# King County Physical and Behavioral Health Integration Design Committee

## *Meeting Summary*

*February 10, 2016; 1:30 – 4:00 PM*
*Navos-Revelle Hall, 1210 SW 136th St., Burien, WA 98166*

***Members Present:*** *Betsy Jones- King County, Tom Trompeter- Healthpoint, Darcy Jaffe- Harborview, Ken Taylor-Valley Cities, Torri Canda- Amerigroup, Steve Daschle-Southwest Youth and Family Services, Molly Donovan-REWA, Debbie Horowski- United Healthcare, Jennifer DeYoung- Public Health Seattle and King County, Angie Riske- Multicare, Roger Dowdy-Neighborcare Health, Maria Yang- King County, Anne Shields- UW Aims, Vicki Isett- Community Homes, Suzanne Peterson-Tannenberg-Children's Hospital and Regional Medical Center, Marc Avery- Community Health Plan of Washington, Stacy Fennell-Sea Mar, Daniel Malone- DESC, Susan Mclaughlin-King County*

***Members Not Present:*** *David Johnson- Navos, Aileen DeLeon-WAPI, Patricia Quinn- Therapeutic Health Service, Emily Transue- Coordinated Care, Maureen Linehan- City of Seattle, Julie Lindberg- Molina*

***Staff:*** *Liz Arjun- King County, Travis Erickson-King County*

***Guests:*** *Evan Oakes- HealthPoint, Cara Dalbey- HealthPoint, and Laura Collins- Harborview*

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## Welcome

Susan McLaughlin welcomed the group and introduced the presenters: Laura Collins with Harborview, Evan Oaks and Cara Dalbey with HealthPoint.

## Updates

At the January meeting, we discussed Medicaid 1115 waiver toolkit papers that were being submitted to the Health Care Authority. Susan flagged a document in the handouts that was prepared for the Accountable Community of Health Interim Leadership Council that described at a very high level the types of ideas that were submitted from the King County region. She also mentioned that the ACH ILC will be working on a letter to the Health Care Authority about what was submitted- we will be sure to share that letter when it is available.

King County will launch its Behavioral Health Organization which will provide integrated Mental Health and Substance Use Disorder treatment beginning on April 1, 2016. In preparation for this, King County will host a forum for community partners and stakeholders who serve people that may need access to mental health and SUD treatment. The forums are scheduled for February 22nd 12:00-1:30 and March 18th from 12:30-2:00 at the Chinook building. Please go here to register for the forums.

## Primary Care Settings & Integrating Behavioral Health

The IDC heard presentations from Stacy Fennell at Sea Mar, Evan Oakes and Cara Dalbey at HealthPoint and Laura Collins at Harborview. The presenters were asked to address the following questions about what their organization does to integrate behavioral health into a primary care setting:

1. What have you done?
2. How have you done it?
3. What works?
4. What doesn't work?
5. Who does the model serve?
6. What are improvements that need to be made?
7. What are some key elements to success?
8. How do people move through the system- one model to another?
9. How are you using virtual or non-traditional tools?

*The presentations are attached at the end of this document.*

## Discussion

**Anne Shields began the discussion by asking the presenters about the attrition rates they saw over time.**

Harborview reported that it tracks patients but does not have that information; HealthPoint does not track this and would have to look at their panels to get a better sense of this; Sea Mar reported that they would also have to look this up, but that they have 25% no-show rate likely due to the higher risk profile of their patients.

As far as populations that are not seen in traditional settings, there was little information. Harborview requires contact twice a month with at least 60% of the patient population- this seems to have helped with retention.

**What do your organizations know about patients also receiving community mental health services or how did you help facilitate enrollment when necessary**?

Sea Mar makes sure there is a referral for a PCP or sets them up directly for services because they are also a CMHC. They do not have an exact percentage on hand of those enrolled in behavioral health services. Harborview checks to see if the patient is already enrolled with a mental health provider and if so, they close the loop by collaborating with the case manager.

**What is your experience with transitions in the MHIP program from Level 1 to Level 2?**

Marc Avery with Community Health Plan of Washington reported that things have become more complicated because of the Affordable Care Act. However, MHIP communities are better at referrals. It really depends on the mobile resources available through the RSN. Sea Mar has integration specialists to

do this and the goal is to hand back to the primary care provider because it is more likely that the PCP will always be there; HealthPoint shared a similar approach to Sea Mar.

**The IDC wanted to know more about the referral process from HealthPoint to Valley Cities.**

Ken Taylor shared that care coordination at Kent Valley Cities acts as the front door, offering same day appointments that are built around care coordinator. The coordinator creates a team around client, looks for PCP, housing, employment and psychiatric provider. This all depends on the individual's needs at that time. The care coordinator is the one that exchanges information with all agencies for patient. A lot is done on the phone. Information exchange is a challenge for HealthPoint because of privacy guidelines. They try to expand to offer as much for the patient as possible.

**The IDC was interested in how MHIP and SBIRT can be used together in regard to patients with co-occurring disorders at the primary care setting.**

HealthPoint has two clinics piloting this approach with the same people doing brief intervention and acting as care coordinators. Harborview has a medical assistant that is trained in brief intervention; if the patient needs more help, the patient is handed off to LCSW. Harborview bills Apple Health for services.

**The committee then discussed workforce issues.**

Sea Mar reported that they have high CDP turnover. They need Spanish speaking staff and they offer incentives to attract qualified staff in Mount Vernon and other areas. The federal reimbursement has helped them offer better wages to offset retention. Other agencies are seeing clinicians move South due to the cost of living in King County. The Community Health Centers have seen a significant struggle in availability for Medical Assistants and have about a 20% vacancy rate and are struggling to stay competitive in the pay scale. They are moving toward MHIP, SBIRT and expanding to same day access for behavioral health. Neighborcare is working with a Valley Cities team at the Meridian Campus to do this.

**What hard data do you have to show the success of behavioral health integration for your populations?**

Valley Cities reported that it has been doing the PHQ9, and trying to find out if it's substantial. They do not have rigorous outcome measures. HealthPoint is doing the same. Most evidence is anecdotal, but they lack hard data figures. They are looking at ways of measuring sustainability with patients over the long term.

HealthPoint has done internal surveys of the medical providers and overwhelmingly it's very popular and having the BHC is very valuable to staff. One key measure should be total cost to care but that data is not owned by one system. It could be helpful to ask the Health Care Authority and in turn CMS for this information. Harborview looked at increasing productivity of the PCP and that cost has been offset.

An older BMI study has shown a cost savings correlated to decreased hospitalization with BHI. That study has also shown a decrease in contact with criminal justice system, these are cross-sector savings and difficult to quantify at the individual clinic level.

Anne Shields discussed the new metric for value based care that will be implemented in the coming years. Monitoring quality measures have been done by the Health Authority, they normally take a subset population of every year and they monitor the health plans. The new measure of depression by NCQA is measured in a 5-7 month time frame, 5% decrease or 50% improvement.

Harborview suggested looking at metrics that are already in place to avoid adding administrative burden.

**How do you bill Apple Health and what are the obstacles with billing?**

It is very complicated. For HealthPoint, services that are Level 1 services are considered to be a primary care, they cannot bill Level 2 services because they are not a licensed mental health center. Without MHIP the financing would not be sustainable. Different payers have different rules, sometimes only certain coordinators qualify as being reimbursable and it is not consistent across the board.

King County BHO is looking for a better approach and to streamline the billing process.

## Discussion Wrap Up

Susan McLaughlin wrapped up the conversation by recounting what were identified as common components across all three organizations including:

- Measurement-based care including focus on population-based approach
- Multi-disciplinary treatment teams
- Stepped care
- Designated care coordinator
- Access to Psychiatric consultant
- Seamless access to specialty behavioral health services
- Strong links to social services
- Preventive approach to behavioral health

She then identified some of the common challenges that the IDC will want to address in developing in new model for the region including:

- Wait lists and lack of immediate access to interventions and coordination
- Unstably housed clients
- Difficulty accessing housing for clients
- Workforce retention and finding qualified staff
- Technology: infrastructure and care coordination
- Bi-furcated mental health benefit that makes it difficult to do early intervention
- Insufficient resources for non-Medicaid eligible people
- Inconsistent and disparate Medicaid state plans

- Inadequate financing

## Mid-Adopter Proviso, Timing and Committee Work

Betsy Jones gave an update on a State Budget Proviso being considered by legislators for regions to be mid-term adopters. The proviso would allocate $1,000,000 per region that elects this option. It would require that mid-term adopters provide a binding letter of intent to the HCA to fully integrate with MCO's by August 2016 for start date of April 2017 and would allow money to flow to the counties that elect this option. King County offered some suggestions including allowing for a start date of July 2018 with a binding letter of intent due in August 2017 in order to allow time for the work of the PBHI committee. Tom Trompeter shared some context from Olympia that the state might not move forward with the proviso due to funding gaps.

The discussion then focused on whether or not the IDC felt it would be able to complete its work regardless of an accelerated timeline. Many felt that in order to accomplish its work, the committee would have to pick up the pace and consider more meeting times. There was no consensus about adding additional meetings. Susan McLaughlin encouraged everyone to think about this option or establishing subcommittees. The Steering Committee will discuss it in its next planning call.

Marc Avery suggested that the group might want to look at the lessons learned through the development of the Mental Health Integration Program and the evolution to a managed care program- others agreed and it was suggested that CHPW could help. These lessons could likely be helpful in conversations with the Health Care Authority.

## Next Steps

The March meeting will focus on care delivery to kids and adolescents. Susan asked the committee to email Liz Arjun with suggestions about guest speakers in addition to someone from Children's Hospital and someone from Public Health with the school-based health centers.

# King County Physical and Behavioral Health Integration Design Committee

February 10, 2016
1:30 PM- 4:00 PM

Navos - Revelle Hall
Burien, WA

# Today's Agenda

- Welcome
- Updates
- Primary Care Settings & Integrating Behavioral Health
  - Stacy Fennell - Sea Mar
  - Cara Dalbey, BHC Lead & Evan Oakes, Medical Director - HealthPoint
  - Laura Collins, Administrator & Darcy Jaffe - Harborview
- Discussion
- Wrap Up & Next Steps
- Adjourn

# Updates

# Sea Mar's Physical and Behavioral Health Integration Model

***Humans are Integrated, so why aren't we?***

Stacy Fennell,
Child & Family Program Director

# Sea Mar's Physical and Behavioral Health Integration Model

**Three Types of Approaches**

Integrated Services:

- (PH, BH, Soc) services provided by the same team and based within the same location.

Co-Located Services:

- Different (PH, BH, Soc) service teams located in the same location that collaborate to provide coordinated services.

Synchronized Services:

- Different (PH, BH, Soc) service teams located in separate locations that collaborate to provide coordinated services.

# Sea Mar's Physical and Behavioral Health Integration Model

**Integrated Services in Medical Clinics**

Main Point of Contact - Physical Health (Medical Clinic)

- MA conducts PHQ2 to identify MH risk
- MA conducts SBIRT pre-screening to identify SA risk (King Co only).
- PCP diagnosis medical conditions and other risk factors identified in patient visits, and initiates team involvement.

↓

**Primary Integration Team:**

- PCP's
- Care Coordinators
- Integrations Specialists

# Sea Mar’s Physical and Behavioral Health Integration Model

**Care Coordinator:**

- Coordinates services for patients with mild to moderate risk factors.
- Identifies and addresses HEDIS measure issues (chronic medical conditions).
- Identifies and makes referrals for behavioral health or social issues.
- Refers to and collaborates with Integration Specialist.
- Refers to and collaborates with Community Care Management team (for highest risk patients).
- Refers to and collaborates with Maternity Support Services.
- Participates in team huddles with PCP’s and other team members and reports updates.

# Sea Mar's Physical and Behavioral Health Integration Model

## Integration Specialists:

- Available for immediate assistance in the Medical clinics to intervene and assess BH risk factors with patients being seen by their PCP.
- BH Specialist (Masters level) cross-trained to understand impact of chronic disease.
- Performs testing to evaluate risk factors and if patients meet access of care standards (ACS's) for Behavioral Health services.
- Assists with warm hand off to other services.

→ PHQ-9
GAD-7
SBIRT (in King Co)

→ Provide brief interventions for patients:

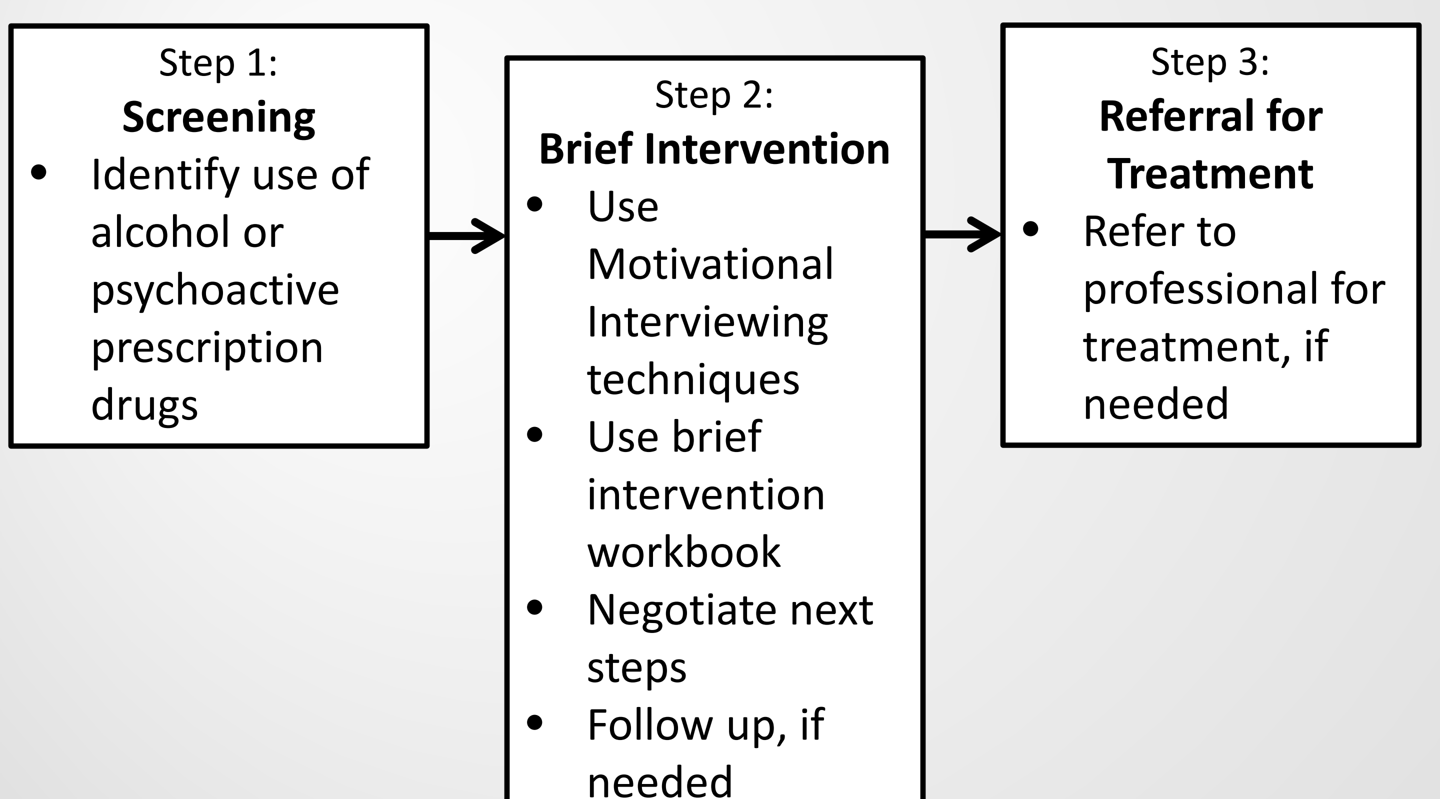
- Who do not meet BH ACS's but have mild BH risk factors.
- Who are in immediate crisis.
- Who meet BH ACS's but are not ready to participate in services. IS's help them with readiness to change.
- Who are not ready to participate in other referrals that will help them with medical or social risk factors. IS's help them with readiness to change.

# Sea Mar's Physical and Behavioral Health Integration Model

**SBIRT:**

**Screening, Brief Intervention, and Referral for Treatment**

*For Substance Use/Dependency*



# Sea Mar’s Physical and Behavioral Health Integration Model

**SBIRT at Sea Mar**

- Sea Mar participated in a King Co. granted funded pilot project that ended last year.
- Sea Mar continues to practice this model in our Seattle clinic.
- Sea Mar has plans to implement this model in further clinics in the future and is working on ways to sustain the model.
- Sea Mar has Inpatient and Outpatient SA treatment centers that support this model.
- The Integration Specialists are the key personnel that are certified to conduct the SBIRT model.

# Sea Mar's Physical and Behavioral Health Integration Model

**Other Integrated Services in Medical Clinics:**

- Medical Nutritional Therapy (Registered Dieticians)
- Health Educators
- Patient Navigators to assist with Healthplan finder (insurance coverage)
- Psychiatric Nurse Practitioners (Medication Management) – *in some clinics*

# Sea Mar's Physical and Behavioral Health Integration Model

**Co-Located Services in Medical Clinics:**

- Mental Health Therapy by BH Team
  - *In several clinics, with plans for more.*
- *Care Coordinators and Maternity Support Services*
  - *Often co-located in clinics, depending on space availability.*

# Sea Mar's Physical and Behavioral Health Integration Model

**Synchronized Services (with other Sea Mar teams)**

- Mental Health: Therapy and Medication Management
- Substance Abuse Treatment: Inpatient and Outpatient
- Strengthening Families/Maternity Support Services
- Community Care Management

Community based PH, BH, and Social Services for highest risk patients

# Sea Mar's Physical and Behavioral Health Integration Model

**Community Care Management Team**

**Strengthening Families Team**

**Synchronized (and often co-located) programs with behavioral health professionals who:**

- Do not provide therapy services but lend their expertise should the need arise.
- Assess patients for harm to self or other.
- Identify potential for hospitalization.
- Use motivational interviewing to increase patient's readiness for change.
- Refer and collaborate with the Behavioral Health team to support patient goals.

# Sea Mar's Physical and Behavioral Health Integration Model

**Who pays for all this?**

- Sea Mar serves primarily Medicaid (Apple Health) patients, with some private insurance and uninsured.
- All services integrated within the Medical teams are paid primary through insurance or sliding fee for uninsured under the Medical umbrella.
- The Community Care Teams and Strengthening Families/MSS teams are also funded through medical funds.
- Co-Located and Synchronized BH services are reimbursed through the RSN Medicaid systems.
- In addition, because of the high risk populations Sea mar serves and the amount of free services Sea Mar offers, we are eligible for federal reimbursement on many of our qualified services, which allows increased stability.

# Sea Mar's Physical and Behavioral Health Integration Model

**Financial Challenges:**

- Medicaid reimbursements can be very low for some services.
- Some services Sea Mar provides do not get reimbursed by State or Federal funds, but they are still needed services.
- Reimbursed services must fall within specific categories, which will only pay for specific qualifications.
- Difficulty getting qualified and experienced professionals for what Medicaid funding will reimburse.

# Integrated Behavioral Health at HealthPoint

Cara Dalbey, Psy.D – BHC Lead Provider
Evan Oakes, MD – Medical Director

February 10, 2016

# Questions we were asked to address:

- What have you done?
- How have you done it?
- What works?
- What doesn't work?
- Who does the model serve?
- What are improvements that need to be made?
- What are some key elements to success?
- How do people move through the system- one model to another?
- How are you using virtual or unconditional tools?

# How the Model Developed…

- PCP workload – panel size + patient complexity
- Up to 70% of PC medical appointments are for problems stemming from psychosocial issues
- Lack of access to therapy services
- Disjointed primary and specialty MH care: patients slip through the cracks or do not follow up with Mental Health referrals

# Three Phases

- Phase 1:
  - *Adding Behavioral Health Consultants (2002)*
  - *Expansion over time to all Health Centers*
  - *Initial Funding through an expansion grant*
  - *On site limited psychiatry consultation*
- Phase 2:
  - *Vets and Human Services Levy and GAU*
  - *Modeled after the IMPACT work at U of W*
  - *Funding allowed hiring of Care Coordinators (5 total)*
  - *Offsite Psychiatry consultation with use of MHITS*
- Phase 3: (trial phase…can elaborate if needed)
  - *Medical provider embedded at a mental health organization*
  - *Co-located mental and physical health*

# The Behavioral Health Consultant

- Behavioral Health Consultant is a member of the primary care team (not a referral for specialty care)
- Provides consultations, (not "therapy" or "counseling"- avoid these terms)
  - *Brief visits, limited and few follow-ups*
  - *Prompt feedback to PCP*
- Focus on improving overall health and quality of life
- Goal is immediate access for any and all health issues-*not just MH disorders and crisis mgmt!!*
- Emphasizes population management and psychoeducation

# The Care Coordinator

- Similarities to Behavioral Health
- Special Populations Served
- Funding based on performance, caseload size, and symptom improvement
- Ability to see patients more long term for general/basic counseling
- Patient enrollment into MHIP tracking (Mental Health Integration Program)

# Fully Integrated Care

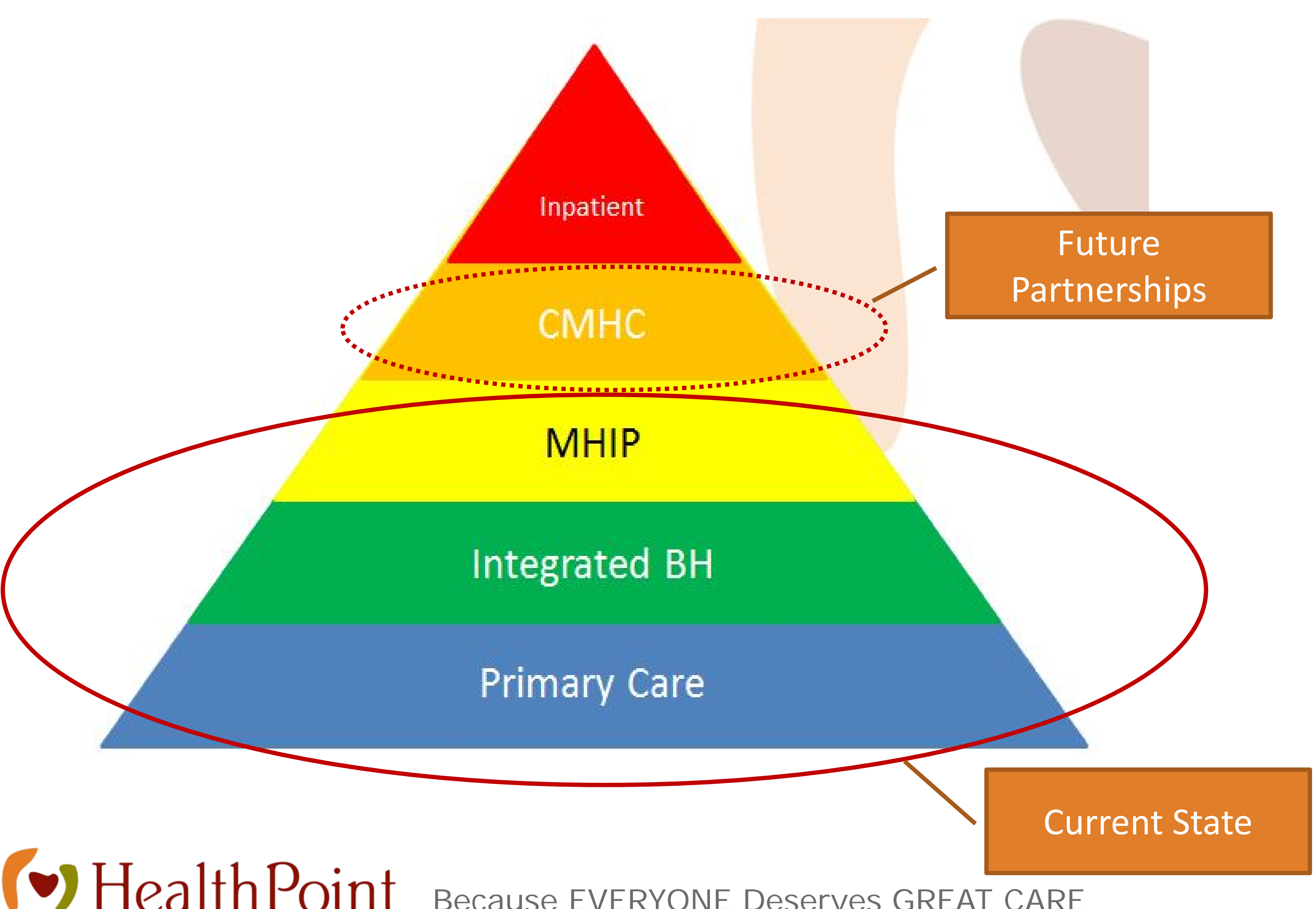
| ension | PCBH | Specialty Behavioral Health (BH) |
| --- | --- | --- |
| el of Care | Population-based | Patient-based |
| ary Care Receivers | PCC, then patient | Patient, then others |
| goals | 1. Promotes PCC efficiency and increases impact on many patients.<br>2. Supports small change efforts in many patients.<br>3. Prevents morbidity in high risk patients.<br>4. Achieves medical cost savings. | 1. Provides intensive services to fewer clients with high acuity in order to resolve MH and SA issues.<br>2. Less capacity to delegate resources to prevention in less acute clients. |
| apist model | Part of an array of primary care services to many clients. | A specialized and separate referral service available to few clients. |
| Manager | PCC | Specialty behavioral health provider |
| inant modality | Consultation | Specialty behavioral health treatment |
| ss to care | Same day, every day | Determined by resources, usually with some waiting periods |
| per episode of | Potentially decreased | Highly variable, related to patient condition |

# What patients benefit most:

- BHC's: Those in need of brief, short-term interventions
- Care Coordinators: Patients needing more information about resources in the community
  - *Case management and wrap around care*
  - *Population/MHITS eligibility permitting, patients that cannot seek outside counseling due to insurance*
- Intended for full spectrum family practice
  - *Adults and Children*
  - *Entire gamut of insurance types (or lack thereof)*

# Stepped Care Model

BHC Goal: Brief Intervention, but higher patient volume/variety
Care Coordinator Goal: Higher intensity intervention, but for specific higher-needs populations.



# Behavioral Issues in Primary Care

- **Chronic medical conditions**
  - *Diabetes, hypertension, chronic pain*
- **Somatic complaints w/behavioral component**
  - *Headaches, insomnia, IBS, obesity, fatigue*
- **"Sub-threshold" conditions**
  - *Bereavement, DV*
- **Psychiatric disorders**
  - *Mood disorders, psychosis, etc.*

# Brief Interventions – The Basics

- Diagnostic assessments, intakes
- Focus on functioning, not symptoms
- Supporting PCP recommendations
- Review and reinforce self-management goals, and help patients stick to treatment plans
- Referral to traditional MH services
- Handouts, patient education
- Usually a 20-30 minute initial visit with 1-4 follow-up visits

# Improved Care with Behavioral Health

- Accurate screening/assessment/diagnosis
- Appropriate prescribing
- Integrated chronic condition management
- Routine use of BH interventions in lieu of higher cost meds and/or treatments
- Optimal use of educational interventions
- Convenient, real time access to BH in clinic

# Benefits of Integration

- Improvement in depression remission rates
- Improved self-management skills for patients with chronic conditions
- Better clinical outcome than by specialized treatment model
- Improved patient adherence and retention in treatment
- Improved patient and provider satisfaction

# Common BHC Referrals

- Typical psychological issues
- Chronic Pain
- Smoking cessation
- Obesity/weight management
- Sleep disorders
- Diabetes
- Headaches
- Hyperlipidemia and hypertension
- Fatigue
- Parenting and pediatric behavioral issues
- Sexual health
- Medication/treatment compliance

# Other Appropriate but Less Common BH Referrals

- Newly diagnosed chronic illness
- IBS and other GI issues
- Acute post-trauma issues
- Some dermatological problems
- Patients currently functioning well but with a higher risk of relapse or non-compliance

# Best Practices…..

- BHC and CC meet weekly to discuss caseload, determine if patients are assigned appropriately
- BHCs and CCs meet monthly as a group with the Medical Director and Director of Medical Operations to review Quality Aims and discuss best practices
- Data Entry Specialist to enter data into MHITS for BHCs and CCs
- Reviews the NextGen schedule for same day/next day, identifies MHIP patients and enters data into MHITS
- Quality Improvement Coordinator runs report for CC to identify veterans and family members of veterans etc…
- MHITS training for all new BHCs, BHC Interns and Care Coordinators
- The Services Due Report is run daily by the Quality Improvement Coordinator and given to the Care Coordinator

# Questions, Clarifications?

# Harborview Medical Center Primary Care:
# An Integrated Model

Laura Collins, Psychiatry Administrator
Darcy Jaffe, Chief Nursing Officer
Harborview Medical Center
2/10/16

# What is Harborview Doing and How?

## Starting with the Behavioral Health Integration Program (BHIP)

- PCPs
- 1-2 FTE Care Manager
- 0.2 FTE Psychiatric Consultant

### Your Integrated Care Team

You

#### What is the patient's role?

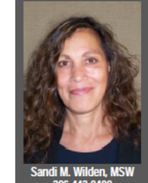
You are the most important person on the team! You will get the best care if you participate actively with your primary care provider (PCP) and your care manager (CM). Tell them what is working for you and what is not. Work with your team to track your progress using a simple checklist. Let them know if you have questions or concerns about your care. If you take medication, know what it is and take it as prescribed.

David Camitta, MD
Cynthia Ferrucci, MD
Jeffrey Hummel, MD
Harry Knaster, MD
Sandra Lord, MD
Janna Chao, MD
Corrine Heinen, MD
Eric Wall, MD
KC Palalay, PA-C
Linda Wilson, PA-C

#### What is the primary care provider's role?

The Primary Care Provider oversees all aspects of your care at the clinic.

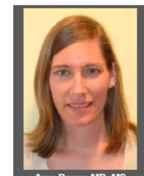
He or she will work closely with the other members of the care team to make sure you get the best care possible. The PCP will make and / or confirm your diagnosis and may write or refill prescriptions for medications. The PCP works closely with your care manager to stay informed about your treatment progress. The PCP may also consult with the team psychiatrist if there are questions about the best treatments for you.



Sandi M. Wilden, MSW
206.443.0400

#### What is the care manager's role?

The CM (care manager) works closely with you and the PCP to implement a treatment plan. The CM answers questions about your treatment. He or she will check-in with you to keep track of your treatment progress and can help identify side effects if you are taking medications. The PCP and the CM work together with you if a change in your treatment is needed. The CM may also provide counseling or refer you for counseling if that is part of your treatment plan.



Amy Bauer, MD, MS

#### What is the psychiatric consultant's role?

The psychiatric consultant is an expert consultant to the PCP and the CM. The team psychiatrist is available to advise your care team about diagnostic questions or treatment options, especially if you don't improve with your initial treatment. The CM meets and consults regularly with the consultant to talk about the progress of patients in the program and to think about treatment options. With your permission, the psychiatric consultant may meet with you in person or via telemedicine to help inform your care.

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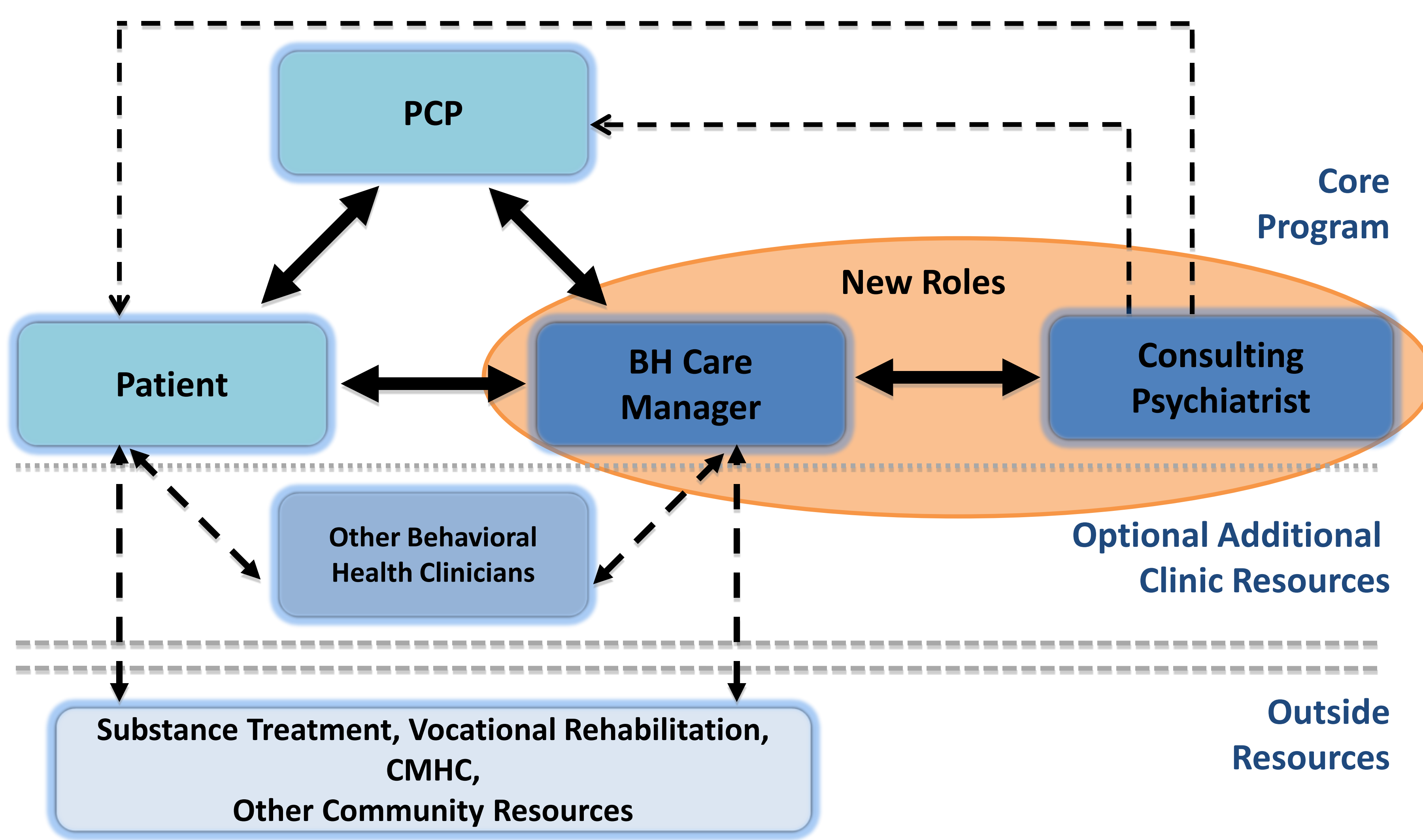
# BHIP: A Collaborative Team Approach



# Evidence-based Collaborative Care

Extend capacity and effectiveness of existing psychiatric consultation and referral services through

Collaborative care: effective multidisciplinary practice:

- Shared workflows supporting PCPs through a care manager and consulting psychiatrist
- Efficient use of limited resources: psychiatry focuses on patients who are most challenging.

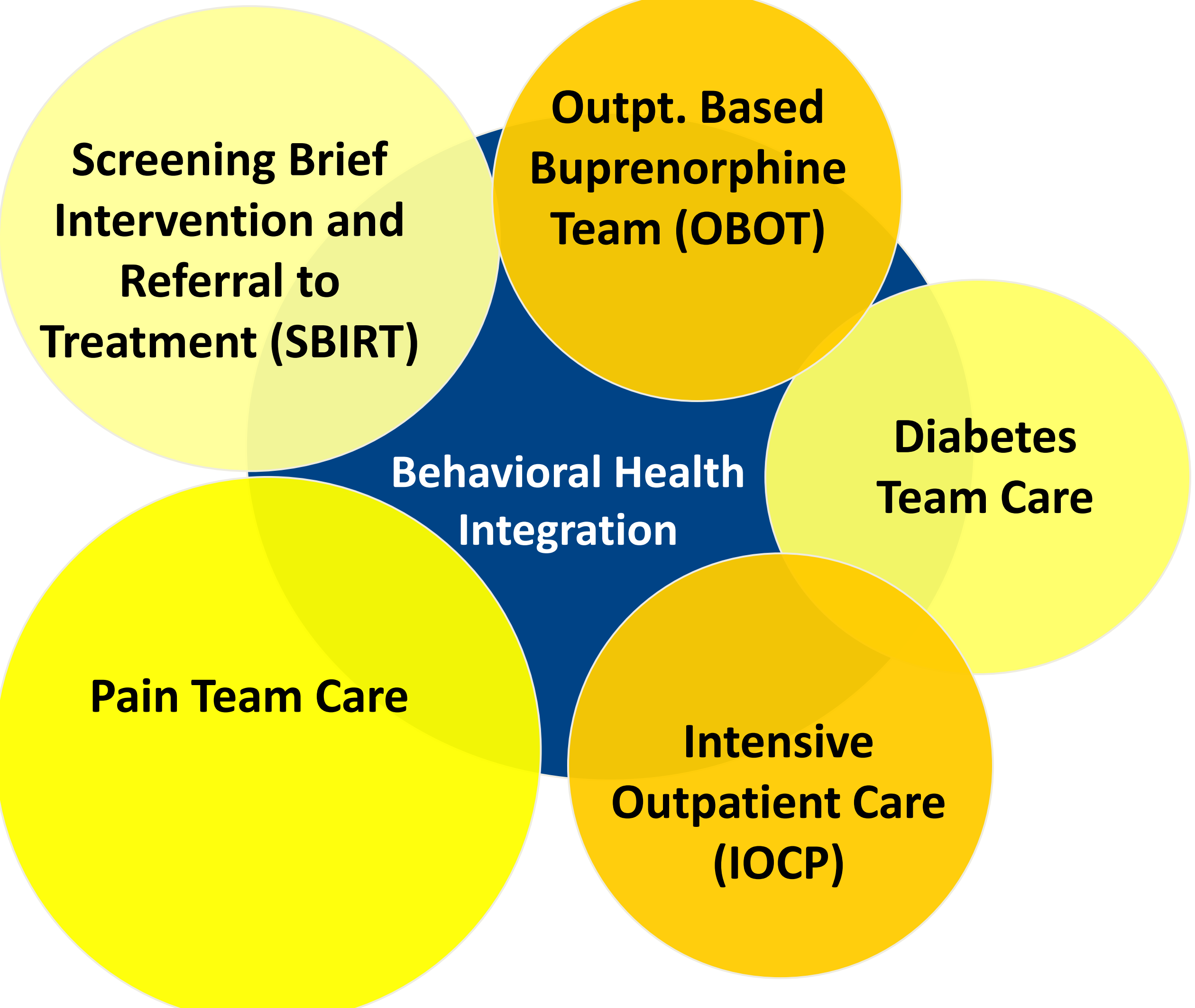
Population-focused care:

- planned, caseload-based care instead of reactive ‘mental health urgent care’; keep patients from falling through the cracks.

Measurement-based care and ‘treatment to target’:

- Systematic use of evidence-based treatments guided by measureable clinical outcomes. ‘Treatment to target’, similar to good care for diabetes or hypertension.

# Adult Medicine Clinic: True Integrated Care



# Integrating ALL care

- HMC Adult Medicine Clinic:

Diabetes Teamcare: Nurse Practitioner, Diabetes Educator, Dietician, and Psychiatrist and/or BHIP Care Coordinator

OBOT(Outpatient-based buprenorphine therapy team): Nurse care manager, a program operations manager, a BHIP care coordinator, and primary care providers

Pain Teamcare: A multi-disciplinary team(pharmacists, pain specialists, BHIP Care Coordinator, primary care physicians.

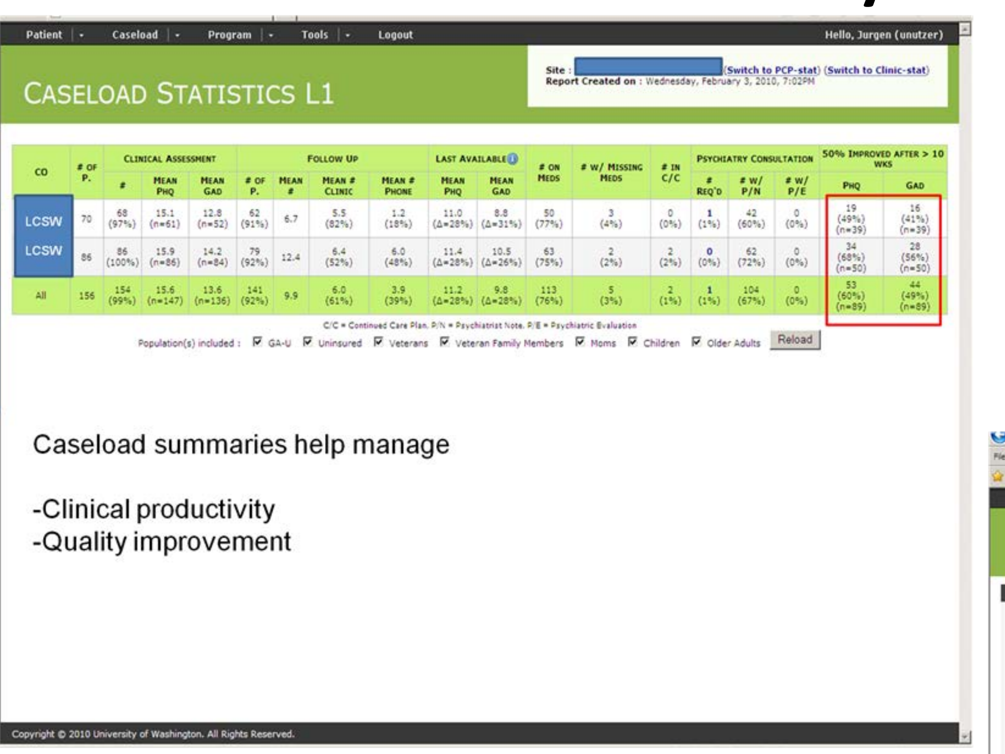
SBIRT (Screening, Brief Intervention and Referral to Treatment): Medical Assistants to PCP's to BHIP, to Social Work

IOCP: Intensive Outpatient Care Program: Interdisciplinary team, including behavioral health, managing medically complex patients and their transitions

# Components to Highlight

- Weekly Meeting with all members of the BHIP team
- Existence of psychiatrists in the clinic, to evaluate the more acute patients that need to be seen by a specialist.
- The registry is also critical to the success of the program.  It structures the caseload and the weekly supervision hour.

# Mental Health Integration Tracking System




| CO | # OF P. | CLINICAL ASSESSMENT | | | FOLLOW UP | | | | LAST AVAILABLE | | # ON MEDS | # W/ MISSING MEDS | # IN C/C | PSYCHIATRY CONSULTATION | | | 50% IMPROVED AFTER > 10 WKS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | # | MEAN PHQ | MEAN GAD | # OF P. | MEAN # | MEAN # CLINIC | MEAN # PHONE | MEAN PHQ | MEAN GAD | | | | # REQ'D | # W/ P/N | # W/ P/E | PHQ | GAD |
| LCSW | 70 | 68 (97%) | 15.1 (n=61) | 12.8 (n=52) | 62 (91%) | 6.7 | 5.5 (82%) | 1.2 (18%) | 11.0 (Δ=28%) | 8.8 (Δ=31%) | 50 (77%) | 3 (4%) | 0 (0%) | 1 (1%) | 42 (60%) | 0 (0%) | 19 (49%) (n=39) | 16 (41%) (n=39) |
| LCSW | 86 | 86 (100%) | 15.9 (n=86) | 14.2 (n=84) | 79 (92%) | 12.4 | 6.4 (52%) | 6.0 (48%) | 11.4 (Δ=28%) | 10.5 (Δ=26%) | 63 (75%) | 2 (2%) | 2 (2%) | 0 (0%) | 62 (72%) | 0 (0%) | 34 (68%) (n=50) | 28 (56%) (n=50) |
| All | 156 | 154 (99%) | 15.6 (n=147) | 13.6 (n=136) | 141 (92%) | 9.9 | 6.0 (61%) | 3.9 (39%) | 11.2 (Δ=28%) | 9.8 (Δ=28%) | 113 (76%) | 5 (3%) | 2 (1%) | 1 (1%) | 104 (67%) | 0 (0%) | 53 (60%) (n=89) | 44 (49%) (n=89) |

C/C = Continued Care Plan, P/N = Psychiatrist Note, P/E = Psychiatric Evaluation

Population(s) included : GA-U, Uninsured, Veterans, Veteran Family Members, Moms, Children, Older Adults — Reload

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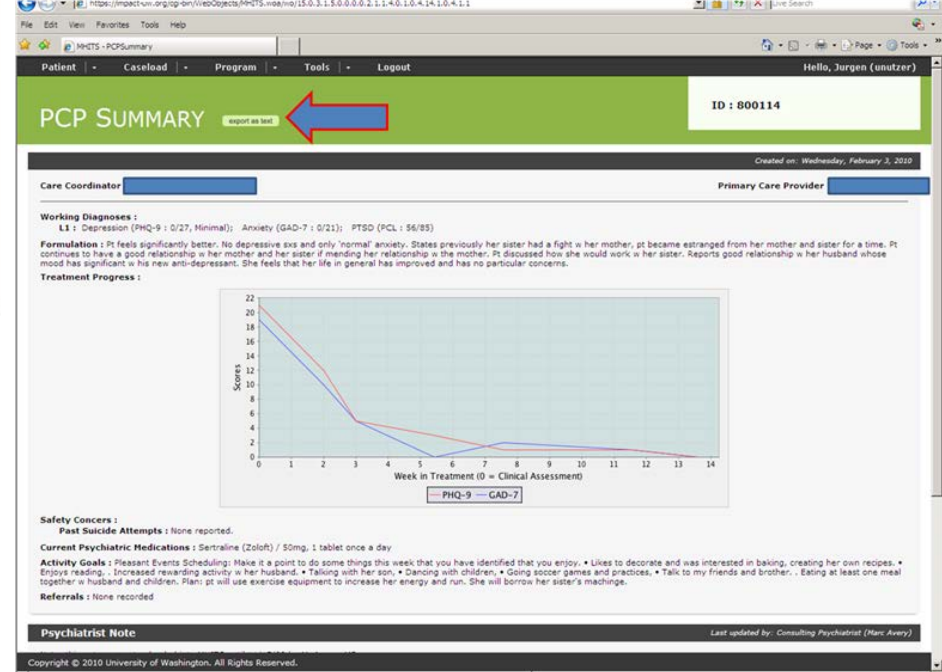
Caseload summaries help manage

-Clinical productivity
-Quality improvement

- Access from anywhere.
- Population-based.
- Supports effective care
- Keeps track of ‘caseloads’.
- Facilitates consultation.
- Allows research on highly representative populations



# Who Does the Model Serve & What Can We Improve on?

- Primarily depression and anxiety, but also the other major mental illnesses. Patients often present with psychosocial stressors.

- We can improve our system to prompt improved coordination between teams, that may also help avoid duplication of efforts. The Healthy Planet Behavioral Health Registry should help address this issue.

# BHIP Common Client Diagnoses

| Diagnoses | % |
|---|---|
| Depression | 76 % |
| Anxiety (GAD, Panic) | 42 % |
| Posttraumatic Stress Disorder (PTSD) | 15 % |
| Alcohol / Substance Abuse | 12 % |
| Bipolar Disorder | 16 % |
| Thoughts of Suicide | 40 % |

… plus acute and chronic medical problems, chronic pain, substance use, prescription narcotic misuse, social stressors …… **NOT THE WORRIED WELL.**

# How Do People Move Through the Care System?

- The referral process is key – the PCP's are primary in the initial referral process.  BHIP has worked to touch every behavioral health referral.  BHIP typically refers out, in coordination with social work (SW).
- The Stepped Care Model: Patients are stepped down and up depending on their clinical and psychosocial picture.  BHIP and SW coordinate to refer patients to appropriate levels of care.

# Challenges & Key Elements to Success

Challenges:

- Managing the sprouting “teams” in each clinic.
- Duplication of work in the registry

Key Elements:

- Same players on the teams – right now the focus is having BHIP representation on each

# Discussion

# Working Definition of Integrated Care

An integrated health care system is one that is able to meet the physical and behavioral health care needs of an individual in a holistic, culturally responsive fashion where the individual is engaged in their care. In this system, care management does not belong to one system and financing supports overall patient outcomes, not individual services. In an integrated system, those providing care work as a team that is accountable to achieving patient outcomes that the patient has helped to identify. The patient experience is one that is **simple and flexible** in meeting a patient's needs when they need it. Those involved in providing care are supported by a shared care plan, shared data and have an understanding of their respective roles in the system.

# Working Vision

By 2020, Medicaid enrollees in King County will experience improved health and social outcomes because:

- Beneficiaries are at the center of care planning, are engaged and activated;
- Beneficiaries are able to access the health and social service supports they need when they need them;
- Payments are based on achieving improved health and social outcomes for beneficiaries because we are paying for value rather than volume that allows for the flexibility at the clinical level to address individual needs;
- Payers in the Region (including King County and the Washington State Health Care Authority) are aligned in how services are contracted and paid for;
- Systems share information seamlessly with one another in order to minimize complexity for the beneficiary

# Wrap Up & Next Steps

**Next Meeting:**

Wednesday, March 9th; 1:30 – 4:00 PM

**Topic:**

Behavioral Health in Primary Care – Children

# King County Physical and Behavioral Health Integration Design Committee
# February 10, 2016

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## Speaker Bios

**Stacy Fennell**

Stacy Fennell is the Child & Family Program Director for Sea Mar Community Health Center. She is a licensed Marriage & Family Therapist and Child Mental Health Specialists and has been working in the field for 17 years. Prior to management, Stacy worked with at-risk youth providing evidence based in home family therapy services. Stacy currently manages the oversight of programs providing office and school based services at 17 Sea Mar locations across Western Washington, including three locations within King County. Stacy is dedicated to serving diverse and economically challenged communities.

**Evan Oakes**

Evan Oakes is a board certified family physician and has been with HealthPoint since 2001. He has held various positions over that time and has been the Medical Director the past 2 years. Evan was involved with the implementation of HealthPoint's integrated behavioral health program since its inception in 2002 beginning with the hiring of 2 BHCs that has now grown to 13 BHCs, 5 Care Coordinators, and a primary care focused behavioral health student and internship program. Through that growth, Evan was also involved in the implementation and incorporation of the MHIP program into the HealthPoint system.

**Cara Dalbey**

Cara Dalbey has been a Behavioral Health Consultant with HealthPoint since 2008. She is currently the Lead BHC for HealthPoint and joined the Family Medicine Residency program in Auburn last October, becoming the Behavioral Health faculty for the residency program and clinic. She has a doctorate in Clinical Psychology (PsyD) and her area of special interest is Diabetes Management.

**Laura Collins**

Laura Collins has been with Harborview for over 18 years, starting on the ground as an Emergency Department and Psychiatric Social Worker, and more recently the Psychiatry Administrator for Harborview Medical Center and University of Washington (UW) Medicine service line. Laura's primary areas include oversight of Harborview's Involuntary Treatment Services and management of the Behavioral Health Integration Program (BHIP) in primary care. At Harborview, the Behavioral Health Integration Program won the Quails Award in 2011 for successfully achieving the "Three Part Aim" of patient care & experience, better health for the population and reduced cost.