-based practices for easy access by county and agency staff, e.g., web-based, links to other resources
  - Build on current web based resources
- Foundation sponsored (?)

5. Competency: A robust Electronic Health Record that includes Patient Registries

- Definition: An electronic health record is a systematic collection of health information about individual patients or populations. The record is in digital format that can be shared across different health care settings, by being embedded in network-connected enterprise-wide information systems. Such records may include a whole range of data in comprehensive or summary form, including demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, and billing information.

5. Competency: A robust Electronic Health Record that includes Patient Registries

- Definition: Disease registries are collections of secondary data related to patients with a specific diagnosis, condition, or procedure. Registries vary in sophistication from simple spreadsheets that only can be accessed by a small group of physicians to very complex databases that are accessed online across multiple institutions. They can provide health providers (or patients) with reminders to check certain tests in order to reach specific quality goals.

5. Competency: A robust Electronic Health Record that includes Patient Registries

- Provide information and engage counties (CalMEND; Small County IT Webinars; IT Conf)
  - What is registry; How to use
  - Differentiate between EHR and registries
- Research: Software compatibility issues; What is being developed – current systems; County/CBO Current and future needs; Anticipate Federal Regulations (?)
    - Lobby developers re: what counties need
    - Facilitate testing
- Tap into federal $ to develop HER (?)
- TA – what is needed? (How to determine?)
- More involvement with Trabin's Tx Plan project (?)

6. Competency: Quality Improvement Processes and Supporting Data Systems

- Definition: Integrated primary care/behavioral health care systems must integrate quality improvement processes and supporting data systems. The systems must become learning organizations that improve practices, using a form of PDSA cycle process, backed by data systems sufficient to track results.

6. Competency: Quality Improvement Processes and Supporting Data Systems

- Participate in national/state measure development (?)
  - Disseminate to counties/CBOs
  - Move from compliance to culture of learning
  - (IHI Break Through Change Model/CQI/TA TBD; CalMEND; SCERP PIP; IT Conf)
- Research and plan: Outcomes/pay for performance
  - (SNG meeting; ?)
  - Disseminate to counties/CBOs

7.Competency: A Solid Approach to PEI and Recovery

- Definition: Organizations interested in developing effective integration strategies must have a solid and effective approach to prevention and early intervention and recovery in its service delivery design.
- Competencies:
  - ✓ Improved and immediate access to care
  - ✓ Focused culturally relevant strategies for specific at risk and underserved populations
  - ✓ Comprehensive screening at first contact
  - ✓ Targeted supports for young people and families
  - ✓ Strong collaborations with community based agencies

7.Competency: A Solid Approach to PEI and Recovery

- Current projects:
  - ✓ Transformational (Person Centered) Care Planning
  - ✓ Webinars; E Learning Modules
  - ✓ Implementation Support Activities
    - Promotores
    - Triple P
    - EDIPP
    - LA TA on PEI
  - ✓ Regional Networks
  - ✓ Workforce Projects - Working Well Together

7.Competency: A Solid Approach to PEI and Recovery

- Proposed Projects:
  - Develop PEI and Recovery Services that cross boundaries (??)
    - Build crosswalk
    - Determine where there are matches on both sides
    - Similar tools
    - Holistic screening (CPCI?)
  - Define and address service models
    - Improve continuum (Support PEI systems/specific counties)
    - First contact – ease of access – seamless
    - Integrate in 3 systems – MH/SU/PC
    - Nexus between physical/mental

8. Competency: The Ability to Practice as a Team to Coordinate Care/Work with Primary Care

- Definition: Professional care providers work in partnership:
  - using the client centered approach as the as the foundation for all treatment / intervention decisions resulting in active participation of both the client and their family
  - A team approach is used to provide multidisciplinary, comprehensive care and decisions of how and when services should be delivered.
  - The team includes an array of substance use, mental health, medical, and social supports.
  - Central to the delivery of service is the coordination of care across disciplines.
  - The client care coordinator is responsible for tracking patients, monitoring symptoms, providing patient education, taking action when symptoms worsen, etc.

8. Competency: The Ability to Practice as a Team to Coordinate Care/Work with Primary Care

- Current CiMH Projects:
  - Integration Webinars; Regional Training; SCERP/PIP; CalMEND CPCI and ICSC Projects; Regional Forums
- Proposed Project:
  - Research and Define what a Person Centered Healthcare Home looks like for SMI (Feb PM presentation; COJAC)
    - What is the criteria; What components are necessary; How is client/family included; Robust HER
    - Develop consensus process: counties/CBOs/PC/condumers/family members

9. Competency: Financial Systems to Manage New Payment Systems, i.e., Case Rate Payments, Prospective Payments, Value Based Payments

- Definition: Case rate payment is defined as the reimbursement of health care providers on the basis of expected costs for clinically-defined episodes of care.
- Described as "a middle ground" between fee-for-service (providers are paid for each service rendered to a patient) and capitation (providers are paid a "lump sum" per patient regardless of how many services the patient receives).

9. Competency: Financial Systems to Manage New Payment Systems, i.e., Case Rate Payments, Prospective Payments, Value Based Payments

- Definition: Prospective Payment is developed thru a case mix group (CMG) using a patient classification system to group together patients with similar characteristics. This provides a basis for describing the types of patients a hospital or other health care provider treats (its case mix). Case mix groups are used as the basis for the Health Insurance Prospective Payment System (HIPPS) rate codes used by Medicare in its prospective payment systems.

9. Competency: Financial Systems to Manage New Payment Systems, i.e., Case Rate Payments, Prospective Payments, Value Based Payments

- Current Projects: Jarvis Project; Regional Training
- Director Concerns:
  - Given funds will not be available for coverage initiative: What's the current thinking about models of reimbursement for specialty providers and for behavioral health providers
  - Different lines of business: How can we explore other avenues of funding and maintain integrity of Medi-Cal cost reporting requirements etc.?
  - At some point, as behavioral is integrated, the financing model will change to a capitated, per member per month method. I think counties need to understand the operational/clinical implications of capitation and the evaluation and setting of capitation rates.

Practice Transformation to a PCMH: Change is Hard

- Six lessons from 36 family practice settings across the country that participated in a two-year practice transformation project
  1. *“Becoming a patient-centered medical home (PCMH) requires transformation.*
  2. *Technology needed for the PCMH is not plug-and- play.*
  3. *Transformation to the PCMH requires personal transformation of physicians.*
  4. *Change fatigue is a serious concern even within capable and highly motivated practices.*
  5. *Transformation to a PCMH is a developmental process.*
  6. *Transformation is a local process.”*
- Resonates with the experience in implementing integrated care—this is also a process of transforming personal and organizational practice in the context of local relationships—ideally, the medical home and integration changes can be woven together

Nutting, P. et al. Initial Lessons From the First National Demonstration Project on Practice Transformation to a Pat Centered Medical Home. Annals of Family Medicine. May/June 2

This is Hard!! Really Hard!!

……..PRESIDENT GEORGE W BUSH