Value-Based Payment Strategies in Allegheny County

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Allegheny County Population: 1.2 Million

- 130 municipalities
- 91 neighborhoods in Pittsburgh
- Manages a budget of over $900 million
- Employs over 1,000 staff
- Funds over 300 providers for 1,600 distinct services
- State-supervised, county-administered system
- DHS serves every 5th resident
Allegheny County Office of Behavioral Health

- Integrated human service system for 20+ years:
  - Children, Youth and Families
  - Intellectual Disabilities
  - Aging
  - Community Services
  - Behavioral Health

- Platform of human service integration with focus on behavioral health needs and focus on special needs/priority populations – housing, employment, forensic, transition age, etc.

- Serve every 4th resident

- Vibrant focus on whole person needs and social determinants of health in conjunction with behavioral health

- Serves as primary contractor governing the Allegheny County HealthChoices program since 1999

- Strong collaboration and partnership with Allegheny County HealthChoices Inc., Community Care and other stakeholders

- Rapidly moving to grow value-based payment models for behavioral health services

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Key Goals

• **Enhance Best Practices**
  – Physical/behavioral integration
  – Enhance social determinants of care
  – Improve member engagement
  – Improve service efficiency

• **Sample Initiatives:**
  1. Behavioral Health Home
  2. Assertive Community Treatment
About Community Care

- Incorporated in 1996 to support PA BH HealthChoices
- Part of the UPMC Insurance Services Division
- 501(c)(3) nonprofit behavioral health managed care organization
- Licensed as risk bearing HMO
- Implemented HealthChoices in 41 counties in Pennsylvania beginning in 1999
- Approximately 1,000,000 Medicaid members
PH/BH Integration
Behavioral Health Home Plus

Behavioral Health Home
- Enhancing capacity of behavioral health providers to meet physical and behavioral health needs.
- Demonstrated Improved Outcomes in:
  - Engagement in primary/specialty care
  - Patient activation
  - Screening for common co-morbid conditions
  - Decreasing tobacco use and blood pressure
Using Value-Based Strategies in BHHP

• Providers earn financial incentives based upon process and outcome measures

• Process and outcome measures are dependent upon the BHHP “phase”

• BHHP phases build provider skill with increasing expectations to produce whole person health outcomes

• Financial incentives help support the cost of additional staff (nurse health navigators) required to deliver the BHHP model

• Incentives range from $80K-$100K yearly but are split into two disbursements
BHHP: Linking Payment to Clinical Outcomes

Advanced Practice Clinical Outcomes

**Tobacco Cessation**
- 100% screening
- 50% of members who use tobacco with motivation to quit (contemplation ladder assessment)
- 50% have a tobacco use-related SMART goal on their service plan and the agency’s tobacco registry indicates a 50% reduction from their baseline tobacco use.

**Hypertension**
- 100% screening
- 60% of members with established hypertension have a hypertension-related SMART goal in their service plan
- Bonus opportunity: 60% of the members with hypertension engaged in wellness coaching and are using a lifestyle modification to reduce blood pressure, and there is at least one reduced blood pressure measurement which has been identified as the goal by the medical provider.
BHHP: Population Health Management

55% of smokers report decreased tobacco use

68% with hypertension see decreased blood pressure

Members in BHH with a PCP visit in 12 months = 91.3% in 2018; 91.4% in Q1 2019
Chartiers Center

- **Overview of Services**
  - BHHP & blended service coordination
  - Outpatient services
  - IDD & family living programs
  - T & SR program
  - RTP
  - CRR & supportive housing
  - LTSR
  - SAP & school-based outpatient services
  - D&A services
  - Multiple HUD housing programs

- **Building Relationships**

- **Becoming a Behavioral Health Home**

- **Integration of Health & Wellness**
Building a Successful BHHP Team

• Leadership buy-in and promotion of the BHHP philosophy
• Integration of the lead wellness nurse into the blended service coordination staff meetings
• Wellness Coaching Training Model at Chartiers – use of materials and Train-the-Trainer concept via Community Care, as well as development of a model to train “hands-on” in the field with BSCs
• “Wellness Coaching” introduction to consumer base by both the Wellness Nurse and the BSCs at in-home appointments
• Integration of the Wellness Nurse into various agency-wide Treatment Team Meetings and “health education” trainings
• Active participation in the Community Care organized Learning Collaborative calls
• Readily available access to the Community Care BHHP team members
• Consistent message to staff and consumers regarding the overall wellness benefits to the individuals we serve
• Promotion of positive and relatable wellness outcomes
• Agency-wide culture change
What is Assertive Community Treatment?

- **Assertive Community Treatment (ACT)** is an evidence-based practice that uses a multidisciplinary team to provide comprehensive services to address the needs of persons with serious behavioral health issues and other co-morbid disorders.

- ACT Teams deliver highly responsive, individualized, recovery-based and rehabilitative services in the client’s natural environment.

- The services are designed to respond to the clients’ personal goals and needs and are provided with appropriate timing and intensity.

- ACT offers recovery oriented services, promotes self-determination and respects individuals served as experts in their own recovery. The primary emphasis of ACT is to support person-centered recovery goals, assisting individuals in becoming more self-sufficient, more active in their communities, obtaining competitive employment and achieving their personally meaningful goals and life roles.
ACT VBP Initiative

- **Goal**: incentivize providers of ACT services to reduce inpatient mental health (IPMH) utilization and increase rates of competitive employment and participation in psychiatric rehabilitation of ACT service recipients

- **Collaboration between**:
  - Originally started in 2014 with two ACT providers in Allegheny County (now 4 providers)
  - Allegheny County, Office of Behavioral Health
  - Allegheny HealthChoices Inc. (AHCI)
  - Consumer Advisory Committee
  - Community Care
VBP Incentive Structure

• Providers can earn up to 110% of current fee schedule rate for ACT services:
  – 80% for all services rendered
  – 20% for meeting IPMH utilization goal (withhold)
  – 5% for meeting competitive employment goal (bonus)
  – 5% for meeting psychiatric rehabilitation goal (bonus)

• Gate and Ladder Approach: ACT providers must meet established threshold per consumer for inpatient cost reduction in order to be eligible for any bonus earnings
Performance Measures

• Inpatient Mental Health
  – Goal of decrease of 10% from about $10,000 per person/per year
  – Outcome of 25-50% decline across 4 providers

• Employment
  – Goal of 15-20%
  – Outcomes of 8 to 17% across 4 providers
Value-Based Provider Experience: Western Psychiatric Hospital (WPH) ACT Teams

• Barrier-breaking model which required increased collaboration between ACT teams and the following entities of a large urban academic medical center:
  – WPH Leadership
  – Psychiatric Inpatient Teams
  – Psychiatric and Medical Emergency Rooms
  – Crisis Services
  – Care Management
  – Primary Care
WPH – Strategies & Interventions

• Paradigm shift for clinical services to a focus on person-centered planning process resulted in:
  – Increased buy-in from persons served and staff.
  – Increased understanding of the “Risk and Responsibility” of mental health recovery
  – Clinical review of the highest utilizers and brainstorming to develop alternatives to long inpatient stays
  – Collaboration with all stakeholders
  – Increased development and use of MH recovery tools such as MHAD, Crisis Recovery Plans, and integrated care with primary physical health providers
  – Participation in “Positive Deviance” project
  – Adoption of “Work is Treatment” philosophy
WPH – Strategies & Interventions

• Revamped supervision
  – Person-centered planning adopted as “core“ instrument to inform supervision sessions
  – Outcomes based supervision with emphasis on real time and historical data
  – Core requirement for staff to participate in continuing education with a focus on evidence-based therapy models

• Use of technical tools
  – Revised existing internal data and tracking reports
  – Use of data dashboard
  – Electronic record planning revised to include crisis and diversion planning
Lessons Learned

- VBPs can enhance clinical services and be cost effective

- They require intensive support from payer (both technical assistance and data sharing)

- Need stepwise developmental process over period of years

- Close partnership between county, county Healthchoices program. BH MCO and providers is essential