INTEGRATION OF PRIMARY CARE AND BEHAVIORAL HEALTH
Integrating silos of care
Goal of integration: “no wrong door” to quality health care

Moving From
- Primary Care
- Mental Health Services
- Substance Use Services

Moving Toward
- Integrated Care
  - Primary Care
  - Mental Health
  - Substance Use Services
OneCity Health Approach

Collaborative Care Model (IMPACT) in Primary Care

Integrating Behavioral Health into Primary Care

Integrating Primary Care into Behavioral Health Settings
A spectrum of services to meet a spectrum of patient needs and preferences

Patients with undiagnosed conditions including depression, alcohol abuse

Patients with mild-moderate behavioral health problems

Patients with more complex behavioral health problems, but not requiring wraparound services

Patients with complex behavioral health problems, +/- need for wraparound services, able to access routine primary care services

Behavioral health patients with difficulty navigating routine primary care services

Primary care screening for undiagnosed behavioral health conditions

Behavioral health managed by primary care clinicians

Behavioral health managed by BH specialists within primary care

Behavioral health site manages BH issues, primary care provided separately

Behavioral health site with co-located primary care

Collaborative Care (IMPACT) model; treatment modalities provided within primary care (e.g. CBT)

Co-location into primary care site

Enhanced care may result from ongoing relationship-building between sites as extension of collaborative or co-located services

Co-location into behavioral health site
Value-Based Payment Metrics are Aligned with Integration

<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Potentially Preventable ED visits (fpr pts with BH conditions)</td>
<td>Rate of potentially preventable ED visits for pts who have claims for a BH condition.</td>
</tr>
<tr>
<td>Diabetes Monitoring for pts with Schizophrenia</td>
<td>Assesses adults 18–64 w schizophrenia or bipolar disorder, who were dispensed an antipsychotic med and had a diabetes screening test during the measurement year.</td>
</tr>
<tr>
<td>Diabetes Screening for pts w Schizophrenia/Bipolar</td>
<td>Assesses adults 18–64 w schizophrenia and diabetes, who had both an LDL-C test and an HbA1c test during the measurement year.</td>
</tr>
<tr>
<td>CVD Monitoring for CVD and Schizophrenia</td>
<td>Assesses adults 18–64 w schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.</td>
</tr>
<tr>
<td>Antidepr Med Mgmt (Acute)</td>
<td>Patients with a new Depression dx and new antidepressant med fill must demonstrate 3 month adherence with medication as defined by med fills.</td>
</tr>
<tr>
<td>Antidepr Med Mgmt (Cont)</td>
<td>Patients with a new Depression dx and new antidepressant med fill must demonstrate 6 month adherence with medication as defined by med fills.</td>
</tr>
<tr>
<td>ADHD (Initiation)</td>
<td>Number of children who had one follow-up visit with a practitioner within the 30 days after starting the medication.</td>
</tr>
<tr>
<td>ADHD (Continuation)</td>
<td>Number of children who, in addition to the initiation visit had at least 2 follow-up visits in the 9-month period after the initiation phase ended.</td>
</tr>
<tr>
<td>Initiation of Alcohol/Drug Tx</td>
<td>Patients newly diagnosed with AOD dx must complete a SA tx visit within 14 days of new diagnosis.</td>
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</table>
Collaborative Care/IMPACT Model
Collaborative Care Model

**KEY COMPONENTS**

**Screening**
Universal screening for behavioral health conditions using a standardized instrument (e.g. PHQ-9, AUDIT/DAST)

**Engagement & Outreach**
- Education provided about BH condition to patient
- Regular encounters (1-3x/month) with Care Manager (either face to face or phone)

**Evidence-Based Treatment**
Motivational Interviewing, Behavioral Activation, Problem-Solving Treatment, Medication

**Psychiatric Consultation**
New patients/patients not improving discussed at weekly case meeting

**Patient Tracking**
Tracking/monitoring of patients in registry to drive outreach, psychiatric consultation, change in treatment
Collaborative Care Implementation

- Collaborative Care Model was implemented across 27 facilities
- Early career social workers from the Mental Health Service Corp were integrated by one partner into the Collaborative Care Model

### PPS Depression Screening Volume

<table>
<thead>
<tr>
<th>Measure</th>
<th>DY2</th>
<th>DY2Q1</th>
<th>DY2Q2</th>
<th>DY2Q3</th>
<th>DY2Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCBH</td>
<td>20000</td>
<td>83174</td>
<td>93623</td>
<td>109225</td>
<td></td>
</tr>
</tbody>
</table>
Patient: 59 yr. old male pt. from Egypt, new to CIH


- Referred from PCP at primary care appointment to Collaborative Care RN via warm hand off

Challenges:
- No meds for 2 years, no f/u with MD
- Smokes 3 packs cig a day for 30 years slowly cut down
- No support, alone in the US
- Financial stress, loneliness, hopelessness

Interventions:
- Motivational Interviewing, Problem Solving Techniques, Brief action planning and scheduling of pleasant activities
Collaborative care: patient story

<table>
<thead>
<tr>
<th></th>
<th>Before Treatment</th>
<th>Progress/Outcomes (3 months into Treatment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>A1C</td>
<td>12.6</td>
<td>9.4</td>
</tr>
<tr>
<td>BP</td>
<td>185/98</td>
<td>129/81</td>
</tr>
<tr>
<td>Smoking</td>
<td>3 packs/day for 30 years</td>
<td>No longer smoking</td>
</tr>
<tr>
<td>Physical Activities</td>
<td>Mostly sedentary</td>
<td>Walks 15 blocks/day</td>
</tr>
<tr>
<td>Social/Emotional</td>
<td>Financial stress, loneliness, helplessness</td>
<td>Attending church weekly, social support network</td>
</tr>
</tbody>
</table>
Collaborative care tasks

- Identify Patients
- Engagement & Assessment
- Provide Treatment
- Track Treatment Response
- Proactively Adjust Treatment
- Relapse Prevention Planning
- Adjust Treatment
- Planning
- Response
Measuring performance

**Process Measures**
- Screening Rate
- Screening Yield
- Active Patients
- Change in Treatment Rate
- Psychiatric Consultation Rate
- Median PHQ-9
- Depression Care Mgr Staffing
- % Telephonic contacts

**Outcome Measure**
- Depression Improvement Rate
Continuous Quality Improvement

Consultation Rate – Among pts in tx for ≥ 70 days who did not improve, % w Consulting Psychiatrist recommendations to PCP or Depr CMgr
Change in Tx Rate - Among pts in tx for ≥ 70 days who did not improve, % where a change in tx was initiated and documented in pt record
Improvement Rate - % of pts in tx for ≥ 70 days with ≥ 50% ↓ in PHQ9 or drop from baseline to PHQ9 < 10
Expansion of collaborative care at NYC H+H

Expansion to new conditions
- Substance Use Disorder
- Anxiety
- ADHD

Expansion to new populations
- Children & Adolescents
- Maternal Health
- Virology
- Cancer Care

Two facilities implemented Collaborative Care for Peds/Adolescents, 10 additional are scheduled.
Four facilities are piloting collaborative care for substance use disorders.
Twelve facilities implemented Collaborative Care for Maternal Health.
Challenges & Lessons Learned from Collaborative Care

1. **Billing** – spend time building strategies to successfully bill for services provided.
2. **Proximity** – locating BH resources close to primary care providers is important.
3. **Workflows** – workflows tailored to specific sites are needed to support the integration of care between medical and behavioral health providers.
4. **Use of Data** – need infrastructure to report metrics and need to develop a culture of using data to help drive performance improvement.
Co-Location of Care
Co-location: Behavioral health in primary care settings

- Co-location of mental health and/or substance use services

- **Target population:** Patients with more complex yet stable behavioral health problems (e.g. schizophrenia, bipolar disorder, severe depression, psychoses) that can be managed in primary care

- Behavioral health services can be provided by a co-located psychiatrist or psychiatric nurse practitioner, preferably supported by a psychologist or social worker
Co-location: Primary care in behavioral health settings

- **Target population:** behavioral health patients with difficulty navigating routine primary care services

- Primary care services can be provided by an independently licensed provider (MD, DO, NP)

- Primary care services include:
  - standard preventive care services
  - screening and medical management issues specific to behavioral health population
  - population health management for common chronic conditions
  - collaboration with care management services
Co-location: Patient examples

Co-location of behavioral health in primary care

Meet Maria

- Maria is receiving depression treatment from her PCP with support from the collaborative care team at the PC clinic.
- She recently lost her job and her depression severity has worsened.
- Maria voiced some concern about the stigma of MH treatment.
- Her primary care provider connected her to the co-located psychiatrist and psychologist at the PC clinic and reassured her they were members of her care team.

Co-location of primary care in behavioral health

Meet John

- He received care for bipolar disorder from a BH provider for the last 3 years.
- He has uncontrolled HTN and was referred to a PCP several times, but has not engaged in care. He feels uncomfortable going to unfamiliar places and has travel challenges.
- The clinic now has a co-located NP that provides primary care services. John’s BH provider introduced him to the NP and helped build the relationship.
- John has a scheduled appointment with the NP after his next group session at the clinic.
## Regulatory Options: Article 28, 31, 32

<table>
<thead>
<tr>
<th>License</th>
<th>Description</th>
<th>Advantage</th>
<th>Disadvantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Article 28</td>
<td>May provide MH services up to 10,000 visits/yr or 30% of clinic’s services</td>
<td>Integration of services for pts</td>
<td>Caps on volume of services that can be provided</td>
</tr>
<tr>
<td>Article 31 or 32</td>
<td>May provide primary care services up to 5% of visit volume without additional waiver</td>
<td>Space can be shared</td>
<td>Two E&amp;M visits on the same day are not reimbursable under APG methodology</td>
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<td></td>
<td></td>
<td>Single oversight agency</td>
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## Regulatory Options: DSRIP Waiver

<table>
<thead>
<tr>
<th>DSRIP Waiver</th>
<th>Description</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>A participating partner/provider with a letter of support from a PPS may obtain a waiver to provide the “integrating services” at an article 28, 31, or 32</td>
<td>Waiver allows integration services for up to 49% of visits</td>
<td>Potentially allows for increase in volume of integrated services</td>
<td>Unclear what will happen to waiver after DSRIP</td>
</tr>
<tr>
<td>A28 can offer MH services w/out license in other location</td>
<td></td>
<td>Waiver sites can only serve clients w/in integrating services not mbrs of the community</td>
<td></td>
</tr>
<tr>
<td>Application process is relatively short</td>
<td></td>
<td>For integrating primary care at A31/32, PC must be at least 16 hrs/wk and meet NCQA L3 PCMH standards</td>
<td></td>
</tr>
<tr>
<td>Single oversight agency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A31/32 clinics can offer primary care w/out license in other location</td>
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</tbody>
</table>
## Regulatory Options: Integrated Outpatient Services License (IOS)

<table>
<thead>
<tr>
<th>IOS License</th>
<th>Advantage</th>
<th>Disadvantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>When A28,31,32 operate in different locations they can apply for IOS license to allow them to provide primary care, MH and/or SUD care in each location. The regulatory body of the host site’s license is responsible for oversight</td>
<td>Single oversight agency</td>
<td>Integrating services can only be offered to pts of host site, not full community</td>
</tr>
<tr>
<td>Modifier is available to facilitate the reimbursement of both PC &amp; BH E/M and other services same day</td>
<td></td>
<td>Integrating A28 PC services in A31/32 host site requires offering all required PC services and cannot offer specialty care &amp; must meet NCQA L3 PCMH standards</td>
</tr>
<tr>
<td>Integrated license removes the 10% same day discounting for 2nd BH service</td>
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<tr>
<td>Relatively short appl process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potential physical plant requirement benefits</td>
<td></td>
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</tbody>
</table>
## Regulatory Options: Dual Licensure for One Agency

<table>
<thead>
<tr>
<th>Dual Licensure</th>
<th>Advantage</th>
<th>Disadvantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A single agency acquires dual licensure</td>
<td>Can offer full range of services for each license</td>
<td>Duplicative oversight by regulatory agencies</td>
</tr>
<tr>
<td></td>
<td>May serve all eligible individuals</td>
<td>Must follow all programmatic and other regulations of licensing agencies</td>
</tr>
<tr>
<td></td>
<td>Can use full range of BH clinicians to deliver A31/A32 services</td>
<td>Record keeping is governed by different licensing agency requirements</td>
</tr>
<tr>
<td></td>
<td>Flexibility to co-locate or share space owned or rented by same agency that has both licenses</td>
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</table>
# Regulatory Options: Two Providers with Different Licenses

<table>
<thead>
<tr>
<th>Two Providers/ Different Licenses</th>
<th>Advantage</th>
<th>Disadvantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two providers with different licenses co-locate/share space to provide “integrated” services</td>
<td>Partner gains experienced provider to deliver co-located service</td>
<td>Must manage a partnership with another provider</td>
</tr>
<tr>
<td>Can share space per NYC space sharing between two or more providers guidance (Oct 2016)</td>
<td>Must fulfill all regulations of licensing agencies</td>
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Co-Location Pilots

Integration:
• Eight sites working toward co-location of behavioral health providers into primary care settings
• Two sites working toward co-location of primary care into behavioral health settings

Vendor Technical Assistance:
• Assess existing financial data to determine opportunity
• Develop strategic plan for billing for co-located services
• Determine projected costs and revenue associated with providing co-located services
• Recommend regulatory approach
• Determine physical space needs
• Determine workforce needs
• Deliver a strategic plan for implementation of integrated services
• Develop tool that can be used by additional sites to determine likely best path to co-location
Co-location pilot:

Tools will be developed during the pilot to support co-location, and include:

- Regulatory guidance (example shown)
- Needs assessment
- IT assessment
- Staffing models
- Clinical and operational standards
- Financial model
- Billing and revenue cycle guidance
- Site-specific implementation plans

ARTICLE (A) 28 CLINIC

To provide MH to current PC patients

- Has Art 31 clinic in any location
  - Recommended Option: Integrated outpatient services (IOS) license

- Does not have an Art 31 clinic
  - Recommended Option: DSRIP Threshold Waiver

To be access point for MH for community

- Has Art 31 clinic in any location
  - Recommended Option: Establish a satellite clinic

- Does not have an Art 31 clinic
  - Recommended Option: Partner with Art 31 provider that can establish satellite clinic
## Challenges: Regulatory Requirements

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Navigating Regulatory Options</td>
<td>Plan on spending considerable time and effort determining which option is best for your organization</td>
</tr>
<tr>
<td></td>
<td>Spend time understanding the specifics of each option</td>
</tr>
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</table>
## Challenges: Financial Stability

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Stability – Billing and earning sufficient revenue over time</td>
<td>Determine financial opportunity before starting</td>
</tr>
<tr>
<td></td>
<td>Conduct an analysis based on existing data to determine the likely volume of patients to be served</td>
</tr>
<tr>
<td></td>
<td>Consider the stability of your regulatory approach</td>
</tr>
<tr>
<td></td>
<td>Determine how to build your model to maximize value-based performance outcomes</td>
</tr>
<tr>
<td></td>
<td>Determine physical plant needs and associated costs</td>
</tr>
<tr>
<td></td>
<td>Understand billing options/limitations and develop workflows and EMR to support maximizing billing</td>
</tr>
</tbody>
</table>
# Challenges: Workforce Development

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Workforce – shortage in primary care and in BH</strong></td>
<td>Determine how/where you will identify qualified staff members</td>
</tr>
<tr>
<td></td>
<td>Build a training plan to invest in staff development</td>
</tr>
<tr>
<td></td>
<td>Develop a plan for building a culture of integration (co-location ≠ integration)</td>
</tr>
</tbody>
</table>
## Challenges: Information Sharing

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>IT &amp; Information Sharing</td>
<td>Build a plan for appropriate clinical documentation and coding</td>
</tr>
<tr>
<td></td>
<td>Build a plan for communication between providers</td>
</tr>
<tr>
<td></td>
<td>Ensure EMR access meets regulatory requirements</td>
</tr>
</tbody>
</table>
Thank You

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