

Primary Care Modernization Behavioral Health Integration Design Group 1

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PCM Overview

- Goal: To create a primary care reform model that enables primary care providers to expand and diversify their care teams and provide more flexible, non-visit-based methods for patient care, support and engagement.
- Engaging stakeholders as well as leadership and consumers across the state in the payment design process.

Skeleton Review

- Considering three things:
 - Does the evidence support including this capability in the PCM payment bundle?
 - Should this be a core universal/required or an elective capability?
 - Should this be in all practices or provided by a subset of docs or practices within each primary care network?
 - Provider/Consumer: In relation to whether the capabilities should be included (and this is addressed to providers and not payers), it may not be appropriate at all; Providers, payers, and consumers could not feel it should be a part of the model.
 - Provider/Consumer- This is an excellent act for mental health. Primary care screenings are key health identifiers, but patients suffering from BH problems are dying 20 years earlier (unless, of course, they have access to and are given proper care).
- Models for Behavioral Health Integration in Primary Care Practice
 - The first model is from the SIM community and clinical integration program aiming to help advanced networks in the state → promote care delivery to patients by delivering better care at lower costs.
 - 1. Screening, 2. Treating, 3. Referral (and then tracking referral outcomes)
 - Requirements were laid out.
 - 1. Develop or use a screening tool, 2. ensure support services for those who cannot complete the screener on their own, 3. utilize a trained behavioral health specialist for more targeted follow-up assessments if needed, 4. conduct screenings every two years, 5. identify re-screening at each routine visit, and 6. capture screening results in the HER
 - FHC: The screenings are just for substance use and depression because the task force was advised that the screenings needed to be based on evidence.
 - When needs are identified, resources also need to be available.
 - FHC Expert: Found anxiety is the most common thing that people come up with and is important to assess when trying to understand what

people are living with and suffering from in terms of BH. Considering screening for anxiety might be a good idea.

- Provider/Consumer - Screening for more than just depression and substance abuse would be ideal.
- If services are not in network-services will be contracted out (but referral and linkage to follow up care is tracked)
 - Start by treating within the primary care practice and educating people using behavioral health references.
 - Communicate with behavioral health specialist on treatment status.
 - Track behavioral health outcomes/improvement
- Second model: Southcentral Foundation Integrated Behavioral Health (Anchorage, Alaska)
 - Key features- Co-locate behavioral health services with their primary care services in their organization.
 - Conduct screenings, interventions, and referrals if needed (for developmental changes, chronic pain, cognition, substance use, depression)
 - Same day access to behavioral health consultant and services
 - Resulted in a reduced number of people on its behavioral health wait list
 - Decreased wait times from 6 to 1 weeks → increased access to behavioral health services
- Discussion
 - Which elements of these models are recommended for inclusion?
 - Provider/Consumer: Can you discuss financing-relative costs? If they are capitated?
 - Insurers are often not better off.
 - Provider: Capitation does allow more flexibility if incentives are appropriately aligned.
 - Consumer: Believes screenings are essential for every practice.
 - Provider: Agreed.
 - Individual self-report is missing/ SDOH screening is important
 - Provider: Agrees but worries about overly prescriptive. There is a high need for screening in different patient populations, but that's not always the case. Can we have outcome measures that give the practice a little more flexibility so that in the long run we are worried about outcomes of how SDOH are affecting patients and what makes sense for their patient population?
 - Provider/Consumer: SDOH is so important.
 - It's important to think about a range in the model and the regulatory barriers.
 - FHC: So, I hear two themes...
 - SDOH
 - Having flexibility through range of models
 - FHC: Is there a minimum that all networks should be doing?
 - Provider: Thinks there should be a minimum screening and believes providers should be able to make that choice.

- It could be helpful to envision the appropriate outcome measures and focus on those rather than mandating more screening.
 - FHC Expert: There aren't any great outcome measures, and it takes a long time to see those changes.
 - FHC Expert: If you make the ability to pay too complicated, it becomes difficult at the primary care level.
- Access mental health is a successful model to refer to.
- Consumer: Larger practices have a lot more capabilities. If you take this model and apply it to other, smaller practices that aren't at a higher level, you run into problems training primary care teams.
- Consumer: Mental health in pediatrics should also be addressed.
- Provider/Consumer: FQHCs that show they're evaluating for something and doing primary prevention should get some kind of bonus.
- FHC: There is a need for data to measure outcomes, training, and education for primary care providers.
 - Provider: Training for behavioral health providers is needed in primary care environments as well.
- Behavioral health specialists don't get paid (or are not reimbursed at the same level) as primary care providers, so that's why a lot of behavioral health specialists are out of network. This should be addressed.
 - Consumer: Reimbursement for behavioral health services are complete inadequate. There is a huge gap between cost and reimbursement.
 - Provider: Many of the services needed in primary care are not currently reimbursed.
 - In the fee-for-service world, there are several things providers don't get paid for.
 - Provider/Consumer: It should be one fee for both; the list provided by insurance companies is inadequate and creates delays in treatment. There are just a lot of reimbursement issues.
- SDOH might stop patients from coming in, so in-home assessments could be helpful.
- FHC: We should use what's already there (Medicare) and not reinvent the wheel.
- Provider/Consumer: Telehealth should also be a part of this discussion.
- Provider: Licensing regulations from last year focused on payment for case specialists and case management services through insurance (so, there are efforts towards this...but we aren't there yet).

Next Steps

- Summary:
 - Essential elements to be included:
 - Training for both primary care and behavioral health providers, flexibility for clinicians to provide these services in home and in office, and ensure adequate reimbursements across the board.
 - Provider/Consumer - The opioid crisis should be included here.

- FHC: Will put this into a revised document and we'll discuss whether this is the right model to include in primary care (in addition to optional v. required; across every practice v. a subset of practices within that network).
 - The Payment Reform Counsel will work out the details and will provide a one pager on this.
- Will reconvene in 2 weeks and will incorporate feedback.