Navigators at the Core of Mental and Behavioral Health Programs in Rural and Frontier Colorado

Mental and Behavioral Health in Colorado Webinar Series:
The Current Landscape and Navigating Into Care

June 3rd, 2020
1:00 pm - 2:30 pm

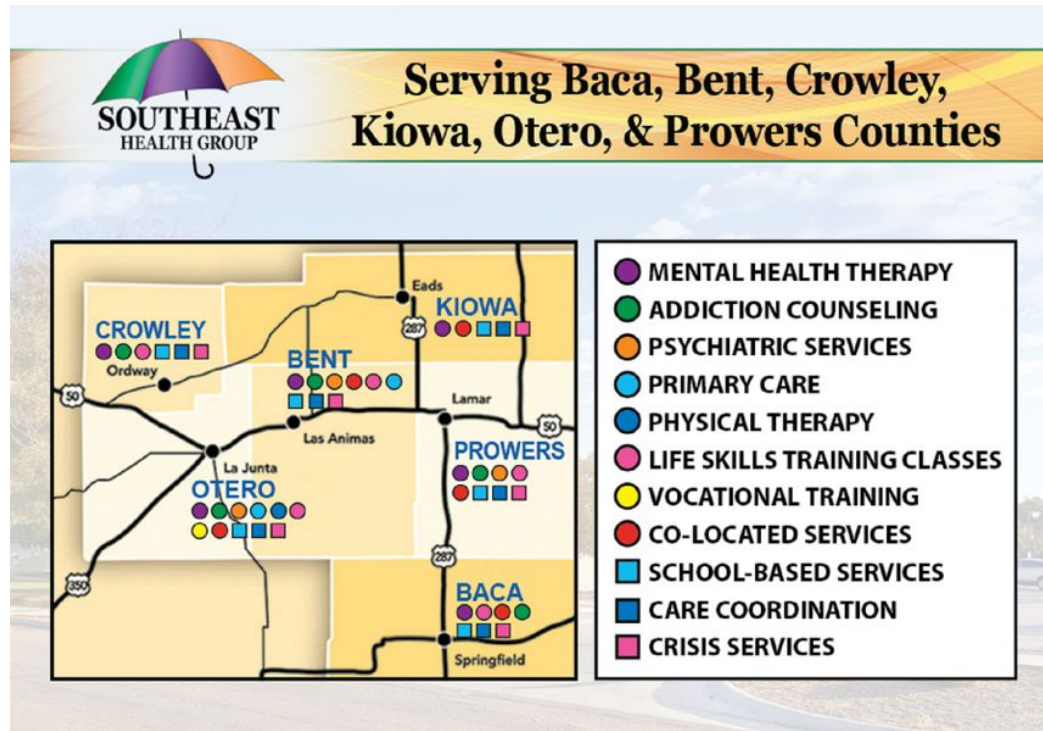**Jackie Brown, MSN, APN**
Chief of Physical Health Operations

Kaysie Schmidt, MPH
Director of Physical Health Operations

Learning Outcomes

1 **Learn how health navigators are increasing access to care in mental and behavioral health programs across Colorado.**

2 **Consider how the lessons learned in existing programs can inform future programming in Colorado.**

3 **Explore the opportunities and complexities of team-based care and role clarity within team based care approaches.**

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Service Area

Serving Baca, Bent, Crowley, Kiowa, Otero, & Prowers Counties

- ● MENTAL HEALTH THERAPY
- ● ADDICTION COUNSELING
- ● PSYCHIATRIC SERVICES
- ● PRIMARY CARE
- ● PHYSICAL THERAPY
- ● LIFE SKILLS TRAINING CLASSES
- ● VOCATIONAL TRAINING
- ● CO-LOCATED SERVICES
- ■ SCHOOL-BASED SERVICES
- ■ CARE COORDINATION
- ■ CRISIS SERVICES

- **Six County Region**
  Rural: Crowley, Otero, and Prowers
  Frontier: Baca, Bent, and Kiowa

- **9,533 Square Miles**

- **48,000 Residents**
  (350,000 Cows)

- **17,500 Medicaid**

- **160 Staff**

- **15 Locations**

Poorer
Less Educated
Higher Incidence of Chronic Disease

Southeast Health Group is committed to delivering exceptional health care services to the communities of southeastern Colorado.
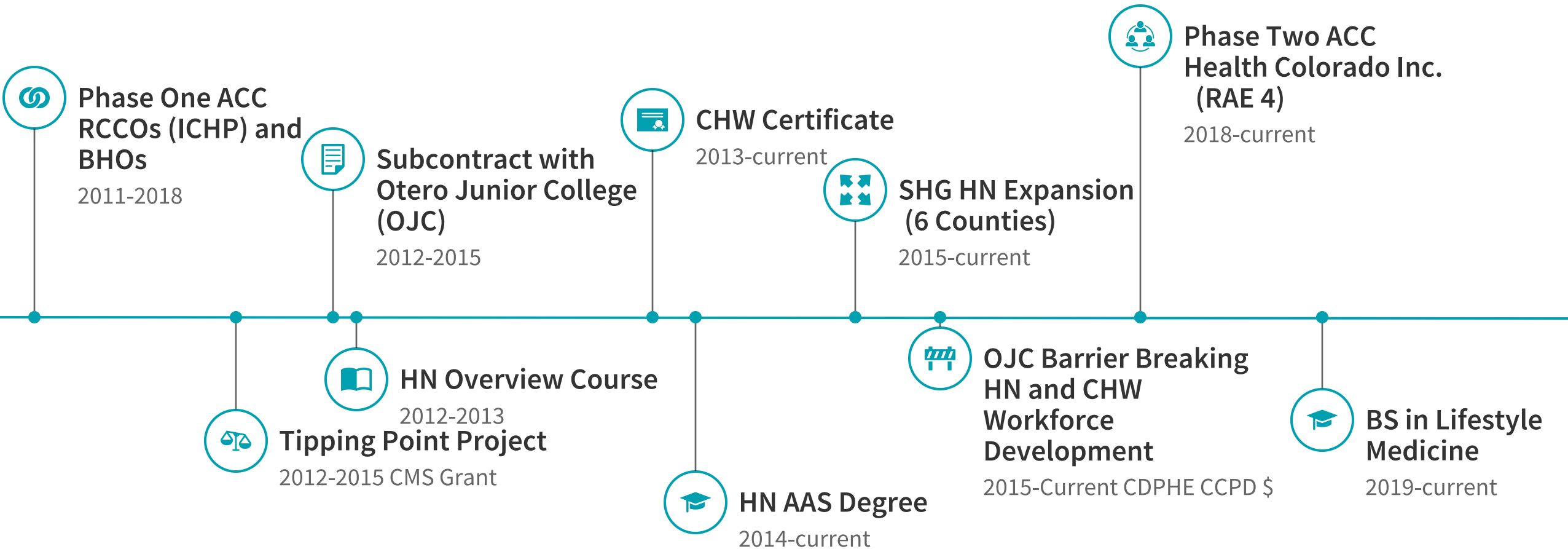
Monthly Population Mix

- **Mental Health Related**

  750

- **Substance Use Disorder/Adjunct**

  275

- **Physical Health Care**

  1100

- **Wellness Center**

  50

- **Health Navigation**

  300

- **Peer Assistance**

  135
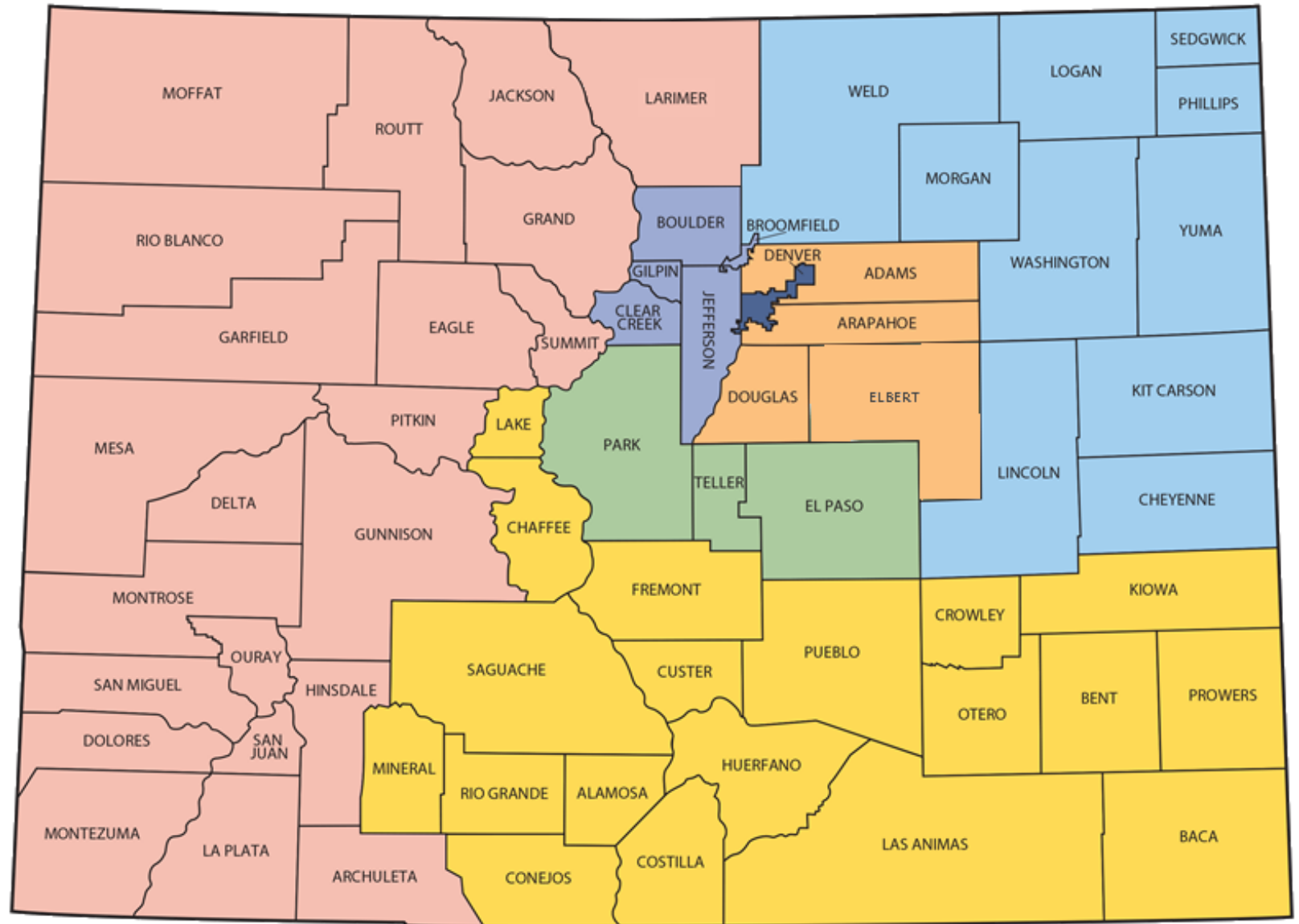
- **Physical Therapy**

  80 (6 weeks)

Together #WERISE

CRISIS · MENTAL HEALTH · SUBSTANCE USE · PHYSICAL THERAPY · PRIMARY CARE · PEER SUPPORT · YOUTH RESPITE · VOCATIONAL · WELLNESS SERVICES

Landscape

Phase One ACC RCCOs (ICHP) and BHOs
2011-2018

Subcontract with Otero Junior College (OJC)
2012-2015

CHW Certificate
2013-current

Phase Two ACC Health Colorado Inc. (RAE 4)
2018-current

SHG HN Expansion (6 Counties)
2015-current

HN Overview Course
2012-2013

Tipping Point Project
2012-2015 CMS Grant

HN AAS Degree
2014-current

OJC Barrier Breaking HN and CHW Workforce Development
2015-Current CDPHE CCPD $

BS in Lifestyle Medicine
2019-current

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Health First Colorado - Medicaid

Accountable Care Collaborative (ACC)

Region 1 — Rocky Mountain Health Plans
Region 2 — Northeast Health Partners
Region 3 — Colorado Access
Region 4 — Health Colorado, Inc.
Region 5 — Colorado Access
Region 6 — Colorado Community Health Alliance
Region 7 — Colorado Community Health Alliance

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Regional Accountable Entity (RAE) 4

Partners

Region 4 at a Glance

31.2% on Medicaid
Other RAEs: 18%-24%

21% Income at or below poverty line

Hispanic
38%

Asian
1%

American Indian
1%

African American
1%

White
59%

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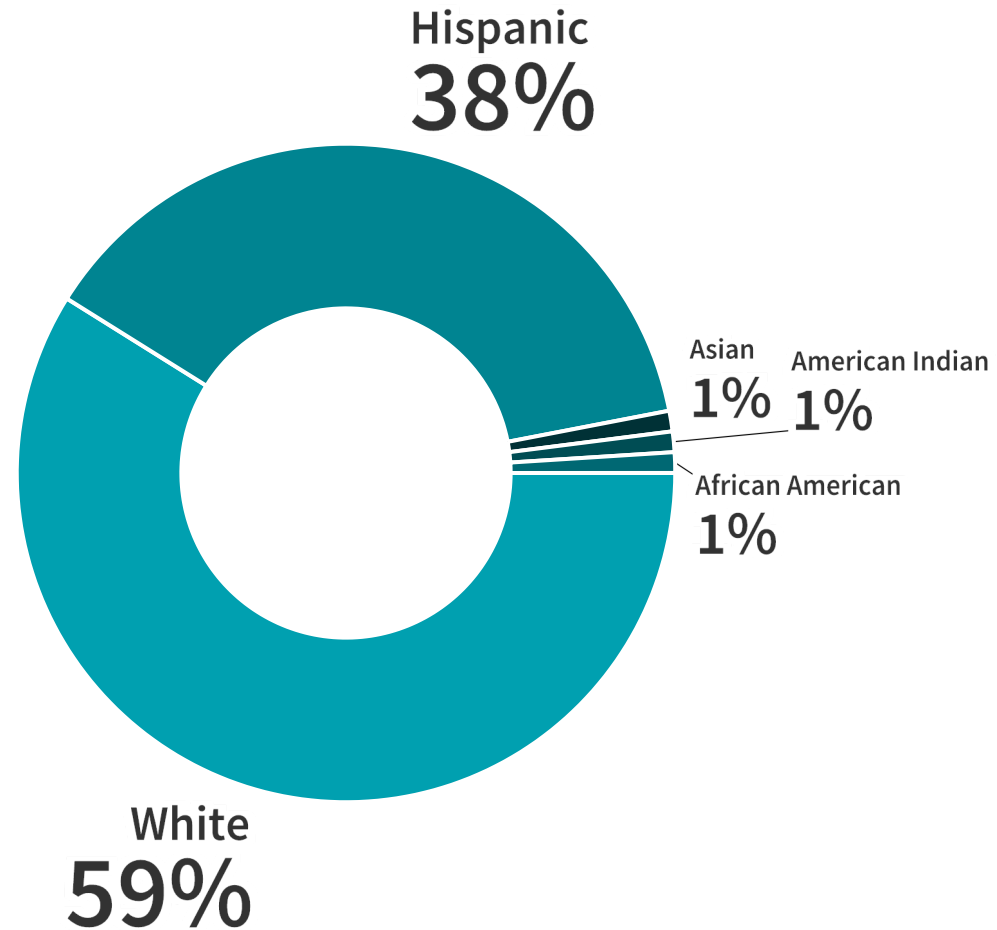
Payment Model

Figure 3. How Payment Works in ACC Phase Two.

Health Navigators help achieve the Institute of Healthcare Improvement's Triple Aim:
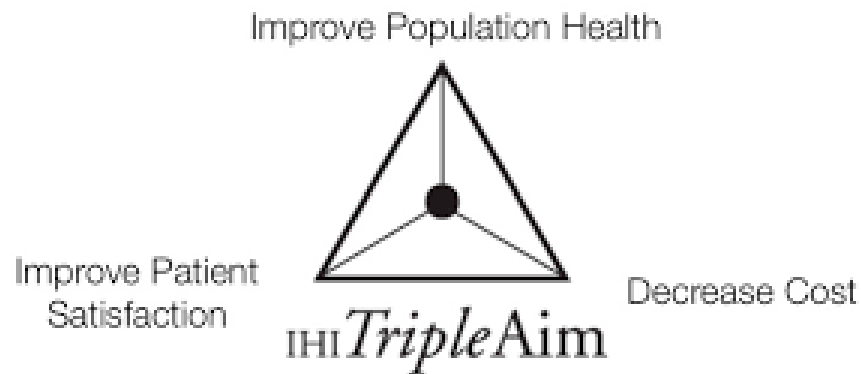
- Improving patient experience of care, including quality and satisfaction;

- Improving the health of populations; and

- Reducing the per capita cost of healthcare.

Focus on Population Health

Health Colorado Population Health Pyramid

February 2020 Impactable List Metrics

Total Population: 119,092
PMPM: $493.18

Complex Care Management

Number of Members: 6,730
Percentage of Total Population: 5.65%
Expected Percentage of Total Population: ~5%
Percentage of Total Spend: 49.09%
Expected Percentage of Total Spend : 45-50%
PMPM: $4,284.44
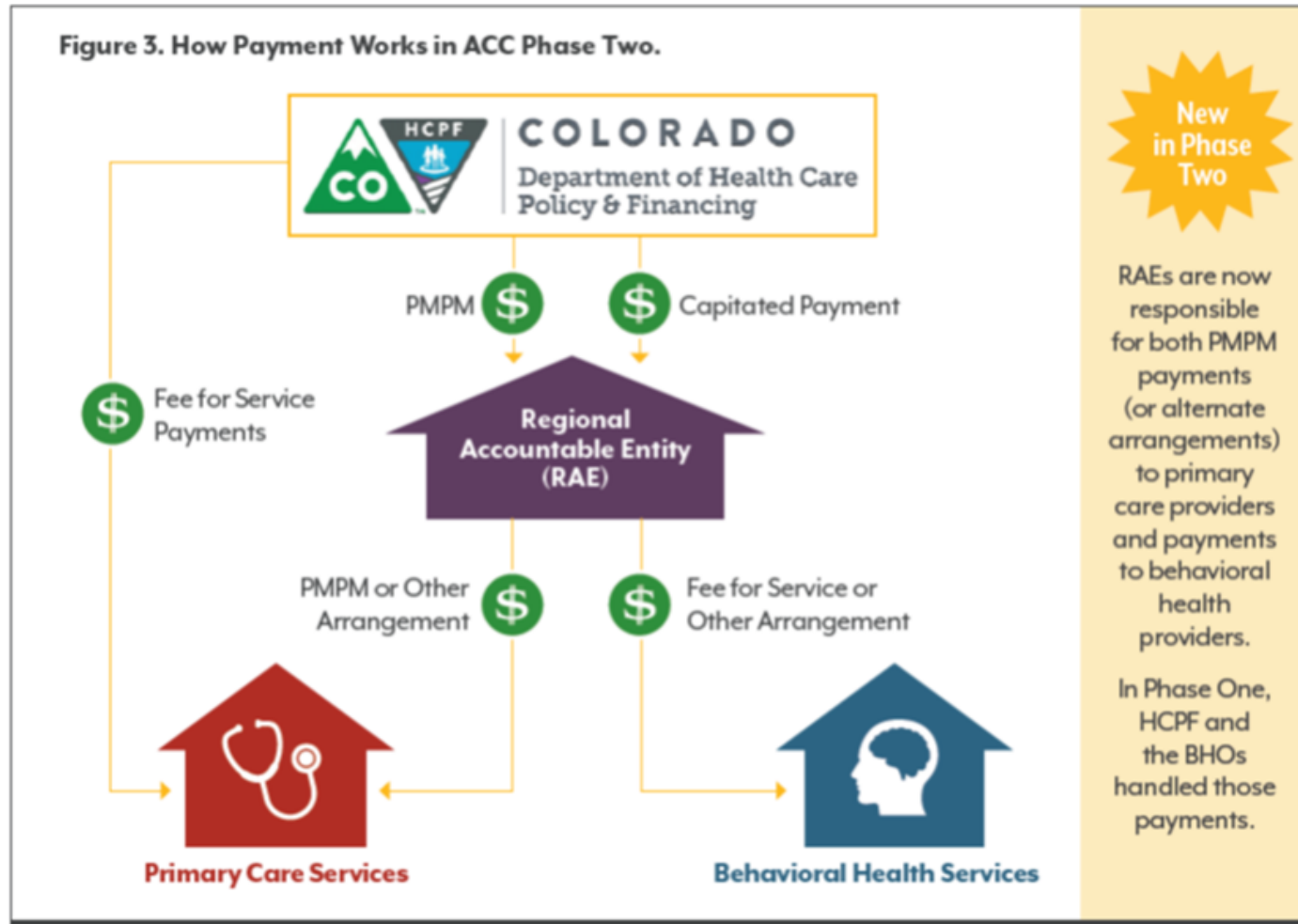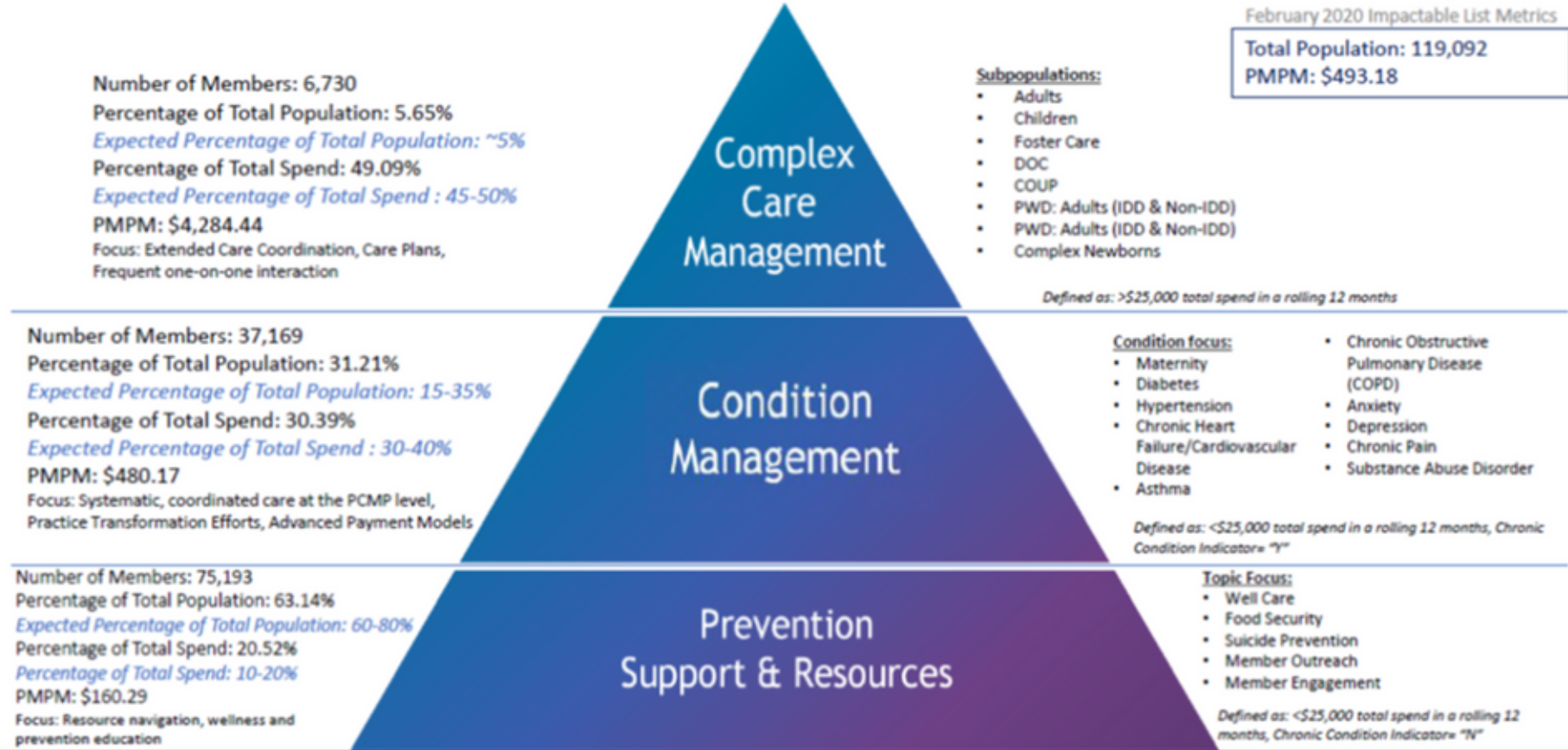Focus: Extended Care Coordination, Care Plans,
Frequent one-on-one interaction

Subpopulations:
- Adults
- Children
- Foster Care
- DOC
- COUP
- PWD: Adults (IDD & Non-IDD)
- PWD: Adults (IDD & Non-IDD)
- Complex Newborns

Defined as: >$25,000 total spend in a rolling 12 months

Condition Management

Number of Members: 37,169
Percentage of Total Population: 31.21%
Expected Percentage of Total Population: 15-35%
Percentage of Total Spend: 30.39%
Expected Percentage of Total Spend : 30-40%
PMPM: $480.17
Focus: Systematic, coordinated care at the PCMP level,
Practice Transformation Efforts, Advanced Payment Models

Condition focus:
- Maternity
- Diabetes
- Hypertension
- Chronic Heart Failure/Cardiovascular Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Anxiety
- Depression
- Chronic Pain
- Substance Abuse Disorder

Defined as: <$25,000 total spend in a rolling 12 months, Chronic Condition Indicator= "Y"

Prevention Support & Resources

Number of Members: 75,193
Percentage of Total Population: 63.14%
Expected Percentage of Total Population: 60-80%
Percentage of Total Spend: 20.52%
Percentage of Total Spend: 10-20%
PMPM: $160.29
Focus: Resource navigation, wellness and
prevention education

Topic Focus:
- Well Care
- Food Security
- Suicide Prevention
- Member Outreach
- Member Engagement

Defined as: <$25,000 total spend in a rolling 12 months, Chronic Condition Indicator= "N"

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ACC Key Performance Indicators

Behavioral Health Engagement
At least one behavioral health service within 12-months

Dental Visits
At least one dental service within 12-months

Well Visits
At least one well visit within 12-months

Prenatal Engagement
At least one prenatal visit within 40 weeks prior to the delivery and be Medicaid enrolled at least 30 days prior to the delivery

Emergency Dept Visits
ED visit counted, if it does not result in an inpatient admission

Health Neighborhood
Comprised of two components that reflect connections and referrals between specialty care and primary care providers

Potential Avoidable Costs
Compares a standard cost of an episode of care to actual costs

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ACC Behavioral Health Incentive Program

Engagement in Outpatient Substance Use Disorder (SUD) Treatment

Two or more additional services for a primary diagnosis of SUD within 30 days of the initiation visit

Follow-Up within 7 Days after an Inpatient Hospital Discharge for a Mental Health Condition

Seen on an outpatient basis by mental health provider within 7 days

Follow-Up within 7 Days after an Emergency Department Visit for a SUD

Seen on an outpatient basis by behavioral health provider within 7 days

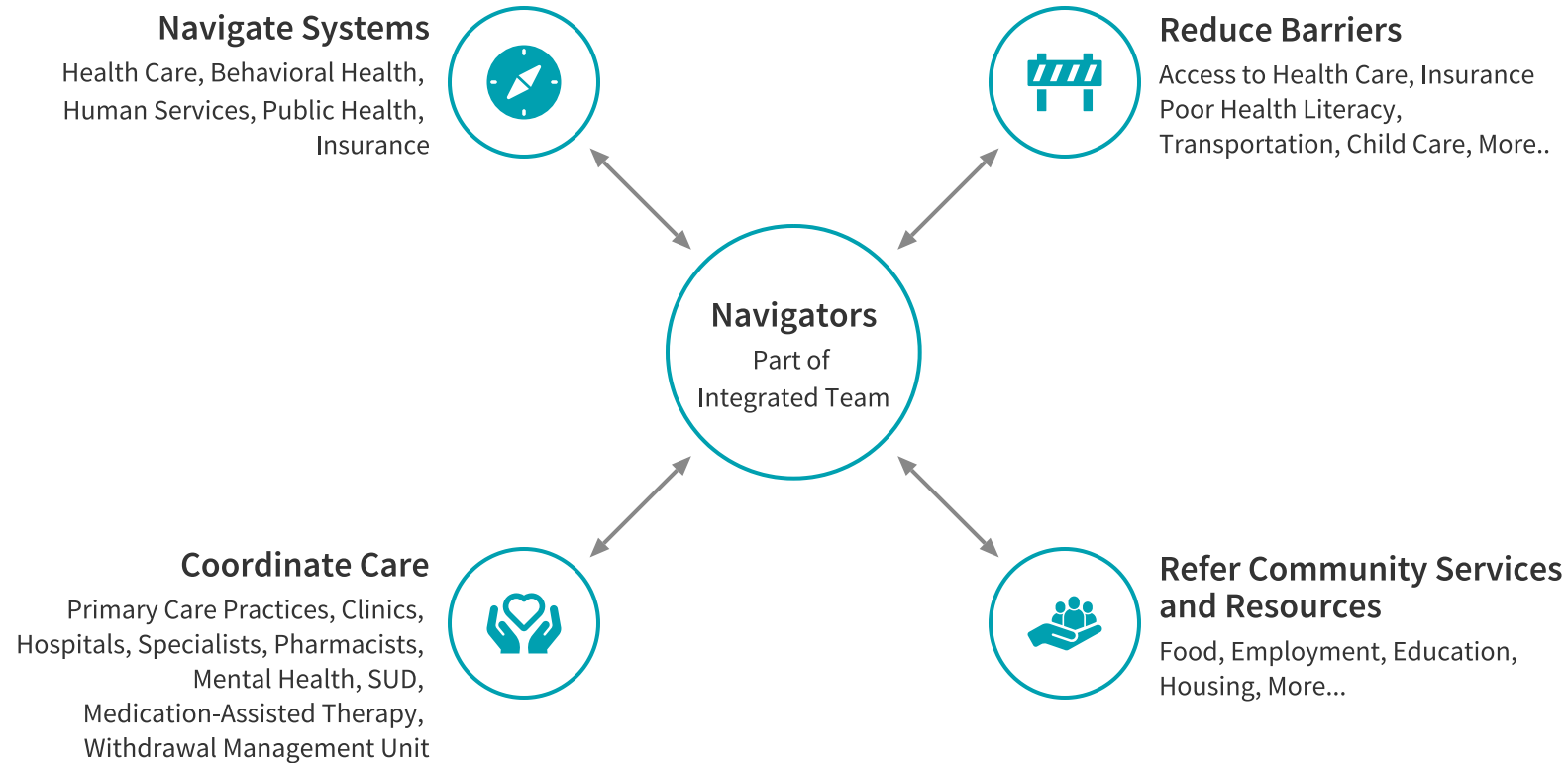**Follow-Up after a Positive Depression Screen**

Engaged in mental health service within 30 days

Behavioral Health Screening or Assessment for Foster Care Children

Within 30 days of RAE enrollment

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Role of Navigators

Navigate Systems

Health Care, Behavioral Health, Human Services, Public Health, Insurance

Reduce Barriers

Access to Health Care, Insurance Poor Health Literacy, Transportation, Child Care, More..

Navigators
Part of
Integrated Team

Coordinate Care

Primary Care Practices, Clinics, Hospitals, Specialists, Pharmacists, Mental Health, SUD, Medication-Assisted Therapy, Withdrawal Management Unit

Refer Community Services and Resources

Food, Employment, Education, Housing, More...

The Right Care - at the Right Place - at the Right Time

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Opportunities & Complexities

Notes from the trenches:

Lessons Learned

- Keep it simple (Rule of 3)
- Let medical professional do what they do best
- Use motivational interviewing and client-centered approaches for client goal setting
- Don't work harder than your client
- Be consistent
- Maintain boundaries
- Documentation is critical (i.e. keep contact info updated in EHR)
- Avoid "cookie cutter" practices, instead look for "best fit" solutions for each client
- Always follow-up
- Have a back-up plan

Barriers

- Difficulty contacting clients
- Lack of information about clients on lists
- Communicating timely for continuity of care
- Lack of funding for some important "unbillable"tasks
- Lack of understanding about role and value of health navgiation/care coordination services - different structures at different agencies
- Changing policies and funding for resources/programs
- Limited providers (i.e. OB, dental, etc.) and resources in rural/frontier region which decreases access and increases need for transportation
- Administrative tasks (i.e. client issues with paperwork)

Successes

- Relationships with clients, caretakers, caseworkers, and partners
- Increasing awareness of navigation services
- Connecting to community and health care resources
- Navigating Medicaid coverage and insurance issues
- Using multiple methods to reach clients (i.e. phone, telehealth, home visits)
- Connecting the dots by thinking outside the box, asking questions, and brainstorming for solutions
- Asking for help - you may not know the answer but you know someone that does
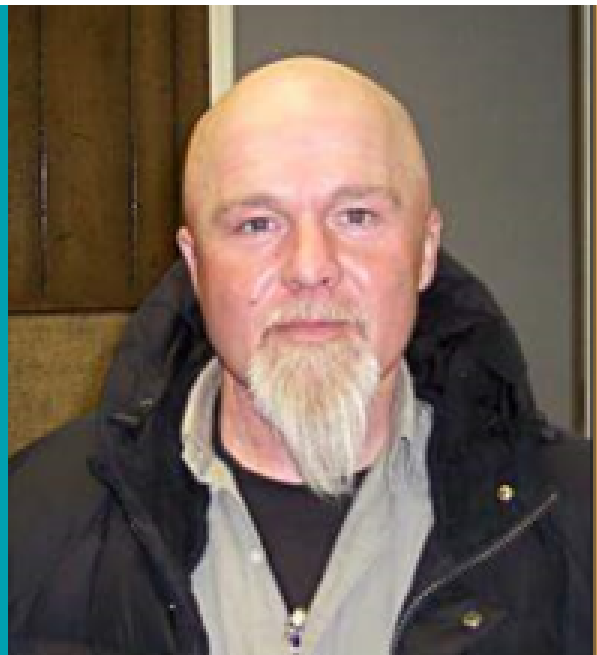
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Success Stories

Client seeking cancer treatment

Client struggling with homelessness

Questions?

Contact Us

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@ kschmidt@shgco.org

☎ 719-363-1592

🌐 southeasthealthgroup.org

THANK YOU!

More Info

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📞 (719) 384-6898

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References

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