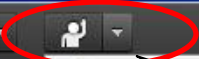
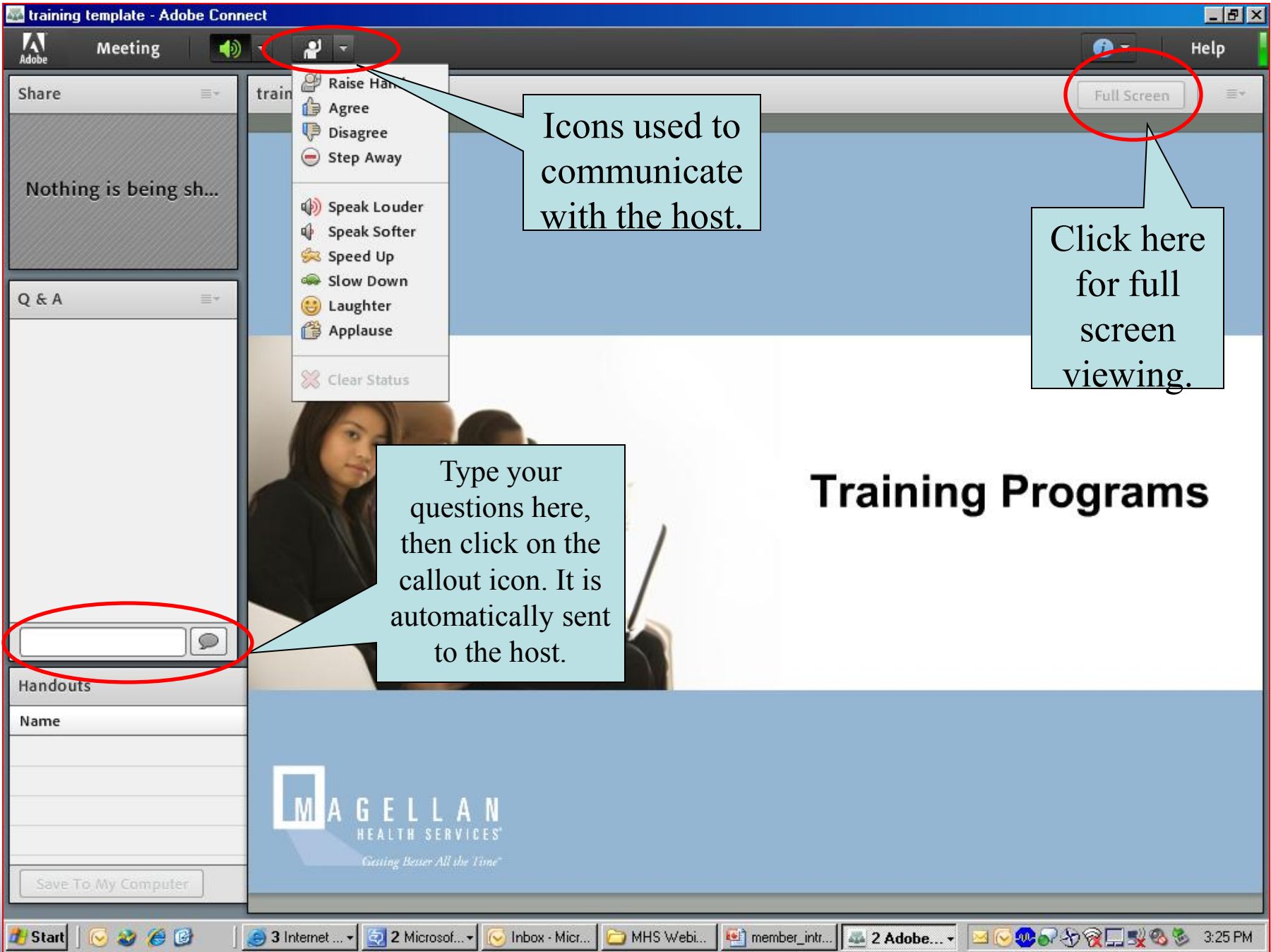




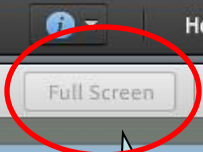
# From Specialty Care through Integration to a Comprehensive Person-centered System of Care: The Journey of Missouri and Crider Health Center





- Raise Hand
- Agree
- Disagree
- Step Away
- Speak Louder
- Speak Softer
- Speed Up
- Slow Down
- Laughter
- Applause
- Clear Status

Icons used to communicate with the host.



Click here for full screen viewing.

Type your questions here, then click on the callout icon. It is automatically sent to the host.



# Training Programs



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# Disclosures:

- Karl Wilson has no relevant financial relationship or commercial interest that could be reasonably construed as a conflict of interest.
- Dorn Schuffman has no relevant financial relationship or commercial interest that could be reasonably construed as a conflict of interest.

# Learning Objectives:

At the end of this exercise, the participant will be able to:

- Identify program and technology steps taken to address preparation for primary and behavioral health care integration,
- Describe the role of the integration of primary health and behavioral health care services in developing a comprehensive person-centered system of care, and
- Explain how plans are being crafted to move from integrated services to health care homes.

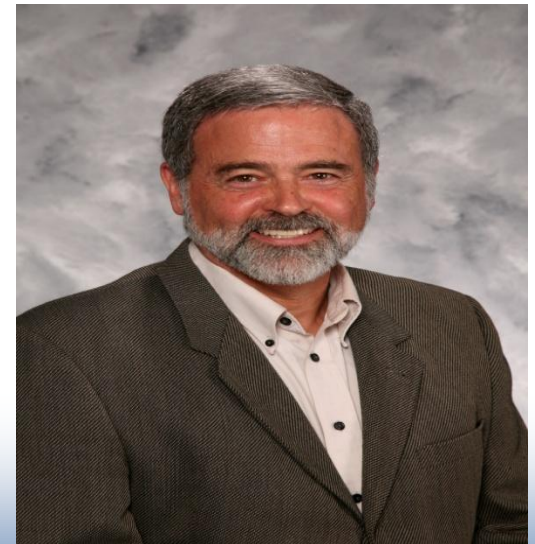
# About the Presenter:

- Dr. Karl Wilson is the first President and CEO of the Crider Health Center, which he has led for 32 years. This safety net community health and mental health center serves the Missouri counties of Lincoln, Warren, Franklin and St. Charles. He has taught at Washington University in St. Louis for 35 years, first in psychology and then in social work where he teaches Mental Health Policy. He has served as Chair of the Boards of Directors of the Missouri Coalition of Community Mental Health Centers, Mental Health America of Eastern Missouri, Missouri Foundation for Health, Non-Profit Services Center and Behavioral Health Response. He currently serves on the Boards of twelve non-profit local, regional and national organizations including Mental Health America, Missouri Health Connection (formerly Missouri Health Information Organization) and SSM Health Care St. Louis and SSM Cardinal Glennon Children's Hospital.



# About the Presenter: Dorn Schuffman

- Mr. Schuffman has over 30 years of experience in behavioral health care administration, including more than 20 years with the Missouri Department of Mental Health where he served as Director under both Democratic and Republican governors. Prior to serving as Director of the Department, Mr. Schuffman also served as Director of its Division of Comprehensive Psychiatric Services, CEO of a state operated mental health center, Director of Community Mental Health Services, and the Department's Chief of Planning. Since taking early retirement from state government, Mr. Schuffman has provided consultation to state agencies and community providers in strategic planning, privatization of public programs, and integration of primary and behavioral health care. Currently, Mr. Schuffman is consulting with the Missouri Department of Mental Health in the development of its CMHC Healthcare Home initiative by providing project management for the statewide effort. Mr. Schuffman is a Senior Consultant with Open Minds, a national consulting firm providing payers and providers in the health and human service industry with innovative solutions designed to improve operational strategic performance.





# The Impetus for Change

- Public mental health system
  - NASMHPD medical directors report 2006
    - Increased morbidity and mortality associated with serious mental illness largely due to
      - Metabolic disorders, cardiovascular disease, diabetes mellitus
      - High prevalence of modifiable risk (obesity, smoking)
      - Underutilization of established monitoring and treatment guidelines to lower risk
- Public primary care system
  - High percentage of patients with behavioral health problems
  - Increasing recognition of the importance of behavioral health supports to assist some individuals in managing their chronic diseases (diabetes) or improving health status (obesity, smoking)
- Public health payers
  - Quality improvement
  - Cost containment



## The Steps We've Taken

- Step One: Psychiatric Rehabilitation Program
  
- Step Two: Health Technology Tools
  - Data Analytics
    - Behavioral Pharmacy Management System
    - Disease Management Reports
    - Medication Adherence Reports
  - Cyber Access



## The Steps We've Taken

- Step Three: Integrating Primary and Behavioral Health Care
  - CMHC/FQHC collaborations
  
- Step Four: Embracing Wellness and Prevention
  - DMH Nurse Liaisons
  - Metabolic Syndrome Screening
  - DM 3700 Outreach Project
  
- The Natural Next Step: Healthcare Homes



# Missouri's Integration Initiative

- Missouri's initiative was as much about bringing two systems of care together, as it was about integrating primary and behavioral health care.
- Seven CMHC/FQHC partnerships
- Approach
  - Integrating behavioral health into primary care
  - Co-locating primary care
- Components
  - CMHC Behavioral Health Consultants (BHC) embedded in FQHC primary care teams
  - FQHC primary care clinics opened at CMHCs
  - CMHC psychiatric services provided at FQHCs (two sites)



# Missouri's Integration Initiative

## Lessons Learned

- Myths, misunderstandings, and real differences
  - CMHCs and FQHCs generally do not understand each other's funding sources and financing mechanisms, often leading to myths and misunderstandings.
  - Real differences, such as differences in approaches to consumer financial participation, do exist.
- “All politics are local”
  - Local conditions dictate nearly every aspect of the actual form, progress, and success of implementation.
  - The history of past collaborations influences progress.
  - The hard work of team building cannot be ignored.
- Training is vital
  - Primary and behavioral health care have very different cultures that must be addressed.
  - Clinical staff typically are asked to serve out of their comfort zone.



# Missouri's Integration Initiative

## Lessons Learned

- Sustainability
  - BHC services
    - Do not yet have a sustaining funding source
  - Primary care services
    - Primary care clinics are only financially sustainable where a very high volume of CMHC consumers routinely attend other programs.
    - FQHCs and CMHCs typically share more patients than they realize, therefore it is important to find ways to identify shared patients and share treatment information.
    - There must be a mechanism to cover the cost of services to uninsured CMHC consumers.

Health Care Reform holds out the hope of reducing the number of uninsured
- Psychiatric services
  - Primary care physicians will often assume the responsibility for care if psychiatric consultation is readily available, therefore it is important to have a mechanism to pay for consultation.
  - Must be leased, if the FQHC is going to bill for their services



# Missouri's Integration Initiative

## The Most Important Lessons

- Integrating BHC's into primary care is critical
- Assuring access to primary care is not enough



# Missouri's Healthcare Homes

- Missouri will have two types of Healthcare Homes
  - **Primary Care Chronic Conditions Healthcare Home**
    - Eligible Providers
      - Federally Qualified Health Centers (FQHCs)
      - Rural Health Centers (RHCs)
      - Physician practices
    - Building in Behavioral Health Consultants
  - **Community Mental Health Center Healthcare Home**
    - CMHCs and CMHC affiliates (Community Support Programs)





# Target Population

- Clients eligible for a CMHC Healthcare Home must meet one of the following three conditions (identified by patient health history):
  1. A serious and persistent mental illness
    - CPR eligible adults and kids with SED
  2. A mental health condition and substance use disorder
  3. A mental health condition and/or substance use disorder and one other chronic health condition



# Paving the Way for Healthcare Homes

## Target Population

- Chronic health conditions include:
  1. Diabetes
  2. Cardiovascular disease
  3. Chronic obstructive pulmonary disease (COPD)
    - Asthma
    - Chronic bronchitis
    - Emphysema
  4. Overweight (BMI >25)
  5. Tobacco use
  6. Developmental disability





# HH Functions: Added Emphasis

- Because healthcare homes take a “whole person” approach, we’ll continue and expand our emphasis on
  - Providing **health and wellness** education and opportunities
  - Assuring consumers receive the **preventive and primary care** they need
  - Assuring consumers with **chronic physical health conditions** receive the medical care they need and assisting them in managing their chronic illnesses and accessing needed community and social supports





# HH Functions: Added Emphasis

- Because healthcare homes take a “whole person” approach, we’ll continue and expand our emphasis on
  - Facilitating **general hospital admissions and discharges** related to general medical conditions in addition to mental health issues
  - Using **health technology** to assist in managing health care
  - Providing or arranging appropriate **education and supports for families** related to consumers’ general medical and chronic physical health conditions



# Healthcare Home Team

- Existing CMHC rehab teams will be augmented by adding:
  - A Healthcare Home Director responsible for implementing the health home and championing practice transformation based on health home principles
  - Consultation by a physician who provides medical leadership:
    - Participates in treatment planning
    - Consults with team psychiatrist
    - Consults regarding specific consumer health issues
    - Assists coordination with external medical providers
  - Additional Nurse Care Managers
  - Enhanced health coach training for CMHC case managers



# Paving the Way for Healthcare Homes

## Healthcare Home Care Team

- **Nurse Care Managers**

- Develop wellness and prevention initiatives
- Facilitate health education groups
- Participate in the initial treatment plan development for all of their Healthcare Home enrollees
- Assist in developing treatment plan healthcare goals for individuals with co-occurring chronic diseases
- Consult with CSSs about identified health conditions
- Assist in contacting medical providers and hospitals for admission/discharge





# Paving the Way for Healthcare Homes

## Healthcare Home Care Team

- **Nurse Care Managers**

- Provide training on medical diseases, treatments and medications
- Track required assessments and screenings
- Assist in implementing DMH Net health technology programs and initiatives (such as CyberAccess and metabolic screening)
- Monitor HIT tools and reports for treatment and medication alerts and hospital admissions/discharges
- Monitor and report performance measures and outcomes



# Crider Health Center

*Who we are, and  
Who we are becoming*

- Community Mental Health Center since 1979
- Community Health Center since 2006
  - Vision: Full, productive, healthy lives for everyone
  - Mission: To build resilience and promote health through community partnerships
  - Became FQHC in 2007
  - total budget FY12 = \$28m

# Who we Serve

- Service area:
  - Four Missouri counties: Lincoln, Warren, St. Charles and Franklin
- Children and Families
  - School-based prevention/ mental health promotion and early intervention (50,000 children and youth/year)
  - School- and home-based interventions (system of care)

# Who we Serve

- Adults with serious mental illness
  - Community Support Teams
  - Two ICCD certified clubhouses
    - Transitional and supported employment
  - Housing
    - Supported community living
    - Psychiatric group home
    - ISLs/ PISLs
    - HUD apartments



# Who we serve

- General public through three integrated care sites
  - Primary health care
  - Psychiatry and mental health supports
  - Pediatrics
  - Dentistry and oral health school outreach
  - One includes Ob/Gyn

 Crider HEALTH CENTER

ENTRANCE



Recognition Walkway



# Integration

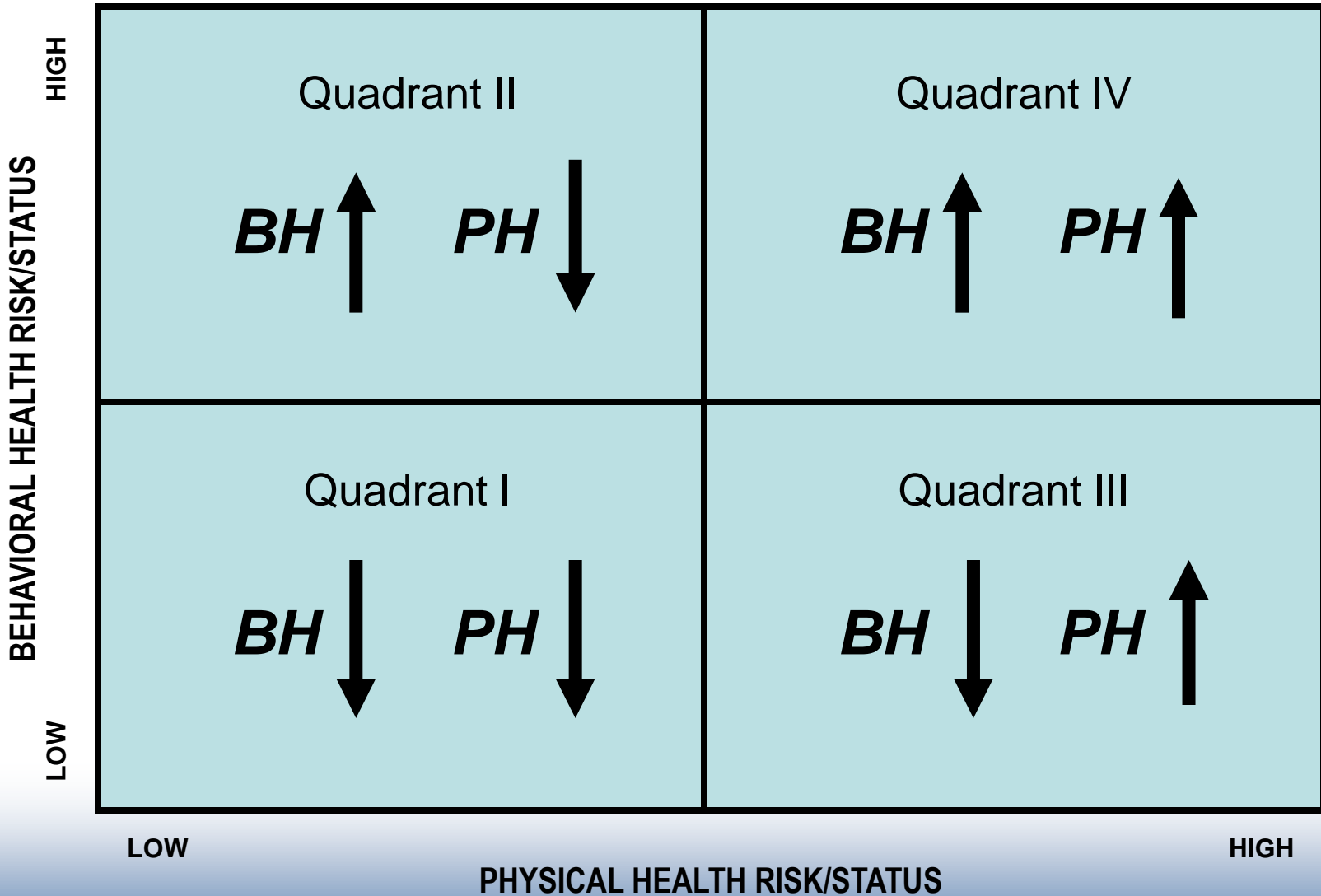
- Target population for integrated services:
  - Service area = 550,000
  - Uninsured/Underinsured = 83,000
- Objectives for Integration:
  - Create One Stop Shop' for consumers (transportation issues and driving distances)
  - Improve Outcomes: enhance monitoring and coordination of care
  - Increase ease of provider communication: team staffing and 'curbside' consults
- Integrated Strategy (after being a CMHC since 1979):
  - 1) Began primary care services (2006) using Cherokee HS model
  - 2) Became an FQHC (2007), expanded integrated services
  - 3) Began integrating Wellness with Recovery services (2010)

# Steps to Integration

- Centralized check-in
- Mental Health Professional (behaviorist) embedded in primary care team
- Screen every primary care patient for behavioral health problems and needs
- Screen every psychiatric consumer for medical and dental needs
- Adoption of an EMR capable of housing medical, dental and behavioral health data

# The Four Quadrant Clinical Integration Model

(from National Council for Community Behavioral Healthcare)



- Target Population: All Four Quadrants
- Quadrant I
  - Low BH complexity
    - » Some incidence of depression and anxiety
    - » Some individuals who are experiencing a period of stable recovery
  - Low physical health complexity and/or risk
- **Quadrant II**
  - High BH complexity and/or risk
    - Individuals with serious mental illness who are not experiencing a period of stable recovery
    - Individuals who may be some risk to themselves or others
    - Individuals who have chosen the specialty BH provider as their “clinical home
  - Low physical health complexity and risk

- Target Population: All Four Quadrants
- **Quadrant III**
  - Low BH complexity and risk
    - Some incidence of depression and anxiety which may be related to a primary medical condition
  - High physical health complexity and/or risk
    - Includes individuals with chronic medical illnesses and acute illnesses
- **Quadrant IV**
  - High BH complexity and risk
    - Adults with serious mental illness who are not experiencing a period of stable recovery
    - Adults who may be some risk to themselves or others
    - Adults who have chosen the specialty BH provider as their “clinical home
  - High physical health complexity and risk
    - Includes adults with chronic medical conditions and acute illnesses

- Behavioral Health Setting
- All mental health services clients screened for primary care needs.
- Quadrant 2
  - Are assigned a Community Support Worker (CSW) or Clinical Case Manager (CCM) and are receiving psychiatric services
  - The CSW or CCM serves as the individuals Health Coach
  - The CSW or CCM ensures that each individual on their caseload gets to their primary care appointments and may attend the PCP appointment if requested by the individual
  - The PCP may refer the individual to a Behavior Coach to assist with primary care patient-centered treatment planning or a variety of behavioral interventions.
  - The PCP can access psychiatric consultation, and may assume medication monitoring for some individuals

- Behavioral Health Setting
- Quadrant 4
  - Individuals in this quadrant require care from the behavioral health, primary care, and medical specialty sectors.
  - As a result, they require a truly integrated team that conducts regular consultative team meetings to coordinate care and address wellness issues.
  - In addition to the consumer, the team may include the CSW, CCM, specialty medical providers, PCP, Behavior and Health Coaches.

# *Behavioral Health Specialist (BHS), Psychologist or LCSW:*

- Partners with physicians to address behavioral health needs identified in the primary care setting.
- Develops joint plans with medical providers on behavioral health aspects of patient care.
- Provides crisis intervention, brief assessment and referral, behavioral interventions, and education for primary care patients with mental health, substance abuse, and issues of medical compliance.



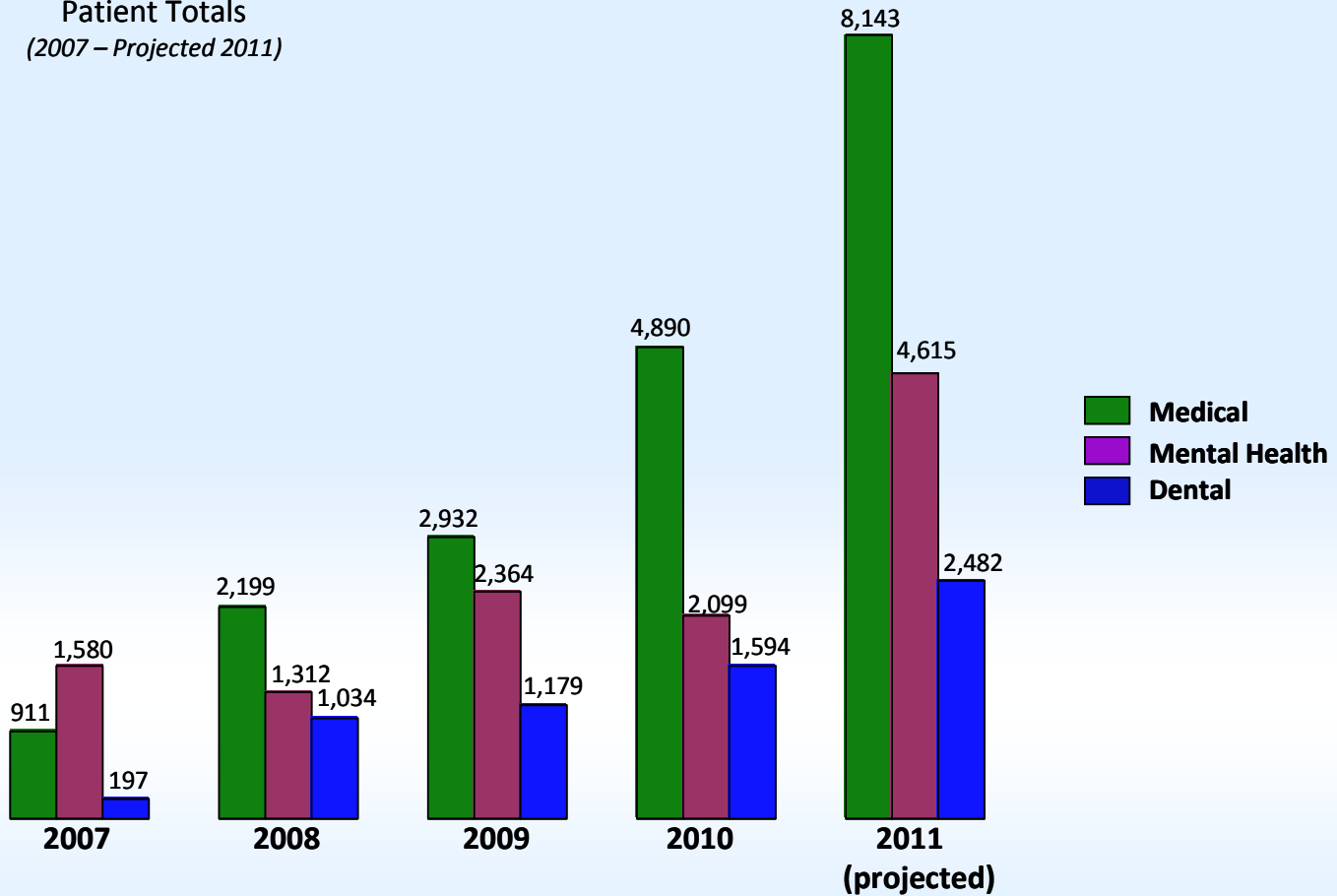
# Changing Roles in Behavioral Health

- *Community Support Workers, Care Coordinators, School Based Mental Health Specialists, Clinical Case Managers and Peer Specialists*
  - Supports clients in meeting their treatment plan goals identified in the primary care, mental health and dental health service settings.
  - Interacts with Behavioral Health Specialist, Medical Case Manager, and Nurse Liaison as needed.
  - New role: Health Coach – Health Navigator



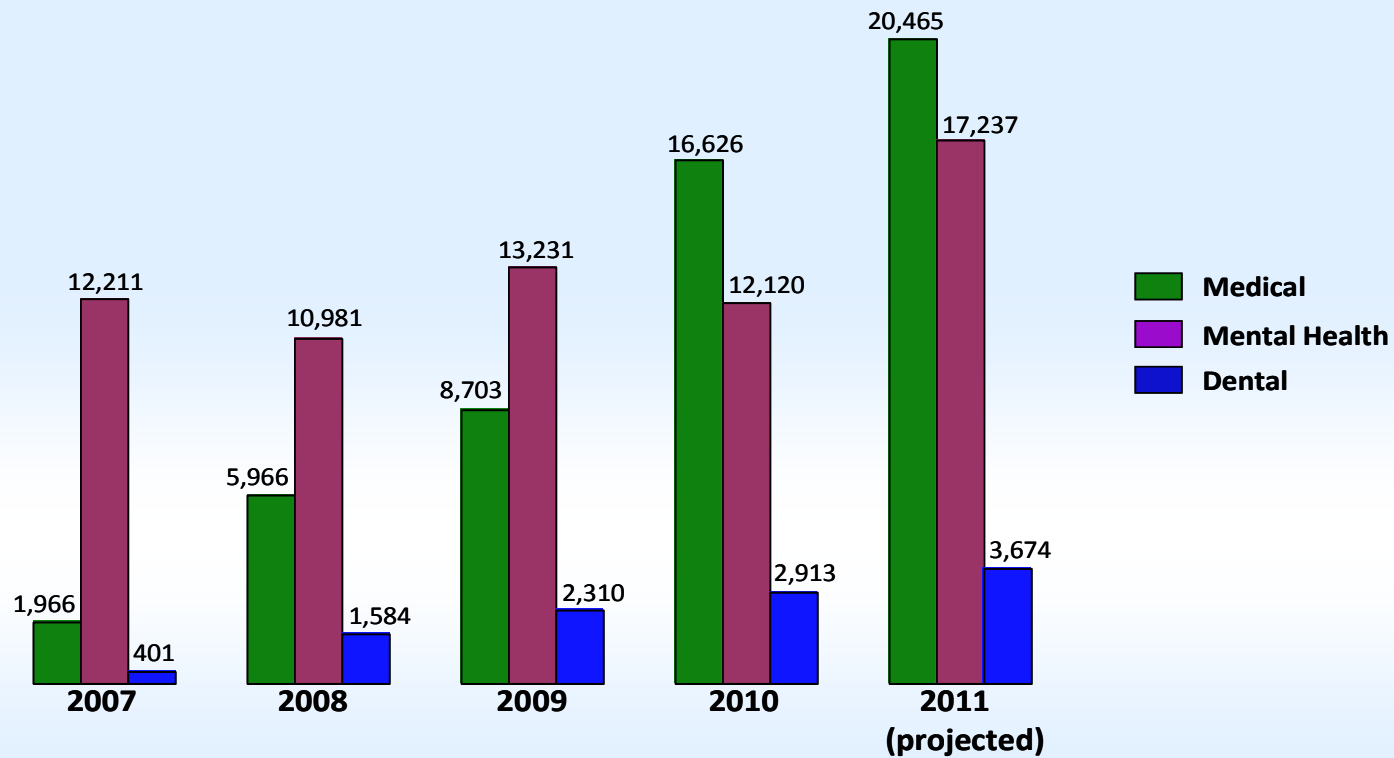
# Crider Health Center Patients 2007 – 2011 (projected)

**Crider Health Center**  
Patient Totals  
(2007 – Projected 2011)



# Crider Health Center Encounters 2007 – 2011 (projected)

**Crider Health Center**  
Encounter Totals  
(2007 – Projected 2011)



# Challenges

- EMR adoption
  - Lack of ‘one size fits all’ EMR
    - Adapting NextGen and converting from PsychConsult
  - Providers comfort with EMR use during visit
  - Providers decrease in productivity since EMR adoption
  - EMR implementation cost and roll-out time
  - Preparation for ‘Meaningful Use’ standards
- Capital costs (space and equipment)
- Culture change: length of time and amount of attention needed
- Workforce recruitment and retention

# Where are we going from here

- Expand clinic sites for better access and expanded integrated services
- Integrate Wellness with Recovery services
  - Extend wellness services to Clubhouses
    - Smoking cessation
    - Dietary education
    - Exercise
  - Train Community Support Workers (adult) and Care Coordinators (children and families) as navigators (extensions of health coaches)

# Where we go from here: Guiding Principles

- The outcomes of our services are reduced by distance:
  - Spatial distance
  - Temporal distance
  - Economic Distance
  - Psycho/social or cultural distance
- Wellness and Recovery need to be integrated
- Therefore: Integration of services is only a step toward building an optimal system of care:
  - *A Comprehensive Person-centered System of Care*



# Paving the Way for Healthcare Homes Expectations

- The Centers for Medicare and Medicaid Services (CMS) expect healthcare homes to:
  - Lower rates of emergency room use
  - Reduce in-hospital admissions and re-admissions
  - Reduce healthcare costs
  - Decrease reliance on long-term care facilities
  - Improve experience of care, quality of life and consumer satisfaction
  - Improve health outcomes
    - HEDIS indicators
    - Management of health conditions





# Paving the Way for Healthcare Homes

## Expectations: We can meet them

- A recent study of 6,757 consumers eligible for Missouri's Chronic Care Improvement Program (CCIP) served by CMHCs showed significant savings when compared with projected costs for this population
- These individuals had mental illness and one of the following conditions:
  - *Asthma*
  - *Pre-diabetes or diabetes*
  - *Cardiovascular disease*
  - *Chronic obstructive pulmonary disease (COPD)*
  - *Gastroesophageal reflux disease (GERD)*
  - *Sickle cell disease*





# Paving the Way for Healthcare Homes

## Expectations: We can meet them

### Cost Savings Analysis of CMHC Clients Enrolled in CCIP

Initial PMPM Cost	\$1,556
Expected PMPM Cost w/o intervention	\$1,815
Actual PMPM Cost following enrollment w/ CMHC	\$1,504
<b>Savings</b>	<b>\$21 million</b>

# References

1. “Morbidity and Mortality in People with Serious Mental Illness”, ed. by Parks, Joe MD; Svendsen, Dale MD; Singer, Patricia MD; and Foti, Mary Ellen MD; National Association of State Mental Health Program Directors, Medical Directors Council, Technical Report #13, October, 2006.
2. Mauer, Barbara J. MZW CMC and Druss, Benjamin G. MD MPH, “Mind and Body Reunited: Improving Care at the Behavioral and Primary Healthcare Interface”, report prepared for American College of Mental Health Administration Summit, Marck, 2007.
3. Schuffman, Dorn; Druss, Benjamin G. MD MPH, and Joe Parks, MD, “Mending Missouri’s Safety Net: Transforming Systems of Care by Integrating Primary and Behavioral Health Care”, Psychiatric Services, May, 2009, Vol. 60, No. 5.

# Questions and Answers

- Use the Q&A pod to type your questions for Dr. Wilson and Mr. Schuffman. We will attempt to get to as many questions as possible.
- Post webinar course evaluation and post test link – <http://www.surveymonkey.com/s/F82N5BN>
- For those seeking CE credits – post-test and course evaluation needs to be completed no later than 9:00 pm, Eastern, today.

# Upcoming Webinars

Children and Psychopharmacology with Dr.  
Brian Kennedy, Magellan Health Services

- October 18<sup>th</sup>, 2011, 2:00 – 3:30 p.m., Eastern

Behavioral Health Issues and Older Adults  
with Linda Shumaker, Pennsylvania  
Behavioral Health and Aging Coalition

- November 17<sup>th</sup>, 2011, 2:00 – 3:30 p.m., Eastern