Integrating Physical and Behavioral Health: The View from Primary Care Providers and Payers

July 17, 2018

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Patient-Centered Primary Care COLLABORATIVE

Welcome & Announcements

•Welcome – Robert Dribbon, PCPCC Executive Member Liaison

•**PCPCC Annual Conference – Key Policies to Elevate Primary Care**
- Washington, DC, November 8, 2018
- Registration: www.pcpccevents.com

•**Members Only Workshop**: Investing in Primary Care – Advancing a National Strategy
- Immediately following the PCPCC annual conference, Executive Members are invited to an **exclusive workshop** on November 9, 2018
- **Registration**: www.pcpccevents.com

- Stay tuned for the release of **PCPCC's annual Evidence Report** on 8/8/2018

- Interested in PCPCC Executive Membership?
  - Email Allison Gross (agross@pcpcc.org) or visit: www.pcpcc.org/executive-membership

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Panelists

Moderator: Robert Dribbon

PCPCC Executive Member Liaison
Merck

Bruce Landon, MD

Professor of Health Care Policy
Harvard Medical School

James Schuster, MD, MBA

Chief Medical Officer of Medicaid, SNP, and Behavioral Services
VP, Behavioral Integration
UPMC Insurance Services Division

Russell Phillips, MD

Director
Harvard Medical School Center for Primary Care

Reactor: James Kingsland

President
National Association Primary Care

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Strategies for Behavioral Integration into Primary Care: Implications from a Microsimulation Model

Bruce Landon, M.D., M.B.A.
Department of Health Care Policy, Harvard Medical School
Division of General Medicine and Primary Care, BIDMC

Russel Phillips, M.D.
Director, Center for Primary Care, Harvard Medical School
Division of General Medicine and Primary Care, BIDMC

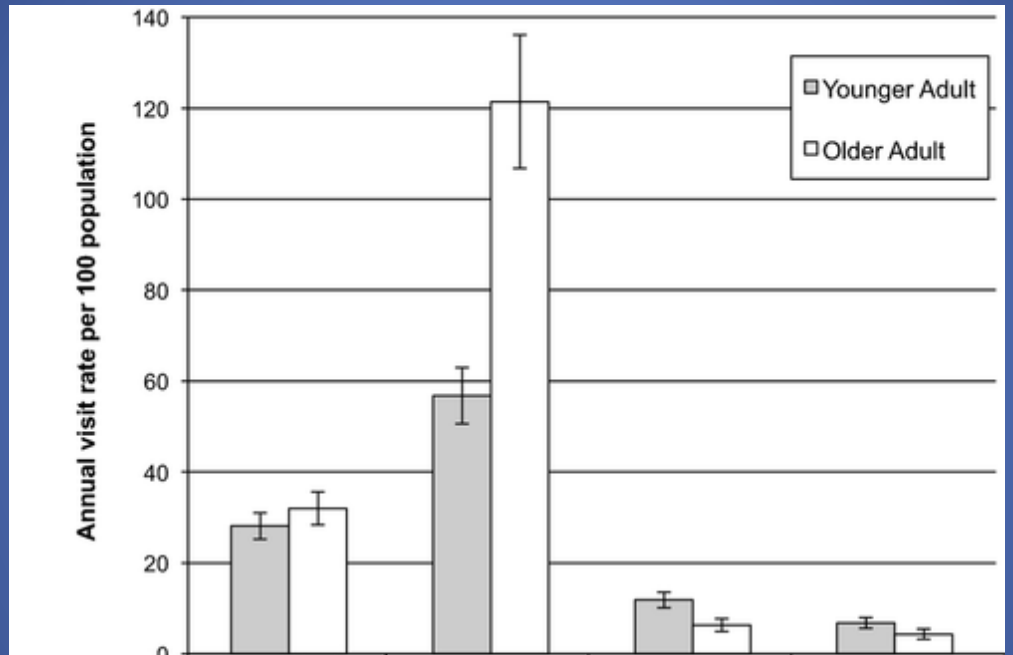
PCPCC Webinar on Behavioral Health Integration
July 17, 2018

Mental Health Problems are Common

	Total	Mod/Severe
Anxiety	18.1	56.5
Mood	9.5	85
Impulse Control	8.9	85.3
SUD	3.8	66.6
Any	26.2	59.6

Source: Kessler RC et al. Prevalence, Severity, and Comorbidity of 12 Month DXM-IV Disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry.* 2005;62(6):617-627. doi:10.1001/archpsyc.62.6.617

And Most Mental Health Care Occurs within Primary Care



	Mental Health Diagnosis	Psychotropic	Psychiatrist	Psychotherapy
Younger Adult, visit rate (95% CI)	28.12 (25.23-31.01)	56.77 (50.61-62.93)	11.82 (10.14-13.51)	6.78 (5.64-7.91)
Older Adult	32.01 (28.36-35.66)	121.40 (106.71-136.09)	6.32 (4.91-7.73)	4.34 (3.23-5.45)

Mental Health Care Delivered to Younger and Older Adults by Office-Based Physicians Nationally, Volume: 63, Issue: 7, Pages: 1364-1372, First published: 03 July 2015, DOI: (10.1111/jgs.13494)

MH Care in Primary Care

- Lack of reimbursement for screening and prevention
- Lack of (until recently) reimbursement for collaborative care and case management
- Inability to bill solely for mental health services (many Medicaid programs)
- Limitations in the ability to bill for physical and mental health services in the same visit (e.g., time based and non-time based billing)
- Lack of training and comfort level

https://www.integration.samhsa.gov/Reimbursement_of_Mental_Health_Services_in_Primary_Care_Settings.pdf

Yet, Collaborative Care Improves both Mental Health and Physical Health

	Collaborative Care	Usual Care
Global Improvement	45	18
>1% ↓n A1C	36	19
>10 point ↓n SBP	10	25
>50% ↓n SCL score	60	30
Satisfaction with Depression care	90	55
Satisfaction with chronic care	86	70
Quality of life	6.0	5.2

Katon WJ et al. Collaborative Care for Patients with Depression and Chronic Illness. N Engl J Med 2010; 363:2611-2620

Using Simulation Modeling to Inform Policy

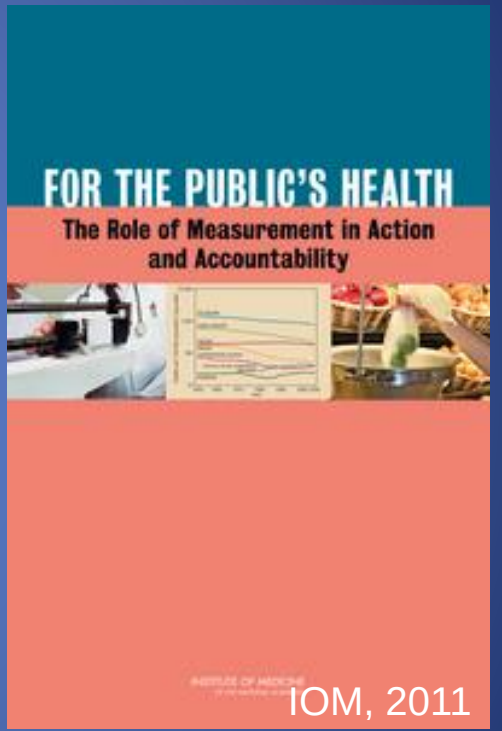
- Practices and policy-makers lack tools to estimate impacts of new practice and payment models on practice finances and outcomes
- Current practice structures are not optimized to deliver high value care

Key Assumption

- It is not rational to expect primary care practices to implement changes that adversely impact their costs or revenues

Why model?

- Used extensively in other fields to model investment and financial decisions
- A “safe space” to write down all possible assumptions and scenarios before piloting
- A technique to determine which decisions have low-uncertainty and which have high-uncertainty (identify future research needs)
- Broaden generalizability beyond single pilot projects



IOM, 2011

Our Approach

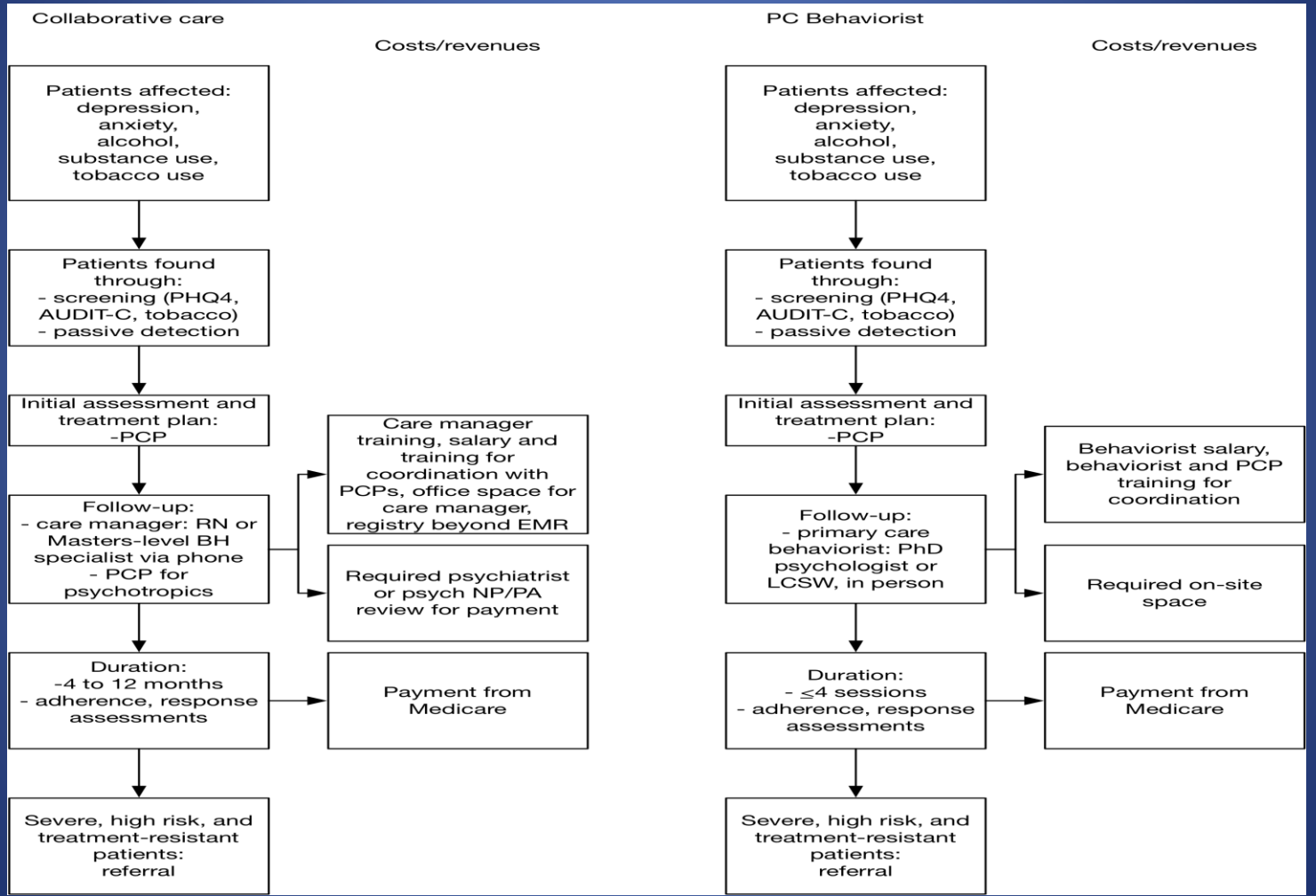
- A microsimulation
  - What it is
    - A simulation of individuals in a population
  - Advantages:
    - Simulates individual patients with complex histories and co-morbidities
    - Simulates individual clinics with complex panels, staff, costs, and revenues
    - “High data, low assumption” modeling
    - Can capture complex non-linear relationships and feedback loops
    - Very flexible: can add queues, vary clinic types, and change fundamental structures in the model
  - Disadvantages:
    - Lots of computer power needed
    - Lots of data needed

New Medicare Payment Approach: Collaborative Care Model

- Involves care plan development often including pharmacotherapy from the PCP, RN/master-level behaviorist follow-up care by phone
- Requires periodic psychiatrist or psychiatric NP/PA review for Medicare payment
- Three new Medicare Part B CoCM Codes
  - G0502 – Initial 30 min behaviorist session w/ 70 min/month overall care management/staff effort
  - G0503 – Each 26-min behaviorist follow-up w/ 60 min/month of care management
  - G0504 – Each additional 13-min of provider visit time w/ 30 min/month of care management

New Medicare Payment Approach: Primary Care Behaviorist Model

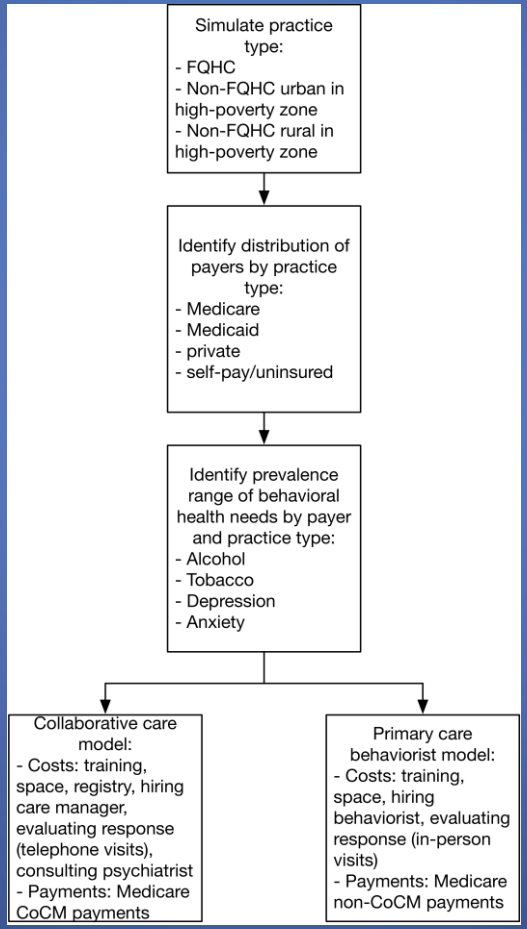
- PCBM involves in-person care by primary care behaviorist (PhD psychologist or LCSW) in brief, time-limited behavioral treatments
- PCBM can be paid via traditional billing mechanisms for psychologist/LCSW visits
- Also can be paid under new Part B behavioral health services codes
  - G0507 – 15 min of behaviorist provider time w/ at least 20 min/month care manager time
  - G0507 provides higher payments per period as compared to traditional codes for routine psychotherapy, psychological testing, and health and behavioral assessment


Collaborative care
Costs/revenues
Patients affected: depression, anxiety, alcohol, substance use, tobacco use
Patients found through: - screening (PHQ4, AUDIT-C, tobacco) - passive detection
Initial assessment and treatment plan: -PCP
Follow-up: - care manager: RN or Masters-level BH specialist via phone - PCP for psychotropics
Care manager training, salary and training for coordination with PCPs, office space for care manager, registry beyond EMR
Required psychiatrist or psych NP/PA review for payment
Duration: -4 to 12 months - adherence, response assessments
Payment from Medicare
Severe, high risk, and treatment-resistant patients: referral
PC Behaviorist
Costs/revenues
Patients affected: depression, anxiety, alcohol, substance use, tobacco use
Patients found through: - screening (PHQ4, AUDIT-C, tobacco) - passive detection
Initial assessment and treatment plan: -PCP
Follow-up: - primary care behaviorist: PhD psychologist or LCSW, in person
Behaviorist salary, behaviorist and PCP training for coordination
Required on-site space
Duration: - ≤4 sessions - adherence, response assessments
Payment from Medicare
Severe, high risk, and treatment-resistant patients: referral

Medicare Payment Rates

- CoCM
  - $140 for 70 min/patient for 1st month, $125 for 60 min/patient for subsequent months
- PCBM
  - G0507: $48 for at least 20 min/patient/month

Modeling Approach



Results: FQHC (Serving Medicare Patients Only)

Model	Time for care manager/behaviorist (hours/yrs)	Cost, annual after year 1, per MD FTE	Net revenue, subsequent years, per MD FTE
CoCM	1205.6	$16,823.10	$33,756.60
PCBM	1810.5	$21,467.30	-($3,744.50)

Results: Urban or Rural, Lower-Poverty Zone (Serving Medicare Patients Only)

Model	Time for care manager/behaviorist (hours/yrs)	Cost, annual after year 1, per MD FTE	Net revenue, subsequent years, per MD FTE
CoCM	1496.0	$19,171.10	$27,009.60
PCBM	1734.9	$20,729.00	-($3,646.30)

Take Home Points

- MH problems are extremely common and most MH care occurs within primary care
- Traditional reimbursement models are poorly supportive of models that integrate PC and MH
- New Medicare billing codes (particularly COCM) might be an attractive method for improving MH care in primary care settings

Thank You

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  - Harvard Medical School, Center for Primary Care
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HARVARD MEDICAL SCHOOL | Department of Health Care Policy

Stanford | CHP/PCOR Center for Health Policy/Center for Primary Care and Outcomes Research

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Behavioral Health Home Plus and Optimal Health

James Schuster, MD, MBA
2018

UPMC HEALTH PLAN

AGENDA

Overview of UPMC

The Behavioral Health Home Plus (BHHP) Model

Implementation Strategies

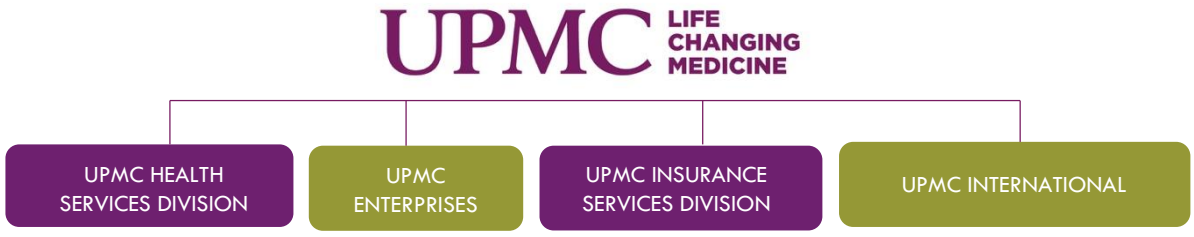
Program Outcomes

Expansion of the Behavioral Health Home Model

Confidential information of UPMC and UPMC Health Plan. Any unauthorized or improper disclosure, copying, distribution, or use of the contents of this presentation is prohibited. The information contained in this presentation is intended only for the personal and confidential use of the recipient(s) to which the information has been distributed. If you have received this information in error, please notify the sender immediately and destroy the original information.

Integrated Delivery and Finance System

Integrated system with a world-class academic medical center, and affiliated with the University of Pittsburgh



About UPMC

- More than 140 hospitals (including 38 UPMC-owned hospitals) and 24,000 providers
- UPMC's community contributions were $912 million and represented more than 15 percent of net patient revenue
- More than 600 doctors' offices and outpatient sites and 60 UPMC Hillman Cancer Center locations
- Region's largest network of rehabilitation services
- More than 4.7 million outpatient visits
- 41 percent medical-surgical market share in western Pennsylvania

About UPMC Insurance Services Division

- More than 3.4 million members in CY 2017
- CY 2017 operating revenue was $7.5 billion (an increase of 11.2 percent)
- Financial strength rating of A- (excellent) from A.M. Best
- Almost 12,000 employer groups
- 35 percent market share in western Pennsylvania
- The largest behavioral health insurance provider in the nation
- A full product portfolio: HMO, PPO, EPO, HSA, dental, vision, COBRA, workers' compensation, absence management, EAP, and more
- More than 97 percent of hospitals and other facilities, as well as more than 98 percent of physicians in western Pennsylvania
- More than 60,000 network pharmacies nationwide

Data verified as of July 1, 2018

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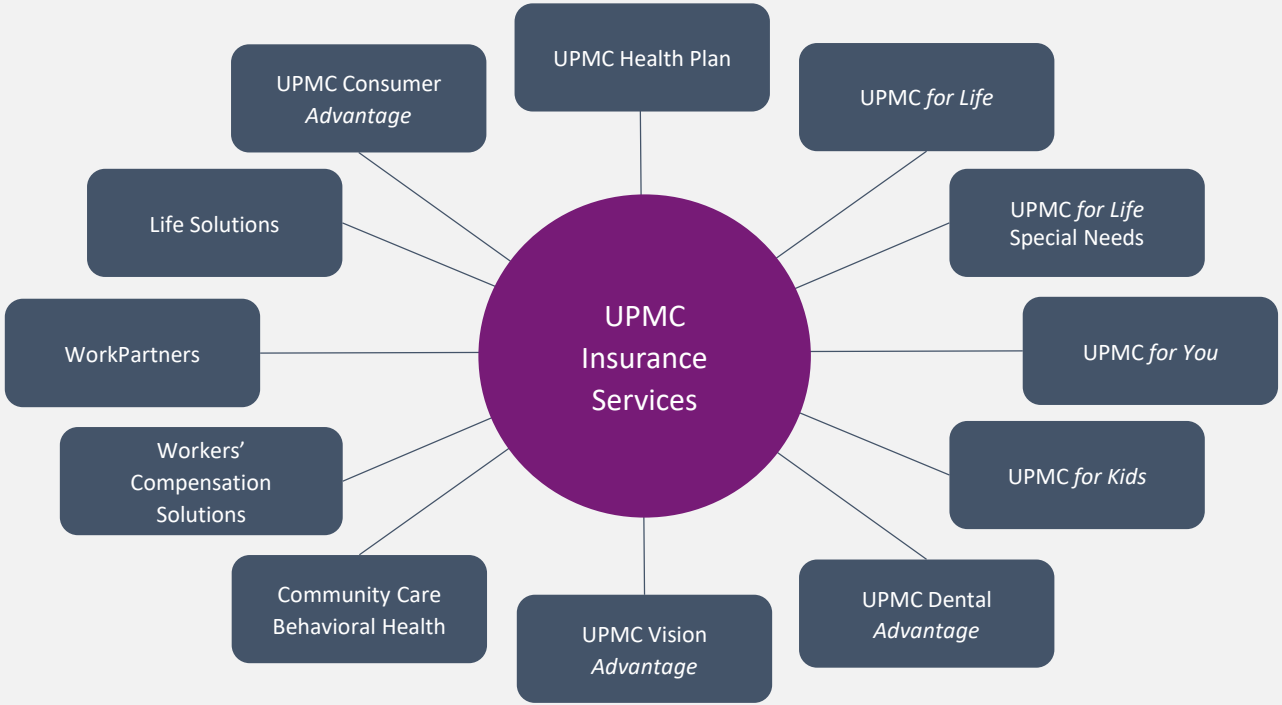
Innovation Drives Company Growth

Large network anchored by UPMC



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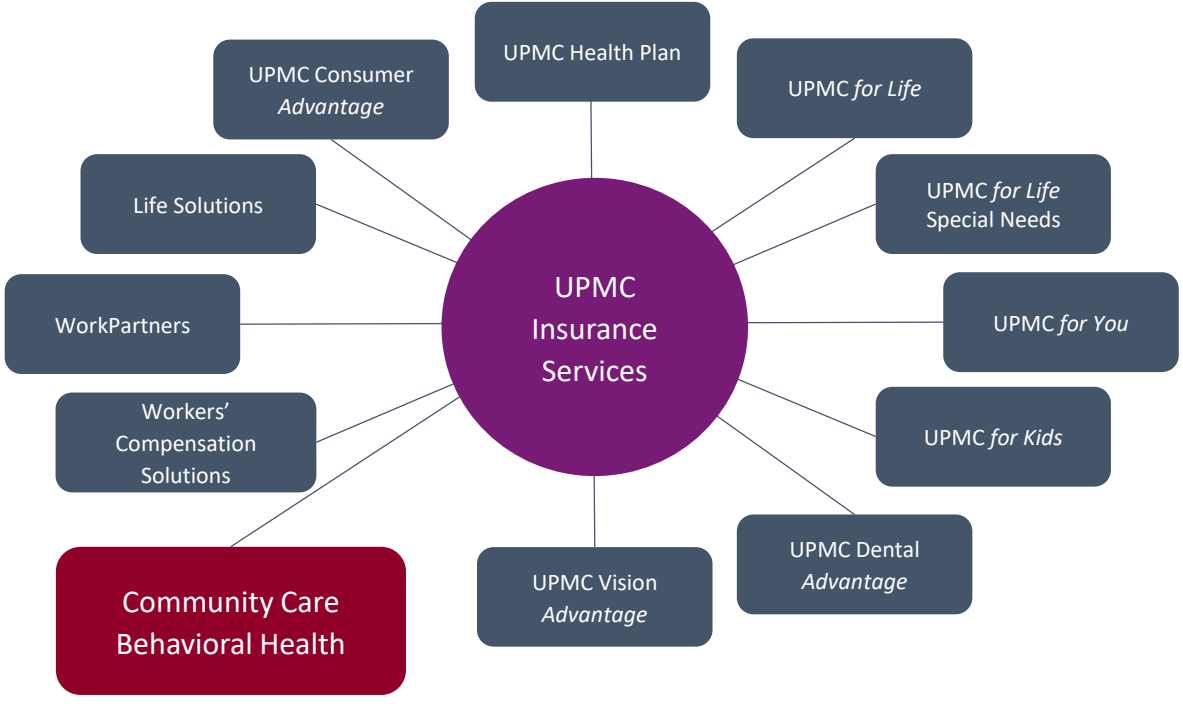
About Community Care

- Incorporated in 1996 primarily to support Pennsylvania
- Part of the UPMC Insurance Services Division
- 501(c)(3) nonprofit behavioral health managed care organization
- Licensed as HMO



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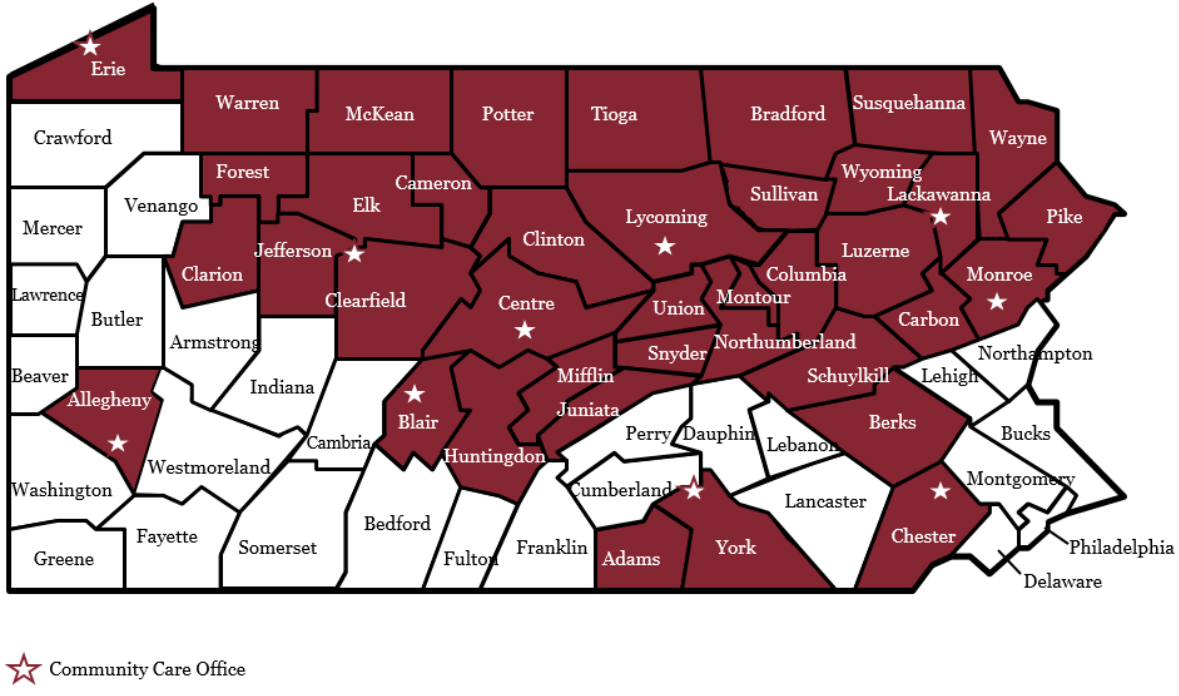
Community Care Behavioral Health Organization



☆ Community Care Office

- 39 of 67 counties in 11 contracts
  - Only BHMCO in all PA HealthChoices regions
  - Four reprocurements from competitors
- Experience with full-risk, shared-risk, and Administrative Services Only (ASO) contracts

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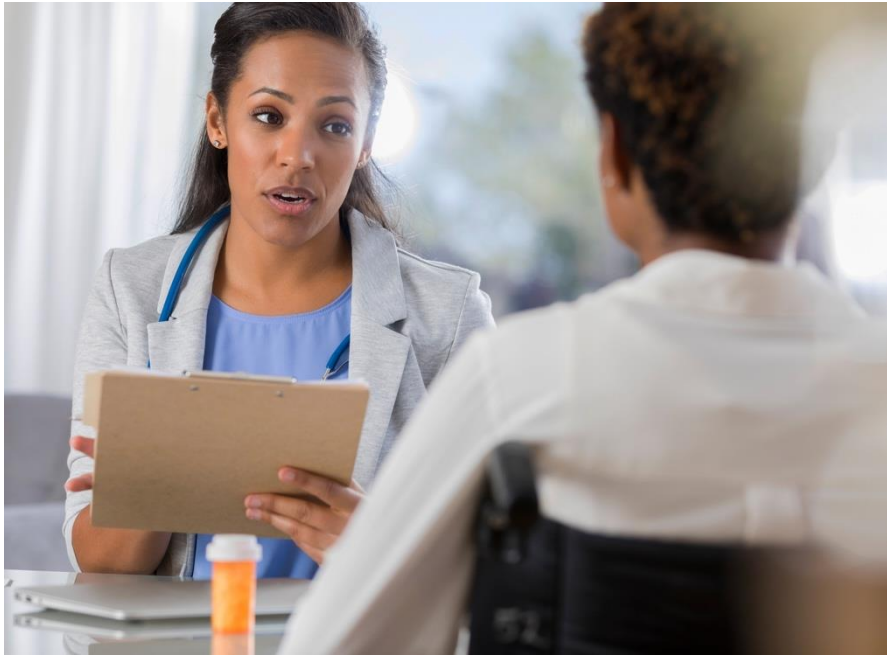
What is a Behavioral Health Home?

A behavioral health home (BHH) is a service delivery model that provides a cost-effective, longitudinal "home base."

The BHH facilitates and coordinates access to behavioral health care, medical care, and community-based social services and supports for people with complex medical, behavioral health, and substance use disorders.



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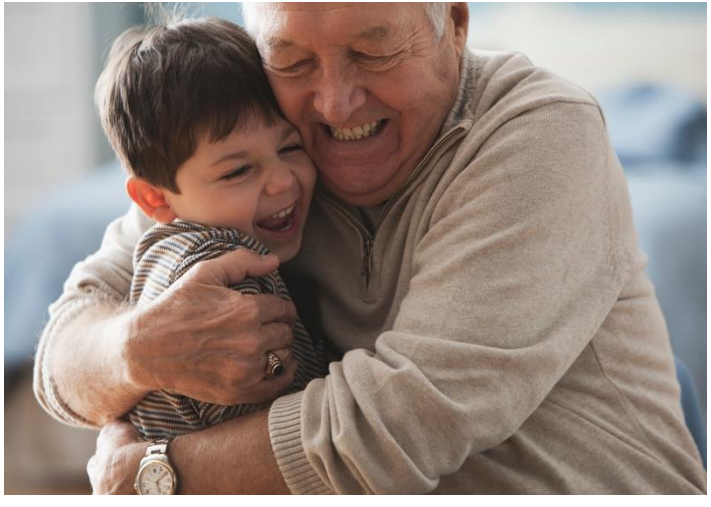
What is a Behavioral Health Home?

The BHH is anchored in wellness guided by the triple aim:
improving individual experience of care, improving population health,
and reducing per capita health care costs



“Wellness is not the absence of disease, illness and stress, but the presence of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body and living environment, and the presence of happiness.”

— Peggy Swarbrick, PhD

Key Behavioral Health Home Components

- **Comprehensive care management**
- **Care coordination and health promotion**
- **Comprehensive transitional care**
- **Enhanced engagement in primary care and other physical health systems of care**
- **Individual and family support**
- **Community and social support services**
- **The use of health information technology to enhance population management**

Community Care's Behavioral Health Home Plus

Successful early collaboration with Community Care and behavioral health providers in North Central region of Pennsylvania to address wellness through BHH model in 2010

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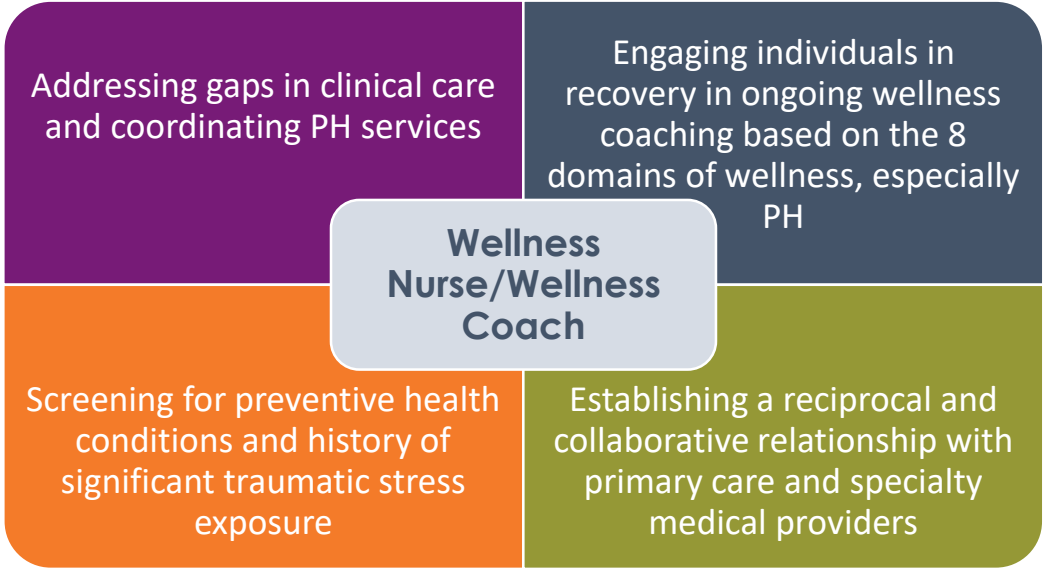
Behavioral Health Home Plus

BHHP enhances the traditional Behavioral Health Home model by:

- Adding a wellness nurse to the existing team
- Using wellness coaching to address self-management of modifiable lifestyle factors
- Developing a health registry to track health needs and improvements
- Improving health literacy and health navigation

Behavioral Health Home Plus

Key components



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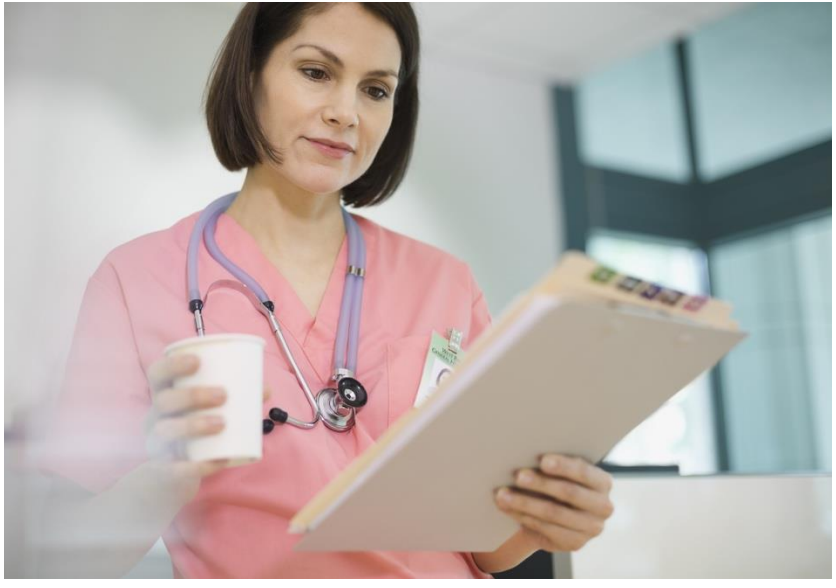
Wellness Nurse

- Coordinates the BHHP team intervention including the “virtual team” of community-based medical and social service providers
- Serves as a medical consultant to non-medical team members and wellness coaches
- Guides the team in identifying and addressing gaps in clinical care and coordinating care
- Develops a health resource library for the team

Wellness Nurse



- “Manages” the monthly registry of population-focused data that identifies and stratifies individuals who have high-risk behavioral and medical indicators
- Reaches out to the highest risk individuals on the registry to discuss doing a physical health assessment which helps to raise the individual's awareness of need

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BHHP Outcomes: Optimal Health

- *Optimizing Behavioral Health Homes by Focusing on Outcomes that Matter Most for Adults with Serious Mental Illness* (Optimal Health) Study
- A multi-stakeholder collaboration to study the key components of the BHHP model
- Contract awardee:
  - UPMC Center for High-Value Health Care

- **Main partners include:**
  - Community Care
  - University of Pittsburgh
  - Stakeholder Advisory Board
  - BHARP, NC and Chester Counties and Providers
- **Principal investigators:**
  - James Schuster, MD, MBA, Community Care
  - Charles (Chip) Reynolds III, MD, University of Pittsburgh
  - Tracy Carney, CPRP, CSP, Community Care
- **Supported by the Patient-Centered Outcomes Research Institute (PCORI)**

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CER to Examine BHH Models' Impact

Patient Self Directed

- Wellness coaches
- Member registry
- Self management toolkits

Provider Supported

- Wellness coaches
- Member registry
- Nurse focused on wellness and health

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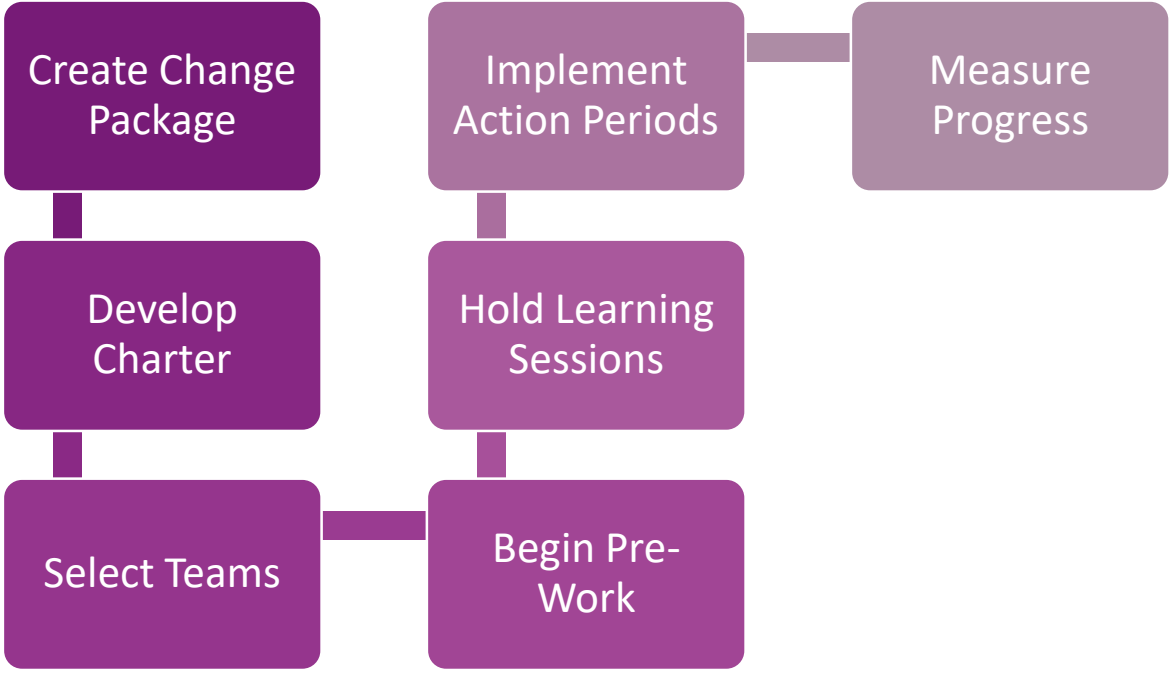
Learning Collaborative Process



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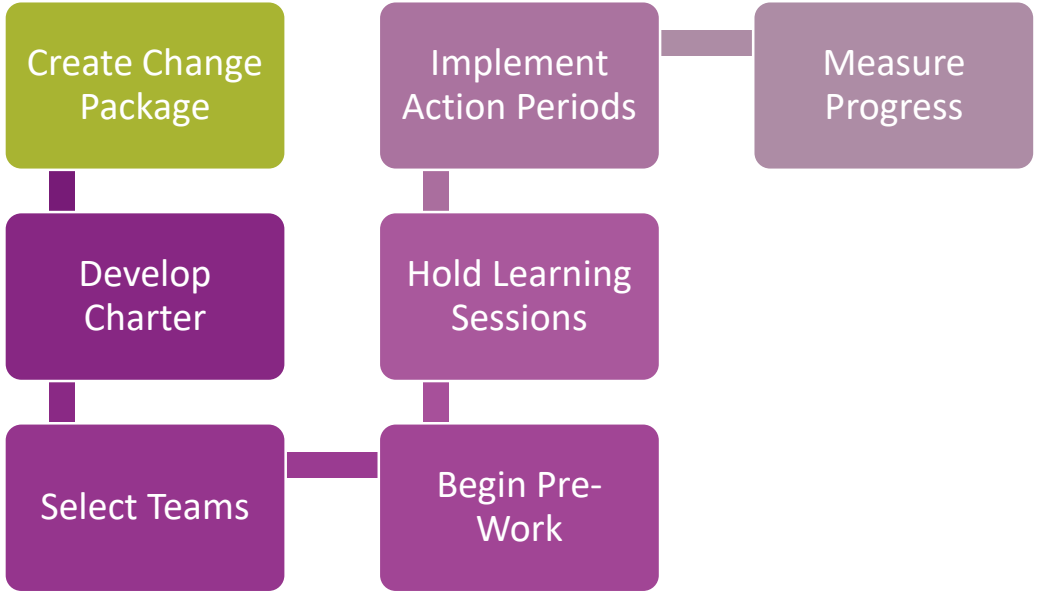
Create Change Package



Topic and content; model and practices and the details of the approach

- Implementation of Behavioral Health Home

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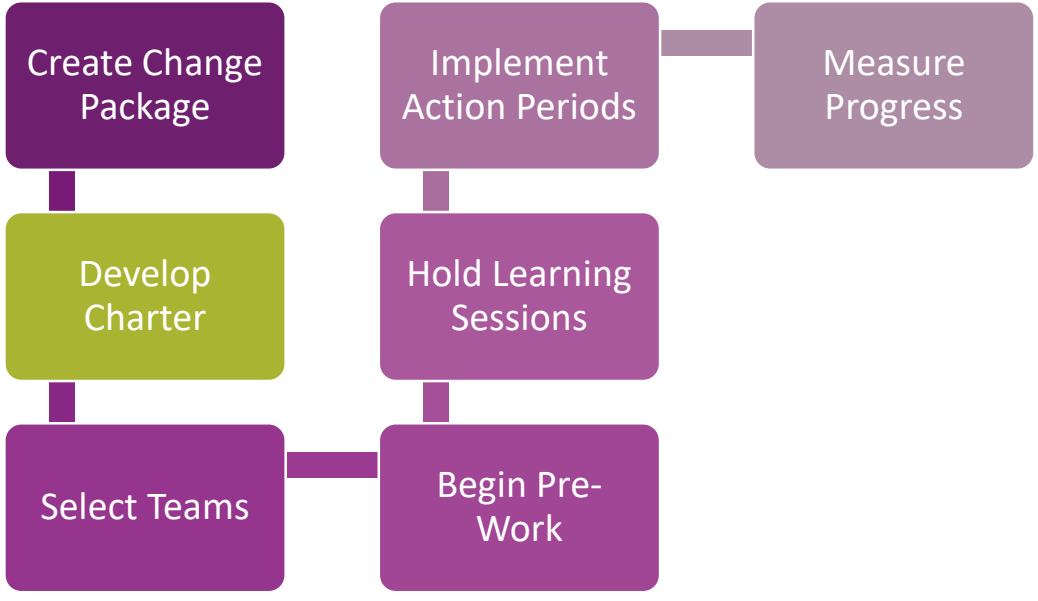
Develop Charter



Mission
- Primary focus of the collaborative
- To facilitate and support implementation of the PHM strategy

Aims
- Written statements of expected accomplishments

Expectations
- Commitments to meet during LC

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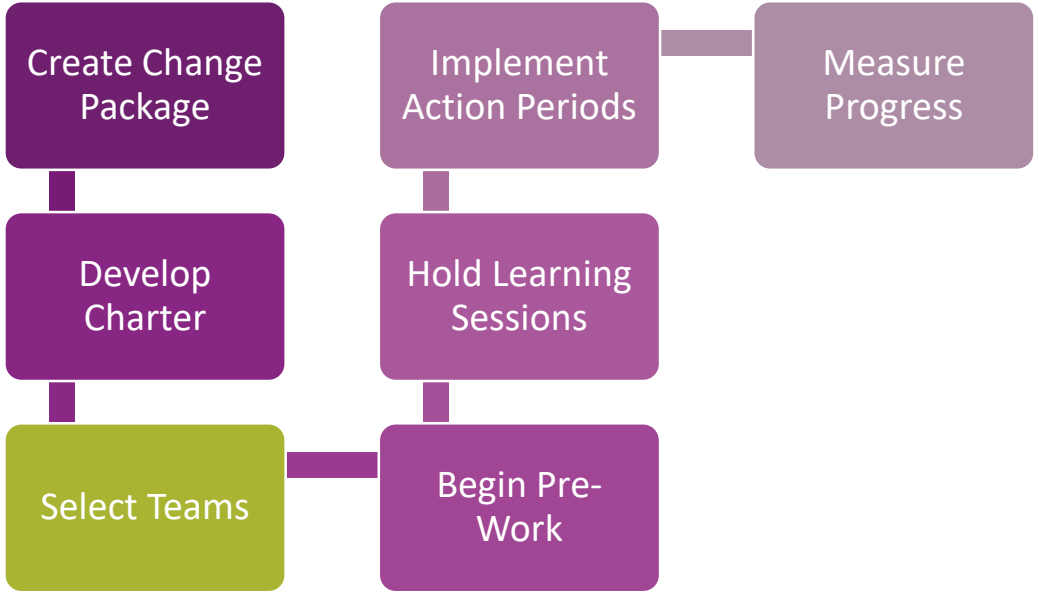
Select Teams



Strategy Leadership and Faculty

- Strategy and operations design
- Provide expert facilitators as resources to the quality improvement teams
- Guide the work through monthly webinar-style coaching calls
- Provide technical assistance to care teams
- Establish aims against which to measure the impact of quality improvements efforts, track progress toward the stated aims, and provide aggregate and individual team feedback
- Evaluate the overall impact of the quality improvement effort both at the organizational level, and at the aggregate level of the entire collaborative

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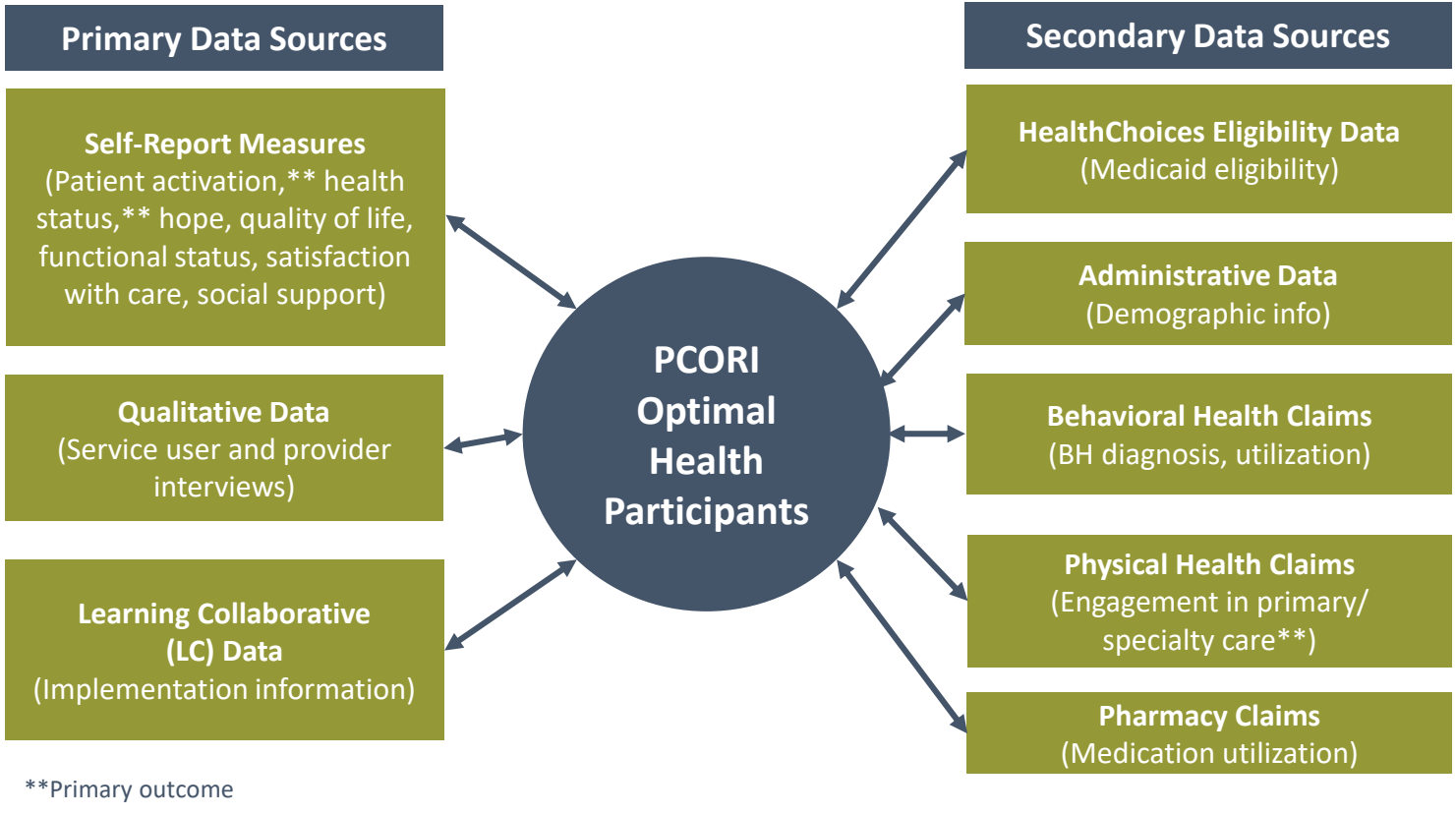
Study Methods and Design

- **Cluster-randomized design with mixed methods approach**
- **Models implemented in 11 community mental health centers (CMHCs) over two years starting in 2013**

- **Research participant inclusion criteria:**
  - Medicaid-enrolled
  - 21+ years of age
  - Diagnosed with a serious mental illness
  - Receives services at community mental health center within Community Care's network
- **Institute for Healthcare Improvement's Learning Collaborative Model used to support implementation**
  - Institute for Healthcare Improvement Breakthrough Series: http://www.ihi.org

Patient-Centered Outcomes and Data



**Primary outcome

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Primary Outcomes Findings

Patient Activation

- More rapid increase in provider-supported sites (with wellness nurse) than self-directed sites
- Greater increase in activation for women in provider-supported; greater increase for men in self-directed

Engagement in Primary/Specialty Care

- 36% increase in frequency of visits in both study arms

Health Status

- Small improvement in perceived mental health status
- Small decline in perceived physical health status

Qualitative Findings: Patient View

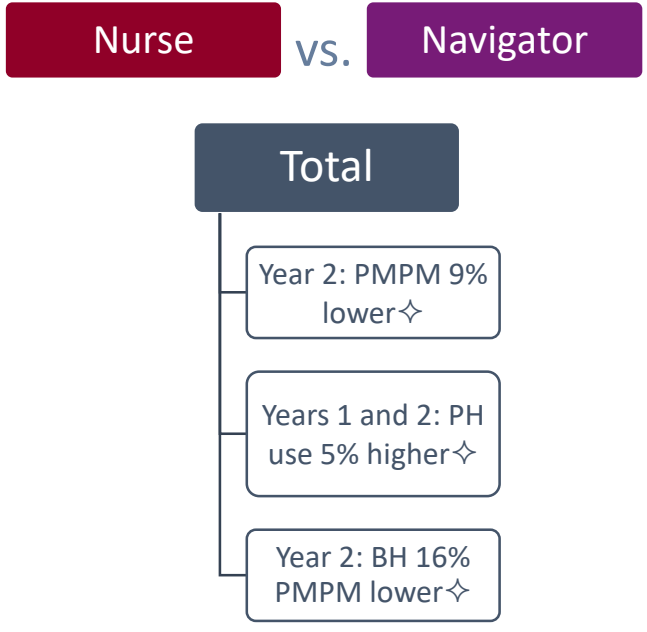
- Shift in definition of health and wellness, away from vague to more personalized
- Increased awareness of interconnectedness of mental and physical health
- Overall favorable intervention experiences
- No major distinctions between arms – no evident differences in engagement in or satisfaction with interventions
- Most important factor leading to intervention participation was relationship with wellness coach

Qualitative Findings: Provider View

- High degree of agency support for wellness coaching
- Culture of wellness that benefitted both service users and providers
- Models integrated into routine practice
- Providers simplified/casualized wellness coaching to increase service user engagement
- Nurses often mentioned as most beneficial component of the model
- Robustly positive impact on service users' health/wellness
- Acute needs sometimes trumped wellness coaching
- Results published at https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1115

Trial Data Only: Outcomes

- Total spending lower with nurse practices in longer term
- Nurse practices engaging patients more with PH services while decreasing PH IP
- BH service use lower with nurse practices, including IP, psychotropics and TCM



✦ Statistically significant (<0.05)
✧ Suggestive; not quite statistically significant (<0.2)

*Controlled for baseline demographics and PMPM

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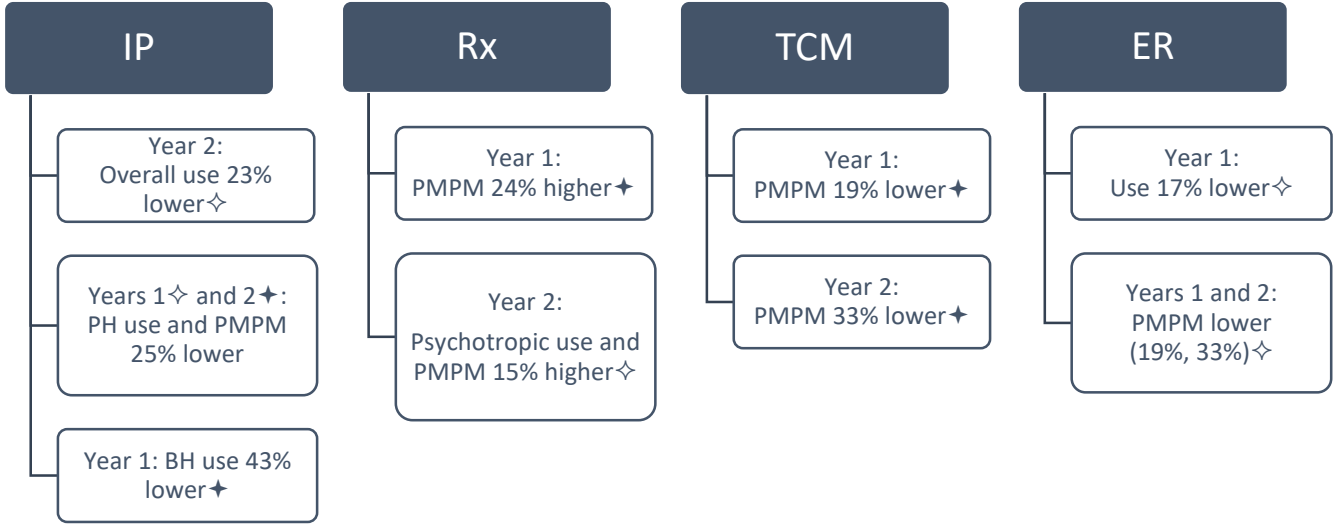
Trial Data Only: Outcomes

Nurse vs. **Navigator**

✦ Statistically significant (<0.05)
✧ Suggestive; not quite statistically significant (<0.2)

*Controlled for baseline demographics and PMPM



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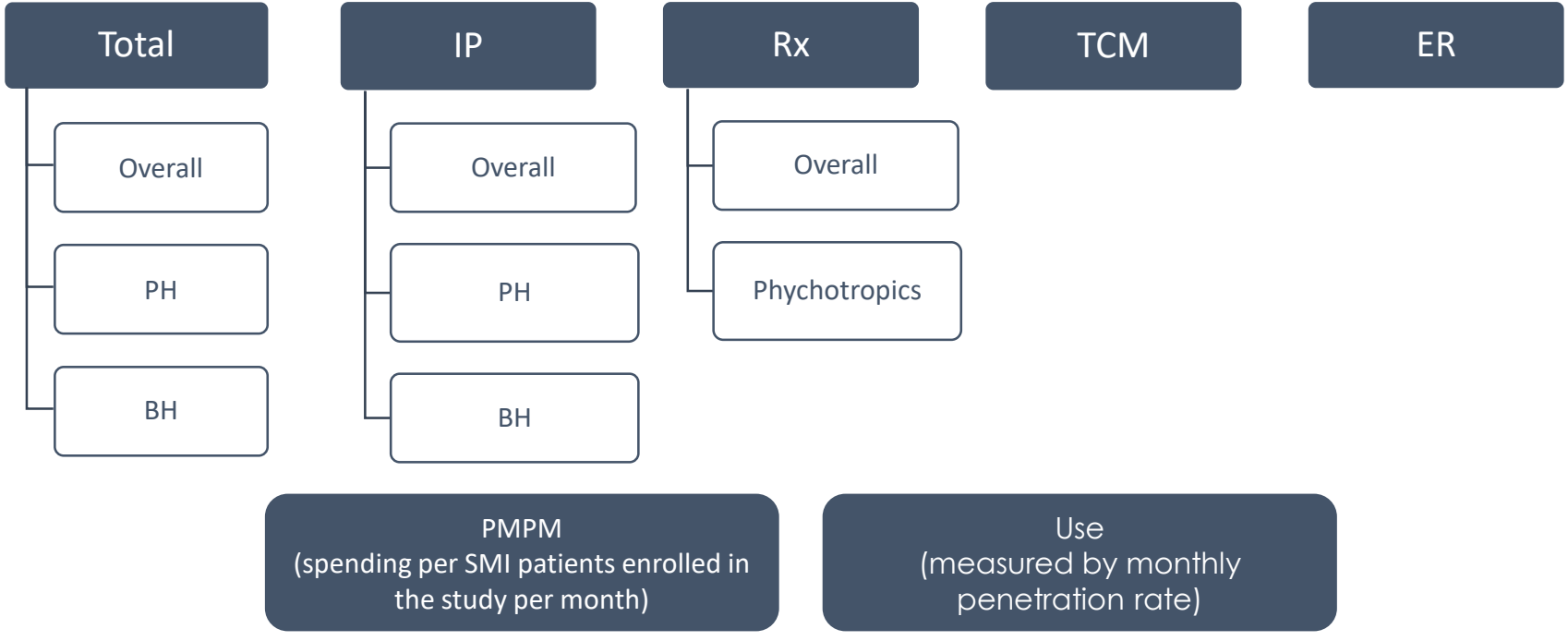
Subsequent Financial Evaluation*

Comparison of utilization and spending



*These analyses were conducted independent of PCORI-funded contract

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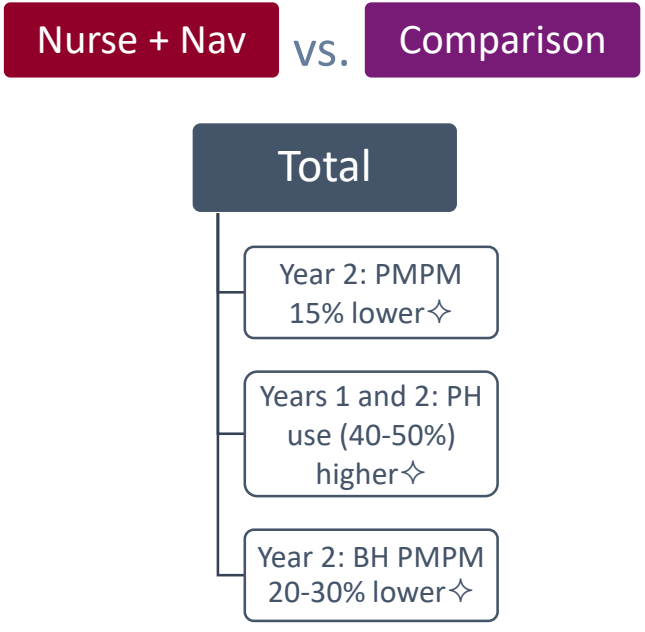
Post-Trial Comparison Group: Outcomes

- Nurse sites have lower long-term spending driven largely by decreases in behavioral health
- Nurse sites have increased PH use but similar PH cost and less PH IP use
- Nurse sites have less prescription use but higher prescription costs
- Nurse sites have long-term decreases in TCM costs



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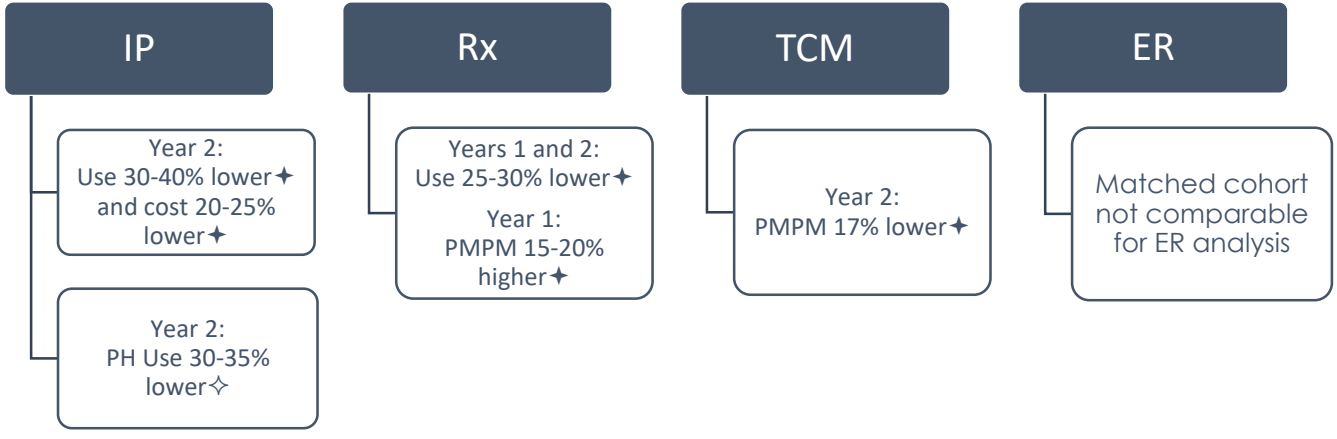
Trial Data Only: Outcomes

Nurse vs. Comparison

✦ Statistically significant (<0.05)
✧ Suggestive; not quite statistically significant (<0.2)



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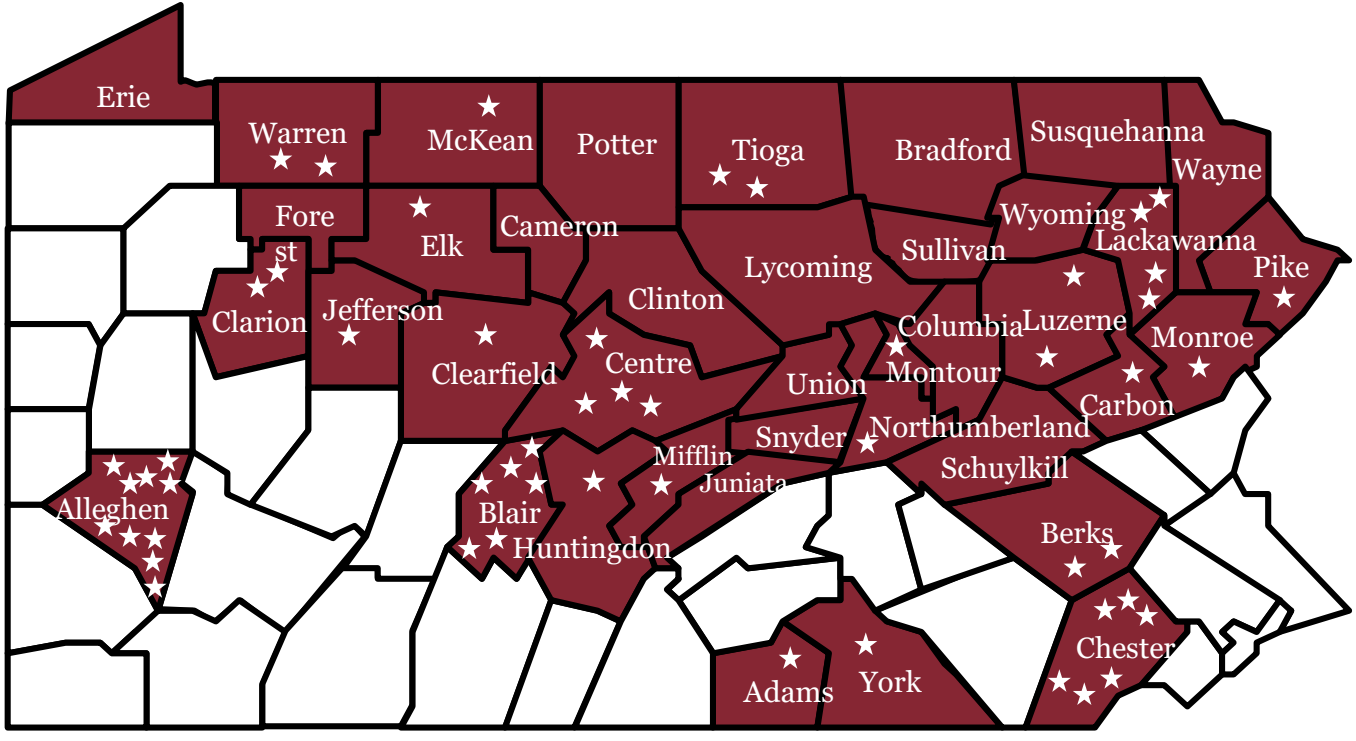
UPMC HEALTH PLAN

BHHP Model Expansion



Additional populations served: adolescents, opioid treatment programs

Population Health LC for mature providers focused on hypertension and smoking cessation

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PCORI Dissemination Award

Contract Awardee

UPMC Center for High-Value Health Care in collaboration with Community Care

Purpose

Disseminate findings from our recently completed PCORI-funded study to improve the overall health and wellness of other priority and high-risk populations

- Residential Treatment Facilities (n=5)
- Opioid Treatment Programs (n=7)

Contract Duration

Two years (March 1, 2018 – February 2020)

Principal Investigator

James Schuster, MD, MBA

- Co-Investigators: Tracy Carney, CPRP, CSP; David Dan, MSW, LCSW; David Loveland, PhD, MA

Goals

Goal 1

Build provider capacity for the consistent and sustained delivery of BHHP

- Implement and assess the feasibility of using a Learning Collaborative approach to support RTF and OTP teams to deliver BHHP
- Assess barriers and facilitators to Learning Collaborative participation and success

Goal 2

Increase service user involvement and confidence in managing their physical health and wellness

Goal 3

Examine change/trends over time with BHHP implementation on engagement in primary/specialty care and unplanned health care utilization

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Methods and Outcomes

Use a Learning Collaborative

- Model adoption
- Sustained implementation
- Fidelity to the model
- Culture of wellness
- Improved staff knowledge/skills/attitudes related to wellness concepts

Gather Qualitative Data

Interviews (n= 20) with providers at the completion of the Learning Collaborative

Use Data to Explore the Impacts and Outcomes

- Engagement with primary/specialty care
- Utilization of unplanned care (emergency department)

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CONTACT INFORMATION

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Thank You

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Questions?

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Patient-Centered Primary Care COLLABORATIVE