Learning Objectives:

Understand the role of behavioral health integration for effectively addressing NCQA PCMH Recognition Standards and responding to the complex healthcare needs of high risk populations (e.g. dual eligibles) in the Patient Centered Medical Home

Identify the critical elements for providing effective integrated behavioral health care within the PCMH

Learn from health centers about their experience with different models of BH integration, partnering with specialty BH providers and lessons learned as they transform their practices to become PCMH

Agenda

- **Judith Steinberg MD**, Deputy Chief Medical Officer, Commonwealth Medicine, U Mass Medical School, will discuss BH integration & the PCMH as part of states' efforts to transform how healthcare is delivered. She will describe one state's experience, how BHI and PCMH align around key components for improving care and outcomes, & lessons learned from the MASS experience.

- **Marty Lynch,** CEO of Life Long Medical in Berkley CA, and **Ann Lewis**, CEO of Caresouth Carolina in Hartsville SC will describe their experience on the front line in their health centers , the models of BHI integration they are using, changes they are making with PCMH, importance of community partners, lessons learned and opportunities ahead.

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Implementing Integrated Care in the Patient-Centered Medical Home: *The MA Experience*

Judith Steinberg, MD, MPH
Deputy Chief Medical Officer
Commonwealth Medicine
UMass Medical School

Agenda

- Behavioral Health Integration and the PCMH
- Primary Care Transformation in MA
- Supporting Behavioral Health Integration in the PCMH
- Addressing Barriers
- Next Steps
- Lessons Learned

Behavioral Health Integration

Goal: Optimized access and engagement in coordinated care to achieve improved health outcomes, reduced costs

Behavioral health focus in primary care:

- Screening
- Behavioral health skills

Care coordination and information sharing

Care management

Community resources

2011 NCQA Standards

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NCQA Measuring quality. Improving health care

I. Access and Continuity

- Access during and after office hours
- Electronic access
- Continuity
- Patient/ Family Partnership
- Cultural/linguistic appropriate services
- Practice organization (team based care)

Behavioral Health Focus

Optimized Access and Engagement

II. Identify/Manage Patient Populations

- Electronic basic and clinical searchable data
- Comprehensive health assessment
- Use data for population management

Behavioral Health Focus

III. Plan and Manage Care

- Guidelines for important conditions
- Care management
- Medication management
- Electronic prescribing

Care Management

IV. Self Management Support

- Self care process
  - Self-care plan & monitoring tools

Behavioral Health Skills

V. Track and Coordinate Care

- Test & referral tracking/follow-up
- Care transitions
- Referrals to community resources

Community Resources

Care Coordination

VI. Performance Measurement & QI

- Performance measurement
  - Prevention, chronic disease, overuse, utilization measures
  - Stratified for vulnerable pops.
- Patient/Family feedback
- Quality improvement
  - Patient/family involvement in QI
  - Improvement in health disparities
- Electronic reporting of performance measures
  - To consumers, health plans, public

Primary Care Transformation in MA

SNMHI Safety Net Medical Home Initiative	**MA PCMHI** MA Patient-Centered Medical Home Initiative
CHIPRA Creating Pediatric Medical Homes in MA Initiative	**Early Childhood Medical Home** MYCHILD, LAUNCH Initiatives

Primary Care Payment Reform

MA Patient-Centered Medical Home Initiative

- Statewide multi-payer initiative
- Sponsored by MA Health and Human Services
- Partners: UMass Medical School, Bailit Health Purchasing
- 46 participating practices
- 3 year demonstration; start March, 2011

Vision: All MA primary care practices will be PCMHs by 2015

MASSACHUSETTS PCMHI
Patient-Centered Medical Home Initiative

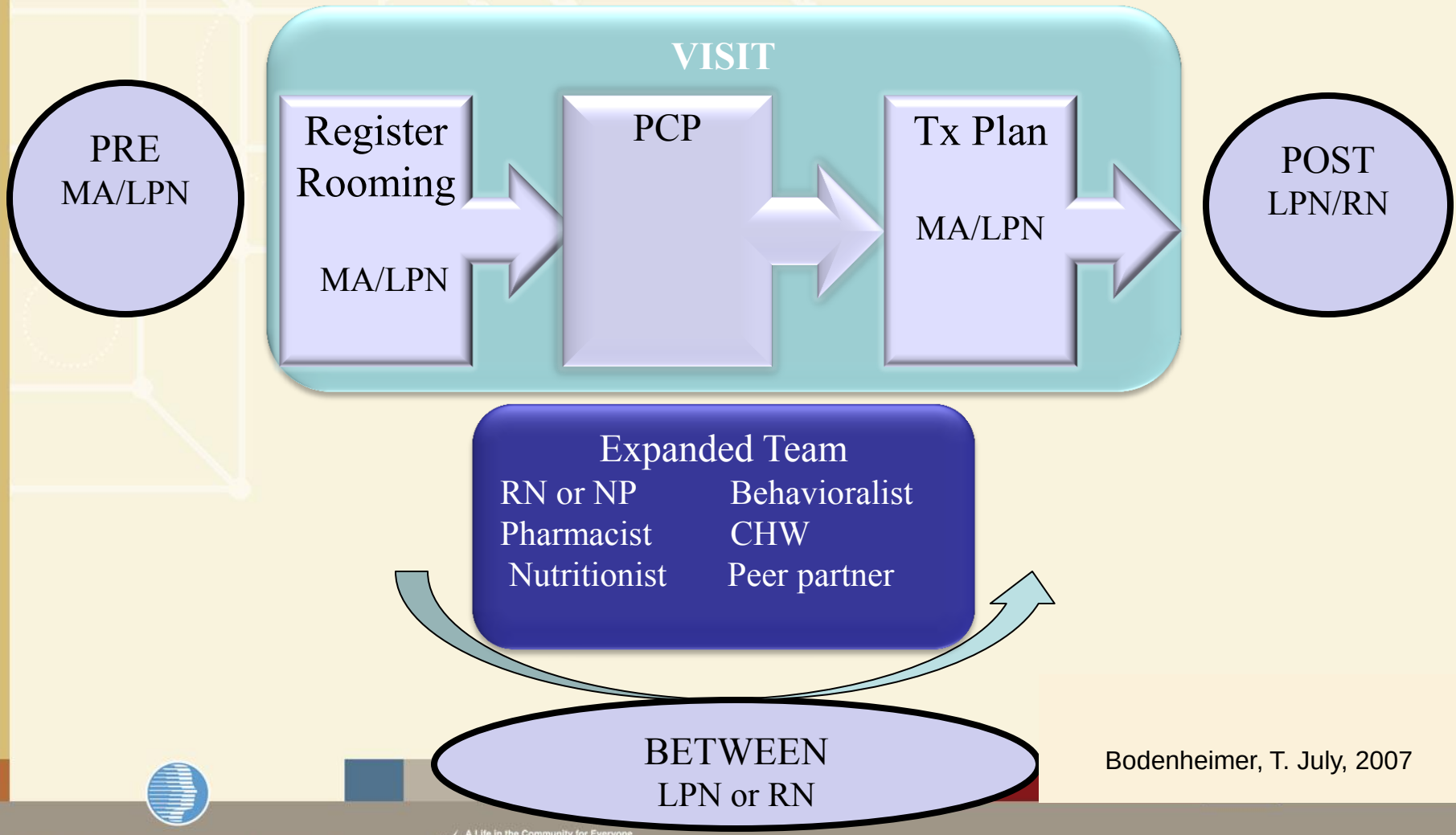
MA PCMHI: Incentive Alignment/Payment Reform

- Payment Streams:
  - Fee for Service
  - Start-up Infrastructure Payments
  - Prospective Payments
    - ✓Medical Home Activities
    - ✓Clinical Care Management
  - Shared Savings

Practice Redesign: Core Competencies

- Patient/family centeredness
- Team based care
- Planned visits & follow-up care
- Registry use for population and patient management
- Care coordination
- Care management for high risk patients
- Self management support
- Patient and family education
- Shared decision making, patient action plans
- Evidence based care
- Integration of QI
- Enhanced access
- Integration of behavioral health and primary care

The Expanded Visit: Pro-Active, Team-based Care

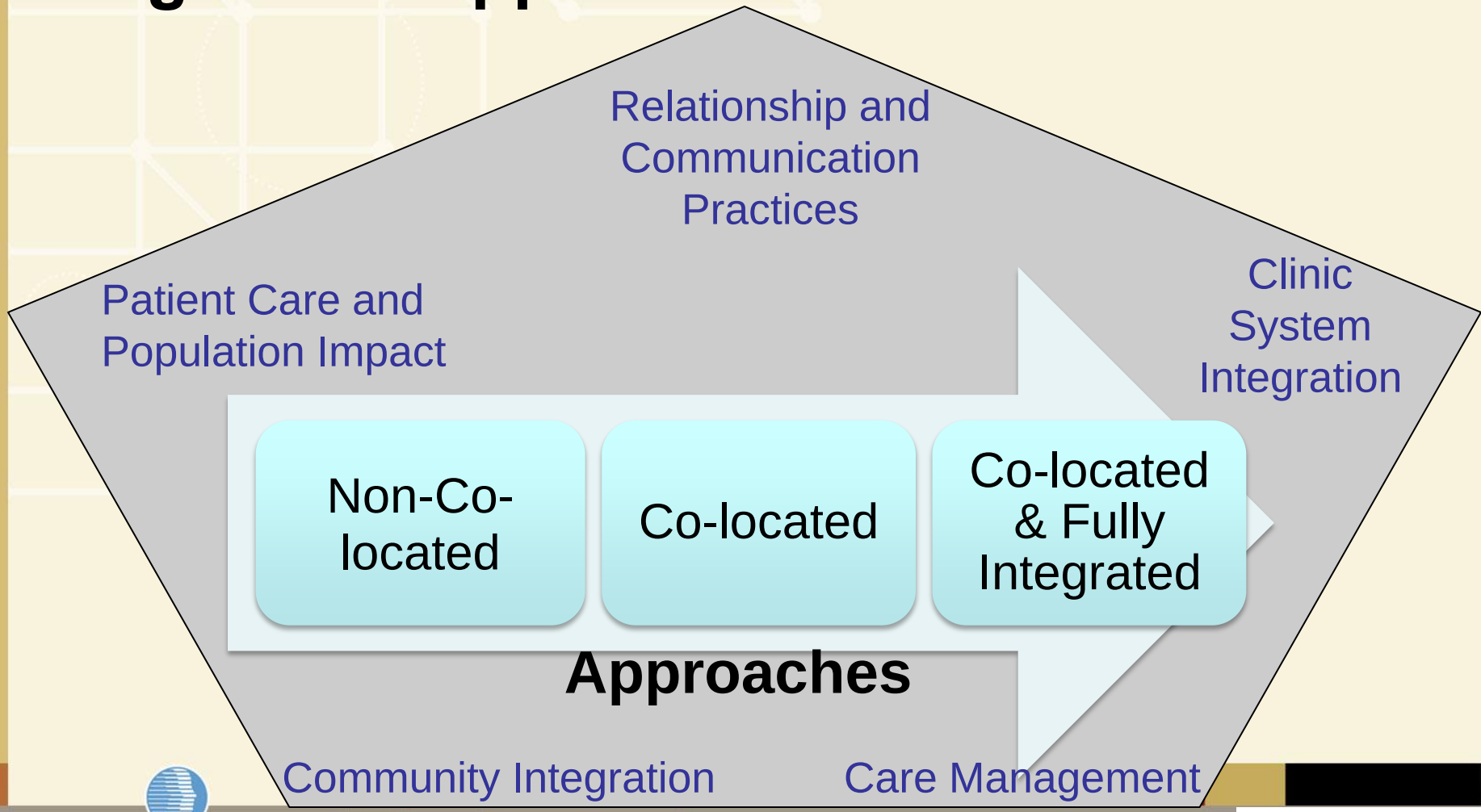


Bodenheimer, T. July, 2007

Supporting Behavioral Health Integration in the PCMH

- Delineated elements of care integration
- Recognized different approaches to care integration
- Administered practice self assessment based on elements
- Included behavioral health integration (BHI) quality measures
- Shared learning through learning collaborative
- Developing an integration toolkit

Behavioral Health Integration: Approaches and Elements



Integration Elements

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Relationship & Communication Practices	Patient Care and Population Impact	Community Integration	Care Management	Clinic System Integration
Triaged access	BH screening and referral	Self help referral connections	Coordination of integrated treatment plan	Schedule accessibility
Smooth hand-offs	BH skills used by primary care team	Specialty mental health & substance use referral	Use of behavioral health skills	Leaders & staff committed to integrated care
Team membership	Integrated clinical pathways	Community resources connections	Use of community resources	Health information exchange
Program leadership	Health care team leader			Process integration
Sharing expertise	Family focused care			Same day access

MA PCMHI Practice Self-Assessment

Goals:

- Establish practice baseline and track progress
- Highlight common gaps in integration to inform curriculum and TA

Methodology:

- Administered through “SurveyMonkey”
- Ideally completed by the primary care team in conjunction with the behavioral health providers

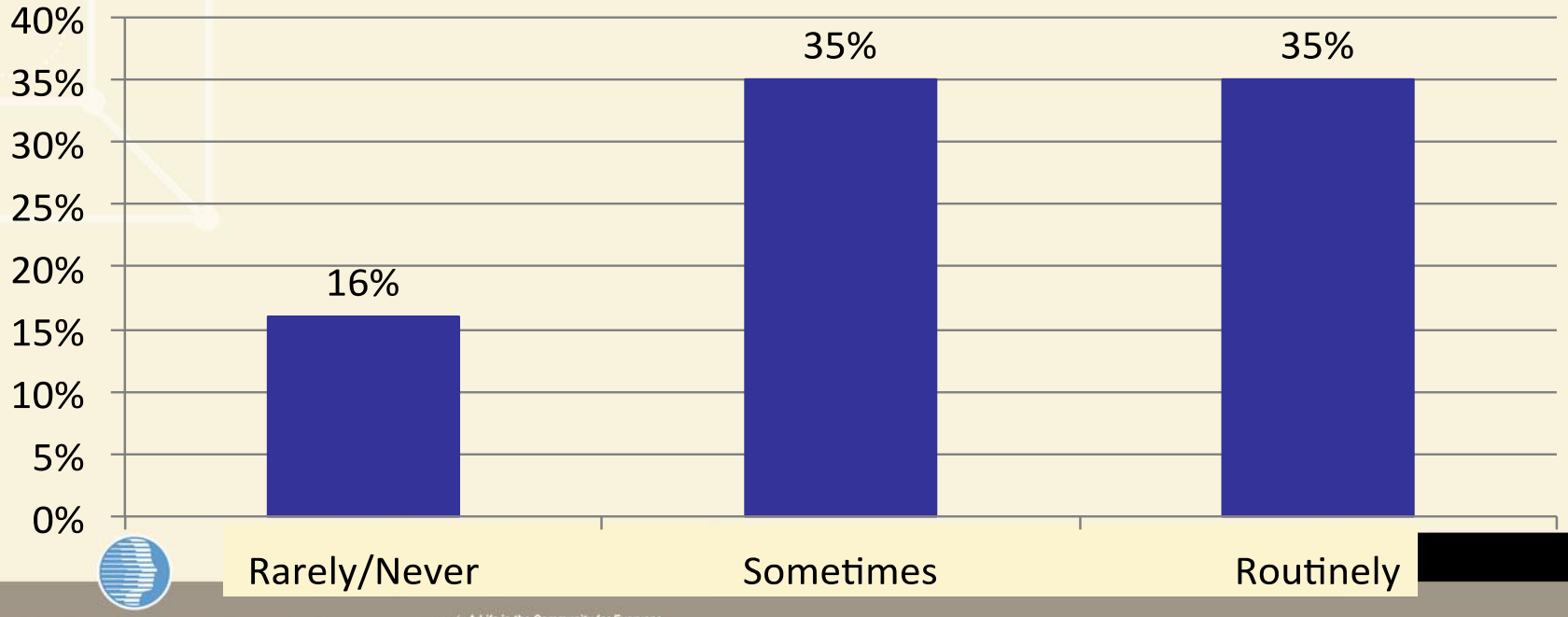
Results:

- 96% response rate

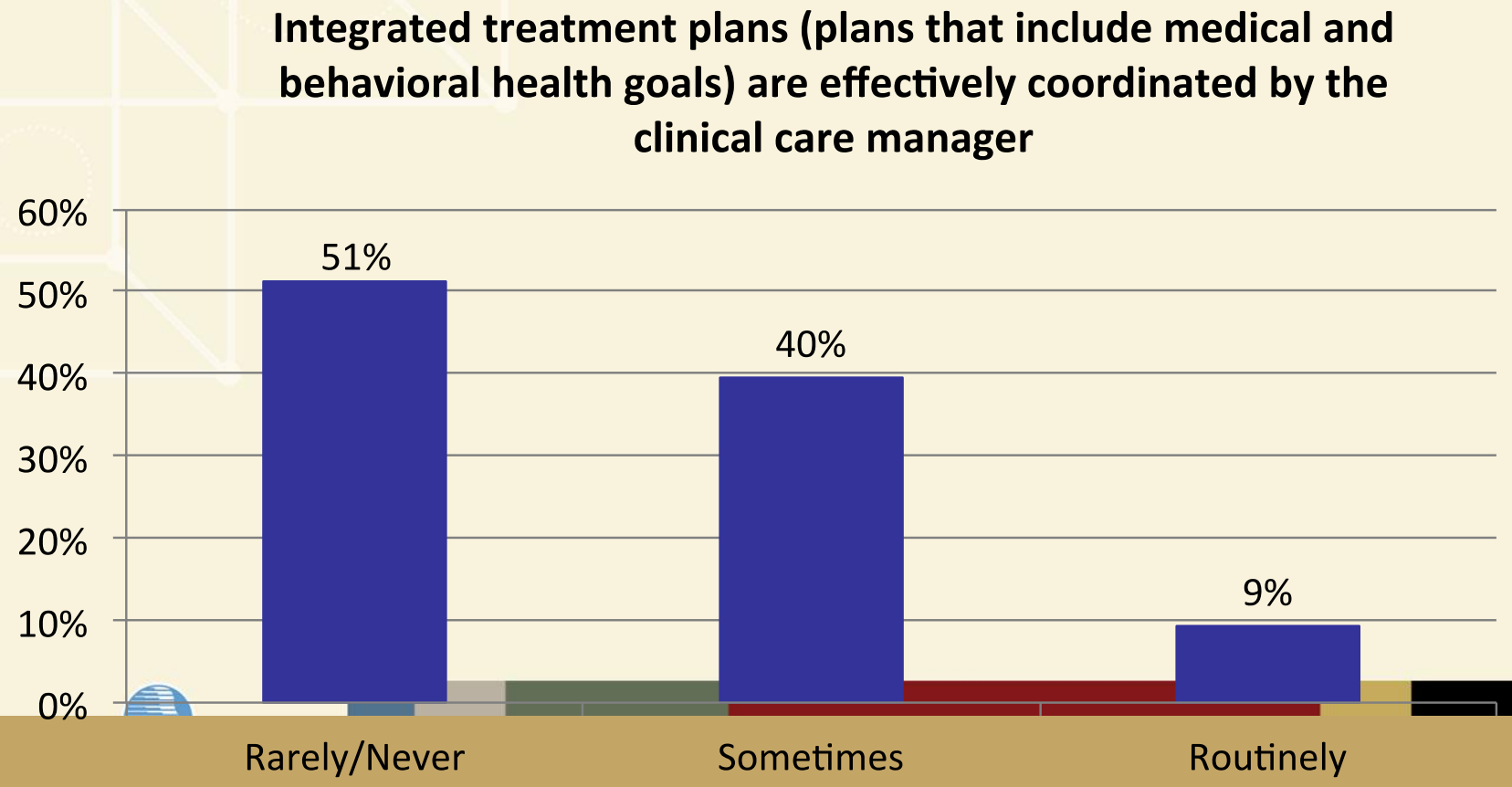
Patient Care and Population Impact Domain

70% of practices screen for depression and alcohol but most do not screen routinely

Patients are routinely screened prior to or during annual physical exams with a standardized tool for both depression and alcohol



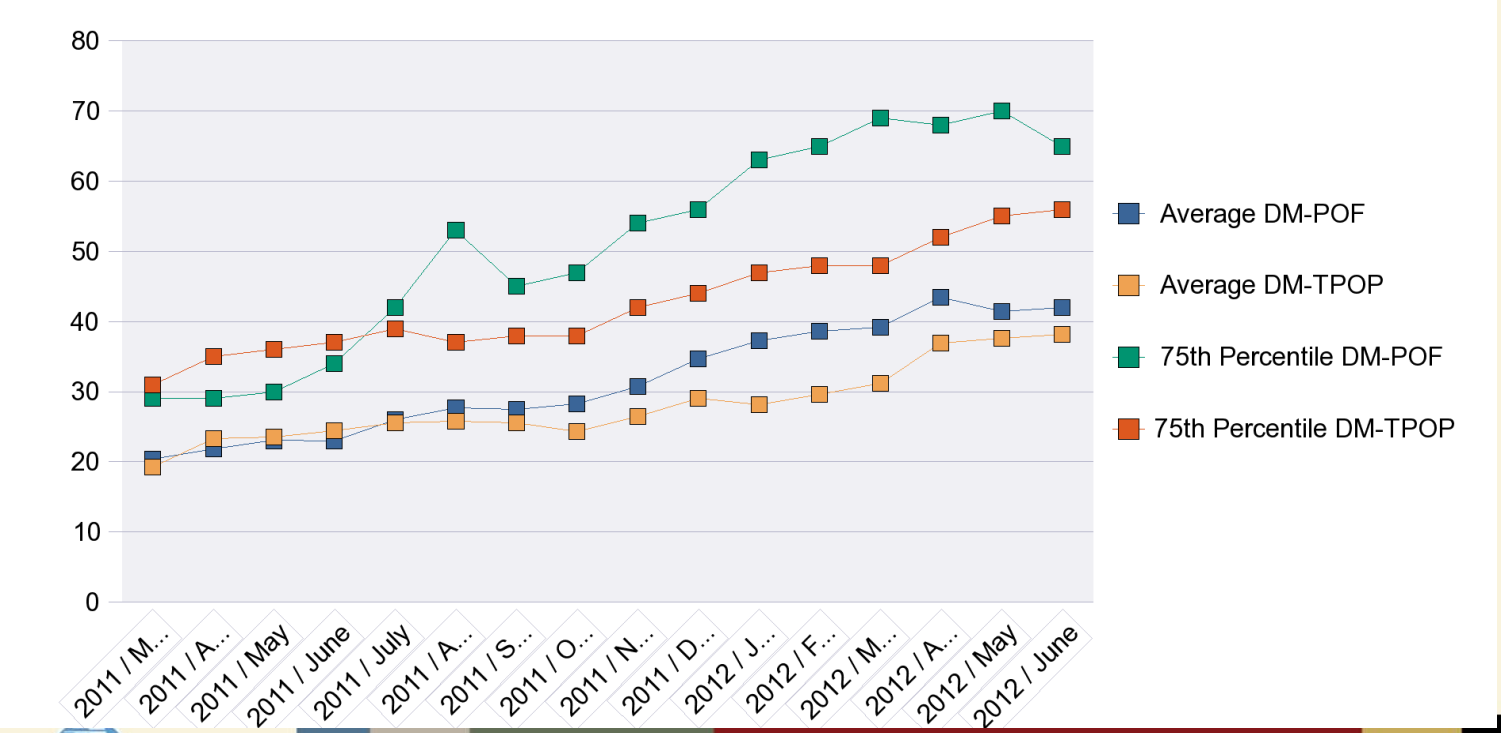
Most respondents do not have effectively coordinated integrated treatment plans



BHI Quality Measures

Depression Screening of Diabetic Patients

Aggregate Data, March 2011- June 2012



Learning Collaborative

Behavioral health integration topics in three learning sessions:

- Practical strategies for co-located practices
- Care coordination with community mental health agencies
- Use of evidence-based screeners and how to handle positive screens
- Care Management
- Role of leadership in behavioral health integration

Online Toolkit for behavioral health integration

Firefox | PCMHI Courses : Community Integratio... | pcmhicourses.ehs.state.ma.us/content.php?cid=416

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Behavioral Health Integration Roadmap

- Home
  - Roadmap Overview: Instructions
    - Step 1: Download Self-Assessment Results
    - Step 2: Identify Domain of Focus
    - Step 3: Identify Elements of Focus
  - Community Integration Domain
    - Self-Help Referral Connections
    - Community Resources Connections
    - Specialty Referral Connections
    - Engagement with Specialty Agencies
    - Patient Participation in Administration
    - Patient Participation in Services
    - Behavioral Education Programs
    - Links and Resources

Community Integration Domain

Community Integration

The seven elements of integration within the Community Integration domain focus on referral to and connection with behavioral health resources in the practice's community. Engagement with the community-based behavioral health resources that exist outside of the primary care setting assists the patient in maintaining their emotional health in between primary care visits.

Addressing Barriers

Barriers: Payment & Regulatory, Real & Perceived

Approach:

- Multi-stakeholder review of regulatory barriers
- CHC/stakeholder summit
- Department of Public Health planned approach to waiving regulation
- Medicaid review of payment barriers
- Planned multi-stakeholder taskforce on barriers to behavioral health integration

Lessons Learned

- Engaged leadership is required for successful transformation
  - Policy/political level
  - Practice level
- Care management and care coordination are key elements of PCMH and integrated care
- Payment reform drives delivery system change
- ***Change is hard!***

MASSACHUSETTS PCMHI
Patient-Centered Medical Home Initiative

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LifeLong Medical: An Integrated Primary Care/ Behavioral Health Model

Marty Lynch, PhD, MPA
LifeLong Medical Care
Nov 8, 2012

LifeLong Medical Care

- Community Health Center (FQHC) serving Oakland, Berkeley, and Richmond, California
  - Ten primary care clinics
  - Two adult day health centers
  - Two Dental clinics
  - Supportive housing program
  - Frequent Users of Health Services program
- Serving >40,000 low income patients
- 75% at or below 100% of federal poverty level
  - 53% Medi-Cal
  - 28% Uninsured
  - 11% Private
  - 8% Medicare
- Integrated primary care/behavioral health

LifeLong: A Model Rooted in Integrated Care

Gray Panthers founded – medical and social service to elderly to maintain independence.

Historical focus on serving the disabled and homeless, mental health and social problems with complex medical problems

Recent focus on managing chronic disease including behavioral interventions – diabetes, hypertension, asthma are all conditions that are most effectively managed through behavioral changes.

Traditional mental health model is now transitioning to a mixture of traditional services, health psychology and short term interventions as well as support groups.

Beyond the Medical Model

A service delivery system that coordinates behavioral care with medical care – reattaching the head to the body

Psychosocial issues are a driving factor in chronic disease predicting poor outcomes and ineffective use of the health care system

Behavioral health, social support and access to resources are key factors impacting health outcomes

Models that integrate primary care and behavioral health have the most power to create positive change

Person-centered

Integrated Medical Homes
A Good Place to Start

Key components of integrated primary care and behavioral health:

- Co-located multidisciplinary staff working as a team
- Assessment tools to identify behavioral risk factors and needs
- Seamless services that are client centered

Expands community capacity for early intervention and triage to appropriate level of services

Consumers respond well to a holistic approach that addresses the real barriers they face and that is truly tailored to their lives

LifeLong's Primary Care Model

MDs, Mid-levels, Psychiatrist and LCSWs/ Psychologists on staff at every primary care site –

Prescribe and provide access to psychiatric medications

Psychiatrists provide consults to PCPs – supports expanded access to psychiatric services

Coordinate with County/City Mental Health programs when person qualifies for services

A Spectrum of Care

We provide traditional mental health services – psychiatry, psychotherapy, long term treatment

We also provide:

- Short term interventions (1 – 3 sessions)
- ½ hour visits
- Includes case management
- Focus on working with people with chronic physical health conditions (e.g. diabetes, hypertension)
- Stages of change and motivation focused

Community Collaborations

Partnerships with Mental Health Non-Profits and Public Mental Health Agencies

- HOST/Bonita House 90 homeless adults receive primary care embedded in BHI team
- BACS – 30 homeless older adults receive primary care, medical case management, psychiatry
- Two half day primary care clinics – one at Bonita House, one at Oakland homeless service provider

Collaboration with City of Berkeley and Berkeley Mental Health to serve chronically homeless

Planning co-location of primary care provider at a large County operated out-patient mental health center

Non-Licensed Staff: Essential Team Members

Medical Assistants (MAs)–screening, facilitating warm hand offs

Case Managers – intensive services for the highest risk/highest need clients. Conduct outreach and assessment, provide education, service brokerage, outreach, harm reduction interventions.

Clinical Care Assistants - panel management, referrals, education and support, triage

Health Educators – provide group and individual interventions focused on behavior change and chronic disease

Students – psychology and social work students who extend our capacity and provide many services that aren't billable

Reimbursement/Policy Barriers

- Ignorance of Medicare reimbursement for mental health services
- Medicare equity
- Medicare Managed Care entities often sub-cap mental health
- Lack of Integration between Medicaid and Medicare

Opportunities for Integration

Dual Eligible Demonstrations in 15 States

PACE: Program of All-Inclusive Care for the Elderly

Managed Care and Accountable Care Organizations (ACO) financing models that reward integration

Patient Centered Medical Home (PCMH) Enhanced Federal Match Demos

Resources

NACHC: Guide to Position Your Health Center to Serve a Growing Elderly Population

http://www.nachc.org/client/documents/publications-resources/GD_ELD_07.pdf

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Integrating Behavioral Health and Primary Care in the Context of the PCMH: The CareSouth Experience

Ann M. Lewis, CEO
CareSouth Carolina
Ann.lewis@caresouth-carolina.com

Objectives

- Description of CareSouth
- CareSouth and PCMH
  - How we are changing
- BH Integration at CareSouth in Context of PCMH
  - Model- how we integrate BH and its impact on patient care
- Working Successfully with Community Partners
- Successes & Lessons learned
- Challenges & Opportunities Ahead

Who are we?

- A Community Health Center (FQHC) located in four counties with ten service locations in rural, medically underserved areas of SC
- Been around since 1980. Started in Society Hill with four staff and me!
- Services include family practice, pediatrics, internal medicine, women's health, integrated behavioral health, 340B pharmacy, social services, outreach, care management, transportable dentistry to children, targeted care for HIV/AIDS, HDRC Older American Act services to the elderly, just to name a few!
- Serving almost 36,000 patients
- Twenty nine providers (both physicians and midlevel practitioners)
- Over 300 staff.
- Community based Board of Directors, the majority of which are also users of the services we provide

Integration
Plan and Manage Care: PCMH Standard 3

- *CSC has been engaged with integrated BH and PC for over 20 years.*
- *Division of Behavioral Health is at the top management level in organizational structure.*
- *Behavioral Health services are part of the strategic plan, healthcare plan, business plan and performance improvement plan.*
- *Senior Leadership supports integrated behavioral health with the will, the ideas and the execution necessary to insure integration.*
- *Behavioral Health has specific system level performance process and outcome measures.*

Integration
Plan & Manage Care: PCMH Standard 3

- *ARHQ Guidelines for Depression Management*
- *PHQ 9 Symptom checklist for Depression Assessment*
- *Psychopharmacology training for all providers and counselors, nurses and social workers*
- *DSM IV training for all Behavioral Health staff*
- *Evidence based problem-solving therapy*

Integration
Identify & Manage Patient Populations: PCMH Standard 2

- *LMSWs and LISWs at every site (14), employed by CSC*
- *Behavioral Health staff provides ‘‘stepped’’ clinical counseling integrated into primary care*
- *Designed appointment systems to support the needs of our patients including: follow-up activities and multiple appointments on same day, max-packing, 15 / 45 minute rule)*
- *Nurses triage all patients for ‘‘red flag’’ depression statements, and initiate PHQ. All patients at least once annually.*
- *Telephone ‘‘visits’’ for follow-up and care management*
- *‘‘Primary care’’ mental health assessment & treatment in addition to specialty mental health care*
- *Co-location of clinical counselors and primary care providers in the same building, down the hall*

Integration
Enhance Access & Continuity: PCMH Standard 1

Use a Registry (PECS data management system) to track, report and trigger follow-up dates for improved depression care and chronic co-morbidities

Mental Health notes are integrated into primary care medical record (tab separation)

Mental Health Providers are part of the Care Team - Huddles

Data is reported monthly on a Scorecard in an Employee Portal.

Data is discussed at site meetings, staff and provider meetings and monthly PI meetings

All data is unblinded.

Integration
Provide Self Care Support: PCMH Standard 4

- *CSC Depression management handbook which includes education and action plan*
- *All clinical staff trained on self-management goal setting*
- *Problem solving tool from www.howsyourhealth.org*
- *Motivational Interviewing trained using National Council of Behavioral Health model*
- *Individualized self management goal setting implemented*
- *Medication monitoring and measurement*

Integration
Community Resources

- *Collaborate with and support local Community Mental Health Centers devastated by state budget cuts*
- *Relationship with DJJ to provide mental health care for DJJ adolescents*
- *Parenting classes for DSS/CPS families*
- *Mental health care for geriatric patients of long term care facilities*
- *Relationship with Pee Dee Coalition Against Domestic Violence for depression treatment for domestic violence patients*
- *Depression treatment for HIV/AIDS patients in Ryan White program*
- *Relationship with McLeod RMC Inpatient Behavioral Health facility for inpatient referrals.*
- *Affiliation with local hospital psychiatric geriatric unit and psychiatrist*

Quick Take aways…

On site Behavioral Health Counselors, masters level, licensed

Program in place for over 20 years! Hang in there!

Provide Comprehensive Assessment/Diagnosis.

Same Day Access: Using “45 / 15 rule”

Hallway Consultations between primary and BH care providers for efficiency, access and continuity

Care Monitoring and Condition Management: Evidenced based (depression) protocols in place.

Patient self management support – Patient confidence

Follow up and tracking is essential

Brief BH change strategies for chronic conditions… AND!

Individual Psychotherapy and Family Therapy

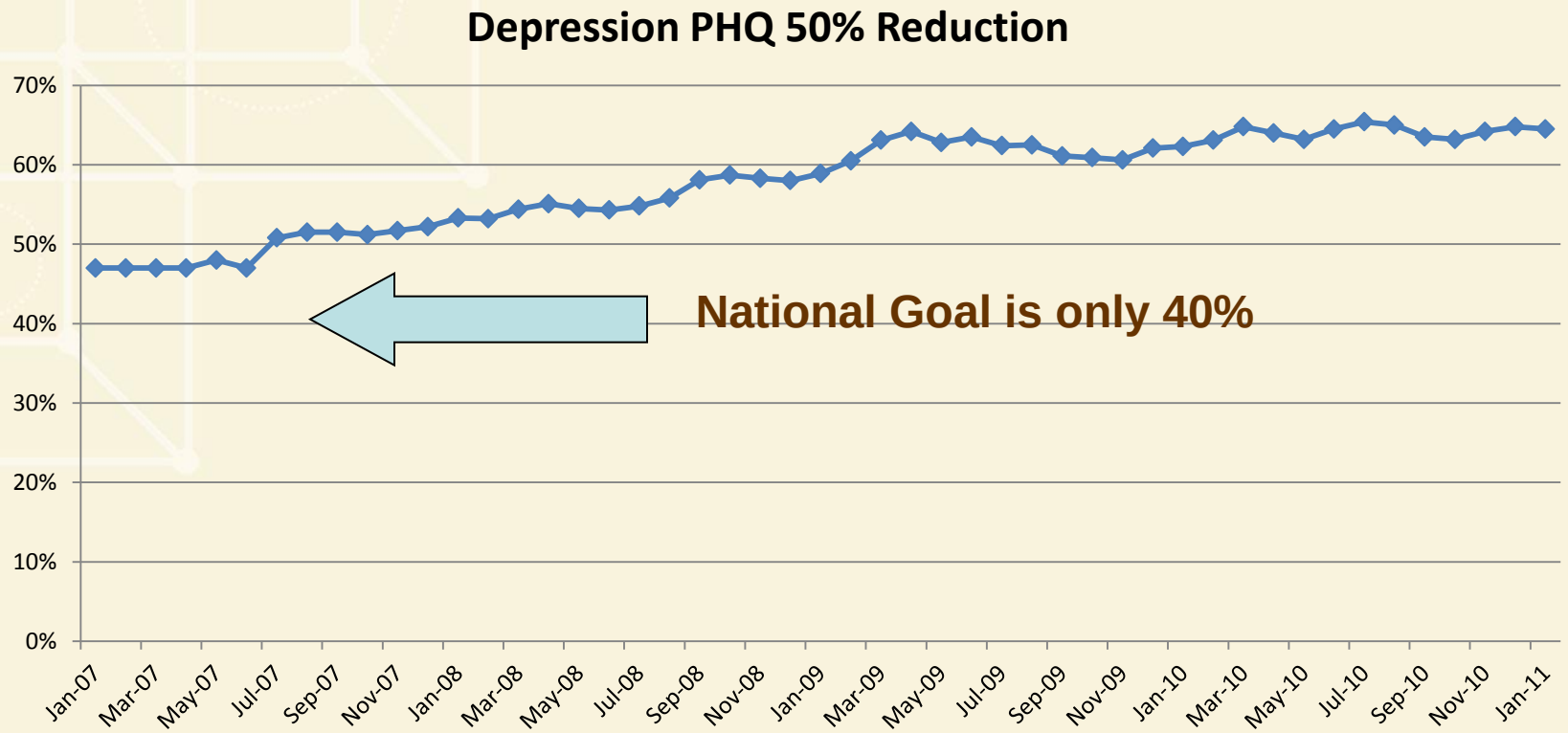
Lessons Learned

- Co-location of the BH / MH and PC is Essential, not marginal !!
- The system must support MH/BH and PC collaboration.
- Aggressive primary care medication management!
- Increased patient access and satisfaction and Improved Outcomes should be the purpose of integration.
- Clinical Information System/Patient registry = focus
- BH paperwork / documentation must be adequate, not voluminous. One chart only.

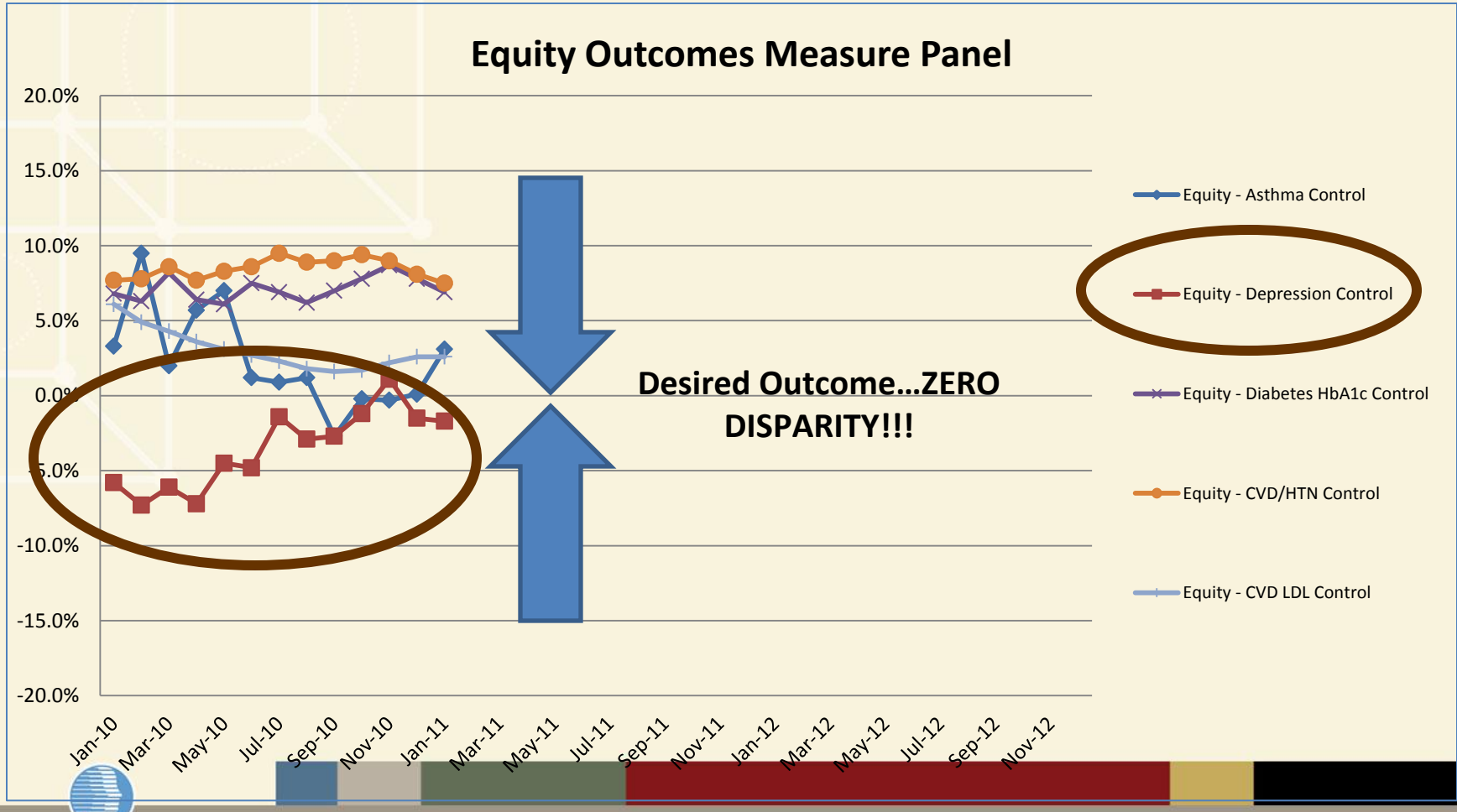
So What?

Depression Outcomes

Physician Health Questionnaire 9 symptom checklist: reduction in scores



Equity Measures



The CareSouth Carolina Integration Model

June 2011 HRSA Office of Rural Policy report: Rural Behavioral Health Programs and Promising Practices

69 nominated programs

- Robust
- Relevant to rural
- Impact
- Sustainability and expansion capability
- Capacity
- Documentation
- Effectiveness
- Community engagement

CareSouth Carolina was one of the 69!

Challenges and Opportunities

- State Medicaid / Managed Care barriers
- Credentialing is all over the map!
- External system silos
- 42% of patients with chronic illness are also severely depressed.

More Questions?

Contact Liz Kershner, Director of Behavioral Health, CareSouth Carolina

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