Virtual Behavioral Health Integration Proven to Lower Costs

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Brief Description

Martha Whitecotton, Senior Vice President for Behavioral Health Services at Carolinas HealthCare System, has proven a lower cost, more efficient way to serve patients with behavioral health conditions. Their virtual Behavioral Health Services helps detect and assist in diagnosing and treating patients during primary care visits. Their services also support emergency departments throughout North Carolina by diagnosing, treating, supporting, and facilitating transportation and placement for emergency room behavioral health patients. The virtual workflow dramatically increases productivity for psychiatrists and other behavioral health clinicians. Pay-for-value contracts are required, however, for large scale deployment.

Gathering patient history and other self-reported information needed for diagnosis in advance of primary care and outpatient psychiatrist encounters would further improve productivity. Integration to the provider's electronic health record and patient portal likely critical for large scale provider and patient adoption.

View: Highlights (3:39) Full Interview (29:01)

Highlights

- Carolinas HealthCare System achieved massive improvements by integrating behavioral health virtually into primary care
- Significant savings in emergency room, inpatient, and ambulatory utilization when present
- Benefits consumers and providers when diagnosing, treating behavioral health or substance abuse conditions
- Value-based payments reward these innovations much more than traditional Fee-for-Service
- Providers with virtual behavioral health integration capabilities better prepared for risk-bearing/value-based contracts
- Further innovation opportunity: Gather patient information digitally prior to first appointment
    - Normally takes 75% of first appointment to gather this info needed for diagnosis
    - Must flow together in EHR to create whole patient picture

Guest Lower Thirds

Martha Whitecotton, RN, MSN, FACHE SVP Behavioral Health Services Carolinas HealthCare System ● Strategic development, execution and oversight for Carolina HealthCare's Behavioral Health Service Line ● Previously President of Levine Children's Hospital ● Masters in Family Nursing & Bachelors of Science, Nursing West Texas State University ● Nurse Executive Fellowship, Wharton School, University of Pennsylvania ● Fellow of the American College of Healthcare Executives ● Member, Sigma Theta Tau Honor Society	**Matthew E. Hanis** Host & Executive Producer Business of Healthcare ● 25-year healthcare industry veteran ● Held leadership roles in health systems, payers, and commercial enterprise ● Day job leading Hanisworks LLC, virtual health business consultancy Business of Healthcare ● Serves healthcare executives across all major industry segments ● Audience of over 10,000 stakeholders including 4,700 decision makers ● Editorially independent focused on meeting Mission and Margin goals

Speaker	Transcript
Hanis	when you get to a value based model how does it change behavioral health as a as a component to total patient care?
Martha	I think that there's a way to be successful in a fee for service world with behavioral health but not in a way that drives that kind or population health outcomes that need to happen and to decrease overall health care spend.
Martha	when you get to a value based model when you're really focusing on outcomes versus a fee for service then you work to intervene as early as possible in illness and keep patients out of those high cost services and so I think it's just flips the model on its head and behavioral health comes becomes a very important part of overall health care not a behavioral health separated from physical health but integrating those two back together to take care of a whole person in order to meet those targeted outcomes that are in the plan.
Martha	say that a patient comes into a practice and they are really in a legitimate crisis this is an appointment that would have taken a primary care provider an hour to three hours out of their day today in our practices that have integrated services patient comes in they're in a legitimate crisis the provider tells his medical office assistant to get our behavioral health specialist and they get us and connect us on the video within three minutes and we have a provider in the room with the patient within three minutes on a video interface and then we start the process with the patient inside that primary care appointment.
Martha	within our model in one year we had a 13% reduction in avoidable ED visits and a 25% reduction in avoidable inpatient hospital stays and an overall decrease in costs in ambulatory visits in our highest utilization population.
Hanis	You sound enormously receptive to the idea of taking that risk
Martha	Absolutely
Hanis	because you're confident you can deliver out more efficiently now you just we need to movement a movement in the general assembly to really tackle two things then one is the integration together of the reimbursement model but the other is aligned reimbursement to outcomes not to fee for units of work performed
Martha	Exactly

Hanis	what portion of that appointment is the psycho is the psychiatrist gathering information from the patient to get to a point to make a diagnosis?
Martha	that's how psychiatrists work right they work by gathering information from the patient so I'm you know I'm guesstimating but I would assume seventy five percent of that appointment is that and then the rest is teaching the patient about their illness and their proposed medication or treatment.
Hanis	so let's imagine that there was a mobile app instrument that was integrated already in the Cerner environment which you live in. And you could use that to trigger interaction with the patient perhaps before they come in for an appointment and do all the screening and ask questions and gather all the history
Martha	I agree I think that's the opportunity is to to link what's going on in the mobile world and digital technology world into an EMR to create a unique service around a patient right now they're pretty disconnected.
	End HIGHLIGHT VERSION
Hanis	so tell me a little bit about your role and responsibility
Martha	I'm the senior vice president for behavioral health services for Carolina's health care system and that involves really executing on an integrated delivery system for behavioral health services across the entire spectrum of services from patient home all the way through hospitalization, outpatient services, primary care.
Hanis	In a way you obviously your end customers is the patient the consumer but your own customers is also the provider and the payer tell me about how you think about in particularly the payer in the context of the work that you do.
Martha	if you think about the payer in the context of value based care which is the direction that our payers are all moving they're interested in providing better outcomes for patients so my responsibility I think the relationship with the payer is first of all the meet the definition of whatever service I am providing but also to provide measurable outcomes in terms of patient improvement
Hanis	how much does the fee for service based what how conducive is that to succeeding with behavioral health as a solution?
Martha	it's probably not going to drive the patient outcomes that we want to see happen I think that there's a way to be successful in a fee for service world with behavioral health but not in a way that drives that kind or population health outcomes that need to happen and to decrease overall health care spend.

Hanis	and tell me a little bit more about that
Martha	overall health care spend is really driven by chronic conditions high utilization. High Utilization of high cost services like emergency rooms, inpatient hospitals and in order to get at the real meat of behavioral health we really need to get much higher in the much earlier in the trajectory of illness so way up stream and our system is that built to incentivize and or fee for service to incentivize payment around a crisis intervention or a crisis in your behavioral health illness it's not designed to incentivize upstream preventive care or early intervention
Hanis	and so what changes when you get to a value based model how does it change behavioral health as a as a component to total patient care?
Martha	when you get to a value based model when you're really focusing on outcomes versus a fee for service then you work to intervene as early as possible in illness and keep patients out of those high cost services and so I think it's just flips the model on its head and behavioral health comes becomes a very important part of overall health care not a behavioral health separated from physical health but integrating those two back together to take care of a whole person in order to meet those targeted outcomes that are in the plan.
Hanis	when you think about the concept of behavioral health integration, What is it about the current payment model that makes it so difficult to achieve that?
Martha	Well the current payment model obviously doesn't address at all the uninsured So that's number one second of all the current payment model is designed to have embedded resources so face to face services and that really doesn't work in rural settings I mean half the counties in the country don't have any behavioral health provider at all so there's going to be no face to face service. it doesn't work at all when there's a provider shortage there's not enough providers conceivable to embed those resources so we have to think of a different delivery model and our current structure isn't set up to accommodate different delivery models
Hanis	is there also an issue with the way that most health plans and Medicaid most payers compensate for behavioral health?
Martha	Yes and that varies widely I'll just start there but in the lot of health plans and in the in Medicaid in the state of North Carolina it's a carve out so it's looked at as an entirely separate service so it doesn't incentivize any integration and incentivizes really running parallel tracks of services for physical health and mental health and that doesn't drive optimal outcomes
Hanis	and I feel like one of the conundrums there is the P&L owner at the at the health plan. The p&L owner for the physicals expenses like acute care and ED. Doesn't have an economic incentive to support

	mental health and vice versa the owner of the mental health P. and L. doesn't benefit from the reduction in downstream physical health costs
Martha	Correct
Hanis	That's just woven through the system
Martha	all the way through across the whole country
Hanis	so if you could take one payer model that's in existence today that you feel leads to a better integration, which of the broad payer models do you like?
Martha	Some Medicaid payors by state because Medicaid varies widely by state so the Missouri Medicaid model integrated physical and mental health and tied the payments to an outcomes basis and really brought those two services back together and started to reward people for integrating care and and providing services. On Both the mental health and physical health side with the financial performance being tied together and that's a perfect example led by Joe Parks who's a great psychiatrist a leader in the country.
Hanis	Yeha. and so. How about the work of Medicare the introduction of
Martha	Medicare has introduced collaborative care codes I think most of the country is trying to work their way through how to effectively use them and meet the Medicare criteria but that's in the right direction because they also allow for different delivery models which is the big one and in the collaborative care codes.
Hanis	talk about that just a little bit more
Martha	so under the collaborative care codes as set up by Medicare you can deliver behavioral health services within the context of a primary care appointment or a primary care panel and you can deliver those services face to face or virtually So there doesn't have to be an embedded provider required as long as the elements of the service are met.
Hanis	And If you had a a large self-insured employer so the C.F.O. of a self-insured employer sitting at the table with you what would your proposition be from Carolinas what would you what would you propose to that CFO to help him and help Carolina's Healthcare
Martha	I think that you'd have to propose that you need to look beyond the savings in your health insurance plan as the when for the C.F.O. because he in addition to any additional spend in his health care plan

	that he has relative to people that have co-occurring physical illness and mental health disorders he has a presenteeism problem he has an absenteeism problem and he has a turnover problem that's being driven by prevalence of illness and so if they can address people's mental health or substance use disorder then they can also improve their return on investment in labor so their employees will be at work they will be healthy or they will not lose their jobs and turnover have to be replaced with additional recruitment cost. So I would say that they need to think bigger than just the health plan savings on the health plan saving side it has to do with the You know the high prevalence of any chronic health care condition having an associated co-occurring mental illness particularly like with diabetes I think forty seven to fifty percent of patients with a diagnosis of diabetes also have depression so if you can get a patient's mental health addressed and then they start to become compliant with their physical health requirements in other words they feel like exercising they feel like making good food good food choices they feel like getting up and out of the house then then their physical health is going to improve and your overall spend is going to go down and that's what they proved really in the Missouri model.
Hanis	do you feel like as a C.F.O. who is a good human being and wants the best for his people but who also has to Report a P. and L. at the end of the year do you feel like a C.F.O. in that position could invest in behavioral health and within that same year start to see a shift in the medical spend in the population or does it take longer than that?
Martha	I don't think it takes I don't know how large scale it would be for a you know on a in a single year most of the models in the eighty randomized control trials are at least two years worth of data but I can say that within our model in one year we had a thirteen percent reduction in avoidable ED visits and a twenty five percent reduction in avoidable inpatient hospital stays and an overall decrease in costs in ambulatory visits in our highest utilization population so we saw a return on investment in the first year. So I think I could promise that given our experience.
Hanis	let's talk a little bit more about how you accomplish that because you guys have done some really amazing innovation work so take me through that journey a little bit.
Martha	well we've looked at the you know we do this things that we've talked about up to this point we have a provider shortage we have they are. We have over two hundred practices in Carolina primary care practices in Carolina's health care system and we thought if we tried to embed a provider in every one of those practices it would be cost prohibitive and it still doesn't guarantee patients access to care because the model is very much an appointment based model and you know it can almost become a co-located situation versus an integrated care unless you're very intentional about that and so we tried to think of a different way of coming at the problem and we thought about the importance of keeping the primary care provider at the center of care so as our country ages and that's the demand

	for health care resources and healthcare utilization goes up our primary care providers are going to have to increasingly handle mild to moderate illness in every specialty because our special start going to be able to accommodate it
Hanis	mild to moderate behavioral health
Martha	or any illness like that like mild to moderate headache problems instead of sending to a neurologist
Hanis	Oh I see what you're saying
Martha	you know what I'm saying you know the sickest of the sick are going to end up with specialists but specialists aren't going to be able to accommodate patients who are just entering into illness and so we try to think about this opportunity to improve the primary care providers competency around managing patients who are in their practice who had mild to moderate mental health or substance use disorders so we we focused on improving their knowledge of the medication utilization we built medication algorithms for them within the medical record we taught them how to do screening. screening brings on a little bit of a Pandora's box because once I screened that I'm going to identify and then what am I going to do so then we knew we had to have a team to support that primary care provider but our team supports that primary care provider virtually and they do that through a variety of ways the simplest way might be a E.M.R. consult to the psychiatrist to review a list of medications or to ask about medication escalation. That's the simplest form of virtual care.
Hanis	and then when you when you move from from that simple form of the consult the curbside consult via the EMR or via phone what happens at the next level of that?
Martha	the next level of that can be a patient who comes into a primary care practice and within that appointment identifies that they have an emerging mental health disorder the primary care provider may start them on a medication but ask our team to then follow the patient so they'll get a phone call the next day from a psychotherapist who will do a diagnostic interview to make sure we're targeting the correct illness and then they'll get a treatment recommendation an alignment between the psychiatrist and the primary care provider and then they'll get health coaching and the health coaching serves several It's a wellness focus it's about motivational interviewing it's about taking your medications and staying on them it's about oh you didn't get your prescription filled let us help you find a place where you can afford it it's about rescreening to make sure the patient's symptoms are are improving so that keeps coaching the patient and that happens outside the primary care practice but all entered into the electronic medical record for the primary care provider knows every step of the way what's going on with that patient.

Hanis	And theres
Martha	and there's a higher level too we can go to go
Hanis	yeah OK So you took the words right out of my mouth Martha
Martha	So say that a patient comes into a practice and they are really in a legitimate crisis this is an appointment that would have taken a primary care provider an hour to three hours out of their day to resolve because they are all of a sudden consumed in the moment by this patient who's in crisis what happens today in our practices that have integrated services patient comes in they're in a legitimate crisis the provider tells his medical office assistant to get our behavioral health specialist and they get us and connect us on the video within three minutes and we have a provider in the room with the patient within three minutes on a video interface and then we start the process with the patient inside that primary care appointment.
Matt	So you're sort of relieving two crises one is the patients crisis in mitigating that but also the other is the physicians crisis who wants to give that patient amazing care but who also has a line of other primary care appointments stacking up
Martha	Yes
Hanis	One of the things that I like about your model is the fact that you're able to make the psychiatrist just so incredibly productive. Go a little deeper into that.
Martha	so our psychiatrist really doesn't have any face to face with the patient at all and we've been able to use about a point two F.T.E. of a psychiatry list and last year with that point two F.T.E. saw over seven thousand patients so incredible use of that resource and then freeing him up to you know to spend that time with other patients so our model is heavily dependent on the psychotherapist and the health coach doing seventy five to eighty ninety percent of the work a little bit of pharmacy consultation but primarily dependent on the skill level of the licensed mental health professional level.
Hanis	and just to to drive a fine point on it for a psychiatrist to provide a diagnostic support for primary care for seven thousand patients if that primary care physician referred that patient to a psychiatrist how many FTE's would you need to serve seven thousand patients that
Martha	Wow oh so probably closer to 7 or 8.

Hanis	so one way that you're driving this incredible efficiency of the scarce psychiatrist resource is because you're overlaying these other skill sets that are a little bit more available and in some cases a lower cost resource.
Martha	right in every case a lower cost resource so you know efficiency in terms of. The ability to scale is highly dependent on how the model expenses align and so we were really focused on keeping the expense per patient down as low as possible and so that was partly what drove us to really deconstruct that role and think who needs to do each piece of that role and then work that person to the highest level of their skill.
Hanis	and then another piece of the efficiency that you've brought in is the working the screening tool into the primary care wellness visit or sick visit. To talk a little bit about how you've done that.
Martha	so we've asked our primary. Care providers to screen their patients and they screen them we ask obviously the first time they ever see the patient we ask them to screen if there are some recognized symptomatology obviously and then we ask them the screening annually and that's particularly screening only for any patients that are on medication that's a psychotropic medication of some sort and the screen this patient self-administered very simple nine questions so the patient fill it out the waiting room and hand it to the medical office assistant when they walk back for their appointment the medical office assistant as they prepare the appointment for the physician can enter the score into the EMR and it's ready for the physician when they see the patient.
Hanis	a psychiatrist appointment for a new patient power long is a first appointment to diagnosis
Martha	usually about a thirty minute appointment some psychiatrists prefer forty five for that new appointment thirty to forty five minutes
Hanis	and in that typical let's call it a thirty minute appointment what would you say what portion of that appointment is the psycho is the psychiatrist gathering information from the patient to get to a point to make a diagnosis? And I know that's a hard one
Martha	I would say it's the bulk of that appointment in a psychiatry model because that's that's how psychiatrists work right they work by gathering information from the patient so I'm you know I'm guesstimating but I would assume seventy five percent of that appointment is that and then the rest is teaching the patient about their illness and their proposed medication or treatment.
Hanis	Are There any trends that you are seeing as relates to how payers are thinking about structuring behavioral health service.

Martha	Well it's very interesting I just attended the payors behavioral health summit so I got a little bit inside and that appears to me that what payers are doing across the country is they're contracting with external vendors to do a sort of virtual care work with patients as an overlay to a provider that they're contracting with so patients in the in the panel under a payor will have access to an external vendor for behavioral health to do health coaching or psychotherapy it's all it's mostly all virtual But it's interesting because to me you lose the opportunity then to integrate the two and that's not integrated that's co-occurring I guess if you would call it it's not integrated and I worry about that trend although across the country you know entrepreneurial businesses are springing up all over the place to fill that niche for payers and my caution would be to payers is you will probably get some improvement in outcomes but I think the research shows that you would get even more improvement with an integrated model where integrating mental health and physical health.
Hanis	Tell me about the barriers to the innovation that you brought to your delivery system.
Martha	the barriers primarily are because of the lack of payment for our model expanding it across every primary care practice becomes a pretty significant financial investment for the health care system in a fee for service world with no return on investment because we're not in risk based contracting deeply in risk based contracting So I think that's our biggest barrier early on we had barriers that we don't have any more like primary care adoption and their willingness to screen that's really all gone because we have such a fan club in the practices that were in that everyone else wants it now so we really don't have the same barriers that we used to have. There's a sometimes a problem from the patient activation side I mean patients still have to be willing to engage with us and there are some patients who for whatever reason just will not and so we you know we can't improve their health if they don't want to engage with the provider
Hanis	so contrast for me. How the market perceives the virtual approach like what you undertaken versus physically embedding a behavioral health clinician into the primary care practice.
Martha	so I would say at this point the industry and behavioral health and people delivering behavioral health services have been resistant to adopting the virtual care model and there is still a bias towards face to face services and I'm curious about that given our results and maybe that maybe the barrier is just that our results are not widespread enough we need to publish those results we need to get the word out we need to have some validity to it relative to payers adopting it but it'll be you know I think when the tide turns it'll turn quickly because the virtual care model lowers costs significantly but I'm currently facing today a fairly significant disbelief that virtual care will deliver the same outcomes within the behavioral health industry.

Hanis	so when you think about the the approach that you've observed health plans are considering the idea that they're going to engage a behavioral health contract vendor and offer that to their membership So certainly one drawback to that is it's not integrated into the primary care practice I perceive that there's another drawback to it which is it's putting the tele medicine moniker on it but it is not changing the workflow it is not truly a virtual solution it is an old way of doing things.
Martha	It's an add on
Hanis	yeah
Martha	it's an add on and and if they're not talking directly to the provider they have to talk to the health plan about the patient's progress that the health plan may be able to view that patients record but the primary care provider doesn't have that relationship with that outside vendor so it's not an it's not integrated. It's just happening at the same time.
Hanis	you don't get the value out of integration you don't get the value for the patient of having that happen in the flow of an actual appointment.
Martha	and then I'd be interested to know if payers could really. Draw s cause and effect like because we added this add on behavioral health service we saw this improvement in patients physical outcomes the two are so separated I don't they may see an overall spend track I don't know but I wonder if they could even tie the two together.
Hanis	so let's imagine that. There was a mobile app instrument. That was integrated already in the Cerner environment which you live in. And you could use that to trigger interaction with the patient perhaps before they come. In for an appointment or in do all the screening and ask questions and gather all the history such that you automated
Martha	Yeah
Hanis	you go ahead
Martha	I agree I think that's the opportunity is to to link what's going on in the mobile world and digital technology world into an EMR to create a unique service around a patient right now they're pretty disconnected.
Hanis	and if you went to go implement their let's play like that perfect app in the world was out there if you went to go implement that and it wasn't integrated into your provider's workflow I would imagine well well you haven't done that which means that the barrier to it is enormous.

Martha	Yes Yes It's just. The provider needs to whoever the primary care provider is or that needs to have a window into everything that's going on with that patient but that window has to be easy it can't be that I log out of the E.M.R. that I log into another system and I look at another platform and I find my patient it has to flow together into that electronic medical record and create a whole picture of the patient in one place and that's where I think our real opportunity lies I think there are some some digital technology companies that are poised to do just that or work on that but I think that's the next frontier of that world.
Hanis	So I know one of the things that that's probably coming is an effort on the part of the state government to propose to the General Assembly that we change the way Medicaid is structured in North Carolina such that the behavioral health services are fully integrated in with the medical or physical health services if you could if you could make a recommendation to the General Assembly as one of the states experts on the topic, what would your recommendation for them be?
Martha	one of the biggest problems that I see today in the in the model that we're in is that Medicaid dollars are to given to providers with no accountability to outcomes relative to those patients so does the patient show up for their appointments do they stay engaged do they go back into the hospital how many times they got back into the hospital you know are you you can say they have an appointment within seven days but do they keep the appointment and you know there's got to be an ability to tie these precious dollars in our state budget to patient outcomes and then to invest them with providers who are building systems that can assure those outcomes for patients versus just any provider that beats a service definition and so that would be my recommendation to them as they design this new model of how we use Medicaid dollars in North Carolina think about how you're going to make it a risk based payment for a provider think about how you're going to tie it to patient outcomes if our overall goal is reducing overall health care spend which it is and improving the health of the patients under our plan, that’s the only way it’s going to happen.
Hanis	You sound enormously receptive to the idea of taking that risk
Martha	Absolutely
Hanis	because you're confident you can deliver out more efficiently now you just we need to movement a movement in the general assembly to really tackle two things then one is the integration together of the reimbursement model but the other is aligned reimbursement to outcomes not to fee for units of work performance
Martha	Exactly

Hanis	Yes. Martha Whitecotton thank you so much for joining the business of healthcare today
Martha	Thank you for having me Matt