Integrating Behavioral Health Services in the Texas Delivery System Reform Incentive Payment Program

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DSRIP Overview

• The Delivery System Reform Incentive Payment (DSRIP) program is one component of the Texas 1115 Transformation Waiver
  • Up to $11.4 billion all funds may be earned from the DSRIP pool over five years (2011-2016)
  • Two target populations: Medicaid and the low income uninsured
• 20 Regional Healthcare Partnerships (RHPs) comprised of 254 counties
  • Conducted regional community needs assessments to determine priority needs
  • Developed regional plans with DSRIP projects to address priority needs
DSRIP Status

- There are over 1450 active DSRIP projects.
- 298 providers – hospitals (public and private), physician groups, community mental health centers, and local health departments
- Major project focuses:
  - 25%+ - behavioral healthcare (400 projects)
  - 20% - access to primary care
  - 18% - chronic care management and helping patients with complex needs navigate the healthcare system
  - 9% - access to specialty care
  - 8% - health promotion and disease prevention

Integrated Behavioral Healthcare in DSRIP

- 90 DSRIP projects focus on integration of behavioral healthcare (BH) with primary care (PC)
  - Most focus on individuals with complex BH needs
- Over 80 projects focus on individuals with co-occurring mental health and substance abuse
- Outcomes baseline data submission began in October 2014
- Most common outcomes selected for integrated BH/PC projects
  - Screening and treatment plan for clinical depression
  - Controlling high blood pressure
  - Depression remission at twelve months
  - Also outcomes related to quality of life, patient satisfaction, diabetes HbA1c control, and reducing emergency department visits for BH/substance abuse
Prospects Courtyard Integrated Clinic

- Center for Health Care Services, San Antonio (RHP 6)
- A comprehensive, integrated care management center offering primary and behavioral health care to homeless adults living at Prospects Courtyard (PCY) within the Haven for Hope campus. The great majority have co-occurring mental health and/or substance use and chronic physical disorders.
- In 2011, there were 600 transports to area hospital emergency departments from the Haven for Hope, most after hours
- Services: walk-in triage, preliminary diagnostics, initial treatment, referral and follow up for medical care, psychiatric care, urgent care, medication management, medication assistance, immunizations, and chronic disease prevention strategies

Prospects Courtyard Integrated Clinic (cont.)

- 60 individuals served, with goals of 125 and 175 individuals served in demonstration years 4 and 5
- Outcome measures
  - Assessment for Psychosocial Issues of Psychiatric Patients and Client Satisfaction Questionnaire 8 (CSQ-8)
- Sustainability planning
  - Increase 3rd party billing by strengthening of the benefits enrollment process and utilization of SOAR (a national program designed to increase access to the disability income benefit programs)
  - Analysis of cost savings to negotiate sustainable funding with community partners, such as local hospitals
  - Partner with universities to use clinic as a training site for residents
  - Integration of peer support services
Integrated Health Care Initiative

• MHMR Tarrant County (MHMRTC), Fort Worth (RHP 10)
• Partnership with JPS Health Network to co-locate primary care and behavioral health services at MHMRTC’s homeless/crisis services center for individuals with severe mental, developmental, and addictions disorders who may also be homeless, and who are not otherwise able to access primary care services.

Services
- Wellness checkup exams, well woman checks, smoking cessation, specialty referrals, medication reconciliation, community-based case management services, substance abuse treatment, counseling, peer support and group classes, community/field-based case management and rehabilitation services, RN care coordination
- Community outreach teams to refer individuals living in campsites or on the street into the integrated care initiative

325 individuals served, with goals of 332 and 553 in demonstration years 4 and 5

Outcome measures
- Controlling High Blood Pressure (HEDIS) and SF-36 Quality of Life instrument
- As of April 31, 2015 119 (45%) of 263 integrated care patients had a diagnosis of hypertension in EPIC. Of those individuals 87 (73%) had more than one blood pressure reading. Of the 87 integrated care patients, 56 (64%) were recorded to have controlled blood pressure (<140/90) at the second reading.

Sustainability planning
- Collaboration with managed care plans to develop innovative contractual ventures
- Integration of primary care services into clinical locations systemwide
Screening, Brief Intervention and Referral to Treatment

- Fort Bend County Clinical Services, Fort Bend County (RHP 3)
- Add a Screening, Brief Intervention and Referral to Treatment model (SBIRT) at intake for at-risk persons and persons with substance use who are patients in the AccessHealth Federally Qualified Health Center (FQHC) clinic in Richmond, Texas. This is an enhancement to the IMPACT model AccessHealth currently uses to integrate depression care into primary care.

- Project Services
  - SBIRT model
  - Patient education and referrals to more extensive services
  - Coordination of wrap-around services in the community and within the FQHC
  - Improvements to the electronic health records system

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Screening, Brief Intervention and Referral to Treatment (cont.)

- 94 individuals served, with goals of 225 and 300 in demonstration years 4 and 5
- Outcome measure
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Other performance indicators
  - Diversions from the emergency department, emergency medical services (EMS), and criminal justice system
- Sustainability planning
  - Collaboration with local partners and stakeholders to identify additional funding sources.
  - Exploration of opportunities for reimbursement through Texas Medicaid managed care plans

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Integrated Care Clinic in Rural Texas

• Burke Center (RHP 2)
• Partner with Angelina County/Cities Health District to create an integrated health home for Burke Center clients with one or more comorbid chronic conditions and expand access to behavioral health services for clients of the Health District Clinic. Targets Medicaid and low-income uninsured clients with serious mental illness.

• Project services
  ➢ Integration of co-located behavioral and primary care services within both behavioral health and primary care settings to meet patients needs.
  ➢ Enhancement of the electronic medical records to include all primary-care related diagnoses
  ➢ Training for primary care workforce in co-managing chronic behavioral health conditions

• 280 individuals served, with goals of 600 and 990 in demonstration years 4 & 5

• Outcome measures
  ➢ Depression Management: Screening and Treatment Plan for Clinical Depression
  ➢ Comprehensive Diabetes Care: LDL Screening
  ➢ Adult Body Mass Index (BMI) Assessment

• Sustainability planning
  ➢ Coordination with County and City Health Districts to support data sharing between primary care and behavioral health care providers
  ➢ Engagement of all Texas managed care plans to improve billing and reimbursement processes for co-located services
Next Steps

• Texas submitted to the federal Centers for Medicare and Medicaid Services (CMS) a five-year extension request for the 1115 waiver.

• Promising DSRIP projects need more time to demonstrate outcomes and work toward sustainability.
  • Clinical Champions Workgroup to assist in assessing promising practices that can be sustained and replicated.
  • Further alignment of DSRIP with Medicaid managed care quality strategy and value based purchasing
  • Will propose shared regional performance bonus pools in extension protocols to further encourage local and regional systems of care and collaboration to improve population health and quality of care for Medicaid and low income uninsured Texans.