Behavioral Health Integration into Primary Care

Hackley Community Care Center (HCCC)
Community Mental Health of Muskegon County
Integrated Health Care

“In essence integrated health care is the **systematic coordination of physical and behavioral health care.** The idea is that Physical and Behavioral Health problems often occur at the same time. Integrating services to treat both will yield the best results and be the most acceptable and effective approach for those being served”.

The ultimate goal is to achieve real time two way seamless consultation.
True Integration

The fact that an individual is seen by both a mental health system and primary care is not in itself integration. It is not sending copies of psychiatric reviews to the PCP. Integration means the services are coordinated.

If you are not talking it is unlikely that there is coordination.
The Problem

“Our minds and our bodies are always together in our lives, except when we enter the health care system. There they are often separated, and totally distinct specialties take over.”

Cynthia M. Watson, M.D.
thepfizerjournal.com
Why Should We Be Concerned?

- Individuals with serious mental illness served by our public mental health systems die, on average, 25 years earlier than the general population.

NASMHPD 2006
Why Should We Be Concerned?

• 2/3 of premature deaths are due to preventable/treatable medical conditions such as cardiovascular, pulmonary and infectious diseases.

• 44% of all cigarettes consumed nationally are smoked by people with SMI.

• Oregon study showed the average age of death for co-occurring disorders is 45. (53 for SMI)

www.nasmbpd.org morbidity and mortality in people with SMI
Consumer’s Take on Integration

• Access
• Attention to treatment preference
• Courtesy
• Coordination and Continuity of Care
WHEN CONSIDERING A PARTNER FOR A COLLABORATION YOU SHOULD CONSIDER

- History of previous relationships
- Mission and Values compatibility
- Shared vision of future direction
- Receptivity to giving up some degrees to autonomy
- Complementarity of organizational culture
- Funders support of partnership
- Predicted long term survival
Integrated Health Grant

- We had a very good opportunity in our community.

- We had become more trustworthy as the FQHCs had names and phone numbers and personal relationships had been developed.

- We met with the two FQHCs and they were in agreement to try and move forward with this.
Initials Steps

- One of the first things we did was contract with a consultant who had a history of assisting behavioral health and primary care organizations to integrate.

- One of our goals was that we co-locate staff in each others systems and CMH would go first by putting an OP Clinician in the FQHC.
We occasionally had a Psychiatrist go to the clinic for in-services and we also had a couple of evening dinners with the help of pharmaceutical companies.

We developed an Integrated Health Care Committee with representatives from the 2 FQHCs and CMH.

We scheduled quarterly meetings.
Memorandum of Understanding

“All parties recognize that multiple barriers currently exist in the health care systems that prevent individuals from accessing care and continuing the type of care they require to improve their health and functioning”.
Challenges

• It seemed like so many new cases that were coming into our system were GF and had significant health issues.

• The FQHCs had limited funding for this and it really became debt to their systems when we referred GF people to them.

• This of course makes administrators skeptical because they saw the risk.
Challenges and Barriers Will Challenge Your Vision

A review of the literature points out the most common issues:

- Incompatible mission
- Vision
- Values
- Egos
Points to Ponder

- You must get to the table and participate in community discussions and figure out how to integrate with PC
- Most behavioral health dollars will flow through health plans
- We have been use to going at it alone and we could even be real choosy about who we work with. This will probably change.
- What is your reputation with the FQHCs, hospitals, large PCP offices?
- Cedric did not like our Agency.
We Lacked Credibility as an Organization

- The dosages of our psychotropics were outside the comfort level for Primary Care
- Individuals would sometimes give mixed messages
- The Medical Directors of the FQHCs saw value in pursuing a collaboration. But the average PCP viewed psychotropics as a specialty and they wanted us to just keep the consumers in our system.
Hackley Community Care Center

- Located in Muskegon Heights, MI
- We have 160 employees
- Medical/OB
  - 8 Physicians/ 8 Physician Assistants
  - 3 Certified Nurse Mid-wives
- Dental
  - 6 Dentist and 6 Hygienists
- Behavioral Health-
  - 1 LLPC
  - 1 LLMSW
  - 1 LLP
  - 1 LMSW
  - 2 BSW
Hackley Community Care Center

- Over 17,000 patients
- 22% uninsured
- 63% Medicaid
- 8% Medicare
- 7% commercial
- More than 677 depression disorder patients
Five Levels of Integration

- Level 1 - Minimal Collaboration
- Level 2 - Basic Collaboration at a Distance
- Level 3 - Basic Collaboration On-Site
- Level 4 - Close Collaboration in a Partly Integrated System
- Level 5 - Close Collaboration in a Fully Integrated System
Level 1-Minimal Collaboration

- **Description:** Mental Health and other health care professionals work in separate facilities, have separate systems, and rarely communicate about cases.

- **Where practiced:** Most private practices and agencies.

- **Handles adequately:** Cases with routine medical or psychosocial problems that have little biopsychosocial interplay and few management difficulties.

- **Handles inadequately:** Cases that are refractory to treatment or have significant biopsychosocial interplay.
Level 2 – Basic Collaboration at a Distance

- **Description**: Providers have separate systems at separate sites, but engage in periodic communication about shared patients, mostly through telephone and letters. All communication is driven by specific patient issues.

- **Where practiced**: Settings where there are active referral linkages across facilities.

- **Handles adequately**: Cases with moderated biopsychosocial interplay, for example, a patient with diabetes and depression where the management of both problems proceeds reasonably well.

- **Handles inadequately**: Cases with significant biopsychosocial interplay, especially when the medical or mental health management is not satisfactory to one of the parties.
Level 3 – Basic Collaboration On-Site

- **Description:** Mental health and other health care professionals have separate systems but share the same facility. As in Levels one and two, medical physicians have considerably more power and influence over case management decisions than the other professionals, who may resent this.

- **Where practiced:** HMO settings and rehabilitation centers where collaboration is facilitated by proximity, but where there is no systemic approach to collaboration and where misunderstandings are common.
Level 3 Cont.

- **Handles adequately:** Cases with moderate biopsychosocial interplay that require occasional face-to-face interactions between providers to coordinate complex treatment plans.

- **Handles inadequately:** Cases with significant biopsychosocial interplay, especially those with ongoing and challenging management problems.
Level 4 – Close Collaboration in a Partly Integrated System

- **Description:** Mental health and other health care professionals share the same sites and have some systems in common, such as scheduling or charting.

- **Where practiced:** Some HMOs, rehabilitation centers, and hospice centers that have worked systematically at team building. Also some family practice training programs.

- **Handles adequately:** Cases with significant biopsychosocial interplay and management complications.

- **Handles inadequately:** Complex cases with multiple providers and multiple larger systems involvement, especially when there is the potential for tension and conflicting agendas among providers or triangling on the part of the patient or family.
Level 5 – Close Collaboration in a Fully Integrated System

- **Description:** Mental health and other health care professionals share the same sites, the same vision, and the same systems in a seamless web of biopsychosocial services.

- **Where practiced:** Some hospice centers and other special training and clinical settings.

- **Handles adequately:** The most difficult and complex biopsychosocial cases with challenging management problems.

- **Handles inadequately:** Cases where the resources of the health care team are insufficient or where breakdowns occur in the collaboration with larger service systems.
Role of Team members

Placement of CMH Master Level Clinician into the FQHC

Role:

- Providing Substance Use Assessments (CAC)
- Providing on-going therapy
- Providing “curb-side consultation”
- Acting as a liaison between CMH and the FQHC
Integrated Health Care Committee

Internal Team:

Mission: Assurance that all individuals receiving Behavioral Health Services from CMH will also concurrently receive quality medical health care.

• Comprised of representatives from all clinical aspects of CMH.

• Have monthly meetings to monitor the various Health and Wellness Groups being conducted through-out the agency.

• Have assured every IPOS includes a health and safety goal.

• Gathered and analyzed data to determine an individual’s health care coverage and coordination of care with a medical home.

• Review death reports

• Provide learning opportunities related to physical health to all primary workers.
Role of Integrated Health Care Team Members:

Integrated Health Care Coordinator (RN)

- Act as liaison between CMH and Primary Care, ER, Nursing Homes, Specialty Offices, etc.
- Act as point person between CMH and FQHC.
- Address urgent and chronic health care needs.
- Serve as an advocate
- Facilitate coordination of care
- Health and Wellness Groups and Individual Sessions.
### Four Quadrant Integration Model

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<tr>
<th>Quadrant I</th>
<th>Quadrant II</th>
<th>Quadrant III</th>
<th>Quadrant IV</th>
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<tbody>
<tr>
<td>BH low, PH low</td>
<td>BH high, PH low</td>
<td>BH low, PH high</td>
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<tr>
<td><strong>PCP Medical Home</strong></td>
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<td><strong>CMH and PCP Co-managed Care</strong></td>
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- **High** Behavioral Health Risk/Status<br>
- **Low** Physical Health Risk/Status

- **Low**<br>
- **High**
Role of Primary Care Provider at CMH

• Un-insured with no medical home
• Quadrant II – BH high, PH low
• Quadrant IV – BH high, PH high
Additional Critical Team Players

- IT Staff
- Financial Staff
- Administration
- Medical Directors
- Access Staff
Culture Shock
Differences in Culture

• We speak a different language

• We are in a different “time zone”
  • Difference in allotted time for appointments
For FY 09/10 --we served 4,639 individuals.

To be counted the individual had to receive at least one f/f billable service.

• MI Child         747
• MI Adult        2930
• DD Child        206
• DD Adult        756

Total             4639
References

- Five Levels of Primary care/behavioral Healthcare Collaboration
  - William J. Doherty, University of Minnesota
  - Susan H. McDaniel, Ph.D., University of Rochester
  - Macaran A. Baird, M.D., HealthPartners, Minneapolis, MN

Integration of Mental Health/Substance Abuse and Primary Care

- Minnesota Evidence-based Practice Center, Minneapolis, Minnesota