TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTIONS

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Project Title	BH Intergration – Fully Integrated Person Centered Health Care

Rationale for the Project

Traditional silo approach to care is ineffective, inefficient, and costly. Over a decade of research clearly defines the value of integrating behavioral/mental and physical health; shifting focus from treating disease episodically to targeting upstream factors that influence health; coordinating care beyond the clinic walls. Without integrated care, achieving the triple aim is almost impossible [IHI Sept-Nov 2013] There is a strong correlation between chronic illness with depression and increased healthcare utilization. One in ten older adults suffers from depression (IMPACT 2012) The solution lies in integrated care, the systematic coordination of general and behavioral healthcare. Integrating mental health, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.

- One fifth of the US population live in rural areas covering 95% of land mass; disparities in care, treatment and services [people in poor households receive worse care and have less access to care than people in high income households{AHRQ disparities report 2014}
- Over 3.5M Medicaid beneficiaries [8.2%] receive prescriptions for anti-depressants, largely from primary care
- There is a strong correlation between chronic illness with depression and increased healthcare utilization. One in ten older adults suffers from depression (IMPACT 2012)
- Integrated settings reduce the stigma of seeking mental health care.
- Approximately 70% of all visits in primary care involve psychosocial factors. (Gater, et al, 1991)
- Primary care providers are the de facto mental health and addiction disorder providers for over 70% of the population. (Kessler, et al, 1994)
- Close to 80% of patients with depression go to their primary care physician first.
- Depression has been shown to increase overall health care costs by 50-100% [UW AIMS Center]
- Higher ACEs are associated with increased prevalence of chronic conditions and increased healthcare cost per person. Depression plus chronic conditions increase costs [State Foundation for Healthy Generations 2014]. Patients are better able to manage chronic conditions when depression is treated and managed [IHI 2-13]
- Integration is associated with better physical and behavioral health outcomes, reduced costs and better patient experience of care. [IHI R&D report 2013].

Using innovative service delivery systems improve care, increase efficiency, reduce costs, increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

Project Description

Research has demonstrated overwhelming evidence that points to the link between mental and physical health. Funding would be used to create integrated behavioral health teams of rural providers that includes primary care providers, care coordinators, pharmacists and behavioral health clinicians. Integrated care is defined as a comprehensive, systematic coordination of general and behavioral healthcare. Integrating physical, behavioral, mental health and primary care is a model that has demonstrated improved outcomes, reduced costs, and a better patient experience [SAMHSA, IHI, AHRQ]. The Washington Rural Health Collaborative (the Collaborative) is an existing, mature and robust rural health network consisting of 13 Critical Access Hospitals; all separately governed and predominately serving the rural areas of Washington. The mission of the Collaborative is to stimulate innovation thru agile partnerships to improve rural health care with a focus on quality, efficiency and sustainability. Together our members serve more than 4,143 patients per day. Annually, we are responsible for more than 7,625 inpatient discharges, 112,187 emergency department visits, 370,190 clinic visits, 499,560 outpatient visits and employ 150 providers. Net patient service revenue was nearly one-half billion dollars in 2013. Collaborative members predominantly serve Medicaid and Medicare beneficiaries, with a combined payer mix of approximately 67%.

Target Population: Adult and pediatric patients with behavioral/mental health disorders such as depression/anxiety, behaviors that influence overall health and individuals with chronic conditions in addition to serving the overall primary

care population. The individuals we serve reside in rural and remote rural areas and generally have low English proficiency and low health literacy. Video remote and in-person interpreter services are available. The model provides for on-site "just-in-time" consultation by the behavioral health provider in addition to scheduled visits, referrals from a variety of sources.

There are a number of models and integration levels. A majority of models follow the basic principles of the McCall Institute's Chronic Care Model, applying concepts of collaborative care for chronic disease specifically to behavioral health issues in the primary care setting [INI R&D 2013]. The Collaborative Care and Primary Care Medical Home models reflect a team based approach that provides the structure to incorporate behavioral/mental health and physical health. Primary care providers [including pediatrics], care managers, behavioral/mental health professionals, pharmacists function as a team.

Behavioral health services within the PCMH (Patient Centered Medical Home) are composed of two synergistic models (the PCBH model and the collaborative care model) designed to address both individual consultative and counseling needs and to address population health community-based screening needs. Because these two models encompass the primary-care-based behavioral assets, this program will address both of them. The overall goal of this blended PCMH-BHT is to assist the PCMH team in identifying, triaging, and managing patients with medical and/or behavioral health problems. In addition, the blending of these two models of care as used in the PCMH-BH allows the empaneled population to benefit from both models while recognize the link between physical health and mental health.

Internal Behavioral Health Consultants (IBHC) provides consultative behavioral health services on a wide range of behavioral health and medical conditions. The IBHC (a psychologist, social worker, or psychiatric nurse practitioner) provides consultation and recommendations to PCMs, focused assessment of referral problems, and brief evidence-based interventions. Patients are typically seen for one to four, 30-minute appointments. The IBHC does not perform psychotherapy or diagnostic procedures exceeding focused assessment or focused intervention.

Behavioral health care facilitators (BHCF) are specially trained registered nurses or Licensed Clinical Social Workers (LCSW) assigned to each practice who track and monitor treatment progress, assist with adherence to prescribed medication, and monitor psychiatric consultation on pharmacological treatment. They work with patients presenting with depression, post-traumatic stress disorder (PTSD), anxiety, and alcohol misuse and provide updates to the PCP on treatment adherence and clinical progression.

Pharmacists will provide expertise in the area of medication management. Onsite Pharmacists will assist and consult on medication reconciliation to avoid inadvertent inconsistencies across transitions in care by reviewing the patient's complete medication regimen at the time of admission, transfer, and discharge and comparing it with the regimen being considered for the new setting of care.

Data Analysts will work closely with the BHCF to identify and track high-risk patients using claims data. In addition to collecting, analyzing and modeling of data, the Analyst will analyze and report on the cost and quality data to ensure we are meeting the project goals.

The model provides for on-site on-demand consultation by the behavioral health provider in addition to scheduled visits, referrals from a variety of sources. The model embodies care coordination/collaboration/management with emphasis on patient engagement, empowerment and self-care. Attention to the social determinants of health is an integral part of this comprehensive model with connectivity to community resources and other agencies such as housing. Evidenced based instruments, tools/techniques are deployed [e.g. motivational interviewing, SBRIT (screening, brief intervention, referral to treatment), acceptance and commitment therapy. Engagement in prevention activities and health behavior change activities is a key component. Outreach activities involve support, education and guidance for lay health care workers/coaches. Staff will be located in each of the Primary Care Clinics.

Core Investment Components

The project will start small and employ rapid cycle improvement management using standard quality tools for implementation, identifying improvements to achieve breakthrough improvements in performance within a rapid time frame allowing us to quickly expand and scale the program.

Staffing is based on ratios as follows:

- 1 IBHC per 3,000 enrolled adult population
- 2 IBHCs per 15,000 enrolled adult population
- 3 IBHCs per 30,000 enrolled adult population
- 1 BHCF > 7,500 enrolled adult population (at least 1 BHCF per community)
- 1 Pharmacist > 6,500 enrollees
- 1 Data Analyst

Optimal caseloads for BHCFs are sixty (60) patients and maximum caseload is eighty (80) patients.
Estimated cost salaries: (Estimate total cost per community is dependent on volume and staffing)

Position	Estimated Annual Salaries
Psychiatric nurse practitioner (IBHC)	$91,000
Licensed Clinical Social Worker (IBHC)	$61,000
Psychiatric RN (BHCF)	$75,000
Decision Support Analyst	$70,000
Pharmacist	120,000
Data Warehouse	.60 pmpm
Clinic Data Warehouse Interface	$4000 per practice

Estimated ROI based on results for the implementation of the Collaborative Care model showed

- Intervention yielded net savings in every category of the health care cost examined, including pharmacy, inpatient and outpatient medical, and mental health specialty care.
- By year two, 2% reduction in costs; return based on other models and demonstrated results anticipated savings
- By year four, for every $1.00 spent will save $6.50 in health costs

Project Metrics

The following project metrics will be used to measure the success of the project:

Short Term:

1. Improved access to care (6,10)
2. Clinical measures such as A1C for chronic conditions [sustained within target range] (14,15, 16)
3. Medication adherence [includes reduction in acute episodes related to adherence failure (36, 37, 38)
4. Improvement in overall depression scores [typically represents a large percent of patients] (4)
5. Decrease resource consumption [admissions, ED visits, repeat office visits] (41,42,43)
6. Patient experience of care [CGCAPHS] (23)
7. Improved continuity of case resulting improved outcomes

Long Term:

1. Reduce annual state-purchased health care spending relative to State's GDP by xx (50)
2. Reduce spending per enrollee by xx (51)
3. Improvement in health ranking scores

In order to successfully measure the success of the work, participants will need full access to claims data.