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TRANSFORMING BHC INTEGRATION INTO PRIMARY CARE IN A MAJOR U.S. CITY:

HOW INTERDISCIPLINARY DISCUSSIONS ARE SHAPING THE CARE DELIVERY LANDSCAPE

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Goals of this Presentation

- Review an evaluation to study level of integration in Philadelphia federally-qualified health centers (FQHCs)
- Discuss pertinent findings and benefits of assessing degree of integration
- Panel discussion on experience of reviewing integration in their health centers and audience Q&A.

Health Federation of Philadelphia

The Health Federation of Philadelphia is a non-profit that serves as the regional association of FQHCs in Southeastern Pennsylvania.

It is our role to provide a wide range of representational and capacity building support to enable health centers to expand their scope of care, operational efficiency and clinical effectiveness.

A particular focus for the last dozen years has been to foster implementation and spread of whole person care in FQHCs using the PCBH approach to integration.

Origins of this Project

Community Behavioral Health (CBH) is the Philadelphia County Medicaid Managed Care Organization and has been a partner in our efforts.

CBH requested that HFP conduct an assessment of the degree of integration that has been achieved across our network. Their goal was to gain a clearer, objective understanding of the current developmental status of our model and to establish a potential basis for tracking process improvement

The Health Federation's Clinical Lead, Dr. Travis Cos, facilitated this process with 28 different FQHCs across 8 health systems, serving 140,000 individuals, and he will now describe both his method and his findings.

What is Integration?

integrate

verb in·te·grate \ ˈin-tə-ˌgrāt \

1. **a :** to unite with something else
   b : to incorporate into a larger unit

2. to form, coordinate, or blend into a functioning or unified whole **:** UNITE

https://www.merriam-webster.com/dictionary/integrate

Integrative Practice Requires

- Site buy-in, reimbursement & policies, model selection
- Effective hiring and training of BHC (and medical team)
- Continuing education and support to develop and maintain integrative practice
- Examining outcomes… 1. Productivity/ Penetration; 2. Provider Satisfaction; 3. Impact on Patients; **4. Degree of Integration**

(Croghan & Brown, 2010)

Levels of Integration---How Medical & Behavioral Health Work Together

- Level 1- Minimal Collaboration: Separate Systems, Minimal Communication; Divided Roles/ Uncertainty
- Level 2- Basic Collaboration at a Distance: Separate Systems, Periodic Communication, Separate Role Appreciation
- Level 3- Basic Collaboration Onsite (Co-Location): Separate Systems, Regular Communication, Some Collaboration, Part of Informal Team

Levels of Integration---How Medical & Behavioral Health Work Together

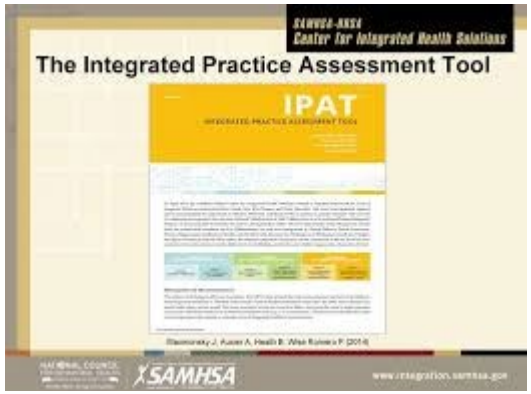
- Level 4- Close Collaboration with Some Systems Integration: Share Some Systems, In-Person Communication, Collaboration, Basic Understanding of Roles/Practice Cultures

- Level 5- Close Collaboration Approach an Integrated Practice: Shared systems solutions; Frequent In-Person Communication, High-Frequency Collaboration, In-Depth Knowledge of Roles/Cultures

Level 6- Full Collaboration in a Merged Integrated Practice: Function as One Integrated Systems; High-Frequency Communication At System, Team, & Individual Levels; Collaboration From A Shared Team Perspective; Blended Roles/Cultures; Meeting Patient-Centered Medical Home (PCMH) Standards for Integration

Integrated Practice Assessment Tool (IPAT)

- A decisional flow chart that reviews degree of collaboration/ coordination, colocation, and integration
- Useful for broad-based understanding of how behavioral health and primary care are working together.



- (See Handout)

Integration Self-Assessment Checklist

- 37-item self-administered checklist reviewing five domains of integration
  1. Degree of **co-location** of medical and behavioral health
  2. **Practice set-up** around referrals and cooperation
  3. **Patient experience** and degree of how care “flows” around patient
  4. **Administrative advocacy** and assistance for maintaining integration
  5. **Business model** highlights sharing of resources and varied revenue streams

Integrated Practice Assessment Meetings

- At a minimum, a behavioral health consultant, a primary care provider, and administrator attended.
- IPAT was completed by each staff member individually, and reviewed as a group
- Facilitator conducted follow-up assessment via questions from the Integrated Self-Assessment Checklist to gauge integration across five domains
- Group discussed site's needs, goals, and plans to maximize integration

IPAT Results—Total Integration Score

Level of Integration	Descriptor	Number of Network Sites
Level 3	Basic Collaboration Onsite	2
Level 4	Close Collaboration Onsite with Some Systems Integration	12
Level 5	Close Collaboration Approaching an Integrative Practice	14
Level 6	Full Collaboration in a Transformed Merged Integrative Practice	0

Integration Self-Assessment Tool

Practice Domain	Average Rating (1-6)
Location	4.82 (range 3-6)
Clinical Delivery	4.29 (range 3-6)
Patient Experience	4.79 (range 3-6)
Practice Organization	4.44 (range 3-6)
Business Model	4.68 (range 4-5)

IPAT by Practice Maturity

Practice Experience	Total IPAT Site Rating
New Practices (<1 yr) (N=9)	4.00
Moderate Practices (1-4 yrs) (N=11)	4.73
Well-Established (5+ yrs) (N=8)	4.63

Integrated Self-Assessment Tool by Practice Maturity

Practice Experience	Location Domain	Clinical Delivery Domain	Patient Experience Domain	Practice Organi-zation Domain	Business Model Domain
New Practices (<1 year)	4.20	3.70	4.20	3.90	4.40
Moderate practices (1-4 years)	5.00	4.45	5.09	4.90	4.73
Well-Established practices (5+ years)	5.50	4.75	5.13	4.50	5.00

Needs Identified During Process

General Themes	Site-Specific Proposed Solutions
1. Trauma-Related Challenges	a. some sites are planning to utilize increased **ACES and trauma-based screening**; b. internal training to improve **trauma competence**
2. Barriers to Pediatric Care Provision	a. use of pediatric **screening** (e.g. Childhood Edinburgh Depression Screening; Bright Futures); b. **shared medical visits** with BHC and medical provider; c. **parental education and brief interventions**
3. Training Needs	a. training **medical assistants** and support staff on model; b. continue to develop with **medical providers** an **understanding, buy-in, and referral** to BHC integration ; c. **utilizing BHC** in **hiring and staff orientation process**

Common Goals for FQHCs

- Expand BHC coverage or number of BHCs
- Increasing referrals of pediatric and health-oriented concerns to BHCs
- BHCs working to increase communication back to medical providers
- Considering ways to use technology/ EHR to better harness population management tools for “smart” BHC proactive visits.
- PCMH: Discuss ways to have shared care plans simply, multidisciplinary, and efficiently

Summative Thoughts

- The most notable finding is most sites are practicing the integrated primary care model with a high degree of co-location and collaboration, as well as emerging integration of services and role-sharing.
- Sites with <1 year experience have already established a highly collaborative model of practice
- More established integrated care sites demonstrate elements of highly developed collaborative practice and emerging integration of systems, workflows, and practices.

PANEL DISCUSSION

Thoughts and Reflections on the Process of Reviewing Integration

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References

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is continually developing new programs in response
to both the needs of underserved communities and the
availability of data indicating improved approaches
to health care and behavioral support.

For more information about our initiatives, please visit:

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