Michigan Primary Care Association

Behavioral Health/Primary Care Integration Conference

What We Are Telling Vendors About the Future of Integration, EHRs, Telebehavioral Health

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National Council for Community Behavioral Healthcare

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Date 11/16/2011
- General Trends in Behavioral Health/Primary Care Integration
- Different integration models
- Software and Process Issues – What vendors need to consider in their products
- Privacy Issues – what SATVA/vendors need to be planning for
General Trends in Behavioral Health/Primary Care Integration

- Integration will be the Norm vs the Exception

- Bi Directional Integration
  - Is Occurring Nationally
    - National Council CIHS T/TA Center
    - Also happening on its own between FQHCs and Behavioral Health Providers

- SAMHSA & HRSA Actively Support Integration
Why Provide Integrated Care?
The Chronic Care Model

Community
Resources and Policies
Self-Management Support

Health Systems
Organization of Health Care
Delivery System Design
Decision Support
Clinical Information Systems

Improved Outcomes

Informed, Activated Patient
Productive Interactions
Prepared, Proactive Practice Team

Developed by The MacColl Institute
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National Council
Think Chronic Continuity/Continuum of Care & Systems of Care When Developing Your Products

How Can your Product Offerings Support

- Care Management
- Real Time Data Sharing & Provider Communication
- Bi Directional Clinical Decision Support
- Improved Disease Registry Functions
- Improved Reporting Functionality
The Four Quadrant Model - A Useful Guide

Quadrant II
MH/SU ↑ PH ↓
- Outstationed medical nurse practitioner/physician at MH/SU site (with standard screening tools and guidelines) or community PCP
- MH/SU clinician/case manager w/ responsibility for coordination w/ PCP
- Specialty outpatient MH/SU treatment including medication-assisted therapy
- Residential MH/SU treatment
- Crisis/ED based MH/SU interventions
- Detox/sobering
- Wellness programming
- Other community supports

Quadrant IV
MH/SU ↑ PH ↑
- Outstationed medical nurse practitioner/physician at MH/SU site (with standard screening tools and guidelines) or community PCP
- Nurse care manager at MH/SU site
- MH/SU clinician/case manager
- External care manager
- Specialty medical/surgical
- Specialty outpatient MH/SU treatment including medication-assisted therapy
- Residential MH/SU treatment
- Crisis/ED based MH/SU interventions
- Detox/sobering
- Medical/surgical inpatient
- Nursing home/home based care
- Wellness programming
- Other community supports

Quadrant I
MH/SU ↓ PH ↓
- PCP (with standard screening tools and MH/SU practice guidelines for psychotropic medications and medication-assisted therapy)
- PCP-based BHC/care manager (competent in MH/SU)
- Specialty prescribing consultation
- Wellness programming
- Crisis or ED based MH/SU interventions
- Other community supports

Quadrant III
MH/SU ↓ PH ↑
- PCP (with standard screening tools and MH/SU practice guidelines for psychotropic medications and medication-assisted therapy)
- PCP-based BHC/care manager (competent in MH/SU)
- Specialty medical/surgical-based BHC/care manager
- Specialty prescribing consultation
- Crisis or ED based MH/SU interventions
- Medical/surgical inpatient
- Nursing home/home based care
- Wellness programming
- Other community supports

Persons with serious MH/SU conditions could be served in all settings. Plan for and deliver services based upon the needs of the individual, personal choice and the specifics of the community and collaboration.
Clinical Models/Strategies – Bi-Directional Integration

Behavioral Health – Disease Specific
- IMPACT
- RWJ
- MacArthur Foundation
- Diamond Project
- Hogg Foundation for Mental Health
- Primary Behavioral Healthcare Integration Grantees

Behavioral Health - Systemic Approaches
- Cherokee Health System
- Washtenaw Community Health Organization
- American Association of Pediatrics - Toolkit
- Collaborative Health Care Association
- Health Navigator Training

Physical Health
- TEAMcare
- Diabetes (American Diabetes Assoc)
- Heart Disease
- Integrated Behavioral Health Project – California – FQHCs Integration
- Maine Health Access Foundation – FQHC/CMHC Partnerships
- Virginia Healthcare Foundation – Pharmacy Management
- PCARE – Care Management

Consumer Involvement
- HARP – Stanford
- Health and Wellness Screening – New Jersey (Peggy Swarbrick)
- Peer Support (Larry Fricks)
Behavioral Health Integration in Primary Care: Making it Real
(Morehouse University, Carter Center, HRSA, SAMHSA Oct. 2008)

Core Components of Successful Integrated Models

- Co-Location
- Communication and Collaboration
- Joint Decision Making
- Shared Problem Lists
- Shared Treatment Plans
- Shared Medication Lists and Lab Results
- Patient Centered Integrated Primary and Behavioral Healthcare
- Share Expertise
- Share Staff
- Share Open Access Scheduling Experience
- Communication & Collaboration as Patient Moves Between Systems
- Specialty Behavioral Healthcare or Primary Care Setting

M. Lardiere 12/2008
<table>
<thead>
<tr>
<th>Function</th>
<th>Minimal Collaboration</th>
<th>Basic Collaboration from a Distance</th>
<th>Basic Collaboration On-Site</th>
<th>Close Collaboration/Partly Integrated</th>
<th>Fully Integrated/Merged</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access</strong></td>
<td>Two front doors; consumers go to separate sites and organizations for services</td>
<td>Two front doors; cross system conversations on individual cases with signed releases of information</td>
<td>Separate reception, but accessible at same site; easier collaboration at time of service</td>
<td>Same reception; some joint service provided with two providers with some overlap</td>
<td>One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model</td>
</tr>
<tr>
<td><strong>Services</strong></td>
<td>Separate and distinct services and treatment plans; two physicians prescribing</td>
<td>Separate and distinct services with occasional sharing of treatment plans for Q4 consumers</td>
<td>Two physicians prescribing with consultation; two treatment plans but routine sharing on individual plans, probably in all quadrants;</td>
<td>Q1 and Q3 one physician prescribing, with consultation; Q2 &amp; 4 two physicians prescribing some treatment plan integration, but not consistently with all consumers</td>
<td>One treatment plan with all consumers, one site for all services; ongoing consultation and involvement in services; one physician prescribing for Q1, 2, 3, and some 4; two physicians for some Q4: one set of lab work</td>
</tr>
<tr>
<td><strong>Funding</strong></td>
<td>Separate systems and funding sources, no sharing of resources</td>
<td>Separate funding systems; both may contribute to one project</td>
<td>Separate funding, but sharing of some on-site expenses</td>
<td>Separate funding with shared on-site expenses, shared staffing costs and infrastructure</td>
<td>Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility</td>
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<tr>
<td><strong>Governance</strong></td>
<td>Separate systems with little of no collaboration; consumer is left to navigate the chasm</td>
<td>Two governing Boards; line staff work together on individual cases</td>
<td>Two governing Boards with Executive Director collaboration on services for groups of consumers, probably Q4</td>
<td>Two governing Boards that meet together periodically to discuss mutual issues</td>
<td>One Board with equal representation from each partner</td>
</tr>
<tr>
<td><strong>EBP</strong></td>
<td>Individual EBP’s implemented in each system;</td>
<td>Two providers, some sharing of information but responsibility for care cited in one clinic or the other</td>
<td>Some sharing of EBP’s around high utilizers (Q4); some sharing of knowledge across disciplines</td>
<td>Sharing of EBP’s across systems; joint monitoring of health conditions for more quadrants</td>
<td>EBP’s like PHQ9; IDDT, diabetes management; cardiac care provider across populations in all quadrants</td>
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<tr>
<td><strong>Data</strong></td>
<td>Separate systems, often paper based, little if any sharing of data</td>
<td>Separate data sets, some discussion with each other of what data shares</td>
<td>Separate data sets; some collaboration on individual cases</td>
<td>Separate data sets, some collaboration around some individual cases; maybe some aggregate data sharing on population groups</td>
<td>Fully integrated, (electronic) health record with information available to all practitioners on need to know basis; data collection from one source</td>
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## Summary of Models: Hallmarks

| Model                  | Behavioral health & primary care are physically and operationally separate | Differences from current practice because active collaboration is initiated | Increases the ability of the physician (or mid-level) to directly deliver behavioral health care interventions within the existing practice | Typically includes augmented capacity for psychiatric consultation | Primary care & behavioral health are in physical proximity, but operationally separate. | There is enhanced engagement and communication because of proximity. | Uses an allied health professional to coordinate care | Uses an allied health professional to coordinate care | Locates a healthcare professional (RN, mid-level or physician) in a mental health clinic or program | Focus is on providing primary care to persons with severe behavioral health problems | Behavioral health & primary care are physically and operationally integrated | Behavioral health screening & triage are typically available at the primary care visit | A psychiatric prescriber is available to see patients if needed and (at least) traditional counseling is available | Behavioral health & primary care are physically and operationally integrated | Uses one of the other models at the primary care practice | The primary care practice forms close alliances with multiple service providers (around a specific theme) |}

| 1. Collaboration       | *Behavioral health & primary care are physically and operationally separate | *Diffs from current practice because active collaboration is initiated | *Increases the ability of the physician (or mid-level) to directly deliver behavioral health care interventions within the existing practice | *Typically includes augmented capacity for psychiatric consultation | *Primary care & behavioral health are in physical proximity, but operationally separate. | *There is enhanced engagement and communication because of proximity. | *Uses an allied health professional to coordinate care | *Uses an allied health professional to coordinate care | *Locates a healthcare professional (RN, mid-level or physician) in a mental health clinic or program | *Focus is on providing primary care to persons with severe behavioral health problems | *Behavioral health & primary care are physically and operationally integrated | *Behavioral health screening & triage are typically available at the primary care visit | *A psychiatric prescriber is available to see patients if needed and (at least) traditional counseling is available | *Behavioral health & primary care are physically and operationally integrated | *Uses one of the other models at the primary care practice | *The primary care practice forms close alliances with multiple service providers (around a specific theme) |
## Summary of Models: Issues

<table>
<thead>
<tr>
<th>Model</th>
<th>Amount of Systems Change Required</th>
<th>Financial Challenges</th>
<th>Degree of Integration Achieved</th>
<th>Training Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Collaboration</td>
<td>*</td>
<td>-</td>
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<tr>
<td>2. Physician-Delivered</td>
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<tr>
<td>3. Co-Location</td>
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<td>4. Disease Management</td>
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<td>5. Reverse Co-Location</td>
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<td>6. Unified</td>
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<td>7. Primary Behavioral Health</td>
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<tr>
<td>8. Collaborative System of Care</td>
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</tbody>
</table>

* These are relative designations, because models are typically implemented in a highly customized fashion.
Federal Health IT Strategic Plan
2011–2015

HHS Goals

> Improve Care,
> Improve Population Health, and
> Reduce Health Care Costs through the Use of Health IT
Federal Health IT Strategic Plan 2011–2015

Four Objectives for these goals

> Support more sophisticated uses of EHRs and other health IT to improve health system performance
> Better manage care, efficiency, and population health through EHR-generated reporting measures
> Demonstrate health IT-enabled reform of payment structures, clinical practices, and population health management
> Support new approaches to the use of health IT in research, public and population health, and national health security
Federal Health IT Strategic Map

2011 – 2012: Data Capture and Sharing
- Accelerated adoption
- Data capture and exchange

2013 – 2014: Demonstrate Health System Improvement
- Widespread adoption and data exchange
- Process improvement

2015+: Transform Health Care and Population Health through Health IT
- Demonstrated improvements in care, efficiency, and population health
- Breakthrough examples of delivery and payment reform

Beyond 2015: Transformed Health Care
- Enhanced ability to study care delivery and payment systems
- Empowered individuals and increased transparency
- Improved care, efficiency, and population health outcomes

Strategic Goals
- Achieve Adoption and Information Exchange through Meaningful Use of Health IT
- Improve Care, Improve Population Health, and Reduce Health Care Costs through the Use of Health IT
- Inspire Confidence and Trust in Health IT
- Empower Individuals with Health IT to Improve their Health and the Health Care System
- Achieve Rapid Learning and Technological Advancement

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Behavioral Health Providers will be included!!

ONC Strategic Plan
Objective A
Strategy I.A.7: Align federal programs and services with the adoption and meaningful use of certified EHR technology

Specifically… The Substance Abuse and Mental Health Services Administration (SAMHSA) is working to foster adoption and implementation of certified EHRs among its providers that are ineligible for the Medicare and Medicaid EHR Incentive Programs, including community mental health centers and substance use disorder treatment programs….

Senator Sheldon Whitehouse introduced the “Behavioral Health Information Technology Act of 2011” March 10, 2011 S. 539
The FQHC Experience & Opportunities

- 70% of Health Centers Currently Provide Behavioral Health Services
- All Health Centers are required to have a behavioral health intervention identified in their annual plan
FQHCs Serve 20 Million Patients – What’s Wrong with this Picture?

**Total BH Patients by Type, 2009**

- **Mental Health**: 758,131
- **Substance Abuse**: 114,565
Who Are We Trying to Reach?

- 1% (1.25 million) Addicted
- 5% (6.25 million) Daily Harmful Drinking or dependence behavior
- 20% (26.25 Million) At Risk Exceed daily limits
- 70% (87.5 Million) Occasional or non drinkers, seldom exceed daily limits for alcohol consumption

Who Are We Trying to Reach?

- 25% engaged in risky, harmful or hazardous drinking
- 32.5 million people could benefit from brief intervention
Skill sets that are needed for any provider in a primary care environment

- Can be any licensed practitioner--training, orientation and skills are the key
- Finely honed clinical assessment skills (MH and SA)
- Cognitive behavioral intervention skills
- Group and educational intervention skills
- Consultation skills
- Communication skills
- Psychopharmacology and Behavioral Medicine knowledge base
- Flexible, independent and action/urgency orientation
- Solution rather than process orientation
Skill sets that are needed for any provider in a primary care environment

- Prevention orientation
- Team and collaboration orientation
- Clinical protocols and pathways orientation
- Focus on impacting functioning, not personality
- Experience with the SMI population and how the public BH system works
- Understanding of the impact of stigma
- Strong organizational and computer competency
- Bilingual and culturally competency in serving the major population groups seen in the primary care clinic

Courtesy of: Freeman, Cherokee Health Systems
Workforce Development

- Develop Curriculum That Supports Integration
  - Start in Undergrad

- Train Current Workforce in Integration Skills

- Home Grown Programs
  - A.T. Still University, Mesa, AZ

- What role can SATVA play in Workforce Development activities?
  - HIT Learning Collaboratives
  - Support ONC Curriculum for Council Members
Drivers Towards Integration

- Medical Homes
- Health Care Homes
- Coordinated Care Organizations
- Accountable Care Organizations
How Will We Share Information and Coordinate Treatment?
Tele Behavioral Health

- Expansion of Services to provide Greater Access
- Current Cost is well within Provider Reach
- Protocols and Procedures Available from the American Tele Medicine Association Tele Mental Health Special Interest Group
- How can Vendors encourage and support these efforts?
Behavioral Health Program Components Embedded in Medical EHRs

- BH/PCP
- MH
- Addictions
- DD

- Blended
- Adults / Children / Adolescents
- Outpatient
- Outpatient / Intensive Outpatient / Residential

- Practice Management – Scheduling, Billing, Reporting
- Data Extraction / Utilization Management
- Systems Integration - Radiology / Laboratory / Pharmacy
- Clinical Documentation
- Workflow
- Efficiency
Tele Behavioral Health

- Expansion of Services to provide Greater Access
- Current Cost is well within Provider Reach
- Protocols and Procedures Available from the American Tele Medicine Association Tele Mental Health Special Interest Group
- How can Vendors encourage and support these efforts?
How it really works - logistically

Real time video

In the clinic

Consultation, evaluation, treatment, whatever

Integration in PC/GM

Conditions and populations

Scheduling & app’t mgmt.

Info. exchange

Admin and distance learning
Medical Home

- Personal PCP
- PCP-directed practice
- Whole person
- Enhanced access [adherence]
- Care is coordinated and/or integrated
- Safety, quality, cost

AAFP - Joint Principles of the Patient-Centered Medical Home, February 2007:
Electronic Health Records

- Patient Registries – for Now
  - Providers need this functionality embedded in EHRs now
  - Eventually they go away

- But there are haves and have nots
  - Build registries as affordable stepping stones to full EHR products for the have nots
  - Ensure seamless data migration to any product
Health Information Exchange

- State HIEs
- NwHIN
- RHIOs
- DIRECT Project
DIRECT Project Scenarios

Priority One
Stories that support Stage 1 Meaningful Use and are targeted for implementation in the first implementations of the Direct Project

- Primary care provider refers patient to specialist including summary care record
- Primary care provider refers patient to hospital including summary care record
- Specialist sends summary care information back to referring provider
- Hospital sends discharge information to referring provider
- Laboratory sends lab results to ordering provider
- Transaction sender receives delivery receipt
- Provider sends patient health information to the patient
- Hospital sends patient health information to the patient
- Provider sends a clinical summary of an office visit to the patient
- Hospital sends a clinical summary at discharge to the patient
- Provider sends reminder for preventive or follow-up care to the patient
- Primary care provider sends patient immunization data to public health
DIRECT Project Scenarios

Most Behavioral Health Organizations Will Start With Simple Scenarios
Continuity of Care Document (CCD or CCR)
Continuity of Care Record/Document

- 1. Patient Demographics
- 2. Immunizations
- 3. Vital Signs
- 4. Problems & Diagnoses
- 5. Insurance Information
- 6. Health Care Providers
- 7. Encounter Information
- 8. Allergies/Alerting Data
- 9. Appropriate Results
Continuity of Care Record/Document

- 10. Medication
- 11. Procedures
- 12. Results
- 13. Necessary Medical Equipment
- 14. Social History
- 15. Statistics
- 16. Family History
- 17. Care Plan

Specific Additions for Behavioral Health Information have not yet been identified
Providers want to share “actionable” data now
- Many CIHS HIT Grantees have this as their goal

Data needs to come in and populate
- Graphs
- Charts
- Reports
  - In the receiving EHR
Continuity of Care
Record/Document +

➢ What else do they want?

➢ Recent Meeting at SAMHSA with all of the Guilds and other Associations

➢ Disability Status
➢ Level of Education
➢ Primary Language
➢ Communication Impairments
Continuity of Care
Record/Document +

- What else they want
  - Physical Health information
  - Medical Equipment
    - Hearing Aids
    - Wheelchair required
    - Mobile Technology Applications used
  - ECT
  - Vegal Nerve Stimulation
Continuity of Care Record/Document +

- What else they want
  - Functional Status in a standard form
    - GAF 7
    - International Classification of Functional Status
  - Vitals
    - Provide the Units next to the number
      - Weight
      - BMI
      - Temp
Continuity of Care Record/Document +

- What else they want

  - Problems/Diagnosis
    - All Problems/Diagnoses
      - Date First Recorded
      - Active/Inactive
      - Date Resolved

  - Medications – Same as above
Continuity of Care Record/Document +

- What else they want
  - Health Care Providers
    - Want to know
      - Credentials and Type of Provider/Specialty
        - MD is insufficient
      - Pharmacist as well
    - Include the entire care team across all organizations
    - Programmed for easy communication with all providers e.g. email or call from the EHR
  - Encounter Data for all Care Team Members
  - Dates of Care
Continuity of Care Record/Document +

- What else they want
  - Allergies
    - Adverse Reactions
    - Response/Type of Reaction
    - Indicate Intolerance vs. Reaction (meds or OTCs)
  - All Medical Procedures
  - Types of Treatment
    - Indiv., Group, Family etc.
What else they want

- Family Hx.
  - Psychiatric Illness & Medical Illness
  - Genograms

- Care Plans
  - All Active/Open Care Plans from All Active Providers
    - Goals
    - Objectives
    - Reviews
What else they want

- Data Segmentation

- Was requested across all three workgroups
  - Substance Abuse Providers
  - Recovery Providers
  - Mental Health Providers

- Better Usability
  - Called for supporting a Workgroup to focus on this specifically
Perceived Barriers

- HIPAA
- State Laws
- 42 CFR

Developing Systems of Care

- Qualified Service Agreements
What is Wrong with This Picture?

Behavioral Health
Capture and Report on Registry Data Specific to Integrated Care

Integrate Telemedicine

Integrate Mobile and Wireless Device Applications
M3 Checklist – The Solution

A patient rated mental health assessment screen that simultaneously assesses the risk of several existing mood and anxiety disorders, including depression, anxiety, bipolar disorder and post traumatic stress disorder.

Key Features

• Patient-rated 27 question screen/3 minutes to complete
• Evidence-based tool to diagnose/detect mood and anxiety disorders
• Highly predictive & sensitive to early detection
• Cloud-based data capture facilitates easy link to EMRs & PHRs
• Longitudinal tracking for continual monitoring

The only patient-rated, validated, multi-dimensional Mental Health screen in the market.
What The National Council is Doing
Focus on Behavioral Health & Primary Care Integration

Region 1 (10 Grantees)
Region 2 (8 Grantees)
Region 3 (8 Grantees)
Region 4 (13 Grantees)
Region 5 (17 Grantees)
HIT Supplement
Assisting Grantees in HIT Implementation

- Implement Certified EHRs
- Meet Meaningful Use Criteria
  - ePrescribing
  - Exchange Data with Partners
  - Participate in HIE
  - Support Integration

- Working with 5 State Designated Entity (SDE) HIEs
  - Examine Barriers to Behavioral Health and Primary Care Data Integration
  - Implement/Recommend State Policy Changes
  - Identify HIE Standards, Policies & Procedures to Support Exchange
For Our Members

- Contact Center
- Vetted Consultants
- Group Purchasing
- HIE
- Data Warehousing
  - Best Practices
  - Clinical Decision Support
- Instituted a HIT Workgroup
For Our Members

- Instituted a HIT Workgroup
- Work with Networks
  - HRSA supported Health Center Controlled Networks (HCCNs)
    - Support over 500 FQHCs Nationally
    - Will increase HIT support to and provide infrastructure for behavioral health organizations
Health Information Technology Strategy

Guidelines on “what you need to know before you start”

Establish an accessible data base of HW & SW vendors used by and evaluated by members & Develop User Groups

Financing Options
Attractive Terms

Quality Center
National Data Warehouse Benchmarking, & Reporting,

National data repository showing the value of behavioral health, best practices, advocacy etc.

Contact Center
Initial information on Hardware, Software, and connectivity

Provide members with objective, trusted information and advice on health information technology resources, vendors, evaluations, investments and operations

Establish relationships with limited number of IT experts including HCCNs

NwHIN Connectivity
With Federal Government & Others

Training & Support
Multimedia Options, Post Implementation Support

Vetered Consultant Referrals
Local Assessments, Contracting, Implementation

Consultants w/ Experience

Software

National Pricing
Govt Pricing or Better

12/5/2011

HCCNs
For more information Contact

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