Montefiore

Advancing Behavioral Health Integration in Primary Care Using a Continuum Based Framework Evaluation (BHI-FE) Project

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Chief Medical Officer
Montefiore Care Management Organization
Agenda

• UHF Project overview
  - Background and goals
  - Review of key integration model literature and common themes
• Draft framework and discussion
  - Overview of key components of integrated care
  - Framework elements and pragmatic value to primary care practices
• Utilizing the framework to support high quality primary care
UHF Project Team

- Henry Chung, MD – Project Director
- Hope Glassberg, MPA – Co-Project Director
  *VP, Strategic Initiatives & Policy, Hudson River Healthcare*
- Nina Rostanski, MPH – Project Manager
  *Montefiore Medical Center*
- Harold Pincus, MD – Senior Project Advisor
  *Professor and Vice Chair, Dept. of Psychiatry, Columbia Director of Quality and Outcomes Research, NY Presbyterian*
- Greg Burke, MPA – UHF Project Advisor
  *Director, Innovation Strategies, United Hospital Fund*
UHF Project Background

- Health reform initiatives promoting focus on behavioral health/primary care integration
- Strong body of evidence around key components of successful integration models in primary care
- Primary care practices differ in size and available resources
  - E.g. number of PCPs, PCMH status, existing support staff
- Ability to implement integrated care influenced by infrastructure support and working relationships with BH providers
- More guidance needed on implementing key components and tailoring model elements to different primary care settings, especially in small and medium size practices
Goals of UHF Project

- Developing a framework of key components of integrated care for different primary care settings
- Offering practical guidance on prioritizing and implementing necessary steps for effective integration, ie “roadmap”
- Influencing Policy to provide support to primary care practices to adopt an advance BH integration
<table>
<thead>
<tr>
<th>COORDINATED</th>
<th>CO-LOCATED</th>
<th>INTEGRATED</th>
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</thead>
<tbody>
<tr>
<td>KEY ELEMENT: COMMUNICATION</td>
<td>KEY ELEMENT: PHYSICAL PROXIMITY</td>
<td>KEY ELEMENT: PRACTICE CHANGE</td>
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<tr>
<td>LEVEL 1 Minimal Collaboration</td>
<td>LEVEL 2 Basic Collaboration at a Distance</td>
<td>LEVEL 5 Close Collaboration Approaching an Integrated Practice</td>
</tr>
<tr>
<td>LEVEL 3 Close Collaboration Onsite with Some System Integration</td>
<td>LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice</td>
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**Behavioral health, primary care and other healthcare providers work:**

<table>
<thead>
<tr>
<th>In separate facilities, where they:</th>
<th>In separate facilities, where they:</th>
<th>In same facility not necessarily same offices, where they:</th>
<th>In same space within the same facility (some shared space), where they:</th>
<th>In same space within the same facility, sharing all practice space, where they:</th>
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<tbody>
<tr>
<td>Have separate systems</td>
<td>Have separate systems</td>
<td>Have separate systems</td>
<td>Share some systems, like scheduling or medical records</td>
<td>Have resolved most or all system issues, functioning as one integrated system</td>
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<tr>
<td>Communicate about cases only rarely and under compelling circumstances</td>
<td>Communicate periodically about shared patients</td>
<td>Communicate regularly about shared patients, by phone or e-mail</td>
<td>Communicate in person as needed</td>
<td>Communicate consistently at the system, team and individual levels</td>
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<tr>
<td>Communicate, driven by provider need</td>
<td>Communicate, driven by specific patient issues</td>
<td>Collaborate, driven by need for each other’s services and more reliable referral</td>
<td>Collaborate, driven by need for consultation and coordinated plans for difficult patients</td>
<td>Collaborate, driven by desire to be a member of the care team</td>
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<tr>
<td>May never meet in person</td>
<td>May meet as part of larger community</td>
<td>Meet occasionally to discuss cases due to close proximity</td>
<td>Have regular face-to-face interactions about some patients</td>
<td>Have regular team meetings to discuss overall patient care and specific patient issues</td>
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<tr>
<td>Have limited understanding of each other’s roles</td>
<td>Appreciate each other’s roles as resources</td>
<td>Feel part of a larger yet ill-defined team</td>
<td>Have a basic understanding of roles and culture</td>
<td>Have an in-depth understanding of roles and culture</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Have roles and cultures that blur or blend</td>
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UHF Process & Deliverables

- **Targeted literature review** on models of behavioral health integration into primary care to identify common building blocks
- **Key informant interviews** of behavioral health, primary care practitioners, policymakers, and others
- **Advisory Feedback Meeting** with multiple stakeholders (practitioners, PPS leads, payers, policy makers)
- Finalize development of **evidence-based framework** for behavioral health integration in primary care
- **Publish issue brief** with a suggested roadmap for practitioners, PPS, and payers
Overview of Integration Models

- Multiple variations of integration models have been implemented in a wide variety of settings
  - Implementation approaches largely based on Wagner’s Chronic Care Model
  - Apply “Measurement-Based Care” approaches
  - Mostly depression and anxiety disorders in adults
  - Multiple high quality clinical trials demonstrate their effectiveness
- IMPACT most studied Collaborative Care Model “CoCM”

Ultimately, “Integration” is on a continuum
- Other integration models support alternative ways to implement and support key elements of integrated care
BHI Framework Domains & Components

1. Case finding, screening, and referral to care
   • Screening, initial assessment, and follow-up
   • Referral facilitation and tracking

2. Multi-disciplinary team (including patients) used to provide care
   • Care Team
   • Systematic team-based caseload review and consultation
   • Availability for interpersonal contact between PCP and BH specialist/psychiatrist

3. Ongoing care management
   • Coordination, communication, and longitudinal assessment

4. Systematic quality improvement
   • Use of quality metrics for program improvement
5. Decision support for measurement-based, stepped care
   • Evidence-based guidelines/treatment protocols
   • Use of pharmacotherapy
   • Access to evidence-based psychotherapy treatment with BH specialist

6. Self management support that is culturally adapted
   • Tools utilized to promote patient activation and recovery

7. Information tracking and exchange among providers
   • Clinical registries for tracking and coordination
   • Sharing of treatment information

8. Linkages with community/social services
   • Linkages to housing, entitlement, and other social support services
# Key components of integrated care

## Identification of patients and referral to care

<table>
<thead>
<tr>
<th>Screening, initial assessment, and follow up</th>
<th>Referral to external BH specialist/psychiatrist through a formal agreement with engagement and feedback strategies employed</th>
<th>Systematic screening of all patients with follow up for assessment and engagement</th>
<th>Population stratification/analysis as part of outreach and screening with follow up, for assessment and engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/clinician identification of those with symptoms - not systematic</td>
<td>Enhanced referral to outside BH specialist/psychiatrist through a formal agreement with engagement and feedback strategies employed</td>
<td>Clear process for referral to BH specialist/psychiatrist (co-located or external) with “warm transfer”</td>
<td>Referral and tracking through EMR or alternate data sharing mechanism with engagement and accountability mechanisms</td>
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## Referral facilitation and tracking

<table>
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<tr>
<th>PCP and patient</th>
<th>PCP, patient and ancillary staff member</th>
<th>PCP, patient and BH specialist</th>
<th>PCP, patient, CM, and psychiatrist (consults and engaged in CM case reviews)</th>
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## Care team

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<td>Communication with BH specialist driven by necessity or urgency</td>
<td>Formal written communication [notes/consult reports] between PCP and BH specialist on complex patients</td>
<td>Regular formal meetings between PCP and BH specialist</td>
<td>Weekly scheduled team based case reviews and goal development focused on patients not improving</td>
</tr>
</tbody>
</table>

## Multi-professional team (including patients) approach to care

| None or very limited Interpersonal interaction (occasionally using a patient as a conduit) | Occasional Interaction, possibly through ancillary staff members perhaps sharing reports or labs | In person, phone, email interaction on a regular basis | PCP and BH specialist/psychiatrist interact informally as needed throughout the day |

## Availability for interpersonal contact between PCP and BH specialist/psychiatrist

| None or very limited Interpersonal interaction (occasionally using a patient as a conduit) | Occasional Interaction, possibly through ancillary staff members perhaps sharing reports or labs | In person, phone, email interaction on a regular basis | PCP and BH specialist/psychiatrist interact informally as needed throughout the day |

## Ongoing care management

| Limited follow-up of patients provided by office staff | Proactive follow-up to assure engagement or early response to care | Maintaining a registry with ongoing measurement and tracking and proactive follow-up with active provider and patient reminder system | Registry plus behavioral health activation and relapse prevention with assertive outreach to patients, including field based visits when necessary |

## Systematic quality improvement

| Informal or limited review of BH quality metrics (limited use of data, anecdotes, case series) | Identified metrics and some ability to review performance against metrics | Identified metrics and some ability to review performance against metrics with designated individual to develop improvement strategies | Ongoing systematic quality improvement with monitoring of pop. level performance metrics and implementation improvement projects by designated CM team |

## Use of quality metrics for program improvement

| Informal or limited review of BH quality metrics (limited use of data, anecdotes, case series) | Identified metrics and some ability to review performance against metrics | Identified metrics and some ability to review performance against metrics with designated individual to develop improvement strategies | Ongoing systematic quality improvement with monitoring of pop. level performance metrics and implementation improvement projects by designated CM team |

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### 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, receptionist, and others.
Framework Levels of Integration

- **Domain 1**: case finding, initial assessment, and referral to care.
- **Component 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 [BH Model 1 & 3]

**Advanced**
- Population stratification/analysis as part of outreach and screening, with follow-up for assessment and engagement
Framework Levels of Integration*

- Domain 1: case finding, initial assessment, and referral to care.
- Component 2: referral facilitation and tracking.

**Preliminary**
- • Referral to external BH specialist/psychiatrist

**Intermediate**
- • Level I: Enhanced referral to outside BH specialist/psychiatrist through a formal agreement, with engagement and feedback strategies employed
- • Level II: Clear process for referral to BH specialist/psychiatrist (co-located or external), with “warm transfer” [BH Model 1]

**Advanced**
- • Referral and tracking through EHR or alternate data-sharing mechanism, with engagement and accountability mechanisms

*See appendix for full list of domains and component levels of integration at end of the slide deck presentation*
Framework Levels of Integration

- **Domain 3: ongoing care management.**
- **Component 1:** *Coordination, communication, and longitudinal assessment.*

### Continuum of Integration

**Preliminary**
- **Level I:** Limited follow-up of patients provided by office staff
- **Level II:** Proactive follow-up to assure engagement or early response to care

**Intermediate**
- Maintenance of a registry with ongoing measurement and tracking
- Proactive follow-up with active provider and patient reminder system

**Advanced**
- Registry plus behavioral health activation and relapse prevention, with assertive outreach to patients (including field-based visits) when necessary
  - *IMPACT Model*
Framework Levels of Integration

- **Preliminary**
  - None or limited training on BH disorders and treatment

- **Intermediate**
  - **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

- **Advanced**
  - Systematic tracking of symptom severity; protocols for intensification of treatment when appropriate

**Domain 5**: decision support for measurement-based, stepped care.

**Component 1**: evidence-based guidelines/treatment protocols.
Framework Levels of Integration

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

- **Intermediate**
  - **Level I**: PCP-initiated, and referral when necessary to prescribing BH specialist/psychiatrist for follow-up
  - **Level II**: PCP-managed with prescribing BH specialist/psychiatrist support

- **Advanced**
  - PCP-managed with CM supporting adherence between visits and BH prescriber/psychiatrist support

Domain 5: decision support for measurement-based, stepped care.

Component 2: *use of pharmacotherapy.*
Framework Levels of Integration

- **Preliminary**
  - Supportive guidance provided by PCP

- **Intermediate**
  - **Level I**: Available off-site through pre-specified arrangements
  - **Level II**: Brief psychotherapy interventions provided by BH specialist on-site

- **Advanced**
  - Brief interventions provided by BH specialist (with formal EBP training) as part of overall care team, with exchange of information as part of case review

- **Domain 5**: decision support for measurement-based, stepped care.

- **Component 3**: access to evidence-based psychotherapy treatment with BH specialist.

Continuum of Integration
Framework Levels of Integration

- **Domain 6**: self-management support that is culturally adapted.
- **Component 1**: *tools utilized to promote patient activation and recovery.*

**Preliminary**
- Brief patient education of condition by PCP

**Intermediate**
- **Level I**: Brief patient education of condition including materials/workbooks but limited focus on self-management coaching and activity guidance
- **Level II**: Patient receives education and participates in self-management goal-setting and activity guidance/coaching

**Advanced**
- Systematic education and self-management goal-setting with relapse prevention guidance, with CM support between visits
  - [BH Model 3]
How can it be Used?

**Readiness Assessment and Goal Planning**
- NYS Delivery System Reform Incentive Program (DSRIP)
- NYS Advanced Primary Care (APC)
- NYC THRIVE Mental Health Service Corps

**Support Training and Technical Assistance**
- Working with practices to guide advancement
- Use QI methods and metrics to verify accomplishment

**Policy: Support and Sustainability**
- Can be used to demonstrate PCMH and APC tiers
- Can be used to support practice reimbursement
- Can be used to support quality reporting and primary care provider training
Discussion

questions and comments!
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