National Dialogues on Behavioral Health

Dealing with Complex Behaviors

Jennifer Black, LPC
VP, Strategy and Development
October 24, 2017

Brief View of Beacon Health Options

- Headquartered in Boston; more than 70 locations across the country
- 5,000 employees nationally serving 50 million people
- 200+ employer clients, including 41 Fortune 500 companies
- Programs serving Medicaid recipients in 25 states and DC
- Serving 8.5 million military personnel, federal civilians and their families
- Partnerships with more than 90 health plans

beacon
health options

The need to focus on behavioral health has never been greater – How do we use data to drive decisions?

Focus on individuals with complex needs

Those driving disproportionate healthcare costs require targeted interventions

- Seriously Mentally Ill (SMI)
- Substance Use Disorder (SUD)
- Justice Involves Individuals
- Social determinants must be addressed

Integration of BH and PH

Focus on integration of behavioral and physical health care at the provider level

- Integration looks different for distinct populations
- Collaborative Care Model, psychiatric consultation

Promote early intervention and access to community care

Create an accessible system of care that can identify and divert individuals from higher levels of care

- FEP and other emergent adults
- Crisis / diversionary/ urgent care - community alter
- natives to emergency departments

Provider alignment on clinical and financial goals

Creating financial incentives with providers to achieve clinical goals

- Value-based payments
- ACO-like models of risk transfer

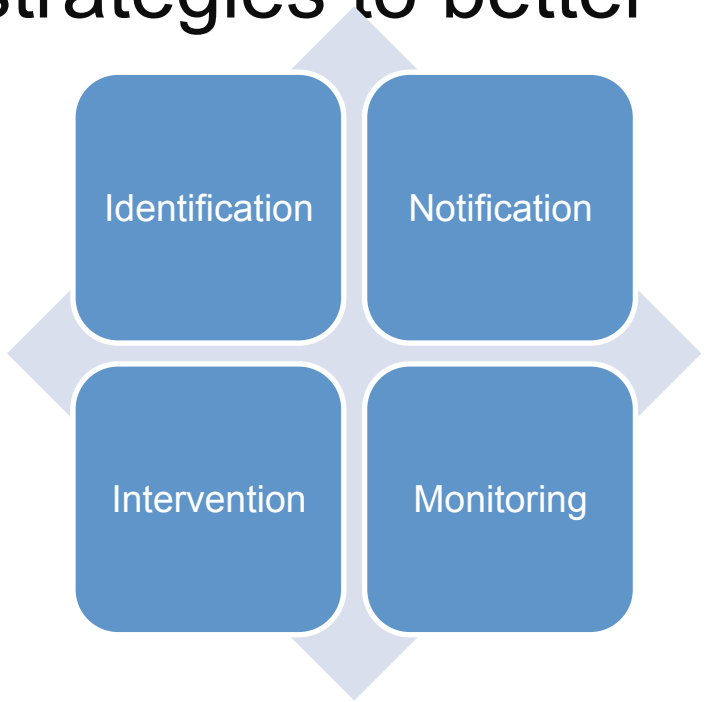
Outcomes:

- Lower ED and IP utilization
- Community stability for individuals with chronic conditions
- Better integration between physical and behavioral health
- System-wide cost savings

Focus on individuals with complex needs

Specialty Programs for individuals with high needs and high costs

- Approximately 5 percent of patients account for about 50 percent of all US health care spending.
- Use a combination of data based approaches and specialized care management strategies to better serve this population
- Steps Include;
  - Identification
  - Notification
  - Intervention (critical issues)
  - Monitoring and Feedback



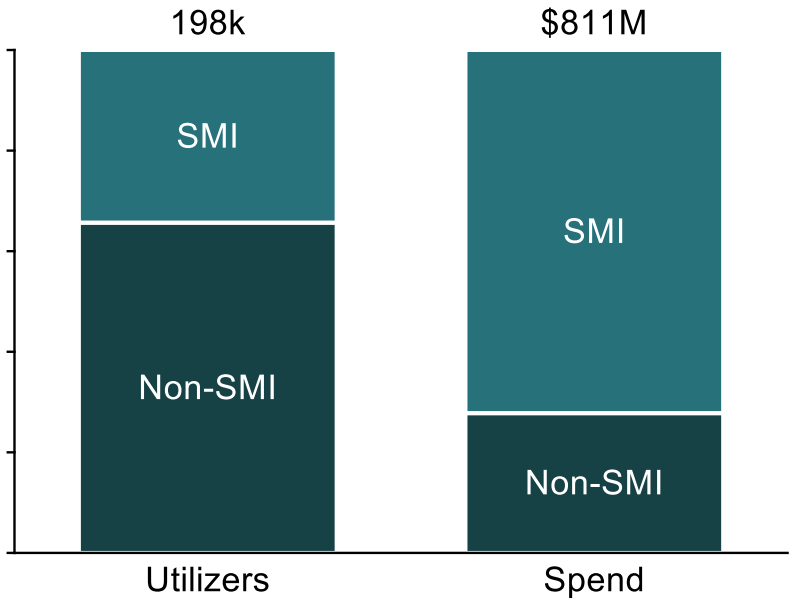
Schoenman JA, Chockley N. Understanding U.S. health care spending [Internet]. Washington (DC): National institute for Health Care Management Research and Educational Foundation; 2011 Jul [cited 2014 Apr 24]. (Data Brief). Available from: http://www.nihcm.org/ images/ stories/NIHCM-CostBrief- Email.pdf

Individuals with Serious Mental Illness (SMI) require health interventions tailored to their specific needs

WHO ARE THE SMI?

- Individuals with: psychotic disorders, bipolar disorder, depressive disorders, severe & persistent mental illness with relapses
- These 39% BH utilizers drive 72% of costs in MD
- People with SMI die 20 years earlier on average compared with the general population

SMI prevalence, MD MCD adult pop



*adults only

WHAT ARE BEST PRACTICES FOR MANAGING THIS POPULATION?

Serious Mental Illnesses are chronic diseases that require holistic approaches to continuous care:

- Repeated **acute care episodes are ineffective**
- People with SMI often have **comorbid chronic physical health conditions** such as diabetes, obesity, hypertension, and asthma
- **Homelessness, lack of transportation, unemployment, and poor social supports** are common among those with SMI

Effective interventions for the SMI address these needs directly:

1. Specialized provider network with wraparound supports
2. Strong focus on integrated care
3. Attention to social determinants of health

CT Behavioral Health Home Dashboard

#imawholeperson
#ctbhh

Behavioral Health Home (BHH) Demographic Data

for All Enrolled Members in CY 2015

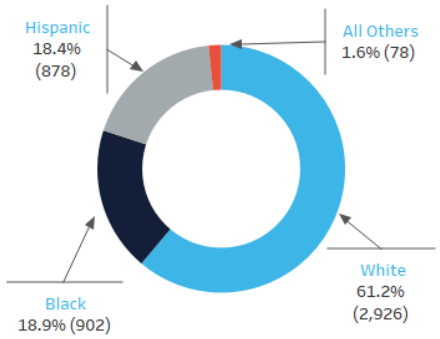
▼ Select BHH Provider
All

Total BHH Enrollees in CY 2015: 4,784

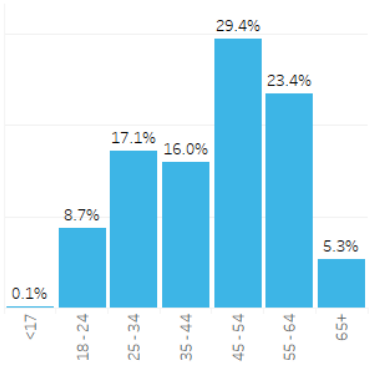
47.0% were Male

53.0% were Female

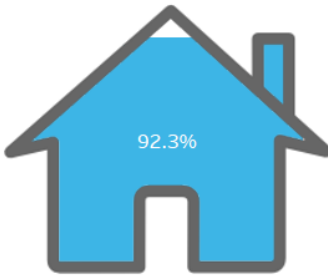
BHH Racial/Ethnic Profile



BHH Age Groups



Percent of BHH Enrollees with Housing



7.7% are homeless.

Diagnostic Prevalence Rates for BHH Members in CY 2015

▼ Select Medical Diagnosis
Hypertension

Hypertension: **46.4%**

▼ Select Mental Health Diagnosis
Depressive Disorder

Depressive Disorder: **54.5%**

▼ Select Substance Use Diagnosis
Alcohol

Alcohol: **30.3%**

Co-occurring Disorders (MH & SA): **63.7%**

Comorbid Diagnoses (BH & Med): **82.3%**

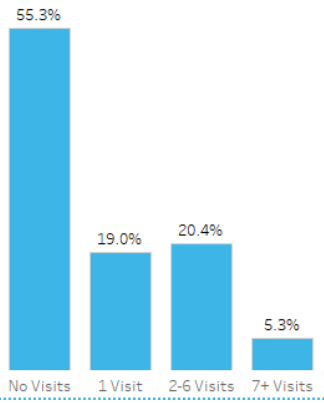
Total Avg. Dollars per Member: **$31,973.23**

Total Spend

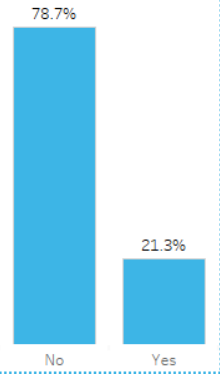
Total Dental Cost	$1,251,760.96
Total Pharmacy Cost	$34,818,588.98
Total Med/BH Claims Cost	$116,889,565.69
Total Member Cost	$152,959,915.63

▼ Select ED/Inpatient Type
Behavioral Health

Behavioral Health ED Visit Frequency



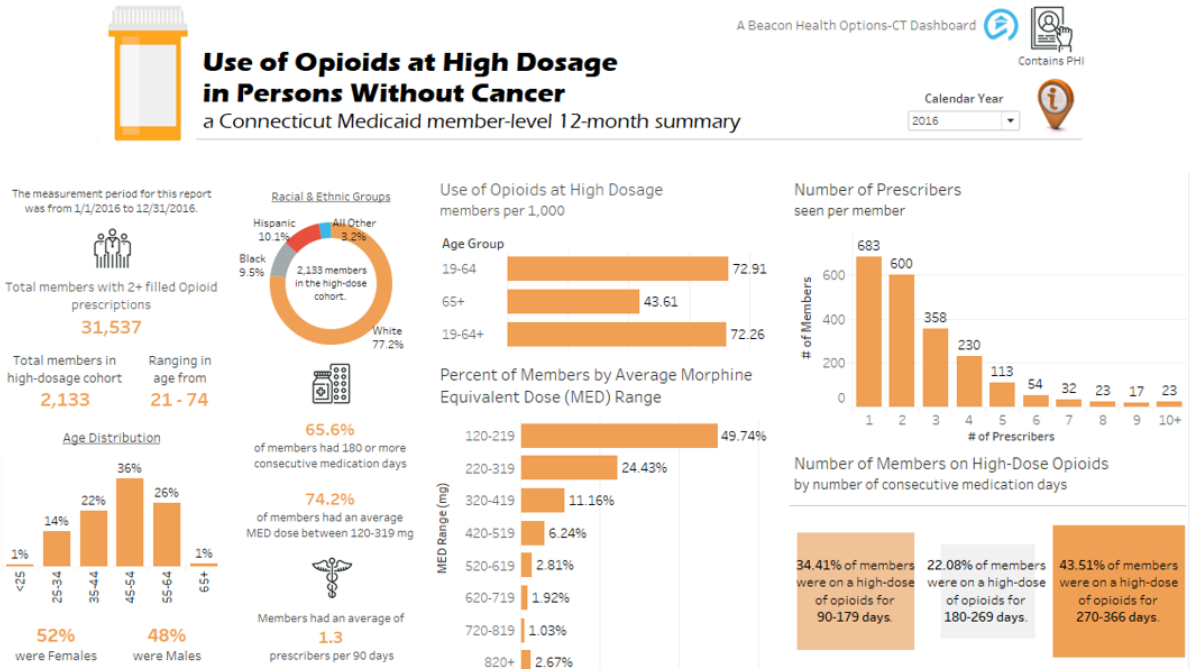
Behavioral Health Inpatient Utilization Rate



A Beacon Health Options-CT Dashboard

High Dosage Opioid – Background and Context

- Deaths from opioid overdose have reached epidemic proportions in Connecticut and the United States[1].
- CT - 917 people died of an opioid overdose in 2016, a 25% increase over the previous year.
- A contributing factor to the epidemic is believed to be over-prescribing of opioid pain relievers
- Beacon began tracking high dosage opioid prescribing within CT Medicaid to provide intervention



[1]SAMHSA, 2016; trendct.org, 2017

Combatting the Crisis of Opioid Addiction: Beacon's Clinical Philosophy

Current pathways of care within the substance use provider network evolved from the context of alcohol as the primary substance of choice and abstinence being the preferred outcome. This treatment model has created discontinuous care pathways that inadvertently disrupt the continuity of MAT from one level of care to another.

CHALLENGES IN THE CURRENT DELIVERY SYSTEM

1. **Patients avoid inpatient detox** because they can't leave their jobs or communities
2. **Patients quit 24-hour care**, preventing engagement in long-term treatment
3. Discharged patients **do not adhere** to treatment
4. The historic addiction model of care is **slow to learn and adapt**

BEACON'S TREATMENT SOLUTION

Expanding Access to MAT via Alternative Payment Models: We promote withdrawal management with stabilization on MAT as a best practice in treating opioid use disorder versus detox. Therefore we expand access to MAT and community-based capacity through value-based purchasing models, such as a bundled payment for MAT treatment.

Reduce early discharges and change care pathways: Because individuals who leave treatment prematurely have less favorable outcomes, Beacon works with providers to implement interventions and meaningful engagement supports that help members complete 24-hour levels of care, improving outcomes and providing a better opportunity to engage them in long-term care. We also foster timely connections between withdrawal management services and MAT. Members are not detoxed to zero, but instead provided a warm-handoff to MAT treatment the day after discharge.

Community support to improve treatment adherence: Beacon acknowledges that at least six months of continuous treatment needs to occur for individuals to benefit from it. We also work with Community Support Programs to ensure care continuity for members discharged from withdrawal management, engage members with peers who have lived experience, and connect them to essential services.

Sharing Best Practices in Opioid Treatment: To promote evidence-based care, Beacon educates members and providers on best practices in treating opioid use disorder, including web-based information about the national opioid epidemic via our Opioid Toolkit for providers and Opioid Resources page for members, provider bulletins, and treatment guidelines. We help combat stigma by educating people on the new substance use language.

Project ECHO®
Beacon Health Options

Beacon is proud to be an official Project ECHO partner. The Project ECHO model reduces gaps in care by increasing provider knowledge and capacity for specialty services. Through videoconferencing, expert teams at the "hubs" conduct virtual clinics with non-specialist community providers to educate them about various health conditions. They participate in case-based learning and didactic education. The goal is to ensure broad knowledge sharing among providers so more members have access to care in the local area. Beacon's ECHO program will focus on opioid use disorders, specifically helping practitioners treat more members with medication-assisted treatment.

Justice-Involved Individuals

WHERE ARE WE TODAY?

- Individuals with behavioral health conditions are over-represented in our country's corrections system
  - In 2016, **5.2% of BH utilizers in MD reported being incarcerated** in last six months vs. 0.5% incidence across entire US population*
- **Maryland is at the forefront of tracking the movement** of individuals with BH needs into and out of the justice system
  - State's data-link system provides real-time behavioral health information on incarcerated individuals to the detention centers
- **Gaps in critical MH and SUD services remain** as JII transition into and out of correctional facilities resulting in high recidivism rates and costly healthcare services

WHERE CAN WE GO?

- Effective programs for JII generally fall into two categories:
  - **Jail diversion**: partnerships with local law enforcement to identify and refer those in need of BH interventions vs. incarceration
  - **Prison re-entry programs**: ensuring timely connection to BH services for individuals released from prison

Key tenants of an effective program

Services are comprehensive, including both healthcare and community supports	**Program is scalable** across counties through partnerships with providers
Outcomes are measured consistently through single corrections state portal	**Behavioral health focus** should be at the crux of program services

*Source: Maryland OMS database (reported by OP BH utilizers for specific OMS providers), US Bureau of Justice Statistics

How Does DataLink Work?

- Beacon receives a daily file from the Maryland Department of Public Safety and Correctional Services of all individuals that have been:
  - Detained and processed at local detention centers in the past 24 hour period;
  - Incarcerated in one of the State correctional facilities; or
  - Remanded to the Department of Parole and Probation
- Data are reconciled with Medicaid eligibility data, utilizing agreed upon data points to identify a detainee as a “match”.
- Once a match is identified, the process looks for mental health authorizations and paid Medicaid pharmacy claims within the past calendar year.

How Does DataLink Work?

- This information is then electronically returned to the DPSCS as well as participating CSAs and local detention centers.
  - At DPSCS, the data is uploaded into the Electronic Health Record system where it can be viewed by authorized medical staff
- Detention center medical staff utilize these data points to more effectively assess and address detainees' medical and mental health needs
- Simultaneously, the data are also shared with local Core Service Agencies who can assist in providing coordinated care for the individual while detained and upon release

37%
Information Match Rate

355
Eligibles for Service Per Day

Integration

Integrated care looks different for distinct population cohorts

Mild

- Many mild behavioral health disorders are treated in PCP settings- goal is improve identification and rapid evidence-based care
- Collaborative Care Model is evidence based
- Colocation of case managers and available psychiatric consultation
- MH and SUD screenings including SBIRT and PHQ
- EAP Wraparound

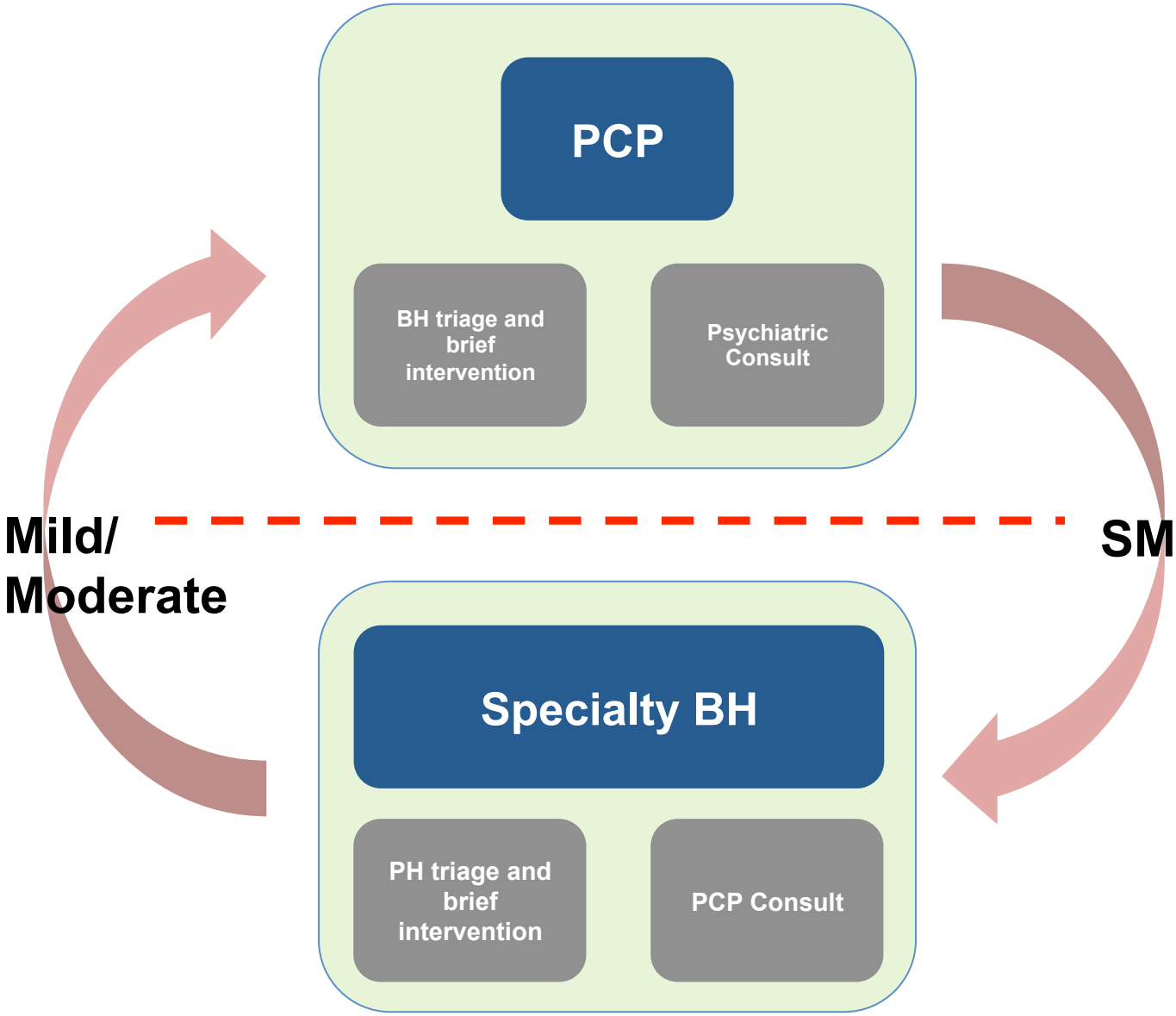
Moderate

- Specialist referrals when indicated with eventual return to PCP setting
- Ensure same-day and next day access for priority referrals
- Use of technology extenders

Severe

- Focus on BH specialty network and array of community recovery services
- Innovative engagement models (UTC strategies)
- Alternative payment arrangements supported by ongoing technical assistance
- Collaborative Care with medical services provided in specialty BH setting

An integrated system addresses access issues, meets members where they're at, and treats comorbidities



Providing access to BH care in the PCP setting reduces burden on the specialty BH system

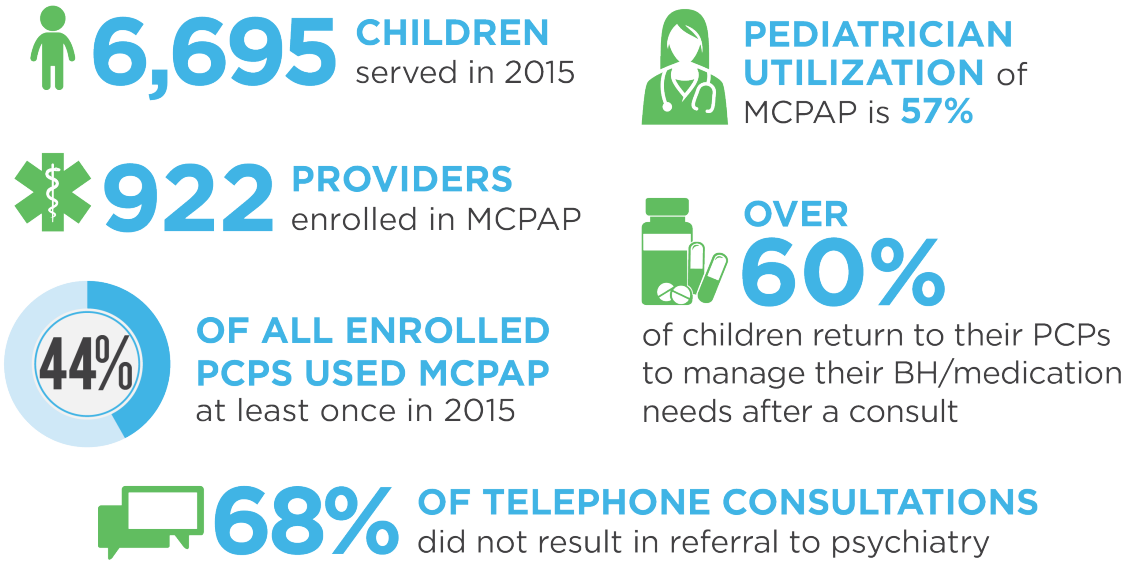
Mild-moderate individuals can be **treated effectively in PCP setting**

Ensuring that those who primarily seek healthcare in the specialty BH setting have access to physical health care

Individuals with **SMI are referred to specialty setting** for **whole-person care** that includes PH needs

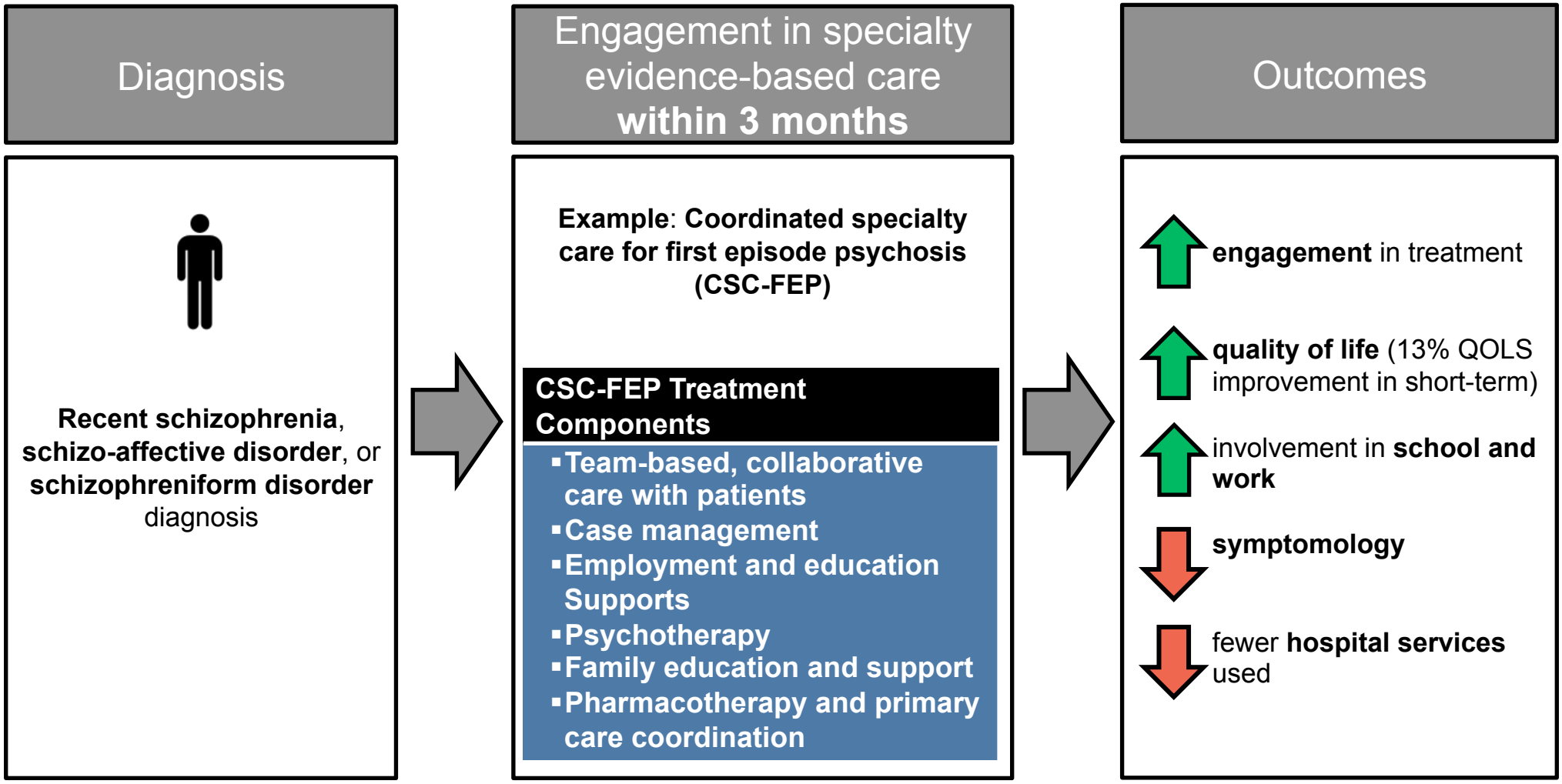
Psychiatric Consultation Improves PCP BH Capability Case Study: MA Child Psychiatry Access Project

- **Increase pediatric PCP's knowledge, skills, and confidence to manage children in primary care** with mild to moderate behavioral health needs (e.g., ADHD, depression, anxiety)
- **Mitigate the shortage of child psychiatrists** by promoting the rational utilization of psychiatrists for the most complex and high-risk children (e.g., children whose conditions require treatment with complex or multiple psychiatric medications)
- **Advance the integration** of children's behavioral health and pediatric primary care



Early Intervention and Access to Community Care

FEP Pathway / Center of Excellence



Notes: CSC-FEP is the most well-tested specialty treatment for FEP to-date. There are >100 FEP programs across the US. QOLS: Quality of Life Scale. 12 weeks is the WHO's quality standard for duration of untreated psychosis.

Sources: http://www.ncbi.nlm.nih.gov/pubmed/16143729; http://www.nasmhpd.org/sites/default/files/Cost%20Effectiveness%20of%20Team-based%20Treatment%20Final%20PPT.pdf; http://pathwaysrtc.pdx.edu/pdf/fpS16.pdf

Quality access to outpatient care means same-day appointments

THERE ARE ACCESS ISSUES TO BEHAVIORAL HEALTH PROVIDERS

- **1 in 5 adults** with mental health needs report that they **are not receiving the services they need**
- Nationally, **only 41% of adults with mental illness received any care** in the past year
- Only **four states were able to provide care to >50% of their mentally ill populations**
- **59%** of primary care physicians report being **unable to obtain outpatient mental health services for patients** due to local provider shortages/wait lists

WAIT TIMES HAVE A HUGE IMPACT ON NO-SHOW AND E.R. ADMISSION RATES

~25% no-show rate if patient has to wait a **single day**

Every **subsequent wait day increases no-show rate by ~1%**

If patients do not receive timely BH care, they:

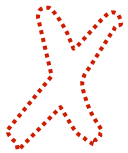
- Have a **higher likelihood** of using **Emergency Rooms**
- **Lower treatment retention** rate
- **Higher hospitalization** and re-hospitalization rate

*Sources: 2014 Beacon site visits, Massachusetts
Gallucci et al, 2005. Impact of the Wait for an Appointment on the Rate of Kept Appointments at a Mental Health Center.

Provider Alignment

Value-based payments can work with BH providers if done right

WHAT WORKS AND WHAT DOESN'T



- VBPs solely for the sake of transferring risk- doing nothing but paying for the same care differently
- Limited provider support in implementation and management

- Start with irrefutable clarity around clinical goals and outcomes- determine the problem you are seeking to address
- Investment in robust system capabilities and strong technical assistance program

EXAMPLES OF EFFECTIVE VBP STRATEGIES WITH PROVIDERS

- Bundled payments to OUD providers **to shape effective transitions of care from detox to MAT** in the community
- Upside Total Medical Expense (TME) risk share with BH providers **to incentivize integration for members with SMI**
- Episode rates to pay for "bridge appointments" and other services **to connect patients discharging from inpatient facilities to community-based services** and keep them engaged

Thank you

Jennifer Black
VP, Strategy and Development

Beacon Health Options
200 State Street, Suite 302
Boston, MA 02109

Cell: 860-384-0193
Jennifer.black@beaconhealthoptions.com
www.beaconhealthoptions.com