Integrated Behavioral Health Alliance

"Innovative Care for Behavioral Health and Substance Use Disorders: Payment, Data, and System Strategies." OHA Conference

30 October 2019

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Primary Care BH Integration: Quality, Standardization and Engagement with PCPCH

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Transformation requirements

New models of care involve

~ new payment models requiring and

~ new ways to evaluate care based on quality & quantity

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Show Me the DATA

- The U.S. health care system is in the midst of transitioning from a payment system driven by volume to one based on value.
- In order to establish “value-based” healthcare there must be another way to “evaluate” health.
- Population Health utilizes outcome data in evaluating if the care delivered is optimal.
- We are asked every day ….

August 17, 2012 https://www.youtube.com/watch?v=gxz9ZVvduGc

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Patient level data gathering

- What is needed is systematically collecting patient-level data that can be used to:
  - (1) monitor patient improvement and escalate treatment as needed,
  - (2) manage care for a population of patients (eg, those with uncontrolled diabetes) and reach out to patients where behavioral health patterns may present barriers to wellness; and
  - (3) monitor practice progress with regard to care quality.

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IBHA – Who?

- The Integrated Behavioral Health Alliance (IBHA) is a diverse workgroup of stakeholders committed to advancing integrated behavioral health, based in Oregon yet invested throughout healthcare.
- Established in 2014, IBHA's group (of healthcare payers, providers, policy developers and more) continues work on furthering integrated behavioral health in meaningful ways that align with achieving the Quadruple Aim within Oregon and beyond

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IBHA's Purpose

- Behavioral health care is an integral component of Patient Centered Primary Care Homes (PCPCH) focusing on mental health, substance use, developmental and health behaviors as well as the social determinants affecting health.
- IBHA promotes the financial sustainability of integrated care including value-based payments and comprehensive reimbursement strategies that address the behavioral, physical, and other determinants of health. http://www.pcpci.org/integrated-behavioral-health-alliance

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Early (and Ongoing) Challenges to Integration

Advancing Care Together (ACT) in Colorado identified challenges in their early integration efforts in 3 areas:

- workflow and access,
- leadership and culture change, and
- tracking and using data.

"These challenges are manifesting across all sites, irrespective of care setting or integration focus."

Integrating Behavioral and Physical Health Care in the Real World: Early Lessons from Advancing Care Together (2013) http://jabfm.org/content/26/5/588.full

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Patient Centered Primary Care Home -PCPCH

PATIENT CENTERED
PRIMARY CARE HOME PROGRAM

Established in 2009 “the Patient-Centered Primary Care Home (PCPCH) Program is part of Oregon's efforts to fulfill a vision of better health, better care and lower costs for all Oregonians.
By recognizing clinics that offer high-**quality**, patient-centered care, we can begin breaking down the barriers that stand between patients and good health.” https://www.oregon.gov/oha/HPA/dsi-pcpch/Pages/About.aspx

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Patient Centered Primary Care Home -PCPCH

CORE ATTRIBUTE 3: COMPREHENSIVE WHOLE-PERSON CARE
Standard 3.C – Behavioral Health Services Measures: (Check all that apply)

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 (Must-Pass)
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, and developmental providers (10 Points)
3.C.3 - PCPCH provides integrated behavioral health services, including population-based, same-day consultations by behavioral health providers (15 Points)

This is a must-pass standard. Clinics must meet measure 3.C.0 at a minimum to qualify for PCPCH recognition at any level. Clinics can receive points simultaneously for meeting the measures within this standard, making a total of 25 points possible.

PATIENT CENTERED PRIMARY CARE HOME PROGRAM

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Integrated Behavioral Health Alliance (IBHA) Consensus Minimum Standards for PCPCHs

- Developed consensus minimum standards for PCPCHs in 2015
  - Cited in the PCPCH Standards Technical Assistance Guide in 2017
    - https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/TA-Guide.pdf

Integrated Behavioral Health Alliance: Recommended Minimum Standards for Patient-Centered Primary Care Homes (PCPCH) Providing Integrated Health Care (2015)

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AHRQ Integration Definitions

Collaborative

- Separate Locations
- Formal exchange of information
- Separate documentation
- Limited collaboration after initial referral

Co-located

- Same location
- Separate documentation
- Separate business and billing services
- Collaboration is more readily available

Integrated

- Same location
- Shared documentation, including care plan
- Shared business & financial services
- Collaboration is systematized.

https://integrationacademy.ahrq.gov/

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Alignment with national medical home payment reform

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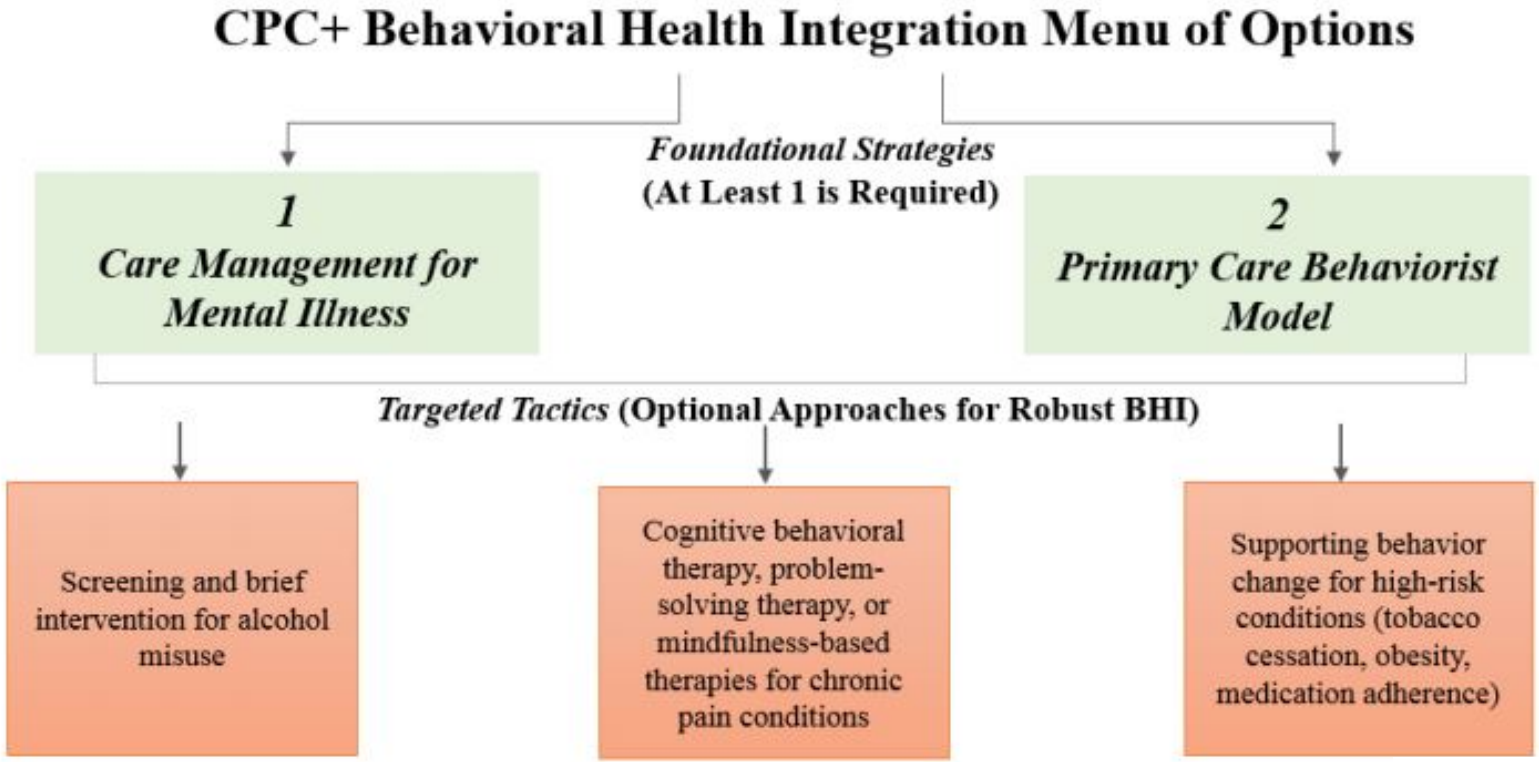
SEP

CMS Comprehensive Primary Care (CPC)



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IBHA's Recommended Minimum Standards (2018)

Integrated Behavioral Health Alliance

June 2018

Recommended Minimum Standards for Patient-Centered Primary Care Homes (PCPCH) Providing Integrated Health Care
IBHA concepts developed by expert consensus—November 2015

Minimum Standard*	Specifications
Integrated behavioral health services are provided as part of routine care at the PCPCH including licensed Behavioral Health Clinician(s) (BHC) delivering an array of services onsite. BHC as defined in ORS 414.025.	BHC(s) provides care at the PCPCH with a ratio of 1 FTE BHC for every 6 FTE of Primary Care Clinicians (PCC). For example, a practice with 4 FTE PCC would need to have .67 FTE of a BHC (approximately 26.5 hours/week). For rural practices with behavioral health clinician shortages, integrated services may be provided virtually as long as other standards are met.
Integrated BHC provides a broad array of comprehensive evidence-based behavioral health services.	BHC services should be applicable to the PCPCH patient population served, including care for: mental illness, substance use disorders, health behaviors that contribute to chronic illness, life stressors and crises, developmental risks and conditions, stress-related physical symptoms, preventive care, and ineffective patterns of health care utilization per ORS 414.025.
Integrated BHC provides same-day open access behavioral health services.	Same-day open access services include warm hand-offs, brief assessments and interventions for patient and families, consultations to primary care clinicians and other care team members, and participation in pre-visit planning and daily huddles. Same-day open access services are provided in real-time at the point of care when behavioral health issues are identified at the PCPCH. On average, at least half of the BHC's hours at the practice each week must be available for same-day open access services.
Primary care clinicians, staff, and BHC utilize shared medical records and have a mechanism in place for collaborative care planning and co-management of patients.	Primary care clinicians, staff, and BHC document clinically relevant patient information in the same medical record system and participate in collaborative treatment planning and co-management via case conferences, consults, pre-visit planning and/or daily huddles.
BHC is an integrated part of the primary care team.	Primary care clinicians, staff, and BHC utilize shared physical space and the BHC participates in practice activities such as team meetings, daily huddles, pre-visit planning, and quality improvement projects.
PCPCH utilizes a population-based approach to delivering and coordinating integrated behavioral health services.	PCPCH utilizes universal behavioral health screening, care coordination, and panel management to monitor the behavioral health needs and outcomes of the PCPCH patient population. PCPCH utilizes written protocols for referrals to appropriate specialist(s) and hospitalization if clinically indicated.
The integrated team includes psychiatric consultative resources.	PCPCH identifies the psychiatric care needs of their population, determines viable psychiatric consultation strategies and provider options, and develops a care model that includes these services.

* Adapted from AHRQ *Professional Practices in Behavioral Health and Primary Care Integration* 2015 http://integrationacademy.ahrq.gov/

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Measurement Sets to Assess Behavioral Health Integration in Primary Care

Have not been fully established and vetted because:

- **Models remain in development**
- **Adoption is not uniform**
- **Payment modeling does not always incentivize and/or prioritize the work**
- **So… IBHA has worked on this…**

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IBHA Recommended Measures to Assess Behavioral Health Integration in Primary Care (in development)

IBHA Recommended Measures to Assess Behavioral Health Integration in Primary Care

Integration Concepts	Process Measures →	Intermediate Outcome Measures →	Outcome Measures →
I. Access to Care	I. a. Percent of completed referrals to outside specialty behavioral health services	I. a. Population Penetration: Access to Integrated Behavioral Health Services: Percentage of unique patients receiving clinical services from a BHC.	I. a. Population penetration: Access to integrated behavioral health - reaching a benchmark population penetration
II. Quality of Care	II. a. Behavioral health screening rates (e.g., SBIRT, PHQ-9, CRAFFT, GAD7, ASQ, etc.)	II. a. Identification & Intervention with Target Sub-Populations: Percentage of a sub-population of patients who could benefit from BHC involvement that received a BHC intervention during the reporting period. (e.g., patients with positive BH screening, patients with new/poorly controlled chronic health condition diagnosis, diagnoses of ADHD or Functional Abdominal Pain)	II. a. Patient-Reported Outcomes (e.g., quality of life surveys) II. b. Demonstrated improvement in scores for behavioral health and/or physical health conditions. (e.g., decrease in PHQ-9 scores, lower HbA1c in patients with diabetes, etc.) for patients seen by a BHC.
III. System of Care	III. a. Progress toward meeting IBHA recommended minimum standards for PCPCHs providing integrated care or 2017 PCPCH Standard 3.C.3 III. b. Must meet some elements of IBHA recommended minimum standards and have a written plan to meet more elements within the next year	III. a. Progress toward meeting IBHA recommended minimum standards for PCPCHs providing integrated care or 2017 PCPCH Standard 3.C.3 III. b. Must meet 1st element and 3 of the remaining 6 and have a written plan to meet more elements within the next 12 months.	III. a. Progress toward meeting IBHA recommended minimum standards for PCPCHs providing integrated care or 2017 PCPCH Standard 3.C.3 III. b. Must meet all 7 elements

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http://www.pcpci.org/sites/default/files/IBHA%20Measures%20Document%202018.final%20draft_v2.pdf

IBHA Recommended Measures to Assess Behavioral Health Integration in Primary Care (in development)

IBHA Recommended Measures to Assess Behavioral Health Integration in Primary Care

Integration Concepts (continued)	Process Measures →	Intermediate Outcome Measures →	Outcome Measures →
IV. Utilization & Cost	IV. a. A fiscal sustainability plan has been established IV. b. Tracking rate of clinic patients receiving integrated behavioral health care for specific quality improvement metrics. Examples: Follow up after hospitalization for mental illness Avoidable emergency department visits ED utilization among patients with serious mental illness(es) Comprehensive Diabetes Care: HbA1c Poor Control Controlling high blood pressure	IV. a. Meet engagement benchmarks for the integrated behavioral health care for specific quality improvement metrics.	IV. a. Comparison of total cost of care for comparably risked patients for patients those receiving integrated care with patients receiving standard (non-integrated) care IV. b. Demonstrate clinical or system impact of integrated behavioral health program on quality metrics and health outcomes
V. Patient Experience of Care	V. a. Patient and family experience receiving integrated care (survey) Note: Preference for real-time data over dated information.)	V. a. Patient and family experience receiving integrated care, demonstrating aggregated improvement (survey data)	V. a. Patient and family experience receiving integrated care, demonstrating improvement and reaching a benchmark (survey data)
VI. PCP Engagement & Satisfaction	VI. a. Measurement of PCP satisfaction with integrated care at practice level (e.g., Likert scale 1-10)	VI. a. Measurement of PCP satisfaction with integrated care at practice (e.g., Likert scale 1-10) VI. b. Measurement of PCP's utilization of BHC	VI. a. Measurement of PCP satisfaction with integrated care at practice (e.g., Likert scale 1-10) VI. b. Measurement of PCP's utilization of BHC demonstrating improvement of benchmark over previous year's measures

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IBHA Recommended Measures to Assess Behavioral Health Integration in Primary Care (in development)

I. Access to Care

- Process Measure:
  - I. a: Percent of completed referrals to outside specialty behavioral health services
- Intermediate Outcome Measure.
  - I. a. Population Reach: Access to Integrated Behavioral Health Services: Percentage of unique patients receiving clinical services from a BHC.
- Outcome Measure:
  - I. a. Population Reach: Access to integrated behavioral health - achieving a benchmark population reach

IBHA Recommended Measures to Assess Behavioral Health Integration in Primary Care (in development)

II. Quality of Care

- Process Measure:
  - II. a. Behavioral health screening rates (e.g., SBIRT, PHQ-9, CRAFFT, GAD7, ASQ, etc.)
- Intermediate Outcome Measure:
  - II. a. Identification & Intervention with Target Sub-Populations: Percentage of a sub-population of patients who could benefit from BHC involvement that received a BHC intervention during the reporting period. (e.g., patients with positive BH screening, patients with new/poorly controlled chronic health condition diagnosis, diagnoses of ADHD or Functional Abdominal Pain)
- Outcome Measures:
  - II. a. Patient-Reported Outcomes (e.g., quality of life surveys)
  - II. b. Demonstrated improvement in scores for behavioral health and/or physical health conditions. (e.g., decrease in PHQ-9 scores, lower HbA1c in patients with diabetes, etc.) for patients seen by a BHC.

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III. System of Care

- Process Measure
  - III. a. Progress toward meeting IBHA recommended minimum standards for PCPCHs providing integrated care or 2017 PCPCH Standard 3.C.3
  - III. b. Must meet some elements of IBHA recommended minimum standards and have a written plan to meet more elements within the next year
- Intermediate Outcome Measures
  - III. a. Progress toward meeting IBHA recommended minimum standards for PCPCHs providing integrated care or 2017 PCPCH Standard 3.C.3
  - III. b. Must meet 1st element and 3 of the remaining 6 and have a written plan to meet more elements within the next 12 months.
- Outcome Measures
  - III. a. Progress toward meeting IBHA recommended minimum standards for PCPCHs providing integrated care or 2017 PCPCH Standard 3.C.3
  - III. b. Must meet all 7 elements

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IV. Utilization & Cost

- Process Measure:
  - IV. a. A fiscal sustainability plan has been established
  - IV. b. Tracking rate of clinic patients receiving integrated behavioral health care for specific quality improvement metrics.
    - Examples:
      - Follow up after hospitalization for mental illness
      - Avoidable emergency department visits
      - ED utilization among patients with serious mental illness(es)
      - Comprehensive Diabetes Care: HbA1c Poor Control
      - Controlling high blood pressure

- Intermediate Outcome Measures
  - IV. a. Meet engagement benchmarks for the integrated behavioral health care for specific quality improvement metrics.

- Outcome Measures
  - IV. a. Comparison of total cost of care for comparably risked patients for patients those receiving integrated care with patients receiving standard (non-integrated) care
  - IV. b. Demonstrate clinical or system impact of integrated behavioral health program on quality metrics and health outcomes

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IBHA Recommended Measures to Assess Behavioral Health Integration in Primary Care (in development)

V. Patient Experience of Care

- Process Measure:
  - V. a. Patient and family experience receiving integrated care (survey)
- Intermediate Outcome Measure:
  - V. a. Patient and family experience receiving integrated care, demonstrating aggregated improvement (survey data)
- Outcome Measure:
  - V. a. Patient and family experience receiving integrated care, demonstrating improvement and reaching a benchmark (survey data)
- Note: Preference for real-time data over dated information.

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VI. PCP Engagement & Satisfaction

- Process Measure:
  - VI. a. Measurement of PCP satisfaction with integrated care at practice level (e.g., Likert scale 1-10)
- Intermediate Outcome Measure
  - VI. a. Measurement of PCP satisfaction with integrated care at practice (e.g., Likert scale 1-10)
  - VI. b. Measurement of PCP's utilization of BHC
- Outcome Measures
  - VI. a. Measurement of PCP satisfaction with integrated care at practice (e.g., Likert scale 1-10)
  - VI. b. Measurement of PCP's utilization of BHC demonstrating improvement of benchmark over previous year's measures

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Summary and Questions -