CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Behavioral Health Integration-Sustainable Solutions

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CTC-RI Overview

- **Vision: Rhode Islanders enjoy excellent health and quality of life**.
- **Mission: To lead the transformation of primary care in Rhode Island in the context of an integrated healthcare system**; and to improve the quality of life, the patient experience of care, the affordability of care, and the health of populations we serve.
- **Approach**: **CTC-RI brings together key stakeholders** to implement, evaluate, refine and spread models to deliver, pay for, and sustain high quality comprehensive primary care.

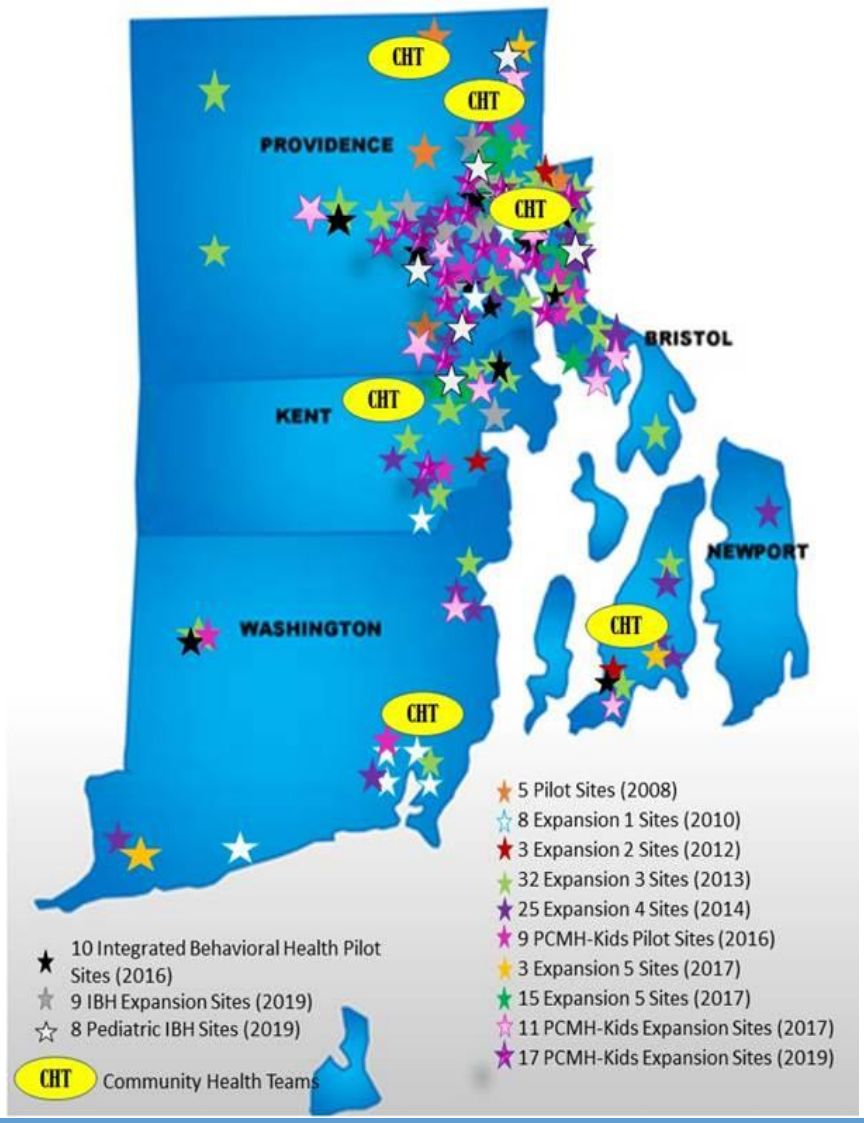
CTC-RI Goals

- Increase Capacity and Access to Patient-Centered Medical Homes (PCMH)
- Improve Quality and Patient Experience
- Reduce Cost of Care
- Improve Population Health
- Improve Provider Satisfaction (“Fostering joy in work”)

Expanding PCMH

The Care Transformation Collaborative of Rhode Island has a growing impact across the state, and includes:

- **128 primary practices**, including internal medicine, family medicine, pediatric practices and **41 primary care practices** which are part of the Integrated Behavioral Health initiative.
  - Over **700,000 Rhode Islanders** receive their care from one of our practices.
  - **800 providers** across our adult and pediatric practices.
  - Investment from **every health insurance plan** in Rhode Island, including private and public plans.
  - **All Federally Qualified Health Centers** in Rhode Island participate in our Collaborative
  - $217 million reduction in total cost of care dollars in 2016 compared to non-patient centered medical homes in Rhode Island, according to data from the state's All-Payer Claims Database.



Integrated Behavioral Health Project Goals

Goal 1: Reach higher levels of quality through **universal screening**

Goal 2: Increase access to **brief intervention** for patients with moderate depression, anxiety, SUD and co-occurring chronic conditions

Goal 3: Provide **care coordination** and intervention for patients with high emergency department (ED) utilization /and behavioral health condition

Goal 4: **Increase patient self care** management skills: chronic condition and behavioral health need

Goal 5: Determine **cost savings** that primary care can achieve by decreasing ED visits and inpatient hospitalization

Pilot sites: Centered Medical Home (PCMH) primary care practices serving 42,000 adults

Funding Partners

RHODE ISLAND FOUNDATION

TUFTS Health Plan

State of Rhode Island

IBH Program Overview

3-year program (2016-2019) with 2 cohorts of practices

Key Program Components:

- Onsite IBH Practice Facilitation: support culture change, workflows, billing
- Universal Screening: depression, anxiety, substance use disorder
- Embedded IBH Clinician : warm hand offs, pre-visit planning, huddles
- Three PDSA Cycles : screening, high ED, chronic conditions
- Quarterly Best Practice Sharing: data driven improvement, content experts
- Incentives: Infrastructure and incentive screening targets paid

Qualitative Evaluation

Providers love it: “When I say how much I love having integrated behavioral health, it is that I can't imagine primary care without it. **It just makes so much sense to me to have those resources all in the same place** because it's so important. So I love it. I can't speak highly enough of it.” *(Medical Provider)*

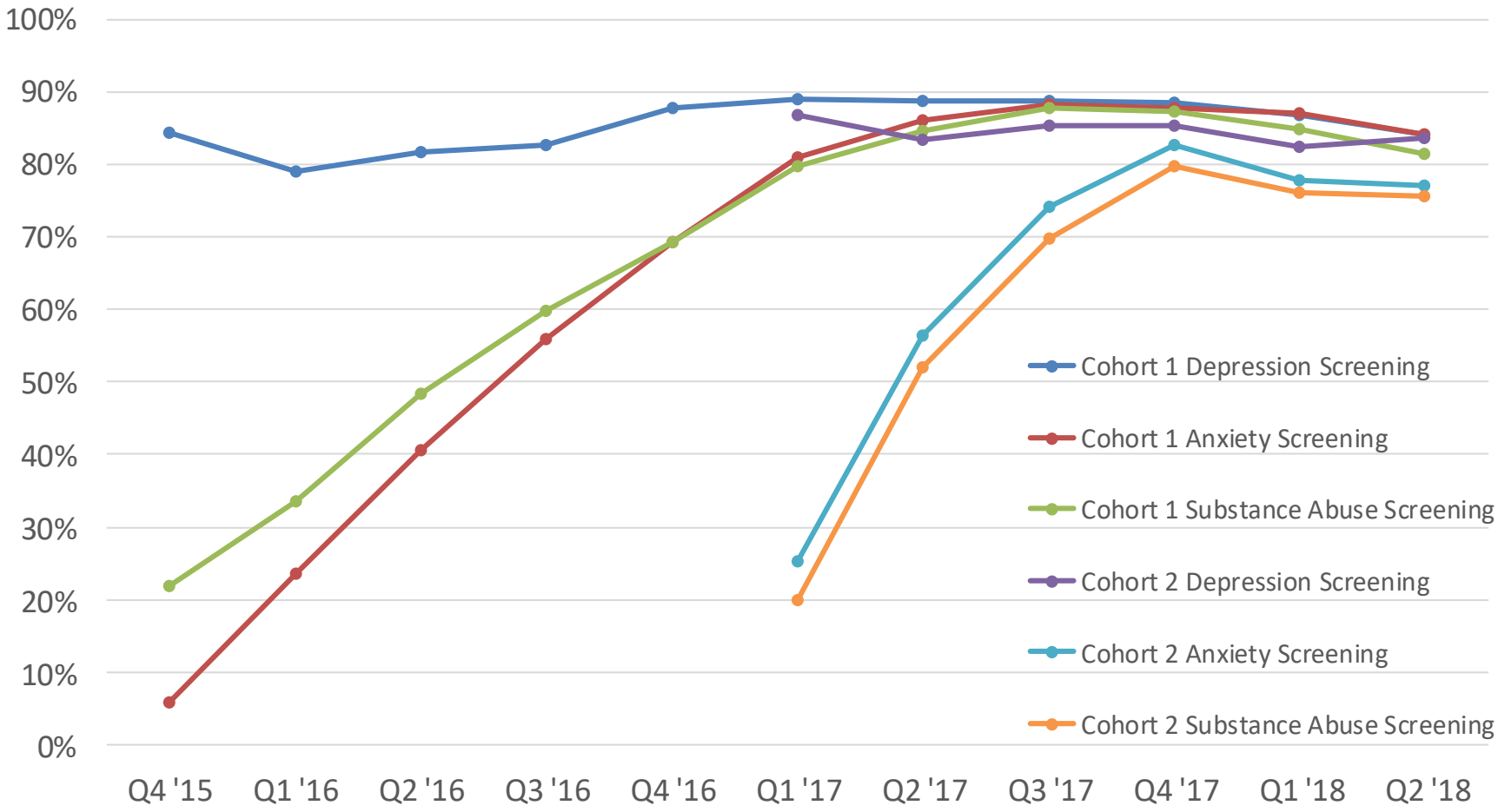
Value of deliberate screening: "**I'm surprised especially with the anxiety screener that there's more out there than I knew about.** I was talking to somebody yesterday. You think this wouldn't be useful information. I know the patient pretty well, and the patients, if they had an issue, I'm sure they would tell me. But it comes up on the screener." *(Medical Provider)*

Impact on ED use: “One of the things we identified [through the program] was somebody was going to the ER almost every other day, and it was due to anxiety. So he was given tools to control that, and it actually empowered him. He felt like he had taken control of this issue. And his ER visits dropped right off.

He was being seen here [at the primary care practice] more frequently, but that's okay. **We'd rather he come here than go to the ER**.” *(Practice Coordinator)*

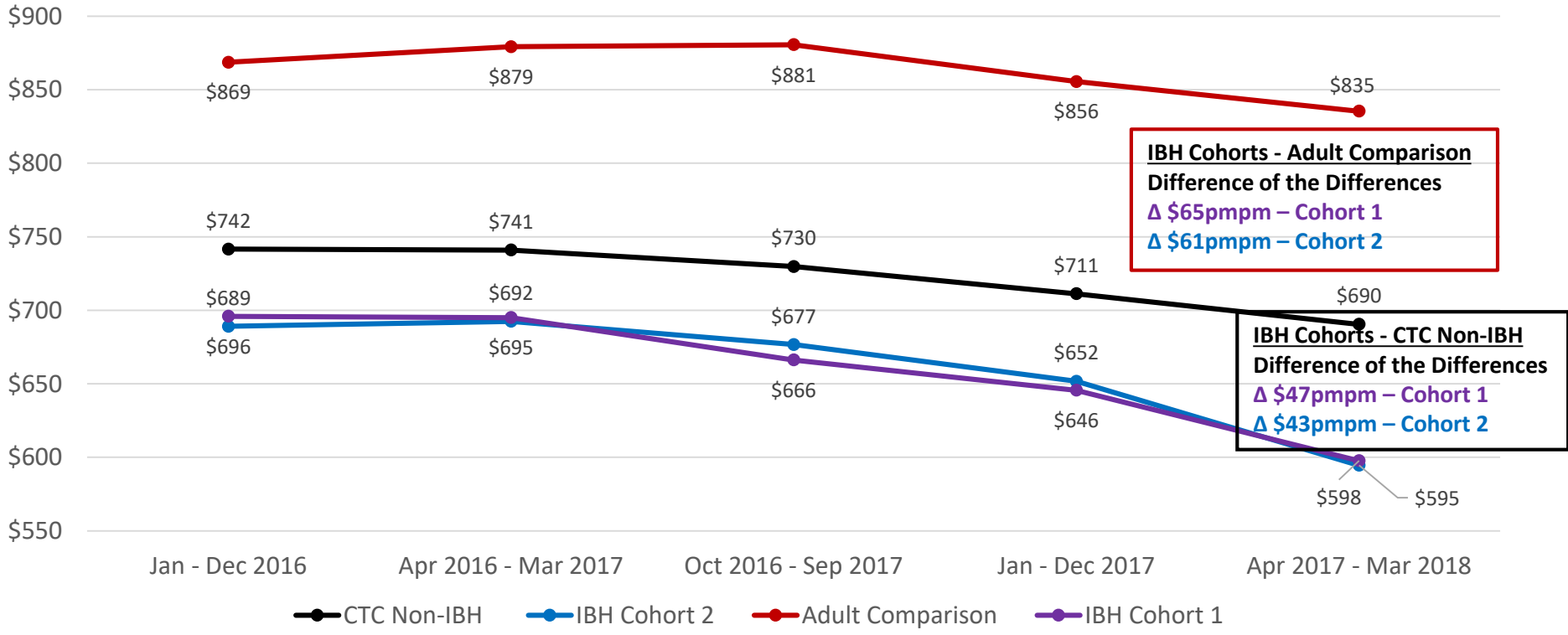
Screening and Utilization Outcome Results

PDSA: Universal Screening Cohort 1 & 2



Better Care - Lower Costs

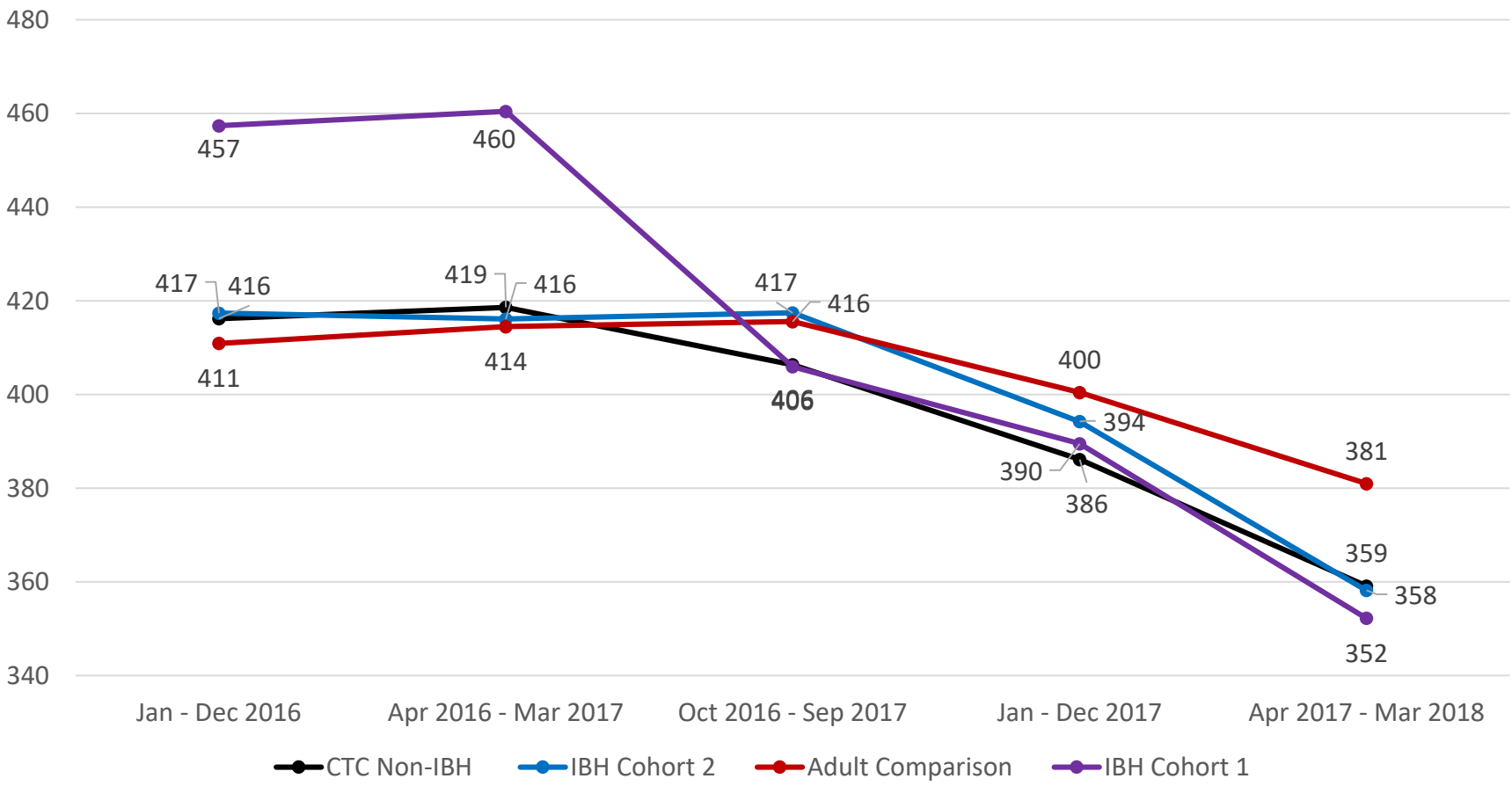
Total Medical & Pharmacy Costs (with Exclusions) Risk Adjusted (Cost per Member-Month)



Data Source: Rhode Island All Payer Claims Database

Emergency Department Visits

Risk Adjusted (Visits per 1,000 Member-Years Count)



Data Source: Rhode Island All Payer Claims Database

Brown University Findings
Using a "matched" comparison group

Overall, analysis suggests positive effects of IBH intervention

	Cohort 1	Cohort 2
Utilization		
ED Visits	↓ 12%*	↓ 20%*
Office Visits	↓ 50%*	↓ 25%*
Costs		
Total Cost of Care	↓	↓
ED Costs	↓	↓
Rx Costs	↓	↓
Professional Services	↓	↑

* Statistically significant p-values

Data Source: Rhode Island All-Payer Claims Database

Lessons Learned

New Unmet or Changing Needs

- **Copays** are a barrier to treatment
- **Billing and coding** difficult to navigate
- Workforce Development IBH **practice facilitators** and IBH clinicians

Things to Do Differently

- Give practices 3 to 6 months to **prepare for implementation**
  - ✓ Billing and coding
  - ✓ Credentialing
  - ✓ EHR modifications
  - ✓ Workflow
  - ✓ Staff training

What Would Be Helpful Post-Pilot

- **Build workforce** for Integrated Care
- **Pilot APM** for IBH in primary care
- **Leverage legislative action**; 1 copay in primary care; treat screenings as preventive services
- Address needs of **small practices through CHT**

Moving Lessons Learned to Action

New Unmet or Changing Needs

- **Copays** are a barrier to treatment
- **Billing and coding** difficult to navigate
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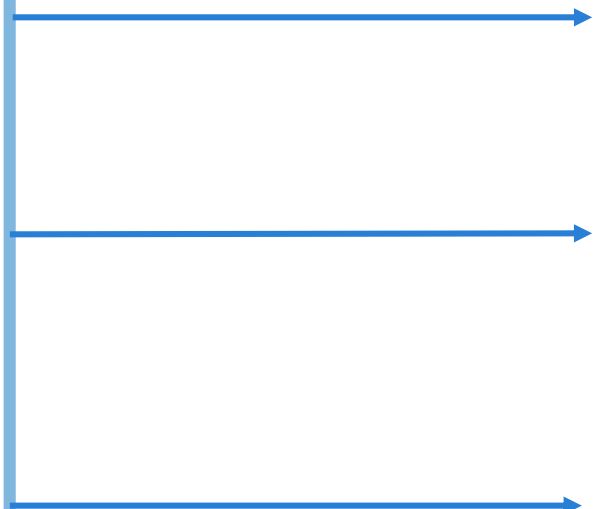


Action Steps

- **OHIC Engagement and removal of double IBH co-pay**
- **Created cheat sheet across all payors and OHIC parity work**
- **Created novel training program for growing workforce**

Informing State Policy

Sustainability from Policy Perspective:

- Engaged OHIC (2019) to convene IBH Work Group
- Effective 1/1/21, no IBH double-copay on same day visits with primary care provider for qualified integrated practices
- Health and Behavior Intervention Codes (HABI) must be reimbursed at parity with other mental health and physical health codes
- Preventative Mental Health and Substance Use Screenings that occur in Primary Care will not have cost-sharing by patient

Workforce Development

Better Care Through Workforce Development : IBH

Wendy Phillips

Jennifer Etue

Kristin David

3 Practice Facilitators specifically trained within IBH in Primary Care

- 6 months Didactic and Experiential training
- Backgrounds include psychology, social work and marriage & family therapy
- 3 PCMH sites are receiving practice facilitation services over 1-year period

Represents the first training of its' kind in the country

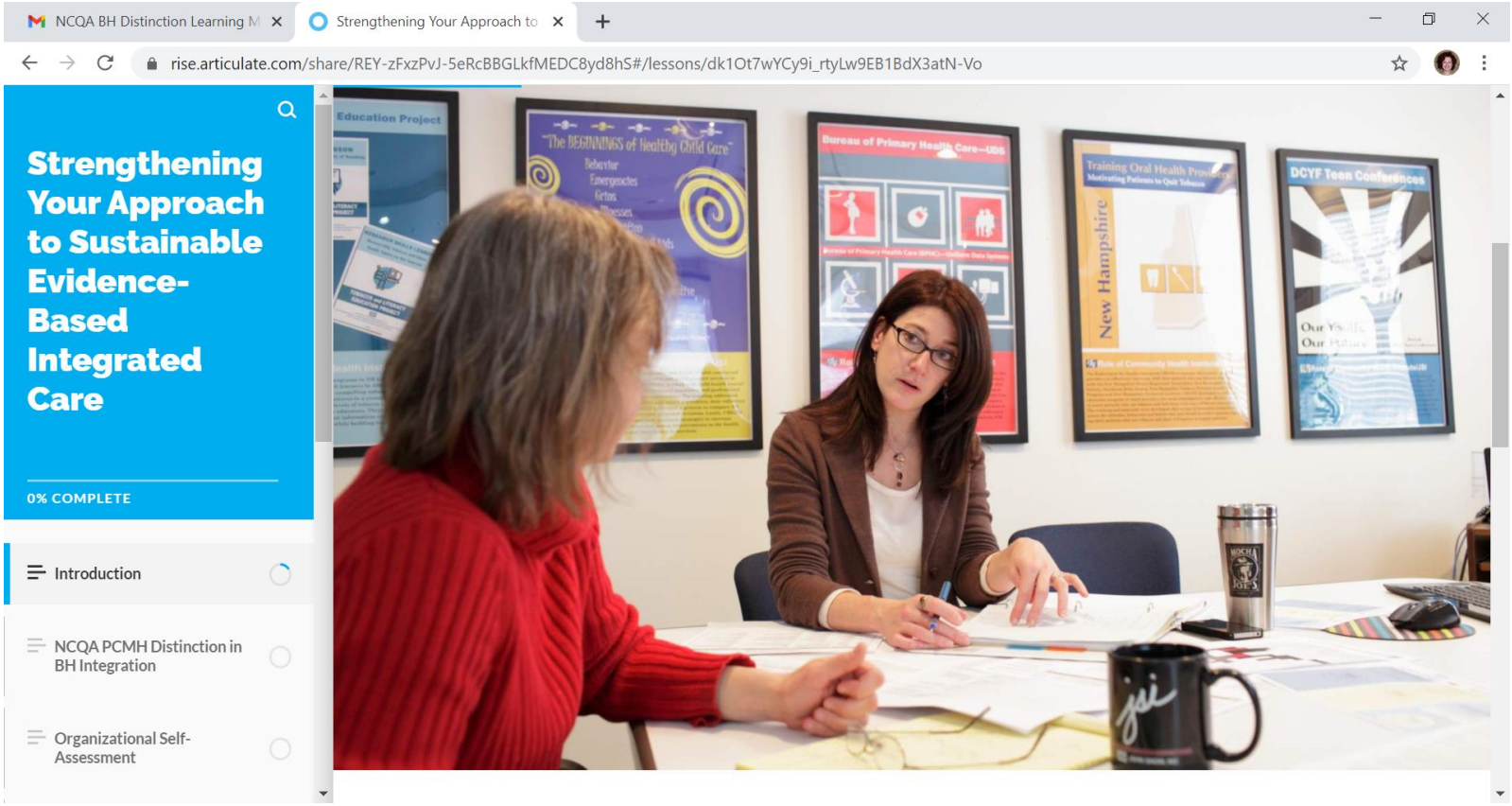
This program was made possible through the support of the RI Foundation and RI College.

Better Care Through Workforce Development : IBH

With funding from: TUFTS Health Plan

- Trained 3 additional IBH Practice Facilitators
- Developed Online web-based IBH Practice Facilitator Training program
  - Consulted with John Snow, Inc., educational content experts
  - Applied content to a learning platform and integrated live “filmed” presentations of Dr. Nelly Burdette.
  - Incorporated homework assignments, reference manual and monthly conference calls
  - Advanced onsite shadowing option available
  - Received NASW approval for 6 CEU credits

Distinction in BH Integration Module



Adult IBH Expansion

With funding from: 

- 1 year program
- Leveraged key learnings and resources from pilot program
- Added social determinants of health component
- 7 additional practices graduated

Pediatric IBH Expansion

With funding from:

RHODE ISLAND FOUNDATION

UnitedHealthcare

TUFTS Health Plan

- **3-year program; 2 cohorts of 4 pediatric practices**
- **Leveraging key learnings and resources from adult pilot program**
- **Tailoring specifically to pediatrics**
  - **Child Psychologist as practice facilitator/content expert**
  - **Pediatric relevant screening measures**

Tele-IBH and NCQA Collaborative

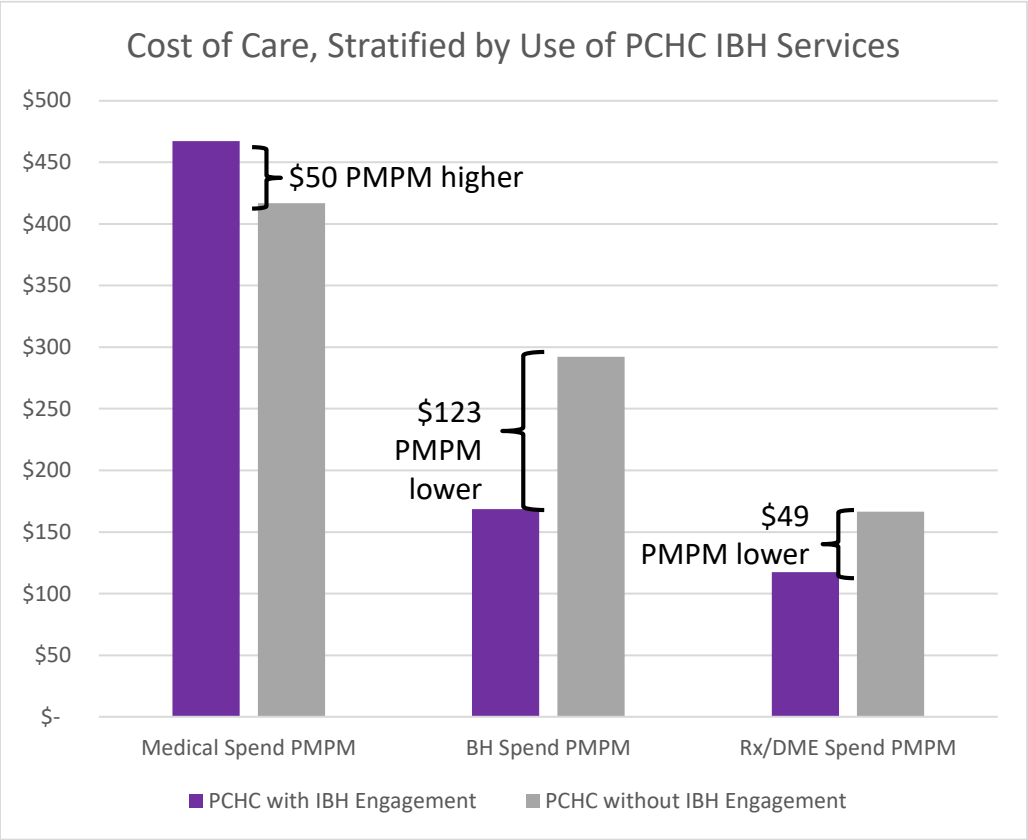
With funding from:

UnitedHealthcare

RHODE ISLAND FOUNDATION

- 1-year program; 2 waves of 11 practices (adult, family and pediatric)
- Option to choose to focus on tele-IBH and/or Behavioral Health Distinction within NCQA
- Practice Facilitation, Learning Collaboratives and Technical Assistance, Incentives up to $10k per site

Sustainability Spotlight



Patients who use IBH services at PCHC are **more likely to be classified as high risk**, and have higher medical spend than patients who have behavioral health needs and are treated elsewhere.

Despite the complexity of IBH patients, they **use significantly less behavioral health services and prescription drugs** when compared to non-IBH patients.

Analysis of Medicaid patients (n = 34,566) with Neighborhood Health Plan who use any BH services (n = 2,845).
Claims from July 2019 – June 2020, reported by NHPRI in Jan 2021.

Main Takeaways

Integrated Behavioral Health in Primary Care Works
Improved access, patient care & reduces costs

Onsite practice facilitation by IBH subject matter experts supports culture change for successful implementation

More action is needed

- APM for Integrated Behavioral Health in Primary Care
- Continue workforce development

Questions

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