



MICHIGAN: MAKING THE CASE FOR INTEGRATED CARE

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Integrated Care



- Latest “buzz words” in health care
- Confusion about the concept
 - What it means
 - What a successful model looks like
- Most agree it's a desirable goal
- Many not sure how to get there

What is Integrated Care?

- “reunification in practice of mind and body”
- Health care model in which physical health and mental health clinicians partner to manage the treatment of mental health disorders in the primary center setting
- Includes a single treatment plan focused on what consumers need
- Moves away from a disease-focused system to a person-centered system

Just How Big is the Problem

- Nearly 44 million Americans (26% of the population) experience a mental health problem annually
- Only 5% of those suffering from a mental health problem receive treatment from a mental health professional
- Michigan Community Mental Health Centers (CMHC) are not required to serve the uninsured population

What does this mean for Primary Health Care Providers?

- More and more needing behavioral health services are seeking it through primary care providers
- 95% seek treatment from a family physician – many for physical complaints
 - 92% of all elderly patients receive MH care from PCP
 - 90% of most common complaints have no organic basis

Why Patients Seek Mental Health Services in Primary Care Settings

- Limited access to specialty service providers
- Lack of adequate insurance coverage
- Cultural beliefs
- Eligibility requirements for public mental health services
- Trust their own physician
- Stigma

More facts.....



- 70-80% of all psychotropic medications are prescribed within primary care settings, sometimes inappropriately
 - 67% of psychoactive agents prescribed by PCP
 - 80% of antidepressants prescribed by PCP
- About 1/2 the time, mental health problems go undetected in primary care settings
- Even when diagnosed, these problems tend to be under-treated
 - MH outcomes in primary care patients only slightly better than spontaneous recovery

Untreated/Under-treated MH Patients

- Over-utilize medical services
 - Visit physician twice as often as those receiving appropriate care
 - Seek treatment in emergency rooms when in crisis
 - People with persistent depression have annual adjusted medical costs 70% higher than those without depression

Morbidity and Mortality Rates

- People with serious mental illness are dying nearly three decades earlier (on average) than general population
 - Suicide and injury account for about 30-40% of excess mortality; 60% of premature deaths in persons with schizophrenia due to “natural causes”
 - High prevalence of obesity, diabetes and cardiovascular disease
- Newer medications for bipolar disorder and schizophrenia can exacerbate metabolic risks
 - BH Providers less likely to screen and monitor regularly



Why Now?

“Research demonstrates that mental health is key to overall physical health. Therefore, improving services for individuals with mental illness requires close attention to how mental health care and general medical care interact. While mental health and physical health are clearly connected, a chasm exists between the mental health and general health care systems in financing and practice.



The Recommendation.....

“Commission suggests that collaborative care models should be widely implemented in primary health care settings and reimbursed by public and private insurance.”

Changes at the Federal Level

- Omnibus Budget Reconciliation Acts (OBRA) of 1987 and 1989 expanded Medicare and Medicaid reimbursements to include clinical psychologists and master's level social workers practicing in rural areas
- All new FQHC's are now required to provide behavioral health
- HRSA is providing grant funding to FQHC's to increase behavioral health staff

Goal #5: Michigan Mental Health Task Force Report to the Governor - 2004

“Coordinate the delivery of mental health services by both federally qualified health clinics and community mental health programs.”



Benefits of Integration

- Improved detection of behavioral health disorders
- Significant increase in patients receiving recommended care and positive clinical outcome
- Higher levels of patient adherence to treatment
- Better clinical outcome than by treatment in either sector alone
- Improved patient and provider satisfaction

Getting there is not a “walk in the park”

- Financial Barriers
 - Not reimbursed for collaborative work
 - Revenue silos
 - Billing requirements; record-keeping regulations
- Firewalls in communication systems
- Legal landmines
- Stigma and discrimination associated with mental health problems
- Lack of resources
 - Human (providers; staff)
 - Funding
 - Time/Space
 - Interest
 - Proper tools
- Language and Cultural Differences

The Great Cultural Divide.....

● Primary Care Docs

- 10-15 minute blocks
- Deal one-on-one w/other physicians
 - Find it difficult to deal with interdisciplinary team
- Medical records short, concise summaries of the diagnosis, treatment and outcome
- Language = patients

● Psychiatrists

- Language = clients or consumers
- 45-60 minute sessions
 - Time with consumers considered sacrosanct
- Behavioral health records are long and complex
 - Contain goals and objectives
 - Variety of provided services; may be re-evaluated over time
 - Contain consumer input

Training.....

A decorative graphic at the top of the slide features a horizontal dotted line. On the left side of the line, the word "Training" is written in a dark grey font. To the right of the line, there are six circles arranged in a row. The first circle is solid light green. The second circle is an outline of a light green circle. The third circle is solid light green. The fourth circle is an outline of a light green circle. The fifth circle is solid light green. The sixth circle is an outline of a light green circle.

- Most primary care physicians receive little training in psychiatry
- Most psychiatric specialty training does not provide much training in primary care issues
- Neither receives significant training in collaborative, integrated practices arrangements

The Michigan Integrated Health Learning Community (MIHLC)

- Purpose: To accelerate the implementation of Integrated Health Services for persons with Severe and Persistent Mental Illness
- Membership: Six CMHC's and their partner primary care clinics
- Under guidance of Washtenaw County Health Organization (WCHO)

Washtenaw County WCHO

- Delonis Homeless Shelter
 - Small health clinic open 35 hrs. per week
- Nurse Practitioner Clinic
 - Services to consumers at CMH facility, including smoking cessation classes
- Packard Community Clinic
 - Full-time MSW and 4 hrs. of psychiatric time per week
- Ypsilanti Family Practice
 - ½ day per week adult and child psychiatrist on site for consultation and resident training
- Corner Health Center
 - Mental health staffing at center for persons 12-21 and children

Goals of State Funded Initiative

- Expand the number of individuals to be served by CMH system by collaboration or integration with community health centers
- Improve the health status of persons with serious and persistent mental illness, developmental disabilities and substance abuse disorders
- Develop and test an effective way to implement integrated health by tailoring a change management program to assist in the merging of the two cultures

Key Components



- Structured ongoing communication that facilitates information sharing and creative problem solving
 - Quarterly meetings with six pilots
 - Existing models; financing; sharing of difficulties incurred in implementing plans and how to overcome; staff training
 - Monthly (at least) meetings with “coaches”
 - Discuss progress on strategic plans
- Shared leadership and resources
 - Presentations; grant writing assistance

Doherty's FIVE LEVELS OF COLLABORATION

BASIC	BASIC AT DISTANCE	BASIC ON SITE	CLOSE-PARTLY INTEGRATED	CLOSE-FULLY INTEGRATED
TWO FRONT DOORS; SEPARATE FACILITIES	TWO FRONT DOORS; SEPARATE FACILITIES	SHARED FACILITY; MAY SHARE RECEPTION AREA	SHARED SITES	ONE FRONT DOOR; SHARED SITE; ONE VISIT FOR ALL NEEDS
SEPARATE AND DISTINCT TREATMENT PLAN AND SERVICES	OCCASIONAL PLAN SHARING; SEPARATE & DISTINCT SERVICES	TWO PHYSICIANS; TWO TREATMENT PLANS; SOME INTERACTION DUE TO PROXIMITY	COORDINATED TREATMENT PLAN; REGULAR FACE-TO-FACE INTERACTION	SAME SYSTEMS; SEAMLESS; ONE TREATMENT PLAN; ON-GOING CONSULTATION
SEPARATE FUNDING SYSTEMS; NO RESOURCE SHARING	SEPARATE FUNDING SYSTEMS	PRIMARY CARE PHYSICIAN WORKS WITH CLINICIAN ON SITE RATHER THAN PSYCHIATRIST	SEPARATE FUNDING WITH SHARED ON-SITE EXPENSES; SHARED STAFFING & INFRASTRUCTURE COSTS	INTEGRATED FUNDING WITH RE-SOURCES SHARED ACROSS NEEDS; MAXIMIZATION OF BILLING AND SUPPORT STAFF
SEPARATE DATA SYSTEMS; LIMITED SHARING	LINE STAFF WORK TOGETHER ON SOME CASES	NO SYSTEMIC APPROACH TO COLLABORATION	SOME DATA SHARING BUT SEPARATE DATA SETS	REGULAR COLLABORATIVE TEAM MEETINGS
LIMITED COMMUNICATION	LITTLE SHARED RESPONSIBILITY	APPRECIATION OF OTHERS' ROLES	BASIC APPRECIATION OF OTHERS' ROLE & CULTURE	SHARED VISION
	LITTLE UNDERSTANDING OF OTHERS' CULTURE	NO COMMON LANGUAGE OR UNDERSTANDING OF OTHERS' CULTURE	SHARED ALLEGIANCE TO BIOPSYCHOSOCIAL SYSTEMS PARADIGM	FULLY INTEGRATED ELECTRONIC HEALTH RECORD; NEED-TO-KNOW ACCESS FOR ALL PRACTITIONERS

One Pilot's Journey



- From Basic to Close Partly-Integrated
- Staff sharing arrangement
 - CMHC – case manager at the primary care sites who will collaborate with primary clinicians and psychiatrists
 - Packard Clinic as model
 - FQHC – primary care clinician at CMHC site to provide screening, treatment adherence and monitoring and education
 - Access to change management program



Another Pilot's Journey

- From Basic to Close Fully-integrated
- Shared Location
 - Primary Care
 - Behavioral Health
 - Dentistry
- Access to change management program
- HRSA grant to develop rural health care network

Potential Actions by Legislators

- Encourage your state to fund pilot projects
- Make sure your state has implemented the necessary codes for reimbursement
- Work to eliminate silo funding issues
- Advocate for cross-culture training and training in collaboration in medical education programs
- Encourage your state association of social workers to develop continuing education programs that include providing services in primary care settings