Statewide Approach to Behavioral Health Integration – Delaware’s perspective

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Delaware’s SIM initiative: how we started

- In 2013, the Delaware Health Care Commission convened stakeholders across the state to build a strategy that would **improve each element of the Triple Aim**: better health, improved healthcare quality and patient experience, and lower growth in healthcare costs.

- This resulted in obtaining a CMMI SIM grant which helped establish the **Delaware Center for Health Innovation (DCHI)**, a consensus-driven multi-stakeholder organization formed to ensure successful implementation of Delaware’s strategy:
  - Public/private partnership with diverse representation across the state
  - Consensus-based approach with input from broad set of stakeholders

- DCHI has **ambitious goals** for the SIM effort:
  - One of five healthiest states
  - Top five state in healthcare quality and patient experience
  - Bring healthcare cost growth in line with GDP

- Due to the large number of primary care practices in Delaware and high percentage of self-insured plans, DCHI’s has heavily focused its initiatives (e.g., Practice Transformation, value-based payment expansion, Common Scorecard) on **primary care practices**

- Step 2 was to focus on **integration of behavioral health services**
### Behavioral Health Integration

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<th>Why is behavioral health integration important?</th>
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<td>~15-30% of the U.S. population currently have a behavioral health diagnosis</td>
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<td>~70% of adults with behavioral health conditions also have medical conditions</td>
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<td>Uncoordinated treatment of behavioral health and primary care conditions leads to poor outcomes and increased costs</td>
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<th>Why is behavioral health integration challenging?</th>
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<td>Operational and structural barriers</td>
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<tr>
<td>Uncertainty around economic sustainability for practices and patient affordability</td>
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<td>Lack of access to behavioral health providers</td>
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<td>Lack of training on working in integrated teams</td>
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<th>Initial support offered in Delaware</th>
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<td><strong>EMR incentive program</strong> was offered to improve broad connectivity between behavioral health providers and primary care physicians—little uptake</td>
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<td><strong>DCHI’s Behavioral Health Integration stakeholder meetings</strong> were held to identify potential local barriers</td>
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Some of the barriers to Behavioral Health Integration we faced in Delaware

Align reimbursement environment
- Varied medical policies and reimbursement practices across payers increases confusion
- BH services billed by PCPs may require extra legwork to get reimbursed, even when covered under policy
- Higher volumes of referrals required to compensate for higher rate 1st time no-shows

Develop operational processes
- BHI requires addressing e.g., workflows, office space, billing systems, medical records
- Supportive services exist to address above issues, but securing support and coordinating across issues may be challenging for small practices

Identify partner(s)
- Potential lack of urgency among PCPs
- No facilitated channel to connect BHPs and PCPs interested in integration
- Shortage of BHPs could make partnership more difficult
- Smaller PCPs’ panel size may not merit full-time BHP

Formalize partnership
- Limited awareness of partnership models and steps needed to formalize (e.g., PCP contracts for block of BH provider time or PCP pays per patient)
- PC and BH practices may have cultural barriers that make formal integration challenging

Small practices, in particular, find it difficult to identify partners and make up-front investments (e.g., modify schedules/workflows, contract for BH services), especially when reimbursements are uncertain
Delaware’s approach to address the barriers

- With the new administration in 2017, the SIM grant management and delivery under the Delaware Health Care Commission was awarded to consultants with DCHI offering advisory support.

- Through this award, in November of 2017, Health Management Associates (HMA) lead a statewide initiative to develop and promote integration of primary care and behavioral health.

  - Methods used:
    - Practice Coaches
    - Learning Collaboratives
    - BHI payment workgroup
    - Establishing pilots along the continuum of behavioral health integration
      - enhanced referrals
      - co-location
      - full integration through the collaborative care model
      - integration of primary care into behavioral health
What we have learned in Delaware

- **Make the value proposition clear to all stakeholders** and be comfortable asking for short term fixes while true reform happens
  - For the long term-
    - Connect behavioral health integration with other value-based initiatives occurring in the state (e.g., value-based payment models, practice transformation efforts) specifically we looked at collaborative care codes and advance payment models
    - Keep it at the forefront for legislators - DCHI and BH Consortium serves
  - For the short term-
    - assist practices with **building their business case** using economic models (AIMS financial worksheet)
      [https://docs.google.com/spreadsheets/d/1Nnjr1GUkLdwUgg4CPgWeNIV-NcYKEy3yx3i1NK4yis8/edit#gid=1871635108](https://docs.google.com/spreadsheets/d/1Nnjr1GUkLdwUgg4CPgWeNIV-NcYKEy3yx3i1NK4yis8/edit#gid=1871635108)
    - Important to **engage major payers early** and explore codes that may help defray costs now (screening, care coordination, consults fees)

[https://aims.uw.edu/collaborative-care/financing-strategies/financial-modeling-workbook](https://aims.uw.edu/collaborative-care/financing-strategies/financial-modeling-workbook)
Don’t be afraid to take on the mountain!!

It will be fun she said!!!!