Integrating Primary and Behavioral Health Care

When patient needs are prioritized collectively, we can all work together for improved outcomes/lives.

Our Goal

- Discuss trends in healthcare reform
- Provide Information on integrated care
- Unveil the multi-dimensional team view
- Present a conceptual idea of the integrated care model
- Provide an overview of two (2) local integrated care programs (RHN & HTC)
- Discuss proposed modifications to our existing programs
- Wrap up and Q&A

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Trends in healthcare reform

- Increased Accountability
- Patient Centered Care Models
- Delivery System Realignments
- Value-Based payment Models
- Population management
- Expanded Focus on Behavioral Health

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What is Integrated Care?

"The care that results from a practice team of *primary care* and *behavioral health clinicians* working together with patients and families, using a systemic and *cost-effective* approach to provide *patient-centered care* for a defined population. This care may address mental health and 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."

Peek CJ and the National Integration Academy Council. Executive Summary - Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. AHRQ Publication No. 12-[P001-1-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013. http://integrationacademy.ahrq.gov

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Integrated Model concept:

Patients with **co-occurring mental and physical health needs** receive care in an **integrated model**, this results in **improved patient outcomes** and experiences. In addition, this integration **enhances the work life** of primary care staff and behavioral health providers by **facilitating** their ability to obtain needed services for their patients in a **more coordinated** and accessible manner. Primary care and behavioral health **providers share the same facility**, have some **systems in common**, have regular face-to-face communication and use a **team approach**.

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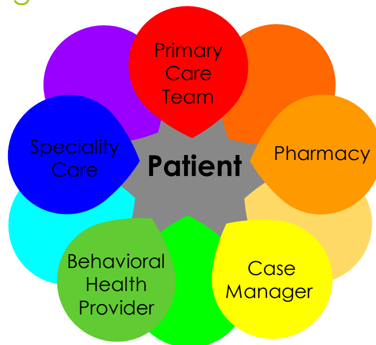
Integrated Model



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Members involved

Primary Care - Provider who works with patient regularly to address chronic health conditions

Speciality Care - Specialist who plays a role in specific areas of patient care

Behavioral Health Consultant - Provider who works with primary care team and patient to develop, implement and assess patient's goal

Case Manager - Team member who assists the integrated team and patient with social determinants to care

Pharmacy - Functioning pharmacy with adequate supply of medications within financial means of patient

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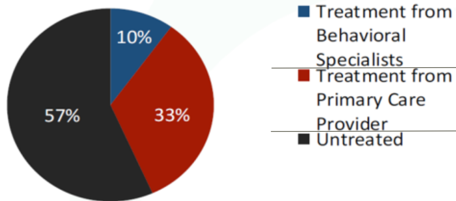
Americans Suffering From a Diagnosable Behavioral Disorder



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Placing a value on Integrated Health Care (IHC)

- Reduced ER Utilization
- Reduce Inpatient Admissions
- Reduced Specialty Referrals
- Increased Patient Satisfaction
- Increased Primary Care Utilization
- Improved Outcomes

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Sustainability

Payer

Allowable

Equitable

Sustainable

Patient

Provider

Acceptable

Policy

A sustainable healthcare "economy" is one that can meet the current needs of all participants with currently-available resources (without compromising the ability of future generations to meet their own needs). More sustainable approaches require that solutions perform well with respect to each of the three dimensions (Patient, Provider and Payer) within the boundaries of Public Policy.

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In primary care do as primary care does!

***Everyone* receives Integrated Care**

- Contact: first line of access
- Comprehensive: anyone that walks through the door
- Coordinated: organizes and synchronizes all elements of care
- Continuous: episodes of care within context of longitudinal partnership.

"There is no wrong door."

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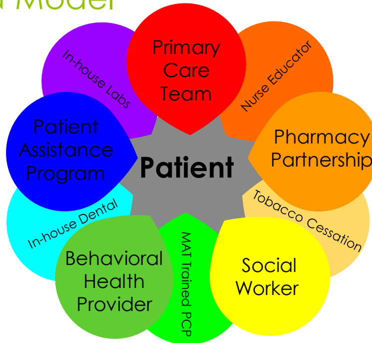
Behavioral Health Care IS Primary Care!

RHN Referral Processes

RHN Model



Define Population

Physical Health	Behavioral Health
Asthma	Bipolar and Related Disorders
COPD	Depressive Disorders
HTN	Anxiety Disorders
Diabetes	Obsessive-Compulsive/Related Disorders
Hyperlipidemia	Trauma/Stress Related Disorders
Thyroid Condition(s)	Somatic Symptom Disorders
Obesity	Feeding/Eating Disorders
Congestive Heart Failure	Sleep/Wake Disorders
Insomnia	Substance Use/Addictive Disorders
Fibromyalgia	Personality Disorders

RHN Integrated Goals

- RHN is working toward a united interdisciplinary team, comprised of primary care staff, behavioral consultants, social workers, case managers, and others that provide integrated healthcare for the patient.
- Increase percentage of individuals receiving both physical and behavioral health care at the established locations.
- Increase percentage of individuals receiving screening, brief intervention and referral to treatment for SUD.
- Utilize validated and evidenced based assessment tools to improve clinic statistics/outcomes.

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Patient Centered Care

- Sliding scale fees
  - BH sliding scale reduced
  - Dental loan repayment
- PAP/MAP
- Staffing/coordinating with specialist
- Tobacco Cessation Program
- Follow patient goal(s) for treatment
- Multidisciplinary Treatment Team

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Recommendations for Improvement

- Identify our population and their needs
  - Universal Assessment for BH/SUD
  - Use a registry model to affect change on a larger scale
  - Identify social determinants of care within our population
- Formalize and Pilot MAT program
- Create a BHS quick reference guide
  - Simplified recovery objectives with patient voice
- Cultural shift by presenting IHC model
  - Provide more training opportunities for staff
- Initiate a Psychiatric Collaborative Model
- Expand model to RHN outreach clinic

We want to create a change on a larger scale with brief, targeted interventions and a focus on making every door the right door for integration.

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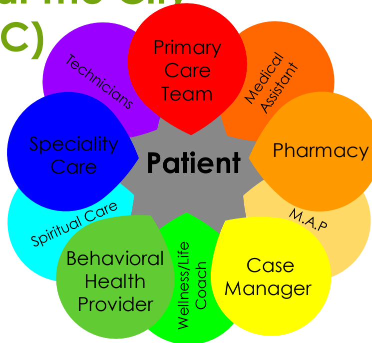
Heal The City Referral Processes

Heal The City (HTC)



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Fibromyalgia	Obsessive-Compulsive/Related Disorders
Insomnia	Personality Disorders
Hyperlipidemia	Schizophrenia/Psychotic Disorders
Hypertension/HTN	Sleep/Wake Disorders
Obesity	Somatic Symptom Disorders
Rheumatoid Arthritis/RA	Stress Disorders
Thyroid Condition(s)	Substance Use/Addictive Disorders

HTC Integrated Goals:

- Coordinate patient services in single location/visit to improve patient follow-through.
- Develop better patient-centered care.
- Educate other community members or organizations with our approach to integrated care.
- Improve patient quality of life and health in: behavioral, financial, physical, spiritual and wellness.
- Increase percentage of individuals receiving both physical and behavioral health care.
- Increase clinic efficiency for all parties involved.
- Grow company culture to foster inivated ideas and continued growth.
- Utilize validated and evidenced based assessment tools to improve clinic statistics/outcomes.

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Patient Centered Care

- Community collaboration(s)
- Follow patient goal(s) for treatment
- Medication samples
- Medication Assistance Program(s) - MAP
- Multidisciplinary Treatment Team
- Provided regionally
- Tobacco Cessation Support
- Wellness Classes

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Recommendations for Improvement

- Build Behavioral Health/Social Department
  - Add more SW positions
  - Identify more effective utilization of community partners
- Community shared EMR
- Create a BHS quick reference guide
  - Simplified recovery plan accessible to all
  - Simplified screening tool accessible to all
- Create a formal brief interventions tool
- Cultural shift by presenting IHC model
  - Provide more training opportunities for staff
- Establish a "Stages/Tier" system to onboard changes
- Open "Faith in Transformation" (FIT) Wellness Center

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Questions?

Answers!