STRATEGIES FOR BEHAVIORAL HEALTH INTEGRATION

THE PMS JOURNEY

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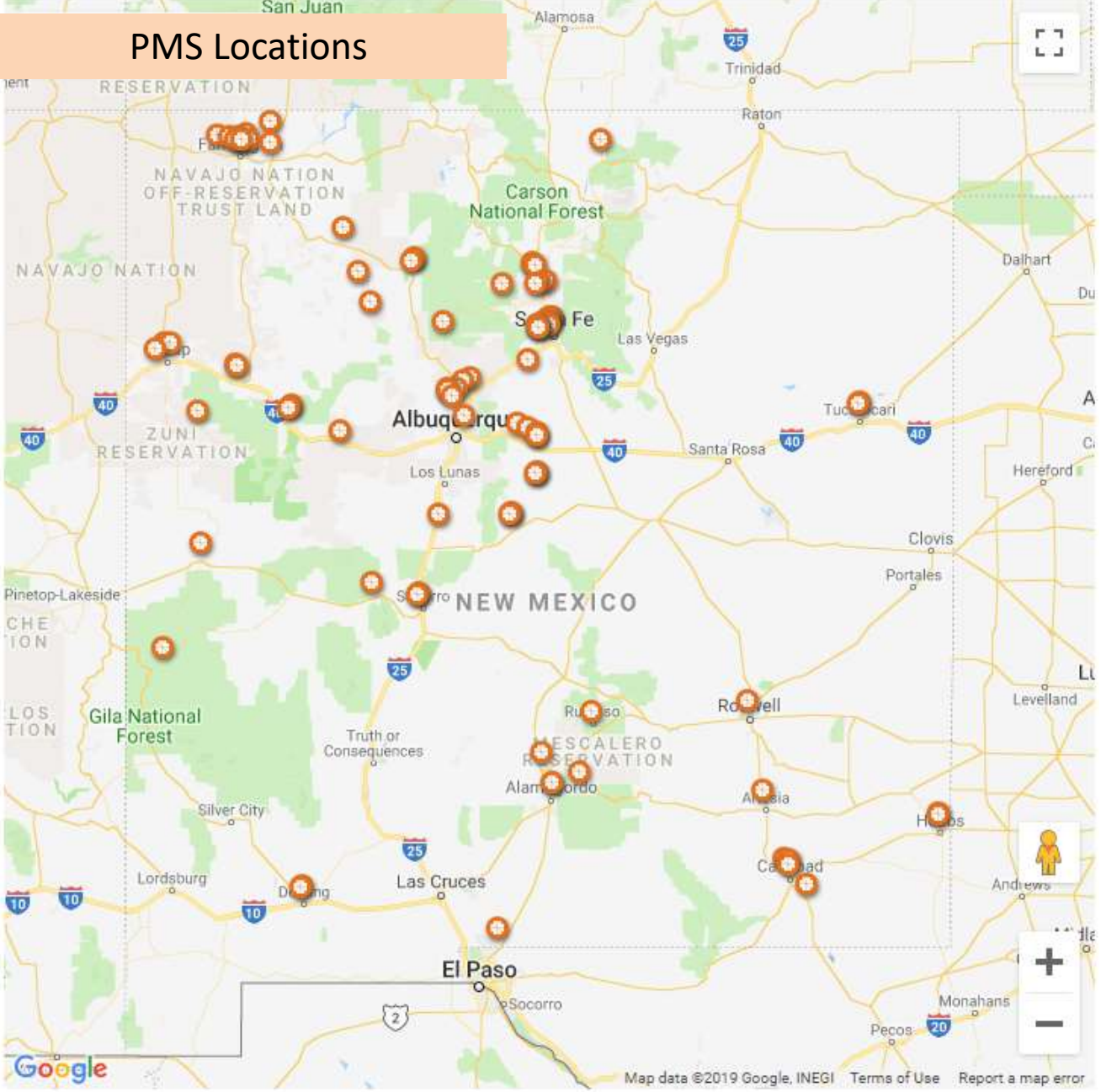
PMS Locations



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HISTORY OF BH IN PMS

- Started providing BH services within an FQHC in 1986
- Slow growth throughout 90s early 2000s
- CMHC services focus
- Co-location focus
- Minor “integration” with Medical Staff
- 340,0000 Total Visits 2015
- 120,000 BH visits 2015

CHALLENGES

- Lack of a defined integration with Medical Providers
- Inconsistent Referral Partners
- Limited Professional Staff

2016 Strategic Initiative – Improve BH integration

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DESIGNING STRATEGY

- Understand your patient population
  - SMI, SED panel
  - SUD panel
  - Co-occurring panel
- Understanding financial models
  - VBP arrangements
  - CMS/State Plan options
- Understand your available resources
  - Existing personnel
  - Community partners
- Comprehensive plan
  - “Go-it-alone”, partner and/or acquire
  - Population specific or generalized
  - Evidence-based model(s)
  - Performance measurement

One in 5 adults experiences a mental health condition every year. One in 17 lives with a serious mental illness such as schizophrenia or bipolar disorder.

Half of mental health conditions begin by age 14, and 75% of mental health conditions develop by age 24.

- National Alliance on Mental Illness

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DEFINING INTEGRATED CARE…….

As is typical, there are numerous definitions and several models……

The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

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Lexicon for Behavioral Health and Primary Care Integration

Concepts and Definitions Developed by Expert Consensus

AHRQ
Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

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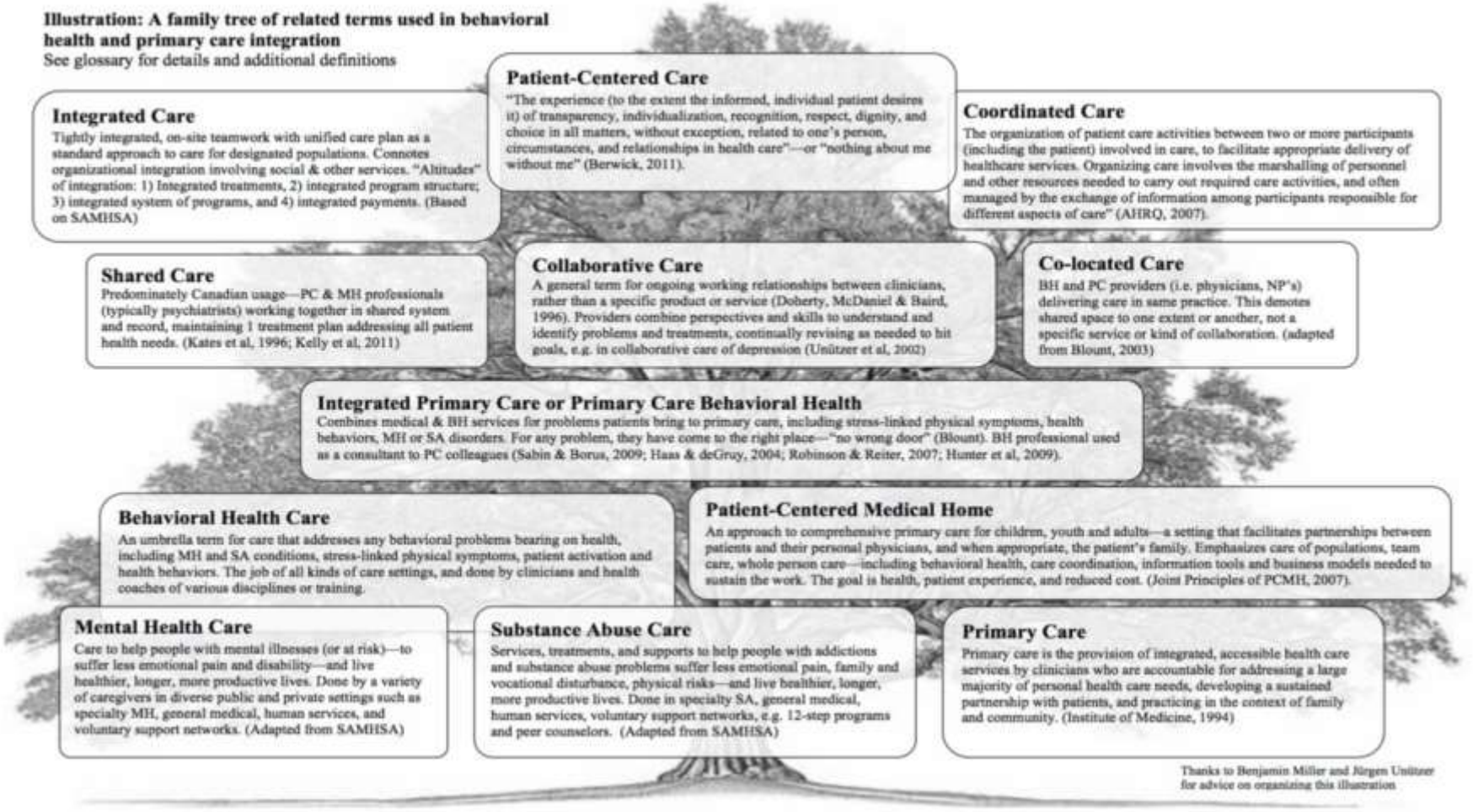
DEFINING INTEGRATED CARE…….



From: Peek CJ and the National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Integration: AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013. Available at http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf

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The solution lies in integrated care, the systematic coordination of general and behavioral healthcare. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.

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The National Council- Four Quadrant

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Integrated Care combines primary health care and mental health care in one setting. There are many ways to integrate care, and they may go by different names, including “Collaborative Care” or "Health Homes."

Providing Integrated Care helps patients and their providers. It blends the expertise of mental health, substance use, and primary care clinicians, with feedback from patients and their caregivers. This creates a team-based approach where mental health care and general medical care are offered in the same setting. Coordinating primary care and mental health care in this way can help address the physical health problems of people with serious mental illnesses

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World Health Organization

Box 2.1 **10 principles for integrating mental health into primary care**

1. Policy and plans need to incorporate primary care for mental health.
2. Advocacy is required to shift attitudes and behaviour.
3. Adequate training of primary care workers is required.
4. Primary care tasks must be limited and doable.
5. Specialist mental health professionals and facilities must be available to support primary care.
6. Patients must have access to essential psychotropic medications in primary care.
7. Integration is a process, not an event.
8. A mental health service coordinator is crucial.
9. Collaboration with other government non-health sectors, nongovernmental organizations, village and community health workers, and volunteers is required.
10. Financial and human resources are needed.

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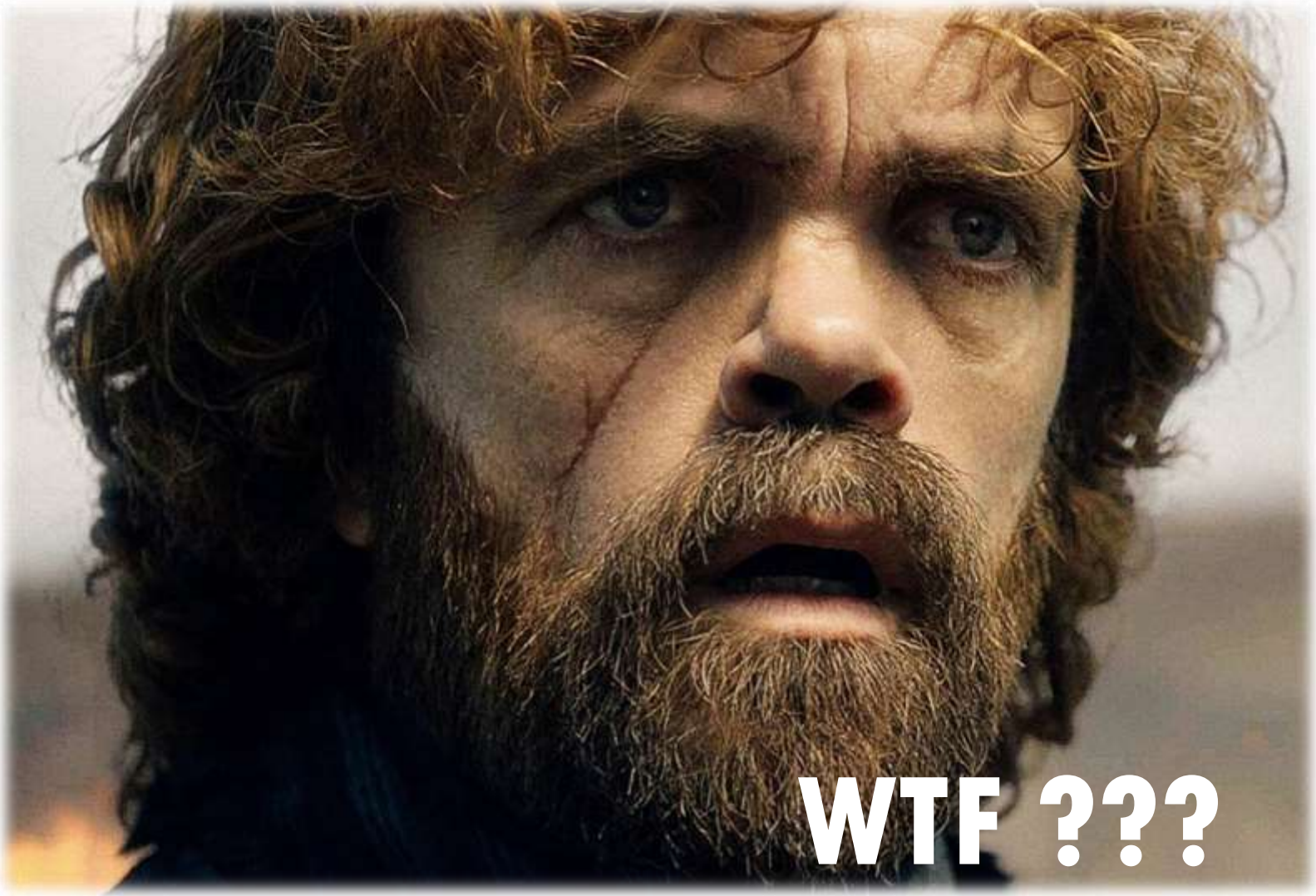

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FINANCIAL IMPLICATIONS

WHAT WE KNOW

- 45k Medicaid Lives
- Top 5% utilizers
  - NICU
  - Cancer
  - **Co-occurring**

Most common in top utilizers:

- Alcohol abuse
- Opioid abuse
- Depressive Disorders
- Bipolar and Related Disorders

	Diagnoses	Total (104)
T31.11	Burns involving 10-19% of body surface with 10-19% third deg	
T31.11	Burns of 10-19% of body surface w 10-19% third degree burns	
R52	Pain management	
R52	Pain, unspecified	
Z59.5	Extreme poverty	
F10.20	Alcohol dependence, uncomplicated	
R41.82	Altered mental status, unspecified	
T50.994A	Poisoning by oth drug/meds/biol subst, undetermined, init	
T50.904A	Poisoning by unsp drug/meds/biol subst, undetermined, init	
Z74.3	Need for continuous supervision	
X02.8XXD	Oth exposure to controlled fire in bldg, subs	
E11.65	Type 2 diabetes mellitus with hyperglycemia	
T20.00XD	Burn of unsp degree of head, face, and neck, unsp site, subs	
T21.02XD	Burn of unspecified degree of abdominal wall, subs encntr	
T21.01XD	Burn of unspecified degree of chest wall, subs encntr	

51 y/o female, dx ALSO include:
F31.32 Bipolar I
F43.01 PTSD

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MODEL DESIGN

SBIRT

Goal: To identify appropriate patients and provide early intervention for substance use and co-occurring mental health disorders

Screening	NM Healthy Lifestyle Questionnaire (PHQ2/9) 13 Qs Screens for Depression, Anxiety, PTSD, Alcohol and SUD SDOH, ACE Use of Telehealth in Frontier Areas
Brief **I**ntervention	Licensed / Peer / CHW
Referral to **T**reatment	**Internal to PMS (CMHC environment)**

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MODEL DESIGN

Integrated Teams –

- Morning Huddle / Treatment planning
- Population Health - Patient Profile (Gaps, Risk Strat)
- Interdisciplinary Team Meetings
- Shared Medical Record
- BH Interventionist embedded in Medical Pod 1:4/ 1: Dental site
- Evidence based practices (ACT, MST, CBT,CRA, MAT)
- Care Coordinator assigned based on defined Cohorts
- CHW Support link patient to services and RT
- CLNM Health Home

Training – **All** Team Members (Medical, Dental and Administrative)

- PMS Clinical Services Orientation
- Motivational Interviewing
- Mental Health First Aide
- Crisis Prevention Institute Training

Communication –

- Morning huddles and IDT meetings provide updates on RT's.
- E.H.R. Tasking (Bi-Directional Tasking)

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IMPLEMENTATION STRATEGY

- Acquire Through Merger or Asset Purchase / Acquisition Stand Alone CMHCs
  - Add Medical Services within Facility
  - Implement SBIRT with existing CMHC staff
  - Progress to date – 7 CMHC Acquisitions (2015-2019)

- Implement SBIRT at Existing PMS locations
  - 10 Locations with CMHC services SBIRT complete or in progress

- Refine Data and Analytics to capture outcome data within CMHC environment (Evidence based practices) and Medical BH.

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MEASURING PERFORMANCE

OBJECTIVE DATA/PATIENT OUTCOMES

Utilization

- Avoidable ED/Admits
- TCC (Percent of Premium)

Standardized screening/assessments

- PHQ 9
- CAGE AID
- Healthy Lifestyles Questionnaire

Softer data but meaningful

- Recovery, including harm-reduction
  - Using less
  - Reduction in self-harm
  - Reduction in risky behavior
  - Increased activity level
  - Housing/employment

Quality Measures

Antidepressant Medication Adherence

7 & 30 day follow up from Hospitalization

Initiation & Engagement of Alcohol and Other Drug Abuse Treatment

MEASURING PERFORMANCE

OBJECTIVE DATA/PATIENT OUTCOMES

Quality Measures	Medical	CMHC
Antidepressant Medication Adherence	X	X
7 & 30 day follow up from Hospitalization	X	X
Initiation & Engagement of Alcohol and Other Drug Abuse Treatment		X
PHQ 9	X	X
CAGE AID		X
Healthy Lifestyle Questionnaire (GAD/PTSD/SU)	X	
GAD-7		X
ACE		X
Housing/MAT	X	X
Employment/MAT	X	X
Incarceration/MAT	X	X

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