



SAMHSA-HRSA Center for Integrated Health Solutions

Integration Models Lessons From the Behavioral Health Field

Presenters:

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Kathy Bianco, Care Plus NJ, Inc

Jennifer DeGroff, AspenPointe



The Wellness Clinic

Weber Human Services

Midtown Community Health Center

Karen Bassett, LCSW
Clinical Supervisor II and Project Director



Our Program

Weber Human Services (WHS) is located in Ogden, Utah and serves a growing urban population.

WHS is currently co-located with Midtown Community Health Center to provide physical health services in the Wellness Clinic.

We provide a medical clinic, behavioral health clinicians and prescribers, a pharmacy, and a laboratory adjacent to one another.



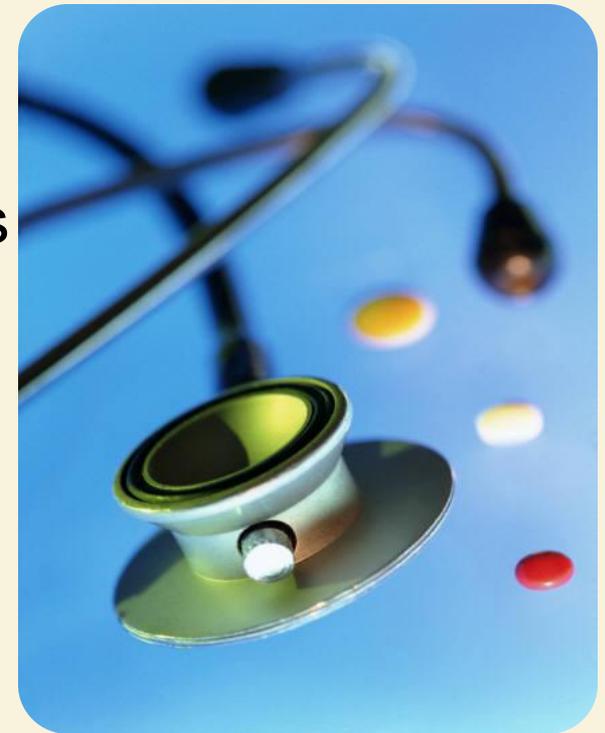
Level of Integration

- WHS is moving towards an integrated Healthcare Home
- Although mental health and primary care staff are employed by two different agencies, ***care is seamless to the consumer***
- WHS and Midtown use the same waiting area, customer care staff, laboratory, and pharmacy
- Joint bi-weekly case staffings include:
 - RNs, MDs, APRNs, Case Managers, Project Director, Care Coordinator, and Wellness Coordinator
- Monthly planning meetings include:
 - Administration from both agencies
 - Wellness Clinic staff



Services Provided—Physical Health

- Health & preventative screenings
- Immunizations
- Treatment for acute & chronic illness
- Medication management
- Referrals to specialty providers
- Prescription Assistance
- Prenatal care, family planning and birth control
- Sexually transmitted disease testing and treatment



Services Provided—Behavioral Health

- 21 MH clinicians providing Evidence-Based Practices
 - Motivational Interviewing
 - Psycho-Educational Multifamily Group Therapy
 - Dialectical Behavioral Therapy
 - Adult Outcome Questionnaire
 - Dual Diagnosis Treatment
- Skills Development
- Case Management
- Medication Management with 3 Prescribers and 4 RNs
- New peer support specialist program to provide 30 hours/week



Other Services Provided

- Free NAMI education groups for consumers and families
- Education Center in lobby
- Fully equipped on-site laboratory
- Pharmacy
- Advisory Board of clients and family members
- Services not provided:
 - Chronic pain management, court-ordered treatment, or prescriptions for controlled substances



Wellness Clinic

Time	Monday	Tuesday	Wednesday	Thursday	Friday
10:00	<p>Freedom From Smoking 6-week class</p> 	<p>*Personal Finances</p> 	<p>Cooking 101: A new adventure</p> 	<p>Food Sense- Helping Families Make Better Food Choices</p>	<p>Monthly Field Trip— Waterfall <u>Cyn</u> Nature Center Parkway</p>
Instructor	Shauna Williams	Shauna Williams	Shauna Williams Shannon, Peer Mentor	USU Extension Service 10:30-11:30 AM	
11:00	<p>Community Projects</p> 	<p>Nurse's Message on Health</p> 	<p>Walking in the Community</p> 	<p>Food Sense- continued</p> 	<p>Stress Management: Simple Yoga</p> 
Instructor	Shauna Williams	Martha Bodily, RN	Shauna Williams Bill, Peer Mentor	Rachel Valenzuela Alex Di Angelo	Sat Mandir Khalsa



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NAMI



Pharmacy



**Uninsured
Prescriber**



**Behavioral
Health**



Physical Health



**Wellness
Coordinator**



Laboratory



Care Coordinator



Wellness Clinic Team

WHS

Project Director
Quality Assurance/IT
Wellness Coordinator
21 BH Therapists
1 Psychiatrist
2 APRNs

Midtown

Clinic Manager
2 PH Providers
Care Coordinator
APRN (Uninsured)
4 RNs
3 Medical Assistants



Lessons Learned – Recruiting

- 50% of those who no-show to a 1st appointment will re-engage if called and offered another appointment
- Care managers of local hospitals are a great referral source
- Convenience:
 - Clinicians must be sold on the benefits of the clinic and have an easy process for referrals; monthly reminders are key; give clinicians a “cheat sheet” with a spiel for referrals
 - BH Med Mgt staff are a great source for referrals
 - The layout of the Wellness Clinic with all services in one wing is helpful for both recruiting and communication between PC and BH staff



Lessons Learned—Recruiting Part II

- Open house = great initial numbers, but retention issues
- Involvement with community partners (letters, visits, brochures) has not significantly increased referrals
- No difference (with recruiting) between our fancy brochure and a very inexpensive one
- Recruit dual diagnosis from substance abuse team
- Monthly drawing for clinician/med team/CC staff referrals



Lessons Learned—EHR--Junction

- Vendor: WHS Internal Software Development Team – 6 FTE
- Costs shared equally with 3 other BH providers
- Benefits of Internally Developed Software
 - Flexibility
 - Set own IT priorities
 - Quickly implement priorities
 - Customization without increased costs
 - Technically support internal initiatives



Lessons Learned – Wellness

- Magnetic wall with Wellness Calendar publicizes wellness tips and activities
- Food of any kind (even healthy) is a great motivator for getting individuals involved in the wellness classes
- “Bring a friend to Wellness” helps increase numbers in both the clinic and the Wellness Center activities.
- Monthly newsletter with health tips and calendar
- Advisory Board is a great recruiting tool



Lessons Learned

- Relationships are what keep our people engaged
- Health Navigator Training gets case managers motivated
- Encourage consumers to come in for all primary care needs and recognize when to use ER and InstaCares
- Monitor TRAC* numbers weekly
- Walk-through by staff of intake process to identify processes that need modification
- Satisfaction surveys also indicate areas for improvement

*TRansformation ACcountability System web-based data entry and reporting system that provides a data repository for CMHS program performance measures



Care Plus NJ Center for Primary and Behavioral Health

Kathy Bianco, APRN
Vice President, Clinical Services



Who We Are:

- Care Plus NJ has been providing community based mental health services for over 33 years
- Our service continuum includes a full range of acute care, sub-acute and community services
- We have over the past 20 years tried different models of addressing our clients multiple medical conditions



Our History With Primary Care

Time Frame	Model	What We Did	What Worked	What Did Not Work
1991-1995	Enhanced collaboration with outpatient hospital based medical clinics	<p>CPNJ nursing staff met with and developed positive collaborative relationships with clinic nurses</p> <p>Consult requests would be sent with dx, psych meds and reason for referral</p>	<p>Nursing staff enjoyed collaboration</p> <p>Appointment were tracked by CPNJ nursing staff so they could ensure consult requests were prepared and given to the client</p>	<p>Long wait for appointments</p> <p>Clients would get to the clinic and go to the hospital coffee shop</p> <p>Consult requests were not returned</p> <p>Any labs or testing would need to be "Chased"</p> <p>Frequent clinic staff turnover</p>



Our History With Primary Care

Time Frame	Model	What We Did	What Worked	What Did Not Work
1996-2002	<p>Collaboration with outside PCP's to provide services on site</p> <p>They billed for the service on their own</p>	<p>Nursing staff would assist PCP's onsite and provide needed follow up</p> <p>Labs were drawn onsite so results were returned directly</p>	<p>Documentation and lab/medical testing were available quickly</p> <p>Medications were entered into a central database and a bit easier to reconcile</p>	<p>Nursing staff were unable to attend to other duties while assisting PCP onsite</p> <p>Consumer often needed care on "off days", which resulted in ER use</p>



Our History With Primary Care

Time Frame	Model	What We Did	What Worked	What Did Not Work
2002-2008	<p>Added a Medical APN to CPNJ staffing</p> <p>This position did not become the primary care provider of record, however, provided sick care and assisted when consumers were “falling through the cracks”</p>	<p>Re budgeted for the position</p> <p>Prepared a small examining room</p> <p>Included this positions as part of the behavioral health team</p>	<p>Consumers utilized the ER less frequently</p> <p>This position served as a good liaison to inpatient medical units and for discharge planning</p>	<p>We were unable to refer to specialty care</p> <p>Consumers would become confused about who was treating them</p> <p>External testing (clinic) continued to be difficulty to track</p>



Our Model

- We hired our own primary care staff
- Bi-Directional and Embedded Care
 - Primary care within the mental health center
 - Mental health care within the primary care center
- Integrated and Multidisciplinary Treatment Team
 - Wellness Services are a Central Component
- Focus on:
 - Nutrition
 - Exercise
 - Stress Reduction



Our Transformation is ongoing....

- Developed a primary care practice
- Integrated teams
- Blended cultures
- Cross trained staff
- Blended treatment planning
- Built enthusiasm over outcomes



Team Roles

- Nurse Care Manager/Liaison
- Advance Practice Nurse
- Collaborating Primary Care Physician
- Psychiatrist
- Case Manager
- Clinician
- Peer Counselor
- Certified Diabetes Educator
- Nutritionist
- Dentist
- Podiatrist



Functional Areas of Integration

Access – “No Wrong Door”

- Psychiatrist, Therapist, or Mental Health Worker can bring client over as a warm hand off
- Reworking our ACCESS center to develop primary care skill set for new admissions

Services

- One treatment plan developed with our higher levels of care ie: partial care and residential services
 - Our goal is to integrate ALL treatment plans utilizing an EMR platform



Functional Areas of Integration cont.

Funding

- Billing will become integrated per project plan
- Funding/staffing will continue as blended for now
- Moving forward into a fee for service environment will require re-work of current system with maximization of all billing opportunities
- Advocacy efforts at the State level with Medicaid, HMO's, DMHS, and DMHSS



Functional Areas of Integration cont.

Governance

- One Board
- Strong project support from the Board of Directors



Functional Areas of Integration cont.

Evidence Based Practices

- Treatment team meeting include behavioral health and primary care
- Wellness programming is a large component of our programming; this takes time to build
- Very complex cases can be reviewed at a “higher level” if team is anxious
 - There is an opportunity weekly for this review



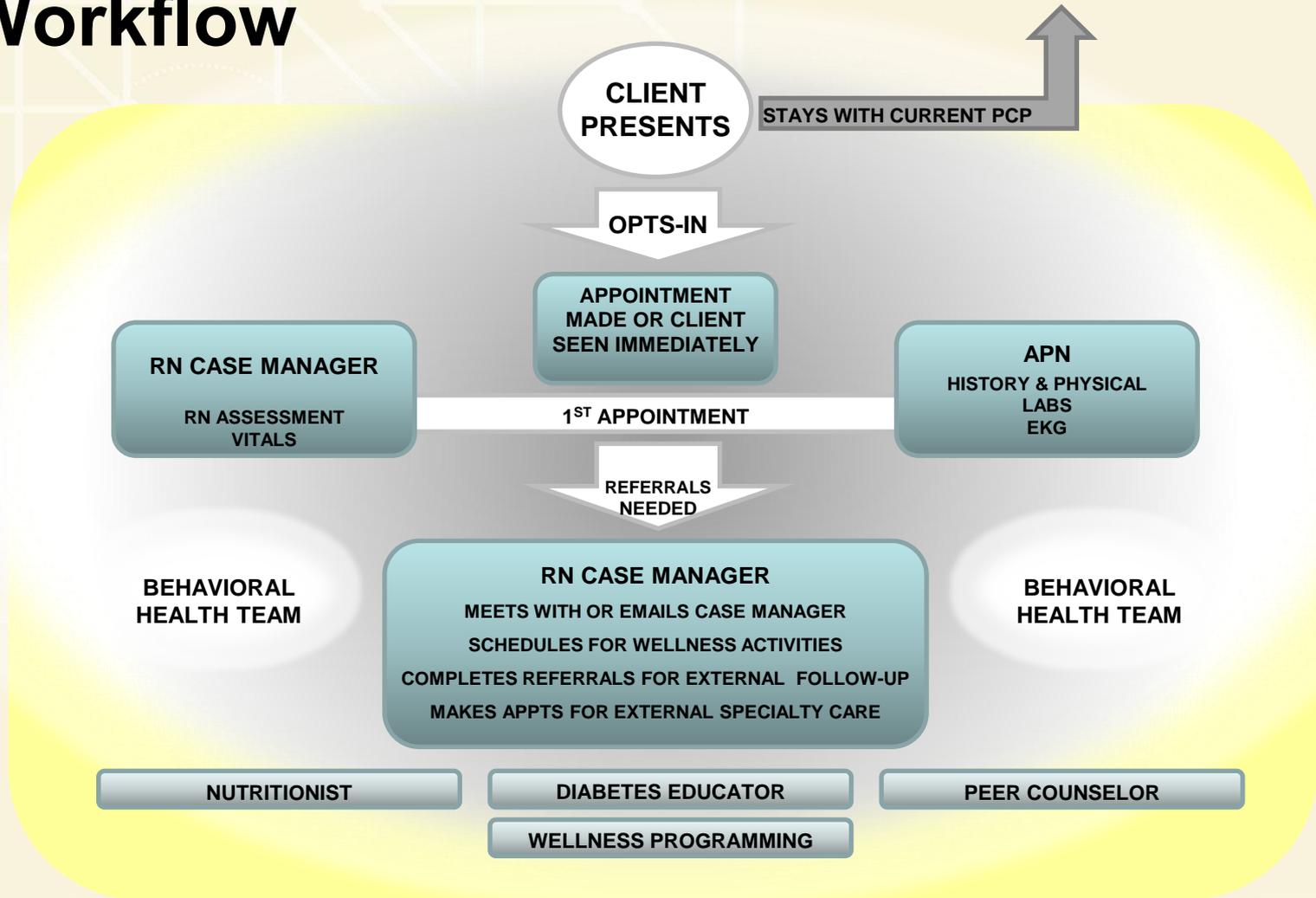
Functional Areas of Integration cont.

Data

- We have purchased an EMR for primary care
- Conducting due diligence for the behavioral health EMR needs
- GOAL – systems talk in real time
- Working with an HIE is underway to ensure system-wide sharing of data



Workflow



Outcomes

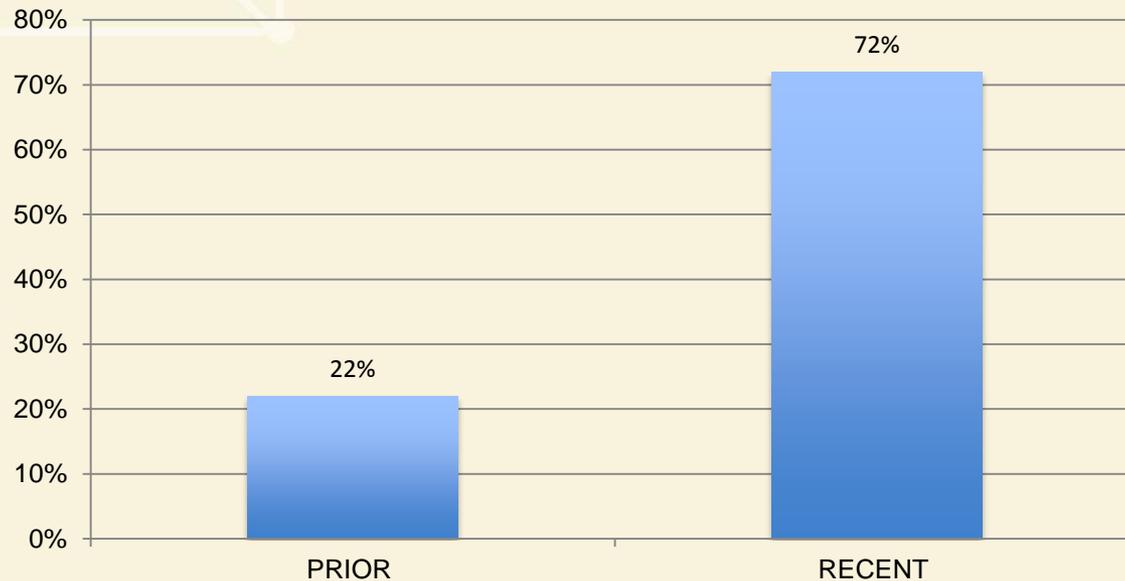
- 39% Initially Diagnosed with Hypertension
 - 92% are now Normotensive
- 48% Initially Diagnosed as Obese
 - Lost an average of 11 pounds
(*national average ~6-9 pounds*)



Outcomes: LDLs

“Bad Cholesterol” decreased for clients through use of Statins

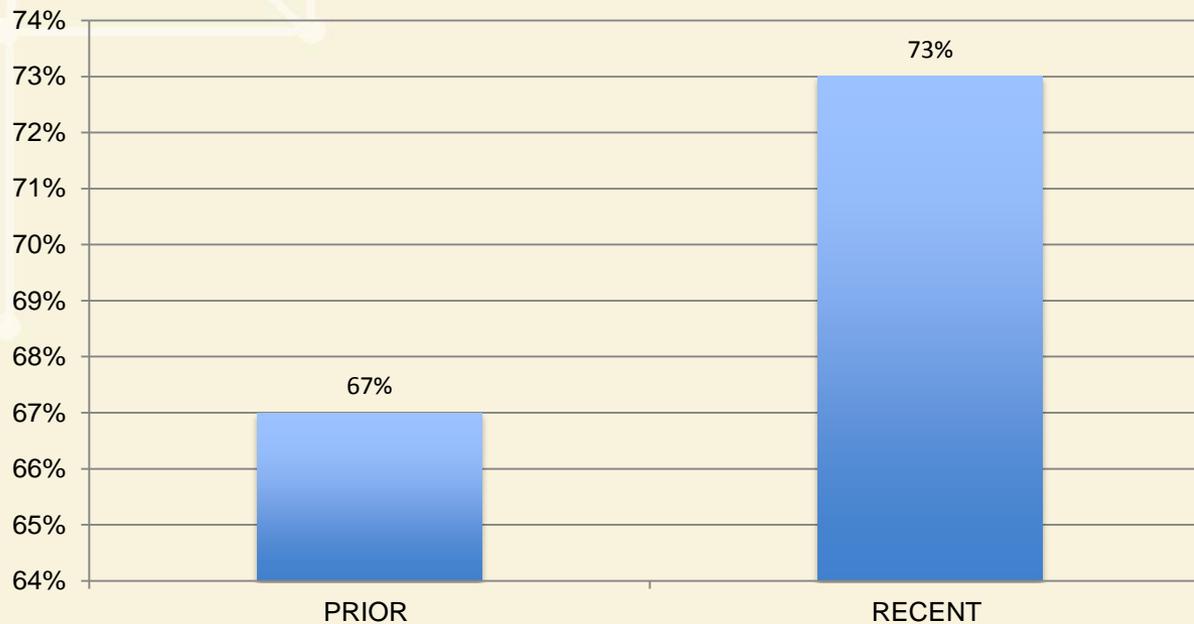
Goal: LDL <100



Outcomes: HDLs

“Good Cholesterol” increased for clients through TLC
(Therapeutic Lifestyle Changes)

Goal: HDL>40



Outcomes: HDLs

Triglycerides decreased for clients through TLC (Therapeutic Lifestyle Changes)

Goal: TRG <150



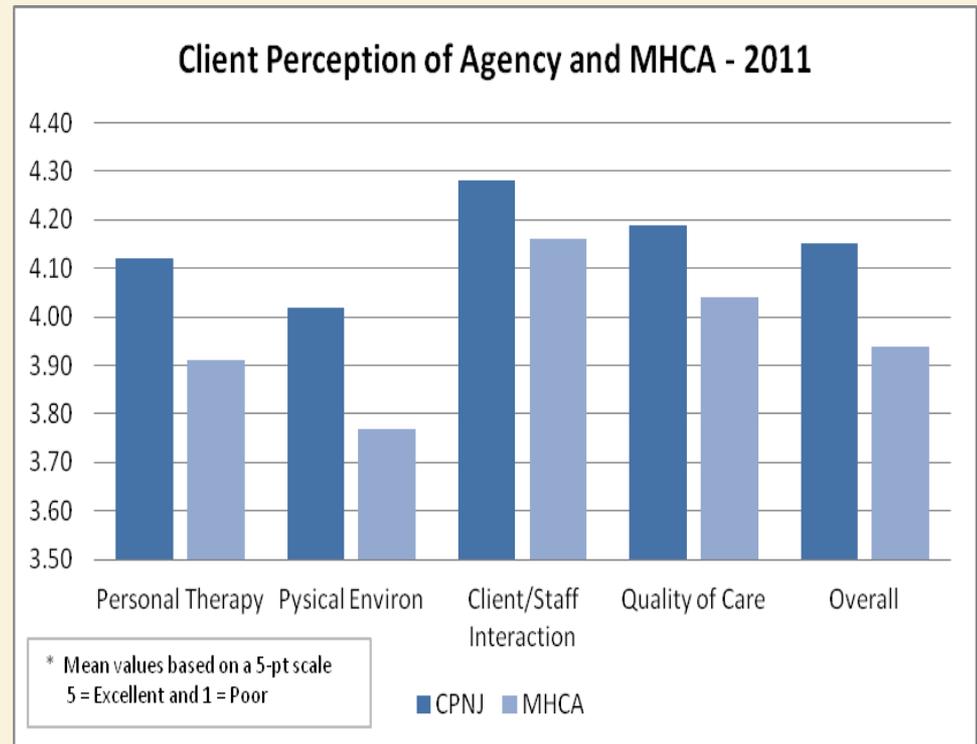
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Group Name	No. of Groups Per Week	Average No. of Attendees per week
Exercise Group	12	87
Walking Group	1	13
YMCA	2	8
YOGA	2	16
Weight Management	1	6
Wellness	1	24
Health Issues	1	17
Healthy Choices	1	24
Nutrition & Healthy Living	1	26
Cooking, Kitchen	1	12
Smoking Cessation/Holistic Wellness	1	18
Diabetes Education	1	12
Meditation & Relaxation	1	7
Breaking Unhealthy Habits	1	22
WRAP	1	6
Total	28	298



Client Satisfaction

- Ranked **Number 1** among all MHCA agencies with 5 or more programs
- Rated **higher than the MHCA** national database across all dimensions



AspenPointe and Peak Vista Community Health Center

Jennifer DeGroff, PhD
AspenPointe Health Services
Director of Outpatient & Integrated Care Services



AspenPointe – Peak Vista Story

The First Integration Project (2001)

- Vision: Co-located and partially integrated model
- Staffing: Therapist only
- Location: Peak Vista CHC Women’s Health Center
- Buy-In: Initially present for staff and leadership, but waned over time.
- Funding: Medicaid funding for some; no funding for non-Medicaid (generally un/underinsured)
- Project fell apart



The Second Integration Project (2006)

- Drivers that brought us together again:
 - CEO's had many concerns regarding future of Mental Health and Physical Health
- Vision: Close Collaboration and Partially Integrated System
 - Common scheduling
 - Treatment team meetings
 - Separate funding, shared on-site expenses
 - 2 governing boards
 - Sharing of EBP's across systems
 - Separate data sets
 - Collaboration around individual cases



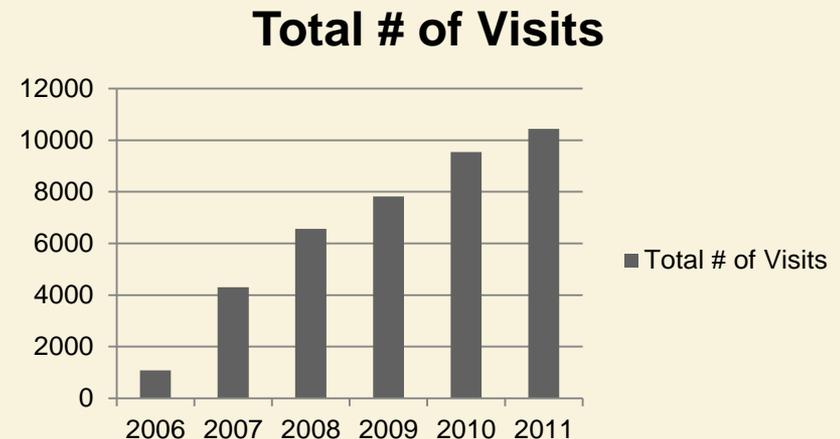
The Second Integration Project (2006)

- Started with a Therapist and then added Psychiatrist time
- Location: Peak Vista CHC Family Health Center @ Union
- Buy-In: Clinical and administration, BUT Increased Commitment to Success by Leadership
 - Regular corporate and management meetings
 - Clear the path attitude
 - **This project will not fail!**



The Current Model

- Partially Integrated / Fully Integrated
- Staffing: 9 licensed BHCs from AspenPointe
- Referrals: Directly to the BHC by the primary provider
- 39,762 BH visits since 2006
 - 2006: 3 staff
 - 2007: 4 staff
 - 2008: 6 staff
 - 2009: 6 staff
 - 2010: 7 staff
 - 2011: 9 staff



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



How do we fund it?

- AspenPointe pays staffing; Peak Vista pays building costs
- AspenPointe receives Medicaid units for services provided:
 - Peak Vista bills the medical visit but does not bill for Mental Health encounters
 - AspenPointe adjudicates against BH Medicaid
- Peak Vista does not bill indigent, Medicare, or 3rd party due to payor restrictions



What's Next for our Model?

- Increased focus on Health and Behavior issues, not just Mental Health issues
- Improved client transition back to Peak Vista once specialty MH care is done at AspenPointe (i.e., “back door”)



LESSONS LEARNED



Access – Must involve:

- Quick screening and assessment
- Brief focused interventions on same day
- Occasional return appointments for brief focused tx, but this cannot impede co-visits
- Ability to refer to higher levels of care when needed

Staff Match to Site and Project needs:

- Skill and temperament match
- Tendency to turn back to prior habits of care
- BHC must be eager to get out and connect – many times sell services to rest of primary care team until team understands the value the BHC brings to the team



Services:

- Service model must be well defined
- Both sides of the house must have familiarity with the Integrated Model

Funding:

- Funding often trips or halts the process – there are not a lot of ways to fund this yet!
- Must be open to looking for alternative sources of funding. Federal, state, private grants, billing code shifts with current payers, braided funding, win-win funding, staff sharing
- Make a decision to invest in your future healthcare opportunities even if there is not a clear funding stream at the start



Governance:

- Boards must be educated on Integrated Care models
- Board knowledge of Health Care Reform trends gives buy-in towards Integrated Care projects and conceptual support
- Board can influence strong ties to other healthcare partners in the community to explore new Integrated Care opportunities

Each organization has its own bureaucracy:

- Each organization needs to understand the organization of the other, including funding streams and restrictions as well as state and federal requirements around their services
- Each organization needs to determine who liaisons with whom at each organizational level



Leadership

- There must be CEO and C-Level buy in and support for human resources, finances, space, etc.
 - Senior leadership must understand the role of Integrated Care and the importance of this approach to our future
- Once the project begins there is a strong gravitational pull to move toward old ways of practice.
 - Corporate leaders and managers need to meet and cross inform beyond just the start up time period.
 - A clear-the-path mentality is essential for success
 - Integrated care must become the standard for many of our staff



Culture – Corporate, Medical/Psych:

- Calendar challenges – holidays
- Standard work hours
- Terminology
- Pace of medicine vs. mental health practice
- Roles of MD vs. NP vs. Therapists
- Having the team believe that this model will have the best outcome on patients/clients



Thank you!

Please feel free to contact me with questions:

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Q&A

Please type your questions into the dialog box



Thank you

For more information about the
SAMHSA-HRSA Center for Integrated Health Solutions
visit our website:

www.integration.samhsa.gov

