

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
- ▶ 40% of premature mortality is caused by behavior (New England Journal of Medicine: We Can Do Better: Improving the Health of the American People, Sept. 2007).
- ▶ 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

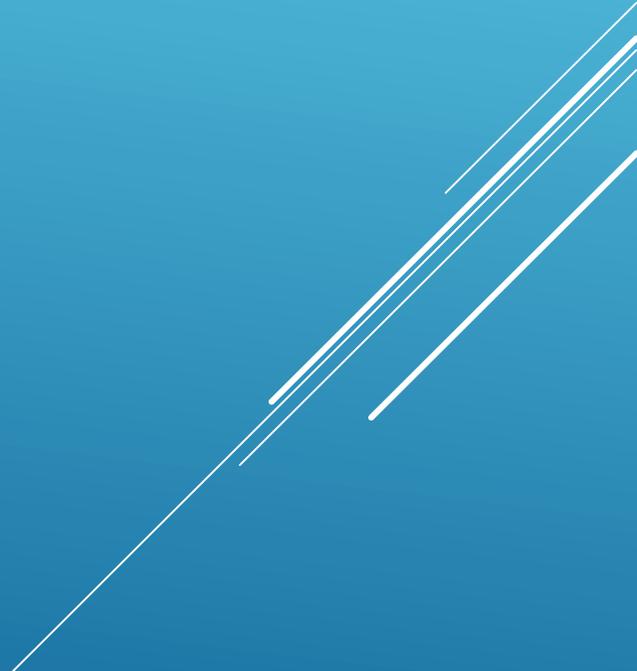
Behavioral Health Services

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

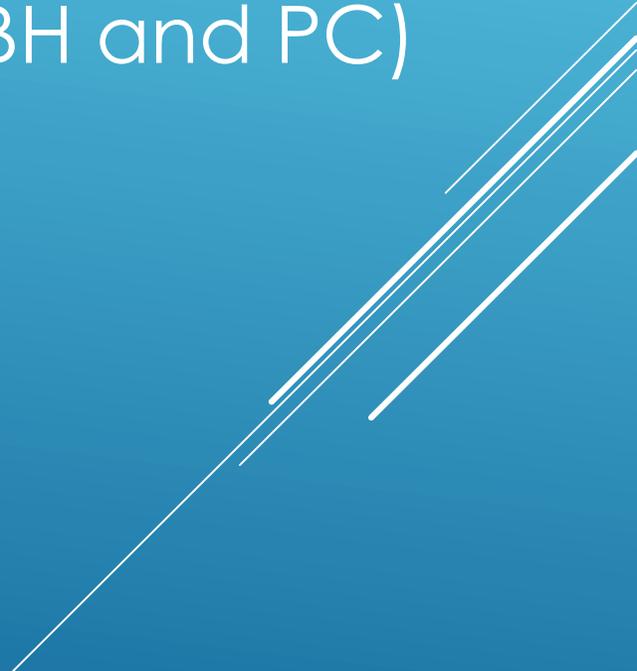
Primary Care Services

- 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
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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
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PRIMARY CARE DSRIP PROJECTS

1. *Integrated Primary and Behavioral Health Care*
 2. *“In-House” Medical Clearances*
 3. *Chronic Care Management*
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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)

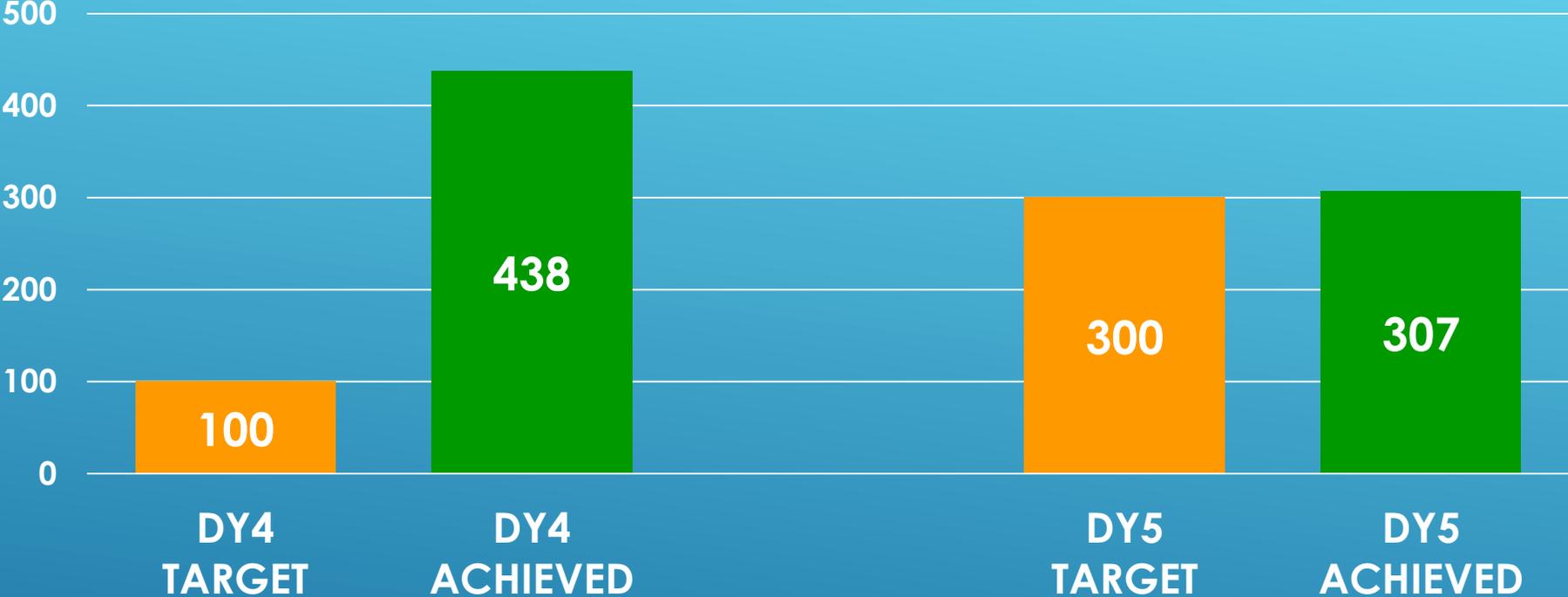
CATEGORY 2 METRICS



ACCESS TO INTEGRATED PRIMARY CARE

CATEGORY 2 METRICS

UNIQUE
CLIENTS
SERVED



“IN-HOUSE” MEDICAL CLEARANCES

CATEGORY 2 METRICS



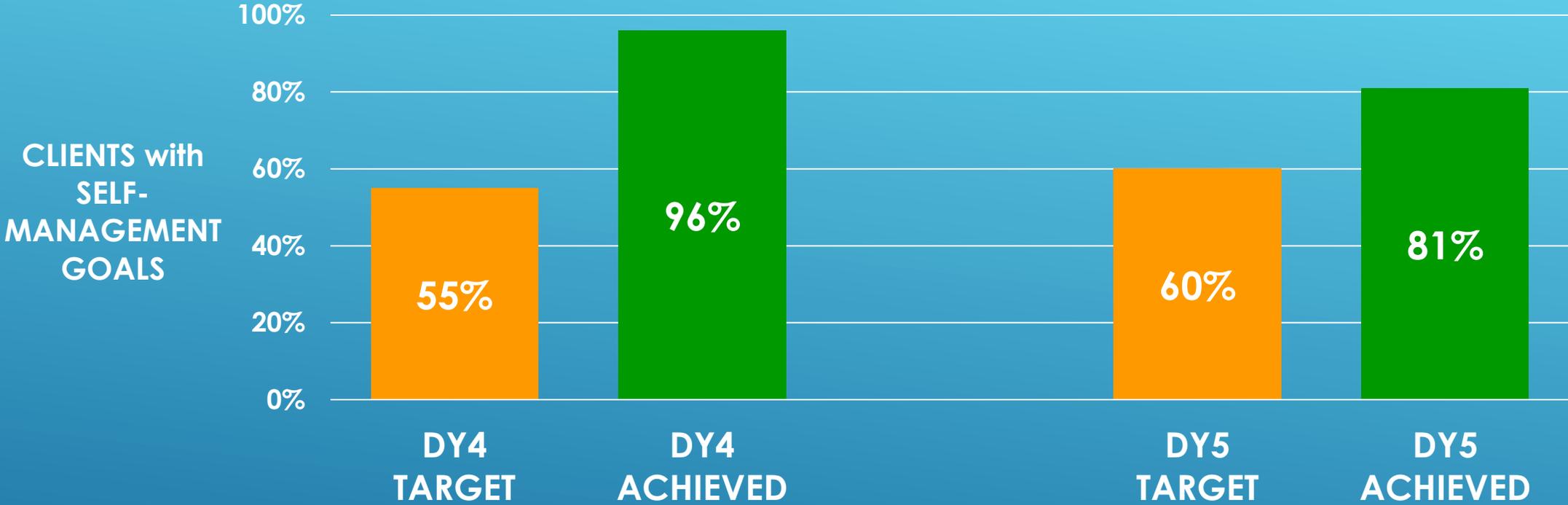
ACCESS TO CHRONIC CARE
MANAGEMENT

CATEGORY 2 METRICS



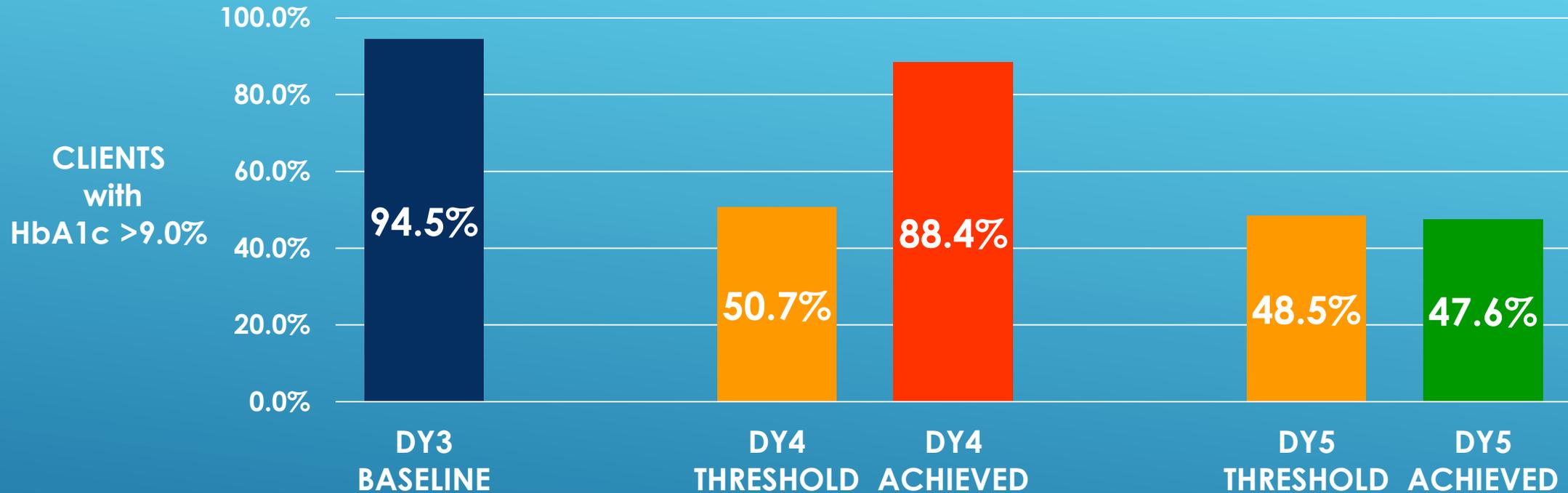
ACCESS TO CHRONIC CARE MANAGEMENT

CATEGORY 2 METRICS



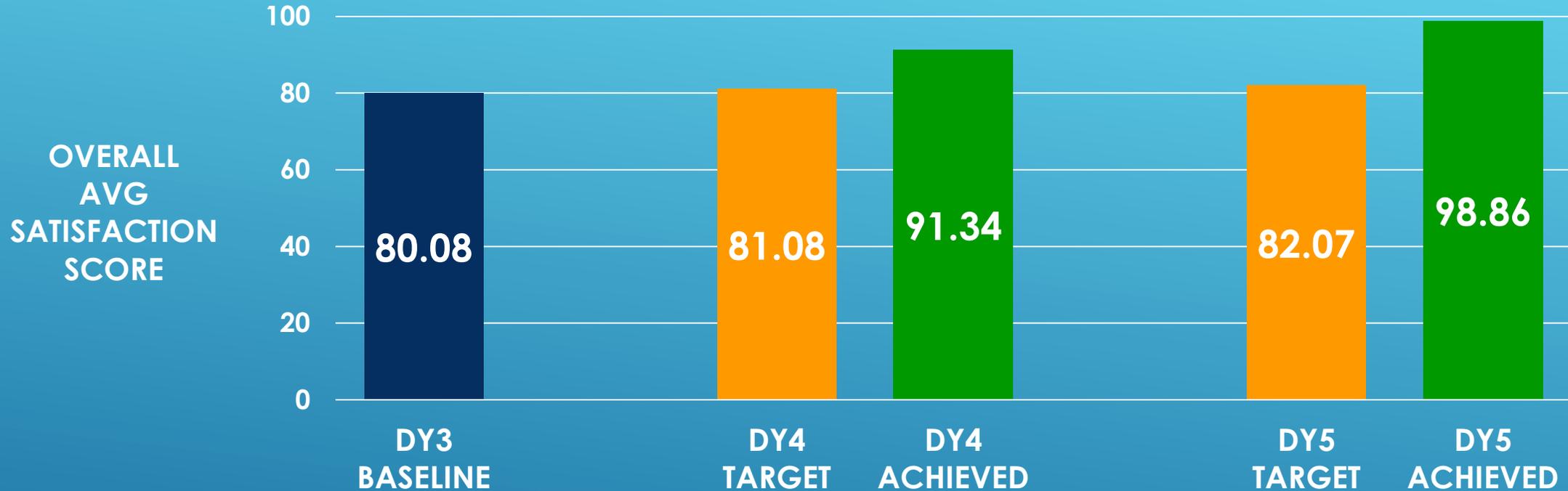
ACCESS TO CHRONIC CARE MANAGEMENT

CATEGORY 3 OUTCOMES



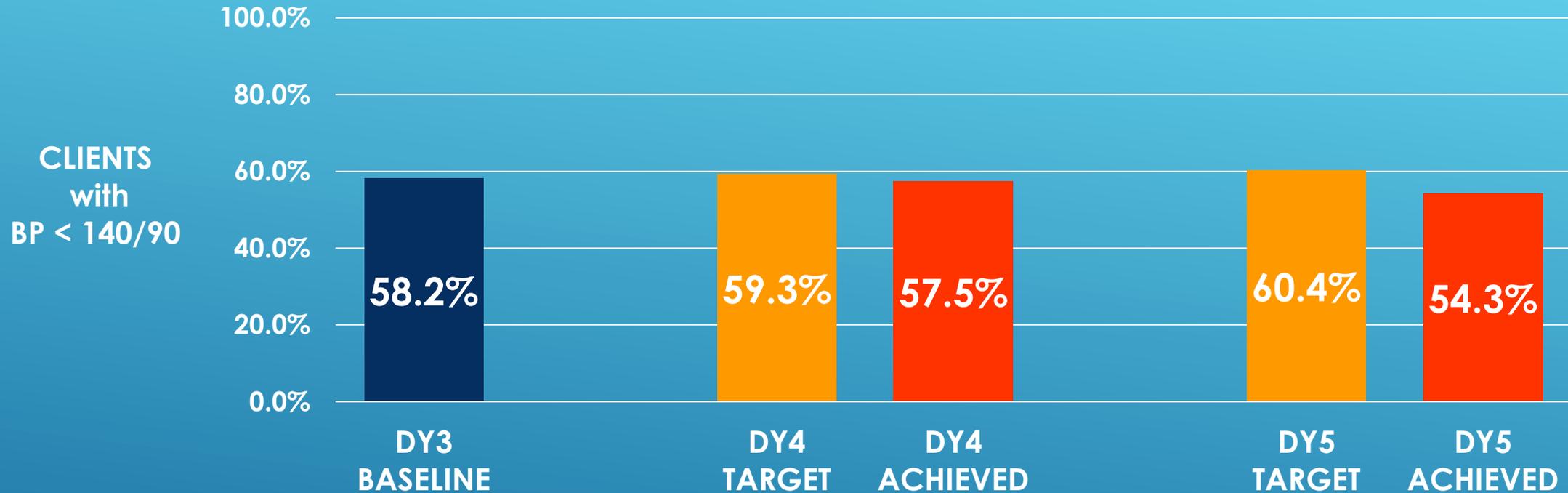
HBA1C POOR CONTROL (> 9.0%)

CATEGORY 3 OUTCOMES



VISIT SPECIFIC SATISFACTION
(VSQ-9)

CATEGORY 3 OUTCOMES



CONTROLLING HBP (< 140/90)

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.
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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
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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
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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

QUESTIONS?

