

Commonwealth of Kentucky  
Cabinet for Health and Family Services (CHFS)  
Office of Health Policy (OHP)



**State Innovation Model (SIM) Model Design**  
**May Integrated & Coordinated Care Workgroup**

**May 19, 2015**  
**1 PM – 4 PM**

# Agenda

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- **Welcome and Introductions** 1:00 – 1:10 PM
  - **Review Integrated and Coordinated Care Models in Nearby SIM States** 1:10 – 2:10 PM
  - **Identify Advantages and Disadvantages of Leveraging Care Models in Nearby SIM States** 2:10 – 2:40 PM
  - *Break* 2:40 – 2:50 PM
  - **Review Current Status of the PHIP** 2:50 – 3:10 PM
  - **Discuss Care Models to Improve Population Health in the Context of the PHIP** 3:10 – 3:55 PM
  - **Next Steps and Q&A** 3:55 – 4:00 PM
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# **Welcome and Introductions**

**Review Integrated and  
Coordinated Care Models in  
Nearby SIM States**

# Tennessee's Care Model at a Glance

In Round Two, Tennessee was awarded a \$65 million SIM Testing grant to implement the Tennessee Health Care Innovation Initiative. This plan was designed in Round One and consists of three strategies – primary care transformation, episodes of care, and long-term services and supports.

## Multi-payer Patient-Centered Medical Homes

- Tennessee is creating a robust PCMH program that features alignment across payers on critical elements.
- Major payers in Tennessee have committed to have 80% of members across books of business cared for through a population-based model within five years.
- Three TennCare Managed Care Organizations (MCOs) will be required to participate in a statewide joint PCMH program.
- The initiative will incorporate commercial payers starting with 12 practices in East and West Tennessee and building up to a statewide aligned commercial and Medicaid PCMH program.



## Pediatric Patient-Centered Medical Homes

- Tennessee is partnering with the Tennessee Chapter of the American Academy of Pediatrics (TNAAP) to implement a portfolio of quality improvement projects with Tennessee pediatricians that meet the distinct health care needs of infants, children, and adolescents.
- Since 2008, TNAAP has collaborated with the Bureau of TennCare in a multi-year medical home implementation project to promote Pediatric PCMH implementation across the state.



**Tennessee's Primary Care Transformation**  
will assist primary care providers in promoting better quality care, improve population health, and will reduce the cost of care through total cost of care accountability with reporting and financial incentives



## TennCare Health Homes

- Tennessee is working with providers to improve integrated and value-based behavioral and primary care services for people with Severe and Persistent Mental Illness (SPMI).
- The state will leverage the enhanced federal match for Health Homes to offer prospective payments for care coordination and case management for two years, coupled with provider training and capacity building, and quarterly cost and quality reporting.

## Shared Care Coordination Tool

- Tennessee is working with stakeholders to build the framework for a state Health Information Exchange (HIE).
- Tennessee's approach is to begin with a state-wide shared solution for the most impactful health information exchange: real-time or daily batch Admitting/Discharge/Transfer (ADT) data collected from hospitals and Emergency Departments and sent to a care coordination interface for attributed primary care providers.
- Over time additional functions and connectivity will be added to this shared solution to get to full HIE functionality.

# Tennessee's Care Model – PCMH

Tennessee will build on the existing PCMH efforts by providers and payers in the state to create a robust PCMH program that features alignment across payers on critical elements. The state's current thinking around the design elements for multi-payer PCMH includes:

**Issue:** There are already 560 primacy care providers (PCPs) in TN recognized by NCQA as PCMHs, and all of the major insurance companies in TN have implemented a medical home program. However, the impact of the programs is muted by the differences between them. Specifically, TN providers note that it is impossible to participate in a PCMH program with more than one payer because of separate systems and divergent incentives.

**Solution:** The major payers in Tennessee have agreed to adopt a multi-payer population-based approach and have signed a “Joint Statement of Intent for Population-Based Models,” committing to have 80% of members across books of business cared for through a population-based model within five years. The initiative will convene a Technical Advisory Group (TAG) of Tennessee clinical experts to advise on the clinical details and quality measures of the multi-payer PCMH program.

## PCMH Program Design Elements

Patient Population: All members not eligible for the Health Home Program

Key Quality Metrics	Attribution Model	Efficiency	Provider Requirements
<ul style="list-style-type: none"> <li>Align the quality metrics used by each participating payer</li> <li>Use nationally recognized quality metrics (such as National Quality Forum endorsed measures)</li> </ul>	<ul style="list-style-type: none"> <li>Require all MCOs to ensure that all primary care services are delivered and coordinated by a single attributed provider (starting 2015)</li> <li>Commercial payers may or may not adopt the same approach</li> </ul>	<ul style="list-style-type: none"> <li>Base rewards to providers on cost and utilization measures such as total cost of care, avoidable emergency department use, and/or avoidable hospitalization</li> </ul>	<ul style="list-style-type: none"> <li>Base requirements for primary care providers participating in the program on NCQA’s PCMH recognition program</li> </ul>
Reports to Providers	Actionable Information	Payment	Scale Up
<ul style="list-style-type: none"> <li>Highlight provider achievement on quality and efficiency metrics, including total cost of care and reward payments earned (similar to Episode of Care provider reports)</li> </ul>	<ul style="list-style-type: none"> <li>Implement a shared provider facing population management software solution</li> <li>Alert providers when their attributed patients go to Tennessee hospitals/ emergency departments</li> </ul>	<ul style="list-style-type: none"> <li>Create a menu of payment approach options for providers and payers to agree upon, understanding that different approaches make sense for different providers</li> </ul>	<ul style="list-style-type: none"> <li>July 2016: 12 practices in East and West Tennessee</li> <li>July 2017: One grand region</li> <li>July 2018: State-wide</li> <li>July 2020: 65% of primary care providers enrolled in PCMH model</li> </ul>

# Tennessee's Care Model – Health Homes

Tennessee is working with providers to achieve integrated and value-based behavioral and primary care services for TennCare members with SPMI.

The state plans to leverage enhanced federal match for Medicaid Health Homes to offer prospective payments for care coordination and case management for these providers for two years, coupled with SIM-supported training and capacity building, and quarterly cost and quality reporting.

At this time, the state is only considering Health Homes for the SPMI population and is not pursuing a chronic condition Health Home Model. The initiative will convene a TAG of Tennessee clinical experts to advise on the clinical details of the Health Homes program.

## Health Homes Design Elements

**Patient Population: All TennCare members who have claims with diagnoses of schizophrenia, bipolar, personality disorder, and major depression (estimated 55,000 members)**

Key Quality Metrics	Attribution Model	Efficiency	Provider Requirements
<ul style="list-style-type: none"> <li>Use all recommended CMS Health Home Core Quality Measures (adult BMI, ambulatory care sensitive condition admission, care transition, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>Require MCOs to ensure all primary care services are delivered and coordinated by a single attributed provider (starting 2015)</li> <li>Consider issues for members with primary care and behavioral health providers that would both benefit from being attributed providers</li> </ul>	<ul style="list-style-type: none"> <li>Base rewards to providers on cost and utilization measures such as total cost of care, avoidable emergency department use, and/or avoidable hospitalization (after first two years of program)</li> </ul>	<ul style="list-style-type: none"> <li>Work toward NCQA Level One PCMH accreditation, NCQA patient-centered specialty practice recognition, Joint Commission PCMH accreditation, Joint Commission Behavioral Health Home Certification, or CARF Behavioral Health Home</li> </ul>
Reports to Providers	Actionable Information	Payment	Scale Up
<ul style="list-style-type: none"> <li>Highlight provider achievement on quality and efficiency metrics, including total cost of care and reward payments earned (similar to Episode of Care provider reports)</li> </ul>	<ul style="list-style-type: none"> <li>Send providers ADT feeds, their risk-stratified member panel, gaps in care reporting, and filled scripts reports</li> </ul>	<ul style="list-style-type: none"> <li>Tie PMPM to process measures (possibility of a quality bonus)</li> <li>Base the rate on anticipated service volumes and staffing needs, member acuity, and provider ability to handle different levels of member complexity</li> <li>Shift to outcome-based payments after two years</li> </ul>	<ul style="list-style-type: none"> <li>Offer an adequate statewide network of providers (Health Homes are a state plan service, and Tennessee plans to launch state-wide)</li> </ul>

# Ohio's Care Model at a Glance

In Round Two, Ohio was awarded a \$75 million SIM Testing grant to rapidly scale the use of PCMHs and episode-based models for most acute medical events statewide.

## Goals

- **Adapt** Southwest Ohio's Comprehensive Primary Care (CPC) Initiative for statewide rollout of PCMHs to one additional market in 2015, all major markets within two years, and statewide within four years.

## Scope

- **Implement** the SIM test models through Medicaid FFS and managed care, state employee benefit programs, and four private payers with 80 percent of the commercial market (Aetna, Anthem, Medical Mutual, and United).
- **Enroll** 80-90 percent of the state's population (10.1 million Ohioans) in some value-based payment model (combination of episode- and population-based payments).
- **Include** all providers within participating payer networks, regardless of size, sophistication, or geographic location (an estimated 90 percent of hospitals, 88 percent of specialists, and 53 percent of primary care practices by 2018).

## PCMH Timeline



## 2015 Priorities

- **Convene** a PCMH model design team to decide what elements of CPC to keep/modify and make statewide design decisions about the Medicaid payment model, attribution methodology, quality metrics, etc.
- **Decide** the PCMH rollout sequence and enroll primary care practices beginning in January 2016

# Ohio's Care Model - PCMH

Ohio has developed and shared its PCMH care model charter with potential degrees of standardization by component.

		“Standardize Approach”	“Align in Principle”	“Differ by Design”
<b>Care Delivery Model</b>	<b>Target patients and scope</b>		<ul style="list-style-type: none"> <li>All patients included</li> <li>Strive for TCOC accountability</li> </ul>	
	<b>Care delivery improvements</b>		<ul style="list-style-type: none"> <li>Aligned vision/ vocabulary of care delivery model</li> </ul>	<ul style="list-style-type: none"> <li>Payers, practices champion unique care delivery models</li> </ul>
	<b>Target sources of value</b>		<ul style="list-style-type: none"> <li>Align on near-term and longer term sources of value</li> </ul>	<ul style="list-style-type: none"> <li>Payers set unique targets to realize sources of value</li> </ul>
<b>Payment Model</b>	<b>Technical requirements for PCMH</b>	<ul style="list-style-type: none"> <li>Standard set of requirements and milestones</li> </ul>	<ul style="list-style-type: none"> <li>Payers do not pose additional barriers to participation</li> </ul>	<ul style="list-style-type: none"> <li>Payers separately design link of requirements &amp; milestones to payment</li> </ul>
	<b>Attribution/ assignment</b>		<ul style="list-style-type: none"> <li>Attribute to provider that can be held accountable for TCOC</li> <li>Provide transparency</li> </ul>	<ul style="list-style-type: none"> <li>Payers maintain unique attribution methodologies</li> </ul>
	<b>Quality measures</b>	<ul style="list-style-type: none"> <li>Standard “menu” of metrics and definitions</li> </ul>	<ul style="list-style-type: none"> <li>Agree to have link between quality and payment</li> </ul>	<ul style="list-style-type: none"> <li>Payers separately design how metrics link to payment</li> </ul>
	<b>Payment streams/ incentives</b>		<ul style="list-style-type: none"> <li>Support for practice transformation</li> <li>Compensation for activities not fully covered by current fee schedule</li> <li>Shared savings or other TCOC incentives/ payment</li> <li>Approach to include small practices</li> </ul>	<ul style="list-style-type: none"> <li>Payers will have unique:               <ul style="list-style-type: none"> <li>- Payment levels</li> <li>- Risk adjustment</li> <li>- Shared savings methodology</li> </ul> </li> </ul>
	<b>Patient incentives</b>		<ul style="list-style-type: none"> <li>Agree to create incentives, communication to engage patients</li> </ul>	<ul style="list-style-type: none"> <li>Incentives, benefit design, etc.</li> </ul>

# Arkansas' Care Model at a Glance

Arkansas is a Round One SIM state that received a \$42 million Model Test grant in December 2012. As part of its SIM, Arkansas Medicaid has developed statewide PCMH and Health Home care models to work in tandem with its episodic payment reforms, which are the central tenant of the state's plan.

The Arkansas Health Care Payment Improvement Initiative, which is a collaborative of Arkansas Medicaid, the Arkansas Department of Human Services, Arkansas Blue Cross and Blue Shield, and QualChoice of Arkansas, designed the Arkansas Medicaid PCMH and Health Home models alongside its robust plan for payment improvement.

## PCMH Model

### Five Dimensions

- Evidence-informed preventative services
  - Diagnosis and management of acute and chronic conditions
  - Use of high-performing referral providers
  - Coordination of care across the health care system
  - Proactive engagement of high-risk patients
- All practices serving as a primary care provider to at least 300 Medicaid patients are eligible to enroll as a PCMH. Practices must also participate in a primary care case management program.
  - Arkansas Medicaid's average \$4 PMPM payment is paid directly to the practice and designed to be used for new investments in clinical operations which achieve effective care coordination, patient engagement, and improved outcomes.
  - In addition to these ongoing PMPM payments for care coordination, another \$1 PMPM payment is paid by Arkansas Medicaid directly to a technical support vendor to promote practice transformation for those PCMH practices that choose to participate.

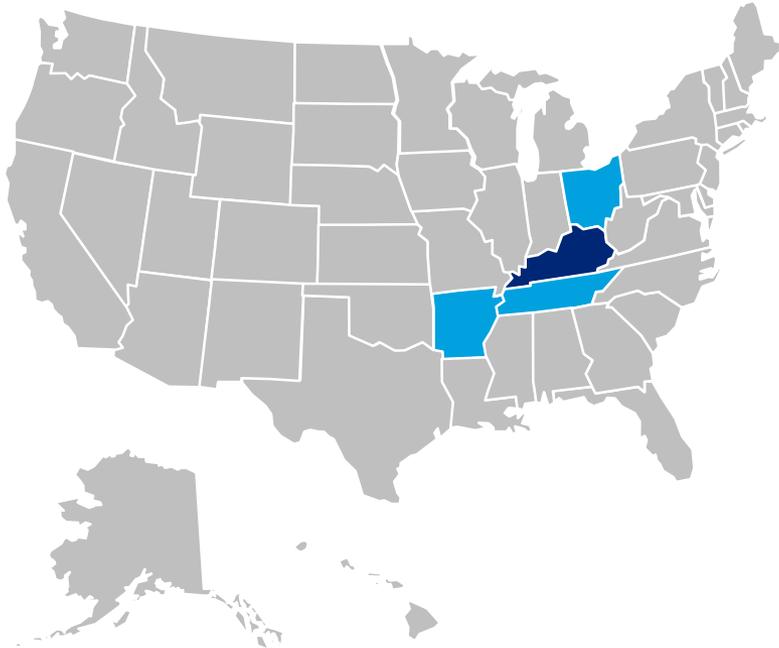
## Health Home

- For developmental disabilities (DD), long-term services and supports (LTSS), and behavioral health (BH) populations, health homes will be centered around a lead provider, the client's main caregiver over time.
- The health home aims to ensure provider accountability for the full client experience including health outcomes, streamlining the care planning process, and ensuring that there is a single integrated plan for each client across DD, LTSS or BH, and medical care. The Health Home complements the medical home and does not replace it.
- The Health Home will coordinate all health care and support services needed by a client over time, while the medical home is responsible for quarterbacking the required medical services.

# **Advantages and Disadvantages of Leveraging Care Models in Nearby SIM States**

## Advantages Discussion

In your groups, brainstorm the potential advantages of Kentucky leveraging the integrated and coordinated care models already underway in nearby SIM states, including but not limited to Arkansas, Ohio, and Tennessee.



### Potential Advantages

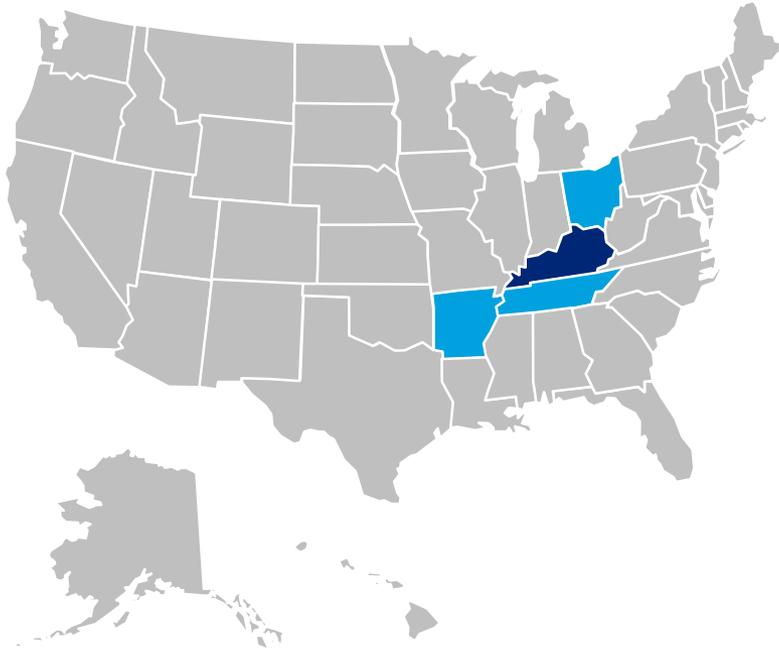
- Experience implementing PCMH and Health Home models statewide
- Ability to achieve buy-in from multiple commercial payers
- Experience achieving alignment amongst public and private payer groups
- Strong two-way communication between the state and hospitals/hospital systems
- Development of care models that benefit smaller, more rural providers

**Others?**

The goal of this workgroup activity is to develop lists of potential advantages in smaller groups and then report out ideas to the full workgroup.

## Disadvantages Discussion

In your groups, brainstorm the potential disadvantages of Kentucky leveraging the integrated and coordinated care models already underway in nearby SIM states, including but not limited to Arkansas, Ohio, and Tennessee.



### Potential Disadvantages

- Incompatibility between the commercial payers operating in the state(s)
- Already established PCMH or Comprehensive Primary Care Initiative (CPCI) programs
- Differing legislative structures and political administrations

**Others?**

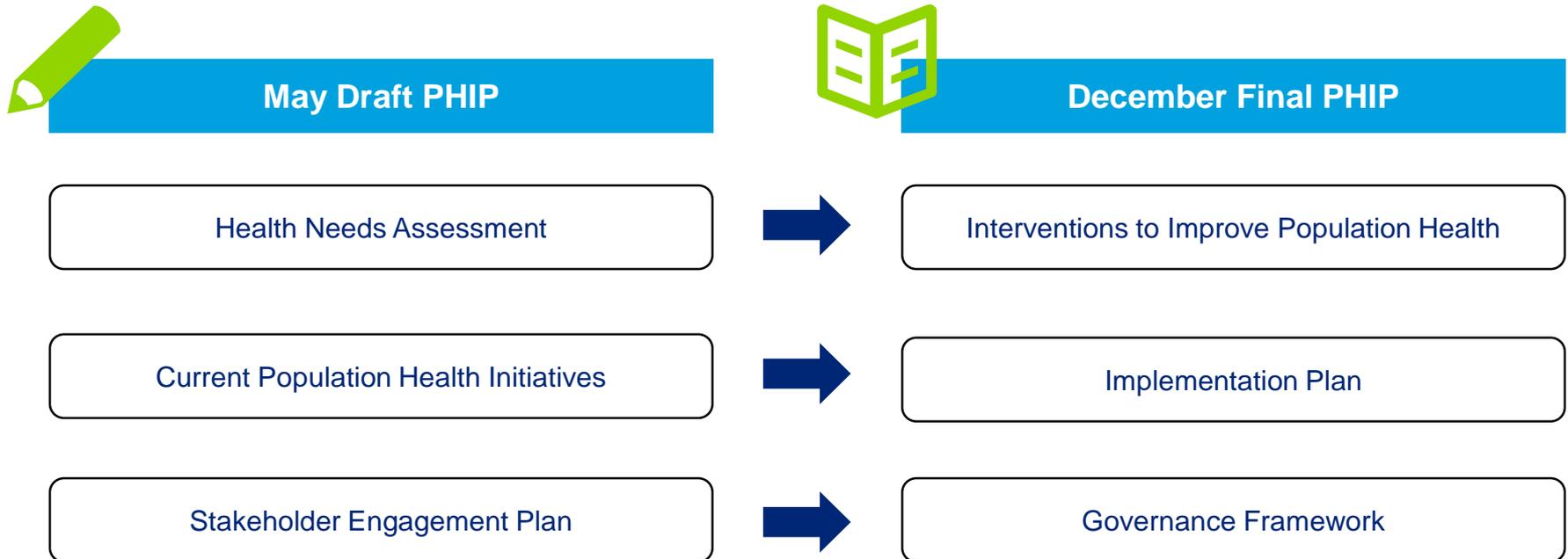
The goal of this workgroup activity is to develop lists of potential disadvantages in smaller groups and then report out ideas to the full workgroup.

**Review Care Models to Improve  
Population Health in the Context of the  
PHIP**

# PHIP Status Update and Process Overview

CMS has created a project structure that promotes crafting the Population Health Improvement Plan (PHIP) **prior** to developing payment and service delivery reforms with a **first draft due on May 29, 2015**.

## PHIP Development Process:



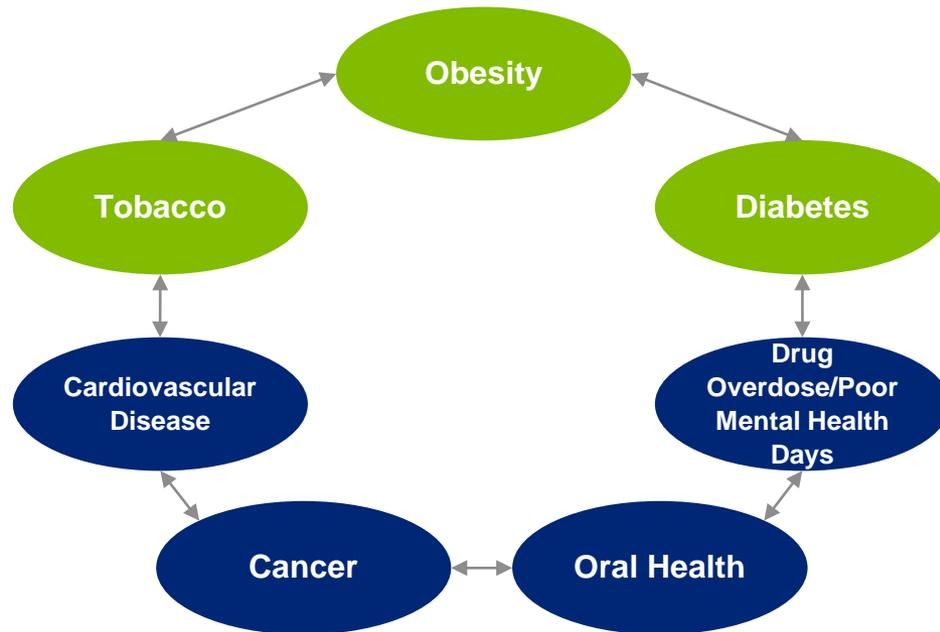
The **May draft of the PHIP** will serve as a **checkpoint** on the unique population health needs that Kentucky is facing, and as a **mechanism to solicit stakeholder input** throughout the remainder of the Model Design process on how to **design payment and service delivery reforms** around these population health needs.

# PHIP Section 1: Health Needs Assessment

The draft PHIP contains a health needs assessment for the three CMS/CDC prescribed population health focus areas, plus the additional four focus areas added to promote the PHIP’s alignment with and as an extension of **kyhealthnow**.

## Health Needs Assessment Outline

- The PHIP draft provides an **initial assessment** of the **gaps in access to care and the health status disparities** that Kentucky seeks to address in the delivery system transformation initiatives designed over the course of the Model Design period.
- For each of the seven population health focus areas, the PHIP describes the current state and its impact on the Commonwealth and its populations, focusing specifically on:
  - **The prevalence of the condition**
  - **The disproportionate populations at risk**
  - **The economic impact**



- CMS/CDC & kyhealthnow Focus Areas
- Other kyhealthnow Focus Areas

## PHIP Section 2: Current Health Initiatives

The second section of the PHIP focuses on describing major ongoing population health-focused initiatives to improve both health outcomes and risk-factors related behavior. While the connection between the PHIP and **kyhealthnow** is inherent throughout, the PHIP describes the work being done in other areas and how stakeholders are playing multiple roles in each.

### kyhealthnow

- **kyhealthnow** established seven health goals for the Commonwealth, along with a number of specific strategies to help achieve these goals through 2019.
- These strategies will be implemented through executive and legislative actions and public-private partnerships.
- In addition, an **Oversight Team** was established to monitor and provide oversight of the administration’s efforts to meet the kyhealthnow goals and carry out the strategies needed to achieve these goals, which is attached to CHFS.
- The PHIP is using **kyhealthnow** and its goals as its framework to develop new payment and delivery system reforms that work towards reaching each identified goal and a new governance process to provide long term monitoring and oversight.

### ER “Super-Utilizer” Initiative

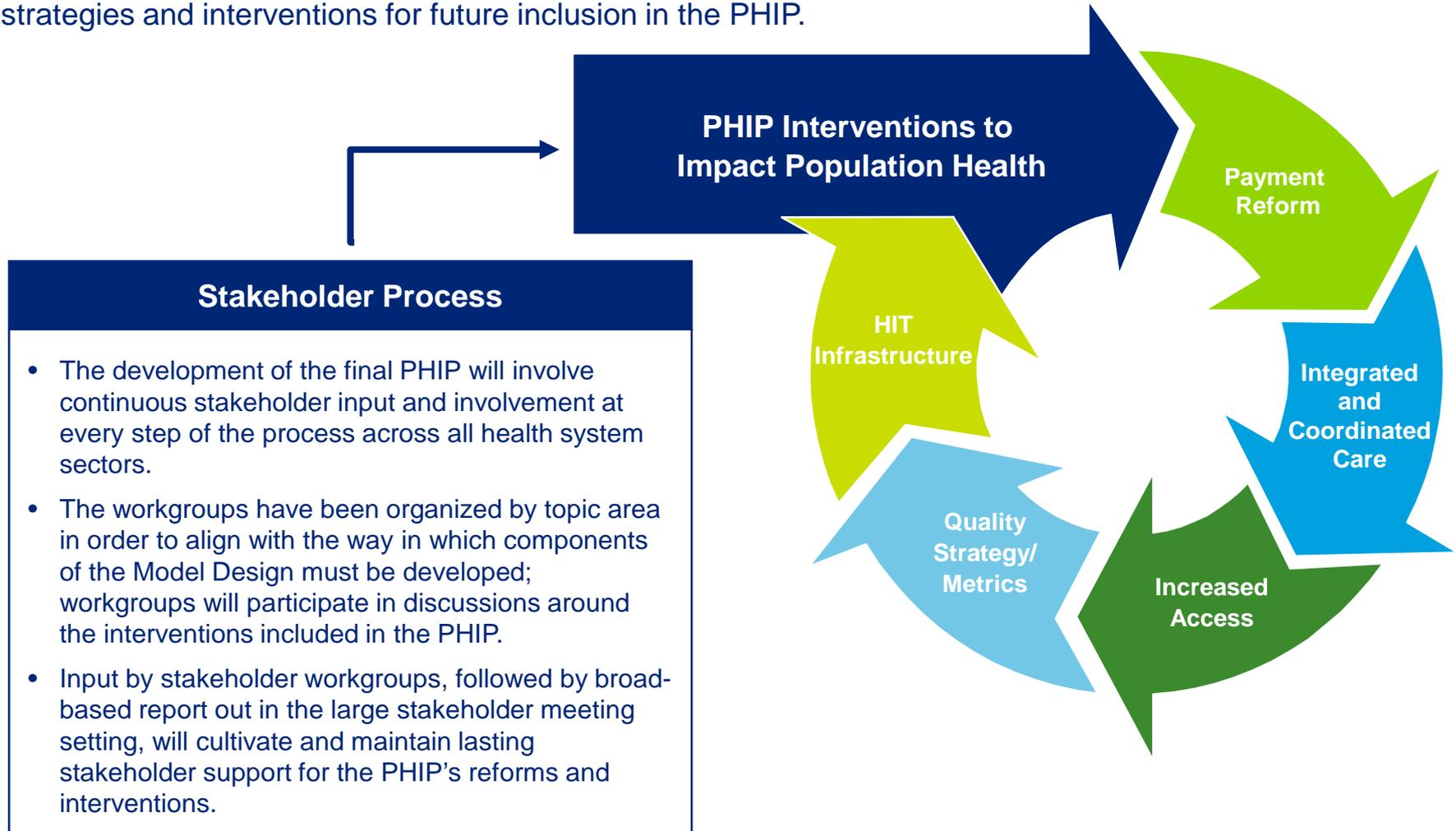
- Kentucky was awarded participation in a National Governor’s Association (NGA) Policy Academy to address **emergency department (ED) super-utilization** in July 2013 and expanded the program statewide in August 2014.
- **Phase I** of the project focused on evaluating, recommending, and implementing models that efficiently navigate patients, focusing on decreasing emergency room super-utilization.
- **16 hospital sites** participated in Phase I of the project, and these sites are already seeing success, including active partner engagement and the development of new tools to monitor super-utilization data.
- The **Kentucky Department for Public Health (DPH)** provides assistance to these hospital sites through workgroup conference calls, data analysis, and specific technical expertise.

### Unbridled Health

- The Coordinated Chronic Disease Prevention and Health Promotion Plan, or **Unbridled Health**, was completed in August 2013 through the work of more than an 80 member steering committee, a committee that continues to meet on an annual basis to identify synergies around the key initiatives included in the plan.
- **Unbridled Health** provides a framework in which organizations and individuals can unite as one powerful force to reduce the significant chronic disease burden in our state.
- **The framework** includes policy, systems and environmental changes that support healthy choices; expanded access to health screenings and self-management programs; strong linkages among community networks; and research data that are used as a catalyst for change.

# PHIP Section 3: Stakeholder Engagement

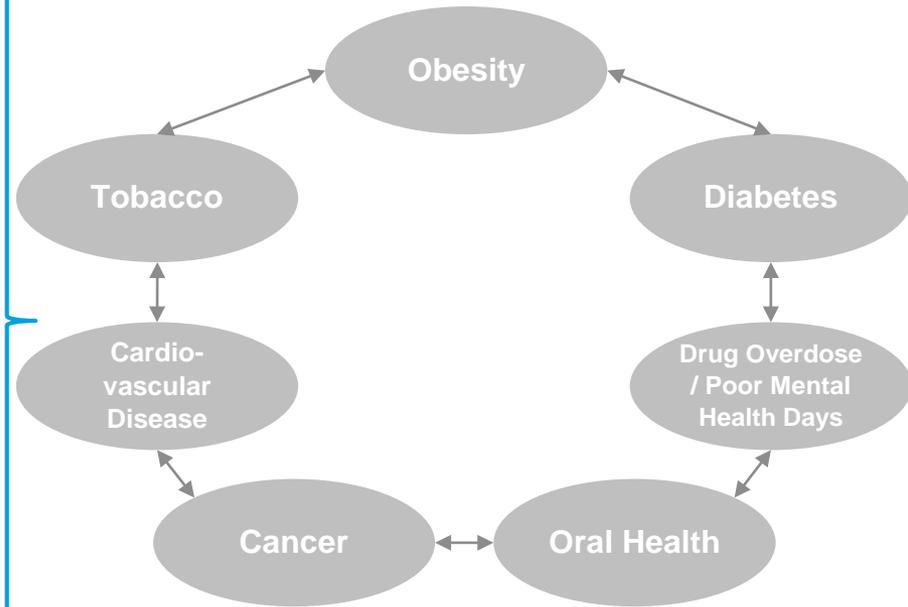
Throughout the Model Design period, CHFS will use a robust, iterative process with internal and external stakeholders to craft the components of the Model Design, the first component being the PHIP. The team has developed a formal stakeholder engagement approach that will be used to develop the strategies and interventions for future inclusion in the PHIP.



# PHIP Section 4: Interventions to Improve Population Health

Using the health needs assessment and population health focus areas of kyhealthnow, stakeholders will develop interventions to improve population health in the context of the SIM workgroups and their topic areas over the course of the Model Design process.

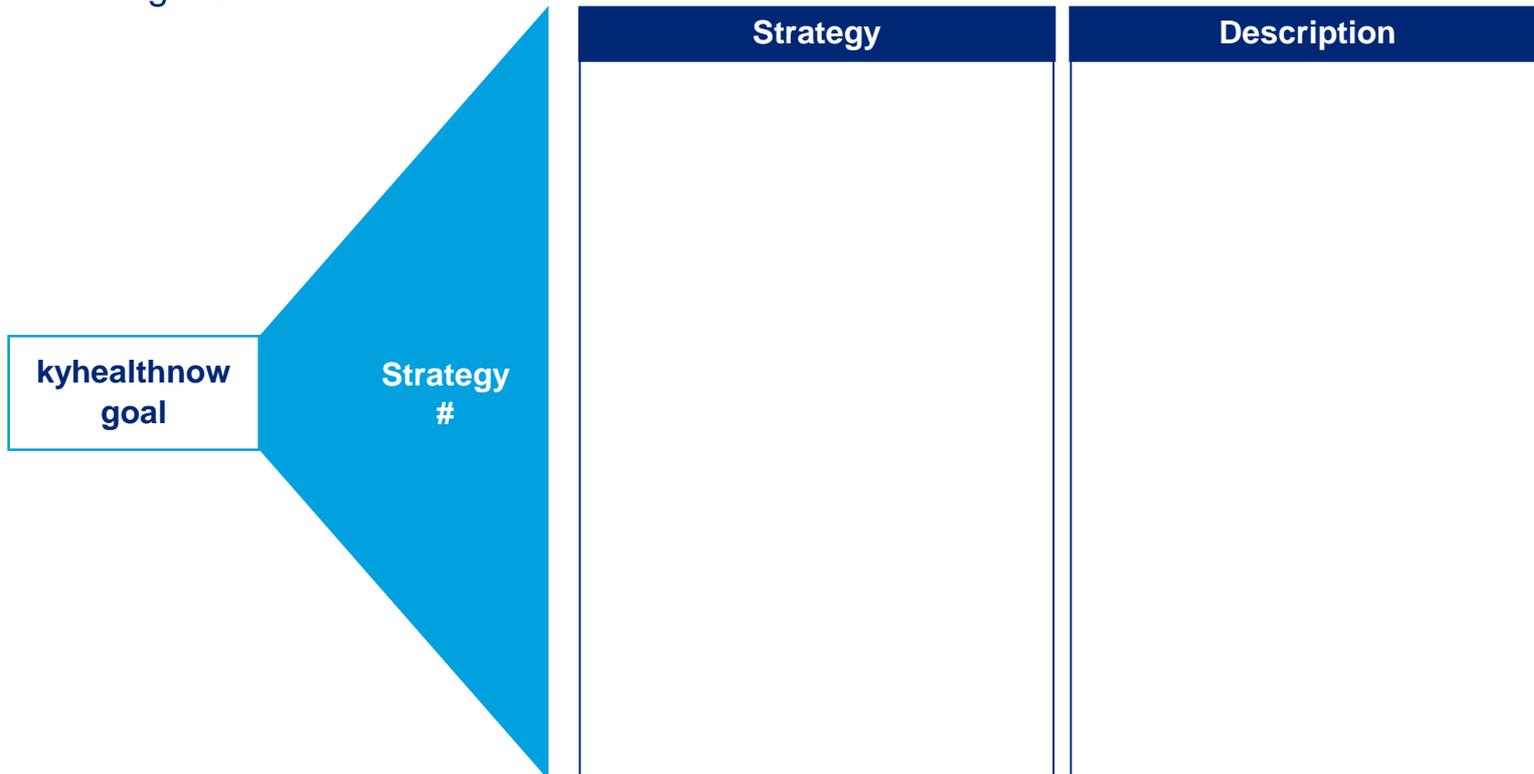
- 1 Service Delivery Model Options
- 2 Payment Methodologies
- 3 Policy and Regulatory Levers
- 4 Workforce Needs Assessment
- 5 Health Information Technology



**These categories of interventions to improve population health and how they apply to the seven focus areas are not comprehensive and lend themselves to expansion, refinement, and discussion with all SIM stakeholders.**

## PHIP Section 4: A Closer Look

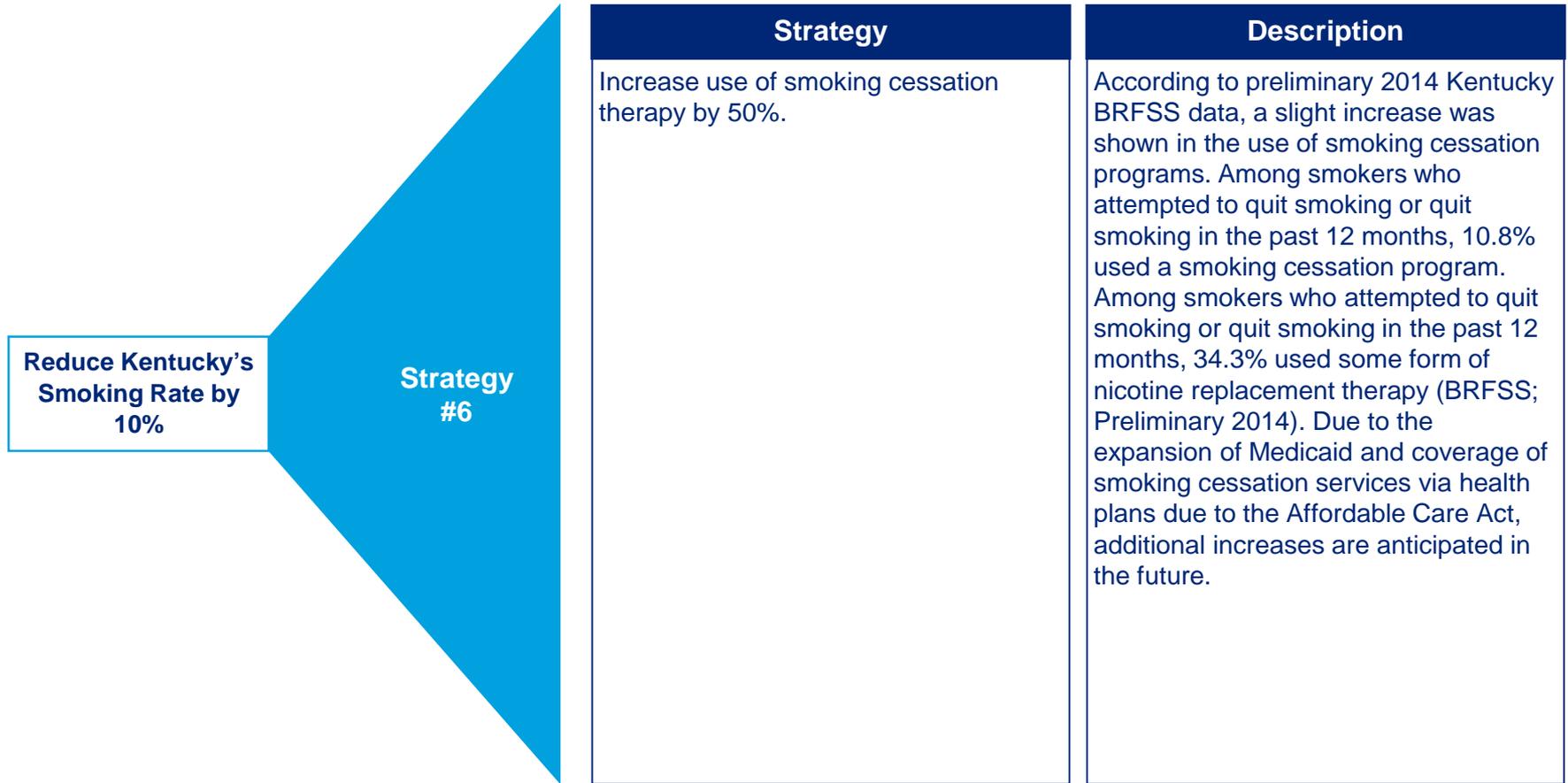
Within the seven kyhealthnow focus areas that the PHIP seeks to address, there are 51 associated strategies to help achieve these population health goals over the next five years. For the purposes of the PHIP, we will explore a subset of these strategies as they relate to integrated and coordinated care to determine which strategies can be impacted by care models, or which models would have the most effect on the strategies.



The goal of this workgroup activity is to develop a set of key themes to designing care models that work towards achieving the kyhealthnow, and therefore the PHIP, population health goals for inclusion in the draft PHIP due at the end of May.

# PHIP Strategies Discussion

How could an integrated and/or care coordination model designed to improve a delivery system impact this kyhealthnow strategy?



# PHIP Strategies Discussion (Continued)

How could an integrated and/or care coordination model designed to improve a delivery system impact this kyhealthnow strategy?



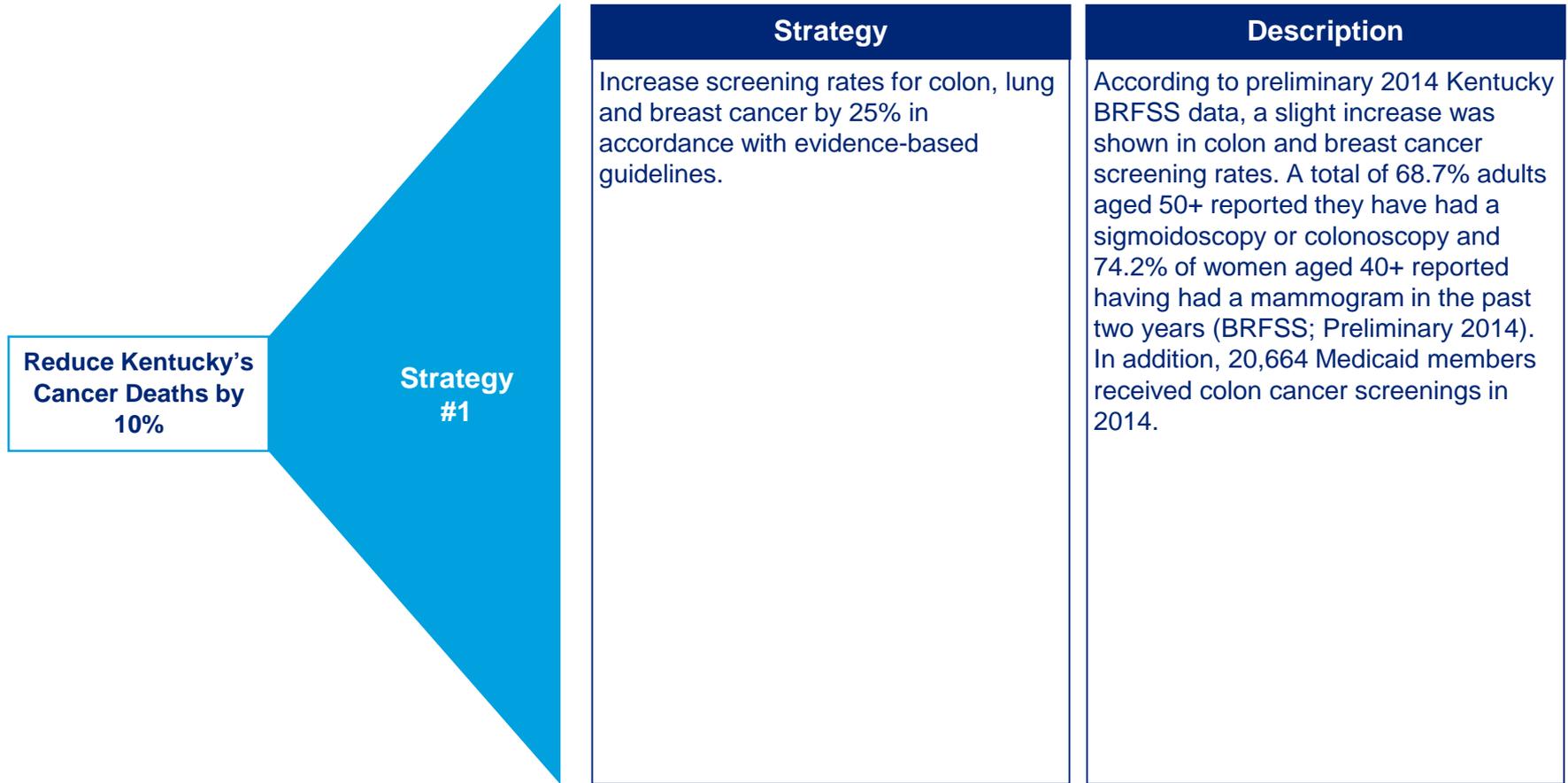
## PHIP Strategies Discussion (Continued)

How could an integrated and/or care coordination model designed to improve a delivery system impact this kyhealthnow strategy?

<p><b>Reduce the Obesity Rate Among Kentuckians by 10%</b></p>	<p><b>Strategy #12</b></p>	Strategy	Description
		<p>Work with early child care providers to increase opportunities to prevent obesity among our youngest children.</p>	<p>A total of 65 early care environments participate in the Early Care and Education Learning Collaboratives (ECELC) Project in Jefferson County, Fayette County, and Northern Kentucky. This is an increase of 38 centers since March 2014. This program consists of intensive training and technical assistance regarding the rationale supporting best practices in nutrition, physical activity, screen time, breastfeeding and family engagement. More sites are scheduled to be added in 2015. The Healthy Communities program has worked with an additional 30 ECE centers in 2014 to provide similar extensive training and technical assistance (KY Department for Public Health Obesity Program; February 2015).</p>

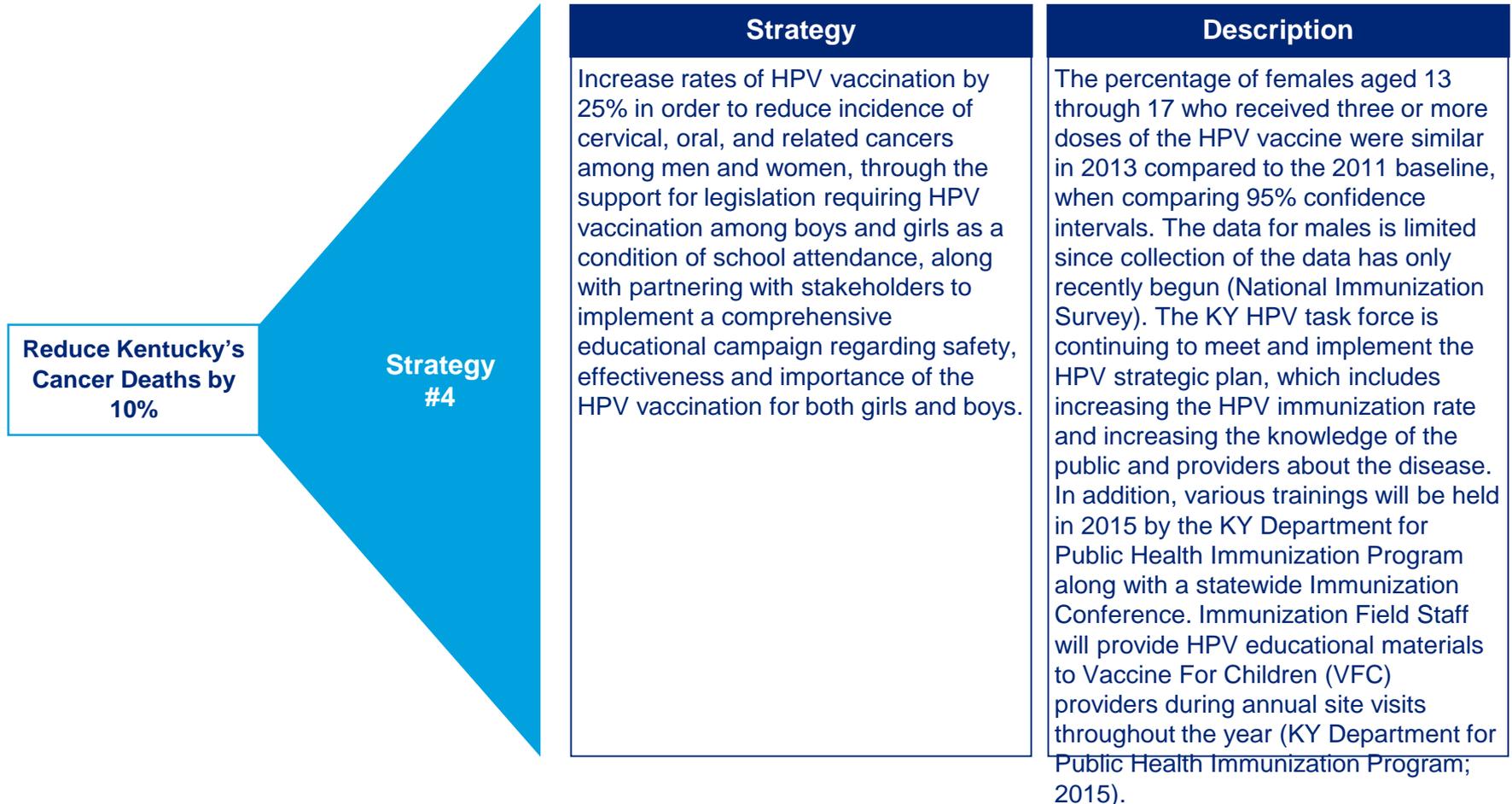
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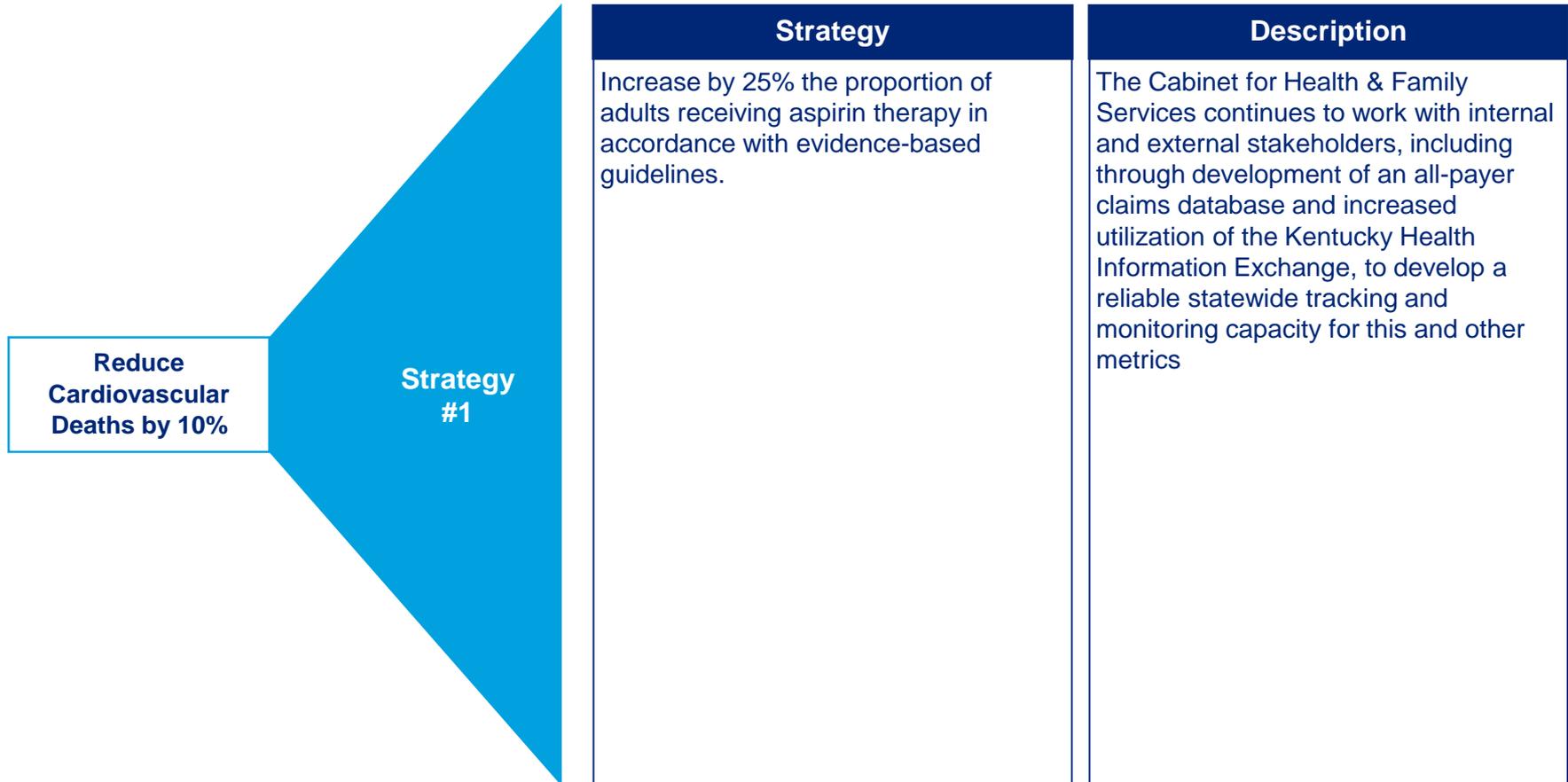
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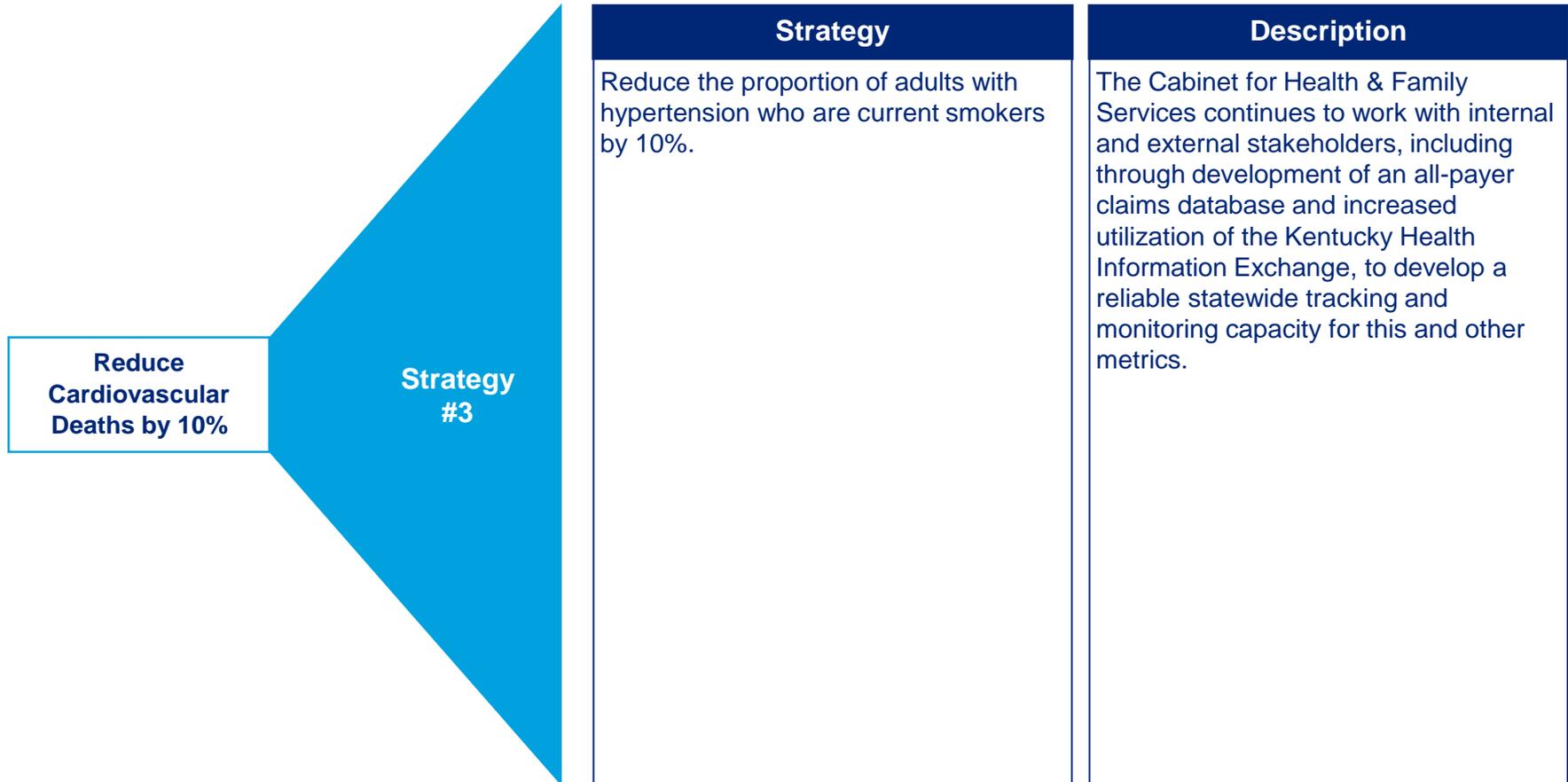
## PHIP Strategies Discussion (Continued)

How could an integrated and/or care coordination model designed to improve a delivery system impact this kyhealthnow strategy?

<p><b>Reduce Cardiovascular Deaths by 10%</b></p>	<p><b>Strategy #2</b></p>	<p><b>Strategy</b></p>	<p><b>Description</b></p>
		<p>Reduce the proportion of adults with uncontrolled hypertension by 10%.</p>	<p>Compared to the baseline, a slight increase was seen in the percentage of adults who have been told they have high blood pressure, 39.1% (BRFSS; 2013).</p>

# PHIP Strategies Discussion (Continued)

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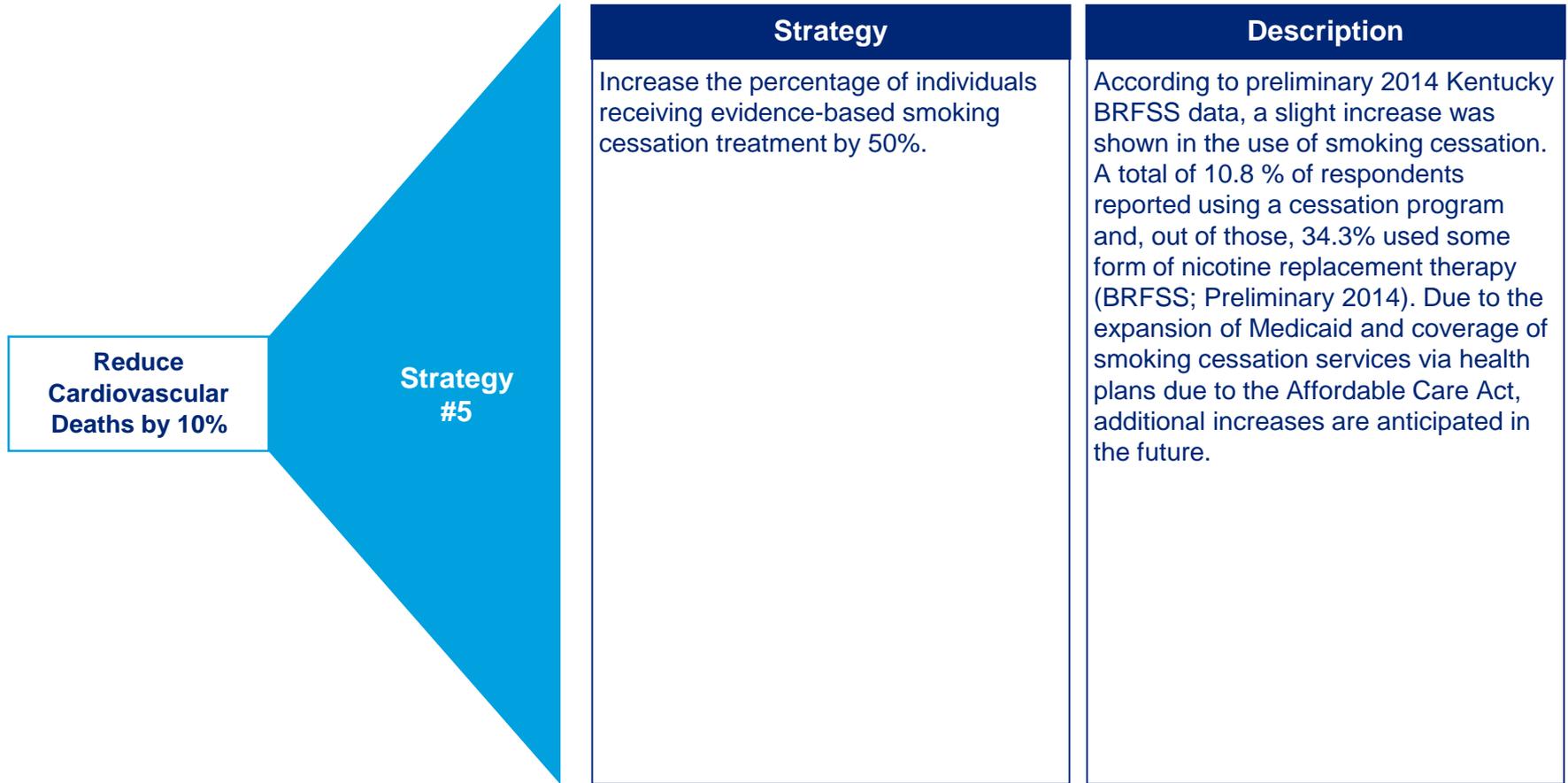
# PHIP Strategies Discussion (Continued)

How could an integrated and/or care coordination model designed to improve a delivery system impact this kyhealthnow strategy?

<div style="border: 1px solid black; padding: 5px; display: inline-block;"> <p><b>Reduce Cardiovascular Deaths by 10%</b></p> </div> <div style="font-size: 2em; color: blue; font-weight: bold; margin-left: 20px;">             Strategy #4           </div>	Strategy	Description
	<p>Increase by 10% the proportion of adults who have had their blood cholesterol checked within the preceding five years.</p>	<p>Compared to the baseline measurement in 2011 of 75.7%, an increase of almost 2% was seen in 2013 among adults who have had their cholesterol checked in the past five years (BRFSS).</p>

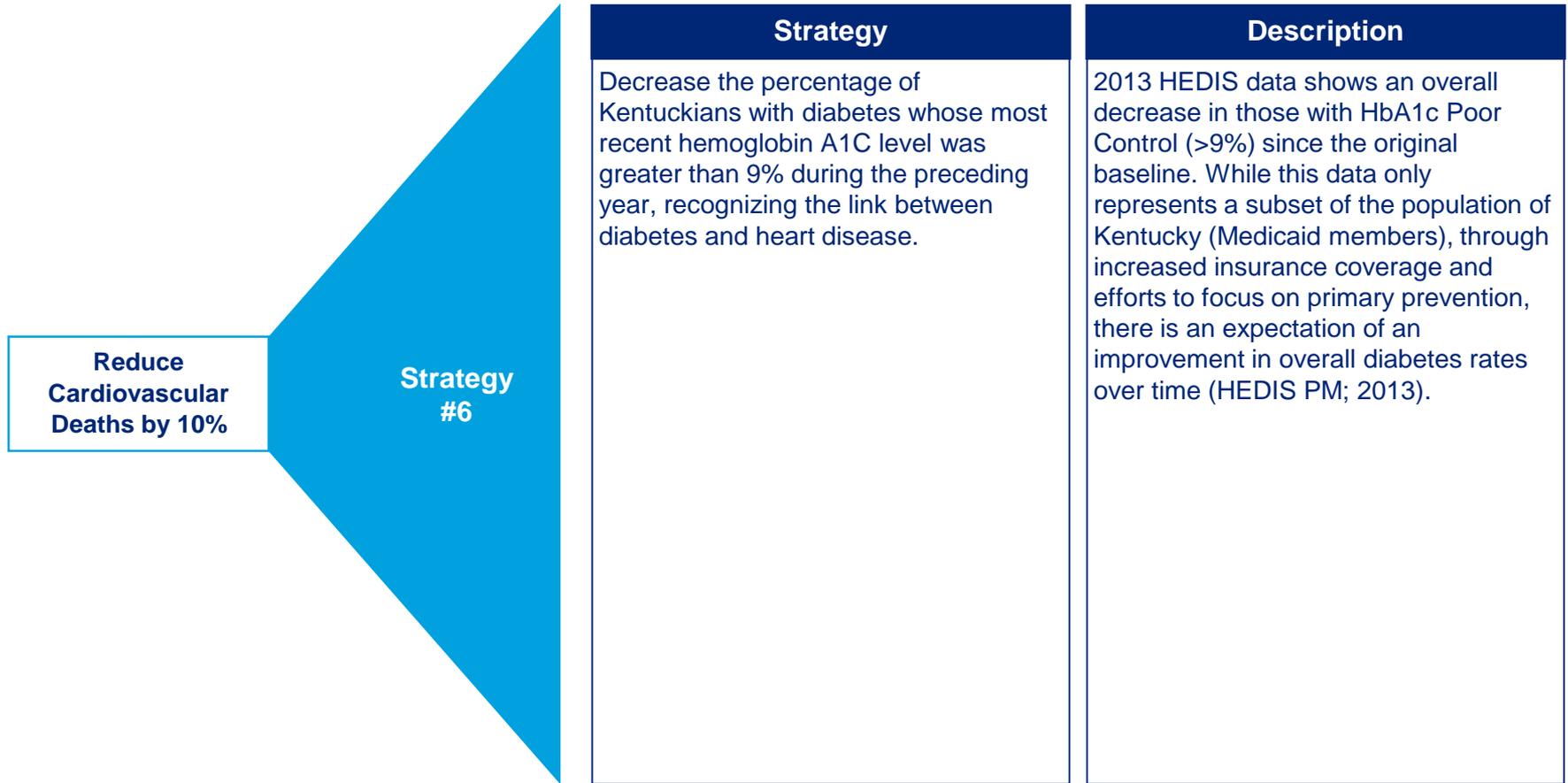
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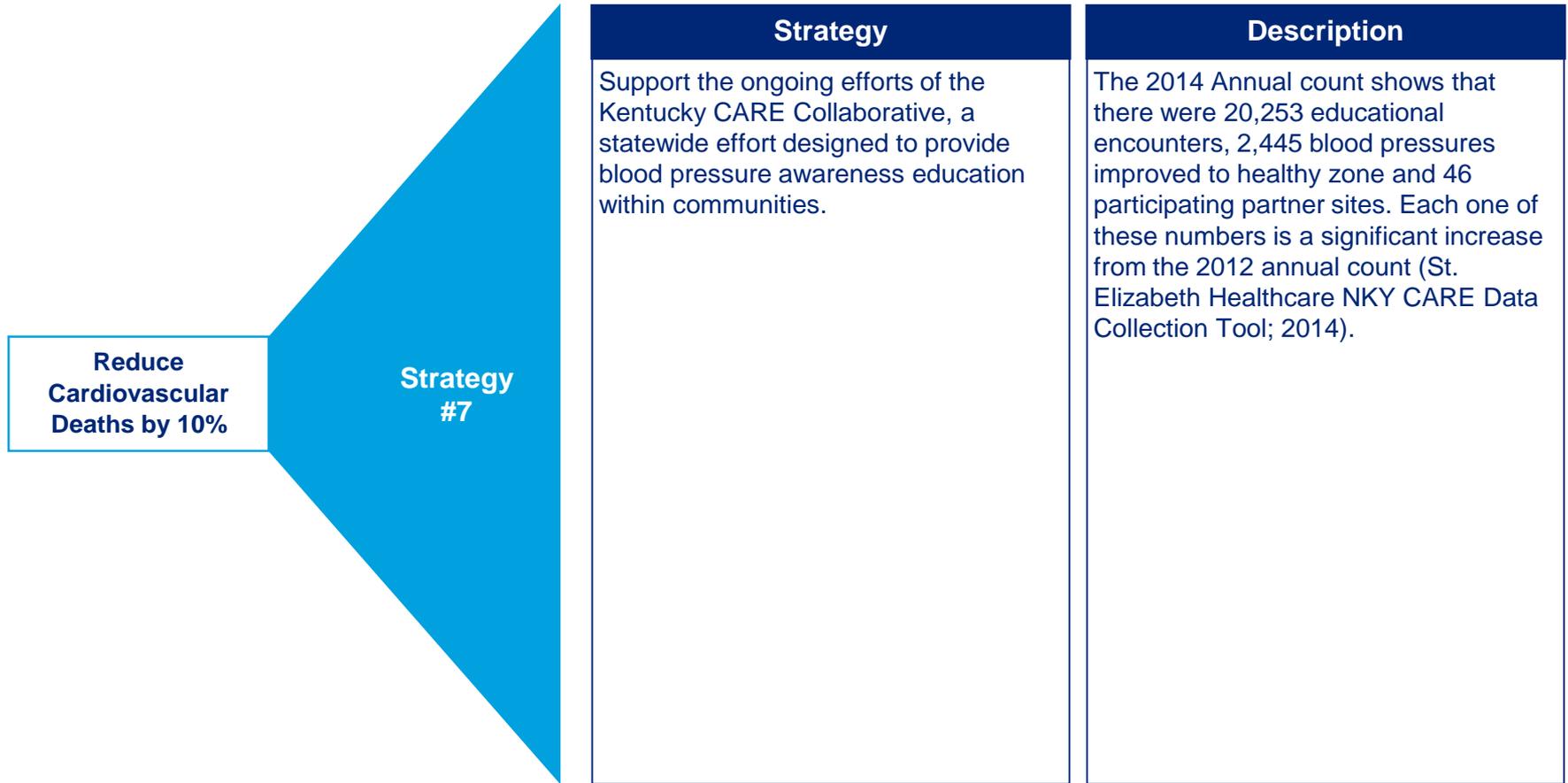
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<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> <p><b>Reduce Cardiovascular Deaths by 10%</b></p> </div> <div style="font-size: 4em; color: #00AEEF; opacity: 0.5; margin: 10px 0;">}</div> <p style="font-size: 1.5em; font-weight: bold; color: #00AEEF;">Strategy #9</p>	Strategy	Description
	<p>Continue support for efforts of the Stroke Encounter Quality Improvement Project, a statewide voluntary initiative among hospitals to implement evidence-based integrated cardiovascular health systems in Kentucky.</p>	<p>The 2014 Annual count shows that there were 22 participating hospitals and 88.8% eligible patients received dysphagia screening. This is only a slight increase in the total number of participating sites compared to 2013 (SEQIP Stroke Registry Data Summary; 2014).</p>

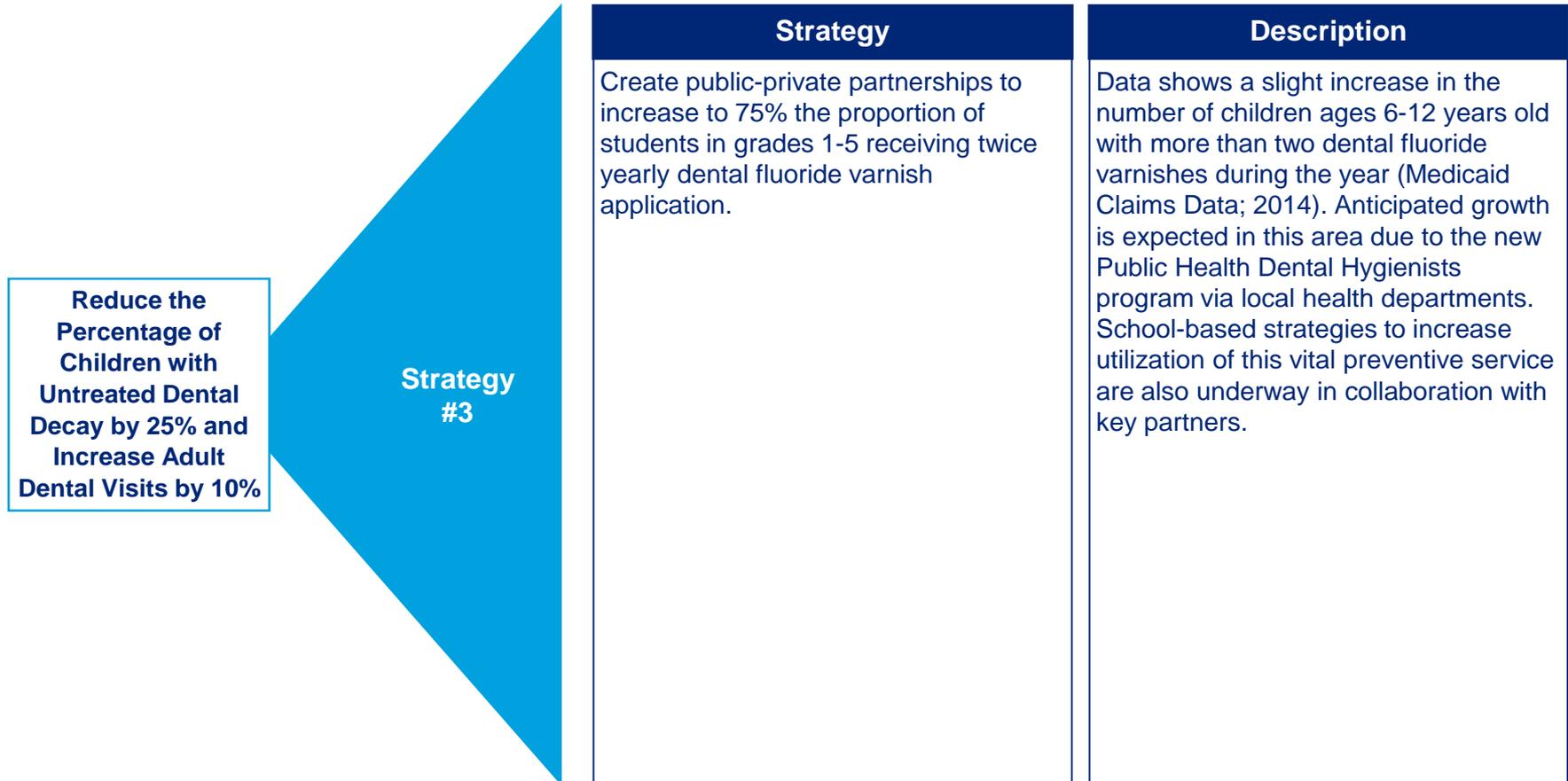
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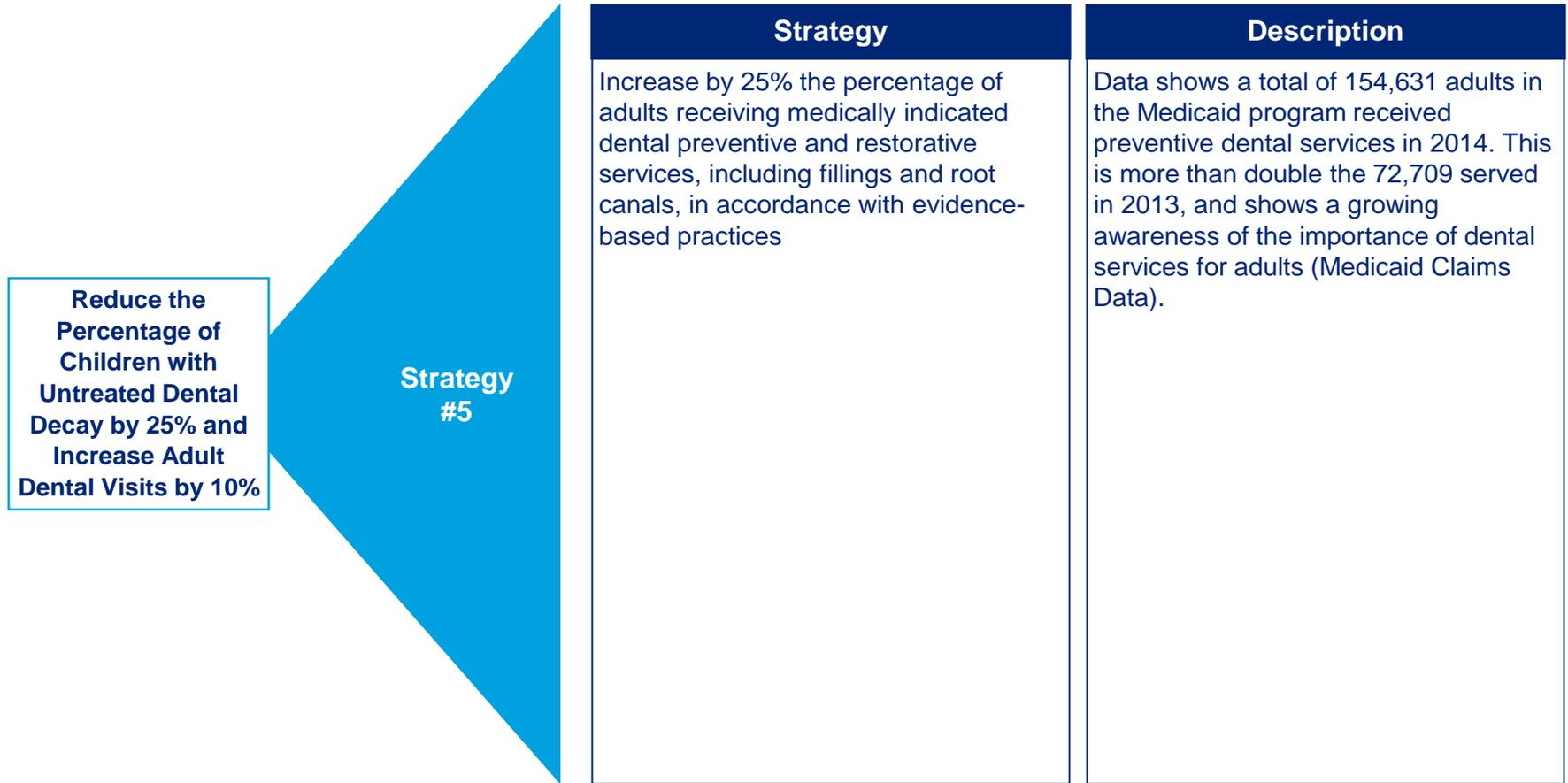
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How could an integrated and/or care coordination model designed to improve a delivery system impact this kyhealthnow strategy?

<p><b>Reduce the Percentage of Children with Untreated Dental Decay by 25% and Increase Adult Dental Visits by 10%</b></p>	<p><b>Strategy #4</b></p>	Strategy	Description
		<p>Increase by 25% the proportion of adults receiving fluoride varnish during an annual dental visit.</p>	<p>Active discussions are ongoing regarding this strategy with the Kentucky Dental Association including possible reevaluation to reflect emerging practices regarding adult preventive oral health strategies.</p>

# PHIP Strategies Discussion (Continued)

How could an integrated and/or care coordination model designed to improve a delivery system impact this kyhealthnow strategy?



# PHIP Strategies Discussion (Continued)

How could an integrated and/or care coordination model designed to improve a delivery system impact this kyhealthnow strategy?

**Reduce Deaths from Drug Overdose by 25% and Reduce by 25% the Average Number of Poor Mental Health Days of Kentuckians**

**Strategy #1**

Strategy	Description
<p>Double the number of individuals receiving substance abuse treatment by the end of 2015.</p>	<p>In 2014, more than 13,000 individuals in the Medicaid program received substance abuse treatment services, which is a newly covered essential health benefit pursuant to the Affordable Care Act as of January 1, 2014. (KY Department for Medicaid claims data; 2015).* Data from Community Mental Health Centers, who serve both uninsured and Medicaid-eligible individuals, indicates that for the first half of FY2015 (July – December, 2014) there were 2,847 individuals who received substance abuse services, which was a 39% increase from the same period in the prior year. (KY Department for Behavioral Health, Developmental and Intellectual Disabilities, 2015) The Cabinet for Health &amp; Family Services continues to partner with internal and external stakeholders, including through development of an all-payer claims database and increased use of the Kentucky Health Information Exchange, to develop a reliable statewide metric to measure substance abuse treatment utilization.</p>

## PHIP Strategies Discussion (Continued)

How could an integrated and/or care coordination model designed to improve a delivery system impact this kyhealthnow strategy?

**Reduce Deaths from Drug Overdose by 25% and Reduce by 25% the Average Number of Poor Mental Health Days of Kentuckians**

**Strategy #4**

Strategy	Description
<p>Increase by 50% the availability of substance use treatment for adolescents.</p>	<p>The Department for Behavioral Health, Intellectual and Developmental Disabilities (DBHDID) provided evidence-based adolescent treatment training in each CMHC and three private agencies. An online learning collaborative for treatment providers who serve adolescents is under development to support training and technical assistance. KY Kids Recovery Adolescent Substance Use Treatment grants allocated \$18.1 million in seed money to 19 agencies for adolescent substance use treatment programming across the state. UK's Adolescent Health and Recovery Treatment and Training (AHARTT) initiative, funded with pharmaceutical settlement dollars, is training providers across the state in two evidence-based treatment approaches and has opened a clinic at UK to serve adolescents (KY Department for Behavioral Health, Developmental and Intellectual Disabilities; February 2015).</p>

# PHIP Strategies Discussion (Continued)

How could an integrated and/or care coordination model designed to improve a delivery system impact this kyhealthnow strategy?

<p><b>Reduce Deaths from Drug Overdose by 25% and Reduce by 25% the Average Number of Poor Mental Health Days of Kentuckians</b></p>	<p><b>Strategy #8</b></p>	Strategy	Description
		<p>Increase by 25% the percentage of adults and children receiving medically indicated behavioral health services by the end of 2015.</p>	<p>In 2013, 87,451 children and 72,539 adults in the Medicaid program received a behavioral health service (e.g., outpatient psychotherapy, outpatient behavioral health service delivered by a physician, behavioral health residential services and had a primary diagnosis of a behavioral health disorder. Those with a primary diagnosis of substance use were excluded. In 2014, 91,572 children and 116,282 adults in the Medicaid program received a behavioral health service (e.g., outpatient psychotherapy, outpatient behavioral health service delivered by a physician, behavioral health residential services and had a primary diagnosis of a behavioral health disorder. Those with a primary diagnosis of substance use were excluded. This represents a 5% increase for children and 60% for adults.</p>

# PHIP Strategies Discussion (Continued)

How could an integrated and/or care coordination model designed to improve a delivery system impact this kyhealthnow strategy?

**Reduce Deaths from Drug Overdose by 25% and Reduce by 25% the Average Number of Poor Mental Health Days of Kentuckians**



Strategy	Description
<p>Increase the proportion of adults and adolescents who are screened for depression during primary care office visits by 10%.</p>	<p>Medicaid MCO contract language requires that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders (KY Department for Behavioral Health, Developmental and Intellectual Disabilities, 2015). In 2013, there were 419 children and 1,679 adults in the Medicaid program for whom the claim indicated that screening for depression occurred during an office visit. In 2014, there were 1109 children and 5593 adults for whom the claim indicated that screening for depression occurred during an office visit. This represents a 165% for children and 233% for adults. (KY Department for Behavioral Health, Developmental and Intellectual Disabilities; 2015).</p>

## PHIP Strategies Discussion (Continued)

How could an integrated and/or care coordination model designed to improve a delivery system impact this kyhealthnow strategy?

**Reduce Deaths from Drug Overdose by 25% and Reduce by 25% the Average Number of Poor Mental Health Days of Kentuckians**

**Strategy #10**

Strategy	Description
<p>Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders by 10%.</p>	<p>Data from Community Mental Health Centers, who serve both uninsured and Medicaid-eligible recipients, indicates that for the first half of FY2015 (July to December 2014) there were 1,666 individuals with co-occurring substance use and mental health disorders who received services, resulting in a 86% increase from the same period in the prior year. (KY Department for Behavioral Health, Developmental and Intellectual Disabilities, 2015).</p>

# PHIP Strategies Discussion (Continued)

How could an integrated and/or care coordination model designed to improve a delivery system impact this kyhealthnow strategy?

**Reduce Deaths from Drug Overdose by 25% and Reduce by 25% the Average Number of Poor Mental Health Days of Kentuckians**



**Strategy #11**

Strategy	Description
<p>Partner with stakeholders to increase the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) to 25% of medical providers (primary care, prenatal care providers, and emergency departments).</p>	<p>SBIRT was successfully added to the Medicaid state plan in 2014. Education of providers in the implementation of SBIRT is ongoing. Efforts to increase utilization of SBIRT include the SMVF Behavioral Health Initiative in collaboration with the KY National Guard, with the goal of increasing the use of SBIRT within the military population. In addition, the KIDS NOW Plus program provides ongoing training in the use of SBIRT to primary care and prenatal care providers. Substance Use Treatment and Recovery Branch staff have collaborated with Public Health staff to support SBIRT planning for improved access and expansion across the state (KY Department for Behavioral Health, Developmental and Intellectual Disabilities; 2015).</p>

**Next Steps**

# Upcoming Schedule

A monthly workgroup meeting will be essential for discussing key topics, reaching consensus, and driving the development of a successful Model Design. The exact meeting dates, times, and locations for the workgroups will be communicated in advance of each session.

## June 2015

M	T	W	T	F
1	2	3*	4	5
8	9 *Rescheduled	10	11	12
15	16	17	18	19
22	23	24	25	26
29	30			

## July 2015

M	T	W	T	F
		1	2	3
6	7	8	9	10
13	14	15	16	17
20	21	22	23	24
27	28	29	30	31

## August 2015

M	T	W	T	F
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28
31				

### Calendar Legend

Workgroup Meeting

Stakeholder Meeting

## Next Steps

- The June full stakeholder meeting that was scheduled for **Wednesday, June 3, 2015** has been **rescheduled**. It will now take place on **Tuesday, June 9, 2015 from 1 – 4 PM** at the Kentucky Historical Society - 100 W Broadway Street in Frankfort, KY.
- Mark your calendars! The next Integrated & Coordinated Care workgroup will be held on **June 16, 2015**.

Workgroup	June Date	June Time	June Location
Payment Reform	Tuesday, June 16 <sup>th</sup>	9AM to 12PM	KY Department for Public Health (DPH), Conference Suites B-C, 275 E Main St, Frankfort, KY 40601
Integrated & Coordinated Care	Tuesday, June 16 <sup>th</sup>	1PM to 4PM	KY Department for Public Health (DPH), Conference Suites B-C, 275 E Main St, Frankfort, KY 40601
Increased Access	Wednesday, June 17 <sup>th</sup>	9AM to 12PM	KY Department for Public Health (DPH), Conference Suites B-C, 275 E Main St, Frankfort, KY 40601
Quality Strategy / Metrics	Wednesday, June 17 <sup>th</sup>	1PM to 4PM	KY Department for Public Health (DPH), Conference Suites B-C, 275 E Main St, Frankfort, KY 40601
HIT Infrastructure	Thursday, June 18 <sup>th</sup>	9:30AM to 12:30PM	KY Department for Public Health (DPH), Conference Suites B-C, 275 E Main St, Frankfort, KY 40601

- Please visit the dedicated Kentucky SIM Model Design website: <http://chfs.ky.gov/ohp/sim/simhome>
  - This website contains an Integrated & Coordinated Care workgroup section that will contain meeting presentations, outputs, and additional resources.
- Please contact the KY SIM mailbox at [sim@ky.gov](mailto:sim@ky.gov) with any comments or questions

**Thank you!**

**Q&A**

# Appendix

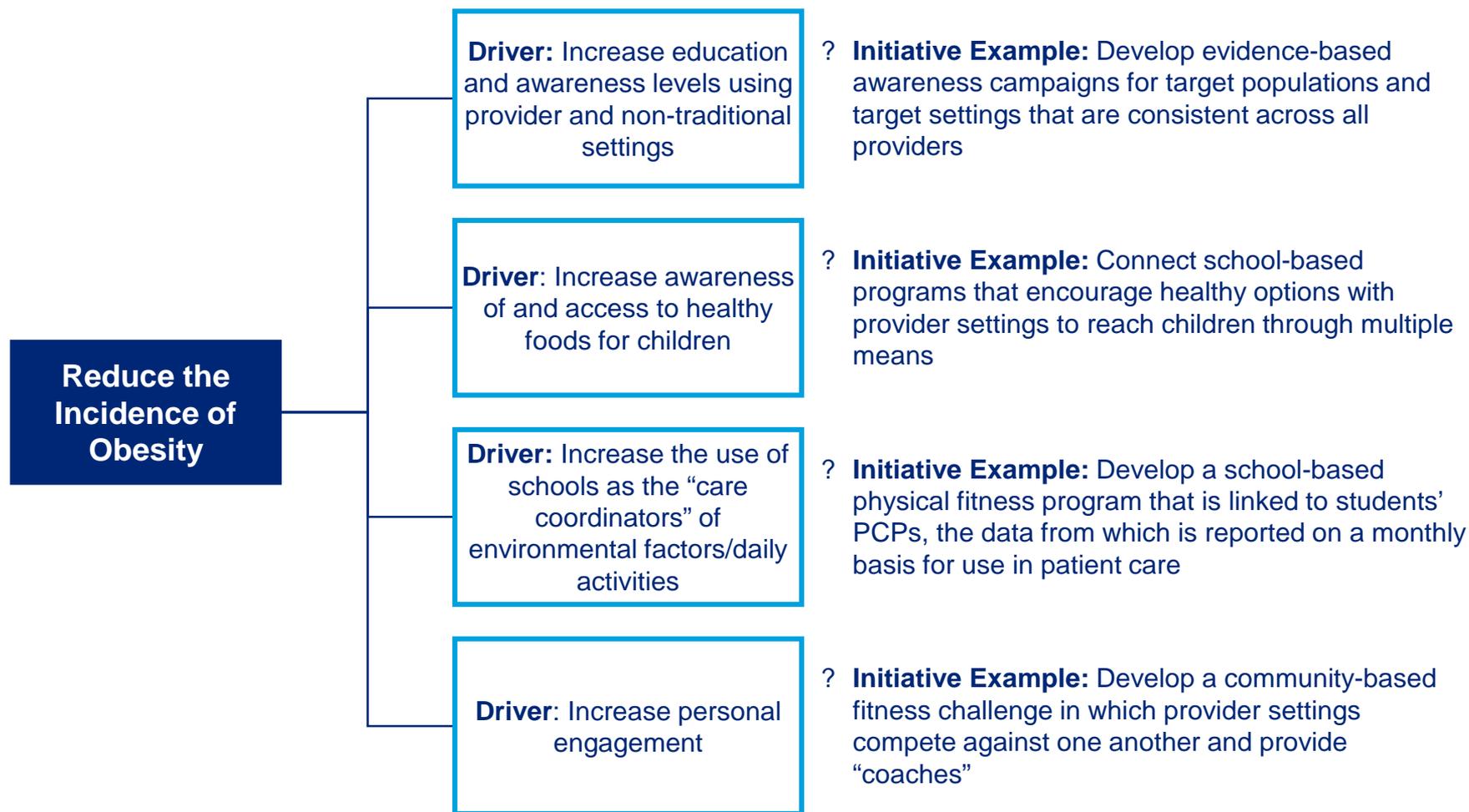
## Integrated & Coordinated Care Driver Diagram – Tobacco

What are the current barriers to reducing tobacco use in Kentucky? What would be the key drivers to reducing those barriers? What initiatives could support those drivers from an integrated and coordinated care perspective?



## Integrated & Coordinated Care Driver Diagram – Obesity

What are the current barriers to reducing the incidence of obesity in Kentucky? What would be the key drivers to reducing those barriers? What initiatives could support those drivers from an integrated and coordinated care perspective?



## Integrated & Coordinated Care Driver Diagram – Diabetes

What are the current barriers to reducing the incidence of diabetes in Kentucky? What would be the key drivers to reducing those barriers? What initiatives could support those drivers from an integrated and coordinated care perspective?

