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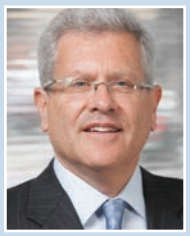
MEDICAID REFORM

September 8, 2016

PANELISTS

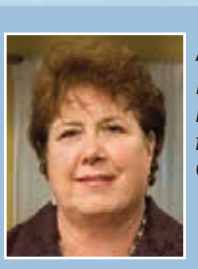


Dr. Jeffrey Rubin
Co-CEO, Elderwood Administrative Services LLC

Howard K. Hitzel, Psy.D.
President, Lakeshore Behavioral Health, Inc.

Al Hammonds
Executive Director, Millennium Collaborative Care PPS

MODERATOR



Ann Monroe
President, Health Foundation for Western and Central New York

In a discussion at Business First's Executive Forum on Medicaid Reform,

panelists shared their expertise on challenges businesses face as they navigate the behavioral health care system. What follows is an edited transcript of that discussion highlighting points raised in the session.

BOTH PHOTOS: JIM COURTNEY

Panelists, from left, Howard Hitzel, Dr. Jeffrey Rubin and Al Hammonds discussed a wide range of Medicaid-related and behavioral health care issues Sept. 8 at an Executive Forum moderated by Ann Monroe, president of the Health Foundation for Western and Central New York.

ANN MONROE: Why should people who are not in the business of health and human services care about Medicaid?

JEFFREY RUBIN: I would like to share with you what Elderwood is and how it is relevant to Medicaid lives. Elderwood is a skilled nursing home facility, and in skilled nursing homes we clearly care for a lot of Medicaid lives. We also are an assistive living company with ALP beds, which are Medicaid assisted living beds. We have a MLTCP, a managed long-term care plan, Elderwood Health Care Plan, which also cares for Medicaid lives. We have an institutional pharmacy that provides pharmacy services to skilled nursing homes, assisted living facilities and community-residing residents. We have a medical adult day care, multiple medical adult day care programs that provide services for Medicaid lives. We have outpatient rehab facilities. And we have a transportation company that transports Medicaid lives. I believe that being here today and being part of the business community is important. First and foremost, we have a moral obligation to do the right thing. I feel that the only way we are going to be successful is if we are collaborative and if dialogue and best ideas evolve from today's discussion. Health care providers can't come up with those ideas by themselves. They need partners and they need help. And so the business community sitting here today are our hopeful partners in collaboratives to move the needle both on costs and where it's going.

DR. HOWARD HITZEL: I've been with Lake Shore for almost 20 years and I've seen a lot of changes in behavioral health care. Lake Shore provides a range of comprehensive services for both people with mental illnesses and substance abuse disorders. We operate a number of outpatient clinics, both for mental health and substance abuse, across the Buffalo metropolitan area. We also do a lot of rehabilitation work for people with serious mental illness. We have assertive community treatment teams who provide outreach services for some consumers with mental illnesses who don't necessarily come to the clinics on a consistent basis. We have an OnTrack program, which is a new and innovative program for young people experiencing their first episode of psychosis or schizophrenia. That's been a really refreshing thing for us, because historically the behavioral health business hasn't done a great job in treating people with serious mental illnesses. Very often those illnesses are undetected until people are quite ill and become disabled. So this department identifies young people early on and surrounds them with services to maintain their relationship with their families, sustain them in school or employment and encourage them to pursue a full, productive life. That's different from what's happened in the past for people with serious mental illness.

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From the Sponsor EXECUTIVE FORUM **MEDICAID REFORM**

Bringing 'Business Best Practices' to Healthcare Reform

In business, it's common to find best practices such as "collaboration," and "continuous improvement" embedded in the cultures of today's leading organizations. It's also been my experience that these same high performers are always challenging their organizations to reject working in "silos" and instead, urge teams to strive for integration with their downstream partners.

In fact, so rich are potential rewards such as increased execution speed, better value, and lower costs, that it's also common for the best companies to deploy standing "Continuous Improvement" teams to partner as "catalysts" to help drive change.

No doubt, the aforementioned concepts are nothing new to today's business reader.

But if you pause for a moment, and imagine yourself looking through the lens of New York State's Medicaid system which serves six million members at an annual cost of over $60 billion; this perspective would show that these ways of working are still relatively new, and represent both complex challenges as well as potential robust rewards.

For purpose of brief context, consider Medicaid was founded in 1965; further expanded in 2010 due to President Obama's signing of the Patient Protection and Affordable Care Act; and turned 50 in 2015. And given the lifecycle of a 50-year-old program, it's also not surprising that on one hand, the overall system had become less efficient and more complex; and on the other; poses great opportunities for lower costs and improved patient satisfaction.

Al Hammonds
Executive Director,
Millennium Collaborative Care PPS

Millennium COLLABORATIVE CARE
Igniting Healthcare Change in WNY

Enter Governor Andrew Cuomo.

In 2014, the Governor initiated a major change effort to significantly improve New York State's Medicaid benefits system. He finalized terms with the federal government for a ground breaking waiver that allows the state to reinvest $8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms. He then launched the Delivery System Reform Incentive Payment (DSRIP) program, enabling New York to invest $7.3 billion of Medicaid savings over the next five years into transforming the health care system, including the creation of 25 Performing Provider Networks across the state with the primary goal of reducing avoidable hospital use by 25 percent over five years (2020).

As one of the 25, Millennium Collaborative Care is the Performing Provider System (PPS) with over 250,000 attributed Medicaid members across the eight counties of Western New York.

Looking at what we do from a "business perspective", you could say the WNY healthcare delivery system is our "company" and the physicians, healthcare providers and community-based organizations across our eight counties are our partners and colleagues. Millennium does not directly provide services to the Medicaid "customer." Rather, our primary role is to serve as the "Continuous Improvement Team" that closely collaborates with our partners to realize specific, measurable improvements through the implementation of projects that have been specifically selected and designed to meet the needs of our Medicaid community.

With guidance from our lead entity the Erie County Medical Center; Millennium's work is organized into five key areas: Acute Care, Ambulatory Services, Behavioral Health, Community Engagement, and Post-Acute Care; and is being implemented by a roster of 35 culturally diverse employees including several nurses, physicians and staff with extensive experience in community-based organizations, healthcare networks, hospitals, payers, diverse clinical environments, and technology firms.

In short, "Igniting healthcare change" is our game, and continuing to be a catalyst in delivering results like the following is our aim!

- Millennium has distributed $10M to Safety Net Providers, and is currently in process of distributing $12M.
- Millennium has distributed $3M in direct contracts to providers and Community Based Organizations which has resulted in the funding of 78 new Community Health Worker positions.
- Millennium has been recognized by the State as a leader in Community-based Engagement and Collaboration. For example, Million Hearts®, a collaborative cardiovascular health initiative between Greater Buffalo United Ministries (GRUM), a network of 58 churches and the University at Buffalo School of Nursing, has conducted six blood pressure screening events servicing 222 parishioners and members of the public.
- Millennium has enrolled more than 500 mothers or expectant mothers into the Community Health Worker Home Visiting Program.
- Over 15,000 recipients have participated in the Millennium Patient Activation Measure® (PAM®) process to identify the motivations of recipients (uninsured, non and under-utilizing populations) to seek healthcare.

These are just a few results. Please visit www.millennium.org; Twitter @ MillenniumCCPPS and facebook.com/MCCPPS where we're committed to regularly reporting many more!

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On the mental health side, we also help people who are homeless and have mental illness. We run a residential program for the chronically homeless and provide almost 100 apartments for homeless people struggling with mental illness. We also do outpatient rehabilitation programs for people with mental illness. On the chemical dependency side, we offer outpatient clinics. We have a 20-bed residential program, which we've operated for more than 10 years. It's a unique program for women who are pregnant or parents of young children. They bring their children into the facility as they work on their addiction. The focus of the program is to help women re-establish themselves as moms who take care of their children as part of their recovery process. We offer housing for people who struggle with substance abuse problems. I think that everybody should care about Medicaid, it's something that affects all our lives as taxpayers; we pay for it. And as Ann said, the costs in New York State are extremely high. Years ago, there was limited interaction between behavioral health and primary care. What's really wonderfully encouraging is through this Medicaid reform process, they've recognized that behavioral health disorders are common and can be very expensive to treat. Care is complicated for people with physical illnesses and behavioral health problems. So I think, we're all interested in reducing costs and improving outcomes. Everybody knows someone with a mental illness or substance abuse disorder. There used to be a lot of stigma attached to those difficulties. I think now that behavioral health is better integrated with primary care, there's much discussion and acceptance of the fact that these are treatable illnesses and people respond very well. Employers know there are employees who struggle with mental illness or a substance abuse disorder. So the more we're open to that idea and afford those people support and help, the better off we'll all be.

AL HAMMONDS: We're one of those 25 PPSs, performing provider systems, in New York State helping to implement this Medicaid redesign transformation across the state. We're part of the delivery system, reform initiative program. Millennium Collaborative Care is an extension of ECMC. ECMC is the parent organization bearing the risk to make sure that we can get this done in an effective manner. So our organization's goal is to be at the center of change to achieve 25 percent reduction in avoidable emergency room visits and a 25 percent reduction in avoidable hospitalizations. It's a big deal. Our job is to collaboratively pull everybody together – all the different types of providers, the behavioral health folks, the post acute, the ambulatory care, the developmentally disabled and the hospital acute care systems. Our job is to make sure we become one big, happy family

JIM COURTNEY

Dr. Jeffrey Rubin says social issues often push people to seek hospital treatment.

to drive change. It's quite the task. We're a year and a half in and it's been quite the journey. We are 100 percent funded by New York State. We've got about 35 employees, we're pretty lean by design, so that we can leverage our partners to make sure we get the transformation done. This is incredibly important work to the business world. I came from the business world. If you look at the numbers on a national scale, there are 75 million people who are part of the Medicaid population on a national level, costing our economy about $500 billion. In New York State there are 6 million people who are part of the Medicaid population, costing the state $60 billion in costs. Our PPS, what we are responsible for, is about 258,000 lives in Western New York, and we have a budget of just over $200 million. So if we can't move the needle on different pockets of the Medicaid population, we don't get paid. That's the way the business world operates. The Medicaid population is the most vulnerable population out there in need, but it's also the most costly. We have to drive the costs down, we have to make sure that we're taking care of people. It's very important that we talk about it in the business community since it bears the cost of paying for a lot of this through the Affordable Care Act.

MONROE: It makes sense that if there's a way to keep somebody out of the hospital, we should have kept them out. And so I understand that as a goal, but what I have trouble with is why we haven't been doing that all along. We know that, for example, folks in long-term care often get re-admitted. People who aren't in the business think about Medicaid as poor people, moms with kids, whereas long-term care is one of the high-cost pieces. Why haven't we been able to do reduce unnecessary hospitalizations?

HITZEL: Well, very often we have consumers who, when they need help or are uncomfortable or having difficulties, they see the emergency room as the place to go. Often in the behavioral health world, we find that their needs aren't so much related to their behavioral health problem as much as social issues that are pushing them to go to the hospital. They have a problem, there's difficulty with their family, they've lost their housing, they don't have adequate food, and so they're really troubled in a lot of ways not directly related to their illness. And they go to the hospital because the hospital is a safe place where in the past they've reliably gotten help. I also think that the community system of care has not been as responsive as it might be. Accountability is being put in place to make sure that people with psychiatric or substance abuse disorders have available support 24/7 where they can seek help in the community and avoid the hospital. So a lot of it is really just informing and teaching people that there are better ways to take care of themselves.

HAMMONDS: What we see are four primary barriers or four primary challenges to why this hasn't happened, why do people go to the emergency room when they don't have to. Why if I've got a toothache at 6 o'clock on a Friday evening, why am I going to the emergency room, you know? If I have a backache on Sunday morning, why am I running to the emergency room? The reason it hasn't happened is because of four things. Number one is patient behavior. We've got to change patient mindset and behaviors. The system is not connected as it should be in terms of primary care physicians to the hospital systems. A second barrier is provider behavior – the doctors, the physicians. Providers have to be incentivized financially to make this connectivity happen. The third thing is the payment system in health care, starting with the Medicaid population. The traditional system is a fee-for-service, volume- driven system. We've got to get this to value based payment, pay for performance system. Lastly is the delivery system itself. Part of the state's redesign efforts are 11 projects to help drive transformation of the delivery system for patient behavior, the provider system, and the payment system changes. These 11 projects are things like cardiovascular health. How do we connect community based organizations to cardiovascular health through the Million Hearts program and then manage that population through an effective payment system. Look at maternal and child health and the health of moms who are pregnant and how they are progressing through pregnancy and then making sure that healthy babies are born. That's why it hasn't happened yet, because if one changes and the other three don't change, you're not going to get anywhere. You have to change the whole thing and it's quite the challenge.

MONROE: Jeff, you serve a little different population than they've been talking about.

RUBIN: I'd like to mirror a lot of what has been mentioned. Historically the payment system was quantity-based medicine versus quality-based medicine. The government inadvertently incentivized the provider community in the wrong direction. Secondly, it speaks to silent management and the lack of coordination of care, the right hand truly did not know what the left was doing. We see this in that study, money was spent on Medicare lives and how poorly it is coordinated in certain markets. I do want to mention that I believe post-acute space can probably make the largest difference in moving this needle because we have the flexibility of taking higher acuity, lower acuity based on what is presented to us. The way we solve this problem is some of the things that we've been working on at Elderwood, such as our SMARTS program, which is our ER divergence program. On an average daily basis, we run between 20 to 30 patients who avoided the ER and the hospital and have been directed to our facilities. I'm extremely proud of that program at Elderwood. We do that in partnership today primarily with managed Medicare programs, but there's opportunity for us to find to do that more with Medicaid lives. The problem with a program like that is the execution, how difficult it is to do it. First and foremost, getting the word out and for people to know that that program exists and for people to refer and take advantage of that program. That requires a great deal of resources. Secondly, because we're taking admissions almost in a hospital-like manner 24/7, you need to move from an LPN model to an RN model, because you need those assessment skills and the ability to triage those patients. Finally, we need to communicate with the community, so we have to make a large investment in electronic medical records.

MONROE: I want to emphasize a point that was made by several panelists about how isolated and how siloed the care systems are. A pleasant example of that is the elderly woman who has congestive heart failure, gets prescribed some significant diuretics, right? No one asks her where her bathroom is. She lives in an old house and it's hard enough to get upstairs once a day to use the bathroom, now she has to go up constantly to use the restroom. What do you think happens? She stops taking her pills because she can't live in her own world with the consequences of the medical action. And so when she stops taking her meds, she's in the hospital with a severe exacerbation of her CHF. The kind of work where people would ask to come to her house and see what it looks like, see how we can manage this for you, has been missing in our health care system. What are your thoughts on how to make that work?

HAMMONDS: Well, you touched

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From the Sponsor EXECUTIVE FORUM **MEDICAID REFORM**

Elderwood invests in technology to improve patient care

WILLIAMSVILLE, NY – Over the past several years, Elderwood has invested heavily in its technological infrastructure, integrating services and accelerating the flow of information at all levels of care. While many of the improvements anticipate state and federal requirements, others set the groundwork for future endeavors, with a focus on improved quality of care, safety and administrative efficiency.

Keeping Records Electronically

Elderwood is among area health care providers taking the lead in introducing electronic medical records (EMR) systems. Using hand-held tablets or wall-mounted kiosks, nurses and caregivers are able to quickly record, update and retrieve residents' medical information. Likewise, physicians may remotely access patient information and can communicate with Elderwood staff via secure texting.

"Pushing data to the right person at the right time to make the right decision is integral to improved patient care," said Chief Information Officer Clay Bozard.

The EMR software enables data to be retrieved in a variety of ways that not only affect clinical decisions, but which benefit staff scheduling and budgeting.

"We can analyze data captured from the nurse call system to schedule staff based on the busiest times of day," said Danelle Wotka, chief nursing officer, "or anticipate the need for particular medications by evaluating prescribing patterns by doctor or building."

Dr. Jeffrey Rubin
Co-CEO, Elderwood Administrative Services LLC

Paying Attention to Detail

Using hand-held electronic devices, aides at Elderwood's assisted living communities develop customized service plans by recording details regarding resident care.

"For instance, an aide can record that Mrs. Smith likes to have her robe laid out on her bed, rather than hung in the closet," said Kim Laviolette, regional director of operations. "With their iPod Touch, that information is readily accessible to all key care providers, not locked away somewhere in a filing cabinet."

By being able to find out everything from a resident's medical care to individual preferences, caregivers can better understand the residents' needs and wants in real time.

Enhancing the Rehab Experience

Point-of-care technology also has advanced Elderwood's rehabilitation services.

"The portability of an iPad enables our staff to quickly and accurately enter information at the point of service, increasing accuracy, saving time and enabling therapists to remain with the patient. All information is at hand to help therapists gain a better overall view of the patient's care plan, provide more effective communication between disciplines and to facilitate more timely care," said Dennis Ng, director of rehabilitation services.

Therapists also use their tablets or larger Smartboards for patient therapy, incorporating age-appropriate activities to help people with cognitive impairments, for instance, or accessing the internet to educate patients about their condition. In addition, a wide array of technology-based therapeutic modalities, from electrical stimulation to the partial body weight treadmill training LiteGait system, help optimize rehabilitation outcomes.

Pre-packaged meds, automatically

Elderwood's new automated medication inspection and packaging system is expected to streamline medication distribution in the assisted living communities. The new system pre-packages a residents' multiple medications all together, ensuring all medications that should be administered at a particular time are delivered correctly, swiftly and safely.

"This multi-dose packaging system is working well for patients currently receiving prescription delivery at home through Woodmark Pharmacy," said Scott Kruse, director of pharmacy services. "It was recently introduced at our Tonawanda assisted living residence and will be implemented at our remaining assisted living communities later this year, followed in Spring 2017 by our skilled nursing care program."

Improving Safety

Elderwood also has leveraged technology to enhance safety. State-of-the-art mechanical lifts for moving or repositioning patients provide for a more comfortable experience, while helping reduce staff injuries.

Susan Robinson, vice president of risk management, said Elderwood is also looking into other ways to create safer environments. Trips and falls among older adults can result in injuries that commonly lead to a spiraling decline in health. Elderwood is considering luminescing options that may include motion sensing lights to provide illumination for assisted living residents who make nighttime visits to the bathroom.

As several Elderwood communities undergo renovations, technology is even helping guide maintenance decisions. Elderwood used a binary output tribometer, or BOT, to measure slip resistance on new and existing floor surfaces. In cases where surfaces scored lower for slip-resistance, adjustments were made on floor care products to help improve their performance.

"Elderwood eagerly embraces the latest equipment wherever and whenever we see a benefit to our patients and staff," said Dr. Jeffrey Rubin, co-chief executive officer. "We will continue to leverage technology to advance patient care and remain a leader in the health care services industry."

Elderwood provides skilled nursing care, specialized subacute care, rehabilitation, assisted living, independent living and memory care to more than 5,000 people each year, with 10 skilled nursing facilities, seven assisted living communities and two independent living communities in Western and Central New York. For more information, visit www.elderwood.com.

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on one of the issues – community health workers and really involving the community health workers and looking at the social determinants of health like housing, food, shelter and clothing. Those are the three big transportational issues that cause the Medicaid population to struggle. So the change of system in terms of this new reward system around value- based payment, what we have to do is we have to form collaborative relationships where we work really close. If best practices are happening in the post acute world, we have to make sure we're using those same best practices in the developmentally disabled population, in the behavioral health arena and in the primary care community. When we form these collaboratives, everybody in the collaborative gets rewarded for taking care of a population. You get paid and you get rewarded based on how you take care of a population. For example, diabetes and hypertension are two things that run rampant in the Medicaid population. So the collaborative gets rewarded based on how they take care of the diabetes population, are measurements of how they're doing with their sugar count. We call it sugar. But how is your hypertension, your high blood pressure? So all these different silos now being forced to work together to get paid based on how that population gets taken care of. That's what's changing and that's what has to change. In the business world, everybody can't be an expert at everything, so you form collaborations and make sure experts work together with measurables and clear deliverables.

RUBIN: From a government policy perspective, change is already started and the provider community has to have skin in the game, so that they can actually lose. And I think you're seeing that more in capitation and bundling. But the way really to make it work is that aspect of dialogue and collaboration, of sitting down and addressing patient populations and developing a program of caring for those groups. And that the payment system has to evolve to skin in the game. We have outpatient facilities, inpatient facilities, home-based services. We have to coordinate those services, and that's what we have not done a good job at.

MONROE: And then you add in behavioral health. How do you see pay for performance working out in behavioral health?

HITZEL: Well, Lake Shore is a Medicaid health home, there are three in Erie County. Medicaid recipients qualify for health home if they have a serious mental illness, that's an automatic qualifier, or if they have two other chronic illnesses. To qualify for a Medicaid health home you're assigned a care manager. If we look at our population of folks with substance abuse disorders or mental illnesses, many are not well connected with primary care.

JIM COURTNEY

Addressing the shortage of primary care physicians is a priority, said Al Hammonds.

And that's for a lot of reasons. For many, they're having a hard time managing their lives, so they have a hard time following through with appointments at the primary care office. So the care managers have been very effective in making sure that everybody has a primary care provider.

MONROE: So would they go to an appointment with a client?

HITZEL: Oh, absolutely. They'll take them to appointments, they'll make sure that they follow through on things. Very often people are reluctant to get lab work done. A care manager can facilitate the transportation. In the bigger picture in terms of outcomes, behavioral health is very regulated in New York state. So often for people to receive services, they're part of a large program that has many requirements, both for providers and really for consumers.

MONROE: You mean like both physical and behavioral in the same place?

HITZEL: This is one project of the DSRIP, is to integrate primary care with behavioral health. So we're trying to really kind of identify where people best get their care and where they'll best benefit from it. I think in the long run that will be behavioral health.

MONROE: I'm interested in how behavioral health needs are met in your population. Do you have a relationship with a behavioral health organization?

RUBIN: Our company has a history of operating TBI (traumatic brain injury) neurobehavioral facilities. And clearly a large component of it is behavioral health. We also own and operate pediatric inpatient facilities for mentally fragile children. And we get stuck on the dual patient, one that has medical fragility but also psychological or behavioral health issues. I've been actually trying to get something opened up here.

MONROE: A residential program?

RUBIN: I believe our company will get these facilities open. Today for the facilities that we own and operate, there's not a large component of behavioral health in them. So we use psychologists, psychiatrists and social workers who come in and provide those services for our population. Theoretically, we could have a discussion about picking a patient population and creating a unit or creating a facility specifically for those patients, and that's where we kind of have to dialogue better, get the regulators from the Department of Health and the payers and create those pilot facilities.

MONROE: Well, we know depression is rampant in the elder population. And now we've been reading that opioid abuse and dependence on opioids is also in the senior population. Any other comments on this? Do you see the systems willing to move to pay for performance?

HITZEL: I think the silos that we've talked about are one of the difficulties – how do people providing different segments of health care really work together. And I think a lot of that comes down to electronic medical records, how we communicate with each other.

MONROE: Sharing information?

HITZEL: That's really been a barrier. We have patients in our behavioral health system and we provide medications for them and do a lot of work with. How do we effectively and efficiently communicate that information to the primary care physicians? I think there's a lot of work to be done on exchanging information so that everybody is on the same page. That's has not happened in the past. Often there's duplicate care or a primary care physician doesn't know that somebody is getting treatment at one of our clinics. Information sharing is an efficient and effective way. I think we aspire to do all sorts of creative things, and I think the technology is not quite there yet.

HAMMONDS: The health information technology is the key to making it all work. So we've got these silos of health care happening, so there are a lot of risks to work with each other. The way to reduce the risk is with good, accurate data. Part of the value that the PPS brings, that Millennium brings to the region, is our value proposition to provide a health information technology solution that connects all electronic medical records systems. We have reduce risks by making sure we're all talking, we're all sharing information, we have the right health analytics in place. A neutral party like us at the PPS level is able to do that, to give everybody the confidence to be able to play in this arena.

RUBIN: I think the Millennium PPS has done a really nice job of getting the provider community thinking about pay for performance. And from our space, their initiative on eINTERACT, which is a tool to do root cause analysis of hospitalizations is a great starting point. Other initiatives like eINTERACT are wonderful ways to get the provider community ready for pay for performance. And so I do think that the Millennium PPS is a perfect vehicle and I think it's accomplishing that.

MONROE: What do you see on the horizon? High drug costs have gotten a lot of press and are a threat to this whole effort in terms of being a money saver for the state. What's coming?

HAMMONDS: One big issue when you talk about high drug costs is to shift all patient behavior towards primary care and the primary care doctor. And there's a shortage of primary care physicians in the industry, period. That's got to get figured out if that's going to be the central point of taking care of people and the Medicaid population. We have to work in conjunction with the university systems to make sure they are training people. We're going to have to make inroads into telemedicine. That's a way to build capacity. And we just have to get creative.

RUBIN: I'm seeing a shortage of health care providers that I haven't seen since the late 1990s. I'm seeing a shortage of nurses, home health aides, CNA's and physicians, and I'm seeing it multi-state. I'm wondering if that is not a result of the Affordable Care Act and 20 million more people that are now insured, and the system is not robust enough to handle it.

HITZEL: Psychiatrists are in a great shortage in Western New York. We have a population of aging psychiatrists and we're not really seeing a lot of new talent coming into the area. Child psychiatry is particularly problematic. What we're seeing on a positive side is a much greater demand for behavioral health services. In the last few years we've seen a greater acceptance that treatment really does benefit people.

MONROE: It's been interesting when you look at how we've spent that Medicaid money five years ago, the least bit of Medicaid money was spent on primary care. And now we're in this five-year rapid transition and we're all concerned that there may not be the resources there to absorb the shift that needs to happen. Is it possible to better utilize nurse practitioners and physician's assistants to supplement and to support the primary care doc?

RUBIN: We use them in our facilities, and I think that they are definitely part of the solution.

HITZEL: We are very much dependent on psychiatric nurse practitioners and we've found them to be very effective. The regulatory environment sometimes requires that you have psychiatrists for certain roles. So I think the state has been

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supportive of use of nurse practitioners, but there's still some things where you need a psychiatrist.

HAMMONDS: We want different categories or different types of like CNA's and community health workers and LPN's and RN's. Everybody has to work at the top of their license, so to speak, to make the whole system effective. There's a lot that community health workers can do. They're not licensed today. There are community health-worker certificate programs out of Canisius College, out of SEIU, that are really effective. If we allow that population of community health workers – people who connect directly at the ground level – to work their magic, it would allow us to better leverage registered nurses and physicians.

MONROE: We haven't talked much about managed care. And Medicaid managed care is pretty big in Western New York. How do you see them playing into all this change that's happening?

HITZEL: In behavioral health, managed care companies have always been familiar with our traditional clinic services because that's what they provide in their commercial plans and have paid for that on the Medicaid side for a while. But we do a lot of other rehabilitative recovery services that managed care companies are only now being asked to be involved with. So, it's a bit of a learning curve at this point. We're in a process now where I think they're going to have to staff up with people who have expertise in behavioral health or they're bringing in insurance companies that are experienced in behavioral health.

RUBIN: We are Elderwood Health Plan, a managed long-term care plan. I think the plan brings real value in care coordination. It's that extra touch in making sure that care is quality and right sized.

MONROE: I'm reminded of the quotation that vision without execution is a hallucination. And I'm really hoping that this is executed in such a way that we can prove that it works. New York is really the first state to be under this kind of pay-for-performance pressure in Medicaid. With the idea that early detection is best, if you were speaking to a group of pediatricians, what would you like to see happen to promote the collaboration?

HITZEL: Pediatricians are very often the folks who see the first indications that young people are having behavioral health problems. In the past, primary care docs were reluctant to identify difficulties because they didn't know what to do with them. As we go along, I hope there will be more resources to support pediatricians within their own practice, They are really the first line of helping children, and then differentiating which kids might require a higher level of more specialized care and which kids can be dealt with effectively within their pediatrician's office.

JIM COURTNEY

Howard Hitzel says workers with diagnosable depression hurt business productivity.

HITZEL: You talk to any pediatrician's office and they will say they have a fairly high presentation of anxious kids, depressed kids. You have young people who are engaging in harmful behaviors like cutting themselves, those kinds of things, as well as substance abuse. They're looking for resources to address those problems in pediatric offices. I think it's a combination of being good about identifying those problems, screening things like depression and then knowing, where to get the resources to help those children.

MONROE: There's been a very high incidence of kids being suspended from pre-K to K for behavioral problems. And when you think about being suspended in pre-K, that does not bode well. The foundation discovered that pediatricians, first of all, didn't really have a tool to screen at that early age. And then if they did find a child, they wouldn't know where to refer them. And if they did get a referral, they never got information back. So, that points again to this need for everybody to be working together.

HITZEL: There's much more availability for evidence-based practices to address those kinds of things. There is parent/child interaction therapy, which is a very valuable – almost like a coaching with parents and their children. They put the parents in a room with their child with a two-way mirror, and the parent interacts with the child. The therapist coaches the parent on how to better respond to child behaviors. It's those kinds of evidence based practices that can hold a lot of promise for helping those families.

MONROE: What do you see employers being able to do to promote HEALTHeLINK, for example, so that you have the data, you have the patient data in the system to be able to share with one another? How can the business community help with that?

HAMMONDS: Because of the Affordable Care Act, everybody has access to care. A significant chunk of the cost is on the business itself, on organizations, on companies, on the private sector. So to get the biggest bang for the buck, folks must make sure that they're attuned with their employees and that all employees have a primary care physician. If they have a primary care physician, there is potential that they won't get caught up in the emergency room high cost care, and that's how cost escalates. That's one way employers could be engaged to help with controlling the cost.

RUBIN: We have to do a better job of educating our employees, and for them to better understand health and wellness. We have a program in our company where we have a financial incentive for the employees and their families to have their primary care visit in their health spending account. They get $100 if they go to the primary care visit. Secondly, we have to educate them better on what's the proper use of an urgent center versus an ER. And not use ER visits in a silly way, such as a toothache. We have about 4,000 employees, so we're putting together health and wellness programs that include competitions to lose weight or diet. I think each business owner has the responsibility to make sure their employees are smarter and better consumers of health care.

HITZEL: Studies show that about 6 percent of the average workforce has diagnosable depression, and I think that shows up in the workplace in lots of ways. It's really estimated that the loss in productivity by workers who are depressed is considerable. Very often those people may have a lot of physical ailments so they miss a lot of work. Part of employee wellness should include an emotional component and use of EAPs. I think that where businesses have an EAP, often there's a reluctance to refer people who are struggling with being excessively anxious or depressed. But those resources are a great service to the employee and the business. We'll just have a healthier workforce.

MONROE: New York is starting with Medicaid, and the premise is that where Medicaid goes, commercial insurance and private practices will follow. I'm wondering if you ascribe to that.

RUBIN: I think it's already happening. Those boundaries are already shifting. You're seeing best practices in Medicaid happening in commercial and other payers, and then I see some of the practices that already exist that are best practices that are commercial now and being adopted by Medicaid. So it's very much chicken/egg. Ultimately, you'll see more uniformity of those best practices.

HITZEL: Managed care plans are really watching this carefully to see what components in the Medicaid redesign are going to result in better outcomes. Care management is a good example of that. Care managers who are actually in the community – touching people, going to their homes – may turn out to be a great way to help keep people healthy.

HAMMONDS: All our providers in our network for PPS, they just don't see Medicaid, they see all types of folks. So this is clearly the tip of the iceberg and just the start of change across the whole continuum.

MONROE: Share your thoughts about your hopes for the future.

RUBIN: I would like to see better quality of dialogue among the provider community and specifically DSRIP, so that we pick and choose smart initiatives. We need to come up with a better plan to dialogue on a more regular basis and brainstorm. I am very concerned about the robustness or lack of the workforce in health care. I think we need to come together and work smarter to solve that issue. And that's physicians and everyone down the chain. So I think that that would be, hopefully, my wish list going forward.

HITZEL: Well, I'm enthusiastic about a lot of things. I really think that the place of behavioral health and managed health care is improving greatly. There's a much greater appreciation that, first of all, behavioral health issues are common difficulties that people have and they're very treatable. So I'm really optimistic about that. And I also think that as we integrate more with primary care, we'll just have better outcomes with people, we will be healthier overall. I think there's so many things in play that are changing at this point in time, that I just hope we don't get too far ahead of ourselves and pose a threat to the delivery system. Everybody is trying to get this out, how is payment going to work, how do you adjust your budgets and staffing and all those kinds of things with changes over time. Hopefully it just doesn't get too far ahead of ourselves, because I think there's a lot of good potential there.

HAMMONDS: I'm cautiously optimistic about where we're headed. I'm right in the middle — we're right in the middle of driving the change, of helping shape the transformation. And I think it's a great thing. I'm personally energized and excited about the changes that are happening, but the cautious part is how fast it could happen. This is major change. It's like turning the Titanic. We've got five years with DSRIP to make major changes. Eighty percent of the provider network needs to be on a value based payment arrangement by the end of the DSRIP period, and DSRIP ends like March of 2020. Is that realistic? I don't know. We're going to charge hard and do the best we can. I think this is longer than five years. I think we've learned from California and Texas and Florida and others that it takes longer than the five years. It's a journey of continuous improvement. And I think significant changes are going to happen and I'm excited about that, but really shaping people's expectations is key in terms of where we're going to go, so — but I'm excited.