

HealthierHere

The Accountable Community for Health of King County

Integration Workgroup: Bi-Directional Integration – Behavioral Health Settings

May 7, 2018



HealthierHere

Integrated Whole Person Care in Community Behavioral Health Centers

Project Goal

Immediate: Integrate Primary Care Services into Community Behavioral Health Centers in King County.

Long-term: Improve screening rates and access to chronic disease management/primary care services among individuals enrolled in behavioral health services.

Deliverables to include:

- Screening of medical needs and primary care preventive care for individuals enrolled in behavioral health services;
- Diabetes monitoring for people with diabetes and behavioral health conditions (HbA1c and LDL-C),
- Diabetes screening for people using antipsychotic medication;
- Screening and referral for treatment for people with uncontrolled asthma;
- Antidepressant medication management - acute and continuous phase treatment;
- Initiation of substance use disorder treatment (1 visit within 14 days) and engagement (initiation and 2 visits within 44 days);
- Screening for clinical depression and follow up;
- Follow up after hospitalization for mental illness within 7 and 30 days; and
- Decrease potentially avoidable ED visits.

Focus Populations

Individuals with mental health and substance use disorders who are also at risk for or have chronic disease conditions (respiratory and cardiovascular disease including diabetes).

Interventions

Providers will be responsible for:

1) Having a partnership with and/or co-locating primary care services at behavioral health treatment sites.
2) Providing or facilitating clients with access to an annual physical/well visit (at a minimum) and address in a timely manner physical health concerns (i.e. sick visits) when indicated.
3) Screening all clients seen by the PCP on site for chronic conditions: i.e. hypertension/blood pressure, diabetes/A1c, asthma and height-weight/BMI and/or collaborating with a PCP at another clinic to understand a client's chronic condition(s).
4) Documenting all screening/lab results for both clinical and reporting purposes in the EHR.
5) Working collaboratively with the PCP to ensure referrals to external pre-identified specialists are made for laboratory tests/treatment when indicated.

6) Working with the PCP to ensure the full scope of primary care services is available to patients being served at behavioral health site.
7) Arranging for shared documentation to ensure communication about the patient is easily accessible and documented for reporting purposes.

Innovations

- Measurement-based care with validated tools
- Coordinated, team-based care
- Stronger linkages to community-based organizations addressing social determinants

Metrics

Patient Engagement Metric

The number of patients receiving primary care services at a Behavioral Health site (Mental Health or Substance Abuse Site) from a Primary Care Provider (PCP, NP, PA working closely with PCP).

Clinical Metrics

- All-Cause Readmission Rate (30 Days)
  - Among Medicaid beneficiaries age 18-64 years old, the percent of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission within 30 days.
- Antidepressant Medication Management
  - Effective Acute Phase Treatment – People 18 and older diagnosed with depression and treated with an antidepressant medication who remained on antidepressant medication during the entire 12-week acute treatment phase.
  - Effective Continuation Phase Treatment – People 18 and older diagnosed with depression and treated with an antidepressant medication who remained on antidepressant medication for at least six months.
- Child and Adolescents' Access to Primary Care Practitioners
  - The percentage of members 12 months - 19 years of age who had a visit with a primary care provider. Report four separate rates: 12-24 months of age; 25 months - 6 years of age; 7-11 years of age; 12-19 years of age.
- Comprehensive Diabetes Care: Hemoglobin A1c Testing
  - The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had an HbA1c test during the measurement year.
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
  - The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening or monitoring test or had evidence of nephropathy during the measurement period.
- Comprehensive Diabetes Care: Eye Exam (Retinal) Performed
  - The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had a retinal or dilated eye exam by an eye care professional during the measurement

period, or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.

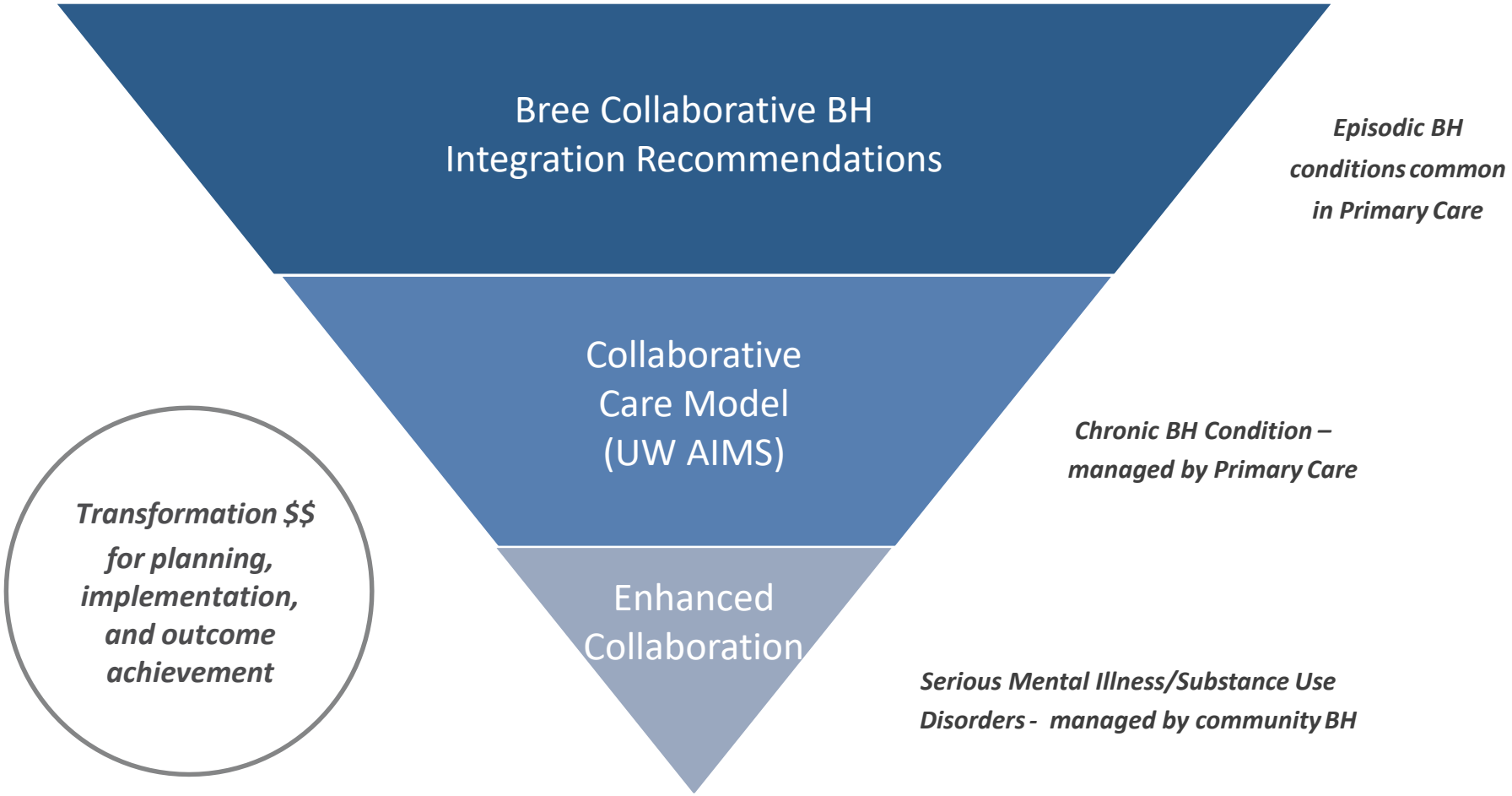
- *Diabetes Screening for People with behavioral health conditions who are Using Antipsychotic Medication
    - People age 18 to 64 with mental health or substance use disorders, who were using an antipsychotic medication who had a glucose test or HbA1c test during the measurement year.
- *Diabetes Monitoring for People with Diabetes and mental health or substance use disorder
    - People age 18 to 64 with behavioral health conditions and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.
- *Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)
    - People age 13 and older with a new episode of substance use disorder who initiated treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, or medication assisted treatment (MAT) within 14 days of the index episode.
- Inpatient Hospital Utilization
    - For members 18 years and older, the risk-adjusted ratio of observed to expected acute inpatient discharges during the measurement year.
- Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence
    - The percent of discharges for members 18 years and older who had a visit to the ED with a primary diagnosis of alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of alcohol or other drug dependence, reported separately for follow-up within 7 and 30 days after discharge.
- Follow-up After Emergency Department Visit for Mental Health
    - The percent of discharges for members 18 years and older who had a visit to the ED with a primary diagnosis of mental health during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health, reported separately for follow-up within 7 and 30 days after discharge.
- Follow-up after hospitalization for Mental Illness
    - The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner, reported separately for follow-up within 7 and 30 days of discharge.
- Medication Management for People with Asthma (5 – 64 Years)
    - The percentage of members 5-64 years of age who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period.
- Mental Health Treatment Penetration (Broad Version)
    - The percentage of members with a mental health service need who received mental health services in the measurement year. Separate reporting for three age groups: 6-17 years, 18-64 years, and 65 years and older.
- All Cause Emergency Department Visits per 1000 Member Months

  - The rate of Medicaid beneficiary visits to emergency department per 1000 member months, including visits related to mental health and substance use disorder, reported for three age groups: 10-17 years, 18-64 years, and 65 years and older.
- *Potentially Avoidable Use of the Emergency Room
  - The percentage of total ER visits considered potentially avoidable based on an agreed-upon list of ICD codes. This is considered a conservative measure of potentially avoidable ER use.
- *Screening for Clinical Depression and Follow-up
  - People 18 and older with an outpatient visit who were screened for clinical depression using a standardized depression tool, and if positive, with follow-up plan within 30 days.
- Substance Use Disorder Treatment Penetration
  - The percentage of members with a substance use disorder treatment need who received substance use disorder treatment in the measurement year. Separate reporting for three age groups: 12-17 years, 18-64 years, and 65 years and older.

*Metrics in addition to Healthier Washington pay for performance metrics for this project

Evidence Based Approaches

All have been demonstrated in small-scale projects within our region already. We will have a clearer sense of the models that will be most appropriate for the various providers.



Adapted from Julie Lindberg, Molina Healthcare

Bree Collaborative BH Integration

Recommendation for integrating behavioral health care services into primary care for those with behavioral health concerns and diagnoses for whom accessing services through primary care would be appropriate.

Step 1	•**Integrated Care Team:** Access to behavioral health and primary care services are available on the same day as much as feasible. At a minimum, a plan is developed on the same day that includes continuous patient engagement in ways that are convenient for patients, in person or by phone or videoconferencing.
Step 2	•**Patient Access to Behavioral Health as a Routine Part of Care:** Access to behavioral health and primary care services are available on the same day as much as feasible. At a minimum, a plan is developed on the same day that includes continuous patient engagement in ways that are convenient for patients, in person or by phone or videoconferencing.
Step 3	•**Accessibility and Sharing of Patient Information:** The integrated care team has access to actionable medical and behavioral health information via a shared care plan at the point of care. Clinicians work together via regularly scheduled consultation and coordination to jointly address the patient's shared care plan.
Step 4	•**Practice Access to Psychiatric Services:** Access to psychiatric consultation services is available in a systematic manner to assist the care team in developing a treatment plan and adjusting treatments for patients who are not improving as expected under their current plan. For patients with more severe or complex symptoms and diagnoses, specialty behavioral health services are readily available and are well coordinated with primary care.
Step 5	•**Operational Systems & Workflows to Support Population Based Care:** A structured method is in place for proactive identification and stratification of patients for targeted conditions. The practice uses systematic clinical protocols based on screening results and other patient data, like emergency room use, that help to characterize patient risk and complexity of needs. Practices track patients with target conditions to make sure patient is engaged and treated-to-target/remission and have a proactive follow-up plan to assess improvement and adapt treatment accordingly.
Step 6	•**Evidence Based Treatments:** Age language, culturally, and religiously-appropriate measurement-based interventions for physical and behavioral health interventions are adapted to the specific needs of the practice setting. Integrated practice teams use behavioral health symptom rating scales in a systematic and quantifiable way to determine whether their patients are improving. The goal of treatment is to provide strategies that include the patient's goals of care and appropriate self-management support.
Step 7	•**Patient Involvement in Care:** Patient goals inform the care plan. The practice communicates effectively with the patient about their treatment options and asks for patient input and feedback into care planning. Patient activation and self-care is supported and promoted.
Step 8	•**Data for Quality Improvement:** System-level data regarding access to behavioral care, the patients' experience, and patient outcomes is tracked. If system goals are not met, quality improvement efforts are employed to achieve patient access goals and outcome standards.

http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Final-Recommendations-2017-03.pdf

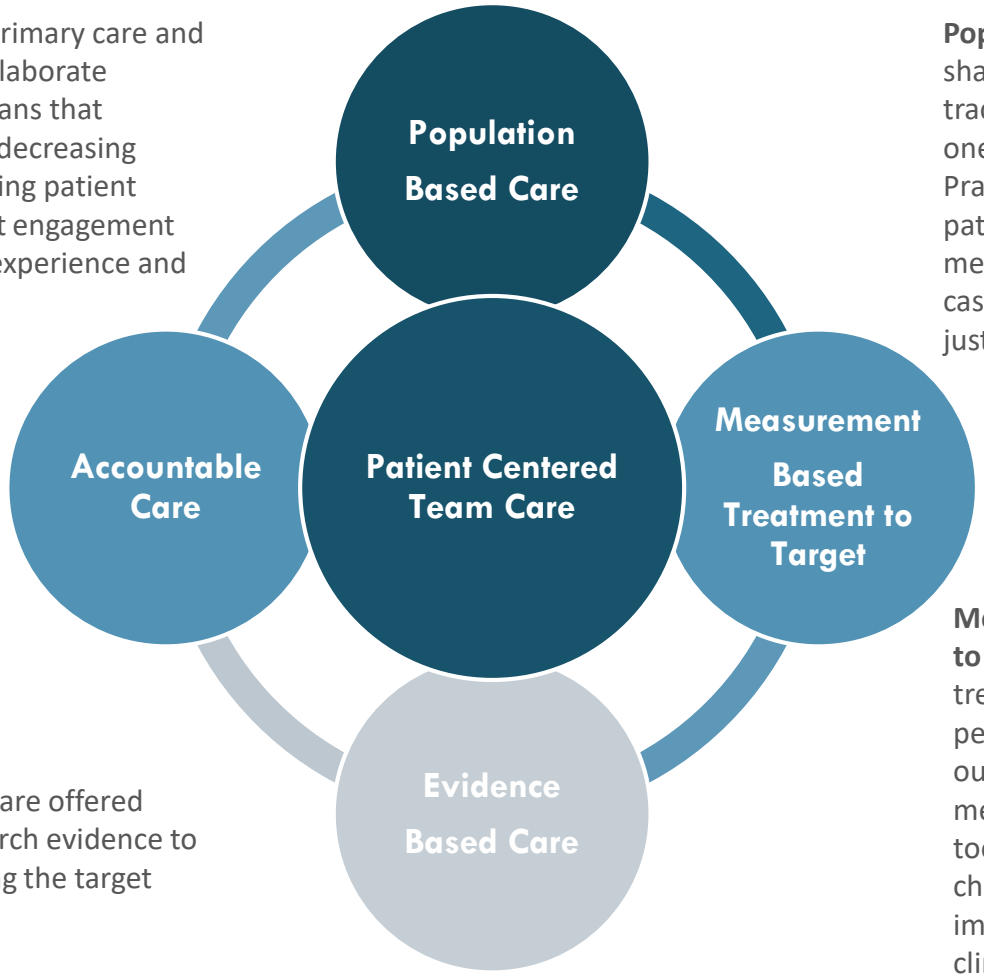
Collaborative Care (UW AIMS)

A type of integrated care, developed at the University of Washington, that treats common mental health conditions such as depression and anxiety that require systematic follow-up due to their persistent nature.

Patient Centered Team Care: Primary care and behavioral health providers collaborate effectively using shared care plans that incorporate patient goals thus decreasing duplicate assessments, increasing patient comfort, and increasing patient engagement (often resulting in better care experience and improved patient outcomes).

Accountable Care: Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

Evidence Based Care: Patients are offered treatments with credible research evidence to support their efficacy in treating the target condition.



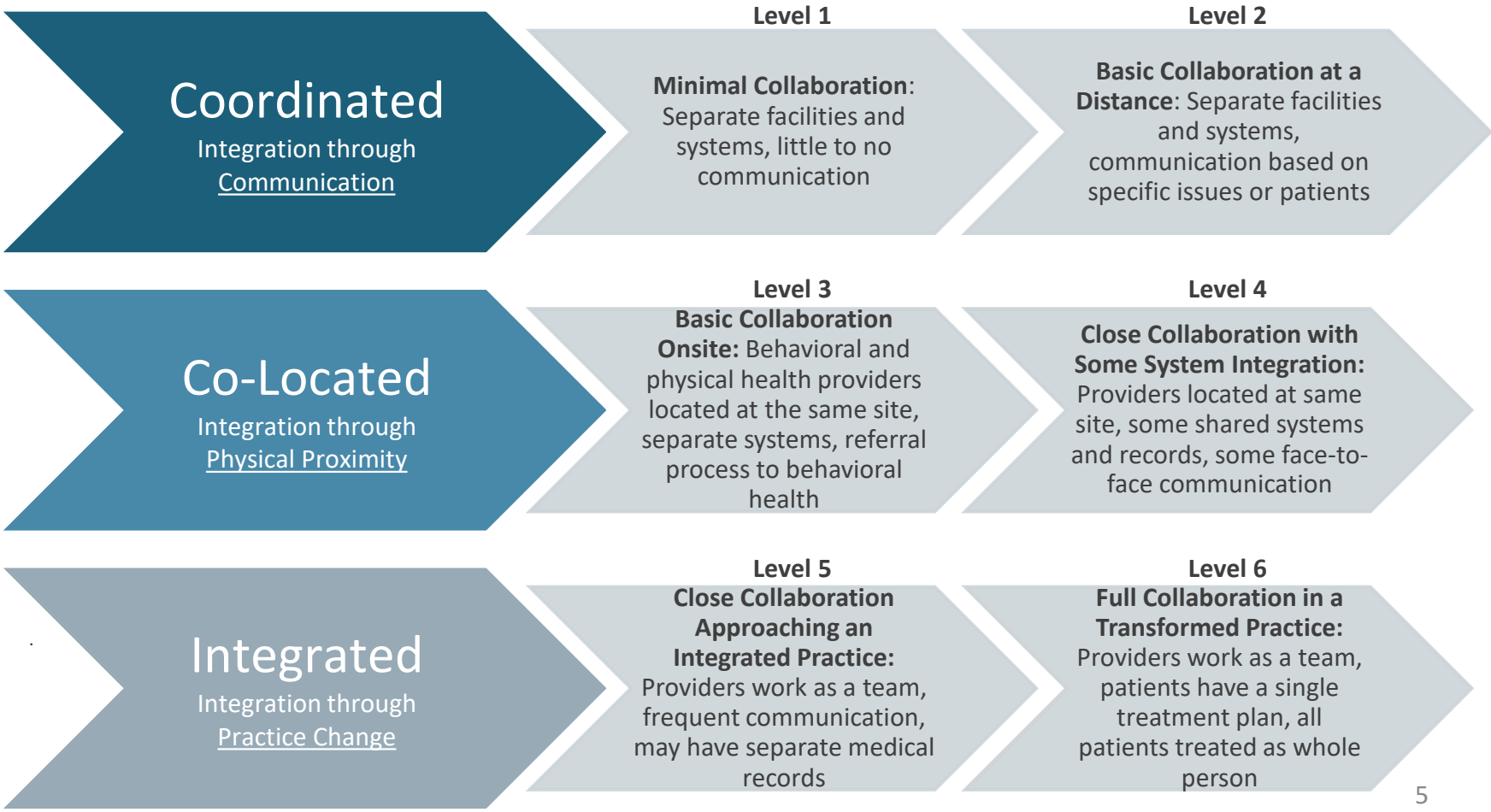
Population Based Care: Care team shares a defined group of patients tracked in a registry to ensure no one falls through the cracks. Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation, not just ad-hoc advice.

Measurement Based Treatment to Target: Each patient's treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured by evidence-based tools. Treatments are actively changed if patients are not improving as expected until the clinical goals are achieved.

http://aims.uw.edu/collaborative-care

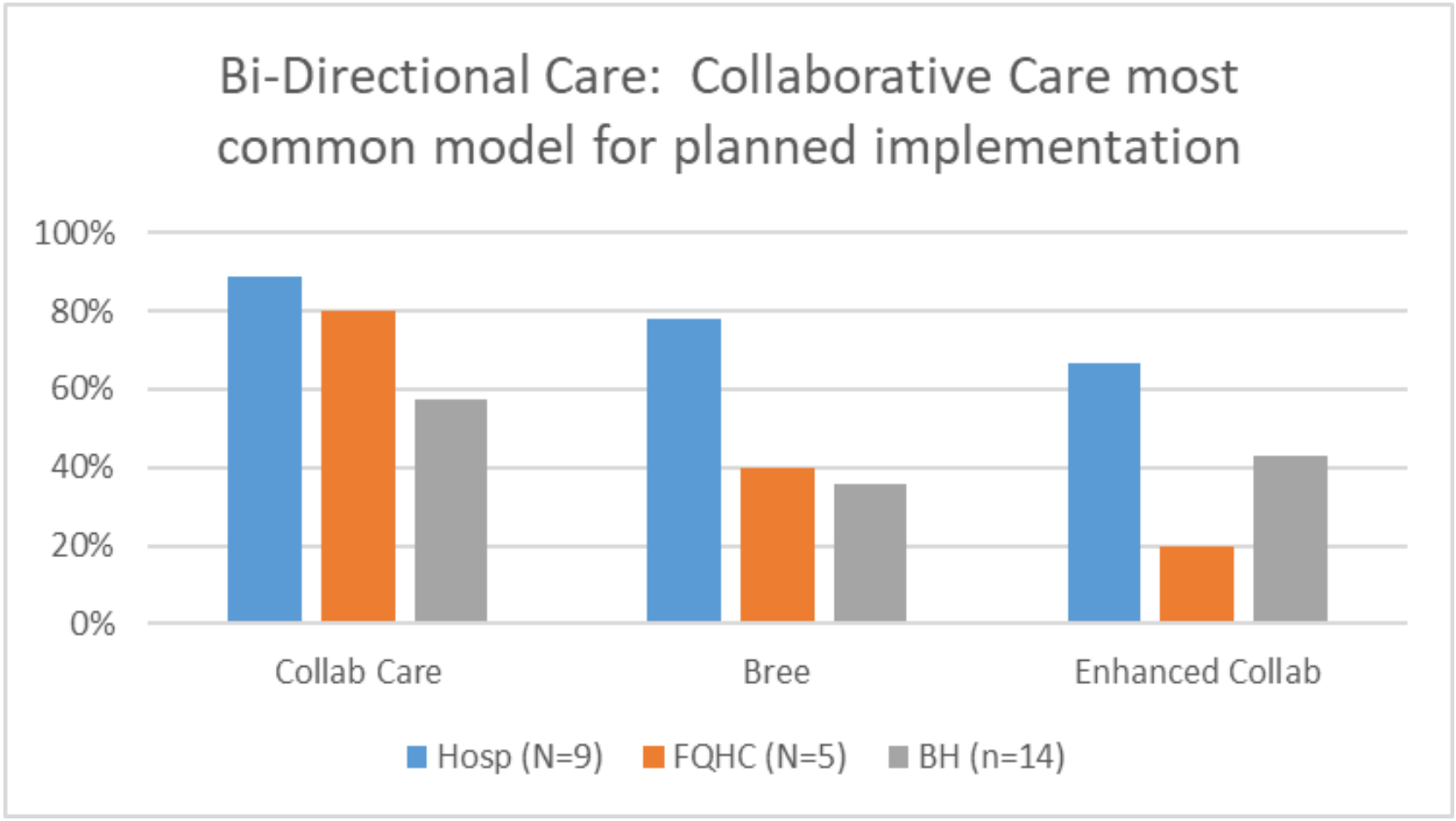
Enhanced Collaboration

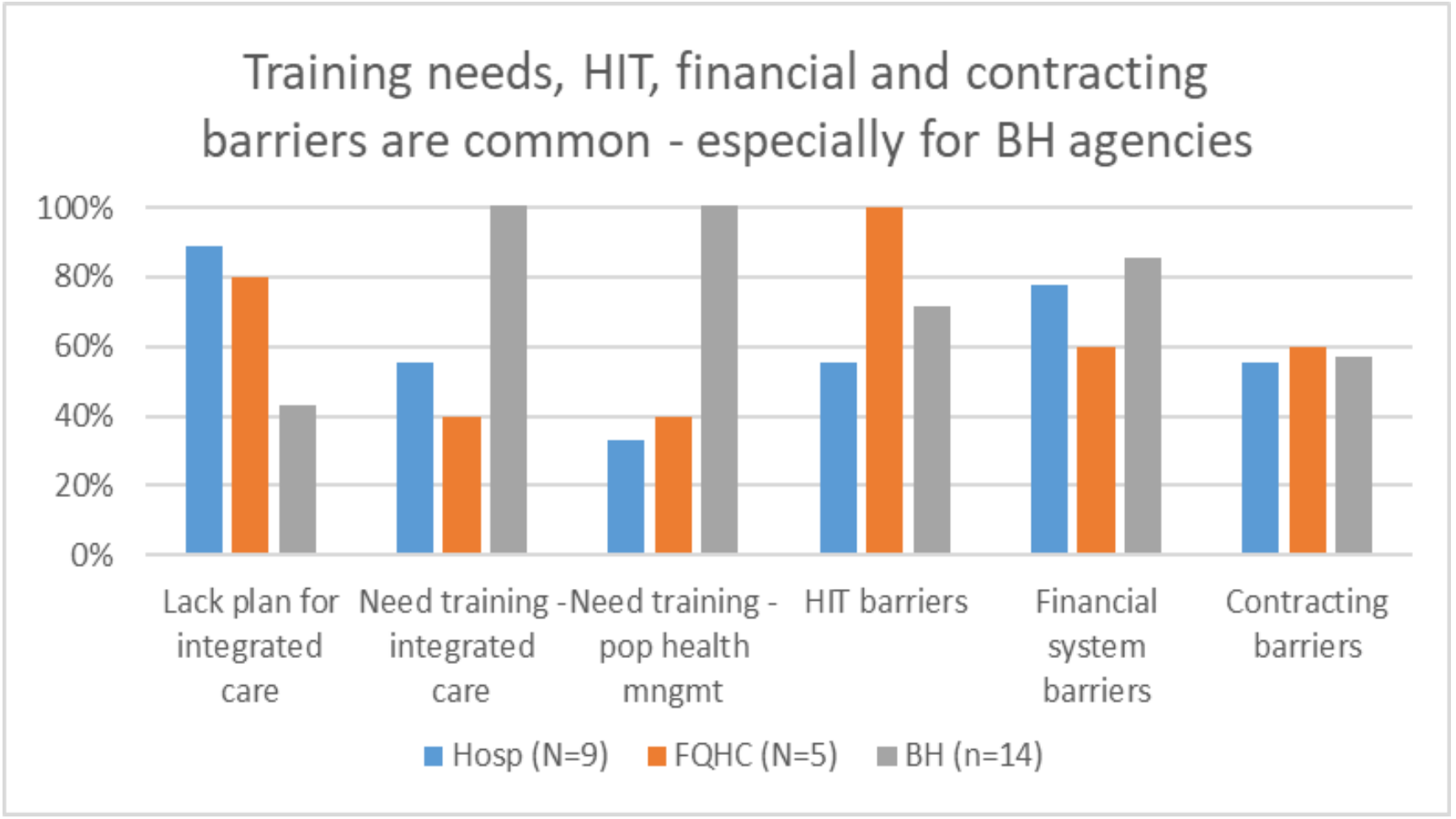
Healthier Here will apply core principles to integrating primary health into the behavioral health setting: 1) Off-site, Enhanced Collaboration; 2) Co-located, Enhanced Collaboration; and 3) Co-located, Integrated.

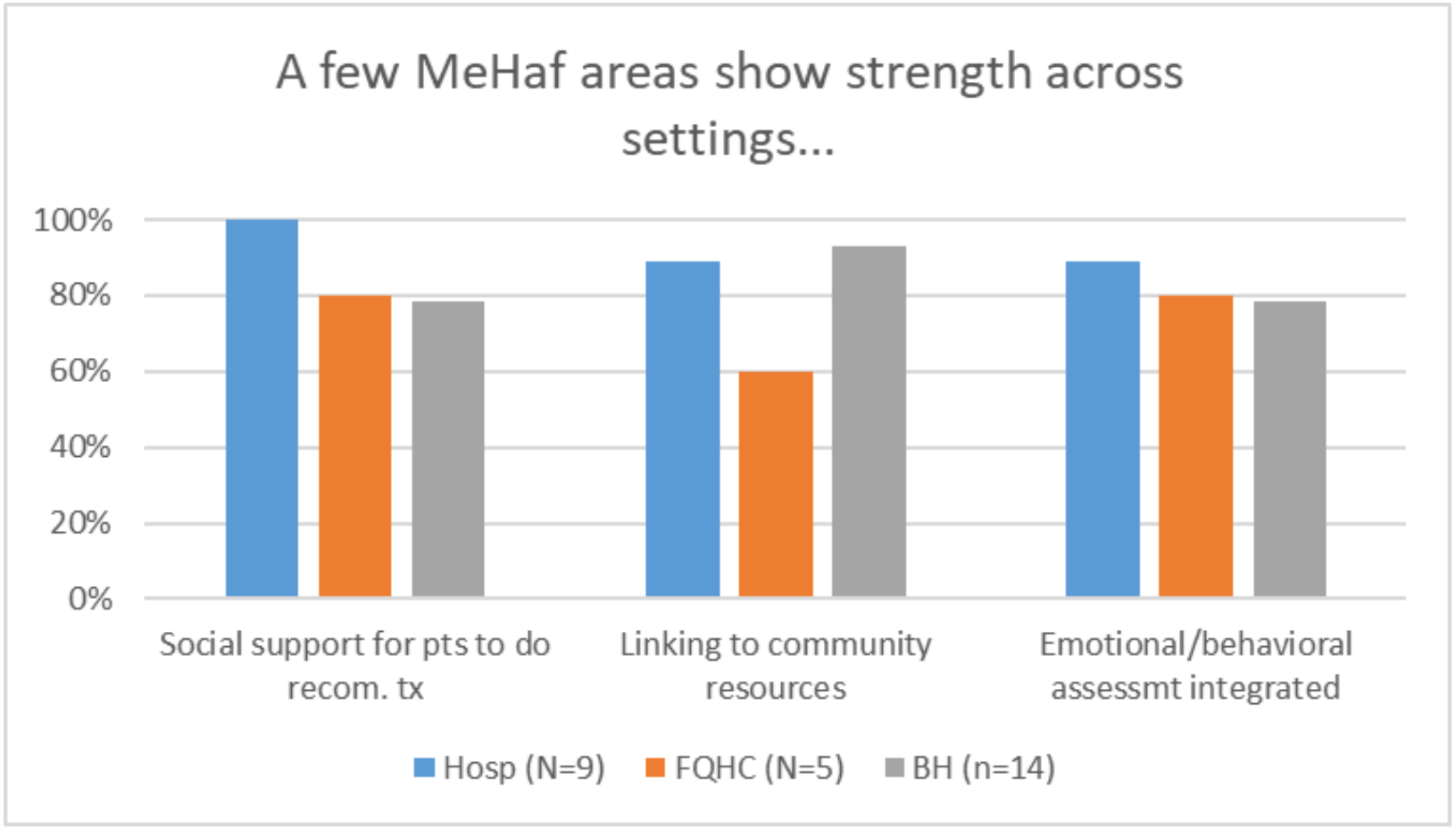


https://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf

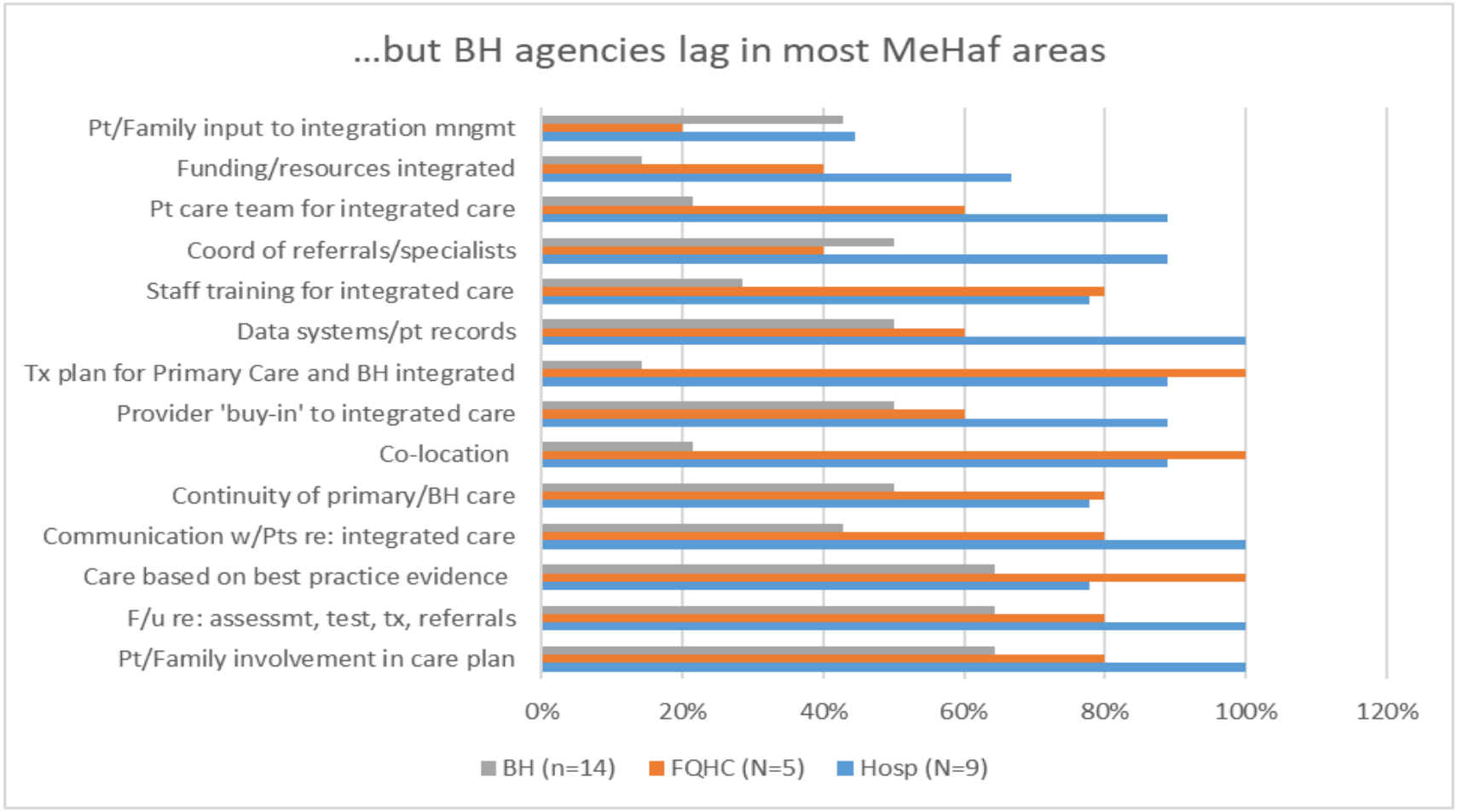
Bi-Directional Integration: Project-specific Current State Assessment Results


Bi-Directional Care: Collaborative Care most common model for planned implementation
100%
80%
60%
40%
20%
0%
Collab Care
Bree
Enhanced Collab
Hosp (N=9)
FQHC (N=5)
BH (n=14)


Training needs, HIT, financial and contracting barriers are common - especially for BH agencies
100%
80%
60%
40%
20%
0%
Lack plan for integrated care
Need training - integrated care
Need training - pop health mngmt
HIT barriers
Financial system barriers
Contracting barriers
Hosp (N=9)
FQHC (N=5)
BH (n=14)

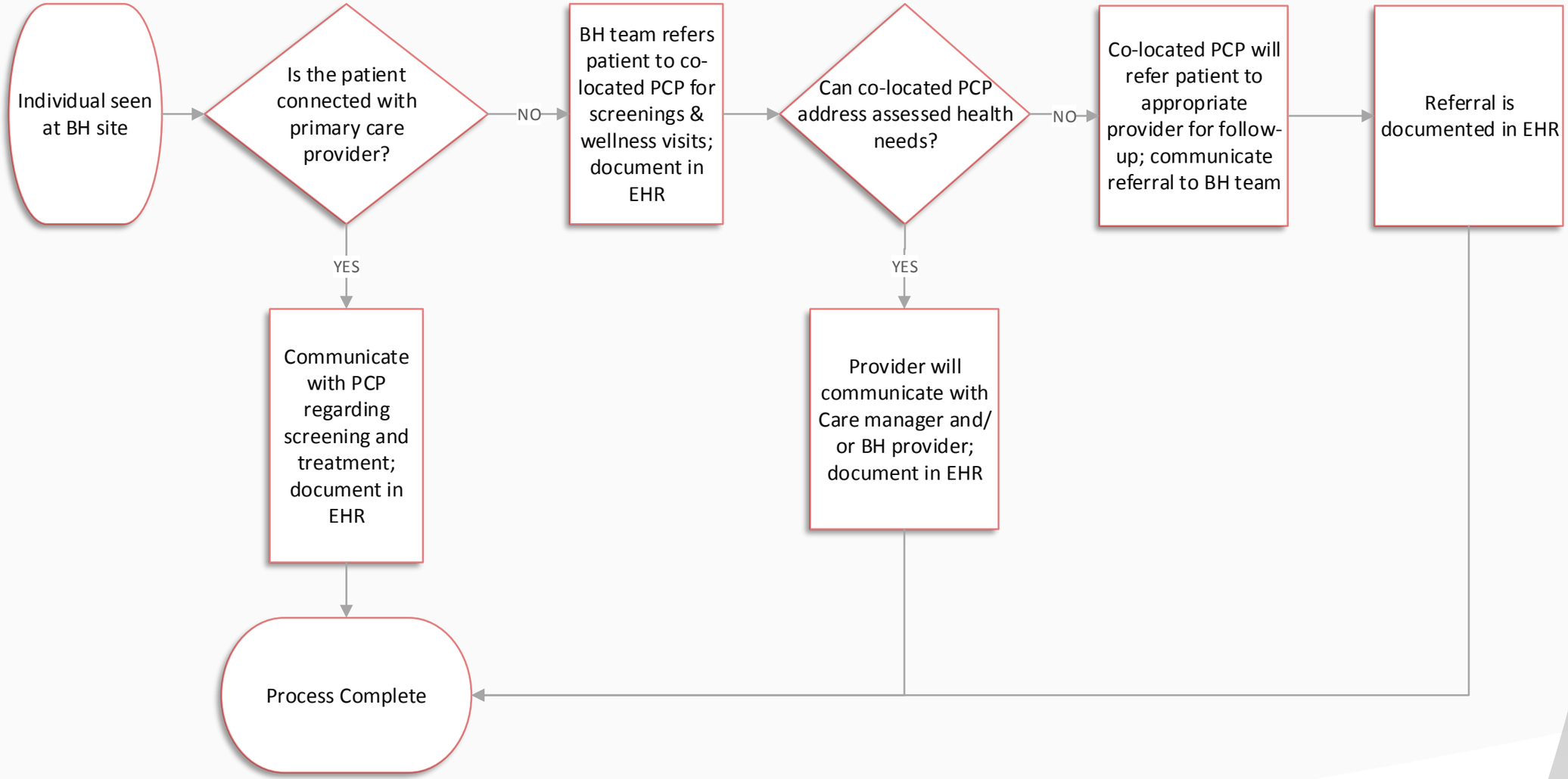


Graph indicates percentage of scores ≥5 indicating partial or full implementation



Graph indicates percentage of scores ≥5 indicating partial or full implementation

Primary & Behavioral Health Integrated Care Program (Model 2) Flow Chart



Suffolk Care Collaborative