Strategies for Funding Coordinated Specialty Care Initiatives

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Implementation of Coordinated Specialty Care for First Episode Psychosis in U.S. Community Mental Health Clinics:

Background and lessons for leaders and funders

Mary F. Brunette, MD
RAISE-ETP: Executive Committee

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<th>Key Consultants:</th>
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<td>NIMH Principal collaborators: Robert Heinssen, Susan Azrin, Amy Goldstein</td>
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<td>Tom Tenhave and Andy Leon assisted in designing the trial.</td>
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<td>Robert Gibbons, Don Hedeker and Hendricks Brown reviewed the data analytic plan.</td>
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<td>Haiqun Lin led the analysis.</td>
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Coordinated Specialty Care

- **Goal:** Early intervention to change the course of schizophrenia

- **NAVIGATE Team-based care – 4 key components**
  - Medication treatment (Psychiatrist/Advance Nurse Practitioner)
  - Individual resiliency training (IRT; Individual therapist)
  - Supported Employment and Education (SEE; Supported employment specialist worker)
  - Family Psychoeducation (Family therapist)

- Weekly team meetings, coordinated treatment planning, strong communication & coordination

- Outreach to engage people into service; linkages with hospital psych units and other community organizations

Mueser et al, Psych Serv 2015; Addington et al, Psych Serv 2013
Comprehensive, coordinated care for people with first episode psychosis: NAVIGATE

Conceptual Model for the RAISE Program

Illness Management
- Medication
- Illness Self Management
- Substance Abuse Treatment

Psychosis/Schizophrenia
- Psychosis
- Negative Symptoms
- Depression
- Cognitive Impairment
- Substance Abuse

Recovery
- Social / Leisure
- Well-Being
- Role Functioning

Rehabilitation
- Social Rehabilitation
- Resiliency Training
- Supported Employment & Education

Family Psychoeducation / Social Support

Color Key
- IRT = Individual Resiliency Training
- FPE = Family Psychoeducation
- SEE = Supported Employment and Education
- Pharm = Pharmacological Treatment
RAISE ETP Study: NAVIGATE vs. community care

• Cluster randomized trail at 34 community mental health sites in 21 states

• Community mental health centers volunteered and could enroll if they:
  • Provided schizophrenia treatment but NOT specialized FEP treatment
  • Were interested in providing FEP treatment using their current reimbursement context
  • Had staff who could provide NAVIGATE components given training and support

• CMHCs provided either NAVIGATE or their usual community care

• Research staff assessed participants with FEP for 2 years
Have you had individual sessions with a mental health provider who helps you work on your goals and look positively towards the future? (%)

Months

Percent with any visit in past 30 days

- Community Care
- Navigate
Have You Met With a Person Who is Helping You Get a Job in the Community or Furthering Your Education? (%)

Months

Percent With Any Visit in Past 30 days

Community Care
Navigate
NAVIGATE Participants Stayed in Treatment Longer

Time to Last Mental Health Visit
(Difference between treatments, $p=0.009$)
Quality of Life Improved

Group by time interaction (p = 0.046)
Cohen’s d = 0.257

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<td>Community Care</td>
<td>2.359 (0.473)</td>
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<tr>
<td>NAVIGATE</td>
<td>3.565 (0.379)</td>
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<tr>
<td>Difference</td>
<td>1.206 (0.606)</td>
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Symptoms Improved

PANSS Total Score (p<0.02)
Consolidated Framework for Implementation Research

- **Intervention characteristics**
  - Evidence strength and quality; complexity; adaptability and relative advantage; costs

- **Individual characteristics**
  - Knowledge, competence, self-efficacy; attitude and stage of change; personal attributes – values and professional identity

- **Organizational characteristics**
  - Structure and workforce, culture, implementation climate, readiness

- **Outer setting**
  - MH authority leadership & engagement, attitudes & advocacy by service users

- **Implementation process**
  - Timelines, collaboration and support of stakeholders, skills of workers, quality monitoring and evaluation
## Implementation stages and activities

(Moullin et al 2015; Menear & Briand 2014; Kilbourne 2007; Torrey 2001)

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<th>STAGE</th>
<th>ACTIVITIES</th>
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<td>Planning</td>
<td>Identify: need; effective practice; barriers; logical service organizations, leaders, and funders Stakeholder engagement and consensus building</td>
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<td>Pre-Implementation</td>
<td>Select implementation working group &amp; leader Learn model of care Develop training, supervision plan, educational materials Identify workflow needs and address them Hire or identify staff Identify funding, reimbursement strategies, incentives Develop supporting contracts, policies, legislation</td>
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<tr>
<td>Implementation</td>
<td>Kickoff meeting Train and supervise staff Measure and track fidelity to model of care Measure and track outcomes Utilize technical assistance to overcome barriers</td>
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<tr>
<td>Maintenance</td>
<td>Ensure model fidelity while addressing organizational needs Identify and address sustainability barriers</td>
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Capacity for NAVIGATE and FEP treatment in U.S. mental health system

Brief summary:

- 20% of screened organizations decided they did not have capacity to implement coordinated FEP care
- 80% had at least basic capacity for FEP service delivery
CMHC Capacity for FEP Care

Good capacity if training provided

- Basic psychosocial rehabilitation
- Medication management
- Psychotherapy
- Family therapy

Variable capacity needing attention

- Case management
- Community-based skills training
- Supported employment and education
- Team meetings for team-based care
- Clinical supervision
- Referral relationships
5 key areas in U.S. public mental health system need attention

- Funding & reimbursement for people who were uninsured and privately insured varied across organizations.
- Capacity to engage target population through outreach and partnership with other organizations.
- Capacity for team based care with supported time to coordinate and plan care.
- Capacity for Supported Employment and Education varied across states and organizations.
- Access to rehabilitation services (including case management, Supported Employment & Education) to people whose illnesses are not yet chronically disabling.
Reimbursements for FEP services in CMHCs – RAISE-ETP data

• Variation in:
  • Sources of compensation for people without insurance (70.6% RAISE-ETP sites had gov't source of funds for uninsured)
  • Willingness to seek reimbursement from private insurances
  • ACA young adult provision & Medicaid expansion will help in some states
Capacity to engage target population through outreach and partnership

- Median duration of untreated psychosis (DUP) = 74 wks; 68% had DUP > 6 months
  - Addington et al 2014
- Advantage of NAVIGATE manifested in those with DUP < mean
- Suggests we should facilitate and expedite pathways to care to reduce duration of untreated psychosis
Outreach and partnership

- Organization-level outreach and partnerships to identify first episode psychosis patients
  - Outreach not typical CMHC activity

- State level public health efforts to education
  - Public health departments do not typically target schizophrenia
Capacity for team based care with supported time to coordinate and plan care

- Build into processes of care
- Team-based care planning may/may not be part of organizational culture, system quality metrics, and reimbursement goals
- Separate Medicaid billing code up to state programs
  - 24% of organizations used direct reimbursement; others built this into cost of care
- Capitated Medicaid plans may provide flexibility
Capacity for Supported Employment & Education

- All RAISE ETP sites were willing to provide SEE;
  - 65% said they had Medicaid reimbursement for it,
  - Actual capacity varied widely based on state and organizational reimbursement arrangements and priorities

- SE can be funded under Medicaid (fed $ with state match)

- SE can also be funded under
  - Vocational Rehabilitation
  - State designated funds
Access to rehabilitation services (including case management, SE) for FEP patients

- Medical model vs. rehabilitation model
- Private insurances may not pay for rehabilitation and team-based care
- State Medicaid programs have varying rules for access to rehabilitation services
- States now have the option to include FEP services by definition through 1915i waivers
Summary

- **Coordinated specialty care** for first episode psychosis improves outcomes and may prevent disability

- **Several areas** are important when considering implementation and funding

  - Capacity to tap various insurance types
  - Capacity to care for those without insurance
  - Capacity for team-based care
  - Capacity for outreach to engage the target population as early as possible
  - Access to rehabilitation services
  - Access to supported employment and education
Interesting in implementing NAVIGATE?

www.navigateconsultants.org

Susan Gingerich, Training Coordinator

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Financing First Episode Psychosis Services

Howard H. Goldman, MD, PhD
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Baltimore
ACA benefits for FEP

- Youth up to 26 years old can remain on parental private insurance
- No insurance denial for pre-existing conditions
- Medicaid eligibility is no longer tied to already disabled individuals on SSI
- State Medicaid plans can be modified to cover FEP services, including case management and supported employment and education
ACA limitations for FEP

- Private insurance and some State Medicaid plans will not cover all FEP services
- Not all States will expand Medicaid
- Even those States that do expand Medicaid may not cover all services in their Medicaid plan and may not supplement those services with State and local resources
How Have FEP Programs Done It?

- Opportunism
- Maximize insurance where available
- Cross-subsidies
- Small numbers – write off bad debt
- Public coverage for insurance short-fall
How Will New Programs Do It?

- Block grant supplement
  - Fund services directly
  - Fund training infrastructure and consultation
- Medicaid expansions
- Medicaid plan amendments using 1915i
- Flexing private benefits
- ACOs and other new sources
- New financing schemes (Tom McGuire)
Paying for Early Interventions in Psychoses: A Three-Part Model

Richard G. Frank, Ph.D.
Sherry A. Glied, Ph.D.
Thomas G. McGuire, Ph.D.
Motivation and Challenges

- Sustainability requires moving beyond ad hoc “cobbled together” funding sources
- Payment system should be compatible with payer experience, encourage provider participation, and generate appropriate incentives
- Needs to support identification, engagement and treatment of a highly heterogeneous population
- First versions will likely need to be substantially modified with experience
Three-Part Financing Model

1) “Prospective” per-case payment made conditional upon patient engagement -- target right patients, should feature risk adjustment;
2) Per-service payment – pay at less than (not a typo) marginal cost;
3) Payment based on outcomes – start simple and put little weight until experience accumulates; engagement, avoidance of hospitalization, criminal justice involvement;
Seek patient group, provider and payer input to design
Broadly gets incentives right (all you can hope for); flexible -- can and should be modified with experience.
Implementation

- Evolving weights: start with least-risk, familiar FFS payments close to covering cost, little weight on prospective/outcomes
- This will maximize participation but be weak on cost control and outcome incentives – buff these up over time with experience from RAISE and elsewhere
- Use experience in existing programs to guide initial calibration; enlist input from stakeholders
- Challenge particularly with private payers is meshing with benefit design/covered services
Final Comments

• A chance to put into place payment system consistent with innovative program goals
• Not an “answer” but an approach that offers a flexible starting point with built-in ability to evolve in response to experience
• Paper available (free!) on Psychiatric Services Website
Questions?