DECEMBER 2018

EVALUATION REPORT BRIEF

Integrating Primary Care into Mental Health Care for Adults with Serious Mental Illness at Community Mental Health Centers in Texas

TEXAS STATE of MIND
THE MEADOWS MENTAL HEALTH POLICY INSTITUTE

INTRODUCTION

In 2014, the first year the Meadows Mental Health Policy Institute (MMHPI) was in operation, MMHPI partnered with the Texas Health and Human Services Commission (HHSC) and the Centers for Medicare and Medicaid Services (CMS) in supporting a study of primary and behavioral health care integration (PBHCI) programs implemented in a selection of Texas community mental health centers (CMHCs). The programs were funded through the Texas 1115(a) Medicaid Waiver Delivery System Reform Incentive Payment (DSRIP) pool, approved by CMS in 2011. DSRIP provided financial incentives to state-funded health care providers for creating a broad range of new programs that would expand access to services and improve the quality and cost-effectiveness of care.[1] DSRIP funds are used in Texas to provide hospitals and physician groups with incentive payments for improving health care infrastructure and initiating program innovation and redesign. A total of 33 CMHCs were using DSRIP funds to implement and support the integration of primary care and behavioral health services when the study began, specifically aiming to improve the care provided for people with serious mental illness (SMI). In December 2017, an extension of the 1115 Waiver was approved for an additional five-year period, with level funding for the first two years, decreasing funding for the next two years, and no funding for the fifth year to encourage providers to develop sustainability plans for the funded programs.[2]

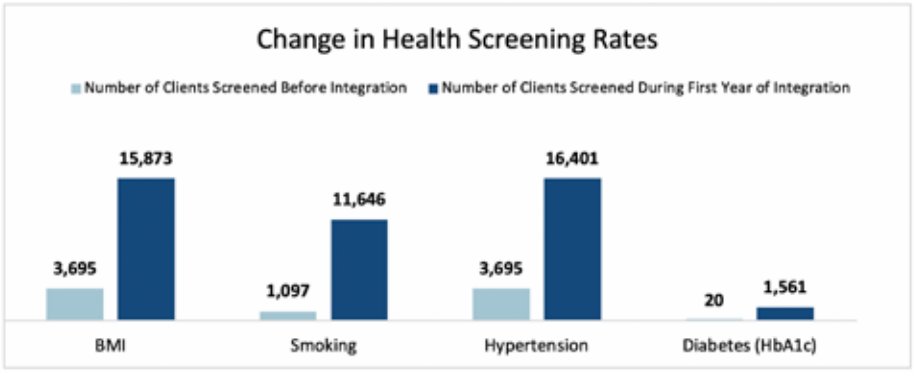
The PBHCI study was led by Dr. Rebecca Wells, who began the research while at Texas A&M Health Science Center School of Public Health and completed the project at The University of Texas Health Science Center at Houston School of Public Health (UTSPH). This evaluation report brief summarizes the major findings of the final report, titled Integrating Primary Care into Mental Health Care for Adults with Serious Mental Illness: Findings from 10 Texas Centers, and suggests key considerations for successful implementation of PBHCI in other provider organizations. Unless otherwise stated, the data and information provided in this document can be found in detail in the full report.[3] This research parallels other MMHPI endeavors to share information on integrated behavioral health (IBH), including a 2016 report developed in partnership with St. David's Foundation, which identifies and describes seven core components of best practice IBH programs.[4]

KEY FINDING: COST-RELATED OUTCOMES

The PBHCI study saw significant client improvement in both the average length of stay per hospitalization and overall hospital encounters, with the average length of stay per hospitalization decreasing by approximately 32% in the first year of integration. The study also found that patients with any hospitalization during the study period were 18% less likely, on average, to use hospital services during the first year of integration. These outcomes suggest patient health conditions were more stable once they received integrated care. The reduction in the number of hospitalizations and shortened length of stay once hospitalized also translated to cost savings. UTSPH researchers estimated that during the two-year period, more than $1,000 per patient per year was saved by reducing the likelihood of hospitalization and, for shorter lengths of stay, more than an additional $1,200 per hospitalization was saved from the accommodations portion of the cost alone.

KEY FINDING: SCREENING FOR CO-OCCURRING CONDITIONS

UTSPH researchers tracked several standard measures of PBHCI program performance. In this study, UTSPH examined programs' efforts to screen for co-occurring physical and behavioral health conditions (the fifth of seven core components cited in the MMHPI/St. David's Foundation IBH report) and found that once patients began receiving integrated care, overall patient screening rates increased for health measures such as body-mass index (BMI), smoking, blood pressure, and hemoglobin A1c (HbA1c) (a measure for diabetes). Routine screening that uses universal tools to identify the most common physical health conditions, such as diabetes and hypertension, can ensure early detection and treatment for identified physical health concerns alongside behavioral health needs. In the first year of the program, the average number of patients screened for various physical health concerns increased significantly: fourfold for the body mass index and hypertension, tenfold for smoking, and 78-fold for HbA1c. The accompanying chart shows the change in health screening rates over the first year of integrated care for seven CMHCs from which UTSPH was able to use pre-PBHCI and post-PBHCI data on these measures.



Note: N=18,505

KEY FINDING: PATIENT-LEVEL OUTCOMES AND EXPERIENCES OF CARE

The UTSPH research team measured aspects of patients' experiences of care, including access to care and participation in health coaching, which often includes good nutrition and exercise.

"My physical health needs are now met; it had been years since I'd seen a doctor."

All projects increased access to primary care and the majority used "warm hand-offs." A warm hand-off is a transfer of care between two members of the health care team, where the hand-off occurs in front of the patient and family.[5] Additionally, the CMHCs were able to achieve the PBHCI goal of ensuring same-day appointments and walk-in access, which, according to program leaders, increased primary care use and follow-through with medication and provider recommendations, including "prescriptions" for self-care activities.

"I'm not missing appointments now. It's easier to come to appointments in one place."

ADDITIONAL FINDINGS RELATED TO SUCCESSFUL PBHCI IMPLEMENTATION

Dr. Wells and her team also examined integrated care outcomes and many of the implementation factors identified in the 2016 MMHPI/St. David's IBH report.[6] The IBH report offers a road map for providers, funders, advocates, and policymakers who are interested in promoting PBHCI and working systematically toward achieving its promise. Core components that are critical to the successful implementation of PBHCI include elements such as an integrated organizational culture, where integration is actively supported by organization leadership and highlighted in the organization's vision and mission, and a population health management approach to care, which ensures that patients are assessed and differentiated by their prevalent co-occurring conditions and patterns of utilizing services, using information technology to help identify and support effective interventions at the right time.

Highlights of additional findings from the study are provided below. Where applicable, connections to the MMHPI/St. David's report on core components of integrated care are noted.

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PROGRAM COMPONENT	IMPLICATIONS FOR SUCCESS
STAFFING AND TEAM DEVELOPMENT	In this study, CMHCs that employed their own primary care providers, rather than contracting with a primary care provider or federally qualified heath center (FQHC), tended to have greater success during the program launch period in acclimating new staff to the behavioral health care environment. Furthermore, the findings underscore the importance of recruiting staff who are well-suited for PBHCI and providing ongoing staff development that rewards high-quality, team-based care (e.g., real-time collaboration, daily team meetings or "huddles," creating protocols for "warm handoffs"). This aligns with the MMHPI/St. David's core component that the "structured use of a team approach" is vital to successful implementation.
POPULATION HEALTH MANAGEMENT	Matching integrated clinical services to prevalent physical and mental health needs is the second core component in the MMHPI/St. David's Foundation IBH report. During the study period, PBHCI programs developed and adapted their integrated services to meet patient needs. At the time of the study, which occurred early in the integration process, fewer than half of the sites had access to data on intensive service utilization (e.g., emergency rooms, inpatient care), maintained patient registries, or utilized outcomes data to track performance. The metrics that were tracked showed an overall decline in the use of inpatient services. While this finding is encouraging, programs might achieve stronger outcomes if they adopted more sophisticated population health management practices, which would allow services to be tailored more specifically to identified patient needs. CMHCs found it difficult to access needed physical health care for conditions that the practices did not treat. Since the time of the study, the CMHCs have continued to seek opportunities to enhance their population health management information systems capacity.
PATIENT SATISFACTION	PBHCI programs may benefit from engaging patients in continuous quality improvement processes to increase opportunities for continually enhancing the program. Measuring patient satisfaction has the potential to help the CMHCs identify areas of strength and needed improvements, and help programs work toward higher levels of satisfaction, which may lead to better health results in general.[7]
PROGRAM SUSTAINABILITY	In this study, CMHC efforts were sometimes complicated by initial delays in managed care contracts, and several CMHC administrators commented on how difficult it will be to continue integrated care programs in the absence of a Medicaid financing strategy. Accordingly, PBHCI programs and their funders may benefit from developing financing and business plans that organize billing requirements, take advantage of new alternative payment models, and fully explore potential sources of revenue.[8]

PRIMARY AND BEHAVIORAL HEALTH CARE INTEGRATION BACKGROUND

Results from a 2006 study of life expectancy among people with serious mental illness (SMI) were pivotal in linking physical health and mental health outcomes, and suggested the need for drastic transformation in the U.S. health care delivery system.[9] The authors of the 2006 study reported that across the eight states in the study, which included Texas, adults with SMI on average died in their fifties – decades younger than people in the general population without SMI diagnoses. The leading causes of death among this group were heart disease, cancer, and cerebrovascular, respiratory, and lung diseases. Although these causes of death were similar to those in the general population, people with SMI had a higher prevalence of certain comorbid physical health concerns (such as diabetes, lung disease, and liver conditions), and were less likely to seek treatment for those physical health concerns because of difficulties associated with mental health needs such as access to care, poverty, lack of housing, and unemployment.

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Over the past decade, leading groups began to promote the integration of primary care and behavioral health services, which included integrating wellness and specialty care coordination services in community behavioral health settings. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) launched a primary and behavioral health care integration (PBHCI) program that funded hundreds of sites nationwide, including several in Texas. One key challenge in implementing PBHCI in community behavioral health settings is the limited amount of evidence-based research that has been conducted on the effectiveness of PBHCI programs for adults with SMI. Nationally, this research is in its early stages and no large-scale, multi-site research has previously been conducted in Texas. The study summarized in this report begins to address the research gap by examining how Texas CMHCs used DSRIP funds to implement PBHCI.

INTEGRATING CARE IN CMHCS

Of the 33 CMHCs in the state that use DSRIP funds for PBHCI, the study selected 10 CMHCs that serve adults in diverse rural and urban areas across the state. CMHCs that did not provide comprehensive services, such as programs only offering one key service (e.g., peer support, health care screenings, health education, or workforce development efforts) were excluded from the sample. The sample of 10 CMHCs had diverse operational structures and approached PBHCI in one of three ways: 1) hiring a primary care provider to deliver services on site; 2) contracting with a federally qualified health center (FQHC) to provide primary care services at the CMHC; or 3) contracting with an independent primary care provider.

UTSPH's study used information gathered from structured interviews with administrators, staff, and patients during site visits; data from patient records; and state hospital discharge records. The study then compared pre- and post-PBHCI data on implementation processes, patient outcomes, and costs for patients with SMI who received PBHCI services at the 10 CMHCs. First, the study examined the various strategies and structures that CMHCs used to implement PBHCI as well as the extent to which they were able to implement aspects of best practices.[10] Second, the study assessed staff experiences of providing integrated care and patient experiences of receiving PBHCI services. Third, the researchers calculated changes in health indicators for people over time. Finally, the study examined cost savings related to hospital use before and after PBHCI implementation, providing preliminary estimates of potential costs savings related to implementing PBHCI in CMHCs.

FINANCING AND SUSTAINABILITY OF INTEGRATED CARE

This evaluation project did not include financing needs as a primary focus. However, addressing these needs is critical to ensuring the sustainability of programming. As discussed earlier in this brief, the Texas 1115(a) Medicaid Waiver was extended for an additional four years: full funding will continue in 2018 and 2019, partial funding will be provided in 2020 and 2021, and funding will be discontinued in 2022. This phasing-out of funding in the fifth year presents a need for CMHCs to address the sustainability of IBH programming and identify funding options that will support continued advancements to integrate care without DSRIP funding.

Participation in the Certified Community Behavioral Health Clinic (CCBHC) program is one way that CMHCs can help support IBH programing. Although Texas was not chosen for the SAMHSA CCBHC demonstration program, HHSC continues to work with the CMHCs that were certified as CCBHCs (including seven that were certified during the SAMHSA planning grant), as well as additional CMHCs, to implement the Texas CCBHC pilot project. HHSC plans to expand the CCBHC model of care in Texas and will require alternative payment methodologies for CCBHCs, which would have the potential for delivering multidisciplinary, team-based comprehensive care.

The MMHPI/St. David's Foundation report on core components of integrated care emphasizes the importance of several financial strategies that can

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help sustain integrated care programming over time in a variety of settings. An important starting point, of course, is to carefully examine and take full advantage of the financing opportunities available from private insurance, some of which are beginning to include value-based payments and other alternatives to fee-for-service reimbursement (in the UTSPH study sample, however, only 8% of the patients had insurance other than Medicaid or Medicare). When a significant portion of the client population is on Medicaid, establishing partnerships with FQHCs could be an effective, financially sustainable approach to delivering IBH. FQHCs under contract with Medicaid managed care organizations (MCOs) receive incentive payments beyond the MCOs' contracted payment for reimbursable services. CMHCs do not receive additional payments that the FQHCs collect, but could obtain higher reimbursements if they are partnered with FQHCs. However, as this study shows, FQHC partnerships may include challenges such as a slower acclimation of physical health care staff to the behavioral healthcare environment.

Finally, by using compelling data that show successful implementation of IBH, providers sometimes have the option of negotiating with insurers to pilot new approaches for financing key components of IBH care that are not always easy to finance, including care coordination and even wellness and preventive interventions. Providers might also consider approaches to alternative payment methods that have the potential to more adequately cover costs using the delivery of multidisciplinary, team-based care.

[1] Texas Health and Human Services Commission. (n.d.). *Waiver overview and background resources.* Retrieved from: https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/waiver-overview-background-resources

[2] Full text of the renewal letter can be found at https://hhs.texas.gov/sites/default/files//documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/1115renewal-cmsletter.pdf.

[3] Wells, R., Kite, B., & Breckenridge, E. (2017, May). *Integrating primary care into mental health care for adults with serious mental illness: Findings from 10 Texas centers*. Houston, TX: The University of Texas Health Science Center at Houston School of Public Health.

[4] Meadows Mental Health Policy Institute. (2016, August). *Best practices in integrated behavioral health: Identifying and implementing core components.* Austin, TX: St. David's Foundation. The full report can be accessed online at: http://texasstateofmind.org/wp-content/uploads/2016/09/Meadows_IBHreport_FINAL_9.8.16.pdf.

[5] Retrieved from https://www.ahrq.gov/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/interventions/warmhandoff.html.)

[6] Meadows Mental Health Policy Institute. (2016, August).

[7] Price, R. A., Elliott, M. N., Zaslavsky, A. M., Hays, R. D., Lehrman, W. G., Rybowski, L., Edgman-Levitan, S., & Cleary, P. D. (2014). Examining the role of patient experience surveys in measuring health care quality. *Medical Care Research and Review*, *71*(5), 522–554.

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[9] Colton, C. W., & Manderscheid, R. W. (2006). Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing Chronic Disease*, *3*(2), 1–14.

[10] Meadows Mental Health Policy Institute. (2016, August).

Support for the study was provided by the Meadows Mental Health Policy Institute and the Texas Health and Human Services Commission (HHSC). The full report was authored by Rebecca Wells, Ellen Breckenridge, and Bobbie Kite at The University of Texas School of Public Health; and Sasha Ajaz and Aman Narayan at Rice University. The report authors would like to thank Tenaya Sunbury, Sarah Roper-Coleman, and Angie Cummings at the Texas HHSC, and Jolene Rasmussen at Texas Council of Community Centers for their instrumental support of this study, as well all the health care professionals, patients, and academic colleagues who provided guidance and other invaluable contributions.

This evaluation report brief was prepared by Kendal Perry, Assistant Director of Evaluation; Lauren Roth, Project Manager, and Jim Zahniser, Senior Director of Evaluation Design. MMHPI team members who provided content and peer review include Andy Keller, President and Chief Executive Officer; Michele R. Guzmán, Vice President of Administration and Senior Director of Evaluation; Nelson Jarrin, Senior Director of Government Affairs; Sam Shore, Senior Director of State-Local Collaboration, and Monica Thyssen, Senior Director of Health Policy. Editorial review provided by Bill Wilson, Senior Clinical Editor. Graphic design was provided by Chris Thiele, Graphic Designer. MMHPI would like to thank the full report authors as well as Monica Smoot, Daniel Dillon, and Gary Rutenberg at Texas HHSC for their contributions to this evaluation report brief.

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