Welcome!

Reducing Emergency Department among the Mental Illness Population Learning Series-

Behavioral & Physical Health Integration: Lessons from the Field-
Virtual Learning Collaborative

The session will start shortly!

Best Practices:

- Please keep your mic muted if you are not talking
- Please rename your connection in Zoom with your full name and organization
- We want these sessions to be interactive! Please participate in the polls, ask your questions and provide your input

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Introduction

Learning Series Goal: to share evidence-based and promising practices and case examples for CCO employees and contracted providers to improve their practices to support the mental illness population

Learning Series Opportunities

1. Systems Improvement- What CCOs Can Do
2. **Behavioral and Physical Health Integration- Lessons from the Field**
3. Whole Health Webinar Series

This program is supported by the
Oregon Health Authority Transformation Center

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Participation Best Practices

- Please type your questions and comments into the chat box
- Please stay on mute unless you intentionally want to ask a question or make a comment
- Please rename your connection in Zoom with your full name and organization you work for
- All sessions will be recorded and shared on the OHA website
- The roster will be distributed after this session; please let Maggie McLain McDonnell know if you do not want your name shared on the roster: mclainma@ohsu.edu
- **Please actively participate in the sessions! We want to hear from you**

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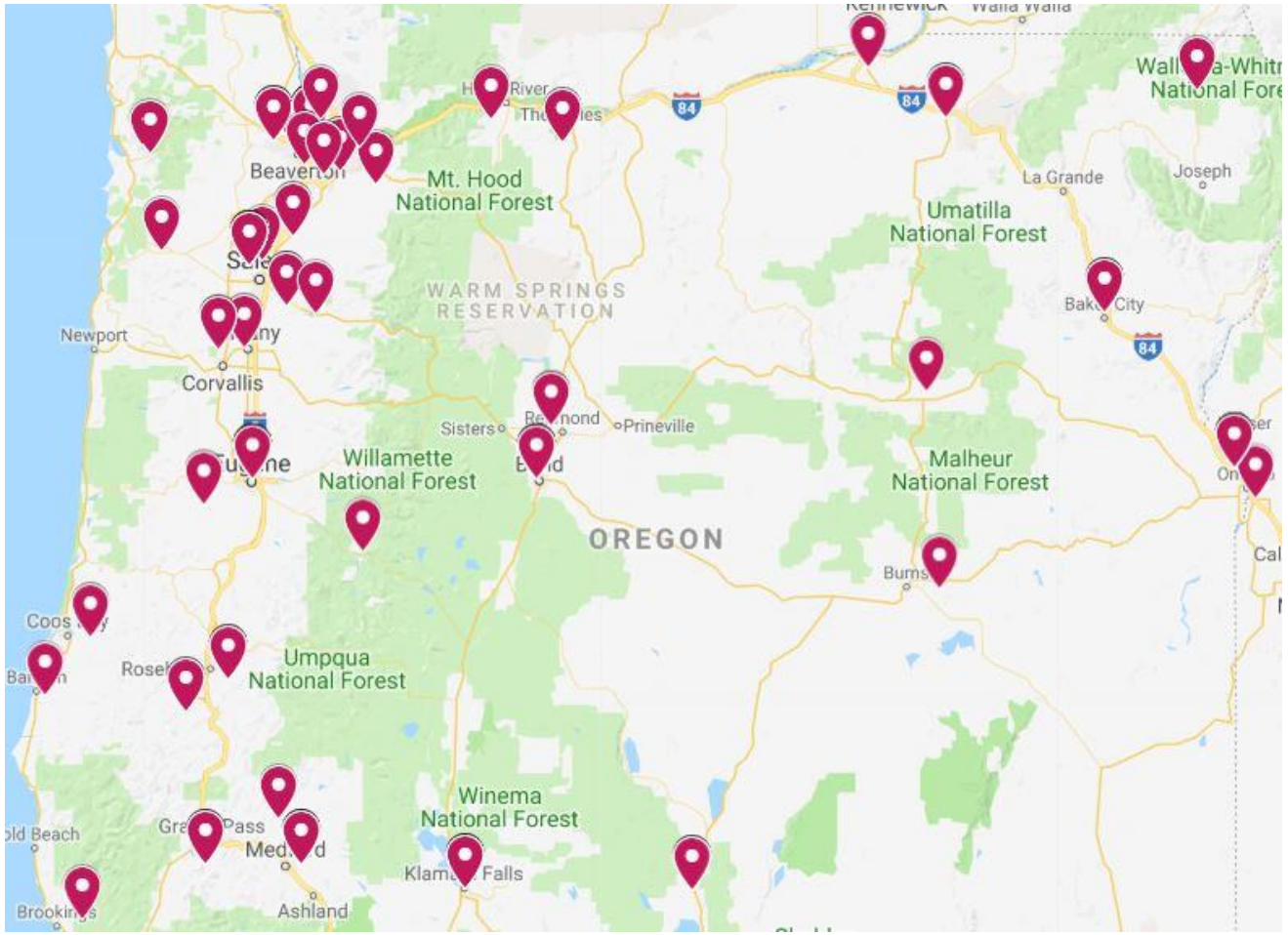
Map of Participating Organizations

Over 140 registered participants from over 80 organizations



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Behavioral & Physical Health Integration: Lessons from the Field

Program Objective: to share what the health care community can do to improve care for populations experiencing mental illness, with the goal to reduce emergency department utilization and hospital readmissions

Today's Session

- Learn the essential constructs for integration: financial, clinical and technological
- Understand the need for evidence that indicates the benefit(s) of the integration of physical health & behavioral health
- Discern the difference between quantity and quality outcomes in measuring integration

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Setting the Stage for Integration

Behavioral and Physical Health Integration- Lessons from the Field

Lynnea E. Lindsey, PhD, MSCP

February 21, 2019

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Learning Objectives

- Learn the essential constructs for integration: financial, clinical and technological
- Understand the need for evidence that indicates the benefit(s) of the integration of physical health & behavioral health
- Discern the difference between quantity and quality outcomes in measuring integration

How do we know?

Outcome measurement of integrated behavioral & physical health care

So we can know what we know and learn what we don't know…

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What do we need to know?

1. Financial: Sustainable payment – FFS/APM
2. Clinical: Population perspective & Team based
3. Technological: Aligned documentation & Outcomes

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Spectrum of Integration

- Primary Care
- Ambulatory/Outpatient/Specialty
- Acute Services/Hospitals

Examples of Integrated Care

1. Primary care medical home (PCMH/PCPCH) with integrated behavioral health (PCBH or IBH)
2. Physical health specialty or hospital with integrated behavioral health
3. Adult and/or pediatric integrated physical & behavioral case management programs
4. Behavioral health organization with integrated physical health (SAMSHA - Certified Community Behavioral Health Clinic (CCBHC), or Behavioral Health Home (BHH))
5. "Collaborative Care Model" (CMM) registry based psychiatric population care
6. Medication management resources: clinical pharmacists/nursing, care management

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Which one is “better?”

- To date there are a variety of studies indicating the value of integrated care
- Studies vary from a single clinic's data (showing cost offset of integration in pediatrics) to aggregated research data (AIMS Center)
- The most evidenced are the PCBH and CCM models.

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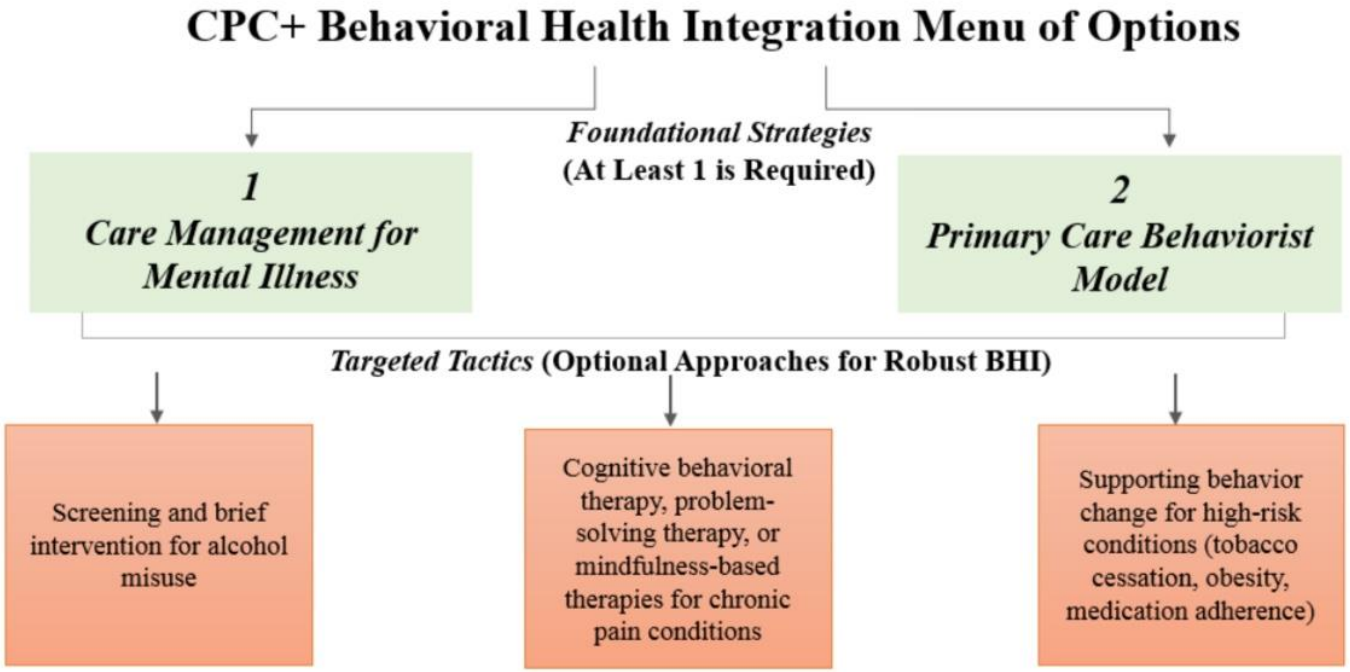
Which one is “better?”

- Comprehensive Primary Care Plus (CPC+) requires one of two models of integration



Essential Components

1. Independently licensed physical health and behavioral health staff working together, at the same site or with tele-health, to deliver care to the patient/family.

2. Open/shared documentation in the shared electronic health record (**without** separate/parallel/partitioned documentation) in brief clinical format. (SOAP/APSO)

3. Shared treatment planning and delivery of care across health behavior, mental health and substance use disorders.

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Essential Components

3. Behavioral Health Homes (BHH) and Certified Community Behavioral Health Clinics (CCBHC) may function with a broader array of staff under their certification.

NOTE: In Oregon if the practitioner is **employed** by an organization functioning under a "Certificate of Approval" (COA) then that practitioner's delivery of services and documentation must conform with the OARs (Oregon Administrative Rules) for COAs <u>including</u> the completion of the MOTS (Measures & Outcomes Tracking System) regardless of their location of work.

Return on Investment

"Medical costs for treating… patients with chronic medical and comorbid mental health/substance use disorder (MH/SUD) conditions are two to three times higher on average compared to the costs for those beneficiaries who don't have comorbid MH/SUD conditions."

Melek et. al. Milliman Report - January 2018

MILLIMAN RESEARCH REPORT

Potential economic impact of integrated medical-behavioral healthcare

Updated projections for 2017

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Return on Investment

"The projected additional healthcare costs incurred by people with behavioral comorbidities are estimated to be $406 billion in 2017 across commercially insured, Medicaid, and Medicare beneficiaries in the United States."

Melek et. al. Milliman Report - January 2018

Return on Investment

"Most of the increased cost for those with comorbid MH/SUD [mental health/substance use disorder]conditions is attributed to medical services (much more than behavioral services), creating a large opportunity for medical cost savings through integration of behavioral and medical services."

Melek et. al. Milliman Report - January 2018

Return on Investment

"Based on our literature review of the results of effective IMBH [integrated mental and behavioral health] programs, we calculate that **9% to 17%** of this total additional spending may be saved through effective integration of medical and behavioral care, ***although additional work and direct experience will be needed in this area to validate the actual savings achievable for any particular program or population***." *(emphasis added)*

Melek et. al. Milliman Report - January 2018

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Return on Investment

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**

Integrated Primary Care

A recent report in Translational Behavioral Medicine found a Colorado program called Sustaining Healthcare Across Integrated Primary Care Efforts (SHAPE) saved about $1.08 million in net cost for Medicare, Medicaid and dual-eligible patients. The savings came via fewer hospitalizations and other downstream utilization. Practices receiving payments showed higher rates of screening and diagnosing of depression and anxiety-related disorders.

Collaborative Care Model (CCM)

The AIMS Center said more than 80 randomized controlled trials tested the Collaborative Care Model (CCM) and found it **consistently improves care, leads to better patient outcomes, better patient and provider satisfaction, improves functioning and cuts healthcare costs.**

- A 2016 study tested the Mayo Clinic's Care of Mental, Physical and Substance-Use Syndromes (COMPASS) model, which incorporates aspects of CCM and found improved health and cost savings. The study of 7,340 patients with depression at four outpatient primary care clinics from March 2008 to June 2013 discovered that **patients enrolled in CCM have a faster rate of remission and a shorter duration of persistent depressive symptoms than patients who received usual care.**

Clinical Outcome Metrics example

The **Integrated Behavioral Health Alliance** (IBHA) is a multi-stakeholder workgroup of healthcare payers, providers and policy developers.

The table below contains a consensus list of recommended measures; IBHA encourages organizations to begin with process measures, building capacity over time to measure more complex intermediate and outcome measures.

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IBHA Recommended Measures to Assess Behavioral Health Integration in Primary Care[3]

Integration Concepts	Process Measures →	Intermediate Outcome Measures →	Outcome Measures →
I. Access to Care			
II. Quality of Care			
III. System of Care			
IV. Utilization & Cost			
V. Patient Experience of Care			
VI. PCP Engagement & Satisfaction			

Must Haves

Financial Model

Documentation Model

Measurement Model

Leadership Model

Communication Plan

Additional Resources

Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

https://integrationacademy.ahrq.gov/

The Integration Academy holds extensive resources on integration of behavioral health and physical health.

Zivin, K., Miller, B. F., Finke, B., Bitton, A., Payne, P., Stowe, E. C., Reddy, A., Day, T. J., Lapin, P., Jin, J. L., … Sessums, L. L. (2017). Behavioral Health and the Comprehensive Primary Care (CPC) Initiative: findings from the 2014 CPC behavioral health survey. *BMC health services research*, *17*(1), 612.

[3]Integrated Behavioral Health Alliance (IBHA) **Recommended Measures to Assess Behavioral Health Integration in Primary Care**
http://www.pcpci.org/sites/default/files/IBHA%20Measures%20Document%202018.final%20draft.pdf

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Additional Resources

AIMS Center: http://aims.uw.edu/collaborative-care/implementation-guide

SAMSHA https://www.integration.samhsa.gov/integrated-care-models/CIHS_quickStart_decisiontree_with_links_as.pdf

Kaile M Ross, Emma C Gilchrist, Stephen P Melek, Patrick D Gordon, Sandra L Ruland, Benjamin F Miller; Cost savings associated with an alternative payment model for integrating behavioral health in primary care, *Translational Behavioral Medicine*, , iby054, https://doi.org/10.1093/tbm/iby054

Presenter Contact Information

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“Brains are in every body!”

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Thank you!

Please complete the post-session evaluation.

Next session is on **Thursday, March 7 from 7:30 - 8:30 a.m.**

- Cascadia- integrating physical health services into behavioral health settings
- La Clinica- integrating behavioral health services into physical health settings

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For more information on ED MI metrics support, visit www.TransformationCenter.org

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