CAPITAL AREA HealthAlliance

Dear CAHA Partners,

Thank you for your interest and participation in CAHA's November program **Integrating Primary Care and Behavioral Health Services: A Community Conversation.**

Since its inception, CAHA has been a trusted regional hub for collaboration, with the ability to convene a broad, diverse group of stakeholders and form community partnerships to collectively address complex healthcare issues, such as expanding and sustaining integrative health models in our community. We want to share with you our planned next steps to work toward this vision.

The attached materials include a summary of the information presented by our four excellent speakers, the outcome of the discussion sessions and the next steps in the process.

I encourage you to review the next steps and let us know whether you would like to engage with CAHA and its community partners in carrying them out. Please contact us at connect@cahealthalliance.org if you are interested in working with us and/or you would like to be on our mailing list for updates.

We look forward to working with you in our mission to empower our community to achieve better health.

Sincerely,

Jason Blanks
Executive Director

Integrating Primary Care and Behavioral Health Services: A Community Conversation

November 18, 2021

The program **Integrating Primary Care and Behavioral Health Services: A Community Conversation** featured presentations and opportunities for discussion. This summary shares highlights from the presentations and question and answer sessions about sustainable models for PC/BH integration.

Presentations included:

Thinking about the Business of Behavioral Health in Primary Care: Virna Little, PsyD, LCSW-r, SAP, CCM, Cofounder and Chief Operating Officer, Concert Health

Dr. Little shared insights on factors that support successful integration of behavioral health in primary care settings, the Collaborative Care Model and understanding the coding options that are available to support a sustainable practice.

Implementing and Sustaining an Integrated Primary Care and Behavioral Health Model: Andrew R. Champine, PsyD, LP, MSHM, *McLaren Health Care Corporation*: Director of Behavioral Medicine Education, Chief Psychologist MICAPT; *MSU College of Human Medicine*: Assistant Professor Departments of Psychiatry, Family Medicine, and Internal Medicine

Dr. Champine discussed how McLaren Flint is utilizing the Health Behavior and Intervention approach in their integrated primary care – behavioral health settings.

Michigan Initiatives for Healthcare Integration and Coordination, 2020-21: Robert Sheehan LMSW, MBA, Chief Executive Officer, Community Mental Health Association of Michigan

Mr. Sheehan shared observations on the progress of integrated care in Michigan and findings from the 2020-21 survey of integration initiatives.

Health Plan Role in Behavioral Health Integration: William Beecroft M.D., D.L.F.A.P.A., Medical Director Behavioral Health BCBSM/BCN

Doctor Beecroft described the Collaborative Care Models and the steps that Blue Cross Blue Shield of Michigan have taken to promote the model and support practitioners' adoption of the model.

Foundational considerations in integrating primary care include:

- An organization-wide commitment to integration.
- Dedicated staff.
- Understanding the needs of your patient population.
- Developing a coherent strategy and goals to manage your population.
- Avoiding a "perpetual launch" during which you might be making some steps toward integration without an end goal.

Sustainability considerations:

- Productivity is part of the sustainability picture, but it is often over- emphasized.
- Knowing the needs of your patient population is essential
- Be informed about what codes are available to you and how they apply to your setting.
- Collaborative care codes and monthly case rates offer flexibility and cover behavioral health and telephonic services under primary care.
- Your sustainability plan: Doctor Little suggests using a grid to capture information. What services are you providing? What is your payer mix? Who is providing the services? Use the grid to identify how you can be reimbursed by each payer for each service and provider. With a sustainability plan developed, workflows can be put in place and expectations set for providers in your primary care/behavioral health integrated setting.

Primary Care Behavioral Health (PCBH) Model:

- The American Psychological Association reports that over one third of health care costs are associated with just six risk factors: tobacco use, poor diet, substance abuse, high BMI, high systolic blood pressure and high resting glucose levels. These factors all have behavioral determinants that can be addressed with health behavioral assessment and intervention (HBAI).
- HBAI is an evidenced-based, co-located, integrated approach utilized by McLaren Flint.
- HBAI services are psychological assessments and interventions that help patients manage physical health problems.
- Workflow: Evidence based assessment tool for all patients; warm handoff to behavioral health consultant.
- Model is sustainable using HBAI codes for billing services:
    - 1 to 6 sessions allowed.
    - HBAI codes are not used when patient has a mental health diagnosis; CPT codes are used.
    - Cannot be billed on the same day as a CoCM service.
- Some of the positive achieved using the HBAI approach include improvements in diet, exercise, weight management hypertension, lipid and blood glucose levels.
- Addressing behavioral health upstream impacts downstream costs.

Collaborative Care Model (CoCM)

- Operates through a patient-centered care team with a registry.
- Team includes a PCP, behavioral health care manager (BHCM), and a consulting psychiatrist.

- Psychiatrist and the care manager meet weekly – typically by phone – for 1-2 hours to review the BHCM's caseload of 40-60 patients with mental health/substance use issues identified through screening in the primary care clinic.
- BCBSM worked with CMS to implement CoCM in its HMO and fee for service and Medicaid products.

CoCM Implementation and Training

- Team approach is new to many primary care practices.
- Curriculum designed with the Michigan Collaborative Care Support Team and University of Michigan for training. Training process includes an analysis of practice readiness.
- Incentives providing for enrolling patients and participating in the training.
    - 295 practices trained in model, including 20 pediatric practices using a curriculum designed for pediatrics.
    - 1200 providers.
    - 8400 patients enrolled.
- Medical lead for CoCM can be physician, nurse practitioner, physician assistant.
- CoCM services are billed using Collaborative Care Codes.
- CoCM Impact:
    - Blue Cross Blue Shield (BCBSM) analysis revealed 14% of patients with behavioral health and physical health diagnoses consumed 28% of spending.
    - Spending on patient population has normalized.
    - Team approach with Care Managers have supported program enrollees in addressing social determinants of care.
- The Community Mental Health Association of Michigan's (CMHAM) Center for Healthcare Integration and Innovation conducts an annual a study of the healthcare integration initiatives led by Michigan's Community Mental Health Services Programs (CMH), the state's public Prepaid Inpatient Health Plans (PIHP), and providers within the CMH system.
- Results showed that more than 626 healthcare integration efforts were in operation in Michigan.
- The CMHs, PIHP, and providers involved in healthcare integration often pursue several efforts simultaneously.
- Each organization that responded to the survey reporting an average of over 20 healthcare integration initiatives.
- Work around physical health-informed behavioral health and intellectual/developmental disability (BHIDD) services, co-location, and identification of super-utilizers underscored the variety and maturity of these efforts.
- Michigan and the Capital Area Region have made tremendous progress in integrating services over the last five years.
- Focus on what patient populations are telling us has spurred innovation.
- Payment models and monthly case rates support integration.

Challenges and Opportunities - Common themes from our presenters:

There are many evidence - based models for integration. One size does not fit all. It is important to know your patient population and identify the models that support their needs.

Whatever the model, integration requires culture change. Work in teams has not generally been the model for many primary care practitioners.

Training primary care providers, behavioral health providers and care managers about existing and emerging models is important to the process.

Developing pipelines of behavioral health providers is important to the success of integrative models.

It may be difficult for smaller practices to adopt integrative models. The Collaborative Care Model could be easier for small practices to adopt, with training and support.

We need to raise awareness of the work being done and the benefits of integrative care.:

- Educating federal and state policymakers and partnering with them to innovate could be beneficial to expanding and sustaining integrative care. As an example, BCBSM worked with CMS to extend use of the model to other populations in their program.
- We also need to share information with our elected officials in Congress and Michigan governments.

Upstream measures can reduce downstream costs, with positive clinical outcomes.

Discussion Groups

Attendees participated in the breakout groups following the presentations and were asked to discuss the questions: *Several factors impact the sustainability of models that promote the integration of primary care and behavioral health service – billing and reimbursement, health workforce shortages and resources for practice transformation, to name a few. Which factor is most important now to your organization's integration efforts? What other issues come to mind when you think about expansion and sustainability of primary care/behavioral health models?* Each of the discussion groups highlighted issues related to the behavioral health workforce, including shortages, the need for a diverse, culturally aware workforce to address racial and ethnic disparities in access to services and outcomes, accessibility, and new models of care.

Resources:

Doctor Little's slides, which include much information on coding can be found here: https://www.capitalareahealthalliance.org/docs/Virna_Little_Slides_11-18-2021.pptx

Information referenced by Doctor Champine on Health and Behavioral Intervention Coding can be found here: APA HBAI Coding

The Michigan Initiatives for Healthcare Integration and Coordination, 2020-21 can be found here: Michigan Initiatives for Healthcare Integration and Coordination 2020-21

Doctor Beecroft's slides about CoCM can be found here: https://www.capitalareahealthalliance.org/docs/William_Beecroft_slides_11-18-2021.pptx

Integrating Primary Care and Behavioral Health Services:
A Community Conversation

NEXT STEPS

1. **Engage** educators, healthcare organizations, and government agencies in strategies to address the shortfalls in the behavioral health workforce and the need to provide our community with a workforce that reflects the diversity of the community. Strategies may include:
    a. Increase the number of MSU Social Work students in clinical settings promoting healthcare integration.
    b. Prepare MSW students and current MSW practitioners for work in integrated care settings with learning opportunities, including health care certification.
    c. Develop a pipeline for undergraduate students to consider clinical MSWs via focused recruiting.
    d. Develop fast track programs for high-need mental health professions.

2. **Promote** integrative care models to primary care providers:
    a. Educate primary care physicians about the Collaborative Care Model (CoCM) and the Primary Care Behavior Health (PCBH) Model.
    b. Identify champions in the community.
    c. Provide information and examples about outcomes and ROI in using CoCM and PCBH Models.

3. **Advocate** for policies that recognize the importance of person-centered integrative care:
    a. Work with health plans serving the Capital Area to accept medical claims using Collaborative Care and Health Behavior Assessment and Intervention billing codes, as appropriate to the clinical circumstances of each patient. Provide information and examples about outcomes and ROI in using PCBH Models.
    b. Learn what measures the Michigan Department of Health and Human Services is taking relative to integrative care and identify how it could impact expansion efforts in the Capital Area.
    c. Work with state agencies and health plans to explore how we can include family/peer support and/or recovery coaches in our integrative teams.

4. **Continuously improve**:
    a. Explore best practices for operationalizing sustainable models of integrative care.
    b. Explore resources to support PCBH consultants and CoCM care managers in the development of clinical pathways.
    c. Offer continuing education opportunities for professionals currently working in integrative settings to learn about new and emerging developments.