Expanding the Toolbox: Quality-Tested Tools for Enhancing Integration of Behavioral Health and HIV Services

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Disclosures

Adam Thompson and Susan Weigl have no relevant financial or non-financial interests to disclose.

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Objectives

- Understand the use of quality tools to support improved integration of behavioral health and primary HIV care services
- Apply lessons learned on the application of the tools in clinical quality management programs, including hospital-based and outpatient ambulatory clinics, federally qualified community health centers, and community-based organizations
- Practice using a toolkit developed to improve the quality of integration of behavioral health and primary HIV care services

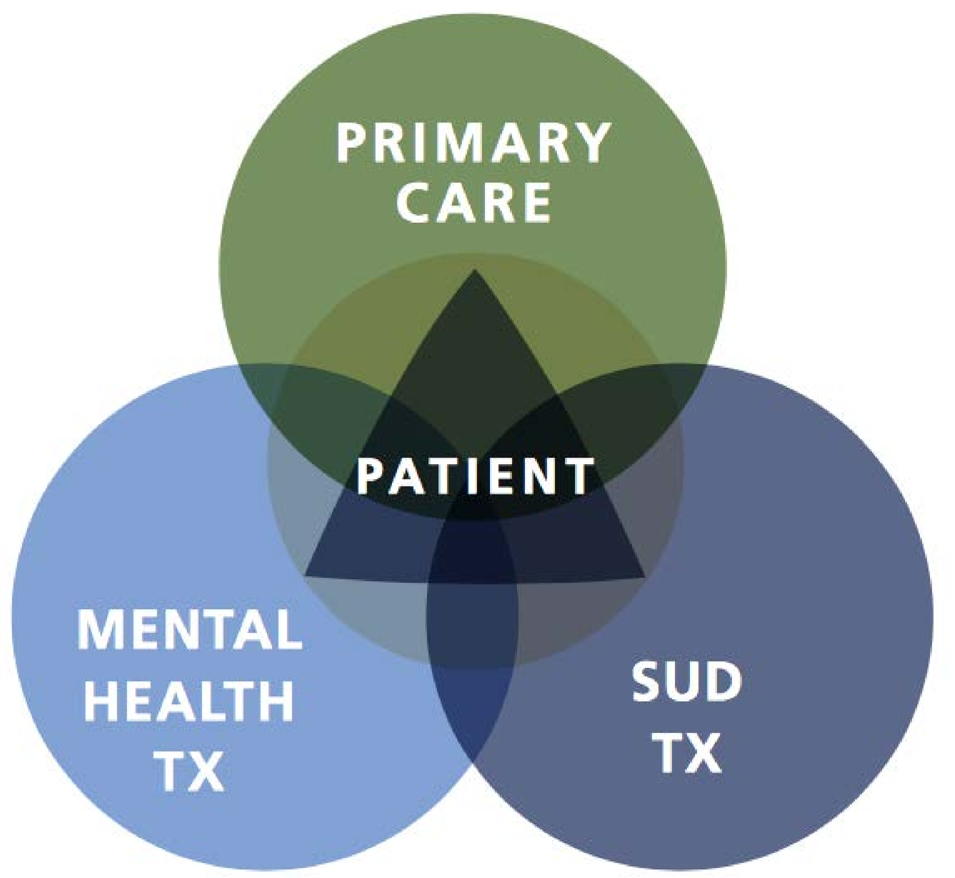
Workshop Outline

- Rationale for Behavioral Health Integration Projects
- The New Jersey Behavioral Health Integration Project Overview
  - Aim and Goals
  - Participants
  - Conceptual Frameworks
  - Components
- Behavioral Health Tools and Methods
  - Traditional Quality Improvement Tools
  - “Homegrown” Behavioral Health Integration Tools
- Pulling it All Together - Storyboarding

Why Implement an HIV Behavioral Health – Primary Care Integration Project?

Behavioral Health Disorders and HIV Infection Are Syndemic at a Global Level

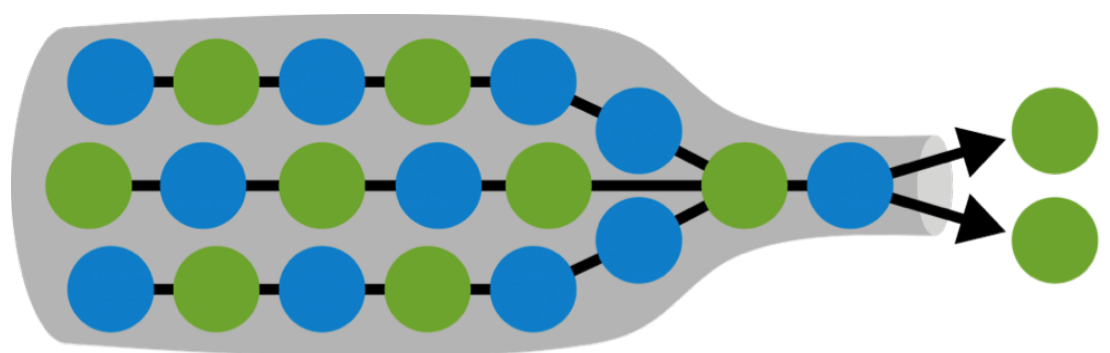
- Behavioral health disorders put people at risk for HIV infection.
- HIV infection puts people at risk for behavioral health disorders.
- These conditions are syndemic: They interact in a manner that worsens patient outcomes for each condition.

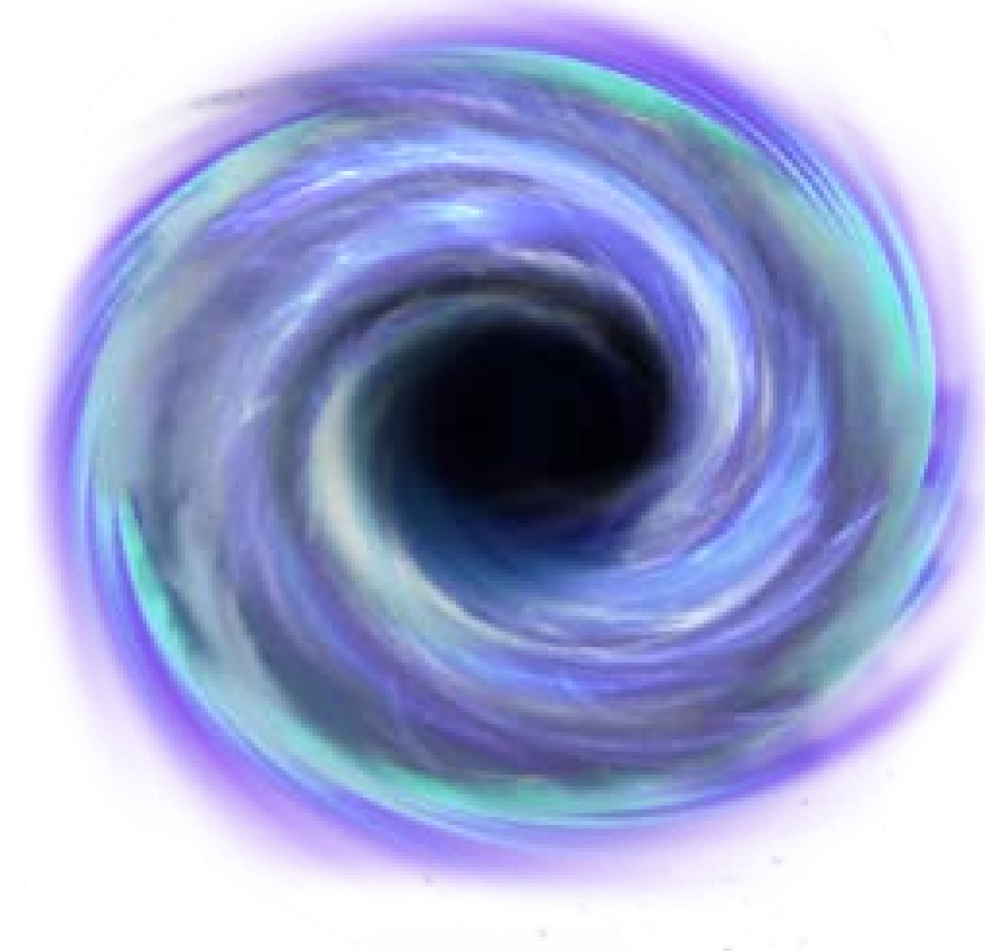


Why did we need to take this on?

- Among people in care for HIV infection:
  - 30-50% have current or past severe-moderate depression
  - Up to 40% have anxiety disorders
  - 22-56% have lifetime substance use disorder
  - Other common disorders include PTSD, Personality Disorders, and SMI
- Among people who acquired HIV infection through injection drug use, close to 100% have current and/or past substance use disorders.
- A medical program for people with HIV infection is by default a program for people with behavioral health disorders.

Bottlenecks and Blackholes





The New Jersey Behavioral Health and HIV Integration Project (BHIP)

B-HIP Aim

Develop a system of care in New Jersey that integrates behavioral health and HIV primary care services to improve system and patient outcomes.

B-HIP Goals

1. **INTEGRATION** of behavioral health and HIV care
2. Improved **ACCESS** to behavioral health care
3. Improved **PATIENT OUTCOMES**
4. **SYSTEM CHANGE** in behavioral health capacity for the NJ HIV care system

B-HIP Participating Agencies

- Community Based Organizations
- Hospital Based HIV Clinics
- Federally Qualified Health Centers and Community Health Centers
- New Jersey Department of Health
- Jefferson Health Foundation – New Jersey
- Northeast-Caribbean AIDS Education and Training Centers
- Columbia University HIV Center for Behavioral Health and Prevention
- Hyacinth Foundation

Essential Evaluation Questions

- INTEGRATION: Did BH integration happen?
- BH SERVICES: Did access to BH treatment/services improve as a result of the program?
- PATIENT OUTCOMES: Did patient clinical outcomes improve as a result of the program?
- SYSTEM: Did the “landscape” of BH treatment/services change in NJ?

NJ-BHIP Conceptual Frameworks

Learning Collaborative Framework Breakthrough Series Model, adapted

Enroll Participants

Select Topic

Prework

P
A
D
S

Recruit Faculty

Develop Framework and Changes

LS1

LS2

LS3

AP1

AP2

AP3

Summative Congresses and Publications

Practice Facilitation Coaching

LS1: Learning Session
AP: Action Period
P-D-S-A: Plan-Do-Study-Act

Supports:
Email • Visits • Phone Conferences • Monthly Team Reports • Assessments

NJ-BHIP Innovative Components

Behavioral Health & HIV Primary Care Integration:

- AETC Leadership
- Learning Collaborative Framework
- Practice Facilitation
- Twinning Opportunities
- Cross-Part Involvement
- Community-Based Organization Inclusion
- Systems Level Change

B-HIP Site Supports

Networking

Learning Sessions & Training

Webinars

Coaching

Twinning

Standard Framework of Integration

COORDINATION

We discuss patients, exchange information if needed. Collaboration from a distance

CO-LOCATION

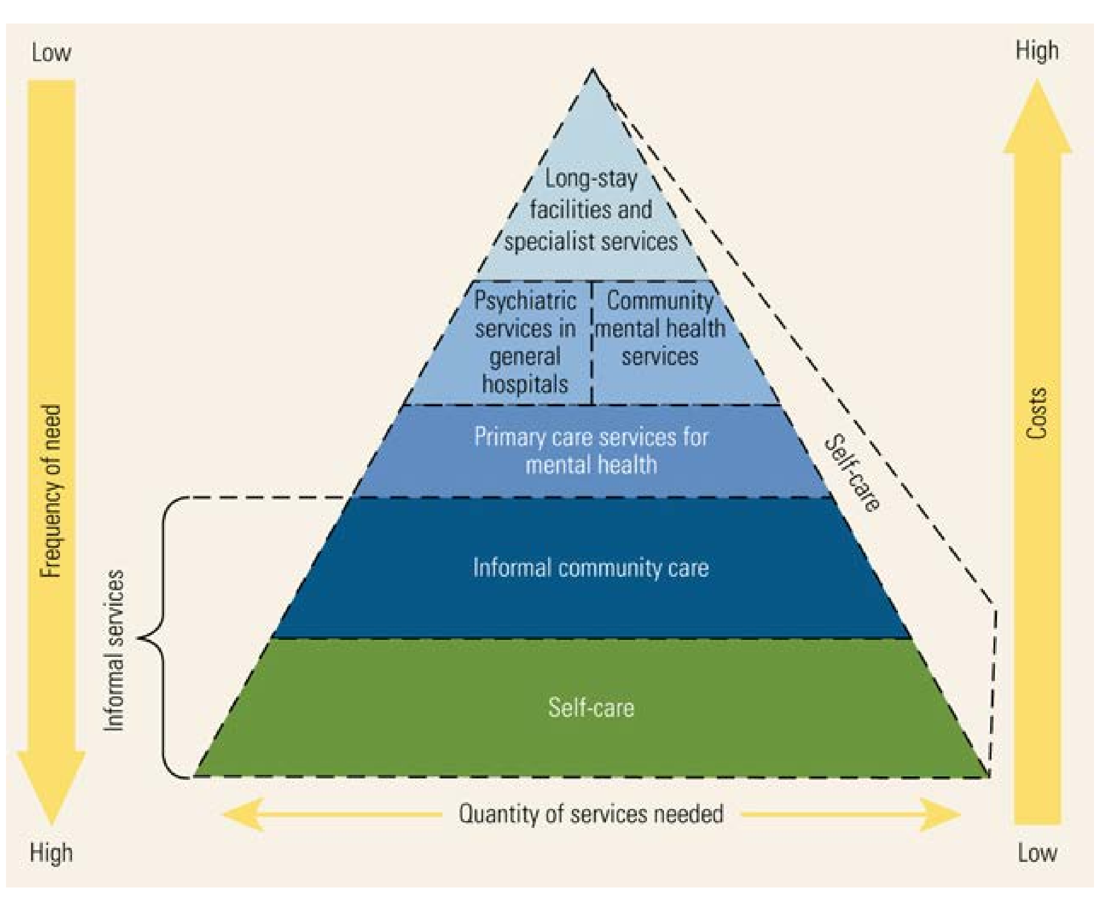
We are in the same facility, may share some functions/ staffing, discuss patients

INTEGRATION

System-wide transformation, merged practice, frequent communication as a team

https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf?daf=375ateTbd56

Optimal Mix of Mental Health Services



- The World Health Organization (WHO) developed the Optimal Mix of Services Pyramid to provide guidance on how to organize services for mental health.
- The pyramid shows the ideal mix of services including self-care, informal community-care, and primary care services

The optimal mix of services. Geneva, World Health Organization, 2007 (http://www.who.int/mental_health/policy/sercices/en/index.html)

Substance use treatment

DSM5: Mild

DSM5: Moderate

DSM5: Severe

Abstinence

Low Risk Use

At-Risk Use

Abuse

Dependence

Primary Prevention Services

Brief Intervention

Brief Treatment

Traditional Treatment Services

BHIP Tools and Methods

Choose the Right Tool for Integration

- Behavioral Health HIV Primary Care Integration Requires Systems Level Changes
- A kit of essential tools is critical to move forward collaboratively
- The BHIP toolkit contains both traditional and “homegrown” tool to address specific questions and challenges that commonly arise with planning and implementing a system-wide behavioral health primary care integration projects

Behavioral Health Integration Toolbox

- Behavioral Health – HIV Primary Care Continuum
- A Model for Improvement PDSA
- Behavioral Health Integration Readiness Assessment
- Performance Measurement Trees and Tools
- Process Mapping
- Information Technology Assessment
- Health Records Mapping Tool
- Referral Mapping Tool
- Screening Frequency Tool
- Cause and Effect Diagrams
- Site and Coach Storyboards

Combined HIV/BH Care Continuum

Behavioral Health Triage and Screening → Diagnostic Evaluation → Linkage to BH Treatment → Evidence Based BH Treatment → Retention/ Engagement in HIV & BH Care → Improvement in HIV Outcomes / Improvement in BH Outcomes

% Screened for BH Disorders → % of Positive Screens with F/U or Diagnosis Documented → % with Internal Care/External Care Referrals → % of Diagnosed with BH Disorder with Tx Plan Documentation → % of Diagnosed with F/U Tx Documentation → % of Diagnosed with Documented Improvement

Screening | Referral | Treatment

Change is a process

The **Plan-Do-Study-Act** or **PDSA Cycle** is one method to accelerate change inside clinics and health systems.

The PDSA Cycle is focused on:

1. Identifying opportunities for improvement (**Plan**)
2. Reviewing current performance and processes (**Plan**)
3. Hypothesizing about potential solutions (**Plan**)
4. Conducting tests of change to determine effectiveness (**Do**)
5. Examining the results of the tests of change (**Study**)
6. Adapting, Adopting, or Abandoning the idea based on findings. (**Act**)

Performance Measurement

Example Measurement Tree Example

Balance – staff and patient experience evaluation

Leading Outcomes

- Percentage of Patients Virally Suppressed

Process Measures

- % Screened for Depression
- % Screened for Substance Use
- % Retained in Medical Case Management
- % Retained in Medical Care

Step Measures (from % Screened for Depression)

- % Staff believing responses are true
- % patients with positive experience
- # of Process Map Revisions
- % Staff receiving customer service training
- % Staff Educated on BH Importance
- % Patients Education on BH Importance

Screening Measures

1. **SCREENING: PLWH Screened for Depression**
   - Denominator: HIV patients 18 years or older who have a HIV primary care visit in measurement period.
   - Numerator: Number screened with the PHQ9 in measurement period.
   - Measurement Period: 12 months.

2. **SCREENING: PLWH Screened for Substance Use Disorders**
   - Denominator: HIV patients 18 years and older who have a HIV primary care visit in measurement period.
   - Numerator: Number screened for a substance use disorder using a valid tool from the list of acceptable screeners in measurement period.
   - Acceptable Screeners: TAPS or any other National Curriculum endorsed screeners at this link. Select only **1** screener for this measure.
   - Measurement Period: 12 months.

Referral Measures

3. **REFERRAL: PLWH with Positive Screens who have Follow-up Plans**
    - Denominator: HIV patients 18 years and older who screen positive for a behavioral health disorder in measurement period.
    - Numerator: Number with a behavioral health follow-up or treatment plan documented in measurement period.
    - Acceptable Screeners: PHQ9, TAPS or any other National Curriculum endorsed addiction screeners at this link. Select only 1 screener for this measure.
    - Measurement Period: 12 months.

4. **REFERRAL: PLWH with BH Disorders Retained in BH Care**
    - Denominator: HIV patients 18 years and older with a behavioral health diagnosis at the end of the measurement period and with a primary care visit in measurement period.
    - Numerator: Number retained in BH care as demonstrated by a BH care plan with follow-up noted, internally/externally in measurement period.
    - Diagnostic Codes: See the table in Basecamp, which includes ICD9/10 codes for common behavioral health disorders.
    - Measurement Period: 12 months.

Treatment Measures

5. **TREATMENT: PLWH with BH Disorders Viral Suppression**
    - Denominator: HIV patients 18 years and older with a diagnosed BH disorder with a primary care visit in measurement period.
    - Numerator: Number who have a viral load less than or equal to 200 copies/mL at last test in measurement period.
    - Diagnostic Codes: See the table in Basecamp, which includes ICD9/10 codes for common behavioral health disorders.
    - Measurement Period: 1 year

6. **TREATMENT: PLWH with Viral Suppression (*collected through NJ CPC*)**
    - Denominator: HIV patients 18 years and older with a primary care visit in measurement period.
    - Numerator: Number with a viral load less than or equal to 200 copies/mL at last test in measurement period.
    - Measurement Period: 12 months.

BHIP Data

Client N FullName2

B-HIP Service Date:

B-HIP PM 1

☐ Depression Screening

QualitativeLabR

B-HIP PM 2

☐ Alcohol Screening

QualitativeLabR

☐ BHIP Substance

QualitativeLabR

B-HIP PM 3

☐ Alc- Monitor and Reassess

☐ Alc-Already in tx

☐ Alc-Refer for Evaluation

☐ Alc- Patient refused referral

☐ MH-Monitor and Reassess

☐ MH- Already in Tx

☐ MH- Refer for Evaluation

☐ MH- Patient refused referral

☐ SUB Monitor and Reassess

☐ SUB Already in Treatment

☐ SUB Refer for Evaluation

☐ SUB Patient refused referral

B-HIP PM 4

☐ BHIP Diagnosis

QualitativeLabResult4

☐ BH TX Plan Integrated-MH

ServiceContra

Price: ServicePr

Qty: ServiceQty2

Total: ServiceTo

☐ BH Tx Plan Integrated-MCM

ServiceContra

Price: ServicePr

Qty: ServiceQty3

Total: ServiceTo

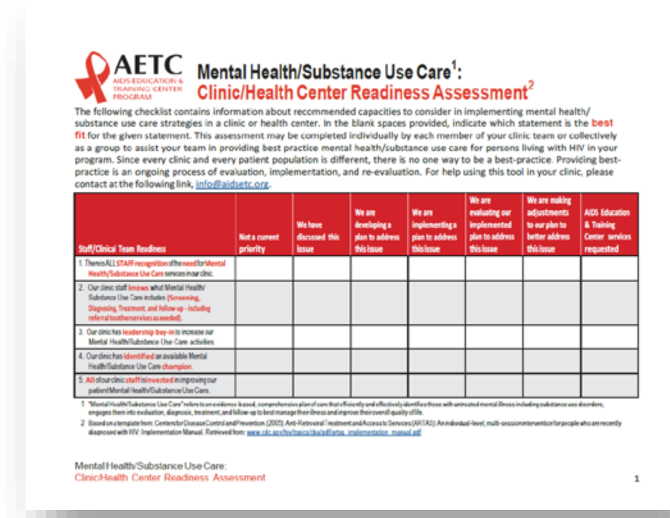
Performance measurement – all agency measures

NJ BHIP – All Measures Performance

Behavioral Health Integration Readiness Assessment

Readiness Assessment

- The Readiness Assessment is a tool that helps teams and coaches better understand the agency's current state of readiness to integrate behavioral health services
- The tool is administered at baseline and re-administered to measure systems level changes overtime
- Domains of the Readiness Assessment
    - Staff and Clinical Team Readiness
    - Assessment Readiness
    - Capacity Readiness
    - Community Readiness
    - Support Readiness
    - CQI Readiness



AETC AIDS EDUCATION & TRAINING CENTER PROGRAM

Mental Health/Substance Use Care[1]: Clinic/Health Center Readiness Assessment[2]

The following checklist contains information about recommended capacities to consider in implementing mental health/ substance use care strategies in a clinic or health center. In the blank spaces provided, indicate which statement is the best fit for the given statement. This assessment may be completed individually by each member of your clinic team or collectively as a group to assist your team in providing best practice mental health/substance use care for persons living with HIV in your program. Since every clinic and every patient population is different, there is no one way to be a best-practice. Providing best-practice is an ongoing process of evaluation, implementation, and re-evaluation. For help using this tool in your clinic, please contact at the following link, info@aidsetc.org.

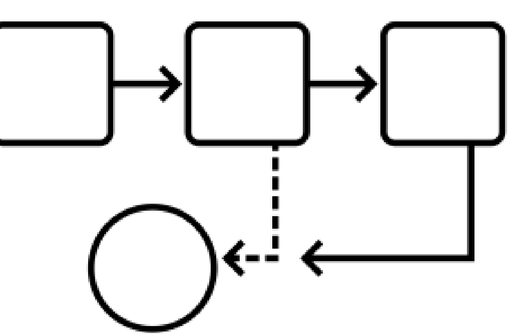
Staff/Clinical Team Readiness	Not a current priority	We have discussed this issue	We are developing a plan to address this issue	We are implementing a plan to address this issue	We are evaluating our implemented plan to address this issue	We are making adjustments to our plan to better address this issue	AIDS Education & Training Center services requested
1. There is ALL STAFF recognition of the need for Mental Health/Substance Use Care services in our clinic.							
2. Our clinic staff knows what Mental Health/ Substance Use Care includes (Screening, Diagnosing, Treatment, and follow-up - including referral to other services as needed).							
3. Our clinic has leadership buy-in to increase our Mental Health/Substance Use Care activities.							
4. Our clinic has identified an available Mental Health/Substance Use Care champion.							
5. All of our clinic staff is invested in improving our patient Mental Health/Substance Use Care.							

Mental Health/Substance Use Care: Clinic/Health Center Readiness Assessment 1

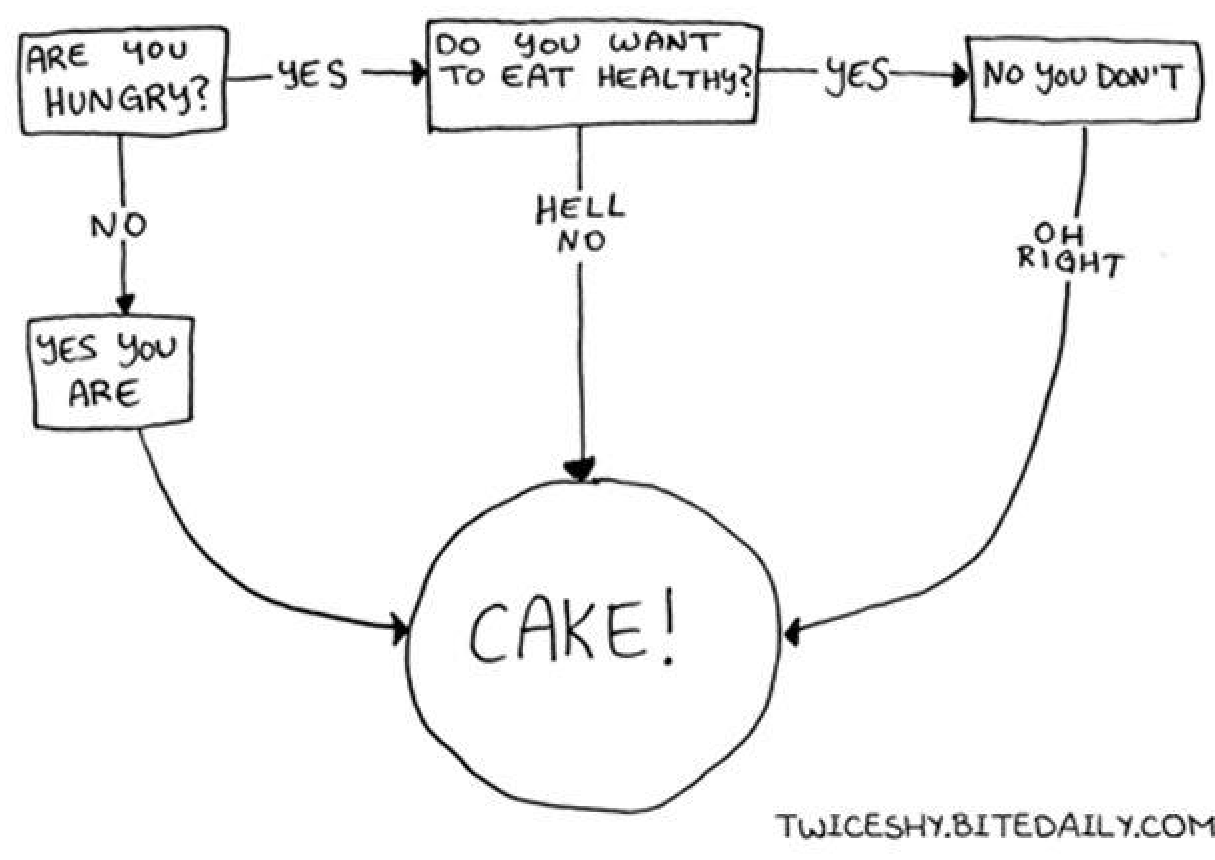
Process Mapping

Process Maps

- Process Maps are visual representations of the sequence of steps in a process
- They are made to develop ideas about how to understand, implement, or improve a process
- A shared understanding of the current process helps quality improvement teams:
    - identify problems or bottlenecks (e.g., breakdowns in communication)
    - focus discussions
    - identify resources



Are You Hungry?
Process Map

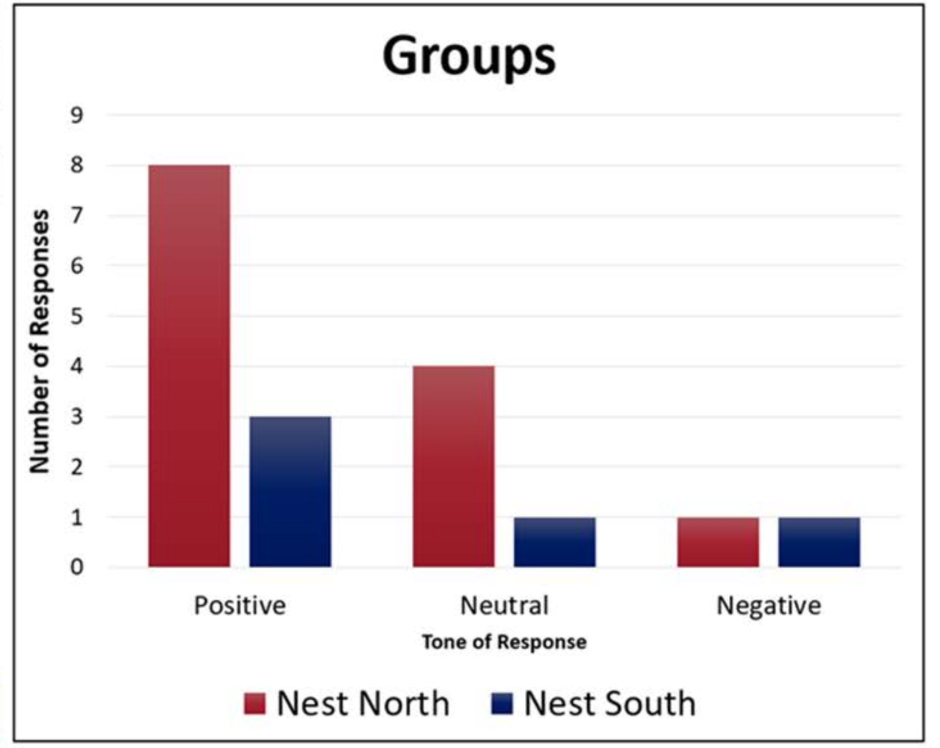


What is Journey Mapping?

- Patient/Client Journey Mapping is one way to think about how a patient/client interacts with your system
- Understanding the touch points of your clients and patients can help you better understand where and what to improve
- Journey Maps are created by asking what interactions does a patient/client have in accessing a specific health service
- Journey Mapping is also known as Touch-Point Mapping

Patient Journey Map Analysis

- Housing program for Gay and Bisexual Young Men of Color
  - Includes co-located individual DBT and group therapy
- Built to evaluate the process map experience
  - Evaluated the experience of the residents through the continuum of residency
- Included qualitative and quantitative elements

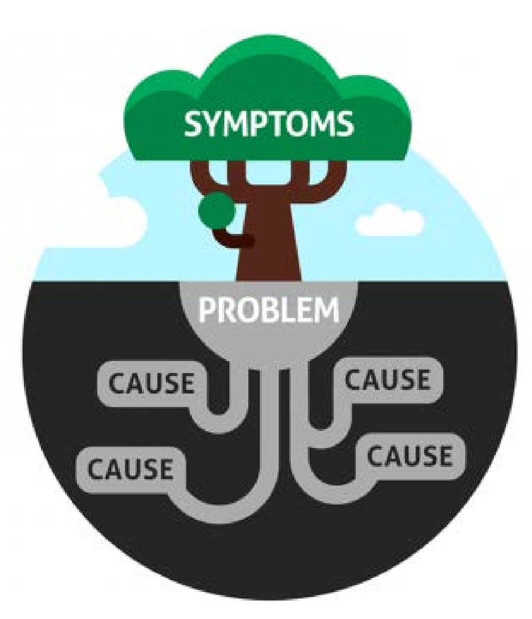


HOUSE	Positive	Neutral	Negative
North	8	4	1
South	3	1	1
Total	11	5	2

Cause and Effect Diagrams

Causal Analysis Tools

- Multiple methods to construct a cause and effect diagram
- BHIP Sites used either (1) Driver Diagram or (2) Fishbone Analysis
- Driver Diagram
  - Identifies the driving forces behind a project aim and represents a shared team vision
  - Shows relationships between the aim, primary drivers, secondary drivers, and specific change ideas to test
- Fishbone Analysis
  - Identifies factors influencing outcomes in specific domains related to the process, people, environment, and resources of the agency
- Opportunity for collaboration with patients and clients through co-production or comparison of outcomes of root cause processes



Example fishbone diagram

Measurement
Gas gage is broken
Too many miles on the car

People
Lack of training
No preventative maintenance

Environment
Engine overheated
Engine too cold

Car Won't Start

Dead battery
Alternator
Machines

Brake not pressed when starting
Methods

No gas
No car key
Materials

Example Fishbone

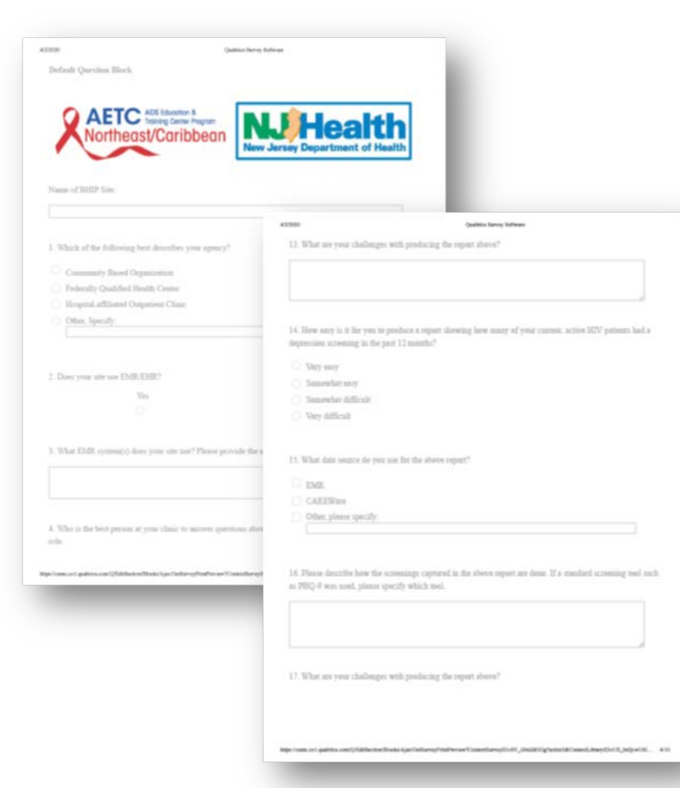
People

- Discomfort by staff to engage/communicate with this population
- Staff not trained to use screening tools
- Lack of peer workforce
- Limited internal BH service skills
- Lack of SU treatment staff
- Staff lacks cultural sensitivity (customer service/empathy)
- Staff unfamiliar with needs of this population
- Case managers lack knowledge of services/resources
- Responsibilities unclear
- Clients disassociate with diagnosis/referral
- Clients not ready to engage
- Clients confused by different case managers

“Homegrown” Tools

Information Technology Assessment

- Tool Rationale
  - Agencies often cite IT barriers when trying to make systems-level changes; understanding the IT environment helps support more feasible projects
- Tool Components
  - The on-line survey tool (*Qualtrics*) assessed clinical and supportive service data systems including:
    - Electronic Medical Records
    - CAREWare
- Tool Benefits:
  - Allowed for peer-to-peer learning around shared EHRs
  - Exposed opportunities for data integration with Community-Based Organizations
  - Guided teams and coaches to ensure projects were feasible



Records Mapping Tool

- Tool Rationale:
  - Agencies have built a patchwork of services with disparate and varied methods of documentation; understanding the current documentation practices helps to integrate patient information into a single actionable record
- Tool Components
  - BH and HIV PC Staffing; Role and Credentials
  - Services and Funding Source
  - Documentation and Location
- Tool Benefits:
  - Internal: used to identify fractured documentation systems
  - External: identify the gaps in knowledge
  - Agencies used the tool to identify data integration points

Records Mapping Tool

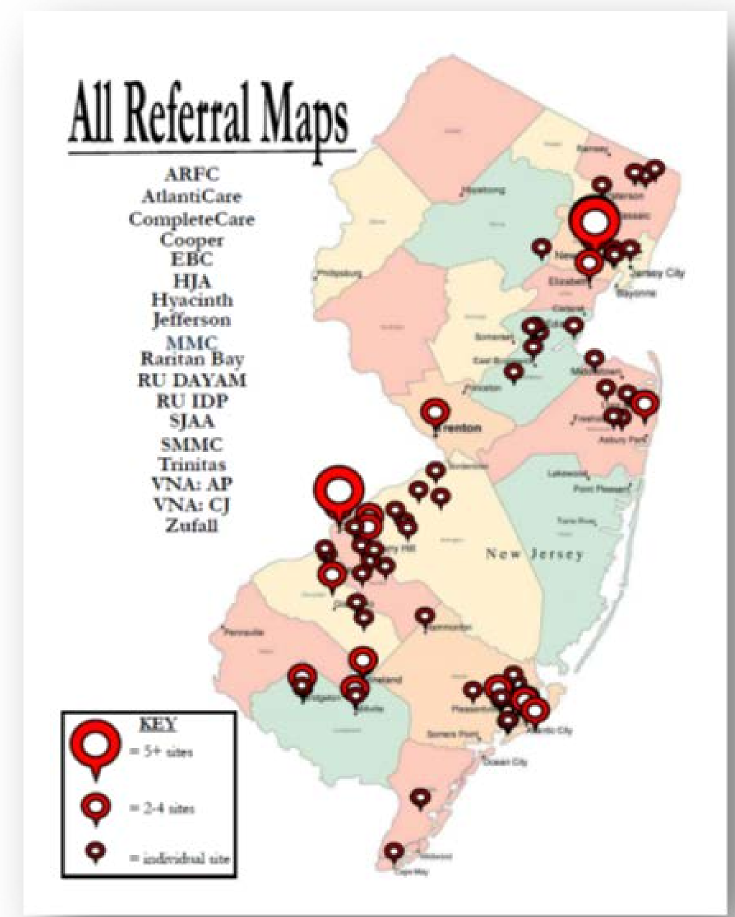
New Jersey Behavioral Health and HIV Integration Project – Record Mapping Tool

Role	What is the title and/or role of the staff (e.g. – Psychiatrist, Nurse Care Manager, Community Health Worker)? What is the full-time equivalent (FTE) of the staff member and how many are there (e.g. 2 Staff/1.0 FTE)?
Credentials	What if any credentials are required for the position or held by the person in the position? e.g. – RN, DO, MSW, LPN, etc.
RWHAP Category	What RWHAP Service Category is the staff member funded under? (If not RWHAP- indicate source of funding – e.g. CDC Direct, State Prevention, SAMHSA, etc.)
Services	What is the nature of the provided service(s) (e.g. – therapy, medication management, counseling, group level sessions, navigation, medical case management etc.)
Documentation and Location	What types of documentation are generated in the delivery of the service including clinical and reporting documentation (e.g. – case notes, treatment plans, screening results, etc.) Where are the above items documented (e.g. – EHR/EMR, Paper Charts, Database (indicate the name of each – Epic, eCompass)?

NJ Health · AETC Program · Columbia University Medical Center · HYACINTH AIDS Foundation

Referrals Mapping Tool

- Tool Rationale:
  - Agencies cited a lack of behavioral health providers as a barrier to care for their patients; examining the current referral networks allowed for a point-in-time look at the NJ referral network
- Tool Components:
  - Map includes referral information by agency; types of services, payment methods accepted, access and special populations
- Tool Benefits:
  - Allows for referral network analysis at regional and statewide level
    - Demonstrated that referral networks were densest in the more urban areas
    - Identified some agency overlap in referral networks
    - Showed variable access for treatment of substance use disorders, particularly Opioid Use Disorder
  - Exposed opportunities to expand provider network by adding private practice providers and networks



Screening Frequency Tool

- Tool Rationale
  - Fee-for-Service and Value-Based Payment Models produce over-screening in mixed specialty-primary care environments
    - Some patients were screened more than five times a year by the same provider
    - Patients who utilized supportive services located at another agency were being screened, at minimum, an additional two times each year
    - Concern that over-screening was leading to complacency by staff and patients
- Tool Components:
  - Agencies identified types of screening tools in use, staff members conducting the screening, and the frequency of the screening
- Tool Benefits:
  - Identified significant overlap and duplication of screening
  - Exposed opportunities to free-up staff time, reduce cost, streamline screening and more effectively identify patients in need of behavioral health services

Screening Frequency Tool

Screening Frequency Tool

		CLINICAL								SUPPORTIVE									
Screening		Intake		Well Visit		Sick Visit		Annual		Intake		Annual		3 Months		6 Months		9 Months	
Name of Screening	N/A	Check if done	Staff Member	Check if done	Staff Member	Check if done	Staff Member	Check if done	Staff Member	Check if done	Staff Member	Check if done	Staff Member	Check if done	Staff Member	Check if done	Staff Member	Check if done	Staff Member
PHQ – 2	☐	☐		☐		☐		☐		☐		☐		☐		☐		☐	
PHQ – 9	☐	☐		☐		☐		☐		☒		☐		☐		☐		☐	
DAST-10	☐	☐		☐		☐		☐		☐		☐		☐		☐		☐	
CAGE	☐	☐		☐		☐		☐		☐		☐		☐		☐		☐	
AUDIT-C	☐	☐		☐		☐		☐		☐		☐		☐		☐		☐	
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TAPS	☐	☐		☐		☐		☐		☐		☐		☐		☐		☐	
Tobacco	☐	☐		☐		☐		☐		☐		☐		☐		☐		☐	
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Acronyms: **MCM** – Medical Case Manager, **NMCM** – Non-Medical Case Manager, **CHW** – Community Health Workers, **NUR** – Nurse, **MA** – Medical Assistant, **PHYS** – Physician, **LTCC** – Linkage to Care Coordinator

Putting it all together - Storyboarding

Storyboards

- Storyboards are visual representations of a process – in the case of BHIP, the process the agencies went through for improvement
- Storyboards are a different method that uses both quantitative and qualitative elements to describe and inform about a project and its outcomes
- In BHIP, agencies were asked to create storyboards of their agency process and six months later, the Coaches for the agencies were asked to tell the agency story from the Coaching perspective.
- Sites were asked to share their Storyboards during in-person meetings
  - The “Gallery Walk” of storyboards provided an opportunity for participating agencies to share their lessons learned and best practices

Storyboard

We are the Champions

Of Behavioral Health Integration at Jefferson Infectious Disease

The Jefferson Health B-HIP Team

1	2	3	4	5	6
Maryann Andrews-Quality Specialist	Lisa Juliano-Quality Team Leader	Bibbi Stokes-Team Recorder	Gloria Taylor-Consumer Liaison	Terri Fox-Data Liaison	Michael Hager-Capacity Builder

Agency Goal Change Idea

Provide insight through trainings with Medical Assistants to increase their knowledge and skills to conduct screenings in ways that promote more detailed open and honest responses leading to improved patient outcomes

PDSA Cycle

What have we done?

LS1
- Reviewed processes
- Created process maps
- Assigned roles, assessed tasks

2% increase in MH screens

LS2
- Increased MH screening in 2% of all patients
- Assessed impact of Sub screening on patients
- Reviewed processes
- Provide additional training and education to staff
- Additional staff training
- Implemented DAST-10 on paper

3% increase in Sub. Use screens

LS3
- Assessed data access, quality, and entry procedures
- Created process for extracting VLS, Retention for BHIP only
- Increased tracking and reporting capacity

B-HIP patients have approximately 20% higher retention rates

Next Steps: Create B-HIP screening procedure feedback loop

Lessons Learned:

STAFF:
- Education is vital for staff.
- Staff are fearful about being intrusive and making the patient uncomfortable/impacting retention.
- B-HIP requires time management of each visit.
- Team communication is imperative.

PATIENTS:
- Education is vital for patients.
- This is a new addition to the 'normal' patient experience.
- Patients have different beliefs about what their habits represent (ie... marijuana use is often discounted as inconsequential when it has implications for treatment).

Question or Comments

Contact

NJ Behavioral Health and HIV Integration Project

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Jefferson Health Foundation – New Jersey

South Jersey AIDS Education and Training Center

Thank you!

THANK YOU!

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