CPC
Comprehensive Primary Care

Advanced Primary Care: The Role of Behavioral Health on the Primary Care Team

Moderator

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Introductory Comments

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Advanced Primary Care: The Role of Behavioral Health on the Primary Care Team

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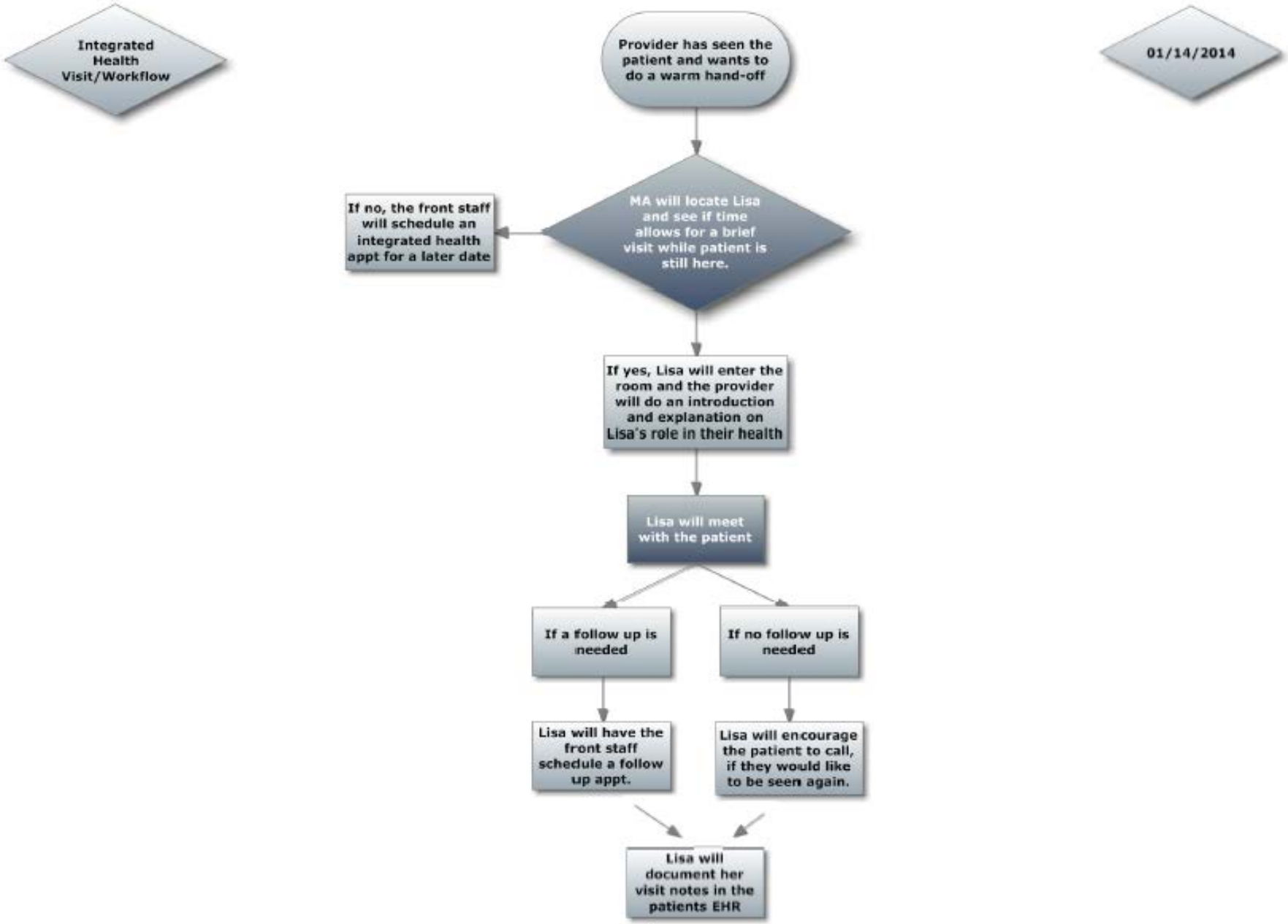
Agenda

- Review Milestone 2 guidance for behavioral health integration
  - Definitions
  - Intent
- Provide an example from a CPC practice
- Highlight strategies for practices and behavioral health

Foresight Family Practice


Integrated Health Visit/Workflow
01/14/2014
Provider has seen the patient and wants to do a warm hand-off
MA will locate Lisa and see if time allows for a brief visit while patient is still here.
If no, the front staff will schedule an integrated health appt for a later date
If yes, Lisa will enter the room and the provider will do an introduction and explanation on Lisa's role in their health
Lisa will meet with the patient
If a follow up is needed
If no follow up is needed
Lisa will have the front staff schedule a follow up appt.
Lisa will encourage the patient to call, if they would like to be seen again.
Lisa will document her visit notes in the patients EHR

Definition of behavioral health integration

- An umbrella term for care that addresses any behavioral health problems bearing on health, including mental health and substance abuse conditions, stress-linked physical symptoms, patient activation and health behaviors
- In CPC, a focus of the integrated behavioral health program can include recognition, diagnosis, assessment, support and treatment of persons with cognitive impairment (including Alzheimer's disease and other dementias).

Milestone 2 intent for BHI

- To address key issues in population health management using risk stratification methodology
- 2013: focus on those at highest risk for poor health outcomes and preventable harm
- 2014: enhance support for patients who may be in lower risk strata but who are struggling to achieve health goals and are at risk for negative outcomes

Why BHI?

- Behavioral health care needs are highly prevalent in primary care setting
  - 80% with a behavioral health disorder will visit primary care at least 1 time in a calendar year
  - 50% of all behavioral health disorders are treated in primary care
  - 30-50% of referrals from primary care to an outpatient behavioral health clinic don't make first appointment

Why BHI cont.

- Behavioral health care needs are often not addressed and exacerbate chronic medical conditions
  - Annual medical expenses—chronic medical & behavioral health conditions combined cost 46% more than those with only a chronic medical condition
  - When depression and diabetes are both addressed, positive diabetic and depression outcomes are generated.
  - Depression worsens chronic disease and is worse when co-occurring with chronic disease, more so than the impact of multiple chronic diseases without depression.

CPC BHI steps

- Declare in 1st Quarter of PY 2014 choice of BHI, SMS, MM
- MS2 BHI quarterly attestation:
  - Respond to questions regarding practice changes used to implement chosen strategy
  - Show progress each quarter

CPC BHI steps

- MS2 BHI – types/pathways to integration

Coordinated
Behavioral and physical health clinicians practice separately within their respective systems. Information regarding mutual patients may be exchanged as needed, and collaboration is limited outside of the initial referral.

Co-located
Behavioral and physical health clinicians deliver care in the same practice. Co-location is more of a description of where services are provided rather than a specific service. Patient care is often still siloed to each clinician's area of expertise.

Integrated
Behavioral and physical health clinicians work together to design and implement a patient care plan. Tightly integrated, on-site teamwork with a unified care plan. Often connotes close organizational integration as well, perhaps involving social and other services.

The details

BEHAVIORAL HEALTH INTEGRATION

Identification

- How do you identify and recognize individuals with behavioral health needs that might not currently be addressed?

Risk stratification

- Look at the patients you are currently treating; what percent have a comorbid behavioral health diagnosis?
  - Examine if the patients you have identified are improving
  - Consider starting your behavioral health interventions with these cohort of patients
  - Patients who may also be in a high risk category who have complex chronic disease but no diagnosis of behavioral health may actually have one

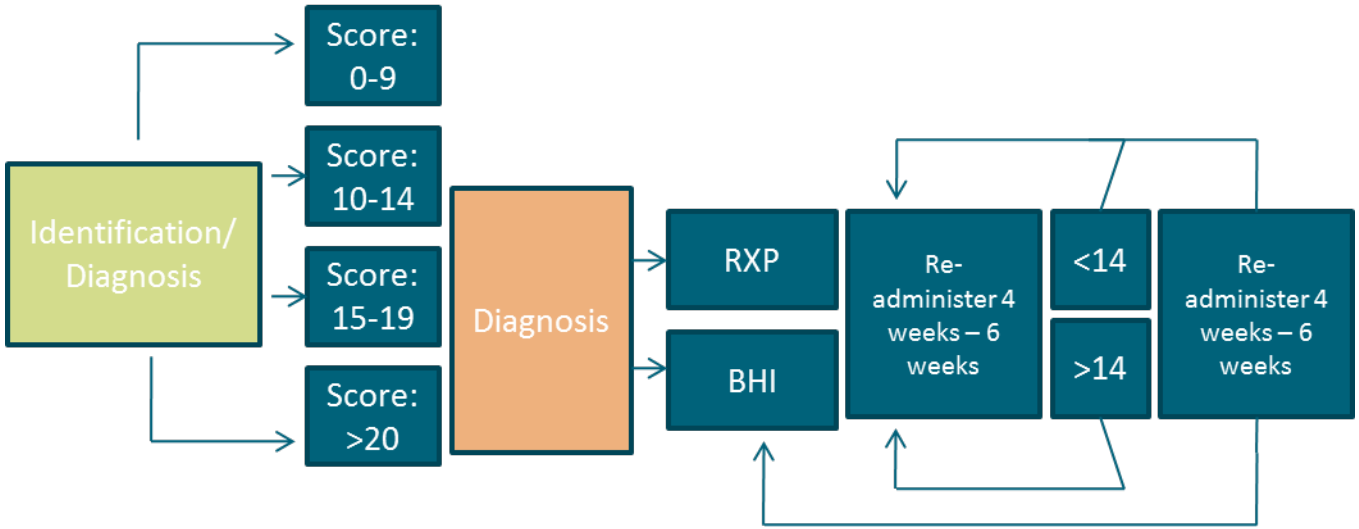
Identification cont.

- In your practice is there someone responsible for screening/identifying BH?
  - Examples include:
    - Front desk administers a screener
    - Patient self identifies with symptoms and a screener is administered
    - Providers use screener to help assess possible underlying BH condition
  - Once a screener has been administered and it is positive, what next?
    - Who is responsible for following up with the patient?
    - Who stores the data from the assessment tool (and where)?
    - How is the screening tool uses to monitor treatment?

Measures

Issue	Name of Measure	Number Items	Score for Positive Screen
Depression	PHQ-9	9	**6-10 moderate** **10-15 moderately severe** **16+ severe**
Alcohol Abuse	AUDIT	3	**7 or more for women** **8 or more for men**
Generalized Anxiety	GAD-7	7	**6-10 moderate** **10-15 moderately severe** **16+ severe**
Bipolar Disorder	Mood Disorder Questionnaire	5	**Yes to 7+ items in question 1 AND Yes to question 2 AND moderate to serious to question 3.**
PTSD	PC-PTSD	4	**Yes to one or more items**
Montreal Cognitive Assessment Tool	MOCA	12	**>26 (out of 30) Normal**

Depression and the PHQ-9 (assessment and monitoring)



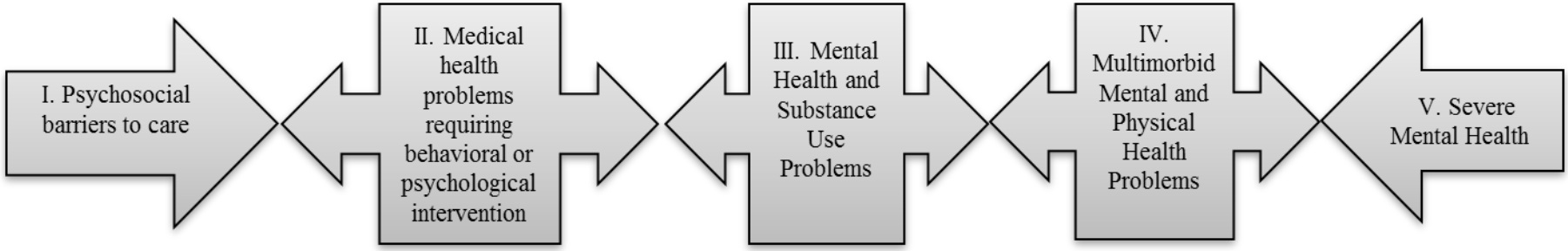
Are patients improving?

- Use standard screening tools for behavioral health conditions (e.g., PHQ-9 for depression, GAD-7 for anxiety)
  - Integrate these tools into the workflow
  - Use tools repeatedly to assess effectiveness of treatment (e.g., TREAT to TARGET, case review consultation)
  - Store these data in structured fields

Where are the behavioral health services?

- Which BH are part of the practice care team or staff resources your system provides you (for those practices that are part of systems), and which are available through established coordinated relationships in the medical neighborhood?
  - Factors to consider:
    - Finding the behavioral health providers in your community
    - The ability to track referrals or communicate with external partners
    - Availability of behavioral health provider to come onsite
    - Role behavioral health provider will play (e.g. brief interventions or more specialty mental health services)

What are the range of behavioral health services offered?



Building practice capacity

- Creating a team oriented practice
  - Offer internal practice team staff, training
  - Consultation/co-management relationships with behavioral health
  - Coordinate relationships within medical neighborhood
  - Share workflow to foster multidisciplinary teams

Assessment

- Assess the degree to which your practice has integrated behavioral health
  - AIMS Center Patient-Centered Integrated Behavioral Health Care Principles and Tasks
  - Integration Academy Self-Assessment Checklist
- Consider a baseline assessment and then further assessment at 6 and 12 months

http://integrationacademy.ahrq.gov/atlas

U.S. Department of Health & Human Services www.hhs.gov

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The National Integration Academy Council (NIAC)

Meet the panel of experts on integration who guide the work of the Academy.

NIAC

Learn More About the NIAC

Vision

AHRQ's vision is that the Academy for Integrating Behavioral Health and Primary Care will function as both a coordinating center and a national resource for people committed to delivering comprehensive, integrated healthcare.

Welcome to the Academy

The AHRQ Academy web portal offers you **resources** to advance the **integration** of **behavioral health and primary care**, and fosters a **collaborative** environment for dialogue and discussion among relevant thought leaders.

New Atlas of Integrated Behavioral Health Care Quality Measures

A new Atlas of Integrated Behavioral Health Care Quality Measures (IBHC Measures Atlas) can help primary care organizations measure whether they are providing high quality integrated behavioral health care.

More...

New & Notable

- Fri, 02/28/14 Rural Women Miss Out on Mental Health Care
- Fri, 02/28/14 Global Focus on Comorbidity of Depression and Chronic Medical Illness:
- Fri, 02/28/14 Get Your Latest News Via the Academy
- Wed, 02/19/14 Pediatric PCPs Hesitate to Prescribe Antidepressants
- Wed, 02/19/14 Coming Soon to the Academy Portal: New Interactive Features

New & Notable items include highlights of current activities of The Academy for Integrating Behavioral Health and Primary Care, as well as new research findings, Federal initiatives and other

Featured Products

Atlas of Integrated Behavioral Health Care Quality Measures

Lexicon for Behavioral Health and Primary Care Integration

Academy Webinars: National experts address various topics related to behavioral health and primary care integration

NIAC Videos: Featuring National Integration Academy Council members

Neil Korsen, MD, MSc

The Academy for Integrating Behavioral Health in Primary Care sponsored by the Agency for Healthcare Research and Quality (AHRQ) is an important online tool for those interested in changing health care. View video description

The IBHC Measures Atlas: Measures

U.S. Department of Health & Human Services www.hhs.gov

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IBHC Measures Atlas | Expert Insight | Latest News | News Archives | Guidelines | Tools | Organizations | Evidence-Based Practices

Find a Measure | What is IBHC? | Integration Framework | Overview of Measures | Guide to Using the IBHC Atlas | Methodological Details

Academy Home » Resources » IBHC Measures Atlas » Find a Measure

Find a Measure

There are three ways to find core measures in t

(1) By measure: If you already know the measur available in the *IBHC Measures Atlas*.

(2) By functional domain: If you know the doma satisfaction).

(3) Guide me to a measure: If you would like a r

For additional measures that apply to a specific instrument, go to "Overview of Measures – Addi

Academy Home » Resources » IBHC Measures Atlas » Find a Measure » Core Measures

VIEW BY: CORE MEASURES | FUNCTIONAL DOMAINS | GUIDE ME TO A MEASURE

Core Measures

- C1. Assessment of Chronic Illness Care
- C2. Behavioral Health Integration Checklist*
- C3. Competency Assessment Instrument Measures
- C4. Consumer Assessment of Healthcare Providers and Syster
- C5. Consumer Assessment of Healthcare Providers and Syster
- C6. Level of Integration Measure*
- C7. Mental Health Integration Programs*
- C8. Site Self assessment Evaluation Tool*
- C9. Young Adult Health Care Survey Measures

Additional Measures

C2. Behavioral Health Integration Checklist*

View the measure

Purpose:

To help organizations planning an integrated care implementation to identify the key components of a successful program and to determine which of these they have and which need to be (further) developed. To help assess the level of implementation of integrated care for a given population.

Developer:

Advancing Integrated Mental Health Solutions (AIMS) Center, University of Washington

Date:

2011

Relevant submeasures:

Not applicable

Format/data source:

Organizational checklist

Development and testing:

Developed by the AIMS Center in collaboration with a national group of experts

Past or validated applications:

- **Setting:** Primary care and behavioral health
- **Population:** Organizations looking to integrate
- **Level of evaluation:** Individual or groups of health care professionals

Sources:

AIMS Center, University of Washington

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Relevant Functional Domains from the Integration Framework:

- Business Model Sustainability
- Care Team Expertise
- Clinical Workflow
- Data Collection and Use
- Desired Outcomes
- Leadership Alignment
- Operational Reliability
- Patient and Family Engagement
- Patient Identification
- Treatment Monitoring

Patient-Centered Integrated Behavioral Health Care Principles & Tasks

AIMS CENTER

About This Tool

This checklist was developed in consultation with a group of national experts (http://bit.ly/IBHC_experts) in integrated behavioral health care with support from The John A. Hartford Foundation, The Robert Wood Johnson Foundation, Agency for Healthcare Research and Quality, and California HealthCare Foundation. For more information, visit: http://bit.ly/IBHC_principles.

The core principles of effective integrated behavioral health care include a patient-centered care team providing evidence-based treatments for a defined population of patients using a measurement-based treat-to-target approach.

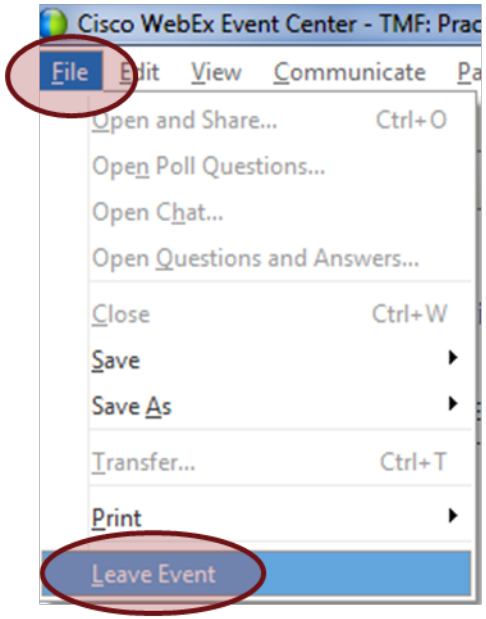
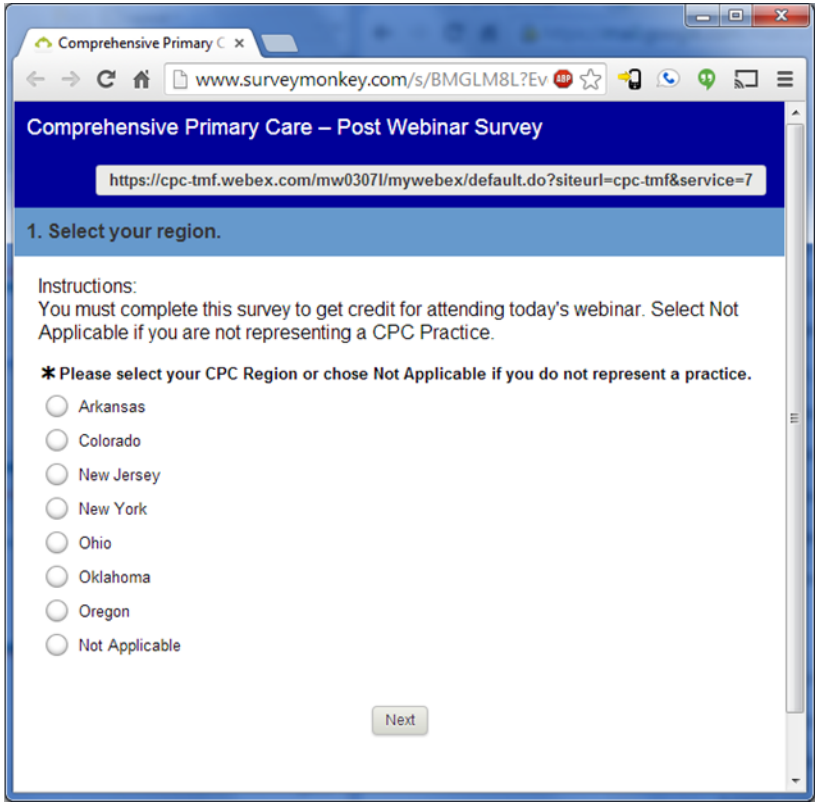
Principles of Care	We apply the principle in the care of of our patients: Rare	Some	Most/All
1. Patient-Centered Care			
Primary care and behavioral health providers collaborate effectively using shared care plans.	☐	☐	☐
2. Population-Based Care			
Care team shares a defined group of patients tracked in a registry. Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation, not just ad-hoc advice.	☐	☐	☐
3. Measurement-Based Treatment to Target			
Each patient's treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured. Treatments are adjusted if patients are not improving as expected.	☐	☐	☐
4. Evidence-Based Care			
Patients are offered treatments for which there is credible research evidence to support their efficacy in treating the target condition.	☐	☐	☐
5. Accountable Care			
Providers are accountable and reimbursed for quality care and outcomes.	☐	☐	☐

Closing

FORESIGHT

QUESTIONS

What's Next

Event Date and Time	Title
Thurs., March 20, 11:30 to noon ET	CPC Attributions Refresher
Thurs., March 20, noon to 12:30 p.m. ET	National Open Mic
Tues., March 25, 2 p.m. ET	Deep Dive into Self-Management Support

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