

Under-service survey responses as of 5/1/2014

Q1 -- What are the most serious access to care challenges in your experience, either current or in the past? Examples include access to a particular treatment, provider type, level of care, or duration/frequency of care.
Answer #1
Detox treatment for adolescents
adolescent access to substance abuse treatment and medication assisted opioid treatment
lack of knowledge of health care needs of people with disabilities
Finding a psychiatrist who will properly treat the diagnosis pharmaceutically
timely access to psychiatrists for outpatient follow-up treatment post inpatient hospitalization
Mental Health Services for Persons with Medicaid
Lack of physician participation in Medicaid
Access to private therapists by seriously mentally ill persons.
lack of qualified specialists
Acute Care Inpatient
access to MH prescribers
Team-based care
access to mental health care
autism and behavioral issues which lead to overuse of ER because other services not available
Patients with serious illnesses being observed in hospitals
Unable to validate coverage due to delays at DSS
Primary Care Access
providers who don't accept Medicare or Medicaid
clients with high service needs either physical or psychiatric.
access to mental health treatment
Poor reimbursement levels for psychiatric prescribers
Access to continuum of care, particularly to support people dealing with mental health conditions
transportation
access to primary carefor individuals with chronic mental illness
access to dental care
specialist for Husky patients
physician productivity/life style conflicts
access to specialists
Too short stays for inpatient care, including after medication regimen has been established, i.e. for people experiencing mental health conditions
stopping therapy too early (e.g., 20 days) in SNF after a major illness/event
accessing rehabilitation therapies for the duration requested by the physician not the insurance company
Mental Health Outreach
complexity in the mental health service system and lack of availability of navigators to assist in connecting consumers with the appropriate providers and resources
lack of providers for adults with disabilities
Finding good home health aide services that are consistent and reliable

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MFP clients who continue to need assistance post 1 year of receiving case management and financial support
Transportation for older adults requiring routine appointments such as dialysis
Long term treatment for seriously mentally ill persons in the private sector.
unwillingness to work with folks with intellectual disabilities
Intermediate Care Inpatient
lack of "psych" urgent care centers in CT (alternative to ED)
Pharmacist for med management
access to dental care
Answer #2
Home health agencies discharging patients when the patient becomes a heavy care user
Referral agency not revealing all information to make an informed decision
Appointments outside normal business hours
difficulty getting to provider offices
clients who do not meet nursing home loc
Medicaid access to specialists
Quality Transportation. Logisticare is abysmal.
Transition of care issues from different levels of care and between different health care entities and support services
wait for medical providers
transportation
access to primary care evenings and weekends
ADHD services for children and teens
patient compliance
getting determined eligible for HUSKY
Too little/inadequate transition coordination and care between different levels of care, e.g., hospital to outpatient or community services; higher-intensity community level to lower level community services, particularly for people experiencing mental health conditions
home care ending when patient chronic condition worsens and patient needs aide services
accessing neuropsychologists
Answer #3
Mental Health treatment for people with high levels of care need
boarding of patients in emergency rooms awaiting an inpatient bed or disposition to an appropriate level of care
concerns over both patient autonomy and rights to decision making
In home nursing
Delays in processing Medicaid applications so for months clients do not have medical coverage
Bilingual practitioners
Continuing connections to medical homes for seriously mentally ill persons; e.g., dual disorder.
Accessing appropriate care for Co-Occurring Disorders

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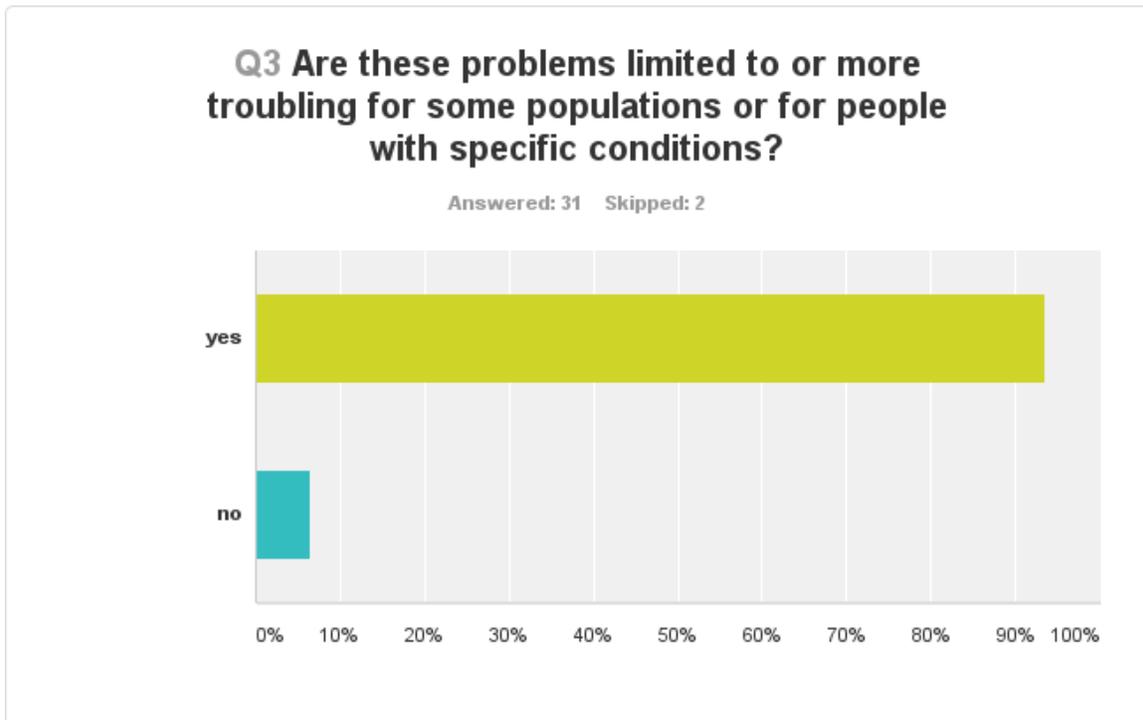
Reimbursement for activities that support care coordination (i.e. medicaid BH providers ability to go to the home, on the IP units etc)
finding providers who accept Medicaid
patients who need outpatient therapy can't get therapy for chonic conditions
Patients sitting in snfs waiting 6mths-1 yr before
providers not located in my town
clients with a diagnosis of personality disorder
affordability issues
PHP is great level of care, yet cost prohibative to clients
Lack of access to primary care or specialist care services, for people with mental health conditions
primary careproviders uncomfortable dealing with cleitns with mental illness
access to specialists
pain mgt services
reimbursement for primary care services
lack of understanding of the value of prevention
Early identification, intervention and prevention services for children, youth, young adults and adults experiencing behavioral and mental health challenges
outpatient therapists refuse to seek exception to cap for patient with chronic condition
accessing neuro optometrists and getting insurance coverage

Q2 - What are the most common access to care challenges in your experience, either current or in the past? Examples include access to a particular treatment, provider type, level of care, or duration/frequency of care.
Answer #1
Prompt access to prescriber for mental health needs
lack of access to specialized behavioral health treatment services: eating disorders, trauma services, problem sexual behavior
transportation
Finding psychiatric services
same as above
Same as responses above.
folks are limited due to where they live
Access to treatment for suicidal patients
access to MH prescribers
access to mental health care
home supports to maintain life in community
Skilled nursing facilities not providing enough therapy following a serious illness
Inadequate reimbursment doesn't cover high cost of care
Primary care
providers who don't accept Medicare or Medicaid
clients with high service needs
Poor reimbursement levels for psychiatric prescribers
Delayed access to care due to numerous factors including complex but not easily understood or accessible health care system (thus shouldn't really be called a 'system' which implies some coordination and/or comprehensiveness of care), lack of care

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coordination among and between different entities; differences between public and private health care 'systems'
transportation
long waits in waiting rooms
practitioners who engage patients in their care
transportation issues
ED being recognized by MA patients as primary care
same
Finding specialists (for mental health conditions) who have capacity and/or accept one's insurance (public and commercial), including psychiatrists, APRNs, psychologists, clinical social workers and specialties within each of these professions
services stop when co-pays are required for SNF
ongoing rehabilitation therapies
Answer #2
Recovery supports for people with private insurance
insufficient reimbursement to sustain evidence based treatment (no monies set aside for ongoing staff development, supervision)
physical accessibility
Access to inpatient psychiatric hospital units by very disruptive patients; they get shifted to public sector units.
unreliable transportation for medical appointments
lack of Medicaid reimbursement ABA/autism spectrum services
access to dental care
Medicare Advantage plans not approving enough therapy
State agencies taking too long to coordinate healthcare workers to care for discharged pts going home
Medicaid access providers
difficulty getting to provider offices
Quality Transportation. Logisticare is abysmal.
Wait list for services for publicly insured persons; denials of services for privately insured persons (particularly for people dealing with mental health conditions)
wait for medical providers
not taking physical complaints of indiv. with mental illness seriously
lack of communication between practices
pain mgt - narcotics mgt
reimbursement levels for government programs
Finding services and programs within one's own community/reasonable distance from one's living place, particularly in more rural areas
inadequate help with hospital discharge planning
access to professionals with experience with brain injury
Answer #3
lack of general behavioral health providers in inner city areas where transportation is accessible
disabilty cultural knowledge
Reimbursement for activities that support care coordination (i.e. medicaid BH

providers ability to go to the home, on the IP units)
finding providers who accept Medicaid
A lack of long term services and support for people not on Medicaid
Dental care
providers not located in my town
PHP is great level of care, yet cost prohibitive to clients
difficulty scheduling/coordinating multiple appointments
inability to track own medical records
weekend access to primary care healthcare services
Inadequate coordination of care between primary care providers and specialists as well as coordination between different levels of care/different programs/services
patient needs SNF care but lacks 3-day hospital stay
access to subacute rehabilitation for individuals with brain injury



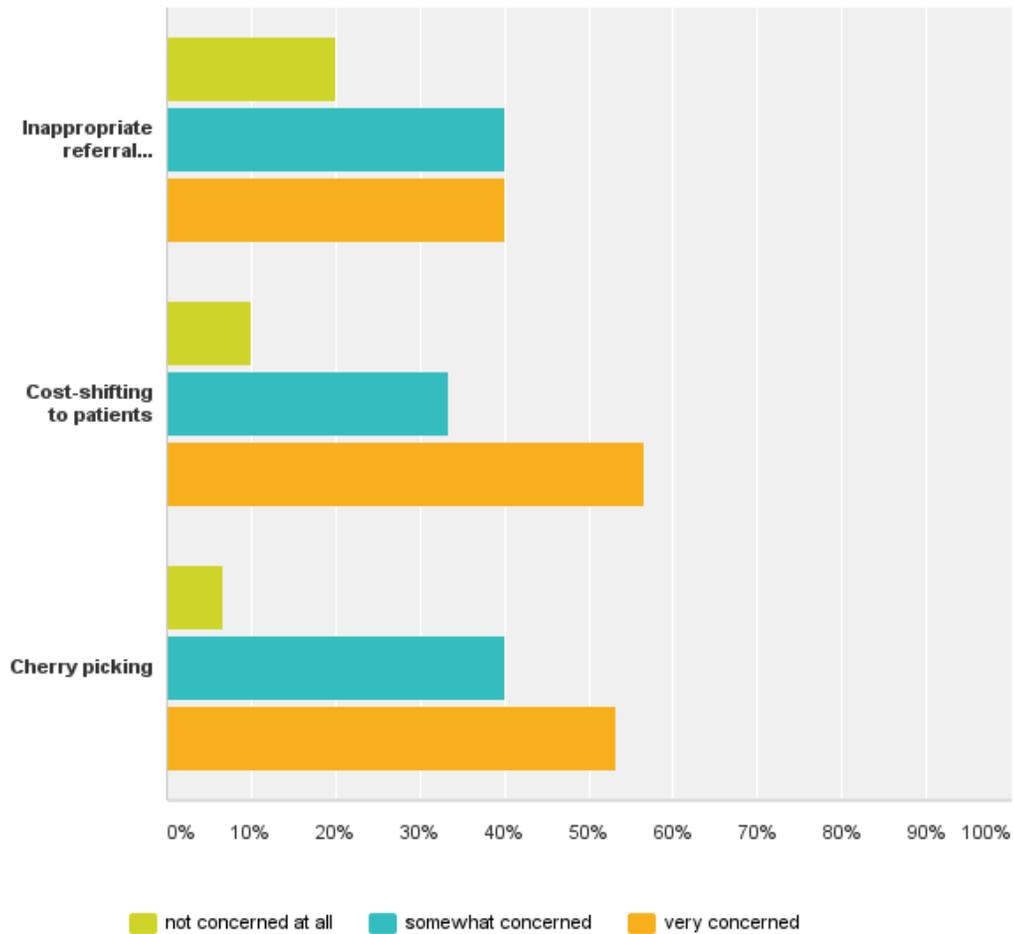
If so, which populations?
People with behavioral health challenges
Monolingual Spanish, all adolescents,
People with disabilities in general
People with intellectual disability who need psychiatric medication oversight
Husky C members
non-English speakers, Medicaid, low-income population, Dual eligible due to lack of

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providers accepting reimbursement
Significant problem for those enrolled in Medicaid
Dual disorders, SMIs.
People covered by entitlement insurances.
children with behavioral health needs
elderly, patient with multiple chronic meds
people with mental health issues and dental problems.
autism, mental health and brain injury patients
People with long-term or chronic conditions have more trouble than people with short-term acute conditions with accessing follow up care that may need to continue
Medicaid beneficiaries, rural parts of the state
People with chronic disease or disability who need more care
lower income people, people with complex medical conditions, people unable to navigate system themselves
More troubling to clients with low to no income.
people dealing with mental health conditions
individuals with chronic mental illness, homeless individuals,
chronic care coordination
state and self pay
lower economic which rely on transportation
those with no insurance or HUSKY, those with language barriers, low income people with little flexibility as far as taking days off from work/limited child care
People living with mental health and behavioral health challenges; within this group for young adults, as they need to be thought of and treated as not simply younger adults but a group (and individuals within this 'group') who grew up in a different era of previous experiences re/ mental health treatment (no longtime institutionalization for the most part) and different era of relating to one another and to others, e.g., use of technology to communicate and express oneself
people with long-term or chronic conditions
Brain injury

Q4 Concerns have been raised about incentives for inappropriate referral patterns, cost shifting to patients or other providers, and cherry picking -- avoiding high cost or difficult patients with hard to treat problems. How concerned are you about each of these potential problems?

Answered: 30 Skipped: 3



Q 5 -- Which patients are at most risk of each of these problems?
Inappropriate referrals
People with speciality care needs

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Sexual offenders, severely mentally ill, dually diagnosed
people with cognitive disabilities
persons with disabilities and mental health issues
Those who suffer from Co-Occurring Disorders
families w/ children w/ BH needs (especially Eastern CT)
patient with multiple chronic conditions and multiple meds
ER utilization
patients who need dental care but don't have dental insurance
Behavioral health
patients with risk issues and high service needs
Clients needing PHP who get sent to OP
people with complex health conditions, i.e. 'mental' health/'physical' health conditions;
people with multiple health conditions
clients with addiction
all
pain management
lower reimbursing insurances being accepted by specialists
not sure
People living with mental health challenges, not only for persons' mental health
conditions but also (interrelated) 'physical' health conditions
brain injury
Cost shifting to patients
medication assisted opioid treatment
poor people
most complex co-morbid patients
persons with disabilities and mental health issues
Persons on: limited income, entitlement insurances; and the elderly
Adults newly enrolled via the AHCT
people on observation status in hospitals who then don't qualify for SNF coverage under
Medicare
Can't cost shift to T19 patients or MME
patients with risk issues and high service needs
everyone - e.g. facility fees
Working poor
people with complex health conditions, i.e. 'mental' health/'physical' health conditions;
people with multiple health conditions
under insured, high deductibles, co pays
all

elective procedures
delaying care due to less \$\$ to pay for basic life needs
underinsured
People living with mental health challenges, not only for persons' mental health conditions but also (interrelated) 'physical' health conditions
home health and SNF patients - plans for new or additional co-pays
Cherry picking
People with medicaid
uninsured, underinsured, medicaid spend downs
people with dual diagnoses that include psychiatric disabilities
Dual diagnosed individuals
most complex co-morbid patients
Seriously mentally ill persons.
persons with disabilities and mental health issues
As noted above.
adults w/ chronic mental illness
avoiding behavioral health issues
Medicare Advantage plans that eliminate certain specialties from the MA network to avoid high cost patients
T19 patients due to inadequate reimbursement
those with high usage/high cost/complex conditions
patients with risk issues and high service needs
problems for medically complex patients
Private agencies that shift low income clients to PNPs
people with complex health conditions, i.e. 'mental' health/'physical' health conditions; people with multiple health conditions
Seriously mentally ill as they are less likely to be held onto due to their tendency to miss more appt.s, not adhere to treatment recommendations
all
young and healthy
limiting access to lower reimbursement
People living with mental health challenges, particularly with serious, persistent conditions and co-morbid and/or co-occurring conditions
Medicare Advantage plans
Brain injury

Other
not taking behavioral health patients
home health agencies trying to get short term acute patients - most profitable
undertreatment-brain injury

Q 6 -- Can you suggest references, cases, existing standards, etc. for under-service monitoring that serve as good examples or best practices?
new CMS guidelines for person centered planning
Close medical monitoring by staff, nursing and IDT team.
HP, the State's billing portal should be able to provide actual experience by procedure code. The current year's data can be used to compare with the new data after the implementation of the project.
Unknown
Not at the moment
class action lawsuits such as Jimmo v. Sebelius - not the most efficient way to obtain healthcare
Not sure, would want to research more
no
Diabetes program in NYC Berwick's access models Medical home with incentive reimbursement
Much depends on the values of the provider. For example, home health providers are compensated based on a "case mix" of easy and hard patients. Won't make \$ on each patient. Some home health providers resent the extra care needed by some patients and try to discharge them when skilled care is still needed.
No- it is difficult to determine best practices as every brain injury is different and could have a different course of treatment that is appropriate

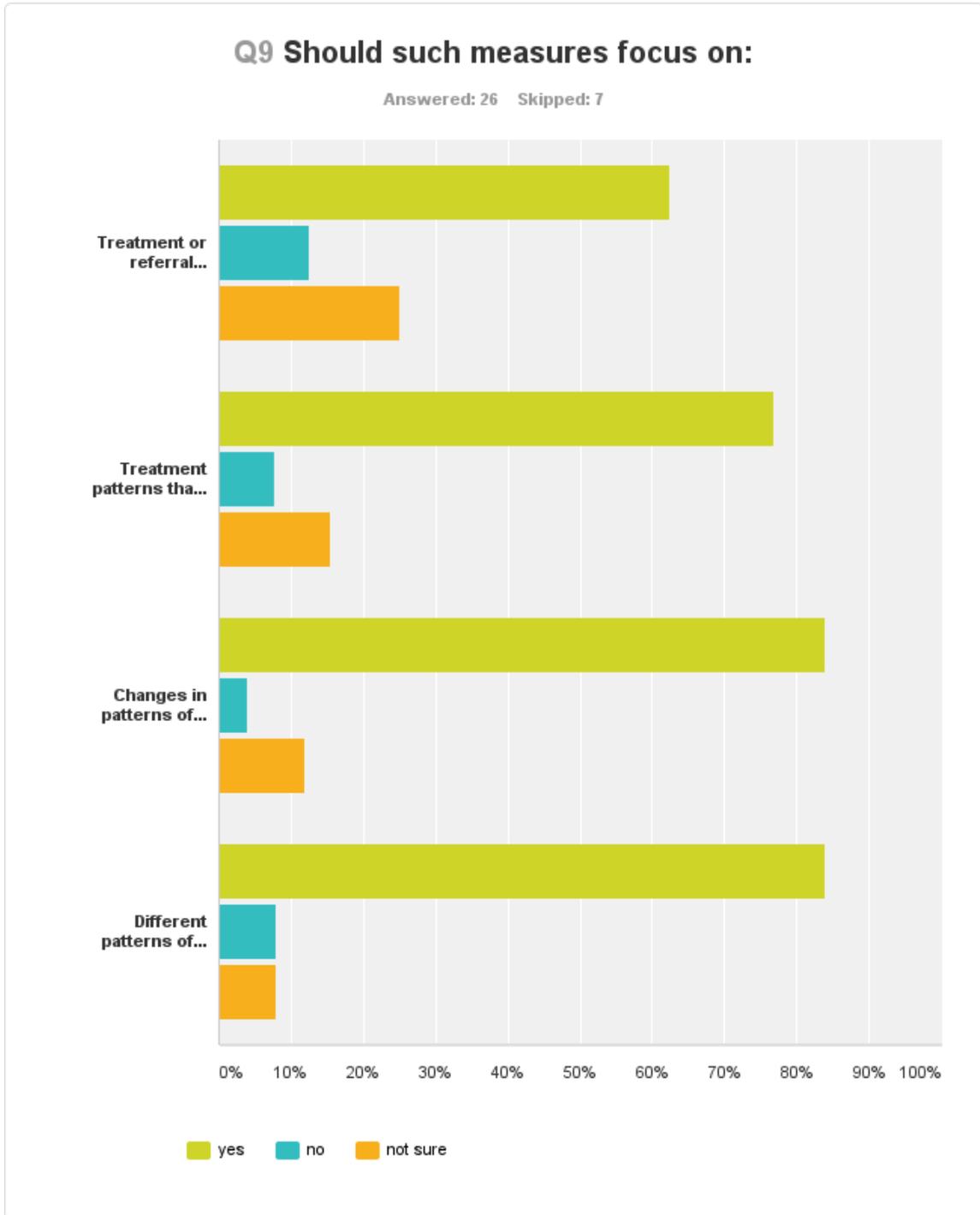
Q 7-- Do you have experience or examples of what to avoid in developing an under-service monitoring system?
At the University Center for Excellence in Developmental Disabilities we can offer provider training in how to deliver competent and effective health care to people with disabilities
When individuals with intellectual disability are left to supervise their own medical care. Lack of medical guardians.
No
I do not.
Yes, my office receives calls from Medicare patients that aren't receiving the care they need

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duplication
Relying on one measure over another; relying on single-stream measures; not looking at impact of services/non-services on the whole 'system'
avoid fee for service model. it promotes cherry picking
no
keep government regs to a minimum
Using simple/high-level measures such as 'client/consumer satisfaction' scales with the services delivered as sole or central indicator that adequate services at adequate levels are being provided
The difficult way is to use the appeal system.
I would wonder if a PCP was the only provider for someone with a severe brain injury if there were not potentially some under servicing going on.

Q 8 -- Do you have thoughts about how to design, implement and evaluate specific measures to monitor for under-service?
The UCEDD has an extensive network of disability related organizations, families and individuals with disabilities. We can offer surveys and focus groups to monitor underservice
Advocate a an agency and a member of the team for the appropriate number of supports to assist individuals with medical care success n the community.
May want to conduct some focus groups of consumers and providers to get their feedback.
As stated above, a comparison of actual previous year to current utilization would be most helpful. Setting up the report similar to a financial report with actual, projected,previous totals by procedure code and variance column would alert the evaluators to any anomalies highly variant categories.
Not at this time.
Not at this time.
Concepts and ideas, but not specific measurements
We are presently assessing this issue.
These are huge issues I need more time to consider options/unintended consequences, etc
Design: multiple measures/diverse ways of measuring to capture what 'not underprice'/appropriate service for a person looks like, i.e. include care experience; health/well being status; presence of good care coordination Implement: surveys for 'patients' and care providers (maybe also family members); data gathering of service providers, including care coordinators; role of advocates/advocacy groups? Evaluate:

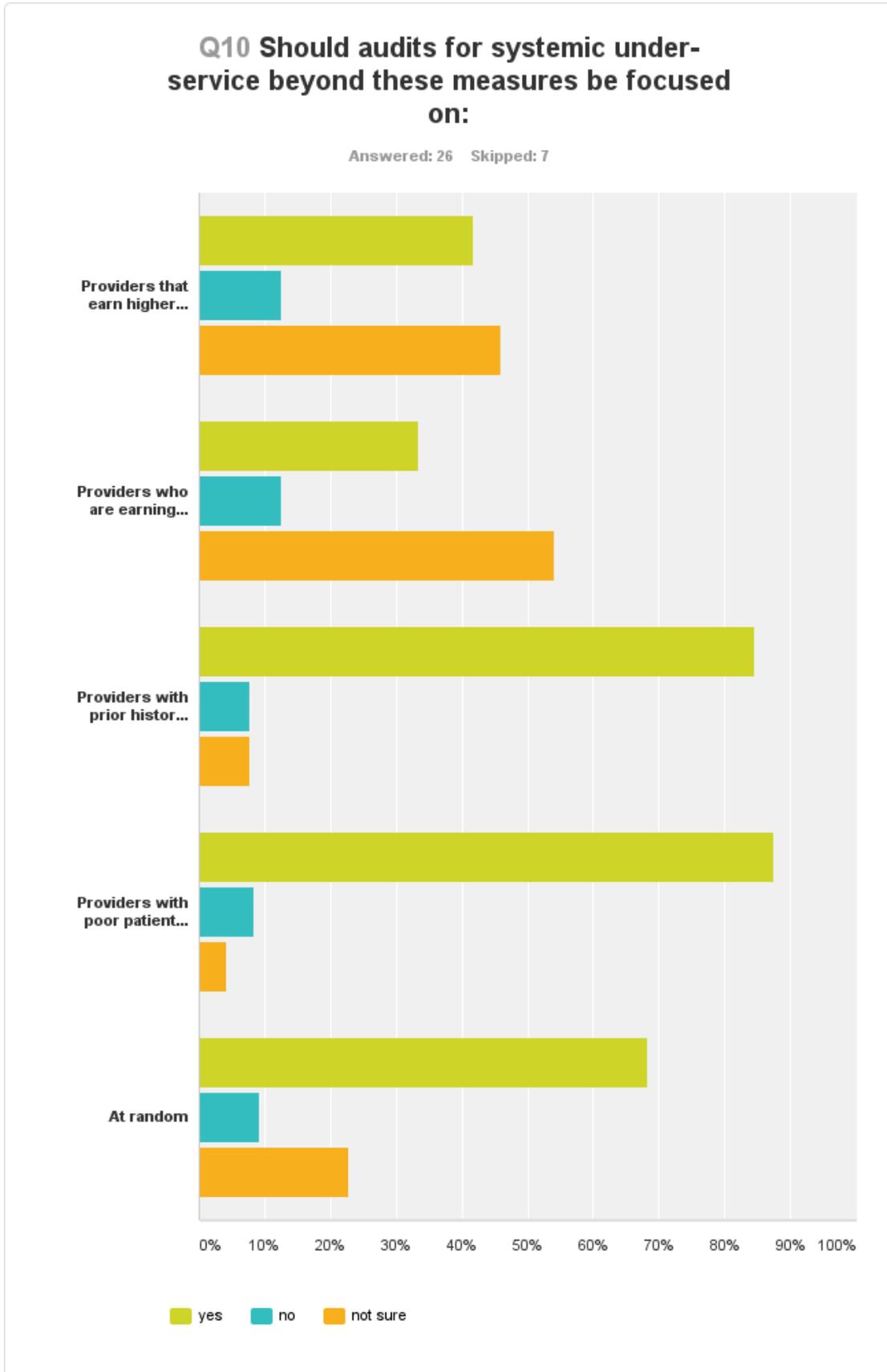
create specific expectations, starting from 'what is our ultimate goal?" and working/designing backward; using independent evaluators
APCD data might be helpful - with that particular focus in mind
yes - set the population up in a registry format. Reference to the rent Registry for patient outcomes: Eisenberg
Include measures for a whole person's status of well-being, that is including their mental health as part of overall (public) health while making specific reference/checking on status of mental health well being
It is a complicated population and the only thing I can think of as a measure would be the absence of professionals (PT, OT, SP, Neuropsychologist, Neuro Optometrist, Physiatrist)



Other?
Disability cultural sensitivity

Labels for Q 9 chart:

Treatment or referral patterns different from colleagues	Treatment patterns that vary from best practice guidelines	Changes in patterns of care over time	Different patterns of care by funding source within a provider's panel (i.e. uninsured vs. Medicaid vs. Medicare vs. private insurance)	Other (please specify)
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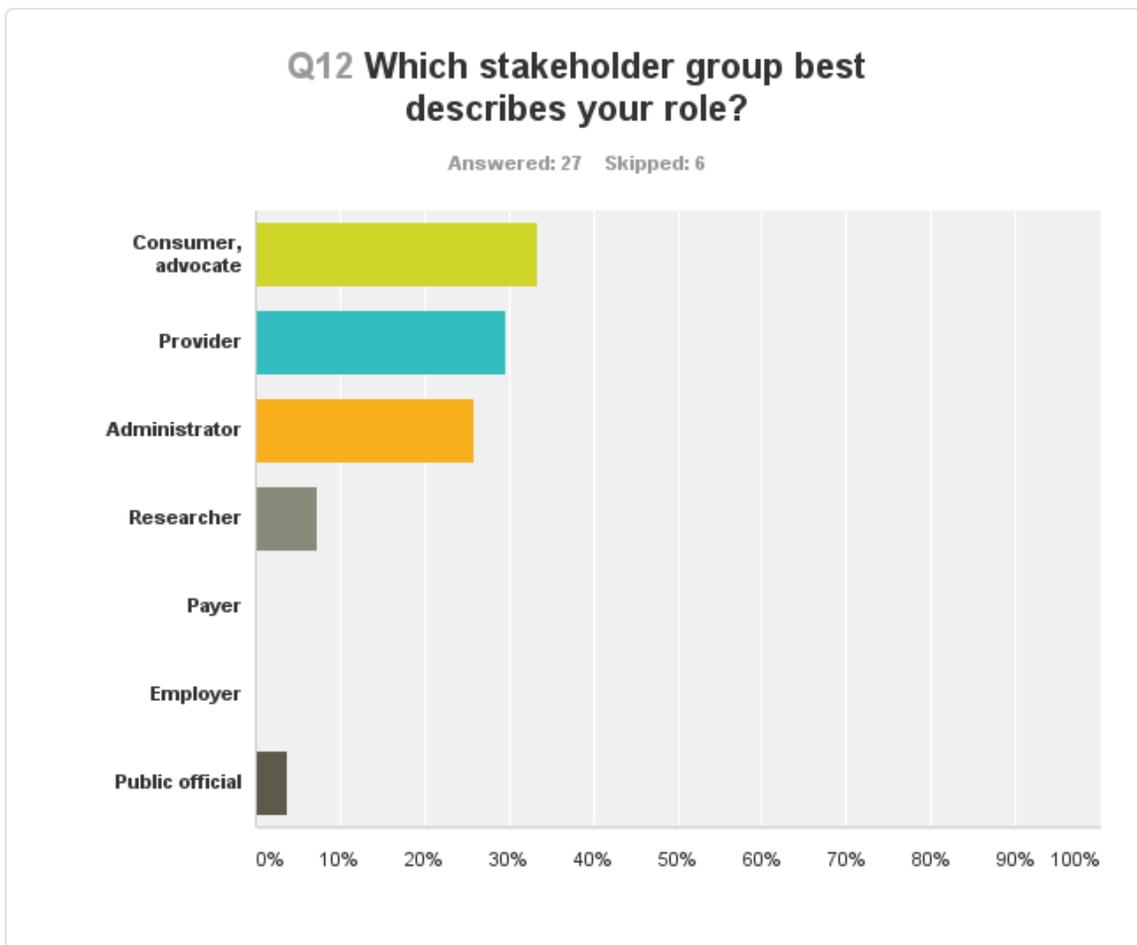
Other?

focus on the patient population - not provider

Labels for Q10 chart:

Providers that earn higher than average shared savings levels	Providers who are earning below- average incentive levels	Providers with prior history of problems - either quality or financial	Providers with poor patient experience of care survey scores	At random	Other (please specify)
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Q 11- Who else should we contact for guidance in building an effective undertreatment accountability system?
Dartmouth; Institute for Healthcare Improvement
Dr. Stanton Wolfe at the UCEDD in Farmington
Home health care and in home nursing agencies
It might be good to outreach to the current ACOs.
Patients
Unknown
The population most affected.
Maybe BHP/VO? They are in other states and can help to identify what others are doing across the country.
Area Agencies on Aging
CT's previous experience with HMO's has been bad. Problems with defining quality. This area demands heavy scrutiny. Beware of unintended consequences.
People directly impacted by these issues, i.e. people dealing with complex health issues, whether its numerous health issues or 'one' health issue that is complex
new to area.....do not know. IHI may have some knowledge in this area.
if not already included: Regional Mental Health Boards
Academics. I believe Brian Biles has data re some of these issues
Maybe OHA. Our callers go there when being denied access to care. But I don't know if that would be a conflict given their role in SIM.



Other (please specify)
Disability Consultant
Behavioral Health Consultant
BH QM and Innovation

