UnitedHealthcare Report Adult IBH 2019-2020 Program

MARCH 26, 2020

CARE TRANSFORMATION COLLABORATIVE OF RHODE ISLAND

Introduction:

We would like to thank UnitedHealthcare (UHC) for their continued support of CTC-RI's integrated behavioral health training programs. Specifically, in December 2018, UHC provided $200,000 to fund a one-year program that provided monthly on-site IBH practice facilitation and practice infrastructure support for up to 10 primary care practices (family or adult) over a one-year time period. With that funding, practices were eligible to receive a total of $10,000 of financial support. Practices were expected to submit quarterly screening rates for depression, anxiety and substance use disorder, of which a portion of their $10,000 financial support was dependent on meeting stated screening targets. In addition, practices had to submit PDSAs for improving universal screening of depression, anxiety and substance use disorder, and for addressing social determinants of health most relevant to their patient population needs. Practice payments were also used for infrastructure needs, such as EHR adaptations, onboarding behavioral health clinicians and to compensate for provider leadership in assisting the team with meeting service deliverables. In addition to financial support, practices and systems of care had access to and were expected to participate in monthly meetings with a trained IBH practice facilitator and quarterly learning collaboratives to assist them with implementing an IBH program geared towards providing holistic patient centered primary care services.

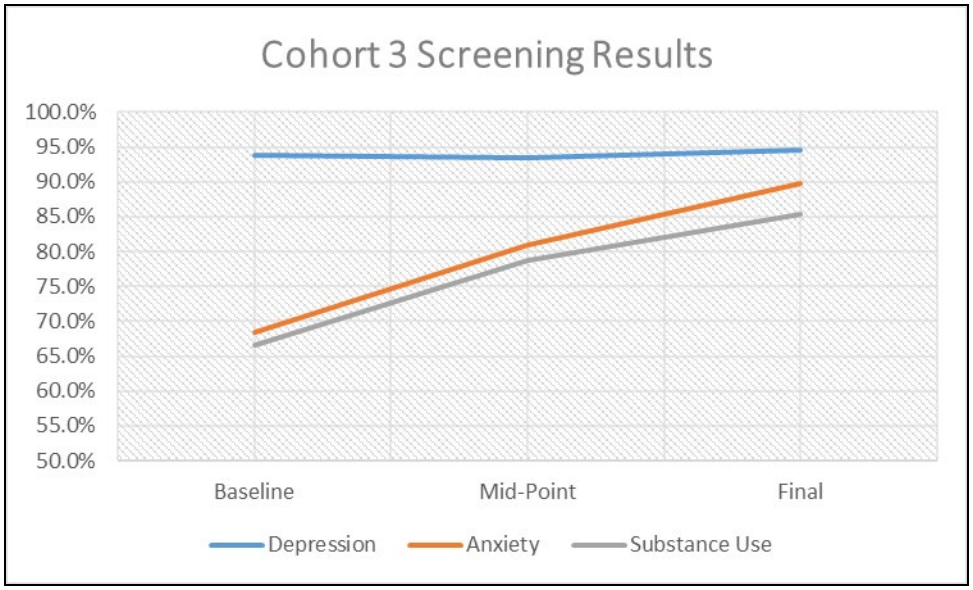
Program Accomplishments:

- In January, 2019, CTC-RI announced the opportunity for adult and family practices to participate in the one-year IBH program. Nine practices applied and were accepted into the program. 2 practices, 1 due to organizational restructuring and 1 due to their inability to find a Portuguese speaking BH clinician were unable to complete the program. Monies made available because of their exiting the program, were diverted to the Pharmacy Quality Improvement project that was launched in February 2020. The seven graduated practices represent ~68,000 covered lives.
- In February, 2019, CTC-RI provided a project overview and reviewed deliverables and expectations for the program at the orientation kickoff meeting. Dr. Nelly Burdette provided an Overview of Universal Screening.
- In May, 2019, practices were expected to report out on their progress and challenges in the 1st three months of the program. Dr. Nelly Burdette reviewed templates and documents available to the practices to assist with their work. Baseline screening rates, billing & coding guidelines, sample adult & pediatric IBH clinician schedules and an IBH Financial Sustainability model were shared.
- In August, 2019, practices were expected to report out on their PDSA plans for improving screening results and update the group on their progress and challenges with behavioral health compacts and hiring plans. Dr. Nelly Burdette reviewed EHR requirements with the group.
- In November, 2019, practices were expected to report out on their PDSA plans for addressing Social Determinants of Health. Linda Cabral provided an Overview of Community Health Team Services that practices might consider for addressing their social determinants of health needs.
- The program wrapped up in February, 2020 with practices reporting out on their screening results and the results of their quality improvement projects to address SDOH needs for their patient population.

Outcomes

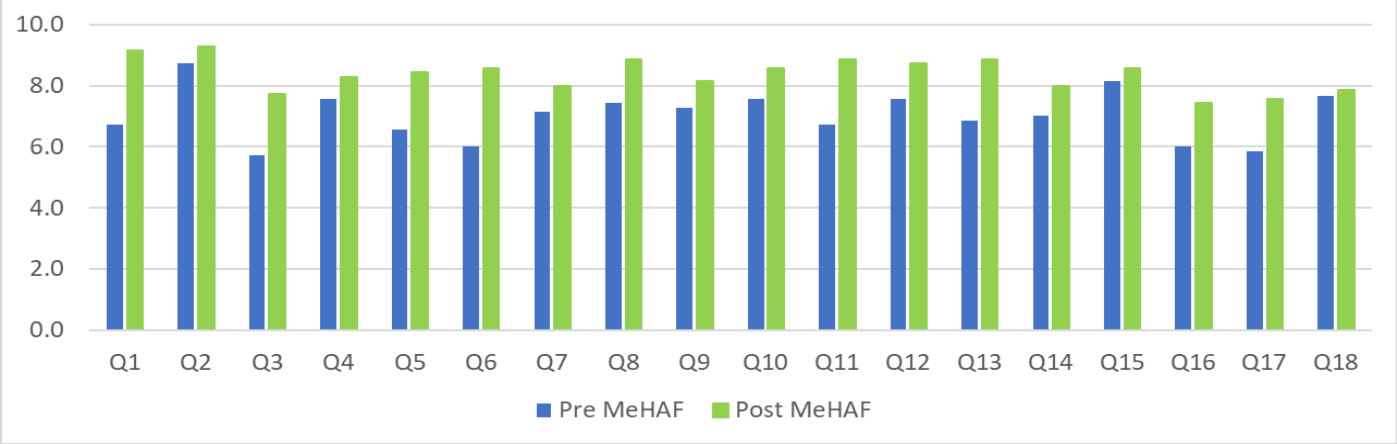
All 7 practices submitted baseline, mid-point and final screening rates for depression, anxiety and substance use and attained target thresholds. In addition, all 7 practices completed PDSA's for improving screening/rescreening rates and addressing SDOH needs of their patient population and presented their key learnings at the wrap session. Practices screened patients using evidence based screening tools, engaged monthly with IBH practice facilitation services and participated in quarterly learning collaboratives.

	Depression			*Anxiety*			*Substance Use Disorder*		
	BL	***Mid***	***Final***	***BL***	***Mid***	***Final***	***BL***	***Mid***	***Final***
Screening Incentive Thresholds		***85%***			***60%***			***60%***	
BVCHC	94.9%	96.9%	95.8%	1.5%	45.5%	87.1%	6.6%	36.4%	69.8%
Brown Medicine	93.7%	86.4%	91.3%	85.2%	72.5%	71.4%	84.8%	71.6%	69.7%
PCHC Central	96.4%	98.1%	98.6%	96.1%	97.3%	97.1%	95.7%	97.0%	96.7%
PCHC Crossroads	97.6%	96.3%	95.8%	16.9%	82%	92.2%	3.4%	80.1%	89.2%
PCHC Randall Sq	93.1%	91.0%	89.9%	93.6%	93.9%	94.5%	92.5%	93.4%	93.8%
Tri County	88.8%		97.0%	88.9%		91.7%	85.5%		85.6%
Women's Medicine	92.4%	91.8%	92.8%	96.7%	93.8%	94.4%	96.9%	93.3%	93.1%
Average	93.8%	93.4%	94.5%	68.4%	80.8%	89.8%	66.5%	78.6%	85.4%



Self-Assessments Improvement

All 7 practices submitted pre and post self-assessments using the MeHAF self-assessment tool. Here are their combined results.



Areas most improved:

- Q6. Communication with patients about integrated care
- Q1. Colocation of treatment for primary care and mental/behavioral health care
- Q11. Patient care team for implementing integrated care
- Q3. Treatment plan(s) for primary care and behavioral/mental health care
- Q13. Continuity of care between primary care and behavioral/mental health

Impact on ED, Inpatient and TCOC utilization measures

CTC utilizes the All-Payers Claims Database through Onpoint's performance reporting portal to compare ED visits, Inpatient visits and Total Cost of Care vs comparison groups' performance. At this time, only 1 data point is available for Adult IBH Cohort 3. We expect to be able to report out on the impact this program has had on these measures in 2021.

Lessons Learned: Key Takeaways

1) Working with sites for one year, who already had established integrated behavioral health, led to more advancements in that time than those sites who had less established integrated behavioral health. Previous CTC IBH Adult pilot (funded by the Rhode Island Foundation) was 2 years in length. For primary care sites starting with little-no integrated care, 2 years seemed to provide just enough time to meet all of the deliverables without feeling strained. It is likely that 18 months might be a better minimum to consider for future initiatives when sites are starting from a basic level with integrated care. One year might be more appropriate for sites who already have IBH services in place and had more capacity to focus on meeting patient social needs as well as behavioral health needs
2) Universal screening for depression, anxiety and substance use is becoming more easily adopted by both patient and health care systems. As technology advances occur and screening questions can be asked with the aid of technology, there is less burden on healthcare workers and more openness in discussing depression, anxiety and substance use in the primary care setting. There continue to be many sites who opt to not bill for these screenings, even when there is an option to do so, because billing mechanisms are not uniform and have varying levels of complexity that office managers and billing staff are struggling to understand. It is hoped that the practices will continue to universally screen all patients post-pilot in spite of questions related to sustainability of this practice.
3) Social Determinants of Health (SDOH) was a new initiative for most of the sites involved. There was considerable hesitation initially in even thinking through where to start for most sites. Having the practice facilitator work with the sites, using a content-expert and evidence-based approach to SDOH, led the sites by and large to become more open to trialing many different approaches to their populations served. Every site took a step towards better identifying and understanding their populations' SDOH needs. Success was measured by better understanding and devising an intervention around SDOH with every site succeeding.
4) In this pilot, we incorporated "lessons learned" from the previous IBH pilot, such as : asking the system of care for a letter of support as part of the application process, incorporating IT as part of the practice core planning team, having a two month planning time prior to implementing universal screening, developing tools such as scheduling templates, Return on Investment (ROI) projection tools , billing and coding guidelines, and offering training on billing & coding earlier in the process.
5) Primary care practices with more behavioral health experience were asked to focus their screening/rescreening PDSA plans on improving warm hand-offs, which led to some very interesting discussions.