Building the Person-Centered Healthcare Home of the Future
Part Two

Washington State
Department of Social and Health Services
Behavioral Health and Primary Care
Integration Collaborative
6-28-10

Barbara Mauer, MSW, CMC
MCPP Healthcare Consulting Inc.
Seattle, Washington

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DSHS Vision: *Safe, healthy individuals, families and communities*

- Priorities: Health
  - Behavioral and primary healthcare integration through person-centered healthcare home
  - Chronic care self-management
  - Improved quality, cost and effectiveness
  - Improved nutrition

Integration Collaborative: Training

Training Part One 5-25-10

Overview of Healthcare Reform

- Coverage Expansion and Parity
- Payment Reform
- Medical Homes

Service Delivery Redesign

- Person-Centered Healthcare Homes
- The Four-Quadrant Model
- Care Management

Training Part Two 6-28-10

Business Case for Integrated Care

Elements of Integration

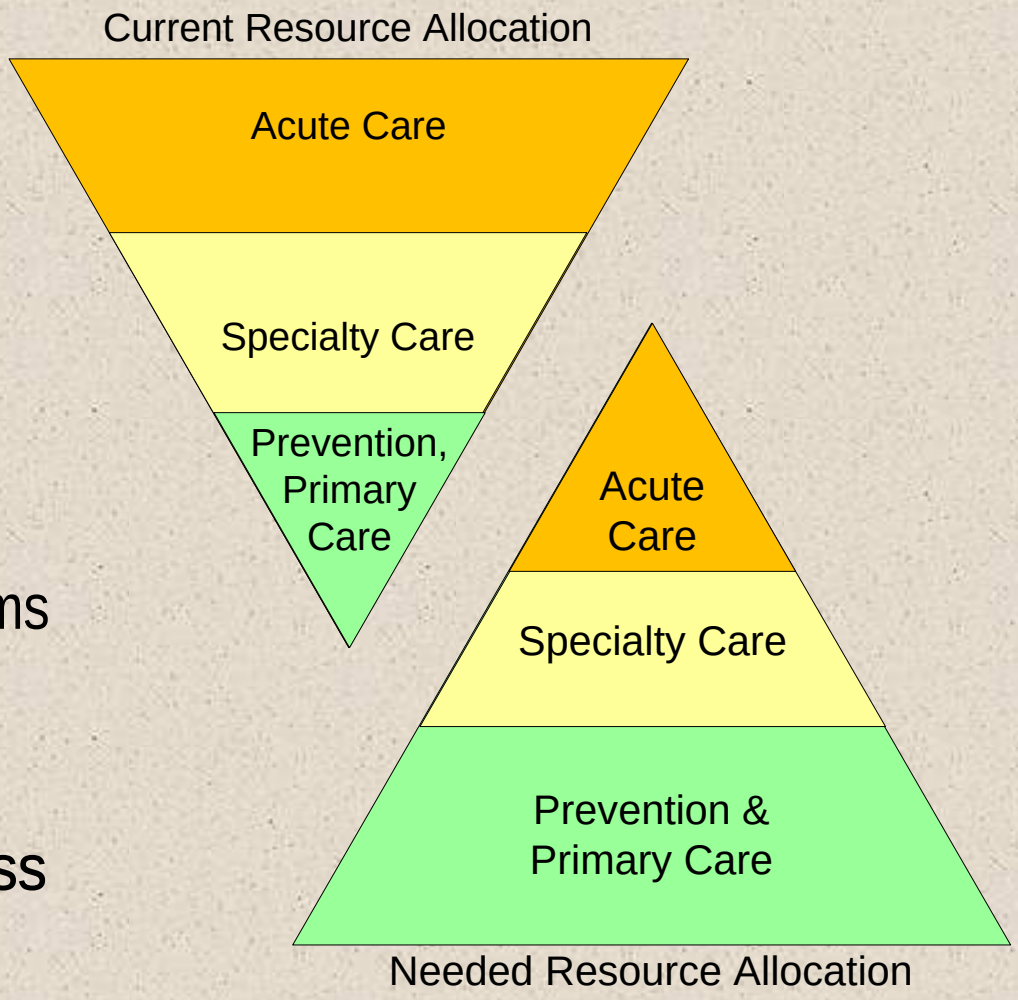
- Clinical
  - Care Model Components
  - Care Management (continued)
  - Information Sharing/Health IT
- Operational/Structural
  - All Healthcare is Local
  - Three Models
- Financial
  - New Financing Paradigms
  - WA Payment Reform

Integration Collaborative: Policy Framework Development

- Build a knowledge base within Washington State government regarding the integration of MH/SU services in primary care and the integration of primary care into specialty MH/SU settings
  - These training sessions and related materials
  - Additional sessions/materials: Integration Implementation Team (office chief and senior staff level) and Dissemination Team (7/14, 8/3, 8/24, 9/13, 10/7, 10/24, 11/15, 12/8)
- Expectation that the program, policy and financing options for DSHS (and HCA, DOH) be shaped by a consistent vision of how integrated services would be delivered, and how program, policy and financing decisions align to this vision
  - Washington State Integration Policy Framework (December 2010)

Implementing Person-Centered Healthcare Homes

- Need to invert the Resource Allocation Triangle
- Prevention activities must be funded and widely deployed
- Primary Care must become a desirable occupation and…
- Decrease demand in the specialty and acute care systems
- These are dramatic shifts that will not *magically* take place
- Today we focus on the **business case for integrated care** and **elements of implementation**



The Business Case for Integrated Care

Medi-Cal Only Population Type	CY 2006 FFS Beneficiaries with 12 Months Eligibility	Medi-Cal Payments in Prediction Year	Per Person Annual Payments
All SMI	249,254	$2,758,001,218	$11,065
Total Risk	28,080	$976,381,877	$34,771
Highest Risk	9,569	$484,485,372	$50,631

Revisiting the data on the Medi-Cal highest risk population with SMI

Savings Opportunity in Highest Risk Patients: Relapse versus Recovery Analysis

- Model identifies high risk population with historical patterns of persistently expensive care
- Analysis of high risk beneficiaries who go on to recover and those who relapse in follow up period demonstrate cost savings opportunity
- In prediction year costs for two care paths
  - $5,062 per month in relapse population
  - $3,156 per month in recovery population
  - Relapse to recovery conversion represents a $1,900 per month opportunity

What Factors Lead to Recovery?

- Factors correlated with recovery trajectory
  - Rehabilitation therapy visits after hospital discharge
  - Physician GP expenditures and visit rates during chronic disease exacerbation
  - Extended hospital length of stay
  - Higher ratio of physical to mental health expenditures
  - Inpatient care over ER care
  - Recent use of psycho-active medication, with special risk associated with initiation management and discontinuation supervision

What Factors Lead to Continued Health?

- Preventive Care
- Factors correlated with continued health in low risk population
  - Ongoing outpatient physician care
  - Flu vaccination
  - Eye exam
  - Ear exam
  - HDL testing in diabetics
  - Uninterrupted use of psycho-pharmaceuticals

Integrating Primary Care in a SU Program

- Kaiser tracked a subgroup of patients with Substance Abuse-Related Medical Conditions (SAMCs)
- SAMC integrated care patients had significantly higher abstinence rates than SAMC independent care patients
- SAMC integrated care patients demonstrated a significant decrease in inpatient rates and average medical costs (excluding addiction treatment) decreased from $470.39 pmpm to $226.86 pmpm

Depression, injury and poisonings/overdoses, anxiety and nervous disorders, hypertension, asthma, psychoses, acid-peptic disorders, ischemic heart disease, pneumonia, chronic obstructive pulmonary disease, cirrhosis, hepatitis C, disease of the pancreas, alcoholic gastritis, toxic effects of alcohol, alcoholic neuropathy, alcoholic cardiomyopathy, excess blood alcohol level, and prenatal alcohol and drug dependence

The Business Case, Summarized

- A ranking of 25 preventive services recommended by the United States Preventative Services Task Force (USPSTF) based on clinically preventable burden and cost effectiveness
  - Alcohol screening and intervention rated at the same level as colorectal cancer screening/treatment and hypertension screening/treatment
  - Depression screening/treatment rated at the same level as osteoporosis screening and cholesterol screening/treatment
- Intermountain Healthcare (Utah) has 68 primary care sites, of which 12 are considered to have mental health integration as the norm
  - Preliminary analysis of claims at these clinics compared to those without mental health integration demonstrated fewer claims for total primary care and psychiatry in the clinics with mental health integration
- Similarly, Southcentral Foundation (Alaska) reported a 19% decrease in ED visits for patients seen by the primary care behavioral health consultant, as well as reduction in primary care visits

The Business Case, Summarized

- Milliman analysis of the cost impact of co-morbid depression and anxiety on commercially insured patients with chronic medical conditions
    - Many individuals with chronic medical conditions and co-occurring depression or anxiety are never diagnosed or treated for their psychiatric conditions
    - Comorbid depression clearly results in elevated total healthcare costs, averaging $505 pmpm
    - Comorbid anxiety also clearly results in elevated total healthcare costs, averaging $651 pmpm
- If a 10% reduction can be made in the excess healthcare costs of patients with comorbid psychiatric disorders via an effective integrated medical-behavioral healthcare program, $5.4 million of healthcare savings could be achieved for each group of 100,000 insured members
- *"The cost of doing nothing may exceed $300 billion per year in the United States"*

The Business Case, Summarized

- Medicaid medical expenses prior to specialty SU treatment and over a five-year follow up were compared to Medicaid expenses for the untreated population
- For the Supplemental Security Income (SSI) population, Washington studied the Medicaid cost differences for those who received treatment and those who did not
  - Average monthly medical costs were $414 per month higher for those not receiving treatment, and with the cost of the treatment added in, there was still a net cost offset of $252 per month or $3,024 per year
  - The net cost offset rose to $363 per month for those who completed treatment
  - Providing treatment for stimulant (methamphetamine) addiction resulted in higher net cost savings ($296 per month) than treatment for other substances—for SSI recipients with opiate-addiction, cost offsets rose to $899 per month for those who remain in methadone treatment for at least one year
- In the SSI population, average monthly Emergency Department (ED) costs were lower for those treated—the number of visits per year was 19% lower and the average cost per visit was 29% lower, almost offsetting the average monthly cost of treatment
  - For frequent ED users (12 or more visits/year) there was a 17% reduction in average visits for those who entered, but didn't complete SU treatment and a 48% reduction for those who did complete treatment

The Business Case, Summarized

- Kaiser Permanente Northern California: Analysis of the medical conditions and costs of family members of individuals with SU conditions using historical data
- Pre-treatment, families of all SU patients have higher medical costs than control families
- Adult family members have significantly higher prevalence of 12 medical conditions compared with control group; child family members have significantly higher prevalence of 9 medical conditions
- At 2-5 years post-intake for SU services, if family member w/SU condition were abstinent at 1 year, family members had similar average PMPM medical costs as control group
- Family members of SU patients who were not abstinent at 1 year had a trajectory of increasing medical cost relative to control group

The Business Case, Summarized

- There are opportunities to impact total healthcare expenditures by integrating MH/SU services with healthcare and initiating care management of co-morbid conditions
- Care management focused on the small proportion of people at highest risk/cost can have an impact on the average cost across the entire population
- Care management that is primary care or MH/SU provider-based promises to be more effective than telephonic disease management models
- This is an emerging practice in Q II and IV, in which we need to understand what works, what does not and how to be most effective at engaging and activating high risk individuals
- Use of data aggregation/risk prediction tools such as PRISM, individual assessment tools such as the Patient Activation Measure tool, and registries for tracking individual status are intrinsic to care management practice

The Business Case, Summarized

- As has been demonstrated in the implementation of other evidence-based practices, fidelity to the researched model is important in achieving the researched results
- This is true for integration initiatives as well—the key model components are critical and are summarized in the IPI Business Case Attachment A (details in packet)
- Widespread application of these models could result in substantial reductions in overall healthcare costs while improving outcomes and the quality of life for those who are served

What questions do you have?

Every System Is Perfectly Designed to Achieve Exactly the Results It Gets

Institute for Healthcare Improvement
Dr. Donald Berwick, President and CEO
Nominee for Administrator of the Centers for Medicare and Medicaid Services

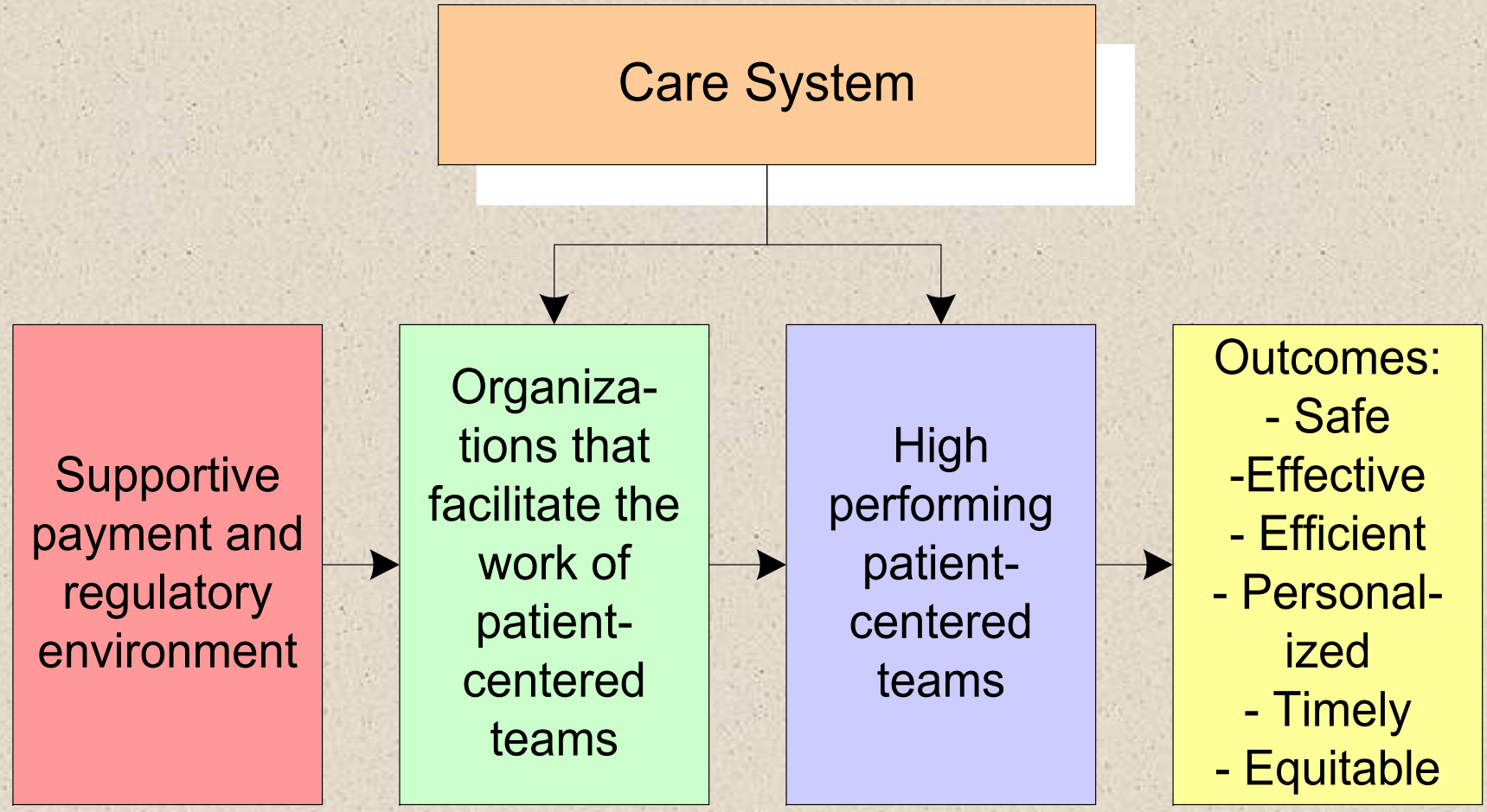
Crossing the Quality Chasm

The need for leadership in health care has never been greater. Transforming the health care system will not be an easy process. But the potential benefits are large as well. Narrowing the quality chasm will make it possible to bring the benefits of medical science and technology to all Americans in every community, and this in turn will mean less pain and suffering, less disability, greater longevity, and a more productive workforce. To this end, the committee proposes the following agenda for redesigning the 21st-century health care system:

- That all health care constituencies, including policymakers, purchasers, regulators, health professionals, health care trustees and management, and consumers, commit to a national statement of purpose for the health care system as a whole and to a shared agenda of six aims for improvement that can raise the quality of care to unprecedented levels.
- That clinicians and patients, and the health care organizations that support care delivery, adopt a new set of principles to guide the redesign of care processes.
- That the Department of Health and Human Services identify a set of priority conditions upon which to focus initial efforts, provide resources to stimulate innovation, and initiate the change process.
- That health care organizations design and implement more effective organizational support processes to make change in the delivery of care possible.
- That purchasers, regulators, health professions, educational institutions, and the Department of Health and Human Services create an environment that fosters and rewards improvement by (1) creating an infrastructure to support evidence-based practice, (2) facilitating the use of information technology, (3) aligning payment incentives, and (4) preparing the workforce to better serve patients in a world of expanding knowledge and rapid change

Crossing the Quality Chasm: A New Health System for the 21st Century (2001) Institute of Medicine (IOM)

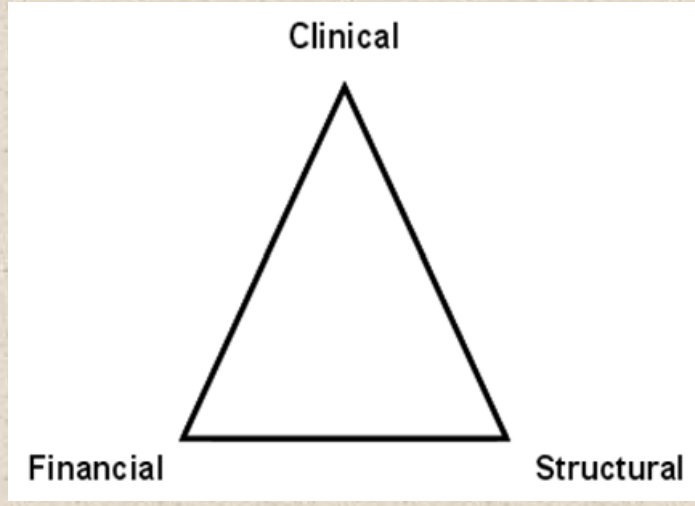
Quality Chasm: Components of an Effective Healthcare System



Implementing Person-Centered Healthcare Homes

- Insurance design is not delivery system design!
- Don’t mistake insurance functions for delivery system functions or assume that the former will create the latter
- Don’t establish policy, regulatory or financing models at cross-purposes with the desired delivery system design
- In the future, ACOs will mediate some of these spheres of activity

Implementing Person-Centered Healthcare Homes



Implementation should be grounded in a **Clinical Design** and address the **Operational/Structural and Financial** factors needed to support the Clinical Design

- Clinical integration focuses on what people need and what services look like “on the ground”
- Financial (all the money in the same pot) or operational/structural (all the services under the same organization and/or in the same building) integration does not assure clinical integration
- BUT clinical integration requires financial and operational/structural supports in order to be successful

Patient-Centered Medical Home Principles (PCMH)

- **Ongoing Relationship** with a PCP
- **Care Team** who collectively take responsibility for ongoing care
- Provides all healthcare or makes **Appropriate Referrals**
- Care is **Coordinated and/or Integrated**
- **Quality and Safety** are hallmarks
- **Enhanced Access** to care is available
- **Payment** appropriately recognizes the **Added Value**

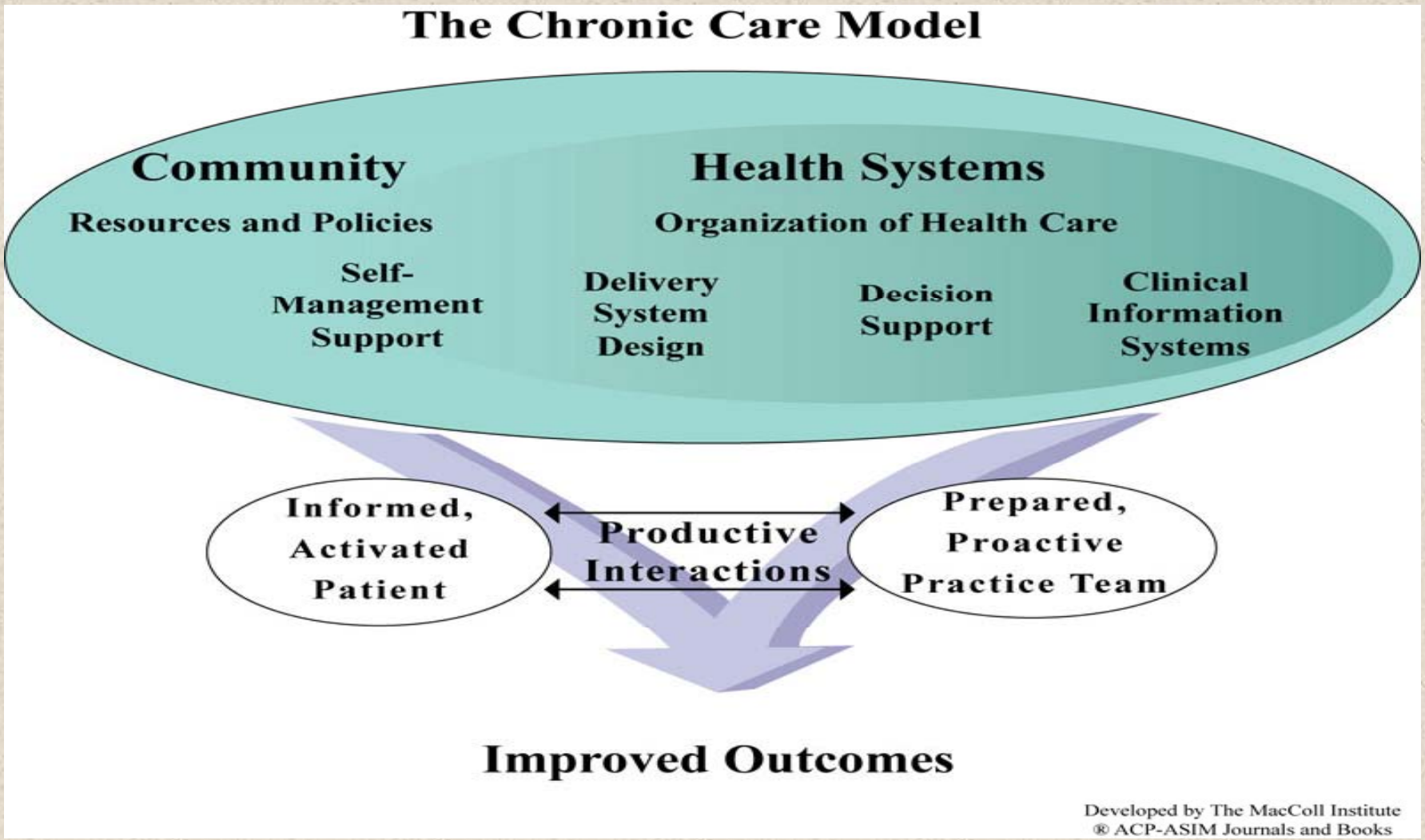
See the www.pcpcc.net site for more information

NCQA Certification Standards for PCMH

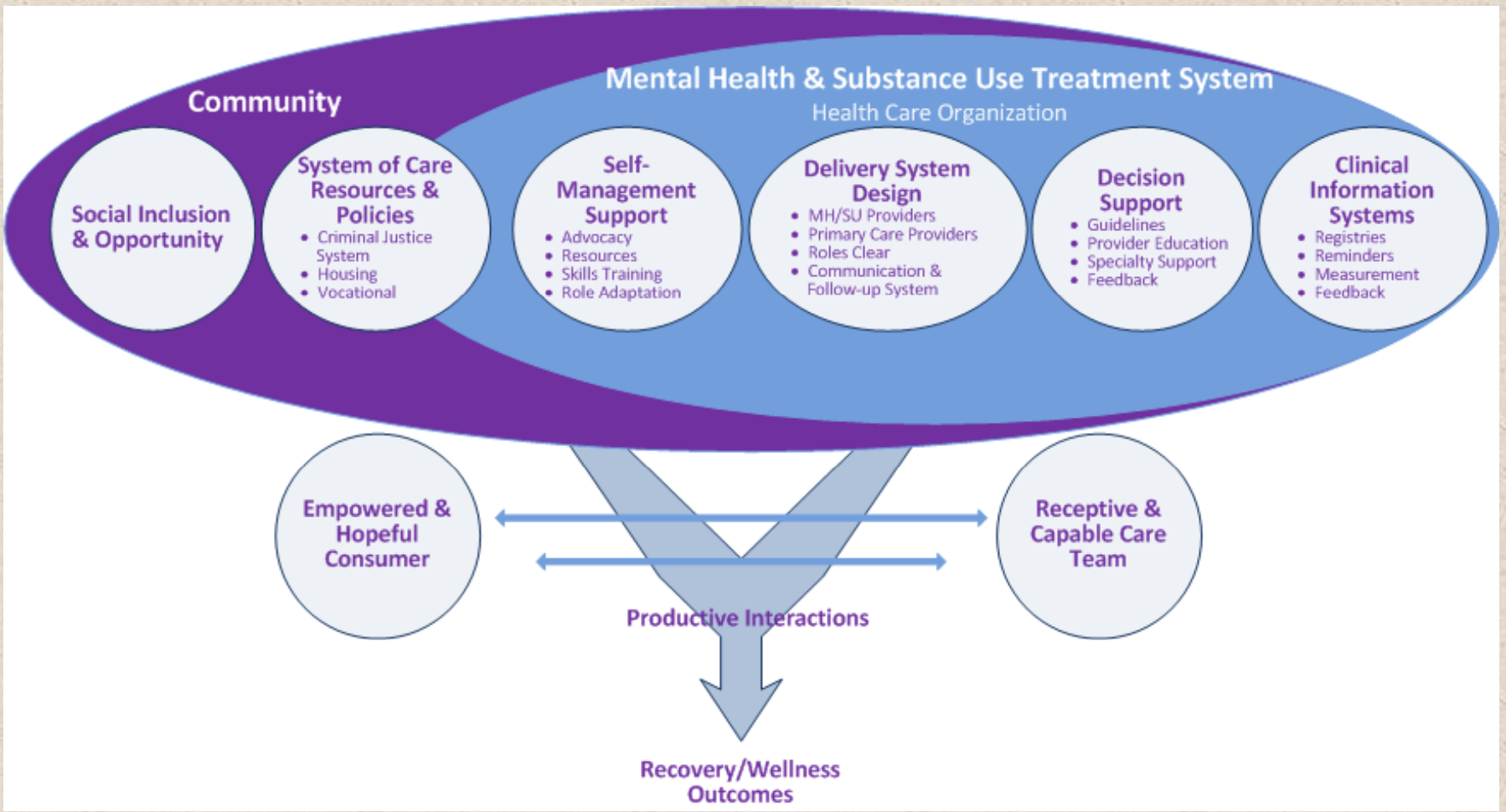
(revised and just posted for comment, * indicates reference to MH/SU conditions)

- PCMH 1: Access and Continuity
  - Access During Office Hours
  - Access After Hours
  - Electronic Access
  - Continuity
  - Patient/Family Partnership
  - Culturally and Linguistically Appropriate Services
  - Practice Organization
- PCMH 2: Identify and Manage Patient Populations
  - Basic Data
  - Searchable Clinical Data
  - *Comprehensive Health Assessment**
  - Using Data for Population Management
- PCMH 3: Plan and Manage Care
  - Guidelines for Important Conditions
  - *Care Management**
  - Medication Management
  - Electronic Prescribing
- PCMH 4: Self-Care Process
- PCMH 5: Track and Coordinate Care
  - Test Tracking and Follow-up
  - *Referral Tracking and Follow-up**
  - Coordination with Facilities/Care Transitions
  - Referrals to Community Resources
- PCMH 6 Performance Measurement and Quality Improvement
  - Measures of Performances
  - Patient/Family Feedback
  - Quality Improvement
  - Reporting Performance Measures

Care Model Components



Care Model Components



Care Model: Key Components

- Organization of Health Care/Leadership
  - Make sure senior leaders and staff visibly support and promote the effort to improve chronic care
  - Make improving chronic care a part of the organization's vision, mission, goals, performance improvement, and business plan
  - Make sure senior leaders actively support the improvement effort by removing barriers and providing necessary resources
  - Assign day-to-day leadership for continued clinical improvement
  - Integrate collaborative models into the quality improvement program

Care Model: Key Components

- Decision Support
  - Embed evidence-based guidelines in the care delivery system
  - Establish linkages with key specialists to assure that primary care providers have access to expert support
  - Provide skill oriented interactive training programs for all staff in support of chronic illness improvement
  - Educate patients about guidelines

Care Model: Key Components

- Delivery System Design
  - Identify target population (for example, depressed) patients during visits for other purposes
  - Use the registry to proactively review care and plan visits
  - Assign roles, duties and tasks for planned visits to a multidisciplinary care team. Use cross training to expand staff capability
  - Use planned visits in individual and group settings
  - Make designated staff responsible for follow-up by various methods, including outreach workers, telephone calls and home visits

Care Model: Key Components

- Clinical Information System
  - Establish a registry
  - Develop processes for use of the registry, including designating personnel to enter data, assure data integrity, and maintain the registry
  - Use the registry to generate reminders and care planning tools for individual patients
  - Use the registry to provide feedback to care team and leaders

Care Model: Key Components

- Self- Management
  - Use self management tools that are based on evidence of effectiveness
  - Set and document self management goals collaboratively with patients
  - Train providers and other key staff on how to help patients with self management goals
  - Follow up and monitor self management goals
  - Use group visits to support self management

Care Model: Key Components

- Community
  - Establish linkages with organizations to develop support programs and policies
  - Link to community resources for defrayed medication costs, education and materials
  - Encourage participation in community education classes and support groups
  - Raise community awareness through networking, outreach and education
  - Provide a list of community resources to patients, families and staff

Washington Patient-Centered Medical Home Collaborative

- Primary care practices of all sizes, urban and rural (33)
- Change package includes these components (details in packet)
  - Engaged leadership
  - Quality improvement strategy
  - Patient-centered interactions
  - Organized, evidence-based care
  - Continuous and team-based healing relationships
  - Enhanced access
  - Population management
  - Care coordination

Comparison of PCMH Models

- Analysis of seven medical home projects across the country
- Four common, value-generating elements
  - **Dedicated nonphysician care coordinator**
  - Expanded access to providers
  - **Accessible, real-time data** to manage performance and track patients
  - Effective incentive payments

Fields, Leshen, Patel. *Driving Quality Gains and Cost Savings through Adoption of Medical Homes*, Health Affairs, May 2010
(emphasis added)

Care Coordination/Management: What is It?

- Definitions of Case Management, Care Management, and Disease Management in the health care system have been evolving
- The terms Care Coordination and/or Care Management used interchangeably
- Definitions have evolved differently in mental health and healthcare over the past 15 years—*pay attention to the functions, not the job title!*

Care Coordination/Management: What is It?

Care Management, also commonly referred to as “disease management” has been widely acclaimed by forward-looking health care experts as the next, major, evolutionary step beyond the cost-focused innovations of “managed care”. Care management is coordinated health care, for logical groupings of members, intended to prospectively improve, maintain, or limit the degradation of their functional status.

Kaiser Permanente, Care Management Institute

Does Care Management = Case Management?

Case Management is a practice in which the service recipient is a partner, to the greatest extent possible, in assessing needs, obtaining services, treatments and supports, and in preventing and managing crisis. The focus of the partnership is recovery and self management of mental illness and life. The individual and the practitioner plan, coordinate, monitor, adjust, and advocate for services and supports directed toward the achievement of the individual's personal goals for community living.

National Association of Case Management

It Depends

- Active Ingredients of Effective Case Management (ACT and Strengths Model analysis)
  - CMs should deliver as much of the service as possible rather than making referrals to multiple formal services
  - Natural community resources are the primary partners
  - Work is in the community
  - Individual and team CM works
  - CMs have primary responsibility for a person's services
  - CMs can be paraprofessionals, supervisors should be experienced and fully credentialed
  - Caseload size should be small enough to allow for a relatively high frequency of contact
  - CM services should be time-unlimited
  - People need access to familiar persons 24 hours a day, 7 days a week
  - CMs should foster choice

Rapp and Goscha, Psychiatric Rehabilitation Journal Spring 2004

Care Management in Healthcare

- Guided Care for older adults (8 sites, randomized controlled trial)
  - Physician/nurse team with RN providing guided care (caseload of 50-60 patients)
    - Comprehensive home assessment
    - Evidence-based care guide
    - Monitor and coach patient monthly
    - Coordinate the efforts of all providers of healthcare
    - Smooth transitions between sites of care
    - Promotes patient self-management
    - Educates and supports family caregivers
    - Facilitates access to appropriate community resources
- Fewer hospital days (24%), SNF days (37%), ED visits (15%)

Leff, Reider et al. American Journal of Managed Care. 2009 15(8)

Mental Health Case Managers: A Different Role

- Generally, the functions of Case Management have included:
  - Obtaining basic supports
  - Crisis prevention and intervention
  - Assessment to determine needed services and resources
  - Outcome focused service/treatment planning
  - Referral and linkage with chosen services
  - Engagement and developing a helpful, trusting relationship
  - Coordinating and adjusting service delivery
  - Advocacy

The Care Coordinator/Manager Focused on Health and MH/SU

- Despite the historical confusion due to the use of differing terms and definitions, there is now is a shared direction for Care Coordination/Management in healthcare and MH/SU services
- Care Coordinators/Managers manage patient care across the care continuum, throughout various care settings, and work in conjunction with the person, providers, payors, and others to improve outcomes and make the best use of health care resources
- Care Coordinators/Managers can play a unique role in regard to system oversight, as they are focused on **individuals, at-risk populations, and the functioning of the system** to achieve improved outcomes and provide valuable insights to quality management and network development

MH/RSN Care Management: Another (and Different) Role

Care Management is a set of clinical management oversight functions that shall be performed by the Contractor (RSN). Care Management functions shall not be delegated to a network CMHA. These activities must be performed by a Mental Health Professional.

- Access Standards
- Eligibility Verification
- Appointment Standards
- Authorization – General
- Authorization for Routine Services
- Authorization for Inpatient Services
- Utilization Management
- Practice Guidelines
- Network Capacity
- Distance Standards
- Choice of MHCP
- Co-Occurring Disorder Screening and Assessment

Washington State RSN Contract

What questions do you have?

Take a break—be back in 15 minutes

Information Sharing and Information Technology

- Confidentiality
  - HIPAA
  - 42 CFR
- Health IT
  - EHRs
  - Registries
  - Health Information Exchanges

Confidentiality

- HIPAA is perceived as (but isn't necessarily) a barrier to communication—sharing information for the purposes of care collaboration is a permitted use under HIPAA, with the exceptions of HIV status and receipt of SU treatment
- 42 CFR, which regulates information sharing related to SU treatment is currently being debated/negotiated in DC—not clear how it will be resolved
- State laws and regulations regarding mental health privacy are frequently more restrictive than HIPAA, in which case they override—WA passed legislation in 2009 (HB2025) to amend state law, adopting the following language:

"*Treatment records of a person may be released without informed written consent in the following circumstances [new language follows]: (i) Consistent with the requirements of the health information portability and accountability act, to a licensed mental health professional…or a health care professional…who is providing care to a person, or to whom a person has been referred for evaluation or treatment, to assure coordinated care and treatment of that person. Psychotherapy notes, as defined in 45 CFR Sec 164.501, may not be released without authorization of the person who is the subject of the request for release of information…(j) To administrative and office support staff designated to obtain medical records for those licensed professionals listed in (i) of this subsection*."

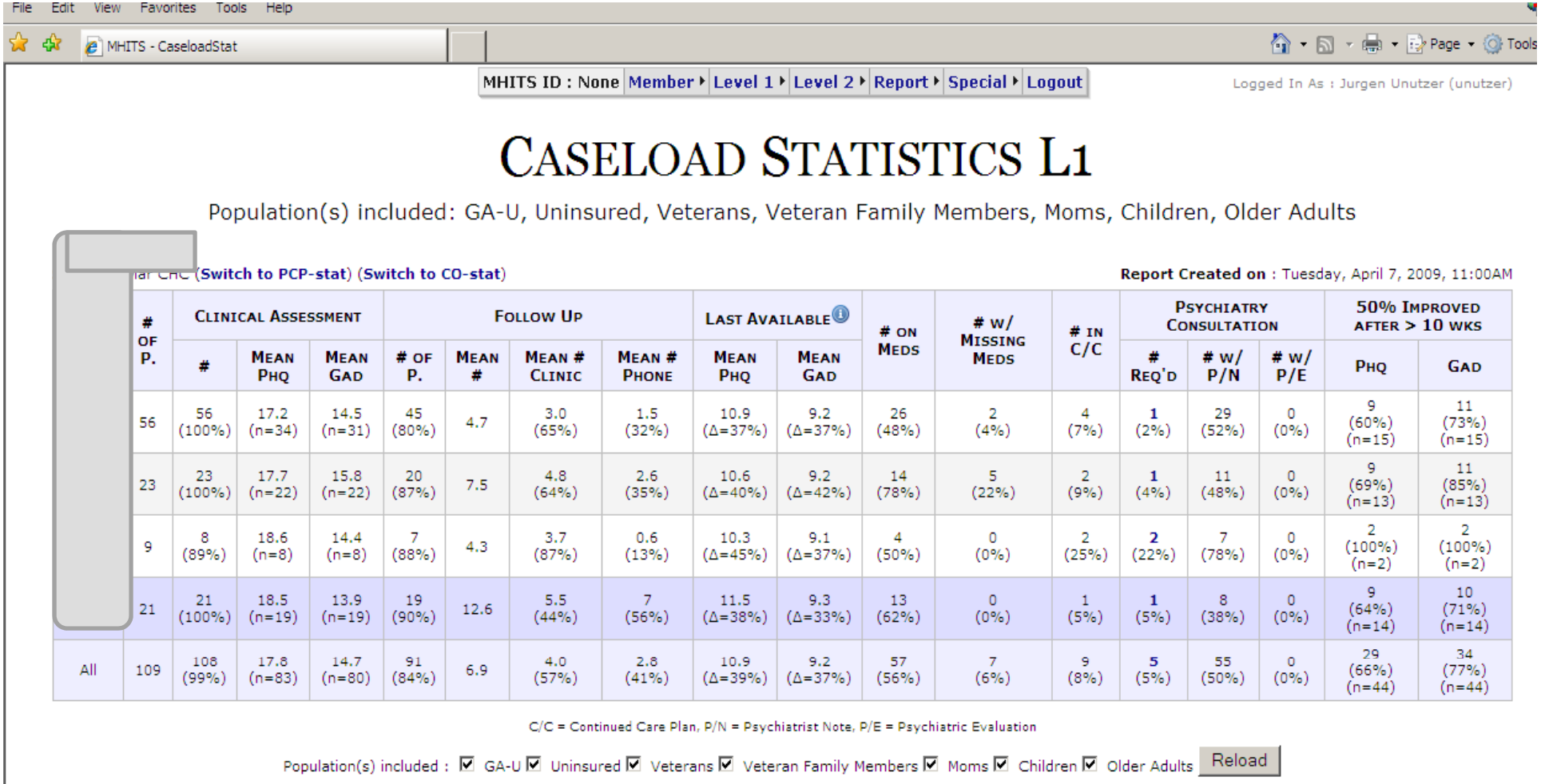
Health IT

- HIT is a central feature facilitating quality improvement and improved integration of services—NCQA includes multiple IT features, including patient tracking and registries, electronic prescribing, and test tracking as key features needed for a practice to be certified as a PCMH
- MH/SU systems have historically lagged behind other areas of healthcare in the development and standardization of these information technology tools
- Unfortunately, MH/SU providers are not eligible to be qualified health care providers under HITECH rules for Medicaid and Medicare EHR incentives (and few EHRS for MH/SU support healthcare tracking or vice-versa)
- New legislation (Health Information Technology Extension for Behavioral Health Services Act of 2010) would include MH/SU providers as qualified health care providers for EHR incentives

Registries

- Disease registries are a well established means of providing timely reminders for providers and patients in primary care; however, very few mental health provider agencies currently use this tool
- Access to low cost, simple to use registries or similar tools is vital to overcoming the obstacles otherwise associated with integrating care
- To assure the timeliness of reminders as individuals move through the care continuum, registries must be developed with sufficient inter-operability to support data sharing among entities across the continuum
- Even the most sophisticated implementations, such as GHC's EPIC, Kaiser Permanente's Health Connect and the Computerized Patient Record System used by the Veterans Health Administration, rely on separate population management systems used in parallel with the EHR

Electronic health records versus chronic disease management systems: A quick comparison. California Healthcare Foundation. March 2008. http://www.chcf.org/topics/index.cfm?topic=CL108&PgNum=4



Example of a Registry: Mental Health Integrated Tracking System (MHITS):

Health Information Exchanges (HIEs)

- HIEs are now being formed to develop electronic networks containing data elements essential to care coordination and accessible by diverse participating healthcare organizations in a defined geographic region
  - Registries must be developed with sufficient inter-operability to support data sharing among providers; this may be accomplished as a function of HIEs
- Across the country, very few HIEs have brought MH/SU providers to the table, as these initiatives have been more focused on the commercially insured population
- King County's Partnership for Health Improvement through Shared Information (PHISI) is focused on the safety-net system and would include MH/SU providers

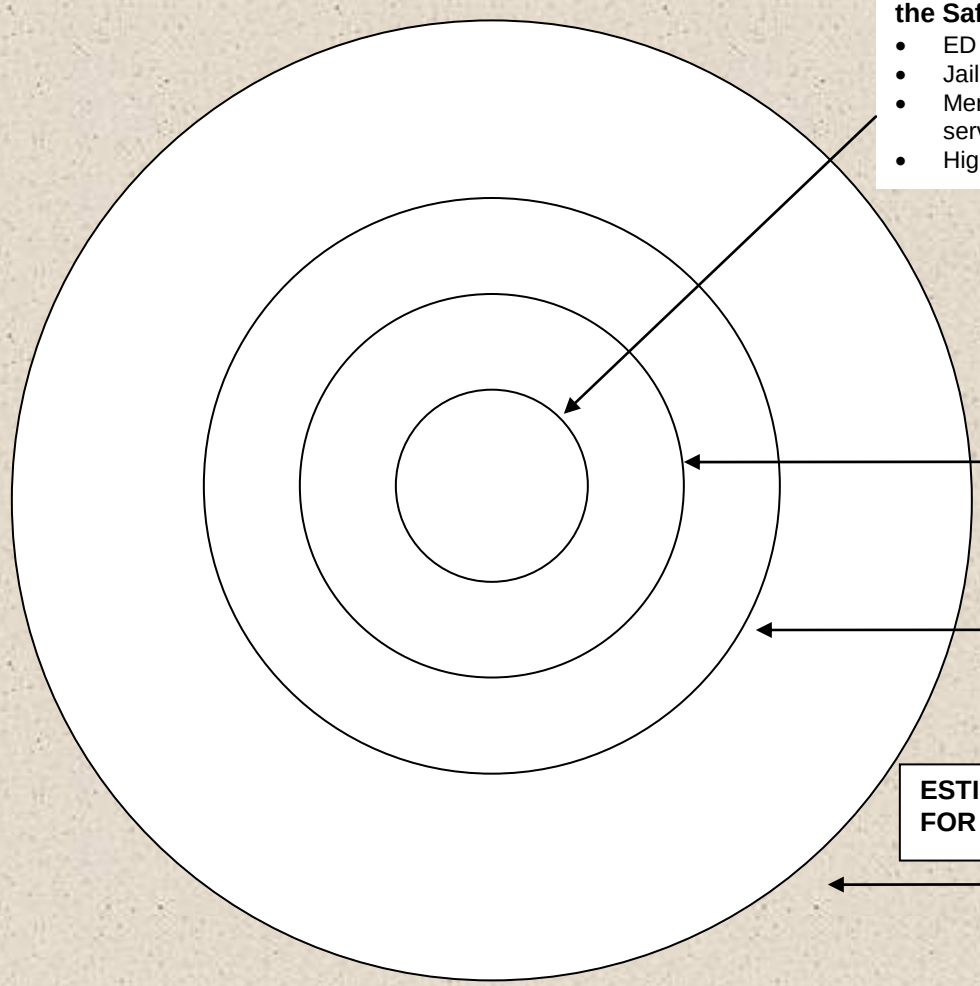
Partnership for Health Improvement through Shared Information (PHISI)

- Goals
  - *Consumer Focused*—Seamless Services/Any Door Gets You Connected to What You Need
  - *Population Health Improvement*—Reduced Morbidity (chronic health conditions) and Mortality (early death)
  - *System Effectiveness*—Shared Accountability to Achieve Consumer and Population Goals

PHISI Timeline: Key Dates

- May 2007: United Way Cross System Work Group Report approved by the Health and Chemical Dependency Impact Council
- October 2007: United Way hosts The Healthcare Safety Net: Shared Information Community Forum
- September-December 2008: King County, City of Seattle, United Way and University of Washington/Harborview convenes to move the initiative forward and names it Partnership for Health Improvement through Shared Information (PHISI)
- March 2009: PHISI Design Day with representatives from King County, City of Seattle, United Way, University of Washington/Harborview, Community Health Plan, Molina, Group Health, EMS/Shared Care Plan, and invited technical experts
- February 2010: Submission for Beacon federal HIT grant firmed up details, governance structure, development of business case

PHISI Populations of Focus: A Phased Approach Starting at Center



High Utilizing Adults in the Safety Net (estimates vary)

- ED use
- Jail health
- Mental health/substance use services
- High risk, complex health conditions

All Adults (18+) in the Safety Net (estimated at 227,000 monthly)

- Uninsured and under 200% of FPL
- Underinsured and under 200% of FPL
- Covered by GAU
- Covered by Medicaid
- Covered by Medicare/Medicaid (dual eligible).

All Children (0-17) in the Safety Net (estimated at 117,000 monthly)

ESTIMATED ANNUAL EXPENDITURES OF $715 M FOR POPULATIONS ABOVE

Total Population of King County (1, 835,000)

All Healthcare is Local: Organizing Operations and Structures to Support Integrated Care in Healthcare Homes

California: The Primary Care, Mental Health, and Substance Use Services Integration Policy Initiative (IPI)

Vision: Overall health and wellness is embraced as a shared community responsibility

- To achieve individual and population health and wellness (physical, mental, social/emotional/ developmental and spiritual health), healthcare services for the whole person (physical, mental and substance use healthcare) must be:
  - seamlessly integrated
  - planned for and provided through collaboration at every level of the healthcare system, as well as coordinated with the supportive capacities within each community
- Ten principles in support of the vision and integrated care
- IPI Continuum as clinical framework for community dialogue

California: IPI Continuum

The IPI Continuum:

A Collaborative MH/SU/Primary Care Continuum for the Safety Net Population[1]

(This Continuum details the vertical MH/SU axis of the 4Q Model and does not attempt to span the horizontal axis, which considers the range of general healthcare services from prevention/health promotion to specialty medical/surgical and inpatient services. The supportive services and systems in the community are also not detailed here, however it is anticipated that development of a locally specific IPI Continuum would describe these as a part of defining seamless services.)

	Mild MH/SU Complexity	Moderate MH/SU Complexity	Serious MH/SU Complexity	Severe MH/SU Complexity
Characteristics of the population with MH/SU needs to be served in each level—for all ages (children, youth, adults, older adults)	• No comorbidities • Family/community supports OR • Need for health behavior change related to medical presentation (e.g., sleep disorder, pain), chronic medical conditions (e.g., cardiovascular, diabetes), developmental/parenting concern	• Medical comorbidity, including pain, or MH/SU comorbidity, and/or • Isolated or chaotic family/ community environment	• Multiple, complex medical, MH/SU comorbidities, and/or • Isolated or chaotic family/ community environment, and/or • Previous treatment ineffective	• Adults 18 years and over, with a severe and/or persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment, but for whom long-term 24-hour care in a hospital, nursing home, or protective facility is unnecessary or inappropriate (NIMH). *(In CA, referred to as Serious and Persistent)*
	• Standardized assessment tool[12] indicates mild to moderate symptoms or developmental concern	• Standardized assessment tool[12] indicates moderate to severe symptoms and their impact on functioning	• Standardized assessment tool[12] indicates severe symptoms and their impact on functioning	• Individuals with SU disorders that require ASAM Level III or IV services
	• Diagnostic examples include V-codes, mild depression, mild anxiety, sleep disorder, somatic disorder, SU disorder	• Diagnostic examples include moderate depression, moderate anxiety (including PTSD), sleep disorder, somatic disorder, SU disorder (abuse)	• Diagnostic examples include severe depression, severe anxiety (including PTSD), schizophrenia, bipolar disorder, schizoaffective disorder, personality disorders, SU disorder (abuse/dependence)	• Diagnostic examples include schizophrenia, schizoaffective disorder, bipolar disorder, SU disorder (abuse/dependence)

California IPI Continuum

- Characteristics of the population with MH/SU needs to be served in each level (mild, moderate, serious, severe MH/SU complexity)
- Estimated population needing MH/SU services
- Healthcare Home physical health services to be made available
- Optimal MH/SU services for each MH/SU level
- Examples of evidence-based/effective MH/SU interventions
- MH/SU measurement of process, capacity and/or outcome measures (with individual and population examples)

Structural Models for Integrated Care

- Three broad approaches:
  - Fully integrated, co-located care provided by a single organization
  - A partnership model in which care is shared across two different organizations via co-located staff
  - A facilitated referral approach in which a site helps clients coordinate care occurring at multiple different clinics or sites
- None of these organizational approaches guarantees or precludes the structural or process elements of care found to be important for improving clinical integration

Structural Models for Integrated Care

- In **fully integrated medical and MH/SU healthcare**, staff within a single organization provides primary and MH/SU healthcare
  - Primarily used in large, quasi-integrated systems such as staff model HMOs and the VA, which include physical facilities that provide co-location of mental health, substance use, and medical services and an integrated electronic medical record (EMR)
    - These systems have administrative and fiscal responsibility for mental health, substance use and medical care of a defined group of patients, providing a rationale and financial mechanism for them to support these models
  - Cherokee Health Systems in Tennessee, which is both a Community Mental Health Center and a Federally Qualified Health Center, is an exemplar system that fully integrates services
    - However, it took nearly 20 years and a unique series of circumstances, including a charismatic leader and funding from a lawsuit with a managed care company, to allow it to financially support its mission of integrated care

Structural Models for Integrated Care

- In **partnerships between community MH/SU organizations and primary care**, primary care staff are embedded in a community MH/SU organization and/or MH/SU staff are embedded in the primary care setting
  - These partnerships provide not only the staff member but also can link to the full range of expertise at their home agency via supervision, consultation, and referrals
  - Onsite clinicians can bill under the license of their home organization, overcoming some of the financial obstacles that primary care sites face in providing MH/SU services and vice versa
  - Challenges include identifying another site that has the requisite staffing and expertise to provide care, and is willing and able to successfully collaborate

Structural Models for Integrated Care

- Community MH/SU organizations can establish **linkages to primary care (or vice versa)** in which primary care staff are not physically present in the MH/SU organization but the MH/SU organization conducts physical health screenings, coordinates referrals to primary care, and shares information with primary care
  - Alternatively MH/SU staff is not physically present in primary care but the primary care provider conducts MH/SU screenings and coordinates referrals to MH/SU specialty settings
- Ideally a care manager ensures that patients can obtain access to, and follow-up with, care outside the organization
  - With care managers and other mechanisms ensuring follow-up and transfer of information across the organizations, these models can improve quality and outcomes of depression in primary care and also primary medical care among patients with serious mental illnesses
- However, this model can only be as successful as the access to and quality of care across a range of community locations

California: CalMEND—Joint Project of Medi-Cal and MH

- State Medicaid and MH agencies working together to use the Care Model and use the IHI Breakthrough Series Learning Collaborative model to make major rapid changes that produce significant breakthrough results and sustained use of these changes
- Pilot Collaborative will bring together mental health and primary care practitioners in teams organized by the County MH Plan
- CalMEND Primary Care and Mental Health Integration Change Package developed over the last year includes change concepts that operationalize the Care Model and integrated care
  - Health Care Organization
  - Delivery System Design
  - Decision Support
  - Clinical Information system
  - Community

California: CalMEND—Joint Project of Medi-Cal and MH

CARE MODEL ELEMENT	CHANGE CONCEPT	TESTABLE IDEA	EXAMPLE
DELIVERY SYSTEM DESIGN	• Develop cross-consultation between clients, MH and PC providers to improve communication	o Use non-licensed staff to coordinate care and services for clients	Medical assistants and peer supporters
		o Case conferences for joint care planning and coordination of planned interventions	
		o Link psychiatrists in MH with PC physicians for consultation and training	
	• Establish and implement shared guidelines or protocols	o Develop methods to identify primary care clients requiring MH and mental health clients requiring PC	▪ PC uses screens for level of MH need: PHQH providers screen for physical conditions (e.g. metabolic syndrome) ▪ MD and PC providers screen for alcohol/drug use
		o Assist practitioners to triage referrals received to ensure that the most urgent referrals are seen first	▪ "Fast Track" automatic referrals for: brief psychotherapy group (CBT, DBT, problem solving therapy, etc.); in place for depression anxiety, unexplained physical disorder, borderline personality disorder ▪ Psychiatric consultation, cross-referral and crisis MH access protocols for primary care providers
		o Standardize information that should accompany a client referral, such as the results of diagnostic tests	Establish criteria for shared registry; include data at time of referral
		o Allow MH to schedule PCP visit and allow PCP to schedule visits with MH	
		o Create a shared formulary	Driven by DHCS drug list
	• Develop team-driven care	o Adopt/adapt shared care plan	Create document for shared care plan to be reviewed and signed by PCP, MHP, and client as part of joint session
		o Organize patient care teams with defined roles that address the integrated mental health/primary care plans	
		o Include peer workforce in teams to enhance client	

California: CalMEND—Joint Project of Medi-Cal and MH

- Pre-Work Activities (details in packet)
  - Checklist of Pre-work Activities
  - Establishing a Partnership
  - Participation in Pre-work calls
  - Developing and Aim Statement
  - Defining the Pilot Population
  - Using a Clinical Information system to Organize Client/Patient and Population Data to Facilitate Efficient and Effective Care
  - Measurement

What questions do you have?

Sorting out the Money – the Carve-In/Carve-Out Debate

- Medicaid MH **carve-in** has been **infrequent and disappointing**
  - **New Mexico** carved in, its 2000 waiver renewal initially was denied (only 55% of BH premium going to services); then reinstated (requires that 85% of BH premium go to services) [note that the three health plans with the carve in contracts hired MBHCOs to manage -- a carve out inside of the carve in!]. The New Mexico system has continued to be restructured
  - **Tennessee** carved in briefly, then carved out, recently carved into one regional plan, with "disappointing" results
  - University of South Florida MH Institute studied state systems regarding **services for children and youth**, and concluded that **carve outs were better than integrated contracts**, covering a broader array of services with more flexibility

Sorting out the Money – the Carve-In/Carve-Out Debate

- State MH systems and behavioral health carve-outs, as currently constructed, are a **barrier to implementation of integrated care**
  - Most state MH systems are **underfunded** to serve the population with most serious/severe needs
  - Carve-outs are used in 23 of the 28 states with Medicaid managed mental healthcare plans with financing generally driven by a **10% penetration rate assumption**, which doesn't cover needs of the mild/moderate population
  - Creates concern that the **populations in Q II and IV will lose services** and access if the inadequate funding gets stretched to populations in Q I and III
  - **Documentation requirements** (20 page enrollment packets) in public MH systems are unworkable for primary care settings

SMHA-Controlled Mental Health Revenue by State, FY 2006

State	Total State Mental Health Revenue	Target # of Persons to Serve/Year	Revenue per Target Client	Rank	$ Over (Under) Top 10 Average	% Over (Under) Top 10 Average
Pennsylvania	$3,332,904,698	544,949	$6,116	1	$1,644	37%
Maine	$464,300,000	76,362	$6,080	2	$1,608	36%
District of Columbia	$229,400,000	38,093	$6,022	3	$1,550	35%
Alaska	$183,200,000	33,512	$5,467	4	$995	22%
New Hampshire	$166,100,000	38,394	$4,326	5	-$146	-3%
Maryland	$810,000,000	233,097	$3,475	6	-$997	-22%
New Jersey	$1,241,600,000	365,082	$3,401	7	-$1,071	-24%
Minnesota	$721,100,000	213,635	$3,375	8	-$1,096	-25%
Vermont	$122,500,000	36,426	$3,363	9	-$1,109	-25%
New York	$3,982,300,000	1,287,434	$3,093	10	-$1,379	-31%
Top 10 Average			**$4,472**			
Montana	$137,500,000	51,778	$2,656	11	-$1,816	-41%
Wisconsin	$600,400,000	230,727	$2,602	12	-$1,870	-42%
Wyoming	$52,600,000	22,248	$2,364	13	-$2,108	-47%
Iowa	$299,300,000	133,468	$2,242	14	-$2,229	-50%
Arizona	$977,900,000	447,063	$2,187	15	-$2,284	-51%
California	$5,300,000,000	2,474,848	$2,142	16	-$2,330	-52%
Oregon	$432,300,000	202,819	$2,131	17	-$2,340	-52%
North Carolina	$1,105,400,000	530,609	$2,083	18	-$2,389	-53%
Michigan	$1,010,000,000	485,839	$2,079	19	-$2,393	-54%
Washington	$624,500,000	304,553	$2,051	20	-$2,421	-54%
Missouri	$597,500,000	294,546	$2,029	21	-$2,443	-55%

Financing Integrated Care: Paradigms

- We need a new paradigm—none of the old models (Carve-in or Carve-out) work for implementing bidirectional integrated care for the whole population
- Lessons from the field
  - Medical Home Pilots— case rate in addition to FFS, to cover prevention, care management of chronic medical conditions (why not build the BHC in PC role into the case rate?)
  - MN—financing the DIAMOND case rate (for BH in PC) out of the healthcare side (rather than the mental health side) believing that cost and quality improvements will be there
  - WA General Assistance project—explicit stepped care model that finances both Level 1 (primary care) and Level 2 (specialty) MH/SU benefits; dedicated financing for Levels 1 and 2; and the transition to specialty MH/SU is structured
  - Washtenaw Co, MI—global budget for Medicaid population; local consolidation of medical and behavioral health funding streams

Population-Based Financing: Paradigm

- Shift to Population-Based Financing in Medicaid & Medicare
  - The most expensive populations in most states are currently outside of managed care for their general healthcare – the elderly and disabled
  - There is a big push to bring this population in from fee for service to managed care

	US Pop. FY2007 (Millions)	US Pop. FY2007 Mix	FY2007 Medicaid Mix
Medicaid Enrollees	30.5	11%	**78%**
Dual Eligibles	8.8	3%	**22%**
Uninsured Persons	45.6	16%	
Total Safety Net	**84.9**	**29%**	
Medicare Enrollees	27.3	9%	
Insured Persons	173.8	60%	
VA/Military	3.2	1%	
Total Other	**204.3**	**71%**	
Total U.S. Population	**289.2**	**100%**	

Population-Based Financing: Paradigm

- The “big idea” is to have Medicare make capitation payments to states to organize and manage Dual Eligible Plans
- Given the effort to combine funding, it seems unlikely that Dual Eligible mental health services would be carved out; especially because of the need to address identified co-morbidities (52% with psychiatric disorder)
- The following example illustrates one PIHP in Washington State

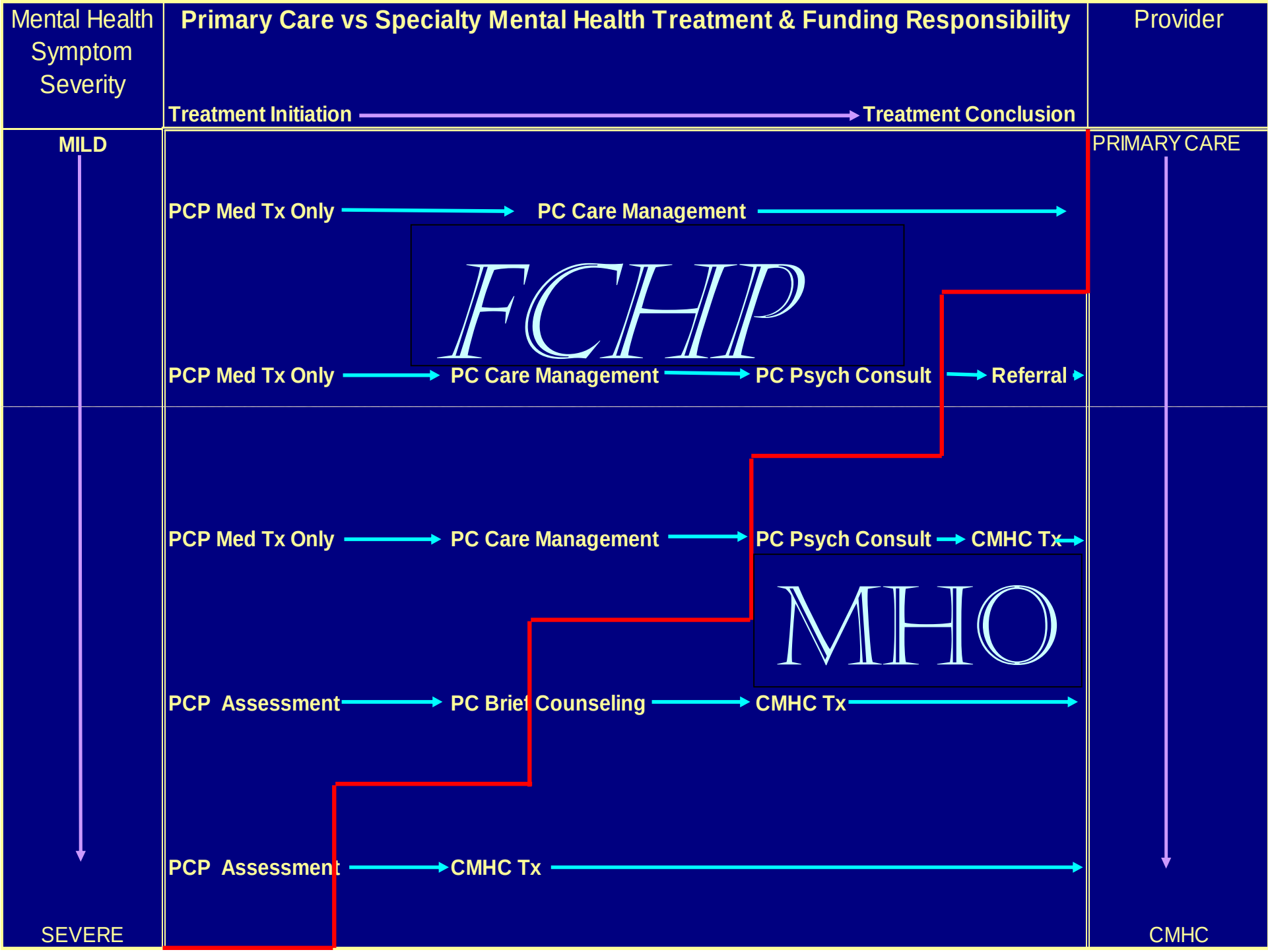
Washington State
Medicaid Mental Health Capitation Rates
October 2009 - June 2010

	Children		Adults		
Prepaid Inpatient Health Plan (PIHP)	**Non-Disabled**	**Disabled**	**Non-Disabled**	**Disabled**	**Total**
Clark County Rates	$11.20	$77.36	$13.83	$119.29	$25.51
Rate % of Average	44%	303%	54%	468%	100%
Clark eligibles	38,268	1,567	11,697	6,429	57,961
Eligibles Ratio	66%	3%	20%	11%	100%
Monthly Revenue	$428,602	$121,223	$161,770	$766,915	$1,478,510
Revenue Ratio	29%	8%	11%	52%	100%

A Business Model for Negotiation of Funding Responsibility between a Medicaid Health Plan (FCHP) and Medicaid Mental Health Carve Out Plan (MHO)

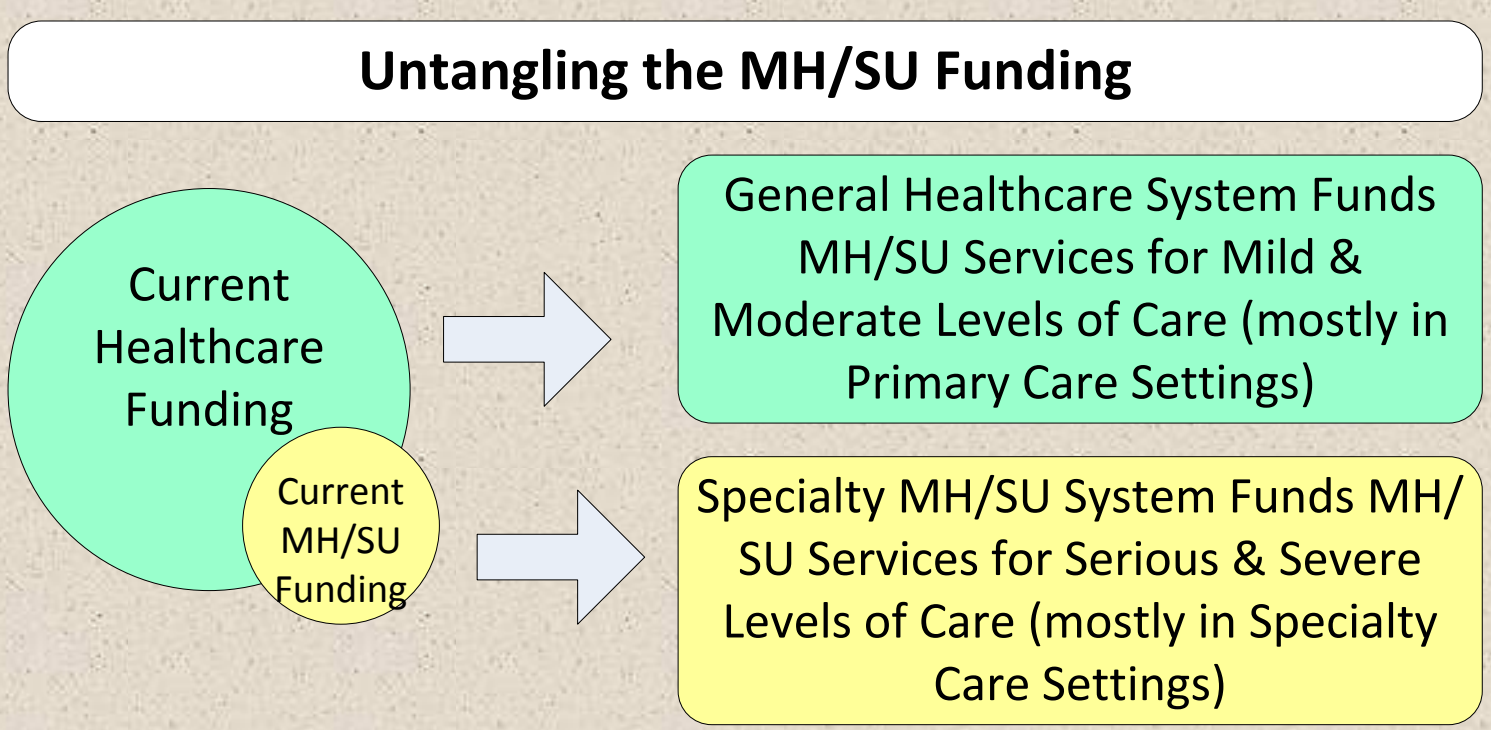
Multnomah County Public Health/Care Oregon/Verity

Developed by Mark Spofford 2005


Mental Health Symptom Severity
Primary Care vs Specialty Mental Health Treatment & Funding Responsibility
Provider
Treatment Initiation
Treatment Conclusion
MILD
PRIMARY CARE
PCP Med Tx Only
PC Care Management
FCHP
PCP Med Tx Only
PC Care Management
PC Psych Consult
Referral
PCP Med Tx Only
PC Care Management
PC Psych Consult
CMHC Tx
MHO
PCP Assessment
PC Brief Counseling
CMHC Tx
PCP Assessment
CMHC Tx
SEVERE
CMHC

Financing Integrated Care: Paradigms

- Parity will be a requirement for most health plans in the new healthcare reform legislation and a broader behavioral health benefit will be available for most people with coverage, and …
- Drawing on the California Integration Policy Initiative framework of Mild, Moderate, Serious and Severe Levels of Care, and …



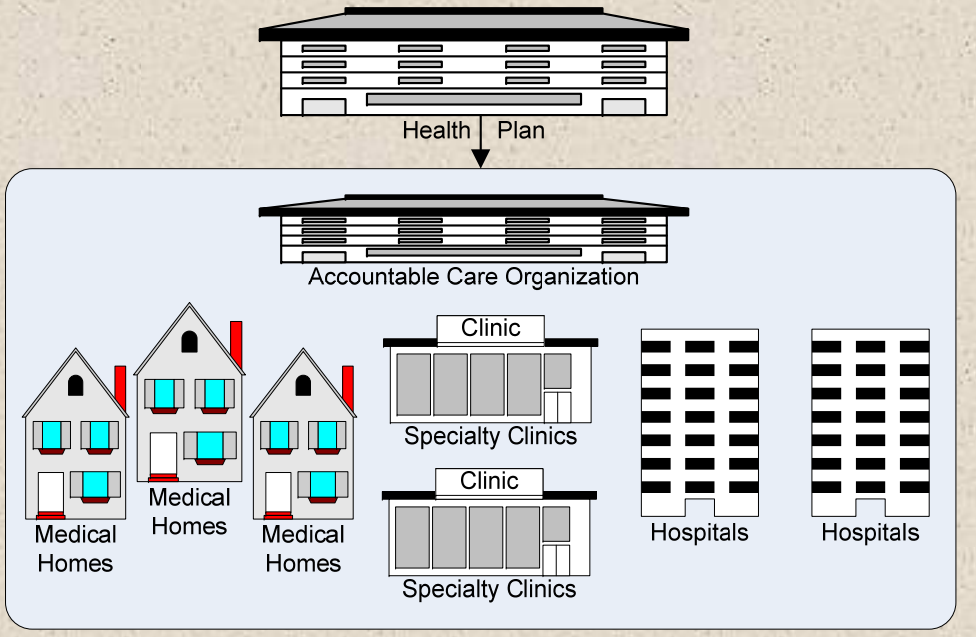
Financing Integrated Care: Paradigms

- New funding mechanisms will be utilized to better fund services that manage total healthcare expenditures—Medicare, Medicaid and commercial insurer pilots
- Many PCMHs will be funded with a 3-layer reimbursement mechanism that could include financing for the MH/SU services to mild/moderate (the DIAMOND case rate model)

Case Rate	• Prevention, Early Intervention, Care Management for Chronic Medical Conditions
Fee for Service/ PPS	• Per Service Payment • Prospective Payment System (PPS) Settlement (FQHC model) to cover shortfalls
Bonus	• Share in Savings from Reduced Total Healthcare Expenditures (bending the curve)

Note: PPS = Prospective Payment System, the FQHC cost-based reimbursement system

Key to Supporting New Service Delivery and Payment Models: Accountable Care Organization

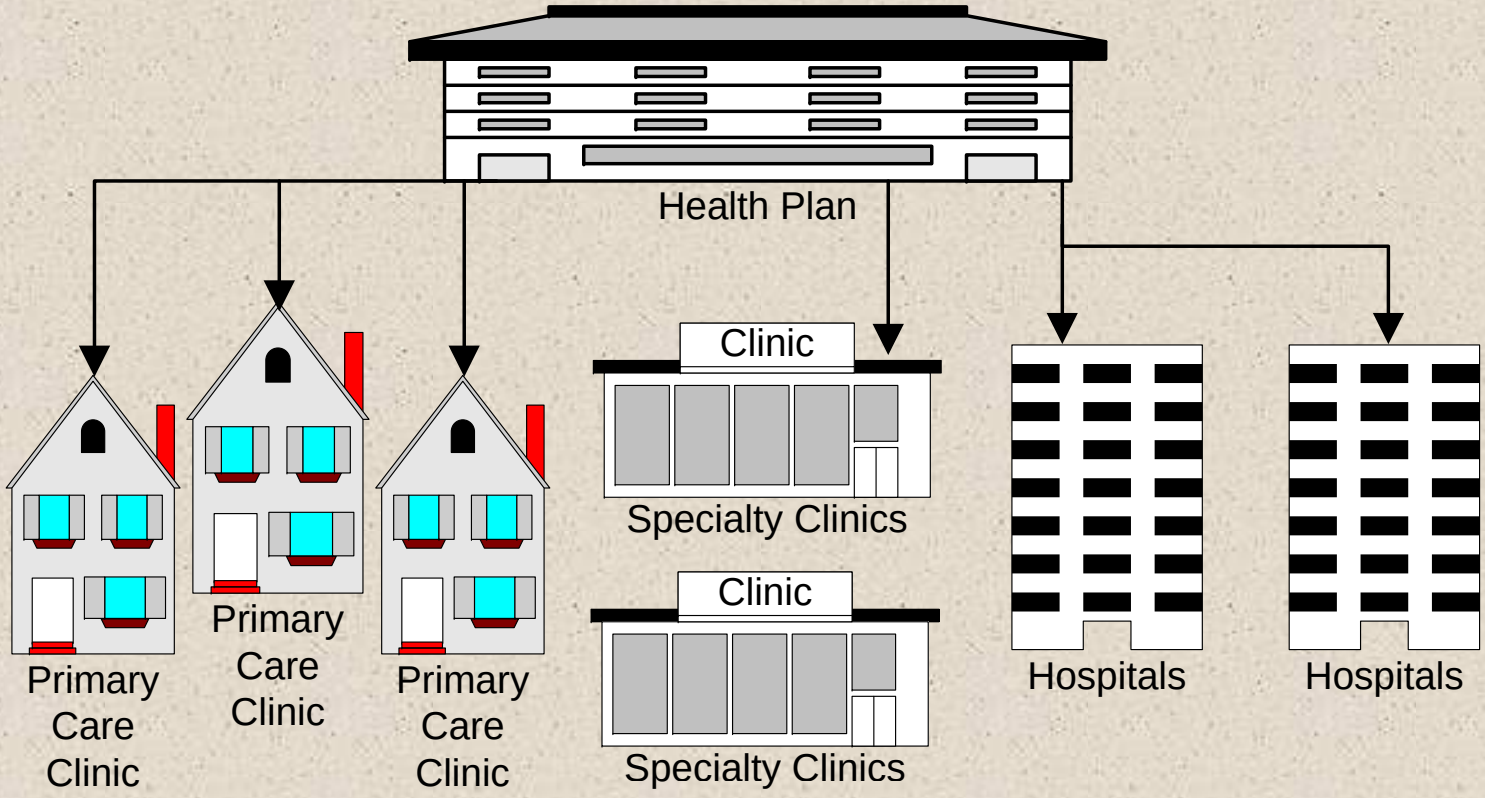


Accountable Care Organizations (ACOs)

- A separate legal entity, with ownership and, more importantly, governance, shared by the hospital and the physicians
  - Have a robust information technology system to track patient health care, which would be accessible to all participants in the ACO
  - Provide primary and multi-specialty care for the patients assigned to it as the recipient of a bundled payment from Medicare or another payor
  - Have an administrative staff separate from the hospital and the physicians, which would establish protocols and monitor patient care both within and outside the hospital
  - Integrate and align the interests of the hospital and the physicians, absorbing the financial risk of the care model
  - Be designed as a profit center to distribute the excess of revenue over expenses to be derived from providing for patient care and the costs of administration of the ACO

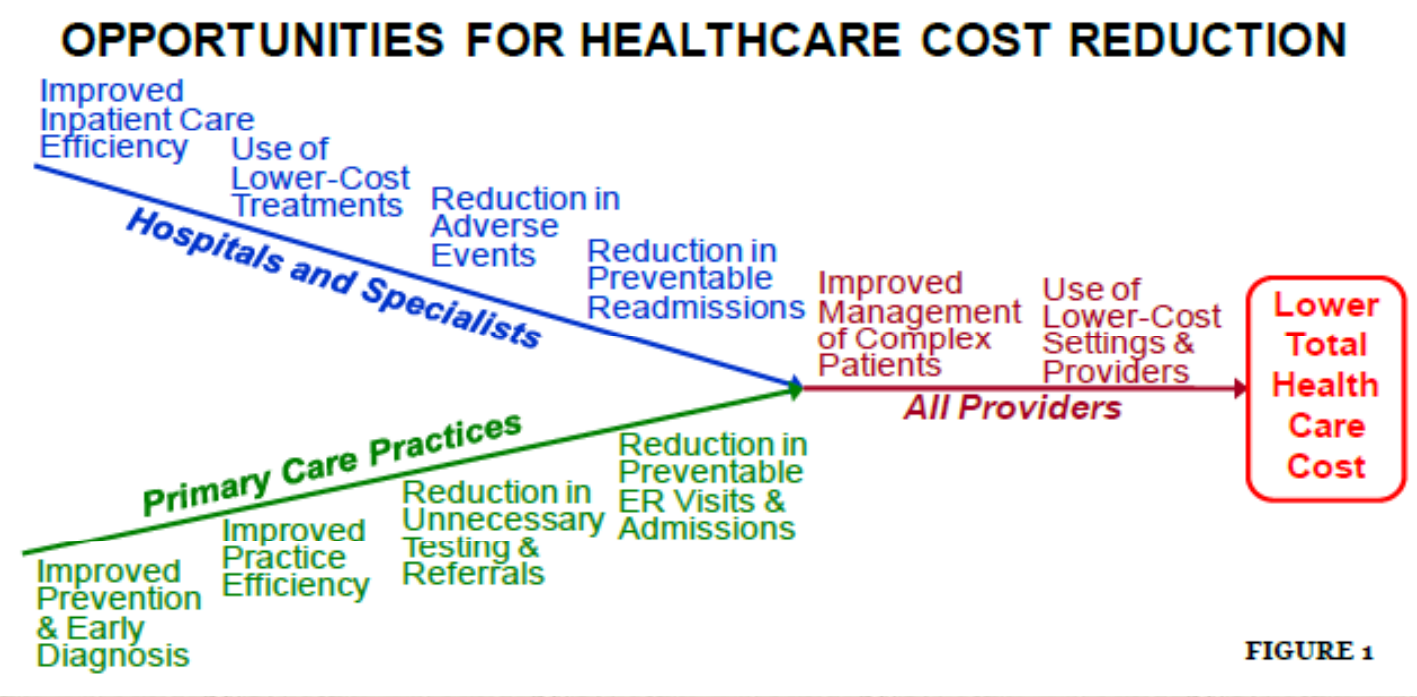
The Status Quo

Fee-For-Service, Non-Integrated Model: All the wrong incentives and disincentives



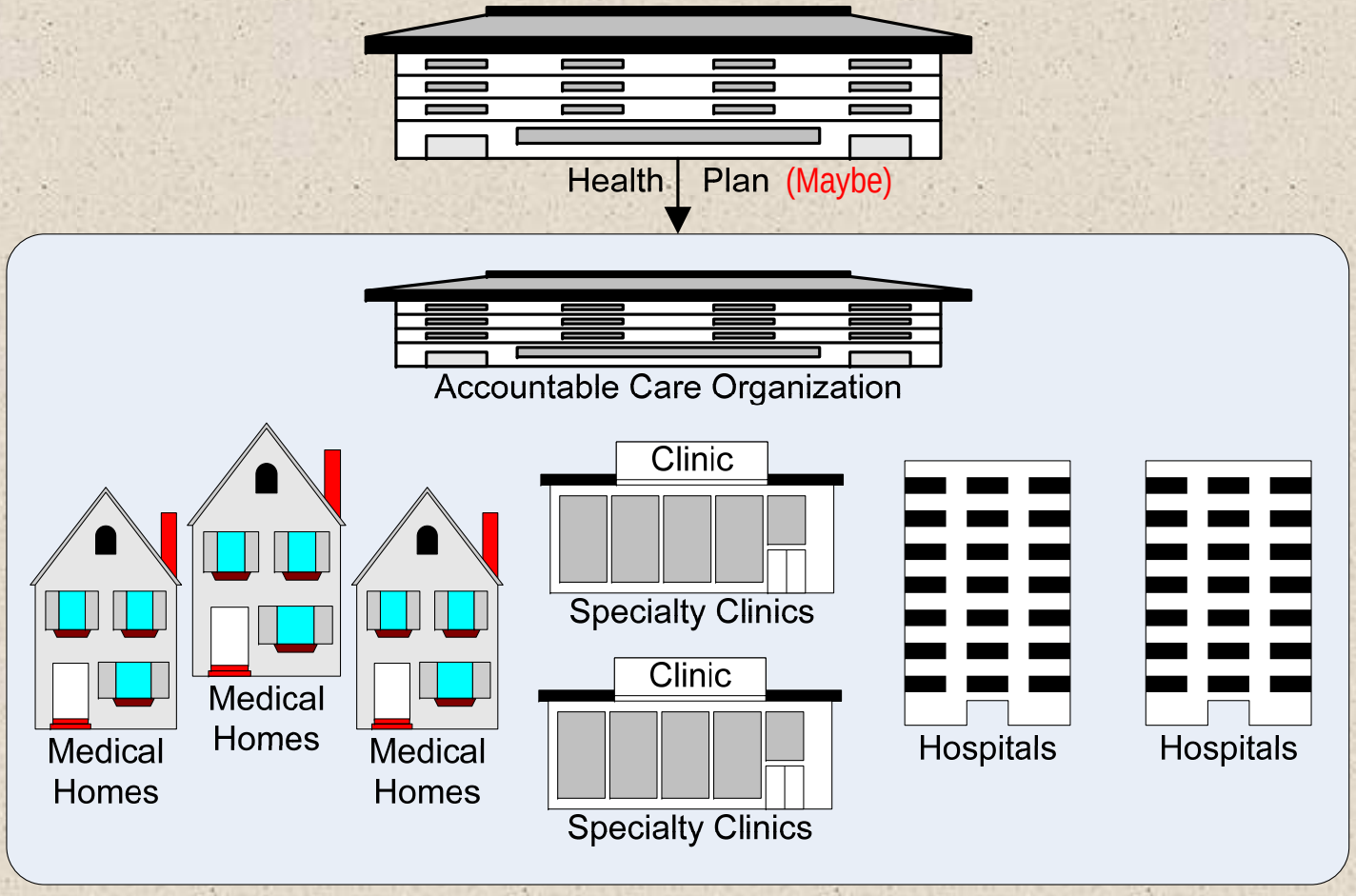
Accountable Care Organizations (ACOs)

- ACOs dual purpose:
  - Organization structure for managing bundled payments for inpatient care
  - Vehicle for small to mid-sized primary care practices that want to become Person-Centered Medical Homes
- Could incorporate MH/SU to support integrated care



Accountable Care Organizations (ACOs)

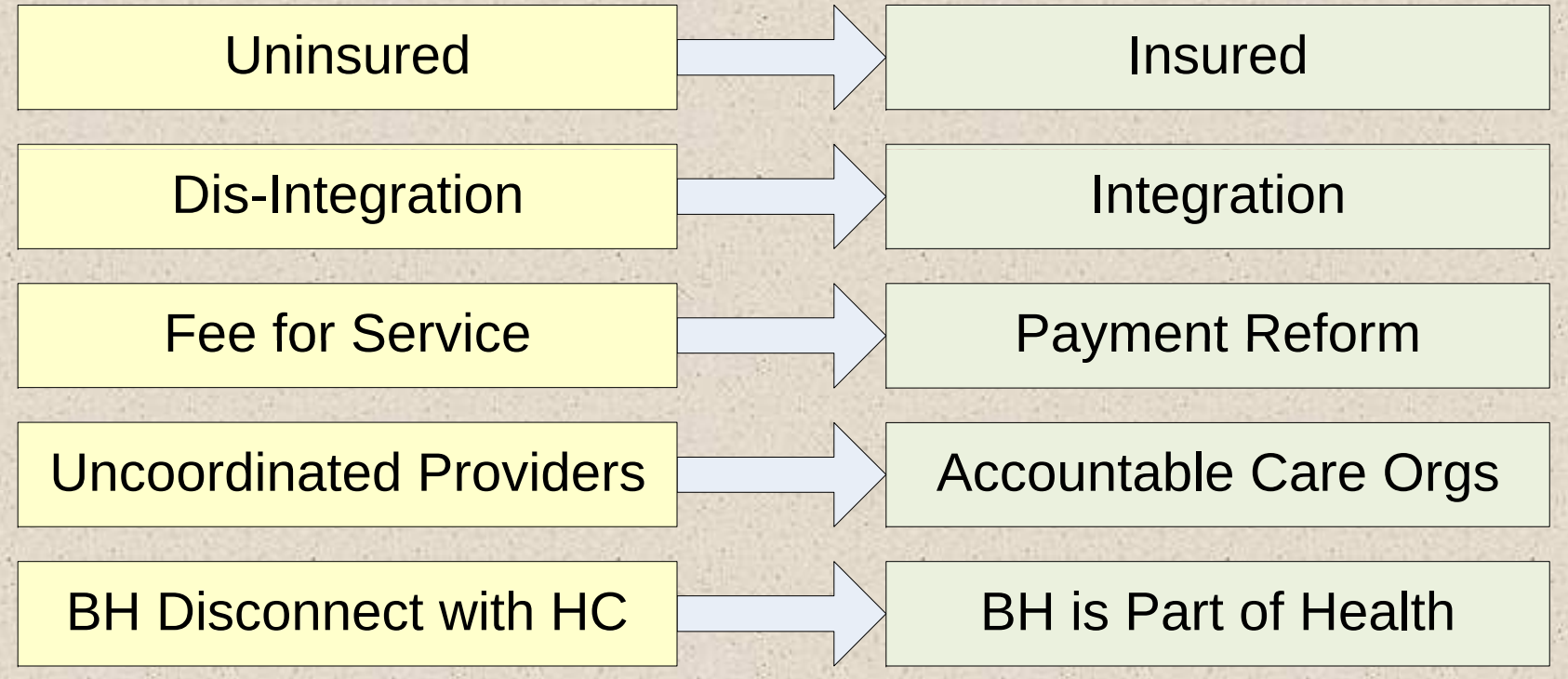
Accountable Care Organization (ACO) Model



So How does the MH/SU System Fit into this New Ecosystem?

- We've learned from 50 years of effort that if you work in the MH/SU Safety Net...
- Focusing inward to create a high-performing MH/SU Provider Organization does not always prevent you from ending up at the bottom...

The New Ecosystem—Many Wheels are Turning



Are County and Regional MH/SU Authorities Ready?

- The answer depends on the state environment (states are at varying levels of implementing change)
- If there are ACOs with enrolled Medicaid patients, they will quickly learn that they need to provide integrated care for those with MH/SU disorders
- If County/Regional Authorities are not responsive to supporting these efforts, there will be increasing pressure to push for carve-in
- If County/Regional Authorities cannot demonstrate that they are supportive of these efforts and are helping bend the Total HC Cost Curve, they will be at risk
- Authorities can get out in front of this wave by sponsoring and participating in ACO Medical Home development

What questions do you have?

Contact Information:
Barbara J. Mauer, MSW CMC
barbara@mcpp.net
206-613-3339