

HEAL 9 Grantee Conference

Integrating Physical & Behavioral Health



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Albany, NY

County Role: NYS Mental Hygiene Law

- ❑ 57 counties and the City of New York each have a governmental manager whose statutory title is "*Director of Community Services*" (DCS)
 - local title: Commissioner, Executive Director, Director
- ❑ NYS Mental Hygiene Law(41.03)- the DCS is the Chief Executive Officer of the county's mental hygiene department
 - legal term-"local governmental unit" (LGU)

Fiscal Authority: NYS MHL

- The LGU is the local identifiable entity authorized to receive state aid for mental hygiene services from:
 - The NYS Office of Mental Health
 - The NYS Office of Alcoholism and Substance Abuse Services
 - The NYS Office for People with Developmental Disabilities

DCS Responsibilities: NYS MHL

- Effective direction & administration of a local comprehensive service system for persons in the county who need mental health, alcohol & substance abuse, and developmental disabilities services
 - Local comprehensive planning in all three disability areas
 - Supervision & program monitoring of local services and facilities in the county
 - Contracting with services providers-Some counties directly operate mental health &/or alcohol& substance services

Monroe County LGU

□ System Oversight

- Maintain Behavioral Health Community Database
- Conduct Medicaid Claims analyses, site visits

□ Cross System Collaboration

- Social Services; Justice; Education
- Collaboration with FLHSA
 - Low Acuity ED Use Work Group
 - Transitions Coaching Sub Group
 - Payment Reform Workgroup

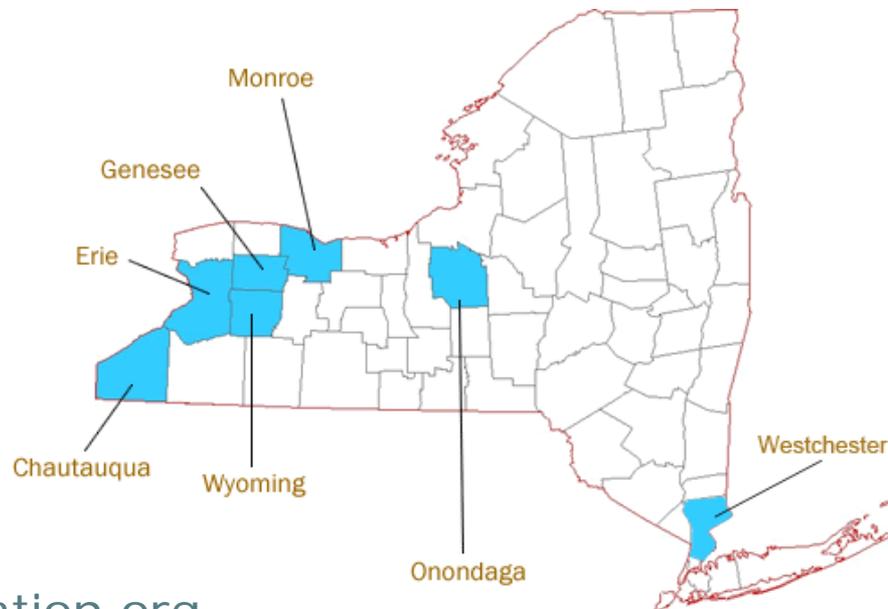
□ System Transformation

- Children's System of Care
- New York Care Coordination Program (NYCCP)

New York

CARE COORDINATION PROGRAM

Creating a person-centered, recovery-focused system of care



A unique, multi-county collaborative

- ❑ Seven-counties- 4 urban/3 rural
 - ❑ population-3.3 million
 - ❑ enrollment: over 3000 individuals
- ❑ Goal: to improve outcomes for individuals with serious behavioral health issues
 - ❑ policy set by multi-stakeholder Steering Committee
- ❑ Implementation at individual county level with focus on highest need adults
 - ❑ key elements cross counties, but implementation draws upon unique resources within each county
 - ❑ able to pilot a variety of initiatives that can be adapted across the collaborative

Key Elements

- Care Coordination
 - Conversion of ICM/SCM/ACT
- Person-Centered Planning
 - Training in groups, on-line, train-the-trainer
 - Consultants: Carol Blessing; Adams & Grieder
- Performance Measurement
 - Fiscal, clinical/QOL, enrollee satisfaction, hallmarks of PCP
- Health Integration/System Restructuring
 - Managed fee-for-service with Beacon Health Strategies- moving toward full managed care

NYCCP adds value

Better quality

- 46% decrease in emergency room visits per enrollee*
- 53% reduction in days spent in a hospital*
- 78% of enrollees report “dealing more effectively with problems” (2009 Enrollee Survey)

Better outcomes

- 31% increase in gainful activity*
- 54% decrease in self harm among enrollees*
- 53% reduction in harm to others*

Lower costs

- 2008 Medicaid mental health costs for Care Coordination populations in NYCCP vs. comparison counties: (OMH August 2010)
 - 92% lower for inpatient services
 - 42% lower for outpatient services
 - 13% lower for community support Physical health savings would be additional.
- \$5,541 lower average cost person

2008

Physical Health Care Services Survey

- ❑ 40% have a BMI >30 (obese); 25% ≥ 25 & <29.9 (overweight)
- ❑ 31% had high blood pressure; 20% had diabetes
- ❑ 67% smoke cigarettes
- ❑ 44% had at least one medical ER visit in past year; 25% hospitalized over night at least once; 7% had 3 or more hospitalizations during the past year
- ❑ 17% take between 7 & 9 different medications; 9% take ≥ 10
- ❑ 57% wanted to lose weight; 54% wanted to exercise more
- ❑ Perceptions re: medical practitioner ability to explain & address physical health care issues were generally positive; but- had concerns re: coordination of care between physical and mental health providers. A significant number would not go to their medical doctor with a personal or emotional problem.
- ❑ 41% would like to receive their physical health care at the place they receive their mental health care

NYCCP Health Integration Initiatives

□ MH Care Coordinator Training

- Focus on Integrating Addiction and Physical Health

□ Well Balanced Program

- Monroe County- Diabetes Management + Health Promotion
 - Wyoming County- Health Promotion

□ Complex Care Management

- In partnership with Beacon Health Strategies in Monroe, Erie, and Onondaga Counties
 - bridges *Medical and Behavioral Health needs*
 - draws upon principles from Wagner Chronic Care Model & practices from Person-Centered Planning

Well Balanced

- Nursing Intervention-AHRQ Best practice
 - More consistent glucose monitoring
 - Verified by Hb A1c
 - Significant weight loss
 - Greatly reduced triglycerides
 - Lowered risk on HRA scale
- Peer wellness coaching
 - Added to support/maintain life style changes
 - Greater emphasis on health activities

Other Monroe County Initiatives

□ Recovery Connection

- Case management for the severely chemically addicted
 - Greatly reduced CD costs; PH and MH go up, but come back down 1-2 years post-enrollment
- RED team collaboration with DSS

□ Monroe Pilot

- Monroe Plan- 75 high health burden SSI individuals using mental health service; matched sample

□ Strong Ties

- Co-located article 28 medical clinic (MIPS program)

□ UR SON-DOH Smoking Cessation grant

- 6 month quit rate- 24.2% (CO verified)

Issues/Barriers Across Initiatives

- ❑ Transitions are difficult-continuity of relationships matter
- ❑ Choice of location varied- home, community or clinic
- ❑ Co-occurring disorders negatively affected retention
- ❑ Lack of social supports hinders adherence
- ❑ Communication among providers still insufficient
- ❑ Funding/sustainability is crucial

Lessons Learned

- ❑ Clients value health promotion
- ❑ HRA is key as feedback and benchmark
- ❑ Training needs exist across systems
- ❑ Adaptations are needed:
 - Longer time, more intensive intervention
 - Greater social support
 - More emphasis on relationships
 - More attention to co-occurring disorders
- ❑ Visual feedback as a helpful aid
- ❑ Rewards/incentives motivate
- ❑ Peer support increases adherence and outcomes

Westchester's Care Coordination Program

To improve health outcomes and reduce costs, Westchester County implemented a more self-directed, recovery-focused, care coordination program for individuals with historically poor outcomes and high costs.

□ Goals:

- Individuals to have greater control of and responsibility for their own care
- Expand the “menu” of services beyond those reimbursed by Medicaid by providing self-directed funds.
- Improve health outcomes and reduce costs
- Ensure access to needed services
- Coordinate services delivered by multiple providers.

Service-Resistant Patients?

OR

Patient-Resistant Services?

Westchester Care Coordination Program

- ❑ One Care Coordinator partners with 12 highest utilizers of service based on Medicaid claims data (total of 4 CC and 48 enrollees)
- ❑ Individual creates an Individual Service Plan (ISP) that is shared across services (Web-based)
- ❑ All enrollees participate in PH, MH, and CD screening as part of ISP creation
- ❑ Arrange admission into desired or needed standard health services
- ❑ Coordinate mental health, chemical dependence, medical, legal, housing and needed support services
- ❑ Collect and report outcomes data

Care Coordination Program Costs

- One-year pre-enrollment average health and health-related costs per enrollee \$167,000
- \$176,000 (county-funded) per year for 48 enrollees in the program

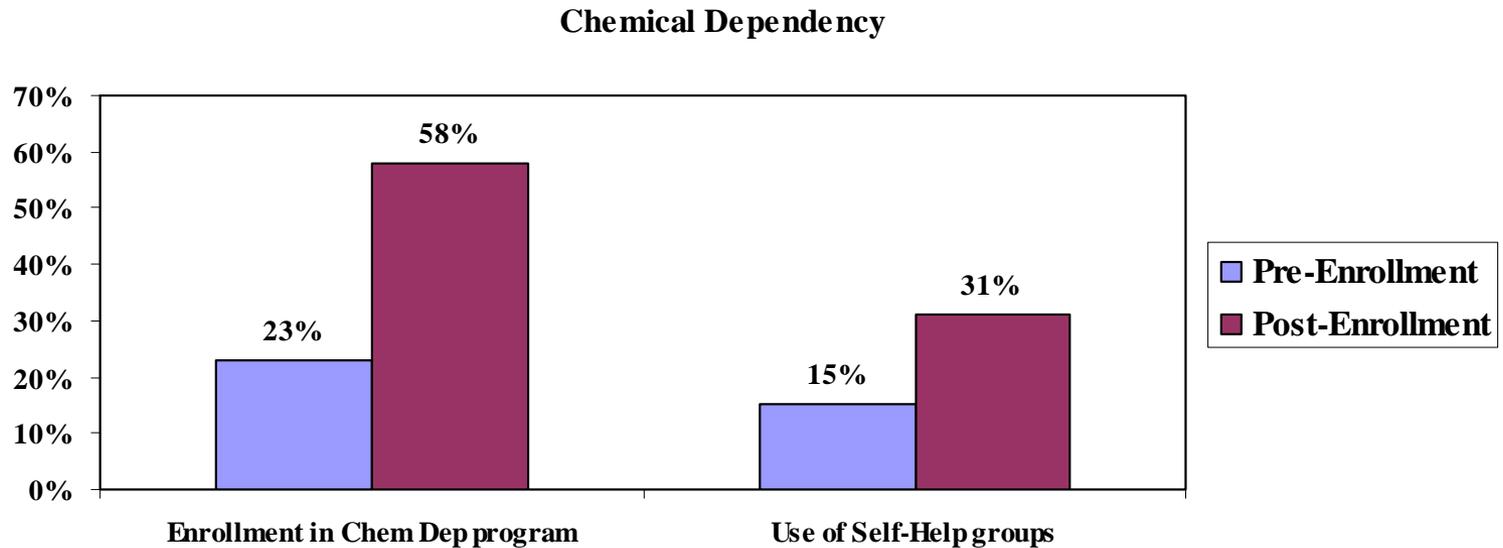
OUTCOMES:

- Medicaid costs, days in hospital, ER visits, homelessness, PH measures, quality of life, satisfaction with program.

Cost Outcomes

	Medicaid (other than hospital)	Hospital		
2007- 2008 Pre-Enroll	\$ 822,119	\$592,150		
2008-2009 1 year after	\$ 535,634	\$129,850		
Savings \$	\$ 286,485	\$462,300		
Savings %	35%	78%		

Chemical Dependency



NYCCP & Health Care Reform

How do we apply the knowledge gained from Care Coordination projects to the changing healthcare environment in NYS?

- ▣ Regional Behavioral Health Organizations (RBHO's)
- ▣ Health Homes

Regional Behavioral Health

Organizations (RBHO's)

- ❑ NYS will be “divided” into several regions (3-6 defined by NYS OMH and OASAS)
- ❑ Moves individuals with mental illness and substance abuse who are not enrolled in managed care (“carved out”) into RBHO
- ❑ Responsible for authorizing and coordinating care, managing utilization of Medicaid BH services (focus on inpt), and integrating BH and PH services

Health Homes

- Person-centered systems of care that support integration and coordination of primary and acute care, behavioral health (MH and CD) and long-term care services.
- Designed to improve health outcomes and reduce ER, inpt, long-term care usage.

Health Homes-Eligible Population

- Three categories of individuals are eligible for enrollment:
 1. Individuals who have AT LEAST 2 chronic conditions including mental health or substance abuse, or asthma or diabetes, or heart disease, or are overweight (BMI over 25)
OR
 2. Individuals with 1 chronic condition AND be at risk for another
OR
 3. Individuals with 1 serious and persistent mental health condition.

Health Homes-Services

- ❑ Comprehensive care management
- ❑ Care coordination and health promotion
- ❑ Comprehensive transitional care from inpatient to other settings, including appropriate follow-up care
- ❑ Individual and family support
- ❑ Referral to community and social support services
- ❑ The use of health information technology to link services, “as feasible and appropriate”.

NYCCP Vision of RBHO/Health Home

- RBHO as superstructure for HH
- Geographic regions that respect established patterns of care when possible and sub-regions that recognize local differences in services and resources
- HH to include multiple provider arrangements to allow for differences in the local service system.

NYCCP RBHO/Health Home

- Possible HH structures within the RBHO
 - Single provider- large provider with a full array of PH and MH services
 - Provider Network- formal network of providers who together provide the full array of PH and MH services
 - Could have one HH serving less populous county/area or multiple HH in a more populous county/area

Role of RBHO as Superstructure

- ❑ Develop and coordinate HH's throughout the region
- ❑ Coordinate care and manage utilization for Medicaid BH services in the region
- ❑ Authorize, coordinate and facilitate continuity and integration of BH and PH services within each HH and between HH in the region
- ❑ Provide office support functions (data analysis, etc) for HH if needed by HH

Four Quadrant Model*

Four Quadrant Clinical Integration Model Adapted for Specialty Behavioral Health Homes

Quadrant II: SMI/Low Physical Health		Quadrant IV: SMI/High Physical Health	
More Complex SMI: Service: Care Coordination Services	Less Complex SMI: Service: Primary Therapist Basic Care Coordination	More Complex SMI: Service: Complex Care Management+ PH Consultation	Less Complex SMI: Service: Care Coordination + PH Consultation
Quadrant I: Non-SMI /Low Physical Health		Quadrant III: Non-SMI /High Physical Health	

*National Council for Community Behavioral Healthcare

Level 1: Low MH/CD, Low PH

Basic HH Services:

- ❑ Outreach and engagement
- ❑ Assessments: MH, CD, social supports/needs
- ❑ PH screening including H & P and linkage to primary care
- ❑ Person-centered service planning
- ❑ Health promotion- basic, onsite
- ❑ Health monitoring
- ❑ MH and/or CD treatment services
- ❑ Linkage to primary care, CD and social supports
- ❑ Document at least basic information in shared EMR.
- ❑ Electronic data exchange with RBHO, HH, and primary care if possible.

Level 2: High MH/CD, Low PH

All Level 1 Services + Care Coordination services including:

- ❑ Outreach to eligible persons in community
- ❑ Assistance in transition from inpatient to outpatient services
- ❑ Assistance with travel related to attendance at medical and/or social appointments
- ❑ Assistance in resolving issues in the community living (housing, legal, etc.)

Level 3: Low MH, High PH

Level 1 MH services +

- ❑ Intensive care coordination
- ❑ Targeted health promotion and coaching
- ❑ PH plan developed by PCP or specialty PH
- ❑ Consultation with Complex Care Manager
- ❑ Assistance working with HMO to arrange and coordinate PH services

Level 4: High MH, High PH

Level 1 plus 2 plus 3 +

- More intensive care coordination
- More intensive complex care management

Conclusion

- ❑ More wide-spread integration of PH and MH/CD with Medicaid population propelled by state and federal healthcare reform
- ❑ Partnerships with MH, CD, PH, and social supports
- ❑ Will involve collaboration with MCO

Project Launch

- ❑ \$4M funding from SAMHSA, collaboration DOH, OCFS, OMH and others to fund more integrated, health, mental health and substance abuse services at 3 sites of an FQHC.
- ❑ Program expands, enhances and integrates existing programs (health care, home visiting, parenting education, etc) to provide a complete range of developmentally supportive services to families with children from birth – 8 years old.
- ❑ Goal: To promote children's social-emotional development, prevent mental health problems in children and families, and intervene with children and families who are affected by mental health disorders

Project Launch

- ❑ Screen all members of family during a primary care visit at FQHC (or during a WIC visit) including social/emotional/physical development, language, depression, anxiety, and domestic violence for parents.
- ❑ If BH issue is identified, more extensive outreach, parenting education and parent-child activities are offered.
- ❑ A fully integrated electronic health record is used. All disciplines document in one shared electronic patient chart.
- ❑ Truly integrates primary care, chronic disease care, behavioral health and specialties such as dental, obstetrics/gynecology, podiatry, and optometry etc. Not just co-location
- ❑ Provides greater access to high-quality care and evidence-based programs for young children and their families

Project Launch

□ Measure:

- There are 2 main levels of the evaluation: family/child and service system.
- Assess satisfaction with program, family strengths, cultural competence, services coordination and service barriers.
- Do the interventions improve school readiness?
- How does having a patient-centered medical home improve health outcomes for children?