Making Integration Possible: Proactive Practices for Successful Collaboration

PRIMARY CARE DEVELOPMENT CORPORATION

CoE Center of Excellence for Integrated Health Solutions

Funded by Substance Abuse and Mental Health Services Administration
Operated by the National Council for Behavioral Health

Today's Moderator

Kristin Potterbusch, MPH
Senior Program Manager
Primary Care Development Corporation
New York, NY

About PCDC

Primary Care Development Corporation (PCDC) is a national nonprofit organization and a community development financial institution catalyzing excellence in primary care through strategic community investment, capacity building, and policy initiatives to achieve health equity.

Disclaimer

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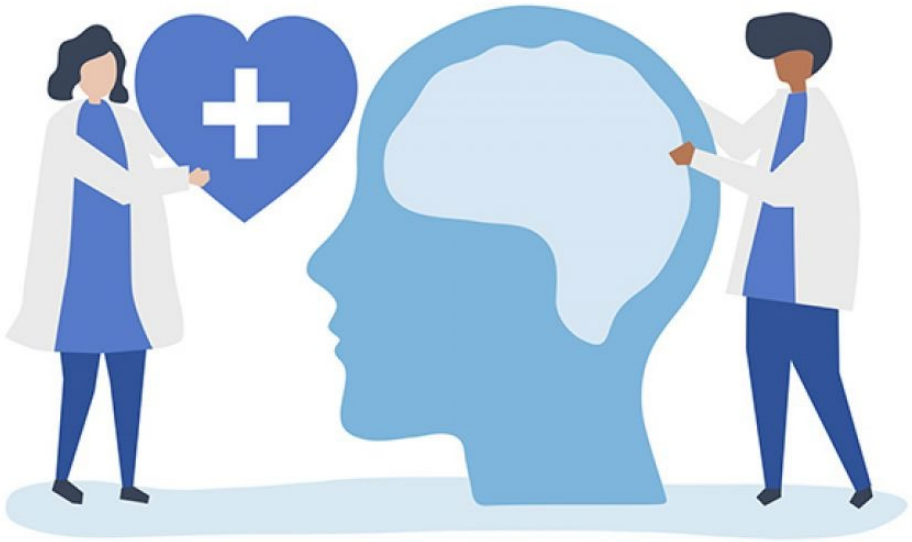
SAMHSA
Substance Abuse and Mental Health Services Administration

www.samhsa.gov

Integration at Work

This year we will be covering critical concepts to support your practice of integrated care such as:

- Integration models
- Quality improvement
- Funding and relationship development
- Behavioral health screenings for primary care
- Primary care considerations for behavioral health



Audience Demographics Poll

Do you work in a:

- Primary care setting
- Behavioral health setting
- Integrated care setting

Are you working primarily as a:

- MD/DO
- Nurse Practitioner/Registered Nurse
- Physician Assistant
- Medical Assistant
- Therapist
- Social Worker
- Care Manager
- QI Manager
- Informatics
- Other

Please rate your current skills and comfort with implementing procedures and policies that operationalize cross-team collaboration within integrated care settings.

1. Very Low
2. Low
3. Moderate
4. High
5. Very High

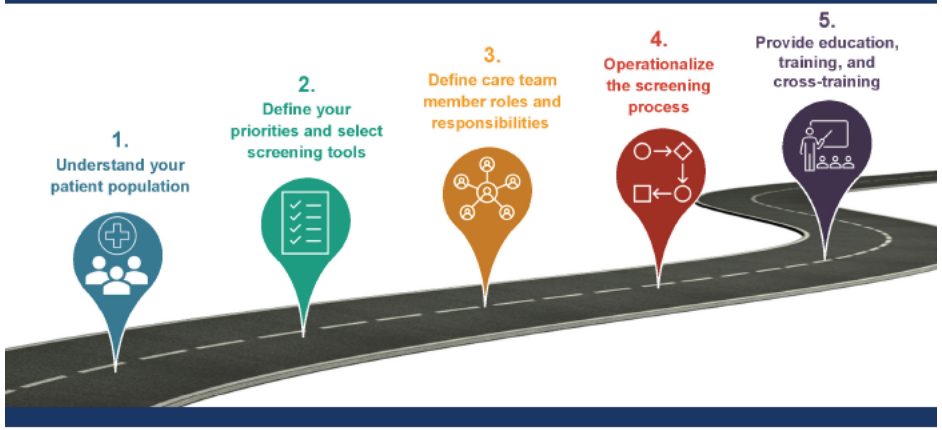
Tip Sheet

PRIMARY CARE DEVELOPMENT CORPORATION

CENTER OF EXCELLENCE for Integrated Health Solutions

PREVENTIVE SCREENING IN INTEGRATED CARE

START YOUR JOURNEY WITH THE PREVENTIVE SCREENING ROAD MAP:



TYPES OF REGISTRIES TO HELP MEET YOUR SCREENING GOALS:

MANUAL
Reports run by individuals using identified criteria

ELECTRONIC
Built into the electronic health record, but must be manually run

AUTOMATED
Reports are built into the system and automatically run at a selected frequency

INTEGRATED
Real-time population management platform that can be viewed by all care team members at any time

REMEMBER: SCREENING NEEDS TO BE LINKED TO SUPPORT AND REFERRALS

Reality Check List:

- Screening for behavioral health conditions does not automatically mean you have access to support/referrals
- Screening does not necessarily mean an increase in billable service
- Screening and patient education does not equal adherence
- Finding referral support may require the PCP network with behavioral health providers to develop referral compacts

BEST PRACTICES

Clearly identify which standardized tools will be used to complete the screenings

Ensure the essential tools are integrated into the electronic health record

Clarify **who** will conduct the screening and **how often**

Some of the evidence-based, standardized tools recommended for screening purposes:

1. Tobacco Screening
2. Depression - PHQ-2 and PHQ-9 for all patients 18 years and older
3. Alcohol and Substance Abuse - SBIRT pre-screen for adults, CRAFFT for adolescents
   - Alcohol - Audit and Audit C for Adults, CRAFFT for adolescents
   - Substance Use - DAST-10 for adults
4. Childhood Developmental Screening
   - PEDS administered during Well-Child Care (WCC) visit for ages 0 to 7 years
   - PSC administered during WCC visit for ages 8 to 13 years
   - CRAFFT administered during WCC visit for ages 14 to 17 years
5. Social Determinants of Health Screening (SDOH)
   - PREPARE tool used for all patients

Contact us to discuss how our services can help your care teams. Email: cqp@pcdc.org

This resource was developed in partnership with the Center of Excellence for Integrated Health Solutions with acknowledgments to Deborah Johnson Ingram, Maia Morse, and Kimberly Mirabella.

Presenters

Ilse Bell, MD, PCMH CCE
Senior Program Manager

Deborah Johnson Ingram, MPH
Senior Director

Maia Bhirud Morse, MPH, CPC
Senior Program Manager

Setting the Stage

Today's key objectives

- Identify real world mechanisms that support cross-team collaboration between providers within integrated care settings
- Understand key aspects of procedures and polices which facilitate the successful operationalization for supporting collaboration
- Review concrete examples that can inform ways your organization can lay the foundation for more effective integrated care plans

Case study

Alan is a 53-year-old contractor who has diabetes. At his most recent doctor's appointment he complains that he has been feeling more tired for the last 6 months. His doctor, Dr. Caring, draws his blood, takes a urine sample and schedules him for a follow up appointment 2 weeks later. At his follow up, he again complains of increasing fatigue, restlessness and insomnia.

Review of Alan's medical history includes the following:

- ½ pack a day smoker x 30 years
- Type 2 Diabetes
- Hypertension
- BMI=32

Case study

Medications include:

- ACE inhibitor
- Oral hypoglycemic

Labs:

- A1c **9.2%** (was **8%**)
- Cholesterol **216**
- LDL **124**
- HDL 68
- Creatinine .90 (BUN/Cr ratio 16)

On physical exam:

- BMI=**34**
- BP **145/85**
- PHQ 9 = **27**

- GFR 77
- TSH .99
- K+ 5.0
- B12 756
- Urinalysis - normal

Assessment and Plan

Dr. Caring reviews all the labs and pertinent changes on physical exam with Alan

He and Alan create the following management plan:

- Maintain the current diabetic medication regimen with diet and exercise
- Return for follow up in 3 months to check in
- Behavioral health referral for severe depression

Alan meets with Janice Soothing, his therapist, two weeks later.

What role can Alan's therapist play?

- She has no role beyond addressing Alan's depression. Alan's condition is being managed by his PCP Dr. Caring.
- She can provide Alan with support to maintain his current treatment regimen.
- She can speak with Dr. Caring during next case consult about how Alan's severe depression may intersect with his diabetes care plan, and they can agree to collaboratively center Alan's care around a shared set of person-centered goals informed by Alan.
- She can ask Dr. Caring to explain aspects of Alan's labs that are unfamiliar to her to ensure she and Dr. Caring are conveying the same messaging to Alan.
- She can provide Dr. Caring with upskilling on Alan's needs, reactions and how to message information to Alan.

Communication is Key

BH providers are critical partners within integrated care

- Help patients understand how their emotions effect how they feel physically
- Promote greater adherence to treatment regimens for chronic conditions
- Focus patients on establishing “person centered” goals to manage physical and behavioral conditions
- Improve the skills of primary care providers to recognize behavioral disorders
- Improve the skills of behavioral health providers to recognize how behavioral health conditions may manifest physical symptoms
- Share in the chat more ways BH providers are critical partners!

Navigating each other's worlds

Part of why it is critical to have collaboration is why communication can present a challenge:

- Often when communicating with each other BH providers and PCPs use acronyms, phrases, and information that wasn't part of their trainings
- It's ok to ask questions and clarify!
- BH and PCP (and many other types of health service providers) need each other in this work

Abbreviations: Cheat Sheet

VS	Vital Signs
VSS	Vital Signs Stable
BP	Blood Pressure
HR	Heart Rate
P	Pulse
RR	Respiratory Rate
T	Temperature
SpO2/SaO2	Oxygen Saturation
Ht/Wt	Height/Weight
BMI	Body Mass Index

CBC	Complete Blood Count
WBC	White Blood Cells
RBC	Red Blood Cells
Plt	Platelets
BMP	Basic Metabolic Panel
CMP	Comprehensive Metabolic Panel
LFT	Liver Function Test
H&H	Hemoglobin & Hematocrit
Hb/HGB	Hemoglobin
HCT	Hematocrit

Na	Sodium
K	Potassium
Ca	Calcium
UA	Urinalysis
ABG	Arterial Blood Gas
PT	Prothrombin Time
PTT	Partial Thromboplastin Time
INR	International Normalized Ratio
T&S	Type & Screen
T&C	Type & Cross

Decoding PC labs and lingo

- Type 2 Diabetes – inability of the body to handle sugar; if left untreated may result in complications like blindness, peripheral amputations, chronic kidney disease
- Hypertension – high blood pressure (e.g. BP **145/85**)
- BMI=**34** – body mass index
- A1c **9.2%** (was **8%**) – measures the level of sugar circulating in the blood over a period of months; one of several screening tests for diabetes
- Cholesterol **216** - measure of cardiac health
- LDL **124** – measure of cardiac health

Policy Informs Process

Procedures Bring Life to Policies

- The actionable component of a policy is the procedure
- The procedure details the process that supports the policy statement

The devil is in the details…

Policy Statement: To ensure our patients get access to clinical, social and emotional wellness services, PCDC Family Health Center will have an integrated Behavioral Health service deliver structure…

Procedure: To support the delivery of BHI, the practice will conduct the Screening, Brief Intervention, Referral for Treatment (SBIRT) protocol.

- Procedures remove variability in how activities are carried out.
- The stakeholders (staff) in the process are informed of their roles and tasks via a workflow diagram or detailed procedure.

Question to the Participants

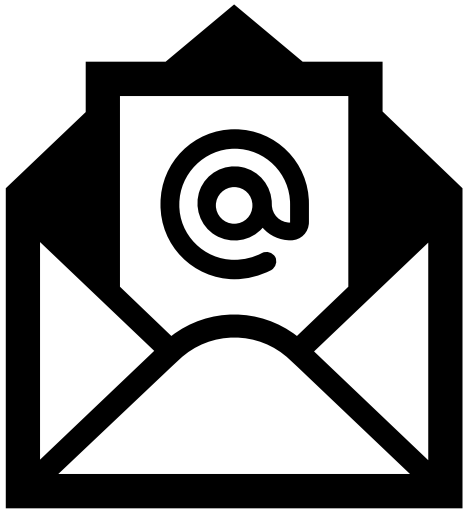
Have you reviewed your organizations' Behavioral Health integration policies and procedures?

- Yes, I read them
- No, I haven't read them, but I know our practice policy exists
- No, I haven't read them, not even sure they exist

Procedures Continued: Who Does What… When?

- Procedures detail activities to be specific to the staff tasked to conduct the activities
- Strategies for well documented procedures:
  - Convening stakeholders to develop PC-BH policy/recommendations
  - Allow for the doers to walk through the process- input is relevant as to how the process gets carried out
  - Should include communication amongst staff, when, where is it entered in the EHR
  - State the method of monitoring and measurement

Procedures Continued: Who Does What… When?



Communication at work

- The PCP is looking for specific clinical markers during the encounter
- BH providers look for social and emotional markers
- Both have screening tools, yet patients fall through the crack due to lack of communication
    - PCP warm handoff to BH – Yes or No?

DM patient post hospital DX not taking meds admission Dx CHF, history of not taking meds. Screened positive for mild depression today but sever depression over past 2 years. Provider encourages change diet, take meds and check blood sugar regularly- 4 months later patient arrives to ED. Blood sugar level 240.

BHI Procedural Considerations

Primary care providers are central point of medical access for many patients

Allow for stakeholder input to develop a sustainable process

Spread tasks to care team members

Informed and engaged staff – support informed and engaged patients

BH providers are trained to elicit patient treatment goals that intersect with the patients' lifestyle.

Ask patient's permission to conduct hand offs. They have the ultimate say in their treatment plan

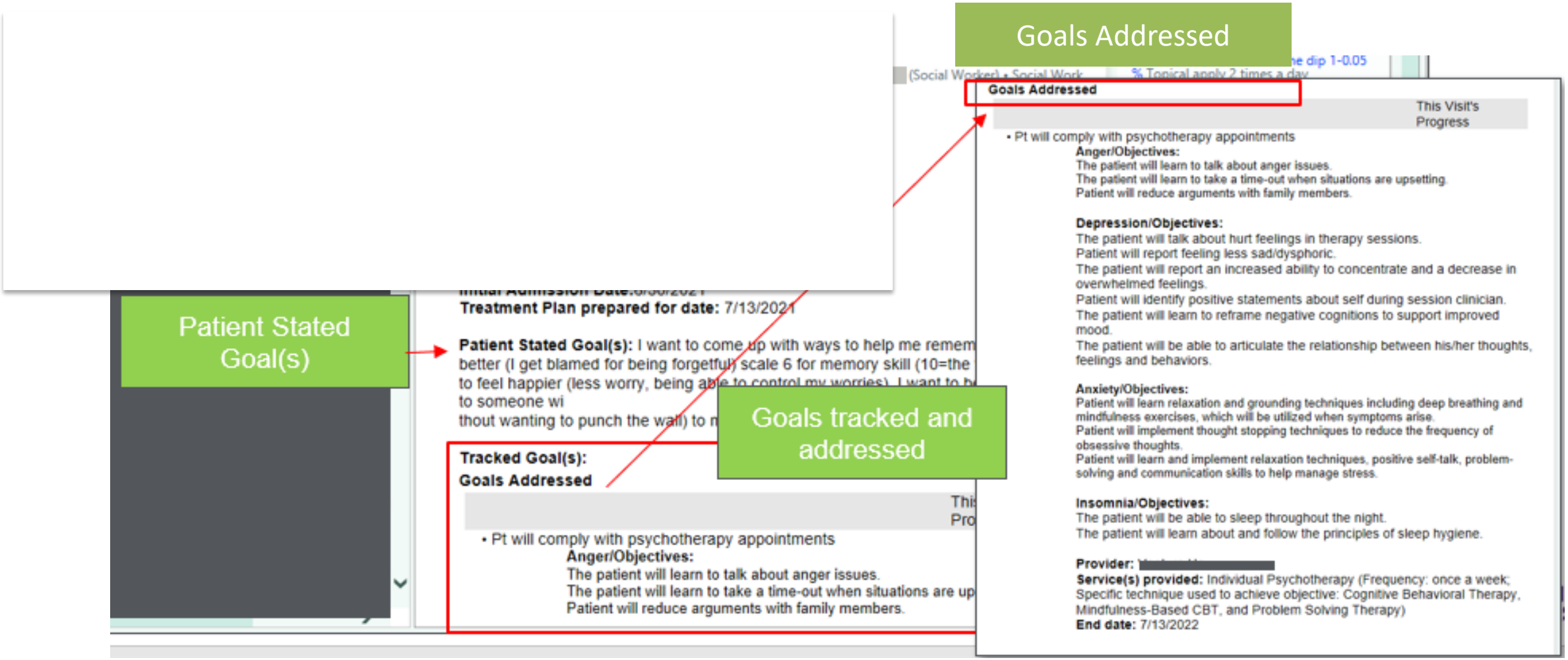
Integrated Care Planning

Integrated Care Plan

- What are fundamental components?
- What are possible limitations?
- Let's take a look at some actual examples…

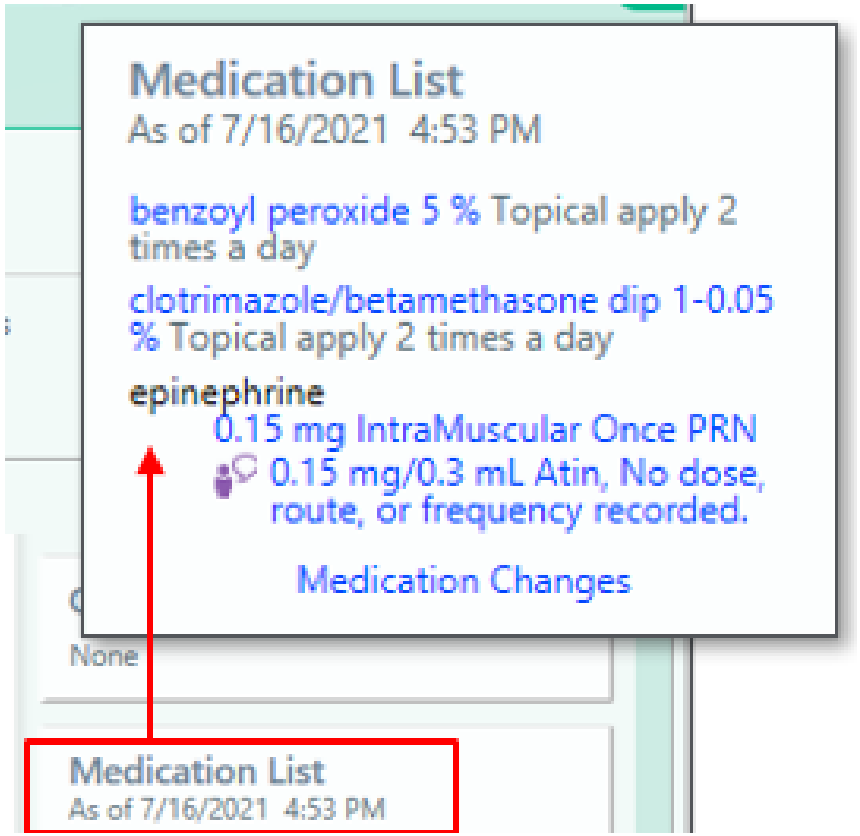
Integrated 'Team'

Goals Tracked and Addressed

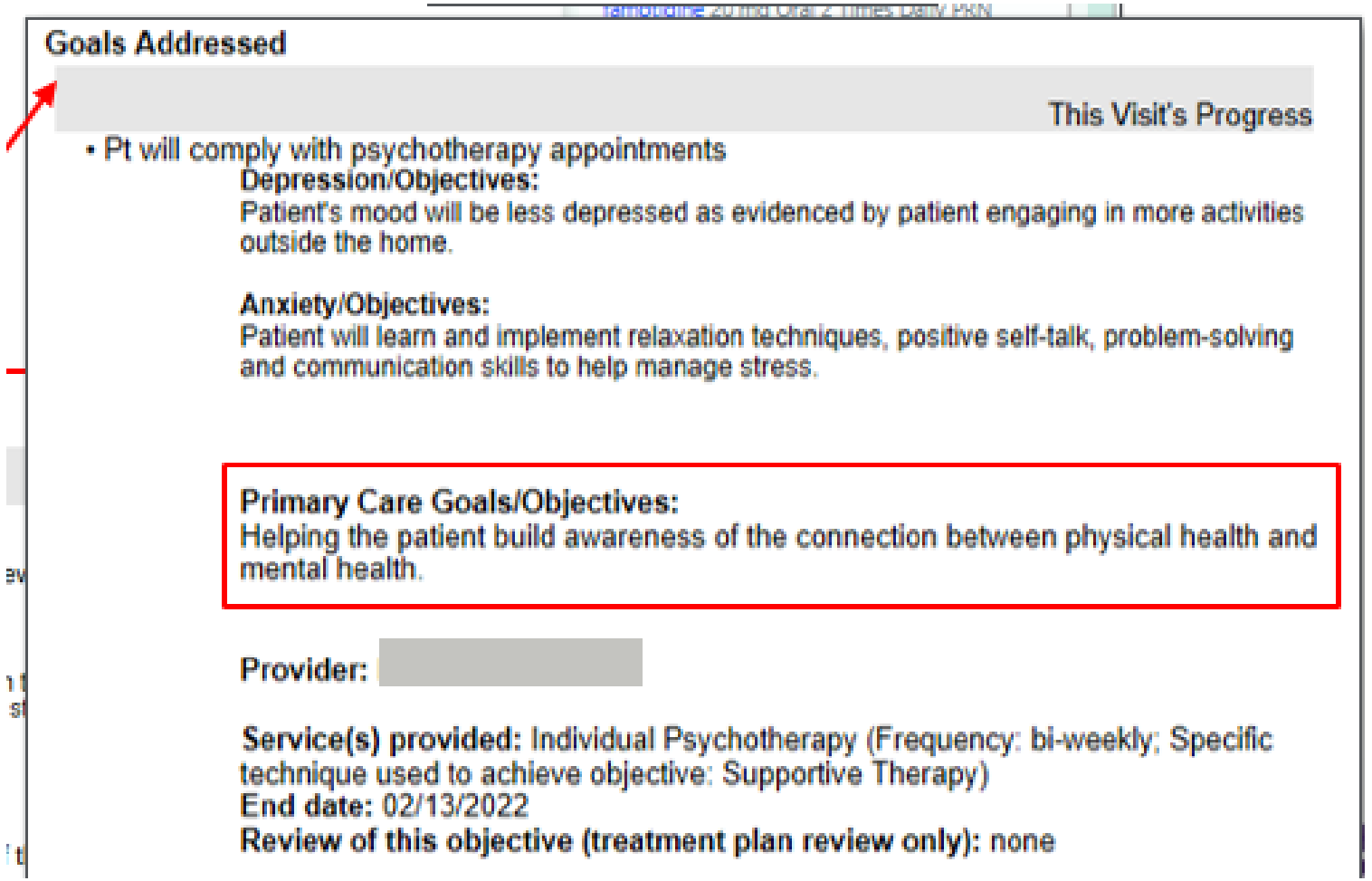


Shared Medication List

- Single care team
- Single list of goals
- Single medication list shared among providers



Identification of Goals and Corresponding Provider



Goals Addressed

This Visit's Progress

- Pt will comply with psychotherapy appointments

Depression/Objectives:
Patient's mood will be less depressed as evidenced by patient engaging in more activities outside the home.

Anxiety/Objectives:
Patient will learn and implement relaxation techniques, positive self-talk, problem-solving and communication skills to help manage stress.

Primary Care Goals/Objectives:
Helping the patient build awareness of the connection between physical health and mental health.

Provider:

Service(s) provided: Individual Psychotherapy (Frequency: bi-weekly; Specific technique used to achieve objective: Supportive Therapy)
End date: 02/13/2022
Review of this objective (treatment plan review only): none

Chat Question:

- Do you have an integrated are plan?
- What is missing? What might make it better? (chat in your response)

The Future

- Graduate medical education is changing – MI, patient centered, culturally relevant care
- Research has demonstrated the value of integrated care for patient and provider
- Primary care of support programs (e.g. LCP) that involve BH support
- Functional goals as key – helping patients determine their motivation and leveraging that to encourage behavior change and improved adherence

Post-webinar Skills and Comfort Poll

After attending this webinar, please rate your skills and comfort with implementing procedures and policies that operationalize cross-team collaboration within integrated care settings.

1. Very Low
2. Low
3. Moderate
4. High
5. Very High

Office Hour

Upcoming Center of Excellence Events:

CoE-IHS Office Hour: Racial Equity & Social Justice in Integrated Care Settings

Register for the office hour on Tuesday, April 26, 3-4pm ET

CoE-IHS Webinar: Comprehensive Health Integration Series

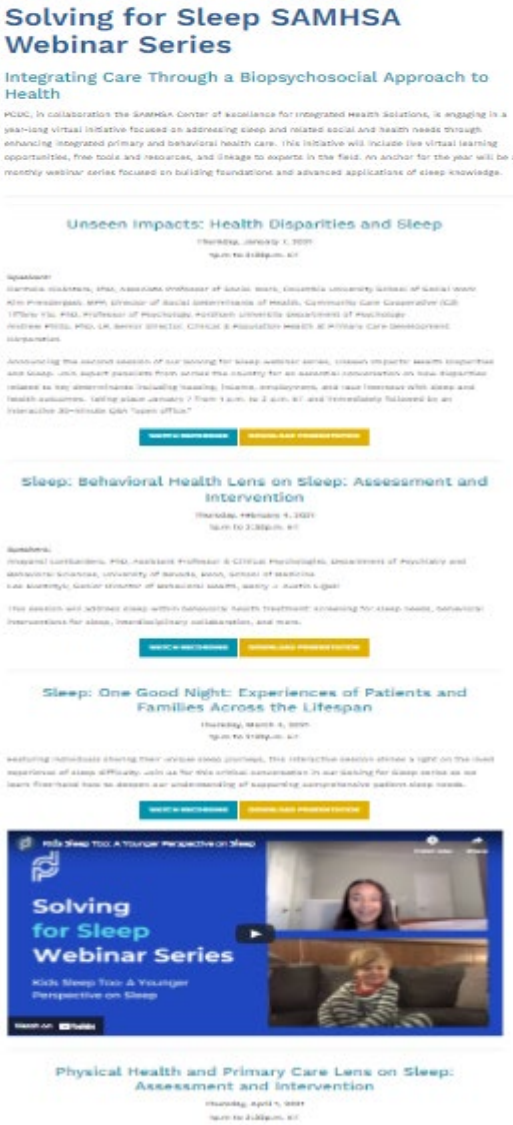
- **Part 1: Introducing a New Framework - Register for the webinar on Wednesday, April 27, 12-1pm ET**
- **Part 2: Domains & Constructs – Register for the webinar on Wednesday, May 25, 1-2pm ET**

CoE-IHS Webinar: Perinatal Health Series

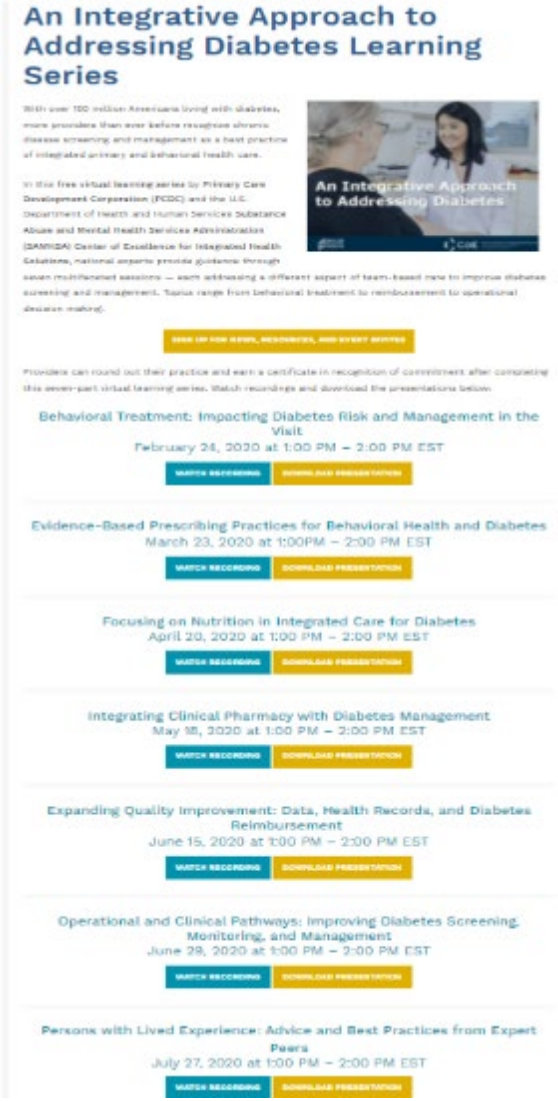
- **Part 1: The Case for Integration & Considerations Across the Continuum of Care - Register for the webinar on Tuesday, May 10, 1-2pm ET**
- **Part 2: Integrating Services for Pregnant & Post-Partum People in High Need Settings - Register for the webinar on Thursday, May 12, 2-3pm ET**
- **Office Hour: Health Equity in Perinatal Health – Register for the office hour on Thursday, May 26, 2-3pm ET**

Contact Us

Kristin Potterbusch
Kpotterbusch@pcdc.org



pcdc.org/sleep



pcdc.org/diabetes