Session Objectives

- Understand the impact of integrated behavioral health and primary care on health outcomes, patient and provider satisfaction, and costs of care.

- Describe the different ways in which three innovative payers have supported the integration of behavioral health and primary care and the tangible process change elements needed (and the landmines to avoid) in implementing an integrated behavioral health model.

- Define key strategies to engage payers and providers in their own communities to move toward sustainable models of integrated care.
Session Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 1:15</td>
<td>Welcome, agenda overview, and introductions</td>
</tr>
</tbody>
</table>
| 1:15 – 1:55 | Case Study: Trillium Community Health Plan  
|           | Q&A, discussion                                                           |
| 1:55 – 2:35 | Case Study: CareOregon  
|             | Q&A, discussion                                                           |
| 2:35 – 2:50 | Break                                                                      |
| 2:50 – 3:30 | Case Study: Inland Empire Health Plan  
|             | Q&A, discussion                                                           |
| 3:30 – 4:20 | Discussion: developing provider/payer relationships around integration  
|             | and answering your questions                                              |
| 4:25 – 4:30 | Wrap up                                                                    |

Getting to know you

- Name
- Organization
- What are your burning questions around payer engagement in behavioral health integration initiatives?
Core features of case studies

- Definitions of integration
- What prompted work on BHI?
- Integration approach
- Payment methods/incentives
- Barriers
- Successes
- Quality measures used
- Results
- Lessons learned

Case Study: Trillium Community Health Plan
INTEGRATION IMPLEMENTATION: ALL WHEELS ON THE GROUND

Lynnea E. Lindsey-Pengelly, PhD MSCP

LEARNING OBJECTIVES

At the conclusion of this session, the participant will be able to:

- Identify the essential stakeholders in the development of a larger-scale integrated care delivery system.
- Discuss the required elements for fully developed sustainable integrated medical homes.
- Describe the barriers to address prior to and during the ongoing work of integrated medical home development with examples from a current integration project.
MEETING THE TRIPLE AIM

- Improved Patient Experience
- Improved Population Health
- Reducing Per Capita Cost of Health Care

The work of integrating physical health and behavioral health requires sustainable changes in the clinical, financial models and in the data/outcomes measurement.

The required steps include simultaneously partnering alternative payment models with team-based care models, along with quality population health practices.

This session will cover how moving all of these components forward, across stakeholders, has been essential to keeping integration as a priority in a quality healthcare system, while bending the cost curve.
Question

What is required to align the work of integrating physical and behavioral health care with healthcare transformation?

Three Essential Pieces

1. Population perspective
2. Team approach
3. Aligned Data/ Outcomes/ Technology

Supported by a sustainable payment model
Spectrum of Care

Physical Health  
Health Behavior  
Behavioral Health

The Cost of Care

**Bending**

**Primary Care**
- Day to day non-emergent care for the whole person

**Secondary Care**
- Outpatient Specialty Services

**Tertiary Care**
- Interventional, Urgent and Emergent Services most often requiring residential and/or inpatient care
Where to jump in?

Clinical Setting Defined → Population Detailed → Local Determinants of Health

Payment Model Decided → Workforce Delineated → Highest Needs Determined

Where to jump in?

“The TIPPing Point”: How Little Things Can Make a Big Difference

“The tipping point is that magic moment when an idea, trend, or social behavior crosses a threshold, tips, and spreads like wildfire.”

- Malcolm Gladwell
TRILLIUM INTEGRATION

Trillium CCO
(Coordinated Care Organization)

• Medicaid Based Payer-Led Project
To provide integrated primary health care services to Medicaid members
• All sites serve patients with other payers

RFP issued (April 2014) – Seeking projects integrating Primary Care and Behavioral Health (“forward & reverse”)
  • Many thanks to the years of community work &
  • Rick Kincade, MD - Family Physician &
  • Michael Reaves, MD - Psychiatrist (retired)

TRILLIUM INTEGRATION INCUBATOR PROJECT

All eight RFP applicants were accepted on May 5, 2014

• 4 Primary Care Medical Homes
  • (~15,000 start/17,737 current)
• 4 Behavioral Health Medical Homes
  • (~2500 start /1509 current)

The small idea became a big PROJECT …
• Total population = 19,246 out of ~94,000 total CCO Medicaid members
TIIP/TIP TIME LINE

- TIIP Launched July 1, 2014
- CCO “Transformation Funds” were given in start-up dollars where requested. (~$500,000 total)
- Financial model set with full Fee For Service (FFS) plus variable Per Member per Month (PMPM) (per RFP requests)
- 12 month Memorandums of Understanding issued (Note: Extended to March 31, 2016)

December 4, 2016
Institute for Healthcare Improvement :: Orlando, Florida

PRIMARY CARE TIIP HOMES

A pediatric practice – brought in two child psychologists and a case manager and now has added two licensed family therapists and a speech/swallow specialist (2032 start, 3000 current patients)

A family practice that partnered with a local behavioral health organization to bring in two qualified mental health professionals (QMHPs) and one social worker (6000 start, 5062 current patients)

December 4, 2016
Institute for Healthcare Improvement :: Orlando, Florida
PRIMARY CARE TIIP HOMES

A pediatric and family medicine practice that partnered with three local behavioral health organization to bring in qualified mental health professionals (QMHPs) & psychologists (3571 start, 4274 current patients)

A family medicine practice in a large health system that brought in in qualified mental health professionals (QMHPs) from their behavioral health services (3000 start, 5914 current patients)

December 4, 2016
Institute for Healthcare Improvement :: Orlando, Florida
BEHAVIORAL HEALTH TIIP HOMES

A behavioral health organization that partnered with a local family practice to open a new clinic and bring in a physician assistant (1000 start, 736 current patients)

A long term substance use provider with a grant from another resource opened a new rapid access clinic and medical clinic and brought in two adult nurse practitioners (1200 start, 189 current patients)

December 4, 2016
Institute for Healthcare Improvement :: Orlando, Florida

BEHAVIORAL HEALTH TIIP HOMES

The county behavioral health organization shared space with community health center clinic (FQHC) with a part-time physician. Created a partnership for some patients. Now adding a full-time physician (200 start, 419 current patients)

An outpatient specialty behavioral health service with an EASA grant created a medical space and brought in a part-time nurse practitioner from family medicine (75 start, 165 patients)

December 4, 2016
Institute for Healthcare Improvement :: Orlando, Florida
OPERATIONAL STRUCTURE

✓ Established TIIP Advisory Committee by expanding original RFP committee (Meets Monthly)

✓ Established TIIP Operations Committee with membership of CCO operations leads (Initially met every other week, now meets as needed)

DATA SHARING

✓ Established monthly learning collaborative (Third Monday, 7-9am)

✓ Weekly TIIP Sheet e-newsletter with brief article linked to current topics and research
DATA GATHERING

✓ Established the “TIIP Wellness Tool”
  ✓ SBIRT/CRAFFT (includes PHQ2) which are required for Oregon CCOs
  ✓ Quality of Life Scales: HR-QOL first for questions (for adults) and the KIND-L
  ✓ Generalized Self Efficacy - GSE-6
  ✓ Reporting differed by site
  ✓ Some sites use data for population focused projects

DATA GATHERING

✓ Developed spread sheet based tool for sites to track non-billable services (huddle, warm handoff, etc.) by staff type and time
  ✓ Initial tracking tool had 20 items, was narrowed to seven items
  ✓ One site placed this tool in the Electronic Health Record for easy completion
  ✓ Variable reporting in initial two quarters as sites began to value the information the tool provided to them
DATA GATHERING

✓ TIIP Quarterly Reports – Included AHRQ Self Evaluation Tool to determine progress to integration (CJ Peek)

TIIP QUARTERLY REPORTS

✓ Clinics initial self-perceptions were they were far along on the road to integration.

✓ The second and third quarter reports indicated the more they learned about integration, they were likely to score themselves as less integrated.

✓ The fourth quarter reports showed improvement beyond initial baseline towards increased integration.
OUTCOMES DATA

✓ Currently crunching the numbers on the first full year (2015) of claims data.

✓ Initial indications:

✓ All sites showed reduction in urgent care visits.
✓ Six of the eight sites saw significant reductions in ED and hospitalization costs. (75%) 
✓ Four of the eight sites demonstrated reductions in readmissions. (50%) 
✓ All sites increased primary care costs from the previous year for their patients.

(Note: Challenged where sites did not bill claims and where panel sizes were small (behavioral health medical homes))

OUTCOMES DATA

✓ One behavioral health medical home (BHMH) self-reported a reduction of ~ $3200 PER MONTH in aggregate hospital based care (ED & IP) for their 75 severe persistently mentally ill patients.

✓ Note: This is a young population average age 25 years.
✓ Increased primary care and outpatient specialty behavioral health costs (fee for service) 
✓ Patient satisfaction scores are 4.8 out of 5 on a question “I feel that I am treated with respect.”
SURVEY OF PROJECT PARTICIPANTS: THE FOURTH AIM.

Has your satisfaction with your work changed due to having integrated health care? (43 responses)

- Extensively Improved
- Moderately Improved
- The same
- Moderately Declined
- Extensively Declined

76% Reported Improved Work Satisfaction

**Extensively declined was a Behavioral Health Practitioner

CHALLENGES/OPPORTUNITIES

✓ Taking a group of practitioners/clinics with big hearts and minimal knowledge of integration and creating standardization.

✓ Working at the payer level with staff with limited understanding of the day to day work of primary care and behavioral health practices.

✓ Developing movement from hybrid to a new culture for integrated clinics as they learned from each other.

✓ Keeping alignment with changes at the state and national level as integration progresses.
MOVING TO TRILLIUM INTEGRATION PROGRAM 2016

✓ Essential Elements for “Standard” Integrated Medical Home (supporting sustained progress)

✓ Essential Elements for “Advanced” Integrated Medical Home (reaching further into integration)

✓ Standardized PMPMs plus FFS

✓ Payment model based upon expected total cost of care

<table>
<thead>
<tr>
<th>PMPM</th>
<th>PCMH</th>
<th>BHMH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Standard</td>
<td>X</td>
<td>X+</td>
</tr>
<tr>
<td>Advanced</td>
<td>X *~1.9</td>
<td>X+*~1.8</td>
</tr>
</tbody>
</table>

Trillium Integration Time Line

Support Early Adoption of Integrated Care
- By July 1, 2016, 40% of Trillium Members care provided in an integrated Medical Home that meets the Oregon Health Authority PCPCH Standards AND the Trillium Standards

By July 1, 2017, have 60% of Trillium Members care provided in an integrated Medical Home that meets the OHA PCPCH Standards AND the Trillium Standards
BIBLIOGRAPHY / REFERENCES


QUESTIONS

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HealthThink
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DrLindseyConsulting@gmail.com
Case Study: CareOregon

INTEGRATED BEHAVIORAL HEALTH IN PRIMARY CARE @ CAREOREGON

Mindy Stadtlander, MPH  Andrew Huff, LPC
Executive Director of Network Services  Behavioral Health Innovation Specialist
Where we’re going [in 20 minutes]...

• Share why CareOregon believes Integrated Behavioral Health in Primary Care is so important
• Understand definition of success from CO perspective
• Discuss where Primary Care payment is headed and how IBH fits in for CO
• Hear about your perspective and answer any questions you have!

CareOregon

• Publically financed healthcare insurer for low-income citizens
• 234,000 Members; Medicaid and Medicare beneficiaries
  – 85% live in the Portland Metro region; rest are spread statewide
• Not for Profit
• Contracted network
  – Contracts with primary care providers, specialists, hospitals, medical equipment vendors, home health agencies, pharmacies
  – About 50% of our primary care providers practice in clinics that disproportionately care for the poor
• Began participating in the Institute for Healthcare Improvement’s Triple Aim Initiative in May 2007
CareOregon Affiliated CCOs

Health Share of Oregon
Columbia Pacific CCO
Jackson Care Connect
Yamhill County Care Organization

CareOregon Member Populations

≈ 234,308 members
- 3 distinct populations

≈ 100,926
43% Children (0-18 yrs)

≈ 121,976
57% Adults (19 yrs +)

≈ 11,103
42% < 65 yrs MAPD

MAPD 1%
Dual Eligible

91% Medicaid

≈ 11,103
42% < 65 yrs

22
Why Integrated BH?

• Work was prototyped and piloted by members of our community
• Response to complexity and needs of the population
• Key feature of Patient Centered Primary Care Home
• Significant emerging evidence

Evolution of Team Based Care

- Panel management
- Role development
- Access
- Ongoing QI
- Identification of at risk sub-populations
- Population identification
- Clinical standards of care
- Role development
Not all behavioral health needs can be met in primary care

Tier 1 Integration

**Basic Requirements:**
- At least 0.5 FTE licensed behavioral health clinician (BHC) as defined by ORS 414.025** is on-site, located in the same shared physical space as medical providers
- Mental Health, Substance Use Disorder, and Developmental Screening strategy is established with documentation for on-site local referral resources and processes

**Communication around Shared Patients:**
- Primary care clinicians, staff, and BHCs document clinically relevant patient information in the same medical record at the point of care; or Care team and BHC routinely engage in face-to-face collaborative treatment planning and co-management of shared patients

**Same-day Access:**
- On average, at least 25% of BHC hours at the practice each week are available for same-day services (may include average weekly late-cancelation/no-shows converted to same-day services)

**BHC as an Integrated Part of the Primary Care Team:**
- Warm hand-offs/introductions between care team members and BHC
- BHC is a regular part of practice activities (such as team meetings, provider meetings, quality improvement projects, case conferences, etc.)
Tier 2 Integration

Basic Requirements:
- At least 0.5 FTE licensed behavioral health clinician (BHC) as defined by ORS 414.025** is on-site, located in the same shared physical space as medical providers
- Mental Health, Substance Use Disorder, and Developmental Screening strategy is established with documentation for on-site local referral resources and processes

Communication around Shared Patients:
- Primary care clinicians, staff, and BHCs document clinically relevant patient information in the same medical record at the point of care; and
- Care team and BHC routinely engage in face-to-face collaborative treatment planning and co-management of shared patients

Same-day Access:
- On average, at least 50% of BHC hours at the practice each week are available for same-day services (may include average weekly late-cancelation/no-shows converted to same-day services)

BHC as an Integrated Part of the Primary Care Team:
- Warm hand-offs/introductions between care team members and BHC
- BHC is a regular part of practice activities (such as team meetings, provider meetings, quality improvement projects, case conferences, etc.)
- Pre-visit planning activities such as scrubbing and/or huddling for behavioral health intervention opportunities

Staffing Ratio:
- BHC(s) provide care at a ratio of 1 FTE BHC for every 6 FTE Primary Care Clinicians

Integrated BH Program Payment

1. Quality Improvement Grant
   - Allow practices to start up an IBH program
   - Provide access to collaborative learning and consultation

2. Capitated Payment
   - Eliminate administrative hassle
   - Allow program innovation
   - Create ability to align

3. Enhanced Fee Schedule
   - Support FFS billing
Payment for Things We Think Are Important

<table>
<thead>
<tr>
<th>Metric</th>
<th>Tier 1 Reporting Requirements</th>
<th>Tier 2 Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access: Productivity</strong></td>
<td>Numerator (N): # of unique CareOregon members seen by a BHC</td>
<td>Numerator (N): # of unique CareOregon members seen by a BHC</td>
</tr>
<tr>
<td>Percentage of unique CareOregon members that were seen by BHC in primary care.</td>
<td>Denominator (D): # of unique CareOregon members seen in primary care</td>
<td>Denominator (D): # of unique CareOregon members seen in primary care</td>
</tr>
<tr>
<td><strong>Access: Same-day</strong></td>
<td>N: average # of BHC hours* per week available for same-day services.</td>
<td>N: average # of BHC hours* per week available for same-day services.</td>
</tr>
<tr>
<td>Average percentage of BHC hours available for same-day services.*</td>
<td>D: average # of BHC hours* per week</td>
<td>D: average # of BHC hours* per week</td>
</tr>
<tr>
<td>*may include late-cancellation/no-shows converted to same-day</td>
<td>*Medication prescribers are excluded from Access: Same-day quality metric.</td>
<td>*Medication prescribers are excluded from Access: Same-day quality metric.</td>
</tr>
</tbody>
</table>

Definition of Success: Access
### Definition of Improvement: Clinical

<table>
<thead>
<tr>
<th>Clinical Target</th>
<th>Tier 1 Reporting Requirements</th>
<th>Tier 2 Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chronic Pain</strong></td>
<td>N: # of patients on &gt;120 or 90 MED opioids with a taper plan in place</td>
<td>N: of those in D, # seen by a BHC</td>
</tr>
<tr>
<td></td>
<td>D: # of patients on &gt;120 or 90 MED opioids</td>
<td>D: # of patients on &gt;120 or 90 MED with a taper plan in place</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td>N: # A1C &gt; 9</td>
<td>N: of those in D, # seen by a BHC</td>
</tr>
<tr>
<td></td>
<td>D: # seen with DM</td>
<td>D: # A1C &gt; 9</td>
</tr>
<tr>
<td><strong>Depression</strong></td>
<td>N: # given PHQ9</td>
<td>N: of those in D, # seen by a BHC</td>
</tr>
<tr>
<td></td>
<td>D: # positive PHQ2</td>
<td>D: # PHQ9 &gt; 14</td>
</tr>
<tr>
<td><strong>Hypertension</strong></td>
<td>N: # BP &gt; 140/90</td>
<td>N: of those in D, # seen by a BHC</td>
</tr>
<tr>
<td></td>
<td>D: # 18 and over seen with HTN</td>
<td>D: # BP &gt; 140/90</td>
</tr>
<tr>
<td><strong>Tobacco</strong></td>
<td>N: # Yes for use</td>
<td>N: of those in D, # seen by a BHC</td>
</tr>
<tr>
<td></td>
<td>D: # 18 and over seen</td>
<td>D: # yes for use</td>
</tr>
<tr>
<td><strong>A&amp;D Screening for Adolescents</strong></td>
<td>N: # screened</td>
<td>N: of those in D, # seen by a BHC</td>
</tr>
<tr>
<td></td>
<td>D: # of 12-17 year olds seen</td>
<td>D: # screened positive</td>
</tr>
<tr>
<td><strong>Autism Screening</strong></td>
<td>N: # screened</td>
<td>N: of those in D, # seen by a BHC</td>
</tr>
<tr>
<td></td>
<td>D: # patients 16-30 months seen</td>
<td>D: # screened positive</td>
</tr>
<tr>
<td><strong>Follow-up after ADHD Rx</strong></td>
<td>N: # with new Rx for ADHD</td>
<td>N: of those in D, # seen by a BHC</td>
</tr>
<tr>
<td></td>
<td>D: # 6-12 year olds seen</td>
<td>D: # with new Rx for ADHD</td>
</tr>
</tbody>
</table>

### Definition of Success

The definition of success includes the following metrics:

- **Paid Cost (PMPM) by Service Category**
  - Paid Cost (in $/PMPM) for each service category.
  - Comparison over quarters (Q1 to Q4).
- **Utilization (PMPM) by Service Category**
  - Utilization (in #/PMPM) for each service category.
  - Comparison over quarters (Q1 to Q4).
The current payment landscape and drivers for future payment structures

Nationally, we know have to move...

Goals of the U.S. Department of Health and Human Services (HHS):

- 30% of U.S. health care payments in APMs or population based payments by year 2016, and
- 50% by year 2018

Source: Health Care Learning & Action Network: [https://hcp-lan.org](https://hcp-lan.org)
APM ROADMAP

Figure 3. The Work Group’s Goals for Health Care Reform

Source: Health Care Learning & Action Network - https://hcp-lan.org

STATE DRIVERS

SB231
MULTI-PAYER
PRIMARY CARE COLLABORATIVE
# Primary Care Payment Evolution

**Past State**
- Fee for Service
- Incentive Payment

*Base FFS payment structure with Primary Care Incentive Program*

**Current State**
- Fee for Service with expanded codes
- Quality Program Based Funding
- Incentive Payment

*Implemented!*

*Base FFS payment structure that supports alternative care delivery models (telephone/e-visits, RN/BH visits, etc) with expanded Primary Care Incentive Program*

**Future State - TBD**
- @ Risk ED or Specialty Utilization
- @ Risk Quality Distribution
- Behavioral Health Integration PMPM
- Fee For Service/Enhanced Fee Schedule
- Layered with portion of payment at risk for quality and utilization outcomes

**Quality Program Based Funding**
- 11% in 2014
- 29% in 2015

**Thank You**
Break!

Case Study: Inland Empire Health Plan
Integrating Behavioral & Physical Health:

Building Integrated Complex Care
Health Homes

Presented by
Marcia Anderson, BSN, RN, CCM, CDMS
Chief Medical Services Officer
&
Jennifer Clancy, MSW
JCC Consulting

IHI Learning Lab
December 4, 2016

Introduction

- IEHP is a Local Initiative Medicaid Managed Care Plan
- Organized as a Public Agency, Not-for-profit HMO
- Became Operational on September 1, 1996
- Mixed Model HMO:
  - Independent Physician Association (IPA)
  - Direct Physician Contracting
- Currently serves over 1.3 million members who are enrolled in:
  - Medi-Cal (Medicaid)
  - Cal MediConnect Plan (Medicare-Medicaid Plan)
  - Healthy Kids
Healthcare access is not the primary determinant of Health

Whole Person Care!!

Proportional Contribution to Premature Death

- Genetic predisposition: 30%
- Behavioral patterns: 40%
- Social circumstances: 15%
- Environmental exposure: 5%
- Health care: 10%

Data/Cost Impact

Cal MediConnect
- 60% mental health diagnosis (including less severe diagnoses)
- 5% substance abuse (probably under-reported)

Cost Implementation
- Medi-Cal data demonstrates 40% higher medical cost for chronic illness with MH co-morbidity

Mortality
- Riverside County study-Members die 20 years younger than expected

IEHP case anecdote (52 year old schizophrenic with HgbA1c at 10.5)
For Decades we have known: Chronic Disease + Depression = Higher Cost

![Graph showing the relationship between chronic disease score and annual cost.](Image)


Agenda

- Why did IEHP support Behavioral Health Integration (BHI)?
- What is IEHP’s approach to Integrated Complex Care with BHI? (BHI-CCI)
- How did IEHP use Payment and Practice Coaching as an engagement and implementation strategies?
**BHI-CCI “Pilot” at Point of Care**

**BHI-CCI** - Behavioral Health Integration and Complex Care Initiative

**Target Population** – Complex members with chronic physical health condition as well as one mental health condition and/or a substance use disorder

**Timeframe** – January 2016 to July 2018

**Program** – Transdisciplinary teams in 13 safety net health care organizations (PC and BH Clinics, SUD Tx. Ctr., Adult Day Health Care) 32 sites in Riverside and San Bernardino Counties.

**Funding / Support** – $31,000,000 MM budget. 10 quarters of funding for integrated complex care teams, practice coaching, learning collaborative

---

**BHI-CCI: Components**

**Jennifer Clancy Consulting (JCC)**
- Multi-disciplinary Team
- Program Development
- Coaching on Site
- Cross System Leadership Dev
- Data / Metrics: Structure and Tool

**IEHP**
- Internal infrastructure
- Data analysis
- dbMotion population health tool

**Sites**
- Staffing paid for by IEHP: Licensed Clinical Social Worker (LCSW), RN Care Managers, Care Coordinators, and Data Analytics Staff
- Memorandum of Understanding – commitment to process and metrics

**University of California-San Diego (UCSD)**
- Formal evaluation
Model of Care

Multidisciplinary Care Teams integrated at point of care

- Medical Doctor/Nurse Practitioner/Physicians Assistant
- Psychiatrist/ Psychologist/LCSW/Licensed Marriage & Family Therapist (LMFT)
- Registered Nurse/LCSW Care Management
- Care coordinators/ Navigators/ Peer Coaches

Assessments

- Health Risk Assessment- ADLs, health status, conditions, etc.
- PHQ-9 (depression)
- GAD-7 (anxiety)
- Substance Use Assessment
## What are the BHI-CCI Goals?

### PATIENT LEVEL

1. Improve Whole Person Care
2. Increase Patient Self-Management
3. Increase Shared Care Planning
4. Improve Coordination of Care
5. Promote Measurement Based Practice

### SYSTEM LEVEL

6. Increase Management of Population Health
7. Improve Health Care Teams’ and Patient Experience of Providing Care
8. Decrease the Cost of Care

---

## BHI-CCI Practice Coaching and Learning Tool Kit

1. Testing the “Roadmap”: Transformational Practice Changes
2. Developing **Foundational Skills**: Motivational Interviewing and Trauma Informed Care
3. Training **Core Competency Modules**: Doing Integrated Complex Care
4. **Standardizing Practice Across the Network**: Clinical Practice Guidelines/Protocols
5. **Promoting Cross System Leadership Skills**: Improving Patients’ Care Transitions
**PROVIDE FUNDING TO IMPROVE QUALITY AND ACCESS**

IEHP invests $31,000,000 over 3 years to improve quality and access in 13 Safety Net Systems of Care (Hospitals/Clinics)

- a) $ for Staff, Exam Rooms, Tech Equip
- b) $ to Improve Integrated Chronic Care by building tailored health homes
- c) $ to Work collectively to improve the Inland Empire local health care system

**SUPPORT PRACTICE TRANSFORMATION WITH COACHING AND EVALUATION**

JCC Coaching Team Practice Improvement Areas

- a) Population health
- b) Patient and Provider team experience
- c) Team-based care and treat-to-target
- d) Integrated Complex Care
- e) Self-Management

UCSD doing formal evaluation

**SUPPORT CULTURE CHANGE FROM VOLUME TO VALUE WITH QI FRAMEWORK**

BHI-I Aim:

Improve the whole health and wellness of all individuals in the Inland Empire by creating an array of population-based, integrated health homes

**Outcome Measurements**

- Depression Scale
- Anxiety Scale
- Comprehensive Diabetes Care
- Blood Pressure Control
- BMI
- Pain Scale
- Substance Use Assessment
- Member Engagement/Experience
- Provider Engagement/Experience
- ED Utilization
- Inpatient Utilization
### How will IEHP Measure Success?

<table>
<thead>
<tr>
<th>What is BHI-CCI tracking?</th>
<th>How is BHI-CCI measuring?</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Experience and Engagement</td>
<td>1. Patient Experience Survey</td>
<td>Data gathered via online survey (tablet administered)</td>
</tr>
<tr>
<td>Team Member Experience and Engagement</td>
<td>2. Team Member Experience Survey</td>
<td>Data gathered via online survey (e-mail administered)</td>
</tr>
<tr>
<td>Stabilization and Improvement of Medical Conditions</td>
<td>3. HbA1c, Blood Pressure, BMI</td>
<td>Clinical data from EHR or population health tool</td>
</tr>
<tr>
<td>Stabilization and Improvement of Behavioral Health Conditions</td>
<td>4. PHQ-9, GAD-7, Substance Abuse Assessment (SAA), Strengths and Difficulties Questionnaire (SDQ), ANSA</td>
<td>Clinical data from EHR or population health tool</td>
</tr>
<tr>
<td>Utilization &amp; Cost</td>
<td>5. Medical Inpatient Admissions</td>
<td>IEHP Claims Data</td>
</tr>
<tr>
<td></td>
<td>6. Psychiatric Inpatient Admissions</td>
<td>IEHP Claims Data</td>
</tr>
<tr>
<td></td>
<td>7. Emergency Department Visits</td>
<td>IEHP Claims Data</td>
</tr>
<tr>
<td></td>
<td>8. Total Cost of Care</td>
<td>IEHP Claims Data</td>
</tr>
</tbody>
</table>

### A Providers Perspective...

Dr. Leung, Medical Director, Riverside University Medical System
Challenges

• Within IEHP
  ➢ Ensuring communication/collaboration across & between units
    ▪ CM, UM, BH, Disability, Pharmacy
  ➢ Data Infrastructure to support population health
    ▪ Mostly one system (MedHok)
  ➢ Bi-Directional transformation
    ▪ Contracts and Credentialing Processes to support ICC

• BHI-CCI Point of Care
  ➢ Building local health care system infrastructure for ICC
  ➢ Leadership
  ➢ Hiring and training staff
  ➢ Learning/ sustaining changes in workflow and processes
  ➢ Data!

Challenges (cont.)

• Communication/ Collaboration/ Data Transfer across all care domains
• Continued barriers to transfer of information
  ➢ Legal interpretation
  ➢ Different data systems
• Behavioral Health/Severe Mental Illness Carve Out
• Money/Time/Effort!
System Level
- Leadership (org. and cross system) and Infrastructure development
- System-level Expectations for Population Health Improvement
- System-level Expectations for Integrated Complex Care
- System Wide Care Transitions Pilots
- Using QI (PDSAs) as Organizational Strategy

Clinic Level
- Daily Transdisciplinary Huddles
- Whole Health Assessments
- Use of Registry: Systematic Patient Outcome Monitoring
- Systematic Case Review: Weekly Pop Health Monitoring
- Integration at Point of Care (hallmark of IEHP approach):
  - BH Clinicians (LCSWs, LMFTs, Psychologists) integrated into PCP sites
  - PCP (MDs, NPs, PAs) integrated into BH sites

Questions
Discussion: Developing Payer-Provider Relationships around Integration

Considerations for payer-provider engagement

- Initial engagement
- Scope of services
- Contracting
- Accountability
- Cross-system leadership
- Care models
- Measurability, scalability, replicability
- Desired outcomes
Wrapping up

- Understand the impact of integrated behavioral health and primary care on health outcomes, patient and provider satisfaction, and costs of care.

- Describe the different ways in which three innovative payers have supported the integration of behavioral health and primary care and the tangible process change elements needed (and the landmines to avoid) in implementing an integrated behavioral health model.

- Define key strategies to engage payers and providers in their own communities to move toward sustainable models of integrated care.