Implementation Team

Minutes

November 3, 2010
8:30AM – 11:00AM

Attendees: Susan Drown, PJ Lockerbie, Kalli Benson, Anita Coen, Quinn Lung, Cliff Moers, Ami Garry, Angie Lawson, Mary Sterritt, Laura Douglas, Janet DesGeorges, Ric Durity, Rebecca Herr

1. Welcome and intros
   A few people were attending for the first time, so the group gave introductions.

2. Updates and discussion from work groups
   a. Early Adopters
      The Early Adopter team is in the process of notifying organizations about different ways they can participate, and a memorandum of understanding is being developed. Training will hopefully begin in February. The goal is to establish a learning collaborative that can potentially be used to apply for grants and sustain the training. The learning collaborative approach has been used by others to advance systems change and adopt best practices within whatever group they are involved in. A learning collaborative for Daylight would involve providers around the state in advancing access on things like infrastructure, standards, environment, training, administration, and clinical issues. The learning cooperative is also part of the sustainability plan. There are 6 early adopters plus MHCD and Arapahoe House.

   b. Training
      An instructional designer is working with the training work group and the consumer and family work group to develop training modules. A draft course was been completed for the CAC endorsement; it is about 220 slides for 14 hours of training. DBH will offer the course, but it will not offer a trainer, and there is not an identified trainer yet. DBH can put the info out to possible trainers, but that may take longer to get feedback/interest. Daylight will receive an additional $60k from DBH for the next phase of the project, so that is a possible source of funds for trainers.

   c. Technology
      The Technology Work Group has two areas of focus. One is on hearing assistive technology and one is on telebehavioral health. On hearing assistive technology, Sara Meade is the audiologist that is working with the work group, and the Commission's technology program is helping also. We are working with early adopters to see what kind of technology needs they have, and Sara will be able to assist in adoption and use of that technology. We're working to see if we can connect it with the Commission's technology program to sustain it

in the future. The focus is more on systems and resources to advance therapy and group therapy rather than personal devices.

With telebehavioral health, some of the early adopters have experience and expertise already, so we will work on helping them use their existing systems with deaf consumers. Some of the early adopters said they don't have the technology yet, so we will work with them to see what they need and then work on training with that technology. The learning collaborative will be an important part of this since the organizations can learn from each other.

d. Consumer and Family
The work group is working on developing modules for potential advocates: one on mental health and substance abuse, one on personal and community advocacy, and one on deaf and hard of hearing. They are also in the process of discussing advocate recruitment and coordinating with other organizations such as NAMI, We Can, and MHAC. They are planning on coordinating a Mental Health First Aid training with We Can but would like to wait to get more advocates on board first. The group has not identified a place or time for the trainings yet, so they have not begun work on the issue of geographic access to the trainings. As the work group moves forward with the training, they will look to group members and other organizations that may have more experience with planning and coordinating trainings.

e. Evaluation
The Evaluation Work Group is continuing key informant interviews and is in the process of finalizing that report. They are also in the process of completing the year one report which needs to get done soon so it can be reviewed. There have been many events that have happened, but they haven't been summarized yet, so that needs to be part of the report. They have put out their last request for interviews for Consumer and Family members; about 13 have been completed so far. Most of the people so far have been with hard of hearing people and only a few have been with culturally deaf. There will also be some outreach events at the American Public Health Association which starts this weekend. There will be 2 presentations from the Daylight Project as well as a networking dinner for people interested in getting involved with deaf and hard of hearing issues. So far, 12 people have signed up for the networking dinner. If anyone has materials that they want to share, they can send or drop things off with Anita to have available at the dinner.

3. Guest speaker- Dr. Carl Clark, CEO of MHCD, on Health Care Reform
Dr. Clark gave an overview of the federal health care reform bill. Health care reform looks at the full spectrum of health, including behavioral health and elder care. The reform focuses on improving health outcomes instead of just health services.

Health Care reform has multiple time points
Beginning 9/23/2010:

- Elimination of pre-existing condition exclusions for children
- Adult children up to 26 can be covered under parents insurance
- Elimination of restrictions on annual insurance coverage limits and bans on lifetime limits
- Efforts to increase access to primary care and prevention services
- End of rescission- unjustified cancellation of insurance policies when people get sick

- Require insurance companies to cover evidence-based preventive services and eliminating copayments for many of those services; includes things like tobacco cessation

US health care reform must address these additional issues:

- Universal coverage- health care reform moves closer to this since more people will be insured.
- Payment reform- trying to move towards paying for outcomes instead of just treatment
- Delivery system redesign- Creating a system where there is case management or coordination among doctors and providers. This looks at how information is shared and how services are coordinated.

Healthcare reform also looks at safety net and early intervention and prevention. Currently, people do not get services until they are sick and sometimes beyond the point of being able to get healthy. Reform measures include:

- Increasing Medicaid eligibility to 133% of the federal poverty level; this is expected to increase the Medicaid population in Colorado by 43%
- Increasing Medicare eligibility
- Providing federal assistance/subsidy for insurance for people between 133% and 400% of the federal poverty level
- Creating an insurance exchange for people to shop for insurance

Most members of Colorado Safety Net will have coverage including mental health and substance use benefits. Expected changes to the safety net population:

- 43% increase in Medicaid enrollees
- Large reduction of uninsured (67% decrease)
- $206 billion of new federal funding

Other provisions can be categorized into 4 broad buckets.

- Medicare reform- donut hole: people have a low prescription copay up to a certain point; then they pay 100% of prescriptions until they reach another point; then they pay a low copay again.
- Insurance reform- for example, eliminating rescission
- Medicaid reform
- Other provisions- includes increased funding for Health Care Fraud and Abuse Control Fund by $250 million over the next decade.

System design changes

- Patient centered healthcare homes- a place where care is coordinated. In the past, this was described as being assigned to a place as a gatekeeper, but healthcare reform is meant to be a gate opener. For example, if a provider manages their patients well and gets their patients referred and cared for quickly, they receive a bonus. It incentivizes doctors to emphasize outcomes.
- Accountable care organizations- a bunch of health care homes and specialty providers that oversee care. Kaiser currently operates as one. It is a model where people pay premiums for health care, and providers have many other providers to refer you to, and if you stay

healthy, the providers make more money. Setting up these organizations will be easier in some areas, like metro areas where many providers are already in place.
- Early intervention and prevention programs- until now, these things have not been paid for very well.

Healthcare Home Principles
- Ongoing relationship with primary care provider
- Care team that takes collective responsibility for ongoing care
- Provides all healthcare or makes appropriate referrals
- Care is coordinated or integrated
- Quality and safety are hallmarks
- Enhanced access to care is available
- Payment appropriately recognizes the added value

Parity will likely improve access and available services
- Mental health and substance use services must be provided at parity with general healthcare services (no discrimination)
- Medicare has always had larger copays for MH treatments, but healthcare reform will change that

Regional collaborative care organization pilot
- Colorado's first step in getting people care.
- Bidders are a group of providers who will treat 6700 Medicaid patients in their area. The collaborative will be responsible for coordinating care for their assigned patients.
- The goal is to drive down health care costs by 7% over the next 14 months.
- If the collaborative is successful, they will get all the Medicaid patients in their area.
- A separate data analytic contractor will look at health care outcomes.
- The boundaries for each of the 7 regions have already been drawn by HCPF because they have had to already send out RFPs. In some places, the RCCO does not match the BHO region. The Denver BHO and RCCO boundaries are the same. The pilot groups are expected to be named in December.

Payment reform
- Case rate- providers are paid a lump sum for taking care of a group of people
- Fee for services/Prospective payment system- attempts to reduce adverse selection by paying providers a different fee for people with certain serious health conditions.
- Bonus- share in savings from reduced total healthcare expenditures
- Bundle hospital and physician services; payments only pay for part of Potentially Avoidable Complications that will penalize providers that have higher error rates and reward those with lower PAC rates.
- Bundled payments may include all costs in the 30 days past an inpatient stay, including any return to the hospital

Some primary concerns for behavioral health organizations leading up to 2014:
- Considering how to merge primary care with mental health and substance abuse services- It may be having them all in the same practice, or it could be partnership/contract arrangements. With Daylight, early adopters should look at whether the health care homes

and the collaborative care organizations are providing services to the deaf and hard of hearing. The contractor that keeps healthcare records should make sure providers are asking the right questions to make sure deaf and hard of hearing issues are addressed.

- There has been some dialogue about health disparities with traditionally underserved groups, but it has not been the major focus. The major focus has been coordination of care.