SAMHSA-HRSA
CENTER for INTEGRATED
HEALTH SOLUTIONS

Five Implementation Essentials for Integrating Primary Care & Wellness into Behavioral Health

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SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

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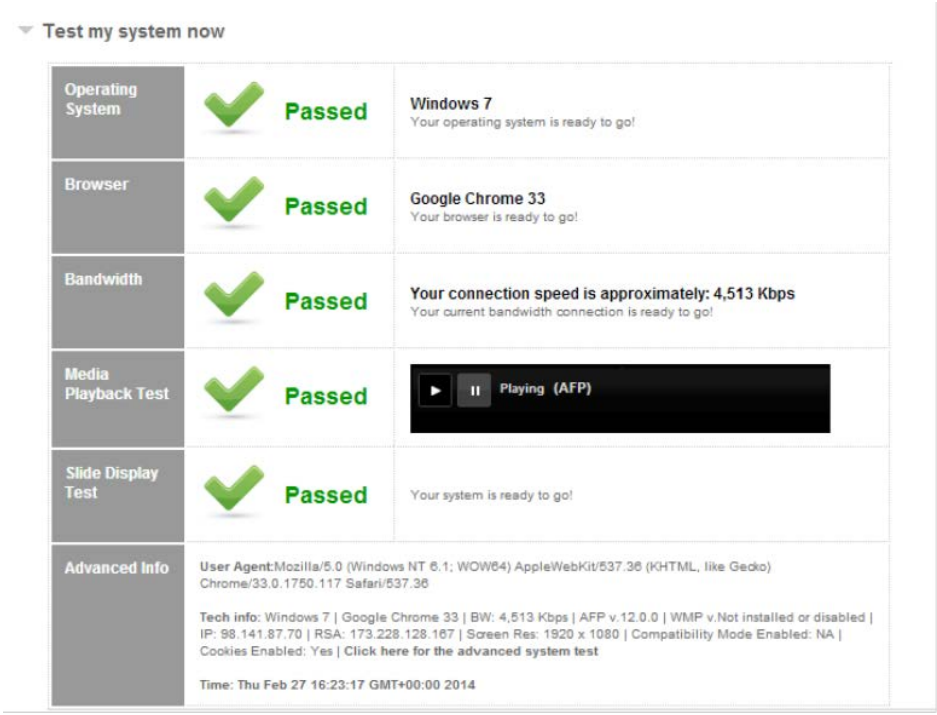

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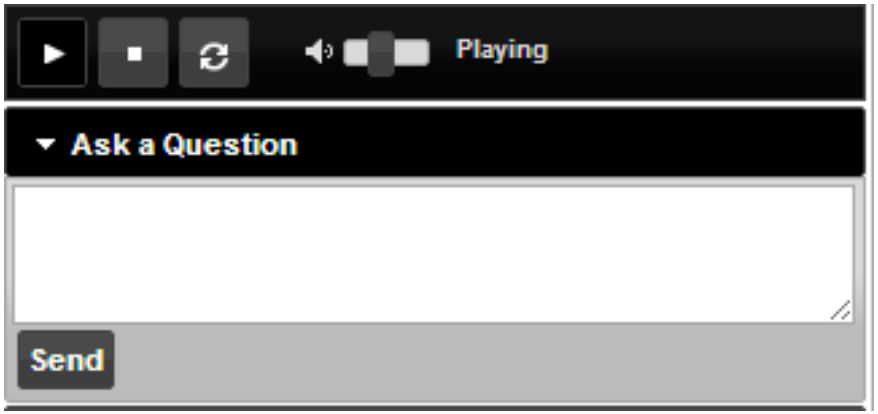
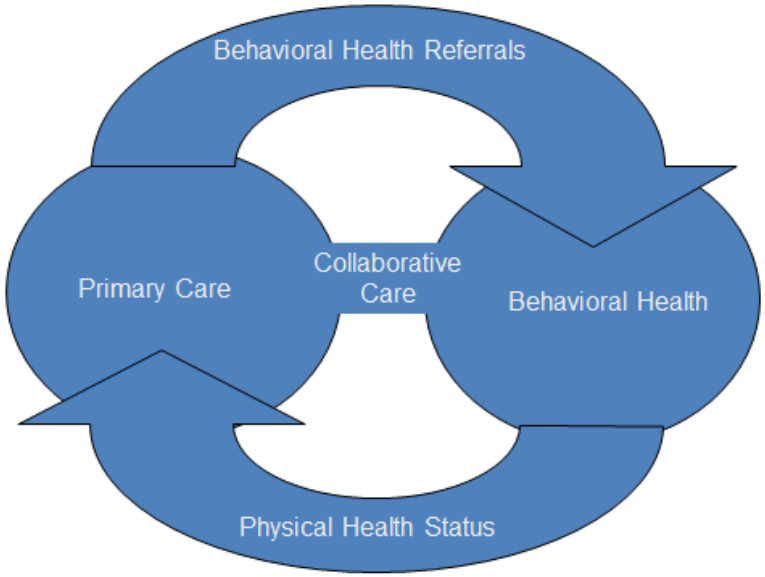


Today's Speakers

Tenly Pau Biggs, MSW, LGSW
Center for Mental Health Services/Division of Services and Systems Improvement
Substance Abuse and Mental Health Services Administration

Laura M Galbreath, MPP
Director, SAMHSA-HRSA Center for Integrated Health Solutions, National Council for Behavioral Health

About CIHS



- Make integrated care the national standard of practice
- Create and operate world-class technical assistance
- Ensure the success of SAMHSA, HRSA funded programs
- Disseminate practical tools, resources, and lessons learned

Today's Purpose

Help inform behavioral health providers that are adding primary care and health promotion services.

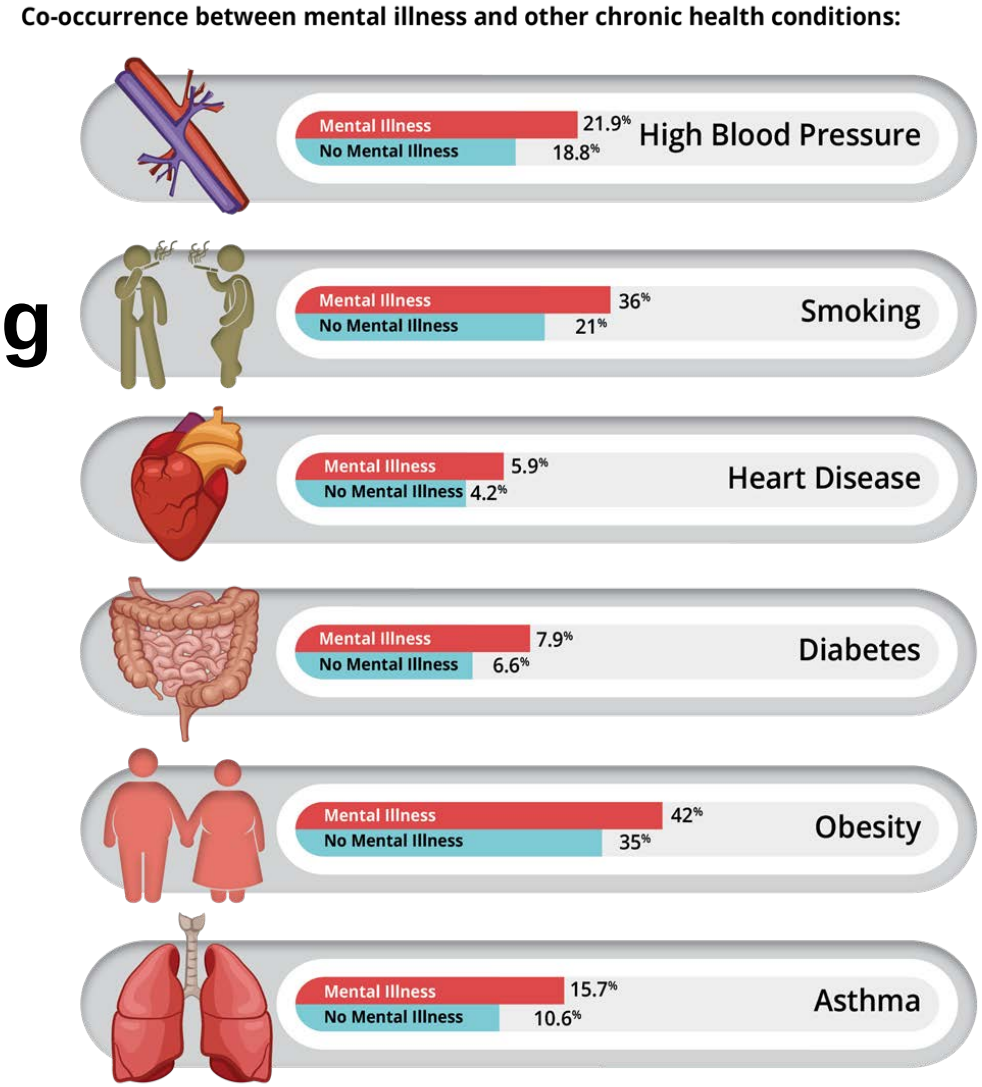
- Highlight essential implementation strategies for integrating primary care and health promotion into behavioral health.
- Share lessons learned and tips from PBHCI grantees on sustaining primary care and wellness services
- Reference resources and tools to support integration efforts

Poll Question

What is your most pressing question about the integration of primary care?

- Paying for Integrated Care
- The Right Staffing
- Measuring Outcomes
- Partnering with Primary Care Providers

Individuals are dying not from a mental Illness but from preventable health conditions



Primary and Behavioral Health Care Integration has the power to…..

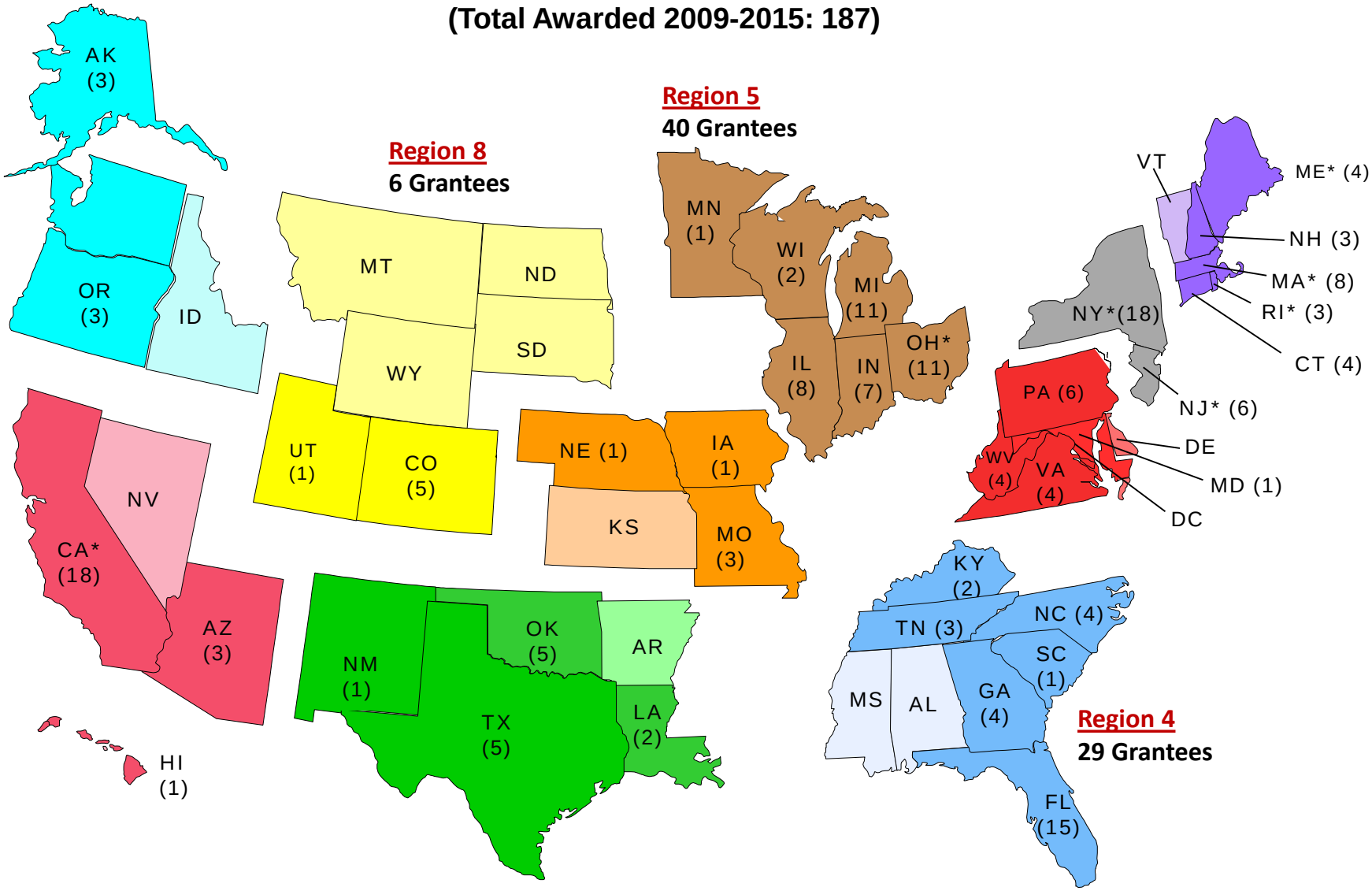
- Eliminate the early mortality gap
- Reach people who will not access primary care
- Intervene early before medical co-morbidities develop or worsen
- Reduce expensive emergency department use
- Improve recovery outcomes
- Addresses the Triple Aim (care, health, cost)

About SAMHSA's PBHCI Program

Purpose: To establish projects for the provision of coordinated and integrated services through the co-location of primary and specialty care medical services in community-based behavioral health settings.

Goal: to improve the physical health status of adults with serious mental illnesses (SMI) who have or are at risk for co-occurring primary care conditions and chronic diseases

SAMHSA PBHCI Grantees by HHS Regions
(Total Awarded 2009-2015: 187)



Core Requirements of the PBHCI Program

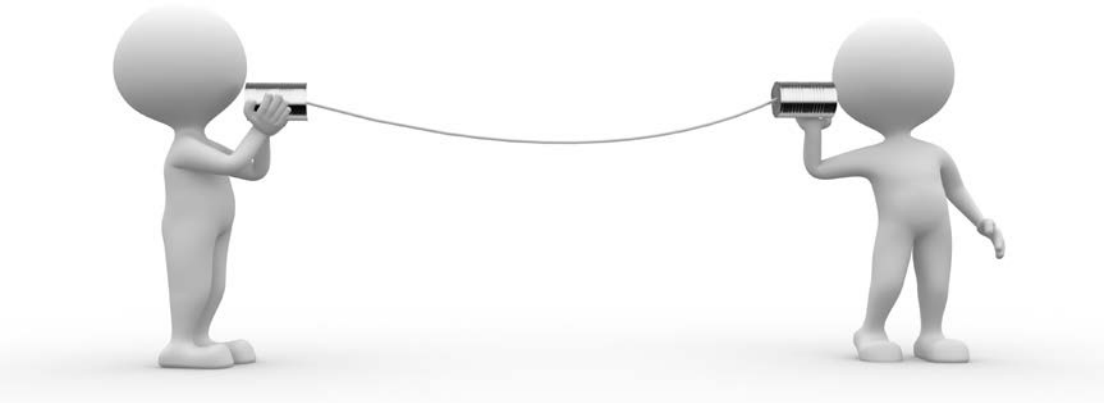
PBHCI grantees must serve as a client's **health home** where grantees provide the following services:

- On-site primary care services and medically necessary referral by qualified primary care professionals
- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
- Individual and family support, which includes authorized representatives
- Referral to community and social support services, including appropriate follow-up
- Evidence-based and promising wellness interventions

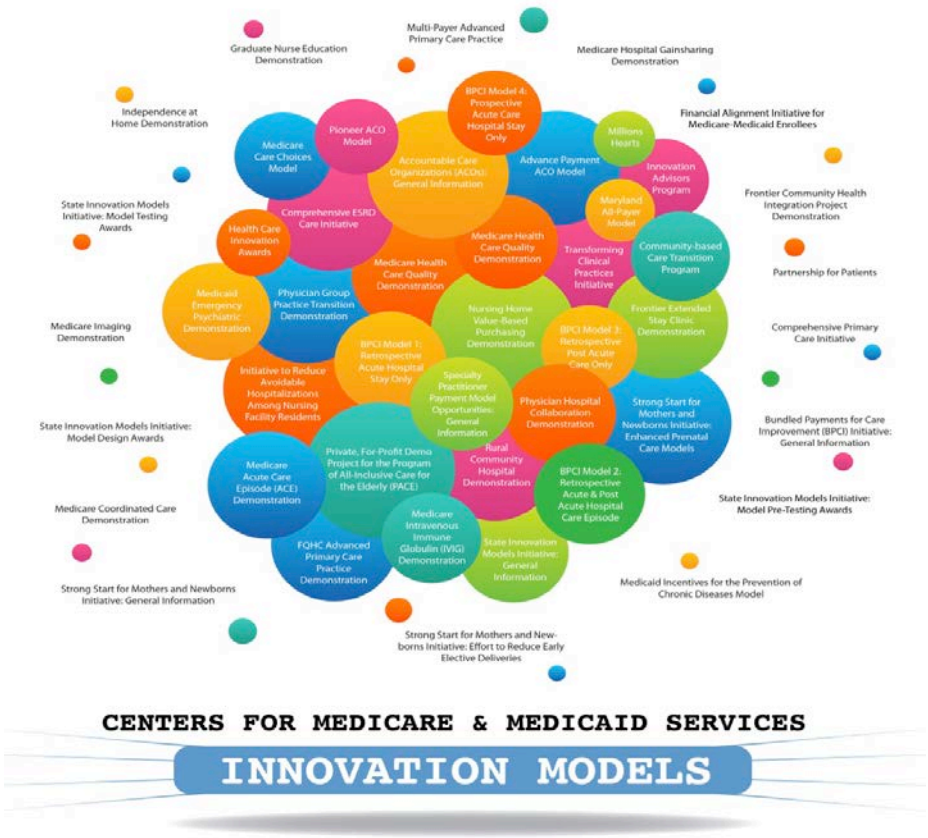
Source: http://www.samhsa.gov/grants/grant-announcements/sm-15-0

Five Implementation Essentials

- Leadership and organizational culture
- Data driven care for effective population health management
- Activating self-management for wellness
- Sustainable health promotion/wellness activities
- Workforce Training and Task Shifting



PBHCI aligns with current health care delivery system changes



- Medicaid Health Home
- Integrated Care for Individuals with Dual Eligibility
- High Utilizer Projects
- Accountable Care Organizations (ACOs)

Leadership and Organizational Culture

Organizational culture is a lens through which an organization views their work.

- Shared value system, mission, vision, and purpose
- Common language that facilitates communication internally and externally
- Policies and procedures that reflect/reinforce a shared vision
- Activities, services, physical, and emotional environment aligned with the vision
- How power, decision making, allocation of resources are distributed

Asian Counseling and Referral Service

SAMHSA PBHCI Grantee

Paradigm shift

Transformation from Mental Health Service model to Wellness Service. Mind and body working together.

Day activities program is Wellness Program.

Exercise, movement, dance are a part of all group activities.

Primary care needs are followed from intake to exit.

Integration and coordination among PC staff and psychiatric staff.

Leadership and Organizational Culture

Tips

- Share your team's vision of what your integrated program is/will be often with your organization
- Increase our shared sense that physical health is part of our work
- Build hope that people want to take care of their health
- Design clear roles & responsibilities of each team member
- Have your team assess your baseline using assessment tools
- Set goals & take actions aligned with the aims of integrated care

Resource

- CIHS' **Standard Framework for Levels of Integrated Healthcare** is a six-level framework that can be used for planning
- **Culture of Wellness Organizational Self-Assessment (COW-OSA)** can help increase an organization's awareness of the key components of a wellness-focused culture
- **Assessment Tools for Organizations Integrating Primary Care and Behavioral Health**
  - Organizational Assessment Toolkit for PC/BH Integration (OATI)
  - Integrated Practice Assessment Tool (IPAT)
  - Behavioral Health Integration Capacity Assessment (BHICA)

Data driven care for effective population health management

Addressing the health risks of adults with mental illness and existing healthcare disparities between different populations, requires an organizational infrastructure for collecting and monitoring health data.

Health outcomes were documented and shared with patients and staff. We also used the data to get buy-in from our executive leadership to seek additional funding and expand the program. PBHCI Grantee

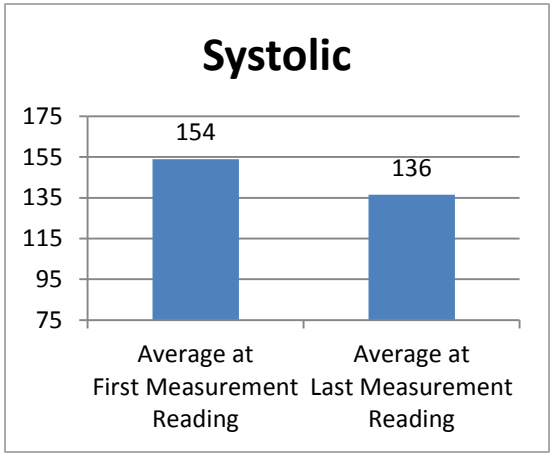
Health Integration Project

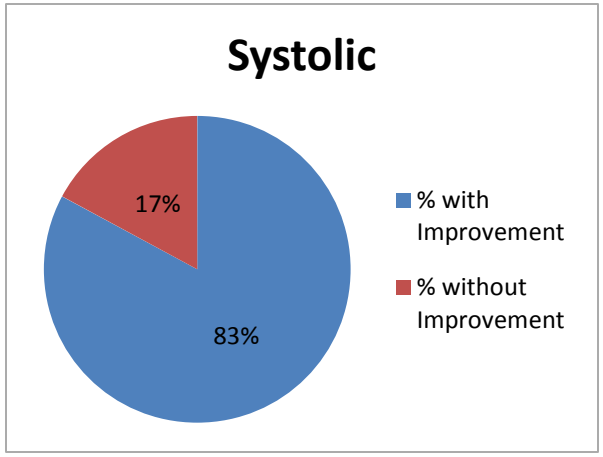
Austin Travis County Integral Care
Behavioral Health & Developmental Disabilities Services

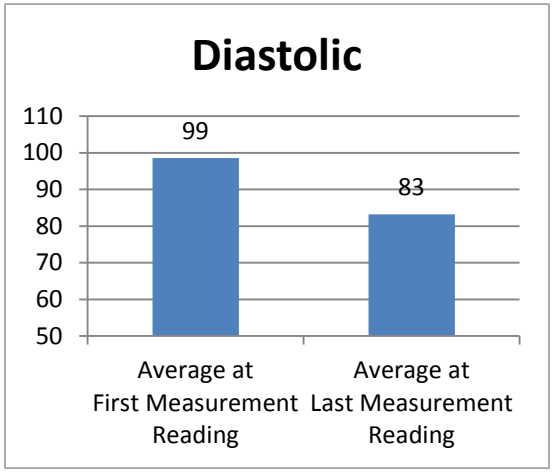
CommUnityCare

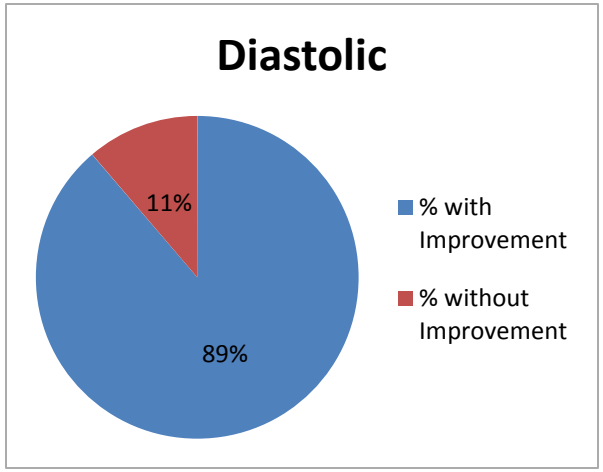
Clinical Health Indicator – Blood Pressure

- Blood Pressure reading is systolic/diastolic.
- Consumers tracked with hypertension (140/90 and above) at first appointment.
- Average Change in measure 18/15.
- Average blood pressure fell from “hypertension” to “pre-hypertension” range.
- For every reduction of blood pressure by 20/10, risk of heart attack and stroke is cut in half.





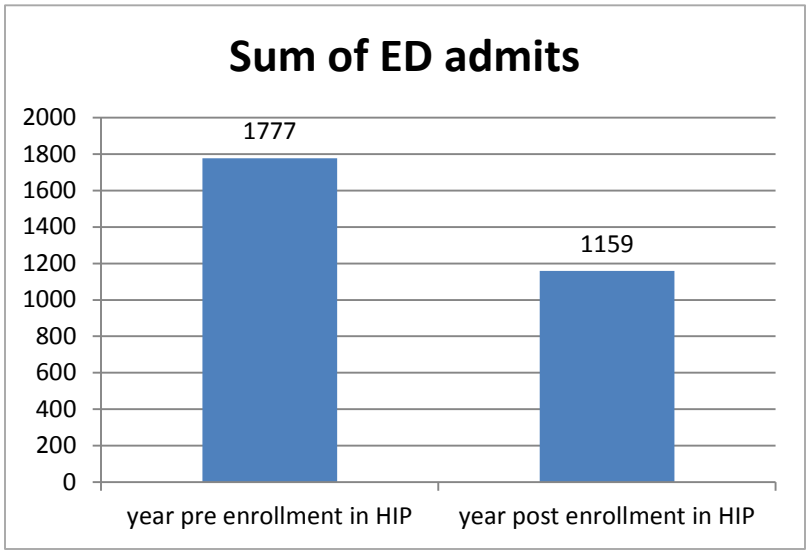


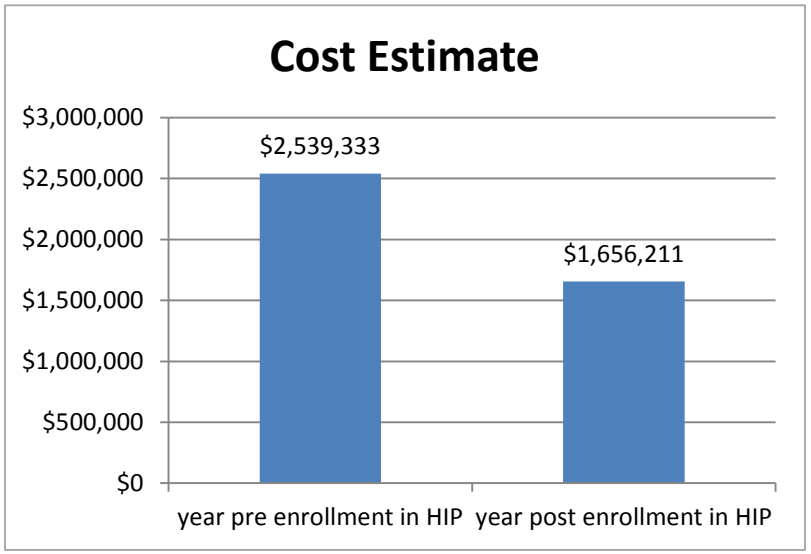


Health Integration Project

Hospital Usage

- ED admits
  - 342 consumers
  - 618 less ED admits in year post HIP enrollment
  - Average of $1429 per admit
  - Estimated annual savings $883,122





Data driven care for effective population health management

Tips

- Use a registry to track clinical outcomes and key process steps for outcome measurement
- Use tools to target specific interventions to appropriate populations
- Use EHR to generate condition-specific reports to use for CQI, reduction of disparities, research & outreach
- Implement protocols for sharing client-level data across BH & PC systems
- Treat to target – systematic tracking of medical severity
- Use your data analytics to inform future opportunities, leadership, strategic goals

Resource

- **Population Management in Community Mental Health** provides 10 essential steps to being a provider with successful population health management practices
- **Exploring the Promise of Population Health Management Programs to Improve Health** covers the concepts and components of population health management (PHM) .
- **PBHCI Population Health 101 Webinar**

Activating Self-Management for Wellness

Self-management is essential to achieving health and wellness; recognizing that treatments, services, supports and interventions are of little value without individuals setting and achieving person-centered goals that change and sustain their health behaviors.

Customer Reaction to Integrated Primary and Behavioral Health Services

"Outstanding, I am learning that it is not only my mental health but also my physical health that needs to be attended to." – Patrick

ICL

People Get Better With Us

F.R.A.M.E.S.

Feedback regarding health behaviors, strengths and needs (e.g., reviewing Diabetes Skills Scale.

Responsibility for change lies with the consumer, who has the right to make choices.

Advice about making healthy choices is given in a non-judgmental manner.

Menu of options for action steps towards change are offered and explored.

Empathic Counseling using warmth, respect and understanding.

Self-Efficacy and optimism are fostered to promote change.

Activating Self-Management for Whole Health

Tips

- Introduce the concept of self-management support to clients and staff
- Ask what support and wellness services consumers need
- Implement evidence-based wellness activities based on culturally relevant practices
- Work with individuals to set visit/exam agenda, become informed, and create a health action plan that can be added to an individual's treatment plan
- Link clients with system and community resources and be proactive about follow-up
- Have Fun - Smoking Cessation classes became "Bye, Bye Butts"

Resources

- **Health Promotion Resource Guide** informs providers on how to make informed decisions regarding evidence-based programs and practices designed to improve fitness and reduce obesity for people with SMI; it includes two checklists.
- AHRQ's **Self-Management Support Resource Library** helps providers teach people how to take informed responsibility for their own healthcare
- SAMHSA's **Bringing Recovery Supports to Scale Technical Assistance Center Strategy** has a wealth of resources

Workforce

The care a patient experiences as a result of a team of PC & BH clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.*

Grantee Examples

Pennyroyal, Hopkinsville, Kentucky

At grant inception, Nurse Care Managers (NCM) trained behavioral health staff on the definitions and wellness interventions for Health Indicators. Training materials were from CIHS, CDC, and condition-specific groups (such as the American Heart Association). The NCM uses multiple materials to convey the same information. This reinforces the message and keeps the training interesting.

Kent Center for Human/Organizational Development, Warwick, Rhode Island

Many consumers participated in wellness programming at the local YMCA. The YMCA has provided specially trained Health Navigators who meet with all consumers prior to becoming a member. The Health Navigator reviews health and wellness goals with the consumer and coaches them on how to use the equipment at the YMCA.

Asian Counseling and Referral Services (ACRS), Seattle, Washington

ACRS case managers have strong relationships with the people on their caseload. Cultural concordance between case managers and consumers helps to build this relationship. This relationship is used to promote healthy living among both case managers and consumers. Case managers have wellness goals and participate in wellness programming with consumers. Many groups incorporate snacks or a potluck, and when the group eats, case managers lead discussions around healthy eating.

Workforce

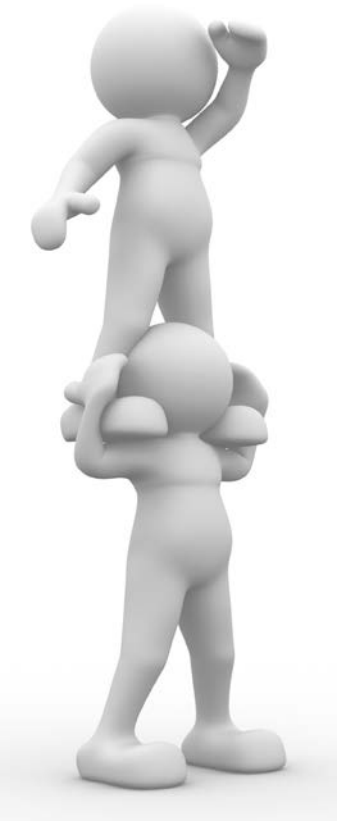
Tips

- Establish team-based care
- Learning about something is not learning to do it
- To break old habits, new behaviors need to be modeled and reinforced
- Invest in routine huddles, caseload review, and de-briefs
- Cross train again and again
- Maximize the skills of non-physician staff in care team
- Expand the role of peer support specialist
- Convene “Lunch and Learns” so providers can introduce themselves to consumers, present different health topics, and encourage discussion
- Care Managers buy-in is critical - cultural broker, health educator, lifestyle coach, interpreter, care coordination and more

Resources

- Core Competencies for Integrated Care - provide practical and logistical assistance to building an integrated care workforce
  - Shape Workforce Trainings
  - Inform Job Descriptions
  - Guide Staff Orientation
- Essential Elements of Effective Integrated Primary Care and Behavioral Health Teams summary reviews team development within effective integrated primary and behavioral healthcare teams.
- Education and Training Program - Integrated care requires revisions and additions to the traditional way in which healthcare providers are educated and trained to practice

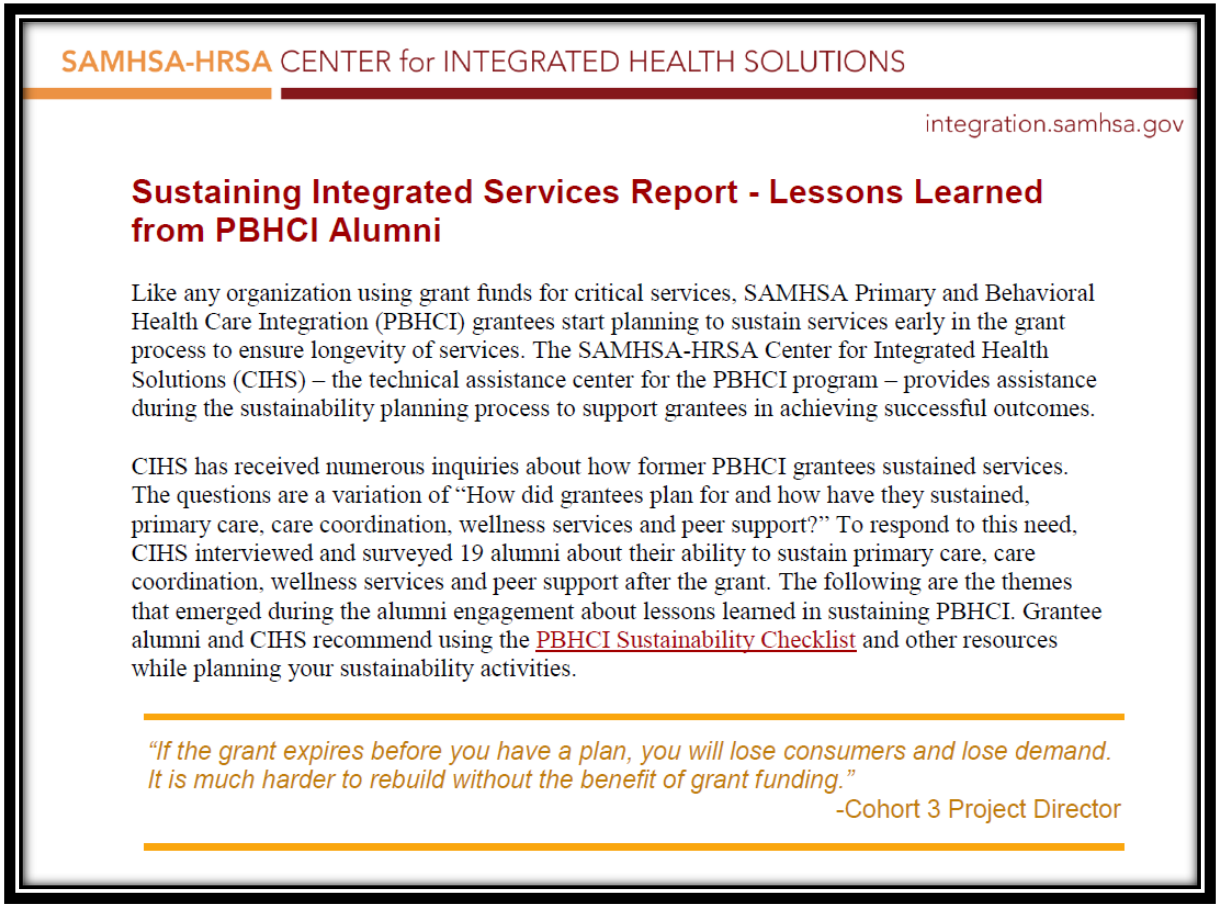
Sustainability



Sustaining integrated care over time is a significant concern for most providers of behavioral health and primary care services. Sustainability requires organizations to imbed both organizational practices and expectations for integrated care in the fiber of its operations and to maximize every possible revenue source

If the grant expires before you have a plan, you will lose consumers and lose demand. It is much harder to rebuild without the benefit of grant funding.

PBHCI Alumni Report



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Sustaining Integrated Services Report - Lessons Learned from PBHCI Alumni

Like any organization using grant funds for critical services, SAMHSA Primary and Behavioral Health Care Integration (PBHCI) grantees start planning to sustain services early in the grant process to ensure longevity of services. The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) – the technical assistance center for the PBHCI program – provides assistance during the sustainability planning process to support grantees in achieving successful outcomes.

CIHS has received numerous inquiries about how former PBHCI grantees sustained services. The questions are a variation of "How did grantees plan for and how have they sustained, primary care, care coordination, wellness services and peer support?" To respond to this need, CIHS interviewed and surveyed 19 alumni about their ability to sustain primary care, care coordination, wellness services and peer support after the grant. The following are the themes that emerged during the alumni engagement about lessons learned in sustaining PBHCI. Grantee alumni and CIHS recommend using the PBHCI Sustainability Checklist and other resources while planning your sustainability activities.

"If the grant expires before you have a plan, you will lose consumers and lose demand. It is much harder to rebuild without the benefit of grant funding."

-Cohort 3 Project Director

Sustainability

Tips

- Start early in the process
- Focus on efficient delivery of primary care services and effective billing to cover the cost of PC services
- Identify your true costs
- Seek opportunities for value-based purchasing
- Creating workable workflows, logistics, and financial break-even point with primary care partners

Resources

- Sustaining Integrated Services Report - Lessons Learned from PBHCI Alumni
- The Primary Care and Behavioral Health Integration Sustainability Checklist lists many of the most important elements of your clinical organization that need to change to support integration in your clinic.
- Using Data for Sustainability explores the link between data and sustainability to maintain the vitality in internal structure, processes and strategies.

Key Dimensions of Success

Unceasing- Top sustaining grantees changed their organization rather than operating a standalone program

Agility – Top sustaining grantees are change adept, operate entrepreneurially, and continuously and quickly adapt operations to the latest needs

Accountability - Clear about their goals and metrics, managed partners and used data to identify opportunities to improve outcomes and make adjustments as needed

Adam Bryant…

Passionately curious – alert and engaged

Battle hardened confidence – ownership and perseverance

Team smarts – understands people

Simple mind set – connect the dots for new opportunities

Fearless – surprising career moves building new skills

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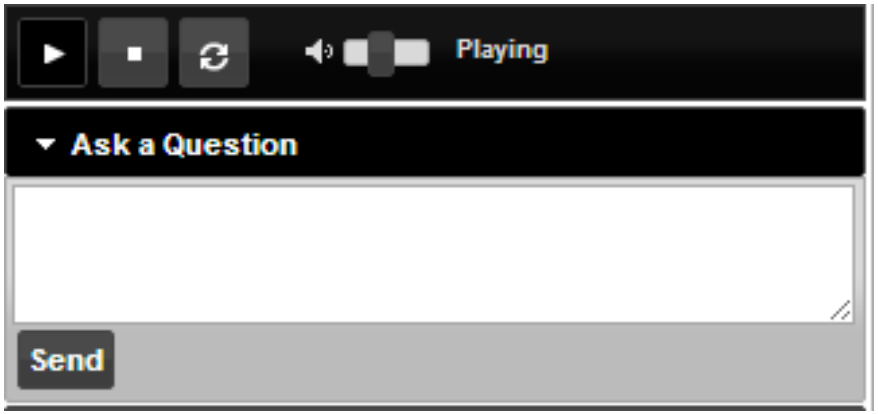

- PBHCI Field Guide
- Grantee Best Practices
- Issue Briefs: Staffing, Sustainability, State Efforts to Support PC Integration
- And more…..

CIHS Website – Focus on Implementation

Integrated Care Models

Financing

Workforce

Clinical Practice

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e-mail integration@thenationalcouncil.org

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