



ADVANCING INTEGRATED HEALTHCARE

Advancing Comprehensive Primary Care: Update on Integrated BH Program

Care Transformation Collaborative of Rhode Island

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MAY 21, 2019



CTC-RI Overview

The State's only multi-payer clinical and payment transformation organization.

- **Established in 2008 – incorporated as a 501c3 in 2015 – 23 member Board with broad stakeholder representation**
 - **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.



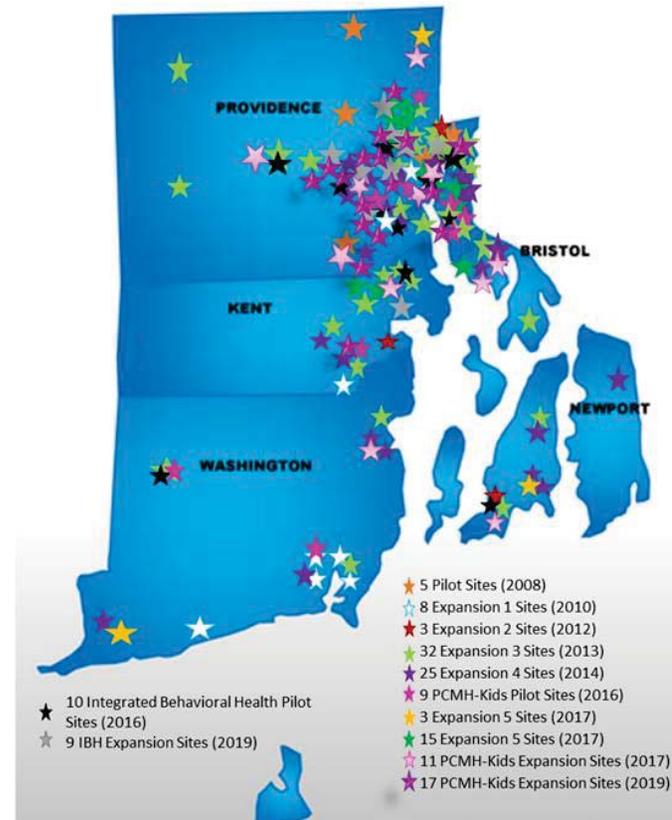


- Increase Capacity and Access to Patient-Centered Medical Homes (PCMH)
- Improve Quality and Patient Experience
- Reduce Cost of Care
- Improve Population Health
- Improve Provider Satisfaction (“Fostering joy in work”)

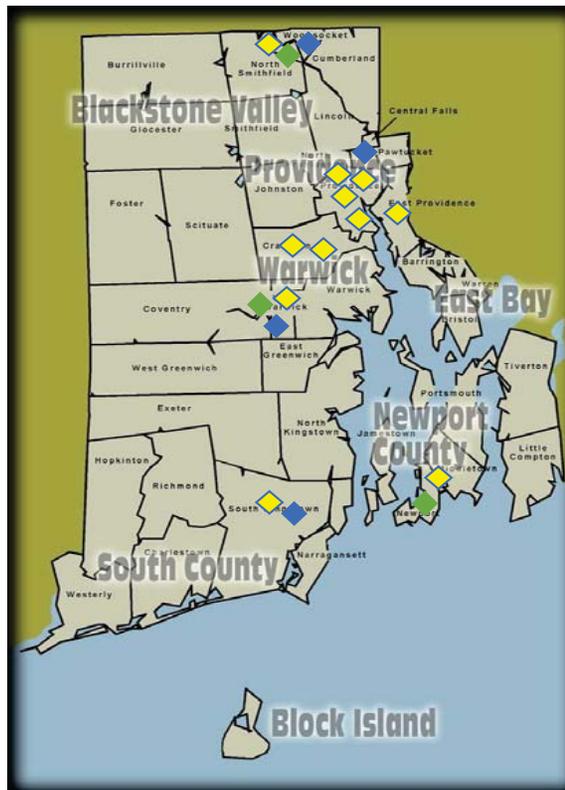
Expanding PCMH

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

- **124 primary practices**, including internal medicine, family medicine, pediatric practices; 19 adult primary care practices are part of 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.
- CTC practices demonstrate **lower total cost of care by \$217 million in 2016** when compared to non-patient centered medical homes in Rhode Island, according to data from the state's All-Payer Claims Database.



Expanding Care in the Neighborhoods



CHT and SBIRT locations:

- Woonsocket
- Blackstone Valley
- Providence
- West Warwick
- Newport
- South County
- New Existing

SBIRT locations:

- Several sites including:
 - Dept of Corrections
 - Kent Hospital
 - Butler Hospital
 - CCAP
 - RIPIN
 - The Providence Center

Advancing Integrated Behavioral Health in Primary Care

Presentation of the IBH Pilot Program

- Unmet Need
- Project Goals and Audience
- Program Overview
- Qualitative Evaluation
- APCD Comparative Cost and Utilization Data
- Workforce Development
- Sustainability
- Main Takeaways



Unmet Need

- RI ranks 5th nationally for severity based on 13 mental illness indicators.
- RI ranks 7th nationally in opioid overdose deaths.
- 2/3 of RI's mental health clients have at least 1 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.

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): 10 Patient-Centered Medical Home (PCMH) primary care practices serving 42,000 adults



Funding Partners



State of Rhode Island



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

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%

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)*



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

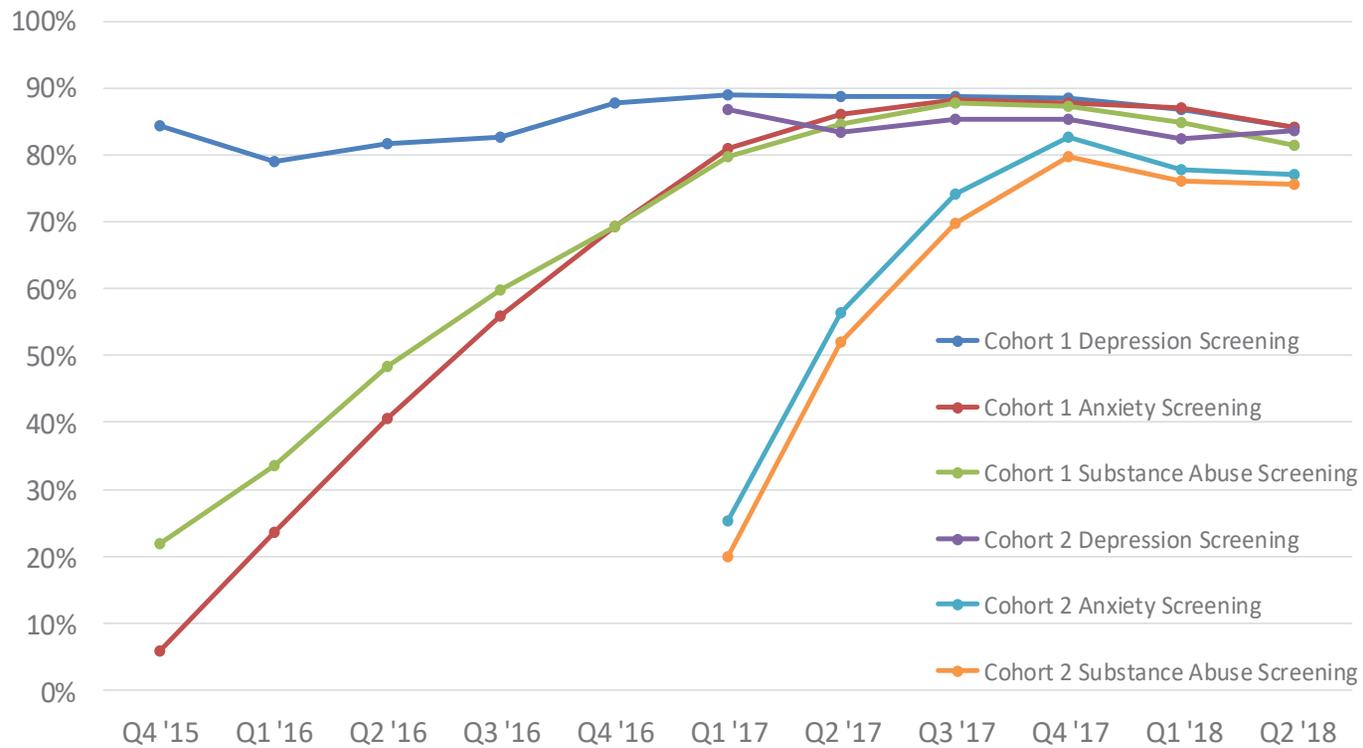
What Would Be Helpful Post-Pilot

- ❖ **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**

Screening and Utilization Outcome Results

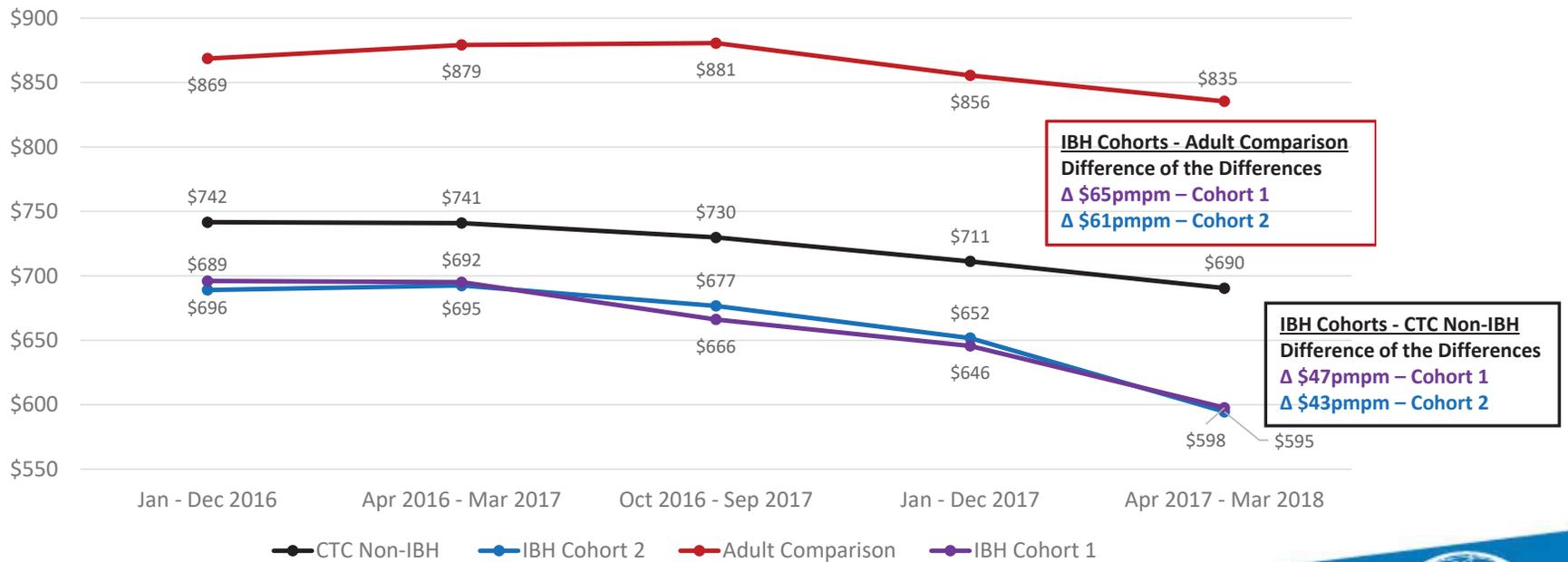


PDSA: Universal Screening Cohort 1 & 2



Better Care - Lower Costs

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

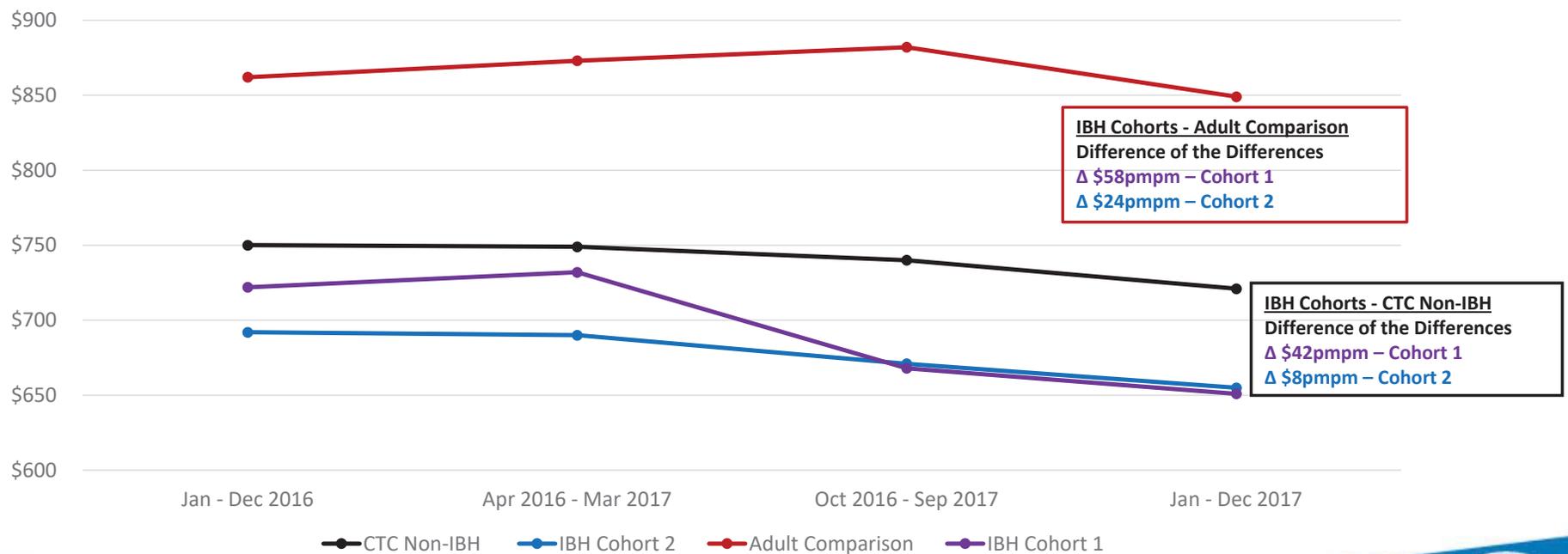


Data Source: Rhode Island All Payer Claims Database



Total Medical & Pharmacy Costs (with Exclusions) Risk-Adjusted

Medicaid

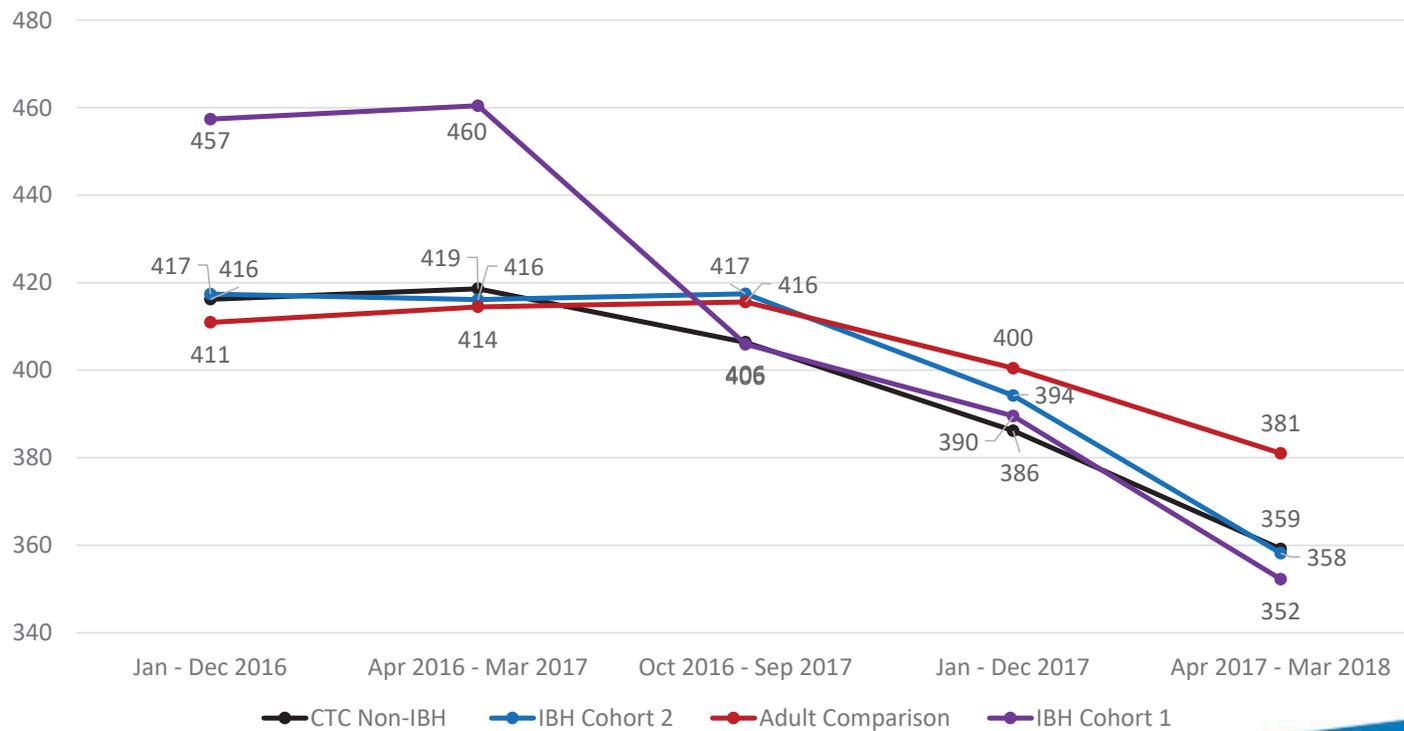


Data Source: Rhode Island All Payer Claims Database



Emergency Department Visits

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

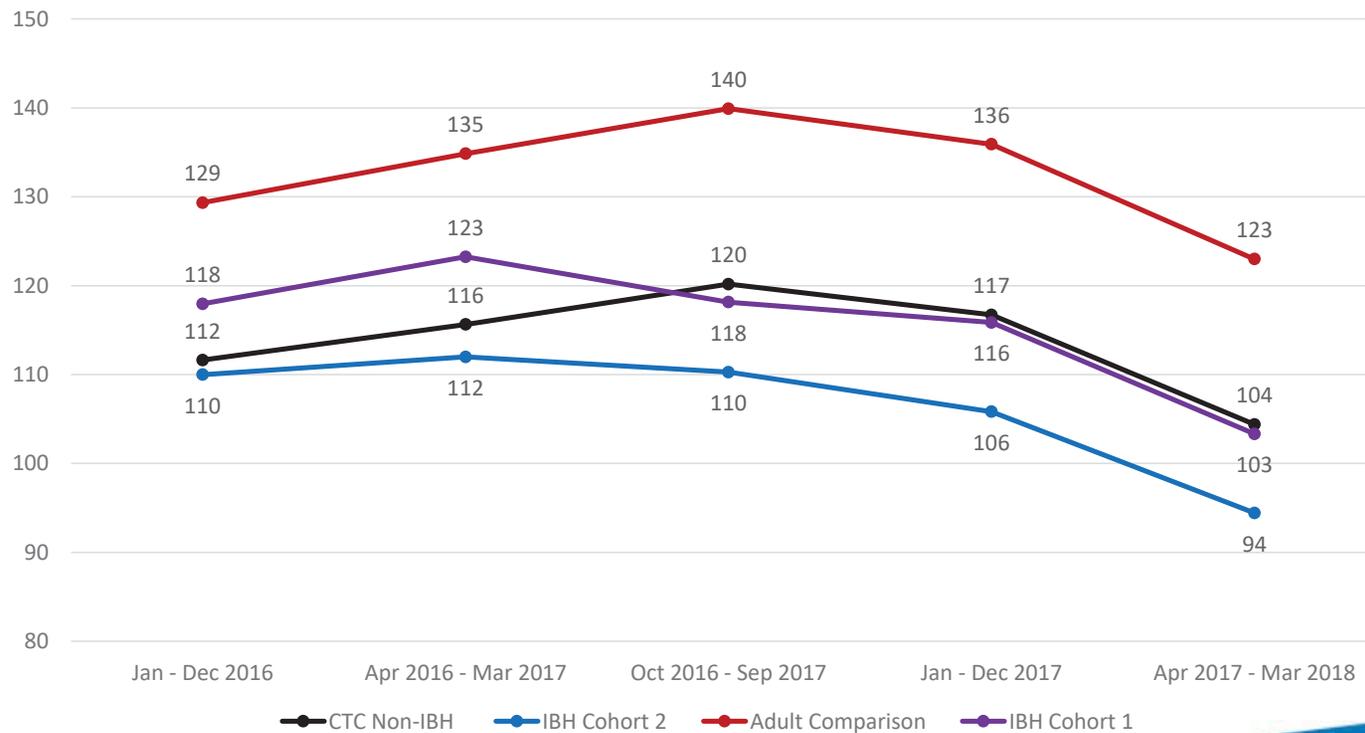


Data Source: Rhode Island All Payer Claims Database



Inpatient Utilization Acute Care Discharges

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



Data Source: Rhode Island All Payer Claims Database



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.



Next Steps / Sustainability

- **Quantitative Evaluation** - Brown University – APCD data using a matched comparison group due out Q2- 2019
- **Partnering with Systems of Care:** spread across the life cycle
- **Payment Reform:** IBH Alternative Payment Model
- **Legislative Action:** co-pay and credentialing
- **Educate:** Present and publish

Main Takeaways

Integrated behavioral health in primary care works with 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
- No copays for behavioral health screenings
- Eliminate second copay for same day visit
- Continue workforce development
- Credentialing

Questions

