

Behavioral Health Integration: A Success Story (in Progress)

PCMH Learning Session #8
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Objectives:

During this session, participants will:

- Consider best practices in hiring an integrated mental health clinician
- Understand the steps in credentialing and preparing to bill for an integrated mental health clinician
- List factors involved in preparing a practice for an integrated mental health clinician

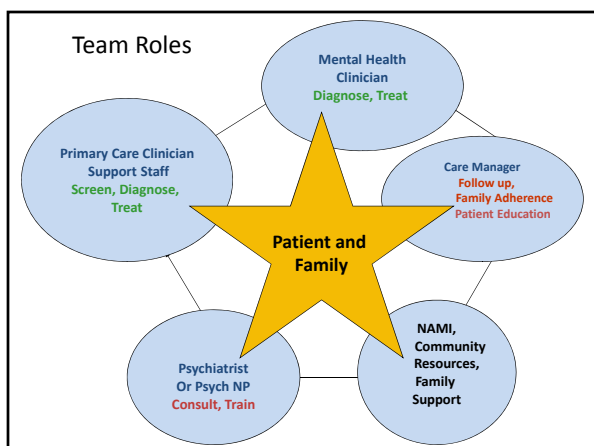
Levels of Integration

	Level	Attributes
Minimal Collaboration	I	Separate site & systems Minimal communication
Basic Collaboration from a distance	II	Active referral linkages Some regular communication
Maximized off-site Collaboration	IIA	Efficient and effective access to specialty mental health. Strong consultative relationships. Links to community resources and providers. Coordinated treatment.
Basic Collaboration on site	III	Shared site; separate systems Regular communication
Collaborative Care partly integrated	IV	Shared site; some shared systems Coordinated treatment plans Regular communication
Fully Integrated System	V	Shared site, vision, systems Shared treatment plans Regular team meetings

Further modified from Doherty, McDaniel, and Baird - 1996

Clinical Model

- Patient and family - the center of care.
- Professional connections between medical and mental health - crucial at all levels.
- Integrated mental health clinician – full member of the primary care team.
- Warm hand-offs & timely scheduling – access to integrated mental health clinician.
- Mental health treatment in primary care – brief/focused.
- Access to specialty mental health care - for patients whose needs exceed services available in primary care.



Why Integration?

Improves patient outcomes, experience of care and cost effectiveness

Mental health services in primary care, when appropriate, have positive impacts:

- **Increased adherence** - to regimens and treatment of mental health disorders
Unutzer et al, JAMA, 2002
- **Improved patient outcomes** - clinical and functional
Rost et al, JGIM, 2001; Simon et al, Psychological Medicine 1998; Unutzer et al, JAMA, 2002
- **Improved patient satisfaction** with care
Rost et al, JGIM, 2001; Unutzer et al, JAMA, 2002
- **Increased cost efficiency** - including primary and specialty costs for physical health care
Gilbody et al, British Journal of Psychiatry, 2006; Katon et al, Arch Gen. Psych 2002; Katon et al, Diabetes Care, 2008; Unutzer et al, American Journal of Managed Care, 2008

Outcomes: From Cherokee Health System

- FQHC's/CMHC's in TN
- Model of integration - similar to the one just described
- Utilization vs. others in region
 - 32% of ED visits
 - 58% of specialty visits
 - 63% of hospitalization rate
 - 78% of overall cost
 - 20% (Medicaid) to 28% (commercial) decrease in overall medical utilization post-MHI implementation

Hiring Process

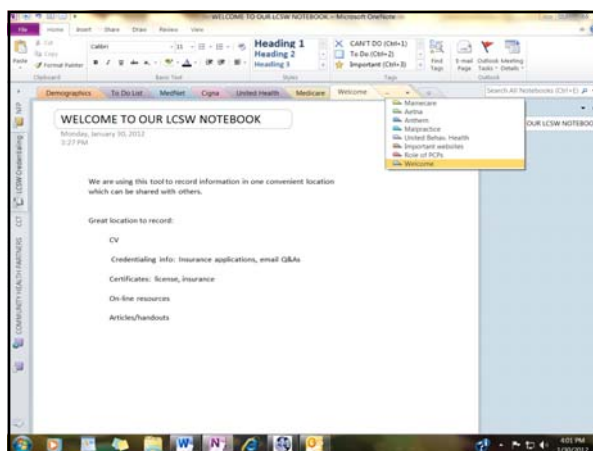
- Meeting Naya (“fit” with practice)
- Employer considerations –
 - salary/ benefits,
 - malpractice,
 - billing for services,
 - HRSA grant for loan repayment
- Role of the LCSW/ Services to be delivered

Practice Considerations

- Work flows
- Scheduling/pt reminders
- Place to see patients
- Computer
- HIPAA/Consents
- Staff confidentiality agreements
- Regular meetings (early & ongoing - a must!)

Funding and Regulations

- Credentialing (pitfalls and tips)
- Billing and coding for BH services
- Documentation/EMR



Preparing Patients and Staff for Integration

- Orientation for staff and providers
- Warm Hand-offs
- Introducing the integrated LCSW to patients
- Coordination with other services in the practice (education/care management) and community (resources and more intensive mh services if needed)

Evaluation

- How will we know this is successful?
 - For the practice
 - For our patients



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