

## Sample Initiatives for SHIP Implementation Consideration

Based on the best/better practice(s) identified by the transformation teams, two recommendations were selected for further analysis of what would be required to pursue these strategies incrementally and as initial implementation pilots, including how to connect the transformation recommendations to the essential enablers of measurement, payment, and health information technology.

1. Expand behavioral health and primary care integration
2. Patient engagement and activation (i.e. chronic disease and diabetes self-management)

### **Expand behavioral health and primary care integration**

1. Identify and describe the initiative and how it aligns with the recommendations from the SHIP workgroups
  - a. One in four individuals experiences a behavioral health illness each year. The majority of these individuals have moderate to high levels of comorbid conditions such as diabetes and receive healthcare services without having their underlying behavioral health illness addressed. These individuals report significant symptoms of anxiety and depression as well as increased levels of moderate to severe distress. They also experience high rates of emergency room utilization for depression.

Recent legislation, including components of the Affordable Care Act, have reduced the lack of parity in insurance coverage between behavioral health illness and physical illness, but access to care has not dramatically increased. Untreated behavioral health conditions, e.g., depression and anxiety, prevent individuals from properly managing a chronic condition and can worsen physical symptoms. These individuals often return to the doctor with problems related to the untreated behavioral condition.

The SHIP Behavioral Health Workgroup has recommended a variety of primary care and behavioral health integration models receive support. The models include behavioral health consultations, co-location of behavioral health and primary care providers, and fully integrated care teams that provide behavioral health services as a routine part of physical care.

Some healthcare organizations have begun to integrate behavioral health professionals on care teams through models such as DIAMOND (Depression Improvement Across Minnesota, Offering a New Direction). This approach allows patients to receive services for depression care in primary care clinics from an integrated care team that features a physician, care manager, and psychiatrist. This model is also known more generically as “collaborative care” for patients with depression.<sup>i</sup>

Other organizations have adopted models that provide primary care physicians with strategic access to psychiatrists and other mental health providers as consultants on an as-needed basis. The consultations allow physicians to better support those patients who don't make progress or have serious mental illnesses. Consultations support the behavioral health needs of patients while addressing restrictions on the types of services that primary care physicians can bill for and low reimbursement rates.

Supporting a variety of primary care and behavioral health integration models helps healthcare organizations, physician practices, purchasers, and payers better and more completely address the needs of patients. It also helps advance the goal to achieve greater value in healthcare faster by better aligning efforts and incentives to deliver better care at lower costs.

2. Describe how the SHIP leadership and backbone organization could engage the population/community to support the pilot; what would be the role of the community vs. the role of steering/backbone?
  - a. The SHIP leadership and backbone organization could facilitate the establishment of a peer to peer learning network composed of payers/purchasers/community agencies and public health programs who are already focused on this population and who may already have initiated similar work. Similarly the leadership and backbone organization could reach out to specific communities (e.g. Milwaukee and Menominee Counties) where prevalence/incidence is disproportionately high.
  - b. The SHIP backbone organization could facilitate the acceleration of education, dissemination, adaptation and adoption of the SHIP best and better practices related to the integration of primary care and behavioral health services by bringing the payer/purchaser/providers and the community partners together to learn, share and connect with one another on how specific transformation/care delivery components (based on the SHIP recommendations), along with the enabling (measurement, HIT and payment) components are being successfully implemented.
  - c. The backbone organization would act as organizer, administrator and connector to help the communities form local collaborative partnerships to support implementation and monitoring of the pilot initiative.
  - d. The backbone organization would provide technical assistance in the form of supporting data and fact finding, best/better practice identification, dissemination, and training.
  - e. The backbone organization could facilitate a review of measurement best practices in the area of integrating behavioral health and primary care, such as Intermountain Health, and work with leadership to select some measures to monitor and test across the selected communities.

3. Describe the anticipated opportunities and outcomes in terms of improved health and healthcare, and smarter spending
  - a. From the SHIP Key Findings Report:
    - i. Reduce avoidable resource utilization and cost
      1. WHIO data indicate about 60 percent of persons with depression and diabetes take at least nine medications. (page 17)
      2. WHIO data shows variation in filling prescriptions for medications throughout the state, but overall compliance is high. Whether patients took medications appropriately after receiving them is unknown. (page 18)
      3. WHAIC data shows patients in the selected populations are treated and released from the ER significantly less. Additionally, percentages representing patients in the selected populations are double or more than double. (page 19)
      4. WHAIC data shows when they visit the hospital, persons with depression and diabetes stay longer on average than other Wisconsin patients. (page 20)
    - ii. Reduce associated societal costs - according to the CDC's Chronic Disease Cost calculator, absenteeism due to depression among Wisconsinites 18 to 64 costs \$137 million annually. (page 22)

**Patient activation and engagement (e.g., chronic disease self-management, diabetes self-management)**

1. Identify and describe the initiative and how it aligns with the recommendations from the SHIP workgroups
  - a. In chronic disease self-management programs, people with a specific chronic disease (e.g. diabetes), or multiple chronic diseases, attend disease self-management training workshops in a community setting. Subjects may include medication usage, nutrition, exercise, communicating with family and health professionals, social support and mental health, navigating clinical care, and health behaviors.
  - b. The SHIP recommends that health care providers work with health plans, payers, employer plans sponsors, Medicaid, and community-based organizations to offer these programs, including encouraging employers, Medicaid, and insurers to include these programs as a covered benefit. Health care providers should screen patients for appropriateness for referral to evidence-based chronic disease self-management programs and make direct referrals to these programs for two reasons: a) health care providers and payers can improve clinical outcomes, reduce complications, and avoid costs by partnering to offer these proven programs; and b) referral recommendations of health care providers are trusted by patients. CDC research has confirmed that provider referrals increase participation.

The workgroups expect chronic disease self-management programs will increase patients'/consumers' active participation in their health and health care by connecting patients with others, teaching them self-management skills, and empowering them to improve their health. The selected populations exercise less frequently than other Wisconsinites, are more likely to smoke, and have higher rates of obesity, than the population in general. They also have lower educational attainment and incomes. The workgroups are confident that improving people's capacity to manage their own chronic conditions will help them improve their health.

2. Describe how the SHIP leadership and backbone organization could engage the population/community to support the pilot; what would be the role of the community vs. the role of steering/backbone?
  - a. Chronic disease self-management programs are an evidence-based strategy to improve health, reduce symptoms and avoid complications from common chronic diseases. They have been proven to reduce unnecessary health care expenditures as well as improve individuals' productivity and functioning with their families and in the workplace. Despite this strong evidence base and the direct connection between CDSMPs and improved healthcare outcomes, this is an example of a community-based health improvement strategy that is not yet well integrated into healthcare delivery and payment. Accordingly, the workgroups recommend that SHIP implementation expand

the identification, in clinical settings, of those who would benefit from participation in a CDSMP, along with referrals of appropriate patients to, and enrollment in, these programs.

- b. Leaders of SHIP implementation, including the steering committee/backbone organization, can support implementation in the following ways:
  - i. Convene partners including, e.g., MetaStar, Wisconsin Hospital Association (WHA), Wisconsin Medical Society (WMS), Wisconsin Collaborative for Healthcare Quality (WCHQ) and the Wisconsin Institute on Healthy Aging (WIHA) to create a plan to expand availability of chronic disease self-management courses across Wisconsin.
  - ii. Work with partners (as noted above) to jointly sponsor a learning session to encourage providers to recommend these courses. MetaStar is currently working with WIHA to increase the number of Diabetes self-management programs and referrals of primary care providers and likely would have resources to support an initial joint learning session.
  - iii. Encourage health benefit plan sponsors, including ETF and Medicaid, to include self-management courses as covered benefits for eligible patients/members.
  - iv. Facilitate the development of a learning forum for providers and payers who have offered CDSMPs with practical strategies for covering the costs and tracking health outcomes/cost avoidance.
  - v. SHIP implementation leaders/backbone organization could partner with a clearinghouse/statewide central organization such as WIHA to serve as the state license holder for these programs, provide leader trainings, provide support to program leaders, provide technical assistance to sponsoring organization, conduct evaluation and continuous quality improvement, and use learnings to inform development of additional evidence-based disease management interventions.
3. Describe the anticipated opportunities and outcomes in terms of improved health and healthcare, and smarter spending
  - a. Stanford's Chronic Disease Self-Management Program (CDSMP) and its Diabetes Self-Management Program (DSMP) have been proven to: reduce hospitalizations, emergency department visits, health distress, fatigue, disability, and patient limitations, and to increase exercise and self-efficacy and improve symptom management, communication with physicians, and self-reported health status.<sup>ii</sup> In some circumstances, CDSMP and DSMP can reduce depression symptoms among those with or without depression, whether delivered in small groups or online.<sup>iii</sup> CDSMP appears to reduce costs through averted hospitalizations and emergency department and physician visits.<sup>iv</sup>

These data yield a cost to savings ratio of approximately 1:4, depending on class size and local costs and savings. Many of these results persist for as long as three years. It is clear that some of these savings will accrue to healthcare payers and providers; it is also clear that some of the benefit should accrue to employers, given that the SHIP focuses on the working-age, 18-64 year old population. There is, therefore, widespread potential benefit to Wisconsin residents, as well as their families, their employers, their health care providers and payers, and the state Medicaid program, from more widespread offering of these programs.

## **Measurement**

1. Describe the measurement that would be leveraged to track progress on identified initiatives
  - a. Expand behavioral health and primary care integration
    - i. Best practices would be gathered to identify appropriate measures.
    - ii. The backbone organization could convene a measurement workgroup to assess and recommend measures for the selected communities.
    - iii. The backbone organization would work with each community to identify a data and measurement plan specific to their interventions but that had line of sight to the state and national goals.
  - b. Patient engagement and activation (i.e. chronic disease self-management)
    - i. The patient activation measure (PAM) is recommended for this strategy.
    - ii. Leadership could work with Medicaid or ETF to facilitate a discount on PAM licenses to begin testing and deploying this measure in the selected communities and with Medicaid practices.
    - iii. The backbone organization would work with each community to identify a data and measurement plan specific to their interventions but that had line of sight to the state and national goals.

## **Payment Models**

1. Describe the value-based payment models that would be leverage to support the identified initiatives

- a. Behavioral Health and Primary Care Integration

In general, the SHIP recommends that health care providers and payers negotiate care coordination payments and pay for performance incentives, to cover the cost of implementing the SHIP recommended strategies. The Payment Models workgroup felt that, where providers and payers have not already moved fully to value based payment

models such as global payments, care coordination payments and P4P can provide flexible resources to primary care practices to cover the aspects of PC/BH integration that cannot easily be billed in the current environment.

The SHIP Payment Models Workgroup also concluded that there are many existing mechanisms to cover services of licensed behavioral health professionals in an integrated primary care/behavioral health model. The more difficult challenges surround time spent in provider to provider consultation, provider to patient consultation that is informal or otherwise falls short of a billable encounter, and services of health navigators and health educators who may not be authorized to bill under certain payers or purchaser contractual limitations. Care coordination payments and P4P provide a bridge to ensure that these services can be offered.

In addition, valuable lessons can be learned from the DIAMOND project in Minnesota, where a PMPM payment covered care managers' salaries and psychiatrist supervision time.<sup>v</sup> Other payers and providers in Wisconsin are beginning to experiment with similar PMPM payments that are intended to cover management of patients with physical and behavioral health needs. These payments are intended to be budget neutral and to eliminate the need for office visits to generate revenue, if an office visit is not in fact the care that patients most need.

b. Chronic Disease Self-Management Program (CDSMP)/ Diabetes Self-Management Program (DSMP)

The SHIP recommended approach of care coordination payments and pay for performance incentives could work to offset the cost of chronic disease self-management classes. Providers should adopt a practice of screening and referring everyone who meets the eligibility criteria to the classes, and all implementation partners, including the statewide clearinghouse/support agency, should encourage all major health plan sponsors (including Medicaid and state employee health benefit programs) and their insurance carriers to provide coverage for these courses. Employers should consider incorporating chronic disease self-management classes as part of their health insurance and/or wellness benefit, including working with their insurance carrier or administrator to determine the most effective means of participant incentive (positive or negative, paid by employer directly vs. incorporated into insurance plan design).

## **Health Information Technology (HIT)**

1. Describe the HIT services that would be leveraged to support the identified initiatives
  - a. Expand behavioral health and primary care integration
    - i. Supporting behavioral health providers in using EHRs and electronically exchanging data is foundational to promoting integration with primary care. The

Health IT team has recommended expanding technical assistance to behavioral health providers to help support EHR adoption and use, as well as health information exchange. The WG's survey of BH providers showed that lack of staffing and training are significant barriers to adoption of EHRs and use of HIE. Any pilot around BH and PC integration should include TA for providers to improve their understanding of how to share data, including improved understanding of data sharing that is allowed under current laws.

- ii. In the longer term, the planned Shared Technology Services (Provider and Organization Directory and Person Identification and Matching services) will make it easier to connect information across care settings for better care coordination and analytics.

b. Patient engagement and activation (i.e. chronic disease self-management)

- i. Consumer-facing health IT, such as text-messaging services, can be helpful in diabetes management and can be especially effective in reaching some underserved populations. Application based health interventions (such as tobacco interventions, depression and anxiety interventions, diabetes self-management) and in-home consumer-facing tools (such as remote monitoring tools that provide real-time data feeds to patients, providers and care givers) can be effective, but many consumers have difficulty finding evidence-based apps that meet their needs. Providers, in turn, often lack the information they need to make recommendations to their patients about apps. Learning collaboratives and TA can help fill this gap.
- ii. Patients can also become more engaged through the OpenNotes initiative<sup>vi</sup>, where access to their clinicians' notes increases understanding of care plans and has been shown to improve medication adherence rates.

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<sup>i</sup> See e.g., <http://www.thecommunityguide.org/mentalhealth/collab-care.html>

<sup>ii</sup> [https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=0ahUKEwifzPjxtInKAhVLOSyKHUI0Ag4QFggzMAI&url=http%3A%2F%2Fwww.commonwealthfund.org%2Fusr\\_doc%2Fclinical\\_disease\\_self\\_management.pdf&usg=AFQjCNEORnx66RF9INnt02KilfCrNEDS7g&sig2=XNdcK4mtxX8vW6a3AzXh2Q](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=0ahUKEwifzPjxtInKAhVLOSyKHUI0Ag4QFggzMAI&url=http%3A%2F%2Fwww.commonwealthfund.org%2Fusr_doc%2Fclinical_disease_self_management.pdf&usg=AFQjCNEORnx66RF9INnt02KilfCrNEDS7g&sig2=XNdcK4mtxX8vW6a3AzXh2Q)

<sup>iii</sup> <http://www.ncbi.nlm.nih.gov/pubmed/?term=Effects+of+chronic+disease+self-management+programs+for+participants+with+higher+depression+scores%3A+secondary+analyses+of+an+online+and+a+small-group+program>

<sup>iv</sup> [https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=0ahUKEwifzPjxtInKAhVLOSyKHUI0Ag4QFggzMAI&url=http%3A%2F%2Fwww.commonwealthfund.org%2Fusr\\_doc%2Fclinical\\_disease\\_self\\_management.pdf&usg=AFQjCNEORnx66RF9INnt02KilfCrNEDS7g&sig2=XNdcK4mtxX8vW6a3AzXh2Q](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=0ahUKEwifzPjxtInKAhVLOSyKHUI0Ag4QFggzMAI&url=http%3A%2F%2Fwww.commonwealthfund.org%2Fusr_doc%2Fclinical_disease_self_management.pdf&usg=AFQjCNEORnx66RF9INnt02KilfCrNEDS7g&sig2=XNdcK4mtxX8vW6a3AzXh2Q)

<sup>v</sup> O'Donnell et al., Overcoming Roadblocks: Current and Emerging Reimbursement Strategies for Integrated Mental Health Services in Primary Care, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3832738/>

<sup>vi</sup> <http://www.opennotes.org/>