The Integration of Mental/Behavioral Health Program into a Primary Care Organization

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The Baton Rouge Clinic Experience

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Learning Objectives

- Explain how to select a partner and an integration model for your practice
- Identify the key operational components that are needed to successfully integrate mental/behavioral health within Primary Care
- Understand key characteristics needed to successfully build a partnership with a mental health organization and a primary care group

THE BATON ROUGE CLINIC AMC

Caring for Generations

Established 1946

Established in 1946, The Baton Rouge Clinic, AMC is the largest physician owned multispecialty clinic in the southeastern region.

One Main Campus With 9 Additional Locations

- 146 Physicians
- 30 Clinicians and Mid-level Providers
- 19 Different Medical and Surgical Specialties

Over 250,000 active patient charts at any one time

Our Partner: Capital Area Human Services

- A quasi-governmental entity defined in law to act as the Mental Health, Addiction Recovery, and Developmental Disability Authority in the greater Baton Rouge Area.
- Oversight ~ Reports to a citizen board to ensure local responsiveness.
- Provides clinic-based/decentralized services to clients of all payers.

Our Partner: Capital Area Human Services:

- Has population health responsibility to identify trends and work with other providers to prevent/respond to community-based needs.

- Mission includes “enhance (clients’) ability to improve their physical health and emotional wellbeing”.

Major Steps	Subcomponents of Each Major Step	
Program Planning, Needs, Readiness and Design	• Assess needs and interests • Determine the right population to focus on • Determine the right model approach • Create your processes, your policies and your tools • Train your staff and communicate your new services to your patients	Prelaunch
Patient Screening, Referrals and Engagement	• Start screening your targeted population • Engage and introduce the patient to the BH team member • Establish a protocol for interventions based on screening results • Refer patients to either a behavioral health therapist or to specialty behavioral health for those with serious mental illness	Post-Launch
Care Delivery/ Patients with a B.H. DX	• Conduct a comprehensive assessment of the patient's behavioral needs, barriers to care, a care plan, an impression of the case • BH therapist to provide cognitive behavioral therapy and will, with failure to progress, determine if changes in care plan may be needed, i.e. medications, consult or staffing with a psychiatrist or PCP • Coordinate findings with PCP & monitor changes in screening scores	
Monitoring of patient and overall program effectiveness	• Evaluate program metrics quarterly • Identify areas of opportunity to optimize metric performance • Evaluate need to create community resource(s) partnerships	

Levels of Integration

MINIMAL	Mental health providers and primary care providers work in separate facilities, have separate systems, and communicate sporadically.
THE COORDINATED MODEL **Basic at a distance**	Primary care and behavioral health providers have separate systems at separate sites, but now engage in periodic communication about shared patients. Communication occurs typically by telephone or letter. Improved coordination is a step forward compared to completely disconnected systems
Basic On Site	Mental health and primary care professionals have separate systems but share the same facility. Proximity allows for more communication, but each provider remains in his or her own professional culture.
THE CO-LOCATED MODEL **Close, Partly Integrated**	Mental health professionals and primary care providers share the same facility and have some systems in common, such as scheduling appointments or read-only medical records. Physical proximity allows for regular face-to-face communication among behavioral health and physical health providers. There is a sense of being part of a larger team in which each professional appreciates his or her role in working together to treat a shared patient.
THE INTEGRATED MODEL **Close, Fully Integrated**	The mental health provider and primary care provider are part of the same team. The treatment team are using the same medical record. The patient experiences the mental health treatment as part of their regular primary care.

Adapted from: "Evolving Models of Behavioral Health Integration in Primary Care" Milbank Memorial Fund by Chris Collins, Denise Levis Hewson, Richard Munger, and Torlen Wade

How to identify a partner for a successful collaboration model

Consideration	Questions to ask yourself
Strategic Alignment	• Is the partner organization ready and willing to create an innovative patient centered model?
Payor Alignment	• Ensure that the mental health provider is capable of filing claims with the same panel of insurers as your clinic
Team Integration	• Is the partner organization willing to collaborate with the referring physicians throughout the operational and therapeutic processes? • Does the partner organization have the ability and willingness to provide educational opportunities to primary care providers?
Capacity Planning	• Is the partner organization able to create adequate access to care? • Is the partner organization able to provide assistance with emergency cases? • Does the partner organization have the ability to provide or identify a psychiatrist as needed to staff cases?
Ongoing Program Evaluation	• Does the partner organization have the capability to collect data and are they willing to share it?

Detailed Step by Step Patient Care Process and Program Assessment

Patient Screening, Referrals & Engagement with Behavioral/Mental Health (B/MH) Diagnosis

- Step 1: PCP/NP/PA screens patient annually and identifies mental health or behavioral health issues or symptoms

- Step 2: Referral sent via EMR to Behavioral Health Therapist (BHT) including the reason for the referral

Patient Screening, Referrals & Engagement with Behavioral/Mental Health (B/MH) Diagnosis

- Step 3: PCP/NP/PA talks to the patient about the practice's new behavioral health services & the role of the BHT team member & encourages patients to set up visit with the BHT

- Step 4: PCP/NP/PA either walks the patient to meet the BHT team member or the BHT team member goes to the physician's office & has a face to face hand-off of the patient

Care Delivery of Patients with a B/MH Diagnosis

- **Step 5:** The BHT conducts a comprehensive initial assessment, determines severity, diagnosis of the case, develops plan of care & sends summary to PCP.

- **Step 6:** If case fails to progress or if PCP requests, or it is determined in collaboration with the PCP that a psychiatry consult would be beneficial, arrangements for referral are handled by the BHT or PCP

Care Delivery of Patients with a B/MH Diagnosis

- **Step 7:** If a psychiatry consult is recommended, the Patient should either be seen face to face by psychiatry within 2 weeks or the case is staffed by a psychiatrist who should write or provide an oral consult to the PCP/NP/PA for modification of the patient's treatment plan. Patient would continue to see the BH therapist from a counseling and/or cognitive behavioral therapy perspective.

- **Step 8:** BH Therapist schedules next appointment within next 2 -3 weeks (based upon severity). BHT appointments may be 30 to 45 min long.

Monitoring of Patient & Overall Program Effectiveness

- Step 9: Use screener tool for patients at appropriate intervals (based on screening tool used) with patient follow-up visits

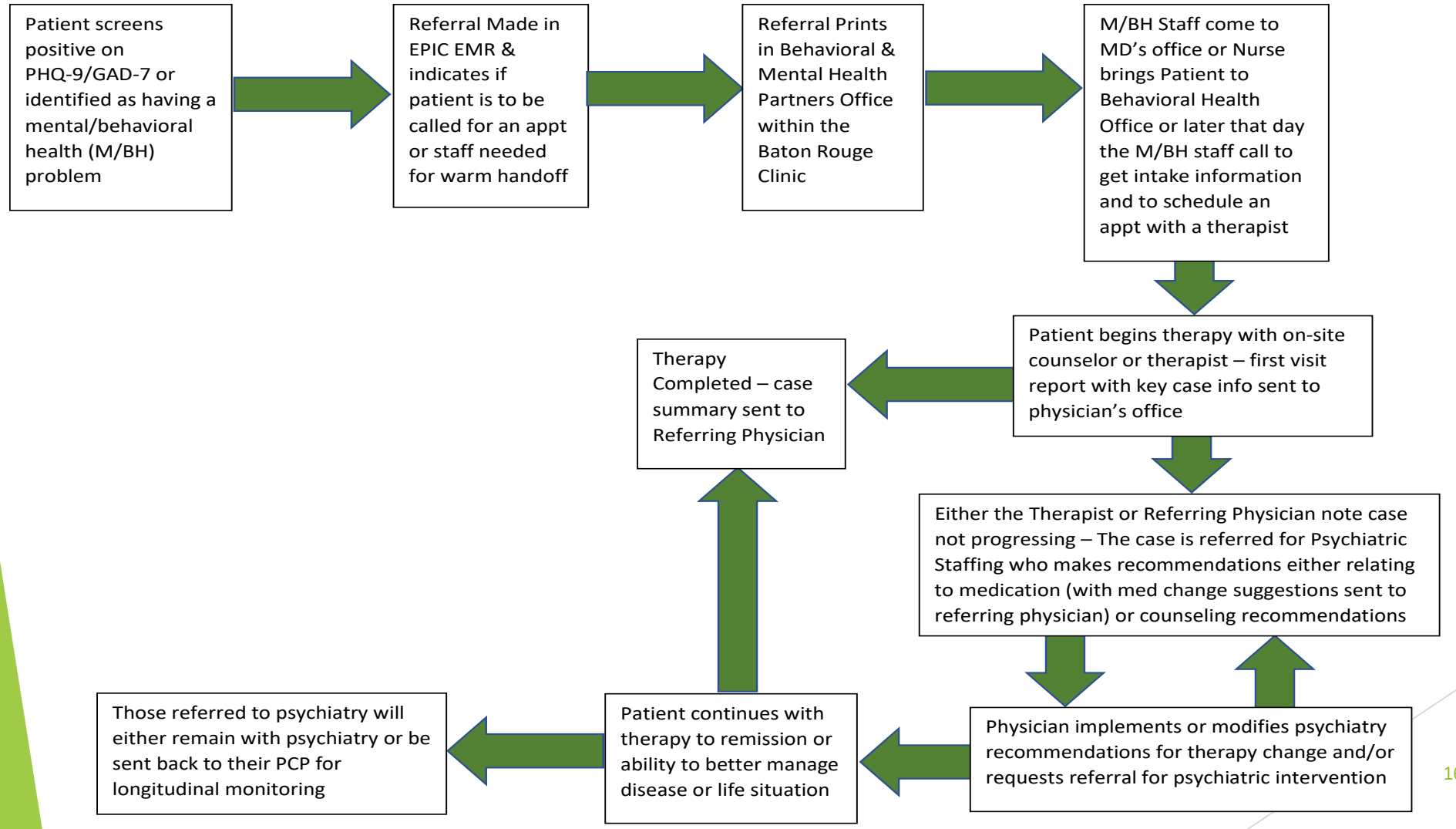
- Step 10: Establish a quarterly or every six-month review of key metrics (process, quality, cost/utilization and patient experience) to assess program effectiveness and adherence to program's standard operating procedures including a random file review. Modify, test & learn on changing procedures to improve performance including integrating and automating actions in your EMR

Monitoring of Patient & Overall Program Effectiveness

- Step 11: Determine a strategy/approach to treat patients in crisis

- Step 12: Use a standard social determinant screening tool to determine if you need to consider partnering with local community services based upon your population needs.

Baton Rouge Clinic Co-located Model Patient Flow



What Have We Observed and Learned

The Baton Rouge Clinic / Capital Area Human Services Co-Located Model

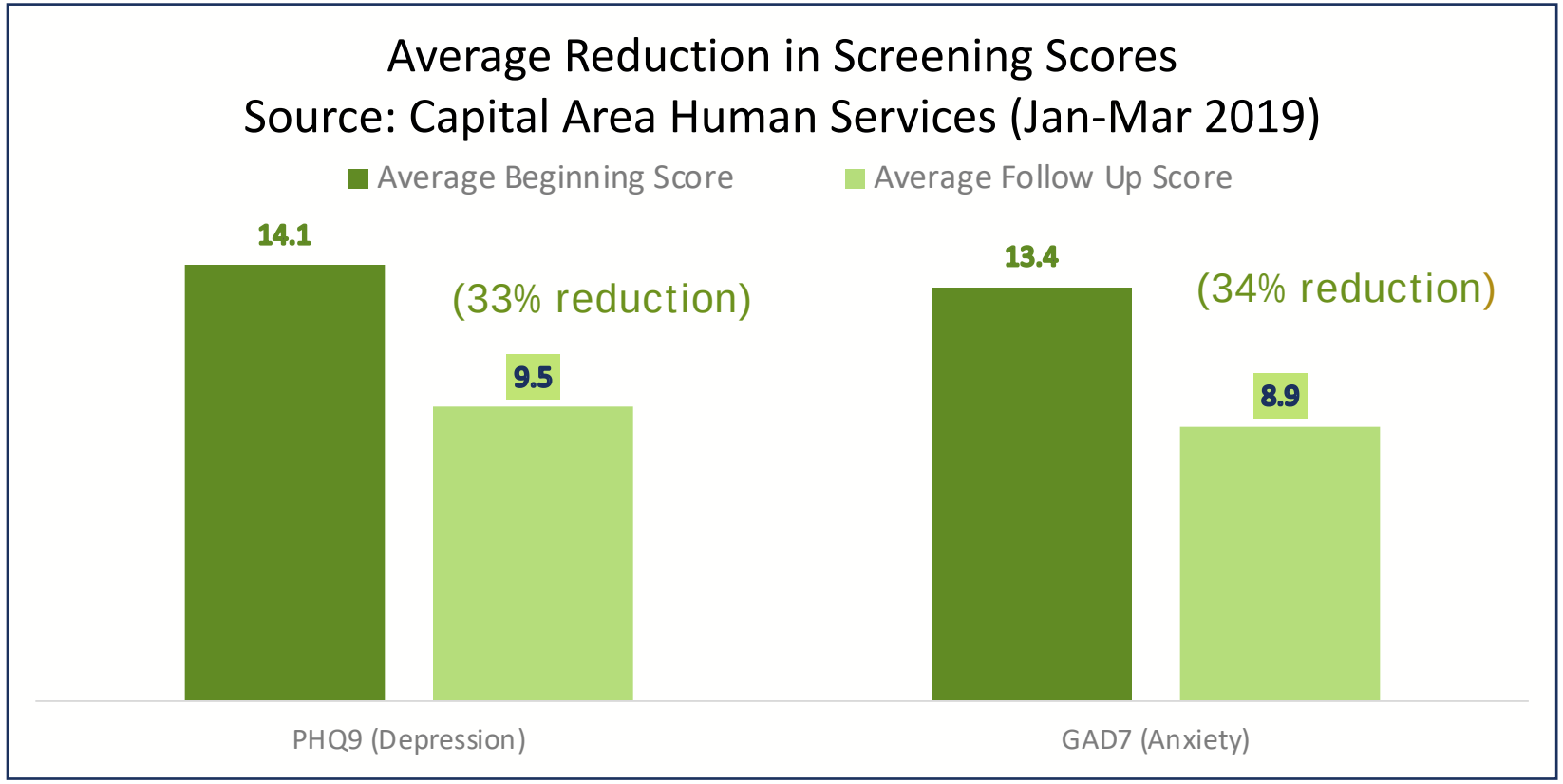
Patient Data From

2/1/18 - 6/1/19

Source: Capital Area Human Services

1,184 patients referred for mental/behavioral health counseling	40 patients referred to a psychiatrist for treatment of mental health and ongoing care	18 on site psychiatrist led consulting sessions regarding patients who may be failing to progress or need medication modifications

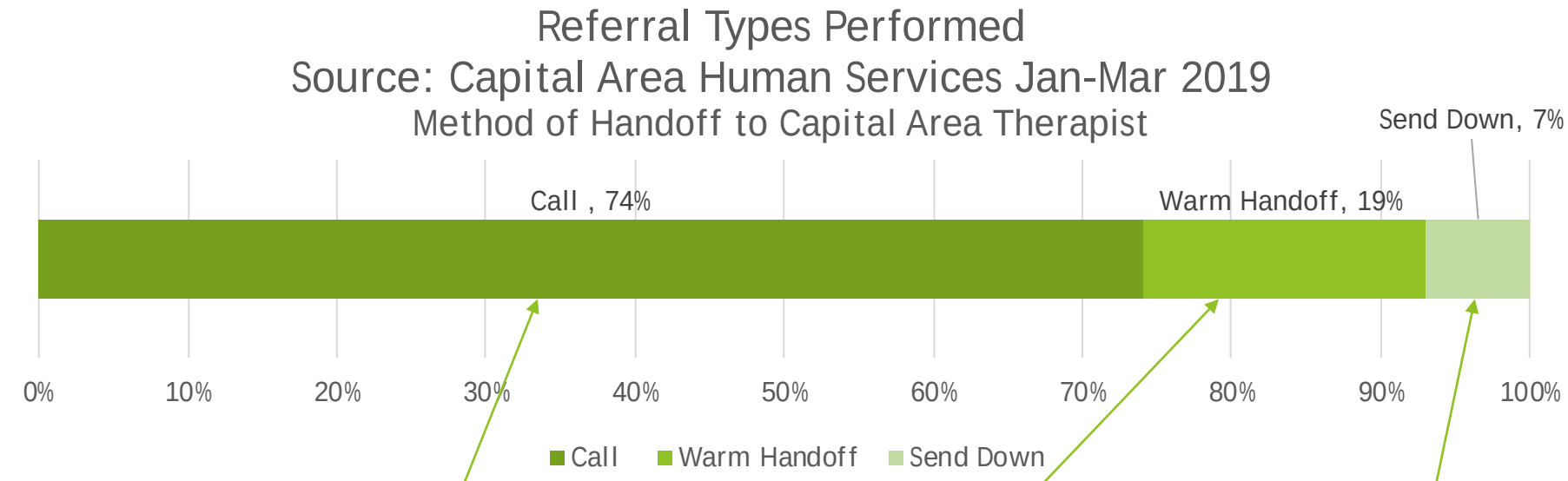
Results to Date



PHQ9 Scoring:
0-4 Minimal
5-9 Mild
10-14 Moderate
15-19 Moderately Severe
20-27 Severe

GAD7 Scoring:
0-4 Minimal
5-9 Mild
0-14 Moderate
15-21 Severe

Completed Appointments by Method of Scheduling



Call = 46%

Warm Handoff = 59%

Send Down = 45%

Warm Handoffs Work Best to Achieve Highest Percentage of Completed, Initial B/MH Appointments

Lessons Learned

- Be sure that your co-located agreement meets all Stark Requirements
- Be sure that your Mental Health Partner is an approved provider for all insurance plans that your clinic accepts. When needed, having psychiatry and mental health professionals who are credentialed with health plans improve patient participation in the therapeutic process
- Provider buy-in is key – don't expect initial universal utilization by all MD/NP/PA providers, some have to be won over by B/MH successes
- Solicit case referrals for Psychiatry/Therapist Staffing sessions from MD/NP/PA's and the mental health therapist(s)

Lessons Learned

- Timely psychiatrist availability will increase primary care provider referrals
- Warm handoffs are best when looking at first, completed B/MH appts
- Primary Care is willing to treat mental health patients at a basic level, but leveraging team-based care increases access and value
- Reduced reluctance of patients to accept a referral within the primary care office

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