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Center for Healthcare Integration & Innovation

Community Mental Health Association of Michigan

Healthcare Integration and Coordination – 2021/2022 Update: Survey of Initiatives of Michigan's Public Mental Health System

February 2022

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I. Abstract

This study serves as an annual follow-up to previous studies conducted in 2016 to present. In November 2020, the Community Mental Health Association of Michigan's (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 study examined varying efforts aimed at integrating behavioral health and intellectual/developmental disability services with physical healthcare services. Results showed that more than 451 healthcare integration efforts, led by these public sector parties, were in operation throughout Michigan. The CMHs, PIHP, and providers involved in healthcare integration, often pursue a number of efforts simultaneously, with each organization that responded to the survey reporting an average of over 20 healthcare integration initiatives. Of this number, work around physical health-informed behavioral health and intellectual/developmental disability (BHIDD) services, co-location, and identification of super-utilizers underscored the variety and maturity of these efforts.

II. History and Background

The responsibility for the management, design, and operation of Michigan's public behavioral healthcare and intellectual/developmental disability services system (BHIDD), has historically been the responsibility of the Community Mental Health Services Programs (CMHSP), the public Prepaid Inpatient Health Plans (PIHP) that were formed and governed by the CMHSP, the provider networks managed by these two sets of public bodies, and the Michigan Department of Health and Human Services (MDHHS). MDHHS funds this system, Michigan's public mental health system, with state General Fund dollars and Medicaid funding, the latter provided through a monthly shared risk arrangement with the State of Michigan in the form of capitation

payments (per Medicaid-eligible). [12] The public BHIDD system (CMHSPs, PIHP, and providers) have historically taken a whole-person orientation to service delivery, working to address a range of human needs in addition to behavioral health and intellectual disability needs, as well as a range of social determinants of health. This whole-person orientation is grounded in the person-centered, community-based, and recovery-oriented philosophies guiding the system. Over the past several years, CMHSPs, PIHP, and providers have focused increasingly on integrating the BHIDD services that they provide with primary care and other physical healthcare services. This practice has:

- Increased access for BHIDD consumers to primary care services
- Improved access to BHIDD services to persons seen in primary care settings but without ready access to the full array of BHIDD services
- Improved prevention and intervention to reduce serious physical illnesses
- Improved overall health status of consumers[3]

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

While, anecdotally, the CMH Association of Michigan knew that a large number of diverse integration efforts were in operation across the state, led by CMHSPs, PIHP, and providers within the CMHSP networks in Michigan, no formal cataloging of those efforts had been completed. In 2016, the initial study conducted by the Community Mental Health Association of Michigan (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, conducted late 2020, aims to update the data collected in the previous years, given the rapid and continual development of these initiatives by Michigan's public mental health system.

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[1] Throughout this document, the term "public mental health system" will be used to describe Michigan's Community Mental Health Services Programs (CMHSP), the public Prepaid Inpatient Health Plans (PIHP) that were formed and governed by the CMHSP, and the provider networks managed by these two sets of public bodies

[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. Accessed February, 2022.

[3] SAMHSA-HRSA Center for Integrated Health Solutions. SAMHSA PBHCI Program. Retrieved from http://www.integration.samhsa.gov/about-us/pbhci. Accessed February, 2022.

III. Methods

In November 2021, CMHA issued an electronic survey to its member agency directors and CEOs, in order to gather information regarding the healthcare integration efforts of Michigan's CMHs, PIHP, and providers. The survey included questions surrounding current healthcare integration activities and services. **Twenty** CMHA member organizations responded, representing a variety of organizational types and settings. This study will continue to be replicated on an annual basis to continue tracking the work being done by the state's CMHs, PIHP, and provider system to foster integrated care. The range of healthcare integration and coordination methods, around which information on activity within the system were sought, is outlined in Attachment A.

IV. Findings and Analysis

This study resulted in a number of key findings:

A. The state's CMH, PIHP, and provider system has **long recognized that the integration and coordination of healthcare services are key tools to improving the health of persons with BHIDD needs**, making services more effective and accessible while working to lower the overall cost of healthcare and related human services to the communities served by these BHIDD systems.

B. The **variety of healthcare integration initiatives** designed and implemented by the state's CMH, PIHP, and provider system is broad, representing dozens of approaches to fostering integration and coordination of care. The range of healthcare integration approaches are captured in Attachment A.

C. **Safety net behavioral and physical healthcare providers are working together to provide vital services through integrated care models.** The current study is the first to examine healthcare integration efforts among Michigan's public physical and behavioral healthcare systems. The study found that the CMH, PIHP, and provider system is involved in over **43** efforts state-wide to coordinate and integrate care with federally funded Community Health Centers (FQHCs). These efforts include active referral networks, co-location, care coordination, collaborative treatment planning, data sharing, efforts to identify and address needs of high/super-utilizers, and joint workforce education and training initiatives.

D. **Three specific types of integration, with considerable complexity, stood out, in addition to a handful of other notable findings**. This 2021 study identified **451** healthcare integration efforts occurring across the state, with the potential for more to come. While there were many different methods of integration implemented by the public system, three of those efforts stood out, given their organizational, clinical, technical, and relational complexity. Those efforts were physical health informed BHIDD services, co-location, and identification of super-

utilizers. These three methods of integration are discussed below, with the frequency of responses summarized in Attachment B.

1. <u>Physical Health Informed BHIDD Services</u>: 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 **71** total initiatives regarding physical health informed BHIDD services.

a. <u>Identification of Patients Without a Primary Care Provider</u>: 20 sites (100%) 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.

<u>Facilitating Communication between BHIDD provider and primary care providers (Fostering Integration)</u>: 17 sites (85%) reported efforts aimed at fostering communication efforts between BHIDD sites and primary care providers. These efforts included communication via case manager, supports coordinators, care managers and similar intensive coordination. Coordinating with primary care providers increases the likelihood of positive outcomes for patients, strengthens coordination and improves quality of care.

b. <u>Health Screening</u>: 16 sites (80%) 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. <u>High/Super-Utilizer Initiatives</u>: A significant segment of the integration initiatives identified in this study are those efforts that address the needs of the high/super-utilizer population. High/super-utilizers are individuals with very high healthcare service utilization patterns, often across disciplines and sectors. These same people often demonstrate high levels of utilization of human services outside of traditional healthcare domains, such as: public safety, housing supports, judiciary, and child welfare. The study found **100** joint efforts between CMHs, PIHP, providers, and primary care practices,

hospitals, and Medicaid Health Plans to address the needs among this population in order to effectively utilize healthcare resources.

a. 17 sites (85%) reported active use of data (Care Connect 360 or other data analytics) to identify high/super-utilizers at the point of access.

b. 16 sites (80%) reported joint efforts with Medicaid Health Plans to address the needs of high/super-utilizers.

c. 16 sites (80%) reported use of hands-on complex case/care management to persons with complex needs.

d. 14 sites (70%) 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.

e. 14 sites (70%) reported joint efforts with primary care practices to address additional needs of increased use of healthcare resources.

3. Co-location Initiatives: This study identified **64** total efforts to co-locate physical and BHIDD services within the same physical space. The most common method of co-location was psychiatric consultation, telephonic, video, or face-to-face, provided by BHIDD party to a primary care site, with **13 sites (65%)** reporting this method of integration. **12 sites (60%)** reported BHIDD staff in hospital emergency departments, or creating regular protocol that BHIDD staff provide crisis screening in emergency departments. **10 co-location efforts (50%)** across the state involve a FQHC.

Other notable findings:

19 sites (95%) reported an active and frequent referral network.

19 sites (95%) reported providing healthy lifestyles education (WRAP, WHAM, etc.) and/or smoking cessation, weight control, or exercise courses.

18 sites (90%) reported receiving Admission, Discharge, and Transfer (ADT) data from hospitals and emergency departments.

18 sites (90%) reported providing system navigation guidance to consumers (by BHIDD party or in partnership with healthcare provider or health plan)

18 sites (90%) reported workforce training on healthcare integration and health literacy.

10 sites (50%) reported

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 **451** healthcare integration initiatives led by CMHs, PIHPs, and BHIDD providers across the state of Michigan, of which **227** were those involving: physical health informed BHIDD services, active referral networks, or efforts to address the needs of the high/super-utilizer population.

As this series of studies represents the first of its kind to catalogue the healthcare integration efforts of the state of Michigan's CMH, PIHP, and provider network, the study will continue to be replicated in the future to track the emergence of new efforts and the changes in the integration services identified in this study.

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

The Community Mental Health Association of Michigan (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.

Attachment A

Healthcare Integration and Coordination approaches sought via Center for Healthcare Integration and Innovation survey (November 2021 study; February 2022 report)

Active referral network

- Formal referral agreements between BHIDD party and primary care provider
- System navigation guidance to consumers (by BHIDD party or in partnership with healthcare provider or health plan)
- Active and frequent referral relationship
- Community Health Centers (FQHCs) are included in referral network

Co-location related efforts

- BHIDD staff co-located in primary care practice (may be team-based care or less intense partnership)
- Primary care provider co-located in a BHIDD site (may be team-based care or less intense partnership)
- BHIDD staff co-located at hospital emergency department or BHIDD staff go to the emergency department as a regular protocol to provide crisis screening or inpatient admission pre-screening
- Psychiatric consultation, telephonic, video, or face-to-face provided, by BHIDD party, to primary care site
- Physical health laboratory or lab pick-up at BHIDD site
- Co-funded positions
- Loaning positions from or to BHIDD party
- Co-location efforts involve a Community Health Center (FQHC)

Physical health informed BHIDD services

- Health screening, including identification of risk factors for undiagnosed, acute, or chronic care issues integrated within the behavioral health assessment process
- Identification of patients without a primary care provider and/or who have not engaged primary care provider in past year and active referral to such care
- Actively facilitated communication between BHIDD provider and primary care providers (via case manager, supports coordinator, care manager, nurse care manager, or similar intensive coordination)
- Use of data by the BHIDD party, including health dashboards and standardized tools to target interventions (often to high utilizers and others) to improve population health
- BHIDD providers work with Community Health Centers (FQHCs) to identify and meet patients' physical healthcare needs

Services/supports/treatment plan and Electronic Health Record (EHR)

- Single care plan reflecting BHIDD services and supports and physical health treatment
- Shared or linked BHIDD and primary care electronic health records
- ADT (Admission, Discharge, and Transfer) data by hospitals and emergency departments with BHIDD party
- Use of portals with primary care and hospital systems as a normal part of workflow to direct treatment
- Integration of primary care coordination measures (MDHHS, HEDIS, or others) into EHR and staff workflows (e.g., physical and behavioral health medication reconciliation)
- Collaborative treatment planning and/or data sharing with Community Health Centers (FQHCs)

High/super-utilizers

- Active use of data (Care Connect 360 or other data analytics) to identify high/super-utilizers at the point of access
- Active use of data (Care Connect 360) to provide outreach to high/super-utilizers who have not accessed the BHIDD system of care
- Joint effort with primary care practices to address the needs of high/super-utilizers of healthcare resources
- Joint effort with hospitals (including emergency departments) to address the needs of high/super-utilizers of healthcare resources
- Joint effort with Medicaid Health plans to address the needs of high/super-utilizers of healthcare resources
- Joint effort with Community Health Centers (FQHCs) to identify and address the needs of high/super-utilizers of healthcare resources
- Use of hands-on complex case/care management to persons with complex needs

Workforce education and training

- Joint educational and networking efforts for BHIDD providers and primary care providers
- BHIDD workforce trained on healthcare integration and health literacy
- BHIDD party provides/facilitates training for primary care workforce on BHIDD issues
- Community Health Centers (FQHCs) are included in training and education efforts

Consumer/patient empowerment and access

- Healthy lifestyles education (WRAP, WHAM, etc.) and/or smoking cessation, weight control, exercise courses

- Medicaid, Healthy Michigan, and exchange enrollment initiatives on BHIDD site
- Movement to integrate SAMSHA wellness and recovery principles into BHIDD services
- Use of collaborative/concurrent documentation to improve healthcare delivery transparency and consumer health literacy and efficient workflow for staff, reducing time onsite for consumers
- Use of same-day/next-day access and just in time prescribing approaches to reduce no-shows and enhance access to services

Attachment B

1. **Physical health-informed BHIDD services**

Health screening, including identification of risk factors for undiagnosed, acute, or chronic care issues integrated within the behavioral health assessment process	16
Identification of patients without a primary care provider and/or who have not engaged primary care provider in past year and active referral to such care	20
Actively facilitated communication between BHIDD provider and primary care providers (via case manager, supports coordinator, care manager, nurse care manager, or similar intensive coordination)	17
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	17
BHIDD providers work with Community Health Centers (FQHCs) to identify and meet patients' physical healthcare needs	12

2. **High/super-utilizers**

Active use of data (Care Connect 360 or other data analytics) to identify high/super-utilizers at the point of access	17
Active use of data (Care Connect 360) to provide outreach to high/super-utilizers who have not accessed the BHIDD system of care	14
Joint effort with primary care practices to address the needs of high/super-utilizers of healthcare resources	14
Joint effort with hospitals (including emergency departments) to address the	13

needs of high/super-utilizers of healthcare resources	
Joint effort with Medicaid Health Plans to address the needs of high/super-utilizers of healthcare resources	16
Joint effort with Community Health Centers (FQHCs) to identify and address the needs of high/super-utilizers of health care resources	10
Use of hands-on complex case/care management to persons with complex needs	16

3. Co-location initiatives

BHIDD staff co-located in primary care practice (may be term-based care or less intense partnership)	7
Primary care provider co-located in a BHIDD site (may be term-based care or less intense partnership)	6
BHIDD staff co-located at hospital emergency department or BHIDD staff go to the emergency department as regular protocol to provide crisis screening or inpatient admission pre-screening	12
Psychiatric consultation, telephonic, video, or face-to-face, provided by BHIDD party to primary care site	13
Pharmacy co-located in CHIDD site	4
Physical health laboratory or lab pick-up at BHIDD site	4
Co-funded positions	6
Loaning positions from or to BHIDD party	2