

What Will BHOs, Health Homes and Managed Care Mean to You?

NYAPRS Fall 2011 LI Regional Forum

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Thanks!

- **Barbara Tedesco, Melissa Firmes, & Sue Parrinello**, NYAPRS Regional Coordinators; **Kelly Stengel, Cheryl White**, NYAPRS
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- **Carlton Whitmore**, NYAPRS Cultural Competence Committee
- **Ellen Healion**, Coalition to Protect the Integrity of Peer Support in NYS
- **Art Fleisher**, LCSW, CASAC, Director, Suffolk Co. Community Mental Hygiene
- **James Dolan**, DSW, LCSW, DCS, Director, Nassau Co. Dept. of MH, CD, & DD Services
- **Robert Detor**, Chief Executive Officer, South Oaks Hospital
- **Richard Sheola**, Senior Vice President, Public Sector, ValueOptions

Goals of Today's Presentation, Discussion

- Raise awareness and readiness amongst peers and providers of impact of coming changes:
 - Introduction of regional BHOs in October
 - Start of new Health Home networks in October
 - Medicaid pharmacy benefit to managed care by December
 - Move to fully capitated managed care in 2014
- Stimulate local discussion, advocacy, networking

New York Association of Psychiatric Rehabilitation Services (NYAPRS)

A statewide coalition of people who use and/or provide community mental health recovery services and peer supports that is dedicated to improving services, social conditions and policies for people with psychiatric disabilities by promoting their recovery, rehabilitation, rights and community integration and inclusion.

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Unprecedented Pace of Change

- **October:** Regional Behavioral Health Organizations begin efforts to improve hospital discharge and community services follow up plans for hospitalized 'high needs' individuals
- **October:** Managed care plans take over the Medicaid pharmacy benefit
- **November:** Medicaid beneficiaries in Phase I counties are assigned to new coordinated Health Home networks
- **2013-4:** Medicaid mental health, substance use and medical services are put into some form of managed care

Plenty of Challenges...and Opportunities!

- Medicaid beneficiaries will have to get enough information and support to be ready for and make good informed empowered choices.
- They may be able to take a more active role and self-direct better coordinated services with fresh new service plans that may help them to improve their health and wellness...and reduce their avoidable trips to hospitals and emergency rooms.

Plenty of Challenges...and Opportunities!

- Service providers who capably promote person-centered, health, wellness and recovery based care (vs more reactive, symptom management based approaches) in more responsive, well coordinated, appealing and effective ways should be able to thrive.

Why are Changes Coming to Your Medicaid Healthcare?

- US and New York state budgets can no longer keep up with Medicaid's rising costs
- At the same time, too many Medicaid beneficiaries don't get or participate in enough of the right kind of healthcare
- As a result, too many spend too much time in expensive visits to emergency rooms and hospitals

Ultimate Goal of These Changes

- Improving health care outcomes
- Improving service quality
- Reducing the runaway cost of care



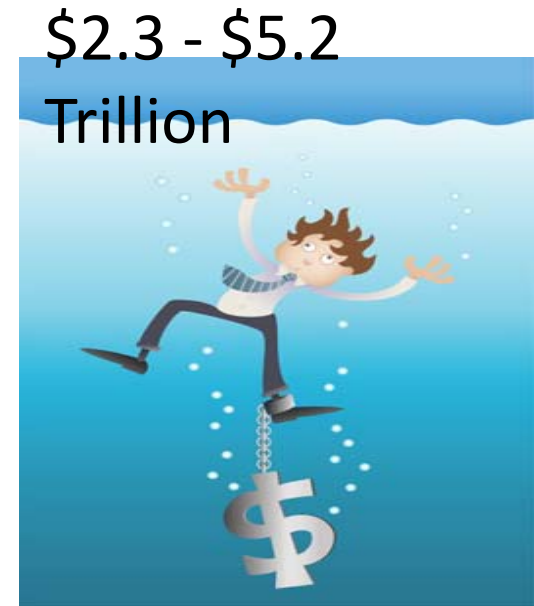
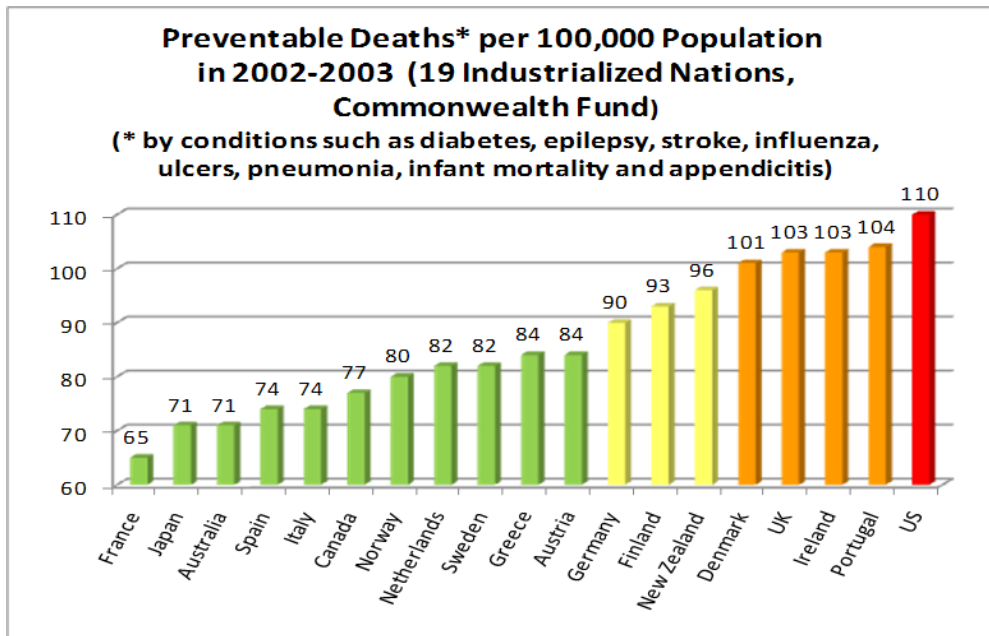
The U.S. has a *Sick Care System* not a *Health Care System*

- Half of Americans have one or more chronic health conditions (155+ million)
- Over half of these people receive their care from 3 or more physicians
- In total, treating chronic health conditions consumes 75%+ of the \$2.5 trillion we spend on healthcare each year in the U.S.
- In large part due to the fact that money doesn't start flowing in the US healthcare system until after you become sick



America's Healthcare System at the Brink

"The American healthcare system is a dysfunctional mess." (Ezekiel Emanuel, MD, Chair of the Department of Bioethics at the Clinical Center of the National Institutes of Health)



"As much as 30% of health care costs (over \$700 billion per year) could be eliminated without reducing quality": Big focus for Nat./State Budget Cutters

Big Stakes for Our Community

- We're among the sickest disability groups, dying 25 years earlier than the general public.
- Compared to non-Hispanic whites with SMI, African Americans and Latinos with major MH diagnoses face serious health inequities due to:
 - Higher rates of obesity, diabetes, metabolic syndrome, and cardiovascular disease
 - Poorer access and quality of medical care

SAMHSA on Affordable Care Act: Major Drivers

- **More people** will have insurance coverage
- **Medicaid will play a bigger role in MH/SUD** than ever before
- Focus on **physical and behavioral health care coordination and integration**
- Major emphasis on **home and community based services** and less reliance on institutional care
- **Preventing** diseases and promoting **wellness**

SAMHSA on Affordable Care Act: Major Drivers

- **Person centered individualized care**
- **Outcomes:** improving the experience of care, improving quality and outcomes while ‘bending the cost curve’
- *Decrease overuse and underuse of services*
- *Electronic healthcare Records*
- *Health Homes and Accountability Care Organizations*

NYS MH and SU Services Funding

- The publically funded mental health system alone serves over **600,000 people** and accounts for about **\$7 billion** in annual expenditures. Approximately **50 percent of this spending goes to inpatient care.**
- The publicly funded substance use disorder treatment system serves over **250,000** individuals and accounts for about **\$1.7 billion** in expenditures.

Fragmentation, Lack of Accountability

- Despite the sizable amount of funding, care to the neediest patients often suffers from a **lack of comprehensive care coordination and accountability** for the provision of **quality** care and for improved **outcomes** for consumers.
- This problem is compounded since mental health and substance use care and treatment systems are **separated with discrete regulations and funding streams** and substantial rates of people with co-occurring serious mental illness and substance use disorders.

Overuse of Costly Institutional Services

- In NYS, Medicaid fee-for-service readmission rates to psychiatric inpatient units are **20% within 30 days of discharge.**
- The **majority of preventable admissions** to any Article 28 Medicaid fee-for-service reimbursed inpatient beds are from **people with behavioral health conditions**; the **majority are for chronic physical health conditions.**

Overuse of Costly Institutional Services

- The overuse of inpatient detoxification and SUD inpatient rehabilitation services by a small number of individuals results in poor outcomes and high Medicaid costs.
- There is an **over-reliance on state hospitals, adult homes and nursing homes** partly due to the system's inability to assign responsibility for integrated community care.

Housing, Economic Instability

- The **unemployment rate** for people with serious mental illness is extremely high, around **85%** based on national surveys.
- Serious mental illness and substance use disorders confer significant risks of **homelessness**.

Poor Health Outcomes

- People with serious mental illness **die 15 - 25 years earlier** on average than the rest of the population. The leading contributors to this disparity are chronic, co-occurring physical illnesses, which are not prevented and are inadequately treated.
- There **are few examples of co-location** of physical and behavioral health services in New York, though co-location is a recognized best practice.
- **Early intervention for psychiatric disorders (usual onset in early twenties) is infrequent** and not promoted under the current regulatory and financing approach.

NYS Backdrop: High Cost of Medicaid Care for New Yorkers w/ Multiple 'Chronic' Conditions

- New York's Medicaid program serves almost 5 million beneficiaries at a cost of over \$50 billion annually.
- ***20% of Medicaid beneficiaries (1,029,621) account for 75% of the program's expenditures: \$31.1 million***
- Average cost per year: \$30,195 which is 15 times higher than the average beneficiary

NYS Backdrop: High Cost of Medicaid Care for New Yorkers w/ Multiple ‘Chronic’ Conditions

- These beneficiaries have “multiple co-morbidities, are medically complicated and require services across multiple provider agencies. Due to their multiple and intensive needs, their care can often be fragmented, uncoordinated and at times duplicative. “
- ***Over 40% of these beneficiaries are diagnosed with mental illness and chemical dependency.***

NYS Ranks 50th in Avoidable Hospital Readmissions

- NYS Department of Health estimated that \$800 million was spent last year on 'avoidable Medicaid hospital readmissions.'
- ***70% of these involved beneficiaries with mental health, substance use and major medical conditions.***
- 65% of admissions for this group were for medical reasons.

NYS Medicaid Redesign Team

Key Initiatives

- **Global Cap:** state share cap, CPI growth cap
- From FFS to **Managed Care** for all: payment for outcomes not for visits
- 1 million to **Health Homes** for “high-need/high-cost groups, fully integrated w managed care
- **Pharmacy Carve-in to Managed Care**
- **Contract with BHOs** to begin transition to care management for behavioral health services with 2014 goal **being full integration of physical and behavioral health**

Focus of NYAPRS Medicaid Advocacy

- Services must promote **recovery and wellness, health literacy and 'self management'**
- In an atmosphere of such great change in expectations and options, beneficiaries must be **guaranteed Informed choice, privacy and other basic rights protections**, supported by **peer advocates and/or enrollment brokers**, with **consumer access to personal electronic records** that prominently features **advance directives**.
- Health outcomes/savings from hospital/ER diversion come heavily from addressing **social determinants of health** like social, housing, economic status.

Focus of NYAPRS Medicaid Advocacy

- Hence, there must be significant **reinvestment** of Medicaid savings into peer services, housing, rehabilitation/ employment services expansion.
- **Peer run services** should play prominent roles in BHO, health homes and managed care re-designs.
- **Open access to medications of choice**
- Crucial importance of **cultural competence** and other strategies to address health disparities

NYAPRS Advocacy at the Table

- **Medicaid Redesign Team**
- **Behavioral Health Work Group**
- **Affordable Housing Work Group**
- **Health Homes Advisory Group**
- **Peer Services Work Group**
- **Pharmacy into Managed Care Group**
- **People First Steering Committee**

2011 NYAPRS Budget Advocacy

Priority #1

- Helping to lead a coalition of 41 state and regional advocacy groups to avoid seeing Medicaid mental health and substance use services going directly to the coordination of managed care plans.

2011 NYAPRS Budget Advocacy

Priority #1: Background

- Most NYAPRS members already get their Medicaid healthcare through Medicaid managed care plans....but not their mental health and detox services, which are 'carved out' and paid for via fee for service.

2011 NYAPRS Budget Advocacy

Priority #1: Background

- To make quick savings, the state wanted to fold all of those services into the managed care health plans and let the plans direct those dollars to approved providers for approved services.

2011 NYAPRS Budget Advocacy

Priority #1

- We feared the plans wouldn't understand and know how to direct provider to best engage and serve our community.
- We feared they wouldn't understand or want to adequately pay for recovery, rehab and peer support services.

The Alternative: Regional BHOs

- We backed an alternative OMH/OASAS proposal to bring in specialty managed care groups called Behavioral Health Organizations.
- BHOs have considerable recent experience in funding and favoring recovery, wellness and peer support services.
- BHOs include ValueOptions, Magellan, OptumHealth, Beacon, Community Care BH

OMH/OASAS: Role of BHOs

- Monitoring BH inpatient length of stay;
- Reducing unnecessary behavioral health inpatient hospital days (working with hospitals for a prompt, effective discharge plan)
- Improving rates of engagement in outpatient treatment post discharge (working with outpatient providers to coordinate with good discharge plan and to implement an effective community plan that results in....)

OMH/OASAS: Role of BHOs

- Reducing behavioral health inpatient readmission rates;
- Better understanding of the clinical conditions of children diagnosed as having a Serious Emotionally Disturbance (SED); and
- Profiling provider performance.

Regional BHO Awardees

- New York City Region: OptumHealth
- Hudson River Region: Community Care Behavioral Health
- Central Region: Magellan Behavioral Health
- Western Region: New York Care Coordination Program
- Long Island: ValueOptions and North Shore LIJ Health System

In 2014

- We move from FFS to a fully capitated and integrated managed care system:
 - Special Needs Plans
 - Integrated Delivery Systems
 - Behavioral Health Organizations

In 2014

- State Medicaid dollars flow to managed care groups who authorize services in approved provider networks according to approved service plans.
- Moving from current state regulations and reimbursement systems
- Greater flexibility to pay for peer services, employment, housing, rehab....based on evidence based outcomes

NYAPRS Advocacy

- Medicaid Redesign Team (MRT) Behavioral Health Work Group
 - Recovery, wellness, community integration
 - Choice and rights advocacy, brokering
 - Reinvestment to peer, housing, employment
 - Cultural competence, overcoming disparities
 - Privacy protections, advance directives in EHR

Maximizing Peer Services

- Promote acknowledgement and respect for the unique contributions **and value of peers in delivering services that help people, promote wellness and decrease costs.**
- Facilitate ways to accommodate Medicaid funding for peer services, such as **waivers, grants and funding for programs rather than for the position itself.** Funding for training and education, certification, and leadership development would strengthen the peer workforce.

Maximizing Peer Services

- Establish an **accreditation process for peer-run agencies** which would professionalize their activities and require that supervision be provided by a trained peer to preserve the unique, whole health/wellness approach that peers provide.
- **Incorporate peer services into health homes** as a required element in health home applications, given the recognition that peer services are evidence-based practices which can improve outcomes while being cost effective.
- Address children and their care separately.

Pharmacy into Managed Care

- 2011-12 budget agreement approved a proposal from the Medicaid Redesign Team (MRT) to move pharmacy from Fee for Service to the control of managed care plans, for those individuals who get their health care via Medicaid managed care plans.
- That meant that beneficiaries will generally get access to those drugs that are on each plan's approved list (formulary).
- Advocates have pushed for open access and prescriber prevails protections, especially for previously protected classes like mental health, AIDS/HIV, organ-transplant and epilepsy-related meds.

Pharmacy into Managed Care

- According to DOH, 19 of the 20 plans will continue open access to these medications; 15 will do so on an indefinite basis and 4 will continue open access for 12 months of study.
- DOH mailed information about these and other changes to 2 million beneficiaries on August 26th.
- They arranged for a special (800) 541-2831 hotline with to help people with questions or concerns.

Pharmacy into Managed Care

- 3 plans are providing open access to these drugs for all recipients
- 16 plans are allowing recipients that are already on a medication in one of these categories to continue on that medication without a prior authorization requirement.
- 4 of these plans will continue this for 12 months, at which time they will re-evaluate.

September DOH Medicaid Update

Q1. What has changed about the Medicaid Pharmacy benefit?

ANSWER: Beginning October 1, 2011, members enrolled with Medicaid and Family Health Plus managed care plans will have their pharmacy benefit paid for by their health plans instead of the Medicaid program directly. This means that **members will need to work with their physicians and health plans to make certain the drugs they use are covered.**

September DOH Medicaid Update

Q4. Which card do I need to use at the pharmacy?

ANSWER: Effective October 1, 2011, Medicaid managed care and Family Health Plus beneficiaries must use their **health plan card** (not their Medicaid/CBIC card) at the pharmacy.

Q6. What if I do not know what health plan I have chosen?

ANSWER: To find out what plan you currently have, please contact the New York State Medicaid helpline at **(800) 541-2831**.

September DOH Medicaid Update

Q8. I do not see my drug on my plan's formulary or list of covered drugs and I've been on this drug for a while; can I stay on it?

ANSWER: If you've been on the drug for a while, you may be able to stay on that drug. For example, many **plans will continue to cover antipsychotics, immunosuppressants, antiretroviral therapy, anticonvulsant and antidepressant drugs for their members that are already on these drugs.** You should contact your plan to find out if the drug you are on is one that your plan will continue to cover for you, **even though it may not be on their list of covered drugs.**

September DOH Medicaid Update

Q14. Will I be able to use the same pharmacy and doctor?

ANSWER: You can continue with the same pharmacy and doctor, **as long as they participate with your managed care plan.** Ask your pharmacy and doctor to check to make sure they are participating.

Q15. I cannot find a pharmacy in my neighborhood that accepts my health plan. What do I do?

ANSWER: You should contact your health plan for assistance in locating a neighborhood pharmacy that accepts your health plan.

Health Homes

- NY health homes are **multidisciplinary teams** comprised of medical, mental health, and chemical dependency treatment providers, social workers, nurses and other care providers.
- The team will be led by a **dedicated care manager** who will assure that enrollees receive all needed medical, behavioral, and social services in accordance with a **single care management plan**.

Health Homes Goal

- The health home provider will be **accountable for reducing avoidable health care costs**, specifically preventable hospital admissions/readmissions, skilled nursing facility admissions and emergency room visits and meeting quality measures.

Health Home Network Leader

- Health home providers can either **directly provide, or subcontract** for the provision of, health home **care coordination** services.
- The **health home provider remains responsible** for all health home program requirements, including services performed by the subcontractor.
- Health homes coordinate services to **network partners who continue to bill Medicaid**

Health Home Network Requirements

- Preferred health home applications will include an integrated health care and community provider network that includes
 - managed care plans
 - hospitals
 - community based organizations,
 - targeted case management providers
 - mental health and substance abuse services providers.

Pre-Health Home Changing Trends

Emergency Services (diversion)

Inpatient Services (diversion)

PH

CDT

Clinic

IPRT

PROS

Clubs

Employment

Peer Services

Recovery Ctr

ACT

Case Management

Housing

Life in the Era of Health Homes

Health Home Applicant IT System (subcontract?)

Managed Care Plan(s)

Case Manager/MATS/COBRA to Care Manager, More Positions

Peer Services (bridging, wellness, diversion, recovery centers)

Hospital(s) and Emergency Services

General Practitioners Specialists

PROS MH Clinics

Housing and Employment Linkages

Stony Brook University

Hospital and University Center

- **Behavioral Health Providers:** Family Services League Outpatient Clinic, PROS; FEGS Outpatient Clinic, PROS Program, Peer Svcs; Hispanic Counseling Center; Maryhaven PROS Program; Pederson-Krag Center Outpatient Clinics and PROS; Phoenix Houses of LI PROS Program; Skills Unlimited Outpatient Clinic and Success PROS Program; Suffolk Co. Comm. Mental Hygiene Services (Brentwood and Farmingville Clinics); Clubhouse of Suffolk - Recovery Concepts PROS Program, Peers; Hand Across Long Island (HALI) PROS Program and Peer Svcs; Mercy Haven; The Way Back; Catholic Charities; Transitional Services for L.I; Mental Health Assoc. of Suffolk Co; Outreach Project of Bellport

Stony Brook University

Hospital and University Center

- **Hospitals:** Brunswick Hosp; Eastern Long Island Hosp. Ass'n; John T. Mather Hospital; Peconic Bay Medical Center; Southside Hospital/North Shore LIJ; The L.I. Home - South Oaks Hosp.; Brookhaven Mem. Hosp. Med. Ctr;
- **Housing:** Family Residences and Essential Enterprises, Inc. (FREE); HALI; Clubhouse of Suffolk; Concern for Independent Living; Options for Community Living, Inc.
- **Health Providers:** Stony Brook Univ. Med. Ctr. Fam. Practice Ctrs; South Shore Health Services; Adelante of Suffolk Co. Visiting Nurse Services;

Stony Brook University

Hospital and University Center

- **Misc:** Economic Opportunity Council of Suffolk, Inc. (EOC)
- **AIDS CaRE;** Maple Rest Adult Home Long Island Assoc. for AIDS Care, Inc.
- **Pharmacy:** Medford Chemist - Pharmacist
- **Crisis:** Response of Suffolk Co.

Federation of Organizations

- **Behavioral Health Providers:** Catholic Charities; Outreach Project; Central Nassau Guidance & Counseling; Family Service League; FEGS; Hispanic Counseling Center; Long Beach Counseling Center; Maryhaven; Melillo Center for Mental Health; Mental Health Association of Suffolk County; Mental Health Association of Nassau County; Mercy Haven; PCHS; Pederson-Krag Center; Clubhouse of Suffolk; HALI; Transitional Services of NY; The Way Back; Adelante of Suffolk County; Options for Community Living; ADD; Concern for Independent Living; Family & Children's Association; Peninsula Counseling Center; Phoenix House; Skills Unlimited

Federation of Organizations

- **Health Providers:** United Cerebral Palsy; Epilepsy Foundation; Suffolk County DOH; Long Island FQHC; Hudson River FQHC; Visiting Nurse Services
- **Crisis:** Response of Suffolk County
- **Housing:** FREE; Community Housing Innovations; Various BH providers
- **Social Services:** The Inn; EOC; HELP Suffolk; Project Real; SAIL; Family and Children's Association;

Federation of Organizations

- **Hospitals:** North Shore-LIJ; Brookhaven Memorial Hospital; NUMC; Mercy Medical Center; Southside Hospital; Long Beach Medical Center; Brunswick Hospital; Mather Hospital; Stony Brook University Hospital; Peconic Hospital; Long Island Home/South Oaks; Eastern Long Island Hospital
- **Developmental Disability Services:** ACLD; Optihealth (DDI);
- **Misc:** Southeast Nassau Guidance Center; LICAAD; South Shore Child Guidance Center; EDNY; Educational Assistance Corporation

Neconset Center for Nursing and Rehab

- **Health Plans:** Aetna
- **Hospitals:** Southside Hospital; St. Catherine's Hospital; Good Samaritan Hospital; Brookhaven Hospital; Stony Brook Uni Hospital; Huntington Hospital;
- **BH Providers:** Pederson-Kraig; Adelante;
- **Health Providers:** Nursing Home rehab; Suffolk Co Health clinics; Home Care Agencies; Primary Care Physicians;

Neconset Center for Nursing and Rehab

- **Misc:** ROCCA; Veteran's Association; Head Injury Association; Touro College; Center for Independent Living; Guild Net, PACE, Center for Rapid Recovery, New York Institute of Technology
- **Housing:** Pilgrim LI Family Care System; ALCD Group Home; Pilgrim Transitional Housing;
- **DD:** OMRDD;

Long Island FQHC

- **Health Plans:** HealthFirst;
- **BH Providers:** Central Nassau Guidance; Clubhouse of Suffolk; Hispanic Counseling Center; MHA of Nassau; Family Service League; FEGS; Peninsula Counseling Center; Pederson-Krag Center;
- **Health Providers:** Hudson River HealthCare; NuHealth;
- **Hospitals:** L.I. Home/South Oaks; NuHealth;
- **AIDS:** L.I. Assoc. for AIDS Care; EOC Suffolk; Options for Community Living;
- **Housing:** Options for Community Living;
- **Misc:** EAC; Coalition on Child Abuse and Neglect; Coalition Against Domestic Violence; Planned Parenthood of Nassau; Health and Welfare Council

South Shore Home

- **Health Plans:** Aetna; Suffolk Health Plan; Affinity; Fidelis; HIP; United; HealthFirst; Oxford;
- **Hospitals:** Northshore LIJ;
- **Health Providers:** Suffolk county DOH; Brookhaven Home care, Brookhaven Hospice; Newtek; Lutheran Home Care; Good Samaritan Home care; Catholic Home Care; Good Shepherd Hospice; Dominican Sisters; Hospice Care Network; Our Lady of Consolation; Horizon Health Care Network; Primecare;
- **BH Providers:** FEGS; Clubhouse of Suffolk; Peer Support /Counseling SILO
- **Social Services:** Nassau County DSS; Suffolk County DSS; Westchester County DSS;
- **Misc:** HALO, Guildnet, EOC, Gentiva, Gurwin

Clubhouse of Suffolk

- **BH Providers:** PSCH/Pederson Krag Center; Family Service League; Clubhouse of Suffolk; FEGS; Sayville Project of Stony Brook; Federation of Organizations; Central Nassau Guidance and Counseling; Family Service League; Federation of Organizations; FREE; Hispanic Counseling Center; Maryhaven Center of Hope; Phoenix House; Response of Suffolk County; Skills Unlimited; HALI; Family and Children's Association; Options for Community Living; Adelante; Mental Health Assoc. of Nassau; Melillo Center for Mental Health; Mercy Haven; Mental Health Assoc. of Suffolk County; The Way Back;
- **Housing:** Concern; Community Housing Innovations; array of BH providers
- **AIDS:** L.I. Assoc. for AIDS Care;
- **DD:** ADD; United Cerebral Palsy; Optihealth (DDI);

Clubhouse of Suffolk

- **Hospitals:** Brookhaven Memorial Hospital; North Shore-LIJ; NUMC; Long Island Home/South Oaks; Mercy Medical Center; Southside Hospital; Long Beach Medical Center; Brunswick Hospital; Mather Hospital; Stony Brook University Hospital; Peconic Hospital; Eastern Long Island Hospital
- **Health Providers:** Brookhaven Outpatient; Suffolk Co. Dept. of Health; Long Island FQHC; Hudson River FQHC; South Shore Health Services; Visiting Nurse Services;
- **Misc:** Epilepsy Foundation; EOC; Outreach Project; HELP Suffolk; SAIL; UCP; ACLD; Park House; Project REAL; SAIL; Transitional Services of NY; The Way Back; ACLD; LICAAD; Peninsula Counseling Center; South Shore Child Guidance Center; EDNY; Southeast Nassau Guidance Center

Nassau County Office of MHCDDD

- **BH Providers:** Angelo J. Melillo Center for Mental Health; Alternative Advocacy Program; Bridge Back to Life Center; Nassau County Office of MH/CD/DD Services; Catholic Charities of Rockville Centre; SAC -Methadone Maintenance Treatment Program; Center for Rapid Recovery; Nassau Health Care Corp; Central Nassau Guidance and Coun. Svcs.; North Shore Child & Family Guidance Association; Community Counseling Service of West Nassau; Maryhaven; F·E·G·S; Federation of Organizations; Central Nassau Guidance & Counseling; Hispanic Counseling Center; Long Beach Counseling Center; Peninsula Counseling Center; Options for Community Living; LIAAC; Mercy Haven; Project REAL; SAIL; Concern for Independent Living; Transitional Services of NY; Youth & Family Counseling Agency of Oyster Bay; Baldwin Council Against Drug Abuse (BCADA); Community Counseling Services of West Nassau; Confide Counseling Center; YES Community Counseling Center

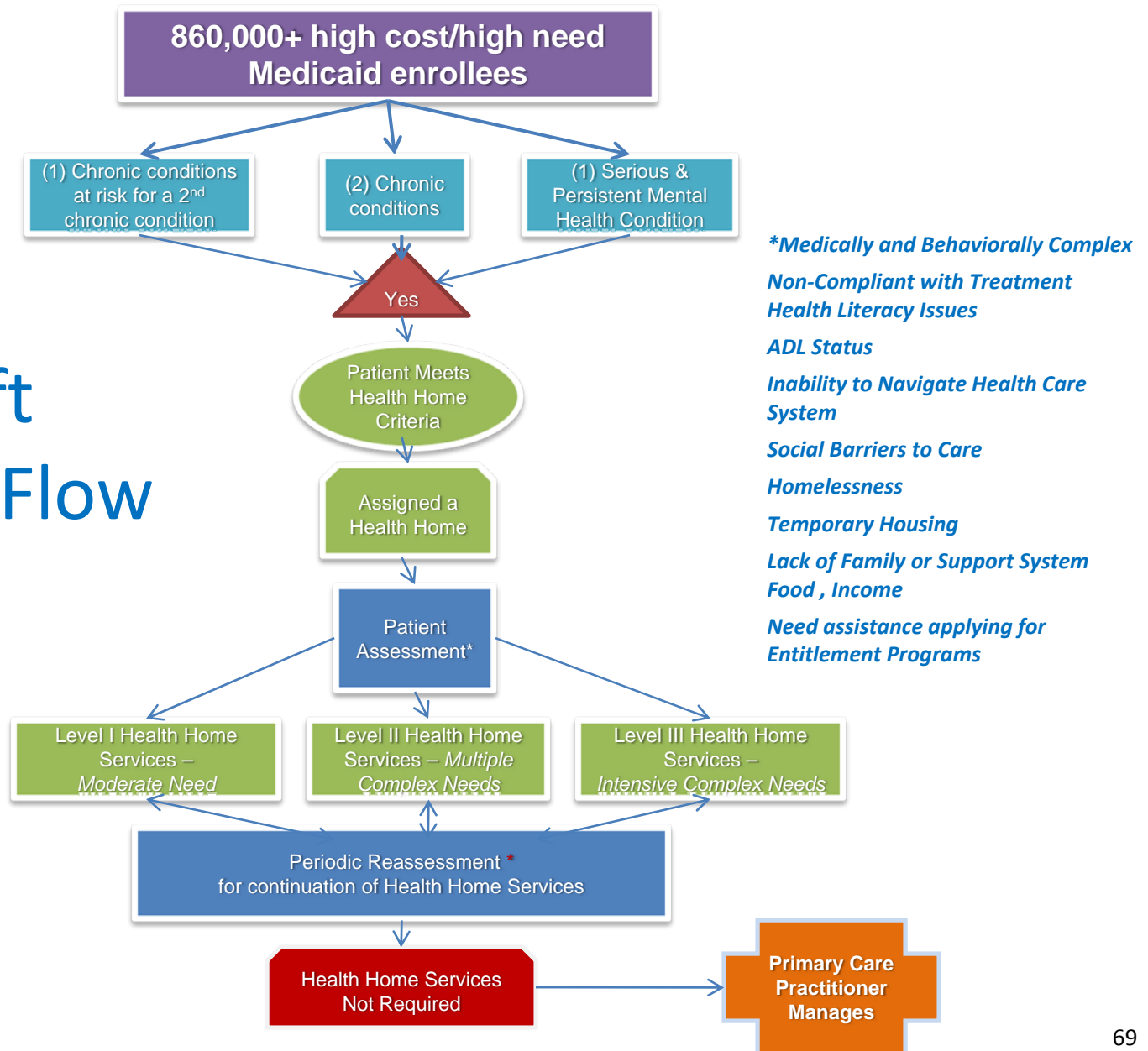
Nassau County Office of MHCDDD

- **Health Providers:** LI FQHC; Visiting Nurse Services; South Shore Health Services
- **Hospitals:** Mercy Medical Center; Nassau Univ Med Ctr; New Island Hospital; North Shore-LIJ; Brunswick Hospital; Long Beach Medical Center; Nassau University Medical Center; Long Island Home/South Oaks;

Nassau County Office of MHCDDD

- **Housing:** MTI Residential Services; et al
- **Social Services:** Circulo de la Hispanidad; Five Towns Community Center (CODA); Freeport Pride; Education & Assistance Corporation (EAC); NAMI Queens-Nassau; Bethpage Adolescent Development Assn.; Community Org. for Parents and Youth; EDNY; Nassau/Suffolk Law Services Committee Inc.
- **Misc:** Abilities, Inc; ACLD; MercyFirst;
- **DD:** United Cerebral Palsy; Optihealth (DDI); ACLD; AHRC Nassau

Draft Patient Flow



Health Home Reimbursement

- Health homes will be paid a **per member per month (PMPM) care management fee** that is adjusted based on **region, enrollment volume, case mix and patient “functional status.”**
- The care management fee will be paid in two increments: **case finding (80% for 3 months) and active care management.**
- Health Home providers will be eligible to receive **15% of shared savings.**
- **Most network providers will not receive HH \$ but bill previous funding sources.**

HH Proposals Must Demonstrate

- **A strong plan to deploy tiered care management plan for:**
 - Low need- stable individuals in ambulatory care with episodic crisis or inpatient need
 - Intermediate need individuals- not as connected to ambulatory care, more frequent emergency room and inpatient use
 - High need individuals- such as those serviced by OMH and HIV/AIDS COBRA TCMs and the MATS program.

Expected Impact on Beneficiaries

- Most people will likely be **auto assigned** into health homes that include their case management program and provider
- More attention, help needed to protect beneficiary rights and choices
- They will likely be asked to participate in fresh new health/BH assessments and to help shape new goal and treatment plans

Expected Impact on Beneficiaries

- Health home coordinators will have and share with provider systems **up to date information about beneficiaries' past and current health issues, their providers and their response and follow up with medications and treatments**
- **Unmet needs** will be identified and referrals will be made and coordinated to new or 'better' health care providers
- Everyone will be focused on **averting avoidable ER and hospital visits.**

From Case Management to Care Management

- Care managers will have **more responsibility** and authority to coordinate a broader array of healthcare (e.g. MH, SU, medical conditions)
- They will be able to **do more** than ‘assess, link and monitor’, e.g. transportation, individualized support
- **More slots** will be needed beyond existing case management/MATS to serve 900,000 health home eligible beneficiaries.

MHAs/Clubhouse of Suffolk Health Workers Retraining Initiative Proposed Training Curriculum

- Pre-Assessment Phase-Analyzes Student Skills
- Course Outline: Principles of Integrated Case Mgmt.; Physical and Mental Condition Interaction: Organization of ICM Management Intervention Worksites: Motivational Interviewing: Triage, Using Open-Ended Questions, and Complexity Assessments
- Health Information System Training: Enhance Basic Computer Skills; Tools available for ICM; Overview of Meaningful Use Program; Overview of Regional Health Information Organization Programs;
- Final Exam

MHAs/Clubhouse of Suffolk Health Workers Retraining Initiative Proposed Training Curriculum

- Support Resources: Recorded Webinars; Live Webinars; Mentoring and Tutoring; ICM Manual; Pre and Post Assessment on Skills and Outcomes
- Proposed Training Format/Schedule: Training program will continue for 2 year period: Training will begin in 2012
- 48 Hours of training to complete course; 24-30 Hours in Classroom regionally located; 18-24 hours of Web Training; Additional Web Training available as support resources; Student should complete course within six months from start

Health Homes and OMH Providers

- **Case Management** programs will be highly sought, expected to provide HH care coordination, slots; there's an opportunity for more CMs
- **Peer Services** can provide key outreach, prevention, support and diversion services; state aid funded services can be reinvigorated, some HHs might fund them.
- **PROS** programs can market themselves as integrated treatment/rehab/support programs that can avert ER and hospital admissions and promote wellness
- **Housing** is a critical resource closely tied to recidivism

HH Program Requirements

- **Coordination of care** and services post critical events, such as emergency department use, hospital inpatient admission and discharge;
- **Language access/ translation capability;**
- **24 hour 7 days a week telephone access to a care manager;**

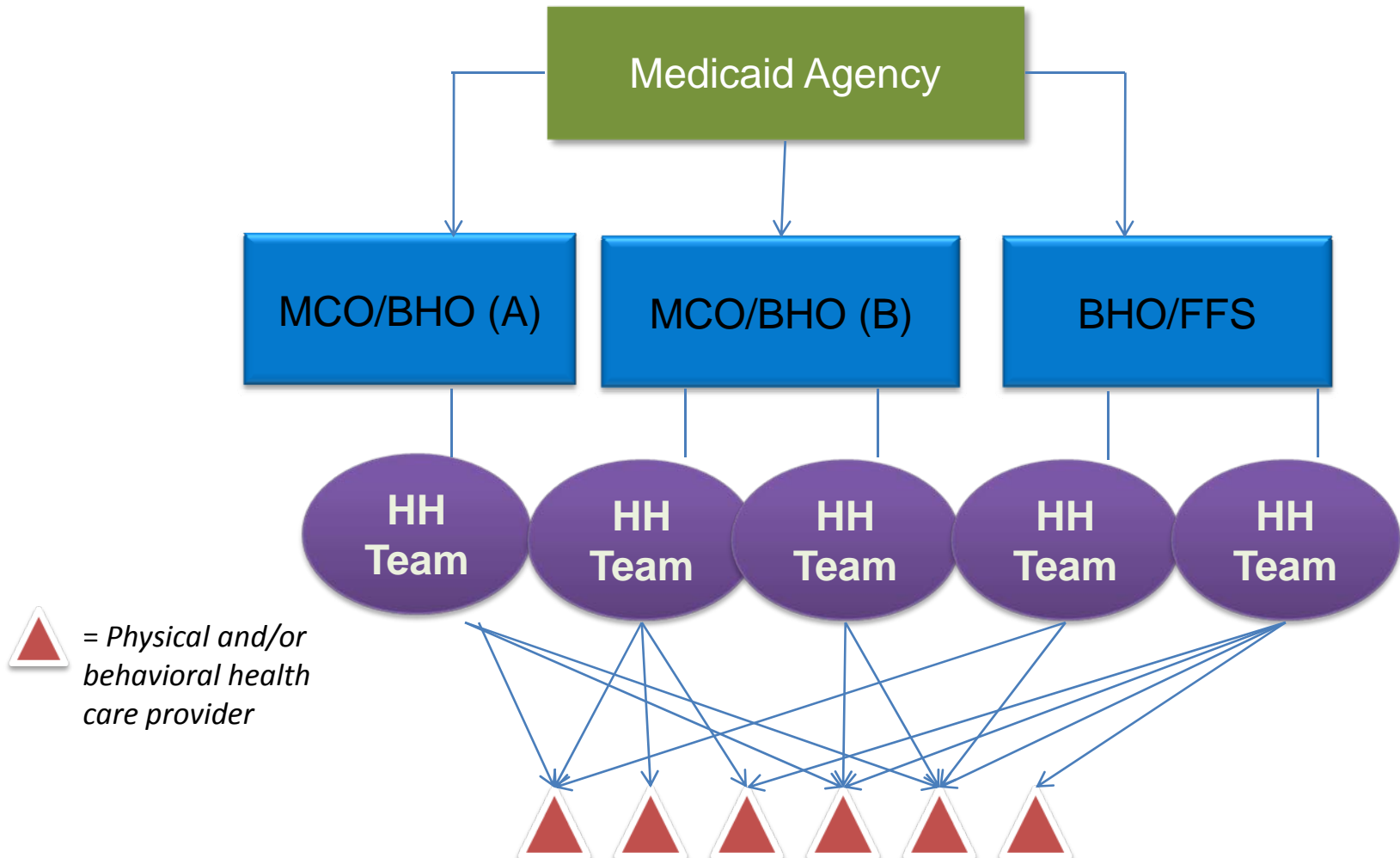
HH Program Requirements

- **Crisis intervention;**
- **Links to acute and outpatient medical, mental health and substance abuse services;**
- **Links to community based social support services-including housing;**
- **Beneficiary consent** for program enrollment and for sharing of patient information and treatment.

Winning Health Homes Will

- Use **health information technology** to link services, facilitate communication among team members and between the health team and individual and family caregivers
- Establish a **continuous quality improvement program**, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Examples of Structuring Health Homes In Managed Care Delivery System



Changing Timelines, Trends

- Health Homes to be Implemented in 3 Phases
- **Phase I Application Due Nov 1, Start Jan 1**
 - Bronx, Brooklyn, **Nassau**, Monroe, Warren, Washington, Essex, Hamilton, Saratoga, Clinton, Franklin, St. Lawrence, Schenectady
- **Phase II – Counties TBD**
 - Target Implementation April, 2012; Application due date TBD
- **Phase III – Counties TBD**
 - Target Implementation June, 2012; Application due date TBD
- 8 quarters of federal 90% Medicaid share begins Jan 1
- Children will not be included in first round

Financial Pressures, Healthcare Reform Can Speed the Pace of Wellness and Recovery Promotion...

- If we do more than simply save dollars by diverting people from ERS and hospitals and are successful...
- at truly helping people meet their health and personal goals via a more responsive and person directed health care and supports

.....Or Are We Back to the Medical Model?

- We have helped advance mental health systems by infusing recovery, rehabilitation, rights and peer support approaches and values.
- In integrating with the healthcare system and its illness, medication and patient based emphases, we must be strong and persistent in infusing these values into those systems by demonstrating that they need us and them to succeed.

Special Role, Value of Peer Services

- Start where the person is
- Promote hope and shared responsibility
- Form strong engaging personal relationships
- Focus on wellness and successful community living
- Promote improved self care and advocacy
- Help prevent relapses and provide alternatives to costly emergency room visits and hospitals
- Are innovative and cost effective

NYAPRS Peer Bridger 2008 Data on Reducing Re-Hospitalizations

In 2008, the Peer Bridger Project worked with 251 individuals and 190 of those consented to the release of their hospitalization data. After a preliminary review of this data, ***136 of these individuals were not re-hospitalized in the state psychiatric centers in 2008.***

72% percent of the people we worked with were able to stay out of the hospital for the following year.

Peer Bridger Replications

- Peer Bridger model adapted by OptumHealth in several states with the following results.
- Tennessee: reduced average number of hospital days per month from **7.42 to 1.98**, a **73.3% decrease**.
- Wisconsin: reduced average number of hospital days from **.86 to .48**, a **44.1% decrease**.

NYAPRS Peer Wellness Coaching: One Person's Outcomes

- Clean for 1 year
- Relapsed 1 year post rehab-went back to rehab-now clean
- 2009-prior to enrollment: **7 inpt stays** (4 different facilities) **\$52,282**
- 2010-1 detox, 1 rehab (referred by the CIDP team) **\$20,650.**
- 2011-1 relapse with detox/rehab no claim yet.

OptumHealthTexas Whole Health Peer Coach Program with Seniors

- Members enrolled in this program **reduced hospitalization by 96%**.
- The **net saving for the first 20 members was \$170,600 for just four months.**
- **Average length of stay also dropped from 6 to 2.3 days** for those who did need hospitalization.

PEOPLE Inc Peer Crisis Diversion Services Continuum

- Hospital Diversion House
- Warm Line
- In-Home Peer Companionship
- Social Structure (Nights Out)
- Emergency Department Advocacy
- Clinic Advocacy



Hands Across Long Island

- Hands Across Long Island (HALI) was formed in 1988 as a grassroots, multi-service, organization managed and operated by, and for, psychiatric survivors.
- Today, we are the largest and most successful peer-run, multi-service agency, mental health organization in NY State, helping over 3,500 consumers each year.
- HALI operates the FIRST peer-run mental health clinic in the United States. Its program include Personalized Recovery Oriented Services (PROS), Supported Housing, Advocacy, Resource Center, Professional Consultation, Forensics and Drop-In services.

MHA of Nassau County

- **Phone Link:** peer-to-peer "warm line" Monday - Friday, 9 a.m. - 9 p.m. Spanish language 4 p.m. - 9 p.m.
- **Peer Support Specialists/Peer Advocates:** individual or scheduled forums on recovery oriented issues at program sites.
- **Self-Help Groups:** helping individuals to actively participate in their own recovery and share their strengths and strategies with others.
- **Travel Training:** helping individuals to negotiate public transportation to increase their independence and build self-confidence.
- **Empowerment Center:** workshops and presentations include self-determination in recovery, relapse prevention, stress management, making decisions about returning to work and wellness
- **Education & Advocacy:** presentations to a broad array of community groups re recovery, stigma, advocacy et al.
- **One-to-one Assistance** with entitlements and other advocacy needs.
- **Consumer Link Newsletter**

Peer Services Transformation Center

- Funded by NYS Office of Mental Health
- Led by University of Medicine and Dentistry of NJ and NYAPRS, in conjunction with peer partners
- Focus on helping peer programs to transition to **recovery centers** (wellness, community inclusion)
- Focus on administration and management, best practice peer services, appeal and effectiveness of peer programs and services in the NYS health and mental health care reform environment
- Oscar Jimenez, NYAPRS director
oscarj@nyaprs.org

Future of the 3Rs

- Will MRT Reforms Advance Wellness, Recovery and Peer Support....or Will Healthcare Integration Bring Us Back to the Medical Model?
- Will There Be a Free-standing Public Mental Health System in 5-10 Years?
- Will We Achieve Reinvestment of Hospital/ER \$ into Housing, Peer Support, Employment?
- Do We Need to Distinguish Between Peer Support and Peer Run Services?

Future of the 3Rs

- Can We Get Cultural Competence the Kind of Attention Given to Recovery?
- Can We Get the MISCC and Community Integration the Kind of Attention Given to the MRT and Medicaid Restructuring?
- Can We Move from Person Centered to Person Directed Care?
- Will Electronic Records Advance or Weaken People's Rights?
- Is Improved Outreach and Engagement the Most Effective Strategy vs Kendra's Law?

Challenges for Peers

- Find/Sustain Hope
- Develop/Articulate Dreams and Goals
- Develop Self Advocacy and Recovery Self Management Skills (WRAP)
- Know/Exercise Your Rights (Advance Directives)
- Build/Sustain Contact with Personal Supports and Community Contacts/Resources
- Prepare for More Risks, Responsibilities
- Strengthen Stamina and Endurance
- Have/Find Faith
- Explore Alternative Forms of Healing

Challenges for Providers

- Train and Sustain Staff Belief in Recovery
- Train and Sustain Staff Competencies on Promoting Rehabilitation Readiness and Person Centered Planning
- Active Engagement and Outreach, Customer Satisfaction in Competitive Environment
- Firm Up Documentation Skills
- Firm Up Good Outcome Systems
- Get Ready for Electronic Records
- Get Entrepreneurial with New Partners and Payers
- Focus on wellness, prevention, employment, community integration

NYAPRS is Poised to Help!

Members Services and OMH funded Technical Assistance

- **Grassroots Advocacy** *January 31, 2012 Legislative Day*
- **Service Transformation:** incorporating recovery, rehabilitation and wellness; PROS and Peer Services TA; Health Home Learning Collaborative edyeschwartz@nyaprs.org
- **Community and Economic Development:** incorporating employment and asset development, Employment Networks TA, We can Work/Save, Peer Employment Support kellys@nyaprs.org
- **Peer Services:** incorporating peer outreach, engagement, bridging and wellness coaching TA, forensic PS tanyas@nyaprs.org
- **Annual Conference Exec Seminar PROS Academy Regional Forums**
- **Cultural Competence:** chackum@nyaprs.org

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