



# **Mental Health and Substance Use Services (MHSUDS) Task Force**

**WELCOME!**

**WE WILL BEGIN AT 10:00AM**



# Ground Rules

1. Speak one at a time
2. Keep discussion moving- we want new ideas
3. Limit multi-tasking
4. Be brief but brilliant

# MHSUDS TASK FORCE AGENDA

TIME	AGENDA ITEM
10:00-10:15	Welcome, Purpose and Structure of the MHSUDS Integration Task Force Process
10:15-12:00	Practice Transformation: Suggestions
12:00-12:15	Public Comment
12:15-1:00	Lunch
1:00-2:45	Practice Transformation: Suggestions
2:45-3:30	Advancing Behavioral Health Integration in California - Potential Concepts
3:30-3:50	Public Comment
3:50-4:00	Next Steps
4:00	Adjourn



# Health Homes for People with Complex Needs- Questions for the Experts

1. As it relates to provider readiness in certain areas, what roles will the MCOs and provider organizations have in supporting PCPs/clinics with the provision of health home services?
2. Can some types of behavioral health providers serve as the whole person care coordination entity?
3. Which geographic areas in CA are ready for health home implementation?
4. How would we define members who would be appropriate to receive their whole person care coordination from a behavioral health provider?
5. What are eligibility requirements for individuals who will have access to health homes located in behavioral health facility (risk level and conditions)?
6. What are definitions for the six care coordination services and provider requirements?
7. What criteria should there be for providers?



# MHSUDS Integration Task Force Meeting

Accountability – Behavioral Health Integration Measures

Karen W. Linkins, PhD Integrated Behavioral Health Project (IBHP)



# Overview

- Performance measures are used to:
  - Assess access, timeliness, quality, and coordination of care
  - Determine individuals who have not received necessary services
  - Compare performance
- Goal is to minimize burden and leverage existing data (e.g., claims and encounter data)
- Any data that are collected need to have a clear use- for accountability, evaluation, clinical or quality improvement, etc. purposes



## Three Critical Areas to Ensure Effective Measurement in Integration

- Infrastructure and capacity to collect data within systems and settings
- Infrastructure and capacity to link and share data across systems
- Expertise and capacity to analyze and use data in a meaningful way – for payers, administrators, providers, and clients



# Measures: Sources of Development

- Centers for Medicare & Medicaid Services (CMS)
- National Committee for Quality Assurance (NCQA)
- Examples from other states (e.g., Ohio, New York)

# Measure List

Condition/Area	Performance Measure
Asthma	Use of appropriate medications for people with asthma
Cardiovascular Care	<ul style="list-style-type: none"><li>• Cholesterol management for patients with cardiovascular condition (LDL-C &lt;100 mg/dL)</li><li>• Controlling high blood pressure (&lt;140/90)*</li></ul>
Diabetes Care	<ul style="list-style-type: none"><li>• Comprehensive Diabetes Care (HbA1c level below 7)</li><li>• Comprehensive Diabetes Care: Cholesterol management (LDL-C &lt;100 mg/dL)</li></ul>
Management of Behavioral Health Conditions	<ul style="list-style-type: none"><li>• Client perception of care – National Outcome Measure</li><li>• Proportion of Days Covered of Medication</li></ul>

# Measure List

Condition/Area	Performance Measure
Schizophrenia	<ul style="list-style-type: none"><li>• Annual assessment of weight/BMI</li><li>• Glycemic control</li><li>• Lipids</li></ul>
Bipolar Disorder	<ul style="list-style-type: none"><li>• Annual assessment of weight/BMI</li><li>• Glycemic control</li><li>• Lipids</li></ul>
Clinical Depression	<ul style="list-style-type: none"><li>• Screening</li><li>• Follow-up plan*</li></ul>
Substance Use	<ul style="list-style-type: none"><li>• Screening</li><li>• SBIRT</li><li>• Initiation and engagement of Alcohol and other drug dependence treatment*</li><li>• Smoking and tobacco use cessation</li></ul>
Obesity	<ul style="list-style-type: none"><li>• BMI Assessment</li></ul>

# Measure List

Condition/Area	Performance Measure
Utilization and Access	<ul style="list-style-type: none"> <li>• Sensitive Condition Admission (1. Grand Mal and other Epileptic Convulsions, 2. COPD, 3. Asthma, 4. Diabetes, 5. Heart failure and Pulmonary Edema, 6. Hypertension, 7. Angina)*</li> <li>• ED Utilization rates</li> <li>• ED Utilization rates – mental health and SUD</li> <li>• Inpatient Utilization rates</li> <li>• Inpatient Utilization rates – mental health and SUD</li> <li>• Follow-up after MH hospitalization*</li> <li>• Successful Linkages to Integrated Care</li> </ul>
Access to Preventive/Ambulatory Health Visits	<ul style="list-style-type: none"> <li>• All-cause readmission (number of acute 30-day readmissions for any diagnosis)</li> </ul>

# Measure List

Condition/Area	Performance Measure
Care Coordination	<ul style="list-style-type: none"><li>• Timely Transmission of Transition Record (transition record sent to health home within 24 hours of discharge)*</li><li>• Medication Reconciliation Post-Discharge</li><li>• Release of Information for sharing PHI across providers</li><li>• Care Coordinator Assignment: Percentage of clients in the target population with an assigned care coordinator</li><li>• Common Care Plan: Percentage of clients in the target population with a physical and behavioral health care plan accessible by all providers and payers</li></ul>

# Measure List

Condition/Area	Performance Measure
Patient Experience	<ul style="list-style-type: none"><li>• Client experience with care</li><li>• Client confidence</li><li>• Satisfaction with coordination of care</li></ul>
Recovery	<ul style="list-style-type: none"><li>• Milestones of Recovery Scale (Improved mental health outcomes)</li><li>• Housing stability</li><li>• Employment</li><li>• Food Access</li></ul>



# Discussion

- Feedback on Conditions and Domain Areas
- Feedback on Measures: Metrics, definitions (e.g., numerator, denominator), exclusions, reporting periods
- How do we advance beyond current measurement and data barriers?



# MHSUDS Integration Task Force Meeting

Practice Transformation: Workforce Capacity Building for Population Health and Improving Patient Experience

Jennifer Clancy, California Institute of Behavioral Health Solutions (CIBHS) & Darren Urada, UCLA Integrated Substance Abuse Programs

# Introduction

- Examples of research-supported programmatic strategies that would facilitate behavioral health integration.
- Just-published article<sup>1</sup>: Accountable Care Organization Hennepin Health incorporated many of these strategy examples, and found reduced ER use, high patient satisfaction. Hennepin realized and reinvested savings.
- Additional research supports each of these strategies.

<sup>1</sup> Sandberg, S.F., Erikson, C., Owen, R., Vickery, K.D., Shimotsu, S.T., Linzer, M., Garrett, N.A., Johnsrud, K.A., Soderlund, D.M., & DeCuellis, J. (2014). Hennepin Health: A safety-net Accountable Care Organization for the expanded Medicaid population. *Health Affairs*, 33(11), 1975-1984, doi: 10.1377/hlthaff.2014.0648



# Practice Transformation Strategies

1. Data Infrastructure
2. Care Coordinators Who Offer Comprehensive Services
3. Multidisciplinary Teaming
4. Psychiatric/PCP Consult
5. Peer Provider Services
6. SBIRT Expansion and Sustaining Training
7. Cross System Training

# Data Infrastructure

- **Behavioral Health Integration requires:**
  1. Electronic communication and sharing of cost, quality, and clinical data via technology
  2. Appropriate and robust cost, clinical, and quality data sets within each of the providers/payers integrating care
  3. Technological system that can assimilate and analyze the data sets from a variety of electronic sources.
- **Objective:**
  - a) Enhance current data systems by expanding the functionality and content so all health providers can use them to support their services -- and all involved providers can use them to work together to coordinate care.

# Care Coordinators who offer Comprehensive Care Coordination Services

- **Behavioral Health Integration Requires:**
  1. Individuals accountable for systematically coordinating care across payer and provider organizations for individuals with complex behavioral and physical health conditions.
  2. The Care Coordinator “intentionally ensures the necessary degree of screening, referrals, tracking, outcome measurement, and care coordination needed to assure good health outcomes.” (Avery, 2014)
  3. Care coordinator differs from a case manager or navigator
- **Objective:**
  - a) Hire Care Coordinators to serve as the single point of contact for complex clients needing care coordination, and for the providers working with these clients.
  - b) Ensure Care Coordination processes tailored for this population, including: outreach and engagement, referrals and screening, release of information, medication reconciliation, self management support, monitoring transitions, etc.
  - c) Place Care Coordinators in multiple settings including Emergency Rooms, primary care, behavioral health, and others

# Multidisciplinary Teaming

- **Behavioral Health Integration Requires:**
  1. Collaboration between providers, which can include care coordinators, clinical social workers, community health workers, psychiatrists, pharmacists, counselors, etc.
  2. Practices informed by evidence. More than 70 randomized controlled trials have shown collaborative care to be more effective and cost-effective than usual care.
- **Objective:**
  - a) Enable providers to finance and implement a collaboration model that works for their circumstances while encouraging use of core evidence based practices such as systematic caseload reviews.

# Psychiatric / PCP Consult

- **Behavioral Health Integration Requires:**
  1. Primary care access to psychiatric services.
  2. Coordination/Integration with primary care.
- **Objective:**
  - a) Increase access to psychiatric consultation.
  - b) Facilitate evidence-based practices such as systematic psychiatric caseload reviews and tele-mentoring

# Peer Providers: Certification and Reimbursement

- **Behavioral Health Integration Requires:**
  1. Common definition of Peer Providers
  2. Framework for the services/supports they provide
  3. Certification
  4. Reimbursement Strategy
- **Objective:**
  - a) Adopt a common definition for California
  - b) Design and implement a services/supports framework- see Optum levels of peer provider services
  - c) Certify and make services reimbursable

# SBIRT Expansion and Sustaining Training

- **Behavioral Health Integration Requires:**
  1. Screening patients for SUDs at all points of care (i.e. ED, ambulatory, mental health visits).
  2. Training for providers in appropriate screenings practices.
- **Objective:**
  - a) Expand SBIRT Locations: e.g. emergency departments, inpatient hospitals, specialty care (e.g., cardiology, endocrinology, etc.), mental health settings.
  - b) Expand Screening services to include other populations: e.g. youth, patients using illicit drugs, patients misusing prescription drugs.
  - c) Expand professionals who can supervise SBIRT services.
  - d) Expand training effort to include learning collaboratives and technical assistance.

# Cross Systems Training

- **Behavioral Health Integration Requires:**
  1. Addressing Key Work Force Barriers including:
    - Insufficient academic training and inadequate skills for integrated practice.
    - Resistance to change practice patterns amidst a myriad of other health reform transformations (change fatigue & training overload)
    - Attitudes and issues related to stigma within and across provider groups
    - Negative attitudes about persons with mental health and substance use problems
- **Objectives:**
  - a) Initiate cross system and intensive training and technical assistance using proven models, i.e. learning collaboratives; learning communities; intensive coaching and mentoring
  - b) Require all system partners engage: SUD, MH, PCPs, Peers, Housing and other SS, & MCPs at a minimum
  - c) Pay participating organizations to cover travel costs and incentivize
  - d) Ensure an overview of evidence-based practices including familiarity with motivational interviewing, self-help, medication assisted treatment



# Practice Transformation Strategies- Questions for the Experts

1. What is needed to advance these programmatic strategies?
2. Of these strategies, which should be tested in the short term?
3. Do you consider these practice transformation strategies priorities?  
What else is needed to advance integrated care?



# Mental Health and Substance Use Services (MHSUDS) Task Force

Advancing Behavioral Health Integration in  
CA

Julie Stone, Mathematica



# Advancing Behavioral Health Integration in CA-Round Robin

We have given you a great deal to think about. What do you see as the key priorities and opportunities for advancing integration that DHCS needs to consider?



# Contact Information

Please e-mail comments, ideas or concerns to:

[MHSUDStakeholderInput@dhcs.ca.gov](mailto:MHSUDStakeholderInput@dhcs.ca.gov)