Integrating Behavioral Health and Primary Care

Chuck Ingoglia
National Council for Community Behavioral Healthcare
January 31, 2014
• Represents over 2,150 community organizations, county and state authorities that provide safety net mental health and substance abuse treatment services to over eight million adults, children and families

• National voice for legislation, regulation, policies, and practices that protect and expand access to effective mental health and addictions services
• SAMHSA-HRSA Center for Integrated Health Solutions (CIHS);
• NY State Geriatric Technical Assistance Center;
• Ohio Training & Technical Assistance Center
• *Training Curriculums* – Psychiatrist; MSW; Case Managers; Peers - Whole Health Action Management (WHAM)
• Consultation to state and local governments, organizations
• Evaluators' Report on the National Demonstration Project (NDP) to the Board of Directors of TransforMED

• Winter 2009

• by The Center for Research in Family Medicine and Primary Care
  Elizabeth E. Stewart, PhD (NDP Qualitative Analyst)
  Carlos R. Jaén, MD, PhD
  Benjamin F. Crabtree, PhD
  Paul A. Nutting, MD, MSPH
  William F. Miller, MD, MA
  Kurt C. Stange, MD, PhD
1. Achieving a PCMH requires whole practice redesign, and is not merely the sum of many incremental changes.
2. Achieving a PCMH requires more than 2 years
3. The journey to the PCMH requires both personal and practice-level transformation
4. Transformation also involves learning to be a 'learning organization.'
5. Change agencies should support multiple connections among practices
Lessons Learned: Health Homes and BH-PC Integration

• **New Expectations and Competencies**
  ✓ Nurses, physicians, case managers

• **Data Collection (and use) expectations**

• **Information/data sharing poses challenges**
  ✓ Hospitals
  ✓ Health plans
  ✓ Between practices/specialties
Lessons Learned: Health Homes and BH-PC Integration - continued

- Change Fatigue across the continuum (Health Homes, Duals, Managed Care)
- Quality and payment not aligned yet
- What about the children?
- Training, quality improvement, etc.
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Integrating Behavioral Healthcare –
The Managed Care Perspective & Role

NACo 2014 Healthy Counties Forum
January 31, 2014

Marianne Burdison, LCSW, Senior Director, Strategic Alliances & Development
Office: 512-406-7261  Cell: 512-538-8048
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Integrated HealthCare

- Healthcare for the whole person v. treatment for specific illnesses

- Ensures the right treatment for each condition in context of the individual’s comprehensive needs

- More than care coordination

- Includes wellness and prevention

- Many paths up the mountain!
Our Perspective as Payer

Integrated Care:

- Improves outcomes
- Improves access
- Increases cost effectiveness
- Requires collaborative partnership
- Demands disruptive innovation
Our Role as Payer

• Impact Policy

• Partner with providers, communities and other stakeholders

• Promote system change that achieves the Triple Aim of ACA
Questions?

Marianne Burdison, LCSW, Senior Director, Strategic Alliances & Development
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PRACTICES FOR INTEGRATING BEHAVIORAL HEALTH INTO ACCS/MEDICAL HOMES

Pat Fleming
Director, Behavioral Health Services
Salt Lake County, Utah
Full Expansion Premium Assistance Model

Medically Frail

“At Risk” Behavioral Health

Local Authorities

(Traditional Medicaid Plan)

100 -> 90/10 Match (2020)

Current Medicaid Plan Remains In Place (~100,000 Members) 70/30 Match

“At Risk” Physical Health

ACO’s

SelectHealth

Molina Healthcare

University of Utah Healthy U

Health Choice

100 -> 90/10 Match (2020)

Current Medicaid Plan Remains In Place (~100,000 Members) 70/30 Match

Non-Medically Frail

Medicaid $ Department of Health 0 – 133%

Employer Plan

Marketplace Private Insurance Plans
(Benchmark Plan – Skinnier Benefits)

Humana Medical Plan of Utah, Inc.

Altius Health Plans

SelectHealth

Arches Health Plan

BridgeSpan Health Company

Molina Healthcare of Utah

The term “medically frail” must include at a minimum certain children with special needs; individuals with disabling mental disorders or chronic substance abuse disorders; individuals with serious or complex medical conditions; individuals with physical, intellectual, or developmental disabilities that significantly impair their ability to perform one or more activities of daily living; or individuals meeting a state’s disability determination.
Expansion As Envisioned in the ACA

<table>
<thead>
<tr>
<th>Federal Poverty Level %</th>
<th>0%</th>
<th>50%</th>
<th>100%</th>
<th>133%</th>
<th>200%</th>
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<tbody>
<tr>
<td>Eligibility Categories:</td>
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<td>Children 0-5</td>
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<tr>
<td>Children 6 - 18</td>
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<tr>
<td>Pregnant Women</td>
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<tr>
<td>Adults &gt; 65</td>
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<tr>
<td>People w/ Disability</td>
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<tr>
<td>Adults w/ Children</td>
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<tr>
<td>Adults w/o Children</td>
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- Current Medicaid eligibility
- Current CHIP eligibility
- Medicaid expansion (optional under ACA)
- Eligible for Tax Credits for use in the Exchange (up to 400% of FPL)

Population Estimates:

- 379,000 (144,000 SL Co)
- 123,586 (49,434 SL Co)
- 270,000 (108,000 SL Co)
County Health Care in a Medicaid Expansion State

Healthy Counties Forum
January 30, 2014
Perceptions of Orange County

- Home to the “happiest place on earth”
- Mega mansions, wealthy housewives
- Lack of diversity
- Republican
The Real OC

- 6th largest county in the nation
  - More residents than 20 states
- 21% of the total population report that they do not speak English “very well”
- Over 46% of students eligible for free or reduced lunch
- Median home sale price $582,930 (2012)
- 21,000 - 35,000 homeless people
- Over 26,000 public school students living in unstable housing conditions
- 12.7% or 379,690 living with food insecurity
Poverty in OC

Countywide Rate (2007-2011): 10.9% of Individuals Under 100% FPL

Poverty Rate by Census Tract

- 0.0 - 4.4
- 4.5 - 10.9
- 11.0 - 13.9
- 14.0 - 60.2
ORANGE COUNTY MEDI-CAL ELIGIBLE POPULATION BY ZIP CODE

Medi-Cal Eligible Residents*  
Rate per 1000 ZIP Code Population

- 0.0 - 49.9
- 50.0 - 149.9
- 150.0 - 249.9
- 250.0 - 384.2

(*Month of eligibility: July 2011)
ORANGE COUNTY MEDI-CAL ELIGIBLE POPULATION BY ZIP CODE

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Rate per 1000 ZIP Code Population

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## Bridge to Affordable Care Act

<table>
<thead>
<tr>
<th></th>
<th>Coverage Initiative</th>
<th>Low Income Health</th>
<th>Medical Safety Net</th>
</tr>
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<tbody>
<tr>
<td><strong>Start Date</strong></td>
<td>Sep. 2007</td>
<td>Nov. 2010</td>
<td>Jan. 2014</td>
</tr>
<tr>
<td><strong>End Date</strong></td>
<td>Oct. 2010</td>
<td>Dec. 2013</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>Starting Enrollment</strong></td>
<td><strong>18,989</strong></td>
<td>38,691</td>
<td>5,600 annual est.</td>
</tr>
<tr>
<td><strong>Ending Enrollment</strong></td>
<td>38,691</td>
<td><strong>68,371</strong></td>
<td>TBD</td>
</tr>
<tr>
<td><strong>Final Funding</strong></td>
<td>$74 million/year</td>
<td>$121 million/year</td>
<td>$19 million/year est.</td>
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</table>
CalOptima Increase

- Approximately 113,000 new members since January 1, 2013:
  - (January 2013) Healthy Families Program – 37,500
  - (January 2014) ACA Medicaid Expansion – 35,981
  - (June 2014) Duals (Medi-Cal/Medicare) Eligible – 40,000
CalOptima: A COHS Plan

- CalOptima is a County Organized Health System (COHS)
  - A public agency authorized by county, state and federal actions. **Separate legal entity from County of Orange**
- Single plan responsible for Medi-Cal
  - Mandatory enrollment of all full-scope Medi-Cal beneficiaries, including dual eligibles
  - Largest COHS in state (473,849 members) insuring:
    - 1 in 6 Orange County residents
    - 1 in 5 Orange County seniors
    - 1 in 3 Orange County children
Pre-1995: Medi-Cal Before CalOptima

- **Fee-for-service (FFS) Medi-Cal**
  - Providers registered with the state to provide Medi-Cal services; they received payments directly from the state
  - Beneficiaries could obtain care from *any willing provider*

- **Voluntary managed care**
  - Beneficiaries could choose to join a managed care plan and could receive services through its network and system of care
What Does CalOptima Do?

- Ensures access to care
  - Contracts with a network of providers to deliver health care services
    - 1,800 primary care providers
    - 4,750 specialists
    - 30 acute and rehab hospitals
    - 30 community health centers
    - 489 pharmacies
    - 106 long-term care facilities

- Responsible for “mild to moderate” mental health care
  - County retains responsibility for SPMI/SED clients, per 1915(b) Waiver
CalOptima Programs

- Medi-Cal
- OneCare (HMO SNP)
- PACE
- Cal MediConnect
- Multipurpose Senior Services Program
- Behavioral Health ASO
- Resource Connection
- Foundation COREC
Integration- Post ACA

- County Behavioral Health clinicians co-located at not for profit community clinics
- Community clinics co-locate primary care team (MD, RN, NP) at County adult mental health clinics
- Funding provided by 2004 voter approved statewide tax on millionaires (Proposition 63- Mental Health Services Act)
- Orange County’s required to spend a portion of funds on “innovative” projects. Innovation component funds integration
- County provided psychiatric consultations for primary care clinicians. County psychiatrists assisted primary care doctors in medication management.
- County continued to manage difficult/complicated cases
Final Thoughts

- Managing in a marketplace with no available data
- Lingering unfunded state mandates provide opportunities for stronger partnerships with private health care community
- Non-expansion states could seek waiver programs as pilots to expand care without full ACA implementation

Comments/Questions
Integrating Healthcare
The Washtenaw Experience

NACo: Healthy Counties Initiative
January 31, 2014
The Local “Public Option”
The Status Quo

“Our minds and our bodies are always together in our lives, except when we enter the health care system. There they are often separated, and totally distinct specialties take over.”

Cynthia M. Watson, M.D.

thepfizerjournal.com
An Alternative: Integrated Care

- “Reunification in practice of mind and body”
- Health care model in which “physical health” and “mental health” clinicians partner to manage health conditions
- Shift away from disease-focused system to a person-centered system
- Single treatment plan focused on what patients/consumers need
Medical Homes

- Medical care and behavioral health care is provided in *one location* that is welcoming and easy to navigate.
- Mental health and primary care clinicians work together as a *single team* for the benefit of the consumer.
- The focus is on *collaboration*, wellness and recovery.
Washtenaw County Demographics

Population (from 2010 census)
-344,791

Race and Ethnicity
- 75% White
- 12% Black or African-American
- 8% Asian
- 5% Multiple Races

Age
- median age is 33 years

Income
- median household income is $59,065 (in 2010 dollars)
Washtenaw County Demographics

Education
- 91% of citizens have high school diploma or higher
- 43% of citizens have bachelor's degree or higher

Poverty
- In 2011, 18% of population living below poverty level
- 30% live 200% of poverty level
- Nearly 1/3 (13,704 students) of those enrolled in public school receive free or reduced-price lunch

Unemployment
- In July 2013- 7% (state unemployment is 10% and nationally 8%)

Ability
- 29,000 (9%) residents of all ages endorse a disability in hearing, vision, cognition, mobility or self-care

Rural v. Urban
- 84% of population lives in urban area (289,570), 16% (55,157) in rural
2010 HIP Survey

- 2000 Adults Surveyed
  - 14.4% reported 10 or more poor mental health days in the past year
  - 39% of those who rated their mental health as fair/poor were currently seeing a mental health professional
  - 16% of adults diagnosed with anxiety disorders
  - 22% of adults have been diagnosed with depression

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Community Support & Treatment Services

- Populations Served:
  - 2,630 Adults with Mental Illness
  - 860 Adults with Intellectual Disability
  - 566 Children with Severe Emotional Disturbance & Intellectual Disabilities

4,056 Total Served
Skeletal-Connective
Gastro-Intestinal
Obesity/Dyslipid
COPD
Infectious Disease
Hypertension
Dental Disorders
Diabetes
Cancer
Heart Disease
Pneumonia/Influenza
Liver Disease

Percent Members

SMI (N=9224)
Non-SMI (N=7352)

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Medical Home Models

- Embed mental health staff in primary care clinics
- Import primary care providers into mental health clinics
"I'm right there in the room, and no one even acknowledges me."
Why Integrate Care?

- Mental health consumers are much less likely to receive care for chronic physical health conditions than the general population.
- Serious mental illness is associated with increased morbidity and mortality due to general medical conditions.
Why Should We Be Concerned About Morbidity and Mortality?

- Individuals with serious mental illness served by our public mental health systems die, on average, 25 years earlier than the general population.
Cumulative Social Disadvantage

Mortality is increased by:

- Lack of adequate housing
- Lower income
- Poor social cohesion
- Limited education
- Multi-morbidity

Housing, income, and social relatedness are treatments
Morbidity and mortality

- Clinical care (20%)
- Health behaviors (30%)
- Social and economic factors (40%)
- Physical environment (10%)
The Medical Model is Necessary But Not Sufficient
## Four Quadrant Integration Model

<table>
<thead>
<tr>
<th>Quadrant II</th>
<th>Quadrant IV</th>
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<tbody>
<tr>
<td>BH high, PH low</td>
<td>BH high, PH high</td>
</tr>
<tr>
<td><em>CMH or PCP Medical Home</em></td>
<td><em>CMH and PCP Co-managed Care</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quadrant I</th>
<th>Quadrant III</th>
</tr>
</thead>
<tbody>
<tr>
<td>BH low, PH low</td>
<td>BH low, PH high</td>
</tr>
<tr>
<td><em>PCP Medical Home</em></td>
<td><em>PCP Medical Home</em></td>
</tr>
</tbody>
</table>

**Behavioral Health Risk/Status**

- **Low**
- **High**

**Physical Health Risk/Status**

- **Low**
- **High**
Recognize That the Needs Exists In the Population

- Know, acknowledge and accept that the needs exist in the target population
  - Already committed to your patients
- If the perception is that it doesn’t exist:
  - Provide evidence that it does
  - Implement simple screening tools to demonstrate presence of behavioral health needs
Consciously Decide How to Address Healthcare Integration

- Refer to outside providers
- Provide onsite comprehensive care
  - Continuum of integration
Staffing the Primary Care Partnership

- A full time behavioral health specialist (MSW) on site and a ½ day per week of psychiatrist
- Joint supervision & oversight of the program by Primary Care and CSTS
Staffing at Community Mental Health

- 5 care coordinator RNs
- 3 full time certified peer support specialist
- 1 registered dietician/health educator
- 1 half-time family nurse practitioner
Establishing a Learning Environment

- Support innovation and creativity
- Support education and team learning and training
- Talk about vision
- Support systems thinking
- If it doesn’t exist -
  - Identify leadership and begin to create it through an organizational development plan
“Strangers in the Night”

- Most primary care providers receive little behavioral health training
- Psychiatrists receive limited training in outpatient management of chronic medical conditions
- Primary care providers and psychiatrists generally receive no significant training in collaborative, integrated practice arrangements
The Great Cultural Divide...

- **Primary Care Docs**
  - 10-15 minute blocks
  - Deal directly with other physicians
    - Find it difficult to deal with interdisciplinary team
  - Medical records short, concise summaries of the diagnosis, treatment and outcome
  - Language = patients

- **Psychiatrists**
  - 30-60 minute sessions
    - Time with consumers considered sacrosanct
  - Team decision model
  - Behavioral health records are long and complex
    - Contain goals and objectives
    - Variety of provided services; may be re-evaluated over time
    - Contain consumer input
  - Language = clients or consumers
Leadership

- Administrative and Board Leadership
  - Identify a champion who won’t give up

- Clinical Leadership
  - Identify a clinician with the commitment to lead other clinicians

- If it doesn’t exist
  - Identify an opinion leader or two within the office and convince them of the viability
  - Get them trained on a model and have them start using it
  - Organizational leadership development program
Sustainability Challenges

- Section 2703 of the Affordable Care Act - Behavioral Health Homes
- Impact of Medicaid Expansion - more questions than answers!
In Summary
Thank you
Sources:

-US Census Bureau, 2007-2011 American Community Survey 5-year Estimates (population, age, race and ethnicity)
-US Census Bureau, 2006-2010 American Community Survey 5-year Estimates (income)
-US Census Bureau, American Community Survey 1-year Estimate, 2011 (poverty)
-US Census Bureau, 2009-2011 American Community Survey 3-year Estimates (ability)
-US Census Bureau 2008-2012 American Community Survey (education)
-US 2010 Decennial Census (rural v. urban)