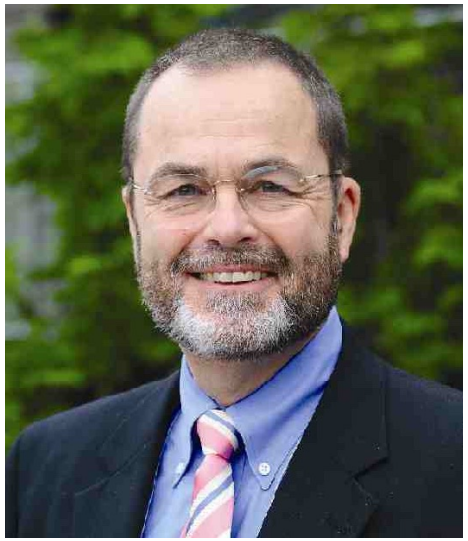
Integrating Primary Care: The Dimensions of the Job



Webinar for the Arkansas Behavioral Health Integration Network

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BHI is crucial to population health.

The vast majority of people with Behavioral Health needs will not accept a referral to specialty Mental Health or Substance Use care offered by a PCP. It is care in primary care or no care at all.

Moving BH services into primary care is the single most effective approach to reducing stigma around access and offering equity in healthcare.

Regier DA, Narrow WE, Rae DS, Manderscheid RW, Locke BZ, Goodwin FK. **The de facto US mental and addictive disorders service system** Arch Gen Psychiatry. 1993 Feb;50(2):85-94.

Behavioral Health Integration is Foundational for Achieving Equity in Healthcare

"…racial and ethnic minorities are less inclined than whites to seek treatment from mental health specialists. Instead, studies indicate that minorities turn more often to primary care."

Surgeon General's Report on Mental Health, 1999. Supplement on Culture, Race and Ethnicity

The national conversation about Behavioral Health Integration has moved from “Why” to “How.”

- Webinar series of Arkansas Behavioral Health Integration Network has provided talks by some of the best in the country on why and a bit on how.
- Strong evidence of overall cost reduction from mature integrated programs.
- Clear evidence of better patient satisfaction and improved quality of life.
- Clear evidence of improved provider satisfaction and reduced burn out in the presence of high functioning clinical teams.

BUT

- To a practice or system facing integration with open eyes, it introduces uncertainty.
- For each new site considering integrating, “why” will have to addressed at the local level.
- “Integration,” in itself, is not the reason to do anything. It is a pathway to better care for <u>your</u> patients. And that is the “why” to bring to your staff.

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The Chinese sinograph for “crisis” “Danger” and “crucial point when something begins or changes.”

http://www.pinyin.info/chinese/crisis.html

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Where to Start?

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Be Clear on Your Version of Why.

Some possibilities:

- Important to the mission of serving your patients.
- You have a sub-group of patients that have particular needs.
  - “Complex” burdens of illnesses and high cost
  - Opioid users
  - Presenting multiple somatic symptoms w/o findings

- Assist stressed PCP’s who feel they currently don’t have enough options.
- Required screening must have treatment options.
- A BH clinician is available and interested.

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Health Systems and Practice Leadership

1. Articulate and regularly affirm BHI as forwarding the mission of the organization.
    1. Whole person care. 2. Population health. 3. Health equity.
2. Support the identification of a “physician champion” for BHI in each setting.
3. Support substantial on-boarding and in-service training for new BHCs.
4. Designate a leader for the BHI effort who is experienced in integrated settings.
5. Treat BHCs as “providers” rather than staff, and expect BH to be represented at what are currently “medical” meetings.

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Will IBH Pay for Itself?

Probably . . . . . Eventually

<u>Some Considerations</u>:

1. Could be the wrong question.
2. Fee-for-service is harder than other forms of payment to make integration work.
3. Clinical routines that bring more revenue may be unfamiliar to BHCs and PCPs
4. BH billing can be challenging to billing, coding, compliance, and other administrative folks. New processes can bring out the risk aversion tendencies in most of us.
5. May take a couple of years to get up to full revenue stream.

On The Other Hand

Behavioral Health service of Community Health of Central Washington (FQHC with 7 sites) contributes $1,000,000 above cost per year to the organization.

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Blount, A., Schoenbaum, M., Kathol, R., Rollman, B., Thomas, M. O'Donohue, W., & Peek, C.J. (2007). The economics of behavioral health services in medical settings: A summary of the evidence. *Professional Psychology: Research and Practice, 38*, 290-297.

Models, Models, Models

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Models of Integrated Behavioral Health

Collaborative Care Model – CoCM	Primary Care Behavioral Health Model - PCBH
CoCM:	PCBH:
Disease based – designated diag.	Program based-all patients identified
Research heritage	Clinical heritage
Patient outcome evidence	Access-Satisfaction-Clinical outcome
Cost evidence with pts served	Cost evidence for practice as a whole
Care manager (SW or Psychologist)	Behavioral Health Consultant (or Clinician)
Beginning to converge	
Care manager does other behavioral health and chronic illness services	BHC does some care management and Care Managers added for SDOH
Array of services beyond disease prgms	Beginning disease programs

Both models have been implemented with very wide variability in model fidelity

How we really look.

Improve in an iterative fashion.

How can we serve our patients better?

Continual learning experiences or consultation.

Broad input on barriers and improvements

Keep studying what works.

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Statewide Program

State Health Dept., Statewide Health Foundation(s), Federal Grant

- Offer some incentive for voluntary participation. (e.g., Advancing Care Together, Colorado).
- Vocal support by statewide leaders. (Report on ACT by Lieut. Gov.)
- Create active learning community with consultative support from professionals experienced in BHI.
- Fund evaluation effort.
- Begin work on future workforce at the start.

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Payers

Offer carrots and remove barriers

Carrots:

Massachusetts (Medicaid) Primary Care Payment Reform:

https://innovation.cms.gov/files/fact-sheet/sim-rd1-mt-ar5-statefs-ma.pdf

Level 1. Care Coordination - @$12 PMPM

Level 2. On site Behavioral Health Clinician (40 hrs) – payment bump

Level 3. On site Psychiatrist (8 hrs) – additional bump

Colorado State Innovation Model:

https://www.healthcaredive.com/news/colorado-payers-collaborate-to-benefit-behavioral-health/404178/

Private payers and Medicaid collaborate to offer payment models that enhance Behavioral Health

Payers

Offer carrots and remove barriers

Barriers:

1. Requiring double co-pays for same day services.
2. Demanding same processes for BH in primary care as in a mental health center.
3. Not accepting “health and behavior” codes.
4. Failing to empanel new BH clinicians in primary care.
5. Restricting participation by some licensed BH clinicians.

Payers

Offer carrots and remove barriers

What payers get for their leadership:

- Cost savings in the whole medical and behavioral spend:

  Mass. Primary Care Payment Reform – savings - yr 1: 6.3%, yr 2: 10%

  https://www.pcpcc.org/resource/massachusetts-payment-reform-model-results-and-lessons

  Colorado – first 2 years of SIM saved $178 million for payers.

  https://hcpf.colorado.gov/sites/hcpf/files/Colorado%20SIM%20Final%20Report_0.pdf

- Documented better and more equitable access for subscribers.
- Subscribers who are happier with their coverage.

JAMA Netw Open. 2021;4(10):e2130770

You could call a meeting.

Or

Representatives

State Health Policy

Medicaid

Private Payers

Major Primary Care Providing Organizations

State BHI experts

BH access advocates

HRSA programs

BHC training

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www.TEAMtelemed.net

Integrated primary care visit for patient with multiple burdens of illness.

Team approach. Using Telemedicine. Delivering patient-centered care.