Physical Health Integration Within Behavioral Healthcare: Promising Practices

9:45 AM – 10:45 AM

Steering Toward Success: Achieving Value in Whole Person Care

Moses Lake, WA

The Healthier Washington Practice Transformation Support Hub

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Steering Toward Success:
Achieving Value in Whole Person Care

Physical Health Integration Within Behavioral Healthcare

AIMS CENTER | UNIVERSITY of WASHINGTON Psychiatry & Behavioral Sciences

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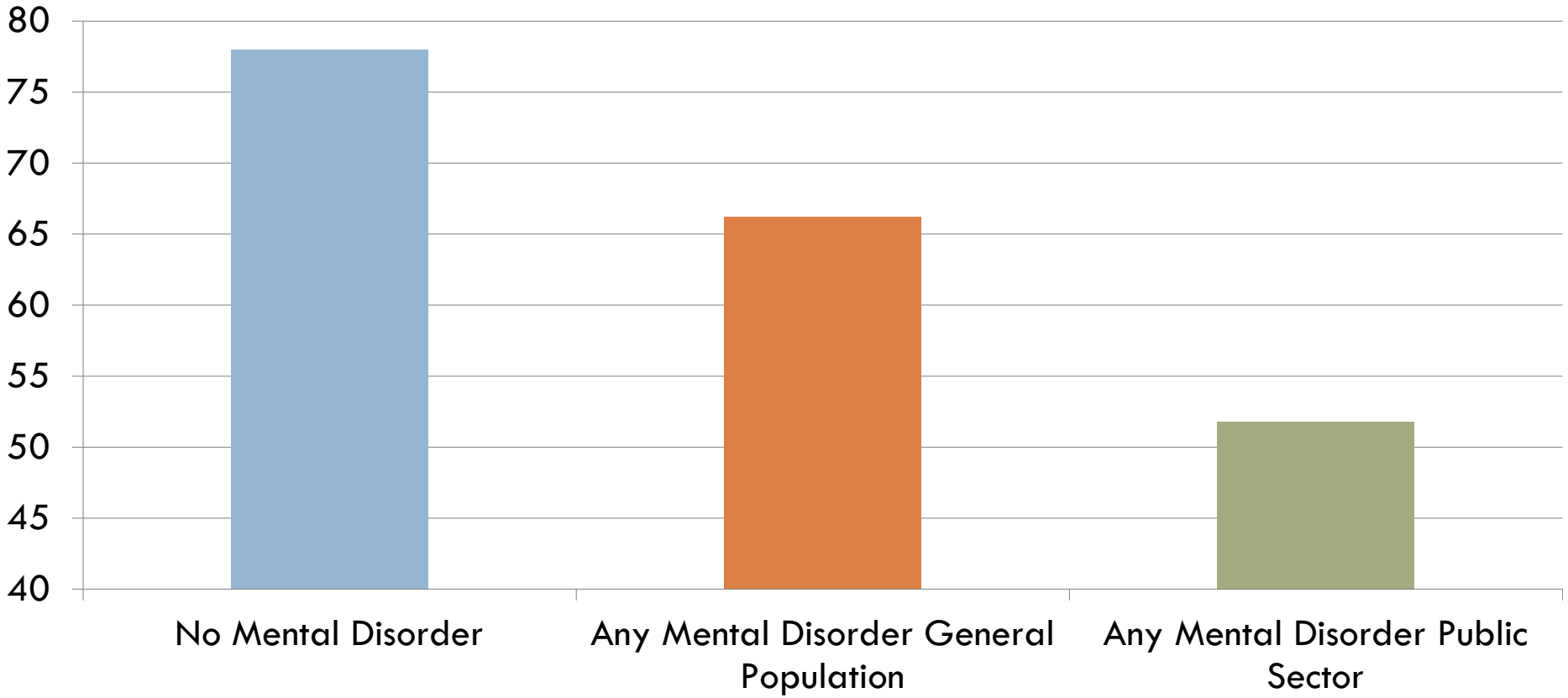
Learning Objectives

- 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.

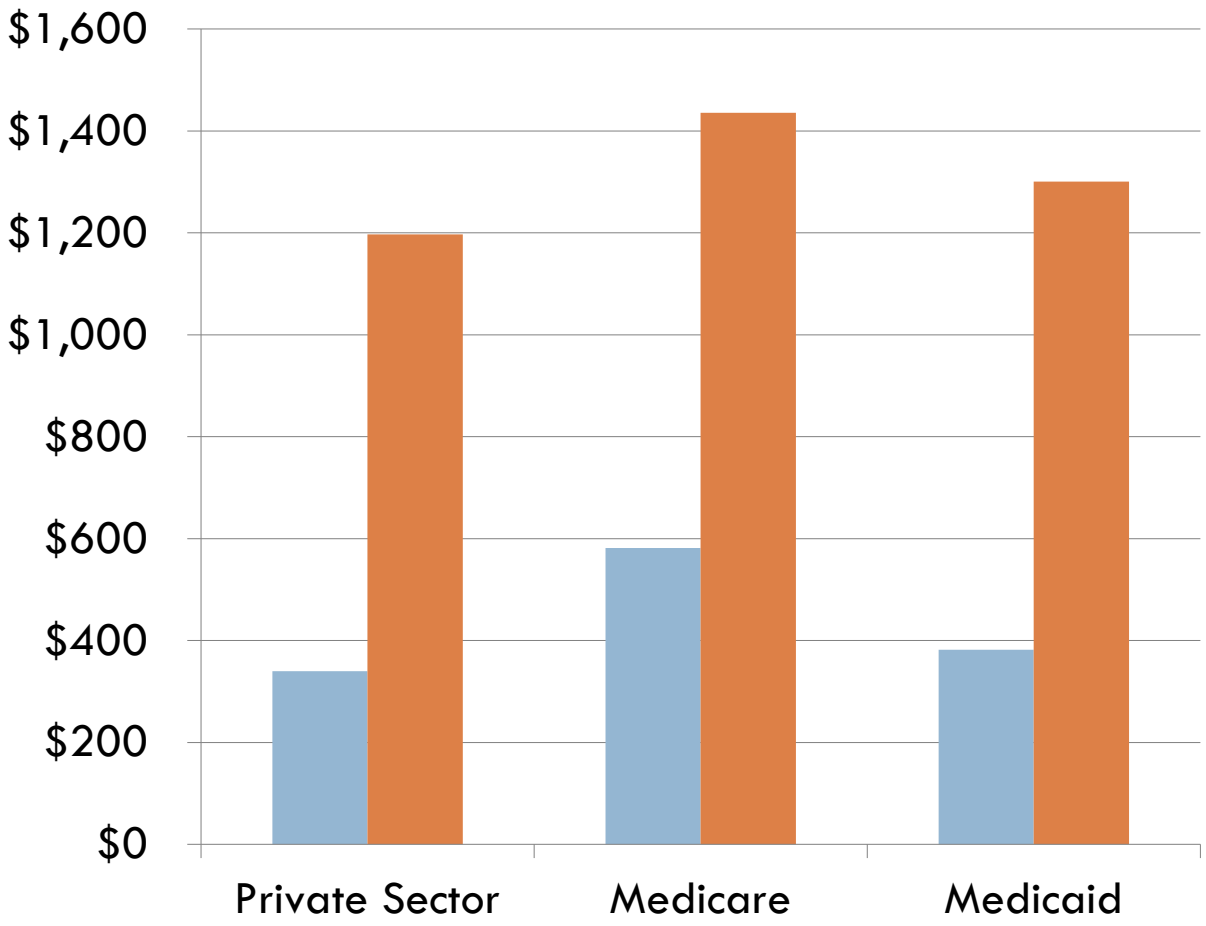
Background: Life Expectancy in SMI Short and NOT IMPROVING



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

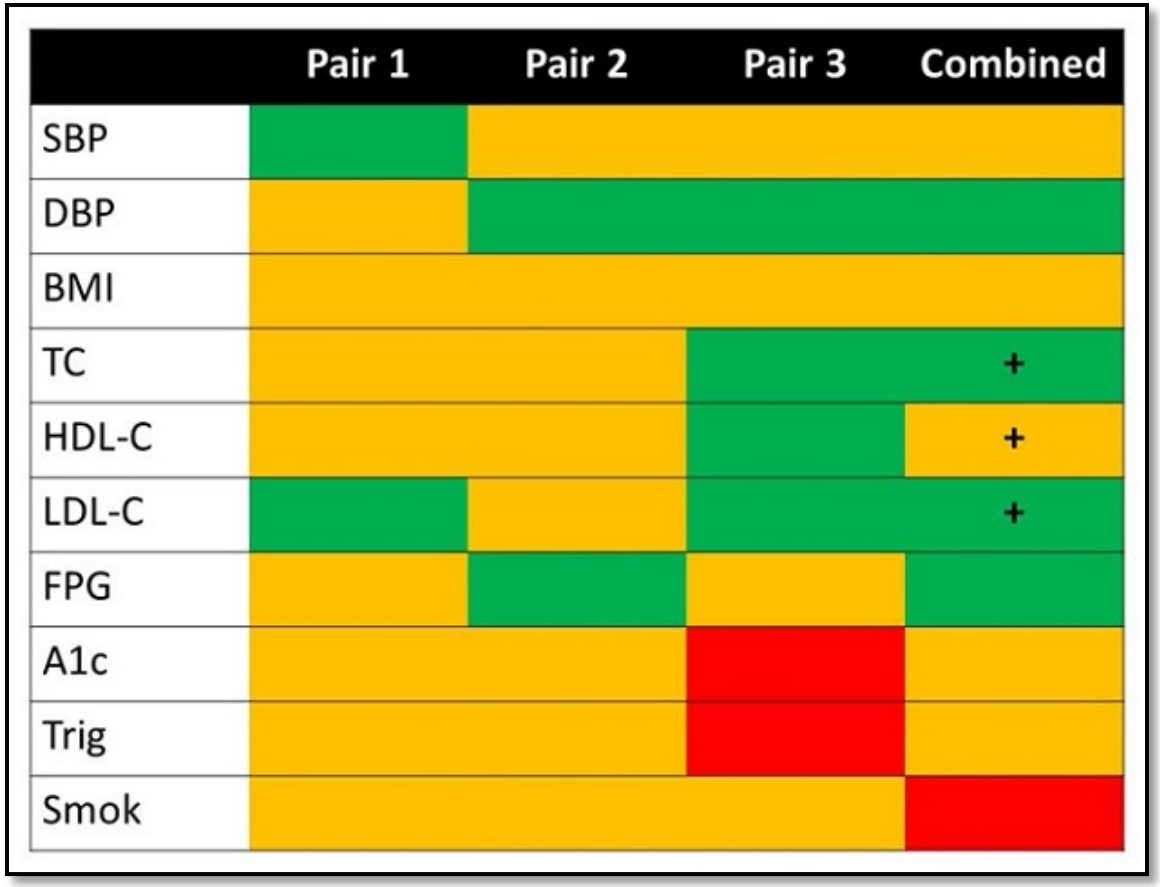
1. Off-site, enhanced collaboration – This can work!

2. Co-located, enhanced collaboration

3. Co-located, integrated

Integration Strategies – An Example:

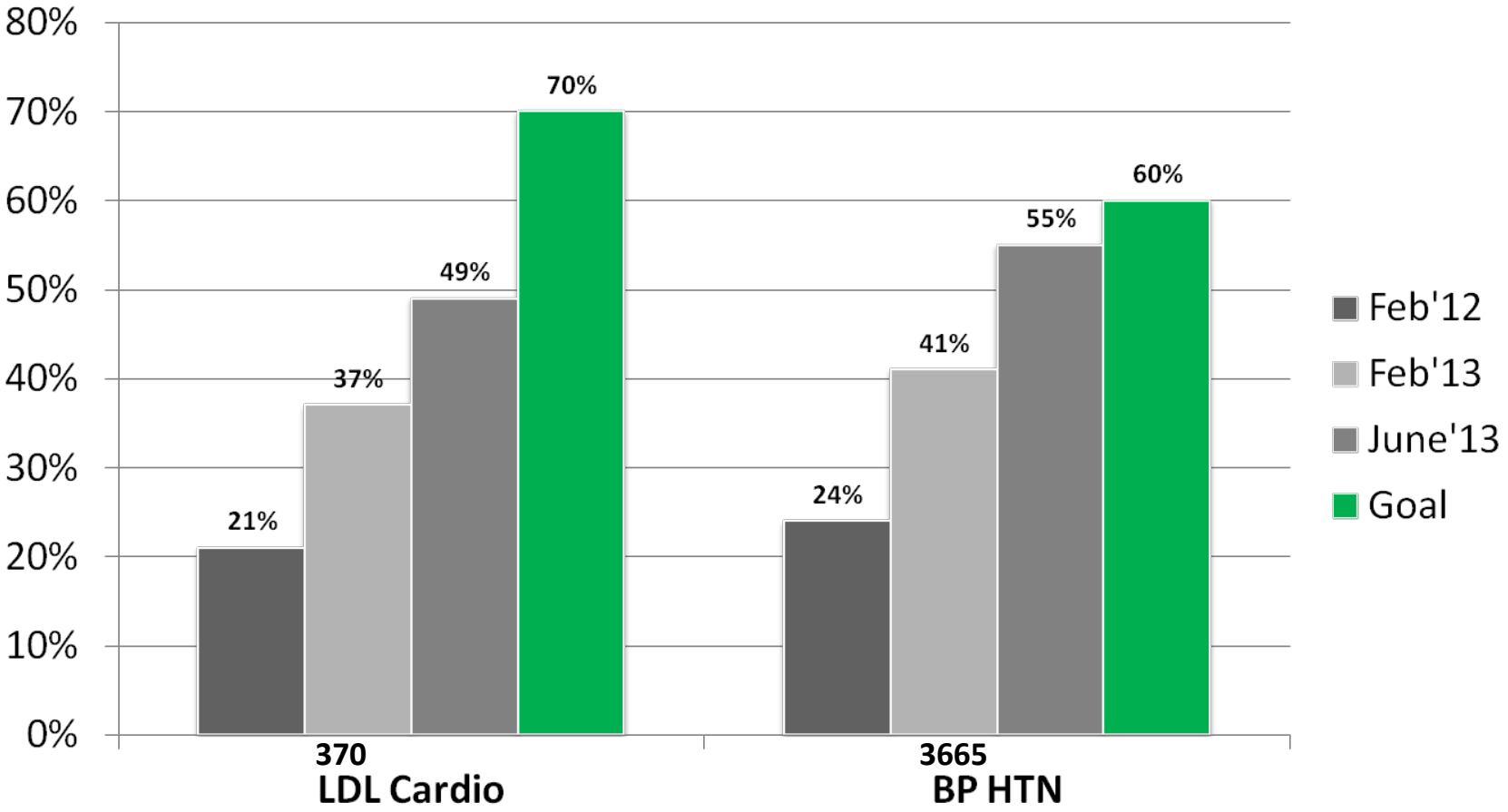
- Primary Behavioral Health Care Initiative [PBHCI]
- 200+ CMHC's in US over 8 years.
  - Co-location of primary care
  - Use of registry
  - Care management
  - Health Behavior change
- It takes more than this!



A Successful Integration Strategy – Missouri Health Homes Overview

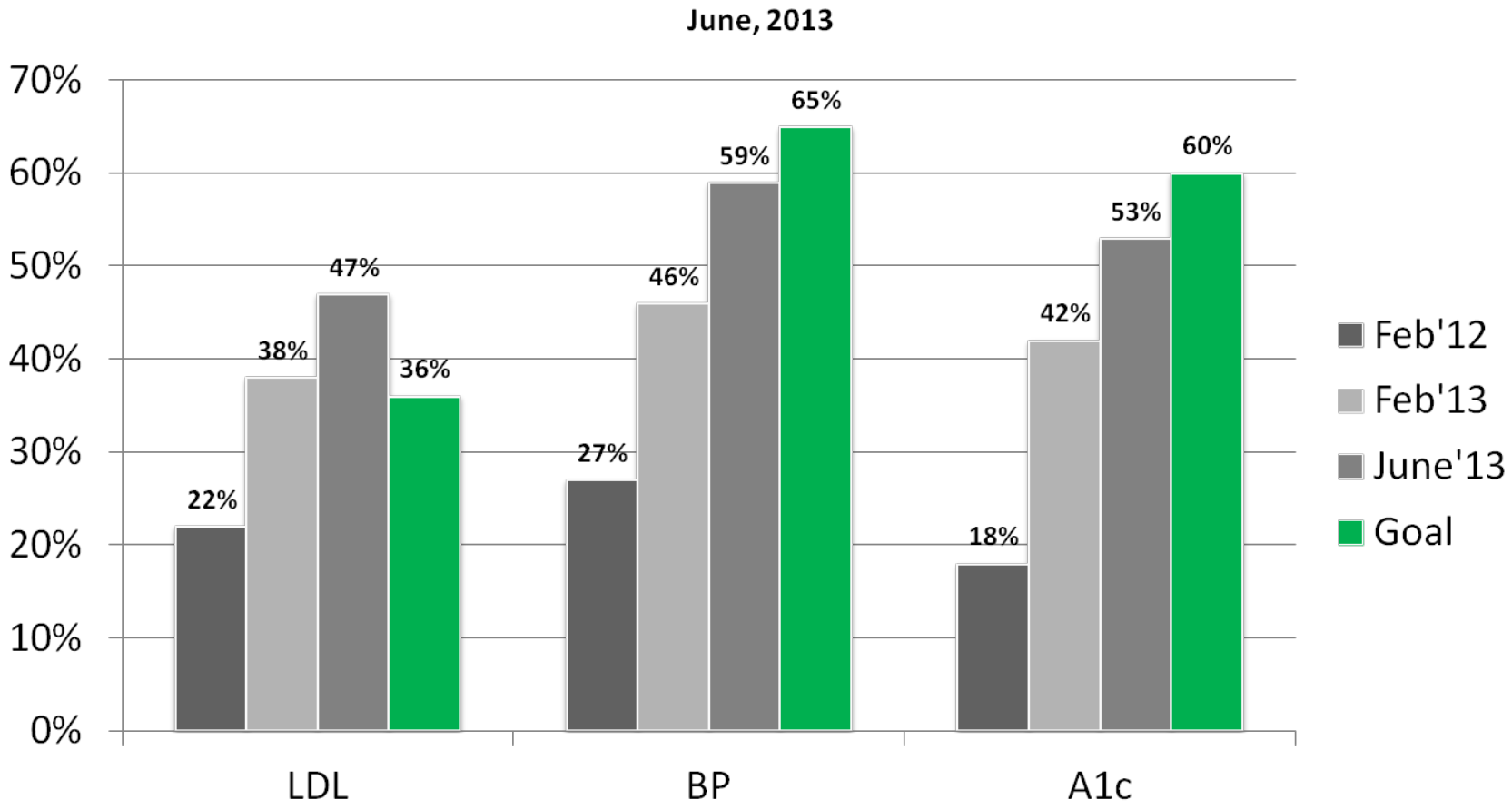
- **Strategies: Case management coordination and facilitation of healthcare**
- Primary Care Nurse Care Managers
- Disease management for persons with complex chronic medical conditions, SMI, or both
- Behavioral health management and behavior modification as related to chronic disease management for 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

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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)

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Promising Practice

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FRONTIER BEHAVIORAL HEALTH

Background

- Geographic region served
- Formed through merger
- Size and scope
- Health Homes provider

Primary healthcare providers in community and partnerships formed

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Integration Story #1: Onsite Primary Care

- Small clinic on main campus
- Two FQHC's
- Patients not connected or not active
- Refer (if not enrolled)
- Coordinated appointment scheduling
- MHCP participation
- Serve several hundred clients

Integration Story #1: Onsite primary care

- Assigned ≠ engaged
- Don't screen out based on "severity"
- Can't make it too difficult to refer
- Not all patients desire one-stop shopping
- Need to be flexible with model

Integration Story #2: Coordination with Pediatric Clinic

- The way it has worked historically
- What we are implementing
- When a referral is made, provider is notified:
  - Once intake completed
  - Once first appointment with clinician occurs
  - Primary diagnosis; care plan if desired
  - Referral to prescriber
  - Kept appointment with prescriber and Rx

Integration Story 3: Deeper Dive with One FQHC

- Shared access to records
  - What we didn't want
  - What we put into place
- Care connectors
  - The way it works
  - Piloted at one site
- Care transitions
  - Patients at our E&T's
  - Patients ending care with FBH
- Onsite intake assessments
  - Coming soon

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Challenges, Barriers and Lessons

- ~~Payment~~ for consultations
- ~~Payment~~ for care coordination for less severe patients
- Health Homes care coordination rates
- Medicaid enrollees changing plans and providers
- Medicare rates
- 42 CFR limitations
- Provider time constraints
- **Integration requires strong shared commitment**
- **Need for an internal champion!**

next steps

- Development of population-based strategies using patient registries
- Development of shared clinical protocols based on risk indicators
- Enhanced tracking of outcomes
- Seamless client experience
- ***Pathways to Wellness*** Program
- Expand and grow partnerships with others

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Promising Practice

Comprehensive HEALTHCARE

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President/CEO, Comprehensive Healthcare

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Background

- Comprehensive Healthcare is a non-profit behavioral health provider serving eastern Washington since 1972.
- We provide services in 10 counties and have some services that draw from the entire state.
- We provide a very broad continuum of mental health, SUD, social service and integrated care activities.

Integration History and Services

- Our integration efforts began in the early 1990s – bringing primary care into residential and office locations.
- Ten years ago – began bringing behavioral health staff into primary care clinics.
- These models were about access but weren't terribly integrated.

Integration History and Services

Within the last ten years we have established many other integrated activities through partnerships:

- Behavioral health specialist (BHS) embedded in primary care (multiple models)
- BHS addressing the behavioral aspects of physical conditions
- BHS embedded in ERs
- Care coordination and Health Homes
- ACO participation

Description of Integration Strategies

- Improve access to needed care - bring care to where the population is. Reaching populations not already seen or serving them better.

- Achieve reductions in high cost care in both behavioral and physical health – timely and effective behavioral health treatment and/or coaching reduces medical costs. Good physical health reduces utilization of high cost behavioral health interventions.

- Opportunities for value-based and outcome based contracting – risk/gain sharing for health outcomes in a behavioral health population, broader capitation.

Description of Integration Strategies

- Improved health outcomes for a population that has significantly poorer health outcomes – measurable changes in health/behavioral health status

- Applying behavioral health skill sets to improve broader health outcomes – boots-on-the-ground care coordination

Success Stories

- BHS in an internal medicine clinic
  - Diabetes and depression populations
  - Statistically significant improvement in A1c, PSQ-9, and patient activation (PAM)

- Boots-on-the-ground care coordination immediately post-hospital for a high cost population with many different types of conditions, some behavioral health and most with other conditions
  - Increased compliance with follow-up appts. with PCP and specialist and with medication possession
  - Reduced ER, re-hospitalization

Challenges and Barriers

- Work force
- Training
  - Hard to teach old dogs new tricks
  - Lack of funding increases pressure to throw people into the fire
- Difficulty in making the money work in a fee-for-service environment
- Poor intersection between billing codes and documentation requirements
- Partnerships work better but are harder work

Lessons Learned: Opportunities for Improvement

- You must have champions in both behavioral health and primary care.
- Newly-trained BHS staff work better than long-term therapists.
- Up-front training time is critical – don't rush it.
- Build in connection time for both BH and primary care staff to have connections with partner organizations.
- Data have many purposes and help cement the work – funding, celebrating success, addressing problems, etc.

Future Planning: Next Steps

- More formal on-boarding and training
- Better EHR and data interfaces
  - Improve workflows
  - Reduce duplication
  - Quicker responses to problems
- Telepsych consultation to rural clinics
- Registries
- EDIE system-wide
- Adaptation of models to better address small and rural clinics

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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