Jessie Micholuk: Thank you, and good afternoon everyone. Welcome to the Disability-Competent Care webinar, *Supporting Participants with Complex Behavioral Health Needs*. My name is Jessie Micholuk, and I'll be getting us started today. Should you have any questions now or throughout the presentation, please feel free to enter them into the Q&A feature on your platform. We'll be addressing your content-related questions during the discussion portion of this webinar.

The Lewin Group, under contract with the CMS Medicare-Medicaid Coordination Office, partnered with Christopher Duff and other disability practice experts to develop the 2018 Disability-Competent Care webinar series. This webinar series builds on the 2017 DCC Webinar Series that introduced the model of care and its 7 foundational pillars. You can view this series and other related resources at the Resources for Integrated Care website.

As I mentioned, this webinar will be interactive with 45 minutes of presenter-led discussion, followed by a 15-minute presenter and participant question-and-answer session. Video replay and slide presentations will also be available after the session, again at our website with the link on your screen.

We're pleased to be able to offer credits for continuing education units (CEUs) and continuing medical education (CMEs) for this webinar. For information about how to obtain credits, please access the CMS Continuing Education Credit Guide, which is located on the left-hand side of the platform on the Resource Library. To receive the credit, the post-test must be completed through the CMS Learning Management System with a score of 80% or higher by midnight on April 2, 2018. Further information is available also at the Resources for Integrated Care website.

I will now hand this presentation over to your moderator, Christopher Duff.

Christopher Duff: Thank you, Jessie. I would like to also welcome everyone to this fourth webinar in the 2018 series. I will be joined today by two speakers.

First will be Sue Abderholden, who has devoted her career to changing laws and attitudes that affect people with disabilities and their families. For the past 16 years, she has served as Executive Director of the National Alliance on Mental Illness (NAMI), Minnesota chapter. She has also held leadership positions with ARC Minnesota and with U.S. Senator Paul D. Wellstone. Ms. Abderholden has also received numerous awards for her advocacy, including several leadership awards. She has a B.A. in Political Science from Macalester College and a Master's Degree in Public Health Administration from the University of Minnesota.

For over a decade, Lauren Easton has served as a Behavioral Health leader for Commonwealth Care Alliance (CCA). Over the years and in various roles, Lauren has been largely responsible for developing CCA's behavioral health integration across its models of care, and for creating a
responsive network and innovative programs, including their Crisis Stabilization Unit that she will be presenting later on in the presentation.

In her current role, Lauren is responsible for the oversight of CCA's Behavioral Health Services delivered through its network of behavioral health providers and internal behavioral health specialists. She is responsible for assisting leadership in providing the level of integration of primary care and behavioral health services for CCA members and for guiding network development across boundaries and quality-proven activities. She oversees the behavioral health development, paying particular attention to the significant mental health needs of this population.

Lauren is a licensed Independent Clinical Social Worker and received her Bachelor's Degree from Boston University and the University of Massachusetts, and her Master's Degree from Simmons College.

Today, we will be focusing on the subgroup of the dually eligible population that many in the field find most challenging; specifically, those with coexisting behavioral health needs. We will explore the prevalence of these needs in the population and how these interplay with a participant's other disabilities. We will demonstrate the role of the interdisciplinary team (IDT) in working with this population and supporting their recovery and engagement.

As the agenda shows, we will start by providing a basic understanding of behavioral health in connection to living with other disabilities. We will use a participant's story to help demonstrate this experience and later address how the IDT can help the participant. We will also discuss the models of recovery and engagement, followed by an example of the program in Massachusetts that has created a unique model to serve this population.

Disability-Competent Care requires a focus on the comprehensive needs of those participants, not simply the medical needs. Most participants with disabilities have a range of needs, perhaps most commonly coexisting behavioral health issues. In the DCC model, physical disability is viewed as a functional barrier or issue, whereas behavioral health conditions may present as compounding illnesses. It is often very difficult to know which came first, nor which is primary. In fact, it doesn't really matter. The IDT needs to work with each participant in responding to their goals and priorities.

Persons living with disabilities experience many barriers in terms of accessing behavioral health services. These include transportation, finances, attitude, and provider preparedness. The IDT can address these barriers by making sure they understand the recovery model involving a behavioral health specialist on the team, and using providers who are experienced in working with persons with disabilities, or, in absence of that, providing some training as needed.

I am now going to tell you about Jose to help you understand these participants. When the IDT started to work with him, he had been disabled for 20 years. He became quadriplegic due to a gunshot wound received during a robbery. He was convicted of a felony, but put on probation due to his injury. After his initial medical care and inpatient rehabilitation, he was moved to a nursing home where he remained for several years until he moved into the community. He was severely depressed, which led to drug-seeking behavior and alcohol abuse.
He was unable to manage basic household functions. His family and friends pulled away due to his anger. He was abusive to his care partners, which resulted in two evictions and returns to nursing homes. In the process, he had numerous skin breakdowns and urinary tract infections (UTIs) resulting in repeat hospitalizations. At that point in his life, he described himself as very depressed saying, "Look at me. Look at my life. Wouldn't you be depressed? I have no friends and no future." I'll get back to Jose at the end of Sue's presentation.

At this point, I'm going to hand it over to Sue.

**Sue Abderholden:** Thank you so much. I'm going to talk a little bit about disabilities and behavioral health. When we look at the categories, we can think of a couple things. One is that mental health is on a continuum. So, you might have someone with just more mild depression or anxiety, or a more serious mental issue such as bipolar disorder, schizophrenia, or depression or anxiety that really is impacting someone's ability to function and to carry out the everyday activities of living.

When we look at substance use disorders, one thing we really need to think about is that often we see people, especially with serious mental illnesses, kind of using alcohol as self-medication. If I drink or if I smoke marijuana, I'm fitting in a little bit better. I'm feeling a little bit better about myself at least temporarily. Sometimes it's not viewed totally as an addiction, but really more as misuse.

Looking at the prevalence of mental illness, generally in the population it's around 20% to 25% depending on which study that you use. We also know that mental illnesses in particular co-occurs with certain medical conditions, particularly things like heart disease, hypertension, diabetes, MS, and those kinds of things. What you're going to see a lot of is a lot of people having both. As you can see on this slide, about 50% of people who are dually eligible also have some type of mental health condition or substance use disorder.

I think what we all need to be concerned about is that people who have a co-occurring disorder also have a tougher time in terms of managing both conditions. They end up having longer inpatient stays for their healthcare conditions. If you think about the symptoms of mental illness in terms of someone not being able to focus or remember things, perhaps even get out of bed and be able to cook a healthy meal, that can really impact those other types of conditions, particularly diabetes and heart conditions. They end up seeing and using a lot more healthcare resources than others.

We also know that people with a serious mental illness tend to die earlier and it is not due to suicide, but it's actually due to healthcare conditions, again diabetes and heart disease in particular. There can be a couple of different reasons for that. One is that there are medications sometimes that promote weight gain and so that can lead to those types of conditions. Also what we've seen is that healthcare providers sometimes don't treat people with mental illnesses’ symptoms in the same way. We have many people who don't want to tell an emergency room, for example, that they're living with schizophrenia or bipolar disorder, because they feel that their symptoms will be dismissed because of their mental illness.
Now, I want to talk a little bit about some of the functional limitations. We know that people with disabilities are less likely to receive comprehensive preventative care. We know that people with serious mental illnesses generally don't even have a primary care physician, so they're not getting those kinds of things. They're really just connected to a mental health clinic or mental health center. When people are really experiencing both conditions, a physical health condition and a mental illness, sometimes they're not getting either of them addressed very well. They're certainly not getting them addressed at the same time.

One of the problems when people do have a substance use disorder or are abusing substances, is it can impact their lives in a lot of negative ways. One way is it may prevent them from successfully engaging in their rehab services. It certainly can interact with a number of the different medications. It can lead to more accidents. If they're, for example, drunk and not able to be physically stable, that can lead to more injuries. It certainly contributes to things like social isolation, bad interactions with family and friends, or people who work with them to help them.

It does add in terms of hurting their overall health and certainly hastening some of those disabling illnesses. The other thing that we find, too, is that a lot of treatment facilities including halfway houses and things like that are not very accessible. There might be older homes in some poor neighborhoods, so it can be very difficult for people to access that care.

One thing I did want to mention having worked in many different areas of the disability world, we are very sensitive to people-first language. Persons with disabilities; we don't use the "R" word anymore. We don't use words like "lame." When it comes to mental illness, we still have a lot of derogatory words. When you think about the slang words for mental illness, there are lots of them; nuts, crazy, psycho, but we don't have slang words for diabetes or heart disease or cancer. It really does impact a person's ability to come forward and say that they're living with these symptoms. It's really important that we think about the language that we're using when we're working with people who have a disability and a mental illness.

We want to talk briefly now about recovery and engagement, which I think is really important. Recovery is a process, kind of a warning to live with what's going on in your life. It's not a cure. Recovery is not a cure, but it actually means that your symptoms are in remission and that it's not impeding your life goals and what you're trying to do. Engagement is really about building on someone's strengths and not on their weaknesses. Instead of looking at what the person can't do, looking at what the person can do is really important.

When we look at working towards recovery, we often see that we have focused not on the individual's goals, but on the provider goal. The provider goal might be that we're going to make sure you don't get bedsores. We're going to make sure that you get out of your apartment, perhaps, but we're not really looking at what does the person really want. How are we engaging them in that treatment plan so that they actually work towards recovery?

We also have to think about what other kinds of services and supports are they getting and how can that all be integrated as well. We really want to make sure that we look at what those barriers are in terms of moving forward. We've had people say, you need to get out and walk around the
block every day. Well, the problem might be that it might not be a particularly safe neighborhood, or the sidewalk is not really well maintained, so that can create a barrier; so really kind of looking at that.

Also, we've certainly seen this in other areas and particularly in developmental disabilities, but making sure that there are people who are not paid to be with them. We have those informal supports in the community that help. One of the things that we have certainly found in the mental health field is when you ask someone with a mental illness when they were hospitalized did they ever receive a get-well card, they're all going to say no. If you ask the families did they ever receive what we call in Minnesota a "hot dish," or did they ever get brought a meal, the answer is going to be no. There aren't those kinds of community supports that you get for any other illness.

Looking at what the resources are in the community, we find we all have our silos and so the mental health community may not know of some of the healthcare or disability resources and vice versa. There are a lot of options available in the community that people should be able to receive. A lot of it is through Medicaid or Social Services and not necessarily private insurance, although some of these things if parity is in force would be available. Community treatment teams and in-home services are important. There are clubhouses or drop-in centers where people can meet others who are experiencing something similar, so they don't feel like they're going through this alone is important.

Supportive housing is hugely important for people to really help keep them stable and so that housing is affordable. Employment is huge. While we have evidence-based practices like IPS or individual services and supports, what we don't see is anyone really understanding accommodations in the workplace for a mental illness. They might understand what those accommodations are if someone is in a wheelchair, but not if they have a serious mental illness.

Really looking at what are those integrated dual-diagnosis treatments for someone who has a mental illness and a substance use disorder, they're often treated separately and you can't, because you really don't know which came first. You need to treat them both at the same time. We do see a lot of pushback in terms of medication-assisted, substance use disorder treatment.

NAMI has done some not very scientific surveys, but certainly surveys of individuals and families. We asked people what they really need in order to get the appropriate treatment for recovery. The first thing that always comes up is housing, and housing is always the number one. People want alternatives to 12-step programs. They feel that that doesn't work very well and a lot of 12-step programs are more faith-based. We have people with mental illnesses who felt that they've really been pushed out of their faith community, so they don't want to engage in something like that.

Again, looking at trying to treat the whole person if they have medical issues as well. Integrated treatment programs help with getting employment so there's a reason to get up in the morning. Again, there's medication-assisted treatment and assistance with insurance barriers in particular. Culturally competent care comes up a lot, and then we do have people who want more gender-specific programming.
I'm going to just whip through these right now, because we're starting to run out of time. I think when we're looking at trying to coordinate all of the services, we need to make sure that again we're asking the person what it is that they want, their short- and long-term goals. How do we build that communication with different providers? For example, if somebody really wants to work but their medication makes it impossible for them to wake up in time, we can work with the prescriber to change the medication so that they can get to work on time.

We make sure that their healthcare needs and their disability needs are also taken care of, and we make sure that the people who are coming in, if it's a personal care assistant, actually understands de-escalation and how to help someone through a crisis.

We also need to make sure that we understand what those barriers are. We have seen quite a bit that people don't recognize that you can have a serious mental illness and be a parent. The reason that someone might not be participating in treatment or a DBT group or something like that is because they don't have childcare. That can be a huge barrier for families, and yet often we don't actually think about that.

The other thing we see again is that each provider has their own goal for the individual, but they're not connected. We're not recognizing as a team what those barriers are to meeting all of those goals or making sure that the goals aren't conflicting.

Next is engagement, and engagement is really key to recovery. Someone has to want to get better. Someone has to have a reason to get better. When we think of Jose, he was like, "Well, I don't have a reason to get better, right? What future do I have?" We try to help them think about that, even if it's small goals that they set, so that they're moving in the right direction, and we have to make sure that there is compassion involved. We try to understand that well yes, I bet your life isn't great right now, but what are some things that could make it better? Let's really talk about that. If you have no friends, how can we help you develop some?

Again, making sure that people have the support network; Jose needs some friends. He needs some family members, and what have we done to really help facilitate that? What have we done on the communication process as well?

No one gets through a serious illness by themselves. I have to say that in the mental health community, in particular, HIPAA is often used as a shield instead of a way to involve and engage families. Families don't want medical records. They want to know how to help their loved one, particularly when it comes to mental illness; they never got this in their health class, so they don't know how to help a loved one. They don't know how to offer advice.

They're often actually given very bad advice from other people, such as use "tough love" and things like that, which don't really help at all. We need to understand that families are often the "canary in the coal mine." They are often the safety net for people, and we need to figure out how to engage them so that they can really help their loved one get better as well. When we look at Jose's family, did they really get any information about the fact that depression would come with this and how could they help him with that?
The next slide shows improving engagement, which makes sure that the person is engaged in the family. We use strength-based language, so that we are working on helping the person get stronger and not just addressing their weaknesses. How do you work effectively across diverse cultures? We respect their decisions, even if that might not be a decision we like. If it's a step in the right direction, that's a good thing.

That shared-decision making model is really important. We're not saying this is your medication. Have we asked them what's worked before? Have we asked them what types of side effects they really can't live with and really working with them on that? We use motivational interviewing to address resistance or ambivalence, and even look at the stages of change to help get them there.

The last slide mentions that providers can move forward if we learn more about each other. We really want to make sure that when you're in the physical disability or developmental disability world, that you're really learning more about mental illnesses and how that is different than the situation that you're in.

We hear a lot of person-centered planning, but when you talk with adults with mental illnesses they really hate that language. Even though we all know what it means as professionals, it just comes off odd because we don't really talk about that with other healthcare conditions, necessarily.

Understand, again, the challenges for those with a substance use disorder or that abusing to make themselves feel better. How can we work with a person on that? Make sure you know who is available in your community. How can mental health and substance use disorder facilities become more accessible to people with disabilities? I think that's really important.

Again, bringing everyone together; a primary care physician, case manager. We've seen some places where you have a drop-in center where actually you have a nurse or a nurse practitioner go there to help people manage their diabetes, blood pressure and things like that.

I will turn it back to you, Chris.

**Christopher Duff:** Thank you very much. That was not only a great picture of the barriers, but you had concrete suggestions along the way. I, for one, who have worked in the field with people with physical disabilities, did not understand behavioral health the way I should have. I totally did not address that, so I really want to support you for your comments at the end there.

I'm going to very quickly now go back to Jose, and I'm going to describe how the IDT began to work with him. The first step, as with all DCC work, was to develop a relationship with him. A motivational interviewing approach was used; expressing empathy, avoiding arguing, identifying discrepancies, rolling with resistance and supporting self-efficacy.

Jose and his team decided to start with his physical health, addressing his skin issues in particular. He got engaged in an ongoing therapy program for strength and conditioning. He was also assessed for and received a new wheelchair with appropriate feeding support for the first time. His next priority was to get out of the nursing home and to stay out. This took many
months due to his criminal background and previous behavioral issue. Once in an apartment, he again had difficulty keeping his care partners, which resulted in a few respite stays in order to find new care partners.

His IDT engaged with him, but he was having trouble keeping these care partners. Over several conversations, they gave him some insight into his behavior and his connection to his mental health and substance abuse. After considerable coaching from the IDT and others in his life, Jose finally decided to take on his substance use issues by going into a treatment program.

In treatment, his team helped him understand his mental health issues and modified some of his medications. His IDT remained involved in this treatment so that they would be prepared to help him transition back into the community. With this foundational work done, Jose and his team can address his goals in the area of maintaining recovery, socialization, work and building new relationships.

Now, it doesn't always go like that. There are always lots of fits and starts in the process. It could happen quickly, or it could take years. What I was really trying to show is the role of the IDT in the process and motivational interviewing. None of that would have happened without a trusting relationship between the IDT and Jose.

With that, I will move it on to Lauren.

Lauren Easton: Good afternoon, this is Lauren Easton. As Chris mentioned, I'm the Senior Director of Behavioral Health for Commonwealth Care Alliance. Today, I'm going to talk about our organization, our model of care, and our innovative approaches to care to help support the most complex individuals in the State of Massachusetts.

So a little bit about CCA; we are based in Massachusetts, we are a not-for-profit, community-based health organization and clinical delivery system dedicated to improving care for individuals who are dually eligible for both MassHealth and Medicare. These individuals have complex behavioral, medical and social needs and include folks with severe and complex disabilities.

What's unique about our organization is we are both a payor and a provider. We have clinical teams that are internal to CCA, as well as a very large network of providers across the State of Massachusetts. We have more than 25,000 members across the state, with two dual-eligible integrated plans. We have our Senior Care Option plan, which serves individuals over 65. In 2013, we were the first state to roll out the One Care program, which was a demonstration program for dually eligible individuals from the ages of 21 to 64.

A little bit about our model of care; CCA's model of care completely emphasizes member-centered and flexible integrated treatment. We meet the needs of incredibly complex participants, and particularly those with functional limitations. Our core attributes of care are a significant investment in comprehensive integrated care, both from a behavioral health and physical health perspectives. We incorporate long-term services and support.
We focus on a team-based, multidisciplinary approach that includes primary care, behavioral health, durable medical, and coordination across all medical and behavioral health services. We focus on collaboration of care through both our internal providers as well as our network of providers, constantly communicating and collaborating on the needs of our members. In addition, every member has an individual assessment and care plan.

A little bit about our membership; all members in the One Care Program experience some form of functional limitation. In addition, participants have significant behavioral health needs and other challenges. Over 70% of our population have behavioral health diagnoses; 30% have co-occurring disorders; 15% have a current or prior substance abuse or alcohol dependency; and 7% are homeless and have difficulty finding housing.

CCA members with behavioral health needs often enter the program with unmet needs. You can imagine this population has difficulty accessing care. There have been many gaps in our system in order for these folks to get care. There are such large disparities in life expectancy and chronic disease management in this population with significant behavioral health and substance abuse needs.

We needed to find our approach with our model of care to meet the health and behavioral health needs of these folks. Again, we focused on an integrated model of care. We offer a variety of services and resources and focus on care coordination and collaboration. We have our behavioral health intensive programs for members with the most complex behavioral health needs and highest utilization of inpatient and outpatient services. These participants also include folks with developmental disabilities.

Our integrated teams consist of primary care doctors, nurse practitioners, nurses, behavioral health specialists who are licensed clinicians, physical therapy, occupational therapy, and what we refer to health outreach workers, which is similar to what folks are probably familiar with as community health workers.

Our team structure is focused on integration. We discuss complex members from both physical aspects and behavioral health aspects. Our team is available for joint visits. They're available for curbside consultation, ongoing support of one another. We collaborate with community-based organizations, human service providers, and have partnered with human service providers to what we define as "our health homes." The human service providers in the State of Massachusetts work with us and identify folks within their organization to care manage for CCA. We also have mobile integrated health services for those with acute care needs.

In terms of stratification, we certainly serve a range of members. We need to tailor our model of care to members with severe mental illness as well as severe physical disability, but folks who are also very high functioning in the community.

As we're stratifying, we look from our least complex. There are folks that do phone care coordination with a non-licensed social worker helping them to coordinate all of their medical appointments, transportation, and access to care in the community.
To low and moderate complex folks, their phone care coordination could be with a nurse or a behavioral health clinician as we stratify them from a medical and behavioral health perspective.

We also have folks with moderate to high complexity who may need in-home care coordination with a nurse and behavioral health clinician. About 80% of our folks in the community actually get in-home care, and 80% of their visits are done in the home.

We have folks who have extreme complexity and have a lot of difficulty accessing primary care, so we have our own primary care practices as well as our behavioral health intensive teams.

Lastly, we have folks who are either very difficult to locate or have become unengaged in treatment. We utilize our health outreach workers, or what we call our "street team," to be able to locate folks, engage folks, and start to develop that very important relationship.

When we rolled out the One Care program, we understood very quickly with the very high level of inpatient utilization that about 70% of our members did not need inpatient psychiatric care and could actually get services in a less restrictive environment. We looked at the access and availability of our community resources across the state and realized that there was really a lack of community-based acute mental health services and crisis beds. We needed to fill this gap and have an innovative approach to how we were going to serve our members that really did not need this inpatient-level of care in a locked unit.

We also understood that folks with a disability often had barriers to getting into inpatient care and, again, didn't really need that level of access. We decided that we were going to start as both a payor and a provider. We were going to start our own crisis stabilization units to fill the gap in care that was not addressed by existing psychiatric care settings. We opened two crisis stabilization units in the State of Massachusetts; one in a hospital setting so we leased a floor from a hospital in Boston, as well as actually purchasing a large residential setting to offer 14 beds in a residential setting and 12 beds in a hospital setting. Both were unlocked units and had a unique opportunity to serve our population and access services in a more seamless way.

We offered longer lengths of stay than a typical crisis unit, so folks may stay with us for 10 to 12 days, as opposed to a typical 3- to 5-day stay in a crisis unit. Again, as both a payor and provider, we were able to tailor the needs of our members and to really understand what was going to be the best setting and best treatment for our members.

On our crisis stabilization, we utilize our internal providers; our nurse practitioners, our behavioral health specialists, and our health outreach workers to really integrate care. Those practitioners are coming on to the units to collaborate and coordinate care with the members as well as the treatment team on the units.

It's a very community-oriented care, which focuses on peer supports and post-discharge follow up, including behavioral health supports and adaptive services for participants with physical disabilities. These are fully accessible programs that as I noted we integrate peer supports. We have peer folks coming onto the unit to run groups and also to help transition folks back into the community setting for a seamless transition to the community.
Our typical participants on the crisis stabilization units may have a physical disability and co-occurring disorders; such as schizophrenia, major depression, bipolar, anxiety, trauma, addiction. Their chronic medical conditions could be; diabetes, chronic pain, HIV infection, liver disease or high blood pressure. Many participants actually present with a history of suicidality or current suicidality We have noted that participants are likely to have a high utilization in inpatient care, as well as other crisis stabilization units.

We also incorporate addiction services into our overall model of care, as well as our crisis stabilization units. We have licensed clinicians who have expertise in identifying and initiating treatment for folks with addiction issues. We offer consultation to all of our providers across our organization, as well as to our members who have addictions to help them understand and access resources for folks with substance use disorder.

At our crisis stabilization units we have many groups that focus on substance use and recovery. It is fully integrated into the treatment at our crisis units, as well as the treatment within our interdisciplinary care team. Some of the group topics may include: fear of sobriety, emotions that trigger relapse, learning how to recognize a trigger and manage cravings.

Here's just a little bit of data about our crisis stabilization units. We really feel that these have been quite successful in providing adequate quality and cost-effective care to our members. As I mentioned before, many of our members were in inpatient settings and getting care at a cost of over $1,000 for an inpatient stay. Our average cost for our crisis stabilization units is $600 to $700 per day.

We have seen over 648 members on the crisis units. Many of these folks have been folks who we have deemed "unreachable." When they have enrolled with us as members of our health plan, we have not been able to reach them. We have wrong numbers. We have wrong addresses. We haven't been able to do our initial assessment. These folks are jumping from ER to ER and now have been referred to our crisis stabilization units. We're now able to do our initial assessment, connect them with appropriate care, and connect with primary care and behavioral health services in the community. Eighty-one percent of the folks who are referred to our crisis stabilization units are diversions from inpatient care. Our CSU staff has developed close relationships with area emergency services and ERs to help facilitate diversion.

As I mentioned, 51% of our assessments were on members who were previously unengaged or unreachable. We currently have an occupancy rate of about 76%. Our goal is 90%, but we are building that capacity. There are multiple barriers at times in getting folks into the crisis units; such as, we're not always notified when somebody does hit an ER so we're not able to divert that person. There are folks who would prefer to be in an inpatient setting and feel safer in an inpatient setting.

We really have seen that we are bending the cost curve in quality of care for acute psychiatric care. As I mentioned, the cost of CCA psychiatric inpatient admissions has leveled off since the creation of our CSUs. In crisis, members will go into ERs waiting anywhere between 48 to
73 hours before being sent for inpatient care at very costly inpatient settings that weren't necessarily the appropriate setting for our members.

Our CSUs have been able to provide a safe and more appropriate environment for members who could be managed with short-term behavioral health and medical services. We are able to seamlessly transition folks back into the community and do a warm handoff to the providers in the community.

Early CSU outcomes have been promising. The member satisfaction with care delivered at the CCA CSUs speaks to the value of the community-based setting and the integration of care delivered. Inpatient psychiatric admissions have decreased from 9.6 admissions per 1,000 members per month between October 2013 and September 2014 to 8.5 members per month. That was very early data.

I am getting close to being over in time, so I'm just going to say that the staff and participants' experiences have really shown that the quality of the care in the CSUs and engagements and ability to transition people and access care in the community has been outstanding.

Just quickly, I'm going to talk about a member of ours who had been with us for many, many years and how our integrated teams, as well as the crisis stabilization unit, really improved his care and allowed him to stay in the community for more years than had been anticipated. Bill had been receiving primary care services from CCA for about 15 years. He had both a developmental disability, a physical disability, and had anxiety and depression.

Oftentimes, he would be calling 911 and be sent to the ER and would be either admitted to an inpatient unit or sent home. If he was sent home, he would call 911 again. With a comprehensive behavioral health plan and his multidisciplinary team, both from the medical perspective and behavioral health perspective as well as personal care assistant, Bill lived independently for almost a decade.

Things went very well for quite some time; however, recently he began calling 911 repeatedly. His legal guardian decided that he could no longer live safely on his own in an apartment. His legal guardian thought that a state institution would be the best setting for Bill. Given Bill's history, we understood that Bill would not do well in an institutional setting. He had a very traumatic experience as a child growing up in institutions, and we understood that he would not do well in this setting. It was both not an appropriate setting, as well as not cost effective for CCA.

We made the decision, although our crisis stabilization units are short term, to have Bill come to the crisis stabilization unit to be clinically and medically stabilized. Although he was there for a longer period of time, he would've been transitioned into a state institution, again probably being re-traumatized from issues that he had had when he was a child.

Over the course of his stay at the crisis stabilization unit, Bill's team worked with state agencies, his team in the community, as well as the team on the unit to really help him not only stabilize at our crisis stabilization unit but to find permanent supervised housing.
After a lengthy search, Bill transitioned to an apartment in a DDS-funded residential community for developmentally disabled individuals. It is a very independent situation. Although there is 24-hour supervision, he is free to go to a day program, into the community to get coffee, and is in a much less restrictive setting than initially asked by his legal guardian. Through integrated care and innovative plans, we were able to help Bill stay in the community where he was best served.

With that I'm going to turn it back over to Chris.

Christopher Duff: Thank you, Lauren, a great presentation with a nice example. Bill gave us another picture of how a team deals with an individual, and it was good to learn about your program.

We actually have a follow-up question on a bit more of what you're doing at CCA. This is from Lauren in Denver. Would you provide some additional information about the behavioral health intensive program at CCA?

Lauren Easton: Our behavioral health intensive program consists of all licensed behavioral health clinicians and a psychiatric nurse practitioner. We developed this program for folks who were enrolled with us who had high complex behavioral health issues and the highest utilization of psychiatric throughout our membership.

So 80% of the visits are done in the home. People are seen at least once a week, very often twice a week depending on what's going on for them. We coordinate with community resources to ensure that folks are accessing community resources, including outpatient psychiatric, day treatments, but we enhance those services through that intensive work that's done in their home.

Our behavioral health clinicians, as well as our psychiatric nurse practitioner may bridge services if outpatient treatment isn't available or prescribing isn't available. As many people know in the State of Massachusetts, as well as across the country, oftentimes there's a long wait list. With our membership sometimes if folks don't make three appointments, then they no longer have access to that facility.

It's a very intensive program for our highest utilizers. They coordinate with our crisis stabilization units. They collaborate quite a bit with that team. We use our crisis stabilization units also for direct admission. If there are folks who are utilizing inpatient care every two weeks, we'll do planned admission on our crisis units, or direct admissions to our crisis units avoiding both costly and oftentimes traumatizing assessment in the ERs.

Christopher Duff: Thank you, Lauren. The next question I'm going to throw to Sue first. I find some of our staff tend to minimize or overlook chemical use, especially alcohol. My sense is that the team members say to themselves that they too would drink if they were living with the other disabilities that the individual lives with. How do I address this issue at the team level or with my peers?
Sue Abderholden: If the substance use is really interfering with the person's ability to get better in terms of recovery or just carry out daily activities of living, or if it's getting in the way of relationships, then it really needs to be addressed. We've had people, even with tobacco use, a lot of people say, oh, they've gone through so much why would we take that away? Well, because they're going to die earlier, that's why. They're going to die earlier from liver disease and things like that, too. I don't think we need to facilitate that use. I think it is something that we do have to talk about with people, because ultimately we want them to be healthy. If this is interfering, you're not doing anyone any favors by not talking about it.

Christopher Duff: Lauren, do you have anything to add to that?

Lauren Easton: I think from our perspective and our care model, as I mentioned so many of our folks have a dual diagnosis and oftentimes are re-presenting at our crisis stabilization units throughout their recovery. So many folks are turned away if they relapse or are defined as unengaged in treatment. I think that it's so important for our clinicians to develop that trust in relationship, no judgment, and continue to treat folks through their recovery regardless of relapse and re-presentation.

Christopher Duff: Thank you and it totally makes sense. A question for Lauren from Andrew at Scan Health Plan in California, are there any providers using telebehavioral health to provide care and what are the outcomes?

Lauren Easton: We have just recently started a pilot within our internal providers. We have not yet extended that to our network, although we are very close to doing that. Internally, we utilize our psychiatrists for telepsychiatry. I do not have early outcomes as of yet to provide for data, but I will say it has been fantastic in providing additional access and efficiency to care for our members. As I mentioned earlier, we really do have a lack of access to prescribing providers.

Christopher Duff: Thank you, Lauren. I just got a message from Sue saying that they do in Minnesota. Sue, would you talk about some of what you're experiencing in Minnesota?

Sue Abderholden: If you look at the State of Minnesota, it's pretty huge. When you get to particularly outside of the metro area and around Rochester and Duluth, you have miles and miles and miles between access to healthcare providers or mental health providers, particularly mental health providers. Telemedicine is used quite a bit, including originating from a person's home. Certainly, in-person is ideal, but this can work pretty well. We've used it including in the jails and in other settings so that people have better access.

Christopher Duff: That's great. If you do some Internet search, there is some research that has begun to pop up just recently about telemedicine, both in behavioral health as well as primary care.

Now, a question and let me read it quickly. The question is basically, I just feel overwhelmed working with someone like your two examples. How do I figure out where to start when I first establish the relationship with them? How do I figure out where to start in addressing their
multitude of issues? I'll start with Sue and then we'll go to Lauren and then we'll probably be out of time.

**Sue Abderholden:** Certainly what we hear from people is, again, what is your goal? Is your goal to, for example, get out of the nursing home because you really don't want to be there and people are older than you and things like that? Then your plan would work around that particular goal. We always believe that it's just important to start with the individual. What is their goal, whether it's short term or long term?

**Lauren Easton:** I would agree with Sue. I think that we're starting with the individual and basing it on what their needs are and meeting that person where they're at. So many of our individuals have such complex medical and behavioral health needs, but yet don't have housing. What is their goal, potentially housing first? How can we support them in accessing housing? We can't get them housing, but we can support them in getting resources.

I will also say it's about developing that trusting, respectful relationship, and it goes back to meeting that person where they're at and really understanding their experience with providers in the past. Start with that engagement and a trusting relationship. I think that's really where we start is building that relationship and then understanding where they're at and meeting them where they're at.

**Christopher Duff:** I just want to reiterate what they both said. Without that relationship you really are just going to be unsuccessful throughout most of your work with the individual. You need to build that to start with and then you can start unfolding and listening to their priorities.

With that we are at the end of our time. I'm going to hand it back to Jessie to do the wrap up.

**Jessie Micholuk:** Thank you, Chris, and thank you everyone for attending our presentation today. Your contributions to our discussion were really helpful. Please feel free to keep sending in any additional questions via that chat or, of course to our email address that we'll have at the end of this presentation, and we'll be sure to follow up.

I'd also like to thank our presenters today, both Lauren and Sue for your participation. This webinar is supported through MMCO to help beneficiaries enrolled in Medicare and Medicaid to have access to seamless, high-quality healthcare that includes a full range of covered services in both programs to support providers in their efforts to deliver more integrated coordinated care to Medicare and Medicaid enrollees. MMCO is developing technical assistance and actionable tools based on successful innovations and care models such as this webinar.

The next webinar in the series will be held next Wednesday, March 21, 2018, and we'll discuss *Interdisciplinary Team Building, Management and Communication*.

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