



Presentation to the NICHQ 8th Annual Forum for Improving Children's Healthcare

Improving Behavioral Health Care for Children with Special Needs: Integrated Care, a Five Year Study

March 12, 2009

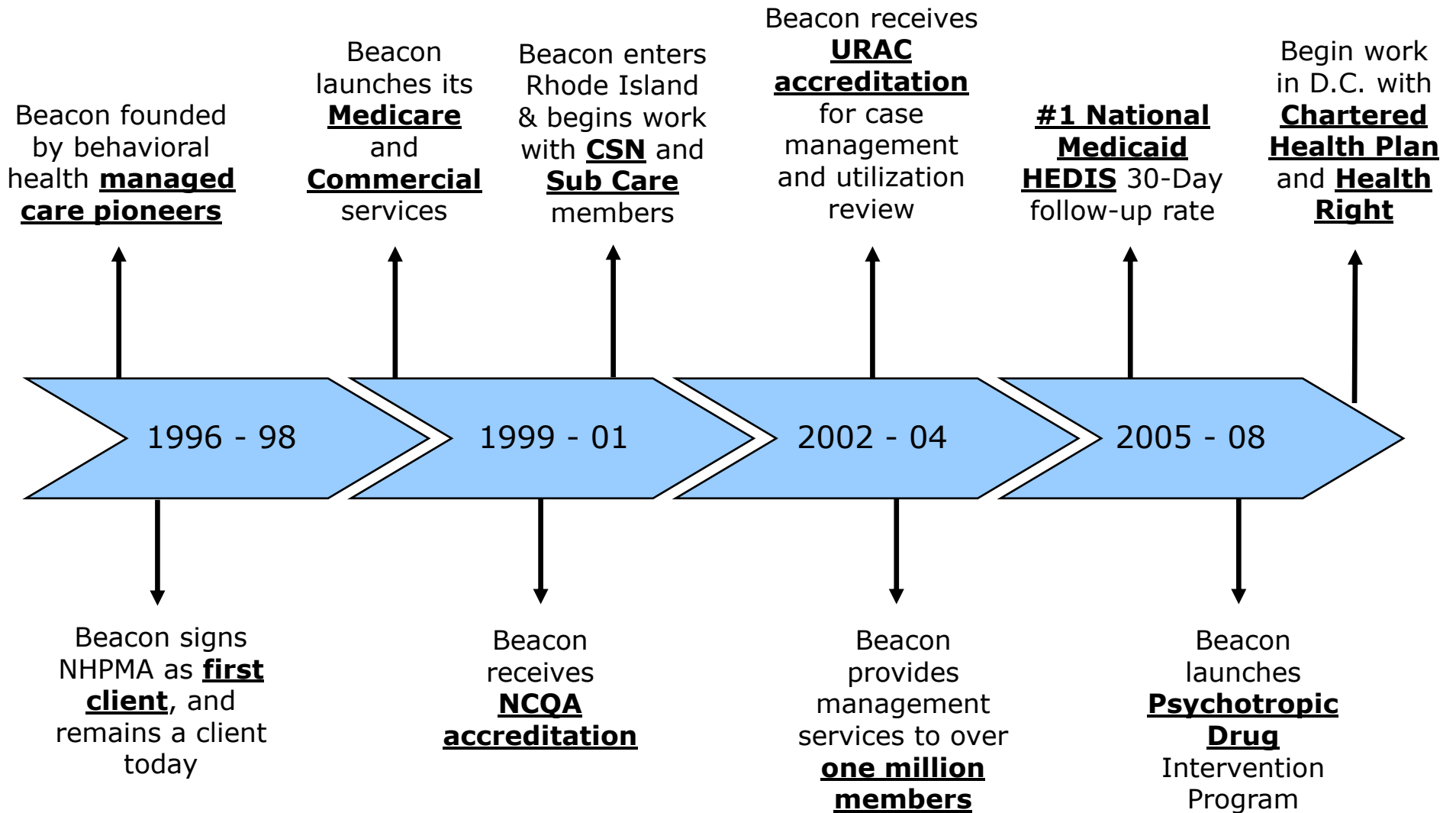


Who we are and what we will be discussing today

- John Colburn Ph.D. Director of Clinical Development
- Kathy Grant, RN, MS State Program Director for R.I.
- How the total health care needs of Children with Special health Care Needs are Managed through a Medicaid Health Plan
- What is Integrated Care for Children With Special Health Care Needs?
- Outcomes – What we accomplished and why it is replicable, cost savings and quality outcomes.

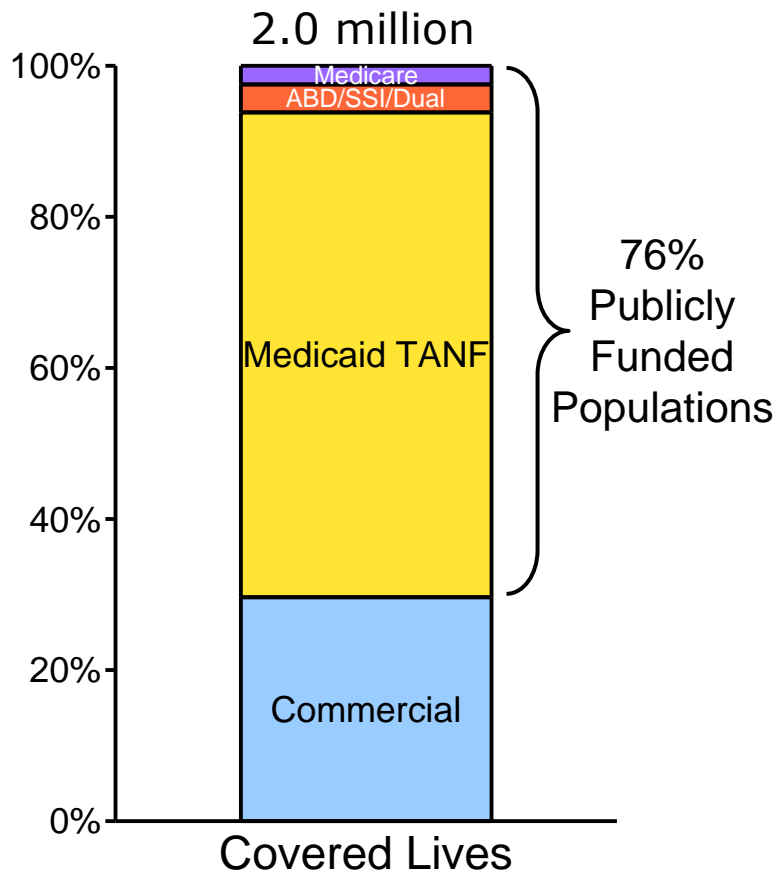


History of Beacon



Beacon specializes in coordinating behavioral health for publicly funded populations

Covered Lives by Payer Type

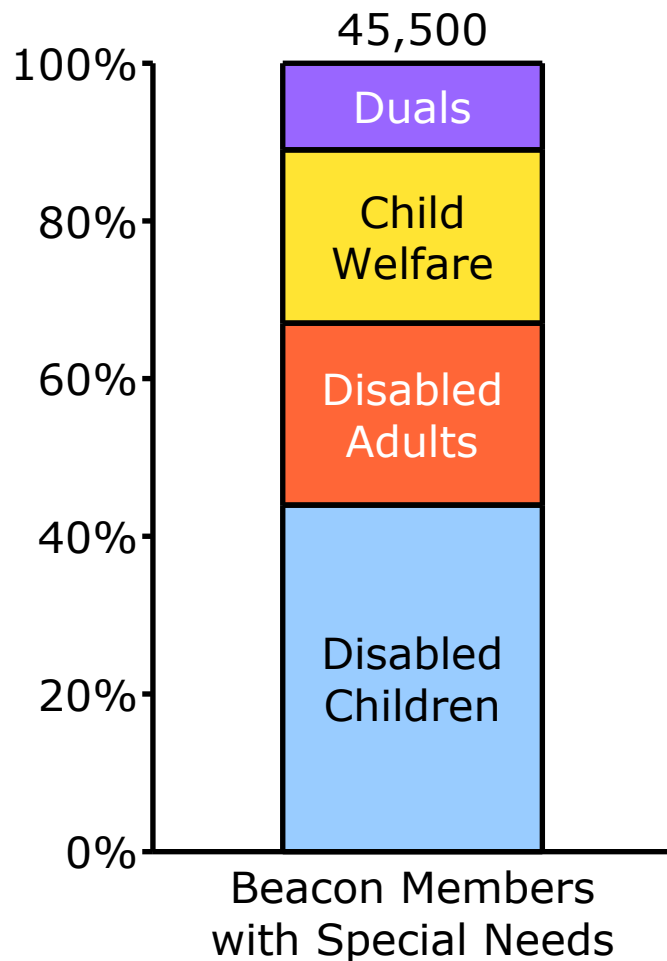


Beacon's Business Model and Services

- **Network** creation and management
- Intensive **case management**
- **Utilization management** and review
- **Psychotropic drug** management
- Chronic **disease management**
- **Administrative support** services
 - Claims, call centers, credentialing, quality
- Agency/Courts/School **care coordination**
- Consulting / **Managed Care Readiness**
- Fully integrated **BH IT** systems

Beacon's Medicaid expertise includes experience with special needs populations

Special Needs and Disabled Populations

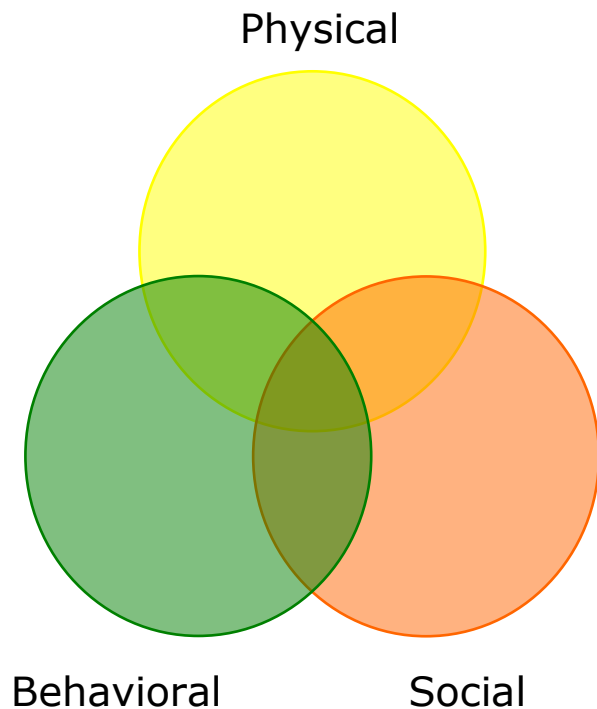


"Best in Class" Services

- Informatic and **clinical integration** of medical care and behavioral health
- **Keen awareness** of working with **protected classes** often found within special needs / disabled populations
- **Network development** experience for lower volume, **highly specialized services**
- Three-tiered **case management** system
 - Case consultation, Case coordination and Intensive case management
- Expertise in **coordination of benefits** with Medicare, Medicaid FFS wrap-services and other payers of last resort
- Business processes for managing involvement of **multiple local, state and federal agencies**
 - DMH, Child Welfare, Criminal Justice, DPH, Schools, etc.

Beacon's member centric approach to integrated case management drives Beacon's clinical model

Treatment Domains



Key Considerations When Developing Tx Plans and Coordinating Care

- Holistic approach
- Member and family participation
- Recovery and resiliency
- Cultural competency
- Coordinated care
- Integration and linkage
- Member rights and responsibilities
- Safety of Members

What is Neighborhood Health Plan of Rhode Island? (Neighborhood)

- Largest RItCare (Managed Medicaid) Health Plan in Rhode Island. 75,000 members, including Substitute Care and Children with Special Health Care Needs (CSHCNs)
- Culturally and Linguistically Diverse
- Founded by RI's Community Health Centers
- Second Medicaid Managed Care Health Plan to Receive NCQA's Excellent Rating (2001) – It has retained this "Excellent" designation since that time
- Consistently ranked as one of the Top 5 Medicaid Health Plans in America (*US News and World Report/NCQA*) - #4 in 2008



Rhode Island/Neighborhood – 2001 situational snapshot

1 Focus Population

- **Children with Special Needs** (4,800) and **Substitute Care** (2,300) members
-

2 Primary Drivers

- Complete **lack of integration of services** among **providers and State agencies**
 - **Extremely high cost** of medical and behavioral care
 - **Poor quality** and **inconsistent services** provided to members
 - **Dreadful clinical outcomes** across the board
 - **Legislative oversight** that was **questioning relative efficacy** of **continued funding**
-

3 Impetus to Act

- **“Best Practice”** partnership between **Neighborhood and Beacon** provided requisite example of **successful coordination of care** between medical and BH, **ROI** in terms of both **cost and quality** and **proof that State was making a sound investment**
-

4 Call to Action

- **State of Rhode Island approached Neighborhood** and asked for help – **Together Neighborhood and Beacon developed a proposal** that was **acted upon favorably** by the State

Neighborhood & Beacon's guiding principles

A

Focus on the Member and Their Family

- **Consistently solicit input** from members and families
- Do "**whatever it takes**" to meet member and family need

B

Establish Milestones and Measure Progress

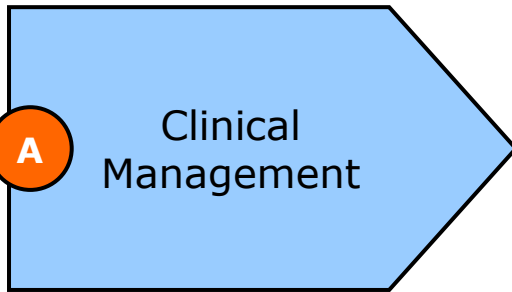
- Set **challenging but achievable goals**
- Establish and achieve buy in on **measures of success**
- **Measure progress, communicate results and modify plans accordingly**

C

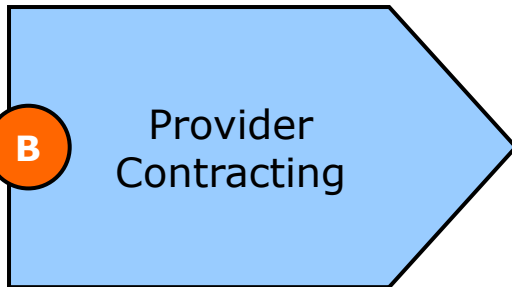
Collaborate Throughout the System of Care

- Take the time to **meet with, understand and appreciate the point of view of all agencies and stakeholders**
- Work to **solicit input and foster constructive dialogue** on system design and operation

Neighborhood/Beacon charter - what we set out to accomplish



- Act as the “connective tissue” and **integrate medical, social and behavioral care**
- **Hone clinical criteria** to meet the express need **of CSN / specialty populations**
- Establish a **dynamic case management program** that addressed and acknowledges the **wide ranging needs and successes** of member in Tx

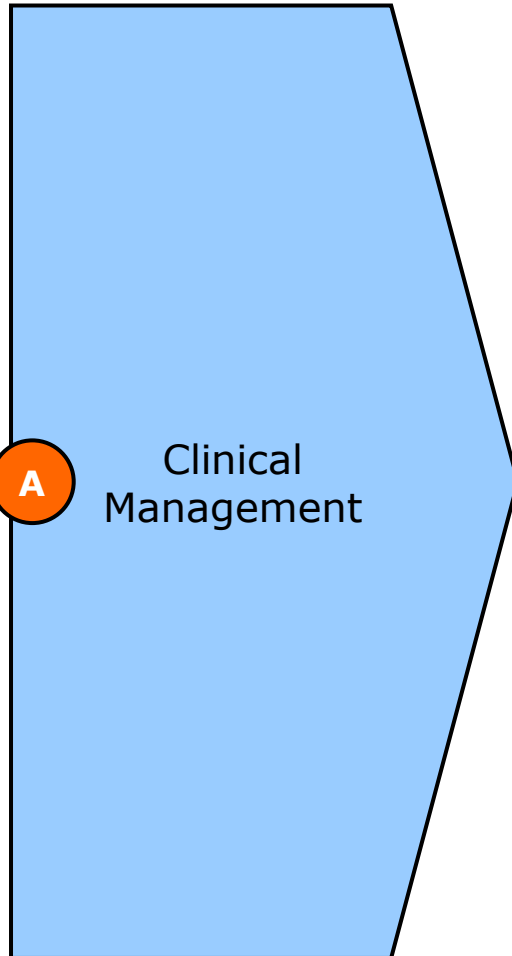


- **Address shortcomings** of provider network
 - Stuck kids, out of state placements, decrease medical boards
- **Involve providers** as **part of the solution** to the problem as **opposed to being the problem**



- **Partner with State officials to develop innovative solutions** to address historic challenges in effectively treating CSN / Sub Care populations
 - Instill accountability, tamp down fiefdoms
- **Collaborate with advocates** to improve access to services for individuals with special needs
- **Demonstrate positive results** and the **Triple Bottom Line** – Good clinical outcomes and excellent direct and indirect fiscal results

What we did - clinical management



- 1** Co-locate Beacon Case Management Team with Neighborhood Medical Management Team
- 2** Jointly refine (with advocate & stakeholder input) clinical criteria to account for CSN / Sub Care and RI BH community nuance
- 3** Develop and implement policies and procedures for joint management of complex cases
- 4** Deploy multi tiered case management program to address wide range of needs of CSN / Sub Care members
- 5** Integrate treatment plans with other state agencies and social care providers to afford members with true "wraparound" model
- 6** Unleash FlexCare's power to integrate Tx, drive consistent workflows, catalogue network resources and generate timely informatics

Integrated Care at the Health Plan Level

The Neighborhood and Beacon Model

- Integrated Care Management (Medical, Behavioral, Social)
- Comprehensive Needs Assessment
- Serve as Primary Health Plan Partners with the State in Developing Innovative Programs and Services for Groups with Special Health Needs
- Member Focus, Listen to Member Needs
- Build Trust with Community Stakeholders
- Expand Provider Networks to Meet Member Needs
- Commitment to integrated care and strong relationships with BH and medical practitioners contributes to the adoption of co-located and integrated care
- Mission: Catalyst for Change in RI's Health Care System

Beacon's Integrated Partner Model (IPM)

Integrated Partner Model - IPM

- Beacon's Integrated Partner Model (IPM) is an industry leading best practice model bringing to bear the focused attention of a Managed Behavioral Health Care Organization (MBHO) within the walls of health plans or state offices.
- The IPM deploys:
 - Licensed MH and SA professionals along with Account Management personnel
 - Board certified multi-specialty psychiatric expertise
 - FlexCare, a fully integrated care management system capable of interfacing with all clinical operating systems
 - A suite of clinical training including treating co-morbidity, addressing depression in primary care, employing a stages of change model and psychopharmacology in BH care etc.
 - Measurement tools for quantifying medical cost offset, member and staff satisfaction, and pre and post medical, pharmacy and MH/SA expenditure analysis

IPM in Action

At Neighborhood, IPM is everywhere!

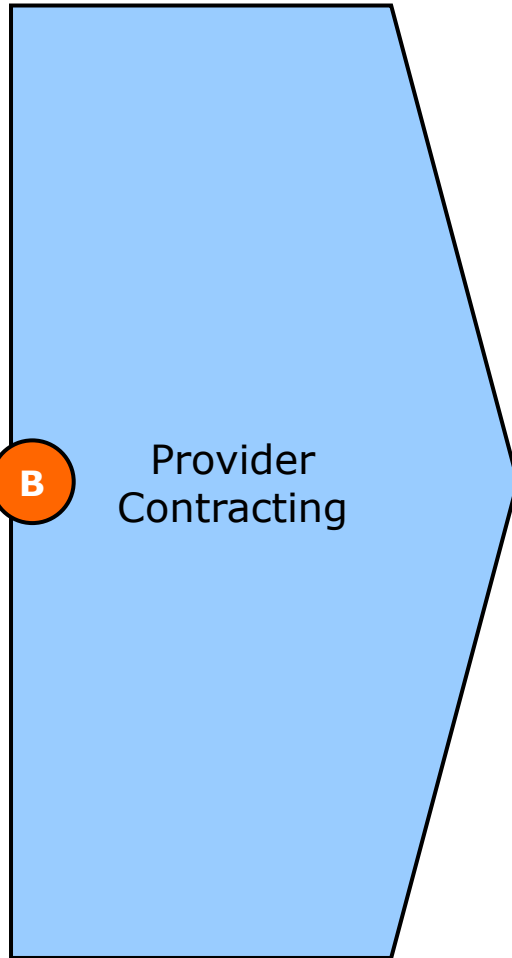
- Joint rounds by Beacon and Neighborhood staff
- Beacon staff engages Social Care Management staff to secure food stamps, housing assistance (whatever it takes) for a member in Beacon's ICM
- Beacon's Senior Program Manager attends Neighborhood Clinical Leadership meeting
- Joint planning by Beacon and Neighborhood staff on all new populations and Lines of Business coming into the health plan.
- Daily analysis of co-management census for triage and discharge planning coordination
- Joint examination of trigger reports for identification of members in need of co-management

Beacon's services are delivered locally and integrated with its partner and their stakeholders



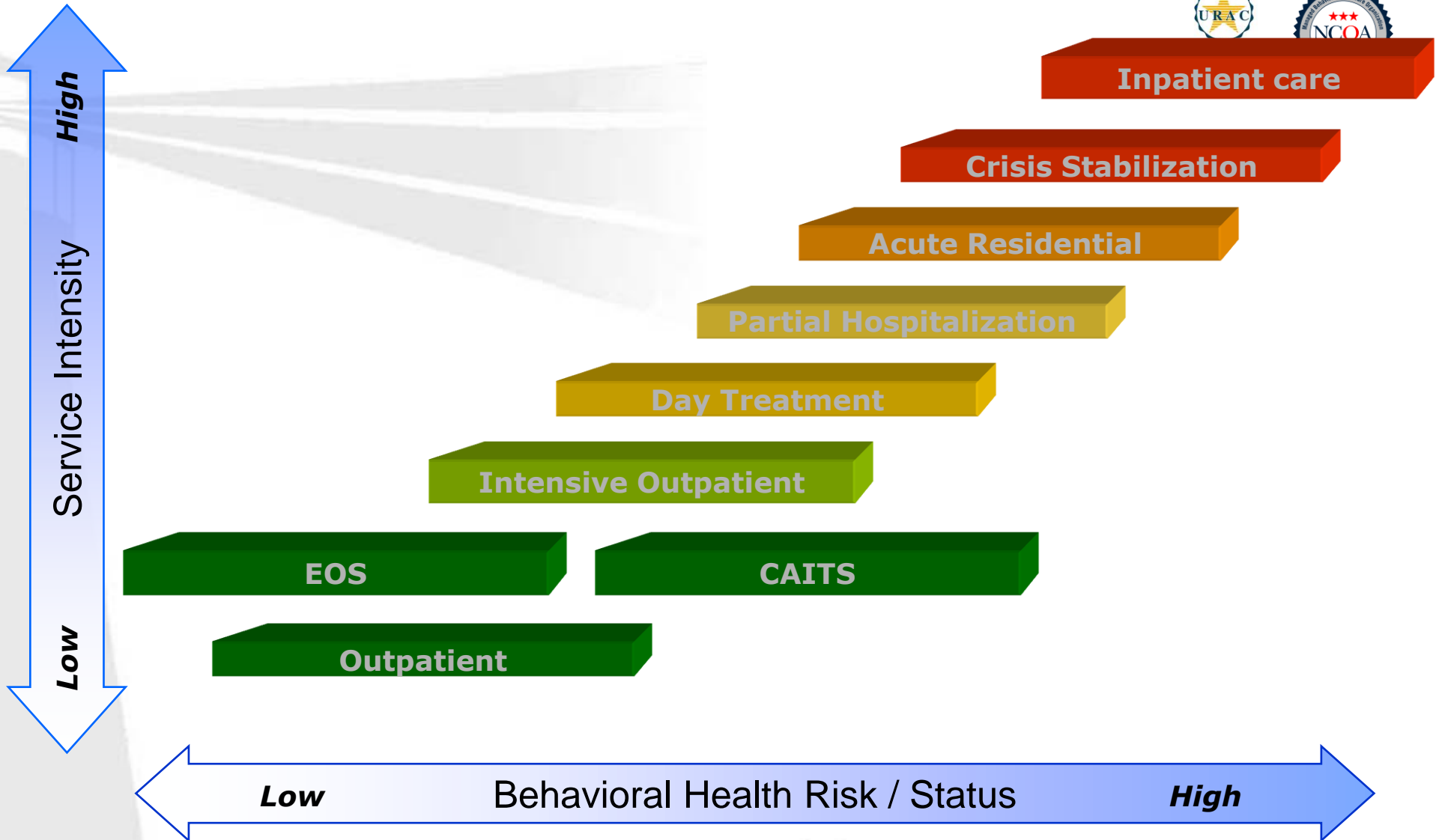
Beacon provides **"connective tissue"** in a **fragmented system** of care

What we did - provider contracting



- 1 **Catalogue provider network assets** including both behavioral and social care providers and ID service gaps
- 2 **Expand the network** via development of new services / Levels of Care – **Present business cases** to entrepreneurial providers and fill gaps
- 3 Partner with BH providers and **build onsite BH capacity** within high volume health centers and primary care sites
- 4 Outreach to and assemble a network of **social care providers offering no cost / low cost service options**
- 5 Perform **intensive training and education** to BH and primary care providers and offer decision support to non BH providers
- 6 **Provide consistent feedback** to providers regarding performance among network peers

Our Levels of Care



Integrated Care in the Community

Assessing the Need:

In 2002 Beacon and Neighborhood initiated a project to place behavioral health clinicians in primary care sites. Our goal was to ultimately have these services in all of Neighborhood's contracted Community Health Centers as well as several other group practice sites.

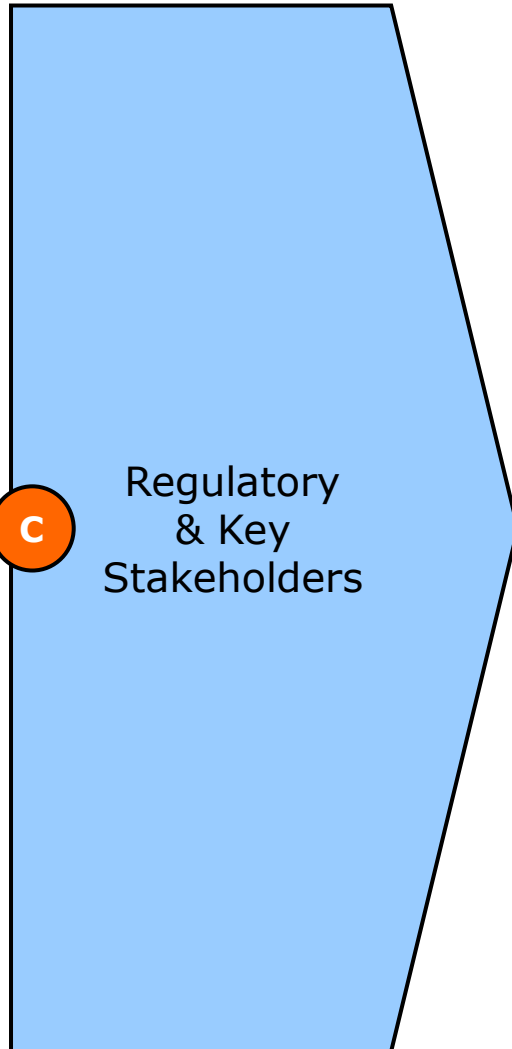
Steps Taken:

Identified a number of behavioral health provider agencies interested in providing co-located and integrated care in primary care sites.

Beacon and Neighborhood offered technical assistance, flexibility in reimbursement rules and incentives (initially) to health centers and other behavioral health providers to create these services.

Neighborhood established reimbursement for PCPs to use most common behavioral health procedure codes (90801, 90862). Beacon and Neighborhood conducted a program evaluation two years after the initiation of this project.

What we did - regulatory & key stakeholders



- 1 **Strengthen and/or build relationships** with State agencies and courts that are either directly or indirectly involved with population
- 2 **Empower regulators and legislators** with programmatic information and data to make informed decisions and sound strategic plans for the future
- 3 **Invest heavily** in making solid and **long lasting connections** with wide range of **member and family advocacy groups** – **Solicit input** from advocates on programmatic design
- 4 **Gain share with advocates and regulators** through **soliciting input, developing and promoting a common programmatic agenda**
- 5 **Demonstrate ROI** through **improved quality** of services, **sound clinical outcomes** and **conscientious fiscal management**
- 6 **Infuse accountability** among all regulators and stakeholders

Who are “Children With Special Health Care Needs”

Cohort I:

Complex social needs with clinically significant emotional, behavioral and psychiatric disorders, including Mild Mental Retardation, Pervasive Developmental Disorders (PDD) and a high incidence of Adjustment Disorders

Often presenting with a short term disruption of baseline functioning (i.e. new out-of-home placement, chaotic family environment, change in routine)

Typically managed by traditional outpatient treatment and community based supports

Who are “Children With Special Health Care Needs”

Cohort II:

Severe co-morbid behavioral, psychiatric, developmental and medical disorders

High incidence of Post-Traumatic Stress Disorder (PTSD) with presence of offending behaviors (animal abuse, sexually acting out, fire setting), highly aggressive towards self and others

High incidence of Mental Retardation and Pervasive Developmental Disorders (PDD) with co-occurring serious and harmful baseline behaviors, requiring family interventions.

Multiple treatment and placement failures, typically require staff supportive settings and/or home-based family supports.

Who are “Children With Special Health Care Needs

Cohort III:

Profound and complex mix of psychiatric, developmental, medical and behavioral needs

Require secure environment with intensive clinical oversight due to extensive self- injurious and aggressive behaviors

Often lengthy hospitalizations, due to acuity of baseline behaviors or become “stuck” on an inpatient psychiatric unit due to the of lack of appropriate placement option



The use of screening tools for entrance into ICM

- Level 1 And Level 2 Screens

- Screening tools identify the need for Integrated Case Management

Case study #1: 6 y.o. female CSN member

1

Presenting Problem

- Following up on an HRA, Beacon identified a 6 year old CSN member who had been inpatient on DD unit for the previous 6 months
- Member had been hospitalized with extreme impulsive behavior inflicting harm to self
- Member's single mother was pregnant with twins, on complete bed rest and had no ability to manage or understand member's condition

2

Diagnosis

- Member diagnosed with autism, ADHD, sickle cell anemia and PICA with lead poisoning
- Hx of ingestion of household chemicals
- Hx of inflicting harm to self

3

Interventions

- With Mom's consent, Beacon enrolled member in Beacon's ICM program
- Multiple providers identified and engaged to build appropriate array of services and supports for member AND mother
 - Member: CEDARR, Enhanced Outpatient Services (EOS), Intensive Home Based Psychotherapy, VNA
 - Mother: Employment and housing assistance, family service / church support / daycare (respite), autism society of Rhode Island (education)
- Extensive coordination and collaboration with NHPRI medical management team and primary care treaters specific to member's sickle cell

4

Outcomes

- Supported by a wide array of services, member was able to successfully return home
- Member also transitioned back to school / day care
- Member's mom was able to return to work and succeeded in finding affordable housing
- Member has not been readmitted for BH services since enrollment into ICM

Case study #2: 15 y.o. female SubCare member

1

Presenting Problem

- Foster parents contacted Beacon for assistance with 15 year old female Sub Care member
- Parents seeking assistance with child's increasing isolation and depression
- Family reports child was lying, stealing, aggressive behavior at school and demonstration in school of inappropriate sexual behavior
- Foster parents felt increasingly "overwhelmed" with the child's behavior and many needs
- Family was contemplating seeking an inpatient stay for the child.

2

Diagnosis

- Member diagnosed with post traumatic stress disorder, reactive attachment disorder, ADD, and bipolar
- Hx of significant medical cardiac disorders
- Hx of severe neglect and physical and emotional abuse

3

Interventions

- Beacon conducted a BH screen and child was placed in Intensive Case Management
- Tx plan included significant collaboration between BH providers, neuro-psych, cardiology, PCP and DCYF
- Parent Support Network (PSN) involved to support foster mom and educate her regarding child's condition and treatment options
- Significant medication management planning took place across treaters to take in all aspects of child's many conditions

4

Outcomes

- Stabilizing member's medical condition resulted in dramatic improvements being made in member's behavioral health conditions (approximately 3 weeks)
- Member remained in ICM for 7 months never requiring any inpatient stays
- Parents continue to receive support from PSN as needed and describe the child as achieving a "wonderful improvement"

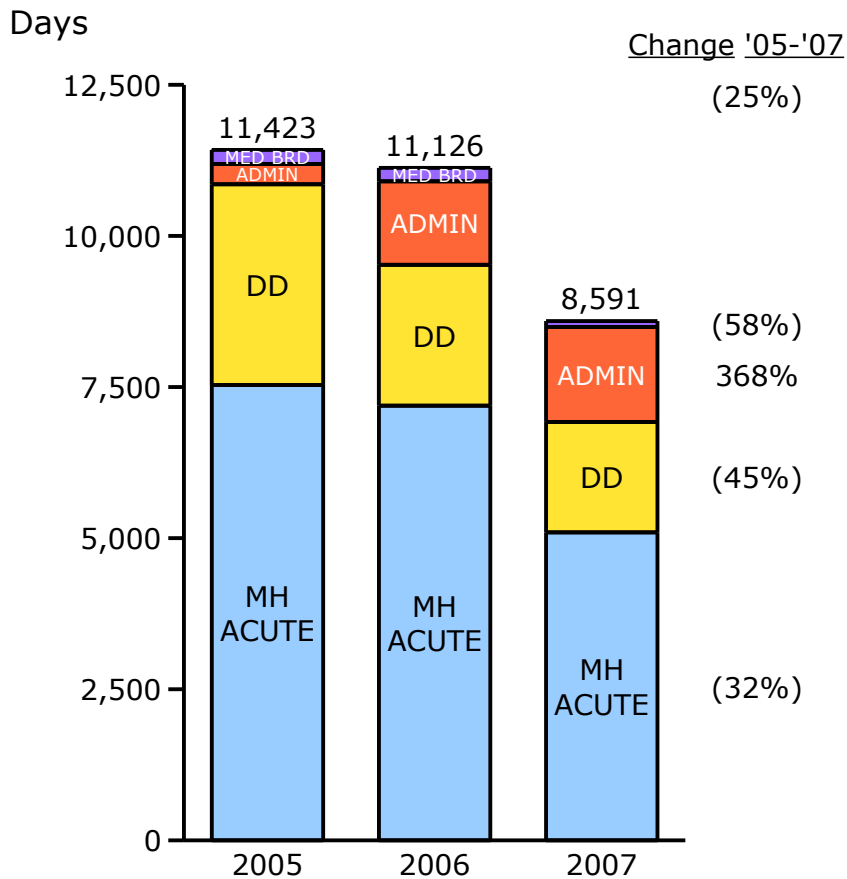
Outcomes and Results

- We will discuss the following:
 - Focusing on specific segments of children lead to significant cost and quality savings.
 - Interventions and process yielded a one year savings of over \$1.1 million.
 - The following of unique members over time in each cohort yields some very interesting results that make an impact for the long term.

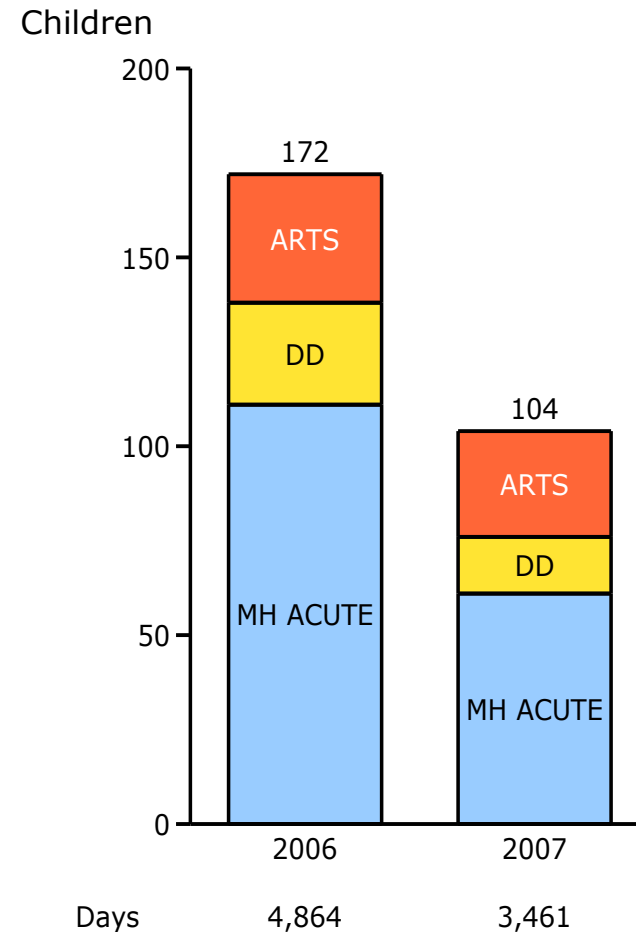


RI: Inpatient hospital psych utilization has declined and fewer children are "stuck" at inappropriate LOC

Inpatient Hospital Utilization 2005-07
by Service Type



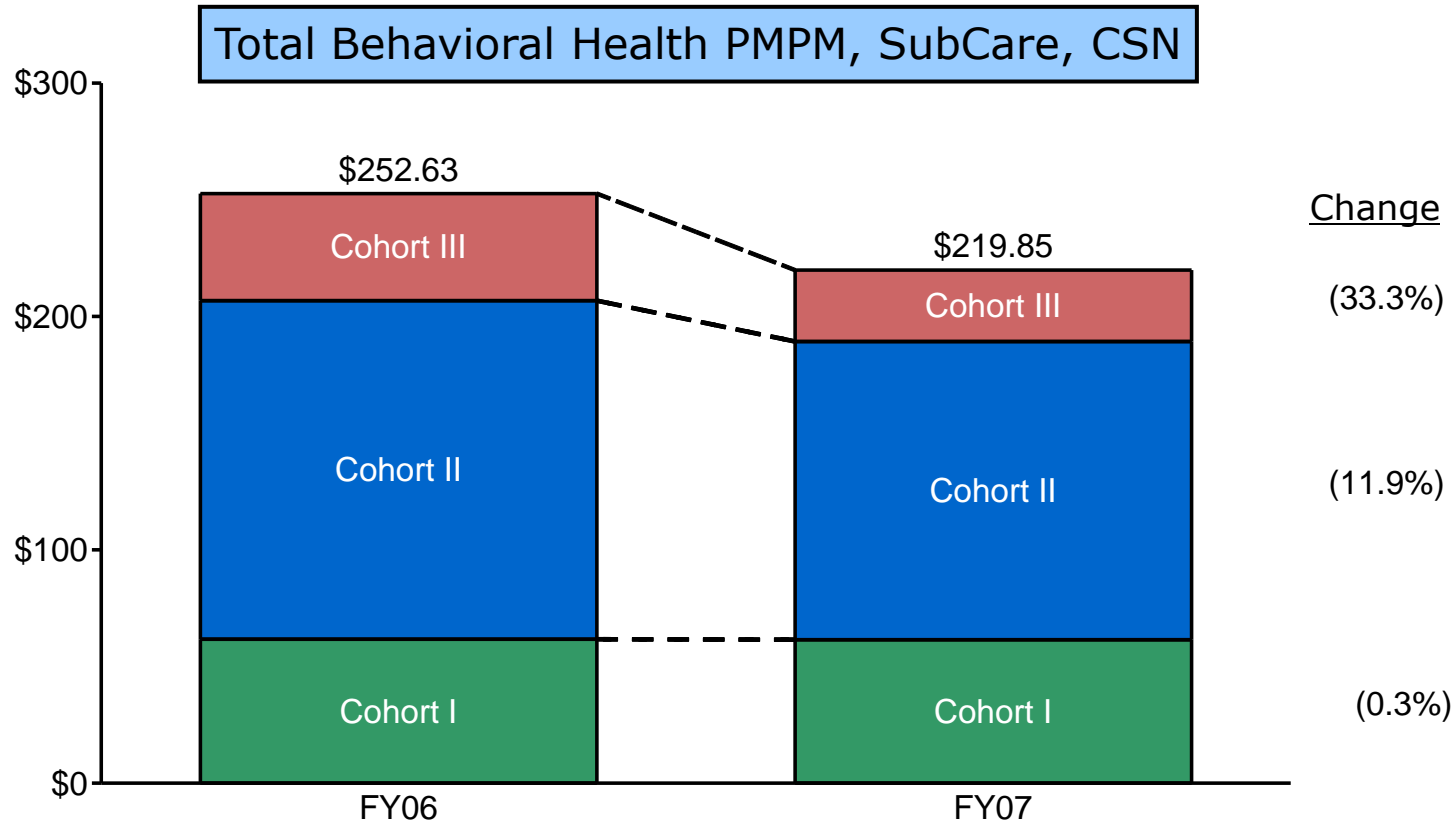
"Stuck Kids" 2005-07
By Level of Care



Note: 2005, 2006, 2007 data from 1/1 through 10/31;

ADMIN- days of inpatient care provided when Beacon Health Strategies concludes that inpatient care is no longer medically necessary, but placement of the Member at an appropriate level of care is not available. AND Days may occur due to DCYF placement limitations, or inability to get the Member into the next clinically appropriate service level (e.g., Acute Residential Treatment Services).

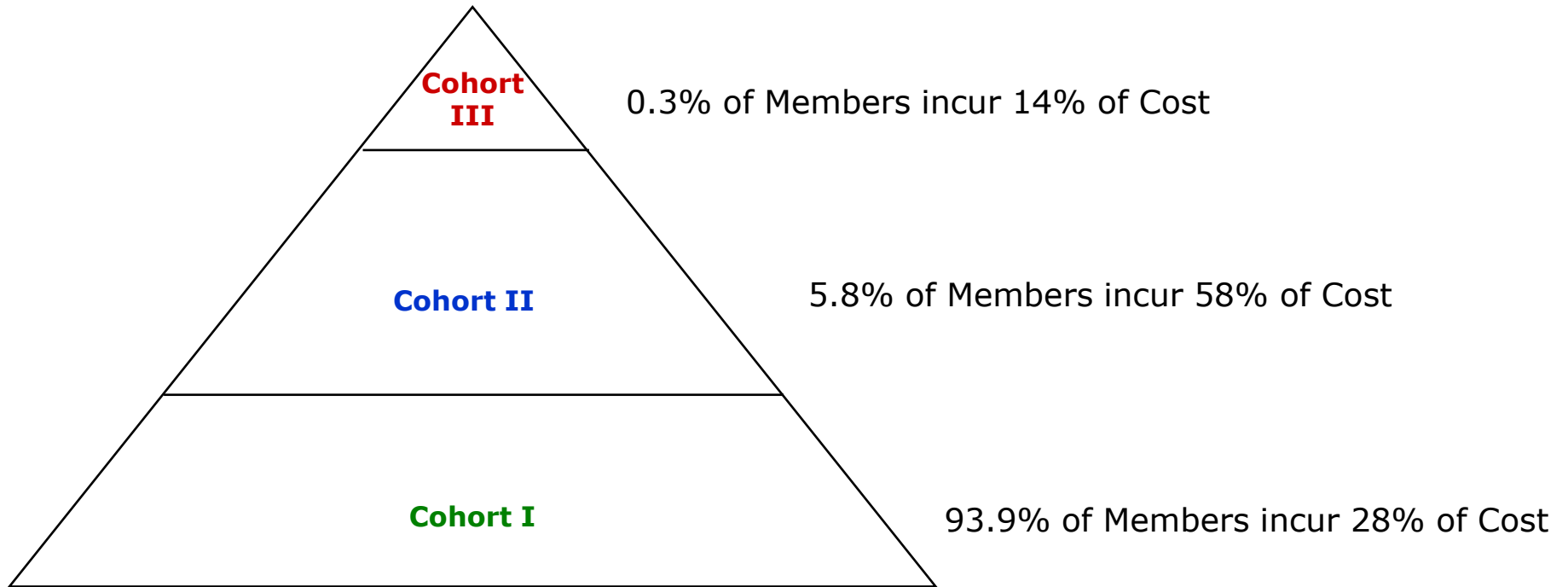
Focusing resources on the right cases continues to yield cost and quality benefits



- Focus on screening and informatics to **identify members at risk of shifting cohorts**
- Continue **expansion of provider network and continuum of care**
 - Crisis stabilization, more ART beds, expertise in developmental disorders
- Present DHS with a case for **bringing key services "in-plan"**
 - Home based therapeutic services (HTBS) and personal assistance services and supports (PASS)

Even within a disability population, a small number of cases drive disproportionate spending

2007 Pyramid Analysis



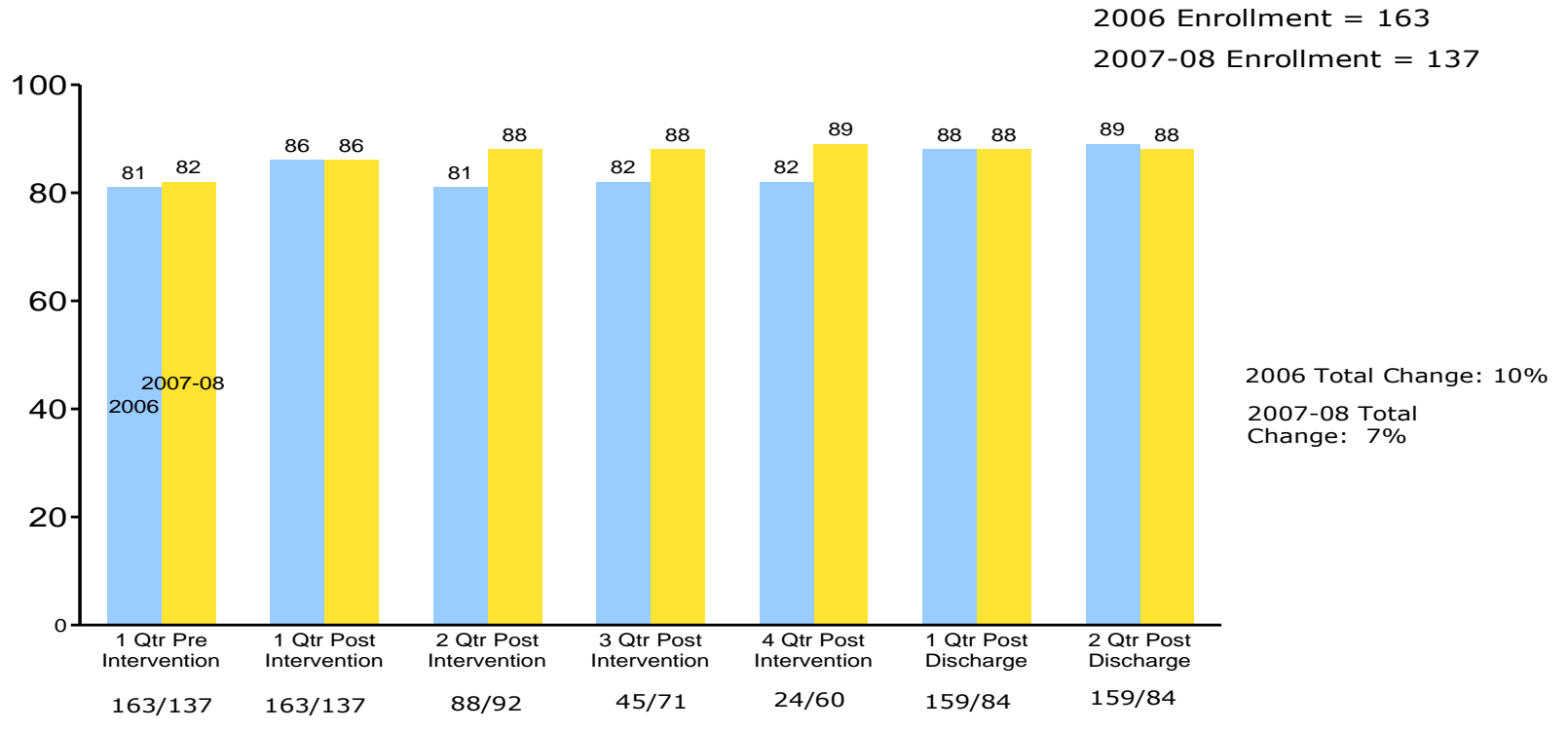
	# of Utilizers	% of Utilizers	Total Cost FY07	% of Total Costs	Avg Cost Per Utilizer Per Month	Cost PMPM*
Cohort I	2,973	93.9%	\$5,226,744	28%	\$146.51	\$61.46
Cohort II	184	5.8%	\$10,868,281	58%	\$4,922.23	\$127.80
Cohort III	10	0.3%	\$2,601,913	14%	\$21,682.61	\$305.9

Overlapping Utilizers During FY06 and FY07

- Of the 200 unique utilizers in Cohorts II and III in FY06, 61 remained in Cohorts II or III in FY07, while 139 had migrated into Cohort I or had dropped into other categories.
- Of these 139 members who were no longer in Cohorts II or III, 85 or 65% of these members migrated to Cohort I . Eleven or (8%) stabilized to the point of incurring no costs in FY07.
- The remaining 43 (31%) were no longer under Beacon management. The breakout of the 43 fall into the following categories:
 - 15 (34%) lost coverage
 - 12 (27%) went to out-of-state placements
 - 10 (23%) were admitted to residential
 - 6 (13%) received out-of-plan services

Average Days in Community

RI CSN: Average Days in Community for All Members Enrolled 2+ Continuous Quarters



Number of Members

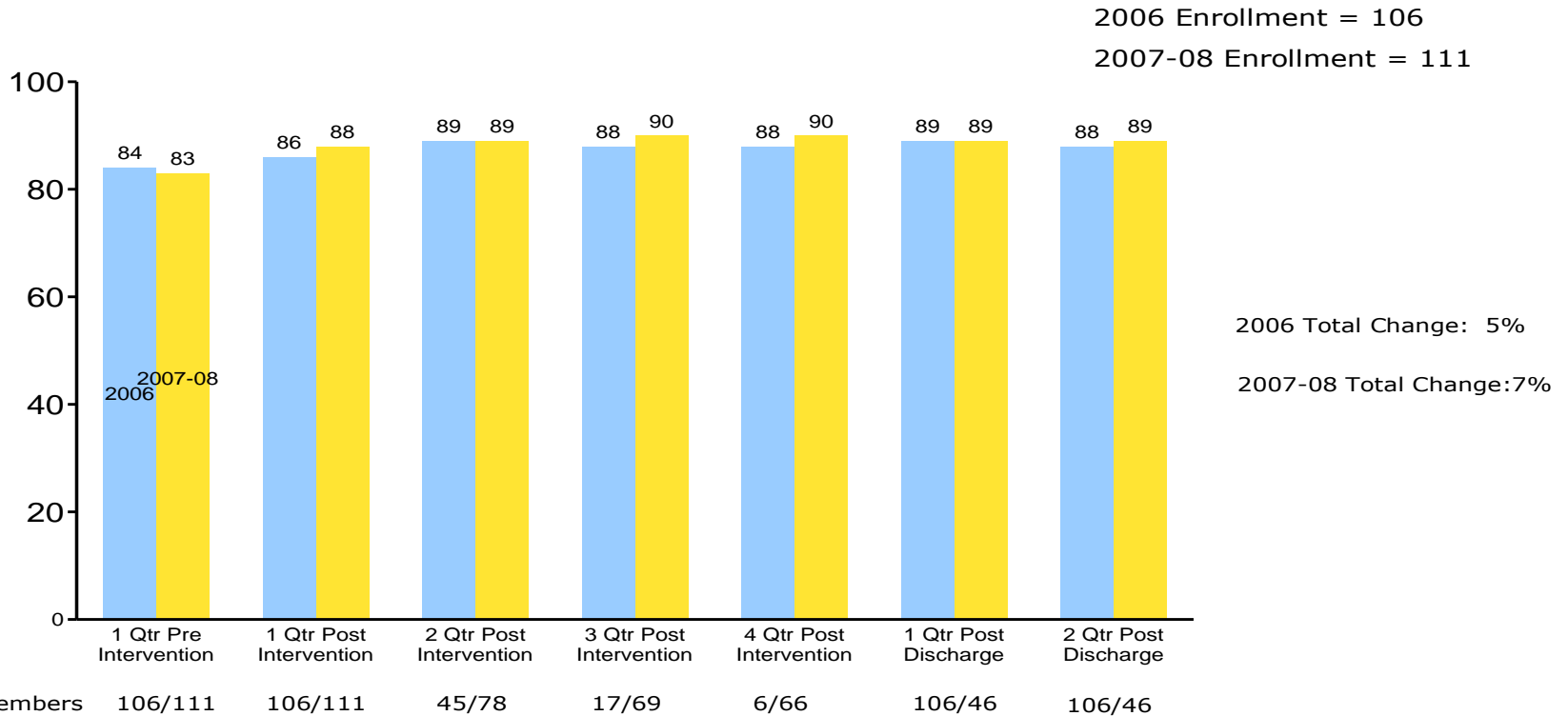
Integrated Solutions *Exceptional Results*

Integrated Solutions *Exceptional Results*

Average Days in Community for Substitute Care



RI Substitute Care: Average Days in Community for All Members Enrolled 2+ Continuous Quarters



Integrated Solutions *Exceptional Results*

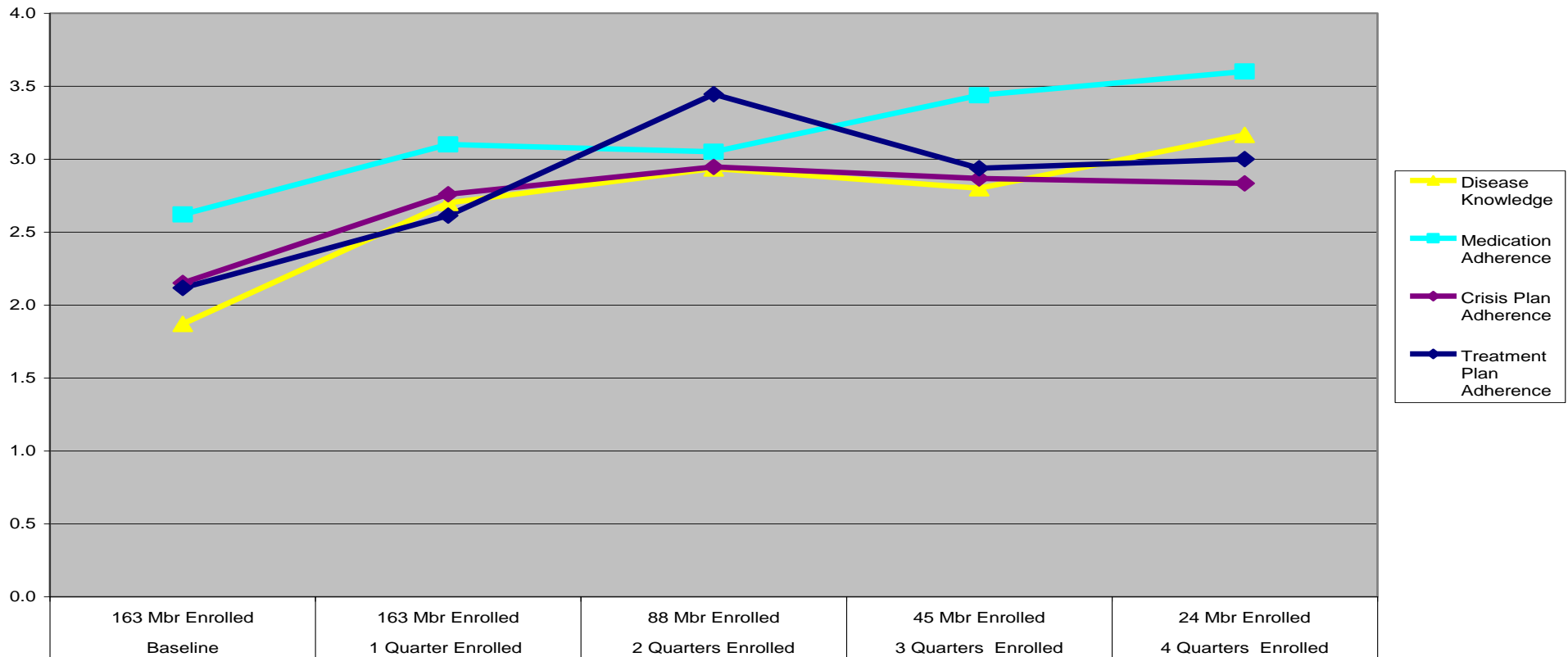
Integrated Solutions *Exceptional Results*

Quality Outcomes Over 4 Quarters - CSN

Children with Special Needs

The Care Management Quality Outcomes Improve from Baseline for Members in ICM throughout the four quarters

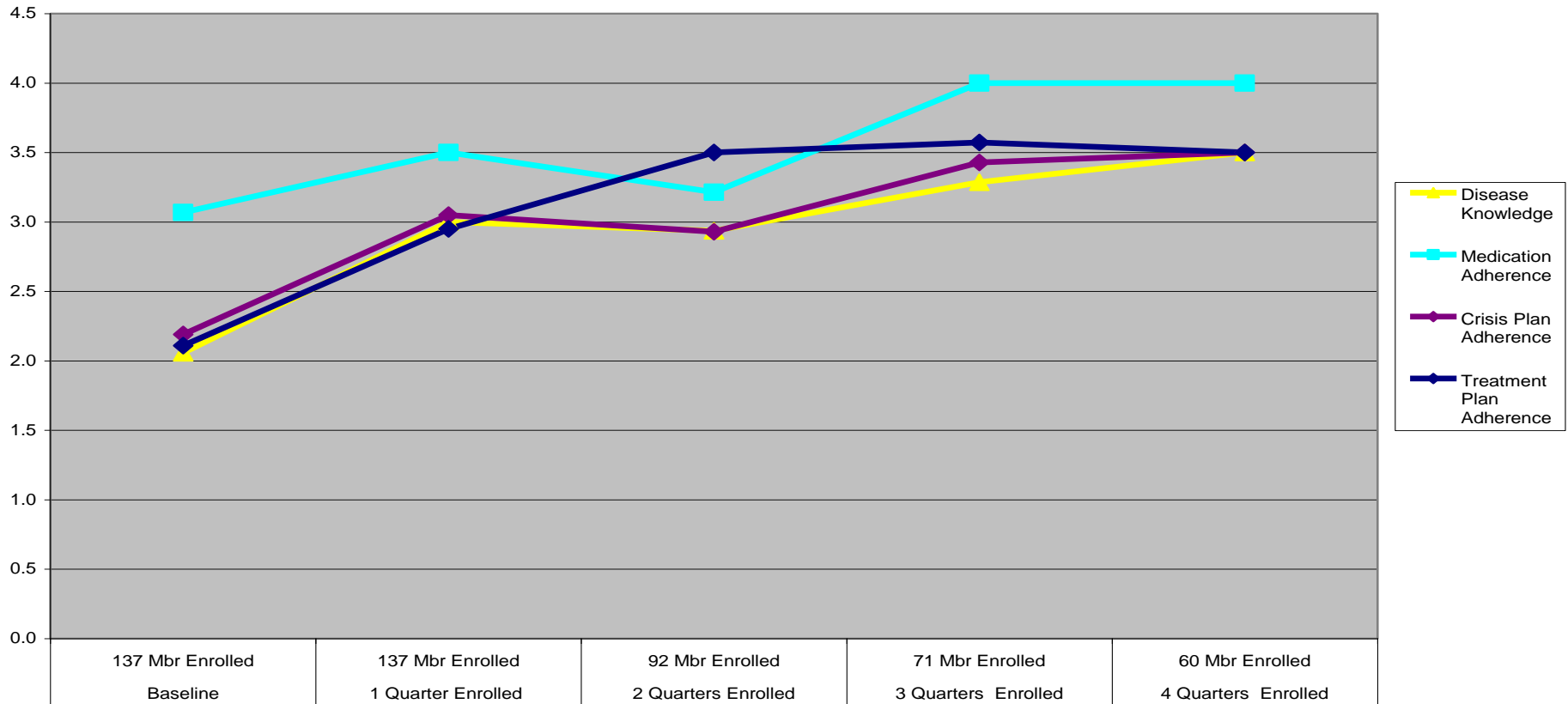
ICM Enrollment and Outcome Measure Measurement 1/1/2006 - 12/31/06



Children with Special Needs

The Care Management Quality Outcomes Improve from Baseline for Members in ICM throughout the four quarters

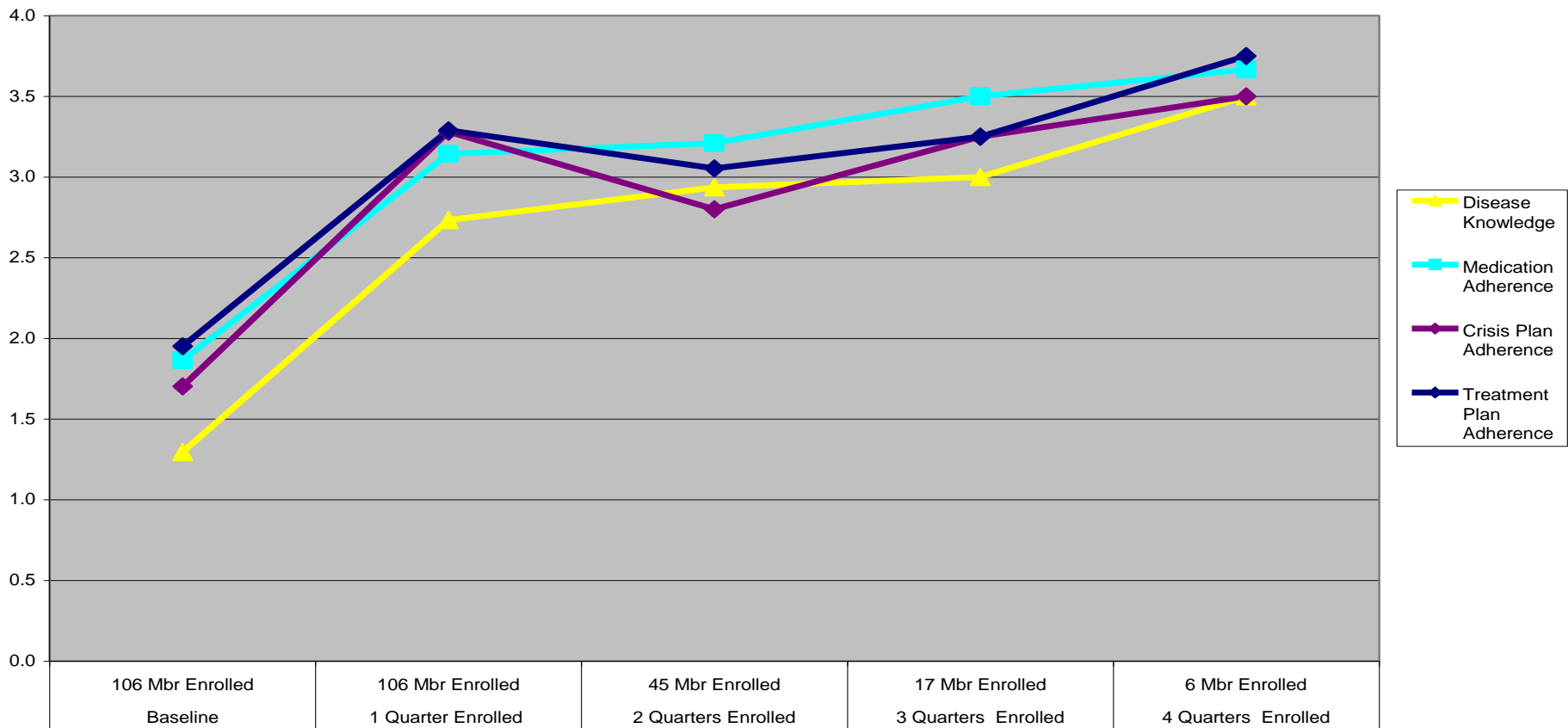
ICM Enrollment and Outcome Measure Measurement 1/1/2007 - 6/30/08



Quality Outcomes Over 6 Quarters – 07/08 Substitute Care

Substitute Care

The Care Management Quality Outcomes Improve from Baseline for Members in ICM throughout the four quarters
ICM Enrollment and Outcome Measure Measurement 1/1/2006-12/32/06



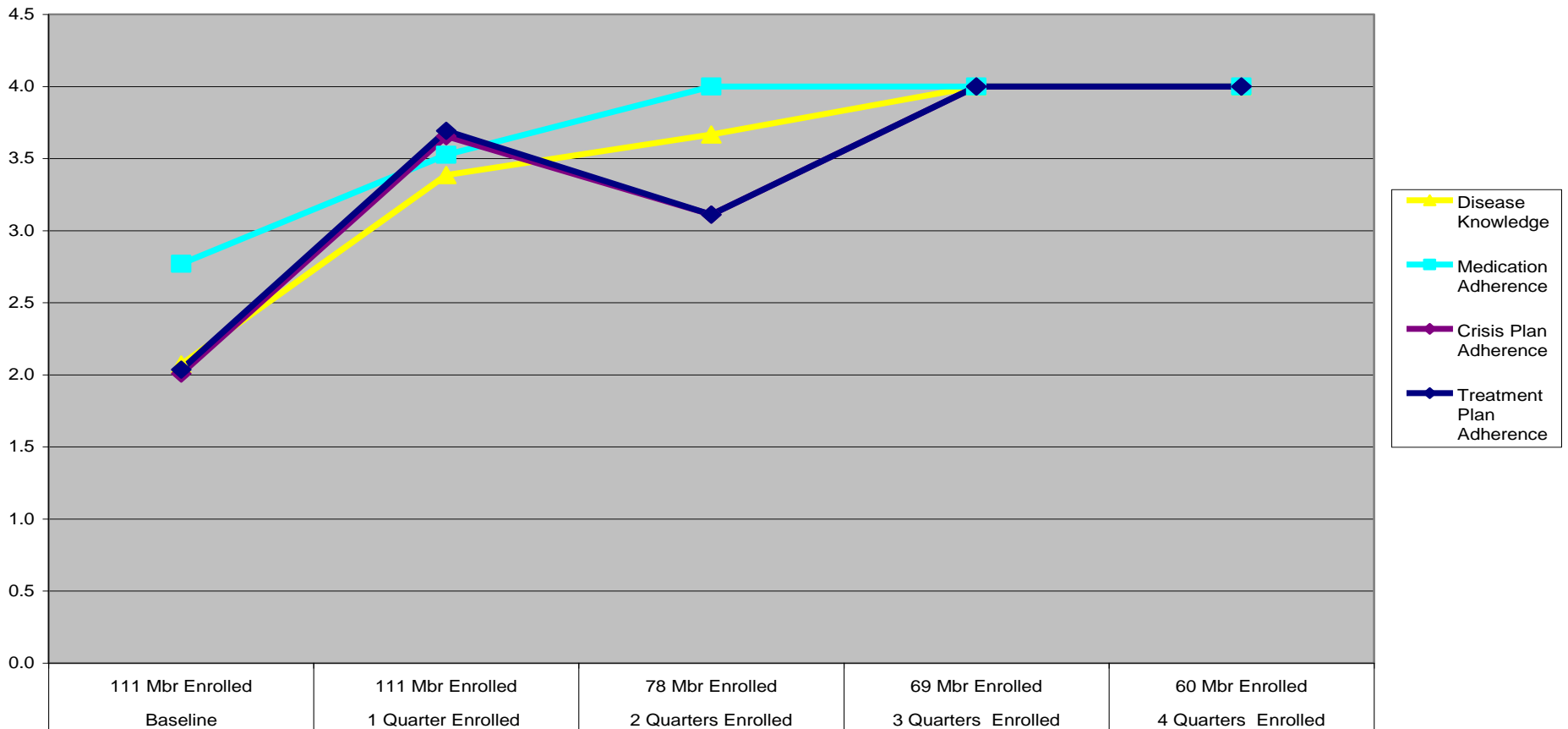


Quality Outcomes Over 6 Quarters – 07/08

Substitute Care

Substitute Care

The Care Management Quality Outcomes Improve from Baseline for Members in ICM throughout the four quarters
ICM Enrollment and Outcome Measure Measurement 1/1/2007 - 6/30/08





Summary: Work with Special Needs Children in Rhode Island

Populations

- “Substitute Care” Children in Care of the RI’s Child Welfare Agency
- Children with Special Health Care Needs

Key Elements

- Co-location of Beacon clinicians onsite at health plan
- Personnel dedicated to coordinating with state agencies and courts
- Network expansion: both the number of providers and new levels of care
 - Diversionary services, home and community based services, wraparound services
- Intensive Case Management; Meaningful utilization management
- On-site transition planning at high-volume providers

Key Success Factors

- Collaboration with Medicaid and state agencies
- Collaboration with Families and advocates
- Collaboration with Providers
- Systems integration with health plan

Selected Results

- 23% reduction in days inpatient
- 30% reduction in inpatient readmission rates
- 39% reduction in “stuck kids”
- 40% reduction in out of state placements
- Launch of Rhody Health Plan for adults with disabilities occurred in 2008
 - Based on success of moving child populations to managed care

Conclusions and Questions

A fully integrated model results in improved quality and financial outcomes.

Creative solutions i.e. working with multiple different stakeholders is one critical to success.

From enrollment, screening, contracting and creative development of levels of care, success can be had with traditional difficult populations.

Questions?