Key Factors in Successful Integration of Behavioral Health and Primary Care

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AIMS CENTER
UNIVERSITY of WASHINGTON
Integrated Care & Public Health

QUALIS HEALTH

GroupHealth.
MacColl Center for Health Care Innovation

Safety Net
Medical Home Initiative

Project Team

AIMS Center: Jürgen Unutzer, MD, MPH, MA
Anna Ratzliff, MD, PhD

Qualis Health: Jonathan Sugarman, MD, MPH
Kathryn Phillips, MPH
Bre Holt, MPH
Jeff Hummel, MD, MPH

MacColl Center: Ed Wagner, MD, MPH

WHO Definition of Health

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (1948).

The Challenge

Behavioral Health

- Psychiatric disorders cause significant disability, morbidity and mortality
- In the US, one suicide every 14 minutes. In PA, ~4 suicides / day in 2010.
- No family goes untouched.

Health Behaviors

- Behavior determines ~ 50 % of all mortality and morbidity.
- Unhealthy behaviors are major drivers of health care costs.
- 40 – 50 % struggle with treatment adherence.
- Employers struggle with absenteeism and presenteeism.

Where are we now?

Current Usual Care

- 5/10 patient seen in primary care
- Poor access
- Low improvement rates

Integrated Care

- Enhanced access
- Enhanced quality
- Improved patient outcomes

Martin Abdo, Certified Peer Specialist and Peer Bridger,
Harborview Medical Center, Seattle Washington

Consumer Perspective Receiving Medical Care and Behavioral Health Care in the Private Sector

- Challenges
- Natural consequences
- Positive outcomes

Behavioral Health Integration Implementation Guide

www.safetynetmedicalhome.org

PCMH Behavioral Health Integration Pathway

Goals

Common Targets

- Patients in crisis and distress
- Patients with common chronic mental illnesses such as depression and anxiety
- Patients needing support to manage serious, chronic and persistent mental illness
- Other populations

Example Responses

- *We need to be able to see several patients per day to support PCPs. Right now a social worker helps with this challenge.*
- *We have a large older adult population with co-morbid depression and diabetes that we would like to serve better.*

Resources

Common Resource Areas

- Geography
- Physical space
- Support of leadership
- Care team and workforce development
- Shared workflows
- Available technology/HIT
- Financial resources

Example Responses

- *The social workers currently sit in an office that is in the back of the clinic and the PCPs sit in the front of the clinic in their workroom.*
- *We have a small grant to start the transformation but then need to work toward financial sustainability. This will be a change because we have never charged for behavioral health visits.*

Options

Common Pathways

- Access:
  - Facilitated referral
  - Onsite behavioral health provider
- Accountability
  - Measurement based treatment-to-target for individuals
  - Commitment to population outcome improvement

Example Responses

- *We might need to increase BHP FTE. We need to address the rate of patient no-shows to maximize existing psychiatric consultant's time.*
- *Some providers have used a screener since getting the new EHR; but this is not routine in the clinic.*
- *We track patients with diabetes so the providers are familiar with the idea but we have not done this for depression.*

Workflow Development

Key Questions

- Staff and training needs?
- What facilities, HIT, and other resources?
- Communication strategies?
- How will our physical space foster collaboration?
- Introduction materials?
- How will our physical space foster collaboration?
- When and how will we evaluate our progress?

Example Responses

- *We will need funding to support increased staff time*
- *We have the care manger office close to the PCP workspace.*
- *Our care manager will schedule most patients but need some open spaces to allow her to see patients urgently, so we will keep some same day slots in her template for warm handoffs*.

Component Resources

- Executive Summary
- Implementation Guide
- Companion Tools:
  1. Making the Case for Change and Overcoming Resistance
  2. GROW Pathway Planning Worksheet *TOOL*
  3. GROW Pathway Planning Example
  4. Common Barriers and Strategies to Support Effective Health Care Teams for Integrated Behavioral Health
  5. Resources to Support Behavioral Health Integration
- Case Examples
- Updates to:
  1. Patient-Centered Medical Home Assessment (PCMH-A), Version 4.0
  2. NCQA PCMH Recognition Crosswalk

Behavioral Health Integration

Why it matters for practice transformation

Experience and lessons from the Safety Net Medical Home Initiative (2008-2013)

Lesson 1: Behavioral health integration is a critical component of PCMH transformation

1. Whole-person orientation was a founding principle of the PCMH Model of Care
2. Other components of the redesign process are challenging if patients' behavioral health needs are not met

Example: Chronic pain patients

Access & efficiency

Lesson 2: Engaging patients is powerful

- Characteristic of high-performing practices
- Involve patients in their own care and in the redesign process itself
- Patients help identify problems; develop, test, and spread solutions
- Practices ask before, during, and after change: *Is this working for you? How could we better meet your needs?*
- **Example:** Investigation on patient “no-shows”

Engaging patients empowers practices by reducing wasted effort

Our Work Reflects Both Lessons

- GROW Pathway positions integration as a core component of practice transformation
- Patient advisor key contributor
- Why include a patient?
  - ✓ Patients are just as expert as we at identifying waste and improvement opportunities–*they live it*
  - ✓ We talk (and maybe even think) differently when a patient is in the room
  - ✓ "Solutions" generated are practical
  - ✓ When new processes work for patients, they stick

Benefits from Peer Specialist Perspective: Integrating Behavioral Health and Primary Care

- Health and wellness primary goal
- Piggy back appointments increase referral outcomes
- Value of integrating peer specialists with clinical team

O.P.A.: Organize Random Thoughts. Prioritize by number. Act

3 in 1 Cognitive Tool: Use for Stress Management, Daily Structure, and/or Goal Setting

Instructions:

1) **Give it a title**-Identify the feeling (stressor), name the day (daily structure), or goal you are trying to manage.
2) **Organize:** List random thoughts/ideas from top to bottom.
3) **Prioritize the random thoughts/ideas by using numbers**-most important idea/task assigned number one, second most important idea/task assigned number 2, etc...**Key:** take your time and be honest with yourself. Decimals make your action list flexible, if future priorities come up. Use dates next to numbers, for achieving action steps with goals.
4) **Act!** Just follow the numbers in numerical order. Focus on one number at a time. Cross out the number once completed.

Title:_____

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Patients as Partners in Redesign

- Creative, useful ideas and tools, even for the most challenging topics and activities
- Behavioral Health Integration Implementation Guide reflects Marty's lived experience (and that of many others):

✓ Patient populations have different needs – a "one size" model won't work for all

✓ Patients face barriers to engaging in care

✓ Making it even more difficult to navigate the system

✓ Patients value providers' collaborating together

✓ Whole-body care; focus on wellness and recovery

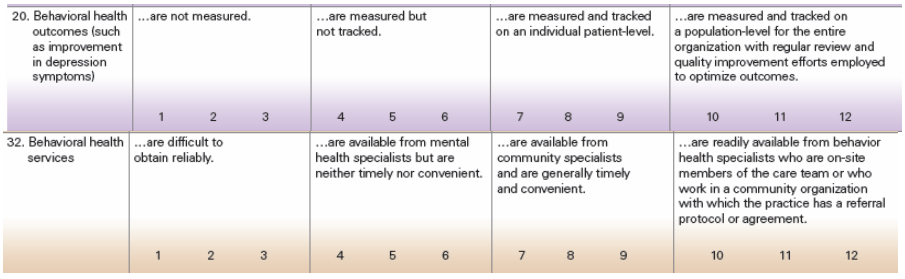
Where do you begin?

Understand Your Organization's Current Degree of Integration: Level A PCMH-A Items

For more information, see the Patient-Centered Medical Home Assessment (PCMH-A).

20. Behavioral health outcomes (such as improvement in depression symptoms)…are measured and tracked on a population-level for the entire organization with regular review and quality improvement efforts employed to optimize outcomes.

31. Behavioral health services…are readily available from behavioral health specialists who are on-site members of the care team or who work in a community organization with which the practice has a referral protocol or agreement.



20. Behavioral health outcomes (such as improvement in depression symptoms)	…are not measured. 1 2 3	…are measured but not tracked. 4 5 6	…are measured and tracked on an individual patient-level. 7 8 9	…are measured and tracked on a population-level for the entire organization with regular review and quality improvement efforts employed to optimize outcomes. 10 11 12
32. Behavioral health services	…are difficult to obtain reliably. 1 2 3	…are available from mental health specialists but are neither timely nor convenient. 4 5 6	…are available from community specialists and are generally timely and convenient. 7 8 9	…are readily available from behavior health specialists who are on-site members of the care team or who work in a community organization with which the practice has a referral protocol or agreement. 10 11 12

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Questions or Ideas?

Thank You