



## **Behavioral Health**

# **Updates on Reform Programs**

October 2016

**Presented by:**

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# Presentation – Questions we will answer

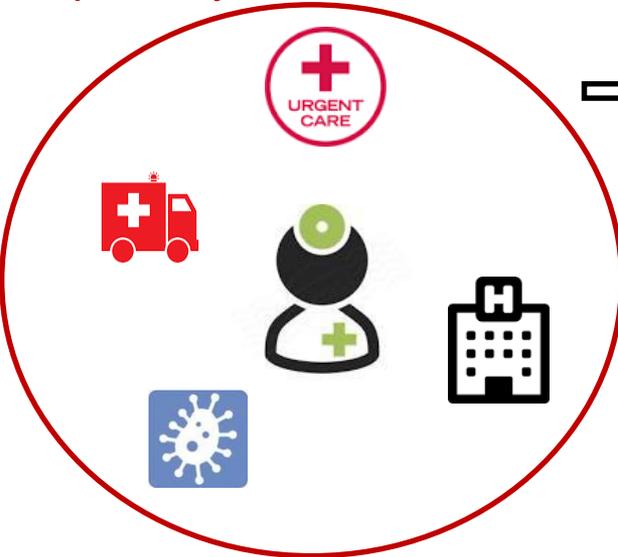
- ❑ How are county mental health plans impacted by the Affordable Care Act?
- ❑ What are the major programs coming that counties will engage in as part of reform?
- ❑ How are reform changes impacting DBH's partners?
- ❑ What should the BHC members remember as we talk with constituents and consumers?

# Section 1 - How are county mental health plans impacted by the Affordable Care Act?

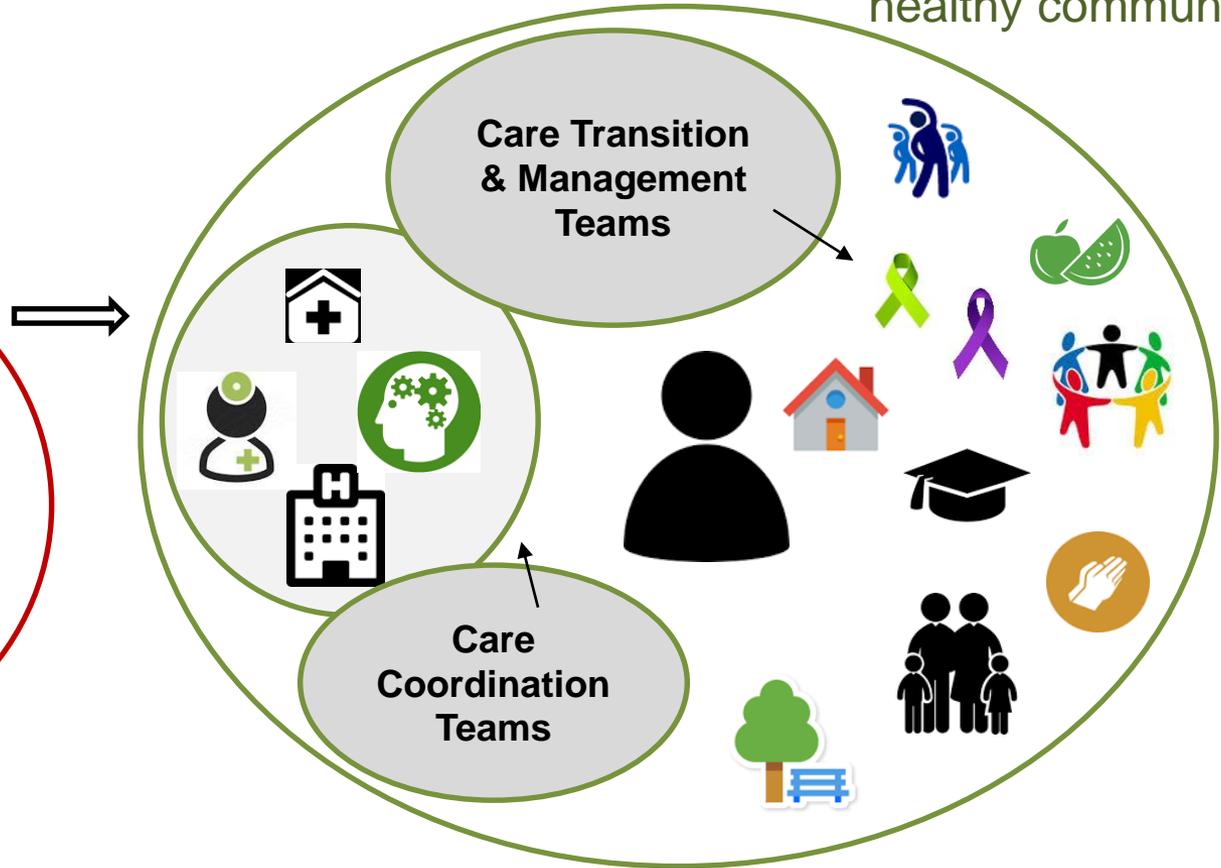
# Section 1 – ACA is shifting the Healthcare System to: Population Health

## Old System:

Crisis episodes, cycles of emergency/crisis services & inpatient hospitalization, specialty-based

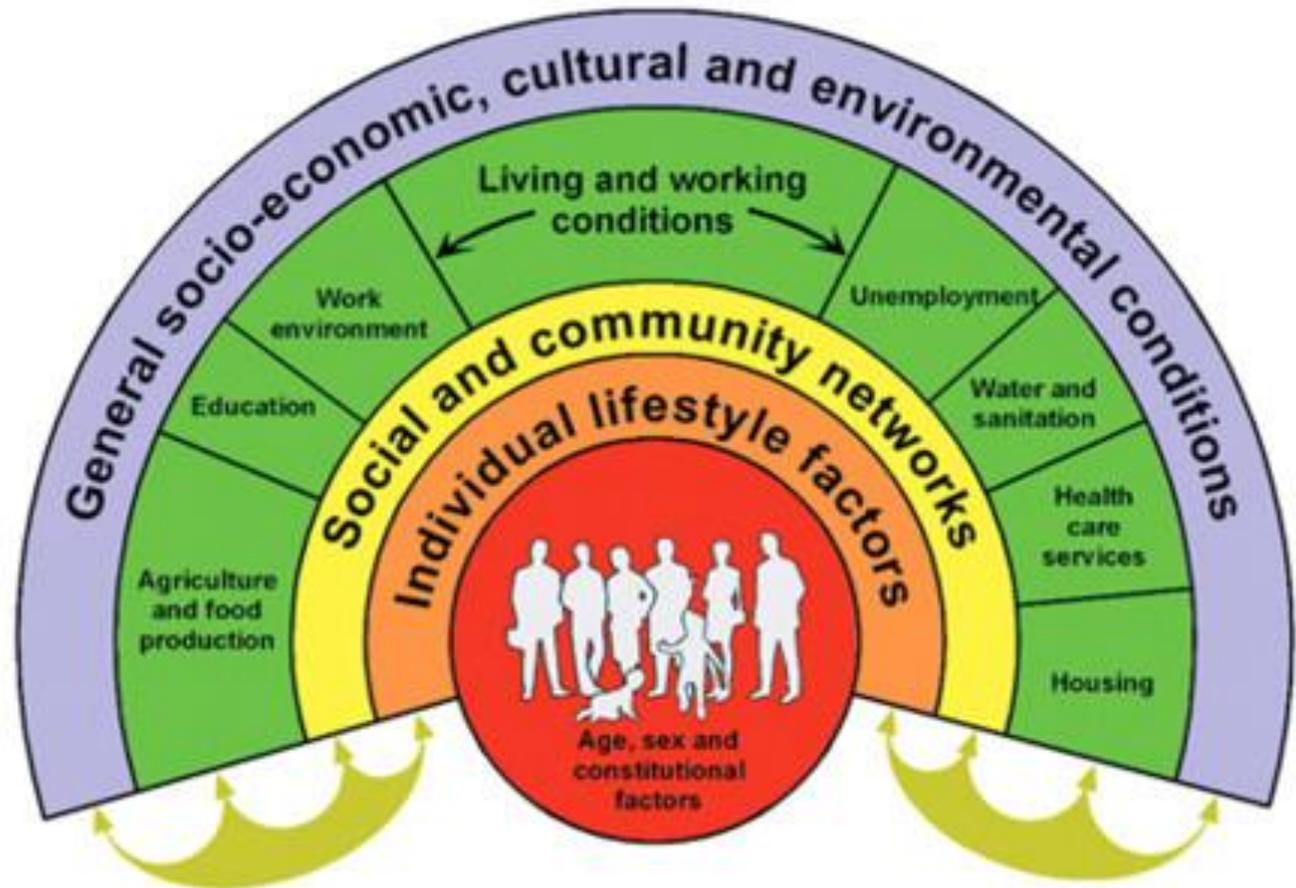


**New System:** Integrated, coordinated care when you need it, help with care transitions. Improve outpatient care & healthy community.



# Section 1- Managing a person in their entire context

- How do we manage someone's health, across their lifespan, in their community, in all areas of life that impact their health and well being?



# Section 1: A good way to think of health reform

Reforming a system to provide the:

Right care,

at the Right time,

in the right setting,

of the highest quality and best experience,

and at the lowest cost.



# Section 1 - Affordable Care Act signed into Law: March 23<sup>rd</sup>, 2010

- The first 6 years of reform have impacted the most expensive health care organizations: Hospitals, large health systems & large doctor groups.
- Pay for performance:
  - Quality of care
  - Reduce the cost of care
  - Improve the care experience
- How well a health organization performs today will impact their reimbursement dollars, in 2-3 years.



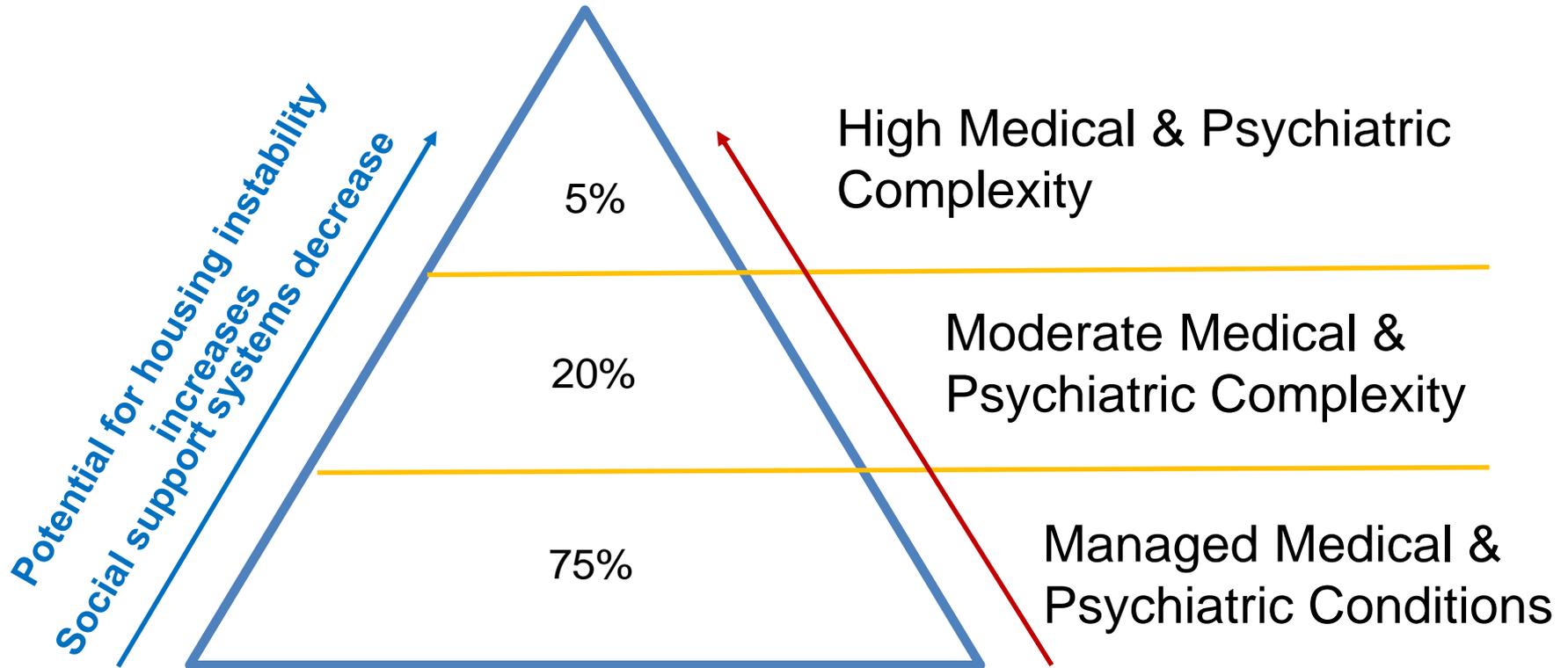
# Section 1 - What about the counties?

- CA Mental Health Plans are beginning to dialogue around
  - Increased visibility on **outcomes** and results; public reporting of outcomes.
  - Possible future **capitation** rates, or a flat rate per person.
  - **New enhanced rules** as a managed care plan (administration).
  - **Integrating behavioral and primary care**: what is our scope relating to services we provide, possibly primary care services?
  - **New types of services** that engage clients into the health care system with health plans and practitioners as much closer partners.
  - Improving:
    - Complex care coordination (Different from case management)
    - Transitions of care

- ❑ **Section 2 - What are the major programs coming that counties will engage-in as part of reform?**

# How to think about our Medi-Cal population?

*(DBH + IEHP + Molina)*



**Decreased ability to manage complexity of health care system intersections & transitions and requires complex care coordination, and increased provider engagement.**

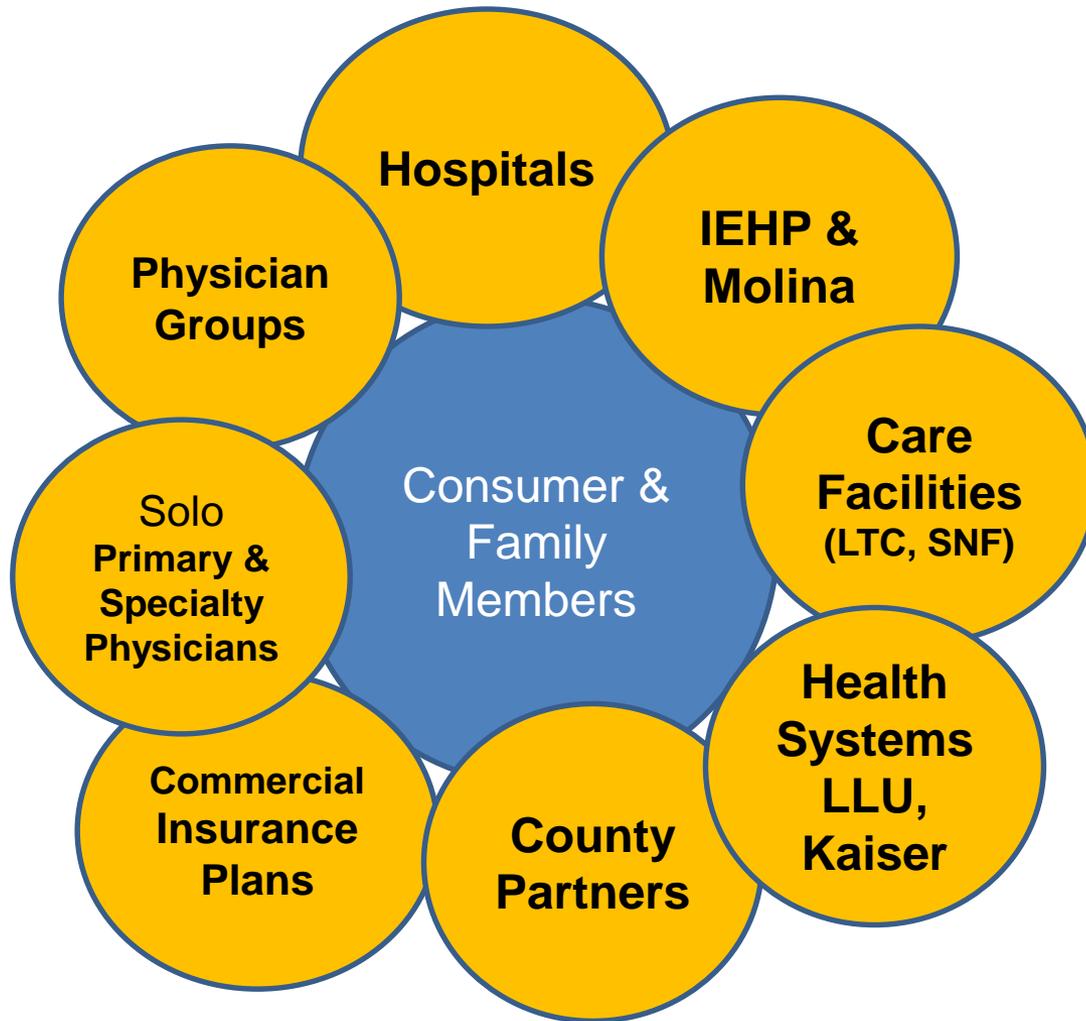
## Section 2 – Characteristics of beneficiaries with high medical and psychiatric complexity

- Numerous negative past histories with health care, a sense of hopelessness, isolation, disillusionment, and a feeling of disenfranchisement.
- Unengaged in available, existing non-emergency health services & benefits.
- Vulnerable due to the difficulty making transitions.
- Difficulty traveling-to and dealing-with wait times for appointments.
- Inability to complete multi-step processes and multiple assessments without support.
- Difficulty remembering instructions for managing own health, organizing care or needs, and identifying needs.
- Inadequate support from their families or support systems.
- Difficulty in coordinating services is experienced by patients and family members.

## Section 2 – What do we need to do?

- Acknowledge current assets, strengths, and experience of county mental health plans to influence and shape new programs:
  - Flexible services that provide flexible, nimble treatment planning models with other providers, to meet needs of beneficiary
  - Relationship-driven, engagement-based
  - Frequent contacts to engage
  - Mobile/field-based
  - Build relationships with the patient and their family members or support systems
  - Improve inpatient to outpatient care transitions
  - Connected care professionals from different systems

# Section 2 – Improve Complex Care Coordination



## Section 2 – Whole Person Care

- **Who:** CMS (Federal) → DHCS (State) → County
  - ARMC
  - DBH
  - DPH
  - Housing / Homeless
  - Community Clinic Association, IEHP, and other community Partners
- **What:** CMS is requesting we test a program to better coordinate care for beneficiaries with 2+ chronic conditions, which could include mental illness, and homelessness.
- **When:** 5-Year Pilot Program, Nov 2016 – Dec 2020
- **Where:** San Bernardino County (one of 17 counties in CA)
- **Budget:** SB County WPC Project = \$3.5 million
- **How:** Hire team of 20-30 staff to provide continuous engagement and coordination to improve health and decrease emergency care & unnecessary hospitalizations.

## Section 2 – Health Homes

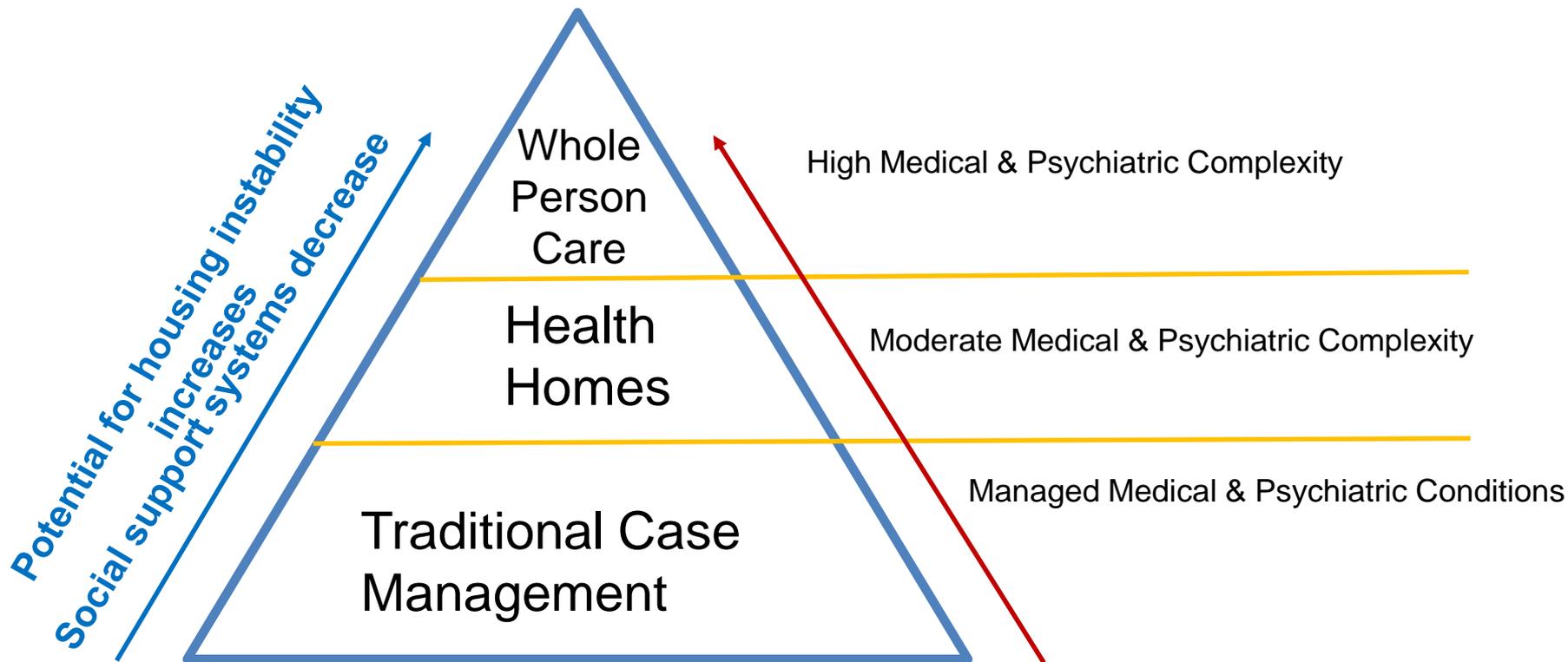
- **Who:** CMS (Federal) → DHCS (State) → Managed Care Plans (IEHP & Molina)
- **What:** CMS is requiring managed care plans to coordinate care for beneficiaries with 2+ chronic health conditions and mental health condition. *Housing needs can be coordinated but not a primary focus.*
- **When:** Originally January of 2017 start, now looks like January 2018.
- **Where:** San Bernardino County Medi-Cal and Medicare beneficiaries
- **Budget:** To be determined by the State
- **How:** Managed Care Plans will run their data to identify who qualifies. Currently, IEHP estimates 30,000 members to qualify for Health Homes, of which DBH estimates 8,000 are DBH clients.

## Section 2 – IEHP’s BHI-CCI

- **Who:** IEHP & DBH and IEHP & ARMC
- **What:** IEHP made funds available for test projects to improve care coordination, in anticipation of Health Homes.
- **When:** July 2016 – June 2018 (if extended 1 year)
- **Where:** DBH is testing a project in Adult Residential Services to add medical care coordination to the services consumers receive, in addition to their mental health care coordination.
- **Budget:** ~\$450,000/year for 2 years
- **How:** DBH hired 4 staff: clinic assistants, nurse practitioner and nurse to coordinate medical care. Engagement-based in the field. We will go where the clients need.
- **Success Story shared by Dianne Sceranka**

# How to think about these programs?

## Complex Care Coordination



**Decreased ability to manage complexity of health care system intersections & transitions and requires complex care coordination, and increased provider engagement.**

# Section 2- Drug Medi-Cal Organized Delivery System Waiver

- **Who:** CMS → DHCS (State) → Counties
- **What:** Standardizes the continuum of care modeled after the American Society of Addiction Medicine Criteria (evidence-based practice) for substance use disorder treatment services, increases local control and accountability, increases administrative oversight, creates utilization controls to improve care and efficient use of resources, and coordinates with other systems of care.
- **When:** Part of 5 Year, Medi-Cal 2020 Waiver
- **Where:** All Counties in CA
- **Budget:** Payment reform for the system
- **How:** DBH System of care will enhance services: Case Management, Recovery Support, Residential Levels of Care.

## Section 3 - Why SUD?

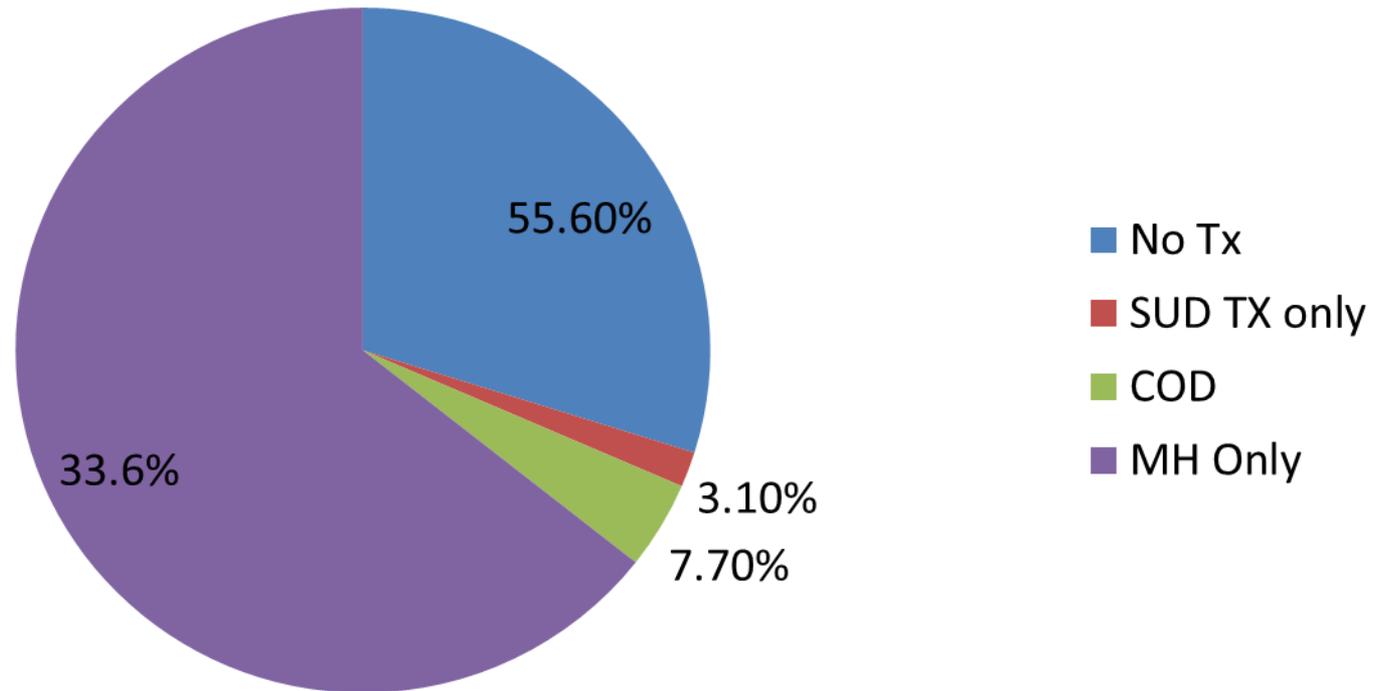


### Co-occurrence with:

- Schizophrenia
- Major Depressive Disorder
- Bipolar Affective Disorder and Anxiety Disorder
- Post Traumatic Disorder

# Section 3 - We Must Treat Both Mental Health and SUD

Past Year Treatment , 2010



# Section 3 – Required services to be Implemented in Drug Medi-Cal Waiver

- ✓ Early Intervention
- ✓ Outpatient SUD treatment
- ✓ Intensive Outpatient SUD treatment
- ✓ Residential SUD treatment
  - ✓ At least 1 ASAM level
- ✓ Narcotic Treatment Program (NTP)
  - ✓ Includes other Medication Assisted Treatment such as buprenorphine, naloxone, naltrexone, disulfiram
- ✓ Withdrawal Management
  - ✓ At least 1 ASAM level
- ✓ Recovery Services
- ✓ Case Management
- ✓ Physician Consultation

## Section 3 - Special Populations in SUD

- Harder to treat SUD populations may include:
  - Criminal Justice;
  - Co-Occurring ;
  - Cognitive Impairments.
- May require more intensive services.
- Additional services may include:
  - Outreach to educate;
  - Length of stay: may be extended based on medical necessity;
  - Promising practices: Drug Court, Probationers Recovering through Intervention/Drug Education (PRIDE), AB 109, Co-Occurring SUD Treatment, Cultural Considerations.

## Section 3 – SUD & Opioid Epidemic

- President Obama’s initiative - \$1.1 billion in new funding for treatment to combat the “Prescription Opioid and Heroin Epidemic”
- Why are opioids like Meth so addictive and causing an epidemic?
  - The units of dopamine (feel good hormones) released by the brain are much higher
- Meth releases almost **1450 units** of dopamine in the brain compared to:
  - Cocaine: ~400 units of dopamine
  - Nicotine: ~220 units of dopamine
  - Alcohol: ~200 units of dopamine
  - **A really great meal: ~180 units of dopamine**

## **Section 3 - How are reform changes impacting DBH's partners?**

## Section 3 - DBH Partners and Reform

- New dialogue and potential population health tools regarding coordinated care within the county system:
  - ARMC
  - Public Health Clinics
  - Housing / Homeless
  - Forensics
  - DBH
  
- New Dialogue with managed care partners:
  - IEHP
  - Molina

# Section 3 – Goal with Managed Care Partners

- Define roles in care coordination :
  - Who has “the ball” when the patient moves between different groups?
- Manage the needs of the patient
  - Don’t “drop” the ball on beneficiaries need.
- Manage the lines of responsibility and risk
- How do we stay true to our core mission of carve-out, specialty mental health services?
  - We don’t have to become primary care provider; however, our interactions in working with primary care will change dramatically.



## Section 4 – Key things to remember

# Most Importantly

DBH is:

- On the **frontlines** of health reform with our partners
- **Increasing our capacity** to provide complex care coordination to improve beneficiaries physical and behavioral health.
- **Working with county partners** to improve our county health system.
- **Working with managed care partners** to determine how we will partner in coordinating care in the future.
- **Fully active in dialogue with DHCS (State)** to influence how new programs impact our beneficiaries.
- **Proactive & ahead of the deadlines** in pulling data to review our consumer's physical and mental health needs.

# Thank you! & Questions?

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