Payer-Provider Collaboration:
The Value of Data Sharing for Whole Person Care
Overview of NC Medicaid System

November 08, 2016
### NC Medicaid SnapShot

#### IC Integrated Dashboard April 2015 through March 2016

**Population Summary**

<table>
<thead>
<tr>
<th>Catchment Area</th>
<th>County</th>
<th>Charlson Comorbidity Score</th>
<th>North Carolina County Map - Percentage of County Population</th>
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<tr>
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<td>BUNCOMBE</td>
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<td>RUTKF</td>
<td>10.00</td>
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<table>
<thead>
<tr>
<th>Total Patients</th>
<th>Population %</th>
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<tr>
<td>1.704M</td>
<td>100.000%</td>
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<table>
<thead>
<tr>
<th>Total Spend</th>
<th>% of Total Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5.060bn</td>
<td>100.000%</td>
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<thead>
<tr>
<th>Hospital Admits</th>
<th>ED Visits</th>
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<tr>
<td>180.4K</td>
<td>994.2K</td>
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NC Medicaid Model – 25 Years of Innovation and Reform

1980
1st Medical Home Pilot
Public MH/DD/SA Authorities

1990
1915B Child Waiver

1995
State Wide PCCM

1999
Dual Eligible Project
Cost Overruns for HRI Services – rate, mgt, trust issues
Area Authorities statutory Language Changed

2006
10 MCOs

2012
Cost Savings Questioned
Chronic Condition Mgt Program

2014
43 to 29 LMEs

2016
7 MCOs/BHOs; phasing out
Mged Care and ACO Provider Plan In Place

Behavioral Health

Physical Health

Expansion of Pilot
1990
1999
2006
2012
2014
2016
Unique Aspects of NC MH/DD/SA Waiver

BH Management is LOCAL

BH Waiver Management is all Public Funds
  • Federal Medicaid
  • Federal Block Grant funding (MH, SA and SS)
  • State Funds
  • Other Grants and Pilot Initiatives funding available

BH Waiver Management is MH/DD/SA
  • Funding to provide services for all three disability groups in both age groups:
    • Mental Health
    • Substance Use Disorders
    • Intellectual and Developmental Disabilities
Challenges Along the Way

- Bifurcated MH and PH Management.
- Regional Management Structures do not Align.
- Player/Stakeholders Historically Compete/not Collaborative: Local Projects prove successful
- MCOs/BHOs and MH/DD/SA Provider system has been slow to collaborate/innovate
- The MH/DD/SA provider system has been slow to evolve quality services/quality providers
- Local MCO Expertise has been slow to evolve
Measures have been developed and modified based on current nationally recognized performance indicators. The following measures are based on HEDIS standards:

- Follow-up After Hospitalization for Mental Health
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Call Answer Timeliness
- Call Abandonment
- Mental Health Utilization
- Identification of Alcohol and Other Drug Services
- Integrated Care Measure – Adult
- Integrated Care Measure – Child and Adolescent
Using Data to Solve Real Problems

Let's solve this problem by using the big data none of us have the slightest idea what to do with.
CMT: The Power Of *ProAct*

A web-based data analytics solution supporting population health

Works in the background to aggregate, analyze and interpret data

Supports evidence-based management of complex populations

Enhances clinical and financial risk analysis
Sandhills Center – Who We Are

• Fully Capitated Public BHO/Managed Care Organization (Medicaid PIHP Model)
• Serve 9 counties in central NC; 160,000 Medicaid Lives Authorize, Manage and Pay for all MH/DD/SA full
• Largest Urban Area—3rd largest city by population in NC—Greensboro where Carter’s Circle of Care is located
• Smallest Rural Area—26,000 population
• Native American/Hispanic—Latino Populations
• Fully accredited by URAC in the areas of Health Network, Health Call Center, and Health Utilization Management.
• QIO Accredited
• 859 Contracted Providers
Origins of Integrated Care Project

- Quality of Care Concern Data
- Critical Incident Data
- Evidenced Based Practices/Clinical Practice Guidelines
- Under/Over Utilization Trends
Origins of Project

- Quality of Care Concerns
  - Lack of physician to physician case coordination
  - Polypharmacy
  - Failure to access opioid data bases
  - Failure to monitor for metabolic syndromes—BH
  - Lack of objectivity in BH diagnostic documentation
Quality Improvement Initiatives

• Support and Grow Integrated Care Models
• Improve egregious Psychotropic Pharmacy Practices –
  ➢ Use of 5 or more psychotropic Medications in a 60 day period (Adult) or 90 day period (Child)
  ➢ Use of 3 or More Antidepressants for 60 or more days
  ➢ Use of 3 or More Antipsychotics for 45 or more days
  ➢ Patient Failed to Refill an Antipsychotic Within 30 Days of Prescription Ending
  ➢ Patient Failed to refill a mood stabilizer within 30 days of prescription ending
  ➢ Use of an antipsychotic in a child 4 years old or younger
  ➢ Use of Benzodiazepine with Long-Acting Metabolites for 30 or More Days (Elderly population)
Supporting Providers with CMT Data Portal

- Selection Criteria for Inclusion
- Expectations of the Providers
  - Use the tool daily
  - Track on the identified Measures
  - Take Actions around care needs/care improvement opportunities
  - Incorporate Quality Indicator measures, Evidenced Based Practices, Clinical Practice Guidelines into clinical policies/procedures/protocols and audit compliance moving forward

- CMT will track progress of indicators month over month and provide provider specific comparison reporting
Where We Are—8 Integrated Care Partners

**FQHC/CMHC Provider**
- **Carter’s Circle of Care**

**Community BH Providers**
- Daymark
- Monarch
- Pinnacle Family Services
- RHA

**Community Hospital**
- First Health
- *Two Others Interested*

**Primary Care/Pediatric Practices**
- Sandhills Pediatrics
- ABC Pediatrics

**Two CCBHC Sites**
- Cone Health—Greensboro
- Monarch—Stanly County
THANK YOU

KNOW MORE. CARE WISELY.
THE “GIFT OF DATA” AND TECHNOLOGY
THE JOURNEY TO OUR PAYER-PROVIDER RELATIONSHIP

• Began with “values based” decisions
• Investment in training staff in Evidenced Based Practices
  • 4 rostered TF-CBT clinicians (NC-CTP)
  • 3 currently in the process of rostering (NC-CTP)
  • 4 rostered CPT clinicians
  • 3 GAIN certified assessors (Chestnut)
  • 4 The Seven Challenges trained (The Seven Challenges)
  • 2 accepted into the Resource Parenting Curriculum Training (NC-CTP)
  • 1 completed Project LIFT (Leadership Initiatives for Tomorrow) (SAMHSA)
“SHIFT” HAPPENS

- Shifting with Medicaid reform
  - “Right service. Right time. Right Amount”
  - Significant loss of revenue
    - 2013- $694,965.36 - IIH
    - 2014-$298,384.80 - IIH
  - New “business” model
GUIDEPOSTS

- Eliminate (barriers to treatment)
- Engage (individuals in their health and wellness)
- Evaluate (treatment outcomes and practices)
WHAT WE KNOW:

• Transportation is the number one barrier to our patients accessing physical and behavioral health care
  • As many as 25-55% of low income individuals report transportation as the number one barrier to attending scheduled appointments AND refilling prescription medications which lead to poorer health outcomes

• Health literacy is another barrier that leads to poor health outcomes for individuals
  • “Nearly 9 out of 10 US adults have difficulty using the everyday health information that is routinely available in our health care facilities, retail outlets, media and communities.” (NPSF, National Action Plan to Improve Health Literacy, 2010)

• Access to health insurance & quality care significantly impact our patient population as well

“You can provide the best care in the world, but it doesn’t matter if the patient has no way to get to it.” - Samina Syed, Endocrinologist
STRATEGIES IMPLEMENTED TO ELIMINATE BARRIERS

- Community based assessments and outpatient therapy
- Integrated Care
- Treatment Navigator
- Rapid Access Services
- Sequential Care
- Friendly Pharmacy
- TelePsych
- TeleHealth
- Orange Card Network Provider
ENGAGE…

WHAT WE KNOW:

• Patient Experience is one of the three tenants of The Triple Aim Approach

• North Carolina is emphasizing the importance of Parent, Youth and Peer voice in the treatment process

• Patient engagement impacted by therapeutic alliance, accessibility of care, and patient’s concern that treatment will address their unique needs (Dixon, Holoshitz & Nossel, 2016)

“We should treat the patient as if we are walking into their house, instead of them walking into our house. We should make this the patients home while they are here.” –Toni Ardabell, CEO Bon Secours Richmond Health System
STRATEGIES TO ENGAGE PATIENTS

• Relationship building starts from the beginning
• Hiring the right staff AND training in interpersonal skills (specifically, common factors of alliance, empathy, positive regard, etc.)
• Ask Me 3
• Satisfaction Surveys
• Social Media/Contests
• Standardized Screeners
• Health Literacy
• Medication
• Using Data to Identify Care Gaps for Patient Outreach
(EXAMPLE)

ASK ME 3®

Health information is not clear at times. The Ask Me 3® program run by the National Patient Safety Foundation can help. The program gives you three questions to ask your health care provider during a health care visit, either for yourself or for a loved one. They are:

- What is my main problem?
- What do I need to do?
- Why is it important for me to do this?

Asking questions can help you be an active member of your health care team.

For more information on Ask Me 3, please visit www.npsf.org/askme3

Ask Me 3 is a registered trademark licensed to the National Patient Safety Foundation (NPSF). [Your organization name] is not affiliated with nor endorsed by NPSF.
EVALUATE...

WHAT WE KNOW:

• Accountability counts AND is now required

• Concerns about services requires measurement of outcomes (e.g., service effectiveness, symptom improvement, client and professional “fit”)

• To satisfy funding bodies and other stakeholders

• Cultural concerns and preferences matter

“Results are derived from good management. Good management is based on good decision making. Good decision making depends on good information. Good information requires good data and careful analysis of the data.” (Martinez, 2005)
CMT PROACT SOLUTION: ACTIONABLE INSIGHTS

Use of Bupropion at Higher Than Recommended Dose for 45 or More Days (Under 18 Years) [I/DD]

Clinical Issue

When treating depression or anxiety as a comorbidity, standard practice guidelines should be followed. (Expert Consensus Guidelines, 2003)

- Increased risk of side effects such as nausea, vomiting, rash, and possible seizures at high doses.
- HICs are often associated with seizure disorder. Use of bupropion may increase risk for seizures.
- May contribute to poor adherence.
- May indicate non-compliance to this class when prescribed for youth typically for ADHD and/or tic disorders.
- May indicate efforts to treat symptoms with bupropion that require environmental change, behavioral treatment, or a different drug.

Clinical Considerations:

If you have not already, please consider the following:

- Ensure adequate behavioral interventions are in place; review appropriateness of behavioral program regularly.
- If possible, implement a family psychological intervention. The American Academy of Child and Adolescent Psychiatry considers psychological treatment an essential component of pharmacological treatment which identifies family and patient factors that may impede a medication trial. The type of intervention guided by the diagnosis.
- Ensure adequate behavioral and educational interventions is in place; review appropriateness of behavioral program and classroom placement regularly.
- Reviewing medication use and adherence with patient and/or family.
- Drink free of caffeine to determine if the higher than recommended dose is needed.
- Reviewing original diagnosis and review treatment to reflect current clinical formulation including co-morbidity.

References:


4/28/2016 | Slide 30
I wonder if you would be open to speaking to this slide here as a follow to your good outcomes comes from good data and good information. So for exa., with our CMT tool, it points us to opportunities for care improvements, it doesn't just tell us the count of people but actually who needs what and the clinical information as to WHY! What is the evidence based info right in the tool.

Carol Clayton, 11/8/2016

Carol Clayton, 11/9/2016
STRATEGIES TO EVALUATE OUTCOMES

- CMT data
- CCNC Provider Portal Data
- Evidenced Based Practices Data
- Timely Access-to-Care Data (Internal)
- Staff Performance Metrics (Internal)
- NC TOPPS
- Analyzing Critical Incident Reports
- Post-Session Surveys
- Stakeholder Surveys
- Standardized Screenings/CCA
- PHQ-9 in Integrated Care
- Medication Reconciliation
- Cultural Competency Plan (practice based evidence)
BENCHMARKS

• Polypharmacy: Completed Suicides, Attempted Suicides, ED Utilization
  • CCOC implementation of the Columbia-Suicide Severity Rating Scale (CSSR)
  • Real time ED data

• Utilization Data:
  • As discussed in slides before, close attention is paid to utilization data in each of our service lines

• High Cost BH Services—Over Utilization
  • Embracing the need to be nimble, tracking the pulse of the MCO, and being creative in service delivery (e.g., Intensive Outpatient Services, Rapid Access, Sequential Care)

• Evidenced Based Practices—Under Utilization
  • Significant efforts over the last five years to ensure that all licensed clinicians are trained in year-long, in-person learning collaboratives focused on Evidence Based Practices
BENCHMARKS (CON’T)

• Lack of physician to physician case coordination By embedding behavioral health medical staff, behavioral health licensed clinicians WITH primary care staff, case AND care coordination have been elevated (e.g., with access to CMT AND HIE data, case coordination is more achievable. Due to our bifurcated system in NC, behavioral health providers with access to these data sets have an opportunity to engage in population management across specific clinical indicators

• Lack of objectivity in BH diagnostic documentation Intentional focus on use of valid and reliable diagnostic and symptom screening tools; goal to more objectively inform and refine clinical diagnosing and monitor symptoms; targeted focus on PTSD, ADHD, Autism, Anxiety, Depression, Suicide, and Bipolar D/O
HOW DO WE MAINTAIN OUR MOMENTUM...

- Focus on *practice based evidence*
- Focused staff training on common factors (e.g., alliance, empathy, positive regard, repairing ruptures, etc.)
- Providing clinicians with real-time patient feedback
- Providing clinical support tools to adjust treatment as needed

*(APA Presidential Task Force on Evidence-Based Practice, 2006)*
Could you elaborate on the latter bullet relative to a clinical support tool, ie, CMT to assist you with treatment adjustment? For example by using CMT’s gaps in care measures, you can take steps of care coordination, beyond the treatment modality offered, to insure whole person care is attended, ie, make sure the foot exam gets scheduled, or take the blood pressure, etc. . . I know you are trying to figure out next steps here but this would be a good time to see “here is what we plan to do with the data coming our way in 2017. We can flesh this out tomorrow night if needed.

Carol Clayton, 11/8/2016