Integrated Behavioral Health & Primary Care

Community Wellness and Recovery for Individuals Living with Serious Mental Illness

WHOLE HEALTH CLINICAL GROUP

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a service of the Milwaukee Center for Independence

The Whole Health Clinical Group is a service of the Milwaukee Center for Independence and is the largest provider of mental health services in Southeastern Wisconsin, serving more than 800 consumers and their families in Milwaukee, Waukesha and Washington counties.

WHCG

What We Do

- Community based service providing care to individuals with Serious Mental Illness – Severe, Persistent and Chronic Illness
  - Outpatient Mental Health and Substance Abuse Clinic
  - Residential Services – Group Homes – Supported Apartments – Apartment Management
  - Crisis Resource Centers
  - Pharmacy
  - Benefit Advocacy

Wisconsin Medicaid Case Management Models

- Community Service Program (Assertive Community Treatment ACT Model)
- Comprehensive Community Services
- Targeted Case Management

Most Frequent Mental Health Diagnosis

Schizophrenia disorders
Post Traumatic Stress Disorder (PTSD)
Anxiety / Obsessive Compulsive
Depression
Bi-polar disorder
Dependency

Addition of Primary Care Services

- Dr. McFarland Family Nurse Practitioner
- Opened clinic January 2014
  - One exam room
  - No nurse
- 2016
  - Expanded space- 3 exam rooms
  - One nurse
  - One medical assistant
  - One Nurse Care Manager
  - 2 Branch sites:
    - Meta House- women with substance abuse issues
    - Autumn West individuals that utilize an area shelter/safe haven

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"Hey you got Behavioral Health in my Primary Care!"

"You got Primary Care in my Behavioral Health!"

WHAT!!!

Integration of Mental Health, Addiction and Primary Care

- **OVERVIEW:** Establish coordinated and integrated services through the co-location of primary and specialty care medical services in community based behavioral health settings
- **GOAL:** To improve the physical health status of adults with serious mental illness (SMI) and those with co-occurring substance use disorders who have or are at risk for co-morbid primary care conditions and chronic disease.

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Triple Aim

BETTER HEALTH
- Improve the health of individuals with Serious Mental Illness

BETTER CARE
- Enhance the consumer experience of care (including quality, access, and reliability)

LOWER COST
- Reducing/controlling the per capita cost of care

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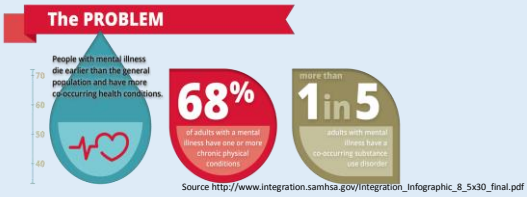
Better Health



Source http://www.integration.samhsa.gov/integration_infographic_8_5x30_final.pdf

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Better Care - Treating Individuals with SPMI- Primary Care

- Complex medical needs related to co-occurring conditions
- Longer visit times – average clinic visit 45 minutes
- High no show rates
- Emphasis on education and motivation to address health care issues

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Lower Cost

- Decrease inpatient cost
- Decrease emergency services cost (ER Visits)
- Decrease need for detox services
- Increase housing stability

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Integration and Transdisciplinary Team Approach

- **Team Members:** Case managers, Therapists, Physicians, Psychiatrists, Nurses, Integration managers, Pharmacist, Nutritionist, Peer Support.
- **Interaction:** Teach learn and work across disciplinary boundaries to plan and provide integrated services.
- **Communication:** Meets regular to share information, learning across disciplines, consultation and staffing are fundamental.

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Role of Transdisciplinary Team Model

- **Establish Patient-Center Home**
- **Clinical Collaboration**
- **Quality Services & Risk Management**

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Patient-Centered Home

- Coordinated care to individuals with multiple chronic health conditions including mental health and substance use disorders
- Connects consumers with community supports/resources and enhances coordination between primary care and behavioral health providers
- Team based clinical approach that includes the consumer, providers, and family members
- Provide Wellness Program that promote healthy living and recovery
- Chronic disease management

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Clinical Collaboration

- Consumer's Transdisciplinary Team meet regular to review, exchange information as part of a continuum of care.
- Share one single care plan
- Coordinate ongoing workflow for integrated services

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Quality Services &Risk Management

- Monitor quality of care and services
- Provide Training/Cross training and staff development for health care and behavioral health
- Assess and review consumer care that are high risk

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Levels of Integration

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
•• Have separate systems •• Communicate about cases only newly and under compelling circumstances •• Communicate, driven by provider need •• May never meet in person •• Have limited understanding of each other's roles	•• Have separate systems •• Communicate periodically about shared patients •• Communicate, driven by specific patient issues •• May meet as part of larger community •• Appreciate each other's roles as resources	•• Have separate systems •• Communicate regularly about shared patients, by phone or e-mail •• Collaborate, driven by need for each other's services and more reliable referral •• Meet occasionally to discuss cases due to close proximity •• Feel part of a larger yet ill-defined team	•• Share some systems, like scheduling or medical records •• Communicate in person as needed •• Collaborate, driven by need for consultation and coordinated plans for difficult patients •• Have regular face-to-face interactions about some patients •• Have a basic understanding of roles and culture	•• Actively seek system solutions together or develop work-a-rounds •• Communicate frequently in person •• Collaborate, driven by desire to be a member of the care team •• Have regular team meetings to discuss overall patient care and specific patient issues •• Have an in-depth understanding of roles and culture	•• Have resolved most or all system issues, functioning as one integrated system •• Communicate consistently at the system, team and individual levels •• Collaborate, driven by shared concept of team care •• Have formal and informal meetings to support integrated model of care •• Have roles and cultures that blur or blend

WHCG Status of Integration

- Co-location of primary care and behavioral health services
- Separate EHR systems – some systems shared (front desk staff combine information)
- Multidisciplinary team that staff behavioral health and health care needs (less frequent for health care)
- Consumers with multiple health issues or complex needs drive the need for consultation- done through personal communication
- Separate treatment plans no single integrated treatment plan

Conclusion: Level 3-4 Integration according to the SAMHSA- HRSA Center for Integrated Health Solutions Levels of Integration

Moving to Full Collaboration and Integration

- Cash
  - Received $1.6 million from SAMHSA to integrate PC and BH services
  - Leverage revenue from case management contracts and primary care services
- Staff
  - Integration Coordinator
  - RN Case Manager
  - QA/Evaluation Specialist
  - Peer Wellness Coach
- Single electronic health record
- Trainings – Train all staff
- Workflow redesigns
- Support and Resources
  - SAMHSA and others in our cohort share information
  - Evidenced based practices

Application of EBP's for Integration Patient-Center Model

- Integrated Primary & Behavioral Health Care – Integrated Treatment Tool
  - Center for Evidence-Based Practices- Case Western Reserve University
  - Based on the concept of a Medical or Healthcare Home
  - Adapted to meet the needs of people who meet criteria for severe and persistent mental health conditions
  - Addresses how each condition (Mental illness, substance use (including tobacco) and other medical conditions) and their treatment impacts the other conditions and treatment
  - Treatment is based on knowledge of the whole person
  - Treatment is also based on the consumers Readiness to Change

Moving to Full Collaboration and Integration

- Key piece of achieving fully integrated services is the addition of a care management to coordinate/facilitate communication and information.
- In addition we leverage our case management programs support our integration services

Approaches to Integrated Care Coordination Essential for Wellness and Recovery

Recovery Principles

1. Self-Direction
2. Individualized and Person-Centered
3. Empowerment
4. Holistic
5. Nonlinear
6. Strengths-Based
7. Peer Support
8. Respect
9. Responsibility
10. Hope

Building Outreach and Relationships- Through Care Coordination

- Engagement
- Reducing No Show rates
- Education
- Medication Management
- Attending sessions with consumer

Evidenced Based Practices

- Assertive Community Treatment
- IDDT
- Principles of Care Coordination
- Motivational Interviewing

Integration in Action

Health and Wellness

Health Promotion Principles

- Universal Rights: Health and Access to Health Care
- Consumer Active Participation
- Health Education
- Addressing Health Characteristics of Environments Where People Live, Learn, and Work
- Holistic and Eclectic
- Address Each Individual's Resource Needs
- Address Differences in Individual's Readiness for Change

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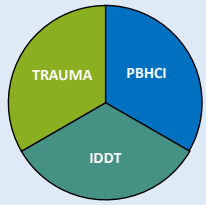
Wellness and Recovery Integration Teams

The WHCG has developed three Integration Teams comprised of individuals who have lived experience, clients in the program and clinical staff to champion our evidenced-based practices of:

- Primary and Behavioral Health Integration
- Trauma Approaches
- Integrated Dual Diagnosis Treatment



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Wellness Program Cont.

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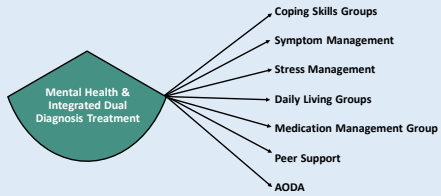
Wellness Program Cont.



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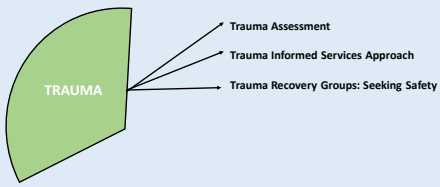
Wellness Program Cont.



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Health Care Guiding the Development of Integrated Service

Data driven models of care management that guide the provision of care

- **Chronic Care Management**
  - Medicare support for non face to face care coordination services by qualified health care professional
  - Comprehensive Care Plan
  - Structured Data Recording
  - Coordinating and sharing patient information
- **Population Health Management**
  - Population identification
  - Health & Risk Assessment
  - Risk Stratification
  - Targeted Interventions
  - Engagement for Behavior Change
  - Evaluation of Outcomes

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Measurement Outcomes and Satisfaction

Back to the triple Aim:

BETTER CARE

BETTER HEALTH

LOWER COST

Outcome Management

Integrating two systems of care amplifies the importance of quality, clinical, process and financial outcomes

This requires a lot of well-organized:

- Goal planning
- Data collection
- Data management
- IT capability
- Reporting
- EHR management
- Financial dashboards
- Training

Data gathering

We identified 14 goals related to the triple aim through integration and collect data from consumers that participate as a SAMHSA participant.

We collect data through:

- The federal data collection survey TRAC – Baseline, 6 month follow ups, and discharge
- BASIS 24 – Baseline, 6 month follow ups, and discharge
- Our EHRs –eClinical Works and EVOL
- Lab reports
- External evaluators
- Client interviews and surveys
- EBP fidelity measures

The vast majority of data is collected from Case Management staff and managers.

Sustainability

Our Strategy:

- Not to rely heavily on grant funds to underwrite costs of direct services to program participants
- Use grant funds to build system capacity to deliver services in a more cost-efficient way
- Leverage fee for service and purchase of service contracts
- Chronic Care Management

Most significant challenge is the reimbursement rates for medical physicians and psychiatrists

- Efficient billing and reconciliation of claims
- Qualify for enhanced Medicaid reimbursement rates associated with attaining FQHC-LA status

Integration at WHCG

- Currently 17% of our consumers receive services in both our primary care and behavioral health clinic
- We've enrolled over 72 consumers through our SAMHSA grant
- They receive all primary care and behavioral health services in our clinic
- RN Care Manager and Integrated Care Manager services
- Monthly Integrated Team Meetings
- Have Integrated Treatment Plans

Thank You and Questions

Treatment Models and Tools

- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Trauma Symptom Inventory
- Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)
- Tobacco protocol
- Hypertension protocol
- Diabetic Protocol
- Integrated Dual Diagnosis Treatment
- Integrated Treatment Tool
- Motivational Interviewing
- Seeking Safety

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