# Welcome to the Webinar
# Integrating Behavioral Health with Primary Care: Collaborative Contracting

## We will begin at 12PM

Use the Chat Box to tell us your name, organization, and position.

**March 3, 2021**

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# *Behavioral Health Integration in Primary Care Continuum Based Framework:*

## Collaborative Contracting

**March 3, 2021 | 12-1PM**

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# Behavioral Health Integration Domains

| | |
|---|---|
| 1 | Case finding, screening, and referral to care |
| 2 | Decision support for measurement-based stepped care |
| 3 | Information exchange among providers |
| 4 | Ongoing care management |
| 5 | Self-management support that is culturally adapted |
| 6 | Multi-disciplinary team (including patients) used to provide care |
| 7 | Systematic Quality Improvement |
| 8 | Linkages with community and social services |
| 9 | Sustainability |



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# Meet our Speaker

## Henry Chung, MD

Senior Medical Director, Montefiore Care Management Organization

Professor of Psychiatry, Albert Einstein College of Medicine



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# Collaborative Agreement

**COLLABORATIVE AGREEMENT**

This document outlines the referral agreement between _____and _____ for pre-consultation exchange, formal consultation, and co-management of chronic disease or illness. The purpose of this agreement is to provide a framework for better communication, coordination of care, and the transition of care between primary care (PCP) and specialty care (SCP) providers to eliminate waste and excess cost of health care, as well as optimizing patient health.

_____(PCP) and _____ (SCP) agree to collaborate in the care and treatment of patients as set forth below.

_____[Allotted days per week], an SCP will come to the PCP office to be available to see patients onsite.

The PCP office will provide office space and a laptop with secure access to create and incorporate patient notes at the time of service. The SCP will be responsible for billing for his/her own services.

The PCP agrees that referrals to the SCP shall include a reason for the referral; any thought process related to that reason; clinical information including diagnosis, problem list, pertinent diagnostic tests, medication list, and allergy list; and the timeframe within which the referral is requested.

The SCP agrees to send all new clinical information back to the PCP with care recommendations.

# Collaborative Agreement *(Cont'd)*

The PCP and SCP agree to the following types of care management/referral transitions. (Check all that apply)

- ☐ **Pre-consultation exchange** – communication between PCP and SCP to:
  - ☐ Answer a clinical question and/or determine the necessity of a formal consultation with the SCP.
  - ☐ Facilitate timely access and determine the urgency of referral to the SCP.
  - ☐ Facilitate diagnostic evaluation of the patient prior to the SCP's assessment.
- ☐ **Formal consultation**—referral for advice:
  - ☐ Request for referral and/or advice on a discrete question regarding a patient's diagnosis, diagnostic test results, procedure, treatment, or prognosis, with the intention that patient care will be transferred back to the PCP after one or a few visits.
  - ☐ The SCP will provide a detailed report on the diagnosis and recommended care and NOT manage the care; this report may include an opinion on the appropriateness of co-management.
  - ☐ The SCP is responsible for communicating with the patient on any diagnostic test results until the SCP transitions the patient back to the PCP.

(Continued)

* Adapted from Keuka Primary Care Associates

# Collaborative Agreement *(Cont'd)*

☐ **Co-management for chronic disease/illness:**

- ☐ Both the PCP and SCP actively contribute to patient care for a medical condition and are responsible for defining their individual responsibilities for communication with the patient, drug therapy, referral management, diagnostic testing, and patient follow-up.
- ☐ The PCP continues to receive consultation reports and provides input on secondary referrals and quality of life and treatment decision issues.
- ☐ The PCP continues care for all other aspects of patient care and new or other related health problems and remains the patient's first contact.

This agreement outlines expectations between the PCP and SCP. It does not, in any way, limit the patient's freedom to select his/her physician of choice or make a self-referral to a provider of the patient's choice. Both parties agree to review agreed-upon objectives and expectations throughout the collaboration, including data for mutual use for the purpose of quality improvement.

Patient confidentiality will be maintained as per HIPAA. SCP access to PCP records is limited to information pertinent and germane to patient issues being treated by the SCP.

# Collaborative Agreement *(Cont'd)*

**APPROVAL SIGNATURES**

**Primary Care Provider**

Authorized name _____

Title _____

Signature _____

Date _____

**Specialist Care Provider**

Authorized name _____

Title _____

Signature _____

Date _____

# Today's Guest Speaker

**Marisa Scala-Foley**

*Director*

*Aging and Disability Business Institute*



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# Bridging the Gap: Collaborative Contracting between CBOs and Health Care Entities

Marisa Scala-Foley

Director, Aging and Disability Business Institute



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# The Business Institute

The mission of the Aging and Disability Business Institute (Business Institute) is to successfully build and strengthen partnerships between community-based organizations (CBOs) and the health care system so older adults and people with disabilities will have access to services and supports that will enable them to live with dignity and independence in their homes and communities as long as possible.

**aginganddisabilitybusinessinstitute.org**

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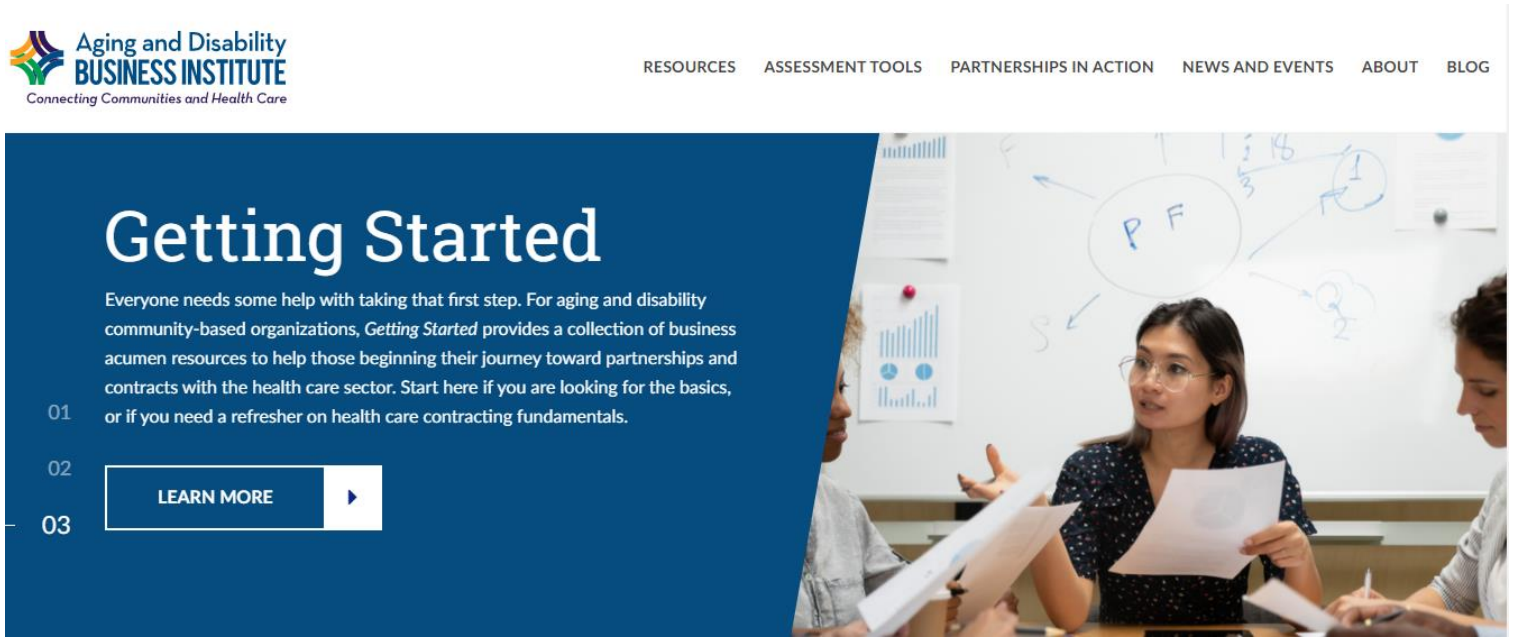
# aginganddisabilitybusinessinstitute.org

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# Our Funders

The John A. Hartford Foundation

THE scan FOUNDATION

ACL

# Our Partners

ncoa Center for Healthy Aging

ASA American Society on Aging

Elder Services of the Merrimack Valley, Inc.
*Choices for a life-long journey*

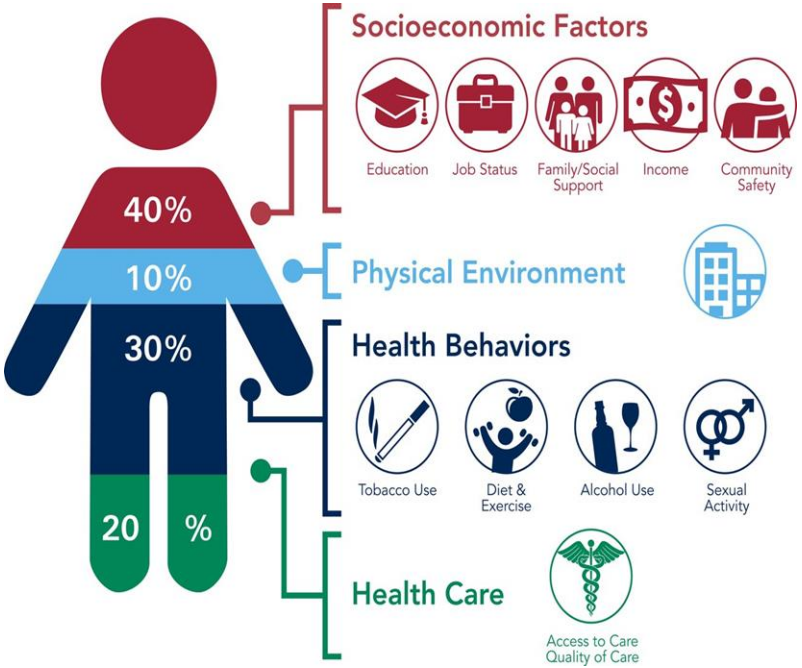
Partners in Care FOUNDATION

ilru

MEALS on WHEELS AMERICA

EBLC Evidence-Based Leadership Council

# The health care world is FINALLY paying attention to social determinants of health…




- **20%** of a person's health and well-being is related to **access to care** and **quality of services**
- The **physical environment, social determinants** and **behavioral factors** drive **80%** of health outcomes

Source: Institute for Clinical Systems Improvement; Going Beyond Clinical Walls: Solving Complex Problems, 2014 Graphic designed by ProMedica.



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# Why these partnerships are important

***For health care providers and payers***

- Emphasis on integration of health care & social services
- Increasing recognition of importance of services addressing social determinants of health (SDOH) and community living services for health outcomes
- Drive toward value-based care

***For CBOs***

- Increasing recognition of the value that they bring to health care providers and payers in improving health outcomes and quality of life, and engaging individuals, their families and communities on What Matters to them
- Need for sustainable revenue sources

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# RFI Survey

## To Take the Pulse of CBO-Health Care



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# Survey Methods

- Partnered with Scripps Gerontology Center at Miami University
- Disseminated via email directly to 617 Area Agencies on Aging (AAAs) and 404 Centers for Independent Living (CILs)
- Key national agencies shared the survey with other Community-based Organizations (CBOs)
- Survey was in the field for just over 10 weeks between March and May of 2020 with a total of 445 respondents

# Survey Limitations

RFI 3 timing

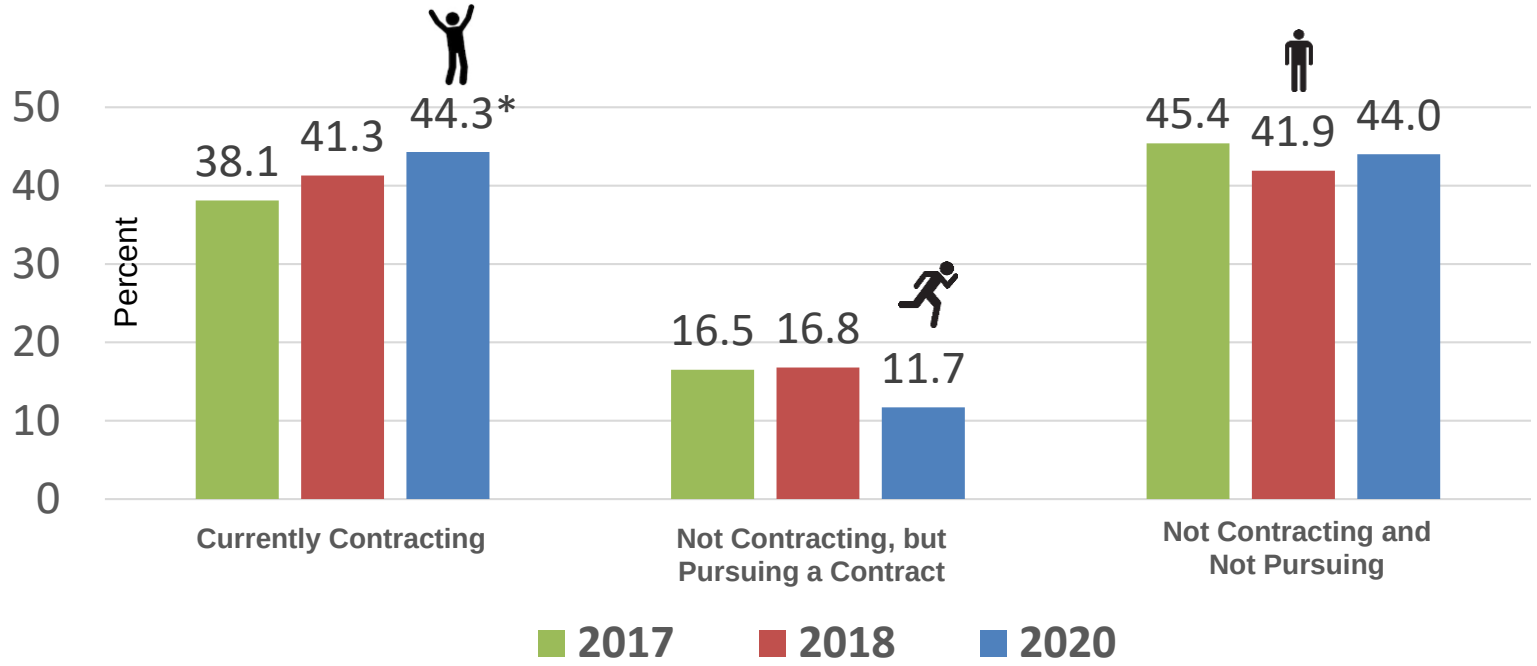
- Launched at the beginning of March 2020
- Priorities and focus turned to COVID-19

Decrease in response rate

Additional analysis

- Non-response bias analysis
- Statistical significance testing

# CBO Contracting Status, by Year




*Statistically significant increase from 2017 to 2020 in proportion of CBOs reporting contracts.



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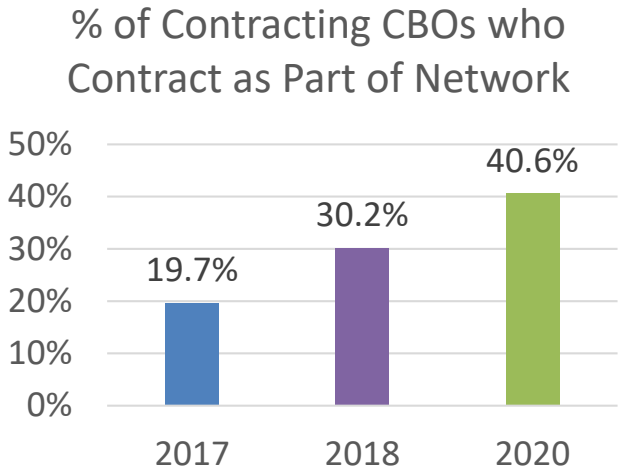
# Rise of CBO Networks

Network: a coordinated group of CBOs that pursues a regional or statewide contract with a health care entity.

The proportion contracting as part of network has doubled since 2020.

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# Populations Served through CBO-Health Care Contracts

| | Percent |
|---|---|
| Older adults (age 60+ or 65+, as defined by the program) | 76.1 |
| Individuals with disability or impairment of any age | 56.8 |
| Individuals with chronic illness of any age | 43.2 |
| Adults (age 18 to 65) without a disability, impairment or chronic illness | 30.3 |
| Veterans of any age | 29.0 |
| Caregivers of any age | 20.0 |
| Children (up to age 18) | 18.1 |
| Other: | 10.3 |

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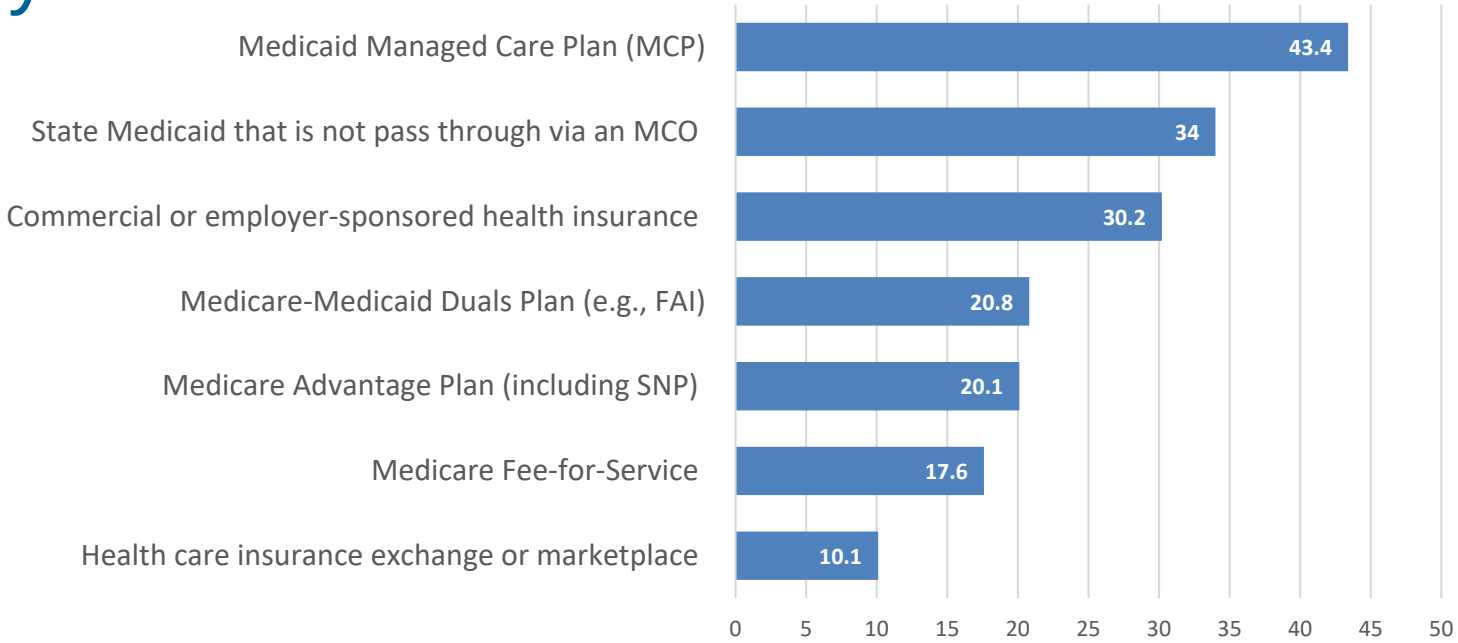
# Most Common Health Care Contract Partners: Payers

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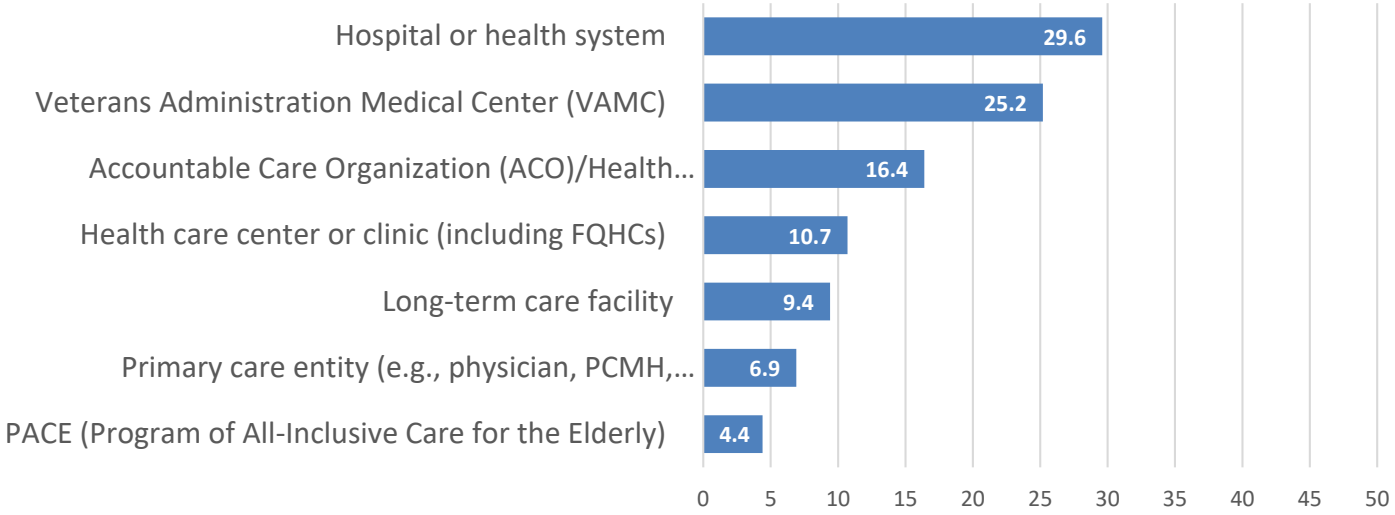
# Most Common Health Care Contract Partners: Providers

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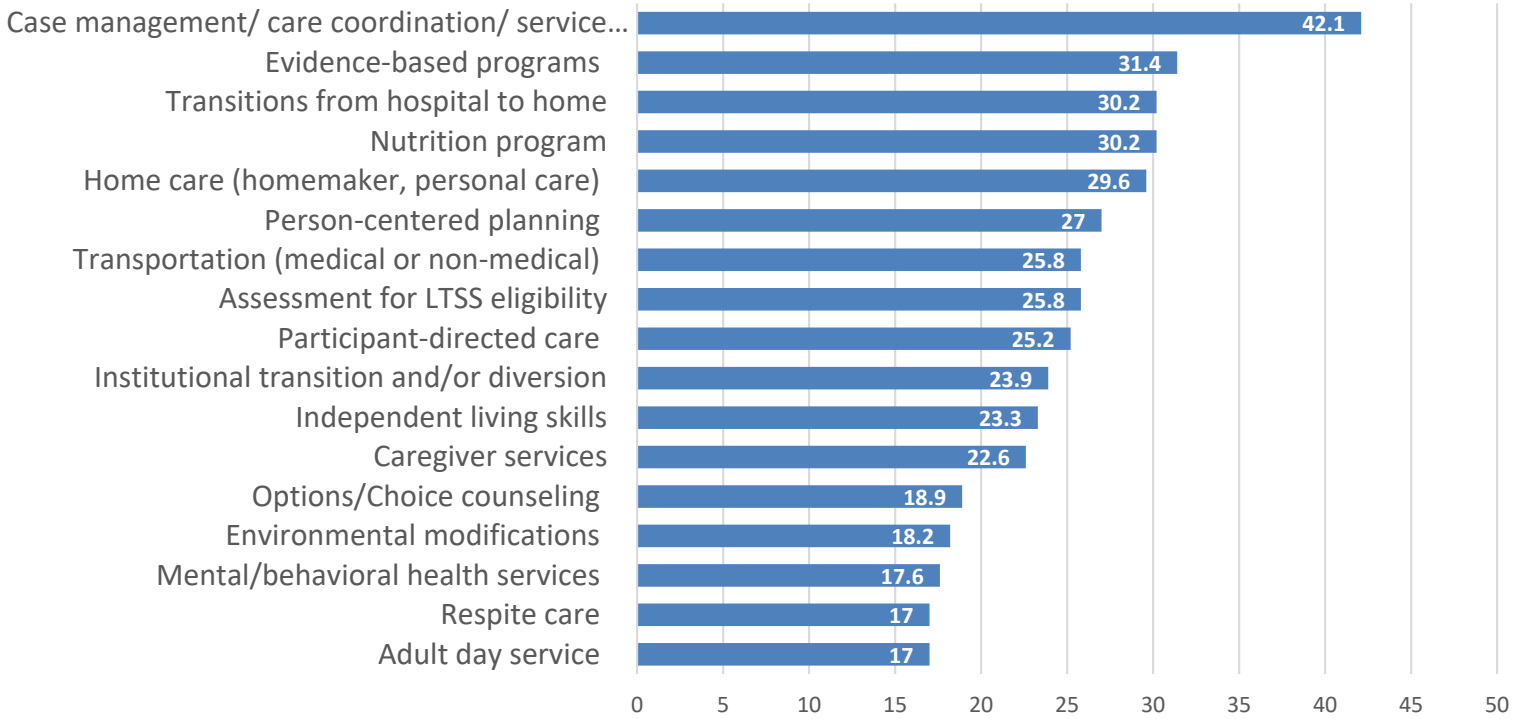
# Most Common Services Provided through CBO-Health Care Contracts

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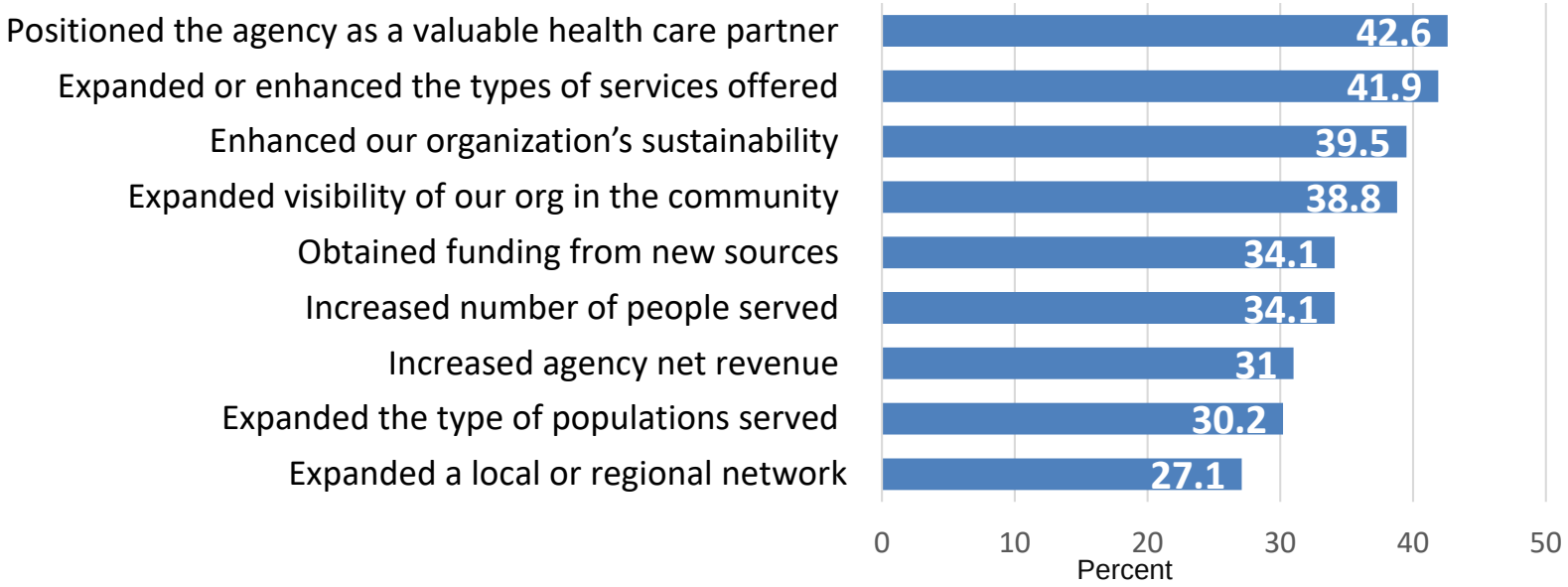
# Top Contracting Challenges for CBOs with Contracts

| | Was a challenge in establishing the contract | | Current challenge in the contracting relationship | |
|---|---|---|---|---|
| 1 | Time it takes to establish a contract | 39.8% | **Timely payment for contracted services** | 30.1% |
| 2 | **Negotiation of price and/or contract terms** | 37.6% | Competing priorities within the health care community | 28.6% |
| 3 | **Staff turnover in the health care entity** | 27.1% | Denial of claims | 28.6% |
| 4 | Common understanding of proposed programs/services | 26.3% | **Referrals and volume** | 27.8% |
| 5 | **Timely payment for contracted services** | 26.3% | **Negotiation of price and/or contract terms** | 27.1% |
| 6 | **Referrals and volume** | 24.8% | **Staff turnover in the health care entity** | 26.3% |
| 7 | Contract specificity regarding scope of work, responsibility, and accountability | 24.1% | Integration of your organization's services into health care system workflow | 23.3% |

# Most Significant Changes as a Result of Contracting



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# Aging and Disability CBO-Health Care Partnerships: What Works and Why?

- Finding and nurturing champions
- Shared vision, mission, and language
- Agreements that support that shared vision, and capitalize on partner strengths
- Openness and flexibility
- Culture change in both sectors…and buy-in at all levels
- Integrated, efficient work flows
- Adequate infrastructure to support the partnership
- Clearly defined and open data-sharing protocols



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# Learn More About the Business Institute

- Visit our website to learn more about the Business Institute: aginganddisabilitybusinessinstitute.org
- Still have questions? Email us: BusinessInstitute@n4a.org
- Stay up-to-date on our events calendar. New webinars added regularly: aginganddisabilitybusinessinstitute.org/events
- Stay connected, sign up for our bi-monthly newsletter: eepurl.com/gg2JGL



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# Discussion

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## We welcome your questions and comments!

# Upcoming Sessions

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| | |
|---|---|
| **March 17** | **Ongoing Care Management Process (Information & Data Sharing)** |

**Virna Little, PsyD, LCSW**
*Chief Operating Officer and Co-Founder*
*Concert Health*

| | |
|---|---|
| **March 31** | **Evidence-Based Care & Self-Management** |
| **April 14** | **Community & Social Services Linkages** |
| **April 28** | **Sustainability: Coding for Behavioral Health Services** |
| **May 26** | **Where to Go From Here** |

# Your SWEEP Team

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## Have a question? Contact us!


| Bonnie Horvath | Laura Benzel | Lynn Wilson | Gail Gresko |
|---|---|---|---|
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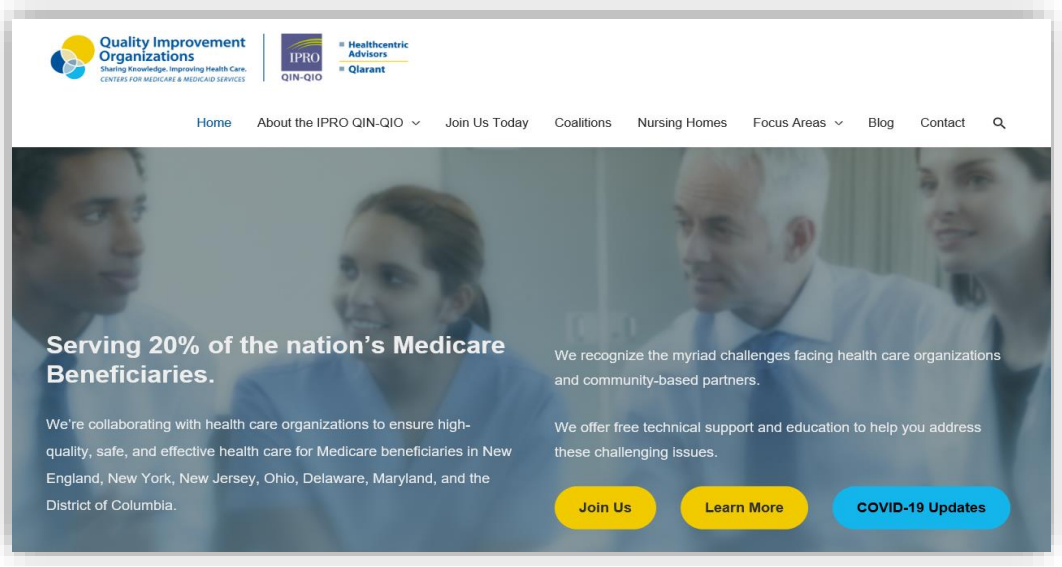
# Learn More & Stay Connected

https://qi.ipro.org/




## Follow IPRO QIN-QIO

This material was prepared by the IPRO QIN-QIO, a collaboration of Healthcentric Advisors, Qlarant and IPRO, serving as the Medicare Quality Innovation Network-Quality Improvement Organization for the New England states, NY, NJ, OH, DE, MD, and the District of Columbia, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents do not necessarily reflect CMS policy. 12SOW-IPRO-QIN-T2-A1-21-282

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