Integrated Mental Health, Substance Abuse Services and Primary Care in Michigan

Michigan Primary Care Association Conference

November 16, 2011
Purpose of Health Care Integration Michigan

- To improve the health of individuals served in the public mental health system
- To identify integrated health models that work for different geographic areas and demographic populations in Michigan
- To reduce health care costs
Integrated Health Model Outcomes

- There wasn’t one integrated health model that worked for all regions. Different integrated health models were needed.
- Committed leadership from both mental health and primary care providers was essential.
Integrated Health Model Outcomes

- Individuals with serious mental health conditions were more likely to prefer primary care services through their CMH.
- Individuals with mild to moderate mental health conditions were more likely to prefer mental health services at a primary care clinic.
Integrated Health Model Outcomes

- Mental health programs that had previously established relationships with physical health care providers were able to more successfully implement integrated health services.

- Peer Support Specialist provided important services such as:
  - Leading PATH (personal Action Toward Health) and other wellness classes
  - Accompanying individuals to physician visits
  - Providing support in Emergency Rooms
Program Cost Outcomes

- Billing guidelines need to be established to coordinate payment for services between primary care and community mental health.

- Barriers in Data Collection:
  - Restricted access to claims data prevented a thorough evaluation of reduced health care costs.
  - Lack of data from health plans made it difficult to identify a target population of highest cost consumers.
Individual Health Outcomes

- BMI was reduced by between 1.45 and 1.58 points
  - Reduction in BMI reduces risk for heart disease, hypertension, type II diabetes, gall stones, breathing problems, certain cancers, and other chronic conditions

- Increased consumer satisfaction with services

- Increased access to health care services in medically underserved areas
Integrated Health Care Projects
Bay-Arenac Behavioral Health (BABH) offers Health Integration services to individuals receiving outpatient, case management, or ACT services through the Bay and Arenac County offices. Access is by referral from the mental health case manager for persons who meet specific morbidity risk factors. Qualified individuals will receive enhanced nursing and physician office liaison services along with other support services identified within their individual person centered plan. The primary service population will be persons with high behavioral health and physical health needs.
Bay-Arenac Project Staff

Peer Lead Whole Health Grant (TTI)
- PATH Workshop Facilitation
- Education and Wellness groups
- Involvement in person centered planning process

Full-time Health Integration nurse
- Completes nursing health care assessment
- Completes metabolic assessment
- Wellness education for individuals
- Outreach to primary care physicians (and community)
- Staff education

Health Integration Website
http://bacnt.com/babha/ - still under construction
Central Michigan CMH

- Were ranked the most un-healthy county in Michigan
- Opened one walk-in clinic in each of their 6 counties
- Clinics are opened at least 2 hours a week, and provide walk in psychiatric appointments
- Employed a full time CPSS who leads a peer-led initiative that assures consumers are receiving appropriate care. Also hold PATH and other wellness classes
New Center CMH Services

- Partnered with Advantage Health Centers/Detroit Health Care for the Homeless, a physical health care provider, for onsite behavioral health services in an effort to prevent medical and psychiatric deterioration of at-risk individuals.
New Center CMH Services (continued)

**Population Served**
- Underserved populations
- Difficult to reach/engage individuals
- Individuals who frequent emergency rooms for health care services
- Homeless
- Uninsured

**Services**
- Primary medical care
- Crisis Intervention
- Clinical Assessment/Therapy
- Psychiatric Evaluation
- Resource/Community Linkage
- Case Management
- Psychiatric Medication Management

**Staff**
- Professional Mental Health Worker
- Nurse/Case Manager
- Physician Assistant
New Center CMH Outcomes

Between April 2010-July 2010, 32 patients were surveyed.

90% reported agreement and/or satisfaction of services at our integrated site.

Scales included:

- The amount of time spent with the patient during the visit
- Their beliefs about health and well-being were considered
- Their concerns regarding the mental health treatment plan were quickly taken care of
- Treatment and information were provided in a language or way that could easily be understood
- They were comfortable receiving mental health services at the clinic
- They were treated the same as other people who got care at the clinic
- Felt they were learning the skills needed to deal with problems
Genesee CMH Initiatives

- GCCMH launched **InSHAPE®** in August 2009, the only wellness promotion program of its type in Michigan. Two other Michigan MH agencies are in the planning stages.

- Designed to lengthen life expectancy and improve the quality of life for persons with SMI through a combination of exercise, diet, coaching by a **Health Mentor** (certified personal trainer), and active use of healthcare services to reduce risk factors contributing to chronic disease and poor health status.

- Created “**wellness stations**” throughout our facilities across the county to provide health/wellness resources and educational materials, e.g., DVDs, BP machines, etc.

- Recruited **peer support specialists** to work alongside health mentors.

- Established the GCCMH **Community Garden Project**.

- Wrote a **five year strategic plan** that centers on promoting wellness and reducing morbidity and mortality.
InSHAPE Outcomes

- As of September, InSHAPE participants (66) have achieved:
  - A combined weight loss of 116.7 pounds
  - A combined decrease of 259.1 cm in waist circumference
  - A combined decrease of 108.75 cm in hip circumference
  - A combined decrease of 39.5 in BMI points

- Average decreases:
  - BMI: 1.58 points
  - Weight: 9.8 lbs
  - Waist: 3.28 in
  - Hip: 2.92 in

* One participant got a job as a chef and has unfortunately gained 40 lbs.!
  Another has been extremely noncompliant and gained 35 lbs. Their outcomes dramatically skew the combined statistics on the prior slide.
Lapeer County CMH

- Created a data integration project to:
  - Improve access to care
    - Verify that all consumers have a primary care physician
  - Obtain an accurate history of medications provided to a consumer to decrease medication errors and interactions
  - Improve utilization management to coordinate care for the costliest consumers
    - Directly improve outcomes for these consumers
    - The resources saved through coordinated care would directly result in providing more services
  - Disease Management
    - Identify chronic disease consumers and coordinate physical health care
Manistee-Benzie CMH
(Centra Wellness)

- Established clinic housed in a local rural primary care clinic in Manistee County
  - The clinics share medical and behavioral health staff and CPSS run PATH classes

- Are working to create a similar clinic in Benzie County, but do not have any primary care doctors on board at this point.
CMH of Muskegon County

- Partnered with FQHC to embed outpatient therapist in FQHC to provide the following services:
  - “Curb Side” consults
  - Substance Abuse screening and treatment
  - Ongoing therapy
  - “Real time” psychiatric consults

- How to pay for MH staff at a community health facility
  - FQHC reimbursing CMH for wages on BH staff person placed in FQHC
  - FQHC billing for Behavioral Health Services
  - CMH billing for Substance Abuse services provided in FQHC
  - Agreement that program would be cost neutral for all parties involved.
Successes

- Providing Primary Care office with “one time psychiatric consults”.
- Providing phone consultation with psychiatrists.
- Identifying “point people” in each agency
- Providing learning opportunities on medical health issues to CMH staff
- Quarterly meetings with FQHC
- The CMH board and administration see the value in Integrated Health and embarked on a strategic plan to move forward
- The development of relationships
- Peer Involvement
  - Peer Support Specialist co-leading health and wellness group
  - Peer Support Specialist on Integrated Health Committee and Doctor’s Work Group
Barriers and Challenges

- Difference in allotted times for appointments
- We “speak” different languages
- Differences in vision
- Getting CMH staff to begin to see Integrated Health as their responsibility
- Human services offices/PCP offices are “maxed out” – makes meeting difficult – meetings in the evenings
- Getting FQHC to apply for change of Scope to place medical staff in CMH location
Network 180 – Kent County

Program description:

- team-based approach to the management of chronic health conditions. It is based on the Chronic Care Model and on the full integration of what have been called behavioral and physical health care. It is a cooperative effort of Cherry Street Health Services, Proaction Behavioral Health Alliance, and Touchstone innovarè

Project Components:

- Primary/Behavioral health Care Community Planning Committee – Membership includes representatives from primary and behavioral health care providers/funders, consumer representatives and other stakeholder groups

- Partnerships with Qualified Health Plans to promote coordination of care between behavioral health care clinician/supports coordinators and Qualified Health Plan care coordinators

Starting construction on new Cherry Street Health Services building that will house behavioral health services to be fully integrated clinic
Summit Pointe
Integrated Health Model

- A Primary Care Practice *fully owned and operated* by the CMHSP
- The PCP is *housed within the CMHSP* and integrated within its operations
- The Primary Care Practice *services CMHSP customers AND the general community*
- **Staffing:**
  - MD
  - **Physician’s Assistant [newly added]**
  - Psy.D/Clinical Psychologist
  - LMSW
  - Peer Support Specialists
- Case Managers and Peer Support Specialists weave BH and PCP services into a *unified person-directed plan*
- **Wellness/Ilness Management Groups** (e.g., PATH, WRAP, IDDT) are increasingly delivered in a range of settings
- Aggressive and **continual health monitoring and referral**
  - Brief Health Check each Med Review (Weight; BP; Temp; BMI)
  - CMHSP → Primary Care
  - Primary Care → CMHSP
Summit Pointe Status Report

- Physician Development on Target

- Primary Care Physician fully integrated into Psychiatric Staff: now a Medical Staff member → Joint Case Staffing

- Enrollment On Target: 125 Customers formally part of Block Grant [N.B.: 230 served by PCP]

- Baseline Data shows the 6 most frequent Medical Diagnoses identified:
  - Hypertension (31%)
  - Asthma (21%)
  - Osteoarthritis (21%)
  - COPD (14%)
  - Hypothyroidism (14%)
  - Diabetes (10%) → additional studies suggest this is an undercount

- Outcome Study facilitated by Flinn Foundation → Baseline Studies are completed

- Peer Support Specialist involvement growing
  - Providing PATH classes regularly
  - Embedded in ACT, CSM, SBH, OP, and Drop-In Center
  - Serving as system integrators

- Nursing in other units are changing
  - More emphasis on physical health elements
  - Greater satisfaction in roles
  - Desire to build Wellness Services in a multitude of programs

- Greater “legitimacy” in the wider physical healthcare world
WCHO: Base Integration Models

- Tracking Health Status & Addressing Needs
  - Health Appraisal/Monitoring as Part of BH Care
  - Promoting Wellness - Addressing Risk Factors
  - Linking with Primary Health Home
  - Coordination Platform Developed with UMHS

- Moving Behavioral Health into Primary Care
  - Behavioral Health Specialists Stationed at High Volume Clinics and Other Practice Sites
  - Demand Management
  - Serve Consumers in Stable Recovery
  - Guidelines for Placement

- Psychiatrist Available to Consult with Primary Care Practitioners
WCHO: Second Generation Integration

- Medicaid Disease Management Pilot
  - Population, Disease States, Condition Clusters
  - Disease Management Interventions
    - Beneficiary
    - Direct Interventions
    - Care Plan
    - Self-Management Training & Peer Supports

- Provider/Practice Sites
  - Medical Home Payments

- System Level
  - Clinical Guidelines and Care Practice Protocols
3rd Year Projects

- Bay-Arenac
- Summit Pointe
- New Center
- Genesee County
- WCHO
Findings

- Common Strengths
- Previously established relationships with physical health care providers
- Key leadership and commitment from the physical health care side
- Commitment from CMH boards to sustain project
- Committed CMH Staff
Findings

- Common Barriers
  - Billing
    - How and who to bill
  - Funding
    - Lack General Fund Dollar
  - Data collection concerns
    - What data to collect and how
Findings

Data collection methods

- There were 3 projects that used electronic medical records to track data, 2 used similar paper questionnaires
- Tracked blood pressure, pulse, weight, and/or conditions such as diabetes, hypertension, asthma, and obesity
- Baseline data – number of hospitalizations, ER visits, and whether or not the consumer is insured and/or has contact with a primary medical provider
Finding

- Peer Support specialists – All sites had PSS working on their integrated health teams
  - PATH or other wellness classes
  - Accompany consumers on physician visits
  - Work in ER
Keys for success

- Previous relationships between mental and physical health care providers
  - Created committed integrated health care leaders on the primary care side
  - This was the case regardless of if there was a FQHC in the area

- Peer Support Specialists
  - Important aspect of grant
    - Peers have been successful in all the CMHs and their roles have varied depending on the need of their area
    - Versatile skills
Keys for success

- Establish billing guidelines to help FQHCs and CMHs understand who gets compensated for specific services
  - Help maintain quality integrated care
  - Avoid difficulty and strained relationships between mental health and primary health care as a result of billing issues
Michigan Association of Community Mental Health Boards

Dual Eligible Initiative
Making Michigan’s Health Care System the Envy of the Nation:

Recommended Components of the Financing and Care Management Structure of Michigan's Dual Eligible Initiative
This set of recommendations builds on the principles and recommendations of the “Consensus Joint Policy Position Statement: Michigan’s Plan for Integrated Care for Persons with Dual Eligibility” - a document of which MACMHB is a co-signer.
Overarching themes behind these recommendations:

Michigan has an opportunity, using the Dual Eligibles initiative as one of its early steps, to create a health care system that will be the envy of the nation.

This system will assure access to the highest quality services with strong, measurable outcomes and controlled costs; while ensuring that the most vulnerable (the state’s dual eligibles) have the quality of care that they need.
The recommendations contained in this document:

• Apply the best of what Michigan has done, over the past 14 years, in successfully managing the state’s Medicaid program Using what has proven to work – Michigan’s Medicaid managed care system - to address what is not working – the unmanaged Medicare system.

• Draw on the best practices of care integration and care management drawn from across the country

• Provide a dual eligibles system which will perform well in the emerging health care environment which will be dominated by integrated provider systems which receive funds from a wide range of payers (via public sources (Medicaid, Medicare) and commercial carriers (via the Insurance Exchange/Market Place and employer-based plans) – and via a wide variety of payment methods (fee-for-service, case rate, capitation)
• Allow for the development of a **range of regionally-driven approaches** – thus providing the state with a rich set of demonstration projects

• **Avoid the considerable fiscal risks (and risks to the dually eligible patients) inherent in the assumption, by Michigan, of responsibility for the Medicare-funded services to these Michigan citizens**
1. **Promote meaningful health care integration and coordination at the point where the patient receives care** - through the state’s efforts to foster **Patient Centered Health Homes** for persons with chronic health conditions (using a Medicaid State Plan Amendment and other methods), linking electronic health records or providers serving the dual population through regional Health Information Exchanges (HIE), unified person-centered plans of service, the sharing of both Medicaid and Medicare data with providers, and other methods.

MACMHB is actively designing, with partners and practitioners within Michigan and from across the country, Patient Centered Health Home models – which apply a number of proven financing, partnering, and clinical practices.
2. Leverage the proven performance of Michigan's current Medicaid managed care system which uses specialized care management organizations to ensure quality, outcomes and cost control to continue to manage the state’s Medicaid program. This system uses three groups of high performing specialized care managers in the areas of physical health care, behavioral health care, and long term health care. [1]

[1] A recent (October 2011) report from the Integrated Care Resource Center (ICRC), a national initiative of the federal Centers for Medicare and Medicaid Services (CMS), “State Options for Integrating Physical and Behavioral Health Care”, outlines a number of models which closely mirror Michigan’s well honed Medicaid Managed Care System and provides guidance for its future development.
This state’s system of managing the Medicaid behavioral health services – its Medicaid Prepaid Inpatient Health Plans (PIHPs) and its Community Mental Health Service Programs (CMHSPs) - have a strong history of:

- **Patient/person-centered care**: Using person-centered (patient/consumer engaging) approaches to health care to ensure quality care for the Specialty Behavioral Health Population in a community-based, multidisciplinary approach

- **Controlling Costs**: Keeping per-enrollee cost increases at 2.2% per year over the past decade (far below cost increases experienced in the health care market) while operating in a risk-based financing structure
• **Ensuring Quality:** Meeting federally approved quality standards in community sites across the state while implementing evidence-based approaches to clinical care

• **Developing a community-based system of care:** Converted a hospital-based mental health and developmental disability system into a system that is nearly entirely community based, serving over 30 times as many persons as were served when the system was hospital based.
3. Use a managed fee-for-service system to the Medicare benefits to the dual enrolled population, (where services are reviewed for appropriateness and medical necessity before being authorized for payment by Medicare – rather than a capitated model) to address inappropriate care. This managed fee-for-service system should be managed by the managed care entities who have successfully managed the state's Medicaid benefit. [2]

[2] Michigan has been successful in using a managed fee-for-service system. From 1995 through 1997, Michigan’s CMH system served as the care manager for the state’s Medicaid payments for inpatient psychiatric care, under a managed fee-for-service system – reining in costs while ensuring that appropriate and medically necessary inpatient psychiatric care was provided to the state’s Medicaid enrollees.
Using this model - rather than a capitated payment system:

• Allows Michigan the **opportunity to develop expertise** in managing the Medicare benefit for this Dually Eligible population

• Allows Michigan to **apply and** learn from the structures and methods being developed and tested within Michigan and nationwide

• **Prevents profiteering and/or windfall earnings** that can occur early in the conversion of a fee-for-service system to a managed care system

• **Avoids the considerable fiscal risks (and risks to the dually eligible patients) inherent in this project** - the assumption, by Michigan, of responsibility for the Medicare-funded services to these Michigan citizens.
4. Expand the service array offered via Medicare to match that offered through Michigan's Medicaid program.

These services, made accessible to Michigan’s citizen through a set of innovative waivers, have made Michigan’s Medicaid system one of the most patient-centered, community-based, and recovery-oriented in the nation.

In the behavioral health care sector, this range of services (and a range of innovative practices) allowed the state’s CMH system to convert a mental health and developmental disability system that was hospital-based into a system that is nearly entirely community based, serving over 30 times as many persons as were served when the system was hospital based.
5. Integrate, into the capitated Medicaid and fee-for-service Medicare system, a number of risk and savings sharing systems – by aligning clinical and fiscal incentives and fostering a range of coordination structures and practices – which control costs while ensuring quality care and outcomes. The savings that are generated through this must be shared among the state – thus allowing many of the currently un-served and under-served to receive needed health care services - the entities managing this care, the providers, and the federal government. [3]

6. Allow for a range of care provision and care management integration approaches to be developed across the state – applying the components noted above. These *regionally-based demonstration projects* will provide the state with a range of approaches to examine relative member/patient satisfaction with the care experience, quality of care, and cost control.
State Options for Integrating Physical and Behavioral Health Care

Options for Integration

• Aligned financial incentives across physical and behavioral health systems

• Real-time information sharing across systems to ensure that relevant information is available to all members of a care team

• Multidisciplinary care teams that are accountable for coordinating the full range of medical, behavioral, and long-term supports and services, as needed

• Competent provider networks

• Mechanisms for assessing and rewarding high-quality care
OPTION #1: MANAGED CARE ORGANIZATION AS INTEGRATED CARE ENTITY

OPTION #2: PRIMARY CARE CASE MANAGEMENT PROGRAM AS INTEGRATED CARE ENTITY

OPTION #3: BEHAVIORAL HEALTH ORGANIZATION AS INTEGRATED CARE ENTITY

OPTION #4: MCO/PCCM AND BHO PARTNERSHIP FACILITATED BY FINANCIAL ALIGNMENT
Conclusion

Whether to leverage existing delivery systems or build new capacity

Whether to have MCOs or BHOs take the lead in integration

Whether to develop a single integrated system or multiple, specialized systems of care for subsets of beneficiaries.