ValueOptions

PROGRAMS THAT ADDRESS BEHAVIORAL HEALTH & MEDICAL INTEGRATION
ValueOptions currently offers integrated care programs in several states. The particular kind of integration is a function of what each state requires, and the nature of the particular contract. Currently, the majority of these efforts involve integrated care management, Health Home Support, and Practice Transformation/Provider Supports, often in partnership with another vendor or health plan.

Integrated Care Management
ValueOptions’ programs in Colorado, Connecticut, Maryland, Massachusetts, Nevada, and New Jersey all have integrated care management programs with varying degrees of attention to medical integration. Arrangements range from virtual staffing, with Care Managers working from home, to co-located staffing with a health plan or other entity. In New Jersey, the emphasis is on a holistic community-based assessment for members enrolled in the Managed Long-Term Services and Supports (MLTSS) program.

Health Home Support
ValueOptions is supporting Arkansas’ Health Home contract, and soon Connecticut’s Behavioral Health Home program, which require an explicit and structured approach to interfacing with medical settings.

Practice Transformation and Provider Supports
In Colorado, we are partial owners of two Behavioral Health Organizations (BHOs) and one Regional Care Collaborative Organization (RCCO) comprising 19 counties. While the BHOs currently operate as carve-outs, the 2014 rebids support the State’s goal that 80 percent of Coloradans have access to co-located health care by 2019. Additionally, Colorado is establishing the primary care-based RCCOs as its major vehicle for delivering health care services to Medicaid recipients.

In Massachusetts, we use behavioral and physical health data sources to provide quality management and regional network management support to primary care providers involved in the Commonwealth’s Primary Care Practice Reform Initiative. This program is looking to expand through a current RFQ for on the ground technical assistance for behavioral health integration in primary care settings.

The following program descriptions demonstrate the wealth of experience that ValueOptions brings to states as they work to address medical and behavioral health integration:

COLORADO
Colorado Behavioral Health Partnerships and Foothills Behavioral Health Partners
Together, these two Behavioral Health Organizations (BHOs) cover 48 counties. Both BHOs are built on an integrated care philosophy and have dedicated resources to integration at the administrative and clinical levels. Our recent baseline network assessment of integration efforts across the State showed that the majority of providers practicing along the integration continuum are working in integrated settings, but that most integrated settings are at a co-located stage. Less integrated practices tend to have fewer providers and/or providers spread across multiple clinical sites. Based on this assessment, we developed an integration plan designed to help providers who are not along all stages of the integration continuum move towards higher levels of integration.

From Pre-Coordination to Full Integration
Our centers of excellence are organized into a formal committee structure whose mission is to develop and promote best-practices for integration throughout the BHO service areas.

We use two Web-based provider-facing instruments that we co-developed in partnership with other agencies and academic institutions to measure movement along the integration continuum.
We routinely analyze data to assess the effectiveness of our integration strategies on integration level. These instruments are the Integrated Practice Assessment Tool (IPAT) and the Vermont Integration Profile (VIP).

**TeleCare Disease Management**
Licensed behavioral health clinicians and registered nurses provide Chronic Disease Management, Depression Care Management, and Recovery Care Management (RCM) through evidence-based supports for self-care, improved clinical outcomes, and treatment adherence. Coaching is tailored to each member based on their responses to the Patient Activation Measure. TeleCare also administers the Transition Care Management Program, a patient-centered process designed to improve quality of care and contain costs for patients with chronic disease and/or complex needs after they have transitioned from the hospital to home or other settings.

**Colorado – Psychiatric Access and Consultation for Kids (C-PACK)**
C-PACK replicates the evidenced-based Massachusetts Child Psychiatry Access Project (MCPAP) to create a system of child psychiatry consultation and training of the primary care providers to achieve the following program outcomes:

1. Promote systematic, evidence-based mental health screening
2. Improve access to treatment for behavioral health issues
3. Increase the capacity of primary care providers to deliver mental health care independently and team with local specialists when needed
4. Develop well-functioning primary care/ specialist relationships among primary care providers and child psychiatrists
5. Assure that scarce specialty psychiatric resources are directed toward the most complex and high-risk children

Provider training is offered by the nationally-recognized REACH Institute and includes Mini-Fellowships in Primary Pediatric Psychopharmacology as well as the Child & Adolescent Training in Evidence-Based Psychotherapies.

**Integrated Community Health Partners**
ValueOptions also supports integration through partial ownership of Integrated Community Health Partners, LLC (ICHP), one of seven regional Accountable Care Organizations in Colorado. ICHP is a partnership of ValueOptions, federally qualified health centers, community mental health centers, and the Colorado Community Managed Care Network, the health center controlled network for Colorado. ICHP’s network notably includes most of the major primary care medical providers affiliated with the 19-county region’s hospitals. Its integrated approach has led to the development of innovative care management solutions to targeted high-risk members, leveraging the extensive experience of its partners. Integration projects include:

- Pain management for members receiving opioid prescriptions from numerous providers and/or numerous pharmacies
- Improving care coordination for adults with diabetes
- Ensuring American Cancer Society recommendations are met for all diabetic children within the service area
- Providing training on depression screening and treatment for primary care providers

We have also developed several technical innovations to support ICHP:
• **I Can Help People Software System:** This Web-based system allows behavioral health care coordinators, physical health care coordinators and case managers to alert other care providers if they have seen a shared member.

• **CHP Care Coordination Dashboard:** The dashboard displays medical, behavioral, and pharmacy data with trend and drill-down functionality. It is updated on a monthly basis.

• **Risk Stratification:** The Business Intelligence team uses claims data and enrollment data to determine care coordination tiers. Tiers are assigned based on a summary score developed from the combination of Total Cost, Emergency Room Visits, and Inpatient Visits. Cost Scoring is based on the sum of the Total Health Claims + the Behavioral Health Claim amount. Once the member tiers are determined, the stratified list is sent to the assigned care coordinators for review and action. The program has achieved success by reducing emergency room visits, high-cost imaging, and recidivism rates for acute care hospitals.

**CONNECTICUT**

**Connecticut Behavioral Health Partnership and Community Health Networks Integrated Care Management**

ValueOptions administers mental health and addiction services for the Connecticut Behavioral Health Partnership (CT BHP). The CT BHP comprises the Department of Children and Families (DCF), the Department of Social Services (DSS) and the Department of Mental Health and Addiction Services (DMHAS). The CT BHP collaborates with providers and community stakeholders in providing appropriate services and support for the state’s 627,000 Medicaid recipients. The program was created in 2006 to manage children, adolescents, parents and their families and expanded in 2011 to include the adult Medicaid population.

Under a subcontract with the statewide medical ASO, Community Health Network of Connecticut (CHN), our co-located Intensive Care Managers work closely with members who have severe persistent mental illness (SPMI) and specific medical diagnoses. Members may be referred to the ValueOptions/CHN Intensive Care Management (ICM) program following a hospitalization, by a provider, by state agencies, community service organizations, or by the members themselves. The program employs seven behavioral health registered nurses to provide a combination of telephonic and face-to-face visits to the members.

An individualized care plan is developed for each member, based on their unique situation and perceived needs. Members participate in a medication review, comprehensive assessment and needs assessment. Using Motivational Interviewing skills, the ValueOptions/CHN ICM nurse assists members in identifying barriers to treatment success and establishing personal goals. The nurses coordinate care with the provider community to improve access, facilitate communication, and empower members to become active participants in their own care and wellness. The resources of ValueOptions complement the services provided by the ICM nurses, through referrals to certified peer specialists and collaboration with ValueOptions’ ICM clinicians.

**Program Data 2013**

• Member enrollment
  - 1,930 referrals were received
  - 1,605 members were outreached
  - 36.2% of outreached members were enrolled in the ValueOptions ICM program
• Face-to-face visits with members
  - 179 face-to-face visits were scheduled
  - 130 face-to-face visits were completed
    o 105 of these visits were provider visits with member, including primary care physicians, specialists and behavioral health providers
• 789 members have been enrolled in the ValueOptions/CHN ICM program from February 2012 through December 2013.

Outcome Data
For the period January 1, 2012 through October 31, 2012, looking at claims for Emergency Department and inpatient admissions six months pre and post-engagement in the ValueOptions ICM program:
• Reduction in inpatient admissions: 50% (43.17% for the CHN ICM program overall)
• Reduction in Emergency Department visit utilization: 15% (6.14% for CHN ICM program overall)

ACCESS Mental Health CT
Access to all of Connecticut’s Children of Every Socioeconomic Status – Mental Health (ACCESS Mental Health CT) is a program that offers free, timely consultation to PCPs seeking assistance in treating youth with behavioral health concerns under the age of 19 years, regardless of insurance. Specialists are available to answer questions and provide valuable resources to the PCP regarding mental health treatment. The vision of the ACCESS Mental Health CT program is to improve access to treatment for children with behavioral health or psychiatric problems while promoting productive relationships between primary care and child psychiatry. ACCESS Mental Health CT is designed to support PCPs by offering telephonic consultation including education on assessment, treatment, and access to community resources for youth with mental health needs. The goals of the programs are to:

• Improve access to treatment for children and adolescents with mental health needs
• Support a trusted relationship between PCPs and child psychiatrists
• Provide mental health focused training for PCPs
• Identify and coordinate community resources for youth and their families
• Support the care of youth with mental health needs within their PCP office

MARYLAND
ValueOptions serves as the administrative services organization (ASO) for the Maryland Department of Health and Mental Hygiene (DHMH)/Mental Hygiene Administration (MHA). ValueOptions works closely with DHMH and MHA to deliver a cost effective, recovery-oriented mental health service delivery system.

This relationship ensures that Medicaid and eligible uninsured individuals can embark upon their own journeys of healing and transformation, while receiving access to behavioral health care within the community. Our program includes utilization management, care coordination, customer service, claims payment, reporting, data analysis, provider relations, training, member advocacy, and peer recovery support. We are currently implementing an expansion of this contract that relies heavily on enhanced integration of care.
To meet this challenge, ValueOptions is providing:

**• Practice Supports and Training of PCPs**
- Alcohol Prevention and Screening during Pregnancy
- Promoting Early Detection and Screening of Alcohol Used by Youths
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Suicide Risk Assessment and Alternative Care Training

**• Clinical Coordination**
- Physician Consult Line
- Utilizing a Nurse Care Manager to coordinate services with MCOs and physicians to ensure integration of behavioral health, medical and pharmacy needs
- Implementing a three-tiered, Intensive Care Management (ICM) Program that will improve health outcomes and achieve behavioral and physical health cost savings

**• Enhanced Analytics, Reporting, and IT**
- Enhancing the exchange of Mental Health and Substance Abuse data with all seven MCOs
- Deployment of the Integrated Practice Assessment Tool (IPAT) Tool with incentives tied to practice improvement on integration measures
- Access to physical health, behavioral health, and pharmacy data as well as integrated care plans and risk assessments via Spectrum, our member-centric record

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**MASSACHUSETTS**

*Massachusetts Behavioral Health Partnership*

In 1998, Massachusetts Behavioral Health Partnership (MBHP) was awarded the contract from the Commonwealth of Massachusetts to provide quality management of the Primary Care Clinician (PCC) Plan’s primary care providers. MBHP provides a Profile Report, a Care Monitoring Registry, and a Reminder Report. This has greatly expanded our ability to provide meaningful and actionable data to PCCs and to advance quality improvement activities, supporting improved outcomes for members. Since the integration of this contract with the behavioral health contract in 2001, we have had the ability to provide report measures drawn from both behavioral health and primary care data sources - an important step in integration that helps unite providers in achieving better health outcomes for members.

Currently, semi-annual visits to selected PCCs by Regional Network Managers (RNMs) are conducted to review data and develop quality improvement action plans. As part of our PCC profiling activities, we have developed a detailed action plan database unique to MBHP where we compile data on areas of improvement, the root causes to be addressed, and interventions that will be made to impact a PCC’s performance.

MBHP’s Integrated Care Management Program (ICMP) connects with primary care and behavioral health professionals (along with state agency case managers) to align service delivery with established clinical guidelines for chronic conditions such as depression, diabetes, and asthma. A base per participant per month rate is paid quarterly to MBHP for members engaged in the ICMP. Performance incentives include reduction in hospitalizations, reduction in polypharmacy, and member reports of improved health outcomes. MBHP also provides the practice-level assessments of primary care practices involved in the Commonwealth’s Primary Care Payment Reform Initiative.

The Profile Report contains information about the following metrics:

- Breast cancer screening
- Cervical cancer screening
- Well-child pediatric BH
- Asthma management
- Diabetes management
- Pharmacy management
- New member access
- Emergency room utilization
Data analysis across many reporting cycles demonstrates consistent results showing that PCC practices managed by the MBHP Performance Improvement Management Services (PIMS) Program have better rates on virtually all measures than those PCC practices that are not managed by the MBHP PIMS program, and that these differences are very often statistically significant. We also provide reports for behavioral health providers that include the top five PCCs that the provider’s members are assigned to, the rate of Well Child Care visits for that behavioral health provider along with the list of children in need of visits, and a list of the behavioral health provider’s members with diabetes and if member is in need of service.

Massachusetts Child Psychiatry Access Program (MCPAP)
In 2004, we developed the Massachusetts Child Psychiatry Access Program (MCPAP), which is a system of regional children's mental health consultation teams designed to help primary care provider meet the needs of children with psychiatric problems. Based on a pilot program at University of Massachusetts, the program is focused on:

- Improving access to treatment for children with psychiatric illness, regardless of their insurance status
- Promoting the inclusion of child psychiatry within the scope of primary care practices
- Restoring a functional primary care/specialist relationship between primary care providers and child psychiatrists
- Promoting the rational utilization of scarce specialty resources for the most complex and high-risk children

This program is the hallmark for quick access (less than 30 minutes), increased personal mentoring with primary care providers, increased ongoing primary care provider education, and increased data collection. Recent outcomes results from our MCPAP program are provided below:

- We currently cover 98 percent of youth in Massachusetts and 98 percent of the primary care providers who care for these youth. This includes both pediatricians and family physicians in six regionally-based teams of child psychiatrists, social workers, and care coordinators.
- A random survey of pediatricians looking at collaborative care by Tufts Medical Center showed over 89 percent usage by pediatricians of MCPAP
- Seventy (70) percent of enrolled practices use MCPAP each quarter
- Annually, over 90 percent of practices and 45 percent of individual providers use MCPAP to demonstrate widespread integration between physical and behavioral health care
- Utilization of MCPAP continues to grow with over 20,000 encounters in the previous 12-month period
- MCPAP produces regular e-mail and Web-based communication to primary care providers regarding important behavioral health issues
- Annual satisfaction surveys show marked improvement over the baseline regarding the ability to get a child psychiatry consult and meet the needs of youth without any change in the number of child psychiatrists available
- MCPAP emphasizes non-pharmacologic treatments, which result in approximately 50 percent of consultations recommending no psychotropic medications

NEVADA
ValueOptions and McKesson, Inc.
ValueOptions collaborates closely with McKesson, Inc., to provide select Nevada Medicaid Fee-For-Service (FFS) members with integrated health care management services. These members are enrolled in the State’s new demonstration program, the Health Care Guidance Program (HCGP). We improve health outcomes for Nevada’s highest risk, most chronically ill
Medicaid enrollees that qualify by providing integrated physical and behavioral health care management and a high level of care collaboration with primary care physicians and specialty providers. The HCGP targets approximately 41,500 high cost/high need beneficiaries in the Medicaid FFS population. Program participation is mandatory for identified recipients.

We provide each member a comprehensive needs assessment to identify his or her risk level and presence of one or more qualifying conditions. We also determine the appropriate levels of intervention for those enrolled in the program and assist them with selection of a PCP. By supporting a medical home model, we improve access to preventive and primary care and reduce inappropriate utilization in emergency room settings.

ValueOptions provides integrated behavioral health care management for members diagnosed with mental health or substance abuse issues. HCGP staff support the Patient-Centered Medical Home model with the provider at the center of the care team. Additional support and services ValueOptions provides include:

• Provider engagement, education, and support
  - Helping develop and execute person-centered care plans
  - Receiving real-time referrals for care management and prioritizing those members referred
  - Supplying providers with actionable patient health information using McKesson’s VITAL technology and ValueOptions’ Clinical Care Alerts that target medication and treatment plan adherence
• Peer support services through Peer Specialists (persons with lived experiences) both telephonically and face-to-face
• Coordinating transportation services and linkage to other community-based resources for members

NEW JERSEY
ValueOptions and Horizon Health Networks of New Jersey Partnership
In October 2012, New Jersey received federal approval for a Managed Long Term Services and Supports (MLTSS) program, a program that uses MCOs to coordinate support services according to a member’s needs. ValueOptions is supporting Horizon NJ Health with the deployment of this program to over 17,000 persons receiving long-term supports or services. Through the MLTSS program, members receive their primary medical, acute inpatient, behavioral, and long-term care needs through a managed care plan. The membership includes current Medicaid beneficiaries enrolled in home and community-based programs such as:

• AIDS Community Care Alternatives Program
• Community Resources for People with Disabilities
• Global Options for Long-Term Care
• Traumatic Brain Injury programs

ValueOptions is providing medical management of the behavioral health services in addition to Comprehensive Care Coordination (of all behavioral, physical health, and MLTSS Services) for members with a primary behavioral health condition.
We help people live their lives to the fullest potential.

valueoptions.com