HealthierHere

Clinical Summary
Integrated Whole Person Care in Community Behavioral Health Centers

Goal

Immediate: Increase access to primary care services and improve screening rates for selected chronic conditions among individuals enrolled in behavioral health services.

Long-term: Integrate primary care services into community behavioral health centers in King County.

Focus Populations

Medicaid members with mental health and substance use disorders (SUDs), including opioid use disorders (OUDs) who meet a minimum of 3 of the following criteria:

- Prescribed antipsychotic medication
- Prescribed four or more medications
- Diagnosed with one of the following chronic conditions: asthma, chronic obstructive pulmonary disease (COPD), diabetes, cardiovascular disease (CVD)
- Low health literacy
- Limited English proficiency
- Limited engagement with primary care (no primary care visit in the last six months)
- Homeless or housing instability
- Limited community supports (e.g., ineligible for other programs such as Health Homes)

Key Project Elements

The following interventions are recommended for participating provider organizations. Pursuing the recommended strategies as appropriate for specific focus populations is likely to help Practice Partners achieve their goals related to HealthierHere's 2019 pay for progress incentives.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care Authority (e.g., Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Based upon the Bree Collaborative Behavioral Health Integration model and the AIMS Center Collaborative Care Model, implementing organizations are encouraged to utilize the following key strategies.

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Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and services that are needed, share integrated care plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary care providers (PCPs), behavioral health providers, social service providers (e.g., supportive housing), individuals, and their caregivers.
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Conduct holistic screenings in the behavioral health setting, or confirm that they have been completed by primary care partner organization, with a focus on asthma, COPD, diabetes, and CVD. Screenings could include:
    - BMI screening for all or an identified subset of individuals served by the organization
    - Blood pressure screening, for all or an identified subset of individuals served by the organization
    - Tobacco use screening, for all or an identified subset of individuals served by the organization
    - Diabetes screening for all individuals using antipsychotic medication.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification, and members could include a PCP, social worker, or other appropriate provider.
- Provide best practice, culturally appropriate interventions to help individuals manage chronic conditions within community behavioral health centers and/or integrated care settings.
- Provide individuals with greater need with ongoing support and treatment via a co-located, integrated, or partner primary care organization.
- Refer individual to community support specialist (e.g., community health worker, patient navigator), as appropriate.

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate treatment plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Ensure that the plan is available to all team members serving the individual's needs.

Provide Self-Management Support:

- The care team will refer individuals to community resources, including chronic disease self-management programs, as appropriate.
- A community support specialist or a member of the integrated health care team will conduct in-person meeting(s) and follow-up by phone and/or telehealth options in service of the following goals:
    a. Increase self-management skills
    b. Ensure personal goals are congruent with individual's self-efficacy
    c. Improve continuity of care with primary care follow-up
    d. Ensure medication management and reconciliation with PCPs or other providers including pharmacists
    e. Practice advocacy by identifying key questions for PCPs/specialists
    f. Educate on health system navigation
    g. Ensure individual can "teach back" expectations from physical and behavioral health appointments, including what medications are needed and why.

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources, including culturally and linguistically appropriate services.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies, and community based organizations depending on the individual's needs (e.g., transportation, food, shelter). For applicable individuals, the integrated care team will work with the individual and community support specialists to support selected activities. In such cases, the community support specialist will communicate with PCP and/or specialist(s) regarding the individual's treatment and progress.

Pay for Performance Metrics

Incentive payments for ACHs and partnering provider organizations are dependent on improvement in project-specific Pay for Performance metrics selected by the Health Care Authority. Partnering provider organizations participating in the Integrated Whole Person Care in Community Behavioral Health Centers project will agree to help HealthierHere improve the following set of metrics.

Metric	Definition
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: 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.
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 year or the year prior.

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.

References/Guidelines

AIMS Center Collaborative Care Model
https://aims.uw.edu/collaborative-care

The Bree Collaborative Behavioral Health Integration Report and Recommendations
http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Final-Recommendations-2017-03.pdf

EPR-3 Guidelines on Asthma (NHLBI)
https://www.nhlbi.nih.gov/files/docs/guidelines/asthgdln.pdf

Global Initiative for Chronic Obstructive Lung Disease
https://goldcopd.org/wp-content/uploads/2018/02/WMS-GOLD-2018-Feb-Final-to-print-v2.pdf

Standards of Medical Care in Diabetes (American Diabetes Association)
https://professional.diabetes.org/content-page/standards-medical-care-diabetes