Patient Access to BH Services:
A CCNC Perspective

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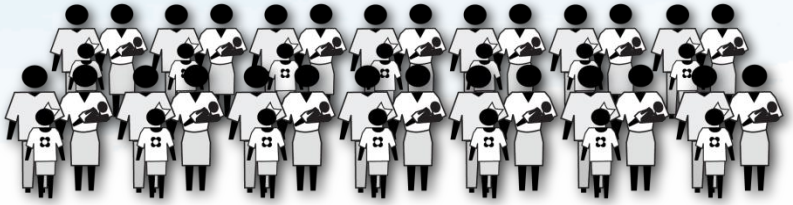
CCNC as Medicaid Contractor

- **Primary Care Case Management System (PCCM) for NC Medicaid**
- **The PCCM program is carried out chiefly through:**
  - (a) the development and support of primary care medical homes
  - (b) a data-driven, statewide care management program

CCNC Footprint Statewide

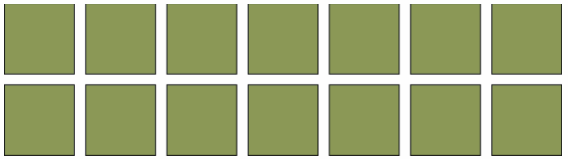
- 6,000 primary care providers (medical homes)
- 90% of PCPs in NC



- 1.4 million Medicaid Patients
- 300,000 Aged, Blind, Disabled
- 150,000 Dually Eligible

All 100 NC Counties

14 Networks



- **Build & support medical homes**
- **Provide care management**
- **Each network averages:**
  - 1.4 Medical Directors
  - 42.8 Local Care Managers
  - 1.8 Pharmacists
  - 1.0 Psychiatrist

Primary Goals of CCNC

- **Improved care of the enrolled Medicaid population while controlling costs**
- **A "medical home" for patients, emphasizing primary care**
- **Community networks capable of managing recipient care**
- **Local systems that improve management of chronic illness in both rural and urban settings**

Behavioral Health Initiative and Community Care

- **Added in 2010, with a focus on:**
  - Treating the "whole patient"
  - Breaking down "Silos" of care
  - Improving health outcomes

***** Not meant to replace Specialty Behavioral Health**

NC Medicaid Statistics of People with Mental Health (MH) conditions

- **20% of Medicaid patients are diagnosed with a Mental Health (MH) condition**
- **80% of patients diagnosed with MH are enrolled in a CCNC medical home/primary care practice**
- **52% of patients actively care managed by CCNC are diagnosed with a MH condition**
- **75% of patients with a MH condition have another chronic health condition (hypertension, diabetes)**
- **35% of patients with a MH condition have 3 or more chronic health conditions**

*Excluding IDD or Autism only

Where do patients with Mental Health Disorders go for treatment?

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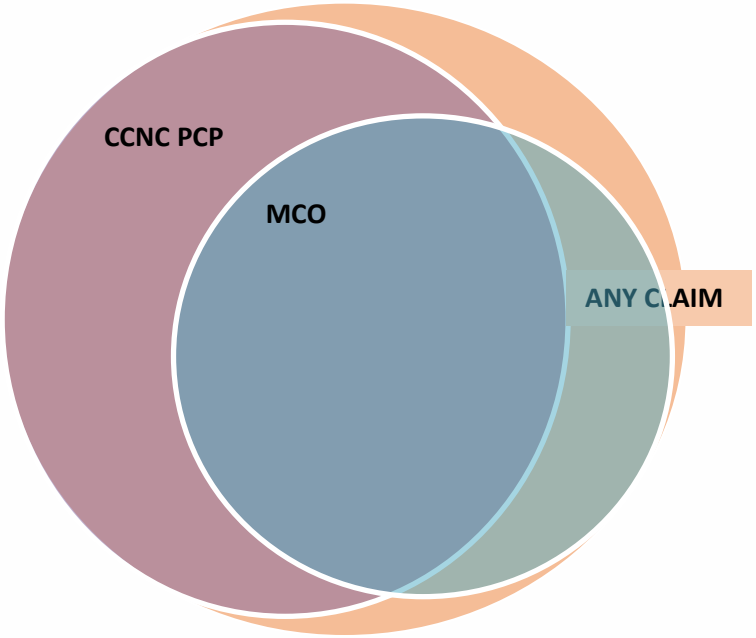
Any Mental Health Disorder* (N = 361,568)

- **43% w/ at least 1 CCNC PCP visit ONLY**
- 13% w/ at least 1 BH Service billed to LME/MCO
- 35% w/ BOTH
- 9% w/neither



*Excluding IDD or Autism only

Where do patients with Severe Persistent Mental Illness (SPMI) go for treatment?

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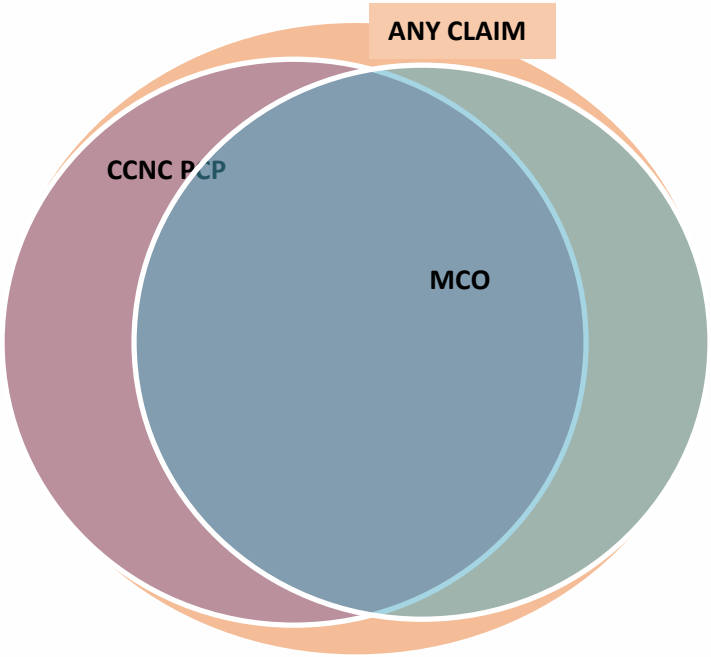
SPMI* (N = 60,304)

- **21% w/ at least 1 CCNC PCP visit ONLY**
- 21% w/ at least 1 BH Service billed to LME/MCO
- 52% w/ BOTH
- 6% w/neither



*Severe Persistent Mental Illness (Bipolar, Schizophrenia, Schizoaffective)

CCNC's Perspective

- **We collected survey information from CCNC Network BH Coordinators across the state**
- **Aggregated the survey information into two categories**
  - Referrals through the LME/MCO
  - Referrals directly to BH Providers
- **Examined the positives and opportunities for improvement**
- **Revealed innovative or new advances in increasing access to BH services**

BH Referrals through LME/MCOs – Positives

- **Can make BH appointments for patients, usually with-in a week or two**
  - Priority given to CCNC CMs / CCNC Medical Homes
  - LME/MCO follow-up after patient appointment
  - Can set up a 3-way call
  - Providers can be chosen based on proximity to patient's address
- **Monthly meeting with CCNC network and LME/MCO to discuss issues with access to particular services**
- **Some LME/MCOs document in CMIS**
- **Some LME/MCOs have expanded care coordination criteria**

BH Referrals through LME/MCOs – Opportunities

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- **Long process for patients and providers (30+ minutes)**
- **Inconsistency in a follow up from the LME/MCO indicating if the patient showed, no showed, or cancelled**
- **Inconsistency in length of time until patient can get an appointment**
  - Long turnaround on follow-up for IDD population
- **General communication issues when substance use/abuse is involved**
- **Inconsistency in choosing a Provider based on proximity to patient's address**

BH Referrals to BH Providers – Positives

- **Some areas have a network of providers large enough to handle the demand**
- **Some BH providers will provide unique services**
  - Will visit patients in the ED/Inpatient units to establish rapport prior to their intake
  - Some willing to provide transportation or meet patients in their homes
    - Psychologist doing in-home therapy for 7 counties
  - Some BH Providers are helping CCNC to provide transitional care after inpatient visit
- **BH providers are beginning to see the value in interacting with PCPs**

BH Referrals to BH Providers – Opportunities

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- **Limited options for BH Providers who take Medicaid**
- **Inconsistency with BH Provider Network size and open access**
- **Inconsistency in a follow up from the BH Provider indicating if the patient showed, no showed, or cancelled**
- **Treatment gaps:**
  - Limited partnerships around transitional care
  - Wait time in Walk-In Clinics
  - Pregnant women and buprenorphine/methadone treatment
  - Gap for patients that need ongoing enhanced services after a CST authorization has ended, but don't meet ACTT criteria
  - General communication issues when substance use/abuse is involved
  - Group therapy vs individualized therapy
  - Initial visits are being booked 1-2 months out

CCNC-CPESN-BH Providers:
An opportunity to work together

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Community Pharmacy Enhanced Services Network

- An open network of 200+ (and growing) NC pharmacies committed to broadening the availability of medication management resources to our state's highest-needs population
- The goal of the CPESN is to improve quality of care and patient outcomes related to medication use, enhance patients' overall health trajectory and reduce the total cost of care
- Core services include:
  - Medication fill synchronization
  - Adherence monitoring
  - Compliance packaging
  - Home delivery
  - Comprehensive medication review
  - Care plan development