Welcome

Integrating Behavioral Health & Primary Care for People Experiencing Homelessness

Tuesday, February 19, 2013

We will begin promptly at 1 p.m. Eastern.

Event Host:

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This publication was supported by Grant/Cooperative Agreement Number U30CS09746-04-00 from the Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA/BPHC.
Presenters

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Health Care and Housing are Human Rights
Integrating Behavioral Health & Primary Care for People Experiencing Homelessness

February 19, 2013
Learning Objectives

- Describe models for integrating behavioral health and primary care in the HCH setting.
- List recommended trainings to help staff deliver integrated care.
- Identify funding mechanisms to support integrated care models.
Multiple Chronic Conditions & Homelessness

- High rates of dual diagnosis (Foster, LeFauve, Kresky-Wolff & Rickards 2010)

- High rates of mental health, substance abuse and medical multimorbidities (Goldstein, Luther, Jacoby, Haas & Gordon 2008)

- Serious mental illnesses increase risk of medical comorbidities (Welsh, et al. 2012)
Multiple Chronic Conditions & Mortality

- General population
  - 4 life years lost due to mental illness (Piatt, Munetz & Ritter 2010)

- Homeless population
  - Behavioral health issues significant contributors to mortality (Baggett, et al. 2013)
Managing Multiple Chronic Conditions

- Integrated care – mental health, substance abuse, medical
- Interdisciplinary care teams
- Effective clinician communication
- Motivational approaches to care
- Community partnerships
Interview Findings

The Daily Planet
Central City Concern
Cherry Street Health Services
Models of Care

- Beyond co-location
- Team-based
  - Multidisciplinary
- Patient-Centered Medical Home
Staffing

- Culture
  - Expect to be interrupted
  - “Warm handoffs”

- Cross-training
  - Primary care learns about behavioral health and vice versa
  - Motivational interviewing

- Working at top of license
  - Support staff
Challenges

- Funding
  - Grants
  - Medicaid billing/reimbursement

- Physical space

- Staff
  - Communication
  - Clinical background
Successes

- Electronic Medical Records
- Staff
  - Flexible
  - Team players
- Commitment from leadership
- Community collaborations
  - Cross referrals
  - Care coordination
- Willingness to change and grow
Greetings from Virginia and
The Daily Planet

Lisa Price Stevens, MD, MPH
THE DAILY PLANET

• Provided almost $650,000 in health care services at no charge to the uninsured in 2011

• UNIQUE PATIENTS – 5,638
  – Safe Haven Residents 33
  – Medical Respite Patients 150

• TOTAL ENCOUNTERS – 31,957
  – Medical Encounters 10,057
  – Dental Care Encounters 2,802
  – Eye Care Encounters 133
  – Behavior Health Encounters 13,762
  – Case Management 5,163
Challenges of The Medical Director

Medical

Behavioral Health
Description of DP Medical-Behavioral Health Relationship

- Co-located
- Siloed
- Cooperative
- Separately - both have potential to be efficient
- Little to no collaboration
- Referral from within treated just like any other outside referral.
2010 Fate Happened

• Network for the Improvement of Addiction Treatment (NIATx)
  – Founded in 2003
  – Works with behavioral health care organizations across the country
  – Improves access to and retention in treatment for the millions of Americans with substance abuse and/or mental health issues
The Daily Planet and The Healing Place Journey to Wisconsin

The Daily Planet (DP) is a FQHC in Richmond offering primary health, behavioral health, dental, and vision care along with case management as necessary to the Central VA uninsured and homeless population. All services are provided regardless of one’s ability to pay.

The Healing Place (THP) of Richmond is a nonprofit organization established to provide shelter for the homeless and a long term residential recovery program for those who are chemically dependent. Services are provided at no cost to the client.
Collaboration Goals and Challenge

• **Goal 1**
  – Improve DP’s primary and behavioral care integrative process both internally as well at THP.
  – Identify barriers to integration and opportunities for better coordination.

• **Goal 2**
  – Improve access and render brief treatment strategies to the identified population—homeless, uninsured, and underinsured individuals who have substance abuse and/or co-occurring disorders.

• **Challenge**
  – Staff buy-in (DP & THP) for integration
1 Year Later......

The Healing Place

- Enhanced health services
- Nutritional infrastructure change
- Introduce the PCMH model of care into this environment
- Integrated smoking cessation/pharmacist services

The Daily Planet

- BH agreement to offered to do “Groups”.
- Improved PH referral to BH services
Collaborative Agreements to Benefit Homeless Individuals (CABHI) Initiative

- Greater Richmond, with VSH as project lead, is one of only 20 communities nationwide to receive funding through SAMHSA's CABHI initiative.

- 3-year, $1.5 million grant
  - Support VSH, The Daily Planet, and Homeward
  - Building data-informed, housing-focused, and collaborative cross-agency homeless outreach
  - Expand access to integrated primary and behavioral healthcare for individuals in permanent supportive housing

- Part-time BHC & psychiatrist
BH /PC Integration

• Staffing

• Training (Bill McFeature, PhD-SBIRT)
  – Screening
  – Brief Intervention
  – Referral to Treatment

• Implementation

• Revision, Re-revision

• Continued Adaptation
Daily Planet BH Integration Model: Depression

- **PHQ2**
  - No → No Further Intervention
  - Yes → Primary Care

- **Primary Care**
  - If + 2 PHQ2, Assess Harm/Self Harm

- **Urgent Care**
  - If + 2 PHQ2, Assess Harm/Self Harm

- Yes = Crisis Management
Daily Planet BH Integration Model: Depression

- Consent to see BHC & Referral to BHC in EMR
  - BHC In-house & Available?
    - NO: Consent to see BHC & Referral to BHC in EMR
    - YES: Hallway intervention – Red Flag, Depression Screening by BHC in room
  - BHC-Referral Screen – If already seen = care coordination with clinician
    - No further Action
- Office visit
  - BHC Intake Appointment PHQ9, Brief Assessment, Provider concerns & Behavioral RX
Daily Planet BH Integration Model: Depression
Thank You
The Nuts & Bolts of Behavioral Health Integration

Susan Marie, PMHNP PhD
Paradigm Shift

• Systems Level
  – Primary Care is focus of intervention
  – 71% FQHCs include behavioral health
  – Primary care prescribes 70% of psychotropics (80% of antidepressants)

• Clinical Level
  – Depression in 3rd most common diagnosis
  – 13-50% patients have psychiatric disorders
  – 70% of visits have a psychosocial basis
What is Integrated Behavioral Health?

IBH exists when primary care and behavioral health staff work together as a team

- with the same clinical record
- in the same physical space
- with ongoing communication
- are rapidly accessible to intervene with patients when needed
Success =

- Clear Roles & Processes
- Preventing Cultural Pitfalls
- Sustainable Revenue
Roles

- **Behaviorist**
  - **Who**
    - Various flavors - social workers, counselors, psychologists, unlicensed MH staff
    - Check licensing/revenue
  - **What**
    - Crisis intervention/suicide intervention
    - Diffusing hostility
    - Brief cognitive-behavioral treatment anxiety
    - IMPACT problem solving intervention
    - Linking to resources
    - Teaching skills: relaxation, trauma management
Roles

- Psychiatric Expertise
  - Who
    - Psychiatric nurse specialist/nurse practitioner or psychiatrist
  - What
    - Focused psychiatric assessments
    - Psychiatric medication management
    - Brief cognitive/trauma interventions woven in
    - Crisis/suicide support
    - Just-in-time consultation to primary care providers
Processes

- Ready Access
  - Warm Hand Offs
  - Referrals
- Support
- Location, location, location
- Health record documentation
- Emergency/High risk procedures
Preventing Cultural Clash

**MENTAL HEALTH**
- Caseload of clients
- Values confidentiality
- Independence
- Never interrupt

**PRIMARY CARE**
- Serve PCP panels
- Values collaboration
- Team
- Encourages interruptions
MENTAL HEALTH

- “Therapist”
- “Sacred 50 min hour”
- Full evaluation before treatment
- Episodic

PRIMARY CARE

- Varied Roles
- Shorter appointments
- Develop full assessment as you go
- Ongoing, as needed
Sustainable Revenue

- Medicaid Fully Capitated Health Plan (medical)
  - E&M Codes
  - Health & Behavior Codes

- Medicaid Mental Health Plan (carve out)
  - “Mental Health” codes
E & M Codes

- FCHP pays E & M codes 99212, 99213

- Operationally defined “primary care behavioral health”
  - Assessing, diagnosing, and treating mental illnesses that the primary care provider would be doing in the context of the primary care clinic if psychiatric provider was not there
  - Provided in same physical and temporal space of primary care
E & M Codes: The Rationale

1) Untreated mental illnesses exacerbate medical conditions and increase the demand for primary care visits

2) Untreated mental illnesses increase utilization of emergency and other high-cost medical services, often without gaining resolution of the underlying problem(s)

3) Primary care providers treat these conditions regardless—they are in our panels
E&M Advantages/Disadvantages

- Similar charting requirements as PCP
- Similar billing as PCP
- No same day payment
- No coverage of non-medical BH staff
- Only brief interventions covered (99212, 99213)
Health & Behavior Codes

- Psychological/mental health services to treat a MEDICAL diagnosis or condition
  - Relaxation training/imagery for hypertension
- Not education (such as teaching diabetics about diet)
- Code the MEDICAL diagnosis to the medical health plan (not mental health insurer)
- Medicare & some states have approved Medicaid
- Providers include nurses, psychologists, psych APRNs, licensed clinical social workers
Advantages/Disadvantages

- Appreciates the benefit “biopsychosocial services” has upon adherence to treatment and outcomes
- Covers services by social workers, psychologists, APRNs
- Do not need a mental illness diagnosis
- Very broad definition of what services can be provided

- No same day payment
- Not approved by Medicaid in all states
- Difficult to understand & correctly record
- Requires PCP referral for an approved medical diagnosis
Medicaid Mental Health Plan

- Services to diagnose and treat mental illnesses
- Different expectations
  - Credentialing/licensing
  - Auditing
  - Prior authorization procedures
  - Clinical record keeping
  - Supervision & review
  - Staffing requirements
Advantages/Disadvantages

- Can bill same day with PCP visit
- Often pays for case management, counseling services not covered by FCHP
- Often pays for wider variety of providers
- Requires a license as behavioral health provider
- Requires contracting with MHO
- State may also have expectations (eg CPMS)
- Different expectations by MHO
Thank you!!
Q & A

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For more information about the National HCH Council

- Contact us at council@nhchc.org.
- Other educational opportunities including technical assistance and regional trainings can be found online at www.nhchc.org.