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The webinar will begin shortly.

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Reaching Rural: Best Practices in Integrating Behavioral Health

February 26, 2015

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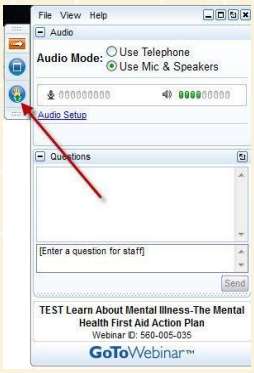

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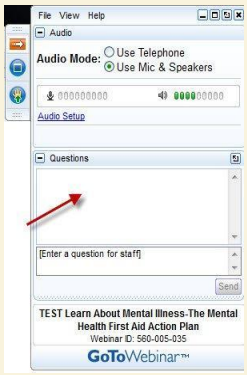

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Welcome

Tom Morris

Associate Administrator for Rural Health Policy
Health Resources and Services Administration
U.S. Department of Health and Human Services

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Today's Speakers

Donald Simila, Upper Great Lakes Family Health Center

John Gale, Maine Rural Health Research Center, Muskie School of Public Service, University of Southern Maine

Moderator: Sarah Steverman, CIHS Consultant

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Today's Purpose

- Identify characteristics of primary care/behavioral health integration models that are unique to rural settings;
- Recognize the various components/stages of adopting integration in rural settings, including planning, collaboration, implementation and financing; and
- Learn about available resources for obtaining further information about integration of primary care and behavioral health in rural settings.

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Poll Question: How do you identify your role in primary care/behavioral health integration?

- Health Center Administrator
- Clinician/Provider
- Policy Maker
- Researcher
- Other Stakeholder

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Poll Question: At what stage of the behavioral health/primary care integration process do you consider yourself or your health center?

- Precontemplative – we should really start thinking about this
- Contemplative – we're seriously thinking about how to integrate services
- Planning – we've taken steps to start integration
- Implementation – we're in the early stages of executing our plan
- Evaluation/Sustainability – we're refining our program

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Donald Simila, MSW, FACHE

President & Chief Executive Officer, Upper Great Lakes Family Health Center

Upper Great Lakes Family Health Center

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Upper Great Lakes Family Health Center

Founded in 2009 – 501 c 3 Corporation

Received FQHC "Look Alike" Designation in 2010 – 2 clinics – 2,500 patients

- 3.5 FTE Primary Care Providers, 2 with OB
- 5,500 unique patients
- 7,500 Medical Encounters

Received ORHP Outreach Grant Award in 2012 – Integrated Behavioral Health

- Over two years added - 2 FTE Licensed Behavioral Health Providers

Received NAP Award in 2013 - Added 18,000 patients and 4 clinics

- 15 FTE Family Medicine Providers
- 3 FTE OB/GN
- 3 FTE Pediatrics
- 2 MSW's – Funded through a Grant from BCBS of MI in 2013

Received SAC Award in 2014 - Added 11,000 patients and 3 Clinics

- 10 FTE Family Medicine Providers

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Upper Great Lakes Family Health Center

- **Today – UGLFHC Total Revenue is $18.5 Million**
- **Total Net Revenue of $12 Million**
- **Operating Margin of 2%**
- **UDS Report 2015**
  - **28,500 unique patients**
  - **70,000 +/- annual medical encounters**
  - **986 BH service encounters**

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Geographic Context

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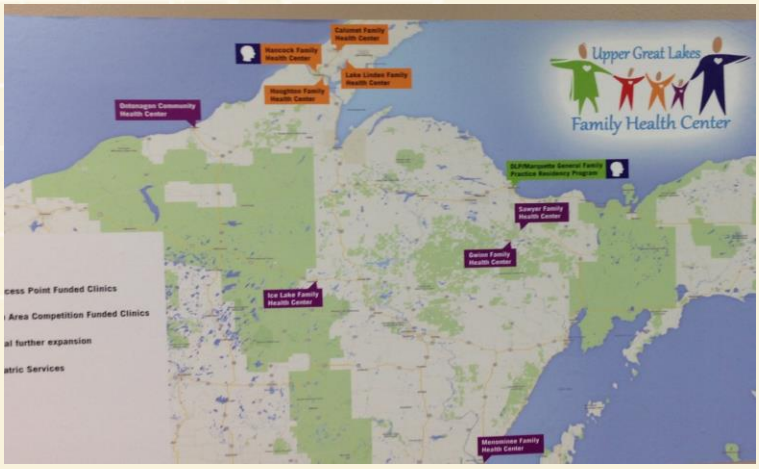
UGLFHC Service Area
West and Central Upper Peninsula



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Service Area Demographics

- **Total Population 150,000**
- **15 people / square mile**
- **Persons 65 Years + 20% -30,000**
- **Persons below 100% FPL 16% +/- 24,000**
- **Persons below 200% FPL 30% +/- 30,000**
- **Median Household Income $32,000 +/-**
- **Medicaid Pop 40,000**

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The Need	The Goal
Consumer need: 60-70% of PCPs panel Rx for BH	Improve Access
Limited access for uninsured to BH services	Improve Access/Outcomes/ Compliance
PCPs demanding BH support and access for patients	Provide Support to Providers
Service site location in high poverty community	Support At-Risk Families
Medicaid Managed Care Plan – patient non-compliance	Reduce Chronic Disease Costs/ Improve Outcomes/Reduce ER Utilization
Policy priorities at the state and federal level	Pursue Start-up Funding (Timing was right for a proposal)
Lack of BH service in conflict with Mission, Board and Senior Leadership expectations	Align Services with Mission of UGLFHC

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Partners

- **UGLFHC** – Lead agency and fiscal agency for the project
- **Upper Peninsula Health Plan** – Medicaid Managed Care Plan in U.P.
- **Great Lakes Recovery Centers** – U.P. wide outpatient and residential substance abuse and mental health treatment center.
- **Pathways Community Mental Health** –Four county CMH in the central upper peninsula.

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The Plan

- **UGLFHC Senior Leadership** - convened a meeting of potential stakeholders – Medicaid Payer, Regional BHS Provider, Community Mental Health.
- **UGLFHC had the patients** - agreed to assume the cost of proposal writing and act as fiduciary/lead agency.
- **UPHP – Medicaid MC Plan** - agreed to provide case management services – as in kind contribution.
- **GLRC** - agreed to commit a LCSW – Leased to the project
- **Community Mental Health Agency** - came in later to improve services to clients.
- **Community Research** - conducted focus groups (qualitative) and surveys (quantitative) with patients at clinics and from UPHP (Payer) members.
- **Empirical Research** - created a team to review data and literature, to build the case.

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Business Model

- **Fee for Service Encounters**
  - Break even Analysis
  - Cash Flow Analysis
- **Physician Productivity**
  - 2012 – 8,600 encounters / 2013 – 10,300 encounters – same provider panel.
- **Billable BHS Encounters**
  - 986 in Year 2
- **Ramp up Revenue Cycle**
  - Enrollments
  - Authorization
  - Coding
- **Private Source fund development** - can be a huge benefit
- **Production based employment/contracting**

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Annual Funding Formula Assumptions

- ORHP Outreach Grant – $150,000 / Year for 3 years
- In-Kind Case Management Services from UPHP - $70,000
- Program Service Revenue – end of project $150,000
  - FQHC/RHC FFS - Medicaid $ 67/ visit; Medicare $75/visit + year end reconciliation (up to $140/ encounter)
- Increase in Provider Productivity – $25,000 (less cost)
  - 1000 visits Annually @ $90/visit = $90,000
- Total Annual Income - $175,000 projected without grant funding at end of project.

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Current Staffing Model - 2 Sites, Year 2

.5 FTE	BHS Director ($36/hr)	
1.5 FTE	BHS/Health Coach Direct Care ($22/hr)	
1.5 FTE	Case Manager (1.0 in-kind by Health Plan)	
.25 FTE	Billing Staff ($15/hr)	
.25 FTE	Medical Records Staff ($10/hr)	
.10 FTE	Quality Manager ($24/hr)	
1.0 FTE	Clinic Officer Clerk ($10/hr)	
4.1 FTE Total	$217,000 ($167,000 + benefits $50,000)	
Revenue	$140,550	Billable BHS Services
	$ 25,000	Increased Medical
Deficit	($51,450)	

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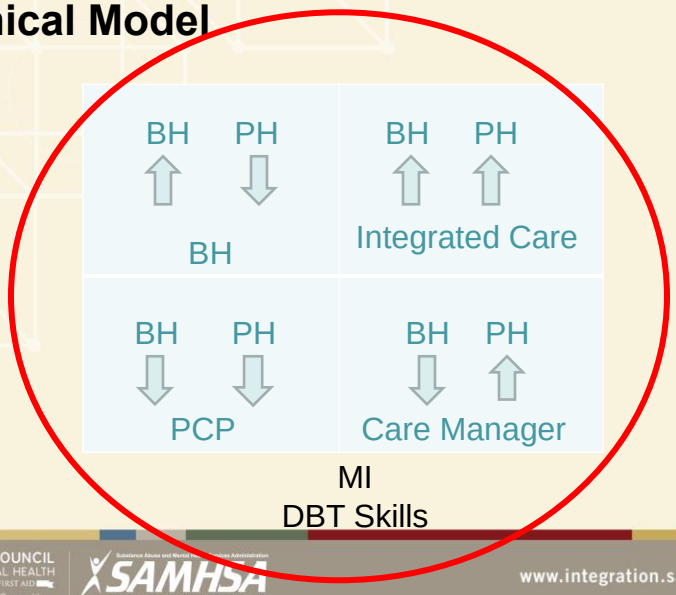
Clinical Model



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Clinical Interventions

- **Evidence Based Screening**
  - **Screening Patients 13-17 years**
    - PSC-Y
    - CRAFFT
  - **Screening Patients 18 +**
    - PHQ-9
    - CAGE
    - DAST-10
- **Trained <u>All</u> staff in Mental Health First Aid**

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Clinical Interventions

- **Trained <u>All</u> Direct Care Staff in Motivational Interviewing**
- **Implemented DBT Skills Training for Patients**
- **Implemented Multi-disciplinary team meetings/case conference**
- **Implemented Morning Huddles (PCMH) to review schedule patients for possible support services**

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Project Management

- **Integration Committee**
  - UGFHC Board Representation
  - Physician Champion
  - Health Plan Representative
  - Community Mental Health Representative
  - Great Lakes Recovery Representative
  - UGLFHC Quality Team Representative
  - UGLFHC Leadership – CEO – BHS Director – Clinic Care Manager – Clinic Manager

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Outcomes

- 76% of patients screened for Depression
- 68% of patients screened for Substance Abuse
- 68% Improvement in Depressive Symptoms
- 51% Reduction in Substance Abuse Symptoms
- 381 Patients Referred to Case Management
- 95% of Patients are compliant with Treatment Plans
- 58% of Patients surveyed report improvement in Well being as a result of Integrated Care.

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Outcomes

UGLFHC Board, Staff, Providers, Administrators and Integration Counsel members were surveyed using an evidenced based "integration" tool to assess the level of integration of services at beginning of the project and end of year 2:

- On scale of 0-20 respondents rated Integration at 11.9 as a baseline.
- At the end of year 1 the respondents rated Integration as 14.2
- At the end of year 2 the respondents rated integration as 15.5

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Challenges/Lessons Learned

- **Fully Integrated Medical Records** - State and Federal Privacy Laws remain problematic to achieving fully integrated records across all providers - clinic-hospital.
- **Fee for Service Case Rates** – continue to challenge sustainability.
- **Limitation on # of visits** by payers and prior authorizations
- **Available licensed MSWs** are trained in "Traditional Psycho-Therapy model"

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Challenges/Lessons Learned

- **Recruitment and retention** of qualified BH staff in rural communities is difficult to achieve given the current payment methodology for BH services.
- **Small, low volume rural clinics** (1.5 FTE Providers) – 1,800 patients struggle to sustain service full time. Leasing a provider is an option.
- **Truly integrated (LCSW/PCP)** – brief therapy models are difficult to fully support in current fee for service environment.
- **Training Revenue Cycle** on BH coding and claims – Prior authorizations and re-authorizations; managing the revenue cycle.
- **No-Show Rates** - BHS No-Show rate 36% (1,467 Scheduled)

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Challenges/Lessons Learned

- **Culture Change**
  - Existing PCP's are trained to function independently – no "team based care" experience.
  - Community awareness of "full scope" of services available.
  - Traditional Clinic Staff required training on privacy and confidentiality of BHS patients
  - Integrated services within the Clinic setting reduces the potential for patient avoidance of BH services.
  - Reframing / renaming services as "Health Coaching"
  - What does bi-directional/integrated care really mean in practice

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Rural Challenges

- Accessibility
  - Longer travel distances and higher rates of uninsurance
  - Less likely to recognize mental illness and understand care options
  - Enter care later, sicker, and with a higher level of cost
- Availability
  - Chronic shortages of behavioral health providers
  - Few comprehensive services
  - Providers are physically isolated from patients
  - Reliance on informal supports, indigenous healers, primary care
- Acceptability
  - Stigma due to the loss of anonymity in rural areas and cultural issues
  - Limited or non-existent choice of providers

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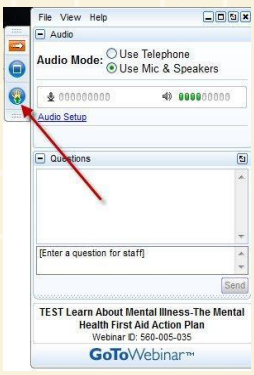

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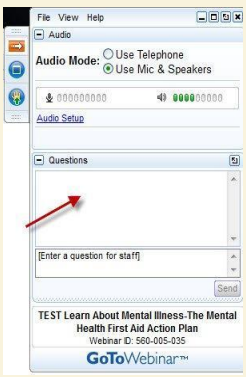

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John Gale, MS
Maine Rural Health Research Center,
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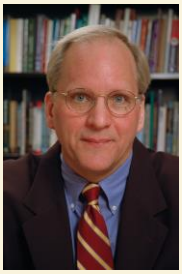

Presentation Overview

- Opportunities for integrated care in rural communities
- Guiding principles
- Rural challenges
- The state of integration
- Overview of the dimensions of integration
- Discussion of models
- Models of integration
- Where to begin?

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Integration can make significant contributions to improving access to behavioral health services, enhancing quality of care, and reducing stigma for rural residents.

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Proposed Guiding Principles

- Integrated care initiatives should be:
  - Patient centered;
  - Expand access to care, decrease burden of illness, and optimize care;
  - Delivered in settings preferred by patients;
  - Evidence based;
  - Driven by clinical and care issues and functions;
  - Focused not only on integrating care within practices/facilities but also across practices and care settings; and
  - Focused on both medical and behavioral health settings.

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Integration Issues

- Continuing interest in integration is high
- Primary focus is on models of integration rather than on the functional components of integration to meet patient and provider needs
- No one model or approach is right for all settings
- Progress is being made on reimbursement – not out of the woods yet
- Integration of behavioral health reduces stigma as a barrier to receiving services altering the settings and source of care

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How do integration models apply in rural settings?

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Rural Examples

- Sierra Family Medical Clinic. Nevada City, CA
  - Service based in an FQHC, started with grant funds in 2002
- Southwest Montana Community Health Center, Butte, MT
  - Two site FQHC system, integrated services started with Outreach Grant
- Sonora Regional Medical Center, Sonora, CA
  - Integrated services in a provider-based RHC
- Swift River Family Medicine Clinic, Rumford, ME
  - Provider-based RHC in partnership with a CMHC
- Cherokee Health Systems, East Tennessee
  - Highly integrated system - multiple sites in 14 East Tennessee counties

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Defining "Integration"

- Continuum from collaborative models (without co-location) to fully integrated co-located models
- Collaboration without co-location (horizontal integration)
  - Focus is on integrating services across practices and providers
  - Barriers: communication, sharing patient information, lack of integrated IT systems, care coordination, available referral sites
- Co-location within practices (vertical integration)
  - Behavioral health services in primary care practices or primary care services in behavioral health settings
  - Barriers: reimbursement, staffing/workforce, billing and coding, space, practice culture, viability, charting/record keeping

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Understanding the Evidence Supporting Integration

- Evidence, particularly for depression, is encouraging
  - Integrated care achieved positive outcomes (improvements in symptom severity, treatment response, and remission response) (AHRQ 2008)
  - Improvements in outcomes did not increase as levels of provider integration or integrated process of care increased (AHRQ 2008)
  - Clinicians/consumers are satisfied with integrated care (AHRQ 2008)
  - Neither the use of evidence-based practices nor measures of trust or collaboration among CICH network agencies were significantly associated with client service use or client outcomes during clients' first year of entering the program (HUD/HHS/VA Collaborative Initiative to Help End Chronic Homelessness)
  - Small rural providers may not have the resources to develop fully integrated systems of care and may need to begin at a lower point on the continuum of integration (Lambert & Gale 2006)

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What Does the Evidence Tell Us?

- Need for integration across medical/behavioral health
- No single model is right for all providers and settings
- Integration at the provider level is a work in progress
  - Assess readiness for integration and implement an appropriate model. With experience, move up the continuum as appropriate
- We need an integration framework that:
  - Recognizes integrated services regardless of provider location on continuum of integration
  - Makes sense for funders, payers, providers, and consumers
  - Facilitates sustainability through adequate reimbursement for all components of integrated care

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What barriers impact integration in rural communities?

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Barriers to Integration

- Practice and Providers
  - Differing practice styles, cultures, and languages
  - Selecting integration model based on practice context and resources
  - Direct care (reimbursable) vs. integrative (non-reimbursable) services
  - Differing coding and billing systems
- Licensure and reimbursement
  - State licensure and scope of practice regulations limit pool of providers
  - Coverage of provider types and services vary by payer type
  - Administrative and access restrictions imposed by third party payers
- Economic challenges of rural behavioral heath practice
  - (e.g., high “no-show” rates, relatively low patient volumes, high costs, and low rates of insurance coverage

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Rural Practice Challenges

- Recruitment and retention
  - Limited supply of specialty behavioral health providers
  - Licensure and scope of practice regs, payer policies further divide pool
  - Retention issues include inability to specialize, professional isolation, and boundary issues in small communities
  - Recruiting local behavioral health providers only rearranges existing resources and does not expand capacity unless replacement providers from outside the community are hired
- Payment, productivity, and administration issue
  - High rates of uninsurance and underinsurance (increases self pay and out-of-pocket costs
  - High no show rates
  - Need to enroll in provider (often multiple) panels for behavioral health

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What level of collaboration makes the most sense in rural settings?

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Levels of Collaboration*

- 1: Minimal collaboration
  - Separate systems and facilities
  - Minimal communication
  - Separate practices, screenings, and treatment plans
  - No coordination for or management of collaborative efforts
- 2: Basic collaboration at a distance
  - Separate systems and facilities
  - Periodic communication, no awareness of "cultures"
  - Separate screening and treatment plans
  - Sharing of patient information may not systematic enough to influence patient care

* Heath, Wise Romero, and Reynolds, (2013)

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Levels of Collaboration

- 3: Basic collaboration on site
  - Shared facility but separate systems – proximity is key
  - Regular communication
  - Appreciation of roles but with a power imbalance
  - Collaboration driven by need for each other's services and referrals
  - Some shared patient information and knowledge
- 4: Close collaboration onsite with some system integration
  - Shared site and some shared systems
  - Regular communication with coordinated treatment plans/models
  - Some tensions systemically and with role influence
  - Agreement on screenings
  - Collaborative treatment plans for some patients
  - Collaboration may involve warm hand-offs to other providers

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Levels of Collaboration

- 5: Close collaboration approaching an integrated practice
  - Shared site and some shared space
  - Regular communication with coordinated treatment plans/models
  - Some tensions systemically and with role influence
  - Actively seek solutions to problems or develop work-a-rounds
  - More consistent team identity – team meetings, agreed upon screenings, collaborative treatment plans
- 6: Full collaboration in transformed/merged integrated practice
  - Shared site and systems
  - Regular face-to-face communication
  - Shared treatment plans and models
  - In-depth understanding of roles and culture
  - Regular team meetings
  - Balanced power

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Collaboration Decisions

- Decisions regarding levels of collaboration are driven by a variety of complex factors including:
  - Available financial, human resource, and administrative resources to develop integrated strategies
  - Trust/rapport between primary care and behavioral health organizations
  - Providers **and** patient needs
  - Willingness of providers to put aside cultural and practice differences
  - Available reimbursement and/or grants to fund and sustain integration activities
  - Administrative and billing capacity to manage integrated services
  - Space issues
  - Local market/competition issues
  - Willingness of providers to share control and management of patients

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When considering the functional aspects of integration, what clinical and structural components are easier or more difficult to implement in rural settings?

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Functional Aspects of Integration

- Clinical – more easily implemented in rural areas
  - Regular communication
  - Use of critical pathways or practice guidelines
  - Internal referral process
  - Common screening tools, treatment plans, and models
  - Shared medical information
  - Collaborative decision making
  - Consultation and education
- Structural – less easily implemented without resources
  - Co-location (e.g. shared space)
  - Fully integrated (one organizational structure/employed staff)
  - Single medical record
  - Shared billing and scheduling systems
  - Shared risk

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Behavioral Health Practice Models*

- Useful for understanding issues underlying development of collaborative and integrated services
- Suggests settings (e.g., small rural practices) where collaborative care is more feasible than integrated care
  - Improved collaboration between separate providers
  - BH care rendered by medical providers
  - Co-located BH services
  - Disease management
  - Reverse co-location (primary care co-located in BH settings)
  - Unified primary care and behavioral health
  - Primary care behavioral health
  - Hybrid collaborative systems of care

* Adapted from Collins, Hewson, Munger , & Wade (2010)

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Models of Integrated Care

- "All models are wrong, but some are useful." Box (1987)
- Target population
  - May focus on the general population of primary care patients or specific populations (e.g., persons with chronic disease, high users of primary care services, persons with depression)
- Types of Services
  - Brief intake followed by short series of visits
  - Traditional BH services
  - Patient education in self-management skills
  - Referral to community resources
  - Referral in acute and emergency care MH situations
  - Behavioral management of chronic and medical conditions
  - Crisis services

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Preparatory Training

- PCPs
  - Type of patient to refer;
  - What to say to patients when referring;
  - How to integrate behavioral feedback into a medical care plan;
  - How to co-manage patients with a behavioral health team member;
  - How to integrate behavioral health into the primary care team; and
  - Population management strategies for patients with mental disorders
- BH providers
  - Understand and adapt to primary care mission, roles, and culture;
  - Adjust to the primary care work pace;
  - Provide curbside and written consults;
  - Chart for medical records;
  - Develop and evaluate population specific treatment programs; and
  - Co-managing patients

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Primary Care vs. Specialty Behavioral Health Care

Primary Care Behavioral Care	Specialty Behavioral Health Care
Population-based	Client-based
Often informal client inflow	Formal acceptance process
Tx usually limited -1-3 visits	Often long term Tx
One component of health care	Focus on behavioral health care
Patient with mild or episodic needs	Often restricted to serious problems
Informal counseling	More formal, private interchange
Typically 15-30 minutes	Often 50 minutes
Lower intensity Tx	High intensity
Counselor part of health team	Counselor not aligned with team
Referrals from medical team	Traditional referral patterns
Care returned to medical provider	Therapist remains point of contact

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What issues must rural communities consider when planning to integrate services?

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Issues to Keep in Mind

- BH and PC providers speak different coding languages
  - PC: ICD-9 coding system (moving to ICD-10 in 10/15)
  - BH: DSM-V (Diagnostic and Statistical Manual of Mental Disorders)
- BH and PC providers diagnose differently
  - BH: diagnose with greater specificity after multiple encounters and testing; low tolerance to schedule and session interruptions
  - PC: diagnose with less specificity based on current symptoms
- Integrated care involves two components
  - Direct services (e.g., psychotherapy) and are typically reimbursable
  - Integrative services (e.g., warm-hand offs, hallway and office consults, staff education) which are not typically reimbursable
  - Must balance the two

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Issues to Keep in Mind (cont'd)

- Allowable providers and 3rd-party payers
  - Medicare limited to psychiatrists, physicians, PAs, NPs, LCSWs, and doctoral level psychologists
  - Medicaid – may be more flexible (e.g., LCPCs) based on state policies
  - Commercial payers vary in types of providers allowed
  - May require enrollment in different provider panels
  - Managed care tools to manage utilizations and costs
  - Mental health parity laws – prohibit differential financial requirements or treatment restrictions on BH
- FQHCs and RHCs are allowed Medicare cost-based reimbursement for BH services but have limitations on ability to serve as distant telehealth sites

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How to Begin?

- Decide what your goals are and prioritize them
  - Expand access to behavioral health services?
  - Provide direct care vs. consultative services for PCPs?
  - Improve primary care provider productivity?
  - Improve treatment of patients with chronic diseases?
  - Improve coordination of care?
  - Reduce primary care utilization
- Determine the best ways to achieve each goal
  - Start simply and evolve with experience
  - Avoid competing for necessary resources

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How to Begin? (con't)

- Understand behavioral health reimbursement policies
  - Use of behavioral health procedure and diagnostic codes
  - Policies implemented by third party payers to control costs (e.g., prior authorization, limitations on # of visits, paperwork requirements, etc.)
  - Recognize which types of providers are reimbursable by payers
- Understand and focus on reimbursable treatment modalities
  - Mental health conditions - evaluation, psychotherapy, medication, evaluation and management services
  - Cognitive, emotional, social, or behavioral issues affecting management of physical health problems – health and behavioral health assessment and intervention
  - Support services – care management

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Resources

Suicide Prevention Toolkit for Rural Primary Care (WICHE): http://www.wiche.edu/pub/12453

Rural Mental Health First Aid: http://www.integration.samhsa.gov/mental-health-first-aid

Establishing Collaborative Initiatives between Mental Health and Primary Care Services for Rural and Isolated Populations (CCMHI Toolkit): http://www.shared-care.ca/files/EN_CcompanionToolkitforRuralandIsolated.pdf

Maine Rural Health Research Center: http://usm.maine.edu/muskie/cutler/mrhrc

National Association for Rural Mental Health: http://www.narmh.org/

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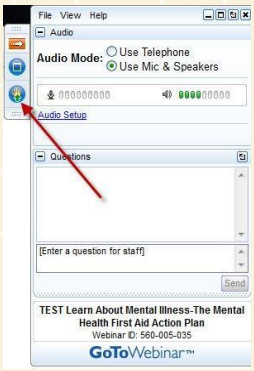

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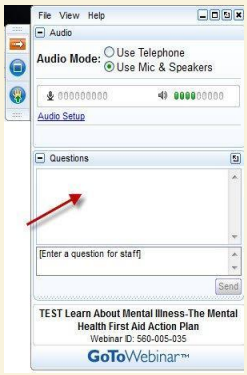

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Additional Questions?
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