Integrating Behavioral Health Services with Primary Care
"Bridging the Divide"

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July 25, 2013

“Mental Health and Primary Care are inseparable; any attempts to separate the two leads to inferior care”
(IOM, 1996)
Learning Objectives

- Describe the unique challenges we face in integration of behavioral and physical health care

- Understand the various starting points and models for successful integration of behavioral and physical health and which ones are more easily implemented in a primary care setting

- Be able to utilize examples from the Colorado PCMH Practices and the Iowa Community Mental Health Centers to evaluate what might work in your practice

- Identify how to get started to increase access to behavioral health care services for your patients
1 in 4 chance that depression will effect you at some stage in your life. Major Depressive Disorder: leading cause of disability in 15-44 year olds.

34,000 Americans die by suicide every year

Patients with medical disorders: 29% have a mental health comorbidity

Cyber Bullying on the Rise

Serious Mental Illness (SMI) Patients: Die 25 years earlier primarily from their physical health comorbidity
Cultural Differences: Barriers or Opportunities?

**PRIMARY CARE**
- Patients
- Practice
- Take all comers
- Continuity is Goal
- Action Oriented
- Flexible Boundaries
- Flexible Schedules
- Tx Time Independent
- Treatment External

**BEHAVIORAL HEALTH**
- Clients
- Clinic
- Tough Love
- Recovery is Goal
- Process Oriented
- Firm Boundaries
- Fixed Schedules
- Tx Time Dependent
- Relationship
Unique Strengths & Challenges for PCPs

STRENGTHS
- Patient Centered
- Team Based Care
- Illness and Prevention
- Population Management
- Held in High Regard by Patient
- No Stigma
- Patient Subjected to Illness-Fix it Mentality

CHALLENGES
- Engaging Community Resources
- Insufficient training on mental health
- Difficult to devote sufficient time/patient
- Payment Insufficient
- Practice staff fear/discomfort with mental illness
Unique Strengths & Challenges for Behavioral Health Providers

**STRENGTHS**
- Integrated with Community Providers
- Collaborators
- Process Oriented
- Empower Individual Clients
- Strong relationship with client
- Fixed schedule/predictable payment

**CHALLENGES**
- Sick care not prevention
- Therapy primarily 1:1
- Little/no training on physical health
- Little to no focus on population management
- No payment for physical health intervention
- Little/no access to physical health information
What Does Integrated Care Look Like?

AT THE PATIENT LEVEL

• Bringing mind and body together in approaching individual care
• Having a larger definition of a care team to include the extended team/medical neighborhood and providing integrated whole person care
• Increasing information sharing and co-management of care
• Patients report better outcomes and result in improved health

AT THE SYSTEM LEVEL

• A variety of models being tried today from minimal collaboration to full integration across the System of Care (Neighborhood/Community)
• All models focus to varying degrees on:
  1. Leadership and Cultural Integration
  2. Work flow integration: team based care & care coordination
  3. Information Technology & Population Information Integration
  4. Value Identification & Financial Sustainability
  5. Community Resource Integration
**Scale of Integration**

<table>
<thead>
<tr>
<th>Coordination</th>
<th>Co-location</th>
<th>Integration</th>
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| Characteristics:  
  • Referrals  
  • Separate Treatment Plans  
  • Some information sharing  
  • Separate responsibilities for care | Characteristics:  
  • Greater Communication  
  • Warm hand-offs  
  • Informed Plans/sharing treatment information  
  • Some targeted collaboration for specific patients  
  • Separate treatment plans but same location | Characteristics:  
  • Consistent screening & use of treatment guidelines  
  • Collaboration for all or most patients  
  • Information sharing and co-management of treatment  
  • One treatment plan  
  • Team Approach |
Coordination

- Leadership: Engaged full team in first step
- Focused work flow on depression screening
- Provided basic training on screening & motivational interviewing
- Utilized PHQ2/PHQ9 screening; posted laminated questionnaire in every exam room
- Financially sustainable
- Identified referral partners
Leadership: Engaged full team in first step

Focused initial work flow on depression screening & onsite therapist availability

Extended services to include a health coach

Marginally Financially sustainable still refer out for high risk patients

Identified referral partners
<table>
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<tr>
<th>Coordination=&gt;</th>
<th>Co-location=&gt;</th>
<th>Integration</th>
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<tbody>
<tr>
<td>- Leadership: Engaged full team in first step, rented space to therapist</td>
<td>- Leadership: Enrolled in pay for performance programs</td>
<td>- Leadership: Enrolled in a shared savings program</td>
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<tr>
<td>- Focused work flow on depression screening, referral and warm hand-offs</td>
<td>- Billed for services where possible; covered services where needed as mental health issues recognized as a barrier to physical health improvement</td>
<td>- Hired therapist to work full time on site</td>
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<td>- Provided staff basic training on screening, utilizing PHQ2/PHQ9</td>
<td>- Financially sustainable (rental fees)</td>
<td>- Broadened services provided</td>
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<tr>
<td>- Financially sustainable (rental fees)</td>
<td>- Financially sustainable (billing &amp; pay for performance incentives)</td>
<td>- Financially sustainable (billing, pay for performance &amp; shared savings incentives)</td>
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Lessons Learned from Primary Care … on Integrating Behavioral Health…

- Leadership is essential:
  - Champion integration & lead by example
  - Form collaborative relationships: providers & patient
  - Catalyze efforts to implement at the beginning
  - Cultivate team’s understanding of value, provide education & training, clarify roles and accountability

- Determine structural capacity (EHR, resources, operations & process re-engineering)
  - Sustainable financial model & proper coding
  - Information availability and exchange
  - Availability & Collaboration with Community Services

- Communication…Communication…Communication
State of Iowa & Magellan
Integrated Health Home (IHH)

- Affordable Care Act
  Supports development of health homes
  Allows for expansion of Medicaid services
  90 percent FMAP for health home-related services for first 8 quarters
  Alternative payment models /Incentive grants
- Grant to create specialized health home for adults with Serious Mental Illness (SMI)
- IHH pilot began 2011...coaching June 2013...CMS program July 1, 2013...Goals:
  - Improve Health Outcomes of Individuals with Serious and Persistent Mental Illness
  - Improve Appropriate Utilization/Site of Care
  - Increase Use of Preventive Services

HealthTeamWorks Support Includes:
- Assessment of Centers on Leadership, Adaptive Reserve & IHH
- On-site Coaching on Leadership, Cultural and System Transformation, and Quality Improvement
- Learning Collaboratives
- Data Driven Improvement

HealthTeamWorks
Coordination of Care

- Leadership: Engaged Health Home team to facilitate coordination
- Focused work flow on manually sharing information between therapist & FQHC PCP
- Little leadership or cultural integration across FQHC & CMHC yet
- Financial sustainability to be proven
- Identified other partners (hospitals-transition of care)

- Leadership: Engaged Health Home team to facilitate coordination
- Struggling to keep NP from FQHC employed
- Team wants time for greater collaboration
- Little leadership or cultural integration across FQHC & CMHC yet
- Financial sustainability to be proven
Co-location

- Leadership: Engaged full team in first step
- Engaged on-site FQHC NP (full time) and set aside time for team huddles-therapist, psychiatrist, NP
- Extended services include integration with case managers, peer support, recovery specialists, counselors, wellness groups
- Financially sustainable through IHH program and increased volume of attributed patients
- Will need to engage community PCPs

- Leadership: Engaged IHH team in first step
- Multiple on-campus, PCP working to engage
- Extended services include integration with case managers, peer support, recovery specialists, counselors, wellness groups
- Financially sustainable through IHH program and increased volume of attributed patients
- Will need to engage community PCPs as well
- Have integrated clinical and behavioral health information
Transformation to IHH

• Revolves around the client as patient and patient as client…it is “person centered”
• Focuses on creating “healthcare partnerships”
• Requires a “systems” perspective
• Utilizes tools, methodology of improvement & coaching to assist in the change process
• Calls for leadership, communication & teamwork, creating a common language
• Requires changes in roles and responsibilities at all levels
# Selected Areas of Focus

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<thead>
<tr>
<th>Behavioral and Physical Health Provider Integration:</th>
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<tbody>
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<td>• Train and foster an understanding of levels of integration</td>
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<td>• Develop common language</td>
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<tr>
<th>Care Coordination</th>
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<tr>
<td>• Care Coordinator &amp; Care Manager</td>
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<td>• Community collaborative agreements: communication, care guidelines &amp; coordination</td>
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<th>Information System Support, Data &amp; Metrics</th>
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<td>• Develop process to engage and activate patients</td>
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<td>• Identify processes for data capture &amp; reporting</td>
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<th>Integrated Team-Based Care</th>
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<tr>
<td>• Role clarification</td>
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<td>• IHH Education and training-all providers</td>
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<td>• Implement care team meetings</td>
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<th>Leadership, Culture &amp; Communication</th>
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<tr>
<td>• Champion Transformation</td>
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<td>• Planning:Q1/2013 metrics, client enrollment, engaging community practices</td>
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<th>Patient-Centered Care</th>
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<td>• Develop and implement shared care plans</td>
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<td>• Link patients with community resources</td>
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<th>Quality &amp; Safety</th>
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<tr>
<td>• Educate QI team on improvement model</td>
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<td>• Create QI plan, reporting process &amp; workflows to improve patient quality, safety and experience</td>
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<tr>
<td>• Identify &amp; Plan for High Risk Patients</td>
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Determine organizational readiness to lead the change, champion the change and integrate the new relationships, processes & services.

Build a plan around patient needs, level of care service integration, creating an extended care team, partner core competencies, Quality Improvement, financial sustainability.

1. Develop your vision for integrated care-ownership!
2. Assess patients’ behavioral health needs
3. Identify your potential community partners & create linkages
4. Allocate Resources & Empower QI team
5. Communications plan

1. Start small create success
2. Develop processes for care coordination, information sharing, patient engagement
3. Identify high risk patients, create prevention and intervention plans

Create and Monitor measures of success: clinical measures for physical and behavioral health, financial, operational, patient experience; Continuously Improve and Expect Bumps in the Road

1. Address cultural differences
2. Increase Patient/Client engagement in care management
3. Monitor Cost of Care & financial sustainability

...And Creating Your Transformation Plan
Questions / Discussion

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