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Center for Healthcare Integration & Innovation

Community Mental Health Association of Michigan

Healthcare Integration and Coordination – 2020/2021 Update: Survey of Initiatives of Michigan's Public Mental Health System

January 2021

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I. Abstract

This study serves as an annual follow-up to previous studies conducted in 2016 to present.

In November 2020, the Community Mental Health Association of Michigan's (CMHAM) Center for Healthcare Integration 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 healthcare services. Results showed that more than 626 healthcare integration efforts, led by these public sector parties, were in operation throughout Michigan. The CMHs, PIHP, and providers involved in healthcare integration, often pursue a number of efforts simultaneously, with each organization that responded to the survey reporting an average of **over 20 healthcare integration initiatives**. Of this number, work around physical health-informed behavioral health and intellectual/developmental disability (BHIDD) services, co-location, and identification of super-utilizers underscored the variety and maturity of these efforts.

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, PIHP, 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

[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

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, PIHP, and providers have focused increasingly on integrating the BHIDD services that they provide with primary care and other physical healthcare 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 CMHSPs, PIHP, 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 Integration and Innovation identified a vast array of integration efforts across the state. The Center for Healthcare Integration and Innovation conducted the second annual study in 2017 to capture a picture of the advancement, breadth, and depth of these initiatives. The current study, conducted late 2020, aims to update the data collected in the previous years, given the rapid and continual development of these initiatives by Michigan's public mental health system.

III. Methods

In November 2020, 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. **Twenty Five (25)** CMHAM members responded, representing a variety of organizational types and settings. This study will continue to be replicated on an annual basis to continue tracking the work being done by the state's CMHs, PIHP, and provider system to foster 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 fifth 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. **Safety net behavioral and physical healthcare providers are working together to provide vital services through integrated care models.** The current study is the first to examine healthcare integration efforts among Michigan's public physical and behavioral healthcare systems. The study found that the CMH, PIHP, and provider system is involved in over **43** efforts state-wide to coordinate and integrate care with federally funded Community Health Centers (FQHCs). These efforts include active referral networks, co-location, care coordination, collaborative treatment planning, data sharing, efforts to identify and address needs of high/super-utilizers, and joint workforce education and training initiatives.

D. **Three types of integration, with considerable complexity, stood out**. This 2020 study identified **626** healthcare integration efforts occurring across the state, with the 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, co-location, and identification of super-utilizers. These three methods of integration are discussed below, with the frequency of responses summarized in Attachment B.

1. Physical Health Informed BHIDD Services: Integrating physical health needs and goals into BHIDD services improves outcomes and proves the most effective approach to caring for people with multiple healthcare needs. The CMHAM Center for Healthcare Integration and Innovation study found two primary approaches to physical health informed BHIDD services in the state of Michigan. The first entails identification of patients without a primary care provider. The second involves health screenings. The study found that there are **100** current efforts surrounding increased health information in place, while recording **126** total initiatives regarding physical health informed BHIDD services.

A. Health Screening: Twenty-nine locations utilize health screenings. These screenings consist of items designed to identify risk factors for undiagnosed acute or chronic care issues integrated throughout traditional behavioral health

assessments. Untreated chronic disease is a major factor in the increased cost of care for people with behavioral health issues or substance use disorders. The implementation of health screening processes allows providers in primary care and other healthcare settings to assess the severity of health issues and identify the appropriate level of treatment.

B. Identification of Patients Without a Primary Care Provider: Twenty-eight locations throughout the state have processes in place 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 coordination among other parts of the healthcare system. Research suggests patients who have a primary care provider benefit from improved care coordination and chronic disease management. They receive more preventative care, are less likely to use emergency services, and have better health outcomes overall.

C. Facilitating Communication between BHIDD provider and primary care providers (Fostering Integration): Twenty-nine out of thirty locations aimed at fostering communication efforts between BHIDD sites and primary care providers. These efforts included communication via case manager, supports coordinators, care managers and similar intensive coordination. Coordinating with primary care providers increases the likelihood of positive outcomes for patients, strengthens coordination and improves quality of care

2. Co-location Initiatives: This study identified **89** efforts to co-locate physical and BHIDD services within the same physical space.

The most common method of co-location was housing BHIDD staff in hospital emergency departments or creating regular protocol that BHIDD staff provide crisis screening in emergency departments, with **18** sites reporting this method of integration. **Thirteen** organizations have BHIDD staff co-located within a primary care practice. **Fourteen** co-location efforts across the state involve a FQHC. Research indicates that colocation of physical and behavioral healthcare is linked to reductions in no-shows, increased primary care utilization, and improved physical health goals among adults with serious mental illness. Co-location may also improve practitioners' understanding and skills in relation to the other professionals with whom they co-locate. The growing number of co-location initiatives across the state represents the CMH system's appreciation for the importance of integration efforts, and the impact they may have on access to care, care coordination, and the overall client experience.

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 **86** 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.

Twenty-one sites 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.

Fifteen sites reported joint efforts with primary care practices to address additional needs of increased use of healthcare resources.

Nine 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 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 demonstrate 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 health of persons with BHIDD needs while controlling the overall cost of their healthcare. This study identified **626** healthcare integration initiatives led by CMHs, PIHP, and BHIDD providers across the state of Michigan, of which **301** were those involving: physical health informed BHIDD services, co-location, or efforts to address the needs of the high/superutilizer population.

As this series of studies represents 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 continue to be replicated in the future to track the emergence of new efforts and the changes in the integration services identified in this study.

The Center for Healthcare Integration and Innovation (CHI[2]) is the research and analysis office within the Community Mental Health Association of Michigan (CMHAM). The Center, in partnership with the members of the CMH Association, leaders, researchers, consultants and advisors from across Michigan and the country, issues white papers and analyses on a range of healthcare issues with a focus on behavioral health and intellectual/developmental disability services.

The Community Mental Health Association of Michigan (CMHAM) is the 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.

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 Center for Healthcare Integration and Innovation survey (November 2020 study; January 2021 report)

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

- Active and frequent referral relationship ○ Community Health Centers (FQHCs) are included in referral network

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
- Co-location efforts involve a Community Health Center (FQHC)

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 case manager, supports coordinator, care manager, nurse care manager 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
- BHIDD providers work with Community Health Centers (FQHCs) to identify and meet patients' physical healthcare needs

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)
- Collaborative treatment planning and/or data sharing with Community Health Centers (FQHCs)

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 healthcare resources
- Joint effort with Medicaid Health Plans, to address the needs of high/super utilizers of healthcare resources
- Joint effort with Community Health Centers (FQHCs) to identify and address the needs of high/super-utilizers of healthcare resources
- Use of hands-on complex case/care management to persons with complex needs

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 ○ Community Health Centers (FQHCs) are included in training and education efforts

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 noshows and enhance access to services

Attachment B

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	23
Health screening, including identification of risk factors for undiagnosed acute or chronic care issues integrated within the behavioral health assessment	24
Actively facilitated communication between BHIDD provider and primary care providers (via case manager, supports coordinator, care manager, nurse care manager, or similar intensive coordination)	25
BHIDD providers work with Community Health Centers (FQHCs) to identify and meet patients' physical healthcare needs	13
Use of data by the BHIDD party, including health dashboards and standardized tools, to target interventions (often to high utilizers) to improve population health	21

Total physical health-informed BHIDD service	106 initiatives

2. Co-location related efforts	
Primary care provider co-located in a BHIDD site (may be term-based care or less intense partnership)	12
Co-location efforts involve a Community Health Center (FQHC)	13
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	16
Psychiatric consultation, telephonic, video, or face-to-face provided by BHIDD party to primary care site	11
Pharmacy co-located in BHIDD site	5
BHIDD staff co-located in primary care practice (may be term-based care or less intense partnership)	13
Physical health laboratory or lab pick-up at BHIDD site	6
Co-funded positions	8
Loaning positions from or to BHIDD party	1
Total co-location initiatives	85

3. High/super-utilizers	
Active use of data (Care Connect 360 or other data analytics) to identify high/super utilizers at the point of access	17
Joint effort with primary care practices to address the needs of high/super-utilizers of healthcare resources	10
Joint effort with Medicaid Health Plans, to address the needs of high/super-utilizers of healthcare resources	17
Joint effort with hospitals (including emergency departments) to address the needs of high/super-utilizers of healthcare resources	17
Joint effort with Community Health Centers (FQHCs) to identify and address the needs of high/super-utilizers of healthcare resources	8
Active use of data (Care Connect 360) to provide outreach to high/super-utilizers who have not	10

accessed the BHIDD system of care	
Use of hands-on complex case/care management to persons with complex needs	21
Total initiatives aimed at high/super-utilizers	100
Total initiatives aimed at integrating care	**291**