Advancing Comprehensive Primary Care - Update on Integrated BH Program

Care Transformation Collaborative of R.I.

BREAKFAST OF CHAMPIONS

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Advancing Comprehensive Primary Care

- CTC-RI Integrated Behavioral Health Model
  - Program Overview
  - Qualitative Eval/learning from other states
  - Comparative Cost and Utilization Data

Program Overview

3 year program with 2 waves of practices

- IBH Cohort I - Feb 2016
- IBH Cohort II - November 2016

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 Practice Facilitation to support culture change, workflows, billing
- Universal Screening depression, anxiety, substance use disorder
- IBH Clinician part of care team, (ideally) pre-visit planning, huddles
- Quarterly Best Practice Sharing (monthly IBH Comm Meetings)
- Three PDSA Cycles (screening, high ED, chronic conditions)
- Data Reporting

Qualitative Evaluation Report CTC Integrated Behavioral Health Pilot Program Overview

Mardia Coleman, MD and Roberta Goldman, PhD

1. Literature review
2. Document and website reviews
3. Site visits to each practice
4. Individual or small group key informant qualitative interviews and data analysis

Medical Provider Quote

"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."

Findings: Provider and Staff Perceptions of IBH are Predominantly Positive

Provider and staff experience	Perceptions of patient experience	Clinical outcomes
• Treats the whole patient • Immediacy of IBH • Team-based care • MAs are key • New/added responsibilities	• Reduces stigma • Increases access to BH • Better care management • But need patient satisfaction data	• Patients learn self-management skills • Reduced ED use • Increased tx compliance • Providers want more data

Findings: Foundational Activities

Laying the foundation	Site preparation	Infrastructure and workflows

• CTC-RI model and requirements were basis for program implementation	• IBH experience, training important
	• Limited/no time
	  • Staff engagement
	  • Cultural barriers
	  • Manage expectations
	  • Organizational readiness
		• Limited/no time
		  • EHR modifications
		  • Patient tracking system or registry
		  • Test and refine workflows

Findings: Implementation

CTC-RI requirements	Practice facilitation, PDSAs	Processes and workflows	Oversight, quality improvement
• Sites implemented the CTC-RI model • Each site's program reflects its organizational needs, values, resources	• PF = technical support • PF = ad hoc project management • PDSAs—mixed results, opportunities	• Location, warm handoffs • Communication • CHCs, ACOs staffing • EHR limitations • Use of students	• Dedicated manager • Initiating and maintaining staff engagement • Training new staff • Using data

Findings: Sustainability

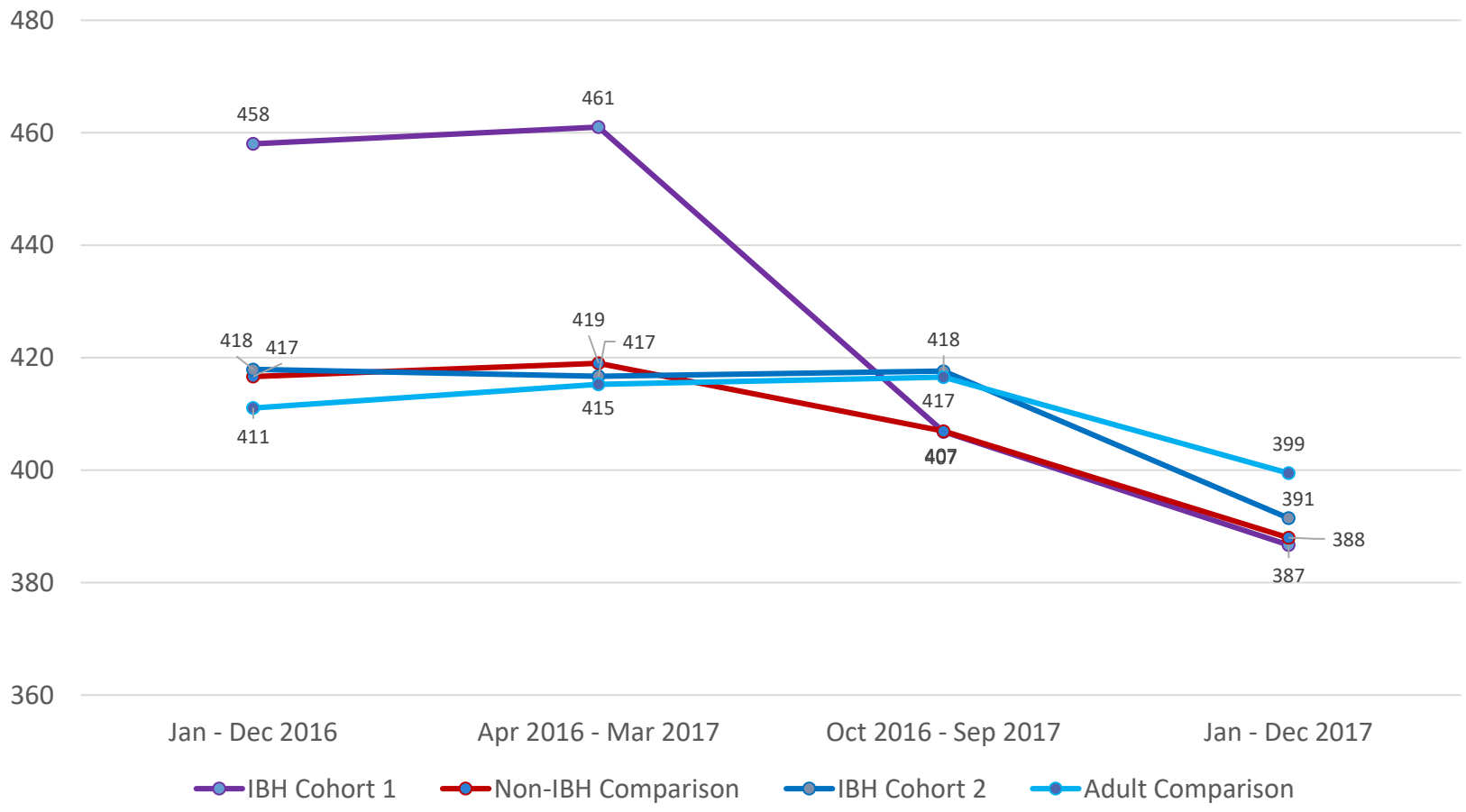
Copays	Billing and coding	Students provide clinical services	Invisible costs
• Overall barrier to treatment • Copays vary and are higher than PCP copays • Equity issues	• Range of code use • Targeted technical assistance needed • Billing for OBH can bring in revenue to help pay IBH salaries	• Social work and psychology students • Further study	• Increased workloads, time to implement • Program, not a pilot

Preliminary Data Results From RI All-Payer Claims Database

- ED utilization and costs
- Inpatient utilization and costs
- Total Cost of Care

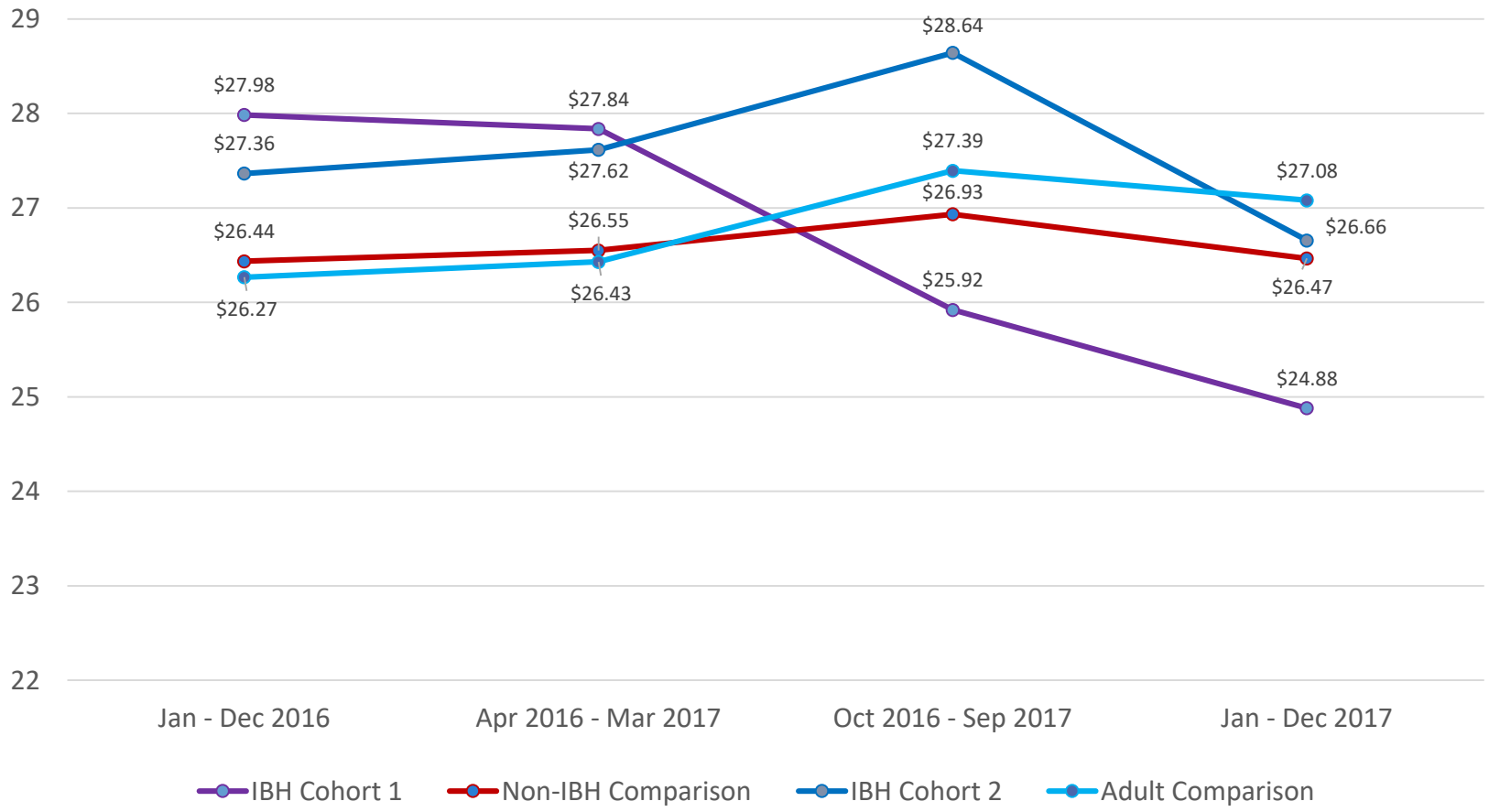
Emergency Department Visits

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



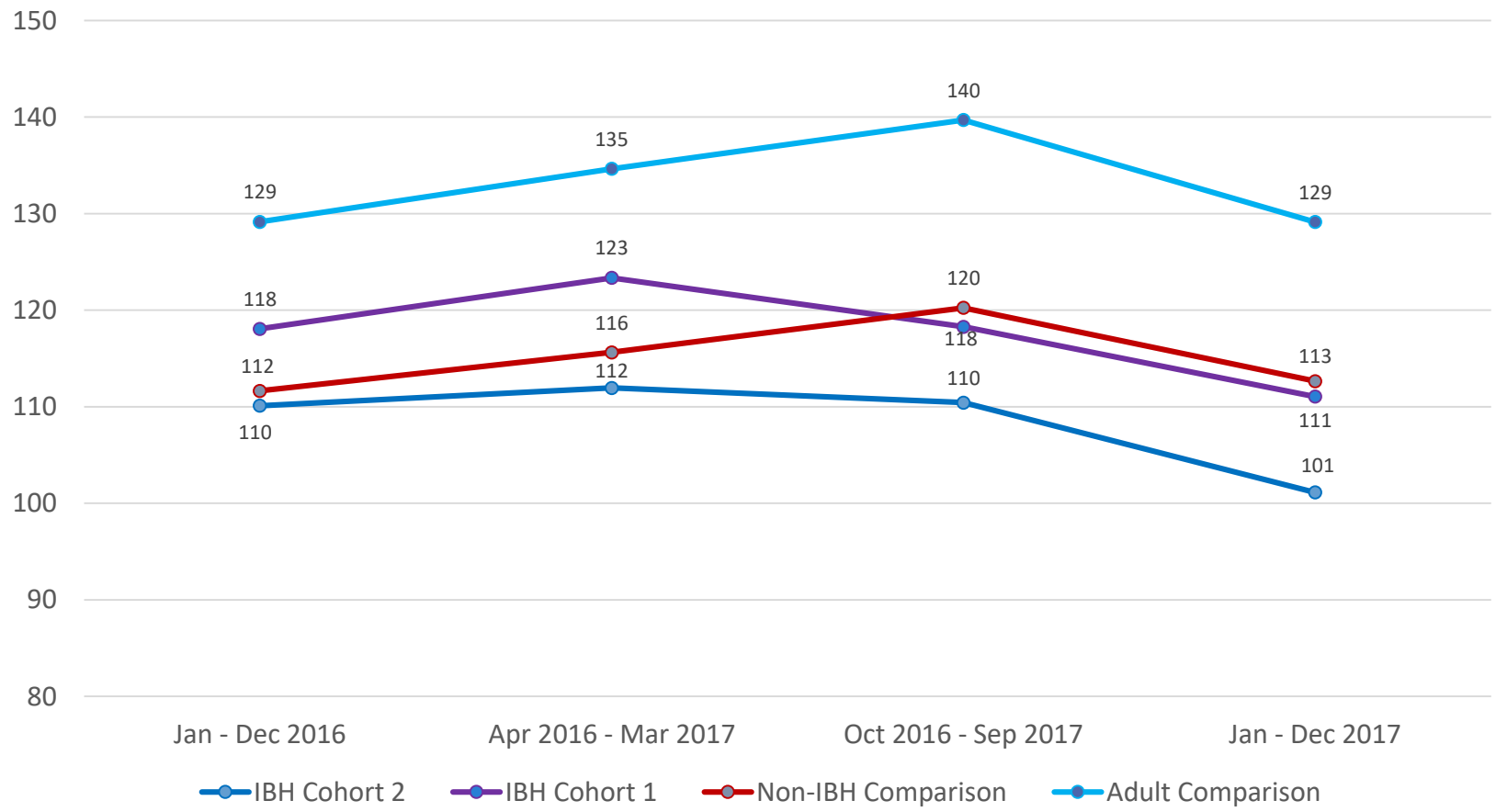
Emergency Department Costs

Risk Adjusted (Cost per Member-Month)



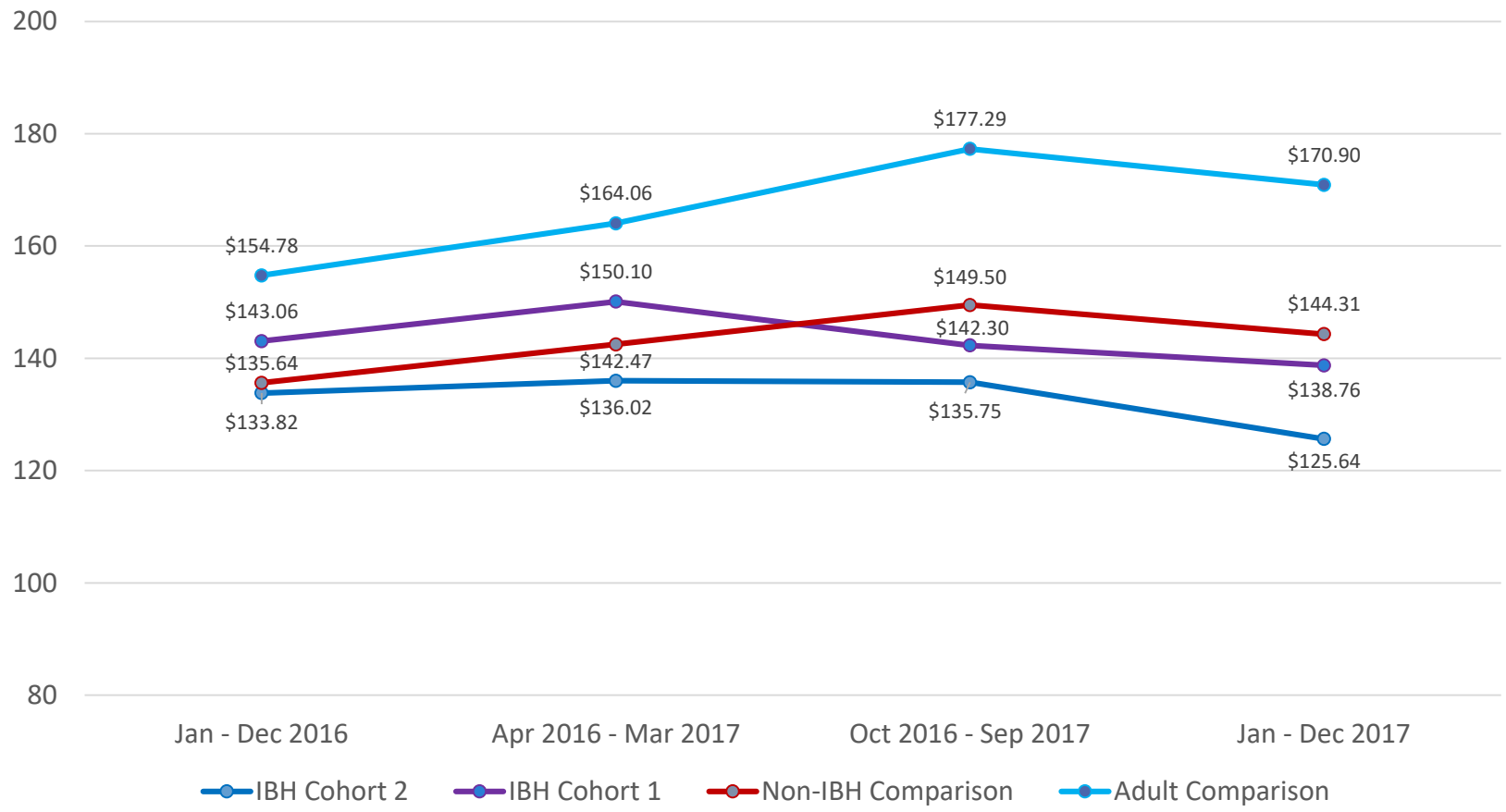
Inpatient Utilization - Acute Care Discharges

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



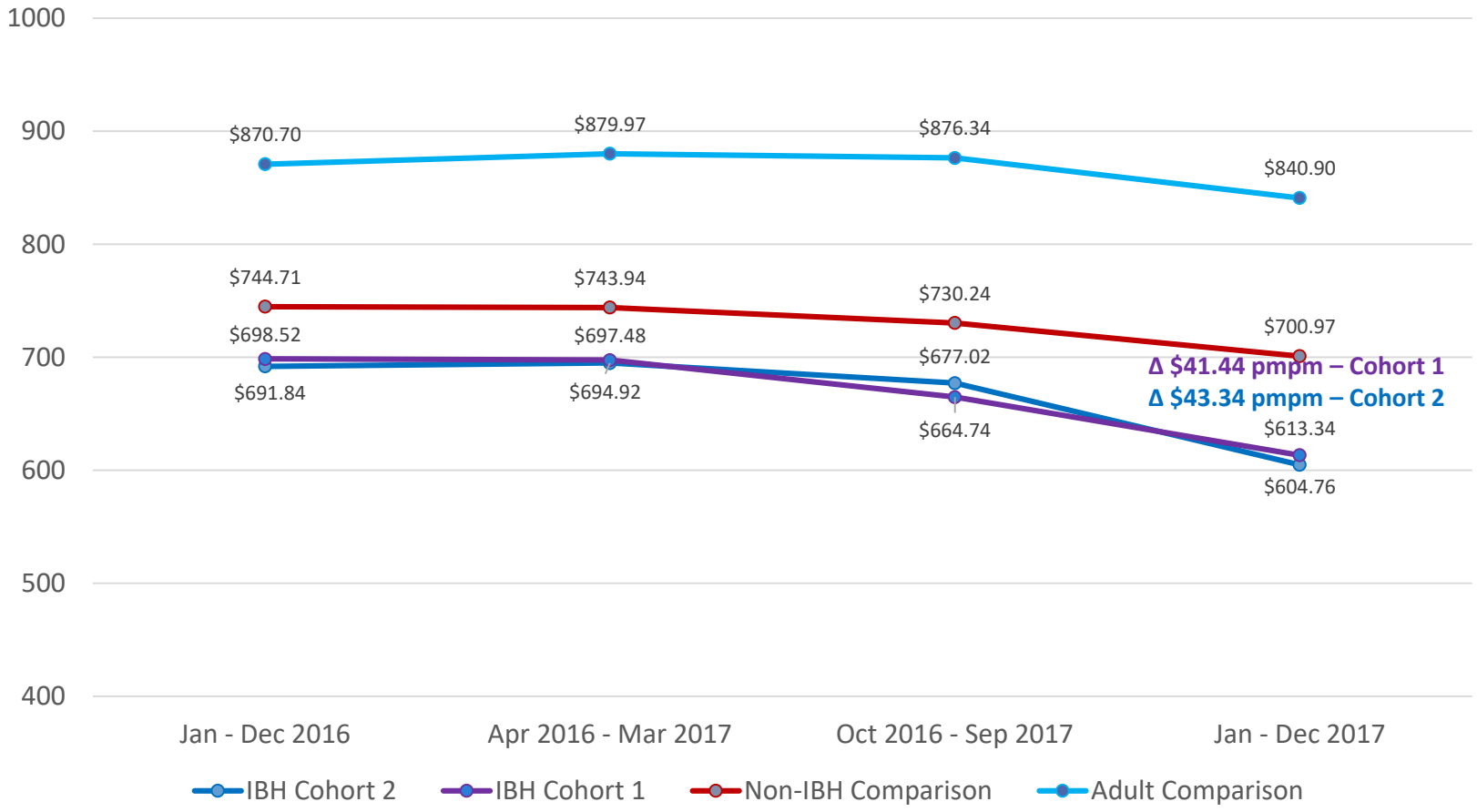
Inpatient Utilization - Acute Care Discharge Costs

Risk Adjusted (Cost per Member-Month)



Total Medical & Pharmacy Costs (with Exclusions)

Risk Adjusted (Cost per Member-Month)



Announcements

- Practice Transformation/Reporting Committee
- Annual Conference Nov 1 – Please register
- Next Breakfast of Champions Feb 8, 2019

NEXT