Redefining the H
Beyond the walls and into the community

Washington State Hospital Association
Association of Washington Public Hospital Districts

The 42nd Annual Rural Hospital Leadership Conference
Mental Health Integration: A Tale of Two Models
Objectives

• To learn more about how rural hospitals are increasing access to behavioral health services

• To understand new resources and approaches

• Hear from the experts
Strategies for Integrating Behavioral Health Treatment into Rural Primary Care
June 26, 2018

Anne Shields, MHA, RN, Associate Director
University of Washington AIMS Center
Advancing Integrated Mental Health Solutions
AIMS Center Implementations & Trainings

WA State BHI & CoCM

Policy
- Bree Collaborative
- Medicaid Transformation

Training and Support
- Integrated Care Training Program
- Healthier WA Practice Transformation Support Hub
- Opioid Treatment Network

Largest WA State BHI Implementations
- Mental Health Integration Program
- UW Medicine
- Providence ACO
Goal: Support Whole Person Care

- Increase access to primary care in behavioral health
- Increase access to behavioral health services in primary care

Collaborative Care
- Behavioral Health Consultant or Specialist
- Primary Care Provider

Community-Based Services & Supports
Regional Approaches to Integrated Care

• No one approach fits all
  – Arguing about the best integration model is a bit like arguing about the best religion

• Evidence-based models adapt to local settings in order to be successful

• Important principles that need to be followed in order to reach the Triple Aim:
  
  Value = Reach * Effectiveness / Cost
Principles for Evidence-Based Integration

Team-Based and Person-Centered
Primary care and behavioral health providers collaborate effectively, using shared care plans.

Population-Based
A defined group of clients is tracked in a registry so that no one “falls through the cracks.”

Measurement-Based Treatment to Target
Measurable treatment goals clearly defined and tracked for every patient. Treatments are actively changed until goals are achieved.
Principle: Measurement-Based Treatment to Target

“Involves the systematic use of symptom rating scales to drive clinical decision making.”

Principle: Population-Based Care

Behavioral Health Caseload Tracking

Tracking systems and registries support proactive patient engagement and active treatment strategies.

No one falls through the cracks!
TeleMed Strategies for Rural Health

- **Virtual or Shared Care Teams**
  - **Offsite or partly offsite** Behavioral health care provider or clinician
  - Remote Psychiatrist or psych ARNP available

- **Telephone and Interactive Video**
  - Interventions and encounters with patients at home
  - Telepsychiatry consultations with patients at primary care clinic
  - *Zoom* teleconferencing is HIPAA compliant

- **Shared Electronic Medical Records**
  - Communication among on-site PCPs and offsite virtual care team

- **Virtually Shared Tracking Systems or Registries**
  - Spreadsheet + EHR
  - AIMS Caseload Tracker
Thank you!

“It is one thing to say with the prophet Amos, ‘Let justice roll down like mighty waters,’ and quite another to work out the irrigation system.”

William Sloane Coffin
Social activist and clergyman
Financial impact

- Claim denials for depression and anxiety screening for Medicaid patients
- For the first 18-months of this integration project has cost us $124,000 more than reimbursements
- Some of the losses are attributed to normal, new service line startup, but the majority of losses stem from salary overhead versus volume and reimbursement
Program modifications

• Reduction in provider overhead to align resources to the need
• Training for our outsourced coders to capture services and reduce denials
• The UW AIMs Center team have billed collaborative care codes and will help us provide the required elements
• Focusing on shorter, more immediate interventions
• Longer counseling interventions may be referred to outside specialists
Patient registry's and initial tracking

- 80% of all patients aged 12 and up screened annually using PHQ-9 and GAD-7
- Number of patients in active treatment
- Wait time for access for assessment, Medicated-Assisted Treatment (MAT), or other effective engagement in treatment
- Brief Addiction Monitor (BAM) Screening
  - % of patients screened for Substance Use Disorders
What success looks like

- A 50% reduction in PHQ-9 score or a score <5
- A 50% reduction in GAD-7 score or a score <5
- Percentage of patients being treated for Opioid Use Disorder
  - % of patients prescribed Medicated-Assisted Treatment
  - Retention in Treatment
  - % of days abstinent
- Percentage of patients being treated for Alcohol Use Disorder
  - % of patients prescribed Medicated-Assisted Treatment or psychosocial intervention
  - % of heavy drinking days
  - % of days abstinent
Achieving system wide integration

• Integrating into our long term care facility where 50% of the residents have behavioral health diagnosis
• Addressing in-patient needs; specifically substance abuse assessments and treatments
• Pursuing a much closer relationship with our local behavioral health and crises team as well a law enforcement and prosecuting attorney
Detentions inclusive of hours spent

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<th>Year</th>
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<th>Hours</th>
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<td>7</td>
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<tr>
<td>2018*</td>
<td>3</td>
<td>6.5</td>
</tr>
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Total crises interventions plus hours spent

<table>
<thead>
<tr>
<th>Year</th>
<th>Clients</th>
<th>Hours</th>
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</thead>
<tbody>
<tr>
<td>2015</td>
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An Integrated Model of Care
Columbia County– Rural and Frontier

Based on Washington State Office of Financial Management, April 2017

Columbia Co. 4,397
Rural Washington
We are an agricultural driven community
Columbia County ranks 37 out of 39 in health outcomes—how long people live and how healthy people feel.

We rank 22 out of 39 for health factors—Examples: Tobacco use, diet, and exercise

Despite ranking 14 out of 39 for Social and Economic Factors and 2 out of 39 for Physical Environment
Percentage of Population over 65

- US Average: 14.90%
- WA Average: 13.60%
- Columbia: 27.40%
Median Age

- US Average: 37.8
- WA Average: 37.3
- Columbia: 50.06
ACO Participation and Medicare Screening

- We participate in an ACO and performed depression and anxiety screening as part of our Annual Wellness Visits.
- 29% of our Medicare Attributed patients screened depressed.
- 14% of our Attributed patients have clinical anxiety.
- A correlation between our highest utilizers and behavioral health considerations.
- We began thinking about our non-Medicare patients.
Medicaid Criteria

- **Disabled–Medicaid**
  - Federally qualified individuals who meet disability criteria
- **Classic Adult–Medicaid**
  - Federally qualified adult pregnant women and adult caretaker/relatives, age 18 and older
- **Expansion Adult–Medicaid**
  - Non-disabled, federally qualified adults between ages 19–64
- **Child–Medicaid**
  - Federally qualified non-disabled children under the age of 18
Behavioral Health Treatment Needs

2016 Behavioral Health Needs By Medicaid Subtype

- Medicaid Expansion
- Medicaid Children
- Medicaid Classic Adults
- Medicaid Disabled

Washington State vs. Columbia County
Substance Use Disorder treatment needs Medicaid

Substance Use Disorder by Medicaid Sub-Populations

- Medicaid-Children
- Medicaid-Expansion
- Medicaid-Classic
- Medicaid-Disabled

Washington State vs. Columbia County
Depression is associated with increased health care costs.

Prevalence of major depression is higher among rural than among urban populations.

Depression and anxiety are likely under-reported as a result of fewer behavioral health resources in rural areas.

Mental Health Awareness

1 in 4

Not all pain is physical and not all wounds are visible.
Our first run at an integrated model

- We hired a psychiatrist in September of 2016
- Co-location was achievable but integration needed a focused and concerted effort
- New patient visits limited initial appointment slots for new BH providers
- Behavioral Health patients have a much higher no-call/no-show rate; closer to 35%
Care Coordination and a team approach

- Added a LICSW in September of 2017 for counseling services and to fill a behavioral health care coordination role
- Our psychiatrist announced his departure for March of 2018
- Evaluated tele-psych vendors
- We signed a contract with UW-AIMS in June but have an expanded model to cover system wide needs
The first medication review appointment performed by our Psychiatrist was covered but follow up, medication review claims were denied.

We do receive encounter rate and FFS reimbursement for psych services.

Successfully billing of FFS or encounter rate for our LICSW.

Collaborative care code G0512 has been challenging for us to bill successfully given infrastructure and coding requirements for the $145.08 payment: requires a NP, PA, or MD, a behavioral health care manager, and a Psychiatric consultant.
Financial impact

- Claim denials for depression and anxiety screening for Medicaid patients as part of an “annual wellness screening”
- For the first 18–months of this integration project has cost us $124,000 more than reimbursements
- Some of the losses are attributed to normal, new service line startup, but the majority of losses stem from salary overhead versus volume and reimbursement
Program modifications

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Our community wide, integrated future

- Exploring involuntary detention beds (single bed certification) for a focus on 72 hour hold – we may need some rule changing efforts here.
- Enhancing our substance abuse support systems and strengthening relationships within our community.
- Looking at Medicaid programs for long term care that would allow us to take more complex patients.
- Assessing the need for an on-site PMHNP.
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509.382.9358
Outline

- Brief Introduction to BHC in primary care
- Cascade Medical Center
  - Our community
  - Our clinic
  - Our behavioral health story
Barriers to MH Treatment

MENTAL HEALTH TREATMENT PATHWAYS

Visits for Individuals with Poor Mental Health

- 49% Primary Care Only
- 18% No Visit
- 14% Primary Care + Mental Health
- 14% Other Combo
- 5% Mental Health Only

Findings from 109,593 respondents to the 2002-2009 Medical Expenditure Panel Surveys (MEPS)

Barriers to MH Treatment

- Could Not Afford Cost: 45.4%
- Thought Could Handle the Problem without Treatment: 28.3%
- Did Not Know Where to Go for Services: 22.7%
- Did Not Have Time: 16.4%
- Treatment Would Not Help: 10.9%
- Might Cause Neighbors/Community to Have Negative Opinion: 10.6%
- Concerned about Being Committed/Having to Take Medicine: 10.2%
- Might Have Negative Effect on Job: 9.5%
- Health Insurance Did Not Cover Enough Treatment: 9.1%
- Did Not Feel Need for Treatment at the Time: 8.8%
- Concerned about Confidentiality: 7.8%
- Did Not Want Others to Find Out: 7.2%
- Health Insurance Did Not Cover Any Treatment: 5.7%
- No Transportation/Inconvenient: 2.7%

SAMHSA, 2014
BHC is...

- Integrated, collaborative, team-based
- On-demand
- Brief
- Evidence-based, results oriented
- Routine
- Flexible
Cascade Medical Center

- Our Community
Cascade Medical Center

- Our Clinic
  - 8 providers
  - ~4500 established patients

- Medicare, 40.00%
- Medicaid, 14.00%
- Other, 46.00%
Cascade Medical Center

- Our behavioral health story
Cascade Medical Center

- A day in the life of the BHC...
  - Warm handoffs
  - Scheduled referrals

- Groups
Common BHC Referrals

- Stress
- Anxiety
- Depression
- Grief
- Insomnia
- Chronic pain
- Alcohol / Tobacco / Substance use
- Parenting
- Aging
Additional BHC Impact

- BH screenings
  - Depression, anxiety, alcohol, tobacco
- Population-based care
- Treatment-to-target
BHC Perspective

- What matters?
  - Love, Work, Play