Chris Hickman, MSW, LICSW
System Director, FCC and Clinical Integration

Fairview Counseling Centers
Outpatient Mental Health Services

21 Clinics
18 FCC clinics are co-located in Fairview primary care clinics

33 Masters and Doctoral level therapists
  12 MSW, LICSW
  2 Clinic Managers & System Director are MSW, LICSWs
Clinical Integration

FCC initiated partnership with Fairview Clinics (40 primary care clinics) in 2010 launching our 1st integrated primary care/behavioral health model in the Fairview Hiawatha clinic.

We have expanded the Integrated Behavioral Health (IBH) model into two additional primary care clinics and one mobile IBH team.
PPACA has significant impact on Clinical Social Work on multiple levels including access to care for a greatly expanded population of covered individuals and seminal shifts in health care design and delivery.
## Insurance Reform

<table>
<thead>
<tr>
<th>Expands Eligibility</th>
<th>Expands Coverage</th>
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<tr>
<td>- Removes preexisting conditions exclusion</td>
<td>- Medicaid Expansion</td>
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<tr>
<td>- Removes spending cap</td>
<td>- Subsidies</td>
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<tr>
<td>- extends coverage to 26 y/o</td>
<td>- Health Insurance Exchanges</td>
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About 180,500 people gained health insurance between September and May, 2014 in Minnesota
Greater Volume
Increase in population of health care consumers

+ 

Static resource capacity

= 

Challenges to Access
Changes in Health Care Design and Delivery

ACA - National quality improvement strategy

- Prevention
- Early detection
- Early intervention
- Care integration
- Care coordination
- Care transitions
- Chronic disease management
- Co-occurring medical/behavioral health conditions
- Reductions in avoidable Emergency Department and Inpatient utilization...
Impact of ACA on Clinical Social Workers

ACA = Increased Volume + shift in care delivery and focus on quality outcomes

Clinical Social Workers need to deliver care that is **efficient** and **effective** as we move towards population-based care.

Mental Health and Substance Use Care Delivery will move **away from silos** to greater coordination, collaboration and integration.
Clinical Social Workers will need to treat the HEALTH of individuals,
not just the mental and/or chemical health
This shift in focus has significant implications for:

- how we view the individual health care consumer
- how we conceptualize the presenting concerns
- how we organize and deliver care
- How we view ourselves as health care providers
Collaboration with primary care providers
- i.e. understanding and addressing the somatic presentation of emotional/psychological distress

Collaboration with community service providers
- i.e. understanding and addressing the Social Detriments of Health

Client and Family Centered Care
- effectively engaging clients and supportive others (MI...)

Impact of ACA on Clinical Social Workers
Changes in Practice Management

Managing a population requires managing access to care which requires **effective structure** in care delivery

**Evidence Based Care**

**Data** – ability to demonstrate value to consumers – to payers – to systems (public and private)
Patient Centered Medical Care Home

Core Components

**Personal physician.** Each patient has a personal and ongoing relationship with their physician.

**Team approach.** Medical care will be quarterbacked by a personal physician leading a group of health care professionals. The operative word here is “team” – each member of the team has responsibilities.

The team consists of the PATIENT and family, the physician, nurses, medical specialists, nutritionists, pharmacists, social workers, behavioral health specialists, and others who would participate in providing comprehensive care for the patient. The team takes collective responsibility for the patient’s care.
Patient Centered Medical Care Home

**Whole-person orientation.** Instead of just plugging holes in problems, the team is to address all stages of life – preventive care, acute and chronic care, and end of life care.

**Coordinated care.** Care should be coordinated across all elements of our health care system. Along with Care Coordinators, care coordination is also be facilitated by use of registries and electronic health records.

**Quality and safety.** Evidence-based medicine, clinical decision support tools, and information technology will be utilized to improve the quality and safety of care.
Patient Centered Medical Care Home

**Enhanced access to care.** Open scheduling, expanded hours, and use of other methods of communication such as email will make it easier to get care when needed.

**Payment reform.** This is very important. Our current Fee for Service system is a burden to implementing an effective health care home model. Development of payment systems that reward coordination of care are important to make this model work. (ACOs, Shared Risk / Shared Savings contracts...
Section 2703 of the ACA permits States the option to offer **health home services** to eligible individuals with chronic health conditions.

Eligible individuals are Medicaid beneficiaries with:

(1) Two or more chronic health conditions;

(2) One chronic health condition and are at risk for a second; or

(3) A serious and persistent mental health conditions.

Chronic conditions identified include: mental health, substance use disorder, asthma, diabetes, heart disease, and a BMI 25+. 

Example of care innovation at the state level in Minnesota...
Behavioral Health Homes

Minnesota DHS is focusing planning on four target populations.

These include adults experiencing:

1) Serious and persistent mental illness (SPMI);

2) Serious mental illness (SMI) and a substance abuse disorder; or

3) Serious mental illness and have or are at risk of having other chronic health conditions; and

4) Children experiencing a severe emotional disturbance (SED).
Behavioral Health Homes

Goals:

1. Improve health outcomes (preventative, routine, treatment of health conditions) of these populations

2. Improve experience of care for the individual

3. Improve the quality of health & wellness of the individual

4. Reduce health care costs
Behavioral and physical health problems co-occur

- Individuals with serious physical health problems often have co-morbid mental health problems, and nearly half of those with any mental disorder meet the criteria for two or more disorders, with severity strongly linked to co-morbidity (Kessler et al. 2005).

- Mental health problems are two to three times more common in patients with chronic medical illnesses such as diabetes, arthritis, chronic pain, headache, back and neck problems, and heart disease. (Milliman 2008)
Behavioral issues frequently present as physical concerns

- An estimated 75% of patients with depression present physical complaints as the reason they seek health care. (Unutzer et al., 2006)

- In approximately two thirds of patients with depression, the clinical picture is dominated by somatic symptoms, such as lack of energy and general aches and pains, (N Engl J Med. 1999) which patients frequently attribute to normalizing causes.
Behavioral issue increases risk of physical health condition

• Depression *increases the risk of developing cardiovascular disease*. It is also associated with higher rates of cardiac death and all-cause mortality. *Cleveland Clinic Journal of Medicine* September 2003

• *For those who have had a heart attack*, experiencing depression *increases their risk for cardiac-related death three-fold*, more than any cardiovascular variable except congestive heart failure. *Diabetes Care*. 2011 Aug; 34(8):1729-34.
Mental Health and substance use disorders are big drivers of health care costs

- The top 10% of high utilizers consume 33% of ambulatory care services and 50% of hospital services.

- Research shows that 50% of the highest utilizers have mental and/or addictive disorders. *Archives of General Psychiatry* 1992

- A meta-analysis of 91 studies found that patients diagnosed with a mental disorder who received active behavioral health treatment had a reduced overall medical cost of 17%, while controls who did not receive behavioral treatment increased an average of 12.3%. *(Chiles, Lambert, & Hatch, 1999)*
THE HEALTH CARE WORLD IS SHIFTING IN UNPRECEDENTED WAYS.

**Clinical Social Workers** are at the epicenter of these changes in our multiple roles as Clinicians, Community Social Workers, Social Workers in Social Services, School Social Work, Administrators, Researchers, Teachers...
As Social Workers we are challenged to define who we are, what we do and how we carry out our vision, our values and our roles as health care providers in the new and quickly changing landscape.