PITTSBURGH MERCY:
COMPREHENSIVE INTEGRATED CARE

JUNE 6, 2018

AN ENHANCED MEDICAL HOME MODEL FOR THE SMI POPULATION

PITTSBURGH MERCY
A HERITAGE OF HOPE

- **Comprehensive Care**
- **Patient Centered Care**
- **Coordinated Care**
- **Accessible Services**
- **Quality and Safety**
- **Plus 1: Longer and more frequent visits**
- **Plus 2: Specialized Training for the Team**
- **Plus 3: Planned and Proactive Communication between the Primary Care team and the Behavioral Health Team**

Pittsburgh Mercy Family Health Center

Integrated Primary Care

PMHS Patient Population:

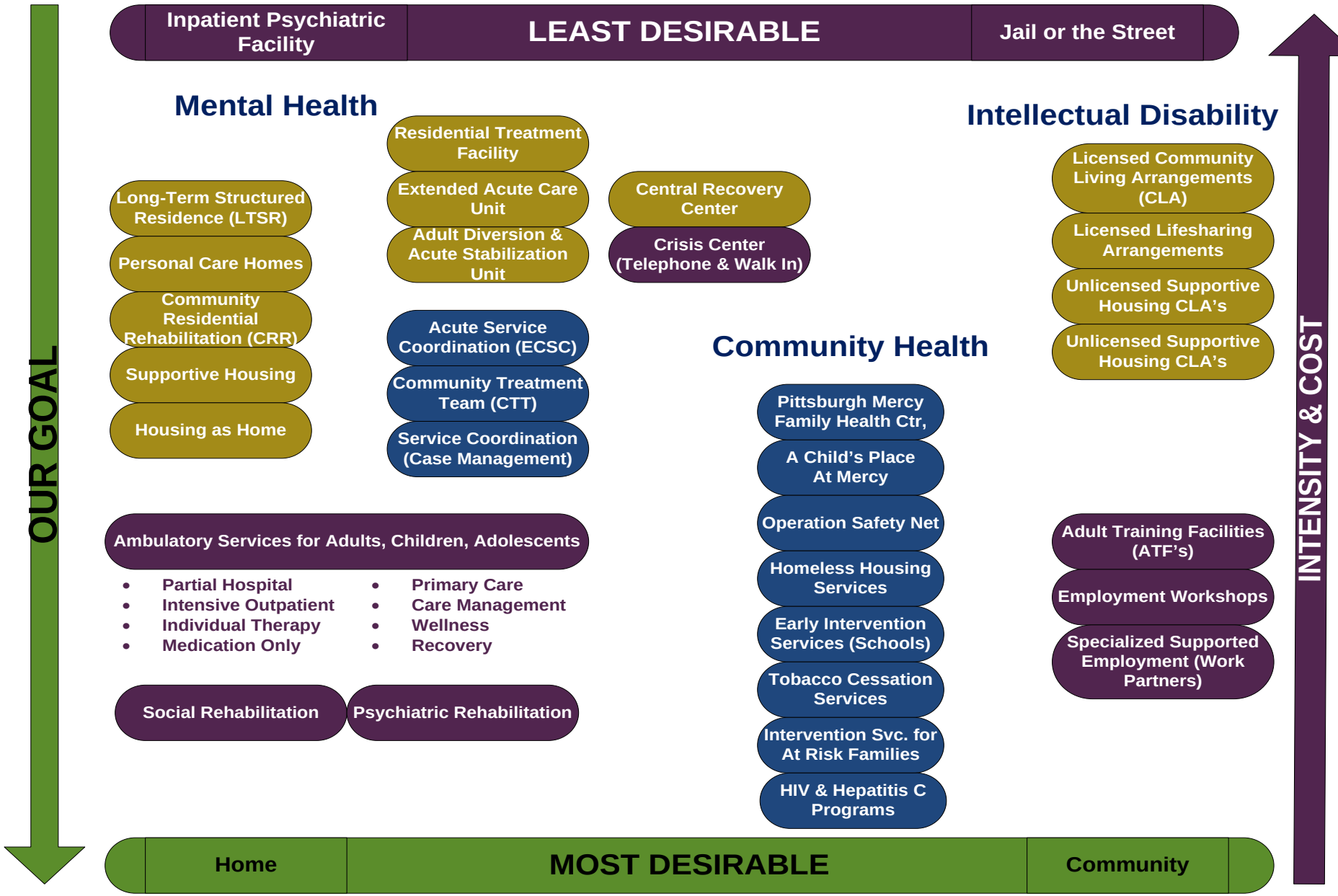
- In 2010, 33,000 individuals were receiving BH or ID care at PMHS - 50% were not receiving *any* routine primary care
- Chronic co-occurring SMI and medically complex with high risk social determinants

Replicating the ACT Model in Primary Care

- Highly engaging team meets the patient where they are in their lives
- Multidisciplinary and cross-community
- Rapid review of highest risk patients for enhance case management

Reverse Integration

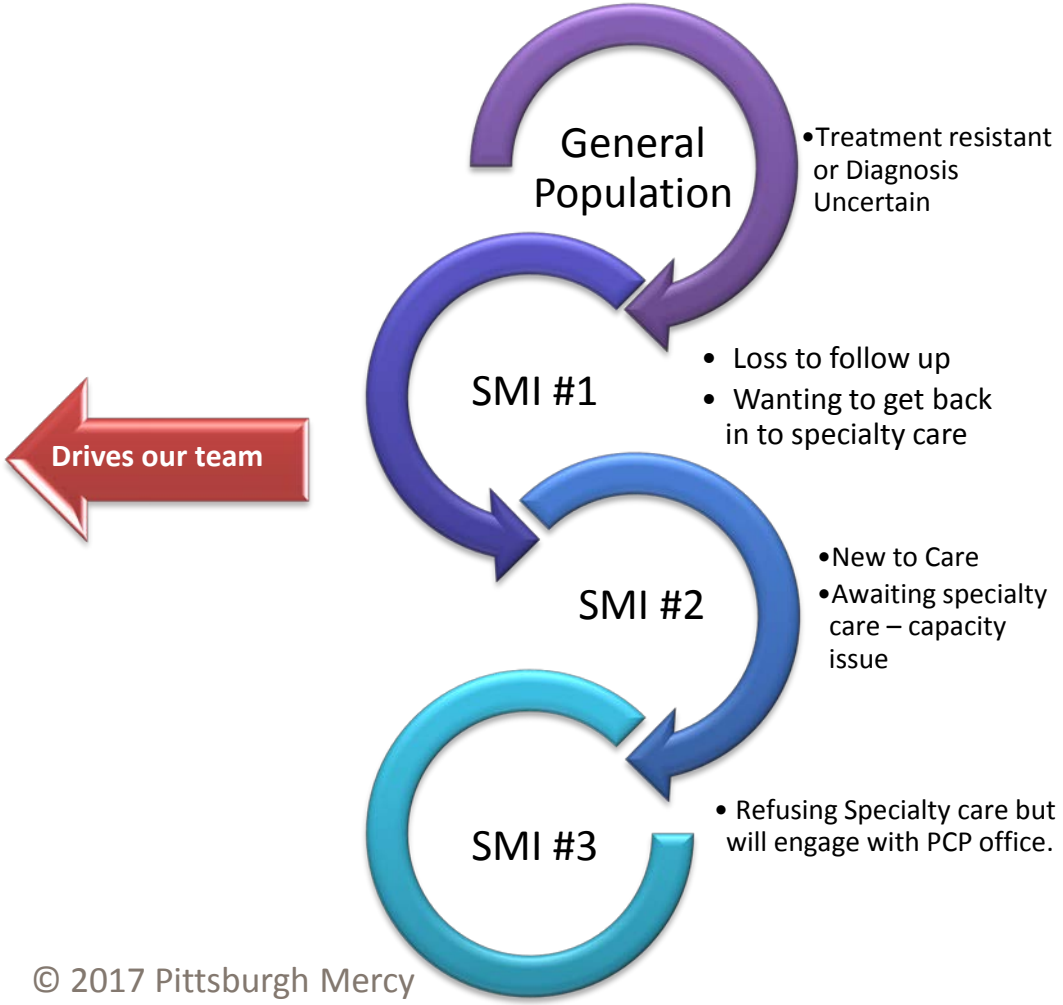
- Community Mental Health Center embedding Primary Care within its programs


Inpatient Psychiatric Facility
LEAST DESIRABLE
Jail or the Street
OUR GOAL
INTENSITY & COST
Mental Health
Residential Treatment Facility
Extended Acute Care Unit
Adult Diversion & Acute Stabilization Unit
Central Recovery Center
Crisis Center (Telephone & Walk In)
Long-Term Structured Residence (LTSR)
Personal Care Homes
Community Residential Rehabilitation (CRR)
Supportive Housing
Housing as Home
Acute Service Coordination (ECSC)
Community Treatment Team (CTT)
Service Coordination (Case Management)
Intellectual Disability
Licensed Community Living Arrangements (CLA)
Licensed Lifesharing Arrangements
Unlicensed Supportive Housing CLA's
Unlicensed Supportive Housing CLA's
Community Health
Pittsburgh Mercy Family Health Ctr,
A Child's Place At Mercy
Operation Safety Net
Homeless Housing Services
Early Intervention Services (Schools)
Tobacco Cessation Services
Intervention Svc. for At Risk Families
HIV & Hepatitis C Programs
Ambulatory Services for Adults, Children, Adolescents
Partial Hospital
Intensive Outpatient
Individual Therapy
Medication Only
Primary Care
Care Management
Wellness
Recovery
Social Rehabilitation
Psychiatric Rehabilitation
Adult Training Facilities (ATF's)
Employment Workshops
Specialized Supported Employment (Work Partners)
Home
MOST DESIRABLE
Community
KEY:
Indicates Community-Based Delivery of Care Systems
Indicates Residential Delivery of Care Systems
Indicates Office or Site Based Delivery of Care Systems

TEAM BASED POPULATION MANAGEMENT

Our Team

- Primary Care Provider
- Consulting Psychiatrist
- Care Manager
- Peer Support Coach
- Tobacco Cessation
- Medical Assistant
- Social Service Program



HOW DOES PRIMARY CARE VIEW ADDICTION?

- Disease
- Chronic and relapsing
- Targets the brain
- Affects motivation, inhibition, and cognition
- Large (50%) genetic component
- Influenced greatly by comorbid psychiatric disorders
- Treatment modalities are polymorphic
- Prognosis is heavily dependent on social supports, premorbid status and access to care

TREATMENT OPTIONS

- Tincture of time
- Inpatient detox
- Residential treatment
- 12 step and abstinence based treatment
- Intensive outpatient treatment
- Family based therapy
- Treatment of co occurring mental illness
- Medication Assisted Treatment

PITTSBURGH MERCY
A HERITAGE OF HOPE

MEDICATION ASSISTED TREATMENT

Primary Care and Behavioral Health Integration

Primary Care Screening, Assessment and Dosing

- Physical Assessment
- Drug Screening
- Dosing of Buprenorphine

Coordinated Care Management

- Induction
- Risk Assessments
- Prior Authorization
- Monitoring Compliance
- Social Service Referrals

Concurrent Behavioral Health Treatment

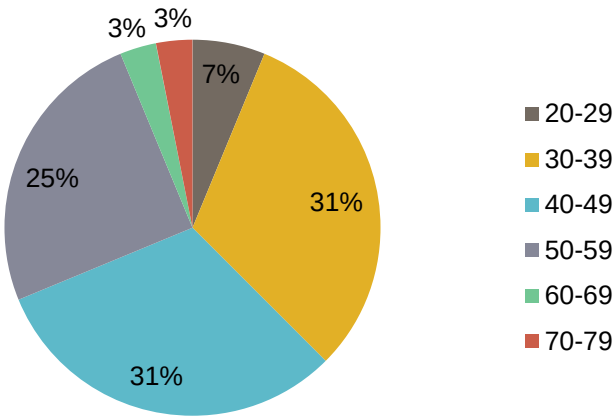
- Counseling and behavioral therapy
- Evidence based
- Treating mental illness

WHO IS A CANDIDATE?

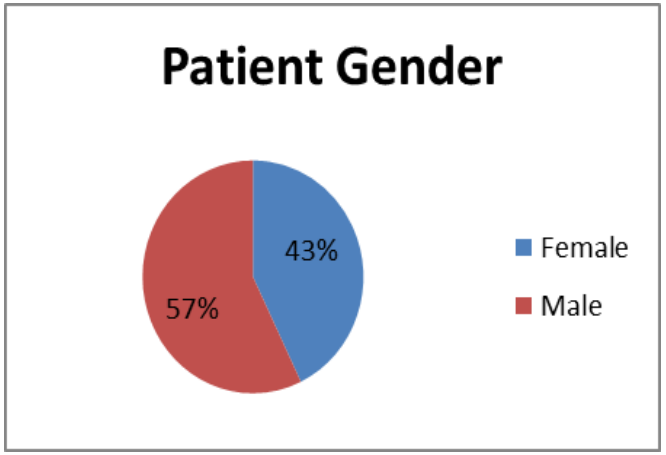
- ❑ Active PMFHC patient above age 18, ***or*** willing to change to PMFHC as PCP
- ❑ Opiate Use Disorder Diagnosis with current opioid dependence moderate to mild in nature
- ❑ Contemplation or Active stage of Treatment
  - Interested in treatment
  - Compliant with daily medications
  - Currently in outpatient/CTT/IDDT treatment
  - Adequate social and recovery supports
  - Able to be adherent to treatment plans
- ❑ Currently not receiving methadone
- ❑ Not dependent on CNS depressants, including benzodiazepines and alcohol, or be willing to taper these medications.
- ❑ No previous allergy to buprenorphine
- ❑ Willing to submit a UDS
- ❑ Willing to sign releases for all current treatment providers
- ❑ Would be better served by a MAT program integrated with community and mental health services

How to refer: Kristi Seemiller, SUD Care Coordinator
Kseemiller@pittsburghmercy.org or call 412-390-2583

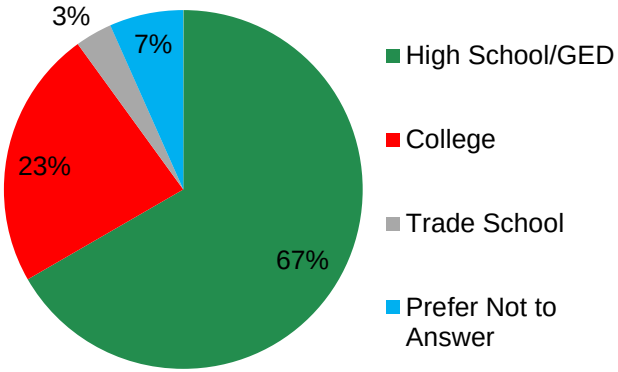
Age



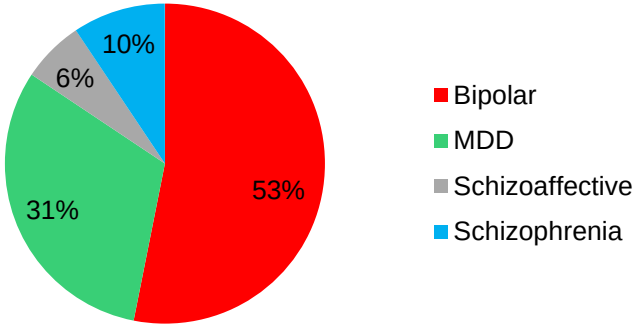
Patient Gender



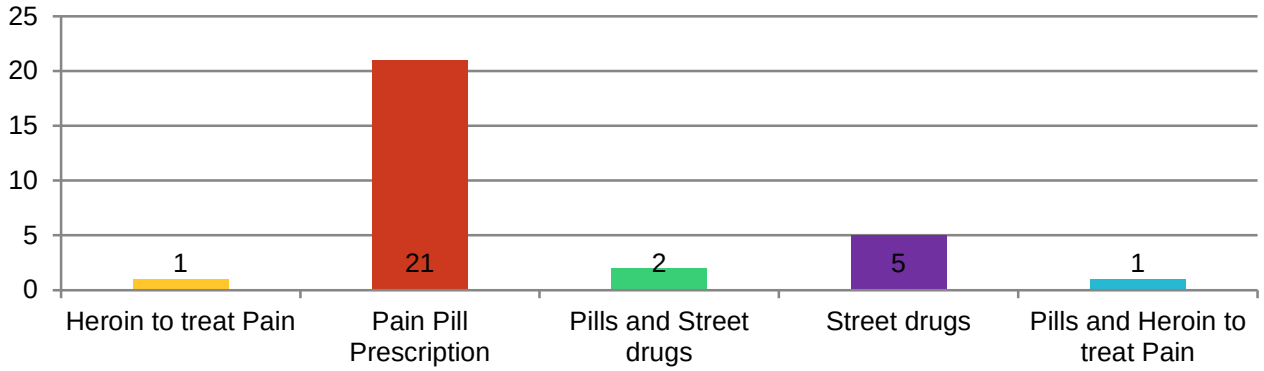
Level of Education



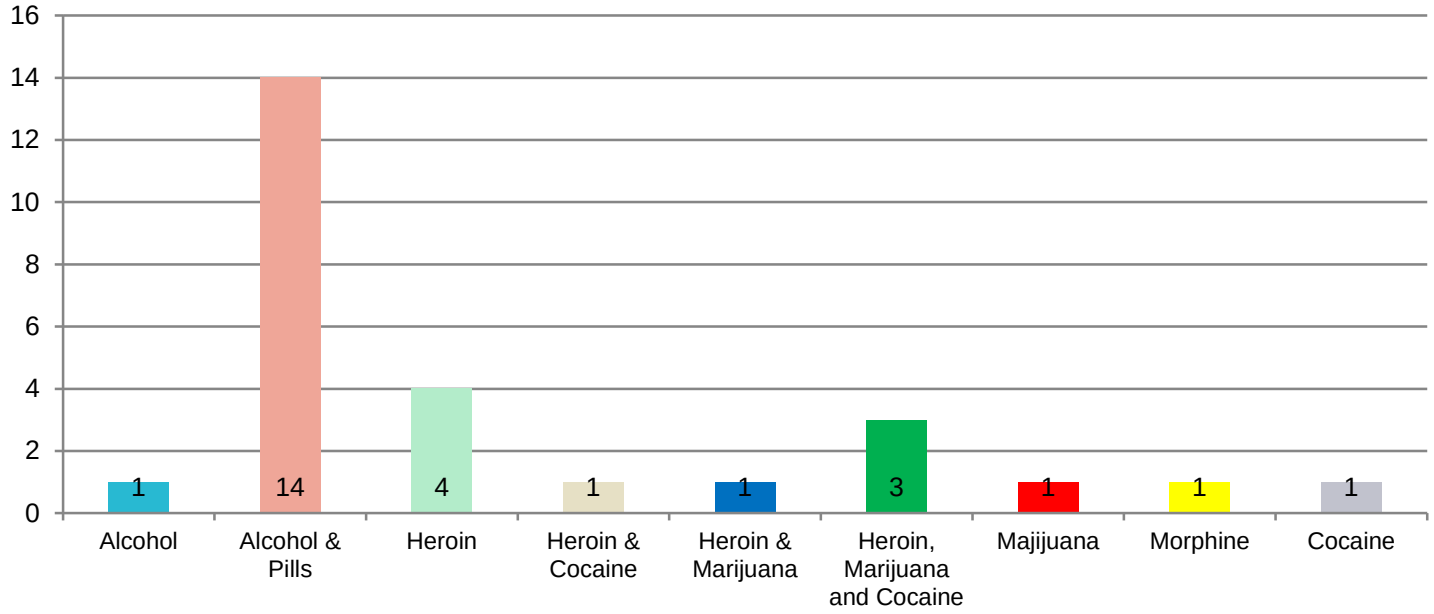
Mental Health Diagnosis



How did you begin opiate use?



Drug of Choice



IS IT WORKING?

- Cassie: 36 years old, white, female
  - PCP was retiring so she needed a new provider
  - Had two teenage children who were removed from her home based on her substance use and pending legal charges
  - Housing was unstable based on her legal involvement
  - Mental health symptoms were increased due to stress of above issues; taking benzodiazepines for anxiety
  - Continued use of cocaine
  - ❑ After 6 months:
    - ✓ Children were returned to her home with minimal ongoing CYF involvement
    - ✓ Housing stabilized through support of numerous systems
    - ✓ Active engagement in individual therapy with appropriate management of mental health symptoms
    - ✓ Tapered completely off of benzodiazepines
    - ✓ Clean drug screens for over 90 days, moved to monthly appointments for MAT

CARE COORDINATION NEEDS

Care Coordination is essential to effectively provide enhanced primary care for comorbid patients with substance use concerns.

- Care Coordination is currently not reimbursable and labor intensive

Areas that could increase the effectiveness and efficiency of Care Coordination include

- Supplement care management cost structurally
- Continue Medicaid Expansion and ensure insurance coverage to those in need.
- Continue to expand the reduction of the prior authorization process
- Expand coverage to alternative treatment methods
- Expand treatment options and accessibility for residential and housing options.

DISCUSSION