Community Mental Health Association of Michigan:
Center for Healthcare Research and Innovation

Healthcare Integration and Coordination – 2017/2018 Update
Hundreds of innovative initiatives identified in a survey of Michigan's Public Mental Health System

February 2018

I. Abstract

This study serves as an annual follow-up to the initial study conducted in 2016.

In November 2017, the Community Mental Health Association of Michigan's Center for Healthcare Research and Innovation conducted a study of the healthcare integration initiatives led by Michigan's Community Mental Health Services Programs (CMH), the state's public Prepaid Inpatient Health Plans (PIHP), and providers within the CMH system. The study examined varying efforts aimed at integrating behavioral health and intellectual/developmental disability services with physical health care services. Results showed that more than 570 healthcare integration efforts, led by these public sector parties, were in operation in Michigan. The CMHs, PIHPs, and providers involved in healthcare integration often pursue a number of efforts simultaneously, with the each organization that responded to the survey implementing an average of over fifteen (15) healthcare integration initiatives. Of this number, work in physical health informed behavioral health and intellectual/developmental disability (BHIDD) services, consumer/patient empowerment and access, and identifying super-utilizers underscored the variety and maturity of these efforts. Fewer integration projects were identified in this year's study due to the development of more mature initiatives, deeper involvement from the health integration partners, and the dropping of initiatives in which, in prior years, the parties leading them were exploring potential substantive involvement.

II. History and Background

The responsibility for the management, design, and operation of Michigan's public behavioral healthcare and intellectual/developmental disability services system (BHIDD), has historically been the responsibility of the Community Mental Health Services Programs (CMHSP), the public Prepaid Inpatient Health Plans (PIHP) that were formed and governed by the CMHSP, the provider networks managed by these two sets of public bodies, and the Michigan Department of Health and Human Services (MDHHS). MDHHS funds this system, Michigan's public mental health system, with state General Fund dollars and Medicaid funding, the latter provided through a monthly shared risk arrangement with the State of Michigan in the form of capitation payments (per Medicaid-eligible).[1]

The public BHIDD system (CMHSPs, PIHPs, and providers) have historically taken a whole-person orientation to service delivery, working to address a range of human needs in addition to behavioral health and intellectual disability needs, as well as a range of social determinants of health. This whole-person orientation is grounded in the person-centered, community-based, and recovery-oriented philosophies guiding the system. Over the past several years, CMHSPs, PIHPs,

[1] Throughout this document, the term "public mental health system" will be used to describe Michigan's Community Mental Health Services Programs (CMHSP), the public Prepaid Inpatient Health Plans (PIHP) that were formed and governed by the CMHSP, and the provider networks managed by these two sets of public bodies

and providers have focused increasingly on integrating the BHIDD services that they provide with primary care and other physical health care services. This practice has:

- Increased access for BHIDD consumers to primary care services
- Improved access to BHIDD services to persons seen in primary care settings but without ready access to the full array of BHIDD services
- Improved prevention and intervention to reduce serious physical illnesses
- Improved overall health status of consumers[2]

Because the CMHSP/PIHP/provider system views the health of the consumer and the broader population as its top priorities, the full spectrum of health-related needs of the people served needs to be considered and addressed.

While, anecdotally, the CMH Association of Michigan knew that a large number of diverse integration efforts were in operation across the state, led by CMHs, PIHPs, and providers within the CMHSP networks in Michigan, no formal cataloging of those efforts had been completed. In 2016, the initial study conducted by the Community Mental Health Association of Michigan (CMHAM) Center for Healthcare Research and Innovation identified a vast array of integration efforts across the state. The Center for Healthcare Research and Innovation conducted the 2nd annual study in late-2017 to capture a picture of the advancement, breadth, and depth of related health care integration initiatives across the state. The 2017 study aims to update the data collected in the 2016 study, given the rapid and continual development of these initiatives by Michigan's public mental health system.

III. Methods

In November 2017, CMHAM issued an electronic survey to its member agency directors and CEOs, in order to gather information regarding the healthcare integration efforts of Michigan's CMHs, PIHP, and providers. The survey included questions surrounding current healthcare integration activities and services. Thirty-eight (38) CMHAM members responded, representing a variety of organizational types and settings. This study will be replicated again, in the near future, to continue tracking the work being done by the state's CMHs, PIHP, and provider system in fostering integrated care. The range of healthcare integration and coordination methods, around which information on activity, within the system, were sought is outlined in Attachment A.

IV. Findings and Analysis

The second annual study resulted in a number of key findings:

A. The state's CMH, PIHP, and provider system has **long recognized that the integration and coordination of healthcare services are key tools to improving the health of persons with BHIDD needs**, making services more effective and accessible while working to lower the overall cost of healthcare and related human services to the communities served by these BHIDD systems.

B. The **variety of healthcare integration initiatives** designed and implemented by the state's CMH, PIHP, and provider system is broad, representing dozens of approaches to fostering integration and coordination of care. The range of healthcare integration approaches are captured in Attachment A.

C. The 2017 study found less integration efforts (572) compared to the 2016 study (750). This indicates that fewer healthcare integration efforts were identified in this study due to a number of reasons. One reason for this is 2016 respondents were exploring or in the initial phases of planning of their integration efforts. The recorded efforts were not pursued with the energy of the respondents focused on a smaller number of more promising initiatives. Qualitative data from the 2017 results indicate deeper integration initiatives that have evolved and become more mature over the past year. These initiatives have become more concentrated, efficient, and advanced in order to meet the demands of the changing social determinants of health.

D. **Three types of integration, with considerable complexity, stood out**. This 2017 study found that there are 572 healthcare integration efforts occurring with potential for more to come. While there were many different methods of integration implemented by the public system, three of those efforts stood out, given their organizational, clinical, technical, and relational complexity. Those efforts were physical health informed BHIDD services, consumer/patient empowerment and access, and identifying super-utilizers. These subsets of the healthcare integration initiatives identified in this study are discussed below, with the frequency of responses summarized in Attachment B.

1. Physical Health Informed BHIDD Services: Integrating behavioral health and physical health into primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs. The CMHAM Center for Healthcare Research and Innovation study found that there are two primary approaches to physical health informed BHIDD services. The first entails identification of patients without a primary care provider. The second involves health screenings. The study found that there are 63 current efforts surrounding increased physical health information in place, while recording 118 total initiatives regarding physical health informed BHIDD services.

A. Identification of Patients Without a Primary Care Provider: Thirty-four (34) locations throughout the state have the ability to identify patients without a primary care provider and/or patients who have not engaged a primary care provider in the past year. Having a regular primary care provider (i.e., family physician or nurse practitioner) is crucial for obtaining compressive, continuous, accessible, and timely healthcare. A primary care provider allows for the coordination with other parts of the healthcare system. There is strong evidence that suggests patients who are identify as having a primary care provider benefit from better care coordination, chronic disease management. They also receive more preventative care, use less emergency services, and have better health outcomes.

B. Health Screening: Twenty-nine (29) locations throughout the state participate in health screenings. These screenings include identification of risk factors for undiagnosed acute or chronic care issues integrated within the behavioral health assessment. Untreated chronic disease is a major factor in the overall higher cost of care for people with behavioral health issues or substance use disorders. Utilizing health screenings can help providers in primary care and other health care settings to assess the severity of these issues and accurately and timely identify the appropriate level of treatment. Referral to treatment is a critical yet often overlooked component of the treatment process. Health screenings allow for the establishment of a clear follow-up method with patients identified as having a possible substance use disorders or in need of specialized treatment for a behavioral health condition.

2. Consumer/Patient Empowerment and Access: Designing personalized interventions is essential to sustain patients' involvement in their treatment, and encouraging patients to take an active role in their own health and health care. Thirty (30) respondents indicated that they provide healthy lifestyles education (WRAP, WHAM, etc.) and/or smoking cessation, weight control, and exercise courses. Twenty-two (22) respondents reported that they are participating in a movement to integrate SAMSHA wellness and recovery principles into BHIDD services. Eighteen (18) use collaborative and concurrent documentation to improve healthcare delivery transparency, consumer health literacy, and efficiency of workflow. These all combine to reduce time spent, by staff, on site for consumers. Seventeen (17) respondents report having Medicaid, Healthy Michigan, and exchange enrollment initiatives on BHIDD site. The 98 initiatives involving consumer/patient empowerment and access work towards allowing consumers to manage their own care by being an expert on their own health and exercising autonomy over their decisions.

3. High/super-utilizer initiatives: A significant segment of the integration initiatives identified in this study are those efforts that address the needs of the high/super-utilizer population. High/super-utilizers are individuals with very high healthcare service utilization patterns, often across disciplines and sectors. These same people often demonstrate high levels of utilization of human services outside of traditional healthcare domains, such as: public safety, housing supports, judiciary, and child welfare. The study found 94 joint efforts between CMHs, PIHP, providers, and primary care practices, hospitals, and Medicaid Health Plans to address the needs among this population in order to effectively utilize healthcare resources. This is improved from the initial 52 joint efforts recorded in 2016. Twenty-four (24) sites also reported the active use of Medicaid claims databases that included both physical and BHIDD services, using the data available through the State of Michigan's Care Connect 360 (CC360) database, portal, and/or other data analytics, to identify high/super utilizers at the point of access and throughout the course of services, supports, and treatment. Twenty-three (23) sites reported joint efforts with primary care practices to address additional needs of increased use of healthcare resources. Ten (10) sites reported active use of data (primarily through CC360) to provide outreach to high/super-utilizers who have not accessed the BHIDD system of care. These 94 initiatives significantly impacted the effectiveness of healthcare resources through the use of the targeting, assertive outreach, and case-management approaches, as well as the provision of adjunct supports including transportation, housing supports, vocational services, and advocacy, to this population.

V. Conclusion

These findings demonstrated the significant gains that continue to be made in Michigan to integrate and coordinate healthcare efforts across BHIDD and physical health systems. Through the integration and coordination of healthcare services, CMHs, PIHP, and providers are working to improve the overall health of persons with BHIDD needs while controlling the overall cost of their healthcare. This study identified 572 healthcare integration initiatives led by CMHs, PIHP, and BHIDD providers across the state of Michigan, of which 310 were those involving: physical health informed BHIDD services, consumer/patient empowerment and access, or efforts to address the needs of the high/super-utilizer population.

As this study represents an update to the first of its kind to catalogue the healthcare integration efforts of the state of Michigan's CMH, PIHP, and provider network, the study will be replicated in

the future to track the emergence of new efforts and the changes in the integration services identified in this study.

The Community Mental Health Association of Michigan (CMHAM) is a state association representing the state's public Community Mental Health (CMH) centers, the public Prepaid Inpatient Health Plans ((PIHP) public health plans formed and governed by the CMH centers) and the providers within the CMH and PIHP provider networks. Information on CMHAM can be found at www.CMHAM.org or by calling (517) 374-6848.

The Center for Healthcare Research and Innovation is the research and analysis office within CMHAM, issuing white papers and analyses on a range of healthcare issues with a focus on behavioral health and intellectual/developmental disability services.

Notes:

1. Michigan Department of Health and Human Services. *Welcome to Behavioral Health and Developmental Disabilities Administration.* Retrieved from http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941-146590--,00.html. Accessed November, 2017.
2. SAMHSA-HRSA Center for Integrated Health Solutions. *SAMHSA PBHCI Program*. Retrieved from http://www.integration.samhsa.gov/about-us/pbhci. Accessed November, 2017.

Attachment A

Healthcare Integration and Coordination approaches sought via CMHAM survey (November 2017 study; February 2018 report)

Active referral network

- Formal referral agreements between BHIDD party and primary care provider or healthplan
- System navigation guidance to consumers (by BHIDD party or in partnership with healthcare provider or health plan)
- Active and frequent referral relationship

Co-location related efforts

- BHIDD staff co-located in primary care practice (may be team-based care or less intense partnership)
- Primary care provider co-located in a BHIDD site (may be team-based care or less intense partnership)
- BHIDD staff co-located at hospital emergency department or BHIDD staff go to the emergency department as a regular protocol to provide crisis screening or inpatient admission pre-screening
- Psychiatric consultation, telephonic, video, or face-to-face provided, by BHIDD party, to primary care site
- Pharmacy co-located in BHIDD site
- Physical health laboratory or lab pick-up at BHIDD site
- Co-funded positions
- Loaning positions from or to BHIDD party

Physical health informed BHIDD services

- Health screening, including identification of risk factors for undiagnosed acute or chronic care issues integrated within the behavioral health assessment process.
- Identification of patients without a primary care provider and/or who have not engaged primary care provider in past year and active referral to such care
- Actively facilitated communication between BHIDD provider and primary care providers (via casemanager, supports coordinator, care manager, nurse caremanager or similar intensive coordination)
- Use of data by the BHIDD party , including health dashboards and standardized tools to target interventions (often to high utilizers and others) to improve population health

Services/supports/treatment plan and Electronic Health Record (EHR)

- Single care plan reflecting BHIDD services and supports and physical health treatment
- Shared or linked BHIDD and primary care electronic health records
- ADT (Admission, Discharge, and Transfer) data by hospitals and emergency departments with BHIDD party
- Use of portals with primary care and hospital systems as a normal part of workflow to direct treatment
- Integration of primary care coordination measures (MDHHS, HEDIS, or others) into EHR and staff workflows (e.g., physical and behavioral health medication reconciliation)

High/super utilizers

- Active use of data (Care Connect 360 or other data analytics) to identify high/ super utilizers at the point of access.
- Active use of data (Care Connect 360) to provide outreach to high / super utilizers who have not accessed the BHIDD system of care.
- Joint effort with primary care practices to address the needs of high/super utilizers of healthcare resources
- Joint effort with hospitals (including emergency departments) to address the needs of high/super utilizers of health care resources
- Joint effort with Medicaid Health Plans, to address the needs of high/super utilizers of health care resources

Workforce education and training

- Joint educational and networking efforts for BHIDD providers and primary care providers
- BHIDD workforce trained on healthcare integration and health literacy
- BHIDD party provides/facilitates training for primary care workforce on BHIDD issues

Consumer/patient empowerment and access

- Healthy lifestyles education (WRAP, WHAM, etc.) and/or smoking cessation, weight control, exercise courses
- Medicaid, Healthy Michigan, and exchange enrollment initiatives on BHIDD site
- Movement to integrate SAMSHA wellness and recovery principles into BHIDD services
- Use of collaborative/concurrent documentation to improve healthcare delivery transparency and consumer health literacy and efficient workflow for staff reducing time onsite for consumers
- Use of same-day/next-day access and just in time prescribing approaches reduce no-shows and enhance access to services

Attachment B
Summary of frequency of a subset of healthcare integration initiatives, implemented in Michigan, led by CMHSP, PIHP, and providers within the CMH system (November 2017 study; February 2018 report)

1. Physical health informed BHIDD services	
Identification of patients without a primary care provider and/or who have not engaged primary care provider in the past year and active referral to such care	22
Actively facilitated communication between BHIDD provider and primary care providers (via case manager, supports coordinator care manager, nurse care manager, or similar intensive coordination)	20
Health screening, including identification of risk factors for undiagnosed acute or chronic care issues integrated within the behavioral health assessment	29
Use of data by the BHIDD party, including health dashboards and standardized tools to target interventions (often to high utilizers and others) to improve population health	21
Total Physical health informed BHIDD services initiatives	118

2. Consumer/Patient empowerment and access	
Healthy lifestyles education (WRAP, WHAM, etc.) and/or smoking cessation, weight control, exercise courses	30
Movement to integrate SAMSHA wellness and recovery principles into BHIDD services	22
Use of collaborative/concurrent documentation to improve healthcare delivery transparency and consumer health literacy and efficient workflow for staff reducing time on site for consumers	18
Medicaid, Healthy Michigan, and exchange enrollment initiatives on BHIDD site	17
Use of same-day/next-day access and just in time prescribing approaches reduce no-shows and	11

enhance access to services	
Total integration of Consumer/Patient empowerment and access	98

3. High/super-utilizer initiatives	
Active use of data (Care Connect 360 or other data analytics) to identify high/ super utilizers at the point of access	24
Joint effort with primary care practices to address the needs of high/super-utilizers of healthcare resource	23
Joint effort with Medicaid Health Plans, to address the needs of high/super-utilizers of health care resources	20
Joint effort with hospitals (including emergency departments) to address the needs of high/super-utilizers of healthcare resources	17
Active use of data (Care Connect 360) to provide outreach to high/super-utilizers who have not accessed the BHIDD system of care.	10
Total high/super-utilizers initiatives	94