Whole Person Integrated Care In The New Drug Medi-Cal Organized Delivery System

Tarzana Treatment Centers, Inc.
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Tarzana Treatment Centers

- Founded in 1972
- 501 (c) (3) Non-profit Corporation
- 600+ Employees and Contract Staff
- 13 locations in Los Angeles County
- Persons served in Calendar 2014
  - Primary care = 7,952 persons
  - Substance use disorder specialty care = 4,567
  - Mental health specialty care = 1,487
  - HIV/AIDS specialty care = 991
Revenue Sources

- City and County Contracts
- Federal, State, Foundation Grants
- Medicare and Medi-Cal fee-for-service
- Managed Care Contracts – Private Insurance
  - Medi-Cal Managed Care
    - Behavioral Health Care
    - Primary Care
- Private Pay
- Sliding Fee and Charity Care
Specialty Care

- Substance Use Disorder Treatment
- Mental Health Disorder Treatment
- HIV / Medical Care and related services
- Housing
- Assessment and Referral Services in Hospital EDs
- In Home Services
Joint Commission Accreditation and Certification

Accredited under:
- Hospital Standards
- Behavioral Health Standards
- Opioid Treatment Standards

Certifications awarded in 2015:
- Primary Care Medical Home
- Behavioral Health Home
Primary Care

• First clinic opened in 1995

• 5 Primary Care Clinics integrated with Other TTC Services

• 2 Primary Care Clinics integrated with BH services provided by other organizations
  - LA County Department of Mental Health San Fernando Mental Health Center
  - San Fernando Valley Community Mental Health Center, Inc.

• Primary Care Medical Home
Specialty Substance Use Disorder / Mental Health Treatment

- Acute Psychiatric Hospital: 60 beds w/ 2300 discharges / year
- Residential Treatment SU/MH and Co-occurring Disorders: 314 beds w/ 1275 discharges / year
- Outpatient SUD/MHD and Co-occurring Disorders: 100,000+ group plus individual sessions /year
- Medication Assisted SUD Treatment (Methadone, Buprenorphine, Vivitrol)
- 20+ Sober Living and Transitional Housing Facilities
- Case Management
- Needle Exchange
Acute Psychiatric Hospital

- 60 bed unit staffed 24/7 by psychiatrists and other medical staff

- Short (3 – 7 days) lengths of stay for Psychiatric stabilization and alcohol and drug detoxification

- Major Referral Sources
  - Step downs from Acute Hospitals - Medicare
  - Contracts with LA County Department of Public Health
  - Kaiser and other Managed Care Organizations
Specialty HIV/AIDS Care

- First HIV Services in 1986 and first HIV/AIDS Medical Clinic opened in 2002
- HIV/AIDS Medical Clinics in Palmdale and Reseda
- Prevention and Testing
- Case Management
- Jail In-Reach
- Integrated MH/SU Disorder Treatment
- Transitional Housing
- Home Heath Care
TTC’s Integrated Continuum of Care

Integrated Services and Care Coordination

SUD Services
- Detoxification
- Residential Rehabilitation
- Partial Hospitalization/Day Treatment
- IOP/Outpatient
- Maintenance/MAT
- Housing

Mental Health
- Acute Psych Hospital/Stabilization
- Intensive Outpatient
- Outpatient
- Housing

Primary Care
- 5 General Clinics
- 2 Specialty HIV

HIV Services
- Medical Clinics
- Prevention & Testing
- Case Management
- Jail In-Reach
- Mental Health
- SUD Services
- Home Health Care
- Housing

Assessment / Case Management
- Community Assessment Service Centers
- Case Management in Hospital EDs
Health Information Technology

- Netsmart Avatar – Cal-PM and CWS
- Primary Care Module
- Integrated Treatment Plan
- Order Connect ePrescribing
- Care Connect Lab interfaces and HIE
- myHealthPointe Portal
- Zirmed for RCM
Screening and Assessment

• Use of ASAM criteria will change the way many providers screen and assess potential admissions. It should no longer be acceptable to not screen and assess for mental health and primary care needs.

• ASAM may change staffing needs at the front end and beyond. Providers need to look at their operations to assess how these new requirements may impact the current way they do business.

• How do I address whole person care? Do I have mental health and primary care in house? Do I need to develop relationships with others for this care? How and what will these relationships look like and play out? How do we incorporate this care into an integrated treatment plan?
Prior Authorization

• All residential episodes will require pre-authorization by county. County has up to 24 hours to authorize or deny care.

• What happens in the event of a disagreement?
• What happens if county doesn’t meet its 24-hour deadline for authorization?

• Will authorizations be granted for the full 90 days under the waiver? Or will they be parceled out in smaller increments requiring much higher levels of utilization review and staff resources? Where do these resources come from?
• What happens to the patient while we are waiting for authorization if it cannot be obtained quickly?
Continuum of Care

• Will there be any incentives or resources available for agencies to develop full continuums of care, to avoid frequent transfers of patients between programs as lengths of stay drop?

• Quality Assurance and Utilization Review
  - The waiver requires participation in a quality assurance and utilization program.
  
  - How will programs fund QA/UM staff in this FFS model? Will additional funds be given to enable participation in this system? If not, how will these costs be factored into new reimbursement rates?
Medical Necessity

- All care, is contingent upon continuing medical necessity.

- How will we deal with patients who no longer meet medical necessity under ASAM yet still need some level of care? How will they receive this care and with what resources?
Recovery Support

• Recovery support services are essential to treatment of SUD as a chronic condition, and are included as a new service under the waiver.

• What are the guidelines and allowable activities under “Recovery Support”? What resources will be used to fund these new services and at what rates?
Workforce Training

- There is a clear need for the current workforce to be fully trained in ASAM criteria and what constitutes medical necessity. Some of this training has been offered by the state and counties. However, much more training is needed. Where are the resources to acquire this training?

- Whole person integrated care requires training. Staff need to gain a much stronger understanding of mental health and primary care, to include other chronic conditions. Lacking a much better knowledge base will negatively impact the efforts surrounding the importance of whole person integrated care and the outcomes. Will there be resources to assist in meeting this need?

- Care coordination is essential in an integrated model. Care coordination can be a complicated service and requires dedicated trained staff.
Youth Services

- While included in the DMC ODS, there has been little discussion and guidance on youth. There is a real need to provide integrated care to the youth population with and even stronger need to coordinate with families.

- Youth residential care is licensed by community care. How will the required ASAM residential certification work in this setting since it cannot be tied to the license as it is with adults?

- There is a significant lack of knowledge and understanding on how EPSDT for SUD services ties in and gets utilized efficiently. Will there be guidance?
Information Technology

- Whole person integrated care relies heavily on technology like EHR and HIE systems. The SUD field as a whole is weak in this area. There is tremendous anxiety that without resources to aid in this infrastructure development, the outcomes we all seek will not be achievable.

- There is also a need for adequate technology to effectively participate in the evaluation components of the DMC ODS.
Integration of CDCR and DHCS/County Populations

- With the realignment of Medi-Cal to counties, counties take on new responsibilities. These responsibilities now include providing SUD services to parolees under CDCR.
- CDCR has historically maintained a separate system of care for SUD services to parolees. CDCR is now undertaking its own system of care redesign.
- How will we now integrate parolee services with county services?
- How will we retain CDCR resources to provide for services not covered by DMC?
- How will we coordinate these services with county service delivery efforts?
Building a Successful Whole Person Integrated System of Care

- If we are to be successful in our efforts it will be essential that the state and counties not only move forward with the implementation of the DMC ODS; but also ensure all current resources allocated to SUD services remain in the system of care and cover the additional services DMC does not pay for.

- This is needed to build upon the overall efforts. If current resources are pulled out of the SUD system, we will not gain or be successful in creating a whole person integrated system of care for SUD services.
Questions?