“INTEGRATING A BEHAVIORAL HEALTH PROGRAM INTO A PRIMARY CARE SETTING IN RURAL ALASKA”

Teri Davis, MS, LPC, CDC-I
About me

- Born & raised in Bethel
- Cultural minority
- Education
- Experience
- Professional qualifications
Objectives

1) Learn what integration is and why it is useful

2) Learn about the speaker's experience of integrating a behavioral health program into a primary care setting

3) Learn about successes, challenges and mistakes in the integration process.
What is integration?

- “the intermixing of people or groups previously segregated” (Dictionary.com)

- Integrated behavioral health care is an emerging field within the wider practice of high-quality, coordinated health care. (The Academy)

- Just like it sounds- intermixing different groups of trained professionals (behavioral health and medical providers)
Why is integration important?

The following 12 slides are:

“Rationale for Integrated Care”
by the World Health Organization.
Rationale 1

- Reduced Stigma for people with mental disorders and their families
Rationale 2

- Improved Access to Care
Rationale 3

- **Co-morbidity:**

  Mental health is often co-morbid with many physical health problems such as cancer, HIV/AIDS, diabetes and tuberculosis, among others.
Improved Prevention and Detection of Mental Disorders:
Primary health care workers are frontline formal health professionals, the first level of contact of individuals, the family and community with the national health system.
Rationale 5

- **Treatment and Follow-up of Mental Disorders:**

  People who are diagnosed with a mental disorder are often unable to access any treatment for their mental health problems.
Rationale 6

- **Better physical accessibility:**

Primary health care is the first level of contact
Better financial accessibility:

When consulting in hospitals, indirect health expenditures (transportation, loss of productivity related to the time spent in accompanying the patient to hospital, etc) add to the cost of consultation and medications.
Rationale 8

- Better acceptability:

Linked to reduced stigma and easier communication with health care providers
Reduced chronicity and improved social integration, decreases the burden:

Both for the people with mental disorders and his/her household
Providing treatment at primary health care, backed by secondary health care and informal community care:

Can prevent people from being admitted into psychiatric institutions often associated with human rights violations.
Rationale 11

- Better Health Outcomes for people treated in Primary Health Care
Improving Human Resource Capacity for Mental Health:

Integrating mental health services into primary health can be an important solution to addressing human resource shortages to deliver mental health interventions.
Behavioral Health can help with...

- Asthma
- Hypertension
- Chronic Pain
- Coronary Artery Disease
- Diabetes
And....

- To assist primary care providers in the recognition and treatment of mental disorders and psychosocial problems.
- To assist in the early detection of “at risk” patients, with the aim of preventing further psychological or physical deterioration.
- To assist the primary care provider in preventing relapse or morbidity in conditions that tend to recur over time.
- To assist in preventing and managing addiction to pain medicine.
- To assist in the prevention and management of work and/or functional disability.
- To help primary care providers obtain quality clinical outcomes with high prevalence mental disorders.
- To help primary care providers treat and manage clients with chronic emotional and/or health problems efficiently and effectively.
- To help providers manage clients who use medical visits to obtain needed social support.
- To more efficiently move clients into appropriate mental health specialty care when indicated.
Medical Providers can help with....

Effect behavioral changes in people with, or at risk for physical disorders.

Some behaviorally modifiable behaviors that contribute to poor health:

- Smoking
- Alcohol Consumption
- Drug Abuse
- Unsafe sex practices
- Poor nutrition Obesity
- Sedentary lifestyle
- Stress
- Failure to seek medical treatment when needed
- Poor adherence to medical treatment plan
- Sleep disorders
The Bethel Family Clinic

Federally Qualified Health Center
Patient Centered Medical Home
Community Health Center
Since 1981
Staff

Executive Director- non-clinical
Medical Director- medical doctor & provider
Nurse Practitioner
Physicians Assistant
2 medical assistants
Behavioral Health- LPC
Behavioral Health- LCSW
Finance and admin support staff
Where integration for BFC began

- October 2014 - grant awarded
- December 2014 - BH clinician hired (me)
- January 2015 - program “begins”
- December 2016 - 2nd year grant awarded
Grant Requirements

- Hiring of at least 1.0 onsite, full-time equivalent licensed behavioral health provider
- Provide on-site behavioral health services (mental health & substance use)
- Use SBIRT model
- Collect data
- 2nd year grant given upon successful completion of 1st year goals
- Become self sustainable
Roles- Administrator

- Allow the program to take risks, financially and organizationally as the program develops
- Conduct ongoing evaluation of programs, financially and organizationally to assist with revision
- Gather feedback from employees and patients about the program
- Hold program accountable to performance/grant goals
- Provide staff training on areas that need improvement
- Address staffing gaps
- Create strong teams
- Make adjustments in staffing to enhance patient experience
- Make clear roles and responsibilities
- Manager involvement in clinical practice
- Maintain policy and procedure manuals
Roles- BH providers

- Implement protocols required by nursing staff and providers
- Pre-visit planning to improve coordination of services (huddles)
- Support timely responses to unanticipated patient
- Establish roles and boundaries between different areas of the organization (medical records, permission, etc)
- Balance consult time vs. appointments
- Keep consult visits brief but effective to keep workflow on track
- Seek clinical supervision
- Communicate before and after consults with medical providers
- Communicate comfort level in treating patients
- De-escalate conflicts
- Debrief as needed about patient encounters
- Offer peer support
- Encourage positive behaviors
- Be an example of positive behaviors and self care
- Communicate in a culturally appropriate manner
- Acknowledge patient concerns about clinic operations
- Be knowledgeable about community resources
- Be able to communicate the team approach to patients
- Motivational interviewing
- Adjust treatment quickly in response to new or acute issues
- Help patients identify problems and set goals
- Support protocols implemented by BH staff
- Respond & intervene on positive screenings
- Pre-visit planning to improve coordination of services (huddles)
- Support timely responses to unanticipated patient needs
- Seek clinical supervision
- Communicate before and after consults with BH providers
- Communicate comfort level in treating patients
- Offer peer support
- Encourage positive behaviors
- Be an example of positive behaviors and self care
- Communicate in a culturally appropriate manner
- Acknowledge patient concerns about clinic operations
- Be knowledgeable about community resources
- Be able to communicate the team approach and reasons for involving the BH team
- Be able to discuss sensitive issues with patients regarding suicide, trauma, self-harm, etc. – seek training if not comfortable with certain areas
Roles- Nurses/Medical Asst.

- Check in BH patients
- Treat all patients with extreme sensitivity regarding possible BH issues (self esteem, body image, social skills, family dynamics, etc)
- Follow PHQ and SBIRT screening policies
- Participate in BH trainings as needed
- Understand the purpose and procedures of integration and your individual role
BH Case Manager- if available

- BH patient tracking (SBIRTS, PHQ, vitals, Medicine, treatment plan review dates, consents)
- Case management of BH patients for treatment referrals
- Provide assistance to BH providers and medical providers during referral and integration process
- Check in BH patients (priority over medical patients)
- Treat all patients with extreme sensitivity regarding possible BH issues (self esteem, body image, social skills, family dynamics, etc)
- Follow PHQ and SBIRT screening policies
- Participate in BH trainings as needed
- Understand the purpose and procedures of integration and your individual role
Front Desk Staff

- Check in BH patients
- Transfer new patient questions/requests to scheduler
- Involve BH provider in financial/insurance issues for BH patients
- Understand the purpose and procedures of integration and your individual role
- Treat all patients with extreme sensitivity regarding possible BH issues (self esteem, body image, social skills, family dynamics, etc)
- Consistent positive customer service
Processes of Integration

- Shared medical records
- Co-located
- Daily huddles
- Intakes for all patients
- Same day services
- Referrals from BH to Medical
- Referrals from Medical to BH
- Warm hand-offs
Shared Medical Records

- Electronic
- Nextgen
- Cost of updates (DSM, ICD, etc)
- BH & medical have access
- HIPAA challenges
- Who documents on a shared encounter
Co-Located

- Office within the same building
- Quick and accessible
- Improved confidentiality/stigma
- Boundary concerns arise
- Noisy
Daily Huddles

- Medical staff
- Behavioral Health staff
- Review of patients on schedule
- Challenges with walk-ins
- Presenting concern is not always the real concern
- Time
- Space
New Patients

- Medical Intake
- Review of medical screenings
- Tobacco and caffeine use
- Military service
- Vitals
- AUDIT
- PHQ-2/9
- Informed consent
Established Patients

- **Medical**
  - Vitals
  - Review of allergies
  - Review of medications
  - Height and weight
  - AUDIT- every 3 months
  - PHQ-2/9- every 2 weeks

- **Behavioral Health**
  - Vitals- once a month
  - Review of allergies- once a month
  - Review of medications- once a month
  - Height and weight-once a month
  - AUDIT- every 3 months
  - PHQ-2/9- every 2 weeks
Screening (SBIRT) AUDIT-screening for alcohol use

**THIS IS TO BE COMPLETED FOR ALL NEW MEDICAL AND BEHAVIORAL HEALTH PATIENTS AND THEN AGAIN EVERY 3 MONTHS**

**Bethel Family Clinic**
P. O. Box 1008
Bethel, Alaska 99559
(907) 543-3773 Fax (907) 543-3545

We're going to ask you some questions about your alcohol use during the past year. We are asking all of our patients these questions because we know that alcohol use can affect many areas of health and may interfere with certain medications. Please try to be as honest and accurate as you can.

<table>
<thead>
<tr>
<th>SBIRT Pre-Season</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How often do you have a drink containing alcohol?</td>
<td>Never</td>
<td>Monthly or less</td>
<td>2-4x/month</td>
<td>2-3x/week</td>
<td>4 or more/week</td>
</tr>
<tr>
<td>2. How many drinks containing alcohol do you have on a typical day when you are drinking?</td>
<td>0-2</td>
<td>Notes: &quot;a bottle&quot; of 750 ml=17 drinks</td>
<td>3-4</td>
<td>5-6</td>
<td>7-9</td>
</tr>
<tr>
<td>3. How often do you have 4 or more drinks on one occasion?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
</tbody>
</table>

**POSITIVE IF FEMALE IS GREATER THAN 3/ POSITIVE IF MALE IS GREATER THAN 4 IF POSITIVE, ASK REMAINING QUESTIONS, IF NEGATIVE, STOP HERE**

| 4. How often during the last year have you found that you weren’t able to stop drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 5. How often during the last year have you failed to do what was normally expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 6. How often during the last year have you had a first drink in the morning to get yourself going? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 7. How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 8. How often during the last year have you been unable to remember what happened because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 9. Have you or someone else been injured because of your drinking? | No | Yes, but not in the last year | Yes, during the last year |
| 10. Has a relative, friend, doctor or other person been concerned about your drinking or suggested you cut down? | No | Yes, but not in the last year | Yes, during the last year |

**TOTAL SCORE (questions 1-10)**

*Positive if total score is equal to or greater than 7 for all females & for men age 65+*
*Positive if total score is equal to or greater than 8 for males under 65*
*Positive if total score is equal to or greater than 5 for patients under 21*
*Positive if total score is equal to or greater than 1 for pregnant women*
*Positive score 20 or greater may indicate dependence*

**Action taken:**

- Patient refused screening
- Negative score—no further action necessary
- Positive score—inform provider

**AFTER ACTION IS TAKEN, SCAN INTO PATIENT'S CHART AND GIVE PAPER COPY TO TERRI**

**Medication: Other**
Screening (SBIRT)

PHQ-2/9 – screening for depression

<table>
<thead>
<tr>
<th>PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over the last 2 weeks, how often have you been bothered by any of the following problems?</td>
</tr>
<tr>
<td>(Use &quot;x&quot; to indicate your answer)</td>
</tr>
<tr>
<td>---------------------------------------</td>
</tr>
<tr>
<td>1. Little interest or pleasure in doing things</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
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<tr>
<td>4. Feeling tired or having little energy</td>
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<tr>
<td>5. Poor appetite or overeating</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
</tr>
</tbody>
</table>

For office coding: 2 + 3 + 4 + 5 + 6 + 7 + 8 + 9

=Total score: 

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
</table>
Same day services

- If BH needs arise, medical is available (sometimes)
- If medical needs arise, BH is available (almost always)
- Monitoring of medical conditions for BH patients
- Lab results during BH visits
Referrals between BH & Medical

Referral to medical provider

- Identifying medical need
- Communicate
- Document
- Medical Emergency
Referrals between Medical & BH

**Referral to BH Provider**

- Identifying BH need
- Connecting patient with BH (attempt same day)
- If same day isn’t available
- Crisis
Referral Goal

- Providers are trained to identify need
- Providers are comfortable addressing need
- Same day services are available when needed
- Warm hand-offs occur
- Providers can handle ambivalence
Warm hand off

Warm Hand-off- “the primary care provider directly introduces the client to the behavioral health provider at the time of the client’s medical visit”.

Establish an initial face-to-face contact between the client and the behavioral health counselor.

Scripts are important

Schedule/time concerns

Reimbursement issues
WHAT NOT TO SAY
(provided by the California integrated behavioral health project)

Example 1 (high levels of stigma): We have already tried 3 medications that have not worked for you, and I know that has been frustrating for you. We have a specialist here who is a doctor for anxiety/depression/voices, who may be able to change your medicine and find something that works for you. He/She is right here, and could see you next week. Is that okay?

Example 2 (previous history with mental health services, run around): You have a long history of struggles with this problem, and since you are a new patient to me, I am wondering if you would be willing to see our specialist to make some recommendations about medicine. She/He is just a doctor, so they don’t do counseling; however we do have a counselor that I think could be helpful to you. Is it okay with you for me to make you two appointments, one for medications, and one for counseling? I will follow up with you in two weeks......
Warm hand off

WHAT TO SAY
(provided by the California integrated behavioral health project)

Example 1: It sounds like you might be having a lot of stress right now. I work with someone who specializes in helping with these issues, and I would like you to speak with them today to better help me help you. Is it alright with you if I introduce you to her/him?

Example 2: From some of your answers on this questionnaire, it looks as if you may be feeling down lately. I have a colleague who I work with who can give you some ideas of ways to help with this. Her/His office is just down the hall, is it okay with you if my MA walks you there after we are done so you can talk for a minute?
Primary Care Provider: [to client] “As part of your overall health care, I’m concerned about (health concern). I have a member of our team who helps me assess these types of problems so that I can provide you with the best care. Together we can develop a plan to deal with this. May I introduce you?”

[The Behavioral Health Counselor is brought in.]

Primary Care Provider: [to client]: “[Client’s name], I’d like you to meet [Behavioral Counselor’s name].”
[to Counselor] “I have a concern about [client’s name] and [problem] and thought you could help.” Note: As discussed in the stigma section, mental health concerns can be described in more neutral terms like stress, sleeplessness, anxiety, etc.]

Behavioral Health Counselor [to client]: “That sounds like the type of thing that may be important to your overall health. I’d be glad to talk with you and see if we can come up with a plan for managing this.”
End of year one- data

- Grant requirement- track SBIRT #’s

- AUDIT (manually tracked in Excel)
  - 664 screened
  - 49 positive
  - 18 refused
  - 597 negative
Successes

- Screenings
- Billing
- Expansion
- Shared Care
- Warm hand-offs
- Co-located
- Awarded 2nd year $
- Manual AUDIT tracking
Challenges:

- Training
- Comfort
- Time
- Staff Buy-In
- Prioritizing
- Role mixing
- Boundaries
- Documentation
- Administration
- Supervision
- Ethics
- Consultant vs. Clinician
- Data Gathering
- Staff Turnover
Patient Surveys

- Patient surveys were given to BH patients who had received integrated care.
- Surveys were started 3/15/16 and are continuing to be collected.
Survey Questions

- **Likert Scale- 5 options**
- 1) How satisfied were you with the medical care you receive at BFC
- 2) How satisfied were you with the behavioral health care you receive at BFC
- 3) All BH patients are required to get vitals once a month, a depression screening every 2 weeks, and an alcohol screening every 3 months. How do you feel about this process?
- 4) How easy and smooth is it to schedule an appointment with your provider?
- 5) How were you treated by the front desk staff on the phone and when you arrived at your appointment?
- 6) How were you treated by the nursing staff during the intake process?
- 7) How do you think your health and wellness has progressed since you started receiving care at BFC?
- 8) We are beginning to incorporate Animal Assisted Therapy into our program, how interested are you in having our therapy dog involved in your treatment?

Please identify areas where we can improve our services and your care. (3 text lines given)

Please write a few sentences about your overall feeling about integrated care
Random Patient Testimony

- Can be difficult to hear after the work you’ve put out
- Helpful for improving the program
- Difficult to capture
- Important to share with staff (anonymously) to increase motivation or improvement
Our Provider Testimony

- “Pulling teeth” for testimony
- Useful in seeing if providers actually understand the purpose of integration
- Useful in improving the program
A survey of primary care clients found that most (107 of 131) found psychological treatment for depression and stress in the primary care setting acceptable.

The parents of children who received primary care-based individualized psychological treatment indicated improvement or resolution for 74% of children and high satisfaction with the psychological service.

“Older adults are more likely to have greater satisfaction with mental health services integrated in primary care settings than through enhanced referrals to specialty mental health and substance abuse clinics.”
-Hongtu Chen et al., “Satisfaction with Mental Health Services in Older Primary Care Patients”, Am J Geriatric Psychiatry April 2006, 14:371-379.
Research Findings- Cost Effectiveness

- Though the primary care depression management intervention added to the total care costs the first year of operation, these costs were largely off-set by general health care savings during the second year. The intervention produced health and mental health improvements without a significant increase in costs. Wayne Katon et al., “Cost-effectiveness of Improving Primary Care Treatment in Late-Life Depression”, Archives of General Psychiatry, 2005, 62.

- Patients who receive care for depression in primary care clinics with routine mental health integration teams and care processes were 54% less likely to use higher-order emergency department services. Brenda Reiss-Brennan et al., "Cost and Quality Impact of Intermountain's Mental Health Integration Program", Journal of Healthcare Management, 55:2, 2010.
### IMPACT OF DEPRESSION ON MEDICAL COSTS

<table>
<thead>
<tr>
<th>Condition</th>
<th>Annual Medical Costs per Patient Without Depression ($)</th>
<th>Annual Medical Costs per Patient With Depression ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart failure</td>
<td>2.56</td>
<td>6.74</td>
</tr>
<tr>
<td>Allergic rhinitis</td>
<td>3.27</td>
<td>8.46</td>
</tr>
<tr>
<td>Asthma</td>
<td>3.73</td>
<td>10.56</td>
</tr>
<tr>
<td>Migraine</td>
<td>3.82</td>
<td>15.47</td>
</tr>
<tr>
<td>Back pain</td>
<td>11.61</td>
<td>33.25</td>
</tr>
<tr>
<td>Diabetes</td>
<td>13.06</td>
<td>27.28</td>
</tr>
<tr>
<td>Hypertension</td>
<td>13.38</td>
<td>27.16</td>
</tr>
<tr>
<td>Ischemic heart disease</td>
<td>62.40</td>
<td>110.94</td>
</tr>
</tbody>
</table>

*Actual annual medical costs per patient based on claims data for 229,776 patients, 1995-1998. SOURCE: OCI 2001, as presented by Dr. David Shern, 2008.*
Research Findings - Reduced Stigma

- In a poll conducted by the American Psychological Association, 30% of the adults responding expressed concerned about other people finding out if they sought mental health treatment, and 20% identified stigma as "a very important reason not to seek help" from a mental health professional.

- A nine-year follow-up of 805 participants in a program treating depression in primary care found that individuals receiving extra therapy were significantly less likely than those in usual care to report concerns about friends learning about their history of depression.
  - Klap, R. et al., (2009) "How quality improvement interventions for depression affect stigma concerns over time: A nine year follow-up study". *Psychiatric Services, 60*(2) 258-261.
In-depth discussion and Q & A

- Share your experiences with integration
- Share successes
- Share mistakes
- Ask questions
- Feel free to answer other people’s questions with me

ASKING QUESTIONS IS NOT ONE OF THOSE!

Dictionary.com
http://www.dictionary.com/browse/integration?s=t

Hongtu Chen et al., “Satisfaction with Mental Health Services in Older Primary Care Patients”, Am J Geriatric Psychiatry April 2006, 14:371-379.

(http://www.who.int/mental_health/policy/services/en/index.html, accessed 4 September 2007; Mental Health Policy, Planning and Service Development Information Sheet, Sheet3)

Integrating Behavioral Health Care. The Academy, 2013
Resources part 2


Klap, R. et al., (2009) "How quality improvement interventions for depression affect stigma concerns over time: A nine year follow-up study". Psychiatric Services, 60(2) 258-261.


Thank You!

Please feel free to contact me anytime

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