California Quality Collaborative

Tuesday, September 11, 2024

11 a.m.- 12 p.m. PT

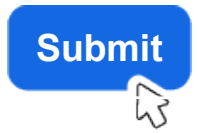
Readiness for Behavioral Health Integration

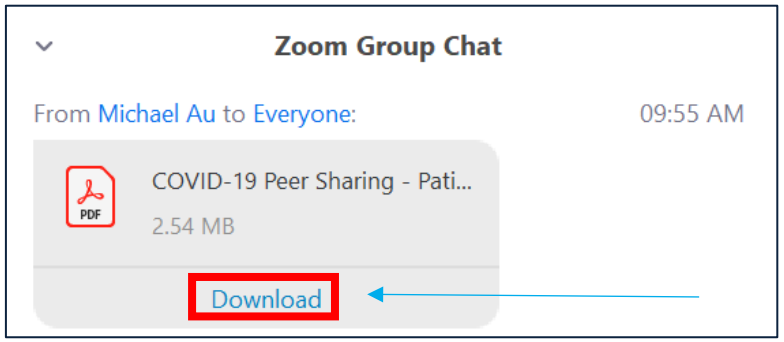
Behavioral Health Integration Implementation Webinar Series

California Quality Collaborative

Tech Tips – Zoom Meetings

Click the blue **submit button** to complete polls





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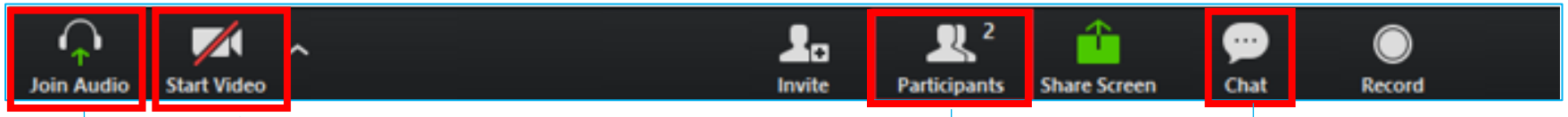


Click to join or mute audio

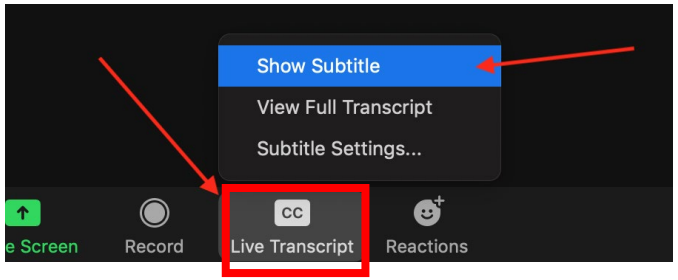
All attendees have video off upon entry

Click to see who else has joined

Ask questions and insert comments

Direct message Anna Baer for technical issues

Recording and deck will be shared with attendees



Request live closed captioning or view full meeting transcript

California Quality Collaborative

Advancing the quality and efficiency
of the outpatient health care delivery system by
creating scalable, measurable improvement.

Launched in 2007, CQC is a **multi-stakeholder program.** Core funding from health plans sharing a delivery system.

Identifies and spreads best practices across outpatient delivery system in California

Trains 2,000 individuals from 250 organizations each year

CQC's track record includes **20% relative improvement** in clinical outcomes and **10:1 ROI**

Sponsors

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Today's Objectives

Understand what key characteristics set organizations up for behavioral health integration success

Analyze how to build internal readiness, including clinical, operational and financial

Prioritize what step to take first to prepare for behavioral health integration

Poll

Where are you dialing in from?

- Northern California
- Southern California
- Other West Coast
- East Coast
- Midwest
- Southwest

What type of organization do you represent?

- Patient
- Provider/Practice
- Health Plan
- Government Agency
- Technical Assistance Organization
- Research Agency
- Other [chat in]

Introducing Our Speakers

Stephanie Gold, MD, FAAFP
Associate Professor,
Department of Family Medicine,
University of Colorado

Lesley Manson, PsyD,
Clinical Associate Professor,
Clinical Associate Chair of Integrated Initiatives,
Integrated Behavioral Health, College of Health Solutions, Arizona State University

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Readiness for Behavioral Health Integration

Behavioral Health: the Need

60%

Percentage of Americans with **unmet mental health needs***

75%

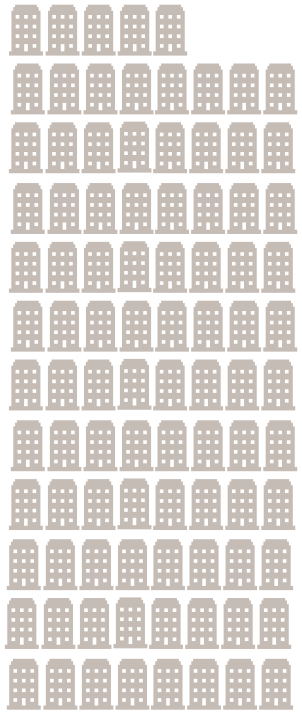
Percentage of primary care visits including **mental or behavioral health components****

28 of 50

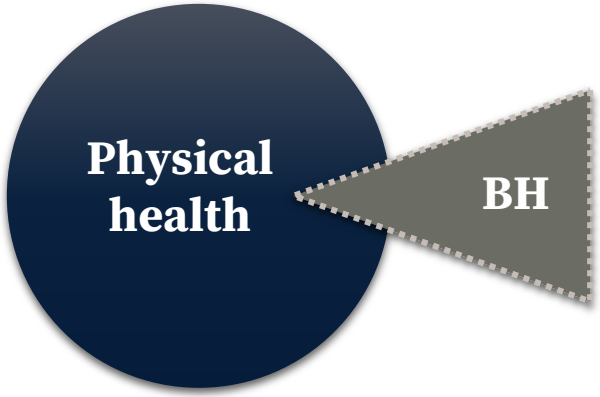
Nationwide **ranking of California** based on a composite measure on prevalence of mental health conditions, substance use, suicidal ideation and access to treatment***

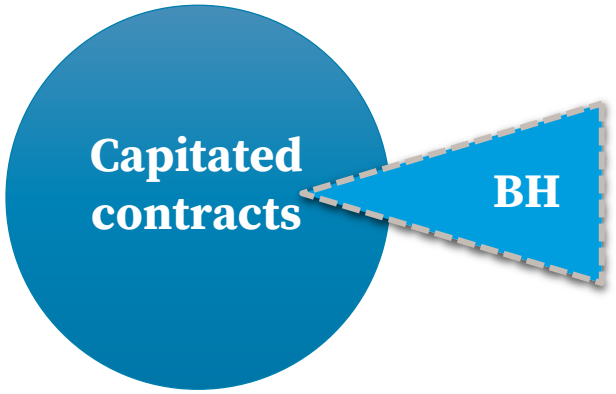
Sources: * JAMA, 2005; **Family Practice Management, 2021; ***Mental Health America, 2022

California's Landscape



93 different payers
(health plans and delegated provider organizations)





Two (often overlapping) **carve-outs**

- Mental health benefits
- Capitated arrangements

Sources: California Health Care Foundation. California Health Insurers and Enrollment – 2023 Edition
"Weaving Together Mental and Physical Health Care Outside the Safety Net," CQC (May 2020)

Moving to Integrated Care | Levels of Collaboration/Integration

Behavioral health integration **fortifies primary care** by bringing together primary care and behavioral providers, working with patients and families.

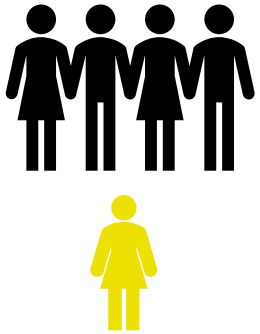
- Patient outcomes
- Patient/family engagement
- Provider care/team satisfaction

- Cost/utilization
- Administrative coordination
- Provider care/team burnout

Coordinated		Co-Located		Integrated	
Level 1 Minimal Collaboration	**Level 2** Basic Collaboration at a Distance	**Level 3** Basic Collaboration Onsite	**Level 4 Close** Collaboration Onsite with Some System Integration	**Level 5** Close Collaboration Approaching an Integrated Practice	**Level 6** Full Collaboration in a Transformed/ Merged Integration Practice

Source. SAMHSA, Six Levels of Collaboration/Integration

Moving to Integrated Care | Two Models

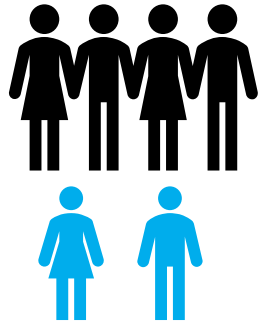


Primary Care Behavioral Health Model

- Available for primary care population for any behaviorally influenced concern
- Adds licensed behavioral health professional as behavioral health consultant
- Often billed under behavioral health benefits, directly by BH provider

Collaborative Care Model

- Targets specific population (mild-to-moderate depression) using registry and PHQ-9 and psychotropic medication
- Adds psychiatric consultant and behavioral health care manager
- Often billed under medical benefits, "incident to" PCP



▶ ***Learn more:***

- CQC BHI Implementation Snapshot: Selecting an Integration Model
- CQC Webinar: BHI Concepts & Models (6/13/23)

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Readiness for Behavioral Health Integration

Clinical & Operational

Behavioral Health Integration in Primary Care: Building Blocks

Project team:

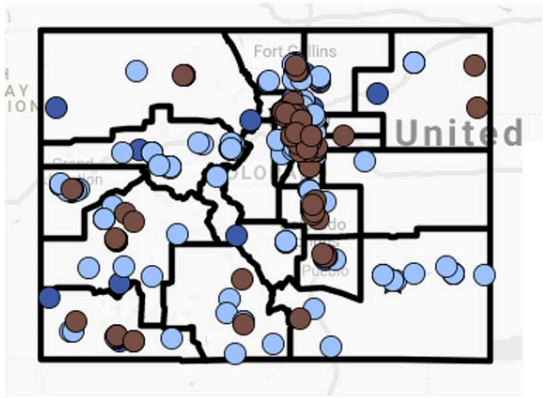
Stephanie Gold, MD
Perry Dickinson, MD
Emma Gilchrist, MPH
Stephanie Kirchner, RD, MSPH
Bahroze Rakeen, MA
Larry Green, MD

Behavioral Health Integration in Primary Care: Building Blocks

…the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Definition prepared for the Agency for Healthcare Research and Quality by CJ Peek and the National Integration Academy Council

Behavioral Health Integration in Primary Care: Colorado's Story



An Act

HOUSE BILL 22-1302

BY REPRESENTATIVE(S) Kennedy and Will, Amabile, Gonzales-Gutierrez, Michaelson Jenet, Bernett, Bird, Boesenecker, Cutter, Duran, Esgar, Exum, Gray, Herod, Hooton, Lindsay, Lontine, McCluskie, McCormick, Sirota, Titone, Weissman, Caraveo, Valdez A., Woodrow; also SENATOR(S) Jaquez Lewis and Priola, Buckner, Hinrichsen, Kolker, Lee, Moreno, Pettersen, Winter.

CONCERNING HEALTH-CARE PRACTICE TRANSFORMATION TO SUPPORT WHOLE-PERSON HEALTH THROUGH INTEGRATED CARE MODELS, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

Be it enacted by the General Assembly of the State of Colorado:

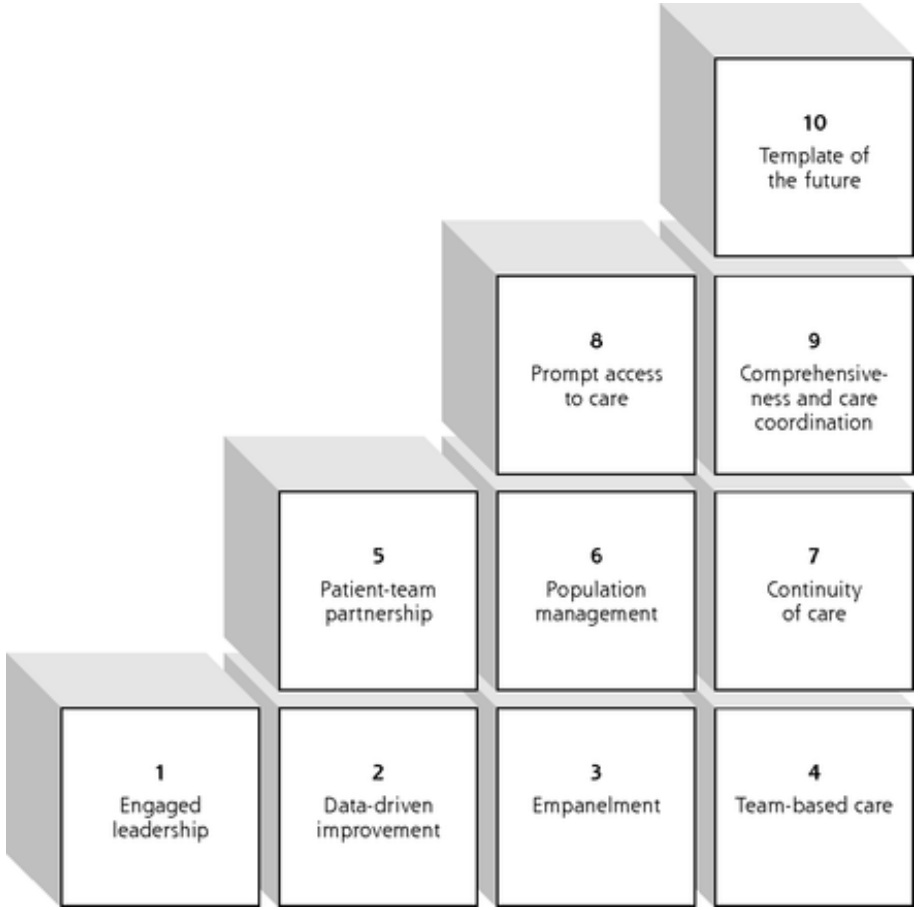
Appendix B: Aligned Core Competencies for Primary Care

The core competencies listed in the following table outline key capacities or skills that are needed for primary care providers to provide high quality, person-centered, whole-person care. Each row represents a "domain" or category of care delivery Each domain is further delineated into three (3) levels or tracks, with Track 1 reflecting competencies for practices that are starting the care transformation process and Track 3 reflecting competencies of a more advanced practice.

The aligned core competencies establish a common set of expectations around the type of care that primary care providers participating in APMs should have in order to deliver high-quality, person-centered, whole-person care. Carriers must support providers' achievement of the competencies through financial incentives. Carriers may determine the level and type of financial incentive(s), including but not limited to upfront payments, incentive structures, target performance levels, and reporting requirements, in mutual agreement with the provider to align with patient panel needs and practice priorities. Carriers and providers may determine additional competencies and activities that are appropriate within each domain, and at each level, and the process for evaluating performance and progress.

Care Delivery Domain	Track 1	Track 2	Track 3
Leadership	• Practice leadership sets practice-wide expectations for evaluating and improving clinical and operational processes and outcomes, and for incorporating health equity principles into operational processes and quality improvement initiatives. • Practice leadership allocates appropriate resources (including time for appropriate quality improvement team membership) to ensure continuous quality improvement.	• Practice leadership develops and implements a process to review and evaluate clinic level quality improvement initiatives, including the creation of an improvement plan for each area of opportunity.	• Practice leadership incorporates health equity principles into quality improvement initiatives.
Data Driven Quality Improvement	• Practice sets quality metric goals using benchmarks and reviews performance on internally validated clinical quality measures at least quarterly.	• Practice uses an organized quality improvement approach to meet quality measure goals/benchmarks for at least one clinical quality measure.	• Practice collects and reports on measures specific to behavioral health efforts and tracks performance relative to targets. This includes tracking reach and outcomes with validated measures (e.g., PHQ-9, GAD-7,

Behavioral Health Integration in Primary Care: Building Blocks



Behavioral Health Integration in Primary Care: Building Blocks

Foundational Care Delivery Expectations: requirements for any practice integrating behavioral health.

Additional care delivery expectations by components:

- **Advanced Coordination and Care Management**
- **Psychiatry**

→ **CoCM**

- **Integrated Behavioral Health Professional**

→ **PCBH**

- **Advanced Care of Substance Use Disorders**

Behavioral Health Integration In Primary Care: Building Blocks

Advanced Coordination and Care Management:

- Practice develops shared expectations and exchanges information with behavioral health providers
- Practice manages a registry of patients with target behavioral health condition(s)
- Practice screens for social needs and links patients and families to services

Behavioral Health Integration In Primary Care: Building Blocks

Psychiatry:

- A psychiatrist supports complex diagnostic evaluation and medication management, providing consultation to the primary care provider.
- They may provide direct patient care either in person or via telehealth.

Behavioral Health Integration In Primary Care: Building Blocks

Integrated Behavioral Health Professional:

- An integrated behavioral health professional (which could be a psychologist, licensed clinical social worker or other licensed professional) works as part of the primary care team.
- The integrated behavioral health professional provides counseling, diagnostic support, crisis management, and behavior change support in partnership with the primary care provider.
- Services can be provided in person or via telehealth.

Behavioral Health Integration In Primary Care: Building Blocks

Advanced Care of Substance Use Disorders:

- The primary care provider prescribes medication for substance use disorders including tobacco use disorder, alcohol use disorder, and opioid use disorder.
- Counseling related to substance use disorders is provided in the practice or coordinated with resources outside of the practice.

Behavioral Health Integration In Primary Care: Foundational Elements Regardless of Model

Building Block	Foundational Care Delivery Expectations
Leadership	• Defined mission and vision • Defined BH champion or team • Budget with allocated resources for transformation and QI work related to BHI
Data-Driven QI	• Regularly review data and processes for QI including related to BH efforts • Collects, reports, and monitors performance on measures specific to BH efforts
Team-Based Care	• Clearly defined roles, responsibilities, and workflows related to BH services • BH training into onboarding and professional development

Behavioral Health Integration In Primary Care: Foundational Elements Regardless of Model

Building Block	Foundational Care Delivery Expectations
Patient and Family Engagement	• Educates patients and family members/caregivers on availability of BH services • Obtains feedback from patients and/or caregivers/family members on BH services • Provides self-management support
Population Management	• Universal screening for at least one priority mental health condition, one priority substance use condition, and one lifestyle behavior • Ensures positive screens are offered treatment • Reassesses symptoms, side effects, complications, and treatment adherence at regular intervals and utilizes evidence-based stepped care guidelines

Behavioral Health Integration In Primary Care: Foundational Elements Regardless of Model

Building Block	Foundational Care Delivery Expectations
Access	• Physical spaces and services are accessible and responsive to diverse needs • BH services available by telehealth and asynchronous communication
Comprehensiveness and Care Coordination	• Medication management for mild to moderate BH conditions • Links to therapy and/or specialty mental health settings as indicated • Referral pathways for patients with BH conditions • Ensures primary referral sources have appointment availability • Tracks completion of BH referrals • Provides crisis resources and referrals

Behavioral Health Integration In Primary Care: Building Blocks

Foundational Care Delivery Expectations: requirements for any practice integrating behavioral health.

Additional care delivery expectations by components:

- **Advanced Coordination and Care Management**
- **Psychiatry**
- **Integrated Behavioral Health Professional**
- **Advanced Care of Substance Use Disorders**

Behavioral Health Integration in Primary Care: What We've Learned About Practice Readiness

- You CAN (and should) get started laying groundwork even before you have a BHP
- Recognize BHI is a transformation of practice, not a small QI project
- For practices newer to change management, practice facilitation and peer learning are valuable

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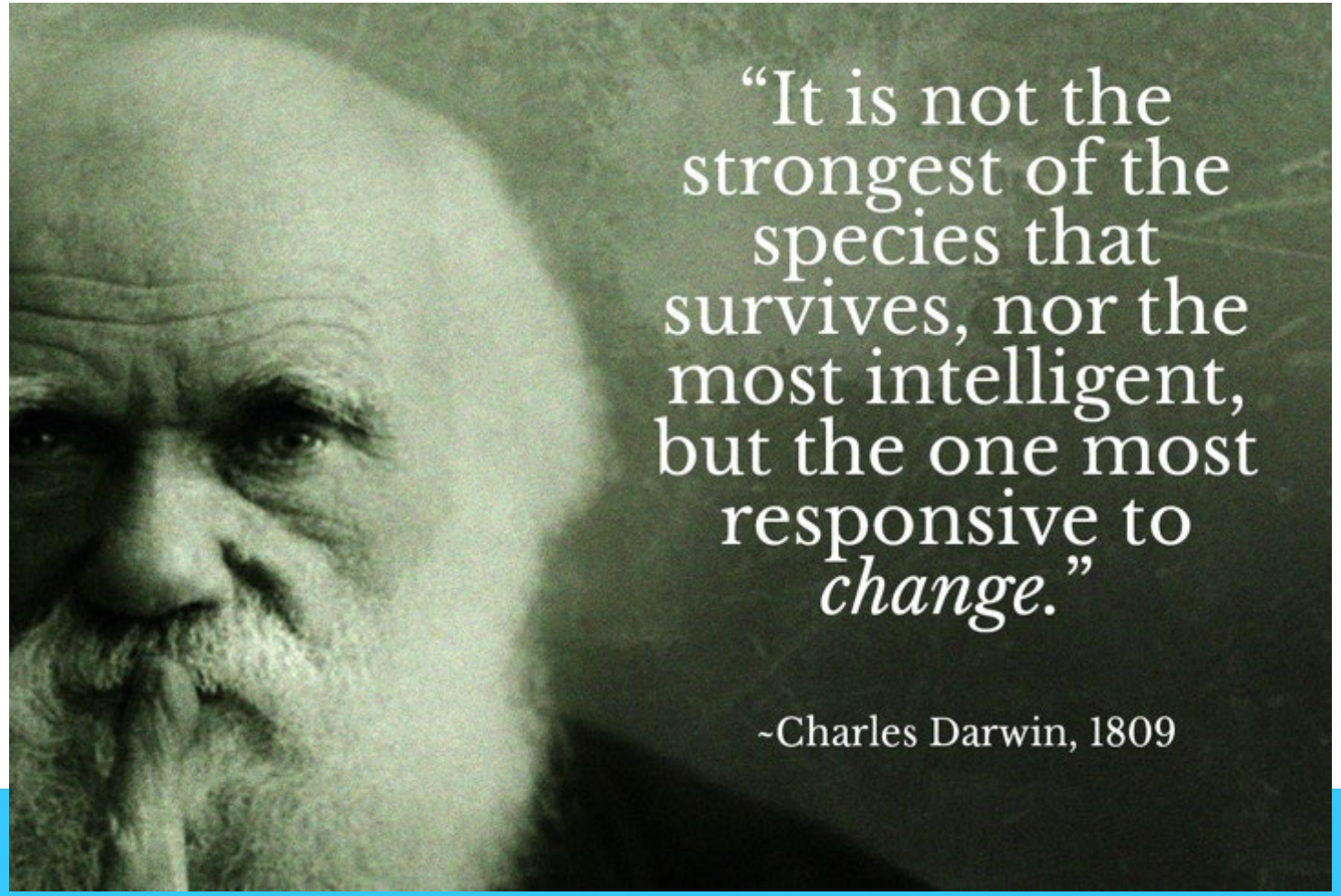
Readiness for Behavioral Health Integration

Sustainability Focus

5-STEPS to Sustainability: Overcoming the Reimbursement/ Fiscal Sustainability Challenge!

- Healthcare Institution Site License (*legalities*)
- Site Type
- Payers (*stakeholders*)
- Provider License Type (*workforce*)
- Service Delivery and Coding (*business case*)



What is your model?

How did you align it?

Integrated Care Assessment Tools

- Integrated Practice Assessment Tool (IPAT)
- Behavioral Health Integration Capacity Assessment (BHICA)
- Practice Integration Profile (PIP)
- Maine Health Access Foundation (MeHAF)
- Level of Integration Measurement (LIM)
- AIMS BHI Checklist
- Referral Barriers
- Readiness Tools (PCBH and CoCM)
- Barriers to Same-Day
- Core Competency
- Standard Framework
- Integrated Tx Tool
- IBHP Evaluation Tool (PPAQ)
- Dual Dx Capability in Health Care Settings (DDCHCS)
- Operational tools (*Dr. Gold's/U of Colorado*)

Planning, Implementation and Sustainability

- **Core Elements:**
  - **Systematic and operationalized**
  - **Employs evidence-based practices**
  - **Promotes change across the system - from patient to policy**
  - **Flexible**
  - **Uses metrics and data for quality improvement and assurance**
  - **Builds and refines return on investment analysis**

Barriers, Pitfalls, Challenges

- Lack of knowledge of BH and PCPs
- Mental health focus
- Closed door
- Communication concerns
- Funding/Cost $
- Lack of brevity in training in brief (CBT, ACT, etc.) or solution focused - self-mgmt. skill building evidence-based treatments
- Lack of training of BH and PCPs
- Buy-In (*executive leadership, practice management, and providers*)
- Transparency
- Space
- Roles and Responsibilities
- Patient's not aware
- Limited Team Based Care Functioning and Training
- Limited Model Fidelity
- Isolation
- Time Management
- Regression (*MH only; closed door*)
- EHR Limitations
  - Data Mining Limits
  - Sharing Limitations
- Lack of Monitoring
- Poor Management

1. Understand Your Legal Requirements

- Identify your health care institution site licensure. This will define your parameters for service provision and hiring. (Example: integrated site, hospice, hospital, other.)
- Identify and review your state office of administrative counsel rule making regarding your facility.
- Review your state laws:
  - Are you **legally** able to offer integrated care or other specific services?
  - Do you need to complete a state application if you are preparing to offer integrated care or CMS services?
  - Do you need to complete a state application for service?

2. Site Type

A. Identify your site type (identify how your site is classified? E.g.: ACO, FQHC, RHC, etc.). *This will assist with identifying state and federal payment models and eligibility for quality reimbursement initiatives. Further, it will provide information on which professionals are reimbursable for which services.*

B. This helps to identify the way you can receive **direct reimbursement**, health savings, and outcome measurements. Fiscal direct pro forma as well as return on investment and cost savings are primarily dependent on site. Many sites have specific eligibility for quality reporting, funding, and reimbursement models.

   i. Are there rules, regulations, and support for my specific entity for integration?

   ii. Do I have or wish to develop certifications in integrated behavioral health care (NCQA, CARF, etc.)?

   iii. Do I report specific behavioral metrics already related to chronic health conditions and behavioral health (HEDIS, NCQA/PCMH, Joint Commission, PQRS, UDS, MACRA), which I can leverage for IBH development and quality health outcome improvements?

3. Stakeholder Communication

- **Develop patient advisory councils, patient questionnaires, and/or community stakeholder** meetings to identify needs, interest, and further insight into program development.
- **Utilize IBH Screening tools and questionnaires to identify and address provider needs in developing IBH programming and services**. Leverage data mining for common diagnoses, treatment considerations, screenings, CPT coding, registry use, and health maintenance and quality outcomes data for further program development.
- **Contact payers (insurance programs)** to identify **reimbursement** (service types, program types, value contracts), health savings, bundling payments, and **outcome measurements** needed for sustainability. Payers identify the licensure, regulations, and documentation requirements of providers, services, and program. Identify specific state, federal, and private rules and regulations for integrated care services.

Patient & Family Outcomes	Team Outcomes
Satisfaction	Satisfaction
Engagement	Productivity
Adherence	Accurate problem and early identification
Self-care	Fewer errors
Fewer missed visits	Less turnover and burnout: Reduced presentism and absenteeism
Clinical outcomes	Fiscal return

National Quality Strategy & Quintuple Aims

- Promote effective chronic care management
- Make full care accessible
- Make care safer
- Promote community and population health
- Promote effective care coordination
- Integrated team-based care
- Strengthen patient and family engagement
- Equitable care

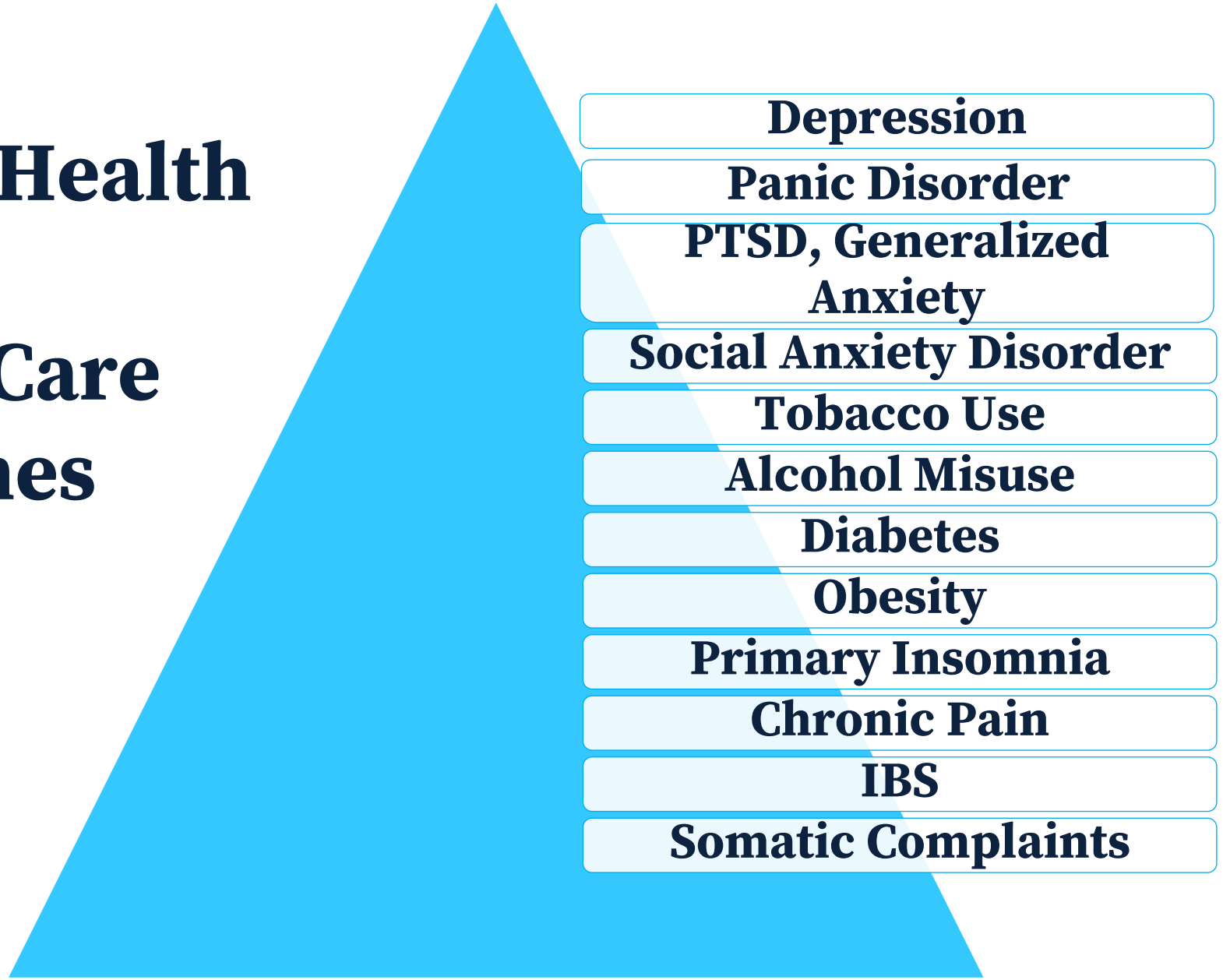
Provider/Team and Patient Satisfaction

Equity in Care

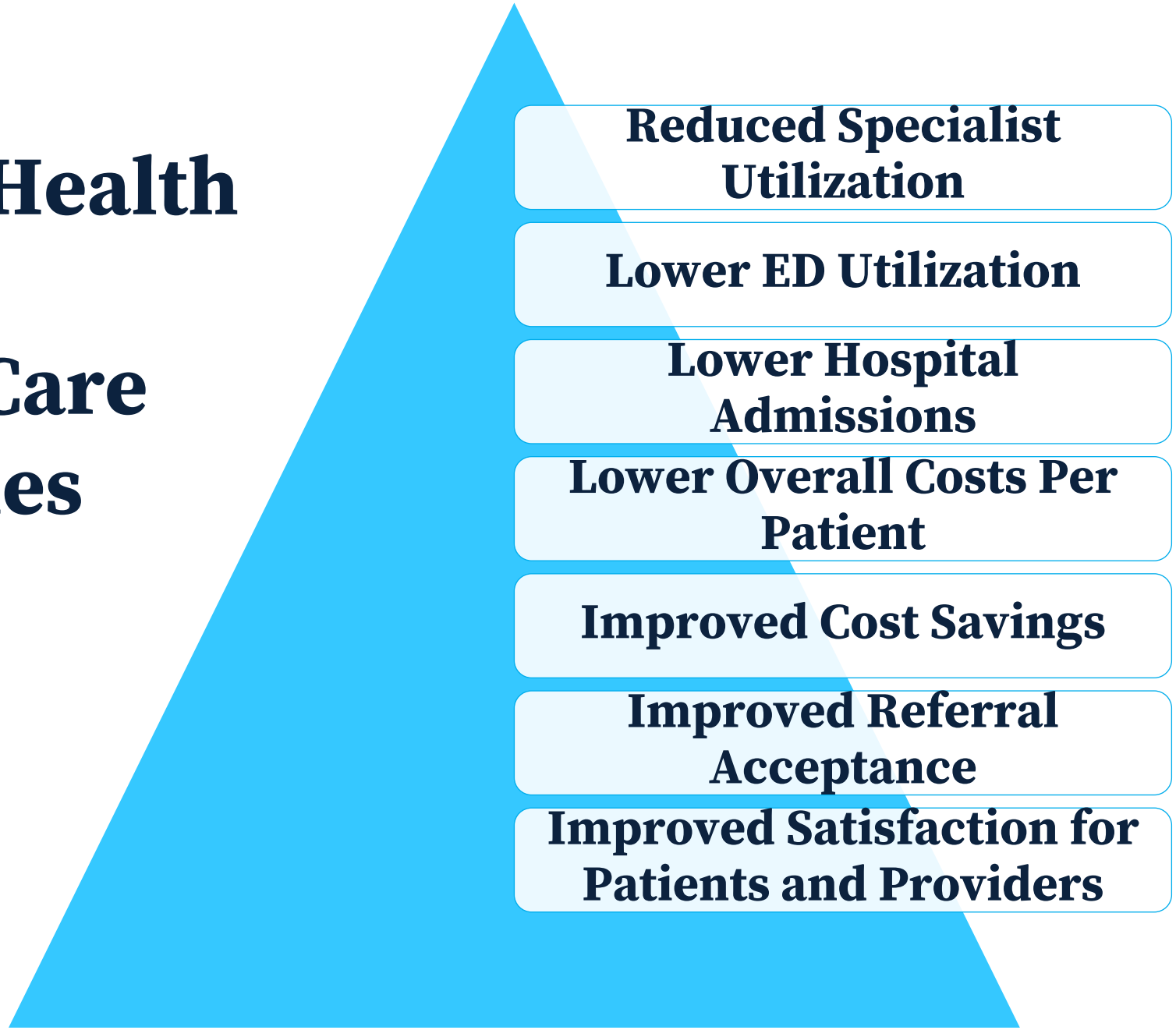
Population Health Improvement

Fiscally Sound Healthcare

Behavioral Health and Primary Care Outcomes



Behavioral Health and Primary Care Outcomes



Metrics/Measures

National Quality Forum (NQF)

Qualified Clinical Data Registries (QCDR)

National Committee for Quality Assurance (NCQA) [PCMH/IC/HEDIS]

Healthcare Effectiveness Data and Information Set (HEDIS) measures

Quality and Performance Measures (QPM)

Uniform Data System (UDS)

CMS Part B Claims Measures

CAHPS, Merit Based Incentive Payment Systems

Joint Commission

Commission of Accreditation of Rehabilitation Facilities (CARF)

Agency for Healthcare Research and Quality (AHRQ)

QPP CMS

Physician Consortium for Performance Improvement

Specialty & Specific Task Forces: Example: American College of Allergy, Asthma and Immunology (ACAAI), the American Academy of Allergy, Asthma and Immunology (AAAAI)]; American Dental Association

Clinical Metrics

- ❑ Mortality
- ❑ Health status
- ❑ Biometrics
- ❑ Disease prevalence
- ❑ Disability status
- ❑ Health Maintenance
- ❑ Population Health
- ❑ Health Assessments (screening tools)
- ❑ ED visits
- ❑ Re-admission
- ❑ NCQA HEDIS
- ❑ QPP: MACRA
- ❑ UDS / NQF / CMS
- ❑ CARF/JACHO
- ❑ QI Goals
- ❑ RVUs/Productivity
- ❑ Fiscal ROI
- ❑ NCQA PCMH, BH
- ❑ Employee wellness
- ❑ Job satisfaction
- ❑ Financial: *cost of care, efficiency, comparisons, productivity, ROI*
- ❑ Employment sustainment
- ❑ Satisfaction
- ❑ Length of visit
- ❑ CPT coding
- ❑ Insurance / coding requirements
- ❑ Diagnosis coding
- ❑ Visit type
- ❑ Productivity
- ❑ Evidence based care
- ❑ Huddles & communication
- ❑ Documentation
- ❑ Access to care
- ❑ Team handoffs
- ❑ Wait time
- ❑ Cost of care

Making it Meaningful

- Create a VBP internal workgroup to determine QI/QA (PDSA cycles) and engagement plan for meaningful VBP.
- Consider a timeline which supports didactics, applied and reinforced learning (consider 12-24 mos. with repetitive learning cycles)
- Introduction to VBP
  - Models, participation, myths, facts, financial considerations, incentives, quality care, sustainability, whys and value in mission
- Overview of current status of organizations data outcomes
  - Equity, SDOH, satisfaction, finance, patient outcomes, population specific, access, team penetration, etc.
- Equity, Access, and SDOH
  - Current population needs, access, and ways integrated team-based care is an effective intervention
  - Review specific interventions, changes, challenges, and opportunities
- Risk Adjustment Factor scores (RAFs), Hierarchical Condition Category (HCC), and Specific Metrics
  - SDOH, access, population health stratification, and implications on health status
  - Intervention and documentation requirements, health plan, organization, and provider risks
- Referrals and Resources
  - Considering referrals, specific PH programs, payer support, and community collaboratives
  - Internal trainings for improved specialty screening, utilization
- Measuring Impact of Care
  - Translating data and mission and outcome driven care (don't lose the mission of our care and impact)
  - Risks and rewards (outcomes and financial implications)
- Advocacy (Workgroups, community relationships, and Legislation)
  - Developing community alignments, consider contract partnerships, join state and federal workgroups
  - Legislation advocacy to direct change, negotiation strategies

Framework

$ Fee for Service	Fee for Service – Link to Quality & Value	Fee for Service Architecture	Population Based Payment
No Link to Quality & Value	Foundational Payments for Infrastructure & Operations (care coordination)	Shared Savings (episode-based payments for procedures and comprehensive payments; incentives)	Condition Specific Population Based Payment (per member per month, payments for integrated care)
	Pay for Reporting (bonuses and penalties re reporting data)	Risk Based Payments Not Linked to Quality	Comprehensive Population Based Payment (global budgets- fixed $, fixed time, fixed population)
	Pay for Performance (bonuses for quality performance)		Integrated Finance and Delivery System (global budgets- fixed $, fixed time, fixed population in integrated systems) Global capitation
			Capitated Payments Not Linked to Quality

Health Plan Risk ← → **Provider Risk**

VBC Foundational Tenants

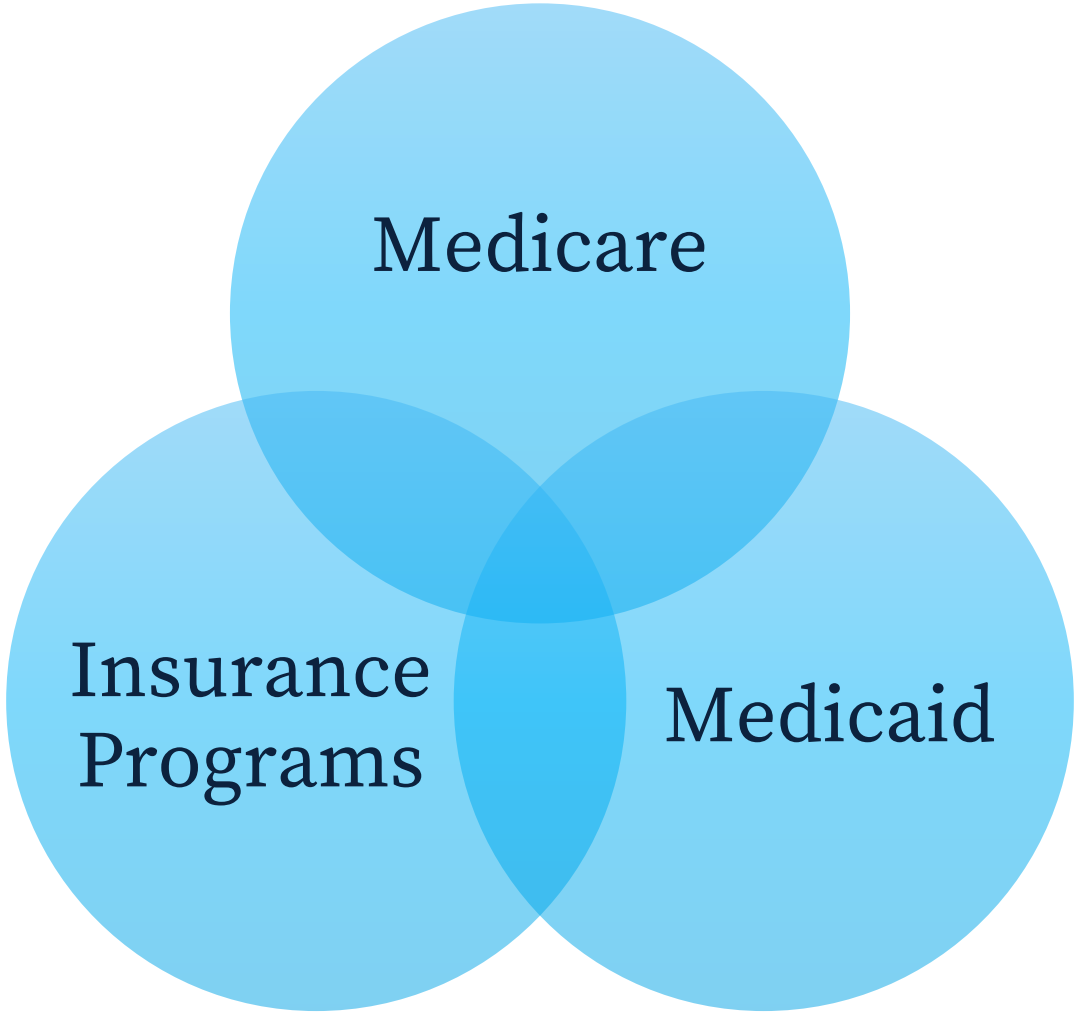
- Performance drivers
- Standardized measures / Improvement activities
- Flexible for program, scope, practice
- High quality care / Improve patient outcomes
- Cost effective care / Efficiency
- Improve the experience of care / Patient engagement
- Collaborative & purposeful patient engagement
- Interoperability / Time cycle / Technology
- Coordinated care (*shared care plans; planned care for chron neighborhoods; registries*)
- Health equity (*screenings*)

VBC Foundational Tenants

- Pay for performance / Payment reform
- Bundling
- Transparent and effective payment methodologies
- Risk management / Efficiency scores (*inpatient hospital, emergency room, medical imaging, pharmacy, laboratory, and specialists; patient risk flags*)
- Cost savings (*drug utilization management, outpatient services, and the sickest members having a greater level of engagement with primary care*)
- Financial adjustments (*cost and utilization, referral patterns, practice patterns, quality and total medical expenses*)

Quick Coding Knowledge

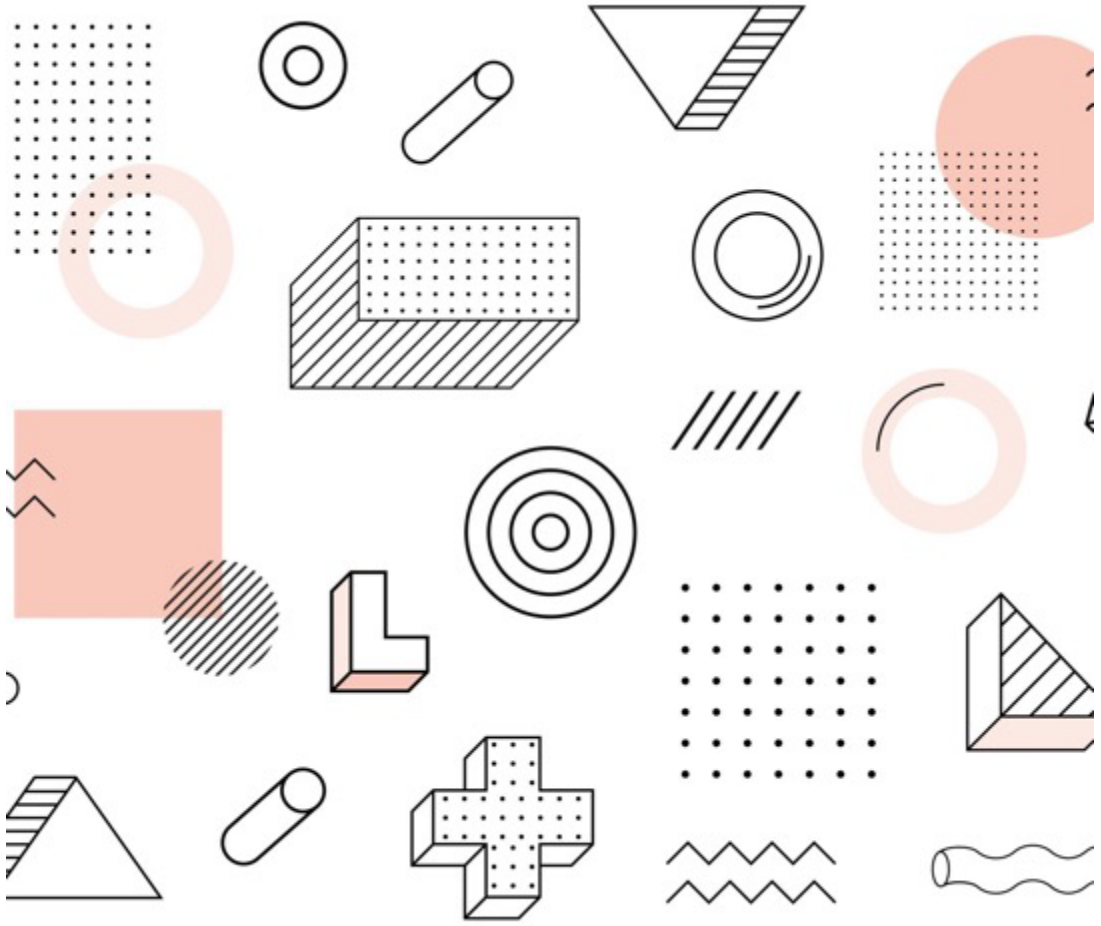
- Provider Manuals
- Cold Calling as Organization
- State Medicaid Manuals or Medicaid Offices
- Medi-Cal & Medicare Websites



4. Workforce Development and License Needs

A. Provider license types identify the areas of specialty, education, training, and **professional practice**, which may be required or encouraged by payer systems, members, and providers. Action: In addition, review state, federal, and payer specific regulations related to licensure requirements for reimbursable and provided services.

B. Create **EHR and practice infrastructure** to support the services and requirements identified for integrated care.



4. Workforce Development and License Needs

C. Consider **workforce development and formal training** opportunities in team-based care, population health, behavioral medicine, and creation of internships, and fellowships. Further, consider augmenting your workforce with training and leveraging community service professionals, allied health, and patient members to deliver specific evidenced based healthcare programs.

D. Understand your **institution, site, stakeholder, and workforce requirements related to service delivery, documentation, coding, interventions, and privacy/consent requirements (Update to NPP).** Ensure all verbiage and service delivery descriptions are aligned for integrated team-based care.

Integrated Care Behavioral Health Provider Common Core Competencies: Align With Your Vision

- Clinical Practice
  - Brief evidence-based interventions
  - Screening tools and protocols
  - Documentation/ health records
  - Comorbidity and population health
  - Huddles
  - Patient self-management
  - Healthcare setting basics
  - Team-based care
  - Consultation
  - Care management
  - Communication

Practice Management

- Visit Efficiency
- Time Management
- Follow-up Planning
- Coding and Compliance
- Quality Improvement and Metrics / Measurement
- Intervention Efficiency
- Visit Flexibility
- Triage
- Care Management
- Community Resource Referrals
- Return on Investment

5. Business Case Development, Service Delivery, and Coding

A. Ensure the service delivery, essential coding, site, payer types, and licensure are aligned appropriately.

B. Identify the business cost of all professionals/programs and the **pro forma** related to billing and/or cost savings for program and performance monitoring.

C. Create **auditing tools** for successful monitoring, continuity of care, quality outcomes, and fiscal measurement. Ensure interventions and documentation meets expectations (continuity, quality care, and regulatory).

D. Create a formal business case and proposal for IBH services inclusive of **return on investment**, shared-cost savings, **pro formas**, and direct reimbursement metrics which align with provider and patient satisfaction, population health improvement, and healthcare costs reduction (quadruple aim).

Most Common Errors to Reimbursement

Coding requirements
License type
Frequency
Documentation requirements
Time
Link to diagnosis
Documentation/filing completion time
Authorization
Necessity
Lack of coding knowledge basics

Pro Forma Development

- **Job Descriptions**
- **Data Points**
- **Performance Indicators**
- **Expansion**
- **Monitoring**
- **Dashboards**
- **Metrics**

Pro Forma Example

- Corso, Hunter, Dahl, Kallenberg, & Manson (2016). *Integrating behavioral health in the medical home: A rapid implementation guide*. Reprinted with permission by Greenbranch Publishing, Integrating Behavioral Health into The Medical Home: A Rapid Implementation Guide, Appendix 7G, pages 108-113, Copyright 2016, Greenbranch Publishing.

Integrated Behavioral Health Provider Pro Forma For FQHC with Wrap-Around Funding PPS Rate $200.00 Visit, No Same-Day Billing Reimbursement

	Annual CMS Visits per provider	2,750	
	Reimbursable visits (50% are same-day)	50%	
			1,375.00
	CMS Psychotherapy code visit	$200.00	$687.00
	Private Insurer	$50.00	$338.00
	CMS HBAI code visit	$200.00	$350.00
	Total Visits		1375
			$224,300
Variable 1	Contribution Margin/Net	150	(conservative 2 patients per week offset or increase in year for PCP: dual visit, upcoding, group visit, increased access)
	Per-Visit Reimbursement	$200.00	
		$30,000	$30,000
	BHP Level Net Revenue		**$254,300**
Variable 2	Grant funding	5,000	
	50 Grant Funded Visits (population specific)	$50.00	
	Total Net Revenue		**$259,300**
	Doctorate Level BHP (1.0 FTE)	$80,000.00	
	Benefits	$20,000.00	
	Total compensation	$100,000.00	
	Masters Level BHP (1.0 FTE)	$65,000.00	
	Benefits	$16,250.00	
	Total compensation	$81,250.00	
	CME	$1,750.00	
	Laptops	$1,500.00	
	Coding & Billing Expense	$11,668.50	
	Total Expenses Doctorate Level		$114,918.50
	Total Expenses Masters Level		$96,168.50
	Doctorate Level BHP Revenue		**$144,381.00**
	Masters Level BHP Revenue		**$163,131.00**

Pro Forma Development

Direct revenue: billable reimbursement associated with this provider/team

Costs (*salary, benefits, indirect, personnel, etc.*)

Indirect revenue: income associated with this provider's team play

Grants directly related to salary/benefits or other provider/team costs

Pro Forma Worksheet

Pro Forma Worksheet

1. Role/Process: _____

2. Annual gain/income from individual/process (follow steps to calculate below)

   a. Billable patients/services each day: # _____

   b. Estimate number of patients/services reimbursed (not all visits are reimbursed): # _____

   c. Daily revenue (calculate below)

Service codes	Revenue per code	# Patients/services per code	Total

Total daily revenue/gain = $ _____

   d. Monthly revenue (calculate below)

 # Days per month provider works x Total daily revenue/gain = $ _____

   e. Annual revenue (calculate below)

Total monthly revenue x 12 = $ _____

3. Estimate percent to be reimbursed (annual revenue x percentage): **$** _____

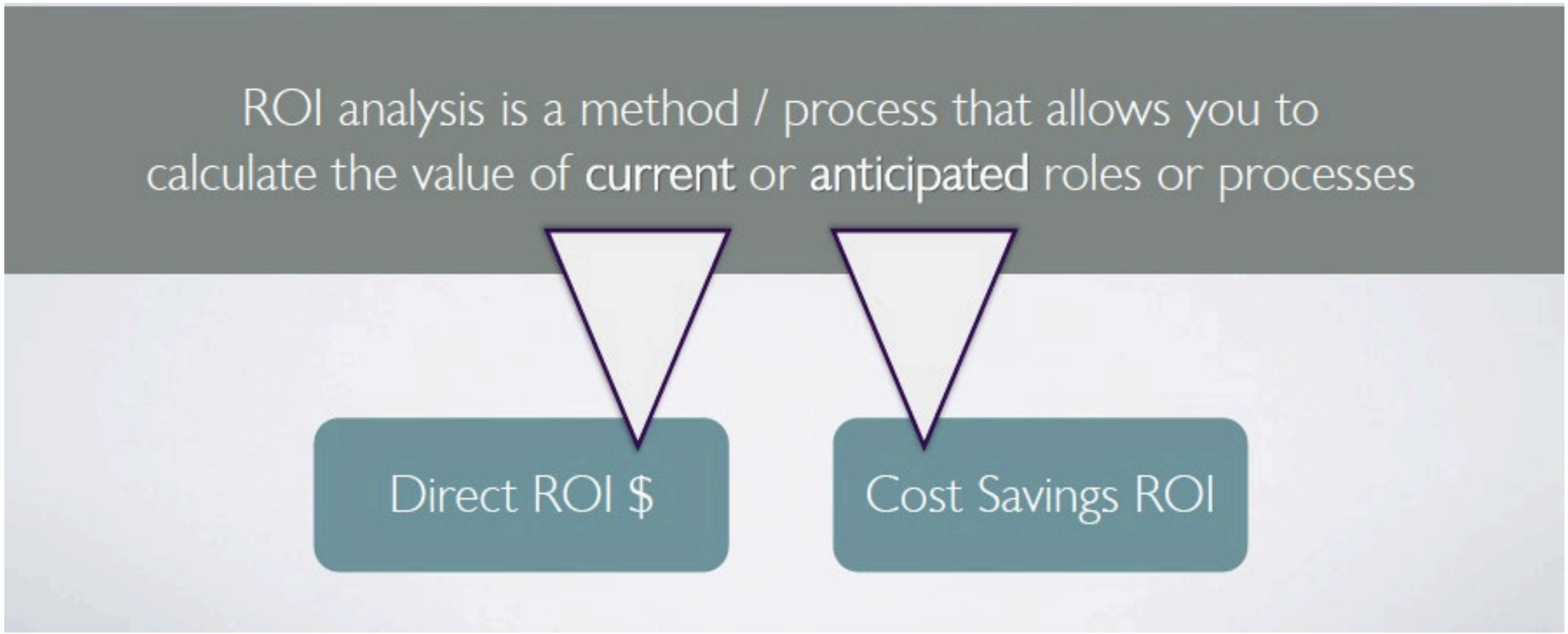
4. Indirect revenue (calculate below)

Indirect Revenue Name	Amount
Contribution 1:	
Contribution 2:	
Contribution 3:	
Grant 1:	

Pro Formas

- Application:
  - Consider when to update your pro formas
  - Who should be in charge of development
  - Who should review and monitor
  - Recognize the linkage to job/program description and development
  - Associate metrics for management
  - Use for decision making on increased hiring and program development
  - Demonstrate your ROI and fiscal sustainability for program

Return on Investment Calculations in Health Care



Return on Investment (ROI): Direct ROI

A performance measure used to evaluate the efficiency of an investment or to compare the efficiency of a number of different investments.

ROI measures the amount of return on an investment relative to the investment's cost.

To calculate ROI, the benefit (or return) of an investment is divided by the cost of the investment, and the result is expressed as a percentage or a ratio.

$$\frac{\text{gain from person/program} - \text{cost of person/program}}{\text{cost of person/program}} \times 100 = \text{percent of ROI}$$

Cost Savings (ROI)

A measure used to demonstrate fulfillment of the objectives of a service at a cost lower than the historical cost or the projected cost.

To calculate cost savings, the cost savings attributed to the program is divided by the standard cost of the services, and the result is expressed as a percentage or a ratio.

$$\frac{\text{cost savings}}{\text{standard cost of program}} \times 100 = \text{percent}$$

Return on Investment

Direct Billing / Direct Return on Investment Calculations

- Health Behavior Assessment Intervention (HBAI)
- BHI Coding
- Psychotherapy codes
- Collaborative Care codes (*CoCM, CCM, TCM: Remember these are pcp billing and time required! For ROI – require population focus*)
- Screening codes

Indirect / Cost Savings Calculations

- Enhanced identification of complexity (*E&M billing; cold/pre-WHO*)
- Improved team satisfaction and retention
- Early identification and improved adherence (*PHM efforts*)
- MACRA (*improvement activities & QP*)

California Quality Collaborative

Panel Discussion and Q&A

Q&A

Perry Dickinson, MD
Professor,
Department of Family Medicine
University of Colorado

Stephanie Gold, MD, FAAFP
Associate Professor,
Department of Family Medicine,
University of Colorado

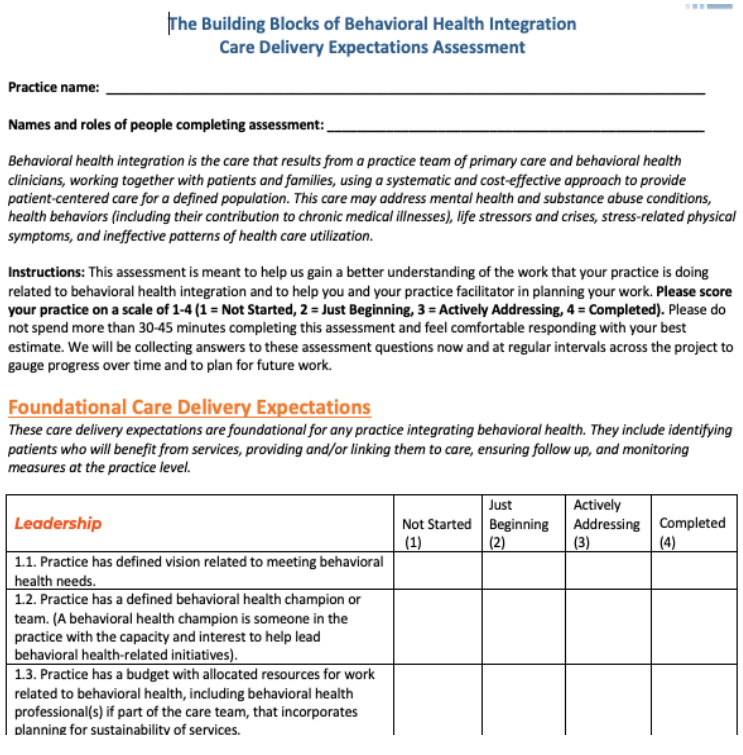
Lesley Manson, PsyD,
Clinical Associate Professor,
Clinical Associate Chair of
Integrated Initiatives, Integrated
Behavioral Health,
College of Health Solutions,
Arizona State University

Takeaway

What is one new approach you learned about readiness for integrating behavioral health into primary care?

Readiness for Behavioral Health Integration in Primary Care: Key Resources

- Building Blocks of BHI Framework
- Building Blocks of BHI Assessment
- Integrated Behavioral Health in Primary Care: Your Patients are Waiting**
- CQC BHI Curriculum



The Building Blocks of Behavioral Health Integration
Care Delivery Expectations Assessment

Practice name: _____

Names and roles of people completing assessment: _____

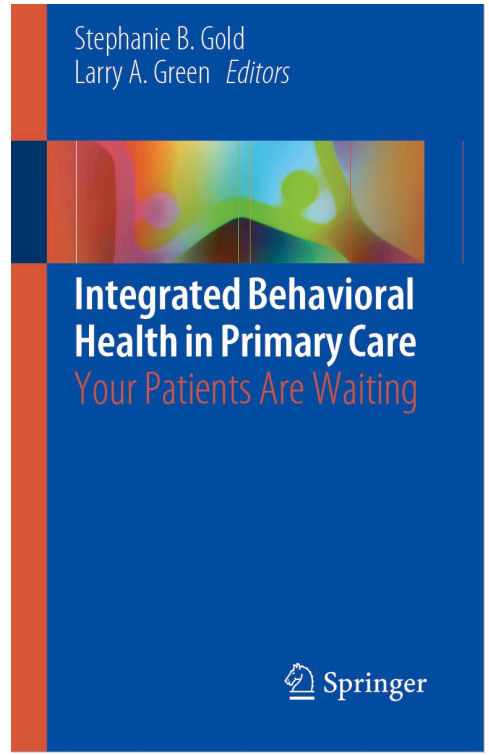
Behavioral health integration is the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Instructions: This assessment is meant to help us gain a better understanding of the work that your practice is doing related to behavioral health integration and to help you and your practice facilitator in planning your work. **Please score your practice on a scale of 1-4 (1 = Not Started, 2 = Just Beginning, 3 = Actively Addressing, 4 = Completed).** Please do not spend more than 30-45 minutes completing this assessment and feel comfortable responding with your best estimate. We will be collecting answers to these assessment questions now and at regular intervals across the project to gauge progress over time and to plan for future work.

Foundational Care Delivery Expectations

These care delivery expectations are foundational for any practice integrating behavioral health. They include identifying patients who will benefit from services, providing and/or linking them to care, ensuring follow up, and monitoring measures at the practice level.

Leadership	Not Started (1)	Just Beginning (2)	Actively Addressing (3)	Completed (4)
1.1. Practice has defined vision related to meeting behavioral health needs.				
1.2. Practice has a defined behavioral health champion or team. (A behavioral health champion is someone in the practice with the capacity and interest to help lead behavioral health-related initiatives).				
1.3. Practice has a budget with allocated resources for work related to behavioral health, including behavioral health professional(s) if part of the care team, that incorporates planning for sustainability of services.				



** Conflict of interest disclosure: Gold co-editor, eligible for royalties

Poll: Webinar Feedback

1. **The content of this webinar was helpful**
   - Strongly Agree
   - Agree
   - Neither Agree nor Disagree
   - Disagree
   - Strongly Disagree

2. I'd like to stay connected to CQC and receive occasional updates, insights, resources and more
   - Yes
   - No

CQC BHI Implementation Webinar Series

✓ Wednesday, September 11 (11 a.m. – 12 p.m. PT)

Readiness for Behavioral Health Integration

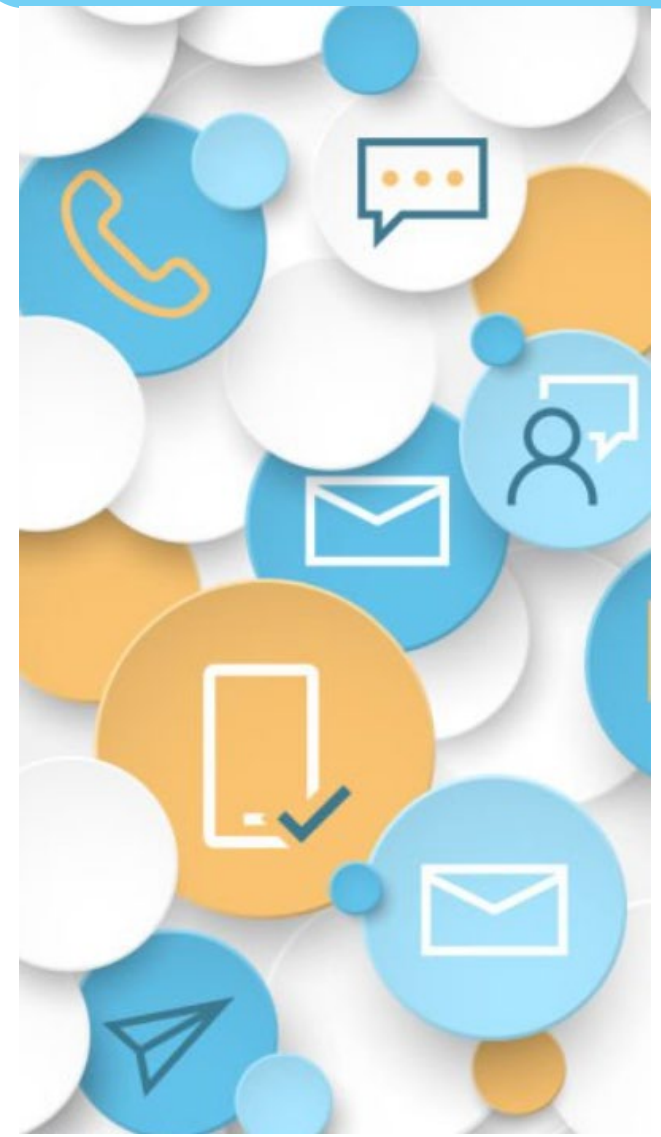
❑ Wednesday, November 13 (11 a.m. – 12 p.m. PT)

Behavioral Health Integration Lessons Learned (registration link)

❑ Wednesday, January 8, 2025 (11 a.m. – 12 p.m. PT)

Behavioral Health Integration Spread & Sustain (registration link)

Stay Connected to CQC



- Visit our website to access webinar materials and register for other upcoming events

  pbgh.org/cqc-events

- Sign-up to receive our e-publications

  CQC Monthly Newsletter | BHI Implementation Quarterly Update

- Join in on the conversation on social media

  LinkedIn | X

- Email us with questions or feedback

  cqcinfo@pbgh.org

California Quality Collaborative

Building blocks of BHI: Practice Examples

Practice A

Small independent primary care practice in the rural Midwest

Priority: high rates of substance use disorder (SUD)

Chooses to implement the advanced care of substance use disorders

All patients > 12 screened for SUDs, and those with needs are offered treatment within the practice.

Establishes relationship with local community-based peer support organization for coordinating referrals

Practice B

Midsize primary care practice in the Pacific Northwest

Priority: most patients referred to behavioral health not getting connected

Chooses to implement integrated behavioral health professional and advanced coordination and care management components

All patients screened for depression and anxiety, and those with needs are offered treatment with both medication and counseling within the practice.

Behavioral health professional also available for counseling for other needs that do not fit a diagnosis (eg lifestyle counseling, medication adherence)

Care compact established with local mental health center to develop expectations for mutual patients

Practice C

Large urban primary care practice

Priority: large population of patients with serious mental illness as well as medical co-morbidities that prefer to receive their care in one place.

Chooses to implement the psychiatry component

Psychiatrist comes to the practice twice a month to provide direct patient care, available during the rest of the month for electronic consultations on initiating and adjusting psychiatric medications.

Once a month when the psychiatrist is at the practice, the providers meet over lunch for a case conference to review particularly challenging cases.

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Appendix: Complete Framework

Building Block	Foundational Care Delivery Expectations *Recommended requirements for any practice integrating behavioral health*	Additional Care Expectations by Selected Components of BHI
Leadership	• Practice has defined mission and vision related to meeting behavioral health needs and a defined behavioral health champion or team. • Practice has budget with allocated resources for transformation and quality improvement work related to behavioral health, including behavioral health professional(s) if part of the care team, that incorporates planning for sustainability of services.	*No component-specific expectations.*
Data Driven Quality Improvement	• Practice, including any behavioral health professionals, meets regularly (minimum monthly) to review data and processes for quality improvement including those related to behavioral health efforts. Where available, practice reviews data disaggregated by subpopulations to identify and address disparities. • Practice collects and reports on measures specific to behavioral health efforts and tracks performance relative to targets. This includes tracking reach (level 1–proportion of target population screened; level 2–proportion of positive screens that are addressed) and outcomes with validated measures such as the PHQ-9, GAD-7, and Edinburgh maternal depression scale. In practices caring for children, this includes developmental screening.	• **Advanced Coordination and Care Management**—Includes tracking rates of follow up after behavioral health related emergency department visits or hospitalizations. • **Integrated Behavioral Health Professional**—Includes tracking adequate FTE and availability of appointments with behavioral health provider.

Continues.

Building Block	Foundational Care Delivery Expectations *Recommended requirements for any practice integrating behavioral health*	Additional Care Expectations by Selected Components of BHI
Data Driven Quality Improvement *Continued.*	• Practice collects and reports on holistic patient-reported measures of experience of care, access to care, and/or patient-reported functioning or quality of life.	• **Psychiatry**—Includes tracking adequate FTE and availability of consultation with psychiatrist. • **Advanced Care of Substance Use Disorders**—Includes tracking of outcomes related to patient initiation and engagement in substance use disorder treatment and follow up after substance use disorder-related hospitalizations.
Team-Based Care	• Practice has clearly defined roles, responsibilities, and workflows related to behavioral health services. • Practice incorporates behavioral health training into onboarding and ongoing professional development efforts, including for primary care providers and all clinic staff.	• **Advanced Coordination and Care Management**—Includes roles, responsibilities, and workflows related to registry management, planned approach to communication and shared care plans.

Continues.

Building Block	Foundational Care Delivery Expectations *Recommended requirements for any practice integrating behavioral health*	Additional Care Expectations by Selected Components of BHI
Team-Based Care *Continued.*		**Integrated Behavioral Health Professional** • In addition to defined roles and responsibilities, practice develops planned approach to communication and development of shared care plans. • The behavioral health provider shares integrated workspace within the practice if providing in-person services. • Schedules for behavioral health providers allow for warm handoffs and real-time consultations in addition to appointments. • Integrated behavioral health providers support and participate in educational efforts for primary care providers and clinic staff. • **Psychiatry**—In addition to defined roles and responsibilities, practice develops planned approach to communication (delineation of asynchronous vs real time communication) and shared care plans.

Continues.

Building Block	Foundational Care Delivery Expectations *Recommended requirements for any practice integrating behavioral health*	Additional Care Expectations by Selected Components of BHI
Patient and Family Engagement	• Practice educates patients and family members/ caregivers on availability of behavioral health services, including substance use disorder services. • Practice obtains feedback from patients and/or caregivers/family members on behavioral health services. Feedback may be obtained through patient experience surveys, Patient and Family Advisory Councils (PFACs), or focus groups. If establishing a PFAC, practice takes steps to ensure those participating reflect the diversity of the practice population. • Practice routinely provides self-management support (including caregiver/family support) and/or incorporates principles of shared decision making for patients with behavioral health issues as well as those without identified behavioral health issues to work towards goals that support wellness and prevention of illness.	*No component-specific expectations.*

Continues.

Building Block	Foundational Care Delivery Expectations *Recommended requirements for any practice integrating behavioral health*	Additional Care Expectations by Selected Components of BHI
Population Management	• Practice identifies patients who need or would benefit from behavioral health services, including through universal screening for at least one priority mental health condition, one priority substance use condition, and one lifestyle behavior. • Practice ensures positive screens are offered treatment within the practice or referred to appropriate services outside of the practice. • Practice reassesses symptoms, side effects, complications, and treatment adherence at regular intervals and utilizes evidence-based stepped care guidelines in adjusting treatment plans if patients are not improving as expected. Practice considers individual patient barriers to treatment.	**Advanced Coordination and Care Management** • Practice maintains registry of patients with target behavioral health condition(s). • Practice conducts proactive outreach to reassess symptoms and ensure follow-up for patients that are not improving. • Practice risk-stratification processes incorporate behavioral health diagnoses and health-related social needs.

Continues.

Building Block	Foundational Care Delivery Expectations *Recommended requirements for any practice integrating behavioral health*	Additional Care Expectations by Selected Components of BHI
Access	• The practice ensures physical spaces and services are accessible and responsive to patients' and families' disability status, sexual orientation and gender identity, racial and ethnic backgrounds, cultural health beliefs and practices, preferred languages, and health literacy. • Patients are able to receive behavioral health services by either audio-only or audio-visual telehealth and communicate asynchronously with providers. Video visits are not a requirement.	• **Integrated Behavioral Health Professional**—Practice assesses access to behavioral health services for its patients through availability of appointments. Practice ensures availability of urgent (within 1 week) behavioral health appointments. • **Psychiatry**—If providing on-site or telepsychiatry direct patient services, practice assesses access to behavioral health services for its patients through availability of appointments. • **Advanced Care of Substance Use Disorders**—Practice assesses access to substance use treatment services through availability of appointments.

Continues.

Building Block	Foundational Care Delivery Expectations *Recommended requirements for any practice integrating behavioral health*	Additional Care Expectations by Selected Components of BHI
Comprehensiveness and Care Coordination	• The primary care provider diagnoses and offers medication management for mild to moderate behavioral health conditions and links patients to therapy and/or specialty mental health settings as indicated. • Practice has referral pathways for patients with behavioral health conditions including potential referral sources for populations with specific needs (e.g. LGBTQIA+ friendly). • Practice ensures primary referral sources have appointment availability and are accepting new patients. • Practice tracks proportion of behavioral health referrals where patients successfully complete an initial appointment. • Practice provides crisis resources and referrals as indicated. • In pediatric practices, the practice has developed protocols for care transitions to adult behavioral health services.	**Advanced Coordination and Care Management** • Practice provides brief interventions (such as problem-solving treatment) in parallel with population health management. • Practice contacts patients within 3 business days of behavioral health-related emergency department visits or hospitalizations. • Practice has care compact or other collaborative agreement in place with at least one behavioral health group or practice which covers timely access, communication, and coordination of services. • Practice routinely assesses patients for social needs and links them (or offers links) to appropriate community resources, including those that support behavioral health and wellness.

Continues.

Building Block	Foundational Care Delivery Expectations *Recommended requirements for any practice integrating behavioral health*	Additional Care Expectations by Selected Components of BHI
Comprehensiveness and Care Coordination *Continued.*		**Advanced Coordination and Care Management** *Continued.* • Practice partners with at least one community organization or local agency (e.g. social services providers, schools, child welfare) to improve bidirectional communication regarding patient population needs. • Behavioral health care management is documented in a shared EHR or other mechanism to share care plans and patient information.

Continues.

Building Block	Foundational Care Delivery Expectations *Recommended requirements for any practice integrating behavioral health*	Additional Care Expectations by Selected Components of BHI
Comprehensiveness and Care Coordination *Continued.*		**Integrated Behavioral Health Professional** • Behavioral health providers deliver therapy, diagnostic support, crisis management, and behavioral change management support for any patient in the practice. This care may address mental health and substance use conditions, health behaviors, life stressors and crises, stress-related physical symptoms, developmental transitions, and ineffective patterns of health care utilization. • Behavioral health and primary care providers use a shared EHR or other mechanism to document shared care plans and patient information. Care plans include patient goals, treatment plans, and relapse prevention plans, where relevant.

Continues.

Building Block	Foundational Care Delivery Expectations *Recommended requirements for any practice integrating behavioral health*	Additional Care Expectations by Selected Components of BHI
Comprehensiveness and Care Coordination *Continued.*		**Psychiatry** • Psychiatrists support complex medication management and diagnostic support. If implementing the Collaborative Care Model, the psychiatrist regularly reviews the behavioral health registry and provides recommendations. • Behavioral health and primary care providers use a shared EHR or other mechanism to document shared care plans and patient information. Care plans include patient goals, treatment plans, and relapse prevention plans, where relevant. **Advanced Care of Substance Use Disorders** • Practice provides medication management for tobacco use disorder, opioid use disorder, and alcohol use disorder, which may include outpatient management of alcohol withdrawal. • Practice provides or refers patients to substance use disorder counseling. Practice provides resources on peer support groups.