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A Two-Way Street Behavioral Health and Primary Care Collaboration

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together
WE WILL!

Learning Collaboratives Enhance Population Health

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As more communities realize the value of primary and behavioral health collaboration, they now have more working examples to learn from. The National Council's Primary Care-Behavioral Health Collaborative project has provided a wealth of valuable outcomes that will help further this growing movement.

A 2007 National Council survey of community behavioral organizations revealed that although 91% of respondents place high or medium priority on increasing the quality of general medical health-care for their clients, only one in two providers has the capacity to provide any treatment for those conditions, and one in three has the capacity to provide the services onsite. The most common barriers to providing general medical services were problems in reimbursement (72.1%), workforce limitations (68.4%), physical plant constraints (60.8%), and lack of community referral options (55.8%).

The National Council's Primary Care-Behavioral Health Collaborative Project – funded in part through the generosity of AstraZeneca and Bristol-Myers Squibb – is intended to help member organizations and their partnering primary care sites overcome some of these barriers and collaborate effectively to provide integrated healthcare. The learning collaborative model that the National

Council has adopted for this project is based on 20 years of pioneering work by the Institute for Healthcare Improvement and the application of that work in the Health Disparities Collaboratives sponsored by the Health Resources and Services.

LEARNING COLLABORATIVE GOALS

- >> Increase ability of primary care clinics to screen for bipolar, addictions, and suicide risk as a part of depression screening.
- >> Increase capacity of primary care clinics to provide proactive follow-up and management of patients identified with depression.
- >> Increase community mental health organizations' provision of psychiatry training and clinical support for primary care, to enable a more comprehensive stepped care model.
- >> Establish processes for ongoing communication regarding collaborative care between primary care and community mental health organizations, including:
 - > Protocols for referral of individuals with bipolar disorder and suicide risk from primary care clinics to community mental health organizations, to assure seamless transition from primary care to specialty mental healthcare.

- > Return of stable patients to primary care follow up as appropriate.
- >> Establish shared methods for medical management of patients treated in community mental health settings who are at risk for metabolic syndrome.
- >> Increase capacity of both primary care and community mental health organizations to document and track care processes and performance.

The Primary Care-Behavioral Health Collaborative project started with four Phase 1 sites in January 2007. Each site is a partnership between a mental health agency and a community health center. The first sites were located in Massachusetts, Iowa, Montana, and Washington.

Phase 2, the focus in this article, expanded into an additional eight sites in fall 2007:

- >> Colorado: Colorado West Regional Mental Health and Summit Community Care Clinic
- >> Colorado: North Range Behavioral Health and Sunrise Community Health
- >> Florida: Life Stream Behavioral Center and Thomas E. Langley Medical Center
- >> Illinois: Heritage Behavioral Health Center and Community Health Improvement Center
- >> Indiana: Porter-Starke Services and HealthLinc
- >> South Dakota: This site dropped out a few months into the project due to a loss of provider capacity in the primary care clinic
- >> Texas: Austin Travis Mental Health/Mental Retardation and Community Care Services Department
- >> Washington: Navos and Neighborcare High Point

GETTING STARTED

When the Phase 2 sites were convened for their initial learning session in September 2007, they were provided training in rapid cycle improvement, evidence-based practices related to delivering behavioral health services in primary care, and

The National Council Learning Collaborative emphasizes rapid cycle improvements, evidence-based practices, and data collection to improve outcomes for populations served through partnerships between community behavioral health and primary care providers.



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approaches to primary care services for the population of people with serious mental illnesses in behavioral health. The goals for the sites are summarized by the graphic at right – to improve the health of their shared population through changes in services and collaboration between the two organizations.

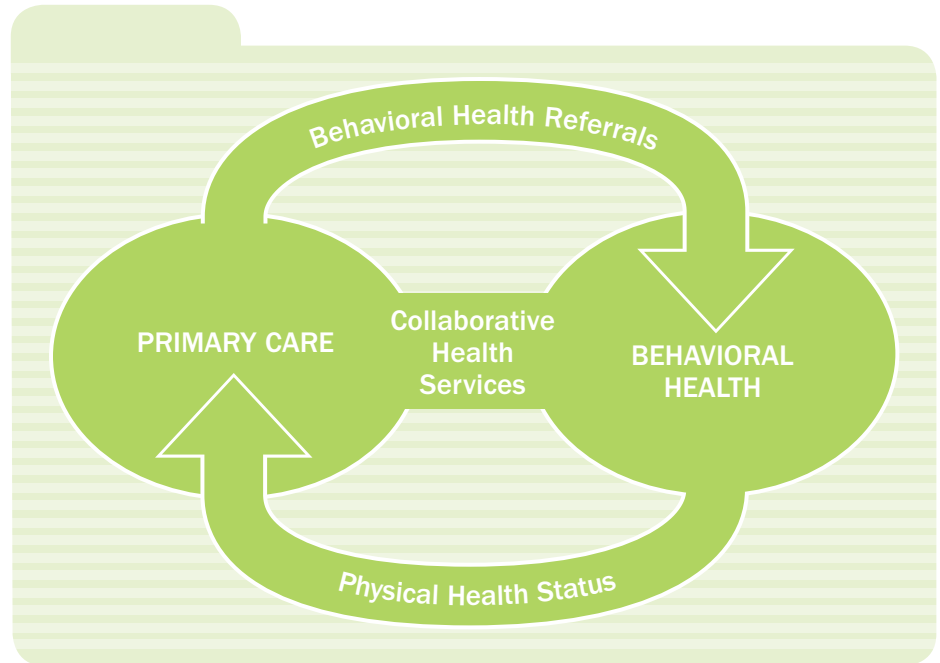
TESTING IMPROVEMENTS

Although each site developed unique project plans, collectively they worked on plan-do-study-act improvement cycles in the following areas:

- >> Establish systematic screening and tracking processes.
- >> Establish a care manager/behavioral health consultant role.
- >> Develop systematic referral protocols from primary care to mental health.
- >> Develop systematic referral protocols from mental health to primary care.
- >> Improve communication mechanisms between primary care and mental health.
- >> Establish measurement protocols regarding weight, lipids, and blood sugars for patients on antipsychotic medications.
- >> Train primary care providers in mood disorder and bipolar screening and treatment.
- >> Establish primary care services in behavioral health settings.

At the Phase 2 Learning Congress in December 2008, each site presented the lessons it had learned during the course of the project. Each site team also developed plans for joint next steps. As teams reflected on the improvement cycles, the following themes emerged at the end of the project:

- >> Workflows – Studying each of the steps from check-in and registration to the end of the primary care visit and establishing consistent processes of initial screening, rescreening, and decision making



about care are core system improvement tasks that generally require skill development on the part of the organization and partnership.

- >> Clear responsibilities – Spreading the responsibility for screening and registry tracking to all practitioners can result in less consistent screening and follow-up than making the tasks the responsibility of an assigned person on the team. This model requires strong organizational support to pursue effectively.
- >> Data constitutes clinical information – Collecting data related to clinical progress in mental health typically requires a change of culture, one in which data are used to inform clinical practice, not just to document clinical encounters. Instigating this cultural change needs to be a focus of practice and reinforced at the organizational level.
- >> Registry tracking – Chart audits are time intensive and don't support real-time care management in the same way that registry tracking (chronic disease management) systems do. Unfortunately, most electronic health records do not yet have robust registry functions (see California HealthCare

Foundation, 2008). Use of a distinct registry, with assigned responsibility, leads to closer monitoring of treatment success.

- >> Scale matters – Implementing change in one practice versus across a clinic results in significant differences in volumes of patients and tracking to be managed. Rapid-cycle improvement methodologies are best suited for starting small and scaling up change within an organization. Scale should be a key factor considered in the development of Quality Improvement strategies.

The National Council's current Phase 3 Collaborative Care project, initiated in August 2008, includes four sites located in Maryland, Indiana, Colorado, and Florida.

Learn more about the Primary Care – Behavioral Health Collaborative Project at www.TheNationalCouncil.org/ResourceCenter.

See Barbara Mauer on page 8.

Laura Galbreath supports the National Council's state and federal policy initiatives and focuses on expanding opportunities for 1,600+ member community mental health and addictions services organizations to meet the primary health needs of the people they serve. Galbreath has extensive experience in health policy analysis, community organizing, and project management. Before coming to the National Council, she served as the senior director of health-care reform at Mental Health America.

REFERENCES

California HealthCare Foundation. (2008). *Electronic health records versus chronic disease management systems: A quick comparison*. Retrieved February 21, 2009, from <http://www.chcf.org/topics/view.cfm?itemID=133586>

VOICES ➤

At a NAMI New York focus group to address the health concerns of persons with mental illness, patients revealed the simple desire to feel deserving of good health. "The most shocking thing was that people really wanted to be healthy but there was a disconnect," says program associate Katie Linn, who ran the focus groups. "A lot of it came down to self-worth – they didn't feel like they were worthy of taking care of themselves."