The Community Mental Health Authority of Clinton, Eaton, and Ingham Counties

# Health Care Innovation and Integration

## Shaping and Responding to the Changing Health Care Environment

Status Report – April 2013

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### Executive Summary

The health care environment, always in flux, has been changing even more rapidly over the past several years, with a focus on improved integration between physical and behavioral health care. In an effort to **shape and respond to these changes**, the Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMH) has, for the past several years, embarked on a number of initiatives, spanning many dimensions of the organization's operations.

The **major drivers of these initiatives** include:

**1.** The emergence of the **triple aim** as a unifying principle across the health care sectors. The triple aim framework drives the nation's health care system to:

- Improve the patient (consumer) experience of care (including quality and satisfaction)
- Improve the health of populations
- Reduce the per capita cost of health care

**2.** The recognition of the need for better health care integration and coordination to fulfill the triple aim – often fulfilled by organizations playing the role of **"integrators"** 1

**3.** The projected **increase in the demand for a wide range of behavioral health care and developmental disability services** - as a result of greater access to health care coverage and the growing recognition of the importance of behavioral healthcare as a core component of this nation's health care system.

**4.** The growing recognition that the continued strength and **centrality of state's public behavioral healthcare and developmental disability service system this system**, one of the most advanced in the nation, as a key component key to advancing Michigan's health care system and its ability to achieve the triple aim.

**5. The value of using the concept of identifiable market segments to link, in strategy and action, the factors regarding increased demand and the desire to retain the central role of Michigan's public behavioral care system.** By tailoring its approach to the needs of the consumers and payers within each of these markets, CMH can best ensure that it thrives and provides high quality, outcome-driven, cost-efficient care.

1 The triple aim and the roles of the integrator are discussed in what has become a seminal article by Berwick, Nolan, and Whittington, in Health Affairs [*Health Affairs* 27, no. 3 (2008): 759–769] and are reinforced in the Triple Aim Concept Design of the Institute for Healthcare Improvement.

**CMH's multi-dimension approach**

Seeing the issue of integration of primary and behavioral care as requiring action on a number of fronts, this CMH initiated a number of parallel efforts. These efforts centered around the following dimensions of health care integration:

1. Pursue a **multi-faceted health care integration initiative**:
    A. Establishing **bi-directional co-location** initiatives:
        1. Behavioral care providers at primary care sites
        2. Primary care providers at a CMH behavioral care site
    B. **Partnering with primary care provider for house calls** to aging CMH consumers
    C. **Facilitated referrals** for CMH consumers, by CMH, with primary care providers
    D. **Healthy lifestyles education**, by consumers, with consumers
    E. **Expanded health checks** within the behavioral health care visit
    F. **Joint educational efforts** (coordination of care learning events) of behavioral and primary care providers
2. Develop into a **comprehensive range behavioral health and developmental disabilities (MI, DD, and SUD) care manager and provider**
    A. Becoming the **Substance Use Disorder Coordinating Agency (CA) for the 8 county region surrounding Lansing.**
3. **Expand access to services for previously un-served or underserved persons** and build CMH's expertise, exposure, and experience in healthcare markets which are **emerging in the changing health care environment**
    **A. Serve previously unserved and underserved persons** with a range of behavioral health and developmental disability needs
    B. Development of **regional autism center**, to serve persons previously unserved and underserved
    C. Expanding services to **children served in the public child welfare system**
4. Operate an **in-house pharmacy** to foster the coordinated management of physical health and mental health medications
5. Operate and continually develop of sound **electronic health record,** ensure continued progress toward interoperability with other healthcare systems, and pursue active involvement in state and local electronic medical record technology initiatives.
6. Address the health care needs **of persons with patterns of utilizing high levels of health care resources**
    A. **Joint financing of sub-acute detox center** by local hospitals, county health plans, substance abuse coordinating agency, and CMH
    B. **Coordination of care between emergency departments** within local hospitals and the CMH system
    C. **Joint effort with Medicaid Health Plans**, in addressing the needs of high utilizers of health care resources
7. Continually apply **evidence-based and promising practices** in meeting the behavioral health and developmental disability needs of the community.
8. Ensure a **strong role for the behavioral and developmental disability provider sector and this organization within the changing healthcare environment**:
    A. Participation in **state level policy discussions** related to the changing health care environment

B. Actively participate in the design and formation of a **21 county regional Medicaid Prepaid Health Plan**

C. Participation in statewide, regional, and local community **health care coalitions**

9. Ensure that CMH's **workforce is of the capacity, diversity, and skill level** needed to meet the growing demand for a diverse behavioral healthcare and developmental disability services

A. **Aggressive recruitment, retention, and promotion strategies**

B. On-going **tailored training of CMH staff and stakeholders** on a range of issues related to the changing health care environment

10. **Ensure that consumers have health insurance coverage** and that CMH can meet the demands of multiple payers and coverage options

11. Ensure that CMH has a **welcoming environment and a customer orientation** at all of its sites and in all of its interactions with all stakeholders: consumers, families, community partners, and CMH colleagues

12. Ensure that CMH has a valid, reliable, flexible, relevant, and sustainable **outcome measurement system** – refining it within the behavioral health care domains and expanding it to reflect physical healthcare measures

13. Revise and expanded the **identity, role and purpose of this CMH** to match its work

14. Establish a **central, internal clearinghouse and learning venue** for organizing CMH's work in this effort

In pursuing this work – as described below- **CMH assumed a number of roles:**

- **Catalyst or convener for integration and innovation**
- **Leader of integration and innovation efforts**
- **Partner within integration or innovation efforts**

The full report, Health Care Innovation and Integration, is available at CMH's website: www.ceicmh.org. Click on the "CMH Resources" tab on the left side of the website and then on the "Healthcare Update" button on the left side of that page.

## A. Impetus behind the Innovation and Integration effort

The health care environment, always in flux, has been changing even more rapidly over the past several years, with a focus on improved integration between physical and behavioral health care. Some of the key drivers of these changes, with greatest relevance to the Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMH) and those whom this organization serves include:

**1. Triple Aim:** The emergence of the triple aim as a unifying principle across the health care sectors. **The triple aim framework** drives the nation's health care system to:

- Improve the patient (consumer) experience of care (including quality and satisfaction)
- Improve the health of populations
  - This includes the growing recognition of the need to prevent he premature death of persons with serious mental illness
- Reduce the per capita cost of health care
  - This includes reducing the inappropriate use or over-use of a range of health care and human services to meet the needs of persons with developmental disabilities, substance use disorders, or mental illness and children and adolescents with emotional disturbance

**2. Key role of Integrators**: The recognition of the need for better health care integration and coordination to fulfill the triple aim – often fulfilled by organizations playing the role of "integrators"

**Role of integrator**: Leading thinkers, writers, and policy makers underscore that the triple aim can be achieved only with several preconditions, one of which is an organization, known as integrator, that accepts responsibility for all three aims for a given population. As described by Don Berwick, et al (Dr. Berwick is the former Director of the federal Centers for Medicare and Medicaid Services (CMS)), "the integrator's role includes at least five components: 2

- partnership with individuals and families
- redesign of primary care
- population health management
- financial management
- macro system integration

**3. Increased Demand for Behavioral Healthcare**: Over the next few years, health care systems will see a steady, sometimes dramatic, increase in the demand for a wide range of behavioral health care and developmental disability services - as a result of greater access to health care coverage (as a result of a number of public and private efforts, including but not limited to the

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federal Patient Protection and Affordable Care Act (ACA) ) and the growing recognition of the importance of behavioral healthcare as a core component of this nation's health care system.

**4. Central Role of the Public Behavioral and Developmental Disability Services System:** The state's public behavioral healthcare and developmental disability service system has served, for decades, as the safety net provider system for persons with a wide range of mental health, substance use disorder, and developmental disability needs**.** While many persons who now have little access to behavioral health care, because they lack health care coverage, will have access due to the ACA, the **competition for the provision and care management of services to these populations is likely to be considerable**.

Providers who had not, formerly, been interested in serving these persons, will now be interested in entering this market given the new sources and levels of reimbursement and financing which the ACA makes available. **The continued strength, centrality, and focus of this system, one of the most advanced in the nation, is key to advancing Michigan's health care system and its ability to achieve the triple aim.**

Spurred by these drivers, CMH has launched, over the past several years, an aggressive set of efforts – addressing this issue from a number of fronts. Given the continual growth in number of these efforts and the rapidity at which these efforts move, it seems wise to take stock of the progress made, to date, in this sphere of our work. This document provides such a status check.

## B. CMH's multi-dimension approach

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1. Pursue a **multi-faceted health care integration initiative**:
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A. **Joint financing of sub-acute detox center** by local hospitals, county health plans, substance abuse coordinating agency, and CMH

B. **Coordination of care between emergency departments** within local hospitals and the CMH system

C. **Joint effort with Medicaid Health Plans**, in addressing the needs of high utilizers of health care resources

7. Continually apply **evidence-based and promising practices** in meeting the behavioral health and developmental disability needs of the community.

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B. Actively participate in the design and formation of a **21 county regional Medicaid Prepaid Health Plan**

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11. Ensure that CMH has a **welcoming environment and a customer orientation** at all of its sites and in all of its interactions with all stakeholders: consumers, families, community partners, and CMH colleagues

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## C. Progress to date

### 1. Pursue a multi-faceted health care integration initiative:

**A. Establishing Bi-directional co-location initiatives:**

**1. Behavioral care providers at primary care sites**

**i. CMH staff or contractors at the site**: Mental health therapists and psychiatrists and/or psychiatric nurses are located at **nine primary care clinics throughout the tri-county region**:

- Three Lansing-based Federally Qualified Health Center (FQHC) clinics, operated by the Ingham County Health Department. Currently, over 800 clients, each year, are receiving mental health services at these three sites each year.
- One primary care clinic, in Charlotte, operated by the Barry-Eaton District Health Department.
- One primary care clinic, in St. Johns, operated by the Mid Michigan District Health Department.
- Two adolescent/pediatric health clinics operated by the Ingham County Health Department.
- One multi-specialty private medical practice, within the McLaren Health System, with a high proportion of Medicaid recipients.
- One free/low cost clinic (Care Free Medical and Dental, Inc.).

**ii. CMH support or supervision of students placed at the site**: In a partnership with Care Free Medical and Dental, Inc. (a free clinic operated by a Lansing-based non-profit organization), CMH's AMHS staff provide in-service training on a variety of behavioral health care subjects, over the course of the academic year, to the social work graduate and undergraduate students providing mental health care at the clinic. CMH has also provided a part time therapist at this site who may refer consumers to a psychiatrist. The AMHS Program supervisor is a permanent member of the Care Free Medical Behavioral Health Planning Committee.

**iii. Crisis recovery assistance for Sparrow Family Health Primary Care Clinic:** The Sparrow Family Health Primary Care Clinic may directly refer consumers with high behavioral health needs to the CMH Crisis Recovery Team. Services to individual consumers referred through this process are available for up to 90 days.

**2. Primary care clinic within CMH site**: A workgroup comprised of staff from this CMH, Michigan State University, the Sparrow Family Medicine Residency Program and the Ingham County Health Department's Federally Qualified Health Centers (FQHC) have designed a primary care clinic to be housed within CMH's Lansing offices. This clinic serves the chronic, acute, and well-check needs of CMH consumers who have little or no access to primary care. As of the end of September 2012, this clinic had an 84.2% show rate among scheduled clients, which is very high by industry standards. This indicates a community demand for this service. The clinic served 23 consumers in its first 8 clinic days.

- **Phase 1**, opened in June 2012, provides two ½ days per month of primary care to CMH consumers at CMH's Jolly Road, Lansing offices
- **Phase 2,** April 2013, as a FQHC-look-alike, 40 hours per week
- **Phase 3**, June 2014, expansion to 6 exam rooms, CMH's RN caremanager to join FQHC primary care team

**B. Partnering with primary care provider for house calls to aging CMH consumers:** For over 20 years, CMH has partnered with a Geriatrician (a primary care physician specializing in care to seniors) from the Senior Health Center of Sparrow, to provide home visits to consumers residing in CMH homes designed to meet the needs of older adults. Annual physicals are completed in the geriatrician's office, with quarterly appointments being held at the consumer's home. A nurse from CMH's Older Adult Services (OAS) accompanies the physician during these home visits, and, along with the residential facility's staff, provides the coordination and follow up of the recommendations. This has enabled:

**i.** an increase in coordination of care between the CMH psychiatrist and geriatrician when discussing side effects of both medical and psychotropic medications.
**ii.** a decrease if office visits and/or diversion from medical and psychiatric hospitalizations when the OAS nurse can discuss, directly with the geriatrician, any medical concerns they may have, including those which can be assessed with lab work or other testing.
**iii.** consumers who have a history of refusing medical care, have been more open to care when they meet the primary care physician in their own home with a familiar face (OAS nurse) and can build a trusting relationship before being physically examined.

**C. Facilitated referrals for CMH consumers, by CMH, with primary care providers:** The mental health care provided to all CMH consumers who receive case management or supports coordination services as part of that package of services, is coordinated with the primary care providers treating these consumers. While this coordination varies widely – depending upon the complexity and frequency of the primary and behavioral care being received by the consumer- it includes, at a minimum, a release of information allowing the behavioral care staff to communicate with the primary care staff. CMH staff may also arrange transportation to primary care sites, implement primary care instructions or apply treatment recommendations. In some instances, staff is directly involved in primary care discharge and may inform primary care providers on whether the consumer's home environment is adequate for fulfilling medical needs. Additionally, for those consumers receiving medication clinic services, a letter is sent to the primary care provider providing him or her with the psychiatric diagnosis and a list of psychiatric medications that have prescribed by the CMH physician.

**D. Healthy lifestyles education, by consumers, with consumers:** Customer Service Specialists/Peer Support Specialists regularly provide a modified series of education seminars on wellness and healthy lifestyles. These programs, known as Personal Action Towards Health (PATH) Wellness Recovery Action Plan (WRAP), Smoking Cessation, Mental Health First Aid and Solutions to Wellness, have been or are scheduled to be provided to a number of adult consumers with serious mental illness and in some cases to the general public (Mental Health First Aid). Additionally, the nursing staff within CMH's Older Adult Services (OAS) program (serving older adults with serious mental illness) provide portions of the Solutions to Wellness modules for OAS consumers.

**E. Health checks, by CMH staff or contractors, within the behavioral health care visit:** Blood pressure, pulse, height and weight health measurements are done in the psychiatric clinics of all CMH case

management teams serving adults with serious mental illness. In the Older Adults Services (OAS) this is done regularly; in the medication clinics associated with other case management teams, such health checks occur less regularly and are dependent on the recommendation of the psychiatrist. Laboratory studies are performed when need is indicated at least once a year. This may happen more often depending on consumer medications.

**F. Joint educational efforts (coordination of care learning events) of behavioral and primary care providers***:* CMH initiated the Coordination of Care Dinner/Seminars Series in 2007 in an effort to increase coordination of care between mental health and primary care/physical health care providers. Prior to this initiative, several other efforts with the same goal had been implemented without measurable success. Research to find a better approach, led to the identification of a study, by a Canadian research team, which found (to no one's surprise) that providers who meet face-to face with other providers are more apt to initiate a contact to discuss concerns about mutual patients. Based on these findings, the coordination of care dinner/seminar series was initiated, as the method to foster face-to-face contact and provide a joint learning experience. CMH staff believed that three components would most likely bring primary and behavioral care providers together: an educational topic of provider interest, a good meal, and Continuing Education Credits.

To date, CMH has held 17 dinner/seminars with an additional 5 scheduled for 2013. Over 1,200 clinicians have attended these dinners. The programs have been well received and have proved to be a venue that promotes discussions between mental health and primary care providers during the evenings and subsequent to the seminars. These events will soon be open to professionals from across the newly formed Midstate regional group. Starting in February 2013, there are plans to add two elements to these events in the spirit of deepened collaboration and coordination:

1. Professionals will be encouraged to bring case studies to stimulate inter-agency and inter-disciplinary discussion. Confidential client information will be omitted.
2. There will be a generally increased emphasis on networking. CEI-CMH psychiatrists will be encouraged to share their experiences with community physicians and vice-versa.

The programs are presented live in Lansing and are simulcast to Manistee, Benzie, Newaygo and Gratiot Counties. The programs are being expanded to include participants from the newly formed 21 county Midstate region of which the CMHA-CEI Affiliation is part.

As indicated by the list of seminar topics that have been presented through this seminar series, below, the speakers present on topics related to mental health and how they can be addressed in the primary care practice. A sampling of some of the topics and presenters featured in this series includes:

| Topic | Presenter |
|---|---|
| Assessing the Risks of Treatment Strategies for Persons with Mental Illness | Dr. George Grunberger, MD, Endocrinology<br>Dr. James Adamo, MD, Psychiatry |
| Morbidity and Mortality Study for Persons with Serious Mental Illness | Dr. Joseph Parks, MD,<br>Director Missouri State Department of Mental Health |
| Michigan Pharmacy Quality Improvement Project: Lessons Learned | Dr. Debbie Eggleston, MD, Medical Services Administration, MDCH<br>Dr. Jonathan Henry, MD, Medical Director CMHA-CEI |

| | |
|---|---|
| Pain Management: A Difficult Dilemma | Dr. John Baker, MD, CMHA-CEI and the MidSouth Substance Abuse Commission |
| ADHD in Children and Adults | Dr. Andrew Homa, MD,<br>Chief, Children's Services, CMHA-CEI |
| Approaching Suspected Bipolar Disorder in the Primary Care Setting | Dr. Jonathan Henry, MD<br>Medical Director, CMHA-CEI |
| Using and Managing Anti-psychotics in the Primary Care Setting | Dr. Karen Blackman, MD and Dr. Amy Odom, DO<br>MSU College of Human Medicine |
| Treatment of Substance Abuse in Primary Care | Dr. Brian Bonfardin, MD,<br>Director SA Services, Mountain Home VA |
| Hypertension and other Cardiometabolic Disorders in persons with Bipolar Disorder | Dr. Dale D'Mello, MD<br>MSU College of Human Medicine |
| Early Identification and Treatment of Eating Disorders in the Primary Care Setting | Dr. Jim VanHaren, MD<br>Forest View Hospital, Grand Rapids, MI |
| Psychiatric Emergencies | Dr. Kathy M. Sanders, MD<br>MGH/McLean Adult Psychiatry |
| Psychological Trauma- A Dynamic Treatment Approach | Dr. Colin A Ross, MD<br>Colin Ross Institute, Boston, MA, Forest View Hospital |
| Medical Marijuana, Drug or Medicine | A Panel Presentation led by Dr. David Picone, DO, Medical Director, CMHA-CEI |
| Pain Management | Jon-Kar Zubieta, MD, PHD<br>University of Michigan |
| Prescribing and Managing Psychotropics in the Primary Care Setting | Dr Jonathan Henry, MD<br>Central Michigan CMH, MSU |
| Bipolar Disorder | Dr. Karen Blackman, MD and Dr. Amy Odom, DO<br>MSU College of Human Medicine |
| Genetics and Genetic Testing in Psychiatric Patients | Dr. Sainen Wei, PhD,<br>MSU Genetics Department |

| **2013 Tentative Schedule** | |
|---|---|
| Monitoring and Management of Metabolic Disorders in the Context of Psychotropic Medications | Dr. W. Craig Washington, MD<br>Adjunct Professor, U of M Dept of Psychiatry |
| PTSD | Dr. Jeff Frey, DO, Assistant Prof of Psychiatry, MSU, and Veteran |
| ADHD | Dr. Jed Magen DO, MS Associate Prof and Chair of Psychiatry, MSU |
| Autism | Dr. Jeanette Scheid, MD, PhD, Associate Prof of Psychiatry, MSU |
| Pain Management | Panel: David Picone, DO, George Smith MD, , Baker, MD, Harris, DO, Pharmacy |
| Depression & Chronic med illnesses | Psychiatrist & primary care (TBD) |

**2. Development into a comprehensive behavioral health and developmental disabilities (MI, DD, and SUD) care manager and provider:** As of October 1, 2012, this CMH assumed the Substance Abuse Coordinating Agency role previously administered by the Mid South Substance Abuse Commission. In this role, CMH serves as the public funding body and coordinator for substance use disorder prevention and treatment for the eight county region which includes: Clinton, Eaton, Gratiot, Hillsdale, Ingham, Ionia, Jackson, and Newaygo Counties.

- For the first time in this area, this integration creates a single system for the organization of the region's public mental health, developmental disabilities (DD), and substance use disorder (SUD) provider network.
- This integration will bring about new efficiencies for consumer services across the spectrum of cognitive and behavioral health.
- This integration also improves CMH's ability to integrate the full range of behavioral health care services, including SUD, with the primary care system.
- Within 6-8 months, online training via the "Essential Learning" system will be up and running to provide SUD specialists with cutting edge knowledge related to their practice and improved opportunities to fulfill continuing education requirements.

**3. Expand access to services for previously un-served or underserved persons and build CMH's expertise, exposure, and experience in healthcare markets which are emerging in the changing health care environment**

**A. Serve previously unserved and underserved persons with a range of behavioral health and developmental disability needs:** CMH, over the past several years, has focused on expanding its reach to the previously unserved and underserved persons with a range of behavioral health and developmental disability needs via the addition of therapy and psychiatric staff to meet the needs of Medicaid enrollees with mild to moderate mental health needs. These efforts have paid off, with significant gains in this CMH's ability to reached the previously unserved, as illustrated below:

| | | Populations with the greatest increase in consumers served | |
|---|---|---|---|
| | Total All CMH Consumers | Adults with Mental Illness | Persons with Developmental Disabilities |
| FY 2008 | 9,353 | 3,684 | 1639 |
| FY 2012 | 10,634 | 5,143 | 1754 |
| Absolute increase in numbers of consumers served | 1,281 | 1,459 | 115 |
| Percentage increase in numbers of consumers served from 2008 through 2012 | 13.7% | 39.6% | 7.0% |

**B. Development of regional autism center, to serve persons previously unserved and underserved:** Current plans include the provision of a new evidence based practice therapy called Applied Behavioral Analysis. This therapy will receive additional funding from private insurance and Medicaid. Occupational therapy and speech therapy will also be among the services offered. This regional autism center will also offer case management, in-home care, and respite for primary caregivers. This program will be housed in its own new facility and will have a focus on prevention and early intervention, with a community education element. Most services are expected to be available by early 2013.

**C. Expanding services to children served in the public child welfare system**: This CMH has had a two decades long history, most recently through its federally funded System of Care Initiative, of working with children, adolescents, and their families who are also served by the public and private child welfare system – those under the jurisdiction of the Michigan Department of Human Services (MDHS). By actively participating in the Incentive Initiative, begun in July 2012 by the Michigan Department of Community Health (MDCH) and the Michigan Department of Human Services (MDHS), CMH entered into a new cooperative initiative with the local MDHS partners designed to streamline funding and reduce duplication of services, including children's counseling services. CMH's Children' Services program is working to take advantage of this developing collaboration to improve consumer services.

**4. Operate an in-house pharmacy to foster the coordinated management of physical health and mental health medications**: For over a decade, this CMH has provided in-house pharmacy services to its consumers. St. John Pharmacy, a subsidiary of St. John Providence Health Systems, on contract with CMH, provides a full range of pharmacy services for our consumers and staff.

The in-house pharmacy dispenses all medications (medical and psychiatric) for consumers who receive community-based services from CMH, including those who live in CMH group homes and those who live in other Adult Foster Care homes, not operated by CMH nor its contractors.

By locating the pharmacy within CMH's Jolly Road offices, where close to a 2500 consumers are served by medication clinics, CMH has have found that the convenience of filling prescriptions at the same location as the prescription is written encourages consumers who live independently to also use our pharmacy for psychiatric and other medications.

The pharmacy:

- fills over 14,000 prescriptions per month
- makes over 1,100 medication deliveries per month

The in-house pharmacy fosters primary and behavioral care integration and improved quality of care by:

- provides 24 hour/day on call service for staff for questions & emergency prescription deliveries
- notifies clinicians of potential drug interactions
- coordinates extensive sample stock program and, jointly with CMH, patient assistance programs (PAP) - ensuring that consumers without insurance can access needed medication
- alerting prescribers when prescriptions are not filled or medications are requested to be refilled too early

- Dispensing medications in formats that best meet the needs of each consumer/patient: blister packaging and other unit dose systems which assist in ensuring that the correct dose is taken at the correct time

**5. Operate and continually develop of sound electronic health record system**: CMH has pursued a focused effort to ensure continued progress toward interoperability with other healthcare systems, and pursue active involvement in state and local electronic medical record technology initiatives.
CMH has had an **electronic health record (EHR) for over a decade** and continually works to refine and expand the reach of the EHR system. The current efforts in this dimension include:

- The examination of CMH's current EHR software platform in light of other EHR software packages
- Increasing the technical support for the 700 users of the EHR, including over 220 clinical laptops which allow for EHR record entry and retrieval in the field, in the homes, workplaces, schools, and health care sites of CMH consumers
- building an electronic link between the CMH EHR and the ERH of the primary care clinics in which CMH has co-located staff
- retooling, within the EHR, all of the core clinical forms with features designed to enhance clinical communication, supervisor/peer review, and work flow efficiency

CMH is involved in two separate initiatives aimed at allowing improving treatment by allowing mental health and physical health professionals to share consumer medical information electronically.

CMH was one of the founding members of, currently holds a board seat on, and is actively involved in clinical information sharing with the **Great Lakes Health Information Exchange** (GLHIE). GLHIE, serving the capital region and the broader mid-Michigan area was created with state sponsorship to serve as the region's health information exchange and build an information system to allow local providers to share healthcare records. Currently, several of CMH's psychiatric staff are exchanging records, through GLHIE, with other health care providers in the region, thus improving the coordination of care provided to CMH consumers. By early 2013, this CMH is on track to be able to pull consumer records directly from GLHIE into its own electronic record keeping system.

At the State level, this CMH works with the **Michigan Health Information Network** (MiHIN), as it designs the technical infrastructure that will eventually allow such sharing of information. This work started with the Governor's "Conduit to Care" planning document in 2006. This CMH was selected to represent the needs of the behavioral healthcare community on the MiHIN Privacy and Security committee.

Additionally, this CMH is leading the effort, by the Michigan Association of Community Mental Health Boards (MACMHB) and the Michigan Department of Community Health (MDCH) to build a set of data bridges between the CMH system and its network of behavioral healthcare providers. This CMH is currently on the verge of producing continuity of care documents using a standard electronic format that is computer friendly across a variety of systems. This system is expected to be in place in early 2013.

**6. Address the health care needs of persons with patterns of utilizing high levels of health care resources**

**A. Joint financing of sub-acute detox center by local hospitals, county health plans, substance abuse coordinating agency, and CMH**: CMH operates a subacute-clinical detoxification program in Lansing's central city, guided and funded in partnership with a number of health care and human services providers (Sparrow Health System, Ingham Regional Medical Center, Mid-South Substance Abuse Commission, Ingham Health Plan, City of Lansing's Human Relations and Community Services Department, City of Lansing's Fire and Police Departments, Lansing City Rescue Mission, Volunteers of America, National Council on Alcoholism, and Michigan State University's Olin Medical Center). The Center aims to:

- improve care for persons with substance abuse disorders
- improve access, by those persons, to a range of recovery, health, and human services
- preventing the inappropriate use of hospital Emergency Departments, and the in appropriate use of law enforcement and emergency medical personnel.

The collaborative nature of this initiative has resulted in:

- Utilization increase of 387% growth rate
- High successful completion rate: Over 77% of the persons served completed their detoxification treatment at the Center
- High rates of engagement in on-going treatment: Of those who successfully completed treatment at the Center, 62.6% of them were admitted to on-going treatment

**B. Coordination of care between emergency departments within local hospitals and the CMH system**: CMH is involved in three efforts related to the coordination of care between the Emergency Departments of local hospitals and CMH.

During 2009, staff of this CMH and the Emergency Department (ED) physicians of the two largest health care systems in the region: the Sparrow Health System (SHS) and McLaren-Greater Lansing identified a wide range of issues of common concern. The major accomplishments, to date, of this partnership has resulted in the development of **a unified Emergency Department Clearance for Psychiatric Evaluations that will be used by the Emergency Departments of both health systems**. It should be noted that this unified clearance is a unique community-based health care tool and is rarely found in communities of this size or complexity.

**C. Joint effort with Medicaid Health Plans and County Health Plans, in addressing the needs of high utilizers of health care resources**: CMH is involved in two efforts aimed at addressing this issue.

1. Through their participation in the Coordination of Care Dinner Seminars (described above), Physicians Health Plan (PHP) proposed a joint effort, with CMH, to identify mutual patients/consumers who are high utilizers of medical and psychiatric services and to develop, collaboratively, methods to:

    - Improve the overall mental and physical health of these patients/consumers
    - Reduce the hospitalization rates, for both psychiatric and medical causes

- Better manage care in both physical health and mental health settings

High utilizers of services were defined as those persons who: receive more intensive outpatient services than the average patient/consumer, have higher, than average, usage of emergency services for both psychiatric and medical reasons, Have complex medication regimens

This program is in its infancy, with the early signs of the value of increased collaboration starting to show.

2. The second initiative, in its early stages, involves the participation of CMH staff in the Utilization Management Committee of the Ingham Health Plan (IHP). The IHP provides primary health care and, for some enrollees, inpatient care, for low income persons who do not have access to Medicaid, Medicare, nor commercial insurance. CMH's involvement was sought by the IHP to work to develop behavioral health care approaches to more appropriately meeting the needs of IHP enrollees with patterns of high health care service use. This effort is expected to bear fruit over the next year.

**7. Continually apply evidence-based and promising practices in meeting the behavioral health and developmental disability needs of the community:** By applying research-based, practice-based, outcome-based and continuous quality improvement approaches to service delivery, CMH has adopted a number of clinical Evidence Based Practices ("EBPs"; these are intervention technologies that have been formally recognized as having a strong research basis) or Promising Practices (these are practices that have nearly enough research support to qualify as EPBs and may be officially designated as EPBs in the near future).

These technologies are used alongside a range of other interventions (often known as practice based evidence – practices that lack a national research basis, but have proven successful as measured by CMH, with the use of standardized outcome measures)

The following grid lists the EBPs or Promising Practices that are used by CMH to serve consumers with developmental disabilities, mental illness and emotional disturbance.

| PRACTICES: | Persons with Developmental Disabilities | Adults with Mental Illness | Children and Adolescents with Emotional Disturbance |
|---|---|---|---|
| Assertive Community Treatment | | X | |
| Certified Peer Support Specialists | | X | |
| Cognitive Behavior Therapy | | X | X |
| Consumer Operated Services Program | | X | |
| Co-occuring Disorders: Integrated Dual Diagnosis Treatment | | X | |
| Dialectical Behavior Therapy | X | X | X |
| Family Psychoeducation | | X | |
| Jail Diversion | | X | |
| Motivational Interviewing | | X | |
| Parent Management Training - Oregon Model | | | X |
| Supported Employment | X | X | |
| Wraparound | X | | X |

**8. Ensure a strong role for the behavioral and developmental disability provider sector and this organization within the changing healthcare environment:**

**A. Participation in state level policy initiatives related to the changing health care environment**: This CMH is an active participant in dozens of state-level policy initiatives, including:

- Involvement in learning collaborative with other CMHs and PIHPs relative to integrated health care.
- State-level political action to ensure that CMH is key player in system serving dually enrolled persons (Medicare and Medicaid) - to ensure that these consumers continue to receive high quality, community-based care.
- Involvement in MDCH-MACMHB visioning workgroup – to develop model for the future structure and function of the state's public behavioral health and developmental disabilities system.

**B. Actively participate in the design and formation of a 21 county regional Medicaid Prepaid Health Plan:** In response to an initiative of the Michigan Department of Community Health (MDCH) to reduce the number of the state's Specialty Prepaid Inpatient Health Plans (PIHPs), this CMH joined eleven other CMHs to begin the design and formation of a 21-county regional PIHP. The formation of this regional PIHP is an integral part of four component proposal being made by the Michigan Association

of Community Mental Health Boards (MACMHB) to MDCH. The MACMHB four part plan includes proposals on the development of:

- Specialty Safety Net Accountable Care Organizations (ACOs)
- Patient Centered Health Homes
- Greater role for the CMHSP system in the management of the state mental health hospital system
- New regional realignment of the state's system of Prepaid Inpatient Health Plans (PIHPs)

The area to be served through this regional realignment includes 21 counties in Michigan:
Arenac, Bay, Huron, Montcalm, Shiawassee, Tuscola, Clare, Gladwin, Isabella, Mecosta, Midland, Osceola, Clinton, Eaton, Ingham, Ionia, Gratiot, Newaygo, Jackson, Hillsdale and Saginaw.
The map of this region is attached.

This regional PIHP (known, for the time being, as Midstate PIHP) meets all of the MDCH criteria for new region design:

1.Covers at least one logical health trading areas
2.Contains a sufficient number of Medicaid covered lives, and Medicaid-Medicare dually covered lives, to result in actuarially sound risk protection
Medicaid covered lives: 371,760
Medicaid-Medicare dually covered lives: 33,423
Seventeen percent (17%) of the total number of Medicaid and dual eligible beneficiaries in Michigan reside in the counties that comprise this new region.
3.Sufficient size to achieve administrative efficiency
4. Contiguous counties
5. Keep CMHSPs whole and ensure a seamless transition for consumers and their families
6. Consider both current Prepaid Inpatient Health Plan (PIHP) regions as context

Additionally, this region aligns with the major system transformation initiatives being pursued within the state and nationally:

1. Provider-sponsored plan design ensures strong consumer focus
2. Increased regionalization of risk management supports development of local accountable care organizations
3. Recognition of CMHSPs as the foundation for specialty behavioral health homes for persons with severe and persistent mental illness, substance use disorders and developmental disabilities
4. Preserves the essential role of habilitative services necessary for recovery and self-determination
5. Supports the continued state and county partnership related to public mental health services

**C. Participation in statewide, regional, and local community health care coalitions:** CMH is involved in dozens of community coalitions, addressing a wide range of human services and community needs. A number of those coalitions revolve around health care. Two of those coalitions, of which CMH has a seat on the Board of Directors, are: the Lansing Latino Health Alliance and the Capital Area Health Alliance. Both work to address, in an integrated way, the physical and mental health needs of this community.

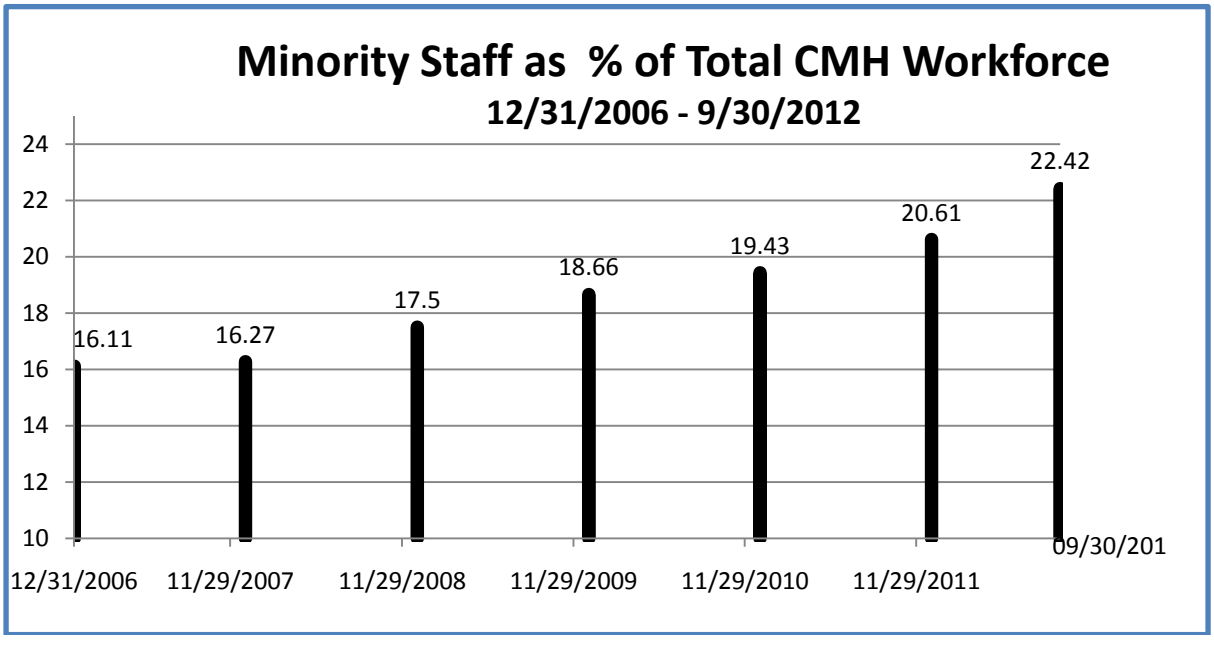
**9. Ensure that CMH's workforce is of the capacity, diversity, and skill level needed to meet the growing demand for diverse behavioral healthcare and developmental disability services**

**A. Pursue aggressive recruitment, retention, and promotion strategies:** To keep pace with the increasing demand for behavioral health services and to better serve an increasingly diverse community, this CMH has pursued a number of human resources initiatives, including:

1. Partnering with the CMH Human Resources Offices and non-CMH Human Resources professionals from across the state, nation, and Affiliation to intensify recruitment and retention efforts

2. Since 2005, CMH has worked to strengthen the organization's diversity and cultural competence. Guided by the Diversity Advisory Council (DAC) – a group made up of consumers and staff from across CMH, CMH Board members, and labor representatives – has applied a range of approaches to ensuring that the power of a diverse and culturally competent CMH workforce is available to meet the needs of this community
    - cultural competence training
    - aggressive employee recruitment
    - multilingual electronic and hard copy materials
    - management mentoring program under development

While there are many ways to measure the diversity and cultural competence of an organization, the degree to which the staff make-up matches that of the community served by the organization is one very concrete measure. As the analysis below indicates, the focus on achieving a diverse workforce has been successful, with the percentage of CMH represented by racial and ethnic minorities climbing every year since the initiation of the organization's focus on diversity and cultural competence – as highlighted in the following chart. To provide some context, the racial and ethnic minority population in the tri-county community makes up 14.5% of the entire population.



**B. On-going tailored training of CMH staff and stakeholders on a range of issues related to the changing health care environment :** Over the past year, CMH staff have been following the implementation of a number of ACA-related efforts and other changes in the health care environment. This has led to a number of exposure and training efforts, including:

- semi-monthly review of CMH's senior management of concepts and supporting documents related to the ACA, its implementation, and other health care environment changes spurred by the ACA
- Placement of a number of key ACA-related documents on CMH's intranet (internal website):
    - within the Reference, Healthcare Reform-ACA site
    - within the Reference, Leadership, Affordable Care Act Handouts site
- Discussion and slide show at CMH Mangers' meeting in the fall of 2012 on the major themes contained in the ACA and CMH's response to it
- Presentation to CMH staff at CMH's Clinical Excellence Committee fall 2012 in-service, on the major themes within the ACA
- Dozens of CMH staff attend the Michigan Association of Community Mental Health Boards' Kick-Off session on Medicaid Health Homes

**10. Ensure that consumers have health insurance coverage and that CMH can meet the demands of multiple payers and coverage options:** CMH has, over the past several years, established and substantially expanded its eligibility assistance office by: adding sites, throughout the community at which eligibility assistance is provided (CMH sites and sites of community partners); increasing staffing levels of the eligibility assistance office; and conducting increased outreach and information efforts.

**11. Ensure that CMH has a welcoming environment and a customer orientation at all of its sites and in all of its interactions with all stakeholders: consumers, families, community partners, and CMH colleagues**

**A. Design and implement a number of physical plant upgrades**. Structural upgrades are being implemented around a three phase plan that extends into 2015, in order to better accommodate expanding and emerging markets. Phase 1, which was completed in Fall 2012, involved restructuring the interior layout of the Jolly Road site to facilitate the integration of new Substance Abuse staff into the workforce. Phase 2 extends into 2013 and includes several projects, including the accommodation of a primary care clinic on the first floor of the Jolly Road site by June. Phase 3 accounts for the likelihood of continued agency growth and provides of a possibility of major building renovations and expansion.

**B. Fostering a customer services orientation through training, coaching, setting a culture**. A 'Welcoming Environment Committee' has been established to recommend improvements to facilities and enhance the customer service experience.

i. Upon the recommendation of this committee, the front lobby of the Jolly Rd. site was renovated for improved consumer comfort in January 2012. Similar improvements to the lobbies and seating areas were implemented at several other CEI-CMH sites as well.
ii. A customer service training program for all employees was implemented in September 2012.

This program is expected to improve the customer service experience for all consumers and make CEI-CMH more competitive in a changing service environment. This program will see continued improvements with ongoing professional consultation through 2013.

iii. By the beginning of 2013, a 'Rewards and Recognition Program' will be in place to recognize CEI-CMH employees for excellence in customer service.

**12. Ensure that CMH has a valid, reliable, flexible, relevant, and sustainable outcome measurement system – refining it within the behavioral health care domains and expanding it to reflect physical healthcare measures:** This CMH, for the past several years, has been refining, where already in place, and institute, where not in place, clinical outcome measures for all consumers, across diagnostic groups, served by CMH. For the past several fifteen years, this CMH as used two nationally recognized tools - the Child and Adolescent Functional Assessment Scale (CAFAS) and the Preschool and Early Childhood Functional Assessment Scale (PECFAS) - to measure the impact of its clinical work with children and adolescents with emotional disturbance and their families. Since mid-2012, the Multnomah Community Ability Scale (MCAS), a proven outcome evaluation tool has been used to measure the outcomes of CMH's adult mental health services programs. The American Society for Addiction Medicine (ASAM) criteria system has recently been implemented to measure the impact of CMH's substance use disorder services. In partnership with and the leadership of MDCH, the Supports Intensity Scale (SIS) has recently been selected for use in measuring the impact of the services provided by this CMH in its work with persons with developmental disability services. This tool is expected to be fully implemented within the first half of 2013.

**13. Revise and expanded the identity, role and purpose of this CMH to match its work:** In order to effectively address the challenges and opportunities in the changing health care market, this CMH must be open to broadening its role to a more encompassing one – one that allows it to use its considerable clinical, fiscal, operational, and collaborative expertise to fulfill its purposes of advancing the common good, serving as the public safety net, and providing high quality, cost-effective, community-based services. These changes will impact, in all likelihood, the following components of CMH's role and purpose:

- **Dimensions of health care for which CMH is responsible and/or playing a significant role**: A greater emphasis on the coordination – and potentially, the provision - of care, across health care dimensions, including physical health care, substance use disorder prevention and treatment, and long term care

- **Geographic region served**: A revision to the geographic boundaries in which it works (currently, this CMH serves as a comprehensive mental health and developmental disabilities provider for the three county region surrounding the Capital region and the Medicaid Prepaid Inpatient Health Plan (PIHP) for an eight county region; discussions are underway for this CMH to serve as the public substance use disorder care manager and funding body for a six county region.

- **Population served**: While the CMH and PIHP systems, statewide, are designed to serve those with significant behavioral and developmental disability needs, this CMH has been able to expand, over the past several years, its ability to serve those community residents with less severe needs. This expansion is likely to continue and grow in the emerging health care environment.

- **Additional roles**: The expansion of its current dual role of comprehensive mental health and

developmental disabilities provider (CMH) and Medicaid Prepaid Inpatient Health Plan (PIHP) to include those of: Patient Centered Health Home, convener of a Behavioral Health/Safety Net Accountable Care Organization (ACO), and a partner/member within a General ACO.

**14. Establish a central, internal clearinghouse and learning venue for organizing CMH's work in this effort:** To ensure that the many facets of this effort are tied together and working in unison, the clinical and administrative leadership of this CMH meet monthly, as the Health Care Integration Work Group, to:

- review the organization's health care integration efforts
- keep current on national, state, regional, and local health care integration efforts and trends
- provide for a learning collaborative in which technical assistance and cross-system guidance and coaching can be obtained
- Development of a uniform approach – across CMH populations – of providing health home services (health coaches, primary care liaisons, nurse case managers, clinical liaisons an consultants) – drawing on national experts and models