BlueCross BlueShield

2022 NATIONAL SUMMIT

# Integrated Behavioral Health: Partnering with Providers to Address Unmet Behavioral Health Needs.


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# Learning Objectives

Upon completion of the session, participants will be able to:

- Outline the benefits and value of Payer-Provider partnerships in behavioral health
- Discuss the experience of implementing a payer-provider collaborative care partnership and the resulting effects on costs and outcomes
- Indicate how payer-provider partnerships offer an opportunity to address unmet behavioral health needs in a cost-effective way

# Target Audience

This activity is intended for Blue physicians, pharmacists, nurses and other healthcare professionals interested in the exchange of medical and pharmacy management information.

# Accreditation Information – Physicians and Pharmacists

Accreditation is provided by the Academy for Continued Healthcare Learning (ACHL).

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of the Academy for Continued Healthcare Learning and the Blue Cross Blue Shield Association. ACHL is accredited by the ACCME to provide continuing medical education for physicians.

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ACPE Universal Activity Number (UAN): 0396-9999-22-014-L99-P

Activity Type: Knowledge
Release Date: 05/03/2022

# Accreditation Information – Nurses


**CBRN – Nurses**

Provider approved by the California Board of Registered Nursing, Provider Number 17273 for 1.0 contact hour.

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- Eric Wilkinson, Ph.D.
- K. Ryan Connolly, MD, MS
- Aaron Smith-McLallen, PhD
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2. Click “Use Certificate Code” (in the upper right-hand corner), enter the certificate code provided at the end of the presentation.
3. Complete the evaluation form and click “Submit”.

You will receive an automated certificate. You may print or save this record for your files. It will also be sent to you via e-mail to the address provided in your profile on **www.ACHLcme.org.** There is no fee to participate in the program or for the generation of the certificate.

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# Agenda

1. Current and Desired States
2. Collaborative Care Model
3. Pilot Experience with Penn
4. Outcomes Assessment
5. Lessons Learned

# Current and Desired States

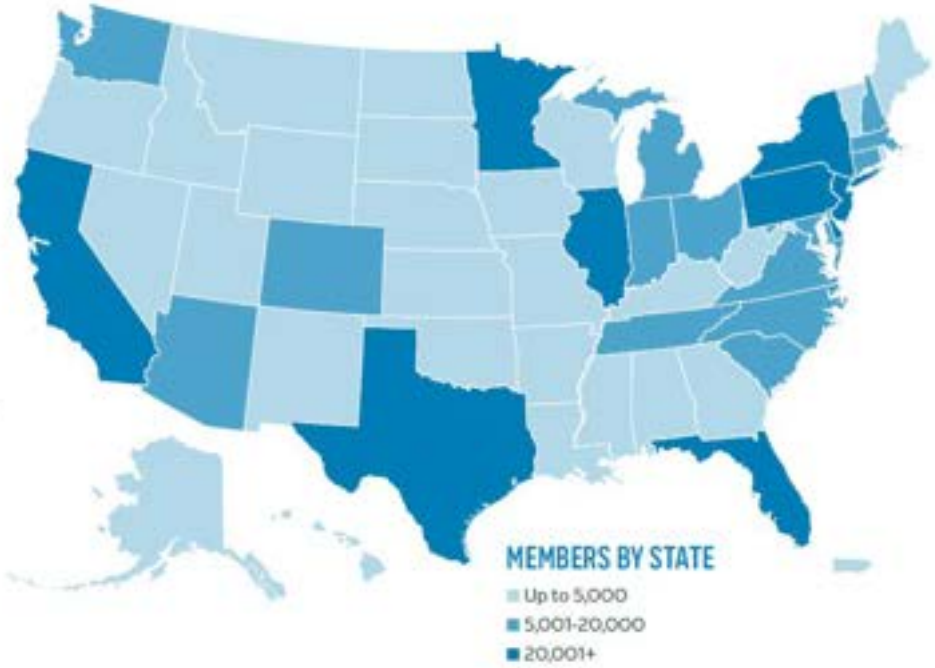
# Independence at a Glance

A diversified leader with a national scope

**80+ YEARS**
enhancing the health and well-being of the people and communities we serve

**10,000+**
employees

**26,000**
employers




**8 MILLION**
members

**26,000**
group customers

**$21.8B**
total revenue

*Information is as of Dec 31, 2020.

# Current State vs. Desired State

## *Access and quality in mental Health care are not optimized*

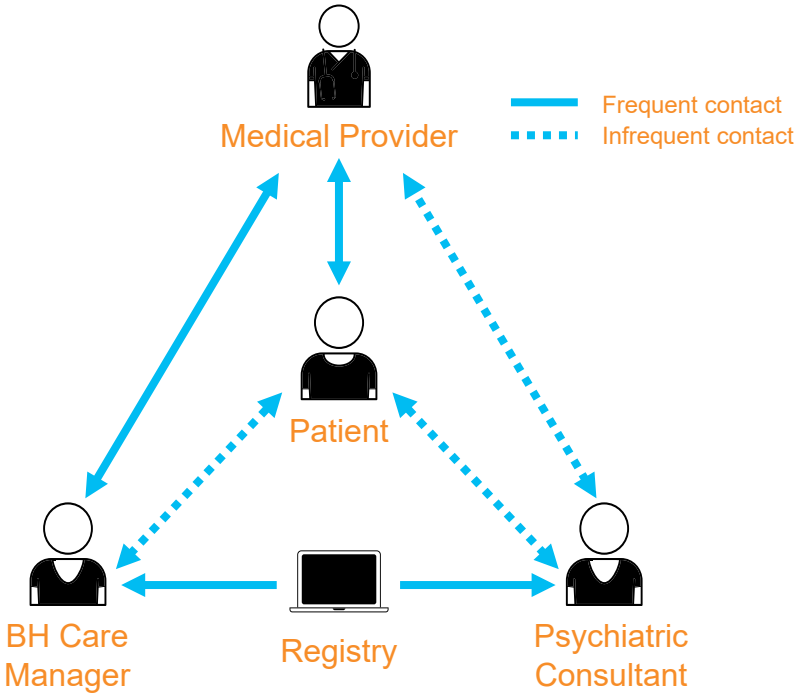
- Leading cause of disease burden
- Major driver of health care costs
- Traditional care delivery models lack:
  - Access
  - Engagement (~50% of referrals don't engage)
  - Not always evidence-based (most do not receive guideline-concordant treatment)
  - Variable outcomes and value

## *Identify unmet needs, intervene quickly and directly*

- Improve screening for earlier intervention
- Empower PCPs to deliver evidence-based, stepped BH care
- Extend the reach and capacity of specialty BH providers
- Remove barriers to collaboration
- Address the whole-person health of members
- Be cost-effective and sustainable

# Collaborative Care Model

# Collaborative Care Model




- Developed by the University of Washington
- Data-driven, patient centered approach to treating depression and anxiety
- Best supported option for BH integration with primary care provider oversight
- Proactively manage mental health conditions as chronic diseases

# Collaborative Care Model

**80+**

trials show improved access, value, outcomes, experience

**60%**

Increase in response to mental health and substance use treatments

(Archer 2012)

**6:1**

Return on investment for patients – reduction in total medical spend over cost of program

(Unutzer 2008)

Reduction in markers of chronic disease, ED visits and hospitalizations

(Rossom 2017, Reiss-Brennan 2016)

# Pilot Project with Penn Integrated Care (PIC)

# 2019 PIC Program Experience

**8**

practices serving 40,000+ members at launch

**3,000**

members referred to PIC

**2,000**

completed evaluation

**500**

had primary integrated care intervention

**300+**

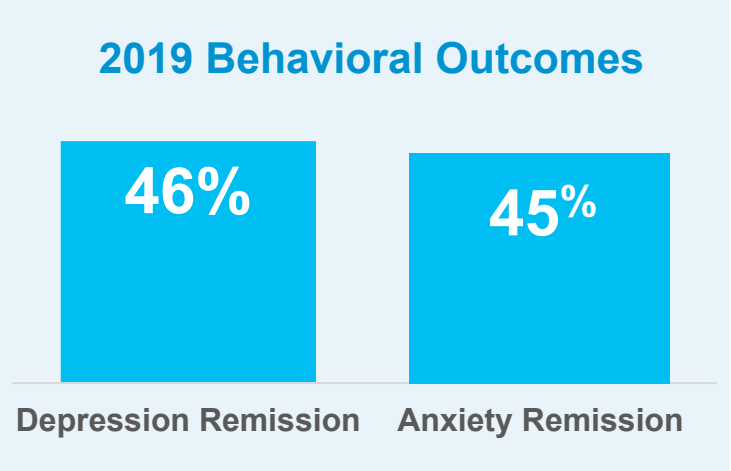
suicidal “catches”

# Outcomes Assessment

# Outcomes Analysis (2019 Program Data)

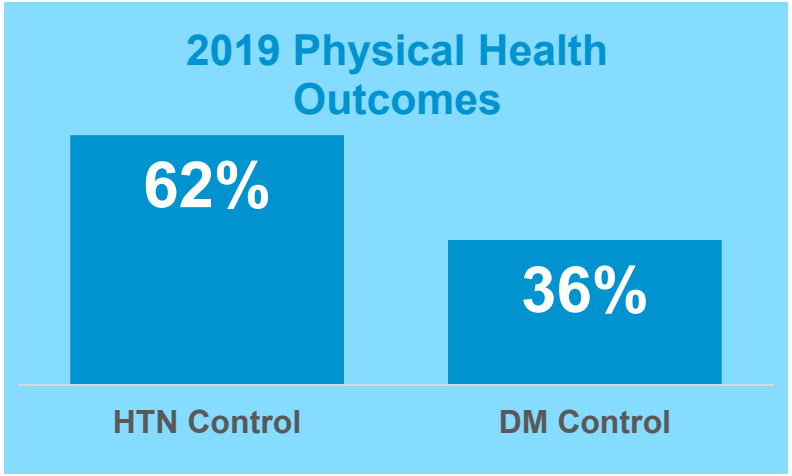
## Embedded behavioral health providers

LCSWs carry 80 patients at a time for 2-6 months, and use a measurement-based, treat-to-target approach




## Brief interventions in the practice

Behavioral activation, motivational interviewing, problem-solving therapy, brief CBT, and SUD care



# Study Design

*Collaboration with research design in mind.*

- Working closely with Penn we were able to ensure that the implementation of the program met the needs of both members and a rigorous evaluation design.
- Ensuring a suitable comparison group:
  - Of the 35 primary care practices operating within the Penn health system, 8 were initially targeted to offer the integrated care program.
  - A phased introduction of the program allowed the 27 non-participating locations' patients to be used as a contemporaneous group of potential controls.
- Identification of the treated:
  - Collaborative care procedure codes were used to identify program participants from the 8 Penn practices.
  - Since these XXXXX codes were only unlocked for the 8 treatment sites the identification of treated patients was clean and accurate.
    - Only required claims data and no need for member lists.

# Study Design

## *Identifying Cases, Controls and Outcomes*

- Study Design:
  - 6-month pre / 12-month post matched difference-in-difference framework.
- Study Period:
  - Index dates between January and December 2019
- Treatment Group:
  - Members from the 8 participating practices with a PIC visit, identified via XXXXX procedure codes
  - Index date is first record of a PIC visit
- Control Group:
  - Members attributed to the remaining 27 non-participating Penn practices.
  - No natural index date, determined in matching process
- Outcomes:
  - Medical Costs, overall and segmented by service type as well as stratified by BH/non-BH.

# Baseline Covariate Balance – Before Matching

| | 12-Month Post | |
|---|---|---|
| **Covariate** | **Non-PIC (N = 52,475)** | **PIC (N = 825)** |
| Male Gender | 0.42 | 0.28 |
| Age | 45.80 | 40.98 |
| Medicare | 0.08 | 0.04 |
| PPO | 0.61 | 0.51 |
| Fully Insured | 0.46 | 0.32 |
| Census Variables (Tract-level) | | |
| %Black | 11.90 | 41.44 |
| %Asian | 5.75 | 6.78 |
| %Other Race | 1.75 | 2.96 |
| Median Income | $121,867 | $78,562 |
| Unemployment Rate | 5.41 | 8.92 |
| % BA Degree or Higher | 48.58 | 35.94 |
| Lives in Phila. County | 0.15 | 0.74 |
| Community Needs Index Score | 2.24 | 3.50 |

*All Differences are statistically different

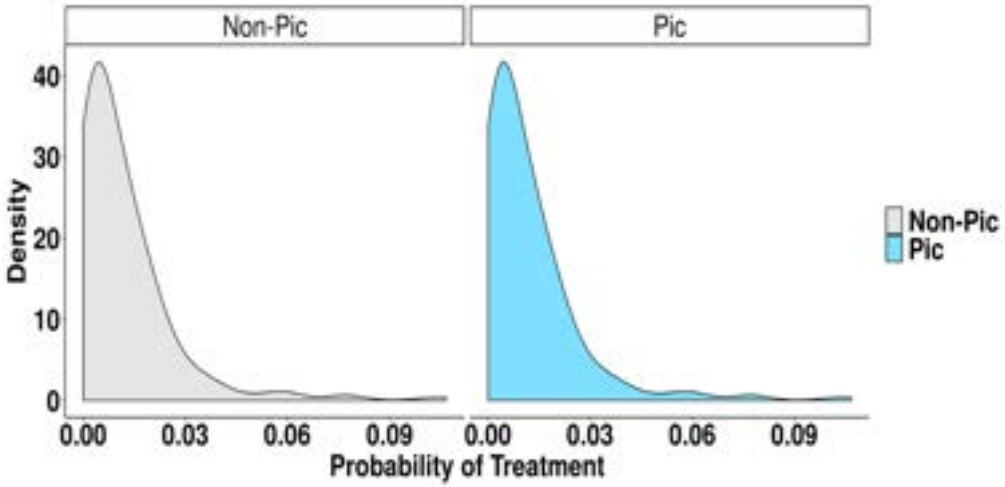
- We see that the pre-matched differences in the sample are significant across all measures.
- Treated members are likely to be:
  - Female
  - Younger
  - Non-white
  - Live in lower income areas
  - Live in Philadelphia
  - Have higher social risk

# Study Sample

| | 6-Month Pre/12-Month Post (Jan. 2019- Dec. 2019) | |
|---|---|---|
| **Penn Attributed Members** | **PIC** | **Non – PIC** |
| Penn Membership in Jan. 2019 – Dec. 2020 | 1,233 | 62,603 |
| Continuous Enrollment with 3 months of Runout | 858 | 52,521 |
| Outliers in Total Medical Costs at Baseline | 856 | 52,475 |
| Remove members with “99” codes prior to index date | 825 | 52,475 |
| **Matching 1:1** | **569** | **569** |

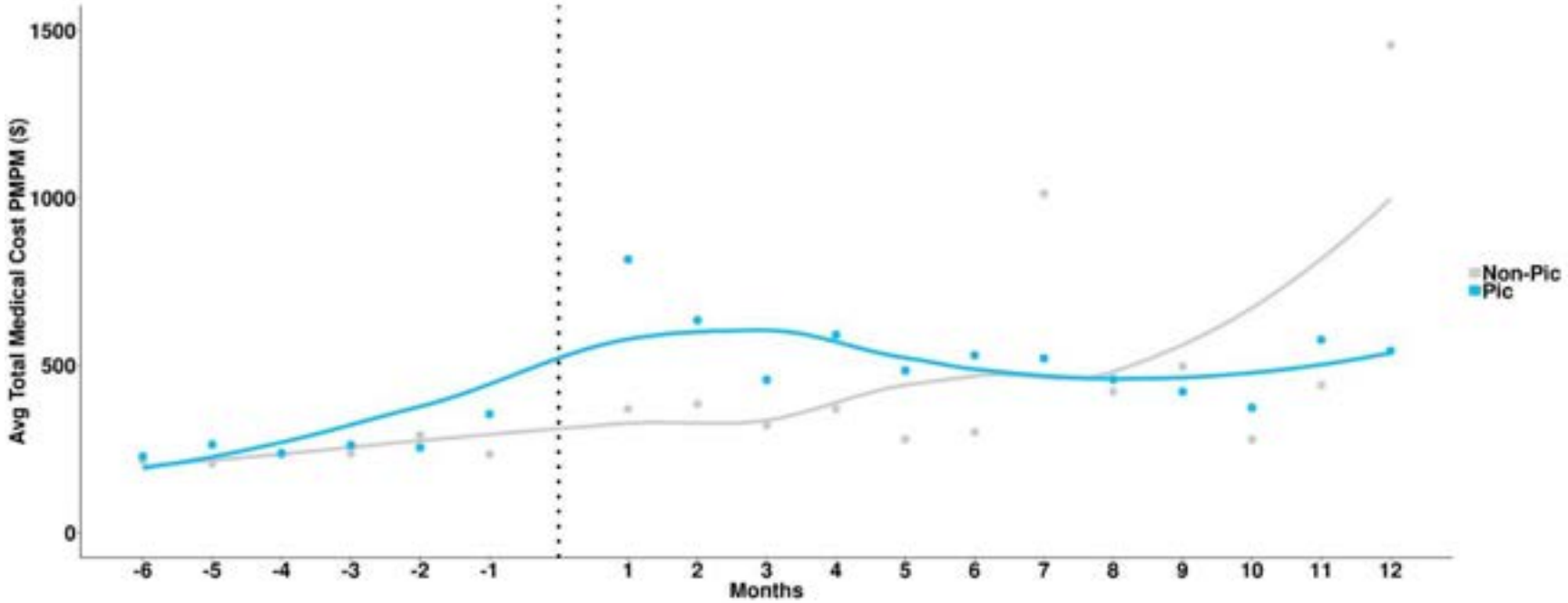
- Members were filtered to those with continuous enrollment and high-cost outliers were excluded as well.
- The remaining 825 treated members were propensity score matched to the pool of 52k potential controls on:
  - Cost and utilization
  - Demographics
  - Census variables
  - Chronic conditions
- 569 treated members were successfully matched.

# Propensity to Enter PIC Program – After Matching



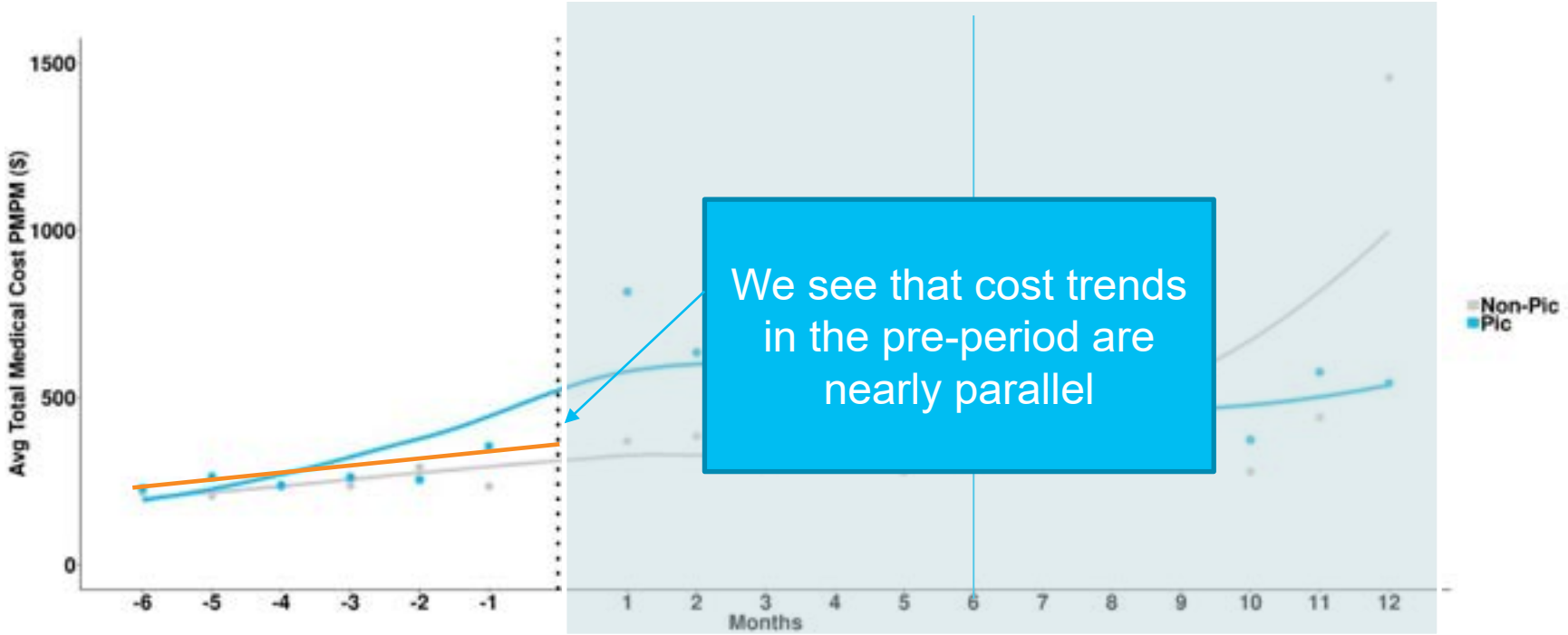

The distributions of the propensity scores between the two segments are nearly identical --- they overlap almost perfectly --- an indication that the matching was successful.

# Trends in Total Avg. Medical Cost




Note: Pre-period trends not entirely parallel, indicating some bias is likely in difference-in-difference analyses. While regression to the mean is possible, evidence of average total medical cost in PIC sample dropping below average total medical cost for non-PIC sample.

# Trends in Total Avg. Medical Cost

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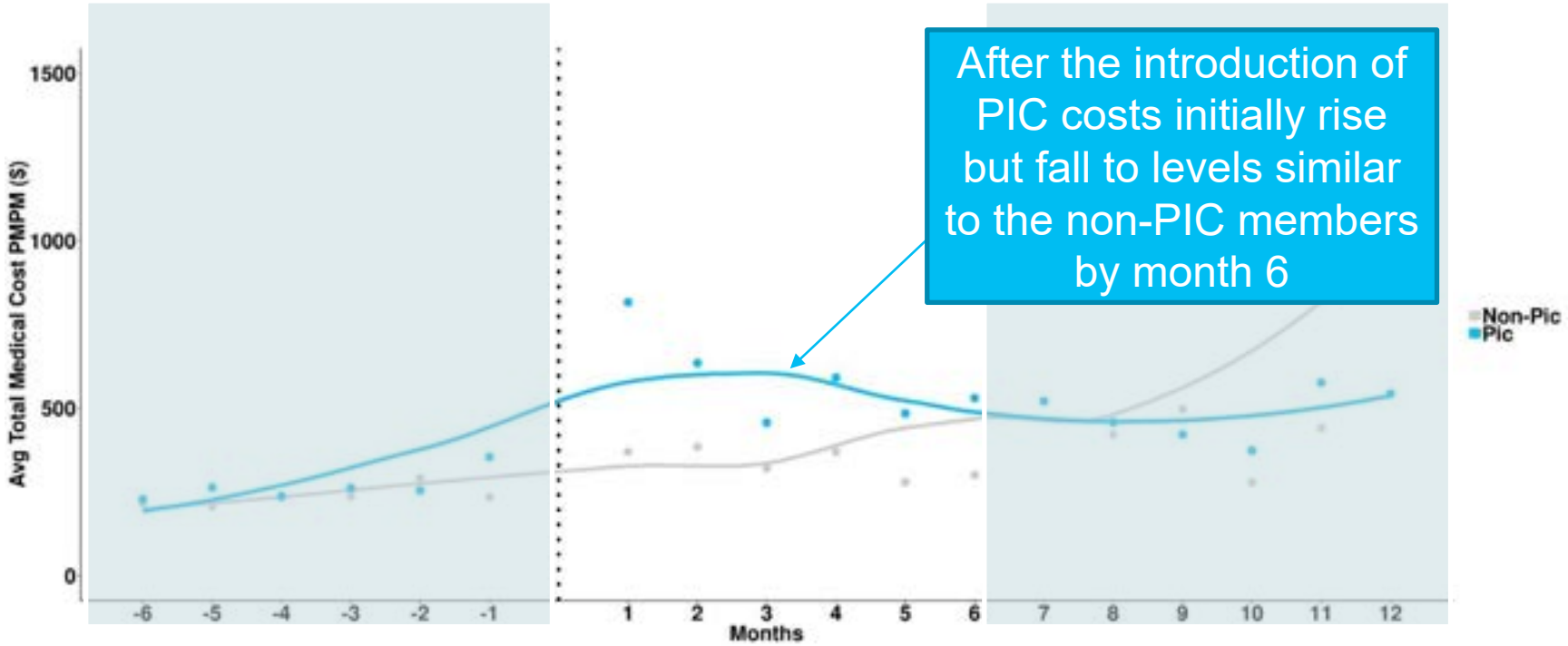


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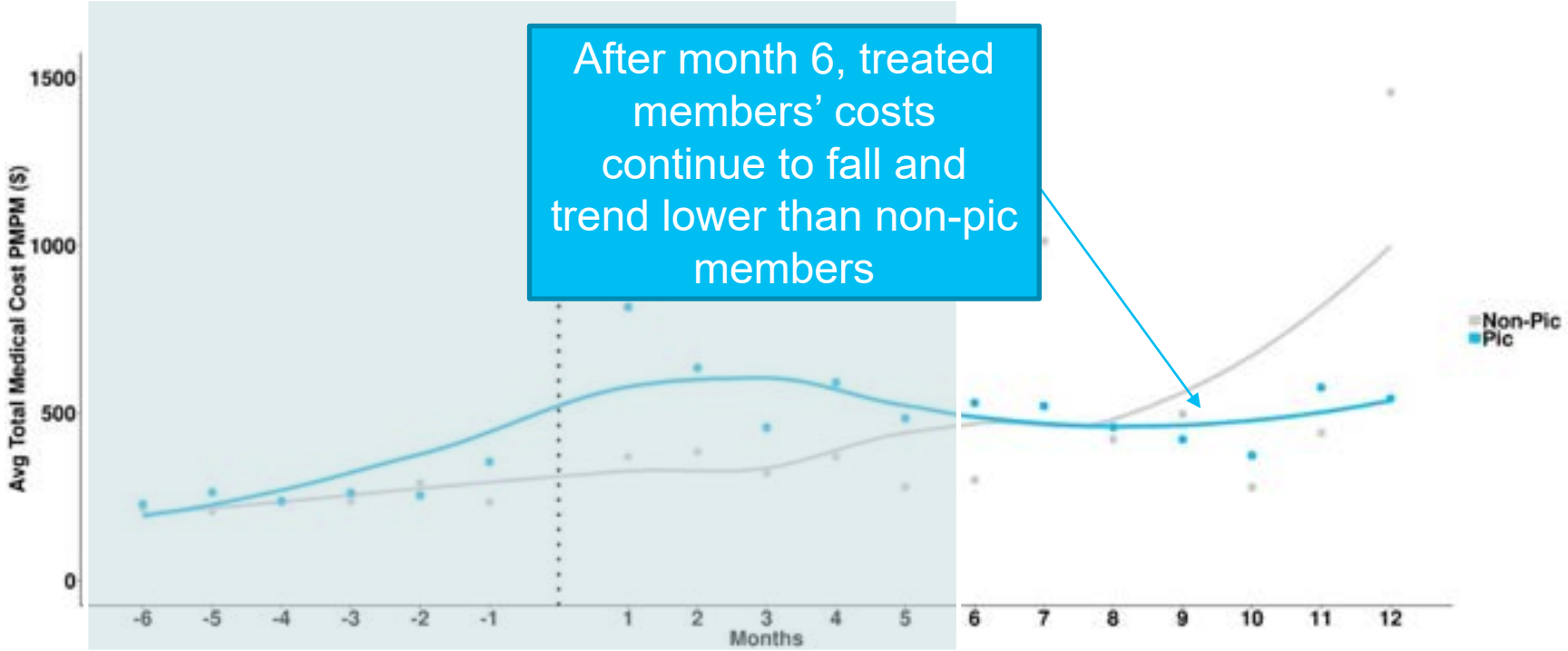


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# Cost Outcomes

| Cost Outcomes | Effect Over 12-Months |
|---|---|
| Total Medical Cost | -11% ⇩ |
| **BH** | ⇧ |
| Non-BH | ⇩ |
| Inpatient | ⇩ |
| ED | ⇧ |
| Urgent Care Center | ⇧ |
| Retail Clinic | ⇧ |
| **PCP** | ⇧ |

**Note: Significant differences in bold**

- We find that, after 12 months, total medical costs trended downward with a 11% decline (not significant)
  - At the very least there is evidence to show that after 12 months the program did not increase costs.
- It appears that a reduction in IP stays is driving down cost though partially offset by increases in primary care spending.

# Lessons Learned for the Future

# Lessons Learned

- Provider and Payer comfort and expertise with CoCM coding is essential, especially for pilot
  - EMR integration
  - Claims system
- Ongoing high-level steering to discuss leading indicators and process measures were invaluable
- Cost share should be waived when possible
- Institutional education necessary for stakeholder buy-in
- Telemed flexibility
- Communication with BH network

# Key Takeaways

- Larger samples and data from longer-term follow-up would be helpful to better characterize the effects of this intervention
- However, a comparison of members in the PIC program, compared to those in usual primary care suggests:
  - The Penn/Independence collaboration delivered:
    - Superior Behavioral Health outcomes
    - Superior Physical Health outcomes
  - This superior care was delivered
    - With more efficient use of BH provider resources
    - No significant increase in payor cost at 12-months post-intervention

# Questions?

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# Crisis services and Certified Community Behavioral Health Clinics: Keeping members well and preventing the need for higher levels of care

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Medical Director of Behavioral Health Strategy and Planning
Blue Cross Blue Shield of Michigan

# Executive Summary

- The **demand** for urgent and **crisis-based interventions** is **growing** across the country.
- **Emergency rooms** are only able to deliver **high cost, low capability services** to patients with severe acute behavioral health needs, this often results in **relapse** and a **lack of integration** with existing care models.
- Effective crisis services get the **right care at the right time to the right people.**
- Increasing **care coordination** for **members in crisis** helps **mitigate the impact of an acute crisis**; it is also an essential strategy to sustain and adjust treatment options, as needed
- **Effective** crisis management **accepts** members **where they are** and **guides** them to where they need to be
- Deploying comprehensive, sustainable crisis management supports **dynamic behavioral health** disease management by creating **care options** that include mental and physical health resources

# Extending traditional behavioral health care

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# The demand for crisis care is rising in communities throughout the United States

## Behavioral health conditions are increasingly prevalent

- **15%** of total BCBSM population has a **diagnosed behavioral health condition**
- **Rates of major depressive disorder increased among every age group** from 2014 - 2018:[1]

  ***Gen Z:*** *+76%*
  ***Millennials:*** *+45%*
  ***Gen X:*** *+44%*
  ***Baby Boomers:*** *+24%*

## Trends have been exacerbated by COVID-19

- **45% of U.S. adults** reported their mental health has been negatively impacted by COVID-19.[2]
- **65%** of **telehealth visits** have been for **behavioral health conditions** since the pandemic started.
- **13% of adults** reported **new or increased substance use** due to worry and stress over the virus.[2]

(1) BCBSA Opioid Epidemic Update, 2018; (2) KFF Implications of COVID-19 for Mental Health and Substance Use; (4) NPR, During pandemic, Fentanyl's spread made illicit drug use far more treacherous, April, 22, 2021.

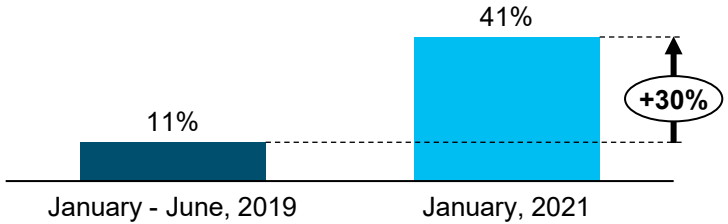
# The depth and breadth of demand for behavioral health crisis services is quickly growing

- Behavioral health crisis can be severely debilitating to patients, their families and communities
- Most of the time these episodes cannot be predicted
- Often these situations are met with delay, confusion, denial of service and even detainment
- How we manage crises creates a burden on emergency medical systems that can be prevented

## Quantifying the demand for behavioral health crisis services

- 52% of behavioral health organizations report seeing an increase in the demand for services
- 40% of all U.S. adults have reported struggling with mental health or substance use in the prior 30 days
- Nationally, among those age 18 – 24, one in 4 seriously considered suicide in the past 30 days – translating to 82.5 million people across the U.S.[1]

## Average share of adults reporting symptoms of anxiety or depressive disorder[2]




[1]The National Council for Mental Wellbeing, 2020: https://www.thenationalcouncil.org/news/demand-for-mental-health-and-addiction-services-increasing-as-covid-19-pandemic-continues-to-threaten-availability-of-treatment-options/
[2] Kaiser Family Foundation – The Implications of COVID-19 for Mental Health and Substance Use: February 2021: https://www.kff.org/report-section/the-implications-of-covid-19-for-mental-health-and-substance-use-issue-brief/

# Imagine a place….

…that could give you care for a behavioral health crisis wherever you are and at any time of day.

…where you would be immediately engaged by a behavioral health specialist for help, regardless of your needs.

…which is quiet, respectful, comfortable and confidential, yet professional and focused on addressing your needs.

…that would give you confidence that care and treatment will work… that gives you hope for the future.

# Crisis services enable individualized treatment

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# Crisis services are designed to assess clinical need, reduce symptoms and initiate treatment

The addition of **crisis services** creates an integrated continuum of care that can coordinate care over time.

Facilitating systems for varying levels of care allows provider partners to deliver the right care in the right setting and at the right time, with the goals of achieving short and long-term remission.

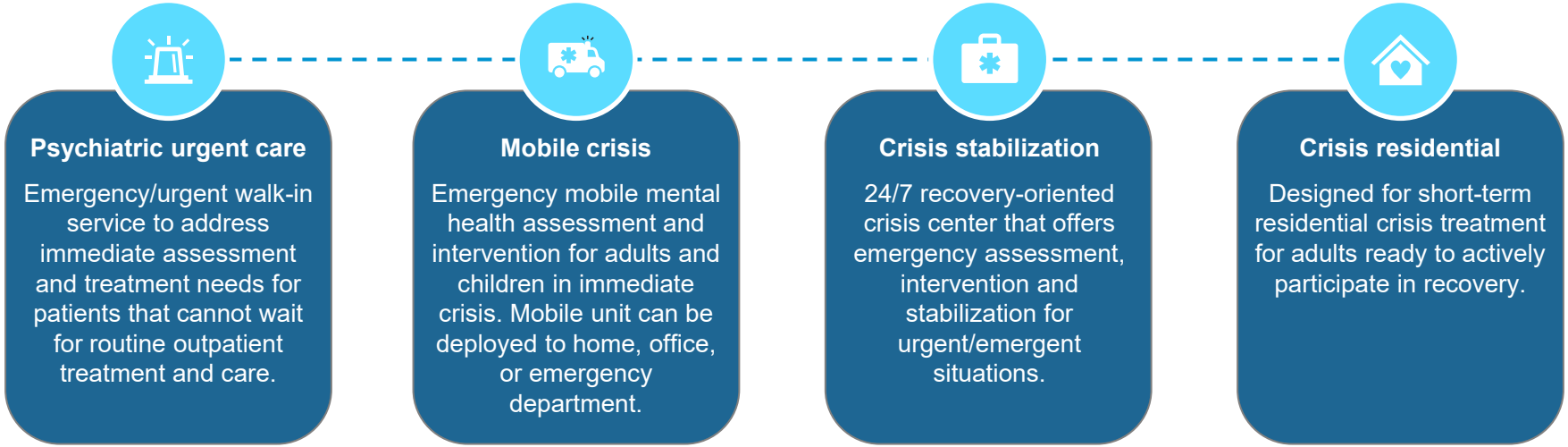
**Traditional behavioral health care**

- Continued provider care service
- Partial hospital program
- Inpatient hospital service

**Emerging crisis services**

- Psychiatric urgent care
- Mobile crisis
- Crisis stabilization
- Crisis residential

# Crisis services promoted by BCBSM include and build on national guidelines for behavioral health care




**Desired outcomes:**

- Reduce unnecessary time spent in the emergency room or hospital
- Keep patients in their homes and communities while they can receive the care they need
- Reduce the need for law enforcement intervention and the criminalization of mental illness

# Psychiatric urgent care centers offer comprehensive, walk-in services to patients who may have acute needs

- Centers offer convenient hours of operation (7 days a week, includes evening hours).
- Services include the immediate assessment and treatment for acute psychiatric symptoms.
- Additional help includes medication, support, and referral/linkage to outpatient treatment for follow-up.
- This lower acuity option creates a lower cost option reduces visits to the emergency department.

One of our provider's urgent care saw 3,000 patients in the first 6 months it opened in 2019[1]

- Two-hour average wait time throughout
- 80% avoided higher levels of care

(1) J. Dawnes. (2019, November 8). *Psychiatric urgent care serves 3,000 in six months*. Grand Rapids Business Journal.

# Mobile Crisis services support higher-need patients while decreasing emergency visits and hospitalizations

## Offering a community-based intervention to patients in need, regardless of their physical location


- Intervention is comprised of emergency mobile mental health intervention for children and adults.
- Teams assess need, reduce symptoms, begin support and transition to a least-restrictive level of care.
- Initial services include a face-to-face intervention; teams may stay connected with patients for 30 days.
- Individualized treatment plans are completed within 96 hours of service; patients are connected to the correct level of aftercare treatment.

# Crisis stabilization units stabilize and evaluate patients for appropriate treatment

- Units are open 24 hours daily and are often small, inpatient facilities of less than 16 beds; patients often receive treatment for less than 24 hours.
- Patients may be referred here from Mobile Crisis, law enforcement, other community-based services, or they may walk-in.
- Services are focused on caring for patients in a mental health crisis whose needs cannot be met safely in other settings.
- Program offers emergency behavioral health intervention services for children and adults.

# Crisis residential programs are designed for short-term stays to support patients ready to participate in recovery

- Crisis Residential care lasts an average of 7 days and helps patients stabilize, resolve problems and connect with possible sources of ongoing support.
- Services include individual, group and family therapy, therapeutic activities, psychiatric evaluation, medication administration, and peer support.
- Treatment involves multidisciplinary staff including physical and medical health physicians
- Patients may be referred to less acute crisis services or longer-term care.

# Imagine a behavioral health support structure that…

…decreases emergency department utilization for issues related to mental health, surgery or trauma.

…can become a referral source for outpatient services while supporting inpatient care behavioral health needs.

…provides an effective emergency department alternative to address social determinants of health.

…decreases physician and provider “burnout” by enabling clinicians to deliver care that focuses on their areas of practice.

# Improving access to crisis care

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# Blue Cross is spearheading crisis intervention innovation in Michigan

## Pilot crisis services

- Enables direct contracting for Mobil crisis, Crisis stabilization and Crisis residential
- Services include assessment of clinical need, reduction of symptoms, initiating treatment, launch of care management and triage to follow-up as needed via multi-disciplinary care teams
- Providers can also coordinate referrals to other levels of care as needed

## Program scope

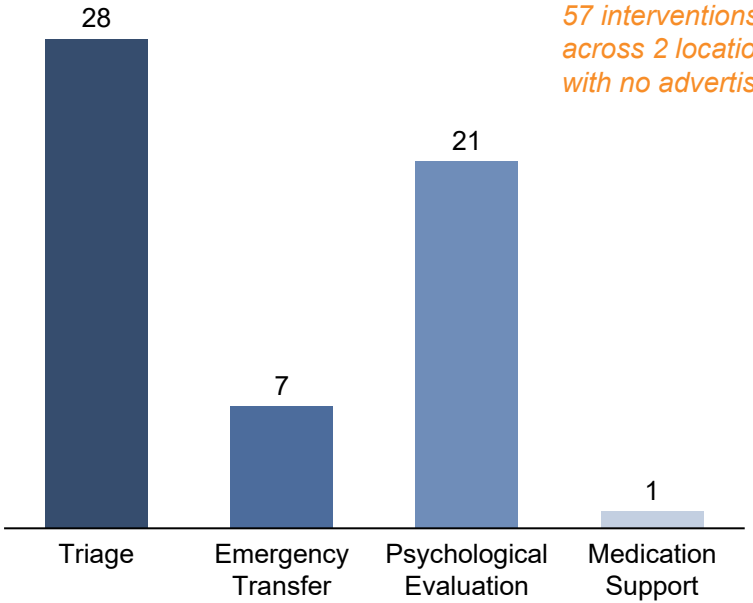
- Face to face crisis intervention
- Psychotherapy and medication support as needed
- Increasing depth of treatment depending on setting
- Mobile Crisis team Follow-up support for up to 30 days following the first intervention
- Referral to outside sources, including referrals to address Social Determinants of Health

## Partners and measurements

- Pilots occurred with two existing crisis service facilities in southeast Michigan for 12 months
- Providers affiliated with these facilities were permitted to bill for expensive medications, imaging, lab testing off  the fee schedule
- Program success was measured by the number and severity of members served and post-intervention disposition

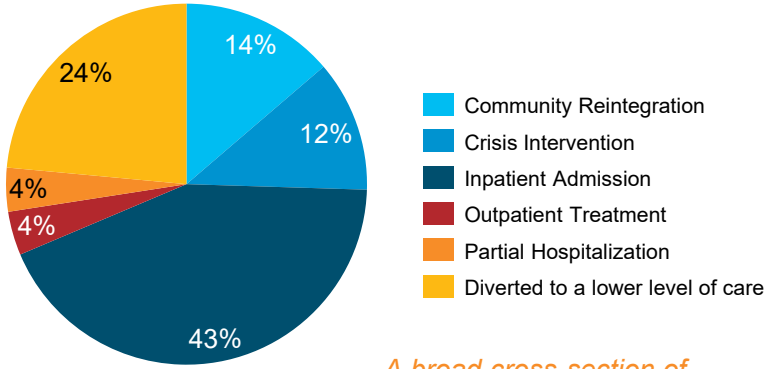
# The pilot produced success by providing the right levels of support and diverting patients to the right care setting

## Interventions offered




*57 interventions across 2 locations with no advertisement*

## Intervention outcomes




*A broad cross-section of outcomes, with a high prevalence of outpatient, lower level of care and reintegration*

# The future of crisis care

# Blue Cross has aligned with and influenced legal requirements by designing innovative crisis solutions

### The expansion of crisis services in Michigan has been underway for three years

- Blue Cross has been developing crisis services with success with HMO members.
- Effective October 2021, crisis services were expanded to include PPO members.
- BCBSM is recruiting providers for expansion focused on southeast and west Michigan. Additional expansion is also planned in the north and rural areas.

### Public Act 402

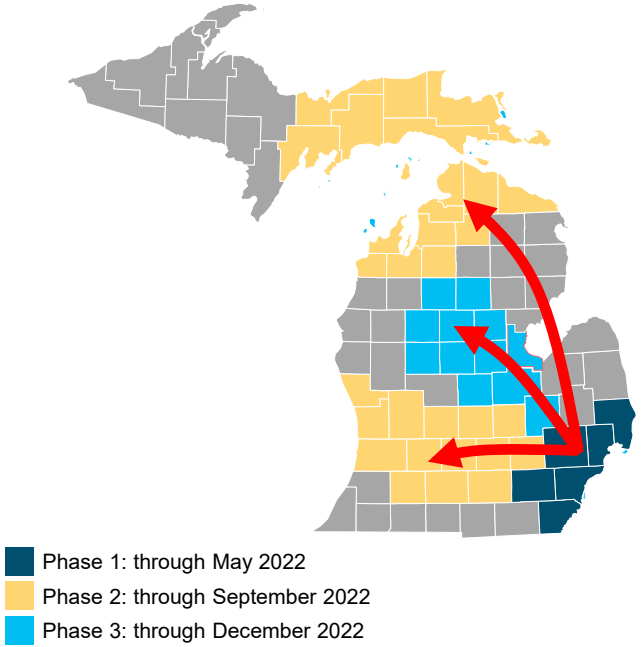
- Requires a uniform certification process and requirements for crisis stabilization units, including billing standards.
- BCBSM is part of the MDHHS Stakeholder workgroup, providing input in finalizing the guidelines and certification process.

BCBSM has representation on the **Governor's Suicide Prevention Commission** and is assisting addressing suicide and crisis prevention across the state.

# Blue Cross Blue Shield of Michigan is expanding the reach of integrated crisis services

- Multiple converging requirements are creating opportunities for Blue Cross to advance the growth of integrated crisis services
- New state requirements make expansion of crisis services easier.
- Guidance from the Substance Abuse and Mental Health Administration helps to standardize crisis care delivery nationally.
- Following extensive engagement, community health stakeholders are willing partners in the adoption of crisis services promoted by BCBSM.

## Proposed growth of integrated crisis services: 2022



# Certified Community Behavioral Health Centers
# possible next step in service delivery

# Certified Community Behavioral Health Clinics aim to be a centralized point for delivery of comprehensive services to members with chronic Behavioral Health needs

**Role and scope**

Comprehensive mental health and substance use services; regardless of the ability to pay, insured status and including active-duty military or veterans

**Eligibility**

Services are available to any person in need, including those with identified conditions; pre-existing diagnoses are not required

Key components
- Crisis services
- Outpatient services
- Case management
- Screening, assessment, diagnosis
- Primary care screening and monitoring


14 demonstration sites in MI

**Required services**

Clinics are required to provide a set of nine comprehensive services to meet diverse behavioral health needs

**Advantages**

Integrated care delivery that meets behavioral and physical needs of the patient

# Key Takeaways

- Crisis programming, especially mobile crisis and crisis stabilization can improve access for your members that need it most.
- Mobile crisis services can provide continued interventions to keep members “on track “ and triage to the correct level of care for 30 days.

# Key Takeaways

- Consider the “costs” of doing nothing” and continuing “treatment as usual”.
- Psychiatric hospitals are life saving but not everyone needs that level of care—focus on the “right level of care”.
- Certified Community Behavioral Health Clinics may be an option for future care of many patients with chronic behavioral health issues.

# Questions?

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# Thank You

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