

Integrating Health Services for People with Mental Illness or Substance Use Disorders

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Why make changes now

- Health disparities must be addressed
- Need outstrips the state's ability to serve individuals
- System needs to prioritize independence and prevent unnecessary use of structured settings
- Delivery system is complicated
- Payment system provides few incentives to manage care effectively.
- Health Reform and creation of OHA provides unique opportunity for change

Health of individuals with mental illness or substance use disorders

- People with serious mental illness and substance use disorders die 25 years earlier than the general population
- 60% due to medical conditions
 - cardiovascular disease
 - Diabetes
 - respiratory diseases
 - infectious diseases
- 40% due to suicide & injury

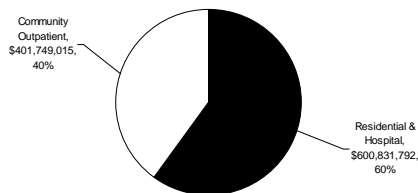
Morbidity and Mortality in People with Serious Mental Illness
 Oct. 2006 <http://www.nasmhpd.org/publicationsmeddir.cfm>

Demand versus ability to serve

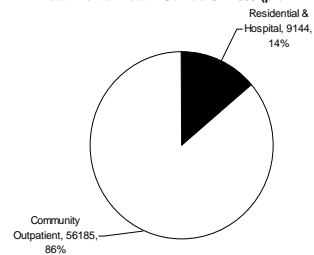
| Age/Category | Prevalence | People served in public system | Percent of need met |
|-------------------------|------------|--------------------------------|---------------------|
| Addictions | | | |
| 17 and under | 26,765 | 6,635 | 25% |
| Over 17 | 235,516 | 56,138 | 24% |
| Mental Health | | | |
| 17 & under | 105,306 | 34,617 | 33% |
| Over 17 | 154,867 | 71,204 | 46% |
| Problem Gambling | | | |
| All | 76,839 | 4,743 | 6% |

System is out of balance

Adult Mental Health 2009/2011 Biennial Budget



Adult Mental Health Served CY 2009 (preliminary)



60% of the funding serves 14% of the clients

No consistent criteria/system to move people through the system to less restrictive care settings



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“Complicated” system

- **Medicaid**
 - 13 Fully Capitated Health Plans
 - physical health and addiction services
 - 9 Mental Health Organizations
 - Mental health services
 - 1 Chemical Dependency Organization
 - Deschutes County
 - Fee-for-service payments and direct provider contracts
- **Non-Medicaid**
 - 36 Local Mental Health Authorities
 - 33 Community Mental Health Programs



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Guiding Principles for Integration (*excerpts*)

- The goal is to assist individuals in becoming self-sufficient.
- Services must address the needs of people holistically.
- Services should be delivered in a seamless and integrated manner.
- Services include health, mental health and addiction services, and Wraparound community services and supports
 - E.g., Housing and Employment
- The system must be managed in the most cost effective and individually focused manner.

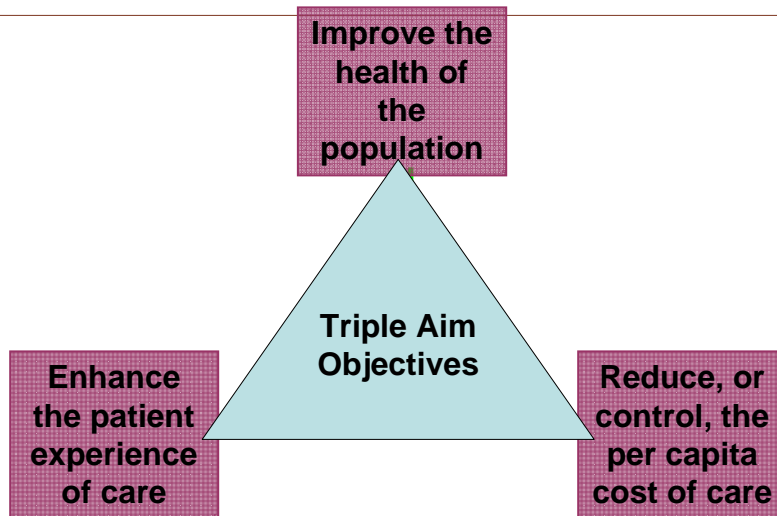
Guiding Principles for Integration (*excerpts*)

- Funding should follow the shortest line possible.
- Consolidate all available funds
- Payment will focus on achievement of measurable outcomes.
- Services must be geographically located
- To avoid duplication, services should be managed regionally

Three Conceptual Frameworks

- Triple Aim
- Four Quadrant Model
- Three Domains

Triple Aim



Triple Aim Goals or a Definition of Success

- **Improve the health of the population**
 - Increase the number of people served
 - Address health disparities for individuals with mental illness and/or substance use disorders
- **Enhance the patient experience of care**
 - Move to community-based services
 - Reduce unnecessary stays in hospitals and licensed residential settings
 - Increase access to primary care services
- **Reduce, or control, the per capita cost of care**
 - Use existing resources more effectively
 - Promote recovery and resiliency
 - Decrease emergency department utilization
 - Focus on early assessment, intervention and supports

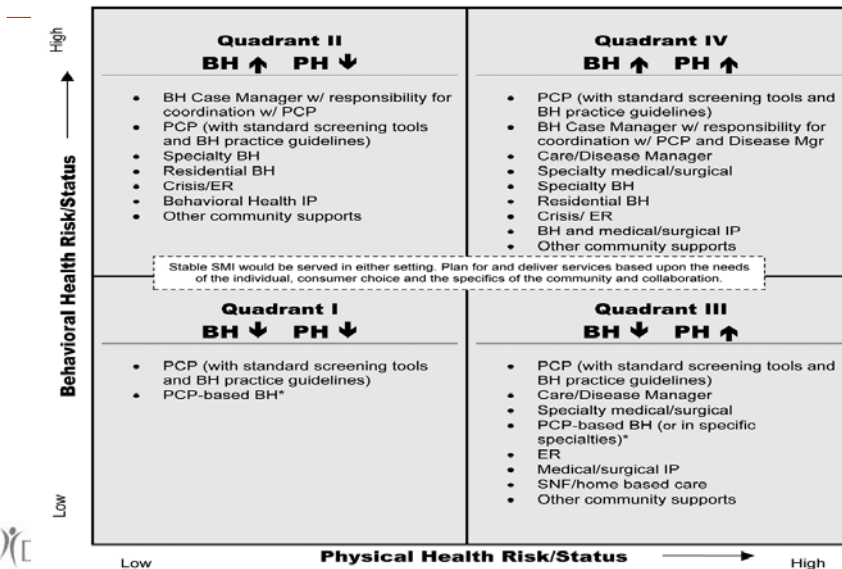


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The Four Quadrant Model



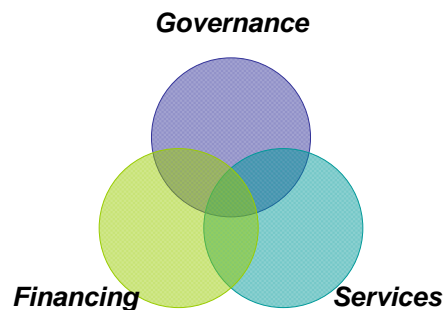
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Four Quadrant Model

- Conceptual framework for designing integrated programs.
- Offers guidance to determine which setting can provide the most appropriate care, and who should provide the medical home
- Defines that the care people need and where care is best delivered depends on the severity of the person's behavioral health and physical health needs.
- Describes the need for a bi-directional approach, addressing the need for primary care services in behavioral health and visa versa.

3 Domains for the DHS/OHA Demonstration Projects

- Governance
 - Single Point of Accountability
 - Locally driven
- Service Integration
 - Medical Home
 - Co-location
 - Health/system navigators
 - Standardized screenings and assessments
- Financing
 - Additional flexibility with state general funds
 - More accountability
 - Braiding financing to support outcomes



Outcomes specified in Budget Note

- Improved response to and follow up for people in crisis
- Reduced lengths of stay in state hospitals and residential settings;
- Reduced contacts with the criminal justice system;
- Increased “permanent” housing;
- Increased employment, job training or education;
- Increased reunification of children with their parents in recovery;
- Reduced use of emergency departments;
- Increased use of appropriate routine medical care
- Increased access to addiction services for OHP members
- Improved health outcomes for people

Process to date

- Direction from Ways and Means
- 2 Stakeholder meetings in April 2009
- Report to Ways and Means on April 20, 2009
- Budget note in June 2009
 - Any willing community that includes all local partners
- Since session ended:
 - Two demonstration sites selected;
 - Central Oregon
 - North East Oregon
 - Creation on consumer/advocate advisory committee
 - Internal work to support integration efforts

Central Oregon – Links 4 Health

- Crook, Jefferson and Deschutes areas
- All parties at the table
 - Counties
 - Public payers
 - Hospital system
 - FQHCs and volunteer programs
 - Consumers and family members
- Working toward a Regional Health Authority
 - Shared financing, decision making, oversight

Central Oregon Integration

- Current focus - ER diversion
- 10-12 Outcomes using “TRIPLE AIM”
- Using the 4-Quadrant Model
- Integrated Care
 - Co-locating services
- Health Home

Utilization in Central Oregon

- Top 15 ED Visitors in Tri-County (single hospital only)
 - Total: 463 Visits = 30.8 visits/person
 - **8 Medicaid**, 5 Medicare, 1 TriCare, 1 Commercial
- Top 50
 - 6 Self Pay, 4 Private Insurance, 9 Medicare (2 Medicare/Medicaid), **31 Medicaid** (COIHS/ABHA)
- Diagnosis
 - 6 Chemical Addiction/abuse + MH
 - 16 Pain “only”
 - 27 Pain + MH + Chemical Addiction/Abuse

NE Oregon

- In process of analyzing Medicaid data
- Using DHS' Integration Assessment to determine “low hanging fruit”
- Reviewing possibility of Accountable Health Organization
- Discussing project/concept with community partners

NE Oregon Data

- 20 individuals in tri-county area with more than 10 visits to ED in one year.
- 3 diagnosis holds true:
 - Pain
 - Mental Health
 - Chemical dependency
- \$125,000 emergency room charges

Source: DHS/OHA - MMIS Fiscal Year 08-09



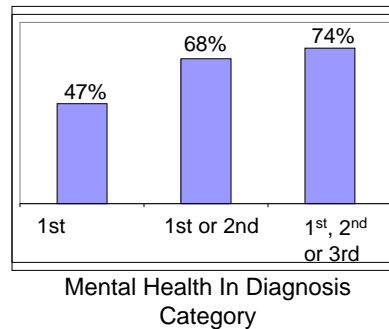
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NE Oregon High Utilizers

| Patient Diagnosis | Number | Percent |
|----------------------|--------|---------|
| All three categories | 12 | 63% |
| Only PH and Pain | 5 | 26% |
| Only PH and MH | 2 | 11% |



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Adult Mental Health Initiative

- Next phase of reform efforts
- Move full range of mental health services to the MHOs
 - Services in licensed residential settings
 - Community services and supports including non-Medicaid services
- 8 of 9 MHOs participating
- 3 phases
 - Phase 1: Additional MHO responsibility and engagement
 - Actively participating throughout the continuum of care
 - Phase 2: Case rates for individuals enrolled in plan
 - Phase 3: Analyzing potential for capitated rates for residential and community supports