Coordinating Behavioral Health and Healthcare – the Basics

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Quality Counts Learning Session
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Objectives

- Define care coordination and the roles of the team members
- Using case scenarios, identify workflows for best utilization of various roles
- Identify areas of overlap and/or gaps
- Explore ways to best utilize members of your team and in your community to better serve individuals with physical and behavioral health needs
Agenda

- Purpose – quadruple aim, comorbidities, context
- Definitions
- Care Team Components –
  - Health home/PCMH
  - BHH
  - BHI
  - CCT
  - Care Management
  - Case Management
  - Pop health
- Case
- Where are you now and where do you go from here?
The Quadruple Aim

- Better patient outcomes
- Best value
- Care Team joy in work
- Better patient experience
Patient Centered Medical Home (PCMH) – the Concept

Care is coordinated and integrated
(Behavioral Health)

Personal Physician
Enhanced Access
Physician Directed Practice
Payment for Added Value

Safety and Quality
Whole Person Orientation

From deGruy 10.10
Who are our patients?

Barnett et al. Lancet 2012
Medical Psychiatric Co-Morbidity

What is the context of their lives?

- Poverty
- Chronic Stress
- Multiple Chronic Conditions
- Isolation
- Loneliness
- Mental Illness

Dahlgren and Whitehead, 1991
Research indicates that persons with serious mental illnesses and substance use disorders die on average about 25 years sooner than the general population – mainly due to preventable risk factors (e.g., smoking) and treatable conditions (e.g., cardiovascular disease and cancer). This research has led the behavioral health field to seek ways to improve access to preventive services, wellness programs, and medical care.
What can we do?

- **Coordinate** care and **optimize** our roles
- Design our care and our team to meet our **patients’ needs**
- Ask - is our care what’s **best for our patients** and their families?
- Work to better understand **patient and family goals** and preference for their care

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2015 Baylor Scott & White Health
“If a person doesn’t have a roof over their head, if they don’t have a meal, if they’re a victim of physical or sexual abuse if their household has a lot of stress in it, if their kids’ school is not safe, then that's going to impact their health.....that health is more than just the pill that we’re giving you or the hospital that we put you in. It’s all the other parts of your life and whether they’re working in harmony.”

Dr. Jeffrey Brenner in interview “What Primary Care has to Learn from Behavioral Health”. National Council for Behavioral Health.
Care Coordination

The deliberate organization of patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of health care services.

“We're all going to have to give up some turf. After all, it's actually the patient's turf.”

Robert McArtor, MD, CMO MaineHealth
Who is involved?

- Care Managers
- Case Managers
- Behavioral Health Clinicians
- Care Coordinators
- Transition coaches
- Peer navigators
- Health coaches
- RN’s in the practice
- Primary care providers
- Primary care staff
- Family and community supports
- Other?
Health homes – Stage A – primary care

- Health Home = Medical Home primary care practice + CCT
- Payment weighted toward medical home
- Eligible Members:
  - Two or more chronic conditions
  - One chronic condition and at risk for another
<table>
<thead>
<tr>
<th>Levels of Integration</th>
<th>Level</th>
<th>Attributes</th>
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<tbody>
<tr>
<td><strong>Coordinated</strong></td>
<td>I</td>
<td>Minimal Collaboration</td>
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<td>Separate site &amp; systems</td>
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<td>II</td>
<td>Basic Collaboration at a distance</td>
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<td>Active referral linkages</td>
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<td>Some regular communication</td>
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<td><strong>Co-Located</strong></td>
<td>III</td>
<td>Basic Collaboration on site</td>
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<td>Shared site; separate systems</td>
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<td>Regular communication</td>
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<td>IV</td>
<td>Close Collaboration Onsite</td>
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<td>Shared site, some shared systems</td>
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<td>Routine communication and coordination</td>
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<td><strong>Integrated</strong></td>
<td>V</td>
<td>Close Collaborative Approaching Integrated Practice</td>
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<td>Shared site; shared systems</td>
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<td>Coordinated treatment plans</td>
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<td>Regular communication</td>
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<td>VI</td>
<td>Full Collaboration in a Transformed Integrated Practice</td>
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<td>Shared site, vision, systems</td>
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<td>Shared treatment plans</td>
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<td>Regular team meetings</td>
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<td>Population based behavioral health</td>
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Levels of Integration

Level I
- Separate site & systems
- Minimal communication

Level II
- Active referral linkages
- Some regular communication

Level III
- Shared site; separate systems
- Regular communication

Level IV
- Shared site; some shared systems
- Routine communication & coordination

Level V
- Shared site; shared systems
- Coordinated treatment plans

Level VI
- Shared site, vision, systems, treatment plans
- Regular team meetings, population-based behavioral health
What is Behavioral Health Integration?

A Behavioral Health Clinician working directly within a primary care practice:

- Treating patients and families in a focused treatment model
- Working as a member of the primary care team
- Consulting to primary care staff
- Linking patients with community services
- Linking patients to specialty mental health services when needed for intensive, ongoing and/or longer term treatment
- Focusing on the health of targeted populations
BHC’s value on CC team

- Direct service to Patient
- Link to specialty MH and SA treatment
- Liaison to psychiatric services
- “Triage” role with psychiatry referrals.
- Consultation to CC team
- System perspective
  - Behavioral lens for medical system
  - Medical system lens for behavioral health
- Expertise with individualized care plans tailored to patient
- Patient and family centered focus
Behavioral Health Clinician in Primary Care: How about those differences?
Behavioral Health Homes (BHH) – Stage B
Case management agency

- Community mental health agency with case management expertise + Health Home/primary care practice
- Payment weighted toward BHH
- Eligible Members:
  - Adults with Serious Mental Illness
  - Children with Serious Emotional Disturbance
- New way of managing care
- Service that
  - Focuses on mental and physical health needs
  - Helps access social services, transportation, and other supports
More than traditional case management

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<tr>
<th>Traditional Case Management Functions</th>
<th>BHH added Functions</th>
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<tr>
<td>Self-management skills and self-care plans</td>
<td>Include health and physical health</td>
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<td>Shared decision making</td>
<td>Extends to work with primary care</td>
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<td>Care coordination</td>
<td>Focused on coordination with primary care</td>
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<td>Person as the center of the team</td>
<td>Team includes primary care</td>
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<td>Access to resources</td>
<td>Include health and wellness resources</td>
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<td>EMR and shared information</td>
<td>Care plan shared with primary care and entire care team</td>
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Health Education and Prevention Activities

- Holistic approach – connecting mental and physical health
- Evidence -Informed Medical Care – use of the portal to understand whole person use of health system.
Community Care Team

- Health Homes
- Behavioral Health Homes
- Community Care Team Social Workers and Health Guides
- Care Managers
- Community Supports and Resources
- Other?
The Primary Care Team –
Can you spot the Behavioral Health Clinician, the Care Manager, the coach, the CCT?
What is population health?

An approach to care that utilizes information on a group of patients (population) within a primary care practice, or group of practices (practice based), to improve the care and clinical outcomes of those patients.
Population health

- Access to population health data to:
  - Inform the work
  - Identify programmatic needs, e.g., groups, education for case managers
- Health Home and BHH Enrollment System Portal
- 10 measures
- Quality Improvement Initiatives
Patient Risk and Capacity

Clinical/Condition Burden

<table>
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<tr>
<th>End of Life</th>
<th>Significant/Critical Clinical Risk</th>
<th>Long-term Condition(s)</th>
<th>Pre-Condition Risk</th>
<th>“Healthy”</th>
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<td>Self-Managing</td>
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<td>Capacity Risk</td>
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<td>Compromised Capacity</td>
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Capacity to Manage Burden
Meet Margaret
Complex Care Teams
(Social, behavioral and medical complexities)

Providing:

- A multidisciplinary approach to complex care coordination;
- Team collaboration;
- Community resource partnerships, and
- Standardized best practice interventions
Care Coordination Success Factors

- Clarity, connection and non-duplication of roles, functions, responsibilities
- Clarity about population being coordinated
- Timely and accurate data
- Tracked and shared outcomes
- “Partnership” approach to care
- Individualized patient centered planning process for care plans
- Shared care plans and “alerts” throughout system
- Standardized coordination of care
  - “Team” members have assigned tasks based on individual care plan
  - “Team” lead to manage complex care situations
Strategies to Improve Care Coordination

- Identify **who is coordinating care**
- Identify **leaders**
- Hold **multidisciplinary case presentations**
- Target specific patients, design services around individual’s goals, coordinate care, **track results**
- Identify **impact measures**, e.g., ED usage for specific populations
- Make **connections with community** providers and continuum of care
Activity
The care coordination team

BHH

PHO Care Manager

HH

Care Coordination Services

PCMH

CCT

Population Health
Resources

Websites

- [www.uwaims.org](http://www.uwaims.org) - Advancing Integrated Mental Health Solutions – resources for implementation from University of Washington
- [www.integratedprimarycare.com](http://www.integratedprimarycare.com) – National clearinghouse site for information on integrated care from University of Massachusetts.
- [www.integration.samhsa.gov](http://www.integration.samhsa.gov) - SAMHSA-HRSA Center for Integrated Health Solutions

Publications