MOVE TO MANAGED BEHAVIORAL HEALTHCARE WORKGROUP: 4/29/2013
SMALL GROUP CHALLENGES

Challenge! Group 1: Using the basics that we have given you here, look at the system NOW, and overlay what you know of managed healthcare … What opportunities can we leverage to create:

-High quality seamless services for consumers and families, opportunity for success and sustainability for providers.
-Leverage family support organizations throughout the state to assist families and children to access services.
-Other states/region (Philadelphia.)
-Consistency across counties in contracting principles so we can make process/administration more consistent.
-Expand Olmstead initiatives out to community referrals (more than "at risk") (aging parents.)
-Relationships with academic institutions, to fill voids in prescriber-licensed professionals (MDs, APNs) incentives (e.g.: National Corps Health – loan forgiveness for underserved areas.)
-HMFA models (DCA) for long-term sustainability for properties for residential.
-Community support services

- Federal match for supportive housing services.
- Peer support services.

"NAMI"/concerned families (assist to educate) ⟶ these exist in state hospitals, should be duplicated.
Needs assessment – better screening and triage.
<u>Expanding limited systems:</u>
In MH ⟶ outpatient commitment for those being discharged from hospital to leverage them to work on their addictions issues (can't keep in hospital.)
Psych Emergency Services, by regulation, is mental health. Take that concept & expand into addictions to support merger of systems.
Case management- short term care facilities need to provide co-occurring services, lacking substance abuse services.
Mental Health community provider fostering relationships, using hospital as Technical Assistance Center.
Expand recovery centers throughout NJ (only two now)
Data systems sharing – using data to drive system of care.
Specialty non-traditionalized that don't fit into regulations (i.e. shared supportive housing.)
Tobacco expertise at UMDNJ (Rutgers) & CHOICES.
211 needs to be more informed about existing resources, bed availability, provide direct case management.
For consumers – simplify systems so clients who lose their housing or other benefits do not have to go through system again (wasting $) in order for them to get what they need.
Operationalize – incentive model to establish accruals for cash flow.
Provider agencies outcome measures to establish benchmarking/outcomes (employment, education, quality of life.)
Successful supported education and employment to learn form ones that are working to expand.
"Learning Communities" to expand knowledge/expertise in co-occurring, physical, development al disabilities and older adults.
DCF Office of Adolescents/Emerging Adults to improve access & services (full continuum of services.)
Transparency to improve relationships with other Departments.
Assess policies and procedures to streamline process (NIATx one option.)
Assess electronic treatment history to inform treatment & assessment.
Streamline data input and avoid duplications, reports and statistics available.
<u>Opportunities for providers:</u>
Rate rebalancing.

Relieve anxiety of providers.
Opportunities for partnerships with other systems.
Use Best Practices to increase consumer engagement.
Reduce unnecessary ER visits.
Partnerships with other behavioral health providers to improve availability of continuum of care.
Services:
Development of more specialized services for consumer.
Opportunities to improve integration of BH and PC.
Streamline access & coordination for consumers by braiding funding & coordinating funding.
Centralize PADS electronically & eliminate calls to centralized admissions.
No Wrong Door.
Increase consumer education.
Services for consumers and families:
Expansion of EISS (MH adult.)
Decrease or eliminate waiting list (through improved use of resources.)
More appropriate referrals may decrease no show rates.
Expand NIATx.
Improve directories and access to information on treatment options including an explanation of terms.
Outcome based provider assessment available to the public.
Workforce development:
Increased training opportunities for providers to prepare for fee fcor service.
Increase rates for providers to attract licensed professionals.
Fund training for all staff, all levels, all providers.
Allow for better integration of MH/SA services. Ensure that levels of care remain/continue.
Referral/bed management.
Allow for development of integrated MH/SA licensing.
Ability to build on SA fee for service experience for MH.
No turf wars. Agencies can share best practices/"what works" with other agencies. Collaboration.
Allow for better program monitoring to ensure quality treatment. Up front monitoring, triage.
Systems of leadership in place that can be brought together to begin unified discussion towards provision of BH services including SA/MH/Physical health.
Information sharing to promote improvement and change in service provision.
Utilize various components of existing system to better serve population.
Build safety net for the benefit of individuals.

Challenge! Group 2: How do we get ready for this large scale change? What might stand in the way of our progress?

Need integrated system to electronically exchange health/client information

- What will the cost be? Can providers who are non-profit afford this cost?
- Will there be another system from the state or do providers need to choose a "compatible" software?
- How much time will providers have to purchase, implement and train?

Process of dissemination to public/consumers about changes to: 1. Their plans, 2. Access, 3. Requirements.

- This has to occur at a local level. Providers will need assistance in explaining changes to consumers.

Need increase in providers for recovery support services.
Clients course of treatment will change, but still need ongoing involvement. Where?
Centers must be providing support in health, MH & SA – Home Health Recovery Center to match language and allow clients to centrally access support for all issues.

- Funding for these services is needed for clients and these services to be sustainable.
- Distance/location:

- Clients need accessible treatment – this may mean an increase in transportation or an increase in outreach services to client (replicate PACT model for other conditions.)

What do we need to get ready?
1. Centralize information.
Local, county, state budgets (fiscal climate.)
Lack of credentialing (a process that is time consuming,) competent workforce.
Transition from unmanaged, contracted system to fee-for-service system.
Not knowing new rates.
How to retain workforce in fee-for-service environment.
State regulations need to accommodate growth of infrastructure/system changes.
Buy-in from educated workforce (provider support for coping with changes and stress management to deal with compassion fatigue.
Cross train any provider in the system to include co-occurring, medical model, SA, MH. Also include administrative staff.
Staffing challenges to address appeals process.
Important to include prevention and family therapy/treatment in service package.
Include individualized treatment plan and a continuing care review process.
Will there be a standardized rate structure?
Limits on services (frequency, duration of services allowed in each prior authorization, care often exceeds predetermined criteria of treatment, providers may often provide care that is not reimbursed and requires provider to pursue other funding streams.)
Current system allows for variation of who gets services by county - move toward ASO would mitigate this situation.
Determine significant tools that speak to validity of this process (specific tools that can identify SA/MH - clinical tool is important to use in this process.
Will ASO replace NJSAMS?
What about the cost for training for the NJSAMS replacement?
Identification of individuals who are intellectually/developmentally disabled (communication between systems.)
Enrollment and retroactive payment for services.

- Timely access to services.
- Provider incentives to assist individual in Medicaid.

Prior authorization Process – look at clinical process/work vs procedure (i.e.: signing of paper.) Make clinical process a priority!

- Capacity – shortage of services.
- Consider alternative treatment philosophies.

Challenge! Group 3: As we work toward systems change, we want to take a stance of prevention, of being proactive to obtain solid, stable outcomes. What milestones can we set to demonstrate our success along the way?

- for consumers and families
- for providers
- for taxpayers

Proficient use and leverage of technology

- Electronic health records implementation
- Cost effective for taxpayers by reducing waste of time/resources.
- Makes sharing of treatment history and information easier for consumers, families, providers, and hospitals.

Measurable outcomes

- Data demonstrates decrease in hospital recidivism, decrease overall hospital admissions, increase utilization of community outpatient services.
- Data shows increase in consumer and family satisfaction
- Data that demonstrates cost savings.

Development of contracting with the fee for service framework that allows expansion of recovery support services for smaller agencies who may be negatively impacted by fee for service changes. (residential, OutPT)
Measures that indicate increased consumer participation in self-help centers and recovery mental health support centers.
Implementation of technological tools that consumers can use to record symptoms and medication adherence, life events and goals

- Develop process to measure consumer ability to use this technology. Saves $, use of resources, used more efficiently, educational opportunity for consumers, promotes independence.

Streamline enrollment/re-enrollment.
Safeguard consumer identification/cost to replace and caps on replacement.
Use document imaging/HER/technology.
Ensure agencies protect individual identification but are equipped to transmit information.
Treatment will be based on wellness and recovery.
Treatment will be accessible.
Consumers will live longer.
Treatment/care will be integrated PH/BH.
Development of an enrollment system (electronic) capable of document imaging, protecting patient health information.
Sufficient capacity of Medicaid psychiatrists and APNs and clinicians/workforce.
Treatment for MI/DD-ID/SA consumers (coordination of care and funding.)
ASO authorizes treatment and resources.
Respite resources are available for consumers and families.
Increase use of Advance Directives and on file with the ASO.
Data driven decision making and use of data to project needs around SVC array and workforce.
Expand case management services.
ASO process to be efficient and effective.
Reduce unnecessary hospitalizations.
Use of current treatment modalities (including pharmacology) at hospitals and consumer provider agencies.
Decrease ER visits.
Urgent care/Behavioral Health (open 24/7) Centers.
Decrease in incarcerations.
Decision re: baseline data.
Improved coordination between physical and behavioral health.
Improved technology to coordinate care.
Consumers/families are aware to access services.
Increased bed capacity on a regional basis.
Adequate reimbursement for providers (Rate setting.)
Periodic re-evaluations of the ASO.
Retention and engagement of consumers (user friendly system) in treatment. Better outcomes.
Aligning fiscal incentives with the outcomes.
Achieving consumer driven objectives.
Develop strategies to avoid adverse selection of consumers.
Examine evidence based practices that may not be in the network today for inclusion in the future.
Outcome measures need to be easier to administer, reasonable in terms of cost & objectivity verified.
Development of method to evaluate fidelity & be cost effective.
Consumers and Families:
Measures, surveys and focus groups. Consumer satisfaction.

Increase in qualified providers.
Consumer and Provider:
Training of contracted personnel.
Transportation options revamped.
Increase independent living choices/options
More outreach/early intervention.
Using evidence based systems.
Decline in readmission.
Improved quality of life for consumers.
Gradual change of level of care.
Increased capacity for OP & timelier access.
Providers
Geographically provide services.
Ability to supply services, to expand, consumer assistance.
Seamless licensing process under 1 entity.

- Increase %age of dual certifications of providers, cross training of disciplines.
- Increase efficiency.
- Increase savings.

Address public safety:

- Measures of recidivism, incarceration.
- Homelessness, re-hospitalizations.
- Reduction in high expensive service deliveries.
- Evaluation of contracted services, having a provider report card.
- Rates that are sufficient to produce the desired outcome.

<u>Comprehensive review</u> of the program standards to ensure the minimum necessary to provide the desired quality and outcome.
Maximize consumer enrollment.
Prevention
Need for baseline data/measure of substance use vs treatment outcomes.
Taxpayers
Decreased homelessness
Decrease in illegal drug activity (?)
Decrease in government benefits due to consumers seeking employment.
Savings to NJ Taxpayers by improved health, shift to community-based care from institutional care.
Better integration of behavioral healthcare with primary care.
Reduction of Emergency Room visits
Reduce/abstinence of alcohol/drug use.
Increase community integration, community tenure, employment.
Measuring increased enrollment of expansion population.
Understanding the components of parity.
Reduce criminal justice involvement (MH/SA)
Decrease homelessness by increasing access to permanent housing, access to benefits, subsidies.