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Center for Healthcare Integration & Innovation

Community Mental Health Association of Michigan

Healthcare Integration and Coordination – 2022/2023 Update: Survey of Initiatives of Michigan's Public Mental Health System

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I. Abstract

In October 2022, the Community Mental Health Association of Michigan's (CMHA) 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 following study is a result of the annual survey that the Association has been conducting since 2016. Results showed that more than 789 healthcare integration efforts, led by these public sector parties, were in operation throughout Michigan. A total of 40 organizations contributed to the survey to discuss the integration between physical, behavioral health, and intellectual/developmental disability (BHIDD) services, co-location, and identification of super-utilizers underscored the variety and maturity of these efforts. The results indicate that most organizations led various health integration efforts simultaneously.

II. History and Background

To understand the findings of this study, it is important to reflect on the concept of integrated health. American Psychological Association describes integrated health as an approach that entails a high level of collaboration and communication between health professionals/organizations. It is done through active communication among different mediums of care to address the biological, psychological, and social needs of the consumer.[1]

The Community Mental Health Services Programs (CMHSP) has historically been in charge of the overall operations and creation of Michigan's public behavioral healthcare and intellectual/developmental disability services system (BHIDD). Through that responsibility, the public Prepaid Inpatient Health Plans (PIHP) 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

[1] American Psychological Association. *Integrated Health Care*. Retrieved from https://www.apa.org/health/integrated-health-care

monthly shared risk arrangement with the State of Michigan in the form of capitation payments (per Medicaid-eligible)[2].

The public BHIDD system (CMHSPs, PIHP, and providers) has 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[3]. 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 fulfilled these objectives:

- 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[4]

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

While, anecdotally, the CMHA knew that several, diverse integration efforts were in operation across the state, led by CMHSPs, PIHP, and providers within the CMHSP networks in Michigan, there was no formal cataloging of any such initiatives. In 2016, the initial study conducted by the Community Mental Health Association of Michigan (CMHA) 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 (2022-2023) aims to update the data collected in the previous years, given the rapid and continual development of

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[2]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.

[3] 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

[4] SAMHSA-HRSA Center for Integrated Health Solutions. SAMHSA PBHCI Program. Retrieved from http://www.integration.samhsa.gov/about-us/pbhci.

these initiatives by Michigan's public mental health system. It also serves as an opportunity to assess the changes in Michigan's healthcare integration efforts.

III. Methods

In October 2022, an electronic survey was sent consisting of ten questions assessing the level of healthcare integration efforts. This survey was sent out to all CMHA members' senior leadership, with the objective of gathering information regarding the healthcare integration efforts of Michigan's CMHs, PIHP, and providers. A total of 40 CMHA member organizations filled out the survey, which helped the Association capture diverse organizational settings. The results of the study are compared to the previous year's study as well to assess the longitudinal changes. The study is cognizant of the fact that the surveys every year have gone through a certain level of modification to capture the integration outcomes appropriately, and members have become more oriented with the therefore, the data cannot be fully compared, but it does give us an idea about the overall trends as shown in Table 1 as part of the Annex at page 8.

IV. Findings and Analysis

The 2022-2023 study resulted in several 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 is captured in Attachment A on page 8.

C. **Safety net behavioral and physical healthcare providers are working together to provide vital services through integrated care models.** The current study is not only the first to examine healthcare integration efforts among Michigan's public physical and behavioral healthcare systems but is also the consistent data source related to this subject since 2016. The study found that the CMH, PIHP, and provider system are involved in state-wide efforts 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 the needs of high/super-utilizers, and joint workforce education and training initiatives. All these areas capture the themes that are required for an efficient integrated healthcare system as established by the definition earlier.

D. Three specific types of integration, with considerable complexity, stood out, in addition to a handful of other notable findings. This 2022-2023 study identified 789 healthcare integration efforts occurring across the state, with the potential for more to come. While Michigan has experience in several health integration methods, there were some that stood out more than others. These three main integration efforts implemented by the public system highlight the system's organizational, clinical, technical, and relational complexity. Those efforts were physical health informed BHIDD services, co-location, and identification of super-utilizers. They are discussed below in detail, with the frequency of responses summarized in Attachment B on page 11.

Expanding Community Support and Enhancing Workforce's Skillset

OnPoint (the CMH serving Allegan County) focused more on supporting their communities through more work on integrated healthcare. Firstly, additional staff was hired to support the expansion relating to the needs identified in the organization's community needs assessments, and the overall staff was also trained on these new forms of service delivery. Secondly, internal treatment of substance use disorder services began through this project. Lastly, there was a lot of work done on improving OnPoint's access department workflows, evidence-based practice tools, and adapting to models of care successfully initiated by other CCBHCs.

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. This study found **157** total initiatives regarding physical health informed BHIDD services.

a. **Identification of Patients Without a Primary Care Provider: 34 sites (85%)** reported 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.
b. **Facilitating Communication between BHIDD providers and primary care providers (Fostering Integration): 37 sites (93%)** reported efforts aimed at fostering communication efforts between BHIDD sites and primary care providers. These efforts included communication via case managers, support coordinators, care managers, and similar intensive coordination. Coordinating with primary care providers increases the likelihood of positive outcomes for patients, strengthens coordination, and improves the quality of care.
c. **Health Screening: 34 sites (85%)** reported utilization of 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.

2. 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 support, judiciary, and child welfare. The study found 147 joint efforts between CMHs, PIHP, providers, primary care practices, hospitals, and Medicaid Health Plans to address the needs of this population in order to effectively utilize healthcare resources.

a. **29 sites (73%)** reported active use of data (Care Connect 360 or other data analytics) to identify high/super-utilizers at the point of access.

b. **17 sites (43%)** reported joint efforts with Medicaid Health Plans to address the needs of high/super-utilizers.

c. **34 sites (85%)** reported the use of hands-on complex case/care management for persons with complex needs.

d. **13 sites (33%)** reported active use of data (Care Connect 360 or other data analytics) to provide outreach to high/super-utilizers who have not accessed the BHIDD system of care.

Efforts to Increase Outreach and Services

In 2022, 52 individuals were served by the high-utilization Integrated Care Team program jointly managed by NorthCare and UPHP.
NorthCare also began a grant-funded project for community health worker supports with Superior Housing Solutions, a recovery organization supporting individuals with co-occurring substance use disorders and mental illness. 90 unduplicated individuals who are not traditionally reached by the CMHSP system received community-based outreach. Supports include assisting people with getting medical care through a primary care physician, following through on physician recommendations, supports to obtain permanent housing, and links to mental health and substance use disorder providers.

e. **14 sites (35%)** reported joint efforts with primary care practices to address additional needs of increased use of healthcare resources.

3. Co-location Initiatives: This study identified **115** total efforts to co-locate physical and BHIDD services within the same physical space. The most common method of co-location of BHIDD staff in hospital emergency departments or creating a regular protocol that BHIDD staff provide crisis screening in emergency departments, with **19 sites (48%).** The second highest was psychiatric consultation, telephonic, video, or face-to-face, provided by a BHIDD party to a primary care site, with **17 sites (43%). 12 co-location efforts (30%)** a reported integration across the state involving an FQHC.

Out of 40 respondents, **17 (43%)** reported having existing integrated partnerships with FQHC. All those 17 were linked to Michigan Health Center Program Grantees FQHC. Except for one member who was linked to both Michigan Health Center Program and Indian Health Service Providers. Other exceptions also became apparent as Genesee Community Health Center reported that it operates its own FQHC.

Other notable findings:

34 sites (85%) reported an active and frequent referral network.

33 sites (83%) reported providing healthy lifestyles education (WRAP, WHAM, etc.) and/or smoking cessation, weight control, or exercise courses.

32 sites (80%) reported receiving Admission, Discharge, and Transfer (ADT) data from hospitals and emergency departments.

25 sites (63%) reported providing system navigation guidance to consumers (by BHIDD party or in partnership with a healthcare provider or health plan)

An Integrated Approach to Crisis Screening and Management

Claire, an eleven-year-old girl, came to the Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMHA-CEI) through a crisis screening. She was suicidal and had recently been diagnosed with Type I Diabetes, a situation her family was struggling to manage as her behaviors worsened.

Claire started in home-based therapy up to three times per week. In addition to home-based therapy, Claire was connected with a nurse care manager (NCM). The NCM met with the family to talk specifically about managing Type I Diabetes and discovered that the mother wasn't happy with their primary care provider; they were in the process of switching to a new provider. The NCM met with the mom a couple of times to help her plan for the first appointment with the new provider so she could make the most of the time together including figuring out what questions to ask and what services to request (e.g., Claire has food sensitivities and was not getting the nutrition she needed).

After the appointment with the new provider, the NCM also connected Claire and her mom with a food therapist, diabetes nutrition classes, and an endocrinologist. The NCM helped coordinate Claire's medical services and care between all her therapists and providers. Specifically, when Claire's weight was dropping, which was a concern, the NCM ensured that the primary care provider, other providers, and therapists were all on the same page with treatment.

After six months, Claire was past the crisis stage. She was still in home-based therapy, which was reduced to one time per week. She was receiving community living support which helped her figure out how to get to

34 sites (85%) reported workforce training on healthcare integration and health literacy.

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 789 healthcare integration initiatives led by CMHs, PIHPs, and BHIDD providers across the state of Michigan, of which 381 were those involving: physical health informed BHIDD services, active referral networks, or efforts to address the needs of the high/super-utilizer population.

school and manage her anxiety about being separated from her mother. In the home-based therapy, Claire focused more on the trauma as it relates to her diabetes diagnosis. She is an active participant in an evidence-based practice called Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).

Claire's parents have realized there is a connection between Claire's negative behaviors and her elevated insulin numbers, so they are monitoring that closely. With the extra support the family received through the CMHA-CEI team and community partners, Claire and her parents are managing the situation much better than they were.

As this series of studies represents the first of its kind to catalog 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 (CMHA). 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 (CMHA) is the state association representing Michigan's public mental health system – the state's 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. Every year, these members serve over 300,000 Michigan residents with mental health, intellectual/developmental disability, and substance use disorder needs. Information on CMHA can be found at www.cmham.org or by calling (517) 374-6848.

Annex

Table 1: Healthcare Integration Trends from 2016 to 2022

Year	Number of Respondents	Integration Outcomes
2016-2017	32	751
2017-2018	38	572
2018-2019	35	663
2019-2020	30	626
2020-2021	25	626
2021-2022	20	451
2022-2023	40	789

Attachment A

- **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 a healthcare provider or health plan)
  - Active and frequent referral relationship
- **Co-location related efforts**
  - BHIDD staff co-located in primary care practice (may be term-based care or less intense partnership)
  - Primary care provider co-located in a BHIDD site (may be term-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

    - 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
    - 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
    - BHIDD providers work with Community Health Centers (FQHCs) to identify and meet patients' physical health care 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
    - Admission, Discharge, and Transfer (ADT) 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/Complex case/care management**
    - 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 health care resources
    - Joint effort with Community Health Centers (FQHCs) to identify and address the needs of high/super-utilizers of health care 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 on site for consumers
    - Use of same-day/next-day access and just in time prescribing approaches reduce no-shows and enhance access to services
    - Do you have any existing integration partnerships with FQHC?

Attachment B

Active referral network	
Formal referral agreements between BHIDD party and primary care provider	**18**
System navigation guidance to consumers (by BHIDD party or in partnership with healthcare provider or health plan)	**25**
Active and frequent referral relationship	**34**
Co-location related efforts	
BHIDD staff co-located in primary care practice (may be term-based care or less intense partnership)	**8**
Primary care provider co-located in a BHIDD site (may be term-based care or less intense partnership)	**11**
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	**19**
Psychiatric consultation, telephonic, video, or face-to-face provided by BHIDD party to primary care site	**17**
Pharmacy co-located in BHIDD site	**13**
Physical health laboratory or lab pick-up at BHIDD site	**8**
Co-funded positions	**6**
Loaning positions from or to BHIDD party	**4**
Co-location efforts involve a Community Health Center (FQHC)	**12**
Existing integration partnerships with FQHC	**17**
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	**34**
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	**34**
Actively facilitated communication between BHIDD provider and primary care providers (via case manager, supports coordinator care manager, nurse care manager, or similar intensive coordination)	**37**
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	**30**
BHIDD providers work with Community Health Centers (FQHCs) to identify and meet patients' physical health care needs	**22**
Services/supports/treatment plan and Electronic Health Record (EHR)	
Single care plan reflecting BHIDD services and supports and physical health treatment	**12**
Shared or linked BHIDD and primary care electronic health records	**7**
Admission, Discharge, and Transfer (ADT) data by hospitals and emergency departments with BHIDD party	**32**
Use of portals with primary care and hospital systems as a normal part of workflow to direct treatment	**12**

	Integration of primary care coordination measures (MDHHS, HEDIS, or others) into EHR and staff workflows (e.g., physical and behavioral health medication reconciliation	**22**
	Collaborative treatment planning and/or data sharing with Community Health Centers (FQHCs)	**10**
Workforce education and training		
	Joint educational and networking efforts for BHIDD providers and primary care providers	**17**
	BHIDD workforce trained on healthcare integration and health literacy	**34**
	BHIDD party provides/facilitates training for primary care workforce on BHIDD issues	**17**
	Community Health Centers (FQHCs) are included in training and education efforts	**19**
High/super-utilizers/Complex case/care management		
	Active use of data (Care Connect 360 or other data analytics) to identify high/ super utilizers at the point of access.	**29**
	Active use of data (Care Connect 360) to provide outreach to high/super-utilizers who have not accessed the BHIDD system of care.	**13**
	Joint effort with primary care practices to address the needs of high/super-utilizers of healthcare resources	**19**
	Joint effort with hospitals (including emergency departments) to address the needs of high/super-utilizers of healthcare resources	**21**
	Joint effort with Medicaid Health Plans, to address the needs of high/super-utilizers of health care resources	**17**
	Joint effort with Community Health Centers (FQHCs) to identify and address the needs of high/super-utilizers of health care resources	**14**
	Use of hands-on complex case/care management to persons with complex needs	**34**
Consumer/patient empowerment and access		
	Healthy lifestyles education (WRAP, WHAM, etc.) and/or smoking cessation, weight control, exercise courses	**33**
	Medicaid, Healthy Michigan, and exchange enrollment initiatives on BHIDD site	**20**
	Movement to integrate SAMSHA wellness and recovery principles into BHIDD services	**21**
	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	**21**
	Use of same-day/next-day access and just in time prescribing approaches reduce no-shows and enhance access to services	**16**