



Understanding Primary and Behavioral Healthcare Integration

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Audience Poll:

How do you self-identify?

- Consumer
- Family member
- Mental health or substance use provider
- Primary care provider
- Advocate
- Policymaker
- Funder

BIDIRECTIONAL INTEGRATED CARE 101: WHAT YOU NEED TO KNOW

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For today – The basics

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- Definition of bidirectional integrated care
- Rationale for integrated care
- Approaches to integrated care
- State & national activities
- How you can get involved & learn more

What is bidirectional integrated care?

Integrated health care

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- “...in essence integrated health care is the **systematic coordination of physical and behavioral health care**. The idea is that physical and behavioral health problems often occur at the same time. Integrating services to treat both will yield the best results and be the most acceptable and effective approach for those being served.” Hogg Foundation for Mental Health, *Connecting Body & Mind: A Resource Guide to Integrated Health Care in Texas and the U.S.*, www.hogg.utexas.edu

Bidirectional integration

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Integrating PC services
into MH/SU settings

AND

Integrating MH/SU services
into PC settings

******In both cases, the services are not just provided, but
coordinated with other care delivered in that setting

***PC** = primary care; ***MH** = mental health; ***SU** = substance use

A word of clarification

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- Focus is on the integration of **services**
- This may or may not involve the integration, or merging, of organizations (often not)
 - NOTE: Will not cover organizational / structural integration or payment / financing today, but useful information on those topics in resource list later in presentation

Why integrate physical and behavioral health care?

Seeking BH care in primary care

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- Most people seek help for BH problems in PC settings
- ~1 / 2 of all care for common psychiatric disorders happens in PC settings
- Populations of color are even more likely to seek or receive care in PC than in specialty BH settings

*PC = primary care

*BH = behavioral health (i.e., MH + SU)

Why seek MH care in PC settings?

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- Uninsured or underinsured
- Limited access to public MH services
- Cultural beliefs and attitudes
- Availability of MH services, especially in rural areas

*PC = primary care

*MH = mental health

BH problems in primary care

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- Mild to moderate BH issues are common in PC settings
 - Anxiety, depression, substance use in adults
 - Anxiety, ADHD, behavioral problems in children
 - **Prevention and early intervention opportunity**
- People with common medical disorders have high rates of BH issues
 - E.g., Diabetes, heart disease, & asthma + depression
 - **Worse outcomes & higher costs if both problems aren't addressed**

Usual care in PC settings

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- ❑ MH problems often go undetected and untreated in PC
- ❑ When PCPs do detect MH problems, they tend to undertreat them
- ❑ Populations of color, children and adolescents, older adults, uninsured, and low-income patients more often receive inadequate care for MH problems
- ❑ SU care involves same issues, if not worse

*PCP = primary care provider; *SU = substance use; *MH = mental health

Medical issues in BH settings

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- ❑ People with serious mental illness (SMI) are dying 25 years earlier than the general population.
- ❑ 2/3 of premature deaths are due to preventable/treatable medical conditions such as cardiovascular, pulmonary, and infectious diseases.
- ❑ 44% of all cigarettes consumed nationally are smoked by people with SMI.

See www.nasmhpd.org for Morbidity And Mortality In People With Serious Mental Illness report (2006)

Medical issues in BH settings

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- Oregon state study found that those with co-occurring MH/SU disorders had worst early mortality gap
- Average age of death for those with co-occurring MH/SU = **45 years** (vs. 53 for those with SMI)

B. Mauer & C. Weisner (2010) California Institute for Mental Health webinar *The Case for Integrated Care*: www.cimh.org/LinkClick.aspx?fileticket=AK6sN-XKyXo%3d&tabid=804

Usual care in PC settings

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- BH consumers in PC settings:
 - Are less likely to receive effective medical care, including preventive services
 - Report difficulties establishing relationships with PCPs
 - Time limitations and stigma

Usual care in MH settings

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- 2007 survey of National Council members (CMHCs) revealed limited capacity to screen and provide medical care:
 - 2/3 can screen for common medical problems.
 - 1/2 can provide treatment or referral for those conditions.
 - 1/3 can provide some medical services on-site.

* CMHCs = Community mental health centers

Druss, et al (2008). *Psychiatric Services*, 59:917-920.

Key opportunity

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- Integrating care offers an important opportunity to **reduce disparities**:
 - Eliminate the early mortality gap
 - Reach people who cannot or will not access specialty BH care
 - Intervene early before issues develop or worsen

What is effective integrated care?

Integrating BH into PC

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- Helpful, but not sufficient
 - ▣ Physician training
 - ▣ Screening
 - ▣ Referrals
 - ▣ Co-location of services

*PC = primary care

*BH = behavioral health (i.e., MH + SU)

Strongest evidence base

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- Collaborative care
 - >25 years of research
 - >38 randomized controlled trials, including IMPACT
- Adaptation of Wagner's chronic care model
 - [www.improvingchroniccare.org/index.php?p=The Chronic Care Model&s=2](http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2)

IMPACT Study: J Unutzer, *JAMA*. 2002;288:2836-2845;
and AIMS Center <http://impact-uw.org/>

Collaborative care's key ingredients

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- ❑ Care management – Patient education & empowerment, ongoing monitoring, care/provider coordination
- ❑ Evidence-based treatments – Effective medication management, psychotherapy
- ❑ Expert consultation for patients who are not improving
- ❑ Systematic diagnosis and outcome tracking
- ❑ Stepped care
- ❑ Technology support – registries

J. Unutzer, 2010, www.cimh.org/LinkClick.aspx?fileticket=84F6JQndwg8%3d&tabid=804

S. Gilbody et al, Arch Intern Med. 2006;166:2314-2321

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

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- ❑ Identification of behavioral problems (alcohol, other drug, tobacco, depression, anxiety) & level of risk
- ❑ Low risk: Raise awareness and motivate client to change
- ❑ Moderate risk: Provide brief treatment (cognitive behavioral, medications) with clients who acknowledge risks and are seeking help
- ❑ High risk: Refer those with more serious or complicated MH/SU conditions to specialty care
- ❑ Used in primary care centers, hospital ERs, trauma centers, and other community settings

See <http://sbirt.samhsa.gov/> for more information

Integrating PC into BH settings

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- ❑ Same principles appear to apply
- ❑ Beginning steps
 - Screening and tracking of basic health indicators for everyone on psychotropic meds
 - Glucose, lipid levels, blood pressure, weight, BMI, etc
 - Identification of & coordination with the PCP
- ❑ Wellness programs, including peer-led
- ❑ Collaborative care

*PCP = primary care provider

*BMI = body mass index

Where does the Medical Home fit in?

The Medical Home

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- Patient-Centered Medical Home (PCMH)
 - ▣ Ongoing relationship with a PCP
 - ▣ Team with collective responsibility for ongoing care
 - ▣ “Whole person” orientation
 - **PCMHs need MH and SU capacity – i.e., MH and SU services need to be *integrated* into the medical home**
- Person-Centered Healthcare Home
 - Healthcare home may be a PC or BH setting depending on a person’s preference

See www.thenationalcouncil.org for more info on the person-centered healthcare home and the role of MH/SU in medical homes.

See www.pcpcc.net site for more about medical homes.

***How do people receiving
integrated services feel about
their care?***

Consumers' take on integration

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- People receiving integrated services report higher quality of life and greater satisfaction with:
 - Access
 - Attention to their treatment preferences
 - Courtesy
 - Coordination & continuity of care
 - Overall care

Druss et al, Arch Gen Psychiatry. 2001; 58(9): 861-8.

Unutzer et al, JAMA. 2002; 288(22): 2836-2845.

Ell et al, Diabetes Care. 2010; 33(4): 706-713.

Consumers' take on integration

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“It is great having my two providers in the same building because **they talk with each other at the time of the problem** rather than me having to wait until I see my provider for psych meds and/or my therapist.” – **Jackie, Pathways Community Behavioral Healthcare, Clinton, MO**

Consumers' take on integration

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“Around the time that my bipolar condition was identified, I was diagnosed with kidney disease. Between the two disorders, it was a pretty upsetting time in my life... My doctors, dialysis clinic staff, and mental health case manager are well connected. **They take a team approach**, and they each check on the status of my health... **Today I have control over my health**; it doesn't have control of me. The coordinated care allows me to feel like I can go out and be a part of the community.” – **Cassandra McCallister, Board Member, Washtenaw Community Health Organization, Ypsilanti, MI**

Consumers' take on integration

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...I'm not saying everything is perfect because it isn't. I'm still working hard with the CBT to change my negative way of thinking. Living with my blindness isn't easy. As Rachel (care manager) says, "It's not for sissies." **But I can't imagine where I'd be now if it weren't for the great team that pulled together to make sure I didn't fall through the cracks.**

– Joann Gilbert, Project Vida Health Center, El Paso, TX

Videotaped at Hogg Foundation's 2008 conference *Integrated Health: Connecting Body & Mind*, Robert Lee Sutherland Seminar XV. Video transcript in English and Spanish at www.hogg.utexas.edu

What is going on around the nation?

Local / regional activities

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- ❑ Thousands of BH & PC providers partnering
 - ❑ Mid-State Health Center (NH)
 - ❑ Meridian Behavioral Healthcare (FL)
 - ❑ Volunteer Behavioral Health Care Services (TN)
 - ❑ Verde Valley Guidance Clinic (AZ)
 - ❑ People's Community Clinic (TX)
 - ❑ Navos (WA)
 - ❑ Sierra Medical Center (CA)
- ❑ Integrated systems
 - ❑ Crider Health Center (MO)
 - ❑ Cherokee Health Systems (TN)
 - ❑ Washtenaw Community Health Organization (MI)
 - ❑ Intermountain Healthcare (UT & ID)

State-level work

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- State efforts via Transformation and block grant funds in AL, MI, PR, WV, MO, OK, OH, NM, & WA
- National Council-led statewide learning communities in TX, ME, & IL
 - ▣ Funded by Hogg Foundation, Maine Health Access Foundation, & Community Behavioral Healthcare Association of Illinois
- Minnesota DIAMOND
- California's CalMEND initiative

National / federal efforts

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- ❑ Health reform – PCMH payment reform via Medicaid; PC in BH demonstration grants
- ❑ SAMHSA PC BH Integration grants
- ❑ HRSA behavioral health expansion grants
- ❑ Patient-Centered Primary Care Collaborative
- ❑ SAMHSA/HRSA TA Center (*upcoming*)
- ❑ AHRQ resource center (*upcoming*)

How do I get involved?

Where to start

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☐ Learn more

Learning more

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- National Council – [listserv & website](#)
- Hogg Foundation for Mental Health – [resource guide](#)
- California Institute for Mental Health – [webinars](#)
- IBHP - CA Endowment/Tides Center – [tool kit](#)
- AIMS Center – University of Washington – [training](#)
- Patient-Centered Primary Care Collaborative
- Collaborative Family Healthcare Association

Where to start

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- Start conversations with local providers or your own PCP
 - ▣ Raise awareness
 - ▣ Share information
- Get involved in advocacy
 - ▣ Financing issues
 - ▣ Incorporation of recovery principles
 - ▣ Training and other workforce issues

Getting started as a provider

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- Map core functions on to staffing resources
 - ▣ What are the basic activities your center needs to accomplish?
 - ▣ Who is doing them currently? If no one, who could take them on?
 - ▣ What additional resources are necessary, if any?
- AIMS Center planning tools
 - http://uwaims.org/implementation_tools.html

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Crider Health Center's Path toward Integration



Who we are and Who we are becoming

- ▶ Community Mental Health Center since 1979
- ▶ Community Health Center since 2006
 - Vision: Full, productive, healthy lives for everyone
 - Mission: To build resilience and promote health through community partnerships
 - Became FQHC in 2007



Who we serve

- ▶ Service area:
 - 520,000 people
 - Four Missouri counties outside St. Louis
- ▶ Children and Families
 - School-based prevention/ mental health promotion and early intervention (53,000 children and youth/year)
 - School- and home-based interventions (system of care)



- ▶ Adults with serious mental illness
 - Community Support Teams
 - Two ICCD certified clubhouses
 - Transitional and supported employment
 - Housing
 - Supported community living
 - Psychiatric group home
 - Crisis beds
 - HUD apartments



- ▶ General public through three integrated care sites
 - Primary health care
 - Psychiatry and mental health supports
 - Pediatrics
 - One includes dentistry and oral health school outreach
 - One includes Ob/Gyn



Active Ingredients of Integration

Overcoming the Barriers

- ▶ Financing (capital and operating)
- ▶ Cultural barriers between primary care/mental health delivery systems/practitioners.
- ▶ Lack of practitioner training in the health service area that is not their own area of expertise.
- ▶ Information sharing
 - Issues of confidentiality
 - Electronic Health Record
- ▶ Space



Behavioral Health Specialist (BHS), Psychologist or LCSW:

- ▶ Partners with physicians to address behavioral health needs identified in the primary care setting.
- ▶ Develops joint plans with medical providers on behavioral health aspects of patient care.
- ▶ Provides crisis intervention, brief assessment and referral, behavioral interventions, and education for primary care patients with mental health, substance abuse, and issues of medical compliance.



Behavioral Health Specialist— Paradigm Shift (from Cherokee Health Systems)

BHS Model

- > population mgmt.
- > 15–25 min. visits
- > 1–3 visits
- > no limit on # of patients per day

vs. Traditional MH Model

- > specialty care
- > 45–60 min. visits
- > 5 or more visits
- > 5–7 patients/day



Behavioral Health Specialist— Paradigm Shift

BHS Model vs.

- > open access
- > any medical issue
- > BHS interruptible
- > Goal: enhance overall health

Traditional MH Model

- > waiting list
- > mental health issues
- > "do not disturb"
- > Diagnose and treat DSM disorder



Changing Roles in Behavioral Health

- ▶ ***Community Support Workers, Care Coordinators, School Based Mental Health Specialists, Clinical Case Managers and Peer Specialists***
 - Supports clients in meeting their treatment plan goals identified in the primary care, mental health and dental health service settings.
 - Interacts with Behavioral Health Specialist, Medical Case Manager, and Nurse Liaison as needed.
 - New role: Health Coach – Health Navigator



Issues

- ▶ Moving to a Wellness Model
 - Nutrition
 - Exercise
 - Healthy Living
- ▶ Maintaining a Recovery Orientation
 - Independent Living
 - Work
- ▶ Enhancing Cultural Competence



Questions?

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