National Association of State Mental Health Program Directors

Medical Directors Council Technical Paper

Integrating Behavioral Health and Primary Care Services

Medical Directors Council Technical Papers

1. Treatment Algorithms for Persons with SMI
2. Reducing Seclusion and Restraint – Part I
3. Programming for Civilly Committed Sexual Predators
4. Involuntary Out Patient Commitment
5. Psychiatric Polypharmacy
6. Reducing Seclusion and Restraint – Part II
7. Access to Psychiatric Medications
8. Reducing Seclusion and Restraint Part III
9. SMHA Response to Terrorism

Medical Directors Council Other Products

- Annual Best Practice Symposium
- NASMHPD Position Statements
- Regulatory Comment
- Technical Assistance
- Liaison to psychiatric professional organizations

11th Technical Report Integrating Behavioral Health and Primary Care

Six Reports in One

3 Background:

- Conceptual Models
- Overview of Community Health Centers
- Relationships among providers – same models

3 Recommendation Areas:

- System Coordination
- Serious Mental Illness
- Primary Care

- Each section can be used independently
- Read the Executive Summary (only 7 pages) to decide what you want

Conceptual Models

- Four Quadrant Clinical Care Model
- Care Model
- Integration Model
- EBP by Quadrant

Overview Community Health Centers

- Types
- Populations Served
- Services
- Funding and Reimbursement
- Benefits
- Behavioral Health Activities

Integration Models

- Staffing
- Cultural Differences
- Planning
- Negotiation

Recommendation Sections - Format

- Principle – Assumptions and Strategy
- Research
- Discussion of Issues from SMHA Perspective
- Recommendations – Federal, NASMHPD, SMHA, Providers

Recommendation Sections - Content

- System Coordination –
  - State level integration team
  - Federal level policy issues
- SMI – How to get good BHC and PC for them
- PC – How to retain/gain SMHA leadership on BHC

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Principles

- Physical Healthcare is a core service for persons with SMI
- MH systems have a primary responsibility to ensure:
  - Access to preventive healthcare
  - Management and integration of medical care

Promising Models

- Case Management coordination and facilitation of healthcare
- Medical Disease Management for persons with SMI
- Preventive healthcare screening and monitoring by MH providers
- Integrated/consolidated CMHC/CHC Services

Recommendation – Medical Needs have same priority as MH needs

- Obtaining a "medical home" – a primary care provider responsible for overall coordination
- Medication adherence – just as important for non-MH meds
- Assisting in scheduling and keeping medical care appointments

Recommendations – Do Preventive Monitoring

- Are vaccinations up to date – hepatitis, pneumovac, tetanus
- Weight, blood pressure
- Review of symptom checklists
- American Academy Family Practice Preventive Care Recommendations

Recommendations – Provide information to healthcare providers

- HIPAA permits sharing information for coordination of care
- Nationally consent not necessary
- Exceptions:
  - HIV
  - Substance abuse treatment – not abuse itself
  - Stricter local laws

Recommendation – provide user friendly information

- Written, legible, brief
- Use medical consult format – get it on the client's medical record
- 4 sections:
  - Provide information
  - Share concerns
  - Ask for help
  - Offer help
- Keep communicating on changes in client status even if no response

Recommendation – Integrate healthcare issues into CMHC Care Mechanisms

- Include healthcare goals on Treatment Plan
- Include healthy life style goals on Treatment Plan
- Identify your internal health care expert/champion
- proven practice – nurse healthcare case manager

Strategies

- Incrementally build your organizations healthcare, competencies internally
- Build <u>and</u> <u>maintain</u> a collaborative partnership with a healthcare organization
- Merge/consolidate with a healthcare organization

Benefits of Co-Location

- Patients prefer it
- Builds personal relationships – the foundation of any enduring arrangement
- Allows more accurate understanding of each others incentives, methods and constraints
- Opportunities for informal consultation
- Single clinical record reduces errors

Community Health Center Overview (CHC)

- Also known as Federally Qualified Health Centers (FQHC)
- Direct Federal Program
- Medical Safety Net
- Comprehensive Mandate

Primary Care	Dental
OB/GYN	Behavioral
Pediatrics	Prevention

CHC - History

- Established in 1960's during War on Poverty
- Early 1970's
  - 140 CHCs serving 1.4 million
- 2004
  - 1000 CHCs serving 15 million
- 2006 estimate
  - 1200 CHCs will serve 30 million

CHC Funding

Federal Grants	20-30%
Patient Revenues	25-40%
Local Funding	30-40%

BH Services Provided by CHCs

- 2002 provided 2 million BH visits (4.4 % of total)
- 2003 employed over 2000 BH clinicians including 145 FTE psychiatrists
- Over 250 BH expansion grants (up to $150,000) awarded
- New sites must include BH
- 2006 target – 75% will provide MH service
  49% will provide SA service

An Overview of Some Cultural Differences in Safety Net Organizations

CHC	SMHA Provider
National System	State Defined
Safety Net Provider	Medicaid Provider
Need-Based Services	Eligibility-Based Services
Population-Focused	Case-Focused
Prevention Oriented	Rehabilitation Oriented
Lifespan Care	Episodic Care
Gatekeeper	Specialty Service
Open Access	Restricted Access
Flexible Scheduling	Rigid Scheduling
Treatment Team	Solo Provider
Symptom Focus	Personality Focus
Generalist	Specialist
Governed by Users	Governed by Community Leaders

Freeman, Cherokee Health Systems

Health Disparities Collaboratives

- Required by HRSA Bureau of Primary Care
- Multiyear, national initiative to implement care model
- Conditions

Diabetes	Asthma
Cardiovascular Disease	Depression

Organization of Healthcare/Leadership

- Make sure senior leaders and staff visibly support and promote the effort to improve chronic care
- Make improving chronic care a part of the organization’s vision, mission, goals, performance improvement, and business plan
- Make sure senior leaders actively support the improvement effort by removing barriers and providing necessary resources
- Assign day-to-day leadership for continued clinical improvement
- Integrate collaborative models into the quality improvement program

Decision Support

- Embed evidence-based guidelines in the care delivery system
- Establish linkages with key specialists to assure that primary care providers have access to expert support
- Provide skill-oriented interactive training programs for all staff in support of chronic illness improvement
- Educate patients about guidelines

Delivery System Design

- Identify depressed patients during visits for other purposes
- Use the registry and care monitoring to proactively review care and plan visits
- Assign roles, duties and tasks for planned visits to a multidisciplinary care team. Use cross training to expand staff capability
- Use planned visits in individual and group settings
- Make designated staff responsible for follow-up by various methods, including outreach workers, telephone calls and home visits

Clinical Information System

- Establish a registry
- Develop processes for use of the registry, including designating personnel to enter data, assure data integrity, and maintain the registry
- Use the registry to generate reminders and care planning tools for individual patients
- Use the registry to provide feedback to care team and leaders

Self-Management

- Use depression self management tools that are based on evidence of effectiveness
- Set and document self management goals collaboratively with patients
- Train providers and other key staff on how to help patients with self management goals
- Follow up and monitor self management goals
- Use group visits to support self management

Community

- Establish linkages with organizations to develop support programs and policies
- Link to community resources for defrayed medication costs, education and materials
- Encourage participation in community education classes and support groups
- Raise community awareness through networking, outreach and education
- Provide a list of community resources to patients, families and staff

American Association of Community Psychiatrists

Minimum Recommendations for Coordination

- Effective bidirectional communications
- Determination of essential information to share
- Appropriate confidentiality and consent protocols

What Drives Primary Care Crazy

- Long delays in getting patient seen for initial consult
- No responses back when they refer a patient
- Long responses that use mental health jargon
- Lack of explicit recommendations they can act on
- No response to a medical record/release of information request

Option

Separate one time consultation and recommendation service

- Rapid access to consultation
- Usual wait list for ongoing service