Behavioral Health Integration: A Key Step towards the Triple Aim

Cindy Hupke, RN, BS, MBA
Robin Henderson, PsyD
Brenda Reiss Brennan, PhD, APRN

March 17, 2015
11:00 AM - 12:15 PM
Session Objectives

- Describe how behavioral health integration contributes to the Triple Aim.
- Understand how to apply collaborative care principles to integrate behavioral health and primary care.
- Identify the key steps to implementing integrated behavioral health care.
- Develop strategies to overcome the common challenges and barriers to integrated care.
Today’s Agenda

- Making the case: Integration and the Triple Aim
- IHI’s work on behavioral health integration
- Case Study:
  - St. Charles Health System
  - Intermountain Health Care
Our Faculty Today

Robin Henderson, PsyD

Brenda Reiss Brennan, PhD, APRN
Today’s Agenda

- Making the case: Integration and the Triple Aim
- IHI’s work on behavioral health integration
- Case Study:
  - St. Charles Health System
  - Intermountain Health Care
Behavioral health conditions are prevalent among adults in the U.S.

Percent of U.S. Adults Meeting Diagnostic Behavioral Health Criteria, 2007

- Anxiety Disorder: 19% (11% within past 12 months, 31% ever in lifetime)
- Mood Disorder: 10% (11% within past 12 months, 21% ever in lifetime)
- Impulse-control Disorder: 11% (25% ever in lifetime)
- Substance Disorder: 13% (35% ever in lifetime)
- Any Disorder: 32% (57% ever in lifetime)

The health care system’s capacity to deliver mental health services has been shrinking.

Chart 5: Total Number of Psychiatric Units\(^{(1)}\) in U.S. Hospitals and Total Number of Freestanding Psychiatric Hospitals\(^{(2)}\) in U.S., 1995-2010

The presence of a mental health disorder raises treatment costs for chronic medical conditions.

### Monthly Health Care Expenditures for Chronic Conditions, with and without Comorbid Depression, 2005

<table>
<thead>
<tr>
<th></th>
<th>Without Depression</th>
<th>With Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health</strong></td>
<td><strong>$20</strong></td>
<td><strong>$130</strong></td>
</tr>
<tr>
<td><strong>Medical</strong></td>
<td><strong>$840</strong></td>
<td><strong>$1,290</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$860</strong></td>
<td><strong>$1,420</strong></td>
</tr>
</tbody>
</table>

The Need for Integrated Care

Percentage of Adults with Mental Health Conditions and/or Medical Conditions, 2001-2003

- 29% of Adults with Medical Conditions Also Have Mental Health Conditions
- 68% of Adults with Mental Health Conditions Also Have Medical Conditions

AHRQ Lexicon….the “What”

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.
AHRQ Lexicon….the “How”

✓ A practice team tailored to the needs of each patient and situation

✓ With a shared population and mission

✓ Using a systematic clinical approach (and a system that enables the clinical approach to function)
Integration is simply good care

**Improved experience of care**
- Team-based, collaborative care is associated with safety, timeliness, efficiency, effectiveness, and is person centered

**Better health of the population**
- More reliable chronic disease prevention and management results in improved medical and behavioral health outcomes.
- Overall health and functional status improves.

**Lower per capita costs**
- Decrease unnecessary utilization of specialty care and ED.
- Typical cost savings estimates of integrated BH care range from 5 to 10% of total health care costs over a two to four year period.
- Milliman (2013) estimates the cost savings of integration could be $26-48 billion!
Today’s Agenda

- Making the case: Integration and the Triple Aim
- IHI’s work on behavioral health integration
- Case Study:
  - St. Charles Health System
  - Intermountain Health Care
Research Project Aims

- Understand the core principles underlying successful approaches to integration of behavioral health services into primary care.

- Develop IHI’s approach to integration.
## Research Methods

- Reviewed peer-reviewed and grey literature and materials from existing models.

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gary Belkin</td>
<td>NYC HHC / NYU</td>
</tr>
<tr>
<td>Benjamin Miller</td>
<td>University of Colorado – Denver</td>
</tr>
<tr>
<td>Mary Rainwater</td>
<td>Integration Consultant, formerly with IBHP</td>
</tr>
<tr>
<td>Laurie Alexander</td>
<td>Integration Consultant, formerly with AIMS Center</td>
</tr>
<tr>
<td>Alexander Blount</td>
<td>UMass Medical Center, Center for Integrated Care</td>
</tr>
<tr>
<td>Parinda Khatri</td>
<td>Cherokee Health Systems</td>
</tr>
<tr>
<td>Jurgen Unutzer</td>
<td>IMPACT / AIMS Center, University of Washington</td>
</tr>
<tr>
<td>Brenda Reiss-Brennan</td>
<td>Intermountain Health Care</td>
</tr>
<tr>
<td>Robin Henderson</td>
<td>St. Charles Health System</td>
</tr>
<tr>
<td>Russell Phillips</td>
<td>Harvard Medical School, Center for Primary Care</td>
</tr>
<tr>
<td>Ileana Welte</td>
<td>Big White Wall</td>
</tr>
<tr>
<td>Brady Cole</td>
<td>U.S. Department of Veteran’s Affairs</td>
</tr>
</tbody>
</table>
Key Research Findings

- Perception is that there are many different ways to implement integration; we found that the commonalities are much greater than the differences.
- Five-step sequence to integrate BH.
- Biggest challenges are business case and operationalizing components into workflows.
- Lack of integration outside of clinic visit.
Five Step Sequence

1. Assess readiness for integration.
2. Develop reliable operations and processes to support integrated care.
3. Develop the business case for integration.
4. Re-design care delivery using collaborative care principles for integration.
5. Operationalize changes into clinical workflows.
IHI Collaborative to Optimize Primary Care Teams to Meet Patients' Medical AND Behavioral Needs

Adapted from the Safety Net Medical Home Initiative Framework
http://www.safetynetmedicalhome.org/change-concepts

Participating organizations will redefine the composition and roles of primary care, building highly functional multidisciplinary teams that are fully equipped to address the physical and behavioral care needs of their population.

- Engaged Leadership
- QI Capacity
- Empaneled Population

Core Measures:
- Customer Experience
- Screening and F/U
- Health
- Team Functionality
- Health Costs

Business Model

- Person & Family Centered Care
- Team Based Relationships
- Integrated BH & PC

Care Coordination
Today’s Agenda

• Making the case: Integration and the Triple Aim

• IHI’s work on behavioral health integration

• Case Study:
  – St. Charles Health System
  – Intermountain Health Care
Our Journey to Integrated Care: Bright Spots, Pitfalls and Hope

Robin Henderson, PsyD
Chief Behavioral Health Officer and Vice President, Strategic Integration
Central Oregon—home to Mt. Bachelor, 48 golf courses, Deschutes River, mountain biking ... and so much more!

250,000 people, one health system, four hospitals (two critical access)

- Level 2 Trauma
- One psych unit/one psych ED

Five PCPCHs, two specialty mental health clinics

14 BHs -- PCPCH, pediatrics, internal medicine, NICU and ....

As CBHO and VP of Strategic Integration, I am part of the system vision -- Creating America’s healthiest community, together -- with our regional partners and the patients and families that we serve.

Ok, now that I’ve adequately plugged my employer ...
Poverty with a view

150 miles north to south

250,000 residents, expected to grow to 300,000 by 2019

Approximately $150m coming into the community through the Coordinated Care Organization

50,000 Medicaid (Oregon Health Plan) beneficiaries in Deschutes, Jefferson, Crook and part of Northern Klamath and Lake counties

More than 50% are children

Top 5% account for most of the spend—primarily complex adults

Global Budget shared with Primary Care—25% risk corridor

Everyone has an incentive to make this work!
Central Oregon Health Council
Vision: the Triple Aim

Creating America’s healthiest community, together.
How’d they do that?
Beginning Initiatives for COHC

Program for the Evaluation of Development and Learning

- Three years of multi-disciplinary assessments on children with special healthcare needs
- Wait list of more than a year

NICU follow up clinic

- Nationally recognized best practice to identify high risk children
- Expanded Behavioral Health Consultants into NICU to reduce length of stay
- First kids are turning four this year

Emergency Department Navigation

- Health Engagement Teams
- 65% reduction in utilization/62% reduction in cost
Primary care: mental health home of the present

Primary Care
• 70% of all primary care visits involve health behaviors
• 85% of all psychotropic medications are prescribed in the primary care home
• 90% of patients referred to Community Mental health do not show up

Community Mental Health
• Serves 5% of population
• Primary focus is severely and persistently mentally ill
• Impact in the global budget: negligible
CCO transformation plan: Nine elements

1. Integrated primary care model
2. Advancing Patient-Centered Primary Care Home
3. Consistent alternative payment methodologies
4. Community Health Assessment and Annual Health Improvement Plan
5. Electronic health records and Health Information Exchange
6. Tailoring communications and services to cultural, health literacy and linguistic needs
7. Diversity and cultural competence
8. Quality improvement plan to reduce health disparities
9. Primary care and public health partnership (COHC only)
All strategies lead to this ...
The truth about integration is that it is not one thing. Any organization thinking about creating an “integrated” care system needs to understand what the philosophies of the organization or agency you work for are, what can you afford and who are your patients.

Reflecting back, our integration preparation was *COMPLETELY LACKING* these factors.
A flawed first trial

- NO daily presence to ensure fidelity
- FEW traditional mental health resources for diversion
- NO provider education in the new model

AND ALL OF THIS EQUALS ...

- Co-located specialty provider model
- Frustrated providers
- Lack of services
What integration preparation takes

• Administrative and provider agreement
• Productivity standards
• Cost (it’s more than just the provider)
• Acceptance of clinic diversities

CULTURE EATS STRATEGY FOR BREAKFAST
Considerations learned the hard way

What is your organization’s philosophy regarding integration?
  • Role of specialty mental health
  • Provider bias toward psychiatry (the “stethoscope syndrome”)

Does your organization speak “whole person or person-centered care?”
  • Have they found the neck yet?

Preconceived notions about integration
  • Anxiety over new/additional providers and their impact on productivity
  • Provider age/generation
  • Clinic response to change
  • Who is the clinic manager and what do they believe?
More things considered ...

Does your organization push out information to the providers about who their patients are?
  • Anecdotal information creates assumptions and well ...
  • Better yet, do you know what your patient mix is?

How do you define success?
  • Quality incentive metrics

Do you have an implementation plan that allows for recognizing fractures and making changes in the moment?
  • Practice facilitation!

Do you have a clear understanding of your model? Are you committed to the fidelity of that model? Where might there be room for flexibility?

Who in your community supports integration?
  • County health services, CCO, competitor clinics
SO WE TRIED AGAIN...
Behavioral health/primary care integration

Current Behavioral Health Consultants in primary care

- Primary Care—4 St. Charles Family Care sites (two open positions)
- FQHCs—3 Mosaic Medical sites (specialty co-location)
- Pediatrics—2 Central Oregon Pediatric Associates sites
- Two Critical Access Hospitals
- Internal Medicine—Bend Memorial Clinic (one open position)

Development of consistent metrics to measure outcomes

- Evaluate efficacy of integrated care models

Global mechanism for payment
Behavioral health consultants in primary care

- Behavioral Health Consultants in Person-Centered Primary Care Homes
  - Increased patient satisfaction
  - Increased provider satisfaction
  - Decreased visits with the primary care provider
  - Initial results show trend reduction in spend

- ADHD medication project
- Chronic pain initiative
- Psychopharmacology consultation
- SBIRT/clinical depression screenings
Psychologist embedded in NICU

- Early identification of NICU follow-up babies
- Early intervention with families
  - Begin training in health engagement from the start
  - Reduce family stressors
- More consistent than other NICU team members
- Advocacy

Early results

- Reduced length of stay
Psychologist consult becomes “House Expert”
Different than a traditional consult/liaison
- Patient mental health needs
- Staff mental health needs
  - Critical Incident Stress Debriefings
  - Organizational Development consultation
- Liaison to community mental health
Behavioral Health Consultant to rural PCPCH
Quality incentive metrics: $3.7 million payoff

- SBIRT screenings
- Screening for clinical depression and follow up
- Poor control of diabetes HbA1c
- Follow up care for ADHD meds
- Ambulatory care utilization in ED and outpatient per 1,000
- Colorectal Cancer Screening
- Adolescent well-care visits
- Developmental screenings during first 36 months
- Timeliness of prenatal and postpartum care
- Mental and physical health evaluation of children in DHS custody
- Elective delivery before 39 weeks
- Controlling High BP
- EHR Meaningful Use adoption
Funded initiatives

• Patient engagement
• Pediatric hospitalists
• Dental care distribution
• Maternal child health
• Pediatric diabetes HET
• Community paramedicine
• CAC small projects
• Clinical pharmacy
• Standardization of Behavioral Health Consultants
Where are we going?

Pediatric obesity
- Intervention with accompanying workbooks, portion plates and pedometers
- Provider/BHC partnership with clinic administration based on DATA

Pain School for patients on chronic narcotic medications
- Dispersed through all our clinics and now going into other community clinics
- Curriculum is free to anyone who wants it

RN care coordinators
- Support health engagement teams
- Complex patient conferences
- Integrate with health system nurse navigators
- EDIE integration

Community Health Workers
- Clinic based
- ED based
- Dental!
Where else are we heading?

Community Paramedicine—partnership with EMS
- Improve our ability to serve patients unable/unwilling to come to clinic.

Co-located psychiatry
- Meet patients where they are
- Care for the 70%

Expansion in the health system
- Cardiac
- Children with special health care needs
  - Pediatric diabetes
  - Pediatric asthma
  - 50% of Medicaid

Other payers
Recommendations going forth

• Don’t assume your degree of integration or what your clinic needs are looks like anyone else's.
  • Assess philosophies and be prepared to engage in dialogue
  • Don’t be rigid unless you absolutely have to
• Determine your individual needs in all areas. What worked for an outpatient clinic may not work for a hospital inpatient unit.
  • What is the commitment your organization is willing to spend on developing and implementing integration

INVOLVE YOUR COMMUNITY!
AHRQ Assessment Tool

- Standard for Behavioral Health and Primary Care Integration
- Level of Integration measure
- Standards and competencies

http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf
Why is integration important?

What Determines Health?

Don Berwick’s charge: The moral test

- Put the patient first
- Among patient’s, put the poor and disadvantaged first—those at the beginning, the end and the shadows of life
- Start at scale—flood the zone
- Return the money
- Act locally

MAKE WHAT IS POSSIBLE REAL

Creating America’s healthiest community, together.
AHRQ Lexicon for Behavioral Health in Primary Care
http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf
http://integrationacademy.ahrq.gov/sites/default/files/measures/5_Level_of_Integration_Measure.pdf
http://integrationacademy.ahrq.gov/sites/default/files/AHRQ_AcadLitReview.pdf

Collaborative Family Healthcare Association
www.cfha.net

St. Charles Health System
www.StCharlesHealthCare.org
Integrating Mind and Body Healing into Medical Care: Normalizing A Team Approach

Brenda Reiss-Brennan, PhD, APRN
Primary Care Clinical Program
Mental Health Integration Director
Highly Integrated Health System

Our Charge: To become a “Model Healthcare System”

Since 1975
- 22 hospitals
- 2,784 licensed beds

Since 1983
- Health plans
- 700,000+ members

Since 1994
- 1,200 employed physicians
- 558 advanced practice clinicians

Since 1997
- 10 key service lines
State Rankings of Healthiness & Value
Compared to Total Health Cost Per Capita Rank

Our efforts are ultimately centered around what matters most to our patients, families, employees members and communities.

**Core Business**
- Perfecting the Clinical Work Process
- Best clinical care in the world doesn’t matter if no one can afford it.
- Always do the right thing!

**The Intermountain Way**
- Improved quality & service
- Evidence-based practice
- Systematic approach - measure & improve

**Culture of Learning**

Success is always led by clinical team but must include operational, financial, governance and patient engagement.
The Intermountain Way

Improved quality & service + Evidence-based practice + Systematic approach, measure & improve

ALWAYS DO THE RIGHT THING!

SUCCESS: Always led by clinical but including operational, financial, and even governance!
1 death every 20 seconds by 2020  (WHO, 2014)
Emma

63 year old who has hip and knee pain, questions about 2 of her 18 meds, “no energy”, has a ten minute appointment at 3:30 pm

Diabetes, Hypertension, MCI, Arthritis, CHF

Exam is unremarkable except for slight low blood sugar

You talk about management of diabetes for a few minutes, answer the med questions, wish them well, stand to leave, and with one hand on the door the husband says

“Um, before you go, we need to ask you about one other thing we are really worried about…”
Emma

Missed 5 days work
Not sleeping, not eating much
Not going out of the house
Cranky

Husband exhausted

Your 3:40 is in a room and waiting, and your 3:50 is here early because they have to pick up a grandchild from soccer practice 20 minutes from now
Usual Care

Option 1: Traditional Usual Care

You obtain some more history (3 min)
Assess suicide risk (3 min) positive
Explore treatment options, insurance, access to care, will the family even follow up…(5 to 25 minutes if you include all staff time)

Staff gives patient drug samples, referral names, husband given number for the ER , Emma is on her own

Your 3:50 yelled at staff and left very upset

Your receptionist has tried to reassure three other patients (4:00, 4:20, 4:30) that the doctor will be in soon (5 to 10 minutes and lots of energy used up)
What Shapes Population Health?

Clinical Integration: Management of Complex Chronic Disease in Primary Care

<table>
<thead>
<tr>
<th>Mental Health Integration Infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes, Asthma, Heart Disease, Depression, Hypertension, Obesity, Chronic Pain, SUD, etc.</strong></td>
</tr>
<tr>
<td>2/3 – cared for routinely in primary care</td>
</tr>
<tr>
<td><strong>Patient &amp; Family, PCP, and Care Manager (CM) as needed</strong></td>
</tr>
</tbody>
</table>

*Primary Care Physician (PCP) includes: General Internist, Family Practitioner, Pediatrician*
IMPROVING OUTCOMES & BENDING THE COST CURVE

Evidence-based Care Process Models
What is Mental Health Integration?

A standardized clinical and operational team process that incorporates mental health as a complementary component of wellness & healing.
Moving to Team-Based Care

Mental Health Integration
Intermountain Primary Care & Specialty Clinics

• Holistic approach to patient’s health
• Best practices in all clinical domains
• Team members work at the “top of their licenses”
• Established routine protocols and system-based care coordination
Primary Care Clinics by Stage of MHI Implementation

Routinized Adoption Potential

Urban Rural Uninsured School Based

Rogers, E. Diffusion of Innovations, 1995—discussion of stages
What does the team score mean?

Planning Score: 25
Adoption Score: 50
Routine Score: 75
# Team performance towards Routinization

## Count of practices by MHI levels (2000-2014)

<table>
<thead>
<tr>
<th>Year</th>
<th>No MHI</th>
<th>Planning</th>
<th>Adoption</th>
<th>Routinized</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>80</td>
<td>77</td>
<td>69</td>
<td>66</td>
</tr>
<tr>
<td>2001</td>
<td>69</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>2002</td>
<td>10</td>
<td>3</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>2003</td>
<td>10</td>
<td>1</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>2004</td>
<td>12</td>
<td>12</td>
<td>33</td>
<td>30</td>
</tr>
<tr>
<td>2005</td>
<td>46</td>
<td>33</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>2006</td>
<td>59</td>
<td>30</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>2007</td>
<td>6</td>
<td>32</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>2008</td>
<td>28</td>
<td>26</td>
<td>25</td>
<td>13</td>
</tr>
<tr>
<td>2009</td>
<td>7</td>
<td>29</td>
<td>24</td>
<td>13</td>
</tr>
<tr>
<td>2010</td>
<td>17</td>
<td>28</td>
<td>18</td>
<td>11</td>
</tr>
<tr>
<td>2011</td>
<td>18</td>
<td>29</td>
<td>27</td>
<td>7</td>
</tr>
<tr>
<td>2012</td>
<td>21</td>
<td>22</td>
<td>21</td>
<td>6</td>
</tr>
<tr>
<td>2013</td>
<td>26</td>
<td>26</td>
<td>26</td>
<td>7</td>
</tr>
<tr>
<td>2014</td>
<td>44</td>
<td>11</td>
<td>18</td>
<td>15</td>
</tr>
</tbody>
</table>

**Planning Score:** 0-20  
**Adoption Score:** 21-40  
**Routine Score:** 41-60
Differences in patient-perceived coordinated team interactions by Mental Health Integration (MHI) clinic phase.
Distribution of patients treated at MHI and non-MHI clinics

By diabetes control and comorbidity

Patient who have depression have their diabetes in better control when treated at an MHI clinic (p < 0.01)
The Quality Challenge

The Right Care

For The Right Person

At The Right Time

Transitioning From Volumes to Value

Social Context Challenge

The Right Community?
The Flow of Information: Team Message Log

Case Identification

- ROUTINE CARE
- PCP + CM
- Responsive Family Support
- GS=1-3
- Mild Complexity

- COLLABORATIVE MHI TEAM
- Complex Co morbidity
- Family Isolated/Chaotic
- GS=4-6
- Moderate Complexity

- MHI
- Psych Co Morbidity
- Family Support
- Burden
- Danger Risk
- GS=6-7
- Severe Complexity

Use of EMR

Team Feedback: MHI dashboard

Registry (EDW) – 1999 to June 2013

Depression registry n = 416,433

- 148,527 currently active (in the last 12 months)

- 70,024 unique patients with phq9 and 53,316 with phq2 for patients in depression registry with a total of 183,175 phq9 and 164,502 phq2

- 106,784 unique patients with phq9 and 153,637 with phq2 for all patients with a total of 234,705 phq9 and 382,048 phq2

- 7.2% of patients not seen in primary care or behavior health

- 67% female
- 48% private insurance
“The circumstances in which people live and work are related to their risk of illness and length of life”

Our focus should be on the conditions for good health
Team-Based Care: More Than Just a Program

“My doctor was the first person to treat me as a whole person…”

Relational Reciprocity
What did your doctor do that was most helpful?

Pearson’s chi squared test and $p$ for trend Chi square $**p < 0.01 \ *p < 0.05$
Effect My Engagement Has On My Doctor

Pearson’s chi squared test and $p$ for trend Chi square $\ast\ast p < 0.01 \ast p < 0.05$
Staff Perceptions of Team Factors that Promote Positive Patient Outcomes

Pearson’s chi squared test and $p$ for trend Chi square $**p < 0.01$ $*p < 0.05$
Mental Health Integration

Option 2: MHI

Obtain more history, explain MHI team (3 min)
Assess suicide risk (3 min)

You agree this is very important and would like to help with it. You give them an MHI packet and instructions to complete it prior to a follow up visit next week (2min)

Emma and husband leave with treatment started and hope

You see your 3:50 at 4:00, apologizing for the delay (she makes it to practice on time)

You send a message to your care manager call this family in 3 days, help with packet and appointment
Common MHI Team Process Steps
Patient & Staff Convergence
Multiple Team Touches

$(p < .001)$
A streamlined implementation process has resulted in exponential growth in MHI clinics (N = 82)
High Performing Team Based Care (TBC) = MHI + PPC

Count of practices by Team Based Care (TBC) levels (2010-2014)
More Effective Utilization of Healthcare Services

Emergency Visits  Hospital Admits  Avoidable Visits and Admissions  Radiology Tests

1  PCP Visits  Urgent Care Visits

An investment of $22 per-member-per year (PMPY) decreased medical expenses by $115 PMPY

-22%  -21%
Patients Are Looked After by a Team of Medical Professionals At Union Square Family Health Center in Somerville, Mass.

**Doctor**
Kirsten Meisinger, supervises the medical team. She also diagnoses patients, performs procedures and prescribes medications.

**Social Worker**
Paula Coutinho assists patients with needs like transportation and financial assistance. She also connects patients to behavioral health services for depression.

**Physician Assistant**
Juliane Liberus handles routine consultations, manages lab results and helps patients with chronic diseases. She is the point person when the doctor isn’t available.

**Pharmacist**
Joseph Falinski advises patients on how to take drugs correctly and possible side effects and interactions. He can adjust dosages and help manage conditions like chronic pain.

**Medical Assistant**
Fabiola Marcelin takes patients’ vital signs and prepares them to see the doctor. A trained phlebotomist, she does blood work and tracks follow-up appointments.

**Registered Nurse**
Amberly Killmer performs triage and directs some routine patient visits like prenatal counseling. She helps patients adopt healthier lifestyles.

“The Doctor’s Team will see you now” WSJ, 2-17-2014
V. National Communities Diffusing MHI Common Set of Value Measures (2014)
Whole Person Centered Care

WHI

1. Culture Leadership
2. Workflow
3. Information System
4. Financing Operations
5. Community Resources

Our Patients and their Families
Thank You

Questions?
AHRQ Lexicon….the “How”

✓ A practice team tailored to the needs of each patient and situation

✓ With a shared population and mission

✓ Using a systematic clinical approach (and a system that enables the clinical approach to function)
Tools and Resources

- AHRQ Integration Academy
- Behavioral Health Integration Capacity Assessment
- SAMHSA-HRSA Center for Integrated Health Solutions
- Milliman Report – Economic Impact of Integrated Medical-Behavioral Healthcare