Integrating Primary Care and Behavioral Health

IMPACT MODIFIED

Presenters

- Bridget Harrison, MD, MPH

  Interim Chair, Dept. of Family Medicine
  Santa Clara Valley Medical Center (SCVMC)
  San Jose, CA

- Elena Tindall, MA Ed.

  Project Manager- Primary Care Behavioral Health Integration,
  Santa Clara County Department of Behavioral Health Services
  (DBHS)

  San Jose, California

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Learning Objectives

- Identify a method to efficiently screen high volumes of primary care patients for behavioral health issues, and to identify and refer those identified

- Describe how the IMPACT model can be used and modified to successfully integrate primary care and behavioral health care teams in an ambulatory setting.

- Explain workflows and system's efforts that facilitate behavioral health-primary care collaboration, sharing examples of improved patient care using this collaborative approach

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Santa Clara County Integration OVERVIEW

Budget Driven

Mental Health Services Act (MHSA) passed in 2004

DSRIP (2009-2015) and Affordable Care Act Number of sites- not all

Partner: The AIMS Center at the University of Washington
- provide training (on-site, remote, phone)
- technical assistance, consulting, customized website
- live and recorded webinars

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About us

SCV Health and Hospital System serves ~64,000 primary care patients across six adult primary care clinics

Co-located at 4 out of 6 our PC clinics
- 54 FTE adult primary care
- 40 FTE behavioral health providers (19.5 FTE LCSWs, 20 FTE Psychiatry)

Clinic facilities influenced staffing placement

Invested in staff training

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Affordable Care Act

Thanks to DSRIP Milestones for CY 2010-2016,

Our system will be better prepared for the DSRIP 2.0 **Integration of Behavioral Health and Primary Care** goals

Integration Requires:
- Strategic Priority
- Practice changes from individual & referral, to team approach
- Customized Reports: Data needs are profound, and there are no canned reports in EMR that relate to integrated care
- Ongoing support
- Structured time for consultation

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Implementing and Modifying IMPACT: Improving Mood Providing Access to Collaborative Treatment

IMPACT Elements:	VMC Elements
Executive Sponsorship	Same
Ongoing Senior & Clinic level organizational review	Same
Physician Champion training	All Staff oriented at launch, trained >70% of all staff (9/2012)
BH Staff provide Care Manager Role & tasks	BH Staff provide Care Management, brief therapy
	Initial Staffing ratio: Under Review

Staffing ratio:
- 1 FTE Behavioral Health Care Manager: 6 FTEs PCPs
- 0.1 FTE Consultant Psychiatrist : 1 FTE BH Care Manager (BHCM)

Initial Staffing ratio: Under Review
- 1 FTE Behavioral Health Clinicians (19.5 FTE LCSWs): ~3 FTEs PCPs
- 1:1 Treating & Consulting Psychiatrist (20 FTE total) : 1 FTE BH Clinician
- 1 FTE BH Clinic Manager: 7 FTE BHCs

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Implementing and Modifying IMPACT: Improving Mood Providing Access to Collaborative Treatment

IMPACT Elements:

Staffing ratio:
- 1 FTE Behavioral Health Care Manager: 6 FTEs PCPs
- 0.1 FTE Consultant Psychiatrist : 1 FTE BH Care Manager (BHCM)
- Consulting Psychiatrist supervises BH Staff

VMC Elements

Initial Staffing ratio (Braided): Under Review
- 1 FTE Behavioral Health Clinicians (19.5 FTE LCSWs): ~3 FTEs PCPs
- 1:1 Treating & Consulting Psychiatrist (20 FTE total) : 1 FTE BH Clinician
- 1 FTE BH Clinic Manager: 7 FTE BHCs
- At MediCal Specialty Mental Health certified- braided staffing includes specialty MH staffing:
  - Rehab Counselor (1.0 FTE:14 BH providers)
  - Licensed Psychiatric Technicians (1.0 FTE: 1.5 FTE ΨMD)
  - Peer Support Workers (0.80 FTE across 4 clinic sites
  - BH Manager (0.5 FTE BH Manager: 5 FTE BH providers

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Implementing & Modifying IMPACT (Cont.)

IMPACT Elements:

Depression Screening protocol:
- All pts 12+
- At every visit or
- Annually

BH Staff =Care Manager (RN, Licensed MH Professional, NP) embedded in PC clinic

Brief interventions only, no SMI pts

Warm hand-offs between PCP and BHC, emphasis on same-day access

VMC Elements

Depression Screening protocol:
- All adult pts 18+
- At every visit (not flu visits/ procedures)
- Are now discussing broader BH Screening tools

BH Staff= BH Clinician: Licensed clinical Behavioral Staff, and Peer Partner

Brief interventions, continued longer maintenance for stable SMI pts

Warm Hand-Offs Limited to pilots: Not routine
Each clinic separate physical plan impacts closeness
Primarly for urgent access as available

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Implementing & Modifying IMPACT (Cont.)

IMPACT Elements:

Care Management Tracking system, adjunct to EMR

Psychiatric Consultation:
- Curbside consultation
- Via EMR PRN with PCP or BHCM
- Weekly 1 hour dedication consultation b/w Consulting Psychiatrist and BHC

VMC Elements

Care Management Tracking system, being developed within our EMR (robustly being updated and viewed by PCP and BH Staff

Psychiatric Consultation:
- Dedicated time for Joint Provider Meetings (monthly)
- Curbside consultation- at those clinics where both at least on the same floor
- Via EMR PRN with PCP or BHCM
- Weekly review of all pts by BHCs
- Developing more robust EMR consultation practice

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Implementing & Modifying IMPACT (Cont.)

IMPACT Elements:

Visits
Utilizes many 15 mins or less warm hand off visits

Between in-clinic visits/ phone calls, weekly for moderate-severe depression

30 mins sessions for follow up

VMC Elements

Visits
Less frequent use of 15 mins or less warm hand off visits

Goal is for weekly visits/ phone calls for the moderate-severe depression, but currently achieving follow up visits every 2-3 weeks
Elements needed:
- BH utilizes EMR cancellation function
- System buy-in for non-billable time in follow up

30-45 mins sessions for follow up

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Scaled Implementation
(by Fiscal Years July 1- June 30)

2009-2010
- First year DSRIP plan approved for IMPACT implementation.
- MHD and VMC Executive staff meet to agree to general plan of implementation
- MHD created new Division to oversee PCBH clinics: Division of Integrated Behavioral Health (IBH)

2010-2011
- Executive Leadership meet PRN to define target population, goals, administrative and operational needs for IMPACT framework
- Modifies IMPACT Framework specific to VMC's operational needs and resources
- Project Manager begins working closely with the team to implement

2011-2012
- MHD created Division of Integrated Behavioral Health and Cross Systems, and assigned dedicated Director to PCBH efforts (2012)

Work with LCSWs to clarify different operational expectations (documentation, productivity, appt templates, etc) for Primary Care Behavioral Health.

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Scaled Implementation

2012-2013	2013-2014	FINAL Year of DSRIP 2014-2015
• MHD created Division of Integrated Behavioral Health and Cross Systems, and assigned dedicated Director to PCBH efforts (2012) • Sept '12- All clinic staff –both licensed and support, medical and BH, attend 7 hour on-site IMPACT training, keeping clinics operational throughout. • LCSWs and Psychiatrists attend a 2nd full-day on-site IMPACT training • Dec '12-first two pilot clinics launch their phased systematic PHQ-9 screening • 100% DSRIP Milestones reached	• HL Go Live (Oct '13) • EVC/ ALX launched • Interdisciplinary Joint Provider Clinical Consultations using HL Tool started (MIL-10/14) • Redesigned All LCSW Staff meetings into small workgroup sessions, empowering staff more input and control • HL Flow Charts and PCBH Report Tool created (11/2014) • 75% of DSRIP Goals reached	• Created first HL PCBH Active Patient Reporting Tool (11/2014) • Piloting HL tool with 11 providers: tool is generally helpful • SUN and EVC piloting Warm Hand Offs in PC • 10/2014- started initial Interdisciplinary Clinical Consultation meetings at each site (using the HL PCBH tool) • Doubled number of pts served by PCBH • DSRIP Goals- achievement uncertain

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Successes in Integration

- Systematic screening of pts for depression
  - Defined no PHQ administration for Flu visits
  - No screening administration for procedure visits
- Multiple examples of same-day BH intervention for PC pts in crisis
- Significant increase in collaboration through EMR
- Joint provider meetings creating trust, team, and robust clinical consultation opportunities
- Significant Increase in diversity of pts served through PCBH since 2010

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Successes in Integration

- Modifications allowed us to adapt to our existing system
- Employ multi-lingual LCSW & Psychiatrists
- Transitioned formerly specialty MH staff into BH Clinicians
- Dedicating a Project Manager to integration kept effort on track
- Emerging culture of using population tools developed in EMR
- Increased access to psychiatric services
- Emerging agreement of transitioning pts from psychiatry back to PCP

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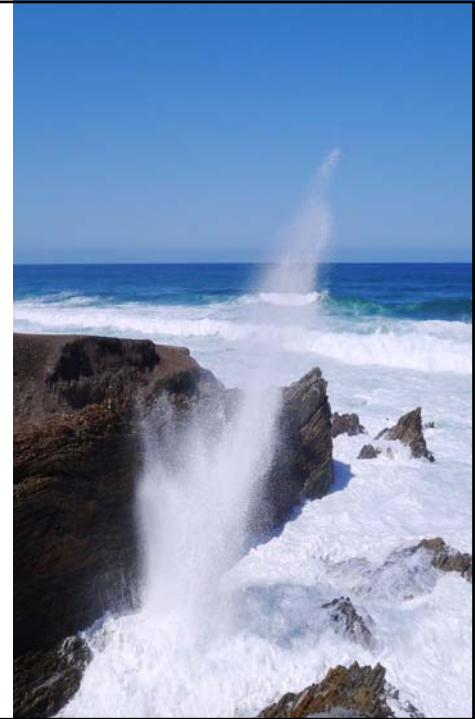
Challenges to Integration

Everything's a strategic priority

Facility foot print

Transitioning specialty MH staff into PCBH Clinicians

Data tracking capacity

Timing: DSRIP, Launching EMR, AND ACA- all at the same time

Transitioning from specialty MH workflow, into population health management and stepped care workflow for PCBH Clinicians

Timely follow up appts for the "moderate +" patients

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Challenges to Integration

PCP same day access to PCBH therapists

Staff fatigue with increased work of passing out PHQ9 paper, reviewing by PCP

8% of Patients Fatigue with PHQ9 at every visit (higher than normal frequent visits with PCP)

A core of Seriously Mentally Ill pts who don't want to transition into Specialty BH Care System

Improving mechanics of how this works within the continuum of our System of Care resulting in…

- Impacted Schedules
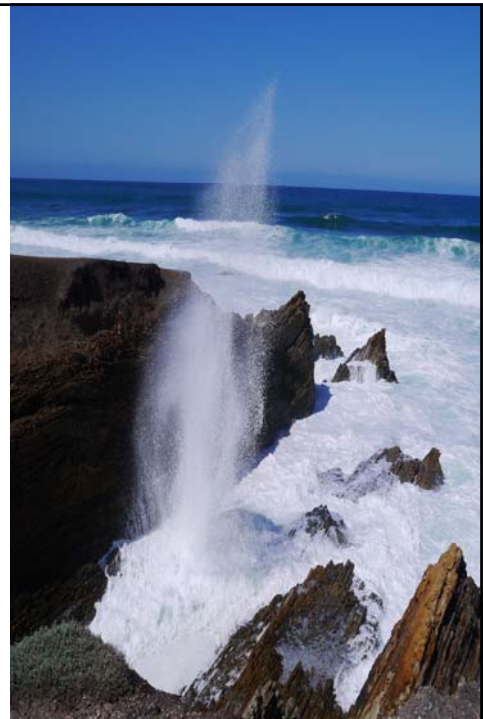
Recruitment of bilingual LCSWs in a tight market

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Provider Perspective

- 2012 Trainings
- Referring to Behavioral Health
- Consultation with Psychiatry
- Joint Provider Meetings

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Outcomes

Increased identification and treatment of patients'
behavioral health needs across diverse patient groups by
40-72% since 2009 launch:

- 40% increase among-Asian/ Pacific Islander
- 64% increase among Other Race
- 66% among White
- 67% Native American
- 68% Hispanics
- 72% increase in Black/ African Americans treated

> 80% compliance with screening (~4,000 PHQ9s administered
past 6 mos, ~3,600 completed)

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Outcomes – Case 1

- 50 y/o homeless female with alcoholism, diabetes,
cirrhosis, hypertension, hyperlipidemia, major
depression, peripheral neuropathy, chronic pain
- Desired alcohol treatment but could not get into
residential program
- Discussed at primary care – behavioral health monthly
case conference
- Behavioral health team arranged inpatient residential
alcohol program

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Outcomes – Case 1- Continues

- Ongoing struggles – still homeless (declined housing offer), struggles with alcohol, recent motor vehicle accident with fractures

- 5150 eval assistance

- Recently symptoms improving, behavioral health rehab counselor to follow

- Patient attached to primary care and behavioral health providers, seeks services

- Care coordination critical to supporting this high-needs patient

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Outcomes – Case 2

- 57 y/o homeless male with major depressive disorder, prostate cancer, familial discord, no source of income

- Often angry, threatening, hostile to clinic staff

- Sent to EPS by 5150 from primary care clinic for suicidality

- Behavioral Health LCSW arranged housing, disability benefits, group support

- Patient now pleasant to staff, functioning well, depression controlled

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Outcomes – Case 3

- 32 year old healthy male with 2 visits in 2 weeks to ED for chest pain and shortness of breath

- Came to new patient primary care appointment extremely concerned about his heart, breathing… multiple somatic complaints, saying he was going to go back to ED

- Primary care NP identified anxiety but patient very resistant to dx

- Warm handoff to LCSW same day
  - Patient initially resistant but then divulged 4 recent family deaths, stressors
  - Immediately taught biofeedback techniques

- No further ED visits

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Next Steps

Transition day-to-day operational management from Mental Health Department, to Ambulatory Care Health Services

Develop Outcomes reports in EMR

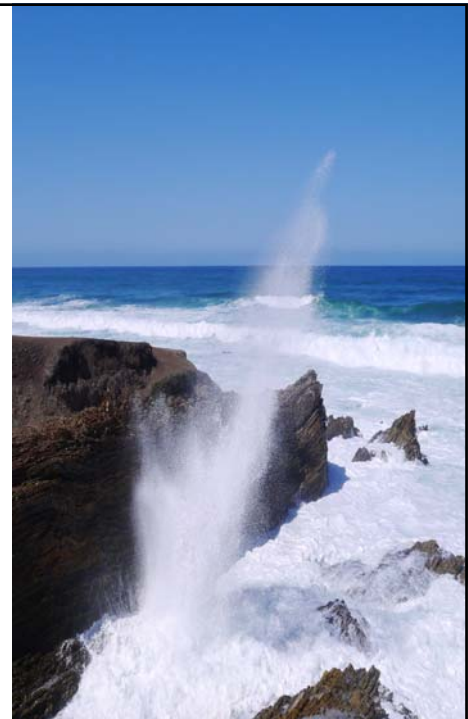Build system to analyze clinical outcomes across population

Define final PCBH staffing model

Implement Stepped Care model

Create a new tier in our system for Moderate Plus

Expand hours to improve access and embed staff

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Questions?

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