Moving Beyond Behavioral Health Integration in Pediatric Primary Care

How True Integrated Primary Care Can Optimize Service Delivery to Underserved Populations

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Roadmap

- A Seat at the Table(s)
- Funding Streams
- Training toward Integration
- The Model in Action
- Challenges and Opportunities
  - Primary Learning Objective
    - Describe key infrastructure building blocks for fostering behavioral health integration within a pediatric primary care setting (Electronic Medical Record [EMR]), workspace, interdisciplinary training, utilization data)
A Seat at the Table(s)

- Which Table(s)?
  - Primary Care Operations Leadership
  - Pediatricians
  - Nursing
  - Social Work, Care Coordinators
  - Psychology, Psychiatry

- Easier to sit at some tables than others
A Seat at the Table(s)

Goals
- Build goodwill
- Advocate for added value of Behavioral Health
- Enhance multidisciplinary collaborations

Methods
- Face time with stakeholders
- Identify Multidisciplinary Champions
- Strategically “just saying yes”
- Shared EMR, open EMR
Managing Expectations

- Integrated care is different than traditional models of behavioral health treatment
  - e.g., weekly appointments, same Behavioral Health Consultant (BHC) for each appointment, on-time families

- Expectations on multiple sides
  - e.g., family, team, BHCs

- Ongoing management of expectations
Funding Streams

- Clinician Support and Infrastructure
  - DSRIP – Medicaid reform
  - Department of Pediatrics
  - New York State Office of Mental Health
  - Fee-for-service revenue

- Training Support
  - HRSA – GPE Program
  - Department of Psychiatry
  - New York State Office of Mental Health (NYS OMH)
  - University of Rochester School of Medicine and Dentistry
    - Dean’s Teaching Fellowship
Training toward Integration

- Integrating care requires multidisciplinary training across three domains:
  1. Foster use of BHCs across a range of services
  2. Increase Primary Care Provider capacity
  3. Enhance skills in collaborative care

- And relates to other domains:
  - Workforce development
  - Sustainability
Training Domain 1: BHCs in Primary Care

- Change in care compared to traditional outpatient mental health:
  - Part of a team
  - Short-term, solution-focused
  - Realistic goals, fast decision-making

- Methods
  - Procedure Manual
  - Monthly team meetings
  - Didactics
    - Shadowing
    - Experiential learning
    - UMass Certificate Program in Primary Care Behavioral Health
      - Sponsored by HRSA GPE grant
      - http://www.umassmed.edu/cipc/pcbh/overview/
Training Domain 2: PCPs for Integrated Care

- Change in ideas about the utility of BHCs:
  - Not just for crises
  - Medical treatment adherence / acceptance
  - Review of testing
  - Episodes of short-term care
  - Collaborative treatment engagement and planning

- Methods
  - BHCs in Huddle and Education
  - Shared remote drive; Clinic Newsletter; Behavioral Health Bulletin Board
  - Jumping into conversations in shared workspaces
  - Education during clinic-wide meetings
  - Didactics
    - REACH Training
      - Sponsored by NYS OMH
      - http://www.thereachinstitute.org/
Training Domain 3: Collaborative Opportunities

- 2015 Dean’s Teaching Fellowship awarded to Dr. Jee:
  - Collaboration with Behavioral Health Team Faculty
  - Afternoon sessions twice per year (Fall, Spring)
  - Basic mental health concepts + specific topic (e.g., depression)
  - Assessment measures and resources
  - Standardized Patient
    - Warm handoff with Behavioral Health and Primary Care (recorded)
    - Discussion of additional info needed and referral process
  - Initial trends and feedback
The Model in Action

- Behavioral Health Screening
- PC to BHC consultation
- BHC to Family/PCP consultation
- BH Intervention/Therapy
- Refer
## The Model in Action – Level 1

<table>
<thead>
<tr>
<th>Level of BH Intervention</th>
<th>BH Role</th>
<th>Tasks and Support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LEVEL 1</strong> BH Screening</td>
<td>• Administered at all visits by Techs / RNs</td>
<td></td>
</tr>
<tr>
<td>* Not billed (at present)</td>
<td>o ASQ-SE2 (3-5yo)</td>
<td>• Selection of measures, scoring, family follow-up</td>
</tr>
<tr>
<td></td>
<td>o PSC-17 (6-18yo) / parent</td>
<td>• Re-format for ease of use</td>
</tr>
<tr>
<td></td>
<td>o PSC-17 (12-18yo) / youth</td>
<td>• Transition from paper to iPad</td>
</tr>
<tr>
<td></td>
<td>o PHQ-9 (19-21yo)</td>
<td></td>
</tr>
</tbody>
</table>
# The Model in Action – Level 2

<table>
<thead>
<tr>
<th>Level of BH Intervention</th>
<th>BH Role</th>
<th>Tasks and Support</th>
</tr>
</thead>
</table>
| **LEVEL 2** Provider Consultation—No Patient Contact *(contact via face-to-face; EMR, email)* | • Additional considerations for care planning  
• Psychoeducation  
• Questions about assessing / recommendations for BH concerns  
• Questions about starting or changing meds  
• Interpreting collateral info (e.g., school test data)  
• Resource ideas | • Shared EMR, drive resources, workspace  
• Communication of BHC availability  
• Internal Referral process  
• Workflow for Phone RN Triage  
• Attend practice leadership meetings  
• Attend daily team “huddle” |

*Not billed*
## The Model in Action – Level 3

<table>
<thead>
<tr>
<th>Level of BH Intervention</th>
<th>BH Role</th>
<th>Tasks and Support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LEVEL 3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Provider Consultation—</strong></td>
<td>Say hello and introduce service to increase adherence and demystify BH service (managing expectations)</td>
<td><strong>Assessment / Intervention manual for BHCs</strong></td>
</tr>
<tr>
<td><strong>With Patient Contact</strong></td>
<td>Brief evaluation, or intervention and psychoeducation</td>
<td><strong>Training in interventions</strong></td>
</tr>
<tr>
<td>(contact via Warm Handoff)</td>
<td>Safety plan</td>
<td><strong>Internal Referral process</strong></td>
</tr>
<tr>
<td></td>
<td>Recommendations about level of care</td>
<td><strong>Workflow for Phone RN Triage</strong></td>
</tr>
</tbody>
</table>

*May be billed*
# The Model in Action – Level 4

<table>
<thead>
<tr>
<th>Level of BH Intervention</th>
<th>BH Role</th>
<th>Tasks and Support</th>
</tr>
</thead>
</table>
| LEVEL 4 | BHC Evaluation / Intervention *(Refer to Integrated BH Team using EMR Internal Referral)* | • Diagnostic clarification  
• Short-term, therapy / treatment  
• Treatment planning for ongoing mental health care  
• Bridge care while waiting for referrals | • Assessment / Intervention manual for BHCs  
• Training in interventions  
• Changes in documentation (BHC)  
• Internal Referral Process (PCP)  
• Workflow for Phone RN Triage |

*Billed fee-for-service via Psychiatry or Pediatrics*
# The Model in Action – Level 5

<table>
<thead>
<tr>
<th>Level of BH Intervention</th>
<th>BH Role</th>
<th>Tasks and Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEVEL 5</td>
<td>BHCs may make referrals as part of treatment planning</td>
<td>Knowledge of local MH resources and procedures</td>
</tr>
<tr>
<td>Refer for Additional Services</td>
<td>PCPs may refer directly to outside providers or to Integrated BH Team for bridge care and treatment planning</td>
<td>Problem solving people whose needs “don’t fit” internal resources</td>
</tr>
</tbody>
</table>

*Not billed

Level of BH Intervention:
- BH Role: BHCs may make referrals as part of treatment planning. PCPs may refer directly to outside providers or to Integrated BH Team for bridge care and treatment planning.
- Tasks and Support: Knowledge of local MH resources and procedures. Problem solving people whose needs “don’t fit” internal resources.

Support available from Care Coordinators, Social Work, BHCs.
Challenges & Opportunities

Workflow and Logistics

- Poor show rates (common for high-need, low-resourced populations in Primary Care)
  - Scheduling strategies
  - Available “urgent” spots
  - Text reminders

- Screening
  - Increase percentage of population screened (with goal of earlier intervention)
  - Transition to iPad screening

- Billing
  - Optimize current fee-for-service reimbursement
    - Bill when possible
    - Upcoding
      - Health and Behavior (H&B) codes (NYS will not pay)
  - Lobbying and advocacy
  - Fee-for-service vs. Value-based payment
Clinical Service

- Staff Recruitment
  - Recognize that recruited clinicians will require training
  - Recruit BHCs to reflect patient demographic

- Determining most efficacious “menu” of behavioral health services
  - Shared Team / BH view of routine vs. urgent patient
  - Algorithm / script for Phone RN Triage
  - Move toward protocol-oriented interventions
Challenges & Opportunities

- Easy access to shareable resources
  - EMR scheduling
  - Shared remote drive

- Workspace constraints
  - Rotate BHCs into shared workspace
  - Facilitate patient / provider access to less extroverted BHCs

- Documentation
  - EMR phrases
  - Concurrent documentation
Challenges & Opportunities

- Ongoing evaluation of clinical benefit, cost effectiveness, sustainability
  - Access to data, metrics, reporting
- Document and quantify behavioral health value added
  - Consult notes ("warm handoffs")
  - PCP
    - Increased job satisfaction
    - Decreased turnover
    - Increased PCP workflow / billables
- Patients
  - Increased service satisfaction
  - Increased engagement
  - Increased adherence
Contact Information

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