Integrating Physical and Behavioral Health: The View from Primary Care Providers and Payers

July 17, 2018
Welcome & Announcements

• Welcome – Robert Dribbon, PCPCC Executive Member Liaison

• PCPCC Annual Conference – Key Policies to Elevate Primary Care
  ➢ Washington, DC, November 8, 2018
  ➢ Registration: www.pcpccevents.com

• Members Only Workshop: Investing in Primary Care – Advancing a National Strategy
  ➢ Immediately following the PCPCC annual conference, Executive Members are invited to an exclusive workshop on November 9, 2018
  ➢ Registration: www.pcpccevents.com

• Stay tuned for the release of PCPCC’s annual Evidence Report on 8/8/2018

• Interested in PCPCC Executive Membership?
  ➢ Email Allison Gross (agross@pcpcc.org) or visit: www.pcpcc.org/executive-membership
Panelists

**Moderator: Robert Dribbon**
PCPCC Executive Member Liaison
Merck

**James Schuster, MD, MBA**
Chief Medical Officer of Medicaid, SNP, and Behavioral Services
VP, Behavioral Integration
UPMC Insurance Services Division

**Bruce Landon, MD**
Professor of Health Care Policy
Harvard Medical School

**Russell Phillips, MD**
Director
Harvard Medical School Center for Primary Care

**Reactor: James Kingsland**
President
National Association Primary Care
Strategies for Behavioral Integration into Primary Care: Implications from a Microsimulation Model

Bruce Landon, M.D., M.B.A.
Department of Health Care Policy, Harvard Medical School
Division of General Medicine and Primary Care, BIDMC

Russel Phillips, M.D.
Director, Center for Primary Care, Harvard Medical School
Division of General Medicine and Primary Care, BIDMC

PCPCC Webinar on Behavioral Health Integration
July 17, 2018
Mental Health Problems are Common

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Mod/Severe</th>
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<tbody>
<tr>
<td>Anxiety</td>
<td>18.1</td>
<td>56.5</td>
</tr>
<tr>
<td>Mood</td>
<td>9.5</td>
<td>85</td>
</tr>
<tr>
<td>Impulse Control</td>
<td>8.9</td>
<td>85.3</td>
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<tr>
<td>SUD</td>
<td>3.8</td>
<td>66.6</td>
</tr>
<tr>
<td>Any</td>
<td>26.2</td>
<td>59.6</td>
</tr>
</tbody>
</table>

And Most Mental Health Care Occurs within Primary Care
MH Care in Primary Care

- Lack of reimbursement for screening and prevention
- Lack of (until recently) reimbursement for collaborative care and case management
- Inability to bill solely for mental health services (many Medicaid programs)
- Limitations in the ability to bill for physical and mental health services in the same visit (e.g., time based and non-time based billing)
- Lack of training and comfort level

https://www.integration.samhsa.gov/Reimbursement_of_Mental_Health_Services_in_Primary_Care_Settings.pdf
Yet, Collaborative Care Improves both Mental Health and Physical Health

<table>
<thead>
<tr>
<th></th>
<th>Collaborative Care</th>
<th>Usual Care</th>
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<tbody>
<tr>
<td>Global Improvement</td>
<td>45</td>
<td>18</td>
</tr>
<tr>
<td>&gt;1% ↓ in A1C</td>
<td>36</td>
<td>19</td>
</tr>
<tr>
<td>&gt;10 point ↓ in SBP</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>&gt;50% ↓ in SCL score</td>
<td>60</td>
<td>30</td>
</tr>
<tr>
<td>Satisfaction with Depression care</td>
<td>90</td>
<td>55</td>
</tr>
<tr>
<td>Satisfaction with chronic care</td>
<td>86</td>
<td>70</td>
</tr>
<tr>
<td>Quality of life</td>
<td>6.0</td>
<td>5.2</td>
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</table>

Using Simulation Modeling to Inform Policy

• Practices and policy-makers lack tools to estimate impacts of new practice and payment models on practice finances and outcomes
• Current practice structures are not optimized to deliver high value care
Key Assumption

• It is not rational to expect primary care practices to implement changes that adversely impact their costs or revenues
Why model?

- Used extensively in other fields to model investment and financial decisions
- A “safe space” to write down all possible assumptions and scenarios before piloting
- A technique to determine which decisions have low-uncertainty and which have high-uncertainty (identify future research needs)
- Broaden generalizability beyond single pilot projects

IOM, 2011
Our Approach

• A microsimulation
  – What it is
    • A simulation of individuals in a population
  – Advantages:
    • Simulates individual patients with complex histories and co-morbidities
    • Simulates individual clinics with complex panels, staff, costs, and revenues
    • “High data, low assumption” modeling
    • Can capture complex non-linear relationships and feedback loops
    • Very flexible: can add queues, vary clinic types, and change fundamental structures in the model
  – Disadvantages:
    • Lots of computer power needed
    • Lots of data needed
New Medicare Payment Approach: Collaborative Care Model

- Involves care plan development often including pharmacotherapy from the PCP, RN/master-level behaviorist follow-up care by phone
- Requires periodic psychiatrist or psychiatric NP/PA review for Medicare payment
- Three new Medicare Part B CoCM Codes
  - G0502 – Initial 30 min behaviorist session w/ 70 min/month overall care management/staff effort
  - G0503 – Each 26-min behaviorist follow-up w/ 60 min/month of care management
  - G0504 – Each additional 13-min of provider visit time w/ 30 min/month of care management
New Medicare Payment Approach: Primary Care Behaviorist Model

- PCB M involves in-person care by primary care behaviorist (PhD psychologist or LCSW) in brief, time-limited behavioral treatments
- PCB M can be paid via traditional billing mechanisms for psychologist/LCSW visits
- Also can be paid under new Part B behavioral health services codes
  - G0507 – 15 min of behaviorist provider time w/ at least 20 min/month care manager time
  - G0507 provides higher payments per period as compared to traditional codes for routine psychotherapy, psychological testing, and health and behavioral assessment
Collaborative care

Patients affected:
depression,
anxiety,
alcohol,
substance use,
tobacco use

Patients found through:
- screening (PHQ4, AUDIT-C, tobacco)
- passive detection

Initial assessment and treatment plan:
- PCP

Follow-up:
- care manager: RN or Masters-level BH specialist via phone
  - PCP for psychotropics

Duration:
- 4 to 12 months
  - adherence, response assessments

Severe, high risk, and treatment-resistant patients:
  referral

Costs/revenues

Care manager training, salary and training for coordination with PCPs, office space for care manager, registry beyond EMR

Required psychiatrist or psych NP/PA review for payment

Payment from Medicare

PC Behaviorist

Patients affected:
depression,
anxiety,
alcohol,
substance use,
tobacco use

Patients found through:
- screening (PHQ4, AUDIT-C, tobacco)
- passive detection

Initial assessment and treatment plan:
- PCP

Follow-up:
- primary care behaviorist: PhD psychologist or LCSW, in person

Required on-site space

Duration:
- ≤4 sessions
  - adherence, response assessments

Severe, high risk, and treatment-resistant patients:
  referral

Payment from Medicare

Behaviorist salary, behaviorist and PCP training for coordination
Medicare Payment Rates

• CoCM
  – $140 for 70 min/patient for 1st month, $125 for 60 min/patient for subsequent months

• PCBIM
  – G0507: $48 for at least 20 min/patient/month
# Results: FQHC (Serving Medicare Patients Only)

<table>
<thead>
<tr>
<th>Model</th>
<th>Time for care manager/behaviorist (hours/ys)</th>
<th>Cost, annual after year 1, per MD FTE</th>
<th>Net revenue, subsequent years, per MD FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CoCM</td>
<td>1205.6</td>
<td>$16,823.10</td>
<td>$33,756.60</td>
</tr>
<tr>
<td>PCBPM</td>
<td>1810.5</td>
<td>$21,467.30</td>
<td>-($3,744.50)</td>
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</table>
Results: Urban or Rural, Lower-Poverty Zone (Serving Medicare Patients Only)

<table>
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<th>Model</th>
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<tbody>
<tr>
<td>CoCM</td>
<td>1496.0</td>
<td>$19,171.10</td>
<td>$27,009.60</td>
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<tr>
<td>PCB M</td>
<td>1734.9</td>
<td>$20,729.00</td>
<td>$(3,646.30)</td>
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Take Home Points

• MH problems are extremely common and most MH care occurs within primary care
• Traditional reimbursement models are poorly supportive of models that integrate PC and MH
• New Medicare billing codes (particularly COCM) might be an attractive method for improving MH care in primary care settings
Thank You

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Team Members

- Sanjay Basu, MD, PhD
  - Stanford University, Prevention Research Center; Institute for Economic Policy Research; Centers for Health Policy, Primary Care & Outcomes Research
- Asaf Bitton, MD, MPH
  - Harvard Medical School, Center for Primary Care; Ariadne Labs; Center for Medicare & Medicaid Innovation
- Bruce Landon, MD, MBA, MSc
  - Harvard Medical School, Department of Health Care Policy
- Russ Phillips, MD
  - Harvard Medical School, Center for Primary Care
- Zirui Song, MD, PhD
  - Harvard Medical School; Massachusetts General Hospital, Department of Medicine
Behavioral Health Home Plus and Optimal Health

James Schuster, MD, MBA
2018
AGENDA

Overview of UPMC
The Behavioral Health Home Plus (BHHP) Model
Implementation Strategies
Program Outcomes
Expansion of the Behavioral Health Home Model
Integrated Delivery and Finance System

Integrated system with a world-class academic medical center, and affiliated with the University of Pittsburgh

About UPMC

- More than 140 hospitals (including 38 UPMC-owned hospitals) and 24,000 providers
- UPMC’s community contributions were $912 million and represented more than 15 percent of net patient revenue
- More than 600 doctors’ offices and outpatient sites and 60 UPMC Hillman Cancer Center locations
- Region’s largest network of rehabilitation services
- More than 4.7 million outpatient visits
- 41 percent medical-surgical market share in western Pennsylvania

Data verified as of July 1, 2018

About UPMC Insurance Services Division

- More than 3.4 million members in CY 2017
- CY 2017 operating revenue was $7.5 billion (an increase of 11.2 percent)
- Financial strength rating of A- (excellent) from A.M. Best
- Almost 12,000 employer groups
- 35 percent market share in western Pennsylvania
- The largest behavioral health insurance provider in the nation
- A full product portfolio: HMO, PPO, EPO, HSA, dental, vision, COBRA, workers’ compensation, absence management, EAP, and more
- More than 97 percent of hospitals and other facilities, as well as more than 98 percent of physicians in western Pennsylvania
- More than 60,000 network pharmacies nationwide
Innovation Drives Company Growth

Large network anchored by UPMC
About Community Care

- Incorporated in 1996 primarily to support Pennsylvania
- Part of the UPMC Insurance Services Division
- 501(c)(3) nonprofit behavioral health managed care organization
- Licensed as HMO
Community Care Behavioral Health Organization

- 39 of 67 counties in 11 contracts
- Only BHMCO in all PA HealthChoices regions
- Four reprocurements from competitors
- Experience with full-risk, shared-risk, and Administrative Services Only (ASO) contracts
A behavioral health home (BHH) is a service delivery model that provides a cost-effective, longitudinal “home base.”

The BHH facilitates and coordinates access to behavioral health care, medical care, and community-based social services and supports for people with complex medical, behavioral health, and substance use disorders.
What is a Behavioral Health Home?

The BHH is anchored in wellness guided by the triple aim: improving individual experience of care, improving population health, and reducing per capita health care costs.

“Wellness is not the absence of disease, illness and stress, but the presence of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body and living environment, and the presence of happiness.”

— Peggy Swarbrick, PhD
Key Behavioral Health Home Components

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care
- Enhanced engagement in primary care and other physical health systems of care
- Individual and family support
- Community and social support services
- The use of health information technology to enhance population management
Community Care’s Behavioral Health Home Plus

Successful early collaboration with Community Care and behavioral health providers in North Central region of Pennsylvania to address wellness through BHH model in 2010
BHHP enhances the traditional Behavioral Health Home model by:

• Adding a wellness nurse to the existing team
• Using wellness coaching to address self-management of modifiable lifestyle factors
• Developing a health registry to track health needs and improvements
• Improving health literacy and health navigation
Behavioral Health Home Plus

Key components

- Addressing gaps in clinical care and coordinating PH services
- Engaging individuals in recovery in ongoing wellness coaching based on the 8 domains of wellness, especially PH
- Screening for preventive health conditions and history of significant traumatic stress exposure
- Establishing a reciprocal and collaborative relationship with primary care and specialty medical providers

Wellness Nurse/Wellness Coach
Wellness Nurse

- Coordinates the BHHP team intervention including the “virtual team” of community-based medical and social service providers
- Serves as a medical consultant to non-medical team members and wellness coaches
- Guides the team in identifying and addressing gaps in clinical care and coordinating care
- Develops a health resource library for the team
Wellness Nurse

• “Manages” the monthly registry of population-focused data that identifies and stratifies individuals who have high-risk behavioral and medical indicators

• Reaches out to the highest risk individuals on the registry to discuss doing a physical health assessment which helps to raise the individual's awareness of need
BHHP Outcomes: Optimal Health

- Optimizing Behavioral Health Homes by Focusing on Outcomes that Matter Most for Adults with Serious Mental Illness (Optimal Health) Study
- A multi-stakeholder collaboration to study the key components of the BHHP model
- Contract awardee:
  - UPMC Center for High-Value Health Care

- Main partners include:
  - Community Care
  - University of Pittsburgh
  - Stakeholder Advisory Board
  - BHARP, NC and Chester Counties and Providers

- Principal investigators:
  - James Schuster, MD, MBA, Community Care
  - Charles (Chip) Reynolds III, MD, University of Pittsburgh
  - Tracy Carney, CPRP, CSP, Community Care

- Supported by the Patient-Centered Outcomes Research Institute (PCORI)
CER to Examine BHH Models’ Impact

**Patient Self Directed**
- Wellness coaches
- Member registry
- Self management toolkits

**Provider Supported**
- Wellness coaches
- Member registry
- Nurse focused on wellness and health
Learning Collaborative Process

Create Change Package

Develop Charter

Select Teams

Implement Action Periods

Hold Learning Sessions

Begin Pre-Work

Measure Progress
Create Change Package

- Create Change Package
- Develop Charter
- Select Teams
- Implement Action Periods
- Hold Learning Sessions
- Begin Pre-Work
- Measure Progress

Topic and content; model and practices and the details of the approach

- Implementation of Behavioral Health Home
Develop Charter

**Mission**
- Primary focus of the collaborative
- To facilitate and support implementation of the PHM strategy

**Aims**
- Written statements of expected accomplishments

**Expectations**
- Commitments to meet during LC
Select Teams

Strategy Leadership and Faculty

- Strategy and operations design
- Provide expert facilitators as resources to the quality improvement teams
- Guide the work through monthly webinar-style coaching calls
- Provide technical assistance to care teams
- Establish aims against which to measure the impact of quality improvements efforts, track progress toward the stated aims, and provide aggregate and individual team feedback
- Evaluate the overall impact of the quality improvement effort both at the organizational level, and at the aggregate level of the entire collaborative
Study Methods and Design

• Cluster-randomized design with mixed methods approach

• Models implemented in 11 community mental health centers (CMHCs) over two years starting in 2013

• Research participant inclusion criteria:
  • Medicaid-enrolled
  • 21+ years of age
  • Diagnosed with a serious mental illness
  • Receives services at community mental health center within Community Care’s network

• Institute for Healthcare Improvement’s Learning Collaborative Model used to support implementation
  • Institute for Healthcare Improvement Breakthrough Series: http://www.ihi.org
Patient-Centered Outcomes and Data

Primary Data Sources

Self-Report Measures
(Patient activation,** health status,** hope, quality of life, functional status, satisfaction with care, social support)

Qualitative Data
(Service user and provider interviews)

Learning Collaborative (LC) Data
(Implementation information)

Secondary Data Sources

HealthChoices Eligibility Data
(Medicaid eligibility)

Administrative Data
(Demographic info)

Behavioral Health Claims
(BH diagnosis, utilization)

Physical Health Claims
(Engagement in primary/specialty care**)

Pharmacy Claims
(Medication utilization)

**Primary outcome
Primary Outcomes Findings

**Patient Activation**
- More rapid increase in provider-supported sites (with wellness nurse) than self-directed sites
- Greater increase in activation for women in provider-supported; greater increase for men in self-directed

**Engagement in Primary/Specialty Care**
- 36% increase in frequency of visits in both study arms

**Health Status**
- Small improvement in perceived mental health status
- Small decline in perceived physical health status
Qualitative Findings: Patient View

- Shift in definition of health and wellness, away from vague to more personalized
- Increased awareness of interconnectedness of mental and physical health
- Overall favorable intervention experiences
- No major distinctions between arms – no evident differences in engagement in or satisfaction with interventions
- Most important factor leading to intervention participation was relationship with wellness coach
Qualitative Findings: Provider View

- High degree of agency support for wellness coaching
- Culture of wellness that benefitted both service users and providers
- Models integrated into routine practice
- Providers simplified/casualized wellness coaching to increase service user engagement
- Nurses often mentioned as most beneficial component of the model
- Robustly positive impact on service users’ health/wellness
- Acute needs sometimes trumped wellness coaching
Trial Data Only: Outcomes

- Total spending lower with nurse practices in longer term
- Nurse practices engaging patients more with PH services while decreasing PH IP
- BH service use lower with nurse practices, including IP, psychotropics and TCM

Nurse vs. Navigator

Total

- Year 2: PMPM 9% lower
- Years 1 and 2: PH use 5% higher
- Year 2: BH 16% PMPM lower

*Statistically significant (<0.05)
◇ Suggestive; not quite statistically significant (<0.2)

*Controlled for baseline demographics and PMPM
Trial Data Only: Outcomes

Nurse vs. Navigator

**IP**
- Year 2: Overall use 23% lower
- Years 1 and 2: PH use and PMPM 25% lower
- Year 1: BH use 43% lower

**Rx**
- Year 1: PMPM 24% higher
- Year 2: Psychotropic use and PMPM 15% higher

**TCM**
- Year 1: PMPM 19% lower
- Year 2: PMPM 33% lower

**ER**
- Year 1: Use 17% lower
- Years 1 and 2: PMPM lower (19%, 33%)

*Statistically significant (<0.05)
◇ Suggestive; not quite statistically significant (<0.2)

*Controlled for baseline demographics and PMPM
Subsequent Financial Evaluation*

Comparison of utilization and spending

Total
- Overall
- PH
- BH

IP
- Overall
- PH
- BH

Rx
- Overall
- Psychotropics

TCM

ER

PMPM
(spending per SMI patients enrolled in the study per month)

Use
(measured by monthly penetration rate)

*These analyses were conducted independent of PCORI-funded contract
Post-Trial Comparison Group: Outcomes

- Nurse sites have lower long-term spending driven largely by decreases in behavioral health
- Nurse sites have increased PH use but similar PH cost and less PH IP use
- Nurse sites have less prescription use but higher prescription costs
- Nurse sites have long-term decreases in TCM costs

**Nurse + Nav vs. Comparison**

**Total**

- Year 2: PMPM
  - 15% lower

- Years 1 and 2: PH use (40-50%)
  - 40-50% higher

- Year 2: BH PMPM
  - 20-30% lower

昇 Statistically significant (<0.05)
✧ Suggestive; not quite statistically significant (<0.2)
Trial Data Only: Outcomes

Nurse vs. Comparison

- + Statistically significant (<0.05)
- ◊ Suggestive; not quite statistically significant (<0.2)

**IP**
- Year 2: Use 30-40% lower + and cost 20-25% lower +
- Year 2: PH Use 30-35% lower ◊

**Rx**
- Years 1 and 2: Use 25-30% lower +
- Year 1: PMPM 15-20% higher +

**TCM**
- Year 2: PMPM 17% lower +

**ER**
- Matched cohort not comparable for ER analysis
BHHP Model Expansion

Additional populations served: adolescents, opioid treatment programs

Population Health LC for mature providers focused on hypertension and smoking cessation
PCORI Dissemination Award

**Contract Awardee**
UPMC Center for High-Value Health Care in collaboration with Community Care

**Purpose**
Disseminate findings from our recently completed PCORI-funded study to improve the overall health and wellness of other priority and high-risk populations
- Residential Treatment Facilities (n=5)
- Opioid Treatment Programs (n=7)

**Contract Duration**
Two years (March 1, 2018 – February 2020)

**Principal Investigator**
James Schuster, MD, MBA
- Co-Investigators: Tracy Carney, CPRP, CSP; David Dan, MSW, LCSW; David Loveland, PhD, MA
Goals

Goal 1
Build provider capacity for the consistent and sustained delivery of BHHP
• Implement and assess the feasibility of using a Learning Collaborative approach to support RTF and OTP teams to deliver BHHP
• Assess barriers and facilitators to Learning Collaborative participation and success

Goal 2
Increase service user involvement and confidence in managing their physical health and wellness

Goal 3
Examine change/trends over time with BHHP implementation on engagement in primary/specialty care and unplanned health care utilization
Methods and Outcomes

Use a Learning Collaborative
- Model adoption
- Sustained implementation
- Fidelity to the model
- Culture of wellness
- Improved staff knowledge/skills/attitudes related to wellness concepts

Gather Qualitative Data
Interviews (n= 20) with providers at the completion of the Learning Collaborative

Use Data to Explore the Impacts and Outcomes
- Engagement with primary/specialty care
- Utilization of unplanned care (emergency department)
CONTACT INFORMATION

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Thank You
Questions?