The SC Behavioral Health Coalition, 9/14/2017

Integrated Behavioral Health and Primary Care

The CareSouth Carolina Story

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About CareSouth Carolina

- Federally Qualified Health Center est 1980 – PHS Section 330 funding, and……
  - 2001 Mental Health and Substance Abuse
  - 2001 Ryan White HIV/AIDS Part C Funding
  - implementation funding
  - 2014 ACA Mental Health Service Expansion - Behavioral Health Integration supplemental funding
  - 2014 ACA Capital Development Funding
- Private, Non-Profit Organization
  - Majority of our Board of Directors are Patients
- Joint Commission Ambulatory Accreditation since 2000, including JCAHO recognition as PCMH
- A staff of 460, 38 are medical providers, 15 are masters level counselors.
- 35,755 patients, 69% at or below 100% poverty
- 13 locations over five counties in rural Pee Dee

Service Locations

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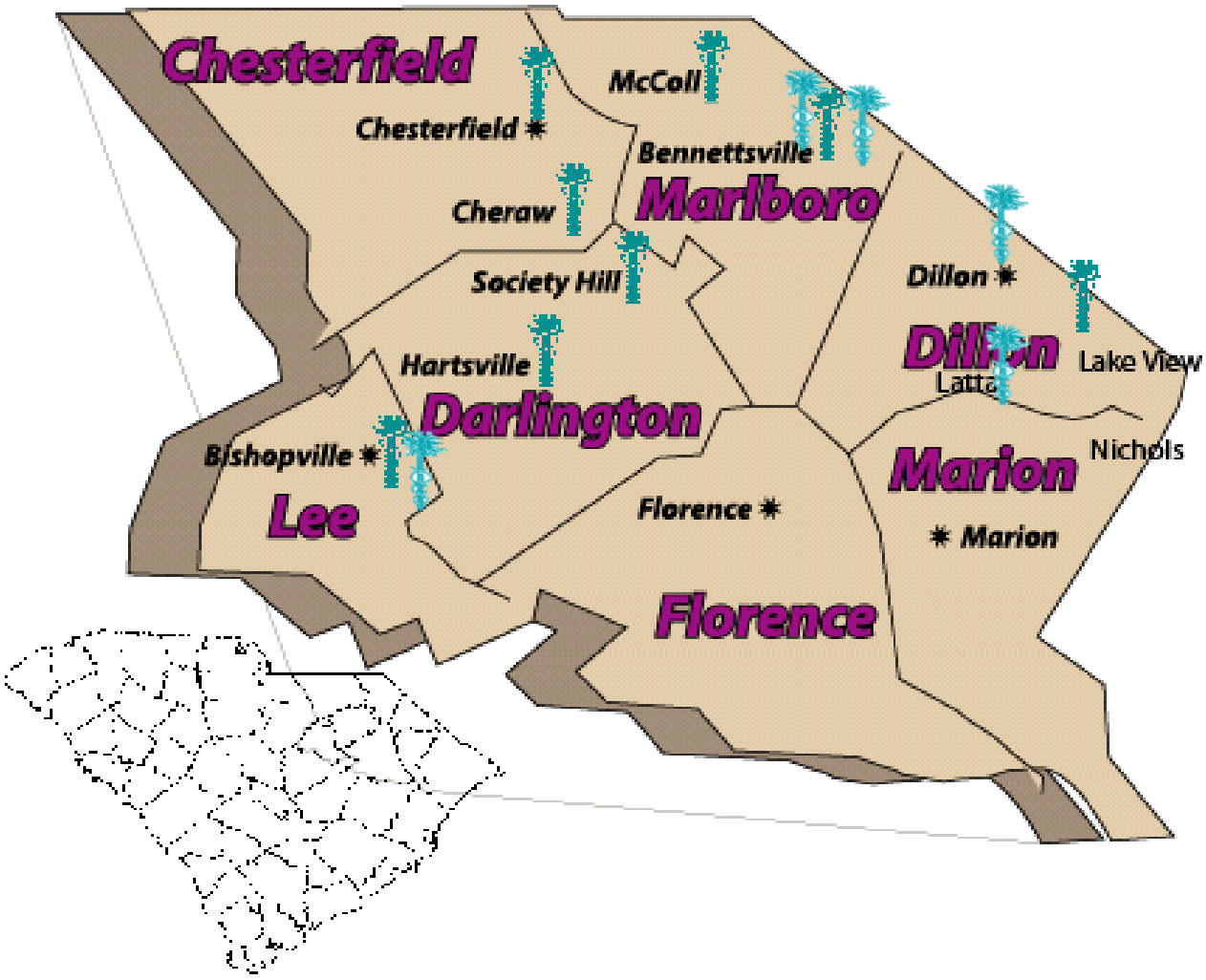
Counties Served:
Chesterfield • Darlington
Dillon • Lee • Marlboro



A *System* of Care

Family practice, pediatrics, internal medicine, women's health (OB-GYN), ***integrated behavioral*** health, pharmacy, chiropractic services, social services, community health outreach, care management, transportable and mobile dentistry, targeted care for HIV/AIDS, Older American Act services (ADRC) to the elderly as an Area Agency on Aging, community development

In formal, direct care relationships with –

Three local area hospitals

- Three local substance abuse agencies
- The local regional community mental health center
- USC for psychiatric telehealth

We considered several models of Behavioral Health Integration

- Linkage / Co-location – provided on-site by non-Center staff health worker
- Referral – provided off site by non-Center staff under formal arrangement
- Enhancement – train primary care practitioners to provide mental health services on site.

Our Approach

- ***Diversification (aka integration) – provided on-site directly with organization's own mental health staff since 1997 – twenty years of integration!***

Core Clinical Functions of Integration at CSC

- **Integrative Activities –**
  - **Patient screening / assessment – using standardized, evidence based tool (PHQ9)**
    - **The PHQ is a 'Core Vital Sign' for ALL patients**
  - **Initial Engagement – Brief introduction to BH staff for evaluation of immediate needs.**
  - **Maintaining "walk in" slots for same day access. Consider 15/45 minute schedule – 15 minutes of every hour is kept "open"**
  - **Part of the PCP team**
  - **Follow up and tracking**
- **Direct Care Services**
  - **Medication management – by PCP**
  - **Counseling and therapy services, individual, family, group – by mental health staff using cognitive behavioral health therapy**
  - **Psychiatric consultation / referral- phone, telemedicine, appointments**

Lessons Learned

- Co-location of the BH / MH and PC is essential, not marginal.
- The *system* must support MH/BH and PC collaboration.
- Aggressive primary care medication management! Grow your own “specialists”.
- Increased patient access, satisfaction and improved outcomes should be the purpose of integration.
- Collect data to build will using Clinical information system/patient registry or EHR for data
- BH paperwork / documentation must be adequate, not voluminous. One “chart” only.

Benefits of Integrated Care

- Seamless for the Patient
- Immediate Access (no referral out)
- Reduces Stigma
- Improves Access for MH expertise
- Immediate “Curbside Consultation”
- Extends Behavioral Change Expertise into the Primary Care Center for improved management of chronic conditions
- Business Case:
  - billable in SC at 330 Health Center rate.
  - Parity is the law!

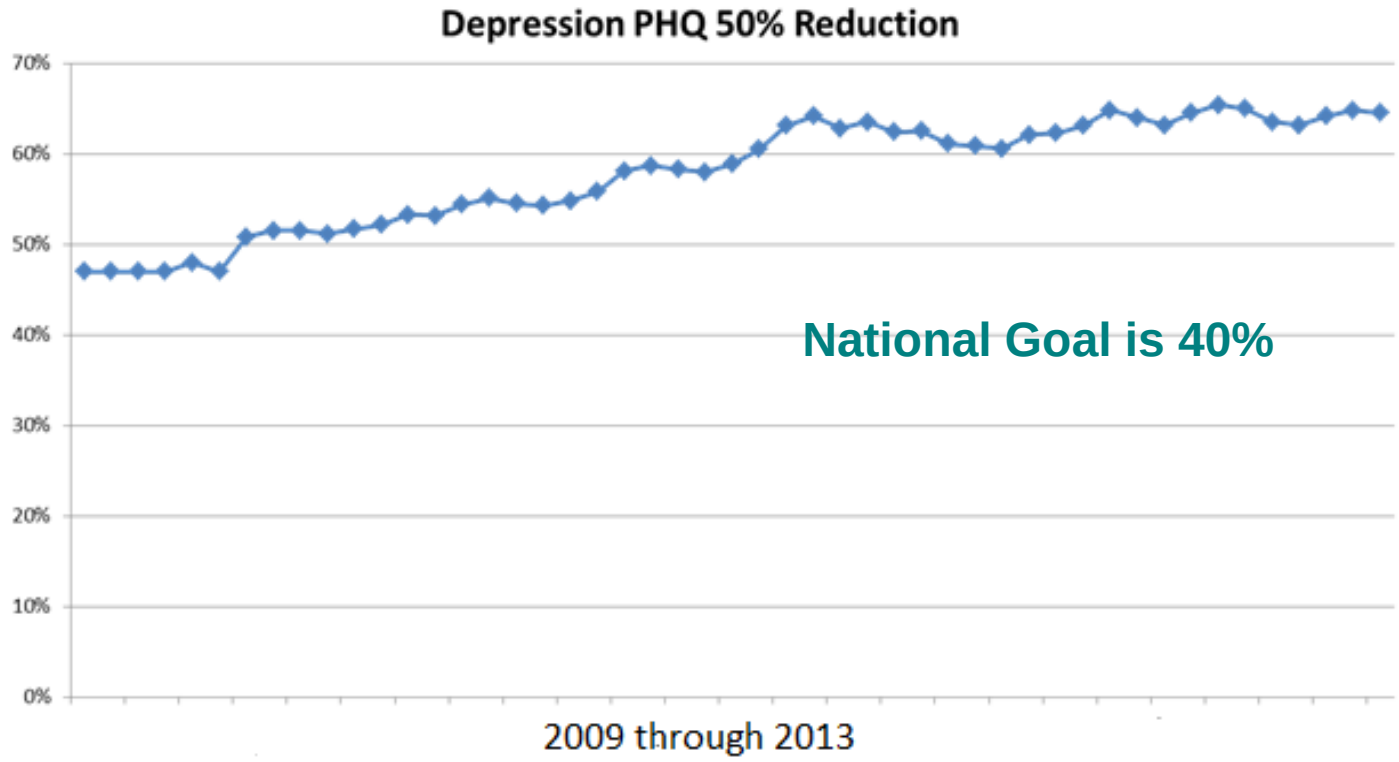
Recognizing the Root Causes of Non-Compliance and the consequences

- Studies, reports, research from a wide range of entities indicate that the percentage of patients with chronic illness who are also clinically severely depressed range from 10% to 42%.
- These patients aren't non-compliant… they are depressed!

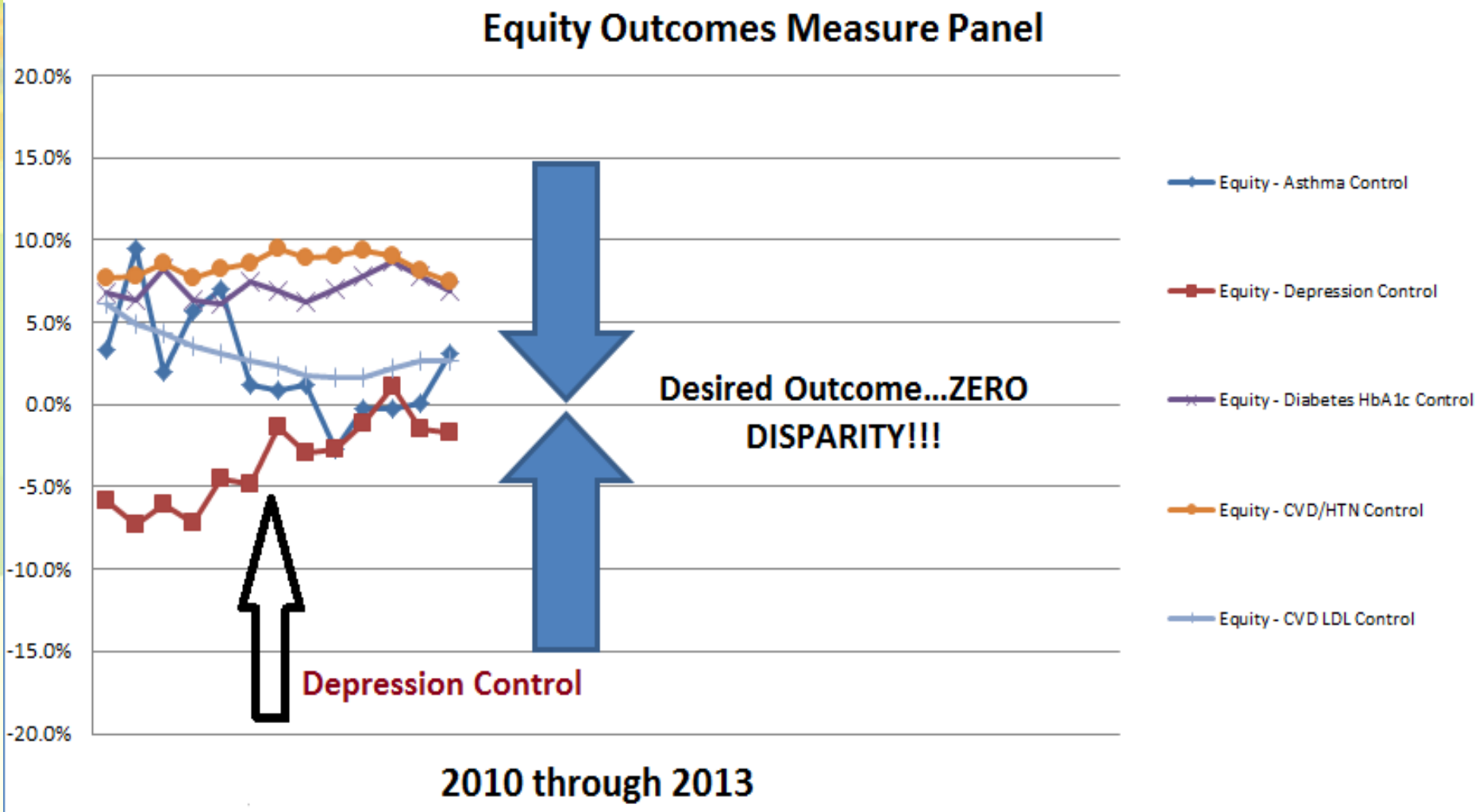
So What?
Does all of this matter?

Depression Outcomes

50% Reduction in Depression over a four year period



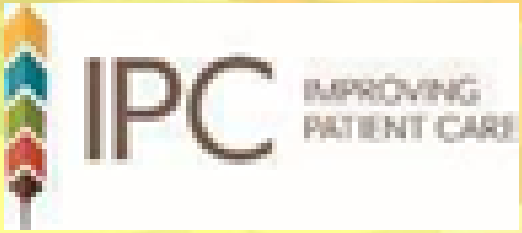
Equity Measures



Recognition of the CareSouth Carolina Integration Model

- June 2011 HRSA Office of Rural Policy report: Rural Behavioral Health Programs and Promising Practices
  - 69 nominated programs
    - Robust
    - Relevant to rural
    - Positive impact
    - Sustainability and expansion capability
    - Capacity
    - Documentation
    - Effectiveness
    - Community engagement
- HHS Partners Best Practice Model, June 2017

Indian Health Service



- Institute for Healthcare Improvement / Indian Health Service program 2008 – ongoing
- Faculty for leadership, workforce development, advanced access AND integrating behavioral health
- 2011 IHS Strategic Plan

Today - New Focus by SC DHHS

- Anti-depressant medication management
- Follow up care for children prescribed ADHD medication
- Follow up within 7 days after hospitalization
- Use of first line psychosocial care for children and teens with prescribed anti-psychotics
- Metabolic monitoring for he group above
- Initiation and engagement of treatment for alcohol and other drug dependence

Behavioral Health Integration and Substance Abuse – a fresh look

- Behavioral Health Integration has led us to the next steps with substance abuse integration.
- We see the same issues and problems with building integration as in the past –
  - Services are in silos across the area
  - Stigma, stigma, stigma
  - Coupled with a tsunami of opioid addiction leading to a crisis of drug overdose deaths
  - Traditional “turf” paranoia

Where are we today?

- We have launched a “formal” Substance Abuse Treatment Program!
- Key attributes
  - Building will with providers to obtain buprenorphine certification – patient success stories
  - Developed *strong* MOAs with community and state alcohol/substance abuse agencies
  - Implemented high level drug screening
    - Weekly for at least one month
  - Patient participation with behavioral health counseling is required
  - Developed nursing Program Management – to overcome the prior authorization barriers and to build will
  - Tracking, follow up, and case management with CHWs and CMA Care managers

Is it Working? What we have learned

- In less than a year…..
  - Four certified providers!
  - Nursing engagement
  - Engaged counselors
  - Three agency MOUs The SC Department of Alcohol and Other Drug Abuse Services (DAODAS) cites us as a “model program” with grant funding!
  - 340b Pharmacy Services have been essential
  - Over 200 patients seen
    - Total failure rate 30%
    - Of those… 90% fail within the first five weeks
    - Of those remaining more than 6 weeks, only 9% fail

In Summary…..

At CareSouth Carolina, we cannot imagine our provision of services without integrated behavioral health care.

It is part of the “puzzle” of assuring our mission as an FQHC: *we will enhance and improve the health and well being of everyone*

CareSouth Carolina, Inc.
PO Box 1090 201 S. Fifth St.
Hartsville, SC 29551
843-857-0111


QUESTIONS