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

Identify health care services with high:
  • Variation
  • Utilization
Without producing better outcomes

House Bill 1311 (2011)
Broader Health Care Community

Developing Recommendations

Recommendations to improve health care quality, outcomes, and affordability

Clinical Committee

Meeting Monthly for 9-12 Months

Public Comment

WA State Agencies

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

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

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

National Standards
- SAMHSA
- AHRQ
- Oregon PCPC

Local Standards
- UW AIMS Center
- Qualis Health
## Care Team and Access

<table>
<thead>
<tr>
<th>1. Integrated Care Teams</th>
<th>2. Patient Access to Behavioral Health as Routine Part of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Practice commitment to culture of teamwork and integrated care</td>
<td>• Clear referral and scheduling process for behavioral health services</td>
</tr>
<tr>
<td>• Clearly defined roles for all team members, including clinicians and non-licensed staff</td>
<td>• Same day access to behavioral health services (on-site or virtual) whenever possible; at minimum same day care plan development</td>
</tr>
<tr>
<td>• 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)</td>
<td>• Behavioral health services scheduled in a way that best meet the patients need (in person, phone, or virtual), especially in first month of treatment</td>
</tr>
</tbody>
</table>
### 3. 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

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

<table>
<thead>
<tr>
<th>7. Patient Involvement in Care</th>
<th>8. Data for Quality Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient voice informs the care plan/goal development and patient input central to care plan</td>
<td>• Systematic tracking of organizational data, such as patient access to behavioral health</td>
</tr>
<tr>
<td>• Shared decision making between patient and team, where appropriate</td>
<td>• Systematic tracking of patient feedback</td>
</tr>
<tr>
<td>• 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</td>
<td>• Quality improvement structure to achieve organizational access goals and other identified outcome standards</td>
</tr>
</tbody>
</table>
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
<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Care Team</td>
<td>Frequency of Integrated Care Team huddles (onsite or remotely).</td>
</tr>
<tr>
<td>Screening Tools</td>
<td>Percentage of patients screened for behavioral health conditions using a validated screening tool.</td>
</tr>
<tr>
<td>Access to BH services</td>
<td>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).</td>
</tr>
<tr>
<td>Shared Care Plan</td>
<td>Percentage of patients with identified behavioral health needs that have a shared care plan through EHR or other shared clinical care management system.</td>
</tr>
</tbody>
</table>
Contact

Ginny Weir, MPH
Director, Bree Collaborative
GWeir@qualityhealth.org
(206) 204-7377

Amy Etzel
Implementation Manager, Bree Collaborative
AEtzel@qualityhealth.org
(206) 204-7387
Collaborative Care Model (CoCM)

Primary care patient-centered team-based care

Registry to track population

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

Active treatment with evidence-based approaches

Validated outcome measures tracked over time

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

PHQ-9
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 individual patients
- 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 assigned caseload of patients
- Recommends treatments and psych meds to PCP
Stepped Strategies for Integration

- **Primary Care Provider**
  - Identifies patients needing BH care
  - Makes diagnosis, initiates treatment, prescribes meds
  - Provides continuity in team-based care

- **Primary Care Panel Mgmt**
  - Systematic screening for common BH conditions
  - Population-based case finding & follow up
  - Practice-based BHP for PCP handoff, brief follow up

- **Collaborative Care Mgmt**
  - Practice-based BHP & psychiatric consultant on PCP’s treatment team

- **Specialty Behavioral Health Care**
  - In-Patient BH Care

Increasing Patient Complexity

Increasing Intensity of BH Services
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](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](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/](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](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](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
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

<table>
<thead>
<tr>
<th>What</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohort 2 application deadline</td>
<td><strong>March 31, 2020</strong></td>
</tr>
<tr>
<td></td>
<td>11:59 PM Pacific Time</td>
</tr>
<tr>
<td>Application status notification</td>
<td>April 2020</td>
</tr>
<tr>
<td>Finalist site visits</td>
<td>May 15 – June 30, 2020</td>
</tr>
<tr>
<td>Finalist site award notification</td>
<td>July 2020</td>
</tr>
<tr>
<td>Award and training start</td>
<td>August 2020</td>
</tr>
</tbody>
</table>

**More information:** [https://aims.uw.edu/premera-rural-mental-health-initiative](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.
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).
42% of patients identify as homeless or migrant/seasonal workers.

The majority of our patients are Medicaid or uninsured (77%).
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. “Alitudes” of integration: 1) Integrated treatments, 2) integrated program structure; 3) integrated system of programs, and 4) integrated payments. (Based on SAMHSA)

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).

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).

Integrated Primary Care or Primary Care Behavioral Health
Combines medical & BH services for problems patients bring to primary care, including stress-linked physical symptoms, health behaviors, MH or SA disorders. 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; Haas & deGraaf, 2004; Robinson & Reiter, 2007; Hunter et al, 2009).

Shared Care
Predominantly Canadian usage—PC & MH professionals (typically psychiatrists) working together in shared system and record, maintaining treatment plan addressing all patient health needs. (Kates et al, 1996; Kelly et al, 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 (Unutzer et al, 2002)

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)

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.

Substance Abuse Care
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)

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)

Mental Health Care
Care to help people with mental illnesses (or at risk)—to suffer less 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)

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 FCMI, 2007).

Thanks to Benjamin Miller and Jürgen Unitzer for advice on organizing this illustration.
### 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

<table>
<thead>
<tr>
<th>Feature</th>
<th>BHC</th>
<th>Traditional MH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Model of Care</strong></td>
<td>Population based</td>
<td>Patient based</td>
</tr>
<tr>
<td><strong>Primary “Customers”</strong></td>
<td>PCP, then patient</td>
<td>Patient, then others</td>
</tr>
<tr>
<td><strong>Primary Goals</strong></td>
<td>- Promote PCP efficacy</td>
<td>Resolve patient’s mental health issues</td>
</tr>
<tr>
<td></td>
<td>- Support change efforts related to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>patient’s medical care</td>
<td></td>
</tr>
<tr>
<td><strong>Service delivery structure</strong></td>
<td>- Brief, intermittent</td>
<td>- Long-term, scheduled</td>
</tr>
<tr>
<td></td>
<td>- 1-3 Sessions (15-30 min)</td>
<td>- 10+ sessions (50 min)</td>
</tr>
<tr>
<td></td>
<td>- Education/Self-Management Focus</td>
<td>- Insight focused</td>
</tr>
<tr>
<td></td>
<td>- “Present” Centered</td>
<td>- Etiology Centered</td>
</tr>
<tr>
<td><strong>Who is “in charge” of patient’s care</strong></td>
<td>PCP</td>
<td>Therapist</td>
</tr>
</tbody>
</table>
Primary Care Culture and Working in the PCP space
Beginnings of BHC

- Open Position
- Filled
- Co-located
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

Live vs. Tele Visits

Jan-19: 30
Feb-19: 20
Mar-19: 26
Apr-19: 29
May-19: 29
Jun-19: 32
Jul-19: 23
Aug-19: 33
Sep-19: 19
Oct-19: 34
Nov-19: 36
Dec-19: 32

Live: 88
90
107
103
83
84
61
74
79
85
62
## Tele-BHC Clinical Outcomes

### TeleBHC vs Live Visits
(Pre/Post Measures)

<table>
<thead>
<tr>
<th></th>
<th>TeleBHC</th>
<th>Live</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant Improvement</td>
<td>33.3%</td>
<td>30.8%</td>
</tr>
<tr>
<td>Significant Decline</td>
<td>13.6%</td>
<td>11.1%</td>
</tr>
<tr>
<td>No Change</td>
<td>53.0%</td>
<td>58.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>TeleBHC</th>
<th>Live</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant Improvement</td>
<td>24.2%</td>
<td>24.8%</td>
</tr>
<tr>
<td>Significant Decline</td>
<td>15.2%</td>
<td>13.7%</td>
</tr>
<tr>
<td>No Change</td>
<td>60.6%</td>
<td>61.5%</td>
</tr>
</tbody>
</table>

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**
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=b656df0c5b