MINNESOTA CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

Present:
J. Pearson, DHS
M. Xiong, DHS
J. Zakelj, DHS
L. Allerson, DHS
J. King, DHS
J. Palen, MACMHP
W. Wilson, MDH
J. Blanchard, DHS
P. Yang, Wilder Foundation
J. Drier, MN Council of Health Plans
D. Kearns (J.Pederson)
M. Mer Gubkin, Pharmacists Association
S. Smith, NAMI MN
P. Fowler
L. Peterson, DHS

Phone:
B. Krahbiel, Zumbro Valley Health Center
G. Petterson (Lyonna Lynch)
H. Geerts, Zumbro Valley Health Center
T. Daniels, MN Hospital Association
Senator M. Wiklund, MN Senate
S. Mulvahill, Mental Health MN
K. Versable,
S. Reitmeier, Northwestern Mental Health Center
L. Vaughn, Northern Pines

Discussion:
Meeting in April
- Established shared understanding of project. History, program, and 6 clinics.

Pilot stated on July 1
- First implementers have been getting up and running
- It will be great to hear updates now that work is live
Questions/update about sustainability

DHS – J. Pearson

- Acknowledge that this is an advisory group so have 4 hours of material in the slides for a 2 hour meeting. The slides will have the information you need and won’t cover all in this meeting
- Further questions could also be answered on the DHS CCBHC website
- We are in demonstration period for 2 years. July 2017 through June of 2109
- State is being tasked to monitor compliance with service standards, data, payment
- Will be reporting on claims data and clinic data and reported to CMS though Rand and Mathematica
- Assessing impact of demonstration in MN also
- Reviewing the PPS rate set for first year and potentially rebasing in year 2
- SAMHSA will submit annual reports to congress. They are submitting an initial report soon. When that comes out, Julie will forward to this committee
- Currently, we have authority to make Medicaid payments through June of 2019
- Step 1: We at DHS are working on figuring out how we can sustain the 6 clinics beyond the demonstration. We will need CMS approval to continue to get Medicaid payment.
- The data we collect will be too preliminary at first to make those decisions
- Step 2: we will need more data and then can consider expanding beyond the 6
- Question: with all the changes at the federal level, are we incorporating into plan A and B? yes, we are considering that
- J. Palen was at the day on the Hill with National Council. Heard that the Excellence in Mental Health Bill has been presented to House. Senator Stabinow also offered an amendment to another bill. This hopes to expand the demonstration to up add 11 more states and add one more year. The goal was to get to the 19 states who applied for the demonstration (of the 24 states that had planning grants)
- Would you need statutory authority to extend beyond demonstration? DHS has authority to apply for extension of Medicaid payment for current 6 clinics

How has implementation been going for 6 clinics?

- Wilder Foundation (CCBHC): definitely feel like 90+ days we are still not experts and that’s okay. That is new for our team to not be perfect. We are providing faster access. Coming across interesting dynamics because even with quick access there are families can’t make it to an appointment within 10 days because they need to time to plan (miss work, get kids out of
school) and need to give longer notice at work. Our controller has been meeting people in parking lot (random people!) and get them in immediately.

- We have used a new lens to see how people access services. A few years ago we had a 9 month wait list. We aren’t perfect but we aren’t at 9 months anymore!
- Still figuring out our metrics
- True internal integration alignment.
- Bringing us back to the why of integrated care.
- We have people who never talked about Diabetes, talking about these things with clients. It takes us back to our philosophy of what health is
- New level of teaming. Some bumps but our team is working more effectively
- We have a foundation wide goal about racial equity including how we recruit and retain our workforce. We have goals about providers matching the community as well as the management level. Between BHH and CCBHC we have been able to bring in a whole new group of people we couldn’t afford to employ before. Peers, CHW, ARMHS practitioners. Much more intentional about career ladder. This has been the most exciting pieces because we can hire from the community we serve and build ladders. Real recovery includes employment and housing.
- What factor has reduced the wait list? The main factor is the assessment is quicker. And it’s our goal. Actually, being able to hire a person dedicated to this work. Quick assessment on what they need first and let evaluation information to be gathered later. On first day of initial evaluations, I kept getting calls of people asking, “is this the whole assessment”.
- We had a mom come in and she pulled me aside and said how great it was to just get asked what I needed and moved into services

Zumbro Valley Health Center (CCBHC)

- Same things as Wilder.
- We are also getting people in faster. Increased numbers in service lines because of increased access
- One program we struggle with best process flow is with SUD services. Meeting the requirements for CCBHC and SUD paperwork is hard. Getting closer to seamless.
- Integrated treatment plan. Getting to stage where we need to pull people together.
- Feedback on positive and negative for having everyone around the table for integrated treatment plan
- Started some of new programs. CTSS, SUD adolescent program (great reception within our community)
We can get people in within 10 days but harder to meet 10 days when clients don't want to come in that fast. Client schedules make it so people are not choosing to come in. We are respecting their schedules and being person-centered.

Trying to figure out when multiple assessments. Not only SUD and MH but external providers as well.

Are you seeing any new partnerships with other entities? Yes. One of the processes was obtaining formal care coordination agreements. There were some partners that didn't know what services we offered. We also found new referral sources. Medication assisted therapy was where we learned the most. We didn't have that in-house.

Care coordination and case management. Will there be coordination with case management redesign? J. Blanchard leads that work. Staff assigned to it full time. Holding all areas accountable to have some better definitions of care management and care coordination. Trying to create consistency. What has been lacking in the past was the how to get it done rather than what needs to be done. J. King (CCBHC services specialist) is on the care coordination sub-committee of that work. Wilder said they worked internally to reduce that duplication. S. Reitmeier, at Northwestern, shared that with care coordination agreements and care coordinators, the care coordinators are coordinating the coordinators to report back to the client. That reduces duplication.

What about civil commitment? DHS said they had a few meetings with counties and CCBHCs. The county still has their obligation to provide case management for civilly committed individuals. Each county seems to be handling it differently. They either take it into county case management or contracted providers. Wilder shared that even prior to CCBHC, staff would take on some of the work when client is committed. S. Reitmeier shared that it tends to be case by case in conversation with county. We historically split the functions. Still finalizing some of those pieces with all 6 counties because each county is different. Zumbro Valley shared that they have been working closely with county to get this taken care of. Sometimes it's hard for us to get our evaluations done because clients are involuntary. Trying to get to them while still in hospital. Trying to get completed documents and shorter interactions.

Northwestern Mental Health Center (CCBHC):

- Echo Wilder and Zumbro. We are running into similar things.
- Biggest shift structurally has been at the front door. People coming and getting the process with initial evaluation and comprehensive evaluation. We are really the only MH provider in area. We serve a lot of commercial insurance. Initial evaluation is not covered benefit for commercial. We have sometimes been going straight for comprehensive evaluation.
Acceptability. We also implemented open access. 3 days per week people can call or walk in and get in for immediate initial evaluation. This has been very successful and well received. We are getting our first quarter’s worth of data. Diving in for information to decide if we need to put in additional resources.

Redesigning our community based services based on regions and having multidisciplinary and cross-generational teams. They can provide the full array of services within team without having to refer to a specific program. If a person can’t come in, our community based teams can do all the assessments, rehab services, psychotherapy, chemical health; can all be done within the mobile team.

Equity

- Asked some of the first implementers how they are addressing equity issues
- Wilder: it allowing us to be more responsive to people. Especially people in our immediate neighborhood. We had someone who came in because she rides the light rail every day. She was served immediately. Racial equity work internally and building career ladders. Adding to work force. This provides us an opportunity to re-look at and widen our perspective on who we can hire. A lot of our staff come from the cultural and neighbor community our facility is in. Question: are you finding diverse applicants to those positions? Yes, there is a very real challenge of work force shortage for MH and especially with certain cultural populations or linguistic skills. Also, we work on our work place culture. We re-look at who is qualified to work here. Is it credentials? Is it something else? Complicated dynamic. This allows us to afford to mentor people. Zumbro also talked about needing continued funding to keep those diverse staff. Allowing us to hire someone to do data analysis and outcome measurement and infrastructure and back office allowed for hiring diverse staff. Shauna echoed CCBHC allows for hiring staff with expert skill sets. Allows Wilder to pay a more competitive salary. Student interns have said that their schools told them to go to a CCBHC for their internship so work is getting out. Northern Pines (CCBHC) has already hired 37 new staff. She has been visiting classrooms at colleges and universities. It has had a wonderful impact on hiring in rural MN.

- Has the hiring of new staff allowed you to reach out to new communities? Yes! Huge focus on infrastructure and training and building up staff so we can take our model out to new communities in a coordinated way. Especially with veterans and Native American population with whom we have not always served. Want to be seamless before going there
- Are there tools or ways we can serve new communities? If the goal is to expand access, how can DHS be helpful in reaching out to communities? Northern Pines: bringing on board the new staff has been time consuming and break down silos and get the evaluations in place.
We need to get 60% of our current clients up to the CCBHC standard before doing outreach.

- J. Pearson: goal 2 of CCBHC has been to focus on increasing access to and availability of services to underserved communities. Are there measures for this? Will present later in meeting
- What is MACMHP doing about equity? We are supporting the clinics with their processes. It is still a bit early. The 6 clinics are getting settled with the model. We are looking for feedback about what is happening.
- W. Wilson (MDH): the center for self-equity (?) in MDH can help with this
- At Wilder they are building the strength of their clinic but would like to know what communities they aren’t serving. They are looking at some of their culturally specific programs and seeing if they really can serve anyone who walks in the door. It is a big culture and identity change. It’s exciting we can serve anyone but don’t want to lose the culturally specific programming.
- J. Blanchard said Wilder is a an organization is clearly intentional about this and could help us all

Evaluation

- Equity and evaluation kind of work together so we will talk about both together
- M. Xiong (DHS) shared the 8 impact measures that were created collaboratively with the 6 clinics
- 2 data sources: 1 is Medicaid claims data from MMIS and client-level data from clinics that will be submitted to DHS
- How they were developed:
  - State did needs assessment to see what was needed to get each clinic up to CCBHC standards. Clinics uncovered needs like transportation, travel time reimbursement, staffing, peer services. Found that persons of color had highest unmet needs and those with language barriers had difficulty obtaining services
  - Developed goals in response.
  - Goal 1 is to increase number of services available. Specifically added in withdrawal management
  - Goal 2 is to increase access to services. Specifically increase access to communities of color and those who don’t speak English as their first language.
  - Developed impact measures to determine if goals are being reached
Impact measures: (follow PowerPoint)

- Expansion of peer services. This is an equity opportunity to hire people from within a community and who can serve their own communities.
- Measuring if the number of people of color and non-English speakers has increased.
- Measuring access to telemedicine services.
- Tracking speed of access to services. Looks at percent of clients who get the initial evaluation within 10 days (J. Blanchard suggested that it would be great to track when an appointment is offered within 10 days and refused. Can this be tracked in EHR? S. Reitmeier has been working on that. They want to capture that in EHR. J. Pearson said she wants to keep gathering info on this to tell federal evaluators. Maybe we learn that 10 days is not our goal in MN. How could we highlight the reality? L. Allerson shared that while talking to other states yesterday, Pennsylvania is gathering some of this. It would be great to have this in EHR but maybe there could be some anecdotal information about what is being offered and refused through tally sheets and more manual collection.
- How many people come back for services after an assessment? And then dissecting that according to language and race. Is there a difference between these groups and can we move the needle?

Client demographic information is gathered by clinics and provided to DHS.

CCBHCs submitting data on quarterly basis even though only need to submit annual report. This is to work through issues and build data integrity.

DHS is also wanting to know other data questions to ask. We will have a lot of claims data and could analyze it different ways. What does this advisory committee want to learn from the state about CCBHC?

Can these outcomes be aligned with other measurement systems? J. Blanchard – that is happening with health partnerships and partnership portals. Want to support Medicare billing as well. Also value-based purchasing. CCBHC is still in demo. Sometimes the State has measures but doesn’t meet the federal requirements. MACMHP can be a strong voice federally for collection of measures here. L. Allerson talked about efforts at DHS working on different payment models and integrating measuring quality into payment models. MACMHP can be a good advocate for aligning measurement.

Let’s continue to get input from this committee about what further data analysis to do. Would it make sense to look at the actual data as it is getting collected to see what surfaces? DHS will have some data by spring. Certainly preliminary results of number of who is served, services provided. Quality measures will take longer to wait for claims to process. Will have client level data...
data that could be reported instead of claims data that will take longer because of waiting for
them to be paid. The demographic data will come out of clinic level data.

- Let’s bring this topic back in a future meeting. Maybe mid to late Spring.

Quality Bonus Measures and Payment (See PowerPoint)

- What M. Xiong presented on were state-determined impact measures. We chose these
  measures
- The federal demonstration also requires 22 quality measures, of those quality measures, some,
  if met, qualify clinics to receive bonus payments
- Bonus payment can average up to 5% of total payments
- In federal application we identified which measures and said what the steps would be
- In first year, all clinics will need to meet the same thresholds. In year 2 they will need to meet
  their own thresholds
- Used regional and national benchmarks and got information from clinics to set these
  thresholds. This will be re-evaluated once numbers come in.
- 6 measures. 2 are subdivided into children and adults.
- Generally used weighted average of clinics from 2016 to set thresholds except for one measure
- There is a lot of variability between clinics
- Hoped that by using weighted average makes the measures achievable for the clinics
- Question: how did we get adherence to anti-psychotics? It is a PDC measure rather than NPR.
  It’s not a perfect PDC but NCQA said it is accurate. PDC is proportion of days covered. Looks at
days in year rather than quantity of medication that got filled and extrapolating to days.
  Comment from committee: This is just based on refills of pharmacy data without being certain
  of taking the meds.
- For quality bonus payments, only Medicaid-only clients will be included. No dual-eligibles will
  be in this data

Next meeting will be on February 14, 2018. Then April of 2018 after that.

All of the materials for the committee will be posted on MACMHP website and the DHS CCBHC website
is hyperlinked from MACMHP website.