Expanding and Ensuring Access to Behavioral Health Follow-Up Care

Improving Behavioral Health Follow-up Care Learning Collaborative: Webinar #1

May 17, 2021

Deirdra Stockmann, Centers for Medicare & Medicaid Services (CMS)

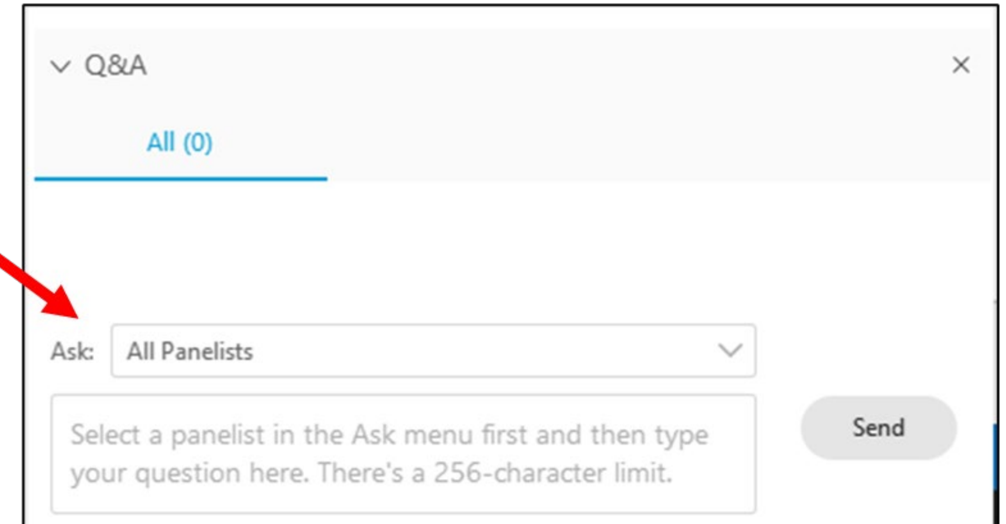
Michaela Vine and Mira Wang, Mathematica

Andrew Brown, Kansas Department for Aging and Disability Services for Behavioral Health Services

Malissa McEntire, Oklahoma Department of Mental Health and Substance Abuse Services

Webinar Logistics

- Phone lines are muted upon entry.
- For technical issues, select "Host" in the drop-down menu of the Q&A window.
- To submit audience questions, select "All Panelists" in the drop-down menu of the Q&A window.



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Welcome and Overview of the Improving Behavioral Health Follow-up Care Learning Collaborative

Deirdra Stockmann, CMS

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Agenda

Topic	Speaker
Welcome and Overview of the Improving Behavioral Health Follow-up Care Learning Collaborative	Deirdra Stockmann, CMS
Why Behavioral Health Follow-up Care?	Michaela Vine, Mathematica
Telehealth Follow-up Care in Kansas	Andrew Brown, Kansas Department for Aging and Disability Services for Behavioral Health Services
Integrated Care in Oklahoma	Malissa McEntire, Oklahoma Department of Mental Health and Substance Abuse Services
Questions and Discussion	Michaela Vine, Mathematica
Wrap-Up	Mira Wang, Mathematica

CMCS's Improving Behavioral Health Follow-up Care Learning Collaborative

Goal: Support state Medicaid agencies' efforts to increase access to timely behavioral health follow-up care among Medicaid and CHIP beneficiaries

Participating states teams will have the opportunity to:

- Expand their knowledge of evidence-based interventions to improve access to behavioral health follow-up care
- Develop, implement, and assess a data-driven quality improvement project
- Network with peers
- Advance their knowledge of and skills in quality improvement

Objectives for Today's Webinar

- Provide national context for behavioral health follow-up care based on states' performance on relevant Core Set measures
- Highlight state initiatives to improve the availability of follow-up care through use of telehealth and integrated care programs (including Health Home programs)
- Provide an opportunity for Q&As
- Review upcoming learning collaborative webinars and affinity group

Why Behavioral Health Follow-up Care?

Michaela Vine, Mathematica

Behavioral Health Follow-up Care Measures in the Adult, Child, and Health Home Core Sets

- **Follow-Up After Hospitalization for Mental Illness**
  - FUH-CH: Ages 6 to 17
  - FUH-AD: Age 18 and older
  - FUH-HH: Health Home members
- **Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)**
- **Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)**

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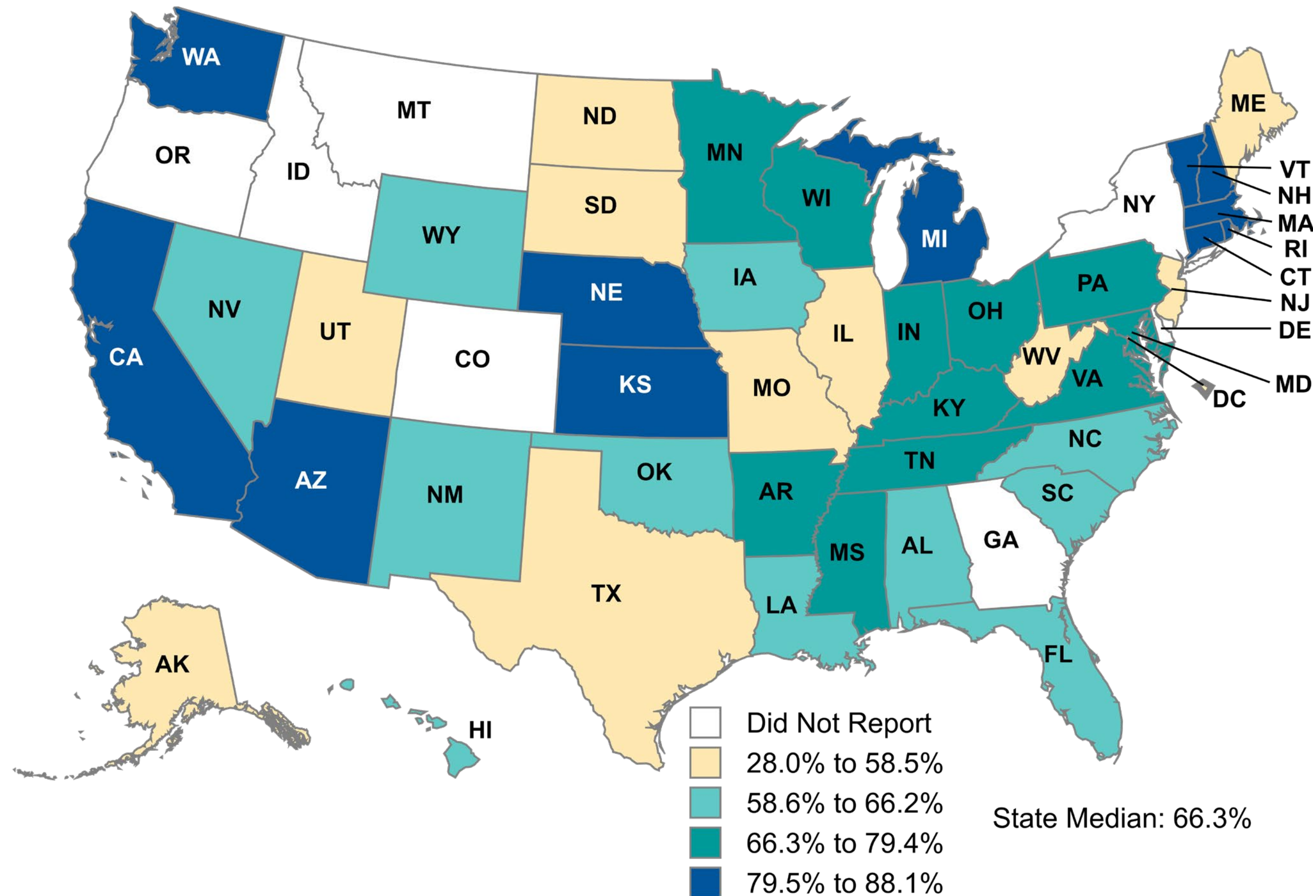
Follow-Up After Hospitalization for Mental Illness Within 30 Days After Discharge (FUH-CH)

Geographic Variation in the Percentage of Discharges for Children Ages 6 to 17 Hospitalized for Treatment of Mental Illness or Intentional Self-Harm with a Follow-Up Visit with a Mental Health Practitioner within 30 Days After Discharge FFY 2019 (n = 44 states)



Source: Mathematica analysis of MACPro reports for the FFY 2019 reporting cycle as of May 31, 2020.

Notes: This chart excludes New York and Oregon, which reported the measure but did not provide data for the 30-Day Follow-Up rate. This chart also excludes Delaware, which had a denominator less than 30. When a state reported separate rates for its Medicaid and CHIP populations, the rate for the larger measure-eligible population was used.

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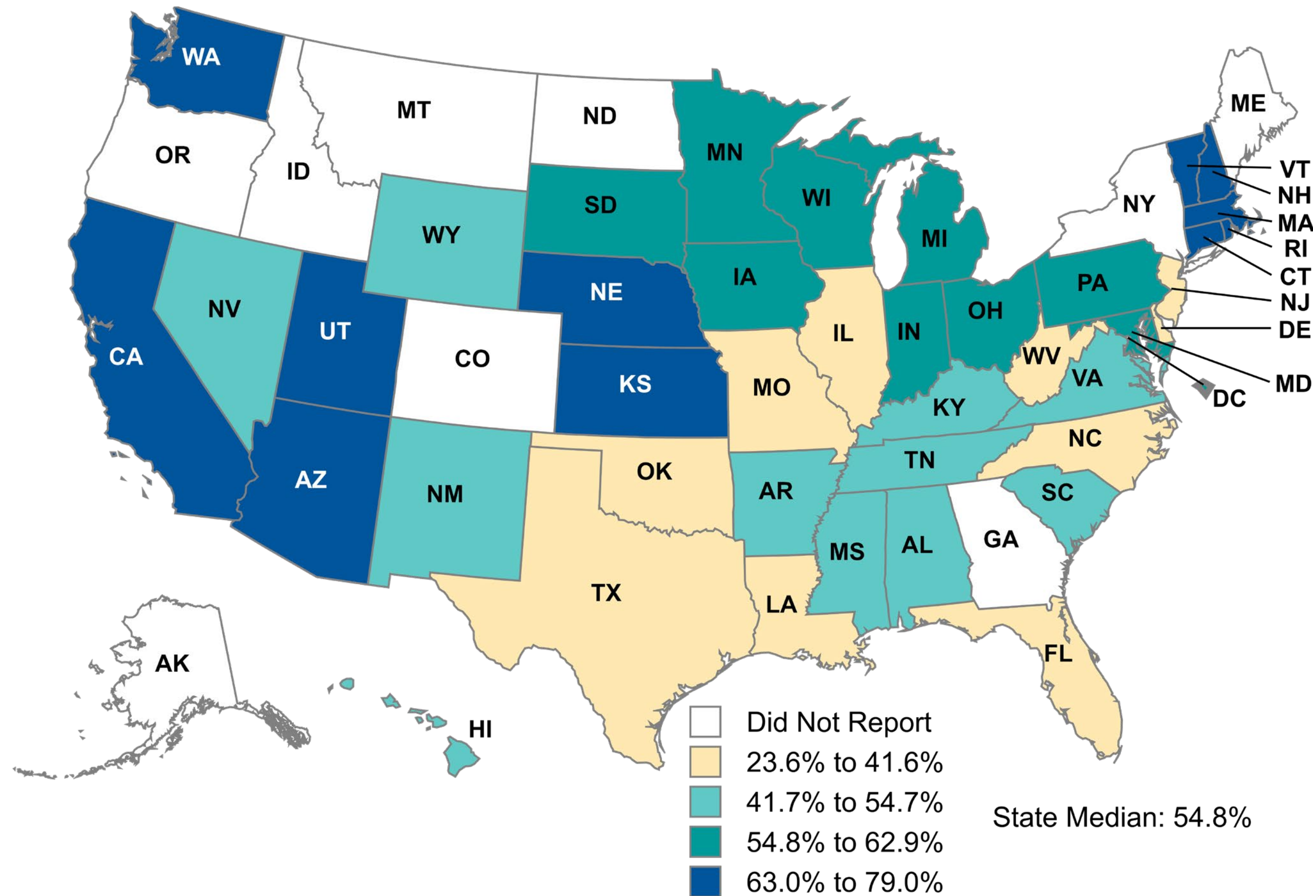
Follow-Up After Hospitalization for Mental Illness Within 30 Days After Discharge (FUH-AD)

Geographic Variation in the Percentage of Discharges for Adults Hospitalized for Treatment of Mental Illness or Intentional Self-Harm with a Follow-Up Visit with a Mental Health Practitioner within 30 Days After Discharge, FFY 2019 (n = 42 states)



Source: Mathematica analysis of MACPro reports for the FFY 2019 reporting cycle as of May 31, 2020.

Note: This chart excludes New York and Oregon, which calculated the measure but did not use Adult Core Set specifications.

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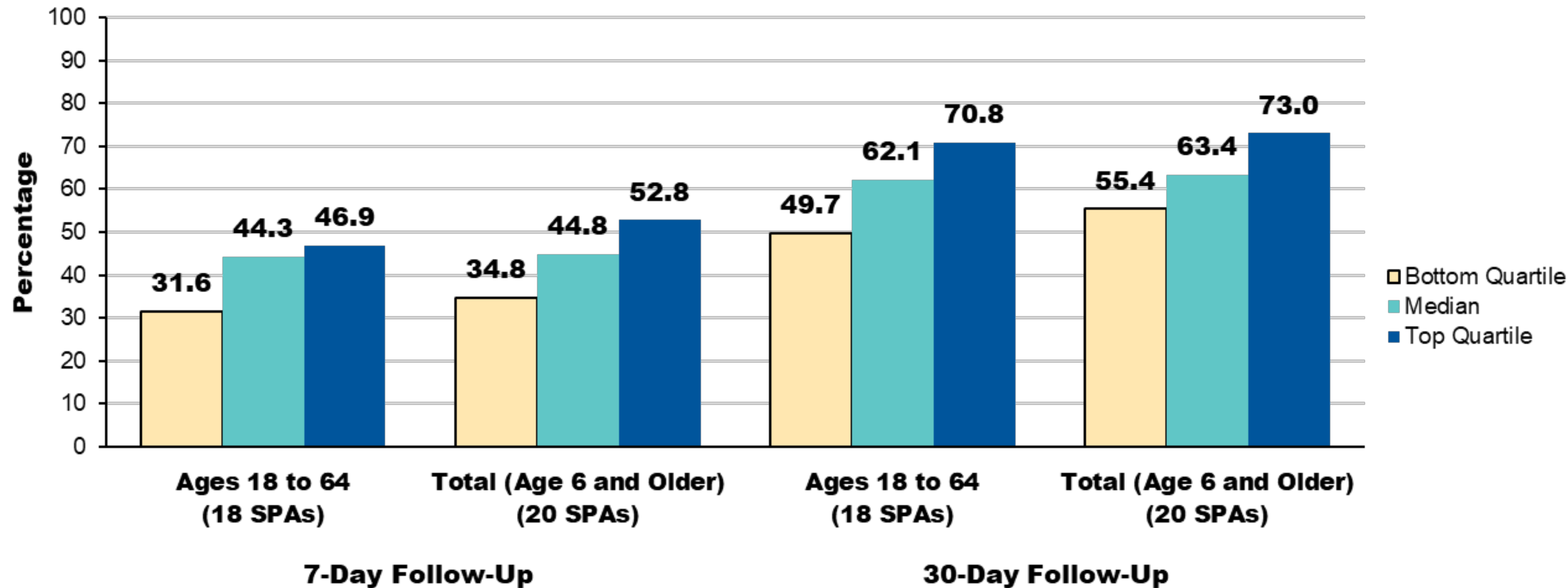
Follow-Up After Hospitalization for Mental Illness (FUH-HH)

Percentage of Discharges for Health Home Enrollees Age 6 and Older Hospitalized for Treatment of Mental Illness or Intentional Self-Harm with a Follow-Up Visit with a Mental Health Practitioner within 7 and 30 Days After Discharge, FFY 2019



Source: Mathematica analysis of MACPro reports for the FFY 2019 reporting cycle as of July 27, 2020.

Notes: This measure shows the percentage of discharges for Health Home enrollees age 6 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses who had a a follow-up visit with a mental health practitioner. Two rates are reported: (1) the percentage of discharges for which the beneficiary received follow-up within 7 days after discharge; and (2) the percentage of discharges for which the beneficiary received follow-up within 30 days after discharge. Specifications for this measure changed substantially for FFY 2019 and rates are not comparable with rates reported for previous years. Rates for Ages 0 to 17 and Age 65 and Older 7-Day Follow-Up and 30-Day Follow-Up rates are not shown because fewer than 15 SPAs reported these rates for FFY 2019. This chart excludes the District of Columbia Chronic Conditions SPA, New York Health Home Services SPA, and New York I/DD Health Home Services SPA, which reported the measure but did not use Health Home Core Set specifications. This chart also excludes Michigan's Chronic Care Model SPA, which had a denominator less than 30.

A median of

45

percent of Health Home enrollees age 6 and older who were hospitalized for mental illness or intentional self-harm had a follow-up visit within 7 days after discharge (20 SPAs), and

63

percent had a follow-up visit within 30 days after discharge (19 SPAs)

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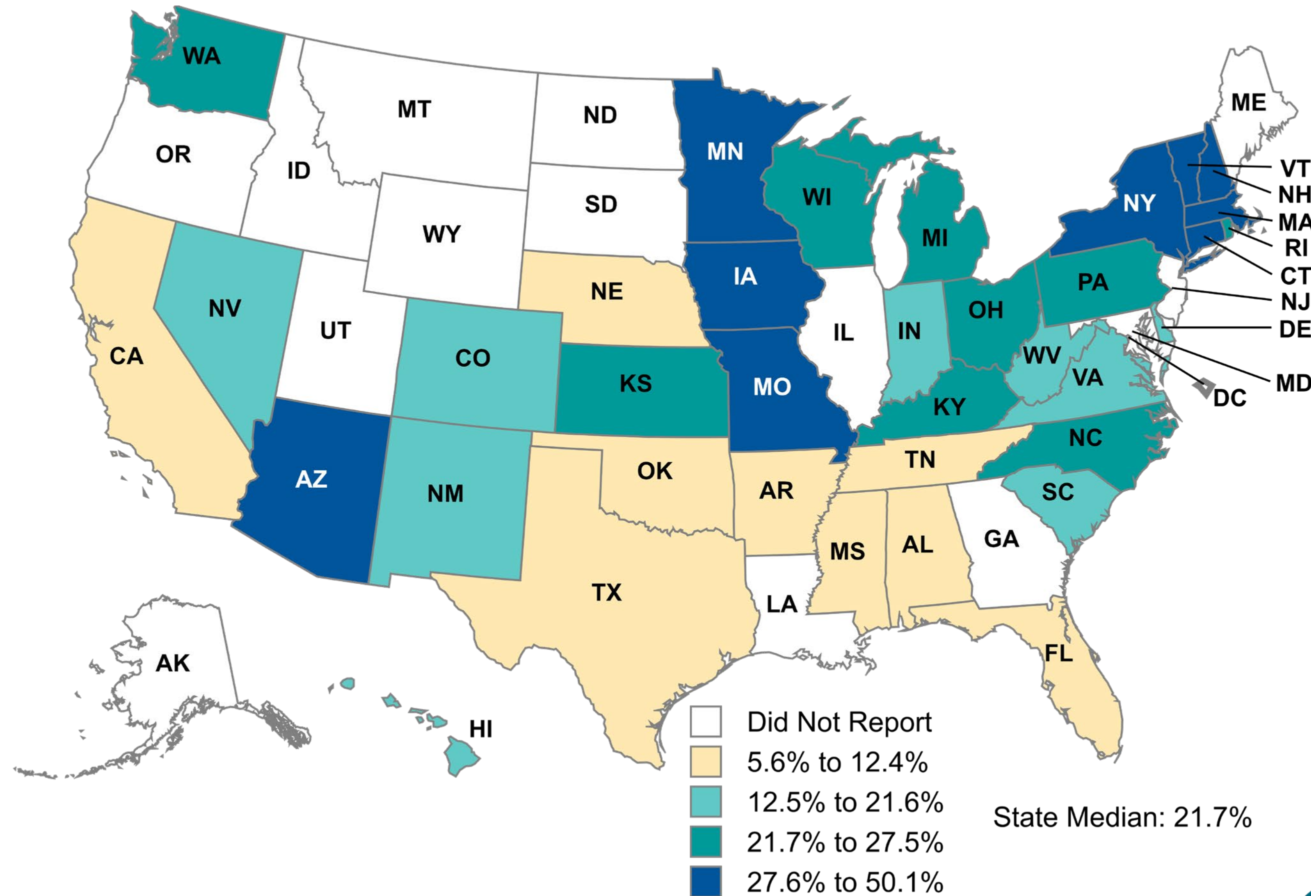
Follow-up After Emergency Department (ED) Visit for Alcohol and Other Drug Abuse or Dependence Within 30 Days of the ED Visit (FUA-AD)

Geographic Variation in the Percentage of Emergency Department (ED) Visits for Adults* Age 18 and Older who had a Principal Diagnosis of Alcohol and Other Drug (AOD) Abuse or Dependence with a Follow-Up Visit within 30 Days of the ED Visit, FFY 2019 (n = 36 states)



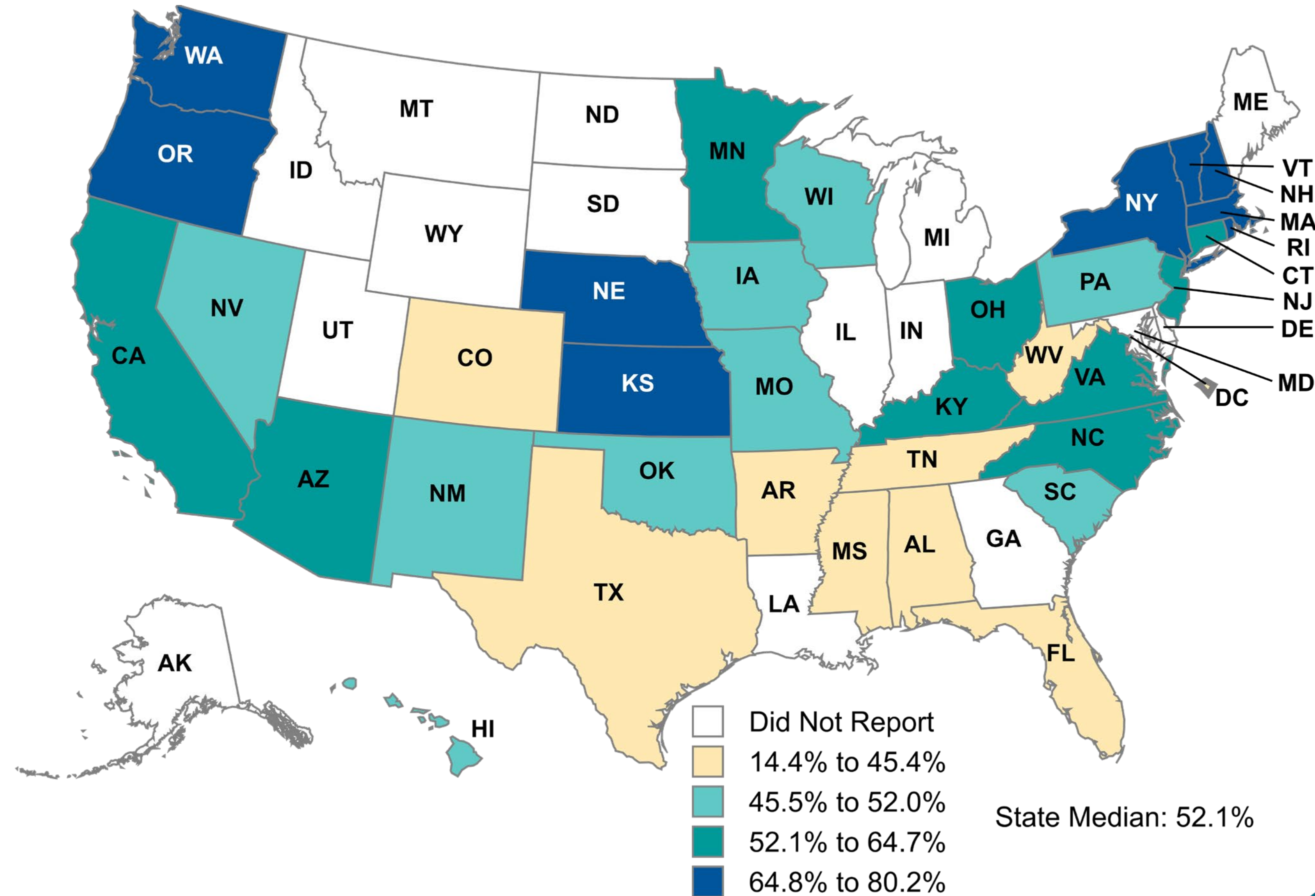
State Median: 21.7%

Source: Mathematica analysis of MACPro reports for the FFY 2019 reporting cycle as of May 31, 2020.

*Data displayed in this chart include adults ages 18 to 64 for 24 states and age 18 and older for 12 states.

Follow-up After Emergency Department (ED) Visit for Mental Illness Within 30 Days of the ED Visit (FUM-AD)

Geographic Variation in the Percentage of Emergency Department (ED) Visits for Adults* Age 18 and Older who had a Principal Diagnosis of Mental Illness or Intentional Self-Harm with a Follow-Up Visit within 30 Days of the ED Visit, FFY 2019 (n = 36 states)



Source: Mathematica analysis of MACPro reports for the FFY 2019 reporting cycle as of May 31, 2020.

*Data displayed in this chart include adults ages 18 to 64 for 32 states, age 18 and older for 2 states, and age 6 and older for 2 states.

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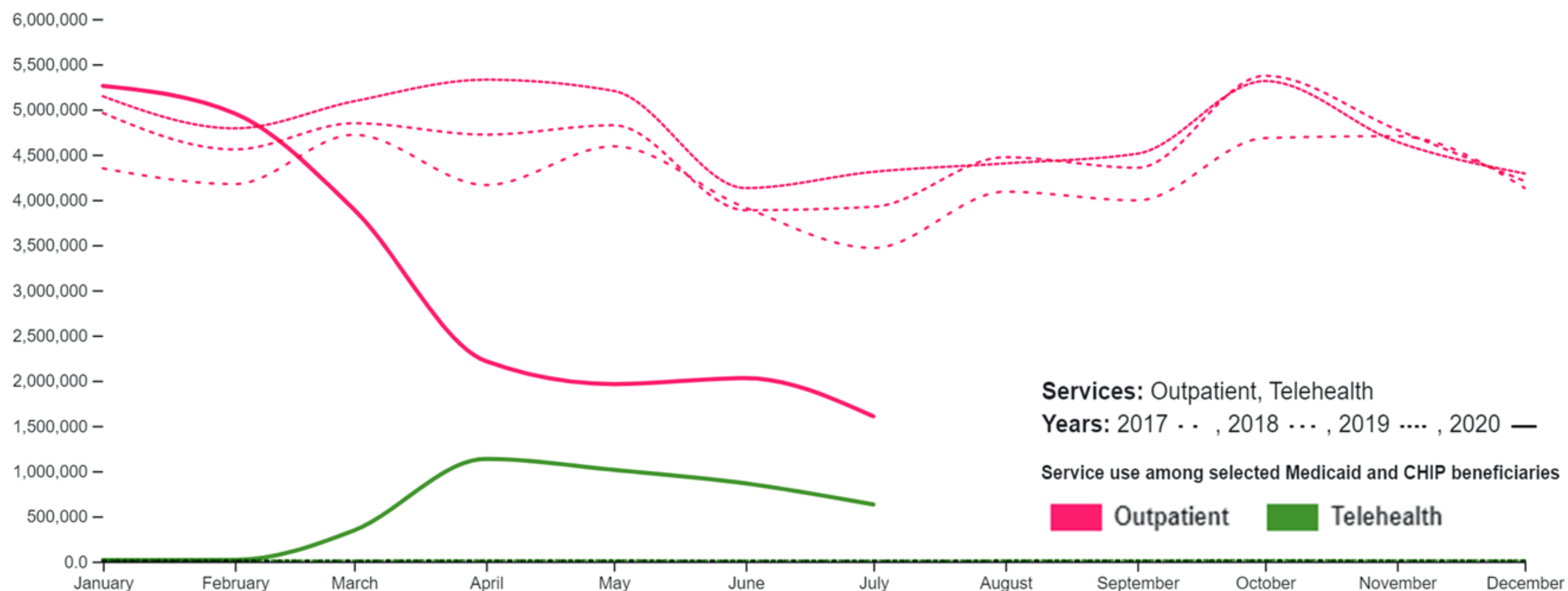
Behavioral Health Services During COVID-19 Pandemic (Children)

Outpatient mental health services and services delivered via telehealth among children dropped from 134 per 1,000 in February to about 59 per 1,000 beneficiaries in July



Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v4 in AREMAC, using final action claims. They are based on September T-MSIS submissions with services through the end of August. Recent dates of service have very little time for claims runout and we expect large changes in the results after each monthly update. Because data for August are incomplete, results are only presented through July 31, 2020.

Data for recent months are likely to be adjusted upward due to claims lag.

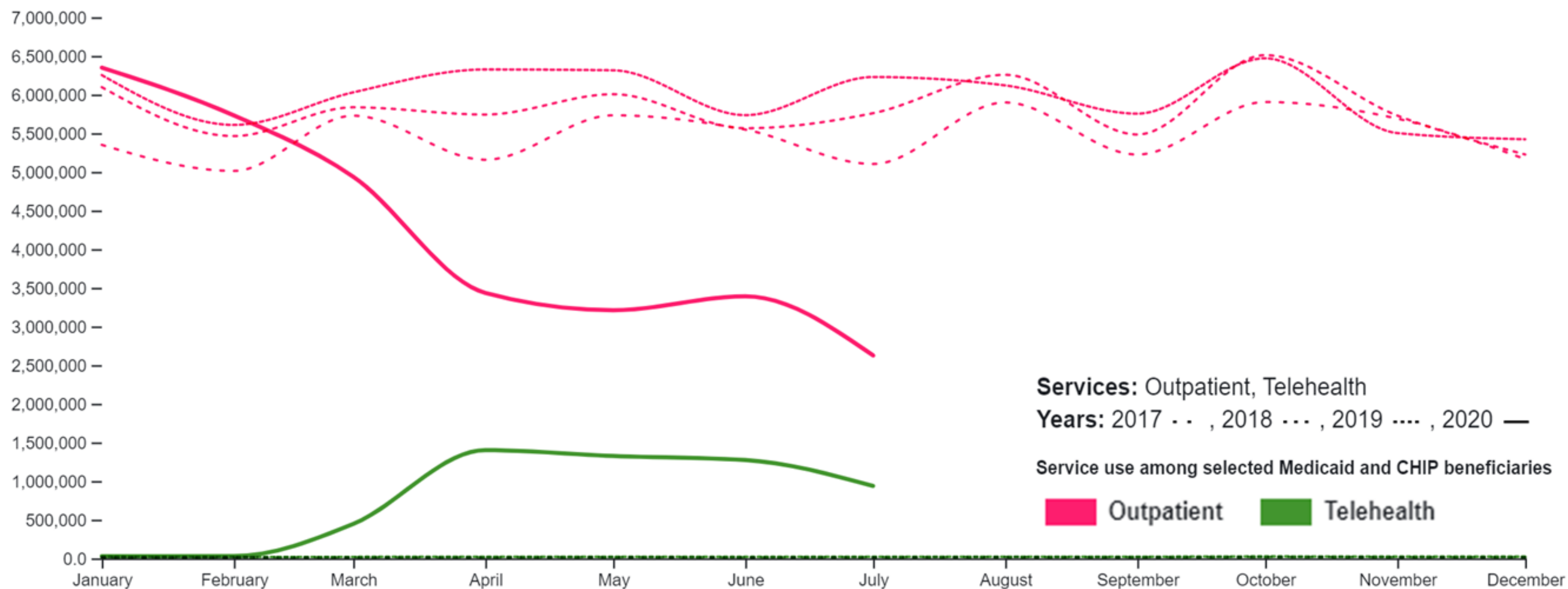
About

35 percent fewer

(8.4 million) outpatient mental health services and those delivered via telehealth between March through July 2020, compared to March through July 2019

Behavioral Health Services During COVID-19 Pandemic (Adults)

Outpatient mental health services and services delivered via telehealth among adults dropped from 159 per 1,000 beneficiaries in February to about 92 services per 1,000 beneficiaries in July



Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v4 in AREMAC, using final action claims. They are based on September T-MSIS submissions with services through the end of August. Recent dates of service have very little time for claims runout and we expect large changes in the results after each monthly update. Because data for August are incomplete, results are only presented through July 31, 2020.

Data for recent months are likely to be adjusted upward due to claims lag.

About

25 percent fewer

(7.8 million) outpatient mental health services for adults between March through July 2020, compared to March through July 2019 after accounting for the increase in services delivered via telehealth

Telehealth Follow-up Care in Kansas

Andrew Brown, Kansas Department for Aging and Disability Services
for Behavioral Health Services

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Background on Kansas Medicaid

- The Kansas Department for Health & Environment's Division of Health Care Finance (DHCF) is responsible for Medicaid KanCare program, CHIP, and the state-funded MediKan program
- On average, about 360,000 Kansans are enrolled in these programs each month, representing approximately 12% of the population
- Current 1115 Waiver 2019-2023
- Managed Care: 3 MCOs (Aetna, United, Centene)
- Largely rural and frontier state

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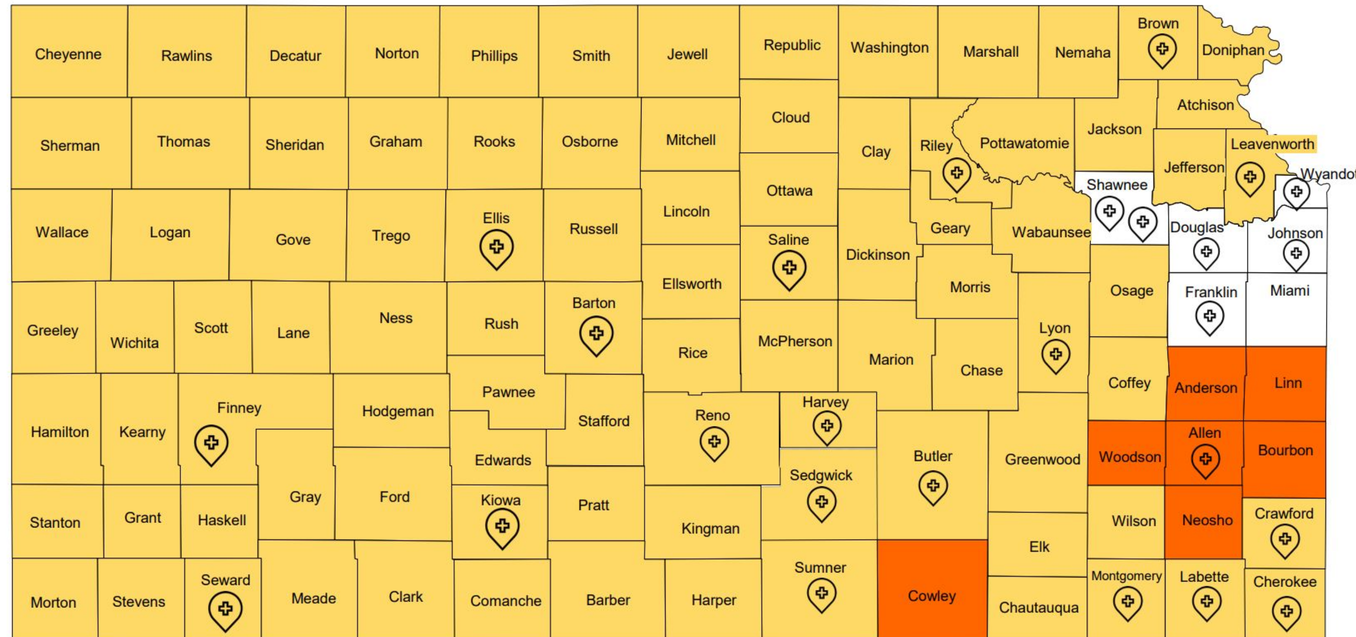
Background on Kansas Medicaid (continued)

Mental Health Professional Shortage Areas
Geographic and Low-Income County-Level Designations December 2020



County-level Mental Health HPSA Score of 18 or higher

County-level Mental Health HPSA Score of 17 or lower

Not eligible for County-level Mental Health HPSA score

Community Mental Health Center Location

Data Sources: Health Resources & Services Administration Data Warehouse, December 2020
Association of Community Mental Health Centers of KS, Inc., 2018

Data Note: HPSA scores shown are listed in Data Warehouse as of December 2020.
Updates to HPSAs made after this date are not reflected.

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Telemedicine in Kansas

- Assumptions from our 1115 Waiver
  - Telemedicine will enhance access to care
  - Telemonitoring will improve outcomes
  - Telementoring will increase provider capacity
- The goal of follow-up telehealth after a psychiatric hospitalization is to facilitate more successful community reintegration, especially in rural and frontier communities

  The Public Health Emergency prompted KDHE/KDADS to greatly expand telemedicine beyond original intention

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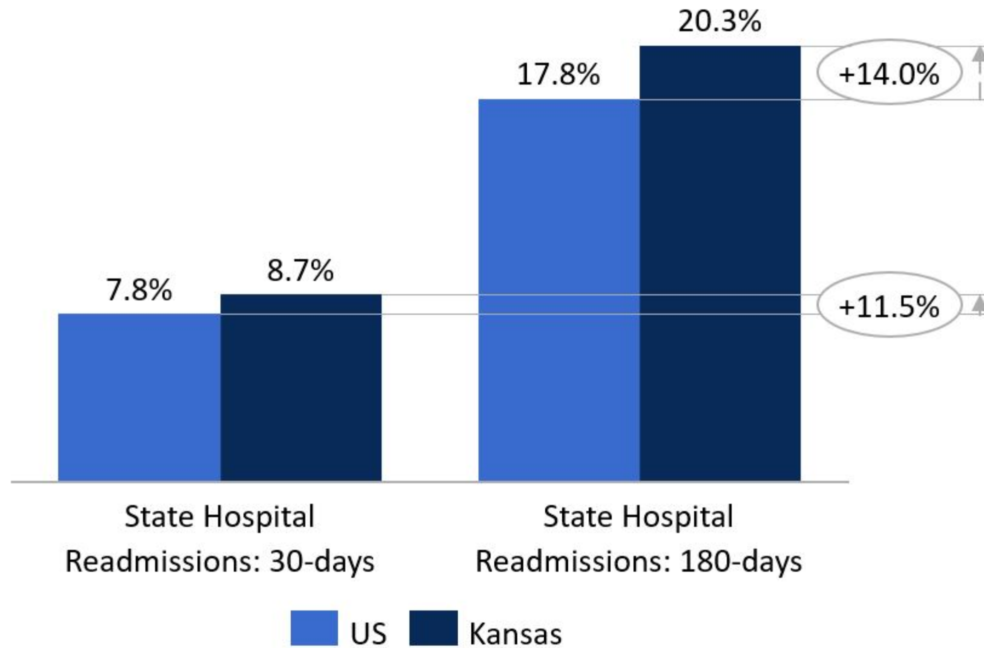
Impact of Telemedicine Follow-up Programs

Kansas has ~10-15% higher psychiatric hospital re-admission rates than the national rate

While Kansas' state and private psychiatric hospitals are exempt from readmission penalties, readmission increases cost of care



In rural & frontier areas with telemedicine follow-up programs:

- Kansas has seen decreases in psych hospital readmissions for those catchment areas of about 17%
- Providers report increased capacity and fewer missed appointments
- Patients report reduced symptoms and increased access to care

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Lessons Learned

- If the technology infrastructure exists and providers are willing, rural residents have demonstrated high rates of use
- Provider interest in offering telemedicine services can be hampered by high start-up costs, level of reimbursement, lack of telehealth training, and fears about quality of care
- Most utilization has been for behavioral health services, which includes mental health services and substance use disorder (SUD) services
- Patients without adequate devices or broadband may be unable to access telehealth services, telephonic services can help overcome this barrier

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Next Steps

- Impact of 988 on telemedicine follow-up opportunities
- Maintaining telemedicine expansion under COVID-19 national public health emergency
- Follow-up telemedicine for Mobile Crisis Response Teams
- ARPA opportunities to help provide needed infrastructure
- State legislation to support telehealth expansion

Contact Information

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Integrated Care in Oklahoma

Malissa McEntire

Oklahoma Department of Mental Health and Substance Abuse Services

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History of Integrated Care in Oklahoma

2015 OK Health Homes

2016 CCBHC Demonstration Grant

2017 CCBHC 2-year Planning Grant

2019 Oklahoma State Plan Amendment for CCBHC

Oklahoma CCBHC Core Components

- Care Coordination
- Crisis Services
- PCP Screening & Monitoring
- Outpatient Services (MH/SU)
- Outreach
- Targeted Case Management
- Psychiatric Rehabilitation
- Housing & Employment Services
- Screening, Assessment & Diagnosis
- Comprehensive Integrated Care Planning
- Integrated Care & Health Promotion
- Peer & Family Support Services
- Veterans Services

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Innovations

- **Aim to serve beneficiaries most in need**
  - Have had two or more psychiatric inpatient episodes in the past 12 months; OR
  - Have had three or more community based structured crisis episodes in the past 12 months; OR
  - Had have 12 or more emergency department visits with a mental health or substance abuse diagnosis; OR
  - Have had two or more substance abuse residential treatment episodes in the last 12 months (but will not be shown until admission due to confidentiality laws); OR
  - Has been discharged from a psychiatric inpatient episode in the last 90 days

Innovations

- **Clinical**
  - Dedicated Outreach Workers
  - Clinical Care Pathways
    - Emergency Department follow up
    - Hospital Follow Up
    - Suicide Risk Protocols
  - Care Coordination

- **Technology**
  - Telehealth
  - iPad
  - CHESS Health
  - Certified Electronic Health Record
  - Health Information Exchange
  - Population Health Care Management tool

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Evidence-Based Practices

- Critical Time Intervention (CTI)
- Individual Placement & Supports (IPS)
- Assertive Community Treatment (ACT)
- Flexible ACT (F-ACT)
- Motivational Interviewing
- Chronic Care Model
- Team Based Care

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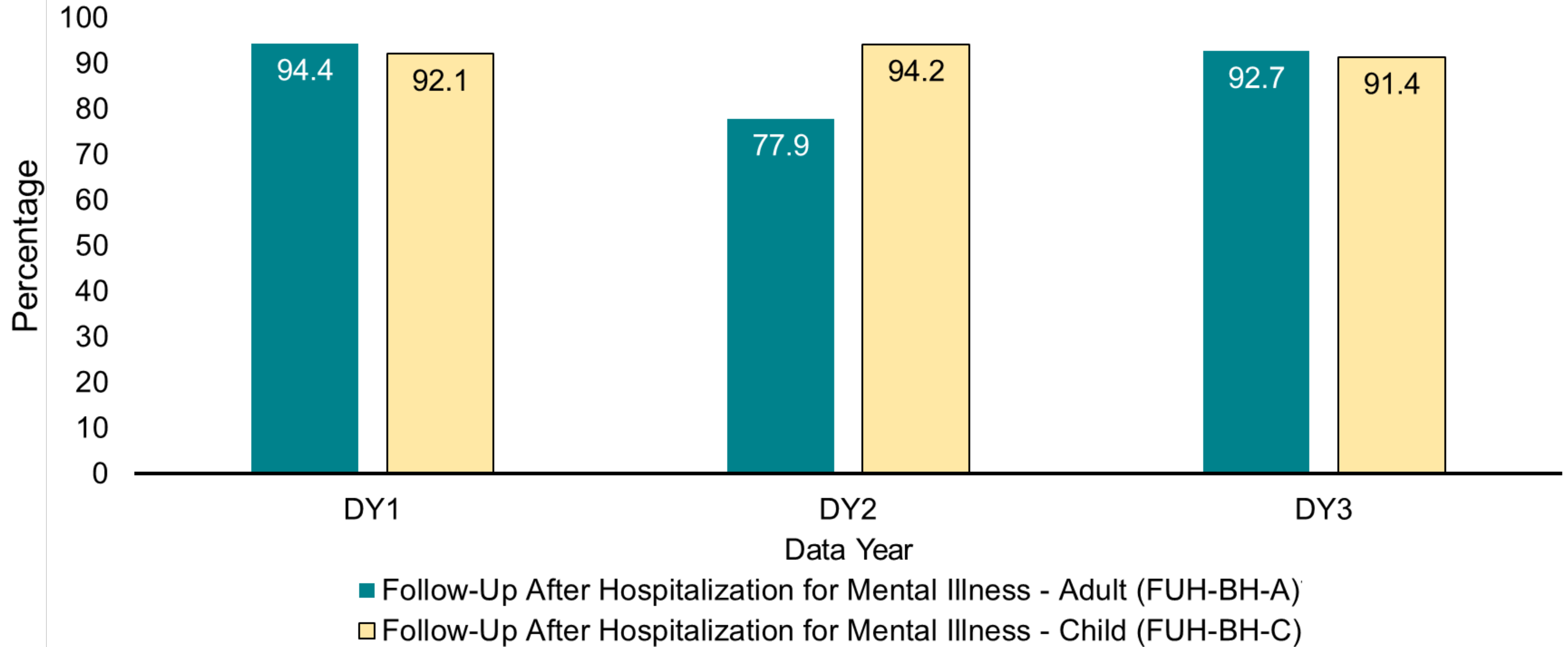
Quality Measures



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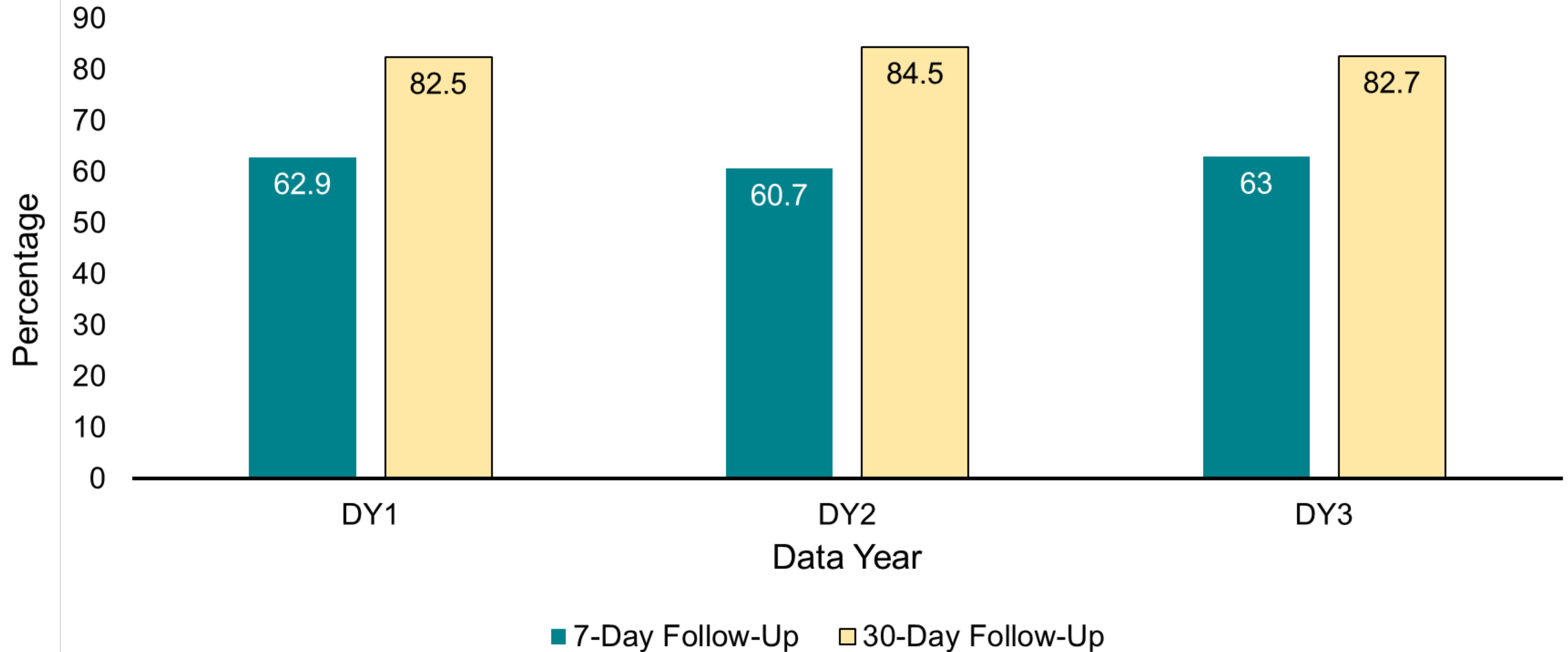
Quality Measures



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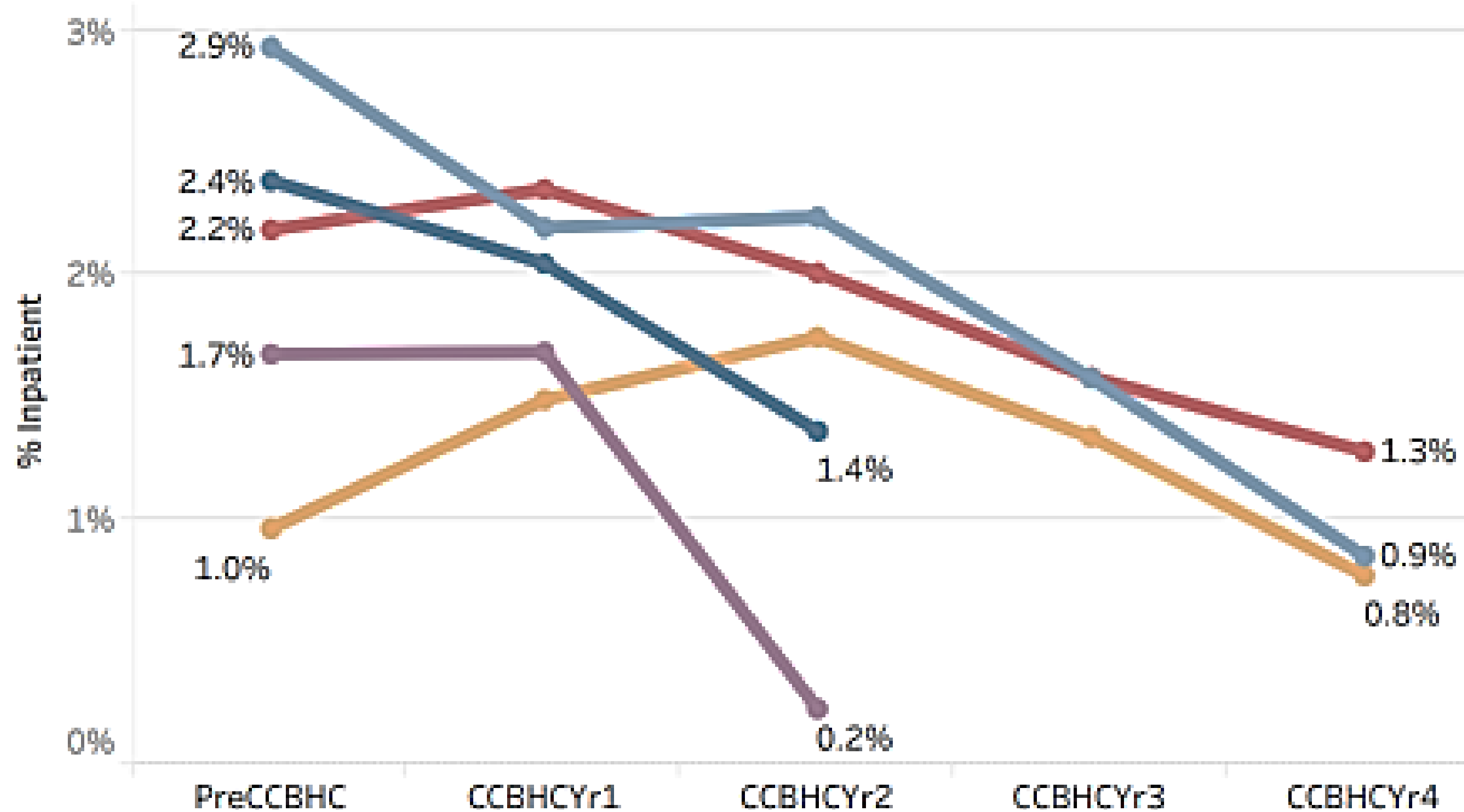
Data Dashboard



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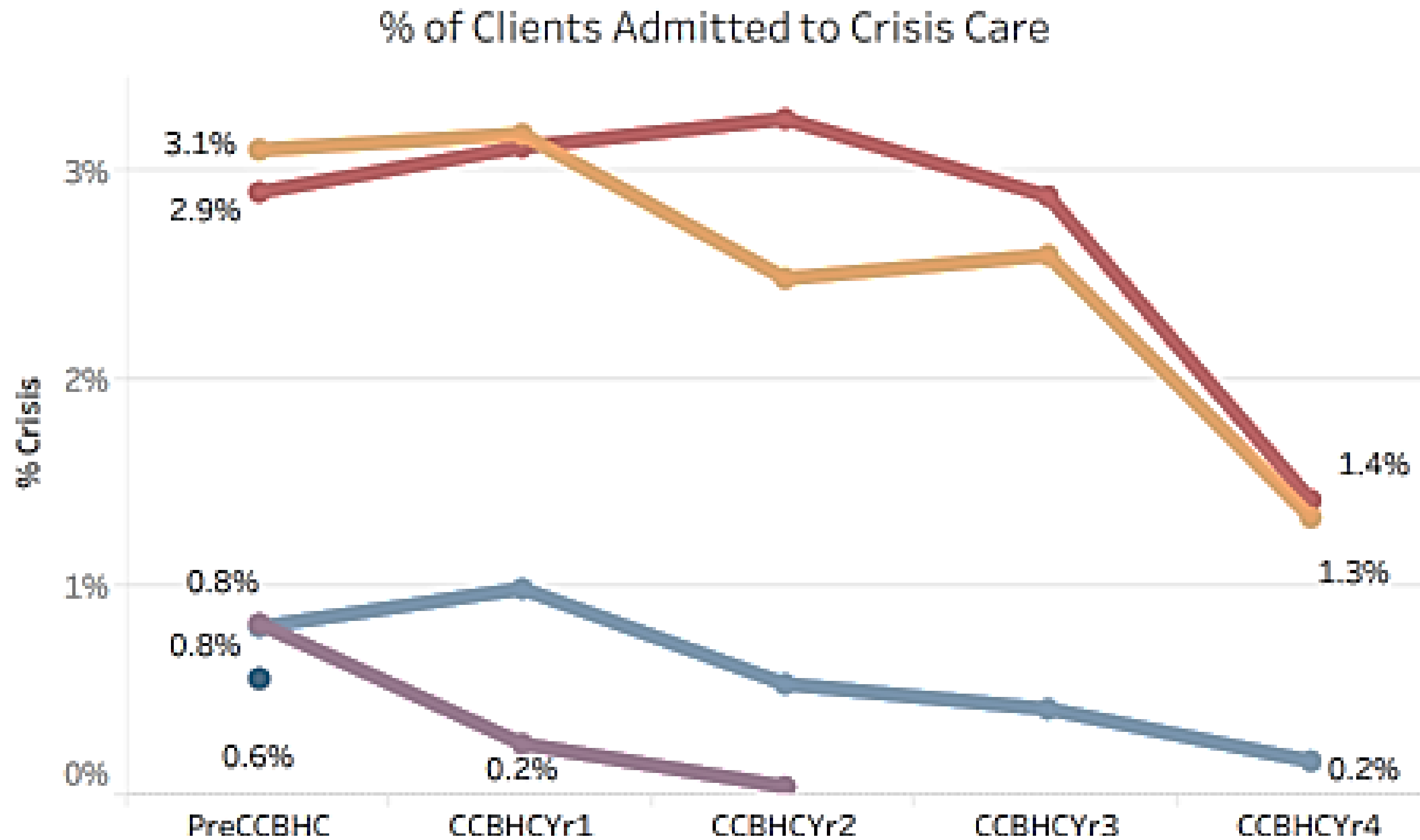

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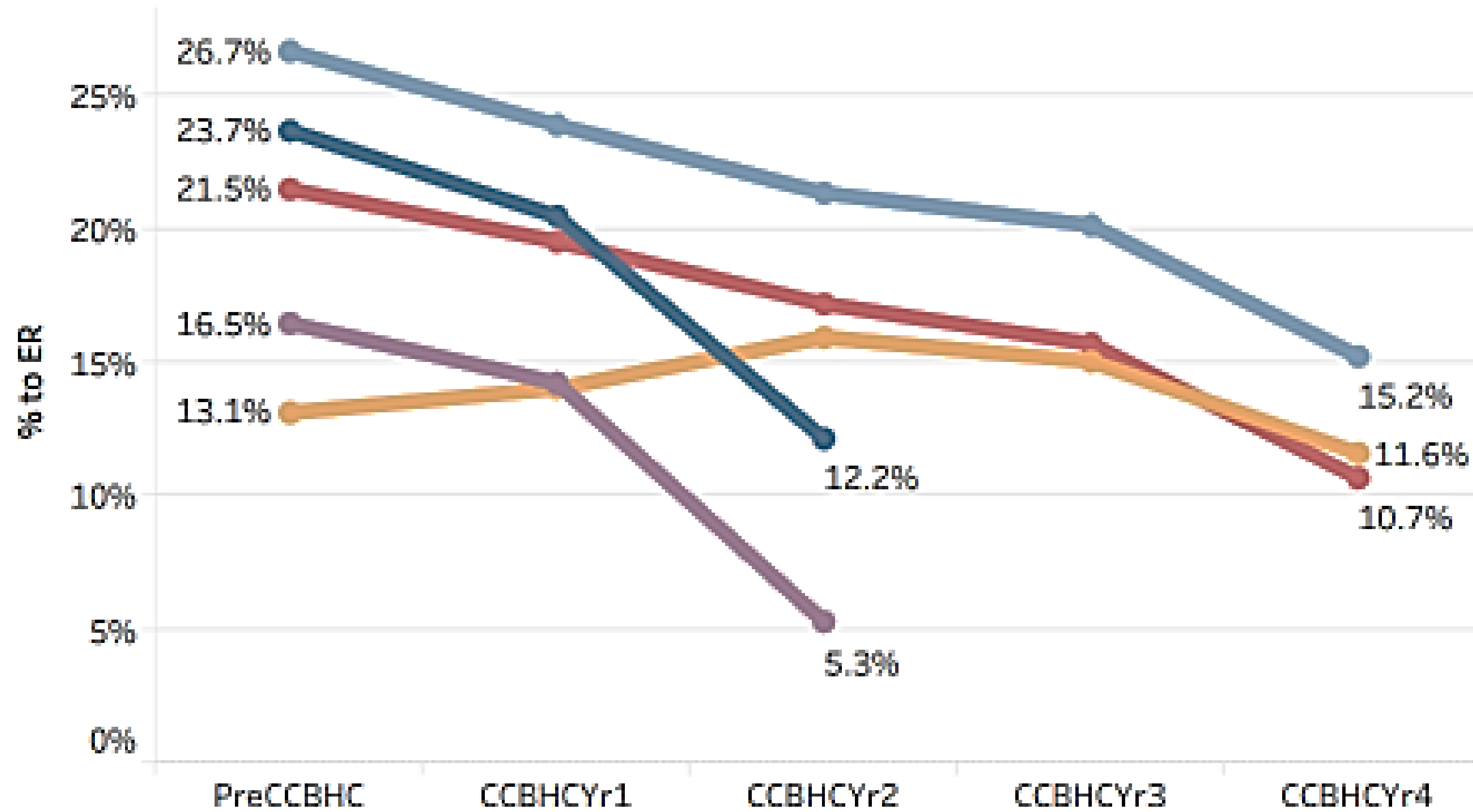

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Questions?

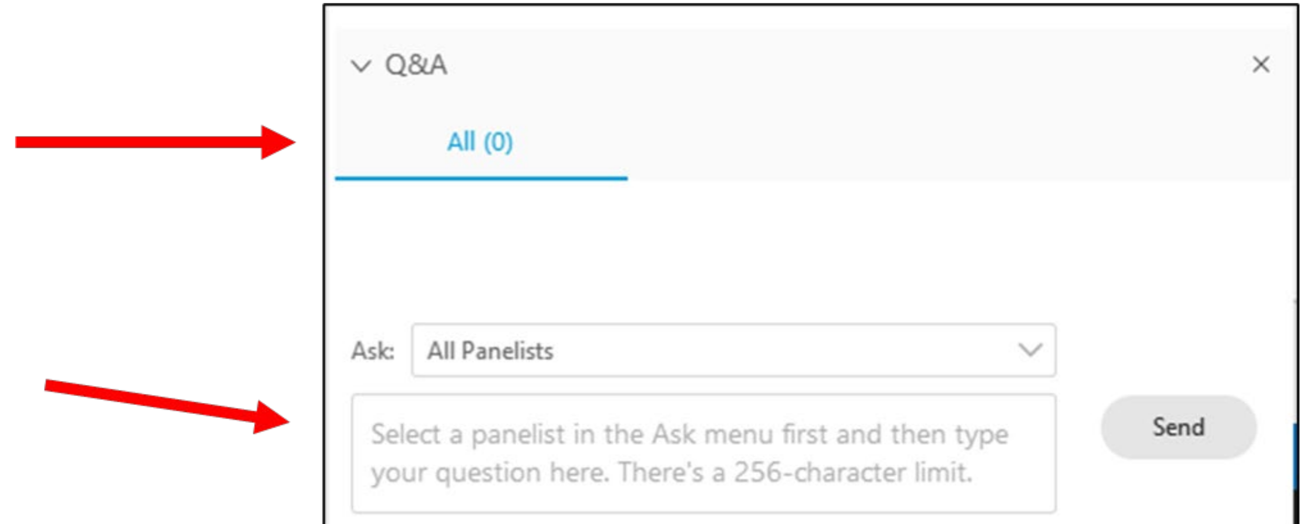
Malissa McEntire
Mmcentire@odmhsas.org

Questions & Answers

Michaela Vine, Mathematica

How to Submit a Question

- **Use the Q&A function to submit questions or comments:**
  - To submit a question or comment, click the Q&A window and select All Panelists in the "Ask" field.
  - Type your question in the text box and click Send.
  - Only the presentation team will be able to see your comments.



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Announcements and Next Steps

Mira Wang, Mathematica

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Announcements and Next Steps

- **Upcoming webinars**
  - **June 15, 2021, 12:00 p.m. ET** Affinity Group Information Session and Q&A
  - **June 29, 2021, 12:00 p.m. ET** Webinar #2: Leveraging Key Relationships in Improving Behavioral Health Follow-up Care
  - **July 15, 2021, 3:00 p.m. ET** Webinar #3: Using Data to Improve Access to Behavioral Health Follow-up Care
- **Register and view webinar recording and slides** https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/behavioral-health-learning-collaborative/index.html

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Announcements and Next Steps (continued)

- **Behavioral Health Follow-up Care Affinity Group Fact Sheet available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/improvement-initiatives/behavioral-health-ag-factsheet.pdf**
- **Behavioral Health Follow-up Care Affinity Group EOI forms are due by 8:00 p.m. ET on Thursday, July 15, 2021**
- **EOI forms are available at** https://www.medicaid.gov/medicaid/quality-of-care/downloads/improvement-initiatives/behavioral-health-ag-interest-form.pdf

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Thank you for participating!

- Please **complete the evaluation** as you exit the webinar

- If you have any **questions**, or we didn’t have time to get to your question, **please email**

MACQualityImprovement@mathematica-mpr.com

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