DELIVERY SYSTEM REFORM:
A MODEL FOR DELIVERY OF INTEGRATED PRIMARY & BEHAVIORAL HEALTHCARE TO INDIVIDUALS WITH SEVERE MENTAL ILLNESS

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PROBLEM

- Many TTBH clients have chronic and co-morbid conditions including hypertension, diabetes, and obesity
- Unable or unwilling to seek Primary Care services
- Physical and behavioral health are interdependent
- Belief that care for the whole person is integral to healing
OPPORTUNITIES

- Establish primary care clinics within TTBH behavioral health clinics
- Provide primary care services to TTBH clients with co-morbid chronic disease using an integrated approach to care
- Improve the Health, Wellness, and Life Expectancy of the SPMI population served
INTEGRATION STRATEGY

“Reverse Co-location”, Bi-Directional model

Employ a team of primary care professionals to staff clinics within 3 TTBH clinics

2 of the 3 clinics funded by DSRIP
STAFFING

Behavioral Health Services
• Psychiatrist or mid-level
• RNs, LVNs
• LPHAs
• QMHP/Case Managers
• Peer Staff
• Support Staff, PAP clerk

Primary Care Services
• Primary care physician or mid-level
• Chronic Care RNs
• LVNs, CMAs, CNAs
• Registered Dietician
• Care Co-coordinator
• Support Staff, PAP clerk
STRENGTHS

- Commitment to organizational transformation
- Integration Champions
- Single Electronic Health Record
- Single Patient Centered Recovery Plan
- Warm Hand-offs
- Continual bi-directional communication
- Plan to integrate new SUDs OP services
STRENGTHS

- All pieces of care provision puzzle under the same roof & administrative umbrella:
  - Decreased treatment non-compliance (BH and PC)
  - Administrative communication
  - Policies & Procedures
  - Accreditation
1. Integrated Primary and Behavioral Health Care

2. “In-House” Medical Clearances

3. Chronic Care Management
DATA

**CAT 2 METRICS**
- UNIQUE CLIENTS SERVED
- ENCOUNTERS
- DISEASE SELF-MANAGEMENT GOALS
- FREQUENCY OF CQI ACTIVITIES

**CAT 3 OUTCOMES**
- Diabetes Care: HbA1c Poor Control (> 9.0%)
- Controlling High Blood Pressure (< 140/90)
- Visit Specific Satisfaction (VSQ-9)
ACCESS TO INTEGRATED PRIMARY CARE

CATEGORY 2 METRICS

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“IN-HOUSE” MEDICAL CLEARANCES

CATEGORY 2 METRICS

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ACCESS TO CHRONIC CARE MANAGEMENT

CATEGORY 2 METRICS

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ACCESS TO CHRONIC CARE MANAGEMENT
Category 2 Metrics

Encounters with Chronic Care Nurse

- **DY4 Target**: 2750
- **DY4 Achieved**: 4920
- **DY5 Target**: 3000
- **DY5 Achieved**: 7901

Access to Chronic Care Management
CLIENTS with SELF-MANAGEMENT GOALS

CATEGORY 2 METRICS

ACCESS TO CHRONIC CARE MANAGEMENT
HBA1C POOR CONTROL (> 9.0%)
VISIT SPECIFIC SATISFACTION (VSQ-9)
CONTROLLING HBP (< 140/90)

CATEGORY 3 OUTCOMES

CLIENTS with BP < 140/90

- DY3 BASELINE: 58.2%
- DY4 TARGET: 59.3%
- DY4 ACHIEVED: 57.5%
- DY5 TARGET: 60.4%
- DY5 ACHIEVED: 54.3%
OUTCOMES

- 44% of clients receiving integrated PC services had a decrease in BMI

- Decrease in BH treatment non-compliance as clients report wanting to maintain primary care services.
CHALLENGES

- Integration of medical model service into a well-established behavioral health system/culture
- Recruitment & Retention of qualified, culturally competent clinicians
- Maintaining Practice Consistency
- Need to expand array of available primary care services
CHALLENGES

- Growing demand for primary care to uninsured with SPMI
- Availability/costs/funding for specialty resources/consultations
- Value to MCO’s unknown
- Quantifying data across systems
- Costs & Sustainability
SUSTAINABILITY

- Revenue generation:
  - Legislation to expand Medicaid for SPMI population
  - Negotiating with MCOs - Include primary care in Managed Care contracts

- Alternative funding sources:
  - Recent 501(c)3 designation
  - Sí Texas: Social Innovation for a Healthy South Texas
  - Local Support – Valley Baptist Legacy Foundation

- Keys:
  - **Outcome data** – Supporting efficacy of our integrated care model for the target population
  - **Evaluation rigor** - Sí Texas project
CQI & FIDELITY

Weekly: LOC 3 Case Staffings

Monthly:
- Integration Workgroup - BH and PC clinical directors, program managers and supervisors
- Integrated BH and PC Case Conferences - Discuss uniquely complex/challenging cases
- 1115 Waiver Performance Improvement Committee - Monitor progress with DSRIP metrics, Cat 3 outcomes, and core components
NEXT STEPS

- Continued emphasis on BH and PC clinicians endorsing collaborative and coordinated care
- Evaluate results of PHQ 9 assessments (6th vital sign) of patients receiving integrated care
- Data sharing & quantifying impacts across systems
- Expansion of primary care resources/services