Behavioral Health Integration

Examining Practices to Inform Policy

May 15, 2014

Safety Net Advisory Committee (SNAC) Learning Lab

colorado health INSTITUTE

SNAC Lab Objectives

- Leverage our collective focus on vulnerable populations
- Provide a forum for opportunities and lessons learned
- Share the latest strategies for using data to measure effectiveness
- Synthesize input from group and develop a shared body of knowledge

Three Takeaways

- Behavioral health integration is a rapidly evolving field.
- Behavioral health integration is an area of focus in Colorado.
- The Colorado Health Institute is exploring how integration is being implemented in different settings and how this can inform policy decisions.

Behavioral Health Integration:

What, Why and How

What is Behavioral Health Integration?

The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. Peek CJ, the National Integration Academy Council. 2013

Behavioral Health Integration May Address:

- Mental health
- Substance abuse conditions
- Health behaviors, including their contribution to chronic medical illness
- Life stressors and crises
- Stress–related physical symptoms
- Ineffective patterns of health care utilization

Why Integrate Behavioral Health and Primary Care?

- **67 percent** of people with a behavioral health disorder do not get behavioral health treatment.
- The 14 most common physical complaints have no identifiable organic etiology **84 percent** of the time.
- **30 percent to 50 percent** of referrals from primary care to an outpatient behavioral health clinic do not make the first appointment.
- **2/3** of primary care physicians reported not being able to access outpatient behavioral health for their patients.

Source: Advancing Care Together

Why Integrate Behavioral Health and Primary Care?

Financial Benefits

- Medical use **decreased 15.7 percent** with behavioral health treatment.
- Treating diabetes and depression together in primary care saved **$896 over 24 months**.
- Treating depression in primary care saved **$3,300 over 48 months**.
- Behavioral health disorders account for **half as many disability days** as all physical conditions.
- Combined expenses for chronic medical and behavioral health conditions are **46 percent higher** than a chronic medical condition.
- **Depression** is the top driver of overall health costs: Work-related productivity + medical + pharmacy.

Source: Advancing Care Together

Why Integrate Behavioral Health and Primary Care?

- In the public delivery system, those with serious mental illness die **25 years sooner** than the general population.
- Disparity is even more severe for those with mental illness and substance abuse. On average, these people die **32 years earlier**.
- Increased morbidity and mortality for those with serious mental illness is **often due to treatable medical conditions**, such as hypertension and diabetes.

Source: National Association of State Mental Health Program Directors

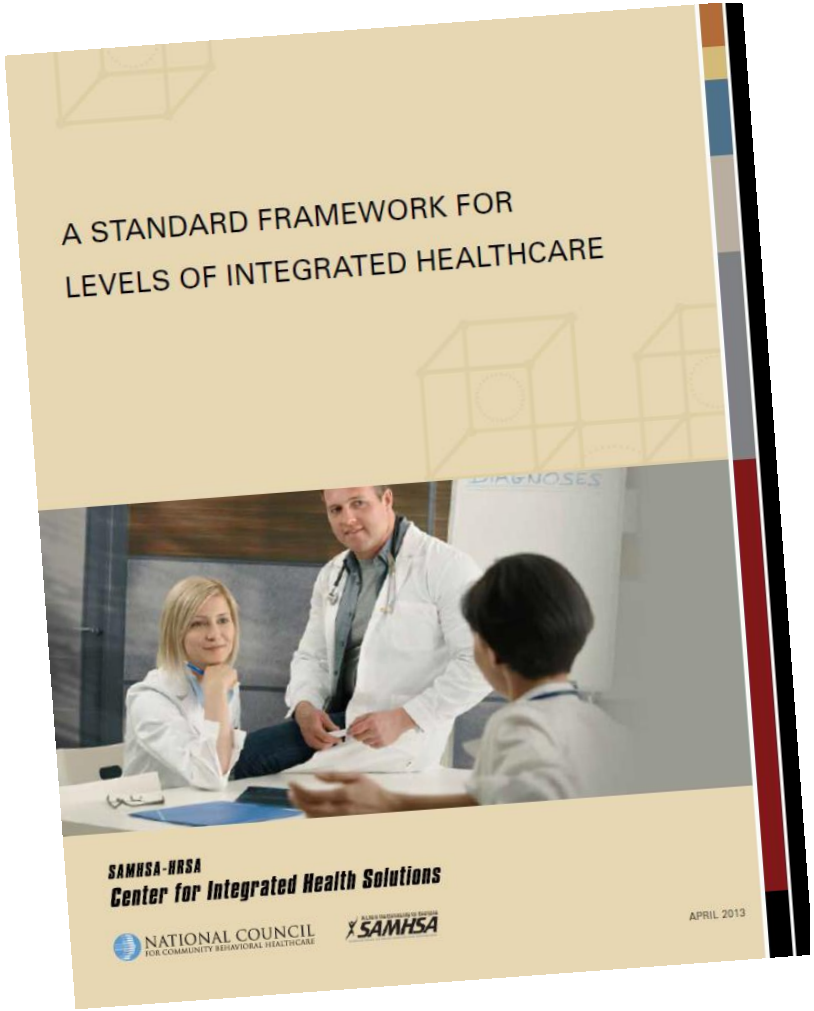
How to Integrate Behavioral Health?

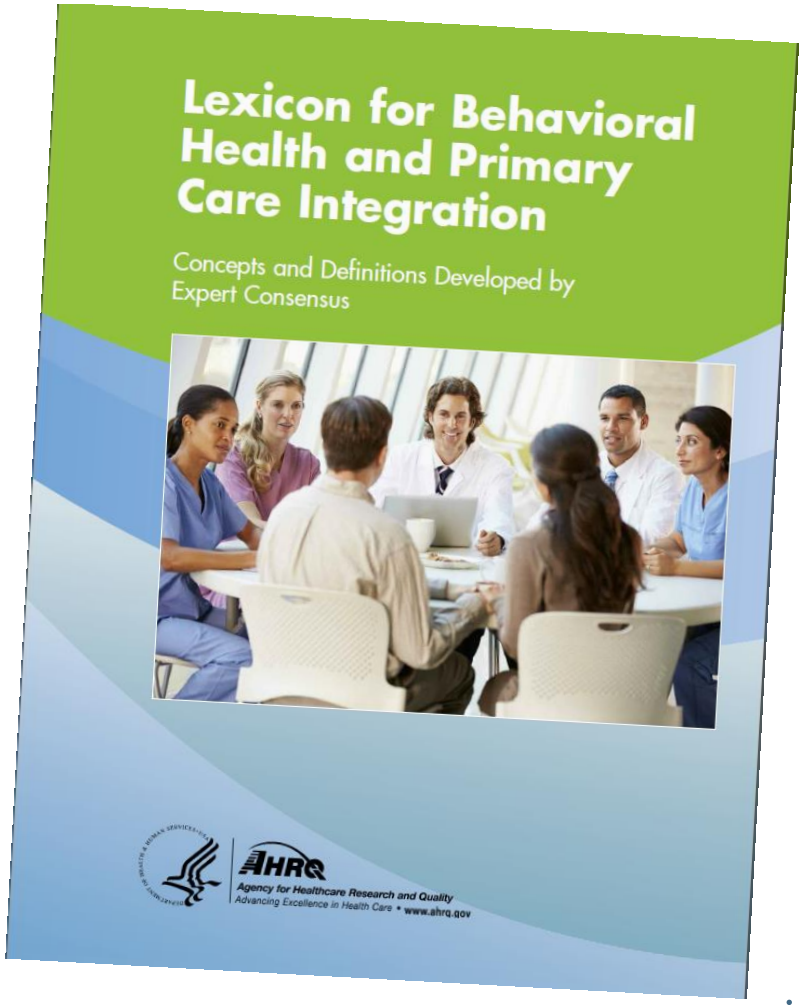
Coordination **Co-location** **Integration**

Things to consider:

- How providers work together
- How data is shared
- How services are paid for
- How to evaluate

Resources for Evaluating Levels of Integration





Colorado Health Institute Research

Why We Conducted This Study

Increased integration of behavioral health is a priority in Colorado:

- **State policy:** State Innovation Model (SIM) and the Medicaid Accountable Care Collaborative
- **Foundations:** Already funding integration projects
- **Providers:** Many organizations working on integration
- **Researchers:** University of Colorado leading research on this topic

The Questions We Asked

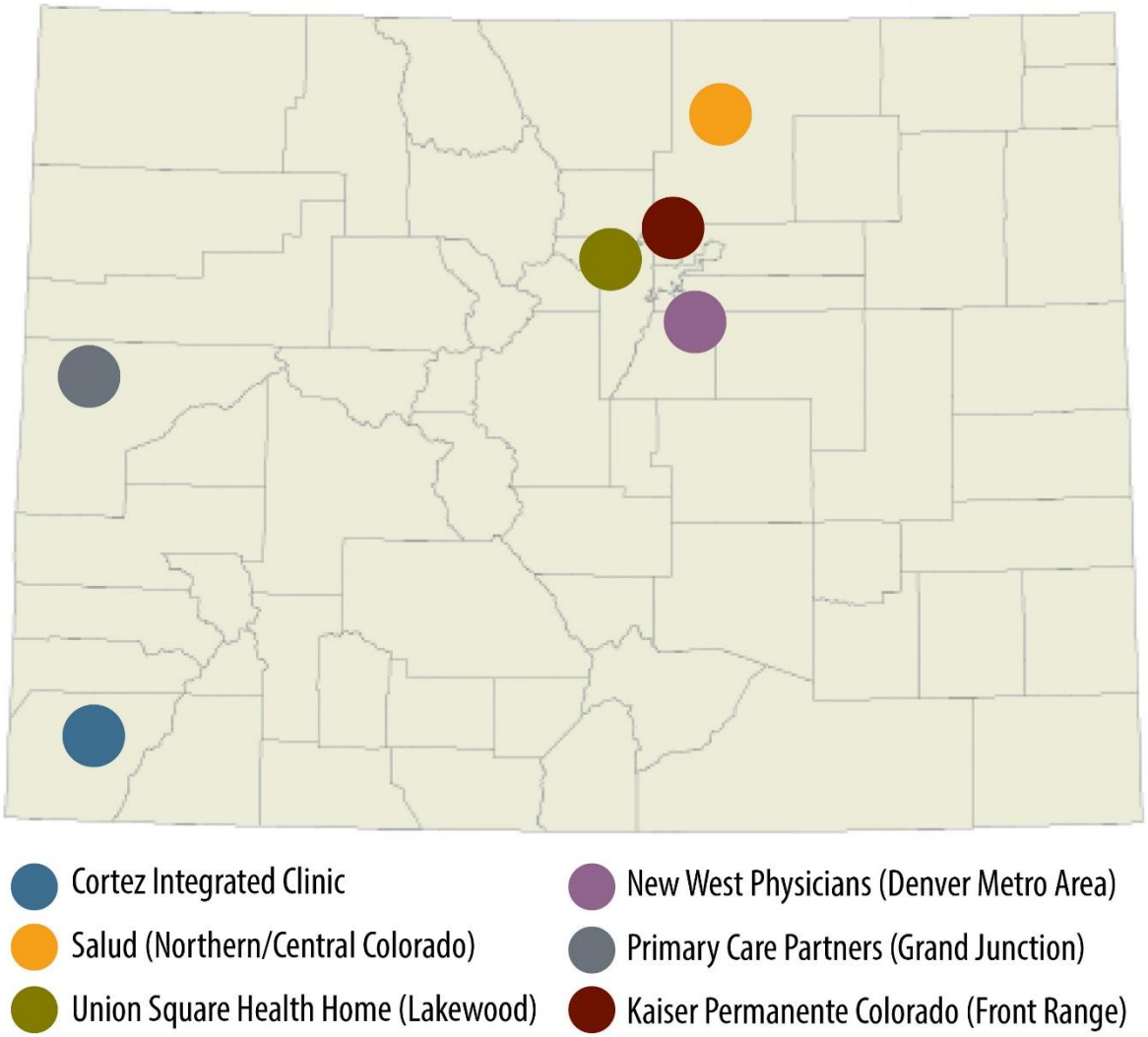
- What can be learned about successful implementation of behavioral health integration from work already happening across Colorado?

- Are there differences based on practice size, location, and population served?

The Colorado Health Institute Analysis

- Explore a variety of examples to see how different organizations made critical decisions about implementing integration.
- Qualitative data about the implementation process and the context in which this is occurring.

Examples of Integration



Safety Net Examples

Example	Organization / Structure	Location
Cortez Integrated Clinic	Axis Health Systems, which operates community mental health, school-based health, and community health centers across Southwest CO.	Cortez
Salud Clinics	Community Health Center	North-central Colorado, 9 clinics in eight counties
Union Square Health Home	Partnership between: • Jefferson Center for Mental Health, a Community Mental Health Center • Metro Community Provider Network, a Community Health Center • Arapahoe House, a substance abuse treatment provider.	Lakewood

Commercial Market Examples

Example	Structure	Location
New West Physicians	Primary care practice with some specialist care	Denver Metro area, 16 locations
Primary Care Partners	Primary care practice	Grand Junction, 3 locations
Kaiser Permanente Colorado	Health care system	Front Range, 32 medical offices Denver Metro area, 4 behavioral health offices

Questions to Consider

- Are these the right categories?
- Are these findings similar to or different from your experience?
- Where are the information gaps?
- What would be helpful to your work?

Areas of Focus

Clinic Description	Location
	Structure: FQHC? CBHC? Private practice?
	Number of patients served
Approach to Integration	Patients included
	Location of behavioral health provider
	Universal screening?
	Shared electronic medical record?
	Care coordinator?
Workforce	Ratio of behavioral health providers to primary care providers
	Training of behavioral health providers

Areas of Focus

Funding	Payer mix
	Physical health and behavioral health services billed separately?
	Primary funding source for integration
Evaluation	Formal evaluation?
	Measures used

Lessons Learned

Lesson 1: Clinic Characteristics Matter

- Safety net providers are innovators and leaders in integration. Different patient populations and incentives have established them as the state's leaders.
- The acuity of need of the population served affects what approach might be most efficient.
- Size matters. A practice needs to be sufficiently large to support full integration.

Lesson 2: Workforce is Key, and Also Challenging

- New kinds of providers are the lynchpin to effective integration.
- It is often hard to find “the right fit” for a care team.
- Each member of the workforce needs appropriate training, flexibility, and good working relationship with the rest of the team.
- Integration “is all about relationships.” Between organizations, providers, and with patients and families.

Lesson 3: The “Value Proposition” is Elusive

- Many behavioral health integration projects are in the pilot phase, and rely on grant funding.
- Questions about if/when/how payment models will change, both in Medicaid and in the private market.

Lesson 4: Evaluations May Not Be Generalizable

- Evaluation scope depends on resources available and a plan for how the findings will be used.
- Can be difficult or impossible to tease apart what is due to behavioral health integration and what is due to other changes – such as increased care coordination.
- May be hard to generalize findings from evaluation specific to one organization or community.

Questions to Consider

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How to Scale Up Behavioral Health Integration?

- What is needed?
  - Information?
  - Communication?
  - Policy change?
  - Something else?

- What does this mean for consumers?
- What does this mean for your organization?

Three Takeaways

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The Access-to-Care Index: Ideas and Opportunities

What is the Access-to-Care Index?

Working Definition:

A synthesis of the best data available over time to understand whether Coloradans have access to the care they need.

Why Create an Index?

To address the questions:

- What are the dimensions of access to care?
- Do Coloradans have adequate access?
- Is coverage translating into access?
- What would we *expect* to happen to Coloradans' access when policy changes are implemented?

Who? When?

- Collaboration between the Colorado Health Institute and Colorado Coalition for Medically Underserved (CCMU).
- Currently being developed for Summer 2014.
- Audience includes providers, consumer advocates, state and local policymakers, foundations, insurers.

Guiding Principles

- Monitor over the long term – not an early warning system.
- Incorporate quantitative and qualitative components.
- Vet with stakeholders.
- Recognize the differences in urban and rural area and develop separate models.
- Prioritize areas of focus: geography, race/ethnicity.

How Will the Index Be Developed?

- Modeled after Urban Institute Framework

Community Characteristics

- Income and Poverty
- Employment
- Racial/Ethnic Diversity

Insurance Coverage

- Uninsured
- Eligibility
- Public and Private Coverage

Potential Access

- Usual Source of Care
- Provider Availability

Realized Access

- Barriers to Care
- Receipt of Timely and Appropriate Care

Themes We Heard from You at Feb. SNAC Lab

- Specific Models of Care
  - Telemedicine, team visits, patient navigation, open office scheduling, workforce expansion
- Specific Populations
  - Immigrants, rural, seniors
- Access to Kinds of Care
  - Specialty care, oral health, behavioral health/integration
- Other Ideas
  - Culturally competent care, underinsurance, transportation, patient compliance

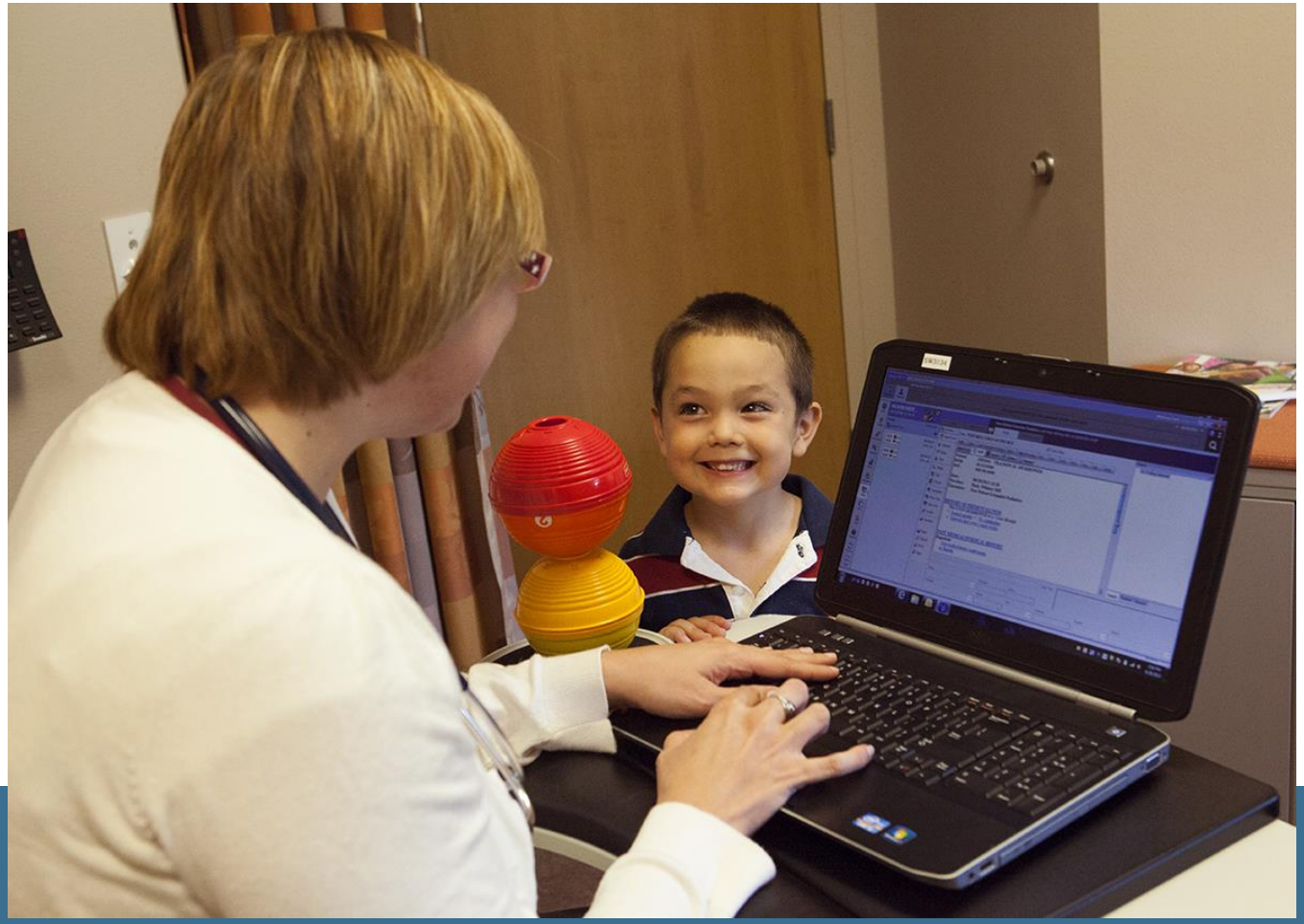
Hearing From You on the Access-to-Care Index

- *What principles should guide our work?*
  - *How should they be prioritized?*
  - *Do we have the domains right?*
- *In what ways can the index be effectively communicated and used?*
- *Would you or your affiliates be willing to serve as a sentinel site?*
  - *What questions should we ask?*

Two-Track SNAC Labs

TRACK 1: ACC	June 19	September 18
TRACK 2: Access	July 17	October 16

All SNAC Labs are held 12:00 – 1:30 pm at the Colorado Health Institute.



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