Sharing the Care: Maximizing Integrated Behavioral Health at an FQHC

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Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.
Conference Resources

Slides and handouts shared in advance by our Conference Presenters are available on the CFHA website at http://www.cfha.net/?page=Resources_2017

Slides and handouts are also available on the mobile app.
Learning Objectives

At the conclusion of this session, the participant will be able to:

• Articulate the key components of an augmented level 6 integrated care model within a FQHC

• Identify the positive outcomes that a hybrid IBH/chronic care management shared care model can provide in a primary care setting

• Articulate main funding considerations for making a hybrid IBH/chronic care management shared care program as fiscally healthy as possible


Learning Assessment

A learning assessment is required for CE credit. A question and answer period will be conducted at the end of this presentation.
Assumptions

- Intersection of physical and behavioral health
- Continuity
- US Health outcomes are unsatisfactory
Our Context

- FQHC serving over 50,000
- 14 Clinical Sites
- 80% fall under Federal Poverty Guidelines
- Ethnically diverse
Our Context

- 12 / 12 / 12
- Sends more graduates to HPSAs than any other in Texas
Our Context
What Drew You to Family Medicine?

- The Most Common Interview Question
- What is the Answer You Would Hope to Hear?
The One-Man Band

To meet all of the acute, preventive, and chronic disease management needs of a usual practice...

= 21 hours every workday
How we got here: PCMH

- **Level 3 Recognition**

- **Minimal Culture Change**
  - Failures of traditional care (e.g., standards of chronic disease care) were brought to light, but real solutions never actualized
  - Rapport injuries along the way
  - Created a hunger that was never satiated
Previous Attempts at Integration

- Adult and Child Psychiatrists in **same system, same building**
- A large counseling center in the **same system, same building**

**Problems**
- Care was parallel and siloed
- Lack of continuity / lack follow up
- Structural barriers
- Patient lack of insight
First Iteration of Full Integration

- Clinical Psychologist and LCSWs as fully integrated consultants using PCBH Model
  - shared all practice space
  - functioned as one integrated system
  - team-based communication
  - blended culture
Problems & Solution
Problem #1: Most patients expect to receive MH treatment in primary care. Primary care is well-positioned but overwhelmed.

Solution: Primary care behavioral health integration

- Integrated
- Accessible
- Personal
- Sustained
- Comprehensive
- Community-oriented
Problem #2: Increasing complexity and prevalence of chronic illness is overwhelming the primary care system

Solution: Care management integrated with primary care team

Chronic Care Management

Primary Care

Integrated • Accessible • Personal • Sustained • Comprehensive • Community-oriented
Primary Care

Integrated • Accessible • Personal • Sustained • Comprehensive • Community-oriented
Integrated Health Manager

Introduce a new provider into the core primary care healthcare team who serves as integrated behavioral health provider and chronic care manager.
A New Professional: Integrated Health Manager

- Licensed Clinical Social Workers (LCSWs) ideal professional for the role

- LCSWs receive generalist training in mental health and advanced case management, priming them for this unique role

- Social workers equipped to pay attention to macro and mezzo considerations that impact the delivery of micro services
6 Plus?
<table>
<thead>
<tr>
<th>Level</th>
<th>Key Element</th>
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| Level 1 | Minimal Collaboration | In separate facilities, where they:  
- Have separate systems  
- Communicate about cases only rarely and under compelling circumstances  
- Communicate, driven by provider need  
- May never meet in person  
- Have limited understanding of each other’s roles |
| Level 2 | Basic Collaboration at a Distance | In separate facilities, where they:  
- Have separate systems  
- Communicate periodically about shared patients  
- Communicate, driven by specific patient issues  
- May meet as part of larger community  
- Appreciate each other’s roles as resources |
| Level 3 | Basic Collaboration Onsite | In same facility not necessarily same offices, where they:  
- Have separate systems  
- Communicate regularly about shared patients, by phone or e-mail  
- Collaborate, driven by need for each other’s services and more reliable referral  
- Meet occasionally to discuss cases due to close proximity  
- Feel part of a larger yet ill-defined team |
| Level 4 | Close Collaboration Onsite with Some System Integration | In same space within the same facility, where they:  
- Share some systems, like scheduling or medical records  
- Communicate in person as needed  
- Collaborate, driven by need for consultation and coordinated plans for difficult patients  
- Have regular face-to-face interactions about some patients  
- Have a basic understanding of roles and culture |
| Level 5 | Close Collaboration Approaching an Integrated Practice | In same space within the same facility (some shared space), where they:  
- Actively seek system solutions together or develop work-a-rounds  
- Communicate frequently in person  
- Collaborate, driven by desire to be a member of the care team  
- Have regular team meetings to discuss overall patient care and specific patient issues  
- Have an in-depth understanding of roles and culture |
| Level 6 | Full Collaboration in a Transformed/ Merged Integrated Practice | In same space within the same facility, sharing all practice space, where they:  
- Have resolved most or all system issues, functioning as one integrated system  
- Communicate consistently at the system, team and individual levels  
- Collaborate, driven by shared concept of team care  
- Have formal and informal meetings to support integrated model of care  
- Have roles and cultures that blur or blend |
Shared Care

- IHM assumes care for panel of patients
  - Providing IBH and Care Management (for physical and behavioral health) services when appropriate

- Bidirectional Warm Handoffs and Co-visits
- The Team determines who is seen
- Moves well beyond consultation
Shared Care

- Assumes the majority of patients would benefit from IHM services

- Integrated at the Family level
  - Allows care to pivot from one individual in the family unit to another
Internal Stepped Care and Support

- Human Behavior and Mental Health Consultation Clinic
  - staffed by Clinical Psychologist and Family Medicine Resident/Faculty

- Clinical Decision Support

- Pathways to more intensive psychotherapy services
New Normal

Doctor and Clerk
Doctor, Nurse, Clerk
Doctor, Nurse, Clerk, Integrated Health Manager
Culture Change
integrated health
MANAGEMENT
What makes IHM unique?

- Known components, novel combination

- Full integration congruent w/ Family Medicine ethos
  - Relational Continuity – no call center in another city
  - Ability to follow family units
Portability

Health Professional Shortage Areas by Geographic Area
IHMs: Relatively Uniform Skillsets

Consistency of Support Across PCPs

- Family Medicine
- Pediatrics
- Internal Medicine
- OB/GYN
Quality Assurance and Training

▪ First, train the trainer
▪ Each IHM receives 4 weeks of individualized training
  ▪ standard syllabus
▪ Bimonthly meetings include ongoing training
  ▪ upcoming trainings include 2 days on pain management
▪ 64 hour certificate program
Certificate Program

Are you interested in...

- increasing access to mental health services through primary care medical practices?
- impacting the behavioral and medical health outcomes for thousands of patients?
- delivering evidenced-based interventions in a transdisciplinary team?
- investing in your current practice and agency by learning best practices for implementation?

Then the new Integrated Behavioral Health (IBH) certificate program beginning in January might be for you! It is open to practitioners and students alike.

The IBH certificate program at GSSW aims to equip psychologists and social workers to fill this role and practice at the highest level of their license in the unique context of primary care. The goal of this training program is to equip clinicians to provide quality integrated behavioral services in primary care settings working with family physicians, pediatricians or geriatricians. Four weekend sessions are offered throughout the spring and in order to earn the certificate in IBH, you must complete three of the four sessions. 16 social work CEUs are also available for each weekend course completed.

For more information, visit Baylor.edu/Social_Work/IBH, email Becky_Scott@baylor.edu or call (254) 710-3018.
Financial Viability

▪ Reactive and proactive role of IHM
  ▪ No wasted time or talent

▪ Continuous revenue generation

▪ Potential increase in value if member of ACO
Financial Considerations

- Same-day billing in your state for Medicaid? Other insurers?
Challenges

- Like all of primary care, IHM is being tasked with more and more
- Competition with local hospital networks for LCSWs
- Graduating Residents hiring existing IHMs aware from the program into their own practices
- Next iteration of PCMH recognition
  - IHMs as box checkers?
Future Directions

- Community Health Workers
- Clinical Champions in High Need Domains
  - Parent-Child Attachment
  - Opioid Dependency and Chronic Pain
  - Sleep Disorders
- Expanding the HBMH Consultation Clinic
- Developing treatment pathways to include specialty MH
- Discussions of IHM track through Baylor School of Social Work
Outcomes?

Shared Principles of Primary Care

- Person & Family Centered
- Continuous
- Comprehensive & Equitable
- Team Based & Collaborative
- Coordinated & Integrated
- Accessible
- High Value
Outcomes?

- Better care
- More satisfied patients
- Lower total medical costs
- More satisfied providers
More Satisfied Providers

Subject: IHM Super Helpful!

The IHM was in our team area today and was a GREAT help. When she came out she had a great history and even had recommendations for him from a counseling perspective. By the time that I saw him it was a quick visit, I felt much better about my assessment and plan (which has NOT been this case with this patient previously) and it was a very efficient visit for us all. It not only helps me but really benefits the patient. So thank you! Seriously!!!

— Rachelle Ramos, MD
I have enjoyed working with the health manager in clinic. She has visited with patients before I've gone in to see them and have found her input to be greatly helpful. She saw a pregnant patient with probable borderline personality disorder which should have been very difficult to tease out in the context of an OB follow up. She also picked up on anxiety/depression and abuse history with a Hispanic patient with multiple somatic complaints who I had been struggling with. Clinic has continued to run smoothly, and she is quick to allow me to go ahead and see the patient when I'm ready and she finishes when I'm done. Overall a very positive experience. — Keri Jo Cummings, MD
Subject: Thumbs up for new mental health

Just wanted to say how helpful it is to have the health manager in Team C seeing our patients with mental health concerns. It has saved me so much time over the past few weeks and she does such a thorough workup - really value having her here and I feel like it makes our jobs less stressful and allows us to do a better job with the medical side of things.

- Samantha Adriana Conroy, MD
Critiques, Feedback, Questions?
Application Exercise

Level 1 – Minimal Collaboration
Level 2 – Basic Collaboration at a Distance
Level 3 – Basic Collaboration Onsite
Level 4 – Close Collaboration Onsite with Some System Integration
Level 5 – Close Collaboration Approaching an Integrated Practice
Level 6 – Full Collaboration in a Transformed/Merged Integrated Practice
Application Exercise

▪ Describe a potential advantage of shared care within your system
Session Evaluation

Use the CFHA mobile app to complete the evaluation for this session.

Thank you!
Integrated Behavioral Health

▪ “Produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs” –HRSA

▪ Improved access to mental health services

▪ Increased rates of mental health treatment

HRSA 2015
Arch Internal Med 2006
Gen Hosp Psych 2008
Care Management

- Improves chronic disease outcomes
- Lowers cost of care
- Reduces emergency department visits
- Improves physician satisfaction
- Improves patient satisfaction

AHRQ 2014
Aetna 2013
Am J Manag Care 2007
Ann Fam Med 2013
Population per Clinical Psychologist
What Research Questions Does this Project Generate?