Practical Approaches for Advancing the Integration of Behavioral Health into Primary Care

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Professor of Psychiatry, Albert Einstein College of Medicine
Disclosure

HENRY CHUNG IS ADVISOR TO VALERA HEALTH, INC.

THERE IS NO MATERIAL IN THIS PRESENTATION RELATED TO THIS COMMERCIAL INTEREST.
AGENDA

Introduction to the Behavioral Health Integration Continuum-Based Framework

Continuum-based Framework Project: Current Findings and Lessons Learned

Support for BH Integration: Collaborative Care Models and NYS- PCMH BHI

Substance Use in Primary Care: Additional Considerations
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 |
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<tr>
<td>Supportive Evidence</td>
<td>• Evidence for key components of successful integration models in primary care</td>
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| 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) |
Continuum-Based Framework

Advancing Integration of Behavioral Health into Primary Care: A Continuum-Based Framework

United Hospital Fund

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. As an independent, nonprofit organization, we analyze public policy to inform decision-makers, find common ground among diverse stakeholders, and develop and support innovative programs that improve the quality, accessibility, affordability, and experience of patient care. To learn more, visit www.uhny.org or follow us on Twitter at @UnitedHospFund.
How to Use the Framework

Self Assessment
Use framework to identify current status of practice elements at every domain and corresponding component

Prioritize and Choose Goals in each domain (at least 3), with a list of initial tactics and resources needed

Develop Timeline and Identify Practice Champions

Identify Infrastructure supports that can be used to facilitate implementation

Identify Performance Measures to ensure progression & fidelity
Continuum-Based Framework

**BHI Framework Domains and 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 (measurement informed)

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
Continuum-Based Framework

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

Integration Continuum
Domain 3: ongoing care management

Component 1: Coordination, communication, and longitudinal assessment

- **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 [BH model 3]
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]
Evaluation of Continuum-Based Framework

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Behavioral Health Integration Issue Brief Series, No. 2

Advancing Behavioral Health Integration for Small Primary Care Practices: Progress, Emerging Themes, and Policy Considerations

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Evaluation of Continuum-Based Framework

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Support for this work was provided by the New York State Health Foundation (NYSHealth).

The mission of NYSHealth is to expand health insurance coverage, increase access to high-quality health care services, and improve public and community health. The views presented here are those of the authors and not necessarily those of NYSHealth or its directors, officers, or staff.

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Framework Project Partners

**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
Continuum-Based Framework

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
Findings

Domain 1: Case Finding Screening and Referral To Care

Referral facilitation and tracking

Integration Level

Number of Practices

<table>
<thead>
<tr>
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<th>Number of Practices</th>
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<tr>
<td>Preliminary: External referral BH specialist/psychiatrist</td>
<td>2</td>
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<tr>
<td>Intermediate I: External referral with MOU or written agreement</td>
<td>0</td>
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<tr>
<td>Intermediate II: “Warm transfers” to a BH specialist or psychiatrist</td>
<td>6</td>
</tr>
<tr>
<td>Advanced: Referral and tracking is performed via EHR</td>
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Referral facilitation and tracking

Preliminary: External referral BH specialist/psychiatrist
Intermediate I: External referral with MOU or written agreement
Intermediate II: “Warm transfers” to a BH specialist or psychiatrist
Advanced: Referral and tracking is performed via EHR

6 Month Progress (N = 9)

Readiness State (N = 9)
Findings

Domain 3: Ongoing Care Management

Coordination, communication, and longitudinal assessment

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<td>Preliminary: Limited, by office staff</td>
<td>1</td>
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<tr>
<td>Intermediate I: Proactive for early response to care</td>
<td>3</td>
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<tr>
<td>Intermediate II: Registry maintained + Active Reminder System</td>
<td>3</td>
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<tr>
<td>Advanced: Registry + Proactive F/U + BH activation + Relapse Prevention</td>
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6 Month Progress (N = 7)

Readiness State (N = 7)
Summary of Key Critical Steps to Behavioral Health Integration in Primary Care

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

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

3. Improve Teamwork in Practice
   - Everyone contributes to whole health

4. Expand Roles of Office Staff to Play Care Management Roles

5. Establish Warm Handoff Capability with on Site or Off Site BH Provider
Montefiore Co-location vs. Collaborative Care (IMPACT): Results

### Depression Symptom Outcomes on PHQ-9

Total enrollment = 240 patients

<table>
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<tr>
<th>Pre – Post Improvement</th>
<th>CoCM sites; N = 118</th>
<th>Co-location sites; N = 122</th>
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<tr>
<td>Mean pre = 15.05</td>
<td>Mean pre = 15.52</td>
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<tr>
<td>Mean post = 10.01</td>
<td>Mean post = 13.30</td>
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Pre to post: **33% improvement**
At post: 44% w/ PHQ9 < 10

Pre to post: **14% improvement**
At post: 31% w/ PHQ9 < 10

### Between group differences

| Mean = -2.81          | \( p = .0005 \) |

Blackmore M et al. (2018). Comparison of Collaborative Care and Colocation Treatment for Patients with Clinically Significant Depression Symptoms in Primary Care. Psychiatric Services
IMPORTANT RESOURCES
NYS Collaborative Care Medicaid Program

Over 160 Primary Care Practices | 1,000+ PCPs | 1,000,000 covered lives

Total # of Sites Participating in CCMP: 161
NYS CCMP

• Provides Medicaid reimbursement to primary care providers using the evidence-based Collaborative Care Model
• Monthly case rate reimbursement methodology
  – $112.50 per patient receiving CC treatment per month
• Medicare also pays for CC as of 2018
• Implementation training & support is available to interested practices

https://aims.uw.edu/nyscc/
NYSCollaborativeCare@omh.ny.gov
Montefiore Virtual Learning Collaborative on Behavioral Health Integration and PCMH

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<th>Project Aims</th>
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<td>Identifying site readiness &amp; outlining tailored steps toward practice integration goals</td>
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<td>Developing implementation plans in preparation of BHI goal-setting</td>
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<td>Understanding screening &amp; follow up workflows for BH screens</td>
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<td>Ensuring high quality documentation for integrated care treatment that supports FFS payments &amp; value-based outcomes, particularly as it relates to NYS-aligned quality &amp; clinical care targets</td>
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<td>Creating strategies to enhance provider communication &amp; shared documentation</td>
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<td>Utilizing clinical decision support tools to understand patient needs &amp; employing registries &amp; tracking tools to measure effectiveness of treatment plans</td>
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<td>Integrating self-management into care management workflows &amp; using strategies for engaging patients in treatment (e.g., using technology or other clinical decision support tools for timely outreach, behavioral activation, between-session contact)</td>
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<td>Assessing quality improvement in integration activities (e.g., adherence to screening &amp; treatment, measurement-informed care workflows to monitor clinical data, program performance toward quality outcomes)</td>
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Interested in Joining Virtual Learning on Behavioral Health Integration and NYS PCMH?

Please contact:
Dr. Michelle Blackmore
mblackmo@montefiore.org
Implementing Care for Alcohol & Other Drug Use in Medical Settings
An Extension of SBIRT

SBIRT Change Guide 1.0
February 2018
Montefiore’s Buprenorphine Treatment Network

- 2015: 1 Clinic
- 2016: 5 Clinics
- 2018: 6 Clinics

Currently:
- Treated >1000 patients
- 4 internal medicine (IM), 2 family medicine (FM) clinics
- All “teaching” clinics for IM and FM residents
- Trained >500 doctors, all IM and FM residents
The opioid epidemic is worsening in our communities

People need access to addiction treatment
There are not enough addiction specialists to treat everyone
Project ECHO® trains community providers to deliver addiction treatment
Patients get the right care, in the right place, at the right time

What is Montefiore Project ECHO for Opioid Use Disorder Treatment?

Project ECHO® is a free tele-mentoring program that connects community providers with addiction medicine experts. Videoconferencing (Zoom) will be used to deliver:

- **Practical didactics** on opioid use disorder treatment, with focus on buprenorphine
- **Case discussions** using patient cases that participants submit
- **Support from peers and experts** within and outside of Montefiore
- **Free CME credit** for physicians, nurse practitioners, and physician assistants
Interested in Joining Project ECHO on Opioid Treatment in Primary Care?

Please contact:
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projectecho@montefiore.org