System Transformation

Strengthening through Collaboration

The ACO and The Designated Agencies

- We are Participants in the ACO, non-risk bearing
- Participating agencies receive a payment for participating in Care Coordination, a practice of designated agencies in both mental health and developmental services for decades
- Primary care receives Vermont Next Generation attributed lives and the DA receives the list to identify its clients
- DAs participate on Patient Care Navigation communication tool, are assigned as lead care coordinators, and participating teams
- At WCMHS, the payment for this participation is approximately $250,000 annually

WCMHS Investment

- In order to participate in this process, WCMHS has trained approximately 40 case managers and therapists; created a 6-person super user implementation team; assigns 15% of our Quality Director's time to this endeavor
- Director of Nursing facilitates monthly regional care coordination table
- Regional leadership of Executive Directors monthly
- Cost is currently being estimated

WCMHS Profile

- 2018 - WCMHS is lead care coordinator, with completed shared care plans for 58:220 high and very high risk clients with 872 open.
- 2019 – There will be some overlap but we have received a new list of patients/clients. There are 232 high and very high risk clients within WCMHS' care with 633 within the Berlin HSA and 933 statewide
- One Care tracks data on cost of care and utilization, asking for our investment in time and resources to reduce ER and in-patient utilization

Investment in Community Mental Health

- Plans for ACOs to invest in the DA community system has currently been through care coordination payments and Howard Center mental health supports within SASH program
- Recent RFP offered expanded opportunities for a response that would enhance integrated programming
- Multiple Designated Agencies responded to this $1,000,000 total opportunity with $250,000 cap
- ACOs had hoped to have more dollars for transformation but there was no state match to meet the dollar amount negotiated within the All Payer Model

Emergency Room Utilization
DA Participation in Care Coordination

High utilization is defined as 4 or more visits in 90 days. WCMHS began meeting with the Emergency Room on high utilizers in November 2017, identified individuals and implemented increased care coordination supports through our services: case management visits, psychiatric visits, phone supports, sharing care plans and crisis plans with the emergency room and employing joint strategies to reduce utilization. Visits were categorized and tracked as medical, psychiatric or unknown.

- November 2017 – 38
- February 2018 - 8
- May 2018 - 11
- August 2018 - 8
- November – 5

Reduction of 75% utilization of high utilization category during this period of time.

Increase in primary care providers for clients from 83.4% in 2017 to 93.5% in 2018

Note: Northwest Counseling Services has done excellent work in the area of ER Utilization reduction, as well.

WCMHS Proposal – One Example
Immediate Referral and Treatment Access Center to Prevent Need for Higher Levels of Care

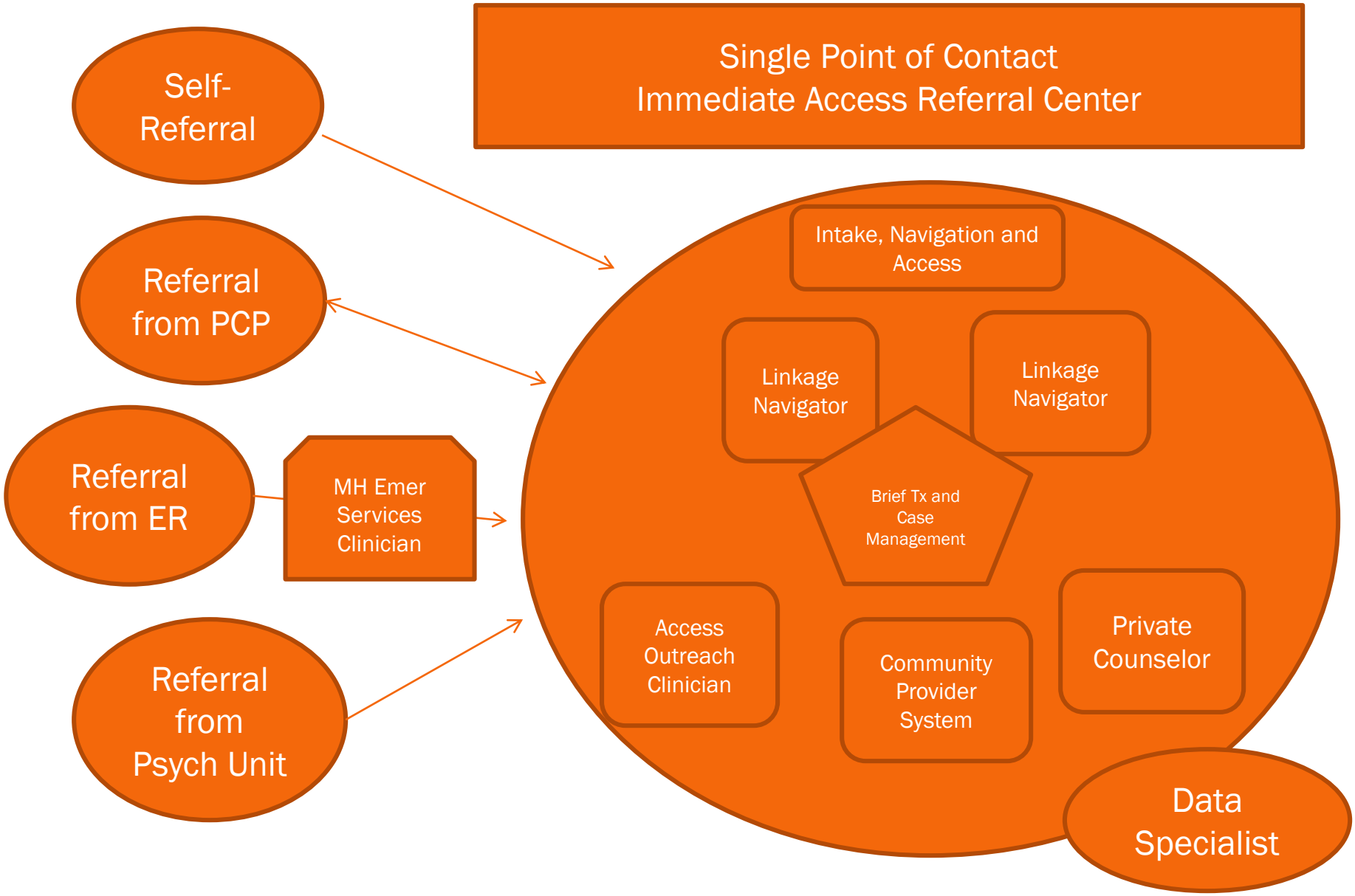
- Immediate **Access** to Out Patient Services for co-occurring mental health and substance use d/o --- NO WRONG DOOR; RIGHT ACCESS POINT; RIGHT TIME

- **Follow up** phone call for those who need/want treatment; tracking the individual to gauge engagement

- Facilitate **Care Coordination**, as appropriate

- Be a Resource for Teams/Providers Who Need **Assistance in Challenging Discharges** from Psychiatric Units and intensive/residential programs

Other DAs have written to do projects that will incorporate peers in the ER, streamline services between primary care and the agencies, enhance service delivery


Single Point of Contact
Immediate Access Referral Center
Self-Referral
Referral from PCP
Referral from ER
MH Emer Services Clinician
Referral from Psych Unit
Intake, Navigation and Access
Linkage Navigator
Linkage Navigator
Brief Tx and Case Management
Access Outreach Clinician
Community Provider System
Private Counselor
Data Specialist

Additional System Innovation to Reduce ER and Psychiatric In-Patient Utilization

- Impact of One Additional Emergency Services Outreach Clinician on ES Team decreased crisis ER utilization by 20% in one quarter

- Living Room model (alternative to ER) w/length of stay to be determined
  - staffed with peer supports, emergency services clinicians, physicians, psychiatrists and/or nurse practitioners
  - Data shows that 91% of hospital admissions are voluntary
  - Our statistics at CVMC show that we see 50% of our total emergency calls in the Emergency Room
  - Of the total screened in the Emergency Room, 70-72% return to the community
  - Of the total screened overall, only 28-30% are hospitalized
  - As CVMC responds to the system's call for in-patient beds for the cohort that is spending time in emergency rooms awaiting beds, we might consider how a Living Room model, where short term support and treatment could be provided, and could enhance an individual's ability to return home more quickly with supports. This would take an investment in the community system to shift the resource upstream and could be coupled with an Immediate Access Referral and Resource Center

Challenge is to Create a System

Utilize each other's strengths and ask :

Who Is Steering the Ship?

- Utilize strengths of the entire system, streamlining wherever possible with DAs, VNAs, AAAs, Blueprint, SASH, Parent-Child Centers; Housing Supports. Integrate therapists into primary care offices through the DA system through contractual arrangements
- Create a bridge between the physician's office and community services as in our WCMHS/Family Center ACES program with Pediatrics; Rutland case managers in FQHCs
  - Could SBINs be hired by DAs to create this bridge?
  - Identify roles so there is not overlap between VT Chronic Care Initiative, Blueprint, SBIRT, SBINS, SASH, DAs --- determine the optimum service for the need and collaborate whenever possible
- Investments in the system should be made based on proven gaps in care and not cause greater pressures downstream
- Develop a Resource & Referral Immediate Access Center for individuals needing immediate treatment
- Incentives should be offered for collaborations that close the gaps (HCRS Family Support program in Housing)
- Consider incentivizing timely discharge from psychiatric units
- Invest in programs that will move people from hospital to community with more fluidity
  - VAHHS/DA/DMH meetings throughout the year have concentrated on these areas of need

Maximize the Total Workforce, Close the Salary Gap, Enhance Quality of Service at the Entry Point for the Patient/Client

Oversight of System Development

- Vermont Legislature
- Agency of Human Services
- Green Mountain Care Board
- Families and Consumers

Testimony presented by: Mary Moulton, Executive Director Washington County Mental Health Services, Inc.

Vermont Care Partners
February 21, 2019