CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

RISE-PC: Reaching Integration and Supporting Excellence in Primary Care

IBH Competencies required to be a RI OHIC Qualified IBH Practice

Introduction

- Why IBH?

  It is widely recognized that unaddressed mental health and substance use conditions increase suffering and total cost of care and that these conditions drive 60-80% of all visits to adult primary care practices (PCPs)[1]. Building and supporting the delivery of Integrated Behavioral Health in adult primary care practices is fundamental and necessary to improve quality of life and to decrease inefficient utilization of healthcare services and dollars. Because pediatricians are often the first point of access for both identification and treatment of behavioral health conditions in children of all ages, integrating BH services into pediatric primary care is also critical to improving BH access and health outcomes for children nationwide. Most children with mental health concerns do not receive the care they need, but upwards of 90% of children see a pediatrician at least annually[2]. This gives pediatricians the perfect opportunity to step in and help identify mental health challenges and risk factors earlier and improve their patients' access to the care and supports they need. Studies have shown that IBH services lead to positive patient outcomes across the age span[3,4,5,6,7], and even one session with an IBH provider can make a positive difference[8].

  A commonly used definition of IBH, from AHRQ, 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"[9]. This definition highlights the importance of both team-based and patient-centered care as well as using a population health approach. The goal of IBH is to improve patient health by addressing behavioral health concerns, as well as ecological stressors and other behaviors that can negatively impact health outcomes.

- Our framework

  There are many models and frameworks of IBH that exist in the research and in practice, and these have evolved over time. After a careful review of existing models, sources, and guidelines (See the list in references) this set of competencies was developed for primary care practices in RI. **The goal of this competency framework is to balance fidelity to an IBH model with practicality. The expectations are intended to be meaningful, to lead to better care and practice, and to feel to practices as achievable improvements that are worth making.**

The competencies in this framework are widely used and supported in the literature as important to IBH success, and are listed in this Quick Reference table:

IBH Competencies – Quick Reference
A. Organizational and Leadership Support for IBH
B. Population Health Approach B1 BH Screening (adult and pediatric) B2 Health Equity
C. Team-Based Care C1 Qualified BH Clinician on site C2 Structured communication between the IBHC(s) and the medical team C3 Access to psychiatry and medication management consultation
D. Access to Care D1 Internal access to BH services D2 Access to external resources and BH services
E. Measurement E1 Monitoring screening rates E2 Monitoring patient and population health outcomes
F. Training in IBH F1 New Staff are trained on IBH model F2 The practice provides and supports ongoing staff training relevant to IBH F3 Patients are educated and informed about the IBH model

Instructions and Scoring

I. Instructions to practices: TBD

II. Scoring:

A. The scoring would be calculated as follows:
Not Established = 0 points
Partially Established = 1 point
Fully Established = 2 points

There are 13 criteria for Adult or Pedi practices, with a range of possible scores from 0-26.
There are 14 criteria for Family Medicine practices, with a range of possible scores from 0-28.

B. Cutoff scores and other scoring details TBD but the following options and considerations are offered:

1. Establish a cutoff score that would be required for qualification, with the following expectations:
    - No specific element or overall competency is optional except where choices are indicated
    - At least one element in each competency must be Fully Established OR (for a higher threshold) only one element in each competency can be Partially Established – the rest must be Fully Established. The exception to the latter would be Competency A because there is only one element, and that would have to be Fully Established.

2. Consider allowing practices to submit a plan for improvement if their total score is within a certain range (TBD) but below the cutoff

Competency A. Organizational and Leadership Support for IBH

Description and Rationale:

Implementing an IBH model in primary care requires myriad changes, including new staffing roles and requirements, EMR builds, and general culture change. Support from leadership is necessary for integration transformation and sustainability. This includes provider champions as well as system senior leadership[10]. In order for a practice to qualify as an IBH practice in RI, it should provide evidence that relevant leadership in the organization and practice supports this transformation, as described below. In addition, the practice needs to identify the person responsible for overseeing the IBH program. CTC-RI can provide a letter template if the practice prefers.

All Practices	Not Established	Partially Established	Established
A. There is organizational and leadership support for IBH in the practice	There is no or minimal evidence of organizational or leadership support	There is some evidence of organizational and leadership support	There is sufficient evidence of organizational and leadership support
Evidence Required		Practice submits a letter of support from one organizational leader attesting to the commitment to support IBH efforts, plus a written plan of how practice will gain support from other leaders	Practice submits a letter of support from at least 2 practice and/or system leaders attesting to the commitment to support IBH efforts (e.g. lead practice physician, CMO, COO, CEO)

* Letter template provided by CTC for reference

Competency B. Population Health Approach

Description and Rationale:

This Competency is comprised of two elements: Universal Screening and a focus on Health Equity

Universal Screening: Practices are required to implement a universal BH screening protocol which is a central component of an IBH program. It helps identify BH concerns across the entire patient panel, and this can promote prevention, early intervention, and quick response. For practices who see adult patients only, depression screening is required, while the practice can choose among other BH screens to meet criteria, depending on the patient population and BH priorities (e.g. anxiety, substance use, postpartum depression, PTSD, eating disorders, etc.). For pediatric practices, it is required that practices consider implementing BH screening across all age groups, from birth to 18+. For pediatrics, both anxiety and depression screening for adolescents is required.

Note that family medicine practices are required to meet criteria for **both** adult and pediatric populations.

Note that any screener chosen must have an evidence base for valid use in primary care (e.g. PHQ-9, GAD-7, EPDS, PSC-17 or PSC-35, etc.)

Health Equity: It is important for practices to know whether BH disparities exist across their patient panel and, if so, to work toward more equitable care and outcomes; practices should be screening for Social Determinants of Health (SDOH) in order to ensure that relevant socio-demographic threats to total health are identified and patients are connected to community resources; in addition, practices should be able to demonstrate that they are addressing disparities in care in whatever way is most relevant to the practice and their patient panel (e.g. through outreach, ensuring interpreter services are available, etc.).

Adult Practices	Not Established	Partially Established	Established
B1. BH Screening in adult patients *Depression** *Anxiety* *Substance Use* *Other BH (e.g. EPDS for postpartum)*	The practice does **not** routinely screen patients for BH concerns, or the practice routinely screens patients in only one area	The practice routinely screens patients in 2 BH areas *Depression screening in adults is required to meet this criterion	The practice routinely screens adult patients in 3 or more areas * Depression screening in adults is required to meet this criterion
Pediatric Practices			

B1. BH Screening across the age span *Age Group 1:* ***Birth – 3 years*** *Social-emotional Development and Post Partum Depression* *Age Group 2:* ***Ages 4-11*** *Psychosocial functioning* *Age Group 3:* ***Ages 12-17*** *Depression** *Anxiety** *Substance Use*	The practice does **not** routinely screen patients for BH concerns, or the practice routinely screens patients from only one age group	The practice routinely screens two age groups for BH concerns *Ages 12-17 screening for Depression and Anxiety are both required to receive credit	The practice routinely screens all three age groups for BH concerns *Ages 12-17 screening for Depression and Anxiety are both required to receive credit
Evidence Required		The practice submits a BH screening report indicating % of patients seen for a visit who were screened by each measure during preceding 12 months; rate for each screener must exceed 75%	
B2. Health Equity is routinely reviewed and considered for patients with BH needs as measured by SDOH screening and routine demographic/health disparity data* review and goal setting *Data should include at least one of the following: race/ethnicity, SES, age, geography, disability status, gender, sexual orientation	The practice does not routinely examine health equity in their practice	The practice routinely administers SDOH screening to patients and has processes and resources in place to respond to positive scores OR The practice routinely reviews practice data to identify and work toward improving health equity goals for patients with BH needs	The practice routinely administers SDOH screening to patients and has processes and resources in place to respond to positive scores AND The practice routinely reviews practice data to identify and work toward improving health equity goals for patients with BH needs

Evidence Required		The practice submits a report indicating % of patients seen for a visit who are screened for SDOH during preceding 12 months (rate must exceed 75%); and, the practice submits description of how positive scores are managed OR The practice submits a report demonstrating how they routinely review health equity/disparity data and a description of how these data are used	The practice submits a report indicating % of patients seen for a visit who are screened for SDOH during preceding 12 months (rate must exceed 75%); and, the practice submits description of how positive scores are managed AND The practice submits a report demonstrating how they routinely review health equity/disparity data and a description of how these data are used

Competency C. Team-Based Care

Description and Rationale:

Team-based care is at the core of IBH, and this competency should reflect the practice's well-established and highly functioning team in 3 ways:

1. The qualified IBH clinician is on site, although a hybrid model can also be effective as long as the practice meets the full range of competencies. The clinician must function effectively in a primary care setting (a traditional therapist who shares space with a medical practice does not qualify). The clinician (or clinicians) should have a degree in a MH field that is licensable (i.e. social work, mental health counseling, psychology) and have training in evidence based IBH assessment/treatment and child clinical training for pediatrics; and, there should be more clinicians on staff the larger the patient panel/need.

2. The team can communicate easily with one another both in person and through the medical record.

3. There is access to a psychiatry professional to advise medical providers on BH medication management[11].

Note: The composition of the IBH team might include additional professionals (CHW, BH Navigator, etc.) – send in a description/list of all IBH team members

All Practices	Not Established	Partially Established	Established
C1. Qualified* BH Clinician on site *Clinician has a degree in a licensable mental health field; pediatric IBH clinician has some child clinical training	There is no BH Clinician on site; or BHC on site is not licensable or licensed	Practice panel under 5000 patients: < .5 FTE BHC Practice panel over 5000 patients: < 1 FTE BHC	Practice panel under 5000 patients: ≥ .5 FTE BHC Practice panel over 5000 patients: ≥ 1 FTE BHC
Evidence Required		Practice submits clinician job description and CV including relevant IBH training (e.g. IBH model, brief treatment, medical conditions, child clinical training etc.) along with panel size/FTE status; If the practice is using a hybrid model, the practice must submit the schedule of the clinician showing how many hours are in person vs virtual.	
C2. Structured communication exists between the IBHC(s) and the medical team as evidenced by: 1. Huddles include BHC 2. Shared patient record 3. Shared treatment or care plan	The practice routinely engages in only 1 of the 3 communication methods	The practice routinely engages in 2 of the 3 communication methods	The practice routinely engages in all 3 communication methods

Evidence Required		1. Huddles: Practice submits Huddle schedule 2. Shared record: Screen shot or MOU if IBHC is a contractor 3. Shared treatment plan: Screen shot or description of how treatment plans are shared if IBHC is a contractor	
C3. Access to psychiatry and medication management consultation	The practice does not have a procedure for accessing psychiatric consultation when needed	Informal relationship with psychiatric consultant	The practice has an established compact with a community provider (for pediatric practices this can be enrollment in PediPRN) OR There is a psychiatric consultant on site
Evidence required		Practice submits name of consultant and estimated frequency of use	The practice submits a copy of the compact and/or evidence of engagement with the consulting psychiatry resource OR On site Psychiatric consultant CV and schedule

Competency D. Access to Care

Description and Rationale:

An effective IBH program results in primary care patients having quick access to internal BH consultation and care; patients should also be assessed and triaged quickly and then connected to community resources in a timely manner. Internal access elements include having a virtual option for patients to access the IBH clinician when needed, a robust workflow for conducting warm hand-offs in the office when the IBHC is there, and building in urgent visits to the IBHC's schedule so patients with more acute needs can be seen and triaged quickly. This access, like with general improved medical access, should lead to a decrease in Emergency Dept. visits for BH concerns and improved patient care overall.

Creating relationships and referral processes with external BH providers is essential for maintaining continuity of care for the primary care patient/family. A practice with an IBH program should be able to track referrals to external BH providers and follow up when needed to ensure that care is coordinated for the patient. Referral pathways are generally smoother when practice staff have positive relationships with external providers, and clear referral, communication, and care coordination expectations.

All Practices	Not Established	Partially Established	Established
D1. Internal Access to BH services 1. Practice has a virtual IBH option 2. Warm Hand Offs are conducted routinely 3. Urgent/same-day BH visits are incorporated into the IBHC schedule	The practice has none or one of these options in place	The practice has 2 of 3 of these options in place	The practice has all 3 of these options in place
Evidence Required		1. Virtual option: Attestation/identify platform 2. WHOs: Practice submits a report showing how many WHOs have been conducted over the past 12 months (or for the duration of the employment of the IBHC if < 1 year) 3. Urgent visits: Practice submits a copy of the IBHC's schedule showing availability of same-day or urgent/next day visits	

D2. <u>Access to external resources and services</u> 1. Referrals to community BH providers are tracked and followed up 2. Referral relationships with community BH providers are established	The practice does not have either of these in place	The practice has one of these in place	The practice has both of these in place
Evidence Required		1. Referral tracking: Practice submits either a report or a copy of the practice's tracking process 2. Referral relationships: Practice submits a copy of at least one established compact or evidence of consultation from (de-identified) patient notes	

Competency E. Measurement

Description and Rationale:

In order to determine whether an IBH program is effective, a practice should be routinely reviewing key metrics. First, since BH screening is such an integral element of IBH, it is important for practices to maintain screening rates at a high level; without routine monitoring, screening rates can decrease for a variety of reasons (e.g. new staff, staff shortages). This competency requires the practice to demonstrate that it is monitoring screening rates AND taking deliberate action if the screening rates start to drop. Second, it is important to evaluate patient and population outcomes. Rescreening is one way to determine whether interventions have been impactful for patients, and the practice is asked to submit a report or registry to demonstrate that there is a rescreening protocol in place and that action is taken when scores increase or remain high. Because patient panels and priorities vary among practices, the second part of this criterion is for the practice to demonstrate another way in which patient outcomes are routinely monitored, selecting from the options provided.

All Practices	Not Established	Partially Established	Established
E1. Monitoring screening rates See B1 for screening options for Adult and Pediatric practices	The practice does not monitor their BH screening rates routinely	Adult Practices: The practice routinely monitors screening rates in 2 BH areas *Depression screening in adults is required to meet this criterion Pediatric Practices: The practice routinely monitors BH screening rates in two age groups *Ages 12-17 screening for Depression and Anxiety are both required to receive credit	Adult Practices: The practice routinely monitors screening rates in 3 or more areas * Depression screening in adults is required to meet this criterion Pediatric Practices: The practice routinely monitors BH screening rates in three age groups *Ages 12-17 screening for Depression and Anxiety are both required to receive credit
Evidence Required		The practice submits a policy/procedure or documentation of a QI initiative indicating the practice's plan for monitoring screening rates and steps to improve if rates fall below 75%; the screening rate reports submitted for B1 are not sufficient as they do not show the practice's ongoing commitment to monitoring these rates and taking action to improve	

E2. <u>Monitoring patient and/or population behavioral health outcomes</u> 1. Rescreening protocol is established and utilized 2. Other systematic review of outcomes in **one** of these areas: a. holding case review meetings for complex patients and amending treatment plans; b. monitoring ED or hospital utilization for BH; c. reviewing BH health disparity data d. monitoring internal BH access (time to first appointment) and show rates	The practice does not have a rescreening protocol or any other way of systematically reviewing patient BH outcomes	The practice has an established rescreening protocol OR at least one other way of systematically reviewing patient or population behavioral health outcomes	The practice has an established rescreening protocol AND at least one other way of systematically reviewing patient or population behavioral health outcomes
Evidence Required		1. Rescreening protocol: The practice submits a registry or other report showing how BH screener scores are tracked and actions taken when scores are high, for patients who receive care directly from the IBH clinician and patients who don't. 2. Other systematic review of outcomes: a. The practice submits a description of case review protocol along with a case example b.-d. The practice submits a report showing how the chosen BH outcomes are routinely tracked	

Competency F. Training in IBH

Description and Rationale:

Due to IBH workforce shortages, it is possible, if not likely, that newly hired IBH clinicians will have minimal IBH training coming into this role. It is imperative that the practice commit resources to provide appropriate training to the IBH clinician(s) as well as to staff practice-wide not only at the outset of implementation but on an ongoing basis as well[10]. IBH clinicians should be well-versed in evidence-based brief interventions for children and adults, motivational interviewing, common chronic illnesses seen in primary care, health behavior change, and functional assessment, among other topics. This competency includes 3 elements:

1. The practice ensures that the IBH model and workflows are part of the orientation for any newly hired practice staff.
2. The practice commits to support evidence-based training in IBH to all staff on an ongoing basis.
3. The practice develops materials and messaging to patients about IBH.

All Practices	Not Established	Partially Established	Established
F1. New Staff are trained on IBH model	New staff are not trained on the IBH model when they are oriented to the practice	New staff receive some orientation to IBH but training is minimal	New staff receive training in IBH as part of their orientation
Evidence Required		Practice submits staff orientation materials relevant to IBH	
F2. The practice provides and supports ongoing, evidence-based staff training relevant to IBH	The practice does not provide or support ongoing IBH training or education	Staff receive ongoing training in- house on IBH topics OR Staff are supported and encouraged to engage in continuing education on IBH topics	Staff receive ongoing training in-house on IBH topics AND Staff are supported and encouraged to engage in continuing education on IBH topics
Evidence Required		The practice submits evidence of internal trainings (e.g. lunch and learns) and external trainings (e.g. CE courses staff attended during the year or participation in IBH special projects); *trainings need to be on evidence-based topics/treatments to qualify*	

F3. Patients are educated and informed about the IBH model	Patients are not routinely educated or informed about IBH model or services	Patients are educated and informed about IBH model and the services provided only sometimes/inconsistently	Patients are routinely educated and informed about IBH model and services provided
Evidence Required		Practice submits examples of materials shared with patients and/or a policy indicating how patients are informed of IBH services	

Open response (Optional): Please provide any additional information about your IBH team members or other aspects of your IBH program (access, measurement, etc.) that further highlights your IBH program's effectiveness and quality:

References

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11. van der Feltz-Cornelis CM, Van Os TW, Van Marwijk HW, Leentjens AF. Effect of psychiatric consultation models in primary care. A systematic review and meta-analysis of randomized clinical trials. J Psychosom Res. 2010 Jun;68(6):521-33. doi: 10.1016/j.jpsychores.2009.10.012. Epub 2010 Jan 15. PMID: 20488268.

IBH Frameworks:

AHRQ The Academy, Integrating Behavioral Health and Primary Care Playbook
https://integrationacademy.ahrq.gov/products/playbooks/behavioral-health-and-primary-care

IBH Cross-Model Agnostic Framework
https://familymedicine.uw.edu/dataquest/wp-content/uploads/sites/10/2020/06/Integrated-Behavioral-Health-Agnostic-Framework-190810-1.pdf

The Comprehensive Healthcare Integration Framework. Washington, DC, National Council for Mental Wellbeing, 2022.
https://www.thenationalcouncil.org/resources/the-comprehensive-healthcare-integration-framework/

NCQA Distinction in BHI
https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/distinction-in-behavioral-health-integration/