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Agency of Human Services

VERMONT Blueprint for Health
Smart choices. Powerful tools.

Blueprint for Health
Executive Committee
Planning & Evaluation Committee

November 20, 2017

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Agenda November 20, 2017

- Welcome
- Developing capacity for expert "behavioral health*" in primary care
- Convergence of evidence-based practices for population health
  - -Zero Suicide -Screening for SDOH
  - -SBIRT - Behavioral Health support for management of chronic conditions
- Discussion
- Blueprint payment manual updates

*treatment for mental health & substance use conditions and support for changing health behaviors

Convergence of population based evidence based practices

- Zero Suicide
- SBIRT
- Screening and intervention for SDOH - economic stability, physical environment, education, food, HC System & **Community & Social Context**
- Behavioral Health Support for Chronic Disease
    - Behavior Coaching to enhance self management and care plan adherence
- ACES
- Successful examples – CHCB, NCSS/NOTCH, others…

Consensus: best practice population screening, brief interventions and appropriate assertive referrals using evidence based techniques by MHSA clinicians should be fully integrated within PCMH practices

What would it take to achieve this and what specific practices could be priorities?

Progress and Challenges for Suicide Prevention in Healthcare Settings

- Suicide deaths continue to rise despite better understanding and approaches
- Healthcare settings remain a major priority for prevention efforts
- Growing momentum for Zero Suicide/Suicide Safe Care…but most health settings aren't there
- Vermont's efforts—like those in the nation—could turn the tide. But there's lots to be done

Suicide and Health Care Settings National

- 45% of people who died by suicide had contact with **<u>primary care</u>** providers in the month before death.

- 19% of people who died by suicide had contact with **<u>mental health</u>** services in the month before death.

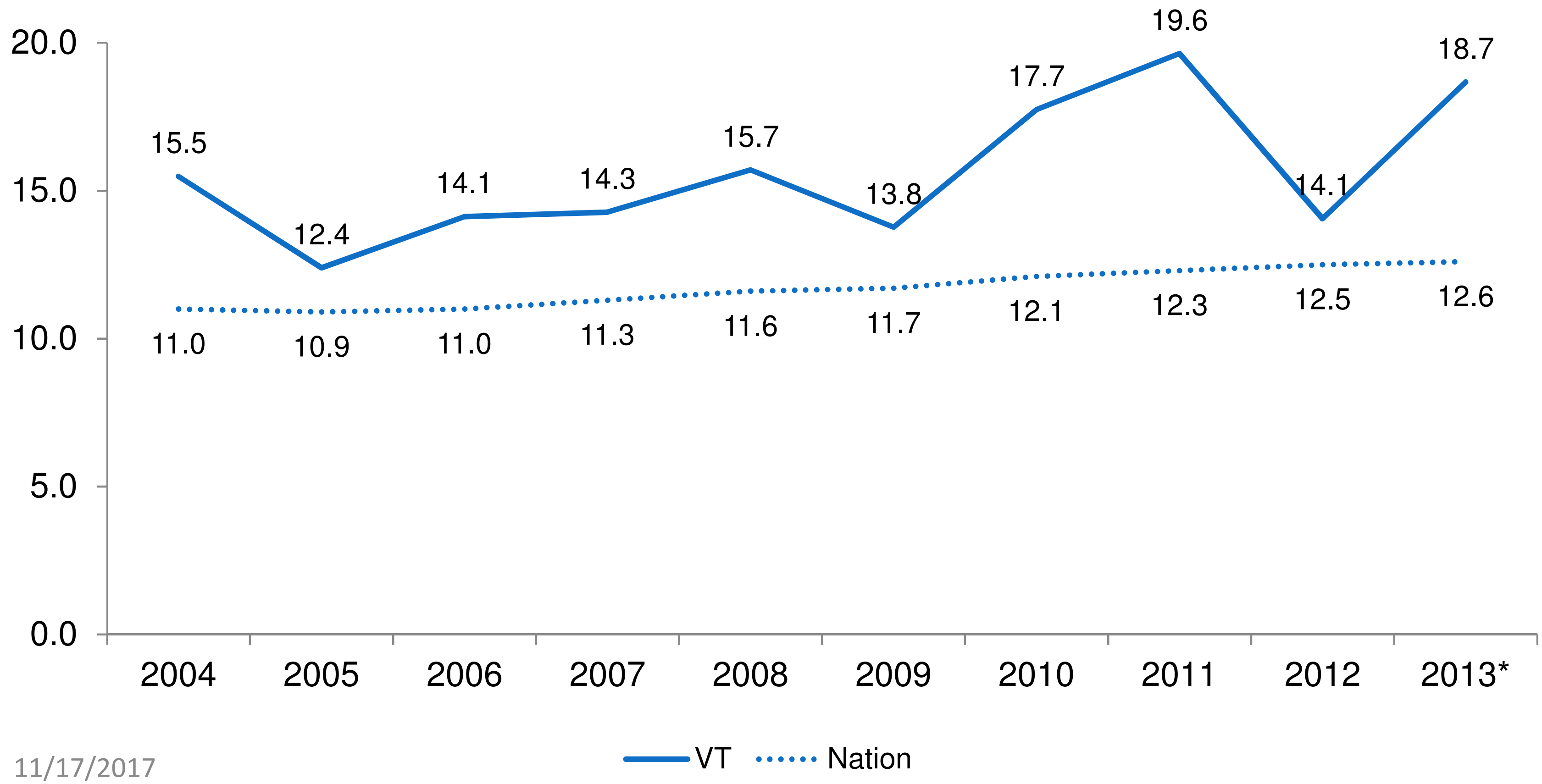
- **Vermont:** In 2013, 20.4% of the people who died from suicide had at least one service from state-funded mental health or substance abuse treatment agencies within 1 year of death.

- South Carolina: 10% of people who died by suicide were seen in an **<u>emergency department</u>** in the two months before death.

Death by Suicide- 2 Vermonters Per Week

41,149 - USA
110 - Vermont

10th Leading Cause of Death across the population
3rd Leading Cause of Death <18



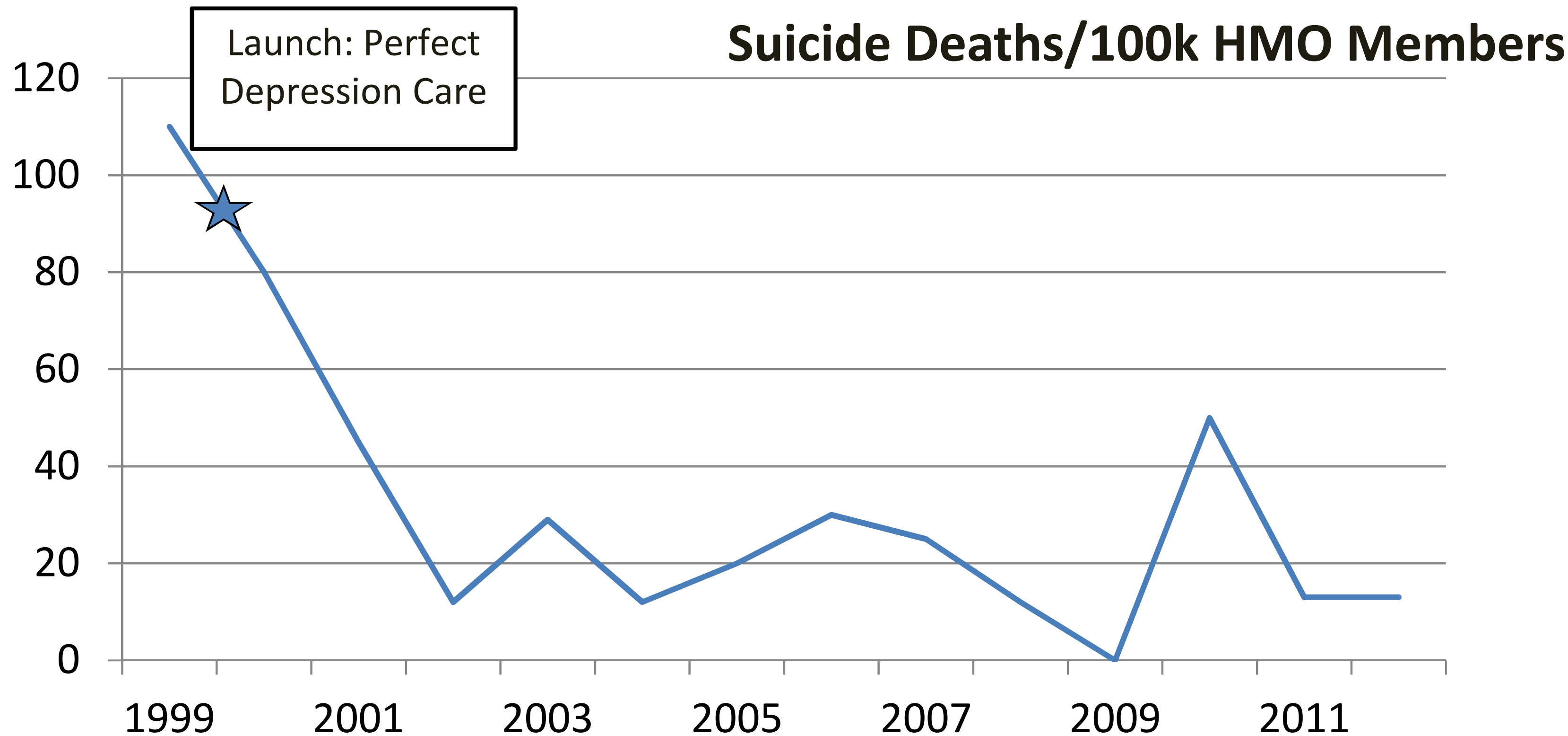
Zero Suicide is…

- A framework for systematic, clinical suicide prevention in behavioral health and health care systems.

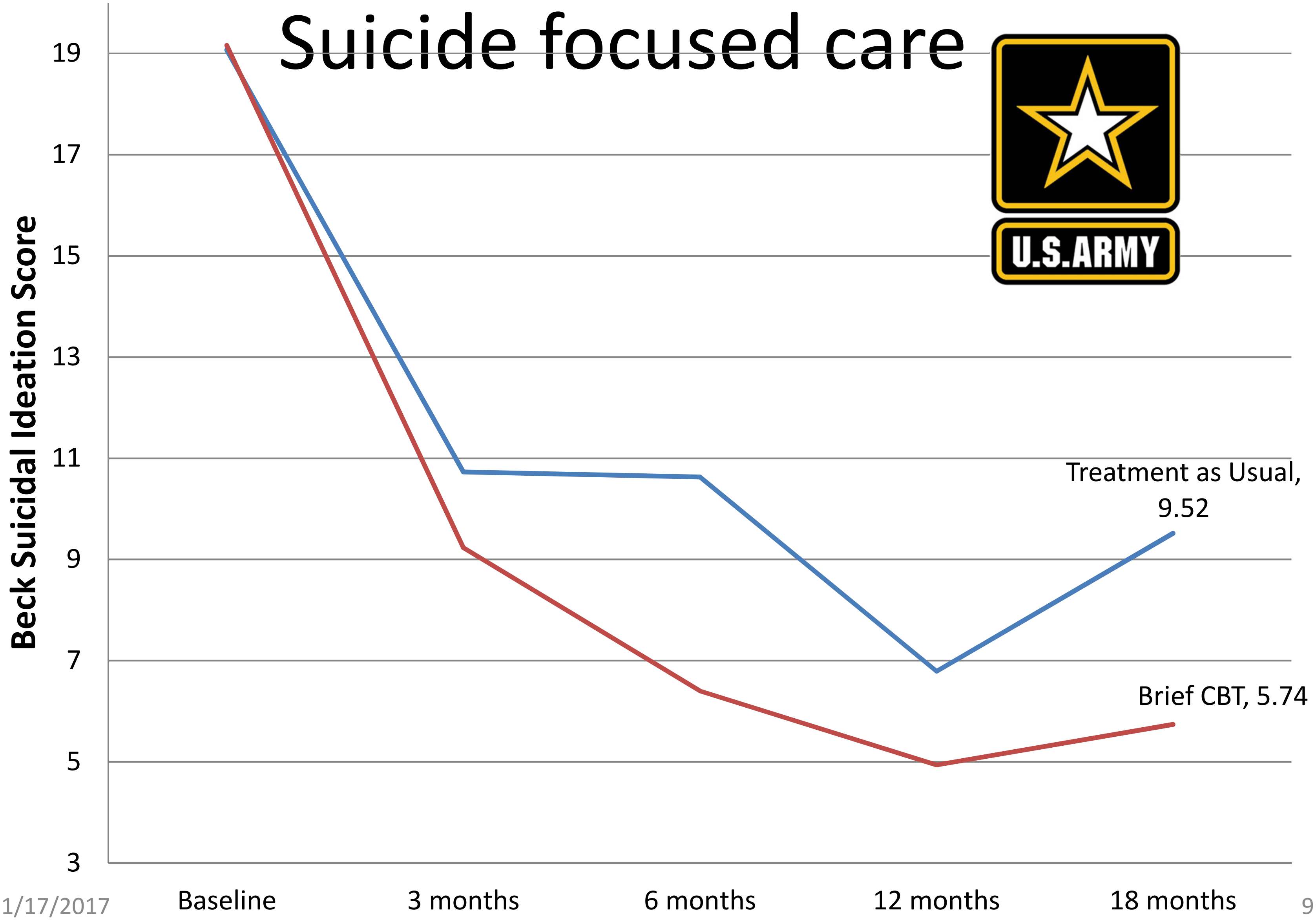
- A focus on error reduction and safety in health care.

- A set of best practices and tools including www.zerosuicide.com.

Systematic Approach works in Health Care: Henry Ford Health System



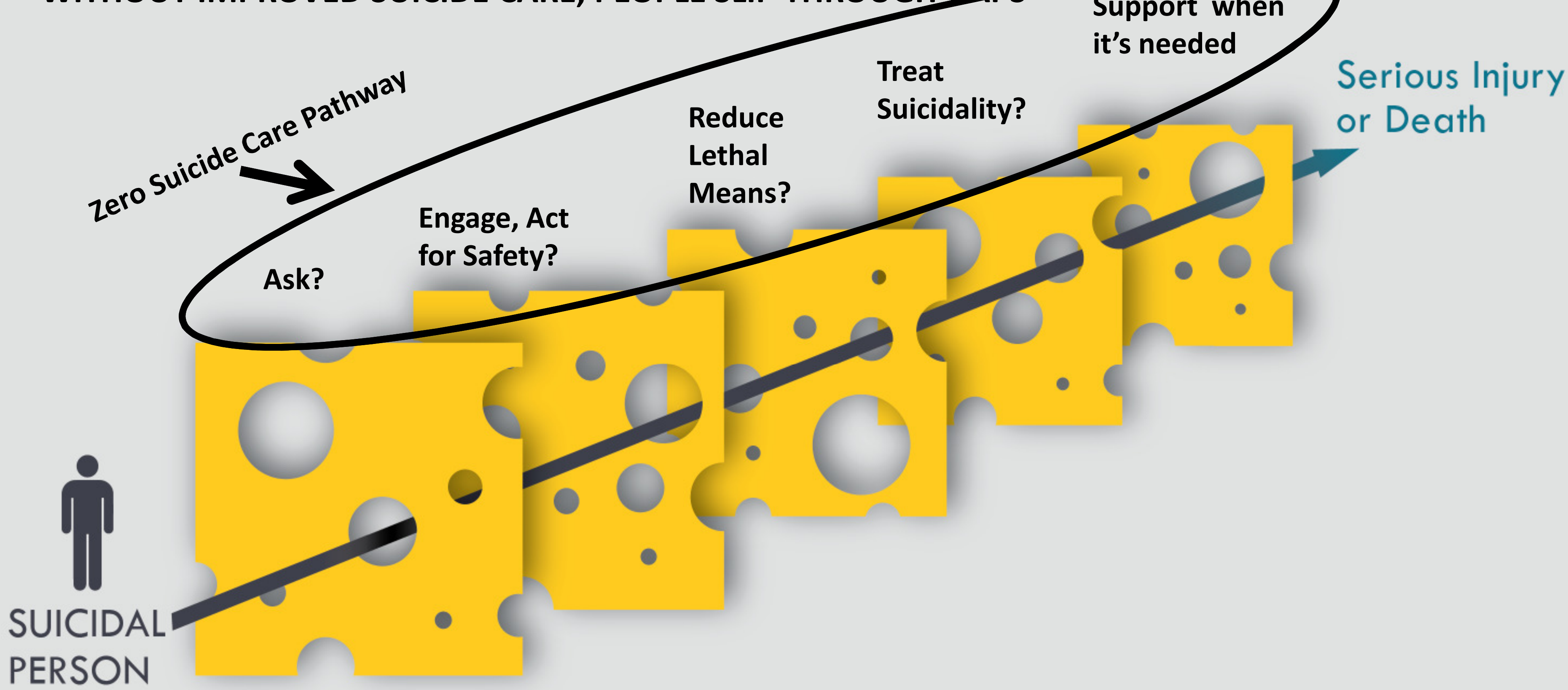
Suicide focused care



ZEROSuicide
IN HEALTH AND BEHAVIORAL HEALTH CARE

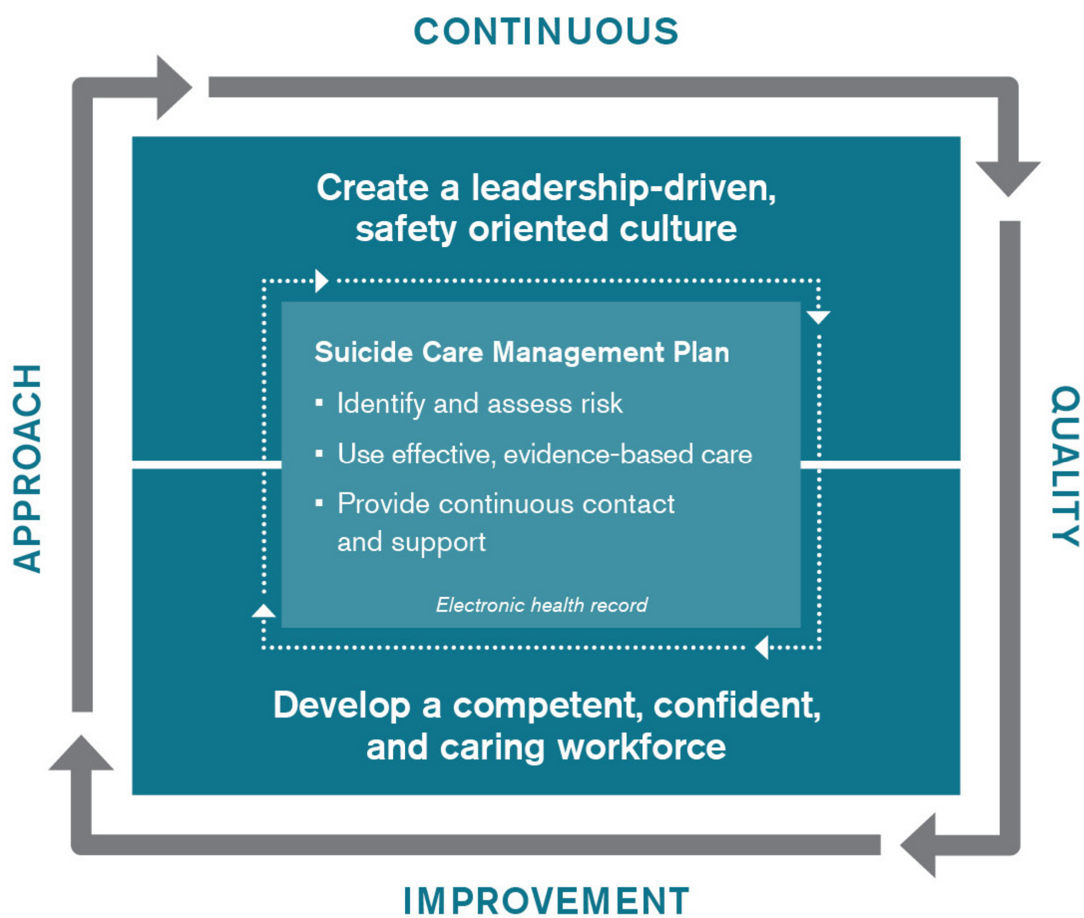
A FOCUS ON PATIENT SAFETY AND ERROR REDUCTION

WITHOUT IMPROVED SUICIDE CARE, PEOPLE SLIP THROUGH GAPS



Adapted from James Reason's "Swiss Cheese" Model Of Accidents

Elements of Zero Suicide



Zero Suicide includes:

- Uniform standards for screening, assessment
  e.g., PHQ2, 9, C-SSRS, CAMS
- Written office policies and protocols focused on detection and response
- Partnerships with Mental and Behavioral Health
- Established local referral network
- Collaborative Care with the patient- a core concept of suicide prevention
- Trained and skilled workforce using Evidence –based Clinical care practice

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Skilled Workforce in EBP

Required Suicide Prevention Training	**Length**	Specify Who is Required by Title
Zero Suicide Leadership Seminar	1.5 in person	Leadership
Gatekeeper	1.5 in person or 1-2 hour online	All staff: Warning signs, risk factors, protective factors, response
Grand Rounds- Prevalance, Epi, Prevention, Risk Assessment, Intervention	1 hour	All staff
Assessment of Suicidal Risk PHQ 2, 9, C-SSRS TBD	45 minutes/online	Clinical
Safety Planning and Crisis Intervention/Support	45 minute/online	Clinical
Counseling on Access to Lethal means (CALM)	2 hours/online- Free	Clinical or all staff
Collaborative Assessment for Management of Suicide (CAMS)	3 hours online, 6-8 follow-up T.A. calls –contracted w/ CAMSCARE	Treatment staff
Structure Follow-up and Monitoring	In development	Office protocol

www.mentalhealth.vermont.gov
www.vtspc.org

Vermont Pilot Sites (n=3)

- Northwestern Counseling and Support Services

Site Coordinator: Dr. Steve Broer, Psy.D., Dir of BH Services

- Lamoille County Mental Health

Site Coordinator: Michael Hartman, Exec. Director

- Howard Center

Site Coordinator: Beth Holden, LCMHC, LADC

What is SBIRT?

SBIRT is a public health approach to prevent, universally screen, and deliver early intervention and treatment services for people with substance, mood and other behavioral disorders and those at risk of developing these disorders.

The Core Processes of SBIRT

Universal Screening	Brief Intervention	Referral to Treatment: Brief & Specialty
• Quickly identify the severity of substance use and identify the appropriate level of treatment	• Increase insight and awareness of substance use; motivate toward behavioral change	• Provide embedded brief treatment • Refer to specialty care when needed

Brief Intervention

What

- Brief motivational discussion to enhance awareness of problem & increase motivation and commitment to behavior change

When

- Patient screens positive for risky alcohol/drug use

Who

- Health educator, nurse, doctor, psychologist, social worker, medical assistant

Where

- Exam room, bedside, private room/office

Embedded Brief Treatment

What

Warm hand-off to a behavioral health clinician embedded in the medical setting.

When

Patient scores in the harmful risk category on the secondary screening and patient wants (and is good match for) additional services.

Who

Social worker, psychologist, psychiatric nurse practitioner, licensed alcohol and drug counselor

Where

Private room/office

Assertive Referral to Treatment

or other services

What

Calling service providers including specialty outpatient, specialty IOP, residential, MAT & detoxification to schedule an appointment, getting medical clearance (for detox), calling about insurance, arranging transportation, giving information: handouts, brochures, contact info., safety supplies

When

Patient scores in the Severe /Hazardous risk category on the secondary screening and patient wants (and is good match for) additional services.

Who

Health educator, social worker, psychologist, nurse, doctor, medical assistant

Where

Bedside, private room/office

SBIRT Sites To Date

- Community Health Center of Burlington
- The Health Center - Plainfield
- The NOTCH – Franklin County
- Central VT Med Ctr Women's Health
- Brattleboro Family Medicine
- Mt. Ascutney Health Ctr* +
- Northern Counties Health Care Inc.* +
- Comm Health Services of Lamoille Valley*
- Central Vermont Med Center ED
- Rutland Regional Med Center ED
- Northwestern Med Center ED
- Southwestern Vermont Medical Ctr ED
- UVM Student Health Services
- Peoples Health & Wellness
- Rutland Free Clinic
- Bennington Free Clinic
- Good Neighbor Health Clinic
- Spectrum Cultural Brokers

*Receiving training & TA now;
+Soon to become funded site

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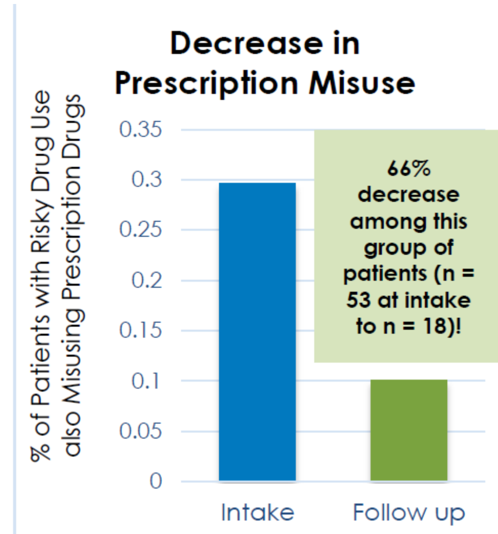
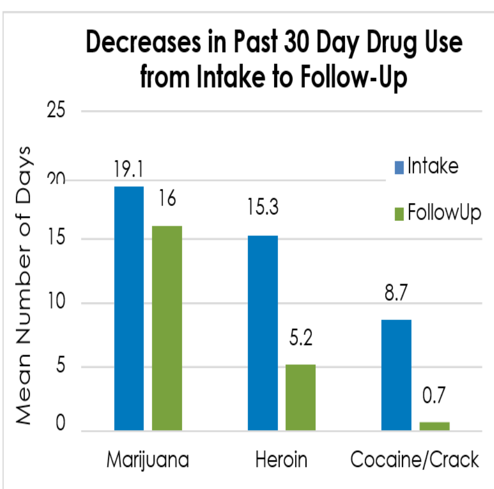
SBIRT Outcomes

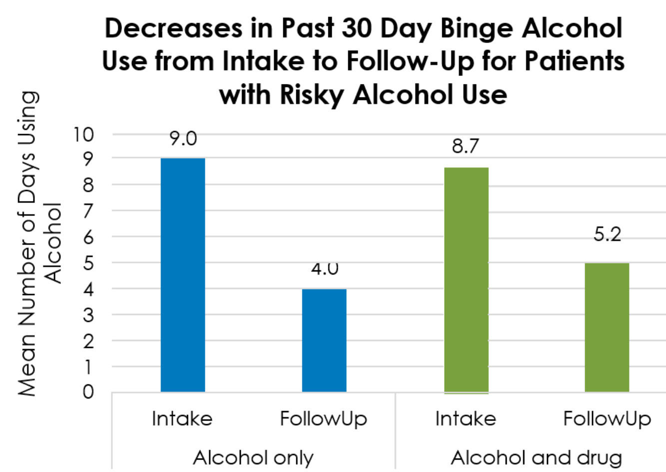
- As of 10/17 in VT – 100,000+ screens/6000+ Interventions
- Estimated Savings - $547 to $806 per person
- 6 month outcomes show sig. ↓ frequency of:
  - drinking & binge drinking
  - Prescription misuse
  - Marijuana and other illegal drug use





The graph to the left shows decreases in past 30 day drug use for marijuana (n=326), heroin (n=23) and cocaine (n=15).

The remaining classes of drugs had too small of an n to test for statistically significant differences.



DISCUSSION

Best practice population screening, brief interventions and appropriate assertive referrals using evidence based techniques by MHSA clinicians should be fully integrated within PCMH practices

How do we achieve this?

Proposed Payment Change

Change Patient Centered Medical Home Per Member per Month Payment (PCMH PMPM) to a common base payment of $2.00

- Under the 2017 Standards which went into effect on April 1, 2017, NCQA eliminated assigning a score from 0 to 100 for PCMH recognition
- Changing to a common PCMH PMPM base payment aligns Medicare with other insurers
  - In 2016 with the exception of Medicare, the Blueprint under the advice of providers shifted away from basing PCMH PMPMs on the NCQA score
  - Providers felt strongly that Incenting higher NCQA scores increases the administrative burden of scoring without enhancing clinical value

Proposed Blueprint Manual Updates

For Final Review:

- Section 5.1 Patient-Centered Medical Home (PCMH) Payments
  - "For Calendar Year 2018, Medicare PCMH payments will be will be distributed through OneCare Vermont and fixed at a rate of $2.00 per patient per month."
- Section 5.2 Community Health Team Payments
  - "For Calendar Year 2018 payments, Medicare CHT payments will be distributed through OneCare Vermont."

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Adjust PCMH Payments with a Common Base $2.00

Blueprint Programs	Calendar Year 2018
PCMHs PMPM $2.00	$1,830,264
CHTs	$2,245,853
SASH	$3,704,400
Total	$7,780,517
Available 2018 Medicare Funding	$7,762,500
Shortfall	(-$18,017)

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Market Share and Impact of Common Base $2.00

Practices Receiving Medicare $	112	100%
Independent Practices	28	25%
FQHC-Owned Practices	39	35%
Hospital-Owned Practices	45	40%

Impact of a Common $2.00	% Change Overall	$ Change Overall	Average Change By Site
Statewide	**-4.03%**	**-$102,149**	**-$912**
% Change Overall for Independent Practices	-2.63%	-$7,541	-$269
% Change Overall for FQHC-Owned Practices	-4.52%	-$34,699	-$890
% Change Overall for Hospital-Owned Practices	-4.47%	-$59,909	-$1,331

Predict 2018 funding based upon annualized 2017 funding