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Behavioral Health Integration Series, Final Report

Evaluation of a Continuum-Based Behavioral Health Integration Framework Among Small Primary Care Practices in New York State:

Practice and Policy Findings and Recommendations

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United Hospital Fund

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Foreword

While the impact of depression, anxiety, and substance use disorders on overall health is widely acknowledged, only a minority of patients with those behavioral conditions in the typical primary care practice are identified and treated, despite an increasing emphasis on whole-patient care. The resource, fiscal, and regulatory realities of bringing systematic screening, treatment or referral, and follow-up to the primary care setting make such behavioral health integration, or BHI, too great a challenge for many practices, especially the smaller ones that make up the bulk of New York's primary care infrastructure.

It was with these concerns in mind that in 2016 a team led by Henry Chung, MD, and Harold Pincus, MD, developed a flexible new approach to BHI in primary care, one that would allow practices to set and advance toward BHI goals on a number of parallel paths—achieving mastery of core elements of BHI at varying rates and within the context of available resources. Their work, funded with grant support from United Hospital Fund and presented in the UHF publication *Advancing Integration of Behavioral Health into Primary Care*, was well received, but it was clear that real-world testing was essential. Since then, with additional funding from UHF and new funding from New York State Health Foundation (NYSHealth), Drs. Chung and Pincus have worked with a diverse group of small primary care practices to apply their "continuum-based Framework" and assess its utility.

This final report, following the release of two previous issue briefs, outlines their work over the course of a year to guide these practices in adopting the Framework and learn from their experiences. This comprehensive report illustrates the progress of the practices and lessons learned, leading to a revised and updated Framework. It provides lessons we believe will prove valuable to providers, policymakers, and payers alike, while also pointing to areas in need of further development.

Just as this groundbreaking initiative was itself a collaborative effort—between the project team and participating practices, and within practices themselves—we see the joint funding provided by UHF and NYSHealth as another example of the value of collaboration in setting and working toward ambitious health care goals to better the lives of New Yorkers. We hope that this report will inspire additional practices to initiate behavioral health integration, and additional funders to support new and expanded efforts to improve health care access and quality in innovative, effective ways.

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Acronyms

ACE	Adverse Childhood Experience Questionnaire
ADHD	Attention-Deficit/Hyperactivity Disorder
AUDIT	Alcohol Use Disorder Identification List
BH	Behavioral Health
BHI	Behavioral Health Integration
BHP	Behavioral Health Provider
CAGE	"Cut down, Annoyed, Guilty, Eye opener" Risky Drinking Questionnaire
CFIR	Consolidated Framework for Implementation Research
CM	Care Management
DASS	Depression, Anxiety, Stress Scales
DSRIP	Delivery System Reform Incentive Payment Program
EHR	Electronic Health Record
FQHC	Federally Qualified Health Center
GAD	General Anxiety Disorder
MHSC	New York City Mental Health Service Corps
NCQA	National Committee for Quality Assurance
NYC	New York City
NYS	New York State
NYSDOH	New York State Department of Health
NYSHealth	New York State Health Foundation
PC	Primary Care
PCP	Primary Care Provider
PCMH	Patient-Centered Medical Home
PHQ	Patient Health Questionnaire
PPS	Performing Provider System
SBIRT	Screening, Brief Intervention, and Referral to Treatment
UHF	United Hospital Fund

Executive Summary

The shortage of affordable and accessible behavioral health providers across New York State (NYS) leaves many people's depression and other behavioral health conditions undiagnosed and untreated. This service gap calls for solutions that help integrate behavioral health care in primary care (PC) settings to take advantage of the significant role that primary care providers (PCPs) can play in diagnosing and treating these conditions and facilitating referrals for those with more complex treatment needs.

Adding to the roles and tasks expected of primary care practices leads to an array of challenges, however, including obtaining buy-in by both PCPs and behavioral health providers (BHPs). Key concerns include whether primary care practices have the capacity to respond to the clinical demands of addressing the behavioral health needs of potentially large numbers of newly screened and identified patients. Many PCPs may not have the practice infrastructure or access to referral networks to adequately treat complex mental health disorders, and not all PCPs are comfortable with managing behavioral health (BH) medications. For their part, BHPs have traditionally worked, in many siloed health care systems, without significantly interfacing with PCPs. And, for both PCPs and BHPs, sustainability of integrated care is a challenge, marked by confusion about how and when to bill for BH services in primary care and inadequate reimbursement for time devoted to care coordination between BH and PC settings.

LESSONS LEARNED

Based on a qualitative assessment of its testing in small primary care practices, the Framework was useful as an implementation guide to advance behavioral health care integration in small and low-resourced primary care settings.

Some of the project's lessons, as reported by the participating practices, included:

- An operationalized set of strategies and overall plan for integration to guide and communicate efforts is valuable and necessary.
- Culture change is difficult: strong personal relationships between BHPs and PCPs are therefore critical to developing team-based care (both internal and external to the practice).
- Medical and executive leadership and integration champions are needed to drive and sustain implementation momentum.
- Screenings and follow-up are essential tasks in BH integration in primary care.
- Building and systematically using a tracking system to monitor patients' treatment progress is important as well as resource intensive.
- Existing BHI billing codes play an important role in addressing the financial sustainability of the integrated model.

In response to these challenges, NYS has launched new behavioral health integration (BHI) initiatives and tackled regulatory modernization to help build PCP capacity for treating BH conditions, as a core strategy for improving access to and quality of care.[1,2,3]

Although evidence-based integration models have been demonstrated to work well when properly implemented,[4] PCPs need practical guidance on the steps they can take to build integrated practice models. Small and medium-sized practices, in particular, face major challenges to BHI, given time limitations and resource constraints. To address these issues, our team developed a Framework to guide primary care practices in the development and implementation of operational plans aimed at achieving effective, evidence-based integration.

The utility of the Framework is based on the premise that implementing BHI is best achieved through a stepwise and progressive process.[5] Not all practices are able to achieve all aspects of advanced BHI, but they can still improve their ability to offer higher-quality BH care to their patients through incremental changes. The Framework was designed to help practices organize their integration efforts by assessing and building on existing strengths and priorities.

Based on a targeted literature review and input from diverse stakeholders, the Framework, as tested, consists of 8 domains and 14 sub-domains that address the core elements of BHI. Each sub-domain is broken down into incremental steps marking preliminary, intermediate, and advanced stages of integration. This continuum allows practices to identify their current level of BHI within each domain and set goals to increase their BHI capabilities in different components of integrated care at different rates. While it is important for practices to strive for fidelity to evidence-based BHI models to ensure quality and efficacy, gold-standard models are often out of reach for smaller practices. This stepwise approach meets primary care practices where they are by presenting BHI as an incremental, more feasible implementation process.

1 Sederer LI, M Derman, J Carruthers, and M Wall. 2016. The New York State Collaborative Care Initiative: 2012–2014. *Psychiatric Quarterly* 87(1): 1–23.

2 New York State Department of Health. *Delivery System Reform Incentive Payment Program.* https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/

3 New York State Department of Health. *New York State Patient-Centered Medical Home.* https://www.health.ny.gov/technology/innovation_plan_initiative/pcmh/

4 Miller CJ, A Grogan-Kaylor, BE Perron, AM Kilbourne, E Woltmann, and MS Bauer. 2013. Collaborative chronic care models for mental health conditions: Cumulative meta-analysis and metaregression to guide future research and implementation. *Medical Care* 51(10): 922–930.

5 Chung H, N Rostanski, H Glassberg, and HA Pincus. 2016. *Advancing Integration of Behavioral Health into Primary Care: A Continuum-Based Framework.* New York: United Hospital Fund. https://uhfnyc.org/publications/publication/advancing-integration-of-behavioral-health-into-primary-care-a-continuum-based-framework/

Framework Evaluation

From February 2017 to October 2018, we conducted a pilot study to evaluate the utility of the Framework in supporting BHI in small practice settings. We sought to characterize the experience of practices and providers using the Framework in combination with technical assistance from the study team. The lessons learned from this evaluation will assist practitioners, policymakers, and payers to advance the integration of medical and behavioral health services. Ultimately, these findings were used to inform a revision of the Framework based on practice feedback.

To accomplish these goals, the project team identified 11 small primary care practices across New York City (NYC) and within NYS representing a diverse range of settings. At the beginning of the project, the sites assessed their baseline level of integration and used those results to set goals for integration at six months, at which point they completed another self-assessment—measuring their progress along the Framework continuum—and again set goals for the following six months. The practices also participated in monthly technical assistance webinars and individualized check-in calls with the project team to facilitate their progress toward their Framework goals.

After 12 months of participation in the project, all practices advanced their continuum-based level of BHI. Some practices moved further along in the Framework as a result of their ability to access a wide range of resources, early and sustained commitment to BHI among PCPs and administrators, and an understanding of billing mechanisms for BH service reimbursement. Upon implementing depression screening as a standard protocol, practices strengthened their BH workflows to manage patients with positive screens, incorporated warm handoffs to onsite or offsite BHPs, and formalized external referrals using collaborative agreements.

The project team conducted site visits with 10 of the 11 practices (one practice withdrew from the project after 6 months) and conducted an extensive qualitative analysis of key informant interviews of PCPs, BHPs, leadership team members, and practice staff. These results, in combination with the surveys described above, provided detailed information on the approaches the sites took to implement the BHI goals identified in the Framework, the barriers they encountered, and the ways that BHI affected practice workflows, staff dynamics, and patient outcomes. Key findings of the evaluation are noted below.

Framework Evaluation: Key Findings

PLANNING

Common Goals: External referral partnerships, patient outcomes tracking, improving BHP-PCP communication and information sharing

Strategies: BHI needs assessments, regular executive team and staff meetings, presence of BHI site champions

Challenges: Inadequate staff training, inconsistent PHQ screening and review

ROLLOUT

Common Workflow Changes:
1) Depression screening with follow-up and referrals to BH, including warm handoffs
2) Engage leadership, providers, and staff in regular meetings to improve communication

Strategies: Increase communication to develop integrated care plans and make use of case conferencing

Challenges: Scheduling, office space, PCP time, training, building BH partnerships, technology to support tracking

ENGAGEMENT WITH FRAMEWORK

Positive Feedback: Adaptable, enables goal setting, assesses progress, breaks down complexity of BHI, organizes efforts, and helps track progress throughout the implementation process

Areas for Improvement: Increase frontline staff awareness of Framework and BHI goals; sustainability of BHI efforts; refinement of some language and terminology

The site visits also highlighted practices' advances toward BHI, strategies, and ongoing challenges.

Key Advances and Challenges

Domains*	Advances	Strategies	Challenges
Screening	Majority achieved systematic screening for adult patient population	Screening tools: PHQ 2 and/or 9, GAD7, ACE, and CAGE	PHQs tracked at individual level, but few sites measure group-level outcomes
Referrals (Internal and External)	Most BHI progress seen with onsite referral, including warm handoffs	Established formal partnerships strengthen external referrals	Consult retrieval, wait times, communication
Quality Improvement	Metrics tended to focus on screening rates	Track outcomes progress and monitor patients on psychotropic medications	Metrics need to be aligned with State measures and reporting expectations
Evidence-Based Care, Medication Management, and Psychotherapy	Increase in PCP use of symptom monitoring with stepped care	PCPs prescribing BH medication with BHP support; refer complex cases with feedback	Limited expertise and lack of reimbursement or time
Self-Management Supports	BH diagnosis and medications handouts available for patient education	Print PHQ trend scores as patient engagement tool	Some PCPs don't use handouts (lack of time, not applicable, or other tools preferred)
Social Service Links	Hire staff to coordinate social services needs	Track referral services in internal records	Transportation challenges, lack of bilingual staff and agencies

* Three domains (evidence-based care, medication management, and psychotherapy) were combined here for ease of representation.

Conclusions and Recommendations

Among participating practices, workflow improvements were noted in screening for depression, tracking patients with positive screens, warm handoffs and easier referrals, communication and information sharing between PCPs and BHPs, and follow-up on patient no-shows. The results provided insights for providers, clinic leadership, policymakers, and other stakeholders as they plan for and support future implementation of BHI.

Lessons for Primary Care Practices in Integrated Care Settings

- Practice champions, early staff involvement, and engagement of executive leadership help promote and advance BHI; engagement of staff at every level is critical.
- PCPs benefit from ongoing training to expand the scope of BH care they can provide.
- BH providers face unique challenges in the integrated setting, such as the lack of coordination with PCPs, insufficient use of BH service billing codes, and the need to work as part of an overall team that shares information and to perform multiple tasks ranging from therapy to care management.
- Collaborative agreements strengthen treatment referrals, communication with external BH specialty care providers, and care coordination between those external providers and PCPs.
- Clinical BH tracking tools are most effective when integrated into the electronic health record (EHR).
- Condensed BH treatment planning notes facilitate information sharing in the EHR.
- Integrated visits with PCP and BH providers together can help engage patients with complex care needs.
- Self-management supports help patients stay engaged in BH care.
- Quality improvement practices require additional support to increase uptake.
- Participation in policy or quality improvement initiatives helps motivate BHI practice advancement.
- Financial sustainability is critical; multiple evolving opportunities require monitoring and adoption.

Anna Leung, PhD, follows up with a patient—here with her emotional support dog—on her BH care. Photo courtesy Koinonia Primary Care, Albany, NY.

Recommendations for Policymakers and BHI Stakeholders

- Continue to modernize policies and regulations that improve implementation and sustainability of BHI.
- Providers seeking NYS patient-centered medical home (PCMH) status should use the Framework to assist with meeting BHI criteria.
- Promote use of National Committee for Quality Assessment (NCQA) measures relevant to BHI to improve measurement/evaluation.
- Support community behavioral health transformation that improves connections to primary care.
- Clarify and support BHI payment policies for practices.
- Expand Project TEACH, which provides remote consults and advice on BH services to pediatricians and maternal health providers, to all PCPs.
- Promote uptake of new technology, such as telehealth, that provides greater access to BH providers.

Based on our project's results and participants' experiences and observations, we have revised several aspects of the original Framework; our new version, Framework 2.0, appears in Appendix A. Among the modifications is the re-ordering of domains into groupings that relate to clinical workflow, workforce, and management support, and the addition of

a *Sustainability* domain to highlight the need for practices to strategize on how to ensure adequate revenue to support and sustain BHI in both fee-for-service and value-based payment models. The revised Framework also makes it easier to track progress between integration levels.

Various obstacles to BHI remain, and this pilot project's small sample size limits its generalizability to other PCP settings. While the Framework offers operational guidance for increasing integration of BH care into primary care, external considerations—including regulation, reimbursement, workforce, and other policy issues—will also shape integration efforts.

Moving forward, it is critical for payers and policymakers to further develop and strengthen financial and policy incentives to help practices support movement toward increased BHI, both in primary care settings and behavioral health settings. Given the utility and success of the Framework as an aid to BHI in primary care, there is also promise in developing such an approach for integrating physical health in behavioral health settings, one of New York State's priorities for health care reform.

Introduction

Behavioral health (BH) conditions can negatively affect the ability to maintain good physical health, manage chronic illness, and attain optimal quality of life and functioning. Because of the interactions between behavioral symptoms and chronic medical illnesses, many primary care physicians (PCPs) are expanding on their traditional responsibilities to ensure that their patients also receive adequate treatment for mental illness and substance use disorders.[6] These PCPs are systematically screening for depression, anxiety, ADHD, and alcohol and substance misuse, as well as diagnosing and managing treatment for these conditions.

This behavioral health integration into primary care, or BHI, has become a key element of New York State (NYS) health care reform efforts. In 2015, NYS prioritized implementation of behavioral health integration models through both the Medicaid DSRIP (Delivery System Reform Incentive Payment) program and the NYS Advanced Primary Care Initiative, later renamed the NYS Patient-Centered Medical Home (PCMH) program. Such evidence-based integration models work well when properly implemented.[7]

Challenges to BHI

Given the range of primary care practice settings and the resource limitations faced, especially by small practices (defined here as having five or fewer PCPs in a single practice location),[8] those models are not necessarily practical and achievable. Instead, more realistic and pragmatic approaches must be developed to allow resource- and time-constrained practices to progress in line with NYS health care reform. To date, there has been relatively little guidance on the underlying steps that all practices—most notably smaller ones—can take to adopt more advanced models and achieve true BHI.

6 Knickman J, KRR Krishnan, HA Pincus, C Blanco, et al. 2016. Improving access to effective care for people who have mental health and substance use disorders. A vital direction for health and health care. *Discussion Paper, Vital Directions for Health and Health Care Series.* Washington, DC: National Academy of Medicine. https://nam.edu/wp-content/uploads/2016/09/Improving-Access-to-Effective-Care-for-People-Who-Have-Mental-Health-and-Sustance-Use-Disorders.pdf

7 Miller CJ, A Grogan-Kaylor, BE Perron, AM Kilbourne, E Woltmann, and MS Bauer. 2013. Collaborative chronic care models for mental health conditions: Cumulative meta-analysis and metaregression to guide future research and implementation. *Medical Care* 51(10): 922–930.

8 Wilson W, A Bangs, and T Hatting. 2015. *The Future of Rural Behavioral Health. National Rural Health Association Policy Brief.* https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/The-Future-of-Rural-Behavioral-Health_Feb-2015.pdf

At the practice level, BHI is likely to require significant workflow, staffing, and other adjustments. Small practices often have difficulty implementing consistent workflows for BH screening, diagnosis, and treatment. They generally have less physical space for co-locating BH specialists or dedicated BH care managers. And they often have less dedicated time for quality improvement work, lack technical assistance for BHI implementation, and find it difficult to support key evidence-based elements of BHI, such as protocols for persistent follow-up and outreach between visits. Since some of these efforts are not reimbursable, many small practices are also limited in their ability to implement BHI because of the impact on revenue.

Further complicating integration efforts are larger policy issues, including complex regulatory demands related to billing, reimbursement, and quality reporting, and challenges related to State or federal certification status (for example, as an Article 28, integrated license, or federally qualified health center [FQHC]). There is also a lack of clarity on payer billing requirements and reimbursement rates for behavioral health services provided in primary care settings, as well as few incentives for BHI quality measures as part of value-based payment models.

Despite these challenges, we believe that a step-by-step approach to BHI, tailored to common practice constraints, in combination with improved regulatory policies and payment mechanisms, will position even small primary care practices to align their efforts on BHI with those of existing NYS initiatives.

An Evidence- and Continuum-Based Framework

Responding to the challenges outlined above, our project team, with United Hospital Fund (UHF) grant support, worked to develop a more adaptable process for integrating behavioral health into primary care. The team reviewed the literature, conducted stakeholder interviews and feedback sessions, and distilled the key evidence-based domains of BHI into a continuum-based Framework outlining a progression of steps along each domain. The resulting guide,[9] published by UHF, was designed to help individual practices achieve effective evidence-based BHI within the context of various NYS health care reform initiatives.

9 Chung H, N Rostanski, H Glassberg, and HA Pincus. 2016. *Advancing Integration of Behavioral Health into Primary Care: A Continuum-Based Framework*. New York: United Hospital Fund. https://uhfnyc.org/publications/publication/advancing-integration-of-behavioral-health-into-primary-care-a-continuum-based-framework/

The Framework lays out key components of integrated care found across integration models, grouped, in the original version, into eight broad domains:

1. Case finding, screening, and referral to care;
2. Use of a multidisciplinary professional team—including patients—to provide care;
3. Ongoing care management;
4. Systematic quality improvement;
5. Decision support for measurement-based, stepped care;
6. Culturally adapted self-management support;
7. Information tracking and exchange among providers;
8. Linkages with community/social services.

For each of those domains, displayed on the vertical axis, the Framework identifies preliminary, intermediate, and advanced steps along the horizontal axis. The rows represent parallel paths toward integration that can be prioritized for implementation based on a practice's resources, current level of integration, and desired speed of change. Practices can identify their current status and set goals within each domain and achieve a sense of movement and momentum along a pathway—increasing capabilities in different aspects of integrated care at different rates based on resources and practice structure. It's a flexible process, rather than one rigidly anchoring practices to a specific level of integration across domains.

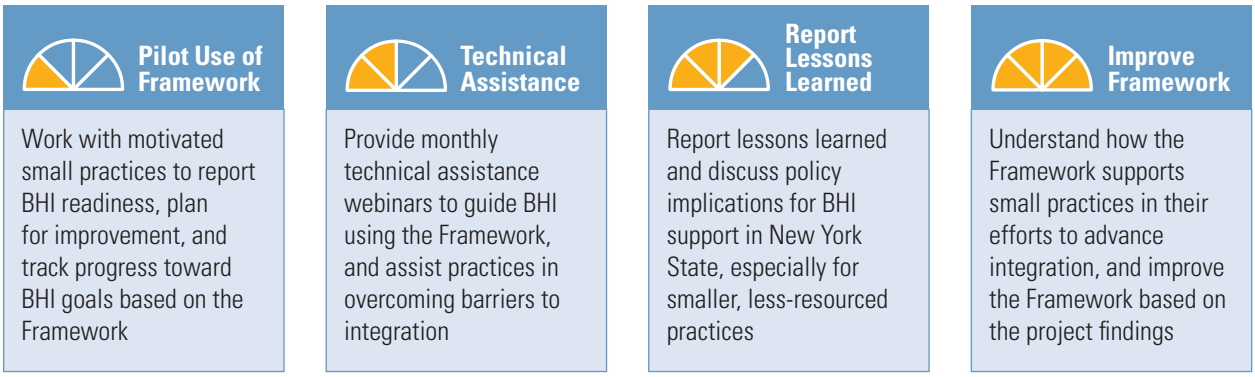
While it is important for practices to strive for fidelity to evidence-based BHI models to ensure quality and efficacy, gold-standard models are often out of reach for smaller practices. The Framework's stepwise approach meets primary care practices where they are—recognizing that there is latitude in how far to advance specific components of integration, and presenting BHI as a more feasible, practical, incremental process for doing so.

While the Framework provides a roadmap to help practices make wise investments in time, training, workforce, and other resources necessary to implement BHI and improve patient care, it also recognizes that achieving the most advanced state of each domain and its components might not necessarily be the ultimate target for every practice. Our perspective is that patients in need of behavioral health treatment in primary care will benefit from practices' implementation of many of the intermediate elements associated with the Framework as well. Still, all practices working on integration should strive to achieve as many, if not necessarily all, of the advanced elements as possible, to achieve meaningful improvements in quality and outcomes.

The Framework Evaluation Project

The 2016 release of the Framework garnered support and recognition from many NYS practitioners and policymakers. However, what was missing was an understanding of how the framework could be utilized in real-world practices. In recognition of the significant barriers to integration for small primary care practices, our team set out to assess the utility of the Framework in a group of practices that fit this profile, focusing on four main objectives (Figure 1).

Figure 1. Evaluation Project Objectives



With additional grant support from UHF (for New York City-based efforts) and new funding from New York State Health Foundation (NYSHealth, for work outside NYC), we selected 11 small primary care practices, all motivated to advance their BHI status, to participate in a year-long pilot of the Framework (Figure 2). Six practices are in NYC and five are located elsewhere in the state. Participants were nominated by a DSRIP Performing Provider System (PPS) or were self-nominated. Each nominating entity had to identify a single pilot site with five or fewer PCPs to qualify.

Figure 2. Participating Practices

New York City (6 practices)	New York State (5 practices)
Centro Medico de las Americas, Queens	Champlain Family Health of Hudson Headwaters Health Network, Champlain
Delmont Healthcare, Queens	Hudson River Healthcare at Hudson, Hudson
Dr. Scafuri + Associates, Staten Island	Keuka Family Practice of Accountable Health Partners, Bath
Metro Community Health Center, Bronx	Koinonia Primary Care, Albany
Tremont Health Center of Community Healthcare Network, Bronx	Lourdes Primary Care, Owego
South Shore Physicians, Staten Island	

In addition to their size, participants were selected to reflect the state's geographic diversity and range of practice types (FQHC, hospital-based, independent). At baseline, eight had National Committee for Quality Assurance (NCQA) recognition as Level III PCMHs; two others had achieved PCMH recognition at the project's conclusion. Practices served an average of 4,336 patients—ranging from 900 to 9,263—annually.

Small Practice Experience: An Overview

At the start of the project, practices used the Framework to assess their current state of integration and develop goals. Those assessments showed the practices beginning the integration process at varying levels of readiness within each domain. Over the subsequent 12 months, the project team released two issue briefs that reported on early findings and provided updates on the evaluation project's progress.

In the first issue brief[10] we described the practices, provided a project overview, and presented results from the BHI readiness assessment and initial six-month goal survey. The readiness survey showed that the majority of practices self-identified as being in the preliminary stages of integration, but several practices self-reported intermediate components of BHI, including systematic depression screening, comfort with PCP-initiated medication management, and occasional formal written communication between providers. Those intermediate levels of integration in various domains were reported more frequently by practices that offered onsite BH services prior to the project's start. For example, four such practices began the project at an intermediate level for referral facilitation (internal and external), compared to only one practice without onsite services at baseline. Similarly, five practices reported intermediate levels for provision of evidence-based psychotherapy at baseline, compared to only one practice without existing onsite BH care.

The most common domains selected by practices to work on were (in order of frequency):

- Screening and referral management
- Information tracking and exchange
- Multidisciplinary team-based care
- Care management
- Systematic quality improvement
- Self-management support

10 Chung H, E Smali, L Elinson, S Matthews, and H Pincus. 2017. *Advancing the Integration of Behavioral Health into Primary Care for Small Practices. Behavioral Health Integration Issue Brief Series, No. 1.* New York: United Hospital Fund and New York State Health Foundation. https://uhfnyc.org/publications/publication/advancing-the-integration-of-behavioral-health-into-primary-care-for-small-practices/

Regardless of reported readiness for integration, all the practices acknowledged that they saw a lot of opportunity for targeted growth and improvement along the Framework.

In the second issue brief[11] we presented a summary of the emerging themes described in feedback from the practices at the midpoint of the project, including challenges and lessons learned. We also spotlighted the experiences of three of those practices, and of a payer piloting a BHI strategy for small practices, in their own words. Finally, we shared some perspectives on policy and payment issues presented during a December 2017 meeting, led by the project team, with a diverse group of NYS leaders and other stakeholders supporting BHI. A number of key themes for policymaker and payer consideration emerged from the meeting (Figure 3).

Figure 3. Stakeholder Meeting: Key Themes

Payer Inclusion and Support

- Provide consistent guidance on billing codes and documentation requirements
- Standardize BH payment to primary care providers across payers
- Communicate anticipated opportunities for BHI in value-based payment models

PC-BH Partnerships and Regulatory Reform

- Clarify guidance on information sharing between PC-BH providers
- Encourage partnership agreements that address mutual expectations on providing care
- Identify opportunities to clarify and revise regulations for community PC and BH facilities, to expand support, collaborations, and resource sharing
- Eliminate restrictions on PC and BH same-day billing

Metric-Driven Quality Improvement

- Shift from claims-based quality measures to key BH integration process and outcome metrics
- Tie PCMH recognition and PCMH with Distinction in BHI to improved reimbursement
- Identify metrics that can be tied to continuum Framework to validate meaningful stages of BH integration

Sustainability

- Increase pay-for-value and FFS incentives to encourage advancement of BHI
- Promote the use of new and existing health and behavioral codes consistent with BHI in primary care billing

11 Smali E, ML Goldman, H Pincus, and H Chung. 2017. *Advancing Behavioral Health Integration for Small Primary Care Practices: Progress, Emerging Themes, and Policy Considerations. Behavioral Health Integration Issue Brief Series, No. 2.* New York: United Hospital Fund and New York State Health Foundation. https://uhfnyc.org/publications/publication/advancing-behavioral-health-integration-for-small-primary-care-practices-progress-emerging-themes-and-policy-considerations/

This final publication brings together observations from the experiences of the small primary care practices participating in our year-long project. It documents the resources and approaches they used as they began to implement or advance BHI with the support of the Framework and highlights their strategies for overcoming obstacles. It includes findings from in-depth onsite interviews conducted with the practices, describing their implementation efforts and how they adopted and used the Framework and its domains. These results informed site-specific BH workflow maps and provide insights into the real-world successes and challenges of BHI in small primary care settings.

The evaluation findings described here have also informed the development of a revised roadmap, dubbed Framework 2.0, that is clearer and more extensive, and offers improved guidance to PCPs interested in BHI. The aim remains the same: to help clinicians and policymakers adopt effective BHI implementation strategies and policies at a time of rapid health care transformation in New York.

Methods

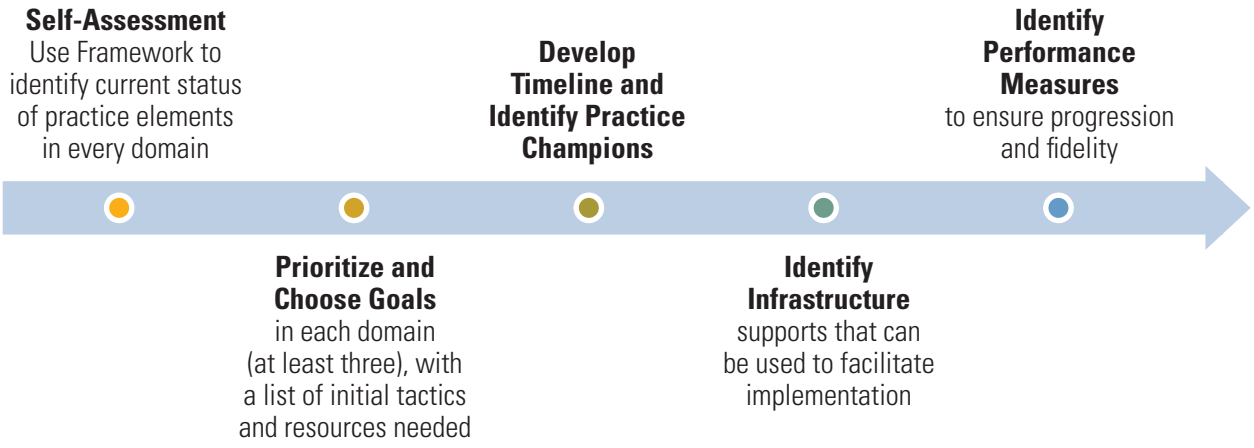
Site Selection

Using a purposive sampling technique aimed at recruiting a mix of small, highly BHI-motivated New York City, suburban, and upstate primary care practices, we identified and obtained agreement from 11 practices interested in participating in the project. Practice champions and implementation teams included a mix of PCPs, practice administrators, nursing staff, and, when available onsite, behavioral health specialists and/or care managers.

The Framework as Quality Improvement Tool

To prepare practice staff for change, we presented the Framework in a kick-off meeting, showcasing its eight domains and describing the various elements of each. We also introduced the project goals and timeline and provided guidance—centered on a five-step approach—on using the Framework as a self-assessment tool and measure of practice progress, and on setting goals among the Framework domains to create an initial BHI advancement plan (Figure 4). Each practice went on to use the Framework as a guide to identify goals based on existing strengths, while setting priorities for how best to advance BHI. Practice leadership teams subsequently met with the project team to discuss their implementation plans.

Figure 4. Using the Framework to Advance BHI: A Five-Step Approach



Technical Assistance

The project team led monthly learning collaborative webinars for sharing of best practices, presentations on a variety of topics important to integration efforts, and ongoing contact between the project team and the individual practices (see Appendix B for a listing of webinar topics).

In addition, the team held three check-in calls with each site to discuss goal setting within the Framework, collect lessons learned, clarify progress made, and discuss strategies to overcome policy and implementation obstacles to integration. These site discussions were held in March 2017, July 2017, and May 2018.

Survey Collection

A baseline survey at project kick-off allowed participants to provide information on practice characteristics: describing staffing and existing behavioral health service workflows, assessing their ability to provide practice survey data, and identifying their motivations for participation. Practices also completed a readiness assessment to identify their BHI status prior to implementation, as well as a six-month planning survey to set their goals for advancing BHI. The results of the baseline survey and readiness assessment were presented in the first issue brief on the project.[12]

After six months, practices completed a follow-up self-assessment that reported on their advancement using the Framework to date, as well as another planning survey to set goals for the final six months of the project. A final survey, completed at the 12-month mark, reflected their progress on the Framework throughout the entire project period. At that point they were also asked to voluntarily complete two additional questionnaires, on their use of BHI billing codes (n=10 responses) and on some relevant quality improvement metrics (n=8 responses).

Quantitative Analysis

All surveys were collected using Survey Monkey.[13] Findings were exported into Microsoft Excel to compare progress on Framework goals and record lessons learned, resources, obstacles, baseline descriptions, and overall experience.

12 Chung H, E Smali, L Elinson, S Matthews, and H Pincus. 2017. *Advancing the Integration of Behavioral Health into Primary Care for Small Practices. Behavioral Health Integration Issue Brief Series, No. 1.* New York: United Hospital Fund and New York State Health Foundation. https://uhfnyc.org/publications/publication/advancing-the-integration-of-behavioral-health-into-primary-care-for-small-practices/

13 SurveyMonkey Inc. © 1999-2018. San Mateo, CA. www.surveymonkey.com

To have a standard for comparability across sites, we converted the Framework elements into an unweighted item survey. Elements in the Framework were assigned scores that increased as a practice moved along the continuum, with preliminary elements of integration scoring 1 point, intermediate I levels scoring 2 points, intermediate II levels scoring 3 points, and advanced levels scoring 4 points. A global score—which could range from a low of 14 to a maximum of 56—was given to each site by summing all points across levels of integration.

Comparative descriptive analysis was also done to identify potential factors influencing practice progress and outlier outcomes in the qualitative results. The sample was too small for any correlative or regressive analysis.

Site Visits and Qualitative Data Collection

Because one practice withdrew from the project after six months (but prior to site visits) only 10 practices are included in the qualitative analysis.[14] The research team visited these 10 participating practices in September and October of 2017, conducting both individual interviews and focus groups with practice leaders, BHPs, PCPs, and support staff. A semi-structured interview guide, developed from areas of interest arising from the planning meetings and check-in calls, was revised in an iterative process based on the initial interviews and focus groups. Areas of focus included the site's successes, barriers, solutions, and improvements according to each of the Framework components and the practice characteristics identified during initial site visits (see Appendix C for an example of an interview guide).

In addition to the site visits, check-in calls during the project provided additional informal input on how the Framework could be improved, with practices identifying unclear verbiage, overlap between integration elements, and additional areas that required further support.

Qualitative Analysis

Interviews and focus groups were audio recorded and transcribed. Transcripts were coded, using AtlasTI,[15] by a senior qualitative researcher, the program coordinator, and a research assistant. Coding proceeded with iterative rounds of codebook development, including the use of the Consolidated Framework for Implementation Research (CFIR)[16] as a

14 The practice withdrew, after completing the six-month survey but prior to site interviews, due to a merger with a large hospital network. Because of the demands of that transition, practice leaders did not feel they had the time and resources to continue participation.

15 Friese S. 2015. *ATLAS.ti 8.3.Version 8*. Berlin: ATLAS.ti Scientific Software Development GmbH. http://atlasti.com/

16 CFIR Research Team. 2017. *The Consolidated Framework for Implementation Research Booklet*. Creative Commons Attribution 4.0 International License. https://cfirguide.org/

guide for identifying and organizing prominent themes. Triangulation was used for codebook validation and to ensure consistency between analysts, with inter-rater reliability improving between coders with each round of refinement of the codebook. Themes from the interviews as well as memos describing workflow processes were used to generate a qualitative model for the experiences of participating practices in integrating behavioral health into primary care.

Mixed-Methods Analysis

Descriptive data for each site were collected and evaluated in parallel with the survey responses and qualitative findings. Further thematic development was conducted to reveal variations in practice experience based on characteristics of the practices, including readiness, current care processes, ability to capture quantitative data, organizational factors, and participation in DSRIP, PCMH, or the newly expanded NYS PCMH program, which includes specific BHI criteria.

Synthesis of Results

Quantitative Results

During the 12-month Framework evaluation, practices made substantial progress toward higher levels of integration (see Appendix D). More than 50 percent of practices focused the majority of their BHI efforts on the following domains: screening and referral, multidisciplinary team, ongoing care management, quality improvement, and information tracking and exchange among providers.

At baseline, practices' global scores on the Framework ranged from a low of 14 to a high of 36, with a median score of 22. At 12 months, scores ranged from 22 to 51, with a median score of 34—a mean change for all sites of 10.5 points overall, signifying advancement in levels of BHI.

By 12 months, most practices had improved by at least one level in most of the domains and subdomains/elements of the Framework (see Appendix E). The sub-domains with the highest percentage of practices reporting improvement were: care team (73 percent), screening and referral (64 percent), and case load review, care management, patient self-management support, patient tracking, and information sharing among PC-BH providers, each with 55 percent indicating advancement. Sub-domains in which practices reported the least advancement were evidence-based care, medication management, quality improvement, access to psychotherapy services, and links to social services.

Key Practice Baseline Characteristics and BHI Advancement

Two baseline characteristics that varied among practices—medical/executive leadership for BHI and availability of onsite BH practitioners—were examined for their influence on the ability to advance a practice's BHI initiative. Medical leadership was assessed based on the involvement of PCP champions and executive leadership in survey submissions and in attendance at BHI planning meetings, project check-in calls, and technical assistance webinars. The influence of other potentially important characteristics, such as PCMH status and DSRIP participation, was not assessed because most practices had these assets at baseline. Validity of the findings below may be limited by the very small sample sizes and the potentially outsize influence of a few sites' status.

Medical Leadership Participation

Practice teams with a designated medical champion and/or an involved senior health executive (n=8) with a clear commitment to BHI efforts appeared to make more progress. On average, practices with strong leadership advanced 12 points on the Framework, compared to 6 points for sites with limited leadership involvement. In addition, the final average

global score for sites with strong leadership was 36 points, compared to 31 points for those with limited leadership involvement.

Onsite BH Services

For onsite BH services, three sites used a social worker, two sites a psychologist, one site an RN care manager, and one site both a social worker and psychiatrist. We observed that practices with onsite BH at baseline (n=7) improved 13 points on the Framework on average, compared to just a 6-point improvement for practices without onsite BH. In addition, the average final global score for sites with onsite BH was 38 points, versus 29 points for sites making external BH referrals.

Practice-Reported Quality Metrics

Although submission of quality metrics was not within the planned scope of this evaluation project, due to perceived site burden, eight practices voluntarily submitted at least partial quality metrics for screening, monitoring, referral, and reimbursement (see Appendix F). To help decrease reporting burden, we asked sites to report data only for the months at project baseline (April 2017) and at the 12-month endpoint (April 2018). The metrics requested were:

- Screening: Percent of patients who received depression screening, percent of positive screens, and average percent of patients scoring ≥10 on PHQ-9 and/or in treatment for depression (clinically significant depressive symptoms);
- Monitoring: Percent of patients with clinically significant depressive symptoms who were monitored, and percent receiving prompt follow-up; engagement of patients following external referral to BH providers, and receipt of information by the practice from external BH providers to whom patients were referred;
- Revenue: Number of depression screens billed, and amount of revenue from them.

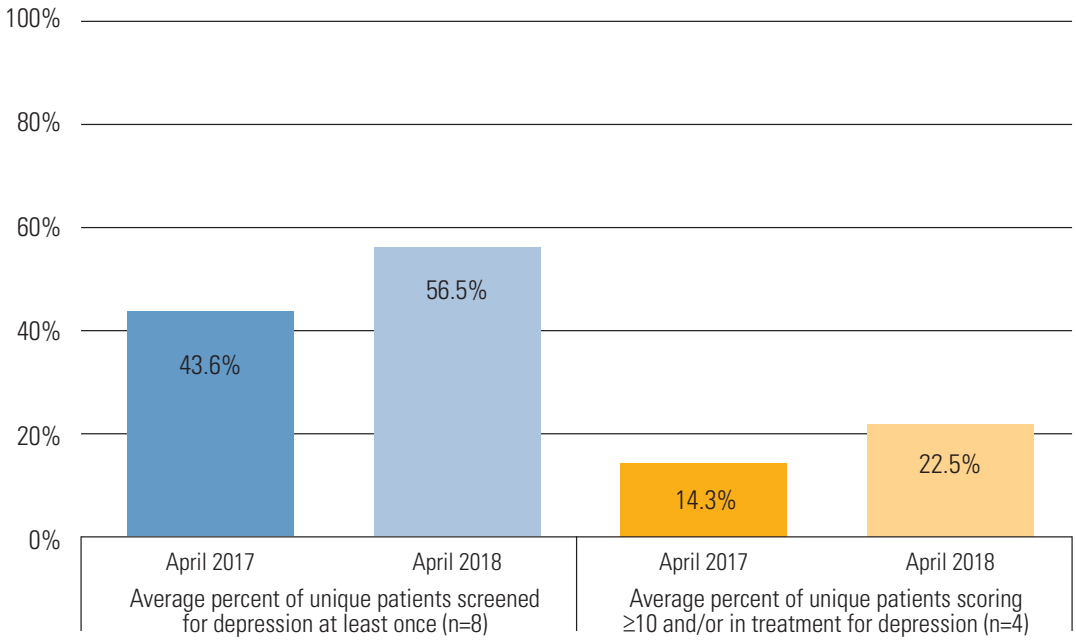
We requested data on the first two of these, screening and monitoring, because they are referenced in the new NYS PCMH BHI criteria.[17] We added the revenue indicator because BHI sustainability was a major concern for all practices.

Eight sites reported on screening. At baseline, an average of 43.6 percent of unique patients were screened for depression at least once that month; that rose to 56.5 percent in April 2018, a 30 percent improvement over the course of the project year. Only four sites were able to report their yield for positive screens and/or patients in treatment for depression (Figure 5).

17 NCQA. *New York State Patient-Centered Medical Home Recognition Program.* https://www.ncqa.org/programs/health-care-providers-practices/state-and-government-recognition/nys-patient-centered-medical-home/

This is an important metric: Medicaid populations have been reported to have greater yields due to a higher frequency of depressive symptoms in this subgroup.[18] For the four reporting practices, yield ranged from zero to 25 percent at baseline, increasing to 6 percent to 37 percent in April 2018. The average percent of unique patients with clinically significant depressive symptoms (PHQ-9 = ≥10 and/or in treatment for depression) increased from 14.3 percent (range: 9-28 percent) in April 2017 to 22.5 percent (range: 15-30 percent) in April 2018, a 46 percent increase.

Figure 5. Overall Improvement in Depression Screening and Yields (Baseline and Project's End)



Only three sites reported on depression score monitoring and prompt follow-up, noting an increase in documented successful follow-ups for repeat depression screens and return visits or phone follow-up within four to eight weeks of initial assessment. Only one site was able to report any data on external referrals and shared communication, so these data are not presented.

Three of the sites also reported on their revenue from depression screening. For two, that revenue increased from 2017 to 2018. The site that did not experience an increase attributed this finding to a difference in reimbursement rates based on each year's patient and payer mix.

18 Kaiser Family Foundation. 2012. Fact Sheet: *The role of Medicaid for people with behavioral health conditions.* https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_bhc.pdf

Qualitative Results

The semi-structured interviews and focus groups with PCPs, BHPs, decision-makers, and staff yielded a range of important findings that highlight both the successes and challenges of BHI as well as the utility of the Framework at each step of the implementation process.

Planning and Rollout of BHI

BHI Planning

The most common goals discussed during site visits were strengthening external referral partnerships, registry tracking of patient outcomes, and improving BHP-PCP communication. Additional goals included revenue opportunities for BHI sustainability, recruiting or partnering with BH providers, and streamlining workflows and referral processes. Practices began early preparations for implementation with needs assessments and regular meetings of practice leaders and the multidisciplinary team, and with strong leadership from site champions. The Framework was uniformly recognized as a useful guide to advancing priorities and gauging progress.

BHI Rollout

Workflows dramatically altered during BHI implementation, most notably those related to the Framework components of depression screening, follow-up, and referrals—including warm handoffs when BHPs were co-located. To strengthen warm handoffs, practices initiated workarounds and created internal referral processes for when BHPs were momentarily unavailable or had limited onsite hours. Respondents noted a number of advantages to having a BHP onsite, including:

- Increased communication with the primary care team, for developing shared care plans;
- Use of secure messaging in the EHR to communicate on treatment;
- Discussion of high-risk patients via case conferencing;
- Multidisciplinary team meetings; and
- Improved collaboration via patient chart reviews.

In general, practices reported that their objectives evolved as participation progressed, shifting from addressing BH issues primarily during crises to more actively engaging with patients about BH care before crises arose. That involved dealing with staff turnover, defining workflows by role rather than by individual, increasing BH referral activity, reducing no-show rates, and partnering with BHPs through collaboration agreements.

"We really ended up talking about behavioral health a lot in the case conferences… I think that's what the [primary care] providers… need to conference about… [They] aren't necessarily used to talking about it with patients."

– Primary Care Provider

One practice developed an innovative integrated care visit for its complex BH patients, structured so that a primary care clinician and a BH provider would meet with the patient jointly or consecutively to reduce potential interruptions in care during provider handoffs. Patients see the providers for 20 to 30 minutes each, typically for four to six visits but for more if needed. The site reports that these visits have been well received by patients and have greatly improved their ability to cope with trauma and adhere to treatment.

During the rollout, common obstacles included:

- Limited or shared office space, which may negatively affect confidentiality;
- The burden of extra time needed to train PCPs and staff;
- BHPs being inundated with referrals and unable to keep up with patient load;
- The need to transition to strong team-based care to avoid duplication of roles.

Engagement with the Framework

Practice leadership and staff were generally positive about the Framework, with comments noting that the Framework better enabled sites to refine and focus their goals, increased understanding of what practical integration entailed, and helped organize the implementation process. A number of respondents felt the Framework was an adaptable tool that helped guide BHI planning and problem solving, which resulted in advancing BH services at practices' preferred pace and setting priorities appropriate to their needs.

"I found the Framework to be an interesting tool. It draws together various models of integration. Rather than advance integration through the promulgation of separate and rigid models, the Framework captures it all. It really helped us to consider things beyond our initial commitment and continues to inform our learning."

– Practice Leader

For practices that were already engaged in BH integration activities, the Framework helped further organize their efforts and provided opportunities to step back and assess progress and remaining needs. Some practices contrasted their experience with the Framework and with previous attempts at BHI through other initiatives; while those earlier efforts quickly faded due to limited time, accountability, and planning, use of the Framework helped them establish alignment among staff and consider approaches to enhance sustainability at the outset.

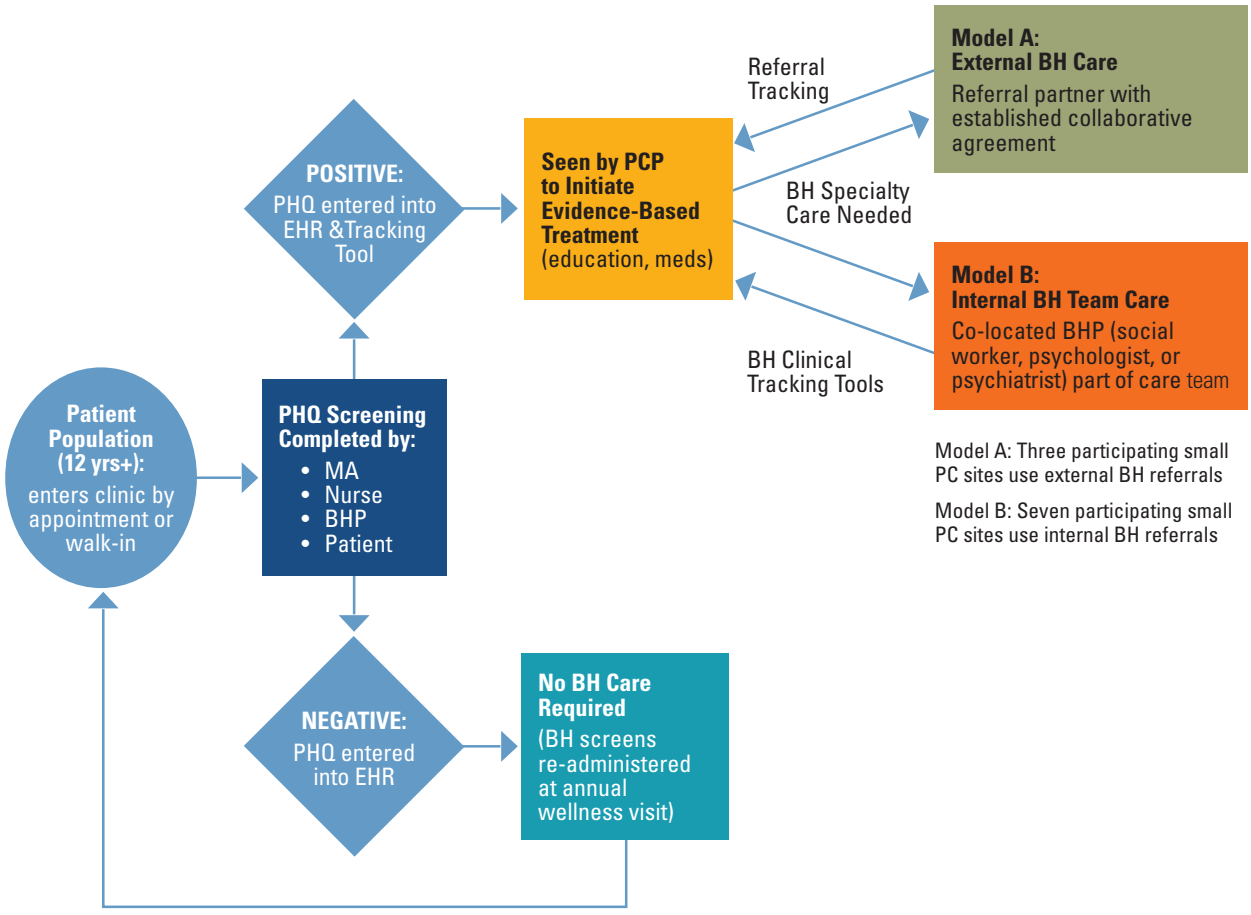
Still, some frontline staff at several sites expressed a lack of knowledge about the Framework and were unaware of practice-specific BHI goals, or even that the project was taking place. Moreover, these staff reported they did not receive BHI training and were not regularly participating in the monthly technical assistance webinars—which suggests that in some practices an opportunity to garner frontline support and buy-in may have been missed.

Overall, practices saw the Framework as a useful instrument to engage staff on planning for integration and encourage dialogue on BHI goal prioritization and resource capacity. It was also seen as providing a good refresher for practice teams, clarifying their progress and reaffirming their commitment to continue toward their set goals.

BHI Workflows

Based on site visit observations and interviews, we developed a "master" BHI workflow (Figure 6) illustrating two key pathways that primary care practices can utilize to address the Framework's screening and referral, multidisciplinary care team, ongoing care management, and information tracking and sharing. The dual approach accounts for internal or external BH services for patients whose depression screening is positive.

Figure 6. Comprehensive BH Workflow: Internal and External Pathways



At three of our participating practices, PCPs initiated referrals to an external BH provider, community mental health clinic, or community-based BH provider after assessment. Seven sites made internal referrals, instead, to a co-located BH provider either hired by the practice or on assignment from another entity.

Screening

Practices' screening workflows varied by instrument, method of administration, frequency of administration, and documentation. BH screening tools included the PHQ-2, PHQ-9, GAD-7, CAGE, and ACE; some practices bypassed the PHQ-2 and administered only the PHQ-9. Both medical assistants (in 50 percent of practices) and nurses (in 20 percent) administered the screening instruments, after training and with ongoing audits by their supervisors to ensure quality. Thirty percent of practices made use of patient self-assessment, using a paper or tablet-based screening tool in the waiting room prior to the visit. Some practices shifted from using a PHQ screen for depression only when a patient complained of suggestive symptoms to more systematic screening, seeking to screen all patients during their initial appointments and annual wellness visits. Most practices attempted to re-administer the PHQ-9 to patients diagnosed with depression at every visit, or at least at a six-month follow-up visit.

All completed screens were either manually entered or scanned into the EHR for PCP review. Practices' use of scores varied, with some considering a PHQ screen to be a vital sign, as integral to care as hemoglobin A1C levels or blood pressure readings, to be graphed in order to illustrate patient progress over time. A few practices did not specifically flag positive PHQ scores in the EHR, so some symptomatic patients could have been missed for review and follow-up; some other PCPs gave screening instruments less credence and preferred to assess risk for depression while reviewing the patient's history with him or her, instead of relying solely on the PHQ screen.

Only a few practices that were managing registries or had Excel-based tracking tools routinely monitored score changes to facilitate patient follow-up. Although most participating practices were PCMHs, those that attempted to use tracking tools were all aligned with New York City Mental Health Service Corp (MHSC) requirements or specific DSRIP projects fostered by their PPS.

PCP Review and Treatment

Patients who screened positive for depression were typically identified for the PCP, in conversation, by the staff member who administered the screen; alternatively, positive scores were flagged in patient charts for PCP review. A more definitive diagnosis was then based on the PCP's in-person

assessment of the patient. In some cases, PCPs reported, depressive symptoms were likely related to patients' chronic health conditions, along with complaints of fatigue, pain, weight gain, or other physical issues. Screening scores were often a useful place to start discussions about a patient's condition and treatment, especially for those who had difficulty acknowledging their BH diagnoses. Some PCPs also used handouts and brochures for patient education, but these were often not easily available. In practices that could graph and track PHQ scores over time, PCPs found that showing patients that visual record helped engage them in treatment and self-management.

Five of the participating practices reported that their PCPs were comfortable with prescribing and managing BH medications. Typically, they followed DSM-5 or DSM-IV criteria for diagnosing depression and other BH conditions, which in turn guided their choice of medication. Having a psychiatrist onsite or available for case consultation increased PCPs' comfort with managing psychotropic medications. For more complex cases, many PCPs preferred to refer patients to a BH specialist, whether in the practice or outside it, for initial treatment, with subsequent follow-up by the PCP, mostly when long-term BH care was not available, when the patient's condition was stabilized. Whether referring out or managing treatment themselves, PCPs noted the importance of receiving reports on any BHP consults to support their own patient monitoring—but well-defined, consistent processes for such information sharing often did not exist.

Internal BH Referrals

Having psychiatric expertise at hand provides PCPs with a readily available resource for consultations on BH medication management and care planning. Practices with a behavioral health specialist as part of the in-house care team benefited from easily achieved warm handoffs, BHP participation in staff meetings, and increased collaboration with PCPs on care planning and medication adjustments, via case conferencing and chart reviews, informal hallway exchanges, EHR notes, and secure messaging. Onsite BHPs also make possible innovations such as integrated care visits that allow some patients to see both a PCP and BHP during one visit.

Despite those advantages, there was less of an incentive for staff and practitioners to allocate time for care coordination between primary care and behavioral health, even with otherwise high levels of integration. Additionally, while practices recognized that internal BH service sustainability could have been supported with integrated patient tracking tools and the use of BH coordination and service billing codes, few were able to implement these capacities within the project's one-year timeframe.

Ideally, practices sought to have patients access internal BH care immediately after referral, but scheduling a first appointment further out was often required. In one practice, the wait for an initial consult took up to two months due to the high demand for BH services. Participants cited long wait times for an initial BH assessment as a hurdle to care plans and starting patients on treatment—leading practices, at times, to make use of external referrals when internal capacity was not sufficient.

External BH Referrals

Seven sites offered BH care primarily through external referrals; the bulk of those referrals were for patients with more complex BH conditions, requiring medication management that went beyond PCPs' comfort zone. Most PCPs also made referrals when they recommended, or the patient requested, psychotherapy in addition to medication. Options for external BH referrals included local community mental health centers, preferred external consultants working under partnership agreements, or other community-based BHPs.

Practices that did not have onsite BHPs instead chose to enter into collaboration agreements with preferred external providers. Creating parameters for the referral workflow, information exchange, and follow-up helped ensure that both the primary care and BH practices were in agreement on a mutually beneficial, and effective, process for care coordination. In many cases, however, practices were unable to refer all patients to agencies with which they had collaborative agreements, making information exchange for external referrals an ongoing challenge.

Challenges in establishing partnerships with external BH providers included the lengthy planning process required to develop policies, rules, and expectations ensuring effective collaboration; a lack of commitment by the BH partner; and a lack of leadership support on both sides. One site, unable to arrange a formal agreement with a BH partner, found itself without any referral option for patients who screened positive. Other factors limiting external referrals included inadequate availability of psychiatrists, insufficient education and support for families and caregivers, the absence of Spanish-speaking providers, and, in urban areas, relatively few BH providers accepting insurance.

Care Management

Where care management was already in place for medical conditions, practices expanded the roles of their care managers to include behavioral health care and follow-up, using a range of tools (including Excel spreadsheets and other tracking and reminder systems) or calls to referral

partners or other providers to help make appointments and request follow-up information. One practice created a care navigator position to aid high-need patients with transportation to referral appointments, assistance with translation and literacy, and appointment booking.

Practices reported common challenges when working with external BH specialty settings, including inadequate interpersonal communication, barriers to retrieving consult reports, long wait times for care and hurdles to setting up open-access appointments, and patients' perceptions of stigma attached to such referrals.

Administrative Tools and Resources

For each step of the workflows outlined in Figure 6, a number of administrative tools were available to support BHI services (Table 1). Access to such resources increases a practice's ability to successfully and seamlessly deliver more advanced levels of BHI.

Table 1. Administrative Tools and Resources Utilized by Small Primary Care Practices

BH Screening	• EHR-based screening tools with prompted PHQ screening questions and automated flag for positive screens • EHR-based tracking tools to record PHQ scores and follow up on BH referrals with reminder notification system
BH Care by PCPs	• PCP notes accessible and openly shared with consulting behavioral health specialist • Team converses regularly via text or e-mail, in-person conversations, and regular meetings and case conferences • Direct provision of evidence-based BH treatment, including use of medication protocols • Patient education tools and self-management supports • Billing for BH screens, BH care coordination
BH Care by Internal BHPs	• Sharing of BH treatment notes among providers via EHR • Billing for BH treatment services • Quality improvement practices, including monitoring of quality and process metrics to inform strategic plans for BHI • Clear processes for staff management of internal BH follow-up and for calls or letters to patients to encourage engagement in care
Referral to External BHPs	• Established collaboration/partnership agreements that formalize communication and information sharing between primary care site and external BH partner • Established protocol for sharing consult notes via EHR or fax • Staff assigned to manage follow-ups with external partners and to call or send follow-up letters to patients to encourage engagement in care • Expansion of telehealth using secure texting and videoconferencing

Other Domain Advancements

The domains related to clinical workflow—which include screening, initial management, referral, and information sharing—are described in Figure 6 and Table 1 above. We also identified themes related to the Framework's other domains.

"We have a continuous quality improvement committee that meets… monthly… so every month we get results per site… and we share that with our [practice] group. We [use this information to] discuss challenges and barriers to care."

– Primary Care Senior Team Member

Quality Improvement and Ongoing Performance Review

Quality metrics, which tended to focus on screening rates, ranged from limited general data collection to individualized feedback for providers. Although some practices wanted to track population-level outcome measures and monitor PCP prescribing practices, none had implemented these efforts by the project's end. Quality improvement efforts focused primarily on internal interventions such as arranging additional trainings, altering clinical workflows, and influencing executive decision making to support BHI with more resources.

Evidence-Based Care

Goals for evidence-based care included improving follow-up on positive PHQ measures, tracking symptoms within the EHR, and following guidelines for psychotropic medication prescribing. Sites aspired to ensure that stepped care was applied based on systematic symptom monitoring, but PCPs found it difficult to consistently adopt these evidence-based practices; many felt they had limited expertise, and a lack of time or reimbursement that would allow them to complete additional training.

Medication Management

In general, PCPs tended to start psychotropic medications for patients they felt had straightforward presentations, such as depression or anxiety. For patients with more complex presentations or symptoms, the typical protocol for medication management was to make a referral to an onsite or external BHP. Some PCPs were reluctant to take on any prescribing of psychiatric medications because of their unfamiliarity with the drugs or concern that BH care was outside their scope of practice and training. For patients already being seen by a psychiatrist, some PCPs continued prescribing current medications but tended to defer any dosage or prescription changes to the psychiatric specialist. One challenge with this approach was that prescribing psychiatrists were not always readily available, so PCPs felt forced to manage medications with which they weren't comfortable.

Non-psychiatric BHPs played important roles in assisting PCPs with medication management, including conducting evaluations and recommending referral for medications, monitoring symptoms and advising PCPs of clinical changes, supporting and educating patients

about adherence to medications, and coordinating supervision from off-site psychiatrists. BHPs also helped patients consider treatment choices between medications or psychotherapeutic alternatives.

Psychotherapy

Most psychotherapy offered in the PC setting was conducted by a BHP and consisted of brief interventions for depression or anxiety. Courses of therapy typically ran 4 to 12 sessions and focused on problem-solving, grief support, and cognitive-behavioral techniques. As patients' symptoms began to abate the frequency of sessions tapered off; those whose symptoms persisted were referred to specialty BH clinics. Warm handoffs were frequently described as a key to engaging patients in psychotherapy, although some patients still declined therapy or did not follow up on referrals, especially if there were longer wait times.

Patient preferences were also considered when setting up referrals and treatment plans. Some patients wanted to try medication only, feeling that psychotherapy had a stigma attached to it, while others were resistant to taking psychotropic medications. Practices recognized the importance of having all providers offer education to patients, families, and caregivers on BH diagnosis, treatment, and self-management.

Self-Management Support

Multiple practices provided patient handouts, including educational materials on BH conditions, information about resources and programs, and guidance on when to seek crisis care. Some practices offered personal training or written or illustrated instruction on specific BH skills, such as breathing and relaxation techniques. One practice showed patients a printed record of their PHQ-9 scores as feedback about their progress, correlating it to adherence to treatment. Some practices stated that handing out educational materials was not enough, and called for specific efforts to reinforce knowledge about patient self-management, support medication adherence, use SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) goals worksheets, and do motivational interviewing.

"One of the big problems here is transportation. I even have a question on my intake [form] asking if it will be hard to keep appointments [due to lack of transport]. Most [patients] don't have cars, so I give out bus passes to people that need them."
– Behavioral Health Provider

Social Service Linkages

Some practices had arrangements with social workers, case workers, community health workers, or peer navigators in the community, including staff from social service agencies who would hold regular onsite hours. The most frequently discussed social service need was transportation to appointments, particularly for migrant farmworkers and other at-risk patients living in rural settings; many practices also helped facilitate transportation, when necessary, to the social service agency.

The Framework in Practice

Use of the Framework

The Framework was well received by participating practices' leadership and staff, who saw it as a flexible, effective tool that broadened their understanding of the integration process by breaking it down into practical steps. Practices utilized it in planning meetings and progress evaluations, finding it helpful for establishing and refining goals and organizing the implementation process so they could advance BHI at a manageable pace, setting priorities appropriate to practice needs.

Survey responses indicated that all sites had made advances in their BHI practices overall. Using the scoring convention described previously on page 10, we found improvements in all domains, most notably in the development of multidisciplinary care teams and in screening and referrals (Appendix D). Our findings suggest that the Framework, in combination with technical assistance, was effective at helping small practices advance at least one level of integration, from preliminary to intermediate or intermediate to advanced (Appendix E).

To further deepen our understanding of practice progress in BH care we requested the voluntary submission of some quality metrics at the end of the project, as described earlier in "Methods." From baseline to endpoint, sites providing these metrics reported increased PHQ screening and yield rates (Figure 5); some sites also improved their ability to monitor and perform follow-up for depression (Appendix F). Three sites shared data on revenue from screening for depression, with two of those sites reporting notable increases (Appendix F). A lack of data kept us from assessing progress on referrals. Given the relative difficulty sites had in reporting quality metrics, we recommend building collection and tracking of quality metrics into future BHI advancement work from the beginning, to ensure the availability of supplementary data beyond self-reported improvement scores.

Assets for Success

We also evaluated domain advancement in terms of baseline assets—such as medical/executive participation and onsite BH providers. We found that practices with strong medical leadership participation and onsite BH providers advanced further on the Framework. Based on our qualitative analysis, these factors appeared to be related to greater BHI buy-in from practice staff, more team engagement in the implementation process (with active leadership participation), highly accessible BHPs who are able to collaborate with PCPs on BH care planning and treatment, seamless warm handoffs (to onsite BH providers), and nimbler BHI workflow modifications.

We observed that executive and other leaders who are true BH champions are more personally accountable and drive improvement efforts with positive and encouraging messages to staff about the importance of BHI. Onsite BH capacity also advances BHI transformation by providing greater access to evidence-based treatment, both medication and psychotherapy, as well as improved BH-PC collaboration and information sharing, and increased visibility for BHI efforts within the practice.

Strategies for Change

Guided by the Framework and the project's technical assistance, practices began to tackle many common integration challenges, including staff turnover, lack of familiarity with BHI concepts, undefined BH care management roles, weak external referral partnerships, lack of patient follow-up, and high no-show rates. Our qualitative analysis of practice site visits demonstrated significant changes to clinical workflows across multiple domains (Figure 6).

Many participants used several strategies that demonstrated how the principles defined in the Framework directly influenced practices' expansion of BHI:

- Systematic screening of all patients by using a PHQ-2 and/or PHQ-9 at annual wellness visits, and follow-up of patients diagnosed with depression by monitoring PHQ scores at every visit;
- Improving care management by using spreadsheets and other tracking tools to monitor patient follow-up and positive PHQ scores;
- Supporting self-management by engaging patients on their PHQ score progress and providing take-home materials about their BH condition and medications;
- Scheduling regular time for case reviews and conferencing to discuss complex patients;
- More consistently getting patient consent and sharing information—including summary psychotherapy notes—between both onsite and offsite providers, to inform patient care plans;
- Establishing collaborative care agreements with external referral partners to create a common understanding and process for consults, provider communication, patient follow-up, and care planning;
- Increasing awareness of the need for and use of quality metrics aligned with DSRIP and health plan reporting requirements, and setting goals for additional reporting in the future;
- Adopting BHI billing as a pathway to sustainability.

Many practices stated that applying the Framework helped them shift from a "crisis-oriented" care approach to one that focused on improved early identification of behavioral health conditions and engagement with patients before a crisis emerges. These changes were possible for these highly motivated small primary care practices in just 12 months.

Framework 2.0: Feedback-Based Revisions

A primary aim of the project was to improve the Framework by incorporating "on-the-ground" practice feedback based on the experiences of the primary care sites. The study team identified multiple areas for improving the Framework, such as adding new domains and clarifying some of the elements within domains. Most notably, the practices stressed the need for a sustainability domain to help sites focus on how to capture revenue and ensure that investments in BHI can be maintained long-term. A list of the most relevant revisions to the Framework appears in Table 2.

Future iterations of the Framework might also add a BH crisis management component, but we did not include that at this time due to a lack of clinical consensus on evidence-based practices specific to crisis care. Evidence-based suicide screening tools such as the P4,[19] SAFE-T,[20] and Columbia-Suicide Severity Rating Scale for children and adolescents[21] might be considered at this time, however, as part of the screening domain. Any future crisis-related core domain may include additional tools and services, such as facilitating access to suicide help lines, coordination with crisis respite settings and mobile crisis teams, and screening for firearm ownership for at-risk populations.

19 Dube P, K Kroenke, MJ Bair, D Theobald, and LS Williams. 2010. The p4 screener: Evaluation of a brief measure for assessing potential suicide risk in 2 randomized effectiveness trials of primary care and oncology patients. *Primary Care Companion to the Journal of Clinical Psychiatry* 12(6):PCC. 10m00978.

20 Education Development Center, Inc. and Screening for Mental Health, Inc. 2009. *Suicide Assessment Five-Step Evaluation and Triage for Mental Health Professionals (SAFE-T).* https://www.integration.samhsa.gov/images/res/SAFE_T.pdf

21 The Columbia Lighthouse Project. *The Columbia Protocol (C-SSRS)* . http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/

Table 2. Framework Revision Highlights

All domains were revised to improve clarity and better distinguish between component elements of integration from preliminary through advanced stages.

Domains were re-ordered and grouped by function, including clinical, workforce, and management support/administrative tasks and workflows.

DOMAIN	REVISION
Case finding, screening, and referral to care	For the component "screening, initial assessment, and follow-up for BH conditions," the advanced stage of integration was refined to more clearly articulate the meaning of population stratification, clarifying the focus on patients with high-risk BH conditions (potentially determined by severity, diagnosis, cost, or other factors). For the component "referral facilitation and feedback," the concept of referrals was expanded to include internal referral, for those practices that provide BH services onsite.
Multidisciplinary team (including patients) used to provide care	The components "systematic team-based caseload review and consultation" and "availability for interpersonal contact between PCP and BH specialist/psychiatrist" were combined to reduce redundancy, as they both focused on interpersonal contact between the PCP and BHP. The newly formed component is titled "systematic multidisciplinary team-based patient care review processes."
Ongoing care management	Follow-up timeframes were more clearly defined between component steps to make it easier to measure progress along the continuum. The term "registry" was replaced with "tracking tools" throughout the Framework, to broaden the definition of potential tools that satisfy this function.
Self-management support that is culturally adapted	The explanation of this domain was strengthened to emphasize patient activation and recovery with adaptations for literacy, language, and local community norms. The revised Framework also adds reviewing symptom scores with patients, and clarifies types of self-management supports and activities for goal setting.
Information exchange among providers	Two components—"clinical registries for tracking and coordination" and "decision support for measurement-based, stepped care"—were combined.
Linkages with community/ social services	Social determinants of health (SDOH) screening tools and SDOH referrals tracking were added to the domain's intermediate and advanced levels.
New Domain: Sustainability	This new domain was included to focus on how practices can sustain BHI efforts. The preliminary level is "limited BHI billing." "FFS billing" and "revenue from quality incentives" comprise the intermediate level. The advanced level consists of "receipt of global payments with achievement of BH and general health outcomes."

The Takeaway

Participant feedback on surveys and during site visits and check-in calls provided invaluable insights on practice-level strategies used to advance BHI and the challenges faced as sites rolled out their implementation plans; their experiences also pointed to larger policy and regulatory issues. Together, these lessons can inform efforts by providers, clinic leadership, policymakers, payers, and other stakeholders as they plan for and support future implementation of BHI.

Lessons for Primary Care Practices in Integrated Care Settings

Practice champions, early staff involvement, and engagement of executive leadership help promote and advance BHI.

Onsite champions for BHI bolster staff buy-in, which promotes implementation by reducing resistance to change. Including a diverse group of practice staff in BHI planning meetings and providing regular progress updates to the entire team establishes greater accountability for achieving results and promotes teamwork within the process, and asking all staff for feedback on implementation plans and their execution helps identify barriers early and create strategies to overcome them. Commitment to BHI by medical/executive leadership and providers also helps ensure that appropriate resources will be provided to support implementation.

Engagement of staff at every level is also critical. Many practices reported that project technical assistance did not trickle down to frontline staff, affecting their commitment to BH services in the primary care setting and, potentially, quality of care. To ensure that practice staff are prepared for BH transformation, they must be made fully aware of the change, be part of the implementation process, and be adequately trained on the BHI goals and workflows that are being introduced. BHI goals should be planned and implemented by all staff members regardless of administrative and clinical position, to ensure accountability and promote adoption of change throughout the practice.

PCPs benefit from ongoing training to expand the scope of BH care they can provide.

BHI is impeded by the limited training PCPs have in behavioral health care, which results in concerns about working beyond their scope of knowledge and experience, burning out from challenging patient encounters, and confusion about when to manage patients and when

to refer them out. PCPs who reported having work time allocated for attending BH-related lectures and trainings were more confident in their ability to manage BH conditions and medications. These providers recognized the importance of developing relationships with their BHP partners, to expand their knowledge of BH treatment and have a more knowledgeable resource for managing complex patient care. By bridging the BH knowledge gap, PCPs are more likely to identify BH conditions in their patient population, initiate treatment, and follow up on patient progress.

"[When consulting a patient] they've got a mountain of other problems. You're spending all your time with that and realize you didn't do the PHQ9. By then, you've got three angry people waiting for you. [So I postpone] the talk about [their] depression for the follow-up visit."

– Nurse Practitioner

BH providers face unique challenges in the integrated setting.

BHPs working within a primary care practice may have difficulty balancing patient privacy in a team-based approach; scheduling appointments when onsite only part time; incorporating assertive patient follow-up strategies; working as a primary care team member; and being flexible based on practice needs. BHPs need adequate support when first integrating into a practice, and part-time positions should be arranged with these logistical challenges in mind.

Clinical BHI tracking tools are most effective when integrated into the EHR.

Clinical teams need a comprehensive BHI tracking tool to document patient progress on screening scores and to better follow up on BH care. The four practices in the project that used stand-alone spreadsheets as a tracking tool found that that impeded information sharing among the entire care team. Integrated BH tracking tools should be populated by the EHR, provide automated reminders on patient follow-up, and report on and graph PHQ scores individually for patient feedback and in aggregate for QI purposes. Practices seeking to achieve intermediate to advanced levels of BHI must allocate adequate financial support to purchase or upgrade this technology.

Condensed BH notes facilitate information sharing in the EHR.

Breaking down the silos between primary care and behavioral health providers promotes collaboration for better management of patients' physical and behavioral health needs. EHR systems generally allow for the sharing of patient notes between providers and their care team, often with a structured template; it's vital to remember, though, that sharing psychotherapy notes requires a separate patient consent. Participating practices with onsite BH services found it useful to create BH notes that included the diagnosis and treatment plan, information on medications, and updates on symptoms, based on follow-up measures, while keeping psychotherapy notes segregated.

Integrated visits help engage patients with complex care needs.

Visits scheduled so patients can see both their PCP and BHP simultaneously or in back-to-back appointments are an important strategy for reinforcing a team-based approach to care for patients with complex BH needs. Patients may spend 20 to 30 minutes with each provider, typically for four to six, but potentially more, visits. This level of engagement is reported to be well received by patients, greatly improving their ability to cope with the challenges of their BH diagnoses and adhere to treatment.

Care coordination improves with collaborative agreements.

Successful collaboration helps facilitate care coordination, higher-quality care, and information sharing between primary care and BH providers. Using a collaborative agreement (see modified version in Appendix H) clarifies mutual expectations between providers, including operational goals for behavioral health service delivery, information sharing, and patient follow-up. It is important, however, to ensure that patients are notified that information is shared among referral providers, and that consent is obtained, to support a collaborative treatment structure.

Self-management supports help patients stay engaged in BH care.

Patients often fear being stigmatized for accessing BH services: they may be uncomfortable answering BH screening questions, resistant to trying BH medications or psychotherapy, and embarrassed or ashamed when given a BH diagnosis. Those feelings may lead to missing scheduled appointments, which impedes treatment and places an additional burden on staff. Providing handouts and worksheets to help patients understand their diagnoses and how to manage their conditions can increase their confidence and encourage their active participation in care. Sharing a graphed record of patients' PHQ scores, showing treatment progress or lack thereof, can also help them stay engaged in care and understand the reasons for treatment changes.

Primary care practices must be more quality driven, receiving more resources to help with QI efforts.

Although some practices collected baseline metrics and set targets for quality measurement, few sites have the resources to consistently track and evaluate their outcomes. Investment in systematic quality improvement may be stalled due to the need to focus limited quality measurement resources on State reporting requirements, concerns that poor outcomes may affect funding, and a lack of experience and training in collecting and interpreting quality metric data like those shown in Appendix F. Yet quality metrics have a major impact on sustainability,

giving sites the ability to show progress that justifies additional State and payer funding and incentives rewarding BHI success. That additional revenue can allow small practices to expand their quality monitoring and adopt more integrated tracking systems to help practitioners translate scores into improvement strategies—a necessity for ensuring that BHI work is sustainable.

Participation in local, regional, and national initiatives helps motivate BHI advancement.

Practices found that participation in programs and initiatives such as the ThriveNYC Mental Health Service Corps, NYS Collaborative Care Medicaid Program, Medicaid Accelerated Exchange Learning programs, and Project TEACH bolstered their BHI efforts. DSRIP participation was a common motivator for BHI, encouraging piloting or early implementation of depression screening and treatment and SBIRT (screening, brief intervention, and referral to treatment) for alcohol and substance use disorders.

Financial sustainability is critical.

Accessing opportunities for revenue from BHI is critical if primary care practices are to create sustainable financial strategies. In general, practices recognized the need to take advantage of potential revenue associated with integrated BH services by billing for FFS codes (see Appendix G), pursuing quality incentive payments, and participating in innovative payment models such as shared savings.

Practices mainly billed for screening (PHQ-9, CAGE, etc.), using CPT codes such as 96127 and creating note templates for their EHRs to satisfy meaningful use requirements. Some practices set goals of billing for longer visits, SBIRT, and treatment of opioid use disorder. Many of the practices noted that value-based payments are on the horizon. Some already receive capitated rates, have risk agreements with managed care plans or participate in other alternate payment models, or receive enhanced payments for NCQA certification as a Level 3 PCMH. In addition, practices are benefiting from enhanced Medicare payments for meeting quality and patient outcomes standards, as well as billing for Medicare Wellness Visits, which include BH screening and assessment.[22] Many practices either joined or positioned themselves to apply for the NYS Collaborative Care Medicaid Program, which provides monthly supplemental care management payments to primary care practices that are using elements of the Collaborative Care Model and sharing quality outcomes with the State.

22 Sederer L, Derman M, Carruthers J, Wall M. 2015. The New York State Collaborative Care Initiative: 2012-2014. *Psychiatry Quarterly* 87(1): 1-23. doi: 10.1007/s11126-015-9375-1.

Regulatory and Policy Implications

Policy-related obstacles to progress in BHI include financial, licensing, and resource issues, among them the difficulty of sustaining services financed primarily by time-limited grants or policy initiatives such as DSRIP, the uncertainty of billing for BHI in primary care, and inadequate BH external referral capacity within health plans. Practices reported that State efforts at times feel uncoordinated and disconnected from local needs in the BHI space. Uncertainty about reimbursement rates and policies, potential integrated licensure to support BHI, and the continuation of Article 28 waivers obtained under DSRIP to increase BH visit caps in primary care are all potential concerns as well.

Some advances have been made to address low reimbursement rates for these services. With the release of the 2018 Medicare Physician Fee Schedule, the Centers for Medicare & Medicaid Services (CMS) introduced new billing codes for behavioral health clinicians participating in integrated care, especially the Collaborative Care Model (CoCM). CMS has also ruled that Federally Qualified Health Centers and Rural Health Clinics are able to receive these separate payments for CoCM and behavioral health services, which are now defined as part of primary care.[23] Still, many billing and documentation challenges remain to be addressed to incentivize and sustain primary care–behavioral health practice transformation with respect to fee-for-service funding.

Specific observations and suggestions arising from this project follow.

The Framework's overlap with NYS PCMH standards provides opportunities for practices seeking accreditation, and for alignment with incentive payments.

In 2017, NYSDOH released updated standards for the State's PCMH primary care transformation program, open to internal medicine, family health, and pediatrics practices.[24] A number of those criteria related to BHI directly overlap with the Framework (Table 3); all nine of the Framework's domains interlace with the core and elective requirements of the PCMH program.

23 CMS. 2017. *Final Policy, Payment, and Quality Provisions in the Medicare Physician Fee Schedule for Calendar Year 2018.* Baltimore: U.S. Centers for Medicare & Medicaid Services. https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-medicare-physician-fee-schedule-calendar-year-2018

24 NYSDOH. *About the New York State Patient-Centered Medical Home Recognition Program.* 2017. https://www.ncqa.org/programs/health-care-providers-practices/state-and-government-recognition/nys-patient-centered-medical-home/

This connection highlights an opportunity to use the Framework as a guide to attaining NYS PCMH accreditation and to aligning the components of the Framework with incentive payments potentially offered to providers meeting PCMH criteria. Furthermore, NCQA's recently announced expansion of its PCMH with Distinction in Behavioral Health accreditation program may signal future opportunities for additional incentive payments that overlap with Framework domains.

Table 3. Comparison of New York State's PCMH BHI Criteria and the Revised Framework 2.0.

NYS PCMH CONCEPT AREA	NYS PCMH BHI CRITERIA (CORE AND ELECTIVE)	LINK TO FRAMEWORK 2.0 (APPENDIX A)
Team-Based Care and Practice Organization	**#08:** BH Care Manager (2 Credits)	Domain 6 (Team-Based Care)
Care Management and Support	**#01:** Identifying Patients for Care Mgmt. (Core) **#08:** Self-Management Plans: Includes a self-management plan in individual care plans (1 Credit) **#09:** Care Plan Integration: Care plan is integrated and accessible across settings of care (1 Credit)	Domain 2 (Care Management) Domain 4 (Self-Management Support)
Care Coordination and Care Transition	**#04:** Referral Management (Core) **#09:** BH Referral Expectations (2 Credits) **#10:** BHI (2 Credits)	Domain 1 (Screening and Referral) Domain 6 (Team-Based Care) Domain 5 (Information Tracking)
Performance Measurement and Quality Improvement	**#01:** Clinical Quality Measures (Core) **#08:** Goals and Actions to Improve Clinical Quality Measures (Core) **#09:** Goals and Actions to Improve Resource Stewardship Measures (Core) **#18:** Reporting Performance Measures to Medicare/Medicaid (2 Credits) **#19:** Value-Based Contract Agreements: Is engaged in Value-Based Agreement (2 Credits)	Domain 7 (Quality Improvement) Domain 9 (Sustainability)
Knowing and Managing Your Patients	**#20:** Clinical Decision Support (Core) **#04:** BH Screenings (1 Credit)	Domain 1 (Screening and Referral) Domain 3 (Decision Support)
Patient-Centered Access and Continuity	**#09:** Equity of Access (1 Credit)	Domain 8 (Linkages to Care)

Link NCQA measures to the Framework and encourage NYS and MCO adoption.

The NCQA's approval of additional metrics relevant to BHI further ties national and State quality efforts to the Framework. Newer metrics include:

- Depression Screening and Follow-Up for Adolescents and Adults
- Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults
- Depression Remission or Response for Adolescents and Adults

These measures directly overlap with Framework domains 1 (screening and referral), 3 (care management), and 7 (information tracking and exchange). By adopting NCQA metrics within the context of the Framework, practices would be able to streamline reporting and potentially tie State funding to various levels of integration achieved along the continuum. New York's Collaborative Care Medicaid Program, for example, which offers supplemental care management reimbursement for practices implementing the collaborative care model, requires reporting for these three metrics.

The ability to apply NCQA measures to the Framework depends on practice characteristics, HIT infrastructure, and quality improvement experience—as well as the clinical team's agreement to the use of these and other BH clinical metrics for quality improvement and monitoring. For sites lacking expertise in monitoring population-level performance metrics, determining benchmarks and risk adjustments for new clinical measures can be a particular hurdle.

Address a dearth of community-based BH specialty care and lack of connections to primary care.

The most frequently described challenge in BHI was the difficulty PCPs faced in getting feedback from BH consults because of the lack of effective mechanisms for information sharing and referral tracking, especially with external referrals. Sites with internal BH support also need more resources for referrals of patients with more severe or refractory BH conditions. There is a persistent and significant need for increasing the number of BH specialty providers and access to them, including innovative models such as videoconferencing and mobile technologies.

Clarify BH payment policies for integrated care settings.

Many sites were concerned about their ability to sustain BHI efforts due to uncertainty about consistent reimbursement for these services. Four sites described Medicaid restrictions on same-day billing for both BH and primary care services as a major obstacle, and requested advocacy

"We all operate in an FFS world supported by FFS revenue. Even though we are talking about value-based [payments] and participate in DSRIP, there is still a time pressure on us [to bill]. So any service that is not a reimbursable encounter represents overhead cost to the agency."

– Primary Care Executive

to change this regulation. Additional concerns included health plans' inconsistent reimbursement policies, primary care capitated payments that preclude additional billing for BH services, and caps and inadequate payment for BH screenings. With current reimbursement inconsistencies among payers, many small primary care practices are unable to project behavioral health revenue so they can measure their dollar return on time, resources, and training. The current paucity of value-based payments tied to BHI performance also limits incentives for practices to measure and track the quality and effectiveness of their behavioral health care.

Expand Project TEACH to include all PCPs.

PCPs often noted that they lacked strong BHP partners to call for timely advice and support on patients with more complex behavioral conditions and on medication management. Many practitioners interviewed praised Project TEACH programs for linking pediatric PCPs with child psychiatrists to provide training and immediate telephone consultation services. In 2018, program goals were expanded to include combatting maternal depression, with expert psychiatrists in maternal mental health being made available to maternal health PCPs. Project participants voiced frustration with the lack of similar services for all PCPs, beyond specialists in pediatric and maternal care. Expanding Project TEACH resources and support to all PCPs in NYS would assist many more practices in need of advice and support on behavioral health.

Promote uptake of new technology.

Reviewing State regulations for and incentivizing the use of newer technologies is an important contribution to increasing access to care. "TeleMental" health care in the primary care setting makes it easier for patients to participate in therapy in an environment perceived to be less stigmatizing than a therapist's office; the use of iPads, videoconferencing, and other technology also improves access for patients in rural areas with limited numbers of BHPs to meet demand. Such technology improves patient tracking for screening and follow-up, as well, with more comprehensive registries and reminder systems alerting care managers when a patient is lost to care or is a persistent no-show. Both EHRs and stand-alone, integrated, and secure instant messaging tools also improve communications among staff, with BH counterparts, and directly with patients.

Conclusion and Future Directions

Although we learned a great deal about BHI advancement from the participating practices in this project and the ways in which our continuum-based Framework assisted their progress, the small number of participants in our surveys (n=11) and site visits (n=10) may limit the generalizability of those findings. We hope that other NYS projects that have used the Framework to support their BHI work will also report on their experiences, to extend our findings and provide additional insights. But to fully measure and understand the impact of this practice-based quality improvement BHI tool, we recommend large-scale and widespread implementation trials.

Additionally, the Framework was not initially designed to result in a calculated global score, although similar frameworks in other fields do use such scoring methodologies. Our score findings should therefore be interpreted as descriptive in nature. It should also be noted that the net changes in certain scores may have been influenced by a ceiling effect, in which sites starting at an intermediate level of BHI within a given domain at baseline had less space or room in which to advance.

Those caveats notwithstanding, this project demonstrated the feasibility of adopting the Framework in small primary care settings, and the continuum's utility for helping practices pursue a coordinated and strategic advancement of integrated BH services.

During the course of our work, many stakeholders and BH partners recommended that we develop a similar framework to advance physical health integration into behavioral health settings. Such an effort was promoted under DSRIP but appears to have had very limited uptake (with some notable exceptions) by BH specialty providers across the state, primarily because the models promoted included co-location of primary care providers in behavioral health settings. Both cost and regulatory barriers make this type of advanced model difficult to achieve. We believe, however, that a new, tailored Framework could help BH practices incorporate a whole-health orientation, up to and including making primary care services available, by introducing the same sort of continuum-based approach to transformation as we developed for primary care. Therefore, our project team will be working on a new continuum-based framework for physical health integration into behavioral health in 2019.

Appendix A. Framework 2.0: Revised and Expanded Guide to Implementing Behavioral Health Integration

Role	Key elements of integrated care		Integration continuum			
	Domains	Components	Preliminary	Intermediate		Advanced
Clinical Workflow	1. Case finding, screening, referral to care	Screening, initial assessment, follow-up for BH conditions	Patient/clinician identification of those with BH symptoms—not systematic	Systematic BH screening of targeted patient groups (e.g., those with diabetes, CAD), with follow-up for assessment	Systematic BH screening of all patients, with follow-up for assessment and engagement	Analysis of patient population to stratify patients with high-risk BH conditions for proactive assessment and engagement
		Facilitation of referrals, feedback	Referral only, to external BH provider(s)/ psychiatrist	Referral to external BH provider(s)/psychiatrist through a formal agreement detailing engagement, with feedback strategies	Enhanced referral to internal/ co-located BH provider(s)/ psychiatrist, with assurance of "warm handoffs" when needed	Enhanced referral facilitation with feedback via EHR or alternate data-sharing mechanism, and accountability for engagement
	2. Decision support for measurement-based stepped care	Evidence-based guidelines/ treatment protocols	None, with limited training on BH disorders and treatment	PCP training on evidence-based guidelines for common behavioral health diagnoses and treatment	Standardized use of evidence-based guidelines for all patients; tools for regular monitoring of symptoms	Systematic tracking of symptom severity; protocols for intensification of treatment when appropriate
		Use of psychiatric medications	PCP-initiated, limited ability to refer or receive guidance	PCP-initiated, with referral when necessary to prescribing BH provider(s)/psychiatrist for medication follow-up	PCP-managed, with support of prescribing BH provider(s)/ psychiatrist as necessary	PCP-managed, with care management (CM) supporting adherence between visits and BH prescriber(s)/ psychiatrist support
		Access to evidence-based psychotherapy with BH provider(s)	Supportive guidance provided by PCP, with limited ability to refer	Referral to external resources for counseling interventions	Brief psychotherapy interventions provided by co-located BH provider(s)	Range of evidence-based psychotherapy provided by co-located BH provider(s) as part of overall care team, with exchange of information
	3. Information exchange among providers	Sharing of treatment information	Minimal sharing of treatment information within care team	Informal phone or hallway exchange of treatment information, without regular chart documentation	Exchange of treatment information through in-person or telephonic contact, with chart documentation	Routine sharing of information through electronic means (registry, shared EHR, shared care plans)
	4. Ongoing care management	Longitudinal clinical monitoring and engagement	Limited follow-up of patients by office staff	Proactive follow-up (no less than monthly) to ensure engagement or early response to care	Use of tracking tool to monitor symptoms over time and proactive follow-up with reminders for outreach	Tracking integrated into EHR, including severity measurement, visits, CM interventions (e.g., relapse prevention techniques, behavioral activation), proactive follow-up; selected medical measures (e.g., blood pressure, A1C) tracked when appropriate

(Continued)

Appendix A. Framework 2.0: Revised and Expanded Guide to Implementing Behavioral Health Integration (Continued)

Role	Key elements of integrated care		Integration continuum			
	Domains	Components	Preliminary	Intermediate		Advanced
Clinical Workflow (continued)	**5. Self-management support that is culturally adapted**	Use of tools to promote patient activation and recovery with adaptations for literacy, language, local community norms	Brief patient education on BH condition by PCP	Brief patient education on BH condition, including materials/handouts and symptom score reviews, but limited focus on self-management goal-setting	Patient education and participation in self-management goal-setting (e.g., sleep hygiene, medication adherence, exercise)	Systematic education and self-management goal-setting, with relapse prevention and CM support between visits
Workforce	**6. Multi-disciplinary team (including patients) used to provide care**	Care team	PCP, patient	PCP, patient, ancillary staff member	PCP, patient, ancillary staff member, CM, BH provider(s)	PCP, patient, ancillary staff member, CM, BH provider(s), psychiatrist (contributing to shared care plans)
		Systematic multidisciplinary team-based patient care review processes	Limited written communication and interpersonal interaction between PC-BH provider(s), driven by necessity or urgency, or patient as conduit	Regular written communication (notes/consult reports) between PCP and BH provider(s), occasional information exchange via ancillary staff or labs, on complex patients	Regular in-person, phone, or e-mail meetings between PCP and BH provider(s) to discuss complex cases	Weekly team-based case reviews to inform care planning and focus on patients not improving behaviorally or medically, with capability of informal interaction between PCP and BH provider(s)
Management Support	**7. Systematic quality improvement**	Use of quality metrics for program improvement	Informal or limited use of BH quality metrics (limited use of data, anecdotes, case series)	Use of identified metrics (e.g., depression screening rates, depression response rates) and some ability to regularly review performance	Use of identified metrics, some ability to respond to findings using formal improvement strategies	Ongoing systematic quality improvement (QI) with monitoring of population-level performance metrics, and implementation of improvement projects by QI team/champion
	8. Linkages with community/ social services	Linkages to housing, entitlement, other social support services	Few linkages to social services, no formal arrangements	Referrals made to agencies, some formal arrangements, but little capacity for follow-up	Screening for social determinants of health (SDOH), patients linked to community organizations/ resources, with follow-up	Developing, sharing, implementing unified care plan between agencies, with SDOH referrals tracked
	9. Sustainability	Build process for billing and outcome reporting to support sustainability of integration efforts	Limited ability to bill for screening and treatment, or services supported primarily by grants	Billing for screening and treatment services (e.g., SBIRT, PHQ screening, BH treatment, care coordination) under FFS, with process in place for tracking reimbursements	FFS billing, and revenue from quality incentives related to BHI	Receipt of global payments that reference achievement of behavioral health and general health outcomes

Appendix B. Monthly Webinar Topics

DATE	TOPIC	DESCRIPTION
February 2017	Project Kick-Off	• Introduction to purpose and participants • Overview of Framework components and next steps in assessment
March 2017	Sustainability and Baseline Survey Review	• Developing a sustainability plan and identifying performance fiscal indicators • Optimizing systems to support sustainability • Results of baseline survey
April 2017	Implementation Planning	• Results of readiness survey • Importance of self-management support • Developing an initial six-month implementation plan
May 2017	Measurement-Informed Care	• Systematic application of depression measurement tools to drive clinical decision making • Talking points for patients on PHQ measurement and its importance to their health • PHQ-9 workflow components and their integration into practice
June 2017	Self-Management Supports	• Collaborative care, goal setting, action planning • Patient education handouts and action plans
July 2017	Care Management	• Integrated care teams, with examples of CM support tools (e.g., for medication adherence, motivational interviewing) • Practice presentation on using onsite CM
August 2017	Quality Measurement Using Registry and Emerging Technology	• Use of patient registry and available tracking tools, with live demonstration • Practice presentation on use of longitudinal graphing of PHQ-9 data to aid in management of mental health disorders
September 2017	Billing for Depression Screening and Approach to Psychopharmacology in Integrated Care	• Practice presentation on championing use of patient registry • Scope and expectations for PCP-BH prescribing; starting BH medications; medication algorithms, monitoring, assessing adherence
October 2017	Co-Morbid Chronic Pain	• Approach to and treatment options for chronic pain and depression
November 2017	Policy Considerations and the NCQA PCMH with Distinction in BHI	• Regulatory environment for BHI and substance use screening and treatment • Overview of "Distinction in BHI," highlighting its overlap with the Framework
February 2018	Role of Evidence-Based Psychotherapy Techniques	• Motivational interviewing, behavioral activation, brief action planning, mindful strategies, problem-solving therapy, and other techniques
March 2018	New Guidance on SBIRT	• Overview of new guidance on, clinical challenges of, and reimbursement for Screening, Brief Intervention, and Referral to Treatment
April 2018	Privacy and Confidentiality —and the Patient Experience	• Overview of HIPAA's Privacy Rule and 42 CFR Part 2 on sharing sensitive patient information and psychotherapy notes • Shared approaches to privacy and confidentiality in the PC setting, using documentation techniques • Principles of patient engagement, keeping patients at the center of BHI advancement
June 2018	Comprehensive Project Survey Results and Wrap-Up	• Results of surveys at 0, 6, and 12 months, and lessons learned over the course of the project • Proposed new Framework domain on sustainability

Appendix C. An Evidence-Based Framework for Primary Care–Behavioral Health Integration: Six-Month Follow-Up Interview Guide for Practice Decision Makers*

INTRODUCTION

Thank you for agreeing to participate in this interview. The purpose of this interview is to learn about your experiences thus far integrating behavioral health into your primary care practice. Specifically, we will ask you about your six-month objectives, the utility of the framework for developing and implementing your plan, and both success factors and challenges you have encountered.

The interview will take about 30 minutes. If you don't mind, I'd like to review the one-page notice of confidentiality with you before we begin, which goes over:

- The project
- Your role in this interview
- That we'd like to audiotape this interview for transcription later on – is that okay with you?
- Confidentiality/anonymity

Date of interview (MM/DD/YYYY)	
Practice Name	

[Begin by asking respondent to describe job and length of time in it]

Respondent's Name	Respondent's job title	Amount of time in job (years/months)

INTERVIEW QUESTIONS

1. Prior to participating in this project, what were the biggest obstacles to providing behavioral health care in this practice?
2. How did you go about deciding what this practice's six-month objectives would be? *[Use prompts below only when necessary]*
    - Staff involvement in decision making
    - Systematic approach to study and evaluate items under consideration
    - Influenced by articles and conferences
    - Discussions with other health care leaders
    - Internal quality improvement process

Now let's review the Framework and the objectives this practice has been trying to achieve in each domain. *[Refer to Framework and review the site's objectives]*

3. How was the Framework used to develop a six-month plan to achieve behavioral health integration?
    - Identification of practice's baseline BHI status
    - Identification and prioritization of feasible objectives
    - Identification of feasible practice changes to meet objectives
    - Use of framework when determining:
        - Appropriate resources (staff/technical assistance/incentives)
        - Assessment of progress
        - Changes and improvements

(Continued)

* This interview guide was developed for use with practice CEOs, owners, medical directors, or their equivalent. A second, condensed interview guide was also developed for practice staff, including PCPs, nurses, physician assistants, care managers, medical technicians, and BH specialists (e.g., psychiatrists, psychologists, social workers).

Appendix C. An Evidence-Based Framework for Primary Care–Behavioral Health Integration: Six-Month Follow-Up Interview Guide for Practice Decision Makers (Continued)

4. Tell me about your overall experience in the past six months in meeting the objectives set for this practice. *[Describe for each domain and element in Framework]*
    - How successful do you think the practice has been in meeting each objective?
    - Are there any domains that your practice worked on besides the initial ones chosen? If so, please tell us what they were and your overall experience.

Now I'd like to ask about your use of the Framework tool to change any of the workflows in your practice.

5. How did this practice go about implementing practice changes needed to achieve objectives?

6. How useful was the Framework for making decisions on six-month objectives and developing the plan? *[Describe for each objective in Framework]*

We'd now like to ask you about some of the factors that may be helping your practice or perhaps creating barriers to meeting the objectives of your six-month plan.

7. What are some factors outside the practice that might be helping you to achieve the objectives of your plan?
    - State pressures and incentives
    - Payer requirements and incentives
    - Specialist availability and cooperation

8. What are some factors outside the practice that might be creating barriers to achieving the objectives of your plan?
    - State pressures and incentives
    - Payer requirements and incentives
    - Specialist availability and cooperation

9. What are some internal factors in this practice that might be helping you to achieve the objectives of your plan?
    - Structural characteristics (e.g., size of practice)
    - EHR issues (tracking capabilities, computer systems)
    - Culture and values
    - Financial considerations
    - Lack of time for training
    - Patient compliance

10. What are some internal factors in this practice that might be creating barriers to achieving the objectives of your plan?
    - Structural characteristics (e.g., size of practice)
    - EHR issues (tracking capabilities, computer systems)
    - Culture and values
    - Financial considerations
    - Lack of time for training
    - Patient compliance

11. How useful have the monthly webinars been to your progress? What improvements or topics for discussion might you recommend?

12. Given your experience in the past six months of trying to achieve behavioral health integration objectives for this practice, how do you think you will use the Framework to develop your next set of objectives?

13. Is there anything else you'd like to tell me about your experiences with the Framework?
    - Suggestions for changes to Framework
    - Feedback on webinars/technical assistance

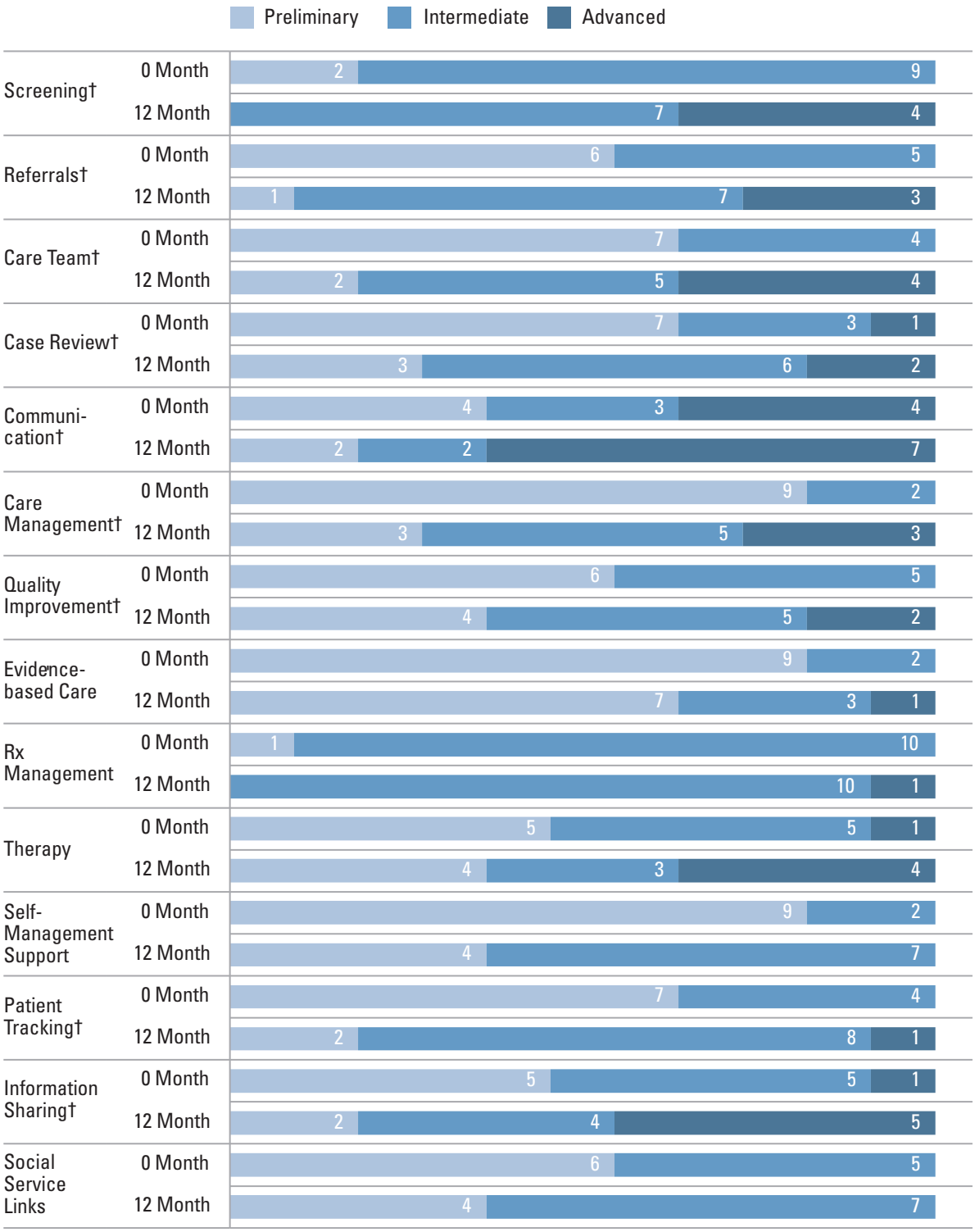
14. At this point, how likely is it that your practice will be able to sustain your BHI work in 2018 and beyond?

15. What factors might help your practice sustain its BHI work beyond 2018?

16. What factors might prevent your practice's sustaining this BHI work beyond 2018?

THANK YOU FOR TAKING THE TIME TO TALK WITH US TODAY.

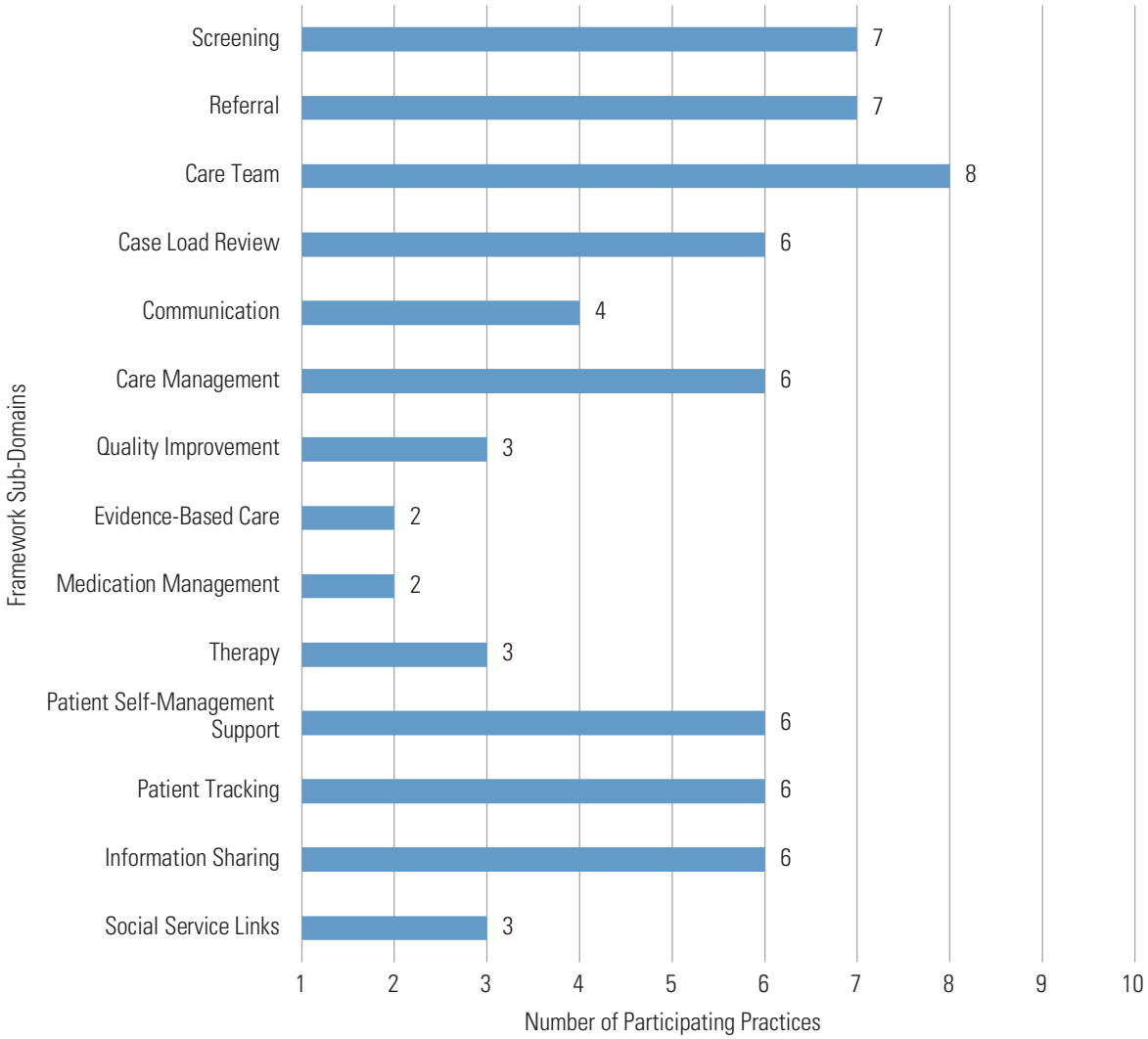
Appendix D. Practices' 12-Month BHI Advancement Along the Original Framework*



* Chung H, N Rostanski, H Glassberg, and HA Pincus. 2016. *Advancing Integration of Behavioral Health into Primary Care: A Continuum-Based Framework*. New York: United Hospital Fund. https://uhfnyc.org/publications/publication/advancing-integration-of-behavioral-health-into-primary-care-a-continuum-based-framework/

† Selected by more than 50 percent of sites to target

Appendix E. Number of Sites Advancing at Least One Stage over Twelve Months (in Domains and Sub-Domains of Original Framework)*



* Chung H, N Rostanski, H Glassberg, and HA Pincus. 2016. *Advancing Integration of Behavioral Health into Primary Care: A Continuum-Based Framework.* New York: United Hospital Fund. https://uhfnyc.org/publications/publication/advancing-integration-of-behavioral-health-into-primary-care-a-continuum-based-framework/

Appendix F. Practices' Self-Reported Quality Metrics (n=8 responses to survey, of 11 practices)

Screening Metrics	Site 1		Site 2		Site 3		Site 4		Site 5		Site 6		Site 7		Site 8	
	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018
Total % of unique patients ≥12 years old seen at the PCP site who received at least one depression screening (PHQ–2, PHQ–9, or PHQ–A)	42%	33%	20%	23%	79%	90%	100%	100%	59%	90%	0%	7%	15%	73%	34%	35%
Total % of unique patients ≥12 years old who had an initial positive screen for depression, at least PHQ2 positive	n/a	n/a	2%	6%	9%	17%	n/a	n/a	n/a	n/a	0%	37%	n/a	n/a	25%	29%
Total % of unique patients ≥12 years old scoring ≥10 on the PHQ–9 or PHQ–A and/or in treatment	n/a	n/a	n/a	n/a	9%	17%	n/a	n/a	28%	28%	0%	15%	n/a	n/a	20%	30%

Depression Monitoring Metric	**Prompt Follow-Up for Patients Diagnosed with Depression**
NUMERATOR: Patients with documented results of at least two PHQ9 or PHQA scores (including the initial PHQ9 or PHQA), within 4-8 weeks after initial assessment	**NUMERATOR:** Patients with two documented contacts (e.g., visits, successful phone calls) within 4-8 weeks after initial assessment of depression
DENOMINATOR: Patients age ≥12 seen for any reason, with a new or existing diagnosis of Major Depressive Disorder or Dysthymic Disorder, or with clinically significant symptoms on a standardized tool (e.g., PHQ-9 score ≥10)	**DENOMINATOR:** Patients age ≥12 seen for any reason with a new diagnosis of Major Depressive Disorder or Dysthymic Disorder, or with clinically significant symptoms on a standardized tool (e.g., PHQ-9 or PHQA score ≥10)

Depression Monitoring	Site 3		Site 5		Site 10	
	2017	2018	2017	2018	2017	2018
Total %	42%	62%	41%	71%	31%	51%

Prompt Follow-up for Patients with Depression	Site 3		Site 5		Site 10	
	2017	2018	2017	2018	2017	2018
Total %	42%	62%	20%	36%	31%	51%

Revenue Metrics	Site 2		Site 3*		Site 4		Site 5	Site 6
	2017	2018	2017	2018	2017	2018		
Monthly revenue for depression screening	$20.92	$2,139.94	$1,090.40	$955.63	$382.20	$2,357.44	No ability to report on relationship between depression screening and revenue	No billing in 2018, only DSRIP reimbursement
Number of patients billed for depression screening	1	573	135	201	55	249		

* Site 3 noted that despite performing more screens in 2018 revenue was comparatively less—possibly due to delays in the billing system capturing the most recent payments. There might also be a difference in reimbursements based on the payer mix for each year, they noted, with some insurance covering depression screening on a fee-for-service basis and others as part of a capitation agreement.

Appendix G. Template: Collaborative Care Agreement*

COLLABORATIVE AGREEMENT

This document outlines the referral agreement between _____and _____ for pre-consultation exchange, formal consultation, and co-management of chronic disease or illness. The purpose of this agreement is to provide a framework for better communication, coordination of care, and the transition of care between primary care (PCP) and specialty care (SCP) providers to eliminate waste and excess cost of health care, as well as optimizing patient health.

_____(PCP) and _____ (SCP) agree to collaborate in the care and treatment of patients as set forth below.

_____[Allotted days per week], an SCP will come to the PCP office to be available to see patients onsite.

The PCP office will provide office space and a laptop with secure access to create and incorporate patient notes at the time of service. The SCP will be responsible for billing for his/her own services.

The PCP agrees that referrals to the SCP shall include a reason for the referral; any thought process related to that reason; clinical information including diagnosis, problem list, pertinent diagnostic tests, medication list, and allergy list; and the timeframe within which the referral is requested.

The SCP agrees to send all new clinical information back to the PCP with care recommendations.

The PCP and SCP agree to the following types of care management/referral transitions. (Check all that apply)

☐ **Pre-consultation exchange** – communication between PCP and SCP to:

- ☐ Answer a clinical question and/or determine the necessity of a formal consultation with the SCP.
- ☐ Facilitate timely access and determine the urgency of referral to the SCP.
- ☐ Facilitate diagnostic evaluation of the patient prior to the SCP's assessment.

☐ **Formal consultation**—referral for advice:

- ☐ Request for referral and/or advice on a discrete question regarding a patient's diagnosis, diagnostic test results, procedure, treatment, or prognosis, with the intention that patient care will be transferred back to the PCP after one or a few visits.
- ☐ The SCP will provide a detailed report on the diagnosis and recommended care and NOT manage the care; this report may include an opinion on the appropriateness of co-management.
- ☐ The SCP is responsible for communicating with the patient on any diagnostic test results until the SCP transitions the patient back to the PCP.

(Continued)

* Adapted from Keuka Primary Care Associates

Appendix G. Template: Collaborative Care Agreement (Continued)

☐ **Co-management for chronic disease/illness:**

- ☐ Both the PCP and SCP actively contribute to patient care for a medical condition and are responsible for defining their individual responsibilities for communication with the patient, drug therapy, referral management, diagnostic testing, and patient follow-up.
- ☐ The PCP continues to receive consultation reports and provides input on secondary referrals and quality of life and treatment decision issues.
- ☐ The PCP continues care for all other aspects of patient care and new or other related health problems and remains the patient's first contact.

This agreement outlines expectations between the PCP and SCP. It does not, in any way, limit the patient's freedom to select his/her physician of choice or make a self-referral to a provider of the patient's choice. Both parties agree to review agreed-upon objectives and expectations throughout the collaboration, including data for mutual use for the purpose of quality improvement.

Patient confidentiality will be maintained as per HIPAA. SCP access to PCP records is limited to information pertinent and germane to patient issues being treated by the SCP.

APPROVAL SIGNATURES

Primary Care Provider

Authorized name _____

Title _____

Signature _____

Date _____

Specialist Care Provider

Authorized name _____

Title _____

Signature _____

Date _____

Appendix H. Cheat Sheet on Medicare Payments for BHI Services*

Code†	Former Code	Description	Documentation Required	Fee Schedule Estimates (PCP Settings)
96127	N/A	**Administration, scoring, and documentation of a brief behavioral/emotional screening** Examples: PHQ-9, GAD-7, AUDIT, DASS-21	Per screen administered with scoring and documentation, per standardized instrument	$5.35
99492	G0502	**Initial psych care management, 70 min/month (CoCM)** First 70 minutes in the first calendar month for BH care manager activities, in consultation with a psychiatric consultant and directed by the treating provider	• Outreach and engagement of patients; • Initial assessment, including administration of validated scales and resulting in a treatment plan; • Review by psychiatric consultant and modifications, if recommended; • Entering patients into a registry and tracking patient follow-up and progress, and participation in weekly caseload review with psychiatric consultant; and • Provision of brief interventions using evidence-based treatments such as behavioral activation, problem-solving treatment, and other focused treatment activities	$161.28
99493	G0503	**Subsequent psych care management, 60 min/month (CoCM)** First 60 minutes in a subsequent month for BH care manager activities	• Tracking patient follow-up and progress; • Participation in weekly caseload review with psychiatric consultant; • Ongoing collaboration and coordination with treating providers; • Ongoing review by psychiatric consultant and modifications based on recommendations; • Provision of brief interventions using evidence-based treatments; • Monitoring of patient outcomes using validated rating scales; and • Relapse prevention planning and preparation for discharge from active treatment	$128.88
99494	G0504	**Initial/subsequent psych care management, additional 30 min (CoCM)** Each additional 30 minutes in a calendar month of BH care manager activities listed above	Listed separately and used in conjunction with 99492 and 99493	$66.60

(Continued)

* AIMS Center. 2018. *Cheat Sheet on Medicare Payments for BHI Services.* University of Washington, Psychiatry & BH Sciences. aims.uw.edu

† Current Procedural Terminology (CPT®). 2017. Copyright American Medical Association. All Rights Reserved. CPT is a registered trademark of the American Medical Association.

Appendix H. Cheat Sheet on Medicare Payments for BHI Services (Continued)

Code†	Former Code	Description	Documentation Required	Fee Schedule Estimates (PCP Settings)
99484	G0507	**Care management services, minimum 20 min (General BHI Services)** Care management services for BH conditions—at least 20 minutes of clinical staff time per calendar month	• Initial assessment or follow-up monitoring, including use of applicable validated rating scales; • BH care planning in relation to behavioral/ psychiatric health problems, including revision for patients who are not progressing or whose status changes; • Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling, and/or psychiatric consultation; and • Continuity of care with a designated member of the care team	$48.60

Initiating Visit, Consent, and Co-Payments: An initiating visit is required prior to billing for the 99492, 99493, 99494, and 99484 codes. This visit is required for new patients and for those who have not been seen within a year of commencement of integrated BH services. This visit will include the treating provider establishing a relationship with the patient, assessing the patient prior to referral, and obtaining broad beneficiary consent to consult with specialists, which can be verbally obtained but must be documented in the medical record. Medicare beneficiaries must pay any applicable Part B co-insurance for these billing codes.

BH Care Manager Qualifications: The BH care manager has formal education or specialized training in BH, which could include a range of disciplines including social work, nursing, and psychology, but need not be licensed to bill traditional psychotherapy codes.

Provision of Additional Psychotherapy and Psychiatric Services: BH care managers qualified to bill traditional psychiatric evaluation and therapy codes for Medicare recipients may bill for additional psychiatric services in the same month. However, time spent on these activities for services reported separately may not be included in the services reported using time applied to 99492, 99493, 99494, or 99484. Similarly, psychiatric consultants working in the CoCM model may also furnish face-to-face services directly to the patient but may not bill for the same time using multiple codes.