2016 Northern California State of Reform Health Policy Conference

**Panel: Integrating Mental Health, Chemical Dependency and Physical Health**

Mercy Maricopa is a not-for-profit Health plan in Arizona. We are the Regional Behavioral Health Authority for Maricopa County. Mercy Maricopa is administered by Aetna Medicaid Administrators LLC (formerly Schaller Anderson). Aetna Medicaid Administrators also provides plan management for Mercy Care Plan.

Mercy Maricopa is responsible for over 800,000 lives. Mercy Maricopa is the largest integrated public mental health system in the U.S. and provides integrated health services to over 19,000 members with Severe Mental Illness. We are implementing integrated health home models to provide integrated health services for our members with severe mental illness using a ‘right care, right place, right time’ approach to meeting our member’s health care needs. I will be discussing integrated care models from a health plan perspective.

**Fast Facts: Why is our discussion today about integrated care important?**

* According to Colton and Mandershceid in a paper published in 2005, people with mental illness are five time more likely than the general population to have a co-morbid medical condition (like diabetes, metabolic disorders, heart disease and hypertension).[[1]](#endnote-1)

i Colton, C.W. and Manderscheid, R.W., Congruencies in Increased Mortality Rates, Years of Potential Life Lost, and Causes of Death Among Public Mental Health Clients in Eight States, Behavioral Healthcare, Sept 2005

* According to data reported by AZ Dept. of Health Services, 70% of primary care visits stem from psychosocial issues, underlying mental health or substance abuse issues are often triggers.[[2]](#endnote-2)
* Data in Arizona also shows that 15% of SMI members have more than 3 co-morbid physical health conditions

ii Arizona Department of Health Services. Quarterly Health Initiatives in Behavioral Health: How to Implement Them and Resources Available (PowerPoint slides). Available at <https://cabhp.asu.edu/sites/default/files/session-47.pdf>

1. **What are the Barriers to an Integrated Model?**
   1. Differences in health care provider’s culture, training and professional identities.
   2. Differences in workflows and service provision approaches between behavioral, physical and substance use providers.
   3. Different rules of client confidentiality can inhibit abilities to share vital client information and interfere with effective care coordination.
   4. Workforce challenges – inadequate number and distribution of well trained staff to work in integrated care settings.
2. **How have you developed partnerships across the continuum of care to increase the efficiency and efficacy of care delivery?** As a health plan we believe it is essential for us to invest in training and workforce development in our Provider Community as a means to increasing the efficiency and efficacy of care delivery. One of our integrated health care goals is to ***“Increase the competence of providers to deliver effective integrated care by providing education and training regarding best practices and new developments in integrated care”***
3. We are working to accomplish this goal through our development of partnerships with academic institutions to develop and/or deliver train-the-trainer curriculums to our Provider Organizations delivering integrated care in Integrated Health Homes. Our focus is on creating and delivering training on interprofessional practice to help clinicians develop skills and best practices in delivering integrated services and ensuring effective care coordination.
4. We have contracted with a university to develop an intensive 4 module “Integrated Care” training for clinicians and support staff in our integrated health homes that focuses on developing knowledge and skills among staff around best practices related to interprofessional practice. The training is based on core tenants of integrated team based care and interprofessional education. The curriculum is focused on core areas of interprofessional practice such as team communication, building shared culture, conflict resolution, care coordination, workflows, ethics, integrated care planning, ethics, etc.
5. We have also contracted with other academic & educational institutions to provide trainer programs in Health Coaching, Motivational Interviewing, Illness, Management & Recovery and SBIRT (Screening, Brief Intervention and Referral to Treatment).
6. We have a focus on workforce development and are partnering with academics institutions around ensuring health students are able to complete practicums in integrated health homes. This approach helps to students to get ‘hands-on’ experience in working on integrated teams and hopefully presents an opportunity for our providers to hire and retain graduates in our Provider community.

**3.       What are the ‘boots on the ground’ lessons you would share with the audience?**

1. Attention to differences in healthcare provider’s culture, training, backgrounds and professional identities is critical to building successful integrated care models. With many universities across the nation focused on interprofessional education - new health professionals graduating will be increasing prepared, and have a desire to work, in integrated care settings. In the current environment it is important to offer training to existing providers to assist with bridging differences in culture and background and helping providers to come together to provide effective integrated care.
2. Partnerships with academic institutions are an important part of a longer term workforce development strategy to: 1) Provide training & skill development for existing health professionals around best practices in integrated care delivery; 2) provide a training ground for the future workforce to gain experience in integrated care; 3) address a shortage of health professionals in certain areas by working to show students the benefits of community based practice; and 4) retain graduating health professionals in the local community.

1. [↑](#endnote-ref-1)
2. [↑](#endnote-ref-2)