

**Behavioral Health Integration subgroup**

**Tuesday, August 3  
10:00 am – Noon**

Agenda Items	Notes
Welcome	<b>Kristin Houser &amp; Sarah Rafton</b>
<p>Seattle Children’s Care Network <i>Experiences with BH integration</i></p>	<p><b>Larry Wissow, MD &amp; Scotty Sontag</b>, Seattle Children’s Hospital <i>See page 5 for slides.</i></p> <ul style="list-style-type: none"> <li>Initially conceived of as identification of early, less intensive problems. Big learning this year: We see the full range of needs including those with intensive or complex needs who either can’t get into intensive services, move in and out of services, or need a PCP to coordinate care.</li> <li>This is a learning collaborative – you can’t just plop MH in and expect it to work – need to work on these 6 buckets of work ( see page x).</li> <li>1<sup>st</sup> cohort – started in November; 2<sup>nd</sup> cohort – joining for 2<sup>nd</sup> round.</li> <li>Toolkit includes coaching from SCCN – working with teams of 5-7, including project management around these goals/buckets.</li> <li>Grant funds are being used for subsidies. For example, in year one, grants will pay 75% of Behavioral Health (BH) managers and psych consultant salaries to cover startup costs. Working toward financial sustainability.</li> <li>Estimate 10-20% of kids in these practices would be candidates for this program. First cohort enrolled 5%.</li> <li>Ultimate goal: get teams up and running; provide brief interventions where indicated; warm handoff through PAL or enhanced PAL, if needed.</li> <li>Core cost: Coordinator to manage program and support practices.</li> <li>Would love to build in family support/interventions such as Triple P</li> <li>Hubs developed spontaneously in Maryland when they went through this process.</li> <li>Technically billable through Collab care, but there is a maximum amount of time you can bill for a family within a current month. Also, not solely doing collaborative care – helping them figure out collab care or psychotherapy – depends on payer, geography and availability of other providers. Care coord a challenge if there are no providers in their region. A lot of practices would love to have someone on their team to help with care management so they can spend more time on the billable services. Also, sometimes hard to tell in pediatrics whether to focus on the kid or on the parents (coaching).</li> </ul> <p><b>Discussion/Q&amp;A</b></p> <ul style="list-style-type: none"> <li>Biggest partnership at Kent-DesMoines is with schools. I really feel we could invest more as a state in building relationships with school psychologist and counselors. Billable through COCM. A little bit outside of the model that Wendy has. And collaborating with Cmty MH partners on who can do what. Rural – school is where we need to look at.</li> <li>More funding for a coordinator who doesn’t have to be a MH professional.</li> <li>Promote health navigator role and its importance. Health navigator needs to be working with your team, not in a silo on their own.</li> </ul>

	<ul style="list-style-type: none"> <li>• Is there a cost reduction for payors? Families? The system? Expect savings across sectors. Efficiency in practices – using less of medical providers’ time. Reduced cost to schools – services they don’t have to provide.</li> <li>• <i>2 hrs/mo/patient billing maximum – is this really enough time?</i> For some, for care coordination, it’s enough. For provision of BH services, including individual and family intervention...probably not. Esp. for practices that don’t have enough community resources to refer out to. Then go with traditional psychotherapy codes, not COCM.</li> <li>• That’s why Kent/Des Moines does a hybrid approach. Can usually do COCM in less than 2 hours/month, but that may be because of the relationships we’ve developed with people. We have tried to stick with the COCM, because you don’t have to have professionals with as high a credential. We are pretty effective w/ 2 hrs.</li> <li>• Child Referral Assist: A year ago, it took us 6 days to find a therapist; in July 2021, it took 19 days (commercial insurance primarily, but also CMCH).</li> <li>• What would it look like to get the startup funds for clinics? So far, clinics have had generous donors.</li> </ul>
<p>Value-based payment and BH integration in primary care – WA Primary Care Transformation update</p>	<p><b>Judy Zerzan, MD, Health Care Authority</b> <i>See page 29 for slides.</i></p> <ul style="list-style-type: none"> <li>• Primary care model developed in 2019-20 – payers and practices of all different sizes, locations; providers of different types. Representative of state’s primary care. 1 patient rep; 2 BH clinicians.</li> <li>• Providers agree on % spend on primary care that will grow over time (like Maryland and Oregon).</li> <li>• Providers receive quality incentives for outcomes and providing care.</li> <li>• Contact <a href="mailto:cybhwg@hca.wa.gov">cybhwg@hca.wa.gov</a> if you want to be included in the stakeholder group.</li> <li>• Planning a legislative presentation and document in October.</li> </ul> <p>Q&amp;A</p> <ul style="list-style-type: none"> <li>• Will HCA get more transformation funds? <i>No, we will get less.</i></li> <li>• How have you been thinking of multi-generational care (families)? <i>Working on this, some will be in October document, some still to figure out – what would PMPM look like?</i></li> <li>• If we move to VBP structures, is it your idea that things like the COCM will fit on top of that so we continue to use that billing structure? Talked about a higher capitation rate for BHI. <i>Great question. Don’t have an answer yet. Lots of support for COCM and also know it’s a lot of work. Not all practices can do it, so it may be outside of the PMPM.</i></li> <li>• From a strategy and tactical point, a lot of people are talking about coordination and laypeople to help families engage in BH care and get other SDOH needs met. How would a practice demonstrate that they meet that criteria and finance those care coordination activities. <i>Great question. Don’t have an answer yet. New licensing is tricky. Doulas are an example of using laypeople. We are hoping the PMPM payment will allow practices flexibility in what they need.</i></li> <li>• How does VBP allow for additional staff needed to do these things? <i>The transformation payment would help to do this.</i></li> <li>• Cost for startup – range of \$250,000 to stand up these models. We need to know if transformation grants would be available to fund part of that. <i>We don’t have an exact amount of transformation payment.</i></li> </ul>

<p>HCA data findings: BH services in primary care settings</p>	<p><b>Teresa Claycamp &amp; Grant Stromsdorfer</b>, Health Care Authority  <i>See page 53 for slides.</i></p> <ul style="list-style-type: none"> <li>• Level setting: BH benefit vs. Physical health benefit (see page x).</li> <li>• Bulk of services 14-17, followed by 5-10. Includes CHIP – state-funded for children whose family income is low but too high to qualify for Medicaid.</li> <li>• Do we know if use of physical health services tracks this or looks differently?  <i>Did not capture answer.</i></li> <li>• How would service through BH integration reflect in service area setting?  <i>Didn't capture the information to answer that question.</i></li> <li>• Follow-up figures are just for PCP, not for BHAs.</li> </ul> <p><b>Discussion/Q&amp;A</b></p> <ul style="list-style-type: none"> <li>• This answers where did care happen. Our hope is to take a subset of kids and say what happened in a year for them (everything).</li> <li>• Median service count – does this reflect the # of BH providers within a region?  <i>Data is dependent on provider self-management – accepting new Medicaid clients or not. We can't necessarily infer that – we can provide the info they have provided us.</i></li> <li>• Healthier Here- higher total utilization – struggled getting data completeness on BHA side. Wonder if it is the same for PCP side. I don't know a benchmark – what % you would expect if you are meeting the need.  <i>This is documented utilization.</i></li> </ul>
<p>Closing</p>	<p><b>Kristin Houser &amp; Sarah Rafton</b></p> <p>Trying to get at:</p> <ul style="list-style-type: none"> <li>• What does care look like in the 2 different settings (primary care and behavioral health clinics)?</li> <li>• Where is care happening between the 2 different settings?</li> <li>• Moving to the recommendation phase. We may do a survey. Maybe go through notes and identify gaps and barriers.</li> <li>• Members, feel free to say “I need more information about this” for any topic.</li> </ul>

**Attendees**

Rachel Burke, Health Care Authority (HCA)  
 Teresa Claycamp, HCA  
 Diana Cockrell, HCA  
 Kahlie Dufresne, Molina Healthcare  
 Kiki Fabian, HCA  
 Dr. Thatcher Felt, Yakima Valley Farmers Clinic  
 Leslie Graham, UW Neighborhood Clinic – Kent-Des Moines  
 Brittany Gross, Graduate student  
 Libby Hein, Molina Healthcare  
 Dr. Bob Hilt, Seattle Children’s Hospital  
 Marissa Ingalls, Coordinated Care  
 Nat Jungbluth, Seattle Children’s  
 Laurie Lippold, Partners for Our Children  
 Joan Miller, Washington Council  
 Shauna Muendel, HCA

Deborah Pineda, Child and Adolescent Clinic, Cowlitz and Clark Counties  
 Wendy Pringle, HopeSparks  
 Sarah Rafton, Washington Chapter of the American Academy of Pediatrics (WCAAP)  
 Noah Seidel, Office of Developmental Disabilities Ombuds  
 Scotty Sonntag, Amazon Care  
 Mary Stone-Smith, Catholic Community Services of Western Washington  
 Grant Stromsdorfer, HCA  
 Lucas Springstead, HCA  
 Beth Tinker, HCA  
 Amber Ulvenes, Consultant  
 Dr. Larry Wissow, UW  
 Judy Zerzan-Thul, HCA

## Chat Log

### Seattle Children's Care Network

- Is the metric for financial viability really numbers of patients per day? Or numbers of patients enrolled in Collaborative Care at a given time?  
*Well both, it can get focused to a target patient per day, per week, per month. But also what the ideal caseload size is at a given time. Example: Eight patients a day is a target for one of the cohort 1 practices.*
- Please also consider the cost savings of the navigator to connecting families to community resources (non profits and other) which help children/families to get support.
- Good point with workforce challenges....Typically this has fallen upon behavioral health, but not the best use of resources.
- I also would not like to oversimplify the coordination with schools. Oftentimes, we are partnering with school teams discussing very difficult behaviors and coming up with treatment plans, IEP suggestions, etc...
- I don't know the origin of the hour limit, probably part of how HCA funded this.  
*No, it is set by coding and the model. The coding was set in a specific way so that makes it a little harder for providers.*
- With using associate mental health license, do you have challenges with staff leaving when they become licensed?  
*No so far, in a year and a half. People are enjoying the work and we are trying to figure out ways to keep salaries competitive.*
- And to restate what we have learned and heard so far on this BHI Subgroup, commercial is not paying Collaborative Care adequately but commercial tends to pay better for traditional psychotherapy codes (while Medicaid is abysmal for those codes.)
- My understanding from Dr. Hilt is that access to psychotherapy is difficult for commercial insurance members as well.  
*Yes, the commercial insurance access is significantly more difficult now overall even than community mental health agency access.*

### Washington Primary Care Transformation update

- Can care gaps related to social determinants of health be identified in family screening?
- Can you speak more about what depression response and remission means as a quality measure? And is there is any consideration of startup costs in VBP to get the staffing in place so primary care can deliver whole person care, including Behavioral Health (BH) care?
- Does the PRISM score system have a child version?  
*No, PRISM has been really limiting, not great for application to kids.*
- Remembering that psychotherapy may also be happening in non-primary care settings for some of these kids.
- Psychotherapy occurring outside of primary care but within BH centers should be in the next iteration.
- It may also be that in King County there are more BHA providers available and so a greater portion of the BH services are being provided from that system.

# Seattle Children's Care Network and Integrated Care

Sheryl Morelli, Scotty Sonntag, Larry Wissow

Seattle Children's Hospital and University of Washington Departments of Pediatrics and Psychiatry

August, 2021



# Significant Need, Access Gaps

Fact: 1 in 5 children ages 13-18 have, or will have a serious mental illness.<sup>1</sup>



20% of youth ages 13-18 live with a mental health condition<sup>1</sup>



11% of youth have a mood disorder<sup>1</sup>



10% of youth have a behavior or conduct disorder<sup>1</sup>



8% of youth have an anxiety disorder<sup>1</sup>

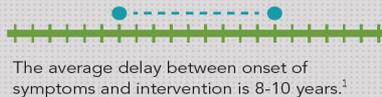
## Impact



50%

50% of all lifetime cases of mental illness begin by age 14 and 75% by age 24.<sup>1</sup>

10 yrs



37%



37% of students with a mental health condition age 14 and older drop out of school—the highest dropout rate of any disability group.<sup>1</sup>

70%



70% of youth in state and local juvenile justice systems have a mental illness.<sup>1</sup>

## Suicide

2nd  
3rd



Suicide is the 3rd leading cause of death in youth ages 10 - 24.<sup>1</sup>



90%

90% of those who died by suicide had an underlying mental illness.<sup>1</sup>

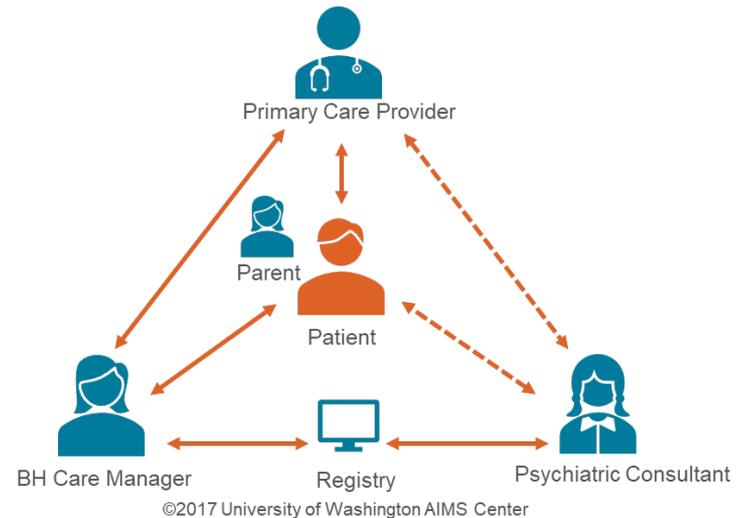
- 77% of respondents to a recent Washington Chapter of the American Association of Pediatrics member survey state lack of mental health resources for patients is the top professional challenge they face (June 2021)
- There is currently a 30-50% vacancy rate for BH therapy positions in community mental health centers. Centers in Spokane, Whatcom, Snohomish and Clark counties are completely closed to new intakes (June 2021)

# Going Upstream: Integrated Care

Equipping pediatric primary care to identify, manage and coordinate services for mental and behavioral health needs within community settings in a financially sustainable model

## What is Integrated Behavioral Health?

- The care a patient experiences as a result of a **team** of primary care and behavioral health clinicians, working together with patients and families, using a **systematic** and **cost-effective** approach to provide **patient-centered care** for a defined population.

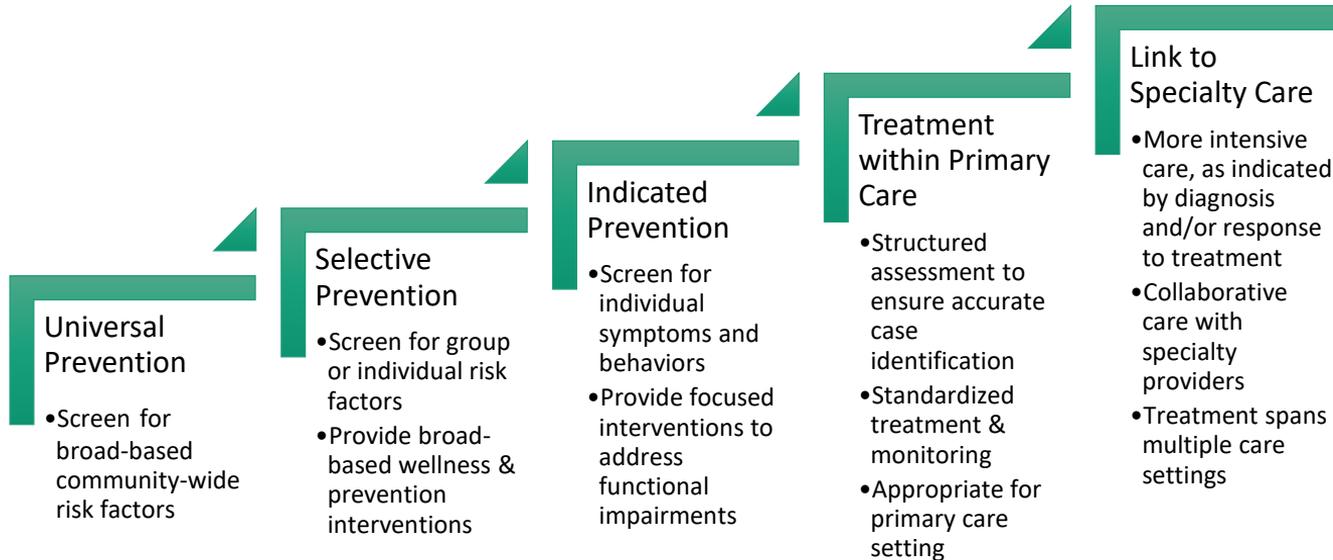


# What We Mean by Integrated Care



# What Does Integrated Behavioral/Mental Health Hope to Achieve?

As much as possible within primary care and for children/youth with a wide range of severity





# Challenges for Pediatric Integrated Care

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- Behavioral and mental health skills and confidence for providers and staff
- Wide range of severity and complexity – it's not just all early identification of low-level, emergent problems
- Meeting multi-generational and social needs along with the child's
- Helping primary care become part of a mental health care system instead of an outsider knocking on the door
- Funding program start-up costs
- Project and change management support
- Data and technology system requirements and support
- Ongoing revenue and consultation to ensure program sustainability

# Funders



Seattle Children's Guild Association



King County Accountable Community of Health



The NCTSN is funded by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services and jointly coordinated by UCLA and Duke University.



# SCCN IBH Cohort Practices



## Primary Care Practices

-  Skagit Pediatrics
-  Pediatric Assoc of Whidbey Island
-  Woodinville Pediatrics
-  Richmond Pediatrics
-  Ballard Pediatrics
-  North Seattle Pediatrics
-  Bainbridge Pediatrics
-  Odessa Brown Children's Clinic
-  Mercer Island Pediatrics
-  Renton Pediatrics
-  University Place Pediatrics
-  South Sound Pediatrics
-  Olympia Pediatrics
-  Northwest Pediatric Center

## Cohort 1 Practices

## Cohort 2 Practices

plus  
UW Kent-Des Moines  
UW Harborview  
UW Roosevelt

## Our Areas of Focus for This Collaborative: Six Elements

### *Office Environment*

1. Develop and Foster a Mental Health and Resilience-Informed Environment

### *Community Relationships*

2. Build Relationships with Communities to Support Families

### *Family Engagement*

3. Engage with Families in Their Own Care and in the Design of Services

### *Assess Health*

4. Assess Whole Family Health and Resilience

### *Address Health*

5. Address Whole Family Health and Resilience

### *Coordinate*

6. Coordinate Services and Supports for Families



# “Toolkit” has areas of work and “PDSA’s”

## Sample Strategies to Test

Change Concept A.  
Use family-friendly,  
accessible language  
when talking with  
families about their  
care

- ✓ **Use family-friendly language in materials (e.g., anticipatory guidance)** that is responsive to the community. Try handing out to a few family members and getting feedback on the usefulness and their understanding. Make adjustments and begin to spread to other providers and families. Also consider when the material should be shared, who should share it, where it should be made available, and the best way to ensure families can use it. *(To study, track how often families take the materials and the types of questions they have about it.)*
- ✓ **Use non-stigmatizing words to talk about delicate subjects** (e.g., “feeling overwhelmed” can be a good phrase for discussing stress). Try it with a few families and evaluate how they respond. Begin to make a list of this language and get additional feedback from family partners and community partners. Find systematic ways to incorporate this language into the standard operations of the office, including materials, posters, policies, tools, forms, etc. *(To study, get feedback from families and partners about the language. Track how often you see and hear the “new” language in use.)*
- ✓ **Use scripts with family-friendly language** to introduce questions and tools so that families understand why the questions are being asked and how the responses will be used to help their family’s care. Try with a few families first and get feedback. As you refine the language, expand to additional providers and families. *(To study, track how many providers are using the scripts and perceptions of families in responding to questions.)*

# Evidence-Based Treatment

- Starts with first interactions and includes office environment
  - So all staff empowered to build therapeutic relationship, help identify family concerns, identify relevant information
- Task sharing between primary care and behavioral health clinicians
  - PCPs know first-line interventions and basic medication management
- Behavioral health clinicians
  - Use problem-focused assessments and brief, transdiagnostic interventions in a stepped model
  - Work effectively with specialists for more complex care



# The Collaborative Care Model (CoCM)

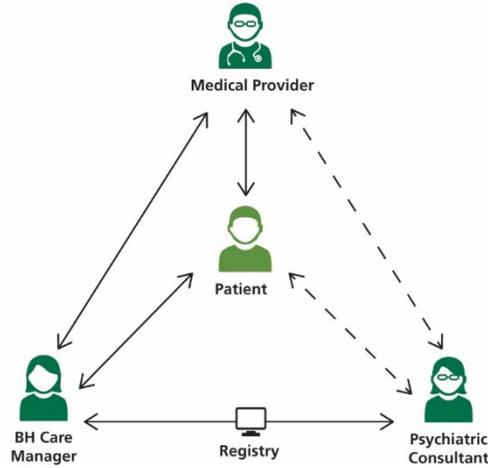


Primary care  
patient-centered  
team-based care

[ACTIVE PATIENTS]

PKID	Primary ID	DOB	Enrollment Date	Sex	Enrollment Type
0001	Test, Test	2/8/2013	[Y]	M	1/24/2014
0002	Test, Test	4/22/2013	[Y]	F	1/23/2014
0010	Test, Test	4/27/2013	[Y]	F	1/26/2014
0033	Test, Age Qualifier	1/30/2013	[Y]	M	1/30/2014
0038	Test Patient, Mile	1/23/2014	[Y]	M	1/23/2014
0041	Test, Test	3/4/2014	[Y]	M	3/4/2014
0042	Test, Test	3/7/2014	[Y]	M	3/7/2014

Registry to track  
population

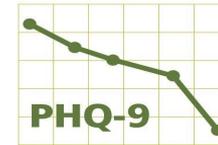


Problem Solving Treatment (PST)  
Behavioral Activation (BA)  
Motivational Interviewing (MI)  
Medications

Active treatment with  
evidence-based approaches



Systematic case review  
with psychiatric  
consultant  
(focus on patients not  
improved)



Validated outcome  
measures tracked over  
time



Used with permission from the University  
of Washington AIMS Center



## What each practice brings as a team

- A family representative
- A “senior leader”
- A primary care clinician
- A behavioral health/mental health clinician
- A psychiatric consultant
- A “day-to-day” champion who helps to move the project forward

## What the practices do:

- Attend a variety of sessions targeting particular skills and processes
- Meet as teams and across teams to adapt the models presented to their own context
- Meet milestones to qualify for subsidies that help with start-up
- Hire behavioral health personnel if they don't have it already
- Arrange for psychiatric consultation if they don't have it already
- Develop plans for financial stability
- Develop ways of measuring their progress in terms of structures, processes, and family outcomes



Nov 20   Dec 20   Jan 21   Feb 21   Mar 21   Apr 21   May 21   Jun 21   July 21   Aug 21   Sep 21   Oct 21   Nov 21

Phase I: Elements 1&2   Learning Collaborative Phase 2: Elements 3&4   Phase 3: Elements 5&6

Prep and Launch Learning Collaborative Cohort 2

Monthly Clinic Implementation Calls

PICC Webinars

CoCM Training

PCP Training

BHP Training

PCP and BHP Monthly Case Conference

Cohort 2 Application Process

IBH Funding Proposals

IBH Advocacy

Element 1 – Office Environment  
Element 2- Community Engagement  
Element 3 - Family Engagement  
Element 4 – Assess Health  
Element 5 – Address Health  
Element 6 – Coordination

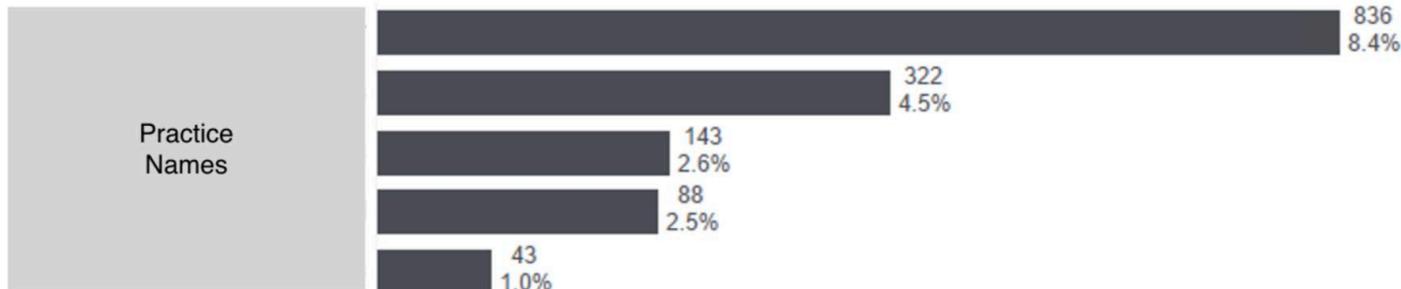
# Proportion of population formally enrolled in integrated care to date

## DRAFT: SCCN Integrated Behavioral Health Implementation: Short-Term Outcomes

Cohort 1: Launched November 2020

Total IBH Patients Enrolled in 2021 (total patients and % of practice age 6-18 years old)

Based on visits between 1/1/2021 - 6/30/2021; some practices had BH programs in place prior to the start of the SCCN IBH program rollout.



IBH Enrollment	
Total Panel	47,755
Panel Age 6-18 Years	30,636
Enrolled in IBH	1,432
% of Panel Age 6-18 Years	4.7%

Represents programs active from a month to several months

# Comparison of screening rates in participating versus non-participating practices

## Behavioral Health Screening (Full Panel)

Rates based on CPT codes billed between 7/1/2020 - 6/30/2021.

■ Not Screened ■ Screened

### Developmental (CPT 96110, age 0-3y)

### Depression (CPT 96127, age 12-18y)

### Postpartum Depression (CPT 96161, age 0-6m)

Cohort 1

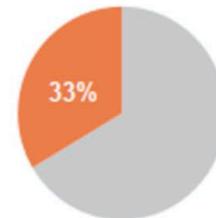
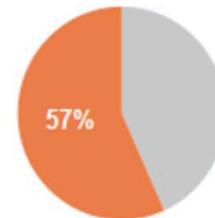
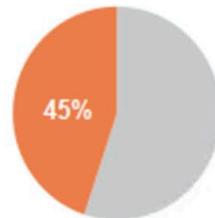
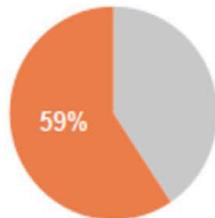
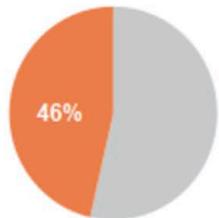
Not participating

Cohort 1

Not participating

Cohort 1

Not participating



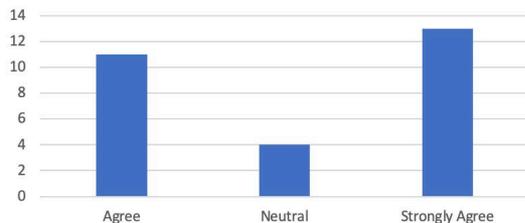
Likely underestimate since based on billing

# Initial impressions from participants

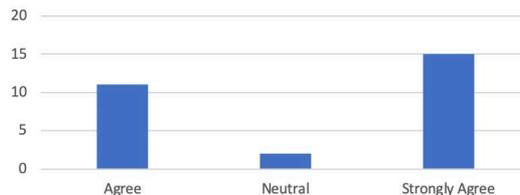
## SCCN SCH IBH Learning Collaborative Overall Evaluation (N=29)



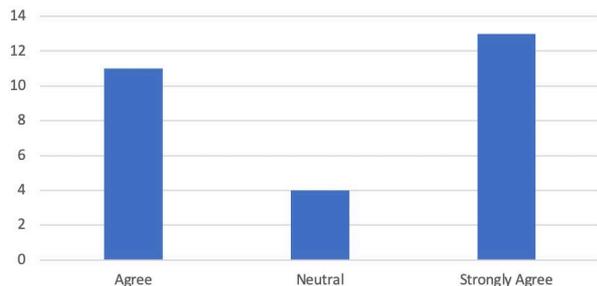
I felt my individual contributions were valued by my Core IBH Team.



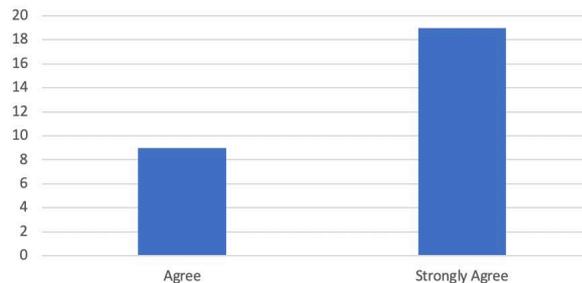
Connecting with other teams at and outside of Learning Sessions and Trainings was valuable.



I have used ideas from other teams in my own agency/work.



Connecting with faculty members (PICC, AIMS, SCH) was valuable.

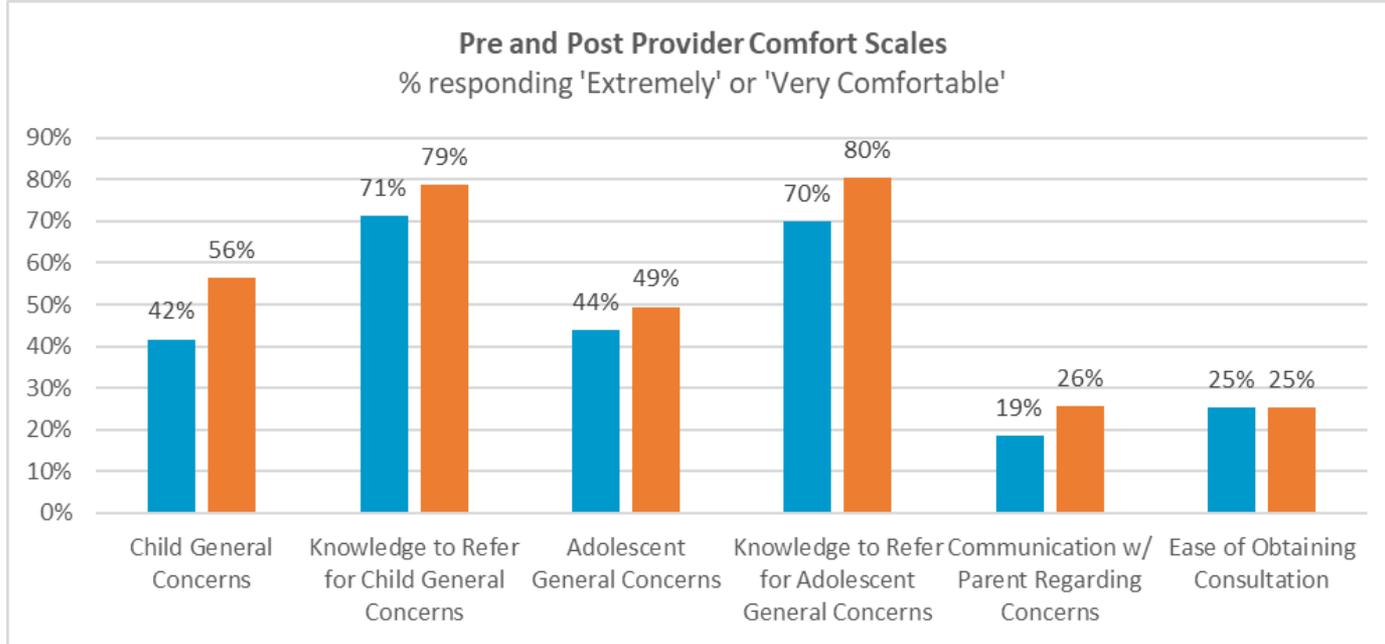


## Eventual outcomes to track

- Emergency room utilization
- Reduction in polypharmacy and use of atypical antipsychotics
- Reduction in costs for somatic health care
- Reduced lapses in care (continuity of medication, episodes ended without resolution of problem)
- Rare but serious outcomes: hospitalization, suicide, serious medical complications of co-occurring problems



# Cohort 1 Provider Survey Results



- Improvement on all components except 'ease of obtaining a psychiatric consultation'
- Marked movement on remaining components along the continuum of provider comfort (somewhat, moderately, very, extremely)
- For providers only somewhat or moderately comfortable, most notable improvement in comfort with child general concerns and knowledge to refer for adolescent general concerns



# Improved system functioning (first step)

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- A case presented that seemed like a standard GI issue. Staff administered a PHQ9 due to their new universal MH screener process.
- They identified high scores indicating depression was present, which initiated a conversation about depression and led to the discovery the child had attempted suicide via overdose of ibuprofen. The team activated their new suicide workflow and administered an additional suicide screener.
- The child was sent to the SCH Emergency Room safely and was admitted to the inpatient unit.

## Provider Quote

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*“Not only did the screener help us discover what otherwise would have been missed, but it is the first time I’ve sent a kid to an ED in a MH crisis where I felt knowledgeable, confident, and capable. Sending them to the ED with the screener results for depression and suicide felt like I was sending a kid to the ED with labs.”*



# Program Growth and Development

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## Current model:

- Cohort 1 finishes year 1 activities; cohort 2 launches – **program scalability**
- Process measures and outcome data reporting begins. Billing and collections experience reported from practices – **financial sustainability** at the practice level

## Next step in development:

- Additional training: behavioral health professionals and PCPs condition-specific and case conference review (“Year 2” activities)
- External (non SCH, SCCN) groups that are not grant funded are able to buy training and coaching services from the team – **program sustainability**

## Aspirational goal:

- Scalable training and implementation support effort with handoff to PAL for long-term support



# Issues in scalability

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Cost of collaborative sessions and coaching alone:

- About \$150,000/year (total for all participating sites; in theory less as ongoing)
- Scalability depends on amount of coaching required and distance to sites – coach can support 12-14 sites across a range of issues or perhaps more if focused only on mental health
- Most training is done virtually and readily scalable but some on-site help seems desirable

Issues for scaling related to subsidies for sites

- Extent to which sites are supported for development time and costs of behavioral health and family representative stipend until full productivity reached (nominally 6 months; up to \$120,000 per practice in full model)

Issues related to long term support

- Mechanisms to streamline data collection
- Use of PAL or programs that could build on PAL to provide ongoing support to PCPs and behavioral health
- Modifications to collaborative care billing that incentivize collaborative care
- Gearing up for enhanced range of severity – mixture of collaborative care and co-located care

## Additions to model

- Support for “navigation” or care management
  - Not a billable service
  - Important for social determinants and to facilitate referrals, work with schools
  - Role in multi-generational care
- Ability to provide group/class services for families across participating practices
  - Individual practices may lack sufficient participants at any given time
- Development of regional “hub” practices that may want to develop a higher level of capacity
  - Maybe all pediatric/family practice sites need some basic mental health capability but some – especially in rural or underserved areas get supported to do more



# WA Primary Care Transformation Update

Judy Zerzan

*August 3, 2021*

# Peds VBP: How the Model Aims to Improve Care



Adopts a new base payment model that frees clinicians from the financial imperative to generate visit volume, allowing them instead to deliver services in a flexible manner that best addresses patient needs.



Enhances primary care providers' capacity to support patients.



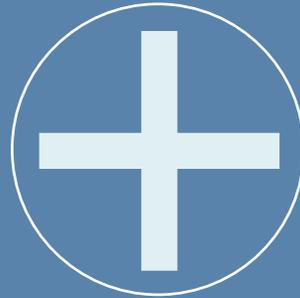
Rewards high quality and advances performance accountability.

# Payment Model Components

There are three components to the Child Health Alternative Payment Model:



Prospective payment  
for common primary  
care services



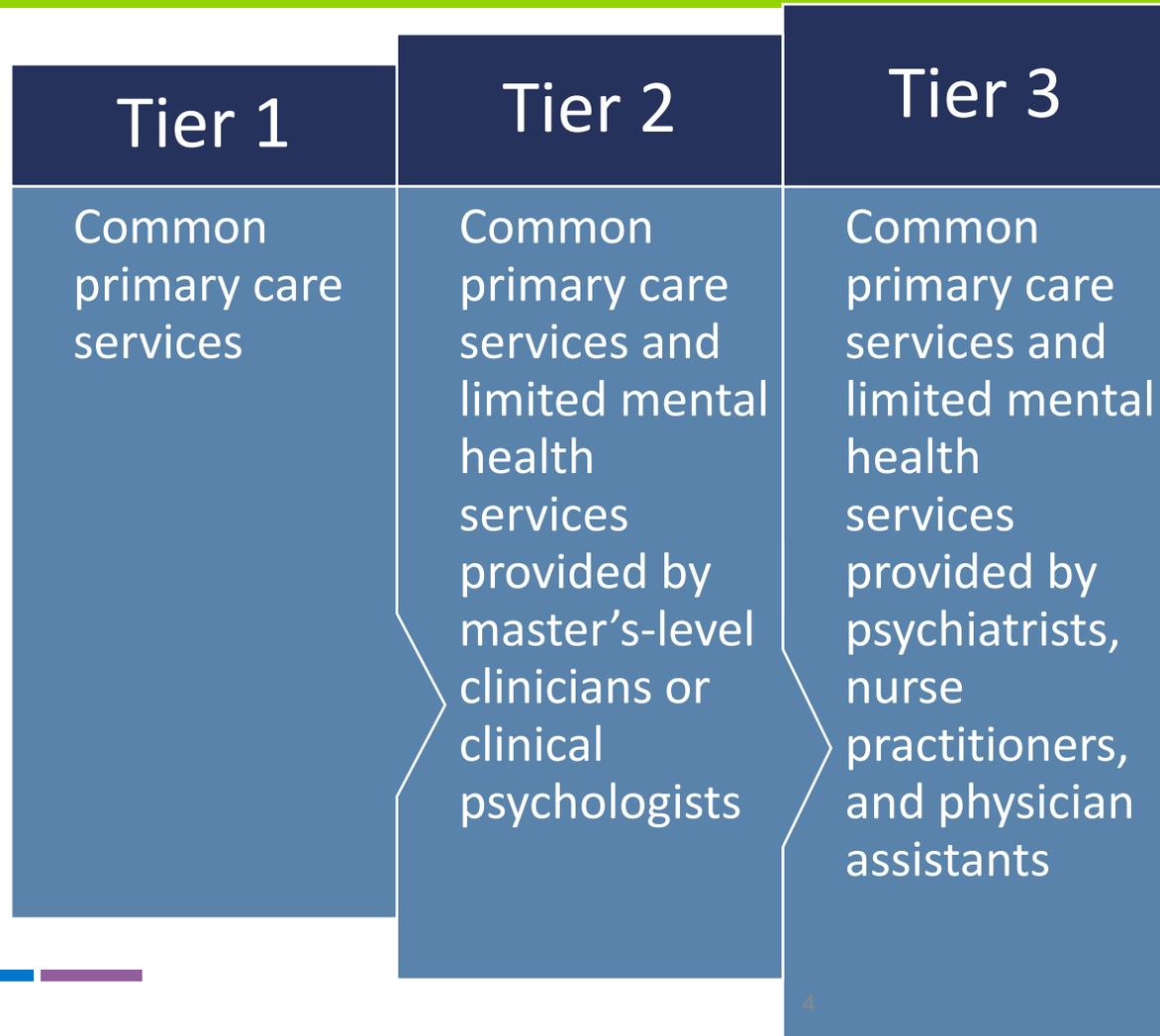
Care coordination  
payment to address  
medical, behavioral  
and social risk factors



Quality incentive  
payment opportunity

# Component #1: Prospective Payment

The model includes three different prospective payment tiers that recognize varying levels of readiness and services offered



# Component #1: Prospective Payment

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- ▶ Common primary care services encompassed in Tier 1 of the prospective payment include:
  - ▶ Limited number of E&M codes
  - ▶ Vaccine administration
  - ▶ Delivery of Bright Futures preventive services
  - ▶ Oral health evaluation and fluoride application
  - ▶ Mental health services
- ▶ All other primary care services would be paid on a fee-for-service basis.

# Component #1: Prospective Payment

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- ▶ For practices that deliver mental health services in an integrated practices, Tier 1 capitation rates would be enhanced depending on whether services are delivered by:
  - ▶ Master's-level clinicians and/or clinical psychologists (Tier 2); or
  - ▶ Treating mental health clinicians including psychiatrists, nurse practitioners, physician assistance (Tier 3)

# Primary Care Transformation Components

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## Payers work to:

Align payment and incentives across payers to support the model

Finance primary care  
(% of spend on primary care)

## Providers work to:

Improve provider capacity and access

Apply actionable analytics (clinical, financial, social supports)

## In support of:

Primary care as integrated whole person care, including BH and preventive services

Shared understanding of care coordination and providers in that continuum

## Resulting in:

Aligned measurement of "value" from the model  
(triple aim outcome measures)

# Model Transformation Measures

Focus Area	Transformation Measure
Access	<ul style="list-style-type: none"><li>• Same day appointments, 24/7 e-health, telephonic access, and communication through IT innovations are offered for both physical AND behavioral health and integrated into care modalities.</li></ul>
	<ul style="list-style-type: none"><li>• Practice regularly offers at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population, such as e-visits, phone visits, group visits, home visits, alternate location visits, and/or expanded hours in early mornings, evenings, and weekends.</li></ul>
Care Coordination	<ul style="list-style-type: none"><li>• Practice has and uses a documented strategy to identify care gaps and prioritize high-risk patients and families, AND proactively manages care gaps and documents outcomes, for example, using and documenting care plans.</li></ul>
	<ul style="list-style-type: none"><li>• Practice consistently implements team-based care strategies (huddles, care mgmt. meetings, high risk patient panel review)</li></ul>

# Model Transformation Measures (Continued)

Focus Area	Transformation Measure
Whole Person Care	<ul style="list-style-type: none"><li>Practice uses an evidence-based tool to screen for behavioral health issues, AND has a documented process for connecting patients/families with behavioral health resources following screening, including standing orders, and protocols for follow up</li></ul>
	<ul style="list-style-type: none"><li>Practice has and uses a documented risk stratification process for all empaneled patients, addressing medical need, behavioral diagnoses, and health-related social needs.</li></ul>
	<ul style="list-style-type: none"><li>Ensure patients' goals, preferences, and needs are integrated into care through advance care planning.</li></ul>
Application of Actionable Analytics	<ul style="list-style-type: none"><li>Capacity to query and use data to support clinical and business decisions.</li></ul>

# Clinical Quality Measures

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1. Childhood Immunization Status (CIS) (Combo 10)
2. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (CDCÑ)
3. Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34)
4. Percent of patients who receive annual BH screening in primary care (using NQF 0418)
5. Reduction in Emergency Room utilization
6. Controlling High Blood Pressure (CBP)
7. Adolescent Well Child Visits (AWC) (12-21 years of age)
8. Medication Management for People with Asthma (MMA) Medication Compliance 75%
9. Depression Remission and Response for adolescents and adults
10. Screening for colorectal cancer

# An Updated Definition Of Primary Care

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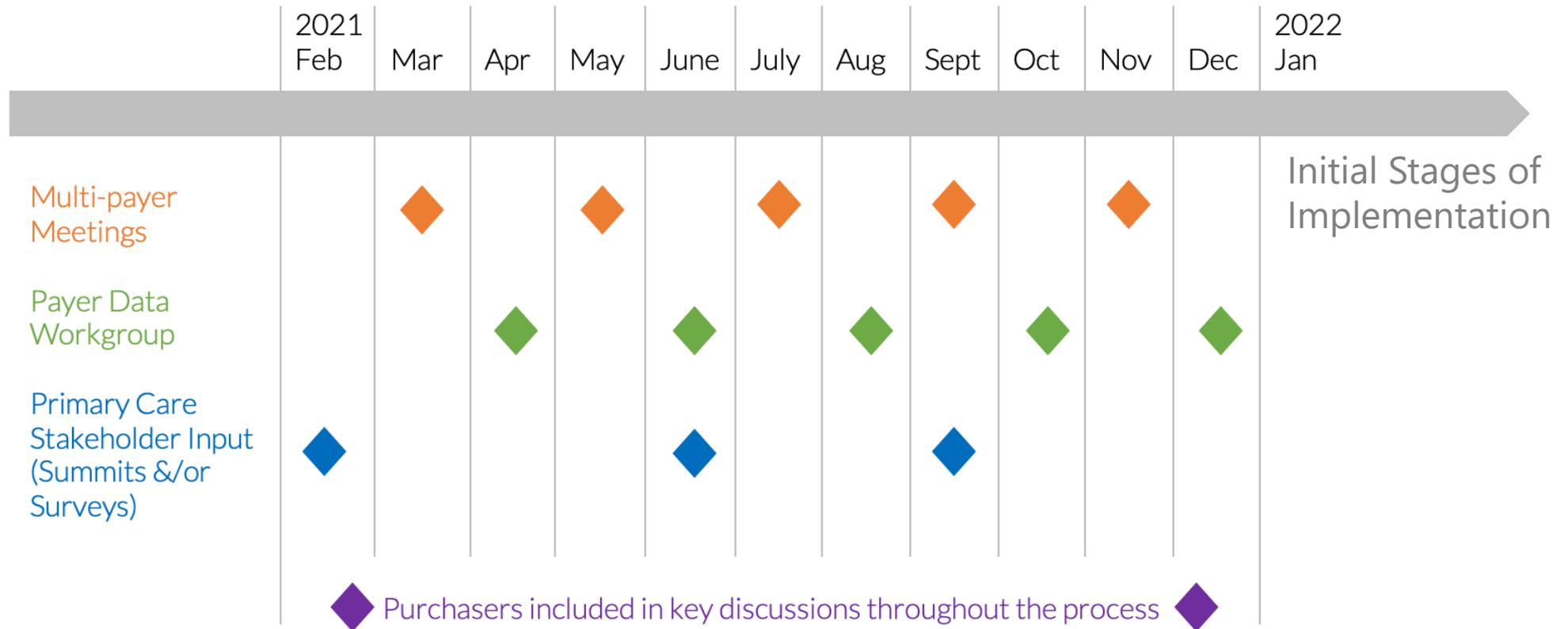
High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across setting and through sustained relationships with patients, families and communities.

*source:*

The National Academies of Science-Engineering-Medicine

May 2021

# Collaborative Process for Model Implementation



# Primary Care Model Implementation Work Streams

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Providers  
&  
Payers

- 1 Baseline of primary care models**
  - ▶ Educates alignment on APM focus, payment approach, implementation staging
- 2 Model definitions & accountabilities**
  - ▶ Clarify model definitions
  - ▶ Articulate payer and provider responsibilities in parallel
  - ▶ Tie accountabilities to payment approach and implementation staging
- 3 Data and information sharing capacities**
  - ▶ Clarify needed data to support payment and care model
  - ▶ Use capacities to educate measurement and implementation decisions
- 4 Implementation staging**
  - ▶ Use all above to delineate an implementation trajectory

# Aligning primary care transformation to the CHART grant and other HCA work

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## ▶ CHART grant proposal

- ▶ Grant dollars are provided to transition a rural WA community medical system to prospective payment, based on historic spend, with the expectation of enhanced service access and proactive management of the community's health.
- ▶ Primary care services are part of the services considered for prospective payment.

## ▶ Health Homes Expansion

- ▶ Health Homes services are available to all AH clients who meet the criteria of a 1.5 or higher PRISM score. A personalized care plan is developed by the patient with the HH Leaders and includes other supports such as attending visits.
- ▶ Paid for through the savings on the dually covered lives as calculated by Medicare. It is a covered medical service and one of very few CMMI supported programs with proven, sustainable results in cost and quality.
- ▶ Currently only about 10% of those qualifying based on PRISM score provided service. Renewing efforts with the MCOs, paying for the tribal administrative fee and an ARPA funding request are areas of focus.

## ▶ Care Coordination Workgroup

- ▶ Inventory available of over 30 care coordination programs funded by HCA
- ▶ Analysis and alignment with the PC Transformation integration important

## ▶ Medicaid Transformation Initiative 1 extension and renewal

- ▶ Renewing state's support of the ACHs is in process
- ▶ Analysis and alignment with PC Transformation integration important

# Stakeholder Survey

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## ▶ Purpose

- ▶ Gather stakeholder input on proposed provider accountabilities under the WA Multi-payer Primary Care Transformation Model

## ▶ Developed from collaborative work to date

- ▶ Proposed WA Multi-payer Primary Care Model and transformation measures for the Model
- ▶ Bree Collaborative's primary care recommendations

## ▶ Survey questions

- ▶ Level of support for the specific proposed accountabilities
- ▶ Supports providers need to successfully implement each accountability
- ▶ How to monitor progress under each accountability

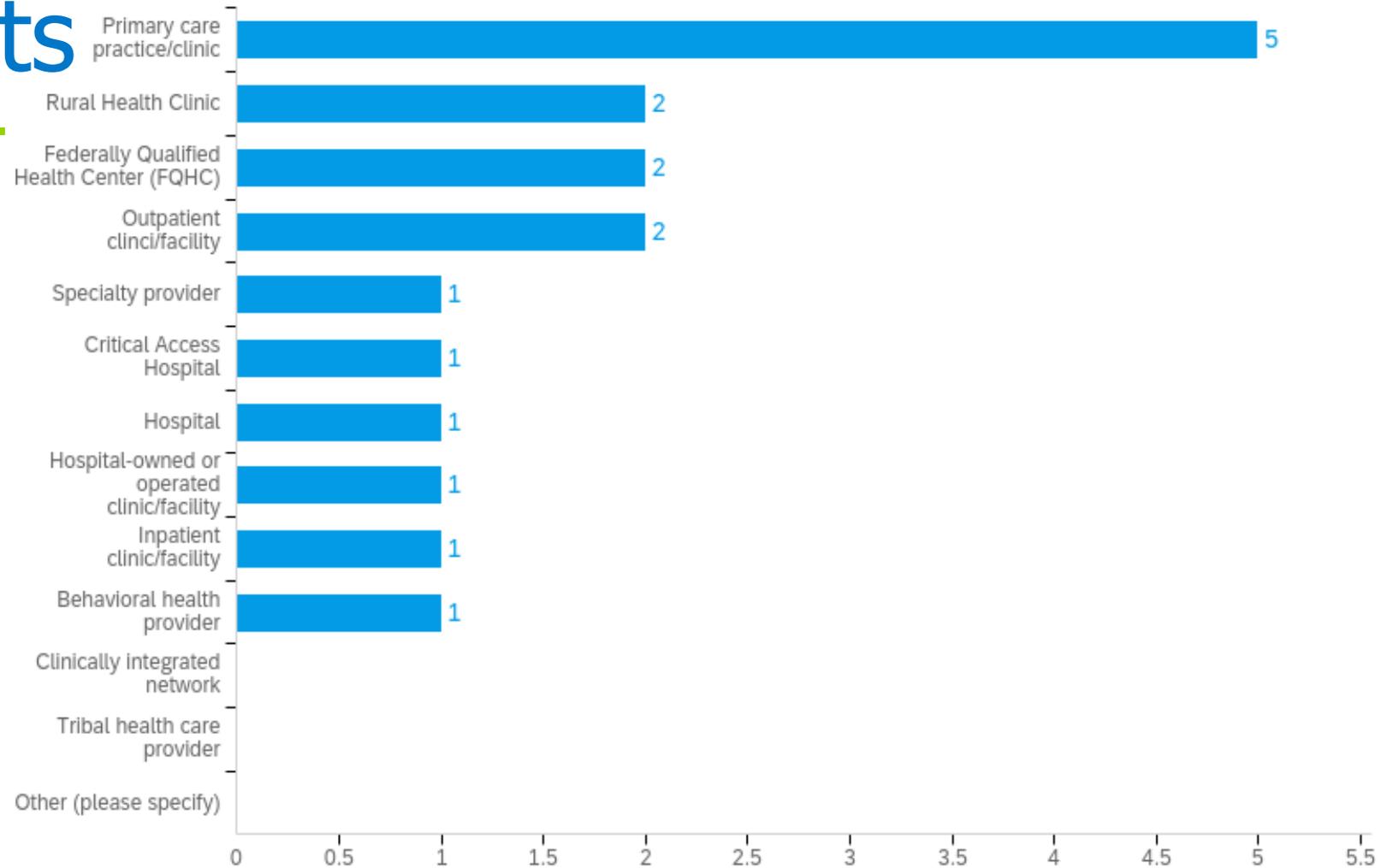
# Proposed Provider Accountabilities

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- Whole-person care
- A team for every patient
- Risk stratification
- Behavioral health screening and follow-up
- Patient support
- Care coordination strategy
- Expanded access
- Culturally attuned care
- Health literacy
- Data capacity
- Aligned metrics to measure value

# 22 Respondents

## Type of Health Care Organization



# Overall Support

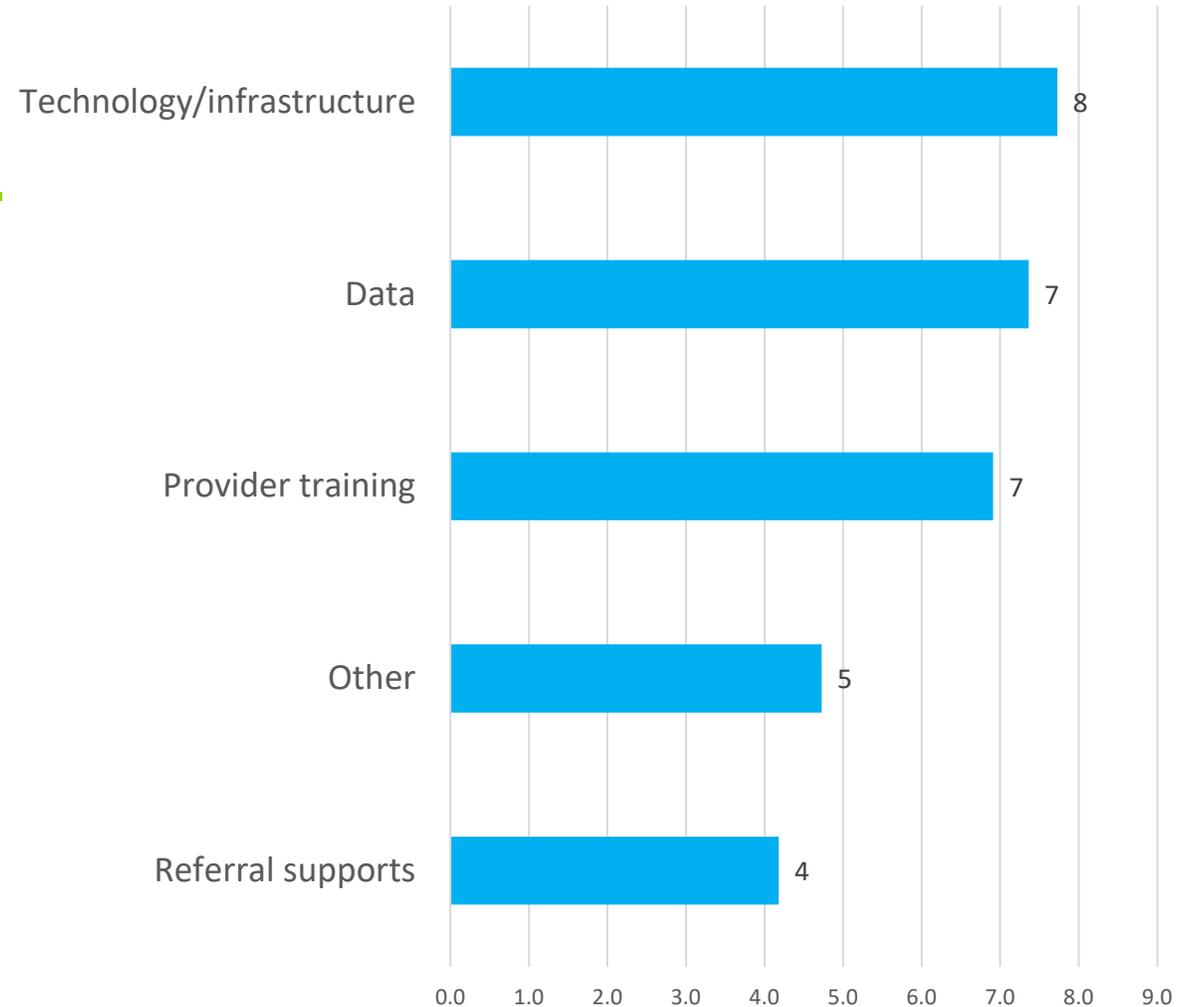
Averaged support scores  
for **overall list** and  
**individual** provider  
accountabilities  
(Scale of 1-5 with 5 being  
strongly support)



# Provider Supports

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Average times each option was selected across accountabilities



# Provider Supports – Examples

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## ▶ Consumer engagement

- ▶ Incentives/education for PCP selection
- ▶ Communication tools to support team model

## ▶ Provider training and tools

- ▶ Behavioral health integration
- ▶ Care team development, delegation, tools
- ▶ QI principles, tools, processes
- ▶ Making data actionable
- ▶ Validated risk stratification tools

## ▶ Data capacity

- ▶ Timely notifications of patient care in other parts of the system
- ▶ Timely and standardized payer data
- ▶ Actionable data on quality and cost metrics
- ▶ Clear methodology and supporting data for attribution
- ▶ Clarity of SUD data sharing under 42 CFR Part 2

# Provider Supports – Examples

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## ▶ Referral Support

- ▶ Robust capacity to track and close look referrals
- ▶ Increased behavioral health capacity in the community
- ▶ Incentives for specialists to communicate with PCPs

## ▶ Technology/Infrastructure

- ▶ Online translation service
- ▶ Single view of patient data not fragmented by payer
- ▶ Robust EHR capacity to extract data

## ▶ Other

- ▶ Central resource on screening, stratification, health literacy, and other tools
- ▶ Collaborative efforts to support smaller providers
- ▶ Culturally-reflective workforce
- ▶ Alignment of payer expectations and data to reduce administrative costs and improve patient care

# Provider Implementation Strengths & Challenges

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**What one word represents what you think is the area in which providers are most ready to implement this model?**



Takeaways:

- Providers are psychologically ready for the model
- Team-based care is an imperative for providers
- They are ready for a focus on prevention

# Provider Implementation Strengths & Challenges

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What one word represents the area in which providers are least ready to implement this model?



Takeaways:

- Time & administration
- Structure of financing
- Staffing capacity

# Current Activities & Next Steps

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- Payer MOU signing celebration held October 2020
- Cross-walk with related work to maximize alignment
- Ongoing payer and provider meetings
- Employer support via WA Health Alliance and PBGH
- Work with state-financed health plan partners on implementation (the ‘how’) for 2023



# Child/Adolescent Behavioral Health Services in Primary Care Settings 2018-2020

Behavioral Health  
Integration Subgroup

August 3, 2021

# A Foundational Understanding of the Washington State Plan

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- ▶ Official agreement with CMS, describing the nature and scope of Washington's Medicaid physical and behavioral health benefit.
- ▶ Scope of care and types of services:  
<https://www.hca.wa.gov/assets/program/SP-Att-3-Services-General-Provisions.pdf>

# A Foundational Understanding of the Washington State Plan

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- ▶ **Behavioral health benefit - Behavioral Health Agency (BHA) side (historically called higher acuity)**
  - ▶ MH and SUD services described in 13d. Rehabilitative Services section
  - ▶ Can only be provided by licensed BHAs
  - ▶ Provider types are diverse, ranging from fully licensed clinicians to agency affiliated counselors and peer counselors
  - ▶ Benefit corresponds to the HCA MH Billing Guide Part 2, SUD Billing Guide, and Service Encounter Reporting Instruction (SERI) Guide
- ▶ **Physical health benefit – (historically called lower acuity)**
  - ▶ Includes mental health outpatient services described in “6. Other Practitioners’ Services”
  - ▶ Practitioners need to be independently licensed with DOH
  - ▶ Benefit corresponds to the HCA MH Billing Guide, Part I

***The data presented is on the physical health benefit side only***

# General Parameters to Data Set

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- ▶ Data source: HCA ProviderOne encounter data
- ▶ Services occurring in calendar years 2018-2020  
(*Note: 2020 data is likely not fully complete or mature*)
- ▶ Ages: 0-20
- ▶ Includes:
  - ▶ fee-for-service claims and accepted managed care encounters
  - ▶ Mainly Medicaid but also some low income, non-Medicaid
  - ▶ Isolates mental health services in primary care settings and collaborative care codes
- ▶ Excludes services provided by Licensed Behavioral Health Agencies

# Demographic Data

# Client Count by Age Group

Percentage of clients served in each age group, by Calendar year				
AGE_GROUP	CALENDAR YEAR			TOTAL
	2018	2019	2020	
0-4	4.70%	5.32%	4.95%	5.00%
5-10	27.61%	27.42%	25.64%	26.91%
11-13	19.64%	19.86%	19.88%	19.80%
14-17	31.28%	30.53%	31.15%	30.97%
18-20	16.77%	16.86%	18.37%	17.32%
<b>TOTAL</b>	100%	100%	100%	100%

# Ethnicity – Behavioral Health Services Utilization Compared to Medicaid Eligible

ETHNICITY	2018		2019		2020	
	TOTAL ELIGIBLE POPULATION	TOTAL UTILIZATION POPULATION	TOTAL ELIGIBLE POPULATION	TOTAL UTILIZATION POPULATION	TOTAL ELIGIBLE POPULATION	TOTAL UTILIZATION POPULATION
Hispanic	29.91%	23.77%	30.48%	26.19%	30.85%	25.66%
Not Hispanic	54.01%	65.47%	54.08%	63.93%	54.18%	64.04%
Unknown	16.08%	10.76%	15.44%	9.88%	14.98%	10.30%
<b>Total Percent</b>	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

# Race – Behavioral Health Services Utilization Compared to Medicaid Eligible

RACE	2018		2019		2020	
	TOTAL ELIGIBLE POPULATION	TOTAL UTILIZATION POPULATION	TOTAL ELIGIBLE POPULATION	TOTAL UTILIZATION POPULATION	TOTAL ELIGIBLE POPULATION	TOTAL UTILIZATION POPULATION
ALASKAN NATIVE/AMERICAN INDIAN	3.93%	7.20%	4.13%	6.92%	4.21%	6.30%
ASIAN	3.85%	2.15%	3.84%	2.00%	3.94%	1.81%
BLACK	8.14%	6.50%	8.43%	6.43%	8.57%	6.44%
HAWAIIAN/PACIFIC ISLANDER	3.51%	1.56%	3.69%	1.56%	3.85%	1.63%
OTHER	18.17%	13.67%	17.77%	14.87%	17.60%	14.08%
UNKNOWN	13.10%	7.29%	12.58%	6.44%	12.08%	6.74%
WHITE	49.31%	61.64%	49.56%	61.78%	49.76%	63.00%
<b>TOTAL PERCENT</b>	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

# Utilization Data: Behavioral Health Services in Primary Care Settings Compared to Medicaid Eligible Population

# State Level – Behavioral Health Services Utilization Compared to Medicaid Eligible

STATE LEVEL DETAIL	2018		2019		2020	
	TOTAL ELIGIBLE POPULATION	TOTAL UTILIZATION POPULATION	TOTAL ELIGIBLE POPULATION	TOTAL UTILIZATION POPULATION	TOTAL ELIGIBLE POPULATION	TOTAL UTILIZATION POPULATION
TOTAL CLIENT COUNT	896,406	58,793	890,940	64,876	935,490	59,178
PERCENTAGE OF UTILIZATION ÷ TOTAL ELIGIBLE POPULATION		6.56%		7.28%		6.33%

# By Region – Behavioral Health Services Utilization Compared to Medicaid Eligible

CLIENT ACH REGION	2018		2019		2020	
	TOTAL ELIGIBLE POPULATION	TOTAL UTILIZATION POPULATION	TOTAL ELIGIBLE POPULATION	TOTAL UTILIZATION POPULATION	TOTAL ELIGIBLE POPULATION	TOTAL UTILIZATION POPULATION
BETTER HEALTH TOGETHER	10.25%	17.74%	10.32%	13.39%	10.25%	13.92%
CASCADE PACIFIC ACTION ALLIANCE	9.47%	8.08%	9.53%	7.91%	9.48%	10.55%
ELEVATE HEALTH	12.27%	7.60%	12.21%	10.13%	12.35%	9.78%
GREATER COLUMBIA ACH	16.01%	13.11%	15.99%	16.83%	15.81%	15.66%
HEALTHIER HERE	20.08%	15.35%	20.09%	13.00%	20.19%	12.83%
NORTH CENTRAL ACH	5.95%	7.06%	5.99%	7.66%	5.92%	7.45%
NORTH SOUND ACH	14.78%	15.54%	14.74%	16.56%	14.89%	15.32%
OLYMPIC COMMUNITY OF HEALTH	3.90%	4.22%	3.86%	4.08%	3.83%	4.00%
SWACH	7.29%	11.31%	7.27%	10.44%	7.26%	10.47%
<b>TOTAL PERCENTAGE</b>	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

# Service Settings and Provider Types

# Service Settings/Service Provider Types

## Primary Care Settings

Distribution (percentage of service counts) of services across combined service settings of **OUTPATIENT PRIMARY CARE CLINIC, FQHC, and Rural Health Clinic service settings**

SERVICE SETTING	SERVICING PROVIDER TYPE	CALENDAR YEAR			TOTAL
		2018	2019	2020	
PRIMARY CARE SETTINGS	BEHAVIORAL HEALTH & SOCIAL SERVICE PROVIDERS	72.10%	79.50%	84.24%	78.46%
	MD/PA/ARNP	6.41%	10.89%	11.72%	9.60%
	OTHER PROVIDER TYPE	21.49%	9.61%	4.03%	11.94%
		<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>

# Service Settings/Service Provider Types

## Outpatient Primary Care Clinics

Distribution (percentage of service counts) of services for only **OUTPATIENT PRIMARY CARE CLINIC** service settings

SERVICE SETTING	SERVICING PROVIDER TYPE	CALENDAR YEAR			TOTAL
		2018	2019	2020	
OUTPATIENT PRIMARY CLINIC	BEHAVIORAL HEALTH & SOCIAL SERVICE PROVIDERS	72.92%	80.03%	85.17%	79.09%
	MD/PA/ARNP	5.64%	10.06%	10.93%	8.74%
	OTHER PROVIDER TYPE	21.44%	9.91%	3.90%	12.18%
<b>TOTAL</b>		<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>

# Service Settings/Service Provider Types Federally Qualified Health Center (FQHC)

Distribution (percentage of service counts) of services for <b>only FQHC</b> <b>service settings</b>					
SERVICE SETTING	SERVICING PROVIDER TYPE	CALENDAR YEAR			TOTAL
		2018	2019	2020	
FQHC	BEHAVIORAL HEALTH & SOCIAL SERVICE PROVIDERS	62.65%	78.25%	80.55%	75.59%
	MD/PA/ARNP	12.42%	14.32%	14.03%	13.78%
	OTHER PROVIDER TYPE	24.93%	7.43%	5.43%	10.63%
TOTAL		100.00%	100.00%	100.00%	100.00%

# Service Settings/Service Provider Types Rural Health Clinic (RHC)

Distribution (percentage of service counts) of services for <b>only RHC service settings</b>					
SERVICE SETTING	SERVICING PROVIDER TYPE	CALENDAR YEAR			TOTAL
		2018	2019	2020	
RHC	BEHAVIORAL HEALTH & SOCIAL SERVICE PROVIDERS	36.63%	44.81%	60.64%	51.42%
	MD/PA/ARNP	60.41%	49.92%	36.11%	44.87%
	OTHER PROVIDER TYPE	2.97%	5.27%	3.24%	3.72%
<b>TOTAL</b>		<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>

# Diagnosis and Service Category

# Diagnosis and Service Category – Distribution (percentage) of clients seen

Percentages of clients seen, by calendar year, diagnosis type, and service category					
DIAGNOSIS TYPE	SERVICE CATEGORY	CALENDAR YEAR			TOTAL
		2018	2019	2020	
ATTENTION DEFICIT DISORDER	DIAGNOSTIC TESTING AND EVAL	3.10%	3.15%	2.94%	3.06%
	COLLABORATIVE CARE	0.00%	0.02%	0.04%	0.02%
	MEDICATION MANAGEMENT	3.56%	4.03%	4.11%	3.91%
	PSYCHOTHERAPY	4.69%	4.65%	4.91%	4.75%
BEHAVIORAL HEALTH	DIAGNOSTIC TESTING AND EVAL	31.56%	32.87%	31.04%	31.86%
	COLLABORATIVE CARE	0.03%	0.25%	0.40%	0.23%
	MEDICATION MANAGEMENT	8.88%	10.44%	11.21%	10.19%
	PSYCHOTHERAPY	48.18%	44.59%	45.35%	45.98%
<b>TOTAL</b>		100.00%	100.00%	100.00%	100.00%

# Diagnosis and Service Category – Distribution (percentage) of services

Percentages of services, by calendar year, diagnosis type, and service category					
DIAGNOSIS CATEGORY	SERVICE CATEGORY	CALENDAR YEAR			TOTAL
		2018	2019	2020	
ATTENTION DECIFIT DISORDER	DIAGNOSTIC TESTING AND EVAL	0.59%	0.75%	0.66%	0.66%
	COLLABORATIVE CARE	0.00%	0.01%	0.02%	0.01%
	MEDICATION MANAGEMENT	1.29%	1.94%	2.00%	1.73%
	PSYCHOTHERAPY	6.30%	6.66%	7.92%	6.94%
BEHAVIORAL HEALTH	DIAGNOSTIC TESTING AND EVAL	6.95%	8.71%	7.65%	7.75%
	COLLABORATIVE CARE	0.01%	0.13%	0.22%	0.12%
	MEDICATION MANAGEMENT	2.87%	4.60%	5.12%	4.16%
	PSYCHOTHERAPY	82.00%	77.20%	76.43%	78.62%
<b>TOTAL</b>		100.00%	100.00%	100.00%	100.00%

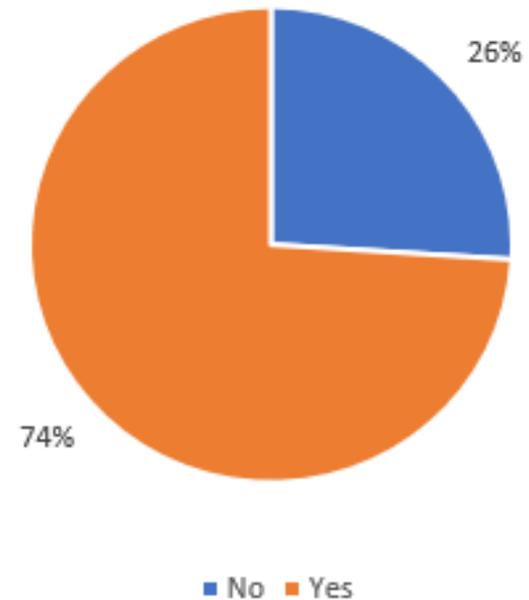
# Service Intensity

# Over the 3 year period from 2018-2020, how many clients received a follow up visit?

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FOLLOW UP VISITS

# of clients	Follow-up visit	% of Total Clients
33,341	No	26%
93,578	Yes	74%

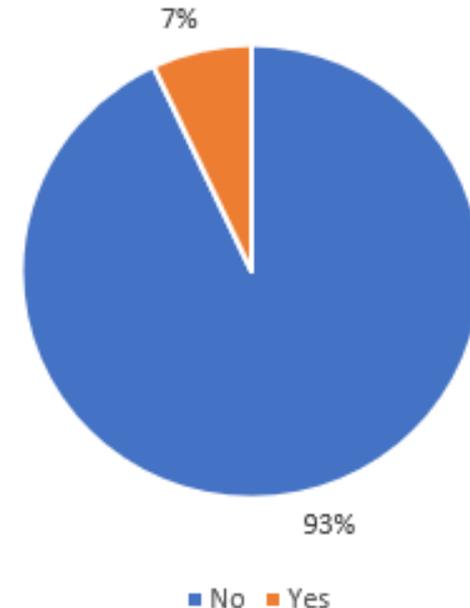


# Over the 3 year period from 2018-2020, how many clients received medication management only?

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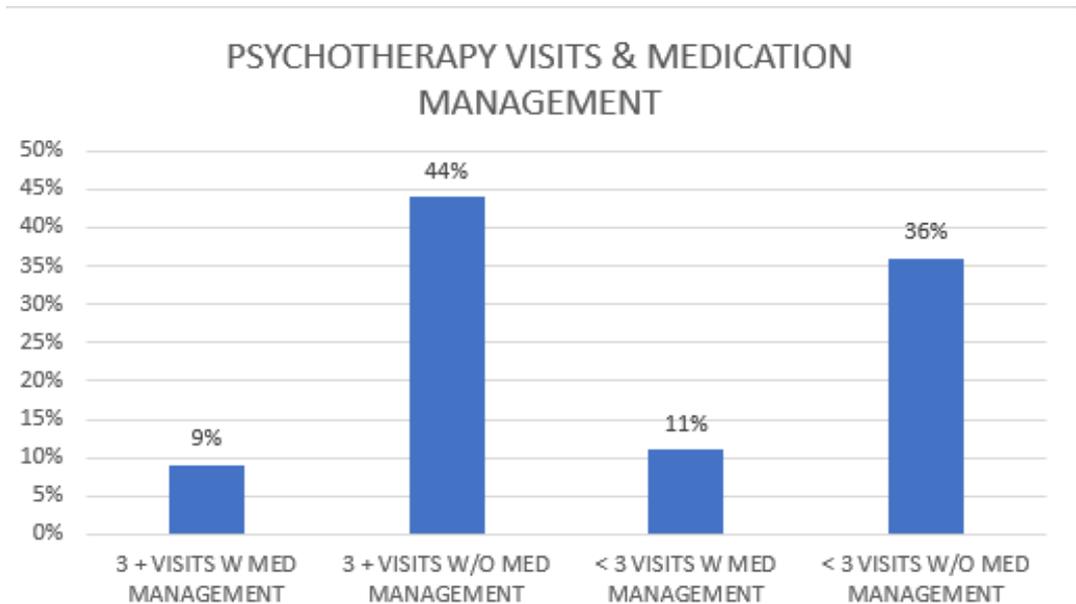
MEDICATION MANAGEMENT ONLY

# of clients	Medication Management Only	% of Total Clients
117,600	No	93%
9,319	Yes	7%



# Over the 3 year period from 2018-2020, how many clients received 3 or more psychotherapy visits?

Psychotherapy	Client %
3+ visits w/ med mngt	9%
3+ visits w/o med mngt	44%
<3 visits w/ med mngt	11%
<3 visits w/o med mngt	36%



## State Level - Over the 3 year period from 2018-2020, what was the average service intensity (median) excluding ER visits?

---

- ▶ The median number of services was 4 for all codes
- ▶ The median is the 'middle' value (number of visits) between the higher and lower ranges of aggregated service counts per client over the 3 year period

# By Region – Service Frequency

**Median service count by ACH region, by Calendar Year**

CLIENT ACH REGION	CALENDAR YEAR		
	2018	2019	2020
BETTER HEALTH TOGETHER	7	4	5
CASCADE PACIFIC ACTION ALLIANCE	2	2	4
ELEVATE HEALTH	3	3	3
GREATER COLUMBIA ACH	2	3	3
HEALTHIER HERE	4	3	3
NORTH CENTRAL ACH	4	3	3
NORTH SOUND ACH	5	5	5
OLYMPIC COMMUNITY OF HEALTH	3	3	3
SWACH	7	7	7

# Next Steps

# Discussion and Next Steps

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## ▶ Possible Next Steps:

- ▶ HCA data team is working to pull a similar data set for services provided by Behavioral Health Agencies from 2018-2020.
- ▶ HCA team is reviewing 2019 data to determine if service intensity and retention can be extracted for both primary care and behavioral health agency side.



# Thank you

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