Navigating Integrated Care Settings: a primer for behavioral health providers

Senior Director, Julie Schilz, BSN, MBA

Senior Program Manager, Kristin Potterbusch, MPH

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Learning Objectives

1: Understand basic principles of integrated healthcare

2: Identify ways for behavioral health providers to improve client care within integrated care settings

3: Recognize opportunities and strategies to build strong communication pathways across interdisciplinary teams

Agenda

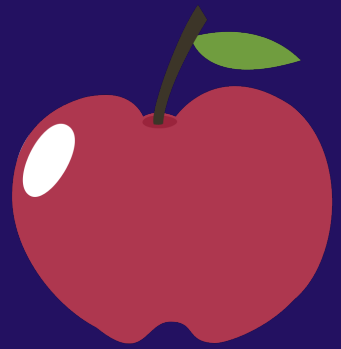
- Integration overview
- Navigating the physical health landscape
- Communication strategies
- Billing impacts

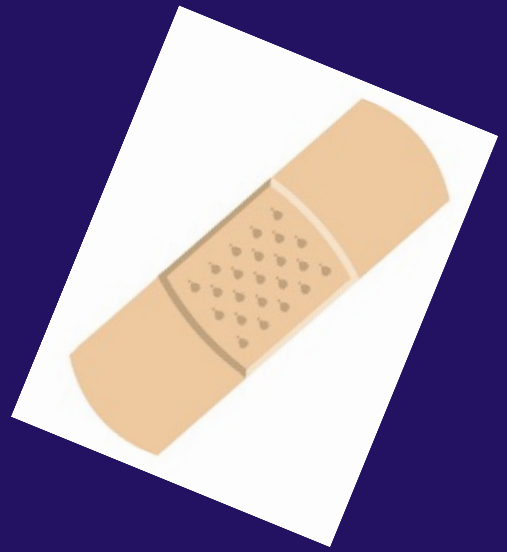
Integration Overview

PCDC Defines Integration as:

"*A unified and collaborative approach to care which centers on people and communities (that):*

- *Achieves a more equitable and inclusive health system*
- *Achieves broadened access to care*
- *Achieves improved health outcomes"*





Integration's Many Facets

Models

- Co-location
- Collaborative Care
- Integrated Primary Care

Pathways

- SBIRT
- MAT
- ACES

Principles

- Social Determinants
- Triple/Quad AIM
- Chronic Disease Management

Spectrum of Integration

Types of Integration

Coordinated Care (off-site)

Level 1: Minimal Collaboration

Patients are referred to a provider at another practice site, and providers have minimal communication

Level 2: Basic Collaboration

Providers at separate sites periodically communicate about shared patients

Co-located Care (on-site)

Level 3: Basic Collaboration

Providers share the same facility, but maintain separate cultures and develop separate treatment plans for patients

Level 4: Close Collaboration

Providers share records and some system integration

Highly Integrated Care

Level 5: Close Collaboration

Providers develop and implement collaborative treatment planning for shared patients but not for other patients

Level 6: Full Collaboration

Providers develop and implement collaborative treatment planning for all patients

Integration Continuum

Key Domains of Integrated Care		Preliminary	Intermediate I	Advanced
Screening, Referral to Care Follow-Up (f/u)	Screening and f/u for preventive and general medical conditions (GMC)	Response to patient self-report of general health complaints and/or chronic illness f/u when prompted.	Systematic screening for universal general health risk factors & proactive health education to support motivation to address risk factors.	Analysis of patient population to stratify by severity of medical complexity and/or high-cost utilization for proactive assessment tracking.
	Facilitation of referrals and f/u	Referral to external primary care clinical(s) and no/limited f/u.	Formal collaborative agreement with external PC clinic to facilitate referral that includes engagement and communication expectations.	Enhanced referral facilitation to onsite or closely integrated off-site PCPs with automated data sharing and accountability for engagement.
Ongoing Care Management	Longitudinal clinical monitoring & engagement for preventive health and GMC	None or minimal f/u of patients referral to primary & medical specialty care.	Some ability to perform f/u of general health appointments, encourage medical adherence, and navigation of appointments.	Use of tracking tool to monitor treatment response and outcomes over time at individual and group level, coaching and proactive f/u.

https://www.pcdc.org/resources/integration-at-work-quality-improvement-tips-for-integrated-care-settings/

When Can a PCP Use a BHC?

Common Behavioral Health Issues

- Parenting skills
- Diagnostic clarification and intervention planning
- Behavior and mood management
- Suicidal/homicidal risk assessment
- Substance abuse assessment and intervention
- Panic/anxiety management
- Co-management of somaticizing patients
- Interim check of psychotropic medication response
- Facilitate consultation with psychiatry regarding psychotropic medications
- Stress and anger management

When Can a PCP Use a BHC?

Common Medical Issues

- Any Health Behavior Change
- Management of High Medical Utilization
- Medication Adherence
- Weight Management
- Chronic Pain Management
- Smoking Cessation
- Insomnia / Sleep Hygiene
- Psychosocial and Behavioral Aspects of Chronic Medical Conditions (Diabetes, Asthma etc.)

Behavioral Health Providers are Key!

- Never underestimate your value
- New terminology can be a barrier
- You are an irreplicable part of the integrated team

Case Study

- MJ West, 15 yr old visiting PCP about knee pain and a cold and trouble breathing that has been exacerbated by existing asthma
- PCP conducts new routine PHQ-9 –A (BH depression screening modified for adolescents) and a CRAFT
  - MJ scores 0-4 range/"mild"
  - MJ quit soccer 2 months ago due to the knee pain
  - MJ reports negative interactions with the person MJ is dating
  - Positive CRAFFT score (2+)
- Review of MJ's medical history includes the following:
  - MJ's father smokes a pack of cigarettes day
  - Asthma

- *PCP realizes even with mild PHQ-9 score MJ needs to be connected to BH ASAP- something is going on.*

MJ's PCP's report includes

Physical exam:

- BMI= **23**
- BP **116/72**
- Pulse Ox= **98**

Screening

- PHQ-9 –A = 5-9 (mild)
- CRAFFT = 2+

Medications include:

- Maintenance inhaler: Inhaled corticosteroid medicine
- Emergency Inhaler: adrenergic bronchodilators.
- Ibuprofen

Assessment and Plan

- PCP reviews MJ's existing asthma action plan
- PCP creates the following management plan with MJ:
  - Maintain current asthma medications
  - Return for follow up in 3 months to check in
  - Behavioral health referral for mild screen and positive alcohol risk screen
- MJ scored positive on both the CRAFFT and PHQ-A. Therefore, the PCP refers MJ to a behavioral health provider (per CRAFFT and PHQ-A protocol)

What Role do you think a BH Provider Plays?

A. BH has no role beyond addressing MJ's depression and YSBIRT score, MJ's asthma and knee pain is being managed by MJ's PCP
B. BH can provide MJ with support to maintain current treatment regimen
C. BH can speak with PCP during next case consult about how MJ's mental health may intersect with MJ's care plan, and both providers can agree to collaboratively center MJ's care around a shared set of person-centered goals informed by MJ
D. BH can ask PCP to explain aspects of MJ's medications, physical health indictors, environmental factors, etc.. that are unfamiliar to ensure both BH and PCP are understanding needs and conveying the same messaging to MJ
E. BH can provide PCP with upskilling on MJ's needs, reactions and how to message information to MJ
F. BH will provide MJ with support and follow up around substance use and connect with PCP on trajectory
G. BH provider can connect with MJ's family around environmental factors and family resources/BH support
H. Other???

Common Chronic Health Conditions

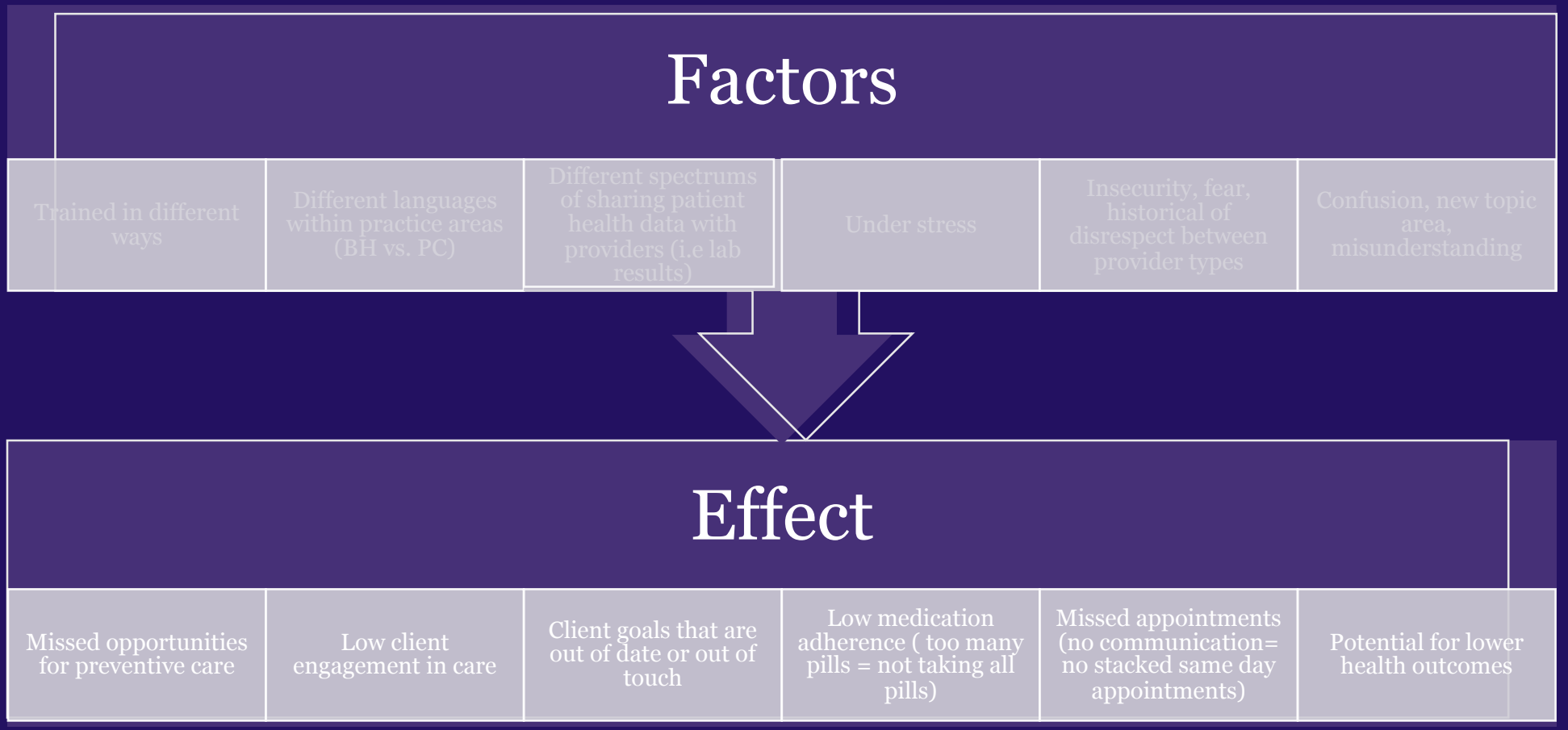
Common physical health areas:

- Diabetes
- Asthma
- Pain
- Sexual health

To check in about:

- A1C (below 5.7 is normal, above 6.5 is diabetic) and at home glucose testing (sugar test)
- Inhalers, ease of breath, panic attacks vs asthma attacks
- Physical therapy, SSRIs, opioid Rx, MOUDs(MAT)
- PrEP

Impacts of communication challenges



Stop, Start, Continue

Action	• What do we need to STOP doing?	• What do we need to START doing?	•What do we need to CONTINUE doing?
In daily huddles	Assuming all providers know the same acronyms	Rose and thorn on Mondays and Fridays	Prioritizing conversations about high intervention clients
In daily huddles		Assuming best intentions	

Common Types of Integrated Care Barriers

- Start law grey area vs. in-house BH (referral to entity where Dr. has financial relationship
- Can't bill for two same day visits
- Needs three visits pre-referral
- No in-house BH Providers and/or no care collaboration pathway infrastructure
- Patient already maxed out number of yearly BH visits (20)
- Would need to stretch truth on forms to allow for easier follow up care

Billing

- Complex within integrated care settings and state specific and/or payor specific
- May lead groups with additional team members
  - i.e smoking cessation group, RN may join
- Impacts on collaborative documentation, “huddles”, case consults and more
- If embedded within PCP setting, culture on billing may be new
- Ask up front to prevent challenges long term

Expansive Opportunities

- Collaboration leads to quicker sustainable pt./client wins
- Higher levels of care
- Actioning responsive care
- Integration allows for more of a strength-based approach
- Working with other providers lifts everyone's burden

Thank you!

Julie Schilz, BSN, MBA: jschilz@pcdc.org
Kristin Potterbusch, MPH: kpotterbusch@pcdc.org

For more resources:
www.pcdc.org/integrationworks
www.pcdc.org/sleep
www.pcdc.org/diabetes

Questions Regarding the Equity and Justice Focused Integrative Behavioral Health Training Project can be directed to:

ibhequity@sfsu.edu

To see a schedule of future events and archived webinars, visit:

ibhequity.sfsu.edu