Providing Specialty Care in the Safety Net

A New Model of Delivering Behavioral Health Care

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Integrating Primary Care and Behavioral Health

- In a 2007 survey of safety net participants, the top three needs were:
  - 1. Access to Specialty Care*;
  - 2. Access to medications; and
  - 3. Recruitment of providers
  - *Mental Health care was the top specialty service need
  - WHY??

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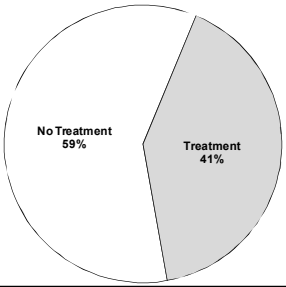
National Comorbity Survey Replication
Provision of Behavioral Health Care: Setting of Service



SOURCE: Wang, Philip S., et al, Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005

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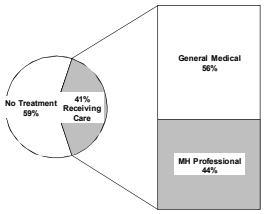

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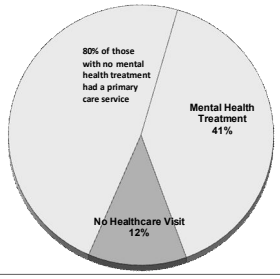
Access to Behavioral Health Intervention



Primary Care in the US: The *de facto* Mental Health Care System

1) More mental health interventions occur in primary care than specialty mental health settings. (Wan et al., 2005)
2) Primary care providers prescribe 70% of all psychotropic medication, including 80% of anti-depressants. (Strosahl, 2001)
3) PCPs end up delivering most of these Rxs because, with 80% of the population visiting a PCP in the course of a year, they penetrate the population the deepest. (Strosahl, 1998)
3) Over one-third of the patients in most primary practices have a psychiatric disorder. (Spitzer, et. al., 1994; Mauksch, et. al., 2001)
4) Psychological distress drives primary care utilization.
5) A variety of studies have concluded that 70% of all health care visits have primarily a psychosocial basis. (Strosahl, 1998; Fries, et. al., 1993, Shapiro et.al., 1985)
6) **Every primary care presentation has a behavioral health component.**
7) The highest utilizers of health care commonly have untreated/unresolved behavioral health needs. (Katon, et. al., 2003)

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Other Issues

- People with Serious Mental Illness (SMI) die on average 25 years younger than the general population.
- The biggest cost factor in the Medicaid program for people with SMI is medical care, not mental health care.

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IMPORTANT

- This is not about professional turf, or scope of practice.
- This is about addressing an unmet need in the context of the Patient Centered Medical Home.
- And, the known gaps that exist.
- Finally, primary care is known not to do a very good job of addressing Mental Health issues, nor managing the Behavioral Health aspects of medical conditions.

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We Have Two Integrated Programs Underway

1. A Magellan-funded program with IME
   - Targeted at those with SMI
   - ARNP placed at our Community Mental Health Center's site (Eyerly Ball)
     - To provide the medical care
   - Along with a team made up of a Social Worker, Nurse, and Peer Support
   - Providing intensive case management

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Two Programs (cont.)

2. A Safety Net Network-funded program that places behavioral health specialists in the primary care setting
   - To address MH needs
   - But also the behavioral aspects of medical care, especially chronic disease and healthy behavior
   - The focus of today's presentation

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Challenges in Behavioral/Mental Health Care *and* Primary Care

In primary care …..	**In specialty mental health care …..**
Why do so few of our patients referred to MH follow through on the referral?	Why didn't the client come in? (we assume they must not be ready for change)
Why are so many MH patients coming in for care when a MH system exists to tend to their needs?	What happened to the no-shows? Are they still struggling?
How can we get patients with chronic conditions like diabetes to change behavior so crucial to managing their disease?	Frustration because at the end of the day, have only seen a handful of clients (many of whom are the same clients seen week after week). How many people are we really helping?
How can the PCP be expected to meet all of the patient's needs with 15-minute visits?	First time clients often fail to show which is frustrating because the wait list is typically lengthy.

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Trends in Primary Health Care

1) Under-recognition of behavioral problems by both PCPs and patients.
   - Given the chronic nature of many MH problems, they may persist and result in frequent PC visits if not recognized and treated.
   - Unfortunately with 15 minutes visits, and on average (3) health concerns voiced by patients per visit (Kaplan, et al., 1995), PCPs have little time to explore problems.

2) Patients often don't help with the above situation.
   - Patients frequently fail to report emotional problems and are often more focused during PCP visits on the physical manifestations of stress than *on the stress itself.* (Bray et al., 2004)

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Trends Continue …

3) Chronic conditions are the fastest growing part of PC (Patterson, et al., 2002); behavioral issues arise when patients present with chronic medical problems.
   - Patients must learn to cope with conditions that can disrupt lifestyle and relationships.
   - Moreover self-management practices such as following a medication regimen and maintaining a healthy lifestyle are basic to good outcomes.
   - PCPs must counsel patients on how to cope, educate family members, and motivate patients to make the lifestyle changes needed to manage the chronic condition.
   - All of this within a 15 min appointment!
4) In addition, PCPs spend much time and energy counseling on behavior issues important to health such as smoking, poor diet, lack of exercise, problematic alcohol and drug use, as well as the use of bike helmets, seat belts, contraceptives, and high risk sexual behaviors.

PCPs and Patients Need *Help!*

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Mental Health & Behavioral Health ***Integrated*** into the Primary Care Practice: A Model for ***Holistic Health Care***

- The current system of *dis-integrated* primary and mental/behavioral health is not working - patients with behavioral issues are not getting the care they deserve.
- PC teams are overwhelmed and underprepared for dealing with behavioral problems and health care for the entire population is compromised.

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A Move Toward Population-Based Care

The goal of the *integrated* model is not to replace the specialty MH care system, but rather to improve the treatment of behavioral problems in primary care.

- The *integrated* model does not solve society's mental health problems; it represents an important step toward improving overall population health.
- Mental health applications in the integrated model are more restrained and geared toward smaller changes in a *larger* number of people.

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How is MH/BH Integration in the Primary Care Setting Different from Traditional Specialty Mental Health Care?

Integration into PC	Traditional Specialty Care
Embedded member of PC team	Ancillary service provider
Patient contact via hand-off	Patient contact via referral
Verbal communication predominates	Written communication predominates
Brief, aperiodic interventions	Regular schedule of sessions
Flexible schedule	Fixed schedules
Generalist orientation	Specialty orientation
Behavior medicine scope	Psychiatric disorders scope

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A **Behavioral Health Consultant (BHC)** is an Embedded, Full-Time Member of the Primary Care Team

- The BHC provides brief, targeted, real-time assessments and/or interventions to address the psychosocial aspects of primary care to **improve the overall health of the population.**
- Instead of focusing on diagnosis, assessments focus on functional assessment and treatment plans are geared toward functional restoration rather than symptom elimination.

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The **Behavioral Health Consultant (BHC)** Role is Multidimensional

- Management of psychosocial aspects of chronic and acute diseases.
- Application of behavioral principles to address lifestyle and health risk issues.
- Emphasis on prevention and self-help approaches, partnering with patients in a treatment approach that builds resiliency and encourages personal responsibility for health.
- Psychoeducation plays an important role in the BHC visits and less time is devoted to development of therapeutic rapport – this is possible largely because of the close collaboration between PCP and BHC which allows the BHC to inherit the rapport between PCP and patient.
- Consultation and co-management in the treatment of mental disorders and psychosocial issues.
- Focus is population management, quite different from specialty Mental Health.

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Three Components of the PC-MH-BH *Integration* Model

Co-Location – refers to the actual placement of the Behavioral Health Consultant (BHC).
- Placing the BHC inside a PC clinic is ideal as this will facilitate communication between provider and ease "warm handoffs" (to be discussed in later slide) and referrals.
- The BHC provides services side by side with the PCP, seeing patients in the exam room: the BHC may see 10-15 patients each day, with follow-ups limited to 1-4 visits.

Collaboration – refers to the relationship between the PC and the BHC.
- A collaborative relationship includes frequent sharing of information, joint treatment planning, and a truly biopsychosocial approach to care.
- The goal is simply to develop a well-rounded treatment plan that the PCP then follows, thus ensuring the patients receive comprehensive biopsychosocial care, and the PCP learns more about behavior change strategies and mental health management.

Integration – occurs when the BHC is considered a regular part of the health care team. In an integrated health care model, a visit with the BHC is as routine a part of care as a visit with the CMA/Nurse.
- Behavioral health services are incorporated seamlessly into care, and both patients and staff view the BHC as just another member of the PC team.
- The BHC helps the PCP manage the psychosocial needs of their patients, the PCP retains control of the patient's care. Given the close working relationship between the PCP and BHC, truly holistic care is enabled.

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How is the **PCP** Role Enhanced Within an Integrated Model?

- The Primary Care Provider (PCP) determines that psychosocial factors underlie the patient's presenting complaints or are adversely impacting the response to treatment.
- During the visit the PCP "hands-off" the patient to the BHC for assessment or intervention, or schedules the patient for an initial visit with the BHC.

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Considerations for PCP "Hand-Offs" for BHC Services

Health Behavior/Disease Management
- Medication Adherence
- Weight Management
- Chronic Pain Management
- Smoking Cessation
- Insomnia / Sleep Hygiene
- Psychosocial and Behavioral Aspects of Chronic Disease
- Any Health Behavior Change
- Management of High Medical Utilization

**** Also refer to "BHC Referrals" Handout***

Mental Health Behavioral issues
- Diagnostic clarification and intervention planning
- Facilitate consultation with psychiatry regarding psychotropic medications
- Behavior and mood management
- Suicidal/homicidal risk assessment
- Substance abuse assessment and intervention
- Panic/anxiety management
- Interim check of psychotropic medication response
- Co-management of somaticizing patients
- Parenting skills
- Stress and anger management

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How Does the **Psychiatrist** Fit into the Integrated Model?

The PCP and BHC *consult* with the Psychiatrist

- Access ↑
- Population-Based Care ↑
- Skills of Primary Care Colleagues ↑

The Psychiatrist participates in primary care:

- Treatment Team Meetings
- Telepsychiatry
- Co-Management of Care *(if a traditional referral is needed, Psychiatrist stabilizes the patient and then returns them to Primary Care)*

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Organizational Decision

1) Moving from a standard primary care delivery model to an integrated primary care/mental health-behavioral health delivery model requires an organizational *paradigm shift*.

2) The Medical Director and Behavioral Health Consultant (BHC), lead the PCPs through this care delivery model change by informing , educating , and reinforcing.

3) A budget; 1) hire a BHC, 2) provide for specialty consultations-psychiatrist (i.e.: child & adolescent psychiatry, complex adult psychiatry cases), and 3) administrative management functions, and 4) additional funds for patient medications as is possible via grants; chronic mental and/or behavioral health conditions require long-term medications and patient adherence.

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How to Get Started: A Brief Overview

Preliminary: Program and CHC leadership peruse the "Purple Book" (and for the over-achievers in the crowd: current literature on PC-MH Integration) to understand care delivery model change.

First: Visit a CHC that has an Integrated Primary Care and Mental/Behavioral Health Care Model.

Second: Determine your billing strategy: grant funding, billing for direct service, no-billing.

Third: Begin ongoing PCP education for all CHC PCPs on the Integrated Model at every opportunity (one-on-one, meetings, professional presentations).

Fourth: Choose a site for your pilot implementation and determine the best location for the Behavioral Health Consultant (BHC) office. The BHC must be easily accessed and highly visible.

Fifth: Define your "Integration Team" at pilot site: PCPs, Behavioral Health Consultant (BHC), CHC Medical Director/Clinical Champion, Administrative Staff person, and Psychiatric Consultation Specialist.

Sixth: Make the "Purple Book" (Behavioral Consultation and Primary Care: A Guide to Integrated Services, Robinson & Reiter 2007) *required reading* for every provider involved in the implementation process.

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The BHC is a Piece of the Primary Care Team

1. The BHC must be visible and if he/she has an office, it must be in the "heart" of the clinic so that he/she is readily accessible to the PCPs.
2. The BHC may work right out of the primary care exam rooms; this puts the BHC in the middle of the action more often with more opportunities to talk with PCPs.
3. If not talking to a PCP or a patient, the door to the BHC office should always be open. When PCPs drop by, they get immediate attention. Interruptions are expected and ok even if they occur during a patient visit. The worst scenario is for a PCP to walk away frustrated because the BHC is unavailable. Accepting interruptions takes some getting used to, but most BHCs come to prefer it over time because of the positive feedback from PCPs.
4. Advertise the BHC service on the door of the BHC office, or in the "common area" of the clinic (at the nurses station): handouts advertising classes, resources in the community, the BHC schedule, behavioral health issues, etc…

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What About the Patient?

- The patient will now experience her/his provider "team;" comprised of their PCP and a BHC, that is available right now and right in the clinic exam room.
- The patient gets the benefit of co-location, collaboration, and assessment from their holistic provider team.
- The Integrated Primary Care/Mental Health/Behavioral Health Model supports patient empowerment and self-management.

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How Does the Patient Clinic Flow Work?

- Patients are scheduled, as usual, with their PCP.
- Patients register at the front desk, as usual.
- Patients are worked up by the Nurse or CMA , as usual, and placed in an exam room.
- All members of the Primary Care Team (Providers, Nurses, CMAs, BHC) are aware of the Provider/Clinic schedule and when there is "time" to bring the BHC in.
- All members of the Primary Care Team (Providers, Nurses, CMAs, BHC) work to keep the PCP "running on time."

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The BHC May be Called Into the Exam Room At Any Point that Mental Health or Behavioral Issues are Identified.

- The CMA may immediately identify that the patient is reporting depressive symptoms; the PCP is running behind, and the CMA radios the BHC to come into the clinic exam room. The CMA moves to their next patient. A "Handoff."
- The PCP has identified either a behavioral or mental health issue that challenges the patient's daily functioning and radios the BHC to come into the exam room. The PCP moves to their next patient. A "Handoff."
- The PCP has completed their appointment and determined that the patient needs specific behavior or mental health follow-up and refers the patient to the BHC for a follow-up appointment on another day.

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Questions?

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