The Integration of Behavioral Health and Primary Care: A Leadership Perspective

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Our Mission...
To improve the quality of life for our patients through the integration of primary care, behavioral health and substance abuse treatment and prevention programs.

Together...Enhancing Life
Strategic Emphases

- Integration of Behavioral and Primary Care
- Outreach to Underserved Populations
  - Training Health Care Providers
  - School-Based Health Services
  - Telehealth Applications
- Value-Based Contracting
Integration is a means to an end...

- Improve the health of a population
- Reduce healthcare disparities
- Improve access
- Focus on wellness and prevention
- Patient centered care
- Evidence based clinical and program decision making
"It’s got to come out, of course, but that doesn’t address the deeper problem."

Blending Behavioral Health into Primary Care

Cherokee Health Systems’ Clinical Model
Why Primary Care?

• Main point of access to care for all healthcare, including behavioral health conditions
• Principal setting for treatment of behavioral health conditions
• Central stage for the complex and bidirectional interplay between medical and mental health disorders, health behaviors, and social determinants of health

Re-engineering Primary Care: An Integrated Team Model

• Functions of care shared across team
• Integrated workflow
• Access to BH expertise “where BH problems show up”
• Improved communication
• Improved care coordination
• Expanded health management support
• Supported patient engagement
What is Integrated Care?

“The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress related physical symptoms, and ineffective patterns of health care utilization.”


<table>
<thead>
<tr>
<th>Minimal Collaboration</th>
<th>Basic Collaboration from a distance</th>
<th>Basic Collaboration On-site</th>
<th>Close Collaboration in a partly integrated system</th>
<th>Close collaboration in a fully integrated system</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving collaboration between separate providers</td>
<td>Medical-provided behavioral healthcare</td>
<td>Co-Location</td>
<td>Disease Management</td>
<td>Reverse Co-location</td>
</tr>
<tr>
<td>*Separate systems and facilities *Infrequent communication *Little appreciation of each other’s culture; little influence sharing</td>
<td>*Separate systems but same facilities *Regular communication *Some appreciation of each other’s roles and general sense of larger picture</td>
<td>*Some shared systems *Same facilities *Face-to-face consultation *Coordinated treatment plans *Basic appreciation of each other’s role and culture; Share biopsychosocial model *Collaborative routines are difficult due to time and operational barriers *Shared influence and some tensions</td>
<td>* Shared systems and facilities in seamless biopsychosocial web *Patients and providers have same expectation of a team *In-depth appreciation of roles and culture *Collaborative routines are regular and smooth *Conscious influence sharing based on situation and expertise</td>
<td></td>
</tr>
</tbody>
</table>

Traditional referral between specialties model 2010 AHRQ Report  Co-located model Organization integration or primary care mental health models
Structure of Fully Integrated Primary Care

• Behaviorist on Primary Care (PC) team
• Consulting Psychiatrist on PC Team
• Shared patient panel and population health goals
• Shared support staff, physical space, and clinical flow
• BH Access and collaboration at point of PC
• PC Team based co-management and care coordination
• Shared clinical documentation, communication, and treatment planning

Role of Behavioral Health Consultant

• Management of psychosocial aspects of chronic and acute diseases
• Application of behavioral principles to address lifestyle and health risk issues
• Consultation and co-management in the treatment of mental disorders and psychosocial issues
Staffing: Integrated Clinical Team

- 4 Primary Care Providers (or 3 Peds): 1 BHC
- Integrated Psychiatry (3-5 hours/week)
- Specialty Mental Health
- Direct Medical Support (1.75 per FT PCP)
- Direct Admin Support (1.25 X + .75Y = # staff ; X = PCP FTEs , Y=BH FTEs)
- Clinical Pharmacists, Health Coaches, Care Coordinators, Care Managers, Nutritionists, Specialists – Cardiology, Nephrology, OB-GYN

Integrated Care at Work

- Behavioral health care is significant part of medical practice (e.g. Post-MI patient may be evaluated for depression and social isolation)
- Behavioral health care is coordinated (e.g. panic management skills are reinforced in medical visits)
- Behavioral health care is the responsibility of the primary care team (e.g. monitoring of depression)
Behavioral Health and Medical Provider Collaboration

• “Curbside” consultation
• Shared written documentation
• Shared treatment planning and monitoring
• Reinforcement of treatment plan goals and strategies

Levels of integrated care

• Level 1 – Consultation and brief targeted interventions in medical setting
• Level 2 – Time limited focused interventions in medical setting
• Level 3 – Referral for longer term therapeutic interventions
Clinical Integration Strategies

• Accurate screening / assessment
• Appropriate prescribing of medications
• Clear clinical practice protocols
• Consistent use of behavioral interventions
• Consistent use of relapse prevention & maintenance treatments
• Optimal use of education based interventions
• Availability of on-site behavioral health support

Clinical System Strategies for Integration

• Screening and Identification in Primary Care (e.g. Well Child Checks, Red Flag Questions)
• Systematic assessment, intervention, and follow-up management guidelines
• Evidence based management protocols for target groups (e.g. ADHD, Depression, Anxiety, CHD, Diabetes, etc.)
# TELEHEALTH: INTEGRATED CARE IN ACTION

## Telehealth Services at Cherokee Health Systems
FY 2013-2014

<table>
<thead>
<tr>
<th>Telehealth Visits</th>
<th>Telehealth Patients</th>
<th>Providers Delivering Telehealth Services</th>
<th>Locations with Telehealth Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>18,270 (5.7% of total visits)</td>
<td>6,469 (10.6% of total patients)</td>
<td>43</td>
<td>20</td>
</tr>
</tbody>
</table>
Implementation: Staffing Needs

- IT Support
- Behavioral Health Consultant
- Primary Care Provider(s)
- Nursing & Front Office Staff – one on-site staff person specifically designated as BHC’s “point person”
Financing the Behaviorally Enhanced Healthcare Home...

It’s harder than it looks!

Payment Policy Disincentives for the Integration Paradigm

- Mental health carve-outs
- Excessive documentation requirements
  - Same day billing prohibition
  - Encounter-based reimbursement
- Antiquated coding requirements
Payment Mechanisms

• Fee For Service (with or without quality incentives)
• Case Rate
• Capitation
• Blended Capitation
• Incentive Pools / Shared Savings
• Percent-of-Premium
• Something Else?

Financing Sustainable Integration – Key Concepts

• “Grants are fool’s gold” CHS CEO
• Cover the cost of direct care plus “behind the scenes” activities
• Deliver value by improving outcomes and reducing overall cost
  • Know your impact, i.e. cost offset
  • You get what you negotiate, not what you deserve
IMPLEMENTATION

Building an Interprofessional Team

- Professional Culture
- Leadership
- Organizational Structure
- Multidisciplinary Leadership
- Integrated clinical team
- Communication
- Staffing
- Processes
Challenges

- Competing Priorities
- Logistical Barriers
- Financing (i.e. billing, coding, payment, credentialling)
- Workforce Development
- Paradigm shift
- Professional Culture
- Organizational Culture

Why Some Integration Initiatives Fail

- Under appreciate the practice transformation required
- Behaviorists are unequipped for integrated practice
- Contracts do not support the care model
- Not in sync with Triple Aim goals
Getting Started

• Identify Patient, Provider, Clinic Needs
• Develop Knowledge and Skill Set
• Assess Readiness to Change
• Understand the System (clinical, operational, financial)
• Shadow Primary Care Providers
• Identify Outcome Goals (# of visits, penetration rates)

Getting Started

• Be realistic about time required
• Clarify details (e.g. charting, billing, referrals)
• Involve ALL staff in process
• Scheduling
• Space: “the final frontier”
• Mimic the pace and mission of primary care
Getting Started

- Behavioral provider must be on-site, highly visible and accessible in the medicine practice area
- Behavioral provider must be able to address full range of needs-horizontal and vertical strategies
- Behavioral and Medical providers must be committed to the philosophy and principles of integrated care

INTEGRATED CARE: ARE YOU READY?
Some Planning Questions

• What will be our model of care?
• What are the functions?
• Who will be responsible for each function?
• How and when will we train our staff?
• How will we track outcomes?
• How will team members communicate?

Planning Questions

• What is our implementation strategy?
• Who will lead and coordinate implementation?
• What changes in structure are needed?
• What barriers and challenges do we anticipate?
• How will we measure success?
Questions?