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How to Integrate Primary Care into a Behavioral Health Setting: Lessons Learned from the SAMHSA Primary and Behavioral Health Care Integration Program (PBHCI)

September 26, 2014

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Agenda

- **Welcome & Introductions**
- **Background on Models, Partnerships**
- **Overview of Clinical, Operations, Financing and Workforce**
- **Overview of Wellness and Data Considerations**
- **Lesson Learned**
- **Group Discussion/Questions**
- **Wrap Up**



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Today's Speakers

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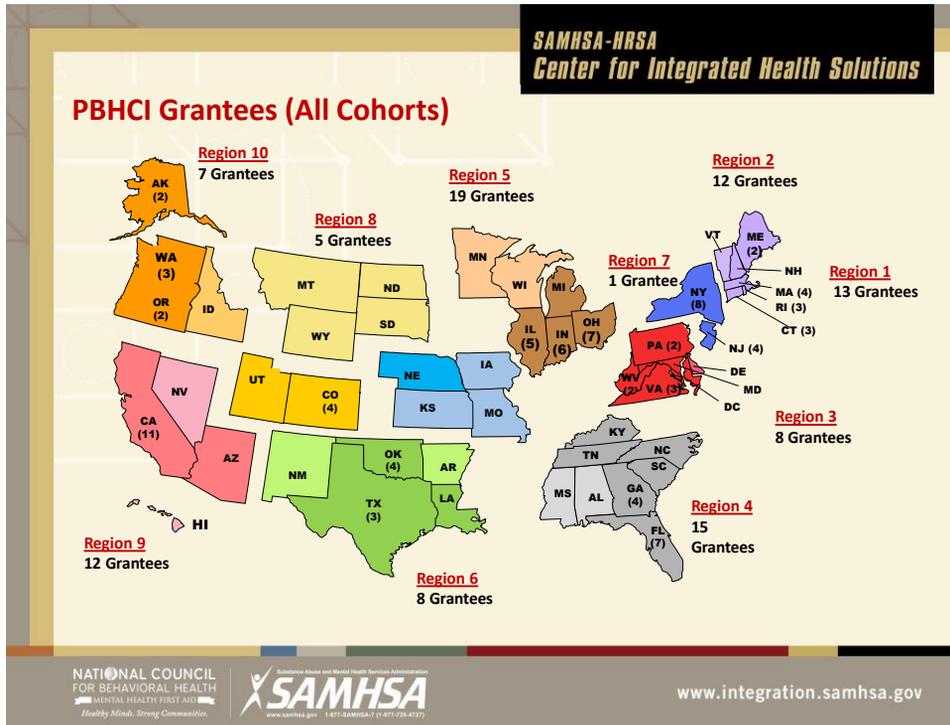
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Trina Dutta, MPP, MPH
Welcome and Overview
Public Health Analyst
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Poll Question

What is your most pressing question about the integration of primary care?

- Paying for Integrated Care
- Models of Integration
- The Right Staffing
- Measuring Outcomes
- Partnering with Primary Care Providers

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Integrated Care Models in Behavioral Health

Behavioral health organization develops a formal partnership with a primary care organization (78% of the PBHCI grantees) — federally qualified health centers, hospitals, private providers

Behavioral health organization hires primary care staff directly and identifies a path for billing (dually licensed, or paneled with a managed care organization)

Overview of PBHCI

- **Purpose:** to establish projects for the provision of coordinated and integrated services through the co-location of primary and specialty care services in community-based mental and behavioral health settings.
- **Goal:** to improve the physical health status of adults with serious mental illnesses (SMI) who have or are at risk for co-occurring primary care conditions and chronic diseases
- **Objective:** to support the triple aim of improving the health of those with SMI; enhancing the consumer's experience of care (including quality, access, and reliability); and reducing/controlling the per capita cost of care.

Overview of PBHCI

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Core Requirements

- Provide, by qualified primary care professionals, on site primary care services and
- Provide, by qualified specialty care professionals or other coordinators of care, medically necessary referrals

Must serve as a client's health home where grantees provide the following services:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
- Individual and family support, which includes authorized representatives
- Referral to community and social support services, including appropriate follow-up

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Other Areas of Emphasis

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- HIT: Grantees must achieve Meaningful Use Standards, as defined by CMS, by the end of the grant period;
- Prevention & Health Promotion: Wellness programs (e.g., tobacco cessation, nutrition consultation, health education and literacy, self-help/management programs) should be available as preventive interventions that involve preventive screening and assessment tools, *incorporating recovery principles and peer leadership and support*
- Sustainability: Grantees must submit a sustainability plan in Year 2 of their grant, detailing how expanded Medicaid eligibility, available CMS/3rd party billing, and other strategies will be utilized to sustain services post-grant

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Data Collection

Blood Pressure—quarterly
 Body Mass Index—quarterly
 Waist circumference—quarterly
 Breath CO—quarterly
 Plasma Glucose (fasting) and/or HgbA1c—annually
 Lipid Profile (HDL, LDL, triglycerides)—annually
 National Outcome Measures (NOMs)—every 6 months



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**Marie Hobart, MD
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Background

Community Healthlink (CHL) is a multi-site community mental health center based in Worcester, MA providing mental health, substance use, rehabilitation, and homelessness services to individuals and families

- Largest provider of mental health, substance abuse and homeless services in central Massachusetts
- Serving over 19,000 unique individuals annually, many individuals with severe and persistent mental illness
- Approximately 70% have comorbidity for psychiatric and substance use disorders



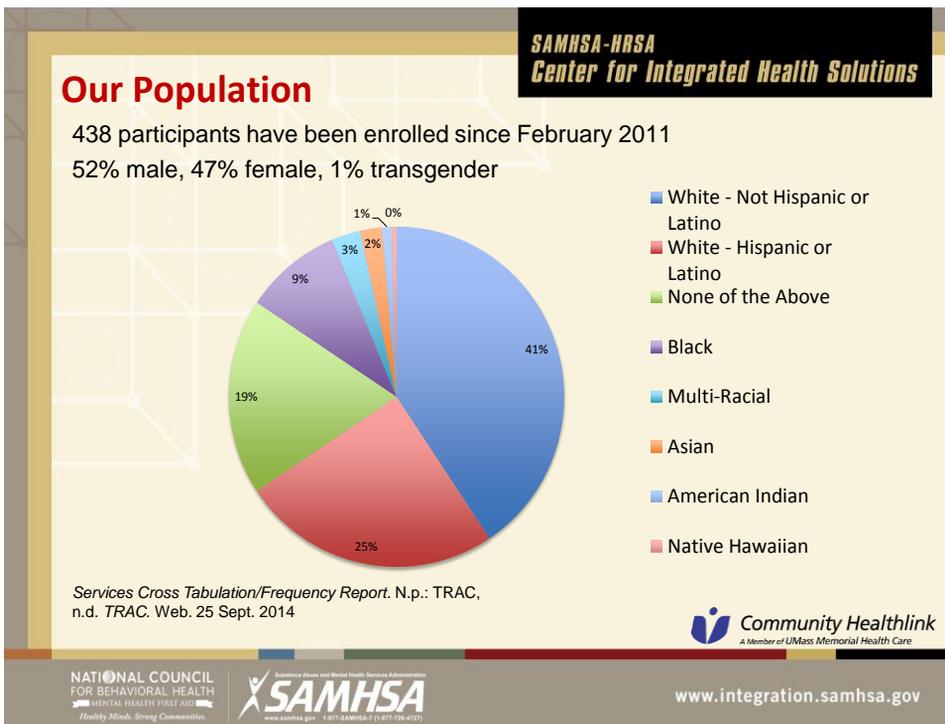
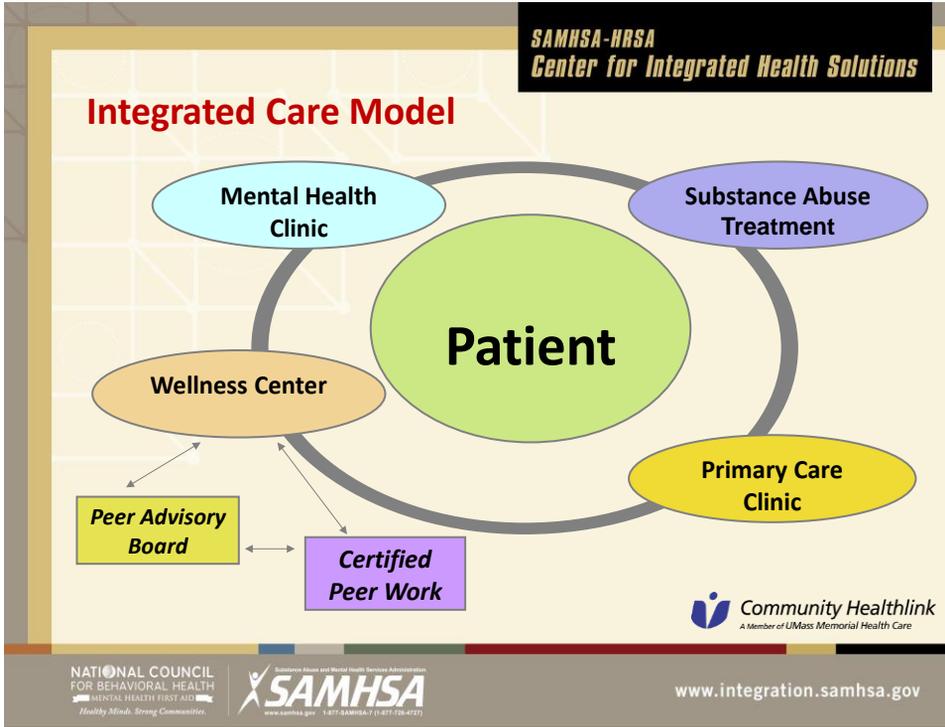
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Background (cont.)

In October 2010, CHL was awarded a 4 year SAMHSA grant to implement a Primary and Behavioral Health Care Integration program.

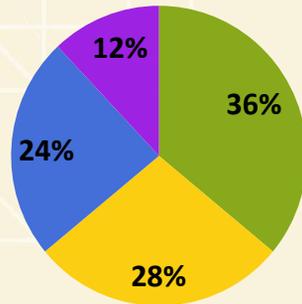
- The program offers on-site primary care, nurse care management, peer support, and wellness groups to consumers already receiving outpatient behavioral health services
- Participants are recruited on a rolling basis from existing outpatients and they may elect to participate in wellness activities and/or primary care





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Primary DSM-IV TR Diagnoses



- Mood disorders
- Schizophrenia, schizoaffective, and other psychotic disorders
- Substance use disorders
- Anxiety or other types of disorders

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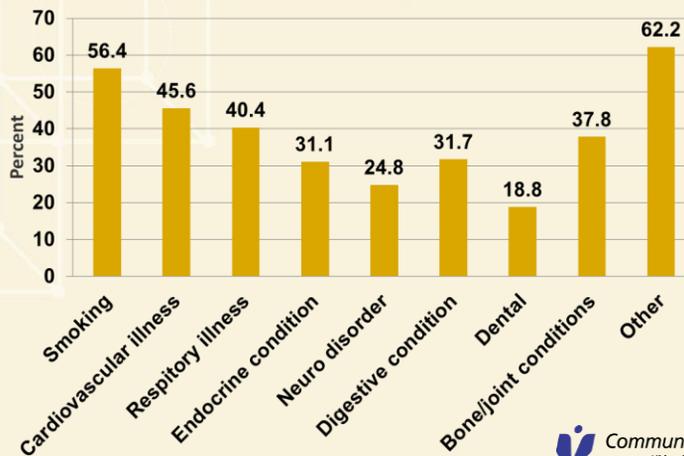
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Medical Areas of Concern



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The Wellness Center at CHL Primary Care and RN Care Managers

The Wellness Center is a stand-alone model in an urban setting providing both behavioral health and primary care interventions.

Access to primary care

- Embedded primary care within the community mental health center
- Some individuals with established primary care continue with their provider, while those in need of primary care utilize care at CHL

RN care managers

- Facilitate coordination of care with mental health team and primary care provider
- Provide education, support the treatment recommendations by PCP and coach about lifestyle change
- Close follow up to avoid people falling through the cracks



The Wellness Center at CHL Wellness Programming

- Individual sessions with RN Care Managers and Peer Specialist for education and follow up
 - Wellness planning around: nutrition, physical activity, smoking cessation, stress management, illness self-management
- Individual treatment plans
- Group sessions, including: Whole Health and Wellness, Stress Reduction, Express Yourself, Women's Road to Wellness
- Utilize fitness resources
 - 2x/week trips to local gym, peer health mentors accompany participants if desired, transportation provided
 - Walking group
 - Yoga class
 - Subsidized membership (\$20/year) to local YWCA



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Administration & Infrastructure

- Initial plan to partner with local FQHC, then partnered with UMass Department of Family and Community Medicine
- Department of Public Health licensing different in each state; regulations can make one approach easier than another
 - Practical considerations, including: Waiting areas, room specification, licensing regulations for mental health and substance abuse facility
- Billing challenges
 - Different in each state
 - Community Health Center status – able to bill state Medicaid at a standard rate
 - Need to be recognized as a primary care provider by managed care organizations
 - Now able to bill CPT codes to Medicare for primary care in addition to behavioral health. Need separate number for primary care.



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Administration & Infrastructure

- Challenge with integrating separate electronic health records:
 - Currently still have two electronic records, two electronic billing and prescribing systems
 - Developing an integrated record with EHR company to integrate ALL our services
- Clinic management issues
 - Hiring staff – Primary Care, Nurse Care Managers, Medical Assistant, Administrative Assistant, Peer Specialist with primary care and physical health and wellness focus
 - Operating a primary care clinic different skill set from traditional outpatient mental health clinic. Practice manager was our key hire.
- Meeting Meaningful Use for eligible providers



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Culture Change

- Increase our shared sense that physical health is part of our work
- Share information about who to refer and how to make the referral
 - Informal process, low barriers for enrollment
 - Warm hand off
 - Individual outreach to providers
 - Attendance at team and department meetings
- Build hope that people want to take care of their health
- Engage staff in wellness
 - Wellness activities and events that engage staff as well as clients
 - Visible wellness messages throughout the agency (fliers, newsletters)



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Primary Care Co-located in Behavioral Health

Co-location in corridor with behavioral health clinicians

Clinic 2 days per week, booking 12-16 patients with an average of 10-12 seen

Coordination of services with nurse care managers

Infrastructure requirements:

- At least 2 fully equipped exam rooms for each provider
- Medication, vaccine, clean utility storage room
- Dirty utility – linens, biohazard materials
- Reception/check-in desk/schedule medical appointments and referrals
- Reminder phone calls
- Primary care clinic manager
- Tracking supplies and equipment calibration
- Phone coverage – Mon-Fri



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Infrastructure requirements cont.

- Off hours & weekend medical coverage
- Medical assistant or nurse to room patients, collect vital signs, reconcile medications, and administer vaccinations, strep tests, urine dips, EKGs, etc.
- Charting area
- Lab/specimen courier
- Phlebotomy, on site or nearby
- Selecting provider (MD/NP)
- Determining manageable schedule

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Primary Care Co-located in Behavioral Health

Benefits

- We are located where clients feel familiar with the physical space; the medical team is a regular presence
- Opportunity for informal discussion between behavioral health clinicians and medical provider about mutual or potential clients
- Warm hand offs and introductions for patients who are in for appointments with behavioral health clinicians
- Shared email and phone systems aid in provider communication
- Monthly provider meetings that include both psychiatry and primary care provider
- Clinicians and psychiatrists can offer in-house solution to primary care need

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Primary Care Co-located in Behavioral Health

Challenges

- Disruptions
- Clinic flow, check in, etc.
- Space limitations
- Components of data collection taking place during primary care visit
- Scope of NP – state regulations and physician collaborative requirements
- Challenge of accomplishing treatment in patients whose mental illness impairs understanding and/or willingness to accept care



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Primary Care Co-located in Behavioral Health

Services provided:

Primary care (prevention, screening, education)

- Complete physical exams
- Pap smears
- FOBT
- Contraceptive education and management
- Scheduling mammograms, colonoscopies, bone density scans
- Glucose and lipid monitoring
- Vaccinations for Influenza, pneumococcal pneumonia, tetanus, hepatitis A and B



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Primary Care Co-located in Behavioral Health

Chronic disease care (most have multiple comorbidities)

- Top 5 diagnoses
 - Tobacco use
 - Hypertension
 - Lipid disorders
 - Diabetes
 - Hepatitis C

Primary Care Co-located in Behavioral Health

Benefits of our model

- Accessibility – Provider comfort with open access, walk-in, adjustment of daily schedule to accommodate individuals
- Patient-centered approach – Trauma histories, struggles with severe mental illness, discomfort with medical interaction
 - Generally, physical exams are not performed on the first visit, and readiness for complete physicals exams is discussed and planned together
- Developing trust and comfort – Clinicians help facilitate connections with on site PCP

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Future Steps & Sustainability

- Establishing and strengthening strategic partnerships with potential integrated care organizations
- Establishing ourselves as the provider of choice for integrated behavioral and primary healthcare in Central Massachusetts
- Establishing components to develop a global payment rate
- Tracking productivity, no shows and data collection rates
- Increasing the number of patient groups
- Creating multidisciplinary care plans
- Further developing the role of the health behavior change clinician (currently our nurse care manager) to utilize evidence based practice guidelines for teaching and motivating clients
- Ongoing training for staff



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Presenter

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Integration Model

- A non-profit community based health care provider (FQHC) co-locates a **primary care clinic** in a county-operated **mental health center**. The site becomes a Medical Home for Seriously Mentally Ill adults in the county's Adult System of Care.
- September 2011: LifeLong Medical Care PATH Clinic opens at the Oakland Adult Community Support Center / Eastmont Mall (200 participants)
- August 2012: Tri-City Health Center PATH clinic opens at the Tri-City Adult Community Support Center / Fremont Family Resource Center (80 participants)



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Integration Model

LIFELONG MEDICAL CARE:
"Safety net" primary care provider since 1976 for uninsured residents with complex health needs in Berkeley, Oakland, Albany, and Emeryville, California

TRI-CITY HEALTH CENTER:
"Safety net" primary care provider since 1970 for uninsured and underserved residents in Fremont and Union City, California

LIFELONG MEDICAL CARE
Health Services For All Ages

TRI-CITY HealthCenter
Our Community. Your Health.

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Integration

- Physicians (Primary Care and BH) located in the same facility with a Clinic Coordinator, BH Nurse, and staff who work together to improve processes, work flow and communication
- PATH staff huddle after each clinic to coordinate health care, medication, referrals, follow up, and to problem solve
- Peer Support Staff help with transportation, wellness groups, and help communicate client needs to the providers
- Wellness classes offer education and engagement to help clients feel supported and motivated to make changes to improve their health.
- Teamwork – Doctors on both sides enjoy working together, and like that there is follow up ("patients listen to me"), and consumer feedback is positive ("the doctors listen to me!")

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Challenges

For the Organizations:

- The bureaucratic processes (everything takes time)
- Getting “billing” up and running on the BH side can be challenging
- Getting data sharing agreements, and working with 2 data collection systems that don’t talk to each other
- Primary Care has “productivity” targets (a different set of measures from BH)

For the Population Served:

- Consumer substance use can affect engagement and compliance
- Consumers may lack transportation, access to healthy food, and live in unsafe neighborhoods
- Staff changes can be upsetting
- Some consumers prefer one-on-one interactions; we originally focused the wellness program on group activities, and some consumers did not attend

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Wellness

- **Wellness Activities:** led by Peer-Educators or Student-Interns (a colorful calendar is posted monthly on the bulletin board)
- **Community Connections:** field trips to farmers’ markets, bowling, movies
- **Cooking:** teaches nutrition and self sufficiency, introduces healthy new foods
- **Meditation/ Movement:** Yoga, Walking Groups - exercise and relaxation
- **Lunch & Learns:** Medical staff present a topic and answer questions (free lunch)
- **Living Well Class:** participants set their health goals based on the Whole Health, Wellness and Resiliency model developed by SAMHSA-HRSA



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Tips

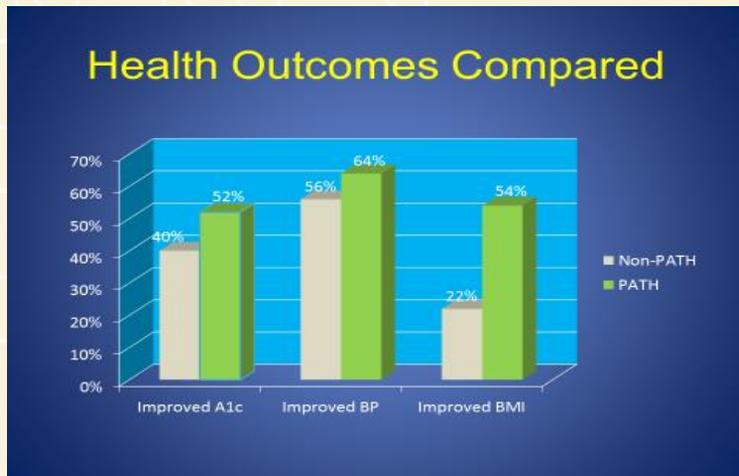
- Create a welcoming environment: a “PATH Café” with colorful posters on the walls; staff were friendly and accessible
- A weekly cooking class (to teach nutrition) attracted participants, (food!) as did outings and events
- Having Fun – Social Work Interns studying Integrated Health ran some of the “Health and Wellness Classes” and re-named them to sound more inviting, bringing new energy;
- Smoking Cessation became “Bye, Bye Butts”; Stress Reduction became “Fun and Games”; Relaxation became “Feel Good Fridays”

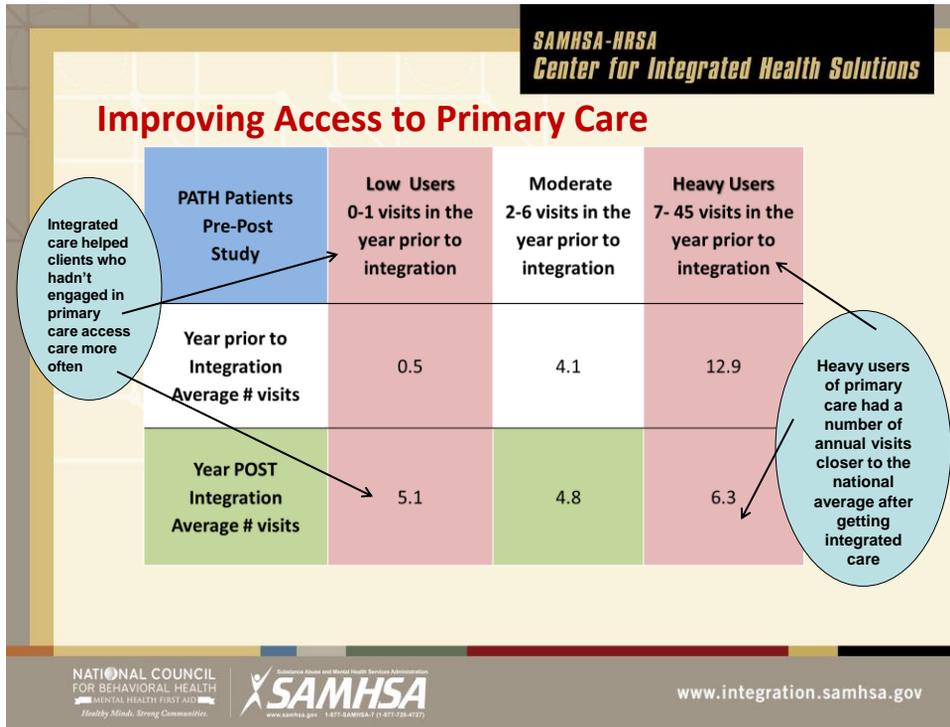


Consumer designed brochure!

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Health Outcomes Compared





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Tips

- Work with your Evaluator and Data team to plan what data to collect, when, how, and why.
- Measure changes in blood pressure, blood sugar, weight, breath CO, cholesterol levels (for example).
- Track number of primary care visits, before and after integration.
- Make charts and graphs for a "data wall" and disseminate your successes widely; integration is a hot topic!



An annual half-day "Visioning Retreat" asked staff and stakeholders "what is working?" "what can we improve upon?" "where do we want to go?" and gave us great ideas for problem solving and quality improvement.

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Sustainability

- Primary Care (FQHC) calculated 4 half-day clinics a week, 7 visits per clinic day, to cover operating costs of \$270,000 a year with Medicaid and Medicare billing.
- Behavioral Health is working on setting up MAA and TCM billing to help cover operating costs of \$250,000 a year per clinic (for 200 participants)
- Additional Funding was secured by Alameda County BH
- County Leadership approved allocation of California Mental Health Services Act funds to sustain PATH and expand to 2 new sites; San Francisco Foundation grant for sustainability planning and data collection/analysis; Tobacco Cessation grants; Blue Shield Foundation grant to improve county-wide interagency data sharing; USC/Cal State University Schools of Social Work Integrated Health Interns (in-kind donation of services); UC Berkeley collaborative proposal to NIMH for SMI sleep improvement study pending approval October 2014

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Collaborative Leadership Skills

- Take ownership of your partner's measures of success (break-even, revenues and expenses, billable patient visits)
- Build trusting, dependable, reliable working relationships with all project staff (BH and Primary Care)
- Always be willing to listen and to help solve issues that might impact the collaboration
- Be willing to lead – even without direct lines of authority
- When you hit barriers (i.e. the bureaucratic process) use patience and persistence
- Think “outside the box” -- because we are changing and improving not only health outcomes, but also our organizations!



Lessons Learned

From Three Perspectives:

- 1) Grantees
- 2) National Rand Evaluation of Early Cohorts
- 3) SAMHSA and CIHS

Grantees Said: Coordination of Care

- Use care coordinators to provide the link between behavioral and mental health care
- Let case managers educate you on the anatomy of the intake and the referral process
- Sell clinicians on the benefit of the integrated clinic and have an EASY process for referrals. Give them a cheat sheet
- Have a good clinical tracking system—manual systems make it very difficult
- Plan for EMR/EHR systems that work together – with registry capability

Communication Within and Outside Your Organization

- Meet regularly—keep lines of communication
- Take advantage of technical assistance
- Provide ongoing clinical education for behavioral health and primary care staff about interactions between physical and mental health
- Monthly PBHCI newsletter for both organizations
- Be more aggressive about gaining buy-in from the beginning of the project

Communication

- Get buy-in from CEO from the start
- Keep staff and consumers engaged with quarterly letters/calendars of activities or groups
- Don't assume everyone on the team understands the details
- Cross-train everyone on the essential functions as there will be staff turnover
- Don't underestimate the cultural difference between behavioral health and primary care clinics

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Wellness

- Base wellness activities on what clients want—LISTEN to their voices—Learn what is important to them
- Incorporate whole health for staff into the agency's strategic plan and activities
- Provide Nicotine Replacement for tobacco treatment
- Include walking groups
- Take advantage of all opportunities to teach how to live healthier lifestyles

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Plan for Sustainability

- Start planning for sustainability in the first year
- Improve payer mix to support primary care billing
- Iron out logistic issues with FQHC upfront
- Let the community know you exist
- Identify funding sources for non-billable services
- Patient volume is key: 22 patients a day

The RAND Evaluation Said:

PBHCI associated with:

- **Clearly reduced risk for:**
 - Cholesterol
- **Moderately reduced risk for:**
 - Diabetes
 - Hypertension
- **More work needed on:**
 - Obesity
 - Smoking



SOURCE: [Evaluation of the SAMHSA Primary and Behavioral Health Care Integration \(PBHCI\) Grant Program: Final Report](#)
HHS's ASPE/DALTCP and the RAND Corporation

SAMHSA and CIHS Said:

Successes

- Role of nurse care managers as a "bridge" across systems has been crucial to successful integrated team functioning and integrated treatment planning
- Changing state/local policy that inhibits integrated care (i.e., changing state policy around requirements for having separate BH-PC break rooms for staff; changing state policy around having separate doors relative to both PC and BH services, etc.)
- Role of peer wellness coaches in supporting health and wellness interventions, and ongoing recruitment and engagement of clients being served
- Using health registries and population management strategies

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Successes Continued

- Screening for chronic health issues including breast cancer, colon cancer, and prostate cancer
- Bridging across distinct electronic data systems in order to share BH and PC client data
- Using client-level data to support overall population health management (and associated continuous quality improvement efforts)
- Implementing mechanisms to support integrated team functioning, including hall-ways consults and daily/weekly team huddles
- Involvement of peers in wellness and care coordination activities are important for recruitment and engagement of clients
- Integration moved from a project to an agency-wide “way of doing business”

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Challenges

- Difficulty finding specialty SUD providers who can take referrals from the CMHC for SUD treatment
- Cross training BH and PC staff on the particulars of SUD treatment, specifically medicated assisted treatment therapies
- Reliably screening for SUD (see bullet regarding challenges in finding specialty providers)
- Maintaining long-term engagement of clients in primary care services, is necessary to impact those health conditions that require longer-term intervention (i.e., weight loss and tobacco cessation)
- FQHC partnerships--without "incentives" for meaningful participation, this partnership can range from "on paper only" to "fully embracing the client population"

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Challenges Continued

- Rural CMHCs have challenges in finding sufficient PC capacity in their areas
- Implementing EBPs with fidelity to the model
- Culture change--both for PC and BH staff (reinterpreting one's clinical role in the context an integrated care environment)
- Functioning in a FFS environment when capitation/PMPM better supports the overall goals of integrated care
- Understanding the cost-benefits associated with integrated care, given challenges in accessing data on hospitalization and ER usage (both on the BH and PC sides)
- Embed wellness services in existing billable services

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PBHCI = Achieving the Triple Aim

- Improved Health Outcomes
- Lower Cost to the System
- Quality and Consumer Experience of Care



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PBHCI Grantees & to Health Reform



- Medicaid Health Homes
- CMMI Innovations
- Hospital ER Reduction
- MCO Models

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Questions & Discussion



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Additional Questions?

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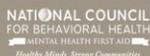


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Thank you for joining us today.

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