Behavioral Health Integration in Primary Care Continuum Based Framework

January 21, 2021 | 12-1PM
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Who’s Around the Virtual Table
The IPRO QIN-QIO: Where We Are

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Healthcentric Advisors:
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Qlarant:
Maryland, Delaware, and the District of Columbia

Working to ensure high-quality, safe healthcare for 20% of the nation’s Medicare FFS beneficiaries
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**SWEEP: Strategic Web-based Education & Engagement Plan**

- A virtual, multi-event learning program.
- Brings together technology, education, and support.
- Consists of
  - **Presentations** - a gathering of healthcare providers from across our network
  - **Learning Circles** - a QIN-facilitated conversation conducted in smaller groups.
Behavioral Health Integration in Primary Care Continuum Based Framework

Henry Chung, MD
Senior Medical Director, Montefiore Care Management Organization
Professor of Psychiatry, Albert Einstein College of Medicine
Project Sponsors

Support for this work was provided by United Hospital Fund (UHF). UHF Works to build a more effective health care system for every New Yorker. An independent, nonprofit organization, UHF analyzes public policy to inform decision-makers, finds common ground among diverse stakeholders, and develops and supports innovative programs that improve the quality, accessibility, affordability, and experience of patient care. The views presented here are those of the authors and not necessarily those of UHF or its directors, officers, or staff. To learn more, visit uhfnc.org.

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Agenda

Goals of BHI Framework in Primary Care

BHI Framework Domains and Subdomains

Framework: Levels of Integration

Next Steps

• Readiness Assessment Timeline
• Sharing resources and publications
• Evaluate the SWEEP progress and present results

Discussion
Framework Development Team

• Project Director: Henry Chung, MD
• Project Manager: Ekaterina Smali, MPA
• Project Consultants:
  – Harold Pincus, MD, NY, Presbyterian Hospital and Columbia University
  – Matthew L. Goldman, MD, MPH, UC San Francisco

References:
Behavioral Health Integration (BHI) Framework Goals

Purpose: To advance the ability of primary care practices to integrate behavioral healthcare into their practices and inform clinicians, policymakers, payers in supporting and sustaining integration efforts.

• **Goal #1:** help practices prioritize BHI implementation activities including plans for sustaining their progress.
• **Goal #2:** inform the primary care field on key project outcomes, inform priorities for BH integration in small practices, and disseminate best practices.
BHI Framework Domains & Subdomains

1. Case finding, screening, referral to care
   1.1 Screening, initial assessment, and follow-up for BH conditions
   1.2 Facilitation of referrals, feedback

2. Decision support for measurement-based stepped care
   2.1 Evidence-based guidelines/treatment protocols
   2.2 Useful psychiatric medication
   2.3 Access to evidence-based psychotherapy with BH provider(s)

3. Information exchange among providers
   3.1 Sharing treatment information

4. Ongoing care management
   4.1 Longitudinal clinical monitoring and engagement
BHI Framework Domains & Subdomains (Cont’d)

5. **Self-management support that is culturally adapted**
   - 5.1 Use of tools to promote patient activation and recovery with adaptations for literacy, language, local community norms

6. **Multi-disciplinary team (including patients) used to provide care**
   - 6.1 Care team
   - 6.2 Systematic multi-disciplinary team-based patient care review processes

7. **Systematic Quality Improvement**
   - 7.1 Use of quality metrics for program improvement

8. **Linkages with community and social services**
   - 8.1 Linkages to housing, entitlement, and other social support services

9. **Sustainability**
   - 9.1 Build process for billing and outcome reporting to support sustainability of integration efforts
# Framework: Guide to Implementing Behavioral Health Integration

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<tr>
<th>Role</th>
<th>Key elements of integrated care</th>
<th>Integration continuum</th>
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<td><strong>Domains</strong></td>
<td><strong>Components</strong></td>
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<tr>
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<td><strong>1. Case finding, screening, referral to care</strong></td>
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<td>PCP initiated, limited ability to refer or receive guidance</td>
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<td>Access to evidence-based psychotherapy with BH provider(s)</td>
<td>Supportive guidance provided by PCP, with limited ability to refer</td>
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<td>Brief patient education on BH condition by PCP</td>
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<td>Workforce 6. Multidisciplinary team (including patients) used to provide care</td>
<td>Care team</td>
<td>PCP; patient</td>
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<td>Management Support 7. Systematic quality improvement</td>
<td>Use of quality metrics for program improvement</td>
<td>Limited written communication and interpersonal interaction between PCP-BH provider(s)</td>
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<td>Linkages with community/social services</td>
<td>Few linkages to social services, no formal arrangements</td>
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<td>9. Sustainability</td>
<td>Build process for billing and outcome reporting to support sustainability of integration efforts</td>
<td>Limited ability to bill for screening and treatment, or services supported primarily by grants</td>
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Framework Levels of Integration

- Domain 1: case finding, screening, referral to care.
- Subdomain 1: screening, initial assessment, and follow-up.

**Preliminary**
- Patient and/or clinician identification of those with symptoms—not systematic

**Intermediate**
- **Level I:** Systematic screening of target populations (e.g., diabetes, CAD), with follow-up for assessment
- **Level II:** Systematic screening of all patients, with follow-up for assessment and engagement

**Advanced**
- Analysis of patient population to stratify patients with high-risk BH conditions for proactive assessment and engagement

Integration Continuum
Framework Levels of Integration

- Domain 1: case finding, initial assessment, and referral to care.
- Subdomain 2: facilitation of referrals, feedback.

- **Preliminary**
  - Referral only, to external BH provider(s)/psychiatrist

- **Intermediate**
  - **Level I**: Referral to external BH provider(s)/psychiatrist through a formal agreement detailing engagement, with feedback strategies
  - **Level II**: Enhanced referral to internal/co-located BH provider(s)/psychiatrist, with assurance of “warm handoffs” when needed

- **Advanced**
  - Enhanced referral facilitation with feedback via EHR or alternate data-sharing mechanism, and accountability for engagement
Framework Levels of Integration

- **Domain 2**: decision support for measurement-based, stepped care.
- **Subdomain 1**: evidence-based guidelines/treatment protocols.

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<th>Preliminary</th>
<th>Intermediate</th>
<th>Advanced</th>
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|                       | • None, with limited training on BH disorders and treatment | **Level I**: PCP training on evidence-based guidelines for common behavioral health diagnoses and treatment  
**Level II**: Standardized use of evidence-based guidelines for all patients; tools for regular monitoring of symptoms  | • Systematic tracking of symptom severity; protocols for intensification of treatment, when appropriate |
Framework Levels of Integration

- **Domain 2**: decision support for measurement-based, stepped care.
- **Subdomain 2**: use of psychiatric medications.

**Preliminary**
- PCP-initiated, limited ability to refer or receive guidance

**Intermediate**
- **Level I**: PCP-initiated, and referral when necessary to prescribing BH provider(s)/psychiatrist for medication follow-up
- **Level II**: PCP-managed with prescribing BH provider(s)/psychiatrist as necessary

**Advanced**
- PCP-managed with care management (CM) supporting adherence between visits and BH prescriber(s)/psychiatrist support
Framework Levels of Integration

- Domain 2: decision support for measurement-based, stepped care.
- **Subdomain 3:** access to evidence-based psychotherapy treatment with BH provider(s).

**Preliminary**
- Supportive guidance provided by PCP, with limited ability to refer

**Intermediate**
- **Level I:** Referral to external resources for counseling interventions
- **Level II:** Brief psychotherapy interventions provided by co-located BH provider(s)

**Advanced**
- Range of evidence-based psychotherapy provided by co-located BH provider(s) as part of overall care team, with exchange of information
Framework Levels of Integration

- Domain 3: information exchange among providers.
- Subdomain 1: sharing of treatment information.

**Preliminary**
- Minimal sharing of treatment information within care team

**Intermediate**
- **Level I:** Informal phone or hallway exchange of treatment information, without regular chart documentation
- **Level II:** Exchange of treatment information through in-person or telephonic contact, with chart documentation

**Advanced**
- Routine sharing of information through electronic means (registry, shared EHR, shared care plans)

Integration Continuum
Framework Levels of Integration

- **Domain 4: ongoing care management.**
- **Subdomain 1:** longitudinal clinical monitoring and engagement.

**Preliminary**
- Limited follow-up of patients provided by office staff

**Intermediate**
- **Level I:** Proactive follow-up (no less than monthly) to ensure engagement or early response to care
- **Level II:** Use of tracking tool to monitor symptoms over time and proactive follow-up with reminders for outreach

**Advanced**
- Tracking integrated into EHR, including severity measurement, visits, CM interventions (e.g., relapse prevention techniques, behavioral activation), proactive follow-up; selected medical measures (e.g., blood pressure, A1C) tracked when appropriate
Framework Levels of Integration

- Domain 5: self-management support that is culturally adapted.
- **Subdomain 1:** use tools to promote patient activation and recovery, with adaptations for literacy, language, local community norms.

### Preliminary
- Brief patient education on BH condition by PCP

### Intermediate
- **Level I:** Brief patient education on BH condition, including materials/handouts and symptom score reviews, but limited focus on self-management goal-setting
- **Level II:** Patient education and participation in self-management goal-setting (e.g., sleep hygiene, medication adherence, exercise)

### Advanced
- Systematic education and self-management goal-setting, with relapse prevention and CM support between visits

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**Integration Continuum**
Framework Levels of Integration

- Domain 6: multi-disciplinary team (including patients) used to provide care.
- Subdomain 1: care team.

Preliminary

- **Level I**: PCP, patient

Intermediate

- **Level I**: PCP, patient, and ancillary staff member
- **Level II**: PCP, patient, ancillary staff member CM, and BH provider(s)

Advanced

- PCP, patient, ancillary staff member, CM, BH provider(s), psychiatrist (contributing to shared care plans)
Framework Levels of Integration

- Domain 6: multi-disciplinary team (including patients) used to provide care.
- Subdomain 2: systematic multidisciplinary team-based patient care review processes.

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<tr>
<td>• Limited written communication and interpersonal interaction between PC-BH provider(s), driven by necessity or urgency, or patient</td>
<td>• <strong>Level I</strong>: Regular written communication (notes/consult reports) between PCP and BH provider(s), occasional information exchange via ancillary staff or labs, on complex patients</td>
<td>• Weekly team-based case reviews to inform care planning and focus on patients not improving behaviorally or medically, with capability of informal interaction between PCP and BH provider(s)</td>
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<td>• <strong>Level II</strong>: Regular in-person, phone, or e-mail meetings between PCP and BH provider(s) to discuss complex cases</td>
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Integration Continuum
Framework Levels of Integration

- **Domain 7: systematic quality improvement.**
- **Subdomain 1: use of quality metrics for program improvement.**

**Preliminary**
- Informal or limited use of BH quality metrics (limited use of data, anecdotes, case series)

**Intermediate**
- **Level I:** Use of identified metrics (e.g., depression screening rates, depression response rates) and some ability to regularly review performance
- **Level II:** Use of identified metrics, with some ability to respond to findings using formal improvement strategies

**Advanced**
- Ongoing systematic quality improvement (QI) with monitoring of population-level performance metrics, and implementation of improvement projects by QI team/champion
Framework Levels of Integration

- Domain 8: linkages with community/social services.
- **Subdomain 1:** linkages to housing, entitlement, and other social support services.

### Preliminary
- Few linkages to social services, no formal arrangements

### Intermediate
- **Level I:** Referrals made to agencies, some formal arrangements, but little capacity for follow-up
- **Level II:** Screening for social determinants of health (SDOH), patients linked to community organizations/resources, with follow-up

### Advanced
- Developing, sharing, implementing unified care plan between agencies, with SDOH referrals tracked

Integration Continuum
Framework Levels of Integration

- **Domain 8: sustainability.**
- **Subdomain 1:** build process for billing and outcome reporting to support sustainability of integration efforts.

**Preliminary**
- Limited ability to bill for screening and treatment, or services supported primarily by grants

**Intermediate**
- **Level I:** Billing for screening and treatment services (e.g., SBIRT, PHQ screening, BH treatment, care coordination) under FFS, with process in place for tracking reimbursements
- **Level II:** FFS billing, and revenue from quality incentives related to BHI

**Advanced**
- Receipt of global payments that reference achievement of behavioral health and general health outcomes
Summary of Key Critical Steps to Behavioral Health Integration in Primary Care

- Systematically Screen for BH Conditions Using Patient Self Report Methods
  - e.g. PHQ9, GAD7, AUDIT-C
  - Collaborative agreement with specialty BH provider

- Repeated Measurement of a Measure Outcome Using a Tracking Tool
  - Assertive Follow-Up/Care Management to Promote adherence to treatment

- Improve Teamwork in Practice
  - Everyone contributes to whole health
  - Integrated patient visits

- Expand Roles of Office Staff to Play Care Management Roles

- Establish Warm Handoff Capability with on Site or Off Site BH Provider
Role of BH Clinician in Practice Sites

- **Diagnostic and Measurement informed**
- **Documentation in succinct and care plan informed style**
  - **NOT** Psychotherapy notes, unless there is another separate section
- **Open to supporting chronic medical conditions, and behaviorally complex (non-adherence, pain)**
- **Open Door Policy**
- **Outreach, engagement, and follow-up**
- **Using behavioral activation techniques to support patient self management**
Comprehensive BH Workflow: Internal and External Pathways

Patient populations: Enters clinic by appointment or walk-in

PHQ Screening Completed by:
- MA
- Nurse
- BHP
- Patient

Positive: PHQ entered into EHR & Tracking Tool
- Seen by PCP to Initiate Evidence-Based Treatment (education, meds)
  - BH Specialty Care Needed
  - Model A: External BH Care
    - Referral partner with established collaborative agreement.
  - BH Clinical Tracking Tools
  - Referral Tracking

Negative: PHQ entered into EHR
- No BH Care Required (BH screens re-administered at annual wellness visit)

Model B: Internal BH Team Care
- Co-located BHP (social worker, psychologist, or psychiatrist) part of care team
Lessons for Primary Care Practices in Integrated Care Settings

- Engagement of executive leadership for early buy-in
- Early and regular staff involvement at all levels
- Collaborative agreements strengthen referrals, care coordination, and external referral communication

- Quality improvement requires additional support
- Participation in policy or quality improvement initiatives
- Financial sustainability is critical

- BH providers face unique challenges in integrated setting
- Integrated visits are effective
- Clinical BH tracking tools that are integrated into EHR
- Condensed BH treatment planning notes facilitate information sharing in EHR

- PCPs benefit from ongoing training to expand the scope of BH care they can provide
- Self-management supports help patients stay engaged.

Practice Champions and Partnerships

Training and Education

Quality and Sustainability

Clinical Workflow and Tracking
Next Steps

Readiness Assessments Timeline

• Readiness Assessment complete by 2/3/21: www.surveymonkey.com/r/B8PHRCK
• Post Assessment complete by April 30th

Bi-weekly Learning Circles from 12-1PM

• February 3 – Sustainability: Coding and Telehealth
• February 17 – Screening & Referral to Behavioral Care
• March 3 – Collaborative Contracting
• March 17 – Ongoing Care Management Process (Info & Data Sharing)
• March 31 – Evidence-Based Care & Self-Management
• April 14 – Community and Social Services Linkages
• May 26 – Where to Go From Here

Publications

• Read the resources shared during the sessions
Discussion

We welcome your questions and comments!
# Your SWEEP Team

Have a question? Contact us!

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<tr>
<td>Bonnie Horvath</td>
<td><a href="mailto:horvathb@qlarant.com">horvathb@qlarant.com</a></td>
<td>Qlarant</td>
<td></td>
<td></td>
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<tr>
<td>Laura Benzel</td>
<td><a href="mailto:benzell@qlarant.com">benzell@qlarant.com</a></td>
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<tr>
<td>Chris Stegel</td>
<td><a href="mailto:cstegel@ipro.org">cstegel@ipro.org</a></td>
<td>IPRO</td>
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<tr>
<td>Lynn Wilson</td>
<td><a href="mailto:lwilson@ipro.org">lwilson@ipro.org</a></td>
<td>IPRO</td>
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<tr>
<td>Gail Gresko</td>
<td><a href="mailto:ggresko@ipro.org">ggresko@ipro.org</a></td>
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Serving 20% of the nation’s Medicare Beneficiaries.

We’re collaborating with health care organizations to ensure high-quality, safe, and effective health care for Medicare beneficiaries in New England, New York, New Jersey, Ohio, Delaware, Maryland, and the District of Columbia.

We recognize the myriad challenges facing health care organizations and community-based partners.

We offer free technical support and education to help you address these challenging issues.

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This material was prepared by the IPRO QIN-QIO, a collaboration of Healthcentric Advisors, Qlarant and IPRO, serving as the Medicare Quality Innovation Network-Quality Improvement Organization for the New England states, NY, NJ, OH, DE, MD, and the District of Columbia, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents do not necessarily reflect CMS policy. 12SOW-IPRO-QIN-T2-A1-20-252