



Supporting Holistic Health through Integration with Physical Health Services

**Moderator: Sara Goldsby (SC)
Speakers: Valerie Mielke (NJ), Mark
Stringer (MO), and Linda Wittmuss (NE)**

**Wednesday, June 5, 2019
3:30 – 4:30PM EST**

2019 CSAT/CSAP Annual Meeting

NASADAD – CSAT/CSAP Annual Meeting Plenary Session
**“Supporting Holistic Health through Integration with
Physical Health”**



VALERIE L. MIELKE, MSW
ASSISTANT COMMISSIONER

NJ DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES

JUNE 5, 2019



Integrating Physical and Behavioral Health Care

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- New Jersey has developed two programs to better integrate physical and behavioral healthcare for pregnant women with, or at-risk for, opioid use disorder
- These programs are intended to provide person-centered, holistic care for pregnant women.
- The foundation of integrated care is a holistic view of the individual and personal health as complex, integrated systems. (Kaiser Commission on Medicaid and the Uninsured, February 2014, Issue Brief)

In-Depth Technical Assistance-Substance Exposed Infants (SEI)

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- 2014 New Jersey awarded In-Depth Technical Assistance (IDTA) on SEI and Neonatal Abstinence Syndrome (NAS) through SAMHSA's National Center on Substance Abuse and Child Welfare (NCSACW):
 - Strengthen collaboration and linkages across multiple systems for opioid dependent pregnant women and other SUDs - Addictions Treatment, Child Welfare, and Medical Communities
 - Improve services for pregnant women with opioid and other SUDs and outcomes for their babies
 - Develop uniform guidelines across Departments of Human Services, Children and Families, and Health
 - Improve collaboration along the entire spectrum (prenatal, labor and delivery, postpartum, continuing care) for women, infant, and their children

IDTA Activities

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- Plans of Safe Care Introduced – DCF lead, formed Workgroup
- NJ Adopted New Rules: N.J.A.C. 3A:26 for Substance-Affected Infants (DCF and DOH)
- Birthing Hospital Survey disseminated to NJ Labor and Delivery Hospitals
 - Birth Survey results guide best practice recommendations;
 - Developed cross system models to ensure families get access to services
 - Established education needs on issues of SEI/NAS to medical, treatment community and other stakeholders on resources such as Central Intake and Project ECHO and SEI

Challenges - Pregnant Women with OUD

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- **Fear of child protective services** - many pregnant women with an OUD do not seek immediate prenatal care for a number of reasons, most prevailing reason is fear of child protective services and when they do present for care, it may be late second and third trimester
- **Systems may be fragmented** – Services vary widely from one community and system to another with a considerable range and mix of approaches, in various settings (medical, substance use disorder treatment, social services and child welfare services) that can affect service coordination between providers, agencies and other organizations;
- **Lack of collaborative planning and implementation of services** - best practices for treating OUD during pregnancy;
- **Lack of understanding regarding rules and regulations and practice standards** – the various systems (medical, substance use disorder treatment and child welfare) may not understand each system and what services are available and who the providers are in each system

Care Coordination and Maternal Wrap Around Program (M-WRAP)

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- In 2017, New Jersey DMHAS developed the M-WRAP - a care coordination system of care between the medical, treatment, and child welfare systems using a collaborative approach by reducing barriers to services to help improve the health, safety, well being and recovery of pregnant women with an OUD and their infants through:
 - Ensuring linkages of pregnant and postpartum women occur within the five intervention timeframes, pre-pregnancy, prenatal, birth, neonatal and early childhood
 - Addressing screening, early intervention, assessment, treatment and recovery support
 - Providing intensive case management and recovery support
 - Developing strong collaborations and communication among the medical, treatment and child welfare/social services systems
 - Requiring Affiliation Agreements with:
 - Federally Qualified Health Centers,
 - Maternal and Child Health Consortia,
 - Substance Use Disorder Treatment Providers including Opioid Treatment Providers,
 - Labor and Delivery hospitals, and
 - Other Formal Services and Related Support Services

M-WRAP

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- M-WRAP is a statewide initiative awarded to providers in six regions through a Request for Proposal (RFP)
- M-WRAP funded with Federal Block Grant Women's Set Aside, Department of Children and Families and Governor's Initiative (each M-WRAP is approximately \$236,283)
- M-WRAP regions serve approximately thirty (30) unduplicated opioid dependent pregnant women, their infants and families during pregnancy and up to one year after the birth event
- M-WRAP goal is to alleviate barriers to services for pregnant opioid dependent women through comprehensive care coordination that is implemented within the five major timeframes when intervention in the life of the substance exposed infants (SEI) can reduce potential harm of prenatal substance exposure

M-WRAP

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- M-WRAP combines intensive case management, wraparound services and recovery supports for opioid dependent pregnant/postpartum women (PPW):
 - Intensive case management focuses on developing a single, coordinated care plan for PPW, their infants and families
 - Intensive Case Managers serve as liaisons to all relevant entities involved with each woman
 - Recovery Support Specialists provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants
 - Cross-system linkages are necessary to ensure services are coordinated across the spectrum of prevention, intervention, and treatment.
 - The M-WRAP model is intended to promote maternal health, improve birth outcomes, and reduce the risks and adverse consequences of prenatal substance exposure

M-WRAP Logic Model

| Name of Initiative: M-WRAP | | | |
|---|--|--|--|
| Target Population: Opioid Dependent Pregnant Women | | | |
| RESOURCES | ACTIVITIES/ OUTPUTS | MID TERM OUTCOMES | LONG TERM OUTCOMES |
| <p>Key resources of your program</p> <ul style="list-style-type: none"> • \$246,350 funding • .25 FTE Supervisor: LPC, LCSW or other Master's or higher level clinical license • 1 FTE Case Manager: Bachelor's degree in health, psychology, counseling, social work, education or other behavioral health profession • 1.5 FTE Recovery: minimum associate's degree preferred; high school diploma or equivalency required | <p>Tangible things done by program staff that reach participants or targeted people – including frequency, duration, etc.</p> <ul style="list-style-type: none"> • Serve 30 families • Initial Screening • Case Management Assessment • Integrated Family Case Plan • Prenatal Coordinated Care Plan • Plan of Safe Care • Recovery Plan • Initial face-to-face meeting and telephone support • Home visits • Linkage to community resources and social services • Care coordination • Recovery support • Data collection | <p>Effects connected to Activities, including changes in behavior, practice, decision making, policies or social action</p> <ul style="list-style-type: none"> • Prenatal care • Healthy pregnancy • Post-Partum care • Neonatal care • Reduction in opiate use • Treatment attendance | <p>Ultimate impact on social, economic, civic or environmental conditions; these are the last set of outcomes that might be observed</p> <ul style="list-style-type: none"> • Healthy baby • Abstinence from illicit drugs • Safe and stable housing • Child and family-well being • Enrollment in community supportive services • Ongoing coordinated services for infant and family • Employment • Maintaining recovery • Retention in treatment, e.g., MAT |

M-WRAP Data Collection Protocol

Data collection is to take place at the following times:

- Maternal Intake; Birth and Postpartum; Maternal Discharge

Data are collected on:

- Demographics
- Prenatal and postnatal care
- Drug, alcohol and tobacco use history, including prescription opioids
- Current drug, alcohol, and tobacco use
- Substance use treatment history
- Housing
- Financial status
- Employment
- Education/Vocational Training
- Criminal Justice involvement
- Child Welfare involvement
- No. of children and no. living with mother
- Current mental and physical health
- Social support
- Referrals for support services

Data are also collected regarding Child Welfare Information and Plans of Safe Care

Screening, Brief Intervention & Referral to Treatment (SBIRT)

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- An integrated, public health approach to the delivery of early intervention services for persons at risk of substance misuse.
- In 2012, New Jersey DMHAS was awarded a 5-year SAMHSA Cooperative Agreement entitled 'NJ SBIRT'.
- NJ SBIRT was grounded in a public health model of holistic care based on the understanding that, in research and practice, prevention works.

Screening, Brief Intervention & Referral to Treatment (SBIRT)

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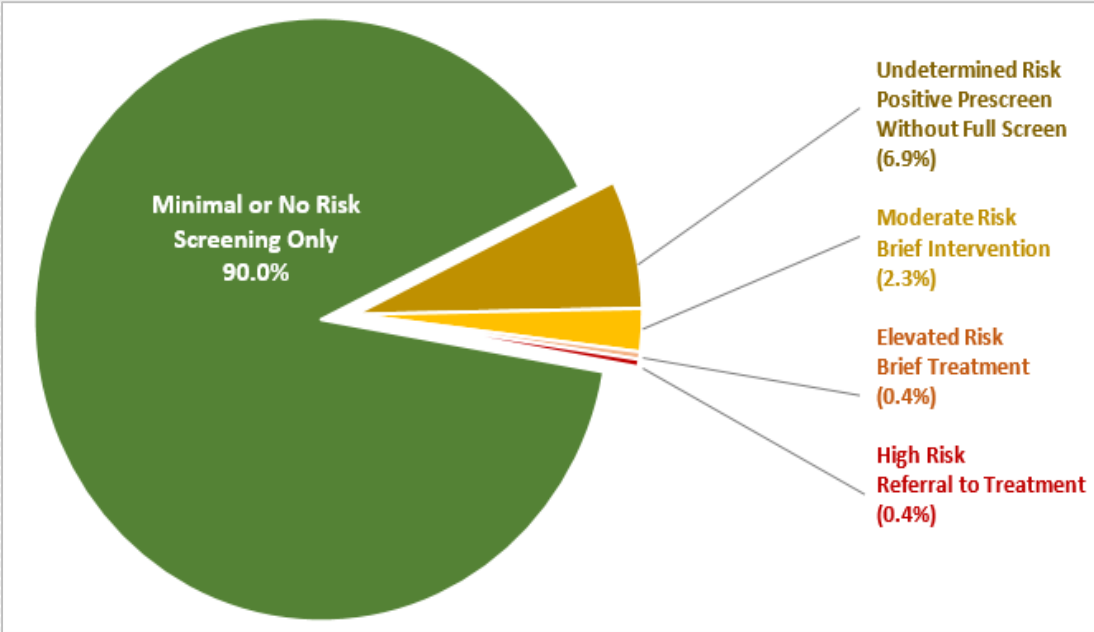
DMHAS collaborated with multiple health systems and partners to seamlessly integrate behavioral health and physical health services. Partners included:

- ✦ Federally Qualified Health Center
 - ✦ Healthcare Collaborative
 - ✦ Acute Care Hospitals
 - ✦ Medical School
 - ✦ School of Osteopathic Medicine
 - ✦ Student Health Center
-
- Substance use screening instruments were embedded in electronic health record systems
 - Improved patient outcomes were enhanced through use of shared health information technology among NJ SBIRT partners
 - Universal substance use screening became a routine part of annual health and wellness services
 - Healthcare professionals were cross-trained in substance use risk identification, and developed core competencies in addressing substance use with patients
 - Cross-system linkages and affiliations with specialty treatment providers were developed and sustained

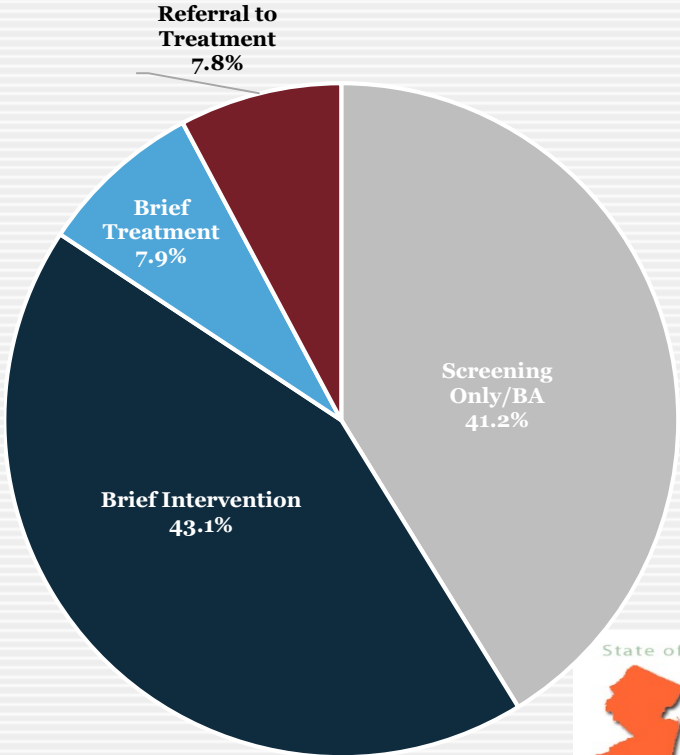


SBIRT Outcomes

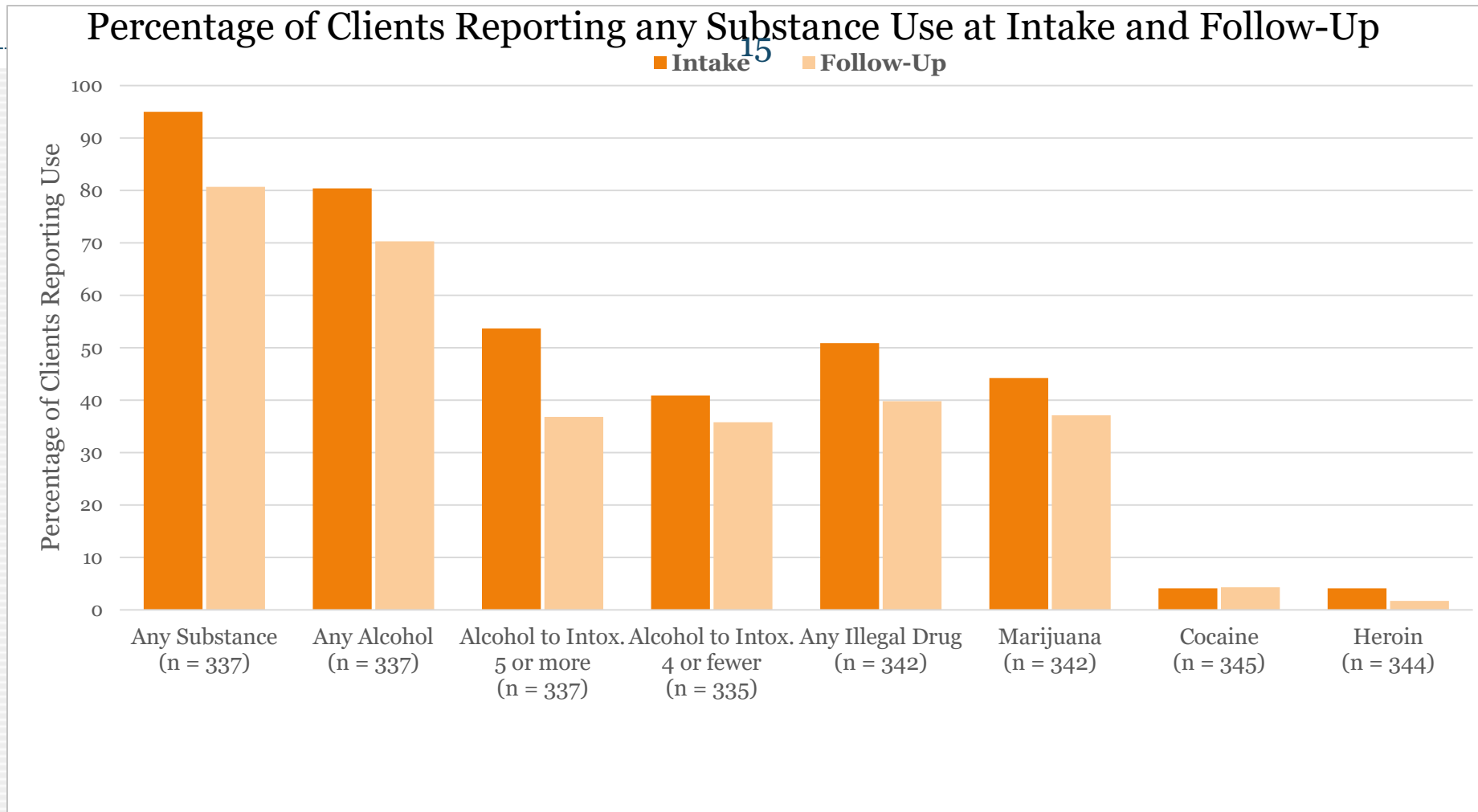
Outcomes of Screenings, Risk Level, and Planned Services (n=55,990)



Planned Services for Unique Full-Screened Clients (n = 2,983)



SBIRT Outcomes

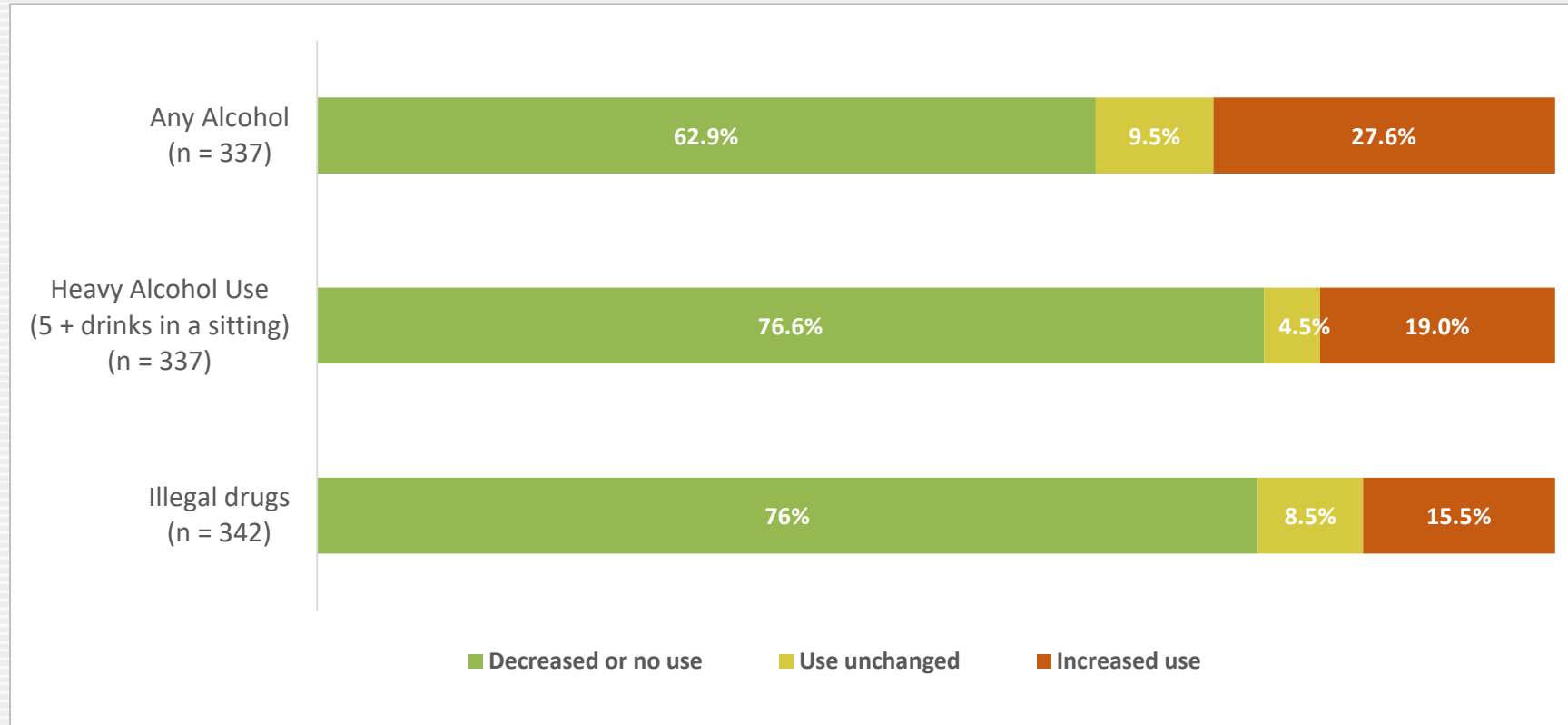


New Jersey



SBIRT Outcomes

Percentage of Clients Reporting Decreased or No Use, Unchanged Use, or Increased Use



Screening, Brief Intervention & Referral to Treatment (SBIRT)

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Next Steps:

DMHAS is proposing to develop new and enhanced SBIRT services with Rowan School of Osteopathic Medicine (SOM) across diverse medical settings:

- ✦ Family Medicine practices
 - ✦ OB/GYN clinics
 - ✦ Internal Medicine
 - ✦ Student Health Center
-
- SBIRT program fidelity is to be maintained across all sites, with greater emphasis on opioid risk identification, using a modified NIDA Single Question Drug Use pre-screen:
 - “How many times in the past year have you used an illegal drug (i.e. heroin, opium) or used a prescription medication (i.e. fentanyl, oxycodone, hydrocodone, buprenorphine) for non-medical reasons (for example, because of the experience or feeling it caused?)
 - Prenatal patients are to be screened using the 4PsPlus Screen at initial visit, again at approximately 28 weeks, and at 6 weeks post-partum
 - On-site trained Health Educators to provide brief intervention services, and “warm handoff” referrals for further assessment, as indicated by patient risk

Supporting Holistic Health Through Integration with Physical Health Services in Missouri

Mark Stringer

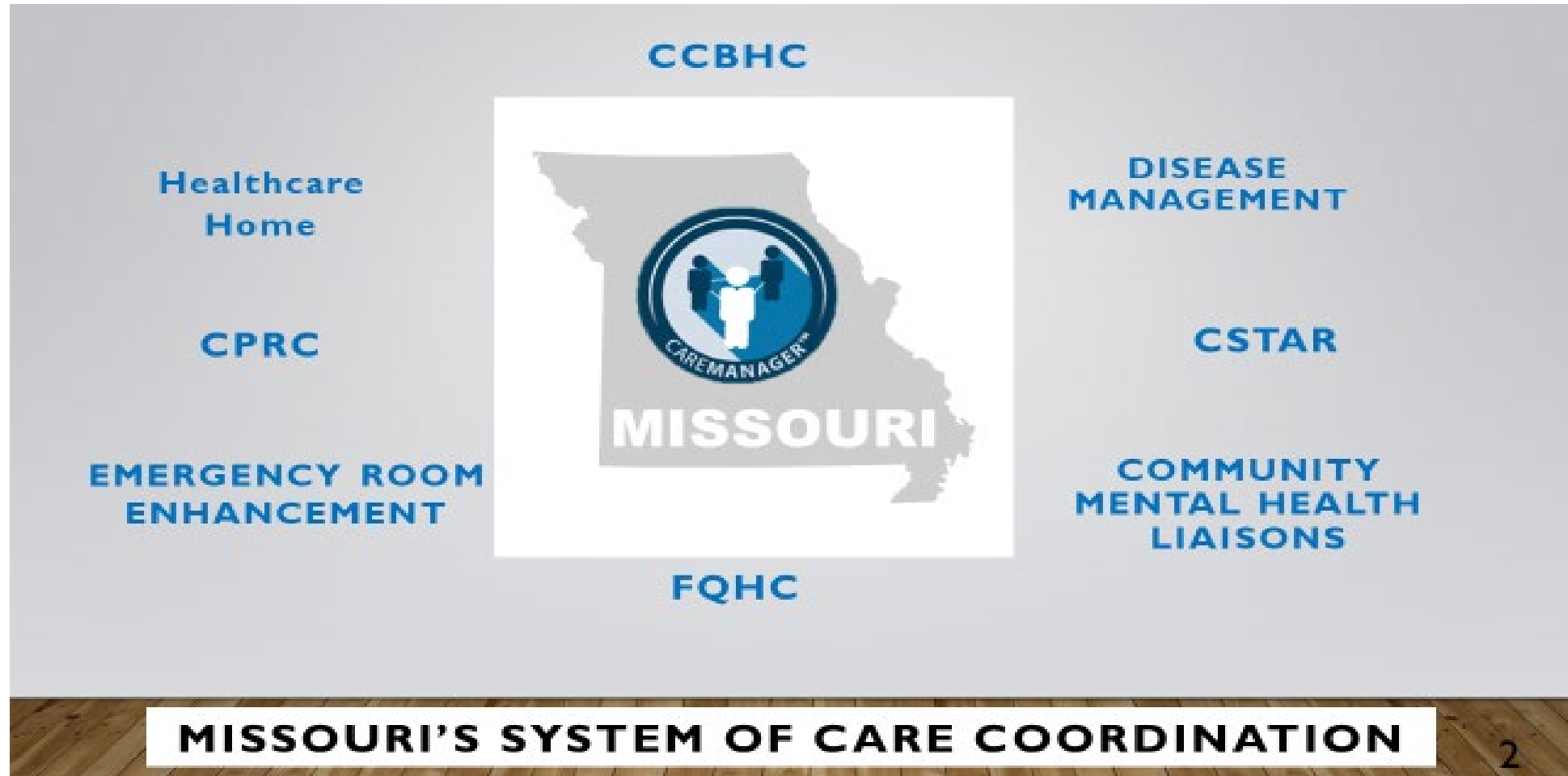
Director

Missouri Department of Mental Health

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Behavioral Health Integration in Missouri



Behavioral Health Integration in Missouri

- **FQHC-CMHC Collaboration**
- **Disease Management Project**
- **CMHC Health Homes**

Behavioral Health Integration in Missouri

- **Emergency Room Enhancement Project**
- **Medical Treatment for Addiction** (“Medication First”)
- **STR/SOR Training for Programs and Prescribers**

Behavioral Health Integration in Missouri

- **Project ECHO for treating people with OUD**
 “ “ **for pain management**
- **Opioid Listserv**
- **Community Mental Health Liaisons**

Behavioral Health Integration in Missouri

Certified Community Behavioral Health Clinics

| | | | |
|--|--|-----------------------------------|---|
| Crisis Services | Screening, Assessment and Diagnosis | Treatment Planning | Outpatient MH and SUD Services |
| Primary Care Screening and Monitoring | Targeted Case Management | Psychiatric Rehabilitation | Peer and Family/Caregiver Supports |

Contact

**Mark Stringer, Director
Missouri Department of Mental Health**

Mark.Stringer@dmh.mo.gov

(573) 751-3070

Supporting Holistic Health through Integration with Physical Health Services

**CSAT/CSAP Annual Meeting
June 2019**

**Linda Wittmuss, PA
Deputy Director, Division of Behavioral Health
Nebraska Department of Health and Human Services**

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Why Integrate?



For the Patient!

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Nebraska's Process for Achieving Integration

We DID NOT:

- Engage in extensive strategic planning.
- Promote implementation of a specific/singular model.

We DID:

- Focus on integration through policy, practice, people/workforce, programs, and partnerships.
- Encourage SAMHSA's Levels of Integration Tool as a QI Process
- Concept, ready, go! Proceed until apprehended or hit a road block, then alter the course as necessary.

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Integration is Really About Healthcare Access

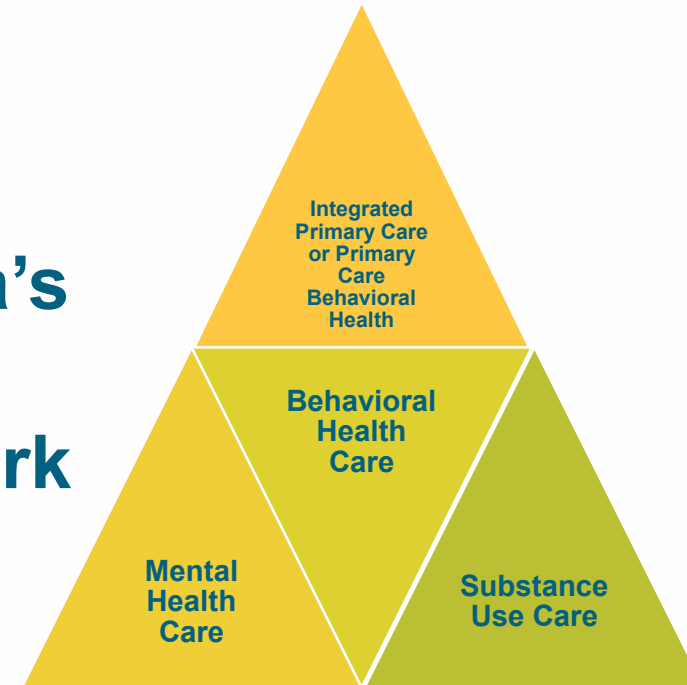
Nebraska's Integration Lexicon

'Lexicon of Integrated Care Terms



Adapted from: Peek, CJ – A family tree of related terms based on behavioral health and primary care integration.
<http://integrationacademy.ahrg.gov/lexicon>

Nebraska's Current Framework



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Building Integration Through Policy

- If we integrate MH and SUD, the integration with physical care is more efficient.
- The Division of Behavioral Health (DBH) is an integrated division within DHHS.
- If you work on the DBH team, policy includes MH and SUD.
- State Joint Advisory Committee Policy and Strategic Planning (MH and SUD)
- Facility/Treatment Center Licensure and DBH Regulations are combined (MH/SUD)
- SAMHSA-integrated block grant application
- Nebraska Association of Behavioral Health Organizations

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Building Integration Through Managed Care Policy

- Designed to address co-occurring mental illness and substance use disorders, physical health and pharmacy by focusing on the whole person.
- Plans are financially and contractually incentivized to invest in preventive case management (social determinants of health) and care/treatment.
- Medicaid and Long-Term Care, the 3 MCOs and DBH meet every other week. All DHHS divisions meet quarterly.



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Building Integration Through Practice

Region 2: SUD and MH combined services in 1989. Primary care and MH/SUD work closely with several family practice docs. One family practice physician is MAT provider in 2 rural clinics and mentoring other physicians.

Region 4: Has BH providers in the FQHC. Payment for BH is via vouchers for treatment and MAT to provide behavioral health and primary health integration.

Region 5: Agreement with FQHC (People's Health Center) to support a patient-centered medical home model and integration of primary care and behavioral health care for consumers receiving MH and/or SUD services.

Multiple Regions: Primary care is also accessible at BH treatment programs. FQHC's now have MAT providers. Critical access hospitals have contracted BH providers.

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Building Integration Through People/Workforce

| | Urban (n=596) | Rural (n=228) | Total (N=824) |
|--|---------------|---------------|---------------|
| ALL | 32.9% | 23.2% | 30.2% |
| Physician | 46.4% | 0.0% | 39.4% |
| Psychologist | 44.8% | 26.9% | 41.2% |
| APRN | 27.3% | 12.5% | 23.3% |
| Physician Assistant | 40.0% | 0.0% | 28.6% |
| LIMHP | 27.2% | 21.4% | 25.4% |
| LMHP | 29.2% | 25.0% | 28.1% |
| LADC | 62.5% | 35.7% | 50.0% |
| CMSW | 25.0% | 50.0% | 33.3% |
| Response among providers currently practicing integrated care. | | | |



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Nebraska Behavioral Health Needs Assessment, September 2016, UNMC College of Public Health

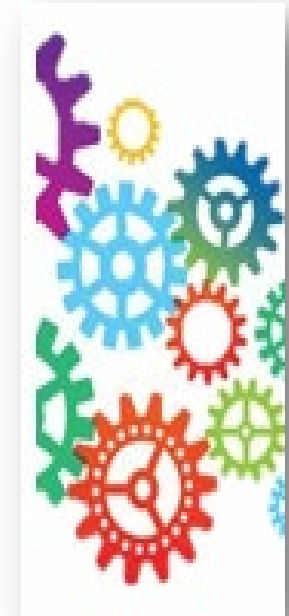
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Ranking of Barriers to Integration Reported by Providers in Nebraska

| Profession | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---------------------|-----------------------|----------------------|---------------------------|----------------------|--------------------------|---------------------------|-----------------------|---------------------|
| ALL | Billing & Reimb (25%) | Adm & Operat (19%) | EHR Capability (18%) | Funding (16%) | Physical Space (8%) | Geographic Location (6%) | Lack of Interest (4%) | Sustainability (4%) |
| Physician | EHR Capability (23%) | Physical Space (15%) | Billing & Reimb (8%) | Funding (8%) | Geographic Location (8%) | Lack of Interest (8%) | -- | -- |
| Psychologist | Billing & Reimb (30%) | Adm & Operat (24%) | EHR Capability (19%) | Physical Space (15%) | Funding (11%) | Geographic Location (6%) | Lack of Interest (4%) | Sustainability (4%) |
| APRN | Billing & Reimb (43%) | EHR Capability (43%) | Adm & Operat (29%) | Physical Space (29%) | Funding (14%) | Geographic Location (14%) | Sustainability (14%) | -- |
| Physician Assistant | Adm & Operat (50%) | EHR Capability (50%) | -- | -- | -- | -- | -- | -- |
| LIMHP | Billing & Reimb (22%) | Adm & Operat (17%) | Funding (17%) | EHR Capability (16%) | Geographic Location (5%) | Physical Space (5%) | Lack of Interest (4%) | Sustainability (8%) |
| LMHP | Billing & Reimb (30%) | Funding (22%) | Adm & Operat (21%) | EHR Capability (15%) | Physical Space (5%) | Geographic Location (4%) | Lack of Interest (3%) | Sustainability (5%) |
| LADC | Adm & Operat (13%) | EHR Capability (13%) | Geographic Location (13%) | Billing & Reimb (7%) | Funding (7%) | Lack of Interest (7%) | Physical Space (7%) | -- |
| CMSW | Billing & Reimb (50%) | EHR Capability (50%) | Funding (50%) | -- | -- | -- | -- | -- |

Multiple responses were allowed for this question about the barrier.

Nebraska Behavioral Health Needs Assessment, September 2016, UNMC College of Public Health



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Building Integration through Programs

Project ECHO

- Highest attended session is Non-Pharmacological Strategies for Pain

DBH and Division of Public Health Office of Rural Health - Rural Health Advisory Commission

- Integrates behavioral health, primary care and academic partnerships
- Professional Tracking Surveys

Nebraska Collegiate Consortium to Reduce High Risk Drinking

- SBIRT Education for Physicians and Student Health Centers

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Building Integration Through Partnerships

- **Nebraska Opioid Coalition**
 - Governor, Attorney General, University of Nebraska Medical Center Chancellor
 - Treatment Workgroup includes physicians, psychiatry, addiction medicine, providers
- **Division of Behavioral Health, Division of Public Health and Nebraska Association of Local Health Departments**
 - Integration of Physical Health/BH, Education, State Health Improvement Plans
- **Nebraska Medical Association**
 - Pain Management Task Force developed Nebraska's Pain Management Guidance Document
- **Executive 1-month Fellowship**
 - Medical professionals in and out of graduate training
 - 8 Participants have completed and obtained their waiver to prescribe MAT
- **Traditional 1-year Fellowship**
 - Accreditation Council for Graduate Medical Education (ACGME)
 - Dr. Ken Zoucha, MD, FAAP, FASAM, Addiction Medicine Fellowship Director
 - Fellowship Located in Family Medicine

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Linda Wittmuss, PA

Deputy Director, DHHS Division of Behavioral Health

linda.wittmuss@nebraska.gov

402-471-7714



@NEDHHS



NebraskaDHHS



@NEDHHS

dhhs.ne.gov

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Questions?