Connecticut BHP
Supporting Health and Recovery

beacon
health options

High Need Adult Member Initiative

Governor's Task Force on Housing and Supports for Vulnerable Populations

September 27, 2019

Agenda

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Connecticut Behavioral Health Partnership (CTBHP)

- Beacon Health Options contracts with the three state agencies that comprise the CTBHP to manage Medicaid Behavioral Health Services in Connecticut.
- Provide Utilization Management, Care Management, Quality and Performance Improvement.
- Manage, Integrate, Analyze, Report Data to support the state agencies, providers, members and internal operations.

DSS DATA
- Eligibility
- Medical Claims
- BH Claims
- Pharmacy Claims
- Transportation

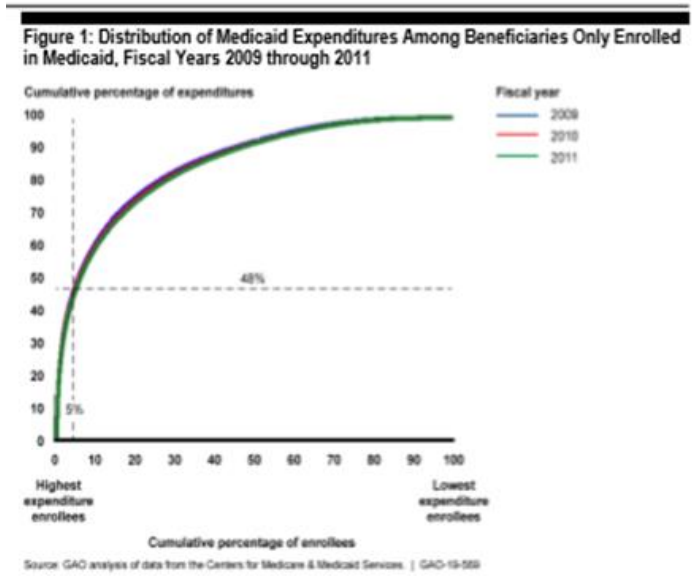
DCF DATA
- DCF Status
- Program Expenditures
- Select Program Data

DMHAS DATA
- Non-Medicaid Service Encounter data
- BHH Quality Data

Background – GAO Study on High Need

- Study of 7 States High Need Projects
- 5% of Medicaid Recipients Account for nearly 50% of costs
- High Need Defined - Statistical Outliers, Diagnoses, Utilization/Cost and Clinical Judgement
- Interventions - Care Management, Incentives, Coverage Changes, Network Restrictions
- Mixed Results – some positive and some inconclusive outcomes
- Lessons - Be Clear and Transparent about Approach

GAO
U.S. Government Accountability Office



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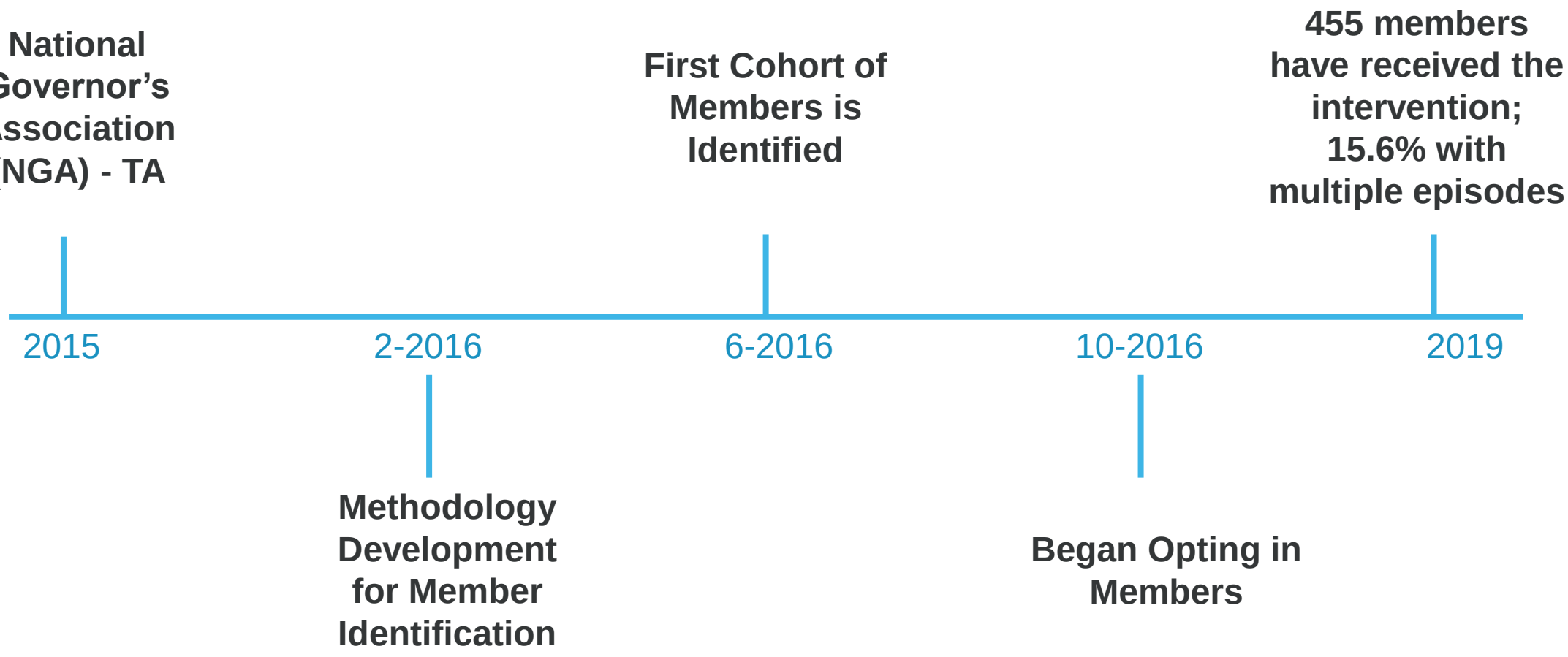
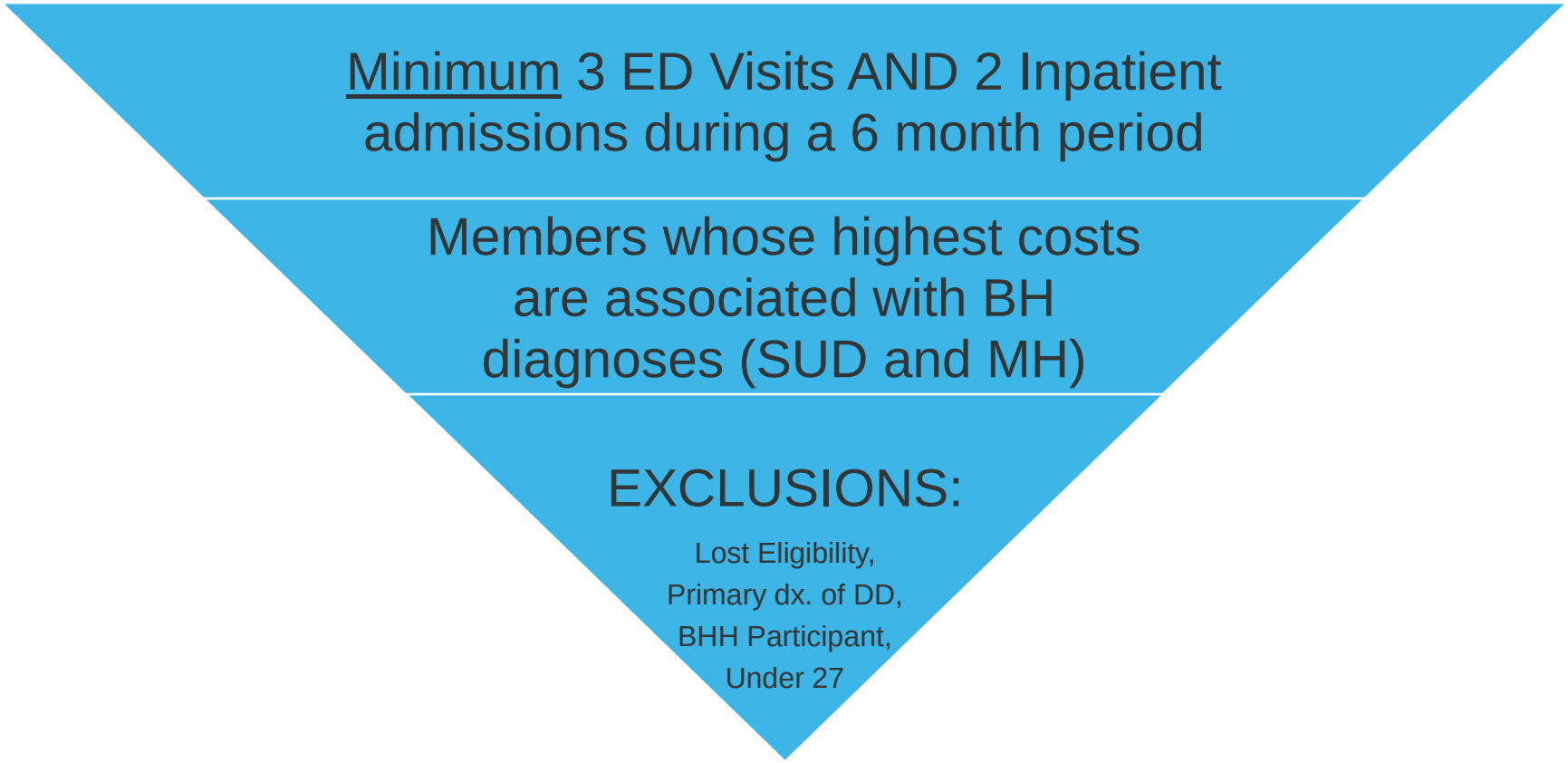
High Need Project Overview

- Identify the highest need individuals in Medicaid with a mental health or substance use disorder diagnosis
- Provide an intervention consisting of Care Management and Peer Support
- Compare the outcomes of those that receive the intervention to a matched group that do not.
- Evaluate the impact of the intervention
- Determine who responds the best to the intervention

High Need Project - Timeline



Identification/Definition of High Need Members



- New lists generated every 6 months
- More than 5000 Members identified to date

Identification of Intervention and Comparison Groups

All High Need Adults were then divided into two groups:

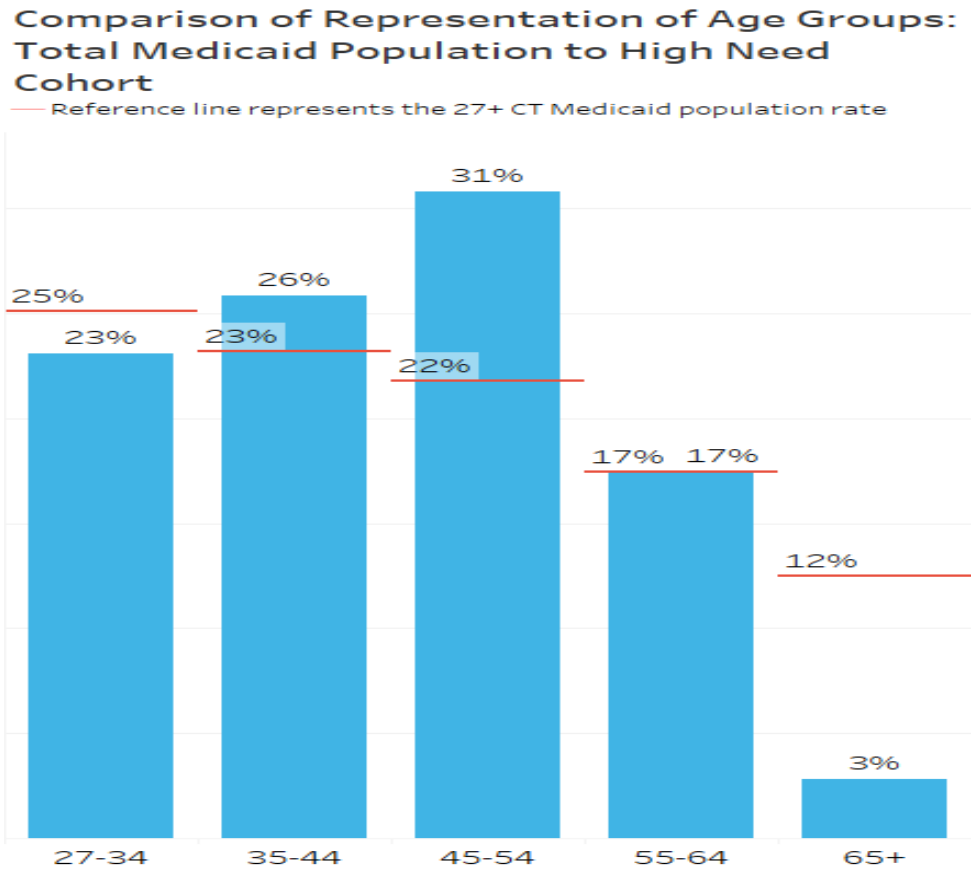
Intervention Eligible Group:

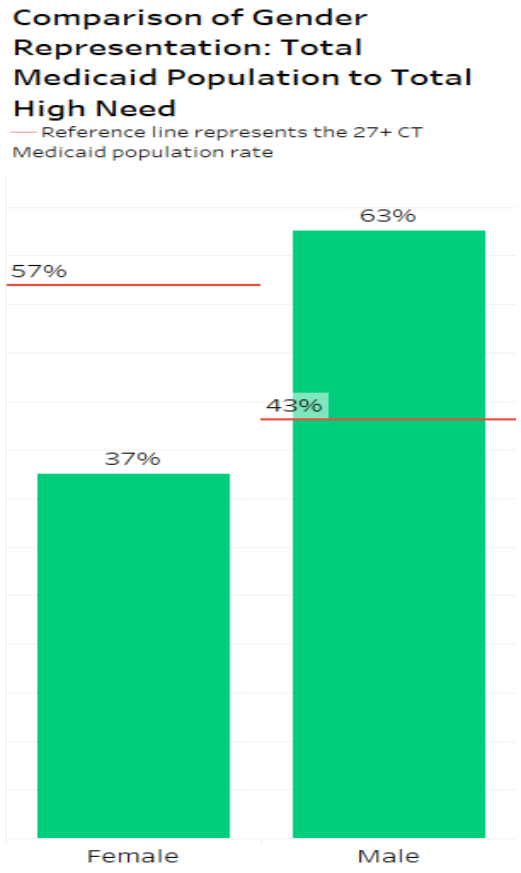
- Individuals with most of their hospital visits (ED and IP) in one of the 6 CT high volume hospitals
- Intensive Care Manager and Peer assigned

Comparison Eligible Group:

- Individuals with most of their hospital visits (ED and IP) in any other CT hospital
- “Treatment as usual”

Demographics of High Need Members Compared to Medicaid Adults



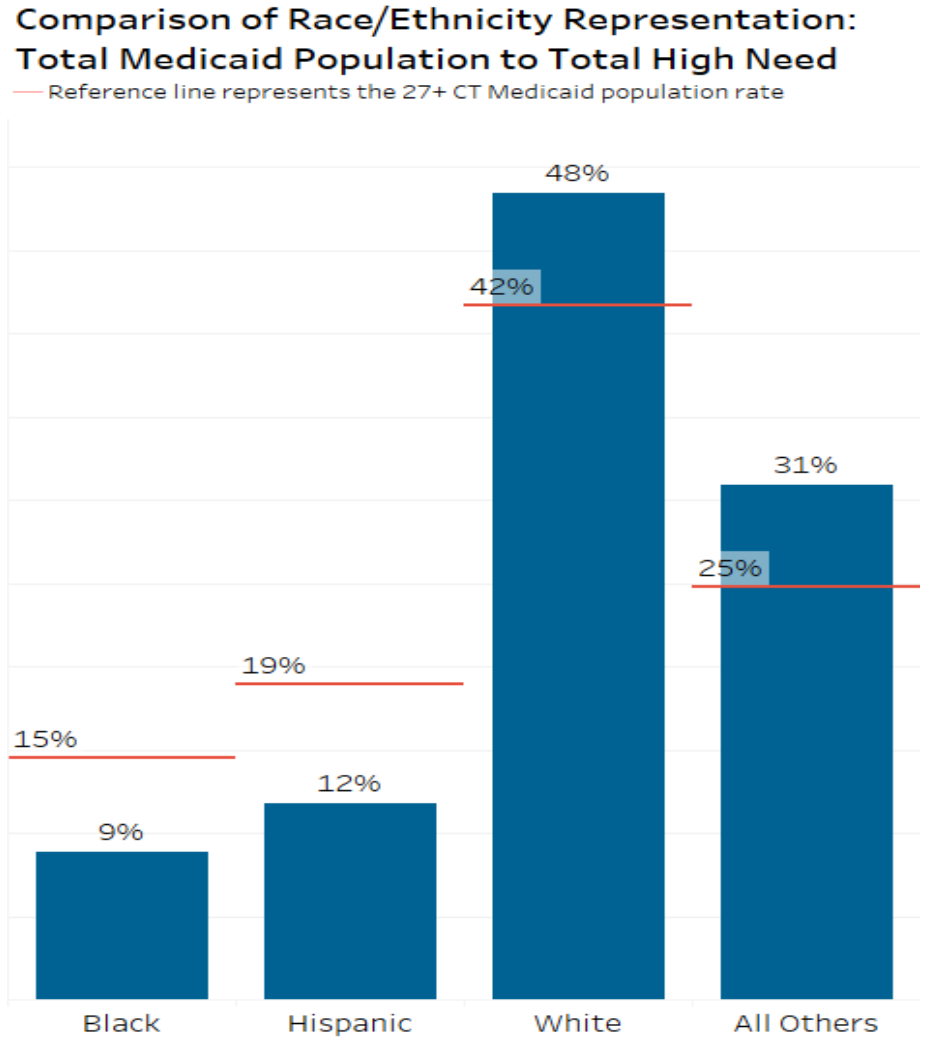


- 35-54 Age Groups are over represented
- 27-34 and over 65 are underrepresented
- Males are significantly over-represented

Demographics of High Need Members compared to Medicaid Adults

- Individuals who are Black and Hispanic are disproportionally under-represented
- White individuals and those in the “all others categories” are disproportionally over-represented

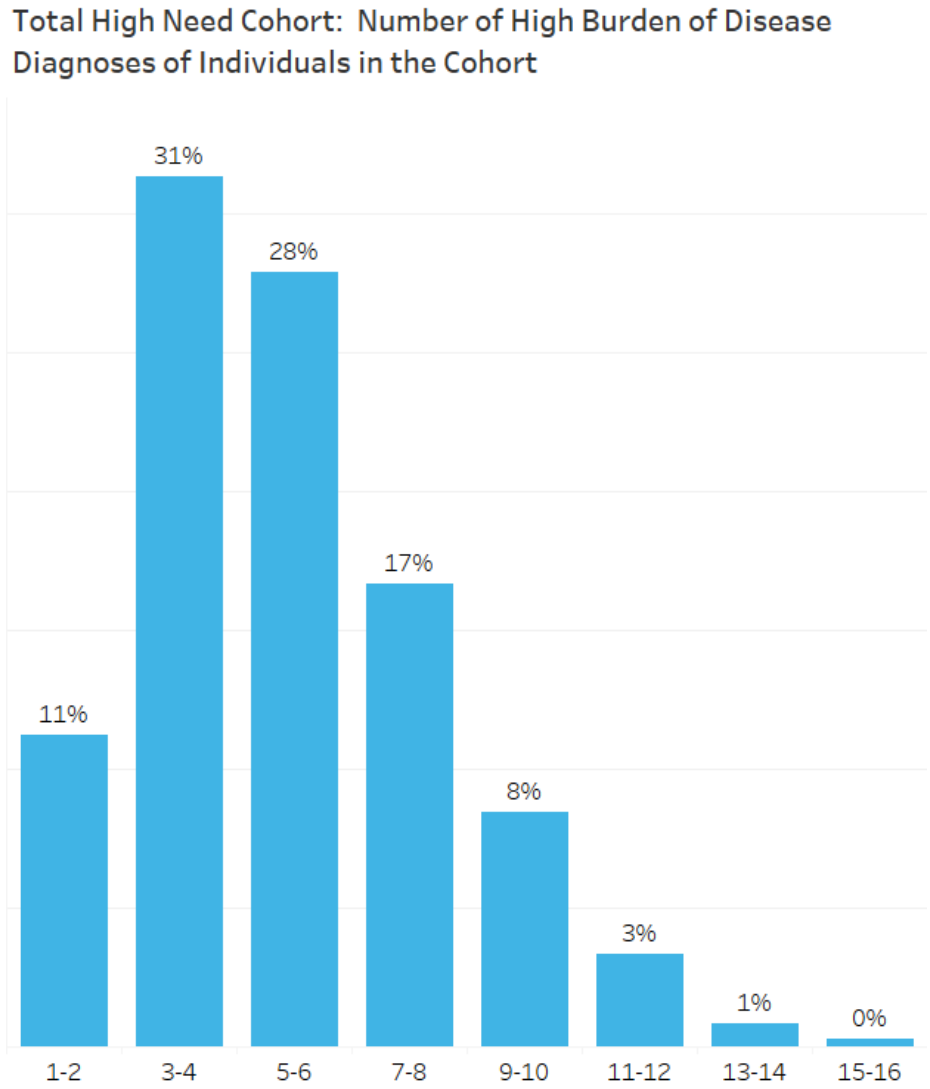
For this slide, “all others” includes a large category of “unknown” race/ethnicity and other racial groups that have a relatively small population in Connecticut including Asian, Native American, Pacific Islander, etc.



Number of Co-Morbid "High Burden of Disease" Diagnoses

"High Burden" Diseases Include:

Substance Use Disorders, Depression, Hypertension, Psychotic Disorders, Cardiac Arrhythmias, Hyperlipidemia, Diabetes, COPD, Epilepsy, Dementias, Chronic Kidney Disease, CAD, Cancer, Congestive Heart Failure, Stroke, HIV, Paralysis, Autism, Osteoporosis, Parkinson's, Multiple Sclerosis, Sickle Cell, Cystic Fibrosis



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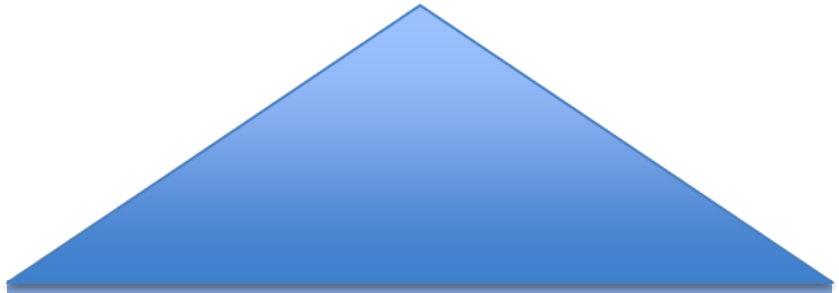
Social Determinants of Health



Housing Needs

- Housing assessed via:
  - DSS Data
  - Beacon Acuity Assessment
- 62% Homeless in Past Year
- 45% Reported significant barriers to housing security
- 22% Reported moderate barrier (substandard housing, “couch surfing”)
- Housing is the #1 SDOH according to the ICM/Peer Team Members

Other Social Determinants

- Financial Challenges
- Lack of Transportation
- Food Insecurity
- Unemployment/Job Skill Deficits
- Social Isolation
- Legal Involvement, Etc.

The Beacon ICM/PEER Team

Intensive Care Manager (ICM)

- Licensed Clinician
- Service System Expert
- Coordination of Clinical Services – No Direct Care
- Advocates to Address Needs
- Advises Care Planning

Peer Support Specialist

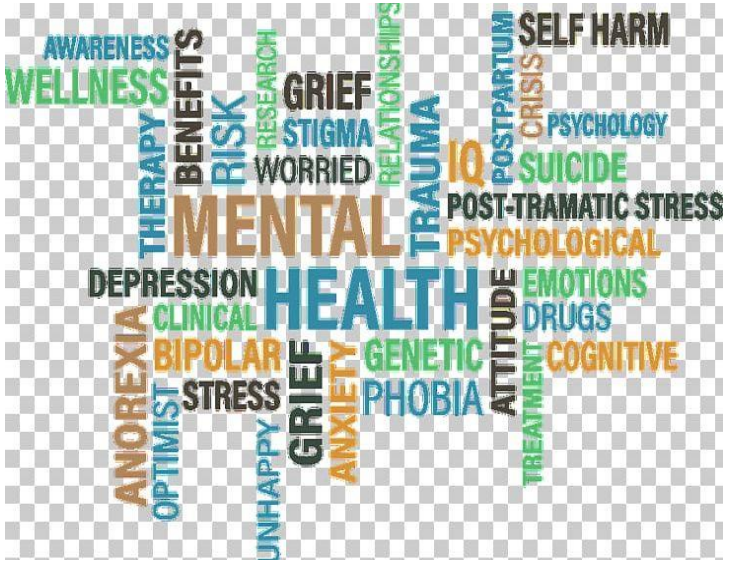
- Lived Experience
- Hope for Recovery
- Member Engagement
- Coordinates/Advocates for housing, food, other needs
- Needs Assessments

Principles & Practices

- Wellness Recovery Action Planning (WRAP)
- Motivational Interviewing
- Team Model with Distinct Roles for ICM and PEER

Assignments

- 6 Target Hospitals/Regions
- Highest Volume Hospitals
- Yale, Hartford, St. Francis, Bridgeport, Hospital of Central CT, and Lawrence & Memorial Hospitals



Phases of Intervention

Evaluation of the Effectiveness of the Intervention

Hypotheses:

Individuals who receive the intervention:

1. Fewer inpatient and ED services and fewer readmissions
2. Higher rates of timely connection to follow-up care
3. Shifts in spending for services - away from intensive hospital-based towards intermediate and community services
4. Improved SF-12, lower Acuity Scores

Comparison - Intervention and Control Groups

- Most high need members return to baseline utilization even without intervention (regression to the mean)
- Pre-post analysis of only the intervention cohort is not sufficient
- Methodology needs to incorporate a control condition
- Propensity Matching – use a score/algorithm to identify a control group that is similar to the intervention cohort
- Matched on Age, Gender, Race/Ethnicity, Count of High Burden Diagnoses, Diagnosis associated with highest cost, and counts of inpatient and ED visits.

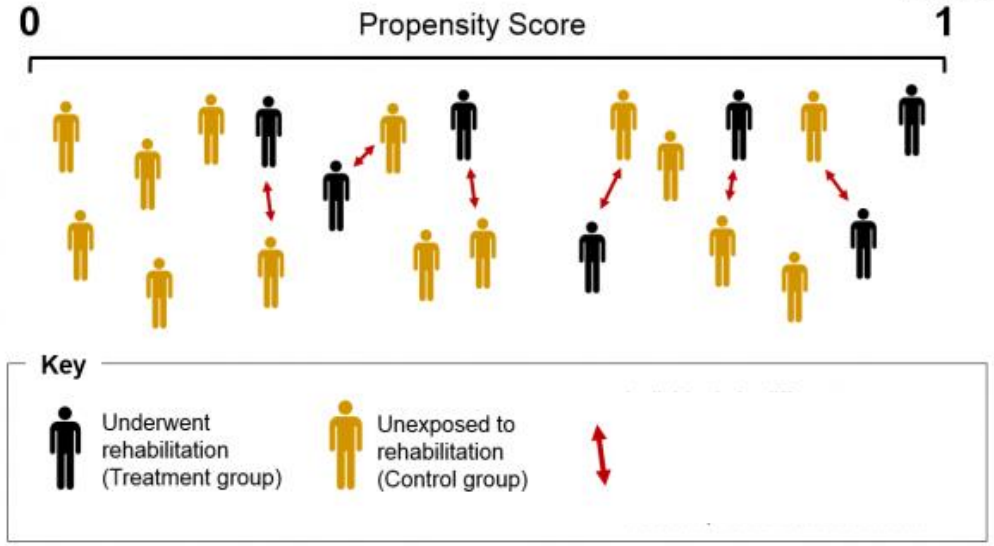


Image adapted from Whatworks.blog.gov.uk

Outcomes

As per GAO Report – Propensity Matched based Findings were mixed:

Propensity Matched comparisons of Intervention and Control Group resulted in some findings in favor of the Intervention Group and others in favor of the Control Group

- Intervention Group had greater improvements in ED use, connection to services following discharge from the ED or IP and improved access to rehabilitation services
- Control Group had greater decreases in IP use and greater decreases in Total Costs, Total BH Costs, and Psychiatric IP costs

2019: Intervention Group Outcomes

Identifying those members who improved as a result of the intervention based on:

↓ ED Visits	↓ IP Stays	↓ Acuity Score
↑ BH SF12 Score	↑ Non-IP BH $s	↑ Non-IP Med $s

- 74% Intervention Group participants had decrease in ED visits
- 80% had decrease in IP stays
- 28% decreased Acuity Score
- 19% increased non-IP BH spend and 12% increased non-IP Medical spend
- Improvement in Housing status improved after >7 months in intervention

Thank You

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