CHCS
Center for
Health Care Strategies, Inc.

Care Management Entity Quality Collaborative
Technical Assistance Webinar Series

CME Coordination with Primary Care

October 28, 2011, 2:00 – 3:30 p.m., ET

For audio and to participate, dial: **(866) 699-3239**
Meeting/Event Number:
In case of technical difficulties, call **(609) 528-8400**

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CHCS Priorities

Our work with state and federal agencies, Medicaid health plans, providers, and consumers focuses on:

- **Enhancing Access to Coverage and Services**
- **Improving Quality and Reducing Racial and Ethnic Disparities**
- **Integrating Care for People with Complex and Special Needs**
- **Building Medicaid Leadership and Capacity**

Maryland, Georgia and Wyoming Collaborative CHIPRA Grant Project

- Goal: Improving the health and social outcomes for children with serious behavioral health needs.
- Implement and/or expand a Care Management Entity (CME) provider model to improve the quality - and better control the cost - of care for children with serious behavioral health challenges who are enrolled in Medicaid or the Children's Health Insurance Program.

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CHIPRA Care Management Entity Quality Collaborative Technical Assistance Webinar Series

Wraparound Milwaukee's Coordination with Primary Care to Improve Health Outcomes for Children with Serious Emotional and Mental Health Needs

October 28, 2011

Presented By:

Bruce Kamradt, MSW,
Director Wraparound Milwaukee
Dennis Kozel, MD,
Medical Director of Wraparound Milwaukee

An Area of Need for Collaboration with Primary Health Care

- Child Welfare population enrolled in Wraparound Milwaukee with serious emotional & mental health needs, but where there had been very little coordination and collaboration among specialty mental health providers and primary health care providers

- Wraparound Milwaukee had not sought out or included the name of the PCP in Plan of Care on any regular basis

- Significant number of Child Welfare youth receiving psychotropic medications but we were not aware of whether they were seeing a PCP and if so whether the PCP was aware that youth was taking psychotropic medications and involved in Wraparound Milwaukee

Wraparound Milwaukee and BCAP Project

- In 2008 Wraparound Milwaukee was chosen by the Center for Health Care Strategies to participate in a Best Clinical and Administrative Practices (BCAP) Project on improving integration of physical and behavioral care

- Our project focus was to promote comprehensive care and collaboration by engaging in an aggressive endeavor to ensure that youth who were involved with both the Child Welfare and Wraparound system of care and were taking multiple psychotropic medications were seen by a PCP at least annually

Wraparound Milwaukee and BCAP Project – cont'd

- The approach used consisted of:
  - Written communication with the primary caregiver regarding the need for youth to be seen by their PCP
  - Changes in the Child & Family Team process to address the medical domain and need for PCP involvement
  - Changes in administrative policy
  - Technological revisions in electronic health record (i.e. requiring identification of PCP, date of physical exam, etc. for all children, not only those taking psychotropic medication)
- Compliance incorporated in our QA/QI plan and activities
- BCAP Project was used as annual Medicaid Performance Improvement Plan (PIP) in 2010

Implications of the BCAP Project

- Increased awareness of the sub-population of Child Welfare youth on multiple psychotropic medications and movement forward on establishing a clinical home, including aggressive efforts to have the youth connect with their PCP

- Prompted related organizational changes in Wraparound Milwaukee
  - Establishment of medication clinics
  - IT enhancements (i.e. MD/dental and "date last seen" fields)
  - On-going training for care coordinators on medical domain, collaboration with PCP, etc.
  - Improved QA/QI best practice measures (i.e. distribution of monthly reminder letter to parents)

Additional Efforts to Improve Collaboration with Primary Health Care

- Initiated meetings with the two Federally Qualified Health Centers that provide PCPs for 70% of youth in care
- Dr. Kozel initiated training with PCPs on psychotropic medication and appropriate referrals to our urgent medication clinic
- Wraparound Milwaukee became regular member of Bureau of Milwaukee Child Welfare Health Committee
- Integrated PCP consent into the electronic medical record
- Trained care coordinators to address medical domain in Plan of Care

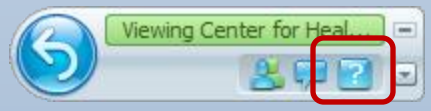
Additional Efforts to Improve Collaboration with Primary Health Care – cont'd

- Initiated discussion with Children's Hospital and Health Plan on proposal to partner on new Medicaid Medical Home Initiative for Child Welfare youth in five-county area (currently underway)

Questions?

To submit a question please use one of the following options:

•***Ask a Question Online***: Click the ***Q&A*** icon located in the floating toolbar at the lower right side of your screen.



•***Ask a Question via Phone***: Phone lines will now be un-muted.

Slides and a video archive of this event will be available on our website, at **www.chcs.org**.

CME Coordination with Primary Care

Katherine E. Grimes, MD, MPH
Associate Professor, Dept. of Psychiatry
Harvard Medical School

CHIPRA CME Collaborative - Webinar
The Center for Health Care Strategies
October 28, 2011

Brief History

- 1982 - child welfare, Jane Knitzer, Unclaimed Children ("fragmented care")
- 1986 - Stroul and Friedman published "CASSP Principles"; least restrictive setting, over-use of (FFS) hospitals a lever to pull
- 1992 - federal funds for "systems of care"; large multi-year grants with state match requirements; flexible funds for wraparound; no financial outcome reporting
- Physical health not included; mental health treatment and $ (docs/meds/hosp) paid for outside the "system of care"

"For Results to be Different, Something Has to Change"

- In Systems of Care, "*clinical*" became negative term, outcome evaluations consistently showed lack of clinical improvement; Bickman (1996): "More is not always better"

- RWJF sought to add strengths of managed care to CASSP principles

- 1997 - RWJF/WBGH,"MHSPY-Replication" one year planning grants to 12 states (including Massachusetts)

Shared Risks, Goals and Outcomes

- 1998 - MA MHSPY unique in country: *global cap*; all physical health, mental health, meds, hospital, wrap dollars; $ accountability to five state agencies
- Everybody gave up a little control, gained flexibility for *individualized service plan*
- Comprehensive identification of *needs* and *strengths* includes physical health
- Successful *coordination with primary care* required for improved outcomes under cap

"Does Coordinated Care Matter?"

- Mental health and substance abuse needs may go unrecognized in primary care
- Serious medical conditions, such as asthma or diabetes, may require community-based monitoring
- Delayed PH or BH treatment leads to greater *morbidity*
- Interactive impact of physical and psychiatric diagnoses, treatments and medication on *clinical* and *financial outcomes*

Culture Change

- All providers are part of child and family team
- Team creates single plan of care with treatment goals and measurement points
- Intervention pathways on behalf of specified goals should include health care provider input and role
- Overall health status and service use (and expense) monitored along with other indicators

How Does Coordination Work?

- Primary care is hurting; grateful for help
- Engage system leadership to sponsor introductory activities (and lunch!) between Care Management Entity and Primary Care
- One-to-one follow-up: brief face-to-face introductory meetings to explain goals, leave contact info
- Clarify roles (i.e. med management or communication with school nurse)
- Pay for time; if provider can attend a child and family team meeting or phone call; share information/notes in real time

Vignettes

- 10-year-old boy, some learning disabilities, more irritable than 12-year-old brother; sometimes "loses it" in physical fights and won't stop

- 8-year-old girl with terminal lung disease; parents divorcing; having trouble in school, few friends, cries, doesn't pay attention

- 14-year-old boy, court-involved, refuses to attend school, runs away

Barriers

- Differences in training mean communication requires more effort
- Lack of time within primary care to drive to community-based meetings or spend 1-2 hours with one family
- No insurance reimbursement for time spent on phone or in transit; can’t bill for two services same day (i.e. pediatrics and psychiatry)
- Most records are not integrated, so mental health notes not accessible to primary care
- Confusion regarding HIPAA; “business partner”, “need to know” and “QI” all relevant for integrated care processes

Opportunities

- EPSDT: Not only screening, but better access to *diagnosis* and *treatment* for vulnerable populations when care is coordinated

- Enhanced recognition and treatment, in both physical health and psychiatric areas, results in use of *fewer medications*, and/or *reduced hospitalization and ER expense*

- *Overflow relationship building* creates processes for greater communication around routine care; also guards against confusion regarding *follow-up steps* (labs, med change, etc.)

Contact Information

Katherine E. Grimes, MD, MPH
katherine_grimes@hms.harvard.edu

Children's Health Initiative
Cambridge Health Alliance
120 Beacon St., 4th fl.
Somerville, MA 02143

Ph: 617-503-8454

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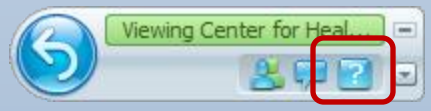

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