Understanding the Determinants of Care

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Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value

In a meeting with nearly two dozen leaders representing consumers, insurers, providers, and business leaders, Health and Human Services Secretary Sylvia M. Burwell today announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients.

HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.

Needed: A rational, objective means of determining level of care

- Our current fee-for-service is likely to be replaced by some form of capitated or case-rated payment system.
- We become attached to certain members for a variety of reasons and we hold onto them because we like them, we feel effective when we work with them, they are easy to bill on, etc.
- Members become attached to us and may believe that they can't possibly maintain or advance their recovery without us.

The Problem

- More and more high-need consumers, particularly from prisons/jails and locked facilities are flooding into the system
- Full Service Partnerships are filling up and creating a bottleneck
- Clients are funded by “silo” (FSP, FCCS, Wellness Center)
  - Moving clients from one funding silo to another is an enormous administrative burden.
  - Providers are hesitant to move clients to a lower level of care for fear they will need to come back.

The L.A. County DMH System of Care

- Level 4 - Full Service Partnerships (FSP)
  - ACT Teams serving highest need clients
- Level 3 - Field Capable Clinical Services (FCCS)
  - ACT “Lite” (Intensive Case Management)
- Level 2 - Standard Outpatient Clinics and Wellness Centers
- Level 1 - Consumer-Run Centers

The FSP Integration Pilot

- Six Provider agencies are given permission to “merge” all their FSP and FCCS clients into a single funding silo.
  - Former FSP clients are now “FSP Level 4”
  - Former FCCS clients are now “FSP Level 3”

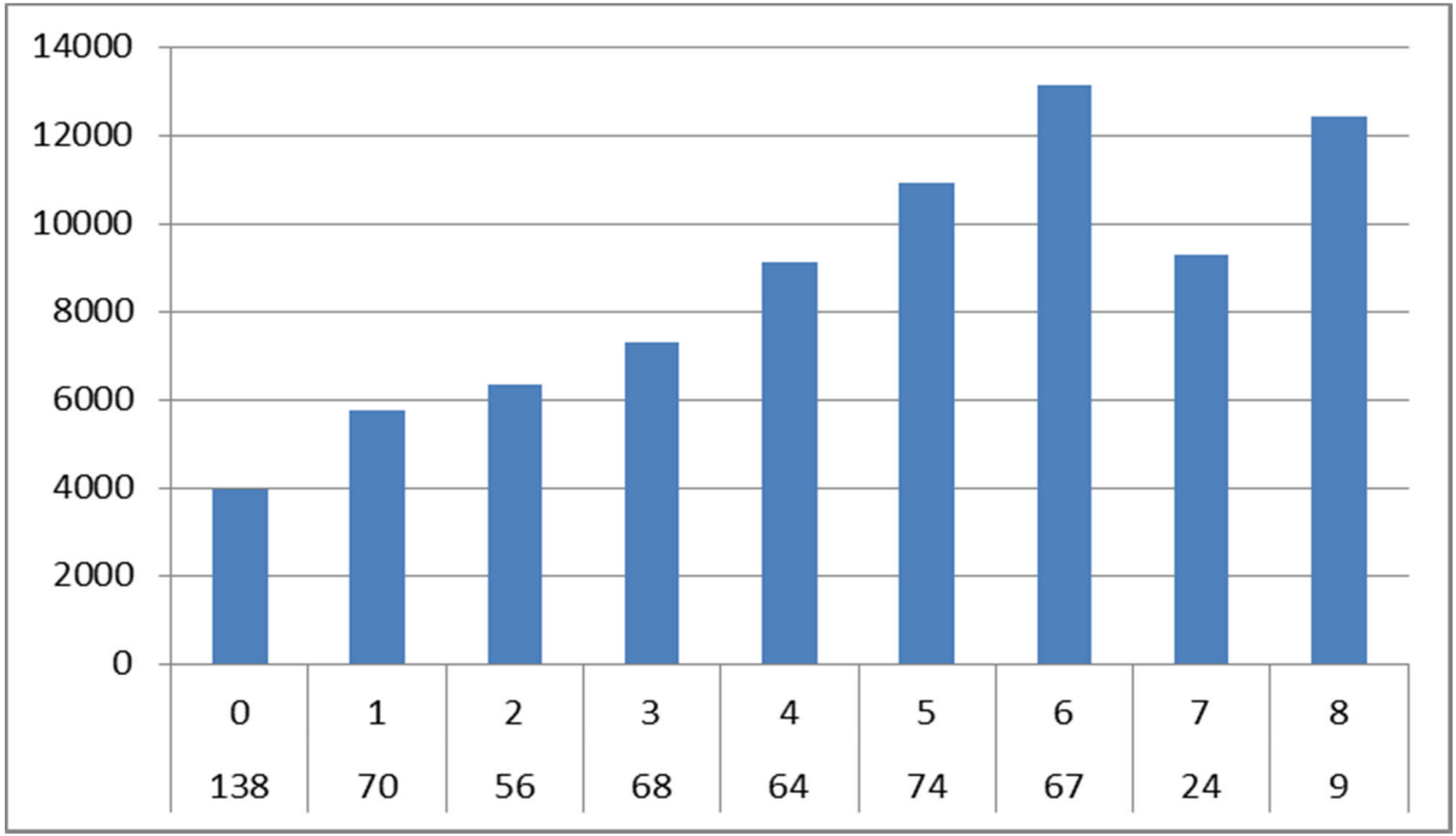
Rationale and Goals for the FSP Integration Pilot

- To Create a more seamless service continuum
  - Resolve the “Bucket Problem”
  - Ability to provide the appropriate level of care to meet client needs
- FCCS used as an FSP-Step Down with funding limitations.
  - FCCS clients often very similar to FSP clients but funding structures don’t always support the level of service needed
- Test out fiscal and programmatic models that are likely to be used under Healthcare Reform. Specify service expectations, outcomes and available funding
- Increase service area capacity

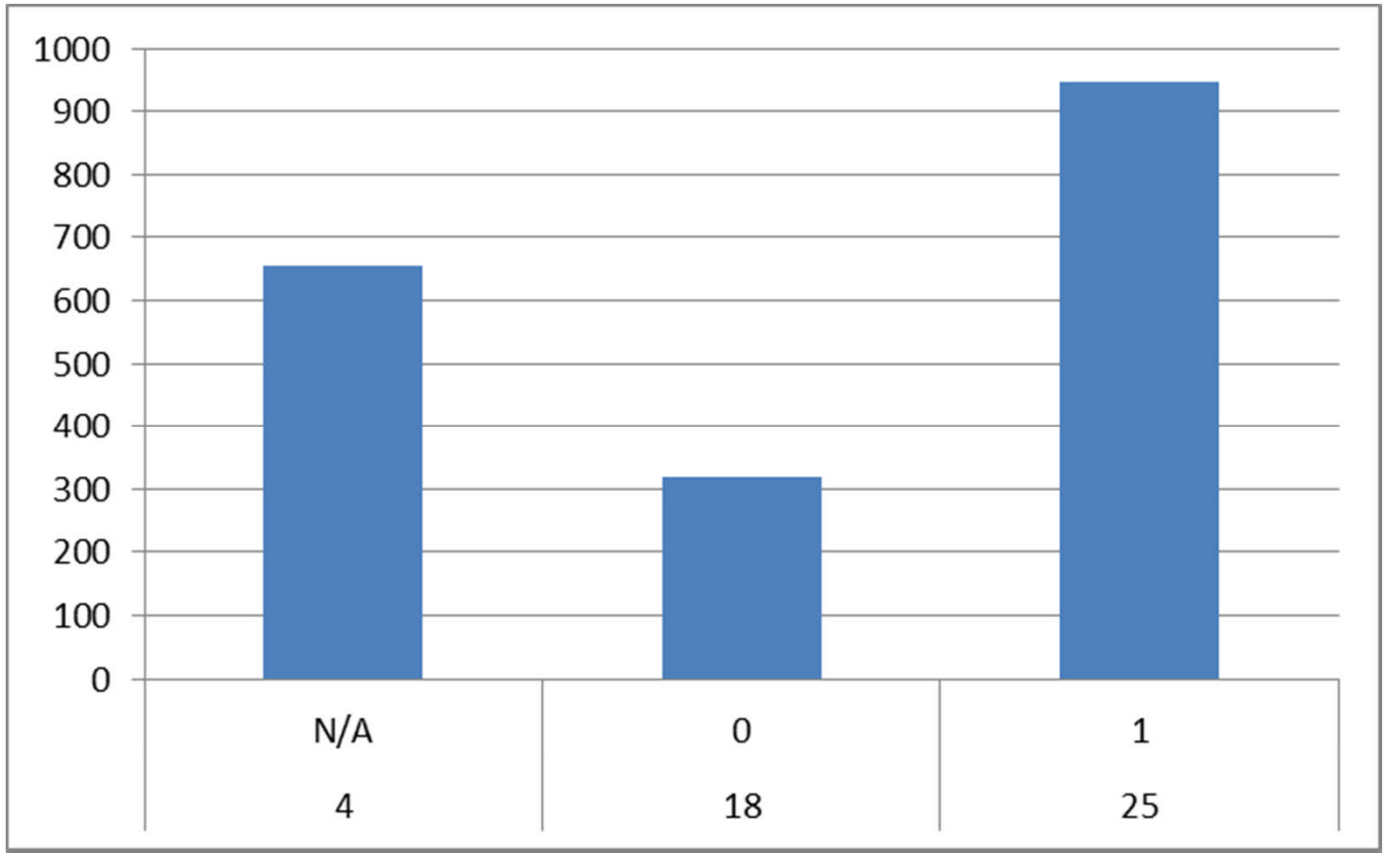
Determinants of Care

- Does the client…
  - …require support to manage his/her own financial resources?
  - …require support to coordinate his/her own transportation needs?
  - …require formal or informal assistance with 2 or more ADLs?
  - …require at least once per week contact with staff to coordinate his/her care?
  - …require support to manage his/her medication?
  - …require support to manage community relations and minimize disruptive behaviors?
  - …show less than 6 months stability at his/her current level of recovery?
  - …require CSS (Flex) funds to meet basic needs (housing and food)?

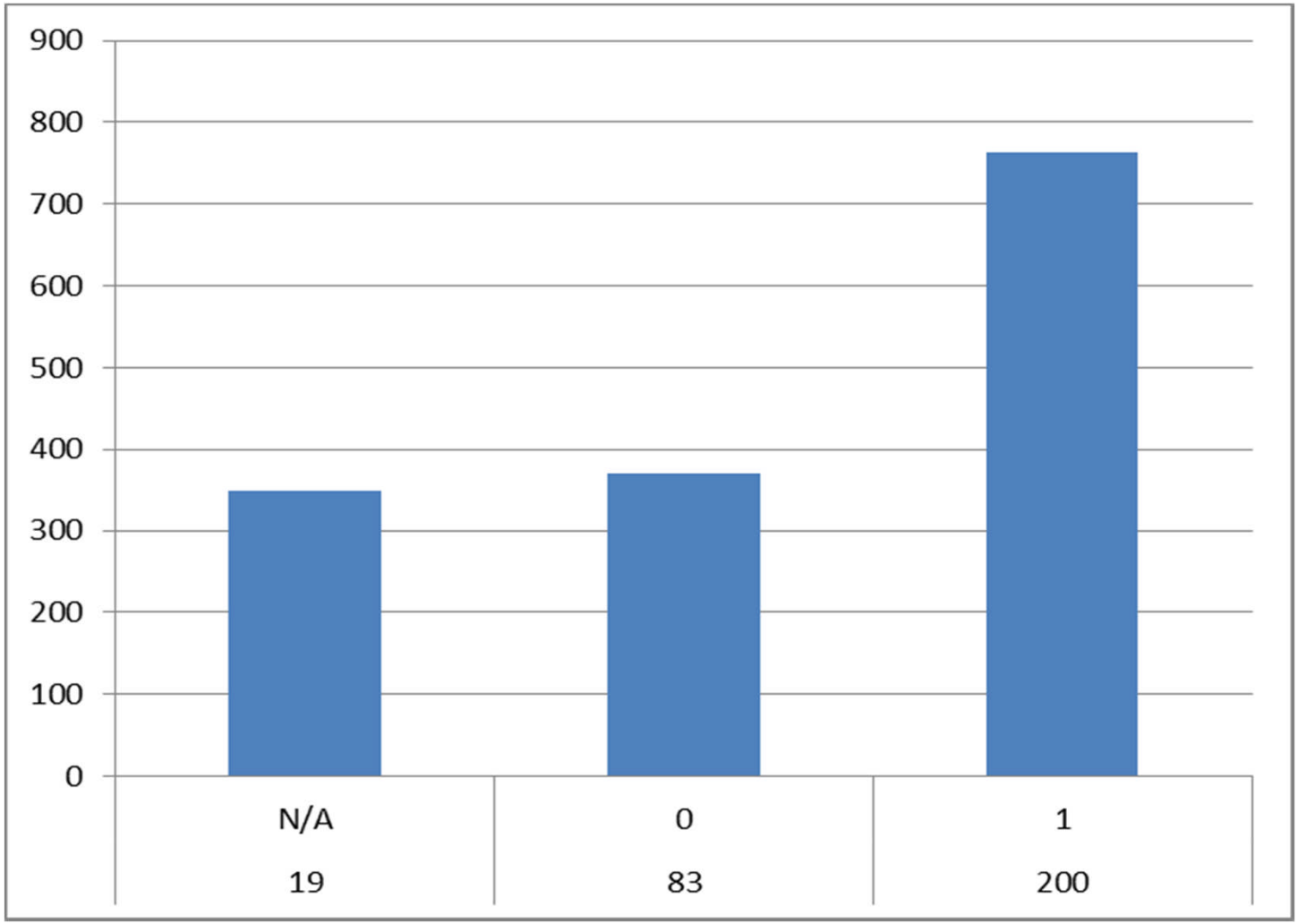
Average Total Cost per Client (April – Sept.) by Number of Staff Determinants



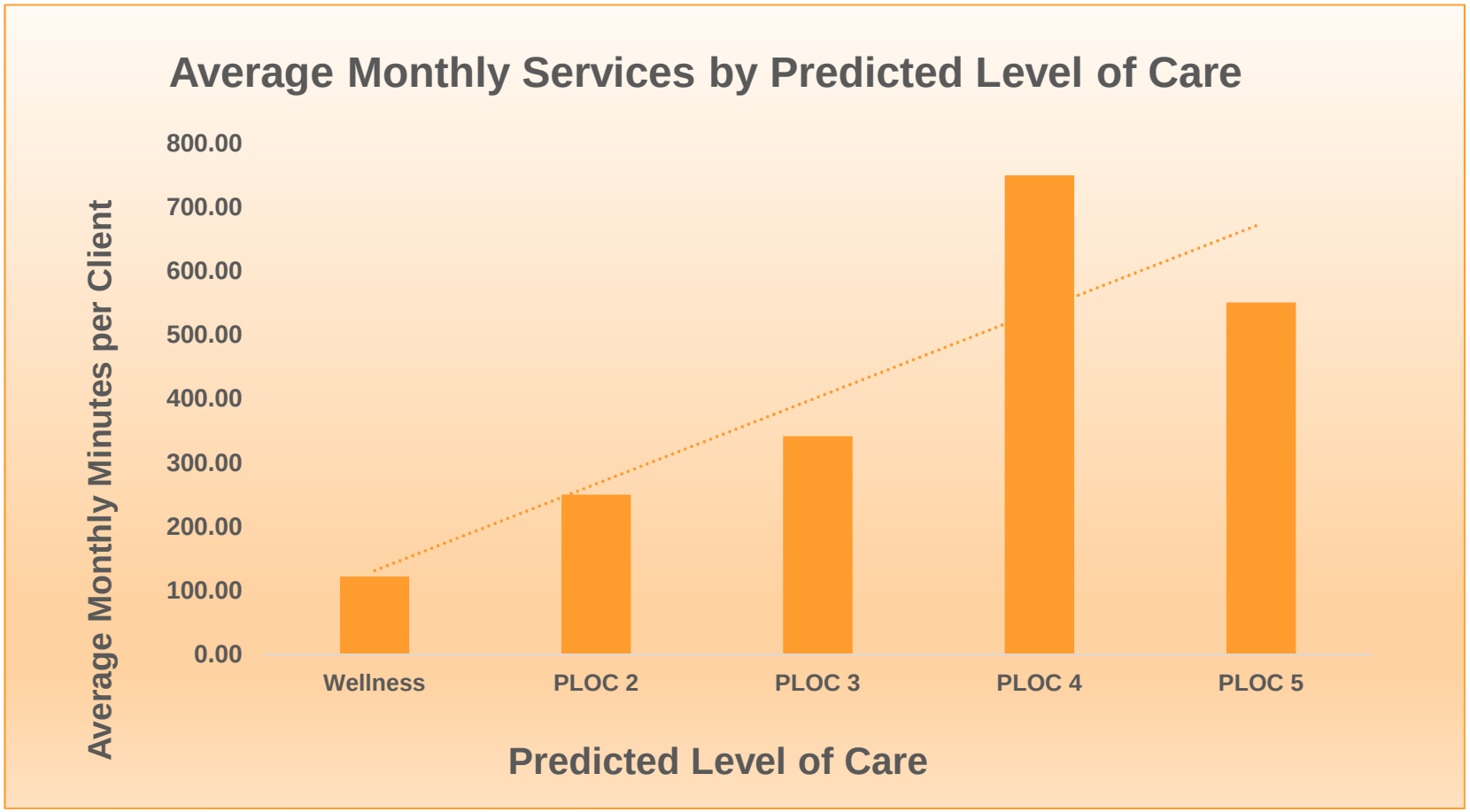
Average Cost of Crisis Intervention Services per Client (April – Sept.) by Staff Determinant of Need for Support with Community Relations



Average Cost of Complex Med Support Services per Client (April – Sept.) by Staff Determinant of Need for Medication Management



LEVEL OF CARE	RULE PARAMETERS
5 **Residential / inpatient services for people who are gravely disabled or are currently a danger to self or others**	If MORS score is a 1 then LEVEL OF CARE is a 5
4 **High Intensity Community Based OP**	If MORS score is a 2 or 3, then LEVEL OF CARE is a 4 and/or If sum of determinants equals 5 or more, then LEVEL OF CARE is a 4 and/or If sum of determinants equals a 3 or 4 and one of those determinants is required weekly care coordination, then LEVEL OF CARE is a 4
3 **Moderate Intensity Community Based OP**	If sum of determinants equals a 3 or 4 and required weekly care coordination IS NOT one of those determinants, then LEVEL OF CARE is a 3 and/or If sum of determinants is 2 or less and MORS score is 4 or 5, then LEVEL OF CARE is a 3 and/or If sum of determinants is 2 or less and MORS score is 6 or 7 and the client has been stable at the current MORS score for less than 6 months, then LEVEL OF CARE is a 3
2 **Wellness Services**	To be determined: All other clients not meeting above rules will be assigned to LEVEL OF CARE 1 OR 2.
1 **Recovery Maintenance**	To be determined: All other clients not meeting above rules will be assigned to LEVEL OF CARE 1 OR 2.


Average Monthly Services by Predicted Level of Care
Average Monthly Minutes per Client
800.00
700.00
600.00
500.00
400.00
300.00
200.00
100.00
0.00
Wellness
PLOC 2
PLOC 3
PLOC 4
PLOC 5
Predicted Level of Care

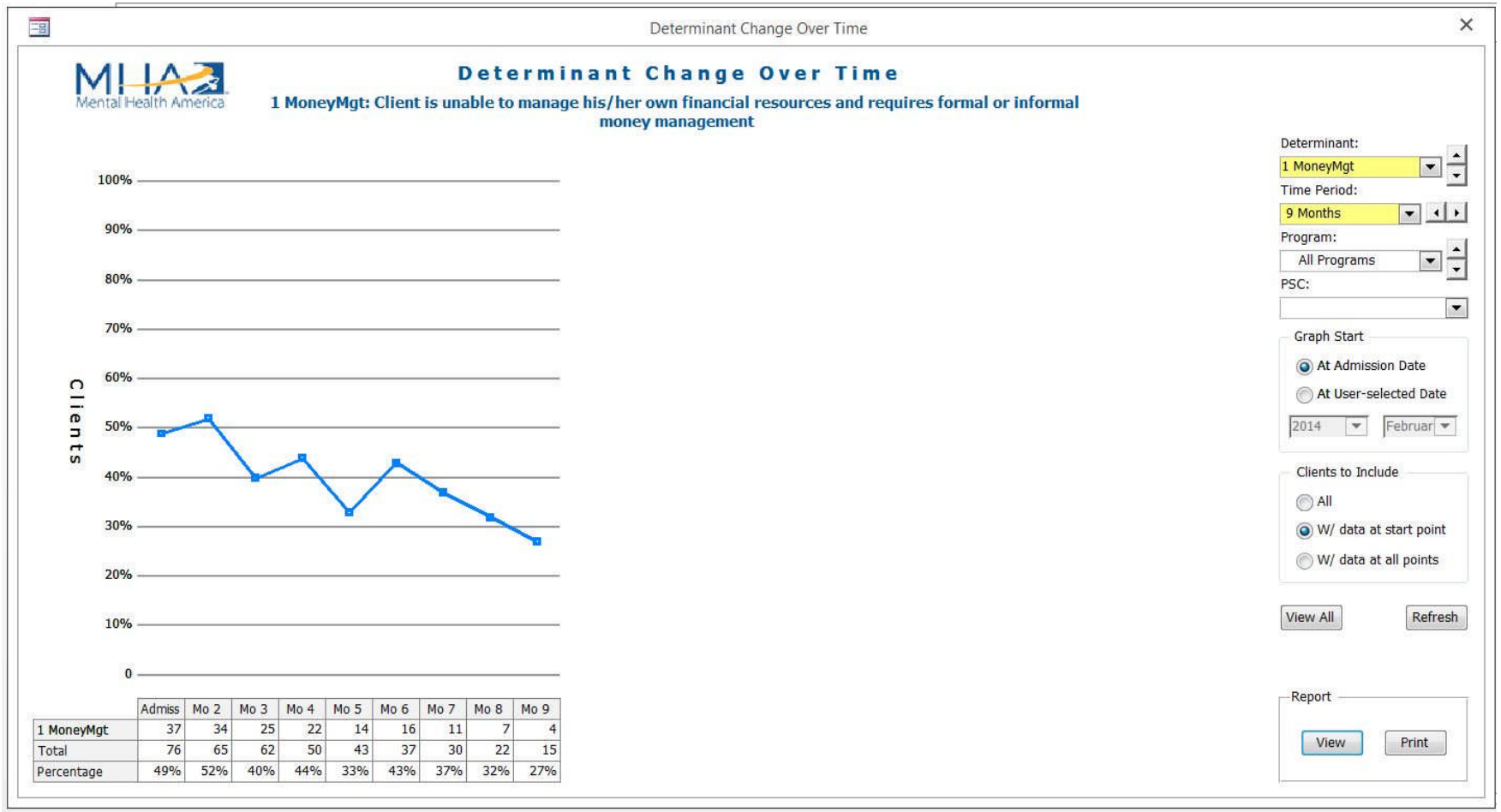
Some Lessons Learned

- Both members and staff experience a significant resistance to the idea of “flow” from higher to lower levels of care
- The determinants have significant clinical utility in that they create the ability for managers to ask the question: “What does this member need to move on?”

Some Lessons to be learned

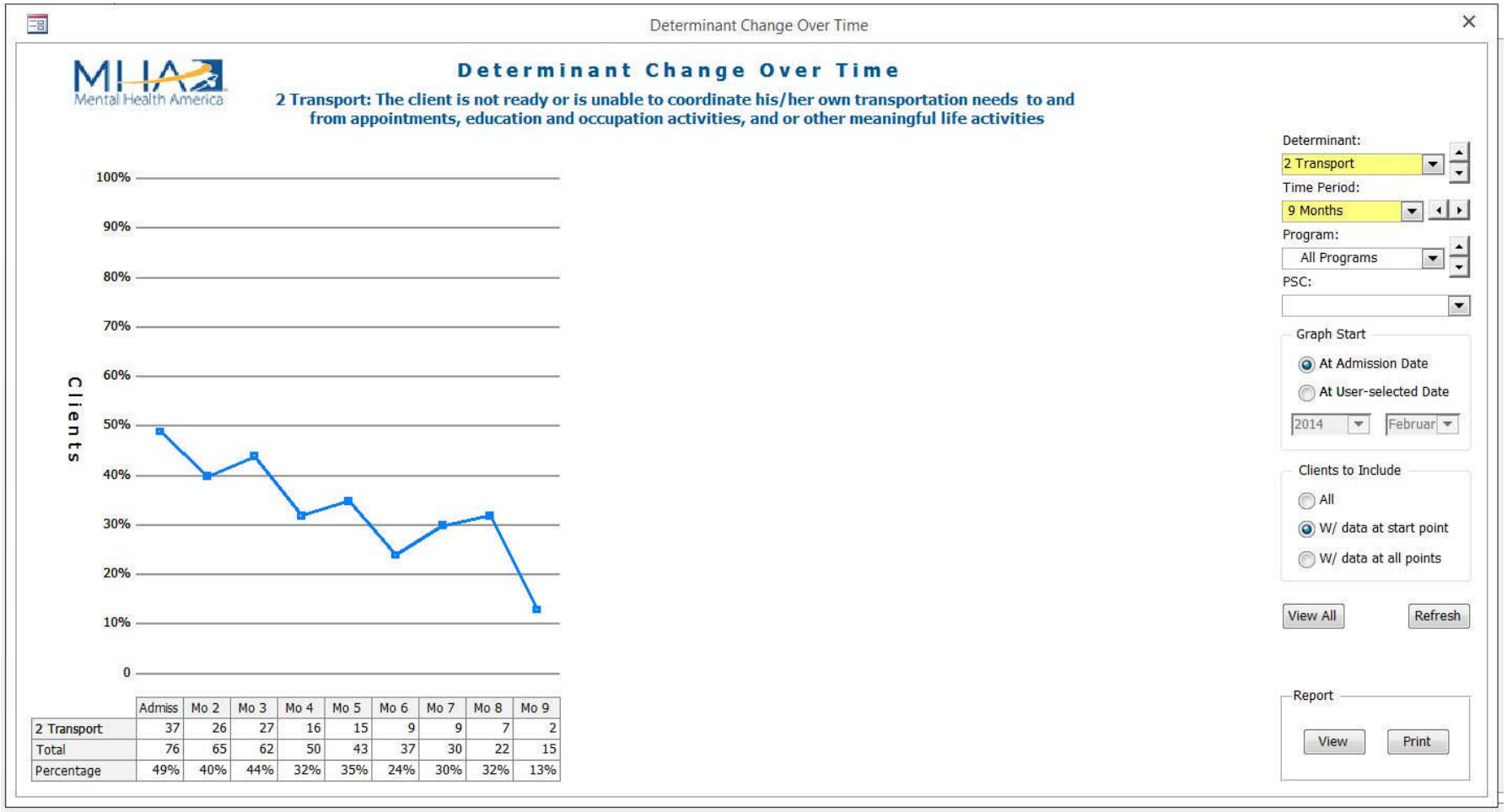
- What is it about the need for “weekly care coordination” that makes it so critical?
- What are the best practices that actually promote movement to lower levels of care?
- What practices might be associated with each determinant?

9 Month Change Money Management



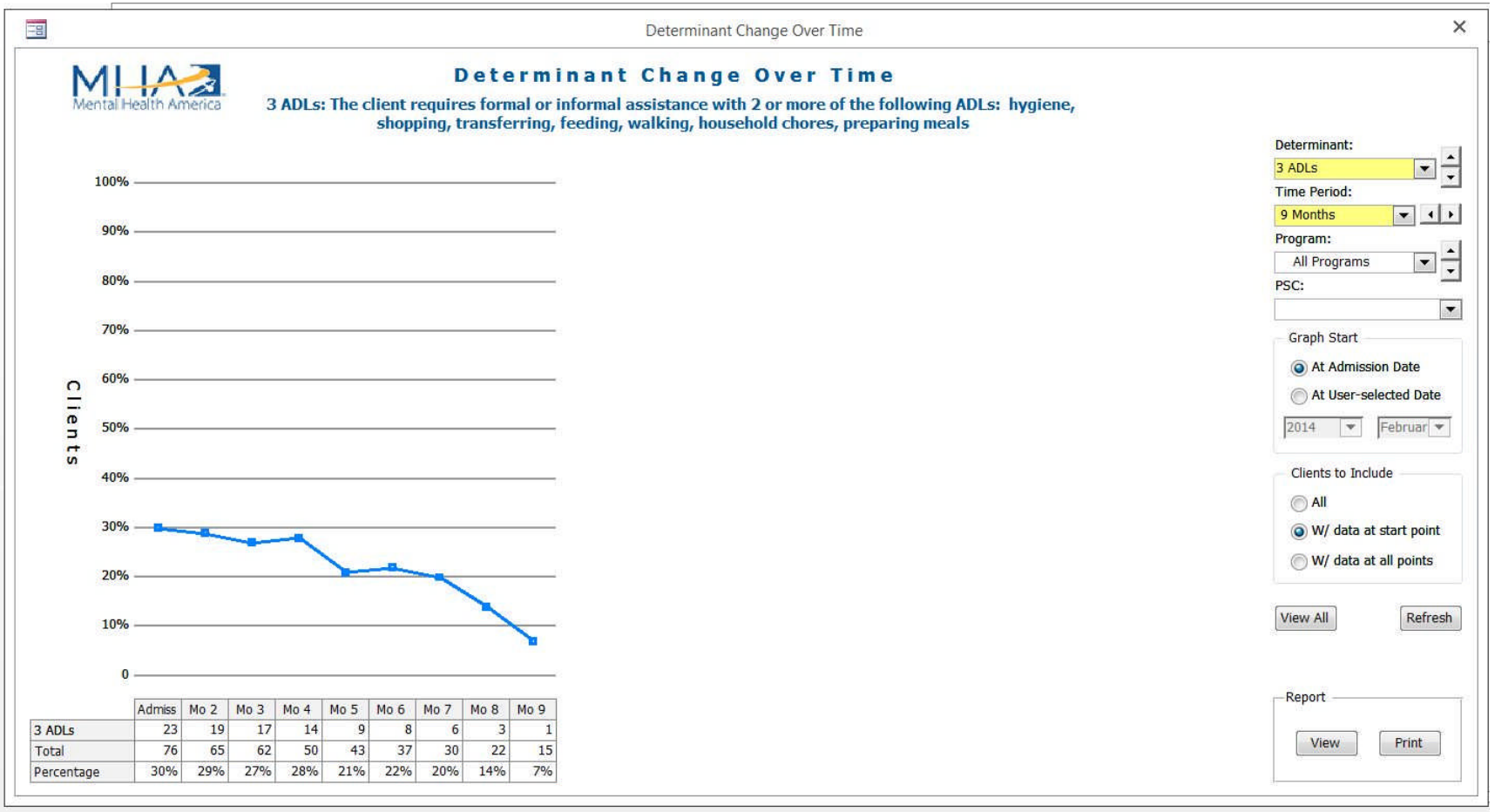
	Admiss	Mo 2	Mo 3	Mo 4	Mo 5	Mo 6	Mo 7	Mo 8	Mo 9
1 MoneyMgt	37	34	25	22	14	16	11	7	4
Total	76	65	62	50	43	37	30	22	15
Percentage	49%	52%	40%	44%	33%	43%	37%	32%	27%

9 Month Change Transportation



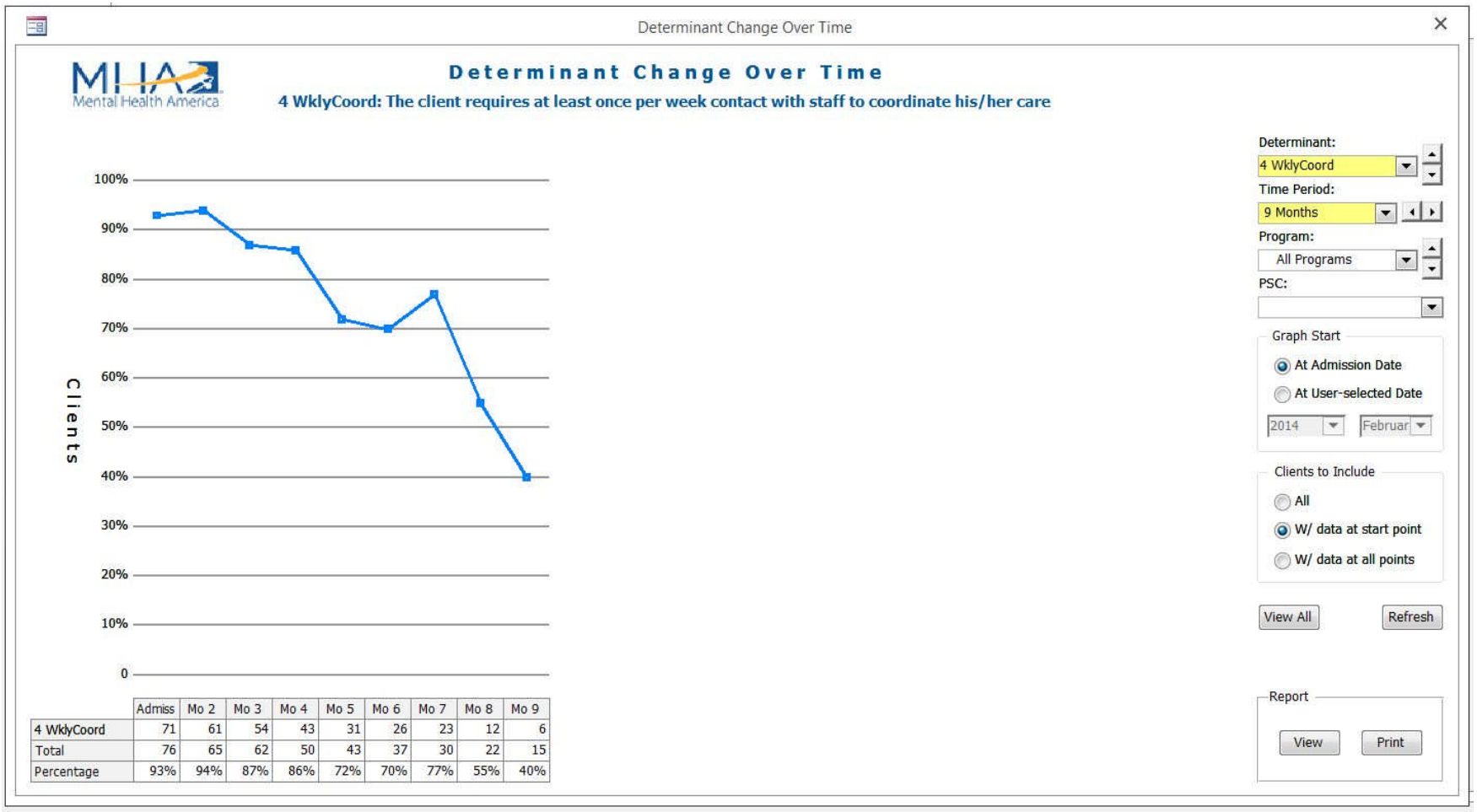
	Admiss	Mo 2	Mo 3	Mo 4	Mo 5	Mo 6	Mo 7	Mo 8	Mo 9
2 Transport	37	26	27	16	15	9	9	7	2
Total	76	65	62	50	43	37	30	22	15
Percentage	49%	40%	44%	32%	35%	24%	30%	32%	13%

9 Month Change Daily Life Activities



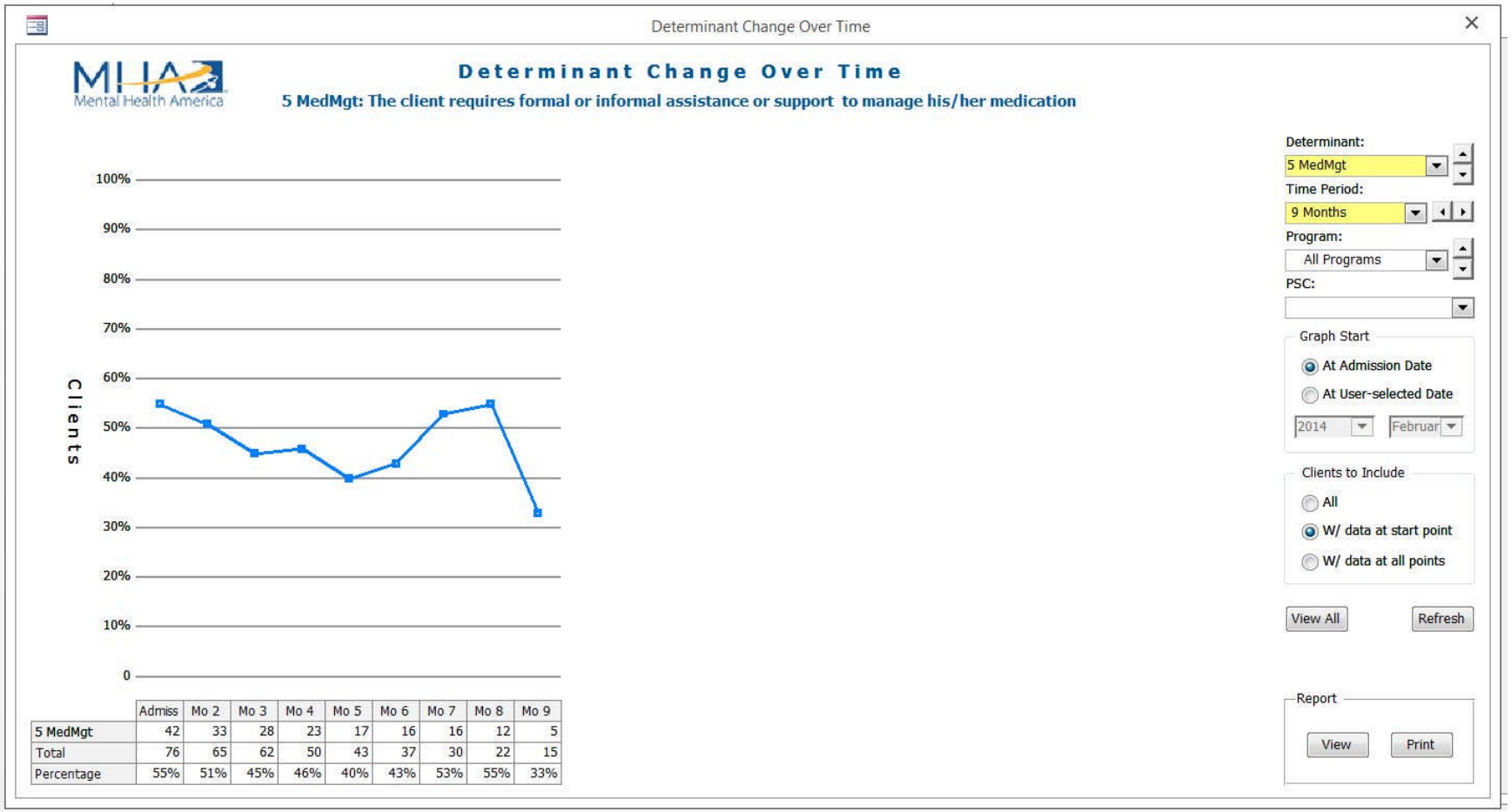
	Admiss	Mo 2	Mo 3	Mo 4	Mo 5	Mo 6	Mo 7	Mo 8	Mo 9
3 ADLs	23	19	17	14	9	8	6	3	1
Total	76	65	62	50	43	37	30	22	15
Percentage	30%	29%	27%	28%	21%	22%	20%	14%	7%

9 Month Change Weekly Care Coord.



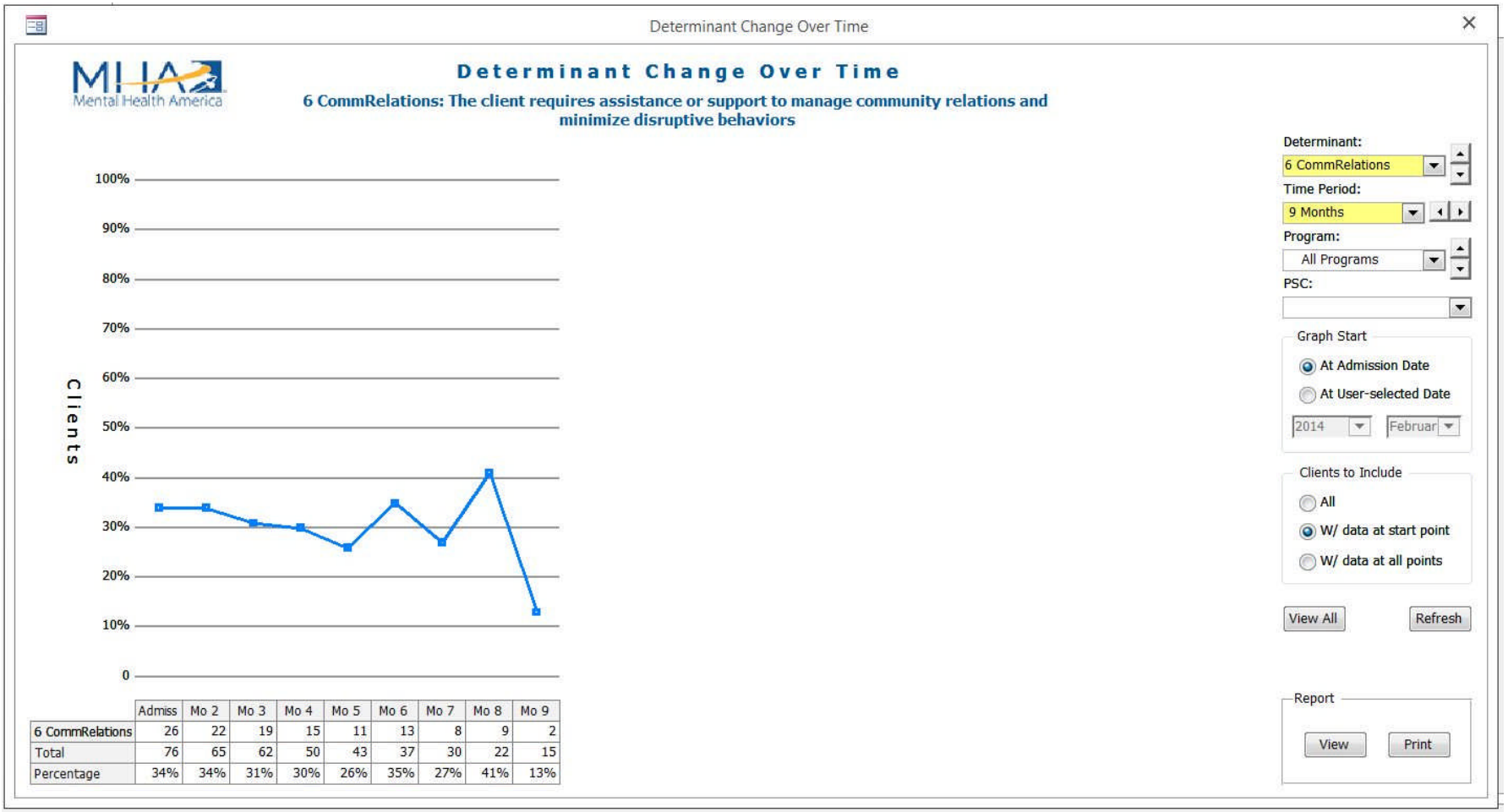
	Admiss	Mo 2	Mo 3	Mo 4	Mo 5	Mo 6	Mo 7	Mo 8	Mo 9
4 WklyCoord	71	61	54	43	31	26	23	12	6
Total	76	65	62	50	43	37	30	22	15
Percentage	93%	94%	87%	86%	72%	70%	77%	55%	40%

9 Month Change Medication Mgmt.



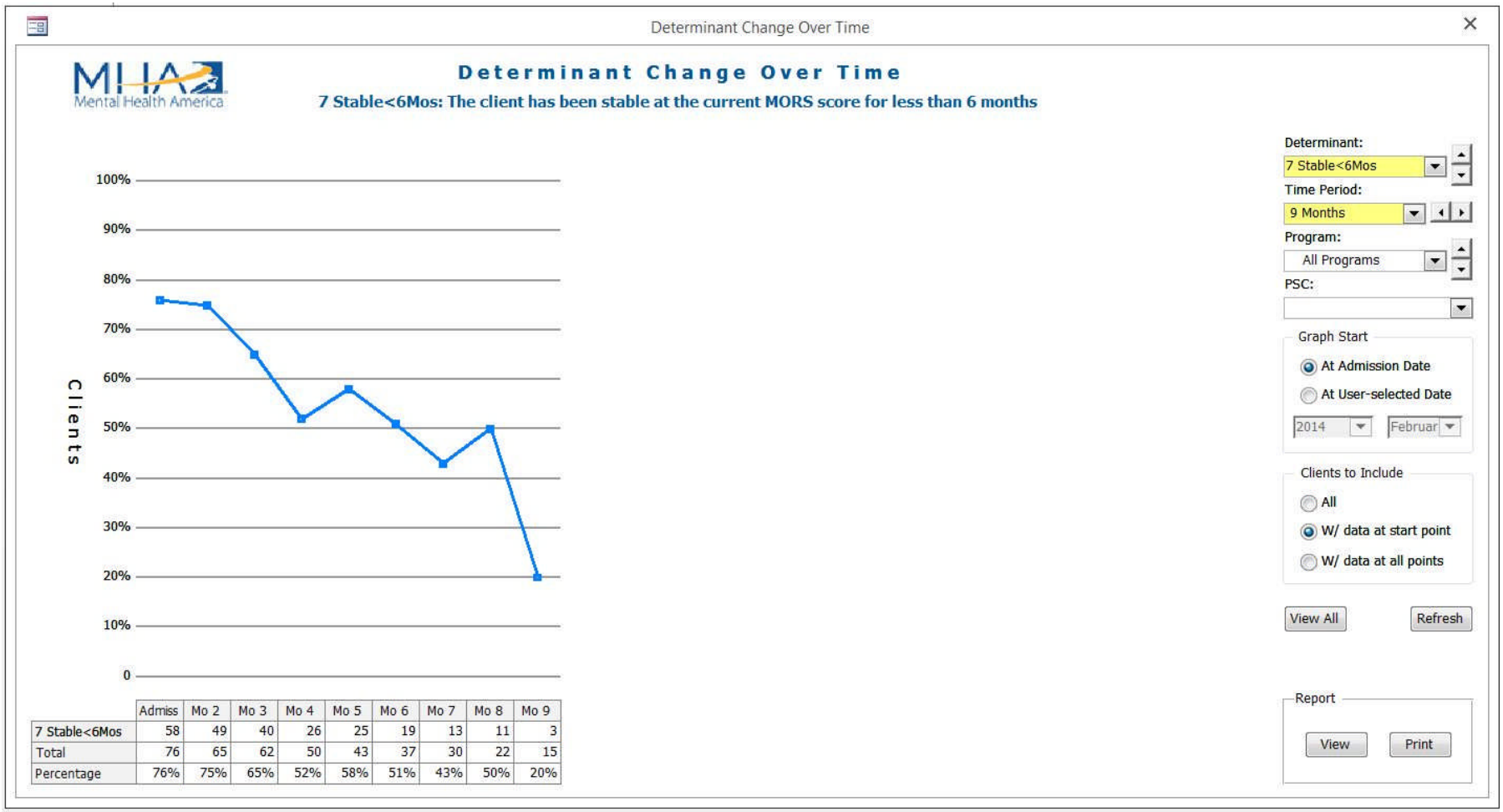
	Admiss	Mo 2	Mo 3	Mo 4	Mo 5	Mo 6	Mo 7	Mo 8	Mo 9
5 MedMgt	42	33	28	23	17	16	16	12	5
Total	76	65	62	50	43	37	30	22	15
Percentage	55%	51%	45%	46%	40%	43%	53%	55%	33%

9 Month Change Community Relations



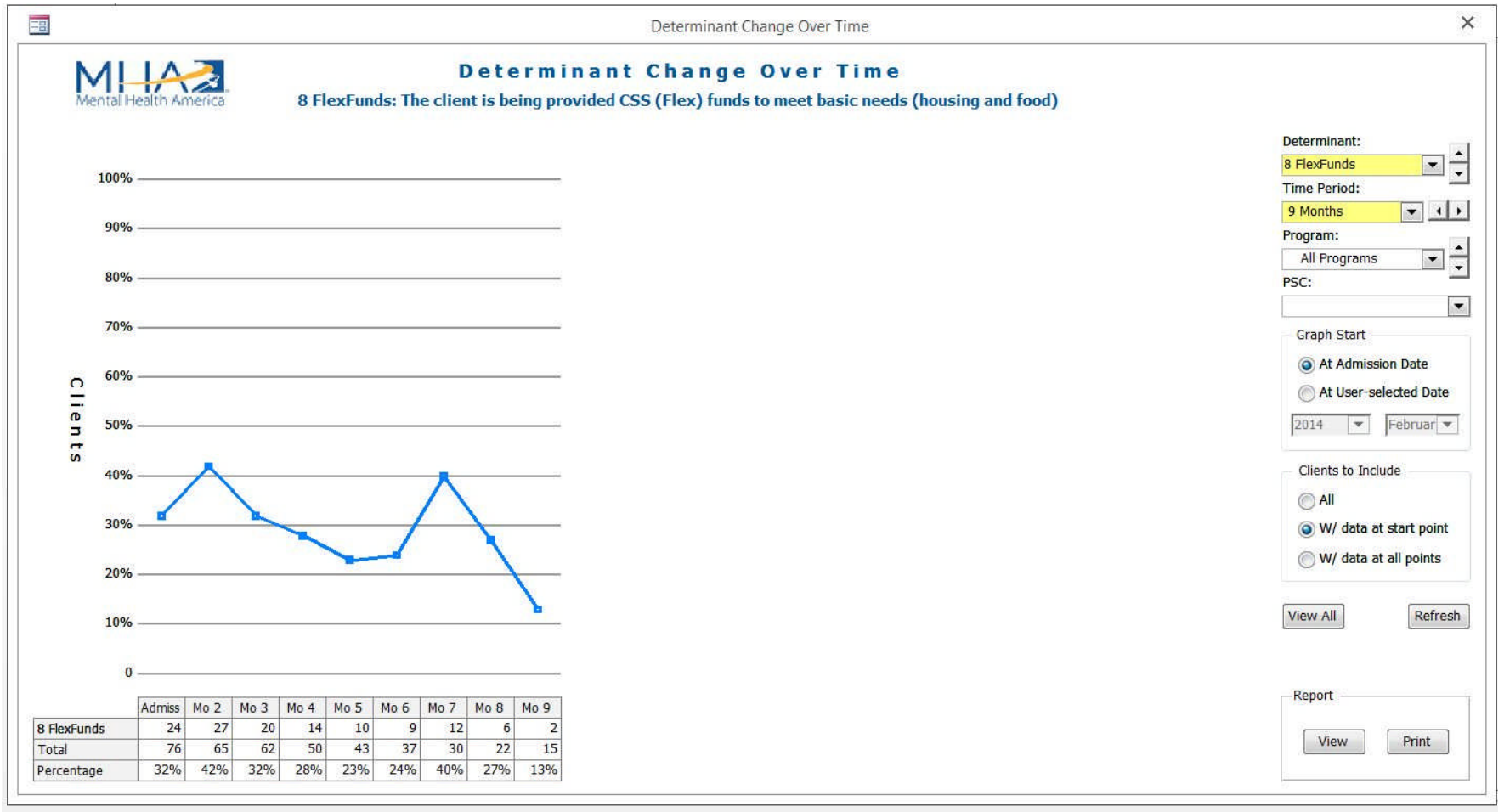
	Admiss	Mo 2	Mo 3	Mo 4	Mo 5	Mo 6	Mo 7	Mo 8	Mo 9
6 CommRelations	26	22	19	15	11	13	8	9	2
Total	76	65	62	50	43	37	30	22	15
Percentage	34%	34%	31%	30%	26%	35%	27%	41%	13%

9 Month Change MORS Instability



	Admiss	Mo 2	Mo 3	Mo 4	Mo 5	Mo 6	Mo 7	Mo 8	Mo 9
7 Stable<6Mos	58	49	40	26	25	19	13	11	3
Total	76	65	62	50	43	37	30	22	15
Percentage	76%	75%	65%	52%	58%	51%	43%	50%	20%

9 Month Change Flex Funds Usage



	Admiss	Mo 2	Mo 3	Mo 4	Mo 5	Mo 6	Mo 7	Mo 8	Mo 9
8 FlexFunds	24	27	20	14	10	9	12	6	2
Total	76	65	62	50	43	37	30	22	15
Percentage	32%	42%	32%	28%	23%	24%	40%	27%	13%