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Advancing Behavioral Health Integration for Small Primary Care Practices: Progress, Emerging Themes, and Policy Considerations

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Foreword

Bringing behavioral health services into primary care, to make the diagnosis and treatment of depression, anxiety, and other common behavioral health conditions as accessible and acceptable to patients as medical care, is increasingly recognized as an important component of high-quality care. But for many of the small practices that are the backbone of primary care in New York City and State, the disruption of routines and the new resources needed place that objective frustratingly out of reach.

With the 2016 introduction of an innovative "continuum-based framework" for behavioral health integration (BHI), a team led by Henry Chung, MD, and Harold Pincus, MD, with grant support from United Hospital Fund, brought the possibility of achieving that goal significantly closer. Since the release of its initial report, *Advancing Integration of Behavioral Health into Primary Care*, the team has worked with 11 small provider groups to test the practicality and efficacy of the framework on the ground. With additional grant support from United Hospital Fund for work with six New York City-based practices, and new support from the New York State Health Foundation for work with five practices elsewhere in the state, the team has been providing guidance, tracking progress, and absorbing lessons about the challenges and successes of implementation.

This issue brief is the second of a series of three reporting on this expanded effort. It discusses the progress made, at the midway mark, toward achieving the specific goals each practice initially set for itself; highlights the experiences of three of the practices, and one payer's efforts to support BHI; and offers insights on policy and financial considerations important to the undertaking.

We are pleased that our collaborative support is helping advance the framework and its promise as an effective, practical approach to making primary care ever more comprehensive, and hope this report encourages additional practices to take their first steps toward behavioral health integration.

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Introduction

Introducing behavioral health services into small primary care settings enhances patient-centered care and provides higher-quality care and greater treatment options for patients with behavioral health conditions such as depression and anxiety. Untreated, these conditions considerably increase suffering and the annual cost of patient care, especially when co-morbid with medical illness.[1] For small practices already facing the burden of narrow operating margins and heavy patient caseloads, the ability to achieve the Triple Aim of improved quality, improved patient satisfaction, and lower costs requires the adoption of a practical and sustainable behavioral health integration (BHI) model. Integration allows practices to improve patient care with more options in treatment planning, reinforces holistic care, and aligns with team-based care.

The continuum-based framework ("the Framework") described in previous United Hospital Fund publications and included here as Appendix A offers a roadmap for successful adoption of BHI by small primary care practices. Additionally, New York State programs such as the Collaborative Care Initiative, Delivery System Reform Incentive Payment (DSRIP) program, and Advanced Primary Care/Patient Centered Medical Home provide incentives and assistance that enable many such practices to begin to augment workflows, measure and track patient outcomes, and identify the appropriate integration approach for their specific practice. But resource gaps and concerns about the sustainability of the required investments to implement full BHI require additional policies and payment mechanisms to sustain ongoing efforts.

Small practices face complex and inconsistent information on billing and reimbursement, program reporting, and State regulations related to their implementation efforts; existing regulations need improvement to better facilitate the advancement of BHI. Payer participation is also needed to clarify expectations on billing requirements and reimbursement rates for behavioral health services, as value-based payment models gain more prominence. Despite these challenges we believe that use of the Framework, in combination with improved policies and payment mechanisms, will position even small primary care practices to align their efforts with existing New York State initiatives.

This issue brief is the second of a three-part series examining the progress achieved by 11 small primary care practices working to implement BHI with guidance from the Framework and monthly technical assistance

1 Institute for Healthcare Improvement. 2014. *90-Day R&D Project Final Summary Report: Integrating Behavioral Health and Primary Care.* Cambridge, MA: Institute for Healthcare Improvement. Accessible at www.ihi.org

webinars. The goal is to provide a current overview of the practices' successes and challenges, to help clinicians and policymakers adjust improvement strategies and policies at a time of rapid health care transformation in New York.

In the first issue brief, we presented results from a baseline BHI readiness assessment and the initial six-month goals of these 11 practices. In this issue brief, we highlight practices' progress toward their initial goals, and spotlight the experiences of three of those practices, as well as a payer piloting a BHI strategy for small practices, in their own words.

This brief also includes a summary of the emerging themes described in feedback from the practices as they progress along the Framework's continuum, including challenges and lessons learned. Finally, we share some perspectives for policymakers and payers to consider, summarized from a meeting of a diverse group of leaders supporting BHI in New York State (Appendix B).

The final report, to be released in late fall 2018, will discuss the extent to which participating practices advanced their level of integration over the course of the year, using the Framework as a guide, and will explore the strategies they applied to achieve their goals. These findings will also help update and improve the Framework for future use and further inform practitioners and policymakers on spreading BHI implementation across the state.

Emerging Themes

Throughout the past six months, four common themes and needs for action have emerged as our 11 participating practices worked on BHI implementation. These themes (see box) were discussed at an expanded stakeholder meeting held at UHF on December 5, 2017, led by the project team. Attendees included providers, policymakers, payers, and advocates, along with our grant funders, UHF and the New York State Health Foundation (see Appendix B). Presentations by participating practices prompted in-depth discussions on opportunities for decreasing regulatory burden to advance BHI, partnerships to foster collaboration between primary care and behavioral health providers, and strategies for increasing financial sustainability for BHI.

Key Emerging Themes for Policymaker and Payer Consideration

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 in value-based payment models

PC-BH Partnerships and Regulatory Reform

- Clarify guidance on information sharing between PC-BH
- 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

- Pay for value and provide incentives to advance BH integration progress on the continuum Framework
- Promote the use of new and existing health and behavioral codes consistent with BHI in primary care billing

Overview of Preliminary Results

The 11 participating practices[2] used the Framework as a guide to identify their level of integration at the start of the project (April 2017) and to set six-month goals for advancement in selected domains of the eight delineated by the Framework. The most commonly chosen were: Case Finding, Screening, and Referral to Care (Domain 1), Information Tracking and Exchange among Providers (Domain 7), and Ongoing Care Management (Domain 3). The practices participated in monthly technical assistance webinars and review calls, and shared their implementation experiences during our site visits.

In September 2017, we administered a six-month progress survey to assess how each practice rated its level of BHI, based on the Framework. Survey results (Appendix C) showed all practices successfully advancing from preliminary levels of integration to intermediate or advanced stages in their chosen domains.

The practices reported that integration efforts resulted in enhancements to billing revenue, referral partnerships, access to and quality of care, and patient engagement. Practices administering the PHQ-2/PHQ-9 depression screening questionnaire had begun to streamline workflows to ensure systematic use of that tool to screen all adult patients, and had begun to bill consistently for this service. As a result, those practices reported greater identification of at-risk individuals and an increase in revenue from billing for depression screening. Providers noted that they now view depression screening scores as a health vital sign, complementing chronic disease management. By integrating depression scores into patients' electronic health records and tracking subsequent scores, providers have been better able to engage patients by showing them their own scores and adjust treatment and patient education on self-management activities.

Once practitioners gained experience in applying PHQ-2/PHQ-9 measures and discussing the results with their patients, their comfort with diagnosing and managing depression also increased. They appear to be more open to learning about medication management and willing to co-manage complex patients. They cited increased attention to "warm handoffs"—in-person transitions from one provider to another—for

2 A merger with another organization led one practice to withdraw when it could no longer devote the resources it had allotted to the project. The practice did complete the six-month survey, and those results will be included in our final report and analysis.

example, directly introducing the patient to the practice's embedded behavioral health specialist during an appointment or, in the case of an external referral, paying greater attention to follow up using tracking tools and/or care management support.

As practitioners become more engaged in managing BH conditions, they are exploring ways in which to work more effectively with their embedded behavioral health colleagues or external referral partners (Appendix D). Information shared between primary care and behavioral health providers is valued when concise and targeted to the patient care plan and to guiding medication management. Additionally, practices are making an effort to create more formal collaborative agreements with their behavioral health partners to outline expectations for information sharing, co-location arrangements and workflows, billing of services, and clinical documentation (Appendix E). Agreements may not need to be legal in nature; rather, they may lay out specific areas and tasks on which both practices are expected to interact to improve care for patients with behavioral health conditions. Participants report that these strategies are reducing obstacles to caring for behavioral health patients and making their treatment more seamless and coordinated.

Integration Advancement: Small Practice Spotlights

To offer a clearer picture of the complexities of implementing BHI, we invited three sites to describe their interim experiences using the Framework as a guide.

At Keuka Family Practice in Bath, NY, our small physician group has made significant advances in improving access to behavioral health services and care management for the nearly 7,000 patients who visit our clinic annually. In a region with limited behavioral health resources, our practice is motivated to become more efficient and effective at delivering behavioral health care and committed to empowering our patients to set goals and guide their decisions on managing their health and well-being. To do this, we selected Framework goals of strengthening our process for warm handoffs to a behavioral health specialist or psychiatrist, either co-located or external, and establishing proactive follow up to optimize patient engagement and improvement (Domains 1 and 3).

With the partnership support of our accountable care organization, Accountable Health Partners (AHP), we were able to embed a care manager into our team to help coordinate complex patient follow ups. The use of a care manager with behavioral health training has provided the practice with the ability to not only manage patients' behavioral health conditions but also to assess how the impact of social determinants of health can be addressed. With the guidance of our care manager, the practice has developed a more patient-centered approach to treatment by setting up regular coordinated care meetings that include the primary care provider, care team, community services, and patient.

In conjunction with care management, our practice developed a close relationship with Clinical Associates of the Southern Tier, a behavioral health care center in the area. With the help of our DSRIP Finger Lakes Performing Provider System we formalized our relationship into a collaborative agreement that sets out our operational expectations for behavioral health service delivery, service billing, information sharing, and co-location (see modified version in Appendix E). With the collaborative agreement, a licensed social worker is co-located at our practice for 1.5 days a week. The social worker shares her clinical notes with our care team in our electronic records system. We notify our patients that information is shared among our providers and receive their consent to support our collaborative treatment structure. This partnership allows us to treat behavioral health conditions in our patient community directly, to minimize stigma and increase adherence to treatment and medication.

We have learned that successful primary care–behavioral health collaborations rely on clear communication, focus on capacity building, and support smooth information flow between organizations. It was important to our practice that our entire team was aware of our collaborative agreement with Clinical Associates to ensure that partnership expectations and goals were supported and adopted by all. Through the collaborative agreement, our practice has experienced first-hand the ease of working with our behavioral health partners to set shared values and become more reflective of and responsive to the needs of our community, our patients, and our clinician teams.

At Koinonia Primary Care we are compelled by our faith to provide compassionate care for the uninsured and underinsured residents of West Hill, the poorest, most underserved neighborhood in Albany, NY. Because we provide care without regard to patients' ability to pay, our care team often operates under a bare-bones staffing structure, relying on modest salary and volunteer support. Our dedication to mental health service delivery and integrated care dates back to our inception in 2001 under the leadership of Dr. Robert "Bob" Paeglow, who grew up in this neighborhood and understood that to keep his patients from falling through the cracks he had to serve both their physical and behavioral health needs.

Many of our patients face great social and mental health challenges. To respond to this crisis, we co-located behavioral health services directly in our clinic with the early hire of Dr. Anna Leung, a licensed psychologist, as a vital member of our care team. With her direction we now screen all our patients 13 years and older for depression using the PHQ-9, along with the GAD-7 for anxiety, ACE for past traumatic experiences, and MDQ screens for bipolar illness. Our regular screening showed us that up to 40 percent of our patients scored above 10 on the PHQ-9 in 2017—indicating a depressed and high-need population. With our participation in the Framework project and recent attainment of PCMH Level III status, we have achieved important recognition of our BHI efforts.

In beginning our work on the project, we were determined to set as our goal advancement in all eight domains of the continuum. This ambitious effort aligned with our work to achieve PCMH status and our long history of working to incorporate behavioral health services directly into our primary care setting. An innovative feature of our practice is the use of integrated care visits for our complex behavioral health patients, to ensure that they are not lost to care during provider handoffs. Recognizing that warm handoffs play a crucial role in the seamless transition of care between behavioral health and primary care teams, we schedule visits so that both primary care providers and behavioral health professionals see patients together or in back-to-back appointments. Patients see both providers for 20- to 30-minute interventions each, typically for four to six, or even more, visits. This level of engagement has been well received by our patients and has greatly improved their ability to cope with trauma and adhere to treatment, as a result of having their needs heard.

To sustain our BHI work, and to continually strive to do it better, we are committed to measuring our progress. We have begun to utilize our screening data to help patients be more empowered and aware of their behavioral health outcomes. We have learned through our electronic health record the power of using graphical depictions of PHQ-9 scores (Appendix F), and frequently use such graphs to show patients how their scores may fluctuate over time depending on their adherence to their care plan and to treatment. Patients are informed about how their scores reflect their outcomes and are engaged in action planning to maintain their progress. With this information, patients can become more proactive in their care.

Lastly, to continue building our behavioral health care acumen and strengthen our integrated practice dynamic, we have incorporated regular case conferences to discuss complex patients, and have hired a consulting psychiatric nurse practitioner to provide additional guidance on the toughest cases. This collaboration among disciplines is allowing us to deliver better behavioral health care for our patients. We value the ability to take concrete steps to improve our patients' health outcomes; as we continue to strengthen our BHI structure, we will find additional ways to incorporate quality and measurement to refine our work. We will also continue our effort to increase reimbursements for behavioral health services to bring life and hope back into this severely challenged health landscape.

At Delmont Medical Care, our practice is determined to make behavioral health integration a sustainable transformation, under the leadership of Jacqueline Delmont, MD, MBA. We are a multi-site primary care practice on the south shore of Long Island, serving approximately 20,000 patients. We began our behavioral health integration efforts at our Far Rockaway location, where we care for 3,500 patients per year. Our behavioral health services have grown through strategic partnerships under the DSRIP BHI project, city initiatives such as NYC Thrive, and our external behavioral health service referral partner, Catholic Charities. Since 2014, we have had onsite PHQ-9 depression screenings for all patients over the age of 12 as part of their annual wellness visit. We have also established a behavioral health co-location partnership through the provision of a New York City Mental Health Service Corps social worker to support warm handoffs and behavioral health care management.

With these investments, we decided to join the Framework project to receive technical assistance on how to motivate our clinicians and staff to adopt our behavioral health service transformation. Our Framework goals are focused on strengthening our ability to manage and track patient referrals, with effective follow up supported by information sharing between the primary care provider and behavioral health providers. We are also developing a registry to identify patients requiring enhanced and ongoing care management through more targeted and facilitated warm handoffs. We prioritize the use of metrics to provide payers with an array of performance and process data that illustrate our BHI investment and patient outcomes.

As a small practice with limited time and resources, it takes a remarkable effort to keep up with the evolving regulatory standards, payment structures, and reporting expectations of New York State and New York City system transformation programs. Our participation in these programs helps to create a sustainable model of care that is driven by quality and performance metrics. Recently, we trained our staff in the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model for alcohol and substance use to tap potential reimbursement for a service we have been providing for many years. These opportunities provide significant financial support for small practices working beyond their capacity to deliver whole-person care to a struggling and overlooked population.

To be successful in BHI, we have learned to continuously seek new ways to be rewarded for our high performance and to have our behavioral health services appropriately reimbursed. Since 2014 we have been billing for PHQ-9 screens (Appendix G); to help our practice teams understand and adopt a standardized billing system we have developed a list of revenue opportunities by compiling behavioral health-related codes (Appendix H). Yet despite all our efforts, we are not close to covering the costs of our BHI investment, because many of our commercial payers are inconsistent in their payments for behavioral health services. We need more payers to recognize the effort that is being invested by primary care clinicians to improve behavioral health care for their patients.

Payer Support: Innovation on the Provision of BHI

For primary care practices, advocacy for payer alignment in behavioral health integration is a priority that spans fee-for-service as well as value-based arrangements so critical to BHI sustainability efforts. In this section, Larry Grab, staff vice president for Behavioral Health Utilization Management at Anthem, and Robert LaPenna, network director for Payment Innovation Programs at Empire BlueCross BlueShield, discuss their work to increase primary care and behavioral health provider partnerships and promote the use of value-based payment in behavioral health service reimbursement.

Empire is focused on total population health management and built various aspects of health improvement into our value-based payment models for primary care, known as our Enhanced Personal Health Care Program. Studies and our own data analysis show the growing cost impact of behavioral health conditions on chronic illness. We have also heard from our medical providers that behavioral health treatment represents a significant gap in care, affecting multiple chronic conditions, which needs to be addressed to improve overall patient care.

One of our initial approaches engaged our behavioral health providers in helping to decrease the potential stigma related to receiving these services. We recognized the opportunity presented by providing behavioral health care in the primary care setting, leveraging the trusted doctor-patient relationship. Empire not only reimburses for various behavioral health screenings and assessments by primary care providers and treatment by behavioral health specialists when necessary but also supports better engagement of specialists to accept referrals for patients who need these services but may not have a formal behavioral health diagnosis.

Thus we promoted the use of Health & Behavioral Assessment and Intervention (HBAI) codes, making it possible for BH specialists to address patient knowledge deficits in chronic illness, stress management, and building skills for treatment adherence in patients with chronic conditions such as diabetes. We allow behavioral health providers to use a medical diagnosis in conjunction with these health codes, thus permitting a referral by a medical provider to a behavioral health provider even if a patient has not yet manifested symptoms of a formal mental disorder. This shifts the provider-patient discussion to focus on a behavioral intervention rather than a mental health condition, to reduce patient stigma and foster holistic care.

As a result of these efforts, in 2016 we experienced a 20 percent increase in the use of HBAI claims submissions, the largest increase since first promoting them in 2014. We continue to promote these codes to our behavioral health care providers and educate our medical providers on how to have conversations with their patients about a potential referral to a behavioral health specialist.

Moreover, in 2017 Empire launched a behavioral health provider pay-for-performance program focused on medical-behavioral integration. We identify primary care practices with a demonstrated commitment to addressing behavioral health issues, and link each practice with a local behavioral health provider. Behavioral health providers are encouraged to collaborate with local primary care providers

through quality incentives focused on development of a mutual care compact, which includes timeliness of referral and engagement in behavioral health treatment, care coordination, information sharing, the use of assessment tools throughout treatment, and accountability for treatment outcomes.

Behavioral health providers engaged in the integrated pay-for-performance programs receive feedback throughout the measurement period on how their performance compares with agreed-upon targets. Identified issues or "pain points" are discussed and assistance in remediating them may be provided. While the program is relatively new we have seen some positive results, including behavioral health providers expanding to office space closer to a primary care practice, or a primary care practice embedding a behavioral health provider for a day or a few hours per week, for immediate consultation, screening and assessments, and education for the primary care team.

Key Policy Considerations

The BHI Framework evaluation project has two main goals: 1) to assess the utility of an evidence-based Framework to be used as a technical assistance tool for BHI by small primary care practices, and 2) to inform practitioners, payers, and policymakers about how to support and incentivize BHI advancement in primary care. At the mid-point of the project, several important issues have emerged with critical relevance to policymakers and payers.

Billing and revenue support. One concern regularly cited by both primary care and behavioral health providers is the need for greater payer involvement, understanding of the barriers providers face, and support for strategies to overcome these barriers. Providers lack a clear understanding of billing requirements that are often seen as vague, inconsistent, inadequate, and potentially unsustainable. Many primary care providers are unsure of the steps involved in billing for behavioral health services or are unaware of codes available to them. Primary care providers would benefit from increased transparency on what services are reimbursable, the reimbursement rate, and how claims should be submitted for payment. With current reimbursement inconsistencies among payers, many small primary care practices are unable to project behavioral health revenue to measure their dollar return on time, resources, and training. Furthermore, the lack of value-based payments tied to BHI performance limits the incentives for practices to measure and track the quality and effectiveness of their behavioral health care.

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 (Appendix I) for behavioral health clinicians participating in the Collaborative Care Model (CoCM). CMS has also ruled that Federally Qualified Health Centers and Rural Health Clinics are able to receive separate payments for CoCM and BHI services, which are now defined as "primary care services."[3] However, there are still many challenges in billing and documentation for behavioral health services that need to be addressed to incentivize and sustain primary care–behavioral health practice transformation with respect to fee-for-service funding.

Assessing quality. To further support value-driven BHI, policymakers and practice groups would benefit from a shift toward reporting on process and outcome measures that reflect evidence-based integration. Most

3 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. Accessible at cms.gov/newsroom; https://www.acponline.org/system/files/documents/about_acp/.../final_policy.pdf

health plan quality measures related to behavioral health integration are primarily claims-based. A common health plan measure such as antidepressant adherence does not measure meaningful clinical outcomes, such as improvement of depression based on PHQ-9 scores, or key process measures such as early follow up after initiation of treatment. These metrics, currently used by the New York State Collaborative Care Initiative, are likely to be more meaningful to both providers and patients.[4]

Certification. One program possibly positioned to help bridge the metrics and payment gap is the NCQA's "Patient-Centered Medical Home [PCMH] with Distinction in BHI." That designation recognizes primary care practices that meet both core and elective criteria across four competencies related to BHI: Workforce, Information Sharing, Evidence-Based Care, and Measuring and Monitoring.[5]

These broad competencies align with certain levels of specific domains in the Framework, and thus offer a model for how measurement can be linked to competencies and incentivized through reimbursement models such as enhanced fee-for-service and value-based payments (Appendix A orange-boxed elements).

The overlap between PCMH with Distinction in BHI and the Framework reinforces the utility of a technical assistance tool that can track progress on specific components of BHI. For example, NCQA's "Information Sharing" competency recognizes that collaborative agreements between primary care practices and behavioral health specialists are an essential component of an effective referral system. This requirement directly aligns with the Framework's Domain 1 objective of referral to care, exemplified by the successful collaborative partnership formed by Keuka Family Practice and its behavioral health partner, Clinical Associates. Without a specific plan with agreed-upon accountability and processes for both organizations' communication, workflow, and billing, many partnerships are unable to close the loop on patient follow up and struggle with fragmented information.

To attain the Distinction in Behavioral Health designation, practices must be working toward or already have PCMH certification. Until 2020, New York State's Advanced Primary Care initiative will provide primary care practices with guidance to help them achieve PCMH. Along with the State's significant technical assistance resources, use of the Framework and lessons learned from our participating practices can help

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

5 NCQA. 2017. *NCQA PCMH Standards and Guidelines. Appendix 4: PCMH with Distinction in BHI.* Accessible at www.ncqa.org; user registration required to access and download documents on NCQA website.

advance efforts to achieve PCMH certification and potentially Behavioral Health Distinction by helping practices plan and prioritize their work to achieve effective BHI. With or without the behavioral health distinction, attainment of Level 3 PCMH status may serve as an adequate vehicle for sustaining the investments needed to advance BHI, by increasing fee-for-service or value-based payment opportunities.

Regulatory innovation. Regulatory policy also plays a key role in BHI by facilitating innovation and reducing obstacles to implementation. State initiatives such as the Regulatory Modernization Workgroup are working to alleviate barriers to BHI, to foster greater access to behavioral health partnerships and services and improve health outcomes for people with co-morbid medical and behavioral health conditions.

Conclusion

The participation in BHI efforts of practices, payers, policymakers, and other stakeholders throughout New York State has highlighted how BHI and practice transformation have been prioritized. Small primary care practices actively engaged in BHI provide critical input to improve both the Framework and payment mechanisms and regulations that could support wider adoption of BHI among such practices, which make up a critical component of health care delivery in New York.

The cumulative goals of this project's issue briefs, stakeholder meetings, and final report are to better understand the challenges faced by smaller primary care practices attempting behavioral health integration, and to identify implementation and policy strategies to overcome these challenges. Regulatory and payment reforms are important levers that have the potential to enhance the ability of these primary care teams to respond to patients' behavioral health needs while maintaining revenue and quality of care.

In the project's concluding phase, we will compare our initial observations with 12-month survey results and feedback from participating practices. Drawing on survey findings and qualitative interviews conducted during site visits, we will revise the Framework as needed to make it a more precise and useful technical assistance tool. As important, we will propose concrete policies that can potentially overcome the real challenges faced by primary care and behavioral health providers seeking to deliver the highest-quality care.

Appendix A. Identified Overlap between Evidence-Based BHI Framework and the NCQA "PCMH with BH Distinction" Components

(see legend)

Key categories of integrated care			Integration Continuum			
#	Domains	Components	Preliminary	Intermediate		Advanced
1	Case finding, screening, and referral to care	Screening, initial assessment, and follow up	Patient/clinician identification of those with symptoms—not systematic	Systematic screening of target populations (e.g., diabetes, CAD), with follow up for assessment	Systematic screening of all patients, with follow up for assessment and engagement	Population stratification/analysis as part of outreach and screening, with follow up for assessment and engagement
		Referral facilitation and tracking	Referral to external BH specialist/psychiatrist	Enhanced referral to outside BH specialist/ psychiatrist through a formal agreement, with engagement and feedback strategies employed	Clear process for referral to BH specialist/ psychiatrist (co-located or external), with "warm transfer"	Referral and tracking through EHR or alternate data-sharing mechanism, with engagement and accountability mechanisms
2	Multi-disciplinary team (including patients) used to provide care	Care team	PCP and patient	PCP, patient, and ancillary staff member	PCP, patient, and BH specialist	PCP, patient, CM, and psychiatrist (consults and engaged in CM case reviews)	PCP, patient, CM, BH specialist, psychiatrist (consults and engaged in CM case reviews)
		Systematic team-based caseload review and consultation	Communication with BH specialist driven by necessity or urgency	Formal written communication (notes/consult reports) between PCP and BH specialist on complex patients	Regular formal meetings between PCP and BH specialist	Weekly scheduled team-based case reviews and goal development focused on patients not improving
		Availability for interpersonal contact between PCP and BH specialist/psychiatrist	None or very limited interpersonal interaction (occasionally using a patient as a conduit)	Occasional interaction, possibly through ancillary staff members, perhaps sharing reports or labs	In-person, phone, e-mail interactions on a regular basis	PCP and BH specialist/psychiatrist interact informally as needed throughout the day
3	Ongoing care management	Coordination, communication, and longitudinal assessment	Limited follow up of patients provided by office staff	Proactive follow up to assure engagement or early response to care	Maintenance of a registry with ongoing measurement and tracking, and proactive follow up with active provider and patient reminder system	Registry plus behavioral health activation and relapse prevention, with assertive outreach to patients (including field-based visits) when necessary
4	Systematic quality improvement	Use of quality metrics for program improvement	Informal or limited review of BH quality metrics (limited use of data, anecdotes, case series)	Identified metrics and some ability to review performance against metrics	Identified metrics and some ability to review performance against metrics, with designated individual to develop improvement strategies	Ongoing systematic quality improvement with monitoring of population-level performance metrics and implementation improvement projects by designated QI team

(continued)

Legend for NCQA "PCMH with BH Distinction" Linkages

- Behavioral Health Workforce Competency
- Integrated Information Sharing Competency
- Evidence-Based Care Competency
- Measuring and Monitoring Competency

Notes

- **BH Specialist** refers to any provider with specialized BH training
- **CM** can refer to a single person or multiple individuals who have training to provide coordinated care management functions in the PC practice
- **Ancillary staff member** refers to non-clinical personnel, such as office staff or receptionist
- **EBP** refers to evidence-based psychotherapy

Appendix A. Identified Overlap between Evidence-Based BHI Framework and the NCQA "PCMH with BH Distinction" Components (continued)

Key categories of integrated care			Integration Continuum: Preliminary	Intermediate		Advanced
#	Domains	Components				
5	Decision support for measurement-based, stepped care	Evidence-based guidelines/treatment protocols	None or 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 pharmacotherapy	PCP-initiated, limited ability to refer or receive guidance	PCP-initiated, and referral when necessary to prescribing BH specialist/psychiatrist for follow up	PCP-managed with prescribing BH specialist/psychiatrist support	PCP-managed with CM supporting adherence between visits and BH prescriber/psychiatrist support
		Access to evidence-based psychotherapy treatment with BH specialist	Supportive guidance provided by PCP	Available off-site through pre-specified arrangements	Brief psychotherapy interventions provided by BH specialist on-site	Brief interventions provided by BH specialist (with formal EBP training) as part of overall care team, with exchange of information as part of case review
6	Self-management support that is culturally adapted	Tools utilized to promote patient activation and recovery	Brief patient education on condition by PCP	Brief patient education on condition including materials/workbooks but limited focus on self-management coaching and activity guidance	Patient receives education and participates in self-management goal setting and activity guidance/coaching	Systematic education and self-management goal setting with relapse prevention guidance, with CM support between visits
7	Information tracking and exchange among providers	Clinical registries for tracking and coordination	Informal method for tracking patient referrals to BH specialist/psychiatrist	Patients referred to outside BH specialist/psychiatrist with clear expectations for shared communication and follow up	Formal patient registry to manage and track patients, including severity measurement, attendance at visits, and care management interventions	Registry integrated into EHR, including severity measurement, attendance at visits, and care management interventions; selected medical measures tracked when appropriate
		Sharing of treatment information	No sharing of treatment information	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, and shared care plans)
8	Linkages with community/social services	Linkages to housing, entitlement, and other social support services	Referral resources available at practice, no formal arrangements	Referrals made to agencies, possibly some formal arrangements, but little capacity for follow up	Patients linked to community organizations/resources, with formal arrangements and consistent follow up	Developing, sharing, and implementing a unified care plan between agencies

Legend for NCQA "PCMH with BH Distinction" Linkages

- Behavioral Health Workforce Competency
- Integrated Information Sharing Competency
- Evidence-Based Care Competency
- Measuring and Monitoring Competency

Notes

- **BH Specialist** refers to any provider with specialized BH training
- **CM** can refer to a single person or multiple individuals who have training to provide coordinated care management functions in the PC practice
- **Ancillary staff member** refers to non-clinical personnel, such as office staff or receptionist
- **EBP** refers to evidence-based psychotherapy

Appendix B. Attendees: Roundtable on BHI in Small Primary Care Practices, December 5, 2017, hosted by United Hospital Fund

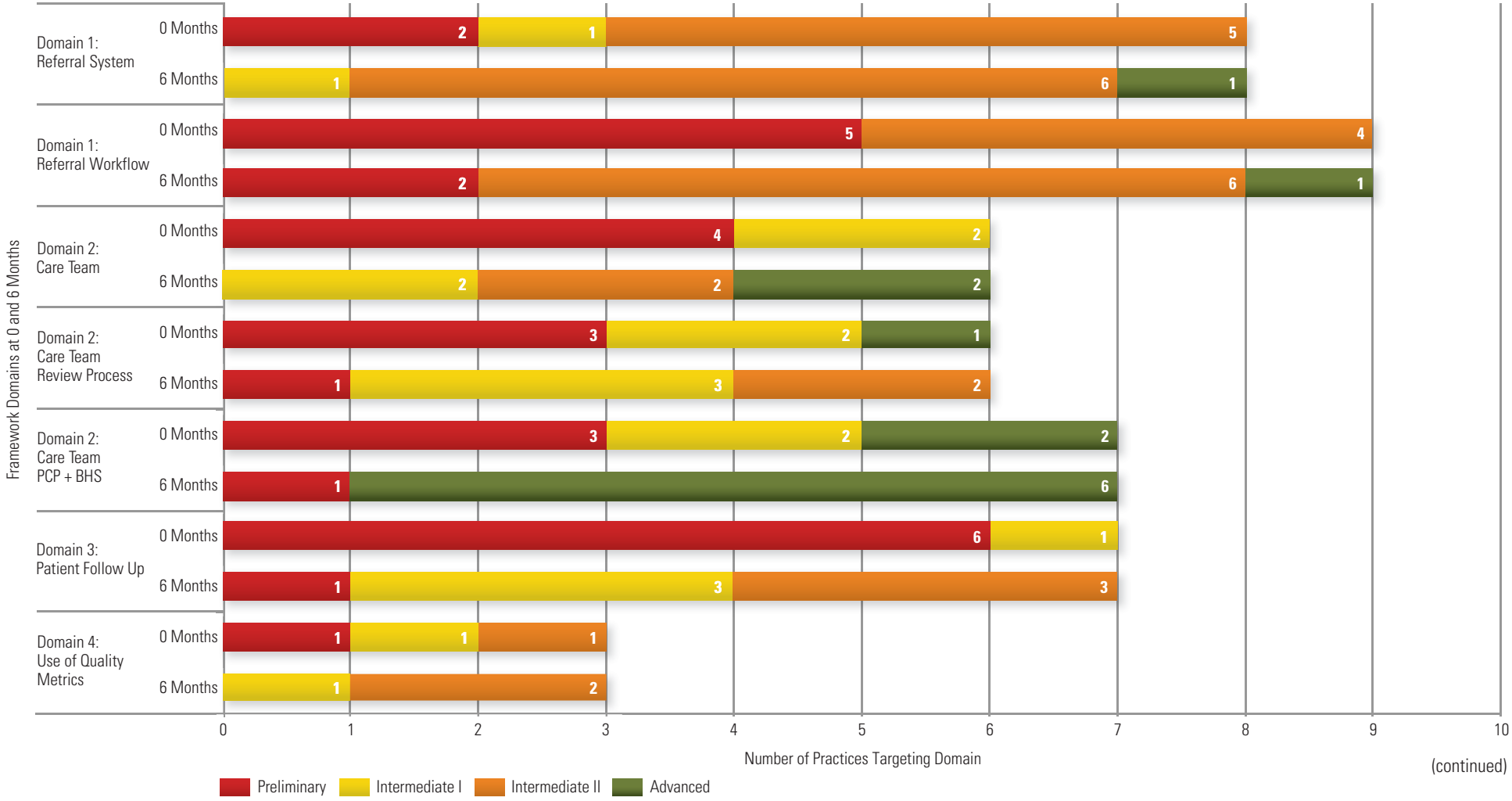
Name	Title	Organization
Melinda K. Abrams, MS	Vice President, Delivery System Reform	The Commonwealth Fund
David Ackman, MD, MPH	Medical Director	Empire BlueCross BlueShield HealthPlus
Jeanne Alicandro, MD, MPH	Medical Director	Office of Quality and Patient Safety, NYC Department of Health and Mental Hygiene
David A. Alloy, PhD	Director of Behavioral Health	Champlain Family Health/Hudson Headwaters FQHC
Gregory Burke, MPA	Director, Innovation Strategies	United Hospital Fund
Brian Byrd, MPA	Program Officer	New York State Health Foundation
Henry Chung, MD	Senior Medical Director/BHI Project Director	CMO, Montefiore Care Management
Richard Cohen, PhD	Director of Behavioral Health	Metro Community Health Center
Jacqueline Delmont, MD, MBA	CEO and Medical Director	Delmont Healthcare
Linda Efferen, MD, FACP	Medical Director	Suffolk Care Collaborative
Florence Fee, JD	Executive Director	No Health without Mental Health
Doug Fish, MD	Medical Director, Division of Program Development & Management	Office of Health Insurance Programs, NYS Department of Health
Matthew L. Goldman, MD, MS	Chief Resident, Department of Psychiatry/BHI Project Fellow	Columbia University, New York State Psychiatric Institute
Larry Grab, MBA	Staff Vice President, Behavioral Health Utilization Management	Anthem BlueCross BlueShield
Deborah Halper, MPH, MSUP	Vice President, Education and Program Initiatives	United Hospital Fund
Kelli Harding, MD	Medical Director of Behavioral Health	United Healthcare, NYS Medicaid Program
Myla Harrison, MD, MPH	Assistant Commissioner	Bureau of Mental Health, NYC Department of Health and Mental Hygiene
Irfan Hasan, MPA	Program Director, Healthy Lives | Health & Behavioral Health	New York Community Trust
Sachin Jain, MD	Executive Director, Primary Care Information Project	NYC Department of Health and Mental Hygiene
Amy Jones, MPH	Director, Primary Care Behavioral Health Integration	NYS Office of Mental Health, Bureau of Psychiatric Services
Linda Lambert, CAE	Executive Director	New York Chapter, American College of Physicians
Robert LaPenna	Network Director, Payment Innovation Programs	Empire BlueCross BlueShield
Sabina Lim, MD, MPH	Vice President, Behavioral Health	Mount Sinai Health System
Pat Lincourt, LCSW-R	Director, Division of Practice Innovation and Care Management	NYS Office of Alcoholism and Substance Abuse Services

(continued)

Appendix B. Attendees: Roundtable on BHI in Small Primary Care Practices, December 5, 2017, hosted by United Hospital Fund (continued)

Name	Title	Organization
Frank Maselli, MD	Medical Director and Partner	Riverdale Family Practice
Daniel Miller, MD	Chief of Clinical Integration and Graduate Medical Education	Hudson River Health Care
Ann Monroe, MA	Co-Chair	NYS Regulatory Modernization Workgroup
Tracy Morgan	Director of Practice Operations	Lourdes Primary Care
Robert Myers, PhD	Senior Deputy Commissioner & Division Director	Adult Services, State Hospitals and Managed Care, NYS Office of Mental Health
Dennis O'Connor, MD	Family Physician	Keuka Family Practice Associates
Robert (Bob) Paeglow, MD	Medical Director	Koinonia Primary Care
Joseph Parks, MD	Medical Director	National Council for Behavioral Health
Jorge Petit, MD	CEO	Coordinated Behavioral Care
Harold Pincus, MD	Professor and Vice Chair of the Department of Psychiatry/BHI Project Senior Consultant	Columbia University
Diego Ponieman, MD	Chief Medical Officer	Advocate Community Partners PPS/Somos ACO
Steven Shamosh, MD, FACP	Internist	New York Chapter, American College of Physicians
Daryl Sharp, PhD, RN	Director of Care Management	Accountable Health Partners PPS
Chad Shearer, JD, MHA	Vice President for Policy	United Hospital Fund
Sarah Shih, MPH	Assistant Commissioner, Primary Care Information Project	NYC Department of Health and Mental Hygiene
Ekaterina (Katy) Smali, MPH, MPA, PMP	Project Manager/BHI Project Manager	CMO, Montefiore Care Management
Joseph Squitieri, MD	Deputy Director of Psychiatry	Community Healthcare Network
Jessica Steinhart, MPH	Director of Ambulatory Initiatives	Staten Island PPS
Anne Sullivan, MD	Commissioner	New York State Office of Mental Health
Sue Sutherland, RN	Care Manager	Keuka Family Practice Associates
David Woodlock, MS	President and CEO	Institute for Community Living
Jin Hee Yoon-Hudman, MD	AVP, Medical Director, Behavioral Health	Healthfirst

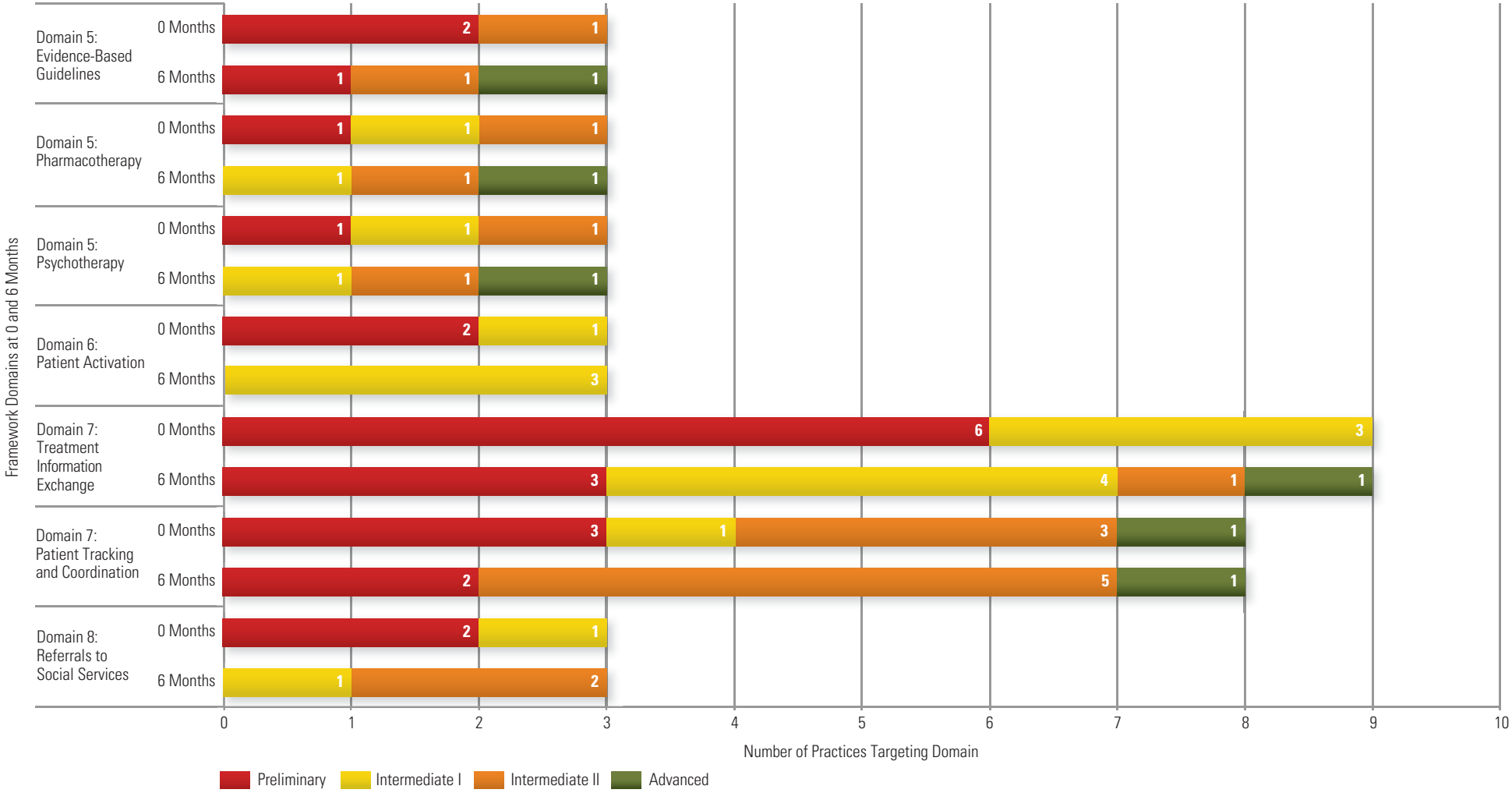
Appendix C. Practice Sites' Six-Month Progress on Framework Goals*



(continued)

* Assessed using the six-month planning and evaluation surveys; these surveys asked respondents to provide feedback only on the domains they had targeted for advancement.

Appendix C. Practice Sites' Six-Month Progress on Framework Goals* (continued)



* Assessed using the six-month planning and evaluation surveys; these surveys asked respondents to provide feedback only on the domains they had targeted for advancement.

Appendix D. Behavioral Health Service Structure and Preferred Referral Partnerships Across the Ten Small Primary Care Practices in the Framework Project

Small Primary Care Practice	NYC/NYS Location	BH Provider, Embedded[§]	Preferred Referral Partner [°ⁱ]	Formal, Signed PC-BH Collaborative Agreement	Informal, Verbal PC-BH Collaborative Agreement
Centro Medico de las Americas	Queens		X	Long Island Consultation Center	
Champlain Family Health	Champlain	X	X	Clinton County Mental Health and Addiction Services for Medication Assisted Treatment	
Delmont Medical Care	Queens	X*	X	Mental Health Service Corps (MHSC), Thrive NY	Catholic Charities St. John's Hospital for Outpatient Psychiatric
Dr. Scafuri + Associates	Staten Island		X		The Center for Integrative Behavioral Medicine, Richmond University Medical Center (RUMC)
Hudson River Health Care, Hudson	Hudson		X	Columbia County Mental Health Center[+]	
Keuka Family Practice	Bath	X*		Clinical Associates of Southern Tier	
Koinonia Primary Care	Albany	X			
Lourdes Family Practice	Owego	X*	X		Lourdes Center for Mental Health
Metro Community Health Center	Bronx	X			
Tremont Health Center	Bronx	X	X		Jewish Board of Family & Children's Services (JBFCS) Bronx R.E.A.L. Recovery-Oriented and Rehabilitation Services (PROS)

§ BH provider is embedded in the practice (co-located or on staff) and paid by the practice administration.

* Embedded BH provider is paid by referral partner or DSRIP PPS dollars.

° Preferred Referral Partner (embedded, co-located, or external) characterized by an informal, verbal agreement OR a formal, signed collaborative agreement (Appendix E) to establish clear expectations for referral communication, information sharing, workflow, and follow up.

+ Formal collaborative agreement is in the process of negotiation and expected to be signed in 2018.

Appendix E. Collaborative Care Agreement Template for Small Primary Care Practices, Adapted from Keuka Primary Care Associates

COLLABORATIVE AGREEMENT

This agreement 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 to send referrals that include a reason for the referral, any thought process that might have come with 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.

Below, the PCP and SCP choose the types of Referral Transitions they agree upon. (Check all that apply.)

TYPES OF CARE MANAGEMENT TRANSITIONS

☐ **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 SCP.
- ☐ Facilitate the diagnostic evaluation of the patient prior to the SCP 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 the care of the patient will be transferred back to the PCP after one or a few visits. The SCP will provide a detailed report on the Dx and the care recommendation 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)

☐ **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 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 the patient and issues being treated by the SCP.

APPROVAL SIGNATURES

Primary Care Provider

Authorized name _____

Title _____

Signature _____

Date _____

Specialist Care Provider

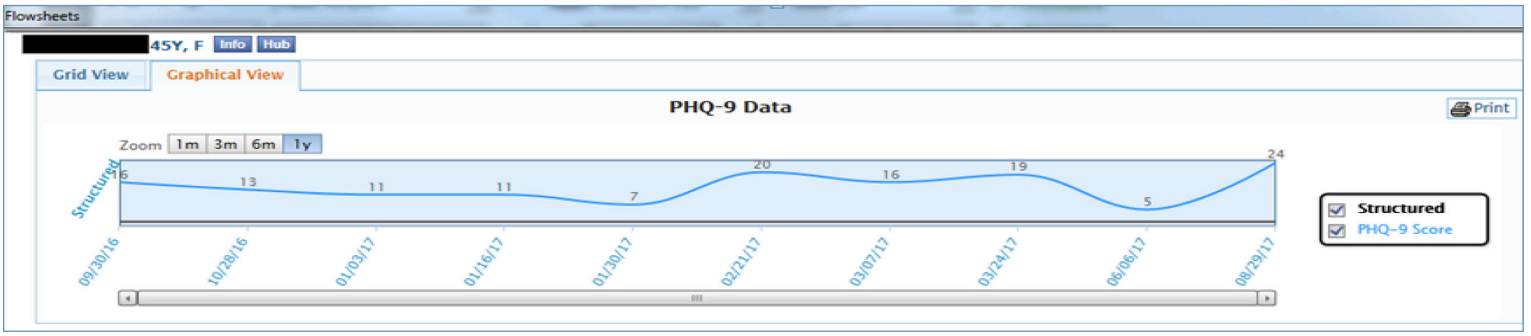
Authorized name _____

Title _____

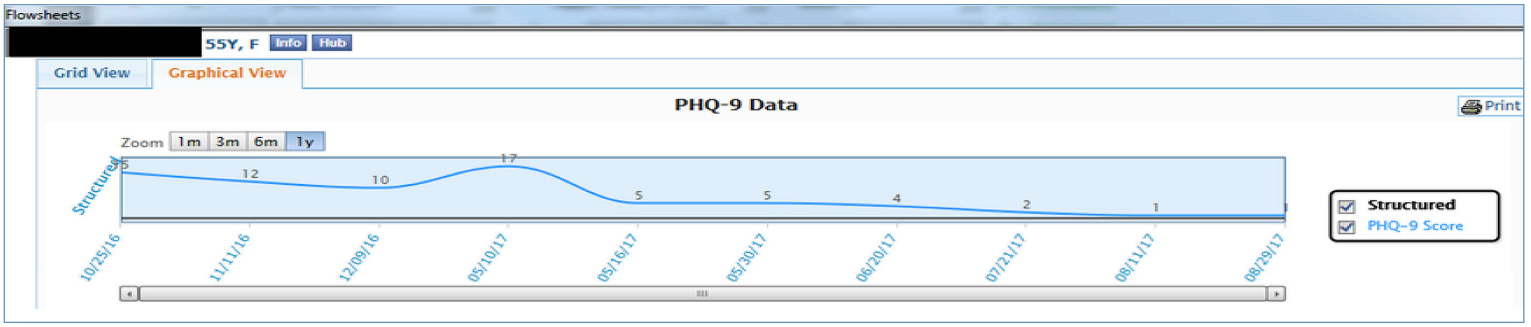
Signature _____

Date _____

Appendix F. EHR-Produced Graphical Depictions and Analysis of PHQ-9 Results Used for Patient Education and Engagement in Care at Koinonia Primary Care, Albany, NY



Patient A: The graph indicates a gradual reduction in the PHQ-9 score, followed by a sudden increase to a score of 20. The score then fluctuates between 20 and 5 before worsening and going back up into the 20s. This graph illustrates how PHQ-9 scores changed while a patient was inconsistently taking his medication. When medication was stopped the PHQ-9 score worsened; after reinitiating treatment the PHQ-9 score decreased (improved). After showing these fluctuations to the patient, he was better able to see the connection between treatment and mood and was more adherent to his medication.

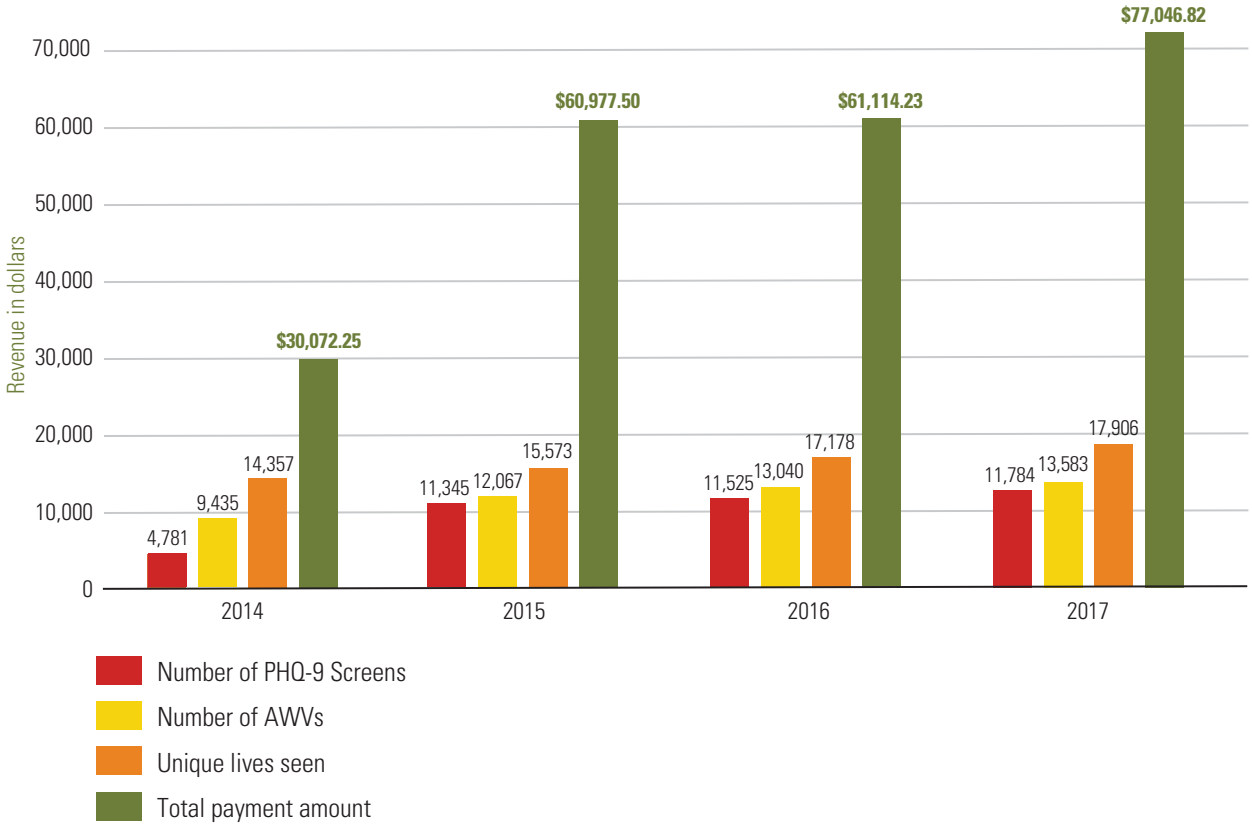


Patient B: This graph shows the progress of a patient whose work to manage her condition led to steadily improving PHQ-9 scores. At one point during her treatment, the patient felt better and decided to stop taking her medication and attending regular psychotherapy visits. As a result, her PHQ-9 began to increase, indicating worsening symptoms. After using the graph to illustrate that the patient's choices were returning her to her previous symptomatic baseline, she resumed taking her medication and returned to psychotherapy. The patient has since been able to maintain her improvement, understanding that adhering to her treatment plan is key to maintaining positive health outcomes.

Appendix G. Delmont Medical Center (DMC) PHQ-9 Revenue, 2014-2017

The graph below shows DMC billing from 2014 through 2017 across all sites, including its Far Rockaway practice. In 2014, 30 percent of adult patients with annual wellness visits (AWVs)—approximately 5,000 patients—were screened for depression using a PHQ-9, for a total of $30,072 in revenue. In 2015, gradually increased PHQ-9 screenings rates for AWVs yielded a total of $60,978 in revenue. This screening and reimbursement rate stayed constant through 2016, with revenues totaling $61,114. In 2017, DMC further increased PHQ-9 screenings to 11,784 patients, for a total of $77,047 in revenue. The majority of PHQ-9 screens were reimbursed by Medicaid health plans. Billing data showed reimbursement from commercial payers to be much lower due to inconsistent and variable reimbursement for PHQ-9 screenings.

DMC PHQ-9 Revenue 2014-2017



Appendix H. Revenue Sources for Behavioral Health Service Billing in a Primary Care Practice, Developed by the Delmont Medical Center Practice Leadership Team

Payer	Code	Description	Fee Schedule
Commercial insurance, Medicaid	99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 min	$33.41
Commercial insurance, Medicaid	99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 min	$65.51
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 min	$29.42
Medicare	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 min	$57.69
Medicare	G0442	Prevention: Screening for alcohol misuse in adults including pregnant women once per year. No coinsurance; no deductible for patient http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Reduce-Alcohol-Misuse-ICN907798.pdf	$17.33
Medicare	G0443	Prevention: Up to four 15-minute brief face-to-face behavioral counseling interventions per year for individuals, including pregnant women, who screen positive for alcohol misuse. No coinsurance; no deductible for patient https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html	$25.14
Medicaid	H0049	Alcohol and/or drug screening (code not widely used)	$24.00
Medicaid	H0050	Alcohol and/or drug service, brief intervention, per 15 min (code not widely used)	$48.00

Appendix I. Cheat Sheet on Medicare Payments for BHI Services, Sourced from the AIMS Center[6]

Code	Former Code	Description	Documentation Required	Fee Schedule Estimates (PCP settings)
96127[7]	N/A	**Administration, scoring, and documentation of a brief behavioral/emotional screening.** Examples: PHQ-9, GAD-7, AUDIT, and DASS-21	The code is per screen administered with scoring and documentation, per standardized instrument.	$5.35
99492	G0502	**Initial psych care mgmt, 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 mgmt, 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 mgmt, addt'l 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)

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

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

(continued)

Code	Former Code	Description	Documentation Required	Fee Schedule Estimates (PCP settings)
99484	G0507	**Care mgmt. services, min 20 min (General BHI Services)** Care management services for BH conditions—at least 20 minutes of clinical staff time per calendar month	Must include: • 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.