Behavioral Health in the Emerging World of Managed Care Organizations

Virgilio Licona, MD
VP Medical Services
Salud Family Health Centers
Ft. Lupton, Colorado

Goals today:

- The Salud model: "*Establishing an Integrated Care Practice in a Community Health Center*"; Auxier, Farley, Seifert: 2011; Professional Psychology: Research and Practice
- Behavioral Health Services provision in a Medicaid 'Carve-Out' state: Colorado
- "*Value Based Financially Sustainable Behavioral Health Components in Patient-Centered Medical Homes*" Kathol, deGruy, Rollman. 2014; Annals of Family Medicine

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- Rocky Ford – ’73

Salud Family Health Centers

- North Central Colorado
- Nine clinical sites, and a Mobil Unit
- 73,000 patients with ~ 300K annual visits
- ~ 550 employees
- ~ 65 medical providers
- ~ 29 dental providers
- ~ 24 BH providers
- ~ $50 million annual budget

Establishing an Integrated Care Practice in a CHC

- **2010 Salud BH Mission Statement:**

"To deliver stratified integrated, patient-centered, population-based services utilizing a diversified team of behavioral health professionals who function as PCPs, not ancillary staff, and who work shoulder-to-shoulder with the rest of the medical team in the same place, at the same time, with the same patients."

Establishing an Integrated Care Practice in a CHC

- Clinical Variables
  - Real time interventions
  - Ensures appropriate care at appropriate the time in the appropriate setting.
  - Population based and not disease specific
  - Emphasis on evidence-based practice and effective outcomes, as well as prevention
  - Co-morbidity the rule, not the exception
  - BHPs need strong generalist training
  - Flexibility: swapping the comfort of the therapy room for the *chaos* of the medical exam room, often with interruption

Establishing an Integrated Care Practice in a CHC

- System Variables
  - Co-location - crucial to success
  - Redefining 'team approach', and dismantling provider power differentials
  - Shared medical record
    - HIPAA and special protection for psychotherapy notes'
    - Progress notes - no such protection, so they can be integrated into the medical record : med info, modality and frequency of Tx, summary of Dx, functional status, symptoms, prognosis, and progress to date

Establishing an Integrated Care Practice in a CHC

- System Variables
  - **Coordination of care within and across health care settings :**
    - Who gets referred out ?
    - To whom ?
    - For what reasons ?
    - Who will be accepted from other agencies ?
    - The role of Community Mental Health Centers with patients with higher level mental health needs ?

Establishing an Integrated Care Practice in a CHC

- Salud's Integrated Model
- Resource allocation based on pt severity
- Level 1 – Imminent suicidal depression, acute psychosis, manic crisis, etc
- Level 2 – severe and persistent mental illness, those that can be monitored in PCP setting when stable, especially when psychiatric consultation available

Establishing an Integrated Care Practice in a CHC

- **Level 3 – chronic problems of lower severity, common in primary care, somatization disorders, nonpsychotic depression, acute stress disorder, and anxiety disorders - none of these completely debilitating**
- **Level 4 - pts with temporary mental health and psychosocial problems like marital difficulties, parenting problems, financial stress, bereavement, etc.**

Establishing an Integrated Care Practice in a CHC

- Distribution of the BH Resource
- 30% time spent on Levels 1 & 2 where approach is more traditional therapy services
- 70 % time spent with Level 3 & 4 patients: less severe, and more prevalent
- Stepped Care Approach

Establishing an Integrated Care Practice in a CHC

- **Services offered are evidence based:**
- **<u>Screening</u> with accepted tools, PHQ 9, Edinburgh Postnatal Depression Scale, PTSD Checklist, etc**
- **Priority population for screening : pregnant patients, postpartum patients, elderly patients, new patients, and children**
- **Brief 5-10 min process**

Establishing an Integrated Care Practice in a CHC

- <u>Consultation</u> -
  - real time
  - PCP initiated
- <u>Psychotherapy</u>
  - Typical session 50 min
  - BHPs can schedule 3 per day
- <u>Psychological Testing</u>
  - R/O learning disorders
  - Evaluate memory
  - Assess intellectual functioning

Establishing an Integrated Care Practice in a CHC

- Financing – this is a cost , not revenue, center
  - PPS subsidization
  - Small amounts generated thru direct pt fees
  - 3rd Party insurance not billed - problems with paneling, credentialing, same day billing restrictions, administrative burden
  - Grants – for post doctoral training, and operations
  - Some BHP's employed thru collaborative

Salud BH Providers

- Director of integrated care
- Staff behavioralists: clinical social workers
- 11 Post – Doctoral Fellows
- Shared staff from local CMHC's and county Health Depts.
- Currently 24 'bodies'

Colorado as a Medicaid BH Carve Out State

- 1995 Colorado received a 1915 B waiver to establish the system
- Principal motive was to try and improve access and reduce costs
- Five regional Behavioral Health Organizations, BHOs
- Participants include the state Community Mental Health Centers

Colorado as a Medicaid BH Carve Out State

- Colorado Medicaid Managed Care
- 1995 - Colorado Access - 14 FQHCs, Denver Health, University Hospital, the Children's Hospital
- 2001-2002 - The state basically pulls the plug on Medicaid Managed Care secondary to a suit by the MCOs over rate setting
- 2014 - Will the ACA increased enrollment in medicaid be the driving force to revive this?

Colorado as a Medicaid BH Carve Out State

- **Difficulties for us billing for BH services**
  - **BHOs wouldn't contract with us until a few years ago - mistrust of physical health**
  - **Colorado Client Assessment Record, CCAR – 6 pages, done annually, or when change in Dx, employment status, admission to BH inpt facility**
  - **Licensure requirements - unfavorable**

Colorado as a Medicaid BH Carve Out State

- MC strategies
  - CHC relations with the BHOs vary by region
  - Historic lack of trust
  - CMHCs becoming PCMHs
  - CHCs adding BH services alone or in collaboration with CMHCs
  - We partnered with Value Options to become a BHO, but did not receive the contract last month

Colorado as a Medicaid BH Carve Out State

- The future ?
- CMHCs and CHCs as strategic partners
  - CHCs doing primary BH ?
  - CMHCs focusing on the severely and persistently mentally ill ?
- Payment to CHCs for BH services
- Co-location of CHCs and CMHCs

Colorado as a Medicaid BH Carve Out State

- What will BH services look like in a Managed Care environment?
- Challenging current thinking on the model of universal screening and counseling
- Challenging current thinking on the payment models
- A provocative split with the present - the current issue of the Annals of Family Medicine

“Value Based Financially Sustainable Behavioral Health Components in Patient-Centered Medical Homes”

- The Problem
  - ~ $350 Billions spent annually on unnecessary medical and surgical services
  - 2/3 on those with significant behavioral conditions receive no treatment
  - PCP time constraints
  - Limited BH expertise
  - <20% of BH care is evidence based
  - Supply / Demand mismatch
  - “ Counseling is not the application of evidence – based psychotherapy and is not effective in improving long term health and cost outcomes”

"Value Based Financially Sustainable Behavioral Health Components in Patient-Centered Medical Homes"

- Recommendations:
  - 1. Case finding efforts should focus on chronic conditions: DM, Asthma, CAD, and Pts with high health costs - not universal screening
  - 2. Tx resources should be deployed in an integrated fashion per 'Program Components'
  - 3. Ensure BH providers have training in evidenced based BH Tx's linked to long-term health status

"Value Based Financially Sustainable Behavioral Health Components in Patient-Centered Medical Homes"

- Programmatic Components of the model:
  - Make BH clinicians part of the 'medical team', and pay thru general med/surg benefits
  - Use EHRs, registries, and claims data to ID pts with greater complexity for targeted assessment and Tx of BH conditions
  - BH 'teams' - nurses, social workers, PhD/PsyD , psychiatrists as integral

"Value Based Financially Sustainable Behavioral Health Components in Patient-Centered Medical Homes"

- Match BH expertise to clinical needs of pt, and escalate BH Tx intensity until improved
- Prospectively define desired medical & BH outcomes and evaluate success real time
- Make evidence based algorithms & protocols standard BH interventions
- Use care coordinators for an integrated, comprehensive, whole person personal care plan

Are we Ready for the future ?

- YES, YES, YES ! ! !
- OUR DELVERY SYSTEM IS THERE
- OUR TEAM IS THERE
- OUR CULTURE IS THERE
- OUR IT CAPACITY IS THERE
- WE’RE POISED TO STRIKE WHEN THE MOMENT PRESENTS
- WE ROCK ! ! !

Being a grandfather always trumps being a physician !