



**Primary Care, Mental Health, and Substance Use Integration
A Webinar Series Sponsored by:**

California Institute of Mental Health, Alcohol and Drug Policy Institute,
and Integrated Behavioral Health Project

Creating Partnerships That Support Integrated Care
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**Creating Partnerships that Support
Integrated Care**

CiMH

**Primary Care, Mental Health, and Substance
Use Integration
Webinar Series 5/6/10**

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Context for Partnerships

- Healthcare Reform and California Medi-Cal 1115 Waiver
 - Universal Coverage and Parity
 - Patient-Centered Medical Home
 - Accountable Care organizations
 - Payment Reform and Financing Integrated Care
- Structural Models for Integrated Care
 - Fully integrated, co-located care provided by a single organization
 - A partnership model in which care is shared
 - A facilitated referral approach
- Four Quadrant Model and Care Model
- California Integration Policy Initiative (IPI) and Consensus Guidelines

Patient-Centered Medical Home Principles

- **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.pccpc.net site for more information

Accountable Care Organizations (ACOs)

- Congress and CMS: an ACO would have at least one hospital, a minimum of 50 physicians (primary care and specialists), commit to be in business for at least 3-5 years, and serve at least 5,000 patients
 - If the ACO met pre-established quality goals, it would receive an incentive payment
 - Penalties would be assessed if care did not meet the quality goals established
 - Incentive payments and penalties would be split between the members of the ACO
 - The providers in the ACO would follow best practices, be patient-centered and contribute to the development of best clinical practices to build standards of evidenced-based medicine
- Medicare: Allow providers organized as ACOs that voluntarily meet quality thresholds to share in the cost savings they achieve (2012)
- Medicaid demonstration projects: Pay bundled payments for episodes of care that include hospitalizations (2010-2016); make global capitated payments to safety net hospital systems (FY2010-2012); Allow pediatric medical providers organized as ACOs to share in cost-savings (2012-2016)

Accountable Care Organizations (ACOs)

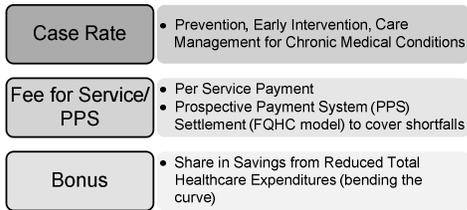
- ACOs may be able to analyze patient experiences across a population and inform quality improvement strategies
 - Vertical integration of primary care, specialty, hospital providers who share risk for quality and total healthcare costs
- ACOs would achieve this by addressing three, key barriers to improved value for healthcare
 - Tackle a fragmented payment and delivery system by fostering local, organizational accountability for the continuum of patients' care including outcomes, quality and costs
 - Focusing provider payments on improved health and outcomes, better quality, and reduced costs
 - Support patient choice by providing information on the risks and benefits of treatment options
- MH/SU providers must prepare to be a part of ACOs and advocate for bi-directional integration

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

Financing

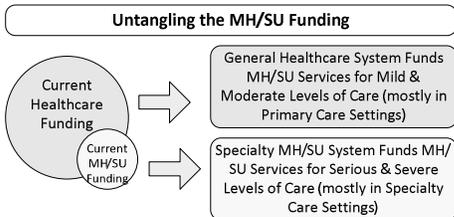
- New funding mechanisms will be utilized to better fund services that manage total healthcare expenditures—Medicare, Medicaid and commercial insurer pilots
- Many PCMHs will be funded with a 3-layer reimbursement mechanism



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

Financing Integrated Care

- 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 ...



California: Align with Healthcare Reform



- California Medi-Cal Waiver activities must be grounded in the healthcare reform legislation and concepts
 - New designs must lead to **Improved Quality** and better management of **Total Healthcare Expenditures**
 - Effective mental health and substance use treatment are key components of managing **Total Health Expenditures** and *bending the cost curve*
 - This involves treating the **healthcare needs of persons with MH/SU conditions** and the **MH/SU conditions of all Americans**
 - Requires creating **PCMHs**
- California's public mental health, substance use and general healthcare delivery systems, financing and management structures need to be better aligned and integrated into Organized Systems of Care (e.g., ACOs) to achieve these aims

California: 1115 Concept Paper

STATE OF CALIFORNIA'S CONCEPT FOR A COMPREHENSIVE SECTION 1115 WAIVER TO REPLACE THE CURRENT MEDICAL HOSPITAL/INPATIENT CARE DEMONSTRATION PROJECT

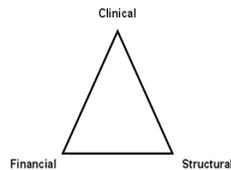
- Focus on High Need/High Cost Enrollees
 - 10% of Medi-Cal beneficiaries account for 74% of the total program costs. Within this population, 4% account for 60% of the costs (Public Policy Institute of California)
 - Approximately 30% of Medi-Cal beneficiaries with disabilities have received treatment throughout the year for a mental health condition, while close to 9% are diagnosed with schizophrenia
 - These individuals are also far more costly than persons with disabilities who do not have a mental health condition
- Promote Organized Delivery Systems of Care in 4 Phases

Seniors & Persons with Disabilities and Children & Families in Rural Counties	Children with Special Health Care Needs	Dual Eligible Beneficiaries	Adults with Severe Mental Illness
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Note: All four priority groups include persons with MH/SU conditions

California: Address the Three Components of Integration in 1115 Waiver Recommendations

- Waiver pilots should be grounded in a **Clinical Design**, as described in the IPI Report, and address the **Financial and Management Structures** 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 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 structural supports in order to be successful

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

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)

Consensus Guidelines

- Methods
 - Review of the literature
 - Convened group of 25 statewide experts (MH and PC)
 - Collaboration with concurrent IPI planning process
 - Visits to best practice sites
- Guidelines
 - Continuum of Care
 - Care Settings
 - Clinical Care Guidelines
 - Bi-Directional Transitions
 - Determining Levels of Care

Neal Adams, MD, MPH
Former Director of Special Projects, CiMH

<http://cimh.org/portals/0/documents/specproj/PCMHConsensusGuidelines.pdf>

Resources:

Enhancing the Continuum of Care: Integrating Behavioral Health and Primary Care through Affiliations with FQHCs (checklist)

Behavioral Health/Primary Care Integration and The Person-Centered Healthcare Home, April 2009

Substance Use Disorders and the Person-Centered Healthcare Home, March 2010

<http://www.thenationalcouncil.org>

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Santa Clara County's Integration Experience

Tiffany Ho, MD
Bruce Copley, MA

Santa Clara Co. Mental Health Department

Santa Clara County Health & Hospital System Mental Health Department and Ambulatory and Managed Care

- MOU to outline the collaboration between Mental Health Department (MHD) and Ambulatory & Managed Care (AMC)
- Shared MHD and AMC vision: to achieve individual and population health and wellness, health care services for the whole person (physical, mental, & substance use health care) must be seamlessly integrated, planned for and provided through collaboration at every level of the health care system (Adopted from the Integration Policy Initiative sponsored by the California Institute of Mental Health)

Program Concept & Target Population

- **Program Concept:** Three FQHCs will expand to include behavioral health services provided by Psychiatrists & Licensed Clinical Social Workers
- **Target Population** – the Integrated Outpatient Services' target population includes:
 - Persons who have mental illnesses that do not require intensive case management referred through the MHD Call Center.
 - Persons who require behavioral health services or outreach/support referred through AMC primary care providers

Tiered Approach

Four levels or categories of care will be provided

- Telephone/Email/Curbside consultation
- Face to face psychiatric consultation
- Ongoing psychiatric treatment
- Non physician behavioral health services

Leadership & Management Authority

• **MHD Roles and Responsibilities:**

- Oversight: MHD will provide oversight of the role, conduct, & outcomes of mental health services and will collaborate with AMC regarding integration of these services with primary care
- Clinic Operations: MHD will be responsible for day to day management of clinic operations
- Staff supervision: MHD will be responsible for day to day supervision of mental health staff

• **AMC Roles and Responsibilities:**

- Oversight: AMC will collaborate with MHD to oversee integration of primary care with mental health services

Documentation, Coding, & Billing

• **MHD Roles and Responsibilities:**

- MHD is responsible to assure mental health staff comply with AMC policies and procedures related to budgeting, accounting, reporting, documentation, coding, and billing.

• **AMC Roles and Responsibilities:**

- AMC is responsible to provide policies and procedures for mental health staff related to budgeting, accounting, reporting, documentation, coding, and billing.

Registration, Record Keeping Pharmacy & Labs

- **Registration:**
 - Same medical records numbers
- **Medical Records:**
 - Medical records keeping is in the same integrated paper chart used by both AMC and MHD. Progress notes are typed. MHD has two separate tabs to file notes.
- **Pharmacy and Labs:**
 - Conveniently located on the same site.
 - Results are available electronically to both AMC and MHD doctors

Lessons Learned

- **Budgeting:**
 - Need to allow for start up time. Our financial goal of generating \$10 M was too ambitious
 - Need to take into account no show rate and budget for about 20% of no shows
- **Clinical Operations:**
 - LCSWs have to move from the case management model with substantial phone work to 9 face to face visits per day for our revenue model. Currently, they are at only 50% of their capacity

Lessons Learned

- **Partnership with Primary Care:**
 - Though we anticipated a higher level of needs, despite 10 months into the operations, we have only received about 150 referrals so far.
 - Primary care at one of the clinics is also trying to build up their caseload and they are learning themselves to move from a traditional medical clinic to a medical home
 - Our collaboration was both a financial response to budget cuts and also a strong desire to coordinate/integrate care. Need more time for advanced planning and testing



San Diego County's Integration Experience

Marshall Lewis, MD
Alfredo Aguirre, LCSW
County of San Diego,
Health & Human Services Agency



Behavioral and Physical Health Integration

Marshall Lewis, MD, DFAPA – Clinical Director
Alfredo Aguirre, LCSW – Mental Health Director

Behavioral Health Division
Health and Human Services Agency
County of San Diego

Background

- Early efforts
- Recognizing importance of relationships
 - Fostering community synergies
 - The Tour



The Vision

Health Strategy Agenda – HHSa

1. Prevention
2. Access
3. Care & Treatment

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Local Models

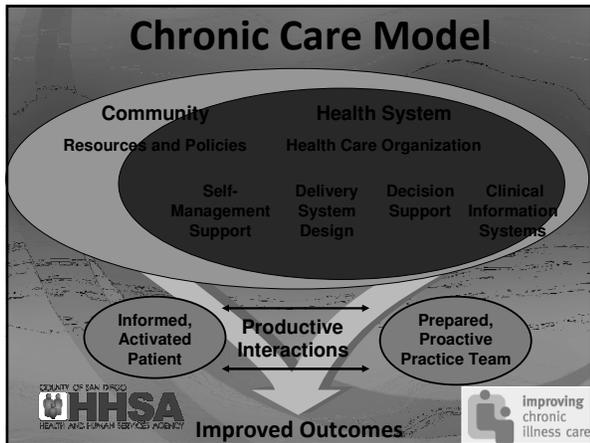
- Fully integrated – co-located
- Partnership – shared across two organizations and co-located staff
- Coordinated care – linkage

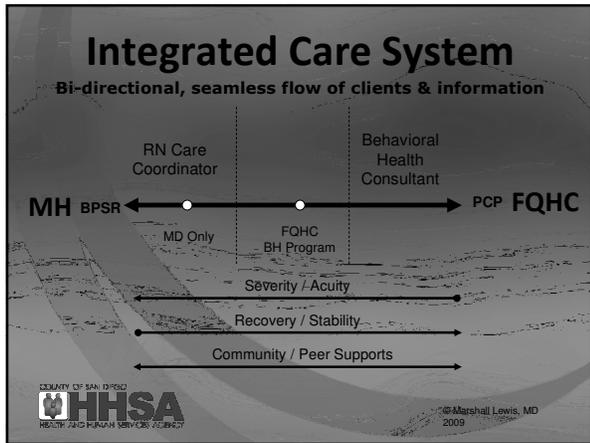
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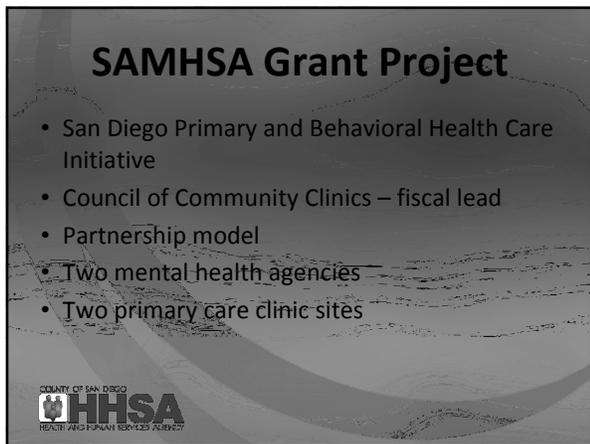
Current Strategies

- Mental Health and Primary Care (PC) Integration Services (CCC)
- SAMHSA grant
- Integrated Health Care pilot
- Rural Integrated BH & PC Services

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Integrated Health Care Pilot

- Behavioral Health Services, Federally Qualified Health Center, mental health clinic
- Stable SMI clients
- Presenting health issues
- Psychotropic medication management
- Overall health & wellness



Rural Health Project

- Rural family practice clinics
- Behavioral health prevention, education, & intervention services
- Treatment of SMI within the primary care team
- Expansion of PC formulary



Lessons Learned

- Structure is everything!
- Respect cultures
- Be explicit in contracting





Questions



Primary Care, Mental Health, and Substance Use Integration Upcoming Webinars	
Addressing Substance Use Issues in Primary Care: SBIRT and Emerging Opportunities	May 13, 2010
Addressing Mental Health Issues in Primary Care: IMPACT Model	June 3, 2010
Bridging Differences in the "Cultures" of PC/MH/SU	June 10, 2010
Paying for integrated Services: FQHC, Medi-Cal and Other Funding Strategies	June 24, 2010
Please go to http://www.cimh.org/Learning/Online-Learning/Webcasts.aspx for more information and to register for future webinars.	
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