INTotal Health®

An Inova Health Plan

INTotal Health Behavioral Health Home Program Description 2015-2016

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Executive Summary

INTotal Health is a Medicaid Managed Care Organization which is committed to improving the healthcare and wellbeing of our members. Our mission is to seek every opportunity to meet the unique needs of each person we are privileged to serve – every time, every touch. We believe that the integration of physical and mental health is an important element for success in improving the health of our members.

INTotal Health's Behavioral Health Home is a member-centered, collaborative care program pilot which revolves around the multidisciplinary care needs of identified[1] members and their primary care providers, care managers and psychiatric consultants. The program is built on evidenced-based care principles and strives to improve the collaborative integration of physical and behavioral health care plans and monitoring of patients' progress across the continuum of care providers from varying disciplines.

INTotal Health's Behavioral Health Home is one element of an overall comprehensive care program that spans a continuum of coordinated services including care management, care coordination, health education, case management (CM), disease management (DM), and utilization management (UM).

INTotal Health's Behavioral Health Home model will encourage providers to develop regular/proactive monitoring and regular, systematic psychiatric reviews and consultation for patients who do not show clinical improvement.

INTotal Health's Behavioral Health Home model seeks to fully integrate the member's care and provide self-management support, multidisciplinary care planning, care management services, peer support and community resource connections.

INTotal Health's membership includes those with complex needs that require services from multiple providers and systems, gaps in care coordination or continuity. These gaps can create barriers to optimal care for affected members. INTotal Health's Behavioral Health Home Program helps reduce these barriers by identifying the unmet needs and then assisting with interventions to reduce gaps in care. This may involve coordination of care, assisting members in accessing community-based resources, providing disease-specific education, or any of a broad range of interventions designed to improve the physical and behavioral health status of enrollees in the most efficient and effective means possible.

The Behavioral Health Home Program Description establishes INTotal Health's model and standards for care delivery for the identified population. INTotal Health uses a strategy that is grounded in evidenced-based interventions. Interventions are customized towards the physical and behavioral healthcare needs of the member enrolled in the Health Home.

Mission

The INTotal Health Behavioral Health Home Program's mission is to improve the health of our members and assure appropriate access and coordination of care and services. To meet this mission, the Behavioral Health Home Program focuses upon appropriate utilization of resources, access to care and coordination of care.

Goal

The goal of the Program is to provide high quality, integrated, culturally-competent services to members with needs ranging from simple to complex. In addressing the member comprehensively, our program addresses behavioral health needs and recognizes the need for wrap around support services. When such support services are offered under the benefit package, INTotal Health Case Managers are able to intervene directly. However when the support services needed are outside of the benefit package offered, our case managers help coordinate services with community resources. Specific measures will be used to determine if the program has improved the health of the program participants. These goals may include the following measures depending on program participation:

- **Improve the disease related care for chronic conditions**
- **Assure members who smoke have received education and strategies for smoking cessation**
- **Effective Medication Management**
- **Follow Up Care Post Hospitalization**
- **Participation in recommended preventative care**
- **Reduction in Emergency Room Visits**
- **Reduction in Acute Care Hospitalizations**

Scope

The scope of the Behavioral Health Home Program includes but is not limited to:

- Member identification using DMAS criteria and utilizing a predictive approach that is designed to focus resources on those members expected to be at the highest risk for poor health outcomes.
- Assessment and management based on evidence-based clinical guidelines.
- Initial and ongoing assessment.
- Problem-based, comprehensive care planning, to include measurable prioritized goals and interventions tailored to the complexity level of the member as determined by the initial and ongoing assessments.
- Coordination of care with PCP's and specialty providers.
- Education for the member and care giver.

- Empowering members through strategies of self-care management and improved health literacy.
- Facilitating effective member and provider communication.
- Ongoing monitoring of the effectiveness and outcomes of case management employing quantitative and qualitative data analysis.
- Annual evaluation of member(s) satisfaction with the Behavioral Health Home Program, complaints and inquiries.

Annual evaluation of program effectiveness through examination of relevant processes and outcomes that have been identified through valid measure specification, comparison of program results with pre-determined performance goals, analyzing results, and identifying opportunities for improvement. The goals and target activities are based upon the opportunities identified in the evaluation.

Coverage Area and Expected Number of Participants

This program pilot will be implemented in Northern Virginia and will include up to 150 members.

Objectives:

The objectives of the Behavioral Health Home Program include, but are not limited to:

- Create a Behavioral Health Home (BHH) program that, responds in a cost-effective manner, to the needs of members with acute or chronic behavioral, and/or social conditions that require case management and/or coordination of services.
- Provide case management approaches that are person centered and provide support, access, and education along the continuum of care.
- Identify barriers that may impede members from achieving optimal health, meeting agreed-upon goals, and participating in the care plan.
- Manage members from a holistic perspective, promoting collaboration and coordination, through all levels of the healthcare continuum, which includes: physical and behavioral health programs, pharmaceutical management, and community-based programs.
- Establish a plan that is personalized to meet a member's specific needs and identifies: prioritized goals, time frames for reevaluation, resources to be utilized including the appropriate level of care, planning for continuity of care, and family participation.
- Obtain member/family/caregiver input and level of participation in developing the care plan to include self-care management strategies to increase the likelihood of improved health outcomes that may result in improved quality of life.
- Use resources efficiently and effectively through emphasis on teamwork, skill development, and cross-training of staff.

- Provide effective outreach to engage members and their families as partners in the care plan process.
- Reduce unnecessary, duplicated, and/or fragmented utilization of healthcare resources.
- Foster improved coordination and communication among practitioners and providers and INTotal Health staff.
- Improve member and provider satisfaction and retention.
- Comply with applicable contractual, regulatory, and accreditation requirements related to case management.
- Serve as advocates for members and caregivers.
- Promote effective strategies to prevent or delay relapse or recurrence of issues, disease, and health impairments through interventions such as member education and improved member self-management.
- Coordinate interventions with ongoing health promotion initiatives such as member education resources.
- Promote health, wellness and self-management
- Help members, their families or support systems as well as caregivers use internal and external resources that will improve health outcomes and manage the cost of care
- Provide culturally-competent services to members.
- Maintain the highest level of ethical standards, including maintenance of member confidentiality.
- Conduct quality management and improvement activities to ensure the highest possible level of service to members, caregivers and a member's family and support network.
- Standardize documentation requirements and reporting mechanisms.

Definitions

Behavioral Health Home: A health home (aka Medicaid health home) — as defined in Section 2703 of the Affordable Care Act — offers coordinated care to individuals with multiple chronic health conditions, including mental health and substance use disorders. The health home is a team-based clinical approach that includes the consumer, his or her providers, and family members, when appropriate. The health home builds linkages to community supports and resources as well as enhances coordination and integration of primary and behavioral health care to better meet the needs of people with multiple chronic illnesses.

Case Management – "A collaborative process which assess, plans, implements, coordinates, monitors and evaluates 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 2010)

Member – A person who is eligible for, and provided coverage under, an INTotal Health.

Caregiver – A person responsible for the care of a member.

Prioritized Goals – Refers to desired outcomes or objectives that are assessed to have the highest impact in improving the members' health status. Factors such as member preferences and resources often alter the priority of patient goals.

Utilization Management (UM) – "The process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing any needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources" (NCQA definition).

Organizational Structure and Accountability

Health Plan

General oversight of the INTotal Health Behavioral Health Home pilot is provided by the INTotal Health Chief Medical Officer (CMO) in collaboration with the Vice-President of Clinical Services who provides daily, direct oversight of the clinical operations. Assisting the VP for Clinical Services in daily program oversight is a staff of directors and managers.

Behavioral Health Program Management

The Behavioral Health Program Manager is expected to demonstrate expertise in identifying and developing appropriate care plans for behavioral health issues including disorders such as adjustment disorders, major depression, anxiety disorders and substance use disorders.

Case Managers work with members with serious emotional disturbance (SED) and serious mental illness (SMI) such as schizophrenia and bipolar disorder. Case Managers are expected to work with members who have medical concerns as well as behavioral health concerns.

The Behavioral Health Physician Advisor consults with Case Managers on an "as needed basis" and through formal case rounds. The Advisor also assists with program development.

Staff Roles and Qualifications

Chief Medical Officer (CMO)

The CMO provides general medical oversight of the INTotal Health Case Management Program. The CMO helps identify Clinical Services Department priorities for the company as a whole, based on an analysis of data and trends. He serves as the principal medical policy advisor to INTotal Health's Executive Leadership and is ultimately responsible for the approval and the operation of the INTotal Health Behavioral Health Program, including all related policies and procedures and Program Descriptions. The CMO also serves as Chair of the Medical Advisory Committee.

Behavioral Health Physician Advisor

Under the direction of the CMO, the BH Physician Advisor provides utilization management oversight, consultation and support for INTotal Health's Behavioral Health Home, and health

plan behavioral health and medical staff. He or she participates in behavioral health rounds, complex case rounds and may participate in large case rounds. He or she also provides behavioral health consultation for Case Managers.

Vice President Clinical Services

The VP of Clinical Services is responsible for day-to-day oversight of medical policies and procedures, standardized clinical operations, clinical training and compliance, along with systems/processes related to medical systems software. She/he supports operational initiatives for medical management.

Behavioral Health Program Manager

The Program Manager is responsible for developing, implementing and managing a comprehensive Behavioral Health Program including access to needed care, provider interfaces and coordination and member support.

Director/Manager of Case Management

The Director/Manager of Case Management/oversees the day-to-day operation of the Behavioral Health Home pilot and all Case Management Programs.

Director/Manager of Utilization Management

The Director/Manager of Case Management/oversees the day-to-day operation of the Utilization Management Program.

Case Managers

Case Managers are responsible for coordinating care, assisting members in accessing community-based resources, providing disease-specific education, or any of a broad range of interventions designed to improve the members' quality of life and functional capacity. CMs function as patient advocates and work with members and practitioners to develop the CM plan and achieve the identified objectives through diverse techniques including but not limited to monitoring of risks, disease management and patient education, case management, and advocating self-management whenever possible. Case Managers may be dedicated to specific programs or targeted populations.

Case Specialists

Case Specialists work in conjunction with Case Managers to coordinate health care services by facilitating, scheduling, and arranging a variety of treatment and services.

Identification Criteria for Enrollment in INTotal Health's Behavioral Health Home Pilot

INTotal Health will identify potential members through a quarterly claims review that follows the approved DMAS criteria as described below.

To be enrolled in the INTotal Health Home Program the member must meet at least ONE of the four categories of eligibility[1]:

1. Medicaid Mental Health Claims History

   A. 6 or more visits with one or more of the following Mental Health codes (INTotal Health or Magellan)

99605, 99606, 99607	Pharmacological Management
H0004	Counseling & Therapy (Ind)
H0004	Counseling & Therapy (Grp)
S9484	Crisis Intervention
S0201	Partial Hospitalization
H0035	Community Psychiatric Support Tx (Ind)
H0036	Community Psychiatric Support Tx (Grp)

   AND

   B. One or more claims containing a primary mental health diagnoses determined by DMAS

   AND

   C. Has had Medicaid claims (Medical & BH) during the member identification period of at least the average total cost of SPMI overall population ($10,471)

2. High Mental Health pharmaceutical use defined as:

   A. Received 6 or more prescriptions during the research time period from the DMAS identified drug classes

   OR

   B. Received any office administered antipsychotic medication ("J code injectable")

   AND In addition to 2A OR 2B, the enrollee must have **BOTH**:

   C. One or more Medicaid claims containing a primary mental health diagnoses identified by DMAS

   AND

   D. Has had Medicaid claims (Medical & BH) during the research period of at least the average total cost of SPMI overall population ($10,471)

3. History of Hospital Inpatient Admission

   A. The member has had one or more inpatient psychiatric hospitalizations in one calendar year.

   This criteria may be met immediately upon discharge from the hospital (prior to the receival of claims) with Medical Director approval and if patient meets the other criteria within this section.

   AND

B. Has had one or more Medicaid claims containing a primary mental health diagnoses identified by DMAS

AND

C. Has had Medicaid claims (Medical & BH) during the research period of at least the average total cost of SPMI overall population ($10,471)

4. History of Emergency Room Use
   A. Has had 4 or more visits to a hospital emergency department for **any** (physical medicine or BH) primary diagnosis

   AND

   B. One or more Medicaid claims containing a primary mental health diagnoses identified by DMAS

   AND

   C. Has had Medicaid claims (Medical & BH) during the research period of at least the average total cost of SPMI overall population ($10,471)

Member Engagement

The Program Manager and/or Case Manager will utilize a list of eligible members who meet the criteria outlined by DMAS to determine program participants. Multiple types of contact are attempted to reach the members. This includes telephone contact, mailings and provider visits.

Service Delivery Approach

INTotal Health utilizes a person-centric, integrated approach to Case Management. Based on the ongoing assessment process, services are individualized and based on the needs of the member. The INTotal Health approach is flexible and responsive to changes in individual member and caregiver needs.

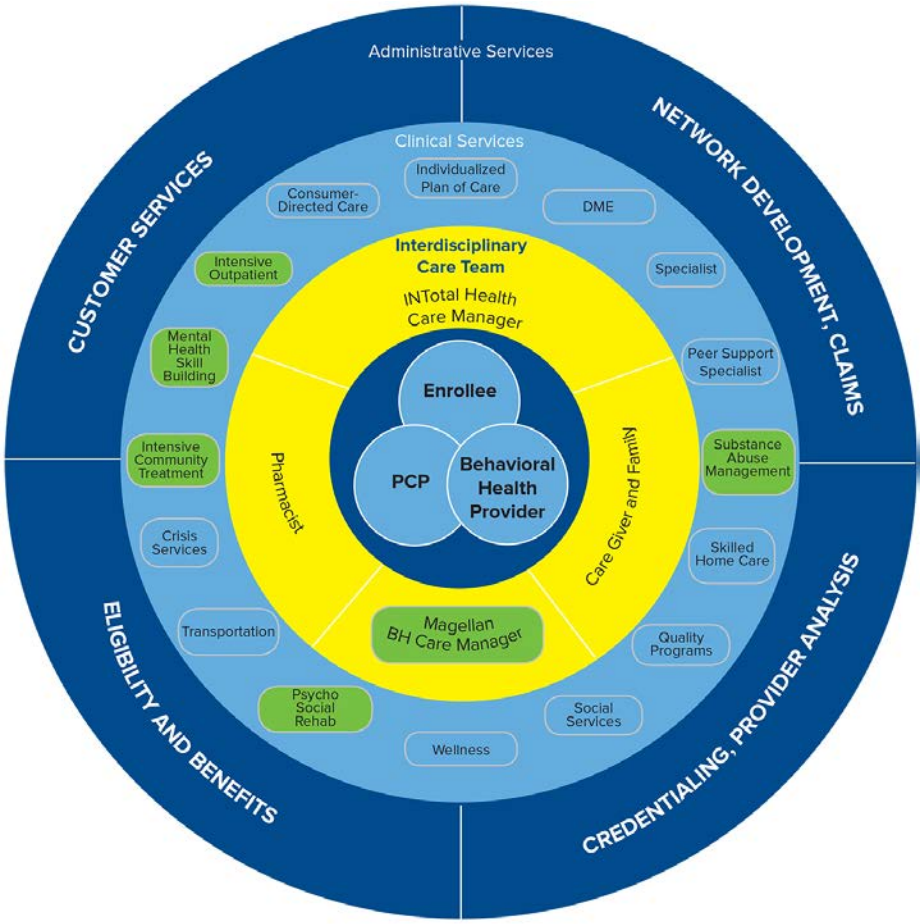
Model of Care

Integration Philosophy

- Integration at the health plan and coordination of care level
- Integration at the level of the provider (point of service)

Overarching Goal of the Model of Care

- Produce an integrated plan of care that improves members' health and the quality of the delivery of services, while managing cost.



Structure of the Model of Care

Interdisciplinary Care Team for Enrollees in "Basic Service Coordination" * Level of Care

- Enrollee, and family member/caregiver, as Enrollee desires
- Primary Care Physician (PCP)
- Behavioral Health Provider, as appropriate
- Case Manager (RNs and/or Behavioral Health Clinician)
- Navigator
- Pharmacist
- Community or Facility Liaison (e.g., from LTSS agency, nursing facility, assisted living, group home)

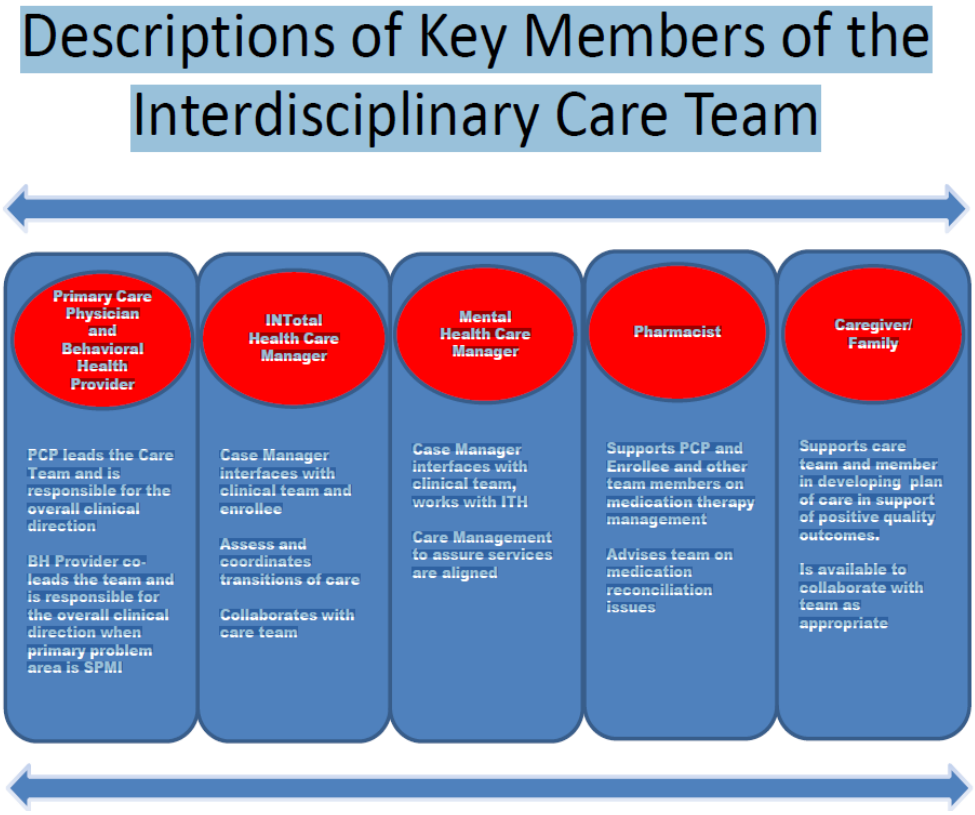
* **Level is determined by specific criteria based on Health Risk Assessment**

Interdisciplinary Care Team for Enrollees in "Enhanced Service Coordination/Care Management" * Level of Care:

- All of the members listed above and any of the following as needed and appropriate:

- Community or Facility Liaison (e.g., from LTSS agency, nursing facility, assisted living, group home, and including a Medicaid State Plan Targeted Case Management Manager)
- Behavioral Health Clinician
- Peer Support Specialist
- Social Worker
- Other medical specialists (e.g., Physiatrists, Neurologists, etc.)

* **Level is determined by specific criteria based on Health Risk Assessment**



Case Planning

Using information gathered through the assessment process, including a review of the relevant evidence-based clinical guidelines, the CM develops an individualized case management plan, including prioritized goals, that considers the member's and caregivers' goals, preferences, and desired level of involvement in the case management plan. The case management plan includes prioritized goals, interventions designed to assist the member in achieving these goals, and identification of barriers and challenges to meeting goals or complying with the case management plan. Case management plans are completed within 30 business days of the initial contact with the member.

Problem Identification

Assessment information, including feedback from members, family/caregivers, and, in some cases providers, provides the basis for identification of problems. Areas identified during the assessment that may warrant intervention include, but are not limited to:

- Conditions that compromise member safety
- History of high service utilization
- Use of inappropriate services
- Current treatment plan has been ineffective
- Permanent or temporary loss of function
- High-cost illnesses or injuries
- Co-morbid conditions
- Medical/psychological/functional complications
- Health education deficits
- Poor or inconsistent treatment/medication adherence
- Inadequate social support
- Lack of financial resources to meet health or other basic needs
- Identification of barriers, or potential barriers, to meeting goals or complying with the case management plan.

Interventions

Once a problem list is developed, the Case Manager works with the member, caregiver, healthcare providers, and the member's support team to develop interventions that support the achievement of the identified health goals. The range of potential interventions is lengthy but most align with one or more of the following general categories:

- Health education.
- Interpretation of benefits.
- Community resource referrals.
- Facilitating referrals to other health organizations.
- Post-discharge service authorizations and member outreach (e.g. DME, home health services and coordination of physician appointments).
- Service coordination.
- Medication reconciliation review.
- Assistance in developing a self-management plan.
- Community-based services (e.g. home or hospital visits).
- Provider-based Intensive Case Management (Behavioral Health).
- Special needs program interventions.
- Ongoing assessment of barriers to meeting goals or complying with the case management plan and interventions to address those barriers.

Individualized Case Management Plan

Preparation of the case management plan includes an evaluation of the member's optimal care path, as well as the member's wishes, values, and degree of motivation to take responsibility for meeting each of the case management plan goals. Wherever possible, the Case Manager encourages the member to suggest his or her own goals and interventions, as this may increase their investment in their successful completion.

The case management plan is personalized and includes:

- Prioritized goals.
- Time frame for reevaluation.
- Resources to be utilized, including the appropriate level of care.
- A self-management plan for the member.
- Planning for continuity of care, including transition of care and transfers.
- Collaborative approaches to be used, including family participation.

As part of the Case management plan, the Case Manager develops and documents schedules for follow-up and communication with the member in the CM plan.

Communication of the Case Management Plan

Once the final version of the case management plan has been formulated, including member self-management plans, the CM discusses it with the member and, if appropriate, the caregiver.

Once completed, the CM mails or faxes a copy of the case management plan to member's assigned PCP's and any active specialty practitioner. Member authorization is not required for such communication as this is considered "coordination of care" under HIPAA regulations. Once the case management plan is finalized, it is reviewed and updated in the care management system

Monitoring

The Case Management process involves a continuous process of delivering and monitoring interventions designed to meet the goals of the case management plan along with ongoing assessment of progress toward achieving those goals. The case management plan is an evolving document that requires continual review and evaluation based on the member's level of progress. As part of the monitoring process, the Case Manager:

- Maintains communication and collaboration with the member and family/care givers (as appropriate) in order to monitor the member's health status and progress toward meeting treatment plan goals.
- Maintains communication and collaboration, as appropriate, with the member's PCP, other active specialty providers, and other members of the healthcare team (e.g. other Case Managers) to assess progress in meeting case management plan goals. Practitioners are advised of any significant updates to the case management plan.

- Monitors the member's progress toward meeting the goals of the CM plan and makes adjustments as necessary.

Case Management Documentation

At a minimum, the following information must be documented in the Case Management system:

- Contacts, or attempted contacts, including method of contact, location, date, and a brief summary of the information derived from the contact, if any.
- A summary of assessment results in a case management plan that includes:
  - Identified problems,
  - Goals (prioritized) expressed in measurable terms, member and caregiver focused with anticipated timeframes,
  - Interventions with timeframes,
  - Assessment for, and as appropriate identification of, barriers to meeting the goals and complying with the plan.
  - Member and provider participation in developing the case management plan, as appropriate,
  - Outcomes affiliated with interventions, and
  - Progress relative to case management plans.
- Monitoring - progress in meeting case management plan goals, expected timeframes for progress, and any modifications in the case management plan based on success or challenges to meeting the goals as a result of interventions.
- Evaluation – Results of periodic re-assessments.
- Outcomes – Results of outcome measures, if appropriate.
- Disposition (e.g. closure, transfer).

Confidentiality

The Health Plan Case Management Program conforms to all INTotal Health policies and procedures related to confidentiality and compliance with HIPAA regulations. In addition to generic training on HIPAA and confidentiality given to all INTotal Health staff, CMs are trained to comply with HIPAA requirements.

Cultural Competence and Awareness

It is important that Case Managers are aware of, and sensitive to, the cultural and demographic diversity of the populations served and of colleagues and stakeholders in the Case Management process. Providing culturally competent and aware Case Management services can potentially enhance the delivery of services and increase the likelihood of successful engagement with the member, and family/care givers. Being culturally competent and aware includes, but is not limited to:

- Becoming knowledgeable about the communication styles and linguistic needs of specific cultural and ethnic groups in order to enhance communication with members and families.
- Seeking to recognize personal prejudices, biases, and assumptions concerning particular cultural and ethnic groups and working to correct these and to avoid allowing these characteristics to impact the delivery of services.
- Obtaining accurate information about patterns of utilization and typical attitudes about healthcare services and seeking to tailor service delivery to take into account such information.
- Seeking to obtain and understand data about incidence and prevalence of certain disease states or conditions within the various cultural and ethnic populations served by the health plan.
- Seeking supervision and consultation to enhance service delivery when issues related to cultural and ethnic diversity of members and families are identified.

INTotal Health provides training for all employees on cultural competence and awareness, and Case Managers should seek opportunities for ongoing continuing education to enhance their ability to deliver services in the most culturally competent manner.

Member and Provider Complaints

In general, complaints are expressions of dissatisfaction expressed by a complainant, orally or in writing, regarding any aspect of service provision or administration other than a request for reconsideration of an authorization decision. The INTotal Health Case Management Program staff adheres to policies and procedures related to handling member and provider complaints.

Program Evaluation

The health plan will develop an annual evaluation of The Behavioral Health Home Pilot Program and review program accomplishments, opportunities, barriers, and effectiveness of performance in meeting established goals for the 2014 – 2015 contract year. The report will include a quantitative and qualitative evaluation of the Program indicators, and uses trended data where appropriate.

[1] **Members are identified for enrollment into the INTotal Health Behavioral Health Home based on specific criteria defined by DMAS and described in section titled "Identification Criteria for Enrollment in INTotal Health's Behavioral Health Home Pilot"**