Baby Steps to Integrating Behavioral Health in Primary Care Settings

Presented to Michigan Primary Care Association- Putting the Pieces Together

October 15, 2014
Outline

• Introduction
• Detroit Wayne Mental Health Authority
• Integrated Healthcare Initiative
• Why Is It Important For You: The Problem
• Forces of Change
• Integrated Healthcare in Primary Care
• Policy Changes Underway
• Baby Steps to Integrated Care

The CMHSP shall provide mental health and developmental disability supports and services to individuals described in Section 1.2 below who are located in or whose county of residence is determined to be in the County of the CMHSP MH/DD service area.

Target Population
The CMHSP shall direct and prioritize services to individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in MCL 330.1208. The CMHSP shall also provide medically necessary defined mental health benefits to children enrolled in the MIChild program and those certified in the Children’s Waiver program.
Prepaid Inpatient Health Plan/ Regional Entity

Prepaid Inpatient Health Plan (PIHP):
An organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR part 401 et al June 14, 2002, regarding Medicaid managed care. (In Medicaid regulations, Prepaid Health Plans (PHPs) that are responsible for inpatient services as part of a benefit package are now referred to as "PIHP".

A Regional Entity established under this section is a public governmental entity separate from the county, authority, or organization that establishes it.
Detroit Wayne Mental Health Authority

Detroit Wayne Mental Health Authority (DWMHA) established October 1, 2013, through legislation, and enabling legislation of Wayne County. Tom Watkins, President and CEO.

DWMHA is the Regional Entity/Authority which functions as the PIHP, CMHSP, and previously the Coordinating Agency for Substance Use Disorders in Wayne County.
Our Authority Vision

To be a culturally proficient leader in the community that is supportive and embraces individuals with disabilities in community life in a manner that reflects the values, roles and responsibilities of full and meaningful citizenship. The values of this organization are intended to advance and support recovery, self-determination and integrated healthcare principles to help benefit the community.
Organization of Community Mental Health System for Serious Mental Illness, Intellectual/Developmental Disability, Substance Use Disorders for Medical and Uninsured Persons in Wayne County

Detroit Wayne Mental Health Authority Board of Directors

Detroit Wayne Mental Health Authority (DWMHA)

Access Center/Crisis Line
Pioneer

Managers of Comprehensive Provider Networks (MPCNs)
To Be Determined

PROVIDERS: Mental Illness; Intellectual/Developmental Disability; Hospitals; etc.

SUD PROVIDERS: Prevention, Treatment and Recovery

AFFILIATED PROVIDERS FOR MI HEALTH LINK PROGRAM:
Mental Illness; Intellectual/Developmental Disability; Hospitals; etc.

10/20/2014
FY 2013 - DWMHA Number of Behavioral Health Consumers Served
Total= 75,742*

*Substance Use Disorder Consumers not included in this number.
SMI=Serious Mentally Ill; DD=Developmentally Disabled; SED= Seriously Emotionally Distrubed; MI= Mild Mental Illness
Journey to Integrated Care for Behavioral Health in Wayne County

We are building the car, while we are driving it.
Mission/Vision

Integrated Healthcare Initiatives

Mission:
To facilitate and create an infrastructure for coordinated and integrated mental health, substance use, and physical health care for persons with serious persistent mental illness (SPMI)/Co-occurring mental illness and substance use disorders, intellectual/developmental disabilities (I/DD), and serious emotional disturbances (SED).

Vision:
DWMHA Consumers will be able to enter at any door and receive recovery oriented services and supports from health care professionals who are welcoming and trained to deliver integrated health care that meets their mental health, substance use, and physical health care needs.
## Organization’s Model of Integration

Variable Based on the Needs of the Consumer Population

<table>
<thead>
<tr>
<th>COORDINATED</th>
<th>CO-LOCATED</th>
<th>INTEGRATED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key Element: Communication</strong></td>
<td><strong>Key Element: Physical Proximity</strong></td>
<td><strong>Key Element: Practice Change</strong></td>
</tr>
<tr>
<td>Level 1: Minimal collaboration</td>
<td>Level 2: Basic collaboration at a distance</td>
<td>Level 3: Basic collaboration on-site</td>
</tr>
<tr>
<td>Level 4: Close collaboration in a partly integrated system</td>
<td>Level 5: Close collaboration approaching a fully integrated system</td>
<td>Level 6: Close collaboration in fully integrated system</td>
</tr>
</tbody>
</table>

**Primary care providers and behavioral health providers work in separate facilities, have separate systems, and communicate sporadically**

Primary care and behavioral health have separate systems at separate sites, but share the same facility. Proximity allows for increased communication about shared patients.

Primary care and behavioral health have separate systems, but share the same facility. Proximity allows for increased communication about shared patients.

Primary care and behavioral health care providers share the same facility and have some of the same systems in common. Face-to-face communication or shared treatment plans may occur.

Primary care and behavioral health care providers share the same system, overcoming barriers and limits to traditional care and funding structures. Joint assessment and treatment plans are standard and all providers have shared responsibility for outcomes. System is cohesive and holistic.

Primary care and behavioral health care providers work in separate facilities, have separate systems, and communicate sporadically.

Primary care and behavioral health providers work in separate facilities, have separate systems, and communicate periodically about shared patients.

Primary care and behavioral health providers share the same facility, the same vision, and the same system. Unified services are provided to all patients. Primary care and behavioral health care staff interact regularly and provide team-based approach to patient care.
DWMHA Provider's Level of Integration - 2014
Based on SAMHSA/HRSA Center for Integrated Health Solutions Level of Integration Framework

In 2014, 63% of providers are at level 4 or greater. 13% increase from 2013.
Observations

- Lots of collaborative partnerships
  - 58% site of integration at the physical health location
  - 42% site of integration at the mental health location

- Funding for collaborative partnerships
  - 50% from grant for partnership at the physical health location
  - 17% shared from the mental health and physical health provider at the physical health location
  - 95% from the mental health provider for partnerships at the mental health location
Observations

- Routine Assessment of BH and PH needs
  - Not consistently performed at mental health or physical health locations
- Shared Treatment Planning
  - 80% at mental health site of integration
  - 56% at physical health site of integration
- Multi-disciplinary team meetings
  - 82% at mental health site of integration
  - 70% at physical health site of integration
- Shared Medical Records
  - 63% at mental health site of integration
  - 50% at physical health site of integration
Observations from FQHC Meetings

- With a few exceptions, majority of FQHC and FQHC Look A Likes carry out the behavioral health service offering through referral relationships with local CMH providers.
- No routine assessment of behavioral health or SUD needs using a evidenced based tool.
- Productivity and funding model for FQHCs present challenge equitable collaborative partnership.
- Practice culture of FQHCs present challenge for behavioral health principles of anti-stigmatization, trauma informed care, person centeredness, and self determination.
- Leadership desire high, practical application challenging.
Why is Integrated Healthcare Important to you?
The Problem

- More than 70% of primary care visits are related to psychosocial issues, including anxiety and depression.
- Persons with severe mental illness (SMI) die, on average, 25 years earlier than the general population.
- 1 in 5 persons have a mental illness or addiction.
- Persons with SMI have higher rates of chronic medical conditions such as hypertension, diabetes, obesity, cardiovascular disease, and HIV/AIDS.
- SMI negatively impacts the outcomes of chronic medical conditions.
- Behavioral Health (BH) settings are often the primary site of health care services for persons with SMI, but are typically accountable only for the BH care.
### Per Member Per Month Healthcare Costs by Population and Presence of Behavioral Conditions - 2012 Costs

<table>
<thead>
<tr>
<th>Pop</th>
<th>BH Diagnosis</th>
<th>Medical</th>
<th>Behavioral</th>
<th>Med Rx</th>
<th>BH Rx</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>No MH/SUD</td>
<td>$280</td>
<td>$3</td>
<td>$53</td>
<td>$4</td>
<td>$340</td>
</tr>
<tr>
<td></td>
<td>Non-SPMI MH</td>
<td>$661</td>
<td>$23</td>
<td>$145</td>
<td>$74</td>
<td>$903</td>
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<tr>
<td></td>
<td>SPMI</td>
<td>$759</td>
<td>$128</td>
<td>$135</td>
<td>$175</td>
<td>$1,197</td>
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<tr>
<td></td>
<td>SUD</td>
<td>$830</td>
<td>$73</td>
<td>$102</td>
<td>$67</td>
<td>$1,072</td>
</tr>
<tr>
<td>Medicaid</td>
<td>No MH/SUD</td>
<td>$309</td>
<td>$4</td>
<td>$63</td>
<td>$5</td>
<td>$381</td>
</tr>
<tr>
<td></td>
<td>MH/SUD</td>
<td>$757</td>
<td>$286</td>
<td>$172</td>
<td>$86</td>
<td>$1,301</td>
</tr>
<tr>
<td>Total</td>
<td>No MH/SUD</td>
<td>$335</td>
<td>$3</td>
<td>$55</td>
<td>$4</td>
<td>$397</td>
</tr>
<tr>
<td></td>
<td>MH/SUD</td>
<td>$751</td>
<td>$100</td>
<td>$148</td>
<td>$86</td>
<td>$1,805</td>
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Projected Healthcare Cost Savings Through Effective Integration (National, 2012)

<table>
<thead>
<tr>
<th>Payer Type</th>
<th>Annual Cost Impact of Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>$15.8-$31.6 billion</td>
</tr>
<tr>
<td>Medicare</td>
<td>$3.3-$6.7 billion</td>
</tr>
<tr>
<td>Medicaid</td>
<td>$7.1-$9.9 billion</td>
</tr>
<tr>
<td>Total</td>
<td>$26.3-$48.3 billion</td>
</tr>
</tbody>
</table>
External Forces to Shift to Integrated Care

Affordable Care Act has been an effective catalyst for change in traditionally valued paradigms of health care delivery.

- Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008
- State of Michigan Mental Health and Wellness Commission 2013 Report
- Healthy Michigan - increased accessibility of health care coverage to low income individuals
- The national health care triple aim of better care, improved health and lower health care costs.
- MI Health Link (Integrated Care for Persons with Medicare and Medicaid) - Better integration of behavioral health services into cross continuum settings can have a positive impact on quality, costs and outcomes.
Integration of Behavioral Healthcare in Primary Care Practice
What Integrated Healthcare Looks Like at the Primary Care Setting

- Identification and Screening
- Primary Care Provider examination and evaluation of medical and behavioral health needs
- Communication with patients, other involved in patient’s care
- If available on site, warm incorporation of behavioral health specialist (i.e. LSW) for brief behavioral health intervention and/or additional behavioral health assessments.
- Documentation of assessment findings in integrated treatment plan
- Treatment and/or Referral, as appropriate
- Coordination of Care, as appropriate
Vignettes of Models of Integrated Care in Primary Care Settings
Integrated Model-FQHC with partner Children’s Behavioral Health

- Integration funded by a SKIPP grant.
- CMH provider was awarded this grant to develop the curriculum, plan, and processes for embedding a Behavioral Health Consultant in the primary care practice.
- More than a social worker for handling referrals or finding community resources, the Behavioral Health Consultant is part of the care team.

Vignette #1:

- 10 year old female, impulsive at home toward mother and younger siblings, asthmatic, BMI approaching obesity, plays video games 2 hours daily, lacks interest in playing with kids her own age.
Vignette #1- FQHC with partner Children’s Behavioral Health

Pt. completes behavioral Health Screen, as appropriate. By Medical Assistant.

Medical Provider exams patient, reviews screening results with family, makes clinical dx and impressions. Using communication skills, suggest colleague comes into the room the explore the results of the screening further.

Behavioral Health Consultant uses diagnostic and communication skills to further explore BH needs, may do additional problem focused assessments (CAFAS).

BH Consultant provides MD with clinical impressions and recommendations for BH needs in the treatment plan.

Medical Provider and Behavioral Health Consultant have conversation with family regarding recommended treatment plan.

BH Consultant Brief Intervention Apt.  Follow Up Apt. with Medical Provider for Asthma

BH Consultant to provide case management services as appropriate.

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Integrated Model- FQHC with partner Children’s Behavioral Health

Vignette #2:

- Parents bring, 2 year old male, 1 of two children to see the primary care provider. He is not walking steady, as the older sibling did at this age. Not using words to verbalize wants. Family knows what his grunts and motions mean. He is response to basic request. No major medical problems.
Vignette #2- FQHC with partner Children’s Behavioral Health

Pt. completes behavioral Health Screen, as appropriate. By Medical Assistant.

Medical Provider exams patient, reviews screening results with family, makes clinical dx and impressions. Using communication skills, suggest colleague comes into the room to explore the results of the screening further.

Behavioral Health Consultant uses diagnostic and communication skills to further explore BH needs, may do additional problem focused assessments (CAFAS).

BH Consultant provides MD with clinical impressions and recommendations for BH needs in the treatment plan.

Medical Provider and Behavioral Health Consultant have conversation with family regarding recommended treatment plan.

- Referral to CMHP BH Specialist to begin screening for Autism
- Follow Up Apt. with Medical Provider well child care

BH Consultant to provide case management services as appropriate.
Co-Located-
FQHC with Adult Behavioral Health Provider

- Both organizations made commitment to work together and fund this co-located model. It is the right thing to do.
- FQHC serves high uninsured, Medicaid population with high percentage of chronic medical and behavioral health conditions. Complete change in scope to add the CMHP as a location for service. Funded Medical Provider, Registered Nurse, Medical Assistant and Registration Clerk.
- Community Mental Health Provider serves adults with severe mental illness. Community Mental Health Provider provided the space.

Vignette #3:
- 32 year old female presented to CMHP for monthly medication review, with Dis-associative Disorder, high blood pressure, depression, and pregnant. Her initial response to learning she was pregnant was that she would terminate the pregnancy. She also wanted to keep the baby.
Vignette #3- FQHC with Adult Behavioral Health Provider

CMHP takes vitals, blood work, and completes screen for depression. Identifies pregnancy. Peer Support Specialist communicates results to consumer and obtain consent to speak to medical colleague about pregnancy.

BH Provider walks down hall to FQHC to alert RN/MD of consumers pregnancy and discuss treatment options.

Peer Support Specialist assist RN/MD in communicating situation with consumer and discuss treatment options with the consumer.

BH Consultant provides MD with clinical impressions and recommendations for BH needs in the treatment plan.

Care developed with involvement of consumer, BH clinician, Peer Support Specialist, and FQHC staff.

Intensive BH case management. Peer Support staff monitoring consumer’s compliance with medications. MD collaborating with BH staff during pre natal visits.

Healthy Baby who was put up for adoption.
Integrated-FQHC with Behavioral Health Services

FQHC has behavioral Services with Psychiatrist, and Licensed Master Social Worker employed by the FQHC.

Vignette #4:
57 year old male, history of substance use (alcoholism), depression, trauma and diabetes. He presents with symptoms of suicidality.
Vignette #4- FQHC with Behavioral Health Services

Patient presents on the Primary Care Provider schedule. Patient completes behavioral Health Screen, by Medical Assistant.

Medical Provider exams patient, reviews screening results with patient, makes clinical dx and impressions. Using **communication skills**, suggest patient talk to colleague.

Patient put on Behavioral Health schedule as add on. Clinical care team huddle to discuss treatment options based on clinical impressions.

Behavioral Health team and Primary Care provider using communication skills to discuss and agree on treatment plan.

**Treatment:**
- Psychiatrist prescribes meds for depression. Patient ready for change in substance use disorders
- Primary Care Provider follows up SUD provider for management of diabetes
- LMSW contacts CMH Access Line to get patient in SUD treatment

LMSW to provide case management services as appropriate.
Outcomes of Integrated Care Vignettes

- Improved Care Coordination resulting in better health outcomes
- Reduced waste of re-testing and paper work
- Averted ER visits for suicide crisis
- Averted Psychiatric and Medical Hospitalizations
- Early screening, identification, and treatment of Autism
- Treatment on demand for SUD services
State of Michigan
Demonstration Program to Integrate Care for Persons Eligible for Medicare and Medicaid (MI Health Link Program)
Policy Changes on the Horizon to Support MI Health Link

- Health Information Exchange- Care Connect 360
- Medicaid Health Plan Patient Information Portals
- 42 CFR part B Compliant Consent Form, January 1, 2015
- Behavioral Health case management billing codes being reviewed turned on for primary care in the demonstration regions
Review of MI Health Link Program

• The MI Health Link Program is designed to test an innovative payment and service delivery model to alleviate fragmentation and improve coordination of services for Medicare-Medicaid enrollees, enhance quality of care and life, and reduce costs for both MDCH and the federal government.

• The MI Health Link Program requires that integrated Care Organizations (ICOs) are required to either directly, or through subcontracts, or through partnership with local Prepaid Inpatient Health Plan (PIHP) provide for all Medicare and Medicaid covered services, as well as additional items and services, under an innovative model of financing.
MI Health Link Demonstration Regions and ICOs

Four (4) Regions of the State were selected in which to implement the Demonstration program. Eight (8) ICOs were awarded.

- **Region 1: Upper Peninsula-**
  ICO- UP Health Plan

- **Region 4: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren**
  ICOs- Meridian Health, Aetna/CoventryCares Health Plan

- **Region 7: Wayne; and Region 9: Macomb**
  ICOs- Aetna/CoventryCares, AmeriHealth of Michigan; Fidelis SecureCare; Hap/Midwest Health Plan; Molina Healthcare; and United Healthcare
Operationalizing MI Health Link in Region #7

Integrated Care Organizations (ICO)
- Molina Health Plan
- Aetna/CoventryCares of Michigan, Inc.
- AmeriHealth of Michigan, Inc.
- HAP Midwest Health Plan
- Fidelis SecureCare of Michigan, Inc.
- UnitedHealthcare Community Plan, Inc.

DWMHA (PIHP)
- Managed the utilization of Medicare and Medicaid Mental Health Benefits
- Method/Rate of Payment Not Defined Yet

MDCH/Medicaid $$
- For SMI/I/DD, SUD, HAB Waiver Services
- MDCH/PIHP Contract (Medicaid, General Fund, SUD Block Grant, Other Waiver Services Contract)
- No increase in capitation for mild to moderate services.

Contracting with Affiliated Providers

Contracting with Hospitals

10/20/2014
Eligibility For MI Health Link

The Demonstration will be available to individuals who meet all of the following criteria:

• Age 21 or older at the time of enrollment;
• Eligible for full benefits under Medicare Part A, and enrolled under Parts B and D, and receiving full Medicaid benefits.
• Reside in a Demonstration region.

The following populations will be excluded from enrollment in the Demonstration:

• Individuals previously dis-enrolled due to Special Disenrollment from Medicaid managed care
• Individuals not living in a Demonstration region
• Individuals without full Medicaid coverage (spend downs or deductibles)
• Individuals with Medicaid who reside in a State psychiatric hospital
• Individuals with commercial HMO coverage
• Individuals with elected hospice services
Enrollment for MI Health Link

**March 1, 2015**
- Voluntary Enrollment Begins for the MI Health Link Program
- MME can Opt-In
- MME can Opt-Out

**May 1, 2015**
- MMEs who have Opt-In
- The MI Health Link Program Begins
- MME can Opt-Out, Opt-In, Change ICO at any point

**July 1, 2015**
- MME has not Opt-In
- MME has not Opt-Out
- Have not been passively enrolled into a M’Care Part D

**IF......**
MME will be passively enrolled into the MI Health Link Program

ON July 1, 2015 all remaining MMEs will be passively assigned to an ICO
What Makes this Program Different?

• Medicare and Medicaid services are managed and integrated
• A care coordinator and an integrated care team is available to all enrollees
• Approach is holistic with person-centered processes
• The delivery system will work in unison rather than in silos
• Data sharing capacity will be increased
MME agrees to participate in the MI Health Link Program and Selects an ICO

ICO Care Coordinator completes LEVEL I ASSESSMENT (HRA)

Behavioral Health Needs and/or Long Term Supports Services Identified

INTEGRATED INDIVIDUAL CARE & SUPPORTS PLAN develop to support the health and quality of life goals of the MME.

INTEGRATED CARE TEAM MEETING (MME, ICO Care Coordinator, PCP, BH Case Manager/LTSS Care Coordinator, other Natural Supports) to develop Integrated Care Plan.

LEVEL II ASSESSMENT PIHP - CMHP confirms level of Behavioral Health Needs with

• ICO Care Coordinator completes NFLOC

CONTINUOUS CARE COORDINATION with communication, alerts of ER, Hospitalizations through the Care Bridge (Health Information Exchange platforms)
Baby Steps to Integrating Behavioral Healthcare into Primary Care

- Establish relationships with community mental health service providers and understand how to access community mental health service.
- Develop a solid understanding of the inter-dependency of behavioral health to chronic medical conditions.
- Use appropriate evidence-based screening tools for behavioral health at initial, annual and problem-focused visits (as appropriate).
- Include behavioral health goals in the treatment plan.
- Use communication skills to share information in a patient-centered way to facilitate change.
- RESULTS! HEALTH OUTCOMES!
INTEGRATED HEALTHCARE!
Resources

- MPRO Behavioral Health Tool Kit
- MPRO- Community Resources List...
  http://media.wix.com/ugd/50392a_b706f4a6d3554efba0a4ccc5797a9dcd.docx?dn=%22BHI%20Community%20Resource%20Guide.docx%22
- The National Survey on Drug Use and Health (NSDUH) 2013 Report on Survey on Drug Use and Health: Overview of Finding, September 4, 2014
- National Council for Community Behavioral Healthcare- Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home, April 2009
INTEGRATED HEALTHCARE INITIATIVES
FUTURE QUESTIONS

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