Clinical Integration of Behavioral Health in Washington State:

The Development of Practice Standards for Primary Care Service Delivery

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Objectives

- Understand the need for clinical definitions and standards
- Learn why primary care integration is important and how it impacts the continuum of care delivery
- Determine how minimum standards align with primary care and PCMH delivery
- Define integrated primary care, who can provide services, and what elements are necessary for integration
- Conceptualize how the integration elements align with HCA priorities and next steps

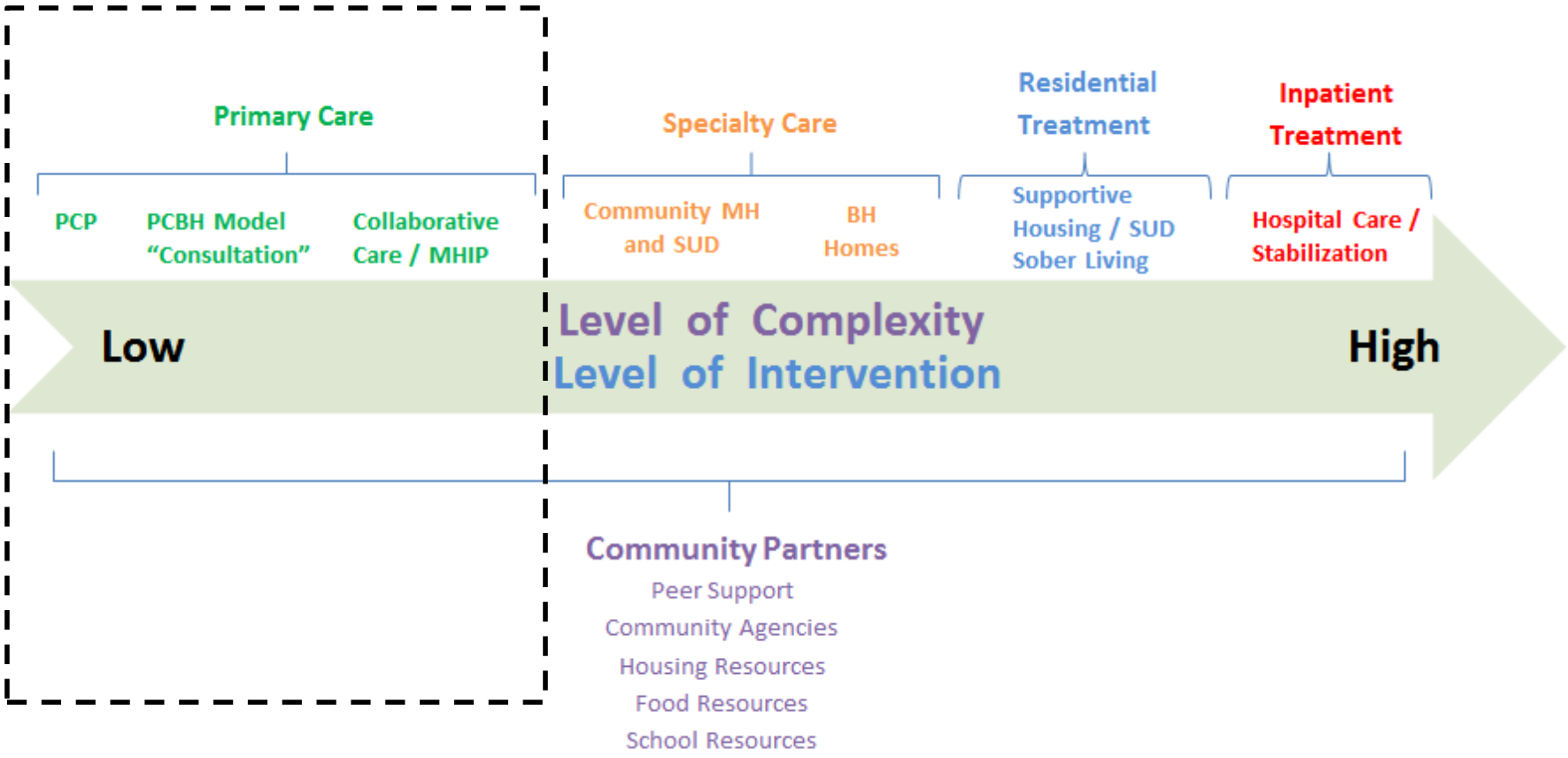
Brief History

- Senate Bill 6312, House Bill 2572
  - Full integration of *funding and delivery* for physical health, mental health, and chemical dependency services by 2020
- Idea was to integrate funding with clinical integration to follow
- Clinics began taking an initiative at “integrating” physical, behavioral, and SUD services
- Without a universal clinical definition, there has been wide variability in the practice of integrated BH across the state

The “Bree”

- Robert J. Bree Collaborative
  - Established in 2011 by WA state legislature, ESHB 1311
  - “Provides a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care”
- Bree’s Behavioral Health Committee - 2016
  - Consolidation of national and local efforts
  - Tasked with defining BH integration in primary care and developing minimum practice standards
    - Scope of work is limited to primary care but should connect to BH system
    - Recommendations to be sent to HCA for review and approval

Behavioral Health Care Continuum



Why Primary Care?

Primary care is the "De Facto" US mental health system

- 50-70% of primary care visits include a psychosocial component
- 11% prevalence of depression, 19% prevalence of anxiety in PC visits
- Depression increases cost of chronic conditions by 50-100%

Barriers in outpatient referrals

- 50% of patients referred for specialty mental health do not make it
- Many patients drop out after just a few sessions

Primary Care integration impacts the BH system

- Poor access and management in primary care places burden on system
- Goal is to improve allocation of resources across the system
  - Matching level of intervention with level of care = better outcomes

Evolution of Primary Care Services

General Primary Care

→ Treat "All Comers," High Volume
→ Brief, Episodic Care and Chronic Care
→ Expedited Access (Same Day)
→ Proactive and Reactive Treatment Strategies
→ "Front Line" of Care
→ Shared Records/EHR among PC Staff

Advanced Primary Care Activities

→ Registries/Tracking (for key conditions)
→ Risk Stratification/Protocols
→ Systematic Follow-up
→ Onsite or Close Collaboration with Specialists
→ Shared Care Plans in EHR

Patient Centered Medical Home

→ Effective Population Health
→ Quadruple Aim
→ Alternative Payment/ VBP

"Comprehensive" Integration

General Primary Care

- ✓ Treat "All Comers," High Volume
- ✓ Brief, Episodic Care
- ✓ Chronic Care
- ✓ Expedited Access (Same Day)
- ✓ Proactive and Reactive Treatment Strategies
- ✓ "Front Line" of Care
- ✓ Shared Records/EHR among PC Staff

Advanced Primary Care Activities

- ✓ Registries/Tracking (for key conditions)
- ✓ Risk Stratification/Protocols Systematic Follow-up
- ✓ Onsite/Close Collaboration with Specialists
- ✓ Shared Care Plans in EHR
- ✓ Focus on specific population outcomes

PCMH

- ✓ Effective Population Health
- ✓ Quadruple Aim
- ✓ Alternative Payment / VBP

PCBH

- → Treat "All Comers"
- → High Volume
- → Brief, Episodic Care
- → Expedited Access (Same Day)
- → Health Behavior Change

BHC

- → Screening/Tracking
- → Collaboration with Psychiatry
- → MH/Depression Treatment
- → Risk Stratification/ Protocols

Psychiatrist

- → Registries/Tracking (for key conditions)
- → Systematic Follow-up
- → Condition-focused outcome goals

Collaborative Care

Care Coordinator

Strength of <u>both</u> models align with PCMH service delivery

General Goals of Standards

Achieve integration in primary care:

- "Routineness" with which care is delivered in daily practice

Consistent practice and alignment across the state

- Focus on integration elements, not models

Alignment with Primary Care service delivery

- BH Needs to match general primary care practice and PCMH practice

Improve access and enhance quality

- WA state is 48th in BH Access nationally

Achievable, yet aspirational

Standards Development

The “What”

“Integrated Primary Care” means care provided to individuals of all ages, families, and their caregivers in a patient centered medical home by licensed primary care providers, behavioral health clinicians, and other care team members working together to address one or more of the following: mental illness, substance use disorders, health behaviors that contribute to chronic illness, life stressors and crises, developmental risks/conditions, stress-related physical symptoms, preventative care, and ineffective patterns of health care utilization.

The “Who”

"Behavioral Health Clinician" means a licensed psychiatrist, a licensed psychologist, a licensed nurse practitioner or registered nurse with a specialty in psychiatric mental health, a licensed independent clinical social worker, a licensed mental health counselor, a licensed marriage and family therapist, a certified clinical social work associate, an intern or resident who is working under a state-approved supervisory contract in a clinical mental health field; or any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.

Standards and Concepts

Integration

- Behavioral Health Clinician is an Integrated Team Member
- Accessibility and Sharing of Patient Information

Access

- Access to Behavioral Health as Routine Part of Care
- Access to Psychiatry Services

Quality

- Operational Systems and Workflows to Support Population Care
- Evidence-Based Treatments
- Data for Quality Improvement

Minimum Standards for Primary Care Integration

Element 1:

Behavioral Health Clinician is an Integrated Team Member

Primary care team has clearly defined roles including for the behavioral health clinician. The behavioral health clinician participates in regular practice activities *in-person or virtually* such as team meetings, daily huddles, pre-visit planning, and quality improvement.

Rationale:

- A practice cannot be “integrated” unless the BH clinician is a routine part of primary care delivery and quality measurement

Minimum Standards for Primary Care Integration

Element 2:

Access to Psychiatry Services

Practice has access to psychiatry services including diagnostic clarification, medication management, care plan development through referral or consultation which includes shared bi-directional communication.

Rationale:

- Access to psychiatry services is necessary to meet complex patient needs
- Psychiatry care without information sharing is not beneficial for population care

Minimum Standards for Primary Care Integration

Element 3:

Access to Behavioral Health as a Routine Part of Care

Access to behavioral health services are available **the same day** as part of routine care in the primary care setting (*either in person or virtually*) to address identified behavioral needs. Follow-up appointments are also available in a timely manner to adequately address each patient's unique concern(s).

Rationale:

- Same day access is necessary for engagement in behavioral care
- Motivation and follow-through on behavioral care is much worse when delivered on alternative days
- Same day access facilitates more coordinated care planning
- Ability for expedited follow-up decreases attrition and allows for f/u assessment

Minimum Standards for Primary Care Integration

Element 4:

Operational Systems and Workflows to Support Population Care

A universal screening method is in place for identification and stratification of patients. The practice uses systematic clinical protocols that are followed based on screening results and patient severity. Clinic tracks identified patients to make sure patient is engaged and treated-to-target/remission and proactively follows-up and adapts treatment for patients who do not show improvement (for selected populations and measures).

Rationale:

- Universal screening for mental health concerns is necessary for population management
- Universal screening without intervention is not beneficial, so clinical protocols are needed to actually improve population outcomes
- Tracking of patients necessary to provide stepped-care and quality reporting

Minimum Standards for Primary Care Integration

Element 5:

Accessibility and Sharing of Patient Information

Medical and behavioral providers have a shared care plan accessible to all members of the integrated care team documented through a shared EHR and/or care management system and work together via regular consultation and coordination

Rationale:

- Shared access to records is necessary to coordinate physical and behavioral care effectively
- Shared care planning is essential for “integrated” whole person care

Minimum Standards for Primary Care Integration

Element 6:

Evidence-Based Treatments

Interventions are supported by evidence, best practices, and adaptable to a primary care setting. The goal of treatment is to provide strategies that include the patient's goals of care and appropriate self-management support.

Rationale:

- Interventions not based on evidence or not amenable to primary care setting are less likely to produce valid outcomes
- Self-Management focus is consistent with primary care practice
- Innovation is key to enhancing the health system

Minimum Standards for Primary Care Integration

Element 7:

Data for Quality Improvement

System-level data regarding access to behavioral care and patient outcomes is tracked. If system goals are not met, quality improvement efforts are employed to achieve patient access goals and outcome standards.

Rationale:

- Quality improvement essential to sustainability and growth
- System-level data necessary for MCOs and pay-for-performance initiatives

Next Steps

- Technical Specifications finalized in early 2017
- Minimum standards document sent out for public comment
- Final recommendations sent to HCA
- HCA approves or requests revision
- Distributed to stakeholders, purchasers, ACH, and others
- Short-term and long-term financial incentives developed

Questions?