

Quality Assurance and Improvement Advisory Group

Behavioral Health and Care Management

April 28, 2011

The Bottom Line

- **Access to Quality Behavioral Health Services for Managed Care Participants Remains at the Center of Our Radar Screen**
- **Significantly Stepped-up Focus is Demanded**
- **Collectively and Individually**
- **Rapid Cycle Improvement Process**

IM-6/2009

Utilization Management

- Proactive procedures, including discharge planning, concurrent planning, pre-certification and clinical case appeals
- Proactive processes, such as concurrent clinical reviews and peer reviews, as well as appeals introduced by the provider, payer or patient
- Utilization management is prospective and intends to manage health care cases efficiently and cost effectively before and during health care administration
- There are four basic techniques in utilization management:
 - Demand Management
 - Utilization Review
 - **Case Management**
 - Disease Management

Utilization Management

- **MHD Contract 2.18.8b**
- **The health plan shall have and implement written utilization management policies and procedures that include protocols for denial of services, prior approval, hospital discharge planning, physician profiling, and concurrent, prospective, and retrospective review of claims that comply with federal and state laws and regulations, as amended**
- **The utilization management policies and procedures must be clearly specified in provider contracts or provider manuals and consistently applied in accordance with the established utilization management guidelines**
- **As part of the health plan's utilization management function, the health plan also must have processes to identify both over and under utilization problems for inpatient and outpatient services, undertake corrective action, and follow up**

Utilization Management (cont.)

- **MHD Contract 2.18.8b**
- **This review must consider the expected utilization of services regarding the characteristics and health care needs of the member population**
- **In addition, the health plan shall use an emergency room log, or equivalent method, to track emergency room services (e.g. daily emergency room report from targeted high volume facilities)**
- **Compensation to individuals or entities that conduct utilization management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member**

Case Management

- “A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes” (Case Management Society of America)
- Case management is a procedure to plan, seek, and monitor services for different social agencies and staff on behalf of a client
- Usually one agency takes primary responsibility for the client and assigns a case manager, who coordinates services, advocates for the client, and sometimes controls resources and purchases services for the client. The procedure allows many social workers in the agency, or in different agencies to coordinate their efforts to serve a given client through professional teamwork, thus expanding the range of needed services offered."

• Wikipedia, 4-11

Case Management

- Case management focuses on delivering personalized services to patients to improve their care, and involves four steps:
 - 1) Referral of new patients
 - 2) Planning & delivery of care
 - 3) Evaluation of results for each patient & adjustment of the care plan
 - 4) Evaluation of overall program effectiveness & adjustment of the program
- In the context of a health insurer or health plan it is defined as:
 - A method of managing the provision of health care to members with high-cost medical conditions
 - The goal is to coordinate the care so as to both improve continuity and quality of care and lower costs

Case Management

2009 MO HealthNet Contract (2.11.1)

The health plan case management service shall focus on:

- **Enhancing and coordinating a member's care across an episode or continuum of care**
- **Negotiating, procuring, and coordinating services and resources needed by members/families with complex issues**
- **Insuring and facilitating the achievement of quality, clinical, and cost outcomes**
- **Intervening at key points for individual members**
- **Addressing and resolving patterns of issues that have negative quality cost impact**
- **Creating opportunities and systems to enhance outcomes**

Case Management Defined

The health plan shall provide case management to selected members :

- Pregnant members
- Members with the following conditions:
 - Cancer, Cardiac Disease, Chronic Pain, Hepatitis C, HIV/AIDs,
 - **Special Health Care Needs,**
 - **Autism Spectrum Disorder,**
 - Eligibility for Supplemental Security Income,
 - **Foster Care or Adoption Subsidy placements,**
 - Sickle Cell Anemia,
 - **Anxiety Disorders**
 - **Pervasive Developmental Disorders**

Case Management Defined (cont.)

- Individuals receiving services through a family-centered community-based coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, as defined by the state agency in terms of either program participant or special health care needs.
- **Within five (5) days of admission** to a psychiatric hospital or residential substance abuse treatment program.
- **After a hospitalization or rehabilitation facility stay** of more than two (2) weeks or if they are discharged with medications that require state agency prior authorization.

Case Management Defined (cont.)

- The last day of the month following the end of a quarter in which a member has had **three (3) or more emergency department visits** as identified through analysis of utilization data.
- **Receipt of a diagnosis of co-occurring** behavioral health and substance abuse as identified through analysis of utilization data.
- **Receipt of a diagnosis of a chronic or debilitating** physical health condition including but not limited to the disease states listed in the Disease Management section (major depression, asthma and at least one of the following: obesity, diabetes, hypertension, or **Attention Deficit Hyperactivity Disorder (ADHD)**) and a behavioral health condition as identified through analysis of utilization data.

Case Management Defined (cont.)

The health plan shall use the initial assessment to identify the issues necessary to formulate the care plan.

All care plans shall have the following components:

- Use of clinical practice guidelines
- Use of transportation, community supports, and natural supports (e.g. friends, family, neighbors, acquaintances, co-workers, volunteers, peers, church members)
- Specialized physician and other practitioner care targeted to meet members needs

Case Management Defined (cont.)

- Member education on accessing services and assistance in making informed decisions about care
- Short-term and long-term goals that are measurable and achievable
- Emphasis on prevention, continuity of care, and coordination of care. The system shall advocate for and link members to services as necessary across providers and settings
- Reviews to promote achievement of case management goals and use of the information for quality management

Case Management Defined (cont.)

Specific to pregnant women the health plan shall include, but not be limited to, the following:

- A risk appraisal form must be a part of the member's record
- **Intermediate referrals to substance-related treatment** services if member is identified as being a substance user

If member is referred to a Comprehensive Substance Treatment and Rehabilitation (CSTAR) program, care coordination should occur in accordance with the Substance Abuse Treatment Referral Protocol for Pregnant Women Under MO HealthNet (MHD) Managed Care

- Case management closure must not be any sooner than sixty (60) days from delivery

Case Management Defined (cont.)

The health plan shall have criteria for terminating case management services that shall be included in the care plans.

Acceptable reasons for termination are, but not limited to:

- Achievement of goals stated in care plan including stabilization of member's condition, successful links to community support and education, and improved member health
- Member request to withdraw from case management or the health plan
- Lack of contact or compliance with case manager

Executive Order 98-12

- The outcomes from utilization data reported in the Executive Order 98-12 Implementation Report for Fiscal Year (FY) 2008 (2007 data) reflected some improved outcomes over time which were sustained in FY 2009 (2008 data) but declined in FY 2010 (2009 data).

Positive Trends for 2010 (2009 Data)

- Consistent annual increase in penetration rate over past eleven years
 - 65.0% increase among the 0-12 year age category
 - 102.8% increase among the 13-17 year age category
- Outpatient visits per 1000 member months increased
 - 136.2% between 1999 and 2009
 - 12.6% increase between 2007 and 2008
 - 13.5% increase during 2009

Positive Trends in 2009 (2008 Data) Troublesome Findings in 2010 (2009 Data)

- **Ambulatory Follow-Up**-important indicator of quality at the national level; an NCQA effectiveness of care measure.
- **7 Day Rate:** 44.7% which is ahead of the 42.6% national rate but below the Missouri rate of 47.0% for 2008 data
 - ✓ Remains above the 2007 rate of 36%.
- **30 Day Rate:** 68% which is ahead of the 61.7% national rate but is below the Missouri rate of 70.2% for 2008 data
 - ✓ Remains above the 2007 rate of 63.8%.

Troublesome Findings (cont.)

- **Readmission Rate**

- 2.5% higher in 2009 than in 2008
- 18.6% higher than the benchmark 2004 rate of 7.0%

- **Inpatient Admissions**

- 12.2% increase in 2009 from 2008
- 32.5% increase between 2001 and 2009

- **Inpatient Days**

- 20.9% increase in 2009 from 2008

Case Management (CMSA)

- The CMSA's philosophy of case management statement articulates that (CMSA, 2009):
- The underlying premise of case management is based in the fact that, when an individual reaches the optimum level of wellness and functional capability, everyone benefits:
 - The individuals being served, their support systems, the health care delivery systems and the various reimbursement sources.
- Case management serves as a means for achieving client wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation.
- Case management services are best offered in a climate that allows direct communication between the case manager, the client, and appropriate service personnel, in order to optimize the outcome for all concerned.

Case Management Adherence

- **Case Management Adherence Guidelines**
- **The Problem**
- Medication Non-Adherence
 - The World Health Organization estimates that only one-half of the patients in the US take their medications as prescribed
 - Studies show that 10 percent of all hospital admissions and 23 to 40 percent of all nursing home admissions are the result of non-adherence
- **The Cost**
- *Some \$100 billion a year from non-adherence alone*
- Even a one-percent reduction in non-adherence would save the health care system \$1 billion, not to mention the benefits to patients
- The consequences of non-adherence include a decrease in quality-of-life and increase in avoidable healthcare costs. Studies cited in CMSA's Case Management Adherence Guidelines (CMAG) show the magnitude
- Source: Case Management Society of America's Adherence Guidelines

Adherence Challenges

- *Adherence is the extent to which a person's behavior—taking medication, following a diet, and/or executing lifestyle changes, corresponds with agreed recommendations from a health care provider (WHO, 2003)*
- *Within every person is a spontaneous need for happiness, understanding, and love, yet neither psychiatry nor psychology has been effective in understanding the steps that lead to a happy life.*
 - ROGER KATHOL, MD
- Source: Case Management Society of America

Recovery

- *“Recovery is about individuals taking control of their own lives and not having others determine their care or treatment*
- *The concept has evolved to mean the process by which an individual comes to terms with [an] illness and learns to cope*
- *Recovery does not imply a cure but a life long journey and process”*

A. KATHRYN POWER, M.ED.,
Past Director, CMHS

Case Management Functions

- Pursuant to CM Model Act, Case Managers shall/should:
- Implement population identification processes when appropriate;
- Use a Consumer-centered, strengths-based, collaborative partnership approach;
- Promote Consumer self-determination through advocacy;
- Use a comprehensive, holistic approach;
- Practice cultural competence, with awareness and respect for diversity;
- Implement collaborative practice models to include physician and support-service providers;
- Facilitate informed choice, consent, and decision-making;

Case Management Functions (cont.)

- Promote the Consumer's self-care management;
- Focus on facilitating Consumer self-advocacy, education, and anticipatory guidance;
- Promote the use of evidence-based care, as available;
- Promote optimal Consumer safety;
- Promote the integration of behavioral change science and principles;
- Link with community resources;
- Assist with navigating the health care system to promote effective care particularly during transitions;
- Pursue professional excellence and maintain competence in practice; and/or
- Use process and outcome measurement, evaluation, and management tools to improve quality performance

References

- 2009 MHD Managed Care Contract
- Attachment 3-MO HealthNet Policy Statements (11/2010 Revision)
- The Psychology/Counseling and Physician Manuals , C-STAR, and Community Psychiatric Rehabilitation (CPR) program manuals , and Special bulletins can be found online at the MO HealthNet Division website <http://dss.mo.gov/mhd/>
- Case Management Society of America – cmsa.org/