Combining models of integrated behavioral healthcare for effective primary care delivery

Evidence-Based and Practical Insights

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- *Disclosures:*
  - *Member and co-owner of Sidari Consultants, LLC.*

Webinar Outline

- Gain an understanding of the continuum for defining "integrated care"

- Describe the evolution of integrated care in the United States, with emphasis on Primary Care Behavioral Health (PCBH) and Collaborative Care Model (CoCM)

- Outline a conceptual framework for creating cohesive and effective cross-model integrated services tailored for an organization

- Explore Cayuga Integrated Behavioral Health (CIBH) as a narrative example of cross-model integrated care

My evolving relationship with integrated care:

Postgraduate training and early clinical practice:
- *Joint civilian / military residency*
- *Air Force officer and psychiatrist*

Post-military clinical experience
- *College mental health (Cornell University)*

Development and directorship for integrated care programming
- *Administrative and clinical role*

SPECIALTY MENTAL HEALTH

INTEGRATED BEHAVIORAL HEALTH

INTEGRATED BEHAVIORAL HEALTH

SPECIALTY MENTAL HEALTH

INTEGRATED BEHAVIORAL HEALTH

ONE-TIME DIRECT EVALS

“Integrated Care:” Shared components on a spectrum

LEAST INTEGRATED

MOST INTEGRATED

Minimal Collaboration

Coordinated Care

Co-Located Care

Partially-Integrated Care

Fully-Integrated Care

Specialty Mental Health -AND- Primary Care

Differing scopes of care, populations, and workflows

Shared Patient-Centered Medical Home (PCMH)

Shared scope of care, workflows, and population served

Typically builds off of best practices for the foundational team (primary care)

Corso *et. al* (2016)

Feinstein *et. al* (2017)

EvolvingCare.pdf (milbank.org)

Primary Care Integration

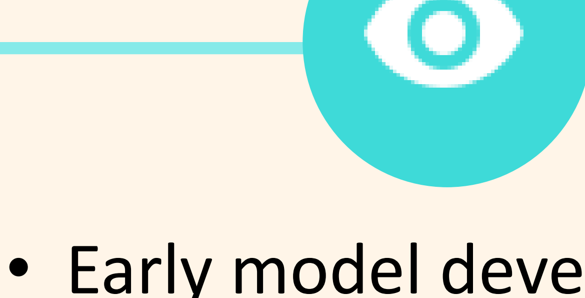
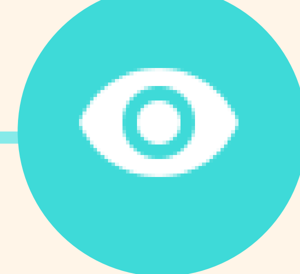
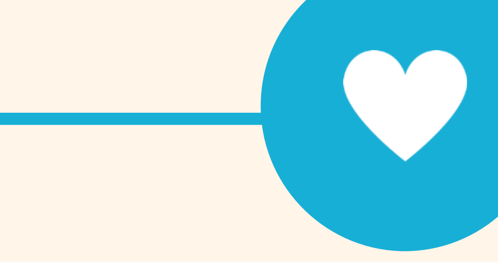
1. Hospital Outpatient — Specialty / Referral-Based Care
2. Maintenance care for primary care needs — Chronic Care Management
3. Focused assessment and intervention, personalized and coordinated approaches — Measurement-Based Care, Focused intervention, Heath and Behavior
4. Universal screening via mental health vital signs, watchful waiting, systematic monitoring with matched stepped care response — Routine Monitoring and Preventative Care

5. Self management and monitoring, social and community supports — Community Care

General framework adapted from Ratzliff *et al.* (2017)

Integrated Care

A brief history for behavioral health

1970s

First large-scale organized program with medical and mental health collaboration

1990s

- Early model development
  - Primary Care Behavioral Health (PCBH)
  - Collaborative Care Model (CoCM)
  - Other models
- Collaborative Family Healthcare Association (CFHA) established (1995)

2000s

- Integrated care becomes mainstream in military and governmental programs
- CPT/CMS introduces health and behavior codes for psychologists
- IMPACT trial published, the first of more than 90 RCTs showing superior CoCM efficacy to usual care

2010

Affordable Care Act (ACA) enacted, promoted funding for integrated practices

2017

CPT/CMS introduced CoCM codes (expanded in 2021) encouraging state-by-state spread

Adapted from A Brief History of the Integration of Behavioral Health in Primary Care - Collaborative Family Healthcare Association (cfha.net) and Evidence Base for CoCM | University of Washington AIMS Center (uw.edu)

WAYS OF ORGANIZING KINDS OF INTEGRATED CARE

- Team composition
- Level of integration
- Care need(s) served
- Accessibility
- Funding modalities
- Scope(s) of care

Fully-Integrated Primary Care Behavioral Health

Strong evidence base for superior to care as usual

Effective, sustainable, accessible, high satisfaction for providers / patients

Augments most care needs

Diagnostic assistance

Safety Planning Help

Acute and routine supports

Patient-centered
Population health
Primary care team
Measurement-based
Evidence-based

Options for mild / moderate / severe primary care conditions

Streamline PCP care and offset burdens

Care coordination

Focused interventions for physical and mental health conditions
(brief therapeutic, lifestyle supports, treatment monitoring, education)

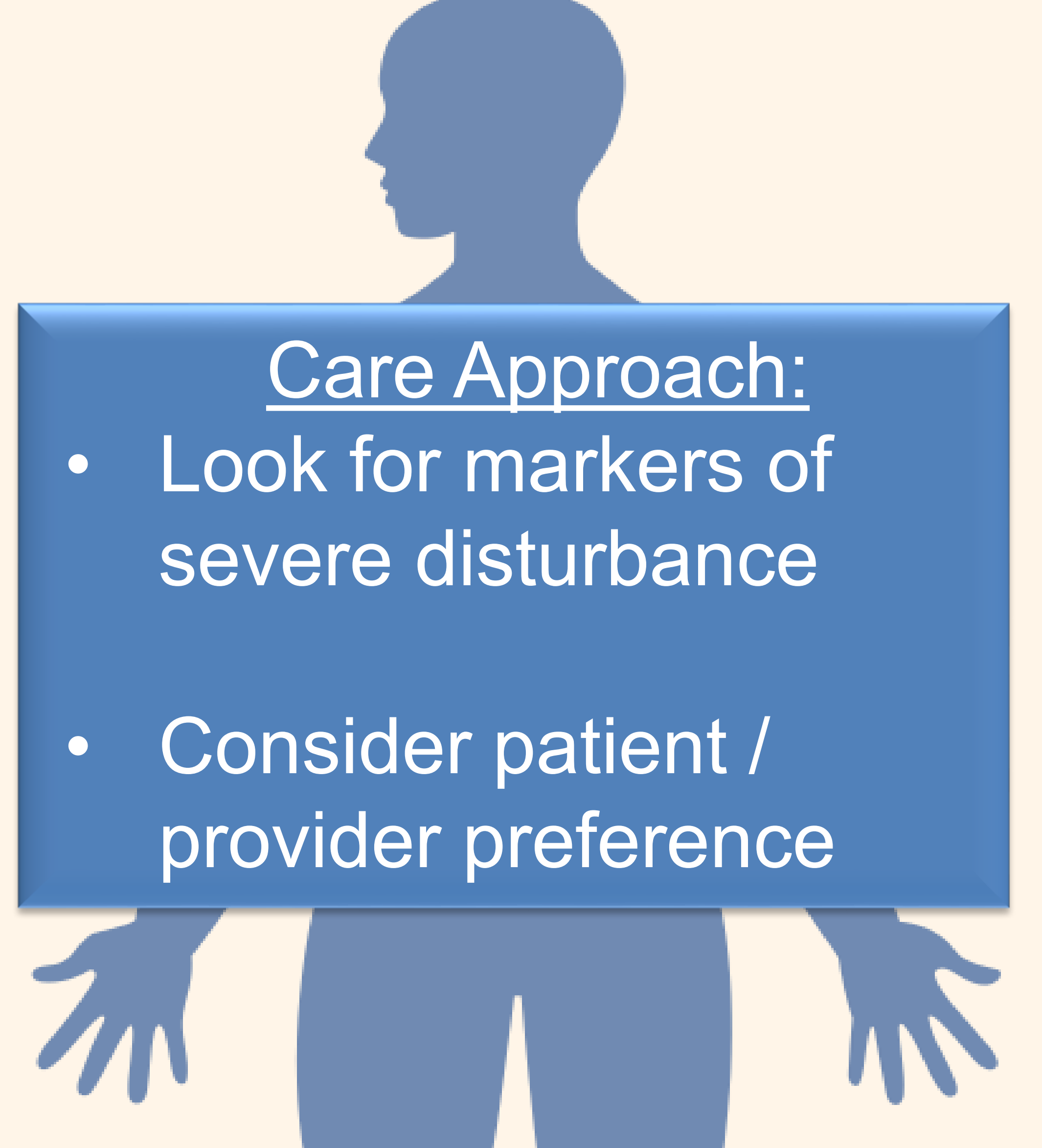
Decreases need for specialty referrals, but does not fully solve for this

Corso *et. al* (2016)
Feinstein *et. al* (2017)

“Why not co-located specialty care?”

No better than care as usual: still an external referral

- Lacking in examples of effective care models
- Short-term benefits without long-term solutions
- Full integration with superior outcomes comparative to co-location
- Co-located specialty care can interfere with uptake of other integrated care modalities

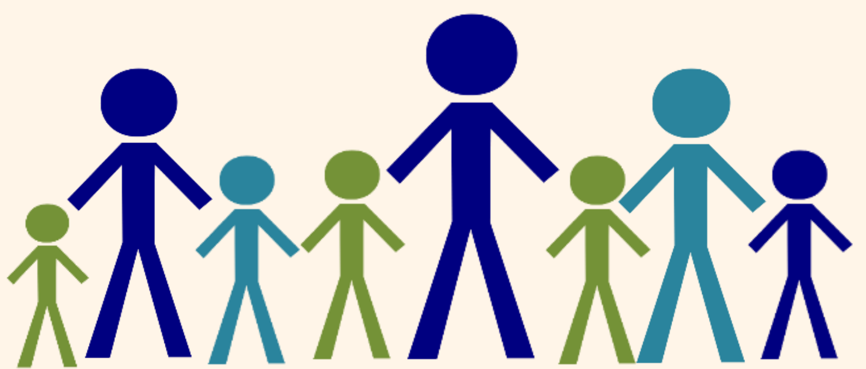


Chung *et. al* (2023)
Corso *et. al* (2016)
Feinstein *et. al* (2017)

“Why Full Integration?” Because it is the most effective way to treat a general population

- Frequent opportunities for engagement and re-engagement
- Accessible as-needed
- Helpful for a diverse range of concerns, to include but not limited to mental health needs

- Stand-alone referrals
- Specific to mental health concerns
- 50% referral follow-through
- <2 mean number of visits attended



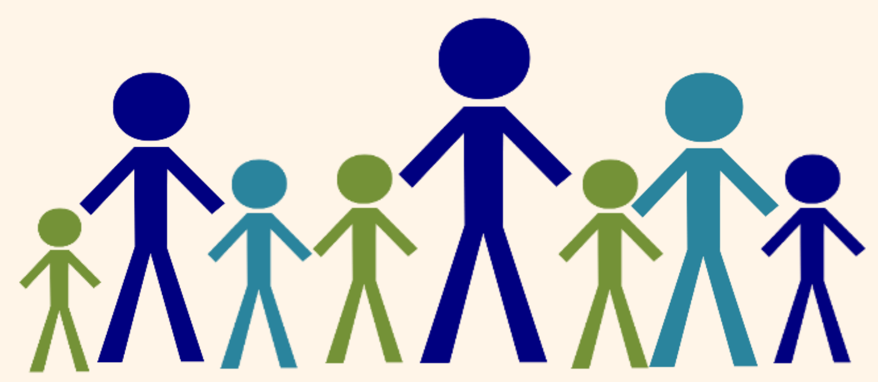
Integrated Behavioral Healthcare in Primary Care

Referral-Based Specialty Mental Health

"Why Full Integration?" It improves psychiatric accessibility for a general population

Service reach for psychiatrist supports:

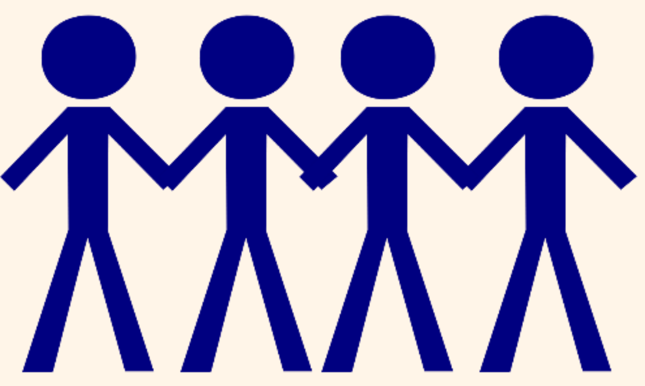
- **40,000-60,000** primary care patients across 30+ PCPs
- **Additional multiplier effects** through strategic workforce training



Integrated Behavioral Healthcare in Primary Care

Service reach for psychiatrist supports:

- **150-250** empaneled patients
- **44% of psychiatrists** do not accept commercial insurance compared to **10% of non-mental health physicians**



Referral-Based Specialty Mental Health

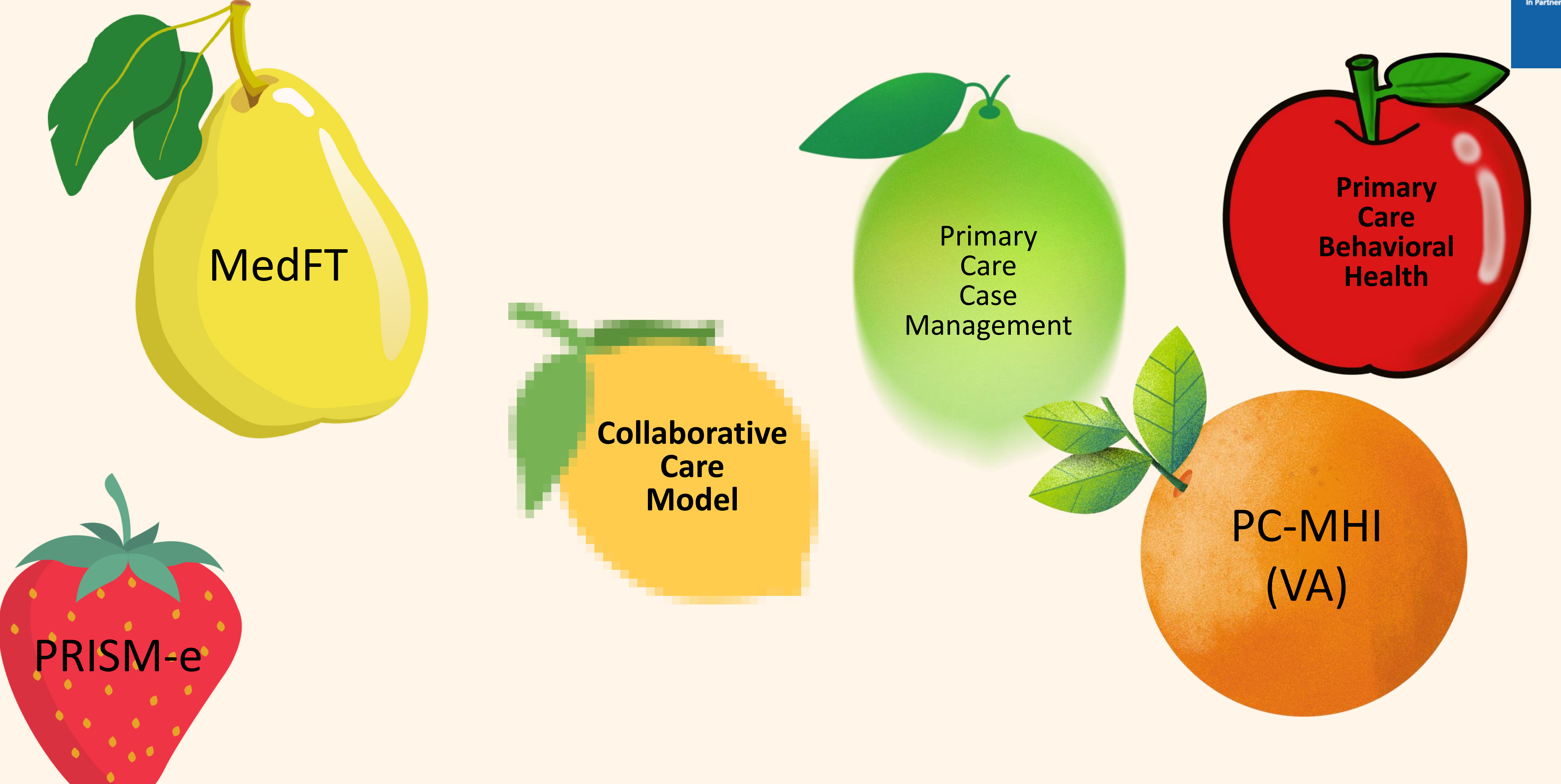
McQuistion HL, Zinns R (2019)
What you need to know about the cost and availability of health care in America (CNBC, 2021)

Factors impacting primary care integration

Barriers	Facilitators
Insufficient staff numbers	Creating a collaboration culture with integration championship at all levels
Disagreements about care roles	Integrated care training and orientation
Information sharing challenges	Warm hand-offs
Financial sustainability	
Workflow / logistical obstacles	

Buche, J *et al.* (2017)
Chung, H. *et al.* (2019)
Wakida E. K. *et al.* (2018)

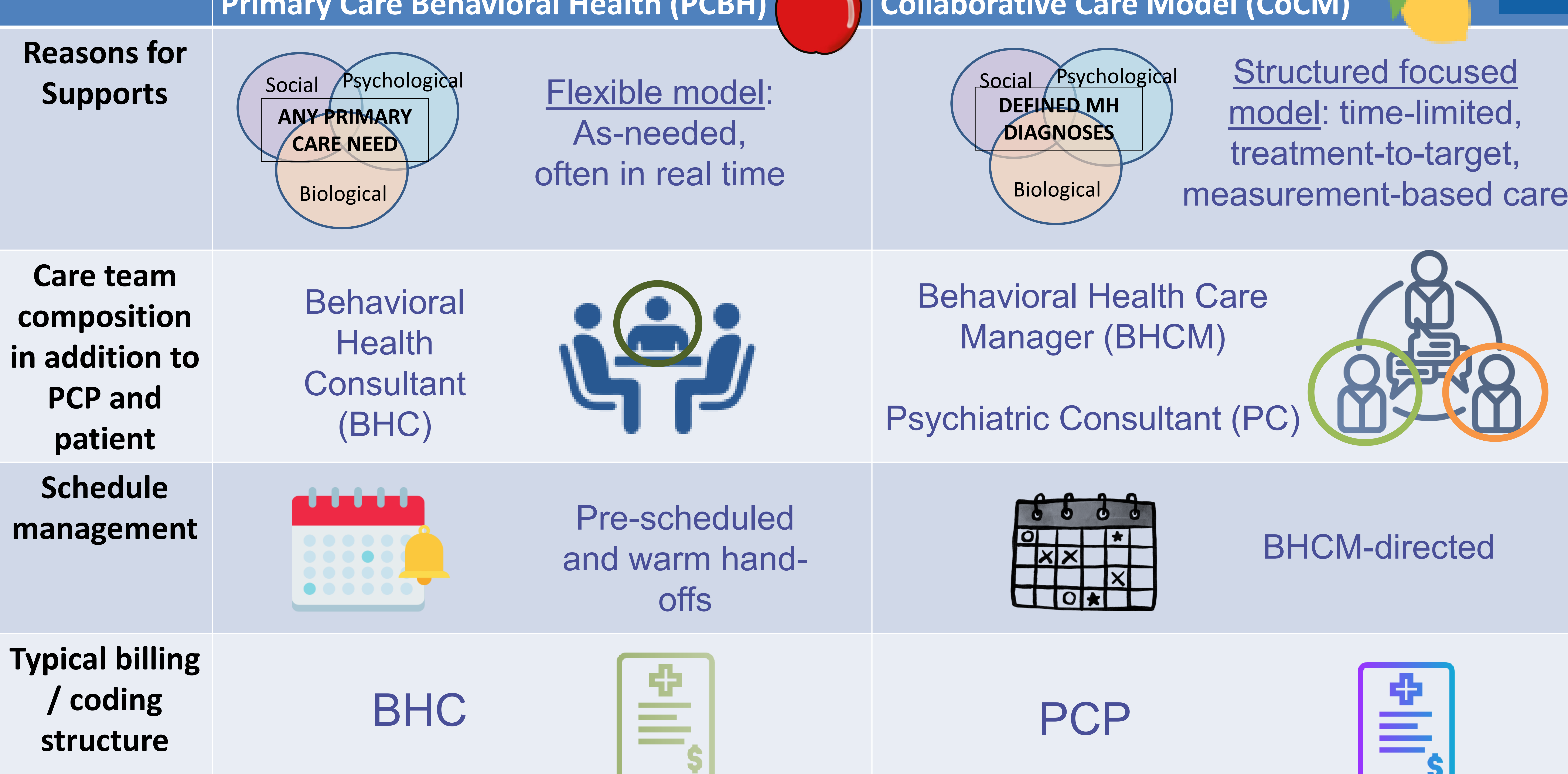
Different Models of Integrated Care



EvolvingCare.pdf (milbank.org)

Corso, K. A et al *(2016)*

Common Model Comparisons



	Primary Care Behavioral Health (PCBH)	Collaborative Care Model (CoCM)
Reasons for Supports	Social / Psychological / Biological: ANY PRIMARY CARE NEED. Flexible model: As-needed, often in real time	Social / Psychological / Biological: DEFINED MH DIAGNOSES. Structured focused model: time-limited, treatment-to-target, measurement-based care
Care team composition in addition to PCP and patient	Behavioral Health Consultant (BHC)	Behavioral Health Care Manager (BHCM) Psychiatric Consultant (PC)
Schedule management	Pre-scheduled and warm hand-offs	BHCM-directed
Typical billing / coding structure	BHC	PCP

Why Consider an Integrated Care Model?

Benefits:

- “Road map” for set-up: Supported by evidence and / or experience
- Established reimbursement models, benefits for defined care needs, team member composition, and care delivery modalities

Challenges:

- Gaps in population coverage are common
- Can be difficult to “retro-fit” or translate a given care model to meet individualized care system needs
- Can require multiple models to meet population health needs

Considerations for Blending / Combining Models

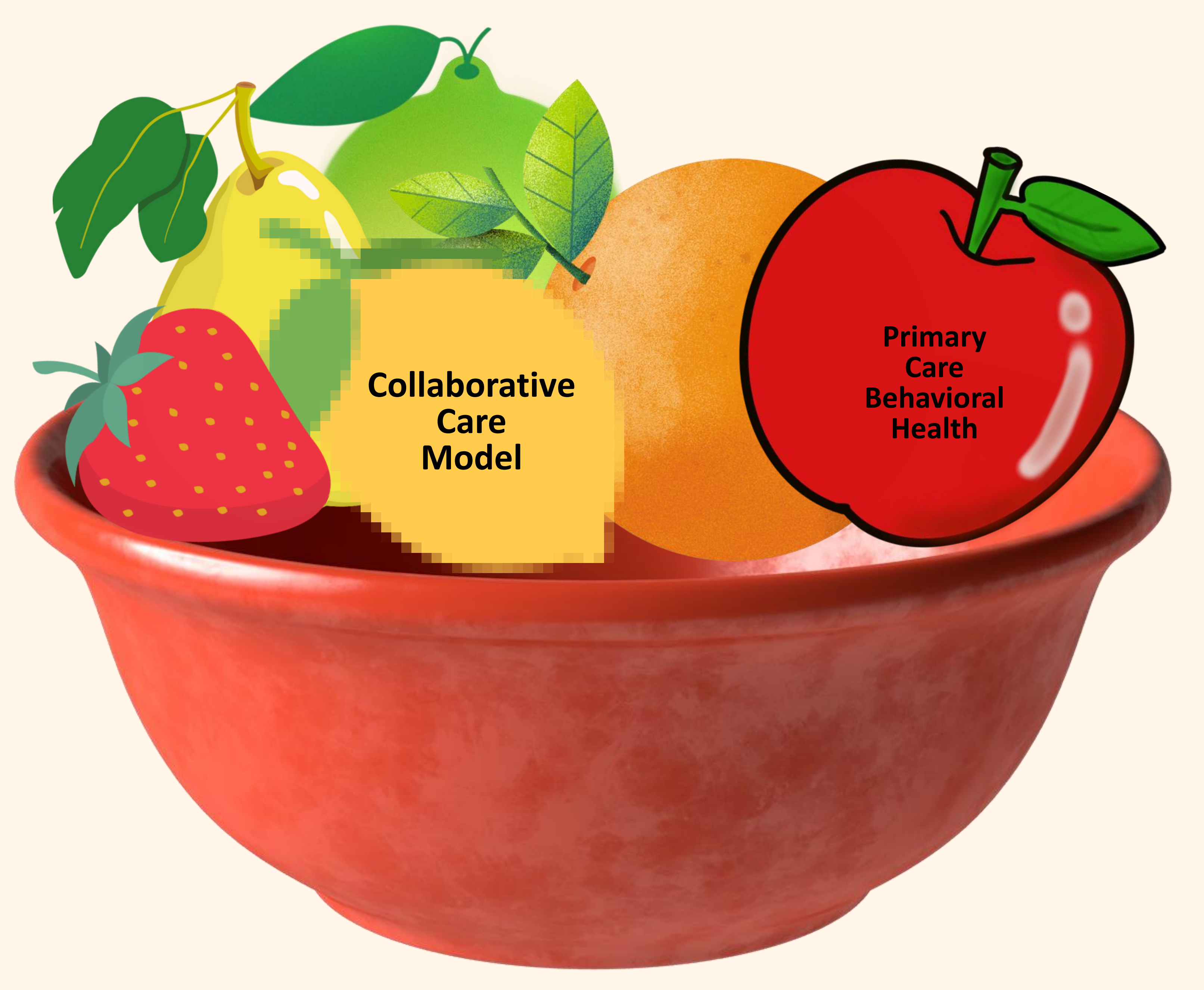
Care system benefits:

- Expanded care options
- Can serve a broader range of patients and care needs, which can be particularly helpful across a general healthcare population

Care system challenges:

- Often added up-front investments
- Requires a unifying care delivery framework to reduce the potential for care fragmentation, duplication of services, and care confusions

Shared framework for blended model care delivery



- Population health approach
- Primary care model
- Measurement-based care
- Treatment-to-target care
- Alignment with health system priorities and capabilities
- Financial sustainability
  - Value-based care
  - Fee-for-service considerations
  - National / state-based factors
- Multidisciplinary team
- Accessible care
- Patient-centered care plan

[The Comprehensive Healthcare Integration Framework (thenationalcouncil.org)]

Buchanan, G. J *et al* (2022)

GROW Pathway Planning Worksheet for Primary Care Practices

Goal: Which populations of patients are we targeting?	
	Do we serve this population now? How do we want to serve this population better?
Patients in crisis and distress	
Patients with common chronic mental illnesses such as depression and anxiety	
Patients needing support to manage serious mental illness	
Other populations	

Resources: What are the resources available to us? What challenges with resources need to be addressed?	
	What resources does our organization have?
Geography	
Physical space	
Support of leadership	
Care team & workforce development	
Shared workflows	
Available technology/ HIT	
Financial Resources	

Options: What capacities do we have now and how can we create capacity to integrate behavioral health?			
		Do we do this?	How can we do this?
Access	Facilitated Referral		
	On-site Behavioral Health Provider		
Accountability	Measurement-Based Treatment to Target for Individuals		
	Commitment to Population Outcome Improvement		

Workflow: What changes will need to be in place for us to deliver integrated behavioral health?	
	How can we do this?
Do staff need to be hired? What types of staff? Do existing or new staff need to be trained?	
What facilities, HIT, and other resources are required to implement the integrated workflow?	
What internal communication materials and protocols, and clinic-specific guidelines and protocols for psychiatric emergencies do we need?	
How will our physical space foster collaboration? Should providers share a pod?	
What materials do we need to introduce the new care delivery pathway to patients and organization clinicians and staff?	
How will we schedule visits? Will we schedule follow-ups interspersed with open access appointments to facilitate time for just-in-time consultations and warm handoffs?	

Figure 1. GROW pathway worksheet.
This worksheet can be used by organizations to assess current practice and move toward behavioral health integration. A modifiable version of this GROW Worksheet and a completed example are also available at http://www.safetynetmedicalhome.org/change-concepts/organized-evidence-based-care/behavioral-health.
HIT, health information technology.

Integrated behavioral health "Project Team:" representatives from the AIMS Center, Qualis Health, the MacColl Center for Health Care Innovation, and The Commonwealth Fund

4 phases of assessment for behavioral health integration

(1) Goals

(2) Resources

(3) Options

(4) Workflow

Ratzliff, A., *et al.* (2017)

About Cayuga Integrated Behavioral Health (CIBH):

Fully-integrated behavioral health services supporting *affiliate primary care teams* via *PCBH and CoCM* delivery

Our care system

Cayuga Medical Associates:

- Multi-specialist, outpatient healthcare group
- Serving the finger lakes region of New York State

Not-for-profit Professional Corporation:

- Predominantly fee for service revenue generation
- Some network-wide performance contracts
- No grant funding for behavioral health

Mostly insured population: 98%

- Roughly half Medicaid / Medicare and half Commercial

Diverse population reach:

- Multi-condition community population with limited mental health referral network
- Pediatrics to geriatrics, college health, rural / urban

About Cayuga Integrated Behavioral Health (CIBH):

Fully-integrated behavioral health services supporting *affiliate primary care teams* via *PCBH and CoCM* delivery

- Since service initiation in Aug 2021: Cohesive practice model combining CoCM and PCBH services established in 3 primary care clinics + 1 Rheumatology care pathway

- Team composition: 1 Director (psychiatrist), 2 Assistant Directors (clinical psychologists), 1 program manager, 7 additional professionals (LCSWs, LMSW, LMHC, psychiatrist)

  Clinical roles: 2 CPs, 4 BHCs, 4 BHCMs

- Population penetration: 2.6% 2021, 9.8% 2022

- For CoCM: >880 patients enrolled and more than 500 (~60%) patients have received psychiatric case review as of Sep 2023

- Sustainable growth model: 3 additional practice sites anticipated by 2024

Service Performance

Population penetration:
2023: 11.9%m

Narrative Case Study: Evolution of CIBH Services

SERVICE MODEL DEVELOPMENT

A

FEB – AUG 2021

CLINICAL WORKFLOW DEVELOPMENT

B

AUG 2021 - 2022

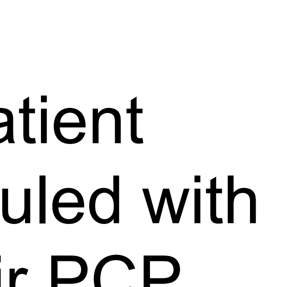
CLINICAL PROCESS REFINEMENT

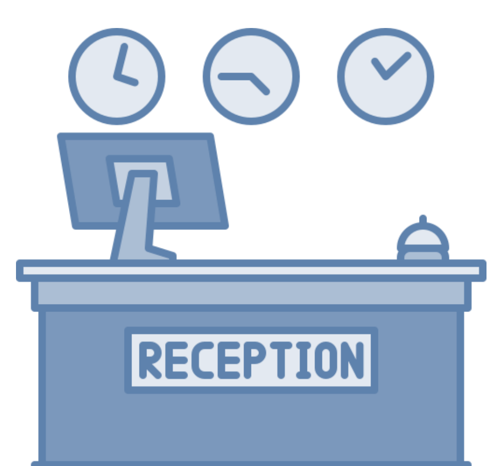
C

AUG 2022 - PRESENT

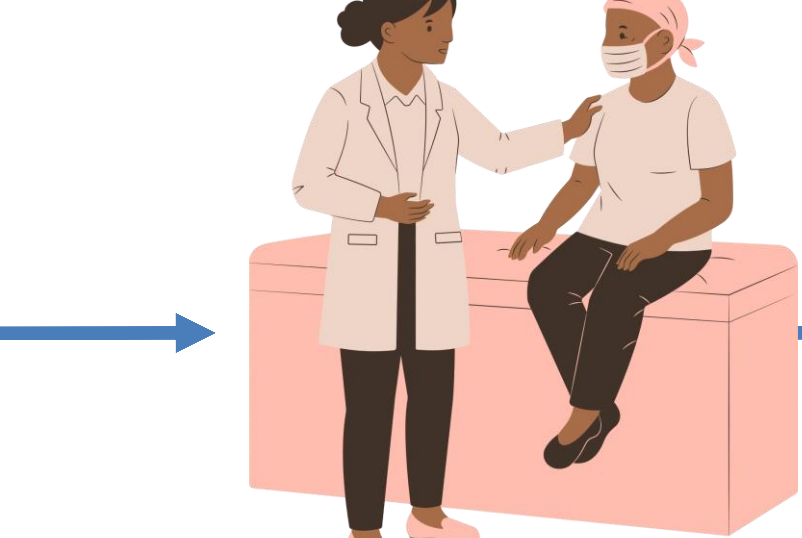
The CIBH Core Workflow:

Patient scheduled with their PCP

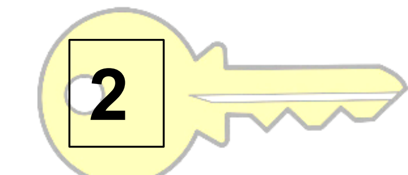


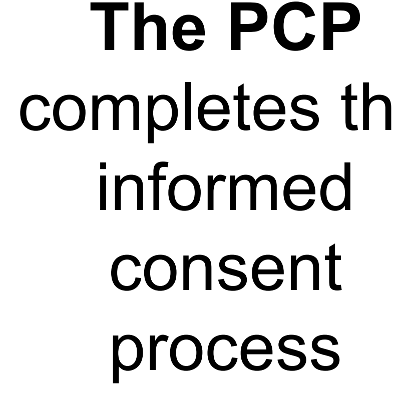


The patient completes Mental Health Vital Signs (PHQ-9, etc.)

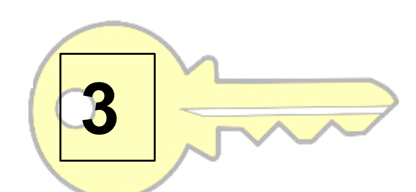


The PCP diagnoses the health problem and establishes the treatment plan



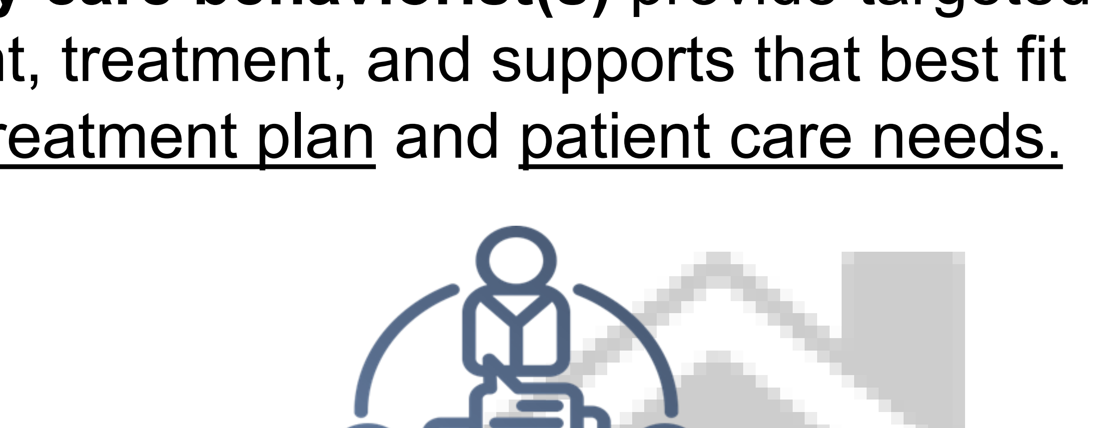


The PCP completes the informed consent process



The PCP prescribes a CIBH care option

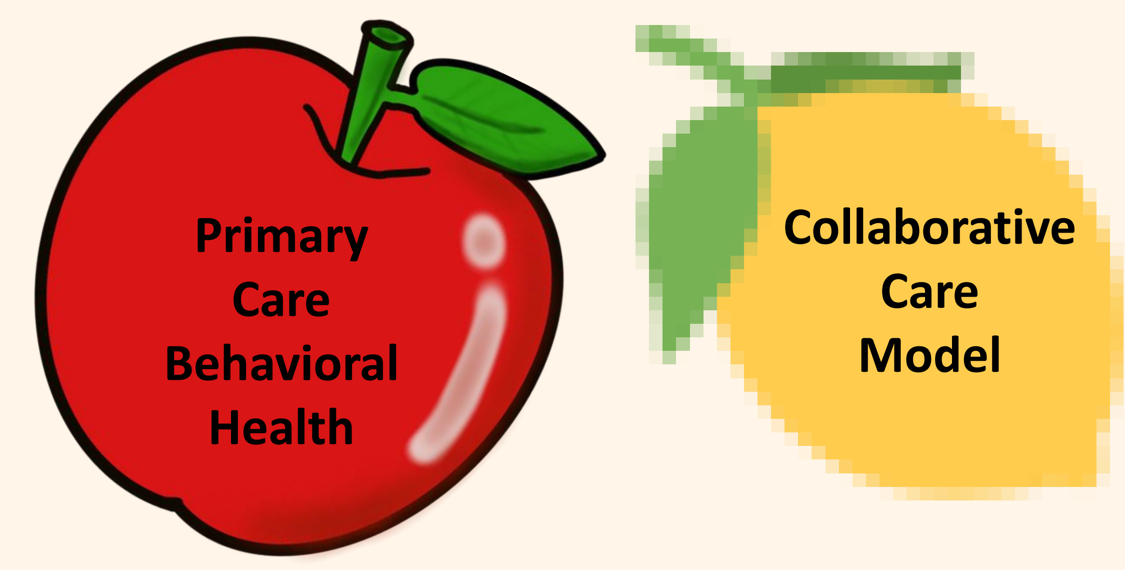
The primary care behaviorist(s) provide targeted assessment, treatment, and supports that best fit with PCP treatment plan and patient care needs.



AND

The PCP continues to monitor the patient's progress and adjust treatment as clinically indicated

Distinct and Shared Elements for CIBH Care:



Distinct elements:

- Care accessibility (in-office vs virtual)
- Target care needs
- Care approach
- Billing / coding structure

Shared elements:

- Shared PCP consent process
- Universal screening
- Primary care scope
- Focused, goal-oriented, problem-based approach
- Program administrative supports

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Resources

EvolvingCare.pdf (milbank.org)

A Brief History of the Integration of Behavioral Health in Primary Care - Collaborative Family Healthcare Association (cfha.net)

Evidence Base for CoCM | University of Washington AIMS Center (uw.edu)

QUESTIONS / DISCUSSION