Building a System of Integrated Care: Lessons from the Field

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Objectives

- Discuss different approaches to implementing a system of integrated behavioral health care.
- Describe how to make the business case for integrated care.
- Understand how to overcome common barriers to the sustainable implementation of integrated behavioral health care.
- Develop an action plan to implement integrated behavioral health care at your organization.
Introductions

- Name
- Organization
- What work have you/your organization done to date on integrated care?
- What do you hope to get out of today’s session?

Agenda

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<td>8:30 – 8:45 am</td>
<td>Introductions and agenda overview</td>
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<td>8:45 – 9:15 am</td>
<td>Exercise: Dispelling Myths</td>
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<td>9:15 – 10:30 am</td>
<td>Approaches to financing integration and making the business case</td>
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<td>10:30 – 10:45 am</td>
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<td>10:45 – 12:00 pm</td>
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<td>Lunch</td>
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<td>Getting started - introduction to self-assessment</td>
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<td>Break</td>
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<td>Exercise: Self-assessment and action planning</td>
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<td>3:30 – 4:00 pm</td>
<td>Action planning report out, final questions, and wrap up</td>
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Exercise: Dispelling myths

- How are you currently sustaining your integrated behavioral health efforts?
- What has proven to be the most effective?
- What remains the most challenging?
The approach

1. Workarounds and creativity in an imperfect world.

2. Make your own case and what to do with these data.
Behavioral health

- Institutionalization (mid 1800s - 1950/1960)
  - Inpatient care model - patients lived in hospitals and were treated by professional staff (used to be considered most effective way to care). Institutionalization welcomed by families and communities (e.g. Uncle Johnny)

- Deinstitutionalization (1950s on)
  - A push for deinstitutionalization and outpatient treatment began (in part due to living conditions and development of antipsychotic drugs). It was believed that community-oriented care could help patients have a higher quality of life if treated in their communities.
  - In 1963, Congress passed the Mental Retardation Facilities and Community Health Centers Construction Act, which provided federal funding for the development of community-based mental health services.

A few problems

- The dollars that had been so prominent in the hospitals did not follow the patients outpatient
- Before the period of deinstitutionalization, there was little incentive for private insurers to cover services already paid for through the public sector
- Not until after World War II did insurance policies include mental health services, when insurers began covering some hospital psychiatric care
- How do you manage a "mental health" benefit?
- Coverage for MHSA care has expanded and contracted over the last 40 years
  - Over the last 15-20 years, has typically been less generous than for medical care.
A few problems

• For past 10-15 years, MHSA care has been more intensively managed than medical care in private sector
• Arguments for and against parity and level of coverage overall and for vulnerable MHSA groups are based on principles/biases, market experience, and some data
  – Opinions are often strong and findings are somewhat mixed and lag behind the evolving market and new policies.

• Complex policy changes and their rationale are often not transparent in the community.

Definition

The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, ineffective patterns of health care utilization.

Value of Integration:
Physical/Behavioral Integration is good health policy and good for health.

The “two pots” of money

Behavioral health and Medicaid

- Carve in or carve out?
Fee for service

• Fee for service often relegates providers to their respective arm of their silo
• Most practices who operate under a fee for service banner have a challenging time integrating care

Who, what, when, and where

Fee for service workarounds

• Behavioral health providers bill only for the services that are reimbursed (predominately co-located specialty services)
• Behavioral health providers make use of “Health and Behavior Assessment and Intervention Codes”
  — 9600 series
  — These CPT codes require a physical health diagnosis.
  — Typically, health and behavior assessment and intervention services address an assortment of physical health issues -- including patient adherence to medical treatment, symptom management, health-promoting behaviors, health-related risk-taking behaviors, and overall adjustment to physical illness.

Fee for service workarounds

• Collaborative visits with physician and behavioral health provider
  — Medical provider may be able to change the level of their visit if they add another level of service with the behavioral health provider (medical provider must be in the room and a part of the visit)
A Colorado story (though could be anybody’s story)

Since 2008 the Colorado Health Foundation has awarded more than 40 grants to support the delivery of integrated primary care and behavioral health services. Grantees report difficulty financially sustaining integrated care due to reimbursement limitations and challenges. Current grants are focused on addressing clinical improvements and staff/infrastructure needed to facilitate integrated care delivery. Sense of urgency to identify policy fixes, but recognition there is considerable confusion among providers and advocates about billing and reimbursement for integrated care.


Oh the tangled web we weave

• How are you currently funding integrated services? Please mark all that apply.
  – Payment arrangements with managed care organization
  – Capitation arrangement (e.g., PMPM-per member per month)
  – Shared risk arrangement
  – P4P—Pay for Performance funding
  – Grant funding
  – Joint blending of funds with another health care/social service organization
  – Internal restructuring of funds
  – Community support/donations/fundraising
  – Billing through CPT codes for medical services (e.g., use of E & M codes)
  – Billing through CPT codes for behavioral health services
  – Billing through CPT codes for health and behavior codes (96150 – 96155)
  – Billing through Healthcare Common Procedure Coding System (HCPCS) codes for services
  – Billing screening codes, such as SBIRT, PHQ 9, etc.
  – Quality assurance project—redistribution of funds
  – Self-pay/sliding scale fee
  – Other, please specify
The predominate payment paradigm

Recommendation #1

Pursue same-day billing codes for physical health and behavioral health services.

Budget Neutrality – Integrated Care Visits on Same Day

Based on Medicaid payment rate for code 98801 for behavioral healthcare service for same day treatment using fee schedule effective 7/1/11. Service cost equivalents based on retrospective 2008 average Medicaid claims levels for each service category.
Recommendation #2

Examine viability of paying for Health and Behavior Assessment codes (CPT 96150-96155) under insurance.

Budget Neutrality – Health & Behavior Codes

<table>
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<tr>
<th>Pay For</th>
<th>Avoidance Target</th>
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<tbody>
<tr>
<td>1,000 H&amp;B Codes</td>
<td>2 IP Admits</td>
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<tr>
<td></td>
<td>44 ER Cases</td>
</tr>
<tr>
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<td>156 Office Visits</td>
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Based on estimates of Medicaid payment rates for Health and Behavior codes 96150-96155, developed from the 7/1/11 rate schedule and relative value units (RVUs) and an average distribution of individual Health and Behavior visits. Service cost equivalents based on retrospective 2008 average Medicaid claims levels for each service category.

Recommendation #3

• Test and analyze the viability of global funding strategies to financially sustain integrated care models.
• Recommendation #4: Clarify current billing regulations and train integrated care sites to optimize use of existing revenue sources to provide cost efficient, medically necessary care.

• Recommendation #5: Determine a plan to implement a standardized statewide data collection system to document financial, clinical, and operational

SHAPE

• Sustaining Healthcare Across integrated Primary care Efforts
  – A partnership between Collaborative Family Healthcare Association, Rocky Mountain Health Plans, Colorado Health Foundation, and University of Colorado School of Medicine Department of Family Medicine
  – To test an alternative payment model to sustain behavioral health in primary care
The “Range”

What’s needed?

• Identify payer
• Identify practices
• Calculate cost (and model)
• Assist in the set up of the model
• Evaluation

• [www.sustainingintegratedcare.net](http://www.sustainingintegratedcare.net)
MAKING THE BUSINESS CASE

Avoiding workarounds and setting your effort up for success

Current System: Structured Around Reimbursement
- Payment and financing “carved out” - independent of medical care and expense
- Disincentivizes collaboration, communication and coordination among clinicians
- Payment is solely for psychiatric disorders and diagnosis
- Ignores behavioral needs of medical patients
- Focuses on individual siloed care delivery not on collaborative treatment
- No relationship to performance

Proposed System: Patient Centered
- Carve in to medical expense target (defragment payment system; blended payment systems)
- Payment related to collaborative medical psychological efforts
- Financing for broad spectrum of medical need for behavioral intervention including psychological treatments of medical problems
- Financing related to performance and quality

Kessler & Miller, 2009
Calculating cost

• Expenditure analysis

Cost and workflow (not just FTE)

Where
• Where are important events happening?
• Examples: clinic, patient’s home, partner site, internet/web

What or How
• What is being done to help integrate care?
• How much time is being spent on this activity?
• Examples: ask questions, look at data, talk with someone, provide instructions, make a decision, connect to a resource

When
• When is the action performed or in what sequence?
• Examples: before, during or after a visit, three months from now, once a year.

Who
• Who is participating, receiving, or doing something?
• Examples: PCP, BH provider, staff, collaborator, patient, computer/Electronic Health Records
Showing the reach

• Calculating numerators and denominators
  — Who is in your denominator?
• Attributing patients to the intervention
  — Which patients received what intervention
• Process measures are not a bad thing
  — % identified
  — % treated
  — % improved
• Tracking patients and matching utilization patterns
  — Unique identifiers and claims connection

Collective Impact

What we can do together
Collective Impact

- The commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem

The risks we take without uniting

-Disconnected brilliance
- Limited ears to listen
- Lack of policy traction
- Letting our patients experience integration and then take it away
Demonstration: AHRQ Expenditure Tool
Oregon’s health reform experience: How behavioral health changed health care

Robin Henderson, PsyD
Chief Behavioral Health Officer and Vice President, Strategic Integration

Objectives for today

• What are Coordinated Care Organizations (CCO)?
• Why and how are CCOs being created?
• How will CCOs achieve the Triple Aim?
  • Better care
  • Better health
  • Better value
• Current initiatives and early successes
• Role of Behavioral Health
• Alternative payment methodologies and the Global Budget
St. Charles Health System

• Central Oregon—home to Mt. Bachelor, 36 golf courses, Deschutes River, mountain hiking ... and so much more!
• 250,000 people, one health system, four hospitals
  – Level 2 Trauma
  – One psych unit/one psych ED
• Five PCPCHs, two specialty mental health clinics
• 14 BHCs – PCPCH, pediatrics, internal medicine, NICU and ….
• As CBHO, I am part of the system vision -- Creating America’s healthiest community, together -- with our regional partners and the patients and families that we serve.

Ok, now that I’ve adequately plugged my employer ...

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The elephant in the living room

• Belief that medical care is the solution to the health care crisis
• Inability for traditional mental health to move beyond the “silo of excellence”
• Focus on the barriers to integration:
  • Widget-based funding models
  • The stigma of HIPAA
  • Scope tyranny

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Why they are elephants...

- We spend $2.8 trillion per year on health care
- 75% of this spend is used to treat chronic health conditions (definition of “sick care system”)
- Working together, we can push $ further upstream to create a true “health system”

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Oregon’s budget realities

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The road to health care reform

- SB 1580 became law in 2012, laying the foundation for CCO development with aggressive timelines
- $1.9 billion in federal funds over five years to support health care transformation efforts
- Agreement with federal government to reduce projected state and federal Medicaid spending by $11 billion over 10 years
  - Oregon will lower the cost curve by two percent over the next two years or face stiff penalties

Oregon’s accountabilities

Savings:
- 2% reduction in per capita Medicaid trend
- Baseline is calendar year 2011 Oregon spend
- Trend 5.4% as calculated by OMB for President’s budget
- State to achieve 4.4% by end of year 2 and 3.4% thereafter
- No reductions to benefits and eligibility in order to meet targets
- Financial penalties for not meeting targets

Quality:
- Strong criteria
- Financial incentives (sticks and carrots) at CCO level

Transparency and workforce investments
Coordinated Care Organizations

• A local network of all types of health care providers working together to deliver care for Oregon Health Plan clients
• Care is coordinated at every point – from where services are delivered to how the bills are paid
• 16 CCOs are now up and running, accounting for 90+% of Medicaid population

Changing health care delivery

Benefits and services are integrated and coordinated
One global budget that grows at a fixed rate
Local accountability for health and budget
Local flexibility

Metrics: standards for safe and effective care
Poverty with a view

- 50,000 Medicaid (Oregon Health Plan) beneficiaries in Deschutes, Jefferson, Crook and part of Northern Klamath and Lake counties
- 150 miles north to south
- 250,000 residents, expected to grow to 300,000 by 2019
- Approximately $150m coming into the community
- Oregon Health Plan (Medicaid) beneficiaries only
- Inclusion of additional state sponsored health benefit programs in 2015 (public employees)
- Potential implications on non-Medicaid lines of business in Central Oregon

Vision: the Triple Aim

- Better Care
- Better Health
- Better Value

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How’d they do that?
Coordinated Care Organization

The COHC is the governance body of the CCO. The councils of the COHC report to the COHC and are advisory to the CCO.

CENTRAL OREGON HEALTH COUNCIL

PacificSource Community Solutions (CCO)

Community Advisory Council

Provider Engagement Panel

Operations Council

Accountability

• Governance
  • CCO board—9 of 12 members are risk bearing
    • Through contract arrangements
    • COHC meetings are public
      • Executive session only for personnel matters
  • Materials posted on website
  • Always allow for public testimony
  • Open to the press
  • All voting members are EQUAL
Operations council

- CCO
- Education (K-12)
- Emergency services
- Health Services Director -- Deschutes
- Health System
- HIE/EHR
- Indigent care
- Long-term care
- Mental Health Director -- Crook
- Mental Health Director -- Jefferson and Chemical Dependency
- Obstetrics
- Oral Health
- Pediatrics
- Primary Care
- Public Health Director -- Crook
- Public Health Director -- Jefferson
- Safety Net clinics (FQHC/RHC)
- Multi-specialty care

Role and function

Implement the operational decisions of COHC
- Regional Health Improvement Plan
- Strategic initiatives
- Transformation plan
- Quality incentive measures

Coordination between agencies to reduce duplication of effort and increase collaboration

Oversees workgroups
- More than 50 individuals in regional workgroups
Community advisory council

15-17 members
Majority consumers
• Bend
• Redmond
• LaPine
• Culver
• Prineville
• Madras
• Warm Springs
• Sunriver

Chair COHC member
Other representatives
• School District
• Mosaic Medical (FQHC)
• United Way
• Crook County Health Department
• Indian Health Services
• St. Charles Health System
• Full Access

Primary care: mental health home of the present

Primary Care
• 70% of all primary care visits involve health behaviors
• Integrated behavioral health movement
  • The primary care provider for mental health
  • Referral mechanism to the specialty mental health

Community Mental Health
• Serves 5% of population
• Primary focus is chronically mentally ill
• Impact in the global budget: negligible
Beginning initiatives for COHC

St. Charles: Program for the Evaluation of Development and Learning
- Three years of multi-disciplinary assessments on children with special health care needs
- Wait list of more than a year

St. Charles: NICU follow-up clinic
- Nationally recognized best practice to identify high-risk children
- Expanded Behavioral Health Consultants into NICU to reduce length of stay
- First kids are turning 4 this year

St. Charles: Behavioral Health Consultants in Primary Care
- Psychologists in St. Charles Family Care and Mosaic Clinics
- Approval of Health and Behavior codes

Emergency department visits per quarter 2010-2011

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COHC initial strategic initiatives

• Maternal child health
• School-Based Health Centers
• Behavioral health/primary care
• Chronic pain
• Transitions of care
• Complex care coordination
• Pediatric RN care coordination
• Integrating care for children with special health care needs

CCO transformation plan: Nine elements

• Integrated primary care model
• Advancing Patient-Centered Primary Care Home
• Consistent alternative payment methodologies
• Community Health Assessment and Annual Health Improvement Plan
• Electronic health records and Health Information Exchange
• Tailoring communications and services to cultural, health literacy and linguistic needs
• Diversity and cultural competence
• Quality improvement plan to reduce health disparities
• Primary care and public health partnership (COHC only)
All strategies lead to this …

The truth about integration is that it is not one thing. Any organization thinking about creating an "integrated" care system needs to understand what the philosophies of the organization or agency you work for are, what can you afford and who are your patients.

Reflecting back, our integration preparation was COMPLETELY LACKING these factors.
A flawed first trial

- NO daily presence to ensure fidelity
- FEW traditional mental health resources for diversion
- NO provider education in the new model

**AND ALL OF THIS EQUALS ...**

- Co-located specialty provider model
- Frustrated providers
- Lack of services

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
SO WE TRIED AGAIN...

Current Behavioral Health Consultants in primary care
- Primary Care—4 St. Charles Family Care sites (two open positions)
- FQHCs—3 Mosaic Medical sites (specialty co-location)
- Pediatrics—2 Central Oregon Pediatric Associates sites
- Two Critical Access Hospitals
- Internal Medicine—Bend Memorial Clinic (one open position)

Development of consistent metrics to measure outcomes
- Evaluate efficacy of integrated care models

Global mechanism for payment
Behavioral health consultants in primary care

- Behavioral Health Consultants in Person-Centered Primary Care Homes
  - Increased patient satisfaction
  - Increased provider satisfaction
  - Decreased visits with the primary care provider
  - Initial results show trend reduction in spend
- ADHD medication project
- Chronic pain initiative
- Psychopharmacology consultation
- SBIRT/clinical depression screenings

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Neonatal Intensive Care Unit

Psychologist embedded in NICU

- Early identification of NICU follow-up babies
- Early intervention with families
  - Begin training in health engagement from the start
  - Reduce family stressors
  - More consistent than other NICU team members
  - Advocacy

Early results

- Reduced length of stay

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Psychologist consult becomes "House Expert"

Different than a traditional consult/liaison

• Patient mental health needs
• Staff mental health needs
• Critical Incident Stress Debriefings
• Organizational Development consultation
• Liaison to community mental health

Behavioral Health Consultant to rural PCPCH

Remember those outcomes?
Quality incentive metrics: $3.7 million payoff

• SBIRT screenings
• Screening for clinical depression and follow up
• Poor control of diabetes HbA1c
• Follow up care for ADHD meds
• Ambulatory care utilization in ED and outpatient per 1,000
• Colorectal Cancer Screening
• Adolescent well-care visits

• Developmental screenings during first 36 months
• Timeliness of prenatal and postpartum care
• Mental and physical health evaluation of children in DHS custody
• Elective delivery before 39 weeks
• Controlling High BP
• EHR Meaningful Use adoption
Funded initiatives

- Patient engagement
- Pediatric hospitalists
- Dental care distribution
- Maternal child health
- Pediatric diabetes HET
- Community paramedicine
- CAC small projects
- Clinical pharmacy
- Standardization of Behavioral Health Consultants

Advanced payment methodology

How will we be paid?
- Pay for outcomes
- Shared savings and gain-sharing agreements
- Case rate bundles
  - Do increased outpatient visits reduce hospitalizations?

Traditional big dogs changing:
- Hospitals become the cost centers rather than profit centers
- Insurers become facilitators of care rather than barriers to care

Goal: Value-based payment system
Hospital performance metrics

Performance metrics

- 30% utilization measures (curb increases)
  - 10% length of stay
  - 10% readmissions
  - 10% ED visits
- 70% process development
  - 35% managing readmissions
  - 5% ED visit follow-up

Source of funds: 25% withhold on hospital services

50% to hospitals
50% to physicians

Quality metrics

- SBIRT screening
- Follow-up care for children prescribed Attention Deficit Hyperactivity Disorder (ADHD) medication
- Development screenings of children < 3 years old
- Early elective delivery rate
- ED visit rate
- Mental/physical assessment for children in Department of Human Services custody
- Providers reporting Stage II Meaningful Use data

Surplus settlement

- 50% of hospital withhold if HCB met

Terms for PCPCH

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Where are we going?

Pediatric obesity
- Intervention with accompanying workbooks, portion plates and pedometers
- Provider/BHC partnership with clinic administration based on DATA

Pain School for patients on chronic narcotic medications
- Dispersed through all our clinics and now going into other community clinics
- Curriculum is free to anyone who wants it

RN care coordinators
- Support health engagement teams
- Complex patient conferences
- Integrate with health system nurse navigators
- EDIE integration

Community Health Workers
- Clinic based
- ED based
- Dental

Where else are we heading?

Community Paramedicine—partnership with EMS
- Improve our ability to serve patients unable/unwilling to come to clinic.

Co-located psychiatry
- Meet patients where they are
- Care for the 70%

Expansion in the health system
- Cardiac
- Children with special health care needs
  - Pediatric diabetes
  - Pediatric asthma
  - 50% of Medicaid

Other payers
Recommendations going forth

Don’t assume your degree of integration or what your clinic needs are looks like anyone else's.

- Assess philosophies and be prepared to engage in dialogue
- Don’t be rigid unless you absolutely have to

Determine your individual needs in all areas. What worked for an outpatient clinic may not work for a hospital inpatient unit.

- What is the commitment your organization is willing to spend on developing and implementing integration

INVOKE YOUR COMMUNITY!

Why is community important?

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Don Berwick’s charge: The moral test

- Put the patient first
- Among patient’s, put the poor and disadvantaged first—those at the beginning, the end and the shadows of life
- Start at scale—flood the zone
- Return the money
- Act locally

MAKE WHAT IS POSSIBLE REAL

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Resources

Community Health Improvement Plan
www.cohealthcouncil.org

Central Oregon Healthy Communities
www.healthiercentraloregon.org/

Collaborative Family Healthcare Association
www.cfha.net

St. Charles Health System
www.StCharlesHealthCare.org