Behavioral Health Integration: A Look at Lessons and Barriers

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Daniel Yohanna, MD
ECHO Chicago
University of Chicago Medicine
Tuesday December 11, 2018
9:30 and 11:15 am

Institute for Healthcare Improvement
Session Code A20 B20
Disclosure Statement

Doriane C. Miller, Daniel Yohanna; Megan Priolo, Robin Motter-Mast, and Robert Roca today have no relevant financial or nonfinancial relationship(s) within the services described, reviewed, evaluated, or compared in this presentation.
Session Learning Objectives

- Describe how the Collaborative Care model can be used to implement system-level change to support behavioral health integration
- Identify strategies for navigating barriers to implementing behavioral health integration in a safety net community primary care setting
- Discuss the impact of behavioral health integration on the cost of providing care
- Explain how health information technology can help manage the cost of providing care
The mission of ECHO-Chicago is to establish a robust community-based knowledge network that reduces the serious health disparities affecting children and adults in underserved communities.
Method

ECHO-Chicago uses case-based, iterative, telehealth curricula delivered via high-grade videoconference technology to bring advanced training and support to primary care providers

- Disseminate best practice management of complex, common, chronic disease
- Leverage advanced technology to reduce cost and time constraints, and eliminate travel
- Engage primary care providers in a local network to share knowledge and experience
• Short term: overall better health, fewer episodes of acute illness, ER visits, hospital admissions
• Long term: reduce complications and higher cost interventions from delayed diagnosis/treatment (e.g., liver transplant for hep C)
• Current unmet demand is met, at a lower cost than normally incurred
• Training and support across the care team: nurses, care coordinators, and pharmacists take on expanded role reducing annual cost per patient
Why is ECHO-Chicago Needed?

- Demand for subspecialty services far outstrip the availability – especially in underserved areas
  - Patients have difficulty accessing subspecialists
  - Social and economic distance reduce care availability
  - Loss of continuity of care for patients and providers
  - Patients must leave their medical home
ECHO Behavioral Health Integration
Subjects

- Behavioral Health Integration through Collaborative Care
- Anxiety and Depression Treatment/Medication Management
- Opioid Use Disorder
- Serious Mental Illness
- Pediatric ADHD
- Childhood Adversity & Trauma
Collaborative Care: Achieving Integrated Mental Health Solutions

- Based on University of Washington curriculum, treatment of depression in primary care
- Covered depression and anxiety in the series
- Additional content based on survey of sites
- Technical assistance offered outside of regular ECHO sessions
Behavioral Health Integration

Collaborative Care: Systems Change
- Multi-disciplinary team play
- Systems based quality improvement strategies
- Multi-institutional faculty team
- Case presentation include systems change, PDSA cycles
- Capstone project

PCP Toolkit
- Expand PCP skills and collaboration with behavioral health providers
- Clinical guidelines/disease management
- Patient case presentations

http://www.mhinnovation.net/innovations/collaborative-care-model
Faculty

- Doriane Miller, MD – University of Chicago
- Will J. Cronenwett, MD – Northwestern University
- Mark Loafman, MD, MPH – Cook County Health & Hospitals System
- Jeffrey T. Rado, MD, MPH – Northwestern University
- Bradley Stolbach, PhD – University of Chicago
- Daniel Yohanna, MD – University of Chicago
BHI/CC: Topics

Core

- Collaborative Care Overview
- Breakthrough Series Methodology (PDSA)
- Practice Re-design/Use of a Care Manager
- Screening and Case Identification
- Measurement based treatment to target
- Accountable Care/Business Case

Special Emphasis

- Medication Management
- Trauma Informed Care
- Recognizing serious and persistent mental illness
- Screening, brief intervention and referral to treatment (SBIRT)
<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Objectives</th>
<th>Required Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/15</td>
<td>Kick-off: 3 hour in person meeting (8:30 - 11:30am)</td>
<td>Understand principles of collaborative care</td>
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<td>1. Overview of Collaborative Care</td>
<td>Understand implementation of PDSA cycles as a way to implement changes</td>
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<td>2. Breakthrough Series Methodology (BTS)</td>
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<td>3. Collaborative Care Part 1a: Practice redesign/Care Manager</td>
<td>Learn how to implement Care Manager for Behavioral Health in the primary</td>
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<td>care setting</td>
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<td>Collaborative Care Part 1b: Practice redesign/Care Manager</td>
<td>Learn to implement Care Manager for Behavioral Health in the primary care</td>
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<td>7/13</td>
<td>Collaborative Care Part 2a: use of a registry</td>
<td>Learn to enter and track patients with depression or anxiety using a</td>
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<td>Faculty: D. Miller</td>
<td>shared registry</td>
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<td>8/10</td>
<td>Special topic: Medication Management</td>
<td>Overview of common medications used to treat depression and anxiety</td>
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<td>Faculty: W. Cronenwett</td>
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<td>8/24</td>
<td>Special topic: Serious &amp; persistent mental health disorders</td>
<td>Learn about management and resources for serious &amp; persistent mental</td>
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<td>9/7</td>
<td>Collaborative Care Part 3a: Screening and case identification</td>
<td>Learn to use PHQ-2, PHQ-9 and GAD-7 for case finding</td>
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<td>Collaborative Care Part 3b: Screening and case identification</td>
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<td>10/5</td>
<td>Special topic: Trauma Informed Care</td>
<td>Learn about trauma screening and community resources for treatment</td>
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<td>Faculty: B. Stolbach</td>
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<tr>
<td>10/19</td>
<td>Special topic: SBIRT</td>
<td>Learn to use Screening, Brief Intervention, and Referral to Treatment</td>
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<td></td>
<td>Faculty: M. Loafman</td>
<td>(SBIRT) for abuse and dependence on alcohol and illicit drugs.</td>
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<td>11/2</td>
<td>Collaborative Care Part 4a: Measurement based treatment to target</td>
<td>Review evidence-based approaches to treatment/stepped care</td>
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<td>11/30</td>
<td>Collaborative Care Part 5a: Accountable Care/Business Case</td>
<td>Learn processes for documentation and billing that support collaborative</td>
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<td>Capstone</td>
<td>Review work to date/future plans</td>
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<td>1/25</td>
<td>Capstone</td>
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Overview of BHI/CC

- Three FQHCs participated in the series:
  - Erie Family Health Center
  - Chicago Family Health Center
  - Near North Health Services

- Sites completed 3-6 PDSAs

- PDSAs focused largely on:
  - Practice redesign (scheduling, team-based care)
  - Screening and identification (when is screening administered, by whom, and in what format)
  - Capstone presentation by each team on accomplishments
Team Feedback and Faculty Observations

Teams

- BHI was a success
- Captured more patients with PHQ-9
- More men accepting help
- Team participation with behavioral health support more successful than one or two people on calls

Faculty

- Difficult to implement registry/need TA
- TA sessions for systems piece not used
- TA sessions for medication management were useful
Opportunities for Improvement

- Additional session on registries
- Incorporation of EHR support for registry development
- Encourage full team participation at clinical sites
- Focus on the operational aspects of integrative care in this series and have the clinical management be addressed in a separate series for providers
## Registry

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<tr>
<th>Patient Information</th>
<th>Treatment Status</th>
<th>Display</th>
<th>Episode Number</th>
<th>Follow-up Contract Number</th>
<th>Date Follow-up</th>
<th>Actual Contact Dates</th>
<th>Measurement 1</th>
<th>Measurement 2</th>
<th>Measurement 3</th>
<th>Measurement 4</th>
<th>Contact Notes and Psychiatric Case Review</th>
<th>Contact Notes and Psychiatric Case Review</th>
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Post-series Implementation: Challenges and Successes

**Challenges**

- Practice redesign
- New roles – PCP, consulting psychiatrist, care manager
- Registry – not being embedded in EMR difficult. Need someone to own it, daily maintenance
- Efficient use of time with psychiatrist, triaging/case presentation/identifying which pts need to see consulting psychiatrist
- Patient engagement
- PHQ-9 frequency
- PCP training around benzodiazepines
- Staff turnover Referrals to psychiatrist

**Successes**

- Universal screening PHQ-9 implemented at some sites (73% completion rate at one health center)
- Dedicated Behavioral Health slots for warm handoffs
- “Report cards” for provider/MA teams on % pts who completed PHQ-9 screener incentivized teams to improve their rates of screening (CFH)
- Practice redesign and normalization of Behavioral Health services as part of medical services made it easier for patients to get behavioral/mental health care
Post-series Implementation: Must Haves for Success

- Dedicated care manager whose time is not being diverted to other projects
- Warm handoffs between providers and BH team
- Good communication among team
Special Population Considerations

- Target goals and definition of depression remission in patient population with high rates of violence, poverty, institutional racism. Role of chronic stress on PHQ-9 scores among pt population.

- Role of adding groups/programs to address other issues that might keep people from getting to goal, i.e. trauma
Contact Information

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Integrating Behavioral Health into Primary Care: Successes & Challenges

IHI National Forum 2018
Presenters

Robin Motter-Mast, DO
- Medical Director of Primary Care & Population Health
  Greater Baltimore Medical Center

Megan Maguire Priolo, DrPH, MHS
- Principal
  Hazel Tree Healthcare Solutions
- Senior Director of Reporting & Analytics
  Chesapeake Regional Information System for our Patients (CRISP)

Robert Roca, MD
- Vice President and Chief Medical Officer
  Sheppard Pratt Health System, Inc.
Integrated Care: Model and process

“To every patient, every time, we will provide the care that we would want for our loved ones”
Impact on Total Cost of Care

To cut costs we have moved the clinic to China.

Please take a ticket for your flight coupon.
Key Points

- Mental illness and substance use (behavioral health problems) are major drivers of health care utilization and cost
- Effective treatments exist, but currently no more than 25% of people in need receive indicated care
- Not enough specialty/mental health providers to address this gap
- EFFECTIVE INTEGRATION of behavioral health care with primary care can achieve:
  - Better access to care
  - Better health outcomes
  - Lower costs
Collaborative Care

Informed, Activated Patient

Effective Collaboration

PCP supported by Behavioral Health Care Manager

PRACTICE SUPPORT

Measurement-based Treat to Target

Psychiatric Consultation

Caseload-focused Registry review

Training
Early Successes

- Increased screening and education on substance abuse and depression
  - 50,000 unique patients screened annually
  - 90,000 screenings completed
- Increased access to substance abuse resources
Patient Story: Mary

46 y.o. married, working, mother of 2 young children. *Alcohol Use Disorder *Depression

7/18/2017: Office visit with PCP: Referred to Substance Use Consultant

7/26/2017: Met with Substance Use Consultant Agreed to enter Kolmac treatment program after an upcoming vacation in August

August, 2017: Attempted to contact patient. Calls not returned.

January 2018: Patient called Substance Use Consultant to report that she was ready to enter treatment.


Office visits to PCP and no ED visits since IOP completion
Key Results

- **> 5,000 Behavioral Health Visits**
- **> 500 Psychiatry Visits**
- **38% reduction in anxiety scores**
- **29% reduction in depression scores**
- **12.1% Behavioral Health No Show Rate**
- **8.9% Psychiatry No Show Rate**
Use of CRISP
About CRISP

Regional Health Information Exchange (HIE) serving Maryland, West Virginia, and the District of Columbia.

Vision: To advance health and wellness by deploying health information technology solutions adopted through cooperation and collaboration.

Guiding Principles

1. Begin with a manageable scope and remain incremental.
2. Create opportunities to cooperate even while participating healthcare organizations still compete in other ways.
3. Affirm that competition and market-mechanisms spur innovation and improvement.
4. Promote and enable consumers’ control over their own health information.
5. Use best practices and standards.
6. Serve our region’s entire healthcare community.
Maryland’s Total Cost of Care Model

• Maryland and CMS entered into a new initiative to improve care and reduce the growth in health care spending
  ➢ Modernized the 40 year-old Medicare Waiver by allowing policies and programs aimed at care redesign
  ➢ Hospital global budgets set under an all-payer model are aligned with non-hospital settings, including mental health and long-term care

• Hospitals, physicians, and policymakers chose to invest in shared health technology infrastructure
  ➢ Existing state-designed Health Information Exchange leveraged and expanded upon
  ➢ Shared tools, resources, and data encourage provider-led innovation and better care coordination
Care Coordination: Encounter Notification Service (ENS)

- Solves a basic problem for organizations responsible for a patient's health – where is my patient? When did my patient access care?
- Real-time or batch alerts to organizations and providers based on known treatment and care management relationships
- Notifications can be delivered via a secure folder, the ULP, EHRs, or databases
- ENS subscription information is displayed at the point of care through ULP or In-Context
Population Health: CRISP Reporting Services

- Dashboards from administrative data to support high-needs patient identification, care coordination, and progress reporting
- Primary data sets are hospital casemix and Medicare claims and claim line feed (CCLF)
- Different levels of patient data available for hospitals based on HSCRC payment requirements and Total Cost of Care Model participation
### GBMA Integrative Care

#### Hospital Utilization

<table>
<thead>
<tr>
<th>Utilization Time Range</th>
<th>Hospital Name</th>
<th>Payer Group</th>
<th>Age Groups</th>
<th>Count of Visits</th>
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<tbody>
<tr>
<td>All Patients</td>
<td>(All)</td>
<td>(All)</td>
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<tr>
<td>Hospital Bedded Care</td>
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<td>659</td>
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<tr>
<td>IP Discharges</td>
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<td>551</td>
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<tr>
<td>Hospital ED Visits</td>
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#### Count of Unique Patients

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<th>Patients with Bedded Care</th>
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<tbody>
<tr>
<td>Patients with Hospital ED Visits</td>
<td>1,052</td>
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</table>

#### Utilization Rate

| Hospital Bedded Care Utilization Rate | 11.9% |
| Hospital ED Utilization Rate         | 29.9% |

#### Total Patients

- Total Patients: 3,490
- Readmissions: 35
- Panel Patient Readmission Rate: 1.0%
- Panel Readmission Rate: 10.9%

#### Payer Breakdown

- Patients with No Visits
- Commercial/Other
- MD Medicaid FFS
- MD Medicaid MC
- Medicare FFS
- Medicare MC
- Self-Pay/Uninsured

- Case Mix Data Range: 08/31/2017 to 08/31/2018
- ENS Data Last Updated: 10/13/2018
Hospital Utilization – All Services (IP, OP, ED) – Summary

All Utilization (IP, OP, ED) - Costs

All Utilization (IP, OP, ED) - Visits

All Utilization (IP, OP, ED) - Members
Breakdown of Charges – All Services (IP, OP, ED) – 1 Month

The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.

### Pre/Post Analysis

**Analysis of 1 Month of Visits Before and After the Enrollment Date**

The breakdown of charges is shown in the table below. The table compares charges before and after the enrollment date for different services. The charges are categorized into various hospital departments such as Anesthesia, Drugs, Emergency Room, etc.

#### Breakdown of Charges Sheet

<table>
<thead>
<tr>
<th>Service</th>
<th>Before</th>
<th>After</th>
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<tbody>
<tr>
<td>Charges Anesthesia</td>
<td>$16,705</td>
<td>$11,638</td>
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<tr>
<td>Charges CAT Scan</td>
<td>$30,876</td>
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<td>Charges CoronaryCare</td>
<td>$252,841</td>
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<tr>
<td>Charges Drugs</td>
<td>$22,907</td>
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<tr>
<td>Charges ER</td>
<td>$29,600</td>
<td>$17,000</td>
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<td>Charges FRG</td>
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</table>

**Hospital Name**

(All)

**Time Period**

1 Month

**Program Name**

20100607 - GHG Integrated C...

**Chronic Conditions**

- All Patients
- NA
- NA
- Chronic Condition Operator
  - AND
  - OR
Operational Requirements
Operational Requirements

New workflows to

- Obtain consent and administer screening tools
- Communicate results of screening to primary care provider to initiate referrals
- Link referred patients to behavioral health consultant, psychiatrist and/or addictions counselor
- Ensure timely feedback to primary care provider
- Ensure timely referral of patients needing treatment in the psychiatric specialty sector
- Ensure compliance with HIPAA and 42 CFR Part 2
Basic Personnel

- Behavioral health consultants
- Psychiatrist
- Substance use disorder counselor

Support Personnel

- Staff to administer obtain consents, administer screening tools, etc.
- Care coordinators
Resources - Systems

- Information Systems Support
- Customize EMR
- Build Registry
- Build Systems to Measure Outcomes
- Data Analysis Support
- Assist in Case Identification
- Evaluate Impact of Intervention
**Revenue Sources**

Billings for evaluations and treatment by BHC and psychiatrists

- Limited by need for BHC to be available for brief consultations, “warm hand-offs”, and other non-billable services
- Limited by the lack of a psychiatric diagnosis for some patients in need of behavioral coaching for medical disease management
- Insurance reimbursement for psychiatrist services is only for direct services and even then does not cover cost of service

Billing Collaborative Care codes

- Revenue goes to primary care provider, not behavioral health
Bottom Line

- It is unrealistic to expect third-party billings to cover the direct costs of the program
- Sustaining integrated care requires an investment on the part of the primary care provider and/or health care system
  - To improve clinical outcomes and experience of care
  - To reduce the total cost of care