Behavioral Health Integration: Return on Investment

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Objectives

• At the end of this session, the participant will be able to:
  o Identify at least two issues associated with providing behavioral health care in rural areas
  o Identify at least three components of integrated care
  o Describe how the “hybrid model” of integrated care can overcome some issues associated with providing behavioral health care in rural areas
  o 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:
  o Availability
    • Workforce, competence
  o Accessibility
    • Poverty, insurance, transportation, workforce...
  o Acceptability
    • Stigma, confidentiality, multiple relationships
  o 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.”
  o 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
  o 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
  o 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
  o 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
  o Nurse or social worker serving as case manager on site
  o Consulting psychiatric prescriber

• Behavioral Health Consultant Model
  o Licensed behavioral health providers on site providing brief interventions
  o May or may not have access to a psychiatric prescriber

• Hybrid or Community First Model
  o Combination of BHC model and traditional outpatient behavioral health model
  o May or may not have access to a psychiatric prescriber
Traditional Outpatient Care vs. Integrated Care

• Traditional
  o 45-50 minute sessions
  o Once a week
  o Sessions are not interrupted
  o Possibly long duration of tx
  o Variety of theoretical orientations / approaches
  o Private office
  o Maybe group practice
  o Personal / group staff
  o Billing and credentialing staff knowledgeable about behavioral health
  o Send out requests for records with releases of information
  o Private notes / psychotherapy note protection under HIPAA

• Integrated (BHC Model)
  o 1-30 minute sessions
  o Once a month
  o Sessions often interrupted
  o 1-3 sessions
  o Behavioral, perhaps with CBT / ACT / SFBT
  o Often a medical exam room
  o Need a group med practice
  o No personal staff
  o Billing and credentialing staff may struggle with coding and collections and credentials
  o No need for primary medical care record requests
  o 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
  o Depression
  o Anxiety
  o Grief / Loss
  o Trauma
  o Crisis
  o Substance mis-use

• Common Medical Issues
  o Diabetes
  o Hypertension
  o Weight loss
  o Exercise
  o Chronic Pain
  o 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
  o We had around 650 encounters billed as WH (590 were 90832WH) – no charge
• For approximately 8000 billed encounters
• Major CPT Codes (rounded numbers):
  o 90791 (Diagnostic Evaluation): 720
  o 90832 (16-37 min): 2575
  o 90834 (38-52 min): 1160
  o 90837 (53+): 500
  o 96101 (Testing by Psych): 550
  o 96102 (Testing by Intern): 75
  o 99213 (OV Est Level 3): 225
  o 99214 (OV Est Level 4): 990
  o 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
  o Medical is 50%
• Because Stone Mountain is an FQHC, services are offered on a sliding scale to patients who qualify
  o 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
  o 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
  o Without relying on non-sustainable grant funding
  o Even with “expensive” providers
  o Even with 3 new providers not licensed for some or all of the fiscal year
  o Even with the new providers not reaching 100% productivity
  o Even with some of the licensed providers spending time supervising interns/non-licensed professionals
  o 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):
  o The nonprescribing licensed BH staff members (i.e., LCSWs, LCPs) need to have 6 billable encounters/day
  o The prescribing staff (i.e., PMHNPs) needs to have 12+ billable encounters because of additional costs (e.g., nurses)
  o 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

<table>
<thead>
<tr>
<th></th>
<th>Pre-Scheduled Appointments</th>
<th>No Shows / Same Day Reschedule or Cancellation</th>
<th>Warm Hand-Offs</th>
<th>Total Seen</th>
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</thead>
<tbody>
<tr>
<td>Haysi + St. Paul</td>
<td>1421</td>
<td>570</td>
<td>41</td>
<td>892</td>
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</table>

~60% show rate based on pre-scheduled appts
Billing Codes Used

Total Encounters

<table>
<thead>
<tr>
<th>Code Description</th>
<th>Total Encounters</th>
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<tr>
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<tr>
<td>96150/96152</td>
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<tr>
<td>Warm Handoff</td>
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</tr>
</tbody>
</table>
Revenue Generated: Payees

- Self-Pay & Sliding Fee: 231
- Medicare: 208
- Medicaid: 324
- Commercial: 129
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.