The Collaborative Family Healthcare Association and the Robert Graham Center Present:

“From Fragmentation to Integration: A Triple Aim Imperative”
PRIMARY CARE FORUM #74

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Director of The Eugene S. Farley, Jr. Health Policy Center, University of Colorado Denver School of Medicine

Introduction & Background
Mental health and primary care are inseparable; any attempts to separate the two leads to inferior care

- IOM, 1996


Of those with diagnosed behavioral health issues:

- 59% do not receive treatment
- 41% received care

56% seen in general practice settings

44% seen by a mental health professional

The cost of care increases in the presence of comorbid behavioral health and physical health conditions. For example, the chart below depicts the monthly cost of care for chronic health conditions with and without comorbid depression.

- **Without Depression**
  - Mental Health Expenditures: $20
  - Medical Expenditures: $840
  - Total Expenditures: $860

- **With Depression**
  - Mental Health Expenditures: $130
  - Medical Expenditures: $1,290
  - Total Expenditures: $1,420
TOP 5 CONDITIONS DRIVING OVERALL HEALTH COST

Depression ─ Anxiety

Obesity ─ Back/Neck Pain

Arthritis

When treated in harmony with mental health, chronic physical health improves significantly, along with patient satisfaction.

The problem

Clinical delivery
Payment /financing
Community expectation
Training/education

Fragmentation
Definition

The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, ineffective patterns of health care utilization.

Value of Integration:
Physical/Behavioral Integration is good health policy and good for health.

The solution

Partners

Collaborative Family Healthcare Association
Parinda Khatri, PhD
Chief Clinical Officer at
Cherokee Health Systems

Delivery of Integrated Primary Care
<table>
<thead>
<tr>
<th>Patient</th>
<th>Presenting Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 yo male</td>
<td>abdominal pain (new)</td>
</tr>
<tr>
<td>40 yo male</td>
<td>depression, diabetes, hypertension (f/u)</td>
</tr>
<tr>
<td>50 yo female</td>
<td>fibromyalgia, insomnia (new)</td>
</tr>
<tr>
<td>44 yo female</td>
<td>chronic pain, suicide attempt (f/u)</td>
</tr>
<tr>
<td>50 yo male</td>
<td>recent heart attack, substance abuse (f/u)</td>
</tr>
<tr>
<td>59 yo female</td>
<td>hypertension, diabetes, coronary artery disease, depression (new)</td>
</tr>
<tr>
<td>54 yo male</td>
<td>panic attacks, morbid obesity (f/u)</td>
</tr>
<tr>
<td>46 yo female</td>
<td>grief from death of child (new)</td>
</tr>
</tbody>
</table>
### A Tale of Two Approaches

<table>
<thead>
<tr>
<th>Component of Care</th>
<th>Traditional</th>
<th>Integrated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>Referral</td>
<td>Point of Primary Care</td>
</tr>
<tr>
<td>Scope of Service</td>
<td>Mental Health Diagnoses</td>
<td>Overall Health Function</td>
</tr>
<tr>
<td>Scheduling</td>
<td>Separate</td>
<td>Shared</td>
</tr>
<tr>
<td>Collaboration of Care</td>
<td>Individual Provider</td>
<td>Team Based</td>
</tr>
<tr>
<td>Health Record</td>
<td>Separate</td>
<td>Shared</td>
</tr>
<tr>
<td>Administrative Operations</td>
<td>Separate</td>
<td>Shared</td>
</tr>
<tr>
<td>Payment</td>
<td>Separate</td>
<td>Global</td>
</tr>
<tr>
<td>Communication</td>
<td>Minimal</td>
<td>Frequent &amp; Timely</td>
</tr>
<tr>
<td>Focus of Care</td>
<td>Provider-Centric</td>
<td>Patient-Centric</td>
</tr>
<tr>
<td>Approach to Care</td>
<td>Case by Case</td>
<td>Population-Based</td>
</tr>
<tr>
<td>Efficiency of Delivery Structure</td>
<td>Fragmented &amp; Inconsistent</td>
<td>Coordinated and Aligned</td>
</tr>
</tbody>
</table>
MEETING TRIPLE AIM: INTEGRATION

INTEGRATED PRIMARY CARE TEAM
- Access, Communication, Collaboration at Point of Care
- Shared Space, Workflow, Documentation, Support Staff
- Collaborative treatment planning
- Anchored in Patient Engagement

INTEGRATED POPULATION BASED CARE
- Integrated Operations
- Global Payment for Integrated Services
- Integrated Health Record
- Clinical Informatics to address population health needs
- Flexible Healthcare delivery to appropriately distribute resources
- Integrated Health Record for quality improvement and assurance
- Clinical informatics at population level
MEETING TRIPLE AIM???

SEPARATE CLINICAL SYSTEMS
• Delayed/Limited Access
• Separate Records
• Minimal Coordination
• Training Silos

SEPARATE OPERATIONS
• Different administrative systems
• Different regulations and requirements
• Different processes and procedures
• Health Information Technology Barriers

SEPARATE FINANCIAL SYSTEMS
• Carve Outs
• Fee for Service model
• Incentivizes for fragmented care
• Regulatory barriers

QUALITY

EFFICIENCY

COST
Susan McDaniel, PhD, ABPP

Dr. Laurie Sands Distinguished Professor of Psychiatry and Family Medicine, University of Rochester School of Medicine & Dentistry

Training the Workforce
Traditional training yields:
I’m OK and you’re not!

“Sometimes I think the collaborative process would work better without you.”

Colocation alone doesn’t yield integration...
I’m OK and you’re not!

• Training now occurs in silos
• Disciplines traditionally define themselves against other disciplines
• Criticism about each other is frequent
• Disciplines function in general ignorance of each other’s knowledge and skill set
What’s needed?

• Workforce expansion
• New kinds of training for primary care clinicians, behavioral health professionals, and staff.
Stop graduating people in silos

- Each profession needs to learn its own set of competencies, skills and knowledge base, AND
- Interprofessional education & training for teams
  - Ethics and collaborative care
  - Collaborative treatment plans together
  - Good communication skills
Professional + Interprofessional education and training = A well trained workforce

Workforce distribution problems

• Primary care, behavioral health clinicians and integrated care are scarce in rural areas
  – 40% of urban primary care practices are co-located with BH professionals
  – 23% of rural primary care practices have BH professionals as part of the practice.

Ideas for Training the New Workforce

• Interprofessional education and training grants (HRSA and SAMHSA)
• Programs to encourage training in behavioral health (National Health Service Corps)
• Incentives for behavioral health clinicians to work in primary care, especially in rural areas (debt relief and low interest loans)
Patrick Gordon, MPA
Associate Vice President
Rocky Mountain Health Plans

Financing Integrated Care
Key Concepts

1. Know the population
2. Create a budget
3. Set targets
4. Invest in value
5. Monitor performance and report feedback
6. Own the results
Global Budget – Conventional Network

- Emergency: 3.7%
- Inpatient: 22.6%
- Outpatient: 18.3%
- Specialists: 20.8%
- Ancillary: 12.5%
- Pharmacy: 17.5%
- Primary Care: 4.6%
Global Budget – Integrated Practices

- Emergency: 3.4%
- Inpatient: 20.9%
- Outpatient: 16.9%
- Ancillary: 11.5%
- Specialists: 19.3%
- Primary Care: 9.1%
- Behavioral: 0.5%
- Pharmacy: 18.4%
Isn’t the Second Pie Bigger? No.

<table>
<thead>
<tr>
<th>Service</th>
<th>Total Cost PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Practices</td>
<td>$479.30</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>$3.55</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$482.85</strong></td>
</tr>
<tr>
<td>Network Average</td>
<td><strong>$505.83</strong></td>
</tr>
<tr>
<td><strong>Risk Normalized Difference</strong></td>
<td><strong>-4.54%</strong></td>
</tr>
</tbody>
</table>
Practice Benchmarking
Total Normalized Cost

Exemplar Practice – Total PMPM Cost of Care

- You
- All
- YouNorm

Chart showing the trend of total normalized cost from 2012 to 2017.
Practice Benchmarking
Normalized IP Utilization

Exemplar Practice – Inpatient Utilization/1,000 Members

- You
- All
- YouNorm
Moving from “provider” to “owner”
Takeaways

• Comprehensive primary care is a “high leverage” investment

• Integrated BH is just another (important) aspect of comprehensive primary care

• Small part of the total health care budget

• Exemplars are performing very well. The question is how to scale this model through accelerated transformation.
Thank You!

➢ To access the materials and resources used in this Primary Care Forum, please visit:

  The Collaborative Family Healthcare Association:
  https://cfha.site-ym.com/?2014PolicyForum
  or
  The Robert Graham Center:
  http://www.graham-center.org/online/graham/home/rgc-events.html

➢ For inquiries and further discussion, please contact Jessica Pittrizzi at jpittrizzi@cfha.net or 303-724-7805.