Healthcare Integration and Coordination:
Hundreds of innovative initiatives identified in a survey of Michigan’s CMHs, PIHPs and Providers

November 2016

I. Abstract
In April 2016, the Michigan Association of Community Mental Health Boards’ Center for Healthcare Research and Innovation conducted a study of the healthcare integration initiatives led by Michigan’s Community Mental Health Services Programs, the state’s public Prepaid Inpatient Health Plans, and providers within the CMH system. The study examined varying efforts aimed at integrating behavioral health and intellectual/developmental disability services with physical health care services. Results showed that more than 750 healthcare integration efforts, led by these public sector parties, were in operation in Michigan. Of this number, work in bi-directional co-location, integration of electronic health records, and high/super-utilizer initiatives 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 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).

The public BHIDD system (CMHSPs, PIHPs, 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, PIHPs, and providers have focused increasingly on integrating the BHIDD services that they provide with primary care and other physical health care 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

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.

A large number of diverse integration efforts are in operation across the state, led by CMHs, PIHPs, and providers within the CMHSP networks in Michigan. The Michigan Association of Community
Mental Health Boards (MACMHB) Center for Healthcare Research and Innovation conducted a study in mid-2016 to capture a picture of the breadth and depth of related health care integration initiatives across the state.

III. Methods
In April 2016, MACMHB 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. Thirty-two (32) MACMHB members responded, representing a variety of organizational types and settings. This study will be replicated again, in the near future, to continue tracking the work being done by the state’s CMHs, PIHP, and provider system in fostering 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
The integration and coordination of healthcare services in CMHSP, PIHP, and providers across the state of Michigan have been critical factors in 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. This 2016 study found that there are 751 healthcare integration efforts occurring with potential for more to come. While there were many different methods of integration, three of the most effective were co-location, integrating healthcare records, and identifying super-utilizers. These subsets of the healthcare integration initiatives identified in this study are discussed below, with the frequency of responses summarized in Attachment B.

1. Bi-directional co-location of behavioral health care providers and primary care providers:
The co-location efforts are a core approach of healthcare integration across the country. The MACMHB Center for Healthcare Research and Innovation study found that there are two primary manners of co-location occurring in the state. The first entails BHIDD clinicians placed in the primary care clinic setting. The second entails primary care providers placed in BHIDD settings. The study found that there are 42 current co-location efforts in place.

   A. Co-location of BHIDD clinicians in primary care clinics: Twenty-two (22) locations throughout the state have BHIDD staff located in primary care practices. The value of such co-location efforts is that they lead to primary care patients receiving BHIDD services that they may not have otherwise received or pursued. The BHIDD services provided within these primary care settings are typically brief clinical interventions provided via a small number of sessions. In this manner, the rate of drop-off typically experienced when primary care providers refer patients to off-site BHIDD providers is greatly reduced, in many cases, eliminated, by the hand-off from the primary care provider to the BHIDD clinician working within the primary care setting, often as an integral part of the primary care team. The needs of those with mild to moderate needs as defined by Quadrants I and III, in the quadrant construct developed by the federal Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration (SAMHSA/HRSA), are served in these settings (see Attachment C - quadrant diagram).3

Additionally—through the co-location of CMHSP and provider staff in the primary care setting as opposed to BHIDD clinicians outside of the CMH system—those with BHIDD conditions that are too severe or complex to be treated in the primary care setting can be
referred within the CMHSP/PIHP/provider system via an internal transfer, thus greatly improving access to higher levels of care. This case finding approach greatly improves access to BHIDD services for persons with a wide range of severities and complexities and allows people with more severe and/or complex BHIDD needs (quadrants II and IV) to be identified and referred within the CMH/PIHP/provider system for more intense services.

B. Co-location of primary care providers in BHIDD sites: Twenty (20) locations throughout the state have primary care providers located in BHIDD sites. This has led to physical care being brought to these consumers who are in need of both types of services but who, without such proximity, would continue to lack access to primary care. The practice of co-location is much more efficient, allowing consumers/patients to receive a range of healthcare services in one location, which saves the consumer/patient time and ensures a more comprehensive approach to treatment. This approach is beneficial to consumers who may not have seen a primary care physician on a regular basis, therefore not getting the physical health care they need. As many consumers of the CMHSP/PIHP/provider system view their CMH or provider as their health home, having their physical health care needs met at these sites provides the consumer with comprehensive, one-stop healthcare access. Patients served through this form of co-location have needs defined in quadrants II and IV in the Four Quadrant Clinical Integration Model.

2. Integrated electronic health records: Another contributing factor in making healthcare integration successful is the integration or linking together of all or parts of the electronic health records (EHR) used by BHIDD providers and primary and other physical healthcare practitioners. Seventeen (17) respondents indicated that they use single care plans that encompass BHIDD services and supports as well as physical health treatments. Nine (9) respondents reported that they have shared or linked EHR between physical care and BHIDD practitioners. Twenty-four (24) utilize admissions, discharge, and transfer (ADT) data from hospitals and emergency departments in their BHIDD centers and clinics. Integration and collaboration efforts that are based on shared or linked EHR are more efficient, effective, and congruent across settings and disciplines while focusing on person-centered care.

3. High/super-utilizer initiatives: 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 52 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. Fifteen (15) sites also reported the active use of Medicaid claims databases that included both physical and BHIDD services, using the data available through the State of Michigan’s Care Connect 360 (CC360) database, portal, and/or other data analytics, to identify high/super utilizers at the point of access and throughout the course of services, supports, and treatment. Seven (7) sites reported active use of data (primarily through CC360) to provide outreach to high/super-utilizers who have not accessed the BHIDD system of care. These 74 initiatives significantly impacted the effectiveness of healthcare resources through the use of the targeting, assertive outreach, and case-management approaches, as well as the provision of adjunct supports including transportation, housing supports, vocational services, and advocacy, to this population.
V. Conclusion
These findings demonstrated the 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 overall health of persons with BHIDD needs while controlling the overall cost of their healthcare. This study identified 751 healthcare integration initiatives led by CMHs, PIHP, and BHIDD providers across the state of Michigan, of which 166 were those involving co-location initiatives, integrated or linked EHR, or efforts to address the needs of the high/super-utilizer population.

As this study 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 be replicated in the future to track the emergence of new efforts and the changes in the integration services identified in this study.

The Michigan Association of Community Mental Health Boards (MACMHB) is a state association representing the state’s public 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. Information on MACMHB can be found at www.macmhb.org or by calling (517) 374-6848.

The Center for Healthcare Research and Innovation is the research and analysis office within MACMHB, issuing white papers and analyses on a range of healthcare issues with a focus on behavioral health and intellectual/developmental disability services.

Notes:
Attachment A

Healthcare Integration and Coordination approaches sought via MACMHB survey (April 2016 study; October 2016 report)

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

**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
- Pharmacy co-located in BHIDD site
- Physical health laboratory or lab pick-up at BHIDD site
- Co-funded positions
- Loaning positions from or to BHIDD party

**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 casemanager, supports coordinator, care manager, nurse caremanager 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

**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)
**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 health care resources.
- Joint effort with Medicaid Health Plans, to address the needs of high/super utilizers of health care resources.

**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.

**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 reduce no-shows and enhance access to services.
### Attachment B
Summary of frequency of a subset of healthcare integration initiatives, implemented in Michigan, led by CMHSP, PIHP, and providers within the CMH system (April 2016 study; October 2016 report)

1. **Bi-directional co-location initiatives**

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-location of BHIDD clinicians in primary care clinics</td>
<td>22</td>
</tr>
<tr>
<td>Co-location of primary care providers in BHIDD sites</td>
<td>20</td>
</tr>
<tr>
<td><strong>Total co-location initiatives</strong></td>
<td><strong>42</strong></td>
</tr>
</tbody>
</table>

2. **Integration of electronic health records**

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single, integrated care plan</td>
<td>17</td>
</tr>
<tr>
<td>Shared or linked electronic health records</td>
<td>9</td>
</tr>
<tr>
<td>Sharing of electronic admission, discharge, and transfer data</td>
<td>24</td>
</tr>
<tr>
<td><strong>Total integration of electronic health records</strong></td>
<td><strong>50</strong></td>
</tr>
</tbody>
</table>

3. **High/super-utilizer initiatives**

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnerships between BHIDD providers and payers (CMHSPs, PIHPs, and providers) and primary care practices, hospitals, and/or physical health plans</td>
<td>52</td>
</tr>
<tr>
<td>Active use of Medicaid claims data to identify high/super-utilizers at point of service</td>
<td>15</td>
</tr>
<tr>
<td>Active use of Medicaid claims data to identify high/super-utilizers to focus outreach on these persons</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total high/super-utilizers initiatives</strong></td>
<td><strong>74</strong></td>
</tr>
</tbody>
</table>
Attachment C
Clinical Integration Quadrant Diagram