CENTER *for* INTEGRATIVE HEALTH

insight to innovation

Convene.
Strategize.
Activate.

Don't Wing It:

Using available tools to plan your next move towards integration

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VISIONARY VOICES

INTRODUCTIONS

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Objectives

- Describe the ways agencies can be more proactive in positioning new and existing co-location arrangements for common and often unforeseen next steps.
- Describe how standardized reference and assessment tools such as SAMHSA's Six Levels of Collaboration constructs can assist in gaining cross-discipline buy-in when planning your next integration steps.
- Discuss how behaviorists can enhance a clinic's value-based outcomes through team-based care in medical settings.
- Explain how to use key concepts of evidenced-based integrated care models to guide your next steps.

Definition

The seamless and dynamic interaction of primary care providers (PCPs) and behavioral health providers (BHPs) working within one agency providing both counseling and traditional medical care services (Curtis & Christian, 2012)

Whole Health Care

The majority of people have comorbid mental health and medical problems, but do not receive care consistent with established practice guidelines (Institute of Medicine, 2006).

“It is in our communities where we must end the distinct and separate histories and management of mental health from physical health; we need to change the dialogue to focus on whole and inclusive health for all people.” (Miller, Gilchrist, Ross, Wong, & Green, 2016)

Skills Lab:
What is the status quo at your agency?

1. Who is the primary clientele / patient group? (primary care, BH, SPMI, etc.)
2. What screenings does your agency perform?
3. Do you have an integrated team member on-site? If so, what services do they provide?
4. Does your agency use repeated measurements to track clinical outcomes?
5. Does your agency use registries or other population health tools?
6. How does your agency handle hand-offs and referrals?
7. How does your agency manage physical health complaints? Chronic pain?

See your worksheet

Progression towards Alternative Payment models or VBP

Source: Slides taken from Health Care Payment and Learning Action Network: https://hcp-lan.org/events/list-2016-11-02

Value-Based Care Metrics and Common Measure Sets

NQF #	CMS Measure Set	Measure Steward	Measure Name
0004	Adult Core	NCQA	**Initiation/Engagement** of ETOH and Other Drug Abuse or Dependence Tx
0027	Adult Core	NCQA	Medical Assistance With **Smoking and Tobacco Use Cessation**
0105	Adult Core	NCQA	Antidepressant **Medication Management**
0108	Child Core	NCQA	**Follow-Up** Care for Children Prescribed **ADHD Medication**
0418/0418e	Child Core	CMS	**Screening for Depression** and Follow-Up Plan: Ages 12–17
0418/0418e	Adult Core	CMS	Screening for Depression and Follow-Up Plan: Age 18+
0576	Child Core	NCQA	**Follow-Up After Hospitalization** for Mental Illness: Ages 6–20
0576	Adult Core	NCQA	Follow-Up After Hospitalization for Mental Illness: Age 21+

2018 Core Set of Behavioral Health Measures for Medicaid and CHIP (Behavioral Health Core Set) Medicaid.gov

Value-Based Care Metrics and Common Measure Sets Continued

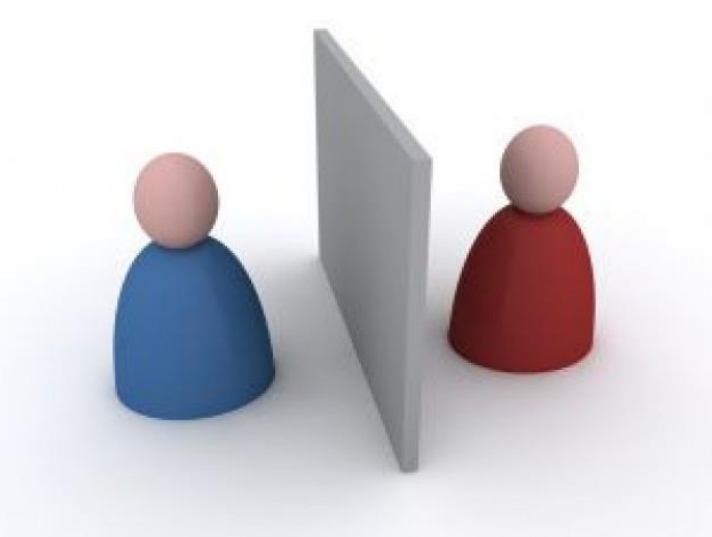
NQF #	CMS Measure Set	Measure Steward	Measure Name
1932	Adult Core	NCQA	**Diabetes Screening for People With Schizophrenia** or Bipolar Disorder on Antipsychotic Medications
2605	Adult Core	NCQA	**F/u After Emergency Department Visit** for Mental Illness or Alcohol and Other Drug Abuse or Dependence
2607	Adult Core	NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
2801	Child Core	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)
2940	Adult Core	PQA	Use of **Opioids at High Dosage** in Persons Without Cancer (OHD-AD)
NA**	Adult Core	NCQA	**Adherence to Antipsychotic Medications** for Individuals with Schizophrenia
NA	Adult Core	PQA	Concurrent Use of *Opioids and Benzodiazepines* (COB-AD)*
NA	Child Core	NCQA	Use of **Multiple Concurrent Antipsychotics** in Children and Adolescents

2018 Core Set of Behavioral Health Measures for Medicaid and CHIP (Behavioral Health Core Set) Medicaid.gov

INTEGRATED CARE MODELS

PCBH
SBIRT
The Collaborative Care Model

Spectrum of Integration – SAMHSA-HRSA



Standard Framework for Levels of Integrated Healthcare

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice

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Six Domains
BH, primary care, and other healthcare providers work: Physical proximity, teamness, systems, culture
Clinical Delivery: Use of similar or shared tools, assessments, evidenced-based practices, shared approaches, shared populations, Tx plans, etc.
Patient Experience: Referrals, Tx location (s), Tx Plan (s), Teaming for decisions, responsiveness
Practice/Organization: Coordination, info sharing, leadership support, model awareness
Business Model: Level of- budget unification, shared expenses and billing & maximization of all
Advantages and Weaknesses: Sustainability, autonomy, balance, relationships

Programs vs. Models

- Programs are unique efforts to make improvements compared to “usual care” that are site specific.
- No evidence base is present specific to the effort, but there may be some general rationale for the effort that links to research.
- Programs are not generalizable since the boundaries of the effort are not portable; all sites have some “programmatic” aspects to their work.
- Typically score between 1 and 5 on the MeHAF on average

WHAT is PCBH?

- Horizontal approach to integration with the goal of population health improvement.
- Can see a wider range and more of patients – In one year, 8 clinics = 8,000 patients with 19,000 visits (Reiter, 2015)
- BHC operates as a consultant and takes a generalist approach – not to create a case load of their own patients but are there to support the PCP.
- BHC conducts functional assessment, with a brief intervention, etc. with goal to get patient's life back on track. Team Based with shared resources
- Often a core model of a practice – with possibly one of the other vertical models

Why PCBH?

- PCP is usually a patient's point of entry into the healthcare system
- Increased need of PCPs by 2025 (462 million in 2008 to 565 million) – the demand for this model will only grow (Petterson, Liaw, Phillips, Rabin, Meyers, & Bazemore, 2012) and support for PCPs will be needed.
- 71.5% of patients with mental health impairment received treatment in a PCBH PCP and demonstrated improvement. (Bryan, Corso, Corso, Morrow, Kanzler, & Ray-Sannerud, 2012)
- Patients with 2 – 4+ visits show clinically significant change. (Cigrang et al., 2006)
- Studies have demonstrated clinical gains two years post treatment of a brief behavioral health intervention in a primary care setting (Ray-Sannerud, Dolan, Morrow, Corso, Kanzler, Corso & Bryan, 2012)
- Provider job satisfaction and retaining (Reiter 2013)

How is PCBH done?

- Relationship between the BHC and the PCP is key. BHC supports and educates medical providers in strengthening their behavioral health skill set.
- BHC remains accessible and maintains no formal schedule, but need structure for follow up that is strategically planned in the day.
- Additionally, BHC serves as “go between” for PCP and consulting psychiatrist helping triage and refer – but is seen as a CORE member of the team.
- Retaining mild to moderate patients

INTERVENTIONS FOCUS ON (Mountain View, 2013)

- *Assisting patients to replace maladaptive with adaptive traits*
- *Skill training through psychoeducation*
- *Developing specific behavior change plans to fit PC pace*
- *Involvement of family as support (e. g. hx gather/behavior mod).*

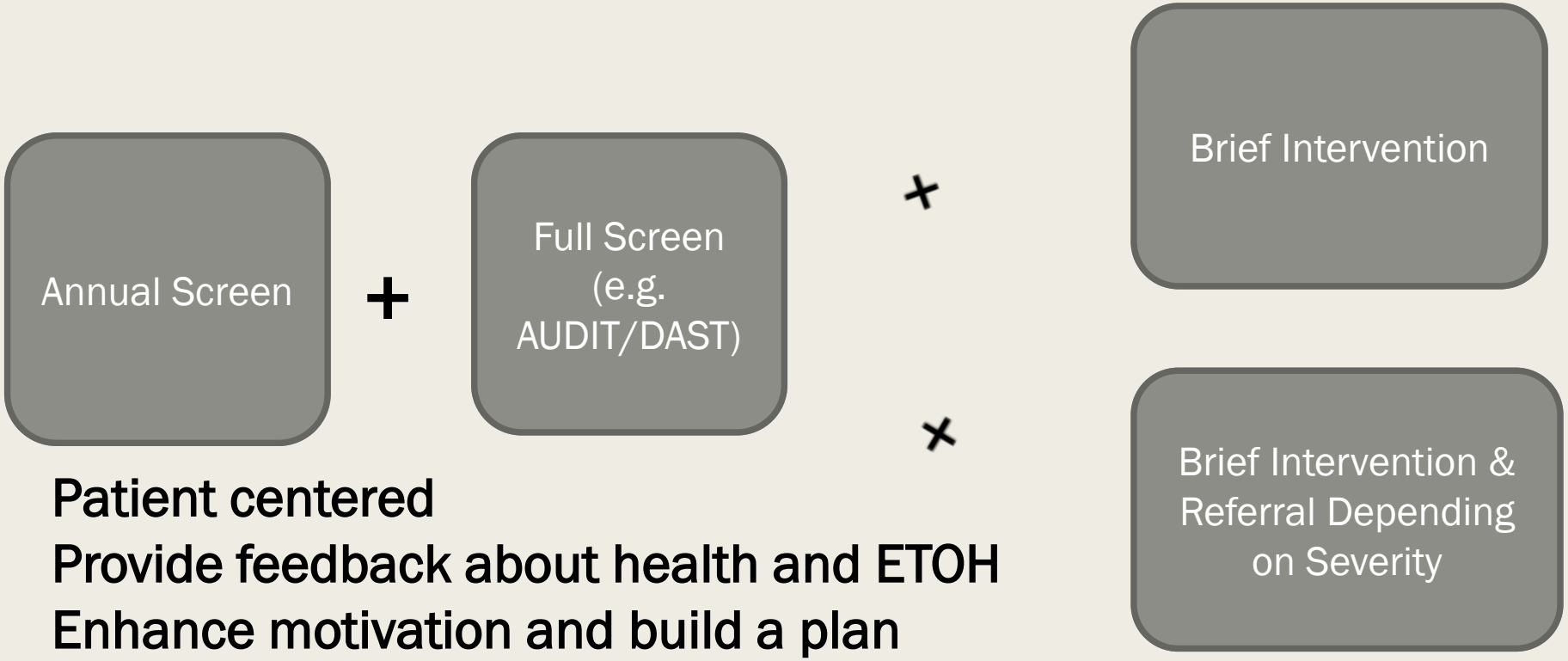
What is SBIRT?

- Screening – Assess patient for risky substance use behaviors using standardized screening tools
  - *Risky – e.g. amount of consumption*
  - *Typically 1-3 questions – with follow up questions as needed*
- Brief Intervention – Engage in a short conversation including feedback and advice
  - *Time limited (5-30 minutes) and patient centered*
  - *Increase insight and awareness regarding substance use*
  - *Psycho-ed around substance use, appropriate limits, etc.*
  - *Encouraged to set goals*
- Referral to Treatment – Refer to brief treatment or additional treatment as needed (typically 5% or fewer)

Why SBIRT?

- Universal screening particular parts of clinic population for substance use
- Helps those are not even looking for treatment (mild to moderate) in pre-contemplation stage
- Targets early intervention for non-dependent substance use
- Person trained in SBIRT to follow up with positive screens
- Substance use complicates healthcare conditions
- For every $1 spent on screening – can save @ $4 in healthcare costs

How is SBIRT done?



Patient centered
Provide feedback about health and ETOH
Enhance motivation and build a plan
Motivational Interviewing Skills
Warm Hand-off preferred
Team-Based Care

What is Collaborative Care? (CoCM)

- Otherwise known as the Impact model
- Evidenced-Based model with dependable ROI
- Registry driven vertical integration model
- Use of medication and visit algorithms
- Disease focused treatment model
- Team based care
- Behavioral Activation and Problem Solving Treatment (PST)
- Improvement is defined by a reduction of the PHQ-9 score by 5 points or 50% within 10 weeks

Why Collaborative Care

- At 12 months, about half of the patients receiving IMPACT care reported at least a 50 percent reduction in depressive symptoms (19% in usual care),
- Analysis of data: survey conducted one year after IMPACT shows that the benefits of the intervention persist after one year and last up to four years
- IMPACT patients experienced more than 100 additional depression-free days over a two-year period than those treated in usual care.
- COST – EFFECTIVNESS
- Reimbursable with Medicare and NC Medicaid

Primary Care Provider	Consulting Psychiatrist	IMPACT Care Manager Role
Oversees all aspects of pt. care at PC clinic	Supports Care Managers and PCP	Educates pt. re: depression
Makes/confirms Dx. for depression using PHQ9	Provides weekly consultation on a case load of patients who are not improving clinically	Offer brief 6-8 sessions, Problem Solving/Behavioral Activation
Starts/fills all scripts (refills)	Provides education and training for primary-care based providers.	Supports anti-depressant therapy if needed
Collaborates w/team members re: txmt progress and adjustments if needed		Monitors depression symptoms for txmt response.
		Completes relapse prevention plan with improved patients
		Reviews registry with psychiatrist regularly

CoCM Workflow

All patients 12+ are given PHQ9 by front desk staff

MA scores PHQ9 & notifies provider of scores 10+

Provider educates patient about IMPACT and makes referral through EMR

Work Flow Continued

ICM calls patient to schedule initial assessment within 72 hours

ICM engages patient in PST & behavioral activation

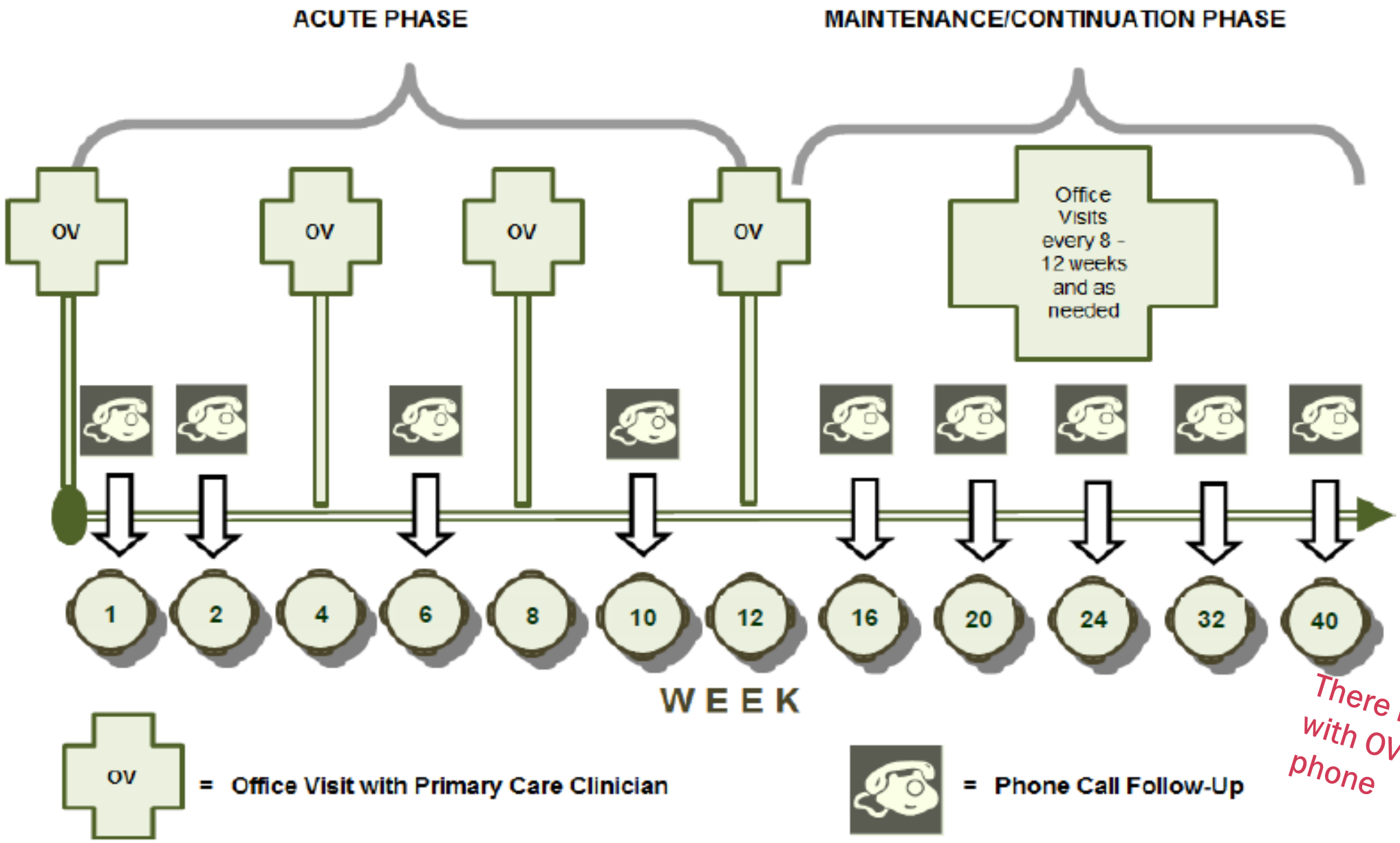
ICM tracks progress in EMR and initiates psychiatric case reviews

PCP Champs attend case review meetings to discuss pts who are not improving

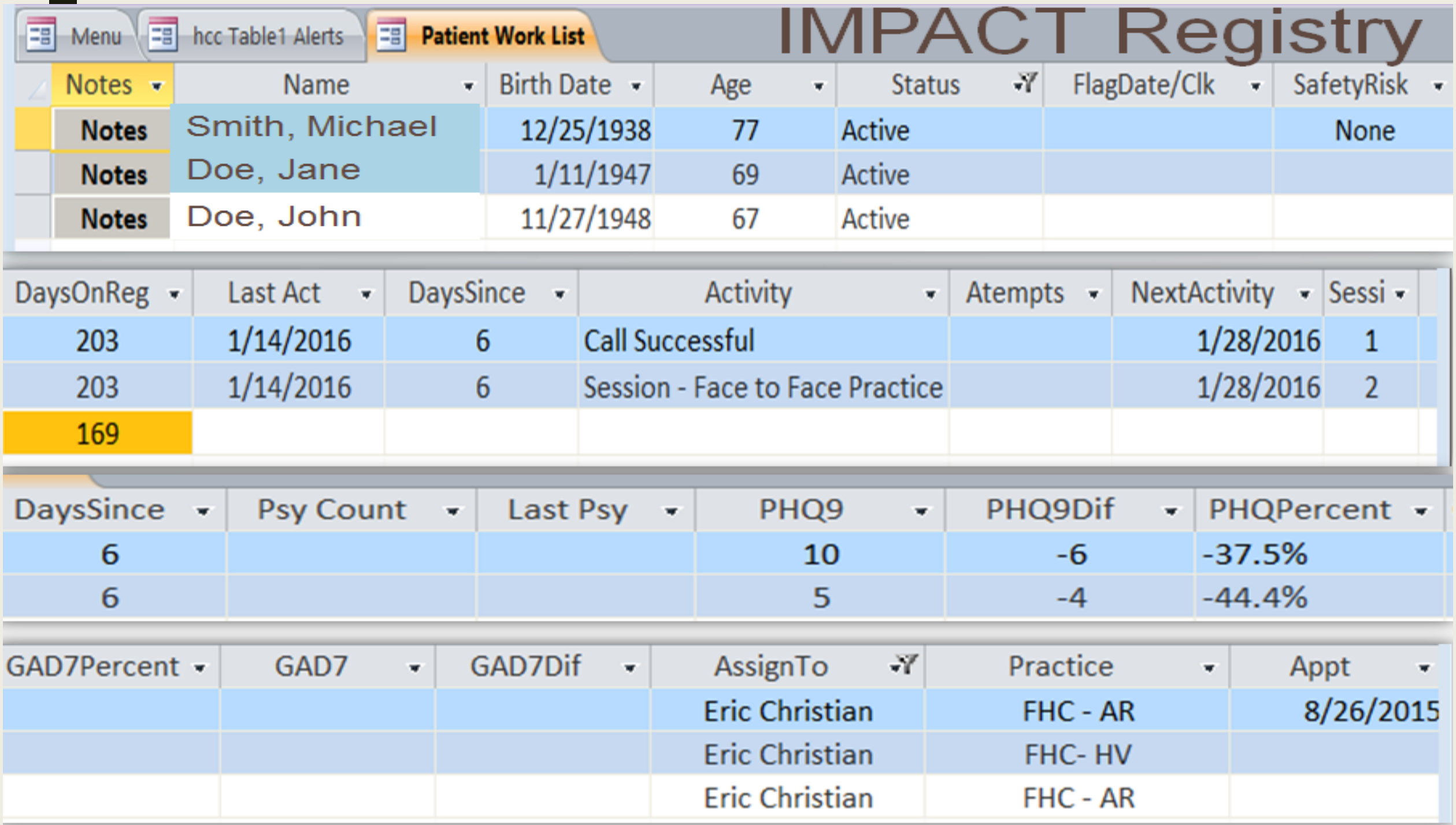
ICM conducts relapse prevention and discharges pts who see improvement

ICM will make referral to behavioral health for patients who don't see improvement

Phone Call Follow-Up Protocol in the Treatment of Depression



There is flexibility with OV vs. phone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hcc Table1 Alerts
Patient Work List
IMPACT Registry
Notes
Name
Birth Date
Age
Status
FlagDate/Clk
SafetyRisk
Notes
Smith, Michael
12/25/1938
77
Active
None
Notes
Doe, Jane
1/11/1947
69
Active
Notes
Doe, John
11/27/1948
67
Active
DaysOnReg
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Atempts
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203
1/14/2016
6
Call Successful
1/28/2016
1
203
1/14/2016
6
Session - Face to Face Practice
1/28/2016
2
169
DaysSince
Psy Count
Last Psy
PHQ9
PHQ9Dif
PHQPercent
6
10
-6
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6
5
-4
-44.4%
GAD7Percent
GAD7
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AssignTo
Practice
Appt
Eric Christian
FHC - AR
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Eric Christian
FHC- HV
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FHC - AR

PHQ9 Chart Report

Report of PHQ9 for Drake, William

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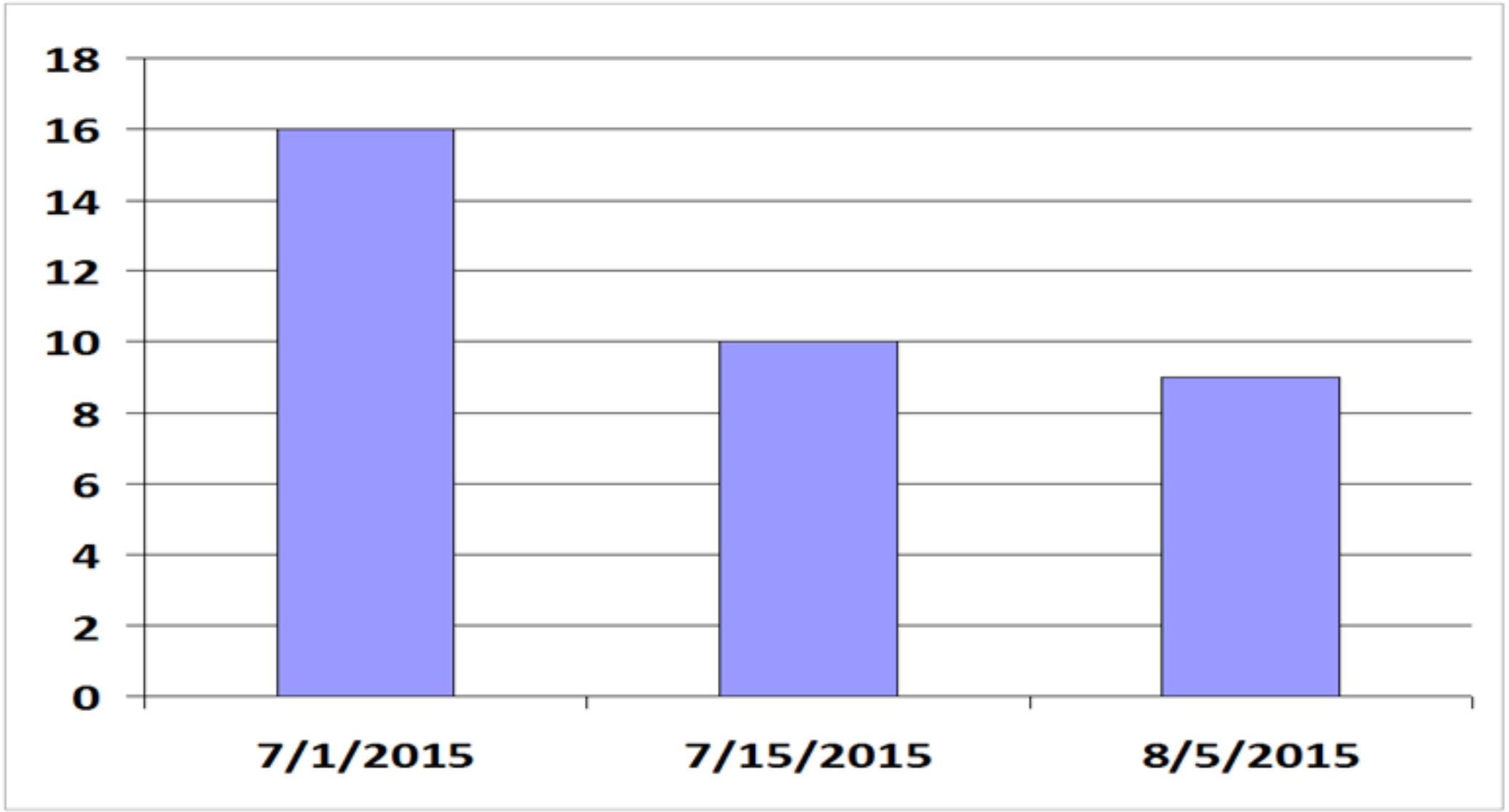


NC Medicaid Bulletin
September 2018

Attention: All Providers

Coverage for Psychiatric Collaborative Care Management

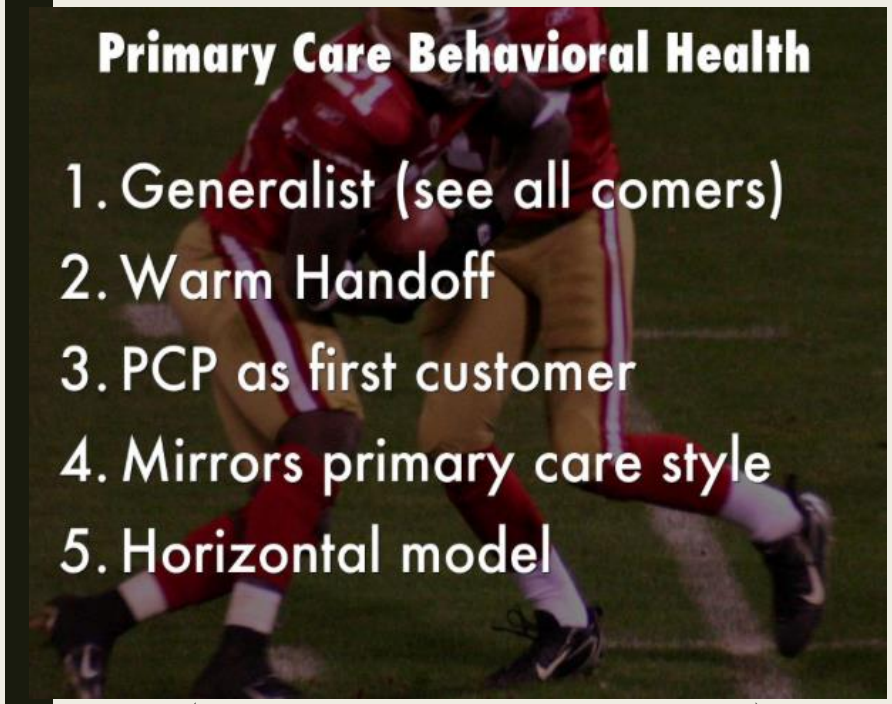
In response to provider requests and to allow reimbursement for behavioral health integration in primary care settings, North Carolina Medicaid is adding coverage for the following evaluation and management codes effective October 1, 2018:

- **99492** – Initial psychiatric collaborative care management, first 70 minutes in the first calendar month
- **99493** – Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities

18

Claims filed "Incident To" the PCP and therefore not through LME/MCO

https://files.nc.gov/ncdma/documents/files/Medicaid-Bulletin-2018-09.pd



Horizontal Integration

Vertical

Vertical

Bi-directional Integration/ Reverse Co-location

- Bidirectional Integrated Care involves placing primary health care providers into specialty mental health settings.
- Levels of bidirectional integration are also on a continuum (coordinated, co-located, integrated)
- Primary care services do not replace the need for more intensive, specialty care. The focus is on targeted medical issues for the population in the setting (Mauer & Jarvis, 2010).

Other Integrated/Co-located Programs

- Improved collaboration at a distance
- Psychiatry consultation to Primary Care
- Psychiatry and Behavioral Health Specialty Co-location
- Hybrid models that utilize care managers to connect clinicians and patients
- Direct access collaborative arrangements

Center of Excellence for Integrated Care

What Is Integrated Care? Definitions and Terms.

Integrated care is defined by the effort to treat the physical health of patients alongside the mental health of patients. How integrated care is delivered varies by setting and by providers, however, well defined ***Models*** of integrated care have emerged in the last decade for integrating behavioral health services into primary care clinics. Some clinics choose to create their own ways of integrating services outside of these models, and these are then called ***Programs.*** Programs are specific to clinics and do not generalize to other situations. More recently programs have emerged to integrate primary medical care into behavioral health settings. These are still emerging and being studied. Both programs and models can also be described as having a certain reach or ***Population Penetration*** into the population. Some models, such as the PCBH model have broad penetration in that almost any patient of a clinic can be impacted by the model whereas the other models by their focus only impact a subset of the clinic population.

MeHAF Score	1 Usual Care	2	3	4	5	6	7	8	9	10 Full Integration
Program or Model Typology	-	Program				SBIRT Model/ Collaborative Care Model			PCBH Model	
Six Levels Crosswalk	1 Minimal Collaboration	2 Basic Collaboration at a Distance			3 Basic Collaboration Onsite	4 Close Collaboration Onsite/ Some System Integration		5-6 Full Collaboration/ Transformed practice		
Population Penetration (Four Quadrants)	Variable					I Low BH/ Low PH	I & III Low BH/ Low PH and/or Low BH/ High PH		I-IV All Quadrants	

Key & Definitions:
MeHAF Level: refers to the degree of integration of physical and mental/behavioral health at a particular site *compared to usual care* as defined by the domains of the MeHAF tool (**http://www.mehaf.org/content/uploaded/images/tools-materials/ssa%20surveyjanuary2015.pdf**).
Program: refers to a site- specific effort to increase the *level* of integration (that is *not* defined by a model) compared to usual care. This effort is not generalizable to other sites and is not evidence-based.
Model: refers to a discrete, well defined, empirically validated, replicable set of characteristics and pathways which systematically apply studied strategies using a defined workforce to achieve integrated care.
Population Penetration: refers to the extent to which a model reaches the population of a site and is represented by the Four Quadrant metric (**http://www.integration.samhsa.gov/resource/four-quadrant-model**).
Six Levels: refers to another commonly used framework of levels of integration (**http://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf**)

The Models

PCBH	A Behavioral Health Consultant works alongside a primary care provider providing real-time support to patients and the medical team to any patients with need in the clinic that day.
SBIRT	A bachelor's or master's level worker screens patients for substance abuse conditions and provides brief intervention to those patients who screen positive.
Collabor-ative Care	A consulting psychiatrist and care manager provides support for prescribing practices of primary care providers for the care of depression.

What is the MeHAF?

- Maine Health Access Foundation designed a site self assessment tool in 2010 to assess integrated care grant sites in a systematic and consistent manner

- based on the model of PCRS – Assessment of Primary Care Resources and Supports for Chronic Disease Self-Management (Brownson, et al., 2007)

- has 16 dimensions for a site's self assessment

- 8 dimensions characterizing "patient support"

- 8 dimensions describing "organizational support"

Why use the MeHAF?

- encourages self assessment by key staff of the sites
- explicit and easily understood dimensions
- describes types of improvement needed to achieve enhanced levels of integrated care
- uses format that is easily and quickly scored
- numeric scores are easily aggregated across sites for evaluation
- numeric scores can show extent and types of improvement over time
- can be given as web-based survey

Integrated Services and Patient and Family-Centeredness

1. co-location of treatment for primary care and mental/behavioral health
2. emotional/behavioral health needs
3. treatment plan(s) for primary care and behavioral/mental health care
4. patient care that is based on (or informed by) best practice evidence for BH/MH and primary care
5. patient/family involvement in care plan
6. communication with patients about integrated care
7. follow-up of assessments, tests, treatment, referrals, and other services
8. social support
9. linking to community resources

Practice / Organization

1. organizational leadership for integrated care
2. patient care team for implementing integrated care
3. providers' engagement with integrated care "buy-in"
4. continuity of care between primary care and behavioral/mental health
5. coordination of referrals and specialists
6. data systems / patient records
7. patient / family input to integration management
8. physician, team, and staff education and training for integrated care

Co-location of treatment for primary care and mental behavioral health care

1	… does not exist; consumers go to separate sites for services
2 3 4	… is minimal; but some conversations occur among types of providers; established referral partners exist
5 6 7	… is partially provided; multiple services are available at same site; some coordination of appointments and services
8 9 10	… exists, with one reception area; appointments jointly scheduled; one visit can address multiple needs

SKILLS LAB

Putting knowledge to work

Vignette

ABC Family medicine is a group practice located in a rural section of North Carolina. They currently have 2 MDs, 2 NPs, 3 PAs, 3 nurses, and administrative staff. Over the years, ABC has found it difficult to refer their patients to mental health services for a number of reasons, including access, stigma, transportation, and patient fears. When the providers try to make a referral, patients say “but why can’t you treat me here? I trust you.”.

Skills Lab

IC Functions/Practices	Current Status/Problems	Next Steps
Screening	Sporadic	Develop protocol PHQ-9
Treat to Target	None	BH to track PHQ-9 scores
Availability	100% scheduled	50% scheduled, 50% PRN
Psychiatric Consultation	None	Networking in community
Increasing functionality of the BH	None	BH will present quarterly on a BH topic at medical lunches

Skills Lab

IC Functions/Practices	Current Status/Problems	Next Steps
Teamwork and Hand-offs	None	Protocol for PRN Hand-Offs
Registries	None	BH to track PHQ-9
Brief BH Interventions	None	Train for BH Interventions
Physical Health Tx	None	BH to attend clinical lunches with medical staff to start learning about common medical issues
Pain/Substance Use	None	BH can present as one of the quarterly lunch and learns

6 months later….

- Realization of value of BHC
- Alternate scheduling for BH (scheduled/PRN)
- Pay hourly at discounted rate for this time until they figure how to utilize her
- Screening protocol implemented for depression as well as workflow
- BHC works on brief intervention skills through training and supervision
- Connects with psychiatrist and begins to track PHQ9/GAD7 on registry
- BHC doing monthly lunch and learns + joining provider meetings
- Feeling more like a team – warm hand offs increasing
- Paying BHC an hourly rate for PRN work and admin – not sustainable

Skills Lab

IC Functions/Practices	Current Status/Problems	Next Steps
Screening	PHQ-9 protocol working	Document protocol and monitor that it is occurring consistently
Treat to Target	BH is tracking PHQ-9	Consulting psychiatrist to work with BH on treat-to-target
Availability	50% scheduled, 50% PRN	Add days, now full-time
Psychiatric Consultation	Engaged psychiatrist available	Start with collaborative care codes
Increasing functionality of the BH	BH presenting quarterly	QI project around antidepressant adherence

Skills Lab

IC Functions/Practices	Current Status/Problems	Next Steps
Teamwork and Hand-offs	Happening regularly	Implement office chat system in EMR
Registries	Informal spreadsheet	Use CoCM registry or EMR registry
Brief BH Interventions	Trained for some simple interventions	Join supervision group for ongoing training and support, possible to find a second BH
Physical Health Tx	BH gaining info from medical staff	BH get more in-depth training in common issues like diabetes and hypertension
Pain/Substance Use	BH has done presentation	Start indicating in registry if patient takes opioids, has SUD

12 months later….

- ABC hired psychiatrist and using Collaborative Care registry
- Money generated sustains the full time BHC salary + 2 hours a week with psychiatrist for consultation
- BHC = busy and happy with combination of patient load
- Provider buy-in greatly increased – want to refer to BHC and do more warm-hand offs but often finding a waitlist or her being unavailable
- Enjoying psychiatrist as consultant – but referring to a different outside psychiatrist is still problematic.
- Consulting psychiatrist is open to taking on some traditional patients with the practice
- Burned out doctor will be audited for their prescribing of opioids and benzos.
- Concern about doctor quitting and/or practice in trouble

Skills Lab

IC Functions/Practices	Current Status/Problems	Next Steps
Screening	Document protocol and monitor that it is occurring consistently	Add protocol for DAST
Treat to Target	Consulting psychiatrist to work with BH on treat-to-target	New protocol around UTOX and monitoring for patients on controlled substances
Availability	Add days, now full-time	Consider adding another BH
Psychiatric Consultation	Start with collaborative care codes	Add 4 hours per week of telepsychiatry for moderate – severe BH issues
Increasing functionality of the BH	QI project around antidepressant adherence	Use psychiatrist to help advance knowledge and comfort about titration of antidepressants

Skills Lab

IC Functions/Practices	Current Status/Problems	Next Steps
Teamwork and Hand-offs	Implement office chat system in EMR	Document protocol for office communication and hand-offs
Registries	Use CoCM registry or EMR registry	Add substance use screening and tracking to registry
Brief BH Interventions	Join supervision group for ongoing training and support, possible to find a second BH	BH to get training in SBIRT or add new BH who has experience in SBIRT
Physical Health Tx	BH get more in-depth training in common issues like diabetes and hypertension	Consider adding diabetes and hypertension to current registry
Pain/Substance Use	Start indicating in registry if patient takes opioids, has SUD	Plan to start SBIRT, start UTOX protocol, use DAST

Your Agency's Plan – See your worksheet

IC Functions/Practices	My Agency's Current Status/Problems	My Agency's Next Steps
1.		
2.		
3.		
4.		

Consider two short term goals and two long term goals

Review and Take Aways

- Form an Implementation Team and meet regularly
- Know your client/patient needs/population
- Consciously examine and choose elements from models of integrated care that fit your client needs and that are realistically feasible
- Use your team: Spread work out across the agency and utilize expertise
- Spend time building a network in your community of strong partners, referral sources, etc.
- Put policies and procedures in place to formalize those community partnerships

QUESTIONS?

References Available Upon Request

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