

Safety Net Medical Home Initiative: *Transforming Practices into Medical Homes*

Integration of Behavioral Health Services into the Medical Home

Moderated by:

Sharon Eloranta, MD, Medical Director, Quality and Safety Initiatives, Qualis Health

with Guest Speakers:

- **Barbara Mauer, MSW CMC, Director of Planning Services for MCPP Healthcare Consulting, Seattle, WA**
- **Lori Abrams Berry, MPH, MSW, Lynn Community Health Center, Lynn, MA**
- **Mark Alexakos, MD, MPP, Lynn Community Health Center, Lynn, MA**

Webinar Series: November 17, 2010

***Mental Health/Substance Use
Services Integrated into the
Medical Home***

**Safety Net Medical Home Initiative
November 17, 2010**

Barbara Mauer, MSW, CMC
MCPP Healthcare Consulting Inc.
Seattle, Washington
National Council Consulting Team

The Hypothesis

- Treating the *MH/SU needs of all Americans* and the *healthcare needs of persons with serious mental illness* will become very important to managing *Total Health Expenditures* in the U.S. and *bending the cost curve...*
- This will drive widespread *integration* of Primary Care and MH/SU treatment and will create *greater demand* for MH/SU treatment services
- Recent examples include:
 - Revised NCQA requirements
 - Oregon State standards
- The National Council's **Four Quadrant** model is intended to support population based planning for bidirectional integration—MH/SU services in primary care and primary care services in specialty MH/SU settings

NCQA Certification Standards for PCMH

(revisions proposed, comment period closed, final due late in 2010, * indicates reference to MH/SU conditions)

- **PCMH 1: Access and Continuity**
 - Access During Office Hours
 - Access After Hours
 - Electronic Access
 - Continuity
 - Patient/Family Partnership
 - Culturally and Linguistically Appropriate Services
 - Practice Organization
- **PCMH 2: Identify and Manage Patient Populations**
 - Basic Data
 - Searchable Clinical Data
 - *Comprehensive Health Assessment**
 - Using Data for Population Management
- **PCMH 3: Plan and Manage Care**
 - Guidelines for Important Conditions
 - *Care Management**
 - Medication Management
 - Electronic Prescribing
- **PCMH 4: Self-Care Process**
- **PCMH 5: Track and Coordinate Care**
 - Test Tracking and Follow-up
 - *Referral Tracking and Follow-up**
 - Coordination with Facilities/Care Transitions
 - Referrals to Community Resources
- **PCMH 6 Performance Measurement and Quality Improvement**
 - Measures of Performances
 - Patient/Family Feedback
 - Quality Improvement
 - Reporting Performance Measures

Oregon Standards and Measures for Patient Centered Primary Care Homes: Example

Core Attribute: COORDINATION AND INTEGRATION

Help me navigate the health care system to get the care I need in a safe and timely way.

- Make sure I understand what care or services I need to stay healthy and manage my medical and mental health problems and where to get them.
- Stay involved in my care and help me to avoid unnecessary tests, procedures or interventions.

Standard: Data Management

- Follow my care closely and let me know when tests or checkups are needed.
- Make sure I understand which tests, prevention services and lifestyle changes are recommended to improve my health.

Standard: Care Coordination

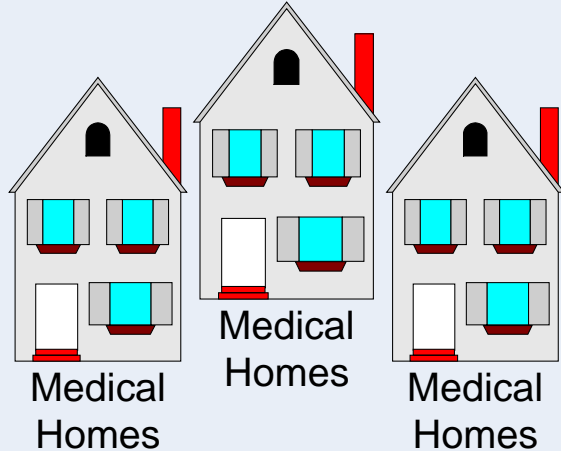
- When I need to go to other providers or places for care or services, help me coordinate and plan my care without delays and confusion.
- ***When I need to see a specialist or get a test, including help for mental health or substance use problems, help me get what I need at your clinic whenever possible and stay involved when I get care in other places.*** (emphasis added)
- Make sure I understand the reasons for sending me to a specialist or for a test, prepare me for what to expect and follow up with me afterwards to make sure I understand the results.

Standard: Care Planning

- Help me and my family set goals and plan for my care in a way that is understandable and meets my needs.
- Provide me with the information I need to care for my own illness and challenge me to actively care for myself.

Patient-Centered Medical Homes in a Larger Healthcare System: Delivery System Redesign

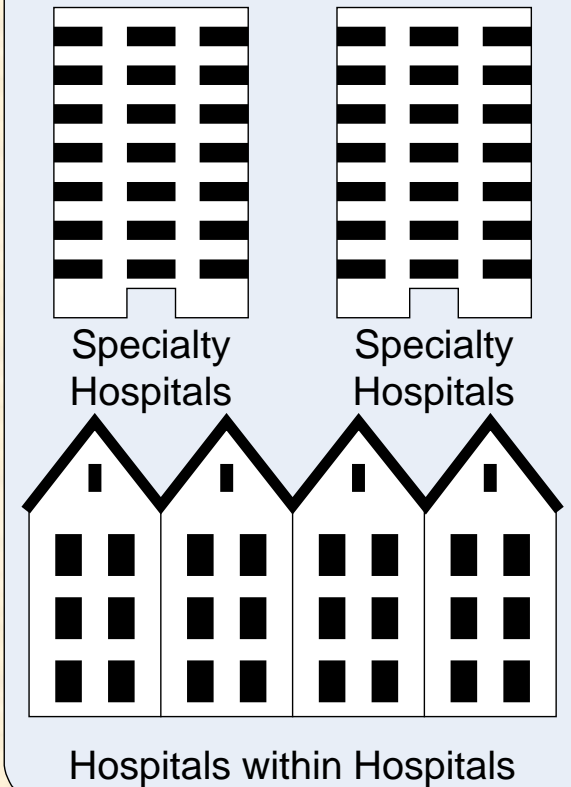
Payment Model to cover Prevention, Primary Care and Chronic Disease Management; Bonus Structure for managing Total Health Expenditures



Linkages to High Performing Specialists that can support the management of Total Health Expenditures and minimize Defect Rates



Bundled Case Rates that pay a Percentage of PACs and Non-Payment for Never Events



Medical Homes



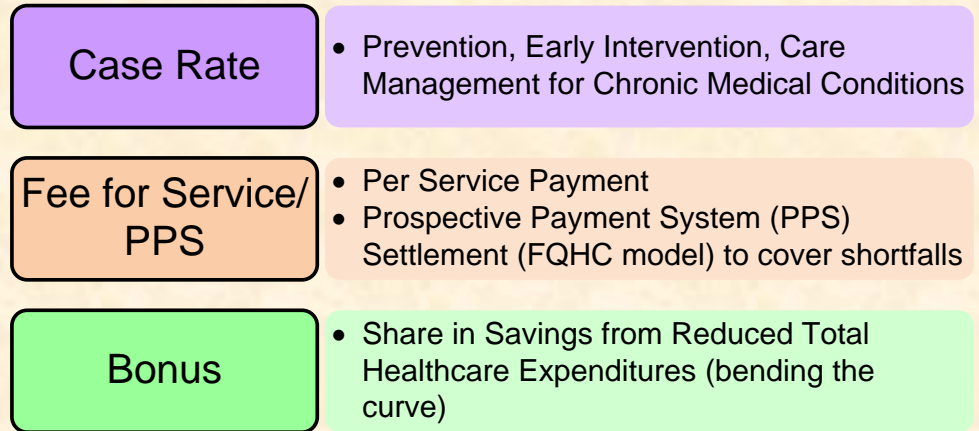
They are all about Improving Quality and managing Total Healthcare Expenditures!

Universal Coverage/Parity Will Improve MH/SU Access

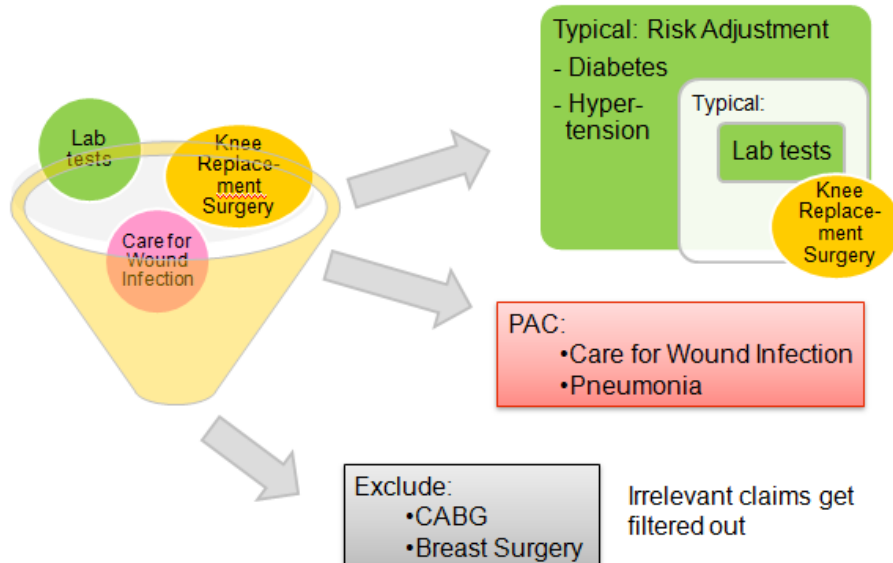
- Expanded Medicaid (31% increase in Medicaid enrollees, 54% reduction in uninsured)
- Mental Health and Substance Use Services must be provided at parity with general healthcare services (no discrimination)
 - Large Employers (Parity Act)
 - Medicaid (Parity Act & Reform Legislation)
 - Health Insurance Exchanges for Individual and Small Group Policies (Health Reform Legislation)
 - Medicare: on the way (Medicare Modernization Act of 2003)
- But... the parity regulations may not be the most important component—keep your eye on the Benchmark Benefit Package
 - Medicaid enrollees guaranteed a benchmark benefit package that at least provides “essential health benefits”
 - Mental Health and Substance Use are included in the definition of “essential health benefits”

Payment Reforms will be Linked to the Ability to Demonstrate Outcomes and Manage Costs

- New funding mechanisms will be utilized to fund services that manage total healthcare expenditures
- Many Person-Centered Healthcare Homes will be funded with a 3-layer model



Potentially Avoidable Complications (PACs)

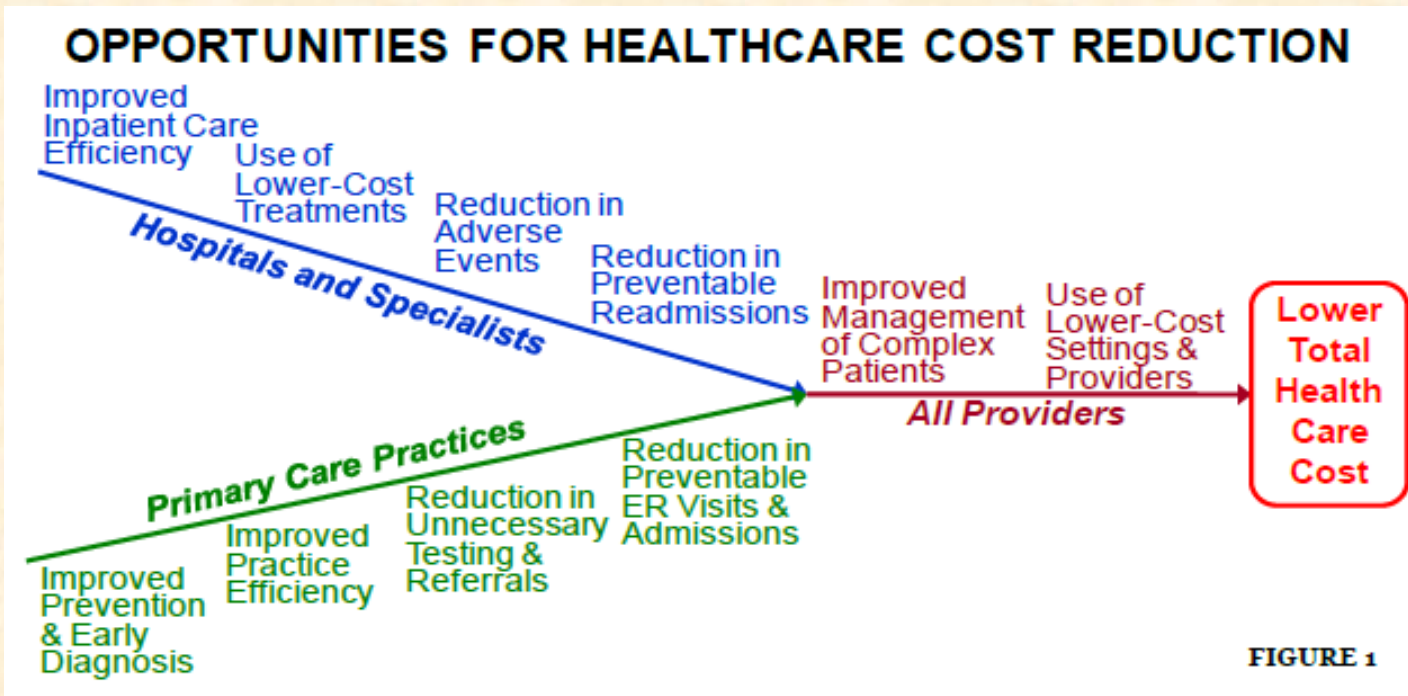


Prometheus Payment, Inc.™. All Rights Reserved

- Payment for inpatient care will bundle hospital and physician services that only pay for part of Potentially Avoidable Complications (PACs)
- Bundled payments may include all costs in the 30 days post an inpatient stay, including any return to the hospital

Accountable Care Organizations (ACOs)

- ACOs dual purpose:
 - Organization structure for managing bundled payments for inpatient care
 - Vehicle for small to mid-sized primary care practices that want to become Person-Centered Medical Homes



The PCMH and ACO will Need Mental Health and Substance Use Treatment Capacity

- 49% of Medicaid beneficiaries with disabilities have a psychiatric illness
- Substance use conditions do not show up in this study at the expected levels because it's based on an analysis of claims and pharmacy scripts

Exhibit 7: Frequency of Diagnostic Dyads by Cost among Medicaid-only Beneficiaries with Disabilities, 2002, CDPS + Rx Data*

Diagnosis 1	Diagnosis 2	Frequency among all beneficiaries	Frequency among most expensive 5%
Psychiatric	Cardiovascular	24.5%	40.4%
Psychiatric	Central Nervous System	18.9%	39.8%
Cardiovascular	Pulmonary	12.5%	34.3%
Cardiovascular	Central Nervous System	13.1%	32.9%
Psychiatric	Pulmonary	11.2%	28.6%
Cardiovascular	Gastrointestinal	10.2%	27.8%
Central Nervous System	Pulmonary	7.0%	26.2%
Cardiovascular	Renal	7.1%	24.6%
Pulmonary	Gastrointestinal	5.9%	24.2%
Psychiatric	Gastrointestinal	9.5%	24.0%

The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions
 Center for Health Care Strategies, Inc., October 2009

Patient-Centered Medical Homes → National Council's Person-Centered Healthcare Homes

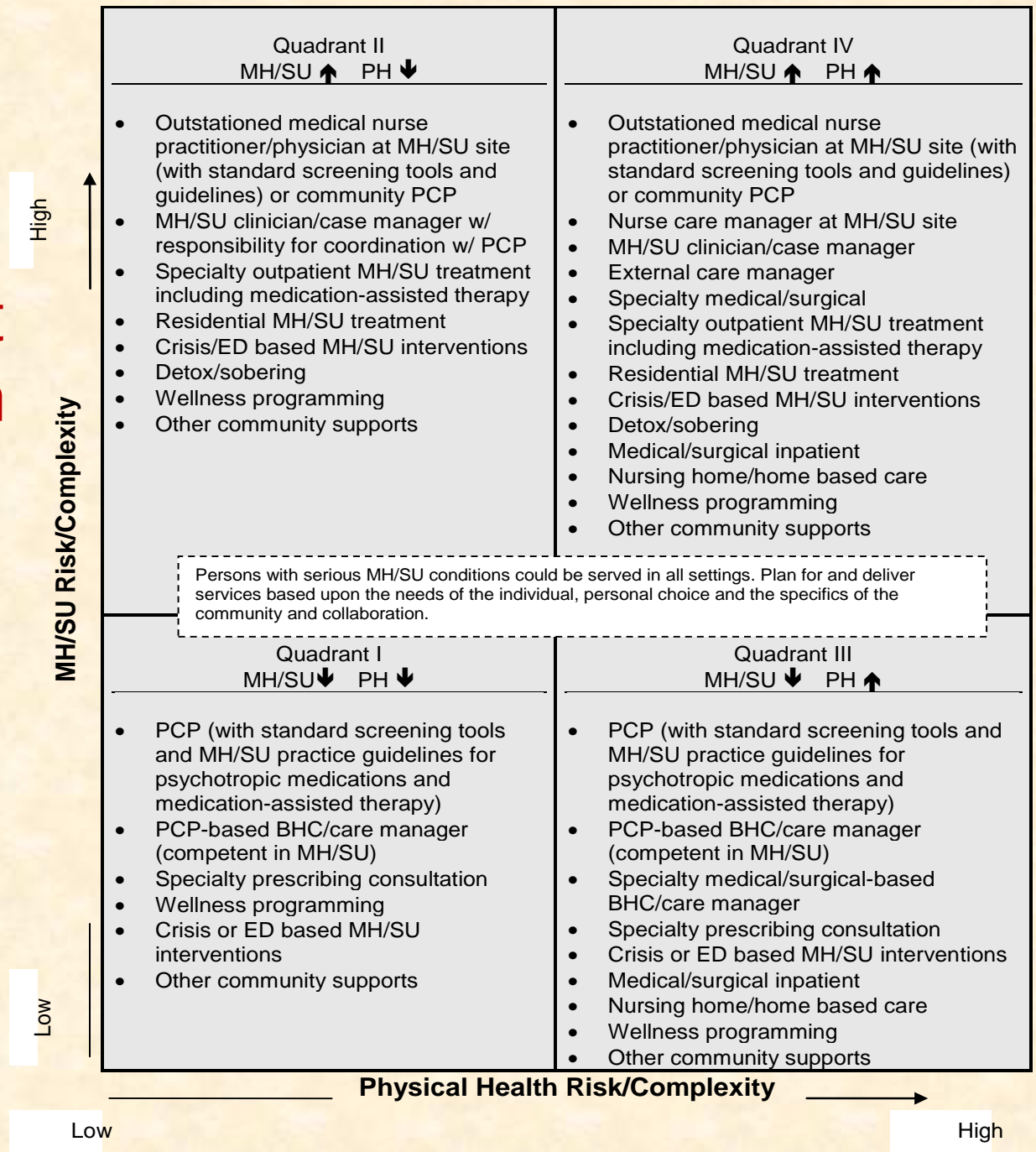
Patient Centered Medical Home (PCMH) Principles

- Ongoing Relationship with a PCP
- Care Team who collectively take responsibility for ongoing care
- Provides all healthcare or makes Appropriate Referrals
- Care is Coordinated and/or Integrated
- Quality and Safety are hallmarks
- Enhanced Access to care is available
- Payment appropriately recognizes the added value

Person-Centered Healthcare Home

- Not a clear articulation in the PCMH model of the role of MH/SU
- Change to Person Centered Healthcare Home signals that MH/SU is a central part of healthcare and that healthcare includes a focus on supporting goals for improved self management
- Use a bi-directional approach to address the integration of primary care services in MH/SU settings as well as the need for MH/SU services in primary care settings
- Build in the care manager/ behavioral health consultant and consulting prescriber functions that have proven effective in the IMPACT model and mirror this model to bring planned primary care into MH/SU settings

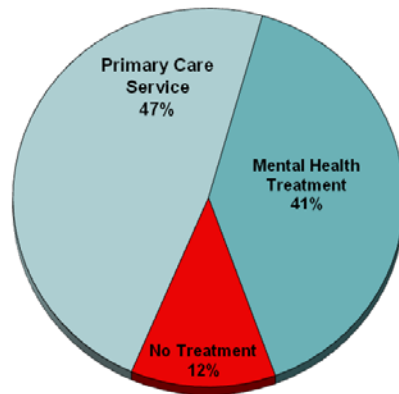
The Four Quadrant Clinical Integration Model (MH/SU)



Focus: Quadrants I and III

National Co-morbidity Survey Replication

Access to Behavioral Health Intervention



Thanks to Dennis Freeman of Cherokee, who prepared the NCS graphic

- 26% of the **general*** adult population will need MH services in any given year (NCS-R), but 59% of those needing treatment may not receive any services
 - 80% of those not receiving care were seen in primary care during the previous year—a missed opportunity
 - Of the 41% who received treatment, half received services from the specialty MH sector, the other half from the general medical sector
- *for safety net clinics, this will be closer to 50%**

IMPACT Collaborative Care in Primary Care

TWO NEW 'TEAM MEMBERS'

TWO PROCESSES

1. Systematic diagnosis and outcomes tracking
e.g., PHQ-9 to facilitate diagnosis and track depression outcomes

2. Stepped Care
- Change treatment according to evidence-based algorithm if patient is not improving
- Relapse prevention once patient is improved

Care Manager/BHC

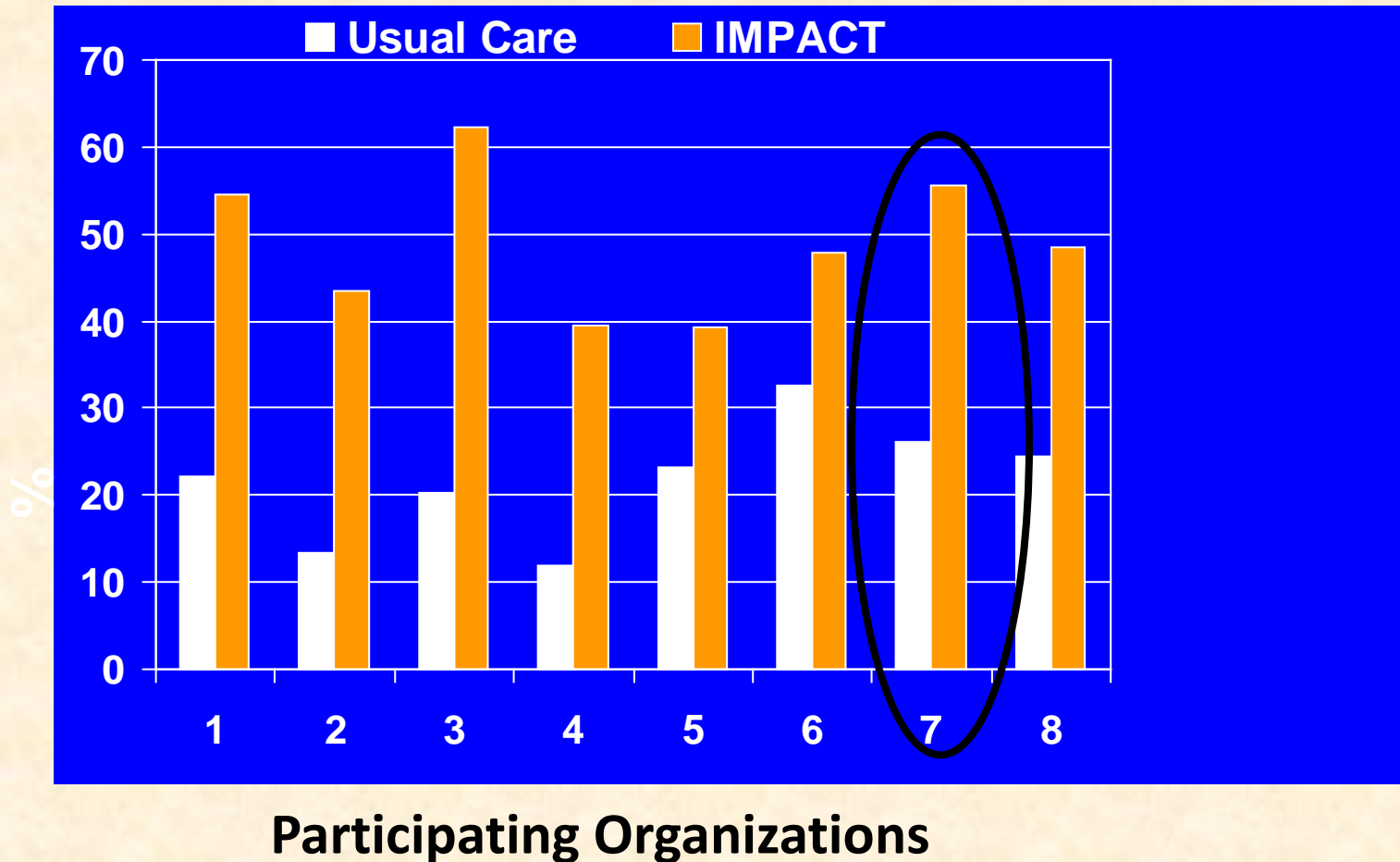
- Patient education / self management support
- Close follow-up to make sure pts don't 'fall through the cracks'
- Support medication Rx by PCP
- Brief counseling (behavioral activation, PST-PC, CBT, IPT)
- Facilitate treatment change / referral to mental health
- Relapse prevention

Consulting Mental Health Expert

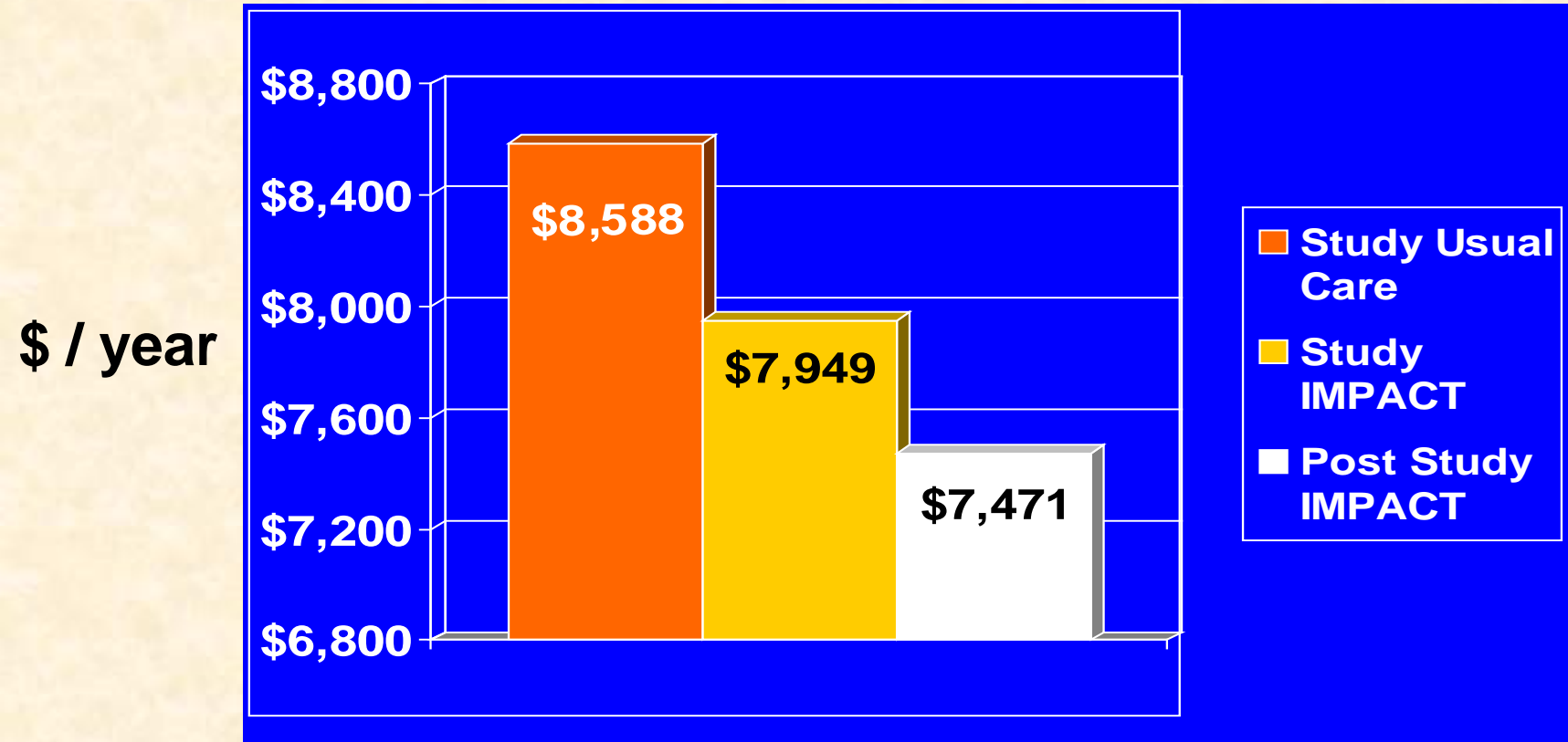
- Caseload consultation for care manager and PCP (population-based)
- Diagnostic consultation on difficult cases
- Consultation focused on patients not improving as expected
- Recommendations for additional treatment / referral according to evidence-based guidelines

IMPACT: Doubles the Effectiveness of Usual Care for Depression

50 % or greater improvement in depression at 12 months



IMPACT Lowers Total Health Care Costs



Washington State Project using IMPACT Approach

(First Year Findings)

- **Clients with follow up within 4 weeks of initial assessment**
 - Level I: 42% (range across clinics: 32%-64%)
- **Clients with Psychiatrist Consultation**
 - Level I: 31% (range across clinics: 20%-83%)
- **Level I outcomes 12 weeks after initial assessment**
 - Clients with PHQ-9 score improved at least 50% over 12 weeks = **20%** (range across clinics: 12%-28%)
 - Clients with GAD-7 score improved at least 50% over 12 weeks = **20%** (range across clinics: 13%-26%)
- **Quality Improvement effort, with attention to core components/workflow**
 - High rates of engagement (100%) and 4 week follow-up (93%)
 - Effective use of in-person and telephone contacts
 - Psychiatric Consultation at 60%
 - **63-72 %** with substantial (>50 %) clinical improvement

SU Services in Primary Care

- Diffusion of screening and brief intervention (SBI) is underway
- Motivational interviewing with fidelity should be a consistent component of SBI
- Repeated BI in primary care is a promising practice
- Medication-assisted therapies in primary care can be expanded

SU Impact on Healthcare Costs

Kaiser Permanente Northern California

- Kaiser studies reported are retrospective, using historical enrollee data
- Pre/Post SU Treatment and Medical Costs
 - Analysis of average medical cost PMPM in 18 months pre and post SU treatment using historical data
 - Treatment group had a 26% reduction in cost, with reduced ER and hospitalizations post treatment compared to matched control group

Connie Weisner, DrPH, LCSW
Associate Director for Health Services
Division of Research, Kaiser Permanente
Professor, Department of Psychiatry
University of California, San Francisco

SU Impact on Healthcare Costs

Kaiser Permanente Northern California

- Analysis of the medical conditions and costs of family members of individuals with SU conditions using historical data
- Pre-treatment, families of all SU patients have higher medical costs than control families
- Adult family members have significantly higher prevalence of 12 medical conditions compared with control group; child family members have significantly higher prevalence of 9 medical conditions
- At 2-5 years post-intake for SU services, if family member w/SU condition were abstinent at 1 year, family members had similar average PMPM medical costs as control group
- Family members of SU patients who were not abstinent at 1 year had a trajectory of increasing medical cost relative to control group

BHC Staff Skills Needed in Q I and Q III Primary Care

- Can be any licensed practitioner--training, orientation and skills are the key
- Finely honed clinical assessment skills (both MH and SU)
- Cognitive behavioral intervention skills
- Group and educational intervention skills
- Consultation skills
- Communication skills
- Psychopharmacology and Behavioral Medicine knowledge base
- Flexible, independent and action/urgency orientation
- Solution rather than process orientation

BH Staff Skills Needed in Q I and Q III Primary Care

- Prevention orientation
- Team and collaboration orientation
- Clinical protocols and pathways orientation
- Focus on impacting functioning, not personality
- Experience with the SMI population and how the public MH/SU system works
- Understanding of the impact of stigma
- Strong organizational and computer competency
- Bilingual and culturally competency in serving the major population groups seen in the primary care clinic

Freeman, Cherokee Health Systems

Wilson, Swope Health Services

Mauer, National Council/MCPP Healthcare Consulting

The Person-Centered Healthcare Home: Q I and III

Q I

- PCP (with standard screening tools and MH/SU practice guidelines [e.g. for medication-assisted therapy])
- PCP-based BHC/care manager (MH and SU competent)
- Specialty prescribing consultation
- Wellness programming
- Crisis/ED based MH/SU interventions
- Other community supports

Q III

- PCP (with screening tools/guidelines)
- PCP-based BHC/care manager (MH and SU competent)
- Specialty medical/surgical-based BHC/care manager
- Specialty prescribing consultation
- ED based MH/SU interventions
- Medical/surgical inpatient
- Nursing home/home based care
- Wellness programming
- Other community supports

Focus: Quadrants II and IV

Morbidity and Mortality in People with Serious Mental Illnesses

- Persons with serious mental illness (SMI) are dying at the average age of 53 (comparable to Sub-Saharan Africa)
- While suicide and injury account for about 30-40% of excess mortality, 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases (NASMHPD, 2006)
- OR state study found that those with co-occurring MH/SU disorders were at greatest risk (average age of death=45.1 years)

CATIE Study

Comparison of Metabolic Syndrome and Individual Criterion Prevalence in Fasting SMI Subjects and Matched General Population Subjects

	Males		Females	
	SMI N=509	Gen.Pop. N=509	SMI N=180	Gen.Pop. N=180
Metabolic Syndrome Prevalence	36.0%	19.7%	51.6%	25.1%
Waist Circumference Criterion	35.5%	24.8%	76.3%	57.0%
Triglyceride Criterion	50.7%	32.1%	42.3%	19.6%
HDL Criterion	48.9%	31.9%	63.3%	36.3%
BP Criterion	47.2%	31.1%	46.9%	26.8%
Glucose Criterion	14.1%	14.2%	21.7%	11.2%

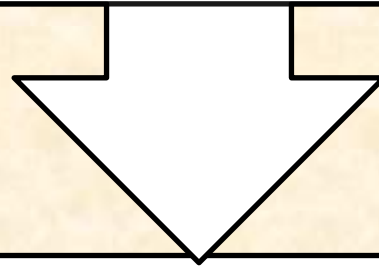
CATIE source for SMI data
NHANESIII source for general population data
Meyer et al., Presented at APA annual meeting, May 21-26, 2005.
McEvoy JP et al. *Schizophr Res.* 2005; (August 29).

At CATIE baseline:

88% of subjects who
had dyslipidemia

62.4% of subjects
who had
hypertension

30.2% of subjects
who had diabetes



**WERE NOT RECEIVING TREATMENT
FOR THESE CONDITIONS**

Kaiser: Primary Care in SU Program

- Kaiser tracked a subgroup of patients with Substance Abuse-Related Medical Conditions (SAMCs)
- SAMC integrated care patients had significantly higher abstinence rates than SAMC independent care patients
- SAMC integrated care patients demonstrated a significant decrease in inpatient rates and average medical costs (excluding addiction treatment) decreased from \$470.39 pmpm to \$226.86 pmpm

Depression, injury and poisonings/overdoses, anxiety and nervous disorders, hypertension, asthma, psychoses, acid-peptic disorders, ischemic heart disease, pneumonia, chronic obstructive pulmonary disease, cirrhosis, hepatitis C, disease of the pancreas, alcoholic gastritis, toxic effects of alcohol, alcoholic neuropathy, alcoholic cardiomyopathy, excess blood alcohol level, and prenatal alcohol and drug dependence

Bi-directional Primary Care/MH/SU Services

- Many individuals served in specialty MH/SU have no PCP
- Health evaluation and linkage to healthcare can improve MH/SU status
- On-site services are stronger than referral to services
- Housing First settings can wrap-around MH, SU and primary care by mobile teams
- Person-centered healthcare homes can be developed through partnerships between MH/SU providers and primary care providers
- Care management is a part of MH/SU specialty treatment and the healthcare home (and is different than case management)

The Person-Centered Healthcare Home: Partnership

- Assure regular screening and registry tracking/outcome measurement for all MH /SU consumers
- Locate medical NPs/PCPs in MH/SU settings—provide routine primary care services in the MH/SU setting via staff out-stationed under the auspices of a full scope person-centered healthcare home MH/SU organization hiring a nurse practitioner directly, without the backup of a skilled PCP and a full scope healthcare home cannot be described as providing a healthcare home, and is not a recommended pathway
- Identify a primary care supervising physician within the full scope healthcare home to provide consultation on complex health issues
- Assign nurse care managers to support individuals with elevated levels of glucose, lipids, blood pressure, and/or chronic medical conditions
- Use evidence-based preventive care practices, adapting these practices for use in the MH/SU system
- Create wellness programs that use peer counselors

The Person-Centered Healthcare Home: Q II and IV

Q II

- Out-stationed medical NP/PCP
- MH/SU clinician/case manager w/ responsibility for coordination w/ PCP
- Specialty outpatient MH/SU treatment including medication-assisted therapy
- Residential MH/SU treatment
- Crisis/ED based MH/SU interventions
- Detox/sobering
- Wellness programming
- Other community supports

Q IV

- Out-stationed medical NP/PCP
- Nurse care manager at MH/SU site
- MH/SU clinician/case manager
- External care manager
- Specialty medical/surgical
- Specialty outpatient MH/SU treatment
- Residential MH/SU treatment
- Detox/sobering
- Crisis/ED based MU/SU interventions
- Medical/surgical inpatient
- Nursing home/home based care
- Wellness programming
- Other community supports

All Healthcare is Local



California Primary Care, Mental Health, and Substance Use Services Integration Policy Initiative

The IPI Continuum:

A Collaborative MH/SU/Primary Care Continuum for the Safety Net Population¹

(This Continuum details the vertical MH/SU axis of the 4Q Model and does not attempt to span the horizontal axis, which considers the range of general healthcare services from prevention/health promotion to specialty medical/surgical and inpatient services. The supportive services and systems in the community are also not detailed here, however it is anticipated that development of a locally specific IPI Continuum would describe these as a part of defining seamless services.)

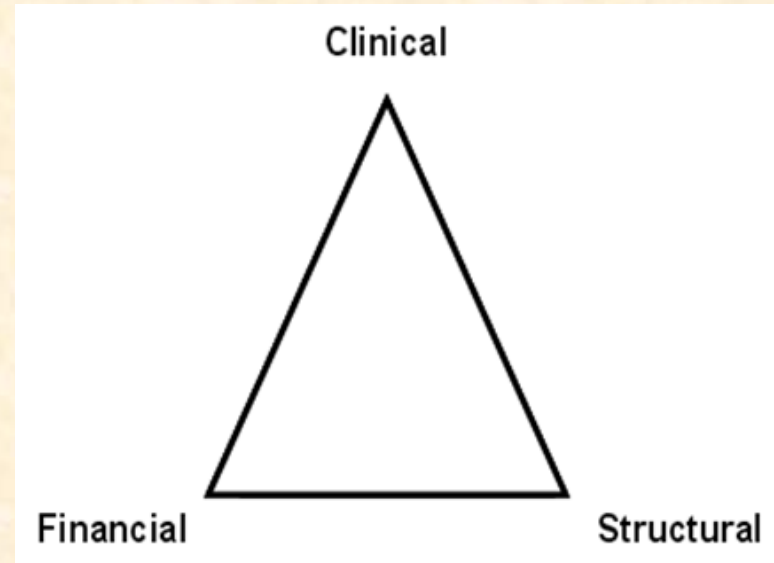
	Mild MH/SU Complexity	Moderate MH/SU Complexity	Serious MH/SU Complexity	Severe MH/SU Complexity
Characteristics of the population with MH/SU needs to be served in each level—for all ages (children, youth, adults, older adults)	<ul style="list-style-type: none"> No comorbidities Family/community supports OR Need for health behavior change related to medical presentation (e.g., sleep disorder, pain), chronic medical conditions (e.g., cardiovascular, diabetes), developmental/parenting concern 	<ul style="list-style-type: none"> Medical comorbidity, including pain, or MH/SU comorbidity, and/or Isolated or chaotic family/community environment 	<ul style="list-style-type: none"> Multiple, complex medical, MH/SU comorbidities, and/or Isolated or chaotic family/community environment, and/or Previous treatment ineffective 	<ul style="list-style-type: none"> Adults 18 years and over, with a severe and/or persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment, but for whom long-term 24-hour care in a hospital, nursing home, or protective facility is unnecessary or inappropriate (NIMH). (<i>In CA, referred to as Serious and Persistent</i>)
	<ul style="list-style-type: none"> Standardized assessment tool¹² indicates mild to moderate symptoms or developmental concern 	<ul style="list-style-type: none"> Standardized assessment tool¹² indicates moderate to severe symptoms and their impact on functioning 	<ul style="list-style-type: none"> Standardized assessment tool¹² indicates severe symptoms and their impact on functioning 	<ul style="list-style-type: none"> Individuals with SU disorders that require ASAM Level III or IV services
	<ul style="list-style-type: none"> Diagnostic examples include V-codes, mild depression, mild anxiety, sleep disorder, somatic disorder, SU disorder 	<ul style="list-style-type: none"> Diagnostic examples include moderate depression, moderate anxiety (including PTSD), sleep disorder, somatic disorder, SU disorder (abuse) 	<ul style="list-style-type: none"> Diagnostic examples include severe depression, severe anxiety (including PTSD), schizophrenia, bipolar disorder, schizoaffective disorder, personality disorders, SU disorder (abuse/dependence) 	<ul style="list-style-type: none"> Diagnostic examples include schizophrenia, schizoaffective disorder, bipolar disorder, SU disorder (abuse/dependence)

California IPI Continuum

- Characteristics of the population with MH/SU needs to be served in each level (mild, moderate, serious, severe MH/SU complexity)
- Estimated population needing MH/SU services
- Healthcare Home physical health services to be made available
- Optimal MH/SU services for each MH/SU level
- Examples of evidence-based/effective MH/SU interventions
- MH/SU measurement of process, capacity and/or outcome measures (with individual and population examples)

Financing Integrated Care: Paradigms

- Integrated care should be grounded in a **Clinical Design** and address the **Financial and Management Structures** needed to support the Clinical Design
 - Clinical integration focuses what people what services look like “on the ground”
 - Financial (all the money in the same pot) or structural (all the services under the same organization and/or in the same building) integration does not assure clinical integration
 - BUT clinical integration requires financial and structural supports in order to be successful



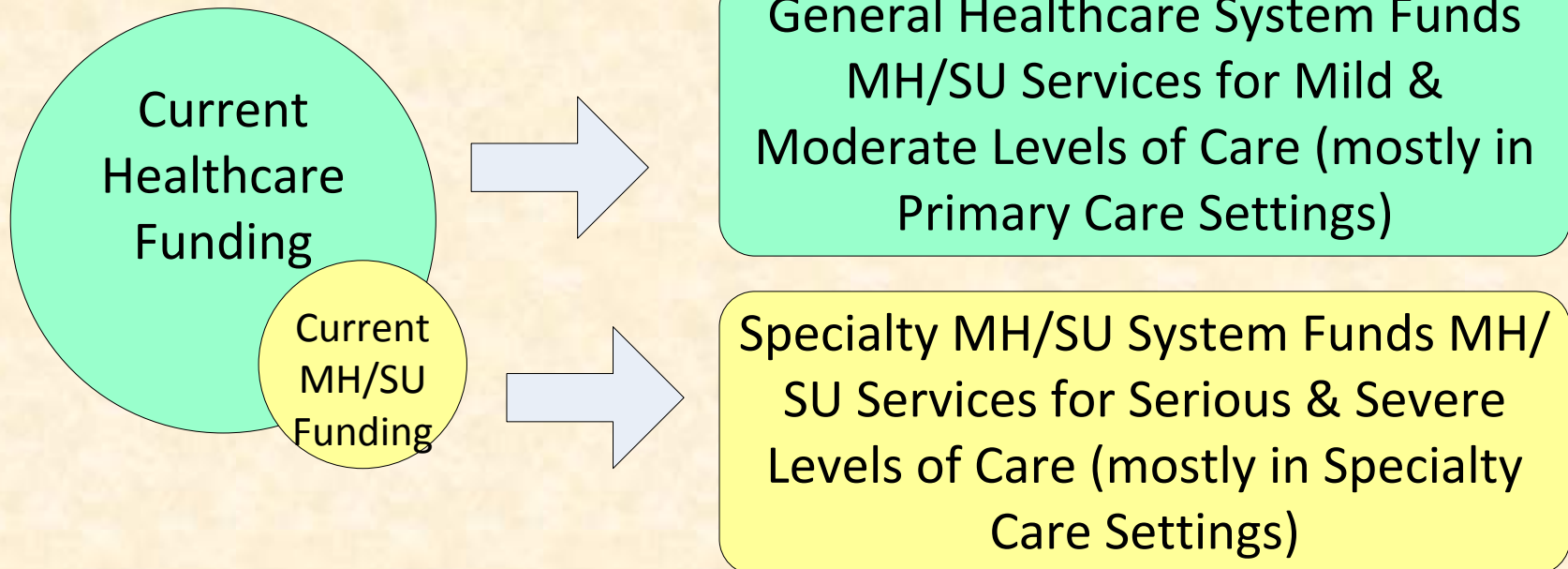
Financing Integrated Care: Paradigms

- We need a **new paradigm**—none of the old models (Carve-in or Carve-out) work for implementing bidirectional integrated care for the whole population
- Lessons from the “field”:
 - Medical Home Pilots— **case rate in addition to FFS**, to cover prevention, care management of chronic medical conditions (why not build the BHC in PC role into the case rate?)
 - MN—financing the DIAMOND **case rate (for BH in PC) out of the healthcare side** (rather than the mental health side) believing that cost and quality improvements will be there
 - WA General Assistance project—explicit stepped care model that finances both Level 1 (primary care) and Level 2 (specialty) MH/SU benefits; dedicated financing for Levels 1 and 2; **neither draw on dedicated mental health funding**
 - CA Mental Health Services Act—earmarked funding source for MH that has a component specifically allocated for prevention and **early intervention outside of the public mental health system**
 - Washtenaw Co, MI—global budget for Medicaid population; **local consolidation** of medical and behavioral health funding streams

Financing Integrated Care: Paradigms

- Parity will be a requirement for most health plans in the new healthcare reform legislation and a broader behavioral health benefit will be available for most people with coverage, and ...
- Drawing on the California Integration Policy Initiative framework of Mild, Moderate, Serious and Severe Levels of Care, and ...

Untangling the MH/SU Funding



Contact Information:

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Behavioral Health/Primary Care Integration and The Person-Centered Healthcare Home, April 2009, The National Council.

Substance Use Disorders and the Person-Centered Healthcare Home, March 2010, The National Council.

http://www.thenationalcouncil.org/cs/resources_services/resource_center_for_healthcare_collaboration/clinical/personcentered_healthcare_homes

California Primary Care, Mental Health, and Substance Use Services Integration Policy Initiative. Vols. I, II, and III. September 14, 2009.

The Business Case for Bidirectional Integrated Care: Mental Health and Substance Use Services in Primary Care Settings and Primary Care Services in Specialty Mental Health and Substance Use Settings. June 30, 2010.

<http://www.cimh.org/Initiatives/Primary-Care-BH-Integration.aspx>

Oregon Standards and Measures for Patient Centered Primary Care Homes.

February 2010. Office for Oregon Health Policy and Research.

http://courts.oregon.gov/OHPPR/HEALTHREFORM/PCPCH/docs/FinalReport_PCPCH.pdf

***Primary Care and Behavioral Health
Services Integration at the
Lynn Community Health Center***

**Safety Net Medical Home Initiative
November 17, 2010**

Lori Abrams Berry MSW MPH,
Executive Director

Mark Alexakos MD, MPP,
Director, Behavioral Health Services



Lynn Community Health Center:

Integration of Behavioral Health and Primary Care

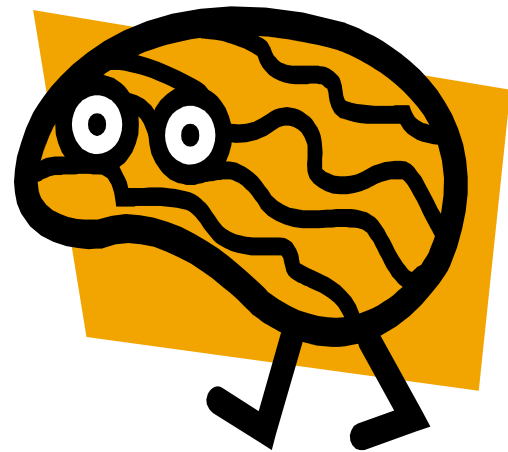
- History
- Initiatives
- Challenges



History

- Lynn CHC opened in 1971 as the Lynn Counseling Center in a storefront, providing mental health services in an exceptionally needy community. This was the highest priority need identified by the Model Cities sponsored planning process.
- Primary Care Services were added in 1976.

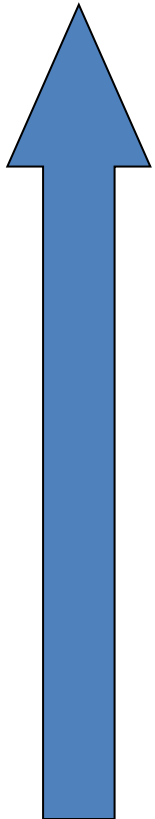
Primary Care Or Behavioral Health?



More
Integrated

Integrated Teams

- Suboxone Program
 - Integrated BH/Primary Care/Substance Abuse team
- School Based Health Centers
 - Integrated BH and Primary Care Team
- Cambodian Program in Refugee Trauma
 - Integrated Multi-Service Team
- HIV Team
 - Integrated Multi-Service Team
- Walk In
 - Nested BH Response Team
- Medical Teams
 - Connected Liaison/Health Psychology teams



School Based Health Centers

- Two years of intensive shared training/supervision
- Integrated Teams
 - Medical NP's, Psychiatric NP's, BH Therapists
- Co-located
 - Work in same space, share resources
- Co-Manage Cases
- Curb Side Communication
- Scheduled Meetings/Supervision

Other Initiatives

- **Clinical Pharmacy Services**
 - Clinical pharmacists integrated into Medical and BH teams
 - Serve as communication link between providers for complex cases
 - Monitor patient medication lists to avoid Adverse Events
- **Metabolic Syndrome Screening**
 - Screening of all patients on atypical antipsychotic by BH providers
 - Building toward a coordinated approach to patients at risk
- **Electronic Health Record system**
 - Used by all disciplines, BH notes not separated
 - Single Problem List
 - Single Medication List and Medication Module
 - Providers can communicate through EHR about patient care needs
- **Shared Chart Summary Template**
 - Summary information seen by all providers
 - SF-36 outcome measure results added so providers can track progress

SF 36 Template

NextGen EMR: PATIENT ZTEST - [05/24/2010 02:29 PM : "LC BH SF36" <Read-only>]

File Edit Default View Tools Utilities Window Help

Exit Save Clear Delete Med Family 269 Union St RYAN, MARCIE PA-C Patient History Inbox Apps Close

BH Short Form 36

1. In general, would you say your health is:

Excellent Very Good Good Fair Poor

2. Compared to one year ago, how would you rate your health in general now?

Much better than a year ago Somewhat better than a year ago About the same
 Somewhat worse than a year ago Much worse than a year ago

The following items are about activities you might do during a typical day. Does your health now limit you in these activities, if so how much

	Yes, Limited a Lot	Yes, Limited a Little	No, Not Limited at All
3. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Lifting or carrying groceries	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Climbing several flights of stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Climbing one flight of stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Bending, kneeling, or stooping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Walking more than a mile	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Walking several blocks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Walking one block	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Bathing or dressing yourself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	No
13. Cut down the amount of time you spent on work or other activities	<input type="radio"/>	<input type="radio"/>
14. Accomplished less than you would like	<input type="radio"/>	<input type="radio"/>
15. Were limited in the kind of work or other activities	<input type="radio"/>	<input type="radio"/>
16. Had difficulty performing the work or other activities (for example, it took extra effort)	<input type="radio"/>	<input type="radio"/>

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any...

New Lock

- OB Medical Summary (LC)
- OB Prenatal Details (LC)
- OB Gestational Age (LC)
- OB_Master
- OB_Prenatal_Record
- 5/24/10 14:29 RYAN, M Med Family 269 Union St
 - LC BH SF36
- 5/21/10 14:21 RYAN, M Med Family 269 Union St
 - LC BH SF36
 - Patient Comments
- 5/20/10 14:46 SMIKLE, Y Med 280 Union
 - Assessment
 - Diagnostics LC77
 - Master Im LC77
 - Referral Orders LC77
 - Order Management

Custom ...

Track 7
Unknown Artist
Unknown Album (11/9/2010)

Ready

Start | Inbox - Micr... | Crystal Repo... | 2 Microsoft... | Organizer - ... | NextGen E... | SF36 Printsc... | Search Desktop | 8:53 AM

Other Initiatives

- **Diabetic Teaching Groups**
 - Include Nurse Educators, Community Health Workers, and BH providers
- **Depression Screening – PHQ9**
 - Patients diagnosed with depression and treated in BH have lower average HgA1c
- **Program in Refugee Trauma**
 - Torture and Trauma survivors have poor medical outcomes
 - Health groups combined with community outreach to address disparities

What Has Worked

- Stronger treatment alliances formed
- Services more seamless
- Co-management of patients
 - Monitor for medication side effects
 - Care planning for co-occurring medical and BH problems
 - Consistent communication with patient
 - Example: patient with ADHD and hypertension
- Multi-disciplinary input on care plan
- Better stress management within care team
- Better care outcomes?

Problems

- Who's on first?
 - Who is supposed to show up where and do what?
- Who is in charge?
 - Some friction in working toward collaborative team effort
- Why do you do it like that?
 - Different treatment and administrative protocols in BH
- Why wasn't I included?
 - Problems in bidirectional communication in protocol development, job tasks, planning of services and space

Challenges

- Space

- Not always suitable co-location
- Space not planned from start for co-location
- State licensure requirements make this even more difficult
- Conflicts over priority use

- Reimbursement Structure

- Lack of parity for rates for BH services across insurances
- The FQHC payment does not apply to BH
- Some patients can't be seen on same day
- Different billing protocol for BH carve outs
- Co-pays and deductibles is a barrier for SMI and SA patients

Challenges

- Culture of primary care sites is not welcoming for SMI patients
- Training PCP's/Team members to achieve a comfort level in treating SMI and SA patients
- Training administrative support staff in BH protocols