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FOR COMMUNITY BEHAVIORAL HEALTHCARE
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Core Issues in Successful Integration of Behavioral Health and Primary Care: Part 1 and Part 2

Colorado Behavioral Health Association

October 3, 2010

Lexicon Part I:

A Family Tree of Related Terms in use in the field of Collaborative Care

C.J. Peek with the CCRN Research Conference Program Committee

This page intended to be printed on 8.5 x 14 paper

Mental Health Care

"Broad array of services & treatments to help people with mental illnesses & those at particular risk of developing them—to suffer less emotional pain and disability and live healthier, longer, more productive lives. A variety of caregivers in diverse, independent, loosely coordinated facilities & services—public and private—often referred to collectively as the de facto MH service system (Regier et al., 1978; Regier et al., 1993).

- *Specialty MH sector:* MH professionals trained specifically to treat people with mental disorders in public or private practices, psychiatric units, general hospitals or tx centers
- *General medical/PC sector:* Healthcare professionals such as physicians and NP's in clinics, hospitals, nursing homes.
- *Human services sector:* Social services, school-based counseling, residential rehab, vocational rehab, criminal justice/prison-based services, religious professional counselors.
- Voluntary support network sector: Self-help groups such as 12-step programs, peer counselors"

SAMHSA,mentalhealth.samhsa.gov/features/surgeongeneralreport/chapter6/sec1.asp

Behavioral Health Care

Care that addresses a client's behavioral issues bearing on health (not only mental illnesses) via clinicians such as psychiatrists, psychologists, social workers, psychiatric nurse practitioners, marriage & family counselors, professional clinical counselors, licensed drug/alcohol abuse counselors & other MH professionals. (McGraw-Hill Concise Dictionary of Modern Medicine, 2002)

Co-located Care

BH and PC providers (i.e. physicians, NP's) delivering care in same practice; describes where services are provided rather than being a specific service. However, co-location employs a referral process, which may begin as medical cases are transferred to BH (Blount, 2003).

Primary Care Behavioral Health

". . Recent term for new relationships emerging between specialty MH services and PC. *Primary behavioral healthcare* refers to at least three related activities: 1) behavioral healthcare delivered by PC clinicians, 2) specialty behavioral healthcare delivered in the PC setting, and 3) innovative programs that integrate elements of PC and specialty behavioral healthcare into new formats. . ."

(Sabin JE & Borus JF; 2009. Changing Roles in Primary Behavioral Healthcare. Chap in "Textbook of administrative psychiatry: New concepts for a changing behavioral health system"; JA Talbott & RE Hales, Eds)

Behavioral Medicine

"An interdisciplinary field of medicine concerned with the development and integration of psychosocial, behavioral and biomedical knowledge relevant to health and illness. (Wikipedia)

Care Management*

Specific type of service, often disease specific (e.g. depression, congestive heart failure) whereby a BH clinician, usually a nurse or other non-physician, provides assessment, intervention, care facilitation, and follow up (e.g., Belnap et al., 2006).

Shared Care

Predominately Canadian usage—PC & MH professionals (typically psychiatrists) working together in a shared system, maintaining 1 treatment plan addressing all patients' health needs in a shared med record (e.g. Craven & Bland, 2006)

Collaborative Care*

An overarching term describing ongoing relationships between clinicians (e.g., BH and PC) over time (Doherty, McDaniel, & Baird, 1996). Not a fixed model, but a larger construct consisting of various components which when combined create models of collaborative care. (Craven & Bland, 2006; Peek, 2007).

Integrated Primary Care

Combines medical & BH services for the spectrum of problems that patients bring to primary medical care. Because most patients in PC have a physical ailment affected by stress, problems maintaining healthy lifestyles or a psychological disorder, it is clinically effective & cost-effective to make BH providers part of PC. Patients can feel that for any problem they bring, they have come to the right place. Teamwork of MH & medical providers is an embodiment of the biopsychosocial model. (Blount; www.integratedprimarycare.com)

Patient-Centered Medical Home

"An approach to comprehensive PC for children, youth and adults—a health care setting that facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family". (Joint Princ of PCMH, 2007)

Family-Centered Medical Home

Family-centered version of "medical home"; emphasize parents and families who play a large role in child health and mental health and who are also "the client" in child / pediatric settings.

Person-Centered Health Care Home

Variation emphasizing BH in PC and PC in specialty MH settings (Maser-NCCBH)

Consultation / Liaison

Activities of psychiatry, psychology, or nursing that specialize in the interface between medicine & MH, usually in a hospital or medical setting. Role is to see patients in medical settings by request of medical clinicians as a "consult". (Adapted from Wikipedia)

Chemical Dependency / SA Care

Services, treatments, and supports to help people with addictions and substance abuse problems suffer less emotional pain, family and vocational disturbance, physical risks, and live healthier, longer, more productive lives.

Provided by 1) specialty addictions or substance abuse clinicians or counselors in SA tx clinics or settings, 2) clinicians or counselors in general medical or hospital settings, and 3) human services contexts such as schools, rehabilitation centers, criminal justice system or religious-based counseling and 4) the voluntary support networks such as 12-step programs and peer counselors.

(Adapted from SAMHSA def. for MH Care)

Coordinated Care*

BH providers and PCPs practice separately within their respective systems. Info regarding mutual patients exchanged as needed, and collaboration is limited outside of the initial referral (Blount, 2003).

Integrated Care*

Tightly integrated, on-site teamwork with unified care plan. Often connotes organizational integration as well, perhaps involving social & other services (Blount, 2003; Blount et al., 2007).

"Altitudes" of integration (SAMHSA):

- *Integrated treatment:* Interactions between clinicians to address pt. needs combining interventions for MH disorders in a primary treatment relationship or service setting.
- *Integrated program:* An organizational structure that ensures staff & linkages with other programs to address all patient needs.
- *Integrated system:* Organizational structure that supports array of programs for individuals with different needs through funding, credentialing, licensing, data collection/reporting, needs assessment, planning, and other operational functions.

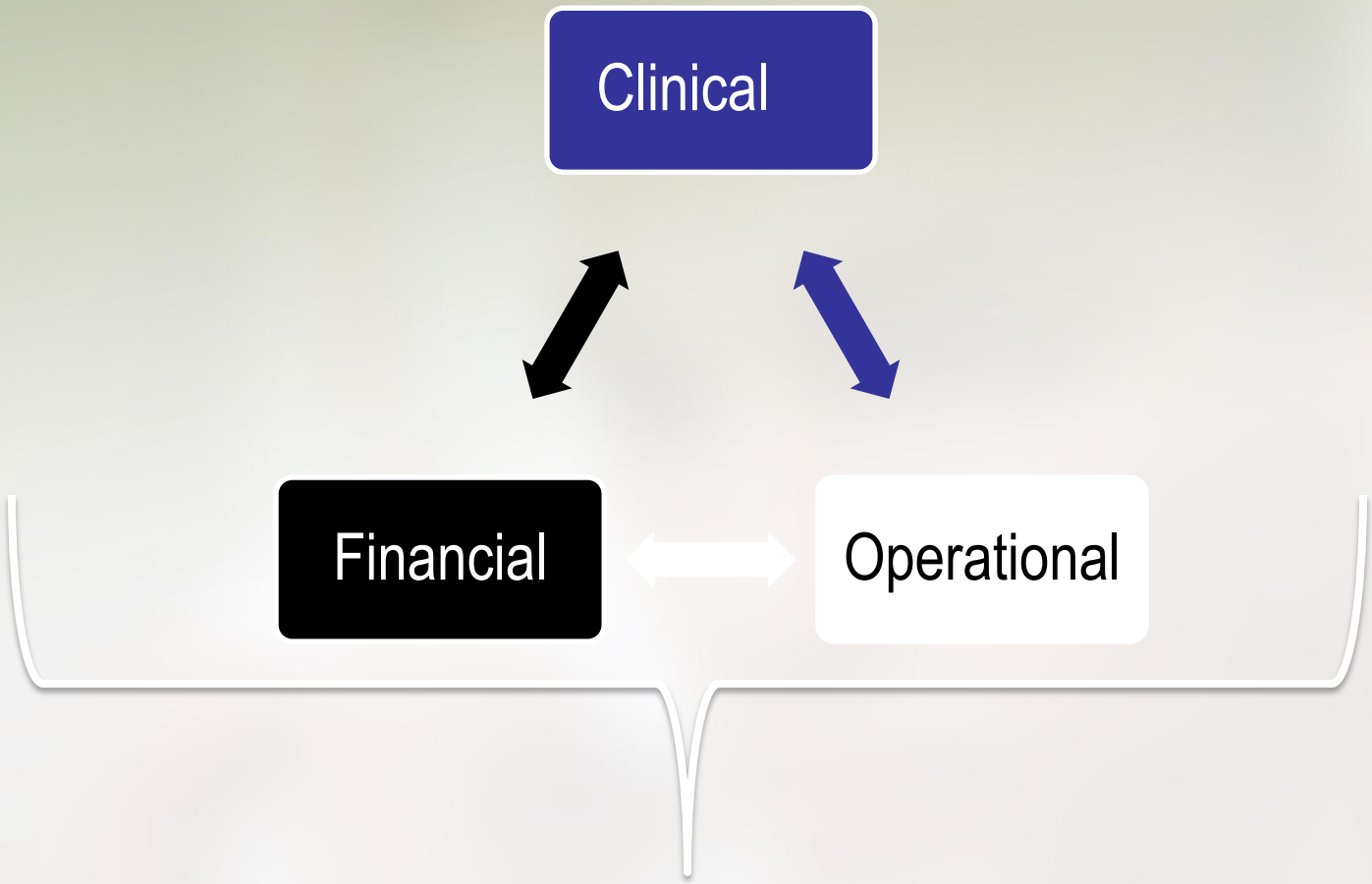
Patient-Centered Care

"Care that is respectful of and responsive to individual patient preferences, needs, and guides all clinical decisions" (Institute of Medicine, 2001)

* A special case or subset of a much larger concept in use across the larger field of healthcare.

Three World Model

- C. J. Peek suggests that in order to impact healthcare, three worlds must be addressed simultaneously
  - Clinical – What do we do?
  - Operational – How do we do it and support it?
  - Financial – What is the return on investment and cost?


Clinical
Financial
Operational

The Operational World

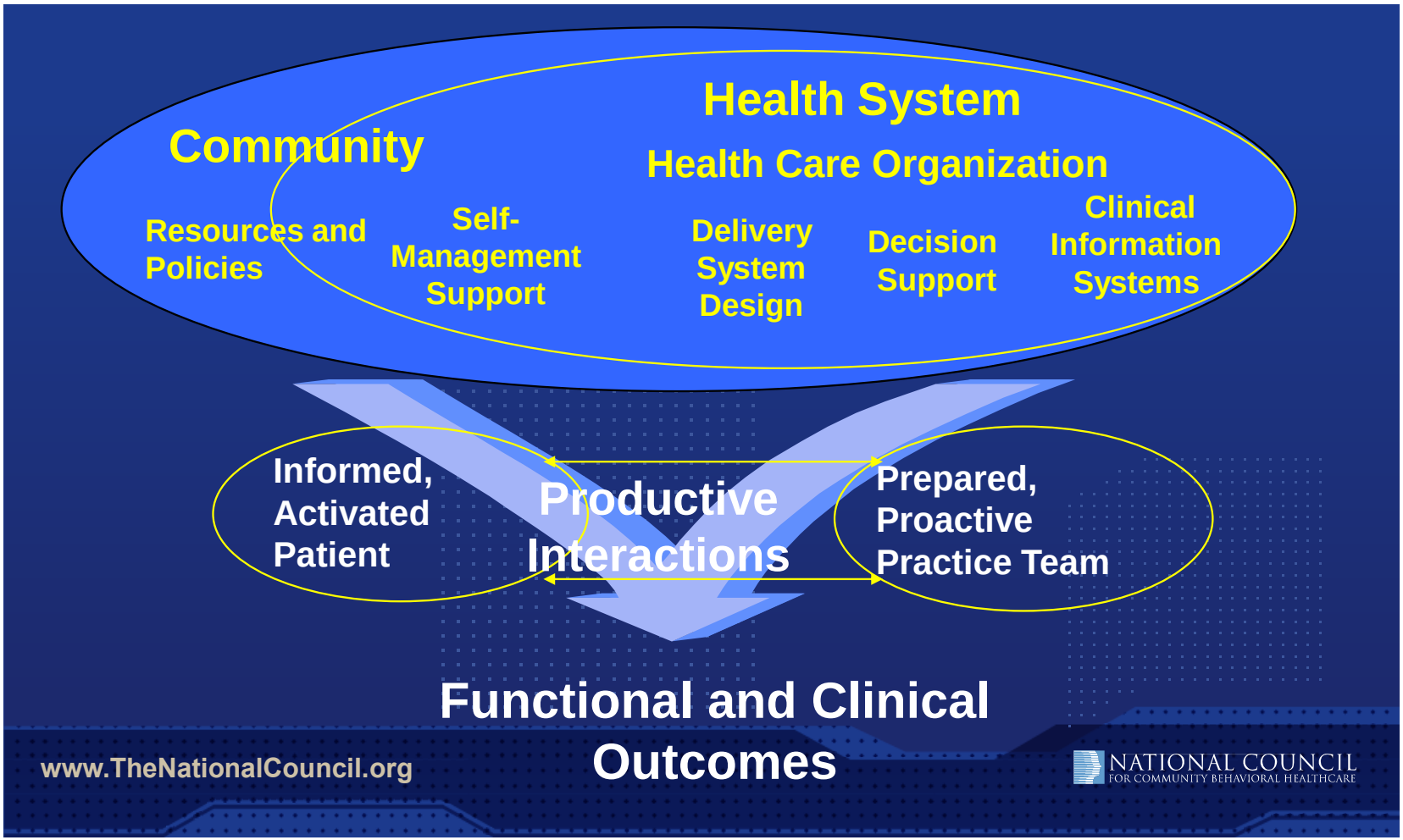
Operational World

- How is care organized? What is the model?
  - Patient Centered Health Care Home
  - Wagner Chronic Care Model
  - Four Quadrant Model
  - Levels of Collaboration

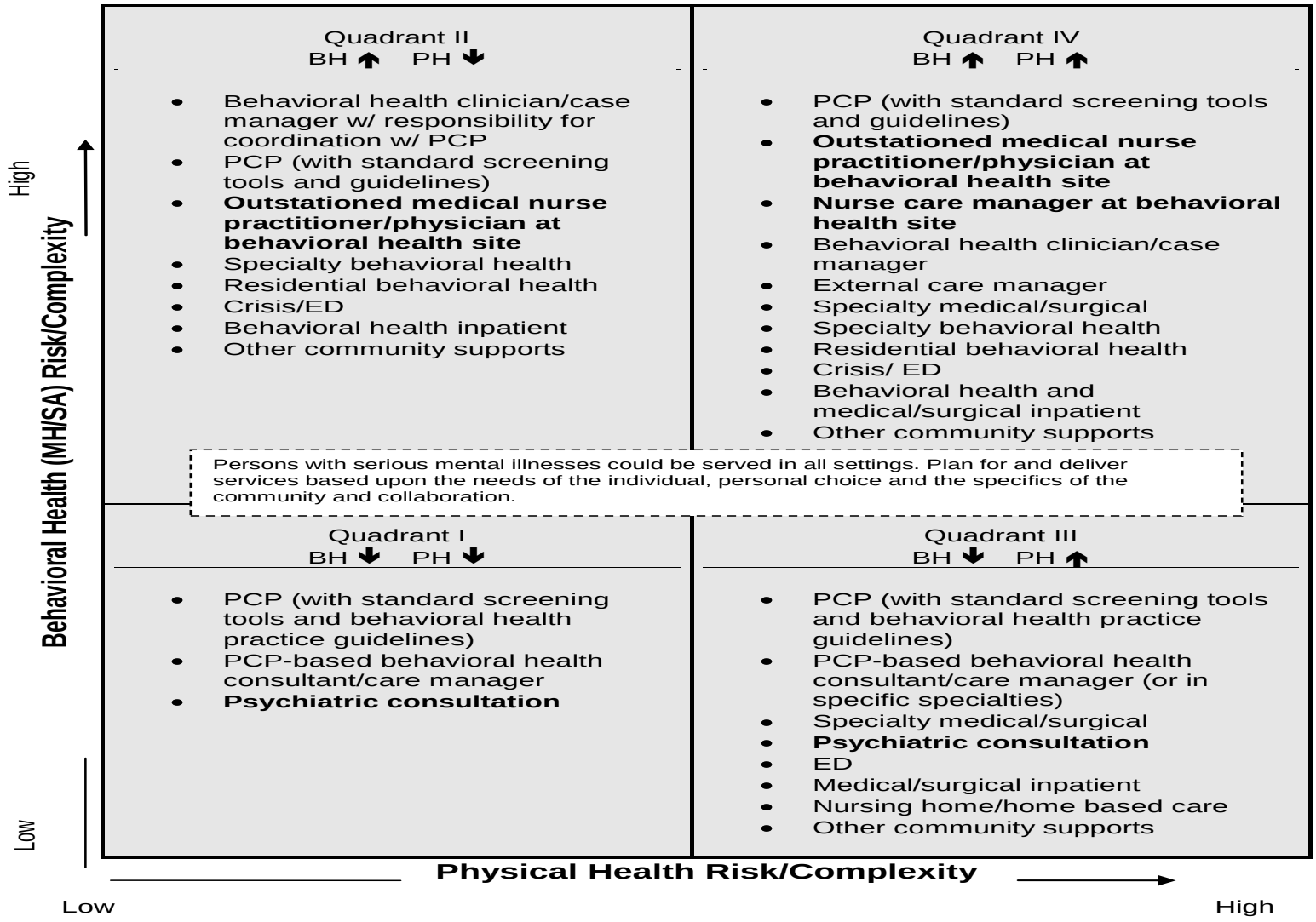
The Patient Centered Medical/Healthcare Home

- American Academy of Family Physicians Definition: "A place that integrates patients as active participants in their own health and well-being. Patients are cared for by a physician who leads the medical team that coordinates all aspects of preventive, acute and chronic needs of patients using the best available evidence and appropriate technology. These relationships offer patients comfort, convenience, and optimal health throughout their lifetimes".
  (http://www.aafp.org/online/en/home/policy/policies/p/patientcenteredmedhome.html
- National Council Definition Adds: use of the word "healthcare" home to insure that behavioral health is included

Wagner Chronic Care Model



The Four Quadrant Clinical Integration Model



Quadrant 1

- **Quadrant I: Low BH/Low PH**
  - PCP (with standard screening tools and BH practice guidelines)
  - PCP- Based BH
- **Interventions**
  - Screening for BH Issues (Annually)
  - Age Specific Prevention Activities
  - Psychiatric Consultation
  - SBIRT Services

Quadrant III

- **Quadrant III – Low BH/High PH**
  - PCP with screening tools
  - Care/Disease Management
  - Specialty Med/Surg
  - PCP based- BH
  - ER

- **Interventions**
  - BH Ancillary to Medical Diagnosis
  - Group Disease Management
  - Psychiatric Consultation In PC
  - MSW in Primary Care
  - BH Registries in PC (Depression, Bipolar)

Quadrant II

- **Quadrant II – High BH/Low PH**
  - BH Case Manager w/responsibility for coordination w/PCP
  - PCP with tools
  - Specialty BH
  - Residential BH
  - Crisis/ER
  - Behavioral Health IP
  - Other Community Supports

- **BH Interventions in Primary Care**
  - IMPACT Model for Depression
  - MacArthur Foundation Model
  - Behavioral Health Consultation Model
  - Case Manager in PC
  - Psychiatric Consultation
- **PC Interventions CMH**
  - NASMHPD Measures
  - Wellness Programs
  - Nurse Practitioner, Physician's Assistant, Physician in BH

Quadrant IV

- **Quadrant IV- High BH/High PH**
  - PCP with screening tools
  - BH Case Manager with Coordination with Care Management and Disease Management
  - Specialty BH/PH

- **Interventions in Primary Care**
  - Psychiatric Consultation
  - MSW in Primary Care
  - Case Management
  - Care Coordination
- **Interventions in BH**
  - Registries for Major PC Issues (Diabetes, COPD, Cardiac Care)
  - NASMPD Disease Measures
  - NP, PA or Physician in BH

Function	Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration On-Site	Close Collaboration/ Partly Integrated	Fully Integrated/Merged
THE CONSUMER and STAFF PERSPECTIVE/EXPERIENCE					
Access	Two front doors; consumers go to separate sites and organizations for services	Two front doors; cross system conversations on individual cases with signed releases of information	Separate reception, but accessible at same site; easier collaboration at time of service	Same reception; some joint service provided with two providers with some overlap	One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model
Services	Separate and distinct services and treatment plans; two physicians prescribing	Separate and distinct services with occasional sharing of treatment plans for Q4 consumers	Two physicians prescribing with consultation; two treatment plans but routine sharing on individual plans, probably in all quadrants;	Q1 and Q3 one physician prescribing, with consultation; Q2 & 4 two physicians prescribing some treatment plan integration, but not consistently with all consumers	One treatment plan with all consumers, one site for all services; ongoing consultation and involvement in services; one physician prescribing for Q1, 2, 3, and some 4; two physicians for some Q4: one set of lab work
Funding	Separate systems and funding sources, no sharing of resources	Separate funding systems; both may contribute to one project	Separate funding, but sharing of some on-site expenses	Separate funding with shared on-site expenses, shared staffing costs and infrastructure	Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility
Governance	Separate systems with little of no collaboration; consumer is left to navigate the chasm	Two governing Boards; line staff work together on individual cases	Two governing Boards with Executive Director collaboration on services for groups of consumers, probably Q4	Two governing Boards that meet together periodically to discuss mutual issues	One Board with equal representation from each partner
EBP	Individual EBP's implemented in each system;	Two providers, some sharing of information but responsibility for care cited in one clinic or the other	Some sharing of EBP's around high utilizers (Q4) ; some sharing of knowledge across disciplines	Sharing of EBP's across systems; joint monitoring of health conditions for more quadrants	EBP's like PHQ9; IDDT, diabetes management; cardiac care provider across populations in all quadrants
Data	Separate systems, often paper based, little if any sharing of data	Separate data sets, some discussion with each other of what data shares	Separate data sets; some collaboration on individual cases	Separate data sets, some collaboration around some individual cases; maybe some aggregate data sharing on population groups	Fully integrated, (electronic) health record with information available to all practitioners on need to know basis; data collection from one source

Collaboration

(Doherty, 1995; Doherty, McDaniel, & Baird, 1996)

"seamless web of biopsychosocial services" providers and pt view team approach to care — 5

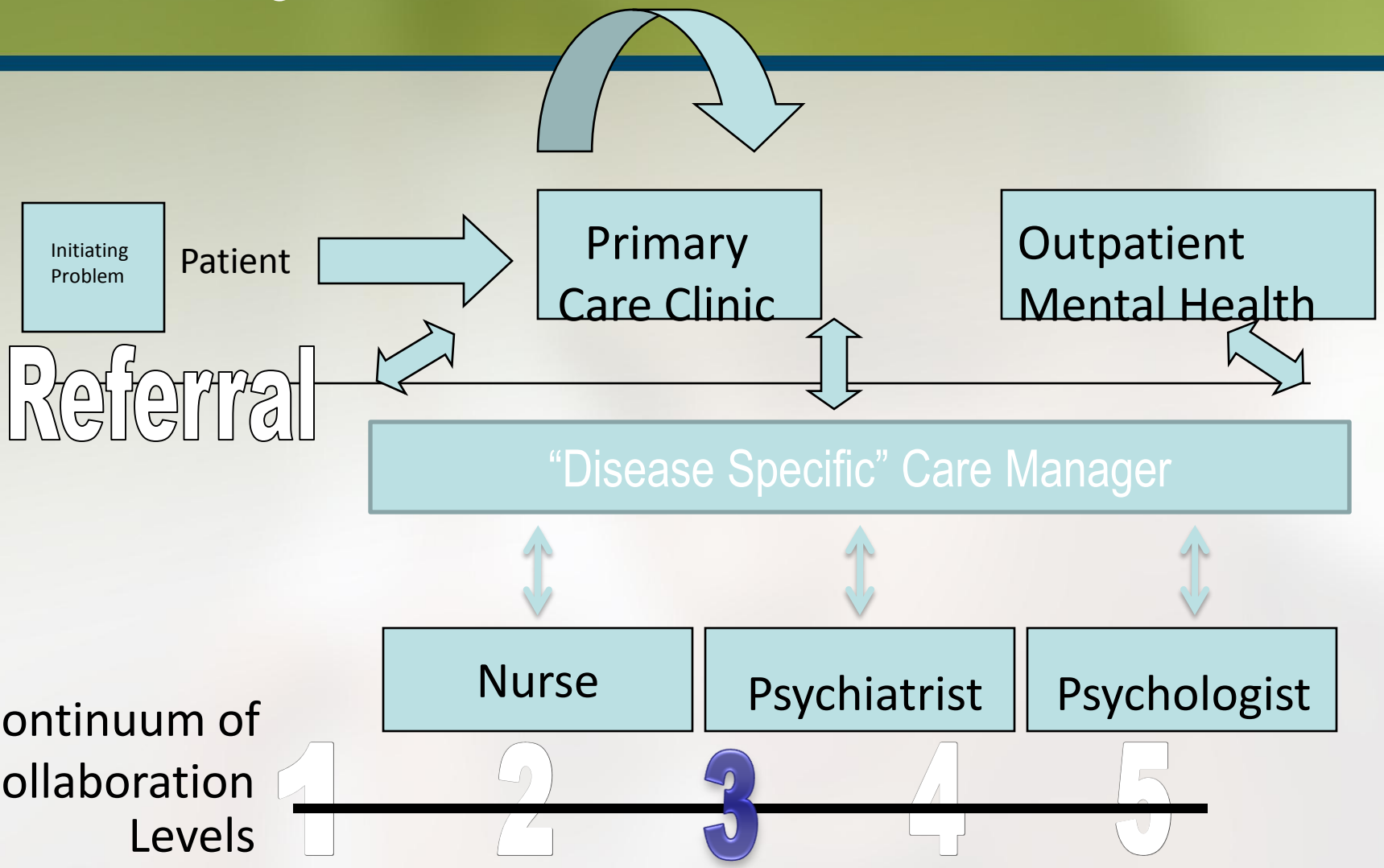
shared site; some systems in common (e.g. charting, scheduling) — 4

regular communication about shared patients (occasionally face to face – mostly letters, phone) — 3

separate systems/sites (telephone, letters) – communication driven by patient issues — 2

minimal collaboration – BH and MD work in separate facilities, systems, rarely communicate — 1

Care Management Model



Integrated Care Model

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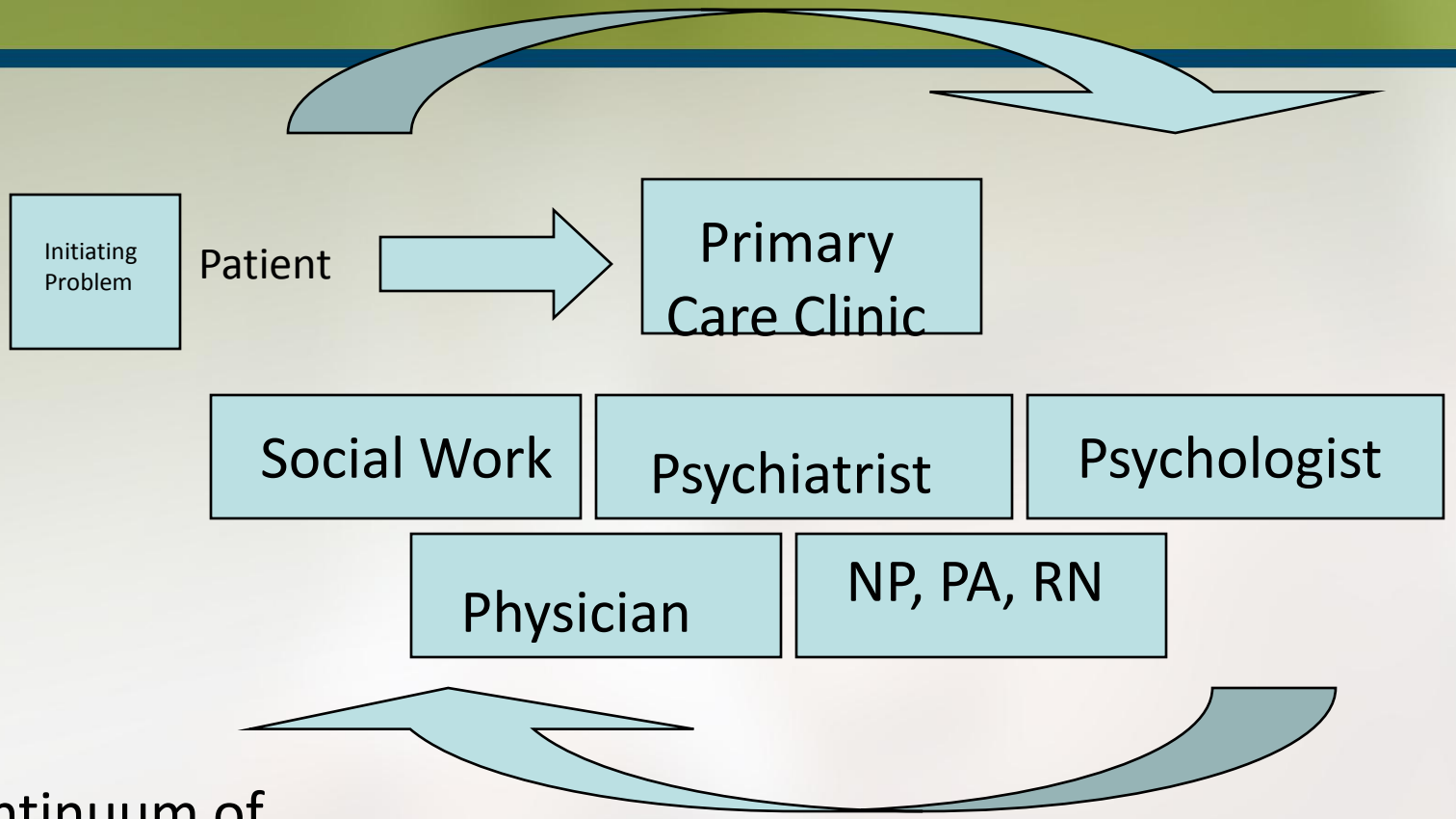


Continuum of Collaboration Levels:

The Clinical World

Keys to Successful Integration

- Use of consulting psychiatrist
- Care Management/Case Management Role
- Prescribing by the primary care provider

Reference: Gilbody, et. al., Archives of General Medicine: 2006.

Team Based Models of Care: Medical Care Management

- PCARE (Primary Care Access, Referral, and Evaluation) study
- 2 nurse care managers (one psychiatric, one public health) help patients get access to and follow-up with regular medical care but do not provide any direct medical services
- Examples of services include patient education; scheduling appointments, advocacy (e.g., accompanying patients to appointments, communicating with PCPs)

PCARE Preliminary Results: Access

- PCARE patients significantly more likely to have a usual source of care and one or more PCP visit
- PCARE patients significantly less likely to report that the ER is their usual source of care and at 12-month f/u had fewer medical ER visits

PCARE Preliminary Results: Quality

- Patients in PCARE more likely to have obtained evidence based preventive services in:
  - 5/5 laboratory screening measures
  - 5/6 physical exam measures
  - 7/7 education measures
  - 6/6 vaccination measures

Consumer Based Approaches: HARP (Health and Recovery Peer) Project[2]

- Adapting Stanford's Chronic Disease Self-Management Program (CDSMP), for MH Consumers
- Peer-led, manualized program designed to improve individuals' self-management of chronic illnesses
- improve self-efficacy and reduce unnecessary health service use[2]

Improving Self-Efficacy through Action Plans

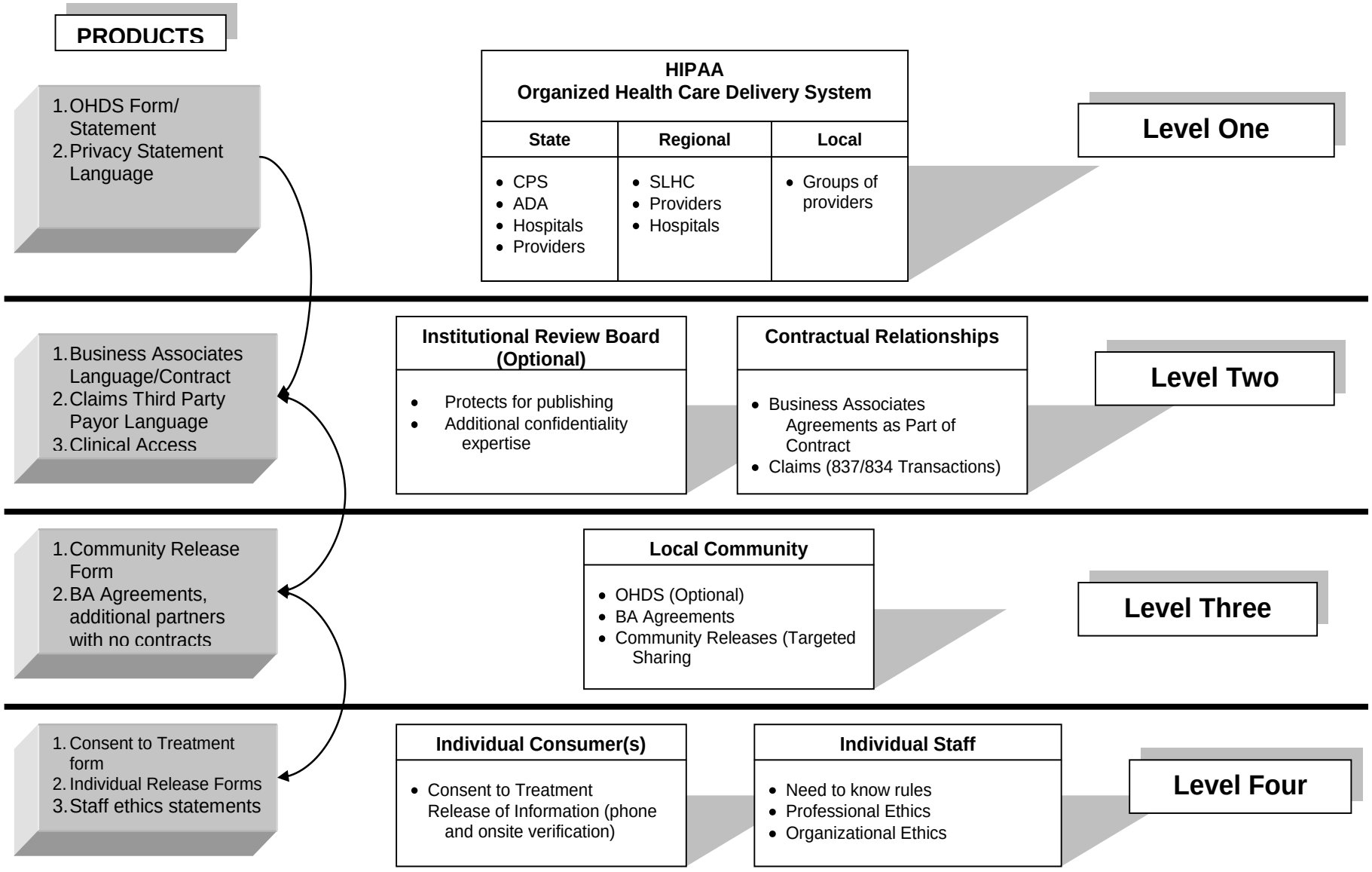
- Set short and long-term goals
- Identify the specific steps and actions to be taken in order to pursue those goals
- Rank confidence, on a scale of 1-10, in achieving these objectives; if the confidence is less than 7 reexamine the barriers.

Evidence Based Practice for Quadrant I & III

- IMPACT Model for the Treatment of Depression in Primary Care
- Disease Management Programs for Diabetes (American Association of Diabetes), COPD, Cardiac Care
- Short Term Solution Focused Therapy
- Robinson/Stroshal Behavioral Health Consultation Model

Local Considerations for Model Selection

- Community Resources: What are the medical referral options in the community?
- Onsite Medical Capacity: Are there qualified staff onsite who can deliver primary care services?
- Reimbursement Factors: Who will pay for the services?
- Consumer Preferences: Are people more likely to accept care in primary care or specialty settings?


PRODUCTS
1. OHDS Form/ Statement
2. Privacy Statement Language
HIPAA
Organized Health Care Delivery System
State
Regional
Local
• CPS
• ADA
• Hospitals
• Providers
• SLHC
• Providers
• Hospitals
• Groups of providers
Level One
1. Business Associates Language/Contract
2. Claims Third Party Payor Language
3. Clinical Access
Institutional Review Board (Optional)
• Protects for publishing
• Additional confidentiality expertise
Contractual Relationships
• Business Associates Agreements as Part of Contract
• Claims (837/834 Transactions)
Level Two
1. Community Release Form
2. BA Agreements, additional partners with no contracts
Local Community
• OHDS (Optional)
• BA Agreements
• Community Releases (Targeted Sharing
Level Three
1. Consent to Treatment form
2. Individual Release Forms
3. Staff ethics statements
Individual Consumer(s)
• Consent to Treatment Release of Information (phone and onsite verification)
Individual Staff
• Need to know rules
• Professional Ethics
• Organizational Ethics
Level Four

HIPAA

Organized Health Care Delivery System

- A clinically integrated care setting in which individuals typically receive health care from more than one health care provider;
- An organized system of health care in which more than one covered entity participates, and in which the participating covered entities:
  - Hold themselves out to the public as participating in a joint arrangement; and
  - Participate in joint activities that include at least one of the following:
    - Utilization review, in which health care decisions by participating covered entities are reviewed by other participating covered entities or by a third party on their behalf;
    - Quality assessment and improvement activities, in which treatment provided by participating covered entities is assessed by other participating covered entities or by a third party on their behalf; or
    - Payment activities, if the financial risk for delivering health care is shared, in part or in whole, by participating covered entities through the joint arrangement and if protected health information created or received by a covered entity is reviewed by other participating covered entities or by a third party on their behalf for the purpose of administering the sharing of financial risk.
    - A group health plan and a health insurance issuer or HMO with respect to such group health plan, but only with respect to protected health information created or received by such health insurance issuer or HMO that relates to individuals who are or who have been participants or beneficiaries in such group health plan;
    - A group health plan and one or more other group health plans each of which are maintained by the same plan sponsor; or
    - The group health plans described in paragraph (4) of this definition and health insurance issuers or HMOs with respect to such group health plans, but only with respect to protected health information created or received by such health insurance issuers or HMOs that relates to individuals who are or have been participants or beneficiaries in any of such group health plans.

Cultural Differences

Traditional Thinking

- The primary care provider is THE leader of the team
- Pace of work
- Documentation
- Long term approach to services

New Approach

- The patient is the leader of the team; non-medical staff can consult
- Behavioral health adjusts to the PC pace
- BH documentation in the PC record
- Short term solution focused therapy

Role of the Physicians

Primary Care Physician

- Shared responsibility for consumer care
- Prescribing for BH as comfort develops
- One treatment plan
- One record for documenting

Psychiatrist

- Consulting role
  - Curbside consults
  - Case conferences
  - Available all hours clinic is open
  - Some (fewer) evaluations
- Training
  - Support Primary Care Physician in prescribing behavioral health meds
  - Combined Grand Rounds/Training

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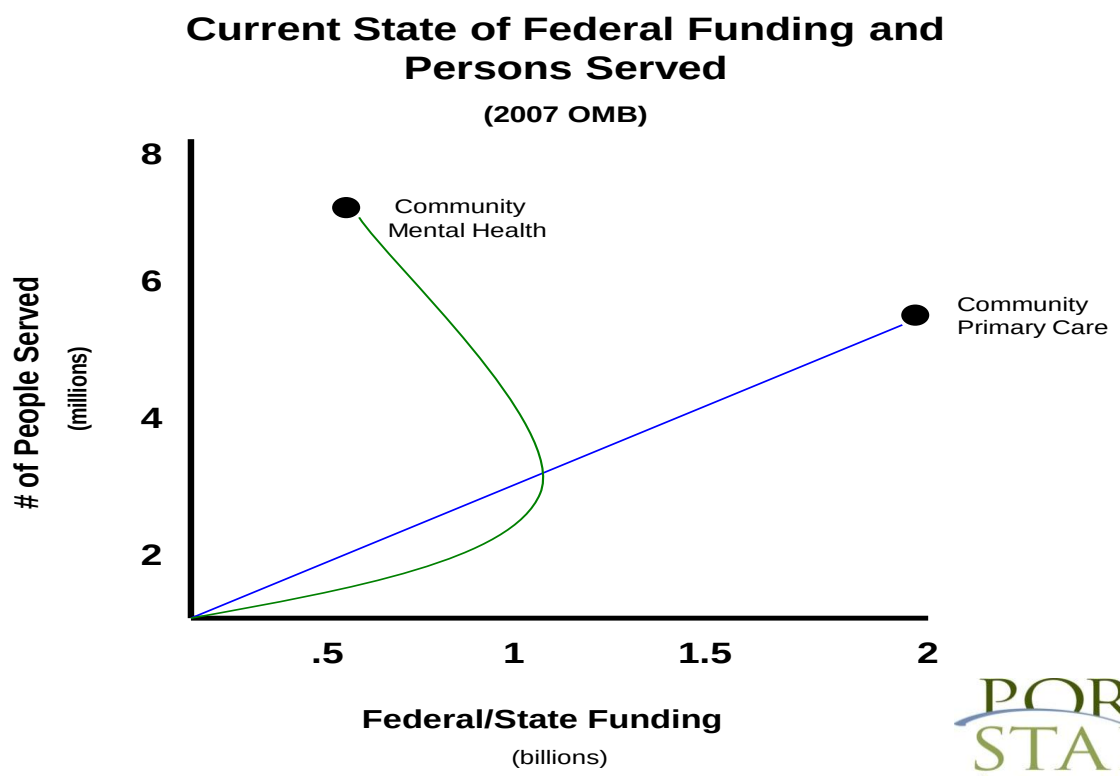
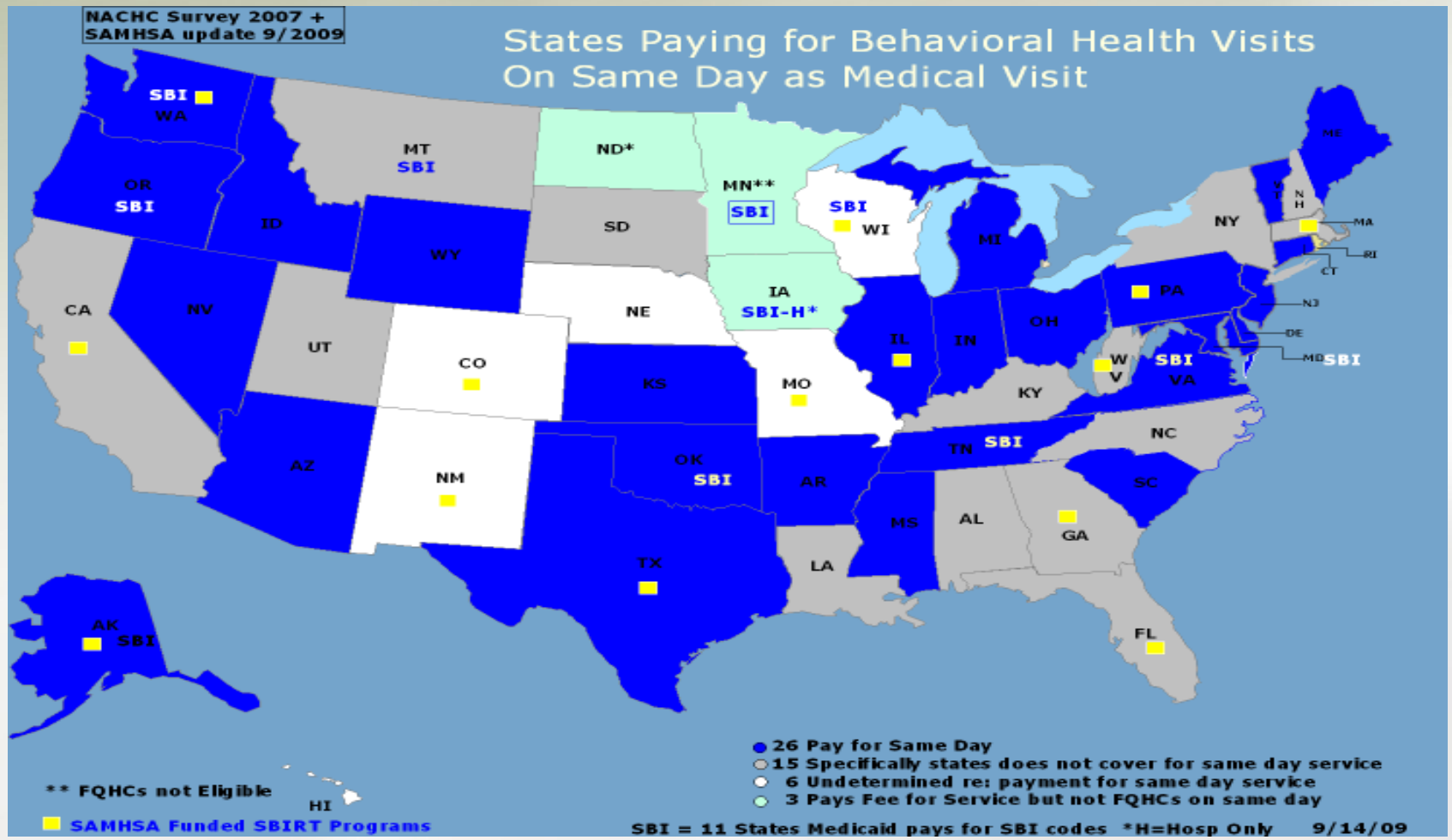
Financing Integrated Health Care

The State of Federal Financing



PORTER STARKE SERVICES
Health • Balance • Hope

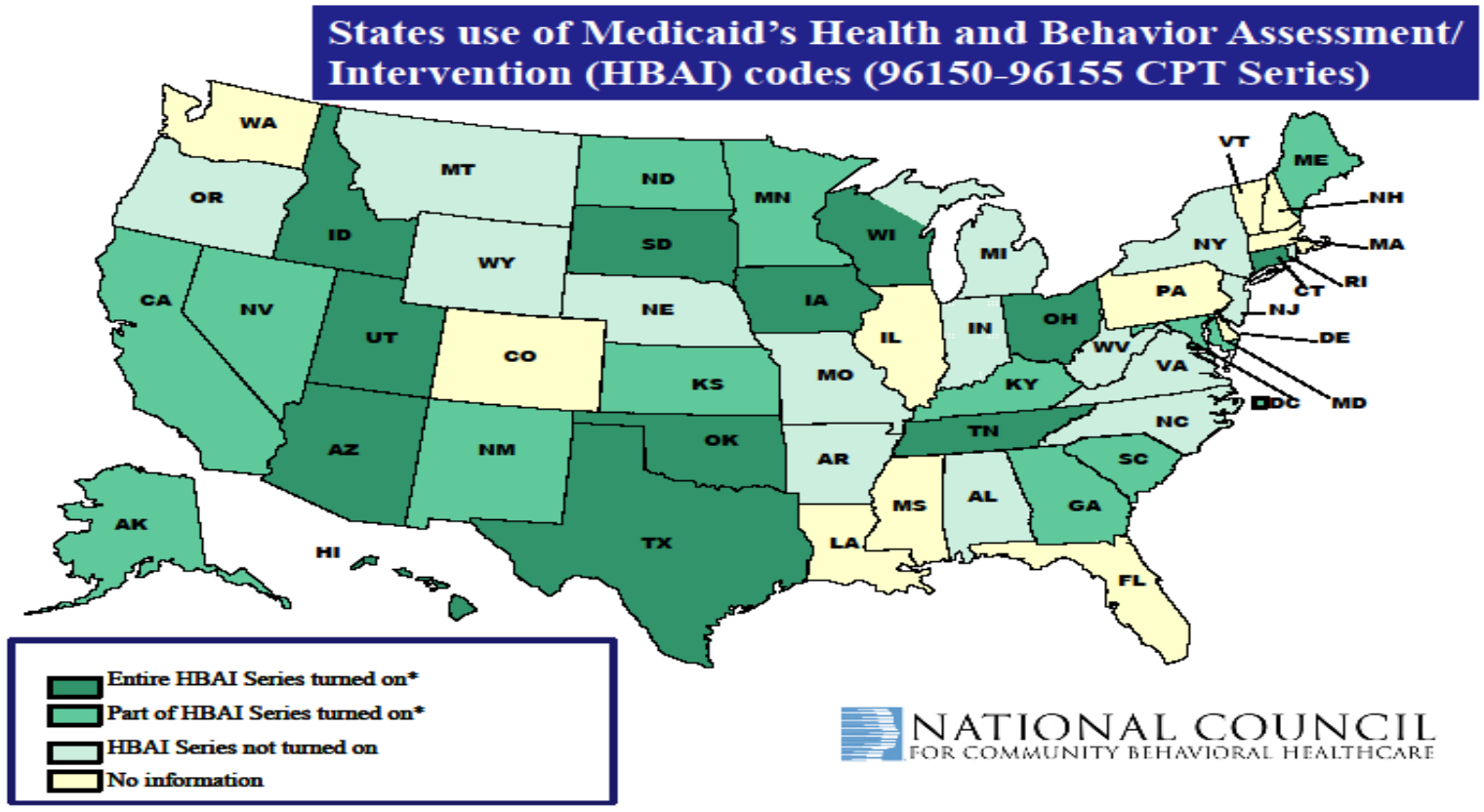
Two Services in One Day and SBIRT



SBIRT

Commercial Insurance	**CPT 99408**	**Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes**	**$33.41**
	CPT 99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	$65.51
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	$29.42
	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	$57.69
Medicaid	H0049	Alcohol and/or drug screening	$24.00
	H0050	Alcohol and/or drug service, brief intervention, per 15 minutes	$48.00

Health and Behavior Assessment Codes



HBAI Codes

- Approved CPT Codes for use with Medicare right now
- Some states are using them now for Medicaid
- State Medicaid programs need to “turn on the codes” for use
- Behavioral Health Services “Ancillary to” a physical health diagnosis
  - Diabetes
  - COPD
  - Chronic Pain

Code Descriptions

Health and Behavior Assessment/Intervention (96150-96155)

Health and Behavior Assessment procedures are used to identify the psychological, behavioral, emotional, cognitive and social factors important to the prevention, treatment or management of physical health problems.

96150 – Initial Health and Behavior Assessment – each 15 minutes face-to-face with patient

96151 – Re-assessment – 15 minutes

96152 – Health and Behavior Intervention – each 15 minutes face-to-face with patient

96153 – Group (2 or more patients)

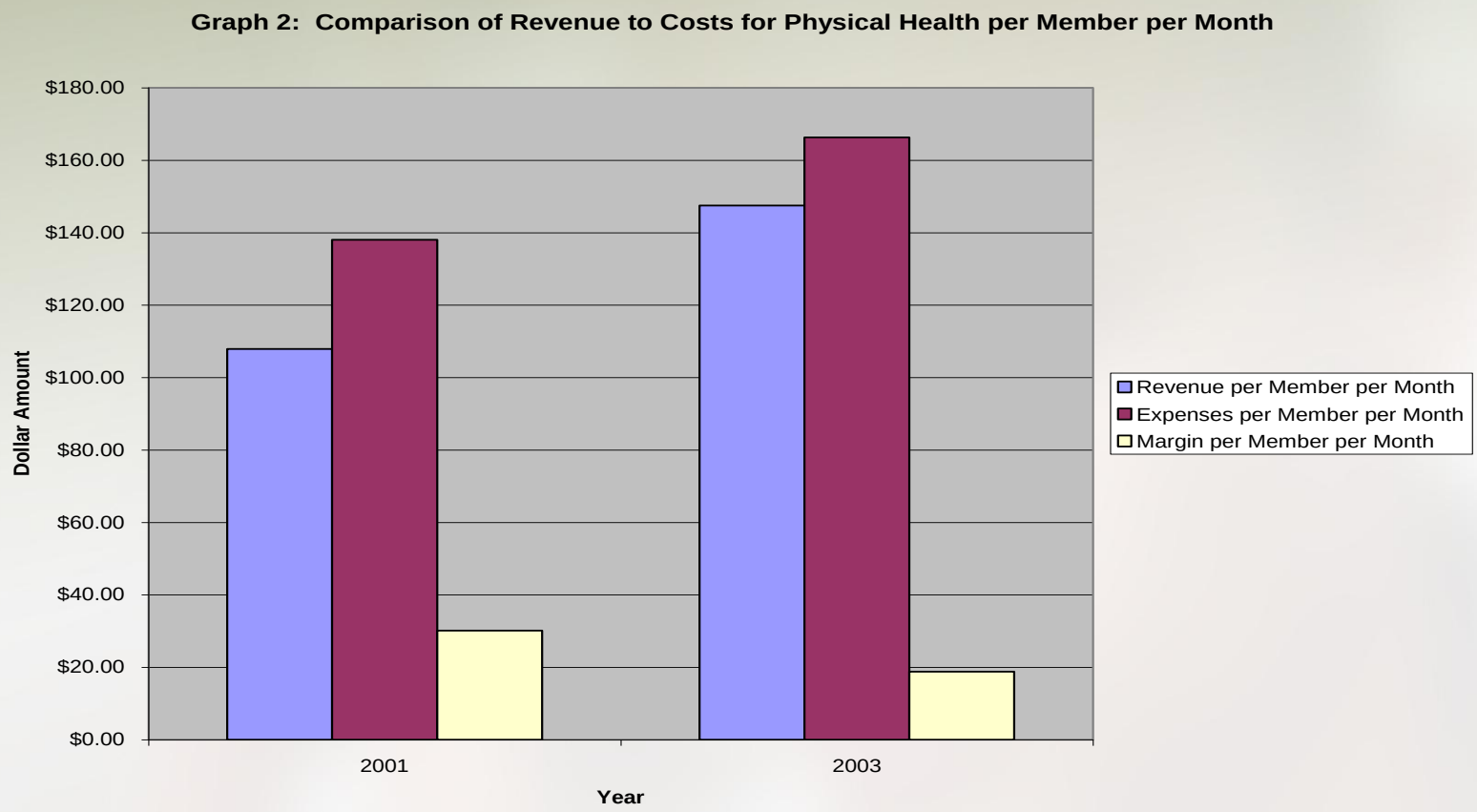
96154 – Family (with patient present)

96155 – Family (without patient present)

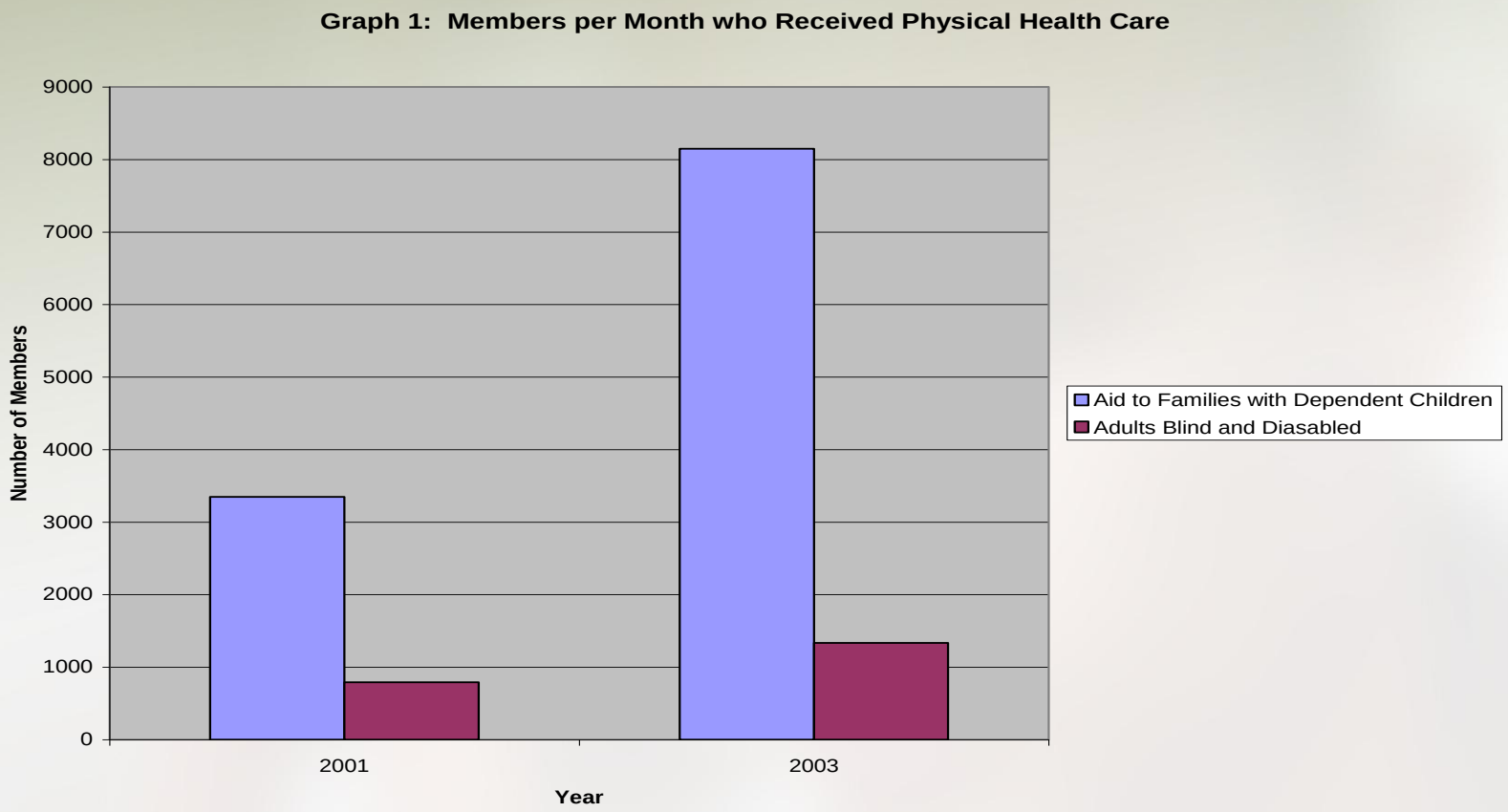
Additional FQHC Billing Options

- Encounters – regardless of length of time
- Enhanced Medicaid rate – wrap around rate
- Billing for BH staff is at encounter rate
- Federal Tort Liability insurance
- Expansion Grants for BH services
- Change of Scope for bringing primary care into behavioral health

Return on Investment – Medical Management

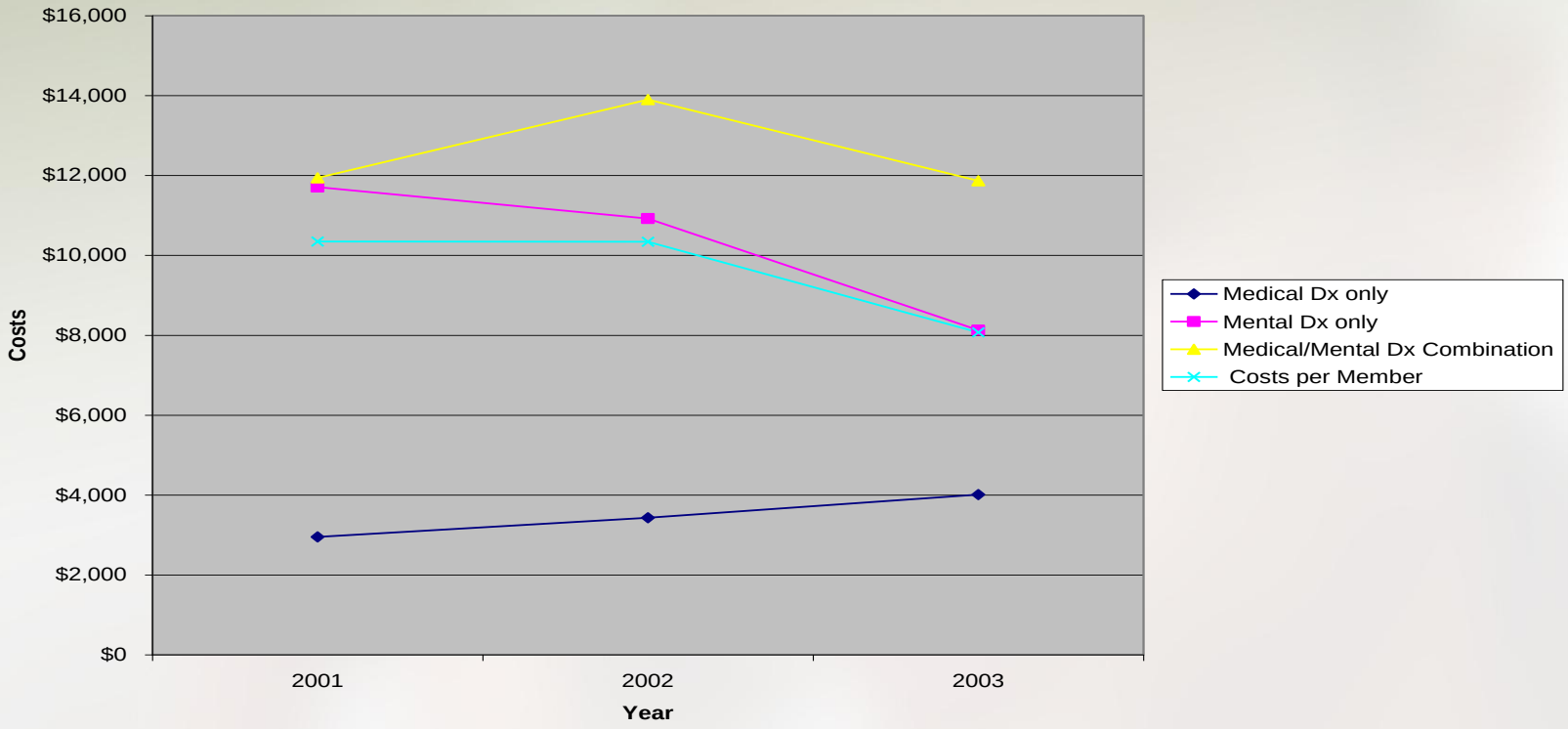


ROI – Increased Access – Decreased Cost



ROI – Cost Per Case

Graph 4: Costs of Services to the Medicaid Population based on Medical or Mental Health Diagnosis



Cost Rank	Treatment	Total Charges	No of members	Average Charges per Member
1	Community Support Services/15 min	$2,890,038	218	$13,257
2	Community Support Services /day	$1,916,375	181	$10,588
3	Personal care per diem	$1,394,614	123	$11,338
4	Habilitation, prevocational/15 min	$758,157	104	$7,290
5	Supported employment/15 min	$713,680	154	$4,634
6	Inpatient room and board	$699,602	90	$7,773
7	Targeted case management/15 min	$557,154	689	$1,009
8	Inpatient- ancillaries	$494,577	81	$6,878
9	Case management/ 15 min	$438,577	470	$1,052
10	Emergency room	$356,478	247	$1,776
11	Psych medication management	$356,478	1,086	$328
12	Inpatient-facility charges	$288,479	52	$5,548
13	Labs	$287,935	437	$659
14	ACT program	$286,773	115	$2,494
15	Medical supplies	$241,812	156	$1,550
16	Family therapy	$221,136	181	$1.222
24	Office visits – primary care	$154,773	616	$215
29	Surgery	$105,085	98	$1,072
36	Ambulance	$54,581	67	$815

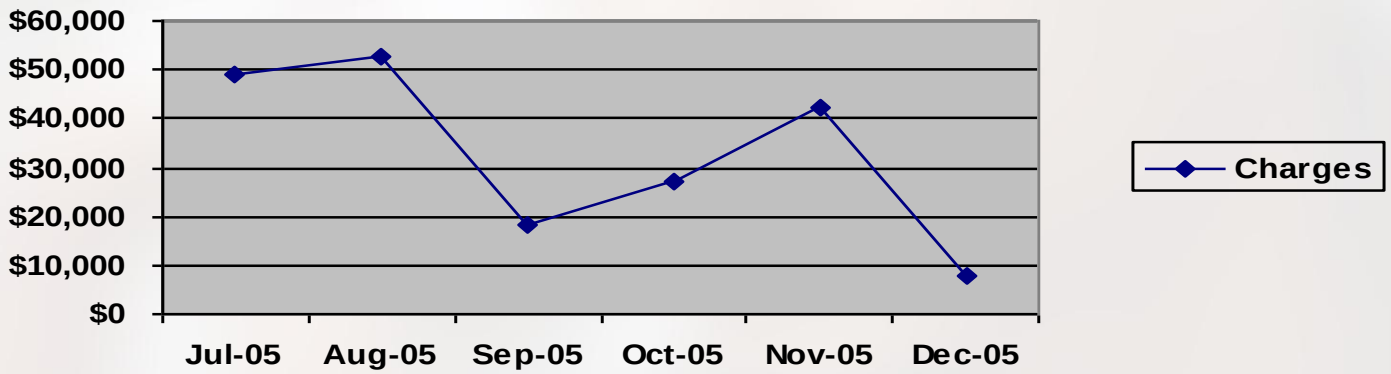
Impacting on Utilization

- **3 consumers with an average cost of $272,652 each**
- Drill down: Consumer with brittle diabetes and personality disorder - frequent ER and inpatient
- **4 consumers with average cost of $236,434 each**
- Drill down: Consumer with SUD without motivation & personality disorder; multiple complex medical conditions
- **4 Consumers with average cost of $85,867 each**
- Drill down: Consumer with SUD- frequent detox ;lack of community services

Looking at a Single Case

Gender	MI DD YF	ER Visits	Total Charges for 6 consecutive months
F	MI	9	$197,619

Timeframe	Jul05	Aug05	Sep05	Oct05	Nov05	Dec05
Charges	$49,010	$52,632	$18,050	$27,376	$42,493	$8,058



Additional Information

- **Visit www.TheNationalCouncil.org/ResourceCenter for**

  - Practical resources including administrative, policy, and
  - clinical documents
  - News on the latest integration and collaboration research
  - Strategies for community engagement and policymaking
  - Information on available trainings and partner resources
  - Opportunities for online dialogue with primary care and behavioral health providers who are also exploring integration and collaboration efforts.

Contact Information

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