TEAM UP Memo: Role-Focused Behavioral Health Plans

March 2022

I. Context and Opportunity Statement

Electronic medical record (EMR) templates provide a standardized and systematic way of documenting and tracking patient care, while simultaneously offering insight into provider assessment and decision making and allowing for corrective feedback loops and quality control.[1] As outlined by the American Medical Informatics Association, clinical data capture and documentation should be efficient and enhance a care team's overall effectiveness and productivity, while also enabling team collaboration, care process management, and advanced clinical decision support.[2] Structured and consistent documentation can be prioritized as a way to maintain high quality patient care through supporting team communication and coordination.

Evidence suggests that EMR documentation templates may be valuable in improving the completeness and efficiency of documentation.[3] One study focused on EMR implementation within a healthcare system found that documentation templates allowed for the maintenance of productivity and quality improvement throughout the implementation period.[4] However, EMRs that lack standardized templates with structured data fields can make it harder for practices to find, extract, and track behavioral and physical health information, monitory quality, and improve integrated care delivery.[5] Though EMR templates provide process benefits and allow for improved documentation of key measures, some evidence suggests that EMRs only marginally improve clinical outcomes[6] and act as a barrier to patient-centered care[7] and communication between providers and patients.[8] Since the templates are standardized they may limit the patient's involvement in their care and not be compatible with all unique patient situations. Additionally, building EMR templates can be costly and require dedicated health information technology staff that work collaboratively with providers and staff.[5]

Previous studies have explored development of EMR templates in the behavioral health integration (BHI) setting as a way to track behavioral and physical health information related to screenings, referrals, treatment, and follow-up.[5] Although EMRs can help exchange health information, this could be difficult in the BHI setting since primary care and behavioral health differ in their language, classification and codes.[5] TEAM UP aims to expand and further develop BHI templates to advance clinical decision support, team collaboration, and behavioral health care data capture through the development of role-focused behavioral health documentation templates. TEAM UP Behavioral Health (BH) Plans for primary care providers (PCPs), behavioral health clinicians (BHCs), and community health workers/family partners (CHW/FPs) were co-created with participating health centers to standardize and streamline documentation of care delivered in the integrated pediatric primary care setting to support data gathering and evaluation, improve care coordination amongst the integrated team, while also optimizing patient care and minimizing staff burden.

II. Goal of memo

This memo is intended to achieve three goals:

1. Describe the pertinent background and research on BHI documentation templates
2. Provide a summary of learnings from initial development and implementation with TEAM UP health centers

Commented [HC1]: This could be a great intro to a manuscript on the BH Plans

Commented [AM2]: Similar to Megan's comment below, but on a broader scale, I am trying to understand the audience for this memo. As written, it is presented as more of a draft of a manuscript, rather than what we usually try to include in a memo, which would be more around narrating the goal, decision-making process, learnings, iterations, and impact of the work done within TEAM UP. I realize that you are undertaking writing this once all the work has already been completed, rather than as a living document that is actually part of the process itself. However, I do think it could be restructured to reflect more of the actual process first, and then add in the manuscript-level data after.

One specific example – all of the content you have above where I started to highlight reads as a manuscript. But we did not undertake this work based on that introduction or really with any of that introduction as the basis of the work. We undertook the work first to facilitate data extraction, and then learned benefits from that around impact on clinical care that informed our decision to create a BHC version and a CHW version.

I might suggest that you start by describing the genesis of the first plan, key learnings, and then how that informed the genesis of the second two plans. So, re-do the introduction to focus on the opportunity we were trying to address just within TEAM UP, then move on to what you have in section V. There is still room for this introduction, but I think maybe as an addendum that gives broader context and learnings pertinent to EMR templates outside of the TEAM UP context.

3. Describe the core elements and goals of each of the three BH Plans

III. Guiding Principles

We relied on the following guiding principles in developing the BH Plans:

1. Commitment to Co-Creation
    - The BH Plans are an important component of the TEAM UP model, co-developed with continuous input and guidance from both Cohort 1 and 2 health centers. TEAM UP is committed to working with health centers to support implementation of the BH Plans, utilizing TEAM UP evaluation data to monitor implementation progress. TEAM UP is committed to soliciting feedback from health centers on the implementation process, facilitators, barriers, and outcomes. This feedback will be used to expand our experiential knowledge and collectively advance the BH Plans to improve integrated care delivery.

2. Feasible to Implement and Sustain Long-Term
    - As a core component of the TEAM UP model, the BH Plans were developed with feasibility and long-term sustainability in mind. Health centers will determine the specifics of implementation (e.g., timeline, tasks, responsible parties, etc.) based on their local context and environment.

3. Use of Data to Monitor Implementation
    - Data from the BH Plans are reported as part of TEAM UP's monthly evaluation reports to guide implementation and monitor progress. Data that include information stratified by site are shared across the TEAM UP community to provide direct feedback to health centers and encourage health center-specific quality improvement.

4. Dissemination and Field Building
    - Data from the BH Plans are used to describe and characterize integrated care delivery, strengthen evidence for templates, and support advocacy particularly around the CHW/FP role.

IV. Available Evidence

- EMR templates aim to fulfill the following expectations and goals:[1,7]
    - Support structured management of patients
    - Promote a systematic approach to care delivery, while simultaneously allowing for corrective feedback loops and quality control
    - Enable standardized and systematic ways of documenting and tracking patient care
    - Assure high-quality care delivery in line with evidence-based guidelines
    - Produce aggregated data that can be used to assess institution performance

- EMR templates impact patient-physician relationships and interactions:
    - Templates help patients become familiar with the goals and expectations of their provider due to the standardized nature of the template[9]

Commented [BM3]: I think we should be careful with terminology- unblended could mean patient identifiers. If you could look through the document just to check that this is not referred to elsewhere that would be great

- Templates may act as a barrier to patient-centered care[7] since the templates are standardized, potentially limiting the patient's involvement in their care and compatibility with all unique patient situations
- EMR systems in general may inhibit communication between physicians and patients[8]
- Reliance on a template can reduce eye contact between the provider and patient and disrupt dialogue[10]

- EMR documentation templates may be valuable in improving the completeness and efficiency of documentation:[3]
  - One study focused on EMR implementation within a healthcare system found that documentation templates allowed for the maintenance of productivity and quality improvement throughout the implementation period[4]
  - However, EMRs that lack standardized templates with structured data fields can make it harder for practices to find, extract, and track behavioral and physical health information, monitory quality, and improve integrated care delivery[5]

- EMR templates may improve care coordination amongst the team:
  - EMRs facilitate within-office care coordination by providing access to data during patient visits and through electronic messages[11]
  - EMRs enable providers to exchange information with other members of the care team and continuously update patient clinical data[12]

V. Prior TEAM UP Learnings and Experience

Cohort 1 – Creation of Original PCP BH Plan

The Primary Care Provider Behavioral Health Plan, or PCP BH Plan, was the first of three documentation templates to be developed. The first iteration was co-created with Cohort 1 health centers during Phase 1 of TEAM UP. The PCP BH Plan was intended to improve BH data collection, as well as address the barriers and limitations that exist in trying to integrate primary care and behavioral health, such as: documenting complex developmental and BH concerns for patients that present at well-child visits, working in different EMR systems, and accounting for various different routes to integrated care. Therefore, the PCP BH Plan was created as a standardized, extractable EMR template to streamline behavioral health integration to allow PCPs to capture the most useful information including screeners, referrals, and treatments. The PCP BH Plan was also meant to empower PCPs to play an active role in addressing their patients' BH care, the assessment process, and decision to refer to members of the integrated team.

The development process with Cohort 1 health centers started in 2017. The TEAM UP community decided that the intent of the PCP BH Plan was to capture what was happening during well-child visits in which the PCP had intent to refer. Initial questions that were raised included whether or not the template needed to be uniform across all health centers, or if it could be individualized based on practice transformation needs and used internally at an individual patient-care level. While it was determined the EMR template would not vary by health center, health centers were free to change and standardize their report system as needed. During the November 2017 Steering Committee Meeting,

Commented [AM4]: Actually, not sure we had these motivations up front. I'm assuming you've gone back to the SC meetings where the PCP BH plan was created, though, so maybe I'm just not remembering the details?

I would say main genesis of the PCP BH Plan was 1) data abstraction, and 2) documenting the PCP's decision-making around BH issues and plan of care in an extractable way.

Commented [AM5]: Was all well child visits, not just when the PCP had intent to refer.

Commented [BM6]: Is this true?

Commented [AM7R6]: Agree with Megan's question, and not sure exactly what report system CHCs were free to change.

plans were discussed to disseminate the BH Plan and train all TEAM UP providers on the initial version of the plan. The final version of the original Plan was disseminated in October 2019.

Cohort 2 – Creation of Updated PCP BH Plan, and New BHC and CHW/FP BH Plans

With Cohort 2, another priority of Implementation Years 1 and 2 was further expanding the EMR templates to include more members of the integrated care team. In partnership with Cohort 2 health centers, TEAM UP developed the Community Health Worker/Family Partner (CHW/FP) and Behavioral Health Clinician (BHC) BH Plans. The PCP BH Plan served as a model for the two new Plans, and the structure, complexity, and goals remained similar. The CHW/FP Plan was initially drafted in May 2020, whereas the BHC BH Plan was initially drafted in March 2020. During the November 2020 Steering Committee Meeting, a pilot was proposed for CHWs/FPs and BHCs to complete a paper-based version of the CHW/FP and BHC BH Plans, respectively. By the end of January 2021, the pilots were complete and feedback was incorporated. After several revisions, the CHW/FP and BHC BH Plans were later disseminated in February 2021 for health centers to integrate into their respective EMR systems.

Moreover, during the Implementation Phase with Cohort 2, TEAM UP continued to make significant changes to the PCP BH Plan in collaboration with Cohort 2 health centers. In the current version disseminated in April 2021, Question 9 (type of off-site BH services) was updated to include Developmental Behavioral Pediatrics. The key issues list in Question 10 was updated to include parent/caregiver mental health concern, early childhood concern (BRANCH), safety/SI concern, and school-related concern. Additionally, some language in Question 10 was reframed to focus on symptoms rather than disorders or diagnoses (e.g., changed "eating disorders" to "eating issues" and changed "other mental illness" to "other mental health concern").

In December 2021, TEAM UP presented a poster on the initial findings of the PCP BH Plan titled, "Co-creation of electronic medical record templates to simultaneously support patient care and implementation." Initial findings based on Cohort 2 data suggest that co-created templates for clinical data capture can optimize patient care and improve implementation with minimal impact on PCP burden. Co-creation of metrics resulted in a feasible and sustainable data capture system perceived as acceptable to PCPs. Of note, data revealed frequent disconnect between screening results and PCPs' assessment of BH need – a finding that replicates published studies of BH screening implementation and augments evidence on clinical decision-making.[13]

VI. Development of TEAM UP Behavioral Health (BH) Plans

Primary Care Provider (PCP) BH Plan

The PCP BH Plan is a documentation template core to the TEAM UP pediatric behavioral health integration model, and intended to be completed by a PCP attending to a patient during a medical visit. The PCP BH Plan is completed at every pediatric medical visit, including well child visits, sick visits, and follow-up visits – regardless of whether or not there were BH or developmental issues identified and/or addressed at the visit, and regardless of the reason for the visit. The BMC team worked with each health center to implement the Plan within their individual EMR system, which resulted in differences in the look and functionality of the Plan. Materials were developed to train PCPs on the Plan, with Clinical Champions and Project Managers helping to lead training and quality improvement efforts.

There are three core elements within the PCP BH Plan:

1. Whether a behavioral health or developmental concern was identified during the visit

Commented [AM8]: Cohort 1 work was actually more of a two-step process. We first decided on the original BH Plan, programmed EMRs, and got initial data. That took at least 6 months or a year. Then, once the data started coming in, it became clear that there was no consistency in how it was being completed. We had a second round of SC meetings to agree to consistent definitions of how it would be filled out. There is an algorithm that is probably linked into the SC folder from that discussion that gives the final version in graphic form.

Also, later in Cohort 1, we realized that there was variability in how consistently the PCP BH Plan was being completed at every visit, and we did some PT work to ensure that it got completed at at least 85% of well child visits, if I remember correctly.

There are some implementation lessons from the Cohort 1 experience that could be described here –

1)Need for consistent agreement on how to complete the plan,
2)Need to revisit after data starts to come in
3)Benefit of a hard of soft stop or validation process to support consistent completion of the plan

Commented [AM9]: Small thing, but would recommend switching the order since we developed the BHC one first, then decided to add on the CHW one.

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Commented [BM10]: One thing I am wondering is the intended audience. I think depending on the answer some details may be more or less relevant

Commented [AM11]: This is a significant piece of learning and I think probably warrants more description in the memo. I think you could add a section at the end that summarizes implementation learnings to data, where you could go into this in more detail, as well as the learnings I noted above.

2. The plans for addressing an identified behavioral health or developmental concern
3. The key issues underlying the identified behavioral health or developmental concern

Data from the PCP BH Plans are included in monthly data sets sent to the BMC team from both the Cohort 1 and Cohort 2 health centers, and are used as part of TEAM UP's evaluation and continuous quality improvement efforts.

Community Health Worker/Family Partner (CHW/FP) BH Plan

The CHW/FP BH Plan is intended to document the key issues addressed, interventions delivered, and plan of care for all services delivered by CHWs/FPs in the integrated environment. All CHW/FPs seeing patients within the Pediatrics (and sometimes Family Medicine) Department complete the CHW/FP BH Plan as part of their standard documentation. The CHW/FP BH Plan is completed for all encounters (in person, phone, or virtual) between a CHW/FP and a patient, family member, school, or other service provider, regardless of the need identified or addressed, or the reason for the encounter. The CHW/FP BH Plan is not filled out when the CHW/FP does not have direct contact with an individual (i.e., leaving a voicemail or sending a text).

Commented [AM12]: Again, would order with PCP first, then BHC, then CHW.

There are six core elements within the CHW/FP BH Plan:

1. The reason for the encounter
2. The type of contact, i.e., in-person, virtual or phone, other
3. The goals identified by the patient/family during the encounter
4. The actual interventions utilized or delivered during the encounter
5. The total time spent on the encounter
6. The treatment plan following completion of the encounter, i.e., next steps identified to support patient/family

Data from the CHW/FP BH Plan are included in monthly data sets sent to the BMC team from the Cohort 2 health centers, and are in the process of being incorporated into evaluation and quality improvement metrics to better understand care delivered by CHW/FPs and patterns in BH service delivery.

Behavioral Health Clinician (BHC) BH Plan

The BHC BH Plan is intended to document the key issues addressed, interventions delivered, and plan of care for all services delivered by BHCs in the integrated environment. All BHCs seeing patients within the Pediatrics (and sometimes Family Medicine) Department complete the BHC BH Plan as part of their standard documentation. The BHC BH Plan is completed for all encounters (e.g., in person, phone, virtual) between a BHC and a patient, family member, or collateral, regardless of the need identified or addressed, or the reason for the encounter. The BHC BH Plan is not completed when the BHC does not have direct contact with an individual (i.e., leaving a voicemail or sending a text).

There are four core elements within the BHC BH Plan:

1. The key issues addressed during the encounter
2. The interventions or techniques utilized or delivered during the encounter
3. The assessment tools completed during the encounter
4. The treatment plan following completion of the encounter, i.e., next steps identified to support patient/family

Data from the BHC BH Plan are included in monthly data sets sent to the BMC team from the Cohort 2 health centers, and are in the process of being incorporated into evaluation and quality improvement metrics to better understand care delivered by BHCs and patterns in BH service delivery.

VII. Supporting Documents

Primary Care Provider (PCP) BH Plan Documents
Original PCP BH Plan
Updated PCP BH Plan
PCP BH Plan Training Guide
PCP BH Plan One-Pager

Community Health Worker/Family Partner (CHW/FP) BH Plan Documents
CHW BH Plan
CHW BH Plan Training Guide
CHW BH Plan One-Pager

Behavioral Health Clinician (BHC) BH Plan Documents
BHC BH Plan
BHC BH Plan Training Guide
BHC BH Plan One-Pager

Academy Health Poster on PCP BH Plan "Co-creation of electronic medical record templates to simultaneously support patient care and implementation"

VIII. References

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