Question & Answer (Q&A): Disability-Competent Care (DCC) Supporting Participants with Complex Behavioral Health Needs Webinar

Webinar participants asked these questions during the Q&A portion of the Supporting Participants with Complex Behavioral Health Needs webinar held on March 14, 2018. Please note, the responses in this document have been edited for clarity. The webinar recording, slides, and transcript can be found on the Resources for Integrated Care website:
https://www.resourcesforintegratedcare.com/DisabilityCompetentCare/2018_DCC_Webinar_Series/Behavioral_Health

Featured Webinar Speakers:

- Christopher Duff, Disability Practice and Policy Consultant
- Sue Abderholden, Executive Director, National Alliance on Mental Illness (NAMI) NM
- Lauren Easton, Senior Director, Behavioral Health, Commonwealth Care Alliance

Q1: Could you provide additional information about the behavioral health intensive program at Commonwealth Care Alliance (CCA)?

Lauren Easton: CCA's behavioral health intensive program is staffed by licensed behavioral health clinicians and a psychiatric nurse practitioner. We have developed this program for participants that have complex behavioral health issues and high utilization of psychiatric services. Visits for the program occur at least once per week, and eighty percent of visits are completed in the home. The frequency of visits can increase to twice per week depending on the participant's needs. The team also coordinates with community organizations to ensure that participants are accessing needed resources, such as outpatient psychiatric day treatments. Finally, the team coordinates with CCA's crisis stabilization units, which can be used to avoid costly and oftentimes traumatizing assessments in hospital emergency rooms.

Q2: How do you address the issue of minimizing chemical use, especially alcohol use, at the care team level or with peers?

Lauren Easton: From the care model perspective, it is important for clinicians to develop trust with the participants, free of judgment. It is important to continue to treat participants through their recovery regardless of relapse and re-presentation of the initial condition.

Q3: Are there any providers using tele-behavioral health to provide care? What are the outcomes?

Lauren Easton: CCA has recently piloted a program with internal providers using tele-psychiatry. There are no early outcomes as of yet in terms of data, but it has been helpful in improving efficiency and providing additional access to care for participants. Tele-health can help to address the lack of access to prescribing providers.

Sue Abderholden: In the State of Minnesota, we have issues with access to healthcare providers, particularly mental health providers in rural environments. Telemedicine is often used to help initiate care at the participant's home. In-person treatment is ideal, but telemedicine has been working well to improve access in rural communities. Currently, Minnesota Medicaid (Medical Assistance) covers up to three mental health telemedicine services per week per member for medically necessary mental health services delivered by a health care provider.[1] Further, the Arrowhead Health Alliance, a coalition between the Health and Human Services agencies of five rural Minnesota counties, is developing an integrated behavioral health network utilizing telepresence connectivity to link community mental health resources with schools, jails, law enforcement, tribal providers, and others.[2]

Q4: How do you determine where to start when you first establish the relationship with the participant in order to address what may be a multitude of health issues?

Sue Abderholden: The best place to start is with determining the participant's goal. The plan of care will work toward that particular goal. This process starts with the individual and focuses on their short-term and long-term goals for their own health and what works best for their individual situation.

Lauren Easton: It is important to start with the individual, basing care on what their needs are, and meeting the participant where they are. It is also important to develop a trusting and respectful relationship with the participant. This goes back to meeting the person where they are and understanding their experience with providers in the past. We start with building this relationship, which leads to better understanding and engagement from all parties.

Christopher Duff: To reiterate that position, without the relationship between the provider and the participant, you are going to be unsuccessful. You have to start with the relationship and then begin to understand and address their priorities.

---

[1] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_160257

[2] https://www.arrowheadhealthalliance.org/telepresence/faqs/

Q5: Is diet and exercise a focus of treatment that your organization addresses?

Resources for Integrated Care: CCA and NAMI host information on their respective websites related to diet and exercise. CCA hosts short audio segments available to stream online focused on health and wellness on the Your Health Audio Library page of their website. Audio segments on diet and exercise include Physical Activity for Older Adults, Healthy Eating, and Healthy Weight. NAMI provides tips and advice on the importance of diet and exercise for sustaining a healthy lifestyle on the Taking Care of Your Body page of their website and provides information on the importance of diet and exercise for the prevention and treatment of Metabolic Syndrome.

Physical activity is an important part of good health. However, according to the Centers for Disease Control and Prevention (CDC), "nearly half of adults with disabilities who are able to be physically active don't get any aerobic physical activity".[3] The CDC offers tips for healthcare providers to approach the subject of physical activity with participants with disabilities, including guidelines for physical activity, understanding the participant's current physical activity level, discussing barriers, and finding other options for physical activity.

For more information, please visit:

- CDC – Including People with Disabilities in Public Health Programs and Activities
- CME Toolkit – Recreational Activities for People with Disabilities

Q6: What is an example of a co-occurring disorder that might be seen with a behavioral health diagnosis?

Resources for Integrated Care: A co-occurring disorder refers to a participant that is diagnosed with a substance use disorder as well as a DSM-5 Mental Health Disorder. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), co-occurring disorders can be difficult to diagnose due to the complexity of symptoms, as both may vary in severity. In many cases, people receive treatment for one disorder while the other disorder remains untreated. People with co-occurring disorders are best served through integrated treatment. With integrated treatment, practitioners can address mental health and substance use disorders at the same time, often lowering costs and creating better outcomes.[4]

Q7: Is dementia and/or Alzheimer's considered a mental illness?

[3] https://www.cdc.gov/features/physical-activity-disabilities/index.html
[4] https://www.samhsa.gov/disorders/co-occurring

Resources for Integrated Care: According to the DSM-5 criteria for mental illness, Alzheimer's and Dementia are not mental illnesses. However, they do have associated neurocognitive disorders that are mental illnesses.[5]

Q8: How does one refer a participant to Commonwealth Care Alliance?

Resources for Integrated Care: The Commonwealth Care Alliance website includes a CCA Member Referral Form for this purpose.

[5] https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Contents.pdf