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# Ask The Expert Series: Population & Behavioral Health Strategies

Dr. Liz McKune, AVP Behavioral Health

# Agenda

- Trends in BH 2013-Present
- Trends in BH During COVID-19 Pandemic
- Passport by Molina Model of Care
- Specialized Populations
- Quality Focus
- Performance Improvement
- Examples of Provider-Led Solutions
- Provider Representatives
- What's Next?

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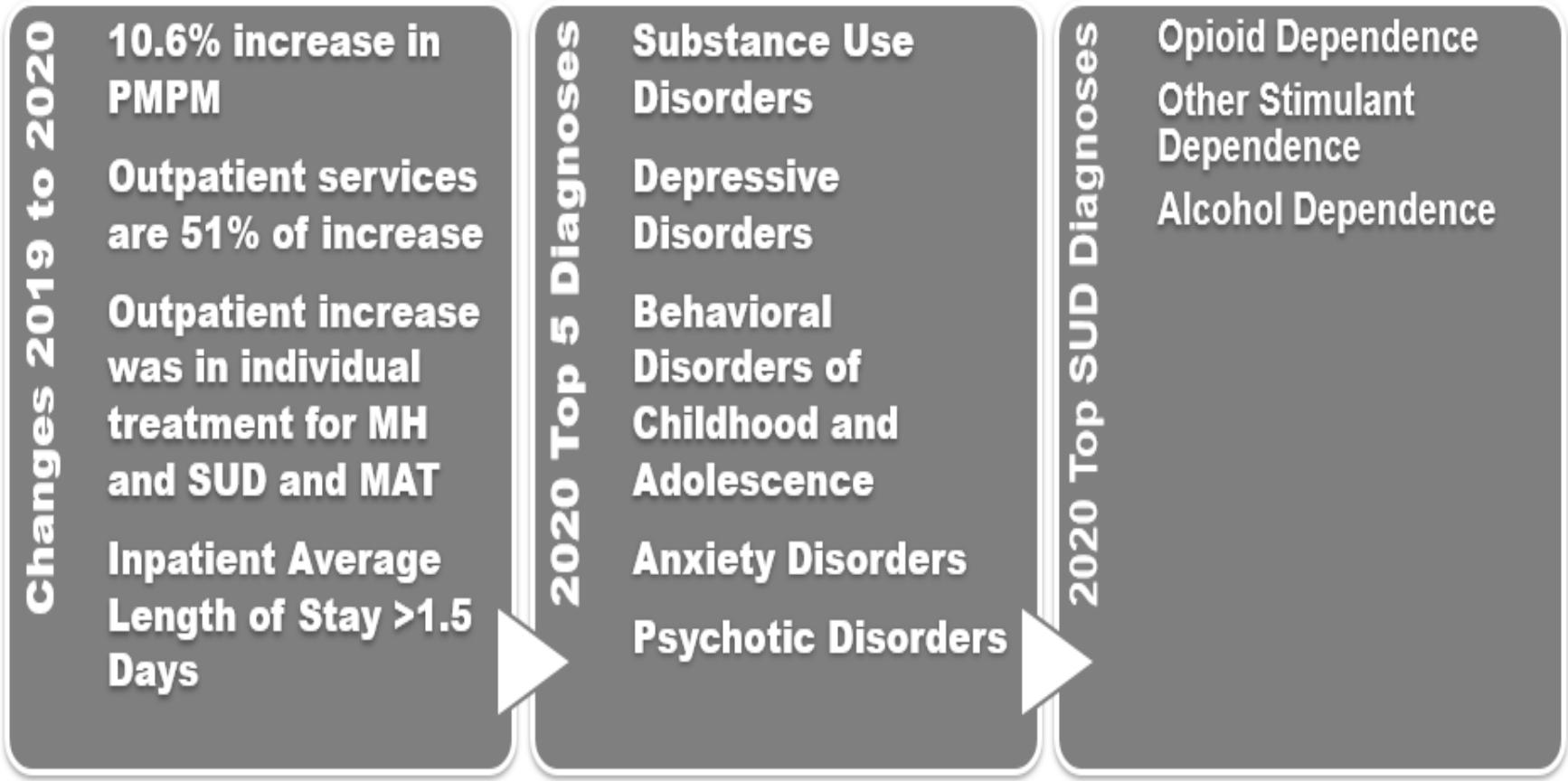
# 2020 Trends

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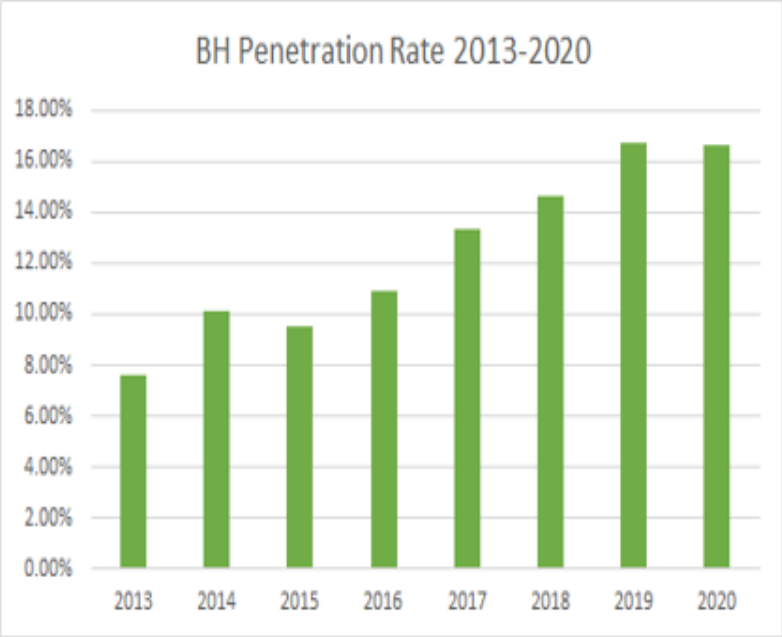
# Behavioral Health Trends 2013-2020

BH Utilization continually matched and then exceeded membership growth. In 2020, over 16% of enrollees utilized BH services.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# 10/19-9/20 Trend Changes: COVID-19 Impact on BH Trends

**18%** Drop in Inpatient Utilization

- Predominately due to changes in adult inpatient utilization
- Offset by increased length of stay by nearly 2 days for first 6 months of period

**6%** increase in Diversionary Level of Care Utilization

- SUD Partial Hospitalization had the largest increase
- SUD Intensive Outpatient Program decreased

Telehealth Impact on Outpatient Services

- Prior to 3/20 Telehealth accounted for **1%** of Outpatient Service Delivery
- Telehealth utilization for Outpatient Services hit peak in April of **41%** of Services
- Final Quarter of 2020 ended with **30%** Telehealth Utilization for Outpatient Services

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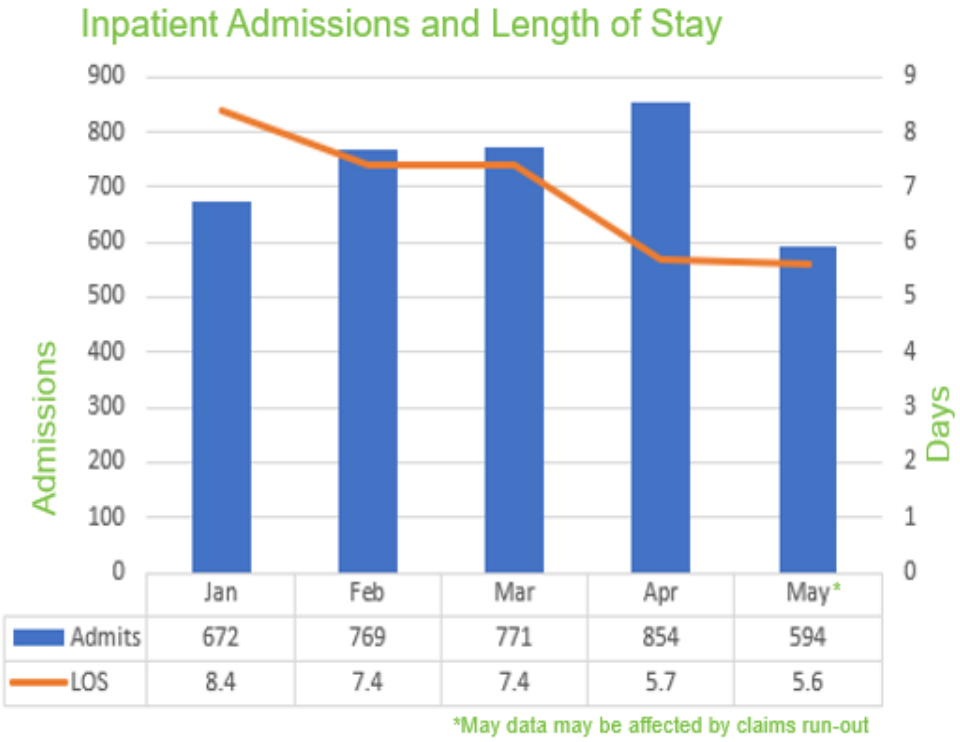
# 2021 BH Inpatient -Admissions




Utilization count by number of unique enrollee inpatient admissions and average length of stay.

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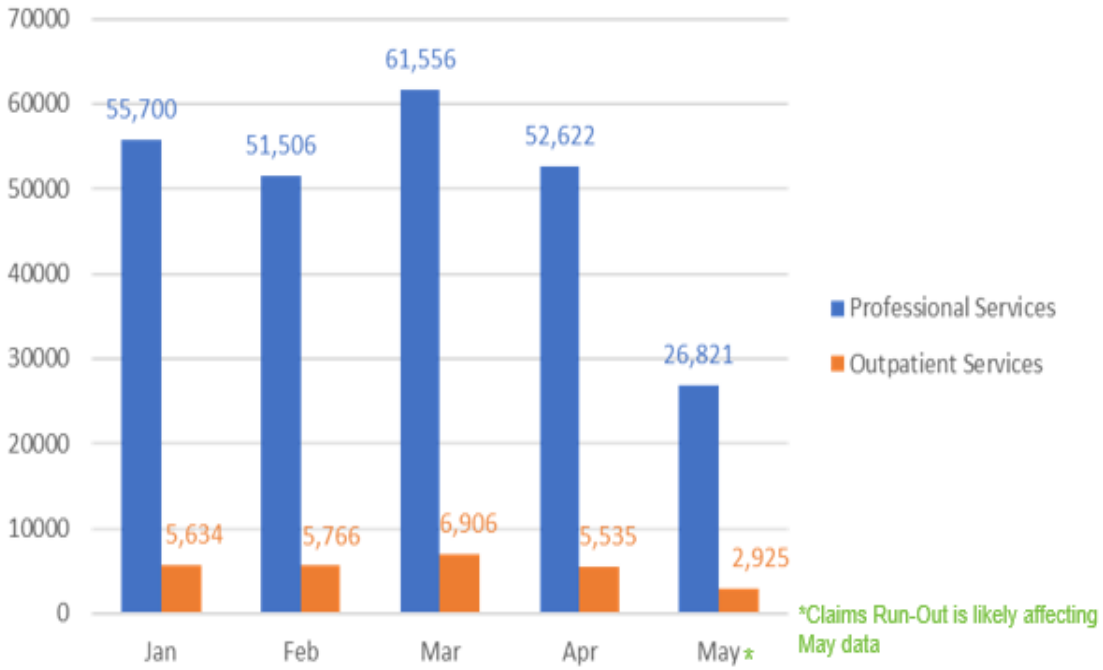
# 2021 BH Outpatient -Claims

Utilization count by number of unique outpatient and professional claims.

Around 81% of Outpatient and Professional BH claims are tied to Telehealth services.

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# 2021 BH Outpatient -Claims

| Highest Service Utilization | |
|---|---|
| 90837 | Individual Therapy, 60 minutes |
| 90832 | Individual Therapy, 30 minutes |
| H0038 | Peer Support Services (15 minute unit) |
| H0015 | Intensive Outpatient Program |

Top 4 Procedures for Outpatient and Professional Claims- Month over Month

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# Transition to Integrated Health Care Services Model

Shifted from BH Silo/Delegated Model to Fully Integrated Model


Integrated BH and PH review teams, composed of Psychiatrists and Psychiatric Nurse Practitioners, RN reviewers.

Follows member post discharge and coordinates after care with PCPs.

Community support including community connectors, housing specialists and BH peer supports with lived experience. Assists with effective transition in the community

Clinical SW and Professional counselors. Includes BH Professionals and RNs for members with BH primary case management needs. Provides assistance in healthcare access, advocacy & coordination.

Multidisciplinary team works together to identify trends in member needs and works to address health from both an aggregated and tailored, member level.

Continuous interaction and communication

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# Multi-Disciplinary Care Team

| Multi-Disciplinary Team | Level I | Level II | Level III | Level IV |
|---|---|---|---|---|
| Health Manager | ✓ | | | |
| Care Manager | | ✓ | ✓ | ✓ |
| Transition of Care Coach | | ✓ | ✓ | ✓ |
| Community Connector | | ✓ | ✓ | ✓ |
| Housing Specialist | ✓ | ✓ | ✓ | ✓ |
| SUD Navigator | | ✓ | ✓ | ✓ |
| Peer Support Specialist | | ✓ | ✓ | ✓ |
| EPSDT Coordinator | ✓ | ✓ | ✓ | ✓ |

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# Individuals with SMI and SED

- Individuals with these conditions often fall into our Level II/Complex Care Management (CM) risk level, but may also be in other CM levels, depending on need
- Attempt to contact members within 3 days of discharge from inpatient setting via our Transition of Care program; then transition to ongoing CM
- Set personalized goals, assist with medication concerns or questions, coordinate care, and educate on health conditions
- Add additional CM supports (Peer Support Specialists, Housing Specialists, Community Connectors) as needed
- Build natural and community support system
- Facilitate team meetings including providers and community-based supports to find creative solutions to meet member needs


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# Opioid Use Disorder Model of Care

- Members with confirmed diagnosis or illicit use
- Use of Substance Use Disorder Navigators (Care Managers with experience/training working with individuals with SUD) and Peer Support Specialists
- Use ASAM and NIDA assessments/screeners (initial and full/ongoing) to assess needs
- Frequency of contact is based on member's risk level
- Risk levels (2-4) are determined from NIDA responses, utilization, and other factors
- Goals include supporting recovery, reducing risks, increasing member self-management of OUD

# Coordinated Services Program (CSP)

- Previously known as “Lock-In.”
- Goal is to prevent death or injury from prescription drug abuse while preventing Medicaid fraud, waste, or abuse.
- Create an avenue for member behavior change with care management support, monitoring and limiting the member to a single pharmacy/provider/setting for care needs.
- Members can decline CM services; they cannot decline provider/facility/pharmacy limits.
- Members can appeal a decision within 30 days of notification.


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# HEDIS Quality Metrics

| HEDIS Measure Name | Sub-measure |
|---|---|
| Antidepressant Medication Management (AMM) | Effective Acute Phase Treatment |
| Antidepressant Medication Management (AMM) | Effective Continuation Phase Treatment |
| Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) | Blood Glucose Total |
| Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) | Cholestrol Total |
| Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) | Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics Total |
| Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) | 30 Day follow-up for discharge Total |
| Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) | 7 Day follow-up for discharge Total |
| Follow-Up After Hospitalization for Mental Illness (FUH) | 30 Day follow-up for discharge Total |
| Follow-Up After Hospitalization for Mental Illness (FUH) | 7 Day follow-up for discharge Total |
| Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) | Total - 30 Day Follow-Up - Age 13+ Years Old |
| Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) | Total - 7 Day Follow-Up - Age 13+ Years Old |
| Follow-Up After Emergency Department Visit for Mental Illness (FUM) | 30 Day follow-up for discharge Total |
| Follow-Up After Emergency Department Visit for Mental Illness (FUM) | 7 Day follow-up for discharge Total |
| Use of Opioids at High Dosage (HDO) | |
| Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) | Engagement of AOD Treatment Total |
| Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) | Initiation of AOD Treatment Total |
| Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA) | |
| Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) | |
| Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) | |

# Performance Improvement Plans

- Two Performance Improvement Plans:  Diabetes & Social Determinants of Health
- All Medicaid Plans are working on the same Performance Improvement Plans (PIPs)
- PIPS are for two years; 2021 & 2022
- Reports are submitted regularly to DMS


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# Diabetes PIP

Objectives

- Improve diabetic control among KY Medicaid Managed Care Enrollees
- Reduce the prevalence of Type 1 Ketoacidosis among children
- Multi-departmental approach to achieving objectives

How Passport is Addressing the Interventions

- Increase referrals to Diabetes Self-Management Education & Support and enhance case management and care coordination for member education nutrition and exercise
- Increase interventions for endocrinologist referrals or follow-ups after adverse lab results
- Enhance education on Type 1 Diabetes Mellitus in children and adolescents and on evidence-based HbA1C testing and referrals to endocrinologists

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# Social Determinants of Health PIP


Objectives

- Improve the quality of SDOH needs assessment by incorporating questions to address social connectivity/isolation
- Improve the rate of return for SDOH needs assessments
- Improve the rate of SDOH referrals, follow-ups, and care coordination with the enrollee, PCPs, and community mental health providers

How Passport is addressing the interventions

- Two new SDOH questions were added to the enrollee Health Risk Assessment
- Implementing new procedures for obtaining alternate enrollee telephone numbers
- Use of an SDOH tool that assesses Social Connectivity/Isolation as part of the comprehensive needs assessment (PRAPARE)
- Provider education about SDOH screening and coding
- Collaborate with discharge planners during a psychiatric inpatient stay to include SDOH assessment
- Care managers are completing a PHQ-2 & PHQ-9 with referrals as needed

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# PRAPARE Assessment Tool

- The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) was developed as a national effort to help providers understand their patients' social determinants of health. The PRAPARE tool helps providers:
- Ask the right questions to collect the data needed to determine the best way to approach the patients needs
- Reach population health goals and identify areas that drive poor outcomes and higher costs of care

**The core measures that are addressed in the PRAPARE Assessment tool are:**

| | | | |
|---|---|---|---|
| Income | Stress | Language | Race |
| Ethnicity | Education | Employment | Insurance |
| Veteran Status | Migrant and/or Seasonal | Material Security | Housing Status/Stability |
| Transportation | Farm Work | Address/Neighborhood | Social Integration/Support |

https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/ky/medicaid/PRAPARE-Protocol-for-Responding-to-and-Assessing-Patient-Assets-Risks-and-Experiences.pdf

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# Examples of Provider Partnerships to Address Care Gaps

## OMNI FITT Program


- Omni's Family Intensive Treatment Team (FITT) provides in-home treatment, crisis response services, and wraparound intervention.
- Serves children and youth who meet the hospital or PRTF level of care.
- Is designed to stabilize members and transition to a community-based lower level of care.
- Provides all services for a single monthly case rate.
- Interventions typically last about 90 days.
- Over 7 months, Passport by Molina served 11 child and youth members
- While receiving FITT, there were four hospitalizations, no change in home placements, and no movement to higher levels of residential care (e.g. private child care residential)
- As measured by the CALOCUS, children decreased in the intensity of their needs on average by one level of care. All children who have completed FITT intervention have been successfully transitioned to lower levels of care.

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# Provider Partnerships to Address Care Gaps

**180 Health Partners**

- Community of Support
  - Care Manager
  - Peer Support Specialist
  - Virtual Community
- Mother-Centered Plan with or without MAT and OB/GYN coordination
- Post-Partum Support
- TCM

180 Health Partners™
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# Multisystemic Therapy Pilot Update

Partnered with Home of the Innocents (HOTI)

- MST is an evidence-based model that treats youth ages 12-17 who exhibit chronic or serious anti-social behavior and are at high risk of out-of-home placement. MST utilizes a home-based model of service delivery, including therapy that educates families on the effects of trauma and helps them heal from past trauma, preventing trauma from manifesting into one or more psychiatric disorders, a child's removal from the home, or detainment in a juvenile justice facility.


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# Behavioral Health

| Territories | Provider Services Rep. | | Provider Type | Contact Info |
|---|---|---|---|---|
| | Teri Hardman |  | Behavioral Health, **Regions 1, 2, 3, 4** and all Community Mental Health Centers & BH for Recovery Works, BH for Baptist Health, KY One, and University of Louisville & Spero | 502-212-6713<br>Teri.Hardman@molinahealthcare.com |
| | Christine Drake |  | Behavioral Health **Regions 5, 6, 7, 8** and BH for Norton Healthcare | 502-212-6704<br>Christine.Drake@molinahealthcare.com |


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# Contact Information

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# September Themes

Clinical Focus: Cold & Flu Season

Health Holiday: National Suicide Prevention Week and Pain Awareness Month

Social Determinant of Health: Social Isolation





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# October Themes

Clinical Focus: Breast Cancer

Health Holiday: Dental Hygiene Month

Social Determinant of Health: Transportation


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# Important Numbers

Member Services: **800-578-0603**

Pharmacy/MedImpact: **800-210-7628**

Provider Services: **800-578-0775**

24/7 Nurse Advice Line: **800-606-9880**

24/7 Behavioral Health Crisis Line: **844-800-5154**



www.passporthealthplan.com

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# Meet the Community Engagement Team

**Nicole Yates** — Associate Vice President, Community Engagement

**Michele Heuglin** — Manager, Community Engagement

**Kristin Blocker** — Department Admin

**Lisa Bellafato** — Manager, DEI and Health Education

**Marji Pilato**

Anderson, Bourbon, Clark, Fayette, Franklin, Jessamine, Shelby, Spencer, Woodford and the following zip codes in Jefferson county: 40023, 40025, 40059, 40202, 40204, 40205, 40206, 40207, 40209, 40213, 40218, 40220, 40222, 40223, 40225, 40228, 40241, 40242, 40243, 40245, 40291, and 40299

**Joy Wickens**

Boyle, Breckinridge, Bullitt, Daviess, Grayson, Hancock, Larue, Marion, Meade, Mercer, Nelson, Ohio, Washington and the following zip codes in Jefferson county: 40118, 40203, 40208, 40214, 40215, 40217, and 40229

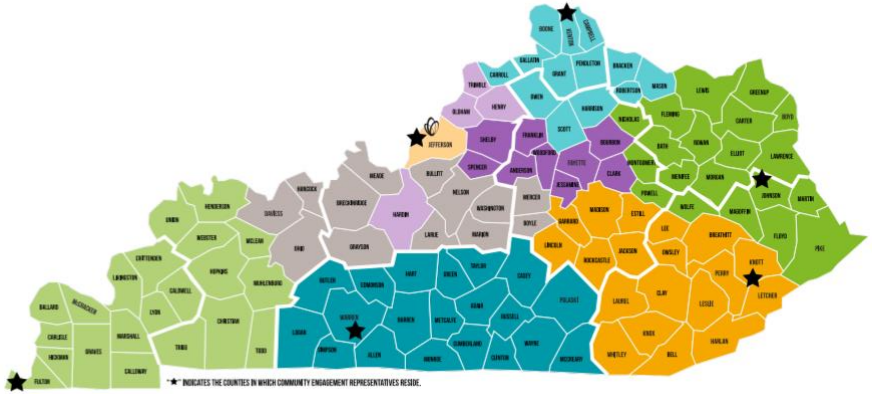
**Carolina Rodriguez Curiel** — Community Engagement Specialist

**Diane Corsey**

Hardin, Oldham, Trimble and Henry and the following zip codes in Jefferson county: 40203, 40210, 40211, 40212, 40216, 40219, 40258 and 40272

**Leslie Salsbury**

Boone, Bracken, Campbell, Carroll, Gallatin, Grant, Harrison, Kenton, Mason, Owen, Pendleton, Robertson, and Scott




**Karastin Hancock**

Ballard, Caldwell, Calloway, Carlisle, Christian, Crittenden, Fulton, Graves, Henderson, Hickman, Hopkins, Livingston, Lyon, Marshall, McLean, McCracken, Muhlenburg, Todd, Trigg, Union, and Webster

**Priscilla Schwartz**

Adair, Allen, Barren, Butler, Casey, Clinton, Cumberland, Edmonson, Green, Hart, Logan, McCreary Metcalfe, Monroe, Pulaski, Russell, Simpson, Taylor, Warren, and Wayne

**Stacy Crum**

Bath, Boyd, Carter, Greenup, Elliot, Fleming, Floyd, Johnson, Lawrence, Lewis, Magoffin, Martin, Menifee, Montgomery, Morgan, Nicholas, Pike, Powell, Rowan and Wolfe

**Tonnie Walters**

Bell, Breathitt, Clay, Estill, Garrard, Harlan, Jackson, Knott, Knox, Laurel, Lincoln, Leslie, Letcher, Madison, Owsley, Perry, Rockcastle and Whitley

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# Ask the Expert Series

Third Tuesday of the month from 12-1 Eastern time

| Date | Team | Topic |
|---|---|---|
| 10/19 | Passport Advantage | Medicare Advantage HMO Special Needs Plan & benefits |
| 11/16 | Community Engagement (Health Education & DEI) | Meet the teams, free health education & DEI trainings, Open Enrollment 2022 Medicaid & Medicare benefits & rewards |
| 12/21 | Provider Network Management | Meet the team and learn how we work with our provider partners to provide quality care! |

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