Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover
Welcome!
SAMHSA’s Program to Achieve Wellness

Crystal L. Brandow, PhD
Assistant Director, SAMHSA’s Program to Achieve Wellness
Disclaimer

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Using Public Health Approaches to Promote & Protect the Whole Health of Individuals with Behavioral Health Conditions

SAMHSA’s Program to Achieve Wellness

April 27, 2017
1:00pm-2:00pm ET
Welcome!

• Shelina D. Foderingham, MSW, MPH

• Assistant Vice President of Practice Improvement, the National Council for Behavioral Health
How to join the webinar?

GoToWebinar INSTRUCTIONS:
Join the webinar:
https://attendee.gotowebinar.com/register/1074586077905203715
Call in using your telephone: +1 (631) 992-3221
Access Code: 138-522-483
Audio PIN: Shown after joining the meeting

The best way to ask a question is to use the question box in your GoToWebinar window.

We will have a brief Q&A session following the presentation.
Agenda:

- Welcome & Housekeeping
  - Housekeeping items (mute yourself unless speaking)
- Setting the Stage: The Importance of Public and Behavioral Health
- Addressing Behavioral Health Through a Public Health Lens
- Behavioral Health Perspective: Integrating Primary and Behavioral Care for Children and Adults
- Moderated Q & A
Webinar Evaluation

YOUR FEEDBACK MATTERS!
Attendee Poll:

• In which type of organization do you work?

Please take a moment to fill out the poll that will pop up on your screen.
Setting the Stage: The Importance of Public & Behavioral Health
Importance of Peer Involvement

During today’s session, remember that peer navigators and a recovery workforce can enhance any efforts designed to integrate public and behavioral health!
Involve the Recovery Workforce

• Practice Inclusion
• Include Stakeholders
• Involve Peers in Every Step of the Process
  – Peer Navigators offer a shared experience
• Capitalize on the Strengths of a Recovery Workforce

Learn more:
https://www.samhsa.gov/workforce
http://www.integration.samhsa.gov/workforce/team-members/peer-providers
Interested in learning more and sharing information?

Coming Soon!

Public Health: What’s Behavioral Health Got to Do With It?

Behavioral Health is a Public Health Concern

- Behavioral health affects people living with mental illnesses (including serious mental illnesses) and/or substance use disorders.
- 60% of premature deaths in persons with serious mental illnesses are due to preventable and treatable medical conditions.
- Nearly one-quarter of persons with HIV/AIDS were in need of treatment for alcohol use or illicit drugs.
- In 2014, persons with serious mental illnesses have health care costs that are 2 to 3 times higher than the general public.

Co-occurrence between mental illness and other chronic health conditions:

- Heart Disease: 41.5%
- Diabetes: 17.3%
- Obesity: 8.6%

People with behavioral health conditions face barriers to accessing primary health care.

Barriers to effective healthcare are due to:

- Patient factors include health risk factors and lifestyle factors, side effects of medications and the effects of mental illness.
- Provider factors such as competing demands, time and resource constraints, negative attitudes towards people with mental illness and addictions, and lack of education/knowledge.
- System factors include the geographic, temporal and resource separation of facilities, lack of clarity as to who takes responsibility for the physical health of patients with mental illnesses, lack of continuity of care, and underestimating of mental healthcare that provides little opportunity for specialists to focus on issues outside their care specialty.

What’s the Solution?

Integrated care is comprehensive, personalized, person-centered care that encompasses mental health and substance use as well as physical health conditions. It considers the influence of multiple conditions, social functioning, and patient preferences to personal assessments, treatments, and goals of care.

Integration of primary care and behavioral health:

- Increases access to care
- Improves care experiences for individuals with mental health and addictions
- Improves overall health for persons with mental illness and addictions
- Decreases the risk of adverse outcomes including hospital admissions
- Decreases discrimination towards people with mental illness and addictions
- Eliminates the early mortality gap
- Reduces the cost of health care

Sources:
Guest Speaker #1

• Jennifer Ludwig, MS
• Deputy Director for Tri-County Health Department,
• Previously the Public Health Director for Eagle County
• Eagle County Public Health formed the Total Health Alliance to specifically address mental health and substance use
Addressing Behavioral Health Through a Public Health Lens

Jennifer Ludwig, MS
Eagle County, Colorado
Home of the Vail Valley

By the Numbers…
Population: 53,000
Square Miles: 1,694
Ski Resorts: 2
Average Age: 34
Average Income: $72,214
2nd Homeowners: 66%

What you don’t see in this ‘happy valley’ is the shortage of health care providers, the ability for many to access care, and huge health disparities.
Why Public Health?

Coming together is a beginning. Keeping together is progress. Working together is success.

Henry Ford
Eagle County, Colorado

- Suicide is the 4th leading cause of death in Eagle County - 87% of which were males between age of 18-80.
- 60 hospitalizations for suicide attempts between 2007-2011.
- 31% of Eagle County residents reported their mental health was not good on 1 or more days in the last month.
Public Health Approach

- Population-Based: the Community is Our Patient
- Focus on Social Determinants of Health
- Neutral Convener
- Systems-Level Changes
- Funding Opportunities
• Eagle County Public Health serves as back-bone for the Alliance.

• A network of health care, law enforcement, non-profit, government agencies and private behavioral health practitioners committed to linking ideas, resource, and people to organizations and agencies.

• Only Alliance in Colorado that focuses solely on behavioral health.
• Comprised of community members, behavioral health practitioners, and organizational representatives, all dedicated to following best practices for behavioral health services and awareness through improved access, outreach, data collection and collaboration. Total Health Alliance meetings are quarterly and are led by the Steering Committee Chair and Total Health Alliance Coordinator. There are 20 voting members and approx. 60 non-voting members.
• **Steering Committee**
  – A seven member committee that assures programs and services are in line with the mission and vision, ensures the adherence to all policies and procedures, and guides long-range planning, and serves as goodwill ambassadors for the Total Health Alliance.

• **THA Coordinator ($$$)**
  – Provides leadership, oversight, and coordination of the Total Health Alliance and carries out the goals and policies as agreed upon by the Steering Committee and THA members. The Coordinator is a grant funded position housed at Eagle County Public Health.
Evaluation ($$)

- Six-Point Evaluation Focused on: network leadership, Total Health Alliance program implementation, affected resident benefits, network performance, community impact, and fiscal and policy recommendations. The evaluator is a subcontractor hired through grant funding.
Resource and Stabilization Team (ReST) ($$$)

• Referral network to more effectively link patients to local, culturally appropriate and contextually competent behavioral health professionals and services.

• Referrals are made to the Resource and Stabilization Team from agencies, the Resource and Stabilization Team develops a care plan, and the Community Health Worker supports and connects the individual to additional wrap around services.

• Agency representatives do not receive compensation for contribution to the Resource and Stabilization Team; the Community Health Worker is paid through grant funds.
Prevention Action Team

- Currently focused on supporting community workplace training opportunities on the topic of behavioral health and employee assistance programs. The Team is led and comprised of agencies and community members who do not receive compensation.
Trends in ReST Populations Served

- Complex health and behavioral health issues
- Aging adjustment
- Severe life difficulties
Moving Forward

• Celebrate Successes!
  – Strengthened Partnerships
  – Built Capacity
  – Increased Awareness

• Plan for the Future
  – Sustainability
  – Evaluation
  – Replication
Guest Speaker #2

- Nick Szubiak, MSW, LCSW
- Director, Clinical Excellence in Addictions, National Council for Behavioral Health
- Integrated Health Consultant at the Center for Integrated Health Solutions
- Previously was Director of Behavioral Health at West Hawaii Community Health Center
Behavioral Health Perspective: Integrating Primary and Behavioral Care for Children and Adults

Nick Szubiak, MSW, LCSW
Please prepare for takeoff....

When the seat belt sign illuminates, you must fasten your seat belt. Insert the metal fittings........
Kawaihae to Hawaiian Ocean View Estates covering 80 miles of coastline, roughly twice the size of Oahu, with 60,000 residents
Who We Are
• West Hawaii Community Health Center serves the West Hawaii communities on the Big Island from Kawaihae to Hawaiian Ocean View Estates (covering 80 miles of coastline, roughly twice the size of Oahu, with 60,000 residents).

• Characterized as rural, ethnically diverse, and under-served, our service area experiences various health disparities.
ALOHA!
Why pursue integration for kids?

Impact

• **One in five** children in the U.S. experience behavioral health problems

• Up to **50%** of adult mental illness begin **by age 14**

• The percentage of kids who meet DSM criteria who are referred to behavioral health services? **< 20%!!**
Why pursue integration for kids?
Impact, Continued

- **Half** of treatment for behavioral health kids provided in **Primary Care**
- **Majority** of psych medication prescriptions by primary care providers
- What is the most **costly** chronic childhood condition?

Behavioral Health Disorder = $8.9 Billion per year
Why pursue integration for kids?

• Child and Adolescent Psychiatrists needed to meet the demand?
  • 30,000
  • Practicing CAPS?
  • 7,000

Critical Shortage of Child and Adolescent Psychiatrists
How did we get started?
Open the Floodgates!
Lost in the Flood?

• Buy In – attitudes, judgements, assumptions
• No existing relationship
• Complex systems of care
• Limited resources
• Sharing information/Liability/Confidentiality
• Working and operating according to mythology (Consent form)
Understanding Each Other

• Admission Criteria
• What do you do? How do you do it?
• Replaced judgements, evaluations and resistance!
• No dumping!
Plan Do Study ACT!

- Strengthening Relationships (continuing)
- Formalize Memorandum of Operation
- Formalize Documentation of Consults
- Clinical Pathways
- Program Evaluation
- Continuing the search for Sustainability

**Mar**
- Initial meetings between sites

**Apr - Jun**
- Assessing systems of care
- First face to face (FTF) steering committee meeting

**Jul - Sep**
- Monthly meetings Big Island sites
- One in-service from HOFGC to KKV staff

**Oct**
- BH workshop for all 14 CHCs & 2 FGCs
- Second FTF steering committee meeting

**Nov**
- Monthly meetings Big Island sites
- One FTF meeting with HOFGC & KKV

**Jan**
- Third FTF steering committee meeting
- Model decision made
- First peer review meeting with HOFGC & KKV

**Feb**
- All sites included on teleconference steering committee meeting
Clinical Pathways

Involvement of FGC with FQHC Activities

Child/Adolescent comes in for a visit

PCP Conducts BH Screening

PCP gives family pertinent advice

Is screening positive or negative for BH issues?

PCP makes referral to in house BH provider

Consult with outside agencies

In house BH provider conducts evaluation and treatment

Does patient make progress with in house BH care?

PCP & in house BH provider make determination to consult with FGC

FGC Consultation from appropriate staff

FGC Involvement needed

Consultation determines further need for FGC involvement

Referral needed

Patient is referred to CAMHD for intensive services

PCP and in house BH provider deal with patient independently of FGC

More levels of care!

Relationship

Game Changer: Consent Form!

Floodgates

DSM5_Level-1-Measure-Parent-Or-Guardian-Of-Child-Age-6-to-17
Screening
Measurement Based Care

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

<table>
<thead>
<tr>
<th>Relationship with the child:</th>
</tr>
</thead>
</table>

Instructions (to the parent or guardian of child): The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the past TWO (2) WEEKS.

<table>
<thead>
<tr>
<th>Question</th>
<th>None Not at all</th>
<th>Slight Rare, less than a day or two</th>
<th>Mild Several days</th>
<th>Moderate More than half the days</th>
<th>Severe Nearly every day</th>
<th>Highest Domain Score (clinician)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Complained of stomachaches, headaches, or other aches and pains?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>2. Said he/she was worried about his/her health or about getting sick?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>3. Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>4. Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5. Had less fun doing things than he/she used to?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>6. Seemed sad or depressed for several hours?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>7. Seemed more irritated or easily annoyed than usual?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>8. Seemed angry or lost his/her temper?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>9. Started lots more projects than usual or did more risky things than usual?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>10. Slept less than usual for him/her, but still had lots of energy?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>11. Said he/she felt nervous, anxious, or scared?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>12. Not been able to stop worrying?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>13. Said he/she couldn’t do things he/she wanted to or should have done, because they made him/her feel nervous?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>14. Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>15. Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>16. Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>
Integration of information supports Integrated Care!
West Hawaii Community Health Center

- BH problems presenting:
  - Disruptive Disorders
  - ADHD
  - Depression
  - PTSD
  - Anxiety
  - Feeding Disorders (FTT)
  - Bullying resulting in PTSD

45% m  55% f  4,958 pts under 18
Data

- 1 Successful referral in previous half year
- 7 Referrals in the first quarter of implementation
- 6 Admissions
- 1 Referral to Federally Qualified Health Center (FQHC) Pediatrician with Family Guidance Centers (FGC) consultation
Low Hanging Fruit

• Learning the process for admission to FGC – wow you have to do all that! I get it!
• Taking the admission packet into the FQHC!
• Documentation to support criteria
• Relationships =
  • Quick calls and consults=makes everything better and easier
  • Doc to docs made simpler
Accomplishments

• Improved relationships and communication (there was no flood!)
• Enhanced bi-directional integration of public health and behavioral health
• Increased referral frequency and utilization
• Decreased referral process time from 3-4 months to 3-4 weeks
• Improved care in our community
• Provider and staff morale and satisfaction
References & Resources


• The page includes links to a number of guides focused on wellness. These wellness strategies are organized into the following categories: http://www.integration.samhsa.gov/health-wellness/wellness-strategies

• This page includes valuable resources on various models of integration: http://www.integration.samhsa.gov/integrated-care-models

• This link is to a valuable resource, The Center for Integrated Health Solutions on all aspects of integrated care: http://www.integration.samhsa.gov/about-us/about-cihs
Questions?

To ask a question, type it into the questions box in your webinar window.
Thank You!

SAMHSA Contacts
Carlton Speight, Public Health Advisor
carlton.speight@samhsa.hhs.gov

SAMHSA’s Program to Achieve Wellness
For More Information or to Request TA, Contact Us:
Phone: 800-850-2523 | Email: paw@prainc.com
Thank you for joining us!

As you exit the webinar, please do not forget to complete the evaluation survey.

Questions? Please contact Lea Simms at LeaS@thenationalcouncil.org