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Project Title	Integrated Health Supports for High Risk, Non-Engaged Adults and Youth with Mental Illness & Chronic Disease

Rationale for the Project

Pursuant to SB 6312, Washington State is committed to fully integrating the financing and delivery of physical health, mental health and substance use services in the Medicaid program by 2020. The anticipated quality gains and cost savings of Washington's Health Home (HH) Program offers an existing model that can be tailored to provide high risk adults with serious mental illness (SMI) or youth with serious emotional disturbance (SED) access to comprehensive care coordination from their usual sources of primary and behavioral health care.

Problem Statement

Care Coordination is essential for persons with SMI/SED and chronic physical disease to successfully navigate the health delivery system and promote treatment plan adherence. For the SMI or SED client, care coordination mitigates the impact of disability, which decreases inpatient hospitalization rates, avoidable emergency department (ED) visits and excess use of criminal justice and social service resources. A portion of Washington Medicaid recipients currently receive care coordination through managed care organization (MCO) assignment to the Health Home Program, which provides comprehensive client support to address multiple chronic health conditions. The HH Program does not, however, have a clinical point of service enrollment process to provide high risk client's access to these services prior to individuals having received a significant amount of services that frequently include avoidable hospitalizations and ED visits. Furthermore, current HH care coordinators are not integrated with multiple organizations providing primary medical care and behavioral care, but rather are employed within single organizations that may or may not provide either primary or behavioral healthcare. This project would enable the two largest providers of medical and behavioral care in Eastern Washington to coordinate care for high risk patients who access or should access care from both organizations using a collaborative, integrated approach.

Supporting Research

Various studies of collaborative care approaches such as the IMPACT model that integrate medical and behavioral health care have shown both health outcome improvements and cost effectiveness. A 21 month evaluation of mental health integration through the General Assistance Managed Care Pilot in King and Pierce Counties demonstrated that a collaborative physical and behavioral health model with Care Coordinator support achieved the following:

- 26% reduction of inpatient medical admissions
- 24% decrease in the number of arrests for participating clients

Key aspects of this type of coordinated care, such as in-home visits and patient-driven care plan creation have shown reduced hospital days and ED use along with increased patient activation[1].

Relationship to Federal Objectives for Medicaid

These services aim to address the federal objectives for Medicaid by increasing the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

[1] Health Affairs http://content.healthaffairs.org/content/28/1/75.full

Project Description

Which Medicaid Transformation Goals[i] are supported by this project/intervention? Check box(es)

☒ Reduce avoidable use of intensive services

☒ Improve population health, focus on prevention

Which Transformation Project Domain(s) are involved? Check box(es)

☒ Health Systems Capacity Building

☒ Care Delivery Redesign

☒ Population Health Improvement – prevention activities

Region and Sub-population Impacted by the Project

The target population is adults with serious mental illness (SMI) and youth with severe emotional disturbance (SED) in Spokane County who are not enrolled in the current Health Homes program and who access behavioral health and/or primary care services from Frontier Behavioral Health and CHAS Health sites. Provider-identified clients at high risk for decompensation and poor health outcomes are referred to a Care Coordinator to confirm eligibility and initiate services. The intervention will especially target:

1. Frontier clients without an active or engaged PCP relationship to manage intensive physical health needs and chronic conditions
2. CHAS patients who lack adequate home or social supports to manage intensive behavioral health needs and could benefit from more intensive outpatient behavioral health services

Relationship to Washington's Medicaid Transformation goals

The proposed services provide individualized case coordination and support for SMI or SED clients to access appropriate medical, behavioral health and social service resources to support treatment adherence. Care coordinator duties meet all four goals of the Care Delivery Redesign model, namely:

1. Bi-directional integrated delivery of physical and behavioral health services
2. Transitional care focused on specific populations
3. Alignment of care coordination and case management to serve the whole person
4. Outreach, engagement and recovery supports

Project Goals, Interventions and Expected Outcomes

This project will expand the reach of the WA Health Homes (HH) Program to give clients with SMI or SED and chronic physical conditions care coordination services that decrease risk for hospitalization due to a lack of coordinated support for medical and behavioral health conditions. The proposed services leverage the experience and collaboration of Spokane County's largest Medicaid behavioral health and primary care providers, Frontier Behavioral Health and CHAS Health, who are participants and experienced with state supported initiatives like the HH Program and the University of Washington's MHIP care model.

Frontier and CHAS will provide administrative support training for six additional Care Coordinators, who will adopt existing training protocols associated with Frontier's three-year participation with the HH Program. Care Coordinators will provide a good-faith engagement for each referred client and complete once monthly visits while performing the following 6 core services:

1) Comprehensive Care Management, 2) Care Coordination, 3) Health Promotion, 4) Comprehensive Transitional Care, 5) Individual and Family Support, and 6) Referral to Community and Social Support Services.

These efforts will result in the following anticipated outcomes:

- Increased access to primary care and appropriate level of behavioral health care
- Reduced emergency department utilization

- Reduced inpatient medical admissions
- Shorter time to improved health outcomes

Complementary Transformation Initiatives

This project's effort support but would not duplicate existing efforts with the following statewide initiatives:

- WA Health Home Program
- Medicaid Transformation Initiative 3: Provision of Targeted Foundational Community Supports
- Mental Health Integration Program (MHIP)

Other Transformation project proposals focusing on behavioral health integration in primary care (such as by CHPW and WACHMC) are complementary to this proposal. Importantly, this proposal focuses on transition and coordination of care for patients accessing both RSN/BHO agencies and primary medical care. It does not negate the need for integrated primary care in behavioral care settings or vice versa.

Organizational Partners

Frontier Behavioral Health; CHAS Health

Core Investment Components

Proposed Activities

Based on Frontier's panel size for HH Coordinators, each of the 6 requested Care Coordinators would serve 80-100 clients per year, ramping up to full capacity in year one, with corresponding average annual service volume of 540 clients per year. The proposed approach could be applied to other regions where clients utilize both FQHC and RSN/BHO services.

Cost Estimates

The fully loaded cost for six care coordinators to perform the above work is $521,633 per year.

Summarized Financial Return on Investment Opportunity

Numerous studies that evaluated similar care coordination services to Medicaid recipients, including many with behavioral and physical comorbidities, show excellent overall savings. Results range from over $6 saved per $1 invested (Collaborative Care per UW AIMS Center), to $66 PMPM savings (WA's MHIP GAU Pilot Project that included a 26% reduction of inpatient medical admissions), and $280 PMP (IMPACT model). Clients who would utilize this program will be those with complicated health care needs who undergo numerous care transitions and have comorbidities – these are just the clients who can benefit the most from strongly integrated care, and therefore reduce total health spending in Washington State.

Project Metrics

Key Process and Outcome Measures

Currently, there are limited behavioral health benchmark data available. The primary sets of metrics come from the following WA Common Core Measures:

- Psychiatric Hospitalization Readmission Rate
- Access to Primary Care
- Potentially Avoidable ED Visit Rate
- Behavioral Health: % of Adults Reporting 14 or More Days of Poor Mental Health