Advancing Comprehensive Primary Care
Update on Integrated BH Program

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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.

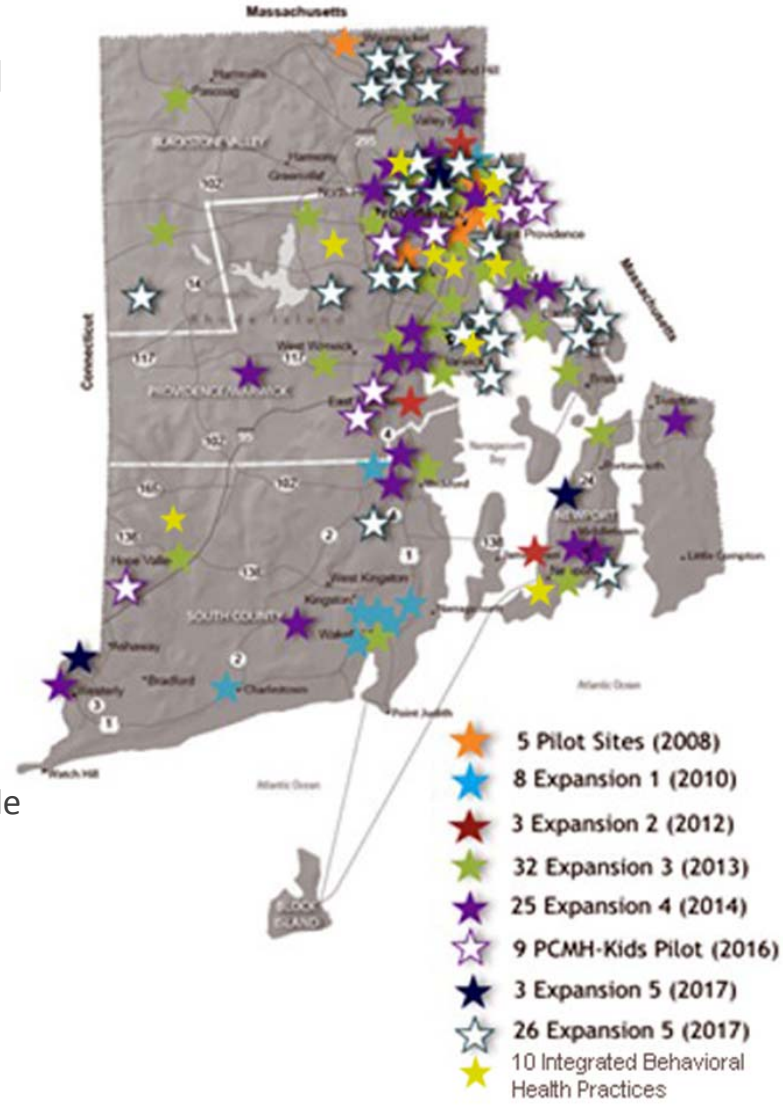
- **Approach**: **CTC-RI brings together key stakeholders** to implement, evaluate, refine and spread models to deliver, pay for, and sustain high quality comprehensive primary care.

- 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”)

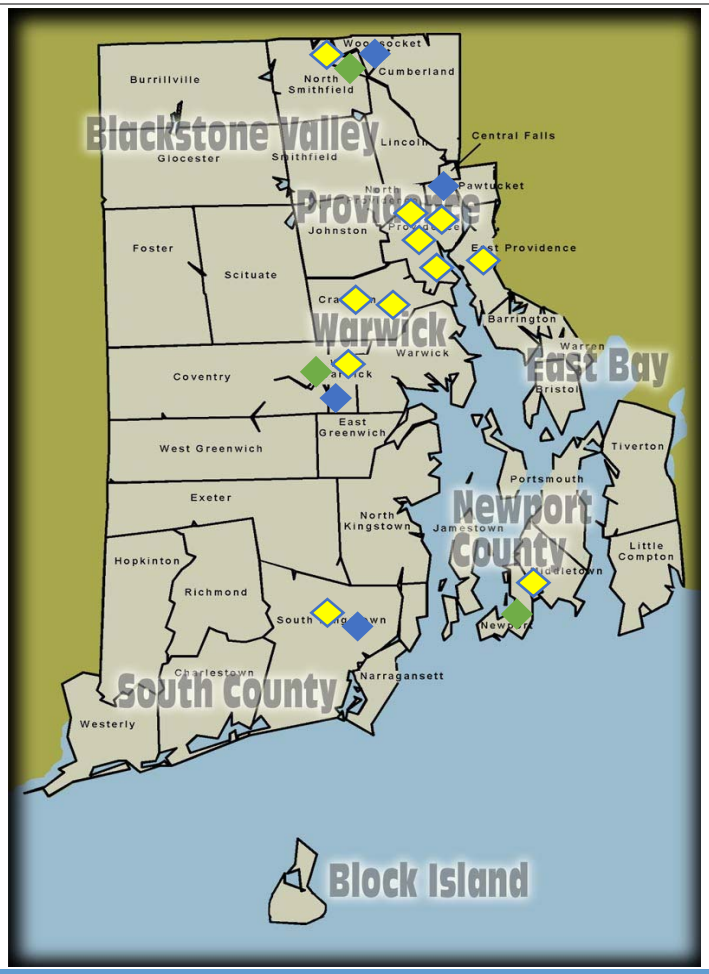
Expanding PCMH

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

- **106 primary practices**, including internal medicine, family medicine, and pediatric practices.
- Approximately **650,000 Rhode Islanders** receive their care from one of our practices.
- **750 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.
- 2019 Integrated Behavioral Health Expansion
- July 2019 PCMH Kids Expansion



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 in the top 5 of states for severity based on 13 mental illness indicators
- Two-thirds 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

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 of Rhode Island

IBH Program Overview

3-year program with 2 waves of practices

- IBH Cohort I - Feb 2016 –December 2017
- IBH Cohort II - November 2016-October 2018

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
- Three 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

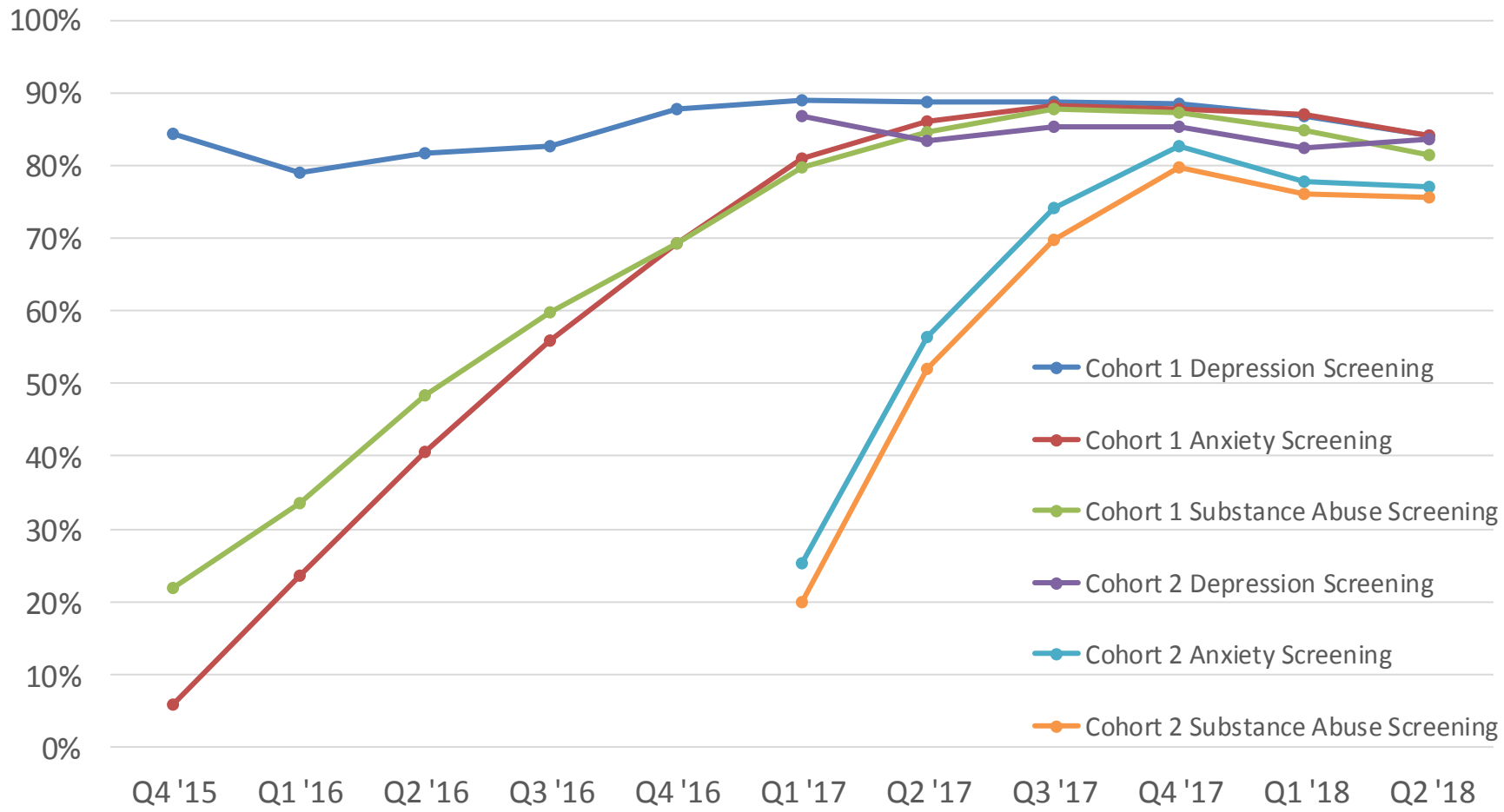
- Give practices 3 to 6 months to **prepare for implementation**
  - ✓ Billing and coding
  - ✓ Credentialing
  - ✓ EHR modifications
  - ✓ Workflow
  - ✓ Staff training

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**

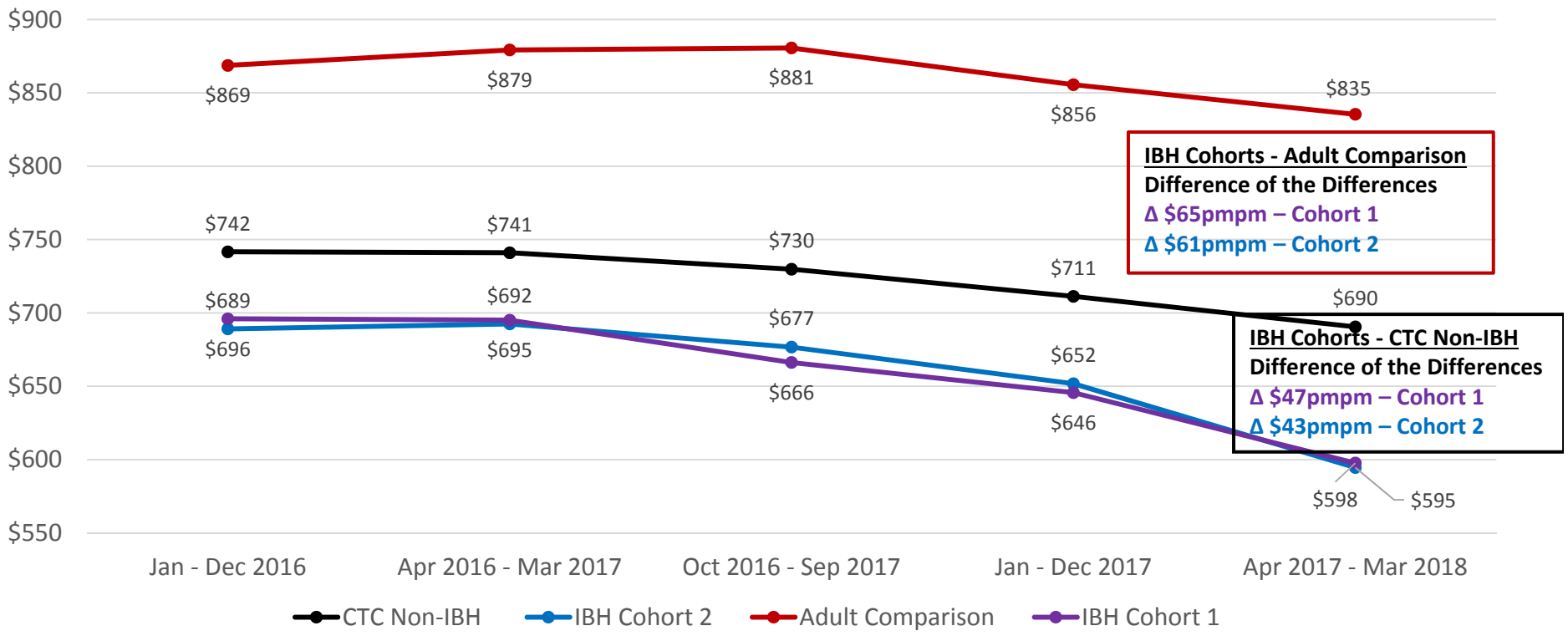
Screening and Utilization Outcome Results

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

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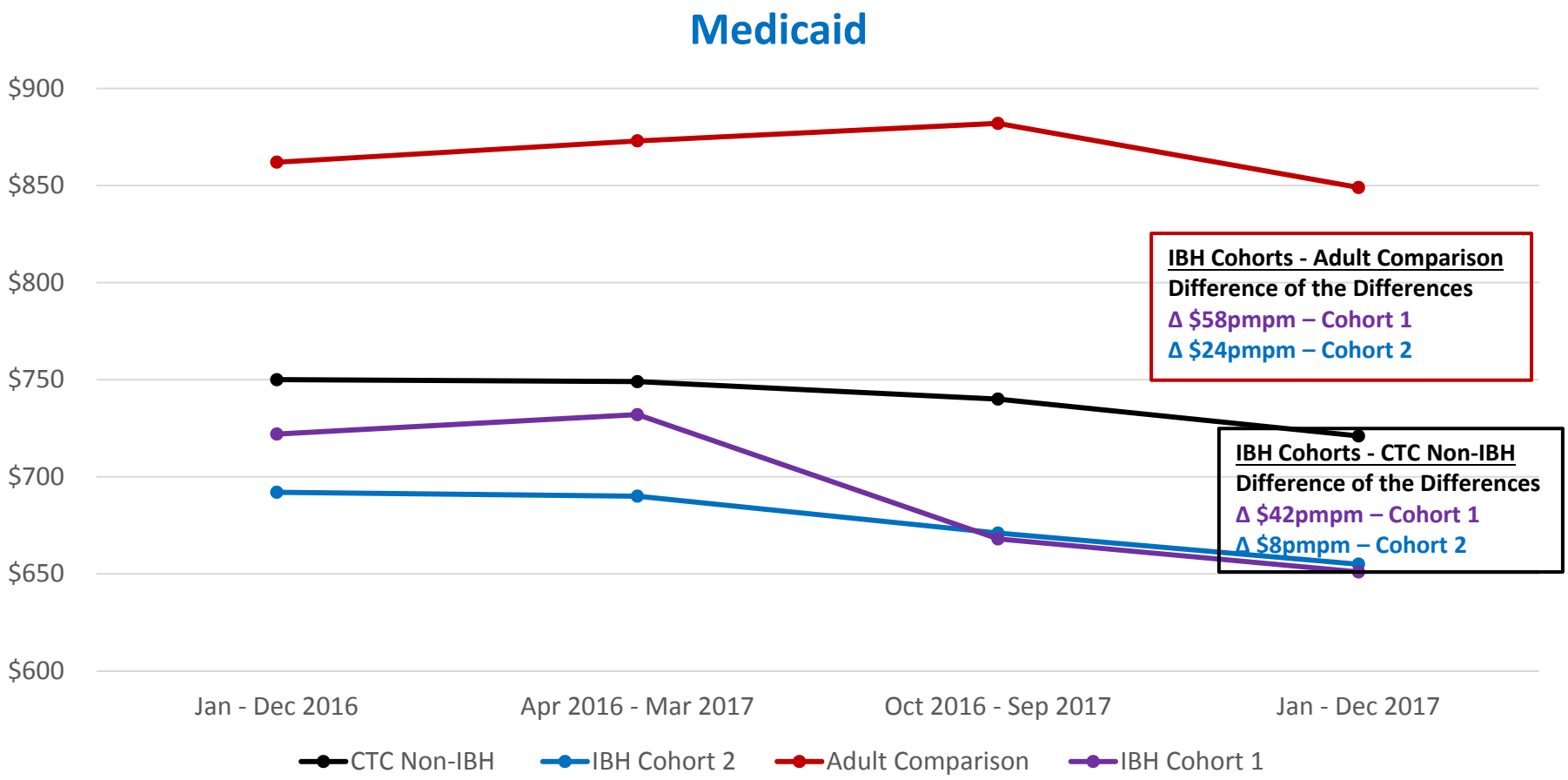

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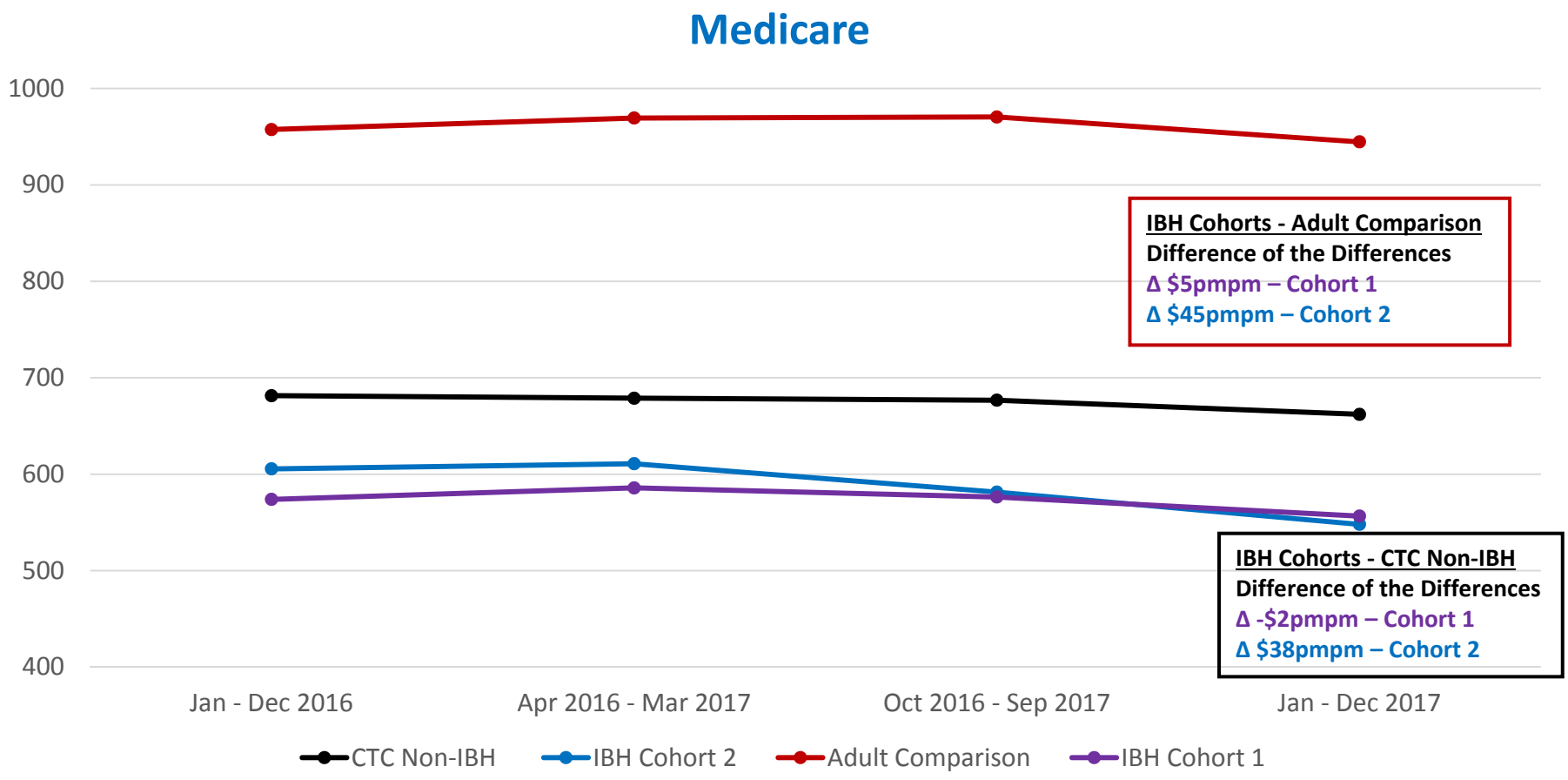
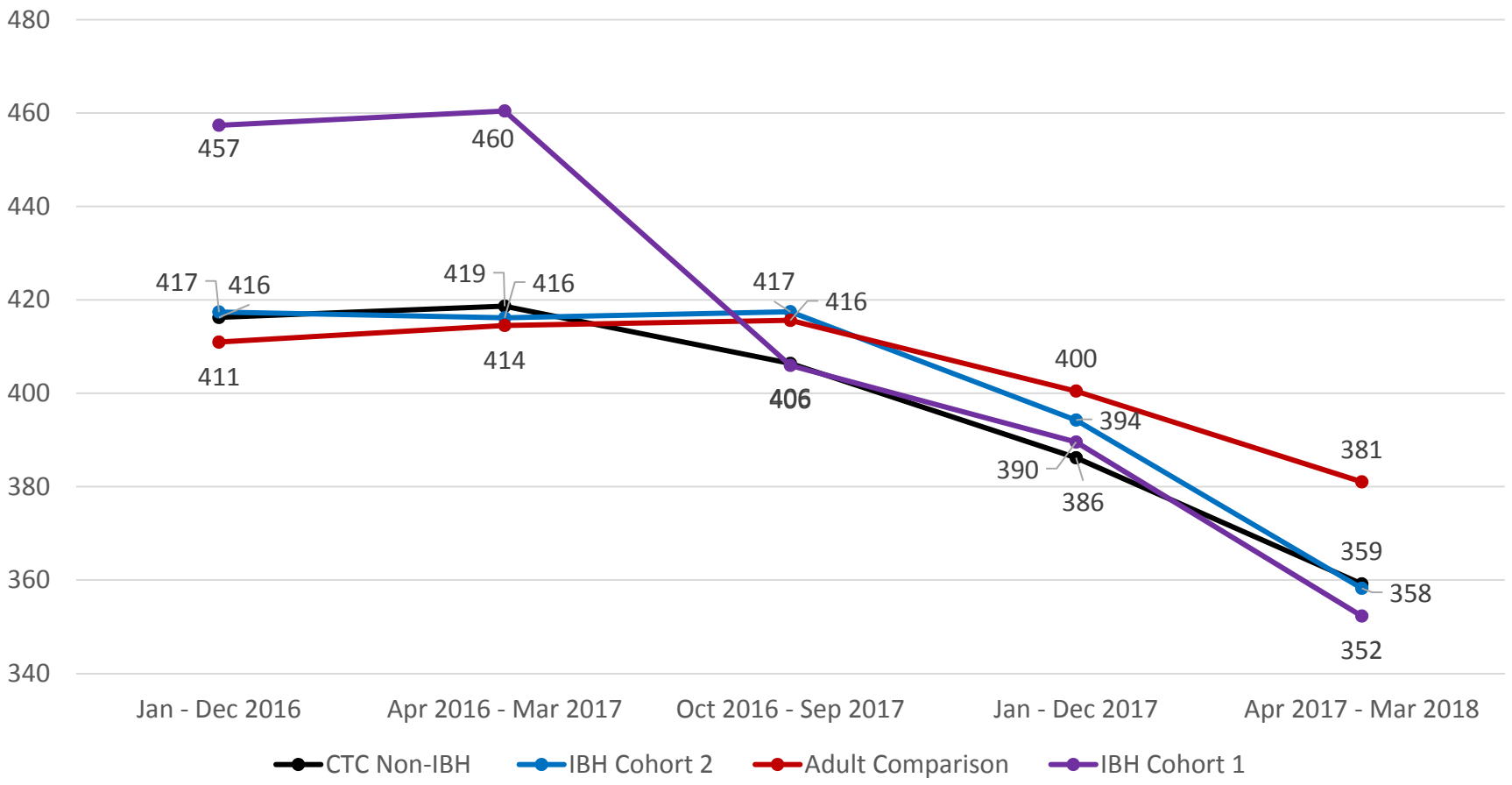


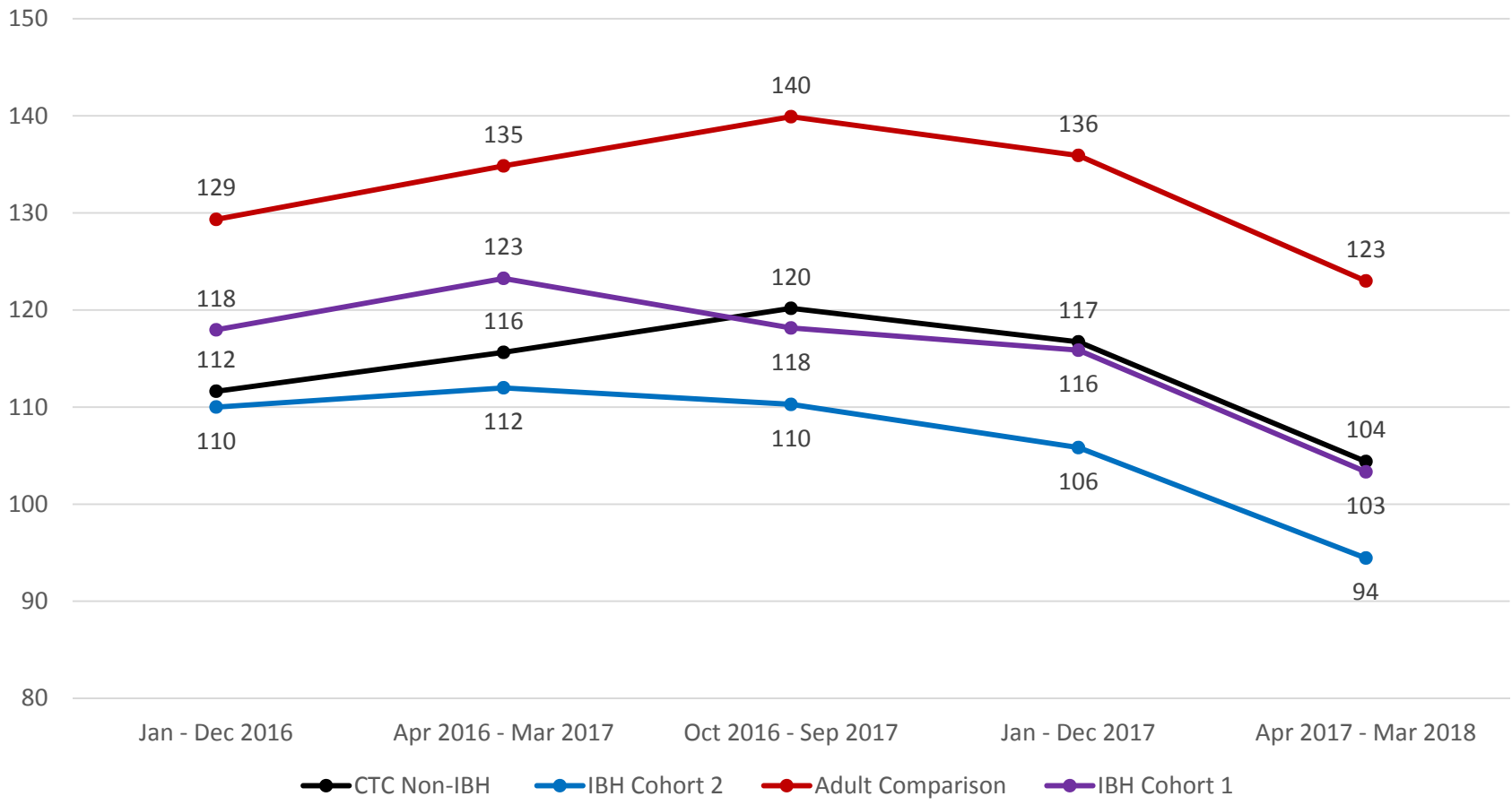
Emergency Department Visits

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



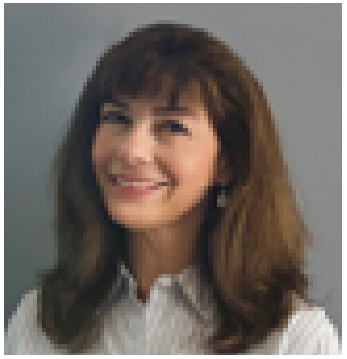
Inpatient Utilization
Acute Care Discharges

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



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

Next Steps / Sustainability

Funding

- SOC: provide primary care practices with infrastructure support to get started
- Universal screening coding and billing for reimbursement, all payers.
- Turn on health and behavior codes, all payers.

Partnerships

- Primary Care practices
- RIF/SIM/Tufts
- Health plans
- OHIC / EOHHS
- Higher education
- Systems of Care
- ACO / AE

Learning

- Extend IBH model in pediatrics
- Staff Training
- Train the Trainer
- On line training with hands on support
- Ongoing Learning Collaboratives
- Present and Publish

Evaluation

- Quantitative analysis from Brown University is due Q2 2019.
- Ongoing monitoring of TCOC, ED & Inpatient visits using APCD
- Supporting Systems of Care in implementation and evaluation

Main Takeaways

Integrated Behavioral Health in Primary Care Works
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

Questions

Technical Methods

Qualitative Evaluation Methods

- Interview participant samples
  - Purposive, criterion-based samples
  - Key informant interviews with internal and external stakeholders (N=9)
  - Key informant interviews with employees at each pilot practice site (N=49)
    - Physician champions, other physicians, NCMs, IBH providers, IBH staff assistants, IBH students, practice managers, IBH program coordinators, clinical supervisors

Qualitative Evaluation Methods, cont.

- Qualitative data analysis and interpretation
  - Iterative individual and analysis team approach
  - Immersion/crystallization method: Review recordings; read transcripts; take notes; repeated discussions of emerging patterns, themes, differences, potential reasons for differences and similarities
  - Periodic 'member-checking' with CTC-RI IBH leadership, practice personnel, and health plan representatives

Qualitative Evaluation Methods, cont.

- Qualitative data analysis and interpretation, cont.
  - Creation of code book to sort and manage data
  - Data extraction method of coding and documenting
  - Immersion/crystallization again of coded data documents and return to transcripts to analyze by topical categories
  - Final interpretations reached through team discussion

APCD Risk Adjustment Methodology

First cap outliers (99th percentile)

Then risk adjust using these variables:

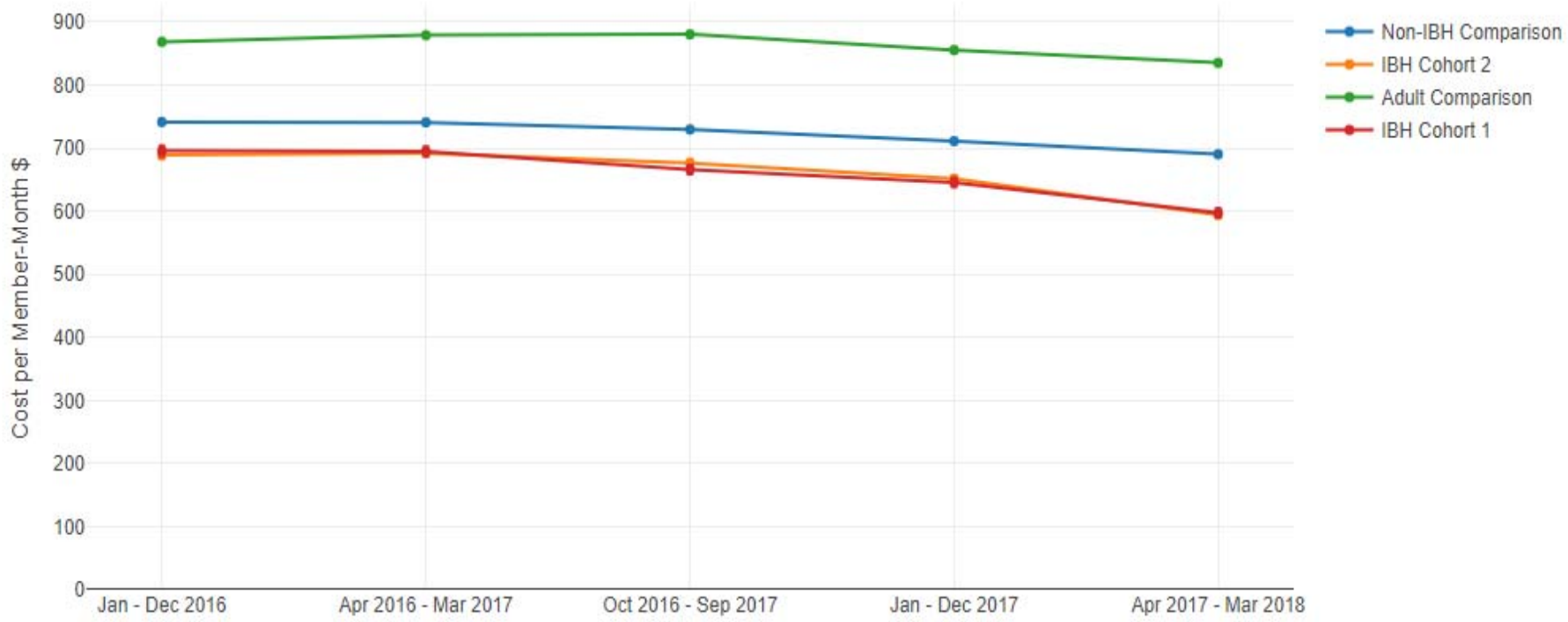
- Product: commercial/Medicaid/Medicare
- Gender
- Age band: 1-17, 18-44, 45-64, 65+
- CRG category: 1 Healthy, 2-3 Acute, 4-5 Moderate Chronic, 6-7 Significant Chronic, 8-9 Cancer/Catastrophic

APCD Attribution Methodology

- Identifies all claims for all patients meeting a distinct definition of a "primary care visit" (including both claim line- and provider-specific requirements), and the rendering and/or attending provider(s) associated with those claims.
- Onpoint's algorithms next determine each patient's single attributed provider per reporting period; tie-breaker logic is applied when necessary.
- If a patient is attributed to a provider through Onpoint's claims-based methodology who is not found in the master provider directory, the patient is not included in the portal's reporting for the particular reporting period in question.
- The next identified rendering and/or attending provider for the patient is not considered for attribution purposes.
- Additionally, if a patient is attributed to a provider whose physical address is outside of Rhode Island, the patient is not included in the portal's reporting for the particular reporting period.

APCD Confidence Intervals

Total Medical & Pharmacy Costs (with Exclusions) (Ages 18+, Cost per Member-Month)



APCD Confidence Intervals (Medicaid)

APCD Confidence Intervals (Medicare)