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pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Advancing Comprehensive Primary Care Update on Integrated Behavioral Health Program

Care Transformation Collaborative of R.I.

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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.

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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”)

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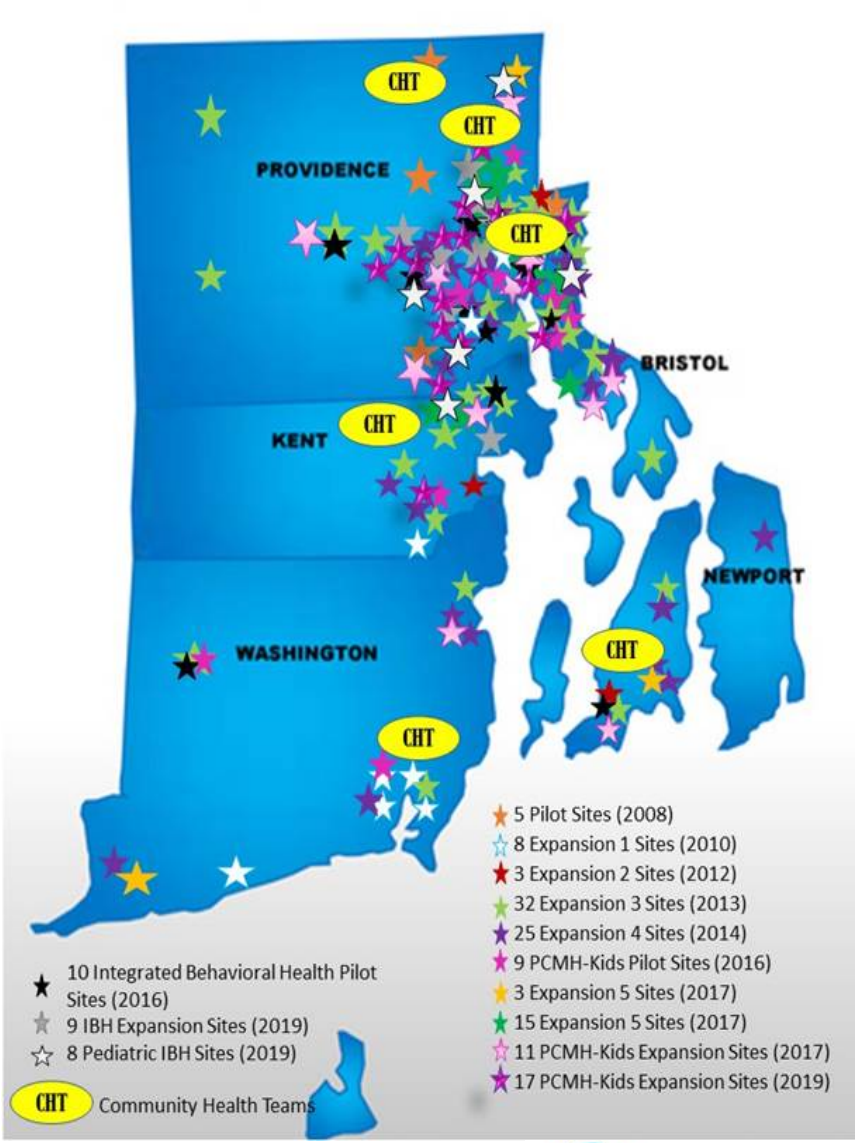
Expanding PCMH

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 **29 primary care practices** which are part of the Integrated Behavioral Health initiative.
  - Approximately **695,000 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.



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Advancing Integrated Behavioral Health in Primary Care

- Presentation of the IBH Pilot Program
  - Unmet Need
  - Project Goals and Audience
  - Program Overview
  - Qualitative Evaluation
  - Screening & APCD Comparative Cost and Utilization Data
- Ongoing IBH Programs

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Unmet Need

- RI ranks in the top 5 of states for severity-based on 13 mental illness indicators.
- 2/3 of RI's mental health clients have at least one serious medical condition.
- In the U.S., most patients with mental health needs rely solely on their PCP.
- Primary care / behavioral health staff have little training in providing integrated behavioral health services in primary care.

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Integrated Behavioral Health Project Goals and Audience

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

Target Audience(s): Ten Patient Centered Medical Home (PCMH) primary care practices serving 42,000 adults

Funding Partners

RHODE ISLAND FOUNDATION

TUFTS Health Plan

State Innovation Model (SIM)

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IBH Program Overview

3-year program with 2 waves of practices

IBH Cohort 1	IBH Cohort 2
Associates in Primary Care	Coastal Medical - Hillside Family Medicine
East Bay Community Action Program (E. Prov & Newport)	Providence Community Health Centers - Capitol Hill
Providence Community Health Centers - Chafee	Providence Community Health Centers - Prairie Ave
Tri-County Community Action	University Medicine - Governor St
Women's Medicine Collaborative	Wood River Health Services

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
- 3 PDSA Cycles: screening, high ED, chronic conditions
- Quarterly Best Practice Sharing: data-driven improvement, content experts

IBH Program Overview Practice Payment: $35,000 over 2 Years

Infrastructure Payment	1st payment: month 1	2nd payment: month 5
$15,000 prorated per 5000 attributed lives	$10,000	$5,000
Incentive Payment	**Year 1: month 12**	**Year 2: month 24**
$10,000 each year for meeting screening targets	Depression: 70% Anxiety: 50% Substance use disorder: 50%	Depression: 90% Anxiety: 70% Substance use disorder: 70%

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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)*

Qualitative Evaluation 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**

Universal Screening and APCD Comparative Cost and Utilization Data

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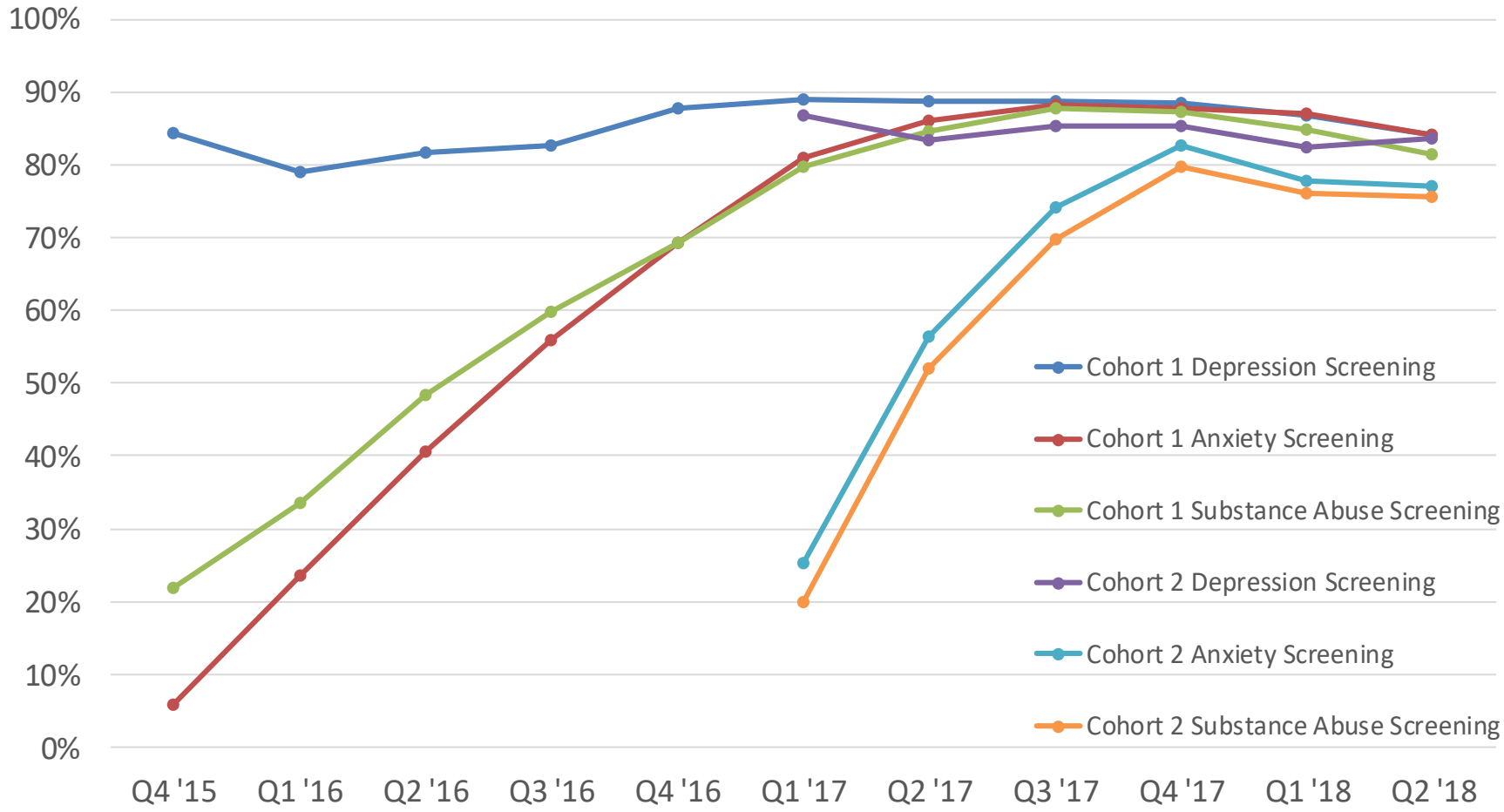
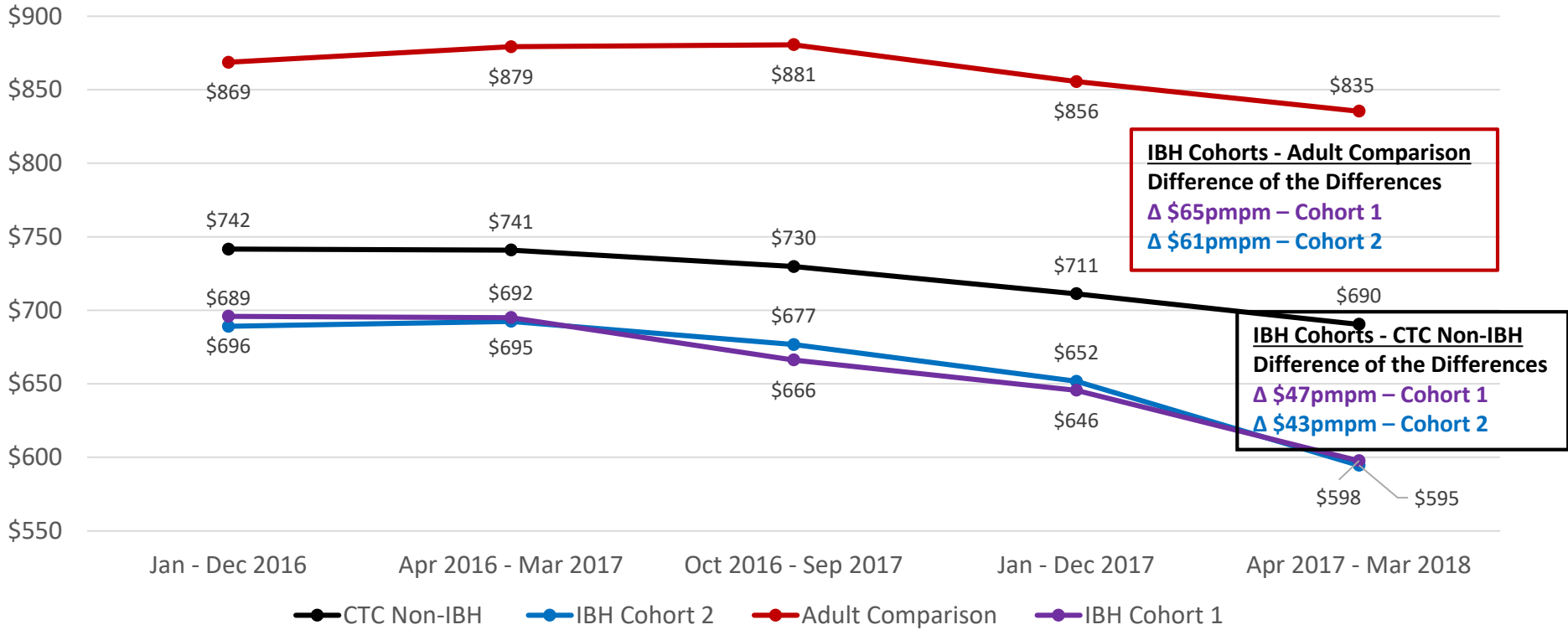
Universal Screening Cohort 1 & 2



Better Care - Lower Costs

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



Data Source: Rhode Island All-Payer Claims Database

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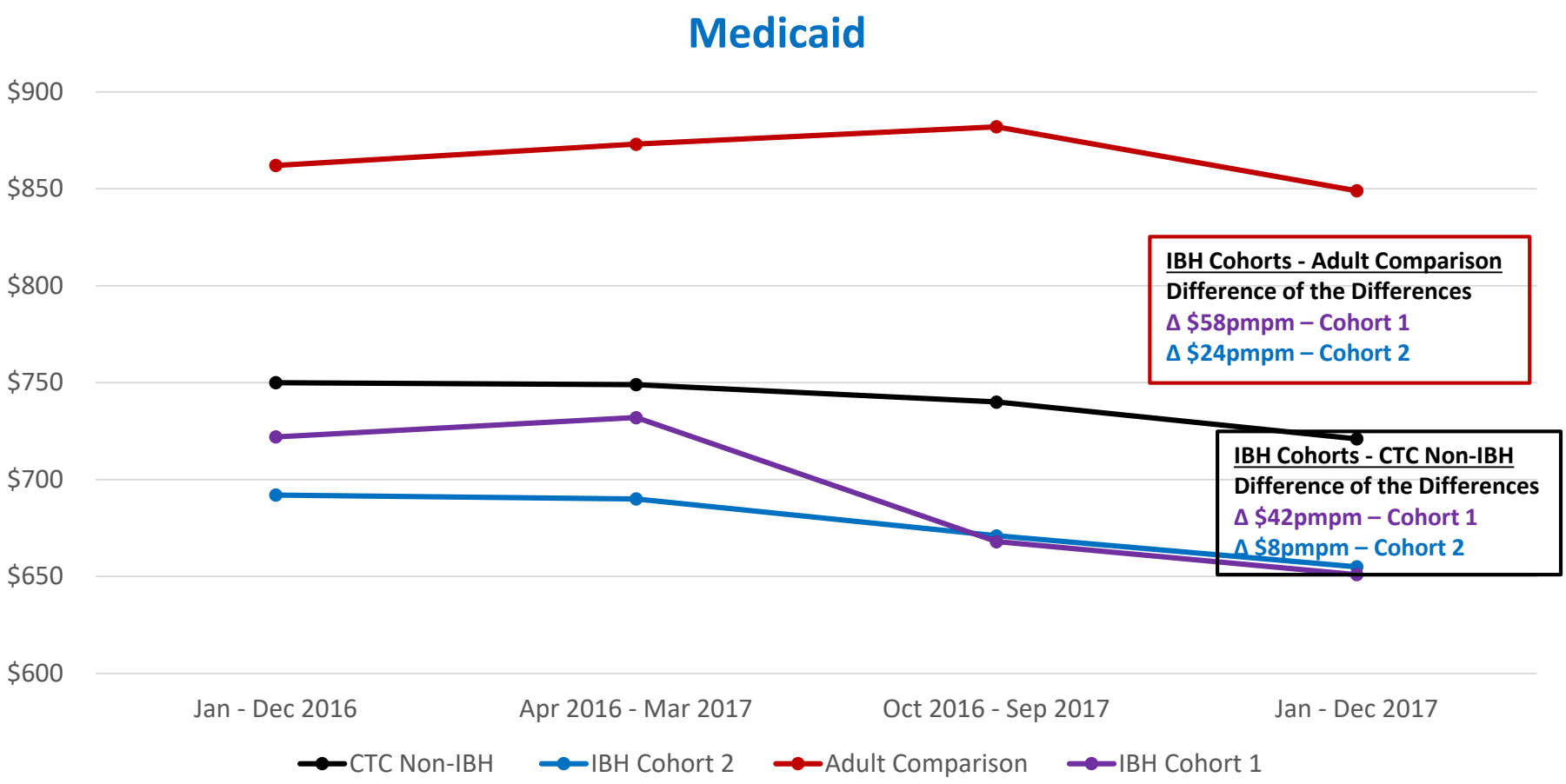

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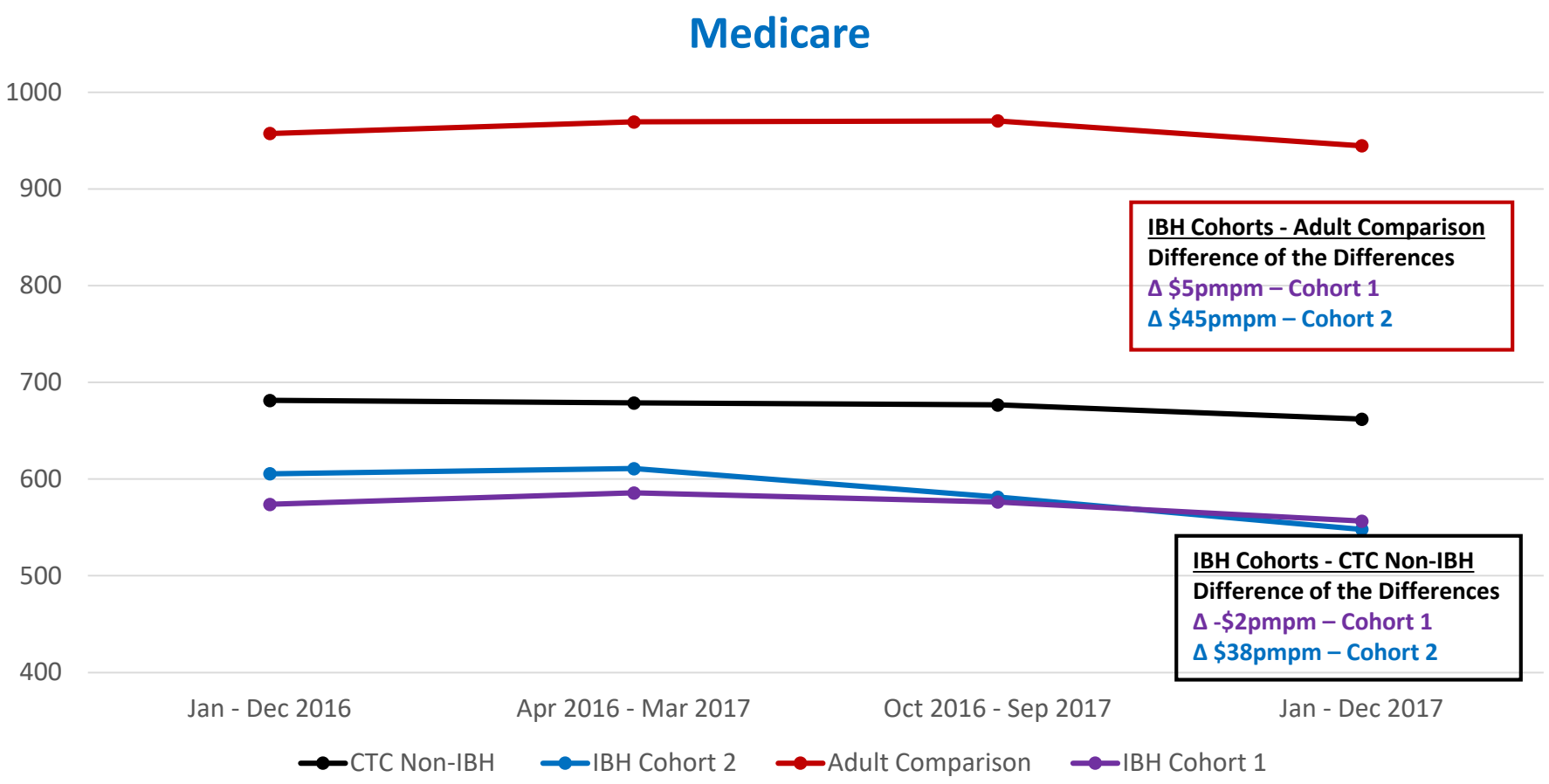
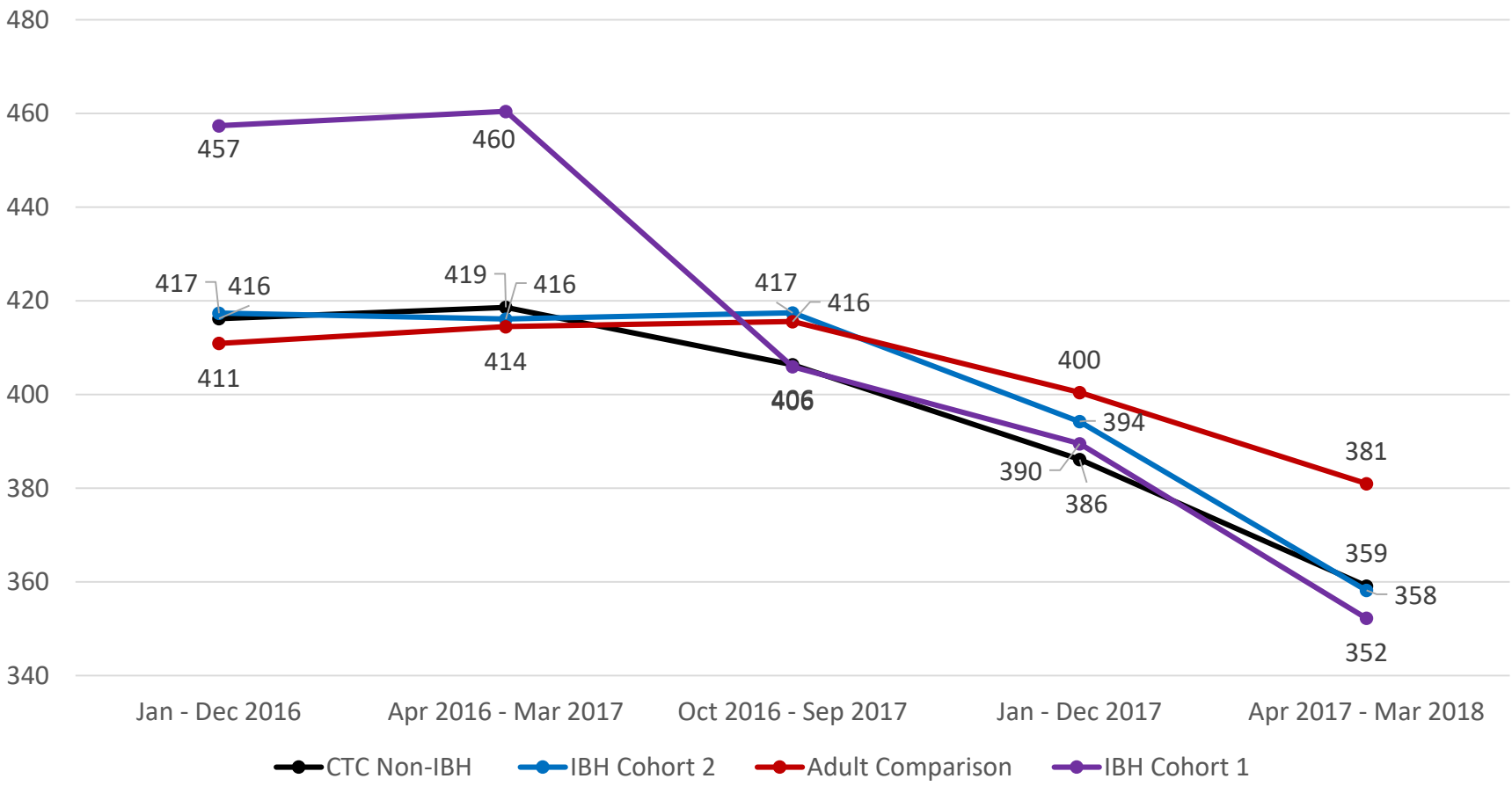


Data Source: Rhode Island All-Payer Claims Database

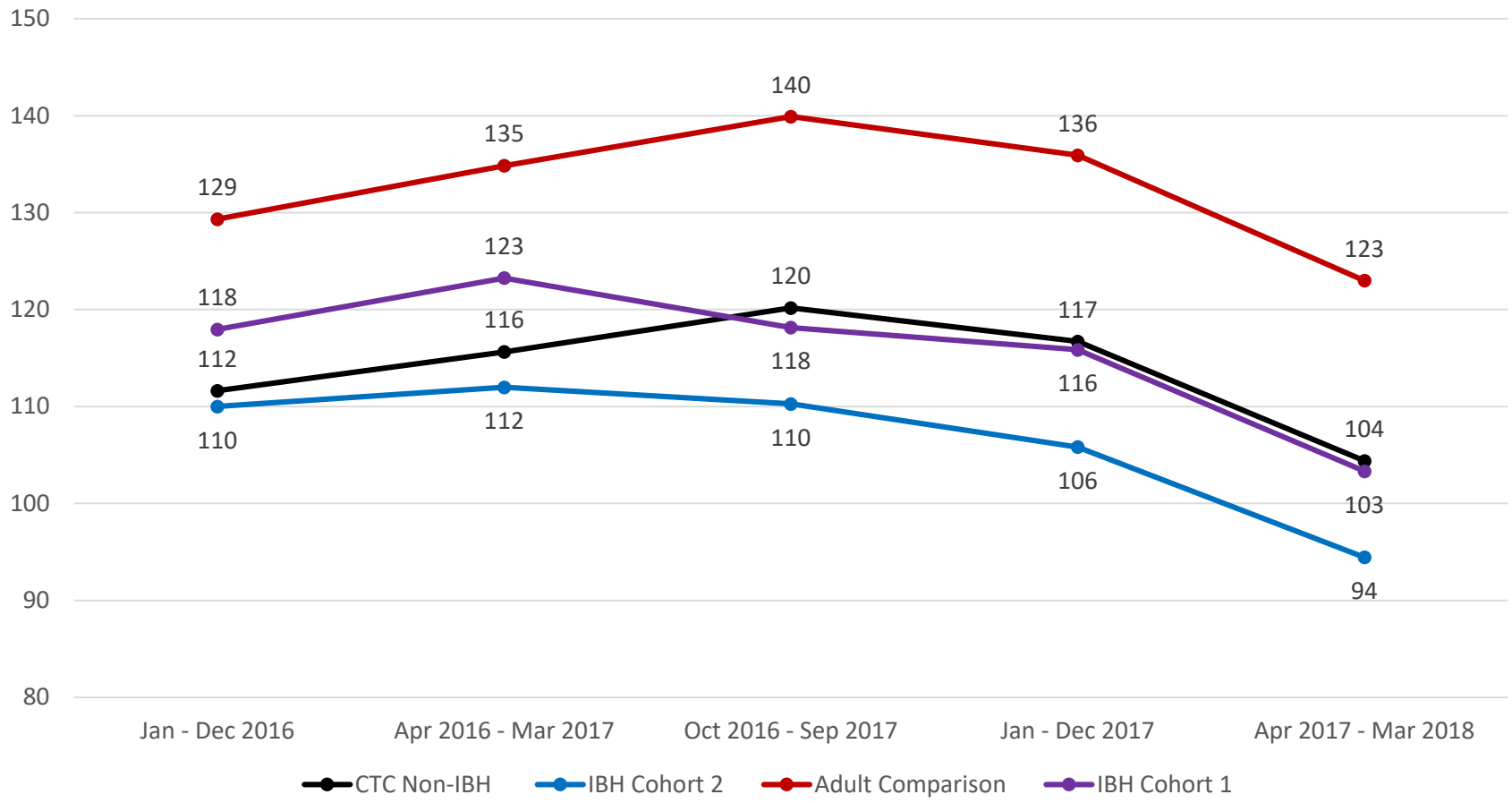
Emergency Department Visits

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



Data Source: Rhode Island All-Payer Claims Database

Inpatient Utilization
Acute Care Discharges
Risk-Adjusted (Visits per 1,000 Member-Years)



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

Ongoing IBH Programs

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Better Care Through Workforce Development : IBH

With funding from: TUFTS Health Plan

- Trained 6 IBH Practice Facilitators
- Developed online web-based IBH Practice Facilitator Training program - NASW approval for 6.5 CEU credits received
- Represents the first training of its kind in the country.

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Adult IBH Expansion

With funding from: UnitedHealthcare

- 1-year program
- Leveraged key learnings and resources from pilot program.
- Added social determinants of health component.
- 7 additional practices successfully completed the IBH program and met criteria for qualifying as an IBH Primary Care Practice.

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Pediatric IBH Pilot Program

With funding from: RHODE ISLAND FOUNDATION

UnitedHealthcare

TUFTS Health Plan

- 3-year program; 2 waves of 4 pediatric practices
- Leveraging key learnings and resources from adult pilot program.
- Tailoring specifically to pediatrics:
  - Child Psychologist for practice facilitating services
  - Pediatric relevant screening measures
  - Pediatric specific content expertise

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Results in One Year

Provider story of how IBH is impacting her practice

- "There are many examples of how having an IBH clinician has helped our office provide **better care to our patients**. This project has been **enormously successful** in helping our patients get services that have been so helpful to them."

- "Emerging from a troubled childhood, this young woman has struggled with anxiety, depression, PTSD, and multiple somatic symptoms and several medical problems for many years. She has not graduated from high school and spends most of her time at home with little energy accomplishing little. My patient has steadfastly refused counseling and feels the many psych medications I have prescribed for her are unhelpful. … My patient finally admitted to Kristi (IBH Clinician) and now to me that the reason she does not want to go back for her GED or apply for jobs is that she really cannot read much at all. Kristi has worked with her on finding literacy resources and we are hoping she can make progress w reading after the pandemic. This patient is more optimistic and **truly benefiting from the IBH input**."

Integra Pediatric IBH

Provider story of how IBH is impacting their practice

“many parents shared with me that our screening program made them much more comfortable having discussions with their children and adolescents about mental health concerns. As we as providers became more comfortable with these discussions - so did our patients and their parents.”

“we developed a reputation in the community as a practice that was able to address the mental health concerns of our patients. We even had new families join the practice because they heard from their neighbors and friends about our screening process and in-office therapy options.”

“one introverted teenage boy told me he was actually excited to come to his annual exam because his sister had just had her exam and told him all about the screening process and how the physicians are willing to talk about "everything". He was able to share his anxieties that had increased over the past few years and without this program I don't think he would have revealed his concerns and sought treatment.”

Next Steps

- **Partnering with Systems of Care:** Spread across the life-cycle
- **Payment Reform:** IBH Alternative Payment Model
- **Legislative Action: C**o-pay and credentialing
- **New IBH Initiatives**
  - NCQA Behavioral Health Distinction
  - Behavioral Health Telemedicine
- **Educate:** Present and publish

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Main Takeaways

Integrated Behavioral Health in Primary Care Works
Improved access, patient care and 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**
- **No copays for behavioral health screenings**
- **Eliminate second copay for same day visit**
- **Continue workforce development**