BEHAVIORAL HEALTH AND PRIMARY CARE INTEGRATION

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Today’s Aim

- Understand Behavioral Health integration and its relationship to Primary Care
- Understand the difference between integration and collaboration
- Rationale for integration and approaches to integrated care
- Direction providers can take
- Know consumer’s expectations
- State and national activities
Levels of Integration

- System
- Program/Practice
- Clinician
Integration Vs. Collaboration

**Collaborative** care involves behavioral health working *with* primary care.

**Integrated** care involves behavioral health working *within* and as a part of primary care or primary care working *within* and as part of behavioral health.

Examples?
Types of Integration

Ken Minkoff has suggested that the mechanisms promoting the goal of clinical integration include:

- Clinician integration: dually trained clinicians or interdisciplinary teams.
- Clinical practice integration: formal collaboration and consultation mechanisms, required screening practices, collaboration practices built into service protocols.
Types of Integration

- Programmatic integration: incorporating health education into psychiatric rehabilitation or incorporating BH interventions into diabetes management.
- Physical integration: Co-location of services in either direction.
Types of Integration

- Structural integration: BH and primary care services under a common administrative authority, which can create standards for collaboration and clinical integration.
- Fiscal integration: MH and primary care services under a common funding stream which can potentially be utilized to promote any of the other activities.
An Integrated Model of Care assumes that:

- One disorder does not necessarily present as “primary.”
- There isn’t necessarily a causal relationship between co-occurring disorders interactions.
- These are co-occurring brain diseases that need to be treated simultaneously.

Assumptions (Cont’d)

- The approach to treating co-occurring disorders utilizes one competent treatment team at the same facility to recognize and address all mental health and substance use disorders at the same time.
- There is a systematic coordination of physical and behavioral health care.
The Case for Integrating Physical and Behavioral Health Care?

- Most people seek help for BH problems in Primary Care settings.
- \( \frac{1}{2} \) of all care for common psychiatric disorders happens in Primary Care settings.

National Council- Laurie Alexander, PhD.
The Case for integrating physical and behavioral health care?

- Cultural beliefs and attitudes.
- Populations of color and older adults are less likely to receive treatment in outpatient. When they do it’s in an ER. They are more likely to seek or receive care in Primary Care settings than in specialty BH settings.
The Case for integrating physical and behavioral health care?

- Availability of BH services, especially in rural areas.
- People with common medical disorders have high rates of BH issues: Diabetes, heart disease, asthma + depression
The Case for integrating physical and behavioral health care?

- Mild to moderate BH issues are common in PC settings:
  - Anxiety, depression, substance use in adults
  - Anxiety, ADHD, BH problems in children

Benefits of Integrated Care

- Reduced need for coordination
- Reduced frustration for clients
- Shared decision-making responsibilities
- Families and significant others are included
Benefits (cont’d)

- Clients are empowered to treat their own illness and manage their own recovery
- The client and his/her family has more choice in treatment, more
- Ability for self-management, and a higher satisfaction with care
Benefits (cont’d)

- Reduces disparities
- Eliminates the early mortality gap
- More prevention
- Ability to reach people who cannot or will not access specialty BH care

National Council- Laurie Alexander, PhD
Getting Started as a Provider

- Use organizational assessment instruments to create a baseline for co-occurring capability.
  (COMPASS, DDCAT, DDCMHT, etc.)
  It’s a way to know the status of your collaboration/integration with other providers.
# Measuring Collaboration Vs. Integration

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

The Four Quadrant Clinical Integration Model

- **Quadrant I**
  - BH ↓  PH ↓
  - PCP (with standard screening tools and BH practice guidelines)
  - PCP-based BH*

- **Quadrant II**
  - BH ↑  PH ↓
  - BH Case Manager w/ responsibility for coordination w/ PCP
  - PCP (with standard screening tools and BH practice guidelines)
  - Specialty BH
  - Residential BH
  - Crisis/ER
  - Behavioral Health IP
  - Other community supports

- **Quadrant III**
  - BH ↓  PH ↑
  - PCP (with standard screening tools and BH practice guidelines)
  - Care/Disease Manager
  - Specialty medical/surgical
  - PCP-based BH (or in specific specialties)*
  - ER
  - Medical/surgical IP
  - SNF/home based care
  - Other community supports

- **Quadrant IV**
  - BH ↑  PH ↑
  - PCP (with standard screening tools and BH practice guidelines)
  - BH Case Manager w/ responsibility for coordination w/ PCP and Disease Mgr
  - Care/Disease Manager
  - Specialty medical/surgical
  - Specialty BH
  - Residential BH
  - Crisis/ER
  - BH and medical/surgical IP
  - Other community supports

Stable SPMI would be served in either setting. Plan for and deliver services based upon the needs of the individual, consumer choice and the specifics of the community and collaboration.

*PCP-based BH provider might work for the PCP organization, a specialty BH provider, or as an individual practitioner, is competent in both MH and SA assessment and treatment.
Getting Started

- Do you have a staff training plan to assure integrated competencies and evidenced based practices?
- Create partnerships – Start conversations with local providers or your own Primary Care Physician. Share information and discuss what each of you can bring to the table.
- Include Peer Recovery Coaches on your team.
Getting Started

- THINK LONG TERM:
  What are the service needs of people in your State/jurisdiction?
- What are the outcomes that are important to your system? How do you measure them?
- What are the basic activities your center needs to accomplish? Who is doing them currently? What additional resources are necessary, if any?
Getting Started

- Understanding what an adequate mix of appropriately credentialed and competent primary care and BH providers will be needed.
- As part of your current Treatment options do you offer any Medication Assisted Treatments?
- What is currently prohibiting you from offering MAT?
Getting Started

- Does your organization have a strategic plan and budget for its technology needs?
- What is your organization’s Electronic Health Record (EHR) status?
- How much experience in contract negotiations with health plans and MCO’s – Panels will be needed?
Getting Started

● Billing Methods and Codes
● Follow the State integrated care process by using the website and attending the forums http://dhmh.maryland.gov/bhd/SitePages/Home.aspx
● Refer to the Seven Guiding Principles For Integrated Care.
Outcomes Expected by Consumers

- People receiving integrated services report higher quality of life and greater satisfaction with:
  - Access
  - Attention to their treatment preferences

Druss et al, Arch Gen Psychiatry. 2001; 58(9): 861-8.
Ell et al, Diabetes Care. 2010; 33(4): 706-713
Outcomes Expected by Consumers

- Courtesy
- Coordination and continuity of care
- Overall care

Druss et al, Arch Gen Psychiatry. 2001; 58(9): 861-8.
Ell et al, Diabetes Care. 2010; 33(4): 706-713
DEPUTY SECRETARIAT FOR BEHAVIORAL HEALTH AND DISABILITIES

MISSION

- To develop an integrated process for planning, policy, and services to ensure a coordinated quality system of care is available to individuals with behavioral health conditions and developmental disabilities.
A VISION FOR MARYLAND

- Coordinated quality system of care
- A full range of services available
- Linkages to service are seamless to the consumer
- Recognition that co-occurring and co-morbid conditions are the norm
- Improved overall health, wellness, and quality of life for consumers
Institute of Medicine (IOM) Six Aims of Quality

- Safe
- Effective
- Person-centered
- Timely
- Efficient
- Equitable
Triple AIM of the Affordable Care Act

- Quality/More Prevention and Primary Care
- Lower Costs
- Positive Patient Experience
Website References

- The National Council
  www.thenationalcouncil.org

- SAMHSA-HRSA Center for Integrated Health Solutions
  www.CenterforIntegratedHealthSolutions.org
THANK YOU!!!

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