Financing Evidence Based Practices for Older Adult Behavioral Health

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Session Objectives

- Highlight key issues relevant to effective delivery of evidence-informed behavioral health approaches for older adults.

- Identify potential financing strategies that could be used by States to support behavioral health evidence-based practices for older adults.

- Stimulate conversation and sharing across participating coalitions.
What I need to say...

- We are all “teachers and learners” and some of you have the “inside skinny.”

- My information is from ongoing scanning and interaction with communities—and a few states—and a few innovators.

- Financing news evolves daily..and interacts with local and state realities.
Session Outline

Briefly review programs and practices with evidence

Highlight key delivery features with implications for organization and financing

Share information on potentially relevant financing and delivery innovations
Behavioral Health Conditions of Older Adults

- 27 Significant MH and Substance Use Conditions: 15 disorders (DSM criteria) and 12 other impairing conditions
  - Most common disorders: Depression, Anxiety
  - Other conditions: Behavioral and Psychiatric Symptoms Associated with Dementia, Fear of Falling,

- At least 14–20% has one or more disorders. By 2030, as Baby Boomers age the numbers of older adults with MH/SU needs will increase by 80%

Connections among Conditions: Taking Preventive and Responsive Action

- Medical Illness
- Anxiety
- Depression
- Cognitive Impairment

Social Stressors

Economic Insecurity
Evidence-Based Treatment Approaches: First Line Approaches for Depression (parallels for anxiety)

- Medications: (i.e., Antidepressants like SSRIs)
- Cognitive Behavioral Therapy (CBT)
- Problem-Solving Therapy (PST)
- Interpersonal Therapy (IPT)
- Integrated Service Delivery in Primary Care (Collaborative Care)
- Family/Caregiver Support Interventions
- Mental health consultation and treatment teams in long-term care
Less Formal Behavioral Approaches Have Their Place *

- Physical Exercise
- Psychoeducation
- Supportive Interventions: promote self-care
What to Consider in Addressing Behavioral Health Needs?

- Array of and capacity of services in the community.
- Trained workforce.
- Organizational support in providing services.
- Payment / Reimbursement factors.
- The population that is targeted for services.
- Consumer preferences.
SAMHSA and NCOA Project

Lessons Learned on Sustainability of Older Adult Community Behavioral Health Services

Embed into ongoing systems
Braid different funding: mh, aging etc.
Explore Billable service

http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/lessons-learned-on.html
Sustainability Framework

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<th>Community Factors</th>
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<td>Demonstrated effectiveness</td>
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<td>Community / state</td>
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<td>Managerial and systems support</td>
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The Triple Aim

1. Improve individual experience
2. Improve population health
3. Control inflation of per capita costs

- The best care
- For the whole population
- At the lowest cost

D. Berwick, Institute of Healthcare Improvement, 2007
What questions are asked in your state about using certain practices, programs for behavioral health?
Medicaid Home and Community Based services – State Options

- Waivers include:
  - Section 1115
  - Section 1915b
  - Section 1915c and 1915i
- Money Follows the Person
- Community First Choice
- State Balancing Incentives Payment Program
- Health Homes
Financing Collaborative Care

IMPACT online training:  http://impact-wuw.org/training/onlinetraining.html

Module 13. Financing Integrated Mental Health Care

- Health Homes: Medicaid
- Practice-based, fee-for-service
- Practice-based, health plan contract
- Global capitation
- Flexible infrastructure support
- Health-plan-based
- Third-party-based under contract to health plan
- Hybrid models


The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes By Jürgen Unützer, MD, MPH, University of Washington; Henry Harbin, MD, Health Care Consultant and former CEO of Magellan Health Services; Michael Schoenbaum, PhD, National Institute of Mental Health; and Benjamin Druss, MD, MPH, Emory University
Collaborative Care Activity

- Low Income Rural Health Clinics: Social Innovation Fund
  - [www.impact-uw.org](http://www.impact-uw.org) and [www.uwaims.org](http://www.uwaims.org)

- DIAMOND Initiative: Depression Improvement Across Minnesota, Offering a New Direction: collaborative financing of depression care management and attention to Substance Use via SBIRT

- COMPASS: Care of Mental, Physical, and Substance Use Syndromes (COMPASS)

- [www.icsi.org](http://www.icsi.org) for more information on financing and delivery of DIAMOND and COMPASS
Depression Care Management

- Active screening for depression
- Trained depression care manager
  - Brief evidence-based interventions
  - Education / self-management support
- Proactive outcome measurement/tracking
- Team approach, stepped care
- Follow-up
About PEARLS and Healthy IDEAS

- Home–based depression care management
- Delivered by trained community–based agency staff
- Brief, practical, evidence–based

Learn more:
- Healthy IDEAS: [http://careforelders.org/](http://careforelders.org/)
- PEARLS: [www.pearlsprogram.org](http://www.pearlsprogram.org)
- AOA Evidence–based Disease and Disability Prevention Program: [http://aoa.acl.gov/AoA_Programs/HPW/Behavioral/Index.aspx](http://aoa.acl.gov/AoA_Programs/HPW/Behavioral/Index.aspx)
Financing PEARLS and Healthy IDEAS

Currently implemented in over 100 sites in 26 states through various sources, including:

- Older American's Act case-management programs through Area Agencies on Aging (AAA) and Family Caregiver Support Programs through state and local agencies
- AAA discretionary funding
- SAMHSA Mental Health Funding to States
- SAMHSA Older Adult Targeted Capacity Expansion Grants
- Medicaid Home and Community Based Services Case Management Programs and Client Training Services
- Medicare
Financing PEARLS and Healthy IDEAS

Additional Funding of Implementation
Includes:

- State-funded case management
- State-funded mental health services
- United Way-funded non-profit case-management programs
- Regional Foundations
- Voter-approved funding (special levies)
- University research and education grants
- Non-profit organizations (discretionary funds)
Scales are Tipping Towards Community-based services

Medicaid HCBS Expenditures as a Percentage of Total Medicaid LTSS, FY 1995 - 2013

Medicaid HCBS Expenditures as a Percent of Total Medicaid LTSS by State

Medicaid plays an important role in states’ efforts to achieve compliance with the ADA and the Olmstead decision, by providing services that help individuals transition from institutional to community settings and maintain their community living status.

- Excluded due to lack of FY 2013 data
- 40 to 49%
- 50 to 59%
- 20 to 29%
- 60 to 69%
- 30 to 39%
- 70 to 79%
Moving Evidence into Funding
Washington State HCBS Example

- Medicaid State Plan:
  - Coverage for Major Depression Only

- Medicaid HCBS 1915–c Waiver
  - Prevalence of depressive symptoms–LTC: 60%
  - Gap in Service for 1/3 of clients
  - Client Training Service: skills to address minor depression

- Cost Information from the PEARLS Studies
  - RCT Average cost: $630/participant
  - Implementation Study: $1,350
PEARLS Program and Medicaid Delivery

- Waiver unit cost based on pilot by King County AAA
  - Infrastructure needed/cost included:
    - screening, supervision, travel, full-time counselor
    - Population density supports economic model
- WA Medicaid waiver reimburses at @$150/session for 9 sessions (1 screening and 8 active)
  Costs vary by staffing needs, number of clients
- Depression Care Management through PEARLS and Washington State 1915–C Medicaid Waiver
Operating in seven Texas Counties
Target population: Nursing home residents ≥ 3 mos.
  w/SMI Diagnosis or BH diagnosis with functional impairment (original focus ≤ 65)
21% of participants aged 65 and older

- EBP: Cognitive Adaptive Training & Substance Abuse
- Offered 6 mos. ≤ Before & up to 1 year after entry to community
BHP Operational Partners (through 2017):

- DADS' Relocation Specialists & the STAR+PLUS Support Unit (SPSU)
- Four local MCOs (Amerigroup, United Healthcare, Superior and Molina) who develop individual HCBS service plans and coordinate medical with community-based services
- Local mh pilot staff, under contract with DSHS, deliver Cognitive Adaptation Training (CAT)
- LMHA staff, under contract with DSHS, provide substance abuse treatment services
Behavioral Health Pilot Outcomes

- Improved individual functioning and the successful deinstitutionalization of 400 adults with severe mental illness and/or substance use disorders

- Recovery and Cost Outcomes encouraging
  - 72% of clients remain in community – after completion of one-year intervention
  - Analysis shows that BHP participants remained in the community for an average of two years to six years in some cases resulting in significant cost savings for the state Medicaid program

- MFP Behavior Health Pilot – Year 3 evaluation: Draft Final Report (July 2014) prepared by The Addiction Research Institute Center for Social Work Research University of Texas at Austin -- Lynn Wallisch, Ph.D., Tom Bohman, Ph.D., Jim Bradley, MSSW
Texas has transitioned from a traditional fee-for-service system into a state-wide, capitated managed care system. Service packages include:

- Mental health rehabilitation
- Substance use disorder treatment
- Targeted case management

The sustainability plan includes three components:

- phasing out the current BHP by 12/31/2017
- building capacity in Medicaid managed care organizations (MCOs) to incorporate BHP practices
- collaborating with a contractor to provide on-going training and technical assistance on best practices to MCOs throughout Texas. MCOs will employ these techniques to provide rehabilitative and SUD services which are now included under their capitated contracts.

- Jessie.Aric@dshs.state.tx.us
1915 (c) Home & Community-Based Services Waiver for Adults with Behavioral Illness

- States with Current or Recent Experience
  - Connecticut
    - CT HCBS for Elders 07/2010 – 06/2015
    - Population: ages 65 – no max age
  - Indiana
    - IN Community Integration and Habilitation 10/01/2014 – 09/30/2019
    - Population: ages 0 – no max age
  - Iowa
    - A HCBS Elderly 08/01/2013 – 07/31/2018
    - Population: ages 65 – no max age
1915 (c) Home & Community-Based Services Waiver for Adults with Behavioral Illness

- **Montana**
  - HCB Waiver for Adults w/Severe Disabling Mental Illness – 07/01/2010 – 06/30/2015
  - Population: ages 18 – no max age

- **Massachusetts**
  - MA Frail Elder 01/01/2014 – 12/31/2018
  - Population: aged 65 – no max age

- **Types of services included in one or more states:**
  - mental health counseling
  - psychological therapy
  - family and caregiver training
  - mental health outreach
  - Psychosocial counseling and consultation
  - Alzheimer's/dementia coaching
Michigan MI–Choice HCBS Waiver

- Home and Community Based Waiver Clients and CDSME (MI–Choice)

- Each CDSME program has a separate code number so number of participants can be tracked by program.
  - Programs include: Chronic Disease Self–Management
  - Diabetes Self–Management
  - Chronic Pain Self–Management
  - Arthritis Self–Management
  - Better Choices Better Health
  - Matter of Balance
  - Healthy Moves
  - Physical Activity Programs
  - Creating Confident Caregivers
  - T–Care

- Waiver clients must complete 4 of 6 sessions for payment to be made. (Differs by program).
- Hosting agency must have a medicaid number.
- Currently we have a small workgroup of waiver agencies that are working on the logistics: i.e. how to verify leader certifications, attendance, etc.
Michigan

- Reimbursement for Certified Peer Support Specialist
- CPSS are a Medicaid Covered Service in the Managed Care 1915 (b) Specialty Services Waiver
  - Have a distinct provider description focusing on health and wellness including: Developing health and wellness plans
  - Integration of physical and mental health care
  - Developing, implementing and providing health and wellness classes to address preventable risk factors for medical conditions
CPSS have a distinct code of H0038 to capture Medicaid funding
CDSMP/PATH is a covered service meeting the description for a CPSS in the Medicaid Provider Manual
The individual plan of service must have a goal & objective with amount, scope and duration related to why the person is attending CDSMP

Sherri King, Michigan Office of Services to the Aging
kings@michigan.gov

Pam Werner, Michigan Department of Community Health, Office of Recovery Oriented Systems of Care Bureau of Community Based Services wernerp@michigan.gov
Impact of Alzheimer’s Disease in California

Within the 8 counties participating in the Pilot Project, an estimated 20,000-28,000 dual eligible beneficiaries have ADRD

10% of nation’s Alzheimer’s patients live in California

60,000-84,000 dual eligible seniors in California have ADRD

Generation Alzheimer’s (Alzheimer’s Association, 2011)
AD Facts and Figures in CA (Alzheimer’s Association, 2009)
Alzheimer’s Association California Southland Chapter (2012)
Slide courtesy of Cordula Dick-Muehlke, PhD
Cal MediConnect Overview

- As many as 350,000 will enroll in Cal MediConnect
- Participating health plans are paid on a capitated basis to provide all Medicare and Medicaid services including institutional care and community-based long-term services and supports
- Plans must conduct a Health Risk Assessment (HRA) of all enrollees
- HRA must include a process to identify need for including caregivers in care coordination
- Plans are required to provide care coordination
Systems Change

- Adapted HRA/other assessments to include cognitive impairment
- Adoption of AD8 as screening tool
- Integration of cognitive assessment into e-medical record (for care manager)
- Integration of cognitive assessment into e-medical record (for primary care provider)
- Protocol if cognitive screen is positive

**Ability to identify caregiver**

- Caregiver assessment adopted
- Adoption of standardized care plans
- Integration of caregiver education
- Adoption of ALZ Direct Connect Fax Referral
Health Care Innovations Award

- Care coordination is a key intervention component for all awardees
  - Integrating behavioral and physical health care
  - Using staff designated as care coordinators
  - Using various forms of health information technology to support service coordination
  - Creating care teams

- Peer support specialist or peer navigators play an important role in many of the awardees’ projects
Health Care Innovations Award

- **Healthlinknow (HLK)**
  - Provide behavioral care services via telehealth between local patients and HLK psychiatrists; instant messaging, email, and telephone calls via HLK between providers and patients; and a HLK IT platform that allows billing, e-prescribing, and practice management for patients with behavioral health needs in rural areas of Montana, Washington and Wyoming.

- **Institute for Clinical Systems Improvement (ICSI)**
  - Implement collaborative care management model for high risk adult patients in several states with Medicare and Medicaid coverage who have depression, diabetes or cardiovascular disease
Health Care Innovations Award

- **UCLA Alzheimer’s and Dementia Care**
  - A coordinated, comprehensive, patient and family-centered program with the aims of achieving better health, better care and lower cost of care for patients with dementia.

- **The Aging Brain Care (ABC) program**
  - Incorporates the common features of several evidence-based collaborative care models into one program designed to deliver high quality, efficient medical care to older adults suffering from depression and or dementia Medicare or Medicaid recipients 65 +.
Emerging Opportunities for Expanding Access Efforts to Watch

- Telehealth Problem–Solving Therapy for Depressed Low-Income Homebound Older Adults
  Namkee Choi, PhD and Meals on Wheels and More–Austin, Texas

- Programa Esperanza (Project Hope): culturally modified psychosocial intervention for Spanish-speaking Latinos 55+ with depression and multiple medical conditions.
  Maria P. Aranda, PhD, and AltaMed PACE program

- Changes in Financing Models: Attention to depression?
  ◦ Medicare Annual Wellness Visit: depression screening
  ◦ Medicare Parity: eligible providers same; consumer payment now 80% vs. 50%
Advancing Evidence for New Workforce Roles and Models

Peaceful Living Data

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*No main effects of treatment group at 18 months

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FEDERAL SUPPORT
AOA and SAMHSA Issue Briefs

OLDER AMERICANS BEHAVIORAL HEALTH
Issue Brief 1: Aging and Behavioral Health Partnerships in the Changing Health Care Environment

Introduction
As the population ages, older adults are more likely to experience behavioral health issues such as depression, anxiety, and substance use disorders, which can negatively impact their health and well-being. Aging and behavioral health services are crucial in addressing these issues.

State Aging and Behavioral Health Partnerships
States are expanding their services through partnerships between Aging, Mental Health, and Aging and Behavioral Health agencies. These partnerships increase access to health services for older adults, including medication management, mental health, and substance use disorder treatments.

Guidelines for Alcohol Use

What's a standard drink?

- A standard drink equals 12 grams of alcohol (e.g., 12 ounces of beer, 5 ounces of wine, 1.5 ounces of 80-proof distilled spirits)
“It is a fact that in the right formation, the lifting power of many wings can achieve twice the distance of any bird flying alone.”

—AUTHOR UNKNOWN