Integrated Primary and Behavioral Healthcare: The Future of Health Care

One Individual at a Time

www.nhsonline.org
The Need for Integrated Care

- Addressing behavioral health needs requires addressing other healthcare issues:

  - Individuals with Serious Mental Illness (SMI), on average, die 25 years earlier than the general population.

  - >60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases.

  - Second generation anti-psychotic medications are highly associated with weight gain, diabetes, dyslipidemia (abnormal cholesterol), and metabolic syndrome.
The Need for Integrated Care

- Untreated or undertreated

- Individuals with SMI - one of three top super utilizers of care (PA Healthcare Cost Containment Council)
  - Most co-morbid problems,
  - Greatest frequency of problems,
  - Highest complexity of problems,
  - Most severe problems, but
  - Receive the most fractured, inappropriate, and uncoordinated care.
# Health Care Changing to a New Paradigm

**TODAY**
- Treating Sickness/Episodic
- Fragmented Care
- Specialty Driven
- Isolated Patient Files
- Utilization Management
- Fee-for-Service
- Payment-for-Volume

**FUTURE**
- Managing Populations
- Collaborative Care
- Primary Care Driven
- Integrated Electronic Records
- Evidence-Based Practices
- Shared Risk/Reward
- Payment-for-Value
# Model for Highly Coordinated Collaborative Care

<table>
<thead>
<tr>
<th>Patient Centered Medical Homes</th>
<th>ACA 2703 Health Homes</th>
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<tbody>
<tr>
<td>Designed for everybody</td>
<td>Designed for eligible individuals with serious mental illness and/or specific chronic physical conditions</td>
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<tr>
<td>Primary care provider-led</td>
<td>Primary care provider is key, but not necessarily the lead</td>
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<tr>
<td>Primary care focused</td>
<td>Focused on linking primary care with behavioral health and long-term care</td>
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<tr>
<td>No enhanced federal Medicaid match</td>
<td>Eight-quarter 90 percent federal Medicaid match</td>
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<td>Significant increase in financial support to providers</td>
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Medical Home Payment Activity - Medicaid
Source: National Academy for State Health Policy

None
- Medical home activity, no payments to medical homes
- Payments to medical homes underway
ACA Section 2703 Health Home Activity

Source: National Academy for State Health Policy
Health Home Services Per ACA:

- Comprehensive care management
- Care coordination
- Health promotion and illness prevention
- Comprehensive transitional care/follow-up
- Patient and family support
- Referral to community and social support services
- Team delivered care
  (above services supported through electronic information sharing)
Guiding Principle of Health Care Reform - CMS Triple Aim:

- Improved quality of care
- Improved outcomes of care
- Reduced cost of care
Evidence of Success in Health Home Implementation
Missouri CMHC Healthcare Homes Progress Report 2012-2015

Metabolic Screening Rates
Blood Pressure Control
Good LDL Cholesterol Levels
72-hour Hospitalization Follow-Up Rates

Average Number of Hospitalizations
Average Number of ER Visits
Reduced Cost of Care
Missouri CMHC Healthcare Homes Progress Report 2012-2015

- **Good Cholesterol (<100 mg/dL)**
  - Feb’12 Baseline: 22%
  - Feb’13 12 Months: 38%
  - June’13 18 Months: 47%
  - June’15 3.5 Years: 57%
  - Dec’15 current enrolled pop: 54%

- **Normal Blood Pressure (<140/90 mmHg)**
  - Feb’12 Baseline: 27%
  - Feb’13 12 Months: 46%
  - June’13 18 Months: 59%
  - June’15 3.5 Years: 73%
  - Dec’15 current enrolled pop: 72%

- **Normal Blood Sugar (A1c <8.0%)**
  - Feb’12 Baseline: 18%
  - Feb’13 12 Months: 27%
  - June’13 18 Months: 42%
  - June’15 3.5 Years: 53%
  - Dec’15 current enrolled pop: 61%
Missouri CMHC Healthcare Homes Progress Report 2012-2015
Psychiatric and Medical Hospitalizations

CMHC Health Homes January 1, 2012

Baseline Year 1 Year 2 Year 3

37% 30% 28% 23%

↓ 14%
Lessons Learned from States Medicaid Health Home Pilot Programs
Lessons Learned from States Medicaid Health Home Pilot Programs

- Make decision on how to credential Health Homes
  - Oklahoma developed its own criteria.
  - Other states identified credentialing organizations (e.g. CARF).

- Support Health Home providers to achieve cultural changes involved in service delivery transformation (e.g. technical assistance).

- Invest in real-time data availability to support effective care coordination.
Lessons Learned from States Medicaid Health Home Pilot Programs

- Target Health Home populations and Health Home options to achieve the greatest ROI and impact on outcomes which are the keys to sustainability.

- Changes in provider reimbursement methodology driven by state policy goals:
  - Deliver higher intensity services to individuals with more complex needs - Iowa tiered payment structure.
  - Strengthen Medicaid provider network - Missouri paid a fee to providers for training, technical assistance, and data management.
  - Payment specifically for outreach and engagement - New York
Lessons Learned from States Medicaid Health Home Pilot Programs

- States provided greater levels of payments to providers initially to assist with changes in processes, training, etc., and then shifted to shared savings or incentive payments once the initial period of structural change was completed.

- Health Home payments (bundled PMPM) for previously unreimbursed services - care coordination, team meetings, home visits, consultation, etc.

- Standardized payment methods and amounts for multi-payer Health Home initiatives
Lessons Learned from States Medicaid Health Home Pilot Programs

- Multi-payer collaboration in arriving at the same measures of performance, thus reducing the burden on providers for responding to a multiplicity of performance requirements and reporting.
Pennsylvania: Patient-centered Medical Home Advisory Council

- Established by 2014 Pennsylvania Patient-Centered Medical Home Advisory Council Act
- Under the Department of Human Services (DHS)

Purpose:

To advise DHS on how PA’s Medicaid program can improve the quality of care while containing costs through a Patient-Centered Medical Home (PCMH) model approach.
PCMH Requirements Per PCMHAC Act

- Improved access to care,
- Care coordination,
- Comprehensive care management,
- Access to medication and medication therapy management services,
- Illness prevention and wellness services,
- Use of Evidence Based Practices,
- Use of electronic medical records and electronic information sharing,
- Monitoring of health outcomes and performance.
Patient-centered Medical Home Advisory Council

Council was charged to recommend:

- Organizational model for the Pennsylvania PCMH system,
- Process to certify PCMHs through accrediting entities,
- Education and training standards for PCMH health care professionals,
- Performance measurement,
- Reimbursement methodology and incentives.
PCMHAC Recommendations

- The Council supports an integrated model of care - team based care (BH and PCP).

- Health Homes should focus on higher risk patients (SPMI/SUD) and individuals living with multiple, complex PH-BH conditions. This would be targeted population, and would include clinics for high-need, high-cost populations.

- Support Health Homes through payment reform that fits within a more outcome, value-based system.
PCMHAC Recommendations

- The Health Home will be primarily positioned in BH, but will reside in both PH and BH arenas, with patient choice driving where the health home is located.

- Medication reconciliation at care transitions and medication therapy management.

- Must have an interoperable EHR per ONC standards, with linkage to HIE and meaningful use of EHR.
PCMHAC Recommendations

- Outcome monitoring and evaluation are central to value-based contracting (See proposed metrics in handout.)
Continuum of Integrated Care
Continuum of Integrated Care

- **Level 1**: Minimal Collaboration - separate systems, separate facilities, rarely communicate.

- **Level 2**: Basic Collaboration at a Distance - separate systems, separate facilities, periodic communication about shared patients.

- **Level 3**: Basic Collaboration Onsite - MH & PC have separate systems but share facilities. Proximity supports more regular communication.
Continuum of Integrated Care

- **Level 4:** Close Collaboration in a Partly Integrated System - sharing of site, some systems in common, regular face-to-face interactions, coordinating Treatment Plans for difficult patients.

- **Level 5:** Close Collaboration Approaching an Integrated Practice - high levels of collaboration, MH and PCP beginning to function as a true team.

- **Level 6:** Full Collaboration in a Merged Practice - collaborative partners’ systems and functioning have become a merged practice. Single health record.
NHS Model of Integrated Care:

Level 4:

NHS Delaware County - co-located primary care practice with established patterns of collaboration, sharing of EHRs, clinical meetings for shared patients, mutual commitment to team process, collaborative effort of outcome monitoring with MCO.

Levels 5 and 6:

To be achieved through NHS SAMHSA PBHCl grant for primary and behavioral healthcare integration.
Setting and Population Characteristics for NHS Delaware County
NHS Delaware County

- Base Service Unit/Community Behavioral Health Center since the early 1970’s
- Serves the northern and eastern half of Delaware County
- Approximately 6,000 children, adults, and families participate in services annually
Population Served

➢ Demographics:
   61% -- White/Caucasian
   38% -- Black/African-American
   1% -- Asian

➢ 96% of services are reimbursed through publicly funded sources - Medicaid, Medicare, and County.

➢ Most common MH diagnoses - schizophrenia, bipolar disorder, major depressive disorders; D&A diagnoses - alcohol, cocaine, opiates
Target Population

- Individuals participating in NHS Delaware County behavioral health programs who have:
  - Serious and persistent mental illnesses and/or substance abuse disorders,
  - Chronic co-occurring physical illnesses or conditions, and
  - Highest total costs for physical and behavioral healthcare (participation in Blended Case Management as proxy for highest cost group).
Chronic Health Conditions:

- Diabetes
- Cardiovascular disease
- Chronic obstructive pulmonary disease (COPD)
  - Asthma
  - Chronic bronchitis
  - Emphysema
- Overweight (BMI > 25)
- Hepatitis C
- Tobacco use
NHS Delaware County

Behavioral Health Services provided:

- Mental Health Outpatient and Intensive Outpatient Program
- MH Blended Case Management
- Office-based Administrative Case Management
- Psychiatric Rehabilitation
- Supportive Employment
- Forensic Assertive Community Treatment Team
NHS Delaware County

- Behavioral Health Services Provided:
  - D&A Outpatient & Intensive Outpatient
  - D&A Intensive Case Management
  - Peer Support Services
  - Residential Programs
    - Long Term Structured Residence
    - Community Residential Rehabilitation Programs
Health Home Plus Co-located Primary Care and Pharmacy

- Primary Care Practice, Sharon Hill Medical, on-site utilizing primary care office suite at NHS Delaware County (800 Chester Pike, Sharon Hill, PA)

- On-site pharmacy - Life Tree Pharmacy
Co-located Primary Care

- Sharon Hill Medical
  - History of providing treatment/services for individuals with chronic illness conditions,
  - History of serving individuals in poverty and insured through publicly funded means - Medicaid, Medicare, etc.
  - Invested in developing integrated primary and behavioral healthcare.
On-site Pharmacy Services

- Life Tree Pharmacy services available to all participants
- Coordination of medication therapy with prescribers and other professional staff
- Immediate medication prescriptions fills
- Medication therapy adherence monitoring
- Medication Therapy Management services
Staffing of Integrated Care Model

- Health Home Team consists of:
  - Participating individuals
  - Psychiatrists
  - Primary care professional staff
  - Nurse Navigators (Registered Nurse on each Adult BCM team or RNs in Outpatient program)
  - Care Managers (Blended Case Managers)
  - Peer Wellness Coaches
  - InSHAPE Health Mentors (fitness trainers)
Staffing of Primary Care
Sharon Hill Medical

- Primary care staff on-site at NHS 5 days/week
- Medical Director - family practice physician
- Certified Registered Nurse Practitioner
- Medical Assistant
NHS Health Home Services
NHS Health Home Services

Tasks of Registered Nurse on Adult BCM teams:

- Assist in the comprehensive care plan development for all participating individuals
- Closely coordinate with the Sharon Hill Medical Group or other primary care practice
- Develop, monitor, and plan care based on illness management registries of participating individuals
- Consult with BCM staff about identified health conditions of individuals served by the team
- Provide smoking cessation 10 week sessions 4x/year
Tasks of Registered Nurse on Adult BCM teams:

- Assist in contacting medical providers and hospitals for admission/discharge
- Provide illness self-management, wellness, and prevention education for participating individuals
- Provide training to Adult BCM staff on medical diseases, treatments, medications and wellness and prevention strategies for general conditions and for specific individuals
- Track required assessments and screenings
- Facilitate health education groups
Tasks of Adult Blended Case Managers:

- Identification and engagement of individuals with poorly managed chronic illness conditions
- Individualized comprehensive care planning with the individual
- Monitoring of health status and treatment adherence
- Coordination with the individuals, caregivers and providers
- Promoting individual illness self-management
Tasks of Adult Blended Case Managers:

- Assuring that individuals receive the preventive and primary care they need
- Assisting individuals in managing their chronic illnesses and accessing needed community and social supports
- Providing connections to health and wellness education and opportunities for practicing wellness skills in the community
Tasks of Peer Wellness Coaches:

- Helping individuals in recovery identify personal reasons for pursuing wellness
- Facilitating Whole Health Action Management groups
- Modeling illness self-management skills
- Coaching and supporting the development of wellness skills
- Connecting individuals to peer and wellness resources in the community
Tasks of Health Mentors (personal fitness trainers):

• Assist in identifying individual wellness goals

• Assist in creating a plan to meet individual objectives to accomplish stated goals

• Provide fitness training in exercise and nutrition

• Provide guidance in use of YMCA facility and equipment

• Provide support and participate in activities with member

• Track and document participant progress
Integrating Care
Integrating Care

- NHS/PCP leadership team meets every other week.
- NHS supervisors trained in integrated care
- NHS case managers trained as care managers
- NHS nurse navigators on each Adult BCM team
Integrating Care

- Weekly care coordination meeting
- Nurse navigator & PCP clinical conferences
- Shared access to EHRs for those mutually served
- PCP attending MH team meetings
- Psychiatrist and PCP consultation
Integrating Care

- Pharmacy providing medications at time of visit
- Smoking cessation program
- InSHAPE program
- Lunch and learn sessions provided monthly
- Annual Health Fair open to community
Integrating Care

- Community-based primary care practices
- Nurse navigators key to communication
- Care coordination through Health Information Exchanges - NHS Delaware County is an early member of HealthShare Exchange of Southeastern Pennsylvania.
Role of MCO in Integration Effort

- Magellan Behavioral Health
  - Supportive of effort throughout
  - Agreed to expansion of nurse navigator staffing
  - Worked with NHS to develop psychiatric consultation procedure code and reimbursement rate
  - Conducting the analysis of hospitalization rates as an outcome indicator for the health home
Outcomes
Program Monitoring and Evaluation

- Improved Chronic Care Delivery for Individuals with Mental Illnesses:
  - Percent of individuals diagnosed with schizophrenia or bipolar disorder, who were dispensed any antipsychotic medication and had a diabetes screening - 92%. Bchmk = 76.9%
  - Percent of individuals who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) - 73%. Bchmk = 52.9%

*2010 Medicaid Benchmarking Report on HEDIS indicators.
Program Monitoring and Evaluation

Improved number of Individuals with serious mental illness who receive preventative care:

- Percentage of individuals who received influenza immunization - 61%. (100% were offered influenza immunization). Benchmark = 60%*.

- Percentage of individuals who smoked or used tobacco who were advised to quit - 100%. Benchmark = 81%*.

- Percentage of individuals diagnosed with major depression, schizophrenia, schizoaffective, or bipolar disorder who had BMI documented - 100%. Benchmark = 75%.

*2010 Medicaid Benchmarking Report on HEDIS indicators.
Program Monitoring and Evaluation

➤ NHS Health Home outcome measures:

• Fewer hospital admissions - both physical health and mental health*

• Fewer hospital re-admissions*

• Follow-up after hospitalization for mental illness (within 7 days)*

• Reduced cost of care per member/month.

*Magellan is tracking these BH measures.
Challenges

- Training of staff—health care integration, motivational interviewing, behavioral activation, WHAM, Wellness Coaching, smoking cessation, etc.

- Staff turnover

- Patient engagement in integrated care dependent upon individual choice
Challenges

- Increasing number and percentage of enrollees who are tobacco-free
- Working with community-based primary care practices
- No focus as of yet on specialized integrated care model for children and youth
- Disparities in health care delivery and outcomes
Challenges

- Access to real-time data for care coordination
- Improving data technologies to facilitate population health management
- IT capability to meet health information exchange needs (NHS Delaware County is a member of HealthShare Exchange of Southeastern PA)
- Performance monitoring through identification and measurement of indicators
Sustainability

- Alternative payment arrangements that adequately reimburse for direct service delivery and for services that are not currently reimbursable but essential to integrated care (care coordination, care coordination team meetings, psychiatric consultation, engagement activities, improved data management, and data exchange capabilities, etc.)