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Rachelle Rene, PhD, BCB, HSMI

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Family Medicine Grand Rounds
Integrated Behavioral Health (IBH) Program Updates and Evidence for IBH in SUD

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Disclosure: Conflicts of Interest

Neither I, nor any immediate family member has any financial relationship with, or interest in, any commercial interest connected with this presentation.
Learning Objectives

At the end of this presentation, the participant will be able to:

1. Describe core components of the Primary Care Behavioral Health Model
2. Identify IBH Program implementation highlights and challenges
3. Discuss at least one intervention to address SUD in primary care
Jefferson Health strategic goal:
- Expand behavioral health access across the organization

January 2017: Awarded 5yr CPC+ grant from CMS
- 60 primary care practices initially enrolled

Goal: integrate behavioral health within CPC+ practices

Jan 2019: implemented Primary Care Behavioral Health (PCBH) model
- CPC+ road map to shift our focus towards the quadruple aim
- PCBH model aligns well within this context and our renewed efforts towards IBH program implementation
Integrated Behavioral Health

“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.”

Primary Care Behavioral Health Model Implementation: G.A.T.H.E.R

Essentials of PCBH is about applying GATHER to help achieve Four C’s…
It’s about patient, provider and team engagement…

- G-Generalist
- A-Accessible
- T-Team oriented
- H-Highly productive
- E-Educator
- R-Routine

- GATHER Four C’s
- First Contact
- Continuity of care
- Comprehensive care
- Coordinate care when needed

Clinical/Theoretical Approach: CBT, Solution Focused, ACT, MI, Trauma-Informed

Source: Special edition on PCBH from the Journal of Clinical Psychology in Medical Settings / Special Issue: The Primary Care Behavioral Health Model of Integration
Issue editors: Christopher L. Hunter Jeffrey T. Reiter and Anne C. Dobmeyer / Volume 25, Issue 2, June 2018
Behavioral Health Integration at Jefferson Health: Our Team

Our Team
- 30 Behavioral Health Consultants (BHCs)
- License Clinical Psychologists (PhD/PsyD) and Clinical Social Workers (LCSWs, DSWs)
- 1 Admin / Program Manager

5 Lead BHCs
- Abington - Mollie Cherson, LCSW & Kate O’Hara, LCWS
- Center City - Angelo Rannazzisi, PsyD
- New Jersey - Manoucheka Emmanuel, LCSW
- Northeast - Charlena Ware, LCSW

Over 50 CPC+ Practices
- 31 practices with embedded BHCs
  - Abington (12)
  - Center City (7)
  - New Jersey (5)
  - Northeast (7)
Behavioral Health Integration at Jefferson Health: Our Partnerships

Population Health

Primary Care

Psychiatry & Human Behavior

IBH

Data Analytics
EPIC
Research Team

IBH Implementation

Credentialeding

Billing

HR/Recruitment

Contracting

Practice Managers
Our Focus: *Improving the Lives We Serve*

- **Quality / Clinical Outcomes** - support practices in managing high risk patients with:
  - Depression / Anxiety
  - Chronic Disease Management (i.e. diabetes, hypertension, chronic pain, etc.)
  - Substance Use / Opioid Use Disorder**

- **Primary Care Behavioral Health Model Implementation**
  - Continue to advance implementation efforts within primary and ambulatory care practices
  - Deliver care that is targeted, transformative and evidenced-based
  - Effectively utilize screening tools to measure impact and outcome
  - Optimize Access to Care (i.e. Unique patients / Warm Handoffs (WHO) / Same Day Access / Referrals)

- **Program Sustainability: Performance / Productivity**
  - Credential and bill for all BHC providers across the enterprise with all available payers
  - Increase total patients within the primary care population BHCs impact each month/year
  - Ensure efficient, streamlined & consistent workflows across all divisions
  - Ensure ongoing workforce development, recruitment and retention
# BHC Performance / Productivity Expectations

<table>
<thead>
<tr>
<th>Level</th>
<th>Level I</th>
<th>Level II</th>
<th>Level III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits per Day</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Weekly (individual)</td>
<td>27</td>
<td>36</td>
<td>45</td>
</tr>
<tr>
<td>Annual (individual)</td>
<td>1283</td>
<td>1746</td>
<td>2183</td>
</tr>
</tbody>
</table>

**Goal**

**July 2021**
- Jefferson Abington MC (6.4)
- Jefferson Center City TR (6.1)
- Jefferson New Jersey CH (7.6)

**July 2021**
- Jefferson Northeast CW (8.2)
- Jefferson New Jersey JH (8.2)
Population Characteristics

Chronic Disease Prevalence by Campus CY20:

Top 4 Chronic Diseases at each Campus & Prevalence

<table>
<thead>
<tr>
<th></th>
<th>Abington</th>
<th>Center City</th>
<th>JNE</th>
<th>New Jersey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>40.80%</td>
<td>36.50%</td>
<td>40.40%</td>
<td>34.30%</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>71.20%</td>
<td>9.00%</td>
<td>59.20%</td>
<td>10.00%</td>
</tr>
<tr>
<td>CAD</td>
<td>22.00%</td>
<td>5.20%</td>
<td>17.00%</td>
<td>5.70%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>13.10%</td>
<td>12.90%</td>
<td>14.90%</td>
<td>13.10%</td>
</tr>
</tbody>
</table>
Program Characteristics

 Incoming Referral Reasons to IBH- Last 12 mos

- Anxiety: 16.1%
- Depression: 8.5%
- Grief & Loss: 6.3%
- Stress: 25.4%
- Other: 43.8%

Note: 14 other referral reasons comprised “other”

<table>
<thead>
<tr>
<th>Covid Impact</th>
<th>First 6 mos (pre-Covid)</th>
<th>Last 6 mos (Covid)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>2092</td>
<td>3678</td>
</tr>
<tr>
<td>Depression</td>
<td>1599</td>
<td>1746</td>
</tr>
<tr>
<td>Total Referrals</td>
<td>6000</td>
<td>7179</td>
</tr>
</tbody>
</table>
Top 4 Reasons for Referral to BHCs

Goal: Encourage referrals to BHCs for chronic disease management (i.e. Diabetes, etc.) utilizing optimize Ambulatory Referral to BH

<table>
<thead>
<tr>
<th>Month</th>
<th>Total Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-21</td>
<td>1366</td>
</tr>
<tr>
<td>Feb-21</td>
<td>1382</td>
</tr>
</tbody>
</table>

Top 4 Referral Reasons to IBH
- **January 2021**
  - Anxiety: 54%
  - Depression: 31%
  - Grief: 7%
  - Stress: 8%

Top 4 Reasons for Referral to IBH
- **February 2021**
  - Anxiety: 56%
  - Depression: 31%
  - Grief/Loss: 7%
  - Stress: 6%
NOTE: Select Integrated Behavioral Health (BHCs)

Please complete with location of service, type of service, behavioral health or chronic disease management. Click Accept.
Impacting Patient Care

Total BHC Visits 2019* - 2021

12,361 Total Visits - CYTD
6,463 Unique Visits CYTD
10,081 Telemedicine CYTD
Impacting Patient Care

PHQ9 and GAD7 Administration
Mar - July 2021

- **ABINGTON**
  - Total Distinct Patients: 4,217
  - Total PHQ9s: 5,682
  - Total GAD7s: 5,795

- **CENTER CITY**
  - Total Distinct Patients: 4,217
  - Total PHQ9s: 5,682
  - Total GAD7s: 5,795

- **NEW JERSEY**
  - Total Distinct Patients: 4,217
  - Total PHQ9s: 5,682
  - Total GAD7s: 5,795

- **NORTHEAST**
  - Total Distinct Patients: 4,217
  - Total PHQ9s: 5,682
  - Total GAD7s: 5,795
Impacting Patient Care: PHQ9 & GAD7 Outcomes Scores

PHQ9 % Improvement

- Improved: 35%
- No Improvement: 65%

GAD 7 % Improvement

- Improved: 36%
- No Improvement: 64%

CY 2020
Impacting Patient Care

**Summary:** BHCs provided equal treatment to patients whether in person or via telehealth during the pandemic.

**Study highlights effectiveness of the IBH model regardless of the modality.**

**Takeaway:** Notable that the majority of patients seen would likely not have received mental health care without the added implementation and feasibility of telehealth visits.

**Study pending publication**
Impacting Staff Care

Employee Wellness Workshops
- 10+ workshops
- 266+ participants
- 400+ Jeff Be Well Sessions*
- 1400+ Participants*

MA Competency Trainings
- 18 sessions
- 125+ participants

Wellness Workshops conducted between Jan-June 2021 and Mar-Dec 2020* across the Jefferson Enterprise

Competency trainings conducted June 2021 - Abington Campus
Integrated Behavioral Health Highlights

All campuses using one EMR (Epic)

Implemented standardized BHC workflows & IBH Note Template
All campuses/practices using new process
Note enhanced and standardized across all campuses

New Screening tools/questionnaires added to Epic flowsheet
DDS (Diabetes Distress Scale)
PTSD Checklist (Post Traumatic Stress Disorder)
MDQ (Mood Disorder Questionnaire)
Screening tools/questionnaires currently used by BHCs:
PHQ9 / GAD7 / DAST / AUDIT / C-SSRS
Integrated Behavioral Health Highlights

Access to behavioral health care for patients!
Neuroflow Integration in Epic

Telehealth Implementation & Response to Covid-19
Article publications

Patient and provider satisfaction
All BHCs credentialed and billing
Integrated Behavioral Health: Barriers

- **Report Limitations**
  - Obtaining BH data from multiple platforms
  - Financial report for BHC visits not available for some campuses

- **Credentialing**
  - Enterprise payer contracts pending - some impact on billing for JNE team

- **Staffing**
  - Lengthy vacancies; hard to fill BHC positions (i.e. JNE campus)
  - Recruitment of appropriate and qualified BHCs
  - Understanding BHC role & utilization / Adjusting: specialty MH to primary care setting
  - Lack of Psychiatry staff (PCPs, consults, access to care for medication management)
Future Projects

• Explore partnership with Quartet Health through IBC

• Establish Project Echo (Extension for Community Healthcare Outcomes) Group

• IBH Data Dashboard / Key Performance Indicators (KPI)

• Transition from CPC+ to Primary Care First

• Long term: Expand number of BHCs across all Jefferson ambulatory and specialty care practices
  • Increase number of BHCs at JFMA
Substance Use Disorder and the Role of BHCs

- Substance Use Disorder
  - DSM5 Definition
  - Prevalence
  - Barriers
  - Evidenced-based treatment
  - BHCs in action
Diagnosing Substance Use Disorders: DSM-5 Criteria

1. Impaired Control
   - Larger amounts or over a longer time than originally intended
   - Persistent desire to cut down
   - A great deal of time spent obtaining the substance
   - Intense craving

2. Social Impairment
   - Failure to fulfill work or school obligations
   - Recurrent social or interpersonal problems
   - Withdraw from social or recreational activities

3. Risky Use
   - Recurrent use in situations physically hazardous
   - Continued use despite persistent physical or psychological problem that is likely to have been caused or exacerbated by use

4. Pharmacological Criteria
   - Tolerance: Need for markedly increased dose to achieve the desired effect
   - Withdrawal: Syndrome that occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged heavy use

(American Psychiatric Association, 2013)
According to SAMSHA’s 2019 National Survey on Drug Use and Health:

<table>
<thead>
<tr>
<th>SUD Prevalence</th>
<th>20.4 million Americans live with substance use disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.1 million live with opioid use disorder</td>
</tr>
<tr>
<td></td>
<td>Only 20% receive formal treatment or specialty addiction treatment.</td>
</tr>
<tr>
<td></td>
<td>Those diagnosed with a SUD are at higher risk for developing major medical conditions (Bahorik, et al. 2017)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Barriers to Treatment</th>
<th>Patients - lack of available treatment programs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Uncertain economic futures, difficulty accessing in-person care (SAMSHA, 2020)</td>
</tr>
<tr>
<td></td>
<td>Social stigma (Hutchinson et al, 2020)</td>
</tr>
<tr>
<td></td>
<td>Clinicians - report lack of mental health and psychosocial support for patients as a perceived barrier to prescribing (Hutchinson et al, 2014)</td>
</tr>
<tr>
<td></td>
<td>Gaps in care lead to patient dropout (Forman et al, 2006)</td>
</tr>
</tbody>
</table>
Research to date focused on the integration of Mental Health services into Primary Care settings (Urada et al, 2014).

Integrating treatment for SUD into primary care settings is an effective strategy for reducing substance use, improving physical and mental health, and maximizing overall healthcare cost savings (Cos, 2019).

Primary care providers in a prime position to identify, assess, and treat SUDs (Sayre et al, 2020)
Substance Use Disorder and the Role of BHCs

- Our BHCs see patients with various substance use disorders.
- Conduct clinical assessments to assess level of readiness for treatment/care, etc.
- Engage in a wide range of interventions including:
  - Motivational Interviewing, Goal setting, Psychoeducation, Harm reduction, CBT and support referrals to higher levels of care as needed.
  - Engage in SBIRT
What is SBIRT?

- **Screening:** Identify patients with unhealthy substance use

- **Brief Intervention:** Conversation to motivate patients who screen positive to consider healthier decisions (e.g. cutting back, quitting, or seeking further assessment).

- **Referral to Treatment:** Actively link patients to resources when needed

Dialogue between provider and patient to improve overall health
FLOW CHART FOR SBIRT PROCESS: Screening

- Screening
  - Low Risk
    - No Further Intervention
  - Moderate Risk
    - Brief Intervention
  - Moderate to High Risk
    - Brief Treatment
  - Severe Risk, Dependency
    - Referral to Specialty Treatment
SUBSTANCE USE DISORDER: BHCs in ACTION_CASE HIGHLIGHTS

- Abington
- Center City
- Northeast
- New Jersey
any got questions?