The Future of Integrated Care

June 23, 2016
Integration: Getting it Together
Mental Health Parity Act (1996)


Crisis Response System (2007)

HB 2196: Integrated Care Study (2009)

Rider Directed: Associate Commissioner of MH Coordination (2013)

SB 58: MH Rehab and TCM into Managed Care (2013)

SB 58: Behavioral Health Integration Advisory Committee (2014)

HB 2303: Expanded Scope of Community Centers (2009)

HS 7: Medical & LTC Services for IDD into Managed Care (2013)

Patient Protection and Affordable Care Act (2009)

1115 Transformation Waiver (2011)

Rider Directed: Certified Community Behavioral Health Centers (CCBHCs) (2015)

Rider Directed: Associate Commissioner of MH Coordination (2013)

SB 58: Behavioral Health Integration Advisory Committee (2014)
The Future of Integrated Care

- Danette Castle, CEO, Texas Council
- Jolene Rasmussen, DOA, Texas Council
- Terry Crocker, CEO, Tropical Texas Behavioral Health
- Susan Garnett, CEO, MHMR Tarrant
- Andrea Richardson, ED, Bluebonnet Trails Community Services
- Chuck Ingoglia, Senior VP, Public Policy and Practice Improvement, National Council for Behavioral Health
- Sonja Gaines, Associate Commissioner of MH Coordination, HHSC
1115 Transformation Waiver
1115 Waiver:
Delivery System Reform Incentive Payments (DSRIP)

Selected by Community Centers

Physical and Behavioral Health Integration
31 Centers developed integrated care projects based on local community needs and resources
Integrated Care at Tropical Texas Behavioral Health - Overview

Terry Crocker, MBA, MA
Chief Executive Officer
Tropical Texas Behavioral Health

23 June 2016
Integration of Primary and Mental Healthcare

**Problem:** Many TTBH patients, who had chronic and co-morbid medical conditions, were unable or unwilling to access primary care services in our community

**TTBH Solution:** Primary care clinics established inside our mental health clinics to provide services for TTBH patients; adding Family Practitioners, LVN/RNs, Dieticians, Chronic Care Nurses
Compulsory Issues:
1. Patient population = TTBH consumers only
2. If co-morbid medical condition noted at mental health visit, ‘warm handoff’ to primary care for follow-up
3. All staff use same EMR, goal is good communication
4. Medical clearance is a priority service
5. Monthly PC/BH team meetings/integrated case staffings to discuss process improvement, improve communication, review complex cases
Example of Project Impact

Primary Care Integration

- Client presented with *Diabetes, High Triglycerides, Obesity and Schizoaffective Disorder*
- Progress:

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<th>3/10/14</th>
<th>7/01/14</th>
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<tbody>
<tr>
<td>Glycated Hemoglobin (HbA1c)</td>
<td>11.5</td>
<td>8.7</td>
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Blood sugars before 3/2014: 543, 389, 529, 448, 436, 469
Blood sugars as of 8/2014: 113, 103, 123, 130, 156
Impact

Primary Care Integration

- Client with Diabetes, High Cholesterol, Obesity, Epilepsy, Schizophrenia, and Major Depressive Disorder

- Progress:

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<th>08-29-14</th>
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<tbody>
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<td>Cholesterol (CHOL)</td>
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<td>Triglycerides (TRIG)</td>
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<td>201</td>
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<td>Low Density Lipoprotein (LDL)</td>
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<td>103</td>
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<td>High Density Lipoprotein (HDL)</td>
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<td>46</td>
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<td>Thyroid Stimulating Hormone (TSH)</td>
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<tr>
<td>Blood Pressure (BP)</td>
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<td>107/63</td>
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<tr>
<td>Glycated Hemoglobin (A1C)</td>
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<td>6.4</td>
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<tr>
<td>Weight (WT)</td>
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<td>268</td>
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<tr>
<td>Body Mass Index (BMI)</td>
<td>45.34</td>
<td>39.7</td>
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</table>
Data from program start in 2013:

Number of people served - 3230

Number of medical clearances provided - 815

35% of Integrated Care patients have a HbA1c of 9 or greater, compared to 90% of BH services only patients*

From 4/2014 to 4/2016, 44% of Integrated Care patients had a decrease in their BMI

*or have yet to be tested
Challenges:

- local demand continues to grow
- further primary care growth needed
- clinical staff resources
- over-capacity/upping the bar with CMS/HHSC/DSHS
- costs / sustainability; value to MCOs unknown
- quantifying value across systems
- availability/costs/funding for specialty resources/consultations
Advantages of TTBH Model:

- Use of same electronic medical record
- All pieces of care provision puzzle are under the same roof
  * decreased treatment non-compliance (BH and PC)
- All pieces of care provision puzzle are under the same administrative umbrella
  * administrative communication
  * policies/procedures
  * accreditation
Successes:
- wonderful patient and family outcomes
- increasing quality of care and coordination of care to our patients
- local stakeholder perception - ERs, Law Enforcement (especially for medical clearance), advocacy groups
- program expansion due to successes - 1115 Waiver funded Edinburg and Harlingen, Methodist Healthcare Ministries has since funded full-time clinic in Brownsville
Future of Integrated Care

Susan Garnett, MSW
Chief Executive Officer

www.MHMRtarrant.org/TexasCouncil
What Does an Integrated Health Home Look Like?

• MHMR Tarrant and JPS Hospital District collaborated to build an integrated health home as part of an 1115 project.
• We are working toward “seamless care.”
Level of Collaboration

The project goal is to function as a Level 4 collaboration:

• Shared facility
• Shared operations (scheduling appointments, medical records, etc.)
• Regular face-to-face communication
• Sense of being part of a team

The patient experiences primary care treatment as part of their regular mental health. “Seamless care”
Integrated Health and Chronic Disease

• The goal is to reduce diabetes, hypertension and emergency room visits.
• Served 745 people in 2014-16.
• 60% improvement in hypertension.
• 64% of individuals seen this year have both chronic disease and behavioral health diagnosis:
  – Obesity: 25
  – Asthma: 57
  – Diabetes: 16
  – Hyperlipidemia: 140

“The staff collaborate for what I need.”

Patricia
Integration of Services

• Behavioral Health and Primary Care
  – Primary Care
  – Mental Health
  – Substance Use

• IDD and Mental Health
  – IDD psychiatric clinic
  – Behavioral Health based on the START model
  – Resource Center

• IDD and Chronic Disease Management
  – RN Care Coordination
Integration/Coordination of Chronic Disease

RN Care Management

• Health assessments, medication reconciliation and health education for individuals with IDD
• Chronic disease tracked in Chronic Disease Registry
• 343 individuals served in 2014-15
  – 20% had hypertension
  – 17% had epilepsy
  – 16% had hyperlipidemia
  – 16% had asthma
  – 14% were overweight or obese
Where Are We Going?

• Chronic Disease Registry
• Care coordination with RNs and QMHPs for physical health
• ED super-utilizer project
• Expanding to other sites
• Sustainability:
  • Strategic community partnerships (JPS)
  • Alignment with MCOs
Mental Health in Schools

A Partnership Supporting Prevention and Early Intervention

The Partners

Elgin Independent School District
Hutto Independent School District
Bluebonnet Trails Community Services
The Challenge

Compared with their peers, persons between the ages of 15 to 24 years with a mental health disorder are more likely to:

- experience homelessness
- be arrested
- drop out of school
- be underemployed
Our Response

Co-locating an integrated health clinic in schools where:

- A child is already served with high frequency by educators and counselors
- Families are already connected with the schools
- Educators and counselors have been trained and are identifying symptoms and concerns
- The school is supportive through referrals and strategic planning to meet the needs of families and the community

…and now may have an option for relief by accessing health care at school.
Our Design

What distinguishes our integrated healthcare partnership at a time when, nationally, school-based healthcare is becoming a more widely practiced model:

• **Relationships**: The administrators, teachers and parents are the eyes and ears providing early detection. Together with the healthcare providers, we work together to ensure consideration of the needs and culture of the ISD, families and community.

• **Comprehensive Treatment**: We provide comprehensive healthcare including primary and behavioral health services whereby providers work alongside the ISD Team.

• **Access**: We are effective because knowledgeable persons working with the children each day are quickly identifying student issues whereby care may be immediately triaged based on the severity of circumstances.
Our Design

- **Continuous Education**: Our ISD staff are educated through Mental Health First Aid and continuous information about available care.

- **Innovation**: As our programs began through the Medicaid 1115 Transformation Waiver, we were able to work creatively to address local needs of the ISDs and families and customize approaches.

- **Measureable Success**: Also as our programs began through the Medicaid 1115 Transformation Waiver, we have outcomes informing our healthcare strategies.

- **Sustainability**: Although initiated through the Medicaid 1115 Transformation Waiver, the sustainability plan includes ongoing funding through private insurance, CHIP and Medicaid.
The Benefits of Partnership

• The ISDs teamed with the LMHA allowing for the ISDs to offer services year-round, beyond the academic school year and during breaks when support for children and youths can be limited.

• LMHA clinicians may see students even if the student is suspended, not attending school, in detention, or in the hospital. The LMHA will also support adolescents after hours through crisis intervention services.

• To meet the needs of the families, the ISDs may benefit from the resources of the LMHA including the latest evidence-based practices, including dialectical behavioral therapy, trauma-focused cognitive behavioral therapy and functional family therapy.

• The ISDs may also offer access to the LMHA assertive community outreach; wraparound services that include family, community, and Family Partner support; substance abuse treatment; and additional services that school district mental health professionals may not have the capacity to provide.
The Partners: Hutto ISD

Identifying the Need

Engaging Critical Administrators

Engaging Families

Defining the Services:

- Medical Services through Advanced Family Practitioner and Medical Assistant
- Counseling services through licensed professionals: Mental Health and Substance Use
- Access to psychiatric evaluations via telemedicine
- Immunization Programs
- Sports Physicals
- Services for Families of ISD Students
- Services for ISD Staff
The Partners: Elgin ISD

Identifying the Need

Engaging Critical Administrators

Engaging the Families and Community

Defining the Services:

• Medical Services through Advanced Family Practitioner and Medical Assistant through partnering FQHC, the Community Health Centers of South Central Texas

• Dentist and Dental Hygiene Services underway through FQHC, the Community Health Centers of South Central Texas

• Counseling services through licensed professionals: Mental Health and Substance Use

• Immunization Programs

• Sports Physicals

• Services for Families of ISD Students and Community of Elgin

• Services for ISD Staff
The Outcomes: Healthy and Fulfilled Lives

After 20 months of experience in partnering:

• Reduction in Days of School Missed: Pre- and Post- Data for the growing districts indicate the number of days is just under the outcome for the previous school year

• All children enrolled in the ISDs were able to achieve the immunization expectations for the 2014-2015 and 2015-2016 School Years

• Reduction of Barriers to Healthcare Reported by Families: Identified as the Top Service Satisfaction Priority Achieved during 2014-2015 School Year by Families Served

• Increased Education through Mental Health First Aid Training: 7 training sessions provided with 3 scheduled during Summer 2016

• Number of Persons Served through Same Day Access to Care: 1,956 children and adults
The Sustainability Plan

Although initially funded through the Medicaid 1115 Waiver Program, we are diligent in working to ensure the financial sustainability for the program:

• The ISDs and ISD Health Plan reimburse the providers for care to ISD employees.
• Financial assessment data is captured so that the provider is able to seek reimbursement from private insurance, Medicaid and Medicare.
• The providers are now privileged on 4 of the 11 Medicaid Managed Care Health Plans serving this area and will continue to seek privileging.
• In choosing to work alongside the FQHC, we are able to seek an enhanced rate through Medicaid.
Next Steps

• Consider best options for presence in individual schools within the ISDs – considering mobile clinics and telemedicine
• Increase involvement with ISD Athletics to offer follow up care for injuries
• Increase availability and frequency of immunization program
• Add dental program with Elgin ISD
• Continue to educate our Health Plans (MCOs) regarding the value of School-Based Programs to ensure financial viability
• Continue to look at innovative ways to partner in serving our children and families with a focus on detection, prevention and early intervention of healthcare concerns
• Measure of health outcomes over time: Impact on disciplinary actions as well as days of school missed
Excellence in Mental Health Act

Senators Roy Blunt and Debbie Stabenow

Representatives Leonard Lance and Doris Matsui

Largest federal investment in mental health and treatment addiction in a generation!
The Vision of CCBHCs

• Improve overall health by bolstering community-based mental health and addiction treatment

• Advance behavioral health care to the next stage of integration with physical health care

• Improve care coordination/collaboration

• Utilize evidence-based practices on a more consistent basis
CCBHCs, CCBHC, PPS, states, health, demonstration, services, FQHC, FQHCs, payment, rate, SAMHSA, CMS, Health, system, including, mental health, clinic, managed care, prospective, crisis, Medicaid, consumers, developed directly, authority, developed, either, certified, methodology, process, prospective, service, members, care, choose, refers, certified, payment, requirements, clinic, reboarding, rebasing, mental, clinic, required, system, guidance, program, meet, may, service, year, selected, organization, allowed, authority.
9 CCBHC Service Types

1. Crisis mental health and addiction services
2. Screening, assessment and diagnosis
3. Person and family-centered treatment planning
4. Direct provision of outpatient mental health and substance use services
5. Outpatient primary screening and monitoring of key health indicators and health risk
6. Targeted case management
7. Psychiatric rehabilitation services
8. Peer support and counselor services and family supports
9. Intensive, community-based mental health care for members of the armed forces and veterans
**MARCH 2014**
Excellence in Mental Health Act demonstration enacted in Sec. 223 of the Protecting Access to Medicare Act of 2014.

**OCTOBER 2014**
SAMHSA announced the 24 states that received planning grant funding to prepare for possible participation.

**OCTOBER 2016**
Deadline for states to submit applications to participate in the demonstration program is Oct. 31.

**JANUARY 2017**
Deadline for the Secretary to select the participating states is Jan. 1.

**JUNE 2017**
Selected states have until June 30, 2017 to begin their CCBHC demonstration initiative.
In Texas: 8 Potential CCBHC Sites

1. Austin Travis County Integral Care
2. Bluebonnet Trails Community Services
3. Burke
4. Helen Farabee Centers
5. MHMR Tarrant
6. StarCare Specialty Health System
7. Tropical Texas Behavioral Health
8. Montrose (private entity)
Senate Bill 58 Behavioral Health Integration Advisory Committee

8 Focus Areas

• Holistic Treatment
• Member Activation
• Access
• Administrative Simplification
• Payment Mechanisms
• Outcome Measurement
• State Oversight
• Health Home Pilots
Texas Statewide Behavioral Health Strategic Plan

**Vision:** To ensure that Texas has a unified approach to the delivery of behavioral health services that allows all Texans to have access to care at the right time and place.

**Mission:** To develop a coordinated statewide approach to providing appropriate and cost-effective behavioral health services to Texans.