

# **Advancing Integration of Behavioral Health into Primary Care:** A Continuum-Based Framework

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## About This Framework

*Advancing Integration of Behavioral Health into Primary Care: A Continuum-Based Framework* addresses one of the major challenges inherent in transforming today's primary care into a system of high-quality "advanced primary care." The need to bring high-quality treatment and management of depression, anxiety, and other common behavioral health conditions into primary care has been well documented. But what is less clear has been *how* to accomplish that at scale, given the varying types of primary care practices and, in particular, the resource limitations of small and medium-size practices and the complexity of the models that are currently the evidence-based standards for integrating medical and behavioral care.

This framework seeks to fill that gap by delineating a series of steps that providers can take to move toward integration of behavioral health services into their primary care practices. It is the result of work conducted, with grant support from United Hospital Fund, by a team headed by two leaders in this field: Henry Chung, MD, vice president of the Care Management Organization of Montefiore Medical Center, medical director of Montefiore's Accountable Care Organization, and associate professor of clinical psychiatry at the Albert Einstein College of Medicine, and Harold Pincus, MD, professor and vice chair of the Department of Psychiatry and co-director of the Irving Institute for Clinical and Translational Research at Columbia University.

The framework is an example of strategic grant making that builds on UHF's focus areas and program activities, including ongoing efforts, through its Innovation Strategies Initiative, to improve the performance of New York's health care system, and to integrate behavioral health into primary care.

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## Executive Summary

Despite significant prevalence, behavioral health conditions frequently go undiagnosed and untreated. Primary care providers can play a significant role in both diagnosing and facilitating treatment of these conditions, making increasing capacity for treatment of behavioral health conditions in primary care settings a core strategy for improving access to and quality of care. Recognizing the importance of this approach, New York State has prioritized implementation of behavioral health integration models through both the Medicaid Delivery System Reform Incentive Payment (DSRIP) program and the emerging Advanced Primary Care (APC) model.

Although evidence-based integration models work well when implemented properly, there has been relatively little guidance on the underlying steps primary care practices can take to build toward more advanced models, including how smaller and medium-sized practices, in particular, can accomplish integration objectives given resource constraints.

Based on a targeted literature review and input from diverse stakeholders, the framework presented in this guide seeks to provide primary care practices, as well as DSRIP Performing Provider Systems (PPSs) and other organizing entities, with practical guidance on incremental steps to achieve and advance key elements of integrated care for all types of primary care practices.

### **An Evidence-Based Framework for Primary Care–Behavioral Health Integration**

The framework presented in this guide is intended to help practices initiate and develop operational plans to achieve effective, evidence-based integration. The framework lays out on the vertical axis key components of integrated care across integration models, grouped into eight broad domains (see Appendix C). These domains are:

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

Building upon existing literature and stakeholder input, the framework identifies preliminary, intermediate, and advanced representations of each component along the horizontal axis. The rows of the framework represent parallel paths toward integration that can be moved along at different speeds, following a series of incremental steps or guideposts. Conveying a sense of movement and momentum, the framework's continuum allows practices to place themselves along the pathway and identify their status within each domain, rather than rigidly anchoring practices to a specific level of integration across domains. The eight domains of the framework allow practices to increase their capabilities in different aspects of integrated care at different rates, based on resources and practice structure.

### **Using the Framework**

The framework, as outlined briefly below, provides a way for practices to organize themselves based on existing strengths while developing resources to advance their integration. Specifically, we recommend that practices initially use the framework to assess their current state of integration and develop future-state goals. Recognizing that there is latitude on how to advance specific integration components, the framework aims to provide a roadmap for practices to make investments in time, training, workforce, and resources that are necessary to improve the implementation of integration and patient care. However, a practice's individual characteristics will influence its goals, making achieving the most advanced state of each domain and its components not necessarily the ultimate target for every practice.

## **A Checklist for Implementing Behavioral Health Integration**

### **GETTING STARTED: MANAGING CHANGE**

- ☐ Establish commitment from senior leadership and identify practice champions.

### **THE FRAMEWORK STEP BY STEP**

- ☐ Assemble an appropriately staffed team to assess the current state of integration.
- ☐ Perform a self-assessment, using data to determine current status of practice in each of the components and subcomponents of the framework.
- ☐ Perform an environmental scan to identify potential external resources for facilitating integration efforts.
- ☐ Prioritize domains for change.
- ☐ Set specific, measurable, and achievable 3- to 12-month goals for each component of the framework.
- ☐ Assess existing and necessary resources for achievement of integration goals, including capital investments, personnel, and technology costs.
- ☐ Assess attainability of goals to ensure they are realistic and appropriate.

## **Observations and Conclusions**

Through ongoing New York State initiatives, there are meaningful opportunities to change the way that behavioral health services are delivered in primary care; however, challenges remain. While this framework offers operational guidance for increasing integration of behavioral health care into primary care, there are external considerations not addressed here that will shape pathways to integration, including regulation, reimbursement, workforce, and other policy issues. Finally, the practice transformation described in this framework requires a fundamental change in practice culture, as both the primary care and behavioral health fields contend with significant workforce shortages in New York State and nationally.

This framework is a work in progress, with more work needed, in particular, on developing metrics that reflect achievement of the key components of integrated care, as well as on incentivizing movement toward increased integration. While discussions of various value-based payment approaches are underway, it will be crucial for payers and policymakers to consider intermediate financial incentives to help practices support movement toward increased integration; this framework may be useful in developing these incentives, in association with measurable performance criteria. Through ongoing efforts, the authors intend to continue to refine the framework and assess its applicability and utility in the significant transformation underway in New York State.



## Introduction

Behavioral health disorders have a major impact on both personal health and health care costs, yet are only diagnosed and treated in a minority of cases. Primary care providers, because of their ongoing relationships with patients, can play a significant role in both diagnosing and facilitating treatment of these conditions, but successfully adopting that role requires both culture change and systematic practice transformation.

This guide offers a practical framework for integration of behavioral health care into primary care settings, both for individual practices and in the context of various New York State health reform initiatives. Organizing key components of integrated care into eight domains arrayed along a developmental continuum, it is intended to help a variety of primary care practice types identify their current level of integration, begin to develop plans for moving further along the continuum, and prioritize and implement necessary steps for effective integration.

### **The Case for Integration**

Behavioral health disorders, with high prevalence both in New York State and nationally,<sup>1,2</sup> contribute to decreased quality of life<sup>3</sup> and can be independent risk factors for and worsen other health outcomes.<sup>4,5</sup> These conditions are also associated with increased health care costs: in some studies, health care costs for Medicaid enrollees with a behavioral health diagnosis were more than three times the costs for those without,<sup>6,7</sup> although successful treatment has been found to reduce such costs.<sup>8,9</sup>

Despite this prevalence and burden, behavioral health conditions frequently go undiagnosed and untreated, with only 22 percent of adults with common mental health disorders receiving care from any type of mental health specialist in a given year.<sup>10</sup> Even when conditions are identified by primary care providers, patient engagement in specialty referral is low,<sup>11</sup> with frequent patient preference for receiving treatment from providers with whom they already have an established relationship.<sup>12,13</sup> These factors make increasing capacity for treatment of behavioral health conditions in primary care settings a core strategy for improving access to and quality of care.

### **New York's Reform Efforts**

In recognition of this urgent need, momentum continues to build in New York State for the integration of behavioral health into primary care. That was, in fact, the sole “transformation” project selected by all 25 of the Performing Provider Systems (PPSs) participating in New York Medicaid's Delivery System Reform Incentive Payment (DSRIP)

program statewide.<sup>14</sup> Under State parameters for this project, primary care practices have the option of implementing behavioral health integration through either an enhanced co-location model or the Collaborative Care/IMPACT model described in Appendix A.<sup>15</sup>

Additionally, as part of its State Innovation Model (SIM) initiative aimed at ensuring that all New Yorkers have access to high-quality primary care using medical home principles, the State is designing a model for Advanced Primary Care (APC) that will include a progressive set of practice capabilities and quality, outcome, and cost milestones, intended to be tied, over time, to value-based payment for all payers and all lines of business (Medicare, Medicaid, and commercial). While the model and its underlying iterations are still being finalized, as of publication of this guide, the integration of behavioral health services into primary care has been identified as a critical component. Yet with practices starting at different points along a continuum and having varying resources to apply to integration goals, questions remain about how to define evidence-based standards that reflect achievement of behavioral health integration.

In fact, although evidence-based integration models work well when implemented properly,<sup>16, 17, 18</sup> there has been relatively little guidance on the underlying steps primary care practices can take to build toward more advanced models, and how smaller and medium-sized practices, in particular, can accomplish integration objectives given the significant resource constraints they sometimes face.

The framework presented here, rooted in evidence on several seminal models of primary care-behavioral health integration, seeks to provide primary care practices, as well as PPSs, health plans, accountable care organizations (ACOs), and other organizing entities, with practical guidance on important incremental steps that can be taken to achieve and advance key elements of integrated care. The framework may also provide insights for state policymakers and payers on how to assess and potentially support movement toward more advanced integration in conjunction with current reform initiatives—including guidance for helping small and medium-sized practices adopt DSRIP and APC model elements.

## **Building the Framework**

This framework focuses on integration of behavioral health into primary care settings for adult patients; it does not address models focused on pediatric settings or integration of primary care into behavioral health settings (reverse integration). Although most of the literature on integrated care has focused on its impact on depression and anxiety conditions, we believe that the framework's elements may also apply to other behavioral health conditions commonly found among adult primary care patients, including substance use,

since the core principles of screening, intervention, and follow-up have been shown to improve outcomes in those conditions as well.<sup>19, 20, 21</sup>

To prepare the framework, the authors performed a targeted literature review (see Appendix A) and conducted 12 semi-structured interviews with key informants from across New York State, including primary care practitioners, behavioral health specialists, PPS leads, payers, and policymakers.

Feedback solicited during these interviews included perspectives on current plans, accomplishments, and challenges to integration in different practice settings, as well as input on a draft version of the framework, including its overall approach, structure, and utility. The framework was then revised and presented to a larger group of key stakeholders at an advisory meeting convened by United Hospital Fund to gather additional feedback, including insights on the framework's applicability under various New York State reform initiatives. The expert feedback from both key informants and a broader stakeholder advisory group (see Appendix B) was crucial to the development and refinement of the current version of the framework presented here.



## **An Evidence-Based Framework for Primary Care–Behavioral Health Integration**

### **How the Framework Facilitates Practice Integration**

This framework is intended to help primary care practices initiate and develop operational plans to achieve effective, evidence-based integration. It is designed to aid assessment of their current state of integration across a range of operational components, rather than attainment of a particular state of readiness (i.e., coordinated stage versus integrated stage) or adherence to the Collaborative Care Model (CCM) or other paradigms, since even those models' elements vary in clinical practice.

The authors anticipate that users can also employ the framework to identify goals for future levels of integration, component by component, and the individual steps to be taken along the way. We recognize that these goals are likely to be tailored to the practice environment (e.g., rural or urban, payer mix, FQHC or other type of center, hospital-based or independent practice, etc.). Although we present preliminary, intermediate, and advanced states for particular elements, we are not suggesting that it will make sense, in all cases, for practices to achieve “advanced” states of all individual components.



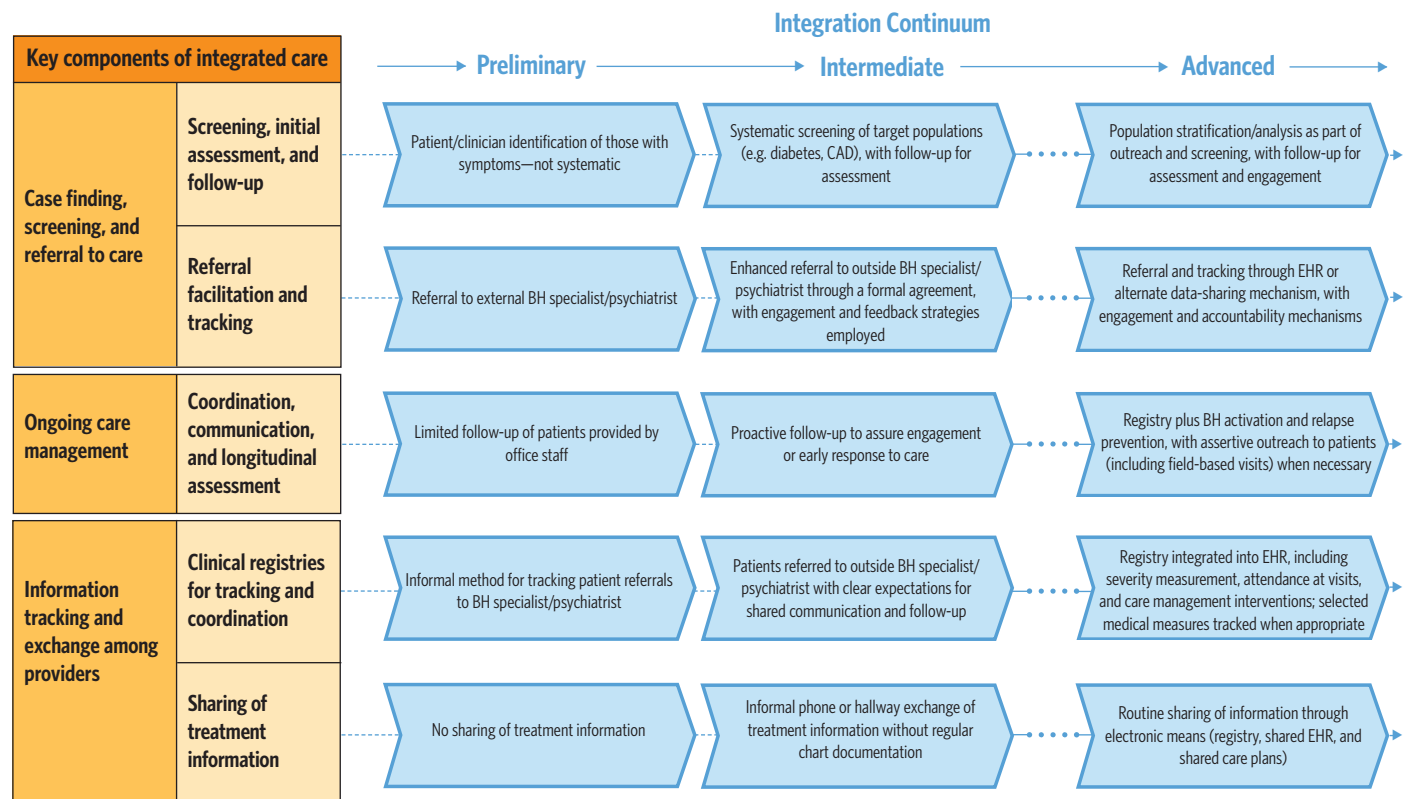
Thus this framework is not designed to be used as a basis for scoring practice performance for quality assessment or reimbursement; instead, it is intended to provide a road map that will be helpful for a wide array of primary care settings in pursuit of common integration goals. We believe that practice settings vary in the elements they can “reasonably” expect to adopt, given resources, space limitations, and workforce capacity. For example, smaller, independent practices may need to aim for elements around the intermediate level—and will likely require near-term payment incentives or direct resources to support this evolution—while larger and well-networked practices can more quickly adopt more advanced elements and embedded value-based reimbursement approaches. Our perspective is that patients in need of behavioral health treatment will benefit from the intermediate elements associated with the framework, and that all practices working on integration should strive to achieve many of these elements (defined and discussed below) in order to see meaningful quality improvements and potential cost savings.<sup>22, 23, 24, 25, 26, 27</sup>

## Structure of the Framework: Key Components of Integrated Care

The framework presented in condensed form below and in full in Appendix C lays out on the vertical axis key domains of integrated care that emerge in the literature across integration models, including but not limited to the CCM. While a variety of studies have

### The Framework's Structure Illustrated

This condensed version of the framework—**not the full working model, only a partial representation of its structure**—illustrates several of the 8 component domains and 57 steps. The complete framework, depicting all domains and steps, appears in Appendix C.





articulated components of these models,<sup>28, 29, 30, 31, 32</sup> this framework builds upon existing literature and stakeholder input to integrate key elements identified in other work.

We've grouped these components into eight broad domains and identified preliminary, intermediate, and advanced representations of each, along the horizontal axis. The eight domains of the framework are:

**CASE FINDING, SCREENING, AND REFERRAL TO CARE.** This domain encompasses steps to develop methods and systems for identifying patients with behavioral health conditions, assessing their symptoms, and meaningfully referring them to and engaging them in treatment. Highlighting the important role of screening in the primary care context, the U.S. Preventive Services Task Force recently revised its recommendation on depression screening to call for screening of all adults, modifying an earlier recommendation that universal screening be implemented only when specific depression care supports were in place.<sup>33</sup>

**USE OF A MULTI-DISCIPLINARY PROFESSIONAL TEAM—INCLUDING PATIENTS—TO PROVIDE CARE.** Involvement of a multi-disciplinary team, including patients themselves, is a key change from the usual approach to care.<sup>34</sup> Individuals involved in the care team vary depending on a practice's level of integration. But as the care team evolves, changes in workflow are necessary to allow for increased contact between the primary care provider and behavioral health specialists (any providers with specialized behavioral health training), to facilitate shared care planning and communication about shared patients across team members and disciplines.<sup>35, 36</sup>

**ONGOING CARE MANAGEMENT.** Ongoing, proactive, relentless follow-up of patients is essential to combatting fragmentation between providers and to engaging patients in their care.<sup>37</sup> While tools used for tracking follow-up may vary, ongoing longitudinal assessment and communication with patients, including a focus on both physical and behavioral health, are important aspects of an integrated approach. The literature and stakeholder feedback both emphasized that care management entails a set of functions, not necessarily a single individual.<sup>38</sup> Additionally, evidence suggests that early initiation of follow-up and patient engagement is key for improving patient outcomes.<sup>39, 40</sup>

**SYSTEMATIC QUALITY IMPROVEMENT.** Effective quality improvement is another key to ongoing advancement in the integration of primary care and behavioral health, and an important aspect of moving toward a population health approach.<sup>41</sup> Essential to guiding these efforts is the use of quality metrics encompassing both process and outcomes. Data

from electronic health records (EHRs) and other sources, ideally along with the attention of designated quality improvement personnel, allow for continuous monitoring of performance and development of strategies for improvement.

**DECISION SUPPORT FOR MEASUREMENT-BASED, STEPPED CARE.** Use of pharmacotherapy when appropriate and coordination of access to some form of evidence-based psychotherapy—whether fully integrated into the primary care setting or through off-site partnerships or technology such as computerized cognitive behavioral therapy or online psychotherapy—are both key parts of any approach to integrated care.<sup>42</sup> This domain covers the use of evidence-based guidelines and treatment protocols, including tools for ongoing symptom monitoring and strategies for intensifying treatment for patients who do not show improvement.<sup>43</sup>

**CULTURALLY ADAPTED SELF-MANAGEMENT SUPPORT.** Beyond a simple focus on medication adherence, self-management support encompasses an exchange of information that helps patients (and their families) understand their behavioral health condition and promotes shared decision making between the patient and the primary care provider.<sup>44</sup> This domain describes tools (e.g., motivational interviewing) utilized to promote patient self-management through effective, culturally appropriate communication, greater patient activation, shared goal development, and a focus on improving overall health and wellness.

**INFORMATION TRACKING AND EXCHANGE AMONG PROVIDERS.** As the care team incorporates additional members, enhanced inter-professional communication is essential to breaking down the silos that frequently exist between primary care and behavioral health services. Yet time constraints in a practice may necessitate the use of multiple methods of information sharing, both formal and informal. This domain encompasses the development of tools for electronically tracking and coordinating information (e.g., formal patient registries or shared EHR systems), as well as protocols for when and how information is exchanged.

**LINKAGES WITH COMMUNITY/SOCIAL SERVICES.** Effective integrated care involves addressing the key social determinants of health, along with behavioral health conditions.<sup>45</sup> This domain focuses on steps for fostering effective linkages to housing, vocational, and other supportive social services and to community organizations and resources, and for incorporation of relevant social determinants into care plans.

## **Structure of the Framework: The Integration Continuum**

Like the CCM and other models, the eight domains described above represent the core elements of integrated care. Unlike those models, however, we approach this not as an either/or set of conditions—readiness or not in all domains—but as parallel paths toward integration that can be moved along at different speeds, following a series of incremental steps or guideposts. That’s a critical point because many practices seeking to adopt integration models may find that they are already actualizing the component parts of some domains and partway there on others, or that a particular component does not make sense for their setting (e.g., modifications may be needed for smaller primary practices in which on-site behavioral support is not possible).

For each domain of our framework we have therefore identified preliminary, intermediate, and advanced stages of integration that practices can—indeed may be likely to—move through. This notion of a continuum was based upon stakeholder discussion, while also drawing from concepts like the SAMHSA-HRSA Center for Integrated Health Solutions’ standard framework for levels of integrated health care.<sup>46</sup>

Conveying a sense of movement and momentum, the framework allows practices to place themselves along the pathway and identify their status within each domain—as illustrated in “Moving Along the Continuum” (see page 8)—rather than rigidly anchoring practices to a specific level of integration across domains. In the preliminary stages, a practice intends to start on or has just begun its journey, tackling initial, limited, incremental steps. Moving along the continuum, toward the intermediate stage, the activities described in each domain indicate a greater level of integrated care, in which some progress becomes measurable. While short of the two primary care–behavioral health integration models specified under DSRIP project 3.a.i, the activities described in each component at this stage still indicate meaningful progress toward increased integration. Finally, the far end of the continuum represents an advanced stage of integration that goes beyond how New York State has defined IMPACT (Model 3) for DSRIP project 3.a.i. In each domain, this advanced stage represents a more population health–focused way of thinking about integration.

# Moving Along the Continuum

**The eight domains of this framework allow practices to increase their capabilities in different aspects of integrated care at different rates, based on resources and practice structure. The examples below illustrate how a practice might progress in two of the domains.**

## Case finding, screening, and referral to care

The first domain describes how a practice can evolve from a strictly clinical case-finding approach to identifying patients all the way to a population health–focused level of systematic case finding. In the preliminary stage, patients with depression or another behavioral health condition are identified only when they present with symptoms; they are then referred out to an external BH specialist. Typically, many do not follow up on the referral. A practice wanting to make progress toward greater integration might begin by implementing a more systematic approach to screening that focuses on certain high-risk target populations (e.g., individuals with diabetes). From this point, the practice can develop workflow processes for assessing positively identified patients and linking them to care, and can work to ensure the capacity to respond to those identified in this limited screening, before moving toward universal screening. Technology to facilitate shared resources for care management and psychiatric consultation support (telephonically or virtually), for example, can help alleviate geographic or workforce limitations and facilitate patient follow-up and referral to care. Finally, at the most advanced stage of integration, data on the patient population is used to flag patients before they even present to the PCP, while the EHR or another tool is employed to facilitate and track referrals.

Fully integrated primary care–behavioral health care practices have shown that the vast majority of patients with behavioral health needs can receive quality care in that setting; however, there will still be a significant number of patients who will benefit from receiving care in specialty behavioral health settings. For many practices in the preliminary phases of the integration continuum, it will be important to develop enhanced referral arrangements that facilitate strong linkages and patient engagement in specialty referral. Examples of these strategies include coordinating with behavioral health providers who are willing to see patients promptly, without a waiting list; sharing accountability for engagement and follow-up between both primary care and behavioral health providers; and sharing information regarding treatment plan updates and consultation actions at timely intervals.\*

Formalizing these enhanced referral arrangements in a written agreement is highly recommended. Similarly, behavioral providers may also derive benefit through these formal agreements if patients in their specialty settings need timely primary care access and follow-up.

## Ongoing care management

The third domain of the framework describes how a practice can evolve from providing very limited follow-up of patients to advanced care management. In the early stages, proactive communication with patients outside of appointments facilitates patient engagement and ongoing symptom monitoring. At its most basic, this follow-up may be provided by general office staff. As the practice becomes more advanced in this domain, care management is provided by designated staff with more formalized training, using a registry that tracks patients and their responses to care and provides reminders to make follow-up more proactive. While available resources may influence how care management is delivered (e.g., face-to-face, by telephone, or online), at its most advanced this ongoing coordination and outreach between clinical visits includes behavioral health activation and relapse prevention, with assertive outreach to patients when necessary. For practices without the resources to maintain a digital patient registry, some form of paper tracking may be the best option initially. Ultimately, however, this will limit the number of patients these practices can track, and they will need support to implement more advanced technology to maximize care management capabilities.

Progress in the domains described in these examples would support performance metrics outlined in DSRIP,<sup>†</sup> e.g., screening for depression using a standardized tool such as the PHQ-9, behavioral health follow-up after hospitalization for mental illness, and 90-day and 120-day antidepressant adherence measures for those receiving medication for depression. While these are important process-related quality metrics, achieving effective integration will improve patient outcomes, such as depression response and remission rates, which are critically linked to improving patient quality of life, and to the potential for cost savings.

\* Krahn DD, SJ Bartels, E Coakley, et al. July 2006. PRISM-E: Comparison of integrated care and enhanced specialty referral models in depression outcomes. *Psychiatric Services* 57(7): 946-953.

† New York State Department of Health. February 25, 2016. *DSRIP: Measure specification and reporting manual. Measurement Year 1.*

[http://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/2016/docs/2016-02-25\\_measure\\_specific\\_rpting\\_manual.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/docs/2016-02-25_measure_specific_rpting_manual.pdf) Accessed May 4, 2016.



## Using the Framework

The framework provides a way for practices to organize themselves based on existing strengths while developing resources to advance their integration; we recommend that it be used initially to assess the current state of integration and develop future-state goals. We recognize that there is latitude on how to advance specific integration components, based on individual practice factors and on what New York State and payers will incentivize through DSRIP and other value-based payment arrangements. In this context the framework can help practices map the investments they will need to make in time, training, workforce, and resources that are necessary to improve the implementation of integration so that it becomes meaningful for patient care and the various aspects of State reform.

As noted earlier, a practice's characteristics will influence its goals: achieving the most advanced state of each domain and its components will not necessarily be the ultimate target for every practice. While moving to the most advanced phase of most components will likely be necessary for practices contemplating value-based activities at the population level, some smaller, less-resourced environments might set meaningful movement toward and adoption of intermediate-phase elements as their ultimate goal. The steps outlined starting below are perhaps most applicable to individual practices; we look at use of the framework in the context of New York State's health reform efforts on page 12.

## A Checklist for Implementing Behavioral Health Integration

### GETTING STARTED: MANAGING CHANGE

- ☐ Establish commitment from senior leadership and identify practice champions.

### THE FRAMEWORK STEP BY STEP

- ☐ Assemble an appropriately staffed team to assess the current state of integration.
- ☐ Perform a self-assessment, using data to determine current status of practice in each of the components and subcomponents of the framework.
- ☐ Perform an environmental scan to identify potential external resources for facilitating integration efforts.
- ☐ Prioritize domains for change.
- ☐ Set specific, measurable, and achievable 3- to 12-month goals for each component of the framework.
- ☐ Assess existing and necessary resources for achievement of integration goals, including capital investments, personnel, and technology costs.
- ☐ Assess attainability of goals to ensure they are realistic and appropriate.

## Getting Started: Managing Change

Before using the framework to assess current practices and set goals for integration, practices should prepare for the transformation inherent in advancing behavioral health integration. As a first step, ensuring that the senior leadership within an organization is committed to integration goals and the underlying work needed to achieve those goals is essential. Developing practice champions is also critically important to help drive quality improvement efforts, at both the project and organizational change levels.<sup>47</sup> Evidence from integration efforts in small primary care practices highlights the benefits of having both physician and non-physician co-leaders for creating and sustaining practice change.<sup>48</sup>

Additionally, preparing staff for change management is important for facilitating relationships between providers and assisting with development of new workflows. Evidence indicates that a focus on change management, in addition to specific changes in clinical care processes, is key for implementing and sustaining improvements.<sup>49</sup> Appendix D offers resources to help with initiating practice change and moving through the steps outlined below.

## The Framework Step by Step

**ASSEMBLE A TEAM.** A team comprising a PCP, a practice administrator, a member of the nursing staff, a behavioral health specialist (when available), and a staff member providing care management support is important for assessing the current level of practice within each component of the framework.

**INCORPORATE DATA FOR SELF-ASSESSMENT.** To the extent possible, this self-assessment should rely on data for determining current practice in each of the components. The authors suggest that if data indicate that the practice is not performing a model element/task at least 70 percent of the time, it should not be considered a systematic practice. A model self-assessment tool is presented in Appendix E.

**PERFORM AN ENVIRONMENTAL SCAN AND CONSIDER THE POTENTIAL FOR EXTERNAL RESOURCES.** Practices should conduct an environmental scan and consider the potential for resources from other partners that might facilitate integration. For example, what supports may be available from the Medicaid Performing Provider Systems (PPSs) under DSRIP, supportive health plan payers, or other funding entities? Can the practice make arrangements with partner organizations to facilitate mutually beneficial staffing, or an enhanced referral process that clearly specifies elements and time frames for communication on patient engagement and outcomes?

### **PRIORITIZE DOMAINS, IF PRIMARILY IN THE PRELIMINARY STAGES OF INTEGRATION.**

While practices will develop individualized goals, we do recommend that they prioritize and focus on the following domains, which are key to developing meaningful integration, if these factors are not already at an intermediate state:<sup>50, 51, 52</sup>

- **Case finding, screening, and referral to care.** Because systematic screening of patients is an element of both DSRIP integration models (co-location and IMPACT), moving toward systematic screening of patients, with follow-up for assessment and ensuring engagement, should be prioritized. In addition, developing an agreement with a behavioral health provider or agency that enhances referral engagement should be included as a key goal for practices that cannot yet provide on-site or virtual (online or telephonic) behavioral health support.
- **Ongoing care management.** Proactive, assiduous follow-up of patients should be prioritized early on to facilitate other integrated care activities, including regular symptom monitoring and patient activation and education.
- **Self-management.** Assisting patients in setting and pursuing self-management goals has been shown to be associated with improved outcomes and should be included as a goal, if not already practiced, to empower patients to become more active in their own care.

### **SET AND ARTICULATE GOALS FOR THE NEXT 3 TO 12 MONTHS, LAYING OUT EXPECTATIONS BY QUARTER.**

After performing a self-assessment, practices should use the framework to articulate near-term goals that are measurable and specific for each of the components. We suggest a time frame of 3 to 12 months for these goals, to help build momentum and focus attention on implementing changes. In setting these goals, practices should consider their patient population and available resources, to develop goals that are achievable.

**DETERMINE NECESSARY RESOURCES AND COMMITMENTS.** Practices will need to consider resources—existing and potential—necessary for implementation and achievement of goals in the components selected, including capital investments, technology costs, and staff expansion, training, and time.

**DETERMINE ATTAINABILITY OF GOALS AND NECESSARY RESOURCES, ASSESSING THE LEVEL OF CONFIDENCE ON EACH ONE.** While identifying goals, practices should assess how attainable each goal is within their 3- to 12-month time frames, on a scale of 1 (lowest) to 10 (highest), to ensure that goals are realistic and appropriate based on the current state of practice and available resources. If a practice determines that its confidence level in reaching a goal is below 70 percent (7 on the scale of 1 to 10) then evidence and experience suggest that the goal may be too ambitious and should be reassessed.<sup>53</sup>



## Using the Framework in the Context of New York's Reform Efforts

While the step-by-step guide to using the framework is geared to individual practices, the framework was developed to be useful for self-assessment and goal setting at the DSRIP/PPS level as well. Based on New York State guidance on DSRIP project 3.a.i,<sup>\*</sup> The framework highlights the specific elements considered to be part of the two primary care-behavioral health integration models put forward by the State. Components outlined in orange are activities that fulfill the description of the co-location approach (Model 1), while those with green outlines fulfill the description of the IMPACT approach (Model 3). As the visual indicates, there is overlap between the two models, which are similarly situated on the continuum; Model 3 falls further toward the advanced end of the framework, but does not necessarily represent an advanced state of integration across all domains.

The experience of the Montefiore Hudson Valley Collaborative (MHVC) provides an interesting case study of how one PPS is using the framework in project 3.a.i planning, as described by Dr. Damara Gutnick:

*We were planning to do a readiness assessment for BH integration project 3.a.i and saw the potential for the UHF Behavioral Health Integration Continuum framework to help us with this. We decided that this would be initially useful as a "current state assessment" for clinical practices in our PPS that were considering integrating behavioral health into primary care as part of DSRIP Model 1 (co-location) and Model 3 (IMPACT). The framework would enable individual practices to assess current integration capabilities in a uniform way, and thus allow MHVC to organize support for its partners to optimize success on DSRIP behavioral health integration projects.*

*DSRIP partners were educated about the tool and the evidence supporting its development during an interactive webinar that I co-facilitated with Dr. Henry Chung. Participants downloaded the tool prior to the webinar so that they could follow along, and were provided ample time for questions and discussions at the end of the webinar. The framework tool was also translated into an online survey instrument that was sent out to clinical practices after the webinar (Appendix E). Using the guidance provided within the webinar, participants were instructed*

*to complete the assessment as a site team, to determine current integration capabilities. The online survey instrument included questions based on each framework component and incorporated skip logic, creating a custom path through the survey based on a participant's responses. Participants were asked to select the response for each BH integration task (e.g., screening, use of registries, provision of self-management support, psychiatric support) that "best captured" the site's current work processes. Follow-up questions assessed the frequency of each described workflow process.*

*Based on the information captured through the survey, MHVC intends to design BH Integration Learning Collaboratives targeted to practice needs, and to track practice sites as they move along the integration continuum. Assessing individual practices' current capabilities in each component of the framework will help MHVC identify those practices that may require additional resources and/or implementation coaching.*

In addition to use by PPS participants, other organizing entities, such as ACOs and health plan payers, may find the framework to be useful for evaluating and supporting individual practices' progress to integration over time. As noted earlier, we do not recommend using the framework as a scoring mechanism for pay-for-performance efforts; however, if practices find utility in the framework's approach to documenting their progress in integrating behavioral health care, payers and policymakers may also glean insights from it on how to assess and potentially support the concrete steps entailed in moving toward more advanced integration.

Other ongoing New York State initiatives, including the development of the Advanced Primary Care model that includes various stages of primary care transformation, raise the possibility of a "graduated path" of primary care-behavioral health integration, perhaps focusing more on achievement of model elements in the intermediate phase. Stakeholder feedback throughout the development of the framework emphasized the concept of shared infrastructure in environments facing significant resource constraints as an alternative approach to be considered.

<sup>\*</sup> New York State Department of Health. June 2015. *Domain 1 DSRIP Project Requirements Milestones and Metrics*. [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrp/docs/domain\\_1\\_project\\_requirements\\_milestones\\_metrics\\_6-18-2015.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/docs/domain_1_project_requirements_milestones_metrics_6-18-2015.pdf) Accessed May 4, 2016.





## Observations and Conclusions

This framework offers operational guidance for increasing integration of behavioral health care into primary care, but there are external considerations not addressed here that will shape pathways to integration, including regulation, reimbursement, workforce, and other policy issues.

New York State offers guidance and regulatory flexibility to support integration within Medicaid DSRIP projects and in other contexts (see Appendix F for guidance related to DSRIP Project 3.a.i, including licensure thresholds, as well as State Integrated Outpatient Services regulations). While that regulatory latitude will provide some relief to practices seeking to support integration, additional State and federal barriers remain. Issues of particular relevance include restrictions surrounding the use of telepsychiatry; billing and coding challenges such as restrictions on same-day billing in federally qualified health centers and certain other settings, and ongoing concerns about applicability of privacy regulations and how they relate to sharing of information among providers (supportive resources on these New York State regulations are also available in Appendix F).

Payment models that recognize the new ways that care will be delivered under integrated models (e.g., between office visits) will be critical for sustaining integration. New York State has articulated several payment approaches, such as bundled payments for depression care, in its Value-Based Payment Roadmap, and has launched a pilot program to provide practices pursuing the CCM/IMPACT model with a per-member-per-month payment. While these developments are important pieces of the puzzle, it will also be crucial for payers and policymakers to consider intermediate financial incentives and other capital resources to help practices facing significant resource constraints support movement toward increased integration; this framework may be useful in developing these incentives, in association with measurable performance criteria.

The practice transformation described in the framework requires a fundamental change in practice culture. Delivering the types of behavioral health treatments envisioned in integration models requires both behavioral health personnel and willing and motivated primary care practitioners—despite both disciplines contending with significant workforce shortages in New York State and nationally. While integration offers an evidence-based

approach to treatment for the majority of patients in primary care, a significant number of patients will need specialty behavioral health intervention, and this sector needs funding support to make the transformation to value-based care. It is critically important that all behavioral providers (including those in training) understand the concepts of integration, many of which—such as measurement-informed care and proactive care management—will increasingly be expected in specialty settings. Similarly, all primary care providers will need to be informed about and trained in at least primary behavioral health care, including diagnostic and engagement skills, evidence-based prescribing of psychotropic medications, and provision of brief counseling and self-management support.

Finally, it is worth underscoring that the framework presented here is a work in progress, and that the external health reform environment in New York is also rapidly evolving. The authors intend to continue to refine the framework and assess its applicability and utility, through field testing at the individual practice and PPS level, in the significant transformation underway in New York State. Through this effort and other ongoing stakeholder engagement, we will be identifying, developing, and fine-tuning metrics that reflect achievement of the key elements of integrated care described in the framework. Additionally, as reform efforts evolve, we will adjust the framework accordingly and develop a use case for advanced primary care, if appropriate, as part of a next phase of this work.

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## Appendix A. Supportive Literature

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The literature on behavioral health integration models spans some 30 years. In developing the framework presented here, the authors reviewed relevant literature and synthesized the findings to isolate key themes and specific components that emerged across such models. Our targeted review focused on randomized or large-system studies of integration models conducted within ethnically and socioeconomically diverse populations, as well as large-scale implementations of integration models in clinical settings. These studies included a range of integration models illustrating alternative ways to implement key elements of integrated care.

These integration models have much in common with Wagner's Chronic Care Model,<sup>1</sup> which has been implemented for a variety of chronic illnesses and in a wide variety of settings. In behavioral health, the Collaborative Care Model (CCM)<sup>2,3</sup>—best represented by the Improving Mood–Promoting Access to Collaborative Treatment (IMPACT) study and the Advancing Integrated Mental Health Solutions (AIMS) Center—has been the most extensively studied.<sup>4,5</sup> Briefly, the CCM calls for instituting an interdisciplinary team, consisting of a primary care provider, a care manager, and a consulting psychiatrist, to work collaboratively to care for a defined patient population using a care management tracking registry. The clinical approach builds upon the principles of the chronic care model and includes use of measurement-based care, with assiduous, proactive patient follow-up and systematic action-oriented assessment, adjusting or intensifying treatment for patients who are not improving. Multiple randomized trials have demonstrated the effectiveness of collaborative care, with a particularly strong evidence base among patients with depression and anxiety.<sup>6</sup>

Collaborative care has also been shown to be effective in diverse practice settings and patient populations. Evidence from Washington State's ongoing Mental Health Integration Program (MHIP) demonstrates the impact of its implementation for a diverse safety-net population, including successful application of a pay-for-performance incentive for follow-up and intensification of treatment.<sup>7</sup> Through the New York State Collaborative Care

<sup>1</sup> Wagner EH, BT Austin, and M Von Korff. 1996. Organizing care for patients with chronic illness. *The Milbank Quarterly* 74(4): 511-544.

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## Appendix A cont'd.

Initiative (NYS-CCI), the State's Department of Health (DOH) and Office of Mental Hygiene (OMH) partnered to support the implementation of collaborative care at 19 academic medical centers statewide, with significant performance and clinical improvement over the course of the two-and-a-half-year initiative.<sup>8</sup> In the Re-Engineering Systems for Primary Care Treatment of Depression (RESPECT-D) study, patients randomized to an integrated model featuring centrally based care managers supervised by shared psychiatrists had significantly better outcomes compared to those receiving usual care, highlighting the feasibility of using shared resources for integration in small practices and rural primary care settings.<sup>9</sup>

Our literature review also focused on studies that included non-CCM variations on integrated models. Insights from the Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E) study, which randomized older adults in diverse primary care settings to a co-location model or an enhanced referral model, highlight the role for specialty referral even in integrated models, as individuals with major depression randomized to the enhanced referral model had better outcomes.<sup>10</sup> The Partners in Care study supported by the Agency for Healthcare Research and Quality (AHRQ) introduced quality improvement (QI) programs for care of depression to a portion of managed care practices in socioeconomically and ethnically diverse communities. Improved outcomes among patients randomized to the QI models in this study highlight how coaching treatment teams (comprising a PCP, nurse, and mental health specialist) in the practice setting through quality improvement initiatives can be effective.<sup>11</sup> The use of telemedicine-based collaborative care to virtually co-locate and integrate mental health providers into primary care settings that lack capacity for an on-site specialist has also been shown to be effective.<sup>12</sup>

<sup>8</sup> Sederer LI, M Derman, J Carruthers, and M Wall. March 2016. The New York State Collaborative Care Initiative: 2012-2014. *Psychiatric Quarterly* 87(1): 1-23. (Published online June 4, 2015.)

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## Appendix B. Key Stakeholders Providing Input for Framework Development\*

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**Jacqueline Delmont, MD**, Delmont Medical Care

**Mary-Ann Etiebet, MD**, Greater New York Hospital Association

**Douglas Fish, MD**, Office of Health Insurance Programs, New York State Department of Health

**David Gould**, formerly, United Hospital Fund

**Larry Grab**, Behavioral Health Utilization Management, Anthem

**Damara Gutnick, MD**, Montefiore Hudson Valley Collaborative

**Amy Jones, MPH**, New York State Office of Mental Health

**Jessie Kavanagh, MPH**, New York State Health Foundation

**Robert La Penna**, Empire BlueCross BlueShield

**Linda Lambert**, New York Chapter, American College of Physicians

**Virna Little, PsyD, LCSW-r, MBA, CCM, SAP**, Institute for Family Health

**Frank Maselli, MD**, Riverdale Family Practice

**Daniel Miller, MD**, Hudson River Healthcare

**Cyndi Nassivera-Reynolds**, Hudson Headwaters Health Network

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**John Rugge, MD**, Hudson Headwaters Health Network

**Kathy Sakraida**, Northeast Business Group on Health

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**Ian Shaffer, MD**, Behavioral Health, HealthFirst

**Steven Shamosh, MD, FACP**, private practice, internal medicine

**Jesse Singer, DO, MPH**, NYC Health + Hospitals

**Emma Stanton, BM, MBA, MRCPsych**, Beacon Health Options

**Jessica Steinhart, MPH**, Staten Island PPS

**William Streck, MD**, Healthcare Association of New York State

**Sal Volpe, MD**, Staten Island PPS, and solo primary care practitioner

\*Also participated in individual key informant interviews.

### With DSRIP Project 3.a.i Model Elements Overlay



### With DSRIP Project 3.a.i Model Elements Overlay



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## Appendix D. Resources on Primary Care–Behavioral Health Integration

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### **SAMHSA-HRSA Center for Integrated Health Solutions**

An overview of various integration models, links to screening and clinical tools, and workforce training development and telebehavioral health resources  
<http://www.integration.samhsa.gov/>

### **Agency for Healthcare Research and Quality (AHRQ) Academy for Integrating Behavioral Health and Primary Care**

AHRQ's Lexicon for BH and PC Integration, screening and clinical tools, and a searchable database of literature on integration  
<https://integrationacademy.ahrq.gov/>

### **Advancing Integrated Mental Health Solutions (AIMS) Center**

Guidance on Collaborative Care implementation, a description of the original IMPACT trial, an overview of the Collaborative Care evidence base, and a searchable resource library  
<http://aims.uw.edu/>

### **Behavioral Health Integration Implementation Guide (developed by the AIMS Center, Qualis Health, the MacColl Center for Health Care Innovation, and The Commonwealth Fund)**

Guidance on integrating care as part of the overall PCMH implementation process, a tool to assist with planning for integration, including resource assessment, and case studies, including one focusing on the Institute for Family Health, a large FQHC in New York State  
<http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Behavioral-Health-Integration.pdf>

### **National Academy for State Health Policy (NASHP)**

Highlights several recent NASHP publications on behavioral health, including one on the role of telehealth/teleconsultation in behavioral health integration, with examples from successful programs (e.g., Project ECHO)  
[http://nashp.org/category/behavioral\\_health/](http://nashp.org/category/behavioral_health/)

### **Center for Health Care Strategies *Integrating Physical and Behavioral Health Care in Medicaid Toolkit***

Online toolkit compiling resources from programs across the country, as well as links to policy-related materials and tools and templates  
<http://www.chcs.org/toolkit/3619-2/>

### **Institute for Clinical Systems Improvement (ICSI) Health Initiatives**

Links to information on various ICSI integration initiatives (e.g., COMPASS, DIAMOND), including implementation guidance and other resources  
[https://www.icsi.org/dissemination\\_implementation/](https://www.icsi.org/dissemination_implementation/)

### **Patient Centered Primary Care Institute *Leadership, Culture, and Change Management***

Resources on initiating behavior and practice change integral to advancing behavioral health integration  
<http://www.pccpi.org/resource-topic/leadership-culture-and-change-management>

### **University of Rochester Medical Center (URMC) *Project ECHO (Extension for Community Healthcare Outcomes)***

Description of URMC's Project ECHO, which provides community-based clinicians with access to behavioral health specialists through video-conferencing technology  
<https://www.urmc.rochester.edu/project-echo.aspx>

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## Appendix E. Behavioral Health Integration Readiness Assessment

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*[The introduction and assessment below are adapted from a survey sent to the component organizations of the Montefiore Hudson Valley Collaborative (MHVC) Performing Provider System (PPS), participating in the New York Medicaid Delivery System Reform Incentive Payment (DSRIP) program.]*

This survey is part of the MHVC Behavioral Health Integration project (3.a.i), which aims to integrate primary care and behavioral health. It is based on a Behavioral Health Integration Continuum framework developed by Henry Chung, MD, of Montefiore Health System, working with Harold Pincus, MD, of Columbia University and NewYork-Presbyterian Hospital, Hope Glassberg, MPH, of HRHCare Community Health, and Nina Rostanski, MPH, of Montefiore Health System.

The framework shows a progression of steps that primary care practices can take to work toward fully integrated status. This survey will be used to determine your site's current positioning on the continuum, in eight distinct domains, and will assist MHVC as we create learning collaboratives in which your team can participate.

We suggest that an interdisciplinary practice team—comprising, at a minimum, a PCP champion, a practice administrator, and, depending on resources, a nursing staff member and a social worker and/or care manager—review the Continuum together (downloadable at [www.uhfnyc.org](http://www.uhfnyc.org)), evaluating the extent to which each component is consistently applied at your site. Then the team can complete the detailed survey below.

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*Please answer all 15 of these questions for your PRACTICE or SITE. Select the response that best describes your site's workflow as it is conducted at least 70% of the time.*

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### Identification of Patients and Referral to Care

#### 1. Does your site have a process for identification and referral to care for patients with BH issues?

- ☐ Yes [proceed to NEXT QUESTION]
- ☐ No [go to NEXT DOMAIN (MULTIDISCIPLINARY TEAM APPROACH)]

**2. Please select the statement that best describes your site's workflow as it is performed at least 70% of the time:**

- A. Patients are only identified when they present with BH symptoms (no systematic screening performed).
- B. Systematic screening, including a follow-up assessment, of *target* populations (e.g., patients with diabetes or CAD) is performed.
- C. Systematic screening of *all patients*, with diagnostic confirmation by a trained clinician as indicated, is performed.
- D. Population stratification or analysis as a component of both outreach and screening is in place, routinely followed by assessment and engagement.

**3. Please select the statement that best describes the system your site utilizes for BH referrals at least 70% of the time:**

- A. Patient is referred to an external BH specialist or psychiatrist.
- B. Patient is referred to an external BH specialist or psychiatrist with an existing memorandum of understanding or written agreement, with engagement and feedback strategies employed.
- C. A process is in place for “warm transfers” to a BH specialist or psychiatrist, either co-located or external to the practice site.
- D. Patient referral and tracking is performed via the EHR or alternative data-sharing mechanism, with engagement and accountability mechanisms.

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**Multi-disciplinary Team Approach to Care (Includes Patients)**

**4. Please select the description of a “care team” that best aligns with your practice at least 70% of the time:**

- A. Care team consists solely of patient and PCP.
- B. Care team consists of patient, PCP, and ancillary staff member.
- C. Care team consists of patient, PCP, and BH specialist.
- D. Care team consists of patient, PCP, care manager (CM), and psychiatrist (who consults and is engaged in CM case reviews).
- E. Care team consists of patient, PCP, CM, BH specialist, and psychiatrist (who consults and is engaged in CM case reviews).

**5. How does the team review and consult on cases *at least 70% of the time*?**

- A. Communication with the BH specialist is driven by necessity or urgency.
- B. There is formal written communication (notes/consult reports) between the PCP and BH specialist on complex patients.
- C. There are regular formal meetings between the PCP and BH specialist.
- D. Weekly scheduled team-based case reviews focus on patients who are not improving.

**6. What is the extent of interpersonal contact between the PCP and BH specialist/psychiatrist *at least 70% of the time*?**

- A. Very limited interpersonal interaction (occasionally using a patient as a conduit).
- B. Occasional interaction, possibly through ancillary staff members or the sharing of reports or laboratory results.
- C. Communication occurs in person or via telephone at scheduled times.
- D. Interaction occurs informally, as needed, throughout the day.

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**Continuous Care Management**

**7. Please select the statement that best describes how patients are followed by your practice *at least 70% of the time*:**

- A. Limited follow-up is provided by office staff.
  - B. There is proactive follow-up to assure engagement and early response to care.
  - C. A registry is maintained with ongoing measurement, tracking, and proactive follow-up, including an active provider and patient reminder system.
  - D. A registry is maintained as described above, and there is behavioral health activation and relapse prevention with assertive outreach to patients (including field-based visits) when necessary.
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### Systematic Quality Improvement

#### 8. How are quality metrics used for program improvement *at least 70% of the time*?

- A. There is only informal or limited review of BH quality metrics (limited use of data, anecdotes, or case series).
- B. Metrics are identified and used to some extent to review performance.
- C. Measures are identified and there is some ability to review performance against metrics and develop improvement strategies.
- D. There is ongoing systematic quality improvement with the monitoring of population-level performance metrics and implementation of improvement projects by a dedicated quality improvement team.

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### Decision Support for Measurement-based Stepped Care

#### 9. How are evidence-based guidelines or treatment protocols used in your practice *at least 70% of the time*?

- A. There is limited training on guidelines or protocols related to BH disorders and treatment.
- B. PCPs are provided training on evidence-based guidelines for common behavioral health diagnoses and treatments.
- C. There is standardized use of evidence-based guidelines for all patients, including tools for consistent symptom monitoring.
- D. There is systematic symptom tracking for all patients with a BH diagnosis; formal stepped-care algorithms are used for patients not responding to treatment.

#### 10. Who is primarily responsible for pharmacotherapy at your site *at least 70% of the time*?

- A. PCP initiates treatment, with limited ability to refer and limited guidance on medications.
- B. PCP initiates treatment and, when necessary, referrals are made to BH specialist/psychiatrist for follow-up.
- C. Prescribing is managed by the PCP with support from the BH specialist/psychiatrist.
- D. Prescribing is managed by the PCP, with a care manager supporting adherence between visits and BH specialist/psychiatrist support.



**11. What access is available to evidence-based psychotherapy treatment with a BH specialist at your site *at least 70% of the time*?**

- A. Supportive guidance is provided solely by the PCP.
- B. Treatment is provided off-site through pre-specified arrangements.
- C. Brief psychotherapy interventions are provided on-site by BH specialists.
- D. Brief psychotherapy interventions are provided on-site by BH specialists with formal evidence-based guideline training, as part of the overall care team; information is exchanged as part of the case review.

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**Self-Management Support that is Culturally Adapted**

**12. What tools are used, *at least 70% of the time*, to promote patient activation and recovery?**

- A. PCP provides brief education about the condition.
- B. PCP provides brief education about the condition, including educational materials/workbooks, but with limited self-management coaching and activity guidance.
- C. PCP provides education and self-management coaching and activity guidance.
- D. Systematic education and self-management goal setting with relapse prevention is provided, with case management support between visits.

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**Information Tracking and Exchange among Providers**

**13. Please select the statement that best describes the type of registry maintained for tracking and care coordination in your practice.**

- A. There is an informal method for tracking patient referrals to BH specialists/psychiatrists.
- B. When patients are referred to outside BH specialists/psychiatrists there are clear expectations for communication and follow-up with the PCP practice.
- C. There is a formal patient registry to track and manage patients, including severity measurement, attendance at visits, and care management interventions.
- D. The registry is integrated into the EHR and includes severity measurement, attendance at visits, and care management interventions; selected medical measures are tracked when appropriate.

**14. How is treatment information shared *at least 70% of the time*?**

- A. Treatment information is not regularly shared.
- B. Treatment information is shared informally by phone or in the hallway, without regular chart documentation.
- C. Treatment information is exchanged through in-person or telephonic contact, with chart documentation.
- D. Treatment information is routinely shared through electronic means (registry, shared EHRs).

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**Linkages with Community and Social Services**

**15. How are referrals to housing, entitlement, and other social support services made *at least 70% of the time*?**

- A. There are no formal arrangements but referral resources are available at the practice.
- B. Referrals are made to organizations; there may be some formal arrangements but little capacity for follow-up.
- C. Patients are linked to community organizations and resources with formal arrangements and consistent follow-up.
- D. A unified care plan is developed, shared, and implemented across agencies.

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## Appendix F. Resources on New York State Regulations

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### DSRIP Project 3.a.i

NYS DOH/OMH/OASAS. January 2016. *Integration of Primary Care and Behavioral Health Services—Models and Approaches* (webinar slides).

[https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/docs/integrate\\_serv\\_webinar.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/integrate_serv_webinar.pdf)

NYS DOH. January 2016. *Integrated Care Approaches—FAQs*.

[http://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/2016/docs/201601\\_integrated\\_care\\_faqs.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/docs/201601_integrated_care_faqs.pdf)

NYS DOH DSRIP Program. April 1, 2015. *A Reference Guide for Behavioral Health Projects Implementation Planning*.

[http://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/docs/behavioral\\_health\\_implementation\\_plan.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/behavioral_health_implementation_plan.pdf)

NYS DOH. *DSRIP Project 3.a.i Licensure Thresholds*.

[https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/regulatory\\_waivers/licensure\\_thresholds.htm](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/regulatory_waivers/licensure_thresholds.htm)

NYS DOH/OMH/OASAS. *Integrated Outpatient Services—Implementation Guidance*.

<http://www.oasas.ny.gov/legal/CertApp/documents/IOSGuid.pdf>

### New York State Advanced Primary Care Initiative

NYS DOH. December 2015. *New York State's Advanced Primary Care Model—FAQs*.

[https://www.health.ny.gov/technology/innovation\\_plan\\_initiative/docs/advanced\\_primary\\_care\\_faqs.pdf](https://www.health.ny.gov/technology/innovation_plan_initiative/docs/advanced_primary_care_faqs.pdf)

New York State Integrated Care Workgroup additional information and ongoing updates

[https://www.health.ny.gov/technology/innovation\\_plan\\_initiative/workgroups.htm](https://www.health.ny.gov/technology/innovation_plan_initiative/workgroups.htm)

### Additional New York State guidance

NYS OMH. *Telepsychiatry Services Guidance*

[http://www.omh.ny.gov/omhweb/clinic\\_restructuring/telepsychiatry.html](http://www.omh.ny.gov/omhweb/clinic_restructuring/telepsychiatry.html)

NYS DOH. *Data Security and Information Sharing*.

[https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/data\\_security/index.htm](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/data_security/index.htm)