The Nuts and Bolts of Integrating Behavioral Health and Primary Care
Overview

This session will provide a brief overview of the integrated behavioral health model but the focus will be on how to make it work and what steps can be taken by administrators, medical providers, support staff, and behavioral health consultants to make it happen. Emphasis will be on the role of the behavioral health consultant's navigating primary care systems, resistance, and "dancing the BHC dance" in a way that benefits the patients, utilizes evidence-based treatments and does not interfere with clinic productivity.
Outline

• Rationale and Research
• Building a Foundation
• Learning to Dance-with two left feet
• Nitty Gritty of “Just Do It”
• Barriers and Problem Solving
• Ways BHC contribute to the Whole System
• A medical provider speaks out
• Resources/Help
Rationale

• Why integrate?
  – 50% of all MH care delivered in primary care
  – 92% of all elderly patients receive MH care from their pcp
  – 50% of high health care utilizers have MD disorder
  – 70% of all primary care visits have psychosocial drivers
  – 90% of most common complaints have no organic basis (Kroenke, K & Mangelsdorff, A.D. (1989). Common symptoms in ambulatory care: Incidence, evaluation, therapy and outcome. American Journal of Medicine, 86, 263-266)
  – 67% of psychoactive agents are being rxed by pcp
  – 80% of antidepressants are being rxed by pcp
  – Work pace often hinders careful management of those who are being rxed in primary care
10 most common complaints in adult primary care

- Chest pain
- Back pain
- Fatigue
- Shortness of breath
- Dizziness
- Insomnia
- Headache
- Abdominal pain
- Swelling
- Numbness
Chronic conditions that require/benefit from a behavioral health component

- Asthma
- Diabetes
- Hypertension
- IBS
- Obesity
- HIV
- Substance Abuse
- Frail Elderly
- Alzheimers
- Chronic Pain
- Somatization
Cost of depression

Increased rate of depression in patients with COPD, Diabetes, Congestive Heart Failure. Patients with chronic illness and depression have 2-5X the healthcare cost of patients with chronic illness alone.

Depression is the common factor in patients disabled (compared with patients equally ill but not disabled) by hypertension, arthritis, ulcers and asthma.

(Bachman, J. [link](http://www.wpic.pitt.edu/dppc/downloads/Depression_in_Disease_Management_Practices?for_Chronic_Conditions_FINAL.doc))
...just in case you are not convinced yet

- 15 US primary care clinics, 19.5% of 965 randomly sampled patients had at least 1 anxiety disorder. Each disorder associated with substantial impairment and 41% not currently receiving treatment. (Kroenke, K., Spitzer, R.L, Williams, J., Monahan, P. & Lowe, B. (2007) Anxiety Disorders in Primary Care: Prevalence, Impairment, Comorbidity and Detection. Annals of Internal Medicine, 146:5, 317-325.)

- Review of 40 studies- 75% of suicide victims had contact with primary care provider within the year of suicide,. 45% within a month of suicide, while 33% had contact with mental health services within a month of suicide. (Luoman, J.B, Martin, C.E., & Pearson, J.L. (2002) Contact with mental health and primary care providers before suicide: A review of the evidence. Am J Psychiatry, 159: 909-916.

- The World Health Organization proposes that there is “no health without mental health.” Their 2005 report comorbidity of chronic conditions with depression predict increased mortality in patients with HIV, coronary heart disease. Lancet; 370, 859-77.
Convinced of the need, but does integrated behavioral health really work?

- Care management is more effective when done by professionals with behavioral health skills (Pincus, Pechura, Keyser, et al., Administration & Policy in Mental Health. 33(1): 2-15, 2006)
- Improved process of care
  - Improved recognition of MH disorders
  - Improved pcp skills in rxing
  - Increased ppc use of behavioral interventions
Analysis of Behavioral Health Needs in Primary Care Population

- Kessler, et al (2005) estimates the following:
Building a Foundation

For no one can lay any other foundation than that which has been laid, which is Jesus Christ.
1 Cor 3: 11
Integrated Behavioral Health is in line with Holistic Christian Health Care

• “I pray that God, who gives peace, will make you completely holy. And may your spirit, soul, and body be kept healthy and faultless until our Lord Jesus Christ returns. The one who chose you can be trusted, and he will do this.” (1 Thessalonians 5:23-24)

• From the CCHF website:

Holistic approach

• People are created in God’s image - body, soul and spirit. We understand that those cannot be separated as we seek to promote health and restoration. Holistic approaches seek to address the health needs of the whole person. Integrated care, multi-disciplined approaches, and care teams can all be examples of holistic approaches.
What is needed to Get Started

- Right People to do the Job
- Buy-in from Providers, Billing, Administration and Support Staff
- Billing is quite a big headache---get some basics in place but don’t wait for a perfect situation before implementing your program
- Templates, assessments
- Works better if there are shared electronic medical records
Good Fit

- Natural curiosity and “learner” spirit
- Humility and humor
- Team player
- Intrigued with idea of helping patients function better
- Able to zone in on main difficulties and not get weighed down by myriad of issues patients experience
- Able to understand relationship between medical conditions and psychological distress
- Knowledge and comfort with psychopharmacology
- Evidence based practices
- Ability to integrate faith in practice while respecting diversity of faith
Good Supervision

- Supervisor needs to be in the trenches, with hands on work at all sites if possible
- Trouble shooter, problem solver
- Team builder, both within department and within agency
- Educator and trainer
- Provides face to face individual supervision with each BHC and monthly department meetings of whole team
- Advocate for staff for needed time during week to do administrative tasks
Buy-in

• Expect some resistance and flow with it
• Other systems within the system need to be understood, considered and reassured, and at times need to establish ways to work around less than optimal situations which may exist
  – Medical assistants
  – Clerical
  – Billing
  – Providers
• Consider assigning a PCP BHC liaison to assist the BHC department in communication, integration, developing protocols, and designing templates
I hereby authorize ________________ to administer such medications, local anesthetics and immunizations; and to perform such diagnostic procedures as may be necessary for any proper health care. This includes oral, surgery, general medicines, nutrition, social services, behavioral health consultation, and counseling. By signing this form I consent to _____________’s use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations. I have the right to read the Notice of Privacy policies before I decide whether to sign this consent, and that I can request restrictions concerning the use of my personal medical information by asking for a Restriction Form at the front desk.
No one seems to know how to get paid
- Complicated licensing and reimbursement rules without accessible experts

SOME INFO:
- AMA determines E&M and CPT codes
- CMS (Centers for Medicare & Medicaid Services) determines if and how they will reimburse the codes for Medicare
  - www.cms.hhs.gov
- Medicaid determines what should be adopted on state level (as long as not in violation of CMS rule)
Medicare

• Variation exists in the interpretation and application of the Federal program rules and guidelines
  – Fiscal Intermediaries often have a more narrow interpretation than Medicare law allows
  – Creates misunderstanding of policies and confusion at the practice level
  – Denies reimbursement for allowable procedures
Medicare

- Use Evaluation & Management codes 99201-99201 or 99211-99215 whenever possible
- Services must be medically necessary
- Practitioner must be practicing within their scope of practice
- Used in conjunction with a medical or psychiatric diagnosis
Health and Behavior Billing

- Medical diagnosis
- Medical bill – not mental health
- Billed by practice with Mental Health Provider:
  - Hospital license
  - Primary care office
  - Rural Health Clinic
  - Federally Qualified Health Center
Health and Behaviors Codes

- Patients with underlying physical illness or injury
- Where biopsychosocial factor may be affecting medical treatment
- Patients with cognitive capacity for the approach
- Physician documents need
- Assessment not duplicate of other assessment
Medicaid

• States have flexibility in defining covered mental health services
• Can choose to contract with managed care
• Billing requires both a diagnosis and a procedure code
  – Some states limit procedures, providers and/or practices that can use these codes
Philly FQHCs

As a network of about 4-5 FQHCs initiating BHC, the Health Federation worked with the local Medicaid HMO (CBH) to get approval to bill for the BHC model. This has worked well.

Medicare payments have not been addressed at a network level, mostly because most of the patients seen by the FQHCs are Medicaid or noninsured, underinsured patients.

At Esperanza possibly 25-30% of our BHC visits are with Medicare patients but we are still in process of figuring out billing.
How to figure it out

• Make friends with your billers and coders
• Make connections at the state level for Medicaid. Talk to the Provider Relations folks
• Find your Medicare site (www.lamedicare.com) and see what is available for you
• Talk with other providers doing this work

Seek out grants.
Foundation, continued
Templates, Assessments and Evidence Based Practices

- SOAP or APSO format for documentation
  Subjective, Objective, Assessment and Plan
  Assessment, Plan, Subjective, and Objective

My philosophy is the more clickers the better!

Usually IT staff are unfamiliar with developing templates in the emr, but providers are more proficient, again a good reason to have a pcp liaison for the bhc department.
Use easy standardized assessments that have solid research behind them:

- PHQ 9 for depression
- GAD7 for anxiety

Others? MMSE for dementia, PHQ 15 for somatization, MDQ or CIDI for bipolar

These are free domain and can be accessed and used without cost to providers.

Remember you are screening. Purpose is not to do a complete psychiatric evaluation. Assessments/screens are to help determine which patients need to be referred to specialty care, which patients can be managed in primary care, what their areas of difficulty are so that medication, if needed, and behavioral interventions can be designed to help improve those symptoms.

I found that when I began using assessments more intentionally, the pcps’ confidence in what I was able to offer increased.
Getting your Toolbox Ready

Know the common presenting problems and comorbid conditions - both psychological and medical
Presenting Problems

- Depression is one of the most common problems presented
  - 10-30% of patients
  - Pcps miss this in about 67% of patients
  - r/o suicide and do risk assessment
  - r/o substance use
- Roughly 20% of primary care patients meet criteria for one of the anxiety disorder diagnoses
- Approximately 30% of adults in US drink at elevated levels
Comorbid conditions

Depression:
  - Diabetes
  - Cancer
  - Heart Disease

Anxiety
  - Asthma
  - IBS

Mood Disorders
  - Neck/Back Pain

Substance Abuse, Trauma
  - HIV


TX that are suited to BHC visits

- Motivational Interviewing
- CBT
- Problem Solving
- Behavior Activation
- Relaxation Strategies
- Cognitive Tx (thought stopping, thought replacement)
- Spiritual Coping skills
Networking

- Internet Search
- Writing to authors of research articles – they love it when someone reads their stuff and actually shows interest 😊
- Participating in Health Federation trainings
  - Dr. Neftali Serrano happened to be the consultant for the Health Federation in assisting with establishing BHC in FQHCs in Philadelphia
- Using CCHF to find other BHCers (Hunter Hansen, Laurie Tone)
- Seeking a mentor
  - Dr. Virna Little of Family Institute in NYC has probably been the most helpful single resource – my boss met her at a conference
Don’t forget

• Child abuse clearance
• Police check
• FBI clearance

Putting it all together and mixing metaphors,
Take those nuts and bolts and waltz/dance/build/tango your way into primary care.
How I learned to dance

With two left feet
When will I see Patients?

Being visible was not quite enough at first

Providers seemed nervous that my services would slow down the flow

It seemed they were not sure what I was supposed to do.
• Shadow the medical providers
• Learn their style and language
• Observe the common issues patients have
• Advertise and sell your services to the provider
• If you wait until everything is in place, you will never start
• Begin with one or two providers who seem not to be threatened by mental health issues
• Take a few risks, don’t wait to be asked, or wait for referrals
In step with administrators

• Susan Post’s vision to provide behavioral health services integrated with their medical visit drove the program and is, in a large part, the reason for the program’s success at Esperanza.

• Collaborative management team paves the way for collaborative team work on the patient floor

• Remember to speak administrator’s language—most administrators look at things like budget, productivity, efficiency and added to the mix in a Christian health center are core values of faith and spirituality.

• Think systemically and offer insight/support to other departments.
In step with medical providers

The Provider:
- wants to know what BHC thinks
- wants information that will help her/him in the medical visit
- Usually does not want a lot of detail - short and sweet
- Is the team leader
- Is your primary “customer”
- Wants you to “have her/his back”
Out Of Sync

• Referrals without information (patient needs to see you, patient would benefit from seeing you, please see this patient)
• Provider not interested in feedback or assessment
• A “fix it” attitude rather than team work

• BHC does not give timely feedback
• BHC de-rails medical visit by lengthy encounters
• BHC does not consider medical conditions and does not read providers notes
In step with Support Staff

• Respect the work others do, and don’t get in their way!
• Offer to help, when you can
• Validate their work
• Make sure the MA is done before going in.
• If clerical has papers to give to the patient, offer to take them in (appointment slips, lab requests, etc.)
Just Do It

• Learn by doing
• Develop policies and procedures as you go
• Call it a PILOT
• Start small and get some processes in place
The “Typical” Patient who is referred to BHC at EHC

- Chronic health conditions: Obesity, diabetes, hypertension
- Medical complaints and no corresponding organic cause
- Many are already in outside psych and on a cocktail of psychiatric medications
- Unemployed or underemployed
- Dysfunctional family systems
- Hx of childhood sexual abuse
- Substance Use
Importance of Introduction

More interest and follow through when provider introduces BHC

Hello, my name is ___. I am a behavioral health consultant who works with your medical provider. This is part of the integrated care we give here at ___. I work with patients in the areas of stress, health concerns, depression and other issues that come up. Today your provider asked me to meet with you to discuss.......
The Ideal First Session

• Hit the ground running. The first session HAS to be therapeutic, it is more than collecting data. Give the patient something to go home with, at the least a sense of being heard, understood and valued.

• Create running hypothesis in your mind as to why patient is experiencing difficulty—be ready to revise as more information is collected. The question is What is keeping this patient from functioning?

• Give Hope in the first Session. Normalizing what patient is experiencing goes a long way.

• Offer to pray, if appropriate and do not be afraid to approach spiritual topics—often patients expect this at a Christian health care center.
Daily Work Flow
7-9 consults a day

“Prevention Education”
• Depression/Anxiety screening
• Sleep Hygiene
• Smoking Cessation
• Weight Management

“Warm Handoff”
• Consultation requested by the provider
• What is the specific consultation question?
• Does the patient share this concern?
Daily Work Flow

• Providing Consultation

  – 15-20 minute consultation in the exam room or consult room.

  – Focus is on functional assessment and behavioral recommendations to the patient and provider.

• Feedback to PCP-curbside consultation or through emr messages/documentation
DRSMAP- provider talk

- Demographics
- Referral reason
- Symptoms
- Motivation
- Assessment
- Plan
Barriers/Challenges

- Billing
- Providers Resistance
  - Will it slow me down?
  - Is it spiritual treatment or just psychobabble?
  - Does it really help?
- Limited Referrals
- Lack of Space
- Lack of Communication
- Learning how to work with patients who have OP tx
- Constantly new things- grant requirements/ PCMH/ new site
To Whom It May Concern, 1/12/12

As a practicing clinician of Esperanza Health Center, I have worked in conjunction with our Behavioural Health Department for the past over six years. In the past couple years a new model of brief interventional care at the time of medical office visits has been implemented under the direction of Les Book, LCSW.

Having practiced medicine for over twenty-five years and taught with the UC Irvine Kaiser-Permanente Family Medicine Residency for seven of those years, I have gained a familiarity with many different models of mental health care. From both professional and personal experience I have acquired a deep respect for the complexity of emotional, mental and spiritual issues that often need to be addressed in the course of health care.
Hence I admit that my initial reaction to a brief interventional model of mental health care during clinic visits was one of skepticism, fearing that disorders with very deep roots would often be only superficially addressed.

However my experience with EHC's behavioral health program has shown otherwise. As our counselors have met with patients at medical appointments, sometimes over the course of several visits, I have witnessed patients with a range of diagnoses and issues move from a place of avoiding mental health care to becoming actively engaged in their own growth. Often they report following the behavioral health "homework" recommendations with improvement in their symptoms. Many have developed a trusting therapeutic relationship with one of our counselors, with concurrent increased understanding of their mental health issues, and progressive growth and healing. Several have made the transition to establishing with other agencies for ongoing psychiatric and psychotherapeutic care.
Hence I can report I've been pleasantly surprised by the effectiveness of this mental health care model and look forward to continuing to work in the medical clinic with our skilled counselors.

Sincerely,

Randal S. Hirsch MD
Family Physician
Esperanza Health Center
Resources

- http://www.depression-primarycare.org/