



ALL ABOARD! DESTINATION: HEALTH REFORM

THE NATIONAL ACADEMY FOR STATE HEALTH POLICY 22ND ANNUAL STATE HEALTH POLICY CONFERENCE

OCTOBER 5-7, 2009 / LONG BEACH, CALIFORNIA

NATIONAL ACADEMY
for STATE HEALTH POLICY

U.S. Health Delivery System

- The dominant models of providing health care in the United States separate the mind and body.
- Separation has a negative impact on health care access, health care costs, and quality of care with a disproportionate share of the burden falling on women, the elderly, racial and ethnic minorities, and rural immigrant populations
- (Health Care for the Whole Person Statement of Vision and Principles, American Psychological Association).

Why Integrate Treatment?

- 25% of primary care provider patients have a primary mental disorder*
- It is estimated that in 60-70% of medical visits, there are no medical or biological diagnosis*
- While effective treatments exist for most common mental disorders, studies have shown many consumers seen in primary care settings do not receive them**

**Bazelon Center for Mental Health Law*

***President's New Freedom Commission on Mental Health*

Barriers to Integration

- Stigma
- Multiple delivery system funding streams
- Delivery system design & licensure barriers
- Workforce training & agency mission and expectations
- Capacity and distribution of services

Tennessee Integration – TennCare Transformation

April 2007: Managed Care Carve-In piloted in Middle TN

January 2009: Managed Care Carve-Ins implemented in East & West TN (without full evaluation of middle TN pilot)

Concerns: Impact on persons with SPMI and SED, viability of public mental health/substance abuse specialty providers, impact of managed care principles on substance abuse services/providers.

Potential Positives: Benefit of increased reimbursable mental health/substance abuse screenings in primary care, behavioral health elements in disease management protocol for chronic medical illnesses, as well as focused management for schizophrenia, major depression and bipolar. Maintained protection for SPMI/SED in the rate corridor.

Lessons learned from Middle TN Integration: Less integration at provider/service level than initially anticipated: contracted managed care plans did not drive clinical integration.

Examples of Tennessee Clinical Integration Sites - 2009

- Cherokee Health Systems
- Frontier Health Systems
- Emotional Fitness Centers
- Community Health Centers
 - United Neighborhood Health Center
 - Matthew Walker Health Center

Tennessee Integration - Rural

Cherokee Health Systems CMHC  a FQHC

- Serving health care needs including medical, dental, & behavioral healthcare since 1960 with 23 sites in 13 TN counties
- Behavioral health consultants (BHCs) in a primary care setting; involved in on-site & timely assessment, brief intervention & consultation with patients
- Services include education, behavioral management, & treatment for mental health disorders

Impact of BHC on Subsequent CHS Service Utilization

- 28% decrease in medical utilization for Medicaid patients
- 20% decrease in medical utilization for commercially-insured patient
- 27% decrease in psychiatry visits
- 34% decrease in psychotherapy sessions
- 48% decrease in mobile crisis team encounters

Tennessee Integration - Rural

Frontier Health Systems (CMHC)

- 12-year collaboration with East Tennessee State University Family Practice Program
- Primary care physicians, psychiatrists, mental health therapists & medical residents participate in case review
- Share behavioral & medical health information
- Referrals to therapist: increases acceptance/access to mental health treatment, treatment continuation & medication compliance
- Integrating primary care into A&D treatment setting
- Increase quality of admissions process including detox
- Create more integrated view of client medications treating physical & psychiatric symptoms and disease
- Reconnect client with primary care in discharge planning

*As a newly initiated program effort, outcome data collection has only recently been undertaken.

Tennessee Integration – Urban

Emotional Fitness Centers

- Grant partnership with TDMHDD
- Faith-based mental health pilot program addressing utilization disparity & under-utilization of mental health/substance abuse services to lessen the stigma often associated with accessing mental health services in minority communities
- Services offered on-site in several local churches, a historically safe & trusted environment for many African Americans
- Model of Care
- Licensed Professional Counselor determines needed services and makes appropriate referral
 - A Peer Advocate Liaison (PAL) helps client navigate systems of care based on referral from Licensed Professional Counselor
 - If physical care is desired or needed, client is referred to the Program's Nurse Practitioner

A Growing Integration Model in TN (FQHCs)

- Expansion of mental health/substance abuse services in CHCs including numbers & intensity of mental health/substance abuse services available
- Federal investments in CHCs through the ARRA (over \$2 billion nationwide)*
- Many CHCs are expanding use of Psych/Mental Health Advanced Practice Nurses as part of Clinical Provider Team
- Many CHCs offer mental health/substance abuse services including SBIRT & depression screening, medication, & counseling on sliding scale fee schedule

*CMHC do not receive “cost plus reimbursement” & did not receive ARRA \$

Caveats For Integration: Lessons Learned From TN

- A carve-in at the health plan level doesn't assure integrated care at the clinical level.
- Co-location is necessary but not sufficient for integrated care.
- Workforce availability and service model values/cultural difference must be addressed.
- Public policy to “turn on” billing/payment codes does not assure their appropriate use.
- “Warm” handoffs between CHC and CMHCs need focused attention and are frequent not successful.

Policy and Practice to Accomplish Integration

- Expand screening & implement collaborative care models in primary care settings
- Reimburse for core collaborative care components by public & private insurers
- Include care management, disease management & mental health/substance abuse expert care or consultation on primary care team
- Include physical health screenings & assessment in mental health/substance abuse settings with pre-arranged referrals/services for needed health services
- Co-locate in either setting; payor contracts must pay for collaborative care

Integration Takeaways from TDMHDD

- Primary care provides the best platform to increase access to behavioral health interventions
- Increases access & improves health outcomes by facilitating a setting/structure of de-stigmatized interventions.
- Integrated care is the best anti-stigma strategy.
- Integrated care is mental health system transformation.
- The time is now to build safety net organizations to provide a care model that addresses the complex needs presented in most clinical encounters.
- When behavioral health is blended into primary care appropriately, patient outcomes improve, providers are happier, & payors save \$\$.

Thank You

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Integrated Primary Care and Behavioral Health in Tennessee Community Health Centers

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Tennessee Primary Care Association

Tennessee Primary Care Association

...a non-profit membership association whose mission is to strengthen community-based comprehensive primary health care in Tennessee

...a network of 34 non-profit Community Health Centers operating a total of 173 clinic sites across Tennessee



TPCA and the Community Health Centers are working with partners to....

...participate in and support the implementation of a clinical model of integrated primary care and behavioral health

Because to be successful...

...community health centers will require resources and training



The Keys To Success Are...

- ..reimbursement for behavioral health services in the primary care setting
- ..a business model that supports integrated care for the uninsured as well as the insured
- ..training on the clinical model of care
- ..mentorship for the primary care providers
- ..behavioral health providers equipped to work in a fast-paced primary care setting
- ..primary care and behavioral health providers working in partnership on primary care team

The Path We've Taken...

- Training on the clinical model for CHC leadership and clinicians
- Meetings with the community mental health center association about partnerships & workforce
- Meetings with state government about the model, funding & reimbursement
- During the carve-out, worked with TennCare/Medicaid to incorporate the Behavioral Health in a Medical Setting (96150 – 96155) code set into the MCO contracts;
- Advocated for the current carve-in in TennCare/Medicaid

The Current Integrated Care Environment

- Majority of TN CHCs provide some level of behavioral health care onsite or are in a deliberate partnership with a community mental health center to offer these services
- TPCA has an Integrated Care Committee of our members to guide & enhance our work
- TennCare/Medicaid now offers an integrated model through the managed care organizations, which will ensure reimbursement and encourage partnerships

The Current Integrated Care Environment

- Americhoice/United has partnered with TPCA to support our work in this area;
- Screening, Brief Intervention, & Referral to Treatment for substance abuse ~ SBIRT
 - National Association of Community Health Centers (NACHC) & Substance Abuse Mental Health Services Administration (SAMHSA) have partnered to provide training and technical assistance to TN and VA FQHCs to implement SBIRT

The Future

- Continue to work with partners to advocate for funding & reimbursement to ensure sustainability of the model;
- Continue to provide training & mentoring to community health center providers on the clinical model
- Maximize use of telehealth to bring additional resources into underserved areas



Thank You

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