NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH

Integration in Practice: A Closer Look at the Physical Health Integration Model

Wednesday, February 19, 2020
2:00-3:00pm ET

CoE
Center of Excellence for Integrated Health Solutions
Funded by Substance Abuse and Mental Health Services Administration
Operated by the National Council for Behavioral Health

Audio Logistics

- Call in **on your telephone**, or use your **computer audio option**

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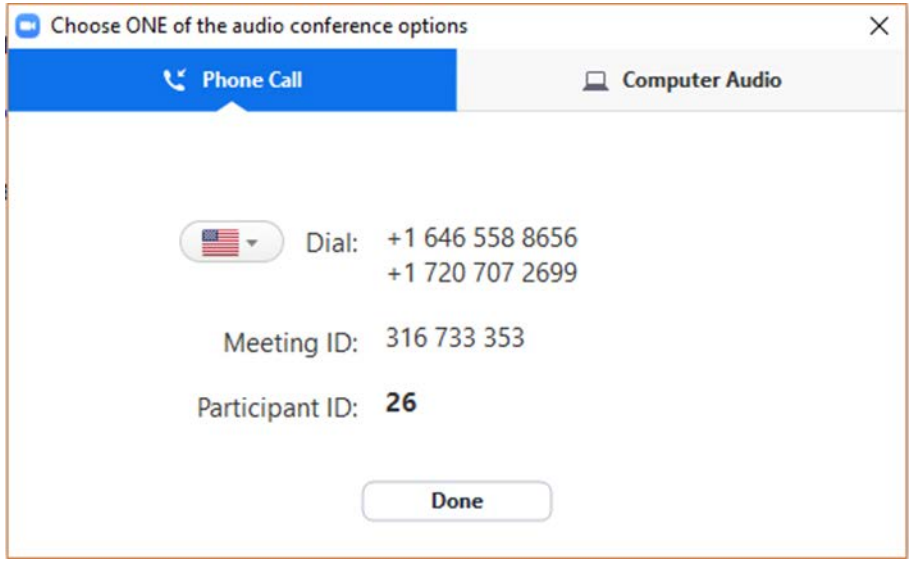
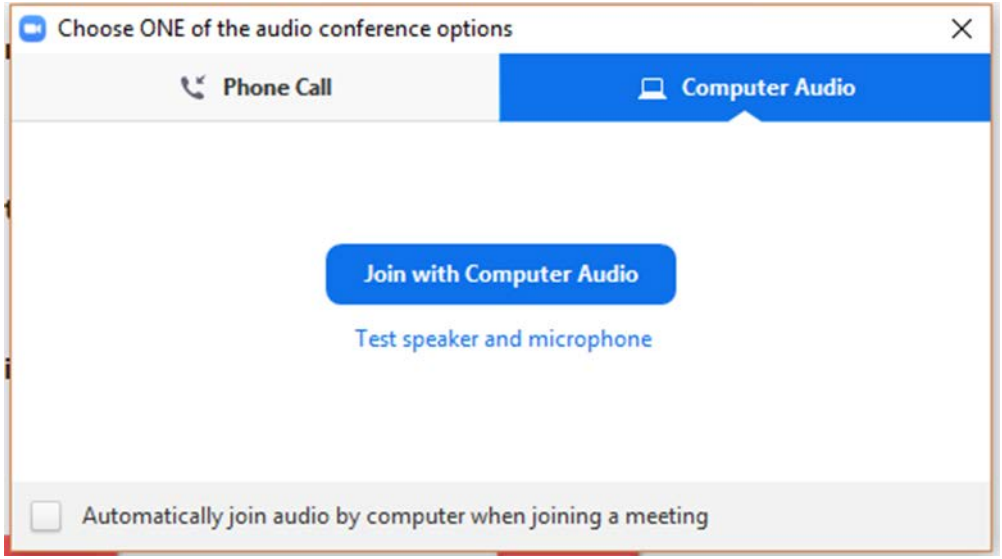
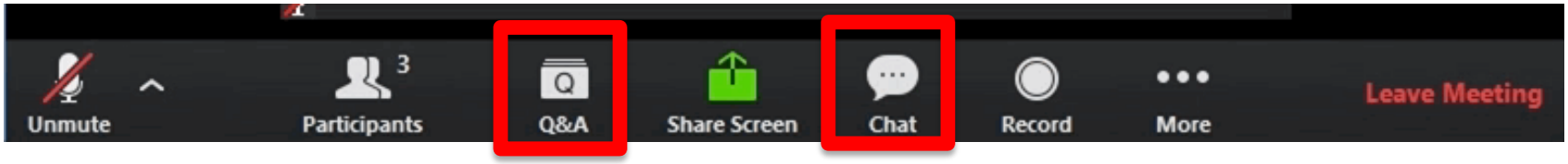




How to Ask a Question/Make a Comment



Type in a **question** in the **Q&A box**
Type in a **comment** in the **chat box**

Both are located at the bottom of your screen.
We'll answer as many questions as we can at the end of the presentation.

Disclaimer

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SAMHSA
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Poll #1: What best describes your role?

- Clinician
- Administrator
- Policy Maker
- Payer
- Other (specify in chat box)

Poll #2: What best describes your organization? (check all that apply)

- Behavioral Health Provider
- Primary Care Provider
- Mental Health Provider
- Substance Abuse Provider
- Other (specify in chat box)

Poll #3: What's your organization's experience with integrating primary care and behavioral health?

- We're **interested and researching** what's involved
- We have a **referral relationship** where we can send patients
- We have **co-located presence or agreement** with another organization to provide services
- We **offer both** primary care and behavioral health services within our organization
- We offer integrated primary care and behavioral health **using a defined model** (e.g., Collaborative Care Model, Primary Care Behavioral Health Model)

Introductions

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Contributors

Project funding support provided by **The New York Community Trust**

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Objectives

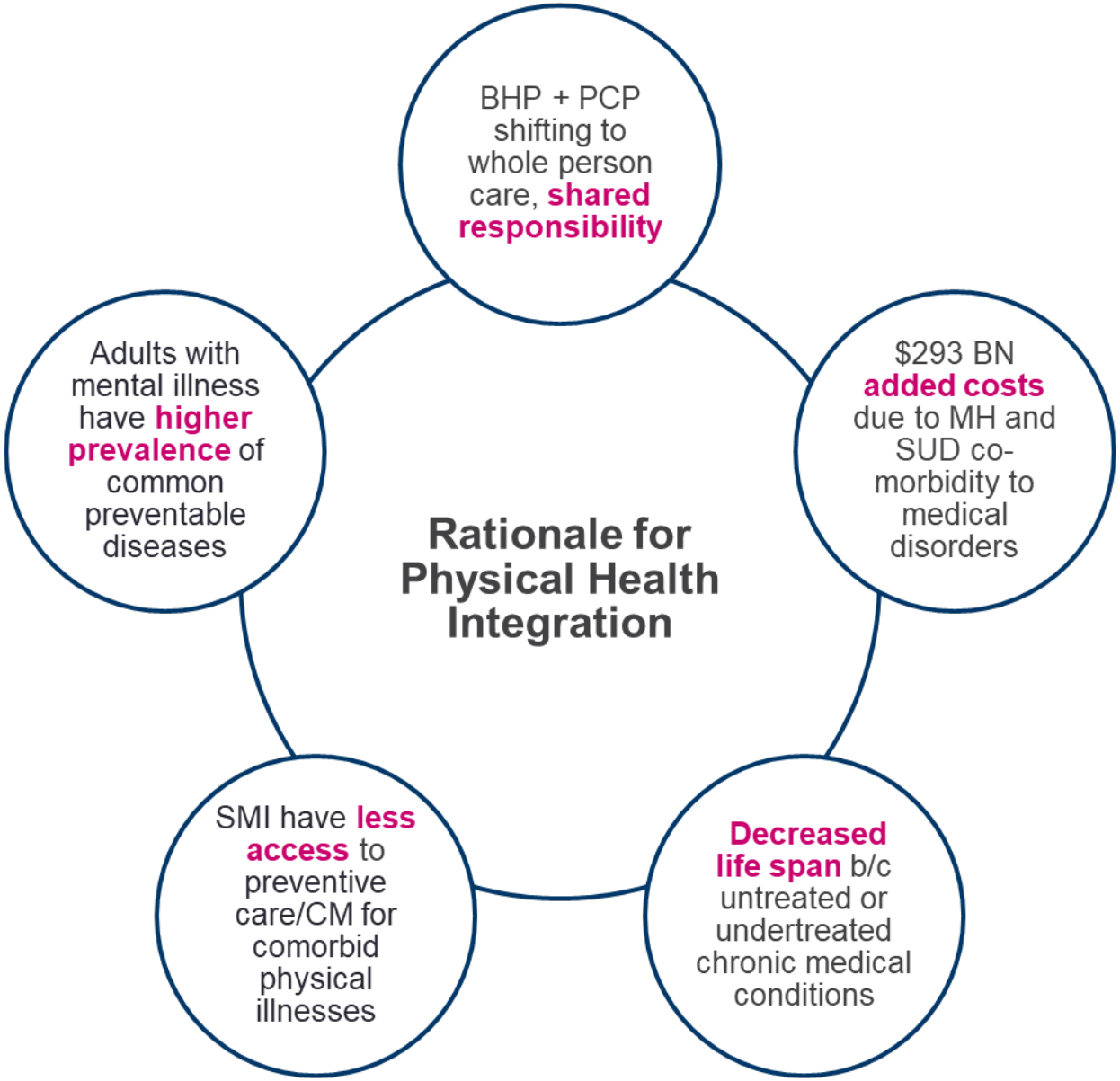
By the end of this webinar, you will be able to:

- Define various risk factors leading to increased morbidity and mortality of patients with behavioral health disorders
- Understand the development of a continuum-based framework for implementation of Physical Health Integration (PHI) for behavioral health settings
- Understand how to prioritize and implement necessary steps for effective integration
- Identify ways of improving care by advancing Physical Health Integration in behavioral health settings using a continuum-based framework

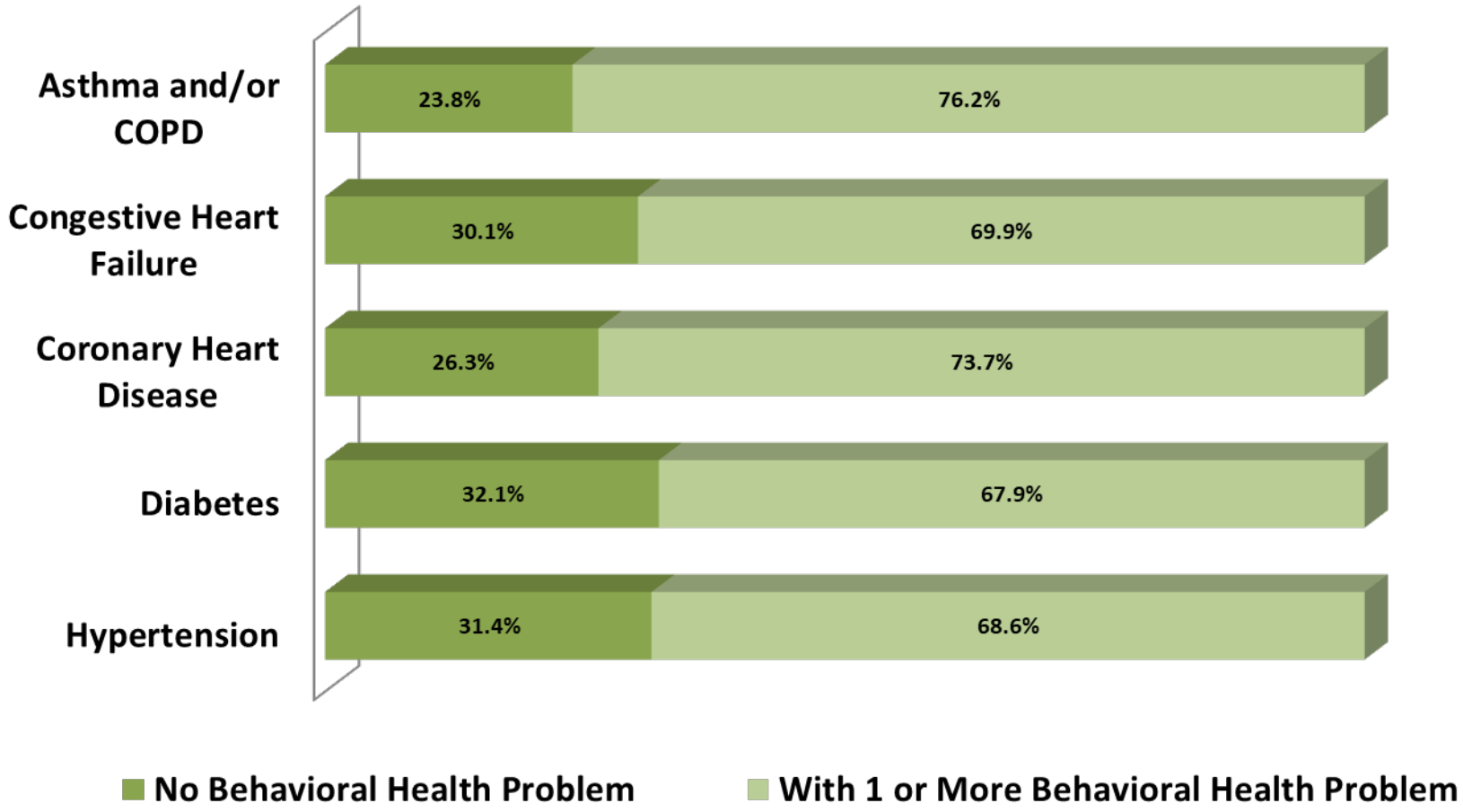
Webinar Agenda

- Background and rationale for Physical Health Integration (PHI) into Behavioral Health
- Project overview
- Development of Continuum-Based Framework for Physical Health Integration
  - Overview of key domains for integrated care
  - Framework of elements and pragmatic value to behavioral health centers
- Pilot evaluation of the Framework in the context of NYC metro area Behavioral Health Clinics

Project Rationale

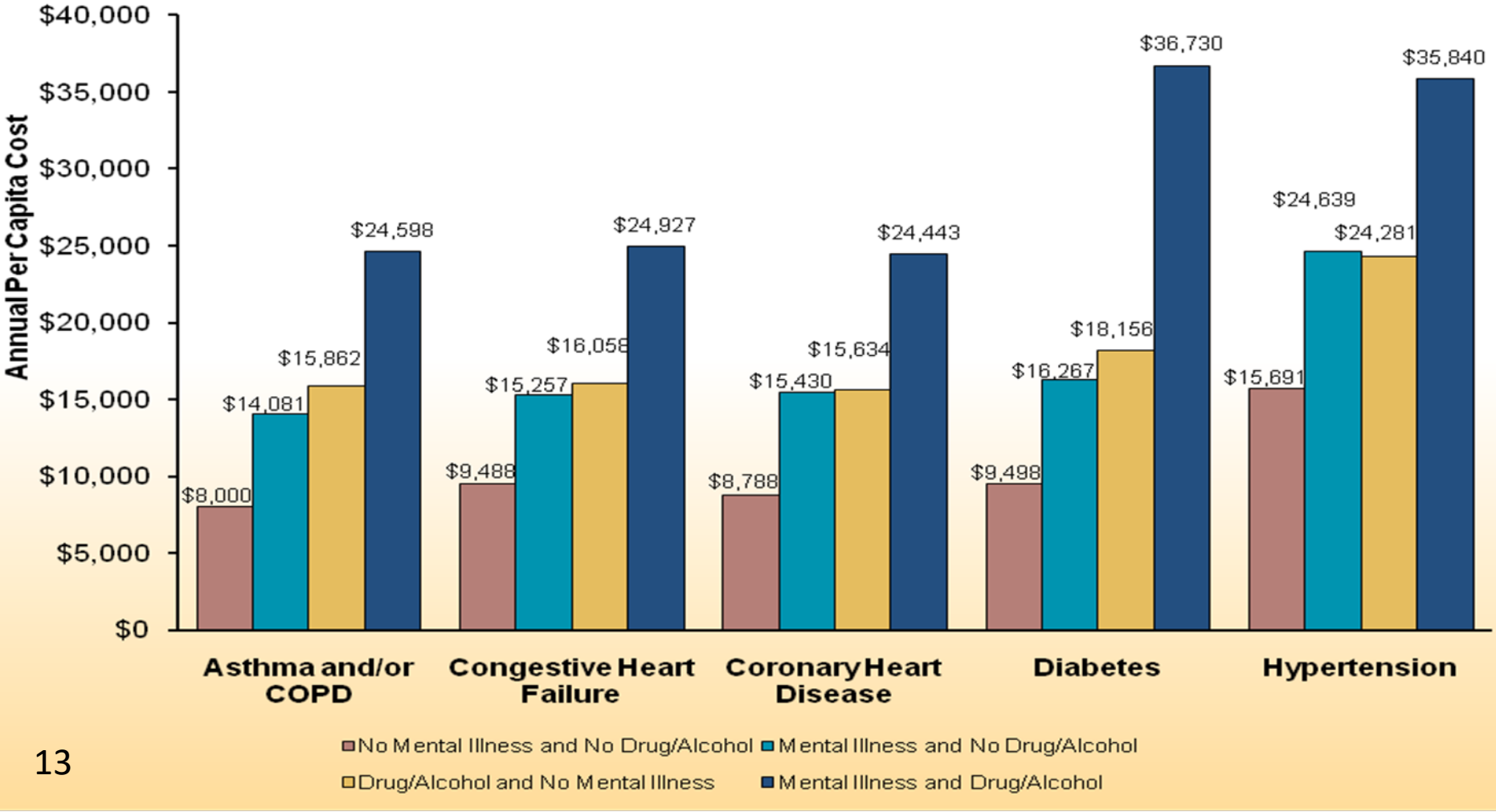


Prevalence of BH Co-Morbidities (Medicaid-only beneficiaries with disabilities)



Boyd, C., Clark, R., Leff, B., Richards, T., Weiss, C., Wolff, J. (2011, August). Clarifying Multimorbidity for Medicaid Programs to Improve Targeting and Delivering Clinical Services. Presented to SAMHSA, Rockville, MD.

Impact of BH Co-Morbidities on Per Capita Costs (Medicaid-only beneficiaries with disabilities)



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Boyd, C., Clark, R., Leff, B., Richards, T., Weiss, C., Wolff, J. (2011, August). Clarifying Multimorbidity for Medicaid Programs to Improve Targeting and Delivering Clinical Services. Presented to SAMHSA, Rockville, MD.

Causes of Excess Mortality in Persons with SMI (10-20 years earlier)[1]

Causes of Mortality	PHI Framework Strategies
Lifestyle Issues; e.g. smoking, poor diet, and reduced physical activity[2]	Screening, self-management supports, ongoing care management, evidence based approach, systematic quality improvement
Social and Environmental Issues; linkages, trauma informed care, care management • Excess rates of poverty and social disadvantage[2]	Linkages with community/social services, trauma informed care, ongoing care management
Poor quality of medical care[3]	Screening, follow up and referral to care, information sharing, multi-disciplinary team care, evidence based approach, systematic quality improvement, use of targeted medications, sustainability
Preventive, primary and chronic disease/co-morbidity care	Screening, follow up and referral to care, information sharing, multi-disciplinary team care, evidence based approach, systematic quality improvement, use of targeted medications, sustainability
Impact of medical effects of psychotropic meds[4]	Use of targeted medications, self-management supports, evidence based

Ward, M., Druss, B. Jama Psychiatry 2019; 76(7): 759-760
de Leon J, Diaz FJ. Schizophr Res 2005;76: 135–157, Compton M et al Harv Rev Psychiatry. 2006 Jul-Aug;14(4):212-22
Wilton et al Soc Sci Med 2004 58: 25-39
Mitchell A. Br J Psychiatry. 2009 Jun;194(6):491-9
Newcomer J. Journal of Clinical Psychiatry. 2007;68 Suppl 4:8-13. Review

Project Background

Reform Priority	• Health reform initiatives began a focus on physical health integration (PHI) in behavioral health (BH) settings, but there are challenges to advancing
Growing Evidence	• Emerging evidence around key components of successful integration models and workflow for PHI
Capacity	• Behavioral health practices differ in size, available resources and treat patients in a variety of environments • E.g. number of BH providers, strengthening partnership with PCPs, existing support staff, specialty BH programs e.g. PROS
Infrastructure	• Ability to implement integrated care influenced by regulatory and payment reform
Implementation Support	• More guidance needed on implementing key components and tailoring PHI models to different behavioral health settings, especially for SMI population and homeless

Review of Current PHI Approaches and Models

Overview of Certified Community Behavioral Health Clinic (CCBHC) Demonstration Model

CMS funded program expanding access to comprehensive and evidence-based MH and addiction care

2-year demonstration extended through May 2020; Federal budget includes $906 million to extend & expand through 2021

Support efforts to advance PHI in the behavioral health sector

Funding will help strengthen the quality of care for MH and SUD organizations

Use Medicaid reimbursement rate based on anticipated costs of expanding services

Augments the goals of integration by enhancing systemic integration and accountability

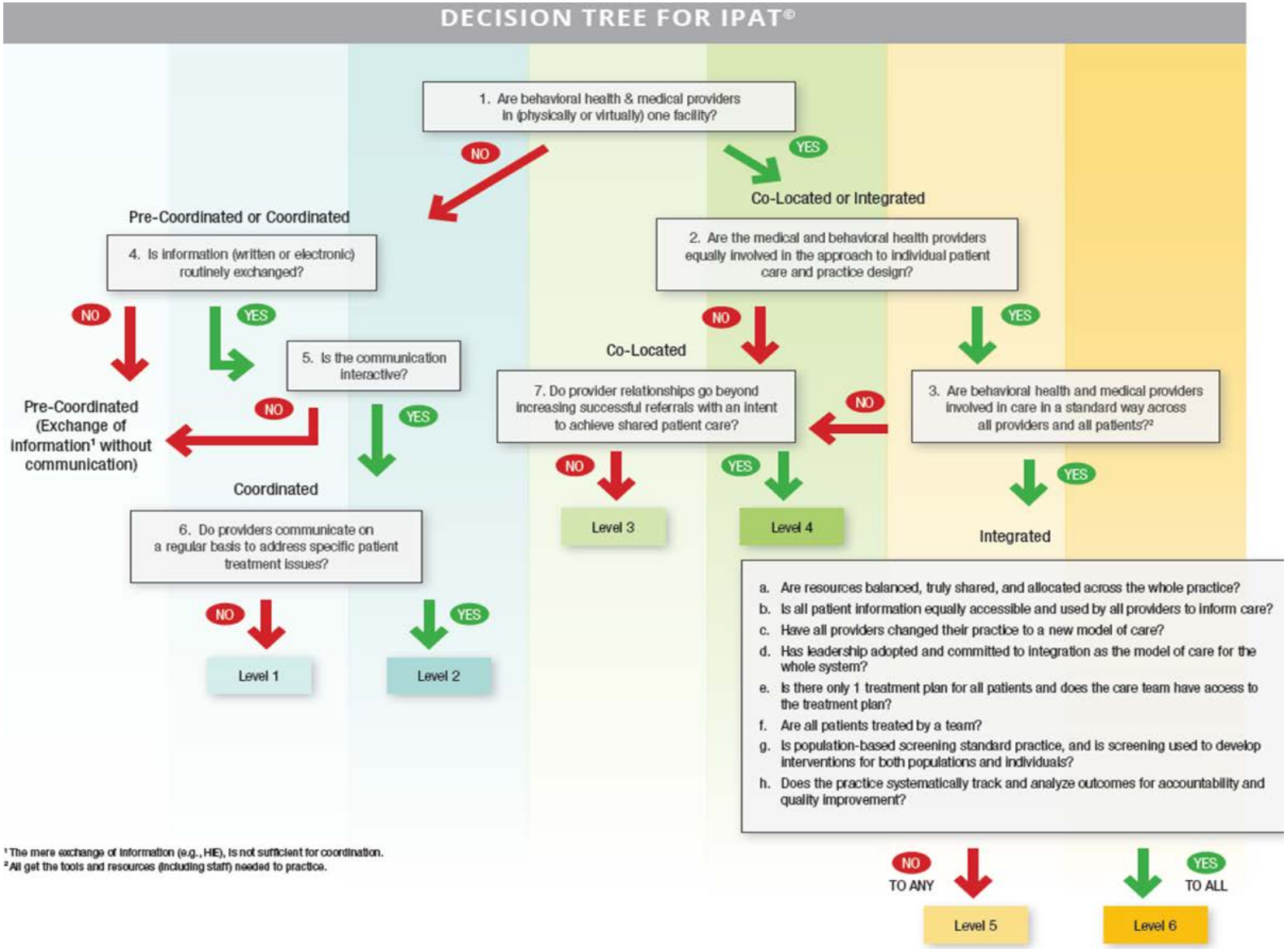
CCBHC State Reported PHI QI Measures

Measures
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling
Initiation and engagement of alcohol and other drug dependence treatment
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications

Integrated Practice Assessment Tool (IPAT) Model Considerations

- One of the few resources published to guide behavioral health specialists on the implementation of PHI
- What the tool offers in simplicity and ease of use, it lacks, however, guidance on the implementation of its specific and achievable elements of PH in BH settings
- Narrow focus may discourage BH centers from implementing alternate but effective forms of PHI

IPAT Model: *uses a series of yes/no questions that cascade to a specific Level of Integrated Healthcare determination*



Organizational Assessment Toolkit (OATI) Compass Model

- **Self-assessment tool** with an array of questions to measure practice level of integration and capacity to deliver primary care and BH services
- Questions in self-assessment tool **align with the PHI** Framework domains and sub-components
- **Limited by** the lack of guidance on how to set goals to advance integration for sites that record low scores
- **Lacks a roadmap** for implementation and continuum model structure to help practices advance based on their level of resource and staffing

Example of Compass Self-Assessment Questionnaire

- Total of 14 sections and 65 questions in self-assessment tool. After each section, there are designated free text for practices to make action plan notes on how to advance.
- At the end of assessment, a Total COMPASS-PH/BH™ Score is produced to measure level of integration.
- Source: https://www.integration.samhsa.gov/operations-administration/OATI_Tool4_COMPASS.pdf

Section 5: Screening and Identification (PCMH*)

12. The program's screening policy states that all individuals are to be screened for issues and immediate risk in a welcoming and respectful manner for mental health issues (including trauma), substance use issues, cognitive issues, physical health issues, and basic safety and social needs.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

13. The program uses evidence based screening processes, checklists, or other tools that are appropriately matched to the person being screened.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

14. The program has an evidence screening process for identifying and documenting nicotine use/dependence.

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

15. The program has procedures for providing evidence screening and intervention services for a full range of physical health and behavioral health conditions or behaviors (e.g., addiction, suicide, metabolic syndromes, infectious diseases such as HIV and Hepatitis C, domestic violence, child/elder abuse, unsafe sexual practices).

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

16. The program has procedures for routine evidence based screening/re-screening, monitoring, and tracking a full range of basic indicators of health and well-being, such as substance use and gambling; common mental health conditions such as depression and anxiety disorders; health indicators such as weight, BMI, and waist circumference; blood pressure; and metabolic status (HbA1c or FBS, liver and kidney function, etc.).

1	2	3	4	5	
Not at all	Slightly	Somewhat	Mostly	Completely	

Total Section Score (Sum of all items answered)	
Average Item Score (Total Section Score divided by number of items answered in the section)	

Action Plan Notes

Developing the Framework

- ✓ **Targeted literature review** on models of physical health integration into behavioral health to identify evidence-based building blocks
- ✓ **Key informant interviews** of behavioral health leadership, behavioral health providers, primary care practitioners, policymakers, and payers
- ✓ Development of a **draft continuum-based framework** for physical health integration in behavioral health settings
- ✓ This approach was successful in developing and evaluating a **Framework for Behavioral Health Integration into Primary Care**
- ✓ *Next steps:* Publication of **issue brief and application to funders for full evaluation** of the Framework

PHI Framework Domains and their Pragmatic Value

PHI Framework Domains & Components

1. Screening, referral to care, and follow-up

- Screening and follow-up for prevention services and general medical conditions
- Facilitation of referrals

2. Evidence-based approach for outcomes & measurement-informed care for common general medical conditions

- Evidence-based guidelines/protocols for preventive interventions
- Evidence-based guidelines/treatment protocols for general medical conditions
- Use of targeted medications for preventive and general medical conditions
- Trauma informed care

3. Ongoing care management

- Longitudinal clinical monitoring and engagement for preventive health and/or general medical conditions

4. Self-management support that is adapted to culture, socio-economic environment, and life experiences of patient population

- Use of tools to promote patient activation and recovery with adaptations for literacy, economic status, language, cultural norms

PHI Framework Domains & Components (Cont'd)

5. Multi-disciplinary team (including patients) used

- Care team
- Sharing of treatment information, case review and feedback

6. Systematic quality improvement

- Use of quality metrics for program improvement

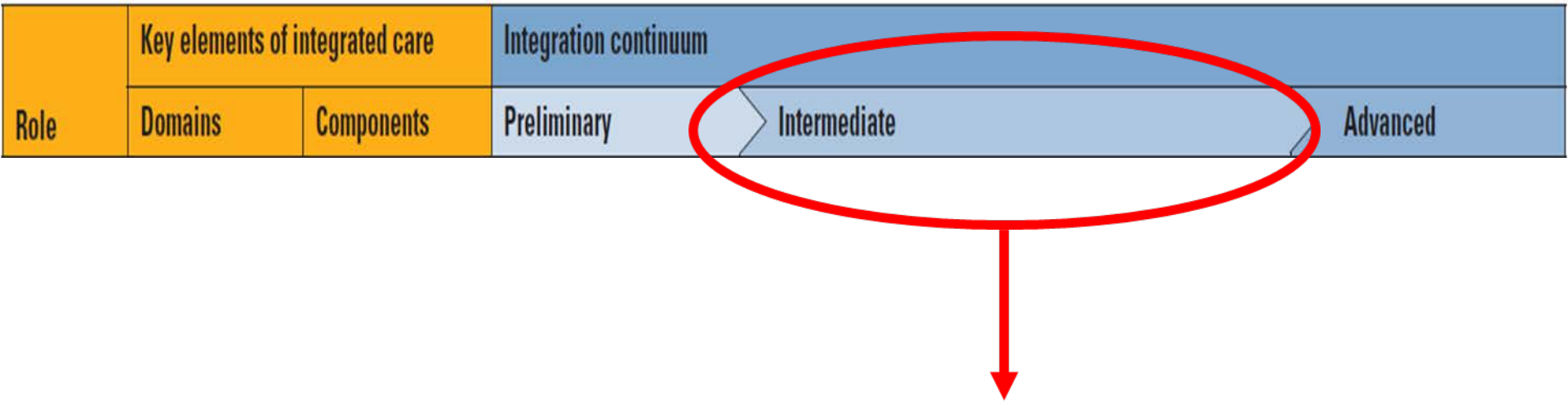
7. Linkages with community/social services that improve physical health or mitigation of environmental risk factors

- Linkages to housing, entitlement, other social support services

8. Sustainability

- Build process for billing outcome reporting to support sustainability of integration efforts
- Build process for expanding regulatory and licensure opportunities

Continuum-Based Integration



Achievable standard?

Primary Care Partnership Support

Three different models of support include:

1) PC Navigation Only

2) Navigation + Provision of Preventive Services Onsite

3) Navigation + Provision of Preventive Services Onsite + Primary Care Treatment Services

PHI Framework Legend Details

Key Definitions

- Basic physical health risk factor screenings include overweight/obesity, tobacco use, alcohol and substance use (including opioid use)
- Comprehensive preventive screenings include above and 3 or more of the following: HbA1c, blood pressure, cholesterol, HIV, hepatitis, colonoscopy, mammogram, pap smear, immunizations, flu shots, annual physical assessment
- General medical conditions include 3 or more of the following: diabetes, hypertension, hyperlipidemia, coronary artery disease, asthma, arthritis, gastrointestinal disease, tooth and gum disease

Requirements

- Individuals with abnormal screens must receive follow-up by a trained BH provider or PCP (external or co-located)
- Embedded and co-located arrangements include PCPs available on site or through telehealth services
- Family caregivers are part of team, if appropriate to patient care

KEY ELEMENTS OF INTEGRATED CARE		INTEGRATION CONTINUUM			
DOMAINS	**COMPONENTS**	**PRELIMINARY**	**INTERMEDIATE**		**ADVANCED**
1. Screening, referral to care, and follow-up	*Screening and follow-up for preventive and general medical conditions*	Response to patient self-report of physical complaints and/or chronic illness with follow-up only when prompted	Systematic screening1 for a limited number of physical health risk factors2 and proactive health education to support motivation to address risk factors	Systematic, comprehensive preventive3 screening and routine follow-up for general medical conditions4	Analysis of patient population to stratify by severity of medical complexity and/or high cost utilization for proactive assessment and consistent tracking
	Facilitation of referrals	Referral to external primary care clinician(s) and no/limited follow-up	Collaborative agreement with external primary care practice to facilitate referral that includes engagement and communication expectations between BH and primary care providers	Referral to on-site, co-located primary care clinician(s), or availability of PCP telehealth appointments with assurance of "warm handoffs" when needed	Enhanced referral facilitation to on-site or closely integrated off-site primary care clinician(s), with automated data sharing and accountability for engagement
2. Evidence based approach for outcomes and measurement-informed care for common general medical conditions	*Evidence-based guidelines or treatment protocols for preventive interventions*	Not used, or minimal guidelines or protocols used for basic physical health risk factor screenings care; no/minimal training for BH providers on preventive screening frequency and results	Routine use of evidence-based guidelines to engage patients on basic physical health risk factor screenings with limited training for BH providers on screening frequency and result interpretation	Routine use of evidence-based guidelines for comprehensive preventive screenings with use of standard workflows for follow- up on positive results. BH staff routinely trained on screening frequency and result interpretation	Systematic tracking and reminder system (embedded in EHR) used to assess need for preventive screenings; workflows for follow-up, availability of evidence-based and outcomes driven programs to reduce or mitigate physical health risk factors (smoking, alcohol, overweight, etc.)
	Evidence-based guidelines or treatment protocols for general medical conditions	Not used, or with minimal guidelines or evidence-based workflows for improving access to care for general medical conditions	Intermittent use of guidelines and/or evidence-based workflows of general medical conditions with limited monitoring activities. BH staff and providers receive limited training on general medical conditions	BH providers and/or embedded5 PCP routine use of evidence-based guidelines or workflows for patients with general medical conditions, including monitoring treatment measures, and linkage/navigation to medical services when appropriate. BH staff receives routine training in basics of common medical conditions	Use clinical decision-support tools (embedded in EHR) with point of service guidance on active clinical management for BH providers and/or embedded PCPs for patients with general medical conditions
	Use of targeted medications by BH prescribers for preventive and general medical conditions	None or very limited use of non-psychiatric medications by BH prescribers. Non-psychiatric Medication concerns are primarily referred to PCP(s) to manage	BH prescriber routinely prescribes nicotine replacement therapy (NRT) or other psychiatric medications for smoking reduction	BH prescriber routinely prescribes smoking cessation as above. May occasionally make minor adjustments to medications for general medical conditions when indicated, keeping PCP informed when doing so	BH prescriber can prescribe NRT as well as prescribe general medical medications with assistance and consultation of PCP

KEY ELEMENTS OF INTEGRATED CARE		INTEGRATION CONTINUUM			
DOMAINS	**COMPONENTS**	**PRELIMINARY**	**INTERMEDIATE**		**ADVANCED**
	Trauma informed care	BH staff have no or minimal awareness of effects of trauma on integrated health care. Limited staff education on trauma and impact on BH and physical health care	Limited staff education on trauma and impact on BH and physical health care	Routine staff education on trauma-informed care model including strategies for managing risk of re-traumatizing. Limited use of validated screening measures for trauma when indicated	Adoption of trauma-informed care strategies, treatment and protocols by BH clinic for staff at all levels to promote resilience and address re-traumatizing and de-escalation procedures. Routine use of validated trauma assessment tools such as ACES and PCL-C when indicated
3. Ongoing Care Management	*Longitudinal clinical monitoring and engagement for preventive health and/or general medical conditions*	None or minimal follow-up of patients referred to primary and medical specialty care	Some ability to perform follow-up of physical health appointments, encourage medication adherence, and navigation to appointments	Routine proactive follow-up and tracking of patient medical outcomes and availability of coaching to ensure engagement and early response	Use of tracking tool (i.e. excel tracker or disease registry software) to monitor treatment response and outcomes over time at individual and group level, coaching and proactive follow-up with appointment reminders
4. Self-management support that is adapted to culture, socio-economic environment, and life	*Use of tools to promote patient activation and recovery with adaptations for literacy, economic status, language, cultural norms*	None or minimal patient education on basic physical health risk factor screenings recommendations	Some availability of patient education on basic physical health risk factor screening recommendations, including materials/handouts, with limited focus on self-management goal-setting	Routine brief patient education on comprehensive preventive screening recommendations and general medical conditions. Treatment plans include diet and exercise, with routine use of self-management goal-setting	Routine patient education with practical strategies for patient activation and healthy lifestyle habits (exercise and healthy eating) delivered using group education, peer support and/or onsite or community-based exercise programs. Self-management goals outlined in treatment plans. Advance Directives discussed and documented when appropriate
5. Multi-disciplinary team (including patients) with dedicated time to provide physical health care	*Care team*	BH provider(s), patient, family caregiver6 (if appropriate)	BH provider(s), patient, nurse, family caregiver	BH provider(s), patient, nurse, peer, co-located primary care clinician(s) (PA, NP, MD/DO), family caregiver	BH provider(s), patient, nurse, peer, primary care clinician(s), care manager focused on physical health integration, family caregiver
	Sharing of treatment information, case review, care plans and feedback	No or minimal sharing of treatment information and feedback between BH and external PCP	Exchange of information (phone, fax) and routine consult retrieval from external PCP on changes of physical health status, without regular chart documentation	Discussion of assessment and treatment plans in-person or by telephone when necessary, and routine medical and BH notes visible for routine reviews	Regular in-person, phone, or e-mail meetings to discuss complex cases and routine electronic sharing of information and care plans supported by an organizational culture of open communication channels

KEY ELEMENTS OF INTEGRATED CARE		INTEGRATION CONTINUUM			
DOMAINS	**COMPONENTS**	**PRELIMINARY**	**INTERMEDIATE**		**ADVANCED**
	Integrated care team training	None or minimal training of all staff levels on integrated care approach and incorporation of whole health concepts	Some training of all staff levels on integrated care approach and incorporation of whole health concepts	Routine training of all staff levels on integrated care approach and incorporation of whole health concepts with role accountabilities defined	Systematic annual training for all staff levels with learning materials that targets areas for improvement within the integrated clinic. Job descriptions that include defined responsibilities for integrated BH and physical health care
6. **Systematic quality improvement**	*Use of quality metrics for physical health program improvement and/or external reporting*	None or minimal use of physical health quality metrics (limited use of data, anecdotes, case series)	Limited tracking of state or health plan- quality metrics, and some ability to track and report group level preventive care screening rates such as smoking, SUD, obesity or HIV screening, etc.	Periodic monitoring of identified outcome and quality PHI metrics (e.g., BMI, smoking status, alcohol status, access to annual physical exams, medications, and common chronic disease metrics, primary care indicators) and ability to regularly review performance against benchmarks	Ongoing systematic monitoring of population-level performance metrics (balanced mix of PC and BH indicators), ability to respond to findings using formal improvement strategies, and implementation of improvement projects by quality improvement team/champion
7. **Linkages with community and social services that improve physical health and/or mitigate environmental risk factors**	*Linkages to housing, entitlement, other social support services*	No or limited/informal screening of social determinants of health (SDOH) and linkages to social service agencies, no formal arrangements	Routine SDOH screening and referrals made to social service agencies, but no formal arrangements established	Routine SDOH screening, with formal arrangements made to social service agencies, with limited capacity for follow-up	Detailed psychosocial assessment incorporating broad range of SDOH needs, patients linked to social service organizations/resources to help improve appointment adherence (e.g. transportation tokens, childcare), healthy food sources (e.g. food pantry), with follow-up to close the loop
8. **Sustainability**	*Build process for billing and outcome reporting to support sustainability of integration efforts*	No or minimal attempts to bill for immunizations, screening and treatment; services supported primarily by grants or other non-reimbursable sources	Billing for screening and treatment services (e.g., preventative care, HBA1c, blood pressure monitoring) under fee-for-services, with process in place for tracking reimbursements for physical health care services	Fee-for-service billing as well as revenue from quality incentives related to PHI (e.g. diabetes and CV monitoring, tobacco screening, etc.). Able to bill for both primary care services and BH services	Receipt of value-based payments (shared savings) that reference achievement of behavioral health and physical health outcomes; revenue helps support PHI services and workforce
	Build process for expanding regulatory and/or licensure opportunities	No primary care arrangements that offer physical health services through linkage or partnership	Informal primary care arrangements that incorporate the basic array (appointment availability, feedback on engagement, report on required blood work) of desired physical health integration services	Formalized primary care arrangements, internal or external, with telehealth if appropriate that incorporate patient centered home services	Maintain a dual license (article 28 and 31) for PHI in a shared services setting and regularly assess the need for administrative or clinical updates as licensure requirements evolve

Primary Care Navigation Support

Three different models of support include:

1. PC Navigation Only
2. Navigation + Provision of Preventive Services Onsite
3. Navigation + Provision of Preventive Services Onsite + Primary Care Treatment Services

Note: Models will have associated quality metrics for reporting and internal monitoring

Key Observations from Stakeholders

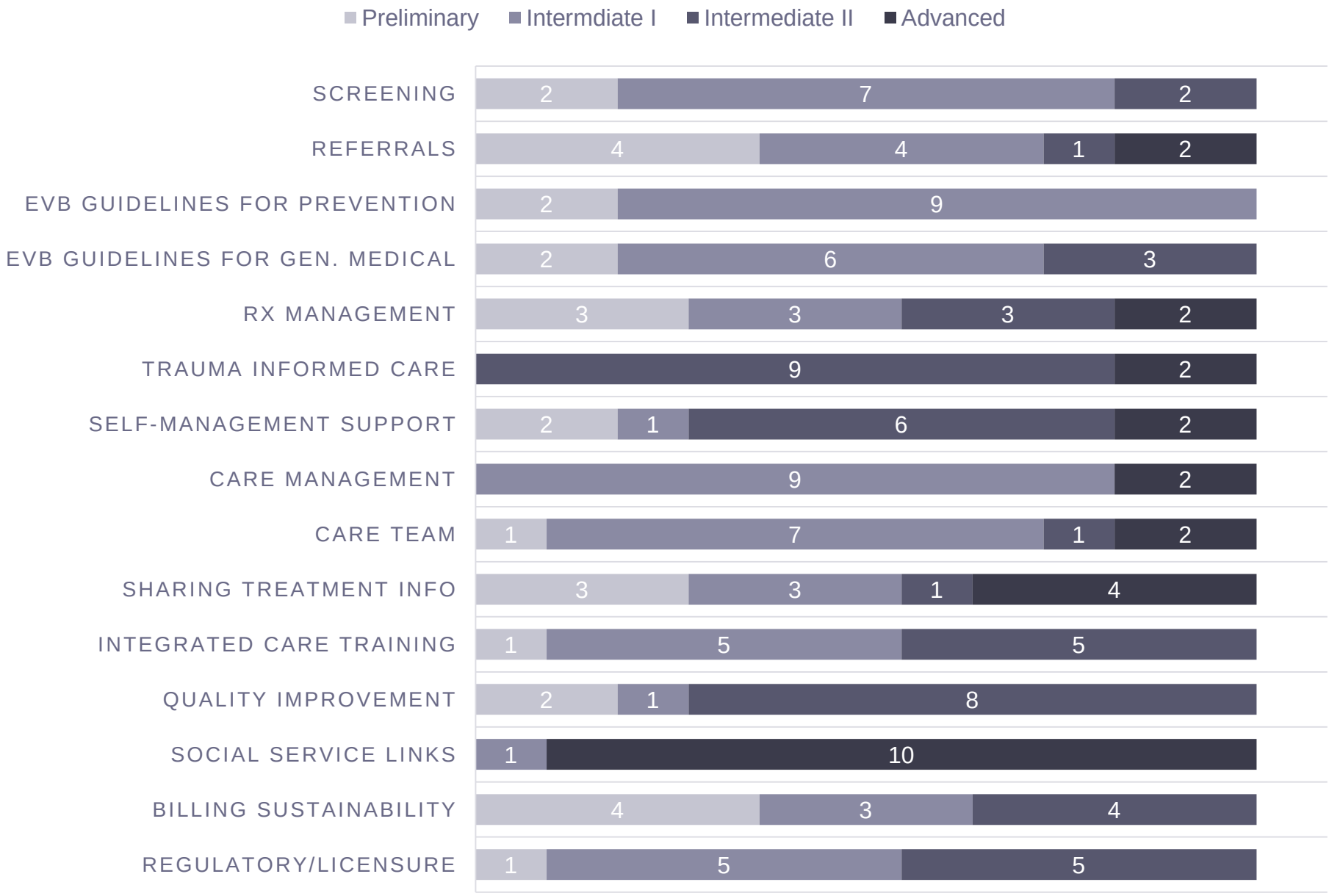
- Broad support for notion of an evolution to integration across a continuum
- Importance of the care team approach and integrated training
- Initial PHI focus on supporting simple but impactful integration initiatives
- Billing and regulatory support required for service sustainability in addition to value-based payments
- Incentives to support the evolution of integration are necessary
- Need to improve quality measurement for chronic conditions
- Establish an EHR system that is transparent and visible between BH and PC

Initial Pilot Self-Assessments Using the Framework

PHI Readiness Assessment Participants

Organization/Branch	Clinic Site	License Type
New York State Psychiatric Institute (NYSPI)/ Washington Heights Community Service	Inwood Clinic	31 (mental Health)
	Audubon Clinic	
Services for the Underserved	Wellness Works- CTI	31 and 32 (Dual license for mental health and substance use)
	Wellness Works- Fulton Street	
Institute for Community Living (ICL)	Guidance Center Brooklyn Heights	31 (mental health)
	Rockaway Parkway Clinic	
	Highland Park Clinic	
The Guidance Center of Westchester	Mount Vernon Clinic	31 (mental health)
	Sunrise Program	32 (substance use)
Westchester Jewish Community Services	Mount Vernon Family Mental Health Clinic	• 31 (mental health) • Intensive Outpatient Treatment and Integrative Outpatient Services
OHEL Children's Home and Family Services	Tikvah	31 (mental health)

CLINIC'S CURRENT PHI STATE ALONG THE CONTINUUM



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Next Steps: Full Framework Evaluation will focus on…

- Ensure greater clinic variation in level of integration and licensure for our participants
- Revise Framework based on participant feedback and experience to achieve greater clarity between domains and their elements
- Collect preliminary quality metrics around certain Framework domains through the clinics' EHR data collection
- Goal setting targeted around implementing the framework and overcoming challenges encountered by the clinics

Questions?

Upcoming Webinars & Events

Webinar - Addressing the Social Determinates of Health: How Non-Medical Factors Impact Integrated Care

March 18, 2:00-3:00pm ET

Register from our website here: https://www.thenationalcouncil.org/integrated-health-coe/training-events/

Learning Communities and ECHOs – Learn more on our website here: https://www.thenationalcouncil.org/integrated-health-coe/learning-collaboratives/

Relias Online Trainings – Learn more on our website here: https://www.thenationalcouncil.org/integrated-health-coe/training-events/

Request Technical Assistance - https://www.thenationalcouncil.org/integrated-health-coe/request-assistance/

HRSA Center of Excellence for Behavioral Health Technical Assistance (CoE BHTA)

- **John Snow Institute's HRSA Center of Excellence**
  - Website: https://www.hrsa.gov/behavioral-health/behavioral-health-technical-assistance-bhta

Thank You

Questions?

Email integration@thenationalcouncil.org

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