2018 Commentary on DMH Budget

Mary Moulton, Executive Director
Washington County Mental Health Services
President, Vermont Council of
Vermont Care Partners

Leveraging Community Relationships to Optimize Population Health

Anna Noonan, RN, BSN, MS
President and COO, Central Vermont Medical Center,
University of Vermont Health Network

Model Development by
WCMHS Integrated Health Home Work Group

Our Partnership with WCMHS

Granite City Primary Care & Washington County Mental Health Services
Integrated Health Home

- Individuals living with a serious mental illness face an increased risk of having chronic medical conditions.

  *Preventing Chronic Disease (PCD: Public Health Research, Practice and Policy, 3(2) 1-14)

- On average, adults living with serious mental illness die 25 years earlier than other Americans, largely due to treatable medical conditions.

  *Association of State Mental Health Program Directors (NASMHPD)

Granite City Primary Care & Washington County Mental Health Services
Integrated Health Home

- Initiated in February 2016; fully operational January 2017
- Integrated Health Home (IHH), pilot project
  - CVMC's Granite City Primary Care partnering with the WCMHS Case Management Team.
- Building on the foundation of our strong partnership.

Goal of Integrated Health Home Pilot

Promote a model of health care that integrates the social determinants of health with specialized treatment for individuals with complex physical health, mental health, developmental, and substance abuse challenges.

Social Determinants Of Health

Figure 2

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

THE HENRY J. KAISER FAMILY FOUNDATION

Source: Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity Nov 04, 2015 | Harry J. Heiman and Samantha Artiga

Eligibility Criteria

- Participants needed to be at least 18
- Enrolled in services with WCMHS
- Demonstrated challenging health issues and in need of primary care physician or
- Had a PCP but mental health or other challenges were preventing a positive working relationship with the medical provider.

Demographics of Pilot Population

- From February 2016 to summer 2017 a total of 16 unique individuals were served by the Integrated Health Home.

- The gender of participants was equally split:
  - 7 females vs 9 males.

- The average age for all participants was 49.1 years:
  - Avg. age F= 43 M=53.
  - Ages ranged from 23 to 66.

Program Expectations

- Participates needed to sign release to allow access of records
- Agreed that they would participate in a team approach to their care, including the presence of their case manager at all medical appointments.
- Case managers agreed that they would accompany clients to all appointments including referrals to specialists.
- In the event of an acute appointment the case manager would attend or arrange for support staff to attend.
- The medical provider's office agreed to work with the client and case manager to schedule appropriately.
- All involved affirmed their willingness to coordinate care and work on appropriate support referrals and treatment planning.

What was different about the Integrated Health Home

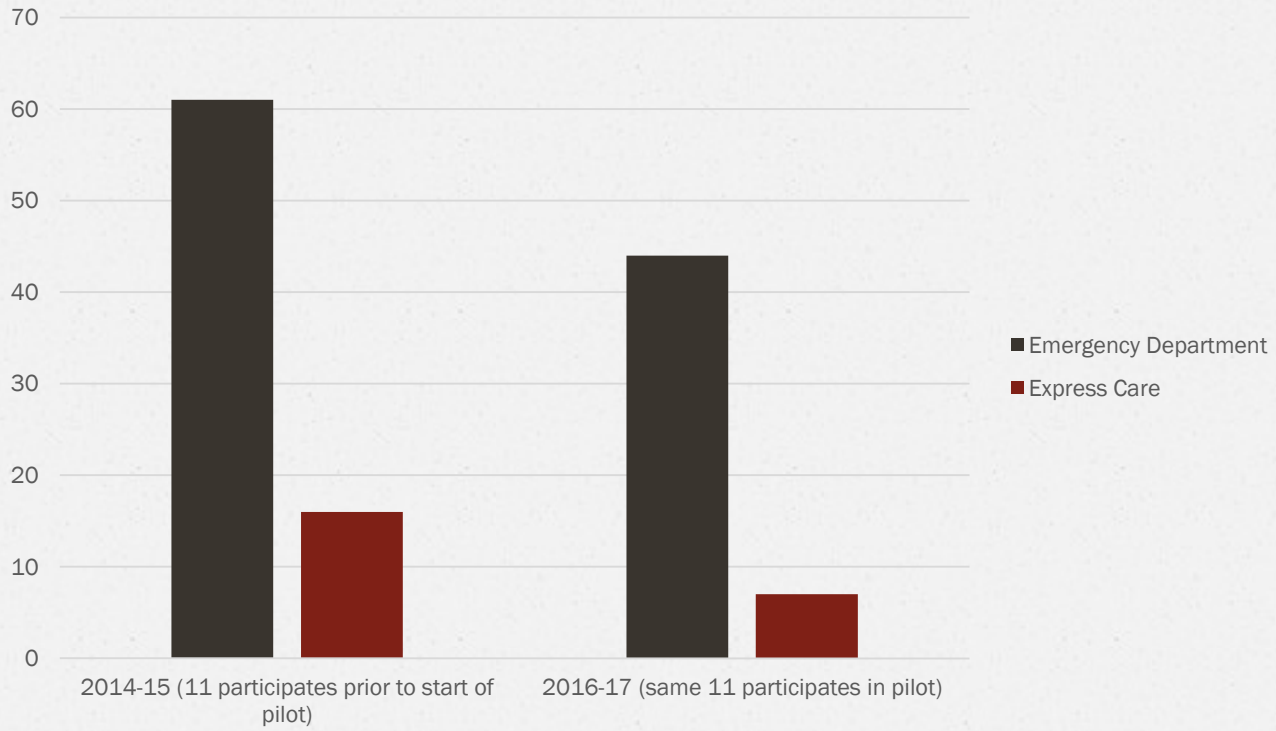
- Optimized person-centered processes for planning and service delivery.
- Case managers communicated with the PCP office if there were significant life changes and if the client saw a WCMHS provider for psychiatric medication management.
- An after visit summary was sent to the PCPs office.
- Participants progressed in their recovery and strong therapeutic working relationships were formed.
- Changes could be made to allow for more independence in accessing care, which fostered a person centered approach.

Outcomes

Of the 16 current participates:

- ✓ 3 Colon cancer screening that had previously declined
- ✓ 1 New diagnosis of diabetes – referral completed to diabetic educator
- ✓ 1 Switched from high doses of narcotics to using legal marijuana buds from dispensary
- ✓ 1 Decreased their A1C from 9.0 to 6.9
- ✓ 3 Decreased their cholesterol levels significantly,
- ✓ 4 Decreased their blood pressure
- ✓ 51 Referrals have been made to specialists, rehabilitation therapy, Screening, Brief Intervention, and Referral to Treatment (SBIRT) counselors (dealing with tobacco, alcohol or narcotic abuse)
- ✓ All Now up to date w/ routine screenings and immunizations
- ✓ Virtually eliminated "no-show" rates for appointments

Emergency Department and Express Care Visits:



Emergency Room/Express Care Utilization

- 32 percent reduction in emergency room utilization
- 56 percent reduction in express care utilization

Client Satisfaction Survey

I felt heard	87.5%
I felt understood	75%
We worked on what I wanted to work on	85%
We talked about what I wanted to talk about	87.5%
My provider's approach/style is a good fit for me	85.7%
My provider challenges me to make changes in my life	75%
I have enough time to address any concerns/issues I may have with my provider	87.5%
Having my case manager at my appointment is helpful	100%

57% Response Rate: Nov. 2016

Other Partnerships with WCMHS*

* Source Javad Mashkuri, MD, Medical Director ED Services

- SBIRT (Screening, Brief Intervention, and Referral to Treatment)
  - WCMHS assistance and expertise helped launch this initiative and supported efforts in our community.
  - Provided clinical oversight, coaching and mentorship to SBIRT clinicians.
  - Clinical space to allow SBIRT clinicians to see clients in therapeutic environment outside of ED.
- WCMH Home Intervention Supported Alcohol Withdrawal Pilot Program:
  - Supported establishment of alcohol withdrawal bed.
  - Provided space and staff.
- WCMH Therapists Embedded in Primary Care Practices; most recent addition being a clinical case manager for a newly defined ACES project within our CVMC Pediatrics practice