Chicago Forum for Justice in Health Policy: Innovative Strategies for Integrated Care
June 21, 2017

Welcome and Forum Overview
Objectives

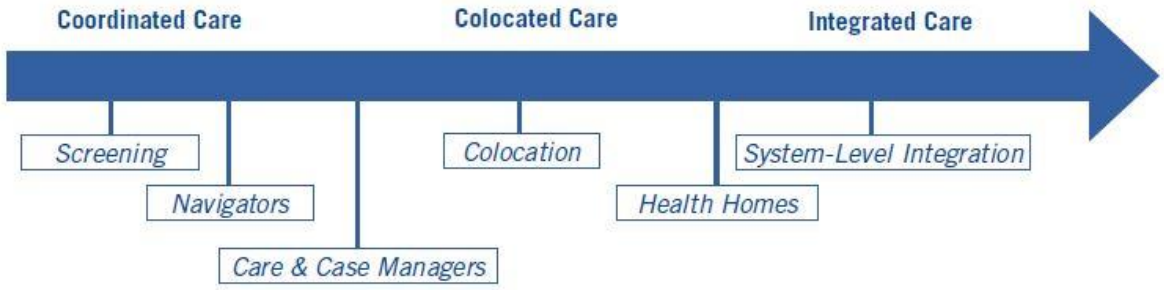
- Explore the conceptual framework and lessons learned of the Behavioral Health-Primary Care Integration Learning Collaborative established from the first two years of shared learning.
- Study three topic areas – data exchange; hospital transitional care; and financial sustainability – to understand best practices and current challenges to integrated care.
- Identify policy reform opportunities to improve statewide behavioral health-primary care integration, and create recommendations for Year Three activities of the Learning Collaborative.

Behavioral Health-Primary Care Integration Learning Collaborative Conceptual Framework and History

Renae Alvarez, Health & Medicine, presented on the US prevalence of mental illness and those experiencing serious mental illness and chronic complex medical conditions as it's the primary target population for the work of the Learning Collaborative. To have a manageable scope with the largest impact, the Collaborative decided to focus on people with serious mental illness (SMI). SMI is a common and chronic condition, but also treatable and recovery is possible. Traditionally treatment of mental illness and substance use disorders (referred to as behavioral health) has been a separate delivery system from other medical, specifically physical conditions. Representatives and advocates from diverse communities (i.e., justice-involved, uninsured, homelessness, dual-diagnosis) were invited to participate, share perspectives and ideas, find common barriers/issues, and interests in collaboration.

Behavioral health and primary care integration is a delivery system approach to reduce healthcare costs and improve health outcomes by coordinating care and improving communication between providers. Integration includes the bringing together of health care components to treat the "whole person" and in practice, occurs along a continuum (see below). It includes a systematic connecting of behavioral health and primary care providers to improve quality care and outcomes.

Figure 1. Continuum of Physical and Behavioral Health Care Integration*



* Adapted from Nardone.[27]

The two years of the Learning Collaborative and plans for the third year were presented on. In the first foundational year, 11 member organizations developed the Six Criteria - a flexible, theoretical, and evidence-based model:

- Technology standards
- Person-centered
- Evidence-based
- Financially sustainable
- Core services
- Workforce standards

In the second year, Collaborative members selected 3 areas to look further into and figure out how to operationalize, test, and meet the requirements of the Six Criteria in a real-world setting. Using a feasibility study design was the method chosen to allow for an iterative and adaptive process necessary for determining the relevance and sustainability of such practice-level changes. Year 2 focused on 3 topics:

- Integrated data collection/exchange
- Hospital transitional care
- Financial sustainability

Since much of the research to date focuses on providing behavioral health services in primary care settings, the Collaborative decided - based on need, strengths of members, and gaps in the literature - to study the "reverse" integration. From the perspectives of the Collaborative, people with SMI are more likely to present at a community behavioral health clinic than primary care, so it was a logical step to integrate primary care into those settings. As this work aligns well with the Health and Human Services Transformation of the State, specifically the Integrated Health Homes State Plan Amendment, members and Health & Medicine staff have continued to advocate for policy changes at the government and organizational levels.

Year 3 will continue the Learning Collaborative and facilitate peer to peer conversations and consultations; partner and coordinate with other groups focused on integrated care; pilot or fully launch the hospital transitional care and financial feasibility study; disseminate a playbook with lessons learned and guidance in how to meet Six Criteria and move integrated practices along the continuum; and continue to communicate and share lessons learned with DHS and HFS on integrated care and health homes.

Plenary Presentations by Learning Collaborative Members

Information and Data Exchange Workgroup
Mary Talen, Erie Family Health Center
Marvin Lindsey, Community Behavioral Healthcare Association of Illinois (CHBA)

- CBHA represents behavioral health agencies across the state

- Learning Collaborative recognized that true integration must include this data exchange among providers
- Ability to integrate BH and PC includes many factors and one of the largest challenges is the ability to exchange clinical data information electronically. Bidirectional exchange of data is ideal and not happening in many places.
    - Incompatibility of data systems means that provider electronic health record systems don't talk to each other
    - Need to protect confidentiality vs. having to protect patient safety
        - For example, why does my foot doctor need to know that I have a mental illness? A physician could prescribe medication that may have a negative effect on a patient.
    - Confusion over purpose and goals of data exchange, which may boil down to trust of providers or system
    - Too much data vs. too little data can be viewed differently per provider and especially thought of differently from BH and PC professionals
    - The range of high tech and low tech options varies across providers
- We have a problems which are solvable but it take some willingness. One thing that needs to change is public policy.
    - For example, one of the state's behavioral health projects was the IL Health Information Exchange and we were able to get some changes around the BH and DD act around mental health information. Those kinds of public policy changes are needed.
- The other is money. Public investment. A lot of this can be solved by public investment, for example, the Illinois Health Information Exchange and Technology Act provided an avenue to invest.

Mary Talen:

- At Erie Family Health Center Mary helps train the next generation of family care physicians to be able to understand this new system of care.
- With all of these ideas around data exchange and integration, there's a need to coordinate efforts. Here are the key areas:
    - Partners will be community-based hospitals and safety net hospitals.
        - Going to the ED is a part of the care system for this population because it is the one place you can go and someone HAS to see you
    - Other key partners primary care/FQHCs CHCs, community mental health systems
- Principles across these key areas are:
    - Seamless: Clients/patients should experience smooth shifting of gears from one healthcare partner to the next
    - Space: Data exchange has purpose and meaning when there are co-located spaces and personal interchange – relationships behind the data
    - Simple: The integration needs to be simple for patients to manage even if the glue that holds together is complex – don't have to start over on data input

Hospital Transitional Care
Matt Hammoudeh, LSSI

- Hospital transitional care, as we are working on it, is about a person who is admitted and then transitioning back to community. We are emphasizing the linkage to primary care among other supports and services and integrating BH/PC with the focus on inpatient integration/connection.
- Trying to address future crisis and readmission by understanding the social factors and health outcomes. Care transitions are important part of continuum of care and a critical moment that can either produce positive outcomes or drive a cycle of readmissions/negative outcomes
    - LSSI has had great success w/ programs in 3 hospitals: helping individuals transitioning back into the community; addressing social determinants; coordinating with specialty and primary care; mitigating risk for crisis or readmission
- The Learning Collaborative work group focused on primary care linkage, but it's also important to focus on social determinants/needs of person and what it takes to stabilizing needs in the community (such as food, money)
    - The population we are serving have limited access to primary/specialty care and even more important to help individuals connect w/ community services (not specific to services but what's best for the individual) without risk of crisis and readmission
    - To achieve this, we have to get a lot stronger at linking to primary care and behavioral health
- Transitional care is also dependent on data exchange and interoperability of systems, but there is a lot of confusion and challenges in this space
    - Data isn't available when we need it
    - For example, legacy utilization on individual patients would be helpful during inpatient admissions to determine if a pt has received primary/specialty care before and getting the most up to date clinical information
- Health education and promotion areimportant for patients, particularly if the person is not in primary care or speciality care
    - Giving them information and educating on benefits of accessing primary care
    - Giving client choice through education
    - Employ peer support to provide balanced perspective

Financial Sustainability
Gwenn Rausch, HHC
Susan Doig, Alice Geis, Trilogy

Alice Geis

- Trilogy Behavioral Health
    - 10 locations
    - 2,500 clients annually
    - Transitioned 400 class members into community
    - 75% of clients are part of intensive outreach
    - > 1/3 clients receive care at the trilogy-heartland healthcare home
- Workforce issues in integrated care
    - Requires good inter-professional communication/collaboration skills
    - Most health professionals are educated in silos and don't have the experience of working in teams
- Benefits of partnerships

  - Clients benefit from well-coordinated evidence-based care in integrated systems
  - CBHOs need primary care to serve people w/ medical and SUD and FQHCs need outreach/social services to serve populations. Both of these need professionals prepared to work interprofessionally.
  - Academic programs need clinical placement for students that support entry into workforce
- Building partnerships are important for financial sustainability
  - Shared vision/values are vital; shared frameworks and leadership styles help; and academic practice partnerships may offer financial and clinical/research benefits (i.e., bringing in additional service hours to clients)
- Gaps in care
  - Acuity of psychiatric, medical, and substance use disorders requires skilled home health care, which is minimally available with Medicaid
  - Nursing/OT are not reimbursed enough
  - Coordination w/ inpatient services is difficult due to lack of interoperability
  - Differing assessment clinically from different settings

Gwenn Rausch

- Heartland Health Centers
  - 15 locations 25,000 patients
  - 3 integrated/co-located health centers
  - Partnership w/ Trilogy started in 2010 w/ SAMSHA grant which allowed data collection
  - 40% of Trilogy participants receive primary care and psychiatry at integrated site and the outcomes have been promising both physical and mental health outcomes
- Getting partnerships started
  - Improved patient/client outcomes must be the motivation and shared goal
  - Organizations must be on “solid footing” financially
  - Must be embraced at all levels of each organization
- Financial considerations
  - External support/grants/rent concessions are needed for 6-12 months of operations
  - Understanding points of ownership and shared responsibility must be clear
  - EMR access/interface costs are important to address up front
  - Respect of obligations of other organization
- Financial issues
  - MCO plan “benefits” may look different from a behavioral health provider’s view
  - Psychiatry is expensive: employed vs subcontract; nurse practitioners and PAs have cost advantages
- Opportunities and Rewards
  - Empowering individuals to participate in their health status
  - Demonstrating improved health and health outcomes (significant database of 2000+ patients)

Question and Answer

Meryl Sosa

- Comment: One challenge is that family physicians only have 15 minutes with each patient, which makes it difficult to check with patients on mental health issues
    - Mary (Erie) Screening for MH issue in primary care has to do with our entire team – the way that patients are vitaled and our MAs. Integrated care is working in collaboration with our psychiatrist and there is team of people addressing this.
    - Gwenn (HHC) In our integrated care clinics, new patients get 30 minutes. Often a nurse and MA are taking some information. Sometimes only part of eval is done at those sites, but a lot of work is done when the provider comes into the room, which allows them to do what is necessary in most cases.
- Question: When you did do the 1115 waiver comments, did you encourage Medicaid to use collaborative care codes?
    - Medicare came out with collaborative care codes, which can be used by community mental health center or fqhc. Then employ the psychiatrists or contract with a provider who can reimburse for the service. We were hoping that the state would start using those codes in their Medicaid program.
    - Kelly (HFS) was willing to take this comment back and make those suggestions with the people who are negotiating with Fed CMS

John Fallon, Corporation for Supportive Housing

- Comment: Concern that we talk about co-location and case management without acknowledging where services are delivered outside of the hospital or care setting. Assertive Community Treatment (ACT) directly delivered services in someone's home and was called wraparound care, which included team-based care where someone lives rather than where they work.

Francis Magnick, Access Living, Consumer Advocate

- Comment: Like idea of the three S's (seamless, space, simple). Going through situation now where I have to call all of these different agencies. I feel like I need a dictionary for all of the different terminology. Two different words or set of letters that are supposed to be equal to one another. I'm losing my sight, my heart, and my fibromyalgia. I'm a 68-year old woman and teacher. I'm trying to explain to someone living on their own...how can I explain to a consumer?

Kathy Powers, Advocate

- Advocacy is my therapy. Representing the Chicagoland Leadership Council. Mostly devoted to peer supported services (i.e. People with lived experiences).
- Comment: Considering the scope of the HMPRG list, I didn't see food insecurity and nutritional deficiency. 9 times out of 10 – people will go into a system, without being tested about nutritional deficiencies. When your body is missing something it is going to act out somehow. A lot of times it is behavioral, but insurers won't pay for this.

Respondent Panels and Audience Discussion

People with disclosed mental health conditions; State of Illinois agency officials

- ➢ Sharing feedback to Learning Collaborative lessons learned from the first two years; and
- ➢ Advancing the conversation on statewide mental health and Medicaid reforms.

First Panel

Kelly Cunningham, HFS, Deputy Administrator, Long Term Care and Behavioral Health (1115 waiver, health homes, Medicaid)

- Representing HFS, State Medicaid agency
- Attended the Learning Collaborative Summit in November 2016
- There's so much work going on now that fits with state's vision around behavioral health integration
- People with behavioral health issues have chronic comorbid complex health issues
- Government can get caught up in policy or lack of budget, but hit home by *lower life expectancy* for patients affected by these things and not addressing these concerns.
- Fragmentation and siloing – pilots/projects demonstrate that this can be improved, and there isn't a single way to approach integration and to get it working at the ground level
- Continuing negotiations with CMS and SAMHSA – both dept of HHS – on the 1115 waivers. Pleased with what they're saying on the Illinois application
- Intrigued by discussion of 3 S's (Seamless, Space, Simple)

Diana Knaebe, DHS, Division of Mental Health

- Used to run a BH Center in Decatur – 2nd cohort in primary behavioral health grant
- Need to look at people holistically – mind body spirit - nutrition, education, wellness, recovery are all critically important.
- Nursing/OT/dieticians are all poorly reimbursed and should be at the table to try to get limited income individuals the correct diets
- Health promotion/prevention is huge
    - Whether individual with lived experience w/ addiction/mental illness/diabetes/heart disease/asthma
- Rule 132 and 140, Illinois lead nation in looking at recovery support with people in recovery and made deliberate distinction to engage in workforce and professionalize/support the role of getting certification (CRSS) for people with lived experience

Alice Gaiter, Thresholds

- Diagnosed with Bipolar disorder and depression, and trauma suffered as a child
- 2007 born again – became member of Thresholds in March 2007 and on the good road since
- People with mental illness experience a lot of medication changes until one works for them
- Bumps in the road, but on the road to recovery due to thresholds
- Sit on board of directors at UIC mile square health center
- Lots of things in life proud to share
- Suffered with depression for so many years, but now has it under control
- Happy to answer Q's around providers, medication changes, options

Sue Atkinson, Depression and Bipolar Support Alliance

- Runs a DBSA support group in Naperville
- Not enough services and supports in the suburbs
- Diagnosed w/ bipolar when 45, now 66
- Hospitalized 15 times in my life
- Recently was in hospital and it cost $1,000/day
- 10 yrs ago, got vagus nerve stimulator implant. First in Dupage county to get that for depression. Only hospitalized once in past 10 years
    - Without Medicare/Medicaid, would not have been possible

Audience Discussion

Fred Smith, Family behavioral health clinic, MCO

- Comment: Concerned with moving to integrated systems with multiple MCOs and being reimbursed in a timely fashion

Kelly Cunningham, HFS

- Response: Looking to establish universal credentialing across managed care organizations; one state credentialing system across MCOs

Debbie, Thresholds

- Comments: Regarding larger systems issues and outcomes based care, there is a challenge for some providers to achieve outcomes. We need real-time integrated data for population health, which for those receiving care at Thresholds, we have access.
- Getting people to primary care leads to specialty care appointments. But there's lots of work with getting to appointments. When someone goes to their appointment, the work doesn't end - someone has to assist with healthy living, for example. As agency with lots of staff (esp with those in 20s), it's hard to educate on health conditions of patients and what they're living with. Workforce must get training on what the real healthcare needs of patients are.
- Mental health providers dependent upon Rule 132 for Medicaid services. It's hard to ensure that the health care provided to patients can be billed as a mental health service.
- For those who are focused on people who are dying on every single day, can't be focused only on mental healthcare, but healthcare in general. And there are no networks and no communication among networks. Providers are up against a lot in the system. Putting them responsible for outcomes at outset puts a lot of hurdles to actually achieving those integration and outcomes

Alice Gaiter, Thresholds

- Comments: Integrated health questions helped address health issues AND psychiatric issues. Was better attention for physical health and psych needs
- Experience with Mercy was traumatic and caused avoidance of health system and bad experiences last.
- Providers should listen to the patients

Marsha Maldrow, healthcare provider

- Question: Many providers don't see it as managed care, but rather managed cost. Medicaid now has MCOs, but many individuals who had private insurance, who opted for MCO, found out that they could not get same services. They returned to other health care coverage, which left individuals who were less capable of financially providing for their care. In dealing with these businesses, you want them to do something other than what they demonstrated that they can and will do, and I'm wondering how you're going to do that?

Kelly Cunningham, HFS

- Response: One reason for the state undergoing managed care reboot (RFP process) is to really make sure MCOs in state are about more than cost control and that they have the patient/client/participant at the center of concerns. There's lots of info on website in terms of

requirements and standards, which is part of the reason that the state is undertaking this process. We are trying to make it more about physical/behavioral health integration and patient needs rather than traditional model of cost control. We are still in middle of process, and still hopeful to have new plans in Jan. 2018.

Laura, HMPRG Learning Collaborative

- Response: The feasibility study of the collaborative is looking into what the *real* cost is, rather than cost containment or cost control. By coming up with real number and making it transparent, and that will be easier to take it back to the payment organizations and say "you aren't reimbursing us enough to make this feasible."

Second Panel

Susan Ciano, Depression and Bipolar Support Alliance, Recovery Support Specialist

- In the northwest suburbs, there's a drop-in center for adults to find peers and support
- Being a recovery support specialist means providing support to peers as a result of mental health diagnosis. With a mental health diagnosis, luckily feeling contentment and resilience
- Medicaid paid for medication and doctor visits. Because of healthcare, I have come full circle after almost 40 years of suffering with mental health issues
- Without Medicaid coverage, healthy way and livelihood is under threat
- Newer medication costs $1,300
- Nonprofit where working is funded through Medicaid
- Move across state lines had gap in coverage. Wait at community center was 3 months
- Nationalized Medicaid would have allowed for better continuity in care

Lore Baker, DHS, Supportive Housing, Employment First

- There's a need for some kind of transformational housing; somewhere between exit from ED or hospitalization and entry into supportive housing
- There's never going to be enough open and permanent supportive units available, because it isn't financially available. Need something for the short-term as you're moving into your permanent home, which is not filled with people that need supportive housing.
- People get confused between difference between supportive housing and affordable housing. We have thousands, millions in need of affordable housing. Supportive housing is affordable and provides additional supports and services.
- Important that the intervention is appropriate/best for each individual and not delivering the services that someone doesn't need (i.e., supportive housing vs. affordable housing)
- As a person who has been in housing services for a long time that knew housing was important, tired of talking about the social determinants of health. It's time to do something about it rather than talk about it
- Important to look at how we finance affordable housing and supportive housing. Employment is another important SDOH, which also helps you pay for your housing
- MCO care coordination is not enough for people with supportive housing need. Needs to be another layer of support and billable via Medicaid
- We all have different roles to take in answering different challenges. Not just: We need more supportive housing
- Need to advocate for more resources both on federal and state level

- Consumers have to arm themselves with knowledge
- Service providers have to figure out how we prioritize. MCOs have to determine how they're going to invest in housing and going to save money. People who have disabilities, multiple hospitalizations will need supportive housing

William Korte, Depression and Bipolar Support Alliance

- Diagnosed with bipolar when 15, now 35 in recovery
- Volunteer with CBHA, talks with young people about stigma around mental illness
- Medicaid has made a positive impact on my life, but hasn't been a bed of roses
- Hospitalized a year ago at Reed Hospital. Was taken by my CRSS before hospitalization. She walked with me to Swedish Covenant Hospital. Left in ED for about 6 hours. May be most traumatic experiences of my life. Left hospital a couple of times. Was about to get on a bus, was suicidal.
- Someone had dropped the ball. Deplorable and should never happen. Transferred to Reed and given a case manager. Case manager never followed up to see how I was doing. Wanted to write prescription and move on. Unsure if I would have been given better care if I had been in private practice. Couldn't tell me when I would be seen again. 2-3 months to see a psychiatrist when you're on Medicaid (in my experience). I relapsed with psychosis.
- People who can't advocate for themselves or navigate these pitfalls. Those who lack the aptitude. I shudder to think what they go through. My heart bleeds for those people who can't get medication, see their psychiatrist, can't get into a hospital.
- Yes, system has helped me in a lot of ways. But I've seen the problems, gaps, pitfalls. I hope the system can help us see the promised land. This is a civil rights issue to me.

Audience Discussion

Jessica, Clayton Residential Home

- Comments: Working as residential provider, we are integrated by nature
- Pilot programs are getting going and we are making best use of resources
- Happy to be a part of pilot program straight out of SMHRF – out of nursing home area into a person first, recovery focus center
- Taking advantage of crisis recovery program where people don't have to be residents but can come stay for 21 days. In using crisis stabilization, people can avoid hospitalization, and get back on feet. We are finding the housing component is a huge part of this and bridging gaps in care

Melanie McQueen, Patient Innovation Center, with the marketplace and Medicaid enrollments. Part of a team of 30 helping people remove barriers to access to care, but question comes from common person and being a mom, from a family affected by mental illness.

- Question: I can tell when someone may be on the brink on the CTA, but what can I do? My husband in law enforcement and he said you don't know whether you're putting yourself in harm's way or if the person wants help

William, DBSA

- Response: As a start, the thought of "what can I do?" is a great beginning. CIT is a resource that can be used to call for bystander intervention. Text or more rapid response might be better for the situation

Susan, Trilogy

- Comments: Thank for Susan/William for highlighting importance of pharmacy. Specialized pharmacy is important so that people are not left without medicine.
- Some models have been defunded as transitional/transformational housing. It's very difficult to go from in-patient unit to permanent housing space. Important opportunity for 1115 waiver

Crisis Intervention Team

- Comments: If you see someone, you can call 911 and say "I want a crisis intervention team to go check on a particular situation." Chicago Police Department is obliged to follow through. They are general law enforcement, so they might also be busy. For CIT trained officers, this is a work in progress, but you are encourage to ask for CIT trained officers when 911 is called.

An idea about people with mental illness wearing an identifying bracelet to help situations which involve the police was discussed.

- Comments: This is an excellent question to take to city hall. People with mental illnesses are disproportionately killed by the police. In fact this just happened yesterday to a woman. A bracelet may help police identify people with mental illness.

Questions for Dept of Health and Human Services:

- Does the department have any focus on stigma on persons with section 8 vouchers? There are disturbing things going on in neighborhoods.
- Is mental health committee looking at stigmatization even by providers?

Response: IL dept on human rights is working on discrimination study on housing/employment/etc. and will be making policy recommendations. The Governor asked for study

Question re: police as first responders

- Lived experience opinion: Would be great to have peer support individuals as a part of the first responders

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Closing Remarks and Discussion

- We are waiting to hear about the State Plan Amendments for Integrated Health Homes. Even though we haven't seen all the requirements, they will involve high-touch coordinators. Some could be internal at the delivery site, and some external.
- We truly need a care coordinating system, which is not currently in place. Laura Zaremba tried mightily for integrated HIE.
- What could be the role of the integrated health home coordinator in making sure that there is a warm handoff – or team based approach to all of the multiple issues that someone has?

Kelly, HFS

- Every individual who is a Medicaid beneficiary will have a care coordinator to help them.
- Will work to coordinate the services with the MCO – who will be the arranger of services

- The state will put out a solicitation (as Julie Hamos mentioned) to have some influence and to arrange alternative services to make sure that outcomes are met
- Outcomes will be based on how they handle transitions between hospital and nursing home, from hospital back to community

Julie Hamos, Former HFS Director

- Policy recommendation: If a hospital admits a Medicaid eligible person for a psych condition, the health home should be called right away so they can get involved immediately in the coordination and warm handoff

Laura, HMPRG Learning Collaborative Staff

- How do we do integrated care? What happens right now? We're already trying to make that system happen. Many already have primary care medical home status, which is a step along the way. Some MCOs already have care coordinators. But what is happening in the state?

Laurie Carrier, HHC

- Runs the medical home at Heartland. We have all the same PCMH standards (Patient centered medical home) with our partners.
- Trilogy is helping documenting self-management goals and all of the care coordination outside of the clinical setting helps. Our care coordinators work inside the systems, such as helping make appointments. Referral team helps with prior authorization of the referrals.
- Case management, recovery counselors are included among the outside coordinators.

Question for the advocates in the room: What do we really need to improve care and advance integrated care?

- From experience, sometimes being in the hospital, I didn't see a doctor. Didn't follow up about conditions. Didn't take blood work. THere was a constant change of medication without questioning the person taking the medication. If doctors and everyone is part of the care, there's a need to do better assessments with people with mental illness. But I also have high pressure and diabetes. It's also important not to neglect those physical needs outside of the mental health needs. (i.e. testing A1-C levels).
- When I was being talked to by the intake nurse who came up on the floor. How you feeling? Not well. What medication are you taking? I didn't talk to a psychiatrist the whole time. Even after I still asked, am I going to see a psych doctor? And told them that I don't think my medication is working for me.
- After seven years not being at the hospital. Great trauma what happened to me. Many of us lie – saying we're feeling better so we can leave the hospital. Don't want to be in the hospital
- Don't think there is a medication for the depression that I have.
- As far as the providers/insurers Meridian was the best that happened to me. Was not late to appointments because they give you a ride. Not getting the proper treatment once you get to an appointment is a problem.