Innovative Approaches to Integrating Behavioral Health and Primary Care

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Session Objectives
- Describe IHI’s framework for integrating behavioral health and primary care.
- Understand two innovative approaches to overcoming different barriers to integrating behavioral health and primary care.
- Identify new ideas to test at their own organization.

Today’s Agenda
- Overview of IHI’s framework for behavioral health integration.
- Learn about two innovative approaches to integration
- Q&A and Discussion

IHI’s Framework for Integration
Mara Laderman, MSPH
Contributions to premature mortality

What Determines Health?

Behavioral health includes:
- Mental health, e.g. depression, anxiety
- Substance abuse
- Health behaviors, e.g. exercise, healthy eating, medication adherence, stress management

Behavioral health services include:
- Assessment of behavioral health needs, including screening for mental illness, substance abuse, and barriers to managing chronic health conditions
- Brief interventions for identified behavioral health issues
- Support for healthy behavior change and self-management
- Connections with community-based services and specialty mental health care if needed

Integration and Triple Aim Outcomes
Medical + behavioral comorbidities are costly

- Better chronic disease management and treatment
- Improvements in overall functioning
- Improved medical and mental health outcomes

3 of the 5 top conditions driving overall health costs are related to BH (depression, anxiety, obesity)

Use of specialty and emergency care
Save 5 to 10% of total health care costs over a 2 to 4 year period; $26 - 48 billion total (Millman, 2014)

Per Capita Cost

Improved patient satisfaction
Improved provider satisfaction

Robert Graham Center, "Why there must be room for mental health in the medical home; RGH: An Employer's Guide to Behavioral Health Services"
Why primary care?

- 59% of patients with behavioral health conditions receive no treatment for their condition.
- ~50% of visits for behavioral health conditions are treated in primary care, but 67% of primary care physicians are unable to access outpatient behavioral health services for their patients.
- 15-30% of patients who receive a referral do not make their first behavioral health appointment.
- Stigma prevents many from seeking behavioral health care – but they go see their primary care provider.

Research Findings

- Perception is that there are many different models and ways to implement integration.
- After examining the core components underlying these approaches, we found that the commonalities are much greater than the differences.
- We have been working with organizations to implement a framework for integrating behavioral health and primary care based on these core components of successful approaches.

Behavioral Health Integration - Defined

- 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, and ineffective patterns of health care utilization.

Framework for Integrated Behavioral Health and Primary Care

- Collect key information to guide program direction, staffing, and determine approach to integration.
- Develop reliable operations and processes to support integrated care.
- Make the business case for integration.
- Redesign care delivery using the core principles of integrated care.
Core Components of Successful Integration

1. Define the behavioral health needs you need and want to address.
2. Choose a behavioral health integration approach to meet the medical and behavioral health needs of your population.
3. Identify how to make the business case for integration.
4. Select the behavioral health providers and organizations with whom to collaborate.
5. Develop and train the workforce.
6. Develop a process for how patients will access behavioral health care.
7. Redesign clinical and operational workflows.
8. Track patient and integration program outcomes.
9. Enhance the capacity to provide evidence-based care.

Innovative Approaches: Cambridge Health Alliance

Emily Benedetto, MSW, LCSW
Lisa Hoffman, MSW, LCSW

Cambridge Health Alliance

Primary Care Behavioral Health Integration (PCBHI)

Emily Benedetto, MSW, LCSW, Program Manager
Lisa Hoffman, MSW, LCSW, Mental Health Care Partner

Institute for Healthcare Improvement National Conference
December 7th, 2016

Cambridge Health Alliance Patients

CHA is a major safety net health system, and essential to Massachusetts’ health care delivery system for Medicaid and other low-income vulnerable patients.
Primary Care-Behavioral Health Integration Model

Population Screening → Brief Intervention → Referral to Treatment → Staffing ratio per 5,000 adult empanelment:
Integrated Psychiatrist – .20 FTE
Integrated Therapist – .75 FTE
Mental Health Care Partner – .50 FTE

PACIENT-CENTERED MEDICAL HOME

Step 0: Primary Care
Step 1: Primary Care (with Mental Health Consultation)
Step 2: Integrated Mental Health
Step 3/4: Outpatient Mental Health

STEPPEED MODEL OF CARE

Staffing to Support the Model

Mental Health Care Partner (MHCP)
- Step 0 & 1 Patients: Positive Screens
- Warm Handoffs: Team Coordination Registry
- Self-Management Support & Coaching

Integrated Therapist
- Step 2 Patients
- Warm Handoffs: Team Consultation Supports MHCP
- Brief Treatment with Evidence-Based Therapies

Consult Psychiatrist
- Step 0-2 Patients
- Team Consultation: Education, Case review w/MHCP
- Psych Evaluation: Medication & Diagnostic Consultation

Measuring Outcomes: PCBHI Dashboard

<table>
<thead>
<tr>
<th>Service</th>
<th>Actual</th>
<th>Target</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Wellbeing Screening</td>
<td>67 %</td>
<td>74 %</td>
<td>In-Range</td>
</tr>
<tr>
<td>Depression Screening &amp; Follow-Up</td>
<td>22 %</td>
<td>27 %</td>
<td>In-Range</td>
</tr>
<tr>
<td>Depression Endorsement</td>
<td>60 %</td>
<td>60 %</td>
<td>In-Range</td>
</tr>
<tr>
<td>Depression Referral Treatment</td>
<td>20 %</td>
<td>20 %</td>
<td>In-Range</td>
</tr>
<tr>
<td>Diabetes Referral Treatment</td>
<td>66 %</td>
<td>66 %</td>
<td>In-Range</td>
</tr>
<tr>
<td>NAXA-2 Alcohol Use Screening Rate</td>
<td>74 %</td>
<td>73 %</td>
<td>In-Range</td>
</tr>
<tr>
<td>Screening and Counseling for Alcohol Use</td>
<td>35 %</td>
<td>35 %</td>
<td>In-Range</td>
</tr>
<tr>
<td>Brief Counseling for Alcohol Use</td>
<td>51 %</td>
<td>50 %</td>
<td>In-Range</td>
</tr>
<tr>
<td>Brief Counseling Drug Use</td>
<td>20 %</td>
<td>20 %</td>
<td>In-Range</td>
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<tr>
<td>Brief Counseling Drug Use</td>
<td>66 %</td>
<td>66 %</td>
<td>In-Range</td>
</tr>
<tr>
<td>Brief Counseling Drug Use</td>
<td>66 %</td>
<td>66 %</td>
<td>In-Range</td>
</tr>
<tr>
<td>Brief Counseling Drug Use</td>
<td>2 %</td>
<td>2 %</td>
<td>In-Range</td>
</tr>
<tr>
<td>Chronic Illness Primary - Controlled Sub-Agreement</td>
<td>57 %</td>
<td>50 %</td>
<td>In-Range</td>
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Identifying technology for patient self-management support

FY15
- Researched Evidence-Base
- Draft listing of Tools in 4 Categories
- Development of Evaluation Criteria

FY16
- Workgroup and Patient Evaluation
- Training/Learning
- Pilot of Tools (Integrated MH in Phase I sites)

FY17
- Distribution across sites
- Ongoing evaluation of landscape
- Business planning

SELF-HELP IN PRIMARY CARE: RECOMMENDED TOOLS

<table>
<thead>
<tr>
<th>MOBILE HEALTH APPS</th>
<th>WEBSITES</th>
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<tbody>
<tr>
<td>STRESS AND ANXIETY</td>
<td>FOR INFORMATION, ADVICE &amp; SELF-HELP</td>
</tr>
<tr>
<td>DEPRESSION &amp; GENERAL MOOD</td>
<td></td>
</tr>
</tbody>
</table>

Warm handoff to Care Partner to introduce websites and apps to patients.

Mental Health Care Partner

The Fixer
Brief Intervention

Triage

Care Coordination

Population Management

Care Partner

Primary Care Provider (PCP)

Care Coordination

Integrated Therapist

Integrated Psychiatrist

CHA Resources

Male, late 20’s
Somatic Complaints
Depression/Anxiety
History of Cancer
Work Impairment

Sam

Care Coordination

Guide

Fixer

Sam

Sam
More Keys to Success & Challenges.....

• Flexibility/Bandwidth of Care Partner Role
• Cultural/linguistic competence of MHCP is a key to building alliances
• Challenge of implementing a new program/role (space, logistics...)
• Patient Centered Medical Home and team-based care
• Shared leadership structure to support integration
• Information Technology support
• Funding incentives
• Fit of model with patient population

Triage
• Level of care
• Available resources

Care Coordination
• Provider communication
• Engagement/follow-up
• Case review

Brief Intervention
• Psychoeducation
• Motivational Interviewing
• Behavior Activation
• Mindfulness
• Self-Management

Population Management
• Registry
• Team meetings
• Outreach

Additional Learning Resource:
Care Partner/Psychiatrist Case Review
https://youtu.be/Wxu6iOqr1g4
Innovative Approaches: The Community-Based Practice Approach

Wendy Bradley, LPC

One Trusted Primary Care Team

- Members and caregivers are involved in every step of the health care process
- Coordinated care
- Integrated care plans to support members' health goals
- Care by telephone and email if a face-to-face visit is not warranted
- Holistic care in the same location

Team Members

Understanding the Community

- Asset mapping
- Identifying Key influencers
- Reviewing data/target areas
- Focus groups/focused conversations
- Strength based
The Data

Demographics:
• Non-Hispanic Black or African-American: 164,921 (76.2%)
• Non-Hispanic White / European: 37,010 (17.1%)
• Hispanic or Latino: 4,328 (2.0%)
• American Indian: 4,112 (1.9%)
• Asian: 3,246 (1.5%)
• Mixed or Other: 2,813 (1.3%)
Working with the Community

Seek input and share information

Partner and collaborate

Facilitate

Problem Statement:

Mental and behavioral health disorders impact individuals, families, and community members across various neighborhoods in the West Philadelphia community. Proper mental health and management services increase quality of life for individuals and families. Reducing stigma and increasing access to mental health services at clinics or partner organizations and family and friends is necessary.

Goal:

Recruit clients. More clients in need of mental health and behavioral health services.

Rationale:

Proper mental health care increases quality of life for individuals with mental health disorders. Mental and behavioral health services are essential for individuals and families.

Resources:

CityLife Clinic and Community partners develop partnerships with City/state public/private institutions and faith-based organizations and community collaboration initiatives to address identified gaps in resources.

Activity:

Engage community members to develop strategies to address identified gaps in resources. Identify mechanisms for improvement. Implement efforts on multiple fronts to ensure collaboration is maintained, goal is commonly achieved, and objectives are met for sustainability.

Outputs:

# of mental health clinics or partner organizations.

Intermediate-Term Outcomes:

Increased enrollment and engagement allows for sustainability and feedback.

Outputs:

# of adults utilizing CityLife neighborhood health services at CityLife neighborhood health services.

Long-Term Outcomes:

Improving health outcomes for individuals and families. Improving health outcomes for individuals and families within a five-year period. Increasing access and utilization of mental health and behavioral health services.

Short-Term Outcomes:

Increase enrollment and encourage engagement.

Outputs:

# of community members trained.

Intermediate-Term Outcomes:

Empower community to develop strategies to address identified gaps in resources.

Outputs:

Newsletter with external events.

Internal Offerings:

- MANNA nutrition counseling
- AUNI Cooking and Nutrition Class
- Help Yourself to Health: CDSMP Class
- Are You Aware?
- Chat n Chew
- Neighborhood pantry program
- Condom distribution program
- CityLife Voices Advisory Group
- Newsletter with external events
Advisory Group

Identified as “Service Leaders,” these individuals would be recruited to represent each of the three CityLife Neighborhood Clinics. The group would consist of volunteer members:
- Members
- Team members
- Community partners

Functions:
- Lead groups that build awareness for health promotion
- Provide peer support to others working toward wellness
- Information sharing especially around pressing issues in neighborhoods served
- Identify gaps in health literacy and delivery of clinical services
- Provide a member perspective in clinical and community workgroups
- Support building volunteer capacity
- Gather member and employee success stories
- Testing of marketing materials
- Collect team member and member satisfaction data
- Actionable input to focus improvement efforts
- Development of creative ways to reach and engage members

Now What?
- Identify member resources
- Build partnerships/seamless referral system
- Facilitate events
- Join community events
- Listen to community needs
- Connect resources
- Join community-wide collaborative

Begin the Conversation

How will you start to think and act differently to...

- Seek input and share information; partner and collaborate as a team with the community, members and each other
- Facilitate the promotion of health, health-related activities, services, education and events
Questions?

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Thank you!

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