InteGREAT!

Building Capacity for Integrated Behavioral Health and Primary Care

PacificSource Columbia Gorge CCO Transformation Award Partnership Project:

- Oregon Rural Practice-Based Research Network
- University of Colorado Denver
- Selected clinics in the Columbia Gorge CCO
- Integrated Care Work Team (ICWT)

June 22, 2015 * Presentation to the Community Advisory Council

InteGREAT: Building Capacity for Integrated Behavioral Health & Primary Care

Presentation Overview

- What *is* integrated behavioral health and primary care?
- Why should we care about integrated care?
- What was InteGREAT!?
  - Project goals and methods
  - Lessons Learned
- Needs/Next steps
- Discussion

What *is* integrated behavioral health and primary care?

Definition: Behavioral Health and Primary Care Integration

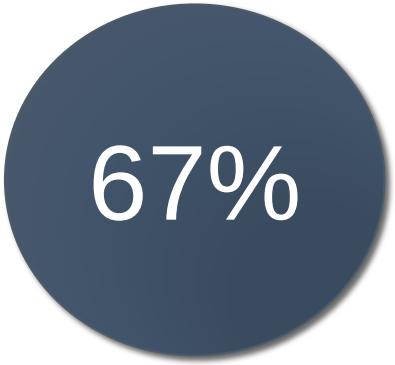
The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

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.

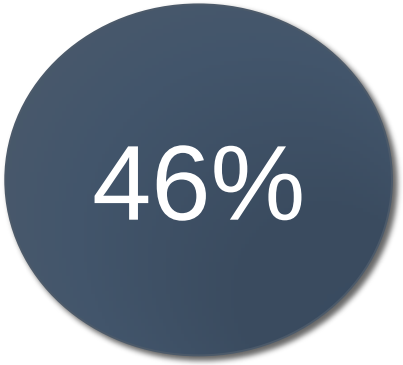
Peek, C. J. and the National Integration Academy Council (2013). Lexicon for behavioral health and primary care integration: Concepts and definitions developed by expert consensus. AHRQ Publication No.13-IP001-EF. Rockville, (MD), Agency for Healthcare Research and Quality.

Why should we care about integration?

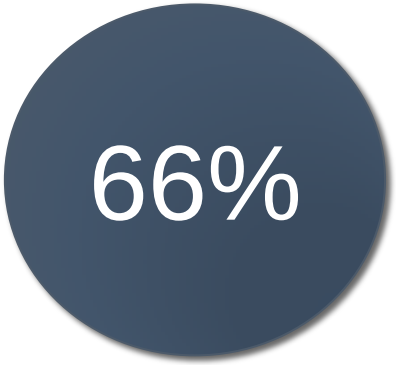
Behavioral Health Needs Present in Primary Care (and vice-versa)



of adults with a behavioral health disorder do not get behavioral health treatment



of adults will experience a mental health illness or substance abuse disorder at some point in their lifetime



of primary care providers report not being able to access outpatient behavioral health for their patients

Top conditions driving overall health costs:

Depression | Anxiety | Obesity | Back/neck Pain | Arthritis

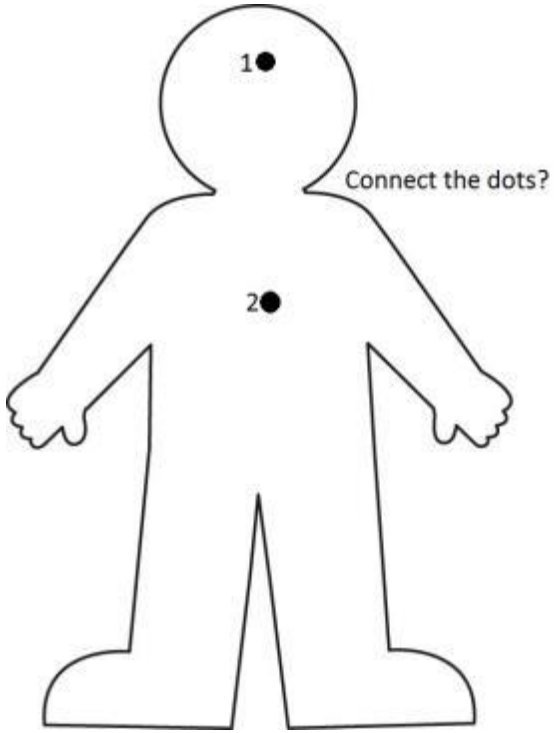
When treated in harmony with mental health, chronic physical health improves significantly, along with patient satisfaction.

Fragmentation is Costly

	Annual Cost – those without MH condition	Annual Cost – those with MH condition
Heart Condition	$4,697	$6,919
High Blood Pressure	$3,481	$5,492
Asthma	$2,908	$4,028
Diabetes	$4,172	$5,559

Petterson S, Phillips B, Bazemore A, Dodoo M, Zhang X, Green LA. Why there must be room for mental health in the medical home. *American Family Physician.* 2008;77(6):757.

The Question is not if but how…

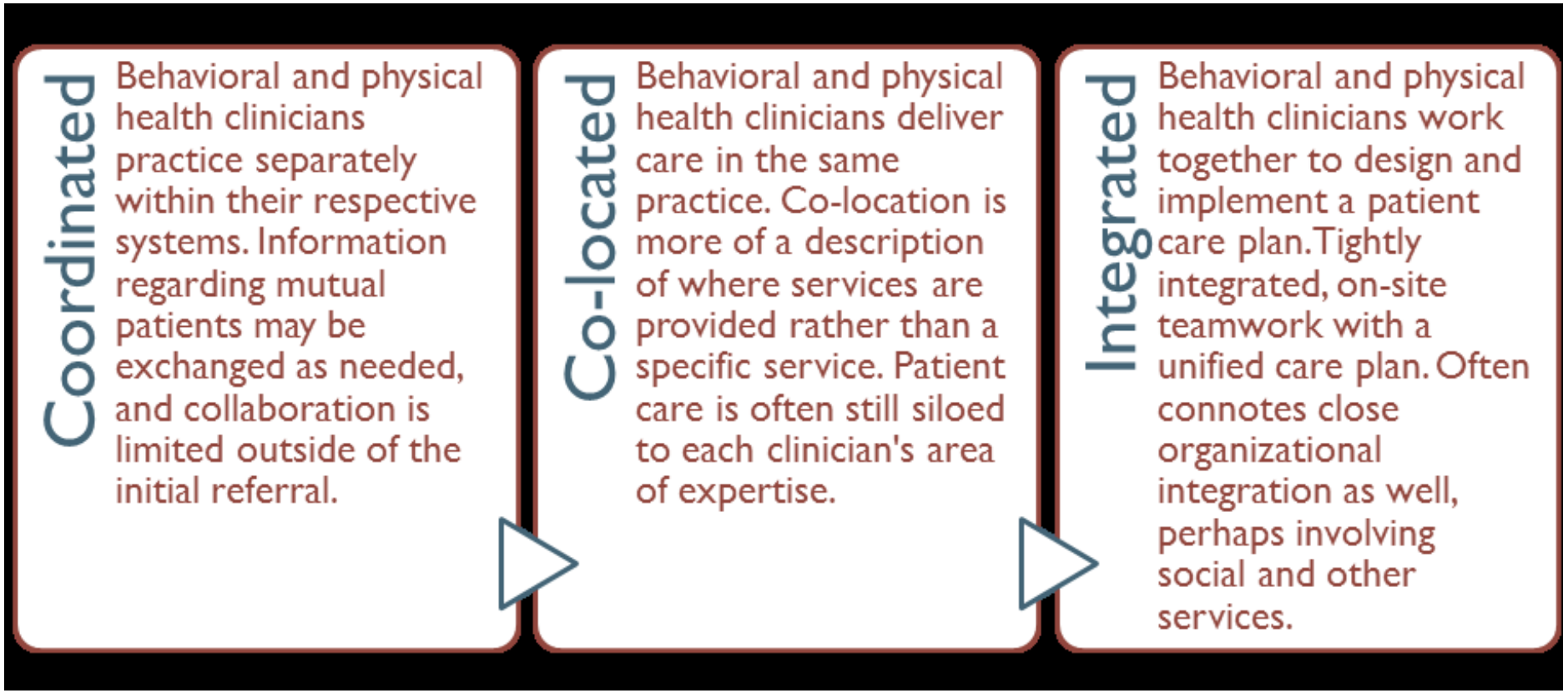


Mental health and primary care are inseparable; any attempt to separate the two leads to inferior care

- IOM, 1996

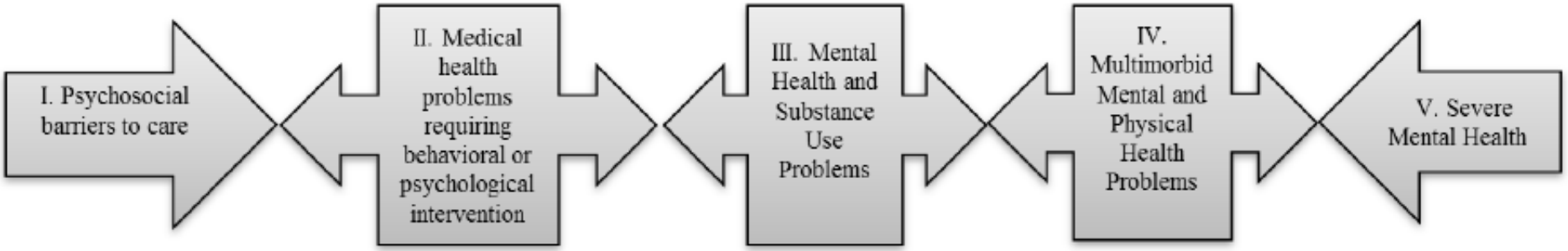
What does integrated behavioral health and primary care look like?

Dimensions of integrated care



CPC: An Initiative of the Center for Medicaid & Medicaid Innovation

The “range” of integrated services



CPC: An Initiative of the Center for Medicaid & Medicaid Innovation

The roles/functions in integrated settings

- Primary care team members: Medical clinician, medical assistant, others?
- Mental Health Therapists: Traditional long-term mental health therapy
- Behavioral Health Consultants: Brief, problem focused interventions during the encounter when a need is identified
- Additional support staff
  - Community Health Workers
  - Care coordinators, care managers
  - Referral coordinators

Advancing Care Together

www.advancingcaretogether.org

Workflow and Access to Care

Leadership and Culture Change

Tracking Patients and Using Data

Davis, M., Balasubramanian, B. A., Waller, E., Miller, B. F., Green, L. A., & Cohen, D. J. (2013). Integrating Behavioral and Physical Health Care in the Real World: Early Lessons from Advancing Care Together. *The Journal of the American Board of Family Medicine, 26*(5), 588-602.

Integration is a Developmental Process

InteGREAT Project Goals (June 2014 – May 2015):

1. Build partnerships among practices that are interested in integration.
2. Collaborate with practices to create the foundation for integration (clinically, operationally, and financially).
3. Provide technical assistance as practices initiate their integrated initiatives.

OHSU/Oregon Rural Practice-based Research Network (ORPRN) Project Team

Melinda Davis, PhD: Research Assistant Professor, Department of Family Medicine; Director of Community Engaged Research, ORPRN

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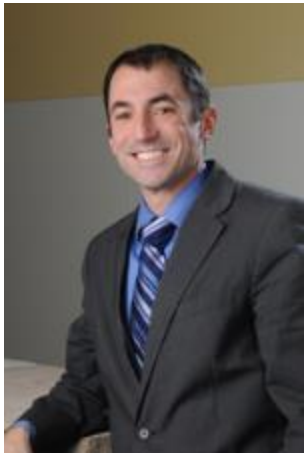
Benjamin Miller, PsyD,
Assistant Professor



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Practice Facilitation Program Manager

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1) Build Partnerships

- Build a relationship between PacificSource CCO, OHSU, and UCD partners

- Work collaboratively with 4 primary care clinics and 1 behavioral health agency identified by Integrated Care Work Team (ICWT)
  - Serve majority of OHP clients/patients in the region
  - Interested in integration
  - Mentors/resources for other clinics in the region

- Foster development of learning ecosystem across the CCO

2) Utilize tools to create the foundation for successful integration

- Clinically
  - Clinical Quality Measures Reporting Assessment
  - Minimal Data Set
- Operationally
  - Practice Information Form
  - Comprehensive Primary Care Monitor or Health Home Monitor
  - Workflow Development
- Financially
  - Coach Cost Tool

3) Provide technical assistance via practice facilitation

- **Practice Facilitation:** the provision of onsite and virtual support to primary care practices and other health care settings to redesign clinical processes and improve clinical outcomes for individual patients and the overall population of patients served.

- **Practice Facilitator:**
  - Specially trained individuals who assist primary care clinicians in research and quality improvement projects.
  - Distinguished from consultants through specialized training, broad scope of practice, and a long-term relationships with an organization, its providers and its patients.

Lessons Learned

- Using the same words, but not with the same meaning

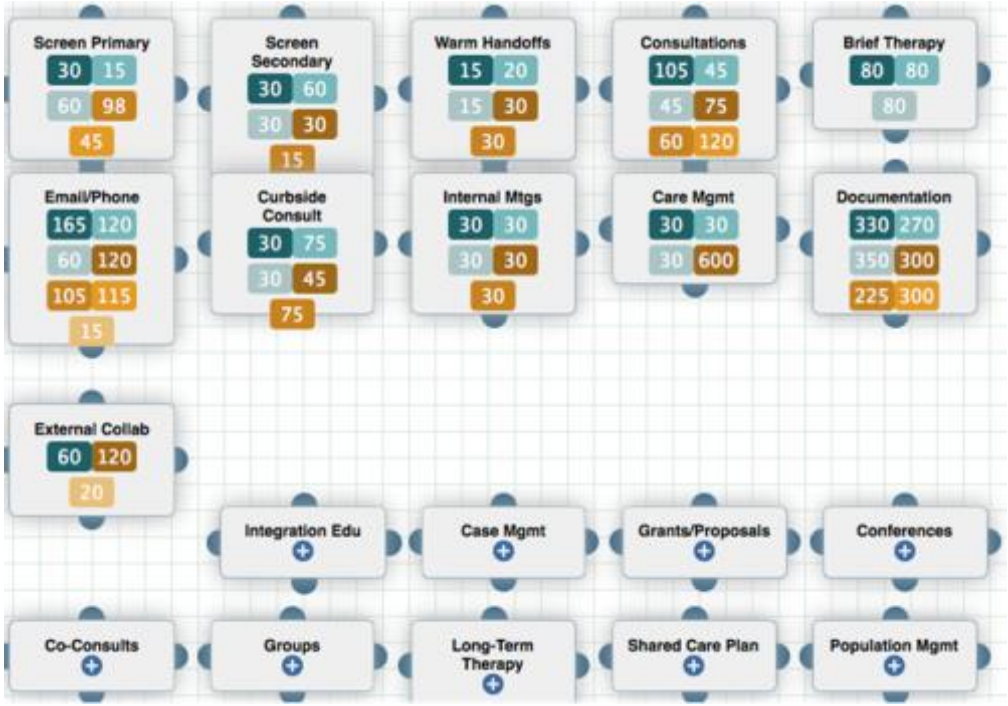
- Pre/post assessments of behavioral health integration may not have changed, but understanding did:
  - “Even when we scored the same over time, our vision and understanding of the questions have changed, such that we’ve framed up where we are/ want to go.”
  - “We are not where we were, but we are not where we want to be.”

Lessons Learned, continued

- Electronic Health Records (EHRs) not up to snuff with data tracking for common behavioral health conditions. Able to track:
  - Screening results (e.g., PHQ for depression, smoking) = Yes, Partial
  - Follow-up plan for patients with a positive screen = Partial, No
  - Patient's improvement over time = No
- Practices need additional help with templates, queries, reporting (and space to use data to inform quality improvement process)

Lessons Learned, continued

- Overall impression: Participating primary care practices have vision for integrated care
- Coach Cost Tool indicates service addition would be cost saving/cost neutral



Vision for Integrated Care in the Gorge

Setting	Baseline model	The Vision
Independent practice	Limited referrals and consultation with specialty mental health, MD as mental health provider	Add 1 FTE LCSW Main activities: Warm Handoffs; Transfer PCP and MA Brief Therapy time
Affiliated practice 1	Co-located mental health services (therapy)	Increase BHC and Counselor FTE Main activities: More time for Warm Handoffs and Brief Therapy
Affiliated practice 2	Referrals and coordination of care with specialty mental health in affiliated practice 1	Add 1 FTE LCSW Main activities: Transfer Secondary Screening, Warm Handoffs, Brief Therapy, Care Management
FQHC	Co-located mental health services (therapy) provided by community mental health center	Increase to 1 FTE LCSW Main activities: More time for Warm Hand offs and Brief Therapy; Add Population Management
Community Mental Health Center	Limited referrals and consultation with primary care	Become Behavioral Health Home, with coordinated, co-located primary care and ancillary support services

Needs/Next Steps

- Needs (from ICWT Discussion)
  - Staffing, training, workforce capacity development
  - Funding to support implementation of integrated care visions
  - Technical support (particularly for IT and QI process)

- Next Steps…(ideas)
  - Payment reform pilot
  - Learning collaborative
  - Ongoing technical assistance

THANK YOU!

Questions? Comments? Discussion?

For more information contact
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Additional Resources

- One stop: http://integrationacademy.ahrq.gov/
- Case study: http://www.advancingcaretogether.org/
- Webinars: http://www.youtube.com/user/CUDFMpolicychannel
- State example: http://coloradosim.org/
- Lexicon: http://integrationacademy.ahrq.gov/lexicon
- Manuscripts:
  - Behavioral health integration: an essential element of population based healthcare redesign (Brown Levey et al., 2012): http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3717906/
  - Integrating behavioral and physical health care in the real world: Early lessons from Advancing Care Together (Davis et al., 2013): http://www.ncbi.nlm.nih.gov/pubmed/24004711