Behavioral Health Case Management and the Enhanced Primary Care Office: A Case Study

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- Not-for-profit health plan
- Physician-founded and guided
- 455,000 members primarily in 24 counties in New York
Vision and Mission

• **Vision:**
  – Create an innovative and sustainable model for the reimbursement of primary care physicians leading to a resurgence in the interest in primary care medicine as a career for medical students. Accomplish this while demonstrating better health outcomes and market-leading satisfaction scores for patients, employers, and physicians.

• **Mission:**
  – The transformation of primary care practice and payment mechanisms to enhance the value of health care delivery and primary care physician satisfaction.

Aligning with CDPHP’s Health Value Strategy and the Triple Aim

• Healthier Populations (Health Quality)

• Lower Cost Healthcare

• Higher Quality Care (the quality of health care services received by individuals)
Patient Centered Medical Home (PCMH)

- The Patient Centered Medical Home (PCMH) provides comprehensive primary care in a setting that facilitates partnerships between patients, their individual physicians and other caregivers, and their families.
- PCMH is widely accepted nationally.
- National Committee on Quality Assurance (NCQA) has recognized approximately 27,000 clinicians at over 5,000 sites as PCMH.
- The efficient team-based model has been very effective at improving quality and enhancing the physician/patient relationship without significant impact on cost.
- CDPHP calls its PCMH model “Enhanced Primary Care” (EPC).

Enhance Primary Care Model

2009
Three pilot practices
- Practice A (7,108)
  - 8.06 physicians, 2 PAs
- Practice B (2,420)
  - 5.06 physicians, 2 PAs, 1 NP
- Practice C (3,972)
  - 3 physicians, 3 NPs

2014
CDPHP Enhanced Primary Care (EPC) now constitutes 194 practices, 848 physicians and 240,345 members.
CDPHP EPC Model

Practice reform

- On site practice assessments to establish baseline and gap analyses with PCMH criteria
- Individual practice transformation work – prioritized to meet the needs of each practice, including
  - Team work & communication
  - Care coordination and Case Management
  - Leadership
  - Population Management
- On going monitoring of progress toward achieving goals
  - Phone calls, webinars, on site practice meetings
  - Quarterly collaborative meetings
    - Agenda based on practice (s) needs, leveraging national experts
    - Practices involved in EHR conversion
- NCQA certification process is necessary as level 3,
Payment Reform – CDPHP

*Targeted at improving base reimbursement by approximately $35,000

Bonus Payment

Goal
To identify metrics that are strongly correlated to lesser costs and the maintenance or improvement of quality and that can be used as a base for bonus payments:

- **Satisfaction** (CG-CAHPS) - threshold for bonus eligibility
  - Want to ensure no deterioration in patient satisfaction (access)

- **Effectiveness** (quality) - creates the bonus opportunity
  - Ensures that the quality of health care delivery is at least maintained or preferably enhanced under this payment model

- **Efficiency** (cost) - distributes the bonus opportunity
  - Ensures that bonus payments are associated with aggregate cost savings to allow for a sustainable payment model
EPC Effectiveness Metrics

- **Population Health**
  - Breast & Cervical Cancer Screening
  - Childhood and Adolescent Immunizations
  - Chlamydia Screening
  - Colorectal cancer screening
  - Lead testing in children

- **Managing Chronic Conditions & Medications**
  - Asthma Medication Ratio
  - Pharmacotherapy management of COPD Exacerbation (bronchodilators & corticosteroids)
  - Composite of three Diabetes measures (Eye, A1C, Nephropathy)
  - Persistent Medication Management (ACE/ARB + Digoxin + Diuretics)

- **Antibiotic Use In Adults & Children**
  - Three antibiotic use measures - adult bronchitis, children with pharyngitis, children with URI

- **Behavioral Health**
  - Antidepressant Medication Management – Continuation phase
  - Follow-up Care for Children Prescribed ADHD Medication – Continuation phase
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (30 day)

- **Member Experience of Care Summary**
  - CG-CAHPS Measures (Summary score of ten questions)

- **Coding Quality for Chronic Conditions**

Calculation of 2013 EPC Bonus Payment

<table>
<thead>
<tr>
<th>PERFORMANCE COMPENSATION CRITERIA</th>
<th>Site ID:</th>
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<tr>
<td>1. PATIENT EXPERIENCE</td>
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<tr>
<td>2. QUALITY: Effectiveness Score</td>
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<tr>
<td>3. EFFICIENCY: Total Cost of Care Score</td>
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<table>
<thead>
<tr>
<th>POTENTIAL EPC PERFORMANCE COMPENSATION OPPORTUNITY FOR PRACTICE SITE *</th>
<th>Base PMPM</th>
<th>PCAL Increment (PMPM)</th>
<th>Imputed PCAL Score</th>
<th>Average PCAL Score</th>
<th>Potential PCAL Performance Compensation Opportunity</th>
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<tr>
<th>AVAILABLE EPC PERFORMANCE COMPENSATION OPPORTUNITY **</th>
<th>Potential EPC Performance Compensation Opportunity</th>
<th>Practice Site Effectiveness Score</th>
<th>Opportunity</th>
<th>Available EPC Performance Compensation Opportunity</th>
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<tr>
<td></td>
<td>$208,239</td>
<td>$566,793</td>
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<table>
<thead>
<tr>
<th>ACTUAL EPC PERFORMANCE COMPENSATION PAYOUT ***</th>
<th>Actual EPC Performance Compensation Opportunity</th>
<th>Practice Site Performance Compensation Opportunity</th>
<th>Actual EPC Performance Compensation Payout</th>
<th>Final 2012 Bonus Payout</th>
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<tr>
<td>$566,793</td>
<td>70%</td>
<td>$126,100</td>
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Base PMPM = $2.66

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* Potential EPC Performance Compensation Opportunity

** Available EPC Performance Compensation Opportunity

*** Actual EPC Performance Compensation Payout

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Final 2012 Bonus Payout = $126,100
Integrated Behavioral Health

Requires a shared vision among providers
  Measurable goals and outcomes must be agreed upon a priori
Engaged health system leadership
  Clinic leaders and administration
  PCPs, care managers, psychiatrists and other specialists
Clinical and operation integration
  Fully functional teams with clear roles of various team members
  Clear lines of responsibility between teams to facilitate handoffs
  Clarity around shared workloads
Adequate resources
  Staff, IT, funding
Agreed upon problem solving system

The Need for Collaboration

• Treatment of behavioral health disorders requires a coordinated effort between the patient and a multidisciplinary teams of caregivers including
  – Primary care physicians
  – Mental health specialists
  – Counselors and therapists
  – Pharmacists
  – Family and significant others
Implementation and Initial Goals

• To develop a working, trusting relationship with the doctors, nurses and office staff.

• To educate the EPC, members and local providers about CDPHP Behavioral Health Case Management services.

• To develop a workflow with the EPC for the referral process, collaboration, consultation, etc.

• Collaborate with the CDPHP on-site Medical Case Manager in targeting populations chronic medical illnesses.

The Need for Collaboration

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Model Scheme

- Patient
  - Chooses treatment in consultation with providers

- Consulting Psychiatrist
  - Counselors
  - Therapists
  - Pharmacy

- Family

- Care manager

- Primary care physician
  - Refers to specialists
  - Prescribes medications
  - Manages co-morbidities

Role of the BH Embedded Case Manager

- Case finding through PCP identification, predictive modeling, ED visits and hospitalizations
- Triaging cases to determine which ones can be impacted for positive outcome
- Tracking members for progress and improvement outcomes and logging in patient registries
- Building relationships with PCP’s and the other PCMH office staff
- Engage members: develop care plans, self management goals, identify barriers that might stand in the way of achieving care goals, teach self management tools, and provide education and understanding of behavioral health illness, coaching, cheerleading and telephone follow-up.
- Screenings such as PHQ-9 or AUDIT
Role of the BH Embedded Case Manager

- Address health complexity (biological, psychological, social and health systems barriers that challenge positive outcome)
- Coordinating with other family members involved in the patient’s care
- Help PCP’s monitor medication compliance and effectiveness
- Monitoring CDPHP member symptoms
- Monitoring adherence to treatment protocols
- Assist PCP’s with the referral process to outpatient BH providers
- Facilitate psychiatric consultation as needed
- Facilitate communication between the BH providers and the PCP
- Create a collaborative link with social service agencies, housing and mental health intensive case mgmt programs
- Provide in-service training as needed

Outcome Evaluation

Data was collected and analyzed for the 161 members referred to Behavioral Health Case Management

For each member, a comprehensive review of records was completed. Data was pulled from:
- Claims
- Electronic Health Records (EHR)
- Behavioral Health Case Management notes
Behavioral Health and Medical Case Manager
Collaborative Efforts

• Of the 180 referrals, 34 (21%) members worked with both the Behavioral Health Case Manager and the Medical Case Manager.

• A review of the medical diagnoses that were identified included:
  Diabetes
  Asthma/COPD
  Pain
  Cardiovascular
  Neurological
  ESRD
  Cancer
  Liver Disease

Member Engagement

Intervention Types
• Was a referral or recommendation given to the member?
• Did they agree to BH and/or Medical CM?
• Did the member refuse all interventions?

Outcome Types
• Did the member engage in treatment?
• Were they compliant with recommendations?
• Did they actively participate in BH/Med CM services?
Member Engagement Data:

**Face to Face Contact**
- 98% Received an intervention
- 83% Positively engaged
- 17% No Outcomes

**Telephonic Contact**
- 90% Received an intervention
- 59% Positively engaged
- 41% No Outcomes

Member Engagement Data:

- Of the 180 referrals, **101 members engaged in treatment** with a behavioral health provider during 2012.
- Of those 101 members, **65 members are still in treatment**.
Quantifying a Reduction in Hospital Costs
Emergency Dept & Inpatient Hospital Admissions
Claims data was reviewed for each of the 180 members referred

Then grouped by reason for visit

Behavioral Health or Medical-Related

Then further categorized by date

Prior to BH Intervention and Post BH Intervention

2012 Annual Report
Analysis of Emergency Department Costs

Out of 180 Members

✓ 76% Absence of or Reduction in ED Visits
✓ 81 members did NOT visit the ED
✓ 56 members REDUCED the number of ED visits
✓ $46.48 per person Reduction of ED costs

Total Emergency Department Savings
$8,366.00
2012 Annual Report
Analysis of Inpatient Hospital Admission Costs

Out of 180 members

- 99% Absence or Reduction in Admissions
- 150 members did NOT have an Admission
- 29 members REDUCED their rate of Admissions
- $1,107.37 per person Reduction of costs

Total Cost Savings for Inpatient Admissions
$199,326.00

2012 Annual Report
Total Savings for Hospital-level Costs

Emergency Department Visits savings $8,366.00
Inpatient Admissions savings $199,326.00
Gross Savings $207,692

CDPHP Administrative Costs (approx) = - $30,000

Total Savings = $177,692
2012 Annual Report

**Hospital-level Costs Savings**

- Costs Before Intervention
- Costs Post Intervention
- TOTAL SAVINGS

<table>
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<tr>
<th>Costs Before Intervention</th>
<th>Costs Post Intervention</th>
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<td>$199,327</td>
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**2012 Annual Report**

**Satisfaction Survey**

- 23 Responders included Doctors, Mid-Level, Nurses, Residents and Staff
- Rating from “No Value” to “Very Significant Value”

**Results**

- Most responders reported “Very Significant Value”
- 67% average improvement of coordination of care
- 22.5 hours per month saved by having BH CM on-site
Behavioral Health Case Management and the EPC
Demonstrating the “Triple Aim”

- 99% Absence or Reduction in Admissions
- Improved Health Outcomes
- 56% Engaged in Treatment
- Experience of Care
- Per Capita Cost
- Savings of $177,692

Questions?
Getting started

- Assess readiness for integration based on:
  - Patient needs
  - Clinic characteristics
  - Policy & financial environment
  - Data & measurement system
- Develop the core team to drive the work forward.
- Build the business case – calculate expenditures, understand baseline costs, and get creative with your data.
- Start small and demonstrate results with outcomes measurement.
- Identify and work closely with community partners.
- Develop the supporting processes and operational infrastructure.

Behavioral Health Integration Capacity Assessment Tool (BHICA)

- Resource for organizations to assess their readiness to integrate behavioral health and primary care.
- Consider potential approaches to integration;
- Understand the current infrastructure to support greater integration;
- Assess the organization’s strengths and challenges in undertaking different approaches to integration;
- Set and prioritize goals for integration efforts.

https://www.resourcesforintegratedcare.com/tool/bhica
Five Sections of BHICA

1. Understanding Your Population
2. Assessing Your Infrastructure
3. Identifying the Population and Matching Care
4. Assessing the Optimal Integration Approach for Your Organization
5. Financing Integration

Evaluation Framework Linked to Organization Processes, Impact, and Resources

"Reliability is defined as a "failure-free operation over time." In health care, it is difficult to achieve 95% reliability for the majority of care-related processes. One simple way to assess reliability is to predict if five front-line individuals are able to accurately describe the process in the same way. If you are not confident that all five individuals are able to do so, evaluate this process as not reliable."
Using your BHICA results

• **Types of planning activities that the results might enable:**
  - Aim setting - establish “aspirational goals” for your organization for each area scored/some of the areas scored…”Where can we go from here?”
  - Use the results as part of your organizations continuous quality improvement process; reshape the work plan and work flows accordingly.
  - Examine your resource capacity to get where you need to go next:
    - Do we have the resources we need to transform the area of practice we are targeting for change?
    - If not, can we get the resources?
    - Where can we go to get those resources?

Using your BHICA results

• **Identify priority areas based on current gaps, needs, and resources.**

• **Use the results to build “champions” for integration and develop leadership to help implement the approach.**
  - Identify your strengths and weaknesses and where partnerships will be required.

• **Build a project cost model that includes the administrative overhead that will be needed to implement your approach.**
  - Results can help you focus in on and plan for what it will take administratively to implement integration, beyond the clinical needs.

• **“Mature” your integration approach based on the results.**
  - Pick one area that you want to strengthen and focus on improvement/growth.
  - Use it to build team cohesiveness around characteristics of good patient care.
Exercise: Action Planning

- See Action Planning worksheet.

Tools and Resources

- BHICA Tool: [https://www.resourcesforintegratedcare.com/tool/bhica](https://www.resourcesforintegratedcare.com/tool/bhica)
- AHRQ Expenditure Analysis Tool
- Useful Papers (see my IHI/enrollments to access files)
Stay in touch!

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