WELCOME!

INTEGRATING PRIMARY CARE AND BEHAVIORAL HEALTH:
LET'S BOLDLY GO!

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LICENSED PSYCHOLOGIST

LEAD ADMINISTRATOR, BEHAVIORAL HEALTH INTEGRATION

ENTERPRISE CLINIC SERVICES

SANFORD HEALTH

ACKNOWLEDGEMENTS…

- Conflict of Interest: I have none

- Conflict of knowledge: I am an adult psychologist, not a pediatric psychologist. So, please keep any clinical questions pretty darn simple.

WHAT MOUNTAIN DO YOU COME FROM?

SOUTHERN CALIFORNIA….

IMAGES FROM MY YOUTH…

UNDERGRADUATE AND GRADUATE TRAINING IN IRVINE AND LOS ANGELES

UNIVERSITY of CALIFORNIA
IRVINE

SANFORD HEALTH DETROIT LAKES, MN 1990-2018
EMBEDDED IN PRIMARY CARE CLINIC

AND THERE ARE THE FAMOUS MINNESOTA WINTERS…

AND NOW……

JEFF'S FAVORITE QUOTES…..

- "*Go into the world and do well. But more importantly go into the world and do good.*" *(Minor Meyers Jr., 1942-2003, 17th president of Illinois Wesleyan University).*

- *"Start where you are, use what you've got, do what you can." (Arthur Ashe, professional tennis player)*

SANFORD HEALTH TODAY

44 medical centers

$6.1 billion in annual revenue

482 clinics

269 senior living centers

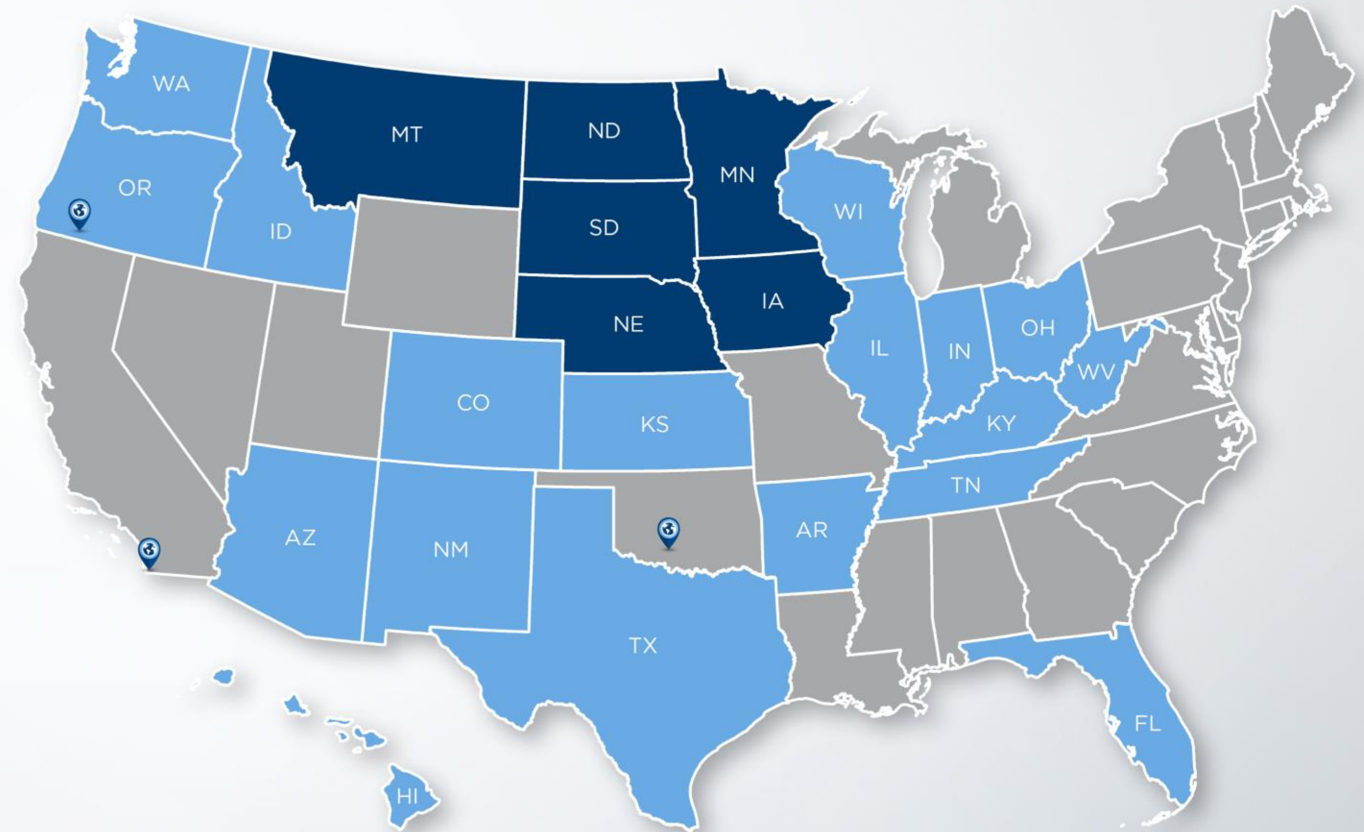
190,000 Sanford Health Plan members

1,453 physicians, **1,001** advanced practice providers and **8,179** registered nurses delivering care in more than **80** specialty areas

49,086 employees

Sanford Health annual statistics:

- **5.4 million** outpatient and clinic visits
- **86,305** admissions
- **138,881** surgeries and procedures
- **9,436** births
- **212,332** emergency department visits
- **2,827,718** post-acute/skilled census
- **687,228** assisted living census
- **1,311,287** senior living census

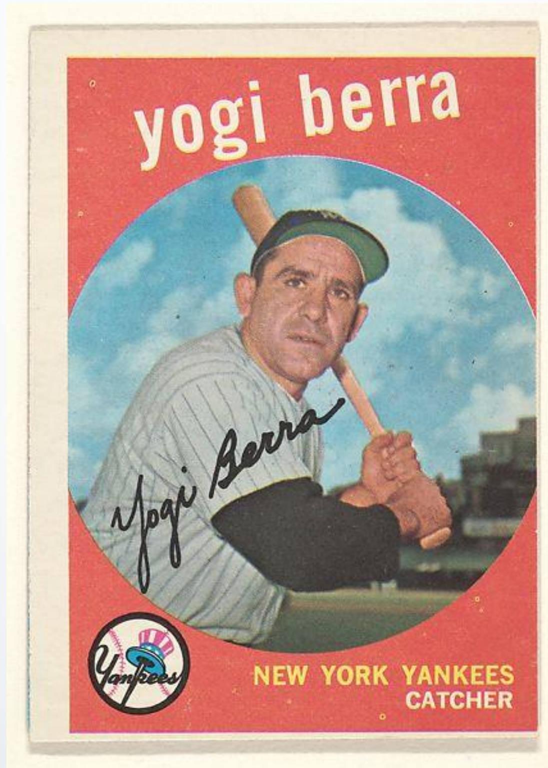


CAN YOU ANSWER THIS QUESTION?

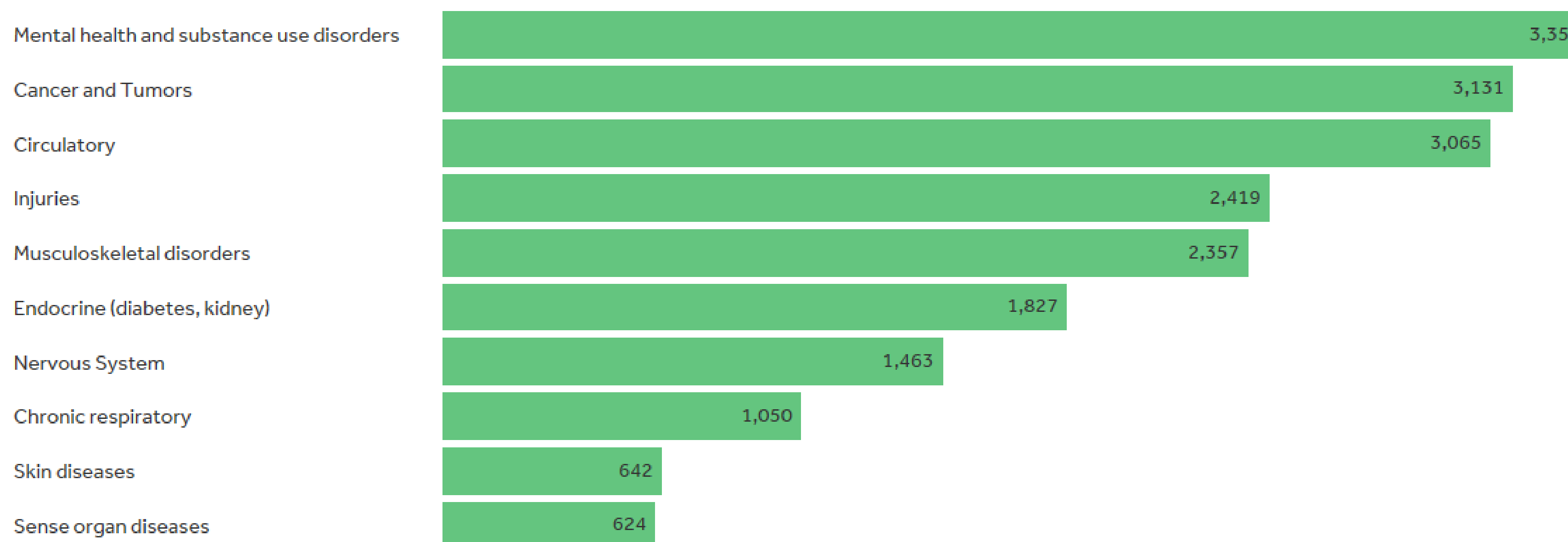
- We at Rady Children's Hospital and Health Center are committed to integrating primary care and behavioral health because....................

WHY IS IT IMPORTANT TO KNOW 'WHY' YOU ARE DOING THIS?

- *"If you don't know where you are going, you will end up somewhere else…"*



MENTAL ILLNESS AND SUBSTANCE USE DISORDERS ARE THE LEADING SOURCE OF DISEASE BURDEN (FINANCIAL COST/MORBIDITY/MORTALITY) IN THE U.S.A.



Peterson-Kaiser
Health System Tracker

WHAT THE HECK IS INTEGRATED CARE ANYWAY?

INTEGRATING THE WORK AND INTEGRATING ATTITUDES

- “*Integrated behavioral health (or integrated care) is the care that results from a practice* ***team*** *of primary care and behavioral health clinicians* ***working together*** *with* ***patients and families****, using a* ***systematic*** *and cost- effective approach to provide* ***patient-centered*** *care for a defined population.*
- *This care may address* ***mental health****, substance use conditions, health behaviors (including their contribution to* ***chronic medical illness****), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.”*
- Peek, C.J. , National Integration Academy Council. Lexicon for behavioral health and primary care integration: Concepts and definitions developed by expert consensus. Rockville, MD: Agency for Healthcare Research and Quality. AHRQ Publication No. 13-IP001. April 2013.

2014 JOINT PRINCIPLES FOR INTEGRATING BEHAVIORAL HEALTH INTO THE PATIENT CENTERED MEDICAL HOME

- American Academy of Family Physicians (AAFP)
- American Board of Family Medicine (ABFM)
- Association of Departments of Family Medicine (ADFM)
- Association of Family Medicine Residency Directors (AFMRD)
- North American Primary Care Research Group (NAPCRG)
- Society of Teachers of Family Medicine (STFM)

"…this practice will rely ***on a team*** *of health care professionals who will act together to integrate the* ***physical, mental, emotional, and social aspects of the patient's health care needs****."*

"…a ***PCMH would be incomplete without behavioral health care fully incorporated*** *into its fabric. A whole person orientation simply cannot be imagined without including the behavioral together with the physical." (Baird, et. al. 2014)*

AN INTRODUCTION TO INTEGRATED PRIMARY CARE

<u>United States:</u>

Spends 18% of GDP on healthcare ($ 3 trillion) but ranks 37th worldwide on health outcomes.

<u>Biomedical Model:</u> Despite its contributions, has been criticized….

- ✓ Reductionistic
- ✓ Ignores role of emotional, social, psychological factors
- ✓ Not adequate attention to cultural, environment, and belief systems

INTRODUCTION (CONTINUED)…

Unfortunately……

- The biomedical model led to an unintended mind/body split or "***dualism***" in which psychological disorders, unless explicable via biomedical processes, were largely ignored or minimized.

- As a result, the American health care system similarly "**carved out**" mental/behavioral treatment out of the mainstream health care enterprise, (Belar, 1996).

- In addition, behavioral and medical providers have historically been:

✓ *trained separately*,

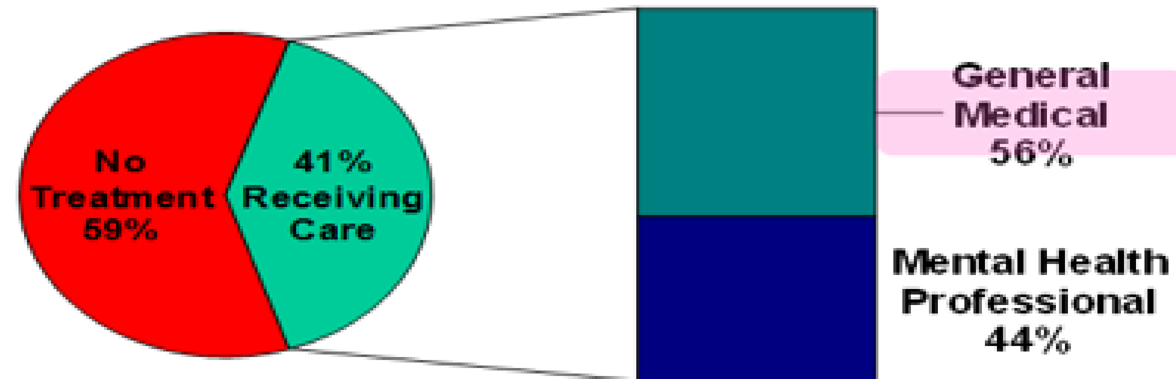
✓ *conceptualize care differently*,

✓ have *limited interactions with one another, even if treating the same patient.*

BUT IT IS INCREASINGLY CLEAR THAT…

- …behavior, culture, environment, and psychological processes are not only relevant to the understanding of the course of health and illness, **but indeed may be a central tenet.**
- It has been estimated that perhaps as much as 95% of the variation in chronic disease outcomes results from patient specific factors such as lifestyle, behaviors related to disease management, and other psychosocial variables (Tuerk, Mueller, & Egede, 2008).
- **"Your zip code may be more important that your genetic code in predicting health, wellness, and longevity."**

PRIMARY CARE IS THE 'DE FACTO' MENTAL HEALTH SYSTEM (YOU ARE ALREADY DOING THE WORK)



Source: Wang P et al. *Arch Gen Psychiatry*, 2005: 62.
Adapted from Katon, Rundell, Unützer, Academy of PSM Integrated Behavioral Health 2014

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WHY INTEGRATE?
BECAUSE YOU (PRIMARY CARE) ARE ALREADY DOING THIS WORK!

- Primary Care:
  - Manages (or helps to manage) 80% of patients with mental illness
  - Prescribes 76% of behavioral health medications
- Patients:
  - 30-50% referred to behavioral health no show
  - Use and spend more on healthcare

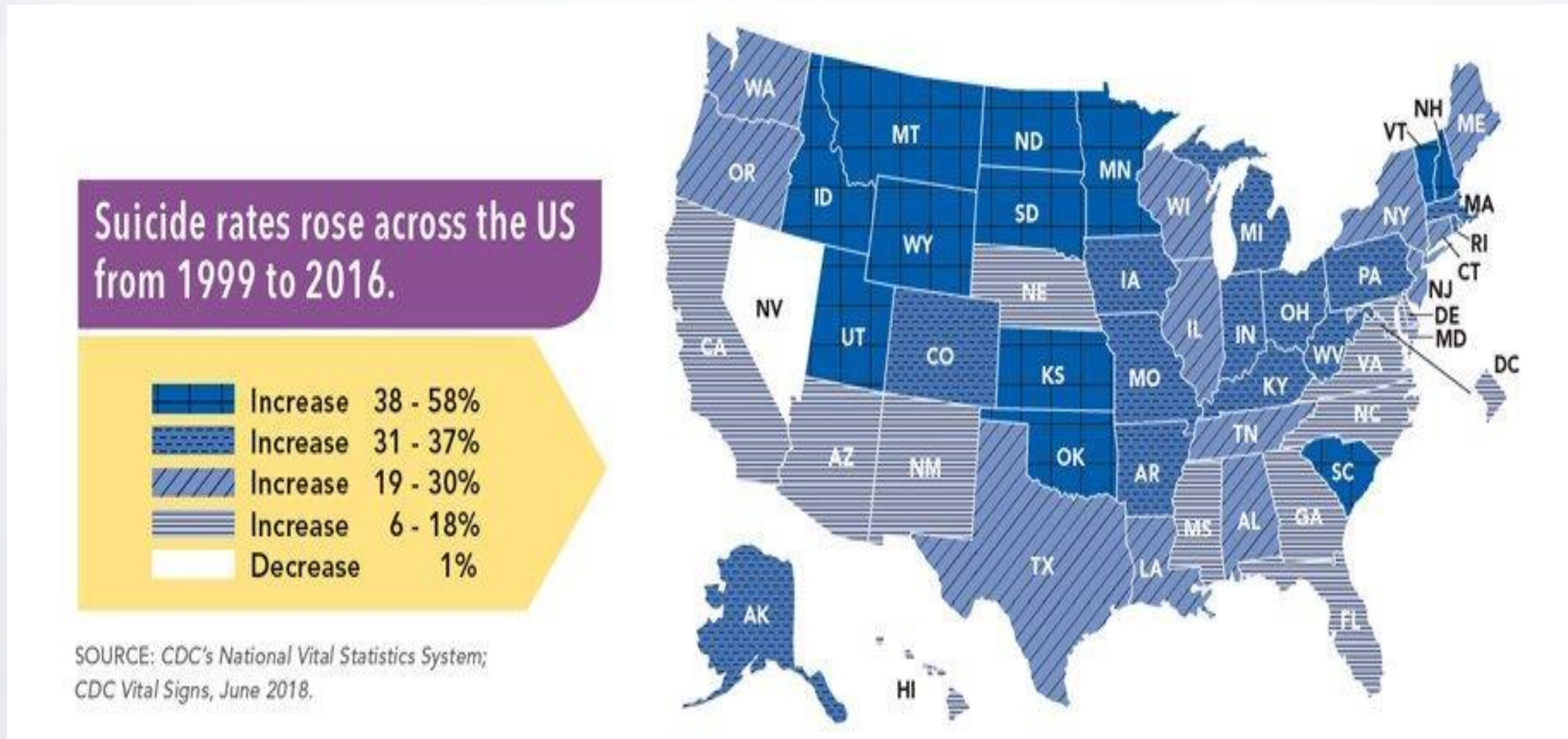
BUT WITHOUT ADEQUATE HELP, IT IS VERY, VERY HARD

- **Misidentification of depression and anxiety disorders in primary care range from 65-97% (**Vermani, Marcus, and Katzman, 2011),

- **Referrals to outside behavioral health specialists are reported as being frequently unsuccessful** (Cunningham, 2009), leading to a cycle of **frustration and helplessness** for patient and provider alike.

PERHAPS MOST IMPORTANTLY….

- Nearly 50% of patients that die by suicide were seen by their primary care provider within 30 days of their death and 20% saw their PCP within 24 hours of dying from suicide (Luoma, et.al. 2002).



- Doesn’t it make sense for mental energies to collaborating with most of the behavioral health

INTEGRATED BEHAVIORAL HEALTH VS. SPECIALTY BEHAVIORAL HEALTH: HOW DO THEY COMPARE?

Domain	Integrated Behavioral Health	Specialty Behavioral Health
Model of Care	Population based	Client based
Location of Care	**Embedded in primary care**	**Often off site**
Primary Consumer	Patient and PCMH team	Typically individual client
Accessibility	**On Demand (warm handoff)**	**Appointment based**
Patient Population	Drawn from ambulatory panel	Typically a serious mental health diagnosis
Productivity/Care intensity	**High/low (often < 6 sessions)**	**Low/high (often long term)**
Problem Scope	Wide (cradle to grave)	Specialized
Service Delivery Approach	Consultation/brief visits	Comprehensive/long term
Ownership of Care	**The team**	**The therapist**

MODELS OF INTEGRATED CARE (BLOUNT, 2003)

Coordinated Care (communication emphasis)	Co-located Care (proximity emphasis)	Integrated Care (practice transformation emphasis)
"I'll send you my patient"	**"I'll stop by your office and refer you my patient"**	**"We will co-manage our patient"**
Routine screenings for behavioral health problems conducted in primary care	Medical and behavioral health services located in same clinic allowing spontaneous interdependent consultations	**Medical and behavioral health services located in the same clinic.**
Existing referral relationship between behavioral health and primary care but practitioners maintain responsibility primarily for their own aspect of a patient's care	Referral processes in place for medical patients needing behavioral health attention	**One unified treatment plan with both behavioral and medical components (shared medical record)**
Routine exchange of information between practitioners	Enhanced informal communication due to proximity of providers	**Working, unified team using shared protocols adjusting care for population health**
Primary care doctor delivers brief behavioral health interventions but specific type will vary by provider	Consultation between the behavioral health and medical provider to increase mutual skill levels but both remain in individual silos.	**Treatment teams composed of physician, extenders, and behavioral health professional with consistently implemented care processes**

CORE QUALITIES OF SUCCESSFUL INTEGRATED BEHAVIORAL HEALTH SERVICES (STROSAHL, 1997)

1. The program must be able to address tremendous unmet demand among primary care patient populations.
2. Since adequate staffing may be difficult to meet, behavioral providers must have a high population focus and impact.
3. The behavioral health service must be consistent with the mission, values, and objectives of the primary care organization.
4. Integrated practices should have minimal separation of services, providers, and infrastructure.
5. Services need to be patient centered and organized to be culturally competent.
6. The services must provide timely access for primary care providers.

CORE QUALITIES (CONTINUED)

7. The services must be a seamless part of primary care and provided in collaboration with primary care physicians.

8. Goals of the service include:

- Increasing impact of team interventions within the medical home,
- Team building,
- Assisting the primary care physician to obtain better outcomes,
- Improve the experience of patients and staff, and minimize financial risk

9. The service should successfully teach the primary care physician "core" behavioral health skills and be capable of training patients in self-management skills.

10. Improving the primary care physician/patient working alliance and help the PCP to manage "at risk" or chronic patients.

VALUE OF PRIMARY CARE BEHAVIORAL HEALTH INTEGRATION

"When my family physician spoke with my daughter's therapist everyone finally was on the same page. I felt like my daughter's treatment moved forward and all of her health needs were being addressed… Finally, everyone—my daughter, my family and I—had hope that treatment was on the right track and things would be better."

– Parent

INTEGRATED PEDIATRIC CARE

- ✓ Like adults, most children with mental health concerns are treated in primary care.
- ✓ About half of all mental health disorders begin by age 14. (Kessler et. al, 2005).
- ✓ Despite the prevalence of symptoms, less than 1% of community-dwelling children and adolescents in the United States receive outpatient treatment for depression each year (Avenevoli et al., 2015).

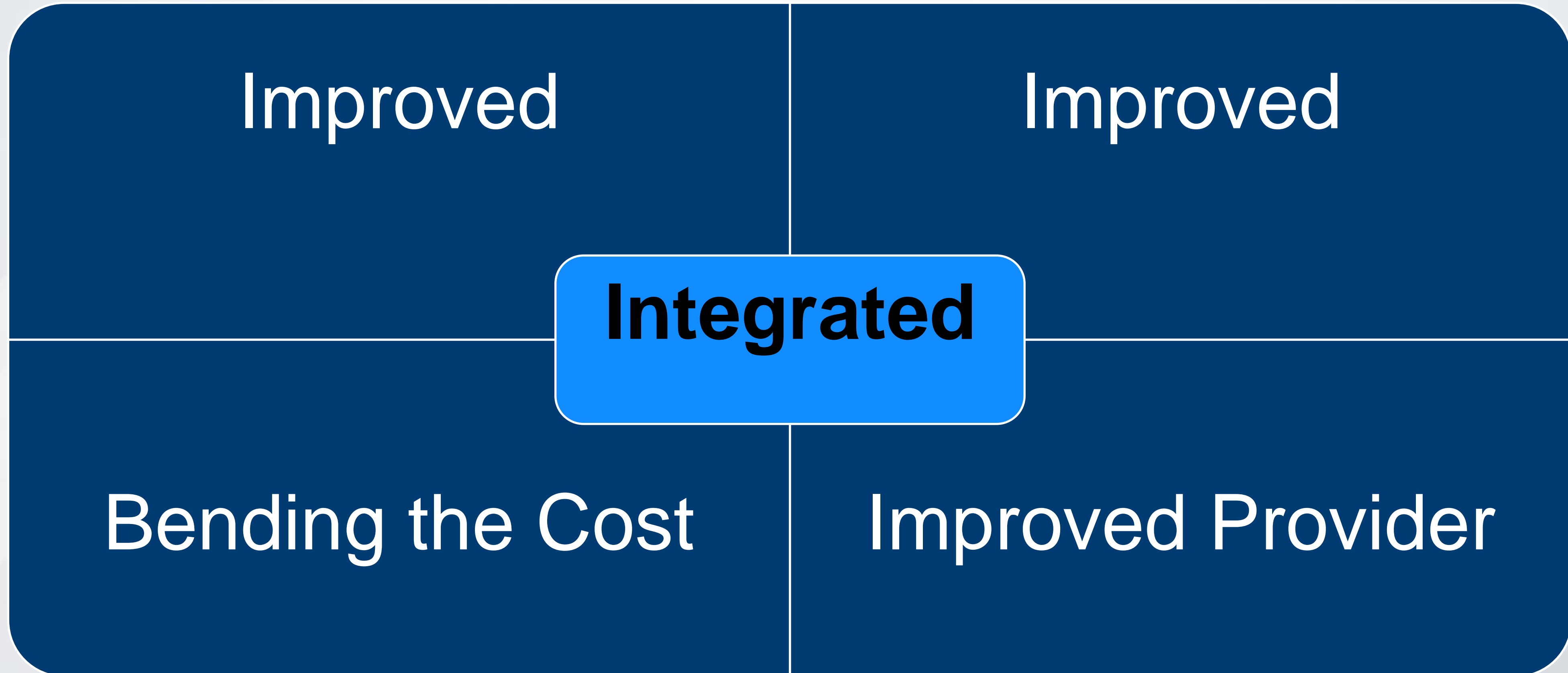
- **Pediatric Integrated Care differs from Adult Integrated Care in three main ways (NIMH):**

1. There is an increased sensitivity to how children are developing, both mentally and emotionally
2. Families play an important role
3. Treatment emphasizes coping and adjustment techniques in addition to standard care

NUMEROUS STUDIES HAVE DEMONSTRATED THAT WHEN YOU INTEGRATE YOU GET….

- ✓**Improved access** to behavioral health care and decreased wait times for services
- ✓**Reduced stigma** for patients seeking care for behavioral health/substance use disorders
- ✓Shared medical record→ **Improved communication, consultation and collaboration between providers**
- ✓**Improved adherence** to treatment plans and follow through with specialty mental health services
- ✓**Decreased use of unneeded medical and emergency services** when behavioral health problems are adequately addressed
- ✓**Increased PCP productivity** by eliminating "*schedule busters*"
- ✓**Increased patient satisfaction** with providers practicing integration

THE QUADRUPLE AIM



Source: Berwick, Nolan, & Whittington (2008). The Triple Aim: Care, Health, And Cost. *Health Affairs*. vol. 27 no.3, 759-769

SANFORD'S JOURNEY INTO INTEGRATED PRIMARY CARE

Pre-2012:

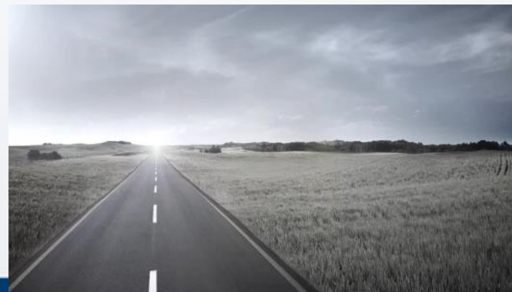
Most behavioral health resources in specialty care settings with sporadic co-located practices in primary care

2012:

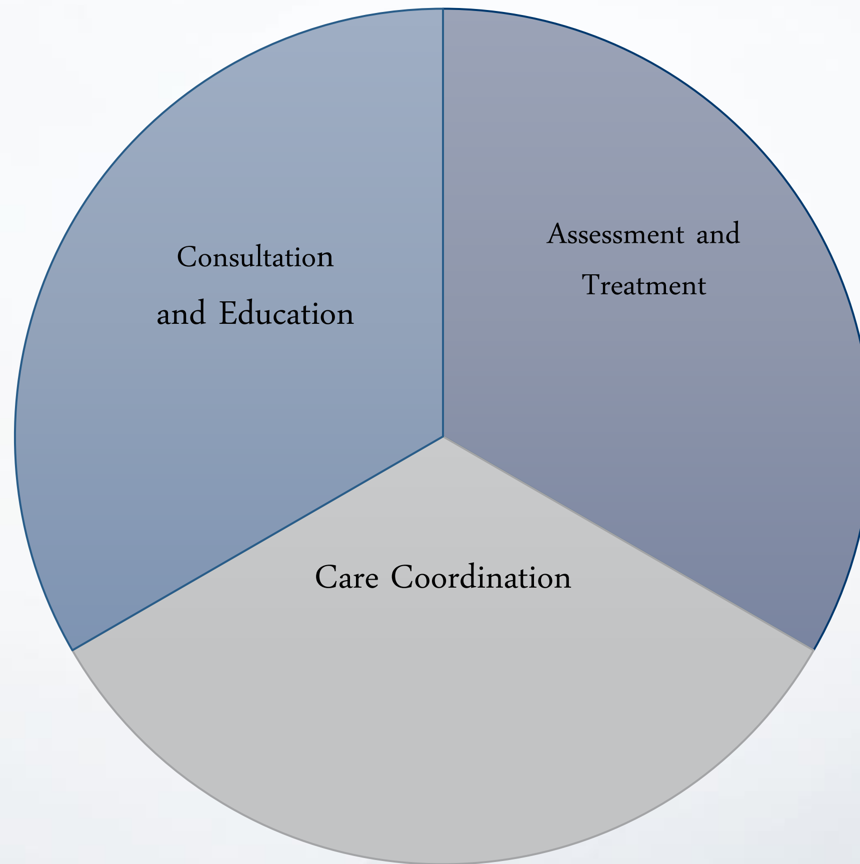
Sanford receives $12 million grant from CMS to institute universal behavioral health screening and begin journey of integration

Today:

~50 IHTs in family medicine, pediatric, OB-GYN primary care clinics/ Standardized screening for mental health and social determinants that impact overall health.



ROLE OF THE INTEGRATED HEALTH THERAPIST (IHT) AT SANFORD



ROLE OF THE INTEGRATED THERAPIST (IHT)

IHT's help with:

- Assessments
- Community Resources
- Education
- Immediate triage
- Brief Therapy
- Crisis Intervention
- Liaison with Psychology/Psychiatry/Specialty mental health
- **Overall goal of IHT: To improve primary care!**

DESIRABLE PROFESSIONAL AND PERSONAL SKILL SET FOR AN IHT

Professional skill	Personal skill
Solid diagnostician	Team oriented personality/attitude
Finely honed clinical assessment skills	Enthusiasm
Ability to sort and rapidly define problems	Desire to educate and upskill colleagues
Skilled in solution focused interventions	Flexible and comfortable with fast pace of primary care care
Consultation/education skills for patient and staff alike alike	Creative and spontaneous
Understanding of the relationship between medical and psychological processes and psychological processes	Passion to make a difference

POTENTIAL BARRIERS TO IMPLEMENTING INTEGRATED CARE

- 1. **Financial**: many activities associated with integrated care are not traditionally reimbursed under typical fee-for-service care such as:

❖ Care management functions

❖ Communication with providers

❖ Brief consultations with patients (in person/telephone)

- *IHTs typically use:*
- Mental health CPT codes (90791/90832/90834/90837/90846/90847)
- Health and Behavior codes (96150-55)

POTENTIAL BARRIERS (CONTINUED)

- 2. **Organizational:**

❑Resistance to change

❑New staff and new roles

❑Balancing competing demands

→*All are difficult to overcome without strong leadership that is committed to integrated care and champions the program.*

- 3. **Sustainability**:

❑*Model drift* frequently occurs as systems regress to old, familiar ways of doing things.

A FEW MISTAKES IN THE SANFORD JOURNEY…

- 1. Reporting structure for IHTs in behavioral health instead of primary care (changed mid-stream)

- 2. Not considering need for workforce pipeline for expanding IHT role (doing that now!)

- 3. Not adequately training primary care clinic directors to the IHT role (recruiting, sustaining, licensure, etc.)

“What if we don’t change at all ...
and something magical just happens?”

PEARLS OF WISDOM FROM THE FIELD

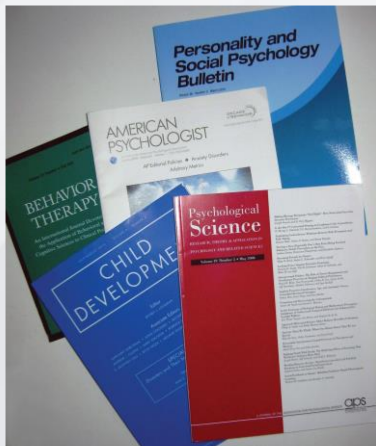
CHECK OUT THIS ARTICLE….

From Our Practices to Yours: Key Messages for the Journey to Integrated Behavioral Health

Stephanie B. Gold, Larry A. Green and CJ Peek

The Journal of the American Board of Family Medicine

January 2017, 30 (1) 25-34



CORE CONCEPTS AND TAKEAWAYS

1. Frame integrated care as a necessary paradigm shift to patient-centered, whole-person health care for the entire organization, not just this initiative.

"We need to stop talking about mental and physical health; there is just health. It needs to be delivered and paid for as one."

2. Define relationships and protocols up front, understanding they will evolve.

"Go ahead and be the change you want to see now: develop workarounds for the obstacles."

3. Build inclusive, empowered teams to provide the foundation for integration.

"Invest in building and training integrated care teams to create trust among patients, providers, staff, and management for integrated BH in PC. Trust empowers integrated care."

4. Develop a change management strategy of continuous evaluation and course correction.

"Do not be afraid of failure: our best lessons (solutions) come from our failures."

5. Use targeted data collection pertinent to integrated care to drive improvement and impart accountability (i.e. depression remission, physician productivity, patient satisfaction, improvement in co-morbid conditions, model fidelity, etc.)

"[You] have to look at data, but also turn data and results into actual change."

WISDOM FROM THE BOOTS ON THE GROUND…

- *“Integration is not the goal. Better patient care is the goal. If that is your ‘north star’, the transformation to PCBH will have broader support and go much more smoothly.”*

Alexander Blount, EdD

Professor of Clinical Psychology

Antioch University New England

Professor Emeritus of Family Medicine and Psychiatry

University of Massachusetts Medical School

Principal, Integrated Primary Care, Inc.

Amherst, Massachusetts

AND……

- *"If you have seen one integrated clinic, you have seen one integrated clinic!*
- *Every single clinic is a totally different culture even in the same system! So, create your workflows and pathways, but be flexible to adapt them to the specific needs and flow of each individual clinic."*

- Laura Schwent Shultz, Psy.D.
- Director of Behavioral Health- Ambulatory Care, Methodist LeBonheur Healthcare
- Memphis, TN

AND…..

"Hire based on personality, interest/motivation in team-based clinical work, and fit.

Do not hire based (exclusively) on credentials or convenience (i.e. graduates from an institutionally affiliated program, existing staff clinicians that you "shift" into the primary care setting)."

Alexander Brown, Ph.D.

Behavioral Health Faculty

Licensed Psychologist

NH Dartmouth Family Medicine Residency

Concord Hospital Family Health Center

250 Pleasant Street

Concord, NH 03301

AND…..

“Invest adequate time assessing your community and clinic needs before deciding on a model or rules. ‘Model first’ thinking can lead to frustration and missed opportunities.”

And

“Invest early in establishing a training program or connections with local academic programs in order to meet staffing needs.”

Joshua Bradley, Psy.D.

Director of Behavioral Health

Licensed Clinical Psychologist

Tri-Area Community Health

14558 Danville Pike

Laurel Fork, VA 24352

AND….

"Every step of the way, develop the program and team you'd like to encounter when you and your family go to the doctor…"

Maria Jesus (Chus) Arrojo, LMHC, LMFT

Behavioral Health Integration Manager Western MA

Pediatric Physicians' Organization at Children's

47 Pleasant Street, Suite 1-SE

Northampton, MA 01060

AND……

"In the beginning it's important to consider that "if you build it they don't necessarily come" (even if they've told you how much they need the service) . Often the system needs to do "marketing, marketing, marketing" to help the providers and the practice know how to incorporate this new resource into their workflows and team."

Mary Jean Mork, LCSW

VP of Integrated Programming

Maine Behavioral Healthcare, a member of MaineHealth

165 Lancaster Street

Portland, Maine 04101

FINALLY……..

- *Expect to make mistakes (that's normal).*
- *Expect things to not go as planned (nearly every day).*
- *Expect territoriality disputes*
- *Expect the vision to evolve in ways you had not dreamed of*
- *Expect "integrated care" to mean different things to different people*
- *Expect resistance as some see 'change' as 'loss.'*
- *Expect some (or many) to ask why we have to change things.*
- *Expect some to scoff, drag their feet, and voice displeasure.*
- ***Nevertheless, do it anyway. It is the RIGHT thing to do for our patients.***

INTEGRATED PEDIATRIC PRIMARY CARE IN ACTION

- https://youtu.be/gd-4daXuTEQ

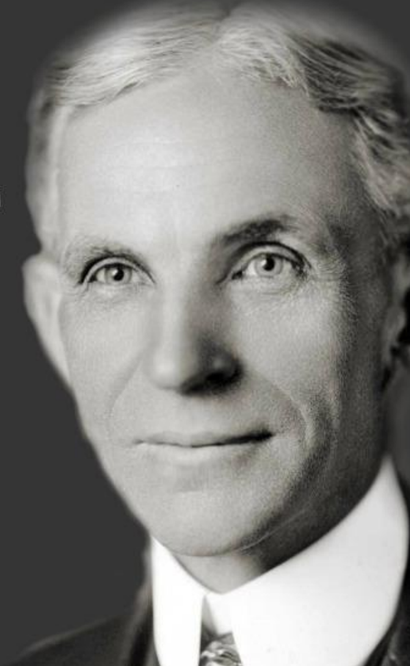
"*They are part of my village*"

Nemours Alfred I DuPont Children's Hospital, Delaware

A TAKE HOME MESSAGE

WHETHER YOU THINK YOU CAN, OR THINK YOU CAN'T - YOU'RE RIGHT

— Henry Ford



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THANK YOU!

LIVE LONG AND PROSPER….

SANFORD
HEALTH