



## Benton Health Services

Integrating Public Health & Primary Care to meet the Health Needs of People with Mental Illness, and Psychosocial stressors

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## The Context For Integration

- National Concern about health care outcomes
- Escalating healthcare costs
- Diminished scope of Public Health, especially Community Mental Health
- Persons with Mental Illness die as much as 25 years earlier than general population, mostly due to medical causes
- More people seek help for mental health problems in primary care

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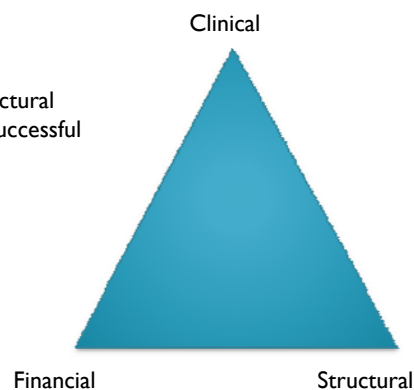
## Why Is Integration Important Now

- Most referrals between Community Mental Health and Primary Care fail
- Mental Health and Substance Abuse programs cannot accommodate the demand, let alone the need
- Stigma around mental illness persists
- Widespread acceptance of holistic health
- Mental Health carve-outs are threatened

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## Elements of Integration

Clinical Integration requires financial and structural supports in order to be successful

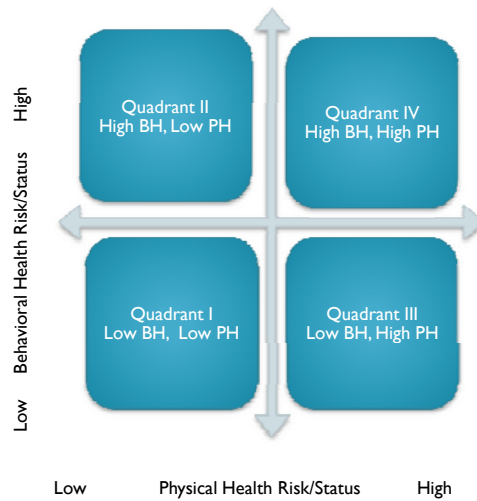


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# Clinical Integration

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## The Four Quadrant Clinical Integration Model



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## Quadrant I: Low BH/Low PH

### Current Initiatives

- Psychiatric Consultation 2 hours per week, and by phone
- PCP – based Mental Health
- Generalized Public Health education and prevention
- Community referrals

### Future Initiatives

- Standard screening tools and BH practice guidelines for Primary Care
- Symptom Specific education and support groups
- Peer Run Support and Services

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## Quadrant II: High BH/Low PH

### Current Initiatives

- Mental Health Professional as Care Manager is responsible for coordination with Primary Care
- Evidence Based Mental Health Practices
- Co-occurring MH/SA treatment services
- Psychiatry in SA services
- Housing, Educational, Vocational Supports
- Community referrals and coordination

### Future Initiatives

- Psychiatric Nurse Practitioner as consultant to colleagues in Primary Care
- Behaviorist as link from Primary Care to Specialty Mental Health

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### Quadrant III: Low BH/High PH

#### Current Initiatives

- Behavioral Health Screening and services
- Patient Education for managing chronic illnesses
- Community referrals
- Psychiatric consultations

#### Future Initiatives

- Supportive Counseling as needed by Psychiatric Nurse Practitioner
- Peer Run Support and Services

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### Quadrant IV: High BH/High PH

#### Current Initiatives

- Evidence Based Mental Health Practices
- Co-Occurring MH/SA treatment services
- Psychiatry in SA services
- Housing, education, and vocational supports
- Community referrals and coordination

#### Future Initiatives

- Behaviorist as Care Coordinator
- Focus on Diabetes, Chronic Pain, and Substance Abuse to start
- Care coordination meetings at least twice annually
- Peer delivered support and services

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## Structural Integration

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### Structural Integration supports Clinical Integration

- Use of Care Teams
- Use Public Health functions to support the model
- Shared EMR when co-located PC and MH
- Shared Quality Assurance/Quality Improvement activities
- Mental Health Screeners triage all requests for Mental Health services: one front door for all

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## Psychiatrist Role

- Psychiatric Evaluation
- Medication reviews
- Consultation & Recommendations to Primary Care
  - Sees for consult and refers back
  - Co-manages with PCP
  - Medical Director and staffs the Mental Health Clinic
- Training

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## The Role of the Mental Health Screener

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## Financial Integration

- Public sector financing is a major barrier to achieving clinical integration in most settings
- Without FQHC, need to explore pilot projects, grants, development opportunities
- FQHCs are “natural” partners in providing care to underserved populations
- Most communities have Primary Care Providers known for their work with the underserved

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## What Are Our Next Steps

### Clinical

- Begin to move care of people who met criteria for Quadrant I and III level of care to Primary Care
- Enhance the screening process at the “front door”
- Improve our prevention and education activities, using evidence based practices
- Evaluate health outcomes for people being served in an integrated care team

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## **Structural**

- Behaviorists on each Primary Care Team
- Fully integrated Electronic Medical Records
- On-going evaluation of the organizational structure, including management
- Continued education, re-training, and skills building of staff (anticipate future staffing patterns)

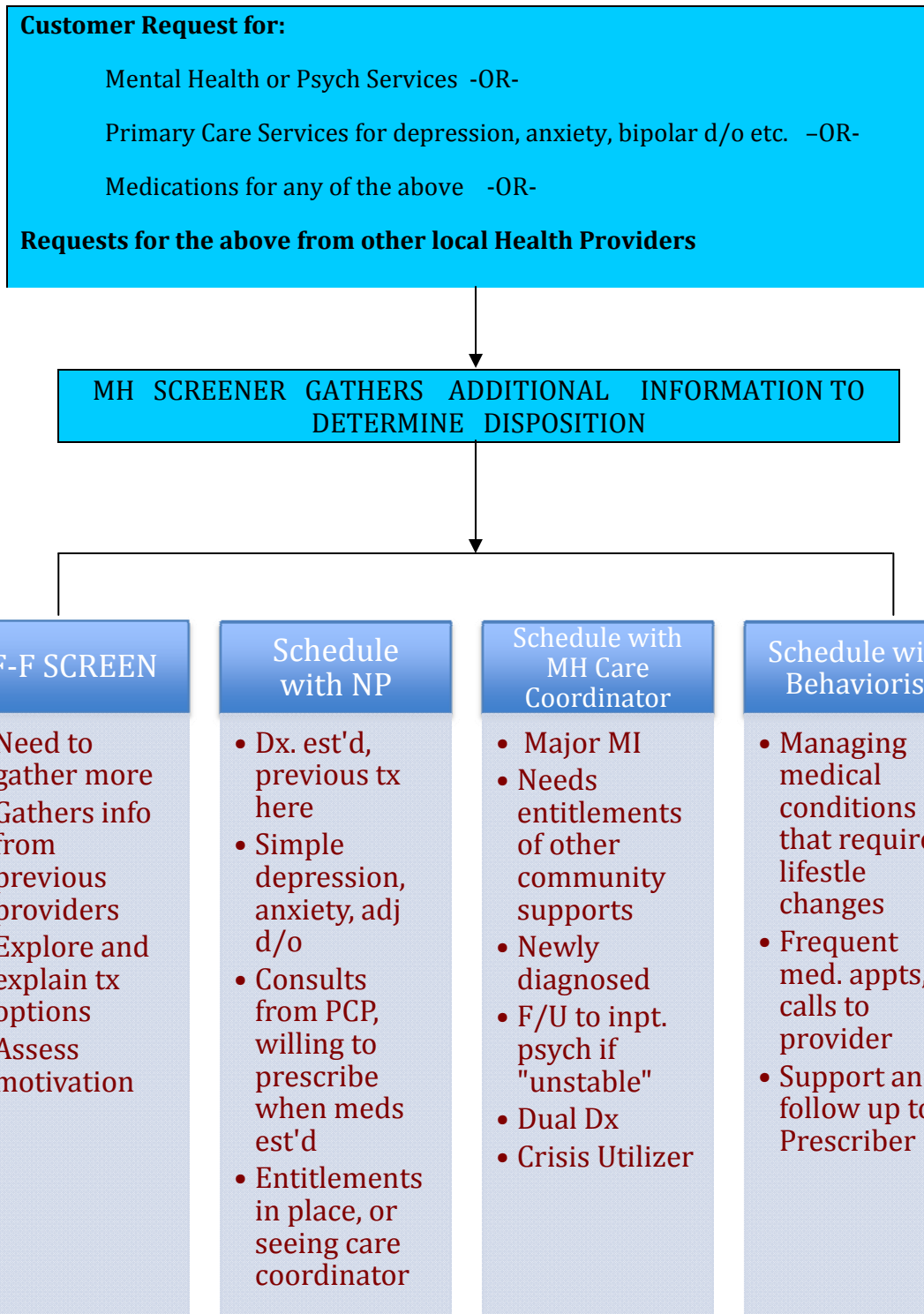
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## **Financial**

- Greater emphasis on billable hours/productivity
- Shared risk/ shared opportunities
- On-going advocacy, education, demonstration of the effectiveness of the model with policy makers: Challenge the funding streams

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# Triage Flowchart



# Triaging People with Mental Health Needs

## Option 1. (Quadrant I): Low Behavioral Health/Low Physical Health Needs

<b>Medical Home:</b>	Primary Care Provider
<b>Description of Care Plan with Provider:</b>	4–6 visits with prescriber for routine care PRN visits otherwise (example: flu, sprained ankle, cold)
<b>Admission Criteria:</b>	Adaptive functioning (GAF: 66 and above) Problem Severity Scale: 0–2 on all subsections No psych admits for 2 years, or crisis activity for past 18 months
<b>Services Available:</b>	Annual check-ups and labs Patient Education for managing chronic illnesses Behavioral health screening and services Solution focused brief therapy Symptom related support and education groups Community referrals Psychiatric Consultation Peer Run Support and Services
<b>Care Coordination:</b>	Does not require specialized care coordination

## Option 2. (Quadrant II): High Behavioral Health/Low Physical Health Needs

<b>Medical Home Location:</b>	Enrolled in Community Mental Health
<b>Care Plan:</b>	4-6 sessions with LMP for evaluation, then monthly for up to 10 months, then as needed for follow-up
<b>Admission Criteria:</b>	<p>Dangerous to self or others (GAF:0-19)  or impaired functioning (GA: 20-45) or  Distressed functioning (GAF: 45-65)</p> <p>At risk for immediate hospitalization, or more than 3 episodes in the last 6 months, or need for continued services to avoid hospitalization</p> <p>PSS: A score of 3 or greater in at least one subsection of "f" thru "l", or "yes" on section "j"</p>
<b>Services offered:</b>	<p>Annual psychiatric evaluation</p> <p>Evidence Based Mental Health/SA practices</p> <p>Screening for the Life Cycle</p> <p>Risk Assessments as indicated</p> <p>Case management, housing, educational and vocational support</p> <p>Community referrals</p> <p>Behavioral Health Consultation</p>
<b>Care Coordination:</b>	Community Mental Health QMHP

### Option 3. (Quadrant III): Low Behavioral Health/High Physical Health Needs

<b>Medical Home Location:</b>	Primary Care Provider
<b>Care Plan:</b>	Unlimited, seen as often as needed
<b>Admission Criteria:</b>	Adaptive functioning (GAF: 66 and above) Problem Severity Scale: 0-2 on all subsections No psych admits for 2 years, or crisis activity for the past 18 months
<b>Services offered:</b>	Patient Education for managing chronic illness Behavioral Health Screening and Care Solution Focused Brief Therapy Symptom Related Support Groups Community referrals Psychiatric Consultation Peer Run Support groups or services
<b>Care Coordination:</b>	RN in Primary Care

## Option 4. (Quadrant IV): High Behavioral Health/High Physical Health Needs

<b>Medical Home Location:</b>	Enrolled in Community Mental Health
<b>Care Plan:</b>	<p>4–6 sessions with LMP for evaluation, then monthly for up to 10 months, then as needed for follow up</p> <p>Unlimited primary care visits</p>
<b>Admission Criteria:</b>	<p>Dangerous to self or others (GAF:0–19) or impaired functioning (GA: 20–45) or Distressed functioning (GAF: 45–65)</p> <p>At risk for immediate hospitalization, or more than 3 episodes in the last 6 months, or need for continued services to avoid hospitalization</p> <p>PSS: A score of 3 or greater in at least one subsection of “f” thru “i”, or “yes” on section “j”</p>
<b>Services offered:</b>	<p>Annual psychiatric evaluation</p> <p>Evidence Based Mental Health/SA Practices</p> <p>Screening for the Life Cycle</p> <p>Risk Assessments as indicated</p> <p>Case management, housing, educational, vocational support</p> <p>Community referrals</p> <p>Peer Run Support groups or services</p> <p>Monthly staffings</p> <p>At least bi–annual care meetings</p>
<b>Care Coordination:</b>	RN in Primary Care