Compassionate Care in a Behavioral Healthcare Business Environment
From Prospective Payment to FFS
and
Its Impact on Provider Case Management and Treatment Delivery

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The Challenge Confronting the Case Manager

BHC Agencies will soon be converting from a prospective payment system that funds services for your clients before the clients receive services to a system that pays for your services after you provide them i.e. a Fee-For-Services (FFS) payment system at all LOC - OP, IOP, PC, etc.

Concern expressed by BHC Agency leadership is that delivery of behavioral health care within FFS system will result in funding shortfalls to agencies.

Case Managers - front line professionals who will be tasked with delivering the volume of services that will generate funds for their agencies within this FFS payment system.

Case manager productivity- producing billable encounters - becomes a core dynamic in the FFS payment system.
The Question That Was Asked

“In a FFS environment, what works with Individuals living with severe and persistent mental illness who do not always engage, often encounter barriers and/or have conflicted motivation?”

- What’s Needed:
  Strategies for case managers and agencies to effectively serve the consumer described above and to generate funding for agency programs in this FFS payment system.

- I don’t suggest here that I have solutions to all the challenges you will face after conversion to FFS.

- You’re likely doing now much of what I will suggest here.
Conversion – From Prospective Payment to FFS?

• Conversion from an unmanaged prospective payment system to an unmanaged FFS system for payment of BHC services is a partial enigma.

• Usual expectation = move from volume-based FFS to managed, prospective payment (often at-risk capitation/case rate) environ enabling valued-based service, “non-volume dependent” funding for services provided.

• FFS conversion presents an incentive to increase your volume (number) of clients and encounters provided to increase agency revenue. Not the usual shift.

• Will suggest later where this increase in service volume for BHC may be offset by a decrease in volume elsewhere in the healthcare system.
Conversion to FFS = Opportunity

• Conversion to an unmanaged FFS presents an opportunity for BHC providers to prepare for coming MANAGED healthcare delivery systems and a value-based service delivery system.

• Value-based = client centered with focus on positive health outcomes especially for chronic disorders (serious mental illness (SMI), addictions, diabetes, cardiovascular illness, respiratory disorders, weight related illness, etc.)

• FFS conversion period = time of preparation for coming reforms in BHC and healthcare generally.

• Within this presentation I hope to stimulate your creative thinking about what approaches you, as Case Managers, might adopt that will meet the needs of both your consumers and your agencies.
Healthcare Reform = Provider Agency Adjustments - Briefly


- Moving to a Value-Based delivery system.

- **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)** - rewards delivery of high-quality patient care via two paths:
  - *Advanced Alternative Payment Models (Advanced APMs)*
  - *Merit-based Incentive Payments System (MIPS)*

  for eligible clinicians and groups under the Physician Fee schedule (PFS).

**Alternative Payment Models (APMs)** can apply to specific clinical condition, a care episode or a population. **MIPS** = Physician Quality Reporting System (PQRS), Physician Value-based Payment Modifier (VM) and Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals (EPS), certified EHR technology (CEHRT).
How Do You Feel About Your Work?

• Are you “comfortable” with what you do?

• Do you feel safe in what you do.

• Do you feel that you are making a difference in the lives of your clients?

• Do you feel productive?

• Is your work meaningful to you?
NOT a Case Management Strategy
Strategies from NIATx

• Designed specifically for behavioral health care, the NIATx model allows payers and providers to make small changes that have a big impact on outcomes – (and revenue).

• As a learning collaborative within the University of Wisconsin-Madison's Center for Health Enhancement Systems Studies (CHESS), they provide research, promising practices and innovative tools that encourage and support the use of the NIATx Model of process improvement.

• See NIATx website – www.niantx.net - for more
NIATx Promising Practices for Case Managers and Agencies

1. **Clients spend too much time waiting** for and attending multiple appointments before the first treatment session.
   ⇒ **Combine** multiple intake, assessment, evaluation and admission appointments into a single assessment appointment.

2. When **clients don’t show up** for scheduled assessments, too many session slots unused.
   ⇒ **Book at rate that reflects typical show rate** – pair high % show clients with low % show clients.

   • **Mid-Eastern Council on Chemical Abuse** in Des Moines and Iowa City, Iowa reduced the impact of no-shows and increased counselor productivity by scheduling 9 admission appointments during 6 hours of available counselor time.

3. Staff spends **too much time making appointments that are not kept**. No-shows for assessment appointments prevent other clients from using that time slot.
   ⇒ **Establish walk-in hours** so that clients are able to see a counselor for an assessment without an appointment.

4. **Too many clients are seen individually** when more could be seen in groups.
   ⇒ **Offer more groups** in place of/in addition to individual sessions, so that counselors can see more clients during the same amount of time.
NIATx = Ask Clients to Participate in Tx Planning –

- **Clients without a personal stake** in their own treatment are less likely to stay engaged and continue treatment.
- **Ask clients to participate** in creating their own treatment plans with goals and objectives and ways of achieving them that meet their individual needs.

- **Gosnold, Inc.** in Falmouth, Massachusetts increased continuation rates through four weeks of treatment from 72 percent to 88 percent by introducing a [solution-focused therapy group](#) for patients to develop their own small scale, rapid-cycle changes using PDSA cycles, which they called Plan-Do-Measure-Act (PDMA) cycles. **Patients made personal changes and tracked their progress.**

- **Often referred to as disease management-client-provider partnership to manage especially chronic disorders.**
Cross-Trained BH Clinicians

• Many clients in FFS conversion population will present with co-occurring disorders.

• Many BH clinicians are not cross-trained to treat both MH and SUD.

• Recommend planned effort to cross-train behavioral staff to address co-occurring disordered clients.
Compassionate Care (CC) & Motivational Interviewing (MI) Keeping the Client Engaged

- Etymologically, compassion means “suffering with” and has been defined as “a deep awareness of the suffering of another coupled with the wish to relieve it.”

- MI & CC = collaborative, person-centered communication strategies to strengthen client’s own motivation to change.

- MI, first developed for addiction counseling, has become accepted technique in public health, health promotion and case management.

- Both CC & MI are two-way communication approaches = case managers talk and listen.

- Compassion provides a sense to patients that their condition and concerns are being heard, recognized and acted upon.

- Case manager is not a helper but a coach for independent functioning through client skills development.
CC/MI = Four General Processes to Achieve Effective Outcomes

• **Engaging** – Involve the client in talking about issues, concerns and hopes, and to establish a trusting relationship with a counselor.

• **Focusing** – Narrows the conversation to habits or patterns that clients want to change = **goals**.

• **Evoking** – Elicits client motivation for change by increasing clients' sense of the importance (benefits) of change, their confidence about change, and their readiness to change.

• **Planning** – Develop the practical steps **clients want** to use to implement the changes they desire.
Engaging the Client: Practical Case Mgr/Agency Strategies

- **YOUR CONSUMER POPULATION** - Individuals living with severe and persistent mental illness who do not always engage, often encounter barriers and/or have conflicted motivation.

- **Going out** to consumers, especially when they don’t show for you – go where they show up and/or congregate = FQHCs, welfare offices, medical groups, ERs, etc.

- Meet the client for the first time *with a colleague*.

- “Buy lunch” or coffee “and”

- For medication management – coach for use of “pill box’

- **Satellites sites** in high volume areas. Other’s sites - medical groups, FQHCs, welfare offices, malls, supermarkets, drug stores?

- **Mobile units** for *home visits*

- **Arrange Transport** to services – LogistiCare, your agency vehicle, etc.
• **Use media:**

• **Tele-health/on-line chat** treatment - especially for at-risk consumers and for **on-demand encounters – virtual/eVisits.**

• **Video healthcare sessions**- especially for psych-ed.

• **Advertise** your BHC services – get the word out to consumers at medical groups, FQHCs, welfare offices, ERs, drug stores, via written material, TV, radio, **social media**, etc.
Compassionate/Collaborative Illness/Disease Management

- A “non-compliant client” may be due to a non-compliant case manager = not complying with who your client is = motivated to make change that is rewarding to the client not to the “helper”.

- Take client’s perspective – ask, “what changes are good for you?” but guide them.

- Keep the family and significant others involved in the case management process.

- Partnering with client, their family and significant others is core dynamic in illness management.

- “An engaged, educated, guided family is as important to recovery as medication.”

- This is especially the reality with co-occurring clients where denial and misstatements about SUDs are frequent-significant others have significant info.
Affirming the Client’s Presentation

• **Maintaining rapport** with the client in the form of compliments or statements of appreciation and understanding.

• Main objective = focus on honesty and specificity.

• Below are some **examples** of “affirmations”:
  
  ‣ “Thanks for coming on time today.”
  ‣ “It seems like in some areas you are a confident person.”
  ‣ “You appear to be happy with other people and to make them laugh too.”
Reflective Listening

- **Reflective listening** is one of the most important and **challenging** skills for a counselor to master- art of meaningful repetition (remember Carl Rogers?)

- Often used to express accurate empathy and understanding of the client’s interpretation of the real world - their view.

- Not merely being quiet while listening, it’s more about the way the case manager responds to what the client says - restating the client’s message to you.

- Especially useful in addressing client resistance to change.

- Case manager can easily fall into the trap of **inactive listening**, which is defined as “roadblocks”-

- **Some examples** include:
  
  *Tell the person what he/she should do;* warning; disagreeing/criticizing; providing solutions; blaming/criticizing; probing.
## Case Manager “Change Talk”

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<tr>
<th>Types of change talk</th>
<th>What is involved</th>
<th>Examples</th>
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<td><strong>Encouraging change talk =</strong></td>
<td>Encourage with particular interest and curiosity both verbally and nonverbally (e.g. pay attention, head nodding),</td>
<td>“What are some other reasons why you might want to change?”</td>
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<td><strong>Reflecting change talk =</strong></td>
<td>Clarify what the client says, carefully select what to reflect upon in order to reinforce change talk</td>
<td>Client: “I want to quit smoking, but I don’t know if I am ready.”</td>
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<td><strong>Summarizing change talk =</strong></td>
<td>Selectively gather and encapsulate client’s change talk, so that client can hear it again in a more condensed manner</td>
<td>Therapist: “You mentioned a few concerns about taking antidepressants. You also said your mood is better and you have more energy while on antidepressants.”</td>
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Client Responses to Compassionate Care Approach

- “Staff communicated effectively and listened to my concerns.”
- “Staff treated me with respect.”
- “Staff did not make me feel ashamed as a result of my mental illness.”
- “Staff provided me with community education and support groups like NAMI.”
“Columbo Approach”-a Non-Confrontational Questioning of Client Discrepancies

• “So, help me to understand, on the one hand you say you want to live to see your 12-year old daughter grow up and go to college, and yet you won’t take the medication your doctor prescribed for your diabetes. How will that help you live to see your daughter grow up?”

• “Help me understand, on the one hand I hear you saying you are worried about keeping the custody of your children. Yet, on the other hand you are telling me that you are using crack with your boyfriend. Ok, since you also told me you are being drug screened on a random basis, I am wondering how using cocaine might affect your keeping custody of your children. What do you think?”
Structured Learning Therapy (SLT)

• If I had to recommend one approach to counseling chronic SMI individuals it is in:


• Not talked about much today.

• For the “forgotten” individuals – “SLT consists of modeling, role-playing and social-feedback reinforcement, a direct form of skill training that can help chronic patients learn socially appropriate behavior.” Gutride et al. (1974) pg. 277.

• Used this approach years ago in an OP and a Partial Care program at a NJ MH agency with good outcomes.
Integrate with Medical Groups & ER Staff

- Partner with physicians, APNs, PAs, Nurses and medical group office staff. (Nurses and Office staff usually attend meetings).

This is most likely an Agency task but this affects what Case Managers do.

- **Train medical staff** to use brief **screening instruments** for:
  - psychosis
  - alcohol/SUD
  - depression/suicidality
  - child behavioral problems

- **Provide service contact information** – warm transfer for referral to provider entity, when possible.

- **Goal** = ID consumers at risk for early intervention/prevention.
Demonstrate to medical providers/hospitals - many medical disorders are behavioral in nature especially for SMI clients.

**Examples:**
- **smoking related** disorders = respiratory (asthma, emphysema, COPD), cancers, dermatological, stroke, etc.
- **dietary behavior related** = gastrointestinal, cardiovascular, diabetes, cancer, etc.
- **weight related disorders** – **overweight** (back and joint disorders) and **underweight** related disorders of children and pregnant mothers
- **alcohol/drug related** = cirrhosis, pancreatitis, etc;
- **violence related** = variety of physical/neurological/psychological injuries, etc.
- **stress related disorders** = gastrointestinal, cardio, depression, anxiety, etc.
- **sexually transmitted disorders** = HIV, viral hepatitis, chlamydia, etc
- **vehicular related disorders** (auto/cycle related injuries, non-use of seatbelts, helmets, DWI, etc.),
- **Right sided endocarditis** accounts for 10% of all IE in population based surveys and a higher proportion of IE in injection drug users. Occurs most commonly in young males in their 20s and 30s. (Moss and Munt, 2003 May)

Each disorder addressed behaviorally to reduce utilization rate of HC services related to these **disorders of lifestyle**.

**Outcome** = in capitated funding systems for medical (and BHC) providers reduces service utilization = resource savings, **but in a FFS environment = an increase in the volume of behavioral services.**
BHC Providers = Addressing Lifestyle Disorders

- smoking cessation (Star – Ledger, January 12, 2017, pgs 29 &32)
- psycho-education for improved nutrition
- psycho-education for proper exercise
- alcohol/drug abuse prevention education
- violence/anger management
- safe driving education
- safe sex education
- stress inoculation/management
- parent training for child management
- couples/family counseling
- All of the above and other lifestyle public health problems amenable to behavioral, e.g. hand washing with soap – (see Curtis and Aunger, 2012)
Medical- Behavioral Link

• “Cancer deaths rate drops 25% from 1991 peak” - Why? = reduced smoking, early detection and tx.
  (Star-Ledger, January 6, 2017, Health, pg. 5)

• Adults (18 plus) with mental illness in the past year more likely to smoke cigarettes than adults who have not experienced a mental illness according to a new report by (SAMHSA).

• At risk populations “defined” = 40% higher death rate for men vs women, 15% higher for African-Americans than whites.

• Continued improvement requires “creative new strategies to increase healthy behaviors nationwide” – a population based approach.

• “‘tremendous opportunity’ to further reduce cancer risks by focusing on risk factors such as weight, diet, physical fitness and exposure to ultraviolet radiation” = behavioral psycho-education- addressing denial.

• “Skin cancer drop in NE” - Why? - preventive use of sunscreen –
  (Star-Ledger, December 29, 2016, pg. 27)
Healthcare Cost Drivers

• “The US spends more on health care than other countries…” = “Within a decade, close to a fifth of the American economy will consist of health care”. BHC providers can contribute to reducing this!

• “Chronic - and often preventable - diseases are a huge driver of personal health spending”.

• The three most expensive diseases in 2013: diabetes ($101 billion), the most common form of heart disease ($88 billion), and back and neck pain ($88 billion).

• Depression was sixth and not far behind the fifth, i.e., falls, for driving healthcare costs.

(All of above in Star-Ledger, December 29, 2016, pg. 27)
Consumer/Demand Side Management with Capitated, At-risk Medical Groups


• Implement “disease management”- a critical activity with target populations.

• Partner with patient, family/significant others to manage chronic disorders - depression, psychosis, SUDs, diabetes, cardiovascular disease, cancers, etc.

• In FFS environ, behavioral provider/staff will increase volume of services with delivery of this service component.
Integrating with Medical Staffs- Demand Management

Primary prevention – psycho-educational activities prior to and at the point of service.

• **Goal** is to reduce utilization of healthcare services - especially for intensive, high cost healthcare services = ER visits, hospital IP stays, surgeries, medical equipment, some medications.

• **Capitated at-risk medical groups will want to achieve this goal.**

• **Care decisions should not be compromised for $$ issues.**

• **Must provide necessary and appropriate care.**
New Agency Opportunities

★ Behavioral Health Homes (BHH). Addressing consumer at risk of being high utilizers of healthcare services.

Using Risk assessment tool – Chronic Illness and Disability Payment System (CDPS):

CDPS categories of illness: Cardiovascular, Psychiatric, Skeletal and connective, Nervous system, Delirium and dementia, Pulmonary, Gastrointestinal, Diabetes, Skin, Renal, Substance abuse, Cancer, Metabolic, Cerebrovascular, Infectious disease, Hematological.

• Opportunities for BHC interventions.

• Close integration/collaboration between BHC providers and medical services delivery systems.
Certified Community Behavioral Health Clinics (CCBHCs)- deliver comprehensive MH & SUDs services directly or through a formal contract with a designated collaborating organization (DCO).

Following services must be offered by the CCBHC and will be paid for even if they are not included in a state’s Medicaid plans:

- Crisis mental health services including 24-hour mobile crisis teams, emergency crisis intervention and crisis stabilization*
- Screening, assessment and diagnosis including risk management*
- Patient-centered treatment planning*
- Outpatient mental health and substance use services*
- Ambulatory WM
- MAT
- Primary care screening and monitoring**
- Targeted case-management**
- Psychiatric rehabilitation services**
- Peer support, counseling services, and family support services**
- Services for members of the armed services and veterans**
- Connections with other providers and systems (criminal justice, foster care, child welfare, education, primary care, hospitals, etc.)**

*CCBHC must directly provide  **Maybe provided by CCBHC and/or DCO
Know About Population-based Healthcare Services

• Framework for “life style” disorders to assure only necessary and appropriate care within the defined population served.

• Consider: limited resources and resource conservation within the defined population served.

• Must “… balance the needs of any one individual against the needs of the larger community.” (Armenti, 1999. pg 46)

• Relevant concern in an at-risk capitated payment environment.

• Assess demographics of subpopulations served within your defined population base - ID higher users and those at risk for high utilization.

• Sub-populations (Medicaid, Medicare, privately covered) some = more at risk than others for high utilization (note SMI).

• Higher utilizers require more creative approaches to service delivery.
THANK YOU

Q & A
References


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http://healthaffiars.org/blog/2016/10/17macra-final-rule-cms-strikes-a-balance-will-docs... ... ./


Prevention Categories - see:
(http://www.iwh.on.ca/wrmb/primary-secondary-and-tertiary-prevention)

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