Integrated Care In Indiana

Lessons from the SAMHSA Integration Projects

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Integrated Care SAMHSA Projects

- Indiana has six funded SAMHSA integration projects that span the state
- Projects include:
  - Centerstone (Funding ended October 2014)
  - Regional (Funding ended October 2014)
  - Adult and Child (Funded extended)
  - Midtown Community Mental Health at Eskenazi Health (final year of grant)
  - Porter-Starke Services (with Oaklawn & Swanson Center; now in the second year)
  - Community Health Network Foundation (with Aspire, now in the second year)

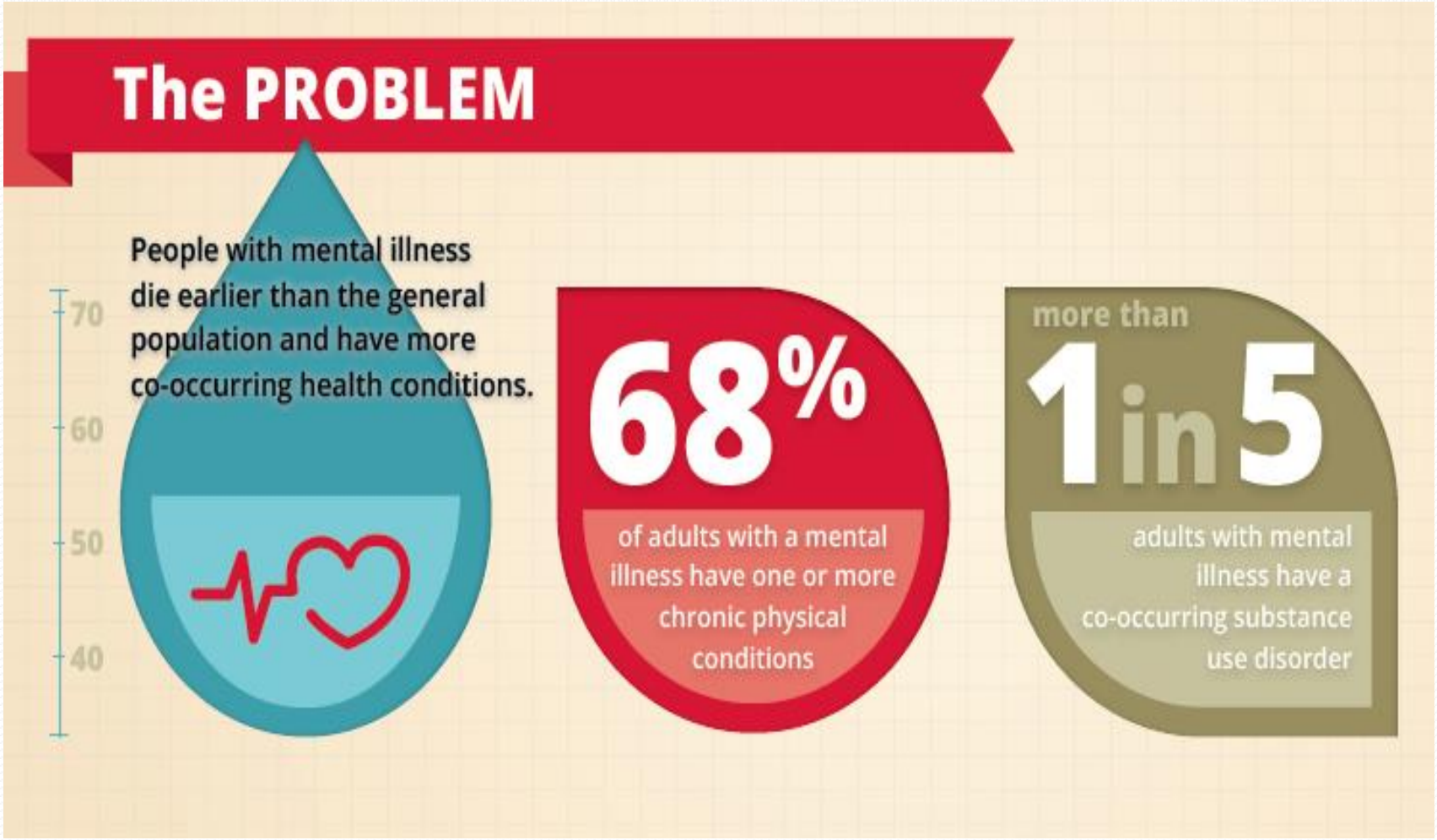
Six Levels of Integration

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice

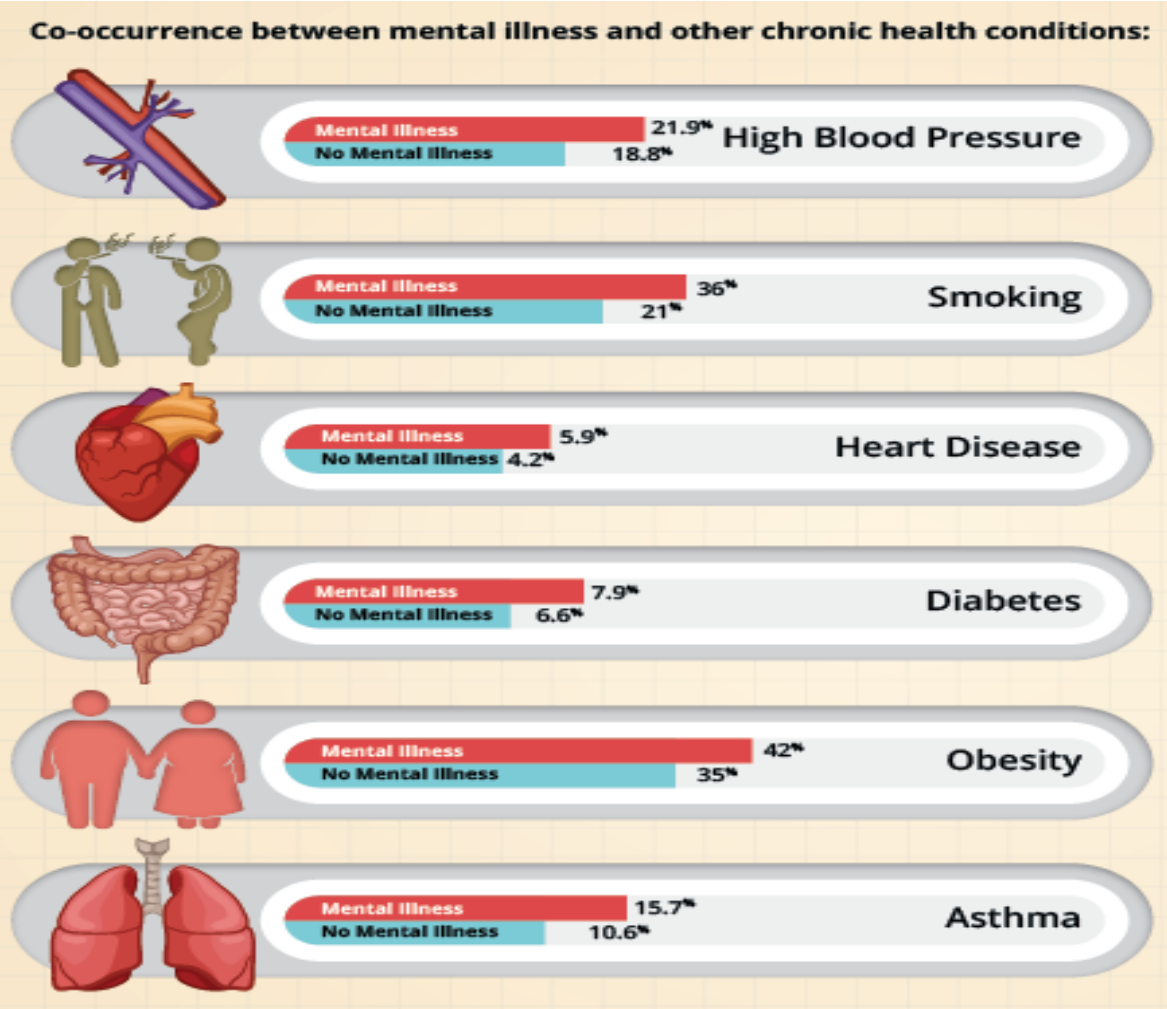
Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

Research Support for Integration



www.integration.samhsa.gov/Integration_Infographic_8_5x30_final.pdf

Research Support for Integration



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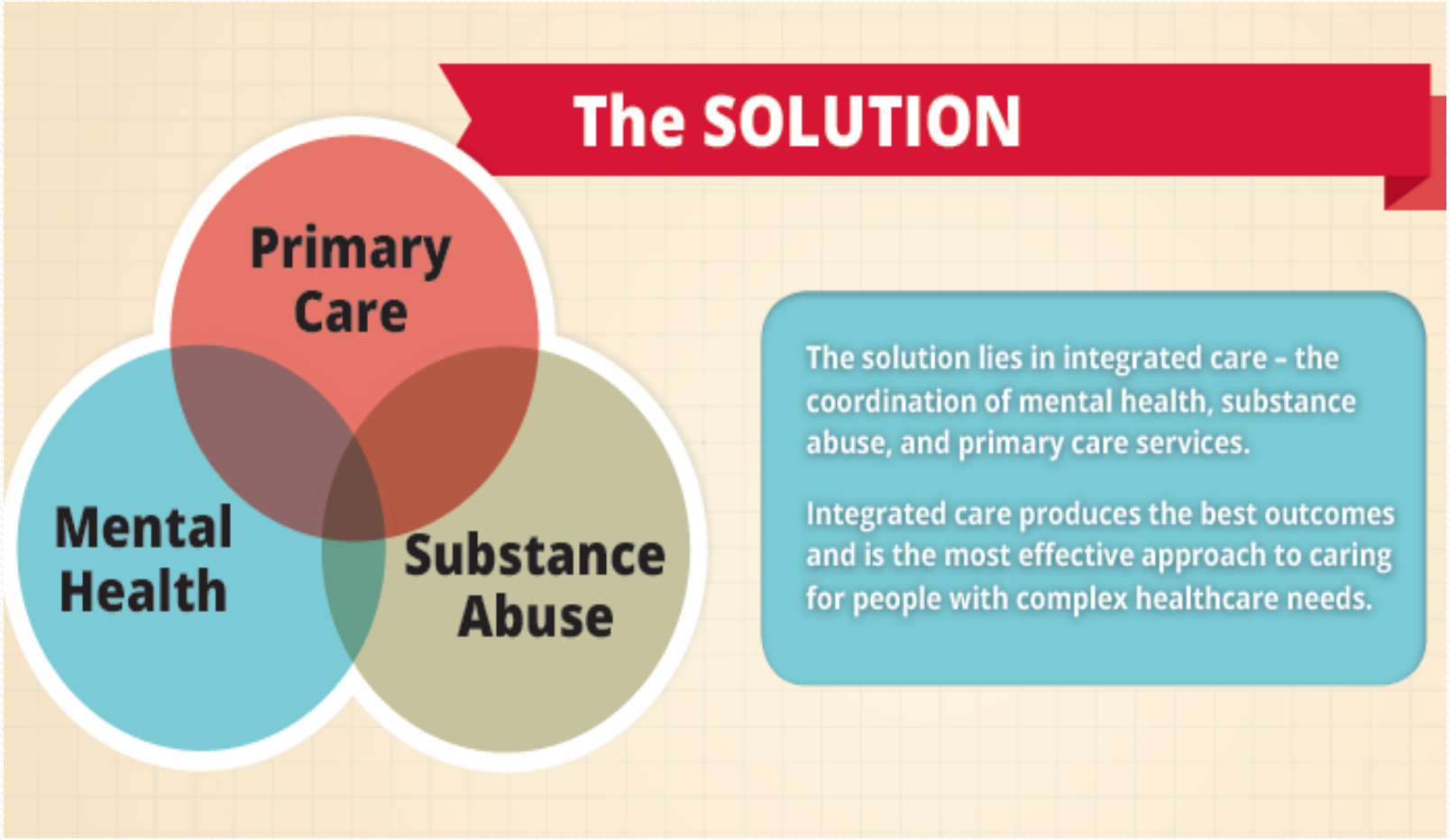


www.integration.samhsa.gov/Integration_Infographic_8_5x30_final.pdf

Rand Analysis of SAMHSA Grant Results

- Looked at the program nationally over three years of operation (56 programs)
- High rates of mental health, substance use and chronic medical problems among the enrolled population
- 22% of enrollees did not continue in the program, with an average of 7 months enrollment per client
- Little variation in contact level based on physical health needs.
- Programs coordinated and managed complex comorbid health conditions
- Clinics in rural locations experienced more difficulty coordinating and managing care.
- Clinic enrollees showed improved (compared to the control group) on some but not all of the physical health indicators. They showed no difference in behavioral health outcomes.

Rand Analysis of SAMHSA Grant Results

Integrated Care
CONTRIBUTED TO IMPROVEMENTS IN PHYSICAL HEALTH

Indicators for select chronic conditions–
diabetes,
high blood pressure, and
high cholesterol–
improved
when consumers received integrated care

behavioral and mental health providers spent **time together at weekly meetings**

practice integration

Consumers were more likely to access integrated services when...

behavioral health and primary care practices were **co-located** in the same building

co-location

provider staff members perceived that they were **part of a team**

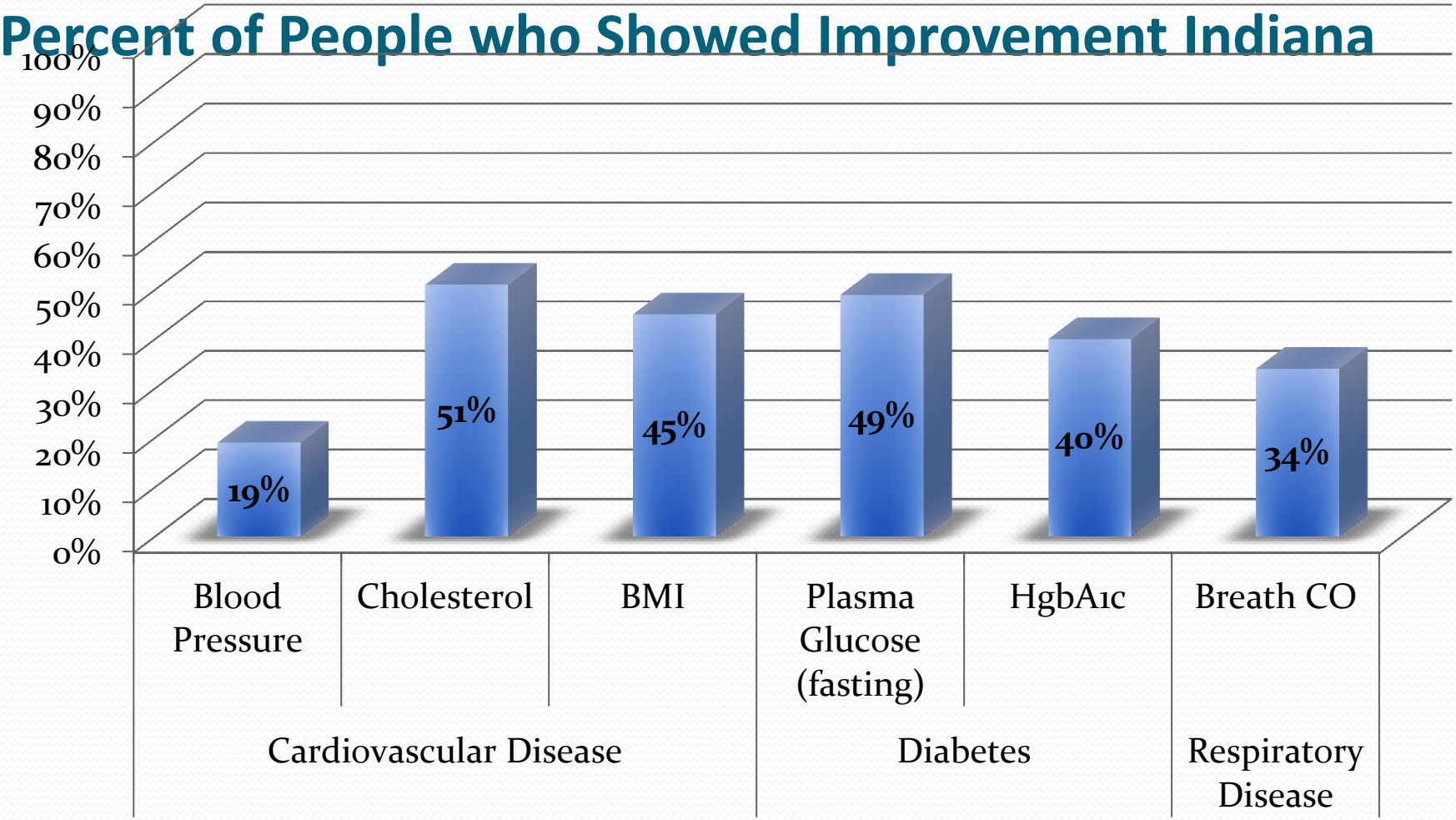
shared culture

Scharf, et. al., *Evaluation of the SAMHSA Primary and Behavioral Healthcare Integration (PBHCI) Program: Final Report (Task 13)*, Santa Monica, CA: RAND Corporation, RR-546-DHHS, 2014. (available at http://www.rand.org/pubs/research_reports/RR546.html)

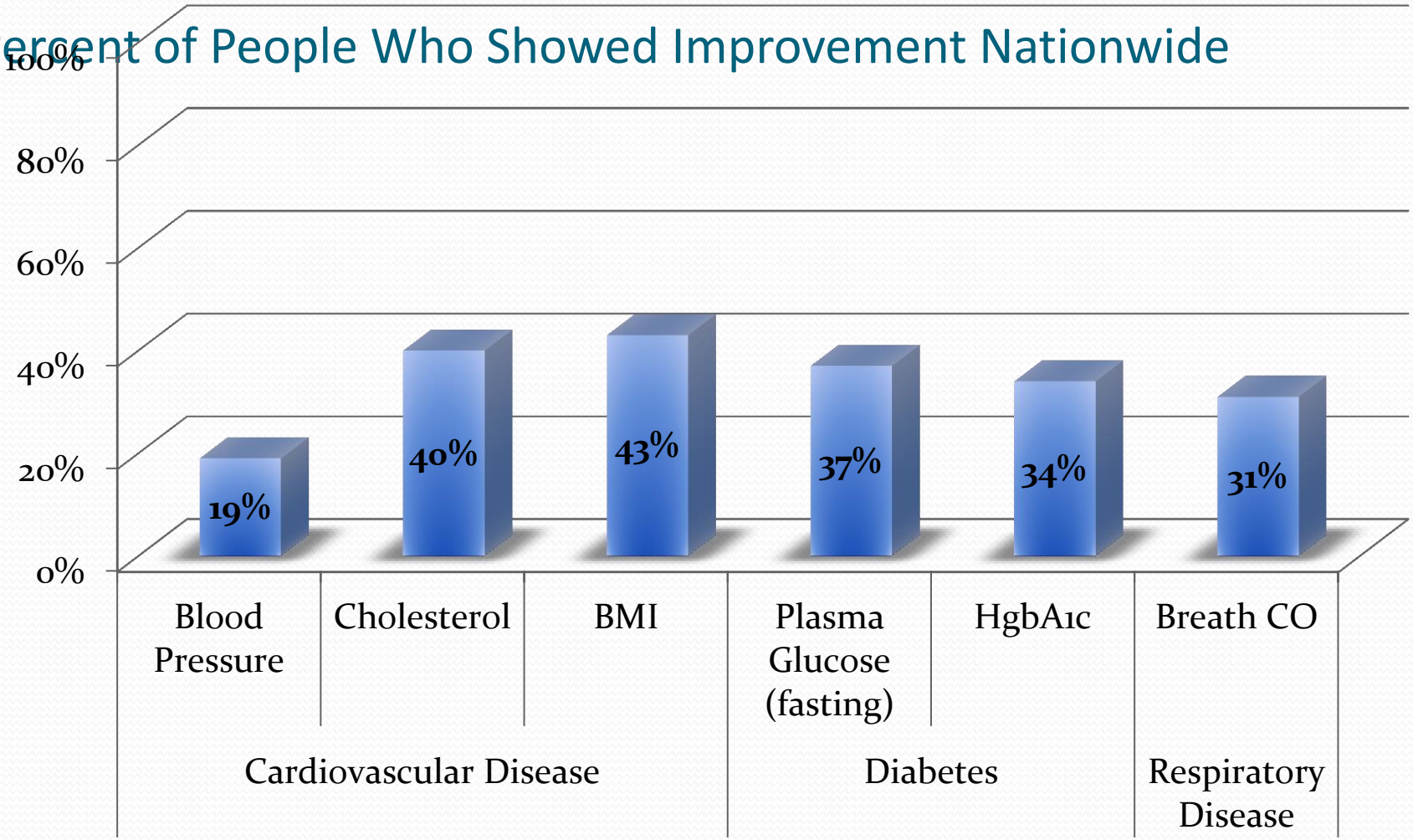
Rand Recommendations

- Systematic needs assessments of client needs, preferences, attitudes and beliefs about integrated care.
- Assessment of barriers to integration at the organizational, community and health care community levels.
- Assessment of processes for identification of individuals and connection to appropriate health care resources (what is, what should be)
- Development of patient registries to insure delivery of services appropriate based on assessed health needs
- Implementation of continuous quality improvement practices
- Use of evidence based practices with fidelity by integrated care clinics
- Facilitate consumer access to care including resolution of transportation barriers
- Provide on-going education to staff about availability of integrated care services and select staff for integration carefully
- Build partnerships with other community organizations with clear expectations for data sharing, roles and responsibilities
- Establish clear performance expectations and quality metrics

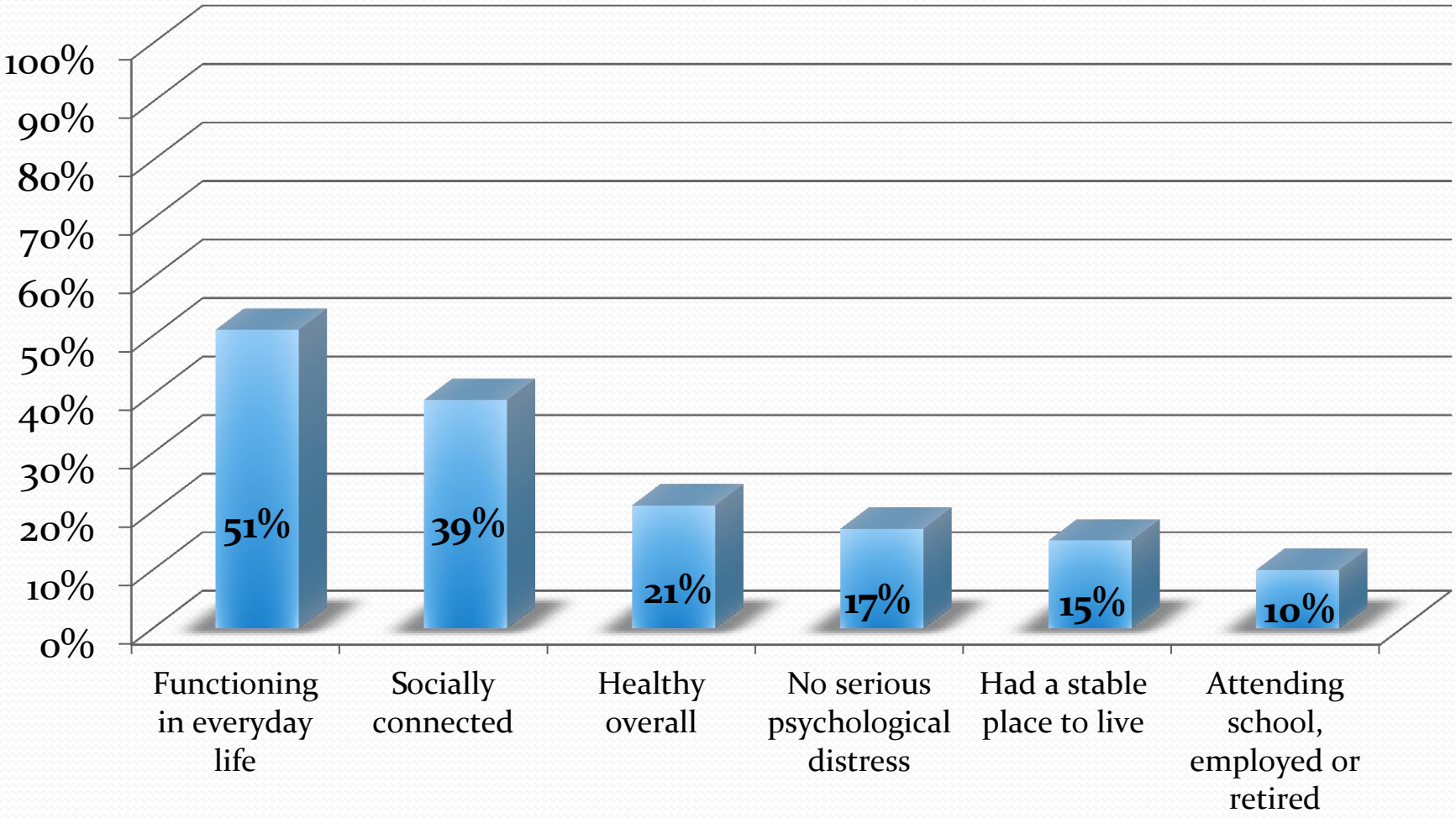
Percent of People who Showed Improvement Indiana



Percent of People Who Showed Improvement Nationwide



Improvement in NOMs Indiana



Strong Mind and Body Wellness Project (Oaklawn, Porter-Starke, Swanson: FQHC's HealthLinc and Indiana Health Center)

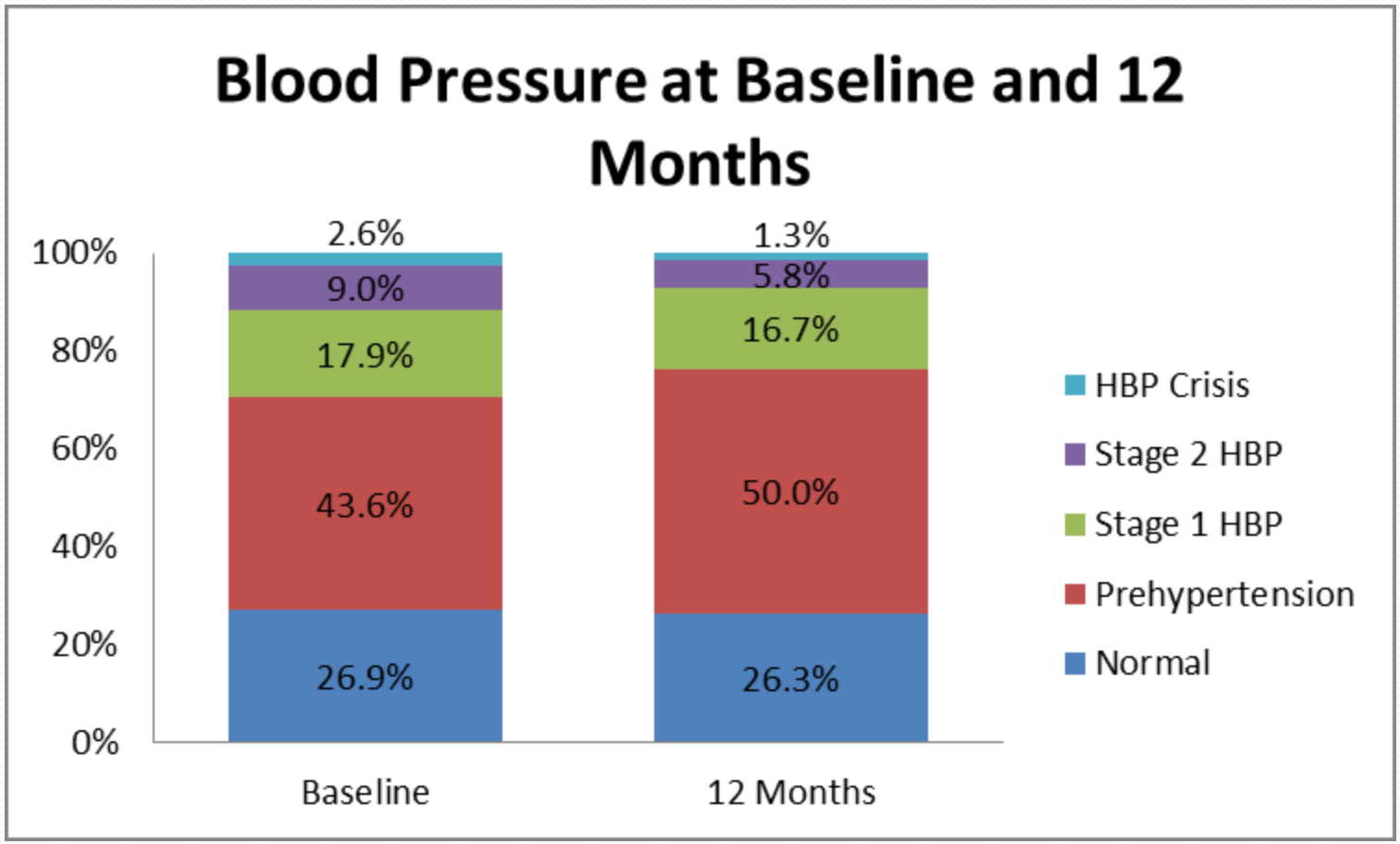
Services Outcome Measures (PBHCI only)

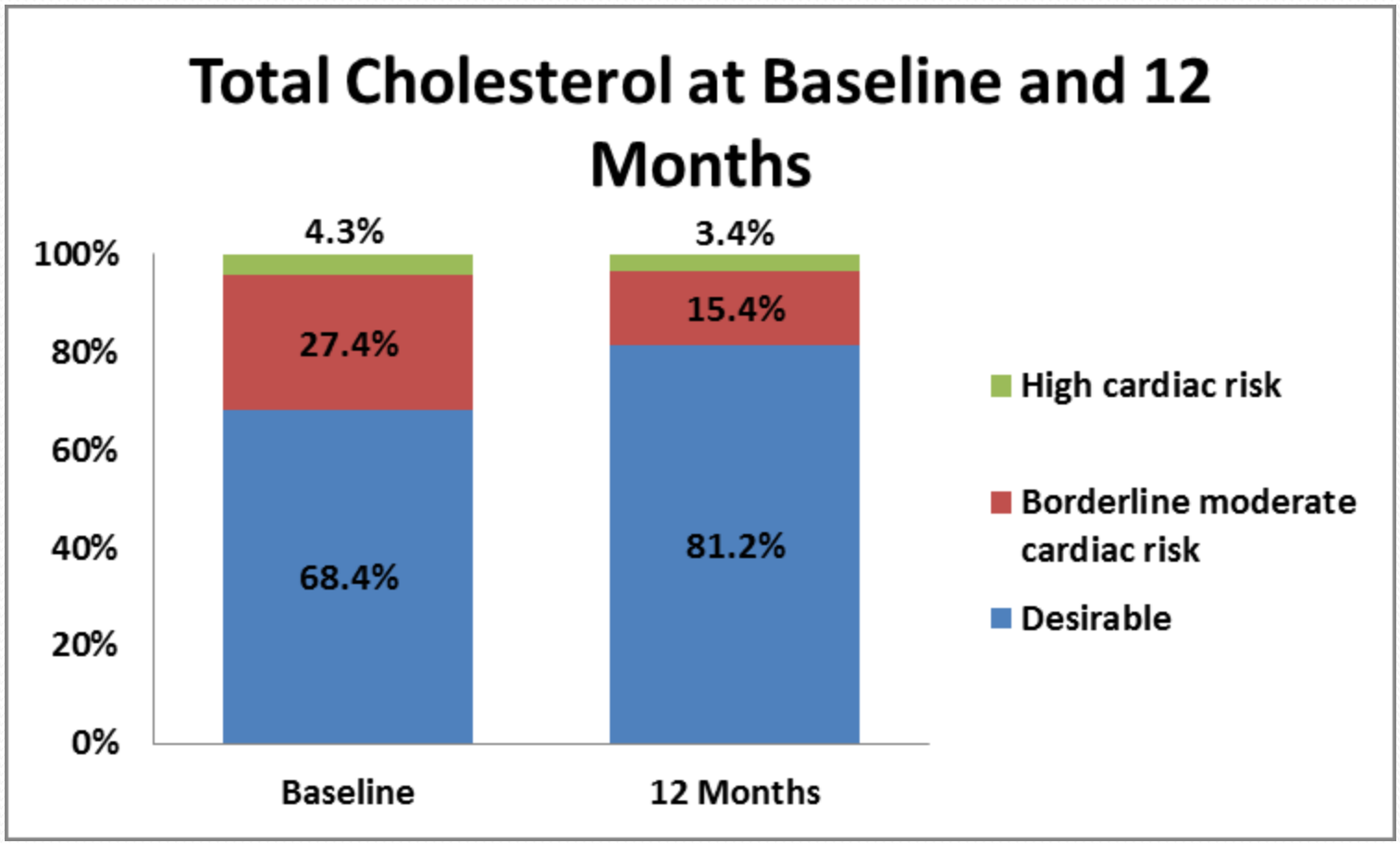
Baseline to 1st 6-month reassessment

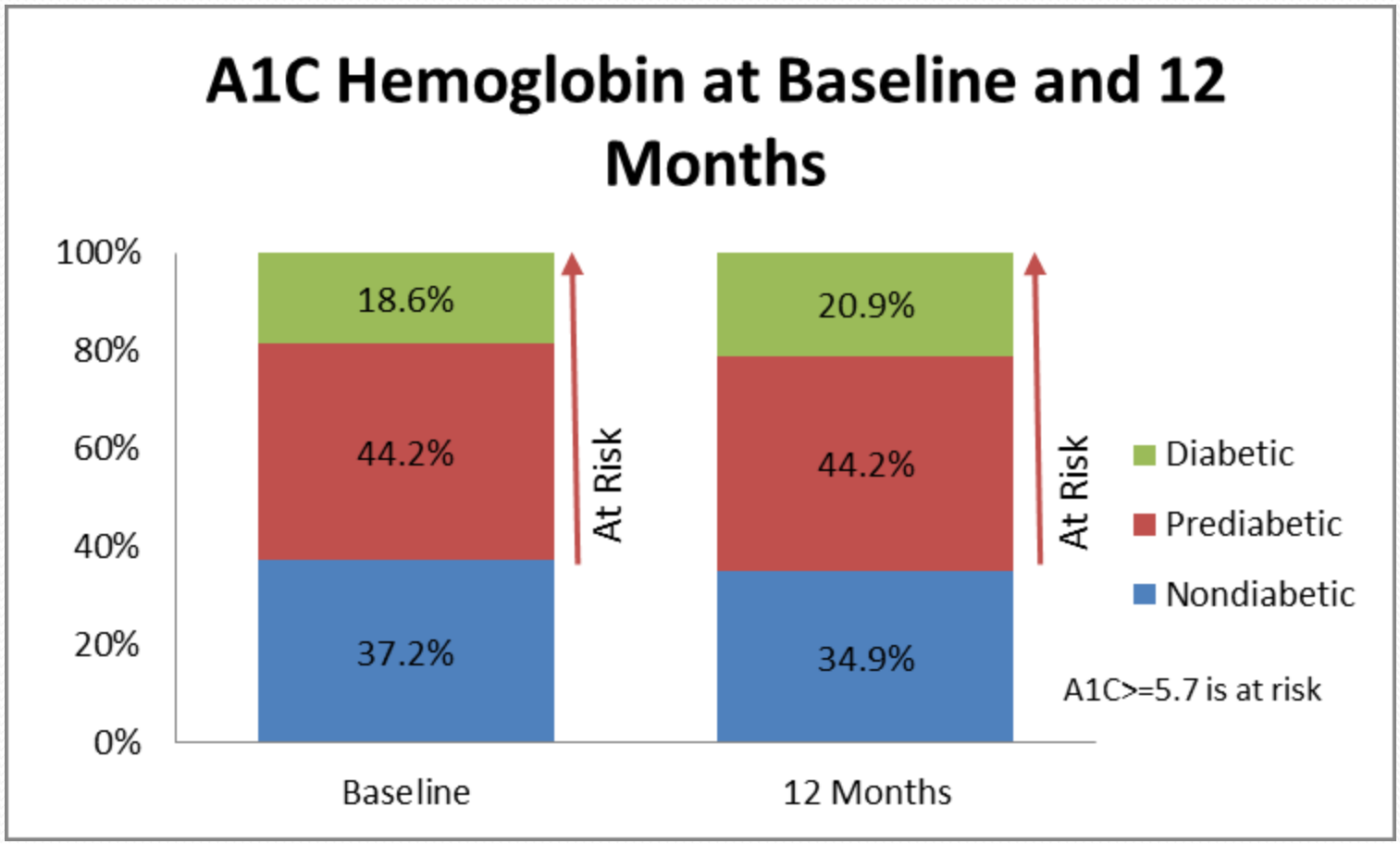
Section H Indicator	Number of Valid Cases	At-risk at Baseline	At-risk at Second Interview	Outcome Improved	No Longer At-risk	Outcome Remained At-risk
Blood Pressure - Systolic	101	43.6 %	30.7 %	15.8 %	21.8 %	21.8 %
Blood Pressure - Diastolic	101	30.7 %	27.7 %	7.9 %	14.9 %	15.8 %
Blood Pressure - Combined	101	48.5 %	39.6 %	14.9 %	19.8 %	28.7 %
BMI	97	87.6 %	87.6 %	41.2 %	5.2 %	82.5 %
Waist Circumference	99	74.7 %	70.7 %	50.5 %	8.1 %	66.7 %
Breath CO	95	60.0 %	65.3 %	41.1 %	2.1 %	57.9 %
Plasma Glucose (fasting)	0	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %
HgbA1c	0	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %
HDL Cholesterol	1	0.0 %	0.0 %	100.0 %	0.0 %	0.0 %
LDL Cholesterol	1	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %
Tri-glycerides	1	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %

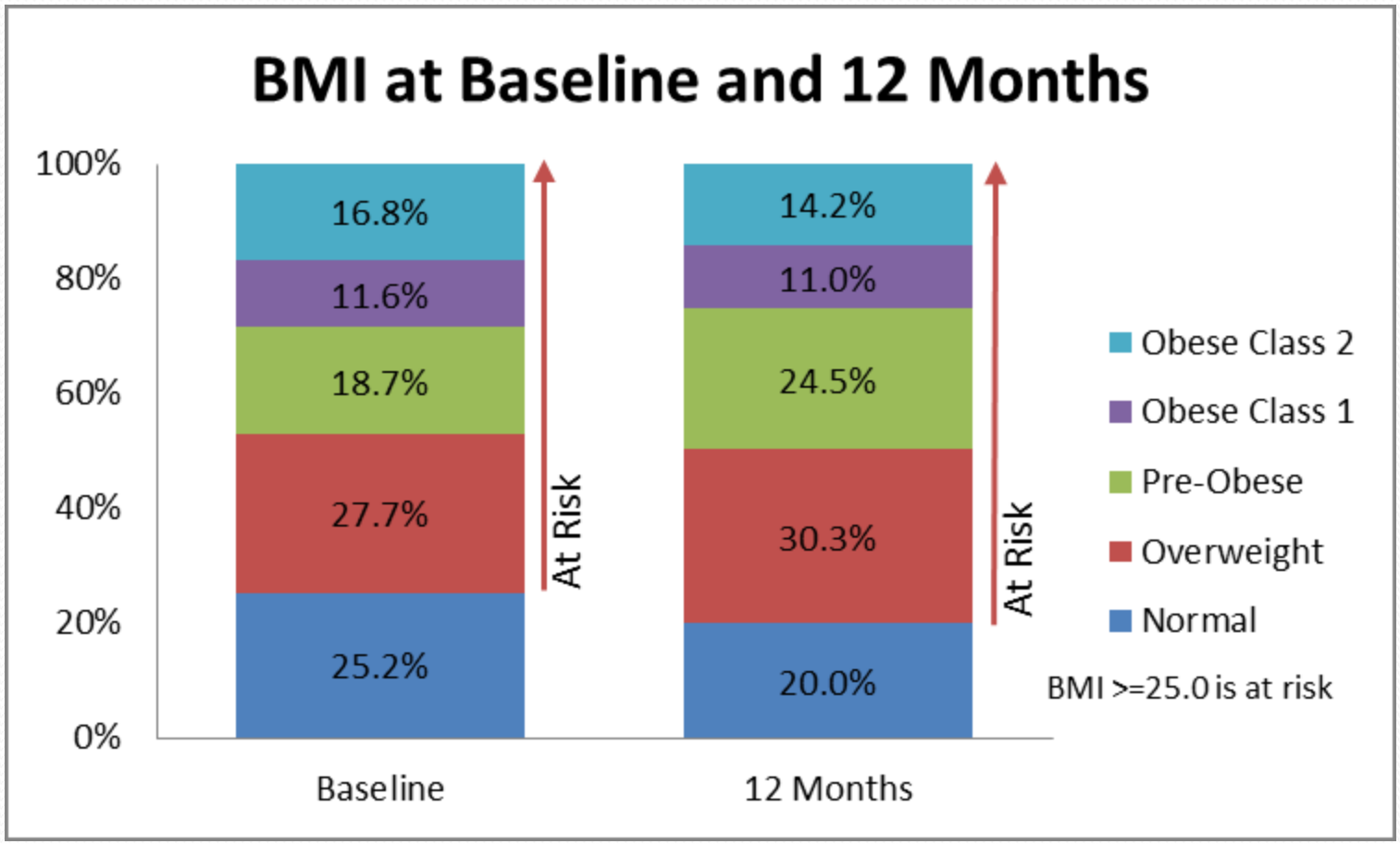
Midtown Primary Care
Data through 9/30/2014

- The Eskenazi Health Primary Care Integration Team began seeing consumers in May of 2012. As of September 30, 2014, the primary care staff has seen 946 consumers for a baseline physical assessment with 688 consumers completing a baseline National Outcome Measures Survey (NOMS).


Blood Pressure at Baseline and 12 Months
100%
80%
60%
40%
20%
0%
2.6%
9.0%
17.9%
43.6%
26.9%
1.3%
5.8%
16.7%
50.0%
26.3%
Baseline
12 Months
HBP Crisis
Stage 2 HBP
Stage 1 HBP
Prehypertension
Normal


Total Cholesterol at Baseline and 12 Months
100%
80%
60%
40%
20%
0%
4.3%
27.4%
68.4%
3.4%
15.4%
81.2%
Baseline
12 Months
High cardiac risk
Borderline moderate cardiac risk
Desirable


A1C Hemoglobin at Baseline and 12 Months
100%
80%
60%
40%
20%
0%
18.6%
44.2%
37.2%
20.9%
44.2%
34.9%
At Risk
At Risk
Diabetic
Prediabetic
Nondiabetic
A1C>=5.7 is at risk
Baseline
12 Months


BMI at Baseline and 12 Months
100%
80%
60%
40%
20%
0%
16.8%
11.6%
18.7%
27.7%
25.2%
14.2%
11.0%
24.5%
30.3%
20.0%
At Risk
At Risk
Obese Class 2
Obese Class 1
Pre-Obese
Overweight
Normal
BMI >=25.0 is at risk
Baseline
12 Months

Integration FQHC'S and CMHC'S Different Cultures

Primary Care (PC) Lens

- Disease Management
- Saved Lives
- Clear Goals
  - Reduce Risk
  - Prevent Decline Function
  - Minimize Suffering
- Patient Stays Patient

Behavioral Health Lens

- Recovery Model
- Meaningful Lives
- Lifelong Aim Toward
  - Independence
  - Community Engagement
  - Planning for Relapse
- Patient→Consumer

Integration FQHCs and CMHCs: Different Focus and Populations

FQHC

- Focus on registry based populations, e.g. individuals with diabetes
- Provide medical home with care management for high risk individuals based on medical condition
- Focus on short term behavioral interventions to improve medical condition

CMHC

- Focus on high need priority populations – adults with SMI, chronic addictions and children with SED
- Provide medical home with care/case management for priority populations with support "on the ground"
- Focus on case management, wellness programming and skills training to change lifestyle decisions to improve medical and behavioral health outcomes.


Processes to Innovate
Innovation Pathways
Blend Cultures
Communicate and Eliminate Barriers
Use People with IT
Stress Simplicity
Innovate
Create Road Maps
Recognize and Reward
Collaborate and Listen
Co-Create Solutions

Midtown Community Mental Health - Lessons Learned

- Initial Model from Grant Application was to hire NP's
- Changed quickly to leasing for capacity from medical group affiliated with hospital IUMG now EMG
- Able to bill for services due to separate NPI numbers
- NP'S spend 100% of time dedicated to seeing patients affiliated with Midtown

Midtown Community Mental Health - Lessons Learned

- Established a clinic within a clinic at our largest clinic site
- Staff hired
  - RN charge nurse-shift in focus from original staffing pattern
  - Medical Assistants
- Fully functioning primary care office suite
  - 2 exam rooms
  - Lab space
  - Registration completed in office suite

Midtown Community Mental Health - Lessons Learned

- It's all Greek to me
- Communicate, communicate, communicate…..
- Patients versus clients
- Keep the message in front of everyone
- Get buy in from all levels of management
- Don't be afraid to change the model when it isn't working right

What are the Advantages that Indiana Has?

- Commitment to integration at the FSSA, DMHA and OMPP levels
- A history of involving stakeholders in the analysis and determination of state direction and policy regarding integration.
- A stakeholder group that is broad based and includes OMPP, DMHA, IDOH, CMHCs, FQHCs, HIE interests etc. and is poised to add the MCEs and others.

Challenges in Indiana: Workforce

- Workforce Issues
  - Shortage of physicians and nurse practitioners (primary care) and shortage of physicians that are knowledgeable about this model
  - Lack of definition of the necessary skill set for Health Advocates , determination of the training programs needed and provision of training in the skills needed to fully support integration
  - Inability of most CMHCs to offer loan forgiveness

Challenges in Indiana: Design and Reimbursement

- Design:
  - Partner with a medical provider, typically a FQHC or,
  - Directly hire and deliver medical care
- Reimbursement:
  - FQHCs can bill at a PPS rate that covers their costs as long as the insurance mix is primarily Medicaid and/or Medicare
  - CMHCs cannot bill under their existing Medicaid number, limiting access to enhanced funding (Facility and Hospital Assessment Fee), making sustainability of this model generally not feasible.
  - Not all services are currently reimbursable (consultations between medical and psychiatry, huddles etc.)
  - Supportable only for those clients that have MRO coverage

Challenges in Indiana: FQHC Partnerships Pitfalls

- Partnerships with an FQHC can be mutually advantageous and provide integrated care to the CMHC priority populations, ideally at the CMHC site.
- FQHCs:
  - May demand a compelling financial basis for initiating a Change in Scope to the CMHC site
  - May or may not be interested in this integrated care model (or integration at all)
  - Have had mental health dollars provided to them and may select to deliver services themselves
  - Partnerships may be dependent on the leadership present at the time and with leadership change commitments may also change.

Challenges in Indiana: Data Sharing

- Difficulty getting cost data especially for medical services
- Some health information exchanges (HIE) are concerned about inclusion of behavioral health data and their ability to manage those data within the current HIPAA and other regulatory environment, effectively excluding those providers from the HIE.
- Electronic medical records when multiple providers are involved make data sharing difficult

Challenges in Indiana: Other

- Culture Change
- Increased attention in behavioral health to medical outcomes and translating that to action, how do you help people increase exercise, decrease weight etc.
- Wellness focus – how do you promote and support wellness
- Effectively linking medical and behavioral health providers, forming joint treatment goals and strategies
- Behavioral health documentation requirements are onerous and do not fit easily into the integrated care, rapid service delivery framework
- Transportation barriers impede expansion into rural areas and interfere with implementation in urban areas.

In Closing

- Integration works but is hard work
- Integration is sustainable only in a partnership model at present due to low reimbursement
- Need robust workforces development efforts at a state level
- State can:
  - Allow CMHCs to bill medical under their existing Medicaid numbers (Council legislative agenda item),
  - Pursue the State Plan Amendment for integration
  - Pursue the planning grant under the Excellence in Mental Health Act
  - Reinvigorate the Stakeholder group
  - Other?