Behavioral Health Specialty Services and Integrated Healthcare: Challenges and Opportunities

Presented by:

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Quality Vs. Quantity Discussion: Quality for Current Caseloads and/or Quality for Persons Waiting For Services? A Scope of Quality Definition Challenge

1. Accessible Services
2. Consumer-Centered Services
3. Cost-Effective Services
4. Outcome Based Services
5. Full integration of Utilization Management
6. CMS Corporate Compliance
7. HIPAA Compliance
8. State/Federal Standards
9. JCAHO/CARF/COA Accreditation Standards
10. Clinical Best Practice Performance Standards
11. Community Support Best Practice Performance Standards
12. Non-Clinical Best Practice Performance Standards
1. From the clinicians’ perspective, are the caseloads in your organization “full” at this time?
   **Yes = 74%**  **No = 26%**

2. Do you know the cost and days of wait for your organization’s first call to treatment plan completion process?
   **Yes = 41%**  **No = 59%**

3. Indicate the no show/cancellation percentage last quarter in your organization for the intake/assessment appointments:
   A. 0 to 19% = 20%
   B. 20 to 39% = 42%
   C. 40 to 59% = 15%
   D. Not aware of percentage = 23%

4. Indicate the no show/cancellation percentage last quarter in your organization for Individual Therapy appointments:
   A. 0 to 19% = 24%
   B. 20% to 39% = 50%
   C. Not aware of percentage = 26%
NCQA Accreditation Standards for Patient-Centered Medical Homes (PCMH)

- NCQA has published accreditation standards for PCMHs
- Primary Care Development Corporation has developed a standard version of the Baseline PCMH Self-Assessment Tool that will guide PCMHs in their need to obtain accreditation
## PCMH 1: Enhance Access & Continuity

<table>
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<th>Documentation Available? (Y/N)</th>
<th>Source?</th>
<th>Notes/Comments</th>
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<td>A:</td>
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<td>1. Providing same-day appointments</td>
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<td>2. Providing timely clinical advice by telephone during office hours</td>
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<td>3. Providing timely clinical advice by secure electronic messages during office hours</td>
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<td>4. Documenting clinical advice in the medical record</td>
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<td><strong>MUST PASS Element - Passed at 50% Level?</strong> NO</td>
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<td>B:</td>
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<tr>
<td></td>
<td>1. Providing access to routine and urgent-care appointments outside regular business hours</td>
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<td>2. Providing continuity of medical record information for care and advice when the office is not open</td>
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<td>3. Providing timely clinical advice by telephone when the office is not open</td>
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<td>4. Providing timely clinical advice using a secure, interactive electronic system when the office is not open</td>
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<td>5. Documenting after-hours clinical advice in patient records</td>
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Source: Primary Care Corporation – PCMH Self-Assessment Tool

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Key Components of a “Reformed” Health Care System

1. Prevention
2. Integrated “Horizontal” Care Delivery System
3. Accountable Care Organizations
4. Medical Homes/Healthcare Homes
5. Payment Reform – Primarily shared Risk models with incentive payments to providers for meeting quality outcome indicators

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Payment Models – Highest to Lowest Provider/Payer Risk

1. Full Risk Capitation/Sub-Capitation Rates (Per Member per Month)
2. Partial Risk Outpatient Only Capitation/Sub-Capitation Rates
3. Bundled Rates/Episodes of Care Rates – Shared Risk
4. Case Rates – Shared Risk
5. Capped Grant Funding – Shared Risk
6. Performance Based Fee for Service – Shared Risk
7. Fee for Service – Payer Risk
“Value-Based Purchasing” Model

1. Payment Reform is moving from “paying for volume to paying for value/quality”

2. VBP requires integration of our clinical, quality and financial information and the ability to track and analyze costs by consumer, provider, team, program, and payor and can operate effectively under fee for service, case rate, and sub-capitation payment models in order to succeed under a variety of Pay for Performance (P4) bonus arrangements.

3. Medicare Case Study:
   - October 2011 – Medicare will launch VBP for hospitals - +1% to – 1% rate adjustment based on quality measures
   - In 2017 = +2% to – 2% Medicare rate adjustment based on benchmarks that get higher each year – “race to the top” in hospital quality
Overview: Parity Law and Healthcare Reform Opportunities and Challenges

1. **Accountable Care Organizations (ACOs)** Model of Service Delivery

2. **Primary Care Practice Medical Homes** – Integration of primary care, and behavioral health needs available through and coordinated by the PCP

3. **CBHO Health Homes/Person-Centered Medical Homes** - Integration of primary care, and behavioral health needs available through and coordinated by the CBHO

4. **Federally Qualified Health Centers (FQHCs)** - Integration of primary care, oral health, and behavioral health needs)

5. **Multi Agency Health Homes** – Integrates medical, behavioral, social services, etc.

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David Lloyd, Founder
Overview: HealthCare Reform Opportunities and Challenges

- **Accountable Care Organizations (ACOs)** Model of Service Delivery

  ![Accountable Care Organization (ACO) Model](Diagram Source: Dale Jarvis)

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Healthcare Reform: Accountable Care Organizations (ACOs) Next Healthcare Model...

2. **Medicare**: Allow providers organized as ACOs that voluntarily meet quality thresholds to share in the cost savings they achieve (2012); foundation for bundled payments

3. **Medicaid Demonstration Projects**:
   a. Pay bundled payments for episodes of care that include hospitalizations (2010-2016)
   b. Make global capitated payments to safety net hospital systems (FY2010-2012)
   c. Allow pediatric medical providers organized as ACOs to share in cost-savings (2012-2016)
Illinois’ Integrated Care Pilot Program Payment Model

1. A Capitated Per Member Per Month integrated care pilot program with the primary risk level is at the managed care entity(s)

2. The Illinois Integrated Care Program includes 40,000 Medicaid clients in Lake, Kane, DuPage, Will, Kankakee and suburban (areas with zip codes that do not begin with “606”) Cook county

- Two HMOs have been contracted to manage the Illinois Integrated Health Program for five years with five year renewal effective 2011 (Aetna and Centene/IlliniCare Health Plan)
- Move from client managed vertical silos of care to care coordinated/managed horizontal integrated system of care
- Estimated savings in first five years = $200,000,000

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CMS needs models for ACOs that target the populations cared for by the Safety Net. Patients covered by Medicaid and the uninsured will be a significant focus for health reform expansion in 2014. Safety Net systems have the opportunity to help shape the evolving concept of ACOs for these groups. Safety Net systems can build collaborations with little active competition from others concentrating on ACOs predominately serving Medicare and commercial patients.

The Safety Net would benefit from the support that will be offered by CMS to prepare for the massive change that this transformation will require. An ACO governance model will need to be built that takes into account the various accountabilities of County systems, FQHCs and private hospitals and physicians. An ACO finance strategy will need to be conceived that transforms the current complexity of Intergovernmental Transfer agreements (IGTs), Disproportionate Share Hospital (DSH) payments and FQHC PPS reimbursement into a “bundled” revenue stream that encourages efficiencies and best practices. Clinical silos will need to be replaced with integrated approaches and shared agreement on approaches to care delivery. This transformation will require an infusion of financial, regulatory, legal and technical assistance.
Overview: HealthCare Reform Opportunities and Challenges

- Primary Care Practice Medical Homes – Integration of primary care, and behavioral health needs available through and coordinated by the PCP

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1. **Healthcare Plans Medical Home** – The state of Washington is considering an amendment to its 1915b Medicaid Waiver that will shift behavioral healthcare funding to support a medical home for non-SED/SMI Medicaid eligible persons through their state health plan (HMO)

2. The 1915b behavioral health carve out waiver will be amended to shift the capitated payments from Regional Service Networks to the state health plan for non-SED/SMI clients.
Specialty Care Medical Homes For People With Severe, Persistent Mental Disorders

ABSTRACT The patient-centered medical home concept is central to discussions about the reform of the health care delivery system. Most descriptions of the concept assume that a primary care practice would serve as the hub of the medical home. However, for people with severe and persistent mental disorders, specialty health care settings serve as the principal point of contact with the health care system. For them, a patient-centered medical home in a specialty setting would be the most expedient way to address their urgent health care needs. Among other issues, implementing this idea would mean reimbursement strategies to support the integration and coordination of primary care in specialty settings.
Arkansas Solution:
Source: Governor Beebe’s Letter and attached application of 2-11-11

Proposal
Arkansas proposes that by May 1, 2011, Arkansas and CMS (Medicaid and Medicare) come to an agreement on the terms and conditions of a Section 1115 waiver under which:

- Arkansas Medicaid, Medicare, Arkansas BlueCross and BlueShield, and any other private insurers that elect to participate will develop a new price system for healthcare that will be employed by Medicaid and other third-party payers who elect to use it (in whole or in part). The new system would be based on the following:
  - Payments to medical-care partnerships for episodes of physical and behavioral care (acute, sub-acute, and chronic).
    - At least one partner would be a primary-care provider.
    - The primary-care providers, with any assistance requested from Arkansas Medicaid, would also assume the role of medical home.
    - No partnership would be required to treat any individual for an episode of care if it felt it lacked the capacity to do so.
    - Some individuals or practices and medical organizations could and likely would belong to more than one “partnership”, reflecting the multiple formal and informal practice patterns that currently exist in Arkansas and elsewhere.
  - Note: Arkansas has tentatively selected the “care partnerships” as the payee for the new pricing system. This reflects the fact that the Arkansas health-care system is characterized by a wide variety of formal and informal relationships, with practices and organizations of varying size and scope. The partnership would appear to be the most flexible form of business and professional organization available today that promotes the mutual respect and assistance required for successful health outcomes.
Arkansas Solution:
Source: Governor Beebe’s Letter and attached application of 2-11-11

- Payments to maternal and child-health partnerships for prenatal, birth and delivery, and post-natal care services, well-child care, and developmental services and to primary-care providers for adult preventive services.

- Payments to long-term-care partnerships caring for individuals who need assistance with activities of daily living (ADLs).

- The new price system would become effective for Medicaid statewide as follows:
  - 100% of the pricing for payments to maternal-and-child-health partnerships would be published by May 1, 2012, and become effective on July 1, 2012.
  - 25% of the pricing for payments to medical-care partnerships would be published by May 1, 2012, and become effective on July 1, 2012.
  - An additional 50% (for a total of 75%) of the pricing for payments to medical-care partnerships would be published by May 1, 2013, and become effective on July 1, 2013.
  - An additional 25% (for a total of 100%) of the pricing for payments to medical-care partnerships would be published by January 1, 2014, and become effective on that date.
  - 100% of the payments to long-term-care partnerships would be published by May 1, 2013, and become effective for new patients on July 1, 2013.
Overview: HealthCare Reform Opportunities and Challenges

1. **CBHO Healthcare Homes** - Integration of primary care, and behavioral health needs available through and coordinated by the CBHO

2. IT capacity to fully integrate EHRs with all other providers

3. Provide care management/care coordination for all integrated health care needs

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David Lloyd, President
Overview: HealthCare Reform Opportunities and Challenges

- **CBHO Healthcare Homes** - Two Types of Involvement
  - Participation in development and deployment of bi-directional integrated care projects
  - Become a health neighbor to a health home as a high performing specialty MH/SU provider organization

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CBHC Position on Healthcare Reform and Integration
Approved CBHC Board of Directors May 2010

Core Principles (partial list):

- Colorado’s community mental health system should be utilized as experts in behavior change to promote overall health outcomes.
- Development of integrated service delivery systems begins with providing mental and physical health services in both settings.
- Community Mental Health Centers and Clinics (CMHC) may serve as the healthcare home of choice for adults with serious mental illness and children with serious emotional disturbance.
- The cost of healthcare can be reduced if the mental health and substance use treatment needs of the population are addressed in conjunction with their physical healthcare needs.
- Services should be integrated at the point of delivery, actively involve patients as partners in their care, and be coordinated with other community resources.
- Technology and health information exchange should be used to enhance services and support the highest quality services and health outcomes...
Cross Roads of Future Behavioral Healthcare Service Capacity

1. **CBHOs focus on serving SED/SMI populations in a carve out funding model**
   - Michigan – 1915b and 1915c Medicaid waivers for MH/SU/DD needs
   - Missouri – 25 CBHOs becoming Healthcare Homes
   - Connecticut – Specialty Care Medical Homes for Adult SPMI Population

2. **CBHOs focus on serving all clients in a carve in service delivery funding model**
   - New Jersey – Four Statewide Accountable Care Organizations
   - Arkansas – Medical- Care Partnerships
Bi-Directional Care Models

Bi-Directional Care: Behavioral Health in Primary Care and Primary Care in Behavioral Health

Clinical Design for Adults with Low to Moderate and Youth with Low to High BH Risk and Complexity

- Primary Care Clinic with Behavioral Health Clinicians embedded, providing assessment, PCP consultation, care management and direct service
- Partnership/Linkage with Specialty CBHO for persons who need their care stepped up to address increased risk and complexity with ability to step back to Primary Care

Clinical Design for Adults with Moderate to High BH Risk and Complexity

- Community Behavioral Healthcare Organization with an embedded Primary Care Medical Clinic with ability to address the full range of primary healthcare needs of persons with moderate to high behavioral health risk and complexity

Source: Dale Jarvis, Dale Jarvis Consulting

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<table>
<thead>
<tr>
<th>Quadrant I</th>
<th>Quadrant II</th>
<th>Quadrant III</th>
<th>Quadrant IV</th>
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<tbody>
<tr>
<td>BH ↓ PH ↓</td>
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- **Quadrant I (Low BH, Low PH):**
  - PCP (with standard screening tools and behavioral health practice guidelines)
  - PCP-based behavioral health consultant/care manager
  - Psychiatric consultation

- **Quadrant II (High BH, Low PH):**
  - Behavioral health clinician/case manager with responsibility for coordination w/ PCP
  - PCP (with standard screening tools and guidelines)
  - Outstationed medical nurse practitioner/physician at behavioral health site
  - Specialty behavioral health
  - Residential behavioral health
  - Crisis/ED
  - Behavioral health inpatient
  - Other community supports

- **Quadrant III (Low BH, High PH):**
  - PCP (with standard screening tools and behavioral health practice guidelines)
  - PCP-based behavioral health consultant/care manager (or in specific specialties)
  - Specialty medical/surgical
  - Psychiatric consultation
  - ED
  - Medical/surgical inpatient
  - Nursing home/home based care
  - Other community supports

- **Quadrant IV (High BH, High PH):**
  - PCP (with standard screening tools and guidelines)
  - Outstationed medical nurse practitioner/physician at behavioral health site
  - Nurse care manager at behavioral health site
  - Behavioral health clinician/case manager
  - External care manager
  - Specialty medical/surgical
  - Specialty behavioral health
  - Residential behavioral health
  - Crisis/ED
  - Behavioral health and medical/surgical inpatient
  - Other community supports

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Persons with serious mental illnesses could be served in all settings. Plan for and deliver services based upon the needs of the individual, personal choice and the specifics of the community and collaboration.

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Source: “Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home”, published by The National Council for Community Behavioral Healthcare
The Levels of Systematic Collaboration/Integration

**Source:** Adapted from *The Collaborative Family Health Care Association’s (CFHA)* by William J. Doherty, Ph.D., Susan H. McDaniels, Ph.D., and Macaran A. Baird, M.D and modified by Pam Wise Romero, Ph.D. and Bern Heath, Ph.D. of Axis Health System for the Colorado Integrated Care Learning Community

- **Level One – Minimal Collaboration**
  - **Description:** Behavioral health and other health care professionals work in separate facilities, have separate systems, and communicate about cases only rarely and under compelling circumstances.
  - **Where practiced:** Most private practices and agencies.
  - **Funding Mechanisms:** Retains funding and reimbursement strategies for each entity.
  - **Regulatory Implications:** Readily understood as practice model. No challenge to existing regulatory structure.
  - **Advantages:** Allows each system to make autonomous and timely decisions about practice using developed expertise; readily understood as a practice model.
  - **Disadvantages:** Service may overlap or be duplicated; uncoordinated care often contributes to poor outcomes; important aspects of care may not be addressed.

**NOTE:** The terminology in this modification reflects a distinction between collaboration which describes how resources are brought together and integration which describes how services are delivered.

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The Levels of Systematic Collaboration/Integration

**Level Two – Basic Collaboration at a Distance**

**Description:** Providers have separate systems at separate sites, but engage in periodic communication about shared patients, mostly through telephone, letters and increasingly through e-mail. All communication is driven by specific patient issues. Behavioral health and other health professionals view each other as resources, but they operate in their own worlds, have little sharing of responsibility, little understanding of each other’s cultures, and there is little sharing of authority and responsibility.

**Where practiced:** Settings where there are active referral linkages between facilities.

**Funding Mechanisms:** Retains funding and reimbursement strategies for each entity.

**Regulatory Implications:** Collaboration is through agreement (formal or informal) with implications for confidentiality but no substantive regulatory implications

**Advantages:** Maintains each organization’s basic operating structure and cadence of care; provides some level of coordination of care and information sharing that is helpful to both patients and providers.

**Disadvantages:** No guarantee that shared information will be incorporated into the treatment plan or change the treatment strategy of each provider; does not impact the culture or structure of the separate organizations.

*Source:* Adapted from The Collaborative Family Health Care Association’s (CFHA) by William J. Doherty, Ph.D., Susan H. McDaniels, Ph.D., and Macaran A. Baird, M.D and modified by Pam Wise Romero, Ph.D. and Bern Heath, Ph.D. of Axis Health System for the Colorado Integrated Care Learning Community
The Levels of Systematic Collaboration/Integration

**Level Three – Basic Collaboration On-Site with Minimal Integration**

**Description:** Behavioral health and other health care professionals have separate systems but share the same facility. They engage in regular communication about shared patients, mostly through phone, letters or e-mail, but occasionally meet face to face because of their close proximity. They appreciate the importance of each other’s roles, may have a sense of being part of a larger, though somewhat ill-defined team, but do not share a common language or an in-depth understanding of each other’s worlds. This is the basic co-location model. As in Levels One and Two, medical physicians have considerably more authority and influence over case management decisions than the other professionals, which may lead to tension between team and single professional leadership.

**Where practiced:** HMO settings and rehabilitation centers where collaboration is facilitated by proximity, but where there is no systemic approach to collaboration and where misunderstandings are common. Also, within some School Based Health Centers (SBHCs) and within some medical clinics that employ therapists but engage primarily in referral-oriented co-located services rather than systematic mutual consultation and team treatment.

**Funding Mechanisms:** Retains funding and reimbursement strategies for each entity.

**Regulatory Implications:** This model can lead to a multi-use facility where all components may not be subject the same or some regulatory entity creating a challenge for state licensing structures.

**Advantages:** Increased contact allows for more interaction and communication among professionals that also increases potential for impact on patient care; referrals are more successful due to proximity; systems remain stable and predictable; opportunity for personal relationships between professionals to grow and develop in the best interest of patient care.

**Disadvantages:** Proximity may not lead to increased levels of collaboration or better understanding of expertise each profession brings to patient care. Does not necessarily lead to the growth of integration – the transformation of both systems into a single healthcare system.

*Source:* Adapted from *The Collaborative Family Health Care Association’s (CFHA)* by William J. Doherty, Ph.D., Susan H. McDaniel, Ph.D., and Macaran A. Baird, M.D and modified by Pam Wise Romero, Ph.D. and Bern Heath, Ph.D. of Axis Health System for the Colorado Integrated Care Learning Community

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MTM Services
The Levels of Systematic Collaboration/Integration

**Level Four – Close Collaboration On-Site in a Partly Integrated System**

**Description:** Behavioral health and other health care professionals share the same sites and have some systems in common, such as scheduling or charting. There are regular face-to-face interactions about patients, mutual consultation, coordinated treatment plans for difficult cases, and a basic understanding and appreciation for each other’s roles and cultures. There is a shared allegiance to a biopsychosocial/systems paradigm. However, the pragmatics are still sometimes difficult, team-building meetings are held only occasionally, and there may be operational discrepancies such as co-pays for behavioral health but not for medical services. There are likely to be unresolved but manageable tensions over medical physicians’ greater power and influence on the collaborative team.

**Where practiced:** Increasingly practiced within Federally Qualified Community Health Centers (FQHC), some Rural Health Clinics (RHC) and especially Provider (hospital operated) RHCs, as well as some group practices and SBHCs committed to collaborative care.

**Funding Mechanisms:** Retains funding and reimbursement strategies for each entity but in closely shared cases the line can blur (e.g., physician/behavioral health treatment of depression). In a fee-for-service (FFS) environment this model begins to bring same-day billing issues to the table.

**Regulatory Implications:** There is an increasing likelihood that this model will result in a multi-use facility where all components may not be subject the same or some regulatory entity creating a challenge for state licensing structures. Entities retain separate identities, but may require an additional organizational licensing category and cross-training of staff may challenge current professional licensing structures (especially in nursing).

**Advantages:** Cultural boundaries begin to shift and service planning becomes more mutually shared, which improves responsiveness to patient needs and consequent outcomes. There is a strong opportunity for personal relationships between professionals to grow and develop in the best interest of patient care.

**Disadvantages:** Potential for tension and conflicting agendas among providers or even triangulation of patients and families may compromise care; system issues may limit collaboration.

*Source: Adapted from The Collaborative Family Health Care Association’s (CFHA) by William J. Doherty, Ph.D., Susan H. McDaniel, Ph.D., and Macaran A. Baird, M.D and modified by Pam Wise Romero, Ph.D. and Bern Heath, Ph.D. of Axis Health System for the Colorado Integrated Care Learning Community*
The Levels of Systematic Collaboration/Integration

**Level Five – Close Collaboration Approaching a Fully Integrated System**

**Description:** Behavioral health and other health care professionals share the same sites, the same vision, and the same systems in a seamless web of biopsychosocial services. Both the providers and the patients have the same expectation of a team offering prevention and treatment. All professionals are committed to a biopsychosocial/systems paradigm and have developed an in-depth understanding of each other’s roles and cultures. Regular collaborative team meetings are held to discuss both patient issues and team collaboration issues. There are conscious efforts to balance authority and influence among the professionals according to their roles and areas of expertise.

**Where practiced:** In a small number of well developed FQHC, RHC and SBHC settings.

**Funding Mechanisms:** Team care crosses professional boundaries and blurs unit of service funding structure. Most compatible with new funding models such as Healthcare Home, Healthcare Neighborhood and case rate shared risk. Requires a larger organizational structure to manage. Same-day billing is essential in FFS environment.

**Regulatory Implications:** Requires a multi-use facility where all components may not be subject the same or some regulatory entity creating a challenge for state licensing structures. Entities retain separate identities, but may require an additional organizational licensing category and cross-training of staff may challenge current professional licensing structures (especially in nursing).

**Advantages:** High level of collaboration contributes to improved patient outcomes; patients experience their care provided by a collaborative care team in one location, which increases likelihood of engagement and adherence to treatment plan; provides better care for patients with chronic, complex illnesses, as well as those needing prevention/early intervention.

**Disadvantages:** Services may still be delivered in traditional ways for each discipline; separate system silos still operate to limit flexibility of the delivery of care that best meets the needs of the patient as a whole person.

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The Levels of Systematic Collaboration/Integration

**Level Six – Full Collaboration in a Transformed Fully Integrated Healthcare System**

**Description:** Providers have overcome barriers and limits imposed by traditional and historic service and funding structures. Antecedent system cultures and allegiances dissolve into a single transformed system. Practice boundaries have also dissolved and care teams use newly evolved methodology to jointly assess, prioritize, and respond to patients’ care needs. Providers and patients view the operation as a single health system treating the whole person. One fully integrated record is in use.

**Where practiced:** In established clinics that have united the resources not just to augment the service array but also as partners in the conceptual leadership of the service structure and design. This is also practiced in a very small number of localized centers of excellence designed and established expressly to achieve a fully integrated service environment.

**Funding Mechanisms:** Team care crosses professional boundaries and blurs unit of service funding structure. Most compatible with new funding models such as Healthcare Home, Healthcare Neighborhood and case rate shared risk. Requires a larger organizational structure to manage. Same-day billing is essential in FFS environment.

**Regulatory Implications:** Requires a multi-use facility and a regulatory structure that supports all uses. Entities merge and dissolve into one corporate entity, but may require an additional organizational licensing category. Cross-training of staff will challenge current professional licensing structures (especially in nursing).

**Advantages:** The patient’s health and well being becomes the focus of care. Care can occur in brief episodes and is sustained over time.

**Disadvantages:** There are currently no financial mechanisms to support integrated care that combines healthcare disciplines. Because this model is new and very limited in its implementation there is even less research currently available to support the value of it.

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**Source:** Adapted from The Collaborative Family Health Care Association’s (CFHA) by William J. Doherty, Ph.D., Susan H. McDaniel, Ph.D., and Macaran A. Baird, M.D and modified by Pam Wise Romero, Ph.D. and Bern Heath, Ph.D. of Axis Health System for the Colorado Integrated Care Learning Community
Healthcare Reform Context:

Under an Accountable Care Organization Model the Value of Behavioral Health Services will depend upon our ability to:

1. Be Accessible (Fast Access to all Needed Services)
2. Be Efficient (Provide high Quality Services at Lowest Possible Cost)
3. Electronic Health Record capacity to connect with other providers
4. Focus on Episodic Care Needs/Bundled Payments
5. Produce Outcomes!
   - Engaged Clients and Natural Support Network
   - Help Clients Self Manage Their Wellness and Recovery
   - Greatly Reduce Need for Disruptive/ High Cost Services

Presented By: David Lloyd, Founder
Mental Health and Alcohol/Drug Abuse Disorders Have to Be Included to Bend the Cost Curve

### California Fee for Service Medi-Cal Analysis - 2007

<table>
<thead>
<tr>
<th>Services</th>
<th>Medi-Cal FFS Total</th>
<th>Medi-Cal FFS SMI</th>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal FFS Enrollees</td>
<td>1,580,440</td>
<td>166,786</td>
<td>11% SMI % of Total</td>
</tr>
<tr>
<td>Medi-Cal FFS Costs</td>
<td>$6,186,331,620</td>
<td>$2,395,938,298</td>
<td>39% SMI % of Total</td>
</tr>
<tr>
<td>Medi-Cal FFS Cost/Enrollee</td>
<td>$3,914</td>
<td>$14,365</td>
<td>3.7 SMI/Non-Ratio</td>
</tr>
<tr>
<td>Diabetes</td>
<td>4%</td>
<td>11%</td>
<td>2.8 SMI/Non-Ratio</td>
</tr>
<tr>
<td>Ischemic Heart Disease</td>
<td>2%</td>
<td>6%</td>
<td>3.0 SMI/Non-Ratio</td>
</tr>
<tr>
<td>Cerebrovascular Disease</td>
<td>1%</td>
<td>3%</td>
<td>3.0 SMI/Non-Ratio</td>
</tr>
<tr>
<td>Chronic Respiratory Disease</td>
<td>5%</td>
<td>13%</td>
<td>2.6 SMI/Non-Ratio</td>
</tr>
<tr>
<td>Arthritis</td>
<td>2%</td>
<td>7%</td>
<td>3.5 SMI/Non-Ratio</td>
</tr>
<tr>
<td>Health Failure</td>
<td>1%</td>
<td>3%</td>
<td>3.0 SMI/Non-Ratio</td>
</tr>
<tr>
<td>Inpatient Episodes</td>
<td>100</td>
<td>293</td>
<td>2.9 SMI/Non-Ratio</td>
</tr>
<tr>
<td>ER Visits</td>
<td>337</td>
<td>1,167</td>
<td>3.5 SMI/Non-Ratio</td>
</tr>
<tr>
<td>Inpatient Acute Days</td>
<td>609</td>
<td>2,094</td>
<td>3.4 SMI/Non-Ratio</td>
</tr>
<tr>
<td>Primary Care Visits</td>
<td>128</td>
<td>492</td>
<td>3.8 SMI/Non-Ratio</td>
</tr>
<tr>
<td>Specialist Visits</td>
<td>1,211</td>
<td>6,058</td>
<td>5.0 SMI/Non-Ratio</td>
</tr>
</tbody>
</table>

Prepared by JEN Associates, Cambridge, MA

Presented By: David Lloyd, Founder
People with severe mental illness served by public mental health systems have rates of co-occurring chronic medical illnesses that of two to three times higher than the general population, with a corresponding life expectancy of 25 years less.

Treatment of these chronic medical conditions comes from costly ER visits and inpatient stays, rather than routine screenings and preventive medicine.

In 2003, in Missouri, for example, more than 19,000 participants in Missouri Medicaid had a diagnosis of schizophrenia. The top 2,000 of these had a combined cost of $100 million in Missouri Medicaid claims, with about 80% of these costs being related not to pharmacy, but to numerous urgent care, emergency room, and inpatient episodes.

The $100 million spent on these 2,000 patients represented 2.4% of all Missouri Medicaid expenditures for the state’s 1 million eligible recipients in 2003.
Total healthcare utilization per user per month, pre- and post-community mental health case management. The graph shows rising total costs for the sample during the 2 years before enrolling in CMHCM, with the average per user per month (PUPM), with total Medicaid costs increasing by over $750 during that time. This trend was reversed by the implementation of CMHCM. Following a brief spike in costs during the CMHCM enrollment month, the graph shows a steady decline over the next year of $500 PUPM, even with the overall costs now including CMHCM services.

**Source:** PSYCHIATRIC ANNALS 40:8 | AUGUST 2010

Presented By:
David Lloyd, Founder
Change Initiatives to Enhance CBHOs “Value” as a Partner in Healthcare Reform

1. Reduce access to treatment processes and costs through a reduction in redundant collection of information and process variances
2. Develop Centralized Schedule Management with clinic/program wide and individual clinician “Back Fill” management using the “Will Call” procedure
3. Develop scheduling templates and standing appointment protocols for all direct care staff linked to billable hour standards and no show/cancellation percentages
4. Design and implement No Show/Cancellation management principles and practices using an Engagement Specialist to provide qualitative support
5. Design and implement internal levels of care/benefit package designs to support appropriate utilization levels for all consumers
7. Develop and implement key performance indicators for all staff including cost-based direct service standards
8. Collaborative Concurrent Documentation training and implementation

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Change Initiatives to Enhance CBHOs “Value” as a Partner in Healthcare Reform

9. Design and implement internal utilization management functions including:
   - Pre-Certs, authorizations and re-authorizations
   - Referrals to clinicians credentialed on the appropriate third party/ACO panels
   - Co-Pay Collections
   - Timely/accurate claim submission to support payment for services provided

10. Develop public information and collaboration with medical providers in the community through an Image Building and Customer Service plan

11. Develop and implement Supervision/Coaching Plan with coaching/action plans

12. Provide Leadership/Management Training that changes the focus from supervision to a coaching/leadership model

13. Develop objective and measurable job descriptions including key performance indicators for all staff and develop an objective coaching based Evaluation Process

Presented By:
David Lloyd, Founder
Partnering with Health Homes and Accountable Care Organizations

Considerations for Mental Health and Substance Abuse Providers

With private and public payers’ growing awareness that they are spending enormous sums for poor outcomes, new service delivery models have been developed to address the healthcare system’s problems with quality and cost. Of these models, health homes and accountable care organizations (ACOs) are likely to serve as foundational elements of healthcare’s future. Pilot efforts have demonstrated the potential of these models to improve quality while reducing costs. Increasing numbers of payers and providers are investing in them, and health reform’s promotion of them will further accelerate their adoption.

Health homes and ACOs are responsible for providing the full range of healthcare services for the populations they serve. In April 2009, the National Council for Community Behavioral Healthcare released the report, “Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home,” which described a person-centered healthcare home as one that is equipped to care for the whole patient and manage multiple, interrelated and chronic health problems. Through new payment mechanisms, these homes will align their clinical and financial incentives to meet the triple aim of improved quality, patient experience, and reduced costs. Neither health homes nor ACOs will be able to reach that goal without effectively addressing mental health and substance use (MH/SU). MH/SU providers must determine what kind of relationship they want with these entities and what they need to do to qualify as partners.

To ensure their readiness to participate in health homes and ACOs, MH/SU providers are urged to undertake the following action steps:

1. Prepare now for participation in the larger healthcare field
   a. Identify community partners and build relationships, especially with primary care.
   b. Develop competency in team-based care and health homes in particular.
   c. Institute a measurement-based approach to care, incorporating standardized clinical assessment tools into routine service delivery.
   d. Gather data on population served in order to support recognition as a “high-volume” specialty provider.
   e. Increase skills and knowledge in population health management, including wellness and prevention and disease management approaches.

2. Establish credentials as a high performer relative to the triple aim
   a. Adopt quality tools and train staff in using them to track performance.
   b. Assess clients’ experience of care (including its patient-centeredness and cultural/linguistic competence) and address gaps.
   c. Document MH/SU and general health outcomes (e.g., body mass index) and implement a plan for improving areas of weaknesses.
   d. Evaluate the cost and value of the care provided.

3. Ensure information technology readiness
   a. Institute IT systems that are able to support:
      i. Exchange of data within and outside the organization.
      ii. Integration of data as a support of clinical work.

4. Plan for an extended period of change
   a. Implement a change management plan.
   b. Identify key resources and support network for staying current around new and emerging practice and financing models.
   c. Invest in educating staff and board on operational and clinical changes.

The National Council works to support MH/SU providers’ development in these areas through educational materials, webinar series, learning communities, trainings, consultation programs, and its annual conference.

With their focus on effective, coordinated care for the whole person, health homes and ACOs hold the potential for significantly improving the health and wellness of those they serve, including those with serious MH/SU conditions. Access to effective MH/SU services will be critical to the effectiveness of both ACOs and health homes. Regardless of the Affordable Care Act’s ultimate fate, health home and ACOs will be foundational elements of the future healthcare system, and MH/SU providers must immediately begin positioning themselves to be recognized as qualified partners.

Full Report “Partnering with Health Homes and Accountable Care Organizations” available at www.thenationalcouncil.org/cs/partnerships_for_behavioral_health
Thank you for your attention...

- Next Steps?