The Health Integration Meeting: A Concrete Example Of Integration Between Behavioral Health & Primary Medical Care

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A New World Of Integrated Health Care

Sharon Hicks, Senior Associate, OPEN MINDS
“Integration” – Care Delivery & Care Coordination Moving From Horizontal To Vertical
Why?

Industry-Wide Focus On The Triple Aim – Particularly for Consumers With Multiple Chronic Conditions
Behavioral Health Affects The Delivery Of Primary Care

50% of all mental health care is delivered by primary care providers (PCP)

92% of all elderly persons receive mental health care from PCP

Top 10% of health care utilizers consume 33% of outpatient services and 50% of inpatient services

50% of high utilizers have mental health or addiction disorders
Today’s Health Care System Is Changing To A New Paradigm

### Today
- Treating Sickness / Episodic
- Fragmented Care
- Specialty Driven
- Isolated Patient Files
- Utilization Management
- Fee for Service
- Payment for Volume
- Adversarial Payer-Provider Relations
- “Everyone For Themselves”

### Future
- Managing Population
- Collaborative Care
- Primary Care Driven
- Integrated Electronic Record
- Evidence-Based Medicine
- Shared Risk/Reward
- Payment for Value
- Cooperative Payer-Provider Relations
- Joint Contracting
## Practice Models Of Integration

### Coordinated
- Routine screening for behavioral health
- Referral relationship
- Routine exchange of information
- Primary care provider delivers behavioral health interventions
- Connections made between patient and community

### Co-Located
- Medical services and behavioral health services located in same facility
- Referral process for medical cases to be seen by behavioral specialist
- Enhanced informal communication between primary care provider and behavioral health
- Consultation between behavioral health and medical provider
- Increase in level of quality of behavioral health services

### Integrated
- Medical services and behavioral health services located either in the same facility or in separate locations
- One treatment plan with behavioral and medical elements
- Team working together to delivery care
- Team composed of physician, physicians assistant, nurse practitioner, nurse, case manager, family advocate and behavioral specialist
- Use database to track the care of patients who are screened into behavioral health services
Elements Of Integrated Care Service Delivery From The Specialist Provider Perspective

Shared Consumer Information

Shared Service Location

Shared Financial Incentives

Global Program Requirements For Integration

- Determining who should be referred to behavioral health treatment
- Teaching physical health professionals to talk about behavioral health issues
- Determining who should lead the clinical team – physical health or behavioral health
- Developing population management strategies for people with mental/addictive disorders
Evolving Expectations For The Primary Care Provider

- Involving and educating the patient and family in the treatment plan and process
- Understanding that common illnesses are linked to mental health problems—these problems need to be addressed to effectively treat these common illnesses
- Recognizing that not everyone should be treated the same—complexities often evolve outside of but related to the presenting problem
Challenges For The Primacy Care Team

- Familiarity with habit formation and self directed behavior change principles
- Knowledge of motivational interviewing and value driven behavior change strategies
- Familiarity with acceptance/mindfulness interventions
- Understanding of evidence-based psychosocial treatments (not just medicines)
- Fluency with strengths-based, solution-focused and strategic change principles
- Knowledge of behavioral medicine treatments for common medical issues (diabetes, chronic pain)
- Fluency with health psychology and health behavior change principles (weight control, smoking cessation)
A Concrete Example Of Integration Between Behavioral Health & Primary Medical Care

Cassandra Eslami, Managing Director of Mental Health, HealthRight 360
The “Integration Meeting”
A concrete example of integration between substance use treatment, mental health care, and primary medical care

Cassandra Eslami, LMFT - Managing Director of Mental Health Services
HealthRIGHT 360

- Primary and behavioral healthcare and treatment
- Serving over 40,000 individuals a year
- Over 65 culturally competent programs in 9 counties in California
Our Family of Programs

- Walden House
- Haight Ashbury Free Clinics
- Prototypes
- Women’s Recovery Association
- Lyon Martin Health Services

- Rock Medicine
- Tenderloin Health Services
- Asian American Recovery Services
- North County Serenity House
Total Budget: $110,620,205
Today’s Agenda

• The Case for Integration
• Intro to Case Example: “Mick”
• Our Approach to Integration
• Who is at the table? How to choose the appropriate staff to participate
• What happens in the meeting
• Case presentation format
• Awareness and importance of shared learning
• “Mick” revisited
• Inherent Challenges
• Costs- Is it worth it?
• Incorporating technology
• Next steps
The Case for Integration

- No internal referral system for BH clients to access psychiatric care within our organization’s medical clinics

- Multiple EHRs make it difficult to access client information between BH and medical clinics

- No process for discussing shared clients
“Mick”

- 37 years old; African American; Male
- In residential treatment and sought care in our clinic
- Hx of depression; auditory hallucinations
- Cocaine/meth dependence; sober for 30 days while in program
- Experiencing cravings
- Severe bi-lateral hip pain affecting ambulation
Our Approach to Integrating

- Implemented a single, agency-wide informing statement regarding confidentiality

Confidentiality is an issue frequently raised by persons receiving our services, especially, for patients or clients receiving both medical and/or behavioral health services from one or more of our programs. Under Federal Confidentiality Regulations (HIPAA & 42 CFR Part 2) internal communications does not require authorization when the communication relates to treatment, payment & operations within an organization.

As a healthcare organization, we are aware of your need to feel safe to talk about the issues that concern you. We work hard to gain your trust and create a safe place for you to heal. That’s why we work as a team and believe it is important that you understand that we share information when it is necessary to help you reach your treatment goals. Your primary care and behavioral health clinicians may need to coordinate your treatment and share information that is relevant to your health as a whole.
Designed and initiated an internal referral system for psychiatric care

A “Clinic Consultation Request” referral form is completed at an OP or residential site

The referral is given to the Clinic Lead to track and submit

The referral is sent to the clinic Referral Coordinator

The Referral Coordinator checks eligibility information and sends referrals to Psychiatrists to triage

The Psychiatrist triages the appts and decides if the client can be seen using the consultative model or needs a direct psychiatry appt

Client attends appt

Referral is returned to Referral Coordinator who schedules the appt and notifies client and facility

Either before or after the appt (depending on severity level and clinical need) the client can be discussed at the integration Meeting by anyone involved in the client’s care
Initiated the weekly “Integration Meeting”
Who is at the table?

• Identify staff from different modalities who have clients in common

• Educate staff on the benefits of attending in an effort to obtain buy-in

• Promote flexibility for staff to attend as needed
What happens in the meeting

• Collaboratively create agenda
• Encourage full participation from all providers
• Create next steps for collaborative client care
• Shared learning and language amongst staff
Case Presentation

- Participants must come to the meeting prepared to ask specific questions regarding their client.

- What do you hope to gain, clinically, by discussing this client?
Shared Learning

• Promotes a safe environment of multidirectional learning through shared language

• Benefit of interagency learning
“Mick”

Mick was referred for psychiatric care using our new internal referral system

1. Appointment with psychiatrist; started on psych meds
2. At the integration meeting, his SUD was discussed with therapists for enhanced relapse prevention interventions
3. Shared learning between staff – psychosis and meth use and tx options
4. Advocacy for ambulation issues
5. Advocacy with the surgeon on behalf of Mick
6. Pain management – monitored low-dose opiates for pain
Inherent Challenges

Challenges: Trust vs. Mistrust; Participant buy-in; Turf issues
Multiple EHR’s, Too many attendees

Building bridges to address challenges
Costs and Applicability

How much does it cost?
Is it worth it?

“Integration was one of the driving reasons of the merger. It’s the belief that we can help clients get better with services together, fully integrated. It’s been challenging, which we knew it would be when we did it in the first place. However, we’ve been able to decrease crisis service utilization, maintain clients in our facilities with higher acuity and have had more engagement in MAT to support recovery from substance use disorders.”

-Vitka Eisen, CEO
HealthRight360
Incorporating Technology

• Automated platform for case conference
• Integrating data

• How can we include clients in this process?
• How can we expand to other regions?
Turning market intelligence into business advantage

OPEN MINDS market intelligence and technical assistance helps over 140,000 mental health executives tackle business challenges and maximize organizational profitability.

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