A Review of Successful but Stressful Integration of Behavioral and Primary Care

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INSTITUTE FOR BEHAVIORAL HEALTHCARE IMPROVEMENT

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- 501C3 Organization
- Dedicated to helping improve the outcome of behavioral health care
- Now nearly ten years old
- Eager to hear your ideas on ways to achieve the goal
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AspenPointe/Peak Vista Story

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The First Integration Project (2001)

- Vision: Basic Collaboration from a Distance
- Staffing: Mental Health Therapist only
- Location: Peak Vista (FQHC) Women's Health Center
- Buy-In: Initially present for staff and leadership, but waned over time.
- Business Model: Diversified Funding
  - Medicaid funding for some
  - No funding for non-Medicaid (generally un/underinsured)
- Project fell apart

The Consumer and Staff Perspective/Experience

Function	Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration On-Site	Close Collaboration/ Partly Integrated	Fully Integrated/Merged
Access	Two front doors; consumers go to separate sites and organizations for services	Two front doors; cross system conversations on individual cases with signed releases of information	Separate reception, but accessible at same site; easier collaboration at time of service	Same reception; some joint service provided with two providers with some overlap	One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model
Services	Separate and distinct services and treatment plans; two physicians prescribing	Separate and distinct services with occasional sharing of treatment plans for Q4 consumers	Two physicians prescribing with consultation; two treatment plans but routine sharing on individual plans, probably in all quadrants;	Q1 and Q3 one physician prescribing, with consultation; Q2 & 4 two physicians prescribing some treatment plan integration, but not consistently with all consumers	One treatment plan with all consumers, one site for all services; ongoing consultation and involvement in services; one physician prescribing for Q1, 2, 3, and some 4; two physicians for some Q4: one set of lab work
Funding	Separate systems and funding sources, no sharing of resources	Separate funding systems; both may contribute to one project	Separate funding, but sharing of some on-site expenses	Separate funding with shared on-site expenses, shared staffing costs and infrastructure	Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility
Governance	Separate systems with little of no collaboration; consumer is left to navigate the chasm	Two governing Boards; line staff work together on individual cases	Two governing Boards with Executive Director collaboration on services for groups of consumers, probably Q4	Two governing Boards that meet together periodically to discuss mutual issues	One Board with equal representation from each partner
EBP	Individual EBP's implemented in each system;	Two providers, some sharing of information but responsibility for care cited in one clinic or the other	Some sharing of EBP's around high utilizers (Q4) ; some sharing of knowledge across disciplines	Sharing of EBP's across systems; joint monitoring of health conditions for more quadrants	EBP's like PHQ9; IDDT, diabetes management; cardiac care provider across populations in all quadrants
Data	Separate systems, often paper based, little if any sharing of data	Separate data sets, some discussion with each other of what data shares	Separate data sets; some collaboration on individual cases	Separate data sets, some collaboration around some individual cases; maybe some aggregate data sharing on population groups	Fully integrated, (electronic) health record with information available to all practitioners on need to know basis; data collection from one source

AspenPointe/Peak Vista Story

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The Second Integration Project (2006)

- Drivers that brought us together again:
  - CEO's had many concerns regarding future of mental health and physical health
- Vision: Combination of a Close Collaboration and Partially Integrated System & Fully Integrated Model
  - Common scheduling
  - Treatment team meetings
  - Separate funding, shared on-site expenses
  - 2 governing boards
  - Sharing of EBP's across systems
  - Separate data sets
  - Collaboration around individual cases

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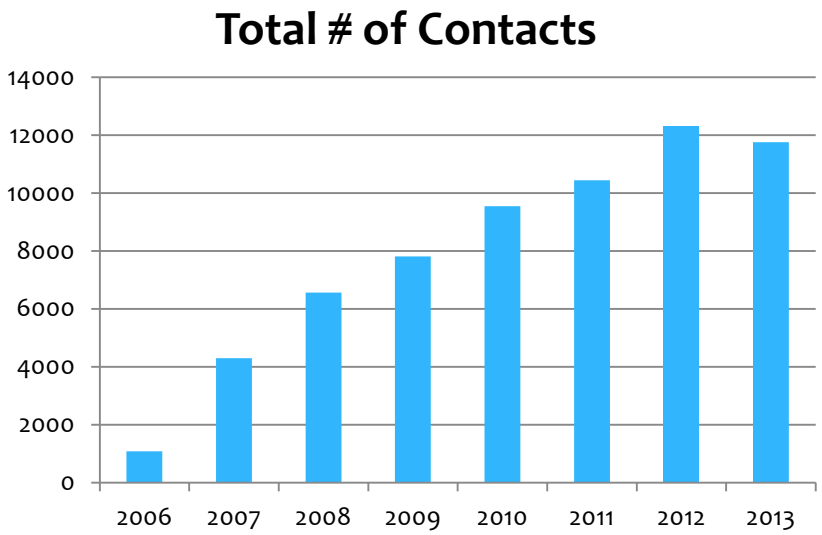
AspenPointe/Peak Vista Story

The Second Integration Project (2006)

- Started with a Behavioral Health Clinician (BHC) and then added psychiatrist time
- Location: Peak Vista Family Health Center
- Buy-In : Clinical and administration, BUT emphasized increased commitment to success by leadership
  - Regular corporate and management meetings
  - Clear the path attitude
  - **This project will not fail!**

The Current Model

- Partially integrated / fully integrated
- Staffing: 10 licensed BH Consultants from AspenPointe
- Referrals: Directly to the BHC by the primary provider
- 63,840 BH visits since 2006
  - 2006: 3 staff
  - 2007: 4 staff
  - 2008: 6 staff
  - 2009: 6 staff
  - 2010: 7 staff
  - 2011: 9 staff
  - 2012: 9 staff
  - 2013: 10 staff



The Role of the BHC

- BHC's do "Co-visits" (immediate referral from provider) and "Follow-ups" (patient returns for scheduled appointment)
  - 85% of our visits are co-visits
  - 15% of our visits are follow-ups
- BHC's provide short-term interventions in the following areas:
  - Behavioral
  - Psychosocial
  - Mental Health

Behavioral Needs

- Changing problematic lifestyle behaviors
- Coping with new medical diagnoses
- Managing chronic illness
- Health Coaching
- Smoking Cessation
- Medication Adherence

Psychosocial Needs

- Identification of barriers that impact physical health care and overall wellbeing
- Interventions for psychosocial problems
- Referrals to social services agencies

Mental Health Needs

- Diagnosis of Mental Illness
- Short term interventions for MH issues
- Substance Abuse interventions
- Determination when patient needs specialty mental health care or support / coordination when patient is already in specialty care

How do we fund it?

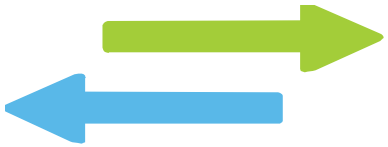
- AspenPointe pays staffing, Peak Vista pays building costs.
- AspenPointe receives Medicaid units for services provided.
  - Peak Vista bills the medical visit against Fee For Service Medicaid
  - AspenPointe adjudicates / bill against BH Capitated Medicaid.
- This system does not bill against indigent, Medicare, or 3rd party for behavioral health services due to payor restrictions.
- In the past, we have had 2 grants that have covered staff positions / psychiatrist time:
  - Homeless Clinic (no longer funded)
  - Intensive Care Clinic (no longer funded)

What's next for our model?

- Increased focus on health and behavior issues, not just mental health issues.
  - Health and behavioral issues may include: disease management, behavioral change, patient activation, etc.
- Improved client transition back to Peak Vista once specialty mental health care is done at AspenPointe (i.e., "back door").

Bi-Directional Integration

Peak Vista Moreno Medical Clinic



Peak Vista Moreno Medical Clinic

- Opened January 2012
- Started with 20 hours per week Physician Assistant and 20 hours per week Medical Assistant
- No grants / other funding

- Issues to be addressed prior to opening:
  - 2 EHRs
  - Building issues – FQHC's have different regulations than CMHC's. We had to do costly construction to update firewalls.

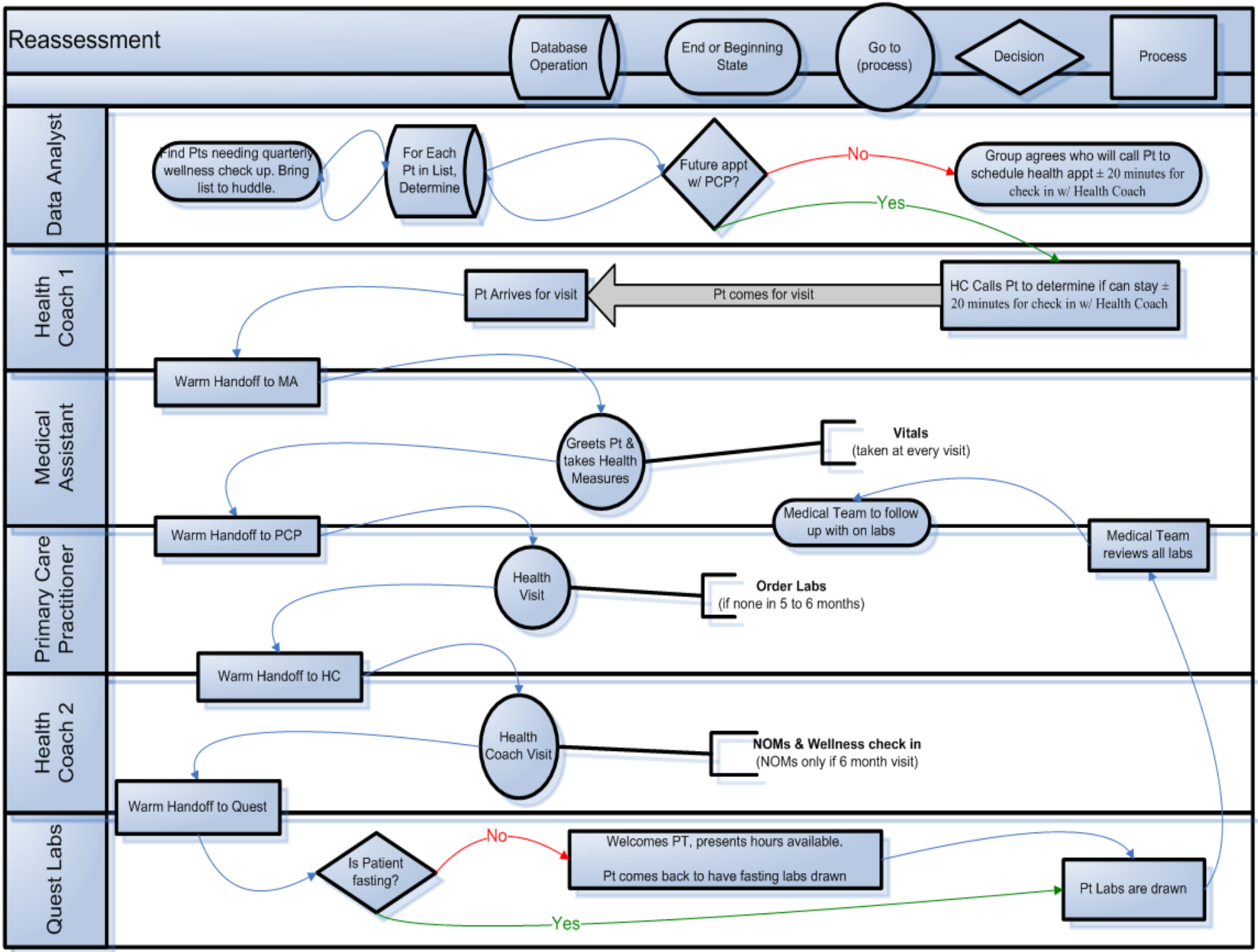
Primary Behavioral Health Care Integration (PBHCI) Grant

- Awarded by SAMHSA in October 2012.
- Assists with funding for non-reimbursable services (care coordination, patient staffing, etc.).
- Assists with payment for indigent patient services, though the number of indigent patients has significantly diminished since January 2014.
  - After Medicaid expansion in Colorado, only 4 of 450+ patients in the clinic are indigent.
- The funding allows for increased focus on wellness within the clinic.

Moreno Clinic – Current

Full time PA (FQHC staff)
Full time MA (FQHC staff)
Full time receptionist (FQHC staff) .
0.2 FTE Health Educator (FQHC staff)
Part time enrollment specialist (FQHC staff)

Full time data analyst (CMHC staff)
3.5 FTE Peer Health Coaches (CMHC staff)
0.5 FTE Telephonic Disease Management RN (CMHC staff)


Reassessment
Database Operation
End or Beginning State
Go to (process)
Decision
Process
Data Analyst
Find Pts needing quarterly wellness check up. Bring list to huddle.
For Each Pt in List, Determine
Future appt w/ PCP?
No
Group agrees who will call Pt to schedule health appt ± 20 minutes for check in w/ Health Coach
Yes
Health Coach 1
Pt Arrives for visit
Pt comes for visit
HC Calls Pt to determine if can stay ± 20 minutes for check in w/ Health Coach
Medical Assistant
Warm Handoff to MA
Greets Pt & takes Health Measures
Vitals
(taken at every visit)
Primary Care Practitioner
Warm Handoff to PCP
Medical Team to follow up with on labs
Medical Team reviews all labs
Health Visit
Order Labs
(if none in 5 to 6 months)
Health Coach 2
Warm Handoff to HC
Health Coach Visit
NOMs & Wellness check in
(NOMs only if 6 month visit)
Quest Labs
Warm Handoff to Quest
Is Patient fasting?
No
Welcomes PT, presents hours available.
Pt comes back to have fasting labs drawn
Yes
Pt Labs are drawn

Lessons Learned from Integration and Bi-Directional Integration Projects

Lessons Learned

Leadership:

- There must be CEO and C-Level buy-in and support for human resources, finances, space, and other clear-the-path issues
  - Senior leadership must understand the role of integrated care and the importance of this approach to our future
  - Full buy-in from CFO that integration is a loss-leader today, but essential for the future of healthcare delivery
- Once the project begins there is a strong gravitational pull to move toward old ways of practice.
  - Corporate leaders and managers need to meet and cross inform beyond just the start up time period.
  - A clear-the-path mentality is essential for success.
  - Integrated care must become the standard for many of our staff.

Lessons Learned

Access – Must involve:

- Quick screening and assessment.
- Brief focused interventions on same day.
- Occasional return appointments for brief focused tx - but cannot impede co-visits.
- Ability to refer to higher levels of care when needed.

Staff match to site and project needs:

- Skill and temperament match.
- Tendency to turn back to prior habits of care.
- BHC must be eager to get out and connect – many times sell services to rest of primary care team until team understands the value the BHC brings to them.

Lessons Learned

Services:

- Service model must be well defined.
- Both sides of the house must have familiarity with the integrated model.

Funding:

- Funding often trips or halts the process – there are not a lot of ways to fund this yet!
- Must be open to looking for alternative sources of funding. federal, state, private grants, billing code shifts with current payers, braided funding, staff sharing.
- Make a decision to invest in your future healthcare opportunities, even if there is not a clear funding stream at the start.

Lessons Learned

Governance:

- Boards must be educated on integrated care models.
- Board knowledge of healthcare reform trends gives buy-in towards integrated care projects and conceptual support.
- Board can influence strong ties to other healthcare partners in the community to explore new integrated care opportunities.

Each organization has its own bureaucracy:

- Each organization needs to understand the organization of the other, including funding streams and restrictions as well as state and federal requirements around their services.
- Each organization needs to determine who liaisons with whom at each organizational level.

Lessons Learned

Culture – Corporate, Medical/Psych:

- Calendar challenges – holidays
- Standard work hours
- Terminology
- Pace of medicine vs mental health practice
- Roles of MD vs NP vs Behavioral Health Consultants
- Having the team believe that this model will have the best outcome on patients/clients

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