New Jersey’s Collaborative Approach to Integrating Behavioral Health in HIV Settings

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Disclosures

Presenter has no conflicts of interest to disclose.
BHIP Beginnings

• HIV Cross-Part Care Continuum Collaborative (H4C)
  • Site Drill Downs
• Part B TA Site Visit
• Relationship between NJ Part B Program and South Jersey AETC
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
Participating Organizations

- NJ Part B
  - Statewide subrecipients funded for ambulatory care or behavioral health services
  - CAREWare system integration
  - 16 participating subrecipient organizations
- Middlesex-Hunterdon-Somerset Part A TGA
  - 3 participating subrecipient organizations
Combined Behavioral Health and HIV 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

Screening
Referral
Treatment

% 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
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
Breakthrough Series Model, adapted

**Select Topic**
- Enroll Participants
- Develop Framework and Changes
- Recruit Faculty

**Prework**
- LS1: Learning Session
  - AP1: Action Period
- LS2: Action Period
- LS3: Action Period

**Summative Congresses and Publications**

**Supports:**
- Email
- Visits
- Phone Conferences
- Monthly Team Reports
- Assessments

**Practice Facilitation Coaching**
Activities to Date

- **Kicking Off**
  - Forming site-based BHIP teams and cohorts of teams
  - Establish monthly capacity building webinars based on site needs

- **4 Learning Sessions**

- **Performance Measurement (6 Rounds spanning 1 year)**
  - Tied to a logic model used to evaluate the overall initiative

- Coaching of teams using a cohort model for practice facilitation coaching
Activities Continued

- Quality Improvement Projects (Continuum Screening Phase)
  - AETC Readiness Assessment, IT Assessment, EHR Record Mapping
  - Process Mapping and Patient Journey Mapping
  - Root Causes and Driver Diagrams
  - Creation of Step Measures for Testing Change Ideas

- BHIP Team Activities
  - Team formation with specific roles tied to staff
  - Role based breakout groups and special webinars
  - Storyboard creation for learning sessions
Evidence Informed Interventions

- Interventions are adapted from the literature and/or peer learning activities where one agency idea is spread to another agency and adapted as needed.
- Interventions are selected based on priorities and using QI tools appropriate for the level of integration and the clinical phase that is targeted (screening, referral, treatment).
- None of the interventions are “off the shelf” or “out of the box” and each has been crafted specifically to meet the needs of the implementing agency.
Example Driver Diagram
Example Storyboard

- Used to share updates across teams at LS
- Used to practice presentation and spread skills
- Can be brought home to post onsite for staff/patient learning
Example Referral Map

- Used to identify opportunities to strengthen network in medical neighborhood
- Strengthens established relationships in the state
- Allows for the strategic solicitation or seeding of new partners in key areas
Performance Measures - Screening

1. SCREENING: PLWH Screened for Depression
   • Denominator: HIV patients 18 years or older who have a HIV primary care visit in measurement period. *(should match measures 2 and 6)*
   • Numerator: Number screened with a valid tool in measurement period. *(note tool used in comments)*
   • 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. *(should match measures 1 and 6)*
   • Numerator: Number screened for a substance use disorder using a valid tool from the list of acceptable screeners in measurement period. *(note tool used in comments)*
   • Acceptable Screeners: TAPS or any other National Curriculum endorsed screeners [at this link](#). Select only 1 screener for this measure.
   • Measurement Period: 12 months.
Performance Measures - Referral

1. 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. (note the cutoff definitions for screeners used in measures 1 and 2 and what is counted as follow-up in comments)
   - Acceptable Screeners: PHQ9, TAPS or any other National Curriculum endorsed addiction screeners at this link.
   - Measurement Period: 12 months.

2. 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. (should match measure 5)
   - Numerator: Number retained in BH care as demonstrated by a BH care plan with follow-up noted, internally/externally in measurement period. (note the data source for retention in comments)
   - Exclusions: Individuals for whom treatment is not indicated (behavioral disorder in remission)
   - Diagnostic Codes: See the table in Basecamp, which includes ICD9/10 codes for common behavioral health disorders.
   - Measurement Period: 12 months.
Performance Measures - Treatment

1. **TREATMENT: PLWH with BH Disorders Viral Suppression**
   - 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. (should match measure 4)
   - Numerator: Number who have a viral load less than or equal to 200 copies/mL at last test in measurement period.
   - **Exclusions:** Individuals for whom treatment is not indicated (behavioral disorder in remission)
   - Diagnostic Codes: See the table in Basecamp, which includes ICD9/10 codes for common behavioral health disorders.
   - Measurement Period: 12 months.

2. **TREATMENT: PLWH with Viral Suppression**
   - Denominator: HIV patients 18 years and older with a primary care visit in measurement period. (should match measures 1 and 2)
   - Numerator: Number with a viral load less than or equal to 200 copies/mL at last test in measurement period.
   - Measurement Period: 12 months.
Results – Patient Counts

- Eligible for Depression Screening
- Eligible for Addiction Screening
- Those With Positive Screens Eligible for Followup Plan
- Those with Diagnosed BH Disorders Eligible to be Retained in Care
- Those with Diagnosed BH Disorders Eligible for Viral Load Testing
- Eligible for Viral Load Testing
Statewide Outcomes after 12 Months

LS1 at end of Round 3
BHIP Next Steps

- Additional Learning Sessions and Twinning Visits
- Quality Improvement Projects (Referral and Treatment)
  - Referral Mapping and Filling Cracks in Available Services
  - Task Shifting and License Maximization
  - Self-care for Program Staff
- Continued Monthly Webinars
- Bi-monthly Performance Measurement into 2021
- Creation of Integration Implementation Manual for NJ DOH
  - Based on performance of BHIP sites, standards may be set for RE-AIM targets that future Part B funded sites would be expected to achieve
Reflections

- Sites are building systems around how they are measured; with increased emphasis of value-based care, a stronger focus on outcomes from BH could benefit the system.
- Sites are challenged in tracking referrals in their electronic health records; offering an opportunity to leverage CAREWare and/or CHAMP as a tracking tool.
- Services are needed to address Self-Care, Informal Community Care, and additional Primary Care Behavioral Health Services.
- Pieces of a complete system of care exist but are fractured across types of health care institutions and providers, including Community-Based Organizations.
Conclusions

- Integrating behavioral health into HIV primary care using a mix of QI approaches and evidence-informed interventions leads to improved outcomes.
- Changes are sustainable when:
  - Policies and procedures are updated
  - Ongoing training and discussion is provided
- Practice facilitation coaching is necessary to guide the process
  - There is no one-size-fits all or silver bullet
  - Similar tools and processes can be used to distill change ideas/priorities on a participant basis
- Integration requires action/attention across multiple divisions at the Department of Health level