HEALTH MANAGEMENT ASSOCIATES

Integrating Behavioral Health Across Integrated Delivery Systems

Speaker
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Presenters

Lori Raney, MD

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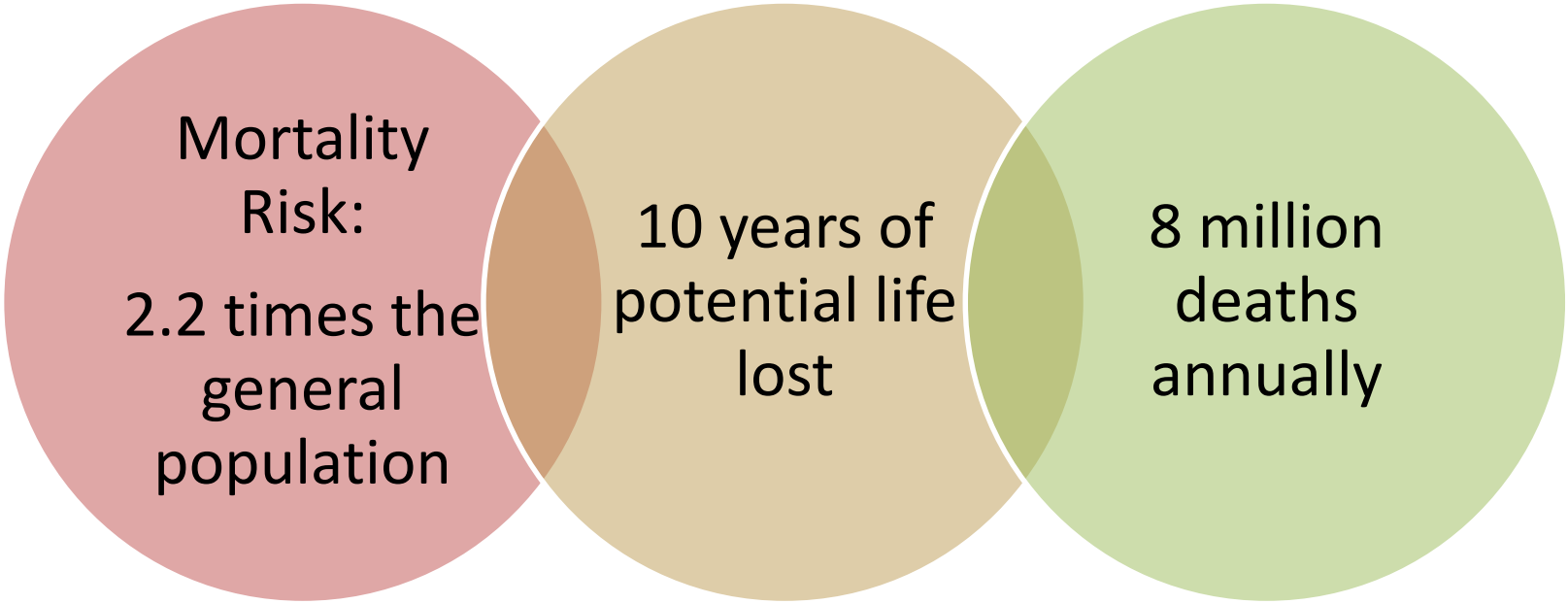
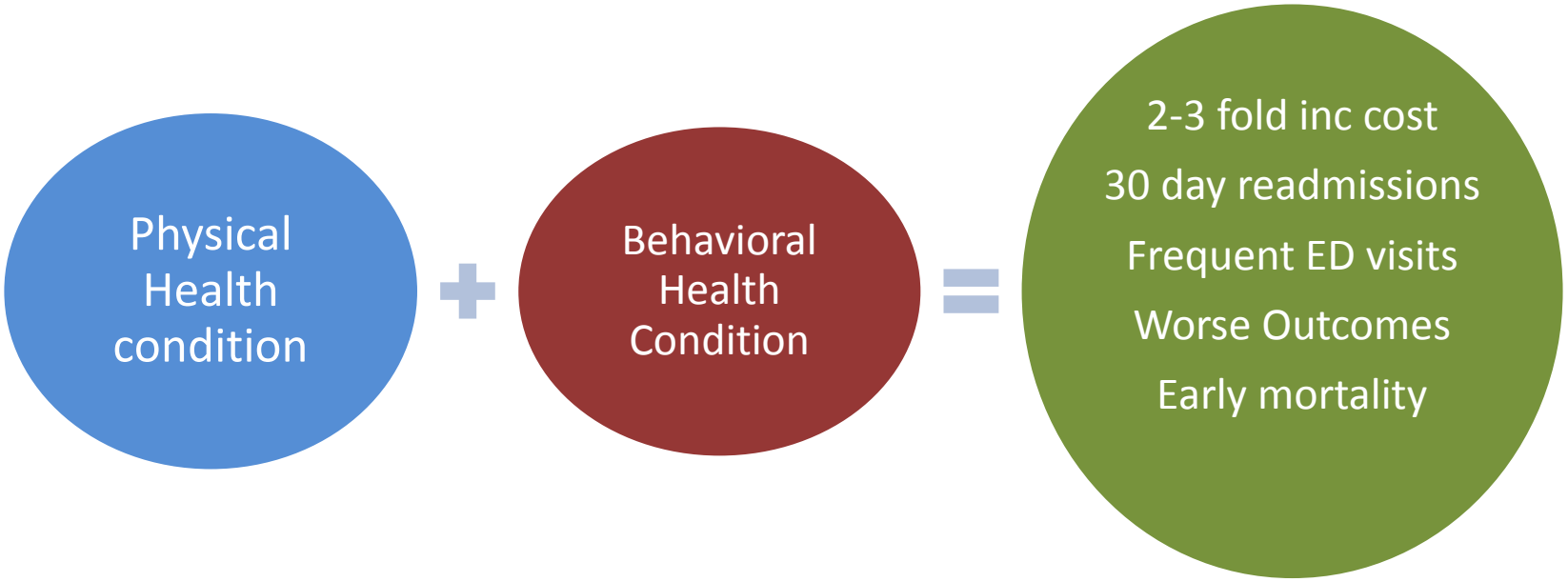
Mental Illness and Mortality



Walker, E.R., McGee, R.E., Druss, B.G. *JAMA Psychiatry*. Epub, doi:10.1001/jamapsychiatry.2014.2502



**Melek S et al APA 2013
www.psych.org

Annual Per Person Cost of Care

Common Chronic Medical Illnesses with Comorbid Mental Condition

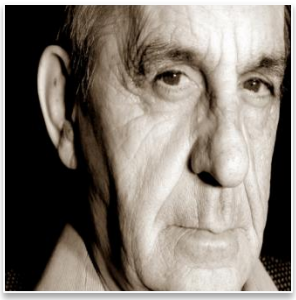
"Value Opportunities"

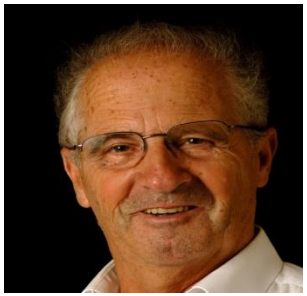
Patient Groups	Annual Cost of Care	Illness Prevalence	% with Comorbid Mental Condition*	Annual Cost with Mental Condition	% Increase with Mental Condition
All Insured	$2,920		10%-15%		
Arthritis	$5,220	6.6%	36%	$10,710	94%
Asthma	$3,730	5.9%	35%	$10,030	169%
Cancer	$11,650	4.3%	37%	$18,870	62%
Diabetes	$5,480	8.9%	30%	$12,280	124%
CHF	$9,770	1.3%	40%	$17,200	76%
Migraine	$4,340	8.2%	43%	$10,810	149%
COPD	$3,840	8.2%	38%	$10,980	186%

Cartesian Solutions, Inc.™--consolidated health plan claims data

How many of these people with behavioral health concerns will see a behavioral health provider?

No Treatment



Primary Care Provider

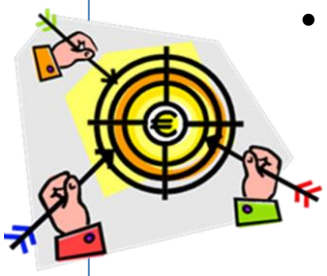

Mental Health Provider (psychiatric provider or therapist)


Wang P, et al., Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005

Integration Environmental Drivers

ACA

- **Insurance Expansion**
- **Triple Aim Initiatives** – better outcomes, lower costs, better experience of care
  - Innovation Grants
    - Collaborative Care
    - Payment Structures
  - Behavioral Health Homes – SPAs
  - Expand CHC
  - Expand PBHCI



Other

- Value-based payment
- Pay for performance
- Risk sharing
- Penalties
- MACRA
- Behavioral "Carve in"
- Integrated Delivery Systems

NCQA PCMH Standards 2014

= BH

NCQA 2011

PCMH Standard 1: Enhance Access and Continuity

- Comprehensive assessment includes depression screening for adolescents and adults

PCMH Standard 3: Plan and Manage Care

- One of three clinically important conditions identified by the practice must be a condition related to unhealthy behaviors (e.g., obesity) or a mental health or substance abuse condition.

PCMH Standard 5: Track and Coordinate Care

- Track referrals and coordinate care with mental health and substance abuse services

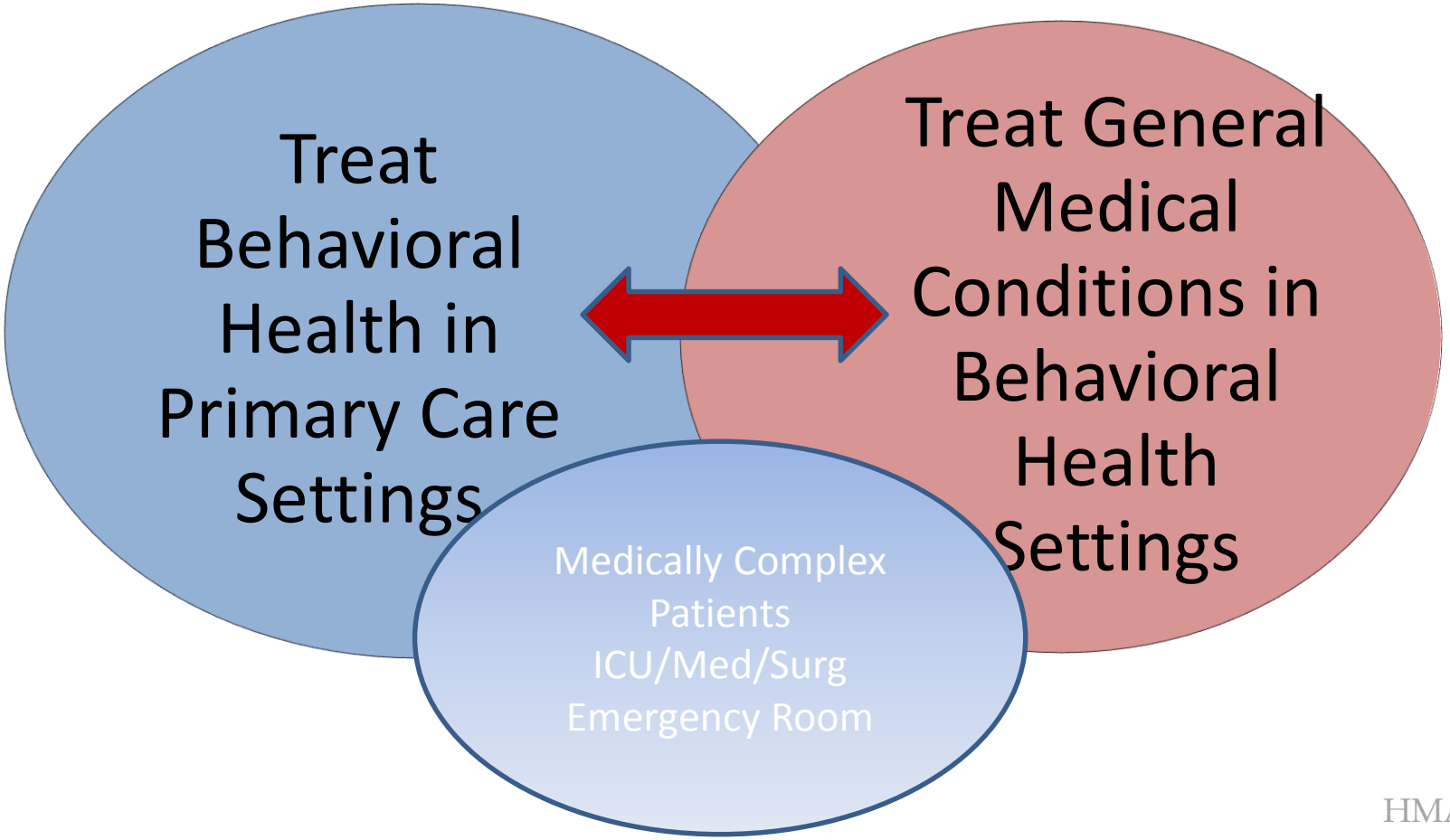
http://www.ncqa.org

NCQA 2014

- Program Structure (QI 1)
  - Does the QI program specifically address behavioral health?
  - Is there a physician and behavioral health practitioner involved in the QI program?
- Accessibility of Services (QI 5)
  - Can members get behavioral health care when they need it?
- 7. Complex Case Management (QI 7)
  - Does the organization assess the charac needs of its member population (including children/adolescents, individuals with disabilities and individuals with SPMI)?
  - Are the organization's case management systems based on sound evidence?
- 9. Practice Guidelines (QI 9)
  - Does the organization adopt evidence-based practice guidelines for at least two medical conditions and at least two behavioral conditions with at least one behavioral guideline addressing children/adolescents?
- 11. Continuity and Coordination Between Medical and Behavioral Health Care (QI 11)
  - Does the organization annually collect data about opportunities for coordination between general medical care and behavioral health care?
  - Does the organization collaborate with behavioral health specialists to collect and analyze data and implement improvement of coordination of behavioral health and general medical care?
- 1. UM Structure (UM 1)
  - Is a behavioral health practitioner involved in the behavioral health aspects of the program?

2017 ?

Range of Opportunities for Integrating Care



Strategies to Provide Value

- Collaborative Care – Primary Care
- Proactive Consultation - Inpatient
- Delirium Prevention - Inpatient
- Hot Spotter Teams – Inpatient and Outpatient
- Complexity Intervention Units - Inpatient
- Addressing medical issues in the SMI population in the behavioral health setting

Setting the Table

- The truth about integration is that it is not one thing
  - Dedicated team effort
- Things to think about
  - Philosophy
  - Culture
  - Cost
  - Patient Mix

What integration preparation takes

- Administrative and provider agreement
- Productivity standards
- Cost (it’s more than just the provider)
- Acceptance of clinic diversities

CULTURE EATS STRATEGY FOR BREAKFAST

Considerations learned the hard way

What is your organization's philosophy regarding integration?

- Role of specialty mental health
- Provider bias toward psychiatry (the "stethoscope syndrome")

Does your organization speak "whole person or person-centered care?"

- Have they found the neck yet?

Preconceived notions about integration

- Anxiety over new/additional providers and their impact on productivity
- Provider age/generation
- Clinic response to change
- Who is the clinic manager and what do they believe?

More things considered …

Does your organization push out information to the providers about who their patients are?

- Anecdotal information creates assumptions and well …
- Better yet, do you know what your patient mix is?

How do you define success?

- Quality incentive metrics

Do you have an implementation plan that allows for recognizing fractures and making changes in the moment?

- Practice facilitation!

Do you have a clear understanding of your model? Are you committed to the fidelity of that model? Where might there be room for flexibility?

Who in your community supports integration?

- County health services, CCO, competitor clinics

What is Providence doing?

- Our 5-year strategic vision is: “Creating healthier communities together”
- As part of that vision, we’re launching innovations to seamlessly integrate BH within broader health care context
- Goal is to integrate BH care into non-traditional settings – with meaningful, effective impact on our patients

The three doors of Providence

- Evidence-based BH care at the point of care
- No wrong door for care
- Population-based reimbursement
- Ease your way to care

Result is effective, caring service and lower costs for everyone

A Case for Integrating **Behavioral Health and Primary Care**

EUGENE S. FARLEY, JR. HEALTH POLICY CENTER
A Collaboration For Studies In Primary Care

66% **of primary care providers report** they are unable to connect patients with outpatient behavioral health providers **due to a shortage of mental health providers and health insurance barriers**[1]

20% of primary care office visits are mental health related[2]

46% **of adults** **will experience mental health illness or a substance** abuse disorder at some point in their lifetime[3]

67% of adults with a behavioral health disorder do not get behavioral health treatment[4]

35% **of children** **receiving outpatient care for mental health** conditions only saw their primary care providers[5]

[1] Cunningham PJ. Beyond parity: primary care physicians' perspectives on access to mental health care. Health affairs (Project Hope). 2009;28(3):w490-501.
[2] Center for Disease Control and Prevention. Percentage of Mental Health-Related Primary Care Office Visits, by Age Group - National Ambulatory Medical Care Survey, United States, 2010. Morbidity and Mortality Weekly Report. 2014;63(47);1118.
[3] Kessler RC, Wang PS. The descriptive epidemiology of commonly occurring mental disorders in the United States. Annual review of public health. 2008;29:115-29.
[4] Kessler RC, Demler O, Frank RG, Olfson M, Pincus HA, Walters EE, et al. Prevalence and treatment of mental disorders, 1990 to 2003. The New England journal of medicine. 2005;352(24):2515-23.
[5] Anderson LE, Chen ML, Perrin JM, Van Cleave J. Outpatient Visits and Medication Prescribing for US Children With Mental Health Conditions. *Pediatrics*. 2015.

Door #1: Primary Care

Optimize BH services through PMG 3.0:

- ***Integrate*** psychologists/psychiatrists as part of care team—BH Providers 1:6-8k patients
  - Double the BHP support per clinic
- Increase ***access*** to psychiatric consults and specialized BH services through ***Behavioral Health Navigation***
- Implement a pilot program with a ***centralized navigation*** system and integrated payment model
- ***Measure*** Triple Aim outcomes

ED: Primary Care for many

- 70% of all ED visits could be handled at a lower level of care
  - 3 out of 4 diverted; 1/3 of admits could be managed at a lower level of care
- 20% increase in ED utilization 2000-2010
  - Average cost of ED visit: $767
  - Average cost of PCP visit: $181
  - $580 per visit
- ED boarding of psych patients is out of control

http://www.rwjf.org/en/library/research/2013/09/quality-field-notes--reducing-inappropriate-emergency-department.html

Door #2: Emergency department

Better serve those with BH needs by:

- Implementing ***multi-disciplinary team*** (nurses, psychiatrists, providers, social workers, primary care, etc.) for care planning high frequency ED patients
- Utilize ***ED Navigation*** to ensure appropriate use of ED and care planning
- Partner with ***community resources*** to expand access to BH specialty care

Mental Health needs on the floor

- Co-occurring MH and substance use in 20-40% of all hospital patients
  - Increased LOS
  - Increased sitter use
  - Decreased patient/provider satisfaction
- Current system reacts to provider requests
  - Inefficient & ineffective
  - Not available outside of hospitals with psychiatric services

Door #3: Med/Surg Units

Reach inpatients with BH needs by:

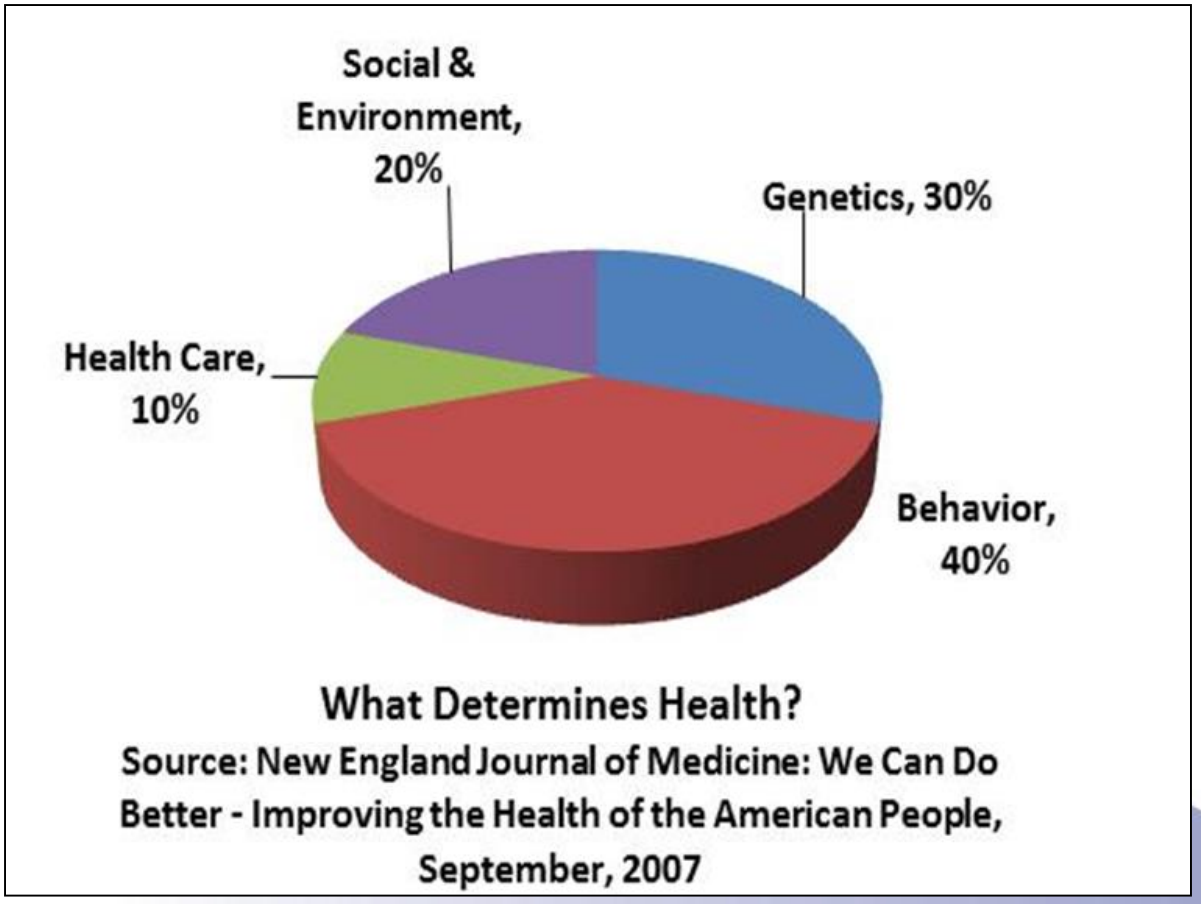
- Implementing ***Behavioral Health Integration Team*** (BHIT) developed at Yale for early intervention to meet inpatients' BH needs
  - Place BH experts as part of multi-disciplinary team on all inpatient units
  - Reduces patient violence, improves physical and BH outcomes, and reduces length of stay
- Support ED in smaller hospitals
- Coordinate care navigation for BH needs across system

Payment reform

Effective payment reform includes:

- Breaking down barriers between physical and BH health care
- Integrating payment streams to achieve seamless care
- Increasing access to specialty care
- Improving how Providence Health Plan addresses BH care: 600,000+ lives

Why is integration important?



What Determines Health?

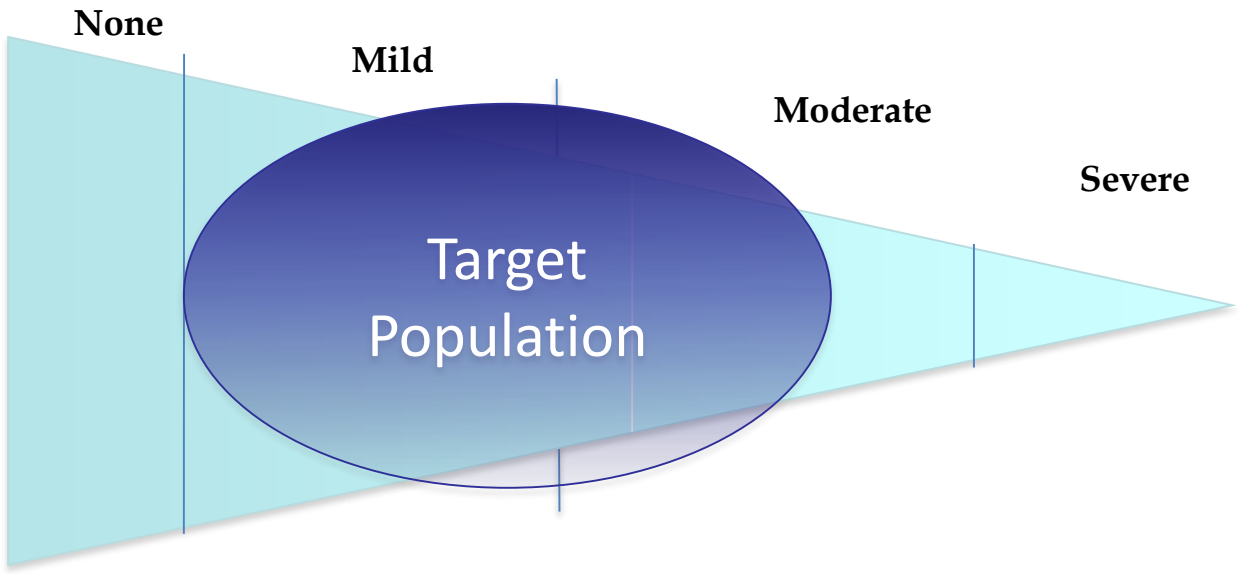
Source: New England Journal of Medicine: We Can Do Better - Improving the Health of the American People, September, 2007

Integrated Care in Multiple Settings Improves Health and Reduces Cost

- Depression and diabetes: 115 fewer days of depression/year; projected $2.9 million/year lower total health costs/100,000 diabetic members[1]
- Panic disorder in PC: 61 fewer days of anxiety/year; projected $1.7 million/year lower total health costs/100,000 primary care patients[2]
- Substance use disorders with medical compromise: 14% increase in abstinence at 6 months (69% vs. 55%); $2,050 lower annual health care cost/patient in integrated program[3]
- Delirium prevention programs: 30% lower incidence of delirium; projected $16.5 million/year reduction in IP costs/30,000 admissions[4]
- Unexplained physical complaints: no increase in missed general medical illness or adverse events; 9% to 53% decrease in costs associated with increased healthcare service utilization[5]
- Health Complexity: halved depression prevalence; statistical improvement of quality of life, perceived physical and mental health; 7% reduction in new admissions at 12 months[6]
- Proactive Psychiatric Consultation: doubled psychiatric involvement with nearly one day shorter ALOS and 4:1 to 14:1 return on investment[7]

Data from 1. Katon et al, Diab Care 29:265-270, 2006; 2. Katon et al, Psychological Med 36:353-363, 2006; 3. Parthasarathy et al, Med Care 41:257-367, 2003; 4. Inouye et al, Arch Int Med 163:958-964, 2003; 5. summary of 8 experimental/control outcome studies; 6. Stiefel et al, Psychoth Psychosom 77:247, 2008; 7. Desan et al, Psychosom 52:513, 2011

Go Upstream: "Sweet" Spot in Primary Care



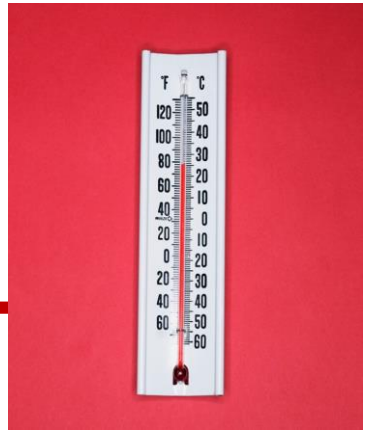
- Issues with depression and substance abuse must be pre-empted, rather than treated once advanced.
- Goal is to detect early and apply early interventions to prevent from getting more severe

Example: Collaborative Care

- Collaborative Care is a specific type of integrated care that operationalizes the principles of the chronic care model to improve access to evidence based mental health treatments for primary care patients.

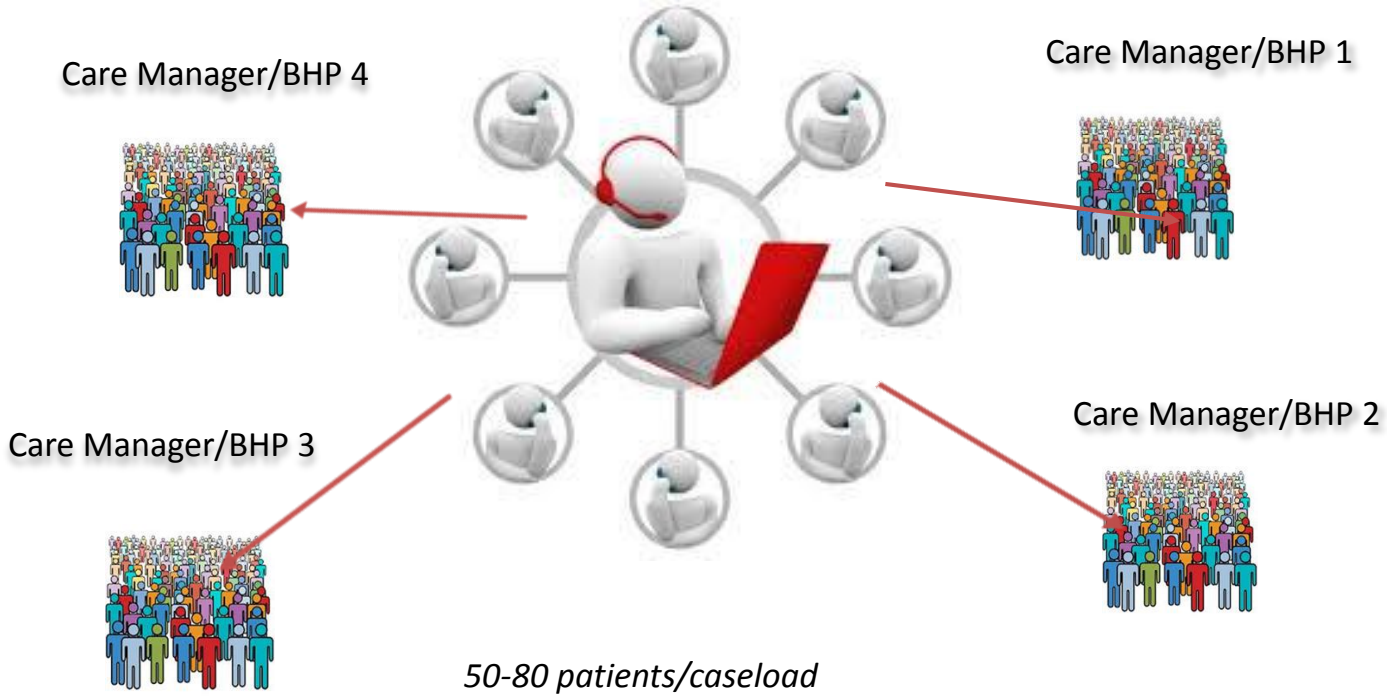
"TEMP"

- Collaborative Care is:
  - **T**eam-based collaboration and Patient-centered
  - **E**vidence-based and practice-tested care
  - **M**easurement-based treatment to target
  - **P**opulation-based care – registry



  - **A**ccountable care

Psychiatric Provider/Behavioral Health Provider Teams



50-80 patients/caseload
2-4 hrs psych/week/ care manager
= a lot of patients getting care

Reduces Health Care Costs

Cost Category	4-year costs in $	Intervention group cost in $	Usual care group cost in $	Difference in $
IMPACT program cost		522	0	522
Outpatient mental health costs	661	558	767	-210
Pharmacy costs	7,284	6,942	7,636	-694
Other outpatient costs	14,306	14,160	14,456	-296
Inpatient medical costs	8,452	7,179	9,757	-2578
Inpatient mental health / substance abuse costs	114	61	169	-108
Total health care cost	**31,082**	29,422	32,785	**-$3363**

Savings

ROI
$6.00: $1

Unützer et al., *Am J Managed Care 2008*.

Performance Measures

- Percent of patients screened for depression
- Percent with care manager follow-up within 2 weeks
- Percent with 50% reduction PHQ-9
- Percent to remission (PHQ-9 < 5)
- Percent not improving that received case review and psychiatric recommendations
- Percent not improving referred to specialty BH

How to Pay for Integration

- ***Case rate*:** PCP bills for the service and a case rate is applied for the care management functions including brief interventions, psychiatric curbside consultation and caseload review. Washington State Mental Health Integration Program
- ***Global capitation*** – A single fixed payment for all health care costs for enrolled members. The Veterans Administration, Kaiser Permanente, and the Department of Defense are examples of this arrangement. Each has internally funded integrated care projects.
- ***Per member per month (PMPM)*** – fixed monthly rate per patient for specific tasks. In the Depression Improvement Across Minnesota: Offering a New Direction (DIAMOND) several private payers joined together to provide a PMPM for the unbillable tasks.
- ***Capitation with shared savings*** – A payment strategy that offers incentives to providers to reduce cost. Sustaining Healthcare Across Integrated Primary Care Efforts (SHAPE
- ***Value-based purchasing***: Buyers of healthcare services hold providers accountable for outcomes and cost. A major initiative of the Centers for Medicare and Medicaid Services (CMS) as health care reform unfolds.
- ***Coding and Payment for briefer interventions***: Use of HABI codes for some services in support of medical condition by the BHP. Some states have chosen to do this already.
- ***Coding and payment for psychiatric provider services***: CMS developing new payment codes to reimburse for psychiatric consultation time for caseload focused registry review

Q & A

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