# Bree Collaborative Implementation Webinar - Behavioral Health Integration


Webinar | 1/29/2020

# Speakers

**Ginny Weir, MPH**

Director, Bree Collaborative

**Amy Etzel**

Implementation Manager, Bree Collaborative

**Sara Barker, MPH**

Assistant Director of Implementation, Washington AIMS Center

**Philip Hawley, Psy.D.**

Primary Care Behavioral Health Director, Yakima Valley Farm Workers Clinic

# Background
## Members and Topic Selection

House Bill 1311 (2011)


Identify health care services with high:

- **Variation**
- **Utilization**

Without producing better outcomes

# Developing Recommendations


- Reimbursement Models
- Transparency/Tracking
- Centers of Excellence
- Shared Decision Making
- Existing Guidelines
- Published Evidence
- Programs and Policies

**Clinical Committee**

Meeting Monthly for 9-12 Months

**Public Comment**

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, re-review 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
5. 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

| 3. Accessibility and Sharing of Patient Information | 4. Practice Access to Psychiatric Services |
|---|---|
| • 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<br>• Regularly scheduled consultations between clinicians to jointly address shared care plan<br>• Systematic tracking of patient progress toward treatment goals | • Systematic access to psychiatric consultation services for primary care providers (on-site or virtual)<br>• Clear referral and coordination process to specialty care for complex symptoms and diagnoses<br>• 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<br>• Systematic clinical protocols to record, track and follow-up on screening results<br>• Systematic clinical protocols to track patients with targeted conditions (i.e. registry) and engage with patients who are not improving | • Evidence-based interventions adapted for patient population (age, religion, language, culturally appropriate)<br>• Quantifiable use of behavioral health symptom rating scale to track patient improvement<br>• 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<br>• Shared decision making between patient and team, where appropriate<br>• 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 | • Systematic tracking of organizational data, such as patient access to behavioral health<br>• Systematic tracking of patient feedback<br>• Quality improvement structure to achieve organizational access goals and other identified outcome standards |

# Behavioral Health Integration Guideline CHECKLIST

DR. ROBERT BREE COLLABORATIVE

## 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
- ❑ Systematic tracking of patient progress toward treatment goals

### 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 warm-hand-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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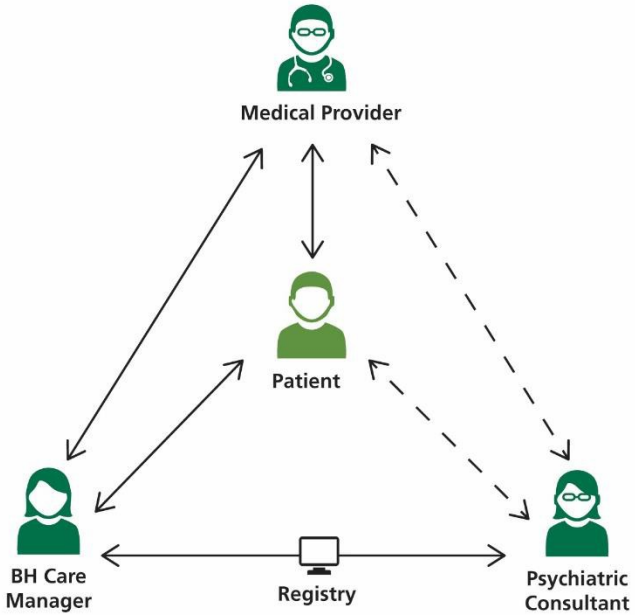
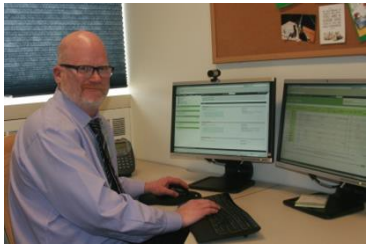
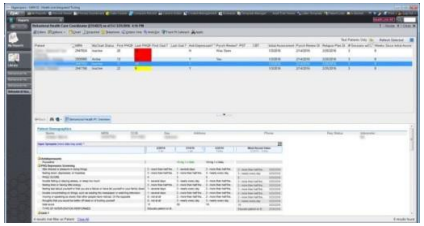
# Collaborative Care Model (CoCM)

Primary care patient-centered team-based care



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



Registry to track population

Problem Solving Treatment (PST)
Behavioral Activation (BA)
Motivational Interviewing (MI)
Medications

Active treatment with evidence-based approaches


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

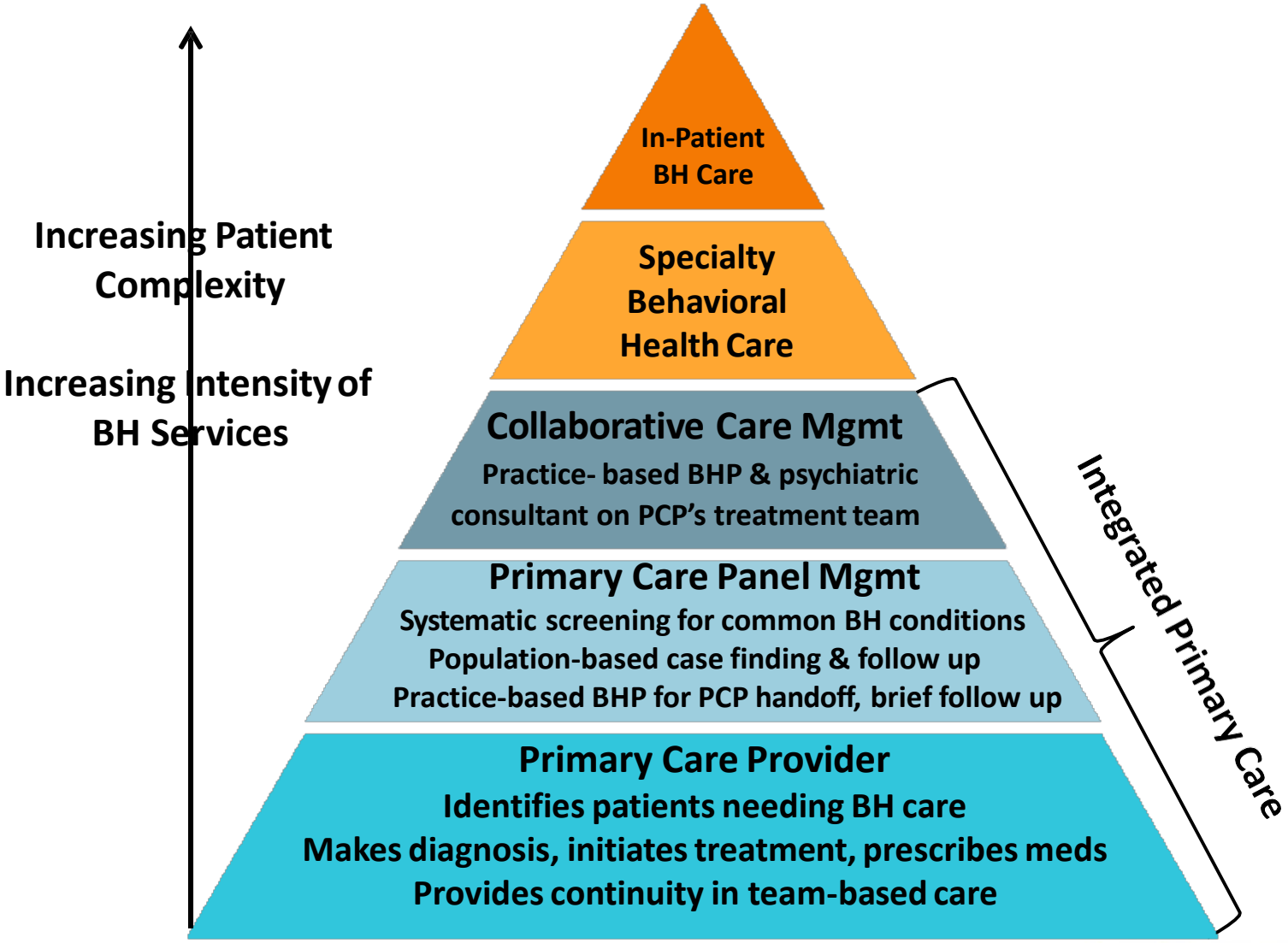
- Virtual or in-person
- Specialty services available, coordinated with primary care
- **Psychiatry provider responsible for care of <u>individual patients</u>**
- Prescribes psych meds and provides treatment

## Collaborative Care Model

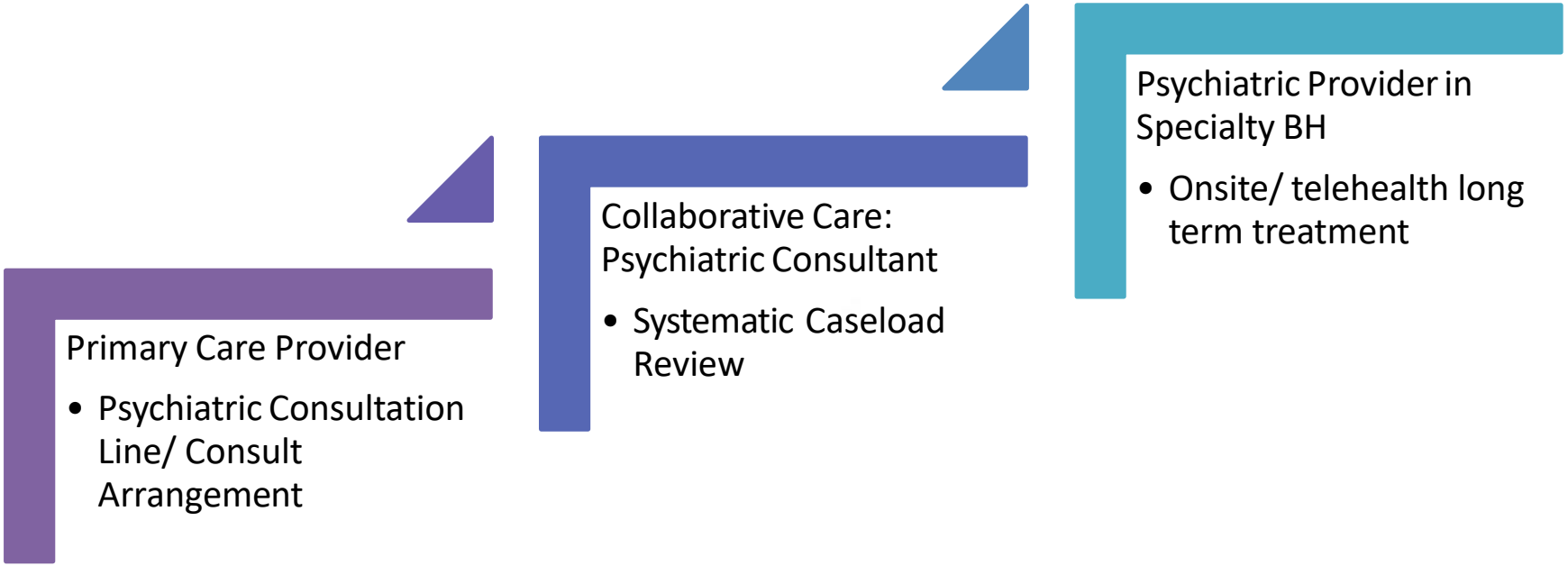
### Systematic psychiatric case review

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

# Stepped Strategies for Integration



# Stepped Psychiatry Services: Example



# 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/access-services/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

PREMERA | BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

- **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**<br>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

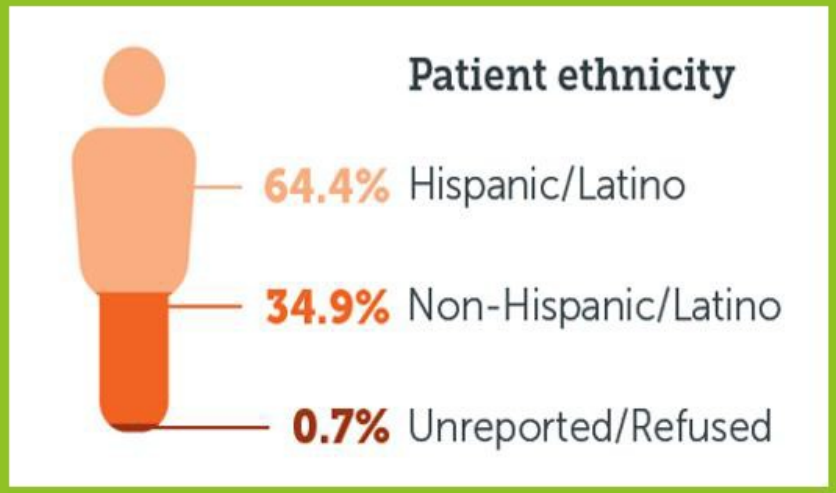
we are family

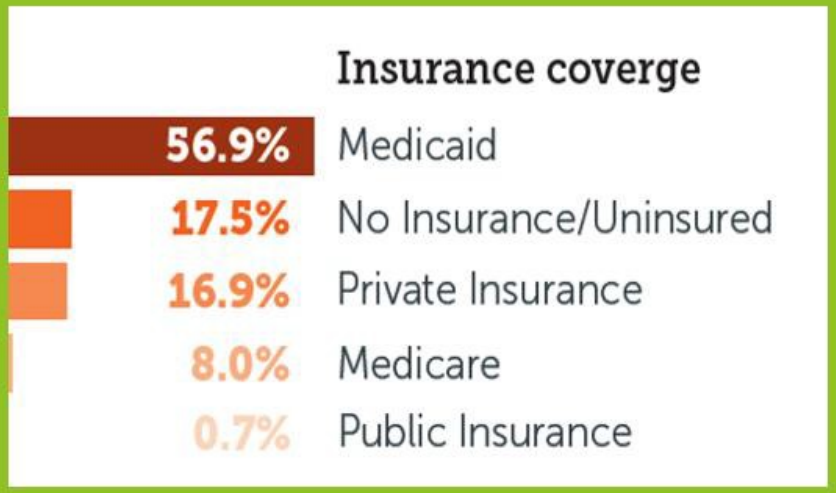
yvfwc.com

# Serving 17 communities throughout the Pacific Northwest

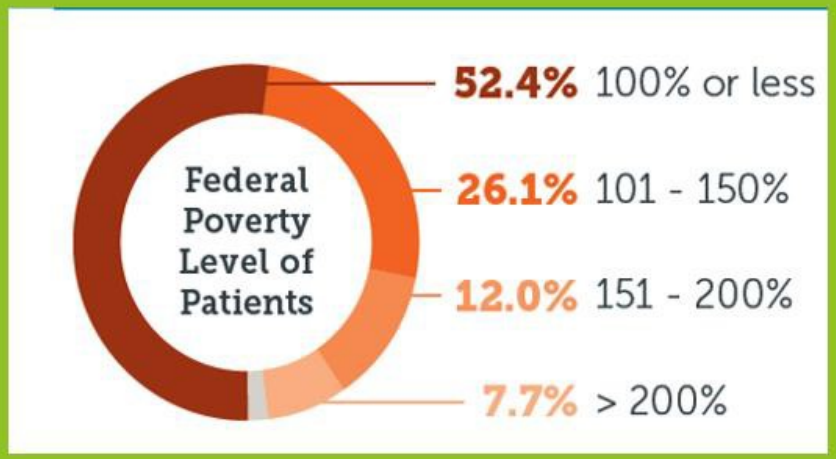
We are commited to providing the highest quality care for families. Here you will find health care professionals with a sincere interest in our patients and the communities we represent.

**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.**


Patient ethnicity
64.4% Hispanic/Latino
34.9% Non-Hispanic/Latino
0.7% Unreported/Refused


Insurance coverge
56.9% Medicaid
17.5% No Insurance/Uninsured
16.9% Private Insurance
8.0% Medicare
0.7% Public Insurance


CHILDREN
45.2%
ADULTS
48.1%
SENIORS
6.7%


Federal Poverty Level of Patients
52.4% 100% or less
26.1% 101 - 150%
12.0% 151 - 200%
7.7% > 200%

Yakima Valley Farm Workers Clinic

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)

Yakima Valley Farm Workers Clinic

we are family

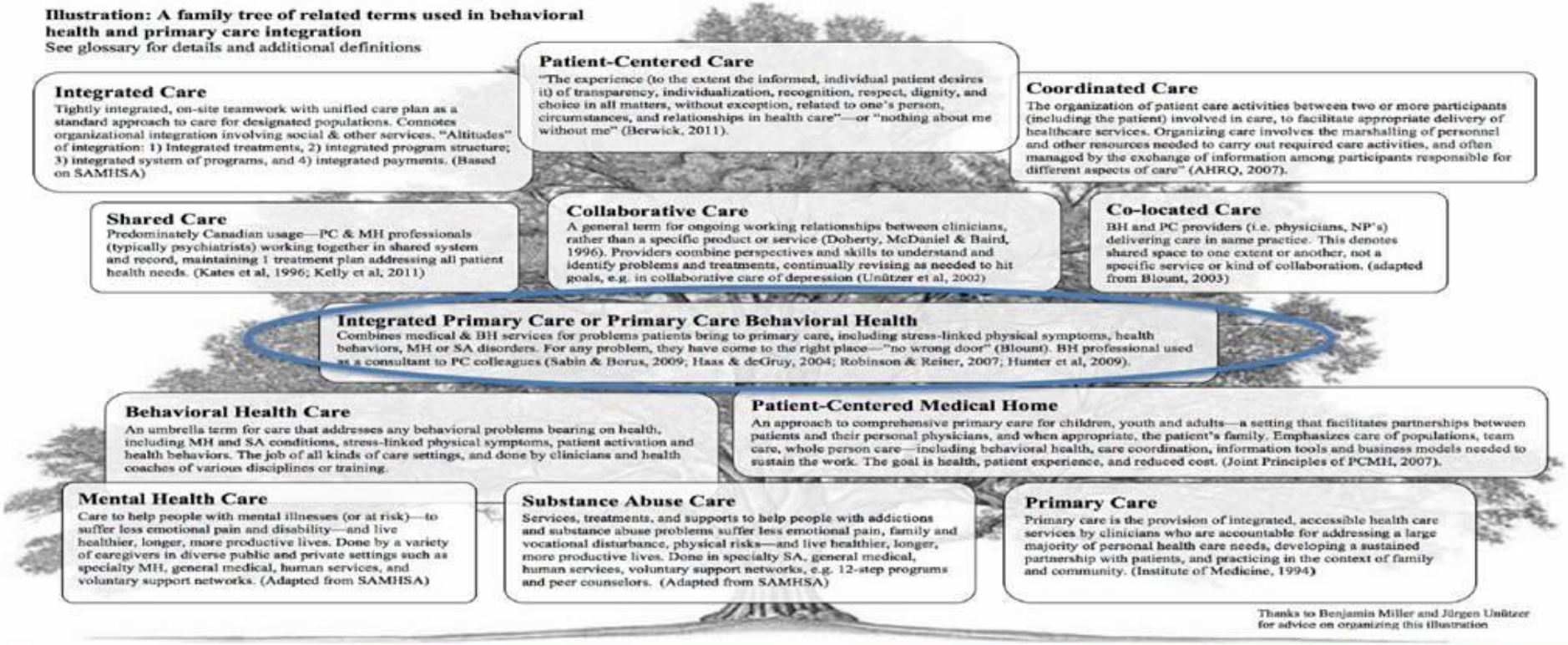
- 42% of patients identify as homeless or migrant/seasonal workers.
- The majority of our patients are Medicaid or uninsured (77%).

Yakima Valley Farm Workers Clinic

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?



# 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:

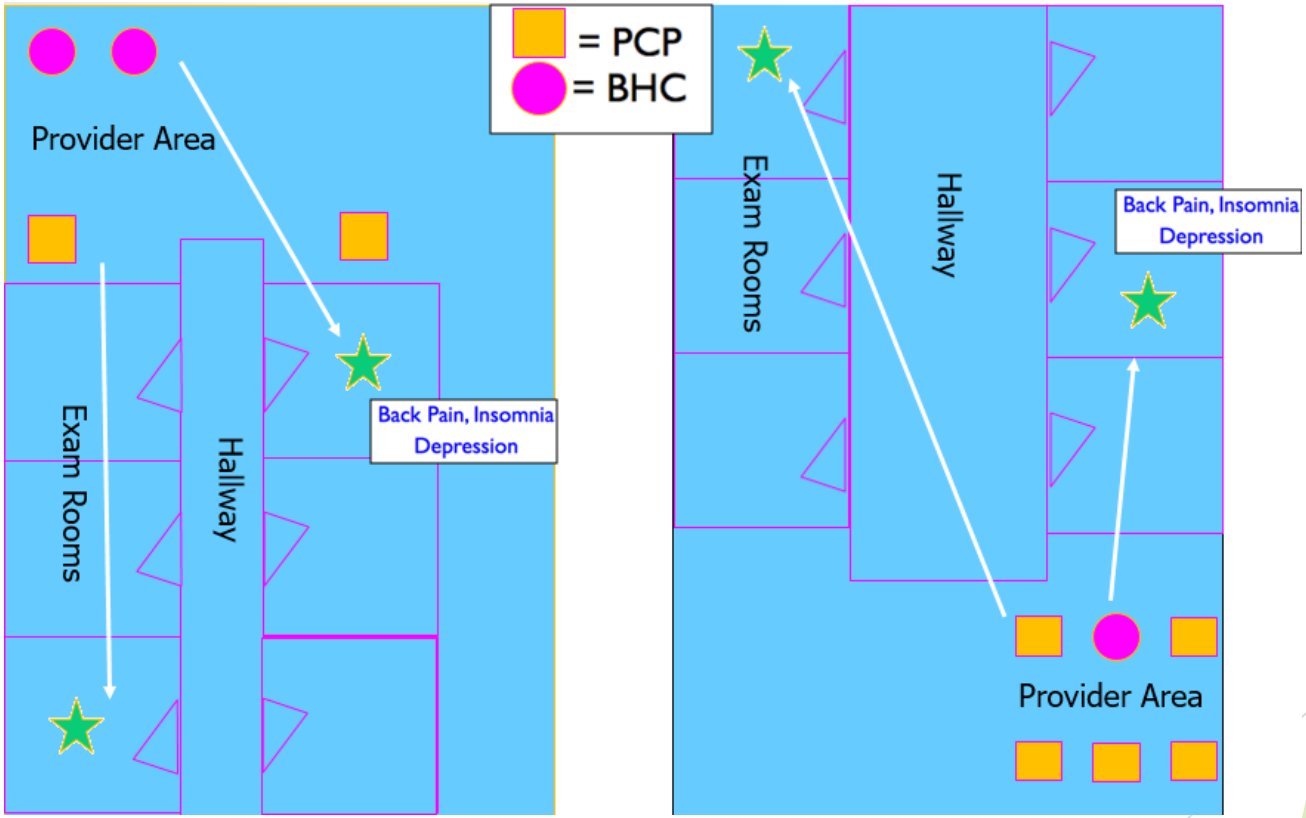
| | |
|---|---|
| **G** ENERALIST | The BHC is a generalist who sees any behavioral issue and all ages. |
| **A** CCESSIBLE | Most BHC services are available on a same-day basis. |
| **T** EAM-BASED | The BHC is a regular member of the team and is ready to help in a variety of ways, such as pre-PCP visits, 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 | BHC | Traditional MH |
|---|---|---|
| **Model of Care** | Population based | Patient based |
| **Primary "Customers"** | PCP, then patient | Patient, then others |
| **Primary Goals** | - Promote PCP efficacy<br>- Support change efforts related to patient's medical care | Resolve patient's mental health issues |
| **Service delivery structure** | - Brief, intermittent<br>- 1-3 Sessions (15-30 min)<br>- Education/Self-Management Focus<br>- "Present" Centered | - Long-term, scheduled<br>- 10+ sessions (50 min)<br>- Insight focused<br>- Etiology Centered |
| **Who is "in charge" of patient's care** | PCP | Therapist |

# Primary Care Culture and Working in the PCP space

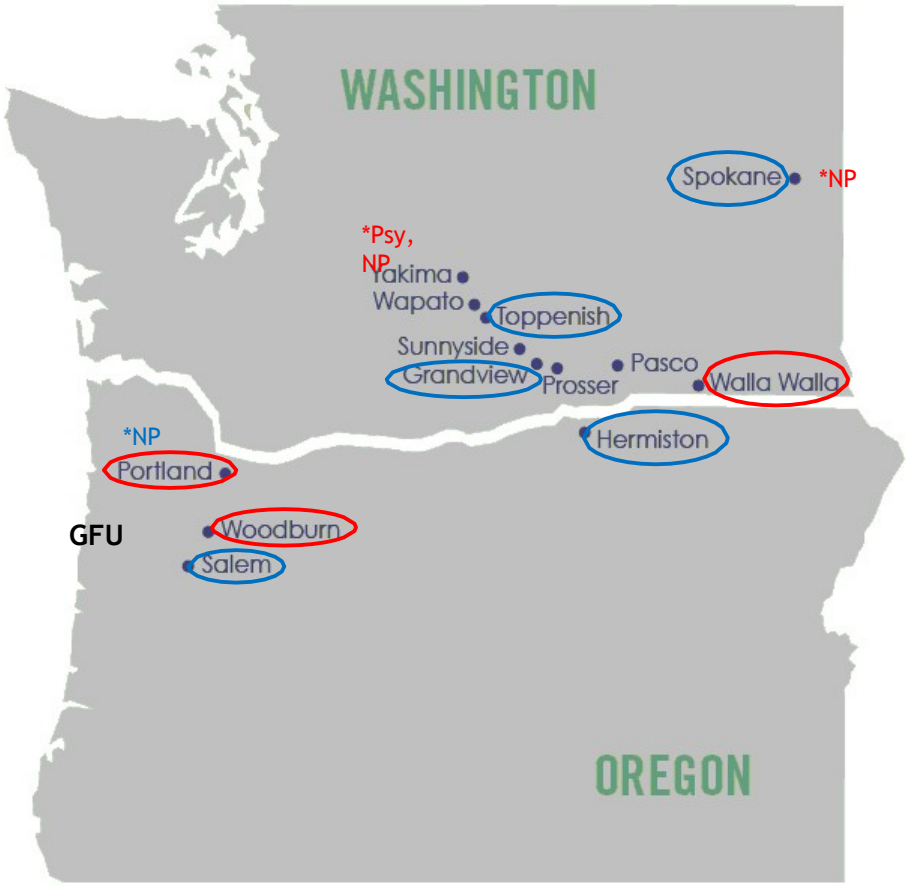


# Beginnings of BHC

-- Open Position

-- Filled

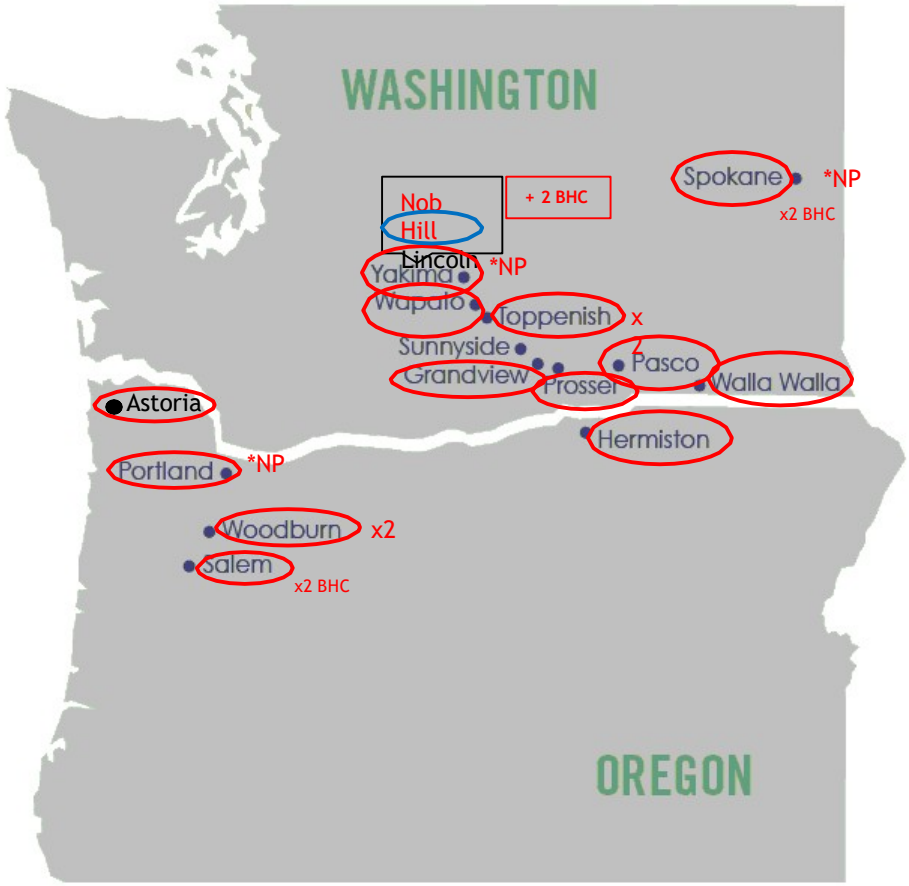
-- Co-located



# 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

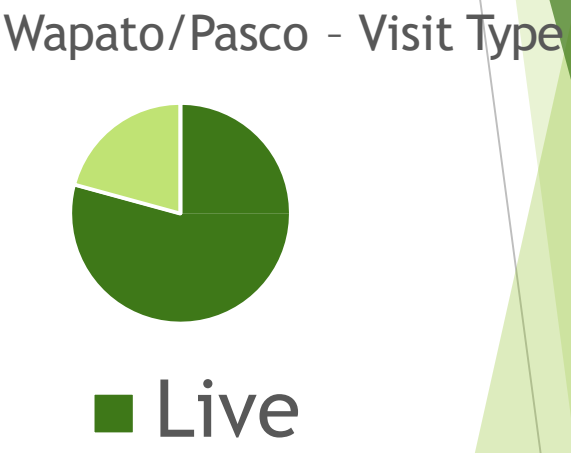
BHCs had a total of 368 visits conducted through Tele in 2019

# TeleBHC Visit Data

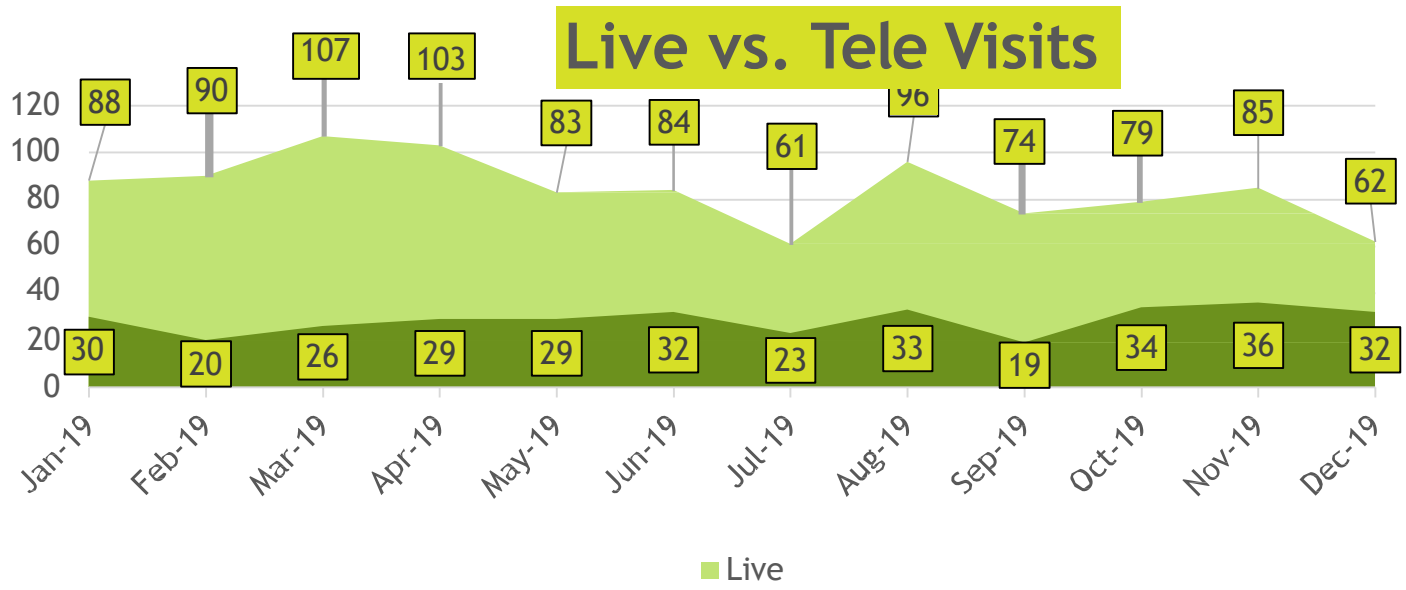
**Wapato and Pasco Clinics- 2019**

- Live Visits: 1012
- Tele Visits: 343

Tele = 33.9%
of all Wapato/Pasco visits



# TeleBHC Visit Data



# 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% |

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

N = 183 Total Patients

TeleBHC = 66
Live = 117

# 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 | MARCH 25 | April 22 |
|---|---|---|
| Wednesday 12:00-1:00 | Wednesday 12:00-1:00 | Wednesday 12:00-1:00 |
| Suicide Care | Addiction & Dependence Treatment | Opioid Use Disorder |

*Registration coming soon*

Join our mailing list here:
https://scoap.us4.list-manage.com/subscribe?u=76f5871d4dbd771599c41c1f9&id=b656df0c5b