Safety Net Health Plans: Working with Providers in Underserved Areas to Integrate Behavioral Health and Primary Care

September 2014

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Association for Community Affiliated Plans

SAMHSA-HRSA
Center for Integrated Health Solutions

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Summary

Better integration of physical and behavioral health is a critical component of improving outcomes and reducing costs for Medicaid beneficiaries, especially those with high levels of need. This fact sheet profiles four examples where the safety net community – health plans, community health centers, community mental health centers, and the centers' primary care and behavioral health clinicians – have collaborated to develop programs to integrate care for this population. The initiatives cover a wide range of activities, and include developing collaborative care models, requiring behavioral health needs assessments for all health plan members, providing mental health providers with information about primary care utilization of their patients, and supporting Medicaid health homes. There are fundamental similarities between the programs, and these principles can serve as a roadmap for community health centers and health plans jointly implementing their own integrated care models.

Acronyms

CHC: Community Health Center
CMHC: Community Mental Health Center
EMR: Electronic Medical Record
FFS: Fee For Service
FQHC: Federally Qualified Health Center
MCO: Managed Care Organization
PCP: Primary Care Provider

Common themes amongst the initiatives include:

- Develop and maintain strong, respectful relationships between health plans and community health centers – share information, decision making, costs, and savings as appropriate.
- All involved organizations need a seat at the table when developing and maintaining such initiatives, and the people at the table need to be senior-level staff with decision-making capabilities in a variety of operational and clinical areas.
- Measure quality and outcomes; not only traditional clinical measures but also data beyond care delivery and claims: arrests/recidivism, housing status, employment.

Background

The separation between physical and behavioral health care poses significant problems for individuals with behavioral health needs. Patients with mental illness have higher mortality rates, on average dying decades earlier but from treatable causes including cardiovascular and pulmonary disease.[1] A 2009 study found that more than 1 in 3 non-elderly adults in the Medicaid program have an identified mental illness. In addition, those with a mental illness were nearly twice as likely to have an additional chronic physical health condition (61%) compared to those without mental illness (33%) and more than twice as likely to describe themselves as having fair or poor health status (56% versus 26%).[2] It is anticipated that the Medicaid expansion population may have similarly high behavioral and substance abuse related needs, although information about the characteristics of this group is still preliminary.

Providing behavioral health services in primary care settings, and vice versa, can reduce costs and improve outcomes, while improving access to services that many patients would not

otherwise receive.[3] Physical and behavioral health care integration can improve care and contain costs for this complex and high-need population. Fully integrated behavioral and physical care results in thoughtful, whole-person care that recognizes and addresses the fact the two domains, and subsequent outcomes, are interconnected.

Not-for-profit Safety Net Health Plans are favorably positioned to draw on their strong community relationships and work collaboratively with community health and mental health centers and their clinical staff to integrate physical, mental, and behavioral health services for their members. As managed care organizations (MCOs) enroll more individuals with behavioral health needs, they are collaborating with providers – frequently community health centers already familiar with this population – to fully integrate the care for these members. In developing this fact sheet, several common themes and lessons learned emerged from the four profiled initiatives.

Common Strategies for Developing Behavioral/Physical Health Integration Programs

- Develop and maintain strong, respectful relationships between health plans and community health centers – share information, decision making, costs, and savings as appropriate.
- All participating partners – MCOs, CHCs, CMHCs, and other parties as applicable, including county mental health agencies and housing support programs – need a seat at the table when developing and maintaining such initiatives, and the people at the table need to be senior-level staff with decision making-capabilities in a variety of areas (clinical, IT, financial).
- Maintain a steering committee for the program so that all relevant parties are present and ready to act when new issues arise.
- Measure quality and outcomes; not only traditional clinical measures but also data beyond care delivery and claims: arrests/recidivism, housing status, employment.
- Make changes along the way, whether they are prompted by outcome data or necessary for feasibility and functionality of the program.
- For the most part, reimbursement structures for intensive care management and integration programs do not exist in primary care; leverage the flexibility of Safety Net Health Plans to create them in a manner that benefits both the plan and the provider.
- Develop your program in the confines of the state policy environment – integration initiatives are still possible with a partial behavioral health carve-out.
- Information sharing is difficult but crucial. Try to ensure all parties use the same system from the beginning, even if that requires implementing a second population-management system for the project.

Implementing a Collaborative Care Model

For more than 20 years, **Community Health Plan of Washington** (CHPW) has worked with community health centers to deliver primary care services to plan members – in fact, the plan was founded by community health centers. This close relationship and the resulting open communication were central to implementing and maintaining CHPW's **Mental Health Integration Program** (MHIP).

In 2004, CHPW began to enroll members of the General Assistance-Unemployable (GA-U) population, a Washington State coverage program for adults deemed incapacitated due to a physical or mental health condition. Initially, the benefit only included medical services, not behavioral health services. But it quickly became apparent to CHCs that excluding a mental health benefit for this population was unsustainable: half the GA-U population had a mental health need, and many had co-occurring chronic physical and substance abuse conditions. Because the coverage expansion was entirely state-funded, the state did not have the resources to implement a full mental health benefit. CHPW, in collaboration with participating CHCs and the University of Washington Center for Advancing Integrated Mental Health Solutions (AIMS Center), developed the MHIP model. The state funded a pilot program of the model in 2007. Because the MHIP model relies upon PCPs with which the patients already interact, behavioral health care coordinators, and consulting psychiatrists, access to scarce psychiatric resources is greatly enhanced. As a result, MHIP demonstrated improved clinical outcomes, lower cost, and improved access to mental health services that would have been otherwise unavailable to the GA-U population.

Sample Quality Measures: CHPW

- Active caseload
- Clinical contacts per month
- Psychiatric consultations for clients not improving
- Improvement in PHQ9 and GAD7 scores
- Improvement in achieving care plan goal

The MHIP model uses the evidence-based Collaborative Care Model, pioneered by the AIMS Center and others.[4] In MHIP, CHPW funds a behavioral health care coordinator who is physically located in the CHC. For patients with an identified behavioral health need, the behavioral health care coordinator works with the PCP and the client to provide behavioral health care. Consulting psychiatrists work with the behavioral health care coordinators and PCPs to systematically review the caseload on a weekly basis and make treatment recommendations. Behavioral health care coordinators have caseloads of 50-60 patients and act not only as conduits between the PCPs and consulting psychiatrists but also as links between patients and other mental health providers and social supports. An online registry, developed by the University of Washington, powers the collaboration at the heart of the MHIP program. CHC electronic medical record (EMR) systems do not yet support the population-based case management required for MHIP, so the behavioral health care coordinator must enter data twice – in the MHIP registry and in the CHC's EMR. The registry allows the consulting psychiatrist, who is not a member of the CHC's clinical staff, access to patient records, facilitating coordination among the decentralized team.

Compared with GA-U clients in similar but non-participating counties, those enrolled in counties in the MHIP pilot had a 17% reduction in inpatient medical admissions and smaller increases in

inpatient psychiatric costs (21% vs. 167%). Compared to those that did not receive services, GA-U enrollees who received services had a 24% decrease in number of arrests, a smaller increase in those living in homeless shelters or outdoors (50% vs. 100%), and a smaller increase in days spent in state hospitals (33% vs. 500%).[5] Bolstered by these successes, the program was expanded statewide for the GA-U population in 2009, and in 2012 to CHPW members who were eligible for Medicaid on the basis of receiving SSI. In the model's first 14 months of statewide implementation, the state saved more than $11.2 million in hospital costs alone.[6] In January 2014, the GA-U population, whose care was previously entirely state-funded, joined the Medicaid expansion population. The MHIP model is now available to any adult CHPW member who receives Medicaid.

CHPW shares savings achieved from reduced admissions with the CHCs, which has led to adoption of the model by 16 of 21 CHC systems (most non-participating systems are smaller CHCs). The MHIP model has now served 45,000 individuals, and it continues to evolve and expand. In 2009, a pay-for-performance component was added to MHIP, with a quarter of funding tied to achieving predetermined outcome and process measures, as reported in the registry. A study analyzing the pay-for-performance (P4P) component, published in the American Journal of Public Health, found that time to improvement in depression score was reduced by 50 percent after implementation of P4P.[7] To expand access to psychiatrists, CHPW has recently added a telepsychiatry component where a consulting psychiatrist can "meet" the patient via a video feed. They are also working to incorporate substance abuse screening, brief intervention and treatment in the model. In Washington, behavioral health is partially carved out for MCOs: health plans are responsible for mild to moderate mental health needs, while the state takes over payment when mental health needs reach a high level. The MHIP tiered model of care operates successfully in this policy environment.

Requiring Behavioral Health Needs Assessments

Founded by CHCs in 1993, **Neighborhood Health Plan of Rhode Island** (Neighborhood) did not have to look far from its founding principles to develop and implement a behavioral health integration program for its 143,000 low- and moderate-income members, the majority of whom are in the Medicaid program. Neighborhood looked to CHCs in the state in early 2014 to partner with the plan and collaboratively establish a behavioral health assessment and treatment program within each CHC. The new initiative will better identify and treat health plan members with behavioral health needs. The program will enable Neighborhood to learn more about its membership on a population scale in a manner not possible from claims information alone.

The initiative is straightforward: when adult Neighborhood members are seen at a participating CHC, they complete a questionnaire that assesses, at minimum, depression, suicidal risk, anxiety, and substance abuse. CHCs are free to use any reliable screening tool. If no behavioral health needs are identified, the member is reevaluated in a year unless there is reason to do so sooner. If the screening tool identifies low to moderate or high risk for a behavioral health issue, the PCP introduces the patient to the behavioral health clinician on site at the CHC in a warm hand-off. For high-risk patients, the behavioral health clinician evaluates whether the member would be better treated in a community mental health center or similar setting.

CHCs are responsible for the scheduling of the on-site behavioral health clinician and use the CHC's electronic medical record system to document all care. In addition, the behavioral health clinician must be able to perform crisis intervention at the CHC. In order to determine the efficacy of the transition, members with identified needs who are referred to a behavioral health clinician are asked to complete an engagement survey to ensure the warm hand-off between the PCP and the behavioral health provider is effective. Beyond these requirements, CHCs are given significant flexibility to design the program in accordance with their staffing, IT infrastructure, and expertise. Neighborhood uses contract incentives to encourage CHCs to adopt the program; seven of the eight CHC systems in the state, most with multiple sites, are participating. For CHCs without an on-site behavioral health clinician, Neighborhood provided funds prior to the initiative so the CHC could hire one. While some CHCs were initially concerned caseloads would be too small to justify the hires, this has not been the case, and CHCs are already looking to add more days to the on-site behavioral health clinicians' schedules.

Sample Quality Measures: Neighborhood

- Number of members screened
- Proportion of members identified in each risk pool
- Member engagement
- Hospital admissions

Neighborhood is leading the initiative, but the CHCs are intimately involved in the planning and implementation. Neighborhood revised the program after feedback from the CHCs, and was able to individually work through concerns specific to each CHC. While initial results from the program are yet to come, Neighborhood and the CHCs will evaluate the program's progress to make necessary adjustments and enhancements. The plan is particularly interested in whether CHCs are receiving sufficient support for the types of members they treat, as there may be significant regional variations in the level of behavioral health need. Neighborhood's strong relationship with the CHCs allowed a relatively fast implementation of the program, and frequent communication between the MCO and CHCs as well as data collection and analysis will guide the program as it evolves and expands.

Encouraging Access to Primary Care for a Serious Mental Illness (SMI) Population

There is significant evidence that individuals with behavioral health needs do not access preventive and primary care at the same rates as those without behavioral health conditions.[8,9] **MDwise, Inc.**, a health plan in Indiana, has devised a number of initiatives to address this disparity since behavioral health was carved into the plan benefit package in 2009. These strategies include a pilot project to incent community mental health centers (CMHCs) to identify patients without recent physical health care and refer them to primary care providers. Bringing physical health awareness and care to behavioral health service settings serves two functions. First, it encourages individuals receiving treatment for a behavioral health need to address any physical health needs, with the message delivered in a familiar setting. Second, the emphasis on the need to access physical health in a behavioral health-focused environment leads to whole-person care, as does an emphasis on behavioral health in a physical health-focused environment.

MDwise teamed with six high-volume pioneering CMHCs around the state to implement the pilot. The program, which began in 2013, has evolved through monthly (and now every-other-

month) meetings with executive staff from the health plan and participating CMHCs. While the program focuses on three HEDIS (Healthcare Effectiveness Data and Information Set) quality measures listed in the text box to the right, the increased focus on overall health benefits all patients served by the CMHC. Every quarter, MDwise sends each CMHC a list of all health plan members seen by the CMHC who meet the criteria for being included in one of the chosen measures, and whether the member has accessed the indicated service in the designated time period. CMHCs integrate this information into their medical record and case management systems, and have modified their intake evaluations and ongoing therapy appointments to address care needs indicated by the data. When CMHCs identify patients who need to access physical care services, they help them arrange appointments with their primary care provider. In addition to the three HEDIS measures, CMHCs have worked with the plan to develop best practices for their providers to encourage tobacco cessation through Indiana's tobacco quit line and monitoring of patients prescribed antidepressant medications. Finally, the plan has devised financial incentives for the CMHCs to increase access to physical health care for the members they serve.

Quality Measures: MDwise

- Adolescent Well-Care Visits (AWC)
- Well-Child Visits (W34)
- Comprehensive Diabetes Care: Hemoglobin A1c testing

The collaborative and respectful relationship between MDwise and the participating CMHCs is critical to the program's success. Instead of making major changes at the end of an evaluation process, the monthly meetings allow discussion and small tweaks to make the initiative feasible, ranging from refining the data the plan provides the CMHCs to determining a replacement measure when the Comprehensive Diabetes Care LDL-C screening HEDIS measure, previously used as a program metric, was retired for the 2014 measurement year. While there are no measurement results yet (2013 data will serve as the baseline year), the program appears promising, and is part of a greater effort to share case management and claims data between the health plan and CMHCs. The pilot is expanding to ten additional centers in 2015, resulting in the participation of over half of the state's 26 CMHCs. Coupled with other initiatives, MDwise and partner CMHCs are bridging the divide between behavioral and physical care, bringing both fields towards comprehensive, integrated, whole-person care.

Supporting Medicaid Health Homes

Hudson Health Plan, which serves more than 150,000 Medicaid and CHIP beneficiaries in New York's Hudson Valley, leveraged its experience in integrating behavioral and physical health benefits to bolster the efforts of New York State's Medicaid health homes initiative.

In 2009, Hudson won a 3-year grant to coordinate care for the highest-cost, highest-utilizing members enrolled in Medicaid fee-for-service in the region through the Chronic Illness Demonstration Project (CIDP). This was Hudson's first significant foray into comprehensive behavioral and physical health integration, given that many behavioral health services such as partial hospitalizations, Peer Recovery Oriented Services (PROS), outpatient substance abuse and methadone maintenance treatment programs were carved out of the managed care benefit package provided to the members enrolled in Hudson Health Plan MCO.

It was clear that to adequately coordinate care for the high-cost FFS population with comorbid physical and behavioral health conditions, Hudson needed to build a care management program that integrated the two. Hudson's Westchester Cares Action Program (WCAP) featured partnerships with many community entities, including shelters, supportive housing organizations, vocational training opportunities, and recovery programs. The model, developed in conjunction with Hudson's behavioral health partner Beacon Health Strategies, was led by a care coordinator who connected WCAP members to primary and preventative care services, as well as behavioral health and substance abuse resources. While some of the high-utilizing WCAP members had previous interactions with social support services, the care coordinator also connected them to these organizations, including those that provided housing, transportation, vocational training, and chemical dependency recovery.

WCAP was enormously successful; Hudson won a number of awards for their work. This success fed directly into Hudson's involvement with the Medicaid health home initiative undertaken by the State in 2012. Health homes are designed to reduce costs and improve outcomes through care coordination and integration for individuals with multiple chronic conditions, including those with chronic behavioral health conditions, and are part of a much larger Medicaid redesign in New York State. Individuals with severe mental health needs are moving from behavioral health organizations into managed care, and the behavioral health benefit will be carved in for Medicaid MCOs in 2015. Given Hudson's experience with WCAP and existing community partnerships, the plan was a natural lead for developing a health home. However, as the state required a provider to lead the health home, the Open Door Family Medical Center, one of Hudson's founding CHCs, led the effort, supported by Hudson's significant expertise.

Sample Quality Measures: Hudson

- Inpatient and ED utilization
- Mental health service utilization and follow-up
- Medication management, adherence, and follow-up

One area in which Hudson was particularly helpful was connecting hard-to-reach patients to their health homes; Hudson's experience working with community partners as part of WCAP prepared them well to find and engage patients who lacked either the know-how or inclination to engage with health care providers. The plan also provided in-kind services to develop and support the health home in its formative stage, and assisted the partners with the development of IT systems, finance management, data submission, and the registration and enrollment of health home members. Hudson and their associated think tank, the Hudson Center, developed Insight Plus with input from the Hudson Valley Care Coalition clinical committee, a web-based care management system the health home uses to enroll, track, monitor, and develop care plans for health home members. Insight Plus integrates with existing EMRs, eliminating the need for double data entry and providing population care management capabilities that EMRs often lack.

Hudson drew on its experience with WCAP, especially with respect to care management and comprehensive behavioral health integration, and assisted in building a new care management model for the health home program to serve Medicaid enrollees who could benefit most from intensive care coordination. The ground-up work of developing an independent organization, although more complex than utilizing existing entities, allowed Hudson to develop a model that truly meets the physical and behavioral health needs of the population they serve, and

proactively positions Hudson and its partners as the care delivery landscape in New York State continues to evolve.

Conclusion

Safety Net Health Plans and community health centers can take a variety of approaches to integrating physical and behavioral health care. Because available resources, policy environments, geographic factors, population characteristics, and desired outcomes vary significantly based on the situation, there is no best single model for such integration. However, similarities and lessons can be drawn from the four partnerships described in this fact sheet. While all projects were led by not-for-profit, community-based Medicaid health plans, the involved CHCs, CMHCs and their clinical staff were full partners in development and implementation. All programs have evolved over time to better fit the needs of the participation organizations and the clients they serve, and this process is driven by frequent and continued stakeholder meetings. Finally, all programs have a quality measurement component, often tied to funding, to assess the impact and value of the program.

Mounting evidence documents the intricate relationship between physical and behavioral health. As the safety net community takes on more responsibility for the whole-person care of their members, full integration of physical and behavioral health benefits and care delivery is a necessity. The highlighted safety net partners have recognized this reality and are working closely to forge innovative ways to bridge the longstanding gap between the physical and behavioral health disciplines in an effort to deliver better care and better health for the populations they serve.

About ACAP

The Association for Community Affiliated Plans (ACAP) is a national trade association representing 58 nonprofit safety net health plans in 24 states. ACAP's mission is to represent and strengthen not-for-profit, safety net health plans as they work with providers and caregivers in their communities to improve the health and well-being of vulnerable populations in a cost-effective manner. Collectively, ACAP plans serve more than ten million enrollees, representing more than 50 percent of individuals enrolled in Medicaid-focused health plans.

This report was prepared by the Association for Community Affiliated Plans (ACAP) with funds under grant number 1UR1SMO60319-01 from the SAMHSA-HRSA Center for Integrated Health Solutions, a national training and technical assistance center dedicated to promoting the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings (www.integration.SAMHSA.gov) . The statements, findings, conclusions and recommendation are those of the author(s) and do not necessarily reflect the view of SAMHSA/HRSA or the U.S. Department of Health and Human Services.

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