Advancing the Integration of Behavioral Health into Primary Care for Small Practices

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1:00 – 2:00pm ET

Today's Speaker

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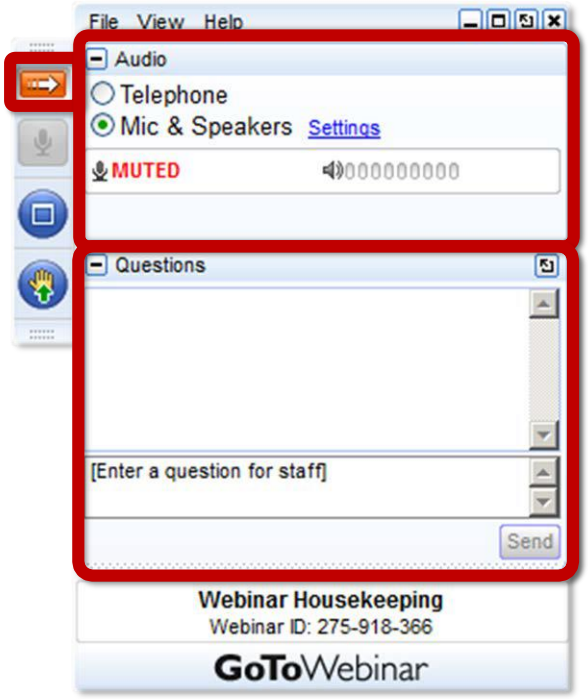


AGENDA

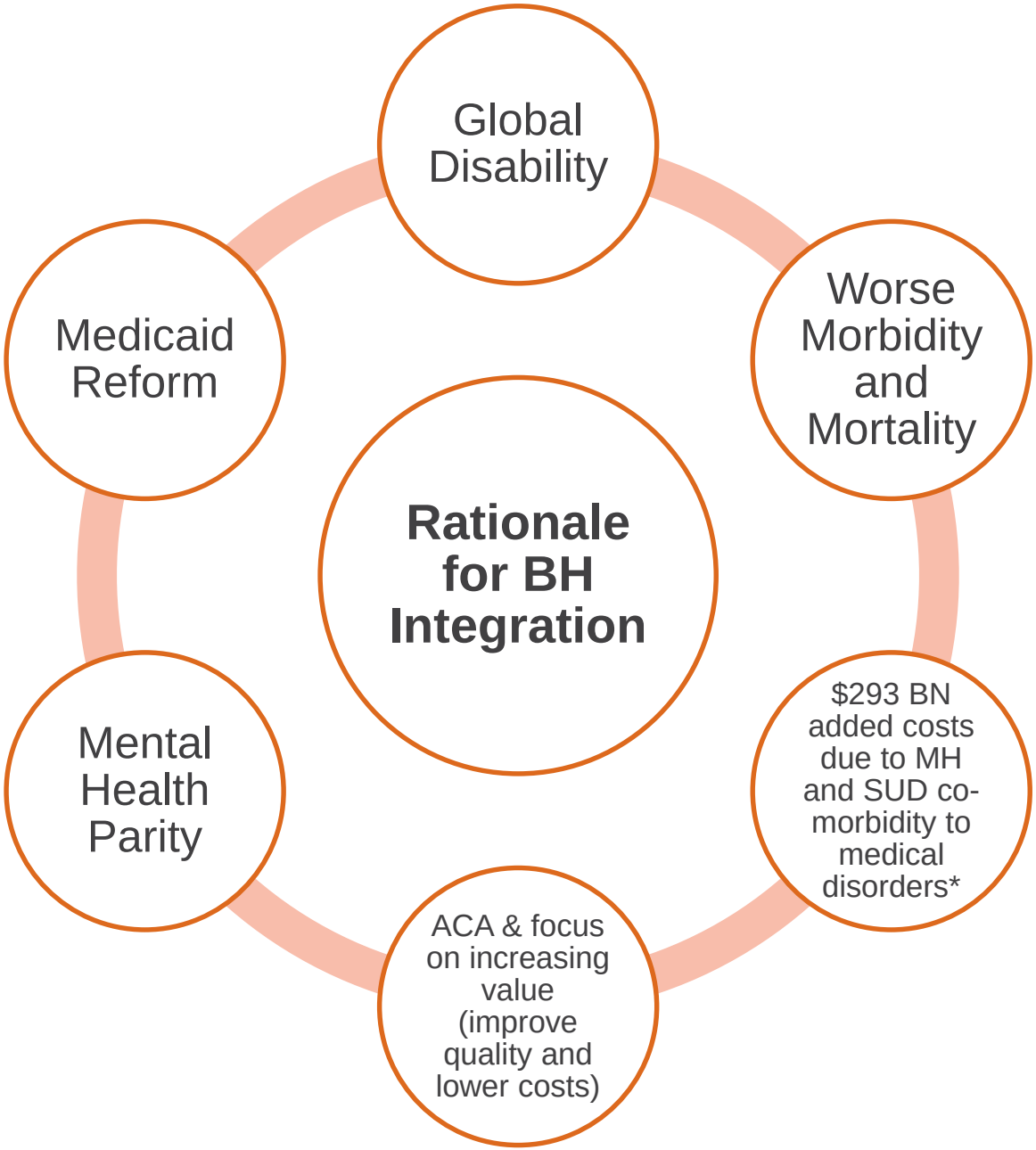
Introduction to the Behavioral Health Integration Continuum-Based Framework

Overview of the Framework Evaluation Project

Continuum-based Framework Evaluation: Framework 2.0 and Findings

Continuum-based Framework Evaluation: Lessons Learned and Recommendations

Expansion of Framework to Physical Health Integration



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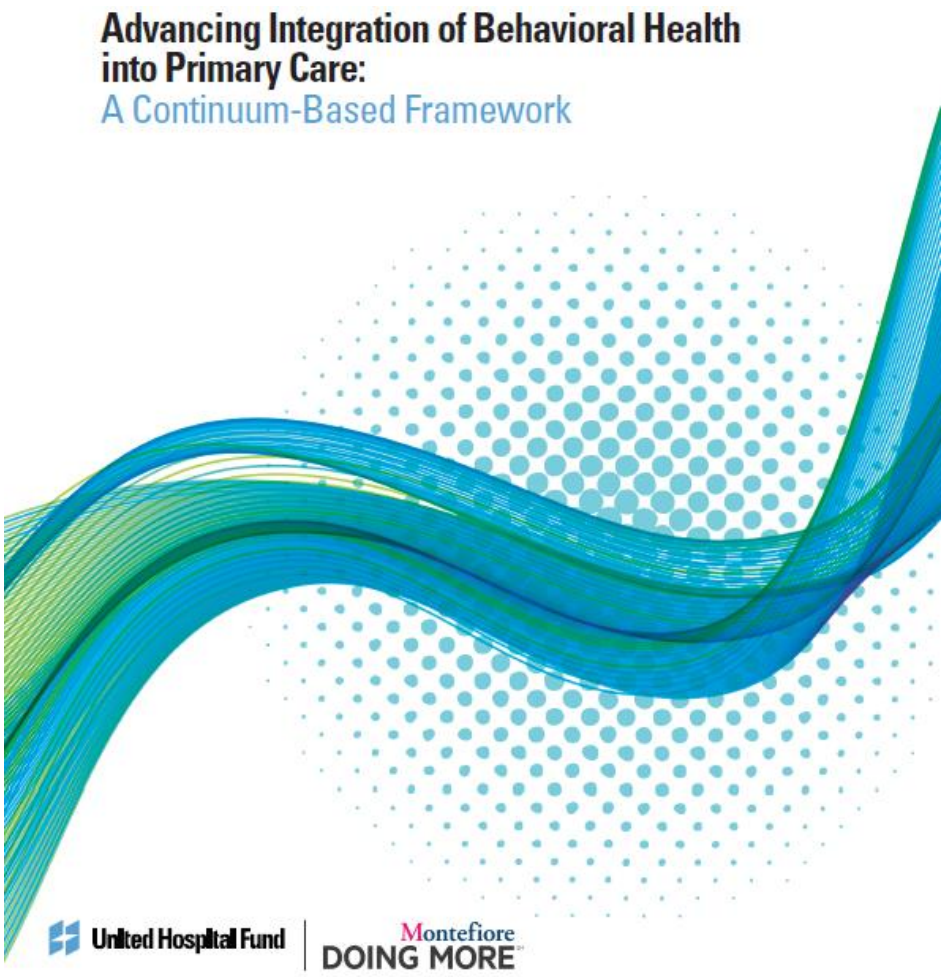
Continuum-Based Framework: *Why Another Framework?*

Reform Priority	• Federal and NYS Health reform prioritize behavioral health and primary care integration • Creation of regional collaboration entities
Supportive Evidence	• Evidence for key components of successful integration models in primary care
Capacity	• Primary care practices differ in size and available resources • E.g. number of PCPs, PCMH status, existing support staff
Infrastructure	• Ability to implement integrated care influenced by infrastructure support and existing relationships with BH providers
Implementation Support	• Guidance needed on implementing and tailoring key model elements to different primary care settings, especially in small (5 or less) and medium size practices (6 to 10)

Accelerated Development

- ✓ **Targeted literature review** on models of behavioral health integration into primary care implemented in SES and racially diverse settings to identify common domains.
- ✓ **Key informant interviews** of behavioral health, primary care practitioners, policymakers, and others.
- ✓ **Key Stakeholder Meeting** to review and provide feedback on initial draft framework.
- ✓ Finalized **evidence-based continuum framework** (v1.0) for behavioral health integration into primary care.
- ✓ Published framework in **issue brief** with a suggested prioritization schema for practitioners, PPS, and payers.

Continuum-Based Framework



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Support for this work was provided by United Hospital Fund (UHF).

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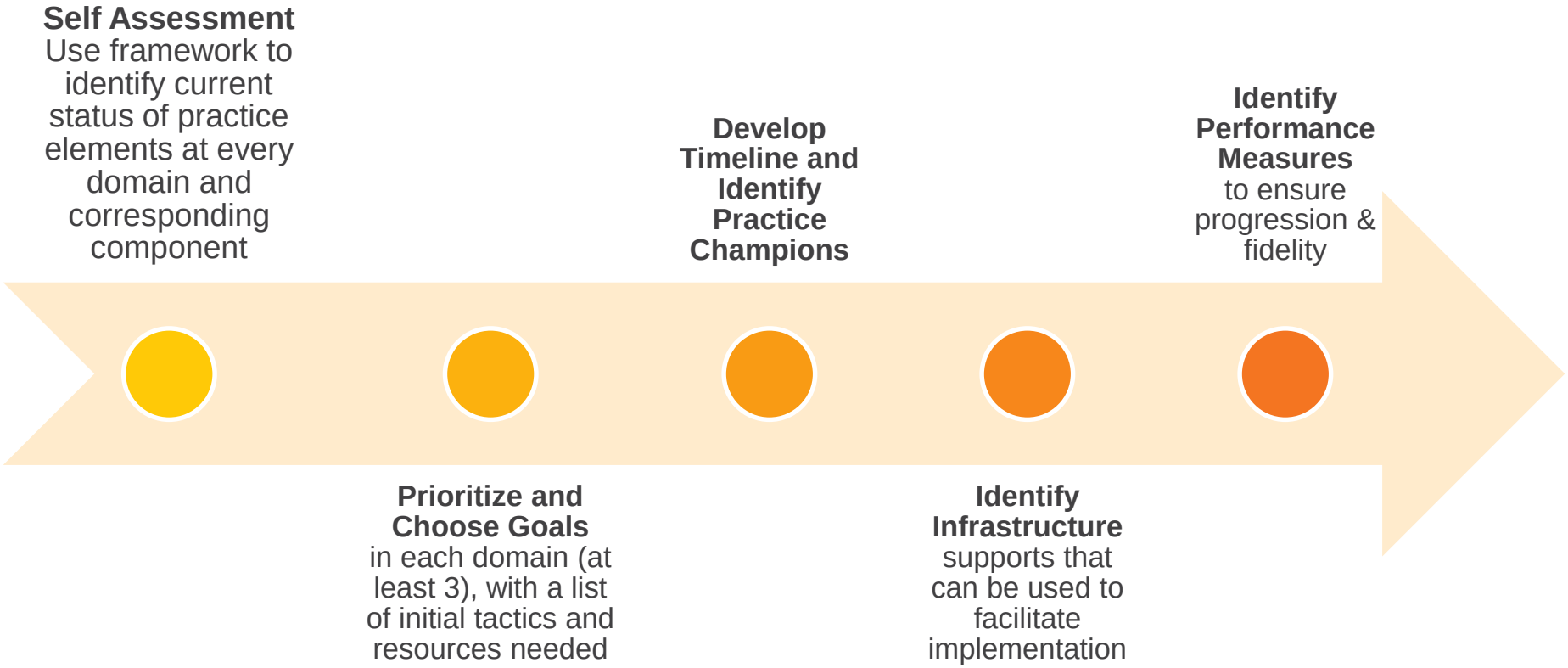
Using the Framework to Advance BHI: A Five-Step Approach



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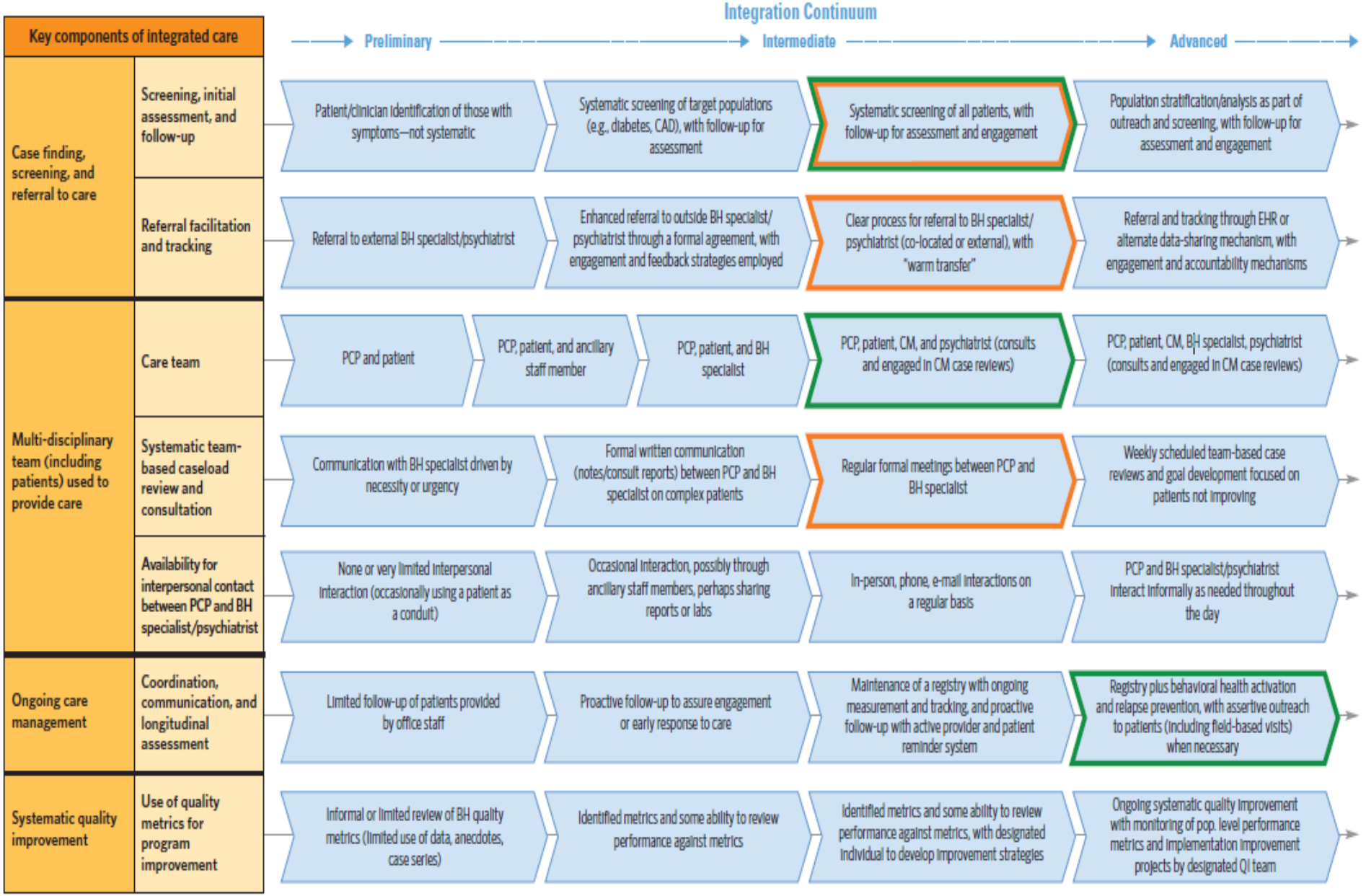
Appendix C. An Evidence-Based Framework for Primary Care–Behavioral Health Integration

With DSRIP Project 3.a.i Model Elements Overlay



DSRIP Model 1 (Co-location) = ■ **DSRIP Model 3 (IMPACT) =** ■

Notes: **BH Specialist** refers to any provider with specialized behavioral health training; **CM** can refer to a single person or multiple individuals who have training to provide coordinated care management functions in the PC practice; **Ancillary staff member** refers to non-clinical personnel, such as office staff or receptionist

Evaluation of Continuum-Based Framework

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Project Objectives

Help small primary care practices implement and sustain meaningful behavioral health integration

Inform practitioners, payers and policy makers in real-time on how to support and incentivize advancement in integration

Measurably improve the health of underserved New Yorkers

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Project Value Commensurate with NYS Reform Initiatives

- Delivery System Reform Incentive Payment (DSRIP)
- Collaborative Care Initiative (CCI)
- Advanced Primary Care (APC)

Target policy barriers that impede innovation and are cumbersome to small practices

Increase the importance of the linkage between progress measurement and incentives

Continuum-based Framework provides the tools and steps necessary for effective BHI

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Small Primary Care Practice Participants

New York City (6 Practices)

- Centro Medico de las Americas, Queens
- Delmont Medical Care, Queens
- Dr. Scafuri + Associates, Staten Island
- Metro Community Health Center, Bronx
- South Shore Physicians, Staten Island
- Tremont Health Center of Community Healthcare Network, Bronx

New York State (5 Practices)

- Champlain Family Health of Hudson Headwaters Health Network, Champlain
- Hudson River Healthcare at Hudson, Hudson
- Keuka Family Practice of Accountable Health Partners, Bath
- Koinonia Primary Care, Albany
- Lourdes Primary Care, Owego

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Project Structure

Data Collection

- Framework Planning & Progress Evaluation Surveys
- Site Visits and Qualitative Interviews
- Quarterly Site Specific Technical Assistance Calls and Email Support

Technical Assistance

- Monthly Group Technical Assistance Webinars
- Provider Training Resources
- Patient Self-Management Material

Publications and Presentations

- Issue Brief Series
- Final Report showcasing revised Framework 2.0
- Presentation at Stakeholder Roundtable and APA Annual Conference

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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

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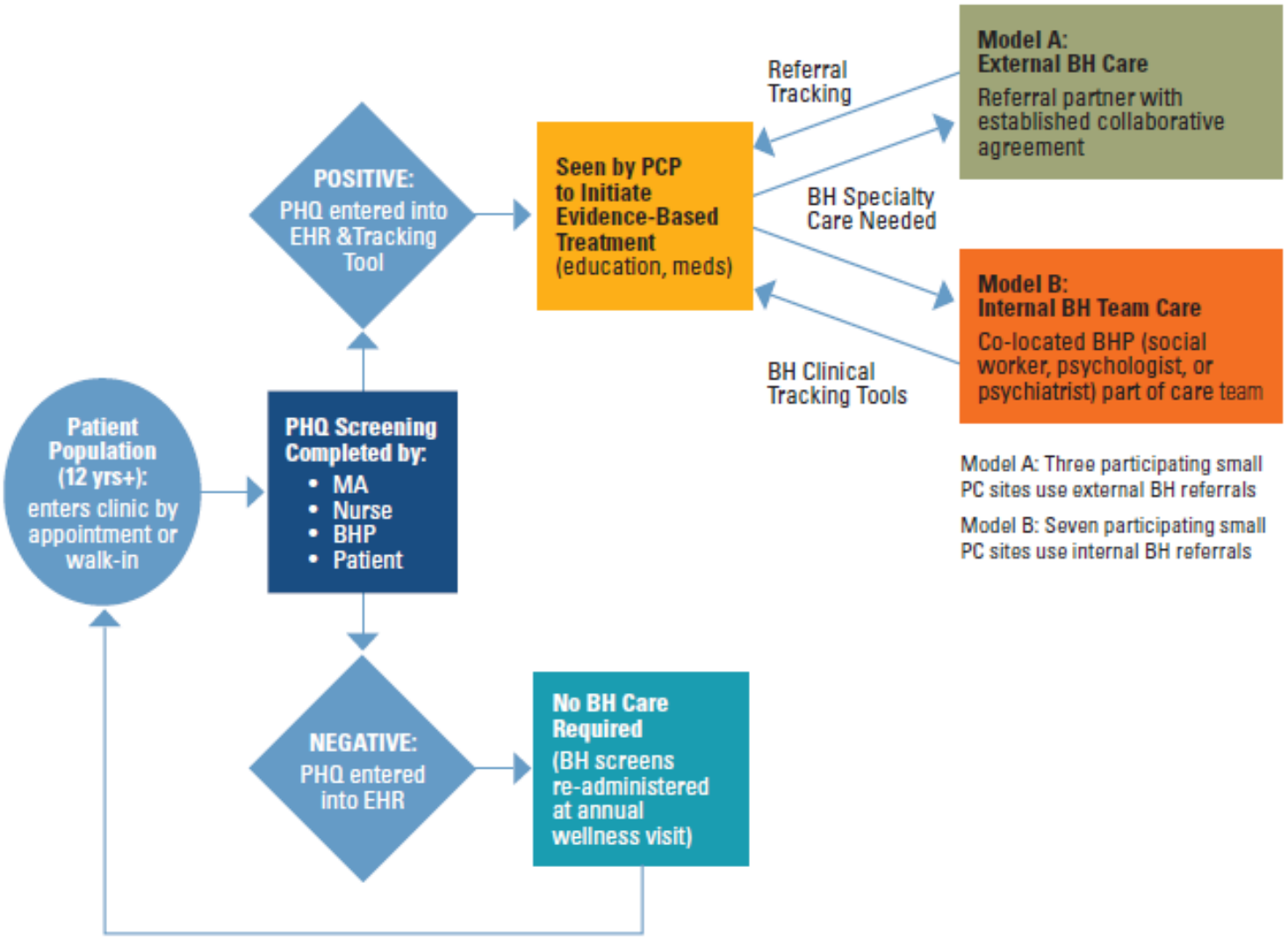
Role of BH Clinician in Practice Sites

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

Comprehensive BH Workflow: Internal and External Pathways



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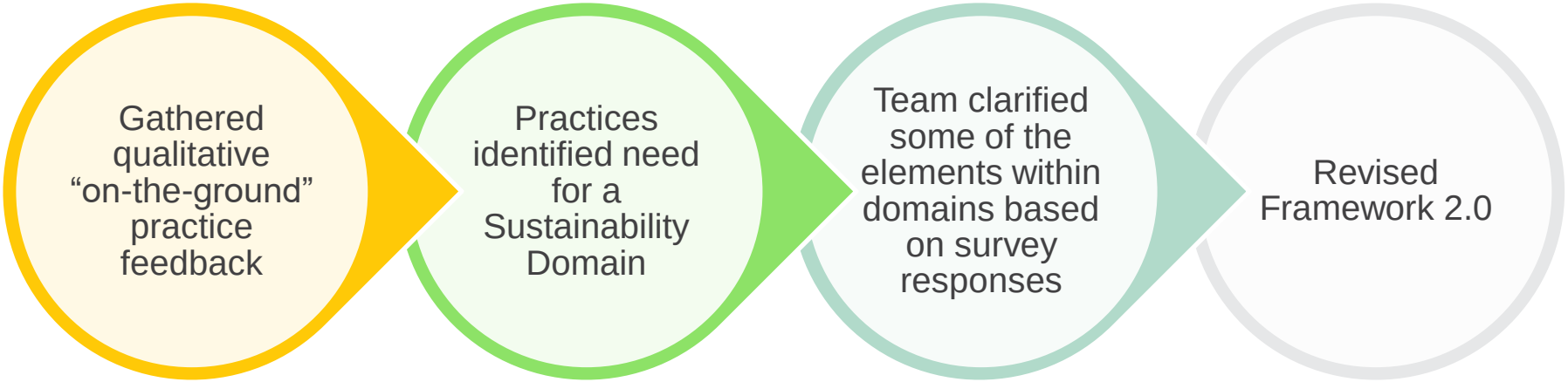
Framework 2.0 Revision Process



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Framework 2.0: Revised and Expanded

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

Framework 2.0: Revised and Expanded (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)
Management 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

Framework Levels of Integration

- **Domain 1: case finding, screening, referral to care.**
- **Component 1:** *screening, initial assessment, and follow-up for BH condition.*

Preliminary

- Patient/clinician identification of those with BH symptoms—not systematic

Intermediate

- **Level I:** Systematic BH screening of targeted patient groups (e.g., those with diabetes, CAD), with follow-up for assessment
- **Level II:** Systematic BH 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

Framework Levels of Integration

- **Domain 1: case finding, screening, referral to care.**
- **Component 2:** *facilitation of referral, 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 4: ongoing care management.**
- **Component 1:** *longitudinal clinical monitoring and engagement.*

Preliminary

- Limited follow-up of patients 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.

Component 1: use of 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

Framework Levels of Integration

- **Domain 9: sustainability.**

Component 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

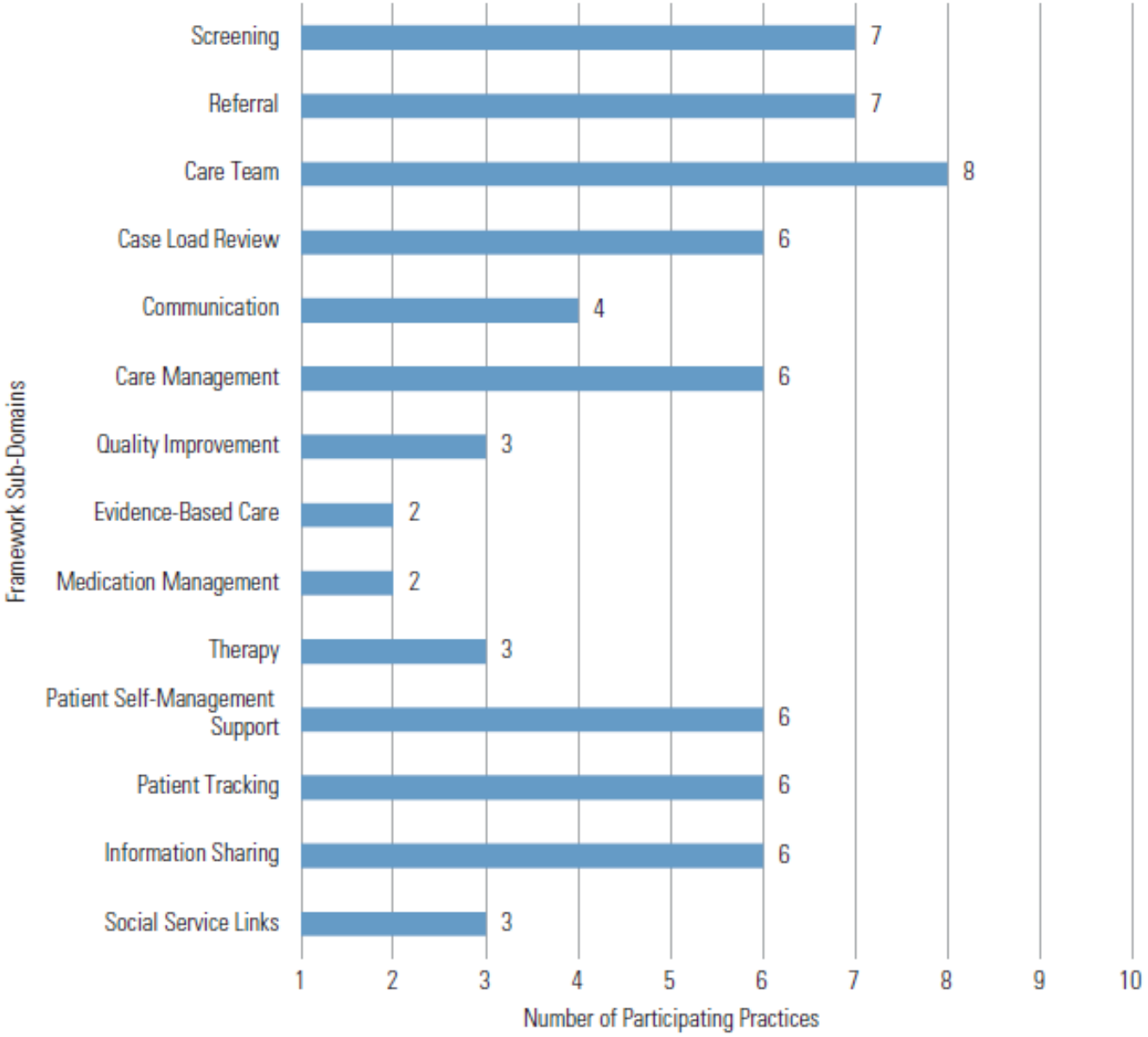
Intermediate

- **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

Number of Sites Advancing at Least One Stage over Twelve Months (in Domains and Sub-Domains of Original Framework)*



* Chung H, N Rostanski, H Glassberg, and HA Pincus. 2016. *Advancing Integration of Behavioral Health into Primary Care: A Continuum-Based Framework*. New York: United Hospital Fund. https://uhfnyc.org/publications/publication/advancing-integration-of-behavioral-health-into-primary-care-a-continuum-based-framework/

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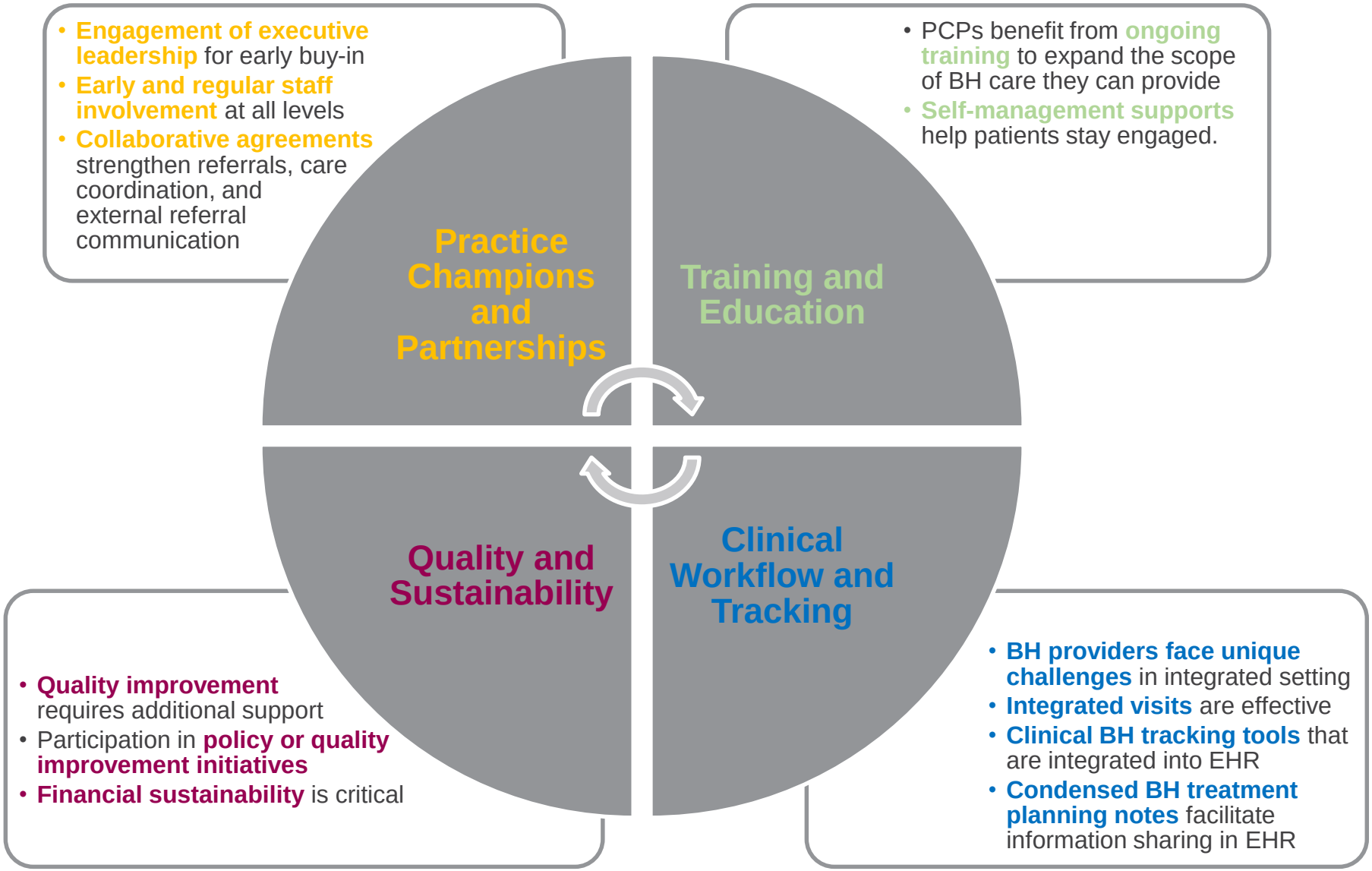
Lessons for Primary Care Practices in Integrated Care Settings



- **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

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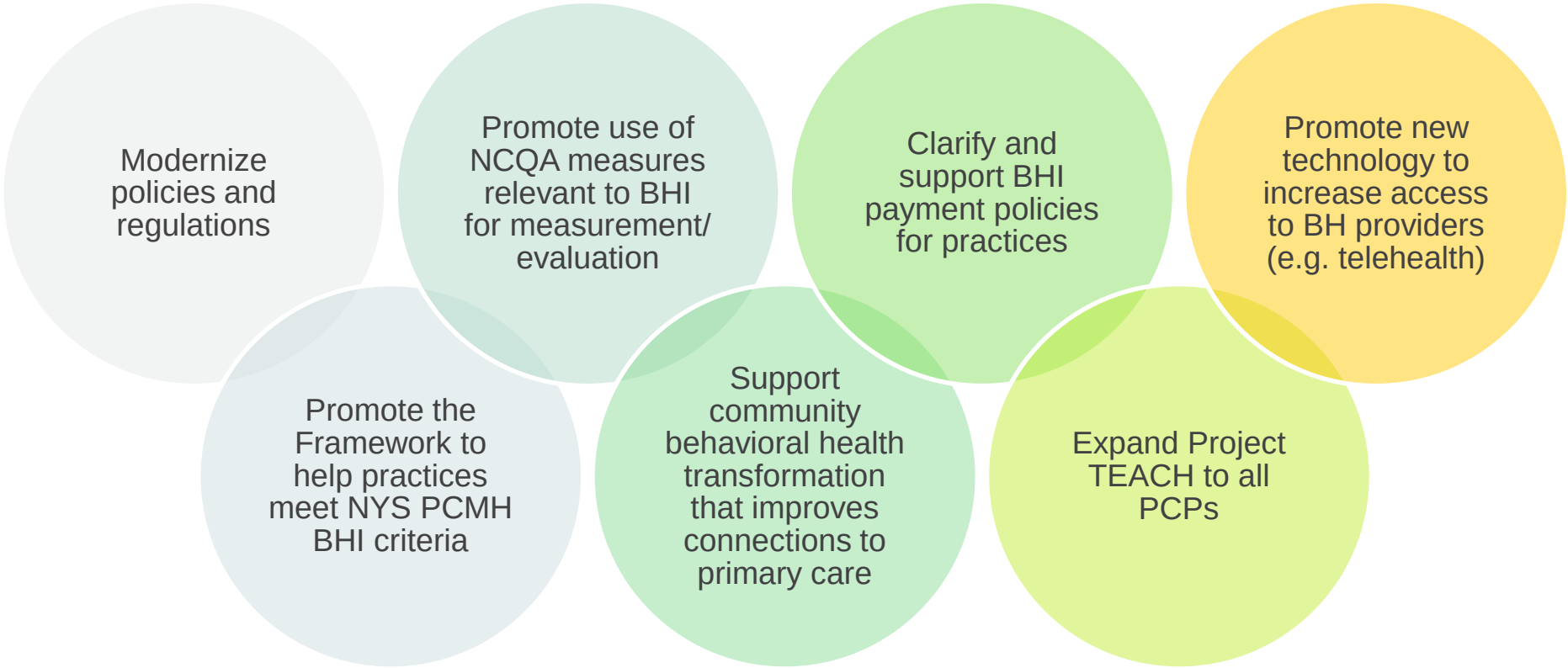
Recommendations for Policymakers and BHI Stakeholders



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Physical Health Integration into Behavioral Health Settings

- Adults with any behavioral health disorder report an unmet need for primary medical care and have greater morbidity.
- There is emerging research but limited guidance to help practices incorporate integrated physical health screening and services.
- Two-year project funded by New York Community Trust to develop a continuum based framework for PHI in BH settings and assess its utility for BH organizations and their stakeholders.
- Project Objectives:
  - ❖ Offer practical guidance on the steps necessary to build a comprehensive and sophisticated model of physical health integration for adult BH patients.
  - ❖ Delineate evidence-based-steps for PHI implementation.
  - ❖ Highlight specific policy and reimbursement needs, barriers and potential incentives that support or impede integration.
  - ❖ Consult with clinical stakeholders, policymakers, payers, and patients/consumers utilizing behavioral health services

Questions


Thank you
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