

# Medicaid Innovation Accelerator Program (IAP)

**Substance Use Disorders (SUD)  
High-Intensity Learning  
Collaborative**

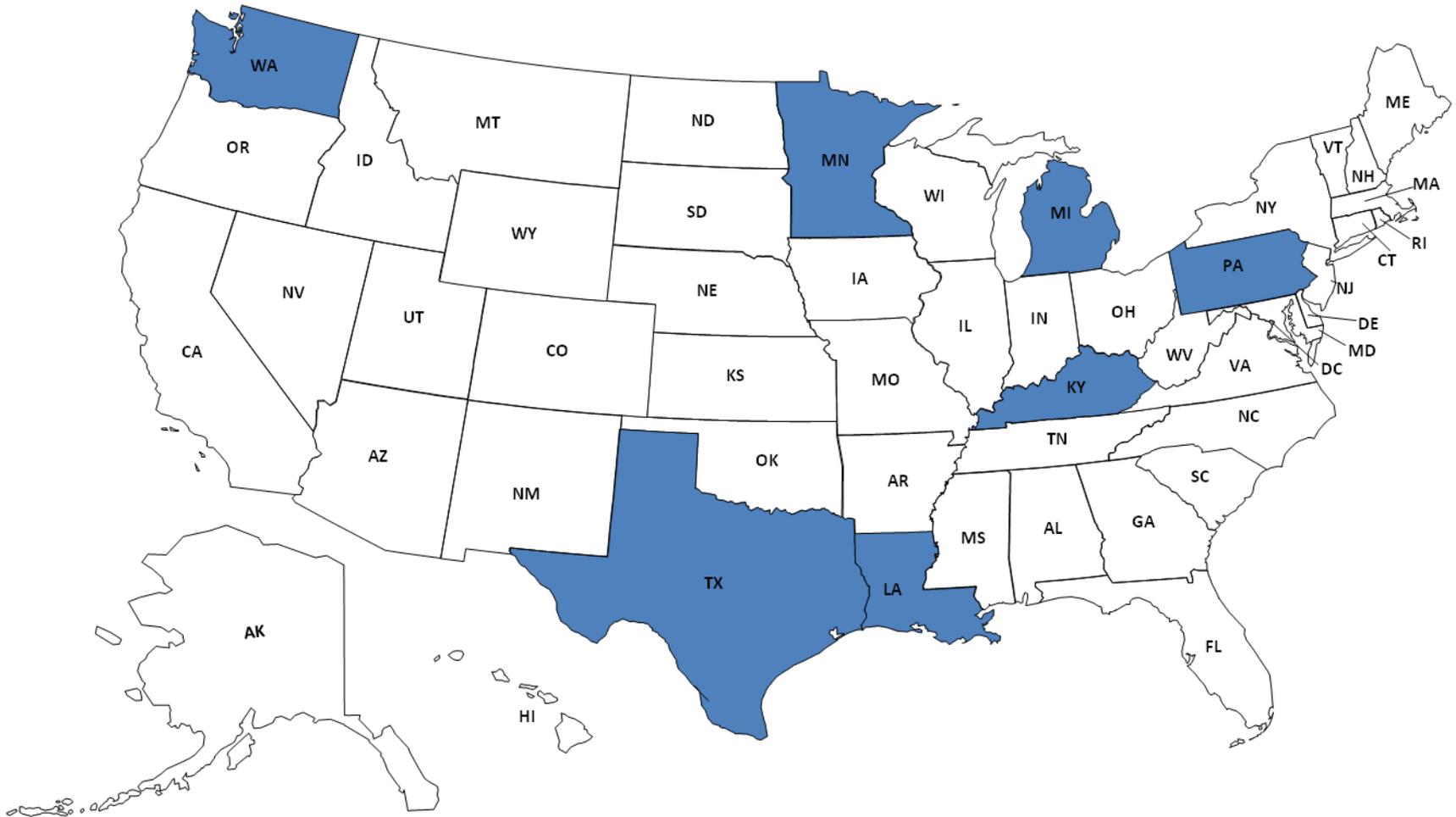
**HILC Meeting 5: Care Transitions**



# Logistics for the Webinar

- Please mute your line and do not put the line on hold
- Use the chat box on your screen to ask a question or leave comment
  - Note: chat box will not be seen if you are in “full screen” mode
- Moderated Q&A will be held periodically throughout the webinar
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# HILC State Roll Call



# Agenda

- Introductions
- Care Transitions for Individuals with SUD: Overview
- Medicaid ACO Care Transition Intervention Example
- State Presentations/Discussion
- Ohio Offender Project
- Questions and Discussion
- Wrap Up and Next Steps

# Purpose and Learning Objectives

- In this session, States will learn about and engage in a conversation about models for successful care transitions across levels of care for persons with substance use disorders.
- Several HILC states will highlight their care transitions efforts, creating an opportunity for state to state interaction and discussion.

# Presenter (1 of 5)

- **Alicia D. Smith, MHA**  
Principal, Health Management Associates



# Presenter (2 of 5)

- **Suzanne Fields, MSW**

Senior Advisor for Health Care Policy & Financing, University of Maryland



# Presenter (3 of 5)

- **Art Jones, MD**  
Principal, Health Management Associates



# Presenter (4 of 5)

- **Stephanie Patrick, L.I.S.W.S.**

Clinical Program Manager, United Healthcare Community Plan/ Optum Health Behavioral Solutions

# Presenter (5 of 5)

- **Deidre Palmer, MSE**

Case Management Supervisor and Project Coordinator for High Risk and Re-Entry Teams, Molina





# Care Transitions for Individuals with SUD: Overview

*Suzanne Fields*

# Remaining in Treatment for an Adequate Period of Time is Critical

- Appropriate duration for an individual depends on the type and degree of patient's problems/needs.
- Most individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment.
- Recovery from drug addiction is a long-term process and frequently requires multiple episodes of treatment.
- As with other chronic illnesses, relapses to drug abuse can occur and should signal a need for treatment to be reinstated or adjusted.

# Remaining in Treatment for an Adequate Period of Time is Critical (cont'd)

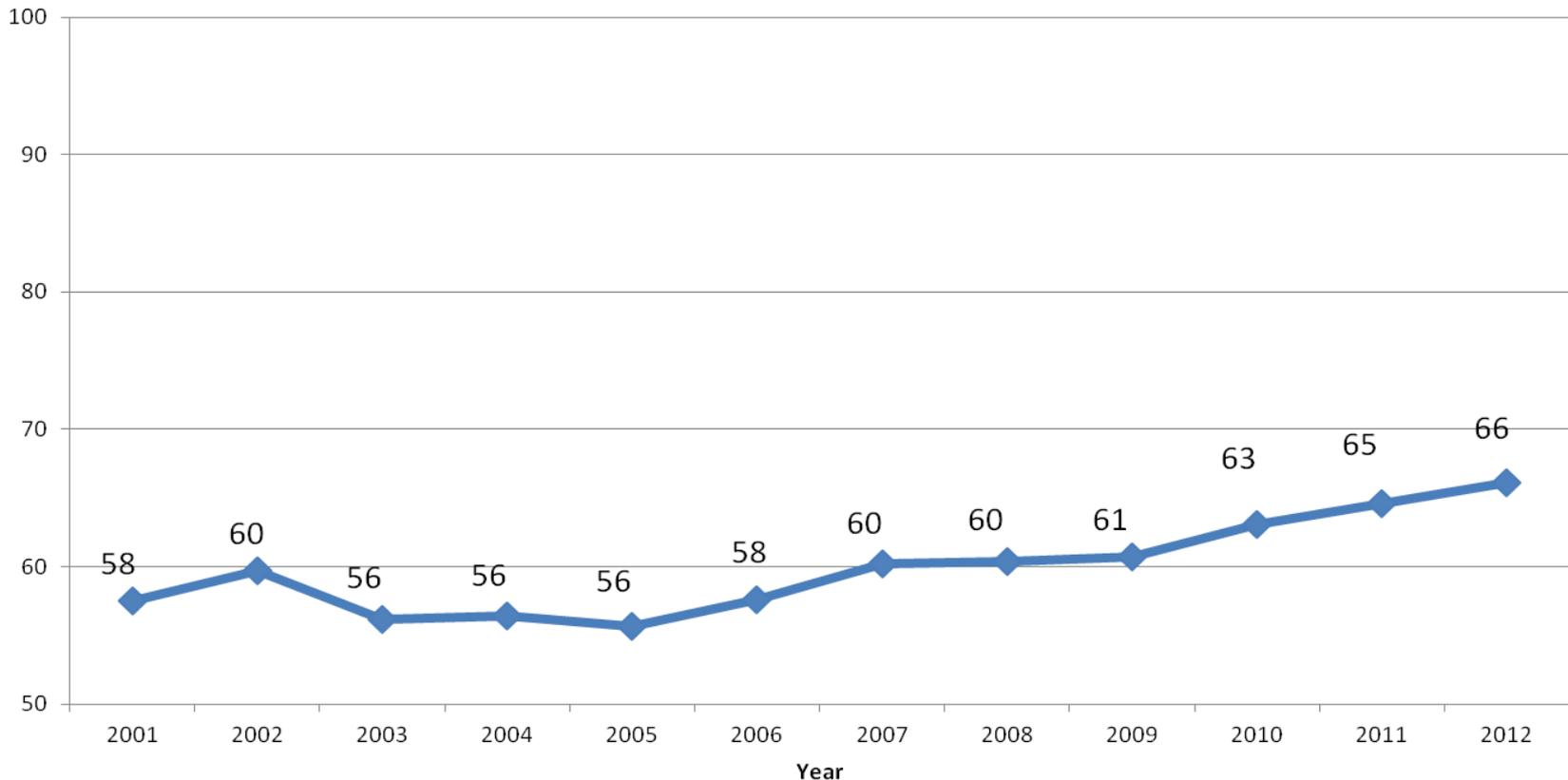
- As with other chronic illnesses, relapses to drug abuse can occur and should signal a need for treatment to be reinstated or adjusted.
- Because individuals often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment

SOURCE: National Institute on Drug Abuse (NIDA)

[Principles of Drug Addiction Treatment: A Research-Based Guide \(Third Edition\)](#)

# Need Better SUD Transitions Between Levels of Care

## 30-day follow-up after SUD inpatient hospital stay



Source: Smith, M & Mark, T. Follow-up Encounters Within 30 Day of a Substance Abuse Related Inpatient Discharge, Psychiatric Services, September 2014, p 1080.

# Two of Most Common Reasons for Medicaid Readmissions are SUD

Principal diagnosis for hospital stay	Readmit Rate
Mood Disorders	19.8%
Schizophrenia/ psychotic disorder	24.9%
Diabetes	26.6%
Pregnancy Complications	8.4%
<b>Alcohol-related</b>	<b>26.1%</b>
Early/ threatened labor	21.2%
CHF	30.4%
Septicemia	23.8%
COPD	25.2%
<b>Substance-related Disorders</b>	<b>18.5%</b>

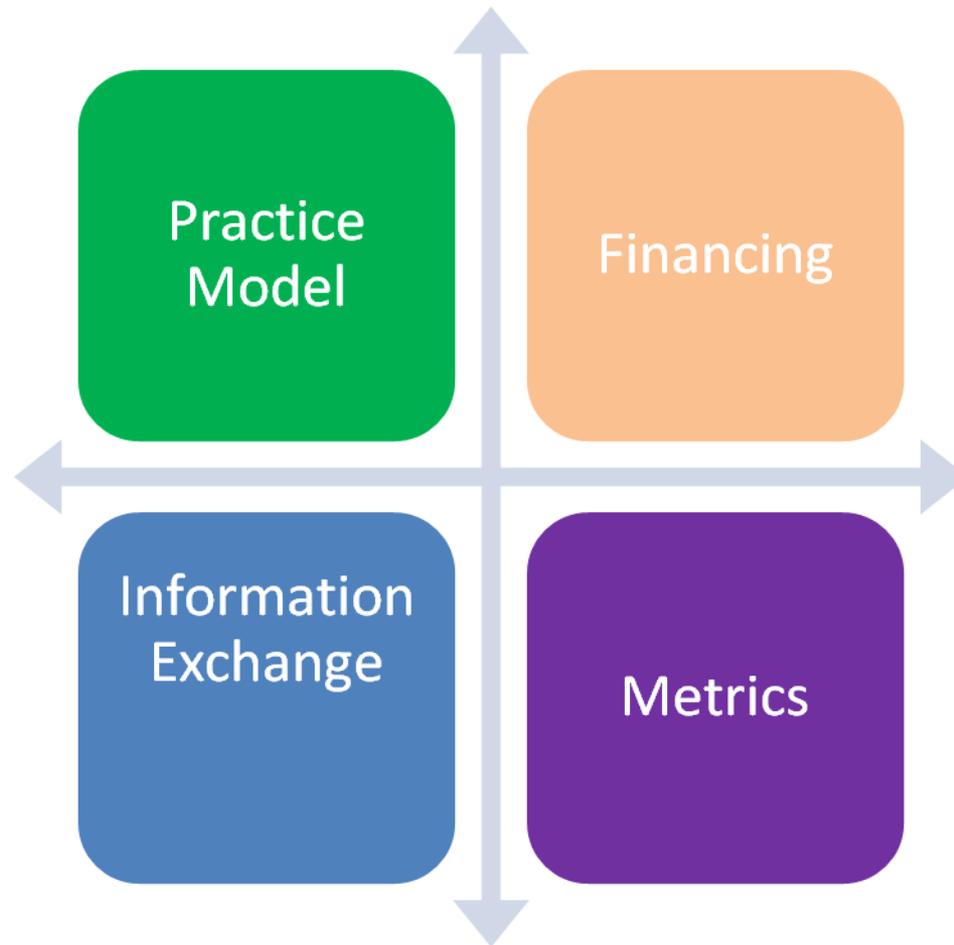
•Source: Weighted national estimates from a readmissions analysis file derived from the Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), SID, 2011.

# “Revolving Door” of Detoxification

- 27% of individuals with a detoxification admission had at least one detoxification readmissions within the same year (Mark, 2006)

Source: Mark, T, et al, Factors Associated with the Receipt of Treatment Following Detoxification, Journal of Substance Abuse Treatment 24 (2003) 299 – 304.

# Customizing Care Transitions for States



# Best Practice Models are Out There...

- **Project RED.** Re-Engineered Discharge
- **Project BOOST.** Better Outcomes by Optimizing Safe Transitions
- **RARE Campaign.** Reducing Avoidable Readmissions Events
- **Coleman's Care Transitions**
- **STAAR.** State Action on Avoidable Rehospitalizations

# Promising Components of SUD Detoxification Transitions (1 of 3)

- Goals for detox programs should be engagement in next level of care, not just referral.
- Connect to next level of care before discharge. Invite programs to meet clients prior to discharge.
- Transport clients to next level of care for an intake session prior to completion. Transport to the program on the day of detox discharge.

# Promising Components of SUD Detoxification Transitions (2 of 3)

- Peer specialists to work with clients in detox to assure that they are connected to treatment and other services (e.g., primary care, housing, etc.) upon completion.
- Case managers/navigators to stick with the clients until they are really engaged.
- Start clients on FDA approved medication to treat SUD while in detox. Connect to a provider who will continue medications upon discharge from detox and make sure they really get there.

# Promising Components of SUD Detoxification Transitions (3 of 3)

- Housing. Make sure that the client has a safe and sober place to live (lack of housing is one of the biggest reasons for return to drug use).
- Metrics to report on detoxification care transitions
- Payment to performance

# Challenges Specific to SUD

- Information Exchange (42 CFR Part II)
- Client Motivation
- Social service needs (e.g., housing)
- Lack of adequate reimbursement
- Lack of provider supply?
- Others?

# Questions?



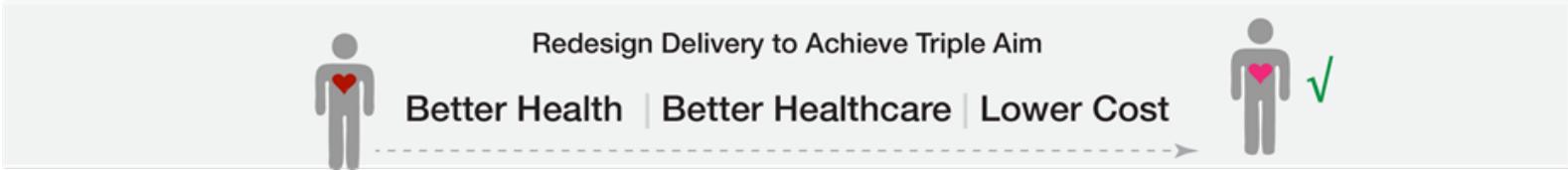
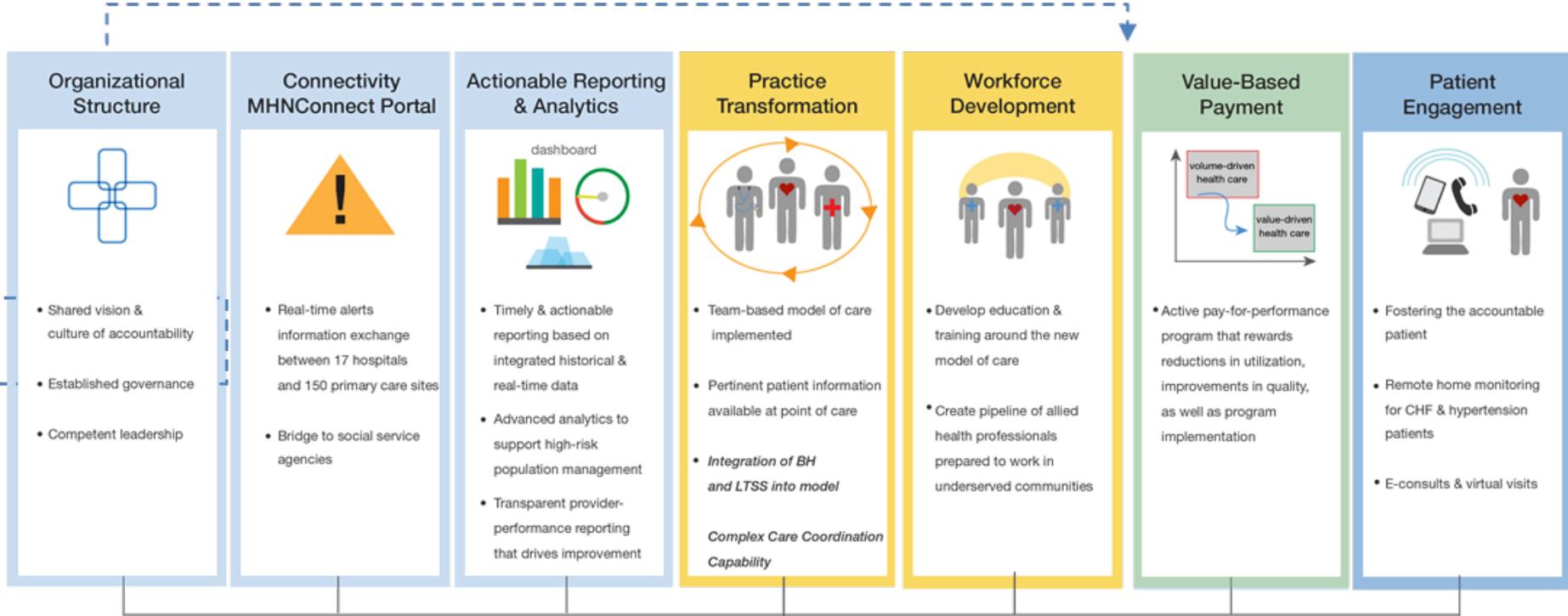
# Medicaid ACO Care Transition Intervention Example

*Art Jones, M.D.*



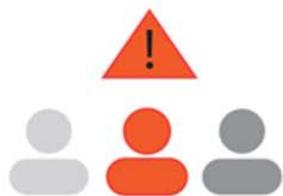
# MHN Building Blocks for Delivery System Transformation and Population Mgmt.

## MHN ACO's Path



# MHNConnect in Action: Interactive and Proactive Care Coordination

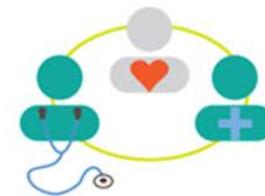
Three steps to better care coordination:



Receive Alert



Interact via  
MHNConnect & Analytics



Patient-centered  
Care Management

1 Care Coordinators in the clinic receive a real-time email alert (ER & Discharge) when a patient presents in the clinic, FQHC or PCP office

2 Care Coordinators assess patient utilization and health history by using the data integrated in MHNConnect and Consilink analytics

3 Care Coordinators proactively reach out to patients resulting in data-informed population health management & increased access to care

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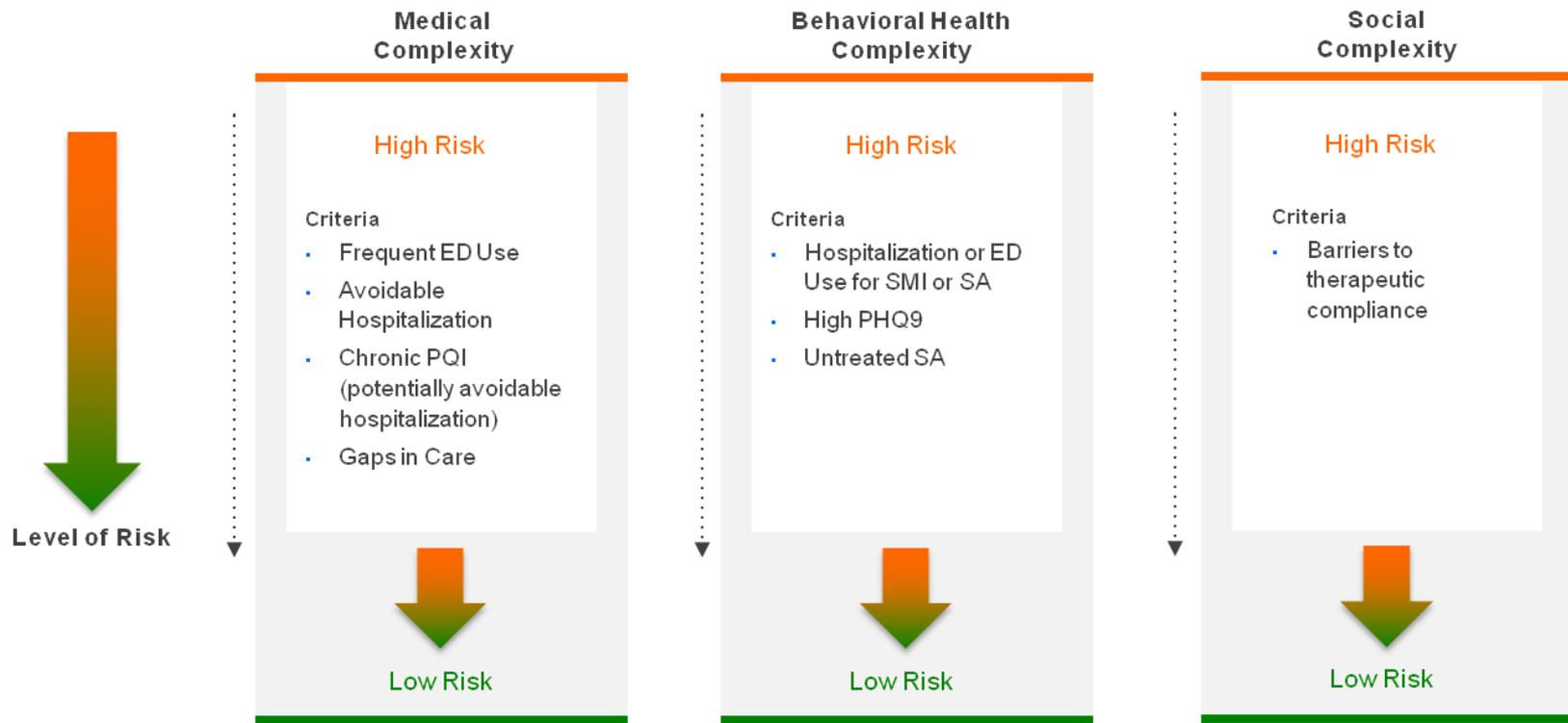


# Hospital Transitions of Care

- Notification of ED visits or hospitalizations triggered by real-time alerts prompting coordination with ED physician, hospitalist and discharge planner
- Follow-up within 2 business days of discharge
- Components:
  - medication reconciliation
  - scheduling of follow-up appointment
  - updating care plan
  - education about specific warning sign recognition and response
  - coordination with community-based services and any new home supports

# MHN: Driving Effective Care Management

Judge effective care management by its ability to lower patient risk



# MHN IL Medicaid Pilot Results: Performance Year 2 Outcomes

## MHN IL Medicaid Performance Year 2 Pilot Results: Non-Risk Adjusted Outcomes

MEDICAL HOME NETWORK		All Population Cohorts			
Measures for MHN Hospitals	Baseline	Performance Year 1	Performance Year 2	Baseline to PY1 % Change	Baseline to PY2 % Change
% Timely Follow-up Visits after IP/ED discharges	20.6%	24.1%	23.6%	16.9%	14.3%
7 Day Readmit Rate (%) Total	12.7%	11.9%	11.1%	-6.4%	-12.6%
30 Day Readmit Rate (%) Total	26.3%	24.8%	22.3%	-5.9%	-15.2%

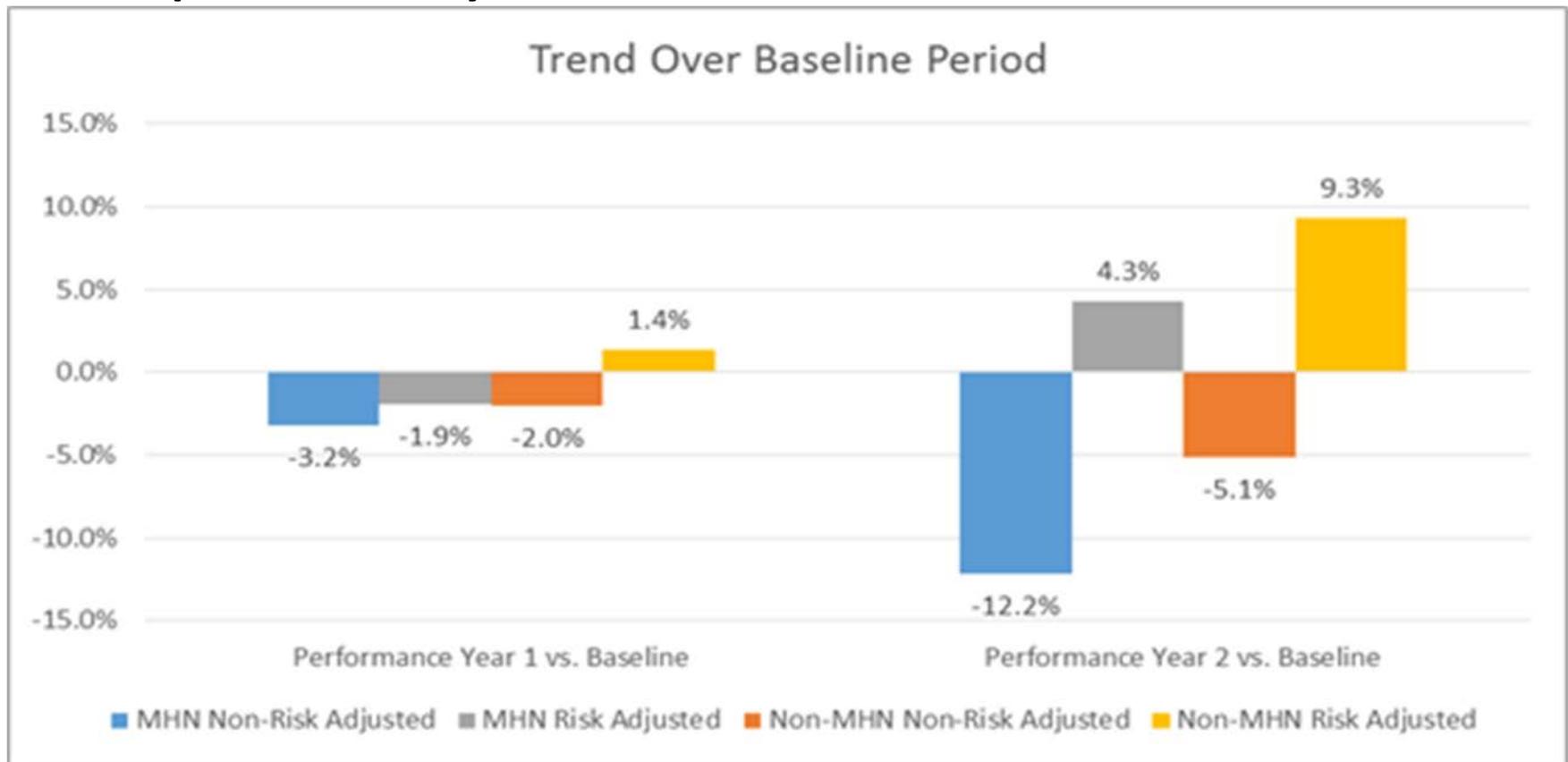
  

Performance Measures All Population Cohorts	Baseline	Performance Year 1	Performance Year 2	PY1 over Baseline Percentage Change	PY2 over Baseline Percentage Change
<b>NON-Risk Adjusted Cost of Care PMPM</b>					
Medical Costs PMPM	\$ 214.91	\$ 209.86	\$ 187.55	-2.3%	-12.7%
Pharmacy Costs PMPM	\$ 39.48	\$ 36.53	\$ 35.87	-7.5%	-9.1%
Total Cost of Care PMPM	\$ 254.39	\$ 246.38	\$ 223.42	-3.1%	-12.2%

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# MHN IL Medicaid Pilot Results: Performance Year 2 Outcomes (cont'd)

## Comparative Analysis: MHN vs. Non MHN-Matched Cohort Trend



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# Questions? (1 of 2)



# State Presentations/Discussion

# State Experiences

- Michigan
  - Ten Sixteen Recovery Network
- Minnesota
  - Native American pilots
- Louisiana
  - Lafayette Parish Office
- Washington
  - University of Washington's Alcohol and Drug Abuse Institute/  
Brandeis

# Ohio Offender Project

*Stephanie Patrick and  
Deidre Palmer*

# Medicaid Expansion in Ohio

- Medicaid Expansion passed (Fall 2013)
- Initially projected to add 575K Ohioans to Medicaid coverage
- Approximately 52K incarcerated in 26+ facilities—release approximately 15K each year
- With Medicaid expansion, approximately 75% of those released would be Medicaid eligible.
- Ohio Medicaid (ODM) and Ohio Dept. of Correction & Rehabilitation (DRC) recognized a need to provide specialized support to Ohioans returning to society.

# Why This Effort is Important

- 4.8 million persons were under community supervision by the criminal justice system in 2011.
- 40.3% of males on probation and 38.3% of male parolees reported an alcohol or illicit drug use disorder in the past year.
- Untreated substance use disorders can lead to relapse and continued criminal behavior, leading to re-incarceration.
- Important to improve access and linkages to community-based treatment.
- ACA can help increase access to these critical services.

*Source: SAMHSA, The NSDUH Report, March 6, 2014*

# Overview of Ohio Offender Program

- Project began in November 2014 with one facility—Ohio Reformatory for Women.
  - Two more women’s facilities added in Feb-March, 2015.
  - First male facility added in May, 2015.
  - Will expand by 1 facility per month

# Ohio Offender Program: Primary Purpose

- Critical risk is defined as two or more identified health conditions as reported to the offender's chosen health plan by the Ohio Dept. of Corrections (DRC). This criterion is:
  - Offender has an infectious disease such as HIV, Hep C, and/or
  - Offender has a chronic condition(s) such as --SMI, addiction, diabetes, COPD, etc.
- Offenders are asked to complete a release of information request in order for DRC to share personal health information with the receiving health plan.

# Eligibility, Notification, Outreach and Enrollment Process (1 of 3)

- Health enrollment materials
  - 90-120 days prior to release, the offender is provided the opportunity to review health enrollment materials
- Peer mentors
  - 5 offenders in each facility are trained to act as peer mentors and provide guidance and support in health plan decisions
- Enrollment Process
  - Once a health plan is chosen, the facility arranges for offender to call the Ohio Medicaid Managed Care Enrollment Center to enroll in a health plan

# Eligibility, Notification, Outreach and Enrollment Process (2 of 3)

- Transition of Care (ToC) Plan Development
  - If the offender has 2 or more critical risk indicators, DRC notifies the chosen health plan via secure Sharepoint site and provides clinical information. This triggers the transition of care plan development process.
- Member ID card
  - Sent to DRC for inclusion in offender's discharge packet

# Eligibility, Notification, Outreach and Enrollment Process (3 of 3)

- Enrollment Confirmation
  - 45-60 days prior to release, health plan is sent an 834 transaction to confirm enrollment
- Establishing Access
  - Within 5 days post release, health plan must attempt to reach offender to confirm address, establish PCP, pharmacy and resend enrollment materials

# Molina's Experience To Date: Ex-offender Member Needs

- Chronic Illness—82%
- Mental Health (MH)— 68%
- Substance Abuse—68%
- Chronic illness + MH + Substance Abuse —32%
- **Initial Outcome:** 100% members seen by BH Provider also had Rx filled

# Role of the MCO Case Manager (1 of 3)

- Role in Transition Planning
  - Educating members about the program and transition process
  - Build rapport with members
  - Identify member needs and barriers
- Point of Contact
  - “Bridge” between member and providers
  - Provides ease with accessing providers and services

# Role of the MCO Case Manager (2 of 3)

- Care Coordination
  - Schedule direct appointments with all necessary providers
    - Arrange transportation for appointments
  - When possible, schedule with provider that offers both MH and SUD treatment:
    - Ironton Family Guidance Center
    - Mental Health Services of Clark County
    - Alvis House in Chillicothe
      - Case Management Services
      - Cognitive Behavioral Groups
      - Outpatient SUD treatment

# Role of the Case Manager (3 of 3)

- Provide referrals and schedule initial visit to programs that provide Medication Assisted Treatment (MAT)
- Provide access to Alcoholics and Narcotics Anonymous in the members' area
- Follow up with members post-release
- Monitor members' progress
- Enrollment into high risk case management, if needed

# Successes

- Post Release Contact
- Case Management Team
  - Experienced CMs with Corrections members and importance of SUD treatment
  - Collaboration with in-house Chemical Dependency Counselors as additional team resource
- Member Satisfaction
- Community Relations

# Member Experience

## Member Story

# Opportunities

- Lack of Member Understanding
  - Increasing member's buy-in for SUD treatment post-release from prison
- Exchange of Information/Accuracy of Demographic Information
- Program Criteria
- Provider Interaction
- Limited Clinical Information from Facility
- Readily Accessible, Low Income Housing

# Next Steps

- Revising criteria
- MCP role inside the prison

# Questions? (2 of 3)



# Up Next

- HILC Meeting #6: At-Risk Populations (August 19th)
- If you'd like to share some populations that you'd be interested in hearing about during this webinar, please share your thoughts.

# Evaluations

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We greatly appreciate your participation!