Impacting Communities and Outcomes Utilizing Peers, Families, Schools, PCPs, and Providers in the Child Welfare and Criminal (and Juvenile) Justice Systems

October 30, 2018

Our mission drives our commitments to clients, providers, and members

We help people live their lives to the *fullest potential.*

This shared mission guides our purpose

Everything we do matters and how we do it helps us improve the lives of those we serve

Beacon has a 35-year history providing managed behavioral health care services

- Headquartered in Boston; more than 70 US locations
- 4,500+ employees serving 40 million people across the country
- 180 Employer clients; 43 Fortune 500 companies
- Partnerships with 65 health plans
- Programs serving Medicaid recipients in 24 states and the District of Columbia
- Serving 5.4 million military personnel and their families
- Accreditation by both URAC and NCQA

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Role of Families and Peers: Advocating, Extending Care, Impacting Outcomes

Advocacy: Consumer and Family Advisory Council

- CT BHP Consumer and Family Advisory Council (CFAC) is a Medicaid member-driven committee that is culturally competent and diverse
- True partnership among consumers, state departments, and service providers to help shape MH and SUD service delivery in order to result in more meaningful outcomes
- The CFAC was established in 2006 with less than ten members, it has over 70 today

CFAC Impact

- Organized into workgroups, including Young Adults, Recruitment Legislation, and Health Equity/Spanish Speaking
- Partnered with the CT Network of Care Transformation (CONNECT) in promoting youth-focused activities
- In 2018 planed, promoted, and implemented annual statewide consumer-driven conference with nearly 300 attendees, 18 exhibitors, and numerous workshops. Planning 5th Year, with goal of transition to national platform
- Held training at CT Legislative Office Building, including state lawmakers
- Developed 14 Culturally and Linguistically Appropriate Services Standards (CLAS) to educate the system of care and advance health equity in service delivery
- Established monthly CFAC/BHOC Joint Workgroup to collaborate with and educate stakeholders, benefiting CT's Medicaid consumers

Beacon's Intensive Care Management Program

- Short-term intervention to bridge, coordinate, help plan, and support treatment for members with more complex, higher risk, and/or persistent behavioral health challenges
- Uses a person/family-centered, strength-based approach to manage the care of individuals who have been unable to stabilize with standard care management strategies
- Designed to connect members to community providers for ongoing support
- Utilizes a team of licensed clinicians and peer support specialists

The Peer – Extenders of Care

A Peer has “lived experience,” meaning he or she has had a mental health and/or substance use experience/challenge, or cared for a family member who has. The Peer helps members to:

- Connect with community resources
- Find traditional and nontraditional services
- Work with providers to develop treatment and discharge plans
- Gain education, tools, and feedback to support recovery
- Advocate for their own care
- Transition from a hospital stay to their community
- Take part in aftercare following programs such as a Partial Hospitalization Program, residential, or detox
- Gain support without judgement
- Personify the fact that recovery is possible

Challenge: ED Visits

- Behavioral Health ED visits continue to rise
- Inpatient beds have decreased, making demand even greater
- An inpatient hospital unit is not an ideal environment for a child, especially post acute stabilization
- By minimizing Discharge Delay:
  - More youth can access inpatient treatment
  - Youth spend less time in the ED (“ED stuck”)
  - Youth are able to return to their families and communities quicker
  - Costs associated with unnecessary inpatient days can be allocated to others in need

ED Impact

Emergency Department (ED) "Stuck" Analysis

Monthly reporting on members identified as being in the ED for 8 hours or more

REPORTING PERIOD: 1/1/2018 - 7/31/2018

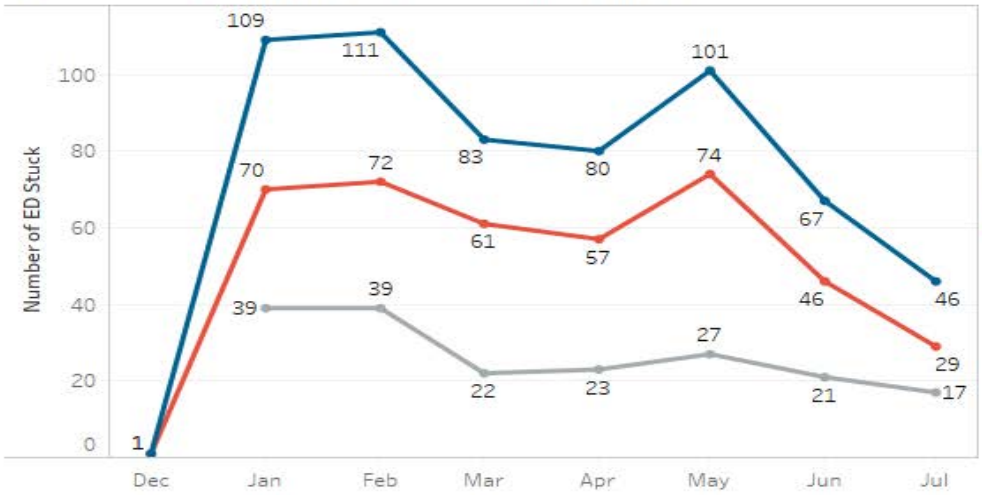
Age Group: Youth (0-17)

Select CCMC Only: All

ED Stuck Youth (0-17) Counts - All

Not unique members; Excluding CARES

● Total ED Stuck ● Recommended IPF ● Recommended Other LOC



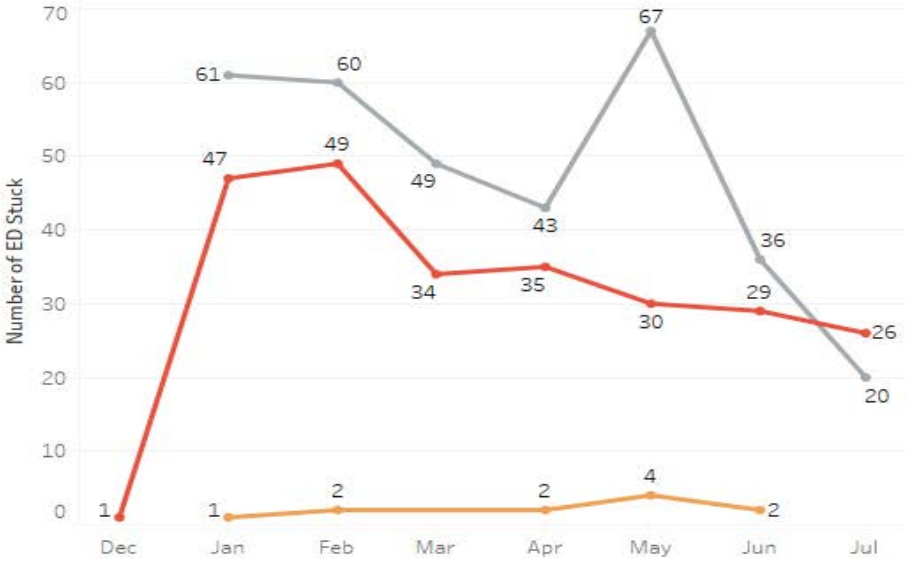
✦ July 2018 ✦

There were 46 youth identified as stuck in the ED. Of those youth, 63.0% were recommended for inpatient (n=29). However, 26 youth actually went inpatient at discharge from the ED.

ED Stuck Youth (0-17) Discharge Disposition - All

Not unique members; Excluding CARES

● Admitted to IPF ● Admitted to PRTF ● Discharged to Other LOC



Percent of Total ED Stuck Youth (0-17) Recommended for IPF

Not unique members; Excluding CARES; All

	D	J	F	M	A	M	J	J
Percent Recommended IPF	100.0%	64.2%	64.9%	73.5%	71.3%	73.3%	68.7%	63.0%
Percent Admitted to IPF	100.0%	43.1%	44.1%	41.0%	43.8%	29.7%	43.3%	56.5%
Percent Recommended IPF that Admitted	100.0%	67.1%	68.1%	55.7%	61.4%	40.5%	63.0%	89.7%

YTD there were 598 ED stuck episodes identified (453 unique youth).

Challenge: High Need/High Cost Individuals

- Majority of BH costs are generated by a minority of individuals with high BH needs
- The High Need/High Cost initiative for identified Medicaid members seeks to improve coordination of care among care managers, peers, families/supports and community providers.
  - In CT, this involves state agencies, ASOs, and the NGA Team
- The Initiative identified members with minimum of three ED visits and two inpatient admissions within three consecutive six-month periods, and with highest costs associated w/ BH diagnoses
- High Need/High Cost cohort is divided into intervention and control groups
- The Peer/ICM team outreaches and engages eligible members. For those who participate, the team addresses social, medical, and BH needs via a person-centered care planning process
- Initiative includes analysis of characteristics of the population, acuity scores, etc.
- Participants track self-reported outcomes (SF-12s)

High Cost/High Need Impact

- High Cost/High Need preliminary analyses based on the first wave of program participants indicates the following results for those that received the intervention vs. those that did not:
- Rate of ED utilization shows a trend towards a greater decline for intervention group
- The rate of outpatient service utilization shows a larger increase
- Inpatient utilization is higher in the first three months post enrollment
- Inpatient utilization is lower in the second three months post enrollment

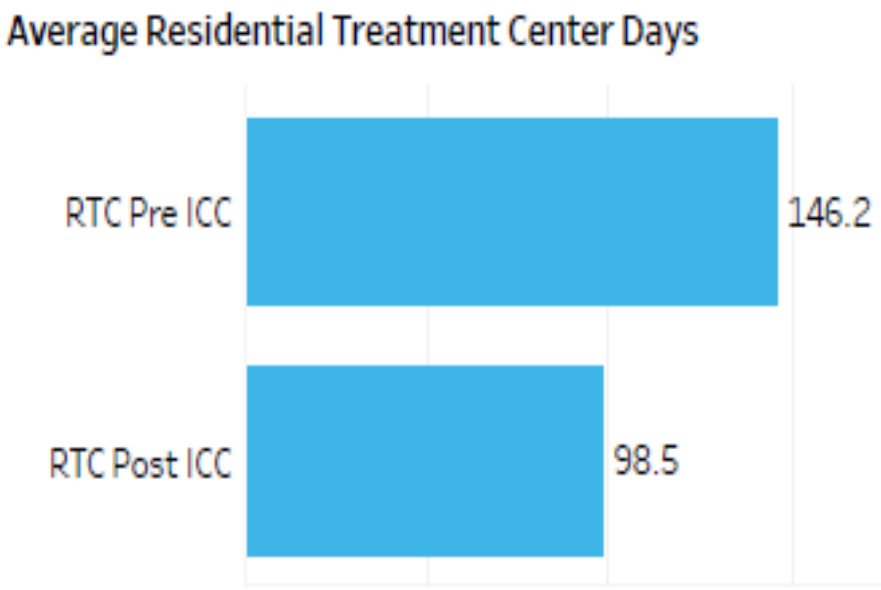
Intensive Care Coordination: Peers and Child Welfare

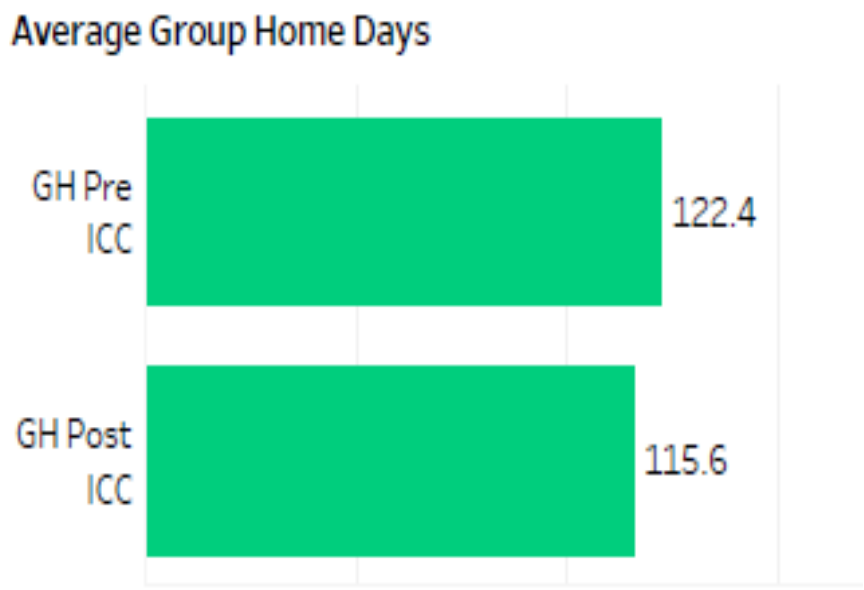
- Intensive Care Coordinators and Peers provide direct community based, non-clinical support and assistance to youth through age 17 and their families who:
  - Have serious BH needs returning to community from congregate care or other treatment setting (ED, psych inpt, PRTF)
  - Are at risk of removal from home/community in need of service coordination and support.
  - Frequently utilize EDs and inpatient care
  - Whose families are in need of community-based, family-driven plan of care
- Utilizes evidence-based Wrap-around Practice Model, assists and supports youth/families to develop sustainable team and an effective plan of care within community setting

ICC Services (Con't)

- ICC staff meet with families weekly at the their home or in the community
- Identify their needs through screening and assessment
- Enhance connections with community supports
- Provide education on navigating the mental health system and self advocacy
- With lived experience, the Family Peer Specialist promotes engagement, education, and empowerment with the family by providing the necessary tools for recovery and resiliency
- Network Managers assist with regional-based service system development

ICC Impact





Includes a total of 150 youth effective in the ICC program between September 1, 2015 through June 30, 2017, and continuously eligible for Medicaid

Role of Primary Care Providers

PCPs, an Essential Resource

- Majority are prescribing psychotropic drugs
- At the center of new models of care (Health Homes, ACOs, etc)
- Less stigmatizing for many of our members
- Greater access
- Often ill equipped to manage BH challenges
- Concerned to identify members with BH needs, and then, where do they go for service/support
- We must develop programs/strategies to support

Child Psychiatry Access Program (CPAP): ACCESS Mental Health CT

- There are 27 states that have a CPAP program similar to ACCESS Mental Health CT. We provide free, telephonic consultation to PCPs treating children with BH concerns, regardless of insurance status
- Our psychiatrists, clinicians, and care coordinators provide valuable PCP education on mental health assessment, treatment, and access to community resources, while our peer specialists help members and their families navigate the BH delivery system
- Such programs increase PCPs' BH knowledge base so they can identify and treat mental health more effectively and expand their awareness of local BH resources and supports
- All state programs participate in the National Network of Child Psychiatry Access Program

ACCESS Mental Health CT – Impact

- In four years of programming (June 2014 – June 2018):
  - 86% of Pediatric and Family Care Practices have enrolled
  - 24,386 Consults have been provided
  - 4,667 Youth and Families have been served

High PCP satisfaction, with a **4.9 out of 5** rating statewide

Additional Technical Assistance to Expand PCP and BH Network Capacity

- Project ECHO® (Extension for Community Healthcare Outcomes) is an Evidenced and Community Based Public Healthcare National initiative that facilitates treatment of common yet complex diseases in under-served and rural areas

- The goals of Project ECHO are two-fold:
  - Develop capacity to safely and effectively treat complex diseases in rural and underserved locations
  - Monitor outcomes centrally to assess effectiveness of the program

ECHO Impact: Providers

Since Program Effective Date in CT 8/17:

- CT ECHO Program focused on OUD
- 13 Provider Sites plus the Department of Corrections have joined
- 23 Clinics held, each presenting a case and didactic component

Provider Benefits:

- Professional interaction with providers who share similar interests
  - Diminishes professional isolation
- Provides access to specialty consultation and mentorship with addictionologist, psychiatrist, and licensed clinicians and peers
  - Develops clinical expertise
  - Enables providers to become a local expert for their clinic or group
- Establishes a good mix of work and learning
- Improves Professional Satisfaction/retention
- Continuing Medical Education credits

ECHO Impact: System

System Benefits:

- Improves Quality and Safety
- Reduces variations in care across settings
- Improves access for rural and underserved patients
- Spreads specialty medical knowledge, enhanced via Medical ASO's participation
- Supports the Medical Home Model
- Cost-effective care – prevents excessive testing and travel
- Addresses the impact of untreated disease (e.g. overdose deaths, comorbid physical health complications)

Corrections

Data and Tracking to Inform Intervention and Collaboration

- Beacon operates JusticeConnect (CO) and Jail Datalink (MD), data sharing initiatives to help ensure people involved in the Justice System have meaningful linkages upon re-entry to the community
- Colorado Justice Coordinator meets with every justice involved member when they are 60 days out from release/reentry
- We help close gap between release in prison and parole
- Under our Accountable Care Organization (ACO) partner model, the Coordinator connects the member to medical, behavioral health, and other services in our partnership

ICM Forensic Peer Specialist Program

- Work with DOC to assist with community reintegration
- Decrease recidivism
- Reduction in overdoses
- Improvement in connection to care
- Improved clinical outcomes

Questions?

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Thank you