Integrated Care Models for Consumers with Complex Behavioral Health Needs

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Webster’s Unabridged Dictionary defines:

Integrate - to make whole

AND

Integration - the act of making entire
Person Centered Integration

- Starts from the person out to the system

- Must occur in all areas
  - Psychosocial needs
  - Social services
  - Clinical care
  - Case management
Key to understanding integration

Where are we and how did we get here

- Individual Care
- Care communication
- Coordinated Care
- Co-location
- Integration
Individual Care

- Each clinician operates independently and does their own work up
  - Multiple repeat lab tests and x-rays
- Clinicians may or may not be aware of each other
- Social agencies do their work independently
- Managed care stays in swim lanes
  - General medical care
  - Behavioral health care
  - True whether both in one company or a managed behavioral health company is used
Care Communication

- **Care delivery**
  - Individual clinicians share information
  - Notes may be sent to update other providers
    - Often an initial evaluation sent but follow up with treatment plan less often
    - Are they read or filed?

- **Social agencies**
  - Often isolated with clinicians not knowing who they are and what they are doing or how they may help

- **Case management**
  - Some communication about treatment needs
  - May send and receive data from clinicians (unsure how this is used)
Coordinated Care

- Communication takes place when a new event occurs
- Key clinicians in person’s care are notified by the current treating clinician
- Social service agencies may be alerted to status and potential new needs
- Case managers share data and help to design an updated comprehensive plan of care
Co-location

- Viewed as creating integration
  - Clinicians all in same geographic space

- Co-location is necessary but not sufficient for integrated care
  - Practice in same building - this can lead to ongoing immediate communication and work with people as needs are noted OR clinicians can do individualized treatment and just share geography

- Key - am I an individual treating this person or part of a team

- Case management located together
  - Real time interaction with one another (location not a key here)
  - Do I remain focused on my area of expertise?
Integration

- Process moves to focus on whole person
- Service delivery and case management become a team sport
- Everyone (clinicians, case managers, social agencies, others e.g. justice) focus on whole person
  - Move beyond their swim lanes
  - More importantly are willing to engage the person beyond their comfort zone
NY State data (2014)

- Medicaid members with a behavioral health diagnosis
  - 20.9% of population but 60% of expenditures
  - 53.5% of hospital admissions
  - 45.1% of ED visits
  - 82% of all readmissions within 30 days of original admission
    - 59% of those readmissions are for a medical condition

- Average length of stay for this population 30% longer than overall Medicaid population

- People with behavioral health conditions experience poor inpatient to outpatient connection
Transactional Integration in Case Management

- Case manager working with member owns the transaction
- Must address all issues raised by the person in that transaction
- Does not limit transaction to their area of expertise
- Healthfirst is using this model in our Health and Recovery Plan (HARP)
What is a HARP?

- **Health And Recovery Program**

- NY State Medicaid Plan for individuals with long term mental illness and/or substance use disorders demonstrating high risk and significant general medical and behavioral health service utilization

- Data run by state to determine eligibility

- Opt out plan
  - Individuals receive letter of plan to enroll them unless they contact state to opt out
  - Healthfirst assures its HARP eligible members they will not need to change any providers

- Plan provides all regular Medicaid benefits plus eligibility to enroll in a Health Home and access to Home and Community Based Services
Typical Member

- Long standing mental illness
- Often a concomitant substance use disorder - few eligible with primary SUD
- All have at least one major general medical disorder (diabetes, CHF, respiratory disease) - most have more than one
- Most inpatient admissions are for general medical conditions
- Poorly connected to the health care system
- Much care delivered in ED and inpatient
- Hard to locate and tend to fall through the cracks
Member Enrollment

- Passively enrolled after waiting period for possible opt out
- Some individuals want enrollment and call state to get enrolled without waiting period
- Once enrolled
  - Assigned to a Health Home (HH) that will outreach and work to engage them
  - Health home assessment provides access to Home and Community Based Services (HCBS) - Process in development for HCBS assessment for those not HH engaged
- Assigned to a Healthfirst case management team based on HH assignment
Plan Management

- HF HARP case management team is made up of a general medical and a behavioral health case manager

- Each HARP team is assigned to a specific health home (HH)
  - Focus on the needs of the population attributed to the HH
  - HH case manager is also a member of the case management team
  - HH case manager represents the boots on the ground primary connection to the individual

- HF case managers
  - Licensed clinicians
  - Work telephonically
  - All interactions entered into a single system immediately available to all members of the HF case management team
  - Meet multiple times per week to do status check and share information on specific cases that have become acute
Transactional Case Management

- In any interaction/transaction with the person the focus on their needs at that time
- General medical and behavioral needs are addressed by case manager in that transaction
- Case manager needs to be prepared to understand and initiate actions to resolve issues raised by the member
- Documentation in single case management system so team members have immediate access to what happened, what was done and what follow up is needed
Case Manager Progress

- Initially case managers stayed within their comfort zones
- HARP case manager leadership understood process and goals
  - Saw case managers staying in their swim lanes
  - Championed the concept of asking about all aspects of the person when speaking with the individual
  - Encouraged removal of swim lane lines
- Leaders acknowledged discomfort
  - Reviewed model and goals for integrated case management
  - Worked to get case manager buy in
  - Recognized need for support and training - all staff case conferences weekly
- Training
  - Short webinar modules developed on over 30 topics (required training but easily accessible when case managers wanted to do them)
  - Had training on understanding types of housing and access
  - Specific cross training (behavioral health group on key general medical issues and general medical on psychotropic medication)
Course Examples

- Introduction To Care Coordination
- Introduction To Care Transitions: The Importance Of Discharge Planning And Early Aftercare
- Team-based Care
- Recovery and Person-centered Care
- Major Psychiatric Diagnoses
- Using Motivational Interviewing to Engage and Work with Members
- Essential Psychopharmacology

- Integrated Care:
  - Collaborative Care: Integrating Mental Health into Primary Medical Care
  - Integrated Care: Providing Medical Care to Individuals with Serious Mental Disorders
- Addiction and substance abuse
- Medication assisted treatment of substance use disorders
- Treatment of trauma
- Importance of families
- Child and elder abuse and neglect
- Commonly seen behavioral health conditions in primary care
- Cultural competence
Training (Cont.)

- Behavioral health case managers needs
  - Understanding management of key general medical conditions
  - Recognizing urgent need vs. reconnect to PCP

- General medical care manager needs
  - Knowledge of psychotropic medication
  - Refinement of risk assessment for this population
  - Initial approaches for treatment engagement

- For all - reinforce motivational interviewing
Key Areas of Attention

- Reinforce concept of team sport
- Continue to address areas of case manager discomfort - understand, support, educate
- Show impact (by example) of working within the transaction and as a team to reinforce value
- Core understanding - Individual is at the center of everything we do
Where is the Team now?

- HARP started with a team of HARP general medical and a team of behavioral health care managers
- Each team had their own leader - leaders worked closely together to merge team into a functioning integrated team
- Today
  - One team of all HARP care managers
  - Led by a Director of HARP Clinical Management (RN)
  - 3 teams report - 2 by general medical RNs and one by a licensed clinical social worker
  - Director reports to a psychiatrist who is Medical Director in charge of the HARP
- Goal
  - Learn from this program of about 20,000 members and expand this to our entire Medicaid membership of almost 1,000,000 and then to our entire membership
Lessons Learned

- Leadership must be on board first
- Make sure staff understands the expectation and that it will occur over time
- Training, training and then more training (monitor through various areas e.g. our weekly case conferences and develop training as gaps are exposed)
- Single access point for information on member (one system everyone uses)
- Regular meetings e.g. case conferences must include all case managers - do not separate general medical and behavioral health in meetings
- Importance of creating case management teams and ensure they have regularly scheduled times to meet each week (ensure they meet even if they think they have nothing to discuss - team building is a key)
Data

- Very early in process
- We do not expect to show strong data until 18-24 months
- Small pilot done before HARP showed a trend toward decrease in inpatient admissions and ED visits
- Population studied
  - Majority of admissions are for general medical conditions
  - Readmit rates high often for general medical conditions
- Improved connection to outpatient lowers readmission rate
Integration at Care Delivery

- Must go hand in hand with case manager integration
- Healthfirst uses a clinical partnership team to work with primary care to further integration at the delivery level
  - Started by supporting introduction of PHQ-9 screening into PCP practices
  - Expanding to other screens
  - Developing specific prompt access referral sources for behavioral needs so PCPs do not feel stuck
  - Behavioral Health Department Director now fully supports the Clinical Partnership team

- PCPs
  - Increased screening across depression, anxiety, substance use disorders
  - Larger practices are implementing collaborative care model
  - Continue to further their relationships with community based behavioral health providers (HF works with these behavioral health providers to help them learn communication skills in working with PCPs and other general medical providers)
Key Takeaways

- Integration and overall care is a **TEAM** sport
- Providers and case managers must buy in
- Case management needs a single point of information available to the team
- Working with general medical and behavioral health providers to understand each other’s needs, delivery model and a clear understanding of how they will work together is a key to success.

**IT’S ALL ABOUT THE PERSON!!!**