

*DIMOCK RESPONSE
DEPARTMENT OF PUBLIC HEALTH
INFORMATIONAL SURVEY -2014
HEALTH RESOURCE PLANNING FOR BEHAVIORAL HEALTH*

1. How do you anticipate health resource planning for Behavioral Health to help you in your work? How do you expect to use the information resulting from the effort?

Health Resource Planning (HRP) for Behavioral Health could be a valuable tool that will inform and support current services; reduce redundancy; most importantly identify gaps in service delivery and identify real time data and current costs that impact on agencies providing services available in the Commonwealth through the following:

- a. Identification of comprehensive resources (prevention, intervention and treatment) available in every region.
- b. Identification of program availability in specific regions.
- c. Identification of subsets of programs being offered within a program.
- d. Identification of gaps in services.
- e. Providing a real time data base that informs agencies regarding needed services for program development.
- f. Provide real time costs that inform agencies regarding needed services and sustainability of those services over time.

Clinical: HRP will help clarify the landscape of available service options for various presentations in a BH/SA population. HRP will allow providers to better know which agencies to call to make referrals and to be mindful of the type of services currently available (including specializations, language/cultural capabilities) to promote utilization and avoid referrals from becoming stuck in lengthy waitlists.

Operations: HRP will allow our agency to consider our current services and possible opportunities for expansion and/or modifying with timely information about costs and outcomes.

2. Are there specific services within Mental Health & Substance Abuse that you would like to see studied, and were not already included in the list of services on page 6? Please describe with as much specificity as possible. Please indicate how they can be addressed through health resource planning.

Intensive Case Management (ICM) models of care are extremely valuable in servicing our most vulnerable. Many of the ICM services have been cut by state agencies. Case Management **is the bridge** that supports our clients during service delivery and upon discharge to the community; provides follow up and tracking during early abstinence - mental health stabilization and ongoing long term recovery. The majority of our clients are complex , living with severe trauma and chronic medical challenges and in need of levels of case management that support long term recovery and crisis stabilization during regression of disease and crisis stabilization . HRP would do a retrospective, current and prospective analysis of programs that utilized ICM in

the past, the effect of ICM and the need today given the complexity of cases. The ICM's were trained, provided with certification and were highly skilled to meet the most complex cases. ICM worked and we saw excellent results in all of our programs.

Home-based services have grown under CBHI and have been an effective support to outpatient level of services. **Barriers:** (i) waitlists have been long and (ii) the referral process has been quite varied depending on the institution receiving the referral. (iii) There has also been noted variation in the type of team and level of expertise of team providers.

Special Services: Additionally, the use of this intervention to serve and support children with Pervasive Developmental Delay or Autism Spectrum Disorder has remained cumbersome and onerous – access could be improved as well as growth in the number of providers trained and able to offer this type of team.

Preventive services: It would be important to identify more specific types of services such as parenting support services for at-risk families. (i) We are especially interested in prevention in the area of early childhood mental health, with a target population of 3-5 year olds. Models of family support and intervention with the parent appear to be recognized but we are unaware of stable programs that are consistently available to offer such services, nor does there appear yet to be a funding stream for reimbursement to allow our agency to put ideas into practice efficiently. (ii) We are also interested in learning about the financial viability of models of BH provision in conjunction with the treatment of chronic disease (i.e. obesity, asthma, diabetes, hypertension) and would hope that the HRP could better inform practice in this area of prevention and co-treatment as we build our practice toward the use of one multidisciplinary treatment plan in our integrated services.

- 3. Given the importance of prevention and also “post-acute” services for mental health & substance abuse, what critical evidence-based services & programs are available, should be expanded, or need to be developed? Are there specific models you suggest we study?**

Trauma Informed Services (TIS) is an Evidenced Based Practice that has had a positive effect on substance abuse residential programs and needs to be expanded. Training of staff is critical to create a staff culture that embraces this practice in every aspect of care twenty four –seven. Excellence in care has four components: Efficiency, Service, Reliability and Quality. Womens Renewal at Dimock staff have been trained in TIS and this practice has been shown to be effective in the delivery of care. Outcome measures include completion rates and next step referrals. Client Satisfaction Surveys are completed on exit of the program with consistent high scores.

Dually Diagnosed: 60% of our clients are dually diagnosed and enter our substance abuse program with multiple medications that can seriously re-addict clients (major increase in prescriptions for women). There needs to be education and cross training of disciplines in primary care, mental health and substance abuse regarding (i) prescribing medications for dually

diagnosed clients ;(ii) Identification of clients who are in need of care that address their mental health needs and substance abuse needs (iii) Identification of clients on the substance abuse and mental health side who are in need of primary care. Primary care, mental health and substance abuse disciplines need to come together to discuss and review these issues internally and externally. There needs to be discussion at the policy level.

Integrated Primary Care /Mental Health/Substance Abuse is a model of care that addresses the holistic needs of our clients and has been implemented at Dimock over the past two years. BHPIP (Behavioral Health Pediatric Integration Program) has been proven to be efficient, cost effective and of high quality and provides accessible services. As we move toward Integrated Primary /BH models of care there is a great deal to plan regarding licensing/regulations; mental health and substance abuse education of health care providers; revamping of payment systems with global fees; increase in prevention and wellness programs and cultural and appropriate linguistic needs for staff and program development.

ABA services for children with Autism – streamlining of the service continuum for such children has been an issue for our team. Many of these children have co-occurring mental health issues or get referred to the MH system for lack of referral options to more appropriate and targeted interventions.

Early Childhood Mental Health – current reimbursement models focus on the child as the identified patient. An expansion of such services to allow interventions with families/parents when risk factors are identified would allow for more timely prevention of more significant behavioral and emotional issues for children and ultimately save costs to the educational and mental health systems.

BH approaches to treating chronic disease with a **Behavioral Health Consultation** approach. Biggest limitation is lack of reimbursement as our staffing model has the needed balance. If we were able to implement such a service, we could improve patient utilization of BH services and avoid funneling them into the traditional BH model which is laborious and inadvertently compartmentalizes symptoms and discourages effective team based care.

4. Obtaining capacity, workload/volume, and demand data for outpatient & community mental health & substance abuse services is a challenge. Do you have ideas for data sources or suggestions for collecting data now or in the future? Are there specific “data gaps” that you feel are important for future data collection?

Data collection: Data collection brings many challenges and has continued to increase with demand for over five years now – however agencies realize that data is critical to the future state of programs, community needs , gaps, implementing resources, developing new models of care, research and most importantly identifying and entering real time data .

Multiple programs as a component of contracts have multiple systems in place where data has to be entered, updated, aggregated and sent to multiple state agencies. Agencies with multiple contracts from multiple state agencies have one to three data bases that need to be in

compliance. This is redundant, and is not cost effective. Program staff takes on these additional responsibilities with no increase in salary due to lack of contract dollars to pay for these positions. Mandates are set with no increase in revenues to pay for the mandates. This needs to be discussed, reviewed and appropriate and fair decisions need to be identified for change. Sustainability of programs depend on evaluating the additional costs associated with data collection and the resources needed to address this vital function.

Suggestion: One universal system for every state agency to reduce redundancy, increase efficiency, increase reliability of the data, maintain quality and inform programs.

Challenges for review by HRP:

1. One universal system
2. Training that is seamless and efficient
3. Contracts that include line items to pay for this component
4. Training of staff for accuracy and relevance to reporting, competitive marketing and outcome reports.
5. Internal and external messaging of data needs to be used as a tool for improvement - not as a negative with consequence.

Our programs have begun to consider how to analyze and use data that is already tracked to make it more meaningful – both in terms of making the work of collecting more meaningful by gleaning more relevant information from what is collected as well as obtaining more meaningful definitions of what our programs are accomplishing for patients. In that vein, a data gap that we notice is in the area of outcome measurement. Billing data as well as mandated screening and outcome tools have been a starting point. With integration we have better access to population data in our Pediatric clinic and are less vulnerable to misunderstanding our data regarding our program only in relation to those patients who engage in services. Having appropriate staffing to use the correct analysis tools to avoid misconstruing data is also an obstacle.