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Provider Network Forum

June 12, 2019



Announcements Beth Lackey

Odds & Ends about the webinar:

- ▶ Beth Lackey, Provider Network Director, is your moderator for today's webinar.
- ▶ The audience is in "listen only mode." You can only hear us talking, but you can't talk with us through the phone in an interactive way.
- ▶ You may submit questions from today's webinar to:
questions@partnersbhm.org



Odds & Ends continued...

- Today's webinar is recorded and will be posted to the Partners BHM web page under the Provider Knowledge tab. Any handouts will be uploaded to this page as well. Previous webinars are also on this page for your viewing pleasure!
- We encourage anyone who is a provider in Rutherford County, with any questions to submit questions here: Rutherford_Questions@PartnersBHM.org
- Rutherford providers can also access FAQ's about the transition here:
- <https://www.partnersbhm.org/wp-content/uploads/2019/04/Rutherford-FAQ-Providers.pdf>



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Provider Network Updates

Agenda

- ▶ Important highlights in the most recent communication bulletin
- ▶ Standard Plan Information
- ▶ Measurement Based Care



6/12/2019 7

Important Highlights from Recent Communications

<https://providers.partnersbhm.org/provider-bulletin-93/>



6/12/2019 8

Medicaid Transformation

<https://www.ncdhhs.gov/assistance/medicaid-transformation>



6/12/2019 9

Measurement Based Care

- ▶ Take aways from the CEO Roundtables
- ▶ Importance of Measurement Based Care
- ▶ Building blocks of Value Based Contracting



6/12/2019 10



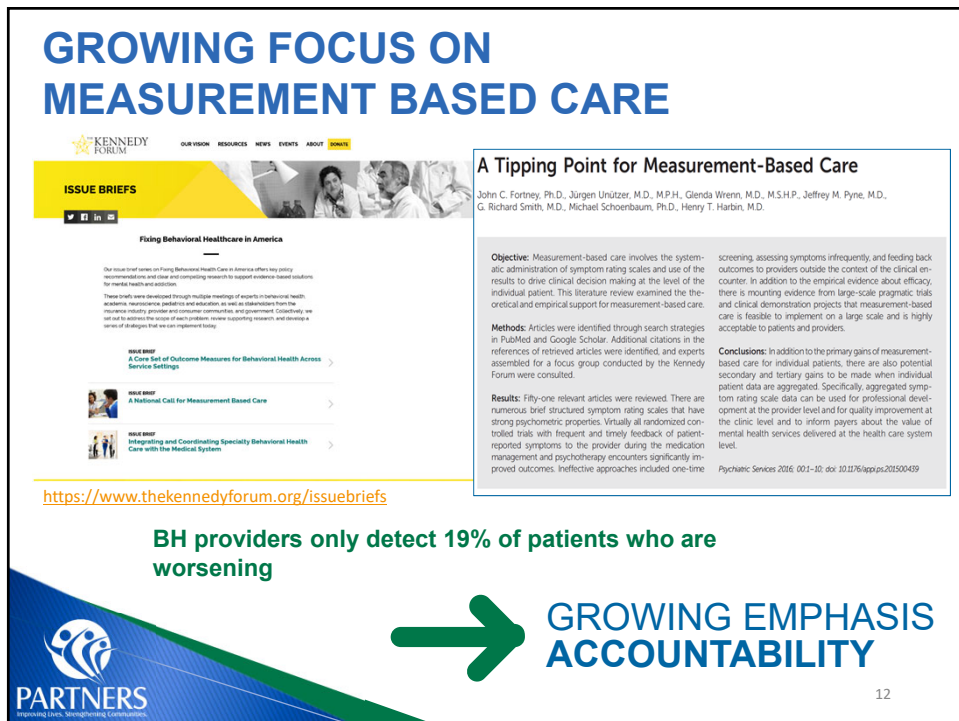
OPPORTUNITY

MBC IS A WIN AT ALL LEVELS

- PAYER**
Demonstration of value with consistent outcomes
- PROVIDER**
Clinical data on what's working and when people are not improving.
- PERSON**
Improved outcomes more rapidly, education, engagement.

11

GROWING FOCUS ON MEASUREMENT BASED CARE



ISSUE BRIEFS

Fixing Behavioral Healthcare in America

Our issue brief series on Fixing Behavioral Healthcare in America offers key policy recommendations and data and compelling research to support evidence-based solutions for mental health and addiction.

These reports were developed through multiple meetings of experts in behavioral health, academic, experiential, pediatric and education, as well as stakeholders from the insurance industry, providers and consumer organizations, and government. Collectively, we set out to address the scope of each problem, review supporting research, and develop a series of strategies that assure improvement in care.

ISSUE BRIEF
A Core Set of Outcome Measures for Behavioral Health Across Service Settings

ISSUE BRIEF
A National Call for Measurement Based Care

ISSUE BRIEF
Integrating and Coordinating Specialty Behavioral Health Care with the Medical System

<https://www.thekennedyforum.org/issuebriefs>

A Tipping Point for Measurement-Based Care

John C. Fortney, Ph.D., Jürgen Unützer, M.D., M.P.H., Glenda Wenn, M.D., M.S.H.P., Jeffrey M. Pyne, M.D., G. Richard Smith, M.D., Michael Schoenbaum, Ph.D., Henry T. Harbin, M.D.

Objective: Measurement-based care involves the systematic administration of symptom rating scales and use of the results to drive clinical decision making at the level of the individual patient. This literature review examined the theoretical and empirical support for measurement-based care.

Methods: Articles were identified through search strategies in PubMed and Google Scholar. Additional citations in the references of retrieved articles were identified, and experts assembled for a focus group conducted by the Kennedy Forum were consulted.

Results: Fifty-one relevant articles were reviewed. There are numerous brief structured symptom rating scales that have strong psychometric properties. Virtually all randomized controlled trials with frequent and timely feedback of patient-reported symptoms to the provider during the medication management and psychotherapy encounters significantly improved outcomes. Ineffective approaches included one-time screening, assessing symptoms infrequently, and feeding back outcomes to providers outside the context of the clinical encounter. In addition to the empirical evidence about efficacy, there is mounting evidence from large-scale pragmatic trials and clinical demonstration projects that measurement-based care is feasible to implement on a large scale and is highly acceptable to patients and providers.

Conclusions: In addition to the primary gains of measurement-based care for individual patients, there are also potential secondary and tertiary gains to be made when individual patient data are aggregated. Specifically, aggregated symptom rating scale data can be used for professional development at the provider level and for quality improvement at the clinic level and to inform payers about the value of mental health services delivered at the health care system level.

Psychiatric Services 2016 | 001-10 | doi:10.1176/appi.ps.201500439

BH providers only detect 19% of patients who are worsening

GROWING EMPHASIS ACCOUNTABILITY

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Engaging Data. Strengthening Connections.

12

PROCESS OF MEASUREMENT-BASE CARE



- + Systematic administration of symptom rating scales – use huddle or registry
 - + Measurement Based Care is NOT a substitute for clinical judgment
- + Use of the results to drive clinical decision making at the patient level – overcome clinical inertia
- + Patient rated scales are equivalent to clinician rated scales



SOURCE: Fortney et al Psych Serv Sept 2016

13

AGGREGATE DATA

- + Professional development at the provider level – MACRA, MIPS
- + Quality improvement at the clinic level
- + Inform reimbursement at the payer level



SOURCE: Fortney et al Psych Serv Sept 2016

14

INEFFECTIVE APPROACHES

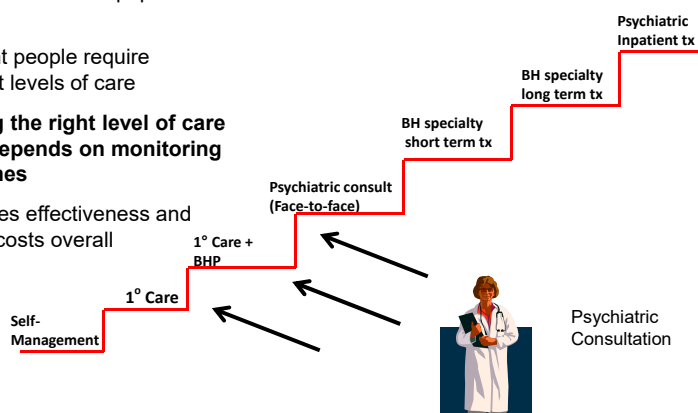
- + One-time screening
- + Assessing symptoms infrequently
- + Feeding back outcomes outside the context of the clinical encounter



15

STEPPED CARE APPROACH

- + Uses limited resources to their greatest effect on a population basis
- + Different people require different levels of care
- + **Finding the right level of care often depends on monitoring outcomes**
- + Increases effectiveness and lowers costs overall



SOURCE: Van Korff et al 2000

16

SCREENING: USE VALIDATED TOOLS

Mood Disorders	Anxiety Disorders	Psychotic Disorders	Substance Use Disorders	Developmental Screening
PHQ-9 Depression	GAD-7: Anxiety	Brief Psychiatric Rating Scale	CAGE-AID	ASQ
MDQ: Bipolar Disorder	PCL-C: PTSD		AUDIT-C	SWYC
CIDI: Bipolar Disorder	SCARED		DAST	CHAT
EPDS: Postnatal Depression	Mini Social Phobia	Positive and Negative Syndrome Scale	CRAFFT	PEDS
			BAM	

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17

VALIDATED SCREENING AND MEASUREMENT TOOLS

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: John Q. Sample DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)

	Not at all	A few days	More than a few days	Most or all of the time
1. Little interest or pleasure in doing things	0	1	✓ 2	3
2. Feeling down, depressed, or hopeless	0	✓ 1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	✓ 2	3
4. Feeling tired or having little energy	0	1	2	✓ 3
5. Poor appetite or overeating	0	✓ 1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	✓ 2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	✓ 2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	✓ 2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	✓ 0	1	2	3
add columns:	2	10	3	
TOTAL:	15			

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	✓
Somewhat difficult	
Very difficult	
Extremely difficult	

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PHQ 9 > 9

- < 5 – none/remission
- 5 - mild
- **10 - moderate**
- 15- moderate severe
- 20 - severe

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18

GAD-7

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
<i>Add the score for each column</i>	+	+	+	
Total Score (add your column scores) =				

Score ≥ 10 indicates possible diagnosis

CHILD AND ADOLESCENT

+PHQ-A –
Depression

+Vanderbilt –
ADHD

+SCARED

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____
Parent's Name: _____ Parent's Phone Number: _____

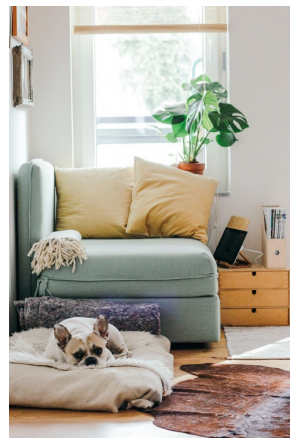
Directions: Each rating should be considered in the context of what is appropriate for the age of your child.
When completing this form, please think about your child's behaviors in the past 6 months.
Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3

FUNCTIONAL MEASUREMENT

- ▶ Identifying tools that support functional assessment including recovery factors:
 - SF-12, 24,
 - DLA-20,
 - Illness Management & Recovery Scale (Dartmouth)
 - Mental Health Recovery Measure
 - Employment Ratings
 - Housing Stability
 - Quality of Life

Behavioral health is better suited for helping to define measurement of social determinants of health.



INTELLECTUAL AND DEVELOPMENTAL DISABILITY MBC TOOLS

- ▶ A1c or Blood Pressure could be important treat to targets for MBC
- ▶ Satisfaction with Life Scale
- ▶ Council on Quality and Leadership (CQL) created a set of Personal Outcome Measures (POMs) (myself, my world, my dreams)
 - Find a sub-section that can be used for measurement?
- ▶ Maryland Ask Me! Survey
- ▶ QOL-Q (Proprietary so have to pay for it)
- ▶ **Tool needs to be Likert-type with quantifiable score, has option for proxy scoring in addition to self-report, be brief, and be measurement oriented—can repeat regularly and see change.**



SCREENING, DIAGNOSTIC, OR MEASUREMENT TOOL?

+ Some tools are *for screening* – examples:

- + PHQ2/9/A
- + GAD2/7
- + Vanderbilt
- + CIDI
- + PTSD – PC
- + AUDIT

+ **None of these are diagnostic** – need to add a dose of clinical judgment and make a diagnosis

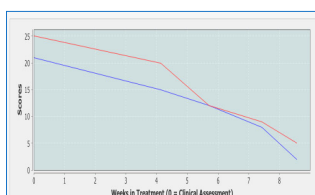
+ Some of these tools are *validated measurement tools* – examples:

- + PHQ9
- + GAD7
- + Vanderbilt
- + SCARED (children)
- + BAM – Brief Addiction Monitor

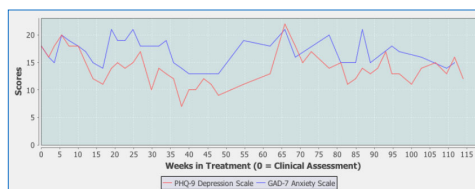


23

MEASUREMENT AND TREAT TO TARGET AT PATIENT LEVEL



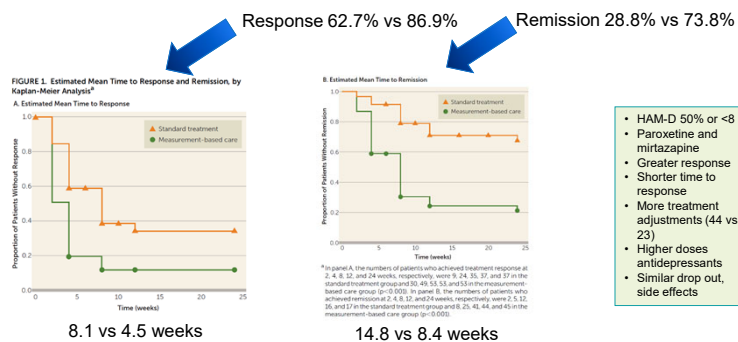
TREAT TO TARGET AT THE PATIENT LEVEL
Identify need for step in care



24

MEASUREMENT BASED CARE

TREAT TO TARGET



Quo T, Correll, et al. *American Journal of Psychiatry*, 172 (10), Oct, 2015 25

WHAT IS A REGISTRY?

- + Systematic collection of a clearly defined set of health and demographic **data** for patients with specific health characteristics
- + Held in a central **database** for a predefined purpose
- + Medical registries can serve **different purposes**—for instance, as a tool to monitor and improve quality of care including risk stratification, or as a resource for epidemiological research.



26

HOW CAN A REGISTRY HELP?

- + Keep track of all clients so no one “falls through the cracks”
 - + Up-to-date client contact information
 - + Referral for services
- + Tells us who needs additional attention
 - + High risk individuals in need of immediate attention
 - + Clients who are not following up
 - + Clients who are not improving
 - + Reminders for clinicians & managers
 - + Customized caseload reports
- + Facilitates communication, specialty consultation, and care coordination
- + Helps to stratify risk
 - + Concentrate resources where needed most
- + Choose the initiative most likely to have significant impact and use to focus educational efforts



27

MEASUREMENT DATA



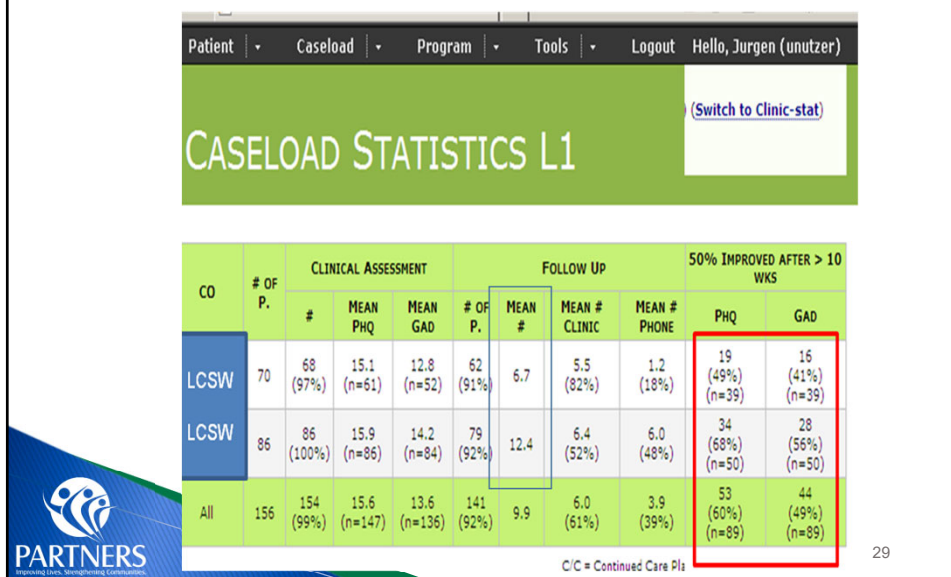
			Treatment Status				PHQ-9				GAD-7				Psychiatric Consultation	
			Indicates that the most recent contact was over 2 months (60 days) ago				✓ Indicates that the last available PHQ-9 score is at target (less than 5 or 50% decrease from initial score) ↓ Indicates that the last available PHQ-9 score is more than 30 days old				✓ Indicates that the last available GAD-7 score is at target (less than 10 or 50% decrease from initial score) ↓ Indicates that the last available GAD-7 score is more than 30 days old					
View Record	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Consultant Note
View	Active	Susan Test	9/5/2015	2/23/2016	10	26	22	14	-36%	2/23/2016	18	17	-6%	1/23/2016	Flag for discussion & safety risk	1/27/2016
View	Active	Albert Smith	8/13/2015	12/2/2015	7	29	18	17	-6%	12/2/2015	14	10	-29%	12/2/2015	Flag for discussion	
View	Active	Joe Smith	11/30/2015	2/28/2016	6	14	14	10	-29%	2/28/2016	10	6	-40%	2/28/2016	Flag for discussion	2/26/2016
View	Active	Bob Dolittle	1/5/2016	3/1/2016	3	9	21	19	-10%	3/1/2016	12	10	-17%	3/1/2016	Flag as safety risk	2/18/2016
View	Active	Nancy Fake	2/4/2016	2/4/2016	0	4	No Score				No Score					
View	RP	John Doe	9/15/2015	3/6/2016	10	25	20	2	-90%	3/6/2016	14	3	-79%	3/6/2016		2/20/2016



University of Washington
AIMS Center www.aims.edu

28

AGGREGATE DATA TO MEASURE PERFORMANCE ON A CLINICIAN LEVEL



29

ROLLING MBC UP TO NETWORK LEVEL PERFORMANCE MEASURES

Network of Providers

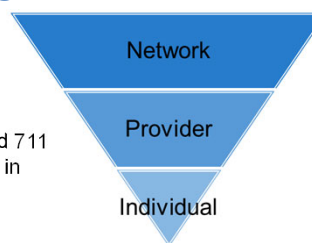
- ✓ Percent with 50% reduction PHQ-9 – NQF 184 and 185
- ✓ Percent reaching remission (PHQ-9 < 5) – NQF 710 and 711
- ✓ 80% of individuals served see a 50% reduction or better in symptoms within X number of weeks.
- ✓ % reduction in psychiatric/medical hospitalizations

Provider

- ✓ 80% of clients have a 50% or greater reduction in symptoms
- ✓ 75% of clients complete treatment in 12-15 weeks (could be by conditions or sub-population)
- ✓ Average number of treatment adjustments is 40 (could be by condition or sub-population)
- ✓ 60% of providers are reaching initial treat to target of 40% reduction in X timeframe

Individual

- ✓ 45% reduction on PHQ-9
- ✓ 60% reduction on GAD-7



30

EXAMPLE OF METRICS—INTEGRATED CARE

Population

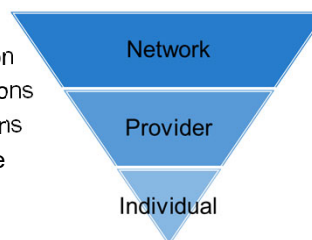
- ▶ % reduction in emergency department utilization
- ▶ % reduction in psychiatric/medical hospitalizations
- ▶ % decrease in costs for chronic health conditions
- ▶ % with readmission within 30 days of discharge

Network of Providers

- ▶ % of individuals screened for BH conditions
- ▶ % of individuals screened for chronic health symptoms
- ▶ % of individuals with a 50% or more reduction in BH symptoms (NQF)-MBC
- ▶ % with controlled medical conditions (A1c, Hyper-Tension, etc.)-MBC

Individual Provider

- ▶ % of warm handoffs between providers (process measure)-Tracked in Registry
- ▶ % of individuals with improved activation/engagement in services
- ▶ % of individuals with adherence to medications as prescribed
- ▶ The number of individuals with two or more follow-ups in a month (process measure)-Tracked in Registry



31

Why Measurement Based Care?

MBC is a path to measurement of value

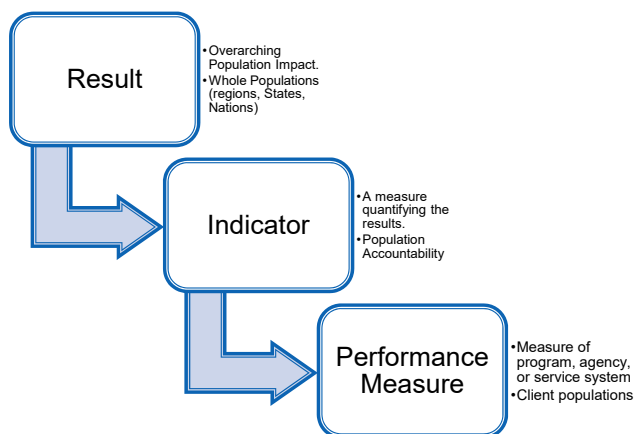
- ▶ MBC supports focus on quality, treatment adaptations, and ultimately value.
- ▶ MBC provides valuable data to the individual, the individual provider, the provider organization, and the payer.
- ▶ MBC data can support achievement of performance measures AND roll into performance measures.
- ▶ Allows behavioral health to demonstrate value and ultimately enhance payment for needed resources.



6/12/2019 32

Population Results/Indicators

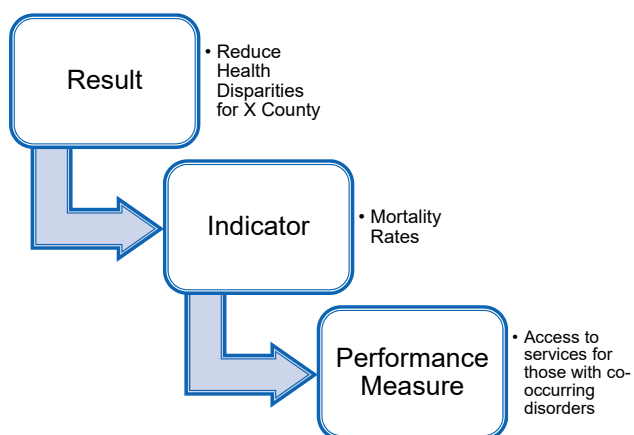
Collective impact of the network—what's the impact on the population?



6/12/2019 33

Population Results/Indicators

Collective impact of the network—what's the impact on the population?



6/12/2019 34

Beneficial Effects of Interventions to Reduce Risks of CVD- Small Changes Have Significant Results

Example:

- ✓ Blood cholesterol
10% ↓ = 30% ↓ in CHD (200-180)
- ✓ High blood pressure (> 140 SBP or 90 DBP)
~ 6 mm Hg ↓ = 16% ↓ in CHD; 42% ↓ in stroke
- ✓ Diabetes (HbA1c > 7)
1% point ↓ HbA1c = 21% dec in DM related deaths, 14% decrease in MI, 37% dec in microvascular complications
- ✓ Cigarette smoking cessation
~ 50% ↓ in CHD
- ✓ Maintenance of ideal body weight (BMI = 18.5-25)
- ✓ Loss of 5-10% can be clinically significant
35%-55% ↓ in CHD
- ✓ Maintenance of active lifestyle (~30-min walk daily)
35%-55% ↓ in CHD



Stratton, et al. *BMJ* 2000
 Hennekens CH. *Circulation* 1998;97:1095-1102.
 Rich-Edwards JW, et al. *N Engl J Med* 1995;332:1758-1766.
 Bassuk SS, Manson JE. *J Appl Physiol* 2005;99:1193-1204

Source: HMA presentation

6/12/2019 35



Partners and Provider Organizational Readiness

Recap: Building Blocks of Readiness for Value Based Payment /Contracting

- ✓ Evaluate operations and strategic revenue use
 - Identify and review cash reserves for sustainability and future allocation of funds (technology/tools, training/billing capacity)
- ✓ Segment clients by risk/need and evaluate data related to clients' costs of care
 - Use data to create baseline for clients costs by segment
 - Build information regarding costs associated with serving segmented populations (at more or less need and/or risk)
 - Identify cost to provide unbillable services, e.g. operational support tied to individual services per segmented populations
 - Leveraging information and segment behavioral health to establish VBP pilot project most representative of your population and establish a system of shadow accounting



6/12/2019

Performance Measures and VBP

38

Standard	National Quality Forum Number
BMI Screening and Follow-up Adults	NQF 0421
BMI Screening and Follow-up Children	NQF 0024
Controlling High Blood Pressure	NQF 0018
Tobacco Use Screening and Cessation Intervention	NQF 0028
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications	NQF 1932
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NQF 2607
Metabolic Monitoring for Children and Adolescents on Antipsychotics	NQF 1933
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	NQF 1933



Process Metrics for VBP Pilot on MBC

TIER ONE

- ✓ Provider is using a validated screening/measurement symptom rating tool for a defined population;
- ✓ Provider is engaged in routine and frequent measurement of symptoms (at least monthly) and;
- ✓ Provider is tracking the target population and measurement in a registry or database.

TIER TWO

- ✓ Provider meets Tier One process metrics;
- ✓ Provider is tracking number of changes in treatment as a result of measurement (data);
- ✓ Provider is engaged in routine follow-up and care management to improve symptom scores (at least 2 contacts per month) and;
- ✓ Provider can report out on aggregate symptom rating change for target population.



HEALTH MANAGEMENT ASSOCIATES

6/12/2019 39

Outcome Metrics for VBP Pilot on MBC

TIER ONE

- ✓ Provider can demonstrate that 30% of target population had a 50% or higher reduction in treatment.

TIER TWO

- ✓ Provider can demonstrate that 50-75% of target population had a 40% or higher reduction in treatment.

TIER THREE

- ✓ Provider can demonstrate 75% or higher of target population had a 50% or higher reduction in treatment and/or
- ✓ Provider can demonstrate that 10-20% of target population reached remission in treatment.



HEALTH MANAGEMENT ASSOCIATES

6/12/2019 40

Recap: Value Based Payment/Contract Model Readiness

- ✓ Value Based Payment/Contracting requires data analysis of underlying client care costs and strategies for optimizing operational efficiency inside and outside the organization.
- ✓ To understand costs, must assess and bench mark financial and operational capacities and systems including:
 - Care Cost of programs/products including costs across units including capacity and productivity
 - Care Process(es) and their effectiveness
 - Care outcomes
 - Consumer satisfaction/perception of care
- ✓ Objective is to assess and benchmark to improve effectiveness and identify efficiencies.



6/12/2019 41



Standard/Tailored Plans

6/12/2019 42

Standard/Tailored Plans

https://i2icenter.org/wp-content/uploads/2019/06/Standard-Plan-NEW-power-point_.pdf



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Housing First

What is Housing First?

It is an evidenced based approach that prioritizes permanent housing with few to no treatment preconditions, behavioral contingencies, or other barriers.



Housing First supports people who are homeless and living with mental illness by combining the immediate provision of permanent housing with wrap-around supports.



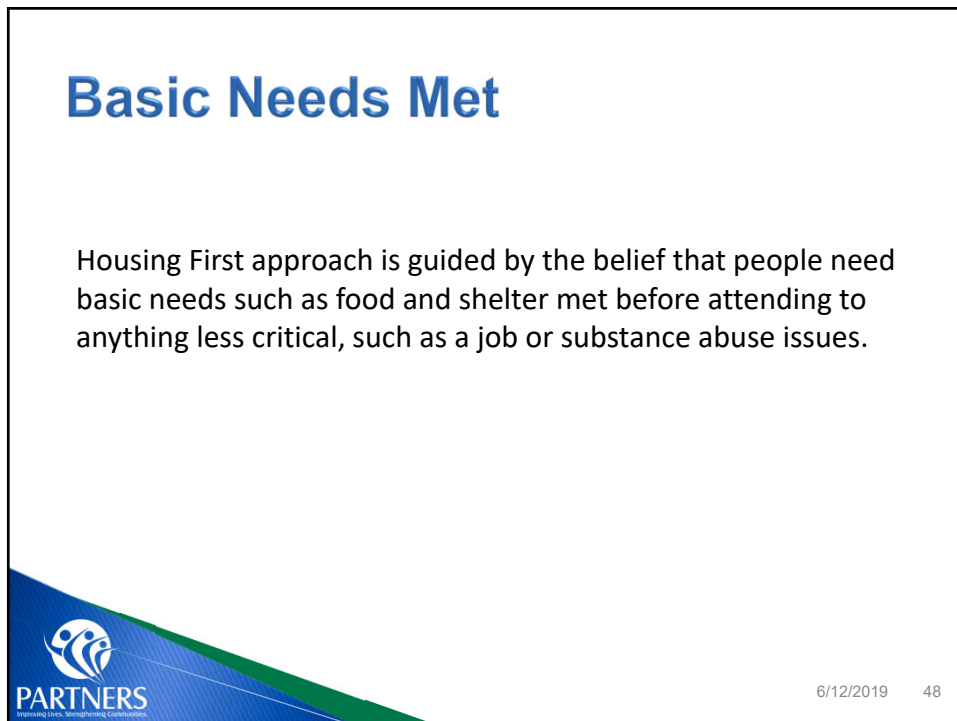
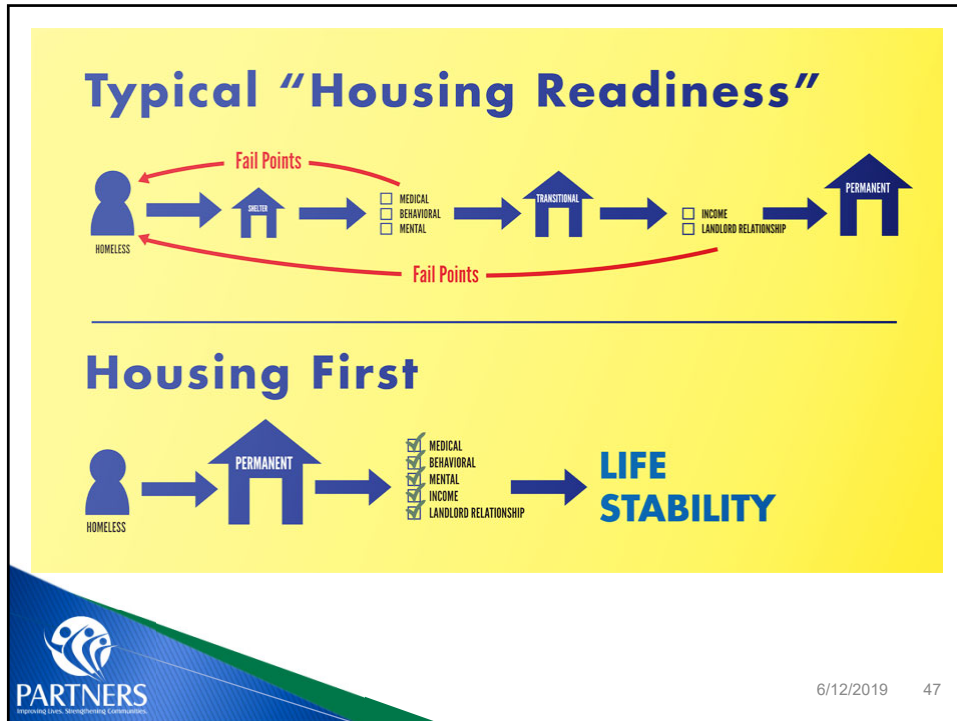
6/12/2019 45

Typical Housing Model

- ▶ Applicants must have income
- ▶ Applicants must be clean and/or sober
- ▶ Applicants must complete treatment/ be in services
- ▶ Applicants must not have a criminal record
- ▶ Applicants must be “ready”



6/12/2019 46



**Housing
First =**



Permanent Housing & Wrap Around Supports



6/12/2019 49

Principles

- ▶ Housing First does not require that members address all of their problems, including behavioral health or substance abuse issues, before they can access housing.
- ▶ Housing First does not mandate participation in services to either obtain or maintain housing.



6/12/2019 50

Services

- ▶ Wraparound Supportive Services are offered to members
- ▶ Studies have found that applicants having a choice and autonomy increases their participation and success rates in services, often resulting in housing stability
- ▶ More likely to participate in job training, attend school, discontinue substance abuse, spend less time in the hospital



6/12/2019 51

Housing First Program Options

- ▶ Permanent Supportive Housing-targeted to people with disabilities who have experienced homelessness. It provides long term rental assistance and supportive services
- ▶ Rapid Re-housing-targeted to a wide range of people and provides short term rental assistance and services. The goal is to help people obtain housing quickly, increase self-sufficiency, and remain housed.



6/12/2019 52

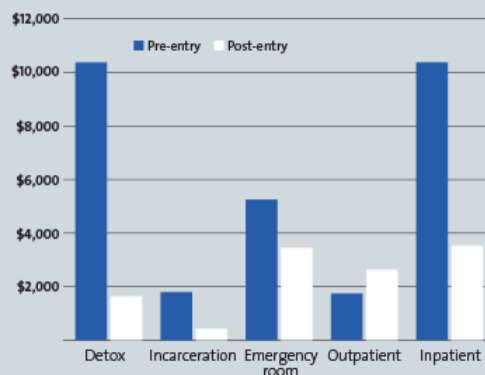
Cost Savings

- Studies have shown that permanent supportive housing (housing first model) is more cost effective. Housed people are less likely to use emergency services, including hospitals and jails.
- Permanent Supportive Housing is less expensive than shelters per year per consumer.



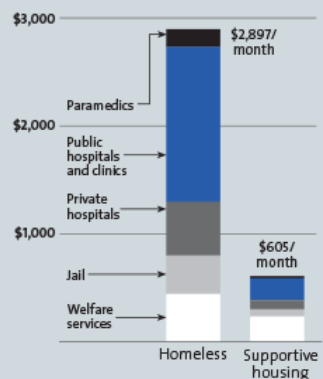
6/12/2019 53

Housing First saved Denver \$17,858 per person over 2 years in these costs alone:



Sources: Colorado Coalition for the Homeless, Economic Roundtable

A person on LA's Skid Row costs 5 times as much as one in Housing First:



Mother Jones



6/12/2019 54

Social Determinant of Health

Affects of Housing on Health

- ▶ Unstable Housing has higher rates of suicide
- ▶ Sexual Assaults
- ▶ Infectious Diseases (tuberculosis)
- ▶ Chronic Health Problems
- ▶ Loss of Self Esteem
- ▶ Increased Risk of Entering Criminal Justice System
- ▶ Mental Health and Addiction Issues



6/12/2019 55

Stable Housing

Once Housed, people show consistent improvement in the following areas:

- Better Health
- Reduced Hospital Stays
- Reduced Healthcare Costs



6/12/2019 56

Quick Screening: Does Your Group Use Housing First Principles?

- ▶ Are members allowed to enter housing without income?
- ▶ Are members allowed to enter housing even if they aren't "clean and sober" or "treatment compliant"?
- ▶ Are members allowed to enter housing even if they have criminal justice involvement?
- ▶ Are members allowed to enter housing even if they refuse service and treatment plans?



6/12/2019 57

So Why Housing First?

Studies have shown that Housing First produces higher housing retention rates, reduces the use of costly crisis services and helps people achieve better health and social outcomes



6/12/2019 58

Questions?



6/12/2019 59

Contact Information

Bre Griffin, Housing Educator

704-884-2514

bgriffin@partnersbhm.org

Or

Teena Willis, Housing Manager

828-323-8084

twillis@partnersbhm.org



6/12/2019 60



Provider Monitoring Training



Enrollment

Enrollment and NC Tracks

DANIELLE R. CLARK-ENROLLMENT
SUPERVISOR



Enrollment in Alpha

- ▶ Provider Network Enrollment staff verifies that the provider is:

- Credentialed with Partners
- Enrolled in NC Tracks

If credentialed and enrolled in NC Tracks:

Enrolled in Alpha MCS
Contract issued



If Provider NOT Enrolled in NC Tracks

- ▶ Partners cannot Enroll provider in Alpha and cannot issue a contract



Common Enrollment Issues for associated clinicians

- ▶ Practice address is not under Name/Address Tab in NC Tracks
- ▶ License has expired
- ▶ Clinician not Affiliated with agency in NC Tracks
- ▶ Taxonomy is not loaded in NC Tracks/NPPES
- ▶ Taxonomy is not an acceptable billing taxonomy



Enrollment Cannot

Make any changes in Alpha until the changes can be verified in NC Tracks.

Accept a managed change request as proof changes have been made.



If Enrollment Status Letter is received

- ▶ Once the manage change request is approved-Please let enrollment staff know, so that the changes can be verified.
- ▶ Enrollment staff do not go back and check NC Tracks for changes unless they are notified.



If you have Enrollment Questions

- ▶ Enrollment group email address is enrollment@partnersbhm.org
- ▶ Danielle R Clark-Enrollment Supervisor can be reached directly at dclark@partnersbhm.org or 828-325-8158



Credentialing

Personnel Change

- ▶ Credentialing Supervisor: Jason Arenillas
- ▶ Email: Jarenillas@partnersbhm.org
- ▶ Phone #: (828) 325 8142



6/12/2019 71

CAQH

- ▶ All clinicians must ensure that their CAQH information is up-to-date:
 - A state release will become available in CAQH once credentialing staff add the clinician to the CAQH Partners BHM roster
 - Credentialing staff will notify the agency and clinician once they are added to the CAQH Partners BHM roster
 - The state release can be found in the document section in CAQH, sign and date and upload back into CAQH



6/12/2019 72

Re-Credentialing/Contract Notices

- Six Months prior to the expiration of credentialing each provider (clinicians, LIPs as well as agencies) receives a re-credentialing notification.
 - The notice to associated clinicians and LIPs goes to the last e-mail address on file for the clinician/LIP.
 - The notice for agency re-credentialing goes to the agency credentialing primary contact via e-mail as well as to the CEO via certified mail.
- If Partners BHM has not received an application 90 days prior to credentialing expiration then providers receive another e-mail notification.
 - Agencies and LIP's also receive a contract warning notice via certified mail at this point.
- If an application is not received prior to the expiration date of credentials then the No further notification is sent to associated clinicians. clinician is removed from the network.
- If Partners BHM has not received a **complete** re-credentialing application from LIPs and agencies **60 days prior to credentialing expiration** then Partners BHM issues a **contract non-renewal letter** via certified mail ending your participation in the Partners BHM network effective the date of the credentialing expiration. Partners BHM is required to begin notifying consumers that the provider is no longer eligible to offer services in the network at this point.



6/12/2019 73

Agency/LIP Application Deadlines

- ▶ The application must be **complete** (information in the application is correct/accurate and no additional information is needed) in order to avoid or stop the contract non-renewal process.
- ▶ **Please remember: the contract non-renewal process can be avoided entirely by submitting your complete re-credentialing application in advance of the deadline specified in the notification(s) you receive from us.**



6/12/2019 74

Credentialing vs. Enrollment

- ▶ Credentialing and enrollment are two different processes and departments within Partners BHM.
- ▶ Partners BHM enrollment is separate from NC Tracks enrollment.
- ▶ Application for enrollment with NC Tracks should be completed first (for providers who are new to Partners).
- ▶ While the NC Tracks application is being processed, the provider should apply for credentialing with Partners.
- ▶ The **credentialing** application process with **Partners** **CAN** be completed while enrollment with **NC Tracks** is still **pending**.
- ▶ **Enrollment** (in Alpha) with **Partners** **CANNOT** be completed until enrollment with **NC Tracks** is **completed**.



6/12/2019 75

Credentialing vs. Enrollment (cont)

A provider CAN be **credentialled** with Partners BHM BEFORE being **enrolled** with NC Tracks OR Partners BHM.

A provider CANNOT be **enrolled** with Partners BHM before being BOTH **enrolled** in NC Tracks AND **credentialled** with Partners BHM.

- ▶ When initiating credentialing for an agency, be sure to submit the Provider Change Form to initiate credentialing for the associated clinicians that will provide the services with the agency at the same time.
- ▶ The Provider Change Form lists out all the information needed to initiate credentialing for a clinician



6/12/2019 76

NPPES

- ▶ Addresses, taxonomies, NPI numbers must all match in NC Tracks, NPPES and Alpha.
- ▶ Inconsistencies among these databases will not stop your credentialing application from being processed but **will** prevent you from billing
- ▶ NPPES must have the most current address/taxonomy information for the agency under the NPI# associated with each site.
- ▶ Credentialing will verify that the site/taxonomy in the application are registered in NPPES under the NPI# listed for it.



6/12/2019 77

NPPES – Making Changes to Information

- ▶ If you need assistance making changes to NPPES:
 - For **individual** NPI numbers:
 - Call: **800-465-3203**
 - For **organization** NPI numbers:
 - Call **866-484-8049**
 - Select the option called “**Identity & Access**” (**I&A**)
 - Ask for guidance in processing a “**role request**” to gain access to organization NPI information
 - For all changes related to the organization NPI, you will likely need to have your W-9 handy when you call



6/12/2019 78

Making Changes to Provider Info

- ▶ For any changes such as name changes, license updates, adding a site, adding services, and updating taxonomy/NPI# to the Partners BHM contract, the provider will need to submit a Provider Change Form with the specific change and information listed.
- ▶ The Provider Change Form is found on the Partners BHM website under the "Provider Knowledge" tab at the top of the website. Once in there, go to "Credentialing and Enrollment" tab. When you scroll down the page you will see an actions grid and the Provider Change Form will be there.
- ▶ Please submit a Provider Change Form to the credentialing team email (CredentialingTeam@partnersbhm.org) for any changes needed to be made to the agency.



6/12/2019 79

Agency Primary Contact Info

- ▶ Please ensure the primary contact information for the agency is correct in the application.
- ▶ If the primary contact for the agency changes let Partners BHM know by submitting a Provider Change Form to update the primary contact info for the agency.
- ▶ This will ensure correspondence is not missed and communicated effectively.



6/12/2019 80

Clinician Insurance Requirements

- Must submit a Certificate of Insurance for the agency's Professional Liability insurance with Partners listed as a Certificate Holder.
- If the clinician is covered under the agency's Professional Liability insurance, please submit either a roster of covered employees or documentation on agency letterhead evidencing that the clinician is covered by the policy.
- In the event the clinician is not covered under the agency's Professional Liability, please submit a Certificate of Insurance for the clinician's individual/personal policy.
- This certificate must list Partners as a Certificate Holder as follows: Partners BHM, Attn: Credentialing Dept., 1985 Tate Blvd. SE, Suite 529, Hickory, NC 28602.



6/12/2019 81

Agency Insurance Requirements

- ▶ Partners BHM is required to be listed as “additionally insured” under the General Liability coverage.
- ▶ Partners BHM is required to be the “certificate holder” for all required insurance coverage policies for credentialing (General Liability, Professional Liability, Auto Liability, and Workers Compensation).



6/12/2019 82

Recredentialing Providers

- ▶ Provider agencies, clinicians, and licensed independent practitioners can keep track of credentialing expiration dates via the lists on the Partners BHM website, below is the link.
- ▶ <https://providers.partnersbhm.org/provider-enrollment-credentialing/>
- ▶ The list of credentialing expiration dates are updated each month



6/12/2019 83

Questions?

- ▶ Jason Arenillas, Credentialing Supervisor
 - (828) 325 8142
 - Jarenillas@partnersbhm.org
- ▶ Credentialing Department
 - (704) 842-6483
 - CredentialingTeam@partnersbhm.org

Please be sure to communicate the credentialing information with the credentialing staff/primary contact for your agency, thank you!



6/12/2019 84



Provider Council Update

6/12/2019

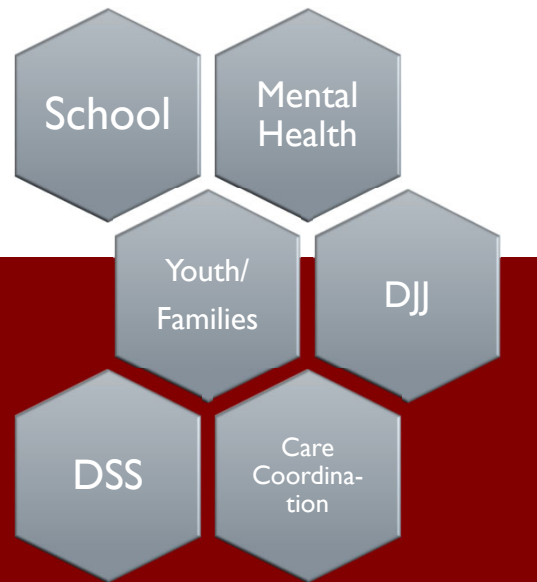
Provider Council Updates

- ▶ Rutherford expansion.
- ▶ Check Medicaid Transformation Website for updated information.
- ▶ NC- Health Connect- proposed legislation.
- ▶ Next Meeting: 6/28/19

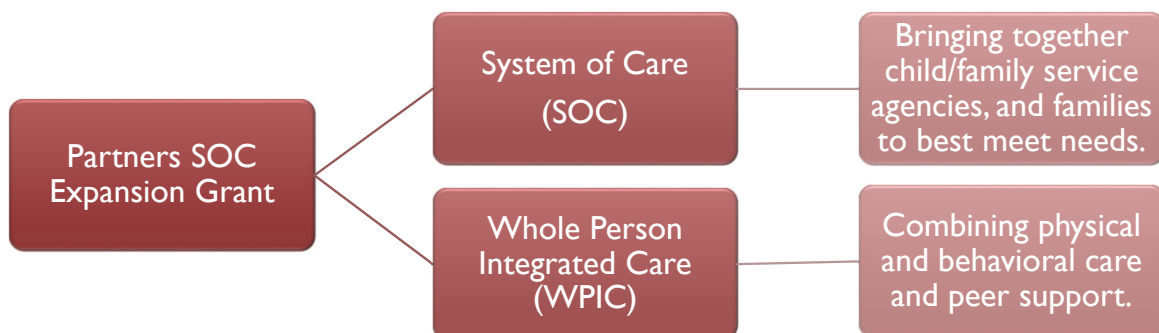


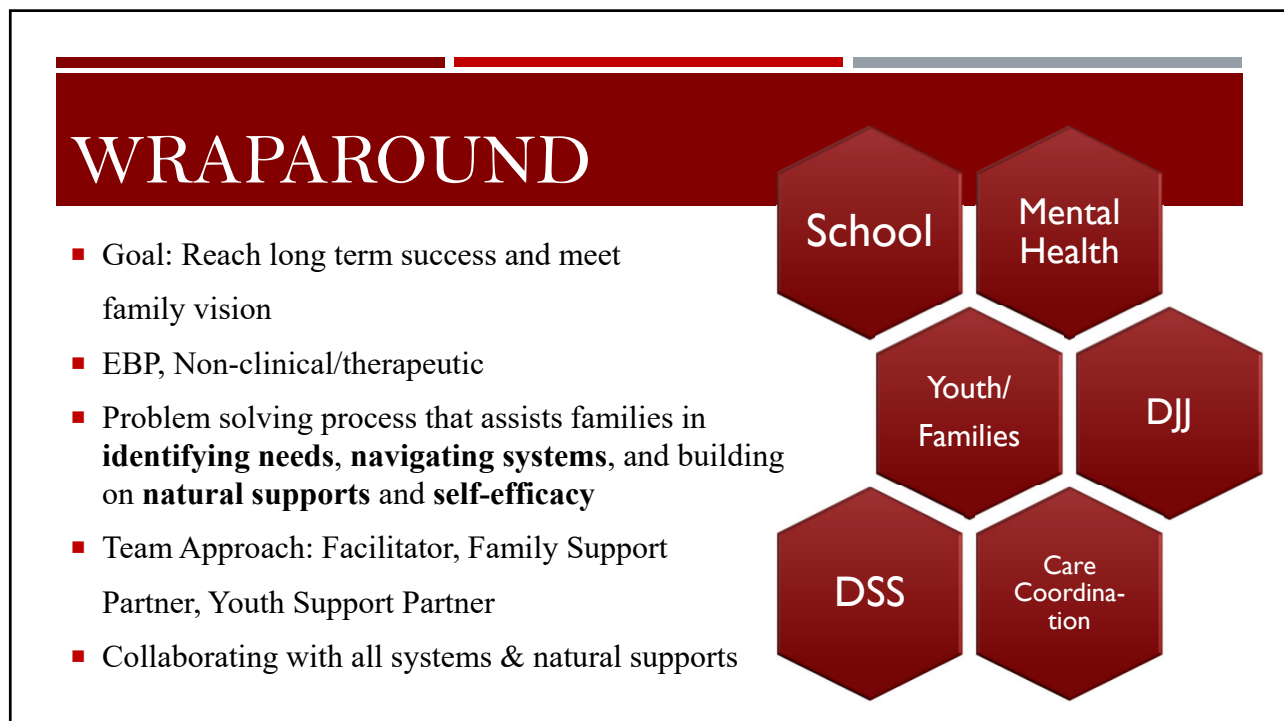
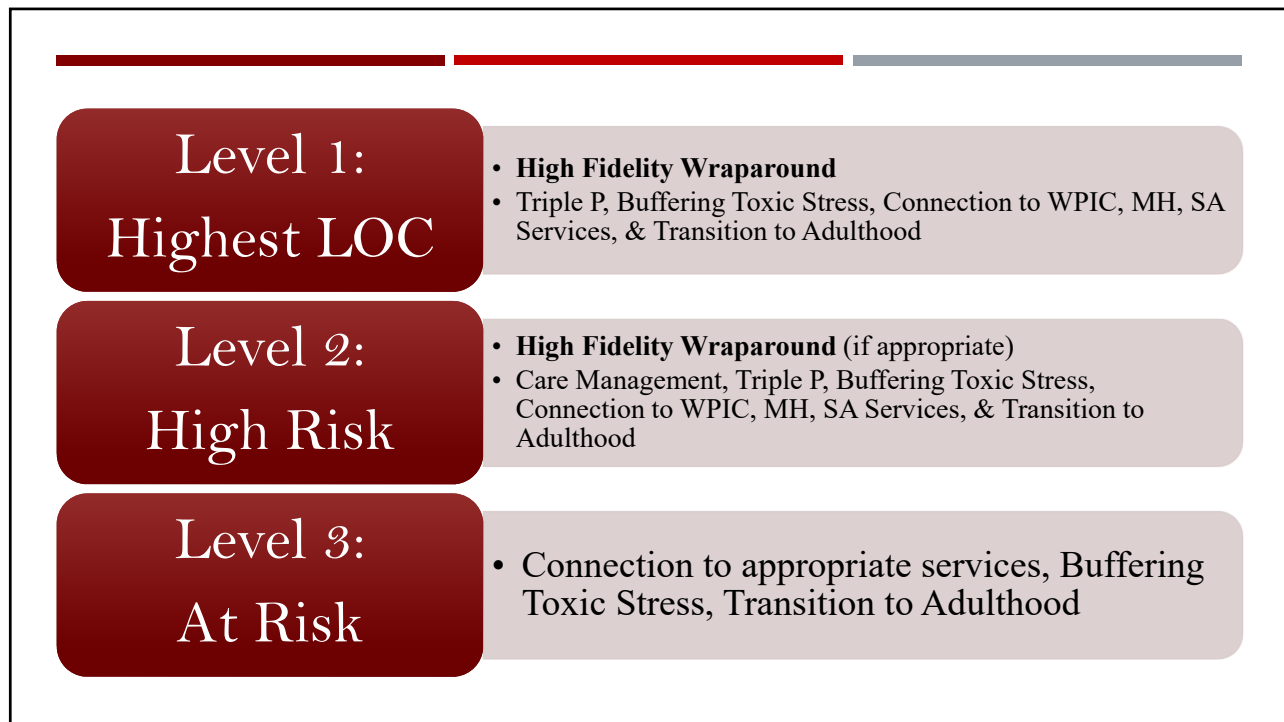
YOUTH VILLAGES

HIGH FIDELITY WRAPAROUND



SYSTEM OF CARE MODEL

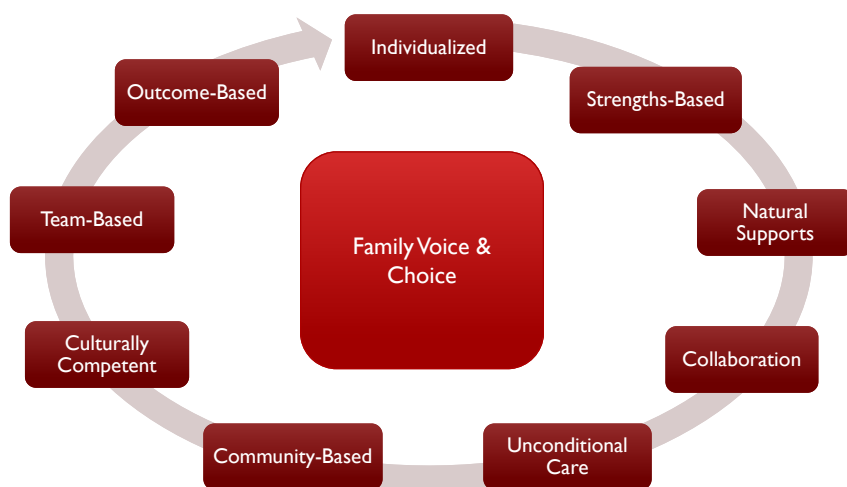




WRAPAROUND THEORY OF CHANGE

Meeting the self-defined needs of youth families, enhancing their confidence and skills to get their own needs met through purposeful transition, and strengthening their natural support network while integrating efforts of the people helping them will result in improved engagement, self-efficacy, social supports, and sustainability of positive outcomes.

PRINCIPLES OF WRAPAROUND



PHASES OF WRAPAROUND

Phase 1: Engagement

- Prepare the family's team
- Gather the family's strengths, needs, and culture (SNCD)
- Safety Plan

Phase 2: Planning

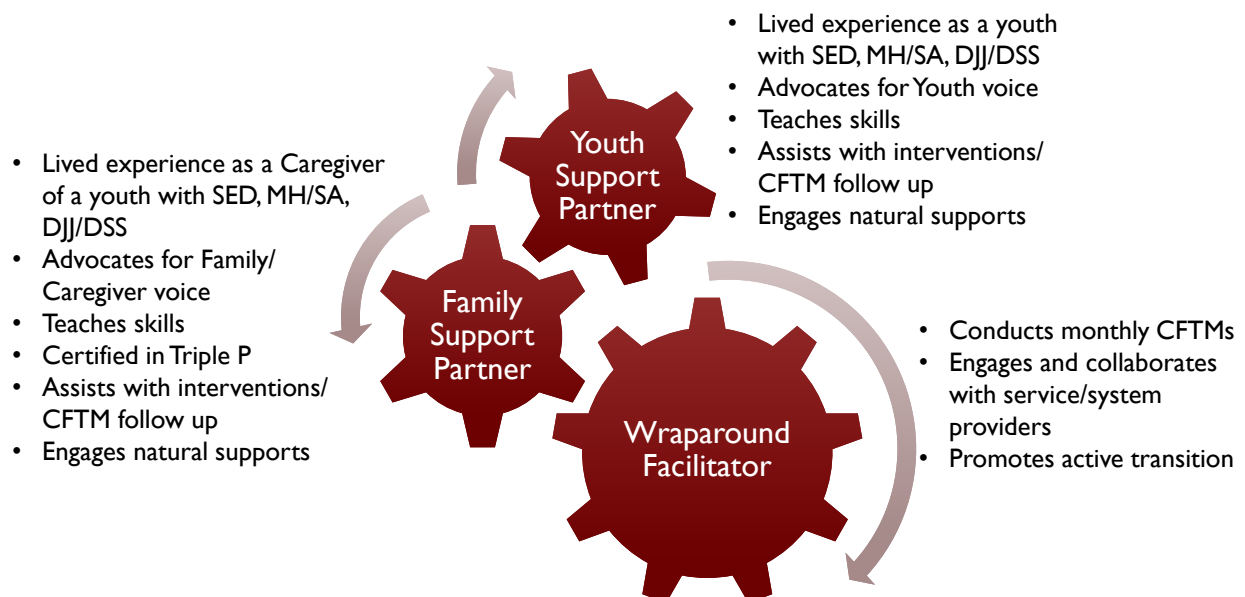
- Develop family vision
- Prioritize needs
- Identify & engage supports
- Meet with family & team (CFTM) to develop goals, objectives, & action steps

Phase 3: Implementation

- Assist with completing action steps
- Build sustainable skills
- Assess for need to change action steps
- Hold ALL team members accountable for assigned action steps
- Ongoing CFTMs to address current and/or new needs

Phase 4: Purposeful Transition

- Prepare family for "life after Wraparound"
- Allow the family to lead their planning process



APPROPRIATE YOUTH/FAMILIES

- Youth ages 5-21
- Diagnosed with an emotional, socio-emotional, behavioral or mental health disorder
- Experienced or is considered at risk for First Episode Psychosis
- Are being re-referred to services often or have not made much progress in previous services
- Experiencing low engagement or progress in current services
- Has a caregiver OR supports involved
- Discharging from higher level of service, or re-entering the home
- Connection to multiple systems

Additional Criteria

Trauma exposure (Abuse, Neglect, DV, Trafficking)	Parent having a chronic mental health condition, substance use/addiction or co-occurring conditions
Two or more MH/SA hospitalizations including crisis unit in the past 24-months	Homelessness now OR in the past 12 months
Episode of care in a psychiatric residential facility in the past 24-months	Current involvement with child welfare (protective investigation, foster care, or other) OR Involvement with child welfare in the previous 12-months
Youth/young adult substance use history or diagnosis	Early childhood adversity experience(s), (toxic stress, significant health issues, or other)
Diagnosed with any disability including Intellectual or Developmental Disability AND/OR Autism Spectrum Disorder	Currently involved with the adult or juvenile justice system (probation, diversion, or other) OR Involvement with juvenile justice in the previous 12-months

REFERRALS FOR YOUTH VILLAGES

Please send referral and accompanying documents to:

AccessYVNC@YouthVillages.org or Fax via 704-510-5601

Referral forms can also be access and submitted at: www.youthvillages.org

For questions about Wraparound or referrals, please contact:

Sequoia Dixon
Wraparound Supervisor
310-766-1154

Whitney Badramraju
Assessor
704-774-5076

Andrew Stehberger
Assistant Director
704-510-5660

REFERRALS FOR SUPPORT INC.

Please send referral and accompanying documents to:

Support Incorporated or Fax via 704-865-3520

Referral forms can also be access and submitted at: www.Supportinc.org

For questions about Wraparound or referrals, please contact:

Jessica Capers
Wraparound Supervisor
704-915-9474

Support Inc. Intake
Assessor
704-865-3525



Provider Monitoring Training

Quality Management Monitoring Clarifications

- **Client Specific Training**
- 10A NCAC 27G .0202(g)(3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan.
- North Carolina uses Person-Centered Thinking as the guiding principle in developing a treatment plan. This guiding principle ensures the plan is developed with the person, for the person and is about the person. This makes it “individualized” to their needs, their strengths and the supports they need to meet their mh/sa/dd needs. Adding the descript word “individualized” does not alter the intent of 10A NCAC 27G .0202(g)(3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan. The key components to point out in this rule: (1) Client, meaning one person; (2) Specified, meaning stated clearly, and (3) the treatment/habilitative plan, meaning the client’s treatment/habilitative plan.

- This rule states training to meet the mh/dd/sa needs of the client as specified in their plan. Again, North Carolina uses Person Centered Thinking as the guiding principle to develop a treatment plan. According to the APSM 45-2, Person-Centered Thinking and Individualized Service Planning, “person-centered thinking and individualized service planning are the hallmarks of the provision of high quality services in meeting the unique needs of each person being served”.

- When using the Person-Centered Thinking and Individualized Service Planning, which most mh/sa/dd services use when developing a treatment plan, there are four components: (1) a profile page; (2) action plan (goals); (3) crisis prevention plan; and (4) signature page. These components tell us about the person, what is important to the person, what’s working or not working, what their goals and strategies are and what to do in the event of a crisis.
- 10A NCAC 27G .0202 staff training shall consist of (3) training to meet the mh/sa/dd needs of the client as specified in the treatment/habilitative plan. All of these components make up the treatment plan and what staff should receive training on to support and work with the individuals they serve.

- **NOTE: There's no specific documentation a provider must use to document the training, but there must be written documentation in some manner that staff have received training on the individual's needs according to their treatment plan. This can be notes from supervision, this can be a certificate, or this can be an outline or statement. The training can be in a group or individual.**

6/12/2019

5

- The DHHS Post-Payment Review Tool for Providers, line item #17, used by Monitoring Specialists, asks "Is there documentation that the staff is qualified to provide the service billed? One of the Review Guidelines is to review education and training documentation on the Staff Qualifications Checklist. The DHHS Staff Qualifications Worksheet Guidelines, item #13, states "Training to meet the needs of the client as specified in the treatment plan? 10A NCAC 27G .0202 (g) Employee training programs shall be provided and at a minimum, shall consist of the following: (3) training to meet the needs of the client as specified in the treatment/rehabilitative plan.

6/12/2019

6

Review Guidelines for Monitoring Specialists

- Refer to the service definition for additional specifications regarding staff training requirements.
- Review the personnel record of staff who provided the service. Review the consumer's plan of care.
- Is there evidence that staff have reviewed the treatment needs (goals and preferred strategies) for the consumer receiving the service? This may be found in supervision notes or as a separate form.
- Does the consumer's plan of care indicate any specific needs of the consumer, such as medical, behavioral, or communications needs, and is there evidence that the staff have received training relevant to their needs?
- Training must be completed prior to the Date of Service to be considered met.
- There is no specific format required for this documentation.

6/12/2019

7

- All Monitoring Specialists are trained on the aforementioned guidelines and strive daily to be consistent and fair with all providers of mh/dd/sa services to ensure the best care is delivered to the consumers we serve at all times.

Individualized Supervision

- 10A NCAC 27G .0104: Paraprofessionals shall receive supervision by a qualified professional or associate with the population served. Employees must be given an initial supervision plan upon hiring. Partners MCO allows providers to put the required supervision plan in place within 30 days of hire date that states name of supervisee, name of supervisor, how often supervision shall take place and individualized goals specific to the employee, to include strengths and weaknesses. The agency's Policy and Procedures in regards to supervision shall match what is indicated on the Supervision Plan in regards to how often supervision is conducted and contents of supervision.

6/12/2019

8

- Individualized supervision forms shall include name of supervisee, name of supervisor, duration of supervision given for that specific event, goals addressed and progress/interventions for the employee to continue to address professionally and personally, as they mature in their assigned position. Providers are reminded that various Clinical Coverage Policies require supervision of other staff such as qualified professionals as part of the service definition. This must also be reflected in agency policy and procedures and be in compliance at all times.

6/12/2019

9

Questions?

Submit questions here:

questions@partnersbhm.org

6/12/2019

10

