Mental Health Integration Pilot Program Summary

Community Care of North Carolina

2007
BACKGROUND

Several networks in the Community Care of North Carolina (CCNC) program began seeing an increasing number of Medicaid enrollees at primary care provider practices with both behavioral and physical health care needs. As a result of efforts in mental health reform and changes in the local service delivery infrastructure, four CCNC networks working in concert with their local management entities (LMEs) began piloting (in July 2005) a collaborative approach to managing Medicaid enrollees who have both behavioral and physical health needs and serve them in the most appropriate setting. The mental health integration pilot is a state level collaboration between the Division of Mental Health, the Division of Medical Assistance, the Office of Rural Health and Community Care (ORHCC), and the North Carolina Foundation for Advanced Health Programs, Inc. This two year pilot began in July 2005 and ended in June 2007.

PROGRAM SUMMARY

The primary goal of the mental health integration pilots was to work on program model development that focused on:

- Integrating the identification and care of depression in the primary care provider’s office;
- Implementing the Four Quadrant Model as the platform for screening, identification, and triage of complex needs patients (combined medical and behavioral concerns); and
- Demonstrating effectiveness in communication and consultation between primary care physicians and mental health providers.

The pilots aimed to do the following:

- increase the comfort level of primary care providers (PCPs) in identifying and treating people with depression who present in their office;
- improve communication between the PCPs and behavioral health care providers;
- adopt standardized screening, assessment, reporting and communication tools;
- implement psychiatric telephone consultations;
- implement co-location models, when feasible;
- ensure, through improved coordination, that patients are able to access care at a point in the system where their health and behavioral health needs are optimally met; and
- adopt uniform process and outcome measurements for program evaluation.
Each network targeted both the adult and pediatric population (this last group broken out by age: 0-5 and 6 and older) using the Four Quadrant Clinical Integration Model as the foundation for communication, collaboration, assessment, referral and clinical management of care. Using CCNC’s web-based case management system, the networks and LME staff were able to document and share information. To ensure that data collection is comparable across projects, common forms and tools have been developed including a telephone consultation form, behavioral health assessment form, case consultation request form, and provider surveys. In addition, based upon the patient’s age, a common set of primary screening tools were chosen: ASQ or PEDS for 0-5; PSC or Y-PSC for 6-18; and PHQ 9 for 18 and older.

The four networks and LMEs involved in the pilot were: Access II Care of Western North Carolina and Western Highlands; Southern Piedmont Community Care Plan and Piedmont Behavioral Healthcare; Central Piedmont Access II and CenterPoint Human Services; and Partnership for Health Management and the Guilford Center.

All networks implemented a universal screening tool and clinical pathway for depression. In addition to the standardized efforts mentioned above, the pilots aimed to demonstrate the following:

- **Access II Care of Western North Carolina** provided incentives to PCPs to complete behavioral risk screenings and to have a trained therapist or an RN following the clinical pathway and administering the evidence based screenings at critical points of care. They planned to develop a system for psychiatric back-up to support the PCPs treating behavioral health issues in the office. And, by analyzing Medicaid claims, Access II Care of Western NC identified population management strategies for both physical and behavioral health care.

- **Southern Piedmont Community Care Plan** identified the screening tools that work best in the PCP setting to identify individuals with depression, ADD, anxiety, conduct disorder, and bipolar disorder. In addition they aimed to develop protocols for determination of Four Quadrant Model assignments. Focused education was given to providers and improvement of consumer self-management skills and participation in disease management programs was an integral part of their initiative. A steering committee comprised of medical and behavioral health physicians and professionals provided planning and oversight to the activities.

- **Northwest Community Care** implemented a co-location model by placing a behavioral specialist in the PCP practice and integrated the school system to target elementary aged children. By creating structured opportunities, such as “collaborative rounds”, Central Piedmont increased the collaboration between PCPs and the mental health providers and created mechanisms for linking mental health and primary care services.

- **Partnership for Health Management** provided ongoing physician education and conducted regularly scheduled lunchtime case discussions/pharmacology reviews between LME providers and PCPs. A dedicated care manager focused on implementation and transition activities. ADHD, depression, and early childhood mental health are specific areas of interest for Partnership for Health Management.

All of the networks have adopted a uniform provider survey format and the preliminary baseline survey has been completed for both primary and behavioral health care providers. The pilots used a uniform and standardized survey instrument, and they completed another survey again at the end of the pilot project. The baseline survey found the following: both behavioral and physical health providers desired
better communication between disciplines and physical health providers wanted to feel more comfortable with prescribing and treatment modalities for depression, ADHD, adjustment disorder, and anxiety.

The outcome and performance measures will be captured through the web-based case management system and through paid claims. These include the rates and PMPM costs for: pharmacy, outpatient visits, ED visits, hospitalizations, psychotherapy visits, overall Medicaid costs, and overall screening rates. Other desired information included: missed school or work days, no-show rates, medication adherence, patient reported functional status, information on telephone consultations, and screening tools.

The lessons learned in the mental health integration pilots have led into a new pilot of co-location models. The infrastructure and models developed and implemented by the pilots will be able to support replication and expansion efforts in other networks and communities and serve as a foundation for the co-location pilots. A model that is able to integrate behavioral and physical healthcare needs will demonstrate the value of a chronic care management model that is patient-centric and able to identify and meet all the needs of an individual.

### DATA DISCUSSION

Across all four pilot networks there was agreement that relationship building between physical and behavioral health care providers is paramount for a successful program. Each network approached this endeavor with their own flavor and creativity, such as hosting “brown bag lunch exchanges”, evening mixers and socials and inviting behavioral health care providers to medical management committee meetings. We have learned that the LME needs to be represented on the network boards and /or steering committees so that partnerships and collaborative efforts begin early.

The four pilot networks captured information on a cohort of individuals that were identified with depression. The following graphs describe the characteristics of the mental health integration cohorts.

The selection of patients for participation in the CCNC Mental Health Pilots was made by the networks in the project. These patients were given screening tests for mental health and then, based on the scores, referred for inclusion into the treatment models. During the two year period there were 547 selected for participation in the four sites. The Medicaid IDs of these patients were matched against claims data to find out their demographic characteristics and their service utilization.
Figure 1 shows the percentage of females and non-whites (excluding those of unknown race). Both percentages were higher than the proportions for the entire patient population in CCNC. The percentage of non-whites was 18 percentage points higher (63% versus 45%) and the proportion on females was 19 percentage points higher (74% versus 55%). The average age was also significantly higher than for the CCNC population as a whole (24.9 versus 15.5).

The admission rates to Inpatient (IP) and to Emergency Departments (ED) are partial measures of success in finding community alternatives for the treatment of this population. The rates are standardized to 1000 member months as patients may vary in the number of months enrolled in CCNC during any given year. The data presented here is a baseline measuring the utilization of these services at one point in time. Subsequent data will allow rate comparison across time. Figure 2 charts the rates. Admissions are counted if a patient was admitted with any diagnosis during the period of time prior to the beginning of the pilot mental health program. These two years constitute the baseline.

*Admissions include any admissions to ED and IP, regardless of diagnosis.
Another measure of treatment effectiveness is the percentage of patients who have a second admission to IP or ED after having been admitted once. Figure 3 demonstrates that, for patients with one ED admission during the two year cycle, 47% were admitted a second time. For patients with at least one admission to IP during the two year period, 19% were admitted a second time to an inpatient facility.

The number of visits to mental health facilities is another utilization measure that gauges the extent to which these patients avail themselves of services in the community. The rate of 649 visits per 1,000 member months is high and is in line with the expectation that these clients used mental health services to a significant extent during the two year period. Another way to describe this statistic is to say that if a patient in these cohorts were enrolled for 12 months in CCNC, he/she would visit a mental health office an average of 7.8 times per year.

The final study on the MHI pilots will be completed by the fall of 2007. The networks are still collecting information to submit to the program evaluator. The final evaluation will also be made available on the CCNC website.

Provider toolkits, communication and referral forms, and screening tools are available for networks to download and use from the CCNC website: www.communitycarenc.com
PRACTICE & PROVIDER SUPPORTS

One of the pilots, Buncombe County, has taken the integration effort to a higher level. Buncombe County community providers, including Western Highlands, MAHEC, Access II Care of Western NC, and Buncombe County Health Department, have developed a successful integration initiative that includes a community-wide planning and implementation process, a very successful depression project, co-location of a psychiatrist in MAHEC family practice sites, phone consultation support for primary care physicians, and “meet and greet” sessions where behavioral health providers and physical health providers can get to know each other.

This type of collaborative process is now being implemented in other communities including Cumberland County, where key community organizations (FAHEC, Carolina Collaborative Community Care, Cumberland County Health Department, Cape Fear Valley Health System, and the LME) are meeting to plan a similar behavioral health integration initiative.

Co-location Pilot Grants – with the joint cooperation of our Medicaid Division and Office of Rural Health and Community Care, the Community Care program is providing co-location grants to primary care practices to improve mental health access for Medicaid enrollees by encouraging the co-location of primary and behavioral health services. Start-up funds are being provided to 41 primary care practices and 3 behavioral health care centers (reverse co-location with a primary care provider in a behavioral health care setting) to implement a co-location model in 12 CCNC networks. These new pilots will include the mental health integration pilot networks and also include some new networks and practices.

The purpose of the grant, which cannot exceed $25,000 per practice – is to help offset the start-up costs involved in co-locating a psychiatrist, psychologist, mental health social worker, or mental health physician assistant/nurse practitioner in a participating primary care practice. There is a companion piece which will also provide a start-up grant for a primary care physician co-locating in a mental health practice (reverse co-location). CCNC is working closely with the ICARE project (ICARE = Integrated, Collaborative, Accessible, Respectful and Evidence-Based) to maximize resources and avoid duplicating efforts and technical assistance. The ICARE project is a three year project with a focus on statewide education and assistance, local model development, and process and policy change. Their website will also include useful information, tools, forms and screenings and can be found at: www.icarenc.org