

ValueOptions CT BHP

Wellness & Recovery Care Coordination Programs *Comprehensive Overview*

JUNE 2012



Wellness & Recovery Care Coordination Programs

Medication Administration & Support Training To Support Recovery (MASTR)

Wellness Care Coordination (McKesson partnership)

Intensive Care Management (ICM)

Peer and Family Peer Specialists & Community Peer Liaisons

ICM Comorbid Coordination (CHN partnership)

Home Health

**Wellness Care
Coordination
Program
(WCC)**
*(ValueOptions &
McKesson
partnership)*

Pilot Program, 300 high risk members

Behavioral and physical health

Assessment, monitoring, coaching and
recovery-building skills

Wellness and Recovery program criteria:

1. Primary BH and/or substance abuse condition,
and
2. Physical health condition, and
3. At least one “tier one” or “tier two” physical
health condition(s), and
4. One or more IP and/or ED event(s) in the
most recent 12 months (primary BH or SA in
claims data)

**Wellness Care
Coordination
Program**
(Con't)
*(ValueOptions &
McKesson
partnership)*

Participating members receive the following services* from a Registered Nurse:

- Comprehensive behavioral and medical assessments
- ,
- Condition-specific interventions,
- Coordination of care via correspondence with providers (with member's permission),
- Health coaching and teaching,
- Referrals

Monthly and quarterly reports on demographics, interventions, enrollment, participation and outcomes.

*telephonic

**Peer & Family
Peer Specialists
&
Community
Peer Liaisons**

Based on a Recovery and Resiliency Model

Each Peer is:

- A Certified Recovery Support Specialist (Advocacy Unlimited),
- A Certified Recovery Coach (CCAR), and WRAP certified, and
- Has completed coursework in Motivational Interviewing

Member centered and family focused care from the perspective and experience of “someone who has been there”.

**Peer & Family
Peer Specialists
&
Community
Peer Liaisons
(Con't)**

Supports the ICM and the WCC programs or may provide services without involvement in ICM or WCC.

Below are services the Peers provide:

- **Explain** mental health and substance use services
- **Assist** members with finding an appropriate provider
- **Connect** members to community resources and supports
- **Help** members apply for programs
- **Inform** members of their rights and responsibilities
- **Encourage** members
- **Teach** self-advocacy skills
- **Support** members & families
- **Assist with** ER diversion
- **Ease** member's transition

Intensive Care Management (ICM)

On-going intensive care management and care coordination

Significant and persistent behavioral health needs

Multi-agency and/or treatment provider(s) involvement

- ICM activities include, but are not limited to:
 - Facilitate the course of treatment
 - Address gaps in care
 - Individualized care management
 - Daily contact with Emergency Departments
 - Coordinate provider meetings and case conferences
 - On-site care management at DCF Area Office and Acute Facilities (PRTFs, Inpatient Units, Riverview, and CARES)
 - Diversions from higher levels of care

**ICM Comorbid
Coordination
(CHN partnership)**

Intensive care management

High risk medical needs and also serious and persistent behavioral health needs

Staffed by a team of behavioral health Registered Nurses (co-located with medical)

Combination of telephonic AND face-to-face care management services with the member

**ICM Comorbid
Coordination
(Con't)
(CHN partnership)**

Criteria for condition identification:

1. Primary physical health condition, and
2. SPMI condition, and
3. At least one “tier one” or “tier two” behavioral health condition(s), and
4. At least one or more IP and/or ED event(s) in the most recent 12 months (primary BH or SA in claims data)

- Stratified according to intensity of need, informing the frequency and type of services

- High risk, Medium Risk and Low Risk

- High Risk members receive face-to-face visits

**ICM Comorbid
Coordination
(Con't)
(CHN partnership)**

Program activities include, but are not limited to:

- Coordination of physical health and behavioral health care
- Addresses gaps in care
- System-level interventions
- Member- and provider-specific strategies and care planning,
- Enhanced access to community resources,
- Provider patient education,
- Collaboration and communication with applicable external entities



Medication Administration Training (MASTSR)

Certifies unlicensed staff to safely assist members with, and/or supervise, medication self-administration

Empowers members; increased independence

- Training curriculum and content approved by the CT Department of Public Health
- Offered in 2012 to adult Residential Care Homes
- Conducted by a ValueOptions Registered Nurse(s)
- Thirty two (32) hours and is comprised of three (3), eight (8) hour modules, and two (2), four (4) hour practicums*
- After successfully completing and passing the MASTSR training program and exams, the participant receives a three (3) year medication administration certification!

*flexible training schedules upon request

Home Health

Home Health behavioral health services

Skilled nursing

Medication Administration

Home Health Aide

PT, OT, and speech

ValueOptions authorizes and manages above for the Department of Social Services

Primary goal

Assisting Home Health providers to encourage members self-sufficiency with medication self-administration



Home Health (Con't)

Activities in place to achieve this goal

- Collect, aggregate, validate, analyze and trend Home Health claims data
- Monitor Home Health authorization activity
- Assist providers with developing social supports
- Develop and implement a provider analysis and reporting workgroup
- Conduct analysis (on-going) on prescriber practice patterns with medication administration
- Conduct Prescriber and Home Health Provider Recovery Trainings
- Collect and trend evidence of skills transfer for medication services for members receiving twice daily and once daily medication services



HIT & Care Coordination

**Wellness Care
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(McKesson
partnership)

**Intensive Care
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(ICM)

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Integrated technology and shared data is essential for high-impact care coordination.

- Our CT care coordination programs that have been described cannot exist successfully in isolation.

Programs are intertwined via our referral and care management triage process and our data information systems.

In real-time, and with the use of targeted reports from our data infrastructure, our care coordination teams at CT ValueOptions provide members with individualized care management.



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- Use Health profile info to inform integrated care plans
- Connect members to social supports
- Track coordination efforts
- Track discharge / after-care coordination
- Share information with care team for full awareness of continued care
- Share At Risk Crisis Plan with provider and care team
- Share Wellness and Recovery Treatment plan with providers and care team
- Risk and intensity identification and stratification
- Shared system platform for documentation by all programs (WCC, Peers and ICMs)

HIT & Care Coordination

Future Projects Pending...

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**Medication
Admin
Training
(MAT)**

Home Health

- Pilot project utilizing medication dispensing units for home health services
- Future development of a 'middleware' IT platform for external entities (BH providers, PCPs, PCC, etc.) to view a member centric record and also add documents that are related to a shared member's care plan
- Expand the MASTSR training program to train other non-licensed staff in safe medication self-administration

Wellness & Recovery Care Coordination Programs

Expected Outcomes



- Decreased hospital readmissions and ED visits
- Increase medication adherence and independence
- Decrease unnecessary costs
- Increase quality of life
- Increase satisfaction
- Increase active use of Health Information Technology