The Colorado Health Foundation™



From Reform to the Norm?

2015 is the year when integrated care and payment overhaul begin in earnest.

If integrating behavioral and physical health, while reforming what doctors get paid for, have long been the holy grails for health system change, then 2015 may someday go down as the year the quest could claim true success.

A slow-moving but determined army of Colorado reformers — battle-hardened over years of trying preparations — has now maneuvered to a point where jobs are changing, new hires are arriving on scene, and reward checks are getting cut in support of integration and payment change.

A revolutionary form of global payment system for all of a patient's health needs is finally in place and seeing real clients on the Western Slope. More than half of for-profit giant Anthem's primary care doctors are getting paid extra to manage whole-patient health. A major federal State Innovation Model, or SIM, grant will spread best integration practices to hundreds more health locations in Colorado. A collective impact effort — recently named BC3, or Better Care, Better Costs, Better Colorado — is now aligning partners across government, philanthropy, nonprofits and business that are targeting delivery system and payment reform to speed up integration. And the massing of three-quarters of a million Colorado citizens in one Medicaid management model will produce visible savings, teachable failures, enormous piles of data and new opportunities for innovation in both integration and payment.



Axis teams meet to prepare for upcoming cases and make handoffs to the needed form of care and provider.

"So after all these years of work and talk and planning and organizing and advocating and cajoling, we're really jumping into this," said Rocky Mountain Health Plans Vice President Patrick Gordon, one of the leaders of the Western Slope global payment design and a member of the BC3 working group.

Reflecting on how long it has taken for some integration and reform efforts to move from plan to reality, Gordon added, "All of this is much harder to do than it is to talk about."

The personal and fiscal toll of keeping physical and behavioral health separate is enormous, and increasingly apparent. A Milliman study pegged the price of ineffective treatment of comorbid (concurrent) behavioral health conditions at $350 billion a year, much of it for unnecessary medical and surgical services. About 30 percent of adults with a medical condition also have a behavioral health condition, such as depression or addiction, yet many are not treated at all for the behavioral problem.

One groundbreaking, randomized study of integrating care found that patients assigned to a progressive integrated model saved more than $3,000 in total health care costs for each patient over four years. The return on investment was $6.50 for

each dollar spent, with improved outcomes.

"It's just been proven over time that the person with behavioral care problems is less compliant and costs more on the medical side," said Ken Nielsen, president and CEO of the practice management group Physician Health Partners, which has long integrated case managers and social workers and now is embedding mental health clinicians in its primary offices. Patients with behavioral issues won't take necessary prescriptions and will seek treatment through emergency room visits and overnight hospital stays far more often than needed, Nielsen said. "So if you're not treating the whole person, medical costs will go up four or five times what they should be."

Surveying the Land

In this edition of Health Elevations, we survey the terrain of integrated care and payment reform efforts in Colorado, point to the remarkable progress made so far and highlight policy changes still needed to win the long battle. From the Western Slope to Westminster, from Cortez to Colorado Springs, our reporters and writers have put together a robust picture of the state of integrated care with vivid personal illustrations.

We begin knowing that things will have changed again even before these words are printed. Knowing whether change worked is at least as tough as making the changes in the first place.

"There's a newness to all of this. It's important to recognize that not everything is supported yet by evidence," said Lorez Meinhold, formerly a top health care advisor to Gov. John Hickenlooper and now a reform consultant with the Keystone Center.

To survey the field, it's helpful to agree on a brief glossary for this edition:

Integrated care at its core is the acknowledgment — medically, psychologically and financially — that behavioral health is as much a key to overall health as are healthy eating, exercise and primary medical care. In practice, this must mean a patient's primary medical provider also manages that patient's behavioral health issues and sets up the practice to monitor and adjust for all needs. Integration, which is further defined below, can mean something as simple as a family doctor reading the chart notes from a patient's stay at a drug treatment center to something as complex as a medical practice hiring staff psychologists in-house and getting a "global payment" to directly treat all of a patient's needs. Increasingly in Colorado, it may also mean an expert behavioral health center adding medical providers on-site, an apparently effective flip side to traditional "integration." Other core providers, such as Mental Health Center of Denver, continually look for new services to round out the definition of "integrated." MHCD, which built an innovative main campus bringing Denver Health medical clinicians into its behavioral practice, also provides extensive housing and benefits connections.

Payment reform recognizes that far too much Colorado money is spent on the back end of health care — at the hospital — instead of the front end of primary medical care. The system has tilted for too long toward high payments for expensive imaging and surgery rather than the more effective but less sexy primary patient intake and office visit. Reform usually means paying the primary providers more so that they can afford to spend more time with patients, screen them for behavioral and substance problems, and hire case managers and mental health staff to fully integrate care. In the past, providers lamented "there was no billing code for that." In the innovative extreme, payment reform has a payer — a government or insurance company — writing one "global" check to a provider to handle all of a patient's needs, from strep throat to substance abuse to spinal surgery.

"You can't tinker enough with a typewriter to make it a computer. And you can't tinker enough with traditional fee-for-service to make it integrated care," said Bern Heath, CEO of Axis Health System, which has combined physical and mental health staff into single locations and practice models for southwestern Colorado.

"We've seen magic happen in our clinics," he said. "We'll look back on this in years to come as primitive, but right now we're doing stuff nobody else is doing."

Promoting Triple Aim

Before the BC3 working group aligned its targets to achieve this Triple Aim, the Advancing Care Together initiative was funded by the Colorado Health Foundation and launched in 2011. ACT chose 11 physical and mental health provider offices around the state to participate in a push for integrating care. Grant money set up a home office to select and advise the providers and to evaluate progress over three years. (Axis and others mentioned in this edition are ACT-selected sites.)

During the ACT transformation, Axis' Heath worked with federal officials from the Substance Abuse and Mental Health Services Administration's Center for Integrated Health Solutions to create a guidebook and common set of definitions. Heath's hierarchy of integration is broken into six levels:

Health's hierarchy of integration is broken into SIX LEVELS:

- **Level 1 —** Minimal Collaboration. Behavioral and physical providers are at separate locations, with separate computer systems and no regular consultation scheme. Any consultation that does occur is case-by-case, initiated by one of the providers.

- **Level 2 —** Basic Collaboration at a Distance. Still with separate locations and systems, behavioral and primary care providers consult on a more regular basis, but primarily on individual case events. Behavioral care is still considered specialty care.
- **Level 3 —** Basic Collaboration On-Site. Behavioral and primary care co-locate their offices in the same building or clinic. Computer and billing systems are still separate, but collaboration and consultation occur more regularly because of the physical proximity. Consultation is still driven primarily by a provider's initiative on a case.
- **Level 4 —** Close Collaboration with Some System Integration. Mental and physical health providers now share actual practice space, not just the same building. Their computer systems begin to talk to each other and allow cross-reading of charts. A behavioral health specialist embedded in this practice runs appointments through the main desk and can add notes to medical charts.
- **Level 5 —** Close Collaboration Approaching Integrated Practice. Teams with members across the primary and behavioral spectra meet regularly to discuss cases, but also make proactive screenings and flag issues in the day's appointments. Case managers begin to bridge any remaining gaps in care. Some medical record access issues may persist.
- **Level 6 —** Full Collaboration in a Transformed/Merged Practice. Patients walk into an office with one name that provides the full spectrum of care from all staff operating on equal levels, with all physical and behavioral appointments and charts flowing through a common system. "The principle of treating the whole person is applied to all patients, not just targeted groups" such as diabetic patients or clinically depressed patients, the guidelines note.

Source: Bern Heath, Axis Health; and federal advisories

In practice, Heath said, integrated care looks like this at Axis sites in Cortez and Durango: An overweight patient walks in, and standard Axis physical and mental health screenings reveal he is borderline obese. A traditional, isolated primary care doctor would say, "You gotta lose some weight," and then it's up to the patient. At Axis, Heath said, "We'll say, 'You need to lose weight, and here's three possible programs: diet, exercise and a support group. Which ones do you want? We'll bring you into our slightly larger exam rooms, which can fit a consultation team with a nutritionist and a physical therapist and the doctor; we'll tell you about the Tuesday night group and get you the transportation to get there.'"

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>
> Larry Green, MD

The problem remaining, Heath added, is that Axis currently loses money under these integration changes because most payers don't compensate for those moments that don't have a defined billing code. "It's great care," he said, "but care management like that is not paid for. You can't fix this by tinkering with the codes. That's like moving deck chairs on the Titanic."

A partial solution at Axis was to apply for federal community clinic status, which pays a higher reimbursement for Medicare and Medicaid cases that the clinic sees. Axis can also get a six-figure grant for treating the un- and underinsured. Axis, Heath said, is the only clinic in Colorado that's a member of both a behavioral

health and a community health association. "I can barely scrape by with that structure," he said.

Working Together

With so many forces moving forward on all fronts to integrate care and to reform the Colorado health care payment structure, broader policy changes must keep pace. An enthusiastic doctor group can hire a psychologist on staff, but can't control what Medicaid pays for a "warm handoff" to an effective counselor; a social worker might intuit that a client's painkiller addiction started with true physical mishap, but can't change a rule that denies access to checking a prescription history.

ACT's leaders are in the midst of wrap-up evaluations of their three-year work with 11 Colorado practices and will publish a series of peer-reviewed academic papers at the end of the year. Their evaluations will have one eye toward pushing policy change that can further the work of integration.

ACT leaders Larry Green, MD, and Maribel Cifuentes, RN, enumerate some of the policy changes they will be looking for:

- Synthesis of "literally thousands" of state-based laws constraining what data can be recorded and shared among practitioners and payers, crossing behavioral and physical health boundaries.
- Education and licensing reciprocity among states so that, for example, a telehealth psychologist in Maine can treat Colorado patients and be paid from in-state sources.
- Grand experimentation within the federal SIM grant to Colorado for integrating care and trying global payments for all of a patient's mental and physical needs.

- Creation of integrated care certification for medical assistants or navigators trained at the community college level, with curriculum designed from best practices learned in the various integrated care pilots.

Gordon of Rocky Mountain Health Plans adds another, one he sees the Western Slope global payment system bumping up against frequently: overlapping and conflicting measurement of patient outcomes. Each government and commercial payer has its own set of quality measures and is loath to give them up for a standardized system. One goal of collective impact efforts in Colorado, Gordon said, could be to push all Colorado payers to adopt standard measures so that providers understand their targets.

The most important lesson for 2015 that Colorado health care reformers have learned, Green said, is that the two very separate "cultural tribes" of behavioral and medical care are ready for integration when it is offered to them in well-thought-out ways.

"One thing we can say with confidence: If you give the primary care and behavioral health folks a chance to work together," Green said, "they will take it."

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