Session # D4

Can primary care practices develop better behavioral health integration via interdisciplinary assessment and discussion? A 28-site outcome study.

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Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

OR

The presenters of this session currently have or have had the following relevant financial relationships (in any amount) during the past 12 months.

(list each conflict here)

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Conference Resources

Slides and handouts shared by our conference presenters are available on the CFHA website at https://www.cfha.net/page/Resources_2019 and on the conference mobile app.

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Learning Objectives

At the conclusion of this session, the participant will be able to:

- Identify the benefits of conducting an integration of behavioral health practice assessment
- Describe the study's observed outcomes on the benefit to interdisciplinary practice
- Define how attendees would enact a similar practice evaluation in a step-wise fashion

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Learning Assessment

- A learning assessment is required for CE credit.
- A question and answer period will be conducted at the end of this presentation.

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Background

- Integrating behavioral health into primary care is rapid expanding its spread across health settings, and effective integration depends on considering clinical, operational, and financial factors (Vogel et al, 2017)

- The American College of Physicians supports the integration of care, increased financial support of this model, and more research to define the most effective ways to integrate care. (Crowley et al, 2015)

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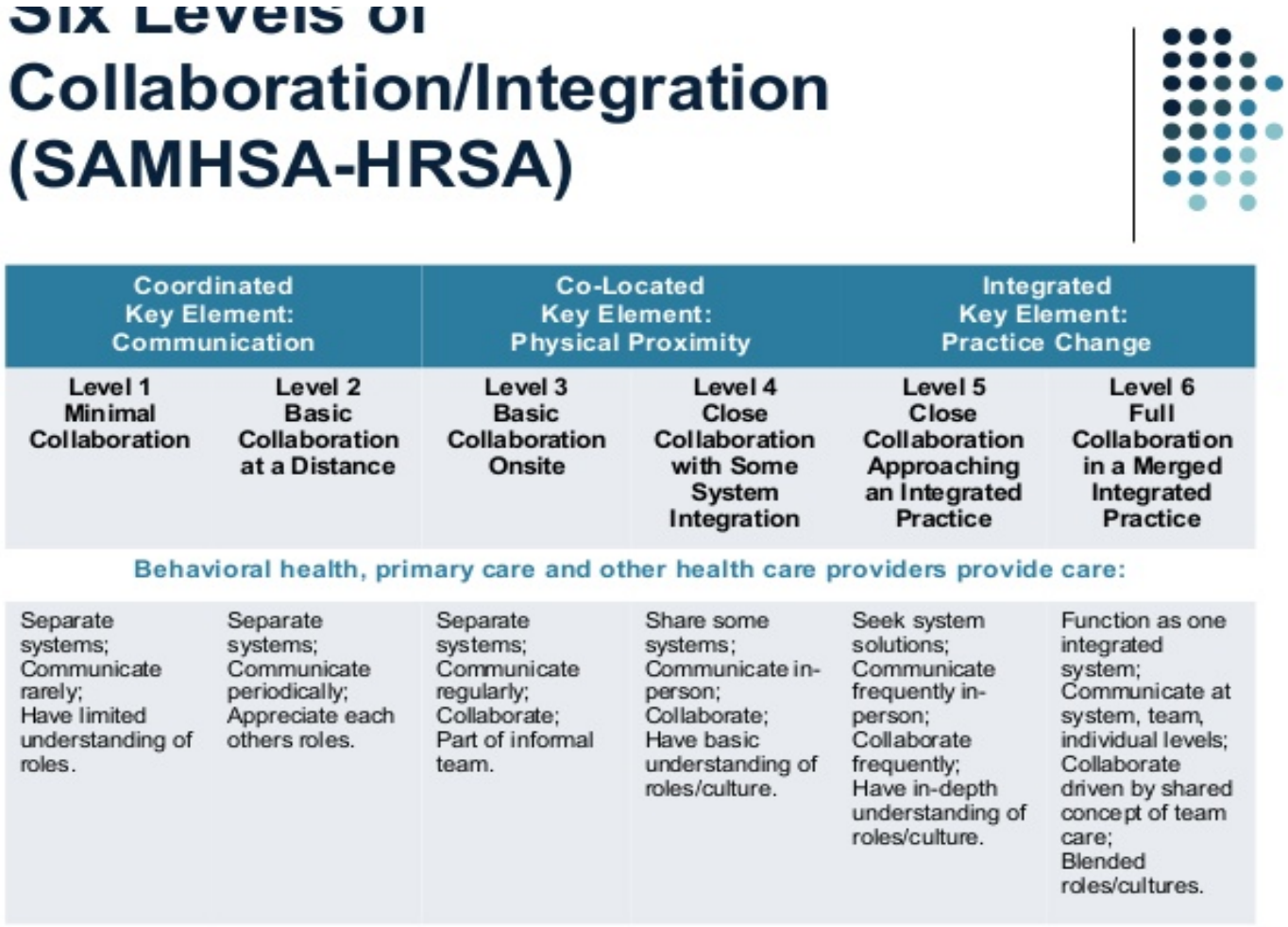
Six Levels of Collaboration/Integration (SAMHSA-HRSA)



Communication

Level 1

Level 2

Co-Location

Level 3

Level 4

Integration

Level 5

Level 6

Integrated Primary Care

- Primary Care Behavioral Health (PCBH) emphasizes the colocation, collaboration, and integration of psychological services in the medical setting, and can be measured on a continuum from minimal collaboration to integrated transformative care

- PCBH is increasingly occurring in community health centers, military settings, university practices, and in more private practices

Doherty et al, 1996; Heath et al, 2013

Benefits of Primary Care Behavioral Health

- Adoption of the PCBH model is associated with improved behavioral health metrics in primary care, overall cost savings, and improved medical provider knowledge of mental health

- PCBH can improve access to behavioral health care, enhance the focus on health behavior change, and also assist with team-based care, to improve task-focus and reduce morale injury/burnout

(Hunter et al, 2017; Ross et al, 2018; Zallman et al, 2017).

Observations about PCBH

- PCBH practices are busy, and time is often not set aside to discuss the “state of integration” of the practice and how behavioral health services can be optimized.

- Sites may have different priorities internally for their hopes and scope of care for BHCs

Challenges in Maintaining Integrated Care

- A Level 4 or 5 practice can embed a behavioral health consultant (BHC), but considerable load/demand can be placed on a BHC to implement the elements of GATHER
  - Generalist care
  - Accessibility
  - Team-Based
  - High-Productivity
  - Educator
  - Routines
- Anecdotal BHC reports---”chasing visits”/ non enough handoffs

(Reiter, Dobmeyer, & Hunter 2018)

Questions Raised about PCBH

- Is Integrated Primary Care reviewed and discussed In the health setting
- Further inquiry is needed into assessing the presence and degree of integrated care
- Additionally, can degree of integration be enhanced by interdisciplinary assessment and addressing needs via training and practice problem-solving?

(Macchi et al, 2016)

Is it Important to Assess Level of Integration?

- Formal mechanisms are warranted to assess integrated care to:
  - Determine **Model Fidelity**
  - Facilitate **Team-Based Examination and Promotion**
  - Provide **Opportunity to Discuss Integrated Care**
  - **Refine Practice Strategies**

Different Ways to Assess Integrated Care

• Self-Review	• N/A
• Integrated Practice Assessment Tool (IPAT:)	• Waxmonsky et al (2014)
• The Academy Playbook.. Self-Assessment Checklist for Integrating Behavioral Health and Ambulatory Care.	• AHRQ (2013)
• MeHAF	• Roderick et al (2017)
• Practice Integration Profile Tool	• Macchi et al (2016)

Different Ways to Assess Integrated Care

- **Self-Review**
  - Pro- Idiographic, Goodness of Fit Qualitative,
  - Con- Unstructured, Non-Grounded
- **Integrated Practice Assessment Tool (IPAT)**
  - Pro- Quick, Grounded to 6-Level Model
  - Con- Difficult to Understand, Not Nuanced
- **Integration Self-Assessment Checklist**
  - Pro- Examines Integration by Domain; Grounded to 6-Level Model
  - Con- Not empirically validated, Lack standardized scoring
- **MeHAF**
  - Pro- Measure sub elements, detailed anchors, easy to consider
  - Con- Not as exhaustive as Academy toolkit
- **Practice Integration Profile Tool**
  - Pro- Research-driven, validity/reliability, practice-oriented domains, good anchors
  - Con- Different than 6-Level Model (Kessler et al, 2016)
- **Overall**
  - Pro- Merits of assessing integrated care, different modalities
  - Con- Limited validity/reliability assessment, further development needed (Bautista et al, 2016)

Brief Review of the IPAT

- Walk-through

- Consider your practice

IPAT Study

Reason & Purpose of this Evaluation

- Medicaid Behavioral Health payer services in Philadelphia, PA are managed by Community Behavioral Health (CBH) associated with the Philadelphia Department of Behavioral Health and Intellectual disAbilities Services

- CBH has been a long-term proponent of PCBH for 13+ years

- The Health Federation of Philadelphia has worked with CBH to promote and support PCBH in local federal-qualified health centers (FQHCs)

Reason & Purpose of this Evaluation

- CBH wanted to learn more about the nature of integration and charged the Health Federation of Philadelphia with evaluating all local FQHCs for their fidelity to PCBH

- It was agreed a PCBH expert would conduct a structured interview of integrated care, individual practice and agency data would not be identified as data would be shared in aggregate, and the interdisciplinary team would be needed to be involved.

- Lunch was provided

Network Background

- Nine FQHC Health Agencies participated in this CBH integration assessment

- 29 unique FQHCs participated in the assessment, 25 completed both Time 1 & 2, three did not complete Time 2 (a BHC vacancy) and 1 did not complete Time 1 (new BHC service)

- The Health Federation of Philadelphia provides: (1) technical assistance for PCBH start-up; (2) monthly CEU trainings to BHCs; (3) a four-day “Boot Camp” for new BHCs; (4) BHC and Directors email list-serves; and (5) on-site shadowing and assistance of BHC needs.

Meeting Format

- Conveyed BHC(s), Medical Provider(s), Administrator, and later, Medical Assistant. Often Integrated BH Director would attend

- Reviewed integrated care from each perspective
- Individuals complete IPAT
- Team discussion of results and use of Integration Self-Assessment Checklist to ascertain domain-specific level of integration
- Recorded and elaborated on potential integrated care needs
- Identified potential solutions/goals to address needs.
- (Time 2: Reviewed Progress from Time 1).

Time 1- Levels of Integration (IPAT)

Level of Integration	Descriptor	Number of Network Sites
Level 3	Basic Collaboration Onsite	2
Level 4	Close Collaboration Onsite with Some Systems Integration	12
Level 5	Close Collaboration Approaching an Integrative Practice	14
Level 6	Full Collaboration in a Transformed Merged Integrative Practice	0

Time 1– Domains of Integration

Integration Self-Assessment Checklist

Practice Domain	Average Rating
Location	4.82 (range 3-6)
Clinical Delivery	4.29 (range 3-6)
Patient Experience	4.79 (range 3-6)
Practice Organization	4.44 (range 3-6)
Business Model	4.68 (range 4-5)

Time 1- Integration by Practice Maturity

Practice Experience	Total IPAT Site Rating
New Practices (<1 yr) (N=9)	4.00
Moderate Practices (1-4) (N=11)	4.73
Well-Established (5+) (N=8)	4.63

Time 1- Integration by Practice Maturity

Practice Experience	Location Domain	Clinical Delivery Domain	Patient Experience Domain	Practice Organization Domain	Business Model Domain
New Practices (<1 year)	4.20	3.70	4.20	3.90	4.40
Moderate practices (1-4 years)	5.00	4.45	5.09	4.90	4.73
Well-Established practices (5+ years)	5.50	4.75	5.13	4.50	5.00

Lessons Learned & Themes, Part I

- Sites were worried at first (e.g., *“is this an audit”)* and consequently, guarded about being critical.
  - Spent time upfront, via education and motivational interviewing, to facilitate space to be more self-critical
- Six distinct themes of need were identified across health centers:
  - 1. Addressing psychological trauma in medical settings; 2. Needs in early child development; 3. Site-based training needs; 4. Barriers to referring to/ accessing behavioral health care; 5. Needing to focus on population health metrics and shared care planning; 6. Electronic health records transition; 6. Site transitions and clinic-based changes.

Lessons Learned & Themes, Part 2

- As sites opened up, we learned impressive stories of patient success, provider devotion to the model, and practice transformation
- We also learned that providers struggled generally or in specific areas of referring to /incorporating BHCs; BHC productivity factors and “cold calling/ follow-up” emphasis.
- Resource gaps for referral and training
  - Conducted training on medication-assisted treatment, chronic health and pain interventions, skills for pediatric assessment, and policy and population management advances including shared care and huddling.
  - Four-day “bootcamp“ refocusing on brief interventions, more case examples, and scaffolding practice by pairing more novice and more experienced BHCs for role-plays

Response and Preparing for Follow-Up

- Sites were enthusiastic and appreciated the protected time (and lunch) to discuss integrated care and consider what it meant to the organization, the clinic flow, patients, and the team

- CBH asked Health Federation of Philadelphia to repeat the process six months later with each of the sites.
  - The majority repeated, except sites which recently had a BHC vacancy and had suspended integrated care in the meantime

Time 2- Levels of Integration- IPAT

Level of Integration	Descriptor	Assessment 1 (January-June) Number of Network Sites	Assessment 2 (July-December) Number of Network Sites*
Level 3	Basic Collaboration Onsite	2	0
Level 4	Close Collaboration Onsite with Some Systems Integration	12	5
Level 5	Close Collaboration Approaching an Integrative Practice	14	19
Level 6	Full Collaboration in a Transformed Merged Integrative Practice	0	2

Time 2– Domains of Integration- *Integration Self-Assessment Checklist*

Practice Domain	Average Rating – Time 1	Average Rating – Time 2
Location	4.82 (range 3-6)	5.23 (range 4-6)
Clinical Delivery	4.29 (range 3-6)	4.77 (range 4-6)
Patient Experience	4.79 (range 3-6)	5.12 (range 3-6)
Practice Organization	4.44 (range 3-6)	4.85 (range 3-6)
Business Model	4.68 (range 4-5)	4.85 (range 3-6)

Time 2- Integration by Practice Maturity

Practice Experience	Time 1 Total IPAT Site Rating	Time 2 Total IPAT Site Rating
New Practices (<1 yr) (N=10)	4.00	4.70
Moderate Practices (1-4) (N=11)	4.73	4.89
Well-Established (5+) (N=8)	4.63	5.14

FQHC Integration Needs- Time 1

Practice Experience	Location Domain	Clinical Delivery Domain	Patient Experience Domain	Practice Organization Domain	Business Model Domain
New Practices (<1 year)	4.20	3.70	4.20	3.90	4.40
Moderate practices (1-4 years)	5.00	4.45	5.09	4.82	4.73
Well-Established practices (5+ years)	5.50	4.75	5.13	4.50	5.00

FQHC Integration Needs- Time 2

↑ = > 0.10 increase, overall, all metrics increased

Practice Experience	Location Domain	Clinical Delivery Domain	Patient Experience Domain	Practice Organization Domain	Business Model Domain
New Practices (<1 year)	4.90 ↑	4.5 ↑	4.80 ↑	4.80 ↑	4.70 ↑
Moderate practices (1-4 years)	5.33 ↑	4.89 ↑	5.44 ↑	4.89	4.78
Well-Established practices (5+ years)	5.57	5 ↑	5.14	4.86 ↑	5.14 ↑

FQHC Integration Needs

- During the IPAT assessment, the facilitator noted areas of need that were mentioned by the staff members. These were reviewed collectively among the team in attendance and the top 3-5 needs of each site to improve the integration of primary care with behavioral health were identified.
- These needs covered disparate topics, depending on individual site circumstances, but there were a number of collective themes: 1. addressing psychological trauma in medical settings; 2. needs in early child development; 3. site-based training needs; 4. barriers to accessing behavioral health care; 5. needing to focus on population health metrics; 6. electronic health records transition; 6. site transitions and clinic-based changes.

FQHC Integration Needs / Goals Progress Degree Completed or Sufficiently Underway

Maturity of Practice	Needs Met	Strategic Goals Met
ALL PRACTICES	75.7%	67.0%
New Practices (<1 yr)	76.9%	66.7%
Moderate Practices (1-4)	70.3%	71.0%
Well-Established (5+)	80.6%	63.0%

FQHC Integration Goals Progress

- Increased utilization of population management software, huddles, and prescrubbing schedule
- Practices working on automatic referrals to BHC by specific metrics
- Shared Care Planning innovations and piloting, especially in highest care need populations

New Lessons Learned & Themes, Part I

- The most notable finding is most sites are practicing the integrated primary care model with a high degree of co-location and collaboration, as well as emerging integration of services and role-sharing in relation to chronic health, referral maintenance, cross-training and communication.
- Data show the BHC model has been quickly expanding across the Philadelphia FQHCs: a highly collaborative model of practice (level 4) is already established in clinics with less than a year of integrated behavioral health experience, and for sites with considerably more experience with the model the average scores on the Integrated Practice Assessment Tool (IPAT) and Integration Self- Assessment Checklist suggested elements of highly developed collaborative practice (level 5) and emerging integration of systems, workflows, and practices (toward level 6)

New Lessons Learned & Themes, Part 2

- Practice barriers were identified in the community
  - One-third of FQHCs were in neighborhoods with insufficient BH resources, especially deemed “hard to access” or “low quality”
  - Limited referral options for trauma, dysregulated eating behaviors
  - Significant barriers for addressing subclinical needs in children and teens, especially related to payment limitations
    - Request for collaborative discussion with CBH to identify service barriers and payment options
  - Barriers for addressing health behavior change and chronic health problems (F54 code isn’t always suitable fit)
    - Reimbursement and referrals being sent to BHC for these needs

Benefits

- The “IPAT” process provided a novel opportunity for practices to stop and reflect on integrated behavioral health: meaning, intention, success, and challenges

- We observed notable increases in integration scores and 2/3 of site integration needs and goals were progressing/met.
  - Can’t conclusively attribute gains to IPAT meetings, but sites were quick to acknowledge this process as a driver of discourse and change.
- Provided detailed information on BHC, site, and network-wide needs, and allowed modification of training and lobbying for community resources
- Opportunity to practice site-based team-building via reflection and discussion

Benefits

Influenced next phase of Health Federation of Philadelphia work:

- Further reshaped Boot Camp around GATHER
- Training calendar will feature more pediatric, chronic health, local CBH resources offerings, as well as detailed evidence-based trainings
- Continue to provide support around huddling, shared care planning, and building out health behavior interventions/resources
- Further support to BH Directors via leadership development forum
- CBH will continue to fund process
  - Will continue IPAT annually, as opposed to twice annually

Limitations

- IPAT-alone was found to be insufficient
- Pros/Cons of Single Health Federation IPAT Administrator
- Pros/Cons: Sites had Varying Staff Members at Each Meeting
- Time: Sites preferred if it could be done in 1 hour, 90 minutes was more ideal

Lessons Learned

- Automation
  - Google Forms, Autocrat for Instant PDF, Google Spreadsheet for Easy Analysis
- Power of Relationships
- Added Checklist in 2019 to Assess Pertinent Areas
  - Substance Use Screening
  - Chronic Health Referrals
  - Internal Processes to Maintain Integrated Care
  - Morale Injury / Burnout Prevention Mechanisms
  - Is Voice of Medical Assistant Being Considered

Discussion

How might you assess integration in your practice setting?

Session Survey

Use the CFHA mobile app to complete the survey/evaluation for this session.

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