Behavioral Health Integration: Return on Investment

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Objectives

- **At the end of this session, the participant will be able to:**
  - Identify at least two issues associated with providing behavioral health care in rural areas
  - Identify at least three components of integrated care
  - Describe how the "hybrid model" of integrated care can overcome some issues associated with providing behavioral health care in rural areas
  - Describe how integrated care can be financially sustainable

Define the Issue

- Identify at least two issues associated with providing behavioral health care in rural areas…

  → Audience participation

Review of the Literature

- Concerns about:
  - Availability
    - Workforce, competence
  - Accessibility
    - Poverty, insurance, transportation, workforce…
  - Acceptability
    - Stigma, confidentiality, multiple relationships
  - Affordability
    - Insurance, Medicaid, co-pays
- Potential Solution: Integrated Care

Behavioral Health and Primary Care Integration

- "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 and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization."
  - From Peek et al., available at http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf

- Video Example: http://www.integration.samhsa.gov/integrated-care-models

Approaches to Integrating BH Care and Medical Care

- Coordinated Care
  - Medical providers refer to behavioral health providers who see clients in their own off-site offices
    - No shared record or appointments, not necessarily quicker referrals
- Co-Located Care
  - Medical providers refer to behavioral health providers who see clients in their own offices located within the medical practice building or suite
    - No shared record or appointments, possibly quicker referrals
- Integrated Care
  - Medical providers refer to behavioral health providers who see patients in the medical exam rooms as part of a multidisciplinary team of practice staff
    - Shared record, immediate access

Models of Integrated Care

- Care Manager Model
  - Nurse or social worker serving as case manager on site
  - Consulting psychiatric prescriber
- Behavioral Health Consultant Model
  - Licensed behavioral health providers on site providing brief interventions
  - May or may not have access to a psychiatric prescriber
- Hybrid or Community First Model
  - Combination of BHC model and traditional outpatient behavioral health model
  - May or may not have access to a psychiatric prescriber

Traditional Outpatient Care vs. Integrated Care

- Traditional
  - 45-50 minute sessions
  - Once a week
  - Sessions are not interrupted
  - Possibly long duration of tx
  - Variety of theoretical orientations / approaches
  - Private office
  - Maybe group practice
  - Personal / group staff
  - Billing and credentialing staff knowledgeable about behavioral health
  - Send out requests for records with releases of information
  - Private notes / psychotherapy note protection under HIPAA
- Integrated (BHC Model)
  - 1-30 minute sessions
  - Once a month
  - Sessions often interrupted
  - 1-3 sessions
  - Behavioral, perhaps with CBT / ACT / SFBT
  - Often a medical exam room
  - Need a group med practice
  - No personal staff
  - Billing and credentialing staff may struggle with coding and collections and credentials
  - No need for primary medical care record requests
  - Shared records, not use psychotherapy notes

Rural Considerations

- Need flexibility because of lack of community resources, smaller clinics, and medical provider preference
    - Number of sessions
    - Length of sessions
    - Scheduling
    - Outside referrals
    - Psychological assessment
    - Group treatment
    - EAP program for employees

Benefits of Integrated Care

- Decreases stigma
  - Person seen in medical clinic
  - Same process as medical patients
- Decreases cost
  - Single day and same location for multiple appointments
    - Reduces transportation expenses
  - May have decreased cost of care through bundled services
- Increase access
  - Immediate opportunity to see BH providers

Information on Stone Mountain Health Services

- Stone Mountain Health Services (SMHS) is a Federally Qualified Health Center (FQHC) with 11 primary care clinics and 2 respiratory care across seven of the Westernmost counties in Virginia (Central Appalachia)
- Catchment area includes three of the poorest and least healthy counties in the state
- Primary medical care in all clinics and behavioral health care in all clinics (in-person or through technology)
- Payment mix: 20% Self-pay, 20% Medicaid, 40% Medicare, and 20% Insurance

Stone Mountain's BH Program

- Behavioral Health and Wellness Services Director

- Psychiatric Mental Health Nurse Practitioners
  - Each with a nurse
  - Psychiatrists available through technology
- Licensed Clinical Social Workers
- Licensed Clinical Psychologists
- Doctoral-level Psychology Interns

- Care Managers for Suboxone Program

- Moving toward adding Peers

- All clinics and all behavioral health providers have access to technology to facilitate sessions

Stone Mountain's BH Program

- Hybrid model
  - Integrated care / BH sessions can be interrupted
    - Time allocated on schedules for warm hand-offs
  - Session length and frequency depends on patient needs and provider availability
    - Typically, 15-30 min sessions, 1-3 times spread over several weeks
    - Also provide traditional outpatient counseling (e.g., weekly, 45-60 min long, no time limit)
  - Goal of 6 billable encounters per day [need to schedule 8+] in addition to warm hand-offs and "curbside consultations"
  - 10,000 encounters each of last 3 fiscal years
  - Financially sustainable without grant funding

Assisting Medical Providers

- Typical Traditional-Type Mental Health Referrals
  - Depression
  - Anxiety
  - Grief / Loss
  - Trauma
  - Crisis
  - Substance mis-use
- Common Medical Issues
  - Diabetes
  - Hypertension
  - Weight loss
  - Exercise
  - Chronic Pain
  - Sleep

Common Interventions and Referrals

- There are several frequently used interventions
  - Depression: CBT and Interpersonal
  - Stress / Anxiety: Breathing and Progressive Muscle Relaxation
  - Grief / Loss: Support and education
  - Trauma: Seeking Safety
  - Crisis: Safety plan, involvement of others
  - Substance mis-use: Motivational Interviewing, Seeking Safety
- Frequent Referrals
  - Community mental health / hospital / sheriff's office
  - Nutritionist / Dietician
  - PMHNP / child psychiatrist
  - Substance abuse detox / inpatient
  - Department for Aging and Rehabilitative Services
  - Assessment (internal and external)

An Overview of the Financial Numbers

- For FY 2015-2016, the 10 full-time BH providers and their interns had almost 9700 encounters, which placed productivity at 97%
- Subtracting about 1050 unbillable intern encounters leaves approximately 8650 encounters for professional BH staff
- We do not bill for warm hand-offs unless the patient consents
  - We had around 650 encounters billed as WH (590 were 90832WH) – no charge
- For approximately 8000 billed encounters

- Major CPT Codes (rounded numbers):
  - 90791 (Diagnostic Evaluation): 720
  - 90832 (16-37 min): 2575
  - 90834 (38-52 min): 1160
  - 90837 (53+): 500

  - 96101 (Testing by Psych): 550
  - 96102 (Testing by Intern): 75

  - 99213 (OV Est Level 3): 225
  - 99214 (OV Est Level 4): 990
  - 99215 (OV Est Level 5): 1160

- The charges for these encounters totaled almost $1.4M
- The payments from co-pays and insurance totaled almost $480,000
- This means that our payments were only 34% of charges
  - Medical is 50%
- Because Stone Mountain is an FQHC, services are offered on a sliding scale to patients who qualify
  - Approximately $390,000 was collected through the federal grant that covers the cost of care for people receiving services on the sliding scale
    - Note: 28% of BH patients are on sliding scale, higher than medical
  - Non-FQHCs would not receive this reimbursement, but they also may not see as many people without insurance or who cannot pay out-of-pocket
- Adding these numbers together, the total payments were approximately $870,000

- For our purposes, the direct "cost" of the 10 full-time professional BHPs is their salary + benefits
- The cost of the staff was approximately $860,000
- Thus, these BHPs generated around $10,000 in revenue
- In addition, Stone Mountain received 2 grants to expand services that covered some of the salary and benefits for 3 BHPs (2 psychologists and 1 PMHNP)
  - The BH portion added $250,000 to the organization's base FQHC grant

Bottom Line

- The BH Team broke-even / generated money
  - Without relying on non-sustainable grant funding
  - Even with "expensive" providers
  - Even with 3 new providers not licensed for some or all of the fiscal year
  - Even with the new providers not reaching 100% productivity
  - Even with some of the licensed providers spending time supervising interns/non-licensed professionals
  - Hard to measure impact on PCPs' productivity but they report an improvement in the quality of their professional work-life
- The "hybrid" model of integrated care can be sustainable

Updated Financial Analysis

- A more recent financial analysis indicates that to cover all the direct costs of the BH program (e.g., BH Director, Interns) using cash (not FQHC grant money):
  - The nonprescribing licensed BH staff members (i.e., LCSWs, LCPs) need to have 6 billable encounters / day
  - The prescribing staff (i.e., PMHNPs) needs to have 12+ billable encounters because of additional costs (e.g., nurses)
  - The major issue is no shows – if we could decrease this rate, we would easily meet productivity and financial expectations

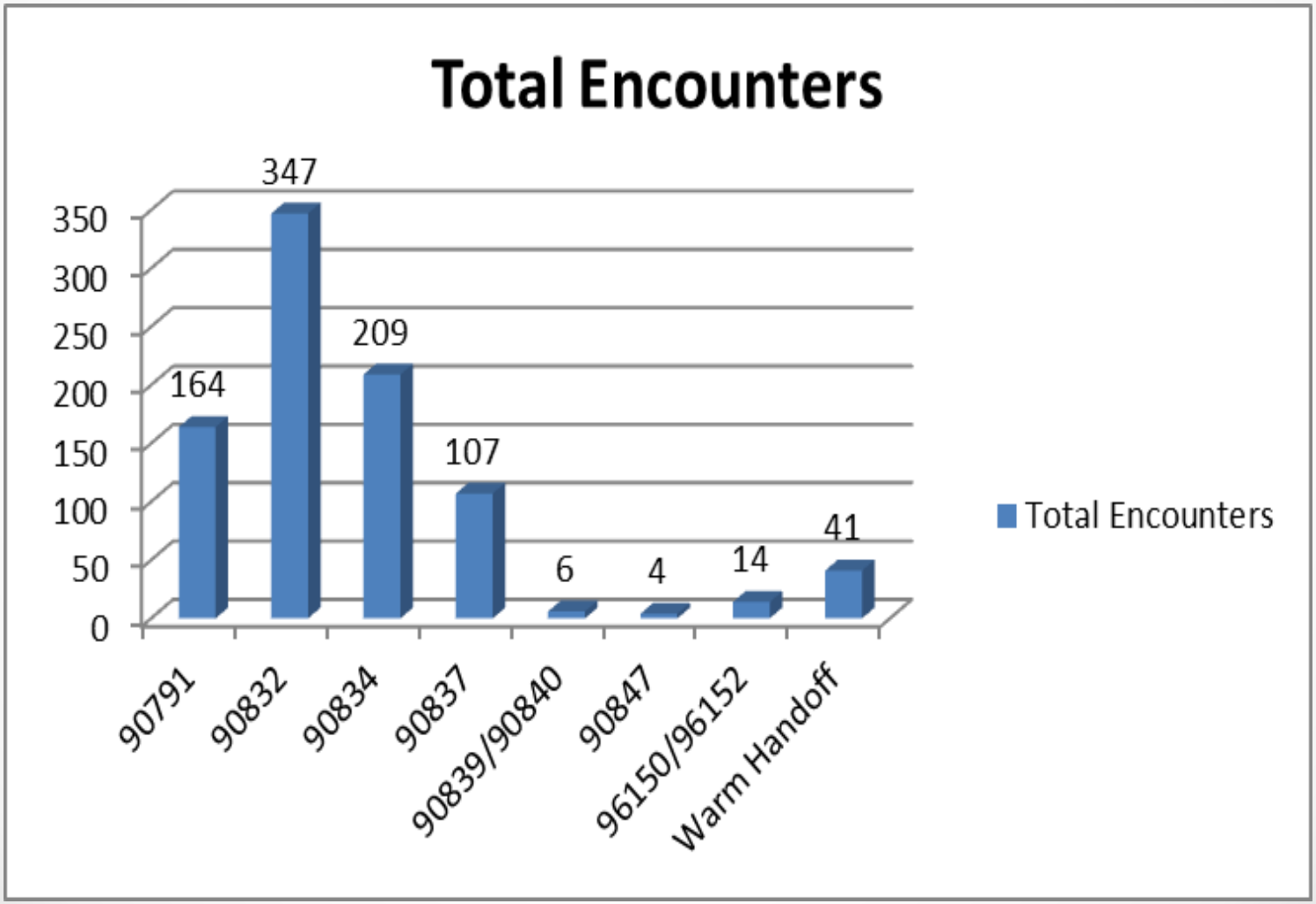
Costs and Revenue Generated by One Behavioral Health Provider

Note: Special thanks to Alysia Hoover-Thompson, PsyD

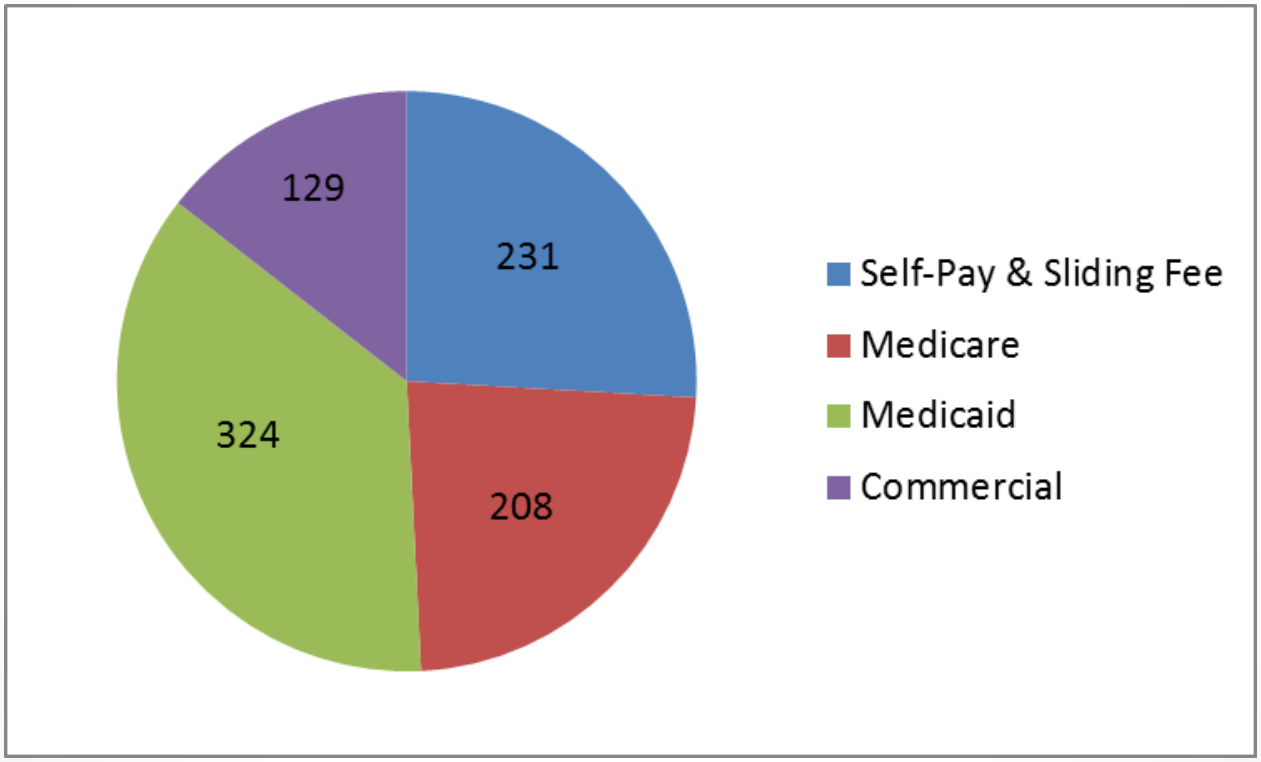
Scheduled Appointments vs. Patients Seen

	Pre-Scheduled Appointments	No Shows / Same Day Reschedule or Cancellation	Warm Hand-Offs	Total Seen
Haysi + St. Paul	1421	570	41	892 ~60% show rate based on pre-scheduled appts

Billing Codes Used



Revenue Generated: Payees



Revenue Generated

- Total Charges = $155,863.50
- Total Payments = $98,797.79
- Payments ($98,797.79) – Cost to SMHS ($90,000) = **$8,797.79 in revenue**

- On average, we collect ~ $110/encounter
- If she saw patients 5 days/week (instead of 4)
  - 5 patients/day x 45 weeks = 225 encounters @ $110/encounter = **$24,750 in revenue**

- Actual Revenue ($8,797.79) + Potential Revenue ($24,750) = **$33,547.79**

Summary

- Integrated care involves placing behavioral health providers in medical clinics where the BH providers offer complementary services and all providers have access to information through a shared record
- Integrated care can decrease stigma, decrease costs (especially transportation), and decrease referral time
- Although there are many different approaches and models, a hybrid model of integrated care can be financially sustainable and responsive to community needs in rural areas
- In general, integrated care can improve availability, accessibility, acceptability, and affordability to behavioral health services