Tackling the Challenges of Behavioral Health Integration

2016 TAHFA & HFMA Lone Star – Road Show

Presented by
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Objectives

- The Problem or Prevalence
- Historical Challenges of Identifying Mental Health Patients
- The Solution is Integration
- Steps Leading to Successful Integration
- Tools & Resources
- Funding Options
- Potential Revenue
- Do’s & Don’ts
- Questions

- A list of source material and relevant behavioral health CPT billing codes are provided on pages 41 - 43.
- No patient photos or PHI have been utilized in the presentation.
The Problem or Prevalence

• Mental disorders (depression, anxiety and substance use disorders) are:
  - Associated with increased medical care costs
  - Associated with increased employer costs
  - The leading causes of disability worldwide
  - Lead to premature mortality

• 1 in 5 adults suffers from a diagnosable, treatable mental illness.

• 1 in 10 adults are diagnosed with depression.
The Problem or Prevalence – cont.

- Mental health facts:
  - 84% of time, 14 most common physical complaints have no identifiable organic etiology
  - 80% of people with a BH disorder will visit primary care at least 1x a year
  - 50% of all BH disorders are treated in primary care
  - 48% of appointments for psychotropic agents are with a non-psychiatric primary care provider
  - 67% of people with a BH disorder do not get BH treatment
  - 30 – 50% of referrals from PCP to a BH clinic do not make 1st appt.
Mental Illness & Jails

- 64% of jail inmates nationally suffer from a mental illness
- 25 – 40% of all Americans with mental illness will pass through the criminal justice system at some point
- 40-45% of Dallas County mental health patients Parkland serves get treatment services in jail
- About 68% of jail detainees struggle with addiction, compared to 18.4% of the general US adult population
- 82% of inmates from rural areas suffer from alcohol dependence
- Collin County’s mid-sized jail incarcerates an estimated 627 individuals with mental illness daily and spends over $12 million annually
- El Paso County’s large jail incarcerates an estimated 1,075 individuals with substance abuse issues daily and spends over $36 million annually

Source: April 2012 Findings Summary: Issues Facing County Jails
Individuals with behavioral health conditions frequently have co-occurring physical health conditions.

Chart 2: Percentage of Adults with Mental Health Conditions and/or Medical Conditions, 2001-2003

- 29% of Adults with Medical Conditions Also Have Mental Health Conditions
- 68% of Adults with Mental Health Conditions Also Have Medical Conditions

Anxiety disorders are twice as common as depression in primary care.

Anxiety 2x More Common

- Anxiety (N = 182): 59 (9.1%), 13 (2.0%), 32 (4.9%)%
- Bipolar: 10 (1.5%)
- Depression (N = 142): 78 (12.1%), 27 (4.2%)

Note: No mood or anxiety disorder = 423 (65.4%)

Source: Gaynes et al, Ann Fam Med 2010
Comorbid Conditions Raise Costs

Behavioral Health (BH) Comorbidities Have Significant Impact on Healthcare Costs

- Asthma and/or COPD
- Congestive Heart Failure
- Coronary Heart Disease
- Diabetes
- Hypertension

Legend:
- Green: No BH or Drug/Alcohol Abuse
- Blue: With Undiagnosed or Untreated BH and Drug/Alcohol Abuse
Comorbid Conditions Raise Costs

• National Alliance on Mental Illness estimates untreated mental illness costs the U.S. economy over **$100 billion a year.**

• Average costs for Medicaid beneficiaries with common chronic conditions increased by 3 ½ times, and hospitalization rates 4 times.

• **Milliman Research Report** looked at 10 chronic conditions and found:
  - Comorbid depression resulted in an average PMPM increase of **$505. Majority of the increase was medical costs - $400.**
  - Comorbid anxiety data analysis found total cost increase for this patient population was $651 PMPM with $538 attributed to medical care.
Across these top 9 chronic conditions, depression and anxiety go UNDIAGNOSED 85% of the time!

<table>
<thead>
<tr>
<th>Chronic Medical Condition</th>
<th>PMPM with Behavioral Condition</th>
<th>PMPM Without Behavioral Condition</th>
<th>% Treated for Depression or Anxiety</th>
<th>Expected Depression or Anxiety Prevalence</th>
<th>% Missed</th>
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</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>$871.88</td>
<td>$564.76</td>
<td>7.1%</td>
<td>32.3%</td>
<td>77.9%</td>
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<tr>
<td>Asthma</td>
<td>$861.99</td>
<td>$470.05</td>
<td>6.8%</td>
<td>60.5%</td>
<td>88.8%</td>
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<tr>
<td>Cancer (Malignant)</td>
<td>$1,180.96</td>
<td>$1,018.45</td>
<td>5.7%</td>
<td>39.8%</td>
<td>85.7%</td>
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<tr>
<td>Chronic Pain</td>
<td>$1,210.56</td>
<td>$884.70</td>
<td>5.9%</td>
<td>61.2%</td>
<td>90.4%</td>
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<tr>
<td>Coronary Artery</td>
<td>$1,305.00</td>
<td>$958.34</td>
<td>5.7%</td>
<td>48.2%</td>
<td>88.1%</td>
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<tr>
<td>Diabetes</td>
<td>$1,110</td>
<td>$828.18</td>
<td>5.2%</td>
<td>30.8%</td>
<td>83.2%</td>
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<tr>
<td>Heart Failure</td>
<td>$2,242.85</td>
<td>$1,888.11</td>
<td>7.0%</td>
<td>43.8%</td>
<td>84.1%</td>
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<tr>
<td>Hypertension</td>
<td>$880.33</td>
<td>$588.04</td>
<td>5.5%</td>
<td>30.5%</td>
<td>82.0%</td>
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</tbody>
</table>

Increased Risk of 30-day Readmission

Depression increases risk of 30-day readmission by nearly 40%.

Challenges of Comorbid Mental Illness

• Common treatments for diseases may actually worsen the comorbid condition
  ➢ Psychotropic medications can cause weight gain impacting type 2 diabetes
  ➢ Treatments for medical conditions have psychological side effects

• Self-care regimens hamper comorbid conditions
  ➢ Depression decreases motivation and energy, impacting all relationships
  ➢ Noncompliance with medical regimens are 3X greater for depressed patients
  ➢ Patients with severe mental illness often exhibit poor adherence to both antipsychotic medications and medications for medical conditions
The Dual Diagnosis Dilemma

• More than 1/3 of all alcohol abusers and more than 50% of all drug abusers are also battling mental illness.
• Drugs / alcohol can be a form of self-medication which almost always makes their condition worse.
• More than 50% of dual diagnosed patients do not receive any medical treatment of psychotherapeutic intervention and less than 5% receive treatment for both issues.
• Prescription pain killers are the biggest increase in substance use – 21% of dual diagnosed patients are addicted to prescription opiates like OxyContin, Percocet, Lortab and others.
• Americans are drinking more than they have in 25 years.
  – Binge drinking (8 drinks) is on the rise among young men and the over 65.
Shrinking Capacity

The health care system’s capacity to deliver mental health services has been shrinking.

Chart 5: Total Number of Psychiatric Units(1) in U.S. Hospitals and Total Number of Freestanding Psychiatric Hospitals(2) in U.S., 1995-2010

Note: Includes all registered and non-registered hospitals in the U.S.
(1) Hospitals with a psychiatric unit are registered community hospitals that reported having a hospital-based inpatient psychiatric care unit for that year.
(2) Freestanding psychiatric hospitals also include children’s psychiatric hospitals and alcoholism/chemical dependency hospitals.
ERs Are Overwhelmed With Mental Health Patients

A story by KCRG.com news in Iowa on Feb. 26, 2014 reported:

Psychiatric patients are now starting to depend more on emergency departments, and they’re staying longer to get the hospital help they need because ER doctors have nowhere else to send them.

“In the early 50’s, hospitals had one psychiatric bed per 300 Americans. Now, it is one per three thousand. We don’t have any beds available in our psychiatric units; we now have to make the emergency rooms our psychiatric units.”

Alan Whitters, MD, Mercy Medical Center Behavioral Health Department Medical Director

“I think once they’ve (chronic mental health patients) hit the emergency room, we’ve failed them. So we need to do a better management of chronic psychiatric conditions.”

Dr. Aucutt, Mercy Medical Center’s Medical Director of the ER
Historical Challenges of Identifying Mental Health Patients

• Behavioral and physical medicine have operated within silos
  - Culture of “our responsibility” and “their responsibility”
  - Exchange of health information is almost non-existent
  - Lack of integration inhibits whole person care

• Most PCPs are not screening every patient
  - Routine screening creates workflow challenges
  - Utilization of PHQ9 or PHQ2 may satisfy “screening” criteria, but results in an increased care burden
  - PCPs fail to recognize up to 50% of depressed patients

• Primary care providers and their staff are not comfortable with behavioral health / dual diagnosed clients

• 2/3 of PCPs reported not being able to access outpatient BH for their patients
The Solution – Behavioral Health Integration

An Integrated Health Home (IHH) is a team of professionals working together to provide both **medical** and **behavioral** health services (ideally) in one convenient location using a patient-centered, team-based approach focused on improving the client’s overall well-being.
Integration Improves Access

Integration of behavioral and physical health care can improve access to appropriate care.

Chart 8: Receipt of Preventive Care Services in 12 Months among Patients with Serious Psychiatric Illness Receiving Integrated Care vs. Patients Receiving Usual Care

Coordinated Care Reduces Costs

Coordination of care can reduce costs for individuals with behavioral health conditions.

Chart 9: Total Costs at 1 and 2 Years for Patients with Serious and Persistent Mental Illnesses Receiving a Medical Care Management Intervention vs. Usual Care

Coordinated Care Reduces Costs

- 15.7% decrease in medical care use when receiving BH services vs a 12.3% increase for controls with no BH services
  - A 28% difference!
- Diabetics with treated depression had $896 lower total costs over 24 months
- Primary care depression patients who received BH treatment had a $3,300 lower total cost over 48 months
- Annual medical expenses for dual diagnosed patients cost 46% more than those with only a chronic medical condition
- Depression is the #1 driver of overall health cost (work related productivity + medical + pharmacy)
A review of claims data from more than 3,000 Integrated Health Home (IHH) members over a six month period as compared to the same period the previous year before integration highlights the effectiveness of integrated programs:

**Mental Health**
- Emergency Dept. claims reduced by 16%
- Inpatient claims reduced by 18%

**Medical Health**
- Emergency Dept. claims reduced by 12%
- Inpatient claims reduced by 16%
Behavioral Health & NCQA PCMH 2014 Recognition

- Behavioral health (BH) elements for NCQA PCMH 2014 recognition:
  - **Element 3C** – Comprehensive health assessment that includes depression screening for adults and adolescents using a standardized tool
  - **Element 3E** – Implement evidence-based decision support including for mental health or substance use disorder
  - **Element 4A** – Identify patients for care management including for BH conditions
  - **Element 5B** – Referral tracking and follow-up including maintaining agreements with BH providers and integrating BH providers within the practice site

www.ncqa.org
Where Integration is Happening

http://integrationacademy.ahrq.gov/ahrq_map
Steps Leading to Successful Behavioral Health Integration

- Explain WHY – “what’s in it for me and my patients? What’s required of me?”
- Educate practices on concepts common to all models of integrated care, lexicon use and motivational interviewing
- Review models of integrated care and identify current state vs ideal state
- Select integration goal and create a shared vision
- Determine approach – vertical or horizontal
  - **Vertical** - all patients get screened for depression
  - **Horizontal** - a defined population gets screened (comorbid / complex)
- Select appropriate screeners (people & tools)
- Determine metrics
- Define care team roles and responsibilities
- Implement and continually assess and modify (PDSA cycle)
Concepts Common to All Models of Integrated Care

• Patient tracking and registry functions
• Use of non-physician staff for care management
• The adoption of evidence-based guidelines
• Patient self-management support and tests (screenings)
• Referral tracking
• Training staff on motivational interviewing
# Basic Scale of Integration

## Scale of Behavioral Health Integration

### Coordination

**Characteristics:**
- Referrals
- Separate treatment plans
- Some information sharing
- Separate responsibilities for care

### Co-Location

**Characteristics:**
- Greater communication
- Warm hand-offs
- Informed plans/sharing of treatment information
- Targeted collaboration for specific patients
- Separate treatment plans, but same location

### Integration

**Characteristics:**
- Consistent screening & Use of treatment guidelines
- Collaboration for ALL or most patients
- Information sharing and co-management of treatment
- One treatment plan
- Team-based care approach

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**Coordination =**
- Leadership – Fully engaged team in 1st step.
- Rented space to therapist
- Focused work flow on depression screening and warm referral hand-offs
- Staff trained on screening and use of screening tool
- Financially sustainable (rental fees)

**Co-Location =**
- Leadership – Enrolled in P4P (Pay-for-performance)
- Billed for services where possible; covered services where needed as BH issues are recognized as barrier to physical health improvement
- Financially sustainable (billing & P4P incentives)

**Integration =**
- Leadership – Enrolled in shared savings program
- Hired therapist to work full time onsite
- Broadened services provided
- Financially sustainable (billing, P4P and shared savings incentives)

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Source: HealthTeamWorks
### SAMHSA-HRSA’s Six Levels of Collaboration / Integration

<table>
<thead>
<tr>
<th>COORDINATED</th>
<th>Key Element: Communication</th>
<th>CO-LOCATED</th>
<th>Key Element: Physical Proximity</th>
<th>INTEGRATED</th>
<th>Key Element: Practice Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LEVEL 1</strong></td>
<td>Minimal Collaboration</td>
<td><strong>LEVEL 2</strong></td>
<td>Basic Collaboration at a distance</td>
<td><strong>LEVEL 3</strong></td>
<td>Basic Collaboration Onsite</td>
</tr>
<tr>
<td><strong>LEVEL 4</strong></td>
<td>Close Collaboration Onsite</td>
<td><strong>LEVEL 5</strong></td>
<td>Close Collaboration Approaching an Integrated Practice</td>
<td><strong>LEVEL 6</strong></td>
<td>Full Collaboration in a Transformed / Merged, Integrated Practice</td>
</tr>
</tbody>
</table>

#### Behavioral health, primary care, and other health care providers work:

| In separate facilities, where they: | In separate facilities, where they: | In same facility not necessarily same offices, where they: | In same space within the same facility, where they: | In same space within the same facility (some shared space), where they: | In same space within the same facility, sharing all practice space, where they: |

- **Have separate systems**
- **Communicate about cases only rarely and under compelling circumstances**
- **Communicate, driven by provider need**
- **May never meet in person**
- **Have limited understanding of each other’s roles**

- **Have separate systems**
- **Communicate periodically about shared patients**
- **Communicate, driven by specific patient issues**
- **May meet as part of a larger community**
- **Appreciate each other’s roles as resources**

- **Have separate systems**
- **Communicate regularly about share patients, by phone or e-mail**
- **Collaborate, driven by need for each other’s services and more reliable referral**
- **Meet occasionally to discuss cases due to close proximity**
- **Feel part of a larger yet ill-defined team**

- **Share some systems, like scheduling or medical records**
- **Communicate in person as needed**
- **Collaborate, driven by need for consultation and coordinated plans for difficult patients**
- **Have regular face-to-face interactions about some patients**
- **Have a basic understanding of roles and culture**

- **Actively seek system solutions together or develop work-arounds**
- **Communicate frequently in person**
- **Collaborate, driven by desire to be a member of the care team**
- **Have regular team meetings to discuss overall patient care and specific patient issues**
- **Have an in-depth understanding of roles and culture**

- **Have resolved most or all system issues**
- **Communicate consistently at the system, team, and individual levels**
- **Collaborate, driven by shared concept of team care**
- **Have formal and informal meetings to support integrated model of care**
- **Have roles and cultures that blur or bend**
Care Management Structure

• **ACO Care Management** – some hiring a BH case manager and others creating care management teams that include:
  – Nurse care manager
  – Behavioral health care manager (LMSW)
  – Health coach

• **Practices** – hiring their own BH staff and/or co-locating someone at their site or sharing resources and revenue

• **Chronic Care Management Programs** – incorporating behavioral health screening tools

• **Community Resources** –
  – Identify local BH community resources
  – Establish a Community Care Coordination Team to meet the needs of high risk patients in the community
Collaborative Care Model or Team Approach

![Diagram of Collaborative Care Model](http://uwaims.org)
Behavioral Health Professional Shortage

- 55% of U.S. counties have no mental health professionals.
- There are approximately 4,000 Mental Health HPSAs (Health Professional Shortage Areas) in the U.S. based on a psychiatrist to population ratio of 1:30,000. It would take approximately 2,800 additional psychiatrists to eliminate this shortage.
- Merritt Hawkins, a physician search firm, conducted more searches for psychiatrists in 2015 than at any time in its 27-year history. Number three (3) on its top 20 specialty search list just behind primary care and internal medicine.
- No increase in federally funded residency slots to train physicians, despite provider groups pushing hard for this for more than 15 years.

*Texas got a “D” by the National Alliance on Mental Illness because Texas spends just $39 per capita on mental health services; the national average is $125. That puts Texas 49th out of 50 states.* (Source: 2013 Dallas News)
**Best & Worst Access to Behavioral Healthcare**

**Taking Care**
How Mental Health America, a patient advocacy group, ranks the states on access to care, from best to worst. The ranking reflects measures including access to insurance, access to treatment, quality and cost of insurance and access to special education.

### Best 10
1. Vermont
2. Massachusetts
3. Maine
4. Delaware
5. Iowa
6. North Dakota
7. Pennsylvania
8. Minnesota
9. South Dakota
10. District of Columbia

### Worst 10
42. Idaho
43. South Carolina
44. Florida
45. Georgia
46. Arizona
47. Texas
48. Louisiana
49. Alabama
50. Mississippi
51. Nevada

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**42.5 million**
Number of adults in the U.S. who have mental illness (18% of adult population)

**1:790**
Ratio of mental-health providers to people in the U.S.

**41%**
Share of people with mental illness who report receiving treatment

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Source: Mental Health America

THE WALL STREET JOURNAL
SAMHSA-HRSA Center for Integrated Health Solutions has a list of screening tools you might consider including:

**Anxiety & Bipolar Disorders:**
- GAD-7 – Generalized Anxiety Disorder – a 7-question screening tool
- PC-PTSD – a 4-item screen designed to screen for PTSD and used by VA
- MDQ - The Mood Disorder Questionnaire – 13 questions associated with bipolar disorders

**Depression:**
- Patient Health Questionnaire (PHQ-2 & PHQ-9)

**Drug & Alcohol Use:**
- SBIRT – Screening, Brief Intervention, and Referral to Treatment
- AUDIT – Alcohol Use Disorders Identification Test – 10 items
- CAGE AID – a commonly used, 5-question tool
- DAST-10 – Drug Abuse Screen Test is a 10 item yes/no self-report

A Cloud-based Solution

Cloud-based, HIPAA compliant, patient engagement tool allows provider-directed testing, screening and at-home monitoring for common medical conditions clinicians face today.

Main CPT code – 96103

<table>
<thead>
<tr>
<th>ADULT Reimbursable</th>
<th>PEDIATRIC Reimbursable</th>
<th>SCREENINGS Free</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Depression</td>
<td>• Depression</td>
<td>• Allergy</td>
</tr>
<tr>
<td>• ADHD*</td>
<td>• ADHD*</td>
<td>• Eating Behavioral Panel (UNFAT/FIT Index)</td>
</tr>
<tr>
<td>• Anxiety GAD</td>
<td>• Pediatric Behavior Panel:</td>
<td>• Exercise History</td>
</tr>
<tr>
<td>• Anxiety Panel:</td>
<td>- Anxiety GAD</td>
<td>• Dieting History</td>
</tr>
<tr>
<td>- OCD</td>
<td>- Bipolar</td>
<td>• Hormone Symptom Inventory (Female and Male)</td>
</tr>
<tr>
<td>- Panic</td>
<td>- Conduct Disorder</td>
<td>• Pain Inventory*</td>
</tr>
<tr>
<td>- Social &amp; Performance</td>
<td>- Disruptive Mood</td>
<td>• Prostate Impact Score (PIS)</td>
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<tr>
<td>- Anxiety</td>
<td>- Dysregulation Disorder</td>
<td>• Weight Loss Monitor</td>
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<tr>
<td>- PTSD</td>
<td>- Oppositional Defiant Disorder</td>
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</tr>
<tr>
<td>• Bipolar</td>
<td>• Suicidal Thoughts or Plans *</td>
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<tr>
<td>• Distress</td>
<td></td>
<td></td>
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<tr>
<td>• Eating Disorders Panel</td>
<td></td>
<td></td>
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<tr>
<td>• Substance Abuse &amp; Misuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Suicidal Thoughts or Plans *</td>
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<td></td>
</tr>
</tbody>
</table>

* Easily incorporated into the CCM care plan – especially since they are free.
# Key Practice Benefits To Cloud-based Testing

| TRANSITION | Assists in the transition from episodic to longitudinal care. Addresses ACO Quality Measure #18 and NCQA requirement for PCMH mental health integration. |
| MONITOR | Incorporated clinical decision support allows easy identification of high-impact patients and provides alerts to screen. Thoroughly track, monitor, and report on care delivered to this population. |
| ECONOMICAL | Economical way to collect patient health data without further burden to limited medical staff resources. |
| AUTOMATE | Automates the process to meet state medical boards’ compliance guidelines for prescribing controlled substances for pain, anxiety, weight loss and ADHD. |
| IMPROVE | Improves the clinic workflow and patient experience. |
| ENGAGE | Engages patients through technology to deliver better care. |
| REVENUE | In addition to revenue from mental health testing, capture ancillary revenue through test results and recommendations. |
Screening Protocol

Screening needs to become a standard workflow process on every patient and/or have testing prompted based upon clinical criteria or gaps in care.
• Telemental health was attributed with a **25% decrease of inpatient admissions** according to a 4-year study (2006 – 2010) by the U.S. Department of Veterans Affairs (VA).

• Research has demonstrated telepsychiatry treatment through videoconference was **as effective to in-person psychiatric treatment**, and an effective means to delivering mental health services to psychiatric outpatients living in remote areas with limited resources.

Medicaid is the single largest payor of mental health services in the U.S., accounting for 26% of the total national mental health care spending.
**How to Fund Behavioral Health Integration**

- **Federal funding (1115 Medicaid Demonstration Waivers)**
  - Each state must apply for the 1115 waivers.
  - Funds allocated at the state level

- **Grant funding**
  - Foundations & Research grants
  - State Innovation Models (SIM) or State initiatives (CO, IA, IL, OR, PA are just a few)
  - Transforming Clinical Practice Initiative (TCPI) grants (39 recipients nationwide)

- **CMS MSSP Investment Model**
  - CMS providing grant dollars to assist more rural ACOs with less than 10,000 beneficiaries to invest in infrastructure necessary to successfully implement population care management.
  - 2015 Medicare Care Coordination fee **$40.39 per month per qualifying patient** to coordinate the care of those with chronic diseases that include diabetes, heart disease, and depression.
    *contingent upon practices addressing patients’ psychological and social needs

- **Revenue Generation / Self-funding**
  - BH staff/PCP share overhead expenses and revenue from reimbursements and cash
    - Traditional BH services and med management
    - Other services - biofeedback, support groups, group appointments, and education codes
### Behavioral Health Testing Revenue Potential

#### Average PCP Clinic BHI Testing Scenario:
- Average US PCP has 3279 unique patients
- All patients screened 1X per calendar year for depression/anxiety
- $\frac{1}{4}$ patients will have mental illness and will receive a 2\textsuperscript{nd} test in same year
- $\frac{1}{2}$ of these patients with mental illness will receive a 3\textsuperscript{rd} test in same year
- $\frac{1}{8}$ of these patients with mental illness will receive a 4\textsuperscript{th} test in same year

<table>
<thead>
<tr>
<th># of Tests</th>
<th>Total tests per PCP per calendar year</th>
</tr>
</thead>
<tbody>
<tr>
<td>= 3279</td>
<td></td>
</tr>
<tr>
<td>= 819</td>
<td></td>
</tr>
<tr>
<td>= 410</td>
<td></td>
</tr>
<tr>
<td>= 103</td>
<td></td>
</tr>
<tr>
<td>= 4611</td>
<td></td>
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#### Estimated Annual Cost Per Provider
- $200$ monthly per provider license fee X 12
- $4.50$ per test fee X 4611 tests

<table>
<thead>
<tr>
<th>Expense</th>
<th>Costs per provider per calendar year</th>
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<tbody>
<tr>
<td>= $2,400</td>
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<tr>
<td>= $20,749.50</td>
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</tr>
<tr>
<td>= $23,149.50</td>
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</tbody>
</table>

#### Annual Revenue to Average PCP
- 100% Medicare patients = $\textbf{11.89 profit per test}$
- 30% Medicare / 70% Commercial patients = $\textbf{15.13 profit per test}$

<table>
<thead>
<tr>
<th>Annualized Revenue</th>
<th>Annual Profit Per PCP</th>
</tr>
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<tbody>
<tr>
<td>= $54,844.88</td>
<td>= $31,695.38</td>
</tr>
<tr>
<td>= $69,771.68</td>
<td>= $46,622.18</td>
</tr>
</tbody>
</table>

#### Net Profit
- 100% Medicare patients
- 30% Medicare / 70% Commercial patients
### Do’s & Don’ts When Integrating

**Do:**
- Understand the clinic culture and get buy in from providers and staff
- Meet practices where they are
- Interview multiple BHI staff to find one that fits. Might have to try several.
- Create provider “registries” for BH or PCPs if not co-located
- Plan for an “every door” access model
- Utilized a phased approach
- Provide tools & resources to practices
- Utilize community resources
- Look for ways to decrease care delivery burdens through
  - Planning and work-arounds
  - Workflow efficiencies
  - Automated processes
  - Centralized care coordination
  - Proactively get HIPAA consents

**Do not:**
- Expect a culture of willingness
- Try a one-size-fits all approach
- Expect BHI staff to do brief therapy
- Expect your billing staff to correctly code BHI
- Implement throughout ACO 1st – get bugs worked out in smaller cohort
- Feel like you have to do it all or start from scratch
- Overlook community resources
- Select tool or BH strategy without input from providers
- Tackle too much at once – phased and steady approach is best
- Expect practices to pay for it themselves or do BH integration without some resources or funding
- Overlook increased care burdens for increased screening
Questions & Answers

Thank you for your time and interest!

Please let me know if you have any additional questions.

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C: 214-681-2987
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To learn how KPN Health’s clinical decision support tools (medical and behavioral) and quality improvement dashboards drive performance improvement and generate additional revenue, please contact me and/or visit our website at www.kpnhealth.com
References / Sources

• Trend Watch, American Hospital Association. “Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes,” January 2012

• Boyd et al. Faces of Medicaid: Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services. Center for Health Care Strategies, Dec 2010


• Center Family Systems Medicine 1995, 13, 283-298


• DiMatteo MR, Lepper HS, Croghan TW. “Depression is a risk factor for noncompliance with medical treat
References / Sources - Continued

- Accountable Care Organization 2013 Program Analysis, CMS, 2013
**Relevant Behavioral Health CPT Billing Codes**

<table>
<thead>
<tr>
<th>Description</th>
<th>Commercial (CPT)</th>
<th>Medicare (HCPCS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Code</td>
<td>Estimated Reimbursement</td>
</tr>
<tr>
<td>Psychological testing, administered by a computer, with qualified health care professional interpretation and report.</td>
<td>96103</td>
<td>$ 40.00</td>
</tr>
<tr>
<td>Brief emotional/behavioral assessment with scoring and documentation</td>
<td>96127</td>
<td>$ 6.00</td>
</tr>
<tr>
<td>Administration and interpretation of health risk assessment instrument (e.g. diet history and exercise history)</td>
<td>99420</td>
<td>$ 15.00</td>
</tr>
<tr>
<td>Alcohol / substance abuse structured assessment and brief intervention, 15-30 min</td>
<td>99408</td>
<td>$ 33.00</td>
</tr>
<tr>
<td>Health and behavior assessment (e.g. health-focused clinical interview, behavioral observations, psychological monitoring, health-oriented questionnaires) each 15 min face-to-face with the patient; initial assessment (must utilize a non-psych, somatic physical medicine ICD-9)</td>
<td>96150</td>
<td>$ 20.00</td>
</tr>
<tr>
<td>Annual depression screening, 15 min</td>
<td>99420</td>
<td>$ 15.00</td>
</tr>
<tr>
<td>Annual alcohol screening, 15 min</td>
<td>99420</td>
<td>$ 15.00</td>
</tr>
<tr>
<td>Brief face-to-face behavioral counseling for alcohol misuse, 15 min</td>
<td>99401</td>
<td>$ 15.00</td>
</tr>
<tr>
<td>Positive screen for clinical depression using a standardized tool and follow-up plan documented</td>
<td>99420</td>
<td>$ 15.00</td>
</tr>
<tr>
<td>No documentation of clinical depression screening using a standardized tool</td>
<td>99420</td>
<td>$ 15.00</td>
</tr>
</tbody>
</table>