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Integrated Behavioral Health and Value-Based Reimbursement: Two Sides of the Sustainability Coin

Michelle N. Cleary, M.A., Facilitator

Courtney Wiggins, Co-Facilitator

Thursday, May 20, 2021

Vision: Healthy Communities, Healthy People

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Session 4: Demonstrating the Value of Integrated Care: Increasing Quality Through Care Coordination

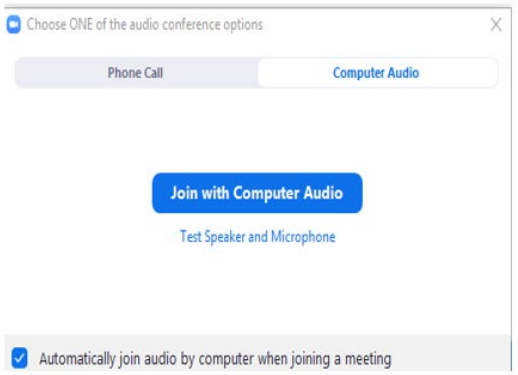
Vision: Healthy Communities, Healthy People

Housekeeping

To establish an audio connection:

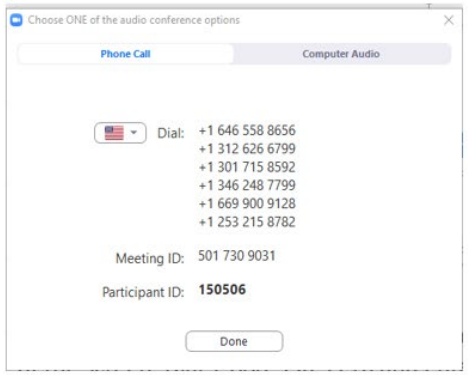
By computer:

- Click **Join with Computer Audio**.

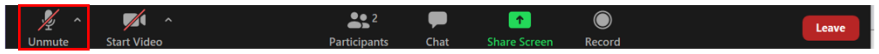


By phone:

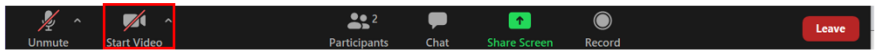
- Click the **Phone Call** tab, dial a listed phone number, and enter **Meeting ID** and **Participant ID**.



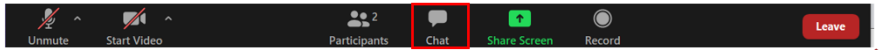
- You will begin muted. To **unmute/mute**, click the **microphone** icon located at the bottom left of your Zoom window.



- We encourage everyone to keep their video enabled. Click **Start Video** to join by webcam.



- To ask a question using the **Chat** feature, click the **Chat** icon located at the bottom center of your Zoom window.

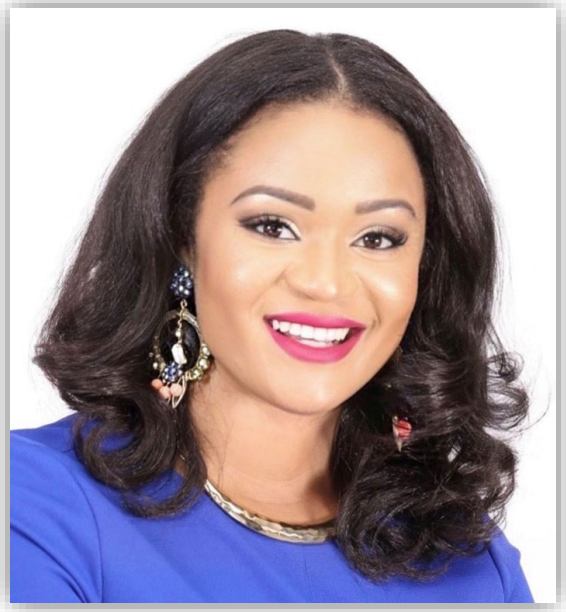


Notes:

- **Please participate and, if possible, be on camera.**
- **Please mute your phone line if dialed in for audio and remain on mute until you would like to speak.**
- **This CoP is being recorded.**

Session 4: CoP Facilitators and Presenter

Facilitator:
Michelle N. Cleary, M.A.
Advocates for Human Potential, Inc. (AHP)



Co-Facilitator:
Courtney Wiggins, CGMP
The Bizzell Group

Presenter:
Bonni R. Brownlee, M.H.A., CPHQ, PCMH-CCE
Senior Consultant, AHP

Agenda

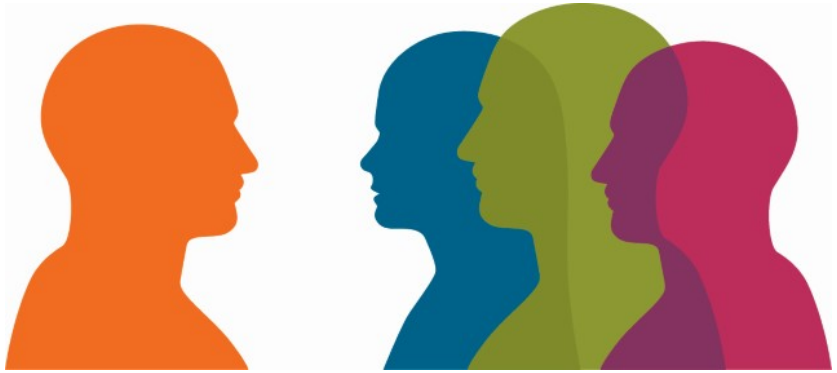
- Participant Check-in
- Subject Matter Expert (SME) Presentation and Discussion
  - *Demonstrating the Value of Integrated Care: Increasing Quality Through Care Coordination*
- Feedback
- Wrap Up/Next Steps

Source: iStock

Today's Discussion Question

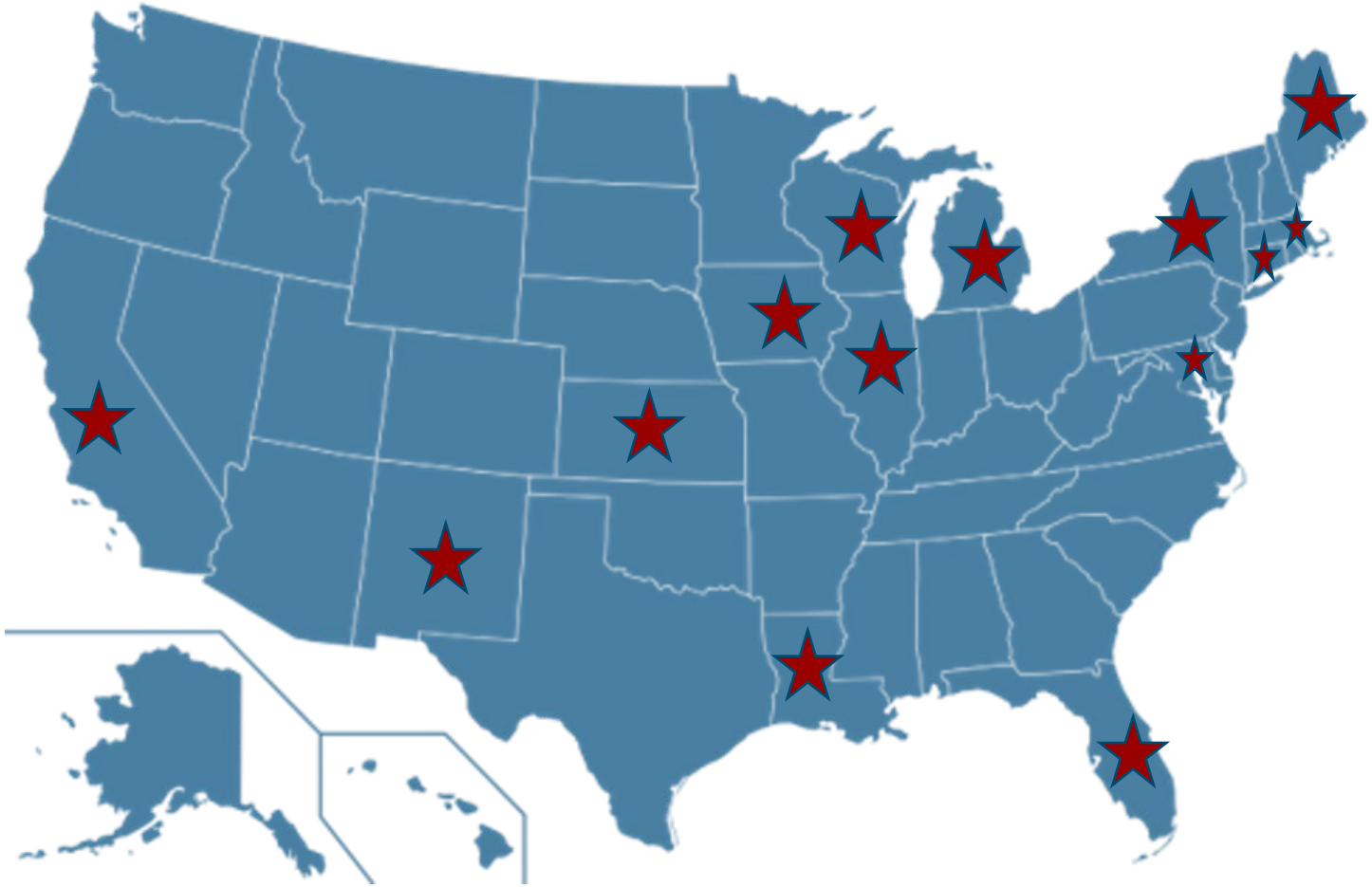
Later in the session, we will ask:

What are ways your organization can increase care coordination?



Source: ThinkStock

CoP Participants



Participant Roll Call

As you're checking in, tell us:

What level of care coordination is happening in your setting?

- *Very little*
- *Some*
- *A lot*

Organization	Name	State
ACCESS Community Health Network	Thea Kachoris-Flores Suzanne Snyder	IL
Advantage Care Health Center	Darci Weissbrot	NY
American Indian Health & Services	John Lee	CA
Cassopolis Family Clinic Network	Mary Middleton	MI
Community Health Centers of Southern Iowa, CHCSI	Kiley Schreck	IA
Crusader Health	Liz Henning	IL
Greater New Bedford Community Health Center	Paul Cassidy	MA
Greater Portland Health	Tammy Shapleigh	ME
Health Partnership Clinic	Tristen Winston	KS
Iowa Primary Care Association/IowaHealth+	Gagandeep Lamba	IA

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Participant Roll Call

As you're checking in, tell us:
What level of care coordination is happening in your setting?

- *Very little*
- *Some*
- *A lot*

Organization	Name	State
New Mexico Primary Care Association	Catherine Reeves Elise Clemens	NM
Osceola Community Health Services	Arselia Klunder	FL
Santa Barbara Neighborhood Clinics	Nancy Tillie Charles Fenzi	CA
Southeast Community Health Systems	Benjamin Larisey	LA
Total Health Care	Seth Rosenblatt	MD
Wheeler Clinic	Sabrina Trocchi	CT
Wisconsin Primary Health Care Association	Molly Jones	WI

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Demonstrating the Value of Integrated Care: Increasing Quality Through Care Coordination

Vision: Healthy Communities, Healthy People

Food for Thought

- Does your health center understand the Quadruple Aim?
- Does your health center support at least one care coordinator position?
- Do you have an electronic care plan template, and technology to support sharing the care plan?

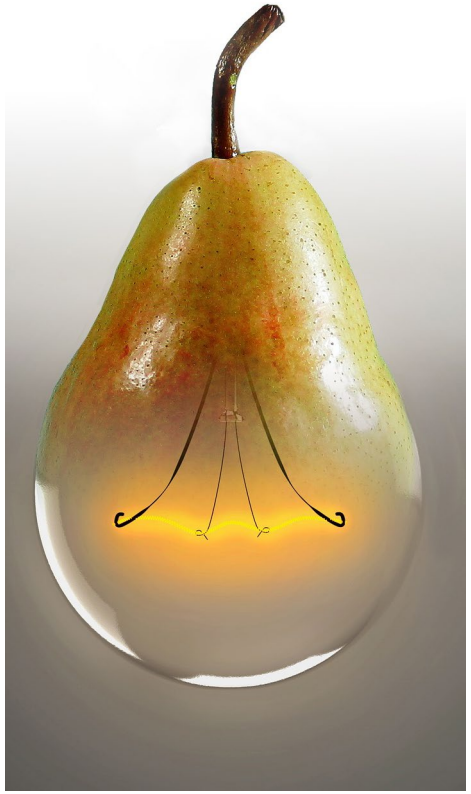

Image by adege from Pixabay

Care Coordination Defined

"Care coordination involves **deliberately organizing patient care activities** and **sharing information** among all of the participants concerned with a patient's care **to achieve safer and more effective care**.

"This means that the **patient's needs and preferences are known ahead of time and communicated at the right time to the right people**, and that this information is used to provide safe, appropriate, and effective care to the patient."

—AHRQ

Source: Care Coordination | Agency for Healthcare Research and Quality (ahrq.gov)

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Care Coordination in Integrated Behavioral Health (IBH)

Integrated care enhances the primary care team through

- **Expanding identification of/screening** for individuals with behavioral health disorders,
- **Improving outcomes** for both physical and behavioral health diagnoses,
- **Avoiding hospital admissions and readmission**,
- **Reducing emergency room utilization** for ambulatory sensitive conditions, and
- **Preparing the practice for value**-based payment models, case rate and episode-based reimbursement.

Source: The Value of Integrated Behavioral Health, n.d.. https://www.thenationalcouncil.org/wp-content/uploads/2020/01/The_Value_of_Integrated_Behavioral_Health_09.07.18-3.pptx

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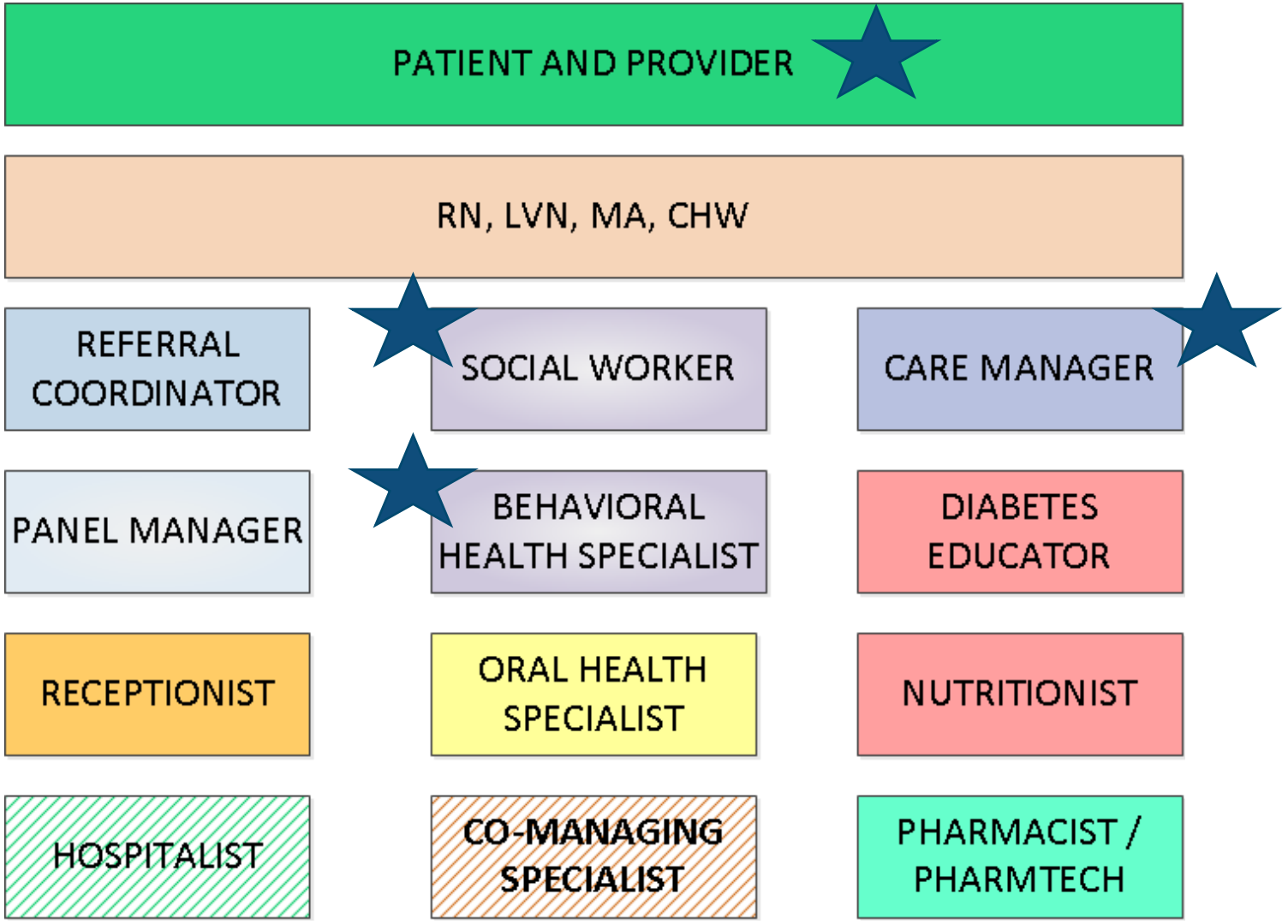
Care Coordination for High-Risk, High-Utilizing Populations

- Researchers, policymakers, and clinicians have all emphasized the need to better coordinate care within and across the sectors of physical health, behavioral health, and social aspects of health (e.g., access to food, housing, transportation, jobs, and education).
- This need for care coordination through a focused, **team-based** approach to care and **better use of frontline workers in care navigation**, and through **offering culturally and linguistically competent care**, is particularly critical for high utilizers of health resources.

Care coordination is a fundamental element of delivery system transformation.

Care Team Composition/IBH Care Coordination Team



The Role of the IBH Care Coordinator

Typical core functions:

1. Outreach and engage clients
2. Conduct screenings and track outcomes
3. Provide health education and support client self-management
4. Facilitate referrals to specialists and community resources
5. Enter data and maintains care registry
6. Conduct systematic caseload review
7. Create longitudinal care plan; facilitates shared access to care plan
8. Ensure communication between providers
9. Coordinate with health plans to identify and address individual client needs

Foundational Elements for Successful Care Coordination

- Adoption of evidence-based guidelines
- Identification of individuals needing extra support
  - Selection criteria, including SDOH
- Team-based care
  - Interdisciplinary—primary care and behavioral health
  - Patient-centered; patient engagement
  - Weekly systematic case reviews (SCR)
- Care coordinator—definitions, accountabilities
  - Credentials
  - Job description
  - Scope of work: care coordination vs. care management
  - Communication channels

Foundational Elements… (cont'd)

- Technology
  - EHRs enable communication between care team members and beyond.
  - Registries with embedded risk stratification algorithms enable identification of persons requiring care management support.
  - Telehealth modalities allow connection to patients without requiring an in-office visit.
  - Health Information Exchange (HIE) allows partners to communicate across the field.
- Shared care plan
- Quality metrics

Poll

Source: iStock

How many of these foundational elements are present?

- Adoption of evidence-based guidelines
- Identification of individuals needing extra support
- Team-based care
- Care coordinator—definitions, accountabilities
- Technology
- Shared care plan
- Quality metrics

Case Study: Hennepin Health

Care Coordinator at the Mental Health Center – RN Behavioral Health Specialist

Primary Responsibilities

- Resolves urgent needs; makes connections for ongoing needs
- Prepares care plan (in collaboration with patient); Treat to Target focus
- Consults face-to-face with clinical social workers and psychiatrists to discuss medication management and housing issues
- Coordinates referrals for her caseload of patients by making appointments with specialists and briefing the specialists' offices about the patients' medical, behavioral health, and social history

Impact

- Referrals from psychologists, psychiatrists, and others on staff have increased.
- Emergency department services are down.
- Primary care visits are up.
- No-show rates at both the mental health center and primary care practice have fallen since the care coordinator joined the team.

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Case Study: Expanded Role

- Co-facilitates a group for homeless men, called “Connections,” two times per week with a clinical social worker
  - This group allows her to meet and identify patients in need of brief primary care interventions.
- Added “drop-in” hours directly following each meeting, and these now allow her to meet with patients while they are already at the mental health center
- Schedules 1-hour appointments with patients to perform comprehensive health and lifestyle assessments or provide education about chronic disease and/or medication adherence
- Provides bus tokens and/or gift cards as incentives to return

The Impact of Care Coordination

Care coordination leads to better medical care through

- Decreased medical errors,[1]
- Decreased medication errors,[1]
- Increased accuracy of post-discharge plans,[2]
- Decreased probability of adverse medication interaction,[1]
- Lower rates of hospital readmission,[2]
- Shorter future hospital stays,[2] and
- Decreased duplication of procedures.[2]

Sources: 1. Moore et al., Medical errors related to discontinuity of care from an inpatient to an outpatient setting. J Gen Intern Med. 2003
2. Misky et al., Post-hospitalization transitions: examining the effects of timing of primary care provider followup. J Hosp Med. 2010

BCBS MA: IBH Initiative

- The majority of participants highlighted care coordination as a critical component of integrated services, noting that having a care coordinator benefits both patients and providers.
- Providers interviewed during site visits reported feeling more confident managing patients' behavioral health needs when they know they have follow-up support and can be sure their patients are linked to appropriate services.
- Documented benefits of care coordination:
  - Single point of contact for patient
  - Ability to easily contact care team
  - Patient perception of a higher level of care
  - Amount of contact with patient correlated directly with patient improvement
  - Care coordinator develops personal relationship with patients
  - Reduction of workload for providers

Results: The COMPASS Consortium

CONDITION	OUTCOME GOAL	ANALYTIC OUTCOME
Depression	Improve control for 40% of patients	61% have shown significant improvement (i.e., decrease in PHQ-9 by 5 points or PHQ-9 less than 10).
Diabetes	Improve control rates by 20%	23% improvement in patients with HbA1C < 8.
Hypertension	Improve control rates by 20%	58% of those who entered with uncontrolled HTN attained blood pressure control.

Source: The COMPASS Consortium, Partnering for Mind-Body-Health, 3-year CMS grant 2012-2015
A Team-Based Model to Treat Patients with Both Mental and Medical Conditions in Primary Care

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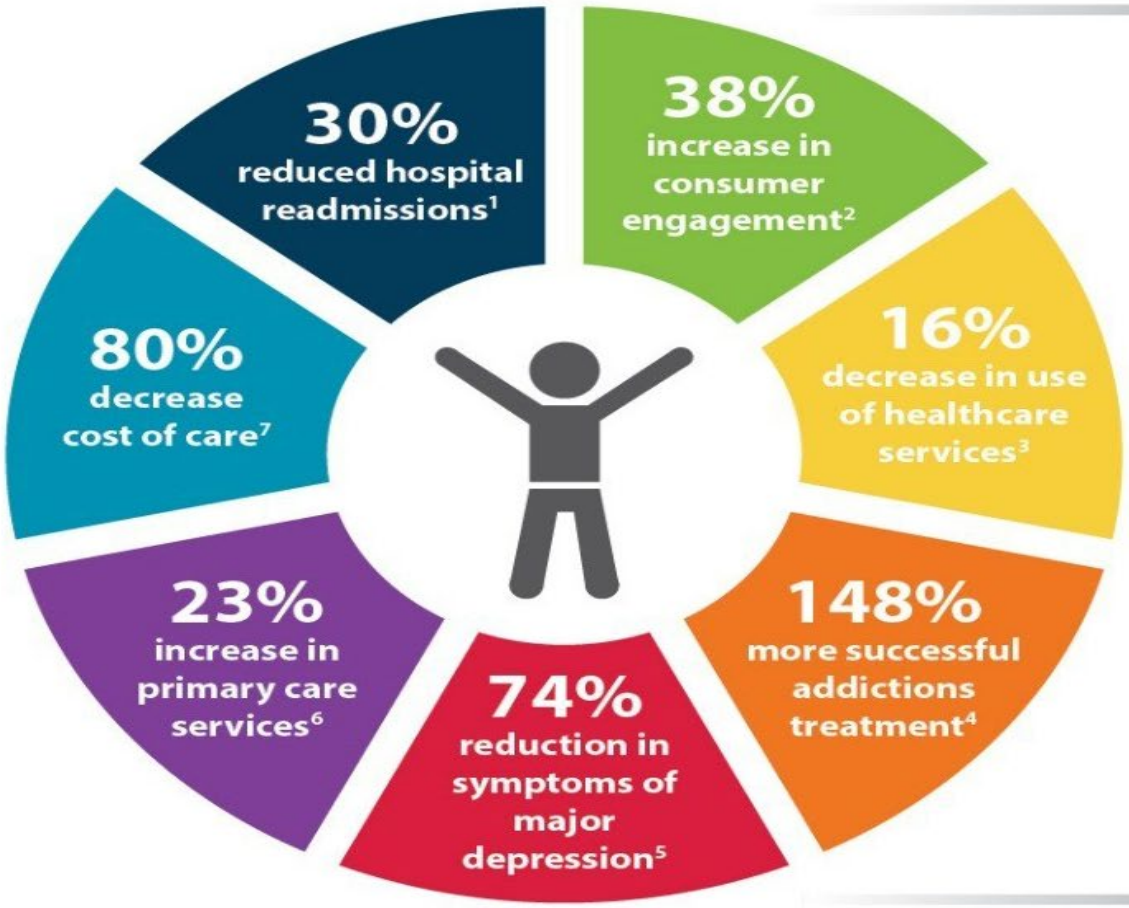
360° View → The Power of Whole-Person Care



In any given year, there are approximately 34 million American adults with co-morbid mental and medical conditions. Coordinating care can improve clinical outcomes, increase care quality while reducing cost, and boost consumer satisfaction.

[1]Source: New York State Office of Mental Health. [2]Source: Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E). [3]Source: Robert Wood Johnson Foundation. [4]Source: Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E). [5]Source: American Psychological Association. [6]Source: Robert Wood Johnson Foundation. [7]Source: Robert Wood Johnson Foundation

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The Quadruple Aim

Improved Patient Experience of Care

Improved Clinical Outcomes

Source: freepik by nucleartist

Source: GerdAltmann from Pixabay

Improved Provider/ Staff Experience in Providing Care

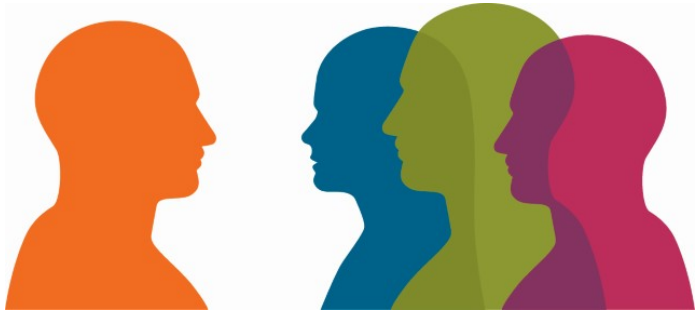
Reduced Cost of Care Overall

Source: Institute for Healthcare Improvement: http://www.ihi.org/

Moving Toward Full Scope Care Management

- **Care Coordination**
  - lab tracking, referral tracking, linking patients to community supports
- **Population Health Management**
  - systematic approach to closing gaps in care
- **Chronic Care Management**
  - chronic disease education, medication reconciliation, clinical assessments, risk assessments
- **Care Transitions**
  - follow-up after ED visit, follow-up after hospitalization, communication with external caregivers

Today's Discussion Question



Source: ThinkStock

What are ways your organization can increase care coordination?

Session 6 - Report Out

Reports outs in Session 6 – *participant sharing*

Possible topic ideas:

- *Action steps taken or planned*
- *Ideas from the CoP that you'd like to act on in your setting*
- *Lessons learned*

Weekly Office Hours

- **Wednesdays, 3:00–5:00 p.m. ET**
- Designed to discuss progress and/or challenges related to
  - Your team's action plan
  - The session topic
- Meet colleagues from other health centers

Next Steps

- Choose an action item related to today's presentation that will help your health center take a step toward establishing or enhancing VBR.
- Before next week's session, using the action plan worksheet, work with your team to build out that action item.
- Complete the ICRC questionnaire.
- Please sign up for a Triage-coaching call
- Remember, Wednesday Office Hours—See you there!

Source: iStock by Getty Images

Reflecting on Today: Plus, Delta

- + What worked for you today?
- △ What would you change?

TA Offerings for Health Centers

- One-on-One Coaching
- Webinars
- Strategies for Community Outreach: How Health Centers Can Use Social Media for Social Marketing
- Virtual Site Visits to Improve Outcomes
- Communities of Practice (CoPs)

BPHC-BH TA Portal

https://bphc-ta.jbsinternational.com/

- Request TA
- Access Learning Management System (LMS) modules
- Learn more about BH TA options
  - One-on-One Coaching
  - E-learning Webinars
  - Strategies for Community Outreach
  - Virtual Site Visits to Improve Outcomes
  - Join a Community of Practice (CoP)

Upcoming TA Opportunities!

Webinars

- **Strategies for Addressing Health Disparities in Medications for Opioid Use Disorders**

  Wednesday, June 2, 3:00–4:00 p.m. ET

  Registration Link: https://zoom.us/webinar/register/WN_hUz8J4lvQ0eidc8x6XCkFQ

- **Reducing Health Disparities by Addressing Integrated Behavioral Health in a Maternal Child Health Care Setting**

  Thursday, July 29, 3:00–4:00 p.m. ET

  Registration Link: coming soon!

Registration links for webinars can also be found on the BPHC-BH TA Portal.

You can receive 1 hour of Continuing Education credit for your participation.

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Upcoming TA Opportunities! (cont'd)

Communities of Practice (CoPs)

- Integrated Behavioral Health and Value-Based Reimbursement: Two Sides of the Sustainability Coin
  - Cohort 2: Thursdays, 6/10/21 – 7/15/21, 2:30–4:00 p.m.

https://zoom.us/meeting/register/tJUuduqhpjIuHtwabD2xSdkmuHLR5Qju0XeD

CoP Satisfaction Assessment

- Please complete a satisfaction assessment of today's session.
- If you plan to obtain CEUs for your time in this CoP, the satisfaction assessment is required.
- There are two ways navigate to the assessment:
  1. Follow the link provided in the chat here.
  2. You will be emailed a link from us via Alchemer, our survey platform.

Continuing Education

- We will be offering **1.5 CE credit per session** attended for a maximum of 9 CEs for participation in all 6 CoP sessions.
- You **must** complete the Health Center Satisfaction Assessment after **each** session for which you plan on receiving CEs.
- **CE credits will be distributed for all sessions at the conclusion of the CoP.**

This course has been approved by JBS International, Inc. as a NAADAC Approved Education Provider, for educational credits. NAADAC Provider #86832, JBS international, Inc. is responsible for all aspects of their programming.

JBS International, Inc. has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6442. Programs that do not qualify for NBCC credit are clearly identified. JBS International, Inc. is solely responsible for all aspects of the programs.

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Thank You!

Presenter Contact Information:

Bonni Brownlee – bbrownlee@ahpnet.com