Best Management Practices In Integrated Behavioral Health/Primary Care Programs

The 2017 OPEN MINDS Strategy & Innovation Institute
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Agenda

I. Integrated Behavioral Health/Primary Care Service Delivery Models

II. Key Ingredients For Success Of An Integrated Practice

III. Case Study Examples Of Successful Integrated Practices
   I. The Family Practice & Counseling Network, a division of Resources for Human Development
   II. Adult & Child Health

IV. Questions & Discussion
Integrated Behavioral Health/Primary Care Service Delivery Models
“Integration” – Care Delivery & Care Coordination Moving From Horizontal To Vertical

Medical

Behavioral

Social

Medical

Social

Behavioral
Why?

Industry-Wide Focus On The Triple Aim –

Particularly for Consumers With Multiple Chronic Conditions
Changing To A New Paradigm

**Today**
- Treating Sickness / Episodic
- Fragmented Care
- Specialty Driven
- Isolated Patient Files
- Utilization Management
- Fee for Service
- Payment for Volume
- Adversarial Payer-Provider Relations
- “Everyone For Themselves”

**Future**
- Managing Population
- Collaborative Care
- Primary Care Driven
- Integrated Electronic Record
- Evidence-Based Medicine
- Shared Risk/Reward
- Payment for Value
- Cooperative Payer-Provider Relations
- Joint Contracting
# Practice Models Of Integration

<table>
<thead>
<tr>
<th>Coordinated</th>
<th>Co-Located</th>
<th>Integrated</th>
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<tbody>
<tr>
<td>• Routine screening for behavioral health</td>
<td>• Medical services and behavioral health services located in same facility</td>
<td>• Medical services and behavioral health services located either in the same facility or in separate locations</td>
</tr>
<tr>
<td>• Referral relationship</td>
<td>• Referral process for medical cases to be seen by behavioral specialist</td>
<td>• One treatment plan with behavioral and medical elements</td>
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<tr>
<td>• Routine exchange of information</td>
<td>• Enhanced informal communication between primary care provider and behavioral health</td>
<td>• Team working together to delivery care</td>
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<tr>
<td>• Primary care provider delivers behavioral health interventions</td>
<td>• Consultation between behavioral health and medical provider</td>
<td>• Team composed of physician, physicians assistant, nurse practitioner, nurse, case manager, family advocate and behavioral specialist</td>
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<tr>
<td>• Connections made between patient and community</td>
<td>• Increase in level of quality of behavioral health services</td>
<td>• Use database to track the care of patients who are screened into behavioral health services</td>
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Elements Of Integrated Care Service Delivery From The Specialist Provider Perspective

Behavioral health and medical providers coordinate treatment and follow-up on a person’s health care.

Shared Consumer Information

Shared Service Location

Shared Financial Incentives
Issues With Choosing The Best Model To Work With Primary Care

Feasibility within that market

- What options are available?
- What options work best for the target consumer groups?
- What are the primary care provider needs for space and licensure?
- What options will be cost effective for the organization?
- How will the various payment structures work together?
- How do you structure to make it work within your organizational culture?
Key Ingredients For Success Of An Integrated Practice
Keys To Improving Collaboration Among Medical & Behavioral Health Professionals

**Planning**

- Develop and implement formal plans to establish collaborative relationships
- Develop plans that target resources to care-integration that are likely to yield a good return on investment
- Set realistic goals and timelines

**Communication**

- Develop feedback mechanisms and information systems that evaluate quality of care and service delivery
- Engage in proactive outreach with collaboration among behavioral specialists and PC
- Participate in behavioral health learning collaboratives and continuing education

**Implementation**

- Establish behavioral health as an integral part of primary practice by adding regular screening
- Incorporate electronic medical records and health information technology to improve the ability to collaborate and practice efficiently
- Explore opportunities and different models for co-locating behavioral health
Keys To Improving Collaboration: Planning

Develop and implement formal plans to develop collaborative relationships

Develop plans that target resources to care integration that are likely to yield a good return on investment

Set realistic goals and timelines

Promoting Participation:

• Identify a population of common concern
• Include providers and stakeholders in planning
• Develop goals addressing all participants' roles
Keys To Improving Collaboration: Communication

Develop feedback mechanisms and information systems that evaluate quality of care and service delivery.

Engage in proactive outreach with collaboration among behavioral specialists and Primary Care.

Participate in behavioral health learning collaboratives and continuing education.

Promoting Participation

• Establish inclusive mechanisms to provide feedback to all participants.
• Develop educational opportunities that are inclusive for all participants.
Keys To Improving Collaboration: Implementation

Establish behavioral health as an integral part of primary practice by adding regular screening.

Incorporate electronic medical records and health information technology to improve the ability to collaborate and practice efficiently.

Explore opportunities and different models for co-locating behavioral health.

Promoting Participation

- Define clear roles for each team member that encourage cooperative participation.
- Identify a mechanism for formal and informal communication for all team members.
The Family Practice & Counseling Network

Stacey Carpenter, Psy.D., Director of Integrated Behavioral Health, The Family Practice & Counseling Network, a division of Resources for Human Development
Best Practices in Integrated Behavioral Health/ Primary Care Programs

Stacey Carpenter, Psy.D.
Director of Integrated Behavioral Health
80% of Primary Care (PC) visits include an underlying psychosocial factor

30-50% present in PC with significant mental health issues

45% of people dying by suicide saw PCP one month prior to death

24% of patients with depression are asked about substance use, a major risk factor for completed suicide
Areas to understand and consider in starting a new program...

Roles

Population

Services
Roles

- Vital to explore functions of each provider's role
  - What are the differences
  - Where do they interconnect
- Understand the complexity of the work environment with roles & responsibilities
- Create clarity among the team
  - Helps formulate the team
Roles

PCP
- Leader
- Medical focus
- Screens
- Provides Warm Handoffs

BHC
- Brief solution focused therapy
- Further assessment
- Psychoeducation and motivational skill building
- The “translator”
○ Recognize what the capacity of the BHC services
  - Not traditional outpatient therapy
  - Only 20-30 minute sessions
○ Consultant to the PCP
  - “the Bridge”
○ Direct, skill building, not process-oriented
Goal is to assist the whole population of the clinic… not a particular subset…

Focus on the clinic’s needs
- Who is the clinic serving?

# of Patients of the Clinic
= BHC caseload
What Our Clinics Look Like…
Patients seen in the last year...

- **Health Annex**
  - Adults = 4108
  - Pediatrics = 1458

- **Annex West**
  - Adults = 175
  - Pediatrics = 2

- **Abbottsford/Falls**
  - Adults = 3785
  - Pediatrics = 872

- **11th Street Family Health Center**
  - Adults = 3133
  - Pediatrics = 1041
Diagnosed in the last 2 years & had BHC visit

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>BHC Visit</th>
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<tbody>
<tr>
<td>Depression – 2575</td>
<td>– 1851</td>
</tr>
<tr>
<td>Anxiety – 1435</td>
<td>– 1095</td>
</tr>
<tr>
<td>Diabetes – 1585</td>
<td>– 731</td>
</tr>
<tr>
<td>Pre-Diabetes – 1542</td>
<td>– 627</td>
</tr>
<tr>
<td>HTN – 3795</td>
<td>– 1665</td>
</tr>
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Rules/ Must See’s
Automatic Warm Hand Offs

Following through…
- + Pregnancy
- New Medical / STD diagnosis
- Screeners: +PHQ-2, + ACE-2

Working on…
- Uncontrolled HTN
- Frequent Fliers – STD
What works & Pit Falls
Things to consider…

○ Group Pods
○ Rapport building
○ Teaching simple introductions
○ What benefits the Pt benefits the PCP… What benefits the PCP benefits the Pt

○ No “Saving” BHCs
○ Coordination of Care
○ Behavioral vs. Physical/Medical Health
Adult & Child Health

Allen Brown, Chief Executive Officer, Adult & Child Health
Integrating Primary and Behavioral Health Care

Adult and Child Health Services Case Study

Allen Brown, CEO, Adult and Child
Open Minds Strategy and Innovation Institute

June 7, 2017
• CMHC and Licensed Child Placement Agency
• Comprehensive BH and child welfare services
• On site primary care services since 2010
• 675 full time employees
• Majority of staff work in schools, homes, etc.
• $48m annual revenue
• Top payors are Medicaid, state grants, and child welfare
To Integrate or Not To Integrate

• Indiana eliminated Medicaid billing rule that prohibited provider reimbursement for PC and BH services delivered same day
• FQHC’s expanding into BH space
• CMHCs want to do primary care, but not sure how to get started or how to pay for it
• Indiana established Integrated Care Entity (ICE) Certification for CMHCs who provide primary care
• Severe workforce shortage
CMHC and FQHC Reimbursement

**Adult and Child**

- Traditional Medicaid FFS Rate inadequate to cover costs for most services
- Minimal grant support for infrastructure or operations
- Traditional Medicaid Rate
  - 99214 (MD): $76.88
  - 99214 (APN): $57.66
  - 90834 (LCSW): $50.39

**Indiana Community Health Clinics**

- HRSA building/infrastructure grants
- 330b grant funding
- 340b pharmacy program
- Enhanced Medicaid Rate
  - FQHC PPS rate ranges from $170 to $280 per unit of service, regardless of service duration
Primary Care: Buy It or Build It?

Building it ourselves = Becoming an FQHC

Collaboration = Partnering to bring it in

• CMHC has insufficient means to pursue FQHC designation

• Community needs do not support adding a new FQHC organization, per HRSA criteria
  – Medically Underserved Area (provider availability)
  – Medically Underserved Populations (poverty, risk)

• Adult and Child has taken 3 different approaches to answer this question
Approach 1: Partner with an FQHC on a PBHCl Grant

• Adult and Child was the second Indiana MHC to win a SAMHSA PBHCl grant
• Collaborated with local FQHC to implement
  – Primary care staff/services on site in MHC
  – MHC staff/services embedded in primary care clinic
• 2 ½ years into grant, the collaboration expanded to include a merger initiative
Approach 1 Outcome:

- Limited success
- MHC clients benefited, but the program was inefficient and too few were served
- Workflow, data, and service integration never evolved beyond a low-level, co-location relationship
- MHC failed to gain financial sustainability
- Merger efforts stalled and eventually broke down
- MHC and FQHC parted ways after grant ended
Approach 2: Partner
Again for Primary Care

But this time differently...

• No PBHCl grant dollars involved
• Shared risk/shared reward
• Agreement structured equitably to leverage highest possible reimbursement
• To make this happen A&C needed an FQHC that was willing to try a new approach
• 15 clinic nonprofit FQHC
  – Comprehensive Family Medicine
  – Behavioral Health Services
  – Pediatrics
  – OBGYN
  – Dental
• $20m revenue
• 150+ staff
Operating Agreement

A&C’s south Indianapolis mental health clinic approved by HRSA to be an FQHC clinic location for Jane Pauley Community Health

• JP leases physical office space from A&C
• BH staff are leased to JP
• JP provides primary and behavioral care services
• Services documented and billed through JP EMR
• Expenses shared for administrative support functions like front desk, BH supervision, QI, IT
• JP reimburses A&C for full cost, plus overhead
Approach 2 Outcome

- Victory!
- Financially viable partnership
- Primary care being delivered to vulnerable, underserved MHC populations
- Medical exam rooms expanding from 3 to 6 to 9
- BH providers delivering services through FQHC receiving higher level of reimbursement
- Project gaining attention from payors and press, winning Indianapolis award for healthcare innovation
What We’ve Learned

• Complexity of moving BH staff from MHC to FQHC
  – Credentialing
  – Contracting
  – Ability to Pay
  – Payor Mix
  – Access Workflows

• 2 different EMRs, with no interface

• BH Supervision occurring without usual complement of productivity reports, audit tools, etc.

• Unhooking from our FQ partner would be complicated
Approach 3: Becoming an FQHC Look Alike

In past 8 months, A&C has

- Opened 2 new health clinics
- Submitted FQHC Look Alike (LAL) application
- LAL process to be completed by 12/15/17
- As a FQHC LAL clinic, A&C will receive enhanced Medicaid rate
The Adult and Child Health Clinic Model

• Community health clinics providing medical outreach to the homeless

• Unifying primary care (face to face or telehealth) with
  – Home-based services
  – Supportive Employment
  – Supportive Housing
  – Peer Support
  – InShape Wellness Program

• Utilizing general practitioners for addictions treatment
  – MAT patients required to participate in IOP

• Health Home accreditation as Joint Commission PCMH in 2018
What We’ve Learned

• All the usual clichés are true!
• Hiring for a start up is difficult
• Converting MH offices to health clinics is costly
• Changes needed at the governance level
  – HRSA requires majority of board members must be active recipients of health clinic services
  – Health clinic oversight by the board may seem like micromanagement by some MHCs
What We’ve Learned

• No fun using 3 EMRS 😩

• Time and effort needed to integrate well different systems, services and workflows

• Direct care staff know best
What We’ve Learned

- Client engagement needed more than ever
- Challenges with the “Brand”
- Limitations of data mining MHC caseloads for primary care patients

Primary Care Visits by Location

<table>
<thead>
<tr>
<th>Month</th>
<th>Wulsin</th>
<th>Northwood</th>
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</thead>
<tbody>
<tr>
<td>Oct-16</td>
<td>81</td>
<td>0</td>
</tr>
<tr>
<td>Nov-16</td>
<td>107</td>
<td>0</td>
</tr>
<tr>
<td>Dec-16</td>
<td>119</td>
<td>13</td>
</tr>
<tr>
<td>Jan-17</td>
<td>159</td>
<td>44</td>
</tr>
<tr>
<td>Feb-17</td>
<td>189</td>
<td>69</td>
</tr>
<tr>
<td>Mar-17</td>
<td>197</td>
<td>93</td>
</tr>
<tr>
<td>Apr-17</td>
<td>201</td>
<td>92</td>
</tr>
<tr>
<td>May-17</td>
<td>300</td>
<td>126</td>
</tr>
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What We’ve Learned
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Addiction Treatment  ▪  Social Services  ▪  Intellectual & Developmental Disability Supports
Child & Family Services  ▪  Juvenile Justice  ▪  Adult Corrections Health Care

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