BHI COLLABORATIVE PRESENTS

OVERCOMING OBSTACLES WEBINAR SERIES

Sustaining behavioral health care in your practice

November 12, 2020
This Webinar is being made available to the general public and is for informational purposes only. The views expressed in this Webinar should not necessarily be construed to be the views or policy of the AMA.

The information in this Webinar is believed to be accurate. However, the AMA does not make any warranty regarding the accuracy or completeness of any information provided in this Webinar. The information is provided as-is and the AMA expressly disclaims any liability resulting from use of this information. The information in this Webinar is not, and should not be relied on as, medical, legal, or other professional advice, and viewers are encouraged to consult a professional advisor for any such advice.

No part of this Webinar may be reproduced or distributed in any form or by any means without the prior written permission of the AMA.

All rights reserved. AMA is a registered trademark of the American Medical Association.
Overcoming Obstacles Webinar Series

This series is focused on enabling physicians to sustain a collaborative, integrated, whole-person, and equitable approach to physical and behavioral health care in their practices during the COVID-19 pandemic and beyond.
About the BHI Collaborative

The BHI Collaborative was established by several of the nation’s leading physician organizations** to catalyze effective and sustainable integration of behavioral and mental health care into 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 patients’ mental and behavioral health needs.

TODAY’S TOPIC:

Financial Planning: Quantifying the Impact of Behavioral Health Integration
TODAY’S SPEAKERS

Henry Chung, MD
Senior Medical Director of BHI Strategy at Montefiore Care Management Organization; Prof. of Psychiatry at Albert Einstein College of Medicine

Paul Saladino, MD
Founding member, Cross Valley Health & Medicine, P.C.; Medical Director, MAT Program at Montefiore St. Luke’s Cornwall Hospital

Christian Plaza MBA, MSN, FNP-C
Co-founder and Clinical & Business Director of Cross Valley Health & Medicine, P.C.; Allied Health Professional at Montefiore’s Saint Cornwall Hospital

Katherine Suberlak
Vice President of Clinical Programs at Oak Street Health
Roadmap to Financial Sustainability for Behavioral Health Integration in Primary Care

Henry Chung, MD
Senior Medical Director
Montefiore Care Management Organization
and
Professor of Psychiatry
Albert Einstein College of Medicine
<table>
<thead>
<tr>
<th>Role</th>
<th>Key elements of integrated care</th>
<th>Integration continuum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Workflow</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Domains</strong></td>
<td><strong>Components</strong></td>
</tr>
<tr>
<td>1. Case finding,</td>
<td></td>
<td>Patient/clinician identification of those with BH symptoms—not systematic</td>
</tr>
<tr>
<td>screening, referral</td>
<td></td>
<td>Systematic BH screening of targeted patient groups (e.g., those with diabetes, CAD),</td>
</tr>
<tr>
<td>to care</td>
<td></td>
<td>with follow-up for assessment</td>
</tr>
<tr>
<td>2. Decision</td>
<td>Evidence-based guidelines/</td>
<td>Referral to external BH provider(s)/psychiatrist through a formal agreement detailing</td>
</tr>
<tr>
<td>support for</td>
<td>treatment protocols</td>
<td>engagement, with feedback strategies</td>
</tr>
<tr>
<td>measurement-based</td>
<td></td>
<td>Systematic tracking of symptom severity; protocols for intensification of treatment</td>
</tr>
<tr>
<td>stepped care</td>
<td></td>
<td>when appropriate</td>
</tr>
<tr>
<td>3. Information</td>
<td></td>
<td>PCP-initiated, with referral when necessary to prescribing BH provider(s)/psychiatrist</td>
</tr>
<tr>
<td>exchange among</td>
<td></td>
<td>for medication follow-up</td>
</tr>
<tr>
<td>providers</td>
<td></td>
<td>PCP-initiated, limited ability to refer or receive guidance</td>
</tr>
<tr>
<td>4. Ongoing care</td>
<td></td>
<td>Supportive guidance provided by PCP, with limited ability to refer</td>
</tr>
<tr>
<td>management</td>
<td></td>
<td>Referral to external BH provider(s)/psychiatrist for counseling interventions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brief psychotherapy interventions provided by co-located BH provider(s)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Minimal sharing of treatment information within care team</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Informal phone or hallway exchange of treatment information, without regular chart</td>
</tr>
<tr>
<td></td>
<td></td>
<td>documentation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exchange of treatment information through in-person or telephonic contact, with</td>
</tr>
<tr>
<td></td>
<td></td>
<td>chart documentation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Routine sharing of information through electronic means (registry, shared EHR, shared</td>
</tr>
<tr>
<td></td>
<td></td>
<td>care plans</td>
</tr>
<tr>
<td>Role</td>
<td>Key elements of integrated care</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Workflow</strong></td>
<td><strong>Domains</strong></td>
<td></td>
</tr>
<tr>
<td>(continued)</td>
<td><strong>Components</strong></td>
<td></td>
</tr>
<tr>
<td>5. Self-management</td>
<td>Use of tools to promote patient activation and recovery with adaptations for literacy, language, local community norms</td>
<td></td>
</tr>
<tr>
<td>support that is...</td>
<td><strong>Integration continuum</strong></td>
<td></td>
</tr>
<tr>
<td>is culturally</td>
<td><strong>Preliminary</strong></td>
<td></td>
</tr>
<tr>
<td>adapted</td>
<td>Brief patient education on BH condition by PCP</td>
<td></td>
</tr>
<tr>
<td><strong>Intermediate</strong></td>
<td><strong>Brief patient education on BH condition, including materials/handouts and symptom score reviews, but limited focus on self-management goal-setting</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Advanced</strong></td>
<td><strong>Patient education and participation in self-management goal-setting (e.g., sleep hygiene, medication adherence, exercise)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Workforce</strong></td>
<td><strong>Care team</strong></td>
<td></td>
</tr>
<tr>
<td>6. Multi-disciplinary</td>
<td><strong>PCP, patient</strong></td>
<td></td>
</tr>
<tr>
<td>team (including</td>
<td><strong>PCP, patient, ancillary staff member</strong></td>
<td></td>
</tr>
<tr>
<td>patients) used to</td>
<td><strong>PCP, patient, ancillary staff member, CM, BH provider(s)</strong></td>
<td></td>
</tr>
<tr>
<td>provide care</td>
<td><strong>Weekly team-based case reviews to inform care planning and focus on patients not improving behaviorally or medically, with capability of informal interaction between PCP and BH provider(s)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Management</strong></td>
<td><strong>Systematic quality improvement</strong></td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td>Use of quality metrics for program improvement</td>
<td></td>
</tr>
<tr>
<td>7. Systematic quality</td>
<td><strong>Informal or limited use of BH quality metrics (limited use of data, anecdotes, case series)</strong></td>
<td></td>
</tr>
<tr>
<td>improvement</td>
<td><strong>Use of identified metrics (e.g., depression screening rates, depression response rates) and some ability to regularly review performance</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Advanced</strong></td>
<td><strong>Use of identified metrics, some ability to respond to findings using formal improvement strategies</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Linkages with</strong></td>
<td><strong>Linkages to housing, entitlement, other social support services</strong></td>
<td></td>
</tr>
<tr>
<td>community/social</td>
<td><strong>Few linkages to social services, no formal arrangements</strong></td>
<td></td>
</tr>
<tr>
<td>services</td>
<td><strong>Referrals made to agencies, some formal arrangements, but little capacity for follow-up</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Advanced</strong></td>
<td><strong>Screening for social determinants of health (SDOH), patients linked to community organizations/resources, with follow-up</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Sustainability</strong></td>
<td><strong>Build process for billing and outcome reporting to support sustainability of integration efforts</strong></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td><strong>Limited ability to bill for screening and treatment, or services supported primarily by grants</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Advanced</strong></td>
<td><strong>FFS billing, and revenue from quality incentives related to BH</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Receipt of global payments that reference achievement of behavioral health and general health outcomes</strong></td>
<td></td>
</tr>
</tbody>
</table>
Domain 9: Sustainability.

Component 1: build process for billing and outcome reporting to support sustainability of integration efforts.

- Limited ability to bill for screening and treatment, or services supported primarily by grants

- Level I: Billing for screening and treatment services (e.g. SBIRT, PHQ screening, BH treatment, care coordination) under fee-for-service (FFS), with process in place for tracking reimbursements

- Level II: FFS billing and revenue from quality incentives related to BHI

- Receipt of global payments that reference achievement of behavioral health and general health outcomes
## Practices’ Self-Reported Quality Metrics (n=8 responses to survey, of 11 practices)

<table>
<thead>
<tr>
<th>Depression Monitoring Metric</th>
<th>Prompt Follow-Up for Patients Diagnosed with Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NUMERATOR:</strong> Patients with documented results of at least two PHQ9 or PHQA scores (including the initial PHQ9 or PHQA), within 4-6 weeks after initial assessment</td>
<td><strong>NUMERATOR:</strong> Patients with two documented contacts (e.g., visits, successful phone calls) within 4-6 weeks after initial assessment of depression</td>
</tr>
<tr>
<td><strong>DENOMINATOR:</strong> Patients age ≥12 seen for any reason, with a new or existing diagnosis of Major Depressive Disorder or Dysthymic Disorder, or with clinically significant symptoms on a standardized tool (e.g., PHQ-9 score ≥10)</td>
<td><strong>DENOMINATOR:</strong> Patients age ≥12 seen for any reason with a new diagnosis of Major Depressive Disorder or Dysthymic Disorder, or with clinically significant symptoms on a standardized tool (e.g., PHQ-9 or PHQA score ≥10)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Depression Monitoring</th>
<th>Site 3</th>
<th>Site 5</th>
<th>Site 10</th>
<th>Prompt Follow-up for Patients with Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017</td>
<td>2017</td>
<td>2017</td>
<td>2017</td>
</tr>
<tr>
<td>Total %</td>
<td>42%</td>
<td>62%</td>
<td>41%</td>
<td>71%</td>
</tr>
</tbody>
</table>

### Revenue Metrics

<table>
<thead>
<tr>
<th>Revenue Metrics</th>
<th>Site 2</th>
<th>Site 3*</th>
<th>Site 4</th>
<th>Site 5</th>
<th>Site 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly revenue for depression screening</td>
<td>2017</td>
<td>2017</td>
<td>2017</td>
<td>2017</td>
<td>2017</td>
</tr>
<tr>
<td>Number of patients billed for depression screening</td>
<td>$20.92</td>
<td>$2,139.94</td>
<td>$1,090.40</td>
<td>$955.63</td>
<td>$382.20</td>
</tr>
<tr>
<td>No ability to report on relationship between depression screening and revenue</td>
<td>No billing in 2018, only DSRIP reimbursement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Site 3 noted that despite performing more screens in 2018 revenue was comparatively low—possibly due to delays in the billing system capturing the most recent payments. There might also be a difference in reimbursements based on the payer mix for each year, they noted, with some insurance covering depression screening on a fee-for-service basis and others as part of a capitation agreement.

The Impact of Behavioral Health Integration in a Primary Care Practice

Paul I. Saladino, MD,
Christian J. Plaza, MBA, MSN, FNP-C
Cross Valley Health & Medicine, P.C. (CVHMPC) Profile

• CVHMPC is a Primary Care and Addiction Medicine practice located in Newburgh, NY

• CVHMPC founded in 2007 and currently provides outpatient care for over 8500 patients in the Hudson Valley

  • Patient demographics

• Since 2007, CVHMPC has differentiated itself by providing diverse medical services for the diverse communities in an urban setting

  • Outpatient Services: Behavioral Health, OUD MAT Program

  • Inpatient Services: OUD MAT Treatment

• CVHMPC currently consist of 2 providers: Physician and Family Nurse Practitioner

  • Collaborative Approach / Strengths of MD/NP Team
CVHMPG Mission & Highlights Supporting Its Vision

• In 2019, Mission and Vision Statement Updated:

  • To transform into a medical practice that provides patients specialized high quality primary care services through an innovative and modern model

• In 2019, Opportunity to Collaborate with Montefiore Behavioral Health Integration Program and Participate in the Medicaid’s Collaborative Care Program

  • Enhanced our current services increasing access to care for patients who otherwise normally experiences barriers

  • Improved communication with specialists and expanded medical management within primary care

  • Collaboration provided CVHMPC to innovate, lead, and expand its Behavioral Health and Addiction Medicine services in the community further improving patient retention and patient outcomes

• In 2020, the Impact of COVID19 & Opportunity to implement Telemedicine in Primary Care

  • Expanded Behavioral Health Treatment via telemedicine

  • Expanded ability to continue providing MAT treatment within primary care
Reasons for Integrating Behavioral Health in CVHMPD

- Differentiation of services typically not offered in a standard primary care practice
  - Implementation of Level I Outpatient OUD MAT Treatment
  - Standardization of screenings - Opportunity
  - Practice retention while overcoming patient barriers

- Availability of Resources
  - Electronic Health Record System
  - Current Collaborative Partnerships
    - Behavioral Health Services of the Hudson Valley
    - Montefiore Behavioral Health Integration Program
  - Leadership

- Within the Framework Levels of Integration
  - Transition from Level II to an Advanced Integration
Reasons for Integrating Behavioral Health in CVHMPC

• Financial Incentive
  • In NYS, by participating in a Collaborative Care Model, there is an additional payment on top of a fee-for-Service encounter
  • Increasing frequency of encounters produce revenue increase
  • Achieve certain quality-based incentives in primary care
    • PHQ9/GAD7/AUDIT Screenings
    • Complex plan of care justifies higher level coding

• Improved Patient Outcomes
  • Achieve certain quality-based incentives in primary care
    • PHQ9/GAD7/AUDIT Screenings
    • Patient more likely to adhere to recommendations, treatment and follow up
Cross Valley Health & Medicine BHI Patient Visits by Diagnosis

DATE RANGE

NUMBER OF VISITS


Depression  Anxiety  Alcoholism  Bipolar Disorder  PTSD
## Practical Billing Guide for Behavioral Health

**CMS.gov** Physician Fee Schedule Search Locality #1320203 (Poughkeepsie/NYC Suburbs) Non-Facility

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare Reimbursement Rate</th>
<th>Real World NYS Medicaid Managed Care Plan (MVP Medicaid)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>E&amp;M Level 3 Primary Care Visit</td>
<td>$81.63</td>
<td>$56.75</td>
</tr>
<tr>
<td>99214</td>
<td>E&amp;M Level 4 Primary Care Visit</td>
<td>$118.08</td>
<td>$84.69</td>
</tr>
<tr>
<td>99215</td>
<td>E&amp;M Level 5 Primary Care Visit</td>
<td>$158.41</td>
<td>$111.74</td>
</tr>
<tr>
<td>99492</td>
<td>Initial Case Management Visit - Behavioral Health Care Management</td>
<td>$168.22</td>
<td>$165.06</td>
</tr>
<tr>
<td>99493</td>
<td>Subsequent Case Management Visit - Behavioral Health Care Management</td>
<td>$134.99</td>
<td>$89.54</td>
</tr>
<tr>
<td>99494</td>
<td>Additional Case Management Visit - Behavioral Health Care Management</td>
<td>$68.22</td>
<td>$47.99</td>
</tr>
<tr>
<td>99484</td>
<td>Generic Case Management Visit - Behavioral Health Care Management</td>
<td>$51.45</td>
<td>$35.08</td>
</tr>
<tr>
<td>T2022</td>
<td>Generic Case Management Visit - Behavioral Health Care Management</td>
<td>$51.45</td>
<td>$35.08</td>
</tr>
<tr>
<td>96127</td>
<td>Behavioral Health Assessment - Monthly/Annual (Medicare)</td>
<td>$5.63</td>
<td>$3.82</td>
</tr>
<tr>
<td>G0442</td>
<td>Alcohol Screening - Annual</td>
<td>$19.73</td>
<td>-</td>
</tr>
<tr>
<td>G0444</td>
<td>Depression Screening - Annual</td>
<td>$19.73</td>
<td>$12.35</td>
</tr>
<tr>
<td>99406</td>
<td>Smoking Cessation Screening - Annual</td>
<td>$16.59</td>
<td>$11.51</td>
</tr>
<tr>
<td>99407</td>
<td>Smoking Cessation Screening - Annual</td>
<td>$31.70</td>
<td>$26.13</td>
</tr>
<tr>
<td>H0049</td>
<td>Alcohol Drug Screening - Annual</td>
<td>-</td>
<td>$8.83</td>
</tr>
</tbody>
</table>

Consideration of Financial Sustainability of Behavioral Health in CVHMPC

- Expand treatment and management of Behavioral Health
  - Include Bipolar Disorder, Binge Eating Disorder

- Partner with other virtual collaborative partners supporting the Collaborative Care Model

- Continue performing routine behavioral health screenings

- Embrace additional Behavioral Health Care training

- Compromise in pursuit of financial models/incentives available

- Balance Behavior Health alongside Chronic Disease Conditions
Oak Street Health Collaborative Care Approach:
Integration of Behavioral Health into Primary Care Practice

Katherine Suberlak, VP Clinical Program

November 12, 2020
Objectives for today’s webinar

Share Oak Street Health’s experience on how we have implemented behavioral health through:

- **Increased access** to qualified mental health professionals in primary care
- Care design that is both **sustainable and fiscally responsible** - we will share how we complete results review
- Adherence to our organizational mission: *Rebuilding healthcare as it should be*
Introduction to Oak Street Health

- Founded in 2012
- Network of primary care centers for adults on Medicare, including dual eligibles, with a focus on driving value, not volume
- Treat patients at more than 70 locations across 10 states (Illinois, Indiana, Michigan, Pennsylvania, Ohio, Rhode Island, North Carolina, New York, Texas and Tennessee)
- Innovative care model integrating team-based care with population health analytics and proprietary suite of workflow applications
- Fully capitated “risk-based” contracts with Medicare Advantage insurance plans to capture the savings earned by keeping our patients healthy, subject to limited exceptions

| 70+ Oak Street Health centers with an average capacity for ~3,500 patients | ~200 Primary Care Providers delivering care in a value-focused model | 80,000+ Patients have been served by Oak Street Health |

Our Mission…
Rebuilding Healthcare As It Should Be

Our Vision…
To Provide Measurably Better Health In All Communities
Oak Street Health Care Model

A Patient’s Journey

1 Longitudinal Primary Care
Preventive care addressing the whole person – medical, social, behavioral – in a welcoming community setting

"Dosage" of Primary Care Visits Driven by Patient Risk Factors

Visits
High risk
Low risk

- Interdisciplinary Care Team
- Evidence-Based Clinical Protocols
- Targeted Patient Education
- Same-Day Visits, Weekend Visits
- 80% Smaller Panels
- Primary Care Enhancers: Podiatry, Group Education, Transportation

2 Population Management
Connecting our patients to the right programs, resources, and care to ensure no one falls through the cracks

Daily Huddling, Weekly Planning, Monthly Reviews

3 Population Health Interventions
Delivering multi-disciplinary interventions on high-risk patients to improve outcomes and cost

Integrated Behavioral Health
- IMPACT model
- Home Care Delivery by PCPs
  - Led by specialized Nurse Practitioners
Medication Management
- Focus on adherence and reconciliation

Social Determinant Support
- Assistance with community resources
- 24/7 Clinical Call Center
  - Live agents, nurse triage, on-call providers
  - Real-time response to patient needs
Hard to Reach
- Local targeted outreach to engage patients

Evidence-Based Assessments
- Screenings
  - Examples include Fall Risk Screening, Activities of Daily Living, VES-13, PHQ, AUDIT-C, DAST-10
- Diagnostics
  - Lab Panels, EKGs, Ultrasounds (Vascular and Cardiac), Pulmonary Function Tests

Data Science
- Proprietary Algorithms
- Predictive Analytics
- Machine Learning

Historical Health Synthesis
- Blue Button
- EMR / HIE access
- Payer claims

Clinician Expertise

Face-to-Face Intake
- Multiple visits
- Health Risk Survey

Risk Stratification

Intake & Assessment

Care Navigation
Navigating the patient journey outside-the-center

Utilization Management

Transitions-in-Care Program
- Transitions Nurses involved in hospital and SNF discharge planning

High-Value Network
- ED / Hospital Relationships
- Post-Acute Partnerships
- Preferred Specialty Network
- Virtual Consultations (e-consults)
Use of data to FOCUS behavioral health intervention

- We have established an integrative BH model with an impressive ROI opportunity. In a full risk model who cares for patients longitudinally we are well positioned to replicate the studies.

To achieve this we focus on two areas:

1) Operations: Enroll optimal number of eligible patients
   a) Leverage and enhance data infrastructure to support point of care interventions and prompt proactive follow up

2) Clinically: Teach teams to use the model effectively
   a) Address provider culture via clinical guidelines
   b) Ongoing training

The purposeful planful model has additional layers since we intend to care for all patients. It is in both the patients interest and our financial model for OSH to be the outpatient provider for behavioral health needs.

Collaborative Care (IMPACT) model & Long term Cost Effects
Distinction between IMPACT model and OSH Integrated BH

- The IMPACT model references intervention for older adults who experience unipolar depression.
- We have a responsibility to implement this model with fidelity. This implementation has been the primary focus on 2020. We know that not all OSH patients meet this criteria.
- We also have a responsibility to provide behavioral health care interventions for patients who will not be part of our collaborative care approach.

Both statements are true that we provide integrated behavioral health for all patients and operate IMPACT model of care for patients that meet criteria.
The BH Team shares a defined group of patients tracked in this Shared Registry to ensure no one falls through the cracks. The BH Team can track and reach out to patients who are not improving and the BH Team provide caseload-focused consultation, not just ad-hoc advice.

Of utmost importance are the 3 columns that contain the PHQ-9 information--The PHQ-9 First, The PHQ-9 Last, and the % Change

The PHQ-9 columns will show the progress of the patient through “treatment toward target” and direct the treatment interventions effectively and efficiently.
**PHQ 9 Analysis**

| Count of PHQ-9 Results                  | 13,507 |
| PHQ-9 Value >10                         | 5,894  |
| Count of enrolled Patients with PHQ-9 >10 in BH | 2,728  |
| PHQ-9 Count of patients who took a second test | 2,612  |
| Difference of 5+ on PHQ-9 Count         | 892    |
| Average Score Difference                | 9      |

Timeline: Jan-Sept 2020

**Items to Note:**
- 44% of patients scored a 10 or greater on their PHQ9, 46% of these patients are enrolled in the BH program
- Of those patients who scored a 10 or greater, 44% repeated PHQ9, ∼15% increase from last month
- Of those patients who took a second PHQ9, 889 of them had a reduction of 5pts or more
How we calculate a reliable Return on Investment

1. **Expected Post-Treatment Contribution Margin for Enrolled Patients**

   We calculate an expected post-treatment contribution margin based on the experience of the comparison group. We use the % change in the comparison group’s pre and post treatment contribution margin for this equation, to account for any baseline differences between treatment and comparison group.

   *The accuracy of the ROI depends on an accurate comparison group*

2. **Change in Enrolled Patients Contribution Margins**

   We compare the observed post-treatment contribution margin for the enrolled group to the expected contribution margin. The difference between observed and expected is the value added by the intervention.

3. **Program ROI**

   We multiply the per member per month added value by the enrolled MM to calculate the total program value and divided by 2019 costs to result in the estimated ROI.
The expected contribution margin was $234 for this result review, the results show -$25. Based on this approach what might be our challenges as we continue to evaluate?
Our Opportunities going forward

● We can demonstrate care excellence when we implement with operational excellence
  ○ There remain unengaged patients who have screened positive on PHQ9
● Program evaluation continues to face challenges with identifying the right comparison group
  ○ Future iterations plan to look at intention to treat rather than current definition
● Our future success depends on our ability to have a purposeful integrate program that builds on the components of the collaborative care.
  ○ OSH Behavioral Health team cares for patients with serious mental illness (SMI: Bipolar disorder, psychotic disorders, schizophrenia, substance use disorders, PTSD)
    ■ Outcomes measures are in development
    ■ Patients in this designation are not included in the program evaluation of collaborative care
Appendix
Overview of use of Collaborative Care

- Leverage the IMPACT model and telepsychiatry to maximize limited psychiatric resources
- Emphasize training and rapport building between site staff and remote providers
- Where possible, schedule BH appointments in accordance with PCP appointments
- Build a consistent care team
Shift towards Integrative BH

<table>
<thead>
<tr>
<th>Traditional Approach</th>
<th>OSH Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Maximum # of visits for $</td>
<td>● Provide quick access to a BH Team</td>
</tr>
<tr>
<td>● Individual provider</td>
<td>● Tracking care with population health registry</td>
</tr>
<tr>
<td>● Lack of cohesive communication across providers</td>
<td>● Cost Control</td>
</tr>
</tbody>
</table>

Collaborative Care
IMPACT model: How well does it work?

N=1600

Twice as many patients responded to treatment for depression as in usual care, using team based model in a primary care setting.
IMPACT model: Why Does it Work?

5 Principles of Collaborative Care

- Population-Based Care
- Measurement-Based Treatment to Target
- Patient-Centered Collaboration
- Evidence-Based Care
- Accountable Care
What is Treatment To Target?

Continuing to address treatment of patients not responding, using measurement tools.

Adjusting the treatment plan based on symptom measures is one of the most important components of collaborative care. Clinicians change the treatment until the patient has at least a 50% reduction in measured symptoms.

Collaborative care requires a change in the treatment plan every 4 - 6 weeks if the patient has not had at least a 50% improvement in symptoms using a validated measure (PHQ9).

In order to make clinical decisions team members need to complete repeat PHQ9s.
### PHQ 9: Directing Treatment to Target

**Using the PHQ-9 to Assess Patient Response to Treatment**

#### Initial response after Four weeks of an Adequate Dose of an Antidepressant

<table>
<thead>
<tr>
<th>PHQ-9</th>
<th>Treatment Response</th>
<th>Treatment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop of 5 points from baseline</td>
<td>Adequate</td>
<td>No treatment change needed. Follow-up in four weeks.</td>
</tr>
<tr>
<td>Drop of 2-4 points from baseline</td>
<td>Possibly Inadequate</td>
<td>May warrant an increase in antidepressant dose</td>
</tr>
<tr>
<td>Drop of 1-point or no change or increase</td>
<td>Inadequate</td>
<td>Increase dose; Augmentation; Switch; Informal or formal psychiatric consultation; Add psychological counseling</td>
</tr>
</tbody>
</table>

#### Initial response after Six weeks of Psychological Counseling

<table>
<thead>
<tr>
<th>PHQ-9</th>
<th>Treatment Response</th>
<th>Treatment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop of 5 points from baseline</td>
<td>Adequate</td>
<td>No treatment change needed. Follow-up in four weeks.</td>
</tr>
<tr>
<td>Drop of 2-4 points from baseline</td>
<td>Possibly Inadequate</td>
<td>Probably no treatment change needed. Share PHQ-9 with psychotherapist.</td>
</tr>
<tr>
<td>Drop of 1-point or no change or increase</td>
<td>Inadequate</td>
<td>If depression-specific psychological counseling (CBT, PST, IPT*) discuss with therapist, consider adding antidepressant. For patients satisfied in other type of psychological counseling, consider starting antidepressant For patients dissatisfied in other psychological counseling, review treatment options and preferences</td>
</tr>
</tbody>
</table>

---

* CBT: Cognitive-Behavioral Therapy; PST: Problem Solving Treatment; IPT: Interpersonal Therapy
CRUCIAL ROLE OF CASELOAD REVIEW FOR EFFECTIVENESS OF COLLABORATIVE CARE

Reduction in PHQ-9 scores with and without Caseload review:

![Bar chart showing reduction in PHQ-9 scores](chart)

**Functional differences:**
- More frequent care manager contact
- Caseload Review

Blackmore M et al., Psychiatric Services in Advance (doi: 10.1176/appi.ps.201700569)
Collaborative Care Model - Basic Team outline
Role of the Behavioral Health Specialist

Behavioral Health Specialist (BHS)

- Assess the mental/behavioral needs of patients, support with **case management**, make **referrals** to appropriate behavioral health resources and specialists, and provides **counseling** and evidence-based treatments as indicated
- Screening for common **mental health** and/or **substance use** disorders
- Work with team to provide treatment for mental health and/or **substance use** disorders
- Collaborate with care team around patients with complex **medical** care needs
Provides care in more than one way:

- Acts as a consultant to the BHS & PCP, for patients cared for by them.
- May provide direct care.
- Collaborate with care team around patients with complex medical care needs.
PCP role within Collaborative Care

PCP

- **Identifies and Engages**
  - Discusses Collaborative Care to the patient
  - Develops treatment alliance with the patient---**crucial**
  - Obtains patient’s consent
  - Initiates a Warm Hand-off

- **Makes a diagnosis in some cases**
  - Uses the PHQ 9, gathers history
  - Works with the BH Team for complex conditions
  - Observes over time

- **Treats in most cases**
  - Works with BH Team to develop treatment plan
  - Prescribes medications as needed
  - Addresses safety concerns
  - Monitors physical health and any potential interactions
  - With support from BH team
The 2 Arms of Securing a Psychiatric Consultation

Deeper: How to obtain a Psych Consult
The 2 Arms of Securing a Psychiatric Consultation

Referral to Behavioral Health Team

- This arm is used when there is a BHS in the clinic.
- A referral is generated in Canopy and an assessment is obtained by the BHS. The BHS and the Psych Provider will plan the management of the case via the shared BH Registry.
- If the Psych Provider determines a consultation is appropriate which includes medication, PCP is responsible for prescribing the medication(s).
- OR the patient may need to be scheduled to see the Psych Provider, the BHS will arrange for this. Once seen by the Psych Provider, the Psych Provider is responsible for prescribing medication(s).
- Consultation could include a medicine be started by the PCP prior to the visit with the Psych Provider.

Direct Psych Consult (PCP to Psych Provider)

- This arm is used when there is no BHS in the clinic. Exceptions would be in an emergency or if the BHS is not available.
- This is accomplished by completing a quick note Direct Psych Consult in Greenway.
- This process is very similar to using Rubicon.
- The Psych Provider will then complete a consultation which may include medications or scheduling the patient to be seen by the psych provider.
- If medication is included in the consult, the PCP is responsible for prescribing the medication(s).
- If the Psych Provider consult includes to be seen for a psychiatric evaluation, the PCP will arrange this. The consult may include medication until the patient can be seen by the Psych Provider.
- PCP is responsible for prescribing the medication(s).
Informal consultations called “Curbside Consults” can be done if patient data or specific patient information is not shared

- **Example**: “If a patient is on the max dose of an xxx medication and still symptomatic is it OK to just add xxx medication?” or “Is there any medication for xxx symptom?”
- Curbside consults do not need to be formally documented in the patient’s record
- Most patients in need of a consult are complex and a thorough review of the record is needed
Some patients may *move* between the three classifications over time.

**Actively Managed**
- Followed by the BH team
- For some: telepsych provider doing the ongoing prescribing
- Being followed in registry until stable.

**Stabilized**
- Followed by the BH team
- For some: telepsych provider doing the ongoing prescribing
- Being followed in registry until graduated (if applicable)

**Referral, with oversight**
- BHS to monitor progress of outside psychiatric care
- Complex enough to require external care [if available]
References


- Stories from IMPACT
- Core principles of Collaborative Care
- Williams, Ratzliff, FOCUS, APA, July 18, 2017


References

- D. Cohn and H. Mahmoud “The Evolving Landscape of Behavioral Telehealth.” Becker’s Hospital Review. August 10, 2017
QUESTIONS?
UPCOMING WEBINARS

Physicians Leading the Charge: Dismantling Stigma around Behavioral Health Conditions & Treatment
November 19, 2020, 6PM - 7PM CT

In this webinar, speakers will share examples of how physicians, and other non-physician clinicians of the care-team, can be leaders in breaking the stigma barrier and normalizing treatment for people with mental health conditions. They will describe key action steps to implement stigma reduction strategies for all patients with an emphasis on those who are underserved or are of special populations in which stigma is magnified. Attendees will also learn how they can integrate an interdisciplinary approach to reduce stigma in their practice settings and support patients in reporting symptoms and seeking care.
Thank you for joining!