Physical Health Integration Within Behavioral Healthcare: Promising Practices

9:45 AM – 10:45 AM
Steering Toward Success: Achieving Value in Whole Person Care
September 25 and October 26, 2017

The Healthier Washington Practice Transformation Support Hub

QUALIS HEALTH Washington State Department of Health Healthier WASHINGTON

Steering Toward Success:
Achieving Value in Whole Person Care

Physical Health Integration Within Behavioral Healthcare

AIMS CENTER | UNIVERSITY of WASHINGTON Psychiatry & Behavioral Sciences

John Kern, MD
Clinical Professor, University of Washington
AIMS Center Faculty

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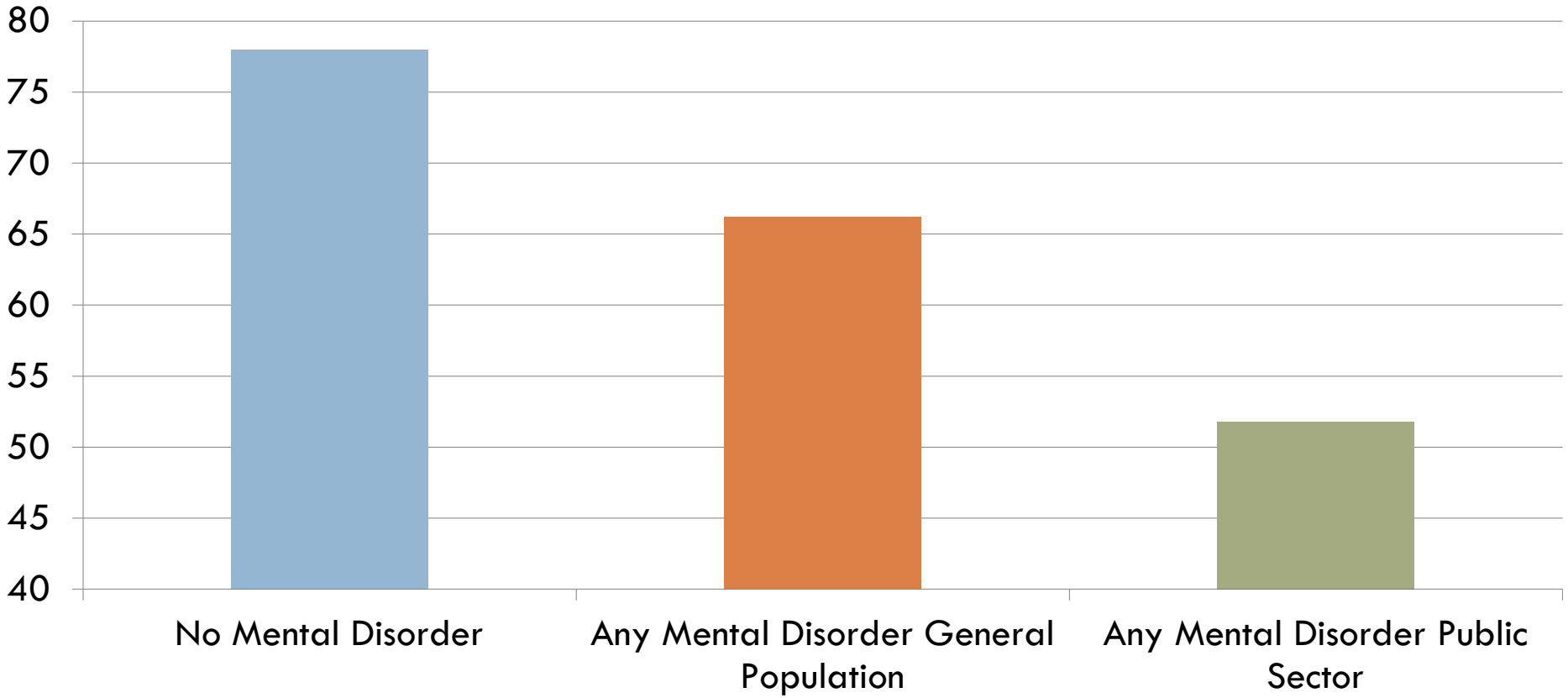
Learning Objectives

- Discuss the opportunities of a fully integrated model of care for behavioral health agencies
- Identify the system barriers and challenges to developing fully integrated models of care for behavioral health agencies
- Assess the role of the client/patient in a fully integrated model of care

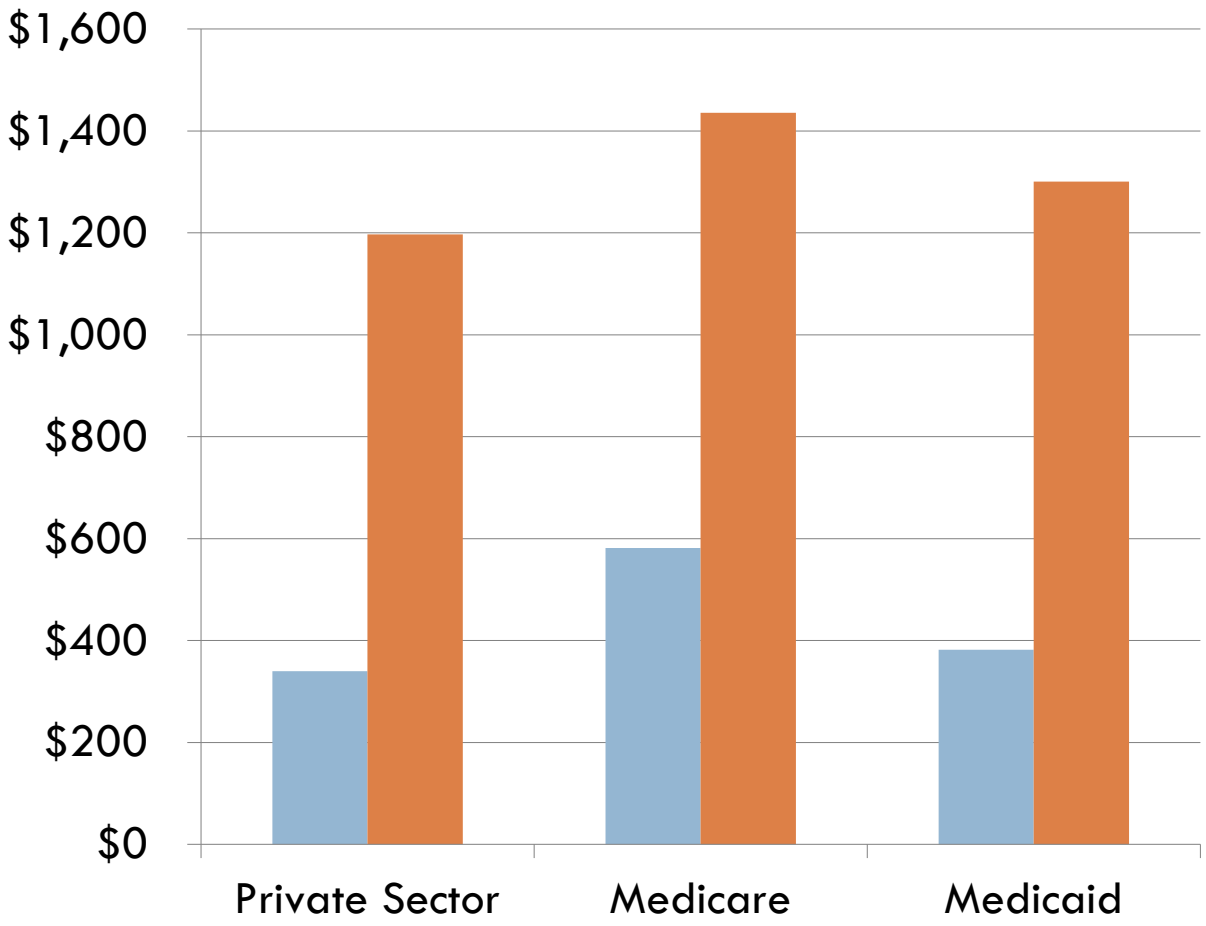
Background: Life Expectancy in SMI Short and NOT IMPROVING



Bar 1 & 2: Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. "Understanding Excess Mortality in Persons with Mental Illness: 17-year follow up of a nationally representative US survey." *Med Care* June: 49(6) (2011): 599-604.

Bar 3: Daumit GL, Anthony CB, Ford DE, Fahey M, Skinner EA, Lehman AF, Hwang W, Steinwachs DM. "Pattern of Mortality in a Sample of Maryland Residents with Severe Mental Illness." *Psychiatry Res.* Apr 30;176(2-3) 2010): 242-5.

MH Disorder as Predictor of High Cost



Melek et al Milliman Inc, 2013

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Core Principles of Collaborative Care

Team-Based and Client-Centered
Primary care and behavioral health providers collaborate effectively, using shared care plans.

Measurement-Based Treatment to Target
Measurable treatment goals clearly defined and tracked for every patient. Treatments are actively changed until clinical goals are achieved.

Population-Based Care
A defined group of clients is tracked in a registry so that no one "falls through the cracks."

Evidence-Based Care
Providers use treatments that have research evidence for effectiveness.

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Approaches for Integrating Primary Care into Behavioral Health Setting: Medicaid Demonstration Toolkit

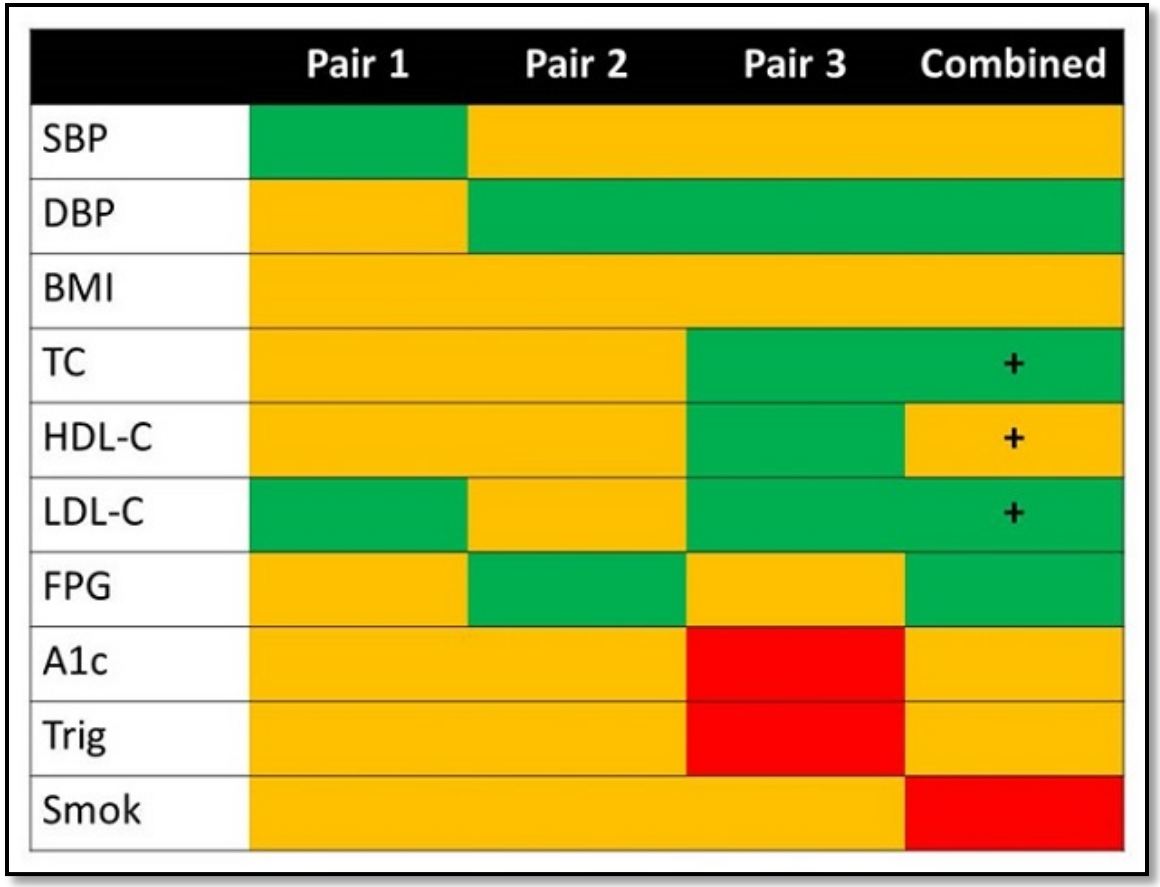
1. Off-site, enhanced collaboration – This can work!

2. Co-located, enhanced collaboration

3. Co-located, integrated

Integration Strategies – An Example:

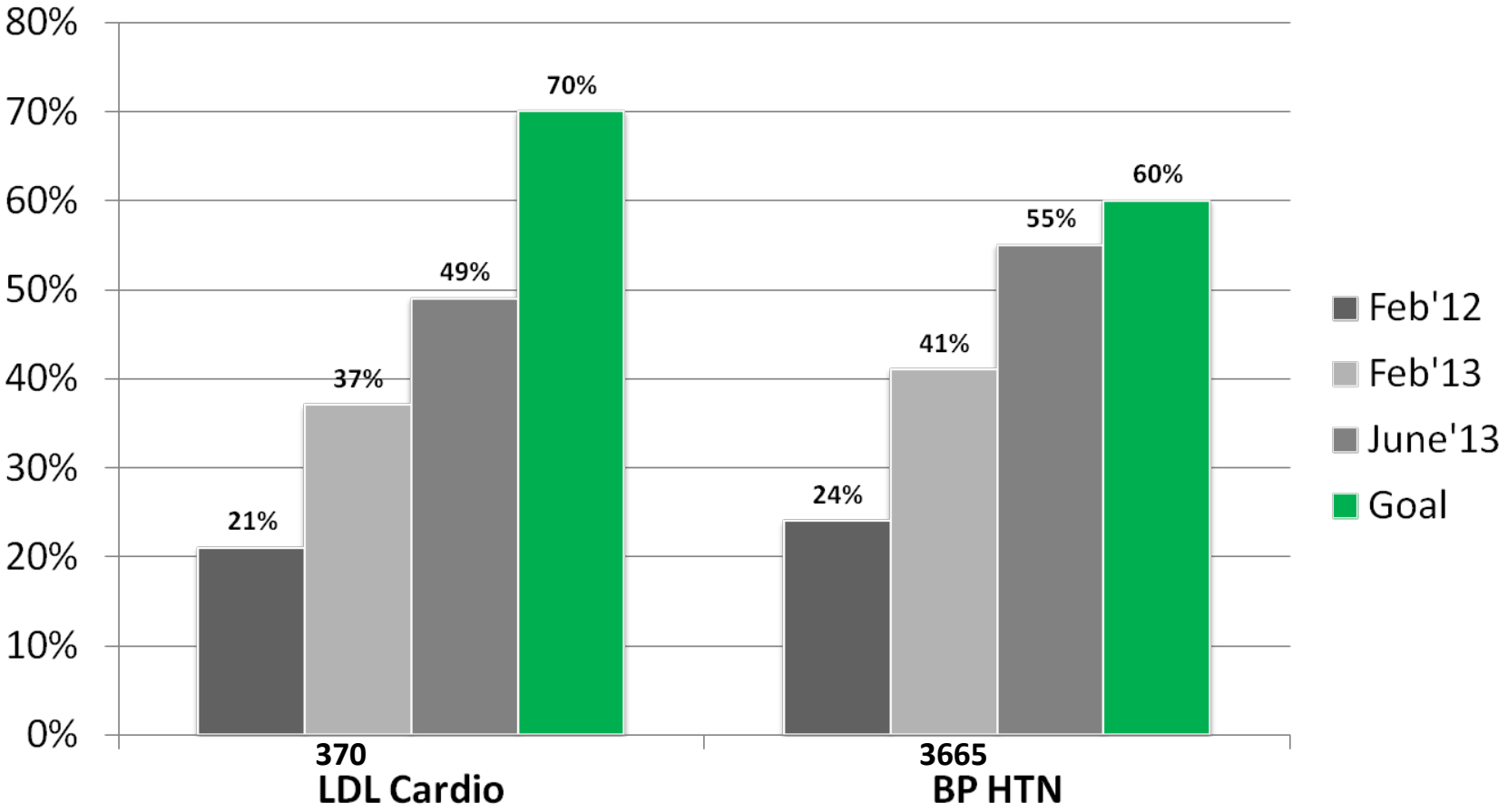
- Primary Behavioral Health Care Initiative [PBHCI]
- 200+ CMHC's in US over 8 years.
  - Co-location of primary care
  - Use of registry
  - Care management
  - Health Behavior change
- It takes more than this!



A Successful Integration Strategy – Missouri Health Homes Overview

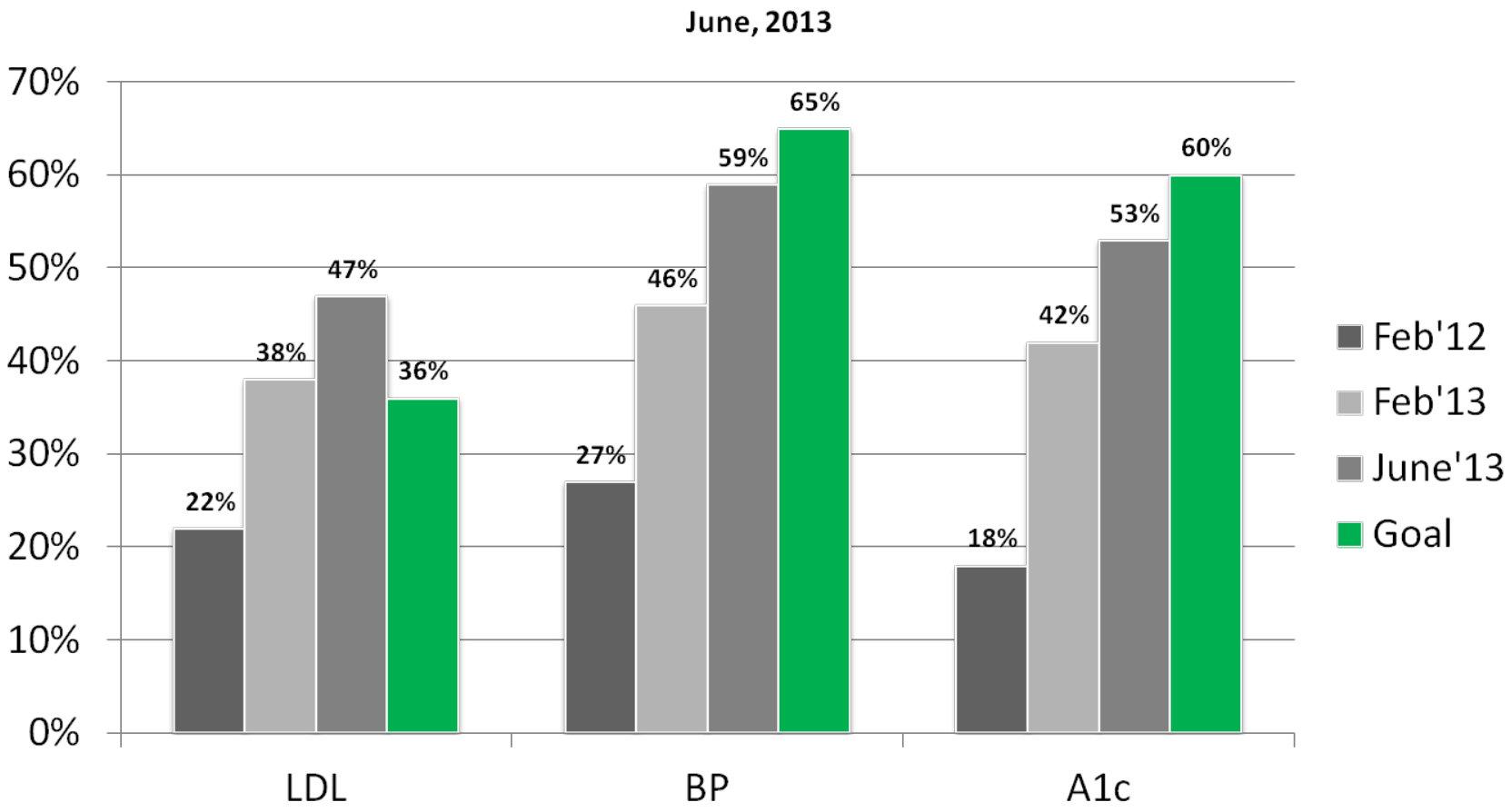
- **Strategies: Case management coordination and facilitation of healthcare**
- Primary Care Nurse Care Managers
- Disease management for persons with complex chronic medical conditions, SMI, or both
- Behavioral health management and behavior modification as related to chronic disease management for persons with medical illness
- Preventive healthcare screening and monitoring by mental health providers
- Integrated Primary Care and Behavioral Healthcare
- Health Home management where you are seen most often

Hypertension and Cardiovascular Disease Outcomes



Source: http://dmh.mo.gov/docs/mentalillness/prnov13.pdf

Disease Management
Diabetes Outcomes
(2822 Continuously Enrolled Adults)*



*29% of continuously enrolled adults

Source: http://dmh.mo.gov/docs/mentalillness/prnov13.pdf

Health Home Take-Homes

- Data to identify treatment and prevention opportunities
- Training helps implement new evidence-based interventions
- Personal interaction is the true change agent
- Data analytics identify the dose response curve of personal interaction required
- Training allows use of a lower-cost FTE to produce an effective personal interaction

Challenges and Barriers

- Medicaid Demonstration requirements - metrics
- Existing funding of FFS care vs. addressing social needs
- Cultural change in dedicated MH staff
- Workforce development [e.g., training in Motivational Interviewing]
- Registry development and implementation
- Money in the short term
- Getting ready for 2020

Project 2A Metrics - example

- Antidepressant medication management
- Child and adolescents' access to primary care practitioners
- Comprehensive diabetes care: Hemoglobin A1c testing
- Comprehensive diabetes care: medical attention for nephropathy
- Medication management for people with asthma (5–64 years)
- Mental health treatment penetration (broad version) outpatient emergency department visits per 1000 member months
- Plan all-cause readmission rate (30 Days)
- Substance use disorder treatment penetration

Lessons Learned: Opportunities for Improvement

- Value-based payment through Medicaid Transformation project creates opportunities for team-based care.
- The high cost of medical care for SMI creates incentives for new funding models.
- Care **CAN** be improved!
- There is some time to practice.
- Let's hear about projects already under way!

How Much Does this Cost? one early example, the CRANIUM study

- SMI agency San Francisco
- N=700 pts
- Added .20 FTE peer navigator, 0.1 FTE off-site primary care consultant.
- Registry with panel management meeting quarterly
- About one hour of staff time per patient per year
- Estimated annual cost per patient: $74

(Psych Services, Sept 2017)

Steering Toward Success:
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Physical Health Integration Within Behavioral Healthcare

Susan Ehrlich, MD
Psychiatrist, Jefferson Healthcare
Medical Director, Discovery Behavioral Healthcare

Background

- JHC: county public Critical Access Hospital
  Rural Health Clinics & four specialties
  3 LCSW in primary care
  22,000+ enrolled, largely Medicare

- DBH: 25+ yr Community MH Clinic
  4 PsyNPs,1 RN, 1 chem dep professional
  1500 contacts largely BHO/Medicaid

Description of Integration Strategies

- Stepwise, sustainable and inexorable
- "De-obstruct helpfulness"
- Spectrum of care across the region
- Cooperation not competition
- Address social influences/population health regionally
- Aware of larger clinical and regulatory pictures

Description of Integration Strategies

- Formal Affiliation JHC & DBH
- Dual employment of providers
- Multiple methods of networking with PCPs
- Collaborative DMHP/Crisis Services
- Awareness/prevention/screening - educ. and capacity, e.g. metabolic syndrome and tobacco use
- Access community resources e.g. Smile Mobile

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Success Stories

- Collaborative psychiatric care
- Cross-agency ad hoc treatment team meetings
- Joint grant applications
- Epic EHR read-only access
- Health education in day treatment program
- On-site Level I BH services
- On-site UDS
- Two waivered PNP's
- "User-friendly" registries

Challenges and Barriers

- Valuing/providing/supporting what it takes to think, create, problem-solve and plan
- Miniscule evidence-base
- Data difficulties
- Payment structures vs integration
- 42 CFR vs integrated MAT
- BHO restrictions vs integrated medical
- Keeping clinical decisions clinical
- Rhythm and pace

Lessons Learned: Opportunities for Improvement

- Need face:face introduction of integration
- Provide education
- Seek feedback from “front lines”
- Keep clinical and admin changes at same pace
- Understand each others’ biz models
- Mixed benefits of pre-assessment tools
- Value of community momentum
- Seize the moment

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Physical Health Integration Within Behavioral Healthcare

navos™

Healthy Mind. Healthy Body. Healthy Community.

David M. Johnson, Ed.D, LMHC
CEO, NAVOS

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Background

- Working toward integration of primary care into our behavioral health campuses since 2000
- PBHI grant from 2010 to 2015
- Continue to receive grant funding as we seek affordability
- 2012: new campus with embedded seven exam room primary healthcare clinic
- 2014 Team WIN (Wellness at Navos)

Description of Integration Strategies

- Co-located, collaborative partnership with Public Health of Seattle and King County providing a health home at the Behavioral Health Center
- Impact model using care coordinator to bridge
- WIN: Wellness Integration at Navos: Nurse care manager and 50 clients convenes primary care, psychiatrist, BH staff, pharmacist
- Affiliation with MultiCare, including the alliance with UW Medicine
- CDC Cancer Education Session through the National Council

Description of Integration Strategies

- Highly intentional structured meetings and protocols
- Tools: EBPs, data-sharing, EDIE, Pre-Manage
- Participation in the Metabolic Syndrome learning cohort
- Partnership with MCO decreasing overall healthcare costs
- Patient education about options (phone line and urgent care) & follow-up calls and visits
- Addressing social determinants of health (e.g. housing)
- Employing peer support specialists

Beverly:
Once hopeless, is now thriving at 62

https://www.youtube.com/watch?v=rITneCLhdv4

- Bipolar and substance use disorders
- Obesity, hypertension, diabetes dangerously unmanaged
- Homeless and thoroughly discouraged, referred by NeighborCare
- 1st an apartment; Team WIN consultations
- Persistent calls & home visits, even the doctor
- Integrated healthcare = “supercharged engagement”
- Sisters Helping Sisters; job in Navos Café
- Public speaking
- “Like a family that refused to give up”

Challenges and Barriers

- Engagement and behavior changes take time, especially for those with BH or SUD issues
- Medicaid rates of primary care don't anticipate time needed for appointments with psychotic, anxious, depressed or traumatized patients
- Relation with the caregiver is the most important factor in success and is difficult in a field with high turn-over due to low salaries
- Everyone is busy! Difficult to find in the time and discipline necessary for conferencing and managing the registry
- Don't allow barriers to result in not doing the right thing (example: finding a way to share the registry)

Lessons Learned: Opportunities for Improvement

- Must expect for co-location and collaboration to take longer and be more complicated than the simple idea suggests
- Must expect to have to subsidize the growing partnership for years as it grows to scale
- Must find ways to bridge the separate EMRs to maximize collaboration
- Eager for the era of Value Based Payment for EBP care and addressing social determinants of health with well-tracked success outcomes and attainment of client-defined goals

Q & A

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More Questions

- How to implement new things when everyone is already busy? [Prioritization]
- How will doing this help me to meet Medicaid metrics?
  - Access to preventative / ambulatory care
  - Potentially-avoidable ED visits
  - All-cause readmission
  - Potentially-avoidable EMS use
- How to train non-medical staff?
- How to interest non-medical staff?
- How to change to team-based workflow?

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