

Spotlight Series

Parinda Khatri, Chief Clinical Officer, Cherokee Health Systems



The NORC Medicaid Managed Care Organization (MCO) Learning Hub shares timely and relevant resources to support Medicaid MCOs and other stakeholders in improving the health of their members and increasing advancements in health equity and health care transformation. We encourage you to share your experiences with us and welcome your feedback on future MCO Learning Hub work to better serve your needs. To start the conversation or join our distribution list, please email us at MCOLearningHub@norc.org.

The Medicaid MCO Learning Hub “Spotlight Series” highlights key initiatives addressing social determinants of health (SDOH) and other issues that impact health equity and that are driven by, or in partnership with, MCOs to inform the Robert Wood Johnson Foundation (RWJF) and its grantees. In addition, the series provides MCOs, community based organizations, states, and other key stakeholders with examples of successful models of organizations working together to advance health equity.

This “Spotlight” is focused on a safety net health system that offers primary care and behavioral health services in Tennessee. Forthcoming Spotlight Series briefs will center on other existing initiatives and partnerships around SDOH and health equity.

Ensuring adequate access to timely and well-coordinated behavioral health (BH) services, which includes both mental health and substance use disorders (SUDs), for Medicaid members is complex and challenging. COVID-19 has increased individuals’ needs for BH, particularly for those with pre-existing mental health conditions and SUDs.

Cherokee Health System is a non-profit, community health organization that offers comprehensive primary care, BH, and pharmacy services in Tennessee. NORC’s Medicaid MCO Learning Hub spoke with Parinda Khatri*, Chief Clinical Officer of Cherokee Health Systems, to discuss how the organization is providing BH services to its members and the effects of the COVID-19 pandemic on its services and its population.

Q: Can you tell us about Cherokee Health Systems?

Cherokee Health Systems is a large, comprehensive community health organization in Tennessee. We are a federally qualified health center (FQHC), licensed community mental health center (CMHC), and licensed alcohol and drug treatment facility.

Cherokee Health Systems started as a community mental health center in a rural clinic in 1968 and provided outreach into primary care in underserved communities. In the early 1980s, the Health Resources and Services Administration’s (HRSA’s) Bureau of Primary Health Care asked Cherokee Health Systems to help manage a primary care clinic as well. We saw the benefit of the “no wrong

door” approach and broadened our access to BH and primary care services.

Cherokee Health Systems has over 20 brick and mortar clinics and an additional 20+ telehealth sites.

Q: What have been the impacts of the COVID-19 pandemic on delivery of BH services?

Because of the pandemic, we are seeing scary increases in substance use and relapse, depression, and suicidality. The population we are seeing is very ill, both medically and psychiatrically. A lot of people have lost their jobs, insurance, and doctors during the pandemic. We are receiving about 8,000 calls a week from people who need to get care quickly. The demand for our services is high, because we are a safety net and no one wants to go to an emergency room.

We are currently experiencing a “twin-demic”; in addition to the COVID-19 pandemic, we have a mental health pandemic that will have devastating consequences. Long-term, the potential implications of the pandemic include generational trauma. Kids are not learning their typical social and emotional skills. There is a lot of fear. There has also been a lot of trauma, particularly among racial and ethnic minority populations. They are disproportionately experiencing deaths in their families. In addition, health care providers are exhausted; when speaking with our teams, we always tell them to take care of themselves. Providers are experiencing a tremendous amount of trauma and they just have to keep going.

On the other hand, the opportunities for delivery of BH services during the pandemic have been tremendous. Telehealth has probably been the most game-changing aspect for the field; for decades, we had archaic regulations that made payment for telehealth difficult.

“Sometimes you have these disruptive forces that shatter the structures and give you flexibilities that you never thought possible.”

You cannot dial back on telehealth. Patients really like it; it is convenient for them. There are some IT literacy issues, but telehealth has been a tremendous boom. Pediatric physicians love that, via telehealth, they can see the world that kids live in as kids get to show off their rooms and show who they are. Their physicians are able to be a fly on

the wall and see their patients’ home environment, which adds a rich experience.

Q: You spoke about the use of telehealth during the pandemic. Have you been using texting as well?

We have primarily used texting for basic patient education and engagement. There are a lot of really good messaging and texting approaches we can use for people with SUD. For example, New Year’s Eve is always a hard day. We can program our systems to push out messaging to our members during those hard days. We also have interactive texting, where the member can answer questions and be directed to services based on those responses.

The way in which people are interacting and engaging is different. Looking at the data, texting is effective and brief touchpoints are effective. Some of the differences in how people want to access care can be generational; younger individuals may prefer brief interventions and multiple touch points. We need to be as flexible as possible.

“I am not saying that moving forward there isn’t a place for traditional mental health, but there are a lot of people that are struggling and are not getting what they need. We need to vary the repertoire [of how we deliver BH services].”

Q: Are there any strategies that have helped Cherokee Health Systems weather COVID-19?

In the beginning, there were days when things were changing every day. As a health system, we needed to be able to adapt quickly, make revisions, and take feedback. The ability of any system to work well as a team and adapt is a pivotal factor in responding to COVID-19. We worked really well as a team, collaborating across operations, IT, clinical, finance, etc. and at a tempo unlike anything we have ever experienced.

Q: What changes are needed to ensure there are enough BH providers to meet the rising demand, especially among Medicaid members?

The workforce issue is a huge limiting factor – if we tripled our workforce, it still would not be enough to meet demand. Currently, BH providers need to be credentialed. HRSA is funding a lot of workforce development, but more needs to be done to overcome the barriers. We need to expand the definition of the BH workforce to include peer navigators, certified peer support specialists, licensed clinicians, outreach workers, and community health workers.

In addition, the payment and financing of BH services needs to change; it is so hard for a BH provider to be paid. Many BH providers do not accept Medicaid patients or limit the number of Medicaid patients they see because payment is so low. We need to significantly change the financing model to change the workforce.

BH providers also face other bureaucratic challenges. For example, prior authorizations for autism assessments. Our track record with autism assessment is that mostly all prior authorization requests are approved. It would be easier if we were able to waive the prior authorization paperwork. Yet the process is bureaucratic and not related to the quality of clinical care. It would be great to have some flexibility in the system for high performing providers so that they have more time to spend of clinical care.

Q: What is the role of MCOs in addressing workforce-related challenges?

MCOs are constrained by the regulations set in place by state Medicaid entities. However, I have been struck by the ability of MCOs to be innovative. MCOs we work with have provided additional per member payments or established global payment models. Others have waived the requirement for pre-authorizations for autism and provided a case rate per member.

Something that would be helpful is for MCOs to pay for additional phone codes. CMS opened up phone codes during COVID to reduce the amount of time for a call that can be eligible for reimbursement, for example, reimbursement for a call that lasts less than 15 minutes. However, most of our MCOs do not pay for those phone codes and we are hitting walls in getting those approved.

Q: How does your health system work with CBOs?

We have worked with charter schools and the public school system. Those have been good partnerships where we have school-based psychologists placed in public schools.

We have also worked with family-based organizations, transportation partners, and churches. We now have a clinic in a recreational facility within an impoverished neighborhood. As we were opening up the center, a woman came up to us to say how the closest clinic was too far for her to walk to, so she was glad we were opening a clinic there. We also have partnerships to address social determinants of health (SDOH), including with food pantries like Second Harvest Food Bank where we have established drive-through food pantries.

Q: What does behavioral and physical health integration look like in your health system, especially for supporting Medicaid members?

Our BH and primary care providers work as a team. If someone is receiving a BH service, they are seen in the exam room where they receive primary care. That is where patients feel comfortable and we can give them access where they need it. Sometimes we have patients that need more than what we can provide in a primary care setting so we provide a continuum of specialty, BH, and day treatment services. Some patients come in for BH services but we try to get them medical care too; for example, to get a flu shot or get their blood pressure checked.

“[Our BH and primary care providers] are not just collaborating; they are in the same space, sharing the same patient panel, and co-managing patients. We have shared care planning and decision-making and that is powerful.”

Q: What are some steps health systems can take to get to a place of real integration?

To get to integration there are both active and passive strategies health systems can take. The passive strategy is structure – you need to make sure BH and primary care

providers are in the same space. During COVID-19, teams are communicating via Microsoft Teams platforms.

The active strategy is getting the right people on the bus; not everyone works well in an integrated setting. You have to hire the right staff. Any time we have hired staff just based on competency, we have realized that these skills of working together are not intuitive and it requires extra work to teach that culture. We do a lot of training and onboarding for our staff. We have to have the right people on board and have to orient them; if you underinvest, you regret it. Integration has to flow through the organization overall, including to health systems and providers. Communication and openness are important.

“The most powerful thing is culture – you have to embrace working together as a team. You have to think about all of the functions of primary and BH care, what is the first contact, how you can provide comprehensive, coordinated care – all of that has to be embedded in the DNA of the staff.”

One thing I hope we can focus on is shared data. There is so much fragmentation and delay in getting data, so we are often operating in a vacuum. When we get data from MCOs and there are many inaccuracies, we have to clean up a lot of that data. I hope we can move to a place where providers have access to good, accurate data in real-time.

“If we’re going to work together, there needs to be an intentional focus [on data sharing] to help us move forward.”

Q: What role does stigma play in delivery of BH services?

Certainly, there are differences. Our goal is to open up access to care. To the degree that stigma is a barrier, we strive to minimize it. We do that with physical spacing, community education, and a culture of integration that is embedded in everything we do. BH issues are not unlike other chronic health problems like diabetes; BH issues are also chronic health issues.

Many of the little things that we do strive to remove stigma. For example, when we have patients come in and take their vitals, we also do a two-question BH screen. We tell our patients that BH is a part of their overall health and it is important to get indicators of social and BH wellbeing.

The separation of mental health and SUD records has been stigmatizing. For any other problem, you would not separate care and data completely. Even though mental health is a significant factor in etiology and response to treatment for a number of physical health problems, the idea that no one else needs to know about a person’s BH issues makes it almost shameful for people. If someone is actively abusing alcohol, if you do not talk about it and say this is what can kill you, then you are really facing a patient safety concern. We need to approach BH just like it is a part of our mind, body, and spirit.

Conclusion

Based on our conversation with Parinda Khatri from Cherokee Health Systems, there are various considerations for states, MCOs, and health systems:

- COVID-19 has exacerbated the BH crisis. BH systems will have to consider how to meet the rising BH needs and address increasing demands for services
- Increased use of telehealth among BH providers has improved access to BH services; providers, MCOs, and states should consider how telehealth can continue to be used post-pandemic in conjunction with traditional mental health models to provide multiple forms of access to the BH services
- BH workforce shortages continue to be a challenge. States and MCOs should consider ways to expand the BH workforce including:
 - Expanding use and facilitating credentialing of peer navigators, peer support specialists, licensed clinicians, outreach workers, and community health workers
 - Improving reimbursement rates for BH providers
- States and MCOs should consider ways to reduce bureaucratic limitations for BH services such as reconsidering need for prior authorization of autism assessments
- Successful integration of behavioral and physical health services requires not only structural changes, like co-location of services, but also promoting a culture of collaboration and integration among staff
- Fragmentation of BH data makes care coordination and collaboration difficult and contributes to increased stigma around BH services. Improving data sharing of BH data can improve delivery of care and integration of behavioral and physical care

*Interview has been edited for length and clarity.

ABOUT NORC MEDICAID MCO LEARNING HUB

The key goal of the NORC Medicaid MCO Learning Hub is to serve as a source of information, expertise, and best practices to support managed care organizations in moving forward with system reform. NORC and its partner organizations identify, develop, and disseminate promising approaches and emerging opportunities for MCOs to improve the physical health, behavioral health, and social needs of their members.

Your ideas and opinions are important to us. We welcome your feedback on future MCO Medicaid Learning Hub work or programs you are working on to better serve your needs. To start the conversation, please contact the senior staff listed here:

www.norc.org/Research/Projects/Pages/medicaid-managed-care-organization-learning-hub.aspx

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