Arkansas Behavioral Health Integration Network

VISION

Better health for all through integrated care solutions

www.ABHINetwork.org

Kim Shuler, LCSW
Patty Gibson, MD
April 12, 2021

Arkansas Behavioral Health Integration Network

Kim Shuler, LCSW - Disclosures

- ABHIN Chief Executive Officer, co-founder
- Private practice, Individual Psychotherapy
- Behavioral Health Integration clinical supervisor and coach
- CPC+ Behavioral Health Work Group Co-Chair, Arkansas

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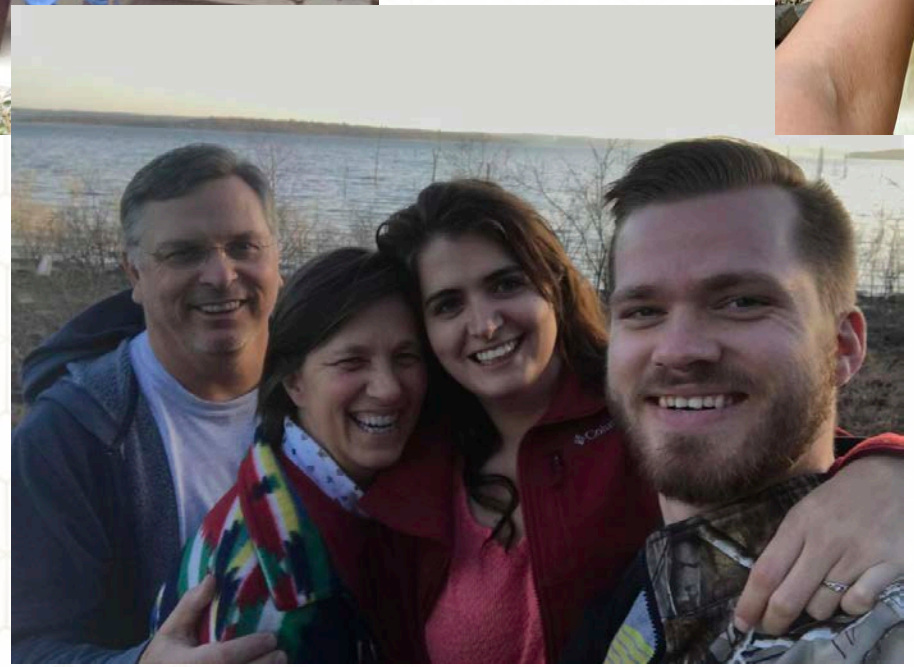
Patty Gibson, MD - Disclosures

- AR Behavioral Health Integration Network – co-founder, CMO
- Baptist - AR Health Group Behavioral Health Integration team
- Baptist Health - UAMS Medical Education Program
- Qualchoice/Centene – Medical Advisory Committee



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What is ABHIN?

>Technical Assistance center

- What do we do?
- Provide support and training to primary care practices
- Facilitate change
- Build the capacity of both organizations and individuals
- Provide statewide local and virtual trainings throughout Arkansas

Agenda for Today

- ABHIN Story
- Lessons Learned
- Future

Keys to Success

Stakeholder Support

Engaged primary care clinics, health systems, and payers who are active participants

ABHIN – independent , nonprofit, local organization, experienced clinicians

CPC+ Stakeholders BHI Workgroup

- Payers, Administrators, Clinicians, Clinic Coaches
- Monthly meetings
- Report/Discussion at Quarterly CPC+ Stakeholder meetings
- Ad hoc consultations

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A brief history

Session # E7

Integrated Behavioral Health Grassroots Statewide Systems Transformation: If Idaho Can Do It You Can Too!

- Jennifer Yturriondobeitia, MSW Executive Director for Cornerstone Whole Healthcare Organization
- Amy Walters, PhD Behavioral Health Director for St. Luke's Humphrey's Diabetes Center
- Anne Daggett, LCSW Behavioral Health Programs Manager for St. Luke's Health Partners

CFHA 20th Annual Conference
October 18-20, 2018 • Rochester, New York

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

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ABHIN

Arkansas Behavioral Health Integration Network

Professional Learning Collaborative

Initial Planning Meeting

Friday, March 1, 2019 -- 10:30-12 noon

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Piecing It All Together

Vision & Mission

Goals & Objectives

Resources & TA

Strategic Planning

Stakeholders

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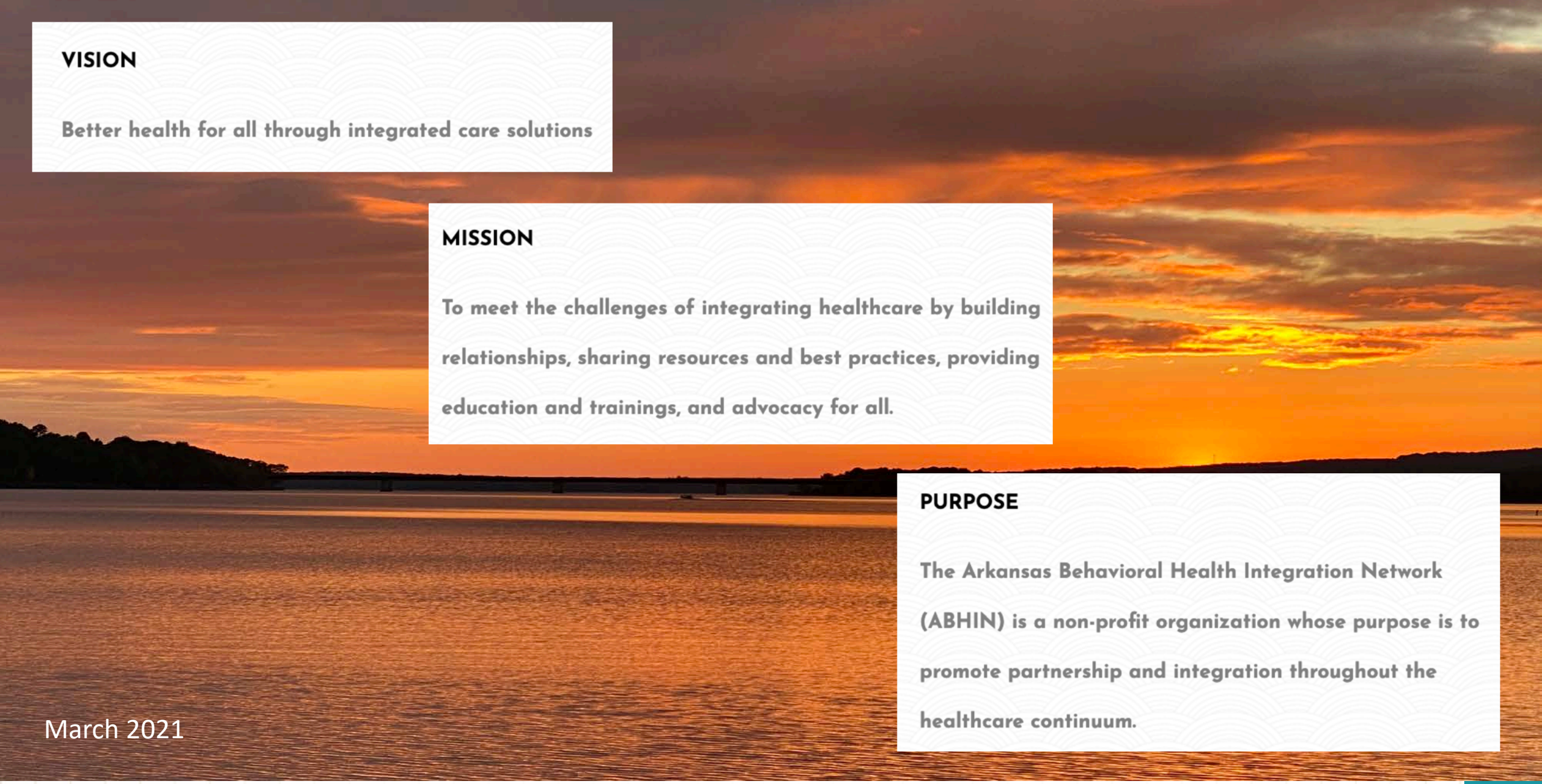


VISION

Better health for all through integrated care solutions

MISSION

To meet the challenges of integrating healthcare by building relationships, sharing resources and best practices, providing education and trainings, and advocacy for all.

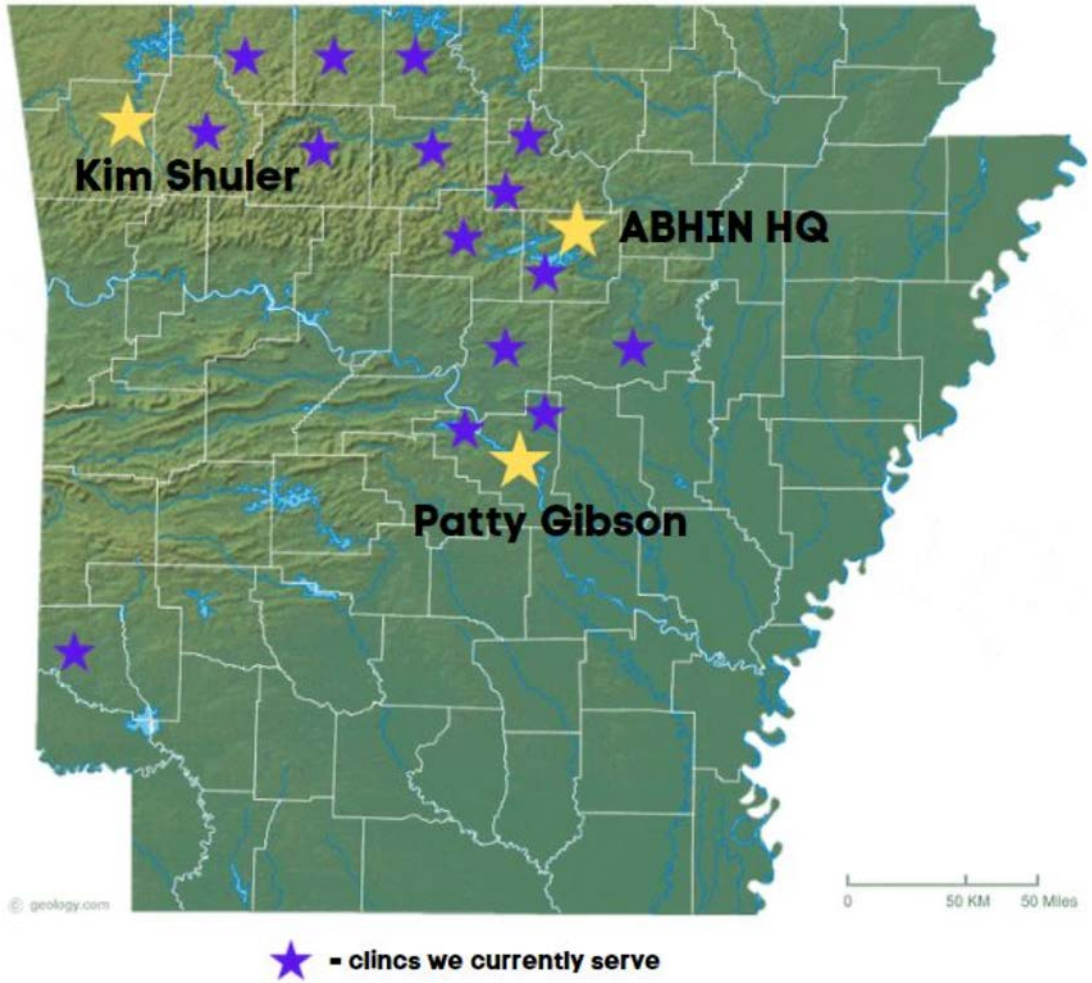
PURPOSE

The Arkansas Behavioral Health Integration Network (ABHIN) is a non-profit organization whose purpose is to promote partnership and integration throughout the healthcare continuum.

March 2021

ABHIN Core Objectives

- Training opportunities
- Develop local expertise
- Professional networks
- Policy and advocacy
- Advance integration



- Headquarters in Greers Ferry
- Patty Gibson lives and works in Little Rock
- Kim Shuler lives and works in Fayetteville

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ABHIN Activities

- **HRSA Rural Health Opioid Use Disorder Planning Grant** – 18 month ($200,000) – Increase primary care teams confidence in managing OUD and decrease anxiety. Increase provider readiness for MAT training and MAT waiver use.

- **HRSA Rural Health Care Coordination Grant** – 3 years ($250,000/year, $750,000 total award) – Focus is Suicide Intervention, Prevention, and Postvention

- PROSPER Suicide Assessment/Management Training (CEUs/CMEs)
- ABHIN Virtual Monthly Webinars – national speakers
- AR Academy of Family Physicians – Presentation, Journal Article
- ABHIN Pediatric Workgroup
- Arkansas Department of Health, Office of Rural Health and Primary Care - Primary Care Needs Assessment
- AR CPC+ Stakeholders Group
- AR CPC+ Participant – statewide training in BHI
- ABHIN website – www.ABHINetwork.org

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JULY 23, 2020
BLOG POST

A Decade of Commitment to Primary Care Transformation Is Starting to Yield Positive Results

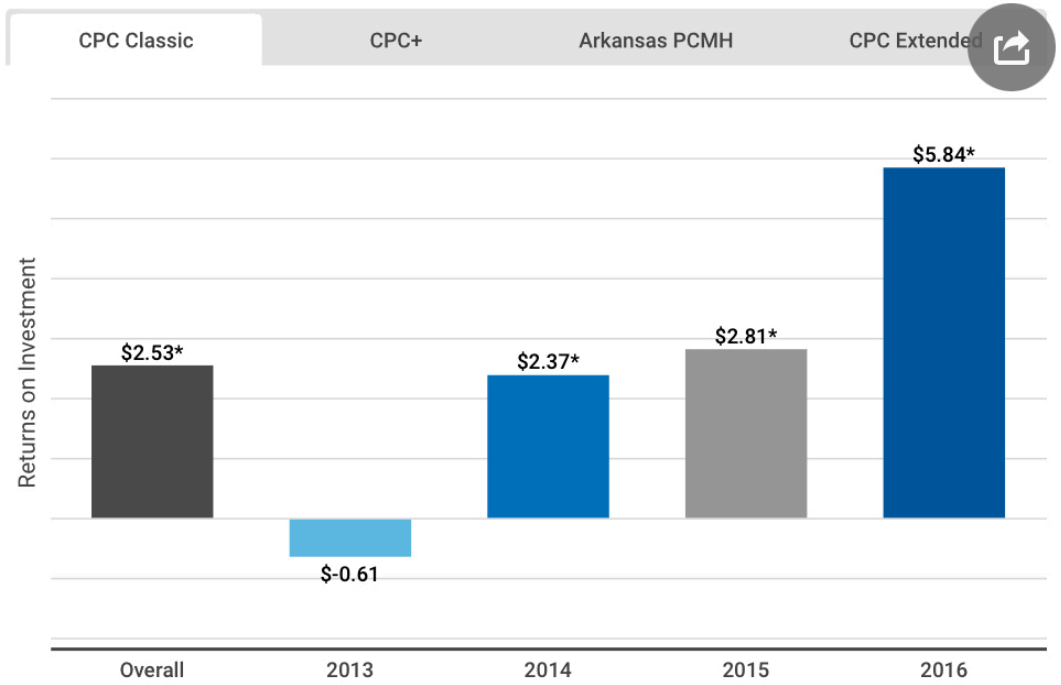
MULTIPAYER PRIMARY CARE NETWORK | PRIMARY CARE TRANSFORMATION | DELIVERY SYSTEM REFORM | PRIMARY CARE INVESTMENT

Author:
LISA DULSKY WATKINS

Milbank Memorial Fund

https://www.milbank.org/2020/07/a-decade-of-commitment-to-primary-care-transformation-is-starting-to-yield-positive-results/

Exhibit 4: Returns on Investment, Overall and by Year



Note: Returns on investment were calculated by dividing average PMPQ savings (i.e., difference-in-difference estimates from Exhibit 2) by average quarterly care management fees. Positive numbers indicate savings for each dollar invested in the program. An asterisk (*) next to a given value indicates a return on an investment value calculated using a statistically significant difference-in-difference coefficient at P<0.05.

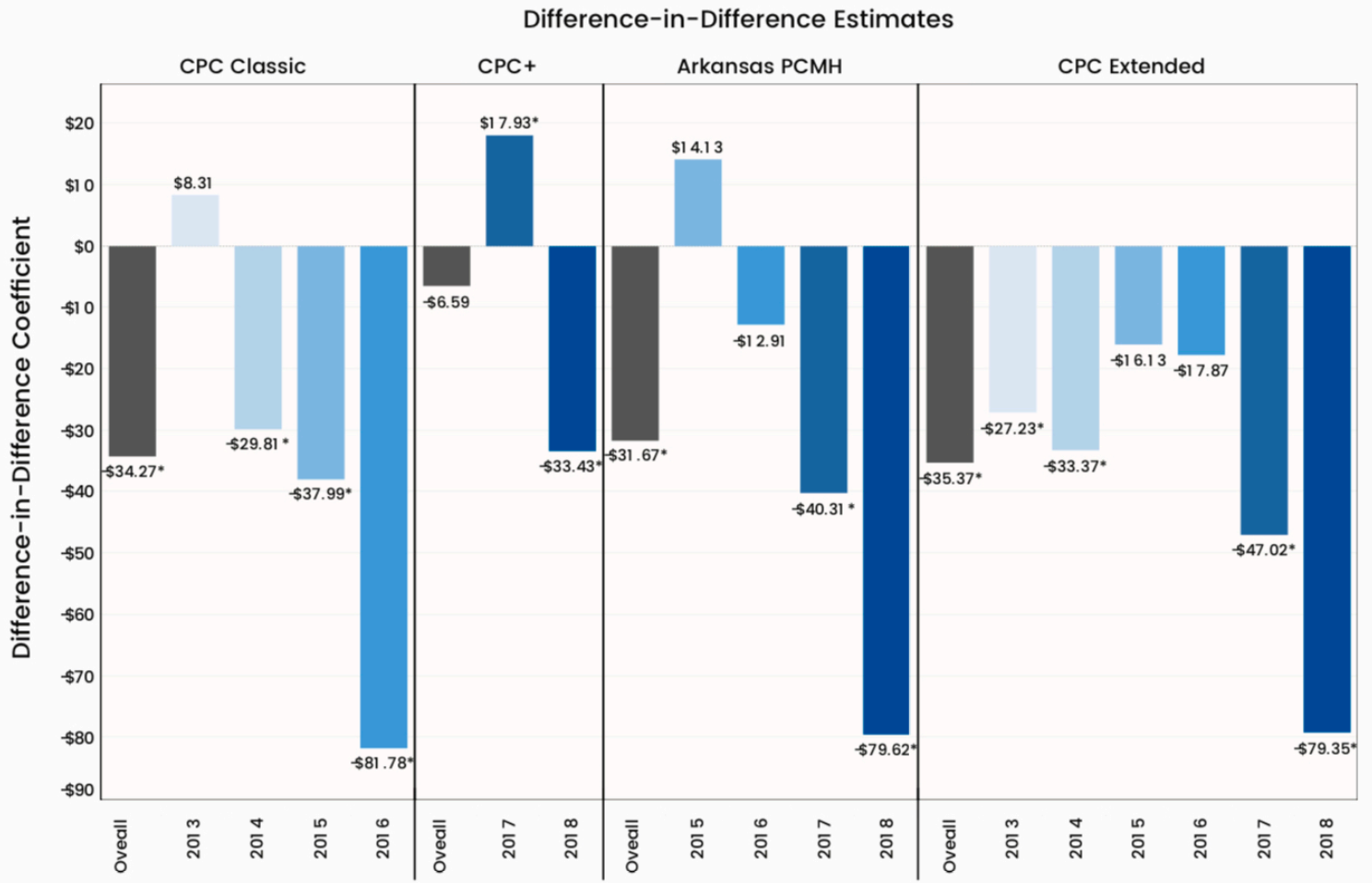
Value-Based Primary Care: Insights from a Commercial Insurer in Arkansas

By Clare C. Brown, PhD, MPH, and J. Mick Tilford, PhD
Contributors: Alicia Berkemeyer, Victor Davis, and Adam Whitlock

Issue Brief
July 2020

Milbank Memorial Fund
Using evidence to improve population health

Exhibit 2. Per Member Per Quarter Savings for All Programs, Overall and by Program Year



https://www.milbank.org/wp-content/uploads/2020/07/Ark_PrimaryCare_issue_brief_v7.pdf

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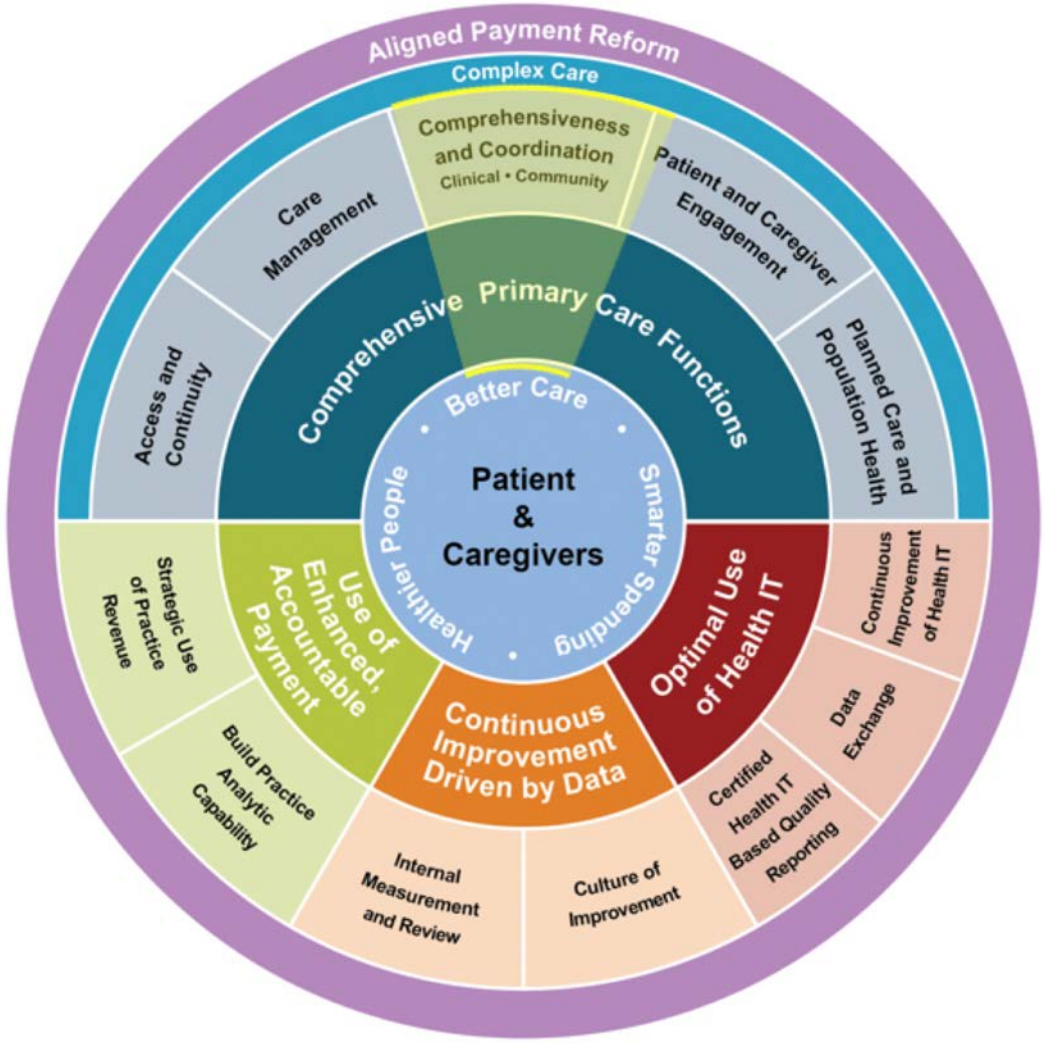
What is Behavioral Health Integration?

Members of a primary care **team** and behavioral health practitioners working together with patients and families using a *systematic, cost-effective approach* to provide patient-centered care for a defined population.



CPC+ Comprehensive Primary Care Plus

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES CENTER FOR MEDICARE & MEDICAID INNOVATION

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CPC+ Behavioral Health Integration Menu of Options

Care Management for Patients with Mental Health Conditions	Primary Care Behaviorist
Key Features • Co-located and integrated care manager with behavioral health training • Evidence-based screening with diagnosis by practitioner • Decision support for complex mental health needs provided by practitioner or psychiatric consult • Algorithm-based, stepped care with proactive patient follow-up and monitoring • Treatment duration three to 12 months	Key Features • Co-located and integrated behavioral health specialists (primary care behaviorist) • Evidence-based screening with diagnosis • Warm hand-offs to behaviorist • Evidence-based behavioral treatments customized for primary care • Treatment duration ≤ six sessions (time limited therapy)

Source: *2018 CPC+ Implementation Guide Guiding Principles and Reporting January 30, 2018, Page 41*

Change is Hard – How do we stay motivated?

Keys to success

RELATIONSHIPS

BRIDGES

CULTURE CHANGE

CPC+ Regional Trainings

- 10/18/2018 – Sharing Solutions to Remove Barriers to BHI
- 12/8/2020 - CPC+ Training – BHI Implementation
- March 2021 – AR CPC+ RING Series:
  - 3/4/21 - BHI Development
  - 3/11/21 – BHI Implementation
  - 3/18/21– BHI Sustainability

"Everyone said the event met or exceeded their expectations"

" I appreciate these meetings, helps me grow and know what others are experiencing."

" It was great! Just the encouragement alone was helpful to me."

" More BHI!"

Arkansas Clinic Feedback

- We need more BHI training
- How do we develop and implement BHI programs
- Workforce shortages (where do we find BHC's, lack of BHC's especially in rural areas)
- How do we utilize BHC's?
- Where do we get training for our BHC's?
- Billing and coding issues
- Questions on how to make BHI financially feasible, financial barriers
- Privacy issues, HIPAA questions, documentation
- Provider and team buy in

Survey – BHI Implementation Barriers in AR CPC+ clinics

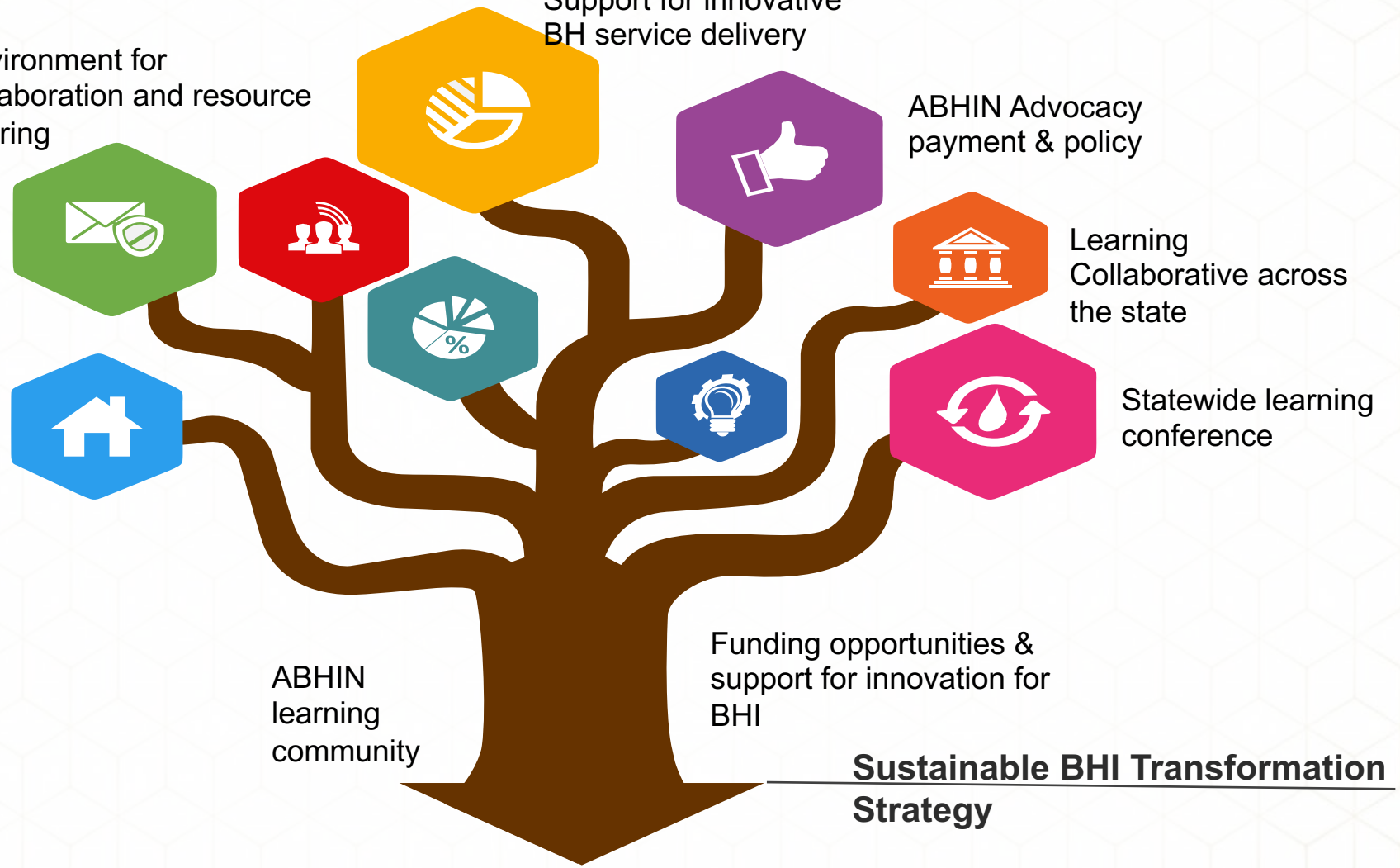
(Informal Survey - 10/14/20 – 3 admin, 5 BHI, 2 PCP)

- Need PCP buy-in & engagement
- Need system/clinic administrative buy-in & support
- Practice transformation is difficult – Change Fatigue
- Lack of Behavioral Health workforce with training in the BHI model
- ROI/Outcome is not clear
- Financial
    - clinics ability to hire workforce & commit time of PCPs
    - credentialing/coding/billing issues
    - BHI model- does not fit traditional FFS model
    - patient co-pays/co-insurance

ABHIN ROLE – BRIDGE

- Bring national expertise to the local clinicians
- Identify training resources & evidenced based practices
- Technical assistance/coaching/mentoring
- Bridging gap for fragmented care

Systems Transformation Outcomes



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RESOURCE SLIDES

Points on Care

- A data brief series examining all aspects of primary care access

PRIMARY CARE DEVELOPMENT CORPORATION

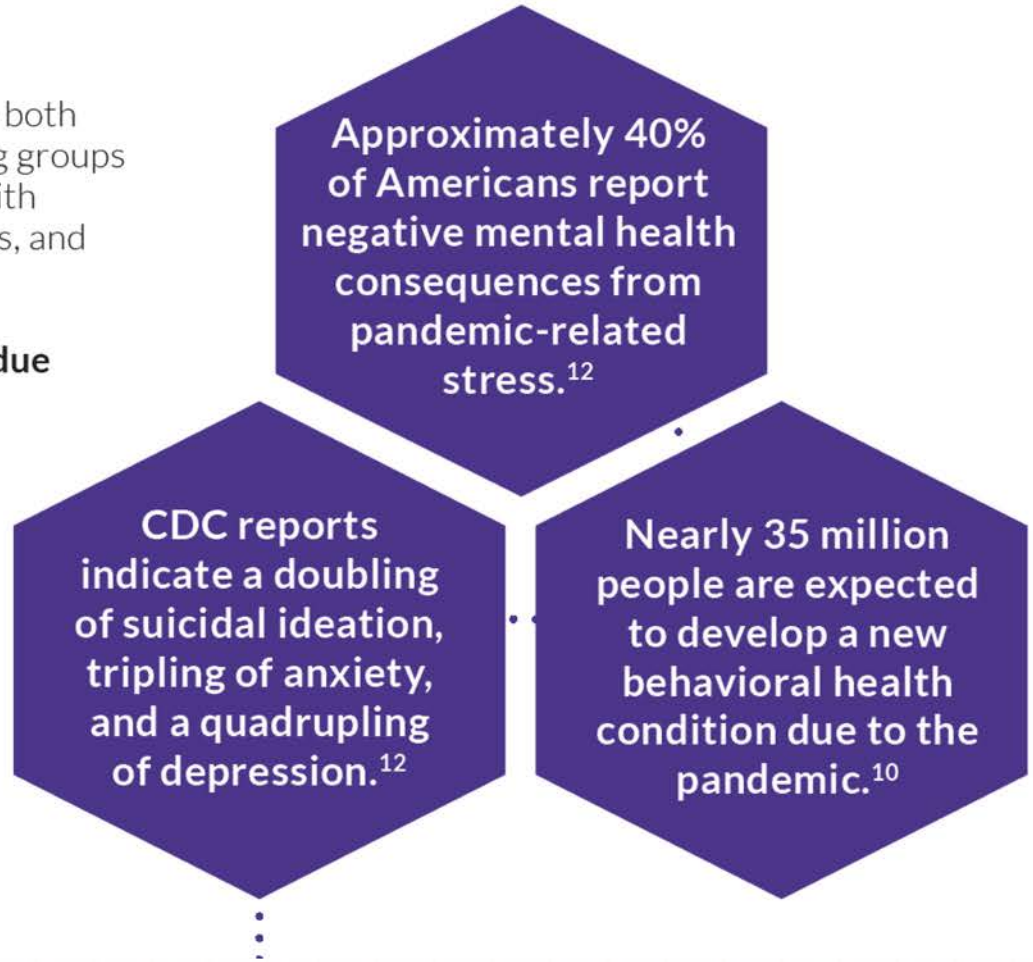
January 2021 | Issue 6 | Page 1

The Global COVID-19 Pandemic Underscores Need for Integration

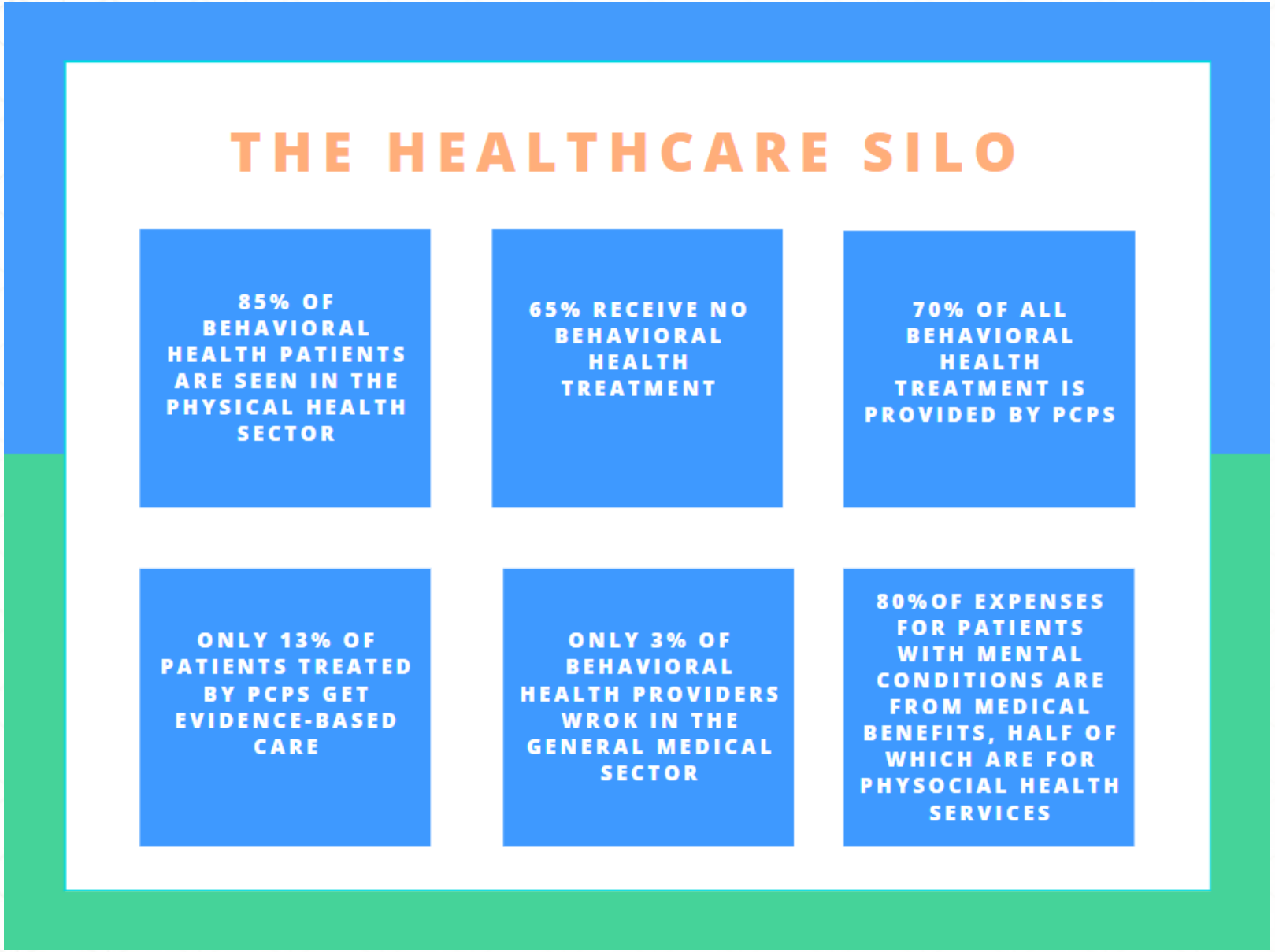
The COVID-19 pandemic poses a major threat to both physical and behavioral health, particularly among groups most directly affected by the pandemic: people with underlying chronic conditions, healthcare workers, and others with poor access to care.

An estimated **$100-$140 billion in added costs due rising behavioral health needs** may result from just the first year of the COVID-19 pandemic.[10] As new behavioral health needs emerge, existing disparities in access to care have been exacerbated by the pandemic in many communities—particularly for Black and Latinx populations, which also have higher rates of COVID-19 incidence and mortality.[11]

As health care providers and systems manage converging crises, integrated care offers an effective strategy for delivering comprehensive care and reducing disparities while containing costs.

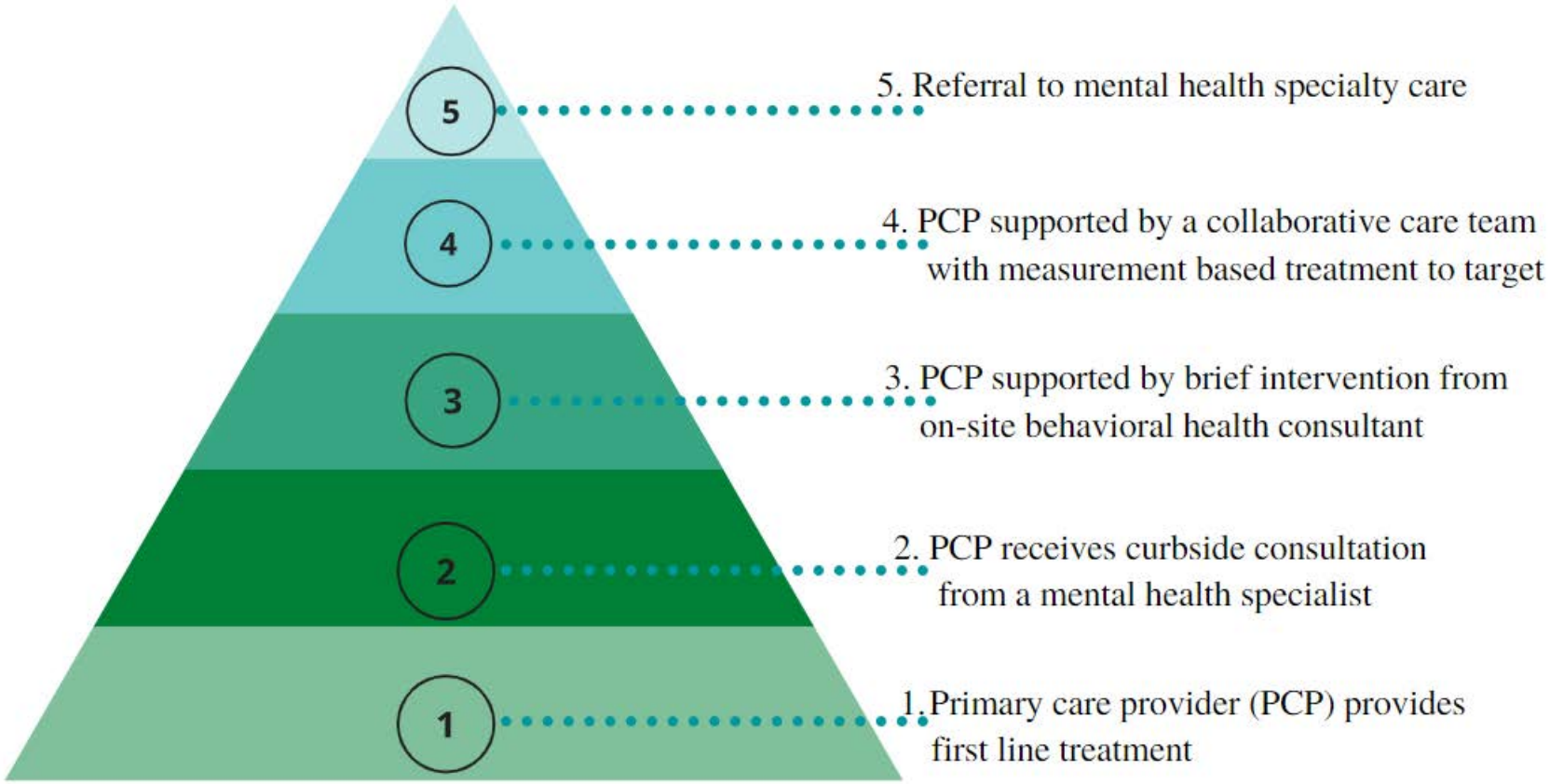


THE HEALTHCARE SILO



Kathol, Roger G., Rebecca Perez and Janice S. Cohen. The Integrated Case Management Manual. New York: Springer Publishing, 2010

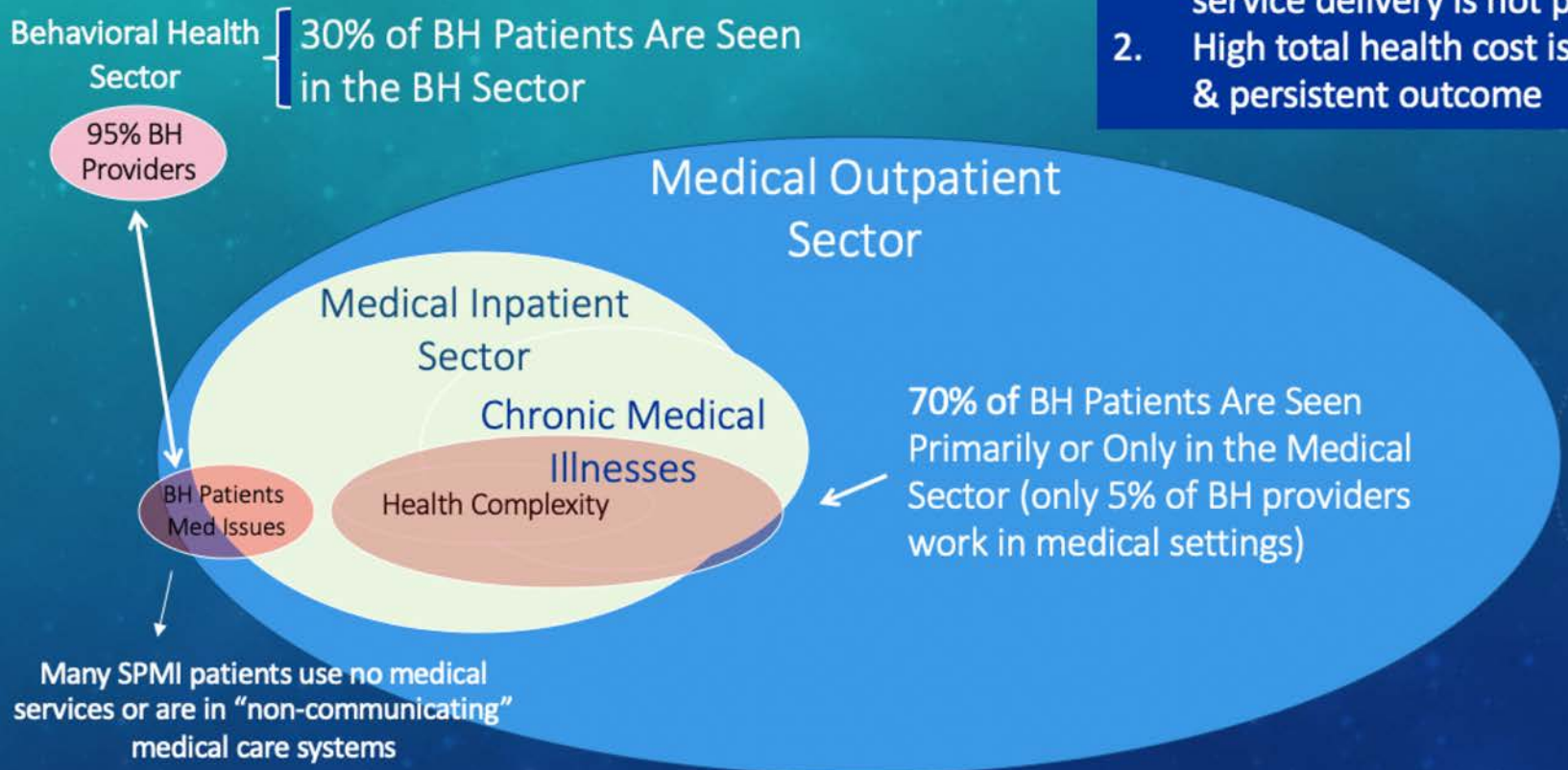
Stepped Model of IBH



Source: University of Washington, Psychiatry & Behavioral Sciences Division of Population Health, Advancing Integrated Mental Health Solutions (AIMS) Center. https://aims.uw.edu/stepped-model-integrated-behavioral-health-care. Accessed: November 9, 2020

The Effect of Delivery System Segregation

1. Integrated psychiatric and medical service delivery is not possible
2. High total health cost is a natural & persistent outcome



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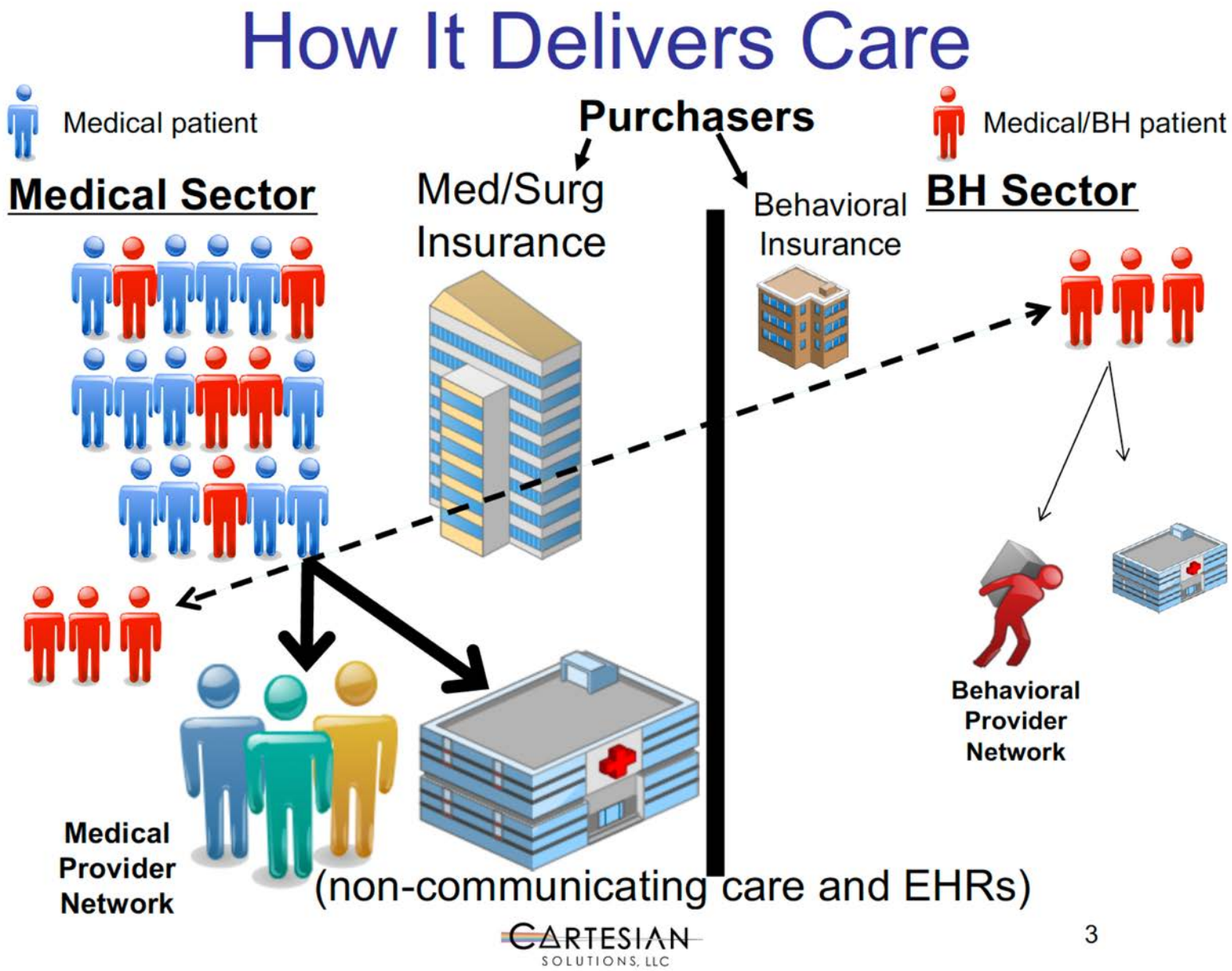
Used with permission from Roger Kathol, MD April 5, 2021

Current Healthcare System



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Effect of Medical and BH Segregation on Total Health Care Cost

Patients	Condition Prevalence	Total Annual Cost for Population	% with BH Condition	Annual Cost when BH Condition Present	% Increase with BH Condition
All Insured		$5,110	17%		
Arthritis	7.7%	$12,290	33%	$24,200	97%
Asthma	3.7%	$9,810	29%	$23,610	141%
Cancer	2.7%	$21,340	31%	$35,660	67%
Diabetes	5.6%	$16,210	29%	$25,980	60%
CHF	1.9%	$20,560	39%	$31,950	55%
Endocrine	17.5%	$12,510	32%	$21,610	73%
COPD	0.9%	$17,350	45%	$33,030	90%

Milliman data, 2017

CARTESIAN SOLUTIONS, LLC

Milliman

Arkansas Behavioral Health Integration Network

https://www.cartesiansolutions.com/

Cost of Psychiatric Comorbidity

MILLIMAN RESEARCH REPORT

How do individuals with behavioral health conditions contribute to physical and total healthcare spending?

Commissioned on behalf of The Path Forward for Mental Health and Substance Use
by the Mental Health Treatment and Research Institute LLC, a tax-exempt subsidiary of
The Bowman Family Foundation

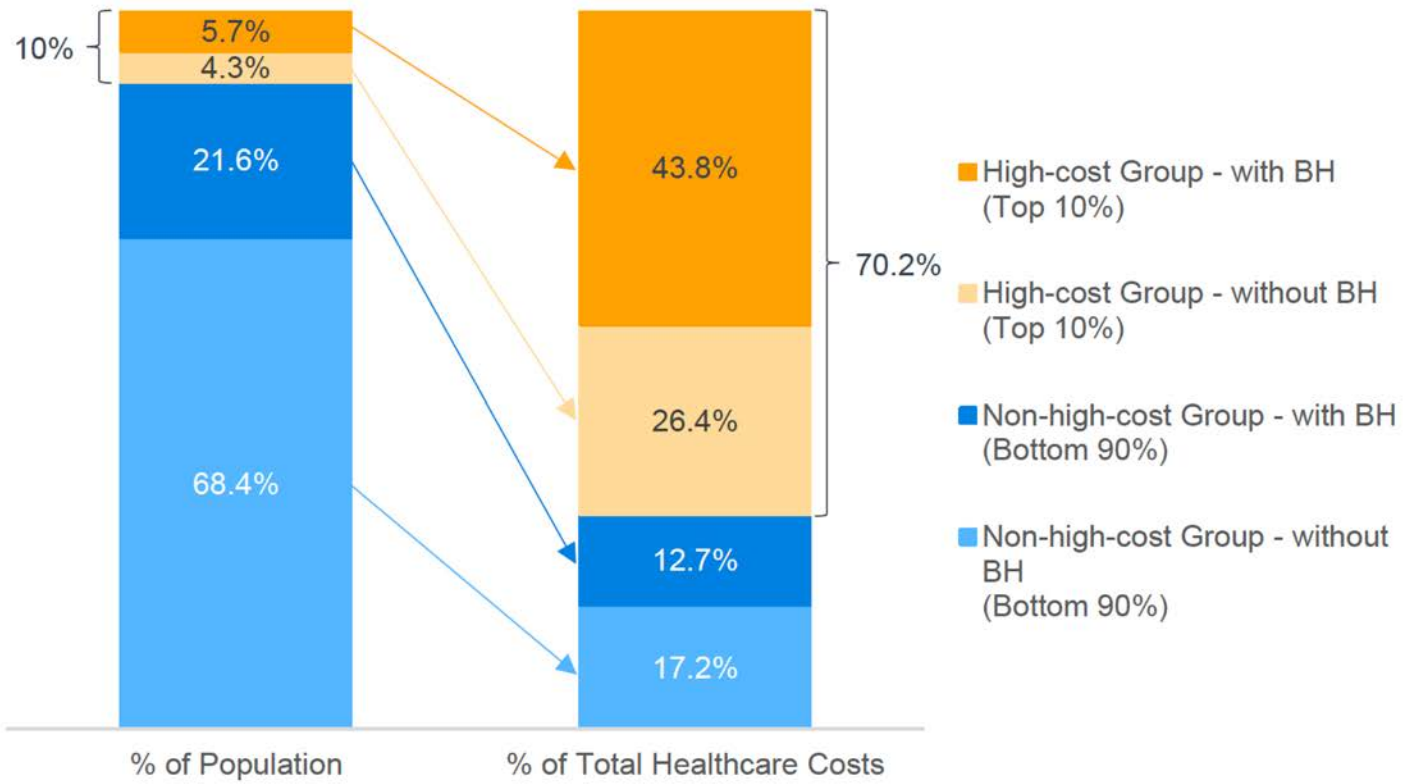
August 13, 2020

Stoddard Davenport, MPH
T.J. Gray, FSA, MAAA
Steve Melek, FSA, MAAA

https://www.milliman.com/en/insight/How-do-individuals-with-behavioral-health-conditions-contribute-to-physical

From 2020 Milliman Research Report

Distribution of Population & Total Healthcare Costs



https://www.milliman.com/en/insight/How-do-individuals-with-behavioral-health-conditions-contribute-to-physical

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From 2020 Milliman Research Report

KEY FINDINGS

1. Within our study population of 21 million insured lives, the most expensive 10% of individuals accounted for 70% of total healthcare costs. In this report, these 2.1 million individuals are referred to as the "High-cost Group."
   - The annual total healthcare costs for individuals in the High-cost Group averaged $41,631—which is 21 times higher than the $1,965 for individuals in the remaining 90% of the population, or the "Non-high-cost Group."
2. Of the 2.1 million individuals in the High-cost Group, 57% (1.2 million individuals) were in the BH Group (referred to as the "High-cost Behavioral Subgroup").
   - The High-cost Behavioral Subgroup constituted 5.7% of the total population of 21 million insured lives, yet accounted for 44% of total healthcare costs.
   - Annual total healthcare costs for individuals in the High-cost Behavioral Subgroup averaged $45,782.
   - Half of these individuals (50%) had less than $95 per year of total spending for behavioral health treatment (i.e., inpatient and outpatient hospital or facility services, and/or professional services coded as behavioral health services, and prescription behavioral health drugs).
3. Of the total population of 21 million insured lives, 27% (5.7 million) were in the BH Group.
   - The BH Group accounted for 56.5% of total healthcare costs for the entire study population.
   - Average annual costs for the BH Group for medical/surgical (physical) treatment were 2.8 to 6.2 times higher (depending on the BH condition) than such costs for individuals with no behavioral health condition.
   - Half of these 5.7 million individuals (50%) had less than $68 of annual costs in 2017 for behavioral health treatment; the next 25% ranged from $68 to $502 of annual spending.
   - Of total healthcare costs for the entire study population, 4.4% were for behavioral health treatment.

https://www.milliman.com/en/insight/How-do-individuals-with-behavioral-health-conditions-contribute-to-physical

Findings from an Analysis of Comorbid Chronic Medical & Behavioral Conditions in Insured Populations (source: Potential Economic Impact of Integrated Medical-Behavioral Healthcare; Melek et.al.)

Projected Healthcare Cost Savings Through Effective Integration (National, 2017)	
Payer Type	**Annual Cost Impact of Integration**
Commercial	$19.3-$38.6 Billion
Medicare	$6.0-$12.0 Billion
Medicaid	$12.3-$17.2 Billion
Total	**$37.6-$67.8 Billion**

https://www.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/2018/potential-economic-impact-integrated-healthcare.ashx