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Comments Prepared for Senate Finance Medicaid Reform Subcommittee
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Southcentral Foundation (SCF) Behavioral Health Integration

Separating the mind from the body never made any sense. About 50% of the highest cost individuals in terms of ED and Hospital use have a major mental health diagnosis. Over and over again there have been trials of integrated care that show dramatic reductions in costs and improvements in quality of life and medical outcomes. Often the results are dramatic.

a. SCF has had integrated, team based care for almost 20- years now, incorporating case management and same day access right from the start. We fully integrated Behavioral Health Consultants over ten years ago now and that represents one of our most transformative changes we have ever done. Our data shows huge reductions in ED and hospital use, dramatic improvements in outcome and quality measures, and very high staff and patient satisfaction ratings. Staff turnover has plummeted. We have won many, many national and international awards for this work, and are Behavioral Integration program is recognized as a Best Practice program across the country.

b. At present we have about 34 BHC's (behavioral health consultants), working in our primary care, pediatrics, Women's Health, Behavioral health, and Community Health Center clinics. All BHC's are master's level trained clinicians (psychologists, MSW, family therapists, etc). At present MCAID does not pay for the care provided by these individuals. This needs to be changed if more of this type of integrated care is going to be encouraged.

c. We have also co-located many of our psychiatrists. This allows for co-management of even the most complex Mental Health supported individuals – and for Suboxone Addictions treatment. As with many of our innovations, however, we are hurt financially by this approach. A payment methodology that rewards collaborative co-management simultaneously for MH and Medical Care would be highly desirable, while holding us accountable for quality and outcome measures. Telemedicine payments would also help drive these teams to do more and more cost effective 'virtual' treatment.

d. During FY 2015, BHCs had 22,458 encounters. These may not be unique

customer-owners.

e. Every empaneled child 2wks-18 who comes into the clinic yearly is offered a BHC visit, most accept. For children 2wks-5 years, BHCs visit with children and families 1-3 times per year during well child checks.

f. For c-o's on a Wellness Care Plan, we are just beginning to track pre/post system utilization in regards to positive/negative utilization. Another way to think of it is value added visits. Negative=ED visit, Positive= BHC, RD. Every c-o on a WCP has an initial assessment with a BHC to determine goals, motivation, etc. and then the plan is co-created with the c-o and team. Our N size is small right now but here is what we have:

WCP Customer-Owners	Pre-WCP Positive Visits per month per customer	Post-WCP Positive Visits per month per customer	Change in Positive Rate	Pre-WCP Negative Visits per month per customer	Post-WCP Negative Visits per month per customer	Change in Negative Rate
367	2.49	2.07	- 0.42	0.23	0.19	- 0.04