**Rapid Fire Workshop: Behavioral Health Integration**

*Moderated by Mara Laderman, MSPH*

*Institute for Healthcare Improvement*

**Monday, March 10**

1:30 PM – 2:45 PM

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**Session Agenda**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>1:30 – 1:35</td>
<td>Introduction by Mara Laderman</td>
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<td>1:35 – 1:50</td>
<td><strong>Rachael Bowers</strong> Dimock Community Health Center</td>
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<td>1:50 – 2:05</td>
<td><strong>Chase Gray</strong> HealthTeamWorks</td>
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<td>2:05 – 2:20</td>
<td><strong>Laurel Simmons</strong> CSI Solutions</td>
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<td>2:20 – 2:35</td>
<td><strong>Benjamin Miller</strong> University of Colorado - Denver</td>
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<td>2:35 – 2:45</td>
<td>Final questions and wrap up</td>
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RFA

These presenters have nothing to disclose.
Rapid Fire Guidelines

- Each presentation will last ten minutes. There will be a hard stop at ten minutes.
- Each ten minute presentation will be followed by five minutes of Q&A facilitated by the moderator.
- To ask a question, please raise your hand and wait for the microphone to begin speaking.

Framing Questions

- Reflect on three challenges that you face in integrating behavioral health and primary care.
- Listen during presentations for how you might address those challenges.
- Ask questions and participate!
- At end of session: email yourself one actionable idea you can try to accelerate your organization’s integration of behavioral health and primary care.
THE NUTS AND BOLTS OF BEHAVIORAL HEALTH INTEGRATION
Rachael Bowers, LICSW
Nandini Sengupta, MD
Holly Oh, MD

WHY INTEGRATE???

- Barriers to Access Behavioral Health Services
- Financial Concerns
- July 2011: Launch Behavioral Health Pediatric Integrated Program (BHPIP)
- January 2012: Complete integration of all Pediatric BH Services into BHPIP
Our Model – Who We Are

<table>
<thead>
<tr>
<th>5 Primary Care Providers</th>
<th>1 Pediatric Social Worker</th>
<th>3 Licensed Behavioral Health Clinicians</th>
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3,000 Patients

Our Model – What We Do

- Individual and Family Therapy
- Psychiatry (weekly)
- School-Based Behavioral Health Services
- Consultation to PCPs during medical appointments
OUR MODEL – HOW WE DO IT

- Strong Clinic Leadership Commitment to Integrate
- Co-location
- Warm Hand Off
- Pediatric Social Worker
- Shared EMR
- Shared Administrative Staff
- Primary Care Behavioral Health Consultation Training
- Creative Access to Child Psychiatry Services
OUTCOMES I - ACCESS

- Referrals to BH increased from 18% to 63%
  - Pre-integration Pedi patients were not prioritized
- Wait time for Services reduced to 1-2 weeks
- Why refer to other agencies?
  - 1. Language Needs
  - 2. Preference for School Based Services at a School Dimock does not serve
  - 3. Preference for Home-Based Services
  - 4. Distance

OUTCOMES II - QUALITY OF CARE

COMPLIANCE WITH INTAKE: 67%
- Rough estimate of compliance pre-integration: ~30%
- School Based Services not included
OUTCOMES III – FINANCIAL SUSTAINABILITY

- Cost Neutral by the end of second Fiscal Year
- More streamlined/efficient use of Employee Time

OUTCOMES IV - MORALE

1. Mutual Respect of Providers’ Disciplines
2. Frequency and Quality of Communication
   - Leading to better understanding of patients (both MD and BH) and better compliance and tracking of patients within BH services
3. Improved Access to Services and Access to Information about Treatment (for MD)
4. Role of SW to facilitate the process from both MD and BH perspectives
5. Feeling of support and efficacy in role (BH)
Bridging a Divide: 
Behavioral and Primary Care

Chase Gray, RN
Regional Director

HealthTeamWorks Experience

- Technical assistance/experience in PCMH, IHH, ACO
- Support clients in achieving the Triple AIM
- Convening, coaching or coach training for:
  - Bi-directional integration of behavioral health initiatives
    - Medicaid Waiver (IHH) and Integrated Care
  - Multi-state Multi-payer PCMH Pilot
  - PCMH Residency program
  - PCMH Foundations
  - Colorado Beacon Consortium
  - NCQA Recognition

  Have trained over 500 practices, 3000 providers, several systems, impacting well over 3 million patients!
Coaching Methodology

Direct Coaching
• Carry a caseload of 8-10 centers
• Attend QI meetings on site 2x per month
• Support goals/objectives each quarter
• Provide didactic learning and tools to reach implementation goals set by initiative/centers

Collaborative Coaching
• All items above are accomplished by HealthTeamWorks mentoring personnel hired by client/system
• Sustainability for ongoing capacity building within a system/community

Guiding Tools
• SAMHSA/HRSA Standard Framework for Levels of Integrated Healthcare
• HealthTeamWorks assessment and implementation tools
• On-going coaching support to reach initiative level and individual center goals
• Different coaching approaches apply:
  • Medical services into CMHC
  • BH services into primary care
Building a Solid Infrastructure
Fundamentals for Transforming

- Practice Viability & Efficiency QI
- Care Mgmt, Coordination & Communication
- Leadership & Team Based Care
- Technology & Outcomes Reporting
- Patient Engagement & Access

Transformation Fundamentals

Building an Integrated Health Home
Fundamentals for Transforming

- Training New Staff/New Roles
- Innovation vs. Regulation
- Marketing & PR for IHH to Clients/Families
- Infrastructure & Logistics
- Creating New Cultures

Integration Fundamentals
### Common Cultural Integration Barriers

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<thead>
<tr>
<th>Barriers</th>
<th>Solutions</th>
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<td>• Logistics of co-location/coordinated care</td>
<td>• Short-term and long-term strategic planning (space to work)</td>
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<td>• Engagement staff/providers</td>
<td>• On-going value &amp; role definitions</td>
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<td>• Different language – different approaches</td>
<td>• Conversations – relationship building</td>
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<td>• Turf issues</td>
<td>• Shared vision and mission</td>
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<td>• Fear/lack of understanding of each others’ specialty areas</td>
<td>• Cross training opportunities, backing each other up, hand-offs</td>
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<td>• Misaligned incentives</td>
<td>• Use parity laws/other incentives to evolve to higher levels of integration</td>
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<tr>
<td>• Release of information/HIPAA issues – reality vs perception?</td>
<td>• Clarify regulations; ensure awareness across settings; develop processes accordingly</td>
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### Magellan: Iowa Integrated Health Home

**HealthTeamWorks: Coaching/Transformation**

- **Start Date:** April 2013
- **Clinical Quality Measures**
  - HWQ
  - BMI
  - A1Cs-DM patients
  - Medication Management
  - ADHD
  - Schizophrenia

- **SPMI/SED with chronic disease**
  - Adults/Pediatric
- **Phase I:** 6 CMHC-5 Counties
  - ~7000 enrolled
- **Phase 2:** 9 CMHC-27 Counties
  - ~21,000 enrolled
- **Phase 3:** TBD (67 Counties)
Magellan Iowa Integrated Health Home
Preliminary Results: ER Visits

Average per Month: Phase I

Magellan Iowa Integrated Health Home
Preliminary Results: Psychiatric Hospitalizations

Average per Month: Phase I
QUESTIONS?

www.healthteamworks.org
720-297-1681
Background

CSI Solutions
- Laurel Simmons, lsimmons@spreadinnovation.com, www.spreadinnovation.com
- CSI Solutions is a healthcare consulting firm that partners with clients for healthcare transformation. CSI offers strategic, improvement and technology expertise.

Missouri Medical Home Collaborative (MMHC)
- October 2011 – September 2013; 78 teams, 35,000+ Medicaid recipients assigned to either PCP or CMHC
- Approach: SPAs, Collaborative combining both PCs and CMHCs, nine outcome and process measures
- Results: significant gains in outcomes for CMHCs; significant gains in most process measures for PCPs

Overview

This presentation aims to convince you that effective Behavioral Health integration also involves improving partnerships between primary care (PC) providers and neighboring behavioral health (BH) providers to the benefit of patients that receive care from both.

- We learned in Missouri that improving the relationship between PC and BH providers is extremely important in addressing the needs of a particularly vulnerable, high-risk, high-utilizing group of people.
- I’ll outline a sequence of steps that helped in Missouri.
Integrating Behavioral Health in the MMHC

- All PC providers in the MMHC added (or already had) BH staff. New staff received training from SLBMI.
- But not all people can receive all the needed BH care from the PC provider’s BH professionals
  - Many people with SMI may still need referral (6% of population have SMI, of which 45% have 2+ BH disorders)
  - Quality of referrals/transitions needed improving . . . a lot of it
- So PC providers in Missouri also improved partnerships with neighboring BH providers (CMHCs)

Access Family Care
The Problem

- Lack of knowledge of what the other does
  - Language, treatment, processes, info systems
- Frustration
  - Knowing how and when to refer
  - Receiving back timely, accurate information
- Conflicting care plans, medication lists, duplicated tests
  - 100% of shared patients had different medication lists
  - A lot of duplicated tests
- Patient/Consumer perspective: confusion, difficulty with access, problems in care

The Solution: Setting Out to Form a New Relationship

- First step: start with an informal conversation.
  - “You know, there’s some people we both care for. We’re trying to provide more coordinated care. We think we could do better for these people if we coordinated with you more effectively. Could we get together and just chat? No, we don’t have to share HIPPA-protected info. Let’s just learn more about each other. If we agree to do more, we can talk about how to set things up.”
- Who starts the conversation?
- Talk about what’s working, what’s not, how to make it better.
The Solution: What the Leaders Need to Do

Next step: develop a Memo of Understanding.
- Address HIPPA and consent concerns

The Partnership and Benefits: Shared Solutions that Help

- Medication reconciliation
- Sharing information to reduce duplication and improve care
- Shared Care plans
- Training across the organizations
  - Example: training CMHC case workers in the signs/symptoms of diabetes exacerbation
  - One CMHC team gave case workers blood pressure cuffs
- Shared training resources
Summary

The existing relationship may not be serving your patients with SMI well. It may be worse than you know.

Better relationships can help patients a lot. They help the BH provider a lot. And they can help you too.

- Start with a conversation \( \rightarrow \) then involve senior leaders \( \rightarrow \) then review shared patients \( \rightarrow \) then develop shared care plans, protocols, joint training, etc.
- Give it time. There is a cultural gulf to cross.
- Focus on the patient rather than the organizations.

The future is integrated

Benjamin F. Miller (@miller7)
University of Colorado School of Medicine
Department of Family Medicine
A statement

Mental health and primary care are inseparable; any attempts to separate the two leads to inferior care

- IOM, 1996

Working Assumptions

Definition of Integration:
The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, ineffective patterns of health care utilization.

Value of Integration:
Physical/Behavioral Integration is good health policy and good for health.
The model?

Primary Care

- Social Work
- Psychiatrist
- Psychologist
- Sub-specialty Service
- MA, RN
- NP, PA

Mental and Physical Health Multimorbidity Coordination of mental and physical health treatment plans

Severe Mental Illness and/or Substance Abuse

Full coordination with specialty care

Example Targeted Service Response

- Mental Health Presentation
  - Medical issues with psychosocial barriers to care
  - Medical issues requiring behavioral or psychological intervention
  - Mental Health and Substance Use Presentations
  - Mental and Physical Health Multimorbidity
  - Severe Mental Illness and/or Substance Abuse

- Psychosocial Support Services
  - Behavior Change Education & Evidence-Based Treatments
  - Mental health treatment plan
  - Coordination of mental and physical health treatment plans
  - Full coordination with specialty care


Advancing Care Together

www.advancingcaretogether.org

**Workflow and Access to Care**

**Leadership and Culture Change**

**Tracking Patients and Using Data**
Resources

• One stop: http://integrationacademy.ahrq.gov/
• Case study: http://www.advancingcaretogether.org/
• Webinars: http://www.youtube.com/CUDFMPolicyChannel
• State example: http://coloradosim.org/

• Benjamin.miller@ucdenver.edu