Behavioral Health Integration in Primary Care: Phases of Integration

Overview

Behavioral health integration is a major endeavor for primary care providers and systems of care. Resources from the Medicaid demonstration work will assist in driving these important changes through new funding available for planning, training, and implementing behavioral health integration into primary care. This work is expected to start soon, with implementation for participating providers required by October 2019.

One of the greatest opportunities of the Medicaid demonstration is advancing bidirectional integration of behavioral health services. Following these transformations, patients should experience better integration of their care, both clinically and within the various wraparound services they depend on. While clinical behavioral health integration will be supported by the financial integration of Medicaid managed care plans and behavioral health organizations, it is not dependent on this. It is also important to realize that integration of the financing and Medicaid benefits will not necessarily result in changes to patient care without on the ground transformation at the practice level.

Integration into Primary Care

For Accountable Communities of Health, there are two options in the demonstration toolkit adopted by the Health Care Authority for integration of behavioral health into primary care: 1) The Bree standards developed and adopted by the Dr. Robert Bree Collaborative (Bree). The Bree is an organization that promotes clinical care improvement by identifying areas of health care services that have high variation and making recommendations on how to improve outcomes. 2) The Collaborative Care model developed by the University of Washington's Advanced Integrated Mental Health Solutions (AIMS) center that is an evidenced-based care delivery model.

The Bree standards and Collaborative Care share many significant elements. Both require behavioral health professionals/clinical care managers in the primary care setting to track and manage patients through regular interventions, with additional support from psychiatric specialists. Other mental health providers can also play critical supporting roles such as psychologists or mental health counselors providing ongoing therapy.

Phases of Integration Template

The following information is applicable to all providers from those just beginning the integration journey to those that are fully integrated and meet the HCA project requirements of the demonstration. Please note that this document is divided into activities that will take place during planning, practice readiness and execution stages.

"Partnering provider organizations" will be asked to commit to this work with binding letters of intent by mid-2018. If providers/organizations decide not to participate in the initial implementation, there may be additional opportunities with the ACH's scale and sustain efforts in 2020. Providers choosing to delay may not be able to access the same level of financial resources to support implementation efforts.

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Phase 1: Planning a Sustainable Model of Behavioral Health Integration in Primary Care (2017-2018)

Planning Steps	Resources & Preliminary Cost Estimates

Structure and Scope for Planning Your Integrated Model
• Identify organizational leadership, clinical champions and other key staff that will need to be involved in planning and key decisions
• Develop an understanding of components and principles, staffing options and evidence base of the Collaborative Care model and Bree standards to inform your planning
• Make preliminary decisions about your initial scope to help inform planning. Decide if your organization will initially focus on depression care before expanding your scope to include treating other behavioral health diagnoses:
  ○ Depression typically represents around 80% of behavioral health diagnoses in adult primary care
  ○ Primary care teams that have little prior experience with integrated care often prefer to begin with a focus on depression
  ○ The Medicaid demonstration project 2A includes three new HEDIS depression measures:
  ○ Depression screening and follow up for adolescents and adults
  ○ Depression remission or response for adolescents and adults
  ○ Utilization of the PHQ-9 to monitor depression symptoms for adolescents and adults
• While depression is a common problem for adolescents, for youth more prevalent behavioral health diagnoses include anxiety disorders, disruptive behavior disorders, and attention deficit disorder. Collaborative care planning for youth should therefore consider addressing these other conditions for pediatric populations[1]
	WSHA Webinar on Integration in Primary Care: https://attendee.gototraining.com/r/1148741544131521793
	
	Safety Net Medical Home Initiative: http://www.safetynetmedicalhome.org/change-concepts/organized-evidence-based-care/behavioral-health
	
	UW AIMS Center has resources and guidance on Collaborative Care: https://aims.uw.edu/collaborative-care/implementation-guide

Gap Analysis and Staffing Plan • Conduct a gap analysis of clinical skills and roles that you need to bring integrated services into your primary care practice(s): • How does your organization's current staffing and care model meet or not meet requirements of the Bree standards and Collaborative Care model? • Determine the resources and changes necessary to implement the model of choice for your organization	Qualis Practice Transformation Support Hub regional coaches can help facilitate planning discussions and bring additional resources to evaluate gaps: HubHelpDesk@qualishealth.org or 206-288-2450 or 800-949-7536 x 2540 Resource for Pediatric Providers: http://pediatrictcpi.org/wp-content/uploads/2017/05/WCAAP_AIMS-Collaborative-Care.pdf

[1] Merikangas KR, He JP, Burstein M, et al. Lifetime prevalence of mental disorders in US adolescents: results from the National Comorbidity Survey Replication—Adolescent Supplement (NCS-A). JAACAP. 2010. 49(10): 980-989

Planning Steps	Resources & Preliminary Cost Estimates
Plan for Access to Psychiatric Services • Both Bree standards and the Collaborative Care model require that you provide access to psychiatric services, via telemedicine or in-person, or through consultation to your primary care providers • Identify options for how your primary care providers will access psychiatric consultation in the Collaborative Care model and/or how your patients can directly access psychiatric services	**Note: Providers, especially in rural areas, could need assistance with paying for equipment to deliver services through telemedicine.*
Evaluate Needs of Your Patient Population • Evaluate the behavioral health needs and complexity of your patient population, including both children and adults • Evaluate diagnoses among your patients that are most commonly diagnosed and treated in primary care – including depression, anxiety, substance use disorders, and disruptive behavior disorders in youth • Also, consider and plan for managing costly medical co-morbidities that may be common among your patients (for example, efficiently managing patients diagnosed with both diabetes and depression or children with special needs)	UW AIMS guidelines and examples from existing programs can help providers to take into account patient complexity including medical co-morbidities in developing your staffing plan: https://aims.uw.edu/resource-library/guidelines-care-manager-caseload-size
Plan for Specialty Behavioral Health Services • Secure a partnership with community mental/behavioral health providers to meet the needs of severely ill patients that require more intensive services and supports. Referral resources may also look different for certain populations, such as patients with Medicare or commercial health plans	
Plan Ahead to Build a Sustainable Model • Begin planning a financing strategy to sustain your model over the long term, including strategies to fund behavioral health staffing	New G-codes reimbursable for Medicare will cover ongoing costs of PCP, care manager and psych consultation.[2] Medicaid will also pay for G-codes, yet rates have yet to be determined
Evaluate Registry Strategies • Identify a tracking system (i.e., patient registry) that your providers can use to track patient behavioral health status and outcomes • Options include starting with a simple spreadsheet, WA State Depression Tracker, or building registry functions into your electronic health record	Spreadsheet: https://aims.uw.edu/resource-library/patient-tracking-spreadsheet WA State Depression Tracker: https://aims.uw.edu/washington-state-aims-depression-tracker

[2] In July 2017, the Centers for Medicare and Medicaid Services in its Physician Fee Schedule proposed rule created two new payment codes for federally qualified health centers (FQHCs) or rural health clinics (RHCs) for Collaborative Care integrated services. We expect the final rule out later in the Fall.

Planning Steps	Resources & Preliminary Cost Estimates
Estimated investment in planning *This is based on a loose estimate of costs, recognizing that those vary across practices/clinics and health systems. How much a practice receives for participating in the demonstration work will need to be decided at the ACH level. This amount does not include equipment costs for the delivery of telemedicine*	**$15,000 to $20,000 per clinic setting**

Phase 2: Practice Readiness (2018-2019)

Practice Readiness Steps	Resources & Cost Estimates
Adjust Staffing to Provide Direct Behavioral Health Services • Hire, promote, train, or contract for behavioral health providers. Examples could include: psychologists, behavioral health care manager (LICSW, RN, master's level mental health counselor), and psychiatric specialist (psychiatric ARNP or psychiatrist), or other behavioral health providers (BHPs) • Determine if this provider will be directly seeing patients (license specific) for certain services as well as providing care through the Collaborative Care model	UW AIMS guidelines and examples from existing programs can help you to estimate BHP/care manager staffing needs and psychiatry resource needs: https://aims.uw.edu/resource-library/guidelines-care-manager-caseload-size A behavioral health Care Manager/behavioral health provider (1 FTE) can typically support a caseload of around 60-100 patients. The caseload typically turns over 2 to 3 times per year * The care manager salary may be around $75,000/FTE * Training may cost up to $10,000 per practice team for Collaborative Care model *Additional training may be needed for clinicians for providing solving and brief interventions with patients. Training may be up to $2,000 per care manager The psychiatric consultant role (psych ARNP, psychiatrist, physicians assistant) typically requires around 3 hours/week per full time (FTE) care manager or BHP in a collaborative care model. This position could be employed or contracted. The average salary for a psychiatrist is around $200,000;[3] the average salary for a psych ARNP is around $114,500[4]
Access Psychiatric Specialist Resources • Hire, train, or contract for psychiatric services. Also, determine if this psychiatric provider will see patients directly, in addition to providing care through the Collaborative Care model • Services can be provided onsite versus by referral or via telemedicine • Work with your specialty partner to develop strategies for shared care planning and enhanced communication	

[3] Bureau of Labor Statistics. https://www.bls.gov/oes/current/oes291066.htm. Accessed 6/16/2017.
[4] 2015 Washington State Advanced Registered Nurse Practitioner Survey Data Report. Washington State Nurses Association and WA Center for Nursing. http://www.wcnursing.org/uploads/file/Reports/2015%20ARNP%20Survey%20Report%2012-31-15%20Final.pdf

Practice Readiness Steps	Resources & Cost Estimates
Implement a Patient Registry and Train Providers • Ensure functionality and compatibility with current systems and incorporate into clinical workflow	
Workflow • Develop clinical workflow and detailed action plan for your care team	
Measuring and Reporting Outcomes • Develop a plan to incorporate new required outcomes reporting into existing quality improvement efforts	
Investments and cost estimates: *Estimated investment in implementation, including lost productivity. Training costs are not included and vary based on number of practitioners.* *This is based on a loose estimate of costs, recognizing that those vary across practices/clinics and health systems. How much a practice receives for participating in the demonstration work will need to be decided at the ACH level.*	***About $12,000 to $17,000 per clinic, plus the actual cost of training.*** For example, UW Medicine AIMS Center trains providers for about $10,000 for a team of 5 people

Phase 3: Execution of Behavioral Health Integration Model (required no later than 2019)

Execution Steps
Assess Patients for Behavioral Health Needs • Screen adult/adolescent depression using the PHQ-9 • Screen youth with PSC-17 or SDQ (general screeners) • Diagnose patients and transition into integrated care as appropriate
Engage Patients in Evidence-based Integrated Care Program • Enter new behavioral health patients into patient tracking registry • Provide evidence-based counseling and psychotherapy • Prescribe and manage psychotropic medications as clinically indicated • Change or adjust treatments if patients do not meet treatment targets
Conduct Systematic Follow-up, Treatment Adjustment, and Relapse Prevention • Use population-based registry to systematically follow all patients • Proactively reach out to patients who do not follow-up • Monitor treatment response at each contact with valid outcome metrics, treatment side effects and complications • Identify patients who are not improving to target them for psychiatric consultation and treatment adjustment • Create and support relapse prevention plan when patients are substantially improved

Execution Steps
Communicate and Coordinate • Coordinate and facilitate effective communication among all providers on treatment team – regardless of clinical affiliation or location • Engage and support family and significant others as clinically appropriate. • Facilitate and track referrals to specialty care, social services, and community-based resources. • Build interagency agreements with specialty behavioral health providers to assure referrals are successfully kept and to share plan of care between providers as well as discharge child from BH to PCP in coordinated fashion when appropriate. Toolkit linked here provides resources to build such partnerships: http://pediatrictcpi.org/bhi/
Conduct Systematic Psychiatric Case Review & Consultation (in-person or via telemedicine) • Conduct regular (e.g., weekly) psychiatric caseload review on patients who are not improving • Provide specific recommendations for additional diagnostic work-up, treatment changes, or referrals • Provide psychiatric assessments for challenging patients, either in-person or via telemedicine
Conduct Program Oversight and Quality Improvement Efforts • Provide administrative and clinical support for the program • Routinely examine provider and program-level outcomes and use for quality improvement efforts
Report on Project Metrics (2019)[5] • Number of primary care providers who achieve special recognitions/certifications/licensure (e.g. For medication-assisted treatment) • Number of primary care providers in partnering provider organizations meeting primary care medical home (PCMH) requirement • Number of providers trained on evidence-based practices • Antidepressant medication management (HEDIS/NCQA) • Comprehensive diabetes care: hemoglobin A1c testing (HEDIS/NCQA) • Comprehensive diabetes care: medical attention for nephropathy (HEDIS/NCQA) • Comprehensive diabetes care: eye exam (retinal) performed (HEDIS/NCQA) (2020) • Medication management for people with asthma (5-64 years) (HEDIS/NCQA) • Plan all cause readmission rate (30- days) (HEDIS/NCQA - primary care medical groups and clinics, and hospitals) • Depression screening and follow-up for adolescents and adults (2020)

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[5] Participating providers will be expected to report additional process metrics to the Accountable Communities of Health. Other metrics will be reported by health plans and by the ACH, but these are the expected project metrics that will be reported from participating providers to ACHs. More information on performance measures at this website.