Integration: An Overview of a Beacon White Paper

February 2016
Beacon Health Options was created to provide the scale necessary to deliver against the capital, IT and compliance requirements necessary to serve the nation’s largest health plans.
Overview of Beacon’s White Paper: Integration
What integration is not

- Screening alone
- Provider education
- Simple colocation won’t magically make a team
- Specialty referral as a route to specialists
- Tracking outcomes in isolation
- Telephone-based disease management
- Integration is not achievable through payment reform alone
Early AQC results have not been compelling

Study compared three cohorts from BCBSMA’s Alternative Quality Contract (AQC) program: AQC w/ BH risk, AQC w/o BH risk and non-AQC

FINDINGS INDICATE SIMPLY SHIFTING RISK ISN’T ENOUGH

- Slightly reduced probability of utilization but MH spend was the same - Members in an AQC contract were slightly less likely to access mental health services, but PMPM MH spend was the same

- Less improvement for members with some chronic conditions - Members with diabetes and cardiovascular conditions who had BH risk fared worse (improved less) in AQC contract than in non-AQC contracts

- Initially, insufficient focus on BH - Interviews suggested that the AQC did not change mental health care delivery in the program’s first years. Organizations now focusing efforts to improve integration

Source: Colleen L. Barry, Elizabeth A. Stuart, Julie M. Donahue, Shelly F. Greenfield Elena Kouri, , Kenneth Duckworth, Zirui Song, Robert E. Mechanic, Michael E. Chernew and Haiden A. Huskamp
“The Early Impact Of The ‘Alternative Quality Contract’ On Mental Health Service Use And Spending In Massachusetts.” Health Affairs, 34, no.12 (2015):2077-2085
Only 14% of ACOs have fully integrated behavioral health into primary care.

Three key factors increase likelihood of integration:
- Inclusion of BH in total cost of care
- Intensity of BH needs in patient populations
- Low availability of BH services

Integrated ACOs use both primary care expansion and reverse integration models.

Notes: Integration is defined by the National Survey of Accountable Care Organizations as the delivery of primary and behavioral healthcare in the same setting. Prevalence of different degrees of integration reflects ACO self-reports.
Through the noise, there is an answer

1. Many different models of integration exist; most models are overly simplistic and reductionist

2. Wayne Katon, M.D., originally published the first large randomized controlled trial of the collaborative care model in 1995

3. Since then, more than 80 randomized controlled trials have validated this approach

4. Proven in different settings and for different populations: youth, seniors, substance use, OB/GYN, etc.

5. The CCM is not a fad
**WITH IMPACT:**
- On average, TWICE as many people significantly improved

**WHY?**
- Team approach with a shared person-centered care plan
- Evidence-based treatments and access to expert advice when treatment needed to be changed; treat-to-target approach with proactive adjustment based on clinical outcomes.
- Population-based care management

**USUAL CARE:**
- 50% of all patients enrolled were on an antidepressant at the time but were still significantly depressed
- On average, 20% of patients showed significant improvement after 1 year; matches national data for depression treatment in primary care

Source: Jürgen Unützer, MD, University of Washington
Collaborative care model: 80 RCTs reveal 5 pillars for integrated care

- Requires all five pillars to be successful
- Collaborative care continues to be developed and supported by Jürgen Unützer and his team at the AIMS Center, University of Washington

Source: “The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes”, Jürgen Unützer, MD, University of Washington
Team-based care is the centerpiece of the collaborative care model.

Source: “The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes”, Jürgen Unützer, MD, University of Washington

- Providers with a large number of patients with SMI conditions have experience with integration
- For others, a collaborative care model must be created to include liaison psychiatry and site-based care management

*Once engaged, evidence supports live and telephonic case management equally
Measurement-based care: PHQ-9

- Assists with identification and diagnosis
- Tracks symptoms over time
- Easy to use
- Can be done over the phone
- A good communication and teaching tool
- PHQ-9 will be a HEDIS measure via NCQA
- 50-70% of people will require at least one change in treatment to get better

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
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</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
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<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
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<td>3</td>
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<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5. Poor appetite or overeating</td>
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<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
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<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
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<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
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</tbody>
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For office coding: 0 + _______ + _______ + _______  
=Total Score: _______
Potential ways that Beacon and stakeholders could collaborate to promote integration

- Start using outcomes tools so they become the norm, not the exception
- Shift the focus on UM and a “mother-may-I” mentality to collaboration on activities that promote better care, not improved utilization statistics
- Shift the focus on claims as the sole source of truth about outcomes to include other ways of assessing members’ mental health
- Improve data and information exchange between Beacon and health plan clients and providers so Beacon can pay claims for members with both BH and medical diagnoses
- Design new payment structures to align reimbursement with value rather than volume
- Work together to improve communication among all providers, especially between PCPs and behavioral health specialists, to better integrate care
Integration for people with SMI
The case for integrating care for people with SMI is strong.

**MEDICAL EXPENSES FOR INDIVIDUALS WITH SMI ARE MORE THAN 2X THAT OF BH SPEND**

Note: Data based on Beacon pilot program in MA
Sources: Beacon 2014 claims data
Addressing the needs of people with SMI won’t magically occur simply by carving into a single managed care organization.

**Challenges with SMI**

- **High comorbidity and total cost of care** – mental health disorders amplify costs of chronic medical conditions
- **Inadequate community infrastructure** – no reliable system to find, treat and support these members in the community
- **Fragmented care model** – care provided by multiple providers in silos
- **Long-term care** – SMI is a chronic disease; long-term care is required
- **Ineffective integration of care**
  - Few PCPs are equipped, or interested, in participating in SMI care (to date, this has included FQHCs)
- **Evidence-based treatment is not universally adopted** by providers – Even when people with SMI are engaged with care, as few as 7 percent actually receive evidence-based practices

**What we know about effective models for SMI**

- The evidence base around what actually works for integration for people with SMI is THIN
- Treating mental illness requires a **chronic disease model**
- **Person-centered care** planning with strong community social supports increase community tenure
- The best results come from a **social care model**: housing, self-management skills, transportation, day-programs, vocational-rehab, etc.
- Focus on **total cost of care** through aligned incentives on medical and behavioral sides
- Both clinical and cost **outcomes** should be tracked and reported
Integration for people with SMI: Integrated Practice Unit (IPU)

- People with SMI achieve better outcomes in a specialist setting
- An IPU is a dedicated team comprised of clinical and nonclinical personnel who provide the full cycle of care for a patient’s condition
- Improved expertise and coordination of care for people with SMI in community settings avoids prolonged hospitalizations and/or prevent initial inpatient admissions
Here-For-YouSM program in Massachusetts: An example of a community-based IPU for people with SMI

- Members receive an individualized, targeted, intervention focusing primarily on a member’s immediate social needs including:
  - Connection to peers and social supports
  - Employment/education opportunities
  - Transportation, food, housing, etc.
  - Education about diagnoses and prescribed treatment plan, including medication adherence
  - Access to routine care

- Provider-based bachelor’s level care coordinators will spend 6 months understanding and addressing members’ needs

- Access to Beacon and Neighborhood Health Plan clinicians will provide necessary clinical oversight and support

- Barriers to routine care are addressed by creating a new system of supports

Individuals exist day-to-day within their immediate social system. It is their primary concern, so we aim to make it our primary concern as well.
1. Integration is a multiyear strategic priority for Beacon and we are looking for partners on piloting the collaborative care model and/or whole person care model for people with SMI

2. We welcome feedback from all stakeholders on how we can better collaborate to achieve integration

3. The collaborative care framework provides the “best-in-class” evidence for integration of BH into primary care. CMS is developing a billing code for CCM; APA is promoting it

4. We know there are things we can stop doing today that stand in the way of integration and improve how we work together to promote integration

5. This is not business as usual; it is about redesigning mental health care delivery; it will be hard to execute

6. As a “carve out”, Beacon can be a “conduit” for collaborative care
Additional resources

- **Beacon’s White Paper**
- Revised Beacon’s Integration Toolkit coming soon
- Twitter chat: #Integration
- Creating academic partnerships to drive integration
- AIMS Center, University of Washington: [https://aims.uw.edu/](https://aims.uw.edu/)
- Contact information: Dr. Emma Stanton at emma.stanton@beaconhealthoptions.com