

# Integrating Primary Care and Behavioral Health Care

*How far we've come*

# My Background

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- Missouri Medicaid Director
- National Council Medical Director
- Distinguished Professor, Missouri Institute of Mental Health, University of Missouri St. Louis
- Practicing Psychiatrist
  - CMHCs – 10 years
  - FQHC – 18 years
- Previously DMH Medical Director – 20 years

# Principles of Integrated Behavioral Health Care

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- Patient-Centered Care
  - ▣ Team-based care: effective collaboration between PCPs and Behavioral Health Clinicians.
- Population-Based Care
  - ▣ Behavioral health patients tracked in a registry: no one 'falls through the cracks'.
- Measurement –Based Treatment to Target
  - ▣ Measurable treatment goals clearly defined and tracked for each patient.
  - ▣ Treatment are actively changed until the clinical goals are achieved.
- Evidenced-Based Care
  - ▣ Treatments used are 'evidence based'.
- Pay for Performance
  - ▣ Payments focused on value, not volume
  - ▣ The delivery system is accountable and reimbursed for quality of care, clinical outcomes, and patient satisfaction , not just the volume of care provide

# Strategies

1. Coordination of care
  - ▣ EHR, CyberAccess, PROACT, and Missouri Health Connection
  - ▣ Care management – CMHC & FQHC as Health Homes
2. Co-location/integration of primary and behavioral healthcare – CMHC/FQHC partnering and Health Homes
3. Medical disease management including persons with mental illness
4. Behavioral health interventions for medical risks
  - ▣ Obesity/activity
  - ▣ Smoking
  - ▣ Screening for prevention and treatment

# Principles for CMHCs



- Physical healthcare is a core service for persons with SMI
- MH systems have a primary responsibility to ensure:
  - ▣ Access to preventive healthcare
  - ▣ Management and integration of medical care

# Principles for All Providers

- One Team
  - ▣ CMHC's composed of pre-2012 CPRC staff plus NCM and PC Consultant
  - ▣ PCHH's composed of new infrastructure and team members
- One Treatment Plan for the Whole Person
  - ▣ Rehab Goals
  - ▣ Medical Goals
  - ▣ Healthy Lifestyle Goals
- Some Goals and Outcomes reference Health Home Performance Measures
- Wrap-Around approach to outside treating PCP, mental health providers, community supports, etc

# Missouri's CMHC/FQHC Integration Project



# Benefits of Co-Location

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- Patients prefer it
  - percentage of f/u raises from 15-20% to 40-60%
- Builds personal relationships – the foundation of any enduring arrangement
- Allows more accurate understanding of each other's incentives, methods and constraints
- Opportunities for informal consultation
- Single clinical record reduces errors

# FQHC/CMHC Integration Initiative

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## ■ Expectations

- Co-location of primary and behavioral health services
- Appropriate adoption of evidenced based practices, best practices, and promising practices
- Receptivity to person centered planning, and consumer empowerment
- Appropriate incorporation of existing care management technologies and initiatives

## ■ Design

- Seven partnerships funded for three years
- Six additional sites received one-time funding for planning per partnership
- Technical Assistance Team (supported by a grant from the Missouri Foundation for Health)

# Use Multiple Models

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- **Traditional MH services at FQHC by CMHC**
  - Brief Therapy
  - Psychiatric Evaluation and Med Management
- **New Approaches at FQHC**
  - SBIRT
  - Embedded BH Consultant on PC team
- **Traditional PC services at CMHC by FQHC**

# Integration Initiative

## *Behavioral Health Consultant (BHC)*

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- Psychological problems, such as anxiety and depression
- Substance use disorders and risk reduction
- Psychological components of physical illness, both acute and chronic
- Psychological components of physical illness, both acute and chronic
- Factors impacting health status: stress, non-adherence, health behavior, social support

# Integration Initiative

## *Behavioral Health Consultant (BHC)*

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- Application of behavioral principles to address lifestyle and health risk issues
- Emphasis on prevention and self-help approaches
- Build resiliency and encourage personal responsibility for health
- Consultation and co-management in the treatment of mental disorders and psychosocial issues

# Financing Mechanisms – Integrated Behavioral Health Services

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- Planning and Start-Up Grants
- Bureau of Primary Health Care Grants
- Contract CMHC Clinicians/Services to Primary Care Providers
- Health & Behavior Assessment/Intervention – CPT Codes 96150-96155
- Enhanced primary care efficiency
- SBIRT Implementation Grants
- SBIRT Billing Codes

# Progress to Date

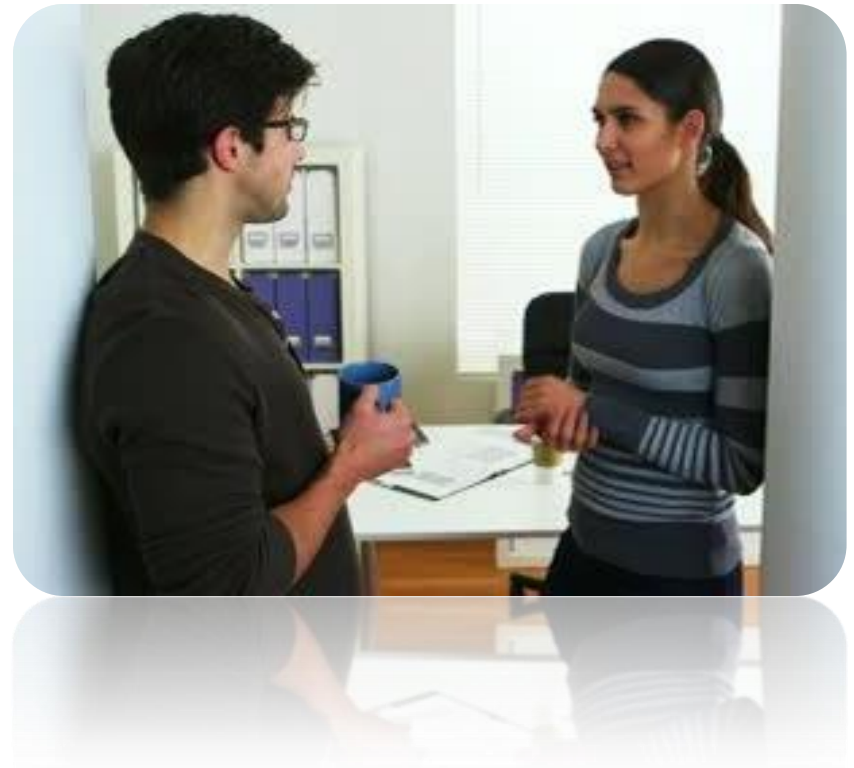
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- More Organizations are both CMHC and FQHC
  - Five CMHCs obtained new FQHC status
  - One merger of a CMHC with a FQHC
- More FQHCs have chosen to contract with CMHCs for BH services at other sites beyond the grant rather than develop their own BH services
- Funding using FQHC method through MPCA leverages funding for uninsured by 30%

# Location Matters

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- Out of sight is out of mind
- Intersperse PCPs with mental health staff
- Do not use separate waiting room
- Assign space so that mental health staff and PC staff constantly run into each other



# Joint Psychiatric/PCP Case Reviews

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- **Pick out a patient with more than three medications for mental illness and three medications for chronic medical illness**
- **10 minutes each**
  - PCP presents medical illness and treatment needs
  - Psychiatrist presents BH conditions and needs
  - Community worker presents on lifestyle
- **20 minutes**
  - what's to be done?
  - Is our clinic set up right to do it?

# Goals for Joint Case Review

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- Educate mental health staff about medical conditions and care
- Educate PCP staff about behavioral conditions and care
- Obtain detailed understanding on how medical and behavioral conditions interact
- Emphasize whole person approach
- Three Actionable Patient care recommendations
- One actionable clinic workflow recommendation

# Pro-Integration Policies

- FQHCs are paid for both PC and BH visits on the same day
- BH organizations allowed to bill for PC services and PC organizations allowed to bill for BH
- SBIRT and HBAI codes covered
- DMH has ongoing and substantial input on Medicaid FFS Pharmacy and psychotherapy PA committees
- Cross Hiring between Medicaid and DMH

# Integration via Managed Care

- ❑ MC plans required to comply with Wellstone-Domenici Mental Health Parity statute and CMS regulations for commercial plans
- ❑ MC plans required to contract with CMHCs as essential providers
- ❑ MC Plans required to use local providers for Care Coordination and Management with P4P
- ❑ MC plans required to use LOCUS/CALOCUS LOC criteria for authorization of BH services
- ❑ Joint DMH/Medicaid review of MC plan case management in BH
- ❑ Substantial DMH input of MC RFP and contracts

# What is a Health Home?



- ❑ Not just a Medicaid benefit
- ❑ Not just a program or a team
- ❑ It's a system and an organizational transformation
- ❑ It's Population Health Management

# Population Health Definitions

- The health of the population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services (Dunn and Hayes, 1999).
- A conceptual framework for thinking about why some populations are healthier than others as well as the policy development, research agenda, and resource allocation that flow from it (Young, 2005).

# Population Management Principles



- Population-based Care
- Data-driven Care
- Evidence-based Care
- Patient-centered Care
- Addressing Social Determinates of Health
- Team Care
- Integration of Behavioral and Primary Care

# Population-Based Care

- Don't rely solely on patients to know when they need care and what care to ask for and from whom - use data analytics for outreach to high need/utilizer patients
- Don't focus on fixing all care gaps one patient at a time - choose selected high prevalence and highly actionable individual care gaps for intervention across the whole population
- The population-based health care provider is the public health agency for their clinic population

# Population-Based Operations



- Payments for HH services will be paid PMPM, not unit by unit
- Service needs will be identified by patient health history and status
- Outcomes will be measured by groups of clients (i.e., by organization, region, medication used, and co-morbid conditions).

# Data-Driven Care



- Patient Registries
- Risk Stratification
- Predictive Analytics
- Performance Benchmarking
- Data Sharing

# Important Provider Competencies

## Characteristics:

- Outcomes-oriented
- Enabled by technology
- Patient-centered
- Use of data and analytics
- Performance transparency
- Ability to partner across organizations

Care Coordination



Care  
Management

Clinical  
Integration

# Six Population Health Management Services



- Care Management
- Care Coordination
- Managing Transitions of Care
- Health Promotion
- Individual and Family Support
- Referral to Community Services

# Comprehensive Care Management



- Identification and targeting of high-risk individuals
- Monitoring of health status and adherence
- Identification and targeting care gaps
- Individualized planning with the patient

# Health Care Home Strategy

- Case management coordination and facilitation of healthcare
- Primary Care Nurse Care Managers
- Disease management for persons with complex chronic medical conditions, SMI, or both
- Behavioral health management and behavior modification as related to chronic disease management for persons with Medical Illness
- Preventive healthcare screening and monitoring by mental health providers
- Integrated Primary Care and Behavioral Healthcare
- Health Home management where you are seen most often

# Health Home Strategy

- Health technology is utilized to support the service system.
- “Care coordination” is best provided by a local community-based provider.
- Mental Health Community Support Workers who are most familiar with the consumer provide care coordination at the local level.
- Primary Care Nurse Care Managers working within each Health Home provide system support.
- Behavioral Health Consultants in each Primary Care Health Home
- Statewide coordination and training support the network of Health Homes

# What is Different about Health Homes



## Treatment as Usual

- Individual Practitioner
- Episodic Care
- Focus on Presenting Problem
- Referral to meet other Needs
- Managed Care
  - Manages access to care
  - Does not change clinical practice

## Health Homes

- Integrated Primary/Behavioral Health Care Team
- Continuous Care
- Comprehensive Care Management
  - Coordinates care across the healthcare system
  - Data driven population management
  - Transforms clinical practice
  - Emphasizes healthy lifestyles and self-management of chronic health problems

# Bi-Directional Integration

## Primary Care Health Homes

- Behavioral Health Consultants
- SBIRT (web-based)
- PHQ 2 screening
- 6 of 20 Quality Performance Measures are BH
- 4 of 8 Medication adherence measures are BH
- BH prescribing benchmarking and feedback

## CMHC Healthcare Homes

- Primary Care Consultants
- Primary Care Nurse Care Managers
- Annual+ Metabolic Screening
- Diabetes Education
- 10 of 20 Quality Performance Measures are Medical
- 4 of 8 Medication adherence measures are medical

# HCH Responsibilities

## Hospital Admissions

- Hospitals are required by most payers, including Missouri Medicaid, to contact the payer at the time of admission to receive an Initial Authorization of Stay
- All-new authorizations for inpatient care are sent in an overnight flat file data transfer from the Inpatient Authorization Unit to the Health Home analytics unit
- An access database is used to automatically sort the patients by health home and generate an automated email listing those patients with new authorizations to each Health Home Director
- HCHs receive daily e-mails regarding hospital admissions

# Hospital Admissions

- HCH members discharged from the hospital must have a contact within 72 hours of discharge
  - This contact may be made by the individual's CSS, case manager, or NCM
  
- Nurse Care Managers must complete a medication reconciliation on HCH members discharged from the hospital
  - Information regarding the enrollees medications may be collected by the individual's CSS or case manager for review by the NCM

# Emergency Room Visits

- In response to the anthrax scare following 9/11 all emergency rooms were required to send a notification of every emergency room visit to the state health department
- All new ER visit notifications are sent in an overnight flat file data transfer from the State Health Department to the Health Home analytics unit
- An access database is used to automatically sort the patients by health home and generate an automated email listing those patients with new ER visits to each Health Home Director
- HCHs receive daily e-mails regarding ER visits



# Training Initiatives

- “Paving the Way” – required for CEO to deliver
- Leadership and team “HCH 101”
- Access to Care – open access scheduling by MTM
- CyberAccess and ProAct training
- Physician Institutes
- CARF

# Facilitating Healthcare Kit

The FH kit contains 8 modules:

- ❑ Overview of Chronic Diseases and Risk Factors
- ❑ Issues Associated with Medication Non-Adherence
- ❑ Asthma and COPD: The Role of the Case Manager
- ❑ Hypertension in Clients with Mental Illness
- ❑ Diabetes and Mental Health
- ❑ Dyslipidemia and Mental Illness
- ❑ Obesity
- ❑ Smoking Cessation

All titles include:

- A 3-8 page Monograph
- A 35-40 minute lecture
- On-line post-test and CEU application online.

More info at: <http://www.mimhtraining.com>

# Creating New Professional Cultures

- Every profession or trade has its own culture
- A living culture automatically trains its members and their roles, skills, and expectations
- Creating and maintaining culture requires regular group contact and discussion of their common experience to form a guild identity
- The new Health Home professions that need their own culture are:
  - Nurse Care Manager
  - Health Home Director
  - Primary Care Consultant

# Culture Creating Activities

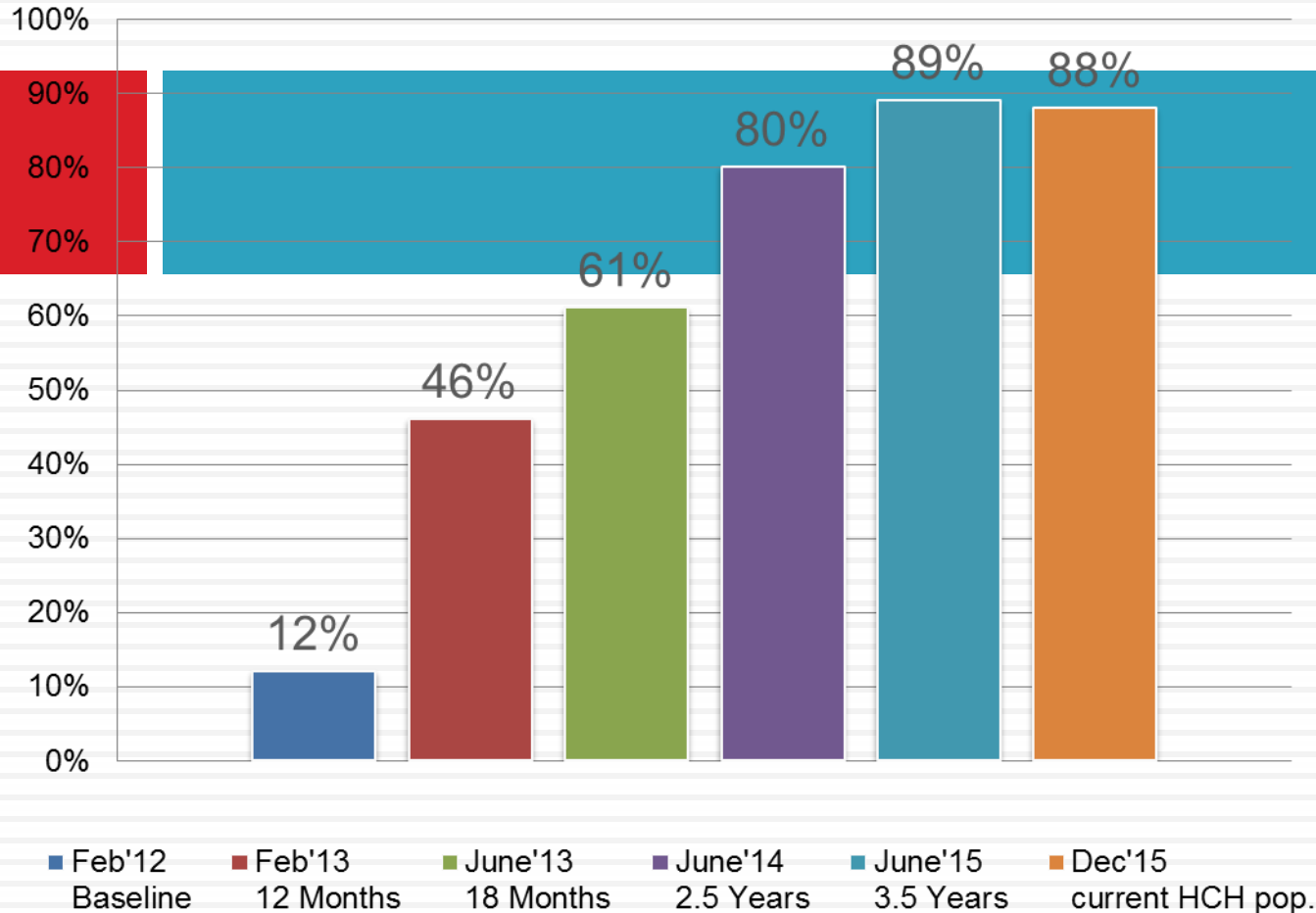
- Separate regular group conference calls
- Separate periodic group face-to-face meetings
  - Presentations from members of the group on "how they did it" to the rest of the group
  - Small group breakout sessions with lots of time for discussion
- Separate training and communication specifically for that group
- Annual awards to the best of the new cultural/professional group

# CMHC Health Home Performance Progress

*LDL, A1C, and Blood Pressure*



# Metabolic Syndrome Screening



All CMHC Health Homes have attained a completion rate above 80%!

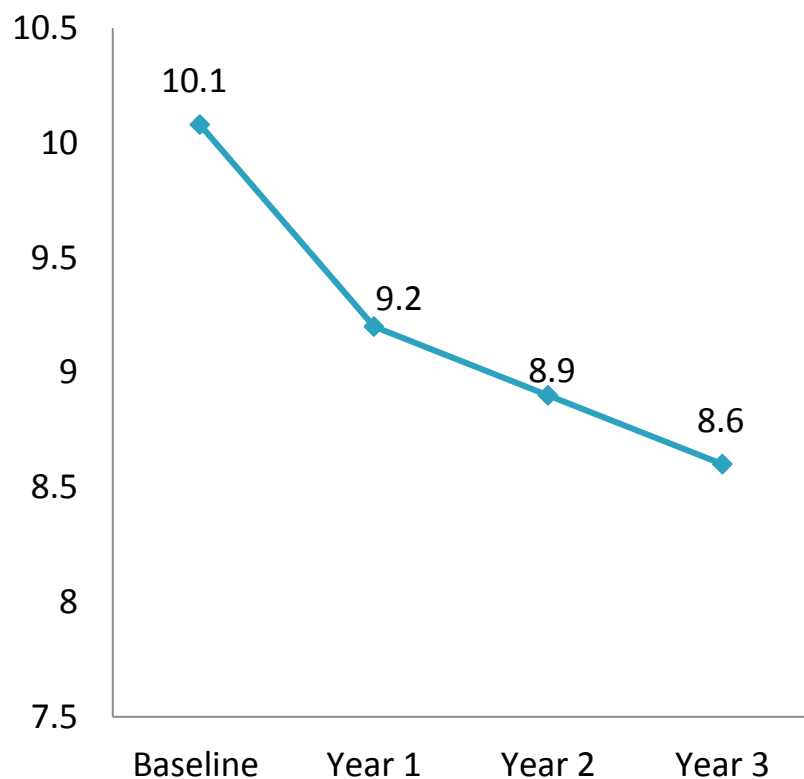
N= 6,553  
(at 3.5 years)

N= 20,648  
(Dec 2015)

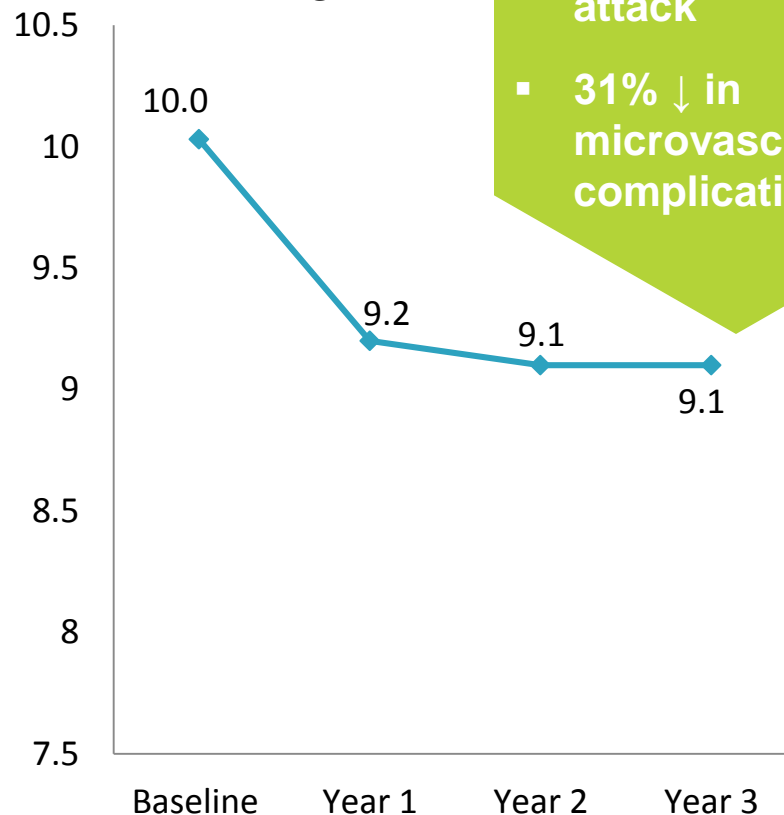
# A1C Levels Over Time

About 7% had uncontrolled A1c levels

## CMHC-HH



## PCHH



**1 POINT DROP  
IN A1C**

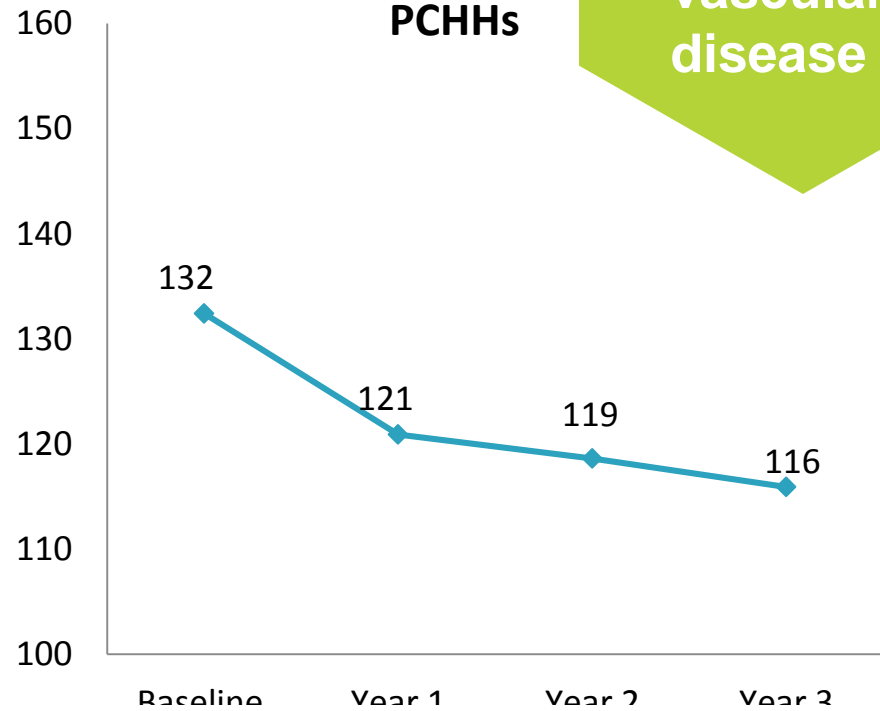
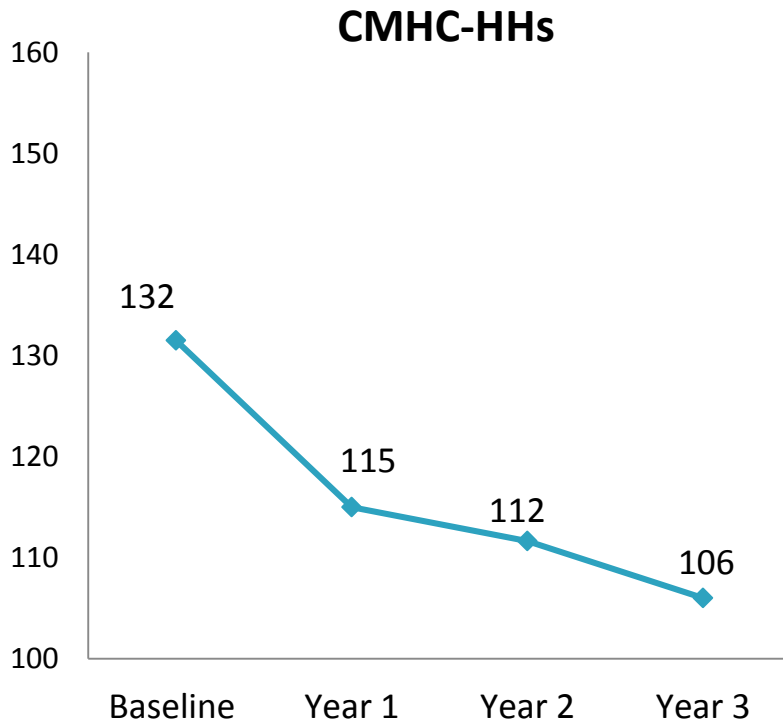
- 21% ↓ in diabetes related deaths
- 14% ↓ in heart attack
- 31% ↓ in microvascular complications

# LDL Levels Over Time

About 45% had uncontrolled LDL levels

10% DROP  
IN LDL  
LEVEL

▪ 30% ↓ in cardio-vascular disease

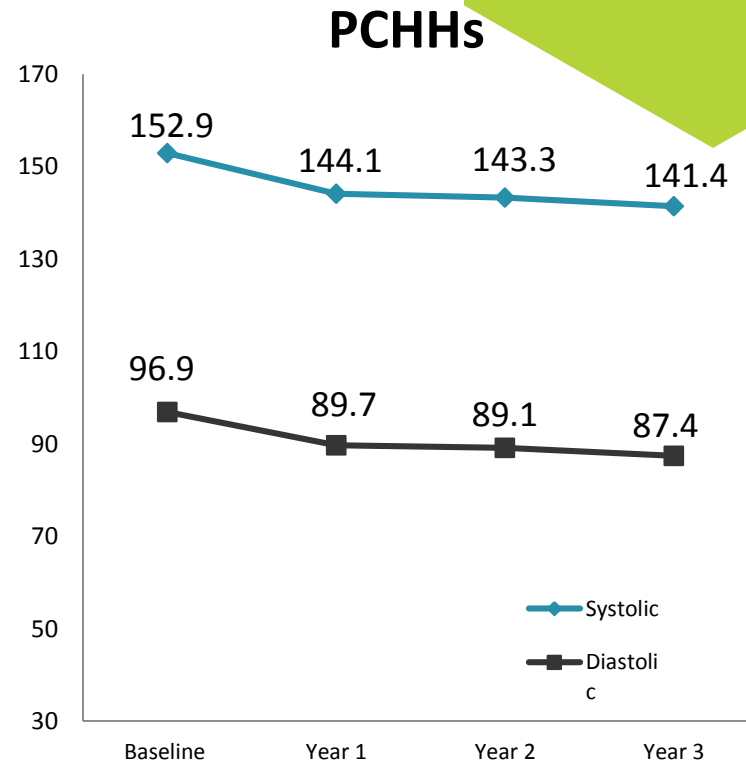
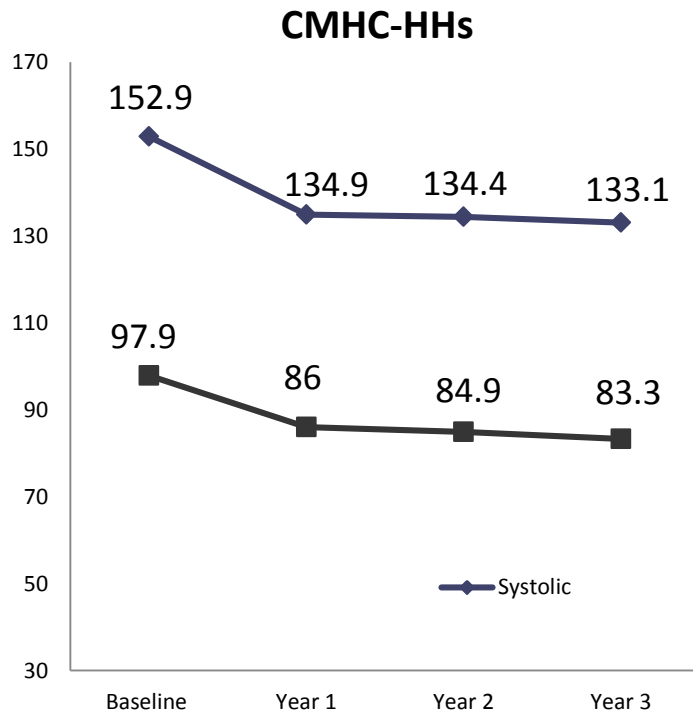


# Blood Pressure Changes Over Time

20-24% had uncontrolled BP levels

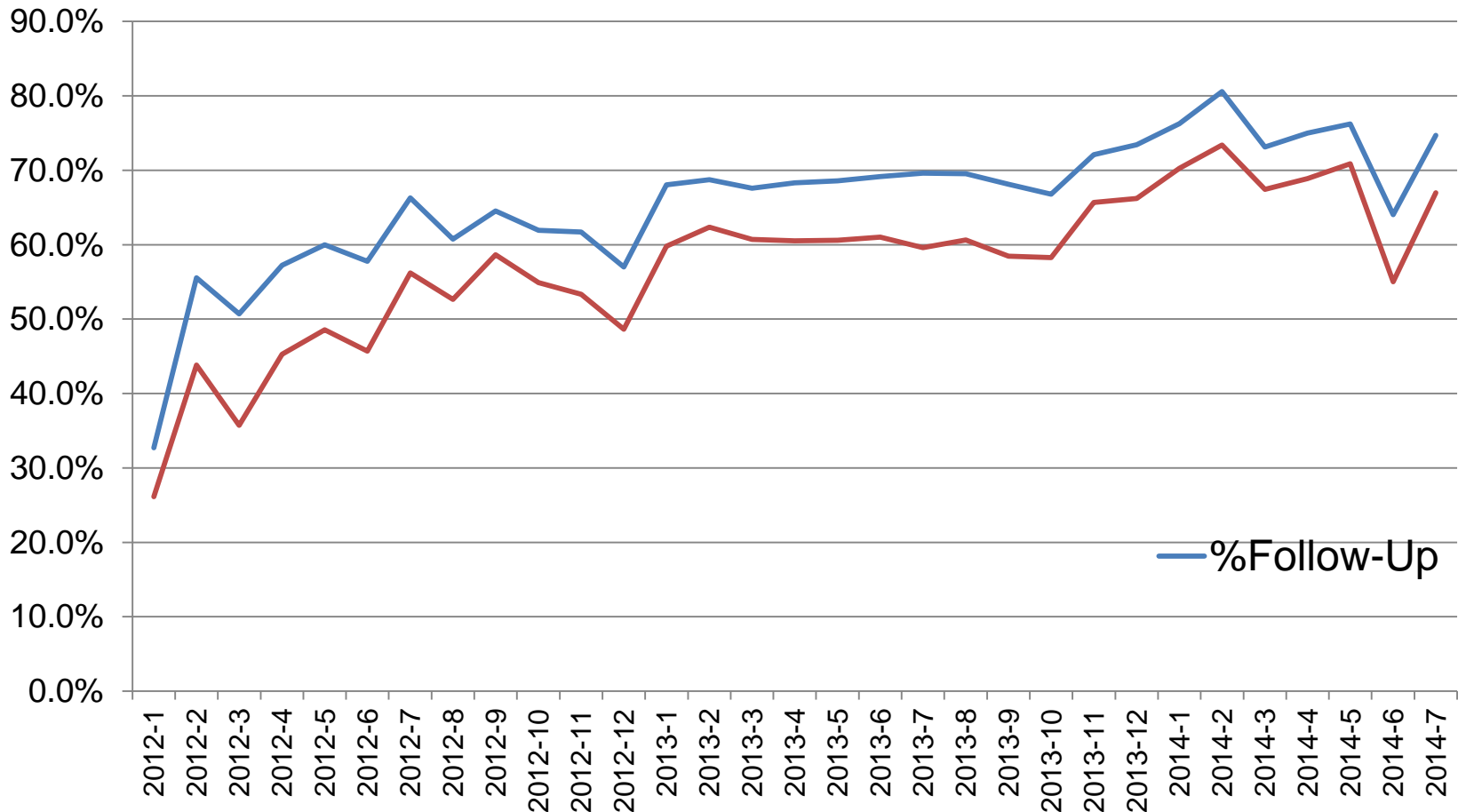
6 POINT DROP  
IN BLOOD  
PRESSURE

- 16% ↓ in CD
- 42% ↓ in stroke



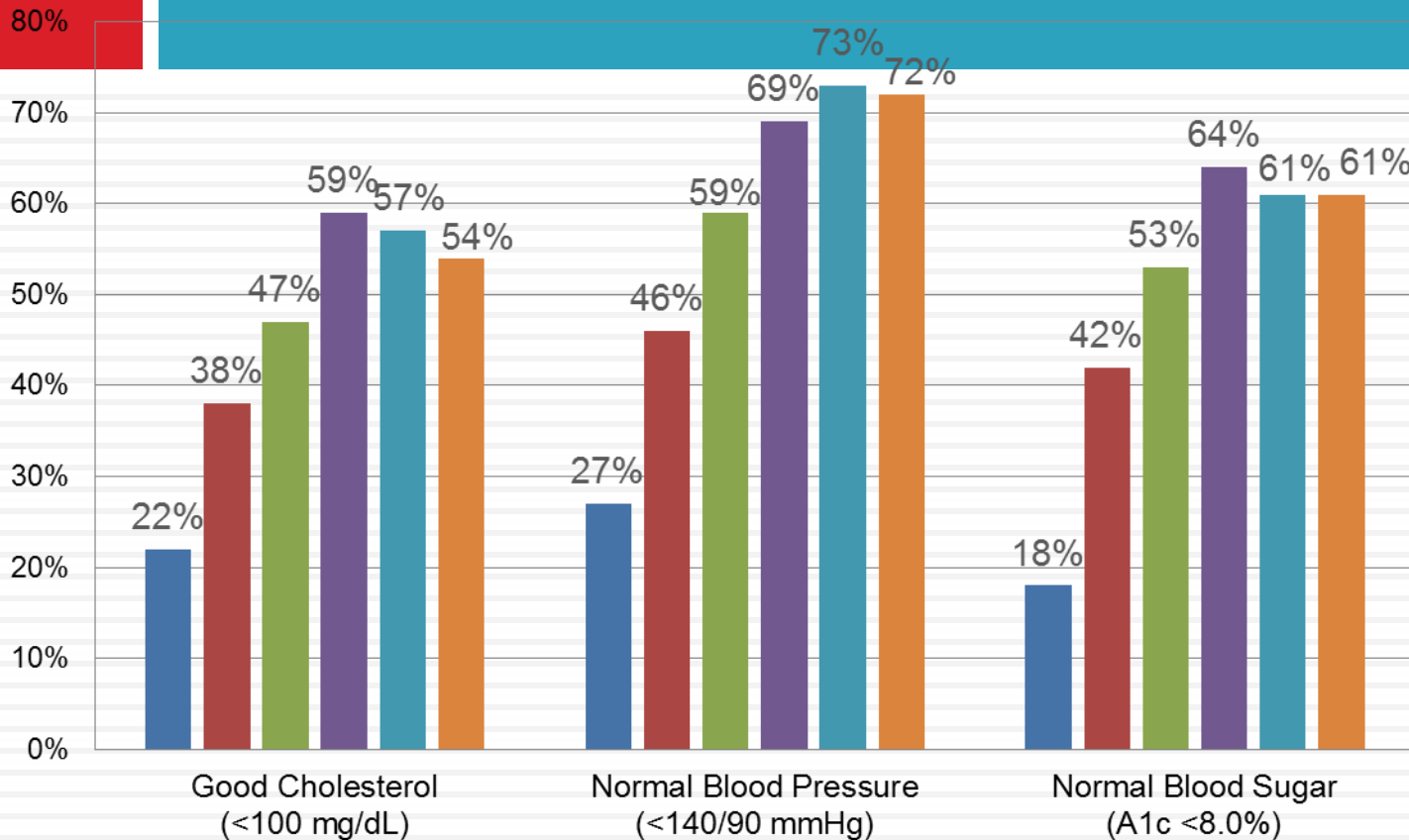
# Hospital Follow-up

## Jan 2012 through July 2014



# Diabetes

■ Feb'12 Baseline   ■ Feb'13 12 Months   ■ June'13 18 Months   ■ June'14 2.5 Years   ■ June'15 3.5 Years   ■ Dec'15 currently enrolled pop

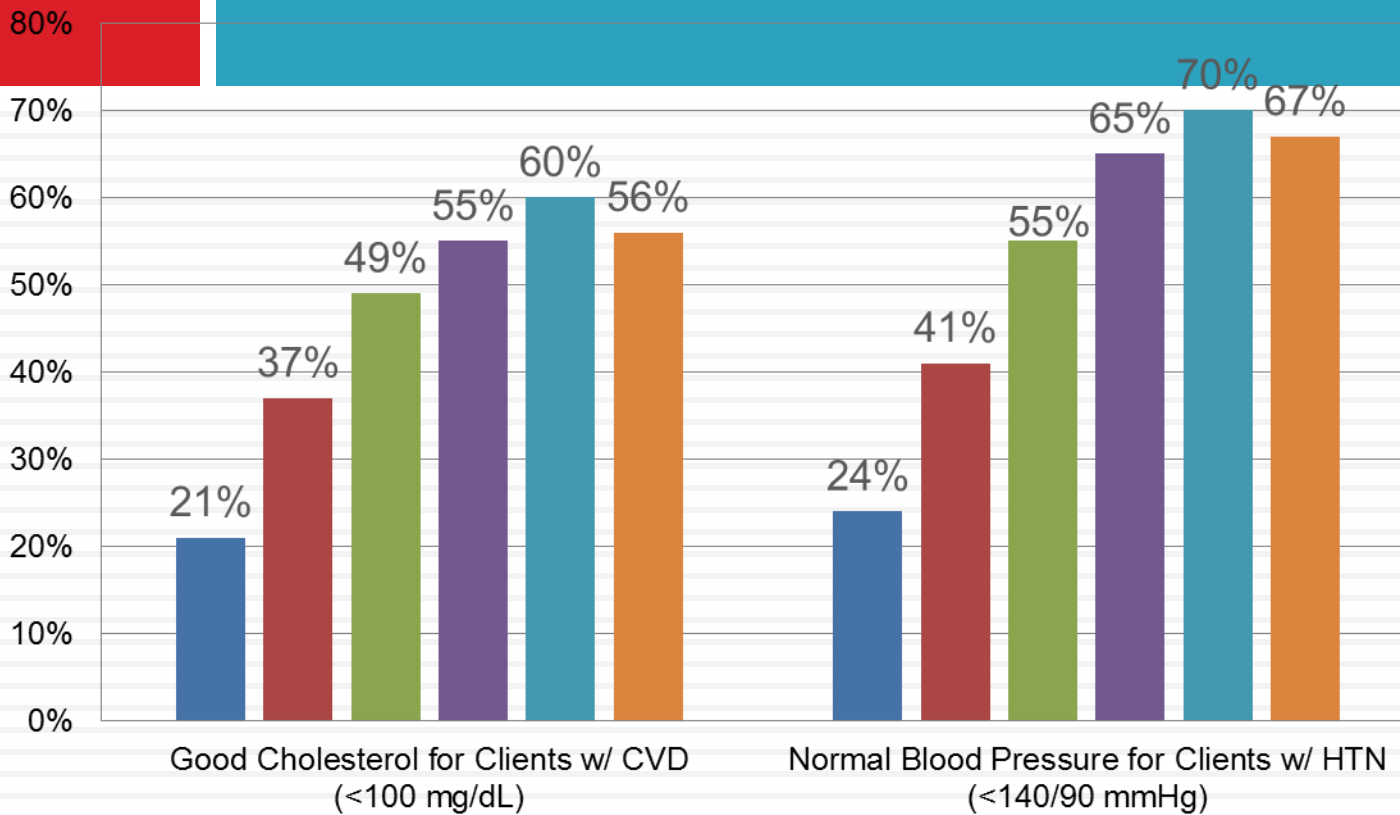


Adults continuously enrolled  
N= 1,889 (at 3.5 years)  
N= 4,526 (Dec 2015)

Data source: CMT

# Cardiovascular Disease

■ Feb'12 Baseline    
 ■ Feb'13 12 Months    
 ■ June'13 18 Months    
 ■ June'14 2.5 Years    
 ■ June'15 3.5 Years    
 ■ Dec'15 current enrolled pop



Adults continuously enrolled

CVD N= 232 (at 3.5 years)

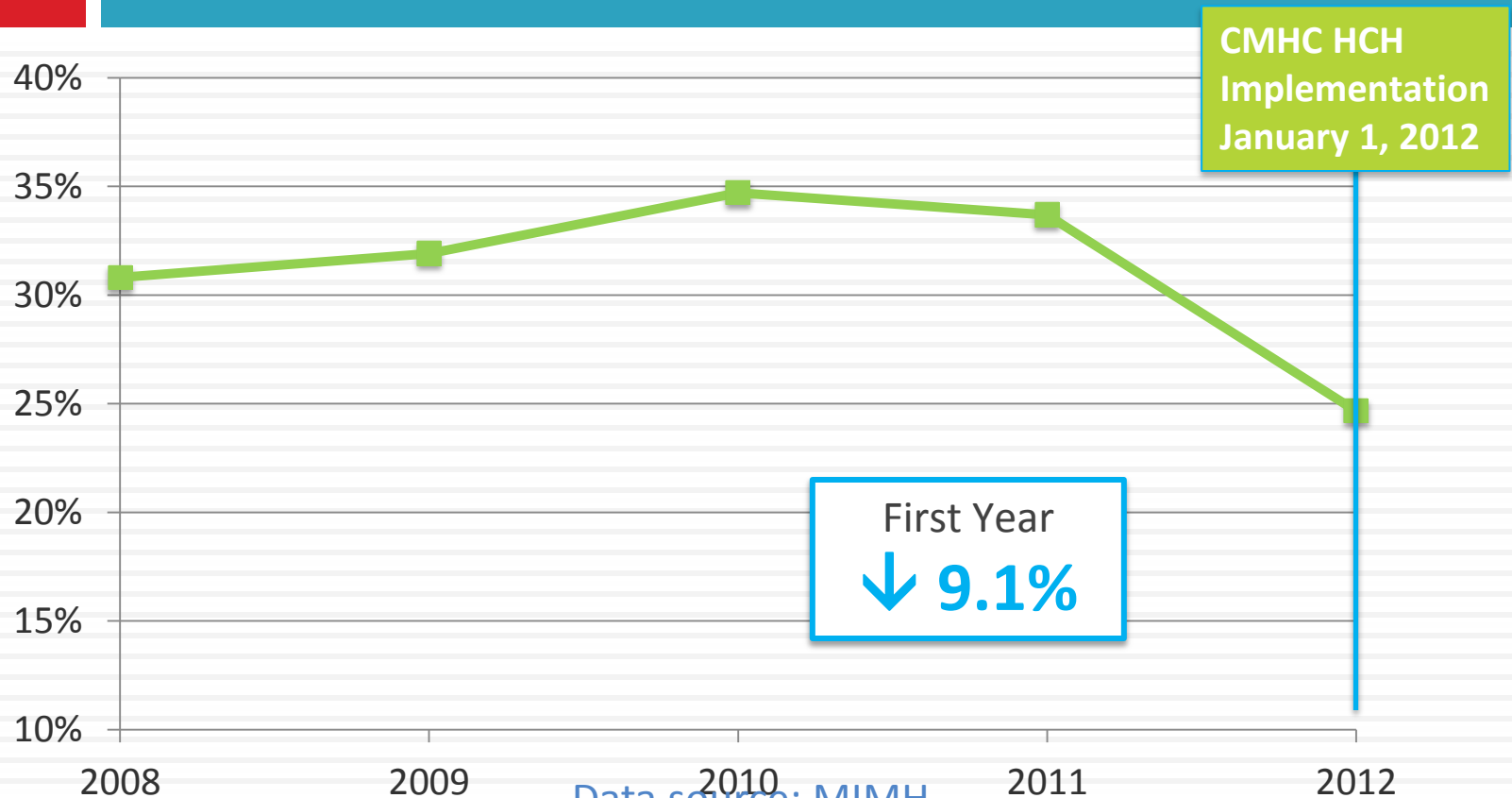
CVD N= 564 (Dec 2015)

HTN N= 2,401 (at 3.5 years)

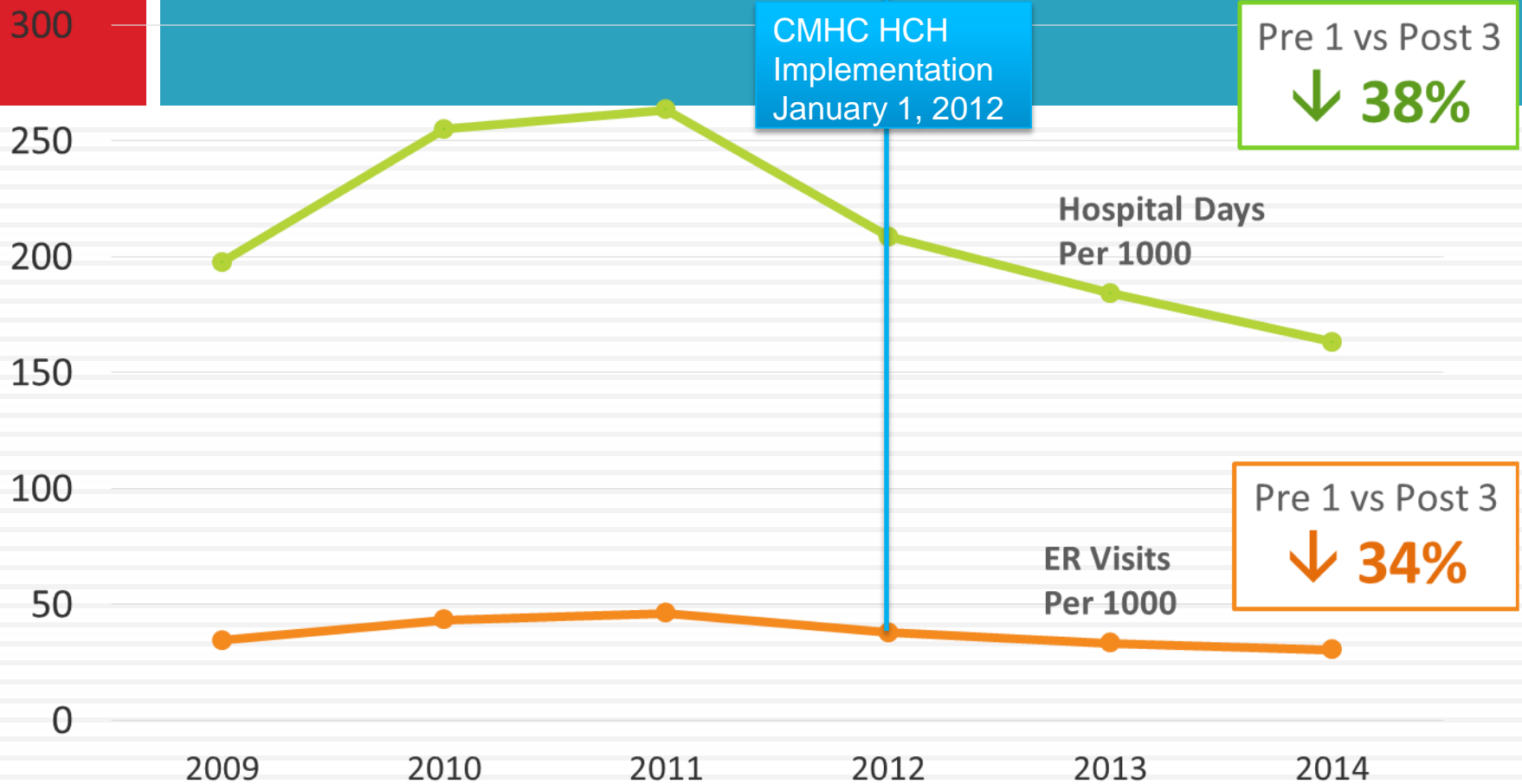
HTN N= 6,111 (Dec 2015)

Data source: CMT

# Percent of Clients with 1+ Hospitalization

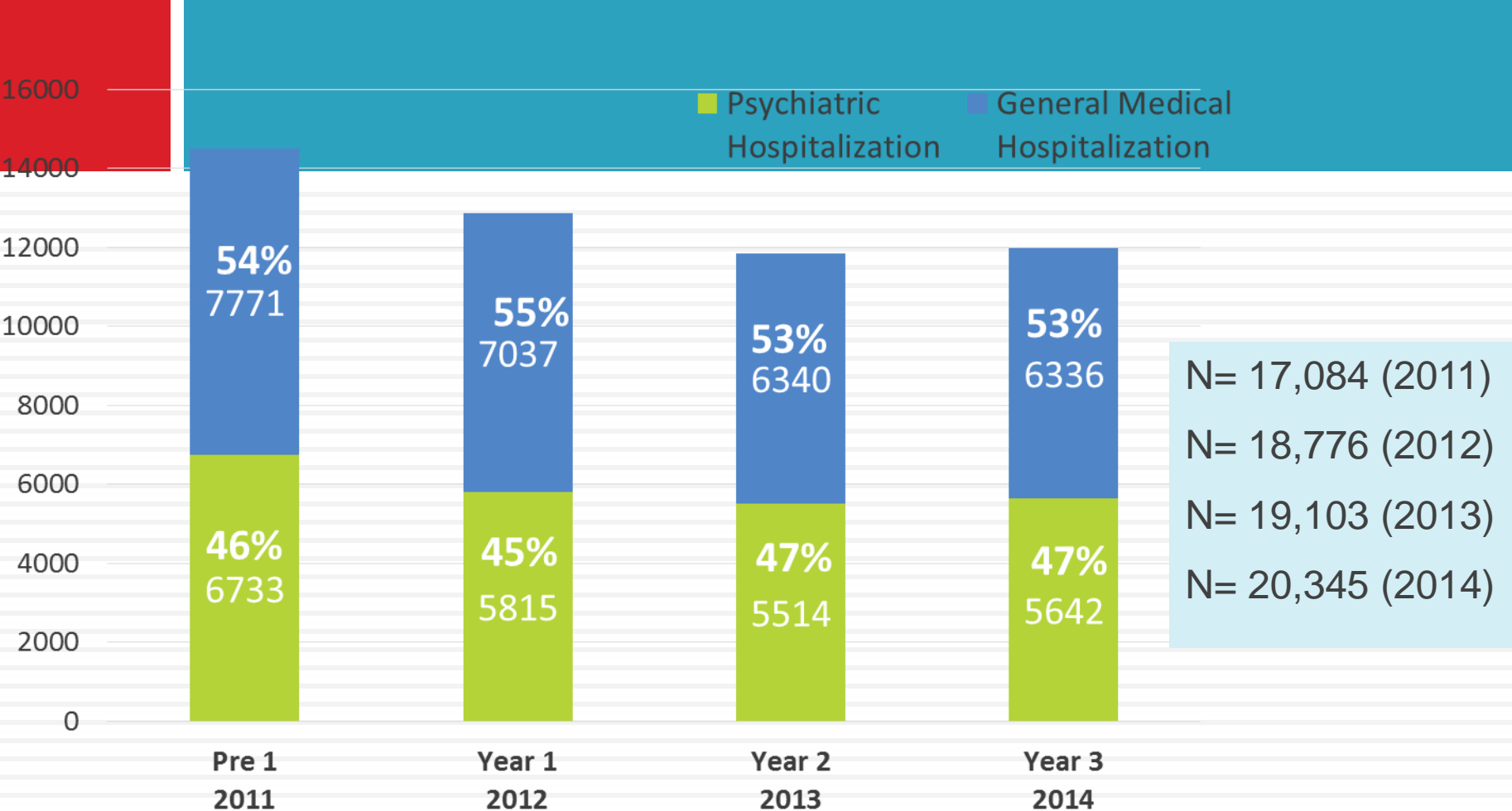


# ER & Hospital Days per 1,000



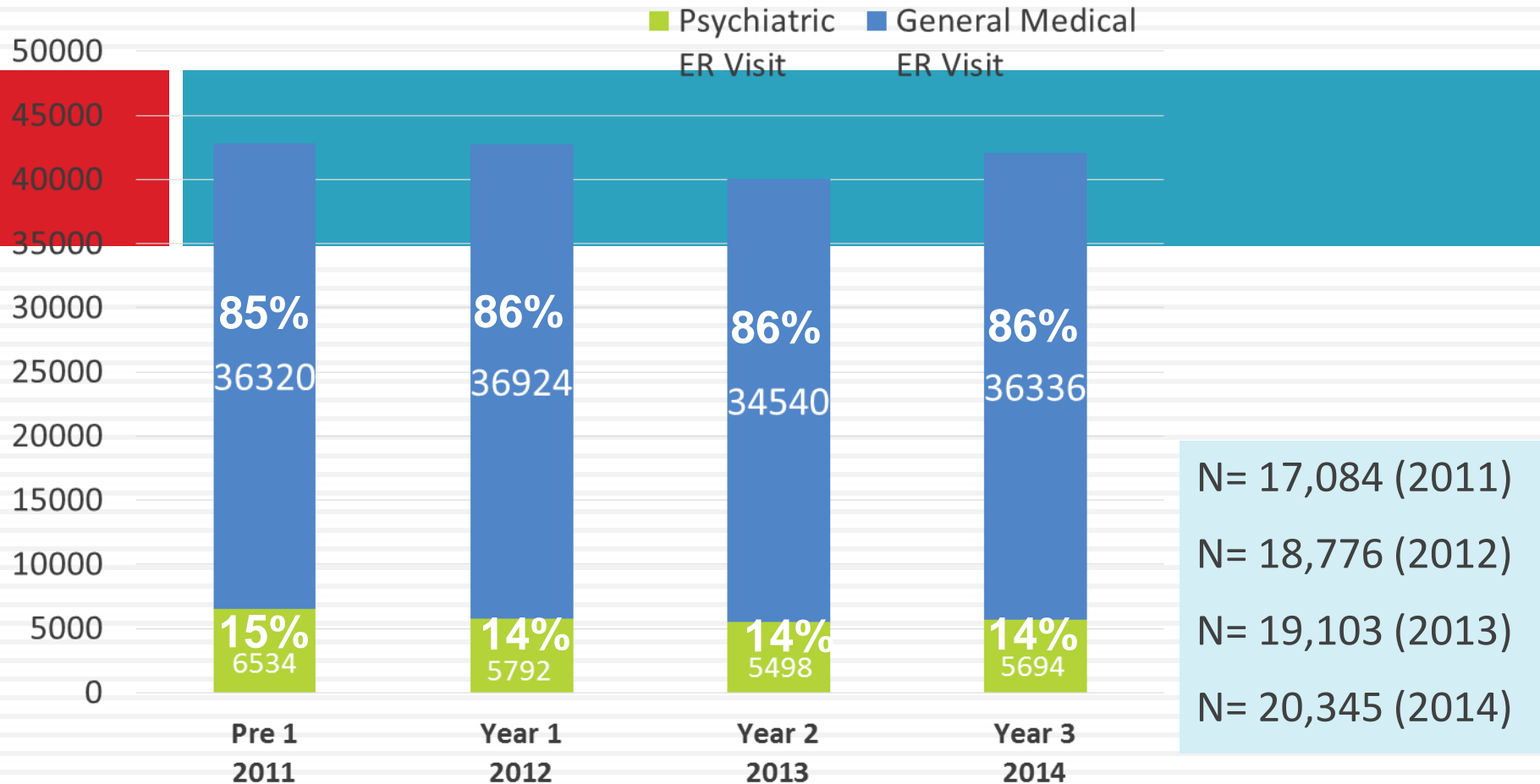
Data source: MIMH

# Hospital Encounters



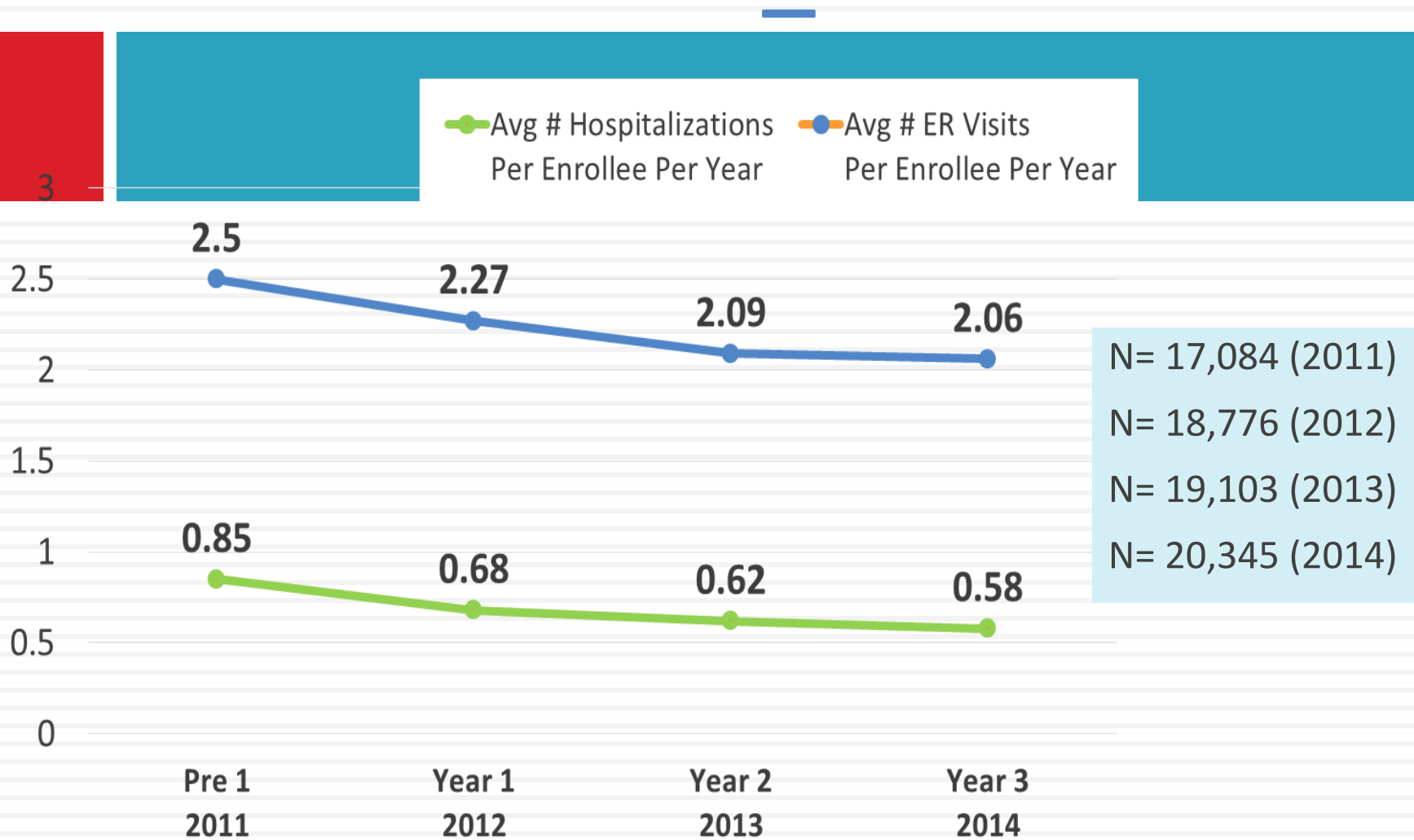
Data source: CMT

# ER Encounters



Data source: CMT

# Average # of ER & Hospital



# Initial Estimated Cost Savings after 18 Mos.

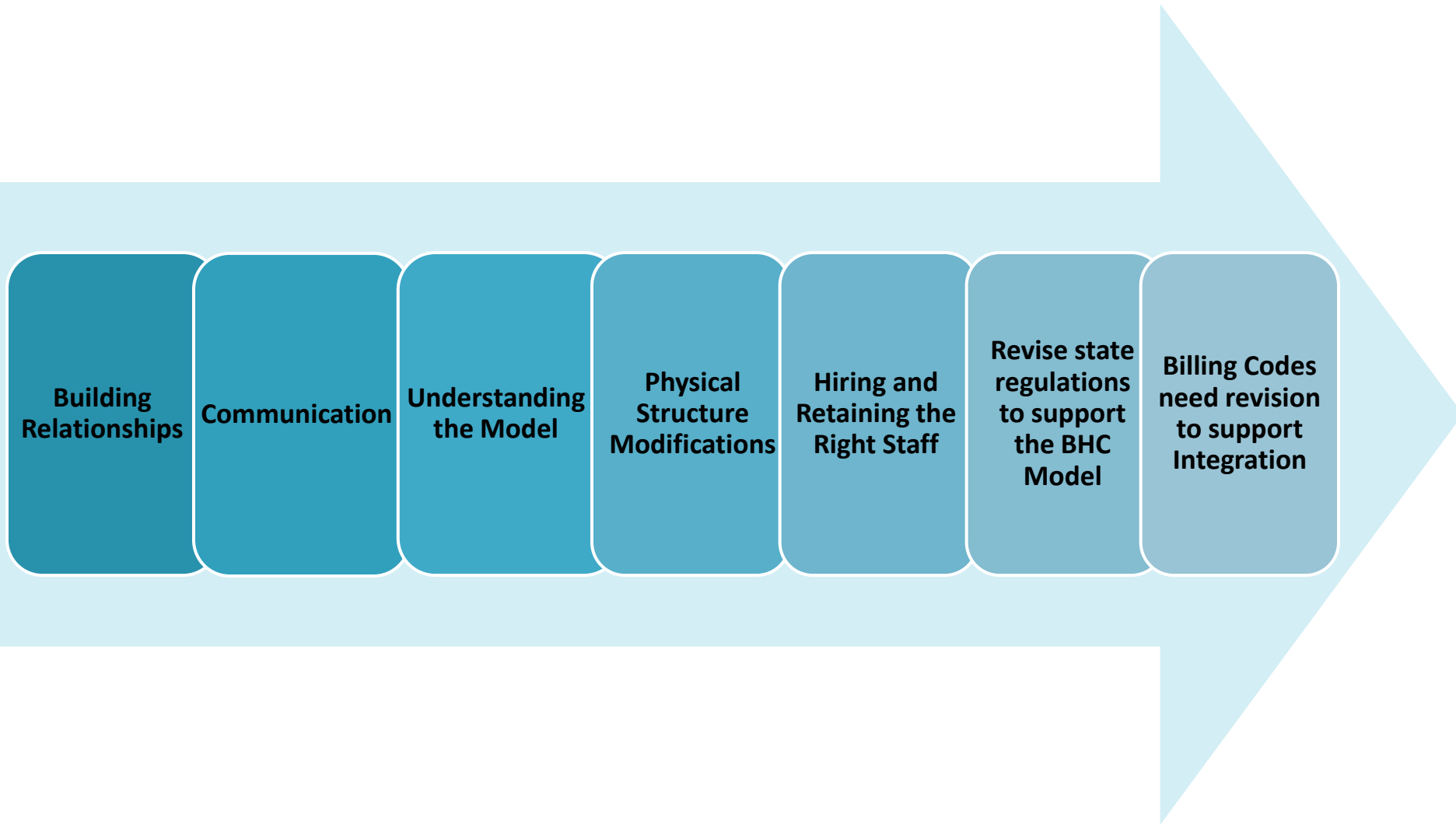
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- PC Health Homes
  - 23,354 persons total served (includes Dual Eligibles)
  - Cost decreased by \$30.79 PMPM
  - Total cost reduction \$7.4 M
  
- CMHC Health Homes
  - 20,031 persons total served (includes Dual Eligibles)
  - Cost decreased by \$76.33 PMPM
  - Total cost reduction \$15.7 M

# Integration Initiative

## *Recurrent Themes on the Path to Integration*

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# Putting It All Together

- Data identify treatment and prevention opportunities
- Training implements new evidence-based interventions
- Personal interaction is the true change agent
- Data analytics identify the dose response curve of personal interaction required
- Training allows use of a lower-cost FTE to produce an effective personal interaction

# What Makes it Possible?

- **A Relationship of basic trust between:**
  - Department of Mental Health
  - MO HealthNet (Medicaid)
  - State Budget Office
  - MO Coalition of CMHCs
  - MO Primary Care Association
- **Transparent use of data instead of anecdotes to explore and discuss issues**
- **Willingness of all partners to tolerate and share risk**
- **Principled negotiation and Motivational Interviewing**





# DYSFUNCTION

THE ONLY CONSISTENT FEATURE OF ALL OF YOUR DISSATISFYING RELATIONSHIPS IS YOU.

S.M.R. Covey, The Speed of Trust

# Behaviors that Promote Trust

## ■ Character

- Talk Straight
- Demonstrate Respect
- Create Transparency
- Right Wrongs
- Show Loyalty

## ■ Competence

- Deliver Results
- Get Better
- Confront Reality
- Clarify Expectations
- Practice Accountability

## ■ Character & Competence

- Listen First
- Keep Commitments
- Extend Trust



# Partnership Principles

## DO

- Ask about their needs first
- Give something
- Assist wherever you can
- Make it about the next 10
- Pursue common interest
- Reveal anything helpful
- Take one for the team

## DON'T

- Talk about your need first
- Expect to get something
- Limit assistance to a project
- Make it about this deal
- Push a specific position
- Withhold information
- Let them take their lumps



# CHANGE

WHEN THE WINDS OF CHANGE BLOW HARD ENOUGH,  
THE MOST TRIVIAL OF THINGS CAN TURN INTO DEADLY PROJECTILES.

## MO Department of Mental Health

[dmh.mo.gov/mentalillness/mohealthhomes.htm](http://dmh.mo.gov/mentalillness/mohealthhomes.htm)

## MO Coalition for Community Behavioral Healthcare

[mocoalition.org/#!health-homes/c14fu](http://mocoalition.org/#!health-homes/c14fu)

## MO Department of Social Services | MO Primary Care Health Homes

[dss.mo.gov/mhd/cs/health-homes/](http://dss.mo.gov/mhd/cs/health-homes/)

## CMS Health Home Information Resource Center

[www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/health-home-information-resource-center.html](http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/health-home-information-resource-center.html)

“The Promise of Convergence: Transforming Health Care Delivery in Missouri” (Harvard Case Study for 2015 NASCA Institute on Management and Leadership)

[www.naspo.org/dnn/Portals/16/2015%20NASCACase%20Study%20-%20The%20Promise%20of%20Convergence%20FINAL%20for%20article.pdf](http://www.naspo.org/dnn/Portals/16/2015%20NASCACase%20Study%20-%20The%20Promise%20of%20Convergence%20FINAL%20for%20article.pdf)

Gold Award: Community-Based Program: A health Care Home for the “Whole Person” in Missouri’s Community Mental Health Centers (APA Achievement Awards 2015)  
[ps.psychiatryonline.org/doi/full/10.1176/appi.ps.661013can](http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.661013can) Psychiatric Association |