HealthierHere

Clinical Summary
Integrated Whole Person Care in Primary Care Settings

Goal

Immediate: Improve identification of behavioral health needs and access to behavioral health services (both mental health and substance use treatment) for individuals being served in primary care settings.

Long-term: Integrate behavioral health services into primary care practices in King County. Expand links to specialty behavioral health, including psychiatry.

Focus Populations

Medicaid members within traditional and non-traditional primary care settings who are at risk for or have a diagnosis of depression and/or substance use disorder (SUD), including opioid use disorder (OUD).

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.

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 standardized screenings in the primary care setting, with a focus on depression and SUD, including OUD.
- Stratify individuals by risk and severity of disease.

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 behavioral health provider, social worker, or other appropriate provider.
- Provide medication-assisted treatment (MAT) when needed.
- Provide best practice, culturally appropriate mental health and/or substance use disorder treatment interventions within primary 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.
- Provide linkage to specialty behavioral health, including psychiatry, when needed.
- 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:

- 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 behavioral health care follow-up
    d. Ensure medication management and reconciliation with PCPs or other providers including pharmacists
    e. Practice advocacy by identifying key questions for behavioral health care providers/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.

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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 Primary Care Settings 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.
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.
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.
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.

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

Evidence-based Screening Tools for Adults and Adolescents (NIH National Institute on Drug Abuse)
https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/screening-assessment-drug-testing-resources/chart-evidence-based-screening-tools-adults

Medication-Assisted Treatment (SAMHSA)
https://www.samhsa.gov/medication-assisted-treatment

Screening, Brief Intervention, and Referral to Treatment (SAMHSA-HRSA)

https://www.integration.samhsa.gov/clinical-practice/sbirt