

Patient-Centered Primary Care Home Standards Advisory Committee

AGENDA

September 25, 2015

Portland State Office Building, Room 1E

800 NE Oregon St., Portland

9 a.m. - Noon

#	Time	Item	Presenter
1	9:00	Welcome, introductions, and charge for the day	Mitch Anderson Doug Lincoln
2	9:15	Staff measure recommendations and discussion: <ul style="list-style-type: none">• 5A1 & 2: Population data management	Evan Saulino
3	9:45	Staff summary from last meeting with amended recommendations and continued discussion: <ul style="list-style-type: none">• 1C: Telephone and electronic access• 2A: Performance and clinic quality• 3A: Preventive Services• 5C: Complex care coordination• 3C: Mental Health, Substance Abuse, and Developmental Services	Evan Saulino
4	10:30	Break	
5	10:40	Behavioral Health Homes <ul style="list-style-type: none">• Concept overview• Concept questions and discussion	Mitch Anderson
	11:50	Public Testimony	
	12:00	Adjourn	

Next meeting:

October 14, 2015

1 – 4pm

Barbara Roberts Human Services Building, Room 137 A/B

500 Summer St. NE, Salem

Patient-Centered Primary Care Home (PCPCH) Standards Advisory Committee
Meeting Minutes
September 1, 2015, 9:00 AM – 12:00 PM
421 SW Oak Street, Transformation Center
Portland, OR

Present

Mitchell Anderson (co-chair)
Doug Lincoln, MD (co-chair)
Tammy Alexander, MED
Carrie Baldwin-Sayre, ND
Maggie Bennington Davis, MD
Seth Bernstein, PhD
Patty Black
Chris Bouneff
Kevin Campbell
Robin Henderson, PsyD
Joe Hromco, PhD
Susan King
Kris Keith
Helen Kurre, MBA
Barbara Martin, PA
Charlotte Navarre
Colleen Reuland
Bruin Ruge, MD
Evan Saulino, MD
Barb Seatter
Megan Viehmann, PharmD
Colleen Smith

Staff

Nicole Merrithew
Deepti Shinde
Megan Bowen
Chris Carrera
Amy Harris
Dan Reece

Joining by phone

Carolyn Anderson
Kristin Dillon, MD
Scott Fields, MD
Lynnea Lindsey-Pengelly, PhD
Jorge Ramirez Garcia, PhD

Absent

David Dorr, MD
Meg Portwood, FNP
Kathy Savicki
Christine Seals, MD

Introductions and Overview of Committee Meetings

Co-chair Doug Lincoln convened the meeting at 9:10 A.M. Members introduced themselves by name and organization affiliation. Following introductions, Doug reviewed the meeting agenda (see meeting materials).

Staff Summary from Last Meeting

Nicole Merrithew stated a summary from the August 21 meeting with be presented at the September 25 meeting.

Staff Measure Recommendations and Discussion

PCPCH Program staff drafted recommended revisions to several measures. Evan Saulino presented the recommendations to the committee for feedback and discussion (see meeting materials).

Measure 1.C.1 – Staff recommended this measure be eliminated from the model as it is duplicative with 1.C.0 (Must Pass). The committee discussed this recommendation and the following points were noted:

- We should align this with NCQA requirements for afterhours access via phone/web
- TA Guide should specifically state documentation in EHR is required for 1C.0 (must pass).

Measure 3.A.1 – Staff recommend adding the following language to the measure: “and identifies areas for improvement.” The committee discussed this recommendation and the following points were noted:

- Remove “age and gender” for this measure; instead identify specific population for preventive services.
- This should be a must pass; greater emphasis on preventative care in model.
- Measure should be more directive in what is required in preventative services.

Committee agreed this measure recommendation needed further discussion at a future meeting.

Measure 5.C.1 – staff recommended change language of measure to read: “PCPCH demonstrates that members of the health care team have defined roles in care coordination for patients, and tells each patient or family the name of the team member(s) responsible for coordinating his or her care.”

The committee discussed this care coordination overall at length, and agreed this measure warrants further discussion at a future meeting. The following points were noted:

- Care coordination needs to be defined. The functions of care coordination are more important than if “individual” or “team member” is listed in the measure.
- Behavioral health does not fit well into this measure. PCPCH should be recognized at a higher level for providing care coordination for patients with behavioral health needs.
- The patient should know who to call or contact at the clinic.

Nicole Merrithew remarked that past committees have discussed care coordination at the conceptual level and that it is incorporated into several PCPCH measures, such as 3.C. She suggested a broad definition of care coordination be included in the TA Guide that would apply to multiple measures.

Standard 2.A., all Measures – Committee agreed with PCPCH Staff recommended changes. (see meeting notes)

Standard 5.A - There was not enough time to review and discuss recommendations for Standard 5.A. but it will be added to a future meeting agenda.

PCPCH Model Tier Structure

Following a short break, Nicole presented the proposed revisions to the PCPCH model tier and point threshold structure (see meeting materials).

Several committee members asked why the changes are being proposed. Nicole explained the proposed changes are rooted in three different perspectives:

1. Payors have expressed Tier 3 is may not be indicative of a high functioning clinic since over 90% of PCPCHs are recognized at this level. This may deter payors from offering incentive payments to PCPCHs.
2. Some providers also feel that Tier 3 status may not differentiate between providers that are advanced primary care homes compared to those doing the work at an intermediate primary care home level since Tier 3 points range from 130 to 380.
3. The current PCPCH model may not fully promote continued primary care transformation, given 90% of clinics are at the highest level of the model.

Following the presentation, committee members first discussed the recommendations as a large group and then in small work groups. The committee was asked to consider the questions listed below in their discussions. The following comments were noted by staff:

What are the positive aspects of this recommendation?

- This will be a good way to see practices really make progress through the tiers
- This is a good way to recognize practices who are really doing the work
- More differentiation in the Tier structure would better support APM work. It would be more attractive and lure payers to pay more attention.
- Increasing robustness of preventive care measures might lead to greater transformation.
- Patients would be better able to “comparison shop” if the tier levels were more defined or there were additional tiers added.
- The Tier restructure proposal would make the recognition more meaningful.

What are the negative aspects of this recommendation?

- This would likely have a negative impact on clinic morale. Clinics may feel the rules are changing mid-game, and many are already struggling to implement transformative processes.
- Concerned about the proposed January 1, 2016 implementation date. Clinics should have more time to prepare for the transition.
- Concerned about clinics losing PCPCH incentive payments from payors if they drop a tier.
- Contracting and payments will have to be re-evaluated with every clinic working with a CCO or other payor.
- One committee member urged against changing the Tier 1 threshold to 60 points from 30 points.

Do the proposed changes to the model meet the intent to move practices along in the transformation process? If not, what do you recommend?

- In order to progress in transformation, Tier 3 clinics should have to add a specific number of measures each time they re-attest for Tier 3.
- Add a 4th Tier that would require verification before being recognized.
- Make 3-STAR the requirements for being Tier 3.
- Add additional Must Pass measures for Tier 3.
- Create a 5 Tier model by adding two additional tiers at the top of the scale.
- CCOs and other payors should create a payment structure that encourage clinics to move from one tier to the next.
- Make no changes to tier structure, emphasize the 3 STAR designation to encourage transformation.

Other comments

- Oregon should set a date to adopt NCQA standards, and move away from PCPCH model.
- There were concerns that CCOs would get less money from the state for transformation if the Tier structure were adjusted. OHA staff explained this was not the case.
- One committee member questioned why the PCPCH Program staff is presenting this proposal when a similar proposal developed by the committee in 2012 was not adopted by OHA. Nicole responded that there has been more communication to OHA leadership, CCOs and other stakeholders about the proposed changes.
- The PCPCH model should move toward a more robust verification process rather than just relying on clinic attestation. It was recognized this will take additional resources at the clinic level and at the OHA.

Conclusion

Nicole stated that measures 3.A.1, 5C, and 5A will be added to the agenda at the next meeting, then the committee will begin discussing behavioral health home standards.

Public Comment

Doug opened the meeting to public testimony at 11:55 A.M. There was no public comment.

Adjourned at 12:00 P.M.

Measure Worksheet

Standard 5.A – Population Data Management

Measure 5.A.1a (5 points) PCPCH demonstrates the ability to identify, aggregate, and display up-to-date data regarding its patient population, including the identification of sub-populations.

Measure 5.A.1b (5 points) - PCPCH demonstrates the ability to identify, track and proactively manage the care needs of a sub-population of its patients using up-to-date information.

Note: This is a check-all-measures that-apply standard and so clinics attest to 5.A.1a and 5.A.1b for a total of 10 points. There are a total of 4 such check-all-that apply standards in the current PCPCH model.

- 71% of clinics attested to both of these measures.

Intent - “Follow our care closely and make sure we know when tests, prevention services, and guidance are recommended to improve our health.”

In order to coordinate and manage care, a primary care home should be able to produce and track basic information about its patient population. In addition, clinics should demonstrate an ability to use this data to proactively manage a population of patients with a specific disease or health care need.

Staff recommendations:

1. Blend these two 5-point measures into one. Add “and utilize” to 5.A.1a language so that the measure reads “PCPCH demonstrates the ability to identify, aggregate, and display **and utilize** up-to-date data regarding its patient population, including the identification of sub-populations.

Site visits have demonstrated that now, with widespread EHR use, 5.A.1a as currently written can reflect the EHR quality and operator technical abilities rather than reflecting active or accurate data use for improved patient care or coordination/integration. Additionally, in order to be able to do 5.A.1b, the clinic **MUST** be able to do 5.A.1a, thus the first measure is duplicative. By adding the words “and utilize” to measure 5.A.1a, this would encourage clinics to act on data, not just be able to produce it. This may encourage those clinics trying to meet the measure to focus more on outcomes rather than process.

2. Implement 2012 Standards Advisory Committee recommendation to add a new intermediate measure focused on patient risk stratification and management as follows:
5.A.2 (10 points) - PCPCH demonstrates the ability to stratify their population according to health risk such as special health care needs or health behavior.

Site visit experience has shown that risk stratification can be a difficult process, but it reaps rewards. Published research demonstrates this strategy can help clinics more effectively target care management and intervention efforts. Further, addition of this measure would align with work and outcomes data from other initiatives such as the Comprehensive Primary Care Initiative (CPCI). Rewarding ability to do risk stratification successfully may encourage the spread of processes being developed in CPCI, Pediatric, and other clinics across Oregon.

Questions

Do you agree or disagree with the staff proposal to "blend" the two 5-point measures (5.A.1.a and 5.A.1.b) focused on population data management into one measure as described? If you disagree, are there changes you would recommend to improve the proposal, so that the concepts of current 5.A.1.a and 5.A.1.b can be combined into a single measure?

2. Do you agree or disagree with staff recommendation to add a new that focuses on risk stratification as described? If you disagree, what would you recommend?

Staff Measure Recommendations and Discussion Summary

Standard 1.C - Telephone and Electronic Access

Measure 1.C.1 (5 points) - When patients receive clinical advice via telephone, these telephone encounters (including after-hours encounters) are documented in the patient's medical record.

94% of clinics have attested to this measure.

Staff Recommendation

Eliminate this measure from the PCPCH model. This is a duplicative measure. Demonstrating this measure is a significant part of how 1.C.0 (the must pass measure) is verified at site visits (see TA guide language below). It is also generally a community standard especially now that EHRs are more widespread (compared to 2012).

From 2014 TA guide: "Documentation required: Attestation only. At a verification site visit, clinics should be able to produce documented examples of advice calls during both normal business hours and after-hours."

Committee Discussion Key Points

- We should align this with NCQA requirements for afterhours access via phone/web
- TA Guide should specifically state documentation in EHR is required for 1C.0 (must pass).

Staff Recommendations Based on Committee Discussion

Eliminate measure 1.C.1 from the PCPCH model, and include language in the TA Guide specifying after-hours access must be documented in the medical record. The language will align with NCQA-PCMH: "documenting clinical advice in the medical record" and "documenting after-hours clinical advice in the patient records." 24/7 access is not a must pass requirement for NCQA-PCMH.

Standard 2.A – Performance & Clinical Quality

Measure 2.A.0 (Must-Pass) - PCPCH tracks one quality metric from the core or menu set of PCPCH Quality Measures.

Measure 2.A.2 (10 points) - PCPCH tracks and reports to the OHA two measures from the core set and one measure from the menu set of PCPCH Quality Measures.

Measure 2.A.3 (15 points) - PCPCH tracks, reports to the OHA and meets benchmarks on two measures from the core set and one measure from the menu set of PCPCH Quality Measures.

Intent: "Take responsibility for making sure we receive the best possible health care." Measuring and improving on clinical quality is a foundational element of primary care homes. The intent of these measures is to demonstrate that primary care homes have the capacity to monitor clinical quality data and improve their performance where appropriate.

Staff Recommendations

Application data submission and site visit experience have demonstrated significant variability in the ability of PCPCHs to reliably access and utilize data for quality improvement work. Staff recommend there be a ladder of 5/10/15 point measures in addition to the must-pass measure, to promote a focus on improvement. Proposed measures for Standard 2.A:

- 2.A.0: Must pass measure unchanged
- 2.A.3: Highest value measure (meet benchmarks on three Quality Measures) unchanged.
- Current 2.A.2 becomes new 2.A.1 and goes down in point value (ie from 10 to 5 points)

- NEW 2.A.2: PCPCH demonstrates improvement on two measures from core set and one measure from the menu set of PCPCH Quality Measures (10 points)

Definition of improvement would not be in the language of the measure, but instead in the TA Guide (see meeting materials).

Committee Discussion

Committee members agreed with the proposed changes to this standard.

Staff Recommendations Based on Committee Discussion

Adopt recommended change.

Standard 3.A – Preventive Services

Measure 3.A.1 (5 points) - PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services based on best available evidence.

34% of clinics have attested to this measure.

Intent: “Help make sure we get the recommended preventive care we need”

Staff Recommendation

Add the following language to 3.A.1: “and identifies areas for improvement.” Site visits demonstrate that the scope of preventive care services offered or coordinated can be variable at different PCPCHs. In particular Measure 3.A.1 is written with such a low bar that clinics could be offering any number of recommended preventive services and still meet the measure. Adding the requirement that clinics identify areas for improvement will require them to demonstrate that even if they are not offering a broad array of preventive services, they have reviewed evidence-based recommendation guidelines, and are knowledgeable about where they need to work to close gaps.

Committee Discussion

Regarding changes to 3.A.1, the committee noted adding the proposed language to 3.A.1 would make the measure appear too similar to 3.A.2, and the measures should be differentiated in some way. The committee focused the remainder of their discussion on preventive services and alignment with NCQA. In general, the following points were noted:

- Remove “age and gender” for this measure; instead identify specific population for preventive services.
- This should be a must pass; greater emphasis on preventative care in model.
- Measure should be more directive in what is required in preventative services.

Staff Recommendations Based on Committee Discussion

Measure 3.A.1

- Adopt the staff recommendation to add “and identifies areas for improvement” to Measure 3.A.1.
- Change “age and gender” to “appropriate for your population (i.e. age and gender)”
- In the TA Guide, add a Best Practice box that describes how a primary care clinic would implement this measure.
- Add language to the TA Guide that clarifies 3.A.1 relates to the number of recommended, evidence-based preventive services offered by the clinic, while 3.A.2 relates to improving the percentage of the clinic's population receiving recommended, evidence-based preventive

Standard 3.B. – Medical Services

In response to the committee’s discussion, the following changes (**in bold**) are also recommended to Standard 3.B – Medical Services.

Measure 3.B.0 (Must Pass) - PCPCH reports that it routinely offers all of the following categories of services: Acute care for minor illnesses and injuries; Ongoing management of chronic diseases including coordination of care; Office-based procedures and diagnostic tests; "**Preventive services**"; Patient education and self-management support.

The TA Guide will include specifications that closely align with NCQA-PCMH standards. To meet Measure 3.B.0., PCPCHs will be required to provide two out of the five following:

- At least four preventive care services, two of which may be immunizations
- At least three different chronic or acute care services

Standard 5.C - Complex Care Coordination

Measure 5.C.1 (5 points) PCPCH assigns individual responsibility for care coordination and tells each patient or family the name of the team member responsible for coordinating his or her care.

73% of clinics have attested to this measure.

Intent: “Help us navigate the health care system to get the care we need, in a safe and timely way. Stay involved when we get care in other places.”

Staff Recommendation

Change 5.C.1 to read “PCPCH demonstrates that members of the health care team have defined roles in care coordination for patients, and tells each patient or family the name of the team member(s) responsible for coordinating his or her care.”

This language recognizes the roles of different members of the health care team in different PCPCHs, and focus on function rather than process. The current language of 5.C.1 as written is difficult to verify at some site visits because of variable clinic structure/teams/workforce in different PCPCHs because many clinics do not have only one person dedicated to care coordination.

Committee Discussion Key Points:

- Care coordination needs to be defined. The functions of care coordination are more important than if “individual” or “team member” is listed in the measure.
- The patient should know who to call or contact at the clinic.
- Add another measure that addresses coordination of specific high risk population (BH, certain Peds) not just included in this measure.

Staff Recommendations Based on Committee Discussion

Adopt staff recommended changes to the measure.

Care Coordination has been recognized by past advisory committees as an important component the PCPCH model. Care Coordination has been incorporated into several other PCPCH measures which are broad enough to encompass specific high risk populations. It is the sum of these measures that fully capture care coordination in the PCPCH model. Measures include:

- 5.C.2 PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs.

- 5.C.3 PCPCH develops an individualized written care plan for patients and families with complex medical or social concerns. This care plan should include at least the following: self-management goals; goals of preventive and chronic illness care; and action plan for exacerbations of chronic illness.
- 5.A.1b PCPCH demonstrates the ability to identify, track and proactively manage the care needs of a sub-population of its patients using up-to-date information.
- 5.E.1 PCPCH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians.
- 5.E.2 PCPCH demonstrates active involvement and coordination of care when its patients receive care in specialized settings (hospital, SNF, long term care facility).
- 5.E.3 PCPCH tracks referrals and cooperates with community service providers outside the PCPCH, such as dental, educational, social service, foster care, public health, non-traditional health workers and pharmacy services.
- 3.C.2 PCPCH has a cooperative referral process with specialty mental health, substance abuse, or developmental providers including a mechanism for co-management as needed.

In addition, the TA Guide currently includes reference hyperlinks and resources that provide examples and tools of care coordination functions from the following sources: PCPCI, MacColl Center, and www.improvingchroniccare.org.

Measures 3.C.0, 3.C.2, 3.C.3 Mental Health, Substance Abuse, and Developmental Services

46% of clinics have attested to all three measures in this standard. Note: This is a check-all-measures that-apply standard and so clinics attest to 3.C.0 and can also attest to 3.C.2 and 3.C.3. There are a total of 4 such check-all-that apply standards in the current PCPCH model.

Measure 3.C.0 - (Must Pass) PCPCH has a screening strategy for mental health, substance use, or developmental conditions and documents on-site and local referral resources.

100% of clinics have attested to this measure. It is a must-pass measure.

Measure 3.C.2 - (10pts) PCPCH has a cooperative referral process with specialty mental health, substance abuse, or developmental providers including a mechanism for co-management as needed.

77% of clinics have attested to this measure.

Measure 3.C.3 - (15pts) PCPCH is co-located either actually or virtually with specialty mental health, substance abuse, or developmental providers.

52% of clinics have attested to this measure.

Intent: “Ask about and effectively manage and care for mental/behavioral health, substance abuse, and developmental issues, which directly affect my overall health.”

Staff recommendation

Site visits have demonstrated significant differences in robustness of screening and intervention strategies. In particular the meaning of cooperative referral process and co-management has shown enormous variability. It is clear that co-location of these services, while potentially and actually beneficial, does not offer the same patient benefits as integration of services. Evidence demonstrating the patient *and* clinic/staff benefits of integration with behavioral health professionals is particularly strong.ⁱ Staff recommend the following changes:

- For standard 3.C.0 replace “or” with “and”.
 - New 3.C.0 – (0 pts.) PCPCH has a screening strategy for mental health, substance use, **and** developmental conditions and documents on-site and local referral resources.

- 3.C.2 becomes a combination of the current 3.C.2 and 3.C.3
 - New 3.C.2 – (10 pts.) PCPCH has a cooperative referral process with specialty mental health, substance abuse, and developmental providers including a mechanism for co-management as needed **OR** is co-located with specialty mental health, substance abuse, or developmental providers.
- New 3.C.3 – (15 pts.) PCPCH offers *integrated* behavioral health services, including population-based, same-day consultations by providers/behaviorists specially trained in assessing and addressing psychosocial aspects of health conditions.
 - Technical specifications will spell out the details of what “integrated” means.

Change from being a check-all-that-apply standard to a check one. Clinics cannot be fully integrated without also having a co-referral process and co-location so they should receive points for the integration but not integration + co-referral+ co-location.

Committee Discussion

The Committee was asked to consider the following questions:

1. Do you think the language and value changes proposed for standard 3.C. (above) capture the correct intent, reflect current evidence, and will reward the expanding scope of efforts to identify, and effectively treat mental/behavioral health, substance abuse, and developmental issues? Is 3.C.2 as proposed an appropriate “middle ground or stepping stone” between screening and integration? Does this language align with the individual’s perspective? If not, what would you recommend to accomplish this?
2. Although it will be defined in the technical specifications and not in the measure language, how would you define co-location and integration? Specifically how should integrated behavioral health services be defined? For example: Threshold of minimum number of hours available, training and background specifications for individuals that provide behavioral health services
3. Should 3C remain as a check-all-that apply standard where clinics can attest and receive points for co-referral/co-location + integration? Or should 3C be changed to a check one standard where clinics can attest to and receive points for co-referral/co-location **or** integration?

Committee members discussed these questions in small groups and then reported their discussion points when the group reconvened. In general, the following points were noted:

- Behavioral health services and specialty mental health should be differentiated in the measure or technical specifications.
- There should be a signed Collaborative Agreement between the PCPCH and community mental health clinics. (Similar to the hospital agreement). However, concern was expressed that some community mental health clinics do not have capacity to manage a formalized referral process.
- Co-location and Integration are not the same. At an integrated PCPCH, both physical and behavioral health providers would have access to care plans, share medical records, can attend in-person meetings, attend huddles (team meetings), and are viewed as members of the care team.
- SB 832 addresses licensure requirements of who can provide behavioral health services, but does not address specific training in primary care. Behavioral Health Providers who work in primary care should have some kind of special training.
- Developmental screenings should not be included in 3.C.0 and should be its own measure.
- Psychosocial screenings should be added to the measure or captured in some way to assess social determinants of health. (3.C.2)

- Measure should still be “check all that apply” since co-location and integration are not the same and co-location does not necessarily lead to integration.

Staff Recommendations Based on Committee Discussion

Standard 3.C will remain a “check-all-that-apply”.

In response to the committee’s discussion, the following modifications to the originally suggested changes(**in bold**) are recommended:

- 3.C.0 – PCPCH has a screening strategy for mental health, substance use, **and** developmental conditions and documents on-site and local referral resources **and processes**.
- 3.C.2 - PCPCH has a cooperative referral process with specialty mental health, substance abuse, and developmental providers including a mechanism for co-management as needed **OR** is co-located with specialty mental health, substance abuse, or developmental providers.
- 3.C.3 – PCPCH **provides** *integrated* behavioral health services, including population-based, same-day consultations by providers/behaviorists specially trained in assessing and addressing psychosocial aspects of health conditions.

The TA Guide will be updated to include:

- A Best Practice Box describing optimal outcome of closed loop referrals.
- A Best Practice Box describing a cooperative referral process for substance abuse counseling and treatment.
- A Best Practice Box describing a cooperative referral process for assessment and treatment of pediatric developmental conditions.
- Definitions from the Agency for Healthcare Quality and Research (AHQR) to provide clinics with guidance on how to interpret the definitions in each measures. See Attachment titled Lexicon for Behavioral Health and Primary Care Integration for definitions.

ⁱ Chris Collins, Denise Levis Hewson, Richard Munger, and Torlen Wade (2010) Evolving Models of Behavioral Health Integration in Primary Care. Milbank Memorial Fund. <http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf>

Overview of SB 832

What does SB 832 require the Oregon Health Authority (OHA) and Coordinated Care Organizations (CCOs) to do?

1. The OHA shall develop rules/standards for achieving the integration of behavioral health services and physical health services in PCPCHs and Behavioral Health Homes (BHHs).
2. In order to promote the full integration of behavioral health and physical health services in primary care, behavioral health care and urgent care settings, providers in PCPCHs and BHHs may use billing codes applicable to the behavioral health and physical health services that are provided.
3. The OHA shall encourage CCOs to use alternative payment methodologies that reward comprehensive care coordination using delivery models such as PCPCHs and BHHs.

What is the PCPCH Standards Advisory Committee charged with doing?

1. Define core attributes of behavioral health homes (BHHs) to promote a reasonable level of consistency of services provided by BHHs in this state.

Definitions adopted under SB 832:

1. **Behavioral health clinician** means:

- (a) A licensed psychiatrist
- (b) A licensed psychologist
- (c) A certified nurse practitioner with a specialty in psychiatric mental health
- (d) A licensed clinical social worker
- (e) A licensed professional counselor or licensed marriage and family therapist
- (f) A certified clinical social work associate
- (g) An intern or resident who is working under a board-approved supervisory contract in a clinical mental health field
- (h) Any other clinician whose authorized scope of practice includes mental health diagnosis and treatment

2. **Behavioral health home** means a mental health disorder or substance use disorder treatment organization, as defined by the OHA by rule, that provides integrated health care to individuals whose primary diagnoses are mental health disorders or substance use disorders.

3. **Integrated health care** means care provided to individuals and their families in a PCPCH or BHH by licensed primary care clinicians, behavioral health clinicians and other care team members, working together to address one or more of the following:

- (A) Mental illness
- (B) Substance use disorders
- (C) Health behaviors that contribute to chronic illness
- (D) Life stressors and crises
- (E) Developmental risks and conditions
- (F) Stress-related physical symptoms
- (G) Preventive care
- (H) Ineffective patterns of health care utilization.

As used in this subsection, “**other care team members**” includes but is not limited to:

- (A) Qualified mental health professionals or qualified mental health associates meeting requirements adopted by the OHA by rule
- (B) Peer wellness specialists
- (C) Peer support specialists
- (D) Community health workers who have completed a state-certified training program
- (E) Personal health navigators
- (F) Other qualified individuals approved by the OHA.

4. **Peer support specialist** means any of the following individuals who provide supportive services to a current or former consumer of mental health or addiction treatment:

- (a) An individual who is a current or former consumer of mental health treatment
- (b) An individual who is in recovery, as defined by the OHA by rule, from an addiction disorder
- (c) A family member of a current or former consumer of mental health or addiction treatment.

Peer wellness specialist means an individual who is responsible for assessing mental health and substance use disorder service and support needs of a member of a coordinated care organization through community outreach, assisting members with access to available services and resources, addressing barriers to services and providing education and information about available resources for individuals with mental health or substance use disorders in order to reduce stigma and discrimination toward consumers of mental health and substance use disorder services and to assist the member in creating and maintaining recovery, health and wellness.

General Principles of a Behavioral Health Home standards development

1. What is the purpose of developing Behavioral Health Home (BHH) standards?

- Are we establishing a model aimed at moving clinics towards becoming great behavioral health clinics or aimed at moving behavioral health clinics towards being integrated with primary care?
- Why would an agency/clinic be interested in this model/designation? Is one of the primary purposes for behavioral health clinics to get increased payment? Increased access to CCO networks? Improved patient care? Other?
- Who is the audience? Should the criteria be sufficiently broad so that behavioral health clinics of different sizes, different patient populations and different resources are potentially eligible?
- What is the goal from the patient perspective?
- From a provider's perspective, what value would a BHH model bring to their clients?

2. At what level should the standards apply (for both the provider and patient "levels")?

- Should the standards apply to a specific program within a clinic or organization, the clinic, or the organization?
- What population should the standards apply to? (The clinic's entire population, a subset of its patient population such as those with complex needs, etc). Will the entire patient population benefit from the type of care provided by behavioral health homes?
- If the designation applies to the entire patient population would the expectation be that all patients served at the BHH get their primary care services there?

3. To what extent should behavioral health care providers be responsible for ensuring their population's physical care needs are met?

- What does access to primary care mean?

Lexicon for Behavioral Health and Primary Care Integration

Definitions from the Agency for Healthcare Quality and Research (AHQR)

<http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf>

Behavioral health care - A very broad category often used as an umbrella term for care that addresses behavioral problems bearing on health, including patient activation and health behaviors, mental health conditions, substance use, and other behaviors that bear on health. In this sense, behavioral healthcare is the job of all kinds of care settings, and is done by clinicians and health coaches of various disciplines or training, including but not limited to mental health professionals. It is a competency of clinics, not only of individuals.

Chemical Dependency/Substance Abuse Care (*sometimes included under mental health care*) - Services, treatments, and supports to help people with addictions and substance abuse problems of all kinds suffer less emotional pain, family and vocational disturbance, and physical risks and live healthier, longer, more productive lives.

Co-located Care - Behavioral health and primary care providers delivering care in same practice. This denotes working in shared space to one extent or another, not a specific service or kind of collaboration. This may be regarded as a step forward for clinicians who have been separated from each other by distance, or in other situations something to go beyond to achieve increasingly shared workflows, culture, and levels of collaboration

Integrated care - Tightly integrated, on-site teamwork with a unified care plan as a standard approach to care for designated populations. Connotes organizational integration as well, often involving social and other community services.

Integrated Primary Care - Combines medical and behavioral health services for the spectrum of problems that patients bring to primary medical care.

Integrated program: An organizational structure that ensures staff and linkages with other programs to address all patient needs.

Integrated system: An organizational structure that supports an array of programs for individuals with different needs through funding, credentialing, licensing, data collection/reporting, needs assessment, planning, and other operational functions.

Integrated treatment: Interactions between clinicians to address patient needs combining interventions for mental health disorders in a primary treatment relationship or service setting.

Mental health care - Broad array of services and treatments to help people with mental illnesses and those at particular risk of developing them—to suffer less emotional pain and disability and live healthier, longer, more productive lives.

Specialty mental health - mental health professionals trained specifically to treat people with mental disorders and substance use conditions in public or private practices, psychiatric units, general hospitals, school-based mental health clinics, or other treatment centers

