Crisis Delivery From a Provider Perspective

Access, Intervention and Prevention

HHS LOC Mental Health Subcommittee

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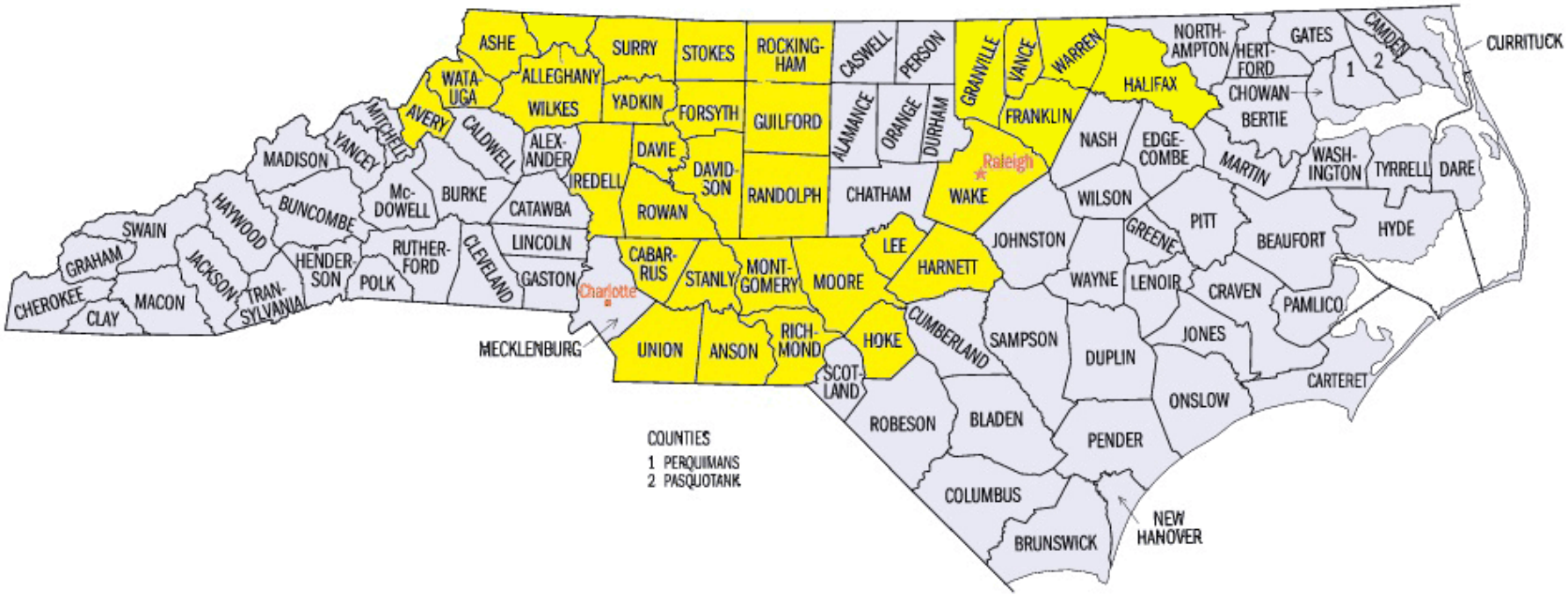
Recovery Services

About DAYMARK

Our Mission:

Daymark® Recovery Services, Inc. is a mission driven, comprehensive community provider of culturally competent mental health and substance abuse services. The Daymark® goal is for skilled medical and behavioral healthcare professionals to support citizens of all ages and their families with the greatest opportunity for recovery, independence and the highest quality of life. We are committed to using the most current best practices and effective, research-based treatment programs to assist all citizens working toward achieving optimum health and recovery.

Daymark Counties



Hallmarks of DAYMARK

- Created by the former Davidson County Area Program and now Cardinal Managed Care Organization (MCO) to assure crisis services, outpatient services and medication management remained available at the onset of mental health reform.
- 10 years old and provides care to approximately 53,000 North Carolinians annually.
- Provides care to some degree for all existing MCOs
- Primarily located in 32 counties in NC with 28 of the counties having full service locations or residential services.
- Provides
  - Advanced Access to care,
  - telemedicine, medical services,
  - crisis services,
  - preventative outpatient care and provision of care that is a low cost per episode.

Goals of this presentation:

- Develop an understanding of how preventative professional services can ameliorate symptoms that cause crisis episodes and the need for higher levels of care.
- Develop an understanding of how the current emergency room and access to care problems for behavioral health and substance abuse patients likely have come to roost today.
- Develop an understanding of a working model of care.
- Develop an understanding of how to monetarily support a better model of care that will lesson the need for crisis services and be a resource for crisis services post crisis episodes.

Professional Services that can provide active and preventive care for both pre- and post-crisis events?

1. **<u>Outpatient Mental Health Services</u>**:

- cheapest service to deliver for private providers
- Issue: existing rates do not support the service and discourage the private sector from building these services.

Service consists of the following:

a) <u>Licensed Clinicians</u>: Clinical social workers, psychologists, counselors, nurses and other mental health and substance abuse professionals.

b) <u>Psychiatric Services</u>: Primary care physicians, psychiatrists, psychiatrist nurse practitioners and physicians assistants.

Outcome possibilities for patient engaging an outpatient level of care:

1. Patient is assessed and found to need on average 8-12 visits per year with a therapist that may or may not included medication management.
2. Patient is assessed and found to be in an acute crisis. Possible events:
   - follow up outpatient care
   - brief inpatient referral
   - a referral to an enhanced service.
   - combination of all of these events.
3. Patient is stable but in need of an enhanced service to remain in the community. Enhanced service includes
   - assertive community treatment team (ACTT),
   - day treatment
   - time at a psycho-social clubhouse as examples.

Why doesn't this system work?

Answer? It does. However, working systems and networks are under development in many parts of our State.

How did we get to where we are today? - 1

- At the onset of Mental Health Reform the service of choice between 2006-2009 was community support (CS), among some other enhanced services.
- CS primarily served Medicaid patients given its good reimbursement rate and low cost to deliver. The private sector abandoned professional outpatient care in most counties to focus on lucrative CS.
- There was no fiscal incentive for the private sector to provide professional outpatient and psychiatric care but instead the incentive was to see primarily Medicaid patients through community support.

How did we get to where we are today? - 2

- During these same years outpatient services rates dropped almost 30%
- During the years 2004-2007 we saw 49,000 North Carolinians no longer receiving CPT/H Codes (outpatient codes) from 2003.
- During parts of this time period we saw community support services expenditure balloon to close to a billion dollars a year with very little treatment given to the indigent patients and poor, often enabling care given to Medicaid patients through community support.

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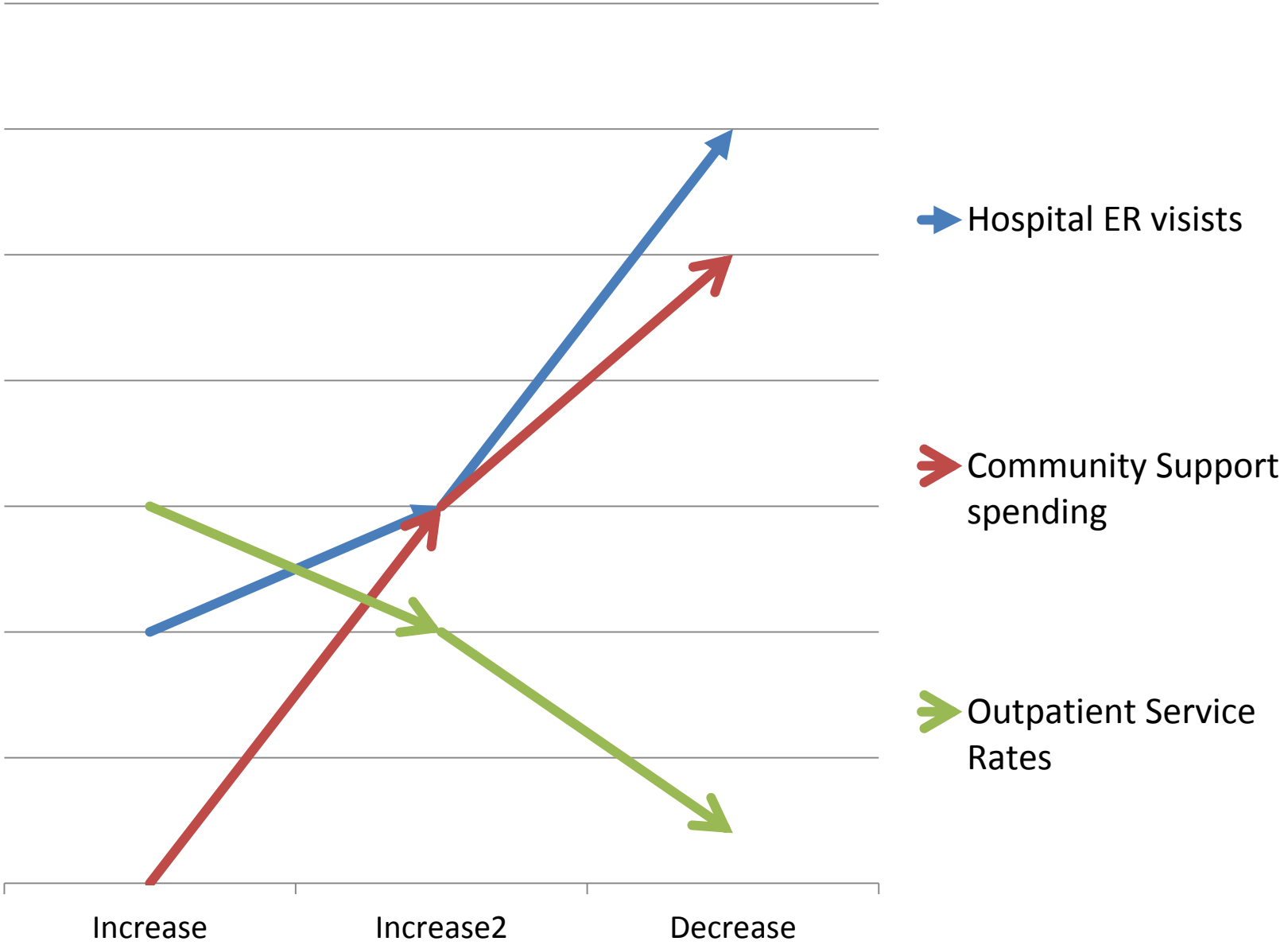
How did we get to where we are today? - 3

- As recently as this year the Centers for Disease Control published a report that showed the national average of mental health and substance abuse patients going to an emergency room was around 5% in 2007 – 2008, but during this same time period this percentage was doubled in North Carolina.
- Informal data review in the Cardinal Area, where community support was restricted and outpatient monetarily supported, have trends/outcomes similar or better than national trends related to emergency room utilization by behavioral health patients

We believe that North Carolina abandoned professional care at the onset of reform in place of what was an excellent service definition in CS. The flaw was a perverse fiscal incentive to deliver CS in the most minimum way possible and without other professional services. Given that history, we do not believe it is an accident we have seen professional care decrease and hospital emergency department admissions increase.


Hospital ER visists
Community Support spending
Outpatient Service Rates
Increase
Increase2
Decrease

What to do?

- Continue the current course with Medicaid Waivers operated by the public sector.
- Focus on outcomes rather than fee for service models. This requires non-traditional funding methodologies.
- Allow the public MCOs to shape networks and have authority over their funding as it relates to rate setting and use of funding.

What A Full Service Provider Looks Like in a 10 Year Old Network:

The DAYMARK and Cardinal Story (Davidson, Rowan, Cabarrus, Stanly and Union Counties)

Characteristics of the Cardinal Network - 1

- Limited number of comprehensive providers in each county to only two. This allows choice as well as both agencies to be healthy.

- This does not close the network to specialty services or independent practitioners.

- Closed networks guard against oversaturation of services, keep existing providers strong and allow the foundation for providers to work together for out of the box ideas like forming accountable care networks, to name one example.

Characteristics of the Cardinal Network - 2

- Develop service continuums within the comprehensive providers.
- This should be a "one-stop shop" when possible.
- This not only improves patient care because they see one provider but also cuts down on the overhead of paying for multiple front desk and back door functions of multiple agencies.

Characteristics of the Cardinal Network - 3

- The MCO must know what it wants to buy and how much it has to spend to buy it.

- The MCO should be able to engage the provider network with payment mechanisms that encourage the outcomes they want without unnecessarily billing lucrative services for sustainability rather than medical necessity.

Hallmarks to make this happen:

Each comprehensive provider should have the following services under their roof or able to access the services through their peer agencies within the network.

1. Advanced Access (walk-in)/Part of an Outpatient Clinic
2. Outpatient/medication management
3. Enhanced Service Continuum
4. Crisis Service Continuum

Hallmarks to make this happen – cont.

1. Advanced Access: This is a service that is available in all clinics. Anyone may make an appointment or walk-in from 8am to 8pm, Monday through Friday. The patient will see a licensed clinician, get an assessment and get referred immediately to the treatment they need. This may include (but is not limited to): seeing a psychiatrist the same day; referral to an outpatient service the same day; referral to an enhanced service; and, if inpatient is needed, we attempt to handle the placement within the clinic to avoid the emergency department when possible. Due to our size and telemedicine capabilities, the payer source of the patient becomes moot for we can handle these assessments with multiple paneled providers or simply on volume if there is no payer.

Hallmarks to make this happen – cont.

2. Outpatient/medication management: These are normally evidenced based services available in group format 65% of the time in order to drive down cost and lesson the expense to patients, MCOs and the agency if there is no payer. Most of the groups are open ended so service start times are immediate. Medication management is handled by individual appointment or a medication clinic model, depending on the number of patients and size of the clinic.

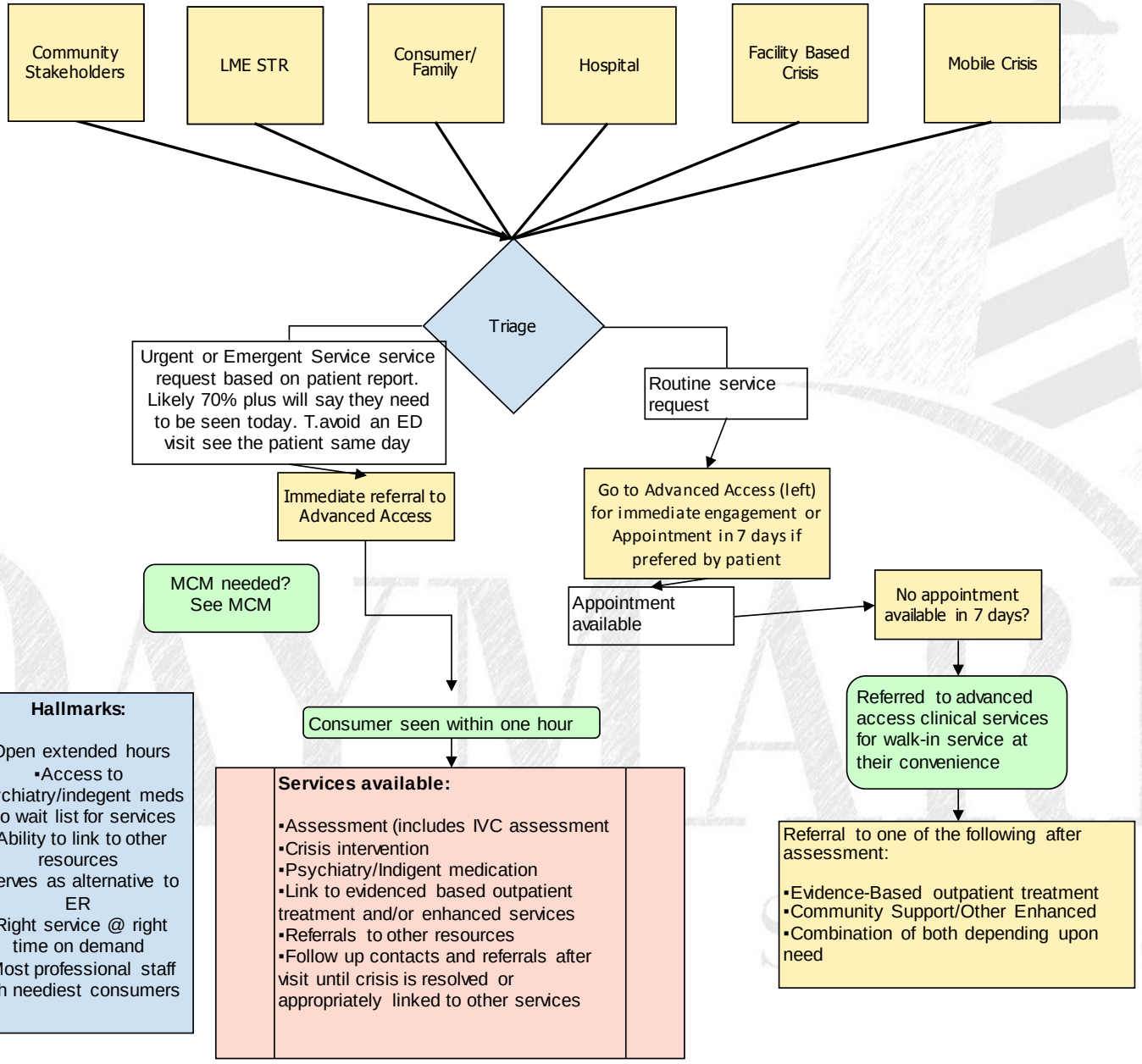
Hallmarks to make this happen – cont.

3. Enhanced Service Continuum: Whether it is our company or a peer company in the network, we can refer patients immediately to a small group of providers if they need enhanced care like ACTT, psycho-social club house, day treatment, intensive in home and so forth.

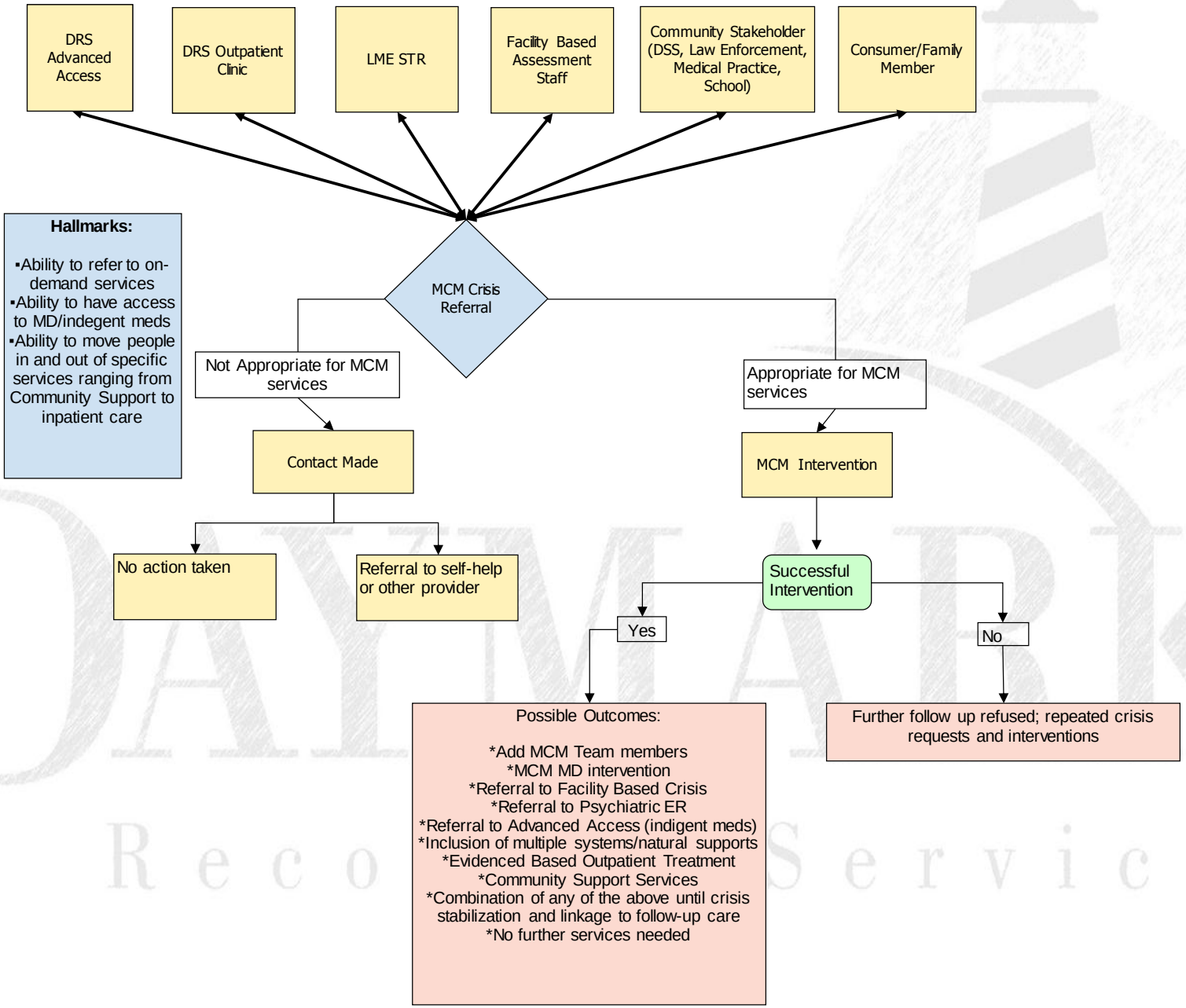
Hallmarks to make this happen – cont.

4. Crisis Service Continuum: We have two facility based crisis units at our disposal if people need immediate care. Essentially these are 16 bed psychiatric inpatient units that cannot force medications. This allows direct admissions for Medicaid and indigent patients for both mental health and substance abuse programs. All of our services are enhanced with our Mobile Crisis teams that accept referrals directly from our clinics pre- or post-assessment and also can follow up post discharge from our inpatient unit.

Advanced Access Clinics



Design of Mobile Crisis Management



Outcomes of our Crisis Continuum:

Advanced Access

1. Open extended hours Monday through Friday 8am to 8pm.
2. This service provided immediate access to care for 8,116 patients on demand for FY 2013.
3. Approximately 30% of the patients reported they had thought about going to the emergency department if they could not be seen.
4. Of those patients seen under involuntary commitment we were able to break that commitment 30% of the time and send the patient home.
5. Indigent medication is readily available on an acute and long term basis. This is important for 51% of patients in this service are indigent, 34% Medicaid, 10% private insurance, 3% Caid/Care, 2% Medicare.

Outpatient Clinic:

1. These clinics treated a total of 16,126 unduplicated patients for FY 2013. Of these 48% are indigent, 34% have Medicaid, 10% private insurance, 5% Care/Caid, 3% Medicare.
2. Treatment model is primarily evidenced based group treatment to lower cost to patients, increase efficacy and decrease impact of no-show appointments.
3. No-show rate is in the single digits to 13% at the highest.
4. Indigent medications are available.
5. All clinics linked via telemedicine and our electronic health record between all services.

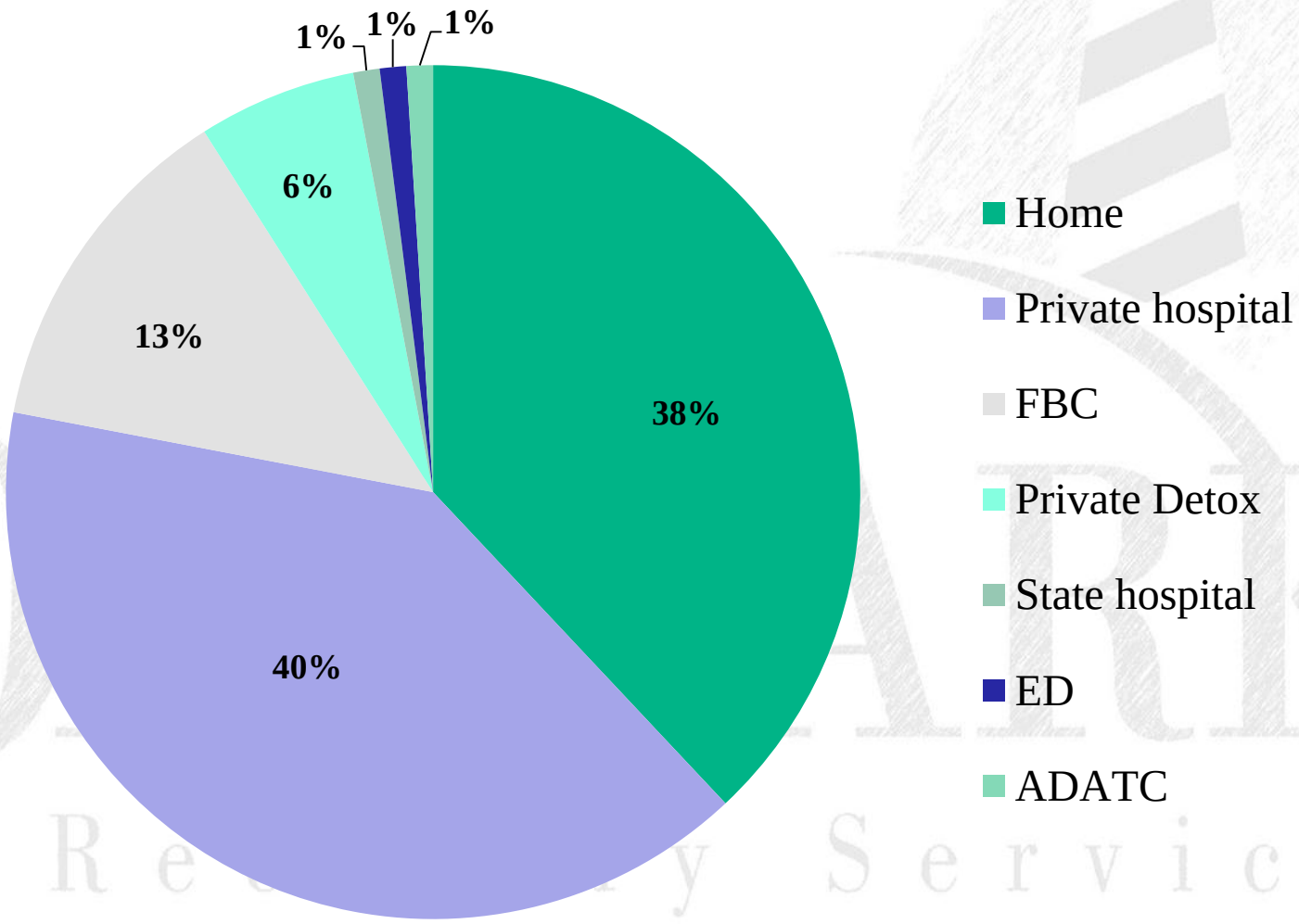
Facility Based Crisis:

1. Our two 16-bed units served 1,454 unduplicated patients for FY 2013. 10,510 bed days were used for a cost of 349.54 per bed day.
2. Once a referral is received, the vast majority of time the decision is made to admit within 15 minutes.
3. The average length of stay is under seven days.
4. 82% of the patients admitted are indigent with only 18% having Medicaid.
5. 100% of these patients avoided a long stay in a psychiatric inpatient unit and had either no stay or a short stay in a local emergency room.

Mobile Crisis Services:

1. Has ability to perform first opinion for involuntary commitment.
2. Shares electronic medical record with Facility Based Crisis and Advanced Access Clinic
3. There were 3,257 calls for service in FY 2013.
   - 57% are indigent
   - 27% have Medicaid
   - 7% have private insurance
   - 7% have Medicare/Medicaid
   - 2% have Medicare

Mobile Crisis Services Dispositions:



How do you support a system like described above?

1. Support Public MCOs

1. Support MCO efforts to right-size networks so that comprehensive providers can operate more “payer source blind” in a “one-stop shop” format.

2. Support MCOs in “out of the box” efforts to set rates differently, pay for services differently, or create or support in the creation of a service organization between like or complimentary providers.

Conclusions

- Private sector abandoned professional care due to poor rates and fiscal incentives to do lessor services to Medicaid patients.
- Decreased professional care resulted in increased crisis services
- Waiver programs can incentivize networks to provide cheaper and effective professional care through increasing rates and/or paying for outcomes.
- Waiver programs need total use of their funds to focus on outcomes and not traditional fee for service structured payment systems.