Bree Collaborative Implementation Webinar Behavioral Health Integration



Speakers



Ginny Weir, MPH

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BackgroundMembers and Topic Selection





Developing Recommendations



Reimbursement Models

Transparency/Tracking

Centers of Excellence

Shared Decision Making

Existing Guidelines

Published Evidence

Programs and Policies

Public Comment

Clinical Committee

Meeting Monthly for 9-12 Months

Recommendations to improve health care quality, outcomes, and affordability

WA State Agencies

Broader Health Care Community

30 sets of recommendations + 4 for 2020



- Pain (chronic and acute)
 - Collaborative care for chronic pain (2018)
 - Low back pain management (2013)
 - Opioid prescribing metrics (2017)
 - Opioid prescribing for postoperative pain (2018)
 - Opioid prescribing in dentistry (2017)
 - Long-term opioid prescribing management (2019)
- Behavioral Health
 - Integrating behavioral health into primary care (2016)
 - Addiction and substance use disorder screening and intervention (2014)
 - Suicide care (2018)
 - Treatment for opioid use disorder (2016)
 - Prescribing antipsychotics to children and adolescents (2016)
 - Risk of Violence to Others (2019)
- Oncology
 - Oncology care: breast and prostate (2015)
 - Prostate cancer screening (2015)
 - Oncology care: inpatient service use (2020)
 - Colorectal cancer screening (2020)

- Procedural (surgical)
 - Bundled payment models and warranties:
 - Total knee and total hip replacement (2013, rereview 2017)
 - Lumbar fusion (2014, re-review 2018)
 - Coronary artery bypass surgery (2015)
 - Bariatric surgery (2016)
 - Hysterectomy (2017)
 - Data collection on appropriate cardiac surgery (2013)
 - Spine SCOAP (2013)
- Reproductive Health
 - Obstetric care (2012)
 - Maternity bundle (2019)
 - Reproductive and sexual health (2020)
- Aging
 - Advance care planning for the end-of-life (2014)
 - Alzheimer's disease and other dementias (2017)
- Palliative care (2019)
- Hospital readmissions (2014)
- LGBTQ health care (2018)
- Shared decision making (2019)
- Primary care (2020)

Behavioral Health Integration Guideline Eight Key Elements



National Standards

- SAMHSA
- AHRQ
- Oregon PCPC

Local Standards

- UW AIMS Center
- Qualis Health

- 1. Integrated Care Team
- 2. Patient Access to Behavioral Health as a Routine Part of Care
- 3. Accessibility and Sharing of Patient Information
- 4. Practice Access to Psychiatric Services
- Operational Systems and Workflows to Support Population-Based Care
- 6. Evidence-Based Treatments
- 7. Patient Involvement in Care
- 8. Data for Quality Improvement

Care Team and Access



1. Integrated Care Teams	2. Patient Access to Behavioral Health as Routine Part of Care
Practice commitment to culture of teamwork and integrated care	 Clear referral and scheduling process for behavioral health services
 Clearly defined roles for all team members, including clinicians and non-licensed staff 	 Same day access to behavioral health services (on-site or virtual) whenever possible; at minimum same day care plan development
 Shared workflows between primary care and behavioral health teams; regularly scheduled team huddles and pre-visit planning include all team members (on-site or virtual) 	 Behavioral health services scheduled in a way that best meet the patients need (in person, phone, or virtual), especially in first month of treatment

Information and Specialty Access



Accessibility and Sharing of Patient Information

- Patient health information and shared care plan accessible by all care team members through EHR or shared clinical care management system at the point of care
- Regularly scheduled consultations between clinicians to jointly address shared care plan
- Systematic tracking of patient progress toward treatment goals

4. Practice Access to Psychiatric Services

- Systematic access to psychiatric consultation services for primary care providers (on-site or virtual)
- Clear referral and coordination process to specialty care for complex symptoms and diagnoses

 Bi-directional communication for all referrals

Workflows and Evidence Base



5. Operational Systems & Workflows to Support Population-Based Care	6. Evidence-Based Treatments
 Proactive patient screening for alcohol/substance use disorder and select mental health conditions 	 Evidence-based interventions adapted for patient population (age, religion, language, culturally appropriate)
 Systematic clinical protocols to record, track and follow-up on screening results 	 Quantifiable use of behavioral health symptom rating scale to track patient improvement
 Systematic clinical protocols to track patients with targeted conditions (i.e. registry) and engage with patients who are not improving 	 Treatment includes goals of care and support appropriate patient self-management strategies

Involving Patients and Data



7-	Patient Involvement in Care	8.	Data for Quality Improvement
•	Patient voice informs the care plan/goal development and patient input central to care plan	•	Systematic tracking of organizational data, such as patient access to behavioral health
•	Shared decision making between patient and team, where appropriate	•	Systematic tracking of patient feedback
•	Patient identified barriers to care related to social support needs are assessed and documented, and staff assist patient in accessing and navigating these social supports	•	Quality improvement structure to achieve organizational access goals and other identified outcome standards





8 ELEMENTS OF INTEGRATION

Integrated Care Team

- Practice commitment to culture of teamwork and integrated care
- Clearly defined roles for all team members, including clinicians and non-licensed staff
- Shared workflows between primary care and behavioral health teams; regularly scheduled team huddles and pre-visit planning include all team members (on-site or virtual)

Patient Access to Behavioral Health as a Routine Part of Care

- Clear referral and scheduling process for behavioral health services
- Same day access to behavioral health services (on-site or virtual); at minimum same day care plan development
- Behavioral health services scheduled in a way that best meet the patients need (in person, phone, or virtual), especially in first month of treatment

Accessibility and Sharing of Patient Information

- Patient health information and shared care plan accessible by all care team members through EHR or shared clinical care management system at the point of care
- Regularly scheduled consultations between clinicians to jointly address shared care plan
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Practice Access to Psychiatric Services

- Systematic access to psychiatric consultation services for primary care providers (on-site or virtual)
- Clear referral and coordination process to specialty care for complex symptoms and diagnoses
- Bi-directional communication for all referrals

SYSTEMS & WORKFLOWS TO SUPPORT POPULATION-BASED CARE

- Proactive patient screening for alcohol/substance use disorder and select mental health conditions
- Systematic clinical protocols to record, track and follow-up on screening results
- Systematic clinical protocols to track patients with targeted conditions (i.e. registry) and engage with patients who are not improving

EVIDENCE-BASED TREATMENTS

- Evidence-based interventions adapted for patient population (age, religion, language, culturally appropriate)
- Quantifiable use of behavioral health symptom rating scale to track patient improvement
- Treatment includes goals of care and support appropriate patient self-management strategies

PATIENT INVOLVEMENT IN CARE

- □ Patient voice informs the care plan/goal development and patient input central to care plan
- Shared decision making between patient and team, where appropriate
- Patient identified barriers to care related to social support needs are assessed and documented, and staff assist
 patient in accessing and navigating these social supports.

DATA FOR QUALITY IMPROVEMENT

- Systematic tracking of organizational data, such as patient access to behavioral health
- Systematic tracking of patient feedback
- Quality improvement structure to achieve organizational access goals and other identified outcome standards

Core Process Measures – Primary Care



Measure	Description
Integrated Care Team	Frequency of Integrated Care Team huddles (onsite or remotely).
Screening Tools	Percentage of patients screened for behavioral health conditions using a validated screening tool.
Access to BH services	Percentage of patients with identified behavioral health needs that receive warm hand-off or same day referral to behavioral health services (if warmhand-off not available).
Shared Care Plan	Percentage of patients with identified behavioral health needs that have a shared care plan through EHR or other shared clinical care management system.

Contact



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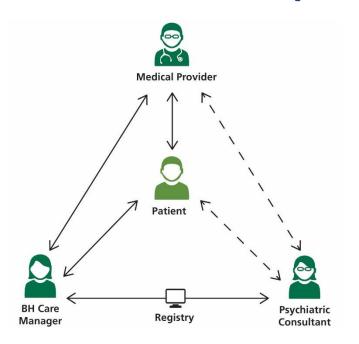
Collaborative Care Model (CoCM)



Primary care patient-centered team-based care



Registry to track population



Problem Solving Treatment (PST)

Behavioral Activation (BA)

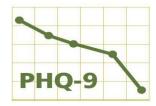
Motivational Interviewing (MI)

Medications

Active treatment with evidence-based approaches



Systematic case review with psychiatric consultant (focus on patients not improved)



Validated outcome measures tracked over time



Same Elements in Bree Recommendations & Collaborative Care

- BH professional as part of primary care team
- Systematic BH screening
- Measurement-based BH services
- Population-based care
- Treatment to target
- Tracking patients and follow up
- Evidence-based treatments
- Access to psych (Bree) vs. psych case review (CoCM)

Different Approaches to Psych Services

Bree Specifications

Access to psychiatry services

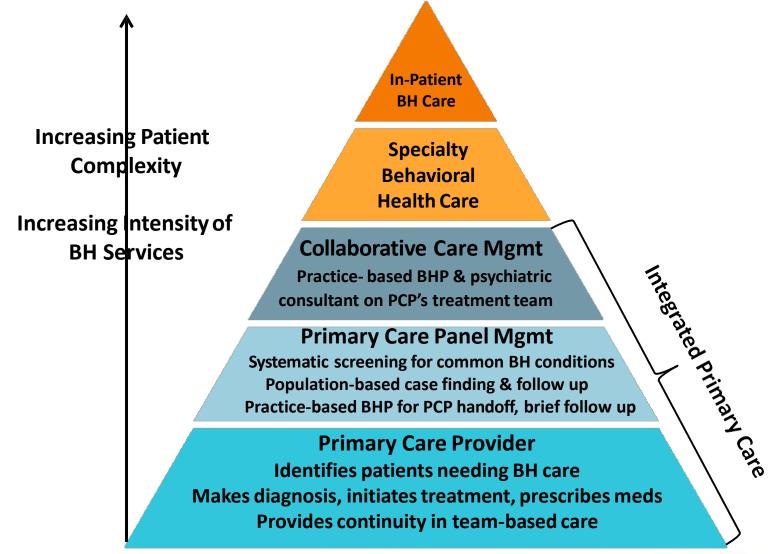
- Virtual or in-person
- Specialty services available, coordinated with primary care
- Psychiatry provider responsible for care of <u>individual patients</u>
- Prescribes psych meds and provides treatment

Collaborative Care Model

Systematic psychiatric case review

- Virtual or in-person
- Usually weekly review
- Psychiatry provider responsible for an <u>assigned</u> <u>caseload of patients</u>
- Recommends treatments and psych meds to PCP

Stepped Strategies for Integration





Stepped Psychiatry Services: Example

Primary Care Provider

 Psychiatric Consultation Line/ Consult Arrangement

Collaborative Care: Psychiatric Consultant

 Systematic Caseload Review

Psychiatric Provider in Specialty BH

 Onsite/ telehealth long term treatment



WA Provider Resources

Expert Support for Diagnostic Clarification, Medication Adjustment and/or Treatment Planning

- UW Psychiatry Consultation Line (PCL)
 - Providers caring for adult patients (18+) with mental health and/or substance use disorders
 - https://sharepoint.washington.edu/uwpsychiatry/ClinicalServices/ConsultationandTelepsychiatry/Pages/pcl.aspx
- UW Perinatal Psychiatry Consult Line for Providers (PAL for Moms)
 - Providers caring for pregnant or postpartum patients
 - https://www.mcmh.uw.edu/ppcl
- Partnership Access Line (PAL)
 - Providers caring for children or adolescent patients
 - https://www.seattlechildrens.org/healthcare-professionals/accessservices/partnership-access-line/wa-pal/



WA Provider Resources

Case Consultation & Skill Building

- UW Psychiatry and Addictions Case Conference (UW PACC)
 - Providers caring for patients with mental health and/or substance use disorders
 - Thursdays 12-1:30pm, Ongoing
 - http://ictp.uw.edu/programs/uw-pacc
- UW Moms' Access Project Echo (MAP Echo): Perinatal Psychiatry Case Conference
 - Providers caring for pregnant or postpartum patients
 - First Wednesdays 12-1pm, Ongoing
 - https://www.mcmh.uw.edu/echo
- Community-Based Integrated Care Fellowship
 - Year-long fellowship for psychiatric providers seeking additional training to deliver integrated care
 - March 2020 February 2021 Applications: Closed
 - https://ictp.uw.edu/programs/community-based-integrated-care-fellowship

Rural Mental Health Integration Initiative



- Three clinic cohorts, ~10 clinics each
 - Recruiting for Cohort 2 now
- Each clinic will participate for 15 months
- Participating clinics receive up to \$245,000 plus:
 - In-person and virtual training for clinical providers
 - Organization-level coaching and technical assistance
 - Free use of AIMS Caseload Tracker (required)
 - Results of a program impact evaluation



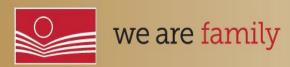
Key Dates and Information

What	When
Cohort 2 application deadline	March 31, 2020 11:59 PM Pacific Time
Application status notification	April 2020
Finalist site visits	May 15 – June 30, 2020
Finalist site award notification	July 2020
Award and training start	August 2020

More information: https://aims.uw.edu/premera-rural-mental-health-initiative

Building PCBH @ YVFWC

Dr. Phillip Hawley, PsyD
PCBH Program Director
Jan 2020



Serving 17 communities throughout the Pacific Northwest

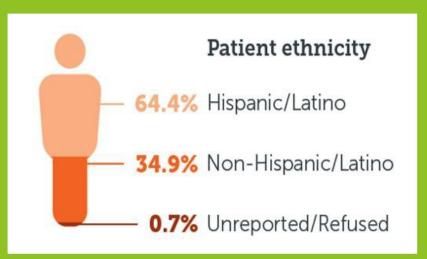
We are committed to providing the highest quality care for families. Here you will find health care professionals with a sincere interest in our patients and the communities we represent.

Our Mission:

Together we are dedicated to lead, with the courage to care, the determination to promote personal growth, and the compassion to champion the cause of those who have no voice.

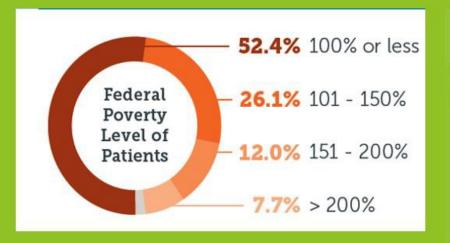
yvfwc.com













we are family

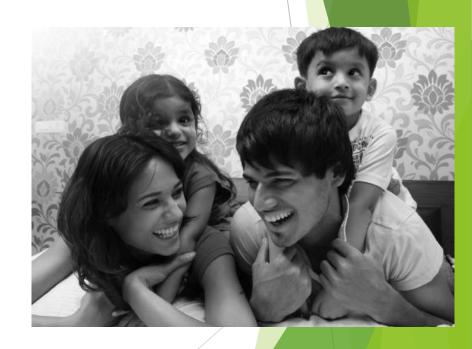
- ► Federally Qualified Health Care center (FQHC) serves approximately 141,000 patients across 683,000 visits each year
- ▶ Of our over 141,000 patients seen in the clinic annually, 41.5% are children, 48.4% are served best in a language other than English (predominately Spanish)





we are family

- ► 42% of patients identify as homeless or migrant/seasonal workers.
- The majority of our patients are Medicaid or uninsured (77%).





we are family

- ► At Yakima Valley Farm Workers Clinic in Toppenish, WA, we utilize the primary care behavioral health model of integration. Behavioral Health Consultants (BHC) provide expert access in primary care to meet this primary care behavioral health needs.
- ► With over 1,000 visits each year per BHC, we recognized the need to be innovative in the delivery and collaboration efforts to better need the needs of our busy clinic and community.



What is Behavioral Health Integration?

Illustration: A family tree of related terms used in behavioral health and primary care integration

See glossary for details and additional definitions

Integrated Care

Tightly integrated, on-site teamwork with unified care plan as a standard approach to care for designated populations. Connotes organizational integration involving social & other services. "Altitudes" of integration: 1) Integrated treatments, 2) integrated program structure; 3) integrated system of programs, and 4) integrated payments. (Based on SAMIISA)

Shared Care

Predominately Canadian usage—PC & MH professionals (typically psychiatrists) working together in shared system and record, maintaining I treatment plan addressing all patient health needs. (Kates et al, 1996; Kelly et al, 2011)

Patient-Centered Care

"The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care"—or "nothing about me without me" (Berwick, 2011).

Collaborative Care

A general term for ongoing working relationships between clinicians, rather than a specific product or service (Doberty, McDaniel & Baird, 1996). Providers combine perspectives and skills to understand and identify problems and treatments, continually revising as needed to hit goals, e.g. in collaborative care of depression (Unûtzer et al, 2002)

Coordinated Care

The organization of patient care activities between two or more participants (including the patient) involved in care, to facilitate appropriate delivery of healthcare services. Organizing care involves the marshalling of personnel and other resources needed to carry out required care activities, and often managed by the exchange of information among participants responsible for different aspects of care." (AHRQ, 2007).

Co-located Care

BH and PC providers (i.e. physicians, NP's) delivering care in same practice. This denotes shared space to one extent or another, not a specific service or kind of collaboration. (adapted from Blount, 2003)

Integrated Primary Care or Primary Care Behavioral Health

Substance Abuse Care

Combines medical & BH services for problems patients bring to primary care, including stress-linked physical symptoms, health behaviors, MH or SA discorders. For any problem, they have come to the right place—"no wrong door" (Blount). BH professional used as a consultant to PC colleagues (Sabin & Borus, 2009; Hass & dcGruy, 2004; Robinson & Reiter, 2007; Hunter et al, 2009).

Behavioral Health Care

An umbrella term for care that addresses any behavioral problems bearing on health, including MH and SA conditions, stress-linked physical symptoms, patient activation and health behaviors. The job of all kinds of care settings, and done by clinicians and health coaches of various disciplines or training.

Mental Health Care

Care to help people with mental illnesses (or at risk)—to suffer loss emotional pain and disability—and live healthier, longer, more productive lives. Done by a variety of caregivers in diverse public and private settings such as specialty MH, general medical, human services, and voluntary support networks. (Adapted from SAMHSA)

Services, treatments, and supports to help people with addictions and substance abuse problems suffer less emotional pain, family and vocational disturbance, physical risks—and live healthier, longer, more productive lives. Done in specialty SA, general medical, human services, voluntary support networks, e.g. 12-step programs and peer counselors. (Adapted from SAMHSA)

Patient-Centered Medical Home

An approach to comprehensive primary care for children, youth and adults—a setting that facilitates partnerships between patients and their personal physicians, and when appropriate, the patient's family. Emphasizes care of populations, team care, whole person care—including behavioral health, care coordination, information tools and business models needed to sustain the work. The goal is health, patient experience, and reduced cost. (Joint Principles of PCMH, 2007).

Primary Care

Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. (Institute of Medicine, 1994)

Thanks to Benjamin Miller and Jürgen Unützer for advice on organizing this illustration

PCBH

G.A.T.H.E.R.

The Essentials of Primary Care Behavioral Health

Here's a way to remember the key features of PCBH work:

G ENERALIST The BHC is a generalist who sees any behavioral issue and all ages.

A CCESSIBLE Most BHC services are available on a same-day basis.

The BHC is a regular member of the team and is ready to help in a variety of ways, such as pre-PCP visits, after-PCP visits, classes, group medical visits, and assisting with resources.

H IGH PRODUCTIVITY The BHC sees 10 or more patients every day.

E DUCATOR The BHC teaches behavioral interventions to others on the team.

R OUTINE PATHWAYS The BHC helps the team develop pathways or protocols that routinely involve BHC help in care for high-impact patient

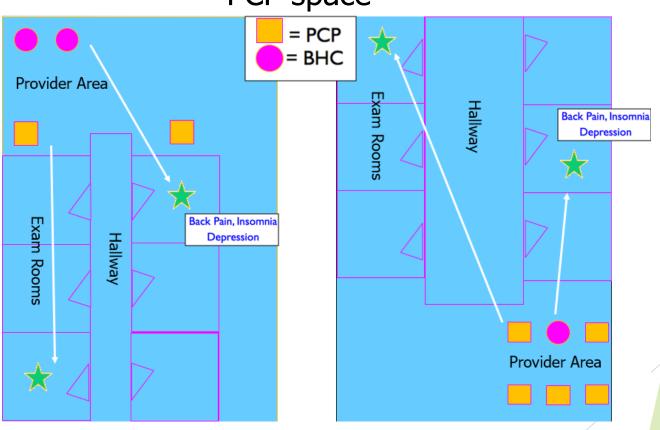
groups.

Let's G.A.T.H.E.R. together!

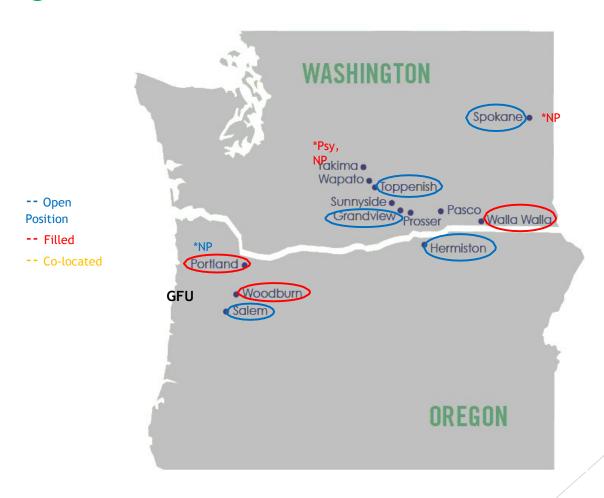
PCBH vs. Traditional MH

Feature	ВНС	Traditional MH	
Model of Care	Population based	Patient based	
Primary "Customers"	PCP, then patient	Patient, then others	
Primary Goals	 Promote PCP efficacy Support change efforts related to patient's medical care 	Resolve patient's mental health issues	
- Brief, intermittent - 1-3 Sessions (15-30 min) - Education/Self- Management Focus - "Present" Centered		- Long-term, scheduled - 10+ sessions (50 min) - Insight focused - Etiology Centered	
Who is "in charge" of patient's care	PCP	Therapist	

Primary Care Culture and Working in the PCP space



Beginnings of BHC



Current

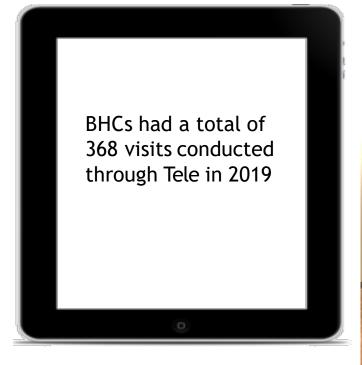
-- Open Position -- Filled



2019 Total Numbers

- ▶ BHCs saw a total of 14,901 unique patients in 2019
- Population reach average across clinics was 11.93%
 - ► Range: 8.15%- 20.4%
- ▶ 21,312 BHC face to face patient visits (up from 19,439 visits in 2018)
- ► +3,710 additional patient touches
 - ► These include telephone calls, EPIC documentation notes, care coordination, and PCP consultation w/o patient present visits.
- ► =25,022 total BHC patient touches

Special Focus Area- TeleBHC





TeleBHC Visit Data

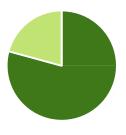
Wapato and Pasco Clinics- 2019

- Live Visits: 1012

- Tele Visits: 343

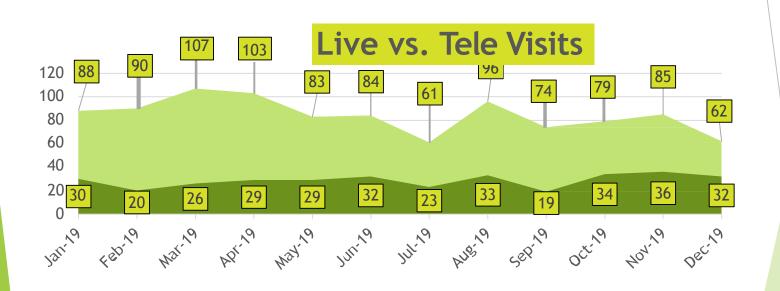
Tele = 33.9% of all Wapato/Pasco visits

Wapato/Pasco - Visit Type





TeleBHC Visit Data



Live

Tele-BHC Clinical Outcomes

TeleBHC vs Live Visits (Pre/Post Measures)

PHQ-9	TeleBHC	Live
Significant Improvement	33.3%	30.8%
Significant Decline	13.6%	11.1%
No Change	53.0%	58.1%

N = 183 Total Patients TeleBHC = 66 Live = 117

GAD-7	TeleBHC	Live
Significant Improvement	24.2%	24.8%
Significant Decline	15.2%	13.7%
No Change	60.6%	61.5%

2020 Focus Areas

- ► Tele-BHC: continued growth and expansion into new locations
- Metrics: Depression Screening and Remission, SBIRT, Medicare Annual Wellness Visits
- ► Training/Recruiting/Retention
- PCBH efficiency/utilization

2020 Challenge Areas

- Recruiting/ Training
- Adherence to PCBH components
- Staff morale and retention
- Demonstrating Productive and Effective work
- ▶ Balancing administrative and clinical requirements
 - ▶ We need a balance of BHCs showing daily work and administrative/systems work to further push payors and legal bodies to advocate for PCBH

Questions/Feedback

Feel free to email me @ phillipH@yvfwc.org

Questions?



SAVE THE DATES





FEB 26

Wednesday 12:00-1:00
Suicide Care

MARCH 25

Wednesday 12:00-1:00

Addiction &

Dependence Treatment

April 22

Wednesday 12:00-1:00
Opioid Use Disorder

Registration coming soon

Join our mailing list here:

https://scoap.us4.list-

manage.com/subscribe?u=76f5871d4dbd771599c41c1f9&id=b656dfoc5b