APRIL
2021

OPEN MINDS
Management Newsletter

Emerging Approaches To Integrated "Whole Person" Care

Sponsored by NextGen Healthcare

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Integrated Care For The Next Normal—Primary Care In Specialty Care Organizations

By Monica E. Oss, Chief Executive Officer

Increased demand for "integration"—of care coordination, consumer data, and consumer services—is being driven by consumers and payers. For consumers, it's a matter of the experience—a single care coordination process, all relevant information in one place, and a connection between basic medical services and specialty care. For payers, it's a matter of value—improved health status and less inappropriate use of expensive resources. And, the pandemic has certainly shed new light on the consequences of ignoring comorbidities, as Betty Rabinowitz, M.D., FACP, Chief Medical Officer of NextGen Healthcare noted in a conversation at the 2021 OPEN MINDS Performance Management Institute (see The True Impact Of Whole Person Care).

The preference for "integrated" care has not been lost on specialty provider organizations. We've seen rapid adoption of the health home concept and "whole person" approaches to care coordination. And, moving beyond that, many specialist organizations are adding primary care services to their service portfolio. Our survey last fall found that 52% of specialty provider organization executives reported they have already started developing models that offer both behavioral health and primary care services. However, provider organizations have not coalesced to a preferred pathway to achieving integrated care—only 14% of the respondents have fully integrated practice models (see Intentional Approaches To Integrated Care). Twenty three percent are pursuing designation as a federally qualified health clinic (FQHC) or FQHC look-alike, 30% are pursuing designation as a certified community behavioral health clinic (CCBHC), and 14% are pursuing designation as a patient centered medical home (PCMH).

A key question for specialty provider organizations is how to make primary care service delivery work, both clinically and financially. Many of the original SAMSHA grant-funded behavioral health/primary care integration programs failed to become sustainable service lines in the long run. And executives of specialty provider organization management teams that have added primary care service lines have commented that getting to profitability has taken longer than expected.

However, the pandemic has ushered in some previously unthinkable changes to primary care—consumers have embraced virtual primary care visits. Given this shift, health plans are moving in this direction. In recent months, we've seen a wide array of new virtual primary care health plan offerings. And employer-sponsored health plans are embracing the virtual primary care concept. For example, health plan Oscar has an app that connects consumers to a telehealth visit with a health care professional within 15 minutes of a call and if a prescription is needed, it is sent directly to the consumer's preferred pharmacy. Oscar's free virtual primary care benefit includes unlimited virtual visits with Oscar primary care physicians, and free at-home vital monitors and in-home lab draws. Doctor On Demand and Community Health Choice, a managed care organization launched a new health maintenance organization plan on the Texas Exchange centered around virtual primary care to give Texans who do not qualify for Medicaid or Medicare a dedicated primary care provider; access to preventive care,

urgent care, and behavioral health—all through convenient video visits, 24/7 support through a dedicated care team, and referrals to in-network specialists and facilities. (see What Virtual Primary Care Means For Specialist Strategy).

The acceptance of virtual primary care makes it much easier for specialty provider organizations to offer primary care physician services to the consumers they serve. Another possibility is that virtual primary care professionals may want to "consult" virtually with behavioral health professionals for cases where they need an expert opinion but want to manage the treatment and consumer relationship themselves.

This move to virtual primary care will also disrupt traditional referral patterns for specialty services. Many of the new primary care platforms promote care for depression, anxiety, and chronic conditions as part of their core offerings. Professionals providing virtual primary care will not necessarily live in the same community as the consumers they are serving or know the "local" specialty provider organizations. Rather they will likely identify specialists virtually (in their virtual networks or via online information) and/or provide a "virtual warm hand off" to specialists—assuming those specialists are able to share consumer data through some interoperable real-time data exchange.

There has also been a significant increase in private equity investment in new primary care delivery systems. Among the 34 health care unicorns (privately help startup companies valued at over $1 billion) in the United States, there are three in the primary care and care coordination space. We have K Health, an app-based telehealth service that uses artificial intelligence (AI) to help users to see how doctors typically diagnose people with similar symptoms and biomarkers. Village MD offers value-based primary care at traditional free-standing clinics, at Walgreens clinics, at home, and via virtual visits. And Cityblock Health coordinates integrated social, behavioral, and medical care for high-cost, impoverished patients, through technology and face-to-face interventions.

These changes—consumer preference for convenience, payer preference for the increased value of integrated models, and the acceptance of primary care delivered by telehealth—have changed the landscape for specialty provider organizations considering adding or expanding primary care services. And in this issue of the OPEN MINDS Management Newsletter, we're focused on organizations that are making primary care services work for the consumers they serve. What is apparent is that there is no "one size fits all" model.

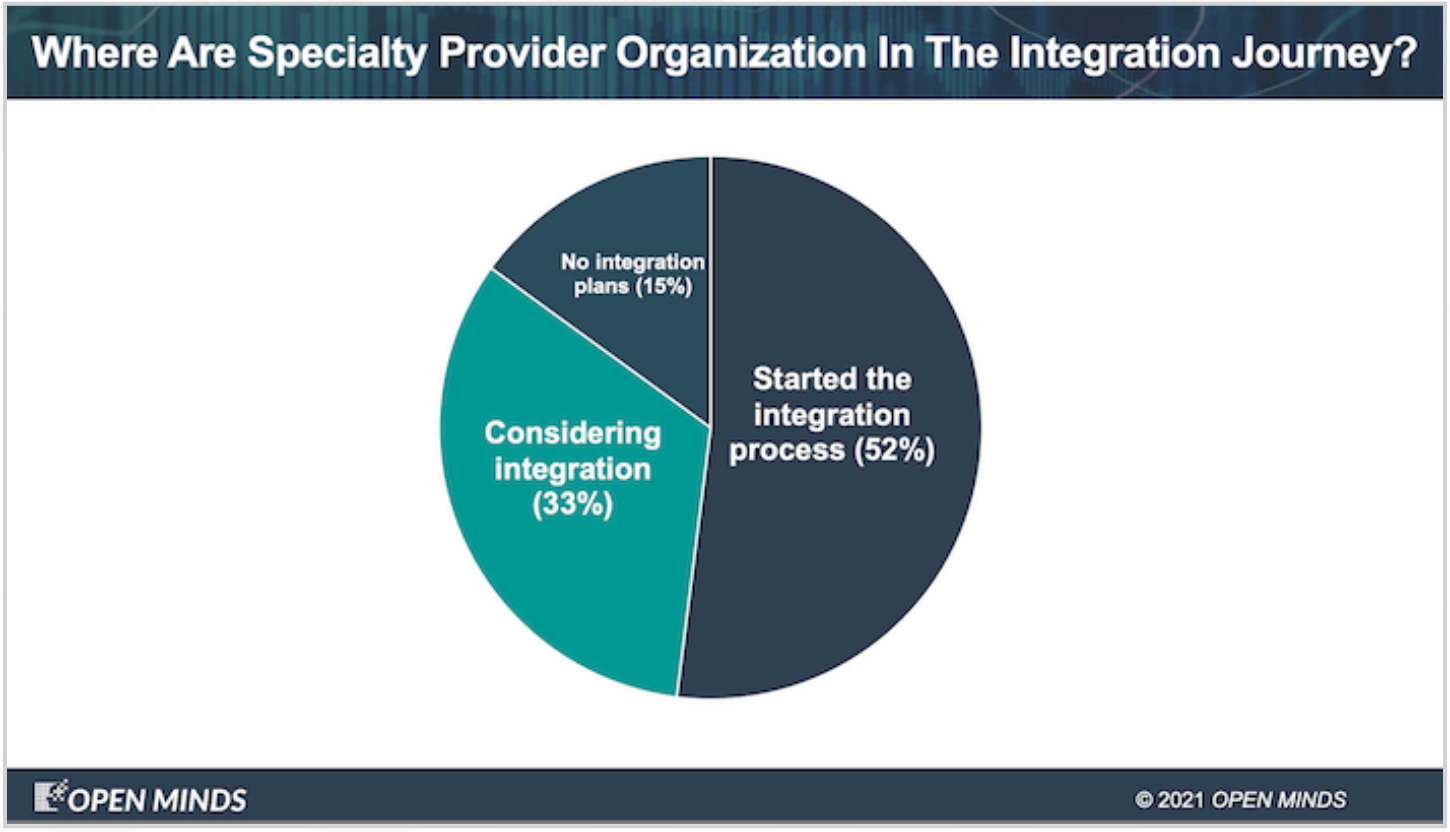
In this issue we take a look at seven approaches to integrated care—the fully integrated collaborative care approach, the colocation of behavioral and physical health services, the certified community behavioral health clinics program approach, the federally qualified health center or community health center approach, the primary care/behavioral health care retail center approach, virtual behavioral health in primary care, and virtual primary care in specialty system (see Seven Specialty Provider Organization Approaches To Providing Consumers With A "Whole Person" Integrated Care Experience). And we profile some successful programs implementing several of these approaches. Dr. Rabinowitz provides pointers for how to take on the challenges of staffing, technology, workflows, and revenue cycle management while adopting integrated care models (see Delivering Whole Person Care: Avoiding The Pitfalls Of Integrating Primary Care Into Community-Based Mental Health Centers). See how you stack up to your peers on the integration journey in Where Are You With Integration: Snapshot Of Specialty Provider Organizations. We hope this landscape assessment will be of use in your executive team discussions on how to become a "next generation" provider of comprehensive health care services.

Where Are We On The Road To Integration Of Physical & Behavioral Health Care?

By Stacy Bowles, Consultant

Simply put, integrated health care is the systematic coordination of mental health care with physical health care services. This means aligning behavioral health care (care for ailments such as depression, autism, or addiction disorders) with primary care—such as treatments for broken bones and seasonal flus. The significance for patients and their families with more than one health condition or comorbidity is that with integrated care, they can have their health needs met by a central provider organization that has all these services available instead of having to make many different appointments with different offices.

In the 1980s and early 1990s, health services researchers began to document that many of the individuals who came to primary care physicians for care were identified as having major depression. Individuals with major depression were more likely to have high numbers of medically unexplained symptoms, more comorbid illnesses, more functional impairment compared to other comorbid illnesses



like diabetes and heart disease. These individuals typically used twice as many health care services as their counterparts, costing insurers twice as much in resources. Studies during this time showed only a quarter to half of patients with depression were accurately diagnosed by these primary care physicians. Even if the individuals were accurately diagnosed, most of those patients did not receive the proper amount of prescribed psychotherapy or pharmacotherapy from their primary care doctors, causing many suffering individuals to discontinue therapies within the first few weeks, and never complete a referral to see a mental health provider.

These gaps in care between primary care and behavioral health are often more pronounced among minority populations and individuals living in poverty, two key demographics that already lack access to quality mental health services.

Today, many behavioral health providers and primary care physician practices are working together to provide more integrated solutions for individuals. In our November 2020 survey, sponsored by NextGen Healthcare, we looked at how behavioral health and intellectual development and disability provider organizations provider organizations are broadening their practices to include primary care and behavioral health services (see Intentional Approaches to Integrated Care: Results of a 2020 National Survey of Behavioral Health and Intellectual & Developmental Disabilities Providers with Case Studies). More than half (52%) of providers surveyed reported that they have already started the process of integrating behavioral health and primary care. A third of provider organizations (33%) said they are considering an initiative to integrate behavioral health and primary care, while 15% of provider organizations were not considering an integration initiative.

Of the organizations that are already integrating services, many have chosen established designations to guide their implementations—23% are considering or pursuing designation as a Federally Qualified Health Clinic (FQHC) or Look-Alike; 30% are considering or pursuing designation as a Certified Community Behavioral Health Clinic (CCBHC); and 14% are considering or pursuing designation as a Patient Centered Medical Home (PCMH).

Clearly, integrated care does not occur overnight—there are many shades of gray. Integrated care models occur along a continuum (see Six Levels Of Collaboration/Integration: Core Descriptions). It starts with coordination—health care settings exchanging the most critical pieces of information about a shared patient and help facilitate their access to care. Among the survey respondents, 31% of provider organizations were at the coordination level—with 8% practicing minimum collaboration and 23% were collaborating “from a distance.” The next level up is co-location—the practice of physically locating a behavioral health clinical professional in a primary care setting or a primary care clinical professional in a mental health or substance use treatment setting. Nineteen percent of provider organizations were doing basic collaboration onsite while another 19% reported close collaboration onsite with some system integration. At the most advanced level is a fully integrated care practice, in which the practice team—which includes primary care and behavioral health clinical professionals working with consumers and families—uses a systematic, seamless, and cost-effective approach to provide patient-centered care for a defined population. Among provider organizations responding to our survey, 18% were engaged in close collaboration approaching an integrated practice and 14% reported full collaboration with a transformed and fully merged and integrated practice.

The infrastructure required to achieve integrated care takes size and scale. Provider organizations with annual revenue of $30 million or more have an edge over their smaller counterparts when it comes

to progress on integration. About two-thirds (63%) of these large provider organizations report have a fully integrated practice or are approaching full integration with close collaboration. Comparatively, only about one-third (35%) of the mid-sized provider organizations and 30% of smaller provider organizations report that they are at these high levels of integrations.

What do provider organizations need to advance on their integration journey? Nearly half (49%) said that ensuring financial sustainability was a top priority, while 30% said they were concerned about creating a business plan to integrate behavioral health and primary care. Other key concerns were implementing coordinated care and shared care planning, workforce development (including recruiting primary care staff), establishing and capturing clinical measures, and integrating organizational structures. Provider organizations are also concerned with marketing their services to consumers and to payers. It's important to make sure consumers and other allied healthcare providers know what resources are available in the area. Some integrated centers have expanded beyond behavioral health and primary care to also include services for consumers with intellectually and developmental disabilities. Other provider organizations have added oral care, housing support, substance abuse treatment, and neurology services. As provider organizations add these service lines, it becomes more important to communicate these resources to other hospitals and health care provider organizations in the area.

Although COVID-19 has disrupted many business operations, less than two-thirds (58%) of provider organizations report that their integration plans have been affected by the pandemic. Rather, 20% of provider organizations reported the pandemic accelerated plans and 27% reported no impact. However, 38% of provider organizations reported the pandemic slowed plans toward integrated care.

Provider organizations report that integrated care is helping the populations they serve, giving these individuals well-rounded care. Many individuals receiving integrated care report improved outcomes with asthma, depression, obesity, and diabetes. Other providers organizations are considering additional services, such as optometry, dentistry, and smoking cessation programs.

Many of the individuals served by integrated care providers are among minority populations and/or living in poverty. Integrated care offers a lifeline to receive a suite of care that they had little access to previously. Provider organizations are finding that this integrated approach not only helps the individuals they serve, but it also helps the providers maintain their bottom line while expanding into new areas to help the community.

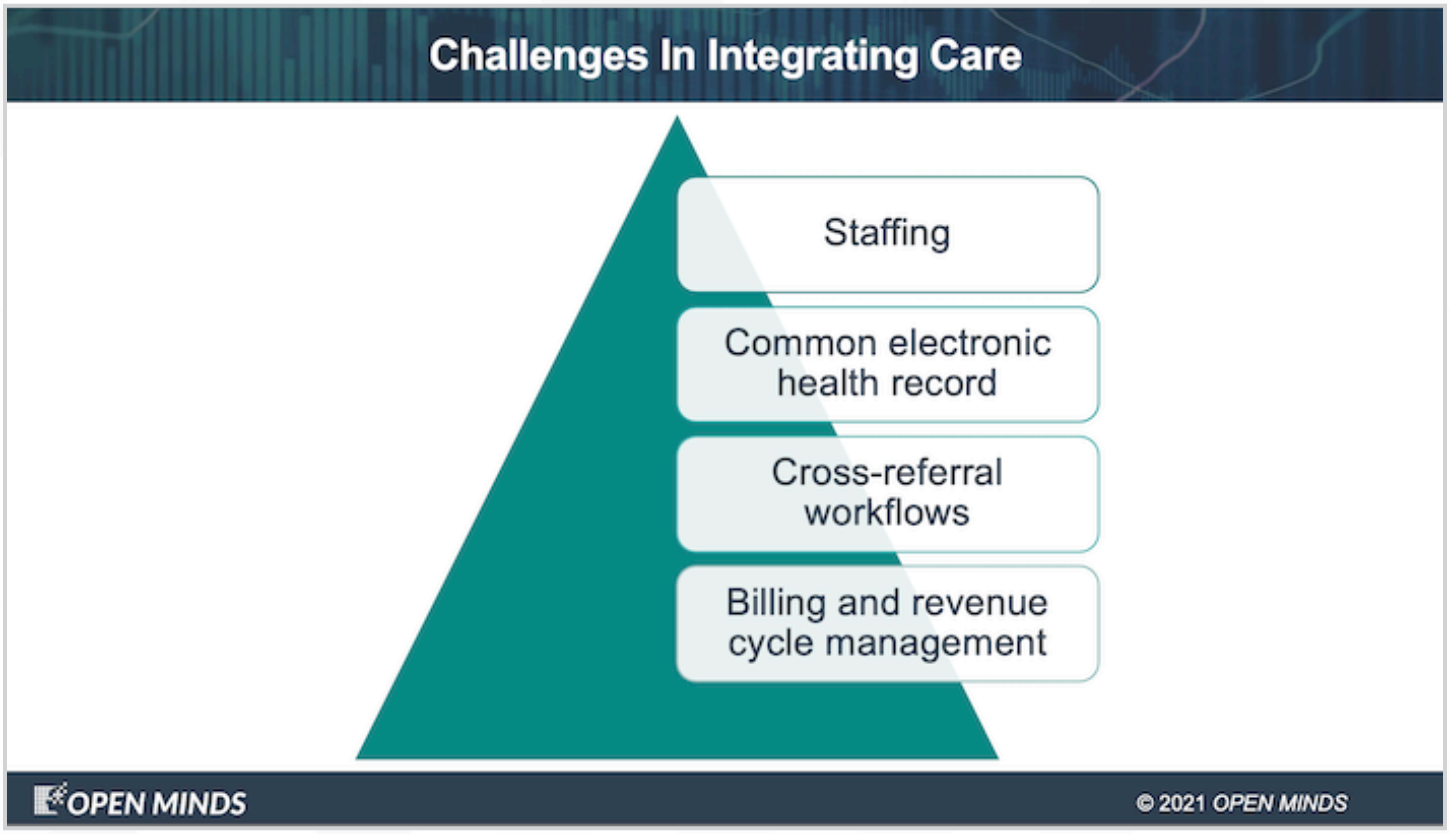
For more on the integrated care survey results, case studies of provider organizations at various points on the integrated care continuum, and strategic advice and executive insights on models and best practices to enhance integrated care, join the free Integrated Care Online community at https://integratedcareonline.com/

Delivering Whole Person Care: Avoiding The Pitfalls Of Integrating Primary Care Into Community-Based Mental Health Centers

By Betty Rabinowitz, M.D., FACP, Chief Medical Officer, NextGen Healthcare (Sponsored Content)

Providing primary care to patients with mental illness is a challenging task that requires highly skilled, experienced practitioners comfortable with the full array of biopsychosocial problems with which these patients present. For example, understanding the side-effect profiles of the psychiatric medications and their impact on problems such as diabetes and other complex endocrinopathies requires highly evolved clinical skills.

Optimally, the successful care of these patients is best provided in close collaboration among the entire health team including the prescribing psychiatrist and the primary care provider. Indeed, integrated care models are becoming more prevalent with patients being cared for by primary care and behavioral health teams, collaborating and/or colocated in the same practice using a single electronic health record.



Many behavioral health practices are considering adding primary care services in order to better address these whole-person healthcare needs. In the NextGen® Advisors' conversations with behavioral health and physician groups across the country we find several challenges that groups are universally grappling with.

Staffing

Establishing primary care services requires a decision as to the skill sets of the primary care providers that will staff the practice, such as:

- Should this team be physician led?
- Should the team include advanced practice providers (APPs)?
- Will the APPs be PAs or NPs or a combination of these skill sets?
- What is the optimal ratio of APPs to MDs?

These are not easy decisions, as the differences between the foundational skill sets of these providers are nuanced and often somewhat opaque to a behavioral health leadership team. A physician-led team will require recruiting family physicians, general internists, or medicine and pediatrics board certified providers. Staff planning is further complicated by a shortage of primary care practitioners of all skills sets in many areas of the country, especially rural communities. It is our experience that many groups will often not have the luxury of very detailed resource planning; they often must build teams by recruiting the resources available rather than the ideal combination of resources and skills.

Introducing these new medical practitioners into a behavioral health practice challenges many areas of the organization. As an example, from a human resource perspective, the process of recruiting, interviewing and onboarding primary care team members is different than the process for behavioral health practitioners. Pay scales are different and guidelines around practice sharing and part-time work may pose new frontiers. Leadership and governance issues such as privacy and HIPAA rules pose an interesting challenge as leaders of the behavioral health practice likely have not had prior experience managing a primary care practice where these issues are handled differently from behavioral health.

A Common Electronic Health Record (EHR)

One of the biggest challenges facing groups adopting an integrated care model by adding primary care services to a behavioral health practice is the fact that their current technology infrastructure does not support both behavioral health and physical health workflows well.

A common EHR is essential since true integration is virtually impossible unless both behavioral health and primary care providers are able to access a single clinical record for the patients they share. We see groups that have done so much work to start and sustain a primary care practice but have not implemented a single common EHR. It is clear that in spite of their best efforts, care continues to be disparate and disconnected as providers in both disciplines are unable to fully access each other notes, and critical information regarding their common patients is not easily shared. It is imperative for groups to consider implementation of a single integrated EHR platform capable of seamlessly and fully supporting both behavioral health and physical health workflows and regulatory requirements.

Cross Referral Workflows

In conversations with behavioral health leaders about their vision for the integrated model in their organizations, they often cite their hope that any patients receiving behavioral health in their organization also receive primary care and that the

same holds true for patients receiving primary care who might need behavioral health services. These cross referrals are at the core of the integrated, whole person model's viability and sustainability.

Achieving this cross-referral is often difficult to operationalize. There are practice-driven barriers, such as the absence of clear workflows for both teams to engage patients at every opportunity to seek mental health treatment as well as primary care in the same organization. We observe that to be successful, these referral workflows need to be formalized, trained, reinforced, and incentivized by the leadership of the practice. There are also patient factors at play where patients already have a primary care provider or with patient reluctance to engage with primary care. It is important to implement a process that makes establishing primary care an easy and seamless step for patients. Many successful integrated practices describe a workflow whereby the behavioral health provider actually walks down the hall with the patient to the primary care office to make their first primary care appointment. Electronic workflows that support this task are easily supported if the providers share the same EHR platform.

Billing and Revenue Cycle Management (RCM)

The financial viability of the integrated, whole person practice can be threatened unless organizations carefully prepare for the initiation of primary care billing. If internal expertise in this area is not readily available, or cannot be hired easily, the practice can always consider outsourcing the primary care billing operations to an outside entity with deep expertise in this area. This is so important as it could make the difference between financial viability or failure of the primary care practice.

In Summary

It is encouraging to see the integrated, whole person care model gaining momentum across the country. Continued study and research will be required to refine the model further to ensure high quality, cost-efficient, and compassionate care is offered to this highly vulnerable segment of the population. Fortunately, the aforementioned deployment of truly integrated health IT platforms in these practices will also generate the clinical, quality, and cost data that can provide the insights needed to further refine and scale this essential care model.

Many behavioral health practices have very successfully integrated primary care services providing their patients with enhanced, comprehensive, whole person care for both their behavioral health and physical health issues. Careful planning and attention to the common challenges will help practices avoid some preventable pitfalls.

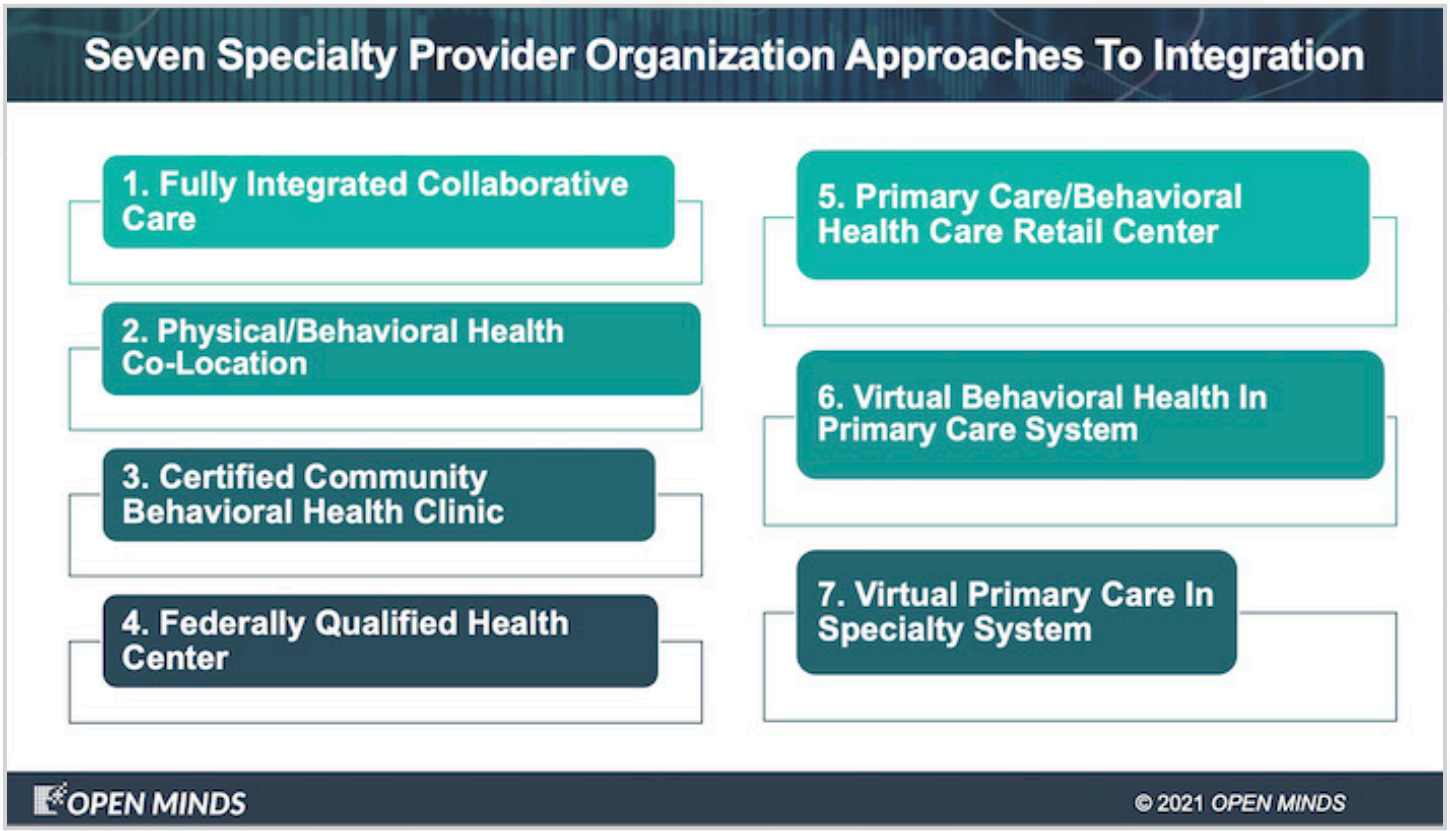
If your practice is struggling with issues pertaining to the integration of primary care, the NextGen® Advisors can help.

Seven Specialty Provider Organization Approaches To Giving Consumers A "Whole Person" Integrated Care Experience

By Meena Dayak, Executive Vice President & John Talbot, Senior Associate

As the health care market pushes for more value-based payment models—and payers and health plans are looking for new opportunities to reduce overall costs, integrated models of health care delivery offer a viable option. Recent years have seen the move of many payers and health plans to integrating behavioral health and primary care. Models that have separate, "carved out" behavioral health financing and delivery are being replaced by models that integrate all service financing and delivery in one managing entity.

In Medicaid, approximately 50.2 million (69%) of the 72.8 million consumers were enrolled in integrated behavioral health financing arrangements as of January 2020—a slight increase over 2019 when 64% were enrolled. There are currently 31 state Medicaid plans that utilize integrated financing of behavioral health, nearly doubling since 2011 when just 15 states (25%) had adopted this behavioral



health financing model. As of 2020, only 17 states (28%) have a primary Medicaid behavioral health carve-out, compared to 29 states (48%) in 2011 (see State Medicaid Behavioral Health Carve-Outs: The OPEN MINDS 2020 Annual Update).

On the health plan front, with the purchase of Magellan by Centene announced in January 2021, there are no more standalone companies focused solely on managing behavioral health benefits (see End of An Era: The Last Of The Standalone Behavioral Health Carve-Outs). The question is what has replaced the behavioral health carve-out as a delivery system for behavioral health benefits? OPEN MINDS Chief Executive Officer Monica E. Oss pointed out that the field appears to be moving to two tiers of behavioral health services. For consumers with mild to moderate conditions, the use of "on demand" services via retail locations, asynchronous artificial intelligence-driven tools, and/or telehealth is growing. For consumers with more complex conditions, the approach is more vertical (integrated) with specialty care coordination programs/health homes and specialty/vertical health plans managing all services.

But how is integrated care defined today? The Agency for Healthcare Research and Quality explains that "Integrated behavioral health care blends care in one setting for medical conditions and related behavioral health factors that affect health and well-being." And behavioral health includes mental health and substance abuse conditions, life stressors and crises, stress-related physical symptoms, and health behaviors that often affect medical illnesses (see What is Integrated Behavioral Health?).

Despite the need and growing customer preference, only 52% of specialty provider organizations are developing models that integrate behavioral health and primary care—and only 14% of these organizations have fully integrated practice models (see Intentional Approaches To Integrated Care).

For years, the dilemma over which integration model to adopt has been exacerbated by lack of clear, consistent, and sustainable funding streams; reluctance to navigate a maze of regulatory and reporting requirements from disparate payers; the requisite staffing and culture challenges that any service line expansion involves; the tenuous nature of any partnerships; and lack of resources for investment in the technology and operational infrastructure required to build an integrated care network.

We take a look at seven approaches to integrated care that address these barriers—the fully integrated collaborative care approach, the colocation of behavioral and physical health services, the certified community behavioral health clinics program approach, the federally qualified health center or community health center approach, the primary care/behavioral health care retail center approach, virtual behavioral health in primary care, and virtual primary care in specialty system.

1. Fully Integrated Collaborative Care Approach

Collaborative care is the integration of behavioral health into the primary care setting to create a comprehensive treatment plan to meet a consumer's overall health care needs. Often, consumers with mental illness and addiction disorders present and are diagnosed in primary care but primary care physicians may not have the expertise and resources to offer the full spectrum of care for these conditions or provide and follow through on referrals. But a care manager and behavioral health clinical professionals embedded in the primary care team (on a full-time or contract basis) can help to develop a unified approach to the care of the consumer. The approach includes coordinating visits to specialty care, development of goals and a specific action plan, monitoring of treatment adherence, and consumer education and support for self-management. Collaborative

care is often characterized by the use of evidence-based treatments and population based care for a defined group of at-risk consumers tracked in a registry to ensure no one falls through the cracks. A collaborative care team could have multiple specialty providers partnering on a unified treatment plan to address the consumer's co-occurring conditions.

Typically, primary care bills for all services delivered and compensates the care manager and behavioral health professionals on the treatment team. Collaborative care is more effective with bundled payment or per member per month payment models.

While there are various models through which the collaborative care approach is applied, the most common is the patient-centered medical home (PCMH). Approximately 13,000 practices (with 67,000 clinicians) are recognized as PCMHs by the National Center for Quality Assurance (see Patient-Centered Medical Home). The Veterans Administration (VA) had implemented collaborative care in 30 of its 170 VA medical centers as of 2019 and planned to scale up the initiative nationally (see Collaborative Care For Mental Health).

For more, see Integrated Care: The Collaborative Care Approach At Cherokee Health Systems and Integrated Care: The Collaborative Care Approach At Caya Health.

2. Physical/Behavioral Health Co-Location Approach

When primary care and behavioral health clinical professionals are located in the same facility, it becomes easier for consumers to access care for multiple conditions at once. No matter which door consumers come in through, they are given comprehensive assessments and care coordinators connect them with the appropriate services. Consumers presenting with behavioral health conditions in primary care are referred to specialists with warm handoffs and follow-up. And consumers coming to behavioral health specialty providers first can be referred to primary care for cooccurring physical illnesses. Appointments can be scheduled so consumers don't have to come back on different days to visit with different clinical professionals. And it is not uncommon to invite other clinical professionals to "stick their head in" during a consumer visit for an impromptu joint consultation if necessary.

The primary care and specialty provider organizations can each bill separately for the services they provide.

A University of Michigan study of 380,690 primary care physicians (PCPs) and 337,108 behavioral health providers showed that 44% of PCPs were physically co-located with a behavioral healthcare provider. Colocation rates were directly tied into the size of the practice—only 12% of solo PCPs were colocated compared to 48% of PCPs at medium size practices and 82% of PCPs in large practices. And, 46% of PCPs in urban settings were likely to be colocated compared to 26% of PCPs in rural locations (see Where is Behavioral Health Integration Occurring? Mapping National Co-location Trends Using National Provider Identifier Data).

For more, see Integrated Care: The Co-Location Approach At Jefferson Center For Mental Health.

3. Certified Community Behavioral Health Clinic Program Approach

Certified community behavioral health clinics (CCBHCs) are designed to provide a range of services—either directly or through a formal contract with a designated collaborating organization—including 24/7 crisis mental health services; outpatient mental health and substance use services; primary care screening and monitoring; targeted case-management; psychiatric rehabilitation services; and connections with other providers and systems (criminal justice, foster care, child welfare, education, primary care, hospitals, etc.). CCBHCs are intended to ensure an approach

to health care that emphasizes recovery, wellness, trauma-informed care, and physical-behavioral health integration.

Currently CCBHCs are funded through multi-year federal demonstration program grants from the Substance Abuse and Mental Health Services Administration (SAMHSA). States participating in the demonstration program are required to implement prospective payment rates to replace fee-for-service reimbursement for CCBHC services. This involves making sure that payments are adequate to deliver open access to integrated mental health and substance use disorder services, wraparound supports, and basic primary care. In recent years, the Centers for Medicare and Medicaid Services (CMS) has approved moves by CCBHC demonstration states to fold these payment innovations into their state Medicaid programs. In non-demonstration states, CCBHC grantees have to work with local payers to develop sustainable payment similar to the models adopted in Demonstration states (see New Interventions To Address Substance Use Disorder Must Take Financial Sustainability Into Account).

There are 340 CCBHCs operating across the country (see SAMHSA Released Grants To 134 Clinics To Become Certified Community Behavioral Health Clinics).

For more, see Integrated Care: The CCBHC Approach At Burrell Behavioral Health.

4. Federally Qualified Health Center/ Community Health Center Approach

FQHCs are community-based health care providers that receive funds from the Health Resources Services Administration (HRSA) Health Center Program to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes consumers.

FQHCs may be community health centers, migrant health centers, health care for the homeless, and health centers for residents of public housing (see Federally Qualified Health Centers).

FQHCs receive support from the federal government in the form of an operational grant, cost-based reimbursement for Medicaid patients, and malpractice coverage under the Federal Tort Claims Act (see What Is An FQHC?).

There are more than 1,300 FQHCs operating in more than 11,000 sites across the U.S. Nearly 90% of health centers offer onsite, short-term counseling, while 57% offer treatment for substance use disorders, and 44% offer medication-assisted treatment for opioid addiction (see The Role of Medicaid Expansion in Care Delivery at Community Health Centers).

For more, see Integrated Care: The FQHC Approach At Terros Health.

5. Primary Care/Behavioral Health Care Retail Center Approach

Retail health clinics are walk-in health care facilities located in commercial stores that have extended evening and weekend hours and accept most insurance and cash payment. They are usually staffed by nurses, nurse practitioners, and physician's assistants and occasionally by physicians. Typically, these clinics treat common illnesses and injuries, offer vaccinations, conduct physical exams and health screenings, and provide preventive health services. Retail clinics are beginning to offer mental health services as well.

Retail health clinics encourage self-pay but usually accept most forms of commercial insurance and Medicare as well. Most offer affordable services with price transparency.

Overall, there are approximately 2,800 retail clinics providing health care in 44 states and Washington

DC, accounting for over 40 million patient visits each year. In effect, 19% of U.S. adults use retail health care.

For more, see Integrated Care: Primary Care/ Behavioral Health Care Retail Center Approach At CVS HealthHUBs.

6. Virtual Behavioral Health In Primary Care System Approach

Primary care facilities can bring in behavioral health clinical professionals virtually to serve their consumers, enabling convenient access to specialty care and enhancing the possibility of follow-up. In addition, consumers now have a choice of several virtual subscription services which offer primary care and behavioral health through a single integrated platform for an affordable annual or monthly fee.

Primary care provider organizations can bill directly for all services and compensate the behavioral health clinical professionals for their services.

A recent report from the American Hospital Association (AHA) notes that hospitals and health systems are exploring a variety of virtual care models, many of which are underpinned by telehealth technology. Thirty six percent of health systems and 29% of community hospitals are using telehealth for psychiatric and addiction treatment. Among academic medical centers, that number is even higher, at 42% (see Telehealth: A Path To Integrated Virtual Care).

7. Virtual Primary Care In Specialty System Approach

Specialty behavioral health provider organizations can contract with primary care clinical professionals to provide virtual visits for consumers with mental illness in their care. These visits can take place at the behavioral health facility or at the consumers' homes, with the presence of a care coordinator or case manager if needed. This is an evolving concept with tremendous potential.

Integrated Care: The Collaborative Care Approach At Cherokee Health Systems

By Cory Thornton, Managing Editor

Cherokee Health Systems in Tennessee is a pioneer in the use of a collaborative approach to integrate physical and behavioral health care. They are a federally qualified health center (FQHC) and approach integration through a "behaviorally-enhanced primary care model." Integration of care has been the norm at Cherokee since 1984 and they found that primary care is the best platform for community mental health programming as it helps to overcome the fear of stigma that consumers might have in seeking specialty mental health treatment. They've seen that comprehensive care delivered in collaboration with a medical provider also helps to improve outcomes and lower the cost of care.

Program Model

Cherokee's base clinical model for integrated delivery system is a primary care medical home model with behavioral health consultants (BHCs) as part of the medical team. The BHCs are specifically trained to work with a panel of consumers seen by primary care providers. The consumers sign a consent form to be treated by a multidisciplinary team. When primary care clinical professionals ask the BHC to see a consumer, about three-quarters of the time, it is for a behavioral health concern. And, a quarter of the time, it's about helping manage chronic medical conditions.

When consumers come in seeking mental health services sign the same consent form and Cherokee establishes whether they have a primary care provider, if they have seen that provider in the last year, and if are they actively engaged in that treatment relationship. If they do not have primary care provider or are not actively engaged, Cherokee encourages them to seek care in its integrated primary care system.

Cherokee explains to consumers on its website that "During your visit, you will meet with several team members who will partner with you to address your healthcare needs. Your primary care provider will ask about your physical and behavioral health including your mood, energy, sleep, and ways you deal with stress. The primary care provider may ask another team member, a behavioral health consultant (BHC), to offer additional assistance meeting your health care goals. As a team, you, your primary care provider, and your BHC, will determine how to best help you reach these goals and develop a plan to help you succeed."

The behavioral health and primary care professionals on the team share a consumer panel and population health goals. They also share support staff, physical space, clinical workflows, clinical documentation, communication, and treatment planning.

In addition to integrated primary care and behavioral health for adults, children and adolescents, Cherokee offers obstetrics and gynecological services, a women's health program, outpatient addictions treatment, an onsite pharmacy, health education, social services and supports navigation, crisis services, and an after-hours nursing line.

Cherokee has 687 employees. Staff includes 31 psychologists and 20 primary care physicians. Specialty clinical professionals include seven psychiatrists, two cardiologists, one nephrologist,

two dermatologists, two dentists, two ob-gyns, and one infectious disease specialist. They have nine psychiatric nurse practitioners and 41 primary care nurse practitioners. 30 social works/counselors, 29 community health workers, and nine peer specialists are also on staff. Their staffing ratio is one behavioral health clinical professional for every four primary care professionals.

Population Served

Cherokee serves 69,461 consumers annually, which includes 14,791 new consumers in 2020. They are primarily a safety-net provider, but open to consumers of any age and any income status.

Currently, Cherokee operates 24 rural and urban clinics in 13 Tennessee counties, in addition to onsite and telehealth services provided in many area school systems.

Program Fees & Funders

Cherokee accepts all payers. Approximately 43% of consumers had Medicaid, 15% were on Medicare, 15% had commercial insurance and 27% were uninsured. Revenue was slightly over $63 million.

They developed win-win relationships with the managed care organizations in Tennessee and advocated for payment models that support the clinical model—case rates, G codes, 96156 codes, and same day visits. They negotiated "smart" capitation contracts so they could get paid for quality, not volume.

Program History

Cherokee is a federally qualified health center (FQHC) that was initially established in 1960 as a community mental health center focused on serving consumers with serious mental illness. In the 1980s, managed care was just taking off in Tennessee, with the state contracting with three health plans for all Medicaid enrollees. At this time, Cherokee decided to respond to the increasing need for primary care services, which were lacking in the community. So they decided to stay rooted in mental health, but expand into primary care in a big way. They set out to create a new model of care using embedded behaviorists in order to treat the whole person in primary care. In 2015, the National Committee for Quality Assurance recognized the organization's work as a patient-centered medical home.

Successes, Challenges & Advice

Dennis Freeman, Ph.D., Chief Executive Officer of Cherokee Health Systems, says integrated care is not "primary care + behavioral health." The integrated model that seems to stand the test of time (both financially and clinically) is behaviorally-led primary care.

His advice—based on 40+ years of experience—for the organizations that are developing an integrated service delivery model? Consumers always point the way—primary care is the portal into the health care system, and the system needs to change, not the consumers. He said it's important to let go of a "specialty" mindset and adopt a more generalist vision to succeed with integrated care. New staffing, administrative, and operational models will be needed to implement integrated care. And provider organizations must also recognize that not every behavioral health clinical professional can make it in primary care—it will take a level of planning and wisdom to recognize which ones can and can't. And finally, it's important to recognize and adapt to primary care as a volume-driven business.

Integrated Care: The Collaborative Care Approach At Caya Health

By Rachel Lilley, Production Manager

Launched in March 2021, Caya (Come As You Are) Health is a fully integrated outpatient family medicine, psychiatry, and counseling practice in Lake Mary, Florida. Caya was developed and founded by Eric Moore, M.D., founder of Moore Medical Group. The organization launched with a mission to "empower people to a greater quality of life through holistic integrated healthcare."

Program Model

Caya's integrative approach to outpatient family medicine, psychiatry, counseling, and addiction medicine is grounded in a fully integrated model of care. Caya's multidisciplinary team, which consists of three physicians, two advanced nurse practitioners, two psychiatrists, two doctorate-level psychiatric nurse practitioners, and two licensed clinical therapists and counselors, work together to develop a whole person care plan addressing emotional and mental health, as well as physical well-being. Caya's practice manager, front desk, and medical assistant provide administrative front office support, including customer service, scheduling, patient processing.

Upon intake, each patient is screened for depression and anxiety and is assessed for the appropriate intervention and provider based on their outcome. Caya's primary care professionals assist with scheduling patients in need of therapy for mental health or same-day psychiatry. Similarly, behavioral health staff provide coordination with primary care services if patients present with medical conditions or needs such as elevated blood pressure, medication refills, or abnormal lab results. Weekly interdisciplinary meetings will be held for behavioral health and primary care staff to collaborate on challenging cases.

Primary care and family medicine services include preventive care, vaccinations, treatment for common ailments, sports physicals and injuries, chronic diseases (e.g., hypertension, diabetes), women's health, medical weight loss, and insomnia. Caya's behavioral health offerings span the full range of behavioral and emotional health, including treatment for depression and anxiety; post-traumatic stress disorder; bipolar disorder; obsessive compulsive disorder; and substance use disorders, smoking cessation, insomnia, and weight control. Services are provided in an individual and/or group setting depending on each individual's needs. Caya medical professionals refer and coordinate services within the Caya Health team to ensure care continuity between the primary care professionals and behavioral health specialists. Transitional care is also offered for patients discharged from psychiatric hospitals, as well as care management and remote patient monitoring.

In addition to physical and behavioral health services, Caya also provides support groups and workshops in areas such as depression and anxiety, smoking cessation, diabetes control, and weight loss, as well as community activities and wellness opportunities such as yoga. For individuals receiving treatment, guided group sessions offer an additional level of support and encouragement.

Telehealth sessions are currently offered in response to the COVID-19 restrictions in the state. The virtual option is provided through Caya Talk, the

organization's online platform for online scheduling and virtual visits.

As a recently established practice, Caya currently serves a daily average of one-to-two patients per day. Individuals are referred from acute psychiatric hospitals, substance use disorder residential treatment, and skilled nursing facilities. In-person services are provided at Caya's main facility in Lake Mary, Florida. The organization has plans to open a second office towards the end of 2021, and recently signed an agreement with Genoa Healthcare to open an on-site integrated pharmacy.

Population Served

Caya serves individuals across the lifespan from youth to older adults. Caya has an affiliation with a local psychiatric hospital and actively works with the facility to ensure patients without primary care receive appropriate follow up care. The organization is seeking additional referral partnerships with acute psychiatric hospitals, substance use disorder residential treatment facilities, and skilled nursing facilities to provide follow up primary and psychiatric care.

While Caya currently operates one facility in Lake Mary, the organization has plans to open additional offices throughout Orlando and Bradenton, Florida, as well as Raleigh and Wilmington, North Carolina. Caya serves between one to two patients per day.

Program Fees & Funders

Moore Medical Group is the CayaHealth's parent company and served as the immediate source of start-up funding along with its lines of credit. The organization does not receive grant funding. In its first year of operation, the goal is to break even in year one revenue as Caya's patient population grows. In its second year of operation, Caya's current revenue projections are $500,000 with 20% increases yearly until capacity is reached or more locations are added.

Caya is in network with Cigna, Aetna, Magellan Complete Care, United Healthcare, and Florida Blue. The organization also accepts TRICARE and Medicare; however, it does not accept Medicaid as of April 2021. Cost per consumer is not available.

Although Caya does not have value-based contracts, the organization will consider entering value-based arrangements in the future after ensuring standard fee-for-service reimbursement processes are in place, with potential to enter into Medicare risk-based contracts.

Program Performance & Outcome Metrics

Because the program is within its first month of operation, there is not yet specific data on client and programmatic outcomes. However, as an integrated system, Caya will track demographic data, inpatient readmissions, intervention efficacy, as well as clinical reporting through the Merit-based Incentive Payment System. In addition, Caya will also utilize the data to glean insights into future integrated program design.

Program Partners

Caya is pursuing strategic partnerships in addition to its referral partners. The organization is seeking to execute an integrated network with Advent Health, as well as other entities in Florida to expand organizational capacity and resources.

Program History

Official planning for Caya Health began in 2018. Over a three-year period, Caya's stakeholders developed and operationalized the integrated care model to ultimately build the overall business plan for the organization's operations. Caya's first office opened in March 2021.

Successes, Challenges & Advice

Caya Health is inherently unique in that it was developed out of Dr. Moore's more than 20 years of history practicing family medicine and passion to develop effective models of health care that integrate

traditional physical and medical care with mental and emotional well-being. To meet the holistic needs of the community Caya serves and overcome the stigma often experienced in seeking psychiatric care in traditional settings, the organization brings together person-centered, fully integrated health care in "one-stop-shop" environment.

Dr. Moore explained one of the most notable challenges experienced in operating an integrated practice is reimbursement. "We've seen it all in our history billing for medical services in a psychiatric hospital. Developing Caya Health, we had to put our greatest minds in setting up our reimbursement and authorization processes. It took three years but we've gotten proficient in understanding how it works."

For organizations seeking to adopt an integrated model of care, Dr. Moore advises that "it's more than just a business proposition," rather it requires a strong passion to serve a historically underserved and potentially complex population. He explained, "This is a challenging population to work with. You have to be passionate about it and give people a fighting chance at quality of life. If you really care about what you are doing, the rest will come together." Dr. Moore also advised that success with any integrated program requires an understanding of how the multiple models of integrated, whole person health care fit into your organization's background, long-term goals, mission, resources, and overall financial strength.

Integrated Care: The Co-Location Approach At Jefferson Center For Mental Health

By John Talbot, Senior Associate

Jefferson Center for Mental Health in Colorado approaches integrated care through a simple model of co-location. Their behavioral health clinical professionals work onsite at local primary care practices. Billing for these mental health services is done directly by Jefferson Center.

Program Model

Since 2012, Jefferson Center has operated a program called Solutions Now focused on the commercial insurance market. Through this program, it has embedded its clinical professionals onsite at 35 local medical offices—pediatric and family practices—to provide mental health services when consumers who come in for primary care visits are referred to them.

Jefferson's Center's staff at the primary care practices serve all consumers referred to them, with very few rule-outs or external referrals (except for some consumers with substance use disorders and eating disorders). There is a "culture of interruption" to connect consumers to care immediately, including through same day consults. The staff follow protocols for timely reporting, communication, and coordination of care. The primary care practices take care of scheduling the behavioral health appointments. They also send the consumer "face sheet" upon referral so Jefferson Center can set the consumers up in its electronic health record system.

In 2012, Jefferson Center received a multi-year, $1.5 million SAMHSA grant to support the creation of an integrated health home. Jefferson Center received SIM funding to open a second health home focusing on children and families. All patients of the health home have access to a spectrum of behavioral health care, depending on their needs. Services range from addiction disorder treatment to health coaching and wellness services.

Jefferson Center also partners with Metro Community Provider Network (MCPN), the local federally qualified health center (FQHC), to offer integrated and co-located services at two integrated health homes. Both Jefferson Center and MCPN are assigned a health care coordinator who helps ensure the success of these integrated services by easing access to care, and by providing case management, health education, and scheduling assistance.

Programs at the center include crisis and emergency services, outpatient services, psychiatric services, hospital alternative programs, wellness services, navigation services, withdrawal management, criminal justice, intensive case management, residential services, and vocational services.

The center has more than 620 employees and 80% of staff are clinical professionals and prescribers.

Population Served

Jefferson Center serves more than 32,000 children, youth, families, adults, and older adults at 26 clinical locations in Jefferson, Clear Creek, and Gilpin counties in Colorado. The center also provides care in more than 41 elementary, middle, and high schools and services in many other community settings such as nursing homes, foster homes, and senior centers.

Program Fees & Funders

Jefferson Center bills directly for services provided by its clinical professionals at any location through its own tax ID, submitting claims through consumers' mental health benefits. No money is exchanged with any of the practices it collaborates with.

Jefferson Center is a 501(c)3 non-profit organization with operating revenue of $60 million. Over 56% of its revenue is from Medicaid, 0.4% from Medicare, 14.6% from pharmacy sales, 3.2% from the state of Colorado and local government contracts, 6.8% from other contracts, 3.3% from commercial and client fees, and 5% from other revenue ($3.6 million).

Successes, Challenges & Advice

While the co-location model has fueled growth, it has also introduced challenges over the years. The program has almost been "too successful" according to the center's executives, leading to overcrowding issues that impede access to care, especially in pediatrics.

Primary care and behavioral health professionals communicating with each other has been a challenge. Additional players like care coordinators, quality improvement coaches and practice transformation staff have been introduced to the mix, adding to the complexity of communication. Structural changes without cultural changes can be ineffective, executives advise.

The key to developing an effective integration approach? Rather than asking which model works best, ask what elements add most value to the practice, and to your organization, said Dan Fishbein, Ph.D., Vice President of Business Development and Systems Management. Rather than establishing a set of standards, and then working to "transform" practices to achieve those standards, ask what practices would find most helpful in extending behavioral health onsite to their consumers and make that happen.

Integrated Care: The CCBHC Approach At Burrell Behavioral Health

By Meena Dayak, Executive Vice President

Burrell Behavioral Health is the second-largest Certified Community Behavioral Health Clinic (CCBHC) in Missouri and one of the three largest in the United States. Burrell received a $4 million CCBHC grant from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) in 2018 and a second CCBHC expansion grant of $4 million in May 2020.

Program Model

With its first CCBHC grant of $4 million from SAMHSA in 2018, Burrell has been able to serve more than 1,500 people, and has made significant advances in its ability to provide telehealth services through its Connection Center in Springfield, Missouri which opened in January 2020.

With this grant, Burrell was also able to support staffing for a 24/7 crisis response line. They equipped local police officers with tablets that would allow them to call a behavioral health clinician while on patrol, and provide individuals experiencing a behavioral health crisis the opportunity to receive immediate attention and be connected to the appropriate services. As a result of this partnership, 87% of consumers were diverted from inpatient psychiatric hospitalization, only 16% were referred to an emergency department, and none were incarcerated—a massive improvement over the default of taking everyone to jail or the hospital.

With the 2020 expansion grant, Burrell extended its comprehensive and integrative CCBHC model to an additional 1,600 consumers in Christian, Dallas, Greene, Polk, Stone, Taney, and Webster counties in southwest Missouri; and Boone, Carroll, Chariton, Cooper, Howard, Moniteau, Morgan, Pettis, Randolph and Saline counties in central Missouri. The expansion focused on services for individuals with serious mental illness; addiction with a focus on opioid use; children and youth with serious emotional disturbances; and those with behavioral health disorders occurring simultaneously with addiction disorders. Returning military veterans, consumers with HIV and AIDS, and the homeless are communities of emphasis.

Burrell uses evidence-based practices to expand access for individuals with a comprehensive system of care. The service array includes crisis mental health services; screening, assessment and diagnosis; person centered treatment planning; outpatient mental health; substance use disorder treatment and recovery; health screening/monitoring; case management; peer and family supports; psychiatric rehabilitation; assertive community treatment; home-based health; and Medication Assisted Treatment for opioids. The project places special emphasis on innovating to increase access in a variety of locations—schools, emergency rooms, primary care facilities, community centers, homes, etc. Behavioral health care will be bolstered by the human and social services provided. Expected outcomes include improvements in: number of individuals impacted, screened and assessed; number and types of services; individual diagnoses; physical and mental health; employment; substance use; housing; and 21 additional SAMHSA CCBHC measures.

The goal of the CCBHC expansion grant is to expand rapid access to quality community behavioral health services, integrated care, and supportive human and social services for those who are uninsured, underinsured, have unaffordable insurance and/or gaps in insurance. This includes those who cannot afford insurance deductibles, insurance co-payments, and co insurance payments. It places special emphasis on increasing access for client services for those experiencing homelessness; the LGBTQ+ population; Hispanic and Latino communities; and African American communities. The grant also continued to serve members of the armed forces and veterans, and those affected with HIV.

Burrell has more than 150 licensed provider organizations that offer a full continuum of care through their integrated network. They offer psychiatric and psychological treatment for individuals, groups, and families, with a focus on enhancing integration with a range of services. Burrell's services include therapy and counseling, psychiatric services, residential services, case management, addiction recovery, crisis intervention, evaluations, developmental disabilities, integrated services, autism, and forensics and neuropsychology.

Population Served

Burrell Behavioral Health works with more than 40,000 clients across 25 counties in Missouri and Arkansas. The 17 counties in Burrell's catchment area in Missouri are designated by the Department of Health and Human Services as Mental Health and Primary Care Professional Shortage Areas, with 82% designated as Medically Underserved Areas. Over 98,000 adults and children in Burrell's service area are without insurance and may not have access to the healthcare services they need.

Program Fees & Funders

The CCBHC program is funded through federal grant totaling to $8 million. $2 million a year has been awarded by SAMHSA since 2018. The 2020 expansion grant was the largest awarded to any CCBHC in the state of Missouri.

Overall, Burrell Behavioral Health has $146 million in annual revenue, of which 2% comes from grants and contributions.

Performance & Outcome Metrics

Overall, in 2020, Burrell saw a 5.4% increase in consumers served (with a 32% increase in psychiatry consumers). They reduced waits times for all Burrell services, from 6.3 days in FY 2019 to 5.1 days in FY 2020. They increased their clinical professional staff by 40%. In terms of outcomes, 62% of consumers reported significant decrease in anxiety symptoms and 73% reported significant decrease in depression symptoms.

Success, Challenges & Advice

In announcing the CCBHC expansion grant in 2020, Burrell President and Chief Executive Officer C.J. Davis said, "As the state-designated Community Mental Health Center for 17 counties in Missouri, we are charged with providing mental health services to our citizens regardless of their ability to pay. These funds will be vital in helping us accomplish this mission and connect our most vulnerable citizens to the care they desperately need, especially in light of the mental health crisis that will affect so many of us following COVID-19."

Mr. Davis also noted, "The CCBHC designation allows us to partner with the medical world in ways that mental health's never partnered with medicine before. So it's extremely innovative."

Integrated Care: The FQHC Approach At Terros Health

By Rachel Lilley, Production Manager

Terros Health provides integrated primary care and specialized mental health and substance use treatment for children and families in Arizona. They operate four federally qualified health centers (FQHCs) which are recognized by NCQA as patient centered medical homes. Terros describes itself as a "whole health, whole person integrated care provider delivering physical health care with specialization in family services, wellness, substance use recovery, mental health, youth and community prevention, and HIV prevention with a focus on healthy living."

Program Model

Terros provides integrated primary care and behavioral health services in eight of its 15 locations. And four of those eight integrated care sites are FQHCs. The FQHC status allows Terros to serve underserved populations and receive enhanced rates to meet the needs in the areas served.

Terros currently serves about 25,000 consumers annually at its eight integrated care locations. Approximately 8,400 of those patients receive primary care, and 3,800 receive both primary care services and behavioral health. Over the next few years, Terros aims to grow its current service volume by reaching consumers who already receive services and engaging them in primary care services.

Terros' vision is to be a premier "behaviorally-led integrated health care company." Terros Chief Executive Officer Peggy Chase said, "Our model of integrated care has a strong focus on whole health and follows the principles of the patient-centered medical care home. We believe that treating the mind and body will have the highest success for healthier people and healthier communities. No matter which door the consumer enters, we have a system of care available to treat the whole person. Our integrated care model provides consumers with primary care, behavioral health, and substance use disorder services under one roof, with a strong care coordination component to ensure that consumers are connected to the services they need, and that medical care information is shared among treating providers. This model affords consumers immediate access to comprehensive care, and provides timely follow-up to a larger number of individuals with complex or chronic co-morbidities that place them at an increased risk of emergency hospitalization."

Ms. Chase added, "As a behaviorally-led company, our teams have the expertise to help consumers with health behaviors that may be impacting their overall wellness. The techniques we use for behavior change can assist in making healthy lifestyle choices, prevent health diseases, and impact chronic condition management with many of our consumers. Our multidisciplinary care teams assess and manage conditions effectively through communication, morning care team huddles, and care management approaches.

To date, there are a few key factors that have contributed to Terros' success with integration. First, they developed a culture that supports a common language between physical and mental health, aligning technology with a fully integrated electronic health record, marketing primary care services, and embracing new models that connect patients to additional resources, such as community health workers. For future initiatives, Terros Health

is focusing on creating a "one stop shop" by adding additional onsite resources, making primary care the entry point to care, and increasing the number of primary care and integrated care consumers overall.

Terros has 900 employees overall. Headquartered in Phoenix, Arizona, they serve locations across Maricopa County and provide specialized services in parts of Northern and Southern Arizona. Terros operates 15 locations in Phoenix, Mesa, Glendale, Tempe, Tucson, Prescott/Prescott Valley, Kingman/ Bullhead City, and Flagstaff.

Population Served

Terros serves more than 50,000 unique individuals each year. The organization offers a full continuum of integrated, whole-person services for children, adolescents, adults, and families. Terros is also recognized as a patient-centered medical home (PCMH).The PCMH program includes primary care, community prevention services (e.g., testing, education, and outreach activities for individuals at-risk or currently infected with HIV/AIDS), youth programs (e.g., life skills training, services to support self-esteem, arts, and cultural activities), prevention services for substance use disorder, and substance abuse reduction, and community outreach and intervention services.

Program Fees & Funders

In fiscal year (FY) 2019, Terros Health had $74.3 million in annual revenue with net assets of $13.4 million. This was a slight decrease from FY 2018 when Terros had $79.1 million in revenue and net assets of $13.7 million. Overall, Terros Health's annual revenue has increased substantially since FY 2015, when the organization had $59.4 million in annual revenue. Over the next two fiscal years, Terros Health's annual revenue increased more than 25% to approximately $74.8 million in FY 2016 and increased again to $77.9 million in FY 2017.

Terros Health offers a full continuum of integrated, whole-person services for children, adolescents, adults, and families. The service lines that comprise the majority of Terros' annual revenue include outpatient services (approximately 61% of Terros Health's total annual revenue), crisis services (approximately 17% of total annual revenue), family services (approximately 15% of total annual revenue), and its patient-centered medical home services (approximately 6% of total annual revenue). The remaining approximately 1% of total annual revenue is comprised of government grants and other contributions.

Performance & Outcome Measures

According to the Uniform Data System measures that health center grantees are required to submit, in 2020, Terros screened 76% of consumers for depression, 82% for tobacco use, 74% for body mass index, 77% for ischemic vascular disease, and 43% for hypertension. They also screened 14% of consumers for cervical cancer and 7% for colorectal cancer.

Program History

Terros was founded in 1969 as a behavioral health provider organization and began its integrated care journey in 2010 with just $60,000 in the form of an integrated care planning grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) and adopted a range of integrated care models along the way.

Three sites achieved FQHC look-alike status in 2014 and 2015; one site started as a community health center in 2016—and all four went on to earn full FQHC designation in 2019.

Successes, Challenges & Advice

Adding primary care requires rearrangement of operations and workflows. Ms. Chase pointed out

that as their primary care initiatives grew, they had to switch to a new electronic health record (EHR) capable of supporting primary care and behavioral health effectively. She said, “We wanted that care team model to be the model of how we used our EHR, so that everyone on the care team could see everything around that patient.”

Adding primary care also means adding new team members with additional skillsets. Terros hired staff with a primary care background not just for clinical positions but also for finance, revenue cycle management, and EHR management, which helped them build the right team. Even their in-patient unit previously operated on a paper record and so there were barriers around access to patient health information. Getting that infrastructure in place was obviously a key component to success.

Developing the culture for integrated care is not as easy as it sounds, cautioned Ms. Chase. “We’re actually merging two cultures. We’re working in a behavioral health culture that has a richness all the way back to the 1960s and has had so much success. And then in addition to that, we have a physical health culture that’s been around even longer. And you’re really pulling these two cultures together and saying we’re doing whole person care now.”

There is also the issue of working with the community culture. Terros found that in one of their communities, 68% of residents, who were part of the Latinx population, did not take to primary care and preventative care well. “So, we really found that we had to work very differently in that community. We had to go where the people were and gain their trust and had to have primary care practitioners that look like them. We really had to work on that community culture, as well as our internal culture,” said Ms. Chase.

Adding primary care services does not mean the consumers will come flocking in. In addition to recultivating the referral pipeline, specialty provider organizations diversifying into primary care must invest in marketing to current consumers and new prospects. Ms. Chase said, “What we learned is that if you build it, you have to work to bring them in. And it was not easy to convince people that were in our care for behavioral health to also be in our care for physical health—because they were fearful of primary care or they did not want to fit it into their schedule or deal with the cost. So internal and external marketing became a really critical piece for us.”

Despite the challenges, integration efforts allow provider organizations to compete and be a viable entity in a “carved in” market. And focusing on the whole health of consumers has long been known to improve health outcomes, change health behaviors, lower costs, and helps the consumers achieve and sustain wellness.

Integrated Care: Primary Care/Behavioral Health Care Retail Center Approach At CVS HealthHUBs

By Meena Dayak, Executive Vice President

CVS Health is a diversified health services company. In March 2021, the company announced that it has launched a behavioral health pilot program at 17 HealthHUB locations in three states: Florida (six locations), Pennsylvania (four locations); and Texas (seven locations). By July 2021, 17 more pilot locations are slated to open with six in New Jersey, one in Florida, three in Pennsylvania, and seven in Texas.

Program Model

For the pilot, the HealthHUBs, which provide consumers with care concierge services for chronic disease management and other primary and preventive care services, are working with the CVS MinuteClinic service, which provides direct medical services. Mental health counseling services are provided by a MinuteClinic® licensed therapist within a CVS® HealthHUB™ location. The social workers provide adults ages 18 and older with behavioral assessments, referrals, on-the-spot counseling, and personalized care plans.

The behavioral health services at the pilot HealthHUB locations are available during standard HealthHUB hours. Appointments are available days, evenings, and weekends. The sessions are held in private consultation rooms. Consumers can opt for in-person face-to-face visits or a telehealth session.

During an initial assessment, a licensed therapist helps to assess the consumer's current situation and explore potential options for care. Together, the consumer and therapist create an individualized care plan to help improve the consumer's mental health and total well-being. The therapist provides ongoing sessions to help you address areas of concern. If the consumer has a need for higher levels of care, the therapist can connect the consumer with an appropriate specialist from CVS Health's extensive provider network or collaborate with the consumer's existing providers when appropriate.

For insured patients, social workers can help map out what is included in their benefits packages. For uninsured users, HealthHUBs will connect them to local resources within their community.

The initial visit with a therapist costs $129 and subsequent sessions are $89 for direct payment. The HealthHUBs also accept most major commercial insurance. Most medical care is available for $99 to $139 a visit. A general medical exam costs $89, smoking cessation costs $59 for an initial assessment with $40 for each follow-up visit, and weight loss costs $69 for an initial assessment with $59 for each follow-up and coaching visit.

CVS HealthHUBs offer a broader range of health care services, new product categories, digital and on-demand health tools, trusted advice, and personalized care. A care team comprising Our nurse practitioners, physician assistants, licensed practical nurses, and pharmacists, and licensed clinical social workers, comes together to help consumers. About 20% of the stores hosting HealthHUBs are now dedicated to health services, including new durable medical equipment and supplies and new product and service combinations for sleep apnea and diabetes care. With personalized pharmacy support programs and expanded MinuteClinic services, HealthHUB teams

are improving care for patients managing chronic conditions, with a focus on recommending next best clinical actions and driving medical cost savings. The HealthHUB store format also includes a variety of pathways to nutritional health with one-on-one and group counseling delivered by an in-store dietitian, as well as access to weight loss programs.

Each HealthHUB has a care concierge—responsible for customer engagement—who educates customers about the new service offerings, helping them navigate the in-store services and events, and connecting them to in-store providers. The design of the HealthHUB also includes community spaces and digitally enabled offerings. Wellness rooms are available for CVS professionals and community partners to host group events like health classes, nutritional seminars, and benefits education. In addition, there are learning tables that include iPads for customers to explore health and wellness apps, as well as shop our expanded product selection on cvs.com.

Program History

CVS opened 50 HealthHub stores in the U.S. in 2019 (starting with three in Houston) and currently has 205 locations open across 22 states. The company plans to open approximately 1,500 hubs by the end of 2021.

According to the CVS Health website, "When CVS Health completed its acquisition of health plan Aetna in November 2018, it set a bold course to transform the consumer health care experience in America. … the combined company is taking an accelerated step in its work by announcing a significant expansion of HealthHUB locations at CVS Pharmacy stores across the country."

Successes, Challenges & Advice

According to Employee Benefit News, Cara McNulty, President, Behavioral Health & EAP at Aetna, said the CVS initiative is an "easy button" for those who have difficulty navigating care. She said, "The traditional mental health care system is complex and it can be very difficult to access. Especially in an environment where so many people need it, we're here to provide a member-centric approach and meet people wherever they're at on this journey."

"Part of the existing mental health system is that people have to wait weeks to get in and they don't know where to go. We're taking that confusion out of it," Ms. McNulty added.