Integration of Behavioral Health & Primary Care in a Homeless FQHC

AtlantiCare
Health Services
Mission Health Care

May 2012

AtlantiCare
MISSION HEALTH CARE

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AtlantiCare
MISSION HEALTH CARE

Federally Qualified Healthcare Center that is a Patient Centered Medical Home, providing an integrated model of primary care, serving the homeless of Atlantic County

Atlantic City
Rescue Mission

Homeless can happen to anyone.
Hope happens here.

The Starfish Story

- A young girl was walking along a beach upon which thousands of starfish had been washed up during a terrible storm. When she came to each starfish, she would pick it up, and throw it back into the ocean. People watched her with amusement. She had been doing this for some time when a man approached her and said, "Little girl, why are you doing this? Look at this beach! You can't save all these starfish. You can't begin to make a difference!" The girl seemed crushed, suddenly deflated. But after a few moments, she bent down, picked up another starfish, and hurled it as far as she could into the ocean. Then she looked up at the man and replied, "Well, I made a difference to that one!" The old man looked at the girl inquisitively and thought about what she had done and said. Inspired, he joined the little girl in throwing starfish back into the sea. Soon others joined, and all the starfish were saved. - *adapted from the Star Thrower by Loren C. Eiseley*

Overview

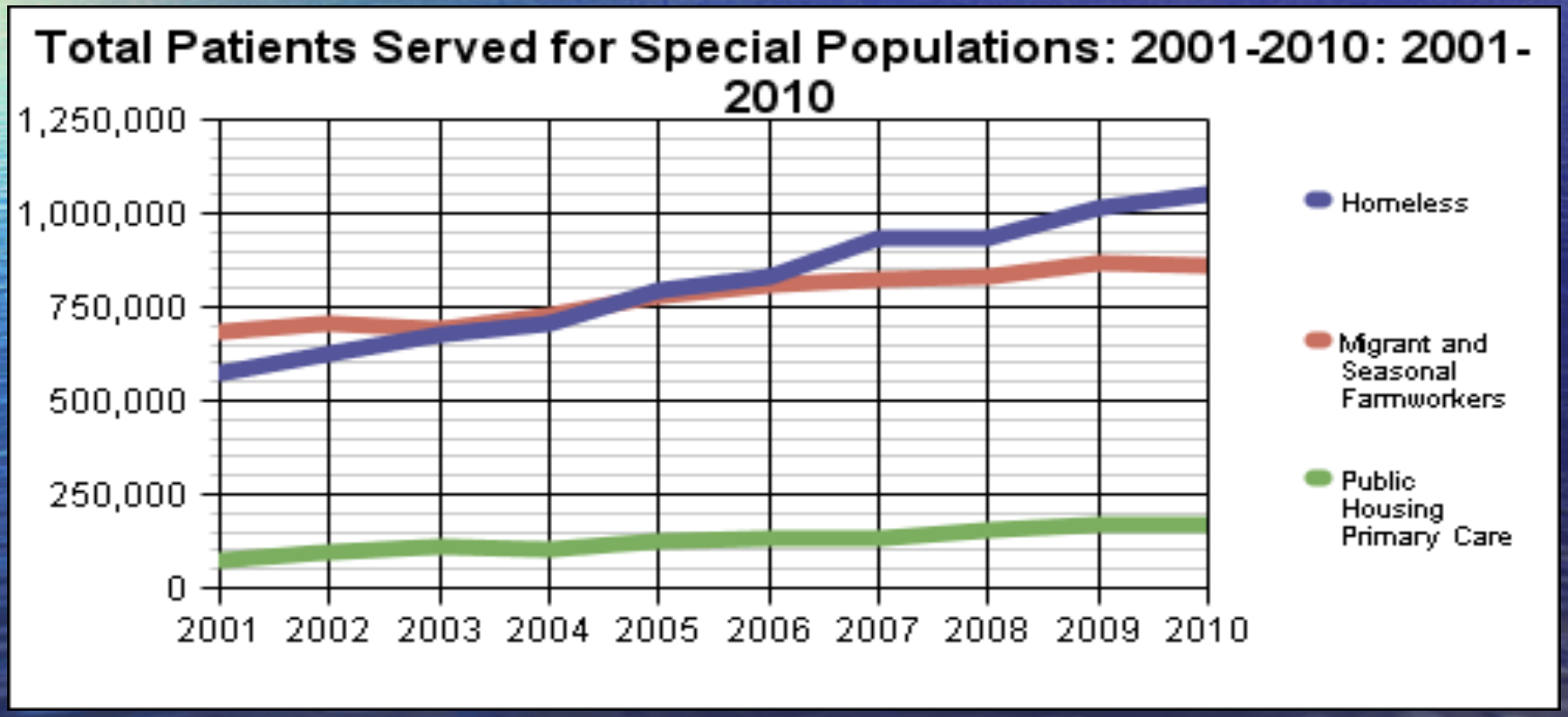
- Medical Home and Integration Concepts
- Program design and delivery
- Outcomes
- Challenges and Opportunities

Statistics

- Over one million homeless individuals served by FQHCs in US in 2010
- Approximately 23,000 homeless individuals seen in FQHCs in New Jersey in 2010 (432,000 total patients seen)
- 5 homeless FQHCs in the New Jersey
- 8.8 million individuals in New Jersey
- Atlantic County- Approximately 274, 000 individuals

Statistics

HRSA- US Data



Mission Health Care

- Established 2003 as homeless FQHC
- Three clinical sites in Atlantic City, New Jersey
- Main site is co-located with the Atlantic City Rescue Mission
- Part of health care organization of AtlantiCare
- New Jersey Primary Care Association and HRSA
- Community Advisory Board
- Numerous community partners

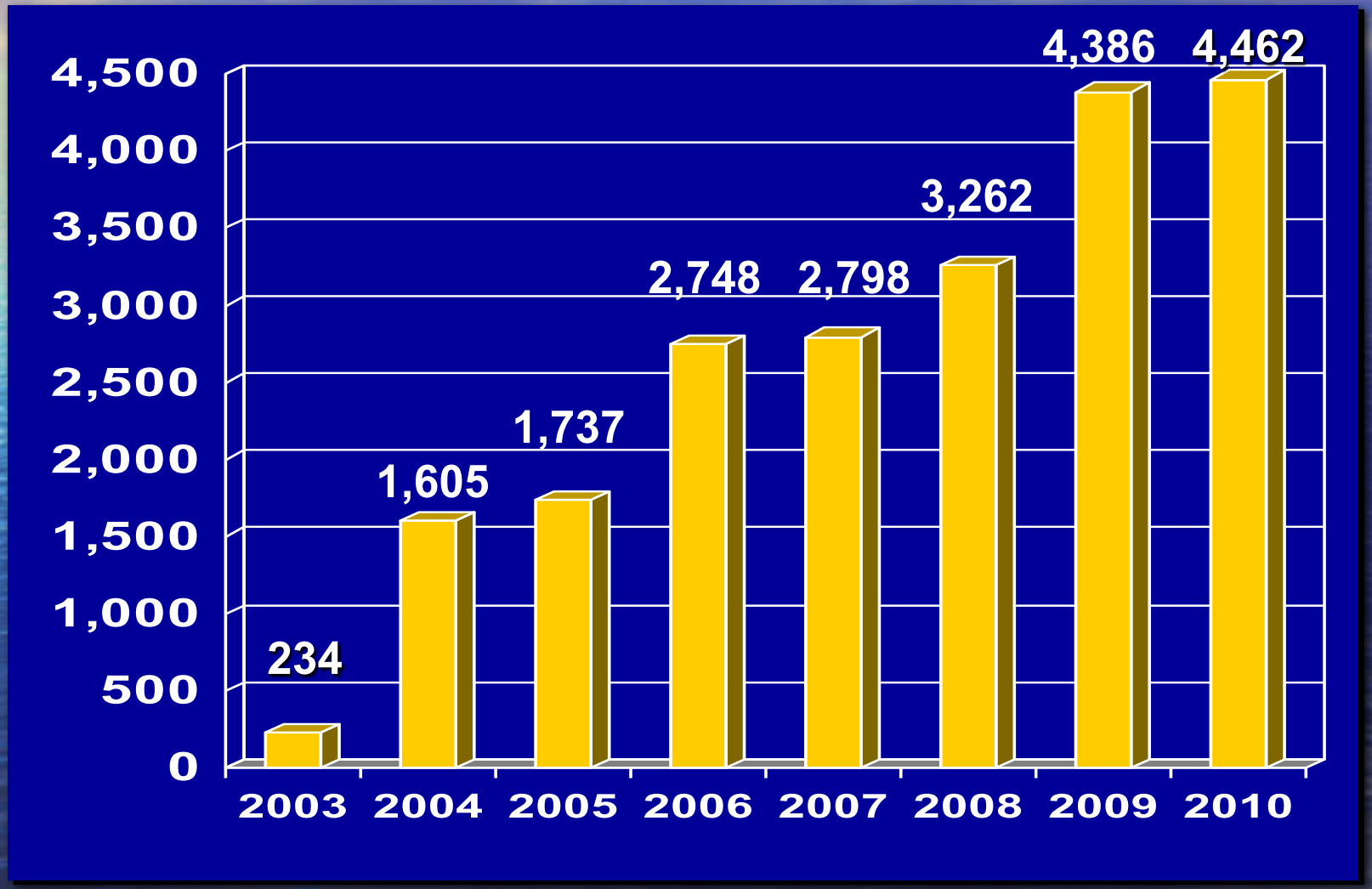
Mission Health Care

- **2011**
  - 4,516 unique patients seen
  - 21,263 encounters

- **Payer Mix**
  - 60% Uninsured/Self Pay
  - 22% Medicaid
  - 5% Medicare
  - 13% Private

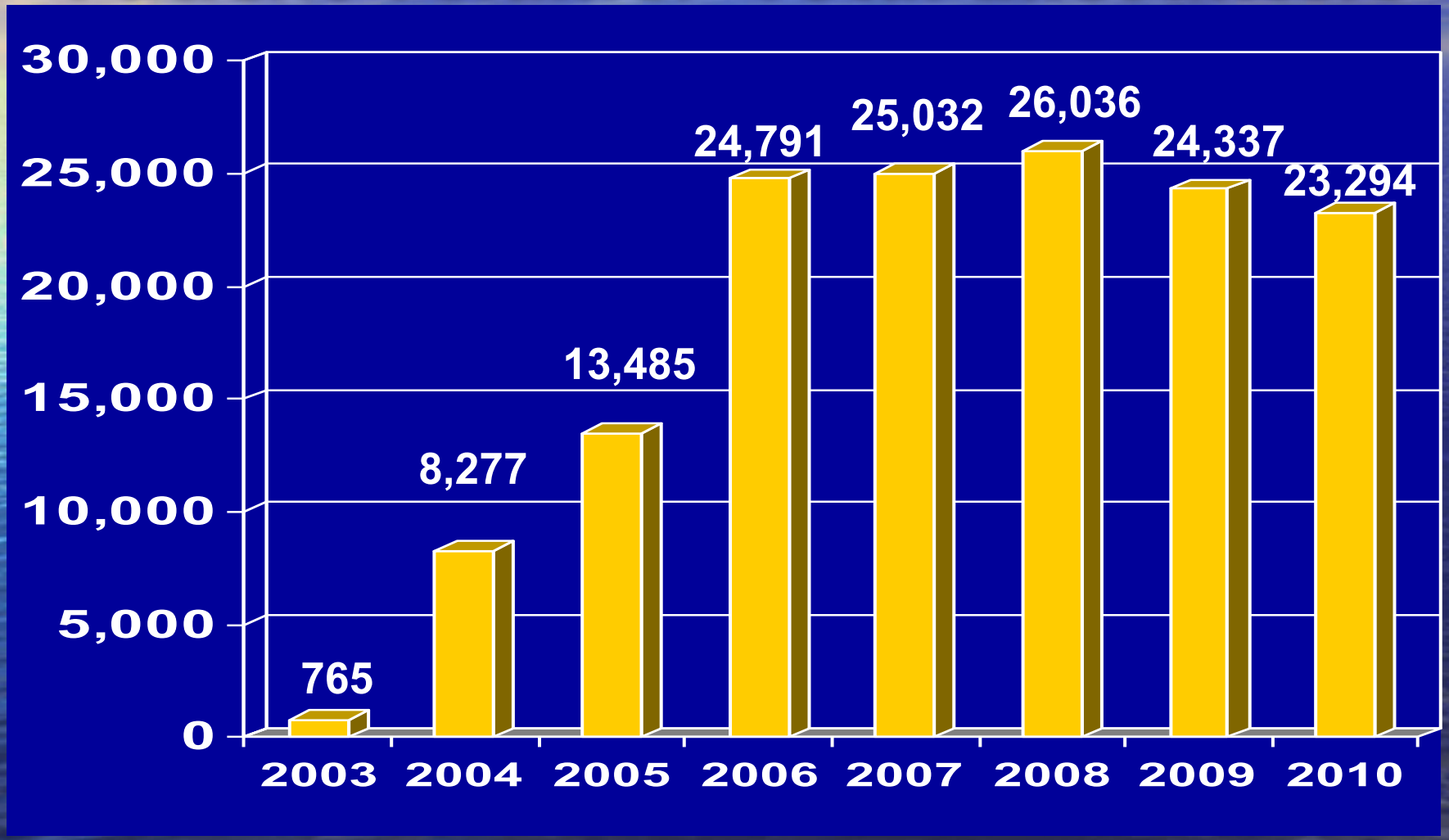
Mission Health Care

Patient Volume: Unique Patients Seen



Mission Health Care

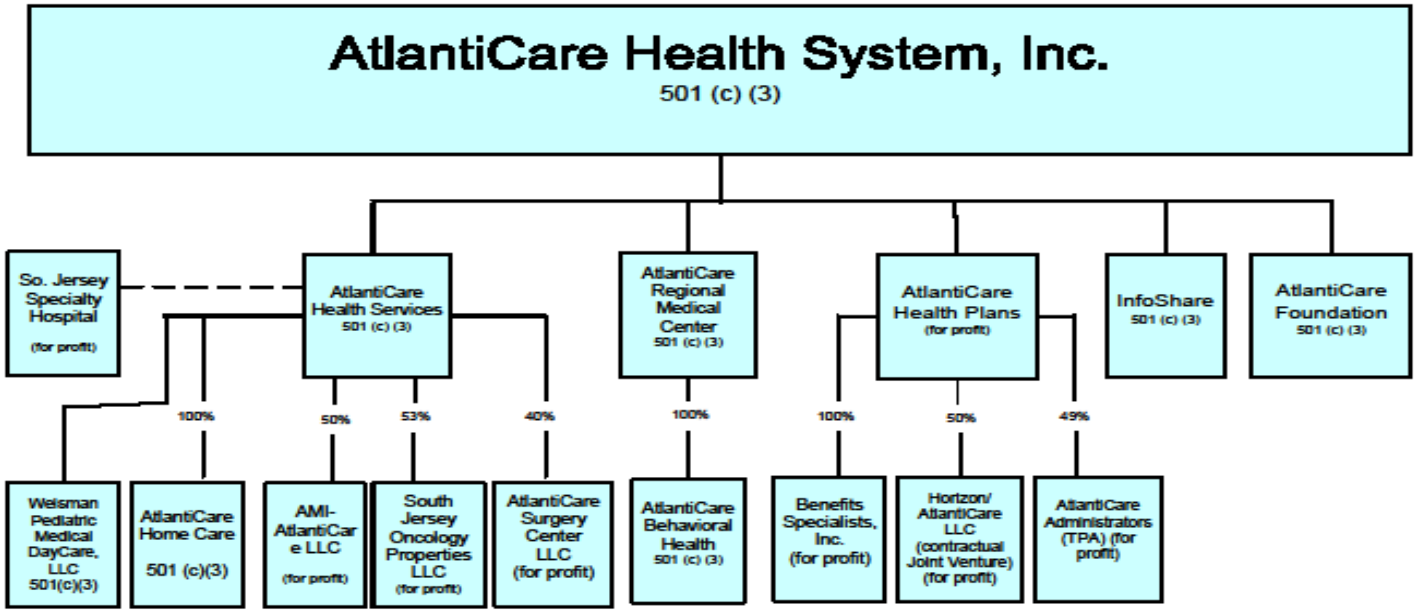
Patient Volume: Total Encounters



Mission Health Care

Earned Patient Centered Medical Home Recognition from NCQA in 2012!

AtlantiCare Organizational Overview



AtlantiCare Strategy Map

VISION: WHERE WE ARE HEADED
ATLANTICARE BUILDS HEALTHY COMMUNITIES

PERFORMANCE EXCELLENCE COMMITMENTS (5 Bs): HOW WE DO IT

- BEST PEOPLE & WORKPLACE
- BEST CUSTOMER SERVICE
- BEST QUALITY
- BEST GROWTH
- BEST FINANCIAL PERFORMANCE

VALUES: HOW WE ACT

- SAFETY
- TEAMWORK
- INTEGRITY
- RESPECT
- SERVICE

MISSION: WHY WE ARE HERE
WE DELIVER HEALTH AND HEALING TO ALL PEOPLE THROUGH TRUSTING RELATIONSHIPS.

Patient Centered Medical Home

- "A model for care provided by physician practices aimed at strengthening the physician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship."
  - -NCQA

Patient Centered Medical Home

- Emphasizes relationships
- Patient Engagement
- Enhanced Access to Care
- Team-based care
- Care Management
- Patient Self Management
- Population Health Management

Integrated Care and Behavioral Medicine

- **Integrated Care-** "*concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency*"- WHO

- **Behavioral Medicine-** links behavior and health in a biopsychosocial model

- **NOT traditional psychiatric care**

Bio-Psycho-Social Health Contributors

Biological	Psychological	Social
Family history	Trauma	Housing
Cognitive Dysfunction	Loss	Finances
Medical Illness	Life in Danger	Employment
Medication side effects	Mistrust	Cultural issues
Physical disabilities	Self Esteem	Religious beliefs
Addiction	Coping skills	Education Level
	Communication Skills	Literacy Skills
	Personality Style	Social supports
	Cognitive Distortions	Legal Issues
		Insurance issues

Factors may Predispose, Precipitate, Perpetuate or Protect

PCMH and Integrated Care Principles

- PCMH concept aligns with integrated care
- Focus on whole patient
- Building relationships with patients
- Self management and treatment goals
- Care coordination
- Team approach to care
- Evidence based care
- Enhanced patient access
- Outcomes

Integrated Care and Homelessness

- High Prevalence of behavioral health issues in homeless:
  - 20-25% of homeless have severe mental illness (vs 6%)
  - Mental illness is a leading cause of homelessness
  - 26-40% of homeless with substance dependence
- Increased severity of illness and co-morbidities in homeless population

Integrated Care and Homelessness

- Mentally ill are less likely to access primary care
- Homeless with greater barriers to health care and healthy behaviors
- Health needs of homeless are unique
  - Ex- diabetes
- Increased stigma for homeless and mentally ill
- Traditionally, more episodic, acute care

Mind-Body Connection

- Behavioral health issues can lead to self neglect of physical health
- Behavioral health issues can exacerbate physical illness (ex- anxiety→inflammation)
- Behavioral health issues can impact treatment adherence
- Substance abuse can be a risk factor for medical illness
- Behavioral health treatments have physical effects

Mind-Body Connection

- Health behaviors impact morbidity and mortality
- Mental illness is associated with increased morbidity and mortality
- Physical Illness can manifest as mental illness
- Physical illness can lead to behavioral health issues- ex- chronic pain
- Greater potential for polypharmacy and drug interactions

Benefits of Integrated Care in a Medical Home

- Holistic Care
- Integration ensures access to behavioral health services for primary care patients
- Minimizes barriers to accessing primary healthcare for patients with mental illness.
- Patients with mental illness will benefit from a reduced stigmatization in primary care
- Opportunity to improve health outcomes and other quality measures

Role of Behaviorist in Primary Care

- Build a trusting relationship with patients
- Identify barriers to health
- Conduct Motivational Interviewing
- Assess treatment adherence
- Aid with “difficult encounters”
- Teach effective communication strategies

Role of Behaviorist in Primary Care

- Coordinate team members
- Develop individualized care plans
- Ensure treatment of Axis I and II disorders
- Increase patients self-efficacy and self management
- Help decrease team burnout

Program Design

- Open access model
- Coordination with Rescue Mission
- Primary and preventive health care
- Behavioral Health Screenings in primary care
- On-site full time behavioral health providers- LCSW and psychiatrist
- On-site social workers for enabling services
- CADC counselor
- Care Coordination

Program Design

- On-site detox, stabilization and IOP
- On-site partial care program for psych
- Medication and psychotherapy
- Integrated team meetings
- 340B pharmacy
- Transportation
- Education and training for professionals
- In house Sub-specialist care

Program Design

- High-risk individuals identified through multiple sources: EMR data, provider referral, screening tools and self referral
  - Ex- PHQ-9, Social Hx, ER utilizers, chronic illness
- Care coordinator engages patient
- PCMH concept reinforced (pt bracelets)
- Treatment plan created
- Resources and team mobilized

Outcomes- 2011

- 100% of ambulatory care patients were screened for depression;
- 100% of patients screening for substance dependence, including tobacco use
- 90% of all patients identified with alcohol dependence were engaged in substance abuse treatment.
- 33% of all behavioral health patients in the clinic received primary care services on-site

Outcomes- 2011

- 73% of patients with tobacco use received counseling
- 7, 839 visits with a primary substance disorder diagnosis
- 8,512 visits with a primary mental health dx
- Average A1c- 8%
- 60% of patients had controlled hypertension
- 13,434 labs were tracked and monitored from July 2011-Feb 2012.

Case Examples- Integration for Psych Patient

- 40 year old male with opioid dependence, presents for treatment with suboxone.
- Pt screened for primary care needs
- Labs ordered by psychiatry
- Found to have HbgA1c >10
- Next day appointment made with PCP
- Medications, diabetic education
- In less than one month, Bg decreased

Case Examples- Difficult Patient

- Male with numerous physical complaints, frequent visits to ER
- Staff burnout, pt perceived as attention seeking and demanding of services
- Behavioral Consult requested by primary team
- Pt found to have alcohol dependence, anxiety
- Brief reassuring nursing visits recommended
- Pt engaged in IOP for alcohol and mental counseling

Case Example- Severe Medical/Low Primary Psych

- Not caring for diabetes and COPD, ER and IP visits
- Primary care frustrated by patient's health behaviors
- Care coordinator identifies patient as high risk through EMR data
- Behavioral health consult for smoking cessation, motivational interviewing for change
- Pt treated for anxiety which was exacerbating her experience of pain and shortness of breath
- A1c decreased, smoking cessation

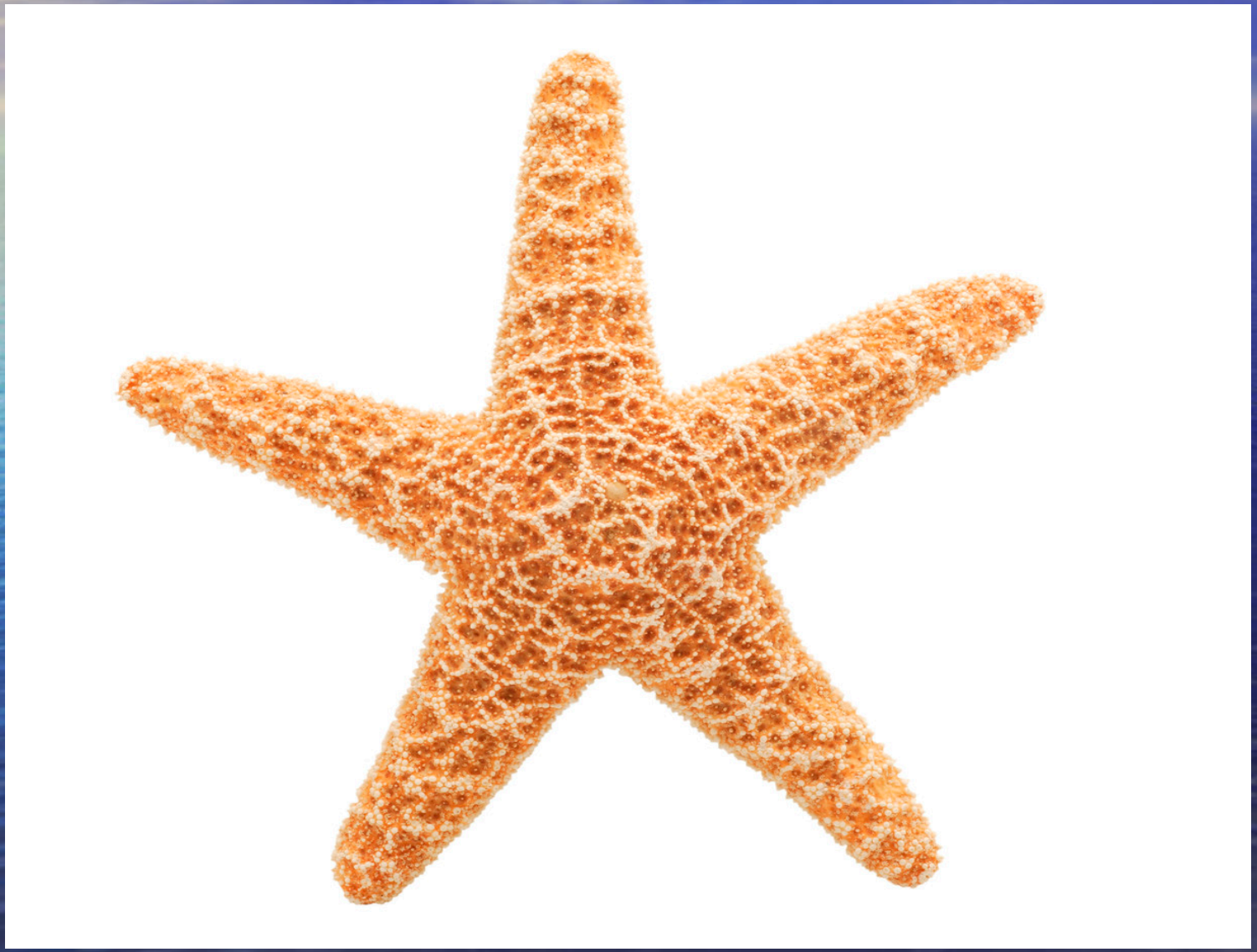
Case Example- Severe Mental and Physical Illness

- Male with schizophrenia, and gangrene of toes, signed out AMA from medical hospital treatment and non adherent with medical and psych care
- Security guard engages patient and he is brought in for psychiatric consult.
- Pt given long acting injectable medication
- Psychosis remits, pt obtains stable housing and has surgery

Challenges

- Limited ability of pre-visit planning in an open access model
- Difficulties with the adoption of a new electronic medical record system
- Limited funding to support behavioral health services for uninsured
- Cross-training of the staff in regards to behavioral health screening and treatment

“ I made a difference to that one.”



Thank You!

Questions?