Integration of Primary Care and Behavioral Health for People with Disabilities

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WE HAVE NO ACTUAL OR POTENTIAL CONFLICTS OF INTEREST RELATED TO THIS PRESENTATION
Learning Goals

Participants will be able to:

1. Envision a system in which medical, behavioral, care management and other service elements work together as a team, synchronously and asynchronously.

2. Describe the elements of a system that integrates behavioral and medical care.

3. Describe the role of care management in such a system.

4. Describe routines for building and passing relationships with members so that the member is the most important player in their own care.
Integration of Primary Care and Behavioral Health: AGENDA

1. Why is it essential to provide Behavioral Health services in Primary Care for people with disabilities?
   - Case example
   - Prevalence
   - Patient Preference

2. Ways of organizing Behavioral Health in Primary Care: Bird’s-Eye View

3. Ways of working together: On the Ground

4. The central role of the Care Manager

5. Re-Designing Your Practice to Optimize Behavioral Health integration
Some “complex” situations are complex

- Joan (not her name) - 55 yo Caucasian woman (in 1999)
- 1st visit to practice took nearly 2 hours (with medical student)
- DM-2, thrombocytopenia, obesity, CAD (s/p CABG), “bipolar disorder,” anxiety, smoker, COPD, using a wheelchair
- Office visits long and frequent
- Always accompanied by husband, Roy
Some “complex” situations are complex

- Began calling after hours, nearly nightly
- Calls handled by residents; often culminated in referral to ER
- Nearly 200 ED visits in a year

This isn’t working!?!?
I need help!?!
Dr. Blount introduced in Primary Care visit

First Behavioral Health contact at HFHC
Early Behavioral Health Work

• Hx of trauma, separation and loss that more than justified anxiety and PTSD Dx.
• Chose to look for and build on her many strengths.
Get the problem sequence

When there is a problem, like excessive ED use, get a clear account of the predictable sequence in which the problem occurs.

How?
Keep asking “Why?” until root causes are identified
Course of Care: Behavioral Health

The most stability came with regular “check-in” meetings every 4-6 weeks.
Course of Care: Medical

It takes a village, but ...

We emphasized the role of her PCP (a resident):
   Proactively scheduled visits every 2 – 4 weeks
Other strategies:
   collaborative efforts/education with ED staff, MD coverage group, nursing staff, BH

Joan liked the idea of regular visits. She felt she went from having incomplete control of her chaotic interaction with the health system to sharing a plan with her team.

This achieved greater stability with fewer ED visits, office visits, and admissions -- though frequent after-hours calls continued.
Course of Care: Team

We had adequate expertise on the team, but not adequate workforce. Joan appreciated the quality of the engagement, but wanted a higher level of interaction.

Plan-based care manager who reached out on the phone to urge improved healthy behavior was overwhelmed and gave up.

We missed a practice-based care manager who was coordinated with the treatment plan.

Team had to be comfortable with having some influence and little control.

Other interventions? Other team members?
Options arise when we develop new descriptions/stories of familiar events

• Health system has a tendency toward “more of the same”.

• Complex situations need new approaches.

• The care manager can be a role that identifies unsuccessful patterns and asks the treatment team for new ideas.

• Joan’s leadership of her team was apparent, and the new ideas that helped foster improvements only worked if they were a fit for her.
Why bring Behavioral Health to Primary Care?
Why not refer to specialty Mental Health or Substance Abuse settings first?

The vast majority of people will not accept a referral to specialty Mental Health or Substance Abuse when offered by a PCP. It is care in primary care or none.

Primary Care is full of behavioral health needs, many unrecognized:

- Mental Health (MH) disorders
- Substance Abuse
- Health Behavior Change Needs
- “Ambiguous” Illnesses
- “Unfamiliar” Cultural Expressions of Problems
- Discovered and undiscovered trauma Hx
- Serious mental illness, in and outside of MH Treatment
Behavioral Health Needs Assessment in Primary Care

<table>
<thead>
<tr>
<th>Disorder</th>
<th>PHQ-3000</th>
<th>Merillac 500</th>
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<tbody>
<tr>
<td>Major Depression</td>
<td>= 10%</td>
<td>24%</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>= 6%</td>
<td>16%</td>
</tr>
<tr>
<td>Other Anxiety Disorders</td>
<td>= 7%</td>
<td>21%</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>= 7%</td>
<td>17%</td>
</tr>
<tr>
<td>Any MH or SA Dx</td>
<td>= 28%</td>
<td>52%</td>
</tr>
</tbody>
</table>
Prevalence of Behavioral Health Problems in Primary Care

Unhealthy Behaviors

- Smoking = 20%
- Obesity = 30%
- Sedentary lifestyle = 50%
- Non-adherence = 20 - 50%
Culture Impacts Depression
Culturally Syntonic Approaches

Signs of Depression found Cross-Culturally:

- Appetite changes
- Sleep changes
- Psychomotor agitation or retardation
- Decreased energy
- Decreased libido
- Diminished ability to think or concentrate

Signs of Depression found in “Western” Cultures:

- Self-deprecation
- Hopelessness
- Guilt
- Suicidality

Underserved and Minority Populations are Particularly Affected

“...racial and ethnic minorities are less inclined than whites to seek treatment from mental health specialists. Instead, studies indicate that minorities turn more often to primary care.”

10 most common complaints in adult primary care
15% x organic pathology found

<table>
<thead>
<tr>
<th>chest pain</th>
<th>back pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>fatigue</td>
<td>shortness of breath</td>
</tr>
<tr>
<td>dizziness</td>
<td>insomnia</td>
</tr>
<tr>
<td>headache</td>
<td>abdominal pain</td>
</tr>
<tr>
<td>swelling</td>
<td>numbness</td>
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(Kroenke & Mangelsdorff, 1989)
Integration of Primary Care and Behavioral Health:

AGENDA

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   1. Case example
   2. Prevalence
   3. Patient preference

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5. Re-Designing Your Practice to Optimize BH integration
Categories of Relationship between Collaborating Medical and Behavioral Health Services

- **Coordinated** = Behavioral services by referral at separate location with formalized information exchange
- **Co-Located** = By referral at medical care location
- **Integrated** = Part of the “medical” treatment at medical care location

Coordinated Care

• Coordinated care elements:
  – Appointment arrival notification
  – Clinical information exchange protocols
  – Coordinated treatment planning and/or problem solving for complex patients or as needed

• Expect communication to go both ways.
  – Mental Health clinicians are healthcare professionals who should be knowledgeable about the patient’s health issues.

• Behavioral Health should ask about the person’s health behavior goals and incorporate them in treatment planning. Medical providers should do the reverse.
Coordination Plus - Specialty Mental Health as a consultant to Primary Care.

- Massachusetts Child Psychiatry Access Program, a national model of psychiatry enhancing Primary Care behavioral health service delivery.

- For adults in NC, Medicaid pays for the time of the PCP and the psychiatrist, at patient visit rates, for consultation about a member, whether the psychiatrist has met the patient or not. (Promoting consultation is good care and cost effective.)

- When behavioral health clinicians are working in primary care, the referrals to specialty care for members needing longer term care are more likely to be successful.
Co-Located Behavioral Health

- *Behavioral health in the same space with primary care*
- *Involvement by referral*
- *Separate behavioral health and medical treatment plans*

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access greatly improved</td>
<td>Referrals don’t show</td>
</tr>
<tr>
<td>Improved patient satisfaction</td>
<td>Case-loads fill up</td>
</tr>
<tr>
<td>Improved provider satisfaction</td>
<td>Slow PCP learning curve</td>
</tr>
<tr>
<td>Cost effective</td>
<td>Communication still difficult</td>
</tr>
<tr>
<td>Improved clinical outcomes</td>
<td></td>
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Integrated Primary Care: The IMPACT Treatment Model

• Stepped protocol in primary care using antidepressant medications and/or 6-8 sessions of psychotherapy (PST-PC)
  – Treat to target

• Collaborative care model includes:
  – Care manager: Depression Clinical Specialist (DCS)
    • Member education
    • Symptom and side effect tracking
    • Brief, structured psychotherapy: PST-PC
  – Weekly consultation meetings with
    • DCS, primary care physician and team psychiatrist

http://uwaims.org/about.html
Integrated Primary Care: Behavioral Health Consultant

- Management of psychosocial aspects of chronic and acute diseases
- Application of behavioral principles to address lifestyle and health risk issues
- Consultation and co-management in the treatment of mental disorders and psychosocial issues
- Proximity and protocol make access easy.
## Models of Integrated Behavioral Health Converging

<table>
<thead>
<tr>
<th>IMPACT/Diamond</th>
<th>Behavioral Health Consultant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease based</td>
<td>Program based</td>
</tr>
<tr>
<td>Research heritage</td>
<td>Clinical heritage</td>
</tr>
<tr>
<td>Patient outcome evidence</td>
<td>Cost and utilization evidence</td>
</tr>
<tr>
<td>BH member: Depression clinical specialist or depression care manager</td>
<td>BH member: Behavioral Health Consultant</td>
</tr>
<tr>
<td><strong>Now adding:</strong></td>
<td><strong>Now adding:</strong></td>
</tr>
<tr>
<td>DCS treats other BH and SA disorders</td>
<td>BHC adds role in population protocols</td>
</tr>
<tr>
<td>Health behavior added to services</td>
<td>Showing strong medical/chronic illness outcomes in addition to BH outcomes</td>
</tr>
<tr>
<td>Now showing some cost impact</td>
<td></td>
</tr>
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</table>
Effective Strategies to Address Substance Misuse in Medical Settings

- Screening
- Assessment
- Triage/Level of Care
- Brief counseling interventions
  - **SBIRT**: Screening, Brief Intervention, Referral to Treatment (On PC program average time between Screening and acceptance of Referral, i.e. Brief Intervention – 1 year)
  - **MET**: Motivational Enhancement
  - **TSF**: 12-Step Facilitation
- Recovery Monitoring
- Medication Assisted Treatment
Bi-Directional Integration

FQHC in partnership with CMHC

Only a few examples of successful programs and the majority of those are grantees in the HRSA/SAMHSA integration project.

Primary care from FQHC in CMHC and often BH from CMHC in FQHC.

Takes a lot of money and/or mutual commitment to overcome cultural and business differences.
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Why Primary Care behavioral health is difficult for clinicians trained only in specialty mental health

- Treat somewhat different population than in Specialty MH or SA services.
  - Less disturbed and less diagnostically clear
  - Won’t accept “mental health” or “substance use disorder” definition of the problems they bring
  - Broader array of needs.
    - BHC must understand medical conditions and practice behavioral medicine and substance abuse care in addition to mental health
- MH graduates tend not to know the difference between PC generalist and specialist in BH or medical care
- Different routines of time, confidentiality and instrumentality
Training is being developed to prepare clinicians for the new roles in the integrated PCMH.

Center for Integrated Primary Care – [http://umassmed.edu/CIPC](http://umassmed.edu/CIPC)

Certificate Program in Primary Care Behavioral Health
BH Clinicians who will work in primary care.

Certificate Program in Integrated Care Management
Care managers in the PCMH who will address BH and medical issues

Certificate of Intensive Training in Motivational Interviewing
Any member of the healthcare team who needs to promote healthy behavior.
The ideas about people with predominantly medical or predominantly behavioral problems don’t fit the data.

- The more chronic illnesses, more they are likely to have one or more psychiatric diagnoses.
- Low income and “neuroticism” correlate with more somatic diagnoses as well as more psychiatric diagnoses.  
- Similar findings in large PCMH pilot done by Boeing Corp.  
  [www.integratedprimarycare.com](http://www.integratedprimarycare.com)
- The sicker you are, the sicker you are.
Integration of Behavioral Health
and Healthcare

• Two elements to consider
  • Expertise (Medical and Behavioral)
    • Do we know how to solve the problem?
    • Do we know when to get more information?
    • Do we know how/where to get more information?
    • Do we have the techniques and tools to engage the member in improving health?
  • Workforce
    • Do we have enough people with the right training to engage the member and help them maintain gains?
    • Does each team member have access to more expertise when they are unable to help the patient solve their problem?
    • Do we have role clarity and task flexibility?
Sometimes a “complex situation” has a simple story:

- Charlie – 50 yo Caucasian man; disabled former LPN
  - COPD, DM, anxiety
  - On oxygen
  - Lives with his brother
- 20+ trips to the ED in 6 months
  - Rarely admitted. Medically inappropriate
- Assigned a care manager
  - Medically skilled nurse who said on day one, “I don’t do behavioral health.”
Support infrastructure for Care Manager at the time

- Weekly lunchtime meeting in person and by video conf.
  - 4 care managers
  - 4 +/- behavioral health clinicians, including trainees
  - 1-2 physicians
- Set up to help care managers and pool expertise on challenging cases
- Discussed ways of gathering more information, rather than challenging “no BH” approach.
  - She was an important resource who could develop a repertoire of behavioral health skills with support.
Step 1: Get the problem sequence.

• The information we had did not explain his use of the ED and no deeper digging about his symptoms and conditions helped.

• Coached CM in asking just what typically happens when he goes to the ED.

Remember: Keep asking “Why?”
Step 2: Try what usually works

- Intensify medication
  - Change anxiolytic to tid, **not** prn
- Patient teaching
  - If you turn up your oxygen, it actually makes it worse because the feeling of air starvation is from too much CO₂.
Step 3: Assess results of Step 2

• Felt he was already on too many meds. He didn’t want another regularly, so he took it prn only – when it was too late ...

• Member believed his experience over the explanation, so he turned up his oxygen.

• So he went back to the ED
Choice Point

• Most common next step:
  – MORE OF THE SAME

• Lunchtime group said there must be a story that makes this sensible ...
  – Has he gone to the ED 20x **every** six months? **No**
  – What happened 6 months ago?

• CM asked to go get the story.
  – Asked to just listen. No interventions.
Step 4: Put the current picture in context

• Lives with brother (also in his 50s)
  – In the past when he would get worried, his brother would tell him he was fine.
• 6 months ago his brother got a girlfriend.
  – The brother was away from home most of the time.
  – An adult day program worked well to keep Charlie relaxed and out of the ED.
  – Charlie was involved in picking a day program. If it had not been a fit for him, he would have been back in the old cycle.
What made it work?

• Adequate **workforce**
  – Care manager had the time to reach out and investigate

• Adequate **expertise**
  – Medical and Behavioral
  – Expectation of a story that must make sense

• Adequate **communication**
  – Meeting time for brainstorming/collaboration

• Finding a place where Charlie could exercise influence over his plan.
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Care Management in Integrated Primary Care

Core element of the PCMH

Maximize connection to services and adherence to treatment:

- **Address social determinants** of health and system holes.
- Default to “nurse care manager” limits possibilities for fit.
- Member “complexity” often rests on behavioral factors.
- Care management is a function, not just a job description.
- Consider Care Manager as a resource to all doing care coordination.

Communication protocols between care sites are crucial for care of complex members. Problem list and med list must be current.
**Engagement:**
The Bedrock Skill of Care Management

- Engagement with members/clients
- Engagement with family members
- Engagement with professionals and staff in your organization
- Engagement with professionals and staff in other organizations
- Helping to foster or repair engagement between members/clients and resources
Services vs. Relationships

• Services may be necessary and useful (housing, dentistry, etc) but relationships are the result of successful engagement. “Plug in services” is a terrible metaphor.

• To foster engagement with new services, the care manager needs to be able to foster new relationships by passing along the engagement of existing relationships.
Fostering Engagement With the Patient (Passing the Connection)

- Whenever possible, speak in front of the member/client.
- Be sure to ask providers if you can have the patient/client join our meeting.
- In order to do that, it helps to have a language that conveys the situation accurately and is respectful of the patient.
What does the PCP (leader) say to the member about BHC’s (new team member’s) role?

- **S** – Situation
- **S** – Skill Set
- **R** – Relationship
- **I** – Indicators
Situation

What is the situation in the care of the member that makes the PCP want to involve a Behavioral Health Clinician?
Skill Set

What is the **skill set** that the BHC brings that makes them able to be helpful in the member’s care at this time?
BHP defined as the one with the right skill for member’s needs:

Case note:

“KB (15yo) F/u for depression. Kathy would like to be in better control of her emotions. She gets angry often when people are mean to her about her weight. She can’t talk to her mother. She would agree to counseling as long as the counselor is not ‘all nice and happy.’ Refer to Dr. Blount, who is neither nice nor happy.”
Relationship

What *relationship* will the member’s work with the BHC have to the overall treatment of the member?
Indicators

What outcomes would indicate that the involvement of the BHC had been useful to the overall treatment of the member?
### Change your language to engage with and activate your member

<table>
<thead>
<tr>
<th>Negative/passive words</th>
<th>Positive/active words</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffers from</td>
<td>Struggles with</td>
</tr>
<tr>
<td>Refused to take</td>
<td>Decided against</td>
</tr>
<tr>
<td>Didn’t keep appointment</td>
<td>Was unable to be here</td>
</tr>
<tr>
<td>Was non-compliant with</td>
<td>Had not seen value of</td>
</tr>
<tr>
<td>Arrived late</td>
<td>Was determined not to miss</td>
</tr>
</tbody>
</table>

*Help me with the list ...*
Organizational Partnership and Resource Sharing Meetings

• A place for new ideas. We involve CMs from different programs, BH clinicians, and physicians.
  – Ideally, the PCP presents the case.

• Regular clinical case discussions teach everyone about the difference in service cultures & help identify unique solutions.

• In some practices with a culture of transparency (sharing notes, speaking in front of the patient, patient centered care plans) meetings about the member are coordinated with member visits so the member always attends.
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Redesigning your processes to optimize care

• Every practice is unique; consider:
  – Resources, personnel, etc. (within and outside the practice)
  – Population needs

• Break free of constraining descriptors
  – whether by professional training or job description

• Align staff along the shared goal of serving the needs of your members

• Establish clear protocols for communication
  – Who, what, how, where, when???

• Frame novel approaches as learning opportunities for staff
Alphabet Soup/Tower of Babel:
Clear communication is critical when working across disciplines

BH, BHC, BHP       Hx, Dx, Tx
CM, CCM, LICSW      DM, CVD, CABG, PPD
MH, SA, BPD          PC, PCP, NP, PA
DCS, HOW, ICT, MCPAP  ED, ER
SBIRT, MET, TSF, CBT, MI  FQHC, PCMH
DMH, DYS, DCF       PCPR, MOU
FTC, CCC          SSRI, MI

Avoid undefined abbreviations
Summary

• Conventional organization of health care often fails our most complex members
• Integration of traditionally disparate elements of health care is much more likely to be successful.
• Thus we need to get out of our silos:
  – Medical/mental/behavioral health
  – PCMH ↔ Medical Neighborhood
• New team members/approaches are essential, but it will take work to establish clear processes for them to function smoothly.
Questions?

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