We Can Do It! Taking Care of the Most Vulnerable Patients Through an Integrated Behavioral Health Approach

Mid-Hudson Family Medicine Residency Program

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AMERICAN ACADEMY OF FAMILY PHYSICIANS

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Introductions

- Institute for Family Health
  - Large non-profit network of FHQCs
  - PCMH & ACO
  - Sponsors 3 FM residency programs
- Who we are and what we do
  - Demographics of our program
  - Ephraim Back, MD, MPH – Program Director
  - Megan McMullan, MD – Associate Program Director
  - Cynthia Kim, LCSW-R – Behavioral Science Director

Learning Objectives

- Audience will have a better understanding of
  - Early attempts at integration and how to operationalize it into a normal patient workflow
  - The impact of increasing demand to understand and treat front-line mental health conditions in the family medicine setting
  - The services, scope of practice, documentation elements, and steps to consider in fully promoting integration
  - The potential value in residency education and in patient care

Poll Question

Do you expect residents to treat basic and stable but complex mental health needs?

A. Yes
B. No
C. Depends on the condition

Poll Question

Do you have easy access to behavioral health precepting or support during medical precepting sessions?

A. Always
B. Sometimes
C. Never

Poll Question

How comfortable are your preceptors in supervising this kind of care?

A. Very
B. Somewhat
C. Not at all

History

- Traditionally, mental health service delivery existed in silos of separate or semi-separate practice from family medicine
  - Case management, therapy, and the like required referrals to county or private services for the underserved and more well-off, respectively
  - Patients may or may not have made their way to these services and there was little communication, if any, regarding process or outcomes

Changing Landscape

- Recent changes in primary care service delivery have created opportunities for integration of mental health and behavioral health services
  - Medical organizations (especially non-profits, FQHCs) building positions for behavioral and mental health providers within the settings in which patients receive their medical care
  - ACO, PCMH models, DSRIP

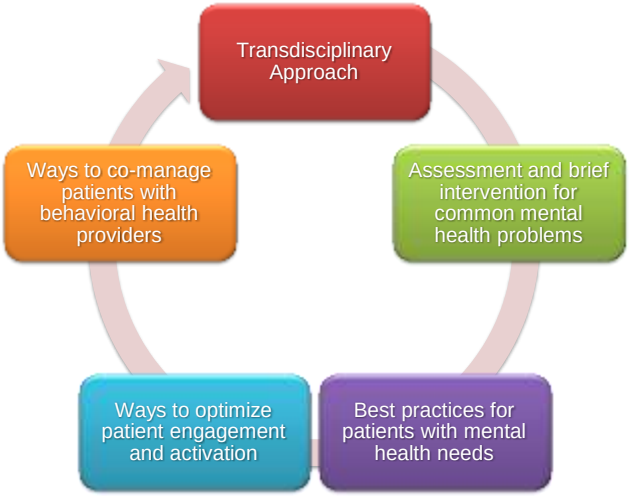
Changing Landscape

- Early attempts at implementing integrated practice have not met expectations
  - Co-location is not enough – often just facilitated referrals to behavioral health by medical providers
  - Many behavioral health providers were not directly collaborating within the medical practice
    - Had instead become enmeshed in a state of pseudo private practice within the larger setting

Changing Landscape

- Common barriers noted by doctors
  - Unaware who the behavioral health providers were
  - Limited access to these providers (e.g., lengthy wait lists)
  - Uncertain what kind or level of care was needed or received
  - Uncertain how to connect patients appropriately
  - Lack of information about patient progress
  - Increasing expectation that mental health needs will be met by family doctors
  - High staff and provider turnover rates

Changing Dynamics



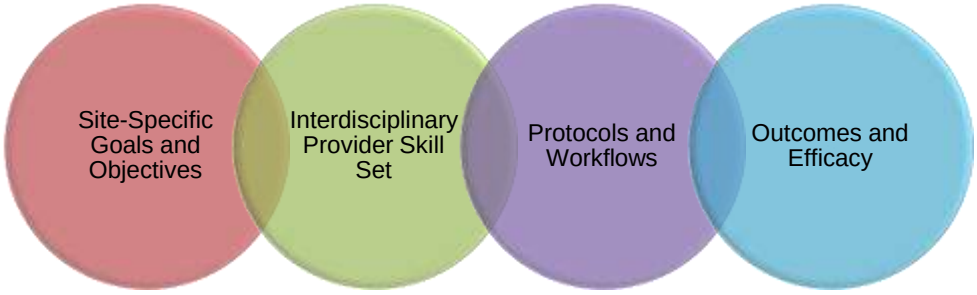
Re(de)fining Integration

- Residency training offers a unique venue for piloting true integration
- Continuum of Services
  - Case management (e.g., insurance, housing)
  - Care management
  - Counseling &Therapy
  - Psychopharmacology
  - Precepting & Consultation

Benefits of Integration

- Increased opportunities for resident education
  - Behavioral health precepting and consultation, psychiatric consultation, modeling of skills for residents
- Increased efficiency and efficacy in service delivery
  - Via interdisciplinary and transdisciplinary collaboration
- Financial benefits
  - Enhanced reimbursement rates and ability for providers to work to the fullest extent of their credentials
- Patient preference to receive care from their family doctor

Methodology



Resources Needed

- Behavioral and mental health providers at different levels of licensure who are committed to family medicine education
- An efficient and dynamic documentation system (EPIC)
- Administrative support
  - Practice management and scheduling
  - Flexibility in utilizing team members
  - Time for team meetings, huddles, case conferences
- Buy-in from family physicians, residents, and faculty
- Financial support (e.g., grants)

Poll Question

What are the barriers your organization or programs might face in attempting to better integrate care? Select all that apply.

A. Financial
B. Personnel
C. Workflows
D. Communication / HER
E. Provider / Admin Buy-in

IFH Model for Integration

- Moving beyond co-location of services and embedded behavioral and mental health services toward transdisciplinary practice
- Structured resident curriculum for behavioral health
- Fewer referrals and more warm handoffs and collaborative care
- Meeting the triple aim of healthcare
  - balancing short term costs with long-term gains in efficiency, efficacy, and patient satisfaction

Applications

- Precepting
- Consultation Clinic
- Warm hand-offs
- Dual-diagnosis and Substance Abuse
- Concurrent and bridge coverage
- Co-management

Optimizing Precepting

Then	Now
Case handed over to SW	SW pulled into visit w/doctor
Referral to BH or MH entered	In vivo case conference
Little ownership by doctor	Collaborative care
Fragmentation of care	Continuous, integrated care
One or two sessions per month of BH precepting	8 sessions per month

Benefits of Precepting

- Inspires confidence in the patient that they are receiving a collaborative, team-based approach to their care
- Ensures better likelihood of patient engagement and follow through/adherence with treatment recommendations
- Builds up the relationship among different providers in different disciplines
- Collateral education of medical preceptors
- Reduces unnecessary and/or inappropriate referrals to behavioral health
- Significant reduction in the latency of meeting patient's treatment needs

Psychiatric Consultation Clinic

- Family Medicine Psychiatric Consultation "Clinics"
  - Vetted referral made by resident or other doctor
  - Resident, psychiatrist, and licensed clinical social worker
  - Two 30-60 minute sessions per month for a one-time consultation for 3 or more patients per session
  - Family physician maintains ownership of psychiatric diagnosis and treatment

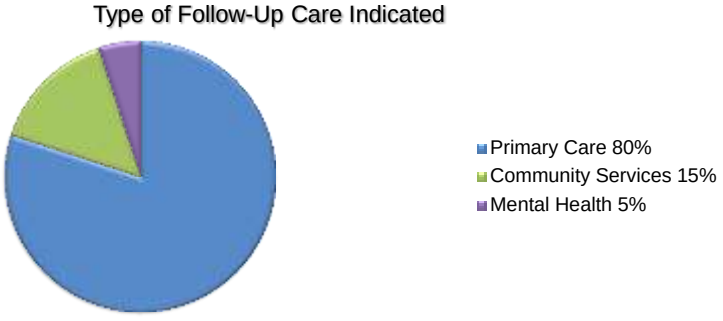
Psychiatric Consultation Clinic

- Process
  - Full biopsychosocial, diagnostic evaluation
  - Treatment recommendations and medication trial if appropriate
  - Follow-up visit scheduled during next available psych/behavioral health precepting session
  - Patient linked to additional resources or services if needed

Consult Clinic Video Clip

Psych Consult Clinic Outcomes

During the pilot year (1/2014-1/2015), over 220 patients were seen through the resident psych consult clinic



Buprenorphine Initiative

- Medication-assisted (buprenorphine) treatment for opioid dependence
- Part of a larger recovery process
- Team-based approach including social work and family medicine residents
- Linkages to community treatment resources

Buprenorphine Initiative

- Process
  - Initial phone screening
  - Biopsychosocial assessment and treatment recommendations
  - Medical consult with resident and attending
  - Induction and medical follow-up by supervised resident
  - Monthly SW health and behavior assessments during medical f/u visits

Documenting Integration

- Documentation elements
  - Ensuring consent is on file if patient is shared between clinic (e.g., article 28 and article 31) services or has outside services
  - Outreach to obtain records from other providers
  - Concurrent documentation and timely completion of progress notes
  - Documenting collateral contacts and case conferences

Documenting Integration

- Chief Complaints and Level of Service
  - Case conference or Case management
  - Collateral Contact
  - Clinical Supervision
  - Health and Behavior Assessments
- Progress Notes
  - Utilizing note templates, SmartSets, SmartTexts and SmartPhrases
- Clinical references or Dynamed documents for patient
- Patient instructions and after-visit summary

Documenting Integration

- Treatment Planning: Shared care plans, care coordination notes, and problem-list-based treatment plans
- Things to Include
  - Chronic illness, especially when exacerbated by mental health symptoms
  - Developmental, personality, or Substance Abuse issues
  - Collaboration with prescribing psychiatry or medical provider
  - List all relevant collaterals in narrative portion of plan and in care teams

Documenting Integration

- Documentation Elements: Care Teams
  - Review case lists and make sure patients' care team members are up to date
    - Critical for accurate and useful reporting
    - Add self and role
    - Add psychiatry provider if applicable
    - Add outside providers and roles if needed
  - Document in the care coordination, progress, or in a case conference note

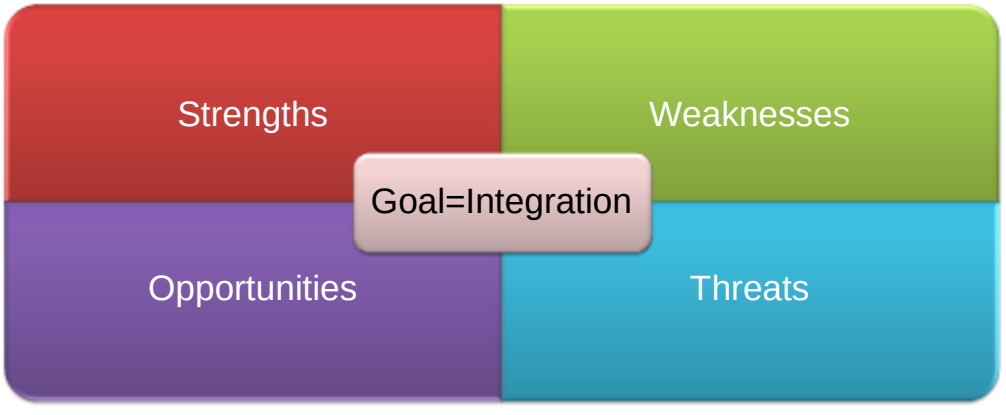
Future Directions

- Establish integration champion teams by program/site
- Group visits
- Exploring enhanced billing and reimbursement
- Pediatric behavioral health consultation model
- Transgender care

Final Reflection

- To what extent do you believe you are integrated into your practice site(s)?
- What are the barriers to integration at your sites?
- What are some ways to use patient outcomes to highlight the importance and efficacy of integration in providing quality patient care?
- What things could you change in your residency practice, in the spirit of integration?

SWOT Analysis



Resources

- Handouts:
  - SWOT worksheet
  - Psych consult clinic and precepting protocol
  - Decision support for psychotropic medication trials
  - Medication monitoring and side effects
  - Assessment tools for precepting
  - Available by request: Buprenorphine protocol for residency training

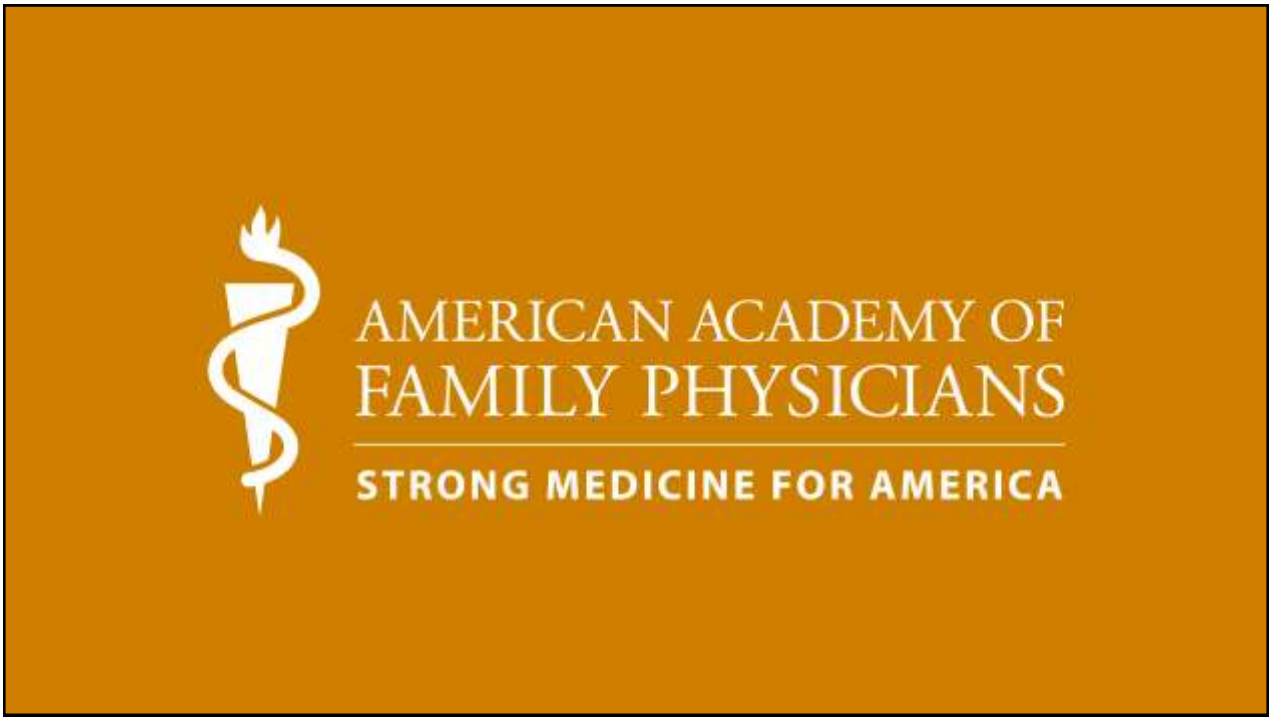
Questions and Answers

References

- AIMS Center (Advancing Integrated Mental Health Solutions): http://uwaims.org
- Davis, M., Balasubramanian, B., Waller, E., Miller, B., Green, L., Cohen, D. Integrating behavioral and physical health care in the real world: early lessons from advancing care together. Journal of the American Board of Family Medicine (2013); 26:588-602.
- Institute for Healthcare Improvement: http://ihi.org
- SAMHSA-HRSA Center for Integrated Health Solutions: http://www.samhsa.gov
- Solberg, L.I., Crain, A.L., et al. A stepped-wedge evaluation of an initiative to spread the collaborative care model for depression in primary care. Annals of Family Medicine (2015); 13 (5):412-420.

During the break…

- Discuss / think about how you might implement the information you just heard.
- Fill out a session evaluation.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