Behavioral Health Integration in Primary Care Continuum Based Framework

January 21, 2021 | 12-1PM

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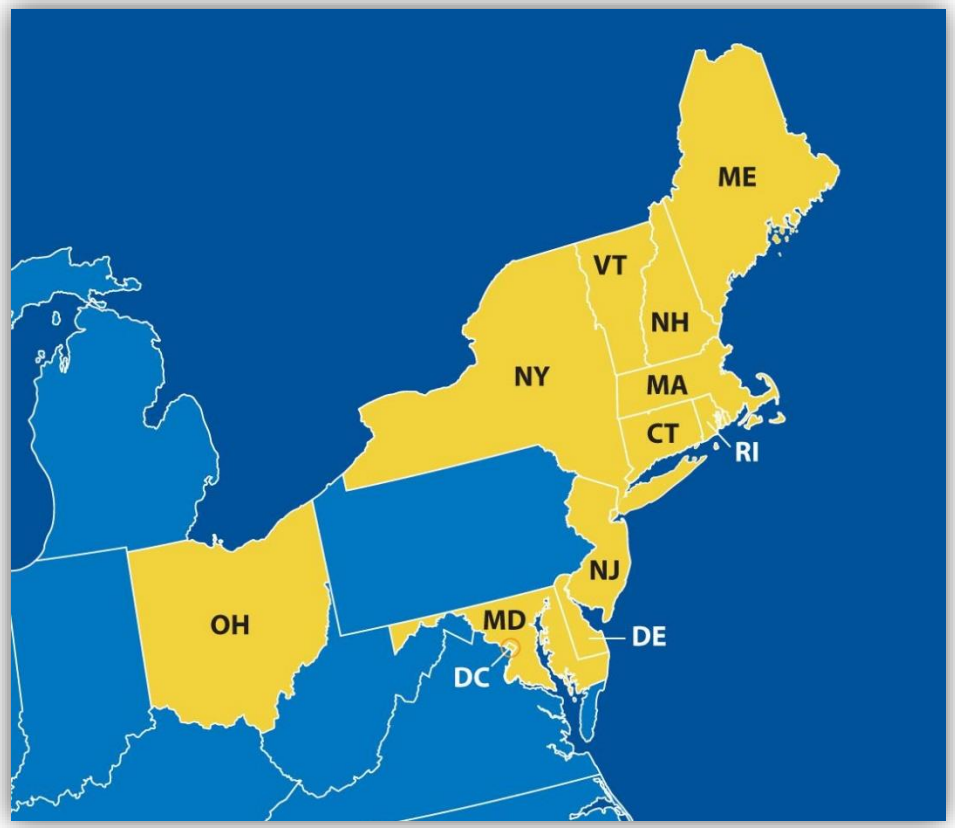

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SWEEP: Strategic **W**eb-based **E**ducation & **E**ngagement **P**lan

- 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.

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Behavioral Health Integration in Primary Care Continuum Based Framework

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Project Sponsors

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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

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Framework Development Team

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References:

Goldman ML, Smali E, Richkin T, Pincus HA, Chung H.Transl Behav Med. 2020 Aug 7;10(3):580-589. doi: 10.1093/tbm/ibz142.

Chung H, Smali E, Goldman ML, Pincus HA. Evaluation of Novel Continuum Based Framework of Integration in Primary Care. https://uhfnyc.org/media/filer_public/61/87/618747cf-9f4b-438d-aaf7-6feff91df145/bhi_finalreport.pdf

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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

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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

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Framework: Guide to Implementing Behavioral Health Integration

Role	Key elements of integrated care		Integration continuum			
	Domains	Components	Preliminary	Intermediate		Advanced
Clinical Workflow	1. Case finding, screening, referral to care	Screening, initial assessment, follow-up for BH conditions	Patient/clinician identification of those with BH symptoms—not systematic	Systematic BH screening of targeted patient groups (e.g., those with diabetes, CAD), with follow-up for assessment	Systematic BH screening of all patients, with follow-up for assessment and engagement	Analysis of patient population to stratify patients with high-risk BH conditions for proactive assessment and engagement
		Facilitation of referrals, feedback	Referral only, to external BH provider(s)/ psychiatrist	Referral to external BH provider(s)/psychiatrist through a formal agreement detailing engagement, with feedback strategies	Enhanced referral to internal/ co-located BH provider(s)/ psychiatrist, with assurance of "warm handoffs" when needed	Enhanced referral facilitation with feedback via EHR or alternate data-sharing mechanism, and accountability for engagement
	2. Decision support for measurement-based stepped care	Evidence-based guidelines/ treatment protocols	None, with limited training on BH disorders and treatment	PCP training on evidence-based guidelines for common behavioral health diagnoses and treatment	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
		Use of psychiatric medications	PCP-initiated, limited ability to refer or receive guidance	PCP-initiated, with referral when necessary to prescribing BH provider(s)/psychiatrist for medication follow-up	PCP-managed, with support of prescribing BH provider(s)/ psychiatrist as necessary	PCP-managed, with care management (CM) supporting adherence between visits and BH prescriber(s)/ psychiatrist support
		Access to evidence-based psychotherapy with BH provider(s)	Supportive guidance provided by PCP, with limited ability to refer	Referral to external resources for counseling interventions	Brief psychotherapy interventions provided by co-located BH provider(s)	Range of evidence-based psychotherapy provided by co-located BH provider(s) as part of overall care team, with exchange of information
	3. Information exchange among providers	Sharing of treatment information	Minimal sharing of treatment information within care team	Informal phone or hallway exchange of treatment information, without regular chart documentation	Exchange of treatment information through in-person or telephonic contact, with chart documentation	Routine sharing of information through electronic means (registry, shared EHR, shared care plans)
	4. Ongoing care management	Longitudinal clinical monitoring and engagement	Limited follow-up of patients by office staff	Proactive follow-up (no less than monthly) to ensure engagement or early response to care	Use of tracking tool to monitor symptoms over time and proactive follow-up with reminders for outreach	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

(Continued)

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Framework: Guide to Implementing Behavioral Health Integration (Cont'd)

Role	Key elements of integrated care		Integration continuum			
	Domains	Components	Preliminary	Intermediate		Advanced
Clinical Workflow (continued)	5. Self-management support that is culturally adapted	Use of tools to promote patient activation and recovery with adaptations for literacy, language, local community norms	Brief patient education on BH condition by PCP	Brief patient education on BH condition, including materials/handouts and symptom score reviews, but limited focus on self-management goal-setting	Patient education and participation in self-management goal-setting (e.g., sleep hygiene, medication adherence, exercise)	Systematic education and self-management goal-setting, with relapse prevention and CM support between visits
Workforce	6. Multi-disciplinary team (including patients) used to provide care	Care team	PCP, patient	PCP, patient, ancillary staff member	PCP, patient, ancillary staff member, CM, BH provider(s)	PCP, patient, ancillary staff member, CM, BH provider(s), psychiatrist (contributing to shared care plans)
		Systematic multidisciplinary team-based patient care review processes	Limited written communication and interpersonal interaction between PC-BH provider(s), driven by necessity or urgency, or patient as conduit	Regular written communication (notes/consult reports) between PCP and BH provider(s), occasional information exchange via ancillary staff or labs, on complex patients	Regular in-person, phone, or e-mail meetings between PCP and BH provider(s) to discuss complex cases	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)
Manage-ment Support	7. Systematic quality improvement	Use of quality metrics for program improvement	Informal or limited use of BH quality metrics (limited use of data, anecdotes, case series)	Use of identified metrics (e.g., depression screening rates, depression response rates) and some ability to regularly review performance	Use of identified metrics, some ability to respond to findings using formal improvement strategies	Ongoing systematic quality improvement (QI) with monitoring of population-level performance metrics, and implementation of improvement projects by QI team/champion
	8. Linkages with community/ social services	Linkages to housing, entitlement, other social support services	Few linkages to social services, no formal arrangements	Referrals made to agencies, some formal arrangements, but little capacity for follow-up	Screening for social determinants of health (SDOH), patients linked to community organizations/ resources, with follow-up	Developing, sharing, implementing unified care plan between agencies, with SDOH referrals tracked
	9. Sustainability	Build process for billing and outcome reporting to support sustainability of integration efforts	Limited ability to bill for screening and treatment, or services supported primarily by grants	Billing for screening and treatment services (e.g., SBIRT, PHQ screening, BH treatment, care coordination) under FFS, with process in place for tracking reimbursements	FFS billing, and revenue from quality incentives related to BHI	Receipt of global payments that reference achievement of behavioral health and general health outcomes

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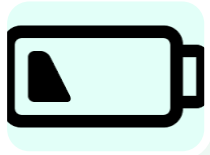
Framework Levels of Integration

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

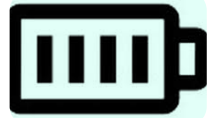


Preliminary

- 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

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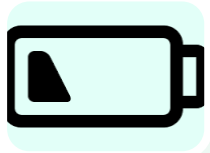
Framework Levels of Integration

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

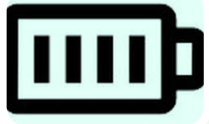


Preliminary

- 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

Integration Continuum

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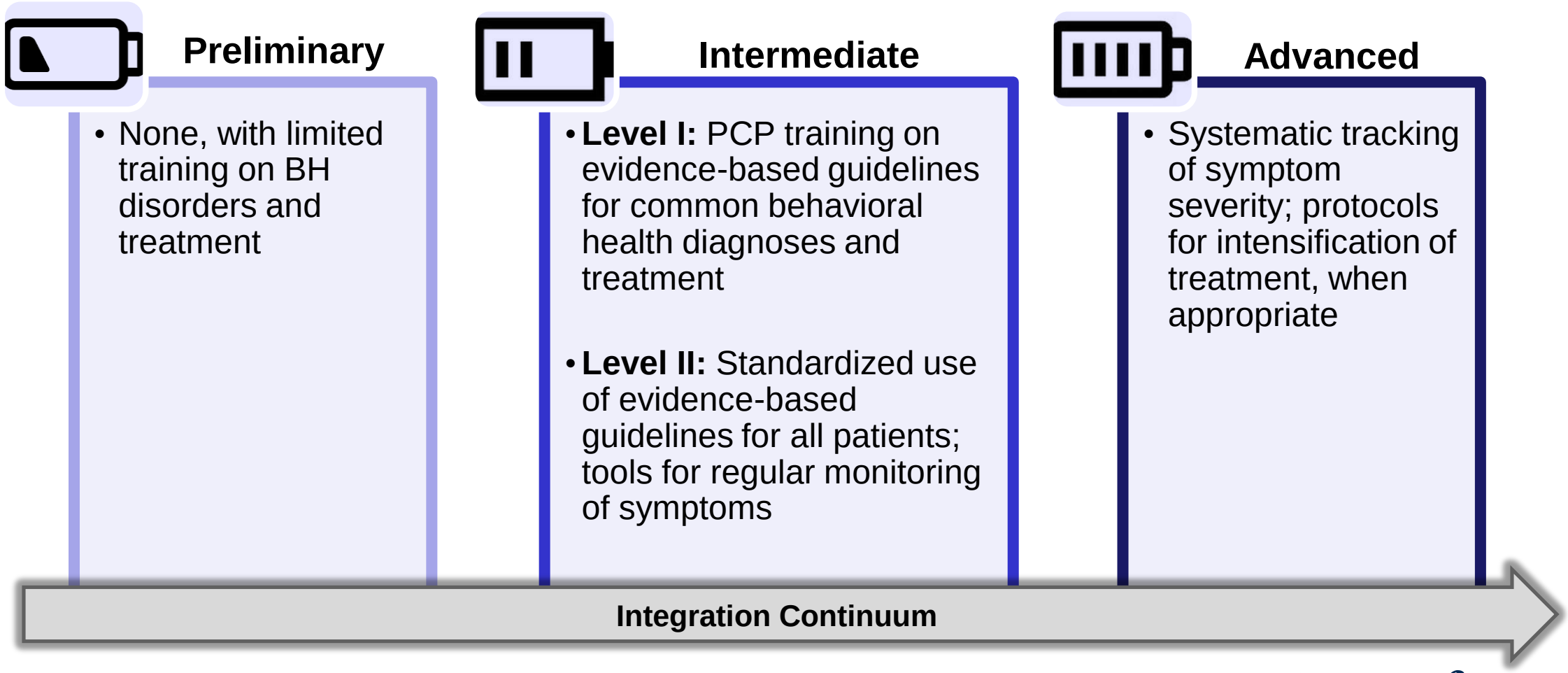
Framework Levels of Integration

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



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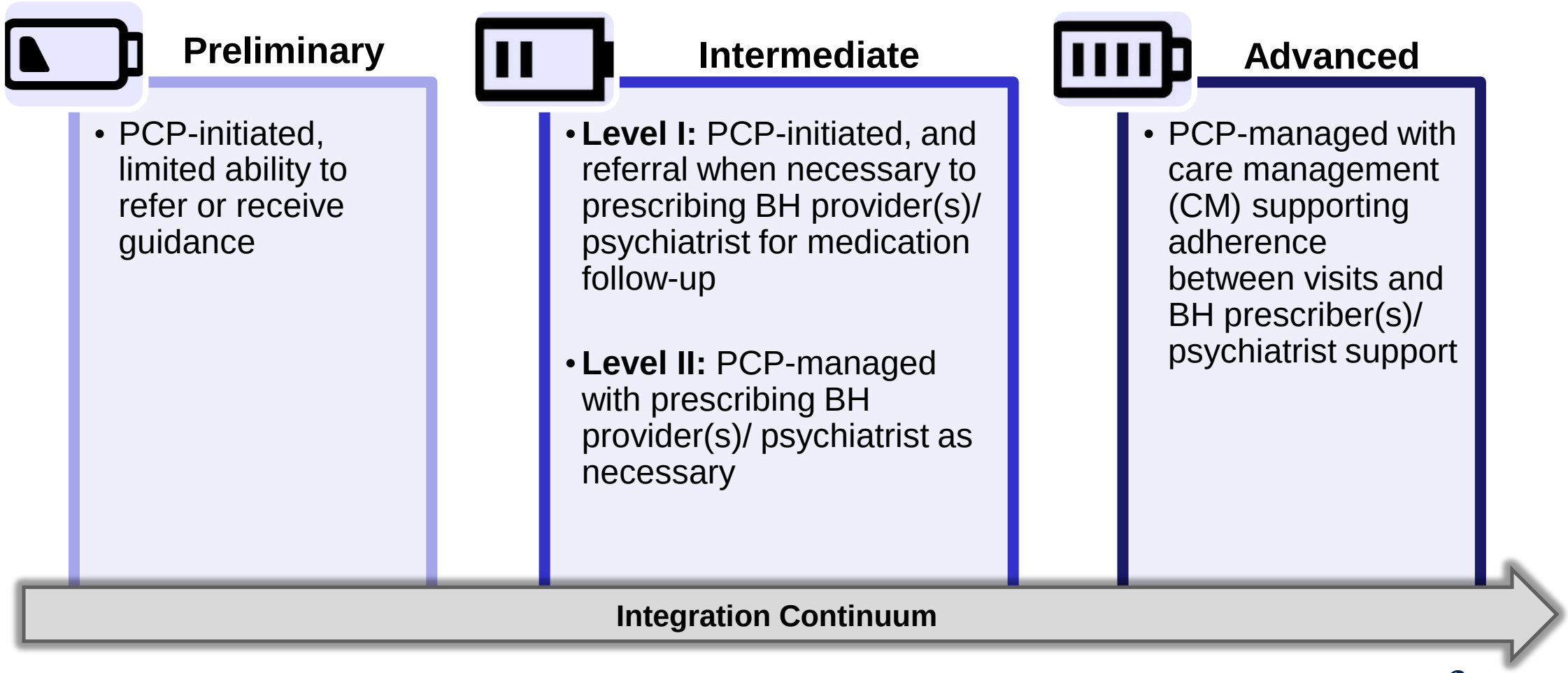
Framework Levels of Integration

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



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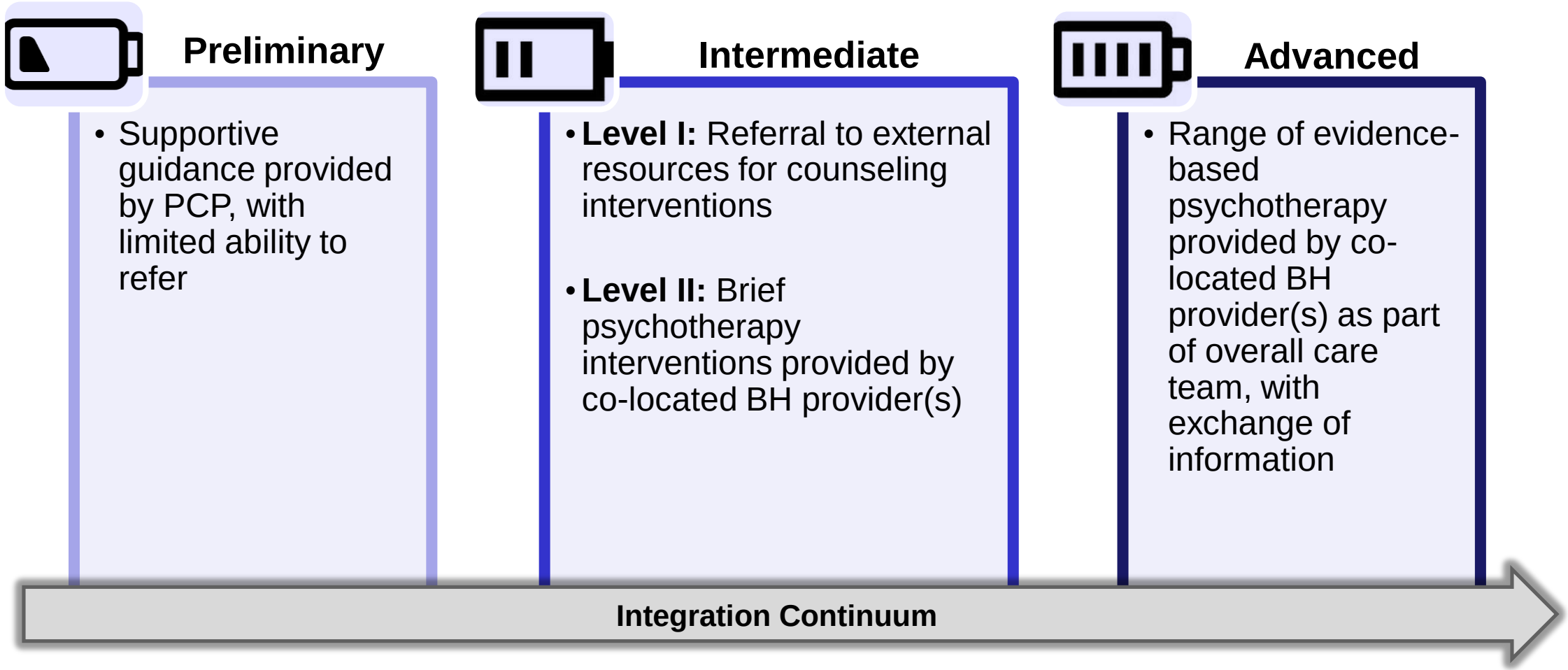
Framework Levels of Integration

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



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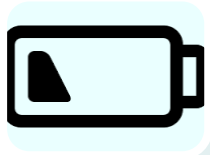
Framework Levels of Integration

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

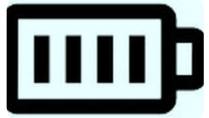


Preliminary

- 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)

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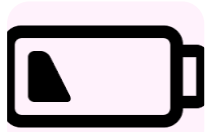
Framework Levels of Integration

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

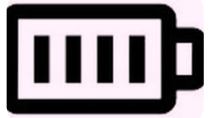


Preliminary

- 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

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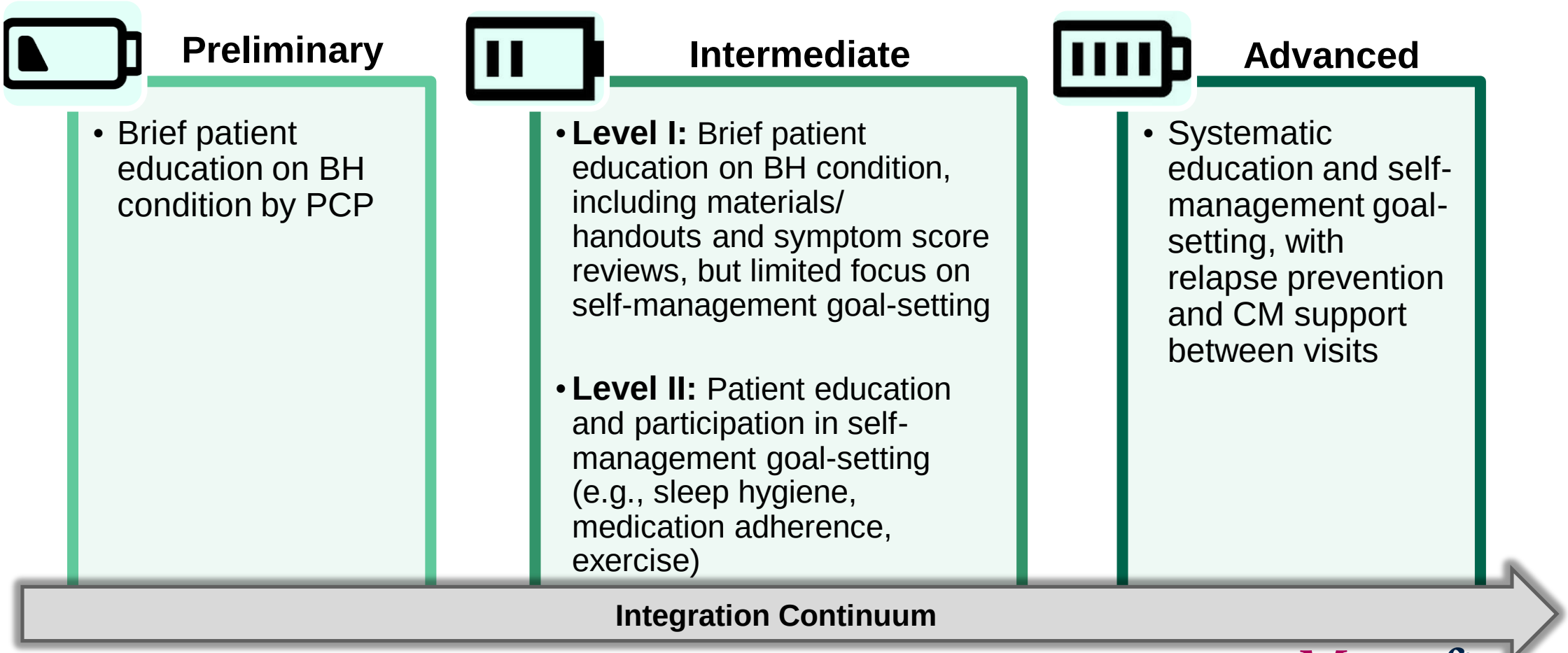
- **Domain 5: self-management support that is culturally adapted.**
- **Subdomain 1:** *use tools to promote patient activation and recovery, with adaptations for literacy, language, local community norms.*



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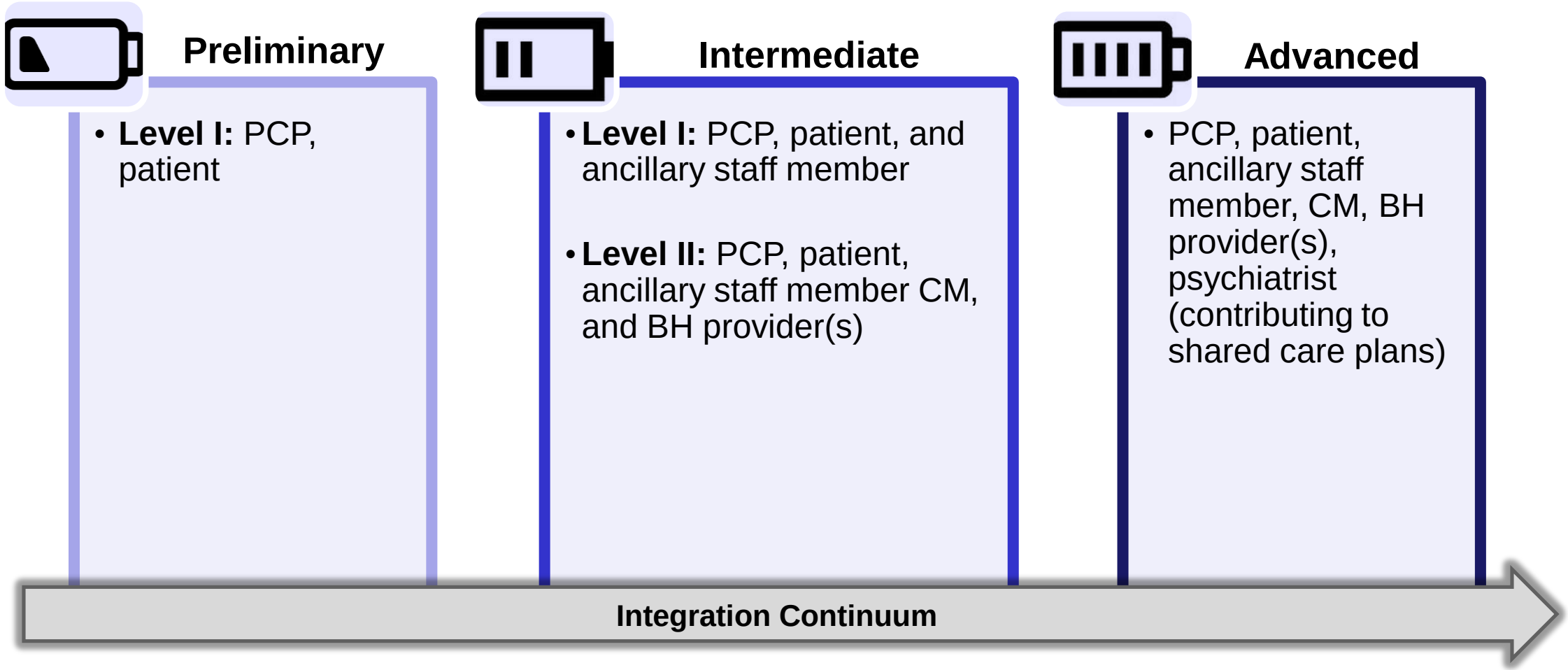
Framework Levels of Integration

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



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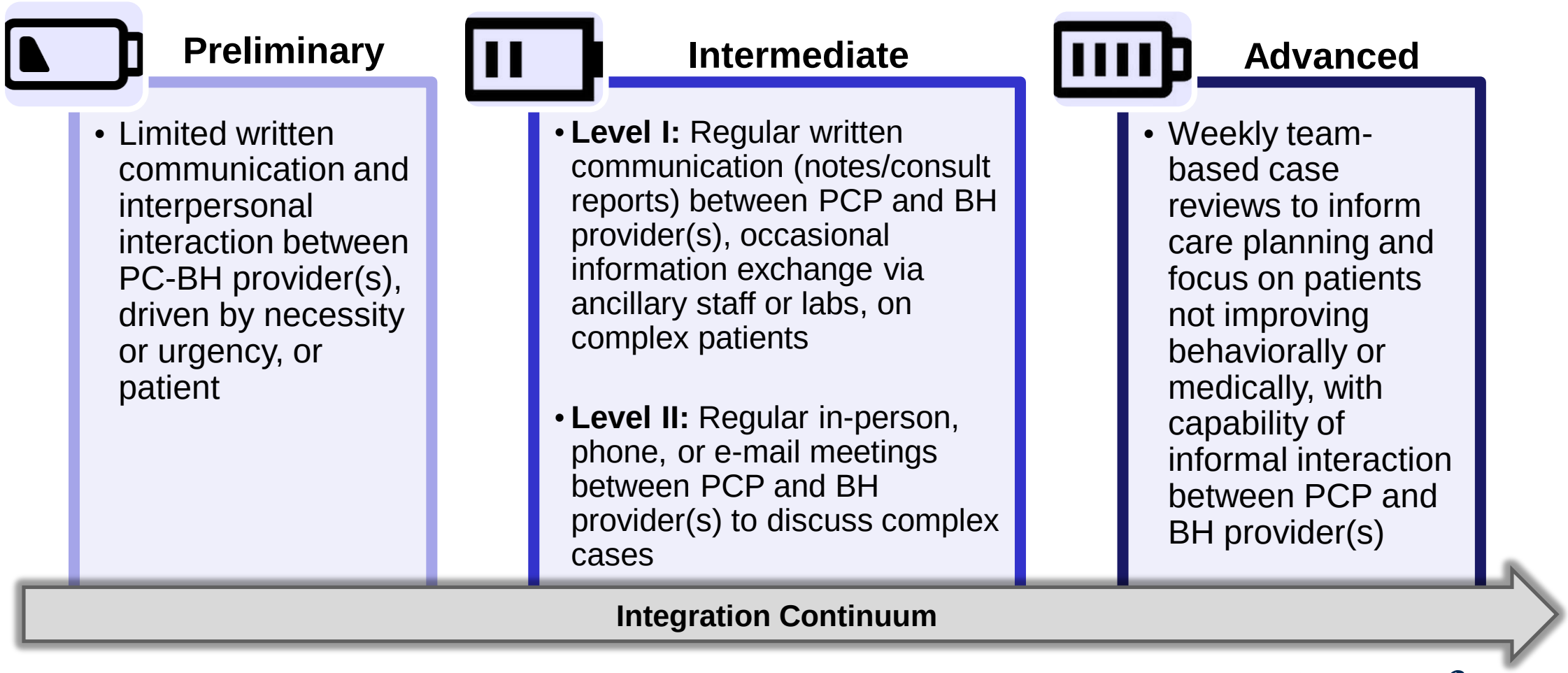
Framework Levels of Integration

- **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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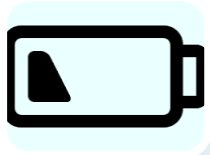
Framework Levels of Integration

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

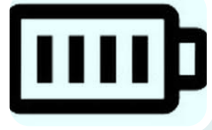


Preliminary

- 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

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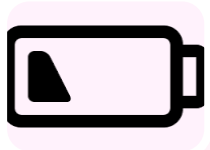
Framework Levels of Integration

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

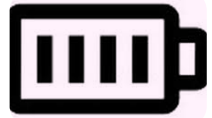


Preliminary

- 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

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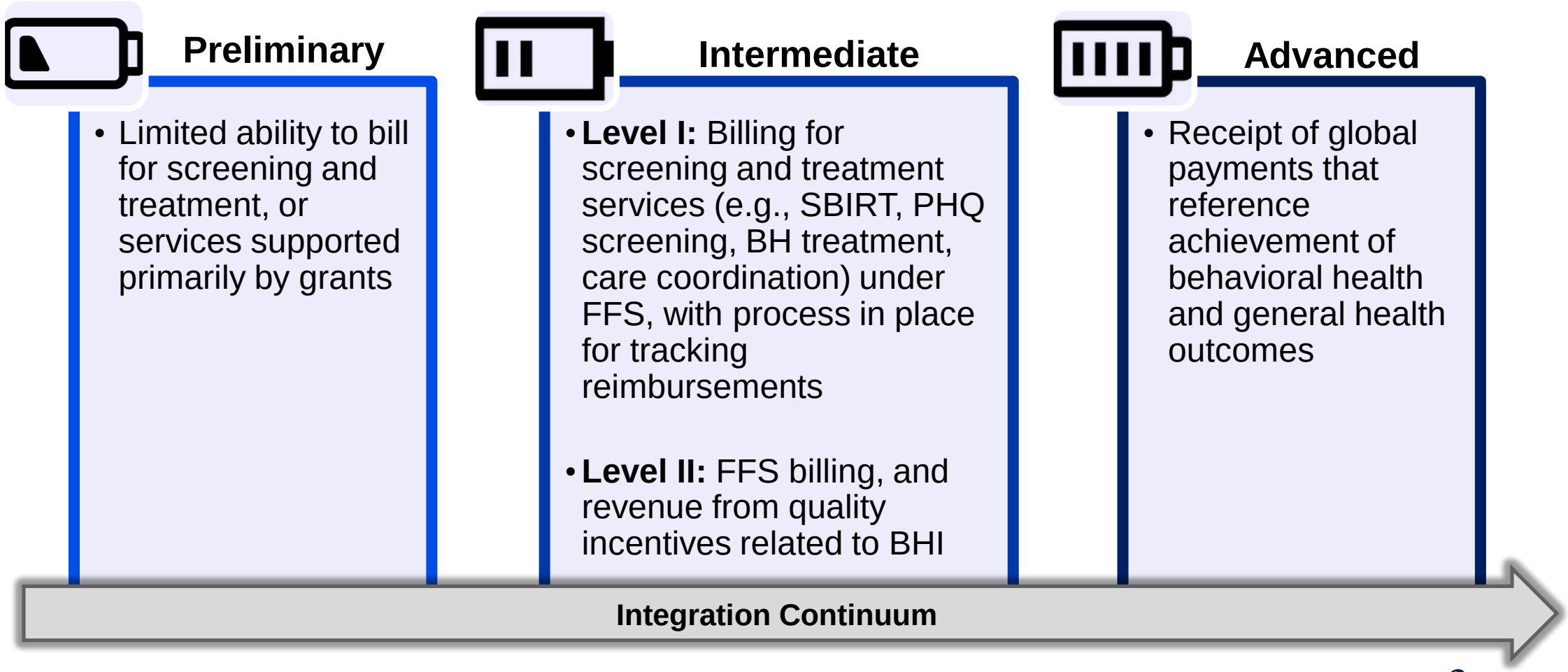
Framework Levels of Integration

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



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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

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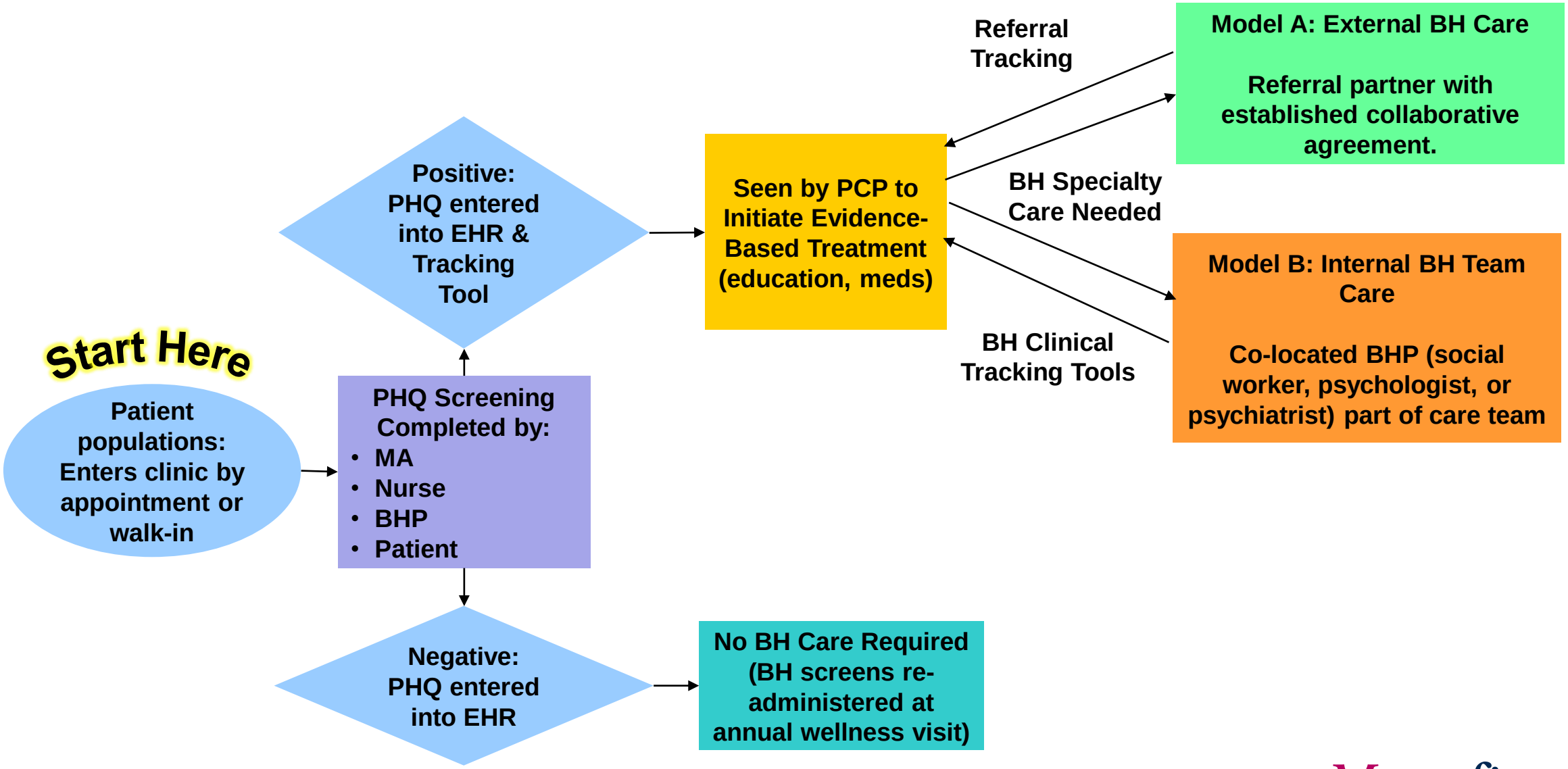
Comprehensive BH Workflow: Internal and External Pathways



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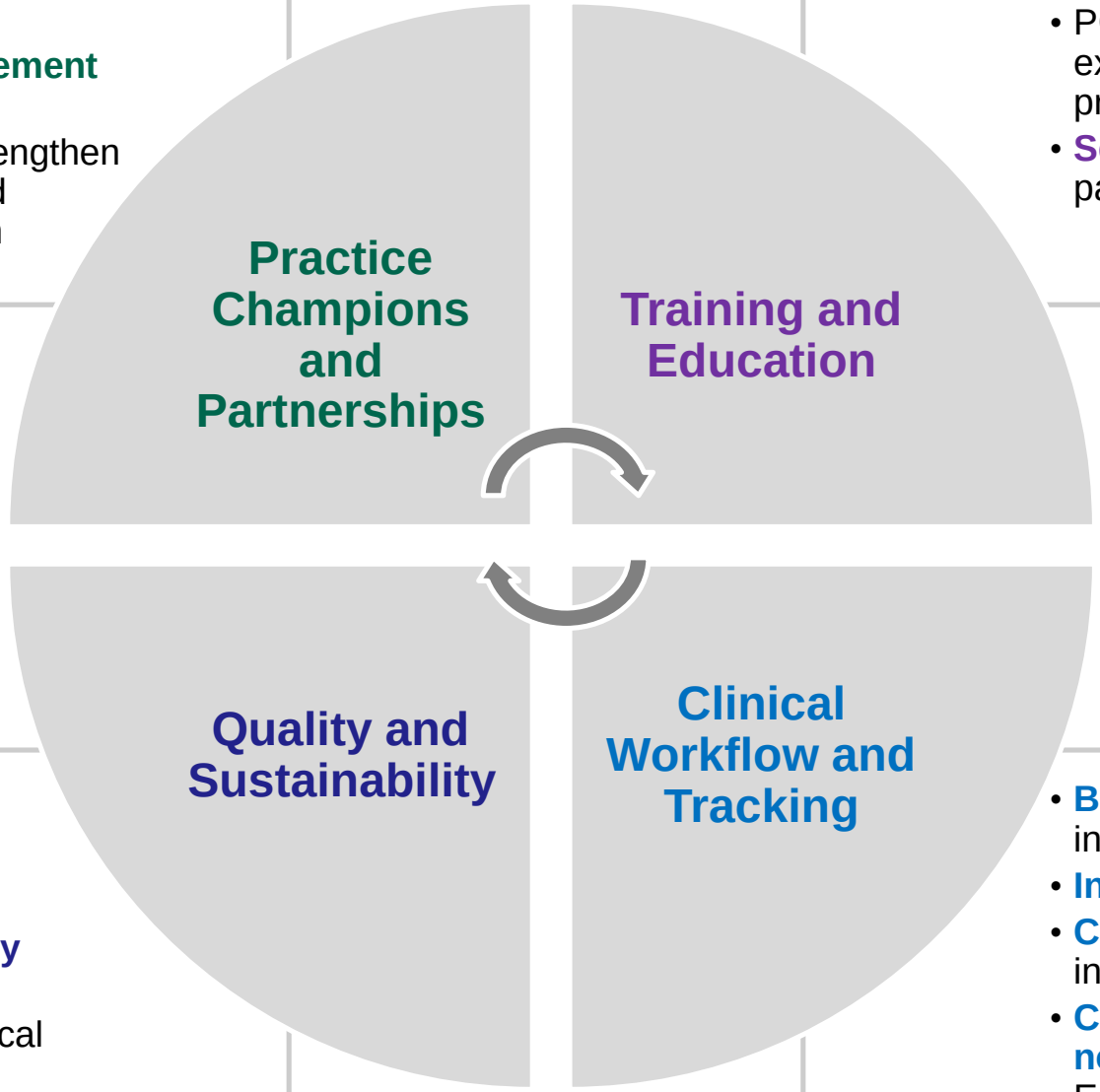
Lessons for Primary Care Practices in Integrated Care Settings

- **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

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



- **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

Next Steps

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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

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We welcome your questions and comments!

Your SWEEP Team

Have a question? Contact us!

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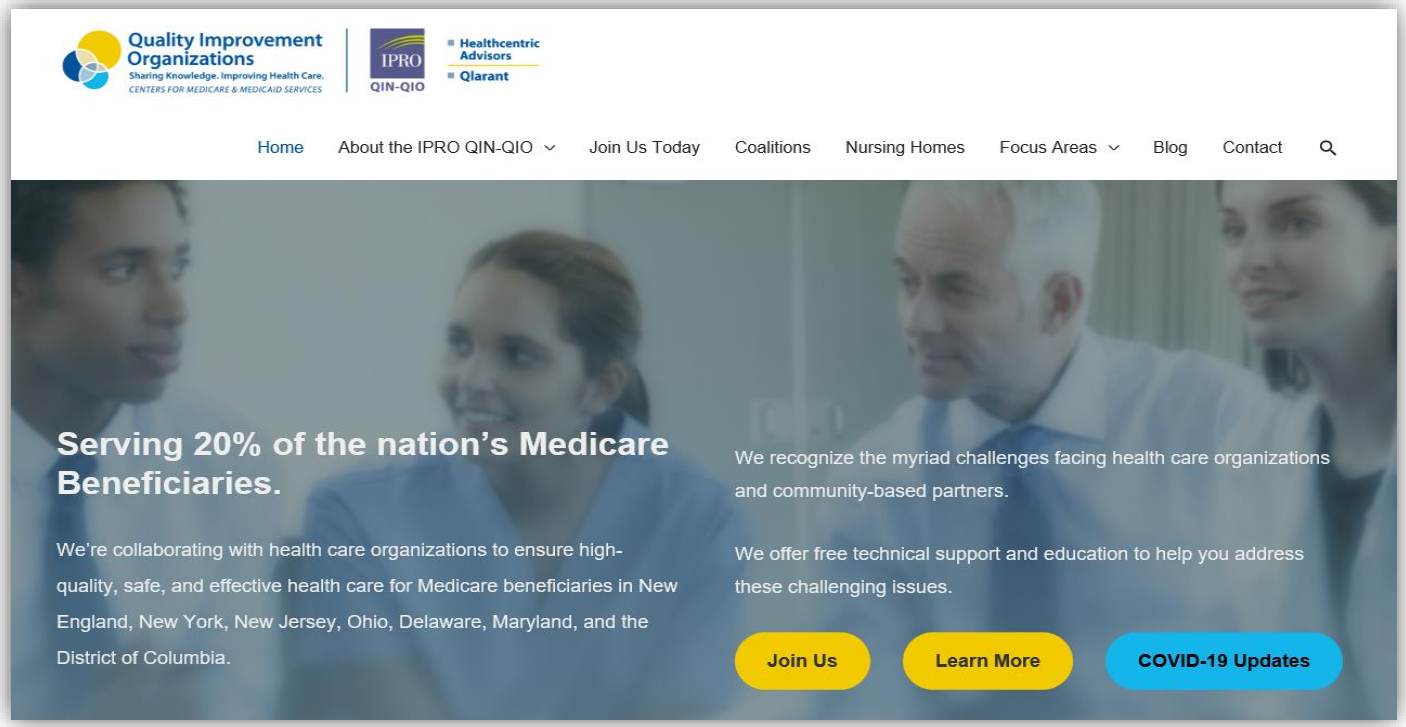

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