MCHRC
Maryland Community
Health Resources
Commission

Building a Base for Integrated Care

By Kimá Taylor, MD, MPH

June 21, 2017

Executive Summary

The Maryland Community Health Resources Commission (CHRC) has commissioned a series of white papers to describe how CHRC funding has increased access to needed behavioral health services for Maryland's vulnerable populations. This brief is the first of three papers and describes programs that provide evidence-based integrated behavioral health and somatic health services throughout the state. Other papers in the series will include a brief that will focus on programs that address Substance Use Disorder and the provision of Medication-Assisted Treatment and another brief that will describe programs that assist in the re-entry for justice involved individuals with behavioral health disorders.

The CHRC has been a leader in preserving and strengthening the health care safety net for those who are uninsured or underinsured and those whose health status is influenced by a myriad of social determinants of health. The Commission has a commitment to ensuring access to integrated, high-quality primary, behavioral, and specialty health care services for the most vulnerable in the State. Increased access to health resources helps Maryland achieve improved patient behavioral and physical health outcomes, lower costs, and increased patient satisfaction. CHRC funding supports the development of the infrastructure necessary for integration between behavioral health and somatic health care providers and other community resources dedicated to improving patient outcomes but lacking the necessary resources to make systemic changes.

CHRC grants have changed the landscape for the vulnerable population with behavioral health treatment needs by:

1. ***Providing the funding to support the clinical time and the development of the infrastructure necessary for behavioral and physical health care providers to expand into new services and build partnerships***. The funding enables providers to initiate programs and then leverage grant funds to obtain additional capital to sustain programs and services.

2. ***Increasing the capacity of providers dedicated to the population in ways that benefit the entire state***. The funding has supported behavioral health providers who are ready for the new world of payment reform despite not having been a part of somatic health systems in the past.

3. ***Providing seed funding for innovative processes and programs for the population that can be replicated statewide and providing technical assistance to organizations interested in implementing similar programs***. Lessons learned with these programs can also inform local and state policies, regulations, and legislation.

Introduction

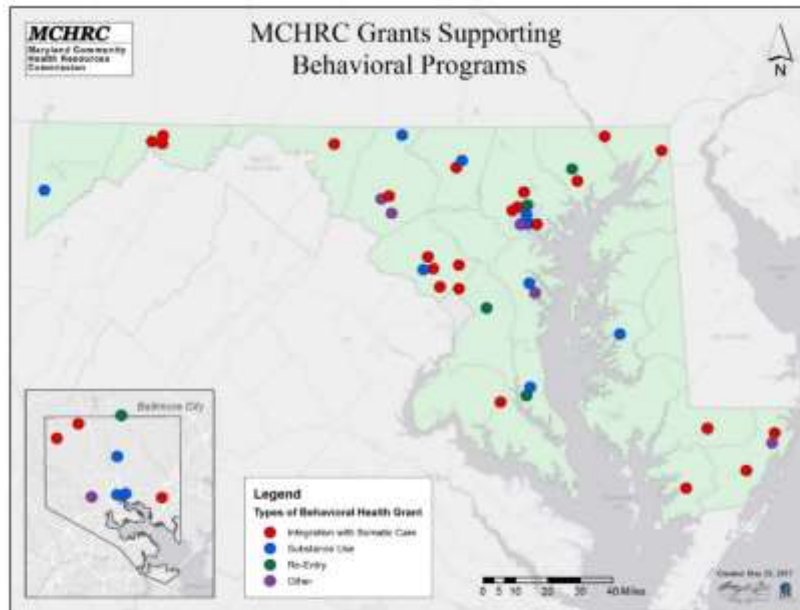
Behavioral health disorders and physical illnesses rarely occur in isolation. People living with a serious mental illness are at higher risk of chronic disease, while people living with poor physical health are more likely to have depression and anxiety than the general population. Mental health, substance use, and general health problems and illnesses are frequently intertwined, and coordination of all these types of health care is essential to improved health outcomes, especially for chronic illnesses. The stigma of mental illness has been a barrier to accessing integrated behavioral health and somatic care services, especially in poor communities and communities of color. Mental and behavioral health care have long been the purview of systems outside of the primary health care system, such as the criminal justice system, the substance use treatment system, and the social welfare system. Passage of the Affordable Care Act, which included a provision requiring coverage for mental health and substance use services, has led to efforts to bridge the gap between the behavioral and somatic health care systems in an effort to save money and improve patient outcomes. These changes increased the awareness of public officials and community members, who now recognize the need for integrated behavioral and somatic health care. In Maryland, the opioid epidemic challenged available resources and current policies and created a new sense of urgency as an adequate statewide system did not exist to respond to the increasing need for behavioral health programs. Currently, there are not enough high-quality, culturally effective behavioral health programs to care for all those who desire formal treatment or secondary prevention services for those who are not willing to enter formal treatment.

The integration of behavioral and somatic health care is complex, as the disciplines do not share similar infrastructure or culture. The two health systems have different payers and different models for evaluating outcomes and accountability, and they do not speak the same health care language. The charting, billing, and accountability systems in the behavioral health system are different than those used in somatic health care and have been siloed out of habit and by dent of federal and local regulations. Improving integration of behavioral and somatic health requires a commitment by both sides to overcome these barriers. Health systems have not held providers accountable for assessing or treating substance use disorders, but new care requirements are forcing providers to begin to think about providing integrated care. Even with these new requirements, few payers or grant programs have recognized the need for, or funded the planning, training, and infrastructure development needed for creating and sustaining high-quality integration models. The CHRC is helping community health providers implement programs that expand access to integrated behavioral health care for the most vulnerable Marylanders. In a quest to foster innovation, expand capacity, and sustain high-quality integrated care models, the CHRC has been willing to invest in the necessary infrastructure for integrated behavioral health care in fulfillment of its statutory requirement to expand access to primary, behavioral health, and dental services in medically underserved areas.

Organizational Background

The Maryland General Assembly created the Maryland Community Health Resources Commission in 2005 to expand access to health care services in underserved communities in Maryland. The CHRC is an independent commission, operating within the Maryland Department of Health & Mental Hygiene (DHMH) and is led by 11 Commissioners who are appointed by the Governor. Since its inception, the CHRC has prioritized expanding access to behavioral health services for underserved communities

with a particular emphasis on the integration of behavioral health and primary care services. The CHRC has awarded 47 grants totaling $12.3 million to support behavioral health programs. The awardees have collectively served 66,504 residents, many of whom face complex medical and co-morbidities. The overall policy goals of CHRC grants have been to: (1) increase access to critical addiction and mental health services for at-risk residents and underserved communities; (2) support the functional integration of behavioral health services with primary care, community-based settings; and (3) work with many stakeholders at the state and local levels to address the heroin and opioid epidemic. The Commission looks to accomplish these goals in a way that leads to models of care that are replicable and sustainable. CHRC grants have supported a variety of programs focused on: (1) addition of behavioral health services in federally qualified health centers and other primary care providers; (2) addition of primary care services in Assertive Care Teams and outpatient mental health programs; (3) implementation of SBIRT (Screening, Brief Intervention, and Referral to Treatment); (4) promotion of re-entry programs which link individuals with primary care and behavioral health services; (5) promotion of community programs that reduce the number of individuals presenting at hospital EDs with behavioral health needs; and (6) increase access to Medication Assisted Therapy. This paper will focus on the work laying the foundation for the provision of integrated health services.



The CHRC issues a Call for Proposals (RFP) approximately once each year. The RFP prioritizes integration planning as part its selection criteria in an effort to grow the number of innovative, cost-effective, and sustainable integration models that would improve access to and provision of care for hard-to-reach populations. Within the focus area of behavioral health, the Commission prioritizes proposals in which primary care providers, behavioral health providers, hospitals, and social services providers agree to collaborate. Joint proposals allow diverse partners to identify shared goals and recognize that solutions require working outside of existing silos. The CHRC's population health focus requires systems to develop a sustainable safety net for the most vulnerable, while also building systems for all population groups. CHRC grants can be used for building capacity by increasing staffing levels, improving performance through staff training, increasing the depth and breadth of program services, and purchasing the materials necessary for program implementation. Funds have also been used to bring in representatives from successful integration programs from outside of Maryland to inform, train, and/or evaluate the work being done in state (the overall aim is to ensure that programs will ultimately become sustainable after grant funds have been expended). The RFP also aims to identify qualified programs from all areas of the state, which propose programs that are designed for their specific needs, local populations, and capacity.

Strategies adopted by CHRC grantees

Grantees have used a variety of strategies to integrate behavioral and somatic health care. Each of these programs was able to provide integrated care successfully to members of their community and has proven that there is a continued need for these services.

- ***Co-locating services; either by adding primary care services to a behavioral health practice or providing behavioral health services to a primary care practice***. These programs developed the agreements and protocols necessary for comprehensive integrated treatment plans, allowing providers to execute successful client hand offs, share information, and measure outcomes. The new services were added either by hiring new expertise directly into the existing organization or by locating a new practice at an existing practice site.
- ***Incorporating behavioral health screening tools such as SBIRT into their primary care or ER sites***. This often led to partnerships with community-based behavioral health providers who accepted patient referrals when individuals were identified as needing and wanting more formal treatment.
- ***Expanding behavioral health services using telemedicine and/or increasing access to Medication Assisted Treatment***. This topic will be highlighted in the next white paper.

Impact of CHRC-funded behavioral health programs

The CHRC has funded 18 programs for $5.6 million which have focused on providing integrated behavioral health services. These programs have served more than 58,000 individuals through more than 151,000 patient visits. Providers that embraced the integrated care model saw a culture change in their staff and an improvement of patient outcomes. The Commission monitors its grant-funded programs and tracks quantifiable metrics to determine program performance and assess impact. Specific metrics and overall outcomes include:

- The number of new patients receiving behavioral health and somatic care in an integrated manner either through co-location of services or through coordinated care management which links patients to nearby services.
- The increase in care capacity, either by adding new staff, adding new services such as screenings or treatments, or increasing access to services by increasing the hours of service availability.
- Improved IT interactions and infrastructure, allowing sites to collect and understand patient level data as well as allowing them to code and bill for services.
- The incorporation of evidence-based practices to programs where they did not previously exist.
- The increased ability to leverage other funding streams, including both public and private funds (i.e., Medicaid, government programs such as health homes and Health Enterprise Zone funding, reimbursement from private payers, or private foundation funding).

The following are two examples of how CHRC funding supported new infrastructure development and increased capacity through implementation of integrated care. A full list of grantees and an overview of these programs are available on the CHRC website, https://health.maryland.gov/mchrc/Pages/home.aspx.

Way Station, Inc., a non-profit behavioral health organization with locations in Frederick, Howard, and Washington Counties, had already been monitoring national behavioral health care trends within the behavioral health field prior to receiving a grant from the CHRC. The organization's leadership recognized that the services being provided by their clinics were not adequately reducing the number of drug overdoses and other drug use sequelae. CHRC funds were used to implement a successful evidence-based program of integrated care of those with serious mental illnesses and co-occurring disorders. The program provided effective patient-centered mental health services, primary care services, substance use disorder treatment, and linkage to social service resources. Way Station replicated the Missouri Health Home Model with technical assistance from the individuals who developed the program. Adopting the Health Home Model not only provided a framework for quality integrated care, it provided increased federal Medicaid reimbursement of wrap-around services for the first two years of implementation, thus leveraging CHRC's initial investment. During the grant period, more than 180 unduplicated clients received primary care within the Way Station center, for a total of 2,207 visits managing diabetes, hypertension, and other chronic somatic diseases. The group has shared its findings, the IT platform used for data collection and evaluation, and lessons learned. The organization now chairs the Medicaid Advisory Committee for Health Homes in Maryland. The Commission's initial investment of $170,000 enabled the grantee to leverage an additional $1,000,000, and this initial funding allowed the organization to develop and implement the Behavioral Health Home Model program that was sustainable over the long term. There are currently 83 Health Homes in Maryland for which the Way Station program served as a pilot.

Mosaic Community Services, a behavioral health organization with locations throughout Maryland, found that most of their patients were receiving primary care services at local hospital emergency departments. Emergency departments were able to stabilize the patients' urgent care needs, but were not able to provide the care needed to treat many of the chronic conditions faced by these patients. Mosaic received an initial grant from the CHRC in 2011, which allowed the organization to hire a nurse practitioner to provide primary care services in-house. The program successfully increased primary care access and decreased ED admissions for this population. The grantee reported that clients enrolled in the program were responsible for 759 somatic and psychiatric ED visits in the year prior to participation, but only 35 ED visits in the year after enrollment. Unfortunately, the level of Maryland Medicaid reimbursements was not sufficient for program sustainability at the end of the grant in 2013, so the organization worked to establish partnerships with external primary care providers to establish a more sustainable model. In 2014, the CHRC awarded a second grant to Mosaic, supporting a partnership with a Federally Qualified Health Center in Baltimore City. Under this program, Mosaic provided behavioral health services to the FQHC's patients, and the FQHC provided somatic care services to Mosaic's clients. More than 34,000 FQHC patients were screened for behavioral health needs, and 9,500 Mosaic patients were screened for somatic health needs over the course of the two-year grant. Nurse care managers continue to provide care coordination and linking to somatic care for Mosaic patients with complex health needs.

Critical Success Factors for Behavioral Health-Somatic Health Partnerships

Successful grantees shared a number of characteristics which serve as examples for providers looking to implement similar integration programs. Each of the programs that were deemed successful implemented models that saw improved somatic care and behavioral health care outcomes. The

leadership of these programs created a work environment that relied on external and internal expertise to inform the development, implementation, and evaluation of the programs. Leadership also prioritized training on how to provide culturally sensitive health services, how to link patients to partner health care organizations, how to link patients to health insurance, how to link patients to social supports, and how to bill for the services that they provide.

Partnerships played a large role in the success of integration efforts. Successful partnerships were those with clearly defined roles and responsibilities. These partners relied on evidence-based models and best practices that could be found locally and nationally to establish their relationships, and they focused on shared goals for their patient populations. Not all partnerships were successful, with some faltering due to a change in leadership or changes in organizational focus. This was not always fatal to a program, with remaining partners identifying alternate partnerships or restructuring programs to succeed with remaining program members.

Successful grantees also understood that data is essential to both measure implementation progress and final outcomes as well as to inform changes in a program when necessary. Finally, these programs prioritized the implementation of behavioral health and somatic health services not just as a trial, grant funded project, but as an essential way to care for the patients that they serve.

Challenges

Even with an infusion of CHRC funds at start-up, these behavioral and somatic health care integration programs faced challenges.

Hiring and retaining key staff

Challenges fell into two major categories: staffing difficulties and difficulty securing sustainability. Behavioral health programs commonly face difficulties in recruiting and retaining staff, as there is a dearth of providers available for these programs. Substance use disorder program positions are especially difficult to staff, as the salary levels are low for these positions, there are too few training programs to bring new workers into the field, and those who have been trained are often unwilling to work in underserved communities. The shortage of a trained workforce, especially in rural areas, led to staffing difficulties for many of CHRC's rural grantees. Similar problems hampered primary care partners and hospitals in rural areas, who also experienced staffing difficulties of their own. Grantees addressed this capacity problem in a number of ways, including student loan repayment initiatives, tax credits, salary increases, and training. These challenges may suggest that policymakers' calls for network adequacy should be coupled with calls to build and sustain a behavioral health workforce willing to serve all, including the underserved.

Sustaining programs after CHRC funds were expended

Grantees were also challenged with making their programs sustainable after grant funds were expended. The rates for Medicaid reimbursement, even after the expansion of Medicaid, were often insufficient to cover the costs of providing the care management and social supports needed by this population with complex needs. The Health Home model normally provides for a more realistic level of reimbursement, but Maryland's model is less comprehensive than other states. The Maryland Health Home model includes only psychiatric rehabilitation programs, mobile programs, or methadone

programs and serves only people who have a diagnosis of serious persistent mental illness, opioid substance use disorders (determined to be at risk for a second chronic condition), or children with serious emotional disturbance. For those who are not part of a Health Home, providers find that each entity – hospital, FQHC, primary care office, somatic specialist, and behavioral health provider – have a different funding stream, contracting procedure, and types of payment accepted. Sites must contract separately with each Managed Care Organization (MCO) and learn each MCO's set of rules for reimbursement for services. While individual grantees may work out contracting plans with MCOs and partner providers, policymakers should work on funding models to promote integrated care for vulnerable populations as has been found to be successful in other states such as Virginia's Comprehensive Services Act for At Risk Youth and Families which pools funding to provide comprehensive services for at risk youth, including those with disabilities.[1] Another example is Minnesota's Hennepin County Medicaid ACO model for expanded Medicaid recipients.[2] Since it is known that cost savings are generated by increased access to behavioral health services, payment reforms and improvements in the ease of contracting can lead to lower costs of care for the State. CHRC funding remains an important support to behavioral health and somatic care integration in lieu of these larger policy solutions.

Conclusion

The CHRC is playing a leading role in helping expand access to community-based integrated behavioral and primary care services and helping to build a growing safety net for people with substance use and mental health concerns. While the Commission's behavioral health grants provided services for more than 65,000 people, the success of these programs was greater than just the number of people touched and served. The success of CHRC's grants have shown that the innovative models of behavioral and somatic health care integration can lead to long-term community, family, and individual benefits, as well as tangible cost savings such as decreased ED utilization through improved access to somatic and behavioral health services. This work helps to highlight, and ultimately resolve, some challenges inherent in the work of bringing together disparate partners. Sites remain frustrated by challenges that require state level and national solutions including, changes to policy and regulatory barriers, increased access to data to help quantify savings and health improvements, and a larger and better trained workforce. CHRC grantees can provide the evidence to policymakers that will assist them in changing the laws and regulations needed to improve the quality of care for those suffering from behavioral health disorders.

[1] http://www.doe.virginia.gov/support/comprehensive_services_act/

[2] http://www.commonwealthfund.org/publications/case-studies/2016/oct/~/media/files/publications/case-study/2016/oct/1905_Hostetter_hennepin_hlt_case_study_v2.pdf