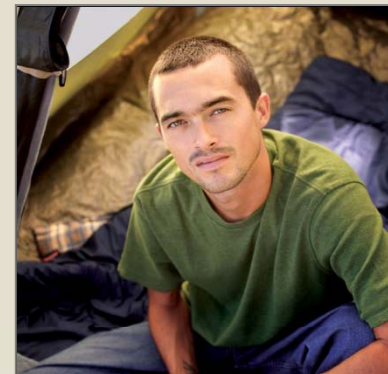




What Works for the Neediest: Lessons from Initiatives Targeting Vulnerable Populations – Serious Mental Illness

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Overview

- Reasons and Goals for Collaborative Care
- Four Quadrant Planning Model/Clinical Models
- Emerging Practice/Financing Models
- What Funders Can Do



National Council Goals for Collaborative Care

- The safety net population in every community served by providers of public behavioral health services and by community health centers has seamless access to both behavioral and physical healthcare.
- There is a strong working partnership among these providers, with roles defined, referral protocols in place, and cross-placement of clinical staff.



- > 49% of Medicaid beneficiaries with disabilities have a psychiatric illness

Exhibit 7: Frequency of Diagnostic Dyads by Cost among Medicaid-only Beneficiaries with Disabilities, 2002, CDPS + Rx Data*

Diagnosis 1	Diagnosis 2	Frequency among all beneficiaries	Frequency among most expensive 5%
Psychiatric	Cardiovascular	24.5%	40.4%
Psychiatric	Central Nervous System	18.9%	39.8%
Cardiovascular	Pulmonary	12.5%	34.3%
Cardiovascular	Central Nervous System	13.1%	32.9%
Psychiatric	Pulmonary	11.2%	28.6%
Cardiovascular	Gastrointestinal	10.2%	27.8%
Central Nervous System	Pulmonary	7.0%	26.2%
Cardiovascular	Renal	7.1%	24.6%
Pulmonary	Gastrointestinal	5.9%	24.2%
Psychiatric	Gastrointestinal	9.5%	24.0%

The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions
Center for Health Care Strategies, Inc., October 2009



Primary Care and Behavioral Health

- Most PCPs do a good job of diagnosing and beginning treatment for depression (Annals of Internal Medicine, 9/07)
 - 1,131 patients in 45 primary care practices across 13 states
- PCPs did less well following up with treatment over time—less than half of patients completed a minimal course of medications or psychotherapy
- Lowest quality of care occurred among those with the most serious symptoms, including those with evidence of suicide or substance use
- “Right now PCPs don’t have the tools necessary to decide which patients to treat and which to refer on to specialized MH care”



Morbidity and Mortality in People with Serious Mental Illness

- Persons with serious mental illness (SMI) are dying *25 years earlier than the general population*
- While suicide and injury account for about 30-40% of excess mortality, 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases



Morbidity and Mortality-SMI

> *Higher rates of modifiable risk factors:*

- Smoking
- Alcohol consumption
- Poor nutrition / obesity
- Lack of exercise
- “Unsafe” sexual behavior
- IV drug use
- Residence in group care facilities and homeless shelters

> *Vulnerability due to higher rates of:*

- Homelessness
- Victimization / trauma
- Unemployment
- Poverty
- Incarceration
- Social isolation



Levels of Integration

Function	Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration On-Site	Close Collaboration/Partly Integrated	Fully Integrated/Merged
THE CONSUMER and STAFF PERSPECTIVE/EXPERIENCE					
Access	Two front doors; consumers go to separate sites and organizations for services	Two front doors; cross system conversations on individual cases with signed releases of information	Separate reception, but accessible at same site; easier collaboration at time of service	Same reception; some joint service provided with two providers with some overlap	One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model
Services	Separate and distinct services and treatment plans; two physicians prescribing	Separate and distinct services with occasional sharing of treatment plans for Q4 consumers	Two physicians prescribing with consultation; two treatment plans but routine sharing on individual plans, probably in all quadrants;	Q1 and Q3 one physician prescribing, with consultation; Q2 & 4 two physicians prescribing some treatment plan integration, but not consistently with all consumers	One treatment plan with all consumers, one site for all services; ongoing consultation and involvement in services; one physician prescribing for Q1, 2, 3, and some 4; two physicians for some Q4: one set of lab work
Funding	Separate systems and funding sources, no sharing of resources	Separate funding systems; both may contribute to one project	Separate funding, but sharing of some on-site expenses	Separate funding with shared on-site expenses, shared staffing costs and infrastructure	Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility
Governance	Separate systems with little of no collaboration; consumer is left to navigate the chasm	Two governing Boards; line staff work together on individual cases	Two governing Boards with Executive Director collaboration on services for groups of consumers, probably Q4	Two governing Boards that meet together periodically to discuss mutual issues	One Board with equal representation from each partner
EBP	Individual EBP's implemented in each system;	Two providers, some sharing of information but responsibility for care cited in one clinic or the other	Some sharing of EBP's around high utilizers (Q4) ; some sharing of knowledge across disciplines	Sharing of EBP's across systems; joint monitoring of health conditions for more quadrants	EBP's like PHQ9; IDDT, diabetes management; cardiac care provider across populations in all quadrants
Data	Separate systems, often paper based, little if any sharing of data	Separate data sets, some discussion with each other of what data shares	Separate data sets; some collaboration on individual cases	Separate data sets, some collaboration around some individual cases; maybe some aggregate data sharing on population groups	Fully integrated, (electronic) health record with information available to all practitioners on need to know basis; data collection from one source



Where Should Care Be Delivered?

Stepped Care

- There is always a boundary between primary care and specialty care.
- There will always be tradeoffs between the benefits of specialty expertise and of integration
- *Stepped care* is a clinical approach to assure that the need for a changing level of care is addressed appropriately for each person—a person may begin receiving services in Q I and need specialty MH/SA services (Q II) or specialty medical services (Q III)



The Four Quadrant Clinical Integration Model





Models/Strategies – Bi-Directional Integration

Behavioral Health –Disease Specific

- IMPACT
- RWJ
- MacArthur Foundation
- Diamond Project
- Hogg Foundation for Mental Health
- Primary Behavioral Healthcare Integration Grantees

Behavioral Health - Systemic Approaches

- Cherokee Health System
- Washtenaw Community Health Organization
- American Association of Pediatrics - Toolkit
- Collaborative Health Care Association
- Health Navigator Training

Physical Health

- TEAMcare
- Diabetes (American Diabetes Assoc)
- Heart Disease
- Integrated Behavioral Health Project – California – FQHCs Integration
- Maine Health Access Foundation – FQHC/CMHC Partnerships
- Virginia Healthcare Foundation – Pharmacy Management
- PCARE – Care Management

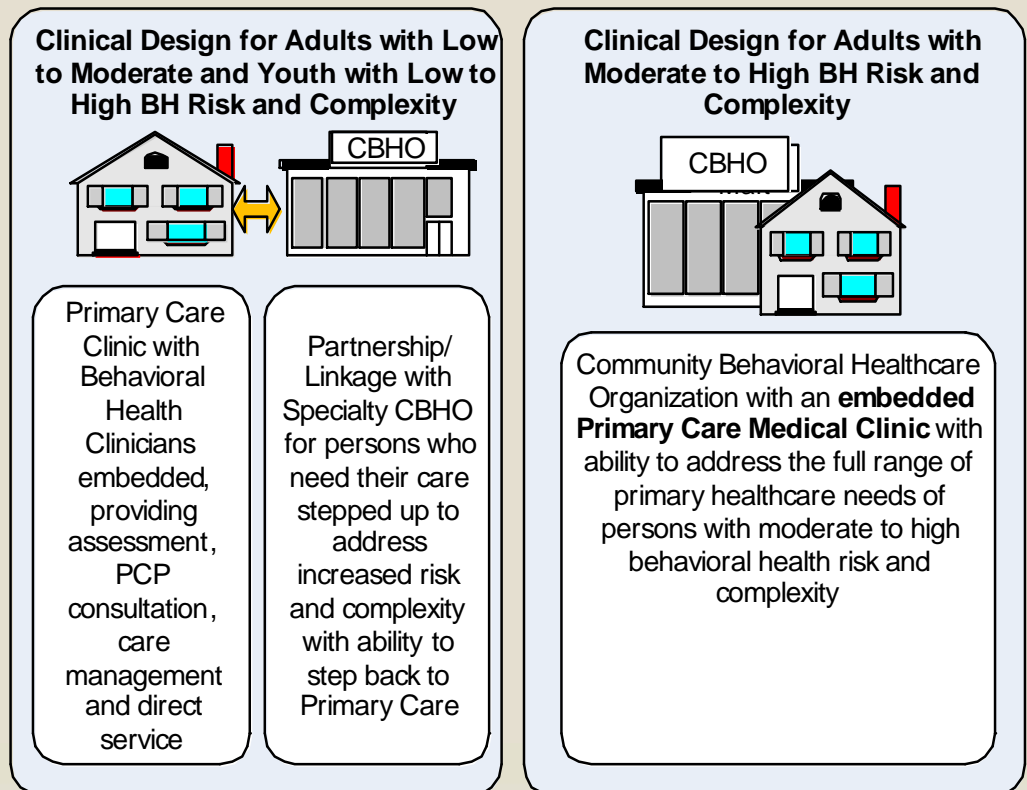
Consumer Involvement

- HARP – Stanford
- Health and Wellness Screening – New Jersey (Peggy Swarbrick)
- Peer Support (Larry Fricks)



New Paradigm – Primary Care in Behavioral Health Organizations

Funding starting to open up for embedding primary medical care into CBHOs, a critical component of meeting the needs of adults with serious mental illness





What is ACA Section 2703?

Goal: enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons across the lifespan with chronic illness

CMS expects that use of the health home service delivery model will result in

- lowered rates of emergency room use,
- reduction in hospital admissions and re-admissions,
- reduction in health care costs,
- less reliance on long-term care facilities, and
- improved experience of care and quality of care outcomes for the individual



Eligibility Criteria

- > To be eligible, individuals must have:
 - Two or more chronic conditions, OR
 - One condition and the risk of developing another, OR
 - **At least one serious and persistent mental health condition**
- > The ***chronic conditions*** listed in statute **include a mental health condition, a substance abuse disorder**, asthma, diabetes, heart disease, and obesity (as evidenced by a BMI of > 25).
- > States may add other conditions subject to approval by CMS



Health Home Services

- > 90% Federal match rate for the following services during the first 8 fiscal year quarters when the program is in effect:
 - Comprehensive care management
 - Care coordination and health promotion
 - Comprehensive transitional care from inpatient to other settings
 - Patient and family support
 - Referral to community and social support services

How does health IT support these activities?



States to Date....

- > 6 States with approved State Plans:
 - Missouri (2) – Behavioral Health and Primary Care
 - Rhode Island (2) – adults and children with SMI
 - New York – chronic behavioral and physical health
 - North Carolina - chronic behavioral and physical health
 - Oregon - chronic behavioral and physical health
 - Iowa - chronic behavioral and physical health
 - Ohio – children and adults with SED and SMI

- > 4 states have submitted State Plans and await approval:
 - Alabama, Wisconsin, New York*, Washington

- > 12 states are in proposal drafting/review process:



Behavioral Health Homes For People With Mental Health & Substance Use Conditions: The Core Clinical Features

http://www.integration.samhsa.gov/clinical-practice/CIHS_Health_Homes_Core_Clinical_Features.pdf



The challenge

- > To create a behavioral health home capable of functioning effectively at ***both*** the administrative and ***clinical*** levels
 - How to improve outcomes for people with MH and SU conditions in a behavioral health-based health home



Redesigning care to serve as health home

> Core elements of the Chronic Care Model:

- Self-management support
- Delivery system design
- Decision support
- Clinical information systems
- Community linkages



Research Review of Health Promotion Programs for People with Serious Mental Illness

<http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>



Conclusions: The Bottom Line

- ***Both*** obesity and poor fitness are killers
- Changing health behaviors is HARD work but essential to improving health and life expectancy
- The best studies demonstrate modest results in reducing obesity but better results in improving fitness



Conclusions: The Bottom Line

- What works better? Intensive manualized programs that combine coached physical activity and dietary change lasting at least 6 months (or more).
- Clinically significant weight loss is likely to be achieved by some, but improved fitness by more..... both are important for heart health.



Conclusions: The Bottom Line

- Integrated health promotion interventions are feasible as a core component of mental health services for persons with SMI.
- Reducing obesity and improving fitness in adults with SMI is *challenging* but possible, and requires a multi-component, intensive, **evidence-based** approach.
- Successful implementation: leadership, culture change, fidelity, financing, training and TA.



What can Health Foundations do to Help?

- > Health Home Capacity Building
 - Care management
 - Health IT
- > Support local experimentation. Relationship and project development between Behavioral Health organizations and
 - Community Health Centers
 - Safety-net clinics and hospitals



Questions?

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