Triumphs and Trials of a Long-Tenured Integrated Delivery System

Integrated Behavioral Healthcare Conference
The Nicholas A. Cummings Doctor of Behavioral Health Program
Arizona State University
Las Vegas
October 16, 2013
SESSION OVERVIEW

• The impact of integration and healthcare reform on the Nation’s safety net – trends, risks and opportunities

• The role of the Behavioral Health Consultant in the Patient-Centered Medical Home

• Sustaining Integrated Care Practice – clinical and financial viability
Community Mental Health Centers: What were they? What are they? What happened?

- Historical roots – Action for Mental Health (1961), Community Mental Health Center Act (1963), 1960’s social activism
- Community Mental Health Centers -- the initial model
- Federal block grants gave the States authority over the program
- Psychosocial rehabilitation and “priority populations”
- Managed care and behavioral health carve-outs
- Advocacy/consumer groups, peer support and recovery models
- Federal, State and Medicaid cutbacks
Community Health Centers: What were they? What are they? What happened?

- Neighborhood Health Centers -- the initial model
- Avoided Federal block granting, Federal authority maintained
- Stability of mission throughout history
- Service expansion grants for mental health services
- Central to Federal health policy
Our Mission...

To improve the quality of life for our patients through the integration of primary care, behavioral health and substance abuse treatment and prevention programs.

Together...Enhancing Life
Cherokee Health Systems: Merging the Missions of CMHCs and FQHCs
Cherokee Health Systems

Number of Employees: 668

Provider Staff:

Psychologists – 47  
Primary Care Physicians – 26  
NP/PA (Primary Care) – 34  

Master’s level Clinicians - 78  
Psychiatrists – 11  
NP (Psych) – 11  

Case Managers - 35  
Pharmacists – 9  
Dentists - 2
Cherokee Health Systems
FY 2013 Services

56 Clinical Locations in 13 East Tennessee Counties

Number of Patients: 63,291 unduplicated individuals

New Patients: 15,325

Patient Services: 484,494
Cherokee Health Systems
Forks in the Road/Epochs of Development

- Rooted in the mission of community mental health
- Circuit riding outreach into primary care
  - Primary care operations
- Embedded Behavioral Health Consultant role
- Blending the cultures, becoming an FQHC
- Behaviorist enhanced Patient-Centered Medical Home
  - Value-based contracting
Federally-Qualified Health Center – Integrated Care Development

- Behavioral Health Service Expansion grants
- Community level frustration promotes innovation
- Trade association (NACHC) beginning to awaken
- Riding the PCMH wave
- Payer interest
Community Mental Health Centers – Integrated Care Development

- National Council leadership
- 4-Quadrant Model, “reverse”/bi-directional integration, health homes, FQCBHCs
- SAMHSA/Center for Integrated Health Solutions
- Primary Care-Behavioral Health Integration grantees
- Trends – partnerships, mergers, FQHC aspirations
In Quest of Integration

FQHC
Healthcare Home
Primary Care
Preventive Care
Disease Management

CMHC
Specialty Care
Psychosocial Supports
Psychiatric Consultation
Case Management
In Quest of Integration

FQHC
- Healthcare Home
- Primary Care
- Preventive Care
- Disease Management

Primary Behavioral Care
- Real-Time Consultation
- Behavioral Medicine Scope
- Patient Self-Management
- Health/Wellness

CMHC
- Specialty Care
- Psychosocial Supports
- Psychiatric Consultation
- Case Management
The First Generation of “Integration”
Initial Forays

- Preferential referral relationships
- Screening
- Specialty consultation
- Disease management
- Co-location
- Bi-directional
- Mental Health Homes
- Mergers and acquisitions
### Integration vs. Co-Location

#### Integrated Care
- Embedded member of primary care team
- Patient contact via hand off
- Verbal communication predominate
- Brief, aperiodic interventions
- Flexible schedule
- Generalist orientation
- Behavior medicine scope

#### Co-Located Mental Health
- Ancillary service provider
- Patient contact via referral
- Written communication predominate
- Regular schedule of sessions
- Fixed schedule
- Specialty orientation
- Psychiatric disorders scope
Best Practice Integration

• Blended care team
• Shared support staff and physical space
• Well orchestrated clinical flow
• One clinical record, unified treatment plan
• Communication is immediate
• Shared patient population
• Reimbursement mechanisms support the model
Best Practice Integration

- Expanded, behavior-focused PCMH
- Blended and blurred professional roles
- Targeting high-risk, high-need populations
- Integration defines corporate identity and mission
- Partnership with payers
- Financing model encourages and supports
- In sync with the goals of healthcare reform
Integrated Care in the Context of Healthcare Reform
Impact of Healthcare Reform on Providers
Opportunities, Challenges, Burdens and Risks

• Innovation is in the air
• Increased accountability
• Payment reform
• Delivery system realignment
US Health and Mental Health Spending as a % of GDP

Sources: data.worldbank.org and economix.blogs.nytimes.com
Americans Suffering From a Diagnosable Behavioral Disorder

- 10% Treatment from Behavioral Specialists
- 33% Treatment from Primary Care Provider
- 57% Untreated

Source: Kathol and Gatteau – Healing Mind and Body, 2007
Factors Prompting Integration

- MH/SU services system can’t accommodate demand, let alone need
- More seek help for mental health problems in primary care
  - Failure of referral
  - Stigma endures
- Behavioral factors in chronic disease management
- Reduce health disparities of individuals with SMI
- Improve the health of populations
- Improve the patient experience (access, quality, satisfaction)
- Reduce per capita cost of care
US Healthcare Expenditures: High Cost Populations

• A small percentage of the population account for most of the cost

• 75% of the cost is devoted to treating chronic conditions

• People with SMI are five times more likely to experience a co-occurring chronic medical condition  
  - Bazelon Center Report

• Healthcare expenditures for Medicare enrollees with a psychiatric diagnosis were 22% higher excluding the costs for mental healthcare  
  - Windsor Health Plan

• Presence of a diagnosis of depression or anxiety predicted higher total healthcare costs  
  - Melek & Norris, 2008

• Mental health disorders and chronic medical conditions are each risk factors for development of the other  
  - Druss, 2011
Percentage of Adults with Mental Disorders and/or Medical Conditions


- People with mental disorders: 25% of adult population
- People with medical conditions: 58% of adult population
- 68% of adults with mental disorders have medical conditions
- 29% of adults with medical conditions have mental disorders
Creating a Future in a Reformed Healthcare System
Challenges and Opportunities

• Unsustainable cost, unacceptable outcomes, millions without access
• Unrealistic to expect increased funding for current services
  • Innovation is in the air
  • Behavioral factors are under-appreciated cost drivers
  • Patients of the safety net – high need, high cost
• Integrated Care – best option for relevance and impact
What is the PCMH?

A PCMH puts patients at the center of the health care system, and provides primary care that is “accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.”

(American Academy of Pediatrics)
PCMH “Joint Principles”

- Personal physician
- Physician led practice team
- Whole person orientation
- Care is coordinated and integrated
- Quality and safety are hallmarks
- Enhanced access to care
- Payment reform

Adopted by AAFP, AAP, ACP, AOA Feb., 2007
NCQA

• National Committee on Quality Assurance (NCQA)
  – 501(c)(3) dedicated to improving health care quality
  – NCQA offers “recognition” programs for various aspects of clinical care: diabetes, cardiovascular disease, back pain
  – One of the recognition programs is for PCMH
  – 3 levels of accreditation: Level 1 (lowest), Level 2, and Level 3 (highest)
NCQA Lingo

- The metrics that NCQA uses to assess your practice are called “standards”

- There are two sets of standards:
  - PPC-PCMH (2008, no longer available)
  - PCMH (2011, released at the end of March)

- NCQA grants recognition for 3 years at a time
each “standard” is composed of several “elements”

Each “element” is composed of several “factors”
# 2008/2011 Comparison

<table>
<thead>
<tr>
<th>2008 Standards</th>
<th>2011 Standards</th>
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<tbody>
<tr>
<td>PPC-PCMH 1: Access &amp; Communication</td>
<td>PCMH 1: Enhance Access &amp; Continuity</td>
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<tr>
<td>PPC-PCMH 2: Patient Tracking and Registry Function</td>
<td>PCMH 2: Identify and Manage Patient Populations</td>
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<tr>
<td>PPC-PCMH 3: Care Management</td>
<td>PCMH 3: Plan and Manage Care</td>
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<tr>
<td>PPC-PCMH 4: Self Management Support</td>
<td>PCMH 4: Provide Self-Care &amp; Community Support</td>
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<tr>
<td>PPC-PCMH 5: Electronic Prescribing</td>
<td>PCMH 5: Track and Coordinate Care</td>
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<tr>
<td>PPC-PCMH 6: Test Tracking</td>
<td>PCMH 6: Measure and Improve Performance</td>
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<td>PPC-PCMH 7: Referral Tracking</td>
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<td>PPC-PCMH 8: Performance Reporting and Improvement</td>
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<tr>
<td>PPC-PCMH 9: Electronic Communication</td>
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PCMH (2011) Overview

1. **Enhance Access and Continuity**
   - A. Access During Office Hours
   - B. Access After Hours
   - C. Electronic Access
   - D. Continuity (with provider)
   - E. Medical Home Responsibilities
   - F. Culturally/Linguistically Appropriate Services
   - G. Practice Organization

2. **Identify/Manage Patient Populations**
   - A. Patient Information
   - B. Clinical Data
   - C. Comprehensive Health Assessment
   - D. Use Data for Population Management

3. **Plan/Manage Care**
   - A. Implement Evidence-Based Guidelines
   - B. Identify High-Risk Patients
   - C. Manage Care
   - D. Manage Medications
   - E. Electronic Prescribing

4. **Provide Self-Care and Community Resources**
   - A. Self-Care Process
   - B. Referrals to Community Resources

5. **Track/Coordinate Care**
   - A. Test Tracking and Follow-Up
   - B. Referral Tracking and Follow-Up
   - C. Coordinate with Facilities/Care Transitions

6. **Measure & Improve Performance**
   - A. Measures of Performance
   - B. Patient/Family Feedback
   - C. Implements Continuous Quality Improvement
   - D. Demonstrates Continuous Quality Improvement
   - E. Report Performance
   - F. Report Data Externally
Key Components of the PCMH

• Ongoing relationship with a personal physician who is trained to provide first contact, continuous and comprehensive care
  • An informed and activated patient
    • Whole person orientation
  • Care is co-managed by a team who collectively take responsibility to provide or arrange for care
    • Levels of care include acute, chronic and preventive
      • Span of life care
    • Care interfaces with family and community context as appropriate
Fostering the Informed and Activated Patient

- Assess readiness to change.
- Mutually establish behavioral goals and behavior change strategies.
- Employ motivational interviewing and problem focused interventions.
- Support patient self-management and self-regulation skills.
- Foster resiliency and personal responsibility for health.
Cherokee’s Patient-Centered Medical Home Model

- Embedded Behavioral Health Consultant on the Primary Care Team
- Real time behavioral and psychiatric consultation available to PCP
  - Focused behavioral intervention in primary care
  - Behavioral medicine scope of practice
  - Encourage patient responsibility for healthful living
  - A behaviorally enhanced Healthcare Home
Blending Behavioral Health into Primary Care
Cherokee Health Systems’ Clinical Model

Behaviorists on the Primary Team
The Behavioral Health Consultant (BHC) is an embedded, full-time member of the primary care team. The BHC is a licensed Health Service Provider in Psychology. Psychiatric consultation is available to PCPs and BHCs.

Service Description
The BHC provides brief, targeted, real-time assessments/interventions to address the psychosocial aspects of primary care.

Typical Service Scenario
The Primary Care Provider (PCP) determines that psychosocial factors underlie the patient’s presenting complaints or are adversely impacting the response to treatment. During the visit the PCP “hands off” the patient to the BHC for assessment or intervention.
BHC Scope of Service

- Consultation and co-management in the treatment of mental disorders and psychosocial issues
- Management of psychosocial aspects of chronic and acute diseases
- Application of behavioral principles to address lifestyle and health risk issues
The Behavioral Health Consultant in Primary Care

Characteristics, Skills and Orientation to Practice

Characteristics

• Flexible, high energy level
• Team Player
• Interest in health and fitness

Skills

• Finely honed clinical assessment skills
• Behavioral medicine knowledge base
• Cognitive behavioral intervention skills
The Behavioral Health Consultant in Primary Care
Characteristics, Skills and Orientation to Practice

Orientation to Practice

• Action-oriented, directive, focus on patient functioning
• Emphasis on prevention and building resiliency
• Utilizes clinical protocols and pathways
• Invested in educating patients, health literacy
The Integrated Care Psychiatrist

• Access and Population-Based Care
• Enhance the Skills of Primary Care Colleagues
  • Treatment Team Meetings
    • Telepsychiatry
• Stabilize Patients and Return to Primary Care
  • Co-Management of Care
Standard 1 Enhance Access and Continuity

Element C Electronic Access
Behavioral health clinicians can submit and access entries in patient record

Element G Practice Team
Care team includes behavioral health clinicians who can assist with diagnosis of mental health and substance use disorders and address psychosocial and emotional aspects of health problems
Standard 4 Provide self-care support and community resources

Element B
On site treatment for mental health/substance abuse disorders/psychosocial and emotional aspects
Arranges referral for these disorders if beyond scope on site
Real-World Model

Real-World Experience

Real-World Training

Primary Behavioral Care Integration Training Academy
November 14-15, 2013

Behavioral Health Consultant Training Academy
January 30-31, 2014

Cherokee Health Systems, Knoxville, Tennessee
Why Most Current Integration Initiatives Will Fail

- Under appreciate the practice transformation required
- Behaviorists are unequipped for integrated practice
- Contracts do not support the care model
- Not in sync with Triple Aim goals
Operation Support of Integrated Care

• Primary care is a complex, volume-driven business

• Achieving PCMH recognition requires practice transformation

• Nuts and bolts – staffing, facility, schedule, EHR

• Data analytics – payers are buying outcomes
Staffing the Integrated PCMH Care Team

• The Care Team
  3 Primary Care Providers
  1 Behavioral Health Consultant
  Nursing Support (1.75 per FT-PCP)
  Administrative Support (1.25 per FT-PCP)
  Care Coordination and Community–based staff
  (support several teams)

• Consultation Support – real time
  Psychiatry
  Pharmacy
Staffing

Get the “right” people on the bus, and the “wrong” people off the bus

— “Right” people
  • Committed to excellence
  • Embrace change
  • See the big picture
  • Attentive to details
  • Flexible/willing to try new ideas
  • Fit the integrated care culture
  • Computer literate

— “Wrong” people
  • Resistant to change
  • Mercenary
  • Negative
  • Inflexible
  • Unwilling to take risks
  • “My turf”
Staffing

“I like change, as long as it doesn’t affect me.”

- Dr. Ex-Cherokee Physician
Facilities and Layout

• Three (3) exam rooms per PCP

• Embed one (1) BHC office between (or beside) the PCP exam rooms
  – The goal is to create a close physical proximity of the PCPs and BHCs
  – Avoid placing the BHC at the “end of the hallway,” or having “closed-door” practices

• Confidential spaces for quick consultations

• Lab and X-Ray Space
Scheduling

Provider schedule

• PCPs – 15 min. established/30 min new
• BHCs – same as PCP schedule
• 50% open slots for BHCs and PCPs

Provider productivity expectations

• 100+ primary care physician encounters/week
• 90+ primary care NP encounters/week
• 60+ BHC encounters/week
Electronic Health Records

• Difficult to do Integrated Care with paper charts

• Electronic charts allow sharing of records **simultaneously** by multiple providers

• As an “early implementer” of EHR, we struggled with finding a system that would accommodate medical, BHCs, behavioral and dental
  
  – We did a lot of customizing of the EHR, especially with behavioral health templates
Financing the Behaviorist Enhanced Healthcare Home...

It’s harder than it looks!
Cherokee Health Systems Revenue History

- FQHC Management
- Primary Care Expansion
- 1st Primary Care
VISITS BY PAYER SOURCE

- TennCare: 42%
- Uninsured: 28%
- Medicare: 19%
- Private: 11%
- BHSN: 11%
- KCHD: 2%

Uninsured: 28%
Medicare: 19%
Private: 11%
BHSN: 11%
KCHD: 2%
Payment Policy Disincentives for the Integration Paradigm

- Mental health carve-outs
- Excessive documentation requirements
- Same day billing prohibition
- Encounter-based reimbursement
- Antiquated coding requirements
Financing Structure for Integration of BHCs into Healthcare Homes

- Health and Behavior Assessment/Intervention
  CPT Codes 96150-55
- Same day billing by PCP and BHC
- Valuing consultation and case coordination
  - Global funding streams
  - Value-based contracting
Funding Mechanisms

- Fee For Service (with or without quality incentives)
- Case Rate
- Capitation
- Blended Capitation
- Incentive Pools / Shared Savings
- Percent-of-Premium
- Something Else?
An Afternoon in the Life of a BHC
(Clinical Perspective)

- 12 yo male with abdominal pain (new) 96150
- 40 yo male with chronic depression, DM, HTN (f/u) 90832
- 58 yo female with fibromyalgia, insomnia (new) 96150
- 44 yo female with chronic pain, suicide attempt (f/u) 90832
- 58 yo male with post-MI, hx SA and meth lab (f/u) 90832
- 59 yo female with HTN, DM, CAD, Depression (new) 90791
- 56 yo male with Panic, Obesity (f/u) 90832
- 52 yo female with grief (new) 90791
- 13 yo male with obesity, weight management (f/u) 96152

9 PATIENTS IN 4 HOURS
An Afternoon in the Life of a BHC  
(Financial Perspective)

<table>
<thead>
<tr>
<th>Age</th>
<th>Status</th>
<th>ID Number</th>
<th>Fees</th>
<th>Charges</th>
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<tbody>
<tr>
<td>12 yo</td>
<td>Commercial</td>
<td>96150(1)</td>
<td>789.00</td>
<td>25.00</td>
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<td>40 yo</td>
<td>Uninsured (BHSN)</td>
<td>90832</td>
<td>296.32</td>
<td>30.75</td>
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<tr>
<td>58 yo</td>
<td>Uninsured</td>
<td>96150(2)</td>
<td>729.1</td>
<td>0.00</td>
</tr>
<tr>
<td>44 yo</td>
<td>Uninsured (BHSN)</td>
<td>90832</td>
<td>296.30</td>
<td>30.75</td>
</tr>
<tr>
<td>58 yo</td>
<td>Uninsured (BHSN)</td>
<td>90832</td>
<td>305.70</td>
<td>30.75</td>
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<tr>
<td>59 yo</td>
<td>Uninsured (BHSN)</td>
<td>90791</td>
<td>311</td>
<td>61.50</td>
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<tr>
<td>56 yo</td>
<td>Uninsured (Slide)</td>
<td>90832</td>
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<td>15.00</td>
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<td>52 yo</td>
<td>TennCare</td>
<td>90791</td>
<td>309.81</td>
<td>70.88</td>
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<tr>
<td>13 yo</td>
<td>TennCare</td>
<td>96152(2)</td>
<td>278.00</td>
<td>34.30</td>
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</table>

TOTAL REVENUE GENERATED IN 4 HOURS = $298.93
BHC Billing, Coding, and Documentation

Medical
- Assessment or Intervention?
  - Initial Assessment 96150
  - Re-Assessment 96151
  - Individual 96152
  - Group (2 or more) 96153
  - Family (with patient) 96154
  - Family (w/o patient) 96155

Primary Focus of Clinical Attention

Behavioral
- Assessment or Intervention
  - Diagnostic Intake (90791)
  - Follow-up Intervention (16-37 minutes) (90832)
2009 HCPCS G9001
Coordinated care fee, initial rate
• Added on Sunday, October 01, 2000
• BETOS Classification: Other
• Medicare coverage status: Special coverage instructions apply

• Added to claim to reimburse for coordination and consultation activities of the Integrated Care model

• Billing entity must have required program components in place to qualify for reimbursement

• Billing entity subject to review or certification to ensure compliance with program standards

2009 HCPCS G9002
Coordinated care fee, maintenance rate
Integrated Care Standards

- Weekly multidisciplinary care team meeting
- Behavioral health provider embedded on primary care team
- Real-time psychiatric consultation available
- Behavioral health screening of primary care patient
- Integrated clinical record & treatment plan
- Teleconference capability to import providers, as needed
Placing a VALUE on Integrated Care

Distribution of Resources – TennCare Integrated RFP Databook

- Inpatient 17%
- MH Inpatient 5%
- MH Outpatient 4%
- E & M Services 16%
- Surgery 16%
- Specialty Services 17%
- Home Health 4%
- Emergency Room 9%
- Other Services 14%
Placing a VALUE on Integrated Care

- Reduced ER Utilization
- Reduced Inpatient Admissions
- Reduced Specialty Referrals
- Increased Patient Satisfaction
- Increased Primary Care Utilization
- Improved Outcomes
Figure 1: Comparison of CHS utilization with regional providers
Payer 1 Clinical Measures

• Appropriate Medications for Asthma
• Diabetes HgbA1C Screening
• Diabetes LDL-C Screening
• Lead Screening in Children
• Frequency of Prenatal Care
Payer 1 “Accountable Care”
Bonus Program

• Improve Access to Care
  – At least 50% of all patient visits are same day

• Reduce Avoidable Hospital Admissions
  – At least 50% of all patient discharged from hospital are seen by a PCP within 7 days of discharge

• Reduce Inappropriate ER Utilization
  – At least 50% of all patients seen in the ER are seen by a PCP within 7 days of the ER visit

• Improve Care of High Risk Patients
  – At least 50% of patients in high-risk cohorts have no hospitalizations or ER visits for 6 months
Financing Sustainable Integration – Key Concepts

• Grants are fool’s gold
• Cover the cost of direct care plus “behind the scenes” activities
• Deliver value by improving outcomes and reducing overall cost
• Know your impact, i.e. cost offset
• You get what you negotiate, not what you deserve
Reflections On 40 Years of Integrated Care

I. Patients always point the way.
II. Never let the manifest demand obscure the unpresented need.
III. Mission is the compass.
IV. Just do it!
V. Developing the care model takes work. Just showing up is not enough.
VI. Not every Behaviorist can make it in primary care.
VII. Friends in high places can be helpful, though not essential.
VIII. Contracting is a high stakes game.
IX. Payment methodology: It’s not the vehicle, merely the fuel.
X. Bring value: Always strive to serve the greater good.
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