WORKING TO BREAK DOWN THE SILOS: INTEGRATING BEHAVIORAL HEALTH AND PRIMARY CARE

FEATURED SPEAKER: Wendy Bradley, Clinic Improvement Advisor, Southcentral Foundation, Anchorage, Alaska

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MATERIALS

Handout: Behavioral Health Consultant Integration in Primary Care
Presentation Slides: Behavioral Health Integration

PRESENTATION HIGHLIGHTS

1. **SYNOPSIS:** A Level 3 Patient-Centered Medical Home, Southcentral Foundation has integrated behavioral health consultants (BHC) into its primary care teams as part of a comprehensive redesign of its Alaska Native Medical Center. In the new design, SCF explicitly recognizes that most physical health issues have a behavioral health component that could be better and more efficiently addressed as part of an integrated primary care and behavioral health system. After finding that co-location of services failed to break down the primary care and behavioral health silos, it moved to the team approach, which now makes it easier to identify both acute mental issues and behavioral health issues that may manifest themselves in physical health issues.

   While integrating behavioral health into primary care was an adjustment for both behavioral health providers and physicians, staff have ultimately found that it frees up provider time and resources to allow for more efficient use of limited appointments, provides customers with a more comprehensive evaluation of symptoms and issues, and enables better access to appropriate services. The system is reducing ER usage and making it easier for physicians to address patient needs within a 20-minute primary care visit. When more extensive mental health or substance use services are required, BHCs and other team members connect customers to those services.

   Work was redefined to move from episodic care to long-term relationship care and to increase use of group and home visits, telephone, email, and fax. It moved from a doctor-centric to team-based care and turned team meetings into problem-solving sessions. The system has people working at the top of their licenses, recognizing that primary care and behavioral personnel come with different skill sets.

2. **THE CONTEXT:** Southcentral Foundation is an Alaska Native-owned, nonprofit health care organization that serves 60,000 Alaska Native and American Indian people living in Anchorage, Matanuska-Susitna Valley, and 60 rural villages. Its mission is to work "… together with the Native Community to achieve wellness through health and related services." Prior to starting its redesign, SCF had a 1200-person waitlist for behavioral health services and documented cases of some patients' committing suicide because of lack of access to care. In preparation for the redesign, SCF conducted a survey of patients that showed that they wanted to have a relationship with their provider, be called "customer owners" rather than patients, and feel like part of the process rather than feel as if things were "being done to them."

3. **APPROACH TO PRIMARY CARE AND INTEGRATION OF BEHAVIORAL HEALTH:** SCF staff are organized into health support teams that include a case manager, Certified Medical Assistant, physician, clinical pharmacist, behavioral health consultant, dietician, and case management support for faxing / scheduling. One behavioral health consultant serves approximately 3 teams. Each clinic has one clinical pharmacist and 1 dietician per floor. SCF embraces a non-traditional "parallel" workflow that enables all staff to work at the top of their licenses. Rather than going through physicians or other clinical care providers for everything, customers work directly with case managers and other staff to address their needs. Primary care teams sit together in an open floor plan, allowing for easy communication and "warm handoffs" from one service provider to another. For example, case managers and clinical pharmacists handle medication refills, and dieticians and behavioral health consultants work with customers to address chronic disease compliance barriers. This allows for more holistic care and more efficient visits in primary care.

   The link between primary care and behavioral health services is made as seamless as possible. Physicians call on BHCs to come into the primary care visit and introduce them as part of the customer's primary care team. BHCs also suggest coming in for particular customers on the panel, based on patient history. Charts are integrated, containing notes from both primary care and behavioral health.

   Once a relationship is established with the customer, BHCs are part of primary care visits as necessary. All BHCs wear pagers and have time allotted during the day for same-day warm handoffs from physicians. BHCs have only 3-4 scheduled 20-minute appointments per day, and only one per hour, usually in the morning when there are fewer walk-ins. In between appointments, they communicate with providers. The rest of the time, they are called by pager, allowing BHCs to be very accessible to customers as their behavioral health needs surface, eliminating the need for customers to make a separate visit. About 80% of behavioral health issues are addressed by BHCs in primary care, while only 20% are referred to specialty care.

   There is one BHC for every 6 primary care provider teams, although when starting integration, Wendy recommends beginning with one BHC for every 3-5 teams.

4. **ROLE OF THE SCF BEHAVIORAL HEALTH CONSULTANT**

   - Provide brief, solution-focused interventions to customers
   - Educate and provide plan for various behavioral health issues
   - Serve as consultant to providers and coach providers in managing difficult situations
   - Conduct screening and assessment for a variety of issues
   - Assess customers for various DSM disorders and provide brief, solution-focused treatment in primary care setting
   - Develop treatment plan to augment PCP patient care
   - Assist providers in managing patients that are struggling with lifestyle changes that are impacting their health
   - Work with primary care team to manage at-risk and complex customers
   - Provide screening and triage to specialty behavioral health services
   - Consult with providers on mental health issues and how they may be impacting their customers' overall health
   - Refer out to appropriate services, e.g. social work, psychiatry, nutrition

Note: The Behavioral Health Consultant DOES NOT provide therapy sessions for chronic behavioral care (customers are referred to a co-located specialist). For example, a patient with child sexual abuse might be in therapy as well as working with a BHC on day-to-day functioning.

5. **SIX KEY ELEMENTS OF INTEGRATION** The keys to effective BHC integration are:
    1. Flexible Communication
    2. Recruiting, Orientation, and Training Behavioral Health Consultants (BHC)
    3. Orientation and Training of Primary Care Providers (PCP)
    4. Maintaining a Strong Connection to Behavioral Health
    5. Outcome Measures
    6. Funding

KEY ELEMENT 1: FLEXIBLE COMMUNICATION

- BHCs must be open to working at a fast pace, with quick consultations, calls by pager, and a high level of visibility that challenge the way they were taught to practice.
- BHCs must be able to explain to and show providers how BHCs make their practices more efficient: Warm hand-offs to BHCs and effective BHC interventions in primary care allow providers to shorten visits and see a higher volume of patients.
- Customers use Skype, e-mail, call, and text BHCs to increase access. They also give feedback to primary care about BHCs.
- BHCs maintain communication among each other, and with additional departments.

KEY ELEMENTS 2 & 3: RECRUITMENT, TRAINING, AND ORIENTATION OF BHCS AND PRIMARY CARE PROVIDERS

<u>BHC Training and Orientation</u>

- BHCs are licensed LPCs or LCSWs, and they are asked to obtain substance abuse certification within a year of joining SCF.
- Personality fit is more important than skill set. In particular, BHCs need to have the
    - Ability to problem-solve quickly
    - Willingness to adapt to primary care environment and seek out non-traditional uses of behavioral health. For example, a BHC might offer to administer deep breathing exercises to an anxious patient while he/she is having a toenail removed
    - Desire and ability to "sell themselves" to providers and teach providers how to use them
- Candidates with 2-3 years of experience post-licensure tend to be open to a new way of practicing (and also possess basic skills). Candidates with extensive background in and fidelity to traditional therapy methods are usually NOT a good fit.
- Training for BHCs includes:
    - New BHCs shadow the other BHCs. This crucial element allows new BHCs to "see" the SCF BHC style in action and understand it.
    - Being shadowed by BHCs and evaluated for core competencies (shared responsibility, commitment to quality, and family wellness).
    - Reading books about integration.
    - 1-year mentorship to facilitate transition to BHC style and working interdependently instead of independently.
    - Ongoing quarterly peer shadowing to make sure BHCs are not deviating from the new style of practice.
    - Ongoing weekly group supervision.

PCP Training and Orientation

- Learning not to bring BHCs into the primary care visit as a "punishment" / last resort once the patient has already exhibited frustration, but to bring them into the visit early, e.g. at the customer's first mention of sleep issues.
- Learning how to introduce BHCs to the customer. BHCs are not introduced as behavioral health consultants (which can sound off-putting to the customer), but as a member of the customer's primary care team specializing in anxiety / depression / whatever the customer's issue is.
- Learning from BHCs how to conduct motivational interviewing with customers. For example, for a situation where a customer is crying in the physician's office because he/she wants meds, the physician learns how to help the customer problem-solve instead of just writing a script.
- Learning from BHCs about chronic pain and addiction issues. (This was initiated in response to a needs assessment in which providers asked for this training.)
- Coaching from BHCs on coping with compassion fatigue that comes from the strong relationships that SCF's primary care teams forge with customers.

Joint BHC and PCP Activities

- Providers and behavioral health consultants sit together on the primary care team, allowing natural ongoing education between providers and behavioral health consultants.
- Providers also sit on the BHC improvement team.
  In the hiring process, BHCs are in the interviews for physicians and physicians are in the interviews for BHCs to help ensure a good fit with the whole primary care team.
- Both BHCs AND primary care physicians are trained on how to integrate BHCs into the primary care teams.

Key Element 4: Maintaining a Strong Connection to Behavioral Health

- In addition to working closely with primary care physicians, BHCs work closely with co-located specialty mental health providers who conduct therapy sessions.
- BHCs and mental health providers communicate regularly about how to best divide up the behavioral health work. BHCs can refer customers to therapy sessions, and specialty mental health can refer customers back down to "therapeutic" sessions with BHCs. For example, a customer with child sexual abuse might be in therapy as well as working with a BHC on day-to-day functioning.
- Mental health providers work at the top of their licenses and specialize in dealing with complex patients, rather than seeing everyone with behavioral health needs.
- Everyone from counselors to PA-level case managers is educated on the spectrum of behavioral health and how they can help address a customer's behavioral health needs. For example, the frontline CMA does basic behavioral health assessment / screening.
- The following specialty mental health services are co-located:
  - Suboxone, naltrexone clinic
  - TBI collaboration
  - Case management
  - BSD screeners
  - Co-located traditional therapists and psychiatrists

Key Element 5: Outcome Measures

- SCF has demonstrated dramatic decreases in high utilization since the integration of BHCs:
  - 19% reduction in ER (measured by number of customers with > 6-visits)
  - 25% reduction in urgent care (measured by number of customers with > 6-visits)
  - 15% reduction in family medical counseling (measured by customers with > 6-visits)
  - 39% reduction in pediatrics (measured by customers with > 6-visits)
- Anti-depressant and narcotic medication and lab orders have reduced.
- Access to behavioral health services has increased 91%.
- Clinic staff report higher satisfaction and increased efficiency:
  - 88% Primary Care Clinic staff are more satisfied with their job since BHC Integration
  - 77% Primary Care Clinic staff reported increased efficiency
- SCF is waiting on a report from a medical economist to translate these numbers to cost savings.
- Tracking outcomes
  - SCF uses Cerner EMR.
  - All of SCF's patients are impaneled to SCF by the Indian Health Service and there is one hospital across the street from SCF, so it is relatively easy to track utilization.

KEY ELEMENT 6: Funding for SCF comes from:

- The Indian Health Service (IHS) – 45%
- 3rd party payers
- Grants (Initially had an SBIRT grant from SAMHSA)
- Reimbursement for targeted case management at a flat monthly rate from state government (targeted case management is used for the "high utilizer" group that has complex medication / mental / behavioral issues, and BHCs can bill under it)
- Bundled rate for Medicaid patients (AFTER SCF started integrating BHCs and showed results, it negotiated a bundled rate with the state which eliminates the need to deal with a lot of paperwork and makes it easier to schedule visits for multiple services on the same day)

NOTE:

- Though e-mail visits reduce revenue, SCF has found that the decrease in cost and utilization makes up for the lost revenue. For example, if revenue drops 20% after introducing e-mail visits, and utilization and cost decrease by 30%, SCF would still be in the black by 10%.
- The hospital had financial troubles because of the reduction in ER visits, so SCF cost-shares with the hospital as an ACO.

QUESTIONS & ANSWERS

1. **HOW LONG DID IT TAKE SCF TO TRANSFORM ITS PRACTICE?**
   It's still continuing now! There was a lot of activity in the first year, as doctors got used to delegating to nurses. BHCs were added on later, and there was subsequent training on how to work interdependently.

2. **HOW MANY PROVIDER TEAMS DO YOU HAVE?**
   Each clinic holds 5-6 provider teams. There are 6 clinics and 32 total primary care teams at SCF.

3. **How long do psychiatrists work per week?**
   Salaried, 40 hrs/week

4. **How do you assess behavioral health needs?**
   - Depression using the Prime MD
   - Substance abuse using the AUDIT & CRAFFT
   - Cognitive function using the MMSE (important for TBI)
   - Child development using the ASQ and M/CHAT, SDQ
   - Behavioral functioning for chronic pain using the MBMD/SCL 90. (Note: BHCs have to do a lot of training with providers on managing somatoform spectrum disorder, since it isn't part of typical BHC curricula.)

5. **What percentage of your population are high-utilizers?**
   - 50% of patients are seen once a year.
   - 25% of patients are seen twice a year.
   - 5% are seen 12 or more times per year. These are the high-risk, complex, high-utilizing patients.

6. **Is there a public mental health system as well?**
   The state contracts with agencies to provide mental health services, including SCF. There is also a public psychiatric hospital.

7. **Is SCF's model financially feasible without IHS payment?**
   Yes – CareOregon and other places have replicated the model. The key is to be concerned with reducing cost, rather than increasing revenue. A parallel workflow design with BHC integration can help keep providers on schedule with 15-minute visits, which is very efficient and cost-effective. Once you operate more efficiently, it's possible to focus more on improvement because you're not always putting out fires. The next step is to talk to states about paying for outcomes and putting the primary care and behavioral health funding pools back together.

8. **Do you deal with any customer information privacy issues?**
   Customers sign necessary paperwork when they get empaneled. The BHC gets informed consent from the customer whenever he/she enters the visit. The BHC does not do treatment or therapy, so the notes are not psychotherapy notes; they're brief intervention notes that go in the primary care record. Providers can have access to internal psychotherapy notes, but when the psychotherapy notes come from outside of SCF, a release of information is required.

9. **I have a situation where medical staff don't listen to the behavioral health staff.**
   Communication is key. The medical staff are the lead, and that needs to be acknowledged – at SCF, the BHC's main purpose is to serve the primary care team. But if a doctor says that he can't deal with a customer because the customer is dangerous, it's also the behavioral health staff's job to use motivational interviewing skills to ask the provider why he thinks the customer is dangerous, and initiate a dialogue about the issue. Team coaching can help address communication issues.

10. **What can we do if we are short-staffed and have just one behavioral health worker that is co-located?**
    SCF has a valley clinic that is under-resourced as well, but the goal is still to best serve customers. One possibility is to provide brief interventions as well as therapy hours. In addition, providers and

behavioral health workers should still communicate about the most efficient way for them to do their work, so the provider isn't just sending customers to behavioral health when it is unwarranted. The behavioral health worker can also start to help providers plan how to address behavioral health-related issues for certain customers.