CT Primary Care Payment Reform
DESIGN GROUP Draft Capabilities Skeleton: *BH Integration- Adult*
This Draft: August 20, 2018

Scope and Purpose of the Design Group

Thank you for joining the conversation about Primary Care Modernization in Connecticut. The Practice Transformation Task Force is currently reviewing the capabilities that should be incorporated into a primary care payment model.

The purpose of the Design Group is to advise the Task Force on whether the evidence supports including the capability in a primary care payment bundle. During the Design Group meetings, we will have an opportunity to confirm the group's understanding of the different options to improve behavioral health integration into pediatric practices and the option's overall impact in terms of better health, better care, patient experience, provider satisfaction and cost. With a shared understanding of the goal of an option, the group will go on to consider whether the option should be elective or required and, if so, how it should be delivered – by all practices, by some practices, or by the network.

This document is a discussion draft. Upon conclusion of the Design Group's work, this document will be amended to reflect the Design Group's input and recommendations; meeting minutes will be attached as an appendix. The revised Capability Skeleton will be reviewed by the Practice Transformation Task Force on September 25, 2018.

Discussion Topics for the Design Group:

- What are the characteristics of behavioral health integration for a primary care payment bundle?
- What are the required elements? What are the optional elements?
- What should the primary care payment model stipulate as available at the practice site? Through the network?
- Should the primary care payment bundle require linkages to community-based services?

Understanding the Need

The Problem:
One in 5 people have a mental illness or substance use disorder and face issue and barriers to obtaining care. African Americans and Hispanics used mental health services at about half the rate of whites and Asians at one-third the rate of whites. For those with both physical and behavioral health needs, 29% of adults with medical conditions also have mental health conditions. Across the top 9 chronic conditions (including arthritis, asthma and diabetes), depression goes undiagnosed as much as 85% of the time (Druss, 2011). Cost of care for patients with chronic conditions and behavioral health issues is two to three times higher than those without such problems (Commonwealth Fund, 2014). In Connecticut, providers report more challenges with behavioral health referrals than other specialties (CT SIM, 2016).

People with mental and substance abuse disorders may die decades earlier than the average person — mostly from untreated and preventable chronic illnesses like hypertension, diabetes, obesity, and cardiovascular disease that are aggravated by poor health habits such as inadequate physical activity,

poor nutrition, smoking, and substance abuse. Navigating complex healthcare systems and making progress towards self-management of physical health can create obstacles for persons with behavioral health disorders.

Traditionally, the behavioral health system was isolated from primary physical care services. A person in need of behavioral health services might receive emergency care, separate medication management services and individual or group therapy services. Patient-centered care has made strides towards connecting physical and behavioral health but are not uniformly integrated across all practices and systems.

Proven Strategy: BH Integration

Definition: Primary Care Behavioral Health Integration is a team-based primary care approach to managing behavioral health problems and bio-psychosocially influenced health conditions.

The specific roles and functions of behavioral health clinicians in primary care can take several different forms. This section offers examples and indicates whether a type of service could be effectively and efficiently implemented at the practice site or as a network service. We can also consider the potential role of technology ("warm hand offs"/ visits via secure video). During its discussion, the Design Group may wish to consider recommending:

- a specific program model highlighted in this document or
- elements of a program model or
- a general statement of support for achieving the goals of the capability

Screening Algorithms – Many primary care clinicians screen for self-reported behavioral health disorders (mental health and substance use disorders) during annual checkups. The American Academy of Family Physicians (AAFP) has developed several algorithms for various disorders. A number of programs in other states are including annual screening for depression, anxiety, substance use disorder. In building strong connections between physical and behavioral health, well-accepted, tested screening tools should be implemented as a requirement in every practice.

Brief Interventions: the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office of National Drug Control Policy have implemented Screening, Brief Intervention, Referral and Treatment (SBIRT) programs. In many cases, brief interventions can be delivered directly by primary care physicians (or clinical staff) with some additional training. SBIRT interventions are effective in reducing both the severity of substance use disorders and the number of unnecessary emergency department visits and hospitalizations. SBIRT involves:

- Screening to quickly assess the severity of substance use and identify the appropriate level of treatment.
- Brief intervention to focus on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment to provide those identified as needing more extensive treatment with access to specialty care).

Collaborative care involves behavioral health specialists working with primary care. In collaborative care, patients perceive that they are getting a separate service from a specialist, albeit one who

collaborates closely with their physician. Collaboration can be in separate locations or co-located and have partially shared systems which is moving closer to an integrated model.

- Integrated Model- In the integrated model, practitioners are ideally co-located, using one treatment plan with behavioral and medical elements and a database to track patients screened into behavioral health. Staff with advanced behavioral health training, such as Advanced Practice Psychiatric RNs, licensed therapists, are members of the practice team and work together with the physician, MAs, other RNs, case manager and family advocate using a pre-arranged protocol to deliver whole person care. The goal is to incorporate learnings from patient-centered medical homes, which seek to understand the whole person, see the patient as part of the team, adding health and lifestyle coaching, links to community supports, and using data to guide improvement. The therapists generally have shorter visit schedules (30 min) and are able to be "interrupted" briefly for warm hand offs/ "meet and greets". They should also be able to participate in pre-visit planning and daily huddles. In smaller practices this could be arranged using technology with assigned IBH clinicians to several practices through the AN.

Integration can be bi-directional. While often thought of psychiatric services integrated into primary care, it can also be integrating primary care services into behavioral health settings. (Reiter, 2017)

Intended Outcomes:

- One treatment plan designed by all providers and consumer/caregiver input
- Prompt follow-up for positive BH screenings (e.g., depression, substance use, post-partum depression)
- Clinical data and medication history and treatment available to all practitioners on need to know basis

Consumer Needs, Question and Concerns [*to be revised to reflect Design Group input*]:

- Difficulty accessing primary care and specialty care (especially psychiatry)
- Need for expanded care teams
- Clinician awareness of the challenges of maintaining self-care for a person with chronic conditions (including behavioral health)
- Finding in-network clinicians who are taking new patients and accept insurance, or finding affordable self-pay options
- Access to counseling for lifestyle issues associated with behavioral health (e.g., nutritional counseling for obesity)
- Clinicians' support and understanding that behavioral health recovery is not linear

Health Equity Lens:

- Language barriers (lack of BH interpreters)
- Access challenges, both geographic proximity and time of day/day of week
- Stigma attached to BH diagnosis and treatment
- Lack of psychiatric resources in underserved communities
- Inadequate cultural competency around behavioral health

Implementing the Strategy

Example Scenario: A 62-year-old patient comes in for his diabetes visit. Before seeing his PCP, the nurse administers the PHQ9 (Depression Screening Tool). The patient scored 12, indicative of a possible moderate depression. He tells his PCP for the past 3 weeks that he 'doesn't want to do much but watch TV'. There were no remarkable changes in his lab work. He agrees to see the psychiatric social worker in the practice who is free and the PCP walks the patient down the hall. After the meeting with the LICSW, the note states he is having marital issues and will come back and see her next week for further evaluation. If his mood persists she will fit him in for a brief visit with the NP to discuss anti-depression medications.

HIT Requirements:

- Shared EMR
- Shared scheduling system
- Appropriate (electronic) screening tools and algorithms

Implementation Concerns:

- Privacy and confidentiality concerns around sharing BH diagnoses, and notes (need to know)
- Access to medication management resources (psychiatrist, psychiatric APN)

- Primary practices may face challenges with Seriously Mentally Ill (SMI) and Serious and Persistent Mentally Ill (SPMI) when staff are not trained to treat these patients in primary care or referral sources or community resources are not adequate.

Impact

Aim	Summary of Evidence
Health promotion/prevention	Smoking Cessation Programs: Persons with mental illnesses and substance abuse disorders report over 44% of the U.S. tobacco market and are nicotine dependent at rates that are 2-3 times higher than the general population. They suffer they suffer greater smoking-related medical illnesses and mortality (Morris 2009). Weight Management and other prevention: Given the high prevalence of excess weight among persons with behavioral health disorders and consequent mortality and morbidity, the limited existing research suggests that developing a healthier lifestyle, which includes daily physical exercise, may not only prevent weight gain or lead to weight loss, but also improve comorbid psychological disorders such as anxiety and depression. Patient-Centered Medical Home (PCMH) and SAMHSA's funding of programs to co-locate primary care in community mental health centers (CMHCs) and new policies might support expanding interest in prevention and wellness through innovative services such peer-to-peer wellness programming and multidisciplinary training in health behavior change (Devine, 2012)
Improved quality and outcomes	In various (adult) studies noted in Hunter/Funderburk, 2018[1] there was either statistically significant reduction in

	"psychological distress", improvement in sleep, reliable improvement, defied as clinically meaningful and reliable increase in Global Mental Health Score (GMH), as indicated by sufficiently large improvement in the patient's overall severity level to a healthier level (e.g., from severe to moderate or mild). Mean number of preventable hospitalizations was significantly lower for the treatment group after treatment in comparison to a control group in one study.
Patient experience	In one study in an integrated student health center, 79 patients (75% female, 65% Caucasian) completed program ratings via an anonymous web-based questionnaire that assessed program satisfaction and comfort with behavioral health providers (BHP) in the health center. Patients reported satisfaction with behavioral health services and reported a willingness to meet again with BHPs and found the program beneficial to clinical care (Funderburk, 2012). In a review of the literature, other studies based on self-report questionnaires, patients reported high levels of satisfaction with the PCBH model services and they would seek this type of care again in the future (Hunter/Funderburk, 2018[1]).
Provider satisfaction	In one study in integrated university health center fifteen providers (nine primary care providers and six nurses) completed an anonymous web-based questionnaire that assessed satisfaction with and acceptability of behavioral health screening and the integrated BH health care (IBHC) program featuring integrated BHPs. Providers reported that behavioral health screening stimulated new conversations about behavioral health concerns, the BHPs provided clinically useful services, and patients benefited from the IBHC program (Funderburk, 2012). In one study of 23 providers completed a self-reported survey (68% response rate), 91% felt that the BH consultant helped them improve the recognition and treatment of BH problems. 100% were satisfied overall with the service (Hunter/Funderburk, 2018[1]).
Lower Cost	In a randomized control study using IMPACT, Intervention patients had 4-year mean total healthcare costs of $29,422 (95% confidence interval, $26,479-$32,365), and usual care patients had mean total healthcare costs of $32,785 (95% confidence interval, $27,648-$37,921), representing a cost savings among intervention patients of $3,363 (95% confidence interval, $-9282 to $2557) or about 10% per patient on average during 4 years. Intervention patients had lower healthcare costs than usual care patients in every cost category observed (outpatient and inpatient mental health specialty costs, outpatient and inpatient medical and surgical costs, pharmacy costs, and other outpatient costs) (Unützer,2008).

[1] Study Author, design, and summary of findings can be found in Tables 3 and 4 of Hunter/Funderburk,2018 article.

[2] Improving Mood-Promoting Access to Collaborative Treatment

APPENDIX

Learning from Others

State and National Scan:

Case Study #1- SouthCentral Foundation, Anchorage, Alaska
The Southcentral Foundation in Alaska is responsible for providing healthcare services to the Alaska Native and American Indian populations in and around Anchorage, including extensive rural communities. Over the past 14 years, the program has hired mental health clinicians as Behavioral Health Consultants (BHCs) and integrated into them into primary care clinics. Each team includes an RN case manager, the primary care provider, medical assistant(s), BHCs (2.5 FTE[1]), a dietician, and case management support. Each team is responsible for 900-1000 patients.

In this model, the primary care team has training and resources to engage quickly and flexibly with patients. The team uses an array of screening tools to assess for depression, substance use, cognition, development and chronic pain. Services at primary care clinics include pain consultation, structured behavioral health referral process, wellness care plans, primary care provider coaching, integrated psychiatry and medication assisted treatment. EHRs were used extensively by including a note that worked for BHCs and the system, including referring/consul question, symptoms and level of functioning, pertinent history, description of the brief intervention and follow up plan, including recommendations and referrals.

The program offers lessons learned for transforming practices. Psychiatrists needed to shift from traditional behavioral health delivery and build an understanding of primary care culture, managing a full case load, and EHR documentation. PCPs needed to learn how to efficiently use the time-limited consultation with psychiatric staff and their skillsets.

Figure 1: SouthCentral Outcomes

Case Study #2 --Wheeler Clinic, Connecticut
Wheeler provides behavioral health, substance abuse treatment, and integrated primary care services across Connecticut, including outpatient counseling, medication-assisted treatment like suboxone, and a comprehensive range of mental health, addiction and primary care services and dental services.

[1] This ratio appears to respond to the needs of a highly at-risk population. Other programs use a ratio of 1 BHC to 5,000 practice lives for a "routine" practice distribution.

Wheeler expanded the scope of its federally qualified health center (FQHC) to meet the health care needs of individuals with serious mental illness and co-occurring substance abuse disorders in Hartford, New Britain and surrounding communities. Individuals with serious mental illness and co-occurring substance abuse disorders are often reluctant to engage in primary care services and experience disparities in access to health care and health care outcomes. Many of the patients Wheeler currently serves from Hartford, New Britain and surrounding communities do not have a primary care physician, experience multiple co-morbid health disorders and are frequently seen in the emergency department. These patients have difficulty engaging in primary care through traditional channels. Their experience of stigma in health care settings and past exposure to trauma often create substantial barriers to care.
As a Patient Centered Medical Home and Health Home, Wheeler serves those with a variety of needs including those with complex needs These may include physical conditions chronic condition such as asthma, diabetes, or heart disease or mental health/ or addiction problems. Wheeler's integrated care teams manage and coordinate with its clients to assess their needs, treat their condition(s), and help them reach their health goals.

Wheeler has a Family Health and Wellness Center in Hartford and Bristol. Some of the services available are:

- Primary Care for Adults
- Dental Care for the Whole Family
- Integrated Behavioral Health and Addiction Services, including Medication-Assisted Treatment
- Complementary Medicine
- Geriatric services
- Care management services and HIV case management

Results and Lessons Learned are not available for Wheeler Clinic.

Case Study #3- Washington State Mental Health Integration Program (MHIP)[3]
Created as a pilot in 2007 in two counties and expanded state-wide in 2009 MHIP, was initially patterned after the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) program. In 2014, with the implementation of Medicaid Expansion funding sources only allowed the program as an option for those Medicaid recipients who selected the original pilot HMO (Community Health Plan of Washington) as their Medicaid carrier. However, the experience here was the first documented experience providing integrated care to a high need safety net population.

Like IMPACT, MHIP uses core components of team-based care, use of clinical BH care manager and a psychiatric caseload consultant. Patients were originally screened using the PHQ-9 (for depression) and for anxiety and substance use conditions. Over time, screening tools for symptom rating, functional rating, and important medical markers have been added. Whenever possible, warm handoffs for referrals are utilized, connecting the BH CM to the patient immediately. The BH CM also has a primary role of referrals and care transitions- including referrals to specialty BH when indicated. The BH CM provides brief evidence-based interventions. The psychiatric consultant provides regular caseload reviews, assists with diagnosis and formulations and makes recommendation regarding medications, psychotherapy and management. The psychiatrist is available during the times he/she is not on-site by phone. They are also available by tele-psychiatry, phone or in person for more complex clinical questions or concerns. There is a web-based tracking system to support systematic outcomes and quality improvement.

Results

Pilot results:

- Program data from the first years of 2008 and 2009 showed that, compared to counties without MHIP, the target population in MHIP counties had 17% fewer inpatient medical admissions and smaller increases in inpatient psychiatric costs (21% vs. 16.7%) over the review period.
- Compared to those that did not receive services, enrollees who received MHIP services had a larger decrease in number of arrests (24% decline in MHIP clients) and a smaller increase in those living in homeless shelters or outdoors (50% vs. 100%),
- There was a smaller increase in days spent in state hospitals (33% vs. 500%).

Statewide results:

- MHIP was expanded statewide in 2009 and during its first 14 months of statewide implementation, the program saved an estimated $11.2 million in hospital costs.
- Overall 50% shorter time to reduce PHQ-9 scores by 50% (achieving a score less than 10) after introduction of quality metrics and pay-for performance program.

Lessons Learned

- Systematic uses of process and outcome measures that are built into clinician workflows are important for program successes.
- Ongoing workforce development, training, and support are critical for program success.

[3] APA-APM

Additional Reading:

http://aims.uw.edu/impact-improving-mood-promoting-access-collaborative-treatment/

https://www.ncbi.nlm.nih.gov/pubmed/12472325 (JAMA, 2002)

https://www.integration.samhsa.gov/integrated-care-models/APA-APM-Dissemination-Integrated-Care-Report.pdf

https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_behavioral_health_guidelines/depression/

https://www.integration.samhsa.gov/about-
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https://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf

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