

## Behavioral health integration webinar series: Quantifying the impact

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On Nov. 12, 2020, the Behavioral Health Integration (BHI) Collaborative held the fourth webinar in the Overcoming Obstacles BHI webinar series: "Financial Planning: Quantifying the Impact of Behavioral Health Integration."

View the video or the webinar slides (PDF).

### About the event

This BHI Collaborative-hosted interactive webinar explored how practices can both financially plan for and sustain the integration of behavioral health care in both fee-for-service and value-based care arrangements. Experts share key strategies for projecting initial financial investment(s) and ways in which practices can review, report and track the overall financial value behavioral health integration can bring to their practices.

### Moderator

- Henry Chung, MD—Senior medical director of behavioral health integration strategy at Montefiore Care Management Organization and professor of psychiatry at Albert Einstein College of Medicine

### Speakers

- Christian Plaza MBA, MSN, FNP-C—Co-founder of and clinical & business director of Cross Valley Health and Medicine, P.C.; he is a family nurse practitioner and a Spanish-speaking

- allied health professional at Montefiore's Saint Luke's Cornwall Hospital.
- Paul Saladino, MD—A founding member of Cross Valley Health and Medicine, P.C., and is also the medical director for Medication-Assisted-Treatment Program at Montefiore St. Luke's Cornwall hospital.
- Katherine Suberlak—Vice president of clinical programs at Oak Street Health

## Transcript

**Speaker 1:** Good evening. Before we get started with tonight's presentation, I'd just like to go over a few housekeeping items for those of you who have joined us for tonight's presentation. Please utilize the chat box for any questions that you may have. We encourage attendees to interact and share comments or questions in that chat box while our panelists are presenting.

Please note that this webinar is being recorded and is informational only. If you have specific questions regarding medical, legal, financial, or other advice, you should consult a professional advisor for those questions. Both the recording and the slides will be shared in an email following the event. A survey will also be included. The staff of the collaborative encourages you to share your feedback on this event following tonight's webinar and as we plan future events. So with that, we'll start tonight's presentation.

**Margo Williams:** Good evening, and welcome to the BHI Collaboratives Overcoming Obstacles series: Sustaining Behavioral Health Care in your Practice. I'm Margo Williams, manager of the medical practice department at the American College of Physicians. As a member organization representative of the BHI Collaborative, I'm pleased to welcome you to our fourth webinar in this series.

This educational series is part of a suite of ongoing activities by the BHI Collaborative, dedicated to equipping physicians with the necessary knowledge to sustain a whole person integrated and equitable approach to physical, mental, and behavioral health care in their practices during the COVID 19 pandemic and beyond. These webinars are a collaborative product of eight of the nation's leading physician organizations established to catalyze effective and sustainable integration of behavioral and mental health care and physician practices.

With an initial focus on primary care, the collaborative is committed to ensuring a professionally satisfying, sustainable physician practice experience and will act as a trusted partner to help them overcome the obstacles that stand in the way of meeting their patient's mental and behavioral healthcare needs. Today's webinar, Financial Planning: Quantifying the Impact of Behavioral Health Integration, we'll explore how practices can both financially plan for and sustain behavioral health integration, including ways in which practices can review, report and track the overall value that BHI

brings to their practice.

At the end of tonight's discussion, we will have a Q&A with our experts to explore common issues or concerns that you may be experiencing. Without further ado, I'm pleased to introduce our speakers. Our moderator tonight is Dr. Henry Chung, senior medical director of behavioral health integration strategy at Montefiore Care Management Organization and professor of psychiatry at Albert Einstein College of Medicine.

Katherine Suberlak is vice president of clinical programs at Oak Street Health. Dr. Paul Saladino is a founding member of Cross Valley Health & Medicine in Newburgh, New York, and is the medical director for the Medication Assisted Treatment program at Montefiore St. Luke's Cornwall hospital, and is also a member of ACP, one of the BHI collaborative organizations.

And Christian Plaza is a co-founder and clinical and business director of Cross Valley Health & Medicine. He's a family nurse practitioner in a Spanish-speaking allied health professional at Montefiore St. Luke's Cornwall Hospital. With that, I'll turn the presentation over to Dr. Chung.

**Dr. Chung:** Thank you so much, Margo. It really is a pleasure to be a part of this panel this evening. Obviously if you're joining from some part of the country where there's a surge going on, we appreciate your attendance and time. This topic of behavioral health integration in primary care I think is so relevant to where we are right now with our patients and the anxiety and depression levels that are being seen. Let's go to the next slide.

As we think about financial sustainability, I want to introduce you to a framework that I and my colleagues at New York Presbyterian at Columbia worked on. We've been very interested in helping particularly small independent practices advance their behavioral health integration. Small practices have lots and lots of unique challenges. And so what we did in this framework was develop a roadmap specifically looking at evidence-based domains of behavioral health integration.

And if you look at the left side of this particular framework, you'll see the main domains: case finding and screening, decision support for measurement based step care, information exchange among providers, ongoing care management. And as you sort of just scan on the right side, what you'll see is that we articulate specific elements within each of those domains that primary care practices should be striving for.

Now, I won't have time to go over with you all of the different aspects of the framework, but I can tell you that financial sustainability was one of the key domains that we identified very early working with small primary care practices. Let's go to the next slide. If you go to the next slide, you'll see... And scan your way again on the left side. Sorry. Let's go back just a little bit.

You'll see that there is a sustainability domain listed as number nine on this framework. It's the very last domain. But I will tell you that based on our experience and our speakers today, it probably should be number one or number two in terms of the roadmap to behavioral health integration. And there's a really good reason for that. Let's go to the next slide.

We did articulate in this New York state based project how we would help our small primary care practices to develop sustainability practices. And if you look at the various elements preliminary, which shows that there's limited ability to bill for screening and treatment in behavioral health, moving on to intermediate, where there is billing fee for service and then ultimately billing fee for service and specifically adding quality incentives that perhaps a health plan partner would recognize, all the way to receipt of global payments or really value-based payment to the advanced part of sustainability.

You're going to see this evening that the speakers will be uniquely positioned to address all of the different elements of financial sustainability and their own journey to behavioral health integration. Next slide. If you just look at the bottom box here, we did some analysis after the project ended. And I just want to point out some of the successes we had with the sites.

The revenue metrics, if you just look at the bottom box and you look at site two, which started off with really no revenue for depression screening, and then ultimately getting monthly revenue of \$2,000, this is money that they began to reinvest in the practice. Site three started off with \$1,000. They stayed roughly the same. Site four went from \$382 to \$2,300. And over time they began to get more sophisticated.

And again, you're going to see that level of sophistication tonight with our practices. Next slide. And finally as I transition to the next speaker, I do want to leave you with a couple of references that you can take a look at that really go into the framework in depth. So I won't go over that, but you'll have that for your own use. Let's go to the next slide.

So I have a personal relationship with this next practice that we'll be presenting, Cross Valley Health and Medicine. They'll tell you a bit about where they're located and the way they're set up. But I can tell you that I've been helping them with starting a collaborative care model within their small practice using a virtual approach where we were doing things to support them at a distance.

And what I've learned over time with this practice is that they started off with an incredibly strong foundation. And then really they began to further advance in terms of their ability to really deepen their integration. I couldn't have been more proud and quite frankly more honored to work with them. So with that, I'll go ahead and turn her over to Dr. Saladino in terms of providing that introduction to the practice. Dr. Saladino.

**Dr. Saladino:** Do you hear me now?

**Dr. Chung:** All right. Paul, we got you.

**Dr. Saladino:** All right. Good evening, everyone. And thank you all for coming out. I'm pretty excited about talking about my experience with this on the clinical end. I'm going to speak about the practice, introduce the practice, talk a little bit about the demographics of the practice, the goals of the practice, and then turn it over to my medical team to talk a little bit about the clinical aspects of our collaborative effort with Montefiore.

And of course some talk about the financials, which I know this much about. So really I'm more on the clinical end. But the practice was started in 2007. Way back then, we were still using paper charts. I kind of saw the writing on the wall with the technology and I knew from the start that we had to incorporate electronic medical records. So going in, we went in sort of full throttle with the technology.

Just a little bit of background of myself. My interest has always been psychiatry. I wanted to be a psychiatrist initially. In my naive state, pre med school, I thought a psychiatrist treated medical illness in a psychiatric population. So if you were schizophrenic and you had hypertension, you'd see a psychiatrist. That was my logic. Of course, psychiatry is not practiced that way, but I still have a love of psychiatry.

So my practice over the years is tailored to that effect. We have about 8,500 patients in the city of Newburgh. Newburgh is still considered part of Metro New York. It's about 60 miles North of Manhattan, a population of about 40,000, 45,000 in the inner city itself. And throughout the years, we've had a wide range of comorbid physical and mental illness, which often goes hand-in-hand.

Since 2007, our practice has expanded. We're about 8,500 patients now. We provide outpatient services, including behavioral health. We provide medically assisted treatment for substance abuse, opiate use disorder, mainly buprenorphine and injectable naltrexone. And of course we manage a lot of the comorbidities that go along with that, including anxiety, insomnia, depression, sometimes personality disorders.

We also provide inpatient services, MAT treatment. We've started induction of opioid treatment in the hospital setting. And then we follow them prospectively outpatient. We are two medical providers, myself and Christian Plaza, who we'll meet shortly thereafter. And essentially I can go on to talk more and more about it, but the collaborative effort that we had was really important in...

Sustainability aside was really important in the sense that it allowed better accessibility in a primary care setting. I mean, I think primary care is about providing essential healthcare, if you will, accessible to individuals and families and providing mental health services in this primary care setting is critical. It's critical. And again, I'm going to turn this over to Christian Plaza. That being said, he's the clinical side of this, as well as the long side of me. And I look forward to answer any questions at the end, if anyone has any. Thank you.

**Plaza:** Good evening, everyone. Thank you for taking the time tonight in listening to our experiences in integrating behavioral health in primary care. And I'd like to thank both Dr. Henry Chung and Dr. Paul Saladino for really giving a good summary about what our practice is about. What I particularly find very special with our primary care practice is that we...

And for me as a family nurse practitioner, coming into this practice and immediately providing behavioral health care as part of the standard for the primary care practice, up until recently I thought that was a standard among primary care practices. And I am constantly reminded that this is actually a unique situation that thanks to Dr. Saladino has really integrated right from the initiation of the practice.

And I would have to say that over the years, since the practice was founded in 2007, that may have been one of the many reasons as to why we have flourished and continue to be a viable practice in that we provide so many diverse services, one of which its component is behavioral health. So in 2019, I knew that we had this unique experience, and I wanted to somehow be able to take this and put this in some kind of framework that we can differentiate ourselves as a primary care practice in the area while integrating behavioral health.

And so we summarize this mission and vision statement to basically state what the slide says, is to transform our medical practice that will provide specialized high quality primary care through some form of innovative and modern model. This was before discussion of the pandemic. This was something that I knew that if somehow we can promote behavioral health services through a telemedicine platform in some form, that this may be something that could be ideal.

Coincidentally, Montefiore, Dr. Henry Chung particularly, had approached our practice having heard through the grapevine that we were already providing some behavioral health level services. And if you will, if you look back at the framework that Dr. Henry Chung had presented, that we were already in this level two phase.

This would have been a great setup in working in this collaborative care model together and get us from a level two to an advanced integrative phase, which at that time was something that, not that it wasn't necessarily impossible, but certainly challenging, at least so I thought.

And as we started diving in and getting a better understanding of what requirements were needed and what resources were needed, who knew that our practice particularly already had many of these foundations in that framework that Dr. Chung had presented, we already had. And it really brought us into this next phase of this advanced integrative care.

And it was a wonderful opportunity because while having that mission and vision statement, we knew that in collaboration with this behavioral health and participating in the collaborative care model actually, it will enhance the services that we already are providing for our patients. It would provide a unique situation in improving our communication with specialists.

Because up until 2018, we would still refer our patients to our colleagues, to psychiatrists or psychiatric nurse practitioners, and many a times we don't necessarily hear from them. And if we are lucky, we will receive a consultation which will come archaically through fax and of course snail mail. And so by us integrating with this collaborative care model and also utilizing our current resources, our current technology, we would have instant communication with the specialists.

So how can we say no to an opportunity like that? So that was certainly something that we were very excited about. It also provided us the opportunity to lead and expand our behavioral services and addiction medicine services in the community. I will have to say that we may have been one of the only small primary care practices that was offering such an innovative model. And we knew that this would in turn provide that high specialized quality care and ultimately improving outcomes.

Next slide. So as stated before, there are so many reasons why we integrate it. So to go more into detail, this would provide us the opportunity to differentiate ourselves in offering these unique services in primary care into the community. This will certainly expand our established level one outpatient opioid use disorder medication assisted treatment program.

Throughout the years, we've always been offering this level one outpatient component based on the American Society of Addiction Medicine guideline and was something that we've always been doing. But through this collaborative care model, we would be able to expand and truly integrate that MAT component, and that patients who have opioid use disorders and with its comorbidities of depression, anxiety, bipolar disorder, and other conditions, we will be able to not only continue refer these patients to the specialists, but can actively continue to manage patients with OUD and depression, or OUD, depression and anxiety, or any other of the comorbidities.

So it was pretty obvious that this was a fantastic reason why we wanted to go into this collaborative care model. We were already providing the standardized screenings that many of us are very much familiar with, which are the PHQ-9, GAD-7 and the audit screenings to determine depression and anxiety and their severity of it. And of course we knew that by integrating behavioral health within the practice, this will help retain patients.

And in turn that actually will help improve outcomes and adherence. Another reason why we chose to integrate and utilize the collaborative care model particularly is because of the availability of resources that were already attainable to us. Our EHR system is a web-based system. And so providing access with another partner, particularly with Montefiore, was something that was very much feasible and something that was able to be done.

And again, having established partnerships particularly with Montefiore's behavioral health integration, alongside with another group called the Behavioral Health Services of the Hudson Valley, we knew that in the event that patients that needed higher level of services that we knew that patients would benefit from or we identified that were not making very good progress in that they may need that

additional perspective, we have these two partners that were readily available to come in and provide a consultation service so that we can continue managing the patients based on their recommendations.

And of course, leadership. That's probably one of the most important pieces for me, why integrating behavioral health was so successful in that we had key players with distinct roles that were able to collaborate not only with the clinical component, but also the administrative component that you'll see in a few minutes. That really required different team members coming in and fully executing the components in the collaborative care model successfully.

And as stated before, Dr. Henry Chung had just mentioned about those phases. We knew that this was a great opportunity from going to a level two phase to an advanced integrative framework. And so we were ready to hop on once we realized that we were already doing services that were already at that level two capacity. Next slide. Of course there were financial incentives.

Because we are a small practice, we wanted to make sure that this was something that was very much viable. And by participating here in the state of New York in collaborative care model, there were additional reimbursement CPT codes that allowed us to be compensated for the additional services in the collaboration of behavioral health care.

Of course we knew that by us performing this, by participating in the collaborative care model, we knew that there were going to be an increase in frequency of encounters to ensure that patients were having the appropriate follow-up. We also knew that by providing these regular screenings that we normally do for our patients and behavioral health, that we will be utilizing these PHQ-9's, GAD-7's, and that that in itself is an additional incentive.

And of course, while we're seeing patients, we're still also considering the other component of primary care, the standard. If we're seeing someone who happens to have clinical depression and anxiety and/or opioid use disorder, and then alongside with that hypertension, hyperlipidemia, the typical chronic conditions, diabetes, mellitus, that will justify higher level complex coding.

And of course, ultimately we knew that integrating behavioral health and primary care is going to improve patient outcomes. Next slide. So what we wanted to do was kind of show you a real-time description of what happens when we integrate behavioral health in our practice and integrating the collaborative care model in it. And as you can see... I'm color blind, by the way. So I think that's color orange. Is that right?

It is color orange. Okay. I am color blind. I am bright green type two deficient. So if there's a red or a spectrum of red and orange, I don't know the difference. So I'm assuming it was orange. It's just a little bit about myself. So that orange line particularly is anxiety. So when we started the collaborative care arrangement, I believe that was in May 2019. Is that correct? May 2019?



So as you could see, prior to May in 2019, specifically with those diagnoses of anxiety and depression, we were on the lower side of the spectrum. Because what you'll see in the next slide, we were really focusing more on the opioid use disorder. But when we integrated the collaborative care model, we had that opportunity to begin managing depression and anxiety particularly.

Now, you'll see that there are three other components that we had taken to consideration, which included alcohol use disorder, bipolar disorder, and post-traumatic stress disorder. And as you could see, because those are higher complex behavioral health conditions, we were just getting the hang of depression and anxiety, and towards the tail end, we started getting a hang of it and started managing those particular conditions.

But for the collaborative care model, we really focused on depression and anxiety. But immediately come May 2019, you'll notice that we overall had an increasing amount of visits as the months went on, particularly with anxiety that we were able to better manage. And I think that's a testament to what would happen when you integrate behavioral health in primary care and in addition to the collaborative care model respectively. Next slide.

This particular screen is our history of opioid use disorders. And as you can see on a monthly basis, we generally tend to see about somewhere along the low hundreds per month for our opioid use disorder, which as Dr. Saldino had mentioned was one of the first things that we had integrated in the primary care service. As soon as we had started the collaborative care arrangement with Montefiore, you'll notice, and again, that's May of 2019, there was some increases there.

Of course there were some dips, and that's an easy explanation. At that particular time period we were also looking at the larger community and Montefiore St. Luke's Cornwall Hospital in itself were looking to provide increase in access for opioid use disorders in different facilities. And so that little dip that you probably are seeing there is just as a result of more access to care that was not readily available prior to 2019. Next slide.

So I'm going to turn my attention and I'm actually going to pass this on to Kyle Russo. He is one of our leaders and practice manager, who's going to speak more about the financial piece. I'm going to switch this around. Excuse me.

**Russo:** Hello everybody. My name is Kyle Russo. I am the practice manager for Cross Valley Health & Medicine, and I am the one who oversees the billing department and the overall administrative end. As Christian was saying earlier that it is important to have key roles that know exactly what they have to do, identifying what your responsibilities are.

And this is going to be done with our medical billing department and being as savvy as they are. Now, this graph in particular shows our BHI revenue from May 2019 through July 2020. May 2019 is when we began the program. And July 2020, the reason why we ended there is because all this is data and

when we made this graph was not complete at this time.

So we want to make sure we had accurate full results for you and not just part of the month so that way you could see the trend. As you can see, the BHI revenue grew rather exponentially, if you will. From May until September, October, it stayed relatively flat, and then it started peaking up. And I know you may be thinking, wow, we must have had a huge jump in patients. We did not.

The patients population was really steep between 17 to about 30, in that range, per each monthly basis for the BHI collaborative. Now, the reason why it still grew in revenue is because these patients were seen more and more frequently. And this also led to more and more billing, which increased the revenue. Now, you do see a nice, sharp little dip there in between March and April 2020.

And I'm sure you can all imagine that COVID-19 did have an effect on this sadly. As you can see though, once everyone started figuring out how to manage their patients during the pandemic, once everyone started to figure out telemedicine, how to continue to see patients in the office, we had a sharp uptick and that has continued through all of this. Next slide, please.

So this is the practical billing guide for behavioral health. So these are just some of the examples of the codes that we want to show to everybody, but also what we use in our own internal office. As you can see, one of these comms is for the Medicare and reimbursement rate. This is based on their physician fee schedule online. On the top they provide where our locality is so that way you see why these numbers may be different than your numbers based on where you live in the country.

On the farthest right column, that is our real-world Medicaid managed care plan. This is MVP Medicaid's plan. This is our local regional insurance company in our area. And this is based on our own internal reporting. I'd want it to show the comparison between the Medicaid and Medicare as well. So at the top, we have our basic ENM codes, the 99213s, the 92214s, and 92215s. This is our level three, level fours, and level five visits.

The reason why I wanted to include this is because as Christian had mentioned earlier, the more diagnoses we have, the higher level visit you may have, depending on how many assessments you may have. And that obviously increases your revenue as well. Then I'm going to skip over the yellow component. We'll go down to underneath it. These are the different screening tools that we use.

Now, some of these have different restrictions. Some you can only do annually, some you may only do monthly, and some you may only have to do biannually depending on what the code is. So for this first one, the 96127 is a behavioral health assessment monthly per annual Medicare, depending on your plan. This has a reimbursement of \$5.63. And our Medicaid reimbursement is \$3.82.

And the reason why this is still substantial is because this is added on top of your visit. So whatever your normal code is, whatever you get paid for that visit that you saw for that patient, this is added on

top of that to help increase the revenue for that visit. And this is the same philosophy for the rest of these codes. So we have alcohol screenings, depression screening, smoking cessations, and alcohol drug screenings as well. And these are just some of the examples of the most common codes that we use are thrown into different visits.

**Dr. Chung:** Kyle, this is Henry. I just need to have you finish up with Christian maybe in about a minute. If you could, maybe you could move on and then see if we can take some questions around billing right at the very end so that we can give time for the next speaker.

**Russo:** Absolutely. So I'll have Christian come back over and finish up the slide so he could wrap it up since we do have only one more slide left. Okay. Christian.

**Plaza:** Time flies. Next slide. So finally, one of the most important pieces of this presentation is how do we maintain sustainability in behavioral health in primary care? So there were a number of things that we had thought of through the experiences we have with the collaborative care model, expanding treatment and management of behavioral health.

So we realized that because we did such a great we did really well with working with patients and really having improved patient outcomes. We wanted to start including more complex disorders that would otherwise have gone to specialists and they would face more barriers into providing access to care. We wanted to start including some of these more complex diagnoses like bipolar disorder or binge eating disorder. So that will be one way of providing that sustainability for behavioral health in primary care.

Another component is to ensure that we are partnering with other collaborative partners. We're now in a post COVID and what we are currently in this COVID pandemic, and so virtual collaboration will be really important for patients and for our practice. Of course it's all about continuing to be consistent in implementing behavioral health screenings.

Without doing those standardized screenings on a regular basis, think of behavioral health screenings as nothing but fingersticks that we do spot checks for patients for diabetics. It's the same thing for mental health. It's to do a spot check and make sure that the patient is in good standing with their overall mental health. Embracing additional behavioral health care training.

This experience that we had with collaborative care model has really made me want to pursue more on behavioral health training, not only for myself, but also for the staff. When you have a staff that's better trained in addressing mental health in all components, administrative or clinical setting, it helps improve the overall experience and improve patient outcomes in general.

Compromise. We have to also learn to compromise. Having this opportunity and going into this advanced integrative phase was fantastic. And we want to continue doing that, but we also have to

learn that we have to compromise. We may not necessarily be able to reach that particular goal like some of the larger practices may have, and being okay with that.

And learning and growing from that component I think is really critical to all of this. And finally being able to balance behavioral health alongside those chronic disease conditions is really important for any primary care practice to sustain and be financially viable. I think that concludes our presentation.

**Dr. Chung:** Well, that was fantastic. And I would just say that you are well on your way to becoming the advanced practice that you envisioned. So now we're going to move on to the next speaker, Katherine Suberlak, who's VP of clinical programs at Oak Street. And you're going to now also see a very, very sophisticated version of behavioral health integration. So Katherine.

**Suberlak:** Thank you. And thank you to the other speakers. It's good to be with all of you tonight. We can move forward to the next slide. My plan in the few minutes that I have with you is to build on what the other speakers have shared around integrated behavioral house, but particularly how at our model of Oak Street Health, that that care design can be both potentially for sustainability and fiscally responsible and how AT Oak Street Health, our organizational mission is rebuilding health care as it should be on that mission is well aligned with what some of the speakers just reviewed of how we're meeting the patients, where they are at in primary care, often seeking mental health and substance use treatment.

So a brief introduction to Oak Street Health, just to kind of set the framework and where maybe some of our differentiators are, and what makes the opportunity for financial sustainability with behavioral health and primary care. So we were founded in 2012. And a few highlights are that we are a network of primary care centers for adults on Medicare. We have just a milestone this year of 70 plus locations across 10 states with a little over 200 primary care providers and a little over 80,000 patients.

Our model, which I can walk you through the patient's journey in the next slide, is that we do receive a global capitation for our patients. And so in that full risk model, our patient, we are responsible for them with longitudinal primary care, but also responsible for their medical costs as they navigate through transitions outside of our four walls. How we operate, I just want to highlight this in a few places as we dig into the behavioral health component, is that a patient's experience with us often face-to-face for that can take an assessment with their primary care provider and also as a Medicare recipient annually with their annual wellness review.

We do leverage a risk stratification process and data science to feed quite a bit of our point of care decision-making both for what is the potential and predictive analytics. So looking ahead to what this patient may experience. But then also we integrate a host of population health interventions, including behavioral health that can help identify when the patient's reporting and measurement based care, their experience.

As a patient may experience care outside our four walls, whether that's through specialty care or perhaps they've had an acute event or have been inpatient or at a skilled nursing facility, we do have a transition team that connects with that patient. And the goal is to engage them back in the center, back with their primary care provider so that we continue to care for them longitudinally. Next slide. So how do we do this with behavioral health? We know, like our partners, that there's a well-established and impressive return on investment opportunity with collaborative care.

What we're going to hear is those of you that may not be familiar with collaborative care, but it was mentioned in the previous presentation. Particularly we look at the impact model that was the randomized clinical trial with work with older adults that demonstrated the ability to both care for patients and improve their quality of care, but also improve cost of care.

And this was over a four-year period seeing a reduced cost based on the intervention they received through this impact model. So how we have implemented that since 2018 at Oak Street Health is we really focus on two areas. We focus on operations, and then we focus on the clinical side. Under operations, our goal there is to enroll an optimal number of patients that are eligible.

So we leverage that enhanced data infrastructure I mentioned of our predictive analytics of past claims based if a patient's experienced a depressive episode in the past, and also those point of care interventions, like our colleagues I mentioned at PHQ-9, both universal or systematic screening, and then repeat screening. Where this is key and maybe a differentiator from what the presentation we just saw is where the opportunity lies in value-based care. Because our drivers or our levers may be different than fee-for-service.

And that starts with kind of how we're set up in that patient relationship in that it matters less to us the frequency at which we see the patient or the revenue gained from a patient encounter. Where we in that global capitation experience are looking at the total care experience, and our goal is to make sure we're enrolling the right patients at the right time and keeping them engaged until we see that the interventions are improving the outcomes.

And so what we have to get right first in that foundation is that operations and the data infrastructure. And then what we have to get right in tandem to that is teaching our teams to use the model effectively. Where we have done that I would say is two key areas, is both addressing our provider culture via clinical guidelines. So partnering with our psychiatric team and developing clinical guidelines for a major depressive disorder, substance use disorder, and now working on neurocognitive impairment is guiding for primary care providers.

And I heard Dr. Saladino describe this. I love the definition that primary care is an appropriate place to take care of the whole patient. Now, that's not always how primary care providers are trained, and it may not be their experience or comfort level. So where we come in is making sure that we can provide those supportive services through an integrated team.

And so our care team centers are made up of behavioral health specialists that integrate into the team along with tele-psychiatry providers that operate both in a direct patient facing ways through tele-psychiatry, but also a consultative model, giving direction. We provided ongoing training to our primary care providers so that we can increase that level of comfort and competency to be able to manage the population.

So what we would highlight here is that while we have built this opportunity on top of the well-researched and proven collaborative care model, we believe within our value-based approach that we have the opportunity for a purposeful and planful model that will have additional layers for all patients. For patients that maybe originally were not part of that denominator in the collaborative care model that looked at the question specifically, but that because we are the outpatient provider for this patient and responsible for their cost of care, that we have opportunities to apply the core concept of collaborative care to the patient's behavioral health.

Next slide. I just wanted to offer a distinction here. So I was briefly touching on that on our purposeful and planful model, but I do think it's important to note that for us we do recognize that there's a distinction between the impact model and then our overall integrated behavioral health. And one of the things that we believe is influencing our financial sustainability is that we have a responsibility to implement the impact model first and with fidelity and be sure that we can track towards this implementation.

And that has been our primary focus in the last year, year and a half. But we also acknowledge that not all patients meet this criteria. So that's where we see our responsibility to both these statements can be true, that we can have drivers and levers and build our operations and clinical teams to replicate the impact model, but that we also plan to innovate and go beyond that to take care of our total population that are experiencing severe mental illness and are under our care.

Next slide. So how do we do this? So brief note on this before we look at the evaluation of sustainability, is that as I mentioned, our data infrastructure, we have built out an internal care management platform that's called Canopy as a reference to that cannot be true within Oak Street Health, where we can have a shared registry, where we're receiving those measurements that are occurring like the PHQ-9 in a systematic fashion, and then repeating it.

The team here can sort those in order to evaluate the patient's response to treatment. And then in the collaborative care model, that treatment towards target, the triad between the psychiatric provider or the behavioral health specialist and the primary care provider can make decisions around interventions for that patient in order to improve the outcome in ideally a shorter amount of time.

And again, because we are not in a fee-for-service model where we might be dependent on visits, then the decision may be between that triad, we can engage with the patient outside of a visit cadence and have that be telephonic or have that be a medication change in between visits in order to reach a

therapeutic level where we see those evolve. Next slide.

So our analysis to date, and this is the most recent review of just January through September population, looked universal count of our PHQ-9 results. You can see our average score for our population. We first see this is definitely impacted by our older adults in isolation and their experience with the pandemic as pacing near that score that would be at a risk level. So where we see both success and opportunity is we can see that we're successfully screening individuals using PHQ-9.

We also see that those individuals that we do enroll that we are repeating the PHQ-9 and that where we have targeted operations to increase the cadence at which people are repeating, we noticed in the last month a 15% increase. So people increasing the cadence and engagement with their patients to make sure we are doing the operational mechanisms or the processes to reach the targeted area.

We also have identified that the average score difference of what individuals are dropping by isn't nearly nine points. So what that means for us is for those, that was nearly out of thousand patients, around 900, that have seen a point reduction that are some of those thresholds that look at someone having a change in either their depressive disorder from severe to moderate to mild, and some even entering into what we can evaluate for a period of remission.

Where we have opportunity, and I'll be highlighting that as we get to the evaluation point is enrollment of patients. So still that focus area of that first operational lift is making sure that those that screen, determining they want to use positive or those that screen at risk, that we are making every effort to engage those patients. So you can see that one note is of the patients that screened, the 10 or greater, just 46% of those are enrolled in the program.

So we know we have opportunity to engage patients that are at risk to benefit from those services that are available. Let me go to the next slide. So how do we evaluate? I'll briefly touch on this, and know that it can be somewhat confusing. In a value-based world, what we want to look at is the return on investment. What we take a picture of is looking at calculating an expected post-treatment contribution margin based on the experience of a comparison group.

We then use the percentage change of the comparison group to pre and post treatment contribution margin for this equation to account for any baseline differences in that group. And so rather than just saying that straight dollar amount of a contribution margin was our target, we looked at a percentage change and applied that. That led us to at the end of the program ROI is we multiply that per member per month to see if there's added value at this time for the program.

If you move on to the next slide, I'll be able to highlight how this is calculated. So the top and bottom you're looking at, you're looking at the enrolled group versus the comparison group. We look at admissions, a few of our metrics that we're looking at. So I'll highlight those. The ADK speaks to admissions per thousand, then EDK are ER use for the group. The per member per month, the

revenue that is coming from that group, that contribution margin. So the Delta between the PMPM and the revenue, and then their member month.

Post-treatment, same pieces. What we can see that is quite remarkable in the pre and post-treatment group is the intervention has had an impact on this individual's admission experience, their ED use, particularly down 17%, and also has a slight increase in the contribution margin. The challenge here with the comparison group or with the ROI is there somewhat of the same impact, not as high in the shift of the percentage in similar metrics. What that left us with when we apply the evaluation process that we set out to do or this methodology is that the expected contribution margin was \$234. We were off by \$25.

And so based on this approach, if we had the chance to dialogue, I'd probably ask the group or get some feedback on what are these challenges? I think if we move on to the next slide, I can identify kind of our greatest challenge is that number two bullet point on there, is that our program evaluation, we continue to face challenges with identifying the right comparison group.

For what you saw on the previous slide, the comparison group there were actually eligible patients who had not scheduled an appointment or had not been enrolled in the program. We think challenges with that on the start is it's a high risk group to begin with, and finding the right comparison group within our population is tough. Our future iterations will be to look at likely intention to treat rather than that current definition, which is just problematic because individuals that may be eligible but not enrolled could be not enrolled for a variety of reasons.

And so that's where our focus will be. We believe and we have strong convictions that the ROI is there. And then it's been proven elsewhere. We also believe given the value based setup and the operations that we've put in place, that it is achievable, particularly as we see that gap just being about \$25. And so we're also making sure that we are both leveraging the right comparison group, but continuing with the levers that we know to be true.

And that's what I think it's the other sandwich bullet point on this slide, which is that we know we can demonstrate care excellence when we implement with the operational excellence. So for us, both the quality of care and the financial sustainability is how we will continue to hold our teams accountable to the expected implementation and execution of our model.

Lastly, we know our future success will depend on our ability to integrate beyond collaborative care and make sure for patients with serious mental illness, that we are identifying outcome measures for them and systematically screening and evaluating those that will be coming. And with that I will pause because I know we wanted to have time for some Q&A and hand it back to Dr. Chung.

**Dr. Chung:** Oh, that was fantastic, Katherine, really providing a nice contrast to what Cross Valley had presented, which is primarily fee-for-service model. So first I'm going to ask folks at the APA to see if



there are any questions that have come in. If not, I'll go ahead and start. And I'll also tell the audience that we may run over a few minutes just so we can get into some discussion and questions.

While we're waiting with the VMA to collect some thoughts, let me start the first question off to Cross Valley. I guess I'd like to ask Cross Valley this question, which is your journey really has been outstanding, but I think looking back at your past experience, the year and a half where your revenue has really grown beyond the OUD work that you were doing, what would you do differently to really enhance your financial return on investment, if you will, on a fee-for-service basis? Could you give any advice to the audience?

**Plaza:** Yes, absolutely. So one of the key components that I had mentioned in the presentation was about the leadership and roles. Something that I think in hindsight if we had to do it over again is making sure that we have all different team members that are going to be part of integrating and applying the collaborative care model into our practice. That particularly included the medical biller.

We do have a in-house medical biller. And even though we had the medical biller participate indirectly with some of the meetings and preparing the medical biller to what it is that was expected, we should have had her more involved and really having a good understanding as she was reviewing over our notes and in working with Montefiore, really having a more active role.

So that I would say is one of those key components that right from the beginning she would have benefited from additional training and really having a good fundamental understanding of what we were doing. Checklist is very important. I think from us, with the resources that we have and what we were able to do was fantastic. In hindsight, specific checklists to make sure that not only did we have all the major components, making sure that we had the contractual arrangement between the organizations, making sure that our CPT codes were in place, but even the day-to-day flow was something that was amiss with our practice.

There were a few weeks, maybe a few months into the program where there may have been better opportunities to communicate with one another and really checking on a much more frequent basis to make sure that we weren't missing anything. And even though we were meeting frequently, I don't recall on top of my head if it was like biweekly. I mean, I know we were meeting frequently, but we really needed to have some like huddles to making sure that the patients that we were going to see that were part of the collaborative care model, that this is what we anticipate providing services and these were the codes that needed to be provided.

And had we done that, we probably would not have had so many disruptions in revenue issues that we had initially. Those are just some items that can think on top of my head.

**Dr. Chung:** That's a fantastic question. Thanks so much. Now let me shift to Katherine. Katherine, you're getting a question from a psychiatrist that I've worked with closely, Dr. Sarah records, who is

actually one of the psychiatrist that had supported the Cross Valley group. You're pretty advanced. And what she wants to know is are you using any non-traditional behavioral health engagement and treatment strategies? So she's thinking about things like smartphone applications, patient portals, telephonic check-ins to support your collaborative care model.

**Suberlak:** Yes. We've leaned in pretty heavily to the telephonic check-ins with our patients that are off cadence from their doctor visit. And so the expectation is using, we actually call it a widget or an impact widget within that registry I showed. And so the register reviews the huddles. I think Christian's concept is spot on, is leveraging a team-based care. The team will leverage the data infrastructure to help drive kind of that smart feature which patients need immediate or that outreach that week that's off cadence from a traditional visit and trigger that telephonic outreach. We do have some text messaging within our practices, yet we haven't pushed it as far within our behavioral health structure. Some of that's been the population we serve is that lower engagement. But we are currently right now testing or piloting some tidal waves.

**Dr. Chung:** Great, Katherine. This question will be for the both of you. And so we'll let Christian go first and then you Katherine. But we are now really playing a long game with regards to COVID. And I wonder for the audience, who are really thinking about financial sustainability, are there red flags or opportunities that you see coming out of the COVID pandemic as it relates to really enhancing sustainability of your work for behavioral integration? So first one of the question because New York was an early epicenter around the COVID-19, so Christian and Carl and Paul, thoughts for the audience, please.

**Plaza:** So from my standpoint, it provided more opportunities and providing care in a more convenient and readily accessible way that in our practice was not necessarily a given in that traditional standard form of primary care that we had provided before COVID. I'll give you a good example. In order for someone to participate with the opiate use disorder treatment program in our practice, the patient would need to have some type of screening, and that may take a few days to have that screening.

And then there's a process of determination that that person was readily available. COVID and telemedicine has really allowed us to immediately evaluate the patient and make a determination if the person is an appropriate candidate for opiate use disorder MAT treatment. And that person, depending on that particular circumstance, may even be given an opportunity to undergo an induction period if the patient had met the qualifications that they needed for our level one practice.

And so it has really expedited and really provided a quick way of taking care of patients. And I've had quite a number of patients that I have had the opportunity to do inductions, and I have pretty good outcomes associated with that. And this just one particular example since COVID what has happened with our practice.

**Dr. Saladino:** Dr. Chung, if I may chime, initially at the start of the pandemic here in New York, my opiate use disorder patients specifically did Okay. unfortunately as time went on and as the pandemic unfolded and the world was locking down and people were isolating, that pocket population was unfortunately with the social isolation is being hit particularly hard. And lack of services, physical groups, AA's, et cetera, those types of formats that are limited, it's driving a lot of people to relapse.

And that's what we're seeing in our practice. I mean, a lot of our patients that were stabilized unfortunately have relapsed. So it's kind of like a boulder dash to try to get them services that at this point continue to be quite limited. So it's a struggle that I think will be very much in the forefront. And as the pandemic unfolds, I think a lot of folks are suffering with anxiety and other know issues and mental health will be critical. And I hope that the government and the powers will realize that and invest the resources to manage that aspect of healthcare.

**Dr. Chung:** It's really so important. Thank you so much for that Dr. Saladino. Katherine, same question to you. You'll have the final word tonight.

**Suberlak:** Well, I'll add to what they had to say. I think echoing the concerns around access and isolation and how that isolation can be monitored to not escalate into possibly worsening symptoms or worsening mental health or substance use experiences. I think there is a profound opportunity for both, whether you're in fee-for-service or value-based care with the tele-health options.

And I think for a couple reasons, I think it's because of how some of the regulations have shifted given people's experience with COVID and many states and the ability for healthcare practices to offer that to their patients. And then I think on the patient experience side, whether it's from FaceTime, Zoom, the way people are interacting, we're finding individuals are more comfortable than maybe they have been in the past with engaging in telehealth. So I think in those ways, it does give us a tool to attempt to bring access to the homes of some of our patients, as well as operate outside of a traditional visit, face-to-face, bricks and mortar in our office.

We're particularly looking at that now while we are in several states that are experiencing another surge. And so an example I would give that I think is a great opportunity is we've moved in from our behavioral health specialists to remote so that they can be safe and at home, but then also remote with their patients in order to do wellness checks and follow up on the registries and make sure that we're trained to target while communicating back to the team. So I think it's looking at how can we leverage both the technology that's available to us as providers, but then also the comfort level of our patients and how we optimize that right now.

**Dr. Chung:** Fantastic, Katherine. We're going to wind up the evening and I'm going to actually turn it back over to Margo who started us off this evening. Margo.

**Williams:** Okay. This is really fantastic. Thanks to all of you for a great presentation. So we're at the end of our time for today's discussion. But before adjourning, we, the BHI Collaborative, would be most appreciative if you were to provide your valuable feedback on our short event survey, which you will receive in an email. Your feedback will help us inform future educational sessions and resource development.

Please note that our last webinar for the year is scheduled for next Thursday, November 19th, and we'll be covering strategies for dismantling stigma within physician practices. There'll be two more webinars available in January 1 on BHI implementation, and one on privacy and security. Stay tuned for more details. If you were unable to attend the previous webinars in this series, a link will be available in the evaluation email. Thanks again, and hope you all enjoy the rest of your evening.

**Dr. Chung:** Thanks so much everyone. Be safe, stay safe. Thank you.

**Suberlak:** Thank you.

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**Disclaimer:** The viewpoints expressed in this video are those of the participants and/or do not necessarily reflect the views and policies of the AMA.

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## About the BHI Collaborative

The American Medical Association along with seven leading medical associations have established the BHI Collaborative, a group dedicated to catalyzing effective and sustainable integration of behavioral and mental health care into physician practices.

With a focus on primary care, the Collaborative is committed to ensuring a professionally satisfying, sustainable physician practice experience and will act as a trusted partner to help them overcome the obstacles that stand in the way of meeting their patients' mental and behavioral health needs.

The medical associations include: the American Medical Association, American Academy of Child & Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Osteopathic Association, and the American Psychiatric Association.

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## 988 Suicide & Crisis Lifeline

With an increased number of people reporting worsening mental health in recent years, it is imperative that people are aware of the 988 Suicide & Crisis Lifeline (formerly known as the National Suicide Prevention Lifeline) telephone program.

People experiencing a suicidal, substance use, and/or mental health crisis, or any other kind of emotional distress can call, chat or text 988, and speak to trained crisis counselors. The national hotline is available 24 hours a day, 7 days a week.

The previous National Suicide Prevention Lifeline phone number (1-800-273-8255) will continue to be operational and route calls to 988 indefinitely.