Presentation at the NAMD Fall Conference on Advances in Addressing Behavioral Health and Substance Use Disorders

Joel E. Miller
Executive Director & CEO
AMHCA
American Mental Health Counselors Association
Washington, DC
Outline of Presentation

- Who is NASMHPD?
- Who is AMHCA?
- Why Integration?
- Brief Look at Mental Health Integration Projects
- A Fresh Look at Integrating Substance Use, Mental Health and Primary Care Integration
- The H.I.T. Imperative
- Payment Incentives
- Lessons Learned
Robert W. Glover, Ph.D., Executive Director, National Association of State Mental Health Program Directors (NASMHPD).

NASMHPD serves as the national representative and advocate for State Behavioral Health Authorities (SBHAs) and their directors, and supports effective stewardship of state mental health systems.

NASMHPD informs members on current and emerging policy issues, educates on research findings and best practices, provides technical assistance, collaborates with key stakeholders, and facilitates state-to-state sharing.

Consumer recovery and resiliency are the overall goals and fundamental values that guide NASMHPD in its mission.
American Mental Health Counselors Association (AMHCA)

Growing community of 7500 clinical mental health counselors (CMHCs). CMHCs make a critical impact on the lives of Americans who have a mental illness. AMHCA succeeds in giving a voice to the profession nationwide and helping to serve members and colleagues in the states. CMHCs are primary mental health care providers.

Our Mission:

- To enhance the profession of clinical mental health counseling through licensing, advocacy, education and professional development.

Our Vision:

- To be the national organization representing licensed clinical mental health counselors and state chapters, with consistent standards of education, training, licensing, practice, advocacy and ethics.
Who Are Clinical Mental Health Counselors (CMHCs)?

- CMHCs are trained to treat clients in a holistic manner, working in tandem with professionals in education, medicine, and related fields to get to the complex roots of each individual client’s unique struggles and disorder. Part of multi-disciplinary teams with other practitioners.

- Employed by community centers, SA facilities, businesses.

- CMHCs diagnose and treat psychological disorders, support clients through difficult life experiences, and teach skills and attitudes needed to bring about behavior change.

- CMHCs provide psychotherapy, assessment, diagnosis to help clients experience depression, suicidal thoughts, aging, stress, addiction. Use talk therapy and group sessions.

- Help avoid serious complications associated with UNTREATED mental illness such as major depression, anxiety disorders, that include health problems that lead to homelessness, unemployment and premature death.
NASMHPD 2006 study by the Medical Directors Council reported a stunning finding: Persons in the public mental health system with SMI are dying 25 years earlier than the general population.

Report found that increased morbidity and mortality was often due to treatable medical conditions such as hypertension and diabetes – 60% of premature deaths were due to preventable chronic illnesses.

It was known that people with SMI in the public system had shortened life spans but what was new was the extent to which premature death was the result of preventable conditions, and the rates have been accelerating.
“A refined view of integration calls for a commitment to patient–centered care for meeting people where they are.”

Richard Frank, Ph.D., Harvard University
Integration on 2 Levels: BH and PC and MH and SU

- Imperative that states address integrating BH and primary care.

- States undertaking a variety of projects to accelerate the integration of behavioral health and primary care.

- Imperative that states address co-occurring MH and substance use disorders due to prevalence (high as 70% co-occurrence in some states) and the health impacts.

- But obstacles remain -- perceived and real barriers to sharing information & different cultures of treatment.
Evolving Models of BH and PC Service Integration

- **Practice Model 1: Improving Collaboration between Separate Providers** – minimal integration, separate systems
- **Practice Model 2: Medical-Provided Behavioral Health Care** – basic collaboration, periodic communication
- **Practice Model 3: Co-location** – basic collaboration onsite
- **Practice Model 4: Disease Management** – close collaboration in partly integrated systems
- **Practice Model 5: Reverse Co-location** – Similar to Model #4
- **Practice Model 6: Unified Primary Care and Behavioral Health** – close collaboration in fully integrated system
- **Practice Model 7: Primary Care Behavioral Health** – BH and PCP providers are part of the same team
- **Practice Model 8: Collaborative System of Care** – specialty providers are integrated with PC services
Two grants awarded under the SAMHSA/HRSA co-location program in the state of R.I. provide examples that represent the “partnership model.” Beginning in 2012, the Providence Center, a community MH center, provided primary care services on site to its clientele.

The Kent County Community Mental Health Center illustrates the second model, “the facilitated referral model,” in that the Center formed a partnership with a PCP that provided a part-time physician to oversee a full-time nurse practitioner, an additional full-time physician & a nurse care manager. The nurse care manager acts as the link between PC, behavioral health care and wellness programs.

In addition, RI’s Health Home program initially targeted individuals with SMI meeting the State’s criteria for designation as a “community support client”. Enrollment in health home was mandatory for all eligible clients with payment for team activity being rolled into a single monthly “case rate” for each active client.
Coordinated Care Organizations (CCOs) – Think Chronic Care Mgt.

- The ever-changing landscape: Health Homes ----- Accountable Care Organizations --- Coordinated Care Organizations

- **Oregon** has embarked on a dynamic experiment that could fundamentally redefine health care in coverage, delivery, and payment. The new organization created by legislation is called a Coordinated Care Organization.

- A CCO is envisioned as a community-based organization that will be a hybrid of insurance companies and accountable care organizations. CCOs will include BH, medical, dental, public health, and most likely other services that are necessary for health, including social services, housing, employment, transportation, and more.

- CCOs are already being designed around innovative service delivery models. These include patient-centered PC health homes; team-based care; BH/PC integration; care coordination; community health workers; proactive treatment of chronic health conditions such as obesity, hypertension, diabetes; and robust prevention and health promotion efforts.

Chronic Care Management Everywhere
INTEGRATED SERVICES FOR SUBSTANCE USE CONDITIONS IN HEALTH CARE SETTINGS
Washington State has also undertaken a somewhat more limited Medicaid integration in which the care for disabled adults (SSI) is provided through co-location of a medical clinic and chemical dependency services in a mental health center.

Financing and reimbursement for integrated services is provided through managed care arrangement with the County.

Also using a co-location model, Washtenaw County in Southeast Michigan is integrating care for persons seeking substance abuse services through the use of a core provider who is responsible for providing or arranging for the provision of services using a “Recovery Oriented System of Care”.

Within this context, primary care services are offered at the Community Mental Health Center for patients with SMI or co-occurring mental health & substance abuse conditions; in addition, medical care as well as MH & SA services are provided at a homeless shelter.
Colorado has focused on integrating screening, brief intervention and referral to treatment (SBIRT) into a large variety of health care settings.

Including rural health clinics (some FQHCs), a rural hospital, urban clinics and hospitals, a dental clinic, primary care physician practices, and the Colorado State Employees Assistance Program.

The extensive integration of SBIRT in Colorado financed through public insurances and the other revenue streams is rare among States, Counties and health plans.
Supports are Key to Successful Integration: Tools for Clinicians & Patients, Workflow Improvements, Medication-Assisted Treatment

- A number of areas with significant opiate addiction have been interested in working towards expansion of office-based opiate treatment, using practicing physicians in PC and/or MH clinics. However, often the initial reaction of physicians is that the time required, especially for induction onto the medications for addiction treatment, is more than is available in a busy primary care clinic.

- To solve this problem and provide support for the physicians, San Francisco County has created & financed an Induction, Stabilization and Support Clinic (OBIC) for a group of participating PCP practices located in PC clinics (FQHCs) and MH clinics for dually diagnosed patients.

- Goal of integrated medication-assisted treatment supported by San Francisco Co. is to create better service model for patients & partnerships between providers.

- In this model, after patients are stabilized, they are then continued in medication-assisted treatment in PC with the induction center providing ongoing physician training and support.
Another model for improving implementation of medication-assisted treatment is being supported by the State of Massachusetts.

Nurse care managers are being used to assist primary care physicians in FQHCs with buprenorphine induction, ongoing counseling, and patient care management.

Magellan Health Services also has undertaken a national initiative to integrate medication-assisted treatment into all of Magellan’s comprehensive services programs, including intensive case management, ambulatory follow-up, disease management and targeted case management.

Care managers receive intensive training in medication-assisted treatment and medical directors work directly with physicians. Training for primary care physicians is accomplished primarily through Webinars.
Articulating a Vision & Bringing Others Along: Messaging, Use of Data, Dissemination of Data Analyses

- In Wis., the SBIRT program’s clinical director is a faculty member at the School of Med. and Public Health at the UW, while the Univ. of Mich. is partnered with Washtenaw County, MI. in integration efforts.

- With such partners, States, Counties and health plans can evaluate their programs, analyze their data, and play a critical role in disseminating the positive health outcomes & the business case for integration – showing how health care utilization, workplace function, auto crashes and arrests can be decreased by broadening the availability of services for SA conditions.

- Such analyses are especially critical to Medicaid funding for integrated substance abuse services and academic participation adds to the credibility of such work.

- An inability to demonstrate that integrated services are cost effective is a barrier unlikely to be overcome in the short term.
Convening potential partners is as important as are alliances with the State Medicaid agency, State PH agency, and strong leadership from PC with a focus on the whole person, including MH, smoking cessation, & related chronic illnesses.

Some alliances have been formalized by the use of written agreements: Washtenaw County, MI. has formal contractual relationships with integrated health clinics, community settings, such as homeless shelters, and other HC systems as well as MoUs for collaboration with drug courts, the State human services department and others.

Lessons Learned: Observers thought that the more likely form of alliances would be through workgroups, reflecting the particular payer, provider & consumer constituents in each State & region.
Creating Broad Alliances: Lessons Learned

- As an example, one Mich. Co. leader involved the following extensive group of agencies in an alliance: Co. & State Alcohol/Drug Agencies, MH & Medicaid Agencies, DoH, HC Authority, Governor’s Office, State Legislature, Statewide Provider Associations for PC, FQHC’s, Alcohol/Drug Provider Association, MH Provider Assoc., consumers, local government, & hospitals.

- Wisconsin’s program to integrate SBIRT into PC and other HC settings included all of these organizations in the public sector initially & later a number of private organizations as well as the business community.

- WI. reported interest of private employers in providing an SBIRT benefit was tremendous & wished they keyed in on importance of private groups earlier.

- In Colorado, alliances that included the State Legislature led to the enactment of legislation requiring insurance companies to pay for preventative services, including alcohol and drug screening, and supported activation of the SBIRT reimbursement codes by Colorado Medicaid.
“Health I.T. is, in many respects, the backbone to making dramatic improvements in improving the health of Americans and slowing down the rate of increase in health care costs – the backbone to payment reforms, the backbone to transparency, the backbone to providing new ways of delivering care. Electronic health records and the opportunities of application for Health I.T. is transformational.”

Former Senator Tom Daschle (D–SD)
Future of Behavioral Health is in Technology

- If BH organizations cannot adopt H.I.T. at a rate comparable with P.C. facilities, hospitals or physicians, it will likely be difficult to provide comprehensive & coordinated care -- & compete in the marketplace.

- Health information technology (H.I.T.), including electronic health records (EHRs), personal health records (PHRs), health information exchange (HIE), mobile health, and other technologies that support health & wellness are key enablers of care coordination and integration.

- However, BH clinicians currently have limited adoption of interoperable information systems. In a recent study, just over 20% of 505 BH organizations surveyed indicated that they had fully adopted an EHR.

- BH organizations cited as barriers to EHR adoption concerns over initial productivity losses, lack of qualified IT and project management staff, provider resistance, and privacy laws.
N.Y. State Initiative: Community–Based & Provider–Centric Approach

- N.Y. is using a community–based and provider–centric approach to BH IT. The Health Care Efficiency and Affordability Law (HEAL), passed in N.Y. in 2004, supports projects to accelerate the adoption of HIT & interoperable EHRs.

- HEAL awarded $120 million to community–based HIT projects to build a more streamlined approach to sharing client information, with a focus on BH and LTC.

- One of the HEAL’s initiatives allows the Regional Extension Adoption Center for Health (REACH) to create a new division of the extension center dedicated exclusively to BH providers.

- The proposed project utilizing NYC REACH's existing H.I.T. & interoperability infrastructure to facilitate health information exchange between designated BH providers & existing Patient Centered Health Home–qualified practices.
A psychiatrist at Maimonides Medical Center in Brooklyn, was talking with his colleagues when his cell phone buzzed in his pocket. What he found in his inbox was an automated alert from the Brooklyn Health Information Exchange (BHIX).

Clicking the link within the email, he navigated to BHIX’s secure Clinical Messaging Center and saw that one of his patients had just been admitted to the ED at Lutheran Medical Center located a few miles away. In a few hours, the physician was able to proactively check in with his patient while she was still in the ED.

“Beyond the benefits of coordinating care between disparate systems and providers, as an individual physician, I now have a greater sense of where my patients are. Having that information is incredibly powerful.”

Because of this, coordination of BH care and general health care through HIE is vital to improving health outcomes.
To get started, BHIX and Maimonides selected a panel of patients using the diagnosis codes that indicate bi–polar and schizophrenia, as well as zip codes for the region they wanted to monitor.

In addition, partners defined several events that would trigger an alert for their selected panel of clients, including an inpt. admission.

When BHIX, Maimonides and the 6 other participating hospital sites (including 4 teaching hospitals, a SNF and LTC facility, and a level one trauma center) were ready to launch, each site designated care coordinators to receive & monitor these alerts and to follow up with clients and clinicians as appropriate.

Through the original HEAL project, BHIX and Maimonides have enrolled more than 5000 clients & generated over 10,000 alerts.
Maimonides & BHIX used initial alerting success as springboard for additional BH coordination efforts; include pt. ed. about BHIX consent.

One home health care organization is receiving BHIX alerts when their clients are admitted to the hospital or the Emergency Dept: H.I.T. is saving time and $ for the agency, which now doesn’t have to send a home care nurse to a patient’s home when they are not there.

Additionally, the alerts allow the home health care providers to better coordinate BH care by following up with caregivers in the hospital or ED after a patient’s discharge.
Office of Mental Health has used the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) as a tool to support several statewide quality collaborative projects. Projects have focused on:

- Reducing psychotropic poly-pharmacy;
- Reducing the use of higher metabolic impact antipsychotics among individuals with existing cardio-metabolic conditions including obesity, hypertension, hyperlipidemia, diabetes and ischemic vascular disease;
- Reducing higher than recommended dosing; and
- Youth psychotropic poly-pharmacy set (“too many, too much, too young”).

New projects include:

- Reducing hospital re-admissions; and
- Health promotion.
The ability to comprehensively review patient medications is imperative for providers when making treatment decisions.

Medication management promotes patient safety, enabling providers to assess and identify potentially harmful drug interactions or dosing errors.

Maintaining active medication lists & performing formulary checks important to providers when prescribing meds. Privacy laws & regs. can present challenges to sharing patient’s BH treatment info., including meds, which creates difficulty when selecting meds or transitioning between providers & settings.

Overcoming barriers to information sharing and coordination of care will be critical for improving safety and efficacy of care for patients with BH disorders.
The Perfect Payment Methodology

- In my search over the years for the perfect payment methodology that will support the perfect BH system, two caveats should be kept in mind:

  - First, is that anytime money changes hands, perverse things can happen.
  - Under FFS, providers have an incentive to do more care.
  - Under capitation, providers have an incentive to withhold care.
Second, payment systems do not exist in a vacuum. The providers who receive payments and the patients who receive care matter.

Capitation is an ideal system for tightly structured delivery organizations that care for patient populations that cannot go outside of them (staff-model HMOs).

But capitation is more problematic when applied to less-organized providers, especially if they are treating patients who expect freedom of choice.

Conclusion: There is no perfect payment method for all settings, and the real search should be for a payment method that optimizes the care delivered by the available providers and nudges them down the road of becoming better, in the future.

STRESS EFFICIENCY AND QUALITY; NOT VOLUME
Realigning Payment Incentives: Lessons Learned

- It is important to recognize that most payment systems are not currently aligned to provide integrated care. BH services may be “carved out”; billing is complex, services provided on the same day may not be reimbursed, and co-pays may exist at a sufficiently high level that they prevent patients from accessing care.

- States, Counties & health plans need to understand at a highly detailed level the complexities of HC financing, including the “nitty-gritty” of billing & payment, as well as the impact of MC, bundled payments, case rates.

- State officials from a number of locales have suggested it would have been easier to solve some of these issues, especially billing & reimbursement problems, if they had involved knowledgeable staff with State agency earlier.

- Engagement with Medicaid is pivotal, but engagement with other insurers and their payers (such as employers) is also essential. A number of participants commented on the difficulty of bringing programs such as SBIRT and med.-assisted treatment that start out as grant-funded to full scale.
It will also be critical to ensure that the payment mechanisms change in PC to incentivize PC practitioners to adopt integrated best practices.

More needs to be done to increase understanding of how payment mechanisms can be changed so that integration financially benefits PC organizations and clinicians.

Some with SBIRT experience noted that payment for SBIRT might be required to bring about change, but in and of itself was not sufficient to produce or sustain SBIRT.

Payment mechanisms also need to be made consistent with the workforce delivering the services which will require a close look at licensing, credentialing and certification requirements.

Answering these questions and meeting these challenges requires policy and billing and reimbursement staff capacity and knowledge, as well as system testing and feedback.
General Lessons Learned

- Increase public–private partnerships by involving major players in the development of a shared vision — include key governmental leadership, professional societies, major public and private payers, educational institutions, consumers, and provider representatives.

- Encourage payers to run integrated financial data for the purpose of analysis with regards to clinical and financial outcomes. This review may identify common areas of concern and potential opportunity that can be the basis for shared objectives.

- Develop a shared implementation plan that is driven by data, evidence-based guidelines, and consumer input.

- Walk through the model from multiple perspectives, taking into consideration state and federal policies, place of service, # of providers, authorization policies, and impact on medical visits and BH visits.
H.I.T. Lessons Learned

- Ensure that implementation tools are designed with input from PC providers, specialty providers, and consumers.

- Remember, it is all about the data – analyzing the data, and using the data to improve clinical and operational practices, not just having the data to play with.

- It is not until your agency captures, analyzes, and uses the data that you can implement care coordination processes and evaluate best practices to improve the quality of care you provide.

- The future is bright for I.T. in BH care. The challenge remains in deciding what to do first within limited financial resources that will have the greatest impact on the quality of care provided to BH consumers.
A landmark event for mental health coverage and benefits occurred on Friday, November 8, 2013.

The federal government issued a long-awaited “final rule” dictating that mental health benefits – offered by health plans – be covered equal to general health benefits. The final rule provides specific clarity that is needed in order to move forward in implementing mental health parity.

With the passage of the ACA -- which dramatically expands coverage to uninsured people with mental health conditions -- that contains an essential health benefits package including MH/SUD benefits next to hospitalization, outpatient and prescription drug benefits and at parity with medical and surgical benefits, we have ushered in a new era for behavioral health care.

Individuals will be able to secure health insurance coverage with a robust benefits package that must be equal to medical benefits.
Thank You Making This Day Necessary

Yogi Berra, Baseball Philosopher
For more info, please contact me at jmiller@amhca.org, or 703-548-6002
Advances in Behavioral Health and Substance Abuse Disorders: The Tennessee Perspective

Vaughn Frigon, M.D.
Chief Medical Officer
Tennessee Health Care Financing and Administration
Bureau of TennCare
Behavioral Health and Substance Abuse Improvement

• Integration
• Data Exchange
• Opportunities
• Challenges
BH Integration in Tennessee

• BH integration achieved at the MCO level
• CMHC and Primary Care integration
• Mental illness and substance abuse integration
Screening/Training

• SBIRT
• Commission on Aging and Disability/Department of Mental Health and Substance Abuse Disorders
• PHQ/SF-12
• Health Risk Assessments
• Blue Care/TNAAP BeHip Program
Co-Occurring Treatment

- SAMHSA Distinction
- 40 Agencies co-occurring disorders capable
- 9 Agencies co-occurring disorders enhanced
- CMHCs also offering outpatient substance abuse services
Data Exchange Issues

• Difference between Mental Health laws and HIPAA that prevent exchange of information

• PCMH increased information to providers
Opportunities and Challenges

• Access
• Psychosocial Rehabilitation
• Case Management
• Employment opportunities
• Co-occurring treatment (substance abuse and mental health)
• Outpatient/In home services
• Outcome/Quality measurement tools
• Data Exchange
Thank You