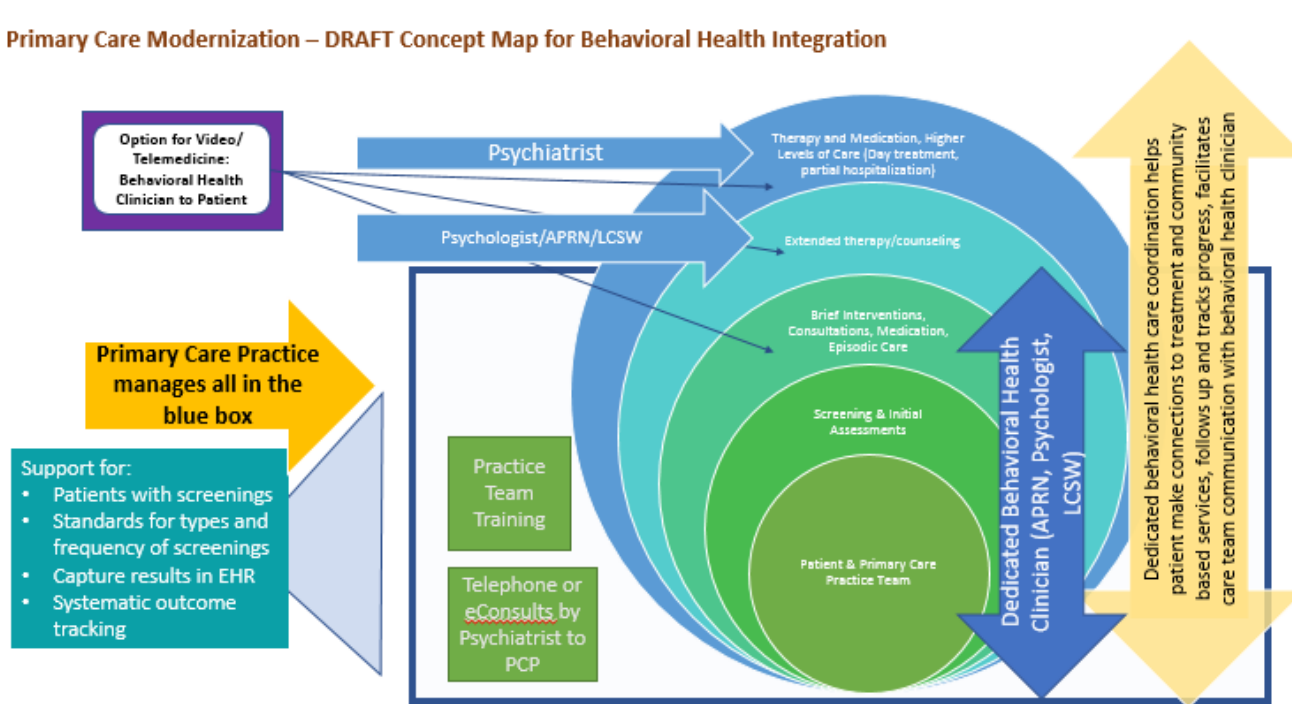


Primary Care Modernization Project Capability Summary Adult Behavioral Health Integration

Definition of the Capability: A team-based primary care approach to managing behavioral health problems and bio-psychosocially influenced health conditions

Goal of the Capability: Increase PCP capacity and resources to improve access to behavioral health services and achieve better patient outcomes.

Primary Care Modernization – DRAFT Concept Map for Behavioral Health Integration



Consumer Comments, Questions, Feedback

- Must screen for more than just depression and substance abuse; must include social determinants of health
- Recognize the opioid crisis
- Address co-occurring behavioral health and physical health to extend life expectancy
- Clinicians need training in initial mental health assessment and treatment
- An on-site mental health clinician (SW, APRN) can improve appropriate treatment options
- Inadequacies in the behavioral health system may lessen the impact of additional connections through primary care: Insurance companies provide inadequate information lists for referrals to behavioral health services and causes delays in treatment; many behavioral health service providers do not accept insurance
- Ensure that payment methodology promotes robust access to treatment.
- Reimbursement for behavioral health providers needs to be adequate to support integration

Specific Elements of the Capability

Type of Service in the Model	Provided by:	
	Practice	Network
Screenings: depression, substance use ¹ , anxiety ²	●	
Dedicated Behavioral health clinician (BHC) for each practice to work with patients and care team; clinician is on-site ³ at practice or available via “Warm Handoff” through phone or telemedicine visit	●	
Dedicated care coordinator with expertise in behavioral health	●	
On-site assessment	●	
Treatment and brief intervention in primary care; referral for further treatment if needed	●	
Patient-to-clinician telemedicine visits	◆●	◆
e-Consult - Primary care provider-to-BH specialist	◆	◆
Tracking outcomes in EHRs	◆	●◆
Training for care team on BH teaming and on chronic illness for BHC and care coordinator	●	●

● Responsible

◆ Needs Infrastructure

Summary of Design Group Recommendations:

- ✓ Support full integration of dedicated behavioral health clinicians (BHCs) and care coordinators into primary care:
 - Train both primary care and BHCs on team-based care and collaboration. BHCs should also be trained in defined core competencies, such as
 - Population care
 - The culture of primary care
 - Common chronic medical conditions
 - Psychopharmacology, brief screening/assessment
 - Brief intervention
 - Brief documentation
 - Team functioning
 - Build flexibility to provide services in different settings: primary care office, home or shelter
 - Prioritize on-site availability of BHC and use of common EHR platform; telemedicine as an alternative means to achieve integration for smaller practices
 - Dedicated care coordinator with BH expertise helps patient make connections to treatment and community-based services, follows up and tracks patient progress, and facilitates care team communication with the behavioral health clinician. Roles may include:

¹ Access to Medication Assisted Treatment (MAT) for identified opioid use disorder is being considered by the pain management design group.

² Depression (eg PHQ 2-9), anxiety (GAD 2-7), substance use disorder (AUDIT/DAS or CAGE AID). Universal screening for social determinants was referred as a recommendation to the Community Integration Design Group.

³ The term “on-site” is used instead of “co-located” because co-location can have multiple meanings, such as the BHC rents space in the practice, runs a typical mental health-type practice, has a separate EHR, bills separately from PC, and consults when convenient. The intent of these recommendations is to have BHCs fully integrated into the primary care practice.

- Following up with patients with BH diagnoses who are on new medications or have missed appointments
 - Tracking patient progress throughout interventions
 - Administering indicated screens at the direction of the primary care provider or BHC
 - Linking patients to community-based supports
 - Coordinating care with outside providers
 - Knowing which services the patient is receiving to identify gaps in services and avoid duplication of services across providers
- ✓ Level of BHC and care coordination support will vary based on higher illness burden and social determinants of health needs.
- ✓ Implement standard screenings at defined intervals to identify issues at an early stage
- ✓ Develop outcome measures that reflect a PCP's progress towards defined goals
- ✓ Implement bidirectional communication as needed between the care team and community-based BH specialist and community supports
- ✓ Create meaningful, actionable measurement and monitoring mechanisms
- ✓ If sufficient behavioral health services are not in network, the network executes a Memorandum of Understanding with at least one behavioral health clinic and/or practice and develops processes and protocols for other behavioral health clinicians⁴

Considerations for Payment Reform Council

- Supplemental bundle accounts for illness burden, severity and SDOH needs to encourage practices to work with those with more serious behavioral health conditions

⁴ This is recommended to ensure that an individual who chooses to seek care from a provider outside of the network or with whom there is no MOU is still assisted and supported in the referral process and does not feel pressured to receive care from a limited set of providers. Additionally, behavioral health needs vary and it may not be realistic to have providers in the network or MOUs with the extent of providers that cover the breadth of behavioral health needs that may arise (e.g., addiction treatment, depression, anxiety, etc.). Processes and protocols should identify how information will be exchanged with provider for whom there is not an MOU (e.g., release of information)

Understanding the Need

The Problem:

One in 5 people have a mental illness or substance use disorder and face issue and barriers to obtaining care. African Americans and Hispanics used mental health services at about half the rate of whites and Asians at one-third the rate of whites. For those with both physical and behavioral health needs, 29% of adults with medical conditions also have mental health conditions. Across the top 9 chronic conditions (including arthritis, asthma and diabetes), depression goes undiagnosed as much as 85% of the time (Druss, 2011). Cost of care for patients with chronic conditions and behavioral health issues is two to three times higher than those without such problems (Commonwealth Fund, 2014). In Connecticut, providers report more challenges with behavioral health referrals than other specialties (CT SIM, 2016).

People with mental and substance abuse disorders may die decades earlier than the average person — mostly from untreated and preventable chronic illnesses like hypertension, diabetes, obesity, and cardiovascular disease that are aggravated by poor health habits such as inadequate physical activity, poor nutrition, smoking, and substance abuse. Navigating complex healthcare systems and making progress towards self-management of physical health can create obstacles for persons with behavioral health disorders.

Traditionally, the behavioral health system was isolated from primary physical care services. A person in need of behavioral health services might receive emergency care, separate medication management services and individual or group therapy services. Patient-centered care has made strides towards connecting physical and behavioral health but are not uniformly integrated across all practices and systems.

Proven Strategy: BH Integration

Definition: Primary Care Behavioral Health Integration is a team-based primary care approach to managing behavioral health problems and bio-psycho-socially influenced health conditions.

The specific roles and functions of behavioral health clinicians in primary care can take several different forms. This section offers examples and indicates whether a type of service could be effectively and efficiently implemented at the practice site or as a network service. We can also consider the potential role of technology (“warm hand offs”/ visits via secure video). During its discussion, the Design Group may wish to consider recommending:

- a specific program model highlighted in this document or
- elements of a program model or
- a general statement of support for achieving the goals of the capability

Screening Algorithms: Many primary care clinicians screen for self-reported behavioral health disorders (mental health and substance use disorders) during annual checkups. The American Academy of Family Physicians (AAFP) has developed several algorithms for various disorders. A number of programs in other states are including annual screening for depression, anxiety, substance use disorder. In building strong connections between physical and behavioral health, well-accepted, tested screening tools should be implemented as a requirement in every practice.

Brief Interventions: Brief interventions encompass a diverse range of approaches, intervention targets, and delivery methods. Brief interventions may address issues such as substance abuse, pain control, prevention and intervention with health risk behaviors, suicide, and others. In many cases, brief interventions can be delivered directly by primary care physicians (or clinical staff) with some additional training. Some of the most common brief interventions include:

- **Motivational Interviewing:** As defined by SAMHSA, motivational interviewing is a clinical approach that helps people with mental health and substance use disorders and other chronic conditions such as diabetes, cardiovascular conditions, and asthma make positive behavioral changes to support better health. The approach includes (SAMHSA-HRSA Center for Integrated Health Solutions):

- Expressing empathy and avoiding arguing
 - Developing discrepancy
 - Rolling with resistance, and
 - Supporting self-efficacy (client's belief s/he can successfully make a change).
- Screening, Brief Intervention, Referral and Treatment (SBIRT) programs for substance use. SBIRT interventions are effective in reducing both the severity of substance use disorders and the number of unnecessary emergency department visits and hospitalizations. SBIRT involves:
 - Screening to quickly assess the severity of substance use and identify the appropriate level of treatment.
 - Brief intervention to focus on increasing insight and awareness regarding substance use and motivation toward behavioral change.
 - Referral to treatment to provide those identified as needing more extensive treatment with access to specialty care).
 - **Collaborative care** involves behavioral health specialists working with primary care. In collaborative care, patients perceive that they are getting a separate service from a specialist, albeit one who collaborates closely with their physician. Collaboration can be in separate locations or on-site and have partially shared systems which is moving closer to an integrated model.
 - Integrated Model- In the integrated model, practitioners are ideally on-site at the practice, using one treatment plan with behavioral and medical elements and a database to track patients screened into behavioral health. Staff with advanced behavioral health training, such as Advanced Practice Psychiatric RNs, licensed therapists, are members of the practice team and work together with the physician, MAs, other RNs, case manager and family advocate using a pre-arranged protocol to deliver whole person care. The goal is to incorporate learnings from patient-centered medical homes, which seek to understand the whole person, see the patient as part of the team, adding health and lifestyle coaching, links to community supports, and using data to guide improvement. The therapists generally have shorter visit schedules (30 min) and are able to be "interrupted" briefly for warm hand offs/ "meet and greets". They should also be able to participate in pre-visit planning and daily huddles. In smaller practices this could be arranged using technology with assigned IBH clinicians to several practices through the AN.

Integration can be bi-directional. While often thought of psychiatric services integrated into primary care, it can also be integrating primary care services into behavioral health settings. (Reiter, 2017)

Intended Outcomes:

- One treatment plan designed by all providers and consumer/caregiver input
- Prompt follow-up for positive BH screenings (e.g., depression, substance use, post-partum depression)
- Clinical data and medication history and treatment available to all practitioners on need to know basis

Consumer Needs, Question and Concerns [to be revised to reflect Design Group input]:

- Difficulty accessing primary care and specialty care (especially psychiatry)
- Need for expanded care teams
- Clinician awareness of the challenges of maintaining self-care for a person with chronic conditions (including behavioral health)
- Finding in-network clinicians who are taking new patients and accept insurance, or finding affordable self-pay options
- Access to counseling for lifestyle issues associated with behavioral health (e.g., nutritional counseling for obesity)
- Clinicians' support and understanding that behavioral health recovery is not linear

Health Equity Lens:

- Language barriers (lack of BH interpreters)
- Access challenges, both geographic proximity and time of day/day of week
- Stigma attached to BH diagnosis and treatment
- Lack of psychiatric resources in underserved communities
- Inadequate cultural competency around behavioral health

Implementing the Strategy

Example Scenario: A 62-year-old patient comes in for his diabetes visit. Before seeing his PCP, the nurse administers the PHQ9 (Depression Screening Tool). The patient scored 12, indicative of a possible moderate depression. He tells his PCP for the past 3 weeks that he ‘doesn’t want to do much but watch TV’. There were no remarkable changes in his lab work. He agrees to see the psychiatric social worker in the practice who is free and the PCP walks the patient down the hall. After the meeting with the LICSW, the note states he is having marital issues and will come back and see her next week for further evaluation. If his mood persists she will fit him in for a brief visit with the NP to discuss anti-depression medications.

HIT Requirements:

- Shared EHR
- Shared scheduling system
- Appropriate (electronic) screening tools and algorithms

Implementation Concerns:

- Privacy and confidentiality concerns around sharing BH diagnoses, and notes (need to know)
- Access to medication management resources (psychiatrist, psychiatric APN)
- Primary practices may face challenges with Seriously Mentally Ill (SMI) and Serious and Persistent Mentally Ill (SPMI) when staff are not trained to treat these patients in primary care or referral sources or community resources are not adequate.

Impact

Aim	Summary of Evidence
<i>Health promotion/prevention</i>	<p>Smoking Cessation Programs: Persons with mental illnesses and substance abuse disorders report over 44% of the U.S. tobacco market and are nicotine dependent at rates that are 2-3 times higher than the general population. They suffer they suffer greater smoking-related medical illnesses and mortality (Morris 2009).</p> <p>Weight Management and other prevention: Given the high prevalence of excess weight among persons with behavioral health disorders and consequent mortality and morbidity, the limited existing research suggests that developing a healthier lifestyle, which includes daily physical exercise, may not only prevent weight gain or lead to weight loss, but also improve comorbid psychological disorders such as anxiety and depression. Patient-Centered Medical Home (PCMH) and SAMHSA’s funding of programs to co-locate primary care in community mental health centers (CMHCs) and new policies might support expanding interest in prevention and wellness</p>

	through innovative services such peer-to-peer wellness programming and multidisciplinary training in health behavior change (Devine, 2012)
<i>Improved quality and outcomes</i>	In various (adult) studies noted in Hunter/Funderburk, 2018 ¹ there was either statistically significant reduction in “psychological distress”, improvement in sleep, reliable improvement, defined as clinically meaningful and reliable increase in Global Mental Health Score (GMH), as indicated by sufficiently large improvement in the patient’s overall severity level to a healthier level (e.g., from severe to moderate or mild). Mean number of preventable hospitalizations was significantly lower for the treatment group after treatment in comparison to a control group in one study.
<i>Patient experience</i>	In one study in an integrated student health center, 79 patients (75% female, 65% Caucasian) completed program ratings via an anonymous web-based questionnaire that assessed program satisfaction and comfort with behavioral health clinicians (BHC) in the health center. Patients reported satisfaction with behavioral health services and reported a willingness to meet again with BHPs and found the program beneficial to clinical care (Funderburk, 2012). In a review of the literature, other studies based on self-report questionnaires, patients reported high levels of satisfaction with the PCBH model services and they would seek this type of care again in the future (Hunter/Funderburk, 2018 ¹).
<i>Provider satisfaction</i>	In one study in integrated university health center fifteen providers (nine primary care providers and six nurses) completed an anonymous web-based questionnaire that assessed satisfaction with and acceptability of behavioral health screening and the integrated BH health care (IBHC) program featuring integrated BHCs. Providers reported that behavioral health screening stimulated new conversations about behavioral health concerns, the BHCs provided clinically useful services, and patients benefited from the IBHC program (Funderburk, 2012). In one study of 23 providers completed a self-reported survey (68% response rate), 91% felt that the BH consultant helped them improve the recognition and treatment of BH problems. 100% were satisfied overall with the service (Hunter/Funderburk, 2018 ¹).
<i>Lower Cost</i>	In a randomized control study using IMPACT, Intervention patients had 4-year mean total healthcare costs of \$29,422 (95% confidence interval, \$26,479-\$32,365), and usual care patients had mean total healthcare costs of \$32,785 (95% confidence interval, \$27,648-\$37,921), representing a cost savings among intervention patients of \$3,363 (95% confidence interval, \$-9282 to \$2557) or about 10% per patient on average during 4 years. Intervention patients had lower healthcare costs than usual care patients in every cost category observed (outpatient and inpatient mental health specialty costs, outpatient and inpatient medical and surgical costs, pharmacy costs, and other outpatient costs) (Unützer,2008).

¹ Study Author, design, and summary of findings can be found in Tables 3 and 4 of Hunter/Funderburk,2018 article.

² Improving Mood-Promoting Access to Collaborative Treatment

APPENDIX

Learning from Others

State and National Scan:

Case Study #1- SouthCentral Foundation, Anchorage, Alaska

The Southcentral Foundation in Alaska is responsible for providing healthcare services to the Alaska Native and American Indian populations in and around Anchorage, including extensive rural communities. Over the past 14 years, the program has hired mental health clinicians as Behavioral Health Consultants (BHCs) and integrated into them into primary care clinics. Each team includes an RN case manager, the primary care provider, medical assistant(s), BHCs (2.5 FTE⁵), a dietician, and case management support. Each team is responsible for 900-1000 patients.

In this model, the primary care team has training and resources to engage quickly and flexibly with patients. The team uses an array of screening tools to assess for depression, substance use, cognition, development and chronic pain. Services at primary care clinics include pain consultation, structured behavioral health referral process, wellness care plans, primary care provider coaching, integrated psychiatry and medication assisted treatment. EHRs were used extensively by including a note that worked for BHCs and the system, including referring/consult question, symptoms and level of functioning, pertinent history, description of the brief intervention and follow up plan, including recommendations and referrals.

The program offers lessons learned for transforming practices. Psychiatrists to shift from traditional behavioral delivery and build an understanding of care culture, managing a full case load, documentation. PCPs needed to learn efficiently use the time-limited consultation with psychiatric staff and skillsets.

Case Study #2 --Wheeler Clinic, Connecticut

Wheeler provides behavioral health, substance abuse treatment, and integrated primary care services across Connecticut, including outpatient counseling, medication-assisted treatment like suboxone, and a comprehensive range of mental health, addiction and primary care services and dental services.

Wheeler expanded the scope of its federally qualified health center (FQHC) to meet the health care needs of individuals with serious mental illness and co-occurring substance abuse disorders in Hartford, New Britain and surrounding communities. Individuals with serious mental illness and co-occurring substance abuse disorders are often reluctant to engage in primary care services and experience disparities in access to health care and health care

Figure 1: SouthCentral Outcomes



needed
health
primary
and EHR
how to
their

substance

⁵ This ratio appears to respond to the needs of a highly at-risk population. Other programs use a ratio of 1 BHC to 5,000 practice lives for a "routine" practice distribution.

outcomes. Many of the patients Wheeler currently serves from Hartford, New Britain and surrounding communities do not have a primary care physician, experience multiple co-morbid health disorders and are frequently seen in the emergency department. These patients have difficulty engaging in primary care through traditional channels. Their experience of stigma in health care settings and past exposure to trauma often create substantial barriers to care. As a Patient Centered Medical Home and Health Home, Wheeler serves those with a variety of needs including those with complex needs. These may include physical conditions chronic condition such as asthma, diabetes, or heart disease or mental health/ or addiction problems. Wheeler's integrated care teams manage and coordinate with its clients to assess their needs, treat their condition(s), and help them reach their health goals.

Wheeler has a Family Health and Wellness Center in Hartford and Bristol. Some of the services available are:

- Primary Care for Adults
- Dental Care for the Whole Family
- Integrated Behavioral Health and Addiction Services, including Medication-Assisted Treatment
- Complementary Medicine
- Geriatric services
- Care management services and HIV case management

Results and Lessons Learned are not available for Wheeler Clinic.

Case Study #3- Washington State Mental Health Integration Program (MHIP)³

Created as a pilot in 2007 in two counties and expanded state-wide in 2009 MHIP, was initially patterned after the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) program. In 2014, with the implementation of Medicaid Expansion funding sources only allowed the program as an option for those Medicaid recipients who selected the original pilot HMO (Community Health Plan of Washington) as their Medicaid carrier. However, the experience here was the first documented experience providing integrated care to a high need safety net population.

Like IMPACT, MHIP uses core components of team-based care, use of clinical BH care manager and a psychiatric caseload consultant. Patients were originally screened using the PHQ-9 (for depression) and for anxiety and substance use conditions. Over time, screening tools for symptom rating, functional rating, and important medical markers have been added. Whenever possible, warm handoffs for referrals are utilized, connecting the BH CM to the patient immediately. The BH CM also has a primary role of referrals and care transitions- including referrals to specialty BH when indicated. The BH CM provides brief evidence-based interventions. The psychiatric consultant provides regular caseload reviews, assists with diagnosis and formulations and makes recommendation regarding medications, psychotherapy and management. The psychiatrist is available during the times he/she is not on-site by phone. They are also available by tele-psychiatry, phone or in person for more complex clinical questions or concerns. There is a web-based tracking system to support systematic outcomes and quality improvement.

Results

Pilot results:

- Program data from the first years of 2008 and 2009 showed that, compared to counties without MHIP, the target population in MHIP counties had 17% fewer inpatient medical admissions and smaller increases in inpatient psychiatric costs (21% vs. 16.7%) over the review period.
- Compared to those that did not receive services, enrollees who received MHIP services had a larger decrease in number of arrests (24% decline in MHIP clients) and a smaller increase in those living in homeless shelters or outdoors (50% vs. 100%),
- There was a smaller increase in days spent in state hospitals (33% vs. 500%).

Statewide results:

- MHIP was expanded statewide in 2009 and during its first 14 months of statewide implementation, the program saved an estimated \$11.2 million in hospital costs.
- Overall 50% shorter time to reduce PHQ-9 scores by 50% (achieving a score less than 10) after introduction of quality metrics and pay-for performance program.

Lessons Learned

- Systematic uses of process and outcome measures that are built into clinician workflows are important for program successes.
- Ongoing workforce development, training, and support are critical for program success.

³ APA-APM

Additional Reading:

<http://aims.uw.edu/impact-improving-mood-promoting-access-collaborative-treatment/>
<https://www.ncbi.nlm.nih.gov/pubmed/12472325> (JAMA, 2002)
<https://www.integration.samhsa.gov/integrated-care-models/APA-APM-Dissemination-Integrated-Care-Report.pdf>
https://www.icsi.org/guidelines_more/catalog_guidelines_and_more/catalog_guidelines/catalog_behavioral_health_guidelines/depression/
<https://www.integration.samhsa.gov/about->
<https://www.integration.samhsa.gov/integrated-care-models/toolkits>
<https://www.integration.samhsa.gov/integrated-care-models/primary-care-in-behavioral-health>
<https://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf>

Bibliography

- AIMS Center. (n.d.). *IMPACT: Improving Mood- Promoting Access to Collaborative Treatment*. University of Washington. Retrieved from <http://aims.uw.edu/impact-improving-mood-promoting-access-collaborative-treatment/>
- Center for Integrated Health Solutions (CIHS). (2013). *Integrating Behavioral Health in Primary Care: Lessons from Health Centers*. SAMHSA-HRSA. Retrieved from https://www.integration.samhsa.gov/about-us/CIHS_NACHC_BH_Integration_September_19_2013_FINAL.pdf
- Center for Integrated Health Solutions. (n.d.). *Primary Care in Behavioral Health*. SAMHSA-HRSA. Retrieved from <https://www.integration.samhsa.gov/integrated-care-models/primary-care-in-behavioral-health>
- Center for Integrated Health Solutions. (n.d.). *Resources from CIHS*. SAMHSA-HRSA. Retrieved from <https://www.integration.samhsa.gov/integrated-care-models/toolkits>
- Collins, C., Hewson, D. L., Munger, R., and Wade, T. *Evolving Models of Behavioral Health Integration in Primary Care*, Milbank Memorial Fund (2010)
<https://www.milbank.org/wp-content/uploads/2016/04/EvolvingCare.pdf>
- Commonwealth Fund, <http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/august-september/in-focus>
- Connecticut State Innovation Model, "A Presentation to HIT Advisory Committee," April 21, 2016, Source: http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2015-04-09/report_physician_survey_feb_2015.pdf
- Devine, Karen, et al, (2012). *Weight Management Strategies for Adults and Youth with Behavioral Health Conditions*. The Behavioral Health & Wellness Program School of Medicine University of Colorado Anschutz Medical Campus

<http://www.bhwellness.org/wp-content/uploads/2012/01/Obesity-Prevention-and-Intervention-Paper.pdf>

Druss, B.G., and Walker, E.R. (February 2011). *Mental Disorders and Medical Comorbidity*. Research Synthesis Report No. 21. Princeton, NJ: The Robert Wood Johnson Foundation

Funderburk, Jennifer S., Fielder, Robyn L., DeMartini, Kelly S., Flynn, Cheryl A.
Integrating behavioral health services into a university health center: Patient and provider satisfaction.
Families, Systems, & Health, Vol 30(2), Jun 2012, 130-140

Heath B., Wise, Romero P., and Reynolds, K. *A Review and Proposed Standard Framework for Levels of Integrated Healthcare*. Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions. March 2013.
https://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf

Hunter, C.L., Dobbmeyer, A.C. & Reiter, J.T. *Integrating Behavioral Health Services into Primary Care: Spotlight on the Primary Care Behavioral Health (PCBH) Model of Service Delivery*. *J Clin Psychol Med Settings* (2018) 25: 105. <https://doi.org/10.1007/s10880-017-9534-7>

Hunter, C.L., Funderburk, J. S., Polaha, j., Bauman, D., Goodie J.L., Hunter, C.M. *Primary Care Behavioral Health (PCBH) Model Research: Current State of the Science and a Call to Action*, *J Clin Psychol Med Settings* (2018) 25:127–156 DOI 10.1007/s10880-017-9512-0.

Institute for Clinical Systems Improvement. (2016). *Depression, Adult in Primary Care*. ICSI. Retrieved from https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_behavioral_health_guidelines/depression/

Morris, C., *Smoking Cessation for Persons with Mental Illness, A Toolkit for Mental Health Providers*, Updated January 2009
<https://www.integration.samhsa.gov/images/res/Mental%20Health%20Tobacco%20Cessation%20Toolkit%20January%202009.pdf>

Peek, C. a. (2013). *Lexicon for Behavioral Health and Primary Care Integration*. AHRQ. Retrieved from <https://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf>

Reiter, J. T., Dobbmeyer, A. C., & Hunter, C. L. (2017). *The primary care behavioral health (PCBH) model: An overview and operational definition*. *Journal of Clinical Psychology in Medical Settings*, 24(4).
https://secure.in.gov/fssa/dmha/files/National_Council_for_Behavioral_Health_Bidirectional_integration.pdf

SAMHSA-HRSA Center for Integrated Health Solutions. <https://www.integration.samhsa.gov/clinical-practice/motivational-interviewing>

The Collaborative Care Model. (2016). *Dissemination of Integrated Care Within Adult Primary Care Settings*. American Psychiatric Association & Academy of Psychosomatic Medicine. Retrieved from <https://www.integration.samhsa.gov/integrated-care-models/APA-APM-Dissemination-Integrated-Care-Report.pdf>

Unützer J, K. W. (2002). Collaborative Care Management of Late-Life Depression in the Primary Care Setting: a randomized controlled trial. *JAMA*, 2836-2845. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/12472325>

Unutzer, J., Katon, W. J., Fan, M.-Y., Schoenbaum, M. C., Lin, E. H., Della Penna, R. D., & Powers, D. (2008). Long-Term Cost Effects of Collaborative Care for Late-Life Depression. *American Journal of Managed Care (AMJC)*, 95-100. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3810022/>

Walkama, S. (2016). *Addressing Behavioral and Primary Health Disparities and Access to Care for Adults*. Wheeler.
Retrieved from
https://www.cga.ct.gov/ph/BHPOC/related/20160101_2016/20160914/Addressing%20Behavioral%20and%20Primary%20Health%20Disparities%20and%20Access%20to%20Care%20for%20Adults%20-%20Wheeler%20Clinic.pdf

Wheeler Clinic. (n.d.). Behavioral Health, Addiction, Mental Health and Primary care in Connecticut. Connecticut, MA.
Retrieved from <https://www.wheelerclinic.org/services>

Primary Care Modernization Behavioral Health Integration Design Group 1

8/29/2018

Participants: Linda Green, Alyssa Harrington, Vinayak Sinha, Heather Gates, Shirley Girouard, Susan Walkama, Brad Richards, Lori Szczygiel, Velandy Manohar, Susan Kelley, Barbara Ward-Zimmerman, Kevin Galvin, Tekisha Everette, Patricia Rehmer, Pano Yeracaris

PCM Overview

- Goal: To create a primary care reform model that enables primary care providers to expand and diversify their care teams and provide more flexible, non-visit-based methods for patient care, support and engagement.
- Engaging stakeholders as well as leadership and consumers across the state in the payment design process.

Skeleton Review

- Considering three things:
 - Does the evidence support including this capability in the PCM payment bundle?
 - Should this be a core universal/required or an elective capability?
 - Should this be in all practices or provided by a subset of docs or practices within each primary care network?
 - Consumer: In relation to whether the capabilities should be included (and this is addressed to providers and not payers), it may not be appropriate at all; Providers, payers, and consumers could not feel it should be a part of the model.
 - Consumer: This is an excellent act for mental health. Primary care screenings are key health identifiers, but patients suffering from BH problems are dying 20 years earlier (unless, of course, they have access to and are given proper care).
- Models for Behavioral Health Integration in Primary Care Practice
 - The first model is from the SIM community and clinical integration program aiming to help advanced networks in the state → promote care delivery to patients by delivering better care at lower costs.
 - 1. Screening, 2. Treating, 3. Referral (and then tracking referral outcomes)
 - Requirements were laid out.
 - 1. Develop or use a screening tool, 2. ensure support services for those who cannot complete the screener on their own, 3. utilize a trained behavioral health specialist for more targeted follow-up assessments if needed, 4. conduct screenings every two years, 5. identify re-screening at each routine visit, and 6. capture screening results in the HER
 - FHC: The screenings are just for substance use and depression because the task force was advised that the screenings needed to be based on evidence.
 - Consumer: When needs are identified, resources also need to be available.
 - FHC Expert: Found anxiety is the most common thing that people come up with and is important to assess when trying to understand what people are living with and suffering from in terms of BH. Considering screening for anxiety might be a good idea.
 - Consumer: Screening for more than just depression and substance abuse would be ideal.
 - FHC: If services are not in network-services will be contracted out (but referral and linkage to follow up care is tracked)
 - Start by treating within the primary care practice and educating people using behavioral health references.

- Communicate with behavioral health specialist on treatment status.
 - Track behavioral health outcomes/improvement
- Second model: Southcentral Foundation Integrated Behavioral Health (Anchorage, Alaska)
 - Key features- Provide on-site behavioral health services with their primary care services in their organization.
 - Conduct screenings, interventions, and referrals if needed (for developmental changes, chronic pain, cognition, substance use, depression)
 - Same day access to behavioral health consultant and services
 - Resulted in a reduced number of people on its behavioral health wait list
 - Decreased wait times from 6 to 1 weeks→ increased access to behavioral health services
- Discussion
 - Which elements of these models are recommended for inclusion?
 - Consumer: Can you discuss financing-relative costs? If they are capitated?
 - Provider: Capitation does allow more flexibility if incentives are appropriately aligned.
 - Consumer: Believe screenings are essential for every practice.
 - Provider: Agreed.
 - Individual self-report is missing/ SDOH screening is important
 - Provider: Agrees but worries about being overly prescriptive. There is a high need for screening in different patient populations, but that's not always the case. Can we have outcome measures that give the practice a little more flexibility so that in the long run we are thinking about outcomes of how SDOH are affecting patients and what makes sense for their patient population?
 - Consumer: SDOH is so important.
 - It's important to think about a range in the model and the regulatory barriers.
 - FHC: Is there a minimum that all networks should be doing?
 - Provider: Thinks there should be a minimum screening and believes providers should be able to make that choice.
 - It could be helpful to envision the appropriate outcome measures and focus on those rather than mandating more screening.
 - FHC Expert: There aren't any great outcome measures, and it takes a long time to see those changes. If you make the ability to pay too complicated, it becomes difficult at the primary care level.
 - Access mental health is a successful model to refer to.
 - Consumer: Larger practices have a lot more capabilities. If you take this model and apply it to other, smaller practices that aren't at a higher level, you run into problems training primary care teams. Mental health in pediatrics should also be addressed.
 - Consumer: FQHCs that show they're evaluating for something and doing primary prevention should get some kind of bonus.
 - FHC: There is a need for data to measure outcomes, training, and education for primary care providers.
 - Provider: Training for behavioral health providers is needed in primary care environments as well.
 - Consumer: Behavioral health specialists don't get paid (or are not reimbursed at the same level) as primary care providers, so that's why a lot of behavioral health specialists are out of network. This should be addressed.
 - Consumer: Reimbursement for behavioral health services are completely inadequate. There is a huge gap between cost and reimbursement.

- Provider: Many of the services needed in primary care are not currently reimbursed. In the fee-for-service world, there are several things providers don't get paid for.
 - Consumer: It should be one fee for both; the list provided by insurance companies is inadequate and creates delays in treatment. There are just a lot of reimbursement issues.
- SDOH might stop patients from coming in, so in-home assessments could be helpful.
- FHC Expert: We should use what's already there (Medicare) and not reinvent the wheel.
- Consumer: Telehealth should also be a part of this discussion.
- Provider: Licensing regulations from last year focused on payment for case specialists and case management services through insurance (so, there are efforts towards this...but we aren't there yet).
- Consumer: The opioid crisis should be included here.

Next Steps

- Summary:
 - Essential elements to be included:
 - Training for both primary care and behavioral health providers, flexibility for clinicians to provide these services in home and in office, and ensure adequate reimbursements across the board.
 - FHC: Will put this into a revised document and we'll discuss whether this is the right model to include in primary care (in addition to optional v. required; across every practice v. a subset of practices within that network).
 - Will reconvene in 2 weeks and will incorporate feedback.

Primary Care Modernization Behavioral Health Integration Design Group 2

9/11/2018

Consumer Comments, Questions, Feedback from Meeting 2

Consumer: Not missing any consumer concerns. I think we'll probably address some issues that are maybe related as we get into it and don't have anything to add right at this moment

Consumer: this is a good list, suggest we put a separate item for cultural confidence, something for linguistic disparities

Notes about the Primary Care Modernization Model

- Provider: points related to the payment model and behavioral health specialty make complete sense to me to keep the specialists separate however I think for providers who are ready to move to a fully integrated model, that could present some challenges. For example, will a behavioral health specialist be able to work side by side with a behavioral health clinician?
 - FHC Expert: Ideally you would have behavioral health attached to primary care, then its part of the bundle
 - Provider: talking about full integration on the behavioral health care team which is a different level of coordination then what is described here. There is a higher level of integration that can take place
- Provider: the behavioral health case manager/care coordinator is separate from a behavioral health provider but agree with full integration. Need to be consistent with terms, you define behavioral provider differently in a couple of different places
- State: We can't bill into the PMPM the services of an integrated behavioral health specialist (BHS) or Behavioral Health Coordinator (BHC) unless it's going to happen
- Consumer: just want to make sure annual limit for these licensed services is no different than from primary care medical services
- State: There are working primary practice models with full integration
- Provider: if not every practice could do it in modernization, perhaps there be some pathway
 - State: we are focused on FQHCs, integrated care partners, mental health. What is it about those settings that wouldn't get them to fully integrated health within three years?
 - Provider: not necessarily a barrier, it just takes time to move cultures and develop a full commitment to that type of practice because its very different to what's currently being done in many primary care settings
 - State: I don't get how if we basically say the package is you'll hire a BHS and a BHC, here's a model for your workflows, its not clear to me why we wouldn't push the envelope on this-especially when we have a shortage of integrated behavioral health, improving access by onboarding and integrating behavioral health
 - Consumer: a BHS wouldn't be paid for within the bundle, it would be the BHC?
 - State: You can have the services of a BHS built into the bundle for flexible support of the practices with a range of services, so the practice doesn't have to worry whether any given activity isn't eligible for billing and lighten administration requirements
 - FHC Expert: workforce availability and training takes a fair amount
 - State: Modeled it out to a PMPM in Rhode Island so it can be done. Onsite, collocated is the optimal, you could introduce the cost of the BHS into the PMPM payment and just because we roll in the cost of the BHS doesn't mean collocation is the only way this could work. Virtual video support does provide for a level of dedicated BH resources to practices that they don't have today
 - Provider: Support the use of telemedicine, telepsychiatry, this is the ideal way to be able to do this along with co-located services

- State: I think we are going to have to be specific with the payment reform council, we can create bundle payment options where the primary care PMPM includes full integration resources. Question is should model pay for integration over the course of 5 years and increase the bundle as integration is fully realized
- Consumer I agree, want to provide incentive and acknowledge reality of the current level; would think we need to have a conversation about behavioral health coordinator –would need to take up SDOH - want to make distinction between what behavioral health coordinator is taking on in the versions you are talking about

Review of Diagram

- FHC: Where primary care's responsibilities end?
- FHC Expert: include anxiety screening as one of the core things, yes there has to be flexibility, if you're talking about brief intervention, you can train medical assistants and CHWs to do this for mild to moderate substance use issues
- Consumer: There are many patients in community health centers not being seen by psychiatrists, definitely want to include extended therapy and counseling
- Consumer: Question is what can be done within the practice and what needs to be referred out. I think one of the most critical elements of this it to know when a treatment requires a specialist
- State: We have other licensed professional in the second arrow that all can practice within their scope. How narrowly do you define the role of the Behavioral Health Coordinator?
- Alaskan model makes sense. Also agree that the diagram the lines that are clearly defined between PCP and BHS, should have a little more overlap where patients are managed primarily by PCP
- Provider: episodic care is also a role for the embedded behavioral health person, so our role is prevention, consultation, and then the brief intervention in episodic care
- Consumer: some things are missing in this diagram- in prevention; screenings as well as interventions making sure screenings are included in that- we want to make sure we are putting substance abuse in there
- FHC Expert: the issue around substance use treatment is really important
- Provider: when folks are mentioning screening there's really those two levels of screening. Targeted screening could be put into the behavioral health provider (2nd stage screening is another useful role)
- State: 2nd arrow should be expanded to include other licensed Behavioral Health Specialists. So have it unambiguous that we are folding in a dedicated resource, and dedicated resource doesn't necessarily mean on site
- Provider: Brief interventions should be brief interventions/consultations
- Consumer: Would still like to see some inclusion of substance abuse. if someone has a real substance abuse problem they need to be at a clinic
- FHC Expert: This idea that you're either providing or arranging and integrating a brief intervention component is a primary care function
- Provider: It is reasonable that a trained BHP is going to have some basic skills in substance abuse but just like other conditions they don't need to be experts and the care coordinator vs the BHP (screen and help determine what the next best step is)
- FHC Expert: Social workers usually have experience in brief intervention or figuring out if the person needs treatment and will make the right referral
- State: There has been a debate as to whether every person should be screened every year for trauma; I think OHS does need to get to some kind of consensus recommendation
- FHC Expert: depression, substance use no question, anxiety yes, and this is the first time I've heard of trauma (question is around what else if anything)
- Provider: Screenings can be done through technology

- Consumer: substance abuse, anxiety, and depression as the core-other assessments may be appropriate- generally is you're covering for those three. Have concern about universal screenings, if you have a BHS as part of the payment bundle that that's going to help deal with the shortage issue; its probably better to address screening as a standard not sure exactly which one should be included, workforce needs to come alongside how we make this decision
- Consumer: conducts four basic screenings as a BHS while working within a primary care setting
- Provider: I worry that making this mandatory is problematic
- FHC Expert, Consumer agreed
- FHC will circulate list of screenings

Performance monitoring recommended measures

- Consumer: accountability is important, not sure what measures are available, want to be able to have that data and have it analyzed in improving health equities
- Provider: When you make a referral outside of the practice, who is following up on that?
- FHC Expert: number of things stated here as descriptive standards, this requires more work and thinking. Participating in the data gathering is an important aspect of the program
- FHC Expert: Performance expectation in the practice and what are the data requirements at the community level
- FHC: the data needed to measure that integration is actually happening
- Consumers: Suggest how many patients are being seen by BHS, how many referrals are being done, how many community connections are being made, how many follows up happen → there are some basic things to show the structure we are trying to put into place you know you're able to quantify it → to be able to have data
- Provider: the health outcomes, better ranges being met?
- FHC Expert: Have to start small with some process outcomes and then build up