Evidenced-Based Approach to Integration
Collaborative Care Model

Mental Health Institute
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http://Arkansas.beaconhealthoptions.com
Agenda

- Brief introduction to Beacon Health Options
  - Erick Messias, MD, MPH, PhD
- Overview of Beacon’s White Paper: Integration
- Integration for people with serious mental illness (SMI)
- Q & A
Beacon Health Options was created to provide the scale necessary to deliver against the capital, IT and compliance requirements necessary to serve the nation’s largest health plans.
Beacon Health Options Footprint

- **BROAD REACH IN THE US AND UK**
  - 5,000 employees nationally and in the U.K., serving 50 million people

- **LEADER IN QUALITY**
  - NCQA- and URAC-Accredited Companies

- **KEY OPERATIONAL AREAS**
  - UM/CM
  - QM
  - IT
  - Customer Service
  - Data Analytics
  - Reporting
  - Processing
  - Sales Support

- **LINES OF BUSINESS**
  - Commercial
  - EAP
  - Exchange
  - Federal
  - Medicaid
  - Medicare

**MEMBERSHIP**
- Over 2.5 Million
- 1,000,000 – 2,500,000
- 500,000 – 1,000,000
- Under 100,000

**CENTERS**
- Corporate Headquarters
- Regional Service Centers
- Corporate Operation Centers
- Engagement Centers

- Alaska
- Hawaii

U.K.
Overview of Beacon’s White Paper: Integration
Objectives for our time today

1. Overview of the collaborative care model: the evidence-based approach to PCP-BH integration

2. Integration for members with SMI conditions: how to organize for the most complex populations

3. Q&A
What integration is not

- Screening alone
- Provider education
- Simple colocation won’t magically make a team
- Specialty referral as a route to specialists
- Tracking outcomes in isolation
- Telephone-based disease management
- Integration is not achievable through payment reform alone
Early AQC results have not been compelling

Study compared three cohorts from BCBSMA’s Alternative Quality Contract (AQC) program: AQC w/ BH risk, AQC w/o BH risk and non-AQC

FINDINGS INDICATE SIMPLY SHIFTING RISK ISN’T ENOUGH

- Slightly reduced probability of utilization but MH spend was the same - Members in an AQC contract were slightly less likely to access mental health services, but PMPM MH spend was the same.

- Less improvement for members with some chronic conditions - Members with diabetes and cardiovascular conditions who had BH risk fared worse (improved less) in AQC contract than in non-AQC contracts.

- Initially, insufficient focus on BH - Interviews suggested that the AQC did not change mental health care delivery in the program’s first years. Organizations now focusing efforts to improve integration.

Source: Colleen L. Barry, Elizabeth A. Stuart, Julie M. Donahue, Shelly F. Greenfield Elena Kouri, Kenneth Duckworth, Zirui Song, Robert E. Mechanic, Michael E. Chernew and Haiden A. Huskamp

“The Early Impact Of The ‘Alternative Quality Contract’ On Mental Health Service Use And Spending In Massachusetts.” Health Affairs, 34, no.12 (2015):2077-2085
Only 14% of ACOs have fully integrated behavioral health into primary care

Three key factors increase likelihood of integration:
• Inclusion of BH in total cost of care
• Intensity of BH needs in patient populations
• Low availability of BH services

Integrated ACOs use both primary care expansion and reverse integration models

Notes: Integration is defined by the National Survey of Accountable Care Organizations as the delivery of primary and behavioral healthcare in the same setting. Prevalence of different degrees of integration reflects ACO self-reports.
1. Many different models of integration exist; most models are overly simplistic and reductionist.

2. Wayne Katon, M.D., originally published the first large randomized controlled trial of the collaborative care model in 1995.

3. Since then, more than 80 randomized controlled trials have validated this approach.

4. Proven in different settings and for different populations: youth, seniors, substance use, OB/GYN, etc.

5. The CCM is not a fad.
IMPACT

WITH IMPACT:
- On average, TWICE as many people significantly improved

WHY?
- Team approach with a shared person-centered care plan
- Evidence-based treatments and access to expert advice when treatment needed to be changed; treat-to-target approach with proactive adjustment based on clinical outcomes.
- Population-based care management

USUAL CARE:
- 50% of all patients enrolled were on an antidepressant at the time but were still significantly depressed
- On average, 20% of patients showed significant improvement after 1 year; matches national data for depression treatment in primary care

Source: Jürgen Unützer, MD, University of Washington
Collaborative Care Model
80 RCTs reveal 5 pillars for integrated care

- Requires all five pillars to be successful
- Collaborative care continues to be developed and supported by Jürgen Unützer and his team at the AIMS Center, University of Washington

Source: “The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes”, Jürgen Unützer, MD, University of Washington
Collaborative Care Model
Team-based care is the centerpiece

- Providers with a large number of patients with SMI conditions have experience with integration
- For others, a collaborative care model must be created to include liaison psychiatry and site-based care management

Source: “The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes”, Jürgen Unützer, MD, University of Washington
WHAT MAKES A HIGH FUNCTIONING TEAM?

- Many different models with lots of overlap
- IOM Report Healthcare Teams
  - Values of team members
    - Honesty, Discipline, Creativity, Humility, Curiosity
  - Accountability
    - Measuring and reflecting on function and continuous improvement
  - Principles of team functioning
    - Shared goals, Clear roles, Mutual trust, Effective communication, Measurable processes and outcomes

Mitchell et al., 2012
Collaborative Care Model
Measurement Based Care

Measurement based care
Population based care

Evidence-Based care
Accountable care

Team based care
**Assists with identification and diagnosis**

**Tracks symptoms over time**

**Easy to use**

**Can be done over the phone**

**A good communication and teaching tool**

**PHQ-9 will be a HEDIS measure via NCQA**

**50-70% of people will require at least one change in treatment to get better**

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**Measurement-based care: PHQ-9**

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use &quot;✓&quot; to indicate your answer)</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**For office coding | 0 + _____ + _____ + _____**

**Total Score:** _____
Collaborative Care Model
Evidence Based Care

- Measurement based care
- Population based care
- Evidence-Based care
- Accountable care

Team based care
Collaborative Care Model
Evidence Based Care

- Depression
  - Cognitive Behavior Therapy
Potential ways that Beacon and providers could collaborate to promote integration

- Using outcomes tools must become the norm, not the exception
- Focusing on UM and “mother-may-I” mentality must shift to collaboration on activities that promote better care, not improved utilization statistics
- Focusing solely on claims as a source of truth about outcomes must shift to including other ways of assessing members’ mental health
- Sharing both medical and BH information is critical so Beacon can pay claims for members with both BH and medical diagnoses
- Designing new payment structures to align reimbursement with value rather than volume
- Improving communication between PCPs and behavioral health specialists to better integrate care
Integration for people with SMI
The case for integrating care for people with SMI is strong

MEDICAL EXPENSES FOR INDIVIDUALS WITH SMI ARE MORE THAN 2X THAT OF BH SPEND

Note: Data based on Beacon pilot program in MA
Sources: Beacon 2014 claims data
Addressing the needs of people with SMI won’t magically occur simply by carving into a single managed care organization

Challenges with SMI

- High comorbidity and total cost of care – mental health disorders amplify costs of chronic medical conditions
- Inadequate community infrastructure – no reliable system to find, treat and support these members in the community
- Fragmented care model – care provided by multiple providers in silos
- Long-term care – SMI is a chronic disease; long-term care is required
- Ineffective integration of care
  - Few PCPs are equipped, or interested, in participating in SMI care (to date, this has included FQHCs)
- Evidence-based treatment is not universally adopted by providers – Even when people with SMI are engaged with care, as few as 7 percent actually receive evidence-based practices

What we know about effective models for SMI

- The evidence base around what actually works for integration for people with SMI is THIN
- Treating mental illness requires a chronic disease model
- Person-centered care planning with strong community social supports increase community tenure
- The best results come from a social care model: housing, self-management skills, transportation, day-programs, vocational-rehab, etc.
- Focus on total cost of care through aligned incentives on medical and behavioral sides
- Both clinical and cost outcomes should be tracked and reported
Integration for people with SMI: Integrated Practice Unit (IPU)

Beacon supports an SMI ACO through linkage to a diverse range of services:

- **Affiliations with BH and substance use inpatient providers** to deliver high quality care. This includes data-sharing infrastructure & technical assistance, billing guidance.
- **Measurement-based outcomes tools & reports**
- **Coordinates with ESP to administer crisis care in a manner that is integrated with other providers in SMI ACO (e.g., leveraging member profiles in crisis care, sending out alerts to other providers)**
- **Evidence-based guidelines**
- **Digital extenders, for example, to measure outcomes**
- **Relationships with state agencies, supported employment, housing, psycho-social rehabilitation, recovery supports & links with justice system**
- **Proactive identification of patients who can be transitioned safely back to primary care**

**Community Mental Health Center**

**Outpatient clinics**

**Multidisciplinary team including:**
- Psychiatrist
- Care managers: LCSW, licensed mental health clinicians
- Peers

Contract directly with PCP and/or nurse practitioner to integrate physical health care into mental health center onsite

**PCP**: Primary Care Provider • **BH**: Behavioral Health • **ESP**: Emergency Services Provider • **LCSW**: Licensed Clinical Social Worker

- **People with SMI achieve better outcomes in a specialist setting**
- **An IPU is a dedicated team comprised of clinical and nonclinical personnel who provide the full cycle of care for a patient’s condition**
- **Improved expertise and coordination of care for people with SMI in community settings avoids prolonged hospitalizations and/or prevent initial inpatient admissions**
Individuals exist day-to-day within their immediate social system. It is their primary concern, so we aim to make it our primary concern as well.

- **Members receive an individualized, targeted, intervention focusing primarily on a member’s immediate social needs** including:
  - Connection to peers and social supports
  - Employment/education opportunities
  - Transportation, food, housing, etc.
  - Education about diagnoses and prescribed treatment plan, including medication adherence
  - Access to routine care

- **Provider-based bachelor’s level care coordinators** will spend 6 months understanding and addressing members’ needs

- **Access to Beacon and Neighborhood Health Plan clinicians** will provide necessary clinical oversight and support

- **Barriers to routine care** are addressed by creating a new system of supports
1. Integration is a **multiyear strategic priority for Beacon** and we are looking for providers to partner on piloting the collaborative care model and/or whole person care model for people with SMI.

2. We welcome feedback from all providers on how we can better collaborate to achieve integration.

3. The collaborative care framework provides the “best-in-class” evidence for integration of BH into primary care. CMS is developing a billing code for CCM; APA is promoting it.

4. We know there are **things we can stop doing today** that stand in the way of integration and improve how we work together to promote integration.

5. This is **not business as usual**; it is about redesigning mental health care delivery; it will be hard to execute.

6. As a “carve out”, Beacon can be a “conduit” for collaborative care.
Additional resources

- Beacon’s White Paper
- Revised Beacon’s Integration Toolkit coming soon
- Twitter chat: #Integration
- Creating academic partnerships to drive integration
- AIMS Center, University of Washington: [https://aims.uw.edu/](https://aims.uw.edu/)
- Contact information: Dr. Emma Stanton at emma.stanton@beaconhealthoptions.com
Thank you