Session I3

Key Factors for Advancing Integrated Care in Central Oregon:

Payer, Provider, Policy, and Technical Assistance

- E. Dawn Creach, MS, Principal, Creach Consulting, LLC and Integrated Care Trainer for Central Oregon
- Mike Franz, MD, DFAACAP, FAPA, Psychiatrist and Medical Director of Behavioral Health, PacificSource Health Plans
- Janet Foliano, PsyD, Manager of Integrated Care, St. Charles Health System

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1

Faculty Disclosure

The presenters of this session currently have or have had the following relevant financial relationships (in any amount) during the past 12 months.

- E. Dawn Creach, MS, Creach Consulting, LLC, receives financial reimbursement from PacificSource to implement the Advancing Integrated Care In Central Oregon project
- E. Dawn Creach, MS, Creach Consulting, LLC is a paid consultant to PacificSource Community Solutions
- Mike Franz, MD, is employed by PacificSource and is a co-owner and consultant with Cartesian Solutions, LLC

2

Conference Resources

Slides and handouts shared by our conference presenters are available on the CFHA website at https://www.cfha.net/page/Resources_2019 and on the conference mobile app.

3

Learning Objectives

At the conclusion of this session, the participant will be able to:

- Describe the four key factors leading to widespread regional implementation of integrated care
- Understand key strategies for transforming payment and care delivery models to support whole-person, team-based primary care
- Describe successful components of building closer relationships between primary care clinics and specialty behavioral health providers in the community

4

Bibliography / Reference

1. Evolving Models of Behavioral Health Integration: Evidence Update 2010-2015. Martha Gerrity,MD, MPH, PhD. May 2016. Millbank Memorial Fund.
2. The Cost Effectiveness of Embedding a Behavioral Health Clinician into an Existing Primary Care Practice to Facilitate the Integration of Care: A Prospective, Case–Control Program Evaluation. Kaile M. Ross, Betsy Klein, Katherine, Ferro, Debra A. McQueeney, Rebecca Gernon & Benjamin F. Miller. Journal of Clinical Psychology in Medical Settings; ISSN 1068-9583; J Clin Psychol Med Settings; DOI 10.1007/s10880-018-9564.
3. Implementation of Oregon's PCPCH Program: Exemplary Practice and Program Findings. Sept 2016; Sherril Gelmon, DrPH, Neal Wallace, PhD, Billie Sandberg, PhD, Shauna Petchel, MPH, Nicole Bouranis, MA.
4. Integrated Care in Rural Health: Seeking Sustainability. Mary Peterson, PhD, Jeri Turgesen, PsyD, Laura Fisk, PsyD, Seamus McCarthy, PhD; Families, Systems, & Health, American Psychological Association 2017, Vol. 35, No. 2, 167–173.
5. Taylor EF, Lake T, Nysenbaum J, Peterson G, Meyers D. Coordinating care in the medical neighborhood: critical components and available mechanisms. White Paper (Prepared by Mathematica Policy Research under Contract No. HHSA290200900019I TO2). AHRQ Publication No. 11-0064. Rockville, MD: Agency for Healthcare; Research and Quality. June 2011.

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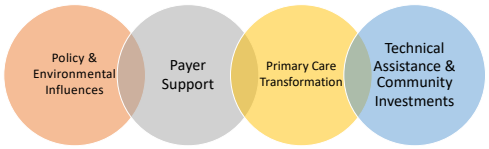
Learning Assessment

- A learning assessment is required for CE credit.
- A question and answer period will be conducted at the end of this presentation.

6

Key Factors for Advancing Integrated Care



7

Our Story

Fundamentally, this is a story of how payers, providers, and community stakeholders can work together to advance integrated care across systems and at a regional scale.

Unless otherwise noted, all photos were taken in Oregon by E. Dawn Creach or Tyler Creach.

8

The Integrated Care Landscape in Oregon

- E. Dawn Creach, MS
  Principal
  Creach Consulting, LLC
- Integrated Care Trainer for Central Oregon

9

Getting On The Same Page in Oregon: Definitions

Integrated Health Care:
Integrated health care means care provided to individuals and their families in a Patient-Centered Primary Care Home or behavioral health home by licensed primary care clinicians, behavioral health clinicians and other care team members, working together to address one or more of the following: mental illness; substance use disorders; health behaviors that contribute to chronic illness; life stressors and crises; **developmental risks and conditions**; stress-related physical symptoms; **preventive care**; and/or ineffective patterns of health care utilization.

- As defined in Oregon Senate Bill 832 (2015) Enrolled
- Adapted from Agency for Healthcare Research & Quality (AHRQ) definition

10

10

Oregon Definitions

Behavioral Health Clinician (BHC):
(a) a licensed psychiatrist; (b) a licensed psychologist; (c) a certified nurse practitioner with a specialty in psychiatric mental health; (d) a licensed clinical social worker; (e) a licensed professional counselor or licensed marriage and family therapist; (f) a certified clinical social work associate; (g) an intern or resident who is working under a board-approved supervisory contract in a clinical mental health field; or (h) any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.

As defined in Oregon Senate Bill 832 (2015) Enrolled

11

11

Integrated Behavioral Health Alliance (IBHA)

- IBHA – Diverse workgroup of integrated care experts across Oregon & Washington
- IBHA promotes comprehensive integration of behavioral health & physical health in primary care, behavioral health, and other healthcare settings
- Developed consensus minimum standards for integrated primary care in 2015
  - Adapted from AHRQ Professional Practices in Behavioral Health & Primary Care Integration
  - Incorporated into Oregon's medical home recognition standards in 2017

Integrated Behavioral Health Alliance: Recommended Minimum Standards for Patient-Centered Primary Care Homes (PCPCH) Providing Integrated Health Care (2015)

IBHA INTEGRATED BEHAVIORAL HEALTH ALLIANCE

12

12

Integrated Behavioral Health Alliance (IBHA) Consensus Minimum Standards for Patient-Centered Primary Care Homes (2015)

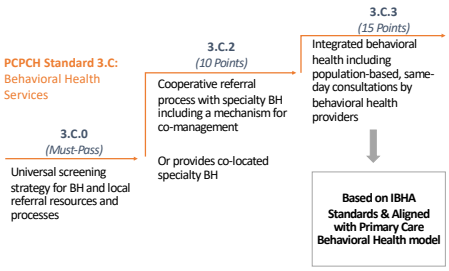
Integrated behavioral health services are provided as part of routine care at the PCPCH including licensed Behavioral Health Clinician(s) delivering an array of services on-site. BHC as defined in ORS 414.025.
Integrated BHC provides a broad array of comprehensive evidence-based behavioral health services
Integrated BHC provides same-day open access behavioral health services
Primary care clinicians, staff, and BHC utilize shared medical records and have a mechanism in place for collaborative care planning and co-management of patients
BHC is an integrated part of the primary care team
PCPCH utilizes a population-based approach to delivering and coordinating integrated behavioral health services
The integrated team includes psychiatric consultative resources

Patient-Centered Primary Care Institute: http://www.pcpci.org/sites/default/files/Recommended%20Minimum%20Standards%20for%20Patient-pdfpdf.pdf

13

13

Oregon PCPCH Recognition Criteria



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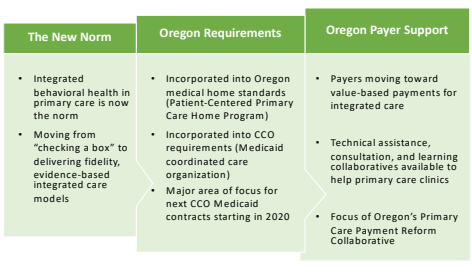
14

The Tipping Point in Oregon: Moving from WHY to HOW



15

15

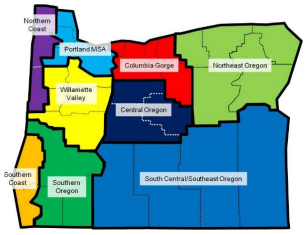
Policy & Environmental Impacts on Behavioral Health Integration in Oregon

2011	2015	2016	2017	2018 - 2019	2020 +
✓ Focus on behavioral health integration required for Oregon's CCOs	✓ Statutory definitions defining WHAT integrated care is and WHO provides it ✓ IBHA establishes consensus minimum standards for integrated primary care	✓ Multiple CCOs launch alternative payment programs based on IBHA minimum standards	✓ IBHA standards incorporated into Oregon's PCPCH recognition criteria ✓ IBHA establishes recommended measures to assess BHI in primary care	✓ PCPRC policy document endorsed by all payers in Oregon ✓ More explicit CPC+ requirements for BHI ✓ Multiple CCOs implement VBPs for BHI (e.g. PMPM tied to meeting metric benchmarks)	✓ New CCO requirements with intense focus on behavioral health and integrated care ✓ Implementation of Primary Care Payment Reform Collaborative recommendations

IBHA = Integrated Behavioral Health Alliance http://www.pcpci.org/integrated-behavioral-health-alliance
CCO = Coordinated Care Organization (Medicaid managed care)
PCPCH = Oregon's Patient-Centered Primary Care Home Program https://www.primarycarehome.Oregon.gov
PCPRC = Oregon's Primary Care Payment Reform Collaborative https://www.oregon.gov/oha/HPA/dsi-tc/Pages/SB231-Primary-Care-Payment-Reform-Collaborative.aspx
CPC+ = Medicare's Comprehensive Primary Care Plus Initiative

16

Central Oregon (Hint: It's not Portland!)



- 3 county region (Deschutes, Jefferson, Crook)
- Population = 228,225
- #2 fastest job growth in the U.S.
- Approximately 6,000 new residents/year (#6 fastest growth in the U.S.)
- Over 4 million visitors/year

17

Payer Influence In Central Oregon

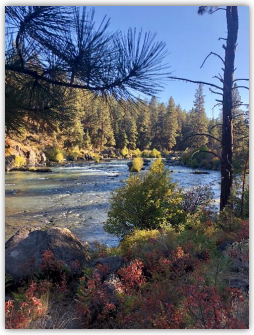
PacificSource HEALTH PLANS

- Mike Franz, MD, DFAACAP, FAPA, Psychiatrist and Medical Director of Behavioral Health, PacificSource Health Plans

18

Overview of PacificSource Health Plans

- Regional, non-profit health plan with multiple lines of business in Oregon, Idaho, Washington and Montana
  - 1/1/2020 will have approx. 450,000 members
- Central Oregon: Medicaid Coordinated Care Organization (CCO), Medicare Advantage, Commercial Lines of Business
- Approximately 40% of market share (all covered lives) in Central Oregon
- Over 90% of Medicaid members now receiving care in a fidelity integrated primary care clinic
  - Also serve our Medicare Advantage and Commercial members
  - Also serve other payers' members accepted at those clinics



19

PacificSource Health Plans Integrated Care Vision & Strategy

- Internal transformation ⇨ Break down siloes between physical & behavioral health (e.g. combining care management departments)
- Align policies across all lines of business
- Remove barriers to integrated behavioral health care
- Expand access (BH assessments, brief treatment in PCPCH) & patient choice (e.g. open the Medicaid BH specialty panel)
- Align with local, state and federal policies (e.g. IBHA, PCPCH standards, CPC+)
- Invest in technical assistance to help clinics be successful
- Link payment to provider accountability & move toward VBPs

20

PacificSource's Strategy to Support Integrated Care in Central Oregon

2015	2016	2017	2018	2019	2020 +
✓ Grant from the state to pilot BHI payment & align across all lines of business ✓ Developed policy for fidelity integrated care; Creates clear distinction between co-located specialty BH vs. integrated care	✓ Use of AG modifier when coding for integrated BH services ✓ Expand FFS codes including psychotherapy codes ✓ Remove pre-authorization requirements for integrated BH ✓ Yearly site visits to verify clinics meet IBHA standards & provide TA	✓ Align with IBHA standards and Oregon PCPCH recognition criteria ✓ Site visits and TA continue ✓ Add policy for specialty medical clinics (e.g. women's clinics) ✓ CoCM codes pay all LOBs	✓ Medicaid QIM grant $ for fidelity integrated primary care clinics ✓ Quarterly reporting on 3 metrics ✓ For full $, clinics must meet population reach metric benchmark ✓ Advancing Integrated Care in Central Oregon (AIC) project begins (payer-blind technical assistance)	✓ Increase metric benchmark to qualify for QIM grant $ ✓ Develop Medicaid VBP (PMPM) for sustainable support for integrated primary care ✓ Removed all pre-auth requirements for BH outpatient services ✓ Expand licensed BH provider types for Medicare Advantage plan	✓ Launch Medicaid VBP program w/ PMPM $ ✓ New CCO requirements with intense focus on BH and integrated care ✓ Create VBP option for Psychiatric Collaborative Care model (CoCM) ✓ Expand to other LOB

21

Clinic Accountability & TA Support

Integrated primary care clinics complete an annual self-assessment form attesting to their level of integration

Based on Integrated Behavioral Health Alliance (IBHA) & state PCPCH (medical home) standards

Consultant conducts annual ½ day site visits to integrated primary care clinics to verify level of integration and identify technical assistance (TA) needs

Key part of justifying financial commitment to transformed care models

After a few years of site visits, documentation review may become sufficient

Clinics not meeting required level of integration must participate in free TA from consultant to help them move toward full integration

TA & consultation also available to any primary care clinics to support BHI

22

Value-Based Payment Program Elements

- ✓ Must meet IBHA/PCPCH standards
  - Complete self-assessment form annually
  - 1:6 BHC-PCP staffing ratio at each site
- ✓ Site visits and/or documentation review annually
- ✓ Report 3 metrics quarterly
- ✓ Meet **population reach** metric benchmarks

Population Reach Metric

Numerator: # of unique patients seen by integrated BHC

Denominator: # of unique patients seen in primary care clinic

Pop Reach = 5% first year, 10% second year, perhaps increase % and/or tie to outcome metrics going forward

PMPMs intended to cover high-value services not easily reimbursed through FFS:

- Prevention and early intervention for common behavioral health concerns
- Same-day brief consultations, assessments & interventions
- Warm-hand offs between the primary care team and BHC(s)
- BHC participation in pre-visit planning, team meetings, and huddles
- Consultations between the primary care team and BHC(s)
- BH care management and care coordination
- Augment FFS reimbursement for BHC services rendered in primary care
- Augment FFS CoCM payments

23

23

BHI Metrics Reported Quarterly

Metric #1: Population Reach of Integrated Behavioral Health Care

- Percentage of unique patients seen by a BHC during the reporting period

Metric #2: Fidelity to the IBHA Standards: Access to Same-Day Behavioral Health Services

- Percentage of same-day BHC encounters during the reporting period

Metric #3: Identification & Intervention with a Target Subpopulation

- Percentage of a target subpopulation of patients who could benefit from BHC involvement and had a BHC encounter during the reporting period
  - Positive depression or substance use screening; failed developmental screening
  - Tobacco use, diabetes, chronic pain, ADHD

24

Primary Care Transformation

St. Charles HEALTH SYSTEM

- Janet Foliano, PsyD, Manager of Integrated Behavioral Health, St. Charles Health System

25

St. Charles Primary Care Clinics

In the beginning:

- Began efforts to integrate behavioral health in Spring of 2011
- Two BHCs in 2 of 5 Family Care clinics
- Primary Care Behavioral Health (PCBH) model
- Used H&B codes primarily
- Major issues:
  - Prior authorizations needed to use psychotherapy codes for Medicaid
  - Too few BHCs - too many PCPs
  - Difficulty referring out to specialty BH for longer term tx

26

St. Charles Primary Care Clinics

Things that helped us move the dial:

- PCPCH standards & IBHA standards implemented – including 1:6 BHC:PCP ratio, 50% same day availability, universal screening for depression, anxiety, SUD and safety
- PacificSource – developed AG modifier for billing allowing psychotherapy codes in primary care without prior authorizations
- PacificSource QIM Grant – grant payments with Population Reach as metric for payment and fidelity standards for inclusion in grant
- Site visits to ensure fidelity to model & provide TA
- **And a lot of trial and error….**

27

St. Charles Primary Care Clinics

Where we are today:

- Total of 7 Family Medicine Clinics in Central Oregon
- Center for Women's Health – Redmond
- Contracted to provide BHC services in 3 local pediatric clinics
- Integrated Psychologist in Inpatient Medicine
- Over 1000 IBH encounters per month across all clinics
- Just over 50 PCPs/Providers
- 15 BHCs (13 FTEs) – with two open positions
- One consulting Psychiatrist
- All clinics are currently meeting at least 10% population reach (range 11%-26%)
- Behavioral health integration is integral part of our Primary Care Transformation efforts

28

Continued challenges/ room to grow

- Difficulty recruiting BHCs for all clinics but especially rural clinics
- Rural clinics – population has limited confidence in community mental health; patients often refuse referral so BHCs ends up with patients who need more intensive care
- Difficulty referring to specialty BH - long wait, no feedback to primary care
- Hope to get other insurance companies on board with BHI efforts – move to more value-based payments vs. FFS – both a positive and challenge
- Integrate BH into specialty medicine – inpatient medicine, sleep medicine, cardiology, oncology, etc. – the challenge is to figure out how to pay for this!
- As part of Primary Care Transformation, developing standard work flows that will include referral to IBH

29

Technical Assistance & Community Investments in BHI in Central Oregon

aic Advancing Integrated Care Central Oregon

- E. Dawn Creach, MS, Principal, Creach Consulting, LLC and Integrated Care Trainer for Central Oregon

30

ADVANCING INTEGRATED CARE IN CENTRAL OREGON (AIC) BACKGROUND

Project Aim

Identify and engage 100% of individuals in Central Oregon that have a behavioral health need and ensure an effective and timely response

- Central Oregon Health Council
  - Regional Health Improvement Plan (RHIP) funding based on identified priorities
  - Funding decisions made by community members who participate in workgroups
  - Nearly $500,000 invested in AIC project
- PacificSource administers grant on behalf of the region, but it is payer-blind
  - Dr. Mike Franz is a collaborator and SME
- E. Dawn Creach, MS, Creach Consulting, LLC, selected as Regional Integrated Care Trainer
- Grant Timeframe: June 2018 – June 2020

31

Advancing Integrated Care (AIC) in Central Oregon
5 key components:

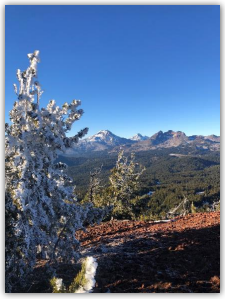
1) Identification:
Universal behavioral health screening in primary care clinics

2) Integration:
Population-based and outcome-oriented behavioral health interventions in primary care clinics

3) Referrals:
Timely and completed referrals to specialty behavioral health for people with needs beyond what can be served in primary care (or by patient choice)

4) Coordination:
Effective communication between primary care & specialty behavioral health

5) Expanding the Care Team:
Identify opportunities to increase use of traditional health workers such as patient navigators, Peer Support Specialists, and Recovery Mentors



32

32

AIC Regional Needs Assessment:
Top 5 needs identified across all populations and communities

1. **Lack of access, particularly timely access, to specialty behavioral health care**
2. **Very little, if any, coordination happening between primary care and specialty behavioral health**
3. Sustainable payment remains the biggest barrier to integrated primary care
4. High prevalence of patients who have experienced ACEs/trauma presenting in primary care
5. Primary care clinics face unique challenges caring for VERY complex patients. Some clinics need additional support & resources - especially rural, Internal Medicine, pediatrics, & School-Based Health Centers

33

33

What I Consistently Heard

What Primary Care Providers Say…

- Many patients can't or don't want to go outside of primary care for behavioral health…so we end up doing the best we can with them
- Specialty BH providers don't accept referrals the way that other medical specialty providers do
  - "We give them a sheet of paper with providers' names and phone numbers and basically tell them good luck!"
- When we refer patients to specialty BH…Either they don't call patients back or their message says they're full and not accepting new patients
- "Why are behavioral health specialists different than other medical specialties? They don't pick up the phone and they don't want our referrals. What is wrong with our system?"

What Specialty Behavioral Health Providers Say…

- We are overwhelmed with clients and can't take everyone
- I can't afford to accept lower-paying insurance plans (e.g. Medicare)
- Kids and/or Medicaid clients are too risky
- I don't have staff the way that medical clinics do - it's just me and I can't do everything
- It's impossible to try to talk to a client's PCP!
- If people aren't motivated enough to call me for an appointment, then they're not going to come to therapy - so why would we accept referrals?

34

34

Integrated primary care is necessary but not sufficient to meet the behavioral health needs of the community

35

35

Building Bridges Between Behavioral Health & Primary Care

- ✓Ongoing learning forum for primary care & specialty BH
- ✓Build relationships and a shared vision
- ✓Create common understanding of the different levels of care
- ✓Focus on solutions to increase BH access & better coordination between specialty BH & primary care

Building Bridges Between Providers
AND
Building Bridges for Patients & Families
Referred from Primary Care to Specialty BH

36

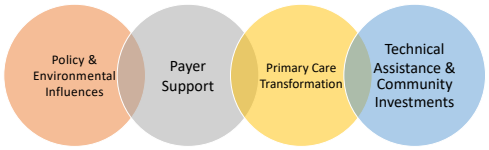
Advancing Integrated Care
Central Oregon

Key Takeaways from First Year of AIC Project

- A neutral convener is key for discovering underlying issues in the community and bringing people together
- Primary care and specialty BH are interdependent on one another, but relationships are strained or non-existent
- Building bridges between primary care & specialty BH is difficult, time-intensive work
- Most stakeholders want to be part of the solution – they just need the right structure to plug into!

37

Key Factors for Advancing Integrated Care



38

Questions…

- What levers do you have, or could you have, to influence policy in your state and/or community?
- Are there payers in your community that you could partner with to help drive integrated care?
- How does your community fund innovative work?
- Are there community organizations focused on improving community health? Could you partner with them? Are there grants available?

39

40

Session Survey

Use the CFHA mobile app to complete the survey/evaluation for this session.

41

Join us next year in Philadelphia, Pennsylvania! Thank you!

42