CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

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ADVANCING INTEGRATED HEALTHCARE

IBH Quarterly Meeting

Care Transformation Collaborative of Rhode Island

Thursday, June 16, 2022
7:30 – 9:00 AM

Introductions

Debra Hurwitz, MBA, BSN, RN
Executive Director

Nelly Burdette, PsyD
Senior Program Director, IBH

Pano Yeracaris, MD, MPH
Chief Clinical Strategist

Patricia Flanagan, MD
Clinical Director

Susanne Campbell, RN, MS, PCMH CCE
Senior Program Director

Linda Cabral, MHA
Program Manager

John Todaro, PhD
CTC-RI IBH Committee Co-Chair

Clinical Psychologist and Director at Providence Behavioral Health Associates

Rena Sheehan, MBA, LICSW
CTC-RI IBH Committee Co-Chair

Managing Director Clinical Integration at Blue Cross Blue Shield

Welcome! Please put your name and organization into the chat

Today's Main Goals & Agenda

Objectives:

- Share CTC's IBH goals and 2022-23 planning work underway
- Share insights and feedback to deepen understanding of the challenges, barriers and opportunities; and strengthen CTC's plan to support the integration of behavioral health in primary care practices

Agenda:

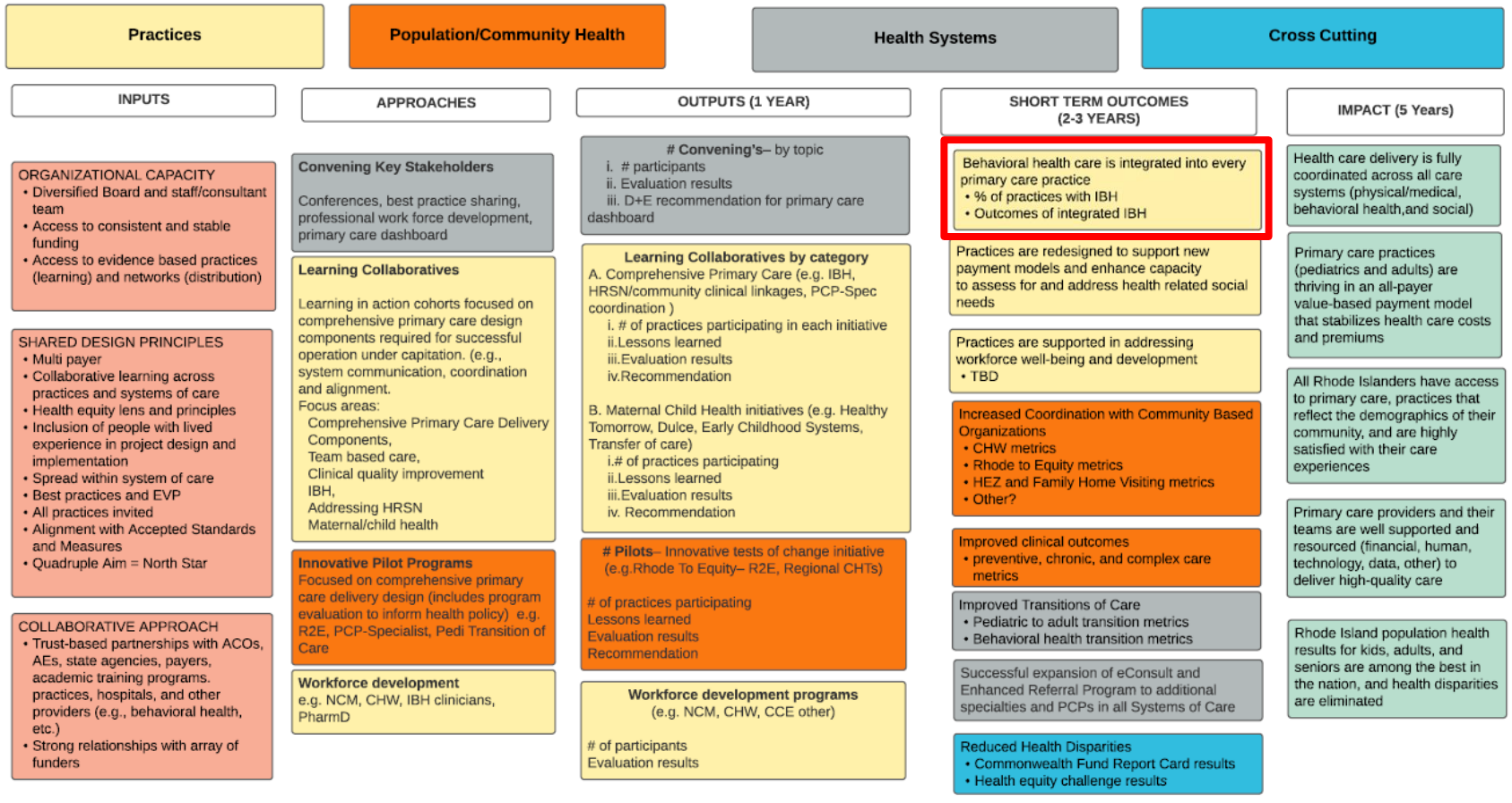
1. 7:30-7:40– Welcome

2. 7:40-8:50– Discussion: CTC's Role in Moving Integrated Behavioral Health Forward in RI
   a. Our Analysis So Far…
   b. Your Insights: Challenges, Opportunities & Potential Models/Solutions
   c. Recommendations & Next Steps

3. 8:50-9:00—Thank you & Brief Announcements

CTC Five Year Strategic Plan

CTC DRAFT LOGIC MODEL FOR IMPACT



SUNSETTING WORK: Cohort 3 PCMH Kids, SBIRT, Telehealth

RI Landscape Review

- ✓ Environmental Scan
- ✓ Current State of IBH at the Practice and System of Care Level
- ✓ Deeper Dive into Data

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Environmental Scan: Reports, Initiatives, Other Inputs: RI & National

	Primary Care	Closely Aligned to Primary Care	Specialty Care
National Academies – "Five Factors"	X		
Biden-Harris Factsheet on Addressing National Mental Health Crisis	X	X	X
RIDOH Primary Care report	X		
OHIC Affordability Standards related to behavioral health integration into primary care TBD	X		
SUD and Psychiatry vendors working with primary care	X		
PediPRN	X		
MomsPRN	X		X
Doula and CHW reimbursement	X		
Workforce Shortage issues	X	X	X
SBIRT (Screening, Brief Intervention and Referral to Treatment)	X		
Geriatrics BH Issues; Alzheimer's	X		
State task force around substance exposed newborns	X	X	
Children's BH System Redesign – key feature mobile response		X	
Family Home Visiting		X	
Kids Count – review of Governor's budget		X	
PIPBC (Promoting the Integration of Primary and Behavioral Healthcare for Children & Families		X	
Unite Us		X	
BH link			X
CCBHC			X
Rhode Island Behavioral Health System Review			X

33% of ED visits in 2018 had a primary and/or secondary diagnosis related to behavioral health

In Rhode Island, drug overdoses have increased by **25%, from 308 in 2019 to 384 in 2020.**

July 2020 had the highest number of fatal overdoses in the state since tracking began in 2014.

Summary of Findings from Past Stakeholder Engagement

These themes emerged from the analysis of previously documented stakeholder engagement, as described on the prior page:

Rates / Payment Models	Capacity / Workforce	Accountability / Responsibility	Care Coordination	Integration between BH and Medical	Health Equity	Gaps in Services / Continuum of Care
• Payment models could be revised to reduce billing/administrative burdens on providers and to better incentivize referrals/BH and medical integration/care coordination • According to BH providers, rates are too low/payments insufficient and providers are operating at a loss • Financial stability of provider organizations a concern, exacerbated by COVID-19 • Many providers are highly sensitive to changes in billing cycles	• Workforce shortages have led to a lack of capacity to meet BH need; challenges with employee recruitment/retention have resulted in high turnover rates among BH providers • A lack of qualified providers (particularly for community-based services/in assisted living and children/youth and geriatric providers) • Shortage of linguistic and culturally competent providers to meet community needs; Black, Latinx, and Asian providers underrepresented	• Need for greater coordination across state agencies (BHDDH, DCYF, Medicaid, OHIC, RIDOH) to align policy goals and resources • Organizational accountability mix across state agencies not distributed in a manner that leads to optimal, cost-effective health outcomes • Need to further emphasize data collection on quality and outcomes, as indicators of a well-functioning BH care delivery system	• Care coordination resources may exist, but often there are duplicated care coordination efforts that may result in conflicting guidance to people receiving services • A need for more effective care coordination and options counseling for clients; many still "fall through the cracks"	• Lack of integration between BH/medical (especially among adults); many administrative, logistical, and billing/payment challenges with integration • Success stories of BH/medical care and care coordination from SIM-funded initiatives (IBH, SBIRT, PCMH-Kids) • Stigma associated with accessing behavioral health care remains an ongoing challenge	• Ensuring equitable access to BH care is a priority for the state • Yet, disparities exist in both health outcomes and in access to BH care, by • Race/ethnicity • Age • Gender • LGBTQ+ • Geography • Shortage of linguistic and culturally competent providers to meet community need • Health equity cross-cuts all other themes	• Lack of capacity for outpatient care and services in the community, which can lead to unnecessary utilization of more restrictive and more expensive levels of care (i.e. emergency department visits, inpatient care) and longer length of stay for inpatient care • Need more investment in step-down services • Need more investment in prevention/early intervention, especially for children – current system is much more reactive than proactive

COVID-19 has impacted all themes, especially on capacity/workforce.

Looking For Your Input…..

- **How can CTC assist primary care practices** to move along the IBH continuum?
- How can we **build off our current programs** to meet primary care practices where they are along the continuum (**fully onsite, hybrid, virtual**)?
- What are the gaps, **challenges** or barriers that CTC-RI should **focus on in the next 12 months?**
- What state-wide initiatives or **opportunities can we build on**?

Integrated Care Delivery Continuum

Silos

Minimal Collaboration: Mental health and other healthcare providers work in separate facilities, have separate systems, and rarely communicate about cases.

Informal

Basic Collaboration at a Distance: Providers have separate systems at separate sites, but engage in periodic communication about shared patients, mostly through telephone and letters. Providers view each other as resources

Co-Location

Basic Collaboration Onsite: Mental health and other healthcare professionals have separate systems, but share facilities. Proximity supports at least occasional face-to-face meetings and communication improves and is more regular

Collaborative Care

Close Collaboration in a Partly Integrated System: Mental health and other healthcare providers share the same sites and have some systems in common such as scheduling or charting. Regular face-to-face interactions, coordinated treatment plans for difficult patients, basic understanding of each other's roles and cultures.

Integration

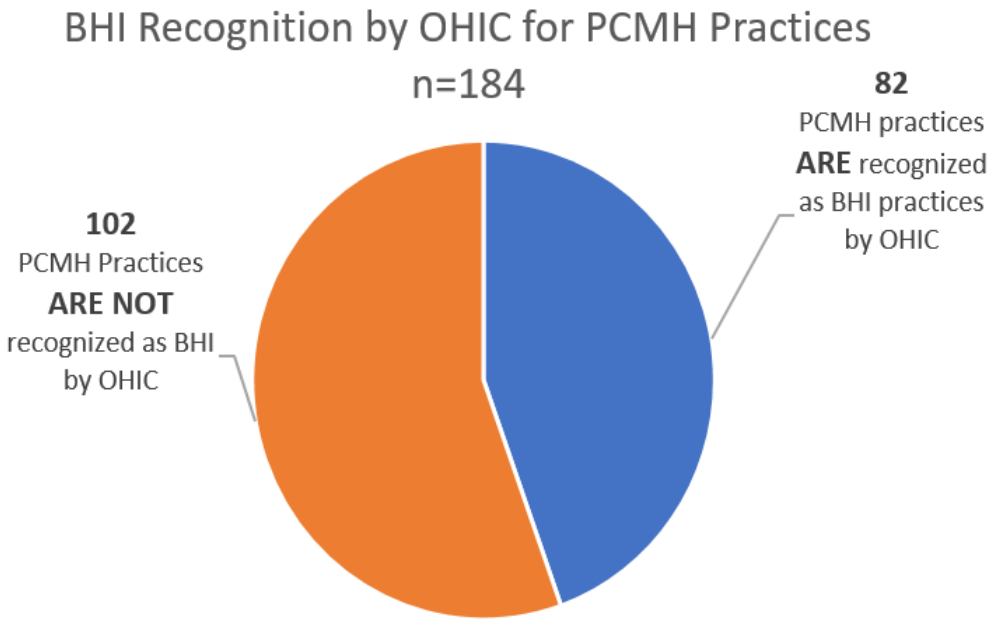
Close Collaboration in a Fully Integrated System: Mental health and other healthcare professionals share the same sites, vision, and systems. All providers are on the same team and have developed an in-depth understanding of each other's roles and areas of expertise

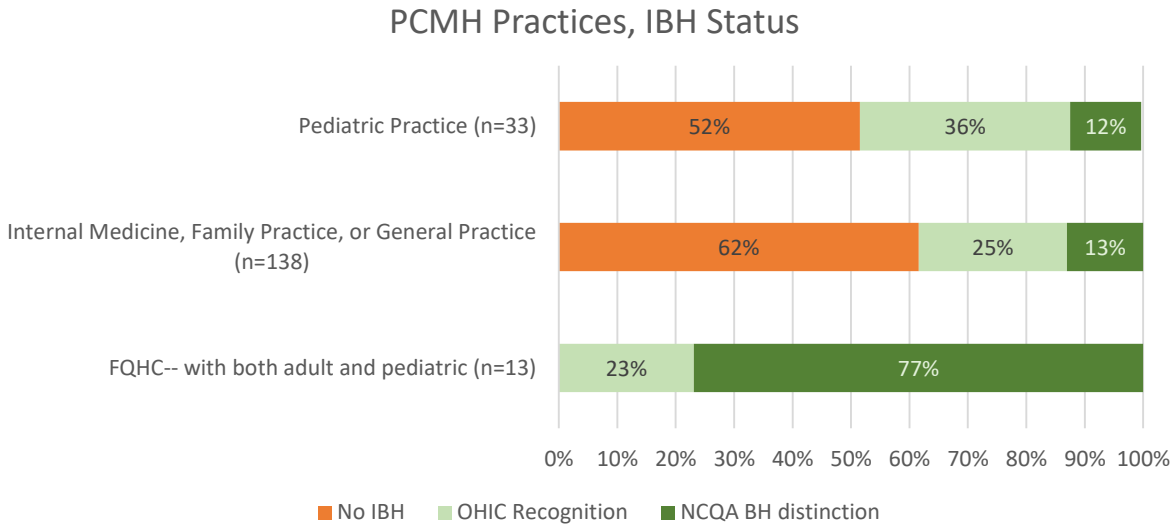
102 (55%) of RI PCMH practices have minimal collaboration between BH and other healthcare providers*

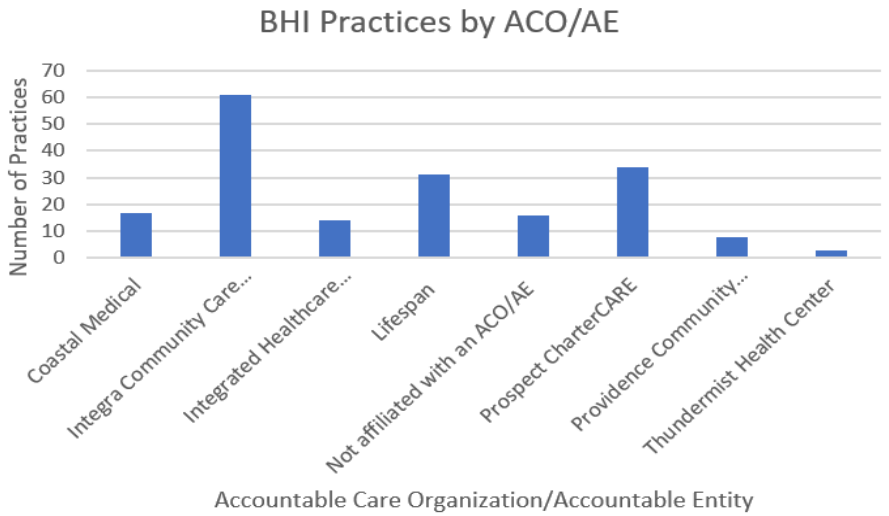
82 (45%) of RI PCMH practices are recognized by OHIC as having IBH*

*Source: All data from the 2021 OHIC PCMH practice list found here.

Statewide IBH Landscape



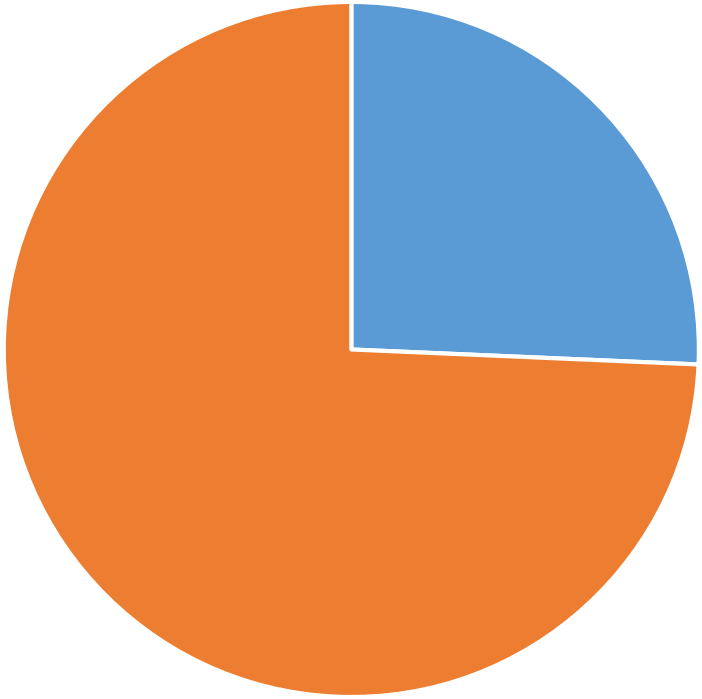




All data from the 2021 OHIC PCMH practice list found here.

CTC-RI Initiatives in Place for 2022

CTC IBH FOCUS FOR 2022–
109 Practices Engaged as of June



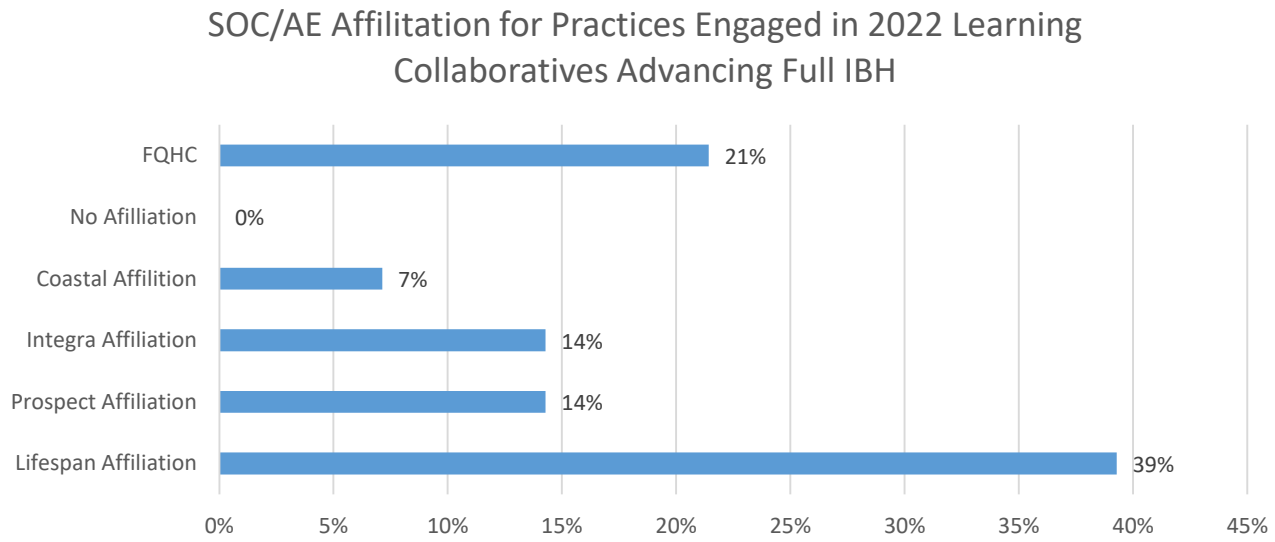
Continue Existing IBH Collaboration and Training to **Advance Full IBH Model**– 28 practices engaged

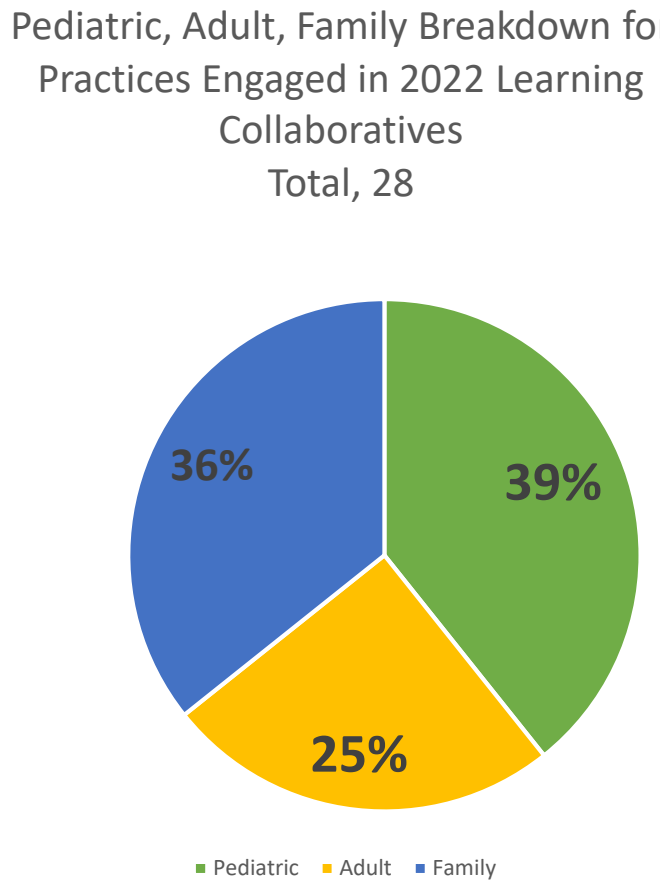
Projects that build capacity and **address barriers to IBH**– 81 practices engaged

CTC-RI activities to advance **full IBH model**

Activities:

1. NCQA BH Distinction Learning Collaborative (2 cohorts)
2. Pediatric IBH Collaborative
3. Integra IBH Collaborative
4. Prospect IBH Collaborative



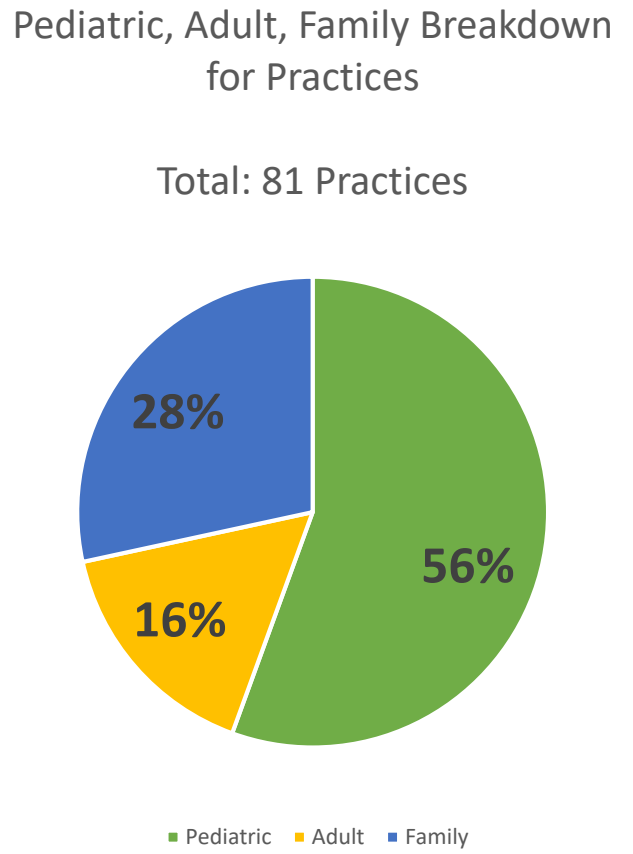


CTC-RI activities that **advance BH capacity**

Activities:

1. Pediatric Medicaid Recovery Program
2. UMASS BH Training
3. System of Care IBH Workforce Development
4. Moms PRN

In planning phase: Pediatric Weight Management, DULCE



Discussion: Data

Did anything stand out to you about the data?

Does the data inform your thoughts about where CTC-RI should focus our attention and resources over the upcoming year?

Identified Challenges Include:

- Workforce
- Smaller Practices: Models & Support
- Knowledge, Skills & Training
- Health Equity
- Funding for practices
- Double Co-Pay (BH/Primary Care): implementation
- Partnerships between primary care & CBOs
- Incentives for primary care and outpatient therapists to integrate BH
- Screening for and addressing HRSN
- Multipayer approach

Discussion: Challenges

- What can **we do right now**, recognizing that we are in a **mental health crisis**?
- How can we assist primary care in improving **health equity** in delivery of IBH in primary care?
- What opportunities exist to **maximize overall impact**?
- In what ways can **tele-behavioral health** address gaps and challenges. What is needed to make this happen?

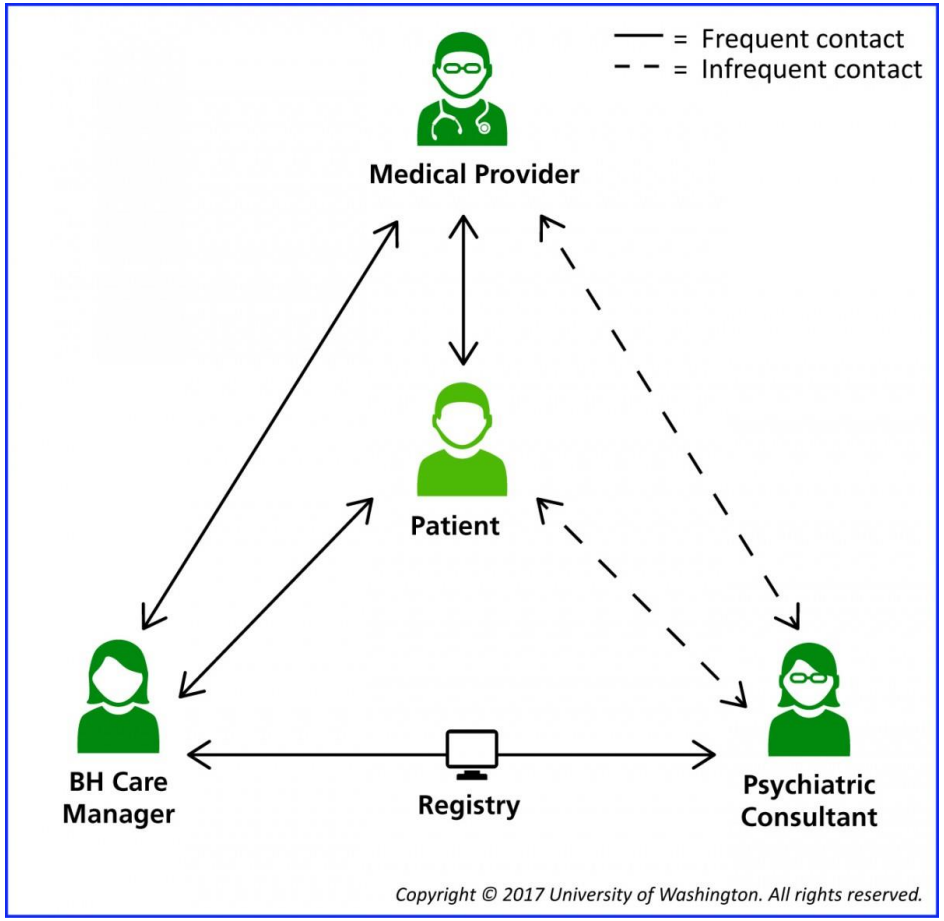
Closer Look at Models for Smaller Practices and Systems of Care

Focused on Collaborative Care Model, an evidence-based *clinical model* for smaller practices

We wanted to understand:
How the model works, both clinically and on the billing/payment side; centralized and decentralized services

How does this work transform the BH delivery system/fit into care transformation?

How might Collaborative Care leverage telehealth to help community-based practices that belong to a larger system of care?



Collaborative Care Model

CTC-RI met with three states (Maryland, New York, Michigan) to learn about their implementation of CoCM. Full details available in deck appendix, (*slide 40*)

Key Takeaways: Is this a model or RI? Not sure….

- Each state was able to take a statewide approach and show positive outcomes on depression and anxiety – **but do not use CoCM for SUD**
- 2 of 3 states **using third party vendors** to provided psychiatric and BH coordination functions as well as handle back office support, including billing and payment (time based billing vs. encounter) , and registry development and management
- Integration with **electronic medical records** was cited as a key facilitator
- Billing a challenges – NY Medicaid has codes for CoCM note --60% of TA spent on billing issues
- Multiplayer approach was limited which impacted sustainability and penetration across the state; Most states had limited payer support
- **In RI: BCBSRI and Medicare pay for CoCM but Medicaid and other payers do not**

Potential Opportunities

- Tele-BH
- Pedi-PRN & MomsPRN
- CCBHC/Mobile Units
- Potential opportunities as a result of the new Affordability Standards
- E-consult for psychiatry
- SBIRT
- Collaborative Care Model
- School-based Mental Health

What are other people doing that has been successful?

CTC Plan: Moving Forward

1. Take this work – and your ideas– to our Board
2. Use what we have learned to inform any opportunities from the new OHIC Affordability Standards

Your Final Thoughts:

What else have you heard today that we should consider adding to our next steps?

Brief Updates, Announcements & Closing

THANK YOU!

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Appendix

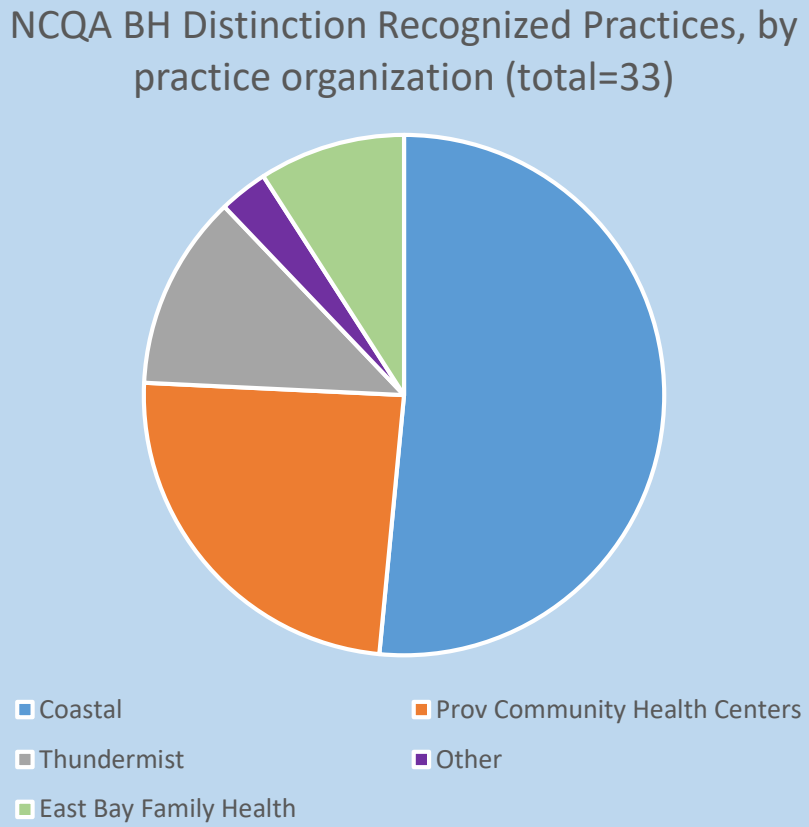
CTC-RI Learning: Take-aways from CoCM Consultation with MI, NY State, MD

We asked….	Michigan	NY State	Maryland
How They Implemented the Model	• Includes Pediatrics starting in 2021 • Primarily telehealth • Approximately 180 practices • Vendor handles licenses and credentials • Clinicians paid hourly; IPA does billing • Conduct robust practice readiness assessment	• No Pediatrics • Includes telepsychiatry • Approximately 320 practices (5-6% of total practices) • Using CoCM billing codes for Medicaid and Medicare • Financial model based on AIMS Center CoCM • AIMS Center provides ongoing training	• No Pediatrics • Hybrid • State mandate to have IBH in all primary care practices (CoCM or something else) • Brought payers to the table (Medicaid only a pilot)
Key Components for Success	• Use Registry; ability to share patient information • Vendor for billing/payment • Opened up codes and waiver co-pays • Providers screen w/Gad7 and PHQ9 • Regularly review cases (usually weekly)	• Use Registry; ability to share patient information • Vendor (or internal capacity) for billing/payment • Billing is not time-based • Medicaid waiver in place • Providers screen w/Gad7 and PHQ9 • Duration of treatment, approx. 20-21 weeks	• Use Registry; ability to share patient information • Vendor (or internal capacity) for billing/payment • Providers screen w/Gad7 and PHQ9 • Focus is on small and medium-size practices • Regularly review cases
Workforce	• Consultant psychiatrist has office hours • BH Care Managers (through vendor) • Experiencing a shortage • Provide ongoing practice support	• Practices engage psychiatrists on their own (typical subcontract is 6 hrs/month) • Pairs non-licensed BH providers with licensed providers • NYS provides technical assistance- quarterly “bootcamp”, monthly webinar, and drop-in hours	• Psychiatrist consults for patients not improving • Licensed clinician best for BH coordinator • Tried hybrid with BA level coordinator; more limited to admin tasks • Coordinator usually embedded in the site
Outcomes & Measurement	• Metrics include screening data for adults and peds • Also collecting quality of life data • Positive outcomes so far	• Metrics include screening data (PHQ-9, GAD-7, PHQ-2)	• Metrics include screening data (GAD-7s, other tools) • Positive outcomes so far: 77% of 4k patients had clinically meaningful reductions in PHQ within 6 months • Positive follow-up care outcomes
Limitations & Challenges	• Primarily depression and anxiety; only SUD if it is co-morbidity • Billing and payment • Shared access to medical records	• Primarily depression and anxiety • Billing and payment (estimated 60% of technical assistance is billing/coding)	• Primarily designed to address depression and anxiety • Billing and payment • Medicaid FFS
Partners/ Vendors	• Array (vendor) – handles credentials for every state they work in; handles billing	• No outside vendor	• Mindoula (vendor) – handles back office, billing • Path Forward (national partner)

NCQA BH Distinction– Status of RI Practices

In 2021, OHIC implemented new pathways for IBH within the state of Rhode Island. In order for a practice to earn the designation of a Qualifying Integrated Behavioral Health Primary Care Practice, it must achieve NCQA BH Distinction within 3 years.

33 practices currently hold NCQA BH distinction, primarily FQHCs and multi-site practice organizations like Coastal Medical



An additional 10 practices are currently enrolled in a CTC-RI learning collaborative which will support them to apply for NCQA BH distinction

Look Forward: What is Up Ahead?

- More focus/effort to address lack of workforce diversity
- More telehealth
- Digital technology (new apps?)
- OHIC: Affordability Standards
- New 988 phone line (launch, July 2022)
- Unite Us platform continued expansion
- HRSA funds (Fed admin priority on mental health, SUD)
- Doula and CHW reimbursement
- More attention to seniors/primary care
- More federal funding for mental health, including pediatric mental health

Drilling Down into CTC's Strategic Plan

CTC 2025 Strategic Goal:

"*Behavioral health care is integrated into every primary care practice*"

Our Focus:

Which areas/opportunities would be most impactful for CTC to effectively address in 2022-23 to meet the 2025 Strategic goal?