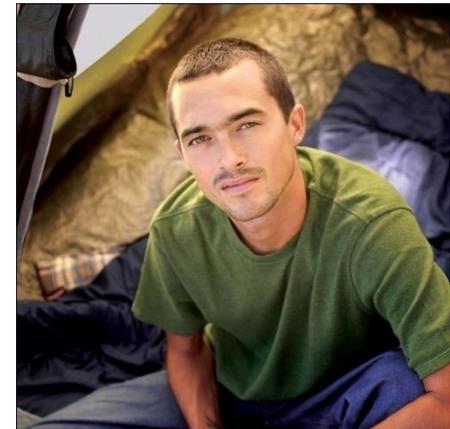


# Bi-Directional Integration: Saving the Lives of Persons with Serious and Persistent Mental Illness



- **Persons with serious mental illness (SMI) are dying 25 years earlier than the general population**
- **While suicide and injury account for about 30-40% of excess mortality, 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases (NASMHPD, 2006)**

- **Higher rates of modifiable risk factors:**

- ✓ Smoking
- ✓ Alcohol consumption
- ✓ Poor nutrition / obesity
- ✓ Lack of exercise
- ✓ “Unsafe” sexual behavior
- ✓ IV drug use
- ✓ Residence in group care facilities and homeless shelters

- **Vulnerability due to higher rates of:**

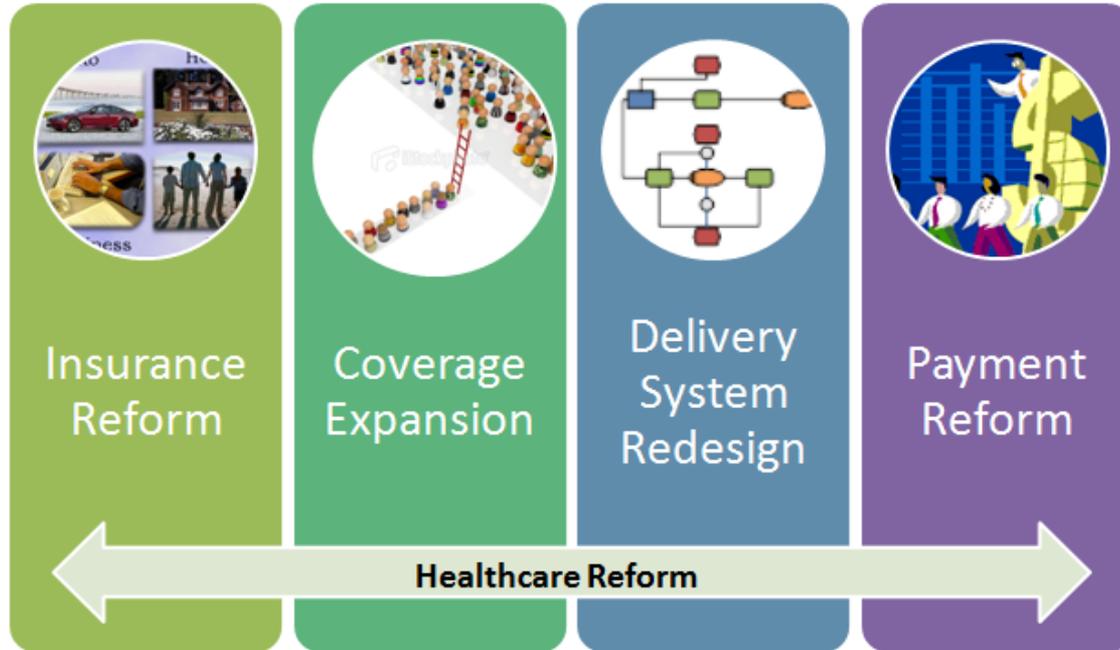
- ✓ Homelessness
- ✓ Victimization / trauma
- ✓ Unemployment
- ✓ Poverty
- ✓ Incarceration
- ✓ Social isolation

**Goal:** enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons across the lifespan with chronic illness

**CMS expects that use of the health home service delivery model will result in**

- lowered rates of emergency room use,
- reduction in hospital admissions and re-admissions,
- reduction in health care costs,
- less reliance on long-term care facilities, and
- improved experience of care and quality of care outcomes for the individual

# Affordable Care Act – Four Key Strategies



- **Essential benefits include mental health and substance use treatment**
- **MH and SUD must be offered at parity with medical/surgical benefits**

**This means...**

**...Most members of the safety net will have coverage, including mental health and substance use disorders**

## **Behavioral Health is Part of Healthcare**

## Prevalence of Psychiatric Disorders in Primary Care

Disorder	Prevalence
No mental disorder	61.4%
Somatoform	14.6%
Major Depression	11.5%
Dysthymia	7.8%
Minor Depression	6.4%
Major Depression (partial remission)	7.0%
Generalized Anxiety	6.3%
Panic Disorder	3.6%
Other Anxiety Disorder	9.0%
Alcohol Disorder	5.1%
Binge Eating	3.0%

Source: Spitzer RL, Williams JBW, Kroenke K, *et al.* Utility of a New Procedure for Diagnosing Mental Disorders in Primary Care: The PRIME-MD 1000 Study. *Journal of the American Medical Association*, 272:1749, 1994.

## Prevalence of Psychiatric Disorders in Low-income Primary Care Patients

- › 35% of low-income patients with a psychiatric diagnosis saw their PCP in the past 3 months
- › 90% of patients preferred integrated care
- › Based on findings, authors argue for system change

Disorder	Low-Income Patients	General PC Population*
At Least One Psychiatric Dx	51%	28%
Mood Disorder	33%	16%
Anxiety Disorder	36%	11%
Alcohol Abuse	17%	7%
Eating Disorder	10%	7%

Source: Mauksch LB, et. Al. Mental Illness, Functional Impairment, and Patient Preferences for Collaborative Care in an Uninsured, Primary Care Population. *The Journal of Family Practice*, 50(1):41-47, 2001.

- **Most PCPs do a good job of diagnosing and beginning treatment for depression (Annals of Internal Medicine, 9/07)**
  - 1,131 patients in 45 primary care practices across 13 states
- **PCPs did less well following up with treatment over time—less than half of patients completed a minimal course of medications or psychotherapy**
- **Lowest quality of care occurred among those with the most serious symptoms, including those with evidence of suicide or substance use**
- **“Right now PCPs don’t have the tools necessary to decide which patients to treat and which to refer on to specialized MH care”**

- **Almost 25% of general healthcare patients report they have a co-morbid substance use conditions likely related to the physical sequelae that result from untreated substance misuse and dependency** (NSDUH, 2005)
- **Substance use conditions often complicate management and treatment of other chronic diseases in primary care such as diabetes, hypertension, asthma and others** (PRISM, 2008)

- Inhalant use among 12-17 year olds and depression are increasing;
- **Patients in chemical dependency programs are 18 times more likely to have major psychosis, 15 times more likely to have depression and 9 times more likely to have an anxiety disorder;**
- **Substance use increases the risk for hypertension (x2) , congestive heart failure (x9) and pneumonia (x12);**
- **HIV patients with a substance use disorder are more likely to be non-adherent;**
- **Medicaid patients with a substance use disorder are more likely to be readmitted to a hospital within 30 days;**

- **More than 1.7 million visits to hospital EDs are related to some form of substance misuse or dependency (DAWN, 2006)**
- **Drug and alcohol disorders are associated with about 3% of hospital stays and \$12 billion in costs. (HCUP, 2006, 2007)**



## **Delivery System Redesign – Health Homes (Medical Homes)**

- **8 State's Plans have been approved:**
  - ✓ Missouri (2) – Behavioral Health and Primary Care
  - ✓ Rhode Island (2) – adults and children with SMI
  - ✓ New York – chronic behavioral and physical health
  - ✓ Oregon
  - ✓ North Carolina
  - ✓ Iowa
  - ✓ Idaho
- **15 States with Planning Grants:**
  - ✓ Alabama, Arizona, Arkansas, California, District of Columbia, Idaho, Maine, Michigan, Nevada, New Jersey, New Mexico, North Carolina, Washington, West Virginia, and Wisconsin

State	Population	Providers	Enrollment	Payment	Geog. Area
Idaho	SPMI or SED; Diabetes or Asthma; D/A and at risk for another chronic condition	Current Healthy Connections Providers	Self referred or referred by provider; opt out	PMPM for comprehensive care mgmt services	Statewide
Iowa	Two chronic conditions or one and at risk for another; includes hypertension	All primary care and CMHCs	Opt in at providers office	PMPM with performance based payment in 2013	Statewide
Missouri	SPMI only and MH or SA plus one chronic condition; MH/SA + tobacco	CMHCs	Auto-assigned with opt out	PMPM	Statewide
Missouri	Physical Health	Primary care	Auto-assigned with opt out	PMPM	Statewide
New York	SMI, Chronic Medical and BH conditions	Any providers meeting criteria	Auto-enroll with opt out	PMPM based on regions, case mix	Statewide

State	Population	Provider	Enrollment	Payment	Geog Area
North Carolina	Two chronic medical conditions or one and at risk for another	Medical Homes	Voluntary through Community Care North Carolina	Tiered PMPM with add on payments for specialized support	Statewide
Ohio	SPMI and SED	CBHCs	Opt out	PMPM	Targeted to 5 counties – statewide year 2
Oregon	Statute based plus Hep C, HIV/AIDS, kidney disease and cancer	PCPCH at Tier 1, 2 or 3 or PCPs meeting state criteria	Opt out	PMPM based on Tier	Statewide
Rhode Island	SMI or SED; two chronic conditions; or one and at risk of another; specific conditions	CEDARR Family Centers	Voluntary	Alternate payment methodology	Statewide
Rhode Island	SPMI	7 CMHO and 2 smaller mhp	Auto- assigned with opt out	Case rate	Statewide

# Defining the Healthcare Home



**Superb  
Access to  
Care**



**Patient  
Engage-  
ment in  
Care**



**Clinical  
Infor-  
mation  
Systems**



**Care Coordination**



**Team Care**



**Patient  
Feed-back**

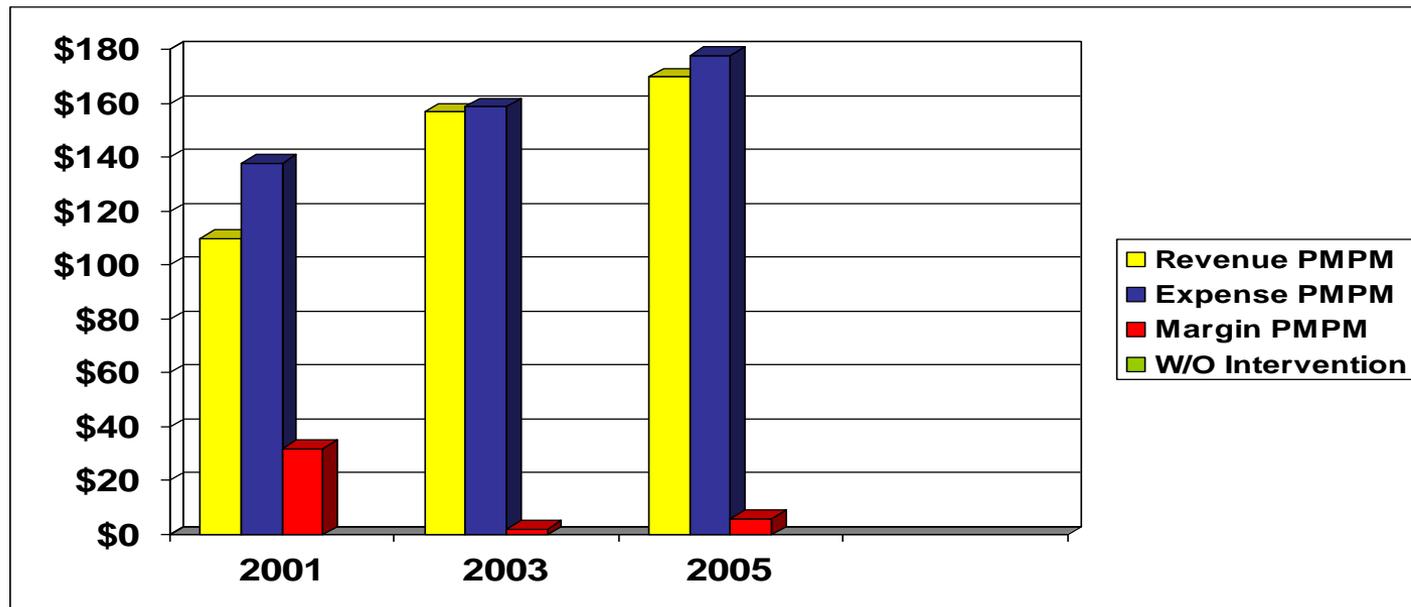


**Publicly  
Available  
Infor-  
mation**

**Person-Centered Healthcare Home**

# Making the Case for Integration in the Health Home

## Impact on Costs



Base Period (CY2006)	\$1,556
Expected Trend	16.67%
Expected Trend with no Intervention	\$1,815.81
Actual PMPM in Performance Period (FY2007)	\$1,504.34
Gross PMPM Cost Savings	\$311.47
Lives	6,757
Gross Program Savings	\$25,254,928
Vendor Fees	\$1,301,560
Net Program Savings	\$23,953,368
NET PMPM Program Savings	\$295.41
Net Program Savings/(Cost) as percentage of Expected PMPM	16.3%

- **Independent Living increased by 33%**
- **Vocational Activity increased by 44%**
- **Legal Involvement decreased by 68%**
- **Psychiatric Hospitalization decreased by 52%**
- **Illegal Substance use decreased by 52%**
- **IN ADDITION- Study shows CMHCs services substantially decrease overall medical cost**

# Models of/for Integration

Function	Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration On-Site	Close Collaboration/Partly Integrated	Fully Integrated/Merged
<b>THE CONSUMER and STAFF PERSPECTIVE/EXPERIENCE</b>					
<b>Access</b>	Two front doors; consumers go to separate sites and organizations for services	Two front doors; cross system conversations on individual cases with signed releases of information	Separate reception, but accessible at same site; easier collaboration at time of service	Same reception; some joint service provided with two providers with some overlap	One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model
<b>Services</b>	Separate and distinct services and treatment plans; two physicians prescribing	Separate and distinct services with occasional sharing of treatment plans for Q4 consumers	Two physicians prescribing with consultation; two treatment plans but routine sharing on individual plans, probably in all quadrants;	Q1 and Q3 one physician prescribing, with consultation; Q2 & 4 two physicians prescribing some treatment plan integration, but not consistently with all consumers	One treatment plan with all consumers, one site for all services; ongoing consultation and involvement in services; one physician prescribing for Q1, 2, 3, and some 4; two physicians for some Q4: one set of lab work
<b>Funding</b>	Separate systems and funding sources, no sharing of resources	Separate funding systems; both may contribute to one project	Separate funding, but sharing of some on-site expenses	Separate funding with shared on-site expenses, shared staffing costs and infrastructure	Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility
<b>Governance</b>	Separate systems with little of no collaboration; consumer is left to navigate the chasm	Two governing Boards; line staff work together on individual cases	Two governing Boards with Executive Director collaboration on services for groups of consumers, probably Q4	Two governing Boards that meet together periodically to discuss mutual issues	One Board with equal representation from each partner
<b>EBP</b>	Individual EBP's implemented in each system;	Two providers, some sharing of information but responsibility for care cited in one clinic or the other	Some sharing of EBP's around high utilizers (Q4) ; some sharing of knowledge across disciplines	Sharing of EBP's across systems; joint monitoring of health conditions for more quadrants	EBP's like PHQ9; IDDT, diabetes management; cardiac care provider across populations in all quadrants
<b>Data</b>	Separate systems, often paper based, little if any sharing of data	Separate data sets, some discussion with each other of what data shares	Separate data sets; some collaboration on individual cases	Separate data sets, some collaboration around some individual cases; maybe some aggregate data sharing on population groups	Fully integrated, (electronic) health record with information available to all practitioners on need to know basis; data collection from one source

## The Four Quadrant Clinical Integration Model



\*PCP-based BH provider might work for the PCP organization, a specialty BH provider, or as an individual practitioner, is competent in both MH and SA assessment and treatment

- **Quadrant I: Low BH/Low PH**

- ✓ PCP (with standard screening tools and BH practice guidelines)
- ✓ PCP- Based BH

- **Interventions**

- ✓ Screening for BH Issues (Annually)
- ✓ Age Specific Prevention Activities
- ✓ Psychiatric Consultation

- **Financing**

- ✓ Primary Care Visits
- ✓ SBIRT Codes for Substance Abuse

- **Quadrant III – Low BH/High PH**

- ✓ PCP with screening tools
- ✓ Care/Disease Management
- ✓ Specialty Med/Surg
- ✓ PCP based- BH
- ✓ ER

- **Interventions**

- ✓ BH Ancillary to Medical Diagnosis
- ✓ Group Disease Management
- ✓ Psychiatric Consultation In PC
- ✓ MSW in Primary Care
- ✓ BH Registries in PC (Depression, Bipolar)

- **Financing**

- ✓ 96000 Series of Health and Behavioral Assessment Codes
- ✓ Two services in one day at an FQHC billable in WV
- ✓ Two Services by two providers is also billable

- **Quadrant II – High BH/Low PH**

- ✓ BH Case Manager w/responsibility for coordination w/PCP
- ✓ PCP with tools
- ✓ Specialty BH
- ✓ Residential BH
- ✓ Crisis/ER
- ✓ Behavioral Health IP
- ✓ Other Community Supports

- **BH Interventions in Primary Care**

- ✓ **IMPACT Model for Depression**
- ✓ **MacArthur Foundation Model**
- ✓ **Behavioral Health Consultation Model**
- ✓ **Case Manager in PC**
- ✓ **Psychiatric Consultation**

- **PC Interventions CMH**

- ✓ **NASMHPD Measures**
- ✓ **Wellness Programs**
- ✓ **Nurse Practitioner, Physician's Assistant, Physician in BH**

- **Financing**

- ✓ Disease Management Pilot in Michigan
- ✓ CMH Capitation
- ✓ Two services are billable

- **Quadrant IV- High BH/High PH**
  - ✓ PCP with screening tools
  - ✓ BH Case Manager with Coordination with Care Management and Disease Management
  - ✓ Specialty BH/PH
- **Interventions in Primary Care**
  - ✓ Psychiatric Consultation
  - ✓ MSW in Primary Care
  - ✓ Case Management
  - ✓ Care Coordination
- **Interventions in BH**
  - ✓ Registries for Major PC Issues (Diabetes, COPD, Cardiac Care)
  - ✓ NASMPD Disease Measures
  - ✓ NP, PA or Physician in BH
- **Financing**
  - ✓ BH Capitation
  - ✓ Primary Care Visits



# Models/Strategies – Bi-Directional Integration

## Behavioral Health –Disease Specific

- IMPACT
- RWJ
- MacArthur Foundation
- Diamond Project
- Hogg Foundation for Mental Health
- Primary Behavioral Healthcare Integration Grantees

## Behavioral Health - Systemic Approaches

- Cherokee Health System
- Washtenaw Community Health Organization
- American Association of Pediatrics - Toolkit
- Collaborative Health Care Association
- Health Navigator Training

## •Physical Health

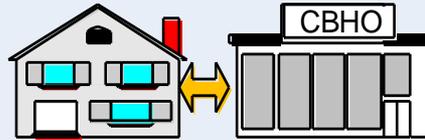
- TEAMcare
- Diabetes (American Diabetes Assoc)
- Heart Disease
- Integrated Behavioral Health Project – California – FQHCs Integration
- Maine Health Access Foundation – FQHC/CMHC Partnerships
- Virginia Healthcare Foundation – Pharmacy Management
- PCARE – Care Management

## •Consumer Involvement

- HARP – Stanford
- Health and Wellness Screening – New Jersey (Peggy Swarbrick)
- Peer Support (Larry Fricks)

**Funding starting to open up for embedding primary medical care into CBHOs, a critical component of meeting the needs of adults with serious mental illness**

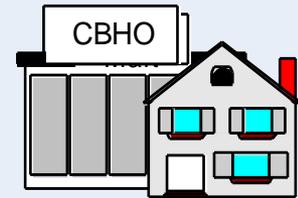
Clinical Design for Adults with Low to Moderate and Youth with Low to High BH Risk and Complexity



Primary Care Clinic with Behavioral Health Clinicians embedded, providing assessment, PCP consultation, care management and direct service

Partnership/Linkage with Specialty CBHO for persons who need their care stepped up to address increased risk and complexity with ability to step back to Primary Care

Clinical Design for Adults with Moderate to High BH Risk and Complexity



Community Behavioral Healthcare Organization with an **embedded Primary Care Medical Clinic** with ability to address the full range of primary healthcare needs of persons with moderate to high behavioral health risk and complexity

- **Contact Information**

- ✓ [kathyr@thenationalcouncil.org](mailto:kathyr@thenationalcouncil.org)
- ✓ [www.integration.samhsa.gov](http://www.integration.samhsa.gov)