

Policy Context and Scaling of Primary Care into Specialty Behavioral Health Settings

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The Challenge of Scaling

“Nearly every problem has been solved by someone
somewhere. The challenge of the 21st century is to find
out what works and scale up”

--- Bill Clinton



Overview

- Policy Change and Behavioral Health Opportunities
- Delivery System Reform, Incentives
- Lessons from PBHCI
- Conclusions

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Policy Change and Opportunities for Behavioral Health

- Expanded health insurance coverage for behavioral health services
 - Parity
 - Affordable Care Act
- Delivery System Reform
 - Payment Systems
 - Institutional change

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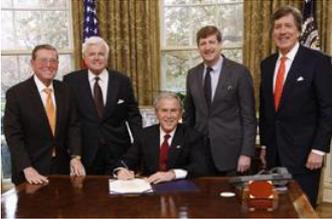
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Parity



- Private health insurance for mental health fails to protect against most serious illnesses and costs +
- FEHB and Parity Study =
- Mental Health Parity and Addiction Equity Act, Pub. L. 110-343



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But...

- Limited to firms that offer MH/SA coverage
- Limited to firms with 50+ employees

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Behavioral Health Benefits

- EHBs include mental health and substance abuse
- Parity applies to qualified health plans “in the same manner and to the same extent as such section applies to health insurance issuers and group health plans” (sec. 1311(j))



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Parity Plus

Universal Coverage

+

Essential Health Benefits
-- Coverage Includes
Mental Health Benefits

+

Benefits are at Parity



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Effect of Parity and Coverage

	Individuals who will gain mental health, substance use disorder, or both benefits under the Affordable Care Act, including federal parity protections	Individuals with existing mental health and substance use disorder benefits who will benefit from federal parity protections	Total individuals who will benefit from federal parity protections as a result of the Affordable Care Act
Individuals currently in individual plans	3.9 million	7.1 million	11 million
Individuals currently in small group plans	1.2 million	23.3 million	24.5 million
Individuals currently uninsured	25 million*	n/a	25 million
Total	<u>30.1 million</u>	<u>30.4 million</u>	<u>60.5 million</u>

ACA Delivery System Reforms

- Accountable Care Organizations (ACOs)
- Medicaid Health Homes
- Innovation Center
 - Bundling
- Patient Centered Medical Homes
- Prevention fund



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Strategy for Delivery System Reform

- More services and dollars under budgets or quasi-budget
- Clinical organizations with capacity to manage continuum of care increasingly delegated responsibility for budgets and populations
- Accountability and rewards for performance
 - Savings
 - Quality indicators

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High Powered Budget Incentives

- Consolidates funding across service lines; moves accountability towards population focus
- Can reward integration of primary care and specialty behavioral health care
- Can favor prevention and early intervention approaches
 - Especially for clinical preventive services
- Challenges
 - Business case relies on savings subject to meeting quality thresholds
 - Behavioral health quality measures are under-developed

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Integration and Delivery Reform

- People with behavioral health disorders are at elevated risk of major chronic illness (diabetes, CHF, asthma)
 - In part due to disadvantage and also treatment side-effects
- Integration by meeting people where they are
 - Behavioral Health to Primary Care (Collaborative Care Model)
 - Primary Care to Specialty Behavioral Health settings
- Performance based accountability
- Challenge: What works and what should we measure and reward to promote scaling?

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Lessons from the PBHCI Evaluation

- Basic Services Use
- Promotion of “integration”
- Observations from qualitative work
- Lessons from related models

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Lesson 1: Basic Health Services-Key

Consumer Physical Health Service Utilization All Cohorts (N=25,648)		
Service	% of Consumers Receiving PC Services During First 12 Months	95% CI
Screening/assessment	86.2%	85.7% - 86.6%
Treatment Planning	72.7%	72.1% - 73.3%
Medication Management	64.8%	64.2% - 65.4%

- Even among PBHCI grantees, gaps in core services persist
- We must track service utilization and ensure consumers are receiving needed services



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What Works from PBHCI for Promoting Integration

	Basic Integration		Comprehensive Integration	
	Point Estimate	95% CI	Point Estimate	95% CI
PC advice by phone or email	0.63 ^c	0.50-0.80	2.18 ^c	1.65-2.88
PC/BH provider meetings/ month	1.16 ^c	1.07-1.24	1.10 ^c	1.03-1.18
PC partner agency	0.61 ^c	0.47-0.79	3.38 ^c	2.60-4.40
Rural	0.23 ^c	0.18-0.28	0.11 ^c	0.09-0.15
PC service days/week	1.72 ^c	1.60-1.86	1.21 ^c	1.13-1.30
Co-location	1.01 ^c	1.01-1.01	1.01 ^c	1.01-1.02
Shared structures/systems	0.98 ^c	0.98-0.98	0.98 ^c	0.98-0.98
Integrated practice	1.02 ^c	1.02-1.03	1.02 ^c	1.01-1.02
Culture	1.01 ^c	1.01-1.01	1.02 ^c	1.02-1.02

c = p<0.001.

- Basic Integration: Screening/Assessment or Treatment Planning, Contact with a PC Provider, and Case Management
- Comprehensive Integration: Screening/Assessment, Treatment Planning, Contact with a PC Provider, Case Management, and Wellness Services



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Observations

- A clear partnership agreement between agencies is of great import
- Regular meetings and multiple lines of communication are especially important for comprehensive integration
- Flexible hours for Primary Care services
- **Surprise:** colocation appears to matter less than one might have expected

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Lessons Learned from Other Models

- The Collaborative Care model has been tested
 - In over 35 randomized trials
 - Numerous demonstrations in typical practice settings
 - Nearly all studies show the model to be highly cost effective
- The essential elements of the collaborative care model includes:
 - Training and supervision of care managers
 - Self-management supports
 - Clinical information systems
 - Primary Care Physician exposure to evidence based treatment



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Common Elements of Successful Models

- Care planning shared across providers
- Use evidence-supported treatment models
- Define treatment team member roles
- Build systems to bring the right information to clinicians and care coordinators
- Consistently measure and track outcomes



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Conclusions

- Integration of primary care into specialty behavioral health settings is especially important because chronic illnesses travel with severe and persistent mental and substance use disorders
- Specific models have not been as systematically tested as has the collaborative care model
- Scaling is likely to depend on
 - Aligned payment arrangements
 - Modest infrastructure investment
 - Commitment and Execution at the ground level



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Conclusions II

- Learning to date suggests that we can measure and reward activities that drive system towards integration and its benefits

