Roadmap to Integrated Care in Mississippi

• March 2017 •

MSPHI
Mississippi Public Health Institute

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Acknowledgements

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About the Mississippi Public Health Institute (MSPHI)

The Mississippi Public Health Institute (MSPHI) is a non-profit organization founded in 2011. Its mission is to improve community health through collaboration and the use of evidence-based population health strategies. The Institute has expertise in programs, policies and partnership development specific to health systems, health services and community health approaches. MSPHI has fostered a network of ties within the academic, government, and healthcare provider communities which has enabled the organization to devise innovative solutions to the most challenging issues.

About the National Network of Public Health Institutes (NNPHI)

NNPHI's mission is to support national public health system initiatives and strengthen PHIs to promote multi-sector activities resulting in measurable improvements of public health structures, systems, and outcomes. Learn more about NNPHI and its member institutes at www.nnphi.org.

About the Robert Wood Johnson Foundation

For more than 40 years the Robert Wood Johnson Foundation has worked to improve health and health care. They are working with others to build a national Culture of Health enabling everyone in America to live longer, healthier lives. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.

Background

Roadmap to Integrated Care in Mississippi

The National Network of Public Health Institutes (NNPHI), with support from the Robert Wood Johnson Foundation, awarded grants to six member public health institutes to build their capacity to advance state and local policy and systems change to bridge health and health care. One of the central activities of the grant was to host state-wide forums aimed at advancing collaboration among the public health and health care sectors. The second phase of the State Forums to Advance Health Systems Transformation aimed to build on the first phase as new grantees replicate or add to the array of approaches to integrate health systems to lower costs and improve population health.

In February 2016, Mississippi Public Health Institute (MSPHI) was awarded a Phase Two grant and chose to focus on behavioral health and primary care integration. Part of MSPHI's mission is to serve as a neutral convener to bring diverse stakeholders together and address public health challenges. This allows MSPHI to create collaboration among Mississippi leaders/stakeholders from public health, primary care, and behavioral health to establish consensus and create synergy around population health and integration of behavioral health and primary care.

To ensure buy-in and subject matter expertise, MSPHI collaborated with the Mississippi Department of Mental Health (MDMH) and requested that the MDMH Integration Work Group serve as the advisory committee for the State Forum event. The MDMH Integration Work Group is a multidisciplinary, interagency work group which was created in August 2011 for the purpose of developing strategies and partnerships to facilitate the integration of mental illness, intellectual and developmental disabilities and addiction services with primary health care to create a holistic approach to care. Since its inception, Integration Work Group activities have been reported in the MDMH Strategic Plan, the Mental Health Block Grant and Implementation Report, the Substance Abuse Block Grant, and on national surveys, federal site visits, etc. Integration Work Group members have actively participated in cross-training efforts to share information about integrated care with various segments of the state's health care system, including the MS Primary Health Care Association, the MS Association of Community Mental Health Centers and the University of Southern Mississippi, College of Nursing. Most recently, the MDMH Integration Work Group served as the Core Implementation Team for a SAMHSA-HRSA Center for Integrated Health Solutions Innovation Community entitled, "Building Integrated Behavioral Health in a Primary Care Setting."

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During the months of preparation for the State Forum, the Integration Work Group met three times and focused primarily on the concept of population health and on creating a definition which would encompass Mississippi's needs and specific culture. On October 24, 2016, MSPHI convened a State Forum to create a path for meaningful collaboration between behavioral health, primary care, public health and other multi-sectorial partners. Particular attention was placed on identifying opportunities for new partnerships with behavioral health and primary care providers and services at the state, regional and local levels. During the State Forum, careful attention was paid to providing opportunities in both large group and small group formats. Throughout the day-long State Forum event, all stakeholders were organized by table which fostered the development of new professional relationships.

The highlight of the State Forum event was the Gallery Walk poster display. The Gallery Walk poster display provided graphic representation of data, statistics and technical information presented in a series of 25 posters. The Gallery Walk technique was utilized to stimulate discussion among the large number of varied stakeholders attending the State Forum, some of whom had never met. The data, statistics and technical information provided a common language and experience upon which the stakeholders could build a common foundation of knowledge.

Posters were organized into four categories: Demographics; Population Health; Behavioral Health; and Integrated Care. State Forum attendees were provided guidance concerning how to progress through the posters as a Table Group and how to gather information to bring back to each table. Also, a hard copy of all Gallery Walk posters were provided for each table. The Gallery Walk helped stakeholders understand the scope and gravity of the issue and helped them become actively involved in synthesizing important concepts and consensus building. **Appendix A—Gallery Walk Posters.**

Dynamic Gallery Walk activities and discussions led the State Forum participants directly into open-ended conversations at each table which resulted in suggestions for a Roadmap to success in achieving integrated care in Mississippi. By the conclusion of the Forum, the group had established a common definition of population health for Mississippi. The definition is as follows:

> *Population health is defined as the health outcomes of a group of individuals often in a geographic area such as a state, region or community. The population health approach understands these outcomes to be the product of multiple determinants of health (social, cultural, economic, environmental, behavioral and biological) and aims: To improve the health of entire populations, Reduce health inequities, and improve the quality, cost and efficiency of the health system.*

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Forum participants also developed practical strategies for innovative health system transformation as detailed in the action plan in Section III of this document. These components will serve as the foundation for the **Roadmap to Integrated Care in Mississippi**. Following the State Forum, two additional meetings of the Integration Work Group were held with the goal of determining next steps and creating a Roadmap for success.

State Forum participants strategize about integrated care in Mississippi

State Forum participants observe and discuss Gallery Walk posters

Introduction

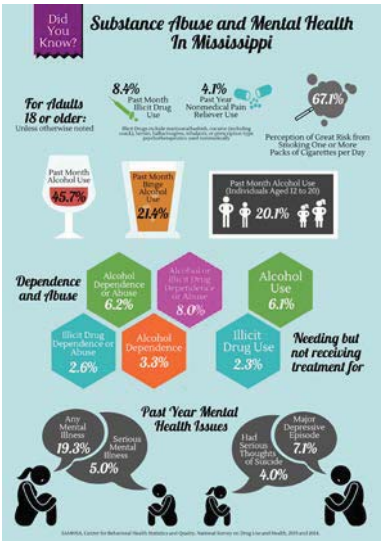
Years of research and key publications have revealed the urgent need for health care systems to take another look at how health care services and behavioral health care services are provided. They reveal that the provision of coordinated physical and mental health care is important to achieve better outcomes for patients in the health care system, a better care experience for patients and their families and all at a lower cost of doing business.

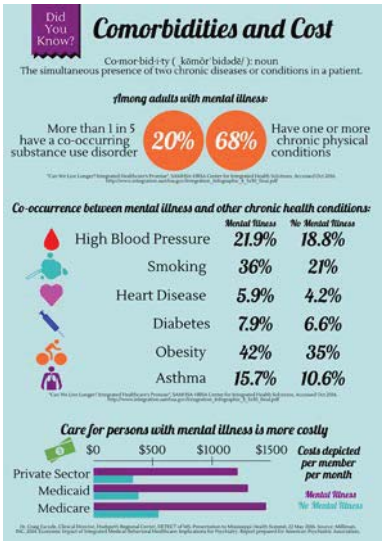
In 2006, the **National Association of State Mental Health Program Directors (NASMHPD)** issued a report entitled *Morbidity and Mortality in People with Serious Mental Illness* (Mauerr, Parks, Svendsen, Singer & Foti, 2006) which revealed that persons with serious mental illness (SMI) die, on average, 25 years earlier than the general population. In addition to an increase in natural causes of death, such as diabetes and cardiovascular, pulmonary and infectious diseases, people with SMI face the challenges of higher rates of smoking, alcohol usage, risky behaviors (unsafe sex, IV drug use, etc.), homelessness, poverty, polypharmacy and the lack of access to appropriate and coordinated health care.

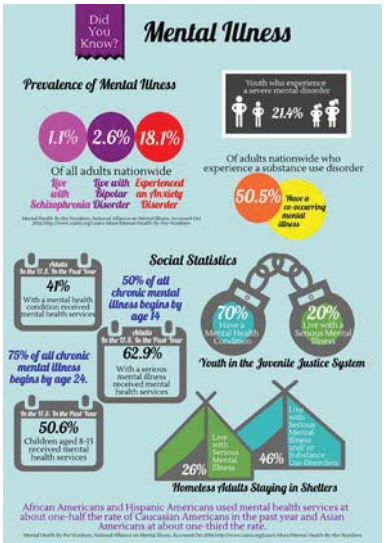
In 2011, the **Robert Wood Johnson Foundation (RWJF)** issued a policy brief entitled *The Synthesis Project, Policy Brief No. 21* (Goodell, Druss & Walker, 2011) which established that comorbidity of mental and physical conditions is the rule and not the exception.

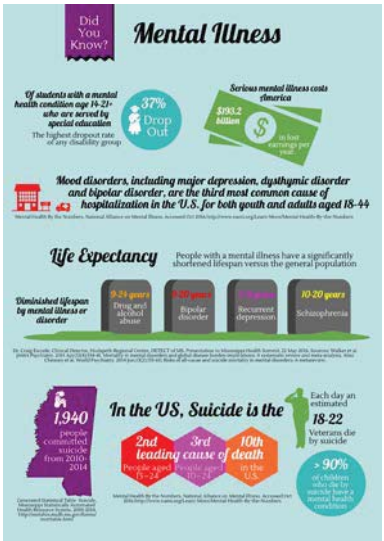
Several gallery walk posters from the MS State Forum featured below underscored the extent of the issues associated with lack of coordinated physical and mental health care in Mississippi. They also reflect co-morbid mental and physical conditions and increased challenges faced by people with serious mental illness.

Mental Health-Related Gallery Walk Posters









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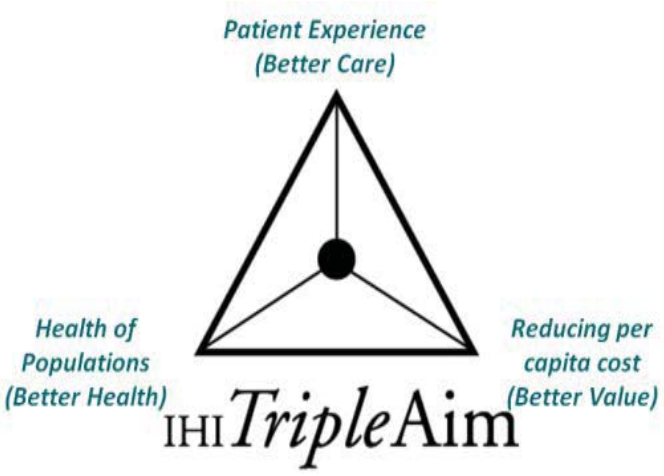
In 2012, the **Institute for Healthcare Improvement (IHI)** published *Pursuing the Triple Aim* (Bisognano & Kenney, 2012). This groundbreaking book brought forward the concept of retooling the health system to focus on better health outcomes (population health), better experience of care (patient-centered care) and at a better cost (lower per capita). This concept is often presented graphically, as in **Graphic 1**.

Graphic 1: IHI Triple Aim



During the same time period, the **Centers for Medicare and Medicaid Services (CMS)** contracted with The Lewin Group, Inc. and IHI to investigate promising practices for serving persons with serious mental illness, physical disabilities, dementia or Alzheimer's disease. The goal was to ensure that persons enrolled in Medicare or Medicaid have high quality health care. In 2012, the results were published in a report entitled, *Approaches to Integrating Physical Health Services into Behavioral Health Organizations* (SAMHSA-HRSA Center for Integrated Health Solutions, 2012). This report concluded that physical health care needs to be integrated into behavioral health services with an emphasis on self-management and navigation services for persons with serious mental illness.

Having established the clear need for transformation of the current health care system, further research, national and state-level initiatives, and legislative action followed. The Patient Protection and Affordable Care Act, commonly known as the **Affordable Care Act (ACA)** (Government Publishing Office, 2010) was signed into law by President Barack Obama on March 23, 2010, and included provisions which were to take effect from 2010 to 2020. In January 2011, a specific provision (Section 2703) went into effect which would improve health care quality through the systematic coordination of primary and behavioral healthcare. Section 2703 of the ACA authorized states to establish **Medicaid Health Homes** as a way to provide more coordinated primary care, mental and substance use services for individuals living with chronic conditions who are enrolled in Medicaid. Section 2703 also provided an opportunity for states to pursue the Triple Aim. To date, Mississippi's Division of Medicaid has not submitted a State Plan Amendment to implement Medicaid Health Homes.

Another specific provision of the ACA which went into effect in January 2011 (Section 3021) established the **Center for Medicare and Medicaid Innovation** within CMS (https://innovation.cms.gov/). The purpose of the CMS Innovation Center was to support the development and testing of innovative health service delivery and payment models. The first State Innovation Models Initiative Award was announced in 2012.

Most recently, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) joined forces to create the **SAMHSA-HRSA Center for Integrated Health Solutions (CIHS)** (http://www.integration.samhsa.gov). CIHS has defined integrated care as "the systematic coordination of general and behavioral healthcare" (SAMHSA-HRSA Center for Integrated Health Solutions, 2013). The primary goal of CIHS is to promote the development of integrated primary and behavioral health care services regardless of the patient's point of entry. In 2013, CIHS released *A Standard Framework for Levels of Integrated Healthcare* (SAMHSA-HRSA Center for Integrated Health Solutions, 2013) which provided a new taxonomy for viewing levels of health care along a six-level continuum of integrated care. It is often presented in an extended chart format, of which an abbreviated version is found in **Graphic 2** below. The full Standard Framework chart also divides services into a number of Core Descriptions/Key Differentiators. They include Location of behavioral health, primary care and other healthcare providers; Clinical Delivery; Patient Experience; Practice/Organization, and; Business Model.

Graphic 2: SAMHSA-HRSA CIHS Levels of Collaboration/Integration

Coordinated Key: Communication		Co-located Key: Physical Proximity		Integrated Key: Practice Change	
Level 1 Minimal Collaboration	**Level 2** Basic Collaboration at a Distance	**Level 3** Basic Collaboration Onsite	**Level 4** Close Collaboration Onsite with some System Integration	**Level 5** Close Collaboration Approaching an Integrated Practice	**Level 6** Full Collaboration in a Transformed/ Merged Integrated Practice

In 2014, CIHS announced the Standard Framework's companion, the **Integrated Practice Assessment Tool (IPAT)** (SAMHSA-HRSA Center for Integrated Health Solutions, 2014). The IPAT is a simple, easy-to-use evaluation tool for healthcare provider programs which is based on an eight question decision tree model. The series of Yes/No questions results in an identification of a specific Level of Integrated Healthcare (as per the Standard Framework chart) for the provider program. The IPAT is designed to be completed by a team of persons who are intimately knowledgeable about the operations of the program.

Introduced in 2009 and finally enacted in 2014, the **Excellence in Mental Health Act** (The National Council for Behavioral Health, 2015) will provide a large federal investment into mental health and addiction services - over $1 billion will be awarded to reenergize the local community mental health system. This act created 2-year, 2-phase (planning and implementation) demonstration projects for eight states to create **Certified Community Behavioral Health Clinics (CCBHCs)**. In addition to establishing criteria for CCBHCs, the act also defines a multi-partnership delivery system and provides for a Prospective Payment System model. In 2015, applications were accepted from States for the planning phase of the project. In December 2016, eight states were selected for the implementation phase of the project: they are Minnesota; Missouri; New York; New Jersey; Nevada; Oklahoma; Oregon; and Pennsylvania.

Section 1

Scan of Current Mississippi Behavioral Health and Primary Care Integration Activity

There are many organizations from all sectors of Mississippi's health care system which are striving to make progress in the provision of accessible, coordinated, efficient health care with better outcomes. Breaking down silos is hard work and progress has been slow at times. Many small steps have been taken over the years, such as increasing collaboration between Community Health Centers (FQHCs) and Community Mental Health Centers. Any number of Mississippi Community Mental Health Centers have applied for SAMHSA-HRSA CIHS's Primary and Behavioral Health Care Integration grants, but none have been awarded to Mississippi programs.

The Mississippi Department of Mental Health and the Division of Medicaid collaborated to create an application, which was favorably reviewed, for the Certified Behavioral Health Clinics Program, but it too failed to be selected for funding. However, service providers, policy makers, state agencies, non-profits, advocates, patients and persons receiving services and even the Mississippi State Legislature continue to move forward. Graphic 3 below provides a brief summary of these efforts.

Graphic 3: Table Reflecting Mississippi's Efforts at Primary and Behavioral Health Care Integration (PBHCI) At-A-Glance

Mississippi's Efforts at PBHCI At-A-Glance				
Who	**What**	**When**	**Where**	**Comments**
		2015-2017	MS Gulf Coast	
Coastal Family Health Center	Integrated mental health services into their FQHC	2008-2011	MS Gulf Coast	RWJF funded this grant which provided training by Intermountain Healthcare (Utah) and implementation of mental health integration model.
MS State Hospital's Lighthouse Medical Clinic	Provided part-time integrated care for MSH patients	2009-2011	Jackson, MS	The Lighthouse Medical Clinic was a part-time clinic with one Primary Care Physician. It operated for two years and closed in May 2011 due to loss of the PCP. Although it operated for only two years, it was an early success.

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Who	What	When	Where	Comments
MS Department of Mental Health (MDMH), Office of Special Projects	Created an interdisciplinary, interagency Integration Work Group (IWG) to promote integration of primary and mental health services	2011-2016	Statewide; Jackson metropolitan area	The IWG was created in 2011 and met quarterly. Among its accomplishments, it developed an informal baseline report outlining the status of integrated care in MS as of FY 2012 with annual updates. In 2016, the MDMH Executive Director permitted the IWG to serve as the Advisory Committee for the MSPHI State Forum on Health System Transformation project.
University of MS Medical Center (UMMC)	Offers several clinics providing integrated care	2011-current	Jackson, MS	The Family Medical Clinic uses the services of several psychologists to provide integrated care. The James Ivory Clinic provides services to the homeless population and partners with MS State Hospital. The Children, Adolescents and Youth Center (The CAY Center) is a multi-disciplinary behavioral health center for children with complex needs. UMMC has also been a leader in the field of tele-health/tele-medicine.
LIFECORE Health Group	This community mental health center provides integrated	2012-current	Tupelo, MS and throughout a 7-county service area	They provide primary healthcare within the community mental health center setting. Services include a 40-foot mobile clinic and onsite pharmacy.
MDMH, Office of Special Projects and IWG Members	Socialized the Integrated Care concept with partners such as: MS State Department of Health; MS Primary Health Care Association; MS	2012-2016	Statewide	MDMH IWG members undertook a multi-year project to cross train with other stakeholder organizations concerning integrated care. This included numerous conference presentations. IWG members participated on planning committees and development of integrated care tracks for statewide conferences. IWG members also participated in Statewide Health Summits, Forums, etc.

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Who	What	When	Where	Comments
University of Southern MS (USM), School of Social Work and Coastal Family Health Center	Partnership to provide behavioral health services post BP disaster at FQHC; also provides workforce development for SW students	2012-2017		The medical settlement with BP over the BP/Deepwater Horizon disaster funded the MS Integrated Health and Disaster Program at USM; Dr. Timothy Rehner, Director of the USM School of Social Work, leads this program.
MS Department of Mental Health (MDMH)	Offered a Spring Symposium for healthcare providers on the topic of integrated care	2013	Invitation was Statewide; Symposium was held in Flowood, MS	A day-long event entitled, "Improving Quality of Life through Integrating Primary Care and Behavioral Health" was provided with three speakers including Lori Raney, MD, on services provided by Axis Health System in rural Colorado.
MS State Department of Health and State Board of Health	Finalized and adopted Patient-Centered Medical Home Regulations	2013	Statewide	The MS State Department of Health utilized a panel of experts to draft regulations which were adopted by the State Board of Health.
Developmental Evaluation, Training and Educational Consultative Team of MS (DETECT of MS)	Supports healthcare providers and patients with intellectual and developmental disabilities to obtain community-based integrated health care	2014-current	Statewide	DETECT of MS provides educational, training and clinical support services for MS healthcare providers, including the topics of medical and dental issues faced by patients with IDD. For patients with IDD, DETECT of MS helps find community-based health care providers. See http://detectms.com/.
MS State Legislature	Passage of Senate Bill 2829, 2014 Regular Session	2014	Statewide	SB 2829 allows community mental health centers in MS to provide primary care to persons receiving care at the CMHC and to family members within the third degree.
Region 8 Mental Health Services	Offers primary care at its facilities	2014	Brandon, MS and throughout a 5-county service area	Following passage of SB 2829, Dave Van, Region 8 Executive Director, announced that Region 8 would begin to offer primary care at the community mental health center.

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Who	What	When	Where	Comments
MS Integrated Health Statewide Summit; the MS Association of Community Mental Health Centers	A one-day integrated care workshop for Community Mental Health Center leadership was sponsored by the MS Association of Community Mental Health Centers	2014	Jackson, MS	Kathy Reynolds, Vice President of Health Integration and Wellness Promotion with The National Council, came to MS and conducted a workshop to address the implementation of SB 2829 (October 2014).
MDMH, Office of Special Projects; MDMH IWG; Hinds Behavioral Health Services; Jackson-Hinds Comprehensive Health Center	MDMH Won award and implemented a SAMHSA-HRSA CIHS Innovation Community called "Building Integrated Behavioral Health in a Primary Care Setting"	2015-2016	Hinds County, MS	MDMH Special Projects staff administered the CIHS Innovation Community partnering with Hinds Behavioral Health Services (local CMHC) and Jackson-Hinds Comprehensive Health Center (local FQHC).
MS Public Health Institute	Health System Transformation	2016-2017	Jackson, MS	Received a National Network of Public Health Institutes Phase Two grant (funded by Robert Wood Johnson Foundation) and brought together many stakeholders to discuss and plan for health care transformation with integrated care as its chosen focus area.
University of Southern MS, College of Nursing	Workforce development for Nursing Graduate students: 1st Annual Patient-Centered Integrated Care Conference (May 2016)	2016-2018	Hattiesburg, MS	USM College of Nursing received a three-year grant from the Health Resources and Services Administration (HRSA) to offer a post- graduate certificate in another Nurse Practice specialty focus area, including a psychiatric and mental health nurse practitioner. Dr. Katherine Nugent, Dean of the USM College of Nursing, and Dr. Anita Boykins, Associate Dean, provide the leadership on this project.

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Who	What	When	Where	Comments
Primary Care Capacity Project (PCCP)	To expand capacity for and access to high quality, sustainable, community-based health care services, including primary care, behavioral and mental healthcare, and environmental and occupational medicine on the Gulf Coast To increase the exchange of behavioral health information with Coastal Family Health Center (CFHC), a committee under the leadership of the University of Southern MS (USM) School of Social Work, comprised of representatives from the MS Department of Mental Health, CFHC, MS-HIN, and MSPHI has identified potential stakeholders to develop strategies to promote inclusion of behavior health records in the MS-HIN system.	2015-2017	MS Gulf Coast	Funded in part by the Primary Care Capacity Project, a program administered by the Louisiana Public Health Institute (LPHI) through the Gulf Region Health Outreach Program, which was developed jointly by BP and the Plaintiffs' Steering Committee as part of the Deepwater Horizon Settlement. Partners include MSPHI, LPHI, CFHC, MSHIN

Section 2

Areas of Opportunity and Collaboration

Mississippi's successes in implementing integrated care have been built upon the foundation of collaboration. Initially, Mississippi organizations began the pursuit of integrated care and the Triple Aim driven by various impetuses. Much of the early work in this field was accomplished in silos. Over time, the coincidental meeting at conferences and the occasional grant opportunity led to increasing conversations which grew into true collaboration.

The Mississippi Department of Mental Health's (MDMH) creation of an Integration Work Group (IWG) was one of the first attempts to bring together a broad range of stakeholders for educational and strategic planning purposes. Each year, the membership of the IWG grew and expanded, thus did the level of collaboration and influence. In fact, the IWG expanded the traditional view of integrated care in Mississippi by including community-based health care for persons with intellectual and developmental disabilities. By 2015-2016, the IWG had reached a newfound level of activity when it served as the Core Implementation Team for a SAMHSA-HRSA Center for Integrated Health Solutions Innovation Community.

In 2016, the IWG had the opportunity to increase the scope of collaboration activities by working with MSPHI to serve as the advisory committee for the State Forum project. While partnering with MSPHI, the IWG continued to grow and expand in influence beyond its original format at MDMH.

Following the successful State Forum in October 2016, the Roadmap began to take shape. The most pressing need identified by Forum participants and the IWG as the first strategy to implement was to engage a neutral party to coordinate the Integration Work Group in an effort to further promote integrated care. Diana Mikula, MDMH Executive Director also emphasized the need to have a neutral party convene the group and augment it with broader stakeholder representation. MSPHI accepted the invitation to oversee the IWG. MSPHI will work with the group to chart a course to continue promoting integrated care in Mississippi in a strategic and consistent manner. MSPHI has been able to elevate the IWG and has attracted many new stakeholders, including the University of Mississippi Medical Center's new School of Population Health.

Section 3

Action Plan to Support Opportunities

What follows are descriptions of the two main strategies that emerged from the Forum and Work Group collaboration. These strategies formed the basis for this Roadmap. Also included are the rationales for each strategy and considerations in implementing the strategies. All parties agree that there should be ongoing activities steered by the Work Group and the overarching pressing issues are to formalize the Work Group steering and activate a primary care behavior health integration awareness and education campaign.

Strategy 1 –Maintain an influential advisory group, backed by a neutral organization, to further statewide efforts to promote and support integrated care.

Rationale:

The convening organization should be one that helps to eliminate the negative stigma of mental health. In addition, it should hold a substantial amount of influence to facilitate changes, however, it should also be a neutral party.

Considerations:

- An advisory group that is appointed or sponsored by state legislators is not recommended
- Formalize the group and consider calling the Work Group a Steering Committee
- Develop a group charter
- Utilize the term "population health" in the mission
- Allow for the creation of sub-groups that work on targeted projects, such as legal issues
- Meet in more frequent intervals at the beginning (ex. Every 2-4 weeks; then move to quarterly)
- Use a collaborative software program to streamline communications
- Establish a formal process for selecting members
- Outline the main sectors that need representation on the group: Some individuals will represent more than one sector; Not all sectors may be represented and there are even more sectors involved with integrated care

S.3

o Limit group size to 12-18 active participants
o Include mid-level managers who have full support from upper managers
o Include individuals with experience in integrated care; however, they should not make up the entire group. Individuals with lived experience represent the group's target audience and as such are vital to the group's success

In addition to the current Integration Work Group members, other recommendations for augmenting the group include the following stakeholders:

Patient
- Local IDD Advocacy Group
- Local Mental Health/Substance Abuse Patient or Patient Advocate
- General Patient Advocate
- MDMH
- Legal aid/Law Enforcement

Payers
- Public
- Private
- Foundation
- Self-Insurers

Provider (include at least one professional organization)
- Federally Qualified Health Center
- Community Mental Health Center
- Hospital
- Primary Care
- Mental Health -private
- Substance abuse treatment-private or recovery community organization
- IDD representative
- Nurse
- Social Worker

Policy
- Law Enforcement/Legal Aid

Public Health
- Office of Health Disparities or Chronic Disease

Other
Telemedicine
Research

S.3

Strategy 2: Coordinate an Integrated Care Awareness and Education Campaign

Rationale:

There is very low awareness of integrated care across the state and among sectors. Some organizations are already using integrated care approaches as previously described in Section 1– *Scan of Current Mississippi Behavior Health and Primary Care Integration Activity*. While others want to use these approaches, they are unclear how to begin. An awareness and education campaign will provide a unified voice to those working to provide whole body care.

Considerations:

o The campaign should include these basic components:

- Branding strategy
- Logo
- Website
- Social media
- One page fact sheet for policy makers

o The campaign should showcase current integrated care models in the state and use them to define integrated care. A focus can be placed on the financial benefits of integrated care, because those are the strongest selling points.

o The campaign should aim to normalize behavioral health conditions. This can be done subtly by packaging the strategy as a population health approach (which it is) and downplaying the use of the terms: mental health, mental illness, substance abuse, alcoholism, drug use, and addiction. Focus on terms like: whole body, body and mind, how you feel, emotions, holistic, synergy.

o Address the widespread prevalence of behavioral health issues and demystify them by explaining them through personal testimonies. The campaign could plug into some national and local stigma-prevention campaigns.

o Incorporate integrated care practices into the curriculum of health care training across the state. Ideally, this will occur across disciplines and at the collegiate as well as continuing education levels.

o Incorporate integrated care practices into state certification requirements for health care professionals across all disciplines.

o Assist primary care, physical health specialists and behavioral health providers in establishing an electronic referral process through Direct Messaging. Although the technological capability is readily available, easy to use, and compatible across electronic health record (EHR) vendors, electronic referrals are not the primary means of referrals.

S.3

o Promote the exchange of comprehensive patient information across EHR systems among primary care, physical health specialists and behavioral health providers. Collaborate with the Mississippi Health Information Network (MSHIN) to learn more about the Health Information Exchange (HIE) and how best to promote this exchange. See the document developed by the Primary Care Capacity Project in Appendix C—Guidelines for sharing behavior health records.

o Encourage providers to complete the integrated care assessments developed by SAMSHA/HRSA Center for Integrated Care. Examples can be found here: http://www.integration.samhsa.gov/operations-administration/assessment-tools

o Target the following groups and introduce the concept and best practices of integrated care:

a. Providers – of both physical & mental care
b. Payers
c. Patients
d. Policy makers –state, county, city and institutions/companies

o Incorporate integrated care into the outreach efforts of UProot MS, which is the State's Health Improvement Plan (SHIP). One of the SHIP's priorities is promoting a Culture of Health.

o Support the replication and expansion of the Learning Collaborative/Innovation Community approach adapted from the Institute for Healthcare Improvement (IHI) Breakthrough Series Collaborative model. The Learning Collaborative model has been used with several national initiatives, including the National Child Traumatic Stress Network and SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) for its annual Innovation Community series. This model will focus on identifying, sharing, innovating and collaborating concerning best practices which will move key components of the State's service system toward integrated primary and behavioral health care.

Section 4

Mitigation Strategies for Potential Challenges

As mentioned previously, the **greatest challenges to integrated** care in Mississippi are:

- **Losing momentum**, especially with regards to following the recommendations of the State Forum and continuation/advancement of the Integration Work Group
- Tendency to return to **organizational silos**
- **Lack of funding** for direct healthcare services and the role of insurance
- **Lack of funding to support the efforts of the Work Group** to implement some of the activities
- The desperate **need for technology** such as Electronic Health Records systems to manage health data and Tele-health/Tele-medicine resources to reach rural communities (and the requisite funding)
- Need for **new payment systems** with Medicaid and third party payers

Strategies to overcome these issues, or to at least moderate their impact, would include:

- **Continued collaboration**, with the most critical issue being continuation/advancement of the Integration Work Group with a willingness for it to modify its name
- **Continued communication** with partner organizations and an openness to bringing additional entities or individuals into the fold
- **Search for** foundation and federal grants to sustain the activities of the Work Group; utilize public health and behavior health interns to assist with activities and marketing firms that will consider pro bono work to help with the education campaign
- **Frank dialogue** with Mississippi State Legislators and other state leaders concerning strategies to alleviate funding problems
- A **continued socialization** of the importance of integrated care, establishment of statewide evaluation measures and the potential benefits of achieving the Triple Aim in Mississippi
- **Focused efforts** toward more in-depth collaboration with Medicaid and the Mississippi Health Information Network (MSHIN) to better understand barriers and to develop collaborative partnerships

Section 5

How the State Forum Leads to Action

The State Forum engaged a diverse stakeholder group. The Forum also served as a catalyst to increase momentum and visibility of efforts aimed at establishing a comprehensive integrated care system in Mississippi. Forum activities connected people and offered resources that helped participants gain a better understanding of what integrated care means and the role they can play in strengthening efforts. The gallery walk posters have been requested by many stakeholders to share with social work and public health students, use at conference exhibitions and in work places. There was unanimous support for continuing the dialogue about ways to support integration efforts and the need for a dedicated organization to steer the efforts. The following feedback from Forum participants further emphasized its impact:

"I can accurately explain population health to a colleague"

"I can accurately explain integrated care to a colleague"

"Need a presentation or information on Mississippi clinics that have integrated models and outcomes"

"Follow up with opportunities for continued collaboration"

"Expand Work Group to include physicians and psychiatrists"

Conclusion

Mississippi stands at a critical juncture. While progress around behavior and primary health care integration can be touted, there are still major challenges, including the need for additional funding, the need for creation of new payment systems and the role of technology and health data. Progress in these areas will require substantial collaboration with entities such as Medicaid and the Mississippi Health Information Network (MSHIN). There is also a significant need to continue to expand the levels of collaboration, bringing more partners into the Integration Work Group (IWG). Additionally, there is a real need for funding for the IWG to ensure this dedicated group of professionals and passionate individuals can facilitate increasing levels of integration statewide. This will bring better health outcomes to Mississippi's citizens, a better experience of coordinated care for the individual patient and better economic outcomes for Mississippi's service providers and others.

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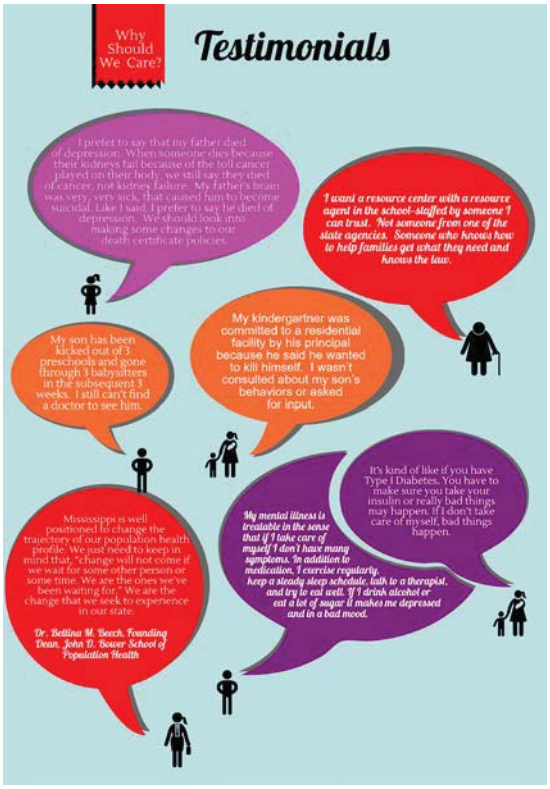
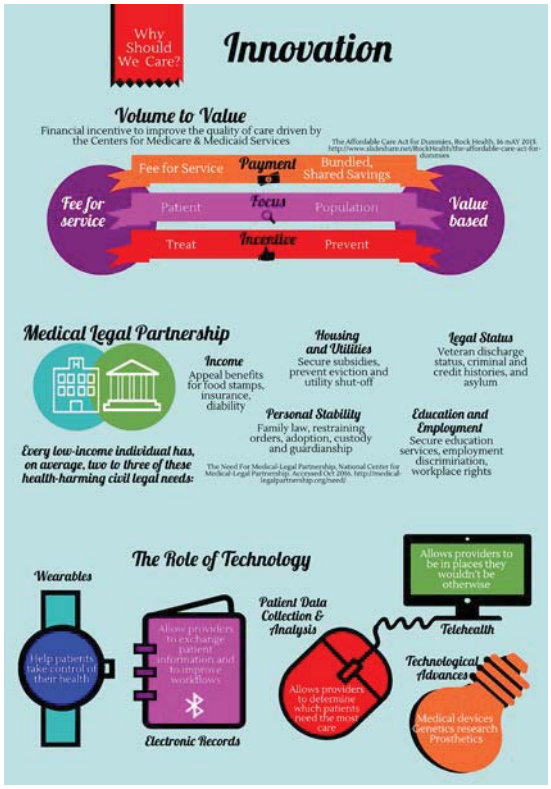
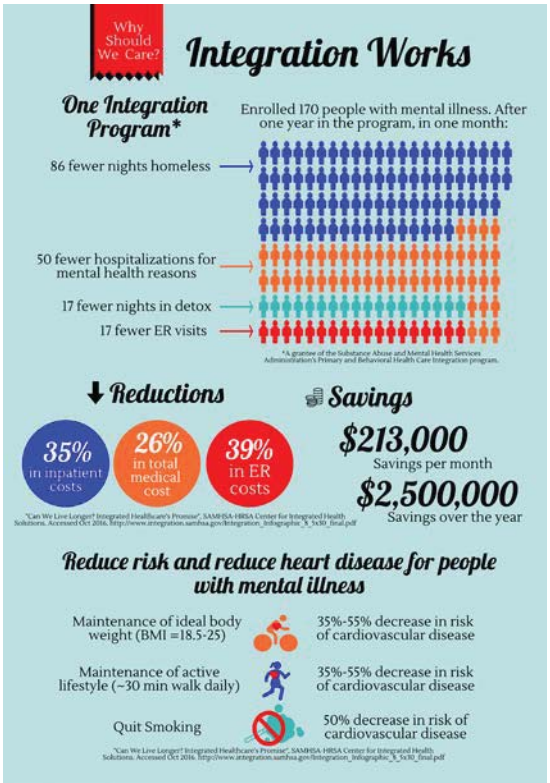
Appendix A

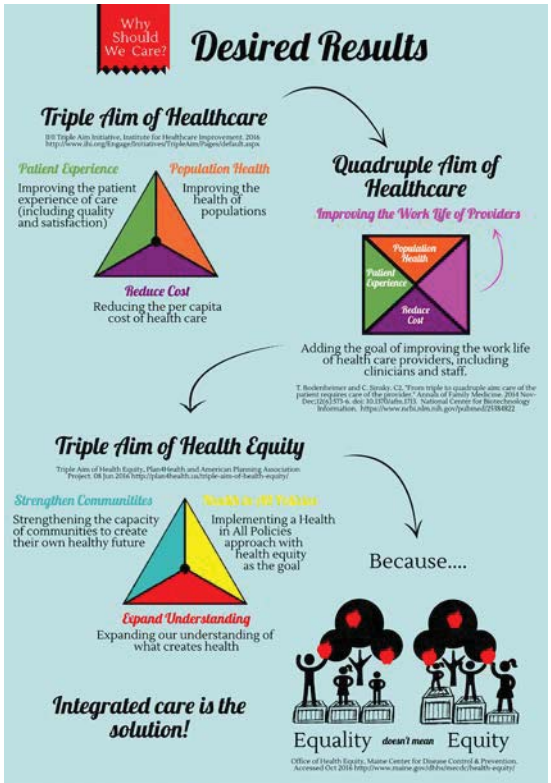
Gallery Walk Posters

A.A


Why Should We Care?
Testimonials
I prefet to say that my father died of depression. When someone dies because their kidneys fail because of the toll cancer played on their body, we still say they died of cancer, not kidney failure. My father's brain was very, very sick, that caused him to become suicidal. Like I said, I prefer to say he died of depression. We should look into making some changes to our death certificate policies.
I want a resource center with a resource agent in the school-staffed by someone I can trust. Not someone from one of the state agencies. Someone who knows how to help families get what they need and knows the law.
My son has been kicked out of 3 preschools and gone through 3 babysitters in the subsequent 3 weeks. I still can't find a doctor to see him.
My kindergartner was committed to a residential facility by his principal because he said he wanted to kill himself. I wasn't consulted about my son's behaviors or asked for input.
It's kind of like if you have Type 1 Diabetes. You have to make sure you take your insulin or really bad things may happen. If I don't take care of myself, bad things happen.
My mental illness is treatable in the sense that if I take care of myself I don't have many symptoms. In addition to medication, I exercise regularly, keep a steady sleep schedule, talk to a therapist, and try to eat well. If I drink alcohol or eat a lot of sugar it makes me depressed and in a bad mood.
Mississippi is well positioned to change the trajectory of our population health profile. We just need to keep in mind that, "change will not come if we wait for some other person or some time. We are the ones we've been waiting for." We are the change that we seek to experience in our state.
Dr. Bettina M. Beech, Founding Dean, John D. Bower School of Population Health

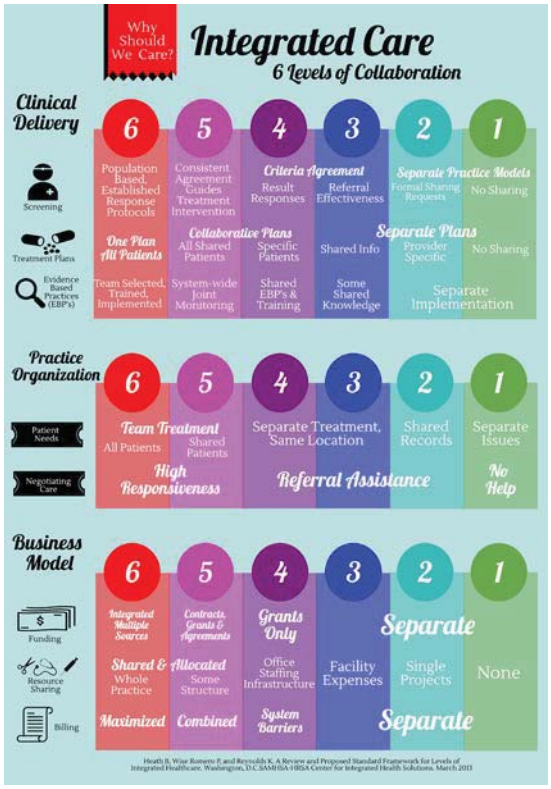

Why Should We Care?
Innovation
Volume to Value
Financial incentive to improve the quality of care driven by the Centers for Medicare & Medicaid Services
The Affordable Care Act for Dummies, Rock Health, 16 mAY 2013. http://www.slideshare.net/RockHealth/the-affordable-care-act-for-dummies
Fee for Service
Payment
Bundled, Shared Savings
Fee for service
Patient
Focus
Population
Value based
Treat
Incentive
Prevent
Medical Legal Partnership
Every low-income individual has, on average, two to three of these health-harming civil legal needs:
Income
Appeal benefits for food stamps, insurance, disability
Housing and Utilities
Secure subsidies, prevent eviction and utility shut-off
Legal Status
Veteran discharge status, criminal and credit histories, and asylum
Personal Stability
Family law, restraining orders, adoption, custody and guardianship
Education and Employment
Secure education services, employment discrimiriation, workplace rights
The Need For Medical-Legal Partnership. National Center for Medical-Legal Partnership. Accessed Oct 2016. http://medical-legalpartnership.org/need/
The Role of Technology
Wearables
Help patients take control of their health
Allow providers to exchange patient information and to improve workflows
Electronic Records
Patient Data Collection & Analysis
Allows providers to determine which patients need the most care
Allows providers to be in places they wouldn't be otherwise
Telehealth
Technological Advances
Medical devices
Genetics research
Prosthetics

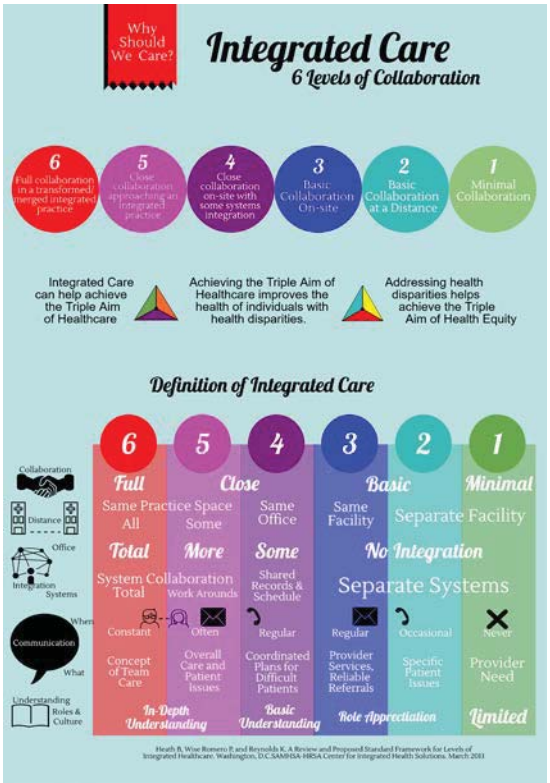

Why Should We Care?
Integration Works
One Integration Program*
Enrolled 170 people with mental illness. After one year in the program, in one month:
86 fewer nights homeless
50 fewer hospitalizations for mental health reasons
17 fewer nights in detox
17 fewer ER visits
*A grantee of the Substance Abuse and Mental Health Services Administration's Primary and Behavioral Health Care Integration program.
Reductions
35% in inpatient costs
26% in total medical cost
39% in ER costs
Savings
$213,000
Savings per month
$2,500,000
Savings over the year
"Can We Live Longer? Integrated Healthcare's Promise", SAMHSA-HRSA Center for Integrated Health Solutions. Accessed Oct 2016. http://www.integration.samhsa.gov/integration_Infographic_8_9x30_final.pdf
Reduce risk and reduce heart disease for people with mental illness
Maintenance of ideal body weight (BMI =18.5-25)
35%-55% decrease in risk of cardiovascular disease
Maintenance of active lifestyle (~30 min walk daily)
35%-55% decrease in risk of cardiovascular disease
Quit Smoking
50% decrease in risk of cardiovascular disease
"Can We Live Longer? Integrated Healthcare's Promise", SAMHSA-HRSA Center for Integrated Health Solutions. Accessed Oct 2016. http://www.integration.samhsa.gov/integration_Infographic_8_9x30_final.pdf

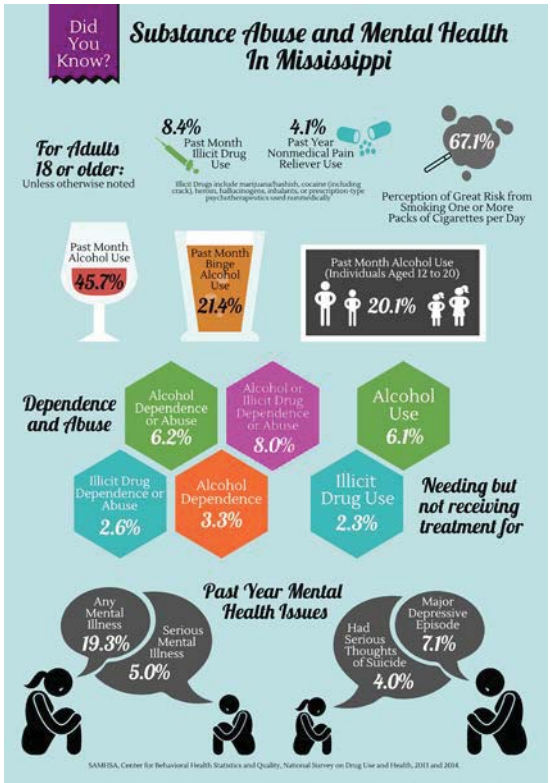

Why Should We Care?
Desired Results
Triple Aim of Healthcare
IHI Triple Aim Initiative, Institute for Healthcare Improvement. 2016 http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx
Patient Experience
Improving the patient experience of care (including quality and satisfaction)
Population Health
Improving the health of populations
Reduce Cost
Reducing the per capita cost of health care
Quadruple Aim of Healthcare
Improving the Work Life of Providers
Population Health
Patient Experience
Reduce Cost
Adding the goal of improving the work life of health care providers, including clinicians and staff.
T. Bodenheimer and C. Sinsky. C2. "From triple to quadruple aim: care of the patient requires care of the provider." Annals of Family Medicine. 2014 Nov-Dec;12(6):573-6. doi: 10.1370/afm.1713. National Center for Biotechnology Information. https://www.ncbi.nlm.nih.gov/pubmed/25384822
Triple Aim of Health Equity
Triple Aim of Health Equity, Plan4health and American Planning Association Project. 08 Jun 2016 http://plan4health.us/triple-aim-of-health-equity/
Strengthen Communities
Strengthening the capacity of communities to create their own healthy future
Health in All Policies
Implementing a Health in All Policies approach with health equity as the goal
Expand Understanding
Expanding our understanding of what creates health
Because....
Integrated care is the solution!
Equality doesn't mean Equity
Office of Health Equity, Maine Center for Disease Control & Prevention. Accessed Oct 2016 http://www.maine.gov/dhhs/mecdc/health-equity/

A.A


Why Should We Care?
Integrated Care
6 Levels of Collaboration
Pros
Cons
6 Full collaboration in a transformed/merged integrated practice
Treat Whole Person
High Functioning Team
Patient Needs Addressed as they occur
Shared Knowledge
Better Response
Sustainability Issues Strain Practice
Few Models to support value
Expected outcomes not established
5 Close collaboration approaching an integrated practice
Responsive Patient Care
Increased Engagement
Treatment Plan Adherence
Increased Flexibility & Satisfaction
Practice changes alienate some providers
High Collaboration takes time
Affect Productivity or Cadence of care
4 Close collaboration on-site with some systems integration
Barrier Remove, closer collaboration
Medical & Behavioral Health Providers more knowledgeable
Patients Viewed as shared
Complete Treatment Plans
System issues limit collaboration
Looser practice boundaries, conflicting agendas cause tension
3 Basic Collaboration On-site
Direct interaction through collaboration
More sucessful referrals
Closer professional relationships
Proximity may not lead to collaboration, limiting value
Developing relationships takes effort
limited flexibility
2 Basic Collaboration at a Distance
No distruptive operating structure change
Some coordination & information
Shareing helpful for patients and providers
Information sharing not enough to effect overall care
Info may not change provider strategy
failed referrals
1 Minimal Collaboration
Timely Autonomous decisions
Understood model by patients & providers
Overlapped, duplicated or conflicting services
Long diagnosis time
Care aspects not addressed
Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013


Why Should We Care?
Integrated Care
6 Levels of Collaboration
Clinical Delivery
6 5 4 3 2 1
Screening
Population Based, Established Response Protocols
Consistent Agreement Guides Treatment Intervention
Criteria Agreement
Result Responses
Referral Effectiveness
Separate Practice Models
Formal Sharing Requests
No Sharing
Treatment Plans
One Plan All Patients
Collaborative Plans
All Shared Patients
Specific Patients
Separate Plans
Shared Info
Provider Specific
No Sharing
Evidence Based Practices (EBP's)
Team Selected, Trained, Implemented
System-wide Joint Monitoring
Shared EBP's & Training
Some Shared Knowledge
Separate Implementation
Practice Organization
6 5 4 3 2 1
Patient Needs
Team Treatment
All Patients
Shared Patients
Separate Treatment, Same Location
Shared Records
Separate Issues
Negotiating Care
High Responsiveness
Referral Assistance
No Help
Business Model
6 5 4 3 2 1
Funding
Integrated Multiple Sources
Contracts, Grants & Agreements
Grants Only
Separate
Resource Sharing
Shared & Allocated
Whole Practice
Some Structure
Office Staffing Infrastructure
Facility Expenses
Single Projects
None
Billing
Maximized
Combined
System Barriers
Separate
Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013


Why Should We Care?
Integrated Care
6 Levels of Collaboration
6 Full collaboration in a transformed/merged integrated practice
5 Close collaboration approaching an integrated practice
4 Close collaboration on-site with some systems integration
3 Basic Collaboration On-site
2 Basic Collaboration at a Distance
1 Minimal Collaboration
Integrated Care can help achieve the Triple Aim of Healthcare
Achieving the Triple Aim of Healthcare improves the health of individuals with health disparities.
Addressing health disparities helps achieve the Triple Aim of Health Equity
Definition of Integrated Care
6 5 4 3 2 1
Full
Close
Basic
Minimal
Collaboration
Distance
Office
Integration
Systems
Communication
When
What
Understanding
Roles & Culture
Same Practice Space All
Same Office
Same Facility
Separate Facility
Total
More
Some
No Integration
System Collaboration Total
Work Arounds
Shared Records & Schedule
Separate Systems
Constant
Often
Regular
Regular
Occasional
Never
Concept of Team Care
Overall Care and Patient Issues
Coordinated Plans for Difficult Patients
Provider Services, Reliable Referrals
Specific Patient Issues
Provider Need
In-Depth Understanding
Basic Understanding
Role Appreciation
Limited
Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013


Did You Know?
Substance Abuse and Mental Health In Mississippi
For Adults 18 or older:
Unless otherwise noted
8.4%
Past Month Illicit Drug Use
4.1%
Past Year Nonmedical Pain Reliever Use
Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically
67.1%
Perception of Great Risk from Smoking One or More Packs of Cigarettes per Day
Past Month Alcohol Use
45.7%
Past Month Binge Alcohol Use
21.4%
Past Month Alcohol Use (Individuals Aged 12 to 20)
20.1%
Dependence and Abuse
Alcohol Dependence or Abuse 6.2%
Alcohol or Illicit Drug Dependence or Abuse 8.0%
Alcohol Use 6.1%
Illicit Drug Dependence or Abuse 2.6%
Alcohol Dependence 3.3%
Illicit Drug Use 2.3%
Needing but not receiving treatment for
Past Year Mental Health Issues
Any Mental Illness 19.3%
Serious Mental Illness 5.0%
Had Serious Thoughts of Suicide 4.0%
Major Depressive Episode 7.1%
SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013 and 2014.

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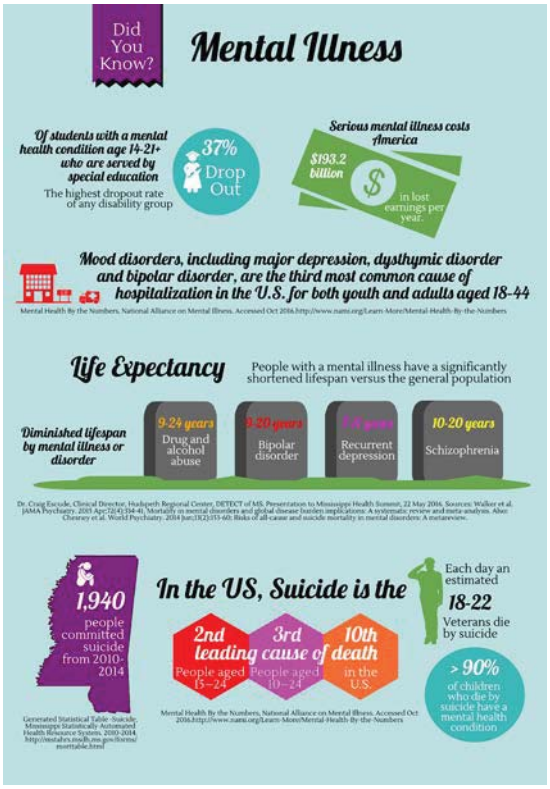
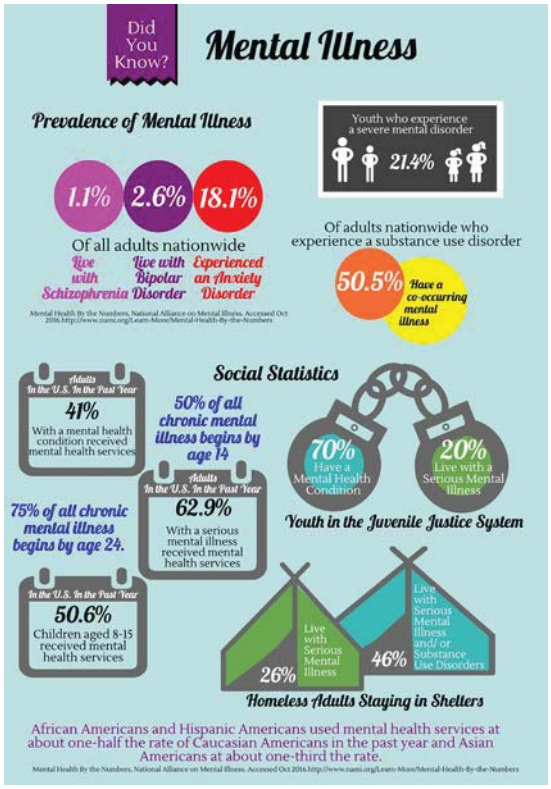
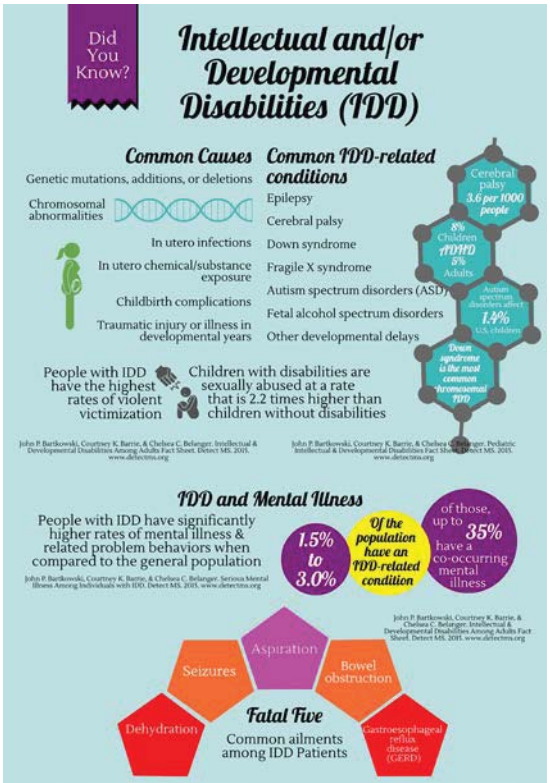
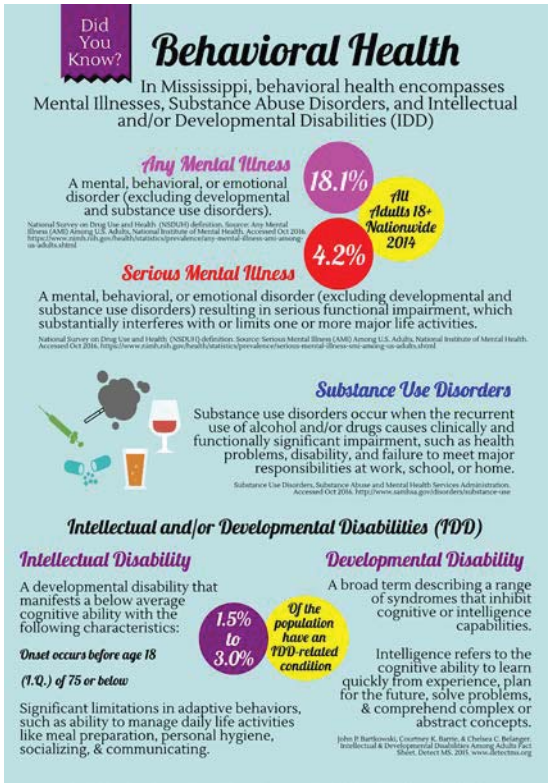

Did You Know?
Mental Illness
Of students with a mental health condition age 14-21+ who are served by special education
The highest dropout rate of any disability group
37% Drop Out
Serious mental illness costs America
$193.2 billion
in lost earnings per year.
Mood disorders, including major depression, dysthymic disorder and bipolar disorder, are the third most common cause of hospitalization in the U.S. for both youth and adults aged 18-44
Life Expectancy
People with a mental illness have a significantly shortened lifespan versus the general population
Diminished lifespan by mental illness or disorder
9-24 years Drug and alcohol abuse
9-50 years Bipolar disorder
9-5 years Recurrent depression
10-20 years Schizophrenia
1,940 people committed suicide from 2010-2014
In the US, Suicide is the
2nd leading cause of death People aged 15–24
3rd leading cause of death People aged 10–24
10th leading cause of death in the U.S.
Each day an estimated 18-22 Veterans die by suicide
> 90% of children who die by suicide have a mental health condition


Did You Know?
Mental Illness
Prevalence of Mental Illness
1.1% Live with Schizophrenia
2.6% Live with Bipolar Disorder
18.1% Experienced an Anxiety Disorder
Of all adults nationwide
Youth who experience a severe mental disorder
21.4%
Of adults nationwide who experience a substance use disorder
50.5% Have a co-occurring mental illness
Social Statistics
Adults In the U.S. In the Past Year
41% With a mental health condition received mental health services
50% of all chronic mental illness begins by age 14
75% of all chronic mental illness begins by age 24.
Adults In the U.S. In the Past Year
62.9% With a serious mental illness received mental health services
70% Have a Mental Health Condition
20% Live with a Serious Mental Illness
Youth in the Juvenile Justice System
In the U.S. In the Past Year
50.6% Children aged 8-15 received mental health services
26% Live with Serious Mental Illness
46% Live with Serious Mental Illness and/or Substance Use Disorders
Homeless Adults Staying in Shelters
African Americans and Hispanic Americans used mental health services at about one-half the rate of Caucasian Americans in the past year and Asian Americans at about one-third the rate.


Did You Know?
Intellectual and/or Developmental Disabilities (IDD)
Common Causes
Genetic mutations, additions, or deletions
Chromosomal abnormalities
In utero infections
In utero chemical/substance exposure
Childbirth complications
Traumatic injury or illness in developmental years
Common IDD-related conditions
Epilepsy
Cerebral palsy
Down syndrome
Fragile X syndrome
Autism spectrum disorders (ASD)
Fetal alcohol spectrum disorders
Other developmental delays
Cerebral palsy 3.6 per 1000 people
8% Children ADHD 5% Adults
Autism spectrum disorders affect: 1.4% U.S. children
Down syndrome is the most common chromosomal IDD
People with IDD have the highest rates of violent victimization
Children with disabilities are sexually abused at a rate that is 2.2 times higher than children without disabilities
IDD and Mental Illness
People with IDD have significantly higher rates of mental illness & related problem behaviors when compared to the general population
1.5% to 3.0% Of the population have an IDD-related condition
of those, up to 35% have a co-occurring mental illness
Fatal Five
Common ailments among IDD Patients
Aspiration
Bowel obstruction
Gastroesophageal reflux disease (GERD)
Dehydration
Seizures


Did You Know?
Behavioral Health
In Mississippi, behavioral health encompasses Mental Illnesses, Substance Abuse Disorders, and Intellectual and/or Developmental Disabilities (IDD)
Any Mental Illness
A mental, behavioral, or emotional disorder (excluding developmental and substance use disorders).
18.1% All Adults 18+ Nationwide 2014
Serious Mental Illness
A mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.
4.2%
Substance Use Disorders
Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.
Intellectual and/or Developmental Disabilities (IDD)
Intellectual Disability
A developmental disability that manifests a below average cognitive ability with the following characteristics:
Onset occurs before age 18
(I.Q.) of 75 or below
Significant limitations in adaptive behaviors, such as ability to manage daily life activities like meal preparation, personal hygiene, socializing, & communicating.
1.5% to 3.0% Of the population have an IDD-related condition
Developmental Disability
A broad term describing a range of syndromes that inhibit cognitive or intelligence capabilities.
Intelligence refers to the cognitive ability to learn quickly from experience, plan for the future, solve problems, & comprehend complex or abstract concepts.

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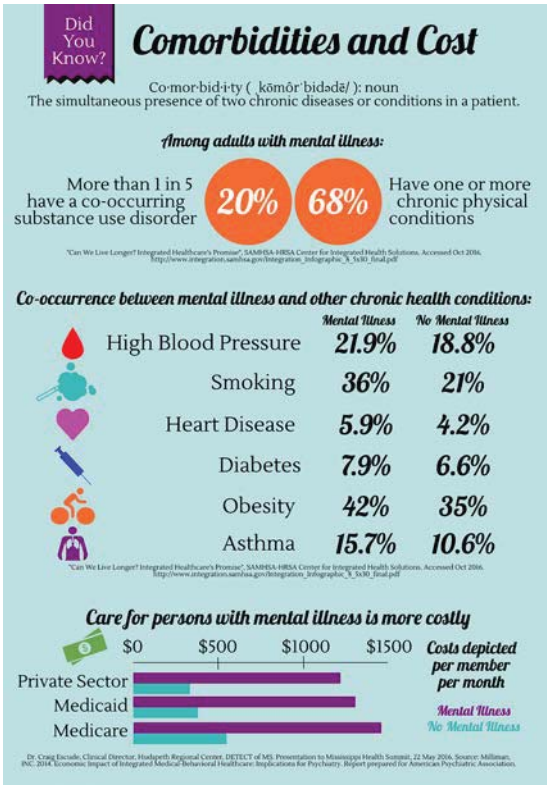
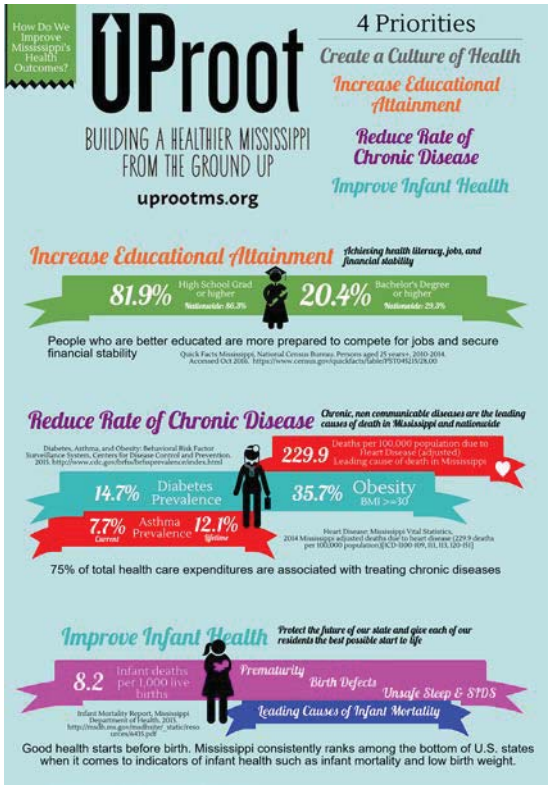
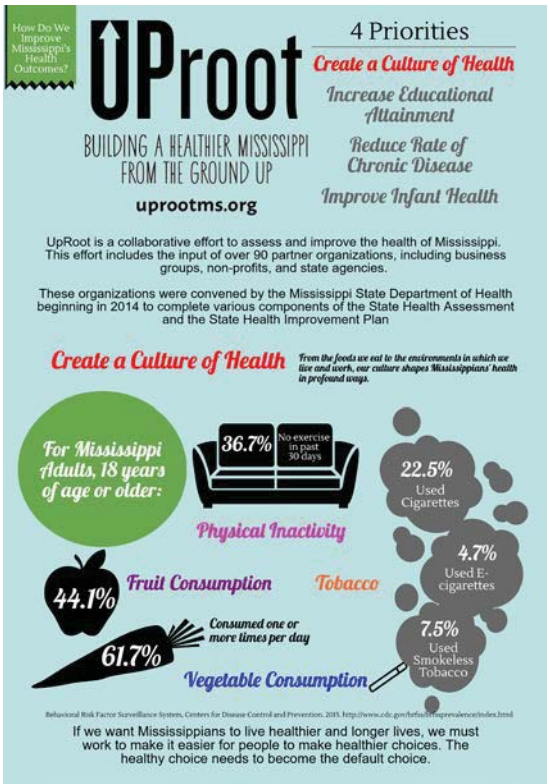
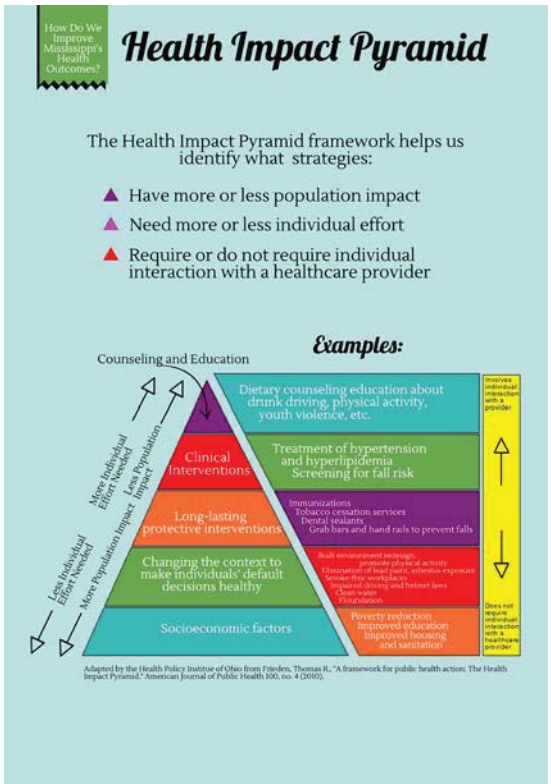

Did You Know?
Comorbidities and Cost
Co·mor·bid·i·ty (ˌkōmôrˈbidədē/): noun
The simultaneous presence of two chronic diseases or conditions in a patient.
Among adults with mental illness:
More than 1 in 5 have a co-occurring substance use disorder
20%
68%
Have one or more chronic physical conditions
"Can We Live Longer? Integrated Healthcare's Promise", SAMHSA-HRSA Center for Integrated Health Solutions. Accessed Oct 2016. http://www.integration.samhsa.gov/integration_Infographic_9_5x30_final.pdf
Co-occurrence between mental illness and other chronic health conditions:
Mental Illness
No Mental Illness
High Blood Pressure 21.9% 18.8%
Smoking 36% 21%
Heart Disease 5.9% 4.2%
Diabetes 7.9% 6.6%
Obesity 42% 35%
Asthma 15.7% 10.6%
"Can We Live Longer? Integrated Healthcare's Promise", SAMHSA-HRSA Center for Integrated Health Solutions. Accessed Oct 2016. http://www.integration.samhsa.gov/integration_Infographic_9_5x30_final.pdf
Care for persons with mental illness is more costly
$0
$500
$1000
$1500
Costs depicted per member per month
Private Sector
Medicaid
Medicare
Mental Illness
No Mental Illness
Dr. Craig Escude, Clinical Director, Hudspeth Regional Center, DETECT of MS. Presentation to Mississippi Health Summit, 22 May 2016. Source: Milliman, INC. 2014. Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry. Report prepared for American Psychiatric Association.


How Do We Improve Mississippi's Health Outcomes?
UProot
BUILDING A HEALTHIER MISSISSIPPI FROM THE GROUND UP
uprootms.org
4 Priorities
Create a Culture of Health
Increase Educational Attainment
Reduce Rate of Chronic Disease
Improve Infant Health
Increase Educational Attainment
Achieving health literacy, jobs, and financial stability
81.9% High School Grad or higher
Nationwide: 86.3%
20.4% Bachelor's Degree or higher
Nationwide: 29.3%
People who are better educated are more prepared to compete for jobs and secure financial stability
Quick Facts Mississippi, National Census Bureau. Persons aged 25 years+, 2010-2014. Accessed Oct 2016. https://www.census.gov/quickfacts/table/PST045215/28,00
Reduce Rate of Chronic Disease
Chronic, non communicable diseases are the leading causes of death in Mississippi and nationwide
Diabetes, Asthma, and Obesity: Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention. 2015. http://www.cdc.gov/brfss/brfssprevalence/index.html
229.9 Deaths per 100,000 population due to Heart Disease (adjusted) Leading cause of death in Mississippi
14.7% Diabetes Prevalence
35.7% Obesity BMI >=30
7.7% Asthma Prevalence Current
12.1% Lifetime
Heart Disease: Mississippi Vital Statistics, 2014 Mississippi adjusted deaths due to heart disease (229.9 deaths per 100,000 population) [ICD-1000-109, 111, 113, 120-151]
75% of total health care expenditures are associated with treating chronic diseases
Improve Infant Health
Protect the future of our state and give each of our residents the best possible start to life
8.2 Infant deaths per 1,000 live births
Prematurity
Birth Defects
Unsafe Sleep & SIDS
Leading Causes of Infant Mortality
Infant Mortality Report, Mississippi Department of Health, 2015. http://msdh.ms.gov/msdhsite/_static/resources/6435.pdf
Good health starts before birth. Mississippi consistently ranks among the bottom of U.S. states when it comes to indicators of infant health such as infant mortality and low birth weight.


How Do We Improve Mississippi's Health Outcomes?
UProot
BUILDING A HEALTHIER MISSISSIPPI FROM THE GROUND UP
uprootms.org
4 Priorities
Create a Culture of Health
Increase Educational Attainment
Reduce Rate of Chronic Disease
Improve Infant Health
UpRoot is a collaborative effort to assess and improve the health of Mississippi. This effort includes the input of over 90 partner organizations, including business groups, non-profits, and state agencies.
These organizations were convened by the Mississippi State Department of Health beginning in 2014 to complete various components of the State Health Assessment and the State Health Improvement Plan
Create a Culture of Health
From the foods we eat to the environments in which we live and work, our culture shapes Mississippians' health in profound ways.
For Mississippi Adults, 18 years of age or older:
36.7% No exercise in past 30 days
Physical Inactivity
44.1%
Fruit Consumption
61.7%
Consumed one or more times per day
Vegetable Consumption
Tobacco
22.5% Used Cigarettes
4.7% Used E-cigarettes
7.5% Used Smokeless Tobacco
Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention. 2015. http://www.cdc.gov/brfss/brfssprevalence/index.html
If we want Mississippians to live healthier and longer lives, we must work to make it easier for people to make healthier choices. The healthy choice needs to become the default choice.


How Do We Improve Mississippi's Health Outcomes?
Health Impact Pyramid
The Health Impact Pyramid framework helps us identify what strategies:
Have more or less population impact
Need more or less individual effort
Require or do not require individual interaction with a healthcare provider
Examples:
Counseling and Education
Dietary counseling education about drunk driving, physical activity, youth violence, etc.
Clinical Interventions
Treatment of hypertension and hyperlipidemia
Screening for fall risk
Long-lasting protective interventions
Immunizations
Tobacco cessation services
Dental sealants
Grab bars and hand rails to prevent falls
Changing the context to make individuals' default decisions healthy
Built environment redesign, promote physical activity
Elimination of lead paint, asbestos exposure
Smoke-free workplaces
Required driving and helmet laws
Clean water
Fluoridation
Socioeconomic factors
Poverty reduction
Improved education
Improved housing and sanitation
More Individual Effort Needed
Less Population Impact
Less Individual Effort Needed
More Population Impact
Involves individual interaction with a provider
Does not require individual interaction with a healthcare provider
Adapted by the Health Policy Institute of Ohio from Frieden, Thomas R., "A framework for public health action: The Health Impact Pyramid," American Journal of Public Health 100, no. 4 (2010).

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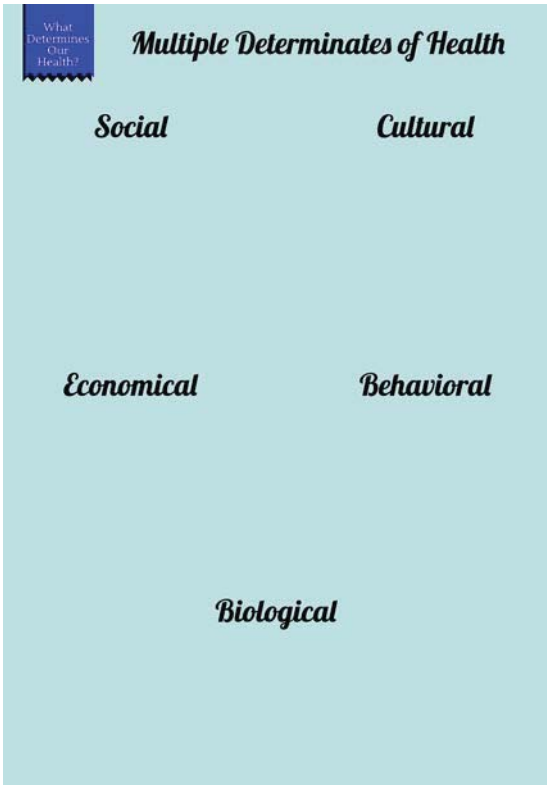
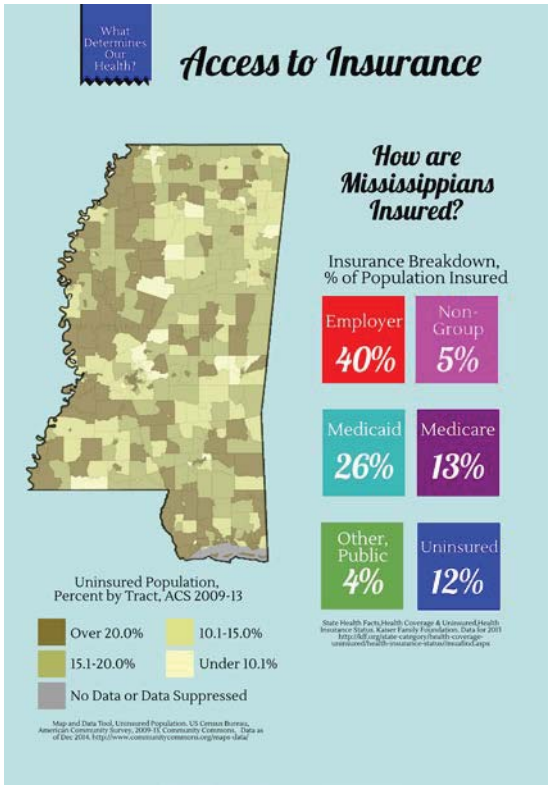
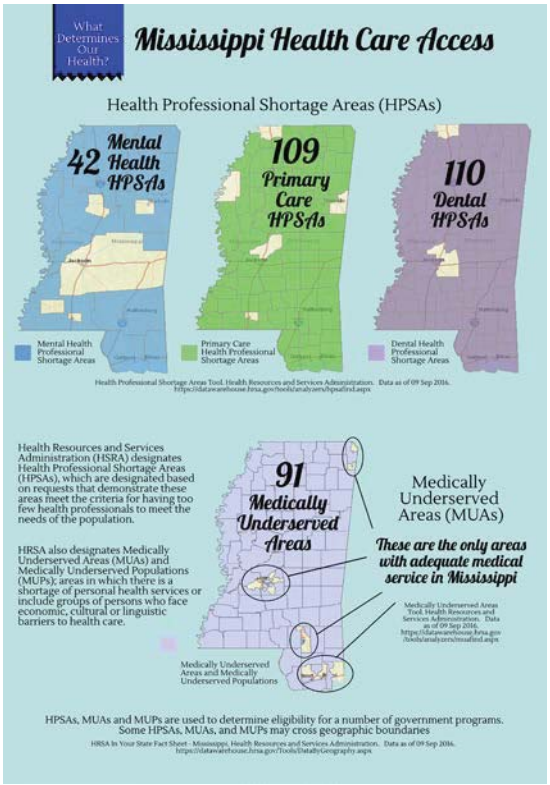
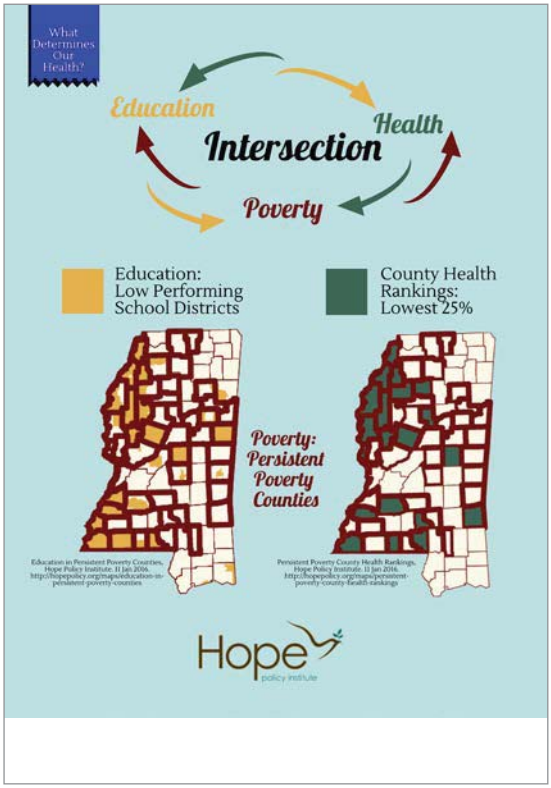

What Determines Our Health?
Multiple Determinates of Health
Social
Cultural
Economical
Behavioral
Biological


What Determines Our Health?
Access to Insurance
How are Mississippians Insured?
Insurance Breakdown, % of Population Insured
Employer 40%
Non-Group 5%
Medicaid 26%
Medicare 13%
Other, Public 4%
Uninsured 12%
Uninsured Population, Percent by Tract, ACS 2009-13
Over 20.0%
15.1-20.0%
10.1-15.0%
Under 10.1%
No Data or Data Suppressed


What Determines Our Health?
Mississippi Health Care Access
Health Professional Shortage Areas (HPSAs)
42 Mental Health HPSAs
109 Primary Care HPSAs
110 Dental HPSAs
Mental Health Professional Shortage Areas
Primary Care Health Professional Shortage Areas
Dental Health Professional Shortage Areas
Health Resources and Services Administration (HSRA) designates Health Professional Shortage Areas (HPSAs), which are designated based on requests that demonstrate these areas meet the criteria for having too few health professionals to meet the needs of the population.
HRSA also designates Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs); areas in which there is a shortage of personal health services or include groups of persons who face economic, cultural or linguistic barriers to health care.
91 Medically Underserved Areas
Medically Underserved Areas (MUAs)
These are the only areas with adequate medical service in Mississippi
Medically Underserved Areas and Medically Underserved Populations
HPSAs, MUAs and MUPs are used to determine eligibility for a number of government programs. Some HPSAs, MUAs, and MUPs may cross geographic boundaries


What Determines Our Health?
Education
Health
Poverty
Intersection
Education: Low Performing School Districts
County Health Rankings: Lowest 25%
Poverty: Persistent Poverty Counties
Hope policy institute

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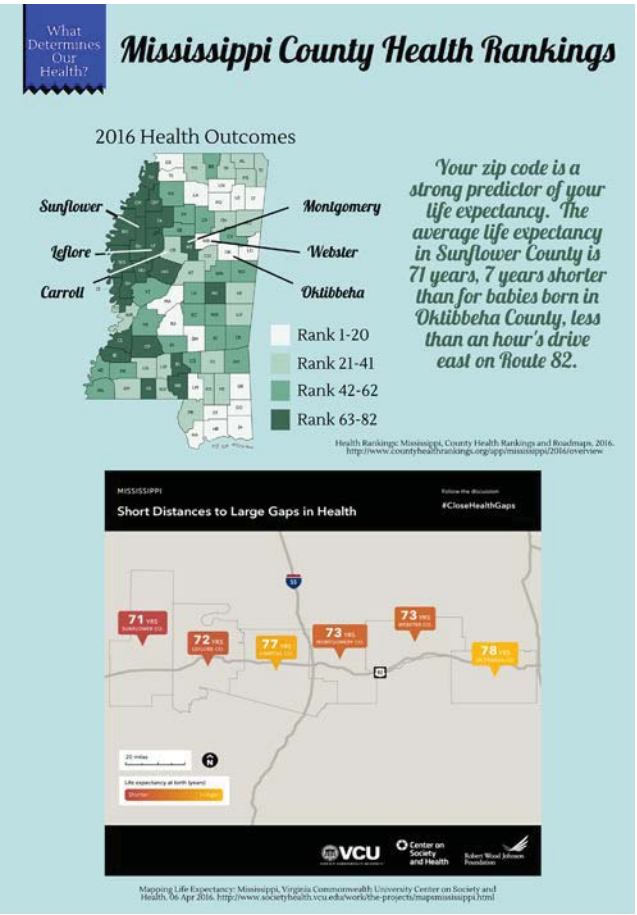
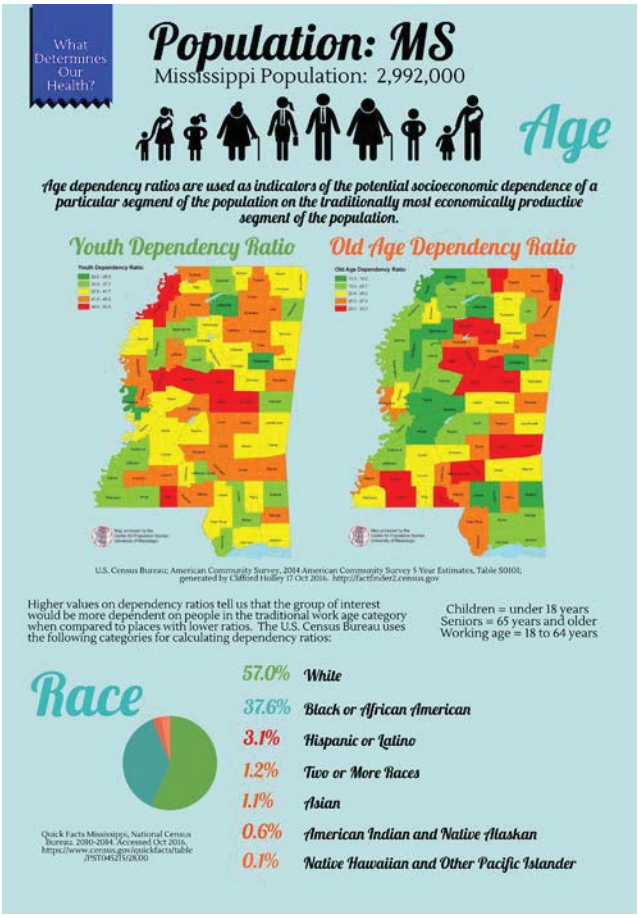
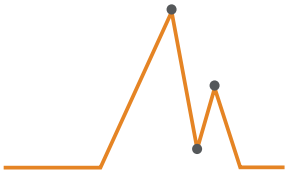

What Determines Our Health?
Mississippi County Health Rankings
2016 Health Outcomes
Sunflower
Leflore
Carroll
Montgomery
Webster
Oktibbeha
Rank 1-20
Rank 21-41
Rank 42-62
Rank 63-82
Your zip code is a strong predictor of your life expectancy. The average life expectancy in Sunflower County is 71 years, 7 years shorter than for babies born in Oktibbeha County, less than an hour's drive east on Route 82.
Health Rankings: Mississippi, County Health Rankings and Roadmaps. 2016. http://www.countyhealthrankings.org/app/mississippi/2016/overview
MISSISSIPPI
Short Distances to Large Gaps in Health
#CloseHealthGaps
71 YRS
72 YRS
77 YRS
73 YRS
73 YRS
78 YRS
VCU
Center on Society and Health
Robert Wood Johnson Foundation
Mapping Life Expectancy: Mississippi, Virginia Commonwealth University Center on Society and Health. 06 Apr 2016. http://www.societyhealth.vcu.edu/work/the-projects/mapsmississippi.html


What Determines Our Health?
Population: MS
Mississippi Population: 2,992,000
Age
Age dependency ratios are used as indicators of the potential socioeconomic dependence of a particular segment of the population on the traditionally most economically productive segment of the population.
Youth Dependency Ratio
Old Age Dependency Ratio
U.S. Census Bureau; American Community Survey, 2014 American Community Survey 5-Year Estimates, Table S0101; generated by Clifford Holley 17 Oct 2016. http://factfinder2.census.gov
Higher values on dependency ratios tell us that the group of interest would be more dependent on people in the traditional work age category when compared to places with lower ratios. The U.S. Census Bureau uses the following categories for calculating dependency ratios:
Children = under 18 years
Seniors = 65 years and older
Working age = 18 to 64 years
Race
57.0% White
37.6% Black or African American
3.1% Hispanic or Latino
1.2% Two or More Races
1.1% Asian
0.6% American Indian and Native Alaskan
0.1% Native Hawaiian and Other Pacific Islander
Quick Facts Mississippi, National Census Bureau, 2010-2014. Accessed Oct 2016. https://www.census.gov/quickfacts/table/PST045215/28,00

Appendix B

Guidance Document for Sharing Behavior Health Records



Data → Sharing
of Protected Health Information

March 31, 2016

The integration of primary care and behavioral / mental health services is essential for providing high quality health care. The exchange or "sharing" of patient data between health providers (primary care and behavioral/ mental health) is necessary for continuity of care in the best of times and essential in times of crisis (i.e., disasters, disoriented patients). Old regulations about data-sharing have not kept pace with electronic medical records nor the capacity for electronic data to increase the efficacy of the treatment process. Health providers have often maintained very restrictive data-sharing protocols – particularly related to "protected" behavioral / mental health and substance use disorder treatment records. The aim of this document is to define what patient data can be shared.

This document is designed to:

(1) Encourage data-sharing between primary care and behavioral /mental health providers using the Mississippi Health Information Exchange (MS-HIN), the state's health information exchange
(2) Emphasize the importance of data-sharing to enhance quality of patient care and
(3) Eliminate misunderstandings that prevent data-sharing between providers

Encourage Data Sharing

MS-HIN is the state agency responsible for facilitating secure data-sharing of patients' medical records between multiple health care providers so as to improve the quality and efficacy of health care for all Mississippians. Patient's medical records must be shared between providers if patient records and continuity of care is to exist for people that move between providers, counties, and across Mississippi. Data-sharing of patient records through electronic means using health information technology is the most efficient and comprehensive method for doing so.

Emphasize data-sharing to enhance quality of patient care

Data-sharing of patient health information provides the most current and accurate data necessary for high quality health systems and conscientious and effective health providers. In our mobile and high-paced society, accurate data available at the time that services are delivered is essential. MS-HIN provides that linkage between past medical and or behavioral / mental health contacts and any present or current health situation.

Eliminate Misunderstandings

Old state and federal regulations governing data-sharing - particularly as they relate to patients with behavioral/ mental health issues - have been very problematic. This was particularly true after Hurricane Katrina when people traveled across the state and did not know what diagnoses or medications they were taking or needed. These same patients then needed services in an emergency room or out-patient clinic and health data was not available or was not released.

A common misunderstanding by health providers has been that behavioral / mental health records could never be shared without patient consent unless it was an emergency situation. In an effort to eliminate this misunderstanding for health providers, MS-HIN requested an *Official Opinion* (https://goo.gl/R6uEJ9) from the State of Mississippi's Attorney General Jim Hood. On November 13, 2015 the Attorney General opined that doctors were allowed to consult and share certain behavioral / mental health information that could be used for the treatment of patients. Data-sharing with MS-HIN for such uses constituted acceptable practices and violated no federal or state laws (HIPAA - 45 CFR 164.502; Miss. Code 41-119-13). Furthermore, data-sharing of protected health information can be submitted lawfully to MS-HIN for the purpose of treatment without patient consent (Miss. Code Section 41-21-97). The only exclusions to this opinion were *psychotherapy notes* and *substance abuse treatment records*.

This document provides guidance for frequently asked questions and cannot be relied on as legal advice. Questions regarding how this information applies in your practice should be directed to your legal counsel and/or Privacy Officer.

A.B

Data → Sharing

of Protected Health Information

March 31, 2016

CAN be Shared?	*CANNOT* be Shared?
Miss. Code Section 41-119-13 and 45 CFR 164.501 allow the following to be submitted and shared. Further, Section 41-21-97 supports the sharing of behavioral and mental health records without express patient consent when done so in furtherance of treatment of the patient. • Medication prescription and monitoring • Counseling session start and stop times • Modalities and frequencies of treatment • Results of clinical tests (blood, lithium, etc.) • Diagnosis summaries • Functional status summaries • Treatment plan summaries • Symptoms and prognostic summaries • Progress to date	The following behavioral / mental health records **CANNOT** be shared without patient consent: • **Psychotherapy notes** may not be shared without a signed consent. 45 CFR 164.508(a)(2). • Records related to substance use disorder treatment are treated differently than behavioral and mental health records and may not be released without a signed consent. These regulations may be found in 42 CFR Part 2 § 2.1 which strictly prohibits the sharing of records related to treatment for substance use disorders for any purpose without a written consent, unless it is a documented medical emergency and you have the ability to electronically tag the information to prevent searches and access.

This document provides guidance for frequently asked questions and cannot be relied on as legal advice. Questions regarding how this information applies in your practice should be directed to your legal counsel and/or Privacy Officer.

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MSPHI
Mississippi Public Health Institute