# Integrated Behavioral Health in Primary Care

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BOSTON MEDICAL CENTER'S STRATEGIC PLAN

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## Introduction

Boston Medical Center began its Integrated Behavioral Health program development in early 2013. The development of the model, implementation of the pilot and monitoring of progress towards goals has been a collaboration between multiple departments within the hospital. In 2013, BMC agreed to fund the pilot and 6 months later the pilot was launched in two of BMC's Primary Care departments: General Internal Medicine and Family Medicine. The content of this presentation will be based on the pilot rolled out in the Internal Medicine department.

BMC's Internal Medicine department treats 35,000 patients and is divided into 6 suites. Each suite cares for approximately 6,000 patients, has 18,000 visits/year, 12 attendings, 20 residents, 3 nurses and 8 support staff.

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## High level timeline of the road to behavioral health integration

| Spring 2013 | Summer 2013 | Fall 2013 |
|---|---|---|
| BH Collaborative formed | Developed model, requested funding | Hired BH providers, developed training and processes for screening and referrals |

| Winter 2014 | Summer 2014 | Fall 2014 |
|---|---|---|
| Launched BH pilot: began screening and referrals to BH providers | Integrated psychiatrist, expanded pilot to additional suite | Launched depression care management |

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## Integrated behavioral health membership

| Name | Role and Department |
|---|---|
| Courtney Urick | Director of Medical Affairs |
| **Hannah Marks** | **Project Manager, Strategy / Practice Manager, GIM** |
| Charlie Williams, MD | Co-chair, Family Medicine |
| Ted Constan | Administrative Director, Family Medicine |
| Christy Odell, MD | Medical Director, Family Medicine |
| Alysa Veidis, NP | Associate Medical Director, Family Medicine |
| **Christine Pace, MD** | **Clinical Lead, GIM** |
| **Ellen Ginman** | **Administrative Director, GIM** |
| Joanna Buczek, MD | Medical Director, Psychiatry |
| Joan Taglieri | Administrative Manager, Psychiatry |
| Cindy Gordon, LICSW | LICSW Lead, Psychiatry |
| **Lee Ellenberg, LICSW** | **Consultant** |
| Alissa Cruz | Consultant |

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## An overview of the behavioral health collaborative

1. **Behavioral Health Collaborative** was formed with representation from General Internal Medicine, Family Medicine, Psychiatry and the hospital's Strategic Implementation department.
   - Drafted Principles of Collaboration
   - Agreed to support and develop the Integrated Behavioral Health program
     - Developing roles and responsibilities
     - Hiring the BH team
     - Determine metrics to measure process and outcomes
     - Develop and advocate for IT systems
2. Presented model to BMC Vice Presidents for **funding**
3. Integrated Behavioral Health submitted as a Delivery Systems Transformation Initiative (DSTI) project.

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## Integrated behavioral health program goals and objectives

**Goals**

Support and develop the Integrated Behavioral Health program in GIM & Family Medicine

**Objectives**

1. Develop model, including roles and responsibilities
2. Screen all patients annually, using standardized tools and document in EMR
3. Design guidelines for referrals and follow-up care
4. Provide education and training for PCP's and nursing staff

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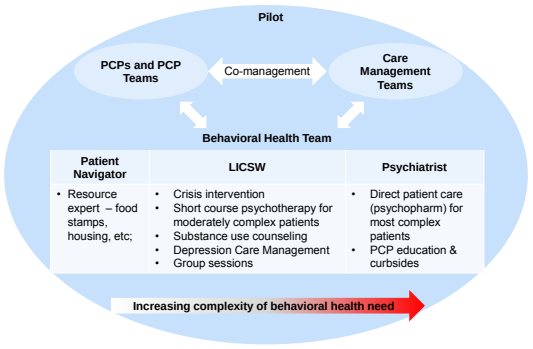
## Future state of integrated behavioral health in Primary Care

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## Proposed pilot in one of the GIM suites

**Fully-staffed future state model**

| Internal Medicine | | | | | |
|---|---|---|---|---|---|
| 5A | 5B | 5C | 6A | 6B | 6C |
| ← | Psychiatrist → | | ← | NP BH → | |
| LICSW | LICSW | LICSW | LICSW | LICSW | LICSW |
| ← | BH Navigator → | | ← | BH Navigator → | |

**Proposed Pilot Model**

| Suite 5B (~6,000 patients) | |
|---|---|
| 0.3 Psychiatrist | • Direct patient care for most complex patients<br>• Supervise depression care management<br>• On-call consultant for entire practice |
| 1.0 LICSW | • Short course psychotherapy<br>• Crisis intervention<br>• Substance use counseling<br>• Depression care management |
| 1.0 BH Navigator | • Resource expert for entire floor |

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## Pilot overview of integrated behavioral health care

- **Screening** for **Depression** & **Substance Use Disorders**
- **Counseling**: ON-SITE, short-course mental health and substance use counseling (LICSW)
  - Includes depression care management (DCM)
  - Expands reach of Behavioral Medicine
  - Complex / very sick patients still referred to Psychiatry for long term treatment; LICSW will expedite process
- **Navigator:** matches pts. with resources
- ON-SITE **psychiatry** for curb-sides, med management, DCM
- Provider and staff **trainings** in collaborative BH care

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## Conclusions and lessons learned from developing the integrated behavioral health model

**Keys to success**

1. Formed the model **in collaboration** with Department of Psychiatry
2. **Specificity** - the details of each role were developed collaboratively and prior to the launch of the program
3. **Start small** – committing to pilot, track and analyze metrics, make improvements and adjust model accordingly
4. **Buy-in from leadership**
5. Selected **process and outcome metrics** to track success of the model

**Challenges**

1. Model does not generate revenue
2. Building consensus among a diverse group
3. Allowing for flexibility in the model

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## Metrics being tracked to determine success

| Metric Category | Definition |
|---|---|
| Access | % of patients referred to LICSW who are scheduled for an appointment within 14 days |
| Volume | Total # of LICSW visits |
| No Show | % of patients who no show for LICSW appointment |
| Screening Rates | % of arrived patients receiving annual BH screening |
| PHQ9 completion | % of patients with depression dx who have a documented PHQ9 score |
| Depression CM | % of patients with a 50% or more reduction in PHQ9 score at 12 months (of patients enrolled in depression care management) |
| Provider Satisfaction | Tracking response to the provider survey question: "Please rate your overall satisfaction with the behavioral health services that are available for your patients." |
| Referrals | % of patients that no show for a dept. of psychiatry appointment with hand-off from BH team |
| Patient Engagement | % of patients with 3 arrived visits with LICSW |
| Outcome | Total Medical Expense for patients seen by BH team ≥ 4 times |
| Outcome | ED/inpatient utilization for patients seen by BH team ≥ 4 times |
| Outcome | Effective Acute Phase Treatment: % of patients who remained on an antidepressant medication for at least 84 days (12 weeks) |

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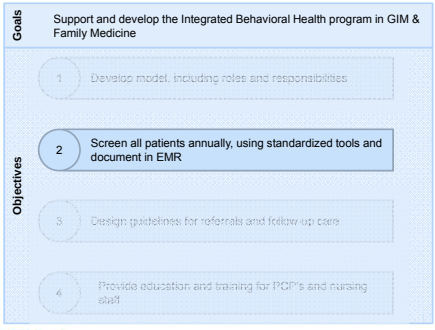
## Integrated behavioral health program goals and objectives

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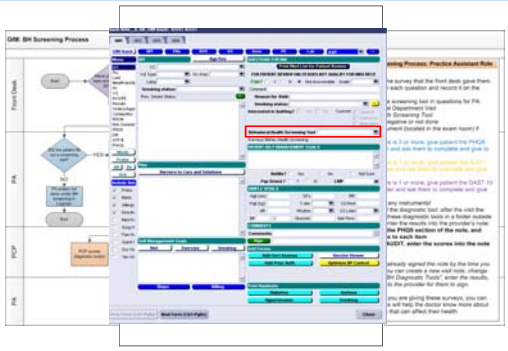
## Developed workflows and protocols for screening patients



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## Conclusions and lessons learned from implementing the screening process

**Keys to success**

1. IT support to track screening process
2. Spread screening process slowly (pre-testing for several weeks and rolled out by expanding to 1 new PCP each week over 2-3 months)
3. Engaged operational lead - monitored screening process closely, including QA and individual feedback to MAs
4. Only screened patients once BH support roles were in-place

**Challenges**

1. System allows for many touch-points of human error
2. Engagement from staff and adherence to new protocols
3. Sustainability

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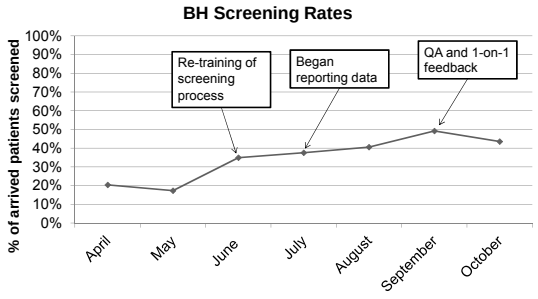
## Gathering data tells you which interventions led to process improvements

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## Integrated behavioral health program goals and objectives


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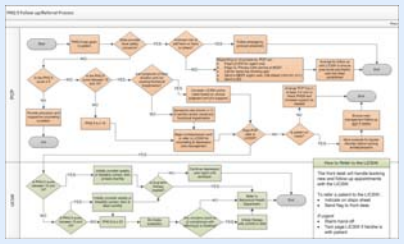
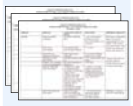
## Designed guidelines for follow-up care

**Guidelines for depression management**



**Clinic Roles and Responsibilities**



**Protocols for referrals to LICSW created**

The roll-out of these protocols was successful because the BH providers were in-place

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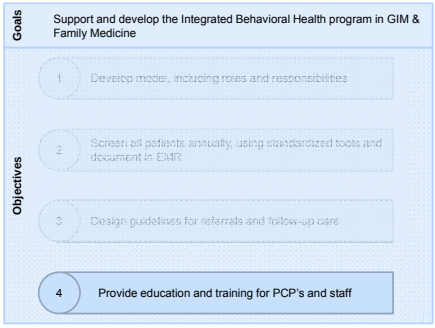
## Integrated behavioral health program goals and objectives

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## Provide education and training for PCP's and staff

**Provider Training**

- Pilot overview, case for integrated behavioral health
- Screening and follow-up care process
- Brief Intervention Training
- Brief Intervention Brush-up
- Depression Care Management and Psychopharm training

**Resident Training**

- 1 session with screening, follow-up care and brief intervention training

**Staff Training**

- Pilot overview, case for integrated behavioral health
- Myths of behavioral health conditions
- Screening process
- Documentation process
- Screening process refresher

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## Final Take-aways

1. Collaboration between Primary Care clinics and department of Psychiatry in the development phase led to a smoother operational execution
2. Strong clinical lead partnered with a strong operational lead – successful BH integration takes both.
3. Tracking and sharing data allows you to:
   - Monitor your progress against goals, tells you if your on track
   - Draw conclusions from interventions/process improvements
4. Protected time to train providers and staff is very important when implementing significant cultural and operational changes

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## THANK YOU! QUESTIONS?

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