NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH

Advancing Integration in Community Behavioral Health: Using a New General Health Integration Framework

Wednesday, November 18, 2020

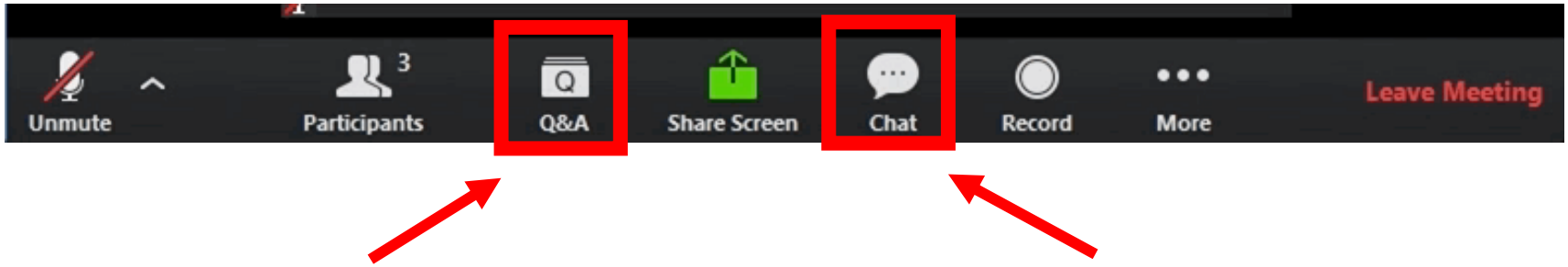
3:00 – 4:00pm ET

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

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

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).

SAMHSA
Substance Abuse and Mental Health Services Administration

www.samhsa.gov

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 Use Provider
- Other (specify in chat box)

Poll #3: Where is your organization in the process of integration?

- Learning/Exploring
- Beginning Implementation
- Advanced/Full Implementation
- Ongoing Quality Improvement
- Other (specify in chat box)

Introductions

Henry Chung, MD
Senior Medical Director, Montefiore Care Management and Professor of Psychiatry at the Albert Einstein College of Medicine

Ekaterina (Katy) Smali, MPA MPH PMP
Project Co-Director, Montefiore Care Management

Montefiore DOING MORE™

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

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

Contributors

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

Project Team includes:

- **Harold Alan Pincus, MD**, Department of Psychiatry, Columbia University and New York-Presbyterian Hospital
- **Charles Ingoglia, MS**, The National Council of Behavioral Health
- **David Woodlock, MS**, Institute for Community Living
- **Varsha Narasimhan, MD**, Department of Psychiatry, Jacobi Medical Center of Health and Hospitals NYC
- **Matthew Goldman, MD, MS**, Department of Psychiatry, University of California, San Francisco
- **Rachel Talley, MD**, Department of Psychiatry, University of Pennsylvania

Objectives

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

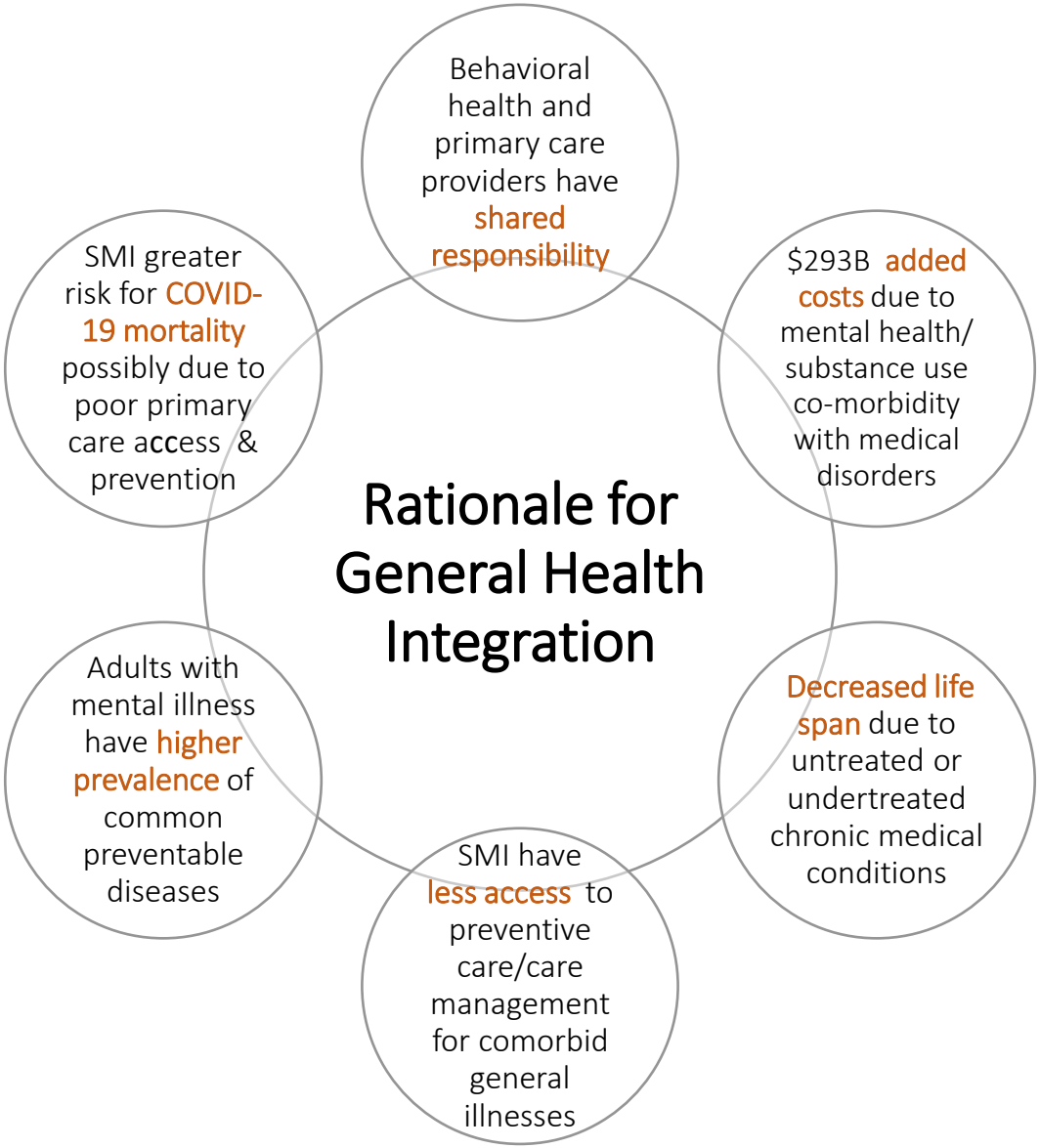
- Define risk factors leading to increased morbidity and mortality of patients with behavioral health disorders
- Understand the components of a continuum-based framework for implementing and advancing General Health Integration in community behavioral health
- Use practical guidance on prioritizing and implementing necessary steps for effective integration

Webinar Agenda

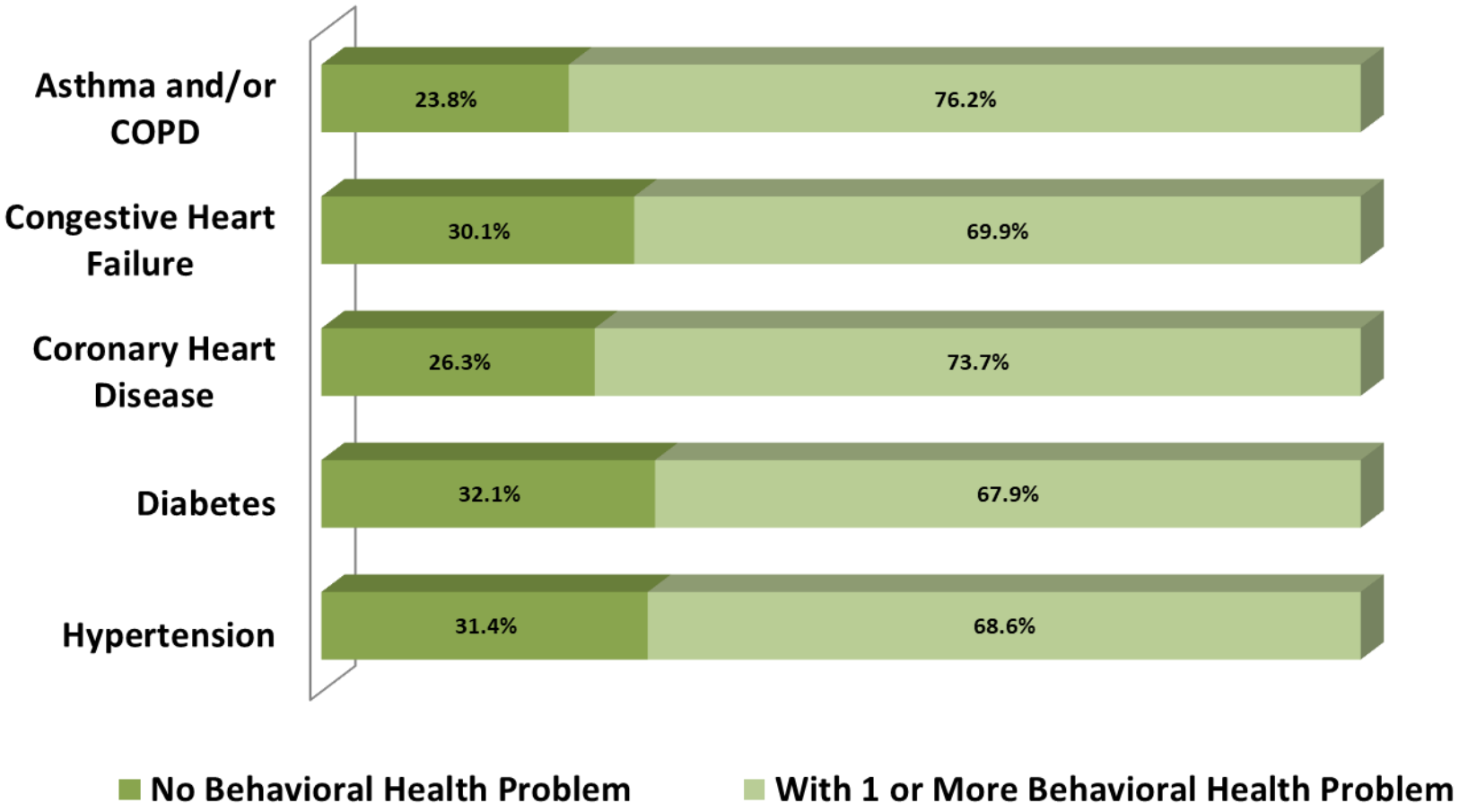
- Background and rationale for the critical need for general health integration into community behavioral health

- Introduction of continuum-based framework for general health integration
  - Overview of key domains and subdomains for integrated care
  - Framework's pragmatic value to CCBHCs and other motivated clinics

- Learnings from the Pilot evaluation of the Framework by NYC metro area community behavioral health clinics

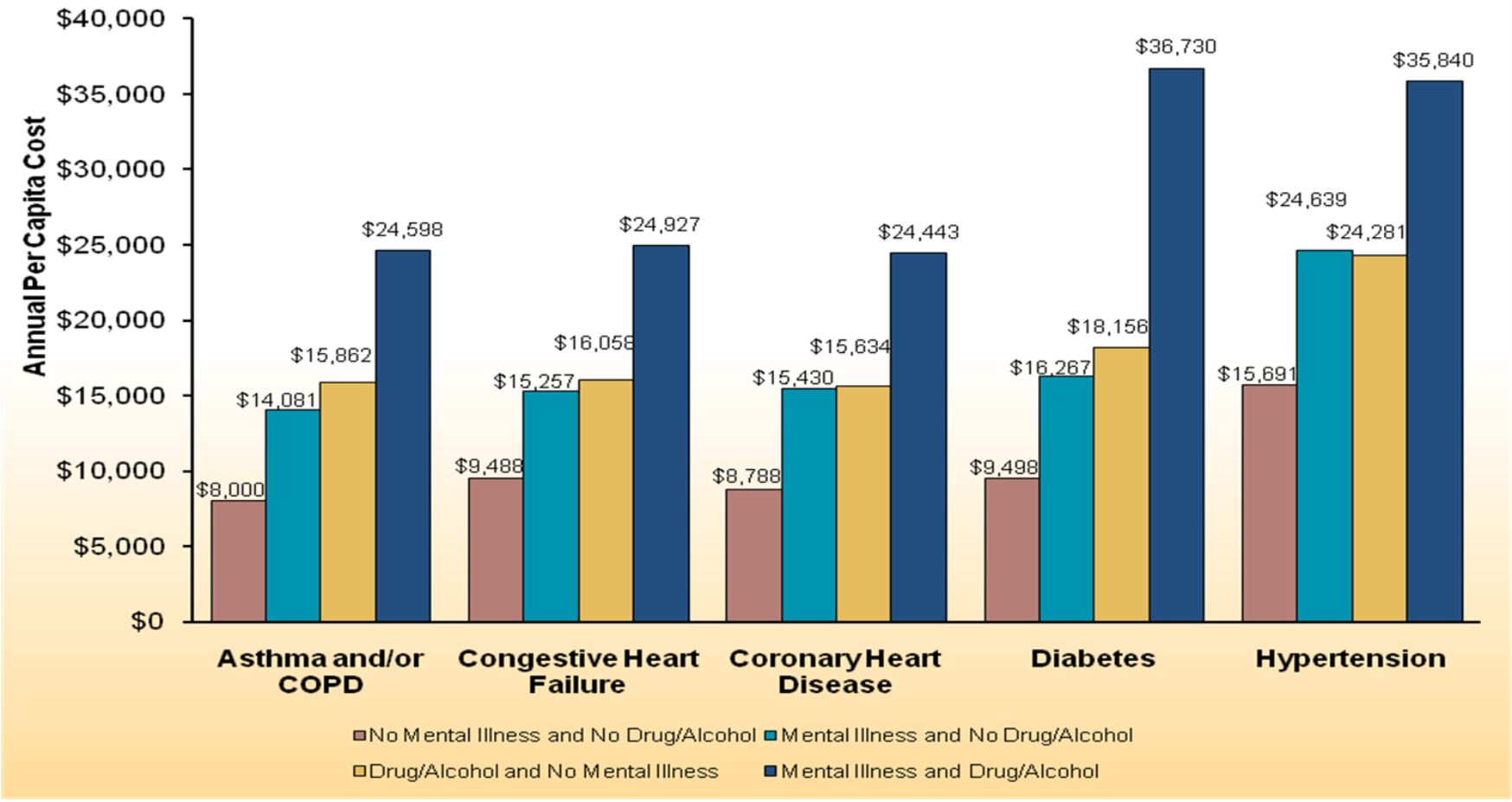

Rationale for General Health Integration
Behavioral health and primary care providers have shared responsibility
$293B added costs due to mental health/ substance use co-morbidity with medical disorders
Decreased life span due to untreated or undertreated chronic medical conditions
SMI have less access to preventive care/care management for comorbid general illnesses
Adults with mental illness have higher prevalence of common preventable diseases
SMI greater risk for COVID-19 mortality possibly due to poor primary care access & prevention

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 & Delivering Clinical Services. Presented to SAMHSA, Rockville, MD.

Impact of BH Co-Morbidities on Per Capita Costs (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.

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

Causes of Mortality	GHI Framework Strategies
Lifestyle Issues; e.g. smoking, poor diet, and reduced General 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

Risk of COVID-19 Mortality with Psychiatric Diagnosis

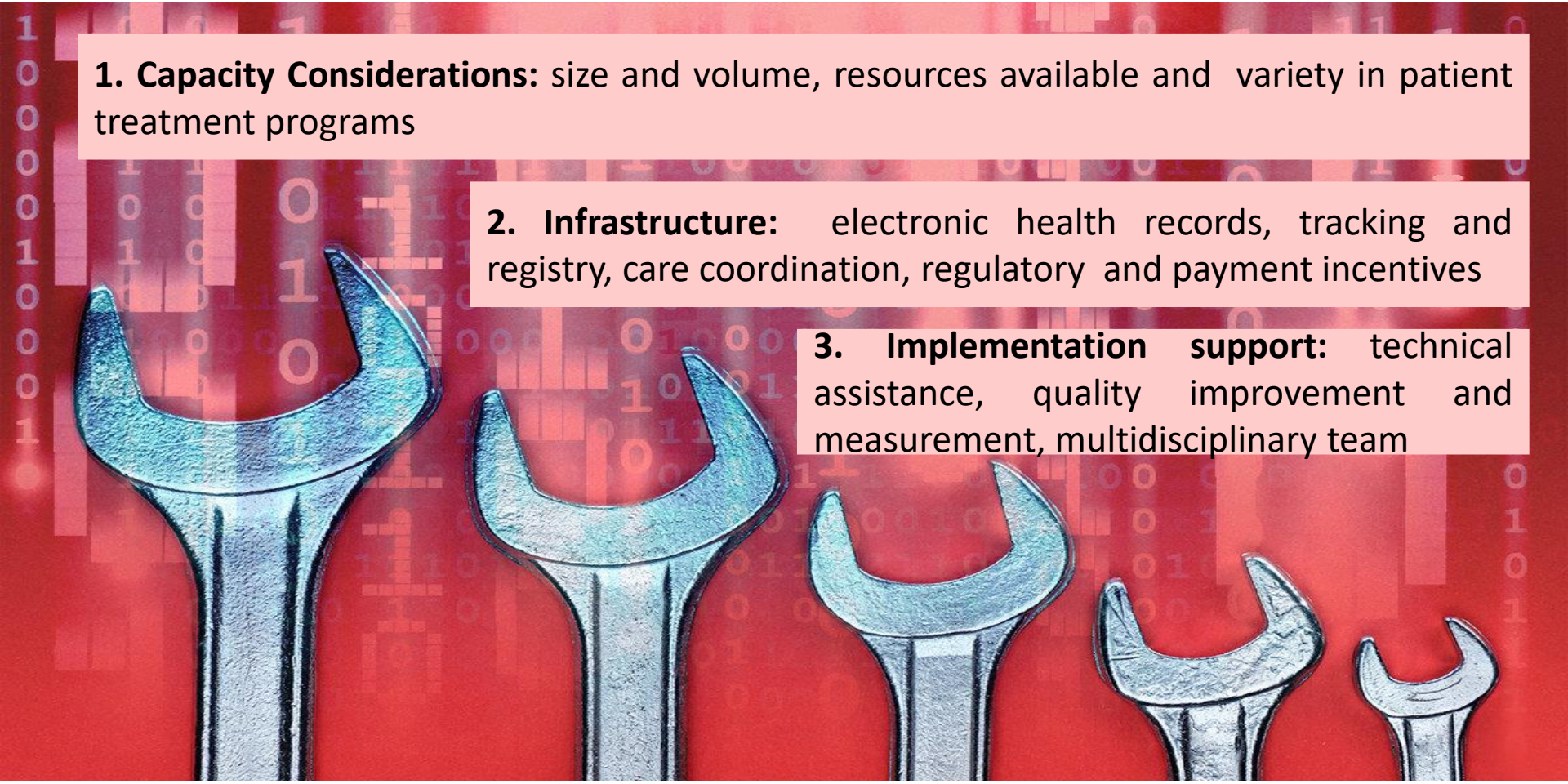
- Study shows that patients with a prior psychiatric diagnosis while hospitalized for COVID-19 had a higher mortality rate compared those without a psychiatric condition.

- Individuals with concurrent psychiatric and medical diagnoses have poorer outcomes and higher mortality.

- The cause is unclear, but psychiatric disorders may augment systemic inflammation and compromise the function of the immune system, while psychotropic medications may also be associated with mortality risk

Reference: Li, L., Li F., Fortunati, F. and Krystal JH: Association of a Prior Psychiatric Diagnosis With Mortality Among Hospitalized Patients With Coronavirus Disease 2019 (COVID-19) Infection. JAMA Network Open. 2020;3(9)

What Do Clinics Need to Consider for Integration?



1. Capacity Considerations: size and volume, resources available and variety in patient treatment programs

2. Infrastructure: electronic health records, tracking and registry, care coordination, regulatory and payment incentives

3. Implementation support: technical assistance, quality improvement and measurement, multidisciplinary team

Poll #4: What type of general health integration support does your organization currently receive? (check all that apply)

- Technical assistance and/or training
- Data analysis for general health performance reporting (e.g. BP, HBA1c, BMI, etc.)
- Funding for general health integration training
- Funding for staff who specifically support general health integration (e.g. medical, nursing, care managers, health educators, peers, etc.)
- Financial Incentives for improving the general health or chronic illness status of patients/consumers
- Other (specify in chat box)

Poll #5: What GH integration quality metrics does your organization currently track or report? (check all that apply)

- No ability to track or report any general health measures

- Able to track and report some basic preventive measures such as smoking status and cessation treatment offered, obesity, recent primary care or medical specialty appointments

- Able to track and report relevant chronic illness measures such as HBA1c, blood pressure, LDL

- Other (specify in chat box)

GHI Evidence Based Framework Domains and Subdomains

GHI Framework Domains & Subdomains

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

1.1 Screening and follow-up

1.2 Facilitation of referrals

2. Evidence-based care for preventive and general medical conditions

2.1 Use of guidelines or treatment protocols

2.2 Use of targeted medications by behavioral health prescribers

2.3 Trauma informed care

3. Ongoing care management

3.1 Longitudinal clinical monitoring and engagement

4. Self-management support adapted to patient

4.1 Use of tools to promote patient activation and recovery

GHI Framework Domains & Subdomains (Cont'd)

5. Multi-disciplinary team (including patients) with dedicated time

5.1 Care team

5.2 Sharing of treatment information, case review, care plans and feedback

5.3 Integrated care team training

6. Systematic quality improvement

6.1 Use of quality metrics for physical health program improvement and/or external reporting

7. Linkages with community and social services

7.1 Linkages to housing, entitlement, other social support services

8. Sustainability

8.1 process for billing and outcome reporting

8.2 process for expanding regulatory and/or licensure opportunities

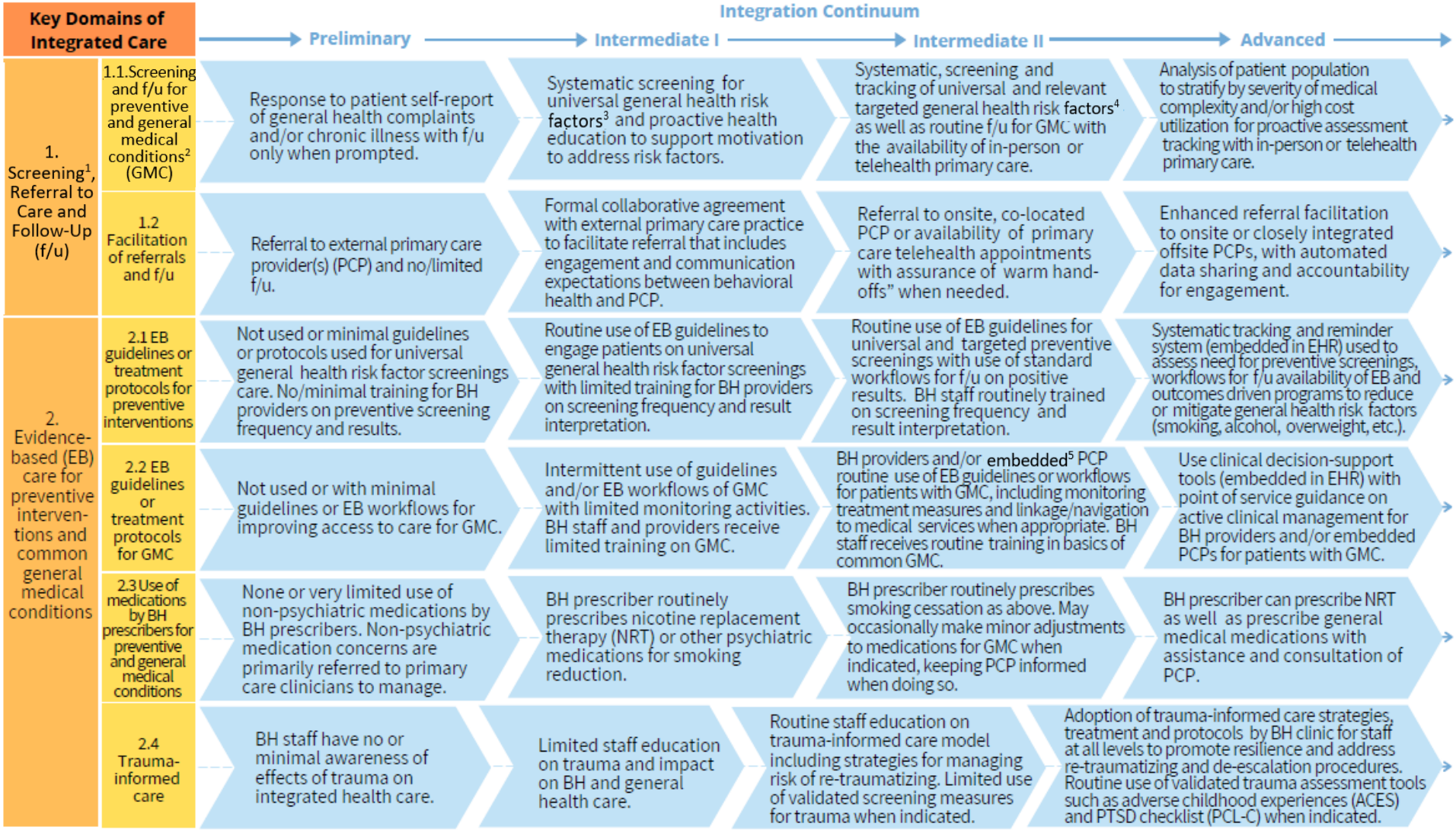
GHI Framework Legend Details

Key Definitions

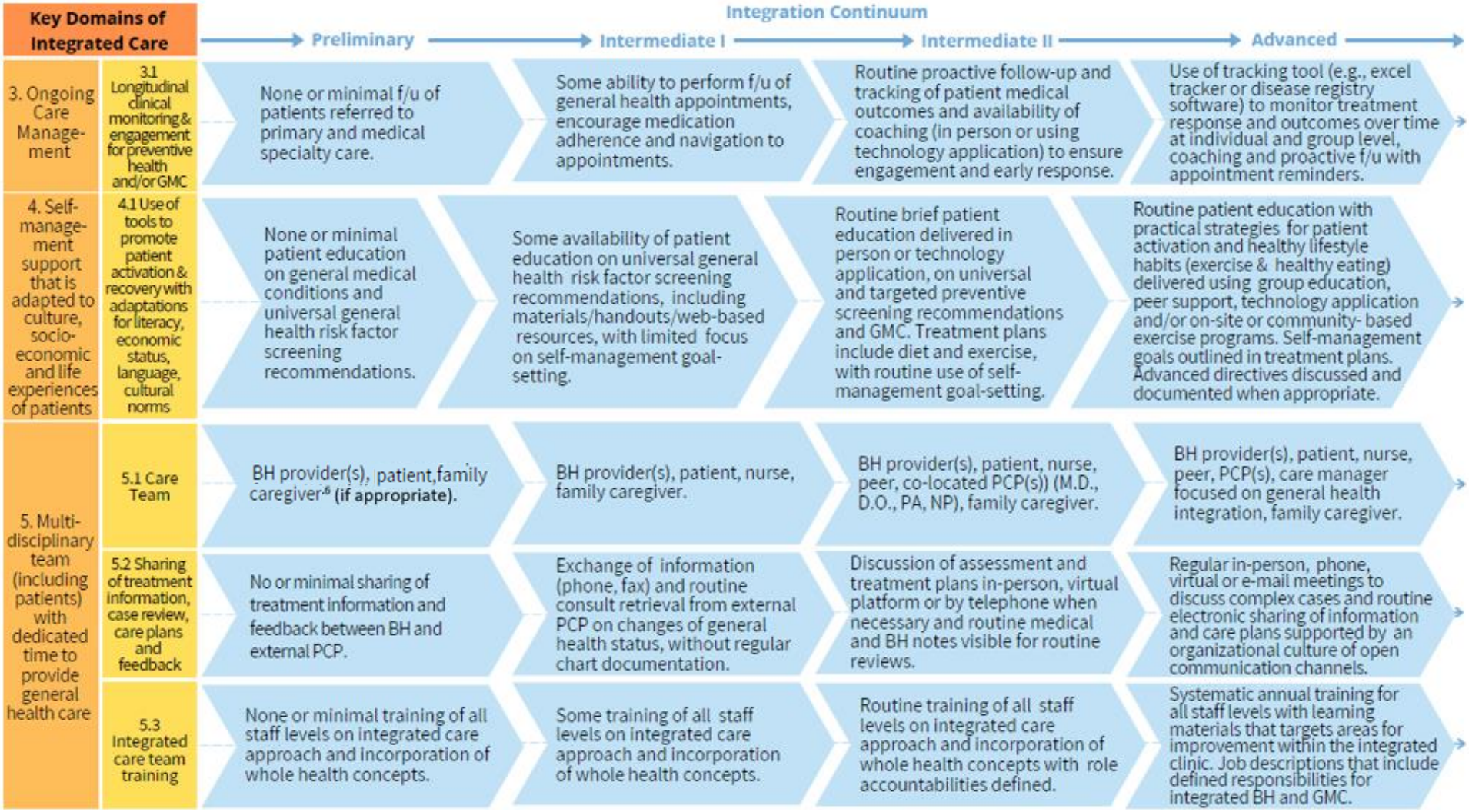
- Basic General health risk factor screenings include overweight/ obesity, tobacco use, alcohol and substance use (including opioid use)
- Comprehensive preventive screenings include above and 3 or more of the following: HbA1c, blood pressure, cholesterol, HIV, hepatitis, colonoscopy, breast cancer and cervical cancer screening, immunizations, annual primary care 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

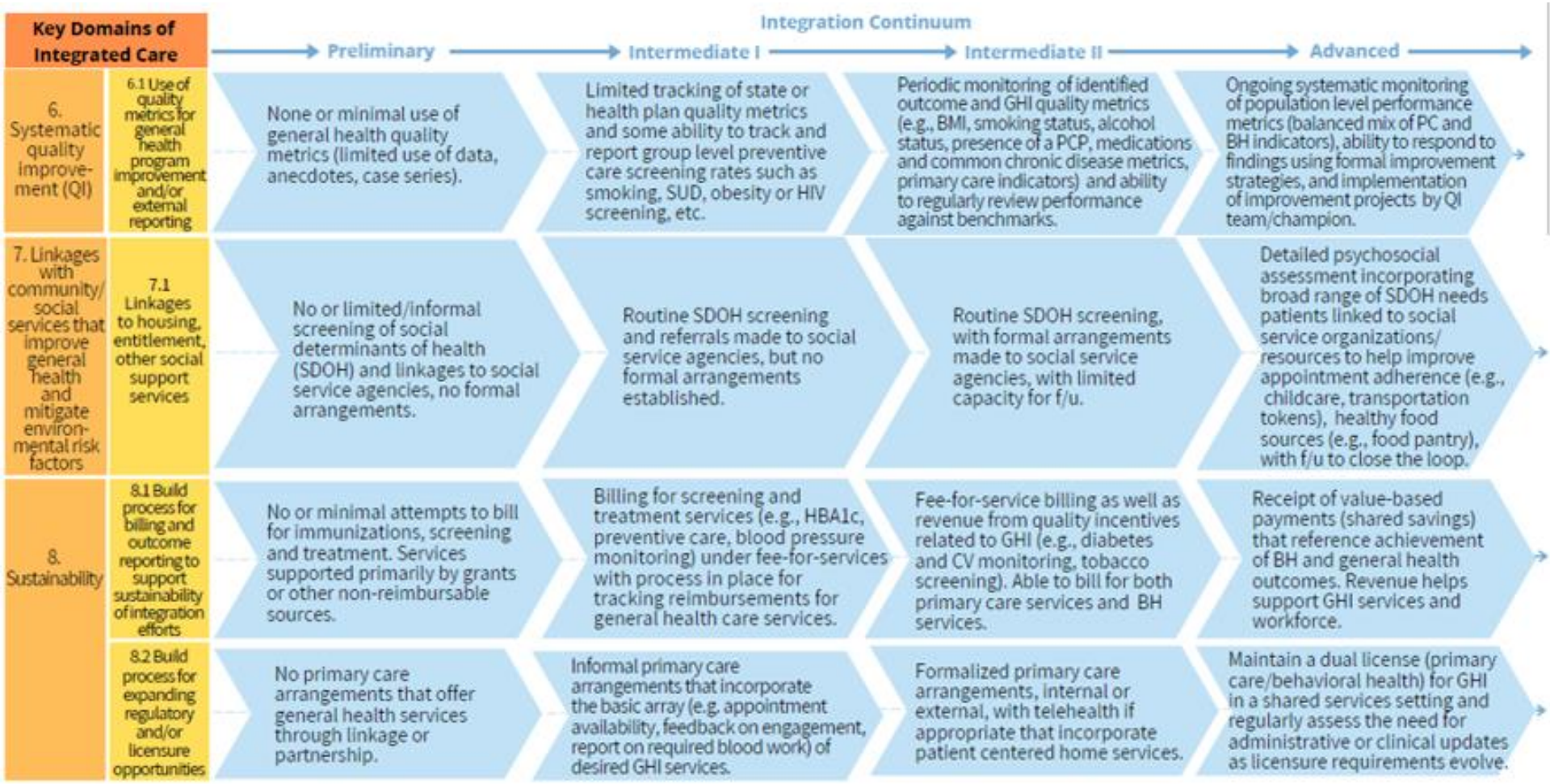
- Individuals with abnormal screens must receive follow up by a trained BH provider or PCP (external or co-located)
- Embedded and co-located arrangements include PCP support available on site or through telehealth
- Patients/consumers are part of team when appropriate



1 Individuals screened must receive follow up by a trained BH provider or PCP (external or co-located). For the purpose of the framework, primary care provider includes M.D., D.O., PA and NP.
2 Common general medical conditions include diabetes, hypertension, hyperlipidemia, coronary artery disease, asthma, arthritis, gastrointestinal disease, tooth and gum disease.
3 Universal general health risk factor screenings might include: visit with a PCP (defined as self-report of a usual source other than ED care with presence of one or more documented primary care visit during the past year), depression, alcohol and substance use (including opioid use), blood pressure measurement, HIV, overweight/obesity, tobacco use and age appropriate screenings for cervical and colorectal cancer.
4 Targeted general health risk factor screenings might include: intimate partner violence, HbA1c, cholesterol, STI, hepatitis B, hepatitis C, tuberculosis and age appropriate screenings for immunizations, mammogram and osteoporosis.
5 Embedded and co-located arrangements include PCPs available through telehealth services.



6 Family caregivers are part of team if appropriate to patient care.


Key Domains of Integrated Care
Integration Continuum
Preliminary
Intermediate I
Intermediate II
Advanced
6. Systematic quality improvement (QI)
6.1 Use of quality metrics for general health program improvement and/or external reporting
None or minimal use of general 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 GHI quality metrics (e.g., BMI, smoking status, alcohol status, presence of a PCP, 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 QI team/champion.
7. Linkages with community/ social services that improve general health and mitigate environmental risk factors
7.1 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 f/u.
Detailed psychosocial assessment incorporating broad range of SDOH needs patients linked to social service organizations/ resources to help improve appointment adherence (e.g., childcare, transportation tokens), healthy food sources (e.g., food pantry), with f/u to close the loop.
8. Sustainability
8.1 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., HBA1c, preventive care, blood pressure monitoring) under fee-for-services with process in place for tracking reimbursements for general health care services.
Fee-for-service billing as well as revenue from quality incentives related to GHI (e.g., diabetes and CV monitoring, tobacco screening). Able to bill for both primary care services and BH services.
Receipt of value-based payments (shared savings) that reference achievement of BH and general health outcomes. Revenue helps support GHI services and workforce.
8.2 Build process for expanding regulatory and/or licensure opportunities
No primary care arrangements that offer general health services through linkage or partnership.
Informal primary care arrangements that incorporate the basic array (e.g. appointment availability, feedback on engagement, report on required blood work) of desired GHI services.
Formalized primary care arrangements, internal or external, with telehealth if appropriate that incorporate patient centered home services.
Maintain a dual license (primary care/behavioral health) for GHI in a shared services setting and regularly assess the need for administrative or clinical updates as licensure requirements evolve.

Poll #6: Domain: Screening and Follow-Up for GMC

Which response best describes your site's GHI screening and follow-up, occurring at least 70% of the time?
(select one response only)

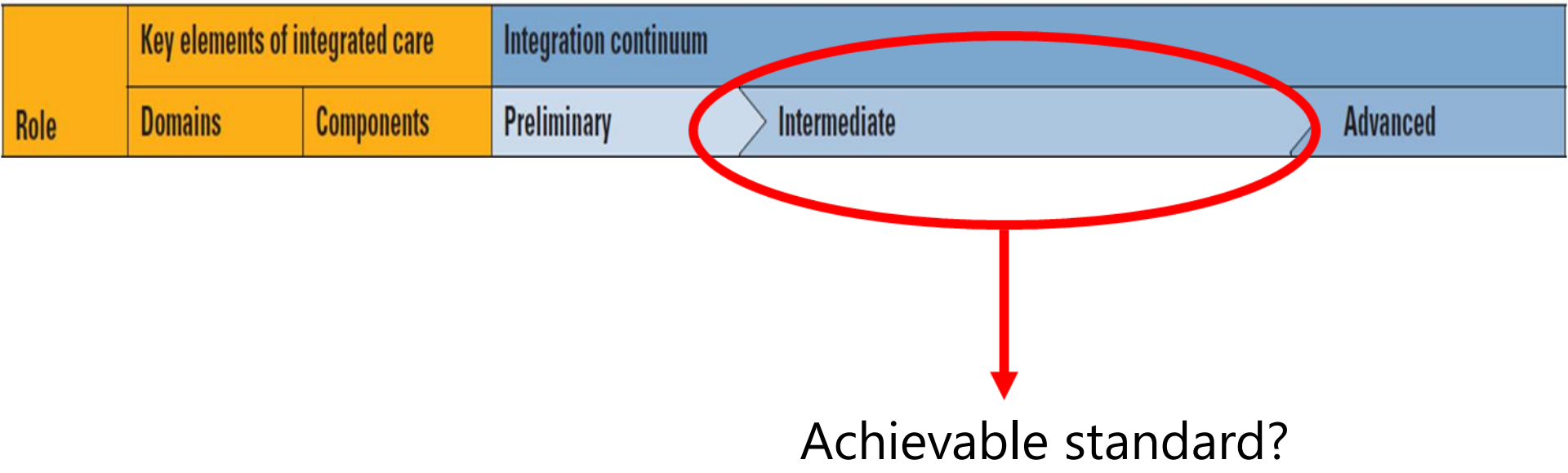
- Response to patient self-report of general health complaints and/or chronic illness with follow-up only when prompted.
- Systematic screening for basic health risk factors and proactive health education to support motivation to address risk factors.
- Systematic screening and tracking of basic and relevant targeted general health risk factors as well as routine follow-up for general medical conditions with availability of in person or telehealth primary care.
- Analysis of patient population to stratify by severity of medical complexity/high utilization for proactive outreach and assessment

Poll #7: Domain: Ongoing Care Management

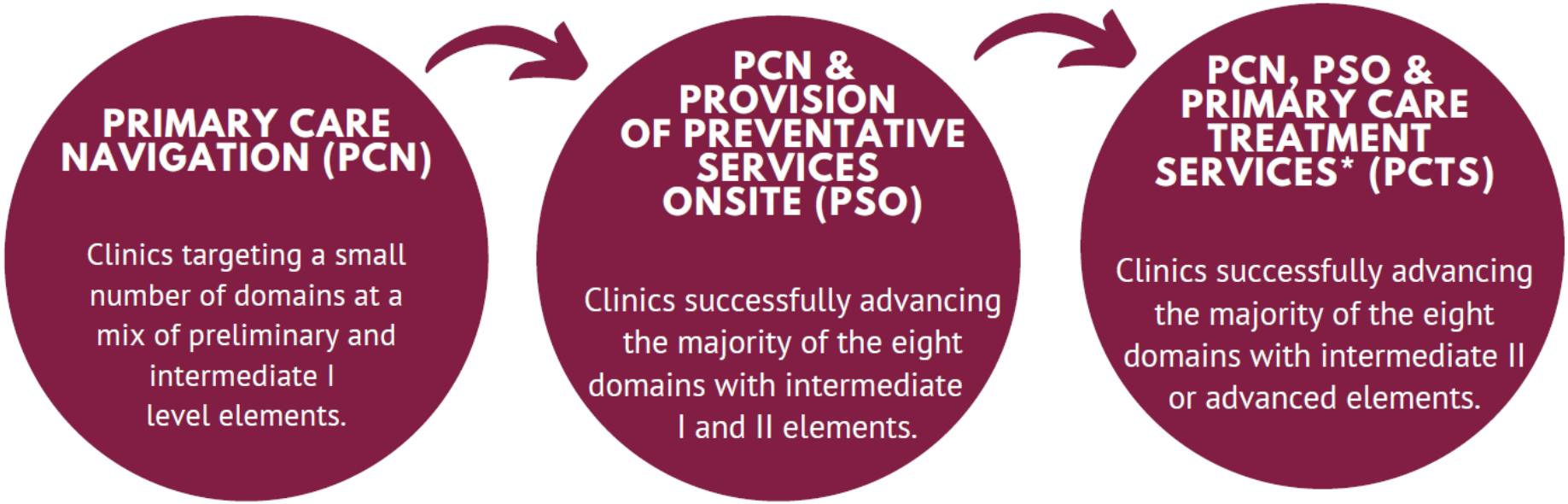
Which response best describes how patients are monitored and engaged for preventive health or general medical conditions, occurring at least 70% of the time? (select one response only)

- None or minimal follow-up of patients referred to primary and medical specialty care.
- Some ability to perform follow-up of general 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 (e.g., 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.

Continuum-Based Integration



Potential Models of Effective Integration



**Few clinics will achieve PCTS this model since it is the most complex and resource-intensive to achieve.*

Pilot: Community Behavioral Clinics Using the Framework as a Readiness Assessment

General Health Integration Pilot Findings: Overall, practices reporting a positive experience using the framework

DOMAINS WITH HE MAJORITY OF RESPONSES (>50%) IN THE INTERMEDIATE II OR ADVANCED PHASE OF INTEGRATION

- Trauma-informed care.
- Self-management supports.
- Quality improvement.
- Social service linkages.

DOMAINS WITH THE MAJORITY OF RESPONSES (>50%) IN THE PRELIMINARY OR INTERMEDIATE I PHASE OF INTEGRATION

- Screening, referral to care and follow-ups.
- Evidence-based care for preventive interventions and common general medical
- conditions.
- Care management.
- Multidisciplinary team.
- Sustainability (billing and regulatory).

GHI Leadership Spotlight

New York State Psychiatric Institute

Jean-Marie E. Alves-Bradford, MD
Associate Clinical Professor Psychiatry
Director of the Washington Heights Community Service at New York State Psychiatric Institute

Washington Heights Community Service

- 3 Mental Health Clinics in Upper Manhattan
  - 76% Latinx, 12% Black, 9% White, 3% Other, 56% SpSp
  - 52% Schizophrenia/Schizoaffective, 25% MDD,
  - 86% public, 8% private, 5% uninsured
- Psychiatric Services
  - Psychopharmacology, Psychotherapy, Psychiatric Testing, Long acting injectable administration, clozapine monitoring, peer services, EBP (CBT, MI, Cog Rem, Supported Employment)
- Primary Care Services – Adult Nurse Practitioner
  - Physical Exams, Walk-in services, Chronic Disease Management
  - Registered Dietician, metabolic screening, phlebotomy, tobacco cessation
  - Health Groups – wellness, exercise, health education

Washington Heights Community Service: Experience Using the GHI Framework

- Team-based effort
- Integration status assessment
- Strengths and opportunities for advancement
- Utilizing the framework
  - to set integration goals
  - measure advancement along the continuum

Next Steps: National Learning Community on Advancing General Health Integration in Community BH Clinics…

- Partnering with National Council to provide technical assistance to community behavioral health clinics seeking to advance general health integration using the framework
- Technical assistance includes setting targets around implementing the framework and overcoming challenges encountered by the clinics
- Partnering to evaluate the utility of general health integration framework with community behavioral health clinics
- Participating community behavioral health clinics will be invited to share quality metrics around certain framework domains through the clinics' EHR and current reporting capacity

Questions?

Resources

- Chung, H., Smali, E., Narasimhan, V., Talley, R., Goldman, M., Ingoglia, C., Woodlock, D., Pincus, H.A. (2020). Advancing integration of general health in behavioral health settings: a continuum-based framework. New York Community Trust. https://www.thenationalcouncil.org/wp-content/uploads/2020/08/GHI-Framework-Issue-Brief_FINALFORPUBLICATION_8.21.20.pdf?daf=375ateTbd56
- Druss, B. G et al. (2001). Integrated medical care for patients with serious psychiatric illness: a randomized trial. Arch Gen Psychiatriy. 58; 861-8688
- Druss, B. G et al. (2018). Psychiatry's Role in Improving the Physical Health of Patients with Serious Mental Illness: a report from the American Psychiatric Association. Psych Serv; 69(3): 254-256.

Upcoming Learning Collaborative

This learning collaborative will bring together organizations interested in implementing the General Health Integration framework, to share challenges, opportunities, and ideas through a peer-to-peer learning format over 12 months, launching in early 2021.

Participants in the learning collaborative will:

- Receive assistance in assessing baseline readiness for advancing general health integration
- Receive support in forming realistic 6- and 12-month goals for integration and measuring their progress using the framework as a self-assessment measurement tool
- Learn about best practices to advance their interventions using the framework
- Participate in discussions related to unique planning and resources needed for the pandemic response and outline specific COVID-19 activities relevant to the framework
- Report on and benchmark general health integration measures (e.g. BMI, blood pressure, HBA1c, etc.)

Find out more about the Learning Collaborative during our Dec 3rd Office Hour session!

Have questions? Contact integration@thenationalcouncil.org.

Upcoming CoE Events:

Advancing Integration in Community Behavioral Health: Using a New General Health Integration Framework

Register here for the Office Hour on Dec. 3, 3-4pm ET

Solving for Sleep: Foundation of Improved Health Outcomes

Register here for webinar on Dec. 3, 1-2:30pm ET

Compassion Fatigue and Resilience: Strategies for School Based Health Center Providers

Register here for webinar on Dec. 10, 2-3pm ET

Tips and Tools for Leveraging Trauma Informed Care Techniques to Reduce Stress for Students, Teachers, and Providers

Register here for webinar on Dec. 15, 2-3pm ET

Interested in an individual consultation with the CoE experts on integrated care?

Contact us through this form here!

Looking for free trainings and credits?

Check out integrated health trainings from Relias here.

Questions?

Email integration@thenationalcouncil.org

SAMHSA's Mission is to reduce the impact of substance abuse and mental illness on America's communities.

www.samhsa.gov

1-877-SAMHSA-7 (1-877-726-4727) 1-800-487-4889 (TDD)