Continuing the Conversation

#HCIntegration
eSolutions

eSolutions is a monthly e-newsletter from CIHS.

Sign up today on the CIHS website to start receiving practical solutions and resources on primary and behavioral healthcare integration from across the nation.

Recent Topics Include:

- Integration Partnerships: A Love Story
- Power of Positive Reinforcement and Personal Strength for Whole Health
- Care Coordination
- Confidentiality
www.integration.SAMHSA.gov

Visit the CIHS website for resources to support Primary and Behavioral Health Care Integration
SAMHSA/HRSA Center for Integrated Health Solutions

The resources and information needed to successfully Integrate primary and behavioral health care

For information, resources and technical assistance contact the CIHS team at:

Online: integration.samhsa.gov
Phone: 202-684-7457
Email: Integration@thenationalcouncil.org
Thank you for joining us today.

Please take a moment to provide your feedback by completing the survey at the end of today’s webinar.
How to ask a question during the webinar

If you dialed in to this webinar on your phone please use the “raise your hand” button and we will open up your lines for you to ask your question to the group. (left)

If you are listening to this webinar from your computer speakers, please type your questions into the question box and we will address your questions. (right)
Slides for today’s webinar are posted on the CIHS website

www.integration.samhsa.gov/about-us/webinars
Why Integrate?

Majority of visits to primary care offices have a mental health, behavioral, or psychosocial component.

Mental health, behavioral, and psychosocial problems in primary care are under-recognized.

Most people won’t go to a mental health center.
Why Integrate?

Traditional approaches to mental health aren’t sufficient

Access to mental health professionals is difficult at best

- particularly for uninsured and underinsured populations

All problems are accentuated in vulnerable migratory populations
Integrated Care Goals

Triple Aim
- Improved quality
- Improved patient experience
- Reduced costs

Other Aims
- Improved provider recruitment and retention
- Enhanced primary care capacity
- Improved community health
Integrated Continuum

Referral model
- Mental health provider works elsewhere
- Could be across town or across the hall
- No meaningful sharing of infrastructure
- Communication generally by phone or letter
Integrated Continuum

Co-located ‘parallel play’ model

- Mental health provider works in same space, but with separate scheduling, charting, billing, etc
Integration Continuum

Co-located consultative model

- Mental health provider works in same space, using shared infrastructure
- Available to see patients at request of medical provider
Integration Continuum

Full integration model

- Mental health provider works in same space on same patients at same time
- All patients have access to services
- MHP does not wait to be invited into room by medical provider
- Care plan for every patient involves assessment by MHP
Requirements for Total Integration

Co-location
Universal screening
Real time access
Brief interventions
Solution focused therapy
‘Cross training’
BHPs as primary care providers
Salud Family Health Centers

Migrant/Community Health Center
9 full service sites plus a mobile unit
Expanded range of primary care services
Large dental program
~ 80,000 unduplicated patients annually
~ 300,000 annual visits
Integrated behavioral health since 1997
Salud’s Integrated Mission Statement

“To deliver stratified, integrated, patient-centered, population-based services utilizing a diversified team of behavioral health professionals who function as PCPs, not ancillary staff, and who work shoulder-to-shoulder with the rest of the medical team in the same place, at the same time, with the same patients.”
Integrated Behavioral Health Dept

16 FTE behavioral health providers
  - Psychologists, Licensed Professional Counselors, LCSWs, MFTs

Part time psychiatrists
  - Consultants to PCPs (not direct patient care)

Trainees
  - Post-docs
  - Interns
  - Practicum students
Salud Integrated Care Model

Population based
- We want to reach EVERY patient

Real time interventions
- Most patients can see therapist today

Casts a wide net in determining need for psychosocial intervention

Exact interventions determined by patient need

Broad evaluative measures
Salud Integrated Care Model

BHP office in medical exam room space
BHP spends 70% of time doing screening, brief interventions, case management, etc
30% of time in more traditional therapy
  ● Solution focused
  ● Limited number of visits
  ● Referral as necessary

Frequent and ongoing consultations among docs and BHPs
Requirements for Total Integration

Co-location
Universal screening
Shared records
Real time access
Brief interventions
Solution focused therapy
‘Cross training’
BHPs as primary care providers
How do patients gain access to BHP?

Screening

Direct appointment

Referral from provider

Patient request at medical visit
Other BHP Functions

Co-leaders of shared medical apptmts
  - Centering pregnancy
  - Chronic pain
  - Diabetes, other chronic diseases

Mentoring Transitions of Care team

Staff education and training, for example in motivational interviewing

Liaison to Mental Health Centers
What Makes Our Program Different

Not a consultative model
Not focused on specialty level services
BHPs are primary care providers
Population-based
Not limited to depression
Goes far beyond ‘warm hand-off’
Resistance

From BHPs

- I can’t just walk in on a patient
- I like to spend more time with patients
- I like to get deep into my patients’ psyche
- I don’t like all the interruptions
- This isn’t the way I was trained
Resistance

From medical providers

- I’m the captain of the ship
- I don’t like other people seeing my patients
- The BHP slows me down
- I’m really good at psych stuff and I don’t need help
- This isn’t the way I was trained
What do patients think?

NO resistance

Accepted part of total care package at Salud

Seen as value added service
Why do we need to integrate behavioral health into the healthcare home?
Primary Care

Primary care is the provision of INTEGRATED, ACCESSIBLE health care services by clinicians who are ACCOUNTABLE for addressing a LARGE MAJORITY of personal health care needs, developing a SUSTAINED PARTNERSHIP with patients, and practicing IN THE CONTEXT OF FAMILY AND COMMUNITY.
### Screening at Salud

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence</th>
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<tbody>
<tr>
<td>Depression</td>
<td>31%</td>
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<tr>
<td>Anxiety</td>
<td>25%</td>
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<td>Alcohol</td>
<td>6%</td>
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<tr>
<td>SA</td>
<td>4%</td>
</tr>
<tr>
<td>Tobacco</td>
<td>25%</td>
</tr>
<tr>
<td>PTSD</td>
<td>9%</td>
</tr>
<tr>
<td>ANY CONDITION</td>
<td>47%</td>
</tr>
</tbody>
</table>
“...LARGE MAJORITY of personal healthcare needs...”:

Can we be considered primary healthcare homes if we don’t take care of behavioral health issues?
Funding
Funding Models

Widgets – Fee for service

- PCPs can’t bill for mental health diagnoses under carve-out system
- Mental health services and medical services can’t be billed on same day
- Not all states have activated the Health Behavior codes
- Only certain licenses valid for billing
- We can’t bill for services which patient did not request
- People shouldn’t be treated like widgets
Technical Assistance

Have a question about primary and behavioral health care integration? Contact the CIHS team for information, resources, and individualized technical assistance.
integration@thenationalcouncil.org

Connect With Us

- Sign up for the eSolutions monthly newsletter
- Sign up for the integration listserv
- Ask a Question
- I'm a PBHCI Grantee

Webinars

- Preparing for Bidirectional Integration: Lessons from the Field
  2012-06-14
  Recording  Presentation

- Billing for Integrated Health Services
  2012-06-12
  Recording  Presentation

- Behavioral Health Homes: The Core Clinical Features
  2012-05-30
  Recording  Presentation

- Integration Models: Lessons From the Behavioral Health Field
  2012-05-23
  Recording  Presentation

- Treatment of Chronic Pain: Our Approach
  2012-03-08
  Recording  Presentation

Videos

SONICWALL  Network Security

Welcome to CIHS
2011-10-18
Laura Glibrecht, deputy director of the SAMHSA-HRSA Center for Integrated Health Solutions, provides an overview of CIHS.

View SAMHSA's YouTube Channel
Funding Models

Mental Health as Cost Center

- Build mental health services into budget
- Mental health services allow medical providers to be more productive
- How many more patients do I need to see to pay for a mental health provider?
- 3 docs working 180 days per year: 1 extra patient per day will pay for a MHP
- Variation on the widget model
MHP: Medical Provider Ratio 1:4

4 providers
x 180 days/year
x $80 avg revenue
x 1 extra patient per day

$57,600
Funding Models

Managed care model
- Part of PMPM can go to mental health services

Pay for Performance model
- Integrated care has better outcomes

Internship program
- Low cost PhDs
- Need to pay for supervision (~$100-150/week)
- Personnel will change every year
Funding Models

Collaborate!

- Work with local mental health centers and others to place mental health providers within health center
- Develop shared plan for integration
- Set up ground rules and expectations from beginning
Salud Integrated Care Funding Models

Mental Health Expansion grant from HRSA
Partnership with local health district
Partnership with local mental health centers
Mental health as cost center – commitment of general operating funds
Grants from private foundations
Allocation of PMPM revenue
Training programs – post-docs, interns, students, etc
Caveats

Requires functional and efficient teams
Costs are incurred and savings are accrued in different places
This is a primary care model – we still need specialist mental health providers
Be careful of evaluation – paperwork is not healthcare