Physical Health Integration Within Behavioral Healthcare: Promising Practices

9:45 AM – 10:45 AM

Steering Toward Success: Achieving Value in Whole Person Care
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The Healthier Washington Practice Transformation Support Hub
Steering Toward Success: 
Achieving Value in Whole Person Care

Physical Health Integration 
Within Behavioral Healthcare

AIMS CENTER | UNIVERSITY of WASHINGTON 
Psychiatry & Behavioral Sciences

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Learning Objectives

• Discuss the opportunities of a fully integrated model of care for behavioral health agencies

• Identify the system barriers and challenges to developing fully integrated models of care for behavioral health agencies

• Assess the role of the client/patient in a fully integrated model of care
Background: Life Expectancy in SMI Short and NOT IMPROVING


MH Disorder as Predictor of High Cost

Melek et al Milliman Inc, 2013
Core Principles of Collaborative Care

**Team-Based and Client-Centered**
Primary care and behavioral health providers collaborate effectively, using shared care plans.

**Measurement-Based Treatment to Target**
Measurable treatment goals clearly defined and tracked for every patient. Treatments are actively changed until clinical goals are achieved.

**Population-Based Care**
A defined group of clients is tracked in a registry so that no one “falls through the cracks.”

**Evidence-Based Care**
Providers use treatments that have research evidence for effectiveness.

*Used with permission from the University of Washington AIMS Center*
Approaches for Integrating Primary Care into Behavioral Health Setting: Medicaid Demonstration Toolkit

1. Off-site, enhanced collaboration – This can work!

2. Co-located, enhanced collaboration

3. Co-located, integrated
Integration Strategies – An Example:

- Primary Behavioral Health Care Initiative [PBHCI]
- 200+ CMHC’s in US over 8 years.
  - Co-location of primary care
  - Use of registry
  - Care management
  - Health Behavior change
- It takes more than this!
A Successful Integration Strategy – Missouri Health Homes Overview

- **Strategies: Case management coordination and facilitation of healthcare**
- Primary Care Nurse Care Managers
- Disease management for persons with complex chronic medical conditions, SMI, or both
- Behavioral health management and behavior modification as related to chronic disease management for persons with medical illness
- Preventive healthcare screening and monitoring by mental health providers
- Integrated Primary Care and Behavioral Healthcare
- Health Home management where you are seen most often
Hypertension and Cardiovascular Disease Outcomes

Disease Management
Diabetes Outcomes
(2822 Continuously Enrolled Adults)*

*29% of continuously enrolled adults

Health Home Take-Homes

• Data to identify treatment and prevention opportunities

• Training helps implement new evidence-based interventions

• Personal interaction is the true change agent

• Data analytics identify the dose response curve of personal interaction required

• Training allows use of a lower-cost FTE to produce an effective personal interaction
Challenges and Barriers

• Medicaid Demonstration requirements - metrics
• Existing funding of FFS care vs. addressing social needs
• Cultural change in dedicated MH staff
• Workforce development [e.g., training in Motivational Interviewing]
• Registry development and implementation
• Money in the short term
• Getting ready for 2020
Project 2A Metrics - example

- Antidepressant medication management
- Child and adolescents’ access to primary care practitioners
- Comprehensive diabetes care: Hemoglobin A1c testing
- Comprehensive diabetes care: medical attention for nephropathy
- Medication management for people with asthma (5–64 years)
- Mental health treatment penetration (broad version) outpatient emergency department visits per 1000 member months
- Plan all-cause readmission rate (30 Days)
- Substance use disorder treatment penetration
Lessons Learned: Opportunities for Improvement

- Value-based payment through Medicaid Transformation project creates opportunities for team-based care.
- The high cost of medical care for SMI creates incentives for new funding models.
- Care **CAN** be improved!
- There is some time to practice.
- Let’s hear about projects already under way!
How Much Does this Cost?
One early example, the CRANIUM study

- SMI agency San Francisco
- N=700 pts
- Added .20 FTE peer navigator, 0.1 FTE off-site primary care consultant.
- Registry with panel management meeting quarterly
- About one hour of staff time per patient per year
- Estimated annual cost per patient: $74

(Pych Services, Sept 2017)
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Physical Health Integration Within Behavioral Healthcare

Susan Ehrlich, MD
Psychiatrist, Jefferson Healthcare
Medical Director, Discovery Behavioral Healthcare
Background

• JHC: county public Critical Access Hospital
Rural Health Clinics & four specialties
3 LCSW in primary care
22,000+ enrolled, largely Medicare

• DBH: 25+ yr Community MH Clinic
  4 PsyNPs, 1 RN, 1 chem dep professional
  1500 contacts largely BHO/Medicaid
Description of Integration Strategies

• Stepwise, sustainable and inexorable
• “De-obstruct helpfulness”
• Spectrum of care across the region
• Cooperation not competition
• Address social influences/population health regionally
• Aware of larger clinical and regulatory pictures
Description of Integration Strategies

- Formal Affiliation JHC & DBH
- Dual employment of providers
- Multiple methods of networking with PCPs
- Collaborative DMHP/Crisis Services
- Awareness/prevention/screening - educ. and capacity, e.g. metabolic syndrome and tobacco use
- Access community resources e.g. Smile Mobile
Success Stories

- Collaborative psychiatric care
- Cross-agency ad hoc treatment team meetings
- Joint grant applications
- Epic EHR read-only access
- Health education in day treatment program
- On-site Level I BH services
- On-site UDS
- Two waivered PNP’s
- “User-friendly” registries
Challenges and Barriers

- Valuing/providing/supporting what it takes to think, create, problem-solve and plan
- Miniscule evidence-base
- Data difficulties
- Payment structures vs integration
- 42 CFR vs integrated MAT
- BHO restrictions vs integrated medical
- Keeping clinical decisions clinical
- Rhythm and pace
Lessons Learned: Opportunities for Improvement

- Need face-to-face introduction of integration
- Provide education
- Seek feedback from “front lines”
- Keep clinical and admin changes at same pace
- Understand each others’ biz models
- Mixed benefits of pre-assessment tools
- Value of community momentum
- Seize the moment
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Physical Health Integration Within Behavioral Healthcare

David M. Johnson, Ed.D, LMHC
CEO, NAVOS
Background

- Working toward integration of primary care into our behavioral health campuses since 2000
- PBHI grant from 2010 to 2015
- Continue to receive grant funding as we seek affordability
- 2012: new campus with embedded seven exam room primary healthcare clinic
- 2014 Team WIN (Wellness at Navos)
Description of Integration Strategies

- Co-located, collaborative partnership with Public Health of Seattle and King County providing a health home at the Behavioral Health Center
- Impact model using care coordinator to bridge
- WIN: Wellness Integration at Navos: Nurse care manager and 50 clients convenes primary care, psychiatrist, BH staff, pharmacist
- Affiliation with MultiCare, including the alliance with UW Medicine
- CDC Cancer Education Session through the National Council
Description of Integration Strategies

- Highly intentional structured meetings and protocols
- Tools: EBPs, data-sharing, EDIE, Pre-Manage
- Participation in the Metabolic Syndrome learning cohort
- Partnership with MCO decreasing overall healthcare costs
- Patient education about options (phone line and urgent care) & follow-up calls and visits
- Addressing social determinants of health (e.g. housing)
- Employing peer support specialists
Beverly:
Once hopeless, is now thriving at 62

https://www.youtube.com/watch?v=rITneCLhdv4

- Bipolar and substance use disorders
- Obesity, hypertension, diabetes dangerously unmanaged
- Homeless and thoroughly discouraged, referred by NeighborCare
- 1st an apartment; Team WIN consultations
- Persistent calls & home visits, even the doctor
- Integrated healthcare = “supercharged engagement”
- Sisters Helping Sisters; job in Navos Café
- Public speaking
- “Like a family that refused to give up”
Challenges and Barriers

- Engagement and behavior changes take time, especially for those with BH or SUD issues.
- Medicaid rates of primary care don’t anticipate time needed for appointments with psychotic, anxious, depressed or traumatized patients.
- Relation with the caregiver is the most important factor in success and is difficult in a field with high turn-over due to low salaries.
- Everyone is busy! Difficult to find in the time and discipline necessary for conferencing and managing the registry.
- Don’t allow barriers to result in not doing the right thing (example: finding a way to share the registry).
Lessons Learned: Opportunities for Improvement

• Must expect for co-location and collaboration to take longer and be more complicated than the simple idea suggests
• Must expect to have to subsidize the growing partnership for years as it grows to scale
• Must find ways to bridge the separate EMRs to maximize collaboration
• Eager for the era of Value Based Payment for EBP care and addressing social determinants of health with well-tracked success outcomes and attainment of client-defined goals
Q & A

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More Questions

• How to implement new things when everyone is already busy? [Prioritization]
• How will doing this help me to meet Medicaid metrics?
  – Access to preventative / ambulatory care
  – Potentially-avoidable ED visits
  – All-cause readmission
  – Potentially-avoidable EMS use
• How to train non-medical staff?
• How to interest non-medical staff?
• How to change to team-based workflow?