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Thursday, June 9, 2022

Integrating Behavioral Health and Primary Care: A Panel Discussion

Frank deGruy, MD, MSFM
Susan McDaniel, PhD, ABPP
Stacy A. Ogbeide, PsyD, ABPP, CSOWM

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Objectives

By the end of this session, participants will be able to:

1: Articulate three reasons to integrate behavioral health into the fabric of our primary care practices.
2: Describe two facilitators and two barriers to integrating behavioral healthcare in your department.
3: Identify at least one (1) evidence-based implementation strategy for a new, Primary Care Behavioral Health service.

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The Why

Why integrate behavioral health into the fabric of primary care practice?
-Susan McDaniel, PhD, ABPP

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New 2022 ACGME Residency Requirement for Family Medicine

II.B.2.i). *Each program should provide experience in integrated interprofessional behavioral health care.*

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Integrating Behavioral Health & Primary Care

AGENDA

*Setting the Stage for Integrating Behavioral Health and Primary Care:
The University of Rochester Experience Susan H McDaniel PhD
*Institutions Established on Integrating Behavioral Health into Primary Care:
The University of Colorado Experience Frank deGruy MD MSFM
*Institutions "Breaking Ground" on Integrating Behavioral Health into Primary Care:
The University of Texas at San Antonio Experience Stacy Ogbeide PsyD
*Discussion You All

ULTIMATE GOAL

To describe and illustrate the general elements that affect the development of an integrated care program, helping you to assess where you are now in the process, and what you want to do in the future.

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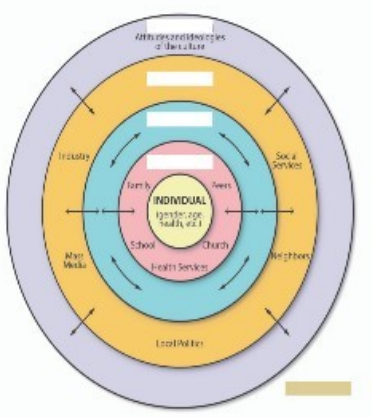
HISTORY OF HUMAN UNDERSTANDING OF OUR PHYSICAL AND MENTAL EXISTENCE

Ancient Chinese Integration

Darwin's Dualism

Descartes' Dualism



General Systems Theory

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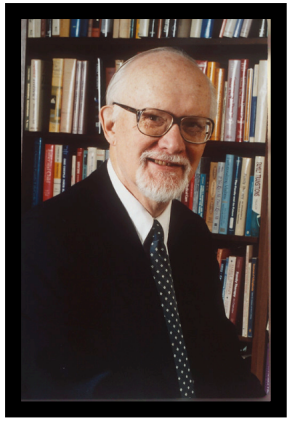
General Systems Theory
(Relationships & Interdependency of the Parts)

BPS Approach
(George Engel MD)

Family Therapy
(Lyman C. Wynne MD PhD)



Systemic, Family-oriented Biopsychosocial Healthcare
(Susan McDaniel & colleagues)

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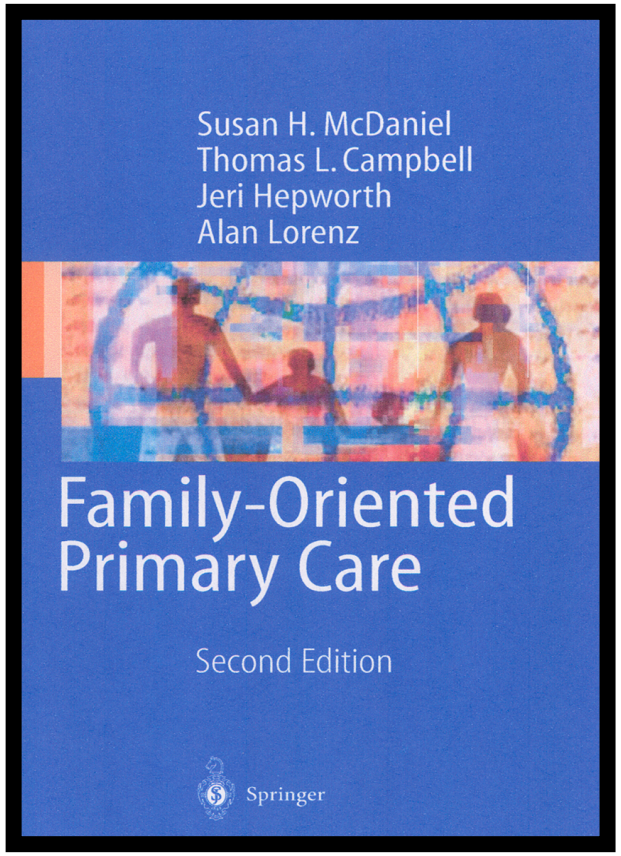
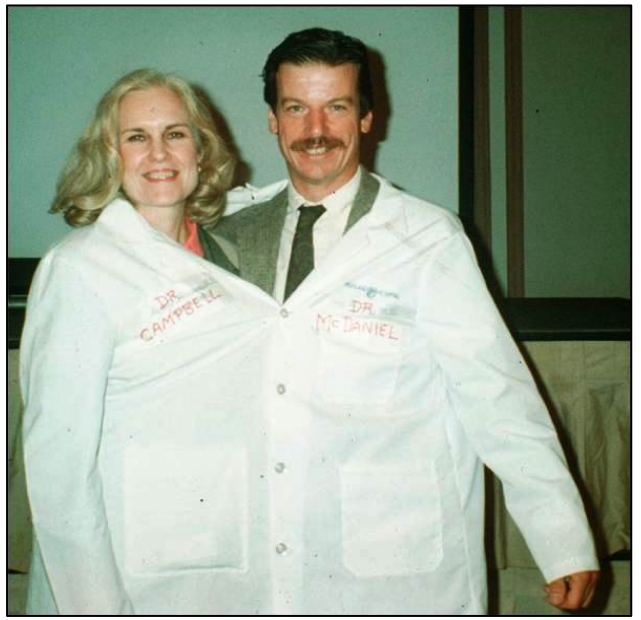
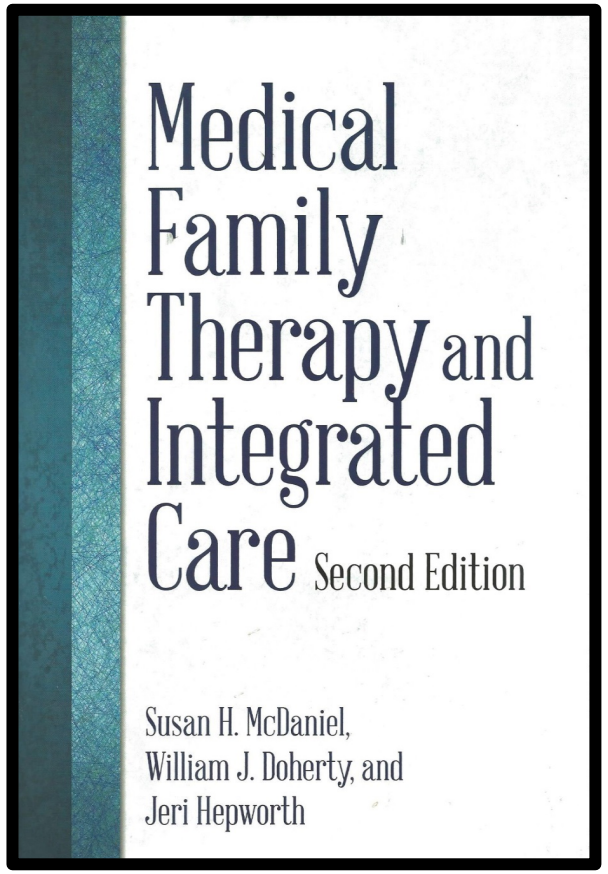
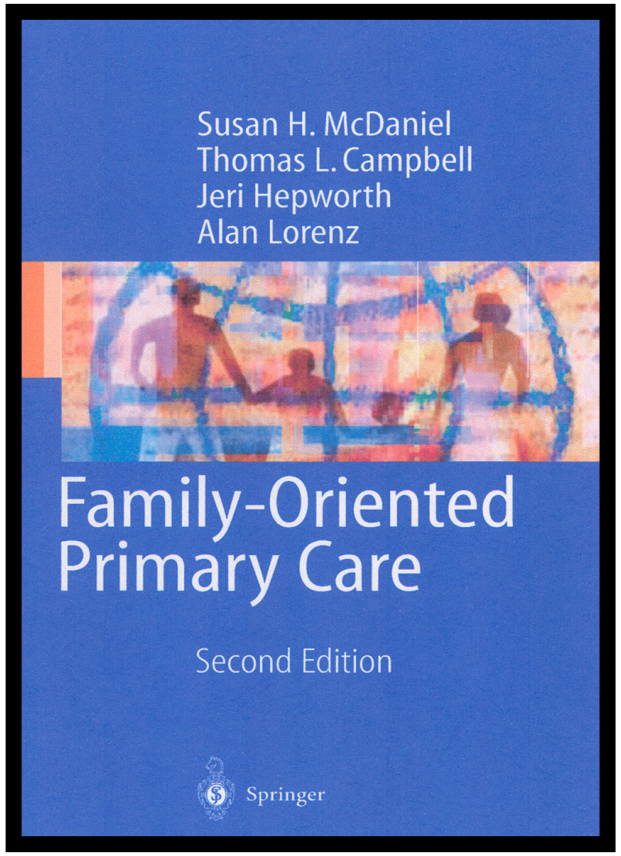

Susan H. McDaniel
Thomas L. Campbell
Jeri Hepworth
Alan Lorenz
Family-Oriented Primary Care
Second Edition
Springer


DR. CAMPBELL
DR. McDANIEL


Medical Family Therapy and Integrated Care Second Edition
Susan H. McDaniel, William J. Doherty, and Jeri Hepworth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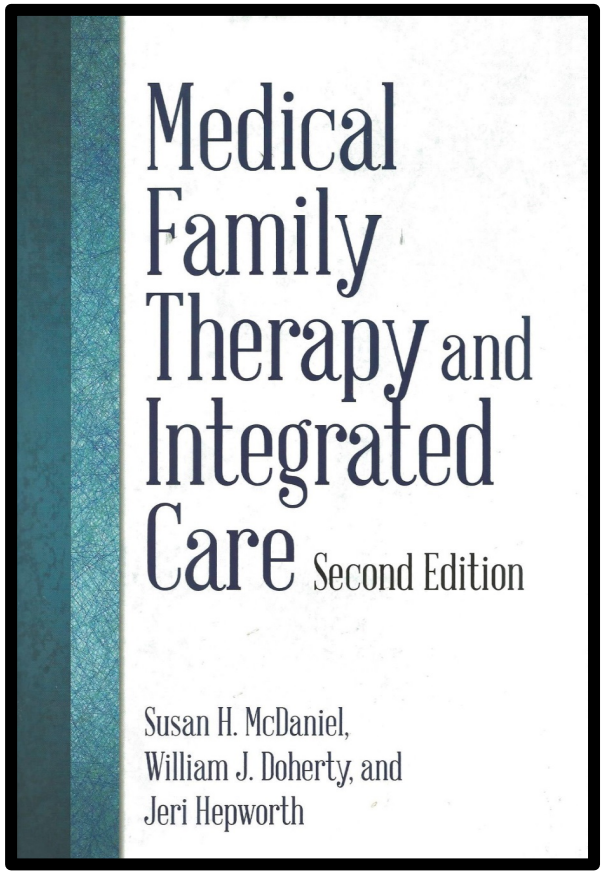
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PRIMARY CARE BEHAVIORAL HEALTH TEAM OF 2022

Family Psychologists

Marriage & Family Therapists

Child and Adult Psychiatrists

Trainees from all these disciplines

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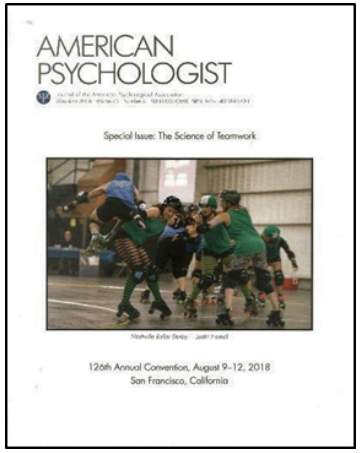
FROM 1985 ----------→2022

*We started with moving traditional psychotherapy/consultation from the community into our clinic, and

*Focused on collaboration between the behavioral health clinician and the family physician.

*We evolved into broader interprofessional, team-based care.



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DIFFERENT APPROACHES DEVELOPED ACROSS THE COUNTRY & ACROSS SYSTEMS

The Military

FQHCs

Kaiser

Family Medicine programs

All working to match the needs of their populations, their regulations, and their financing mechanisms

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MODELS OF INTEGRATED CARE

*Primary Care Behavioral Health

*Collaborative Care

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Models of Integrated Care

PRIMARY CARE BEHAVIORAL HEALTH (PCBH)

*Generalist approach
*Focus on common mental health and relational problems,
*Health Behavior changes important to managing chronic illness, and
*Team Effectiveness.
*Used by Psychologists and other behavioral health clinicians who
*Provide assessment and brief intervention for any patients in the practice as
*A routine part of primary care.

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Models of Integrated Care

COLLABORATIVE CARE (CoCM)

*Targets serious mental illness and its effect on other chronic illnesses.

*Research-based approach

*Used by Psychiatrists who consult to nurse or social work care managers who then

*Provide coordination and direct care to patients.

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Current Best Practice

BLENDED MODEL OF PRIMARY CARE BEHAVIORAL HEALTH AND COLLABORATIVE CARE

*Together effectively cover most behavioral health problems seen in primary care.

**Those that require intense specialty mental health care are referred out.

FACILITATORS AND BARRIERS TO THE ADOPTION OF INTEGRATED BEHAVIORAL HEALTH

*External Factors: policies, incentives, dominant paradigms

*Organizational Factors: culture, resources, staff mix, engagement

*Individual Professional Factors: underlying philosophies of care and competencies

*Intervention Characteristics: their benefit, ease, & adaptability to the local environment

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Integrated Behavioral Health

INTERVENTION CHARACTERISTICS

*Brief

*Flexible

*Consultative

*Part of a team-based approach to Family Practice.

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RESISTANCE to INTEGRATING BEHAVIORAL HEALTH

Can Occur at ALL 4 Levels:

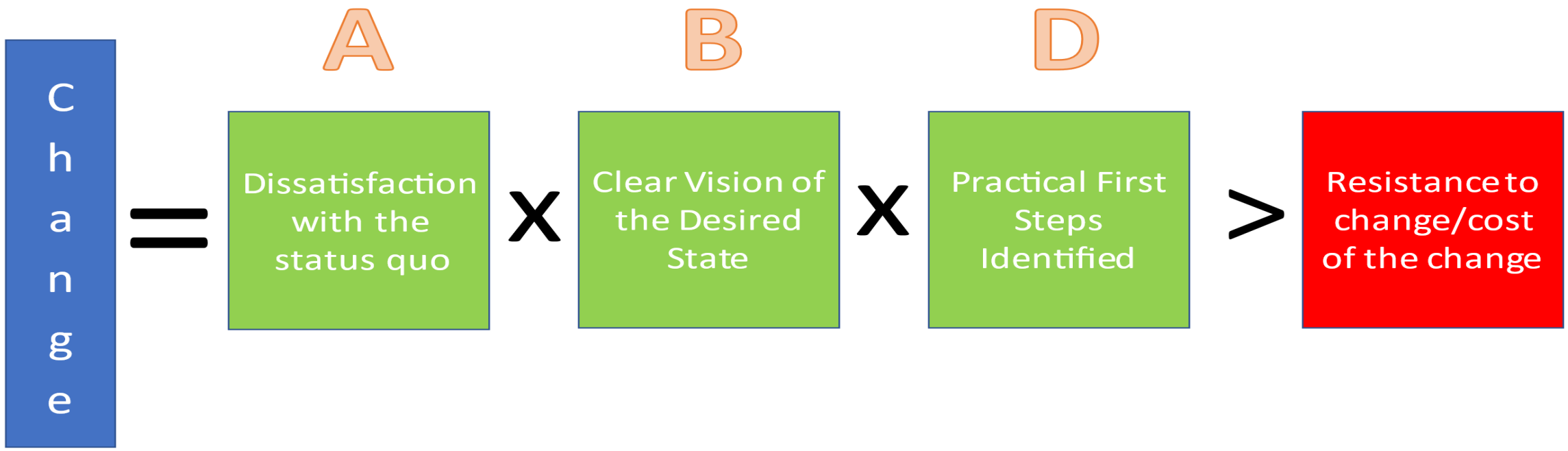
*Policies and Regulations

*Culture, Training & Resources

*Individual Competencies

*Adaptive Reserve

Change = (ABD) > X



Adapted from Beckard, R. (1975) and Dannemiller & Jacobs, (1992).

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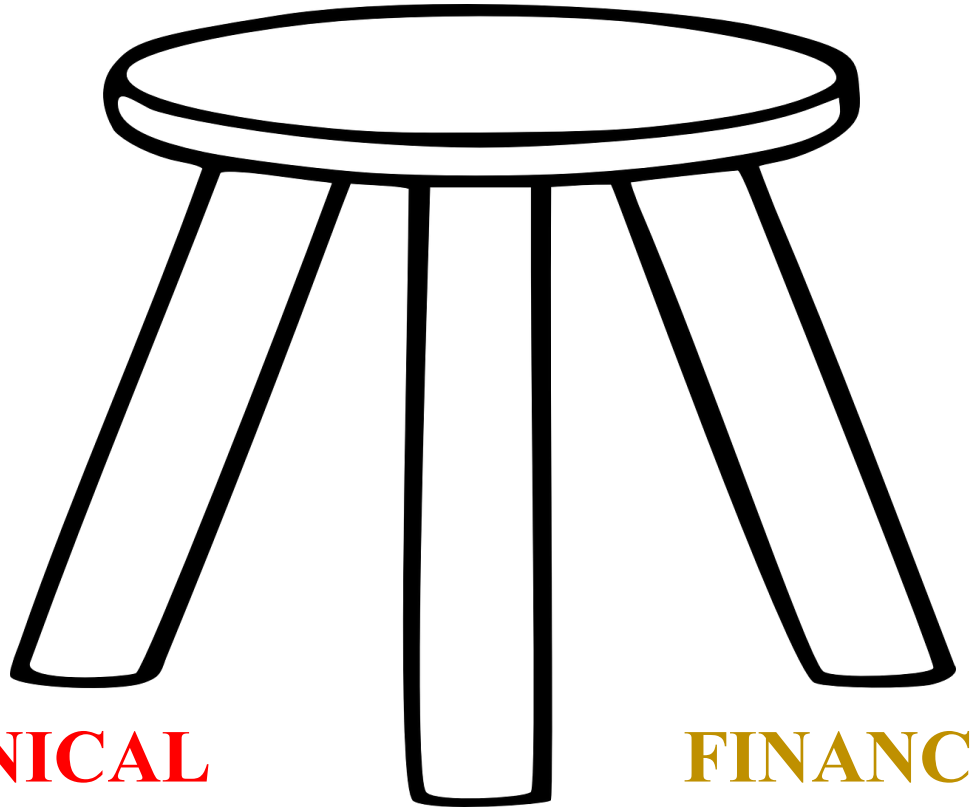
CJ PEEK'S 3 SYSTEMS ORGANIZATIONAL MODEL FOR INTEGRATED CARE



CLINICAL **FINANCIAL**

OPERATIONAL

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BEGIN WITH A PRACTICE NEEDS ASSESSMENT

*Determine your system's facilitators and barriers in each of the 3 realms-- Clinical, Operational, and Financial

*Include representatives from each realm to plan and identify metrics for evaluation

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INTEGRATED CARE MOTIVATES US TO CONTINUE OUR COLLECTIVE EFFORT TO BUILD THE HEALTHCARE SYSTEM WE ALL DESERVE!

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Barriers and Facilitators

The IBH+ Model of Integrated Care
-Frank DeGruy, MD

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Rationale, Assumptions

- "…addressing most or all of a patient's health concerns…."
- Most problems have a behavioral dimension
- Behavioral health is health

- Program has been running for 20+ years; exponential recent growth.
- The chassis is the primary care setting
- Advanced primary care is team-based care
- Behavioral clinicians are primary care clinicians
- The "+" in IBH+ signifies the inclusion of psychiatrists into the team.

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Structure, 1

- Seven clinics; four in the DFM
- 100,000+ patients; 65,000 in the DFM
- 71 PCCs; 29 FTEs
- 15 psychologists; embedded in each clinic as a team member
- 4 psychiatrists; 1.2 FTE
- 8 care managers
- Pharmacists, Social workers, Health coaches, Navigators, others
- Learners!

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Structure, 2

- Embedded psychologists always available for warm handoffs, consultation, direct patient care, teleconsultation
- Psychiatrists available to PCPs, psychologists, and patients in person and via telehealth
- Addictionologists available via consultation
- Care managers coordinate visits, handoffs
- Team collectively produces and updates personal care plan with patient
- Evaluation team: 4 bodies, +/- 1 FTE. Elaborate evaluation structure.

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Function

- Blended model of tele-health and in-person services
- Synchronous and asynchronous care
- Stepped care:
  - Screening for psychosocial issues
  - E-consults via EPIC
  - Provider-to-provider consultation: scheduled or curbside
  - Co-consultations: scheduled or curbside
  - Psychiatric evaluation: In-person or telepsych; plan for deep-end problems
  - Interdisciplinary team meetings
  - Didactic education: all team members contribute
- Complexity of patients is stunning!

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Outcomes

- In last three years, 1000 pts/mo received integrated services
- Psychiatry used at about 60 visits/mo (45% telepsych, 32% in-person contact, 23% chart review only.
- Clinicians and patients highly, highly satisfied with IBH+
- Evaluation pending re productivity, clinical improvement
- Billing covers cost of program with hospital and practice plan supplement. UPL dollars cover cost of expansion, evaluation, administrative horsepower.

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Evidence-Based Implementation

Starting a New Service? Maintaining a Service?
-Stacy Ogbeide, PsyD, ABPP, CSOWM

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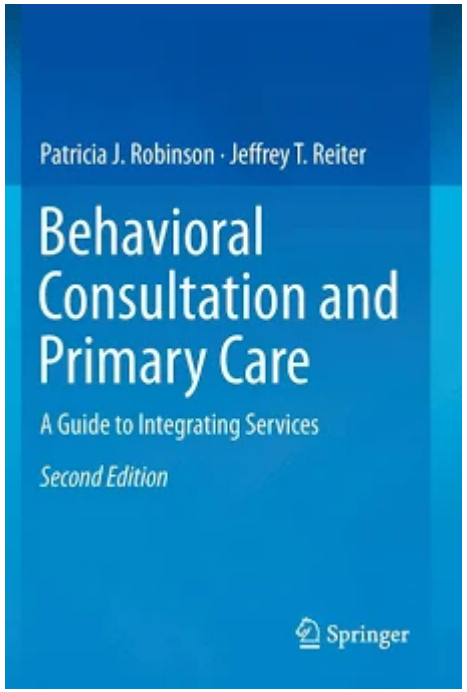
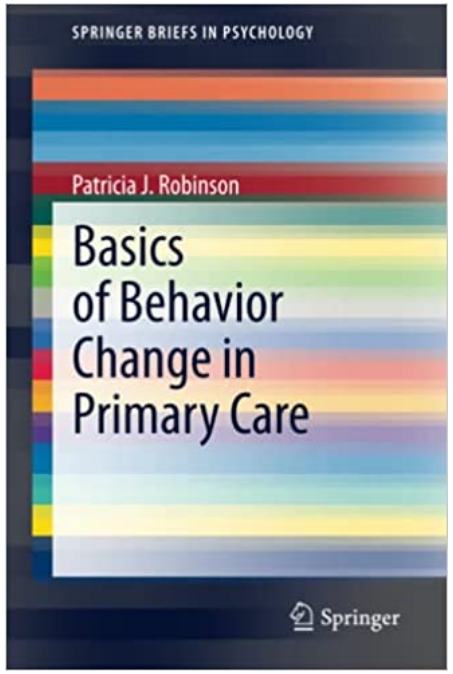
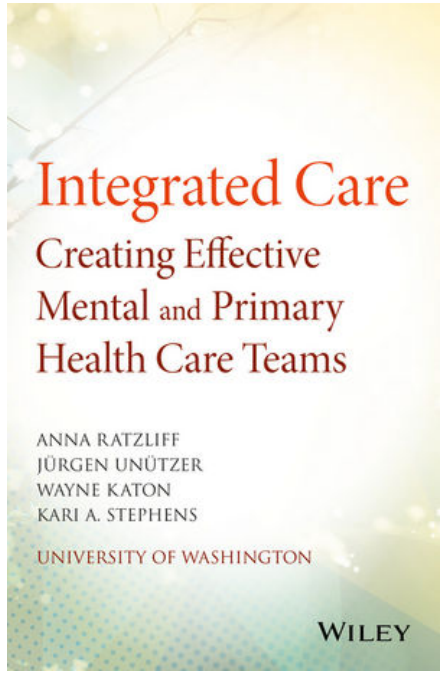
Evidence-Based Approaches

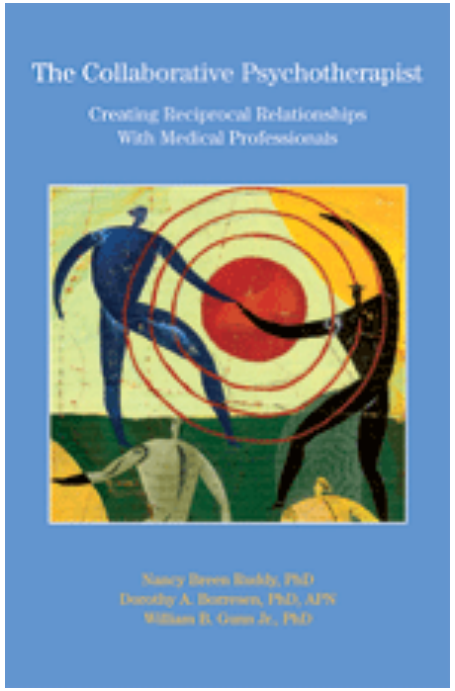




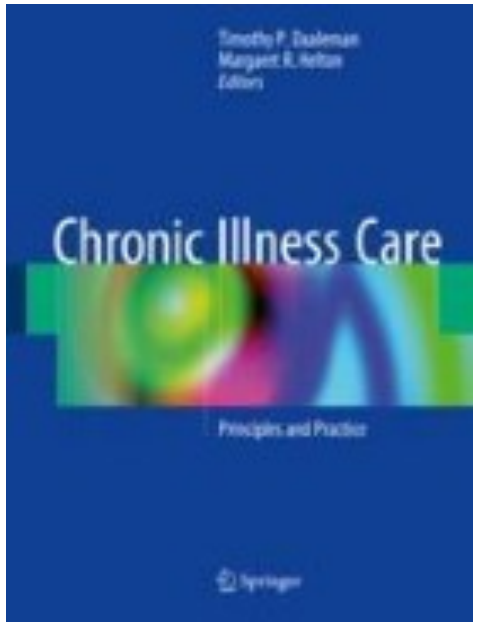
PCBH



CoCM



Co-Location



Chronic Care Models

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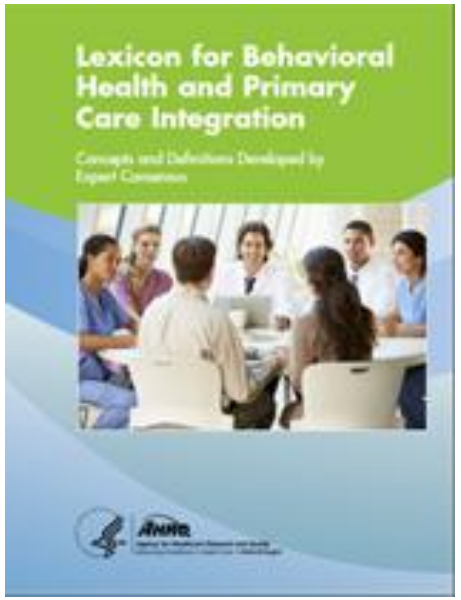
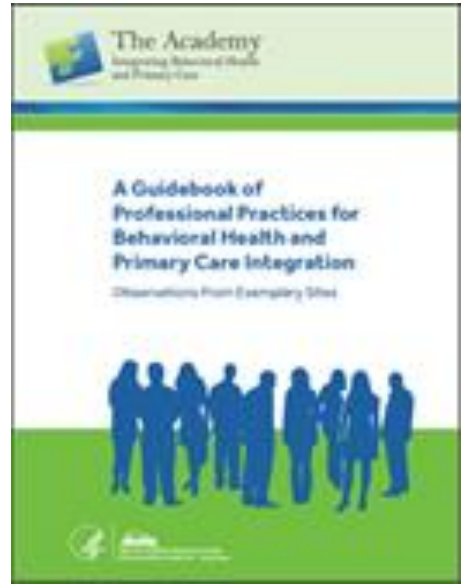
Evidence-Based Implementation





METHODS ARTICLE

HSR Health Services Research

Measuring the integration of primary care and behavioral health services

Daniel J. Mullin PsyD, MPH[1] | Lee Hargreaves PhD[1] | Andrea Auxier PhD[2] | Stephanie A. Brennhofer MPH, MS, RDN[3] | Juvena R. Hitt BS[4] | Rodger S. Kessler PhD, ABPP[3] | Benjamin Littenberg MD[4] | C. R. Macchi PhD[3] | Matthew Martin PhD[3] | Gail Rose PhD[4] | Felicia Trembath PhD, MPH[3] | Constance van Eeghen DrPH, MHSA, MBA[4]

[1]Department of Family Medicine and Community Health, University of Massachusetts Medical School, Worcester, Massachusetts
[2]New Directions Behavioral Health, Kansas

Objective: To perform a factor analysis of the Practice Integration Profile (PIP), a 30-item practice-level measure of primary care and behavioral health integration derived from the Agency for Healthcare Research and Quality's Lexicon for Behavioral

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What's needed – on the ground?

Your team:

- **Do they have the expertise to do this work?**
  - Training
  - Mentorship
  - Communities of Practice
- **Do they understand billing and coding? For your state?**
- **Is there "actual" departmental/clinic support for integration?**
  - Are they on an island?

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Questions? Comments?

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Stacy Ogbeide: www.stacyogbeide.com