CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Case STUDY

Value Based Care
Learning System

Clinica Family Health's Integrated Behavioral Health Model

The Community Health Provider Alliance accountable care organization (ACO) is a network of federally qualified health centers (FQHCs) in Colorado. This case study describes how Clinica Family Health, a network of FQHC clinics participating in the ACO, delivers behavioral health services in a primary care setting.

To increase access to care, Clinica's integrated behavioral health (IBH) model incorporates three core components: (1) fully integrating behavioral health providers in the primary care setting; (2) prioritizing the provision of real-time integrated care that benefits the patient and works for the primary and behavioral health care providers; and (3) using electronic health record tools and team processes to plan and coordinate care. Clinica's IBH model could be instructive for other organizations seeking to provide behavioral health services in a primary care setting.

BACKGROUND

Community Health Provider Alliance (CHPA) accountable care organization (ACO) is a network of 19 federally qualified health centers (FQHCs) with 173 locations across Colorado. CHPA joined the Medicare Shared Savings Program in 2017 as a Track 1 ACO and switched to BASIC Level D in 2022. The ACO serves more than 15,000 Medicare beneficiaries annually.

Clinica Family Health participates in the CHPA ACO network and runs seven clinics in the Denver metro area. Clinica's behavioral health and medical professionals are integrated operationally and clinically into all the clinics. Staff share physical space and a common electronic health record (EHR) system. All Clinica patients are empaneled to an integrated care team.

OVERVIEW OF THE INITIATIVE

Clinica offered co-located primary care and mental health services from the 1980s through 2006 and partnered with community mental health centers (CMHCs) to provide intensive, ongoing therapy for complex patients. However, during this time, Clinica noted that more than 70 percent of its referrals for mental health care were incomplete, despite the proximity of behavioral health services. To address this, in 2006, Clinica shifted to an integrated model in which behavioral health providers (BHPs) were embedded in each primary care team. Rather than send patients down the hall to see a BHP as in the original co-located model, where they might not be able to schedule a same-day appointment, the side-by-side model brought BHPs to patients during their primary care visit.

> *"These patients are not looking for us; we are looking for them."*
>
> —Janet Rasmussen,
> Chief Integrated Services Officer, Clinica

INITIATIVE DETAILS

Staffing

Team-based care is central to Clinica's IBH model. Each care team includes three to four PCPs, a BHP (such as a licensed clinical social worker), nurses, a care coordinator, a health coach, medical assistants, and administrative staff. Every FQHC patient is assigned to a PCP who is part of a care team, and each care team is assigned a maximum of 5,000 patients. Depending on its size, a clinic might have as many as four care teams. The teams have access to supportive resources, including the expertise of a psychiatrist, a clinical pharmacist, an obstetrician-gynecologist, a dental hygienist, and a registered dietitian.

Figure 1 provides an overview of a Clinica care team. The staffing numbers are presented as full-time equivalents (FTEs).

Figure 1

FTEs Per Panel

Funding sources

The IBH model at Clinica predated its participation in the CHPA ACO, so the ACO represents a limited portion of the funding stream for the clinic. About six percent of Clinica patients have Medicare, and most have Medicaid or are uninsured.

Funding for the IBH model primarily comes from two sources: federal grants to deliver care to uninsured patients and Medicaid reimbursement. When Clinica provides traditional therapy for Medicare patients, it is a billable service. However, Clinica does not limit its care to only those services that are billable.

Tools used to identify patient needs

Care teams use information from two homegrown tools—the Outreach Tool and Care Planner—to coordinate services on behalf of patients, ideally during a single appointment. Information from the Outreach Tool helps Clinica staff identify patients with care gaps. If during the review of a patient's Care Planner, the team sees the person is flagged as requiring a depression follow-up and an HbA1c test, for example, the team can proactively arrange to take care of both services during one appointment.

Information from the Outreach Tool is also used to streamline and tailor the clinic's mode of communications to patients. For example, Clinica staff might send a text message reminder to a patient about upcoming tests or make a phone call to check in with a patient assessed as being at high risk for depression.

Table 1 highlights the core features of the Outreach Tool and the Care Planner.

Care delivery

Supporting established patients with recognized behavioral health needs

All Clinica sites run two to three care sessions daily—in the morning, afternoon, and evening—three days per week. Each care session consists of multiple patient appointments. Before each session, care teams huddle to review care plans (in the Care Planner tool) for patients on their schedule. During the huddles, the teams discuss which of their patients might need a behavioral health intervention during the appointment. If they think a patient will need such an intervention, or if behavioral health needs are identified during the appointment, BHPs try to make themselves available to see the patient immediately.

Supporting patients with newly identified behavioral health needs

When a patient has behavioral health needs identified during a clinic visit, a clinician or medical assistant with an established patient relationship facilitates a warm handoff to the care team's BHP. The BHP assesses the patient's immediate needs and provides brief intervention if the patient consents. When the BHP has built a relationship with the patient, the PCP and BHP might conduct co-visits for future appointments, depending on the patient's needs and wishes. If the BHP sees the patient before the PCP, the BHP documents the action plan and next steps in the EHR, which the PCP reviews during the appointment.

Supporting patients with complex behavioral health needs

For patients with complex diagnostic or medication needs, the BHP or PCP makes a referral to one of Clinica's two psychiatrists. The IBH model uses a "consulting psychiatrist" approach—the psychiatrists do not carry a patient panel, as most of their appointments are one-time consults or evaluations. This

Table 1

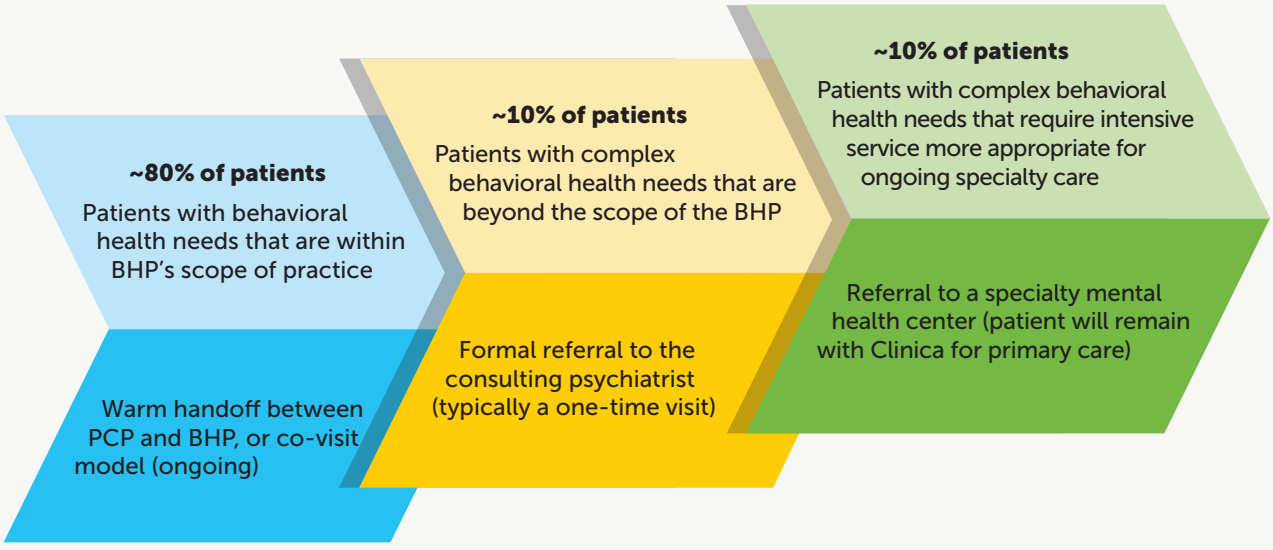
Key tools used to identify patient needs

blank	Outreach Tool	Care Planner
Description	Population health management tool	Point-of-care tool
Key functions	Identifies patients due for services, vaccinations, tests, or with other care needs	At-a-glance clinical summary of patient diagnoses, medication list, recent emergency department visits, scores on screening tools (such as PHQ-9), and care gaps that need to be addressed
Data sources	• Clinical registries • Encounter data	• EHR data • Colorado Health Information Exchange for inpatient stays
Purpose	Streamlined, proactive communication to patients about their upcoming appointments or care gaps	Care teams' pre-visit huddles
Timing of use	Used between patient visits	Used before and during patient visits

approach ensures that the psychiatrist can quickly accept referrals and that the PCP becomes more comfortable treating a range of behavioral health conditions. PCPs or BHPs can schedule a patient directly into the psychiatrist's schedule, or they can ask the psychiatrist to review the patient's chart and make treatment recommendations. Typically, the psychiatrist makes recommendations or develops a care plan that the PCP and BHP manage. After reviewing the psychiatrist's recommendations, the PCP prescribes the necessary medications and manages ongoing maintenance with the patient. When a patient's behavioral health needs exceed what the psychiatrist can provide, Clinica refers the patient to a specialty CMHC. Figure 2 shows the different levels of behavioral health support Clinica offers.

Figure 2

Matching clinical support with patients' behavioral health needs



Provider story: Several years ago, medication-assisted therapy (MAT) for alcohol use was becoming increasingly common. Initially uncomfortable with prescribing MAT, Clinica PCPs relied on the consulting psychiatrist for MAT care plans. With the psychiatrist's teaching and reassurance, PCPs gradually became more comfortable with the treatment plans to provide this therapy. Many Clinica patients use MAT, but the psychiatrist rarely sees referrals for this anymore. Clinica PCPs now have the training and tools to manage this type of treatment for patients with substance use disorder.

LESSONS LEARNED

Clinica shared its experience from nearly 15 years of providing IBH services. Staff highlighted lessons that are particularly relevant for organizations considering the use of multidisciplinary teams to deliver behavioral health care:

- **PCPs and BHPs co-managing patients supports the delivery of coordinated, integrated care.** Medical providers at Clinica have valued programs to provide behavioral health care that date back to the days when Clinica used a co-located model. In a recent internal survey on provider satisfaction, PCPs stressed that having access to BHPs during care sessions is one of the most important aspects of the medical care they deliver. Incorporating BHPs into primary care settings and workflows enables PCPs to see more patients and focus on their medical needs, while drawing on BHPs' expertise to deliver focused behavioral health care. Also, using one EHR system facilitates information sharing and enables the delivery of team-based, whole-person care.
- **Patients are more receptive to behavioral health care when it is offered along with medical care, rather than at a separate time and location.** Quarterly patient satisfaction surveys, which include questions adapted from the Consumer Assessment of Healthcare Providers and Systems surveys, confirm this. Patients say they have access to behavioral health care when they want it.
- **An IBH model might not succeed without systematic organizational support.** To promote engagement, BHPs should be appropriately represented across the organization, particularly at the levels relevant to implementing the IBH model, such as care delivery teams and clinical program leadership.
- **FQHCs' operational structure enables them to deliver comprehensive services beyond what a traditional fee-for-service-oriented primary care practice typically offers.** Located in medically underserved communities, FQHCs act as a hub for patients of all ages by providing primary care, dental care, behavioral health services, care coordination, and other services. Yet integrating a BHP into primary care is an approach that is not unique to FQHCs and can be adapted for many types of practices and clinics.
- **Recruiting BHPs requires an ongoing effort, given the rising demand for behavioral health care.** To deliver team-based care, all team members must work a common schedule, and Clinica staff described burnout and a desire for more flexible schedules as particular challenges.

Patient story: A patient with a significant history of mental illness needed therapy but could not find a provider that accepted her insurance coverage. One of her payer's care coordinators reached out to Clinica and asked if they would provide behavioral health services for the patient. Clinica agreed, and the patient's symptoms improved under Clinica's care. Clinica helped fill the gaps in this patient's care when no other provider would see her. The patient was relieved and happy that a BHP could see her during a difficult time in her life.

RESULTS

The CHPA ACO tracks how many patients receive behavioral health services to understand the overall utilization of behavioral health care in the ACO. It estimates that 40 percent of ACO beneficiaries had at least one behavioral health visit in the past year. CHPA's inpatient psychiatric hospital stays and substance use treatment claims are, on average, three times higher than other Medicare Shared Savings Program ACOs. CHPA ACO regularly shares evidence-based best practices for behavioral health care with participating FQHCs and also offers practice transformation support. The ACO also provides monthly reports of patient utilization and quarterly performance trends on quality measures to each FQHC.

Clinica staff anecdotally report that the IBH model improves access to behavioral health care. This is especially important for patients who face access barriers because of their insurance (such as individuals on Medicaid, Medicare, dual eligible, and the uninsured).

> *"Many of these patients would have never received a behavioral health intervention if they weren't being treated at Clinica."*
>
> —Emily Vellano, LCSW
> Vice President of Behavioral

Clinica monitors the impact and success of its IBH model by assessing the utilization of key behavioral health services, such as screening and treatment for depression and substance use:

- As part of routine visits, Clinica seeks to screen all patients over age 12 for depression. Clinica's goal is to screen 80 percent of its patients over age 12 annually. In 2021, Clinica screened 79.56 percent of patients, and as of November 2022, they have screened over 80 percent of patients for the 2022 calendar year. In addition, Clinica tracks treatment for patients who screen positive for depression. Staff monitor changes in patients' PHQ-9 scores[1] for improvements and to see if patients move into remission.

[1] The Patient Health Questionnaire, or PHQ-9, is used both to diagnose and assess the severity of depression.

- Clinica also monitors substance use screening and treatment. Staff assess how many patients are screened, how many are identified as struggling with substance use, and how many patients who screened positive received treatment (such as counseling or MAT).

NEXT STEPS

In the future, Clinica would like to offer more services across the continuum of behavioral health care, such as longer-term therapy. Currently, Clinica does not have the in-house capacity to provide more complex services but is exploring staffing solutions to integrate these new services.

About this case study
This case study was prepared on behalf of the Centers for Medicare and Medicaid Services (CMS) by Margaret Johnson, Heather McPheron, and Angel Rollo of L&M Policy Research. CMS released this case study in February 2023. We are grateful to Community Health Provider Alliance ACO and Clinica Family Health for participating in this case study.

For more information, contact the VBC Learning System at VBCLearningActivities@mathematica-mpr.com