Integrated Health Care In Indiana: MDwise Grant Project Updates
## Integrated Health Care in Indiana: MDwise Grant Project Updates

### Conference Agenda

Friday, November 4, 2011 • MDwise, Inc., Lower Level 1 & 2 • 8:30 a.m.–12:00 p.m.

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>8:30</td>
<td>Registration</td>
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<tr>
<td>9:00</td>
<td>Welcome</td>
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<tr>
<td>9:05</td>
<td>Concept of Integrated Care</td>
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<td>9:20</td>
<td>Healthnet Project</td>
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<td>9:40</td>
<td>Midtown Project</td>
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<td>10:00</td>
<td>Break</td>
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<td>10:15</td>
<td>Regional Project</td>
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<td>10:35</td>
<td>Aggregate Data on Cost Outcomes</td>
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<td>10:50</td>
<td>National Trends Update on SAMSHA Conference</td>
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<td>11:10</td>
<td>Panel Discussion</td>
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<td>11:50</td>
<td>Wrap-up and Evaluation</td>
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### Objectives

1. Participants will understand the need for an integrated model of healthcare for the Indiana Medicaid population.
2. Participants will gain knowledge of patient and cost outcomes as a result of integrated care.
3. Participants will have resources for how to deliver integrated care.
• Welcome/Administrative Information
  Jennifer Layden, LCSW, LMFT; Behavioral Health Manager, MDwise

• Concept of Integrated Care
  Lynn Bradford, PhD., HSPP; Director of Behavioral Health MDwise
HealthNet

“One Year Later”

Integrated Care: Behavioral Health and Primary Care
(or, We’re Still Here To Tell The Story!)

Presenters:
Mr. Booker Thomas-CEO/President
Dr. Yvonne Oropeza-Manager of Behavioral Health
FRONT DESK
Provides GAD7/PHQ-9 screening form to every patient aged 18 and over, on the patient’s first visit after the site adopts the Behavioral Health Model, then annually thereafter.
Gives completed screening forms to the site’s Patient Navigator who will contact patient for immediate appointment.

PATIENT NAVIGATOR
Scores each screening form
Enters scores in the BH Access Database
Enters “ICM done (date) GAD7 (score) PHQ2 (score)” into the notes field in ECW (ICM= Integrated Care Model)
Schedules appointments for patients who score ≥3 on the PHQ2 or ≥10 on the GAD7
Discharges patients in the BH Access database who decline services as “patient declined”
Tracks appointment outcomes/ Reschedules appointments

PATIENT NAVIGATOR
(*) Discharges patient in the BH Access database as “excluded”
(**) Discharges patient in the BH Access database as “referral”

PATIENT (**)
Referred to:
• Access Center
• Adult & Child
• Midtown
• Valle Vista
• Other

THERAPIST
Completes and reviews PHQ9 on all patients who score ≥3 on the PHQ2
Completes a CAGE on all patients who score ≥10 on the GAD7 OR PHQ9
*(except for those with a BH Diagnosis of: Bipolar, Psychosis, Schizophrenia, Dementia, Delirium, Cognitive Impairment, or Developmentally Disabled) *These patients will continue with therapy as needed
Completes an ANSA on all patients who score <2 on the CAGE, within 3 months of the patient scoring ≥10 on the GAD7 or PHQ9 *(patients who score ≥2 on the CAGE are excluded from the ANSA) *These patients will continue with therapy as needed
Completes a reassessment ANSA on all patients who score ≤2 on the ANSA, within 7 months of the first ANSA
**(patients who score ≥3 on the ANSA will be referred out for treatment)

Currently at 4 of 6 primary care sites
Roll out to last two sites-December 1, 2011
The Elusive Goal
What are we looking for with integration?

• Healthier patients
• Increased productivity, more revenue, more services
• Prescribers getting back to medicine vs counseling/social work/case management
• Decreased readmissions to Hospital/ER
• Cost benefits: you can pay now or pay later—it will always be more later!
What’s Working?

• Increased number of “Champions” for BH/PC
• This integration thing really does work!
• Case conferencing with OB staff—will eventually move to medical
• EMR 😊
• Case conference with psychiatrist(s)
• Higher patient satisfaction
What still needs to be done?
• Capturing all 18 year olds and older
• Working out “flow” issues
• The culture within (HN) the culture without (State)
• Billing (need we say more?)
• Continued education of the role of the Psychiatrist and Psychiatric Nurse Practitioner
What's Next?
• Additional therapists
• Begin process of screening of our patients 17 and under
• Build play therapy rooms
• Continue to have what we are doing
• Listen & evaluate!
Black 42-year old female, suicidal thoughts came in for routine exam with her PCP. She tested positive for depression. She had been seen numerous times in the ER, 32 visits YTD. She initially refused referral to Behavioral Health, then called 3 days later and spoke with our Navigator. The patient was seen immediately and referred to PCP who prescribed psychotropic meds.

Patient is now stabilized and sees staff psychiatrist and therapist. She has not been to the ER in the past 2 months.
Midtown Primary Care
Continuing the Journey

Cynthia Wilson, MSN, PHMCNS,BC
Clinical Nurse Manager, Midtown Primary Care, Midtown Base Program
Objectives

- Provide overview of program
- Define metrics utilized to evaluate outcomes
- Clinical
- Access
- Barriers to implementation-initial and current
- Successes-acknowledge progress to date
- Next Steps- Where do we go from here?
Overview of Program

- Collocated Care- Started January 2009
- 11 Sites-Wishard Community Health Centers
- 26 Staff placed in the CHC’s
- Provide real time consults to primary care patients
- See patients for scheduled visits
- See patients referred from our Access and other Midtown programs
Overview of Program

- Top diagnosis treated
- Depression
- Anxiety
- Substance Abuse
- Brief solution therapy
- 1-6 sessions
- Utilize outside agencies when appropriate
- Direct patients to most appropriate level of care
- Work with PCP’s to treat complex medical cases
Metrics

• Clinical- Looked at 2 of the 9 sites to compare outcomes
• PHQ-9- Depression
• GAD-7- Anxiety
• Audit C- Alcohol
• Single Drug Question
• Pain Scale- Rate on scale of 1-10
Metrics

• Westside Community Health Center- W. Michigan Street
• 3 Clinic Staff
• CNS
• 2 LCSW- adults, child/adolescents
• Demographics
• Results of Screening
Metrics

- Forest Manor- Sherman Drive and 38th Street
- 3 Clinic Staff
- CNS
- 2 LCSW- Adults, Child/adolescents
- Demographics
- Results of Screening
Patient Surveys

• N = 21

• How long a patient at this site
  – Average ➔ 3.5 years

• How many times seen Clinician (total)
  – Mode ➔ 2 visits

• Amount of time with Clinician
  – Fair – 5% (1)
  – Good – 19% (4)
  – Very Good – 38% (8)
  – Excellent – 38% (8)

• Helped by the care received during visit
  – Poor – 5% (1)
  – Fair – 5% (1)
  – Good – 24% (5)
  – Very Good – 29% (6)
  – Excellent – 38% (8)
Patient Surveys

• Overall quality of care received
  – Good – 48% (10)
  – Very Good – 29% (6)
  – Excellent – 24% (5)

• Recommend family or friends
  – Probably Not – 10% (2)
  – Probably Yes – 29% (6)
  – Definitely Yes – 62% (13)

• How satisfied with care received this visit
  – Very Dissatisfied – 5% (1)
  – Somewhat Dissatisfied – 5% (1)
  – Neither Dissatisfied nor Satisfied – 5% (1)
  – Somewhat Satisfied – 24% (5)
  – Very Satisfied – 24% (5)
  – Completely Satisfied – 38% (8)
Patient Surveys

• Clinician involved you in decision making about treatment options
  ─ Minimally – 10% (2)
  ─ Sufficiently – 10% (2)
  ─ Very Much – 38% (8)
  ─ Completely – 43% (9)

• How would you rate your health
  ─ Poor – 19% (4)
  ─ Fair – 19% (4)
  ─ Good – 29% (6)
  ─ Very Good – 29% (6)
  ─ Excellent – 5% (1)
Medical Provider Survey

- N = 21
- How many years work in current clinic?
  - *Average ➔ 7.6 years*

- I am satisfied with the ability of the medical team to address needs of patients with behavioral disorders.
  - Strongly Agree – 5% (1)
  - Agree – 62% (13)
  - Disagree – 33% (7)

- I am effective in addressing behavioral disorders in medical exams.
  - Strongly Agree – 5% (1)
  - Agree – 57% (12)
  - Disagree – 38% (8)

- I am confident in my ability to use behavior change interventions...in lieu of or in combination with medicines.
  - Strongly Agree – 10% (2)
  - Agree – 48% (10)
  - Disagree – 33% (7)
  - Strongly Disagree – 10% (2)
Medical Provider Survey

• I feel I am effective in addressing patients who present with barriers to treatment (e.g., low motivation to change)
  – Strongly Agree – 5% (1)
  – Agree – 43% (9)
  – Disagree – 48% (10)
  – Strongly Disagree – 5% (1)

• I think that addressing behavioral issues has a positive impact on my satisfaction with medical practice.
  – Strongly Agree – 38% (8)
  – Agree – 52% (11)
  – Disagree – 10% (2)

• How often do you use the onsite Clinician?
  – Occasionally – 14% (3)
  – Frequently – 71% (15)
  – Always – 14% (3)
Medical Providers Survey

• How would you rate your satisfaction with access to behavioral health services?
  – Excellent – 24% (5)
  – Good – 33% (7)
  – Average – 19% (4)
  – Below Average – 19% (4)
  – Poor – 5% (1)

• Does the Clinician provide the kind of services you want for your patients?
  – Always – 19% (4)
  – Usually – 62% (13)
  – Sometimes – 19% (4)

• The behavioral health consultations have been [good] for my patients.
  – Strongly Agree – 19% (4)
  – Agree – 52% (11)
  – Disagree – 29% (6)

• The consultations with Midtown providers are very helpful to me as a medical provider.
  – Strongly Agree – 43% (9)
  – Agree – 52% (11)
  – Disagree – 5% (1)
Medical Providers Survey

• In regard to your communication with Clinician, how would you rate the timeliness of the Clinician’s feedback?
  – Excellent – 24% (5)
  – Good – 38% (8)
  – Average – 29% (6)
  – Below Average – 10% (2)

• Overall, how would you rate the quality of the behavioral health consultation services provided to you and your patients?
  – Excellent – 33% (7)
  – Good – 38% (8)
  – Average – 10% (2)
  – Below Average – 19% (4)

• Overall, I am satisfied with the Midtown Clinician services in my clinic.
  – Strongly Agree – 33% (7)
  – Agree – 43% (9)
  – Disagree – 19% (4)
  – Strongly Disagree – 5% (1)
Please comment on what you think are the most important and useful aspects of Midtown Clinician services:

- “Med management of schizophrenia and other severe psych illness.”
- “Child psychiatric services and people with mood disorders.”
- “Having a person to provide onsite is excellent, but availability is very significantly below the amount we actually need for the size and needs of population we serve.”
- “More bilingual access needed.”
- “We do not have enough access.”
- “Having onsite services and Spanish speakers.”
- “Accessibility and assistance with assessments. I love them!”
- “Dr. Maust and his team....have done an excellent job...”
- “Crisis Intervention.”
- “The patients [seem] more likely to come to the clinic for services than at the downtown [hospital].”
Barriers- Initial

• Transition from “therapist” to “behavioral health clinician”
• No set office space
• Resistance from clinic staff
• Billing
• Flow of patients in the clinic
• Confusion about what services are provided by the staff
• Stigma of having “Midtown” patients in the CHC’s
• Different Electronic Medical Record System
• Confidentiality Confusion
• Storage of medical records
Barriers-32 months later

• 11 different sites with 11 different models
• Differences amongst PCP’s about prescribing practices
• Hospital has specific rules about who can prescribe some psych drugs
• Billing
• Confidentiality Confusion
• Seeing patients that don’t have a PCP in our system
• Difficult to obtain outcomes that support integrated model
Barriers 32 months later

• Difficulty finding bilingual providers
• Patients with serious mental illness are attempting to receive services in primary care
Successes

• PCP’s utilize the services in the clinics
• Decreased stigma for patients
• Patient’s able to get in for services more efficiently
• Increased communication between medical doctors and mental health doctors
• Most clinics have bought into the “warm handoff” model
Successes

• Each site has carved out an approach for providing services that is unique to their clinic
• Starting to see patients with chronic medical conditions and utilizing Motivational Interviewing techniques to improve health outcomes
• Seen as a valuable resource that the clinics don’t want to lose
• Registration and billing processes began at the beginning of 2009
• Utilizing the same scheduling system (PHS) for scheduling patients as the CHC’s use
Next Steps

• Promote more screening
• Develop mechanisms to capture outcomes with more meaningful data
• Provide education to PCP’s about psychotropic medications
• Continue to refine billing practices
• Refine algorithms for referring patients
• Decrease no show rates
• Encourage increase in same day visits
Next Steps

• Implement SBIRT grant
  – Will increase the interaction between medical and psych providers
  – Screening will become a standard of care in each CHC
  – Focus on substance abuse, depression and anxiety
  – Able to collect specific information from patients using the “GPRA”
  – Weekly meetings amongst providers to discuss cases
Next Steps

• Train all staff on Brief Solution Therapy

• Incorporate trauma informed care into services
Integrated Care Update at Regional

John Kern, MD
Regional Mental Health Center
Merrillville, IN
Our milieu: Rustbelt urban & suburban
Not all bad: there is Rustbelt aesthetic!
Regional / NorthShore

- Regional MHC [formerly Southlake MHC] 30+ years old, recently doubled in size. ~10,000 clients per year.
- NorthShore Health Center FQHC 11 years old, ~100,000 visits per year. 4 sites.
- Integrated Service 3500 visits / yr. Approx 2.5 visits/pt.
- Service areas only partly overlap, but share one service location.
- Considered merger.
• Since March 2008
• In three NorthShore sites.
  – Move to IMPACT model, especially use of registry.
Access

- Immediate [less than 1 hour] >90% of time
Penetration Enrollment Graph

Projectwide Weekly Accumulated Enrollment

Number of Patients

Start Date = 11/1/2008, End Date = 8/30/2011
## Caseload Tracking Report - For BH in PC

**Report Created on:** Tuesday, August 30, 2011, 8:18AM

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<th>PHQ-9</th>
<th>MDQ</th>
<th>CIDT</th>
<th>MED</th>
<th>RELAPSE PREVENTION PLAN</th>
<th>PSYCHIATRIST NOTE</th>
<th>PSYCHIATRIC EVALUATION</th>
<th>NEXT APPOINTMENT</th>
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<td>17 Positive</td>
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### Depression Outcome

**Caseload Statistics - For BH in PC**

**Site:** Southlake/NorthShore  
**Report Created on:** Tuesday, August 30, 2011, 8:03AM

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<tr>
<th>CM</th>
<th># of P.</th>
<th>Initial Contact</th>
<th>Follow Up</th>
<th>Last F/U</th>
<th>Psychiatry Consultation</th>
<th>Treatment after &gt; 10 Wks</th>
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<td># of P.</td>
<td>MEAN #</td>
<td>MEAN # Phone</td>
<td>MEAN Phq</td>
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<td>MEAN Phq</td>
<td>MEAN</td>
<td>MEAN # CLINIC</td>
<td>MEAN # Phone</td>
<td>MEAN Phq</td>
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<td>Diane Vojslavek</td>
<td>700</td>
<td>699 (100%)</td>
<td>14.4</td>
<td>390 (56%)</td>
<td>3.0 (96%)</td>
<td>2.9 (96%)</td>
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<td>Jennifer Noonan</td>
<td>955</td>
<td>963 (100%)</td>
<td>15.0</td>
<td>489 (51%)</td>
<td>3.1 (95%)</td>
<td>2.9 (95%)</td>
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<tr>
<td>Michelle Mcbrayer</td>
<td>823</td>
<td>820 (100%)</td>
<td>14.6</td>
<td>424 (52%)</td>
<td>3.3 (99%)</td>
<td>3.2 (99%)</td>
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<tr>
<td>All</td>
<td>2488</td>
<td>2482 (100%)</td>
<td>14.7</td>
<td>1303 (52%)</td>
<td>3.1 (97%)</td>
<td>3.0 (97%)</td>
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</table>

R/P = Relapse Prevention Plan, P/N = Psychiatrist Note, P/E = Psychiatric Evaluation
Response is defined as most recent PHQ-9 is at least 50% improved. Remission is defined as most recent PHQ-9 is less than 5.
Primary Care in MHC

• This actually the need that started our collaboration with NorthShore

• Our FQHC access point was delayed for two years, meanwhile went ahead with behavioral health program.
• NorthShore put a nurse practitioner in place.
• Very little business. Why not?
  – Separate FQHC registration a significant barrier.
  – It turns out staff are needed to shepherd the transition, even in the same office suite.
  – All CMHC staff didn’t have message repeated and repeated and repeated...

If you build it, they will not necessarily come...
Tasks prior to setting up

• PR, PR, PR!

• Getting your story straight – it is surprisingly difficult to explain exactly what the point is, to patients, to staff, to your mom. [“Improving health outcomes” is a good tag.]

• Why does your patient care about population health?

• Agreements with primary care providers – if you don’t have pre-existing relationship, they may not be that interested.
Wellness activities

• 4 modifiable behaviors responsible for much of poor health outcomes:
  – Tobacco use
  – Excessive alcohol & drug use
  – Lack of physical activity
  – Poor nutrition

• Goals to improve health behaviors
  – Eating
  – Exercise
  – Smoking
  – Stress reduction
Creating new wellness programs

• Using **evidence-based principles of behavior change**
  – Weight Watchers
    • Record-keeping
    • Social Support
    • Simple guidelines
  – UCSF smoking cessation
    • Cochrane report – meds plus social support
What we have done so far

• Enrolled 201 clients [goal was 180 by 9/30/11]
• How many activities per client?
• Screening, tracking of labs, appts for all 201
• Linkage with primary care
  – NorthShore on-site nurse practitioner
  – East Chicago on-site primary care clinic
  – On-site lab
  – North Point Internal Medicine
  – Cardiology
Accomplishments

• Making warm handoffs happen using Google Voice phone number.
• Lunchtime exercise program – so popular, the staff want to join. Yoga, relaxation training.
• Engaging a volunteer to help us succeed with the task of the Rand Registry.
• Linkages for bringing in trainees from Purdue Calumet School of Nursing, IU Northwest, IU School of Medicine.
• Linkage with local and state-wide Area Health Education Center to expose medical and nursing students to integrated care.
• Getting almost all of Regional’s 340 FTE’s moved to make room for clinic space
• Purdue Extension nutrition teaching in-home.
Challenges

• Unable to construct our own registry.
• A large # of clients cannot be recruited.
• We fear a large number may be once-only.
• Data gathering for SAMHSA slow to get organized.
• Exchange of information with primary care electronic medical record.
Still to come – making it simple

• Eating / shopping / cooking. Garden?
• Eating healthy on little money
• Weight Watchers – like program [WW great but $ an issue.]
• Smoking cessation.
• Sustainability – billing issues.
• FQHC?
Cardiac screening for exercise

**PAR-Q & YOU**

*(A Questionnaire for People Aged 15 to 69)*

Regular physical activity is fun and healthy and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 60, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Complete service is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly. Check YES or NO.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td>1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?</td>
<td></td>
</tr>
<tr>
<td>2. Do you feel pain in your chest when you do physical activity?</td>
<td></td>
</tr>
<tr>
<td>3. In the past month, have you had chest pain when you were not doing physical activity?</td>
<td></td>
</tr>
<tr>
<td>4. Do you have your blood pressure at a normal level?</td>
<td></td>
</tr>
<tr>
<td>5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?</td>
<td></td>
</tr>
<tr>
<td>6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart conditions?</td>
<td></td>
</tr>
<tr>
<td>7. Do you know of any other reason why you should not do physical activity?</td>
<td></td>
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</table>

**YES to one or more questions**

Talk with your doctor by phone or in person before you start becoming much more physically active or before you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES. You may be asked to do any activity you want — as long as you start slowly and build gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his advice.

Find out which community programs are safe and helpful for you.

**NO to all questions**

Start becoming much more physically active — begin slowly and build gradually. This is the safest and easiest way to go.

If you answer YES to any of the questions, you can be reasonably sure that you can start becoming much more physically active — begin slowly and build gradually. This is the safest and easiest way to go. Start doing regular physical activity — this is an excellent way to determine your baseline fitness so that you can plan the best way for you. It is also highly recommended that you have your blood pressure measured. If your reading is over 140/90, talk with your doctor before you start becoming much more physically active.

**PLEASE NOTE:** If your health changes so that you need to answer YES to any of the seven questions, tell your fitness or health professionals. Ask whether you should change your physical activity plan.

No changes permitted. You are encouraged to photocopy the PAR-Q but not if you use the code form.

*Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if the condition changes so that you would answer YES to any of the seven questions.*
How to Find **Real Food** at the Supermarket

- **No** Does it have a label? **Yes**
  - **No** Was it ever alive? **Yes** Does it make health claims?
    - **Yes**
    - **No**
      - You're probably in the home improvement aisle
        - **Yes**
          - Does it have nutrition info?
            - **Yes**
              - Might it contain bacon anyway?
                - **Yes**
                - It's either a hair or household product
                  - **Yes**
                    - Probably dog food
                    - **No**
                      - Are there more than 5 ingredients?
                        - **Yes**
                          - Run each ingredient through flowchart
                            - **No**
                              - Is it a dairy product?
                                - **Yes**
                                  - It's food
                                  - **No**
                                    - Not food
                                    - **Yes**
                                      - Eat at own risk
                                      - **No**
                                        - Eat it
                          - **No**
                            - It's food
                            - **No**
                              - Do not eat
                              - **Yes**
                                - Grab light bulbs for the garage
        - **No**
          - Well done, you're at the produce aisle or meat counter

- **No**

**MDwise**
Impact of Integrated Care on the Cost of Healthcare

Lynn Bradford, PhD, HSPP
Director of Behavioral Health
MDwise
HealthNet Integrated Care

- 1228 RIDs Examined after 5 Statistically Extreme Outliers were Removed
- All Visit Types are Included
- Pharmacy is Excluded
Midtown and North Shore Integrated Care

- 68 RIDs Examined after 2 Statistically Extreme Outliers were Removed
- All Visit Types are Included
- Pharmacy is Excluded
State and National Trends

11-4-11

Debbie Herrmann,
Deputy Director, Office of Recovery, Integration, Policy and Planning,
Indiana Division of Mental Health and Addiction
2011 Focus Areas

• Affordable Care Act (ACA)

• Federal Level Changes to Block Grants

• DMHA Priority Areas
Major Drivers

- More people will have insurance coverage
- Medicaid will play a bigger role in MH/SUD than ever before
- Focus on primary care and coordination with specialty care
- Major emphasis on home and community based services and less reliance on institutional care
- Preventing diseases and promoting wellness is a huge theme
8 Strategic Initiatives

1. Prevention of Substance Abuse and Mental Illness
2. Trauma and Justice
3. Military Families
4. Recovery Support
5. Health Reform
6. Health Information Technology
7. Data and Outcomes and Quality
8. Public Awareness and Support
Changes to Federal Block Grants

• SAMHSA encouraged states to submit a combined application for the MH and SAPT Block Grants.

• Emphasis on Non-Medicaid funded recovery supports.

• Emphasis on outcomes which will be tied to funding strategies.

• Accountability for every dollar down to the individual, service received, and benefit gained.
DMHA Priority Areas

1. Prevention of Substance Abuse and Mental Health Promotion

2. Integration of Primary and Behavioral Health

3. Recovery Supports

4. Safe and Affordable Home in the Community for All Consumers
Prevention of Substance Abuse and Mental Health Promotion

• Identify gaps in programming and population focus for mental health promotion and addiction prevention efforts statewide.

• Received $600,000 Strategic Prevention Framework State Prevention Enhancement Grant from SAMHSA for planning purposes.

• Completion of revised State Suicide Prevention Plan
Integration of Primary and Behavioral Health

• Creation of Integration Workgroup with representation from primary stakeholders to begin meeting in third quarter of SFY12.

• Group will determine best practice principles for bi-directional integrated primary and behavioral health practices with state approval within SFY13.
“Be careful about reading health books—you may die of a misprint”—Mark Twain

John O’Brien
Senior Advisor on Healthcare Financing
SAMHSA
What Are The Goals?

• Improving Access and Quality Care

• Ultimately—Develop a workable strategy to address individuals with health conditions and MH/SUD

• Build partnerships for collaboration, integration and alignment of goals, services and resources
HRSA Perspective
Health Center Program:
Partnership Opportunities

IMPROVING ACCESS AND QUALITY CARE FOR THE BEHAVIORAL HEALTH CLIENT
May 17-18, 2011
ALBUQUERQUE, NM

Kim Patton, PsyD
Public Health Analyst
U.S. Department of Health and Human Services
Health Resources and Services Administration
Office of Regional Operations
HRSA, Public Health and the Affordable Care Act

- Increasing Access to Primary Care
- Investing in the Health Workforce
- Supporting Maternal and Child Health
- Broadening Access to 340b Program Discounts and Supporting Rural Programs
What is a “Health Center”?  

- Located in or serve a high need community  
- Governed by a community board  
- Provide comprehensive primary health care  
  ✓ Primary & Preventive Care  
  ✓ Enabling Services  
- Provide services available to all with fees adjusted based on ability to pay.  
- Meet other performance and accountability requirements regarding administrative, clinical, and financial operations  

**Synonyms:** Federally Qualified Health Centers (FQHC), Community Health Centers, Section 330 Health Centers
Health Centers: Access

- 1/3 provide on-site substance use disorder services

- Screening, Brief Intervention, and Referral to Treatment (SBIRT)

- 2/3 provide on-site mental health services

- Depression - the third most common reason for a visit behind diabetes and hypertension. (2008 UDS Data)
Health Centers: Workforce

- 3,400 Behavioral Health Workforce (2009 UDS Data)
  - 348 Psychiatrists
  - 318 Psychologists
  - 1,070 Social Workers
  - 822 Substance Use Disorder Service Providers
  - 826 Other Licensed Behavioral Health Provider
CMS Perspective:
Section 2703: State Option to Provide Health Homes for Enrollees with Chronic Conditions

Mary Pat Farkas, Health Insurance Specialist
Disabled and Elderly Health Programs Group
Center for Medicaid, CHIP, and Survey & Certification
Centers for Medicare & Medicaid Services

May 17 -18, 2011
• A goal of implementing Section 2703 will be to expand upon the traditional and existing medical home models to build linkages to community and social supports, and to enhance the coordination of medical, behavioral, and long-term care.

• Health Home is a new Medicaid State Plan Option that provides a comprehensive system of care coordination for Medicaid individuals with chronic conditions.

• Health Home providers will coordinate all primary, acute, behavioral health and long term services and supports to treat the “whole-person”.

DMHA State and National Trends 11-11
Eligibility Criteria

- Medicaid eligible individual having:
  - two or more chronic conditions,
  - 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).

- Through Secretarial authority, States may add other chronic conditions in their State Plan Amendment for review and approval by CMS.
Designated Provider Types and Functions

- There are three distinct types of *health home providers* that can provide health home services:
  - designated providers,
  - a team of health care professionals, and
  - a health team.

- Health home providers are expected to address several functions including, but not limited to:
  - Providing quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
  - Coordinating and providing access to high-quality health care services informed by evidence-based guidelines;
  - Coordinating and providing access to mental health and substance abuse services;
  - Coordinating and providing access to long-term care supports and services.
Health Home Services and Enhanced Federal Match

➢ The health home services include:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings;
- Individual and family support;
- Referral to community and social support services; and,
- Use of health information technology, as feasible and appropriate.

➢ There is an increased federal matching percentage for the above health home services of 90 percent for the first eight fiscal quarters that a State plan amendment is in effect.

➢ The 90 percent match does not apply to other Medicaid services a beneficiary may receive.
Next Steps

• CMS is providing technical assistance to States interested in submitting a State plan amendment.

• CMS will be engaging in rapid learning activities to prepare for the release of well-informed regulations.

• CMS will continue to collaborate with Federal partners, including SAMHSA, ASPE, HRSA, and AHRQ, to ensure an evidence-based approach and consistency in implementing and evaluating the provision.
Mental Health and SUD: Opportunities in Health Reform

Mary Pat Farkas, Health Insurance Specialist
Disabled and Elderly Health Programs Group
Center for Medicaid, CHIP, and Survey & Certification
Centers for Medicare & Medicaid Services

May 17-18, 2011
CMCS and Behavioral Health

• Medicaid is the largest payer for mental health services in the United States
• In 2007, Medicaid funding comprised 58% of State Mental Health Agency revenues for community mental health services
• Comprehensive services available through Medicaid; many are optional under Medicaid so state’s have considerable flexibility in benefit design
Medicaid MH/SA Service Users

- Mental Health Service Users: 10.9%
- Substance Abuse Service Users: 0.7%
- All Other Medicaid Beneficiaries: 88.3%

Source: SAMHSA
Medicaid Expenditures for MH/SA Service Users

- Mental Health Service Users: 29.9%
- Substance Abuse Service Users: 1.8%
- All Other Medicaid Beneficiaries: 68.3%

Source: SAMHSA
MH/SUD: Federal Medicaid Goals

• Federal policy supports the offer of effective services and supports
• Improved integration of physical and behavioral health care
• Person-centered, consumer-directed care that supports successful community integration
• Improved accountability and program integrity to assure Medicaid is a reliable funding option
## The Consumer and Staff Perspective/Experience

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

<table>
<thead>
<tr>
<th>REGION 1</th>
<th>REGION 2</th>
<th>REGION 3</th>
<th>REGION 4</th>
<th>REGION 5</th>
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</thead>
<tbody>
<tr>
<td>AK: Wrangell Community Services</td>
<td>AZ: CODAC Behavioral Health Services</td>
<td>FL: Coastal Behavioral Healthcare</td>
<td>IL: Human Service Center</td>
<td>CT: Bridges – A Community Support System</td>
</tr>
<tr>
<td>CA: Mental Health Systems</td>
<td>CO: Mental Health Center of Denver</td>
<td>FL: Lifestream Behavioral Center</td>
<td>IL: Trilogy Inc</td>
<td>CT: Community MH Affiliates</td>
</tr>
<tr>
<td>CA: Asian Community MH Services</td>
<td>TX: Lubbock Regional MH &amp; MR Center</td>
<td>FL: Community Rehabilitation Center</td>
<td>IN: Adult &amp; Child Mental Health Center</td>
<td>ME: Community Health and Counseling Service</td>
</tr>
<tr>
<td>CA: San Mateo County Health System</td>
<td>TX: Montrose Counseling Center</td>
<td>FL: Apalachee Center, Inc</td>
<td>IN: Southlake Community Mental Health Center</td>
<td>NH: Community Council of Nashua</td>
</tr>
<tr>
<td>CA: Glenn County Health Services Agency</td>
<td>OK: North Care Center</td>
<td>FL: Lakeside Behavioral Healthcare</td>
<td>IN: Centerstone of IN</td>
<td>NJ: Care Plus NJ</td>
</tr>
<tr>
<td>WA: Asian Counseling and Referral Services</td>
<td></td>
<td></td>
<td>OH: Center for Families &amp; Children</td>
<td>NY: Postgraduate Center for Mental Health</td>
</tr>
<tr>
<td>WA: Downtown Emergency Service Center</td>
<td></td>
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<td>OH: Shawnee MH Center</td>
<td>NY: Bronx-Lebanon Hospital Center</td>
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<td></td>
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<td>OH: Southeast Inc</td>
<td>NY: International Ctr for the Disabled</td>
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<td>OH: Greater Cincy BH Services</td>
<td>NY: Fordham Trenton CMHC</td>
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<td></td>
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<td>WV: Prestera Center for MH Services</td>
<td>PA: Milestone Centers</td>
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<td>PA: Horizon House</td>
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<td>RI: Kent Center for Human/Org Development</td>
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<td></td>
<td>RI: The Providence Center</td>
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<td>MD: Family Services, Inc</td>
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</tbody>
</table>
Panel Discussion and Questions