Accelerating Integrated Care Series

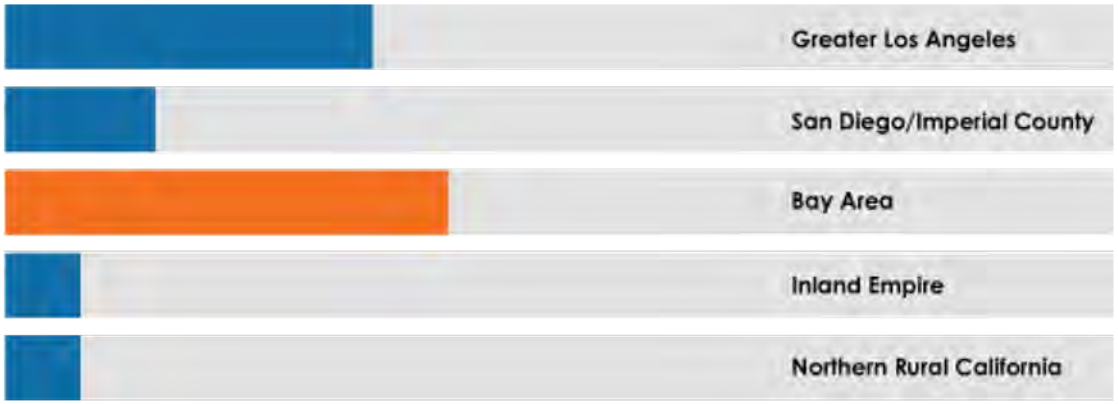
June 24, 2020

ALIGN PAYMENT

CQC
CALIFORNIA QUALITY COLLABORATIVE
Breakthroughs for Better Health Care

Poll: Who's in the (virtual) room?

From where are you dialing?



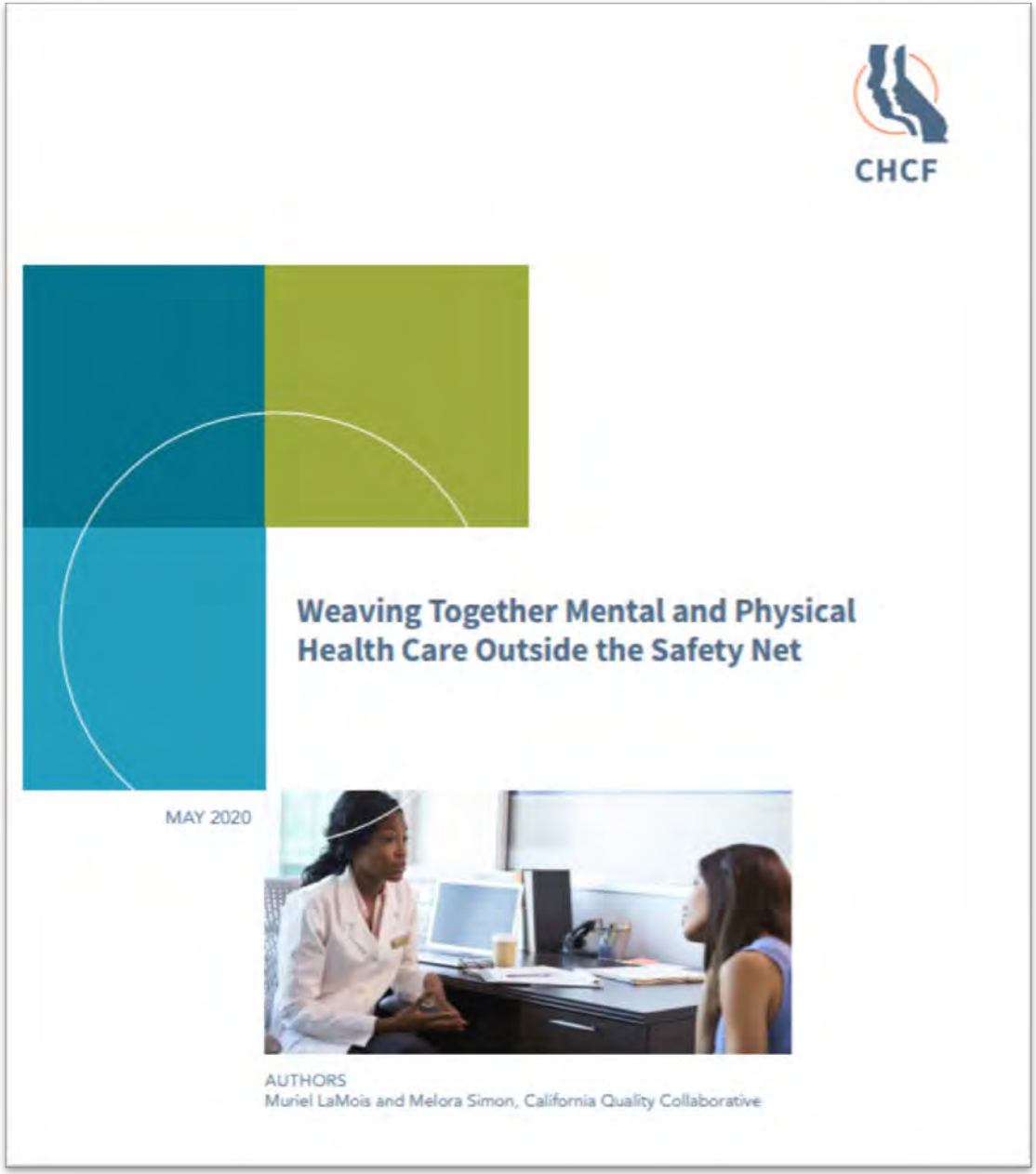
What type of organization do you represent?

Who is the California Quality Collaborative (CQC)?

California Quality Collaborative (CQC) is a healthcare improvement organization dedicated to advancing the quality and efficiency of the health care delivery system in California.

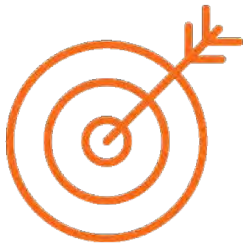
- Generates scalable and measurable improvement in the care delivery system important to patients, purchasers, providers, and health plans.
- Governed by a multi-stakeholder committee and is administered by the Pacific Business Group on Health.

Issue Brief



Click cover to view PDF

Today's Objectives



In this webinar, participants will:

- Examine the current state of integration of behavioral health into primary care in California
- Consider innovations enabled by aligned payment
- Hear about actions payers and providers are already taking to offer integrated care
- Identify immediate actions your organizations can take to offer integrated care

Today's Speakers

Crystal Eubanks

Director,
Care Redesign Strategy & Programs

CQC
CALIFORNIA QUALITY COLLABORATIVE

Melora Simon, MHA

Health Care Strategy and Innovation Consultant

Dr. Tiffany Nelson

Desert Ridge Family Physicians (her independent Arizona practice) and Chief Strategy Officer, Innovation Care Partners (300 provider ACO in the Phoenix area)

Desert Ridge Family Physicians

INNOVATION CARE PARTNERS
AFFILIATED WITH HONORHEALTH

Julie Fortune, LMFT

Director of Behavioral Health and Primary Care Integration at Providence St. Joseph Health in the Anaheim area

St. Joseph Health

Behavioral Health in Primary Care – The Case for Integration

- **Mental health conditions are common and access is difficult** regardless of insurance type.[1]
  - Among those with insurance who tried to make an appointment for mental health care in the past 12 months, almost half (48%) found it "very difficult" or "somewhat difficult" to find a provider who took their insurance.
  - Moreover, 52% of those who tried to make an appointment (with or without insurance) believe they waited longer than was reasonable to get one.

1. Health Care Priorities and Experiences of California Residents: Findings from the California Health Policy Survey (CHCF; 2020)

Behavioral Health in Primary Care – The Case for Integration

- **Mental health issues commonly present in primary care.**[2]
  - Twenty percent of primary care visits relate to mental health, and 79% of antidepressants are prescribed by primary care providers (PCPs).
  - Most PCPs do not have the time and expertise to diagnose and treat mental illness. Stepped care is important: 50-70% need at least one change in care to show improvement.

2. ncbi.nlm.nih.gov/pmc/articles/PMC3670434/

Behavioral Health in Primary Care – The Case for Integration

- **Coordination is wanted, but rare**.
  - Vast majority of patients say they would want their primary care provider to be informed of their treatment for a mental health condition (82%) or treatment for an alcohol or drug use problem (79%).[1]
  - Yet, only 3% of psychiatrists and psychiatric nurse practitioners coordinate care with PCPs.[3]

1. Health Care Priorities and Experiences of California Residents: Findings from the California Health Policy Survey (CHCF; 2020)
3. https://blogs.scientificamerican.com/observations/the-case-for-collaborative-care/

True integration requires practice change

INTEGRATED CARE

Integrated care is a widely used term that can mean a host of different things. The framework from the SAMHSA-HRSA Center for Integrated Health Solutions helpfully distinguishes between coordinated, colocated, and integrated care.[7] As noted above, this paper focuses on practice change in primary care to deliver integrated care (levels 5 and 6 below).

Six Levels of Collaboration/Integration

COORDINATED		COLOCATED		INTEGRATED	
Key element: Communication		*Key element:* Proximity		*Key element:* Practice change	
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	**Level 6**
Minimal collaboration	Basic collaboration at a distance	Basic collaboration on-site	Close collaboration on-site with some system integration	Close collaboration approaching an integrated practice	Full collaboration in a transformed/ merged integrated practice

Source: Bern Heath, Kathy Reynolds, and Pam Wise Romero, *A Review and Proposed Standard Framework for Levels of Integrated Healthcare*, SAMHSA-HRSA Center for Integrated Health Solutions, March 2013, www.integration.samhsa.gov.

Paper informed by interviews with the following organizations

Barriers cited

Network Participation

- Not enough providers participate in insurance networks
- Directories don't indicate who actually has availability

Coordination and Communication

- Unlike physical health, there are payor-specific workflows, as mental health not included in delegated arrangements
- Information exchange is challenging due to privacy law interpretations, cultural divide, and lack of shared systems between primary care providers and behavioral health providers

Reimbursement and Risk

- Fragmented accountability
- Limited reimbursement for BH
- Behavioral health excluded from capitated contracts

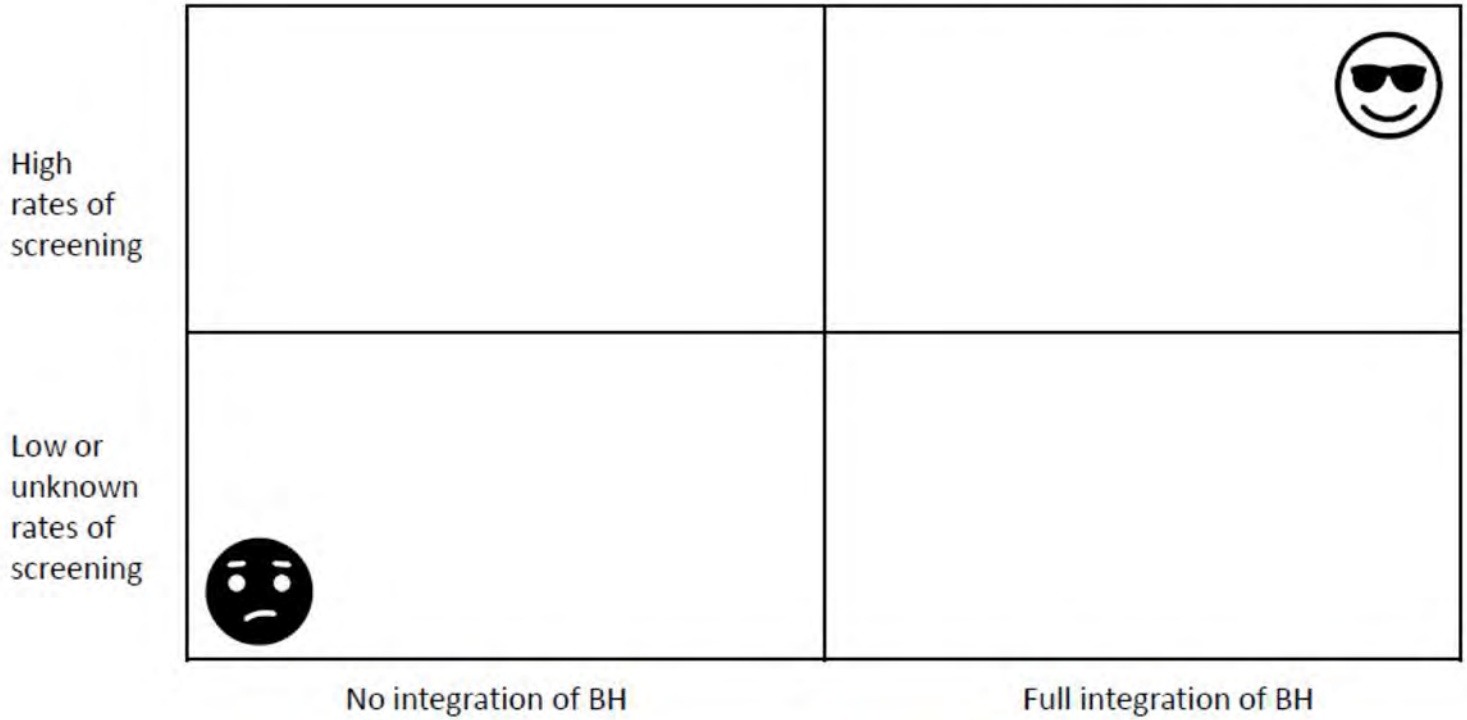
Screening

- The good news:
  - 92% of interviewed POs recommend screening to clinicians
  - 90% use PHQ2 and/or PHQ9
- The not-so-good news:
  - Few interviewed organizations could report on what percent of patients were being screened
  - Physicians articulate concerns about screening when they don't feel confident they can successfully refer patients.
  - Among patients surveyed, only one in 3 are being screened for anxiety and one in 4 for depression.[1]
- The opportunity:
  - California FQHCs, which have aligned financing, are screening 2/3 of patients and 194 of 200 clinics offer mental health services. Mental health service volume grew by 29% between 2015 and 2017.
  - Minnesota, which embraced a multi-payer strategy to pay for integrated behavioral health care, is screening almost 75% of adults and 86% of adolescents

1. 2015 PAS Results.

Our discovery process: care redesign and high rates of screening are highly correlated

NOT SCIENTIFIC - ILLUSTRATIVE AND OVERSIMPLIFIED



5/29/2019

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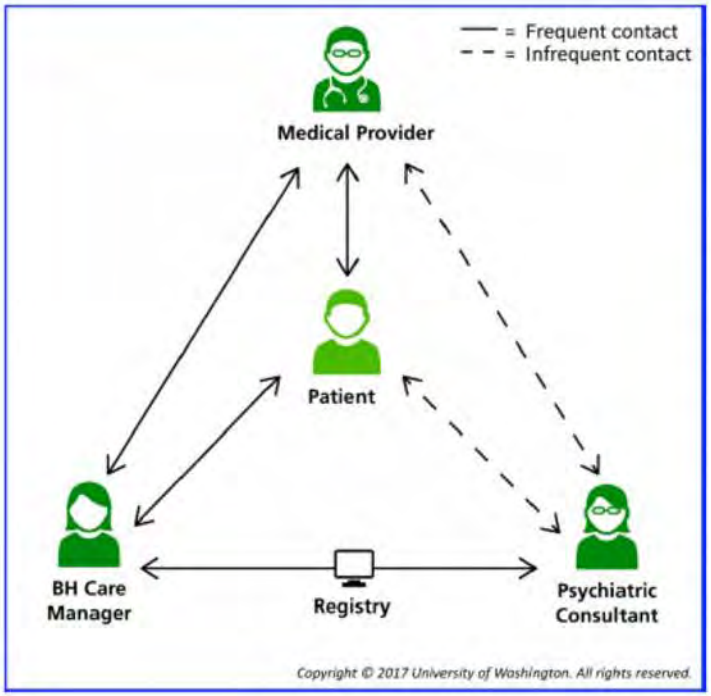
Integrated Healthcare ASSOCIATION

PBGH PACIFIC BUSINESS GROUP ON HEALTH

The collaborative care model was often used among those systems with high rates of screening



Patient-Centered Team: Primary care and behavioral health providers collaborate effectively using shared care plans that incorporate patient goals.

Population-Based Care: Care team shares a defined group of patients tracked in a registry to ensure no one "falls through the cracks."

Measurement-Based Treatment to Target: Treatments are actively changed if patients are not improving as expected until the clinical goals are achieved.

Evidence-Based Care: Patients are offered treatments for which there is credible research evidence to support their efficacy in treating the target condition

Accountable Care: Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

Source: AIMS Center, University of Washington.

BHI will not spread without multipayer alignment

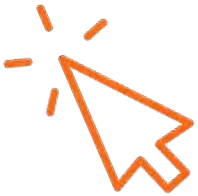
Outside capitated arrangements, turn on CMS's CoCM Codes

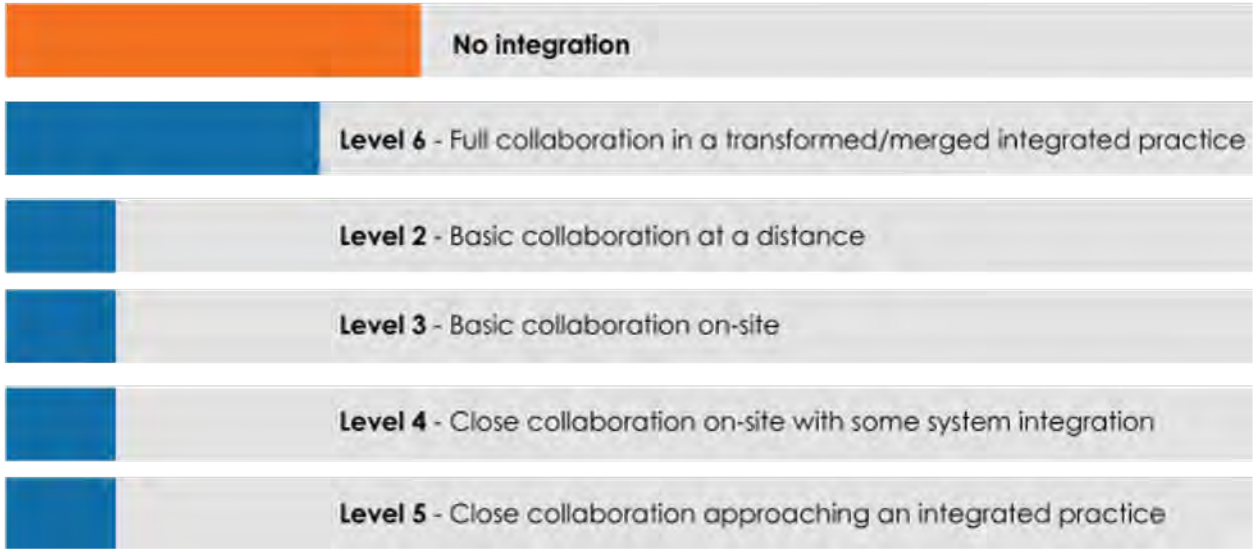
- Monthly care management codes, billed by the PCP, that include the efforts of the PCP, the consulting psychiatrist, and the behavioral health care manager

Develop ***standardized approach for capitated arrangements*** that acknowledge the expanded scope of collaborative care (could be contracted on the physical health side or the MBHO side)

- Monthly case rate for those enrolled in the model – or –
- Develop experience over time to inform a monthly cap amount – or –
- Another value-based arrangement that rewards outcomes and reductions in total cost of care

Poll:
What stage of integration is your organization currently in?





Hear from those that are offering integrated behavioral health

Dr. Tiffany Nelson

Desert Ridge Family Physicians (her independent Arizona practice) and Chief Strategy Officer, Innovation Care Partners (300 provider ACO in the Phoenix area)

Desert Ridge Family Physicians

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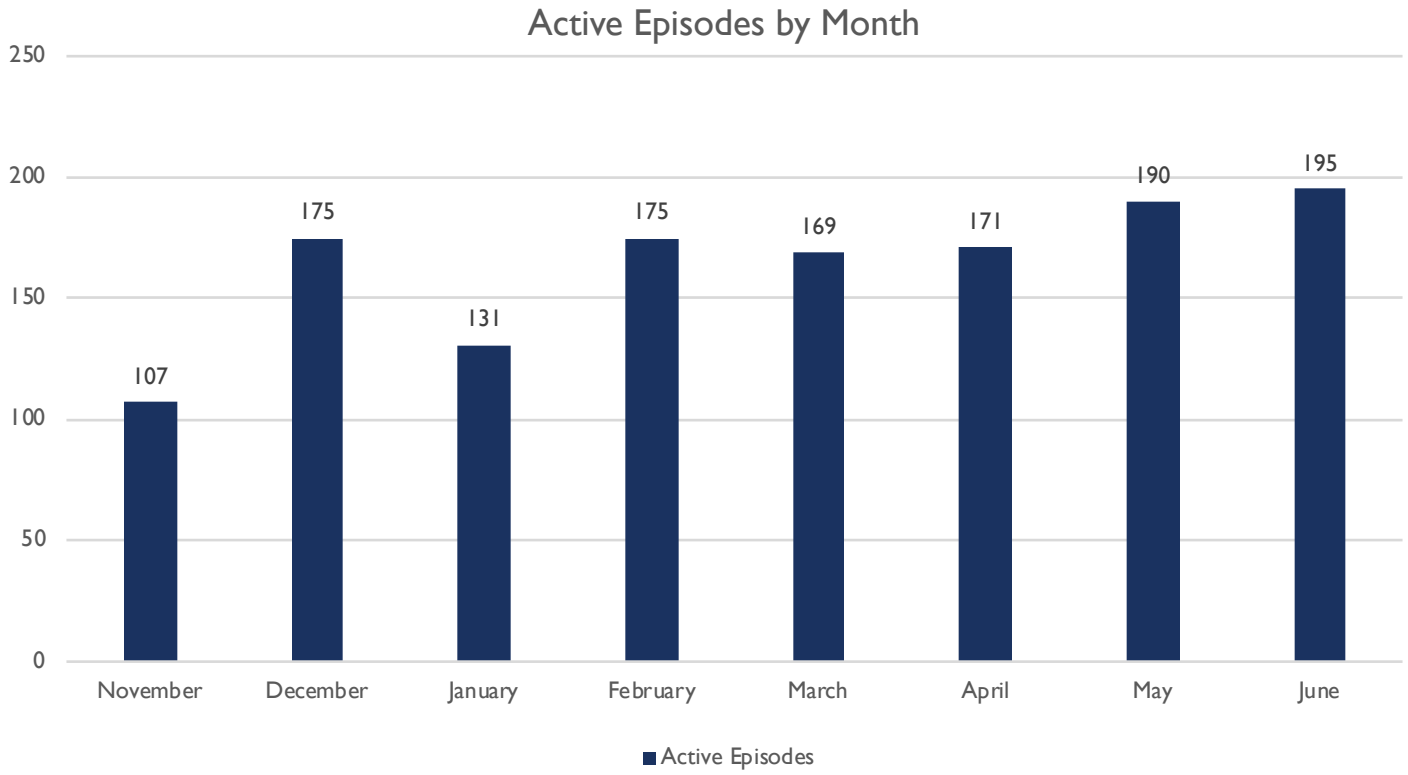
DESERT RIDGE FAMILY PHYSICIANS

COLLABORATIVE CARE IMPLEMENTATION

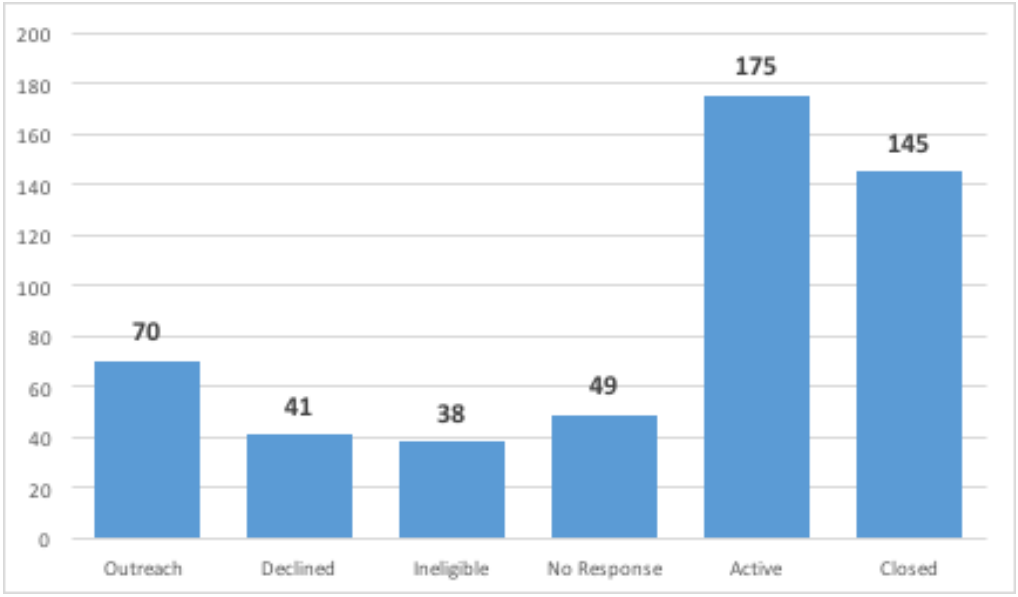
NOVEMBER 2019- JUNE 2020

DESERT RIDGE OVERALL COLLABORATIVE CARE ENROLLMENT

Desert Ridge has continued to build their patient caseload each month.



REFERRALS AND TREATMENT ENGAGEMENT



Outreach: patient is in process of being called up to 6 times post-referral

Declined: patient has been spoken to, but declined to participate

Ineligible: patient had existing behavioral health or insurance, thus unable to participate

No Response: patient was called at least 6 times post-referral, did not answer

Active: current open episode, patient has had at least one visit

Closed: episodes that had at least one visit while open, but are now closed

61.7% of referred patients that became an active episode (had at least one visit).

STANDARD GOAL OF COLLABORATIVE CARE: AVERAGE LENGTH OF ENGAGEMENT

Nationally, the average length of engagement in traditional outpatient mental health services is just under 4 visits/contacts per patient, or roughly one month's worth of care.[1]

Results for Desert Ridge:

- Across all opened episodes at Desert Ridge, there is an average of **16 contacts** per patient.
- The average episode length per patient was **73 days**, more than double the national average.

1. https://www.cdc.gov/nchs/data/databriefs/db311.pdf

STANDARD GOAL OF COLLABORATIVE CARE: 90 DAY IMPROVEMENT RATE

90 Day Improvement Rate: % of patients having a 50% or 10 point reduction in PHQ-9 or GAD-7 during first 90 days of treatment. The standard goal is for >50% of patients to achieve this.

The only state who actively tracks this is New York State, and their last report demonstrates 51% of patients achieving 90-day improvement rate.

Results for Desert Ridge:

- **November** 74% achieved 90-day improvement rate
- **December** 63% achieved 90-day improvement rate
- **January** 63% achieved 90-day improvement rate
- **February** 66% achieved 90-day improvement rate
- **March** 69% achieved 90-day improvement rate
- **April** 69% achieved 90-day improvement rate
- **May** 69% achieved 90-day improvement rate

CONCLUSIONS

Benefits of Collaborative Care, as seen at Desert Ridge:

- Desert Ridge has increased their patient population consistently since the start of the program.
- 61.7% of referred patients became an active episode (had at least one visit).
- Patients are engaged in care more than twice as long (73 days) in Collaborative Care compared to the national average (one month) of traditional outpatient visits.
- Identifies and flags patients at risk of suicide in primary care and completed safety plans with 17% of all active patients.
- Over 69% of Desert Ridge patients achieve their 90-day improvement rate, above the standard goal of 50%, and above NYS's rate of 51%.

STANDARD GOAL OF COLLABORATIVE CARE: PATIENTS AT RISK FOR SUICIDE

- **5 patients were flagged for Suicide Risk after screening, this is 3% of the patient population**
  - The current % of patients in the general population that are flagged for suicide is 2%.

Patients who are flagged for suicide risk get an average of two evidence-based treatments.

These evidence-based treatments include:

- Columbia-Suicide Severity Rating Scale (C-SSRS)
- Suicide Safety Plans
- Behavioral Activation
- Interpersonal Therapy (IPT)
- Cognitive Behavioral Therapy (CBT)
- Relapse Prevention
- Problem Solving Treatment (PST)
- Motivational Interviewing (MI)
- Behavioral Activation (BA)

FOR MORE INFORMATION:

For more information on the Collaborative Care Model, please visit https://concerthealth.io/

or email info@concerthealth.io

Concert Health helps physicians integrate screening, therapy, and psychiatric consultations into their practice and adopt Medicare's Collaborative Care Management Program.

PROVIDENCE ST. JOSEPH HEALTH: MENTAL HEALTH INSTITUTE – PRIMARY CARE INTEGRATION

Julie Fortune, LMFT
Director of Behavioral Health &
Primary Care Integration
julie.fortune@stjoe.org
(714) 937-7407

St. Joseph Health
St. Joseph Heritage Healthcare

COVID-19 RESPONSE

How did we pivot our current Primary Care Integration program to provide continued quality behavioral health care while keeping our staff safe and healthy?

A New Way of Serving

- We transitioned all embedded therapists into a remote work space and reviewed the opportunities that this created for better access to appointment times and the ability to serve additional sites.
- "We are here to serve all, especially those who are poor and vulnerable." To stay true to our mission statement, we opened our doors to all payers and patients.

A NEW WAY OF SERVING

We transitioned all embedded therapists into a remote work space and reviewed the opportunities that this created for better access to appointment times and the ability to serve additional sites.

- All therapists were issued ZOOM licenses and trained on its utilization by our telehealth department.
- Each therapist had to individually work with ITS to ensure that their at home work stations were in compliance and allowed for all work functions to be done remotely.
- We worked directly with our director of coding to ensure that work done via tele-behavioral health would qualify as part of the Collaborative Care Model and how to appropriately code and capture this time.
- We increased our lines of communication with the Primary Care practices to ensure that referrals continued although the therapists were not physically on site.
- We added a weekly Friday lunch check-in via ZOOM (cameras on) to make sure that we were supporting one another during this unique time.

A NEW WAY OF SERVING

"We are here to serve all, especially those who are poor and vulnerable." To stay true to our mission statement, we opened our doors to all payers and patients.

- Contracting:
  - Weekly calls to ensure that Collaborative Care CPT codes were included in our current commercial medical contracts
  - Create a financial grid with reimbursement rates for the Collaborative Care CPT codes for each of the health plans.
- Billing Cycle:
  - Create new workflows with our billing cycle partners to ensure that our Collaborative Care CPT codes are processed appropriately.
- Marketing:
  - Open Communication with our primary care practices in regards to updates to our program.
  - Attend provider meetings to educate them on the different financial responsibility for commercial payers and our ACO (full risk) patients.

Areas of Opportunity

- Contracting and billing workflow management
- Clinician Support
  - EAP/CAP services
  - Clinical connection
- Communication with practices
  - Referrals to Primary Care Integration
  - Engagement and Collaboration

Take action!

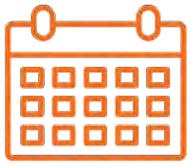
Payors/Risk-bearing groups paying on a FFS fee schedule:

- Find out if you are currently paying for the CoCM codes (99492, 99493, 99494, G0512 for FQHCs/RHCs)
- Ask on both the physical health and behavioral health sides
- Look at utilization and go talk to the groups who are using the codes – ask them what is working/not working and how you could help

Provider organizations

- Find out which of your payors are currently paying for the CoCM codes
- Ask others why they aren't paying for them
- AIMS Center has great resources to help think through feasibility – including an economic model with considerations for building out your team

Accelerating Integrated Care Series



- **Align Payment**
- Measure Impact
- Increase Screening
  - Depression
  - Adverse Childhood Experiences (ACEs)
  - Maternal Mental Health
- Expand Access
  - Tele-health Best Practices
  - Utilizing internal and external behavioral health specialists

Registration available soon!

Visit calquality.org/events for an update on dates and times.

Thank you!
Stay Connected to CQC

- Stay up to date with us at calquality.org

- If you have questions, want to register for our newsletter, or would like more information, email us at cqcinfo@calquality.org

- **Crystal Eubanks**
  Director, Care Redesign Strategy & Programs
  ceubanks@calquality.org