



Transformation Support Webinar: Behavioral Health Integration

September 24, 2015

HSCRC

Health Services Cost
Review Commission

Webinar Agenda

▶ Speakers

- ▶ Karen Batia, Principal, HMA
- ▶ Nancy Jaeckels Kamp, Principal, HMA

▶ Agenda

- ▶ Introduction
- ▶ Impact of behavioral health on chronic medical conditions
- ▶ Specialty behavioral health
- ▶ Collaborative Care
- ▶ Questions
- ▶ Next Steps

Introduction

Health care providers, the public and payers have come to recognize:

- ▶ Untreated depression and other serious mental illness have both a negative financial and health impact
- ▶ Early identification and access to treatment can lead to improved outcomes
- ▶ An integrated behavioral health strategy is essential to meeting the three aims (improving patient experience of care, improving the health of populations and reducing cost)
- ▶ Health disparities (race/ethnicity, income level, geographic location, and insurance status) are key determinants in both physical and behavioral health across populations

Current Challenges

- ▶ Health care providers struggle to routinely screen for behavioral health issues despite evidence that screening for depression and substance abuse is critical to providing quality care
- ▶ If screening is completed, the typical response is to refer for specialty care despite the fact that most communities and funding systems have limited capacity
- ▶ Primary care practices tend not to have resources or models of care to be able to treat people within their setting who screen positive for depression, anxiety and substance use disorders
- ▶ Communication and collaboration across service providers is difficult
 - ▶ Data often cannot be shared or barriers exist
 - ▶ Providers don't have the time to consult and share critical information
 - ▶ Significant cultural barriers exist between hospitals, PCPs and behavioral health providers

Transformation Requires New Strategies

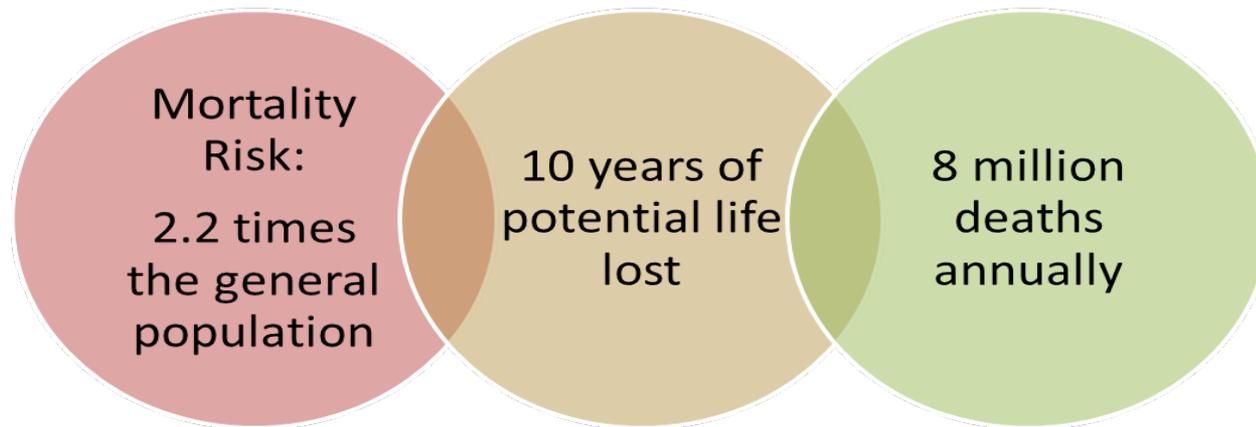
- ▶ A critical element for success within the Regional Partnerships to develop processes, procedures, accountabilities with supporting tools, technologies and data that *connect disparate providers in the activities and events associated with care coordination* (Domain 6 of the Transformation Framework)
- ▶ Specific to Behavioral Health – What does a PCP or specialist office do when a patient or practitioner identifies a mental health issue? What does a hand-off look like? When does one do a “hand-off,” and when does one work collaboratively or not rely upon a BH specialist? What is the BH specialist responsibility and what is the responsibility of the PCP or others?

Transformation Plan Template

Physician Alignment

Describe any new processes, procedures and accountabilities that will be used to connect community physicians, behavioral health and other providers in the regional partnership and the supporting tools, technologies and data that will assist providers in the activities associated with improved care, cost containment, quality and satisfaction.

Mental Illness and Mortality



Walker, E.R., McGee, R.E., Druss, B.G. *JAMA Psychiatry*.
Epub, doi:10.1001/jamapsychiatry.2014

Annual Per Person Cost of Care

Annual Per Person Cost of Care

Common Chronic Medical Illnesses with Comorbid Mental Condition “Value Opportunities”

| <u>Patient Groups</u> | <u>Annual Cost of Care</u> | <u>Illness Prevalence</u> | <u>% with Comorbid Mental Condition*</u> | <u>Annual Cost with Mental Condition</u> | <u>% Increase with Mental Condition</u> |
|-----------------------|----------------------------|---------------------------|--|--|---|
| ■ All Insured | \$2,920 | | 10%-15% | | |
| ■ Arthritis | \$5,220 | 6.6% | 36% | \$10,710 | 94% |
| ■ Asthma | \$3,730 | 5.9% | 35% | \$10,030 | 169% |
| ■ Cancer | \$11,650 | 4.3% | 37% | \$18,870 | 62% |
| ■ Diabetes | \$5,480 | 8.9% | 30% | \$12,280 | 124% |
| ■ CHF | \$9,770 | 1.3% | 40% | \$17,200 | 76% |
| ■ Migraine | \$4,340 | 8.2% | 43% | \$10,810 | 149% |
| ■ COPD | \$3,840 | 8.2% | 38% | \$10,980 | 186% |

Cartesian Solutions, Inc.™--consolidated health plan claims data

**Melek S et al APA 2013

www.psych.org

Cartesian Solutions, Inc.™ ©

Milliman Report – April 4, 2014

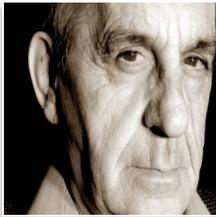
Large claims data base Medicaid, Medicare, Commercial Insurers 2010 – no MH/SUD, non-SMI MH/SUD, SMI, SUD

Patients with treated MH/SUD cost more (\$400 PMPM compared to \$1,000 PMPM)

Most of the added cost is in costs (ER and inpatient) for medical care

How many of these people with mental health concerns will see a mental health provider?

No Treatment



Primary Care Provider



Mental Health Provider

Wang P, et al., Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005



Screening Tools as “Vital Signs”

- ▶ Behavioral health screeners are like monitoring blood pressure!
 - Identify that there is a problem
 - Need further assessment to understand the cause of the “symptoms”
 - Help with ongoing monitoring to measure response to treatment
- US Preventive Services Task Force (USPSTF) recommendations
 - ROI for depression and substance abuse screening

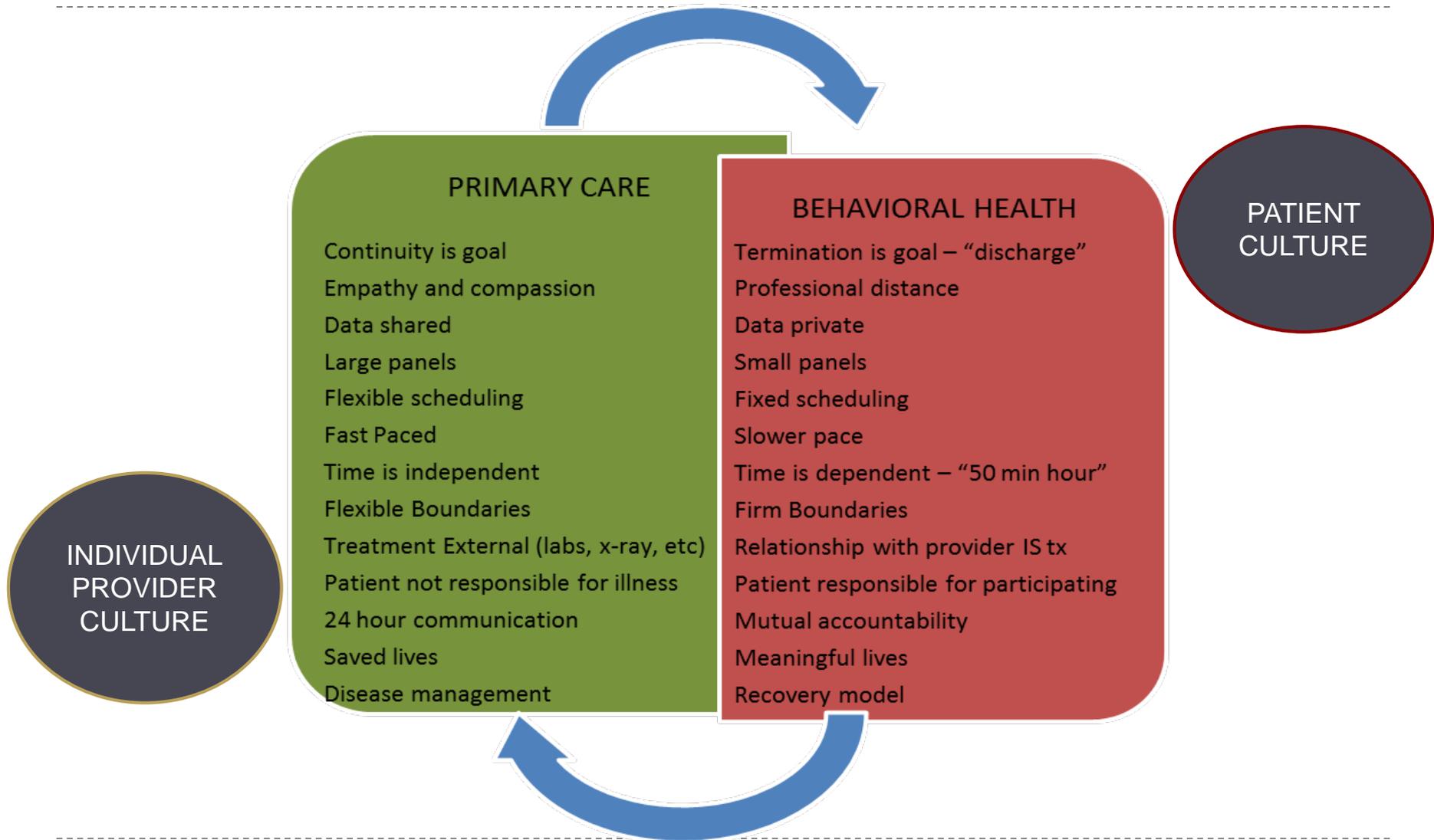
- ▶ Sample screening tools
 - Depression
 - Patient Health Questionnaire (PHQ9 and PHQ2)
 - HEDIS, Medicare ACO and draft CCM codes for collaborative care
 - Substance Use
 - CAGE (4 question brief alcohol screen)
 - AUDIT (specific to alcohol, brief screen)
 - ASSIST (past and current inventory of alcohol and other substances)
 - Trauma/Post-Traumatic Stress Disorder
 - Primary Care PTSD Screen (4 question screen)
 - PTSD Checklist (PCL 17 question screen/6 question version specific for PC)
 - Anxiety (Generalized Anxiety Disorder-7)



Clarify Terms

- ▶ Specialty Behavioral Health – services provided to people experiencing serious and persistent mental illness (bipolar, schizophrenia, psychotic disorders, major depression). Often provided within the community including psychiatric assessment/treatment, Assertive Community Treatment, IOP (intensive outpatient services), psycho-social rehabilitation
- ▶ Integrated Care – addressing physical and behavioral health conditions concurrently in various settings- primary care, community mental health centers, inpatient, ERs, etc. Many “models” – many not evidence-based but have merit
- ▶ Collaborative Care - often used interchangeably with the term integrated care. It’s how we interact with other disciplines. Sometimes used as shorthand for the Collaborative Care Model
- ▶ THE Collaborative Care Model – pioneered by Wayne Katon, has the most robust evidence base of any approach in primary care settings for addressing depression and other psychiatric disorders. Specific core features, psychiatric consultation needed to reach outcomes, allows accountability for outcomes and cost

At Least Two Cultures, One Patient

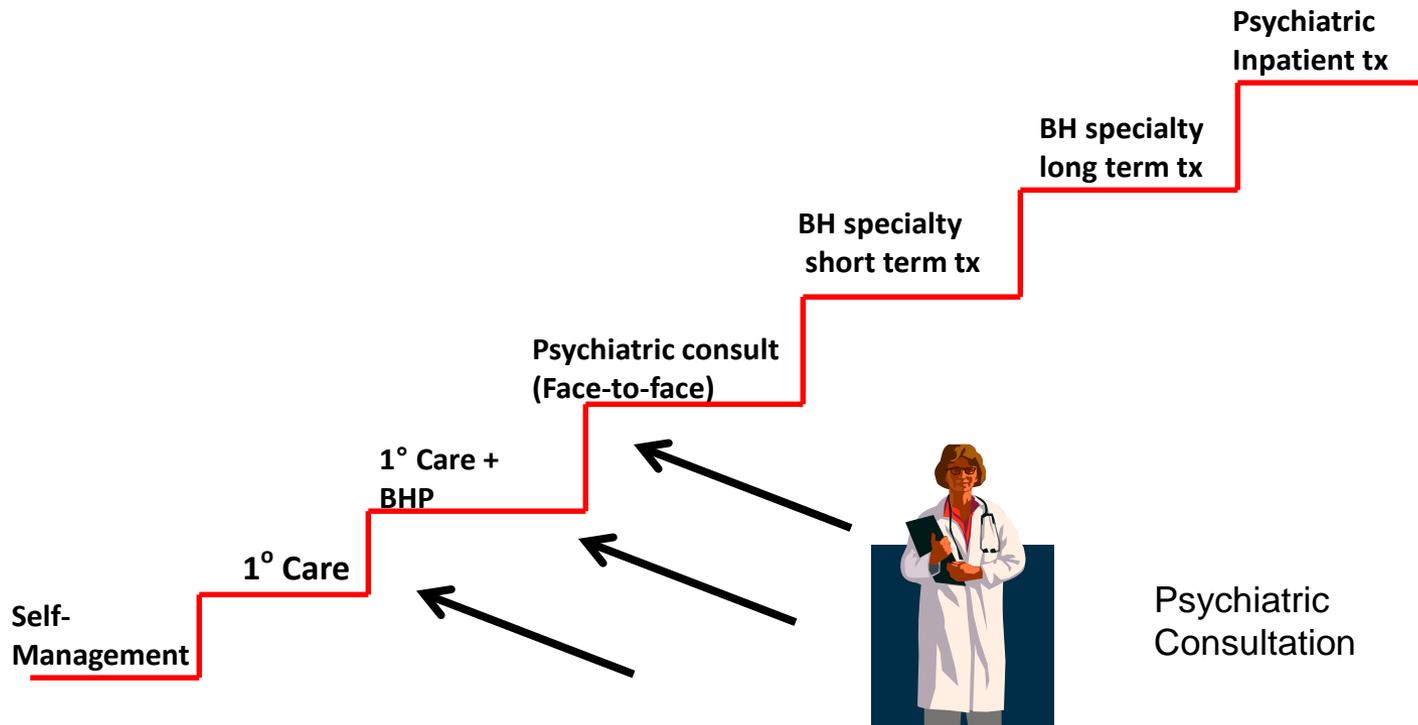


Bridging the Silos to Coordinate and Integrate Care – Both are necessary to manage population health

Requires significant investment

- ▶ Building relationships at both leadership and direct service level
- ▶ Understand business and model drivers
 - ▶ Financial incentives and funding streams
 - ▶ Outcome and performance metrics
 - ▶ Staffing models and documentation expectations
- ▶ Develop shared processes and workflows that address
 - ▶ Referral mechanisms
 - ▶ Sharing of data and information
 - ▶ Management of transitions across levels of care and service providers
 - ▶ Medication management and coordination

Stepped Care Model



Specialty Behavioral Health ~ Behavioral Health Homes

- ▶ Individuals served by a health home must have one or more chronic conditions such as a mental health or substance use condition, asthma, diabetes, heart disease, or be overweight
 - ▶ Person-Centered Care
 - ▶ Population-Based Care
 - ▶ Data Driven Care
 - ▶ Evidenced-Based Care
- ▶ Follow the Chronic Care Model however relationship is with a Behavioral Health Organization
 - ▶ Self-Management Support
 - ▶ Delivery System Design
 - Multidisciplinary teams
 - Care management
 - ▶ Decision Support
 - ▶ Clinical Information System
 - ▶ Community Linkages

Definition of Collaborative Care

- ▶ Collaborative Care is a specific type of integrated care that operationalizes the principles of the chronic care model to improve access to evidence based mental health treatments for primary care patients.
- ▶ Collaborative Care is:
 - ▶ Team-based collaboration including PCP and BH specialists
 - ▶ Patient-centered
 - ▶ Evidence-based and practice-tested care
 - ▶ **M**easurement-based treatment to target
 - ▶ Treatment goals are defined and tracked for each patient
 - ▶ Interventions, typically brief interventions, change to meet goals
 - ▶ **P**opulation-based care

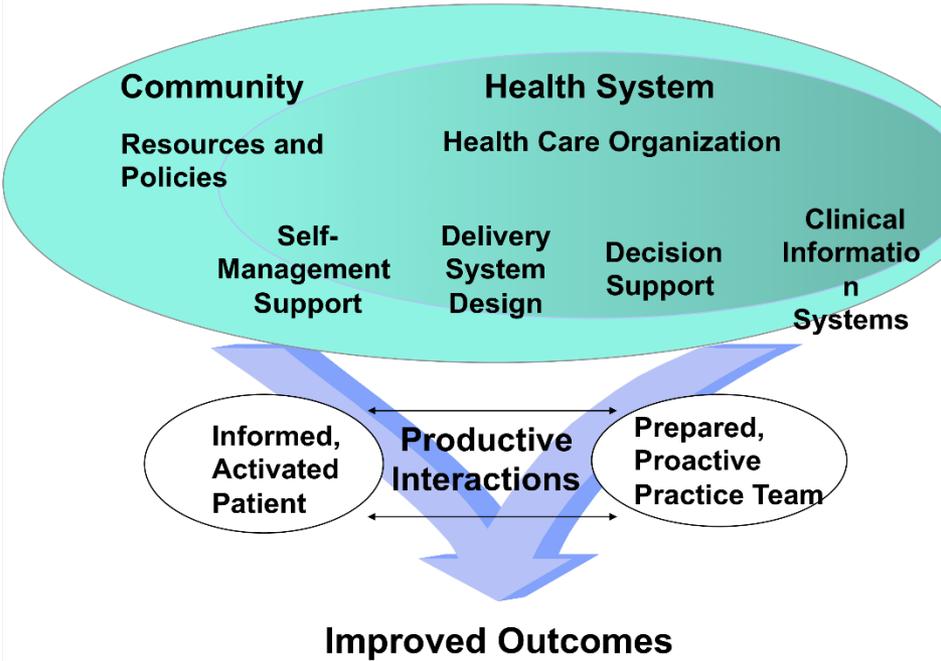
Stories from the Field
Nancy Jaeckels Kamp, HMA



Proof of Concept and Evidence-Based Model Implementation

- ▶ **IMPACT** – largest RCT on integrated care
 - ▶ Focus on Medicare patients (≥ 65) with depression (most had diabetes or other chronic disease)
- ▶ **DIAMOND** – >85 PCP sites in one state - evolved IMPACT into all adults and any payer type
 - ▶ Depression with or without other chronic conditions
 - ▶ Bipolar and schizophrenia were excluded
 - ▶ Bundled payment model designed to financially support
- ▶ **PIC (Partners in Integrated Care)** – integration of IMPACT/DIAMOND and SBIRT model for substance abuse – across 3 states
- ▶ **COMPASS** – integration of IMPACT/DIAMOND, and chronic disease mgmt. (Pathways model)
 - ▶ All adult patients
 - ▶ Criteria for program – depression, and hypertension or diabetes. Substance abuse optional as third co-existing condition
 - ▶ CMMI grant awardee
 - ▶ Spread model across 8 states
- ▶ **SBIRT** – Screening Brief Intervention and Referral to Treatment

Chronic Care Model



IMPACT Integrated Care



Effective Collaboration



Partners in *Integrated Care*
 Patients, Payers, Providers, Primary Care, Purchasers



COMPASS

DIAMOND (and COMPASS) – Integrated Care

New processes, tools and roles:

1. Consistent method for assessment/monitoring (PHQ-9)
2. Presence of tracking system (registry)
3. Stepped care approach to intensify/modify treatment
4. Self-management skills and relapse prevention
5. Care manager for follow up, support, care planning and coordination
6. Consulting psychiatrist for caseload review and primary care team support

How did we do it?

- ▶ Readiness assessments – 86 PC practices implemented in 4 waves
- ▶ 6 month learning collaborative (similar to IHI LC)
 - ▶ Monthly meetings focusing on building each of the 6 components of the model
 - ▶ Progress reporting
 - ▶ Final team and CM training right prior to implementation
- ▶ Finding and contracting with consulting psychiatrist role – building relationship
- ▶ Hiring right person in the BHCM role
 - ▶ Some hired RNs with BH background
 - ▶ Some hired LCSW and partnered with a nurse CM for medical conditions
 - ▶ Some hired LPNs and MAs that reported to a psych RN
- ▶ Patient education and marketing about new integrated care program
- ▶ Scripts for providers about the program and warm-hand-offs
- ▶ Common metrics set and monthly measurement review
- ▶ Payer involvement in payment redesign to support sustainability

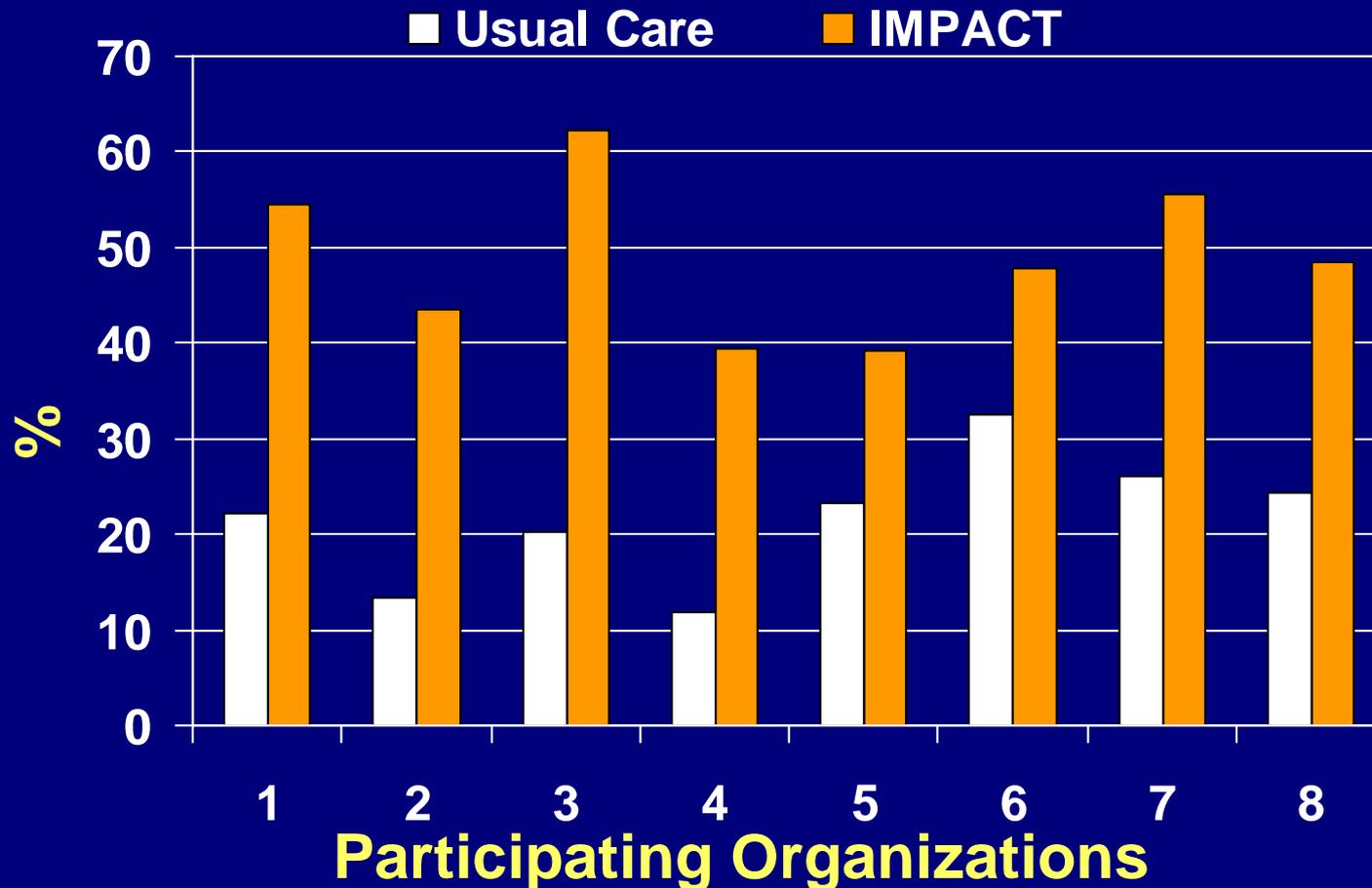
Post-Implementation

- ▶ Monthly care management support calls – discuss difficult cases, team challenges, warm hand-offs, etc.
- ▶ Monthly measurement – process measures and outcome measures
 - ▶ Adjustments made to process and team approach based on measurement
- ▶ Site visits
- ▶ Re-training held quarterly and impromptu based on practice-specific measures
- ▶ Ongoing measurement and learning around
 - ▶ Employee productivity
 - ▶ Patient satisfaction
 - ▶ Some costs data
 - ▶ Growing PCP confidence and capability in depression management over time



IMPACT: Doubles the Effectiveness of Usual Care for Depression

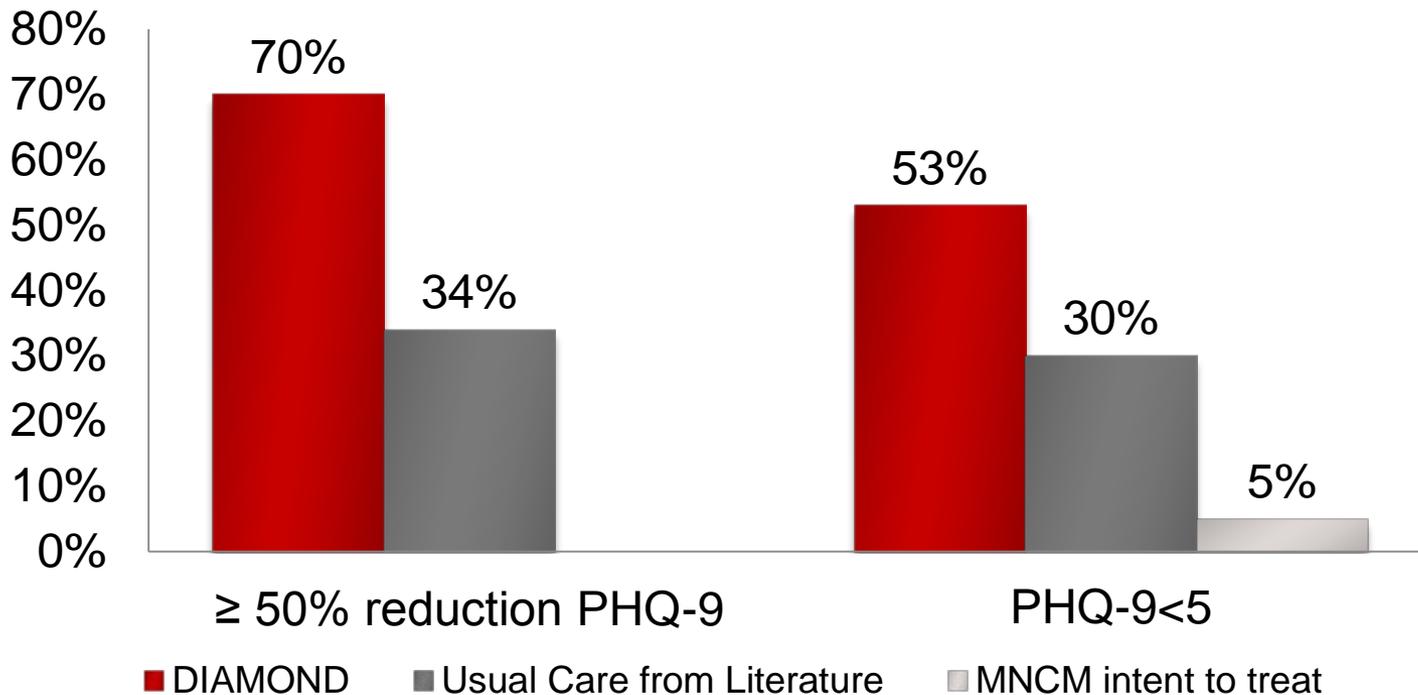
50 % or greater improvement in depression at 12 months



DIAMOND Outcomes

Implemented DIAMOND in 86 Practices, and enrolled >8,300 patients

Response and Remission at 12 Months



Minnesota Community Measurement (MNCM); Publicly Reported Measure

Lessons Learned – Effective Implementation: 9 Factors

■ **Table 1.** Factors Considered Important for Implementation of DIAMOND

| Ranking | Implementation Factor | Definition |
|---------|--|---|
| 1 | Operating costs of DIAMOND not seen as a barrier | The clinic has adequate coverage or other financial resources for most patients to be able to afford the extra operational costs. |
| 2 | Engaged psychiatrist | The consulting psychiatrist is responsive to the care manager and to all patients, especially those not improving. |
| 3 | Primary care provider (PCP) “buy-in” | Most clinicians in the clinic support the program and refer patients to it. |
| 4 | Strong care manager | The care manager is seen as the right person for this job and works well in the clinic setting. |
| 5 | Warm handoff | Referrals from clinicians to the care manager are usually conducted face-to-face rather than through indirect means. |
| 6 | Strong top leadership support | Clinic and medical group leaders are committed and support the care model. |
| 7 | Strong PCP champion | There is a PCP in the clinic who actively promotes and supports the project. |
| 8 | Care manager role well defined and implemented | The care manager job description is well defined, with appropriate time, support, and a dedicated space. |
| 9 | Care manager on-site and accessible | The care manager is present and visible in the clinic and is available for referrals and patient care problems. |

DIAMOND indicates Depression Improvement Across Minnesota—Offering a New Direction.

Whitebird, Jaeckels, et al. Am J Manag Care. 2014;20(9):699-707



Cost Analysis to Operate

| DIAMOND Components | Hours per pt | Cost per pt | Weighted mean |
|--------------------------------|---------------------|--------------------|----------------------|
| Care Manager | 1.8 - 6.1 | \$48 - 181 | \$97 |
| Consulting psychiatrist | 0.0 - 0.6 | \$9 - 115 | \$31 |
| Billing and coding | 0.0 - 0.9 | \$0 - 17 | \$3 |
| Registry and IT systems | 0.0 - 1.4 | \$0 - 38 | \$8 |
| Supervision of DIAMOND program | 0.0 - 0.9 | \$0 - 86 | \$11 |
| Other significant costs | 0.0 - 0.9 | \$0 - 23 | \$1 |
| Total | 2.0 - 7.6 | \$82 - 402 | \$151 |



Value - Quality Improvement and Cost Savings

- ▶ Clinical outcome data are significantly improved from usual care
- ▶ IMPACT HealthCare Cost savings of \$3,300 * per Patient over 4 years
 - ▶ 1ST year cost money, 2nd year, cost neutral, year 3 and 4 shows cost savings

| | Usual Care | Care Mgmt |
|---------------------------------------|-----------------|-----------------|
| Total cost/50% improvement | \$30,634 | \$18,290 |
| Total cost/remission | \$53,994 | \$29,957 |

Unutzer et al, Am Journal of Managed Care, Vol 14, No.2



Challenges to Implementation

- ▶ Payment to sustain non-billable services and staff
 - ▶ And no patient responsibility such as co-pays
- ▶ 2 cultures melding (BH and PC)
 - ▶ Finding and building relationships with psychiatry
- ▶ Initial PCP buy-in and allowing for others on team to co-manage their patients. (once the PCP experiences this, they would not go back to not having a CM)
- ▶ Blending it into PCMH and other CM – not seeing it as separate, silo'd programs.
 - ▶ Same patient has multiple diseases

Screening Brief Intervention Referral to Treatment (SBIRT)

- ▶ Set of 4-5 screening questions routinely used during triage to identify patients with medium- to high-risk alcohol or drug use
- ▶ 3-5 minute conversation between medical practitioner & patient to review screening results, educate patient on link between substance use & medical conditions patient has or is at risk of developing
- ▶ Assess & increase patient motivation to reduce risky behaviors, negotiate a plan & refer patient to substance abuse treatment if appropriate
- ▶ SBIRT in Maryland
 - ▶ 5-year, \$9.8 million federal grant awarded to DHMH/BHA in 2014 to integrate behavioral health and medical care in community health centers and hospitals across Maryland
 - ▶ Reduce alcohol & drug use, improve health status of Marylanders, and promote universal behavioral health prevention & early intervention approaches
 - ▶ Reduce overdose deaths and increase the availability of substance abuse treatment
 - ▶ Develop recommendations for full adoption of SBIRT as a routine component of health care delivery & standardize SBIRT in electronic health records & State's health information exchange

Funding & Support Available to Hospitals

- ▶ Technical assistance & training to incorporate SBIRT into routine patient care & document SBIRT in electronic medical record systems
- ▶ Grant funding to help cover infrastructure costs, electronic health record modifications & hiring recovery advocates
- ▶ Trained peer-recovery advocates link high-risk patients with treatment and provide ongoing support

How to participate in the Maryland SBIRT project:

Contact Bonnie Campbell, Maryland SBIRT Project Director, 410-637-1900 ext. 7790 or Bonnie.Campbell@bhsbaltimore.org

Hospitals currently using SBIRT:

- ▶ Bon Secours Health System –SBIRT in ED & all medical units since 2012
- ▶ Mercy Medical Center –SBIRT in ED since 2013
- ▶ MedStar Harbor Hospital – SBIRT to start January 2016

Integration of SBIRT and DIAMOND

| Activity | SBIRT | IMPACT/DIAMOND |
|--|------------------------|-----------------------|
| Screening | ✓ | ✓ |
| Feedback/Education | ✓ | ✓ |
| Recommendation | ✓ | ✓ |
| Healthcare Specialist | ✓ | ✓ |
| Change Plan or Behavioral Activation | ✓ | ✓ |
| Problem Solving Treatment (PRN) | | ✓ |
| Follow-up and monitoring | ✓ (interventions, PRN) | ✓ |
| Pharmacotherapy (PRN) and Stepped Care | | ✓ |
| Referral (PRN) | ✓ | ✓ |
| Consulting Psychiatrist | | ✓ |

PIC Model Core Components

Screening for depression and unhealthy AOD use

Dedicated role in primary care for:

- Patient engagement, brief interventions, monitoring, and facilitation of team-based collaborative care

Brief Interventions

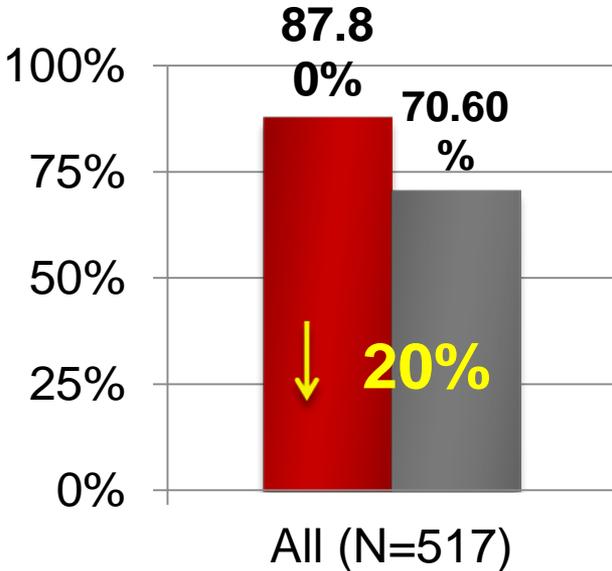
Caseload review by consulting psychiatrist

Systematic follow-up and tracking

Stepped care approach

WIPHL Outcomes (Wisconsin)

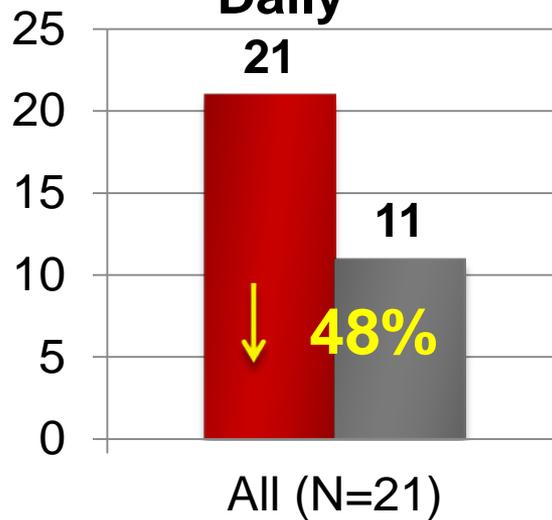
At-Risk Drinking in Past 3 Months



■ Baseline ■ 6 months

Chi-square test;
p<0.001

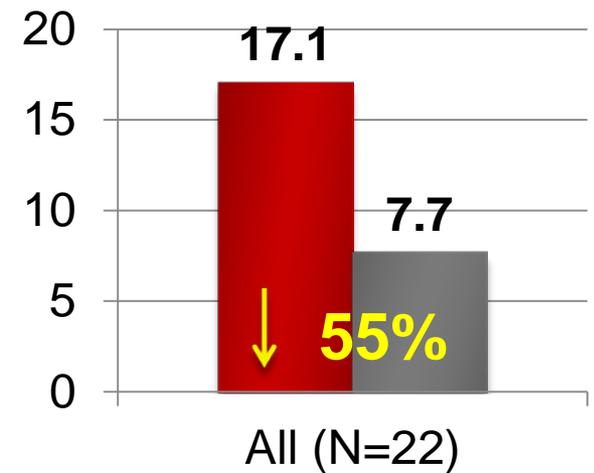
Marijuana Use "Daily or Almost Daily"



■ Baseline ■ 6 months

Fisher's exact test;
p<0.001

PHQ-9 Depression Symptom Scores



■ Baseline ■ 8 - 12 weeks

Paired t-test; p<0.001





Questions and Sharing of Other Models/Ideas



Next Steps/Updates

- ▶ October 1 – Learning Collaborative conference call (all hospitals)
 - ▶ October 8 Webinar – GBR
 - ▶ October 22 Webinar – TBD
 - ▶ November 5 – Learning Collaborative – in-person (Regional Partnerships only)
 - ▶ November 12 Webinar – TBD
-
- ▶ The Implementation RFP response, the Transformation Plan Final Report and the Hospital Strategic Transformation Plan are now all due on **December 7th**. This has been extended one week due to the holiday.



Appendix



SUD and Physical Illness

8 Medical Disorders: Diabetes, heart disease, hypertension, asthma, gastrointestinal disorders, skin infections, malignant neoplasms, and acute respiratory disorders.



RESULTS

- Patients with a psychotic disorder and co-occurring SUD had the highest odds for five of the eight disorders (heart disease, asthma, gastrointestinal, skin infections, and acute respiratory).
- Patients without a psychotic disorder who were treated for SUD had a higher risk for all the disorders except hypertension.

US Preventive Services Task Force (USPSTF) Recommendations



Alcohol – Grade B

Screening and behavioral interventions to reduce misuse by adults in primary care



Depression – Grade B

Screening when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up

USPSTF, Screening for Depression in Adults, 2009; USPSTF, Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse, 2004.

Rankings of 25 Preventive Services Recommended by USPSTF

| # | Service | Preventable Benefit | ROI |
|---|--|---------------------|-----|
| 1 | Aspirin to prevent heart attack & stroke | 5 | 5 |
| 2 | Child hood immunizations | 5 | 5 |
| 3 | Smoking cessation | 5 | 5 |
| 4 | Alcohol screening & intervention | 4 | 5 |

PB & ROI scoring: 1 = lowest; 5 = highest

Ranked higher than:

- Screening for high BP or cholesterol
- Screening for breast, cervical, or colon cancer
- Adult flu, pneumonia, or tetanus immunization

Maciosek, *Am J Prev Med* 2006; Solberg, *Am J Prev Med* 2008;
<http://www.prevent.org/National-Commission-on-Prevention-Priorities/Rankings-of-Preventive-Services-for-the-US-Population.aspx>

SAMHSA's Center for Integrated Health Services Levels of Integration

| COORDINATED KEY ELEMENT: COMMUNICATION | | CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY | | INTEGRATED KEY ELEMENT: PRACTICE CHANGE | |
|---|---|---|---|---|--|
| LEVEL 1 Minimal Collaboration | LEVEL 2 Basic Collaboration at a Distance | LEVEL 3 Basic Collaboration Onsite | LEVEL 4 Close Collaboration Onsite with Some Systems Integration | LEVEL 5 Close Collaboration Approaching an Integrated Practice | LEVEL 6 Full Collaboration in a Transformed /Merged Integrated Practice |



Center for Integrated Health Services, Levels of Integration

www.integration.samhsa.gov



Core Principles of Effective Collaborative Care

Patient-Centered Care Teams

- Team-based care: effective collaboration between PCPs and Behavioral Health Providers.
- Nurses, social workers, psychologists, psychiatrists, licensed counselors, pharmacists, and medical assistants can all play an important role.

Population-Based Care

- Behavioral health patients tracked in a registry: no one 'falls through the cracks'.
Population-based screening

Measurement-Based Treatment to Target

- Measurable treatment goals clearly defined and tracked for each patient
- Treatments are actively changed until the clinical goals are achieved

Evidence-Based Care

- Treatments used are 'evidence-based', having credible research evidence