From Head to Toe: Integrated Care to Meet the Whole Person’s Needs
From Head to Toe:

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Chief Psychiatric Officer
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Today’s Focus

• What is Integrated Behavioral Health and Primary Care and Why Is It Important?
• MeHAF Experience: Genomic Insertion
• What We Learned
• Policy and Leadership Issues
• PCHC: What Taking Care of Head to Toe Needs Really Looks Like
IHI Triple Aim

- Population Health
- Experience of Care
- Per Capita Cost
Why is Integrated Care needed?

- 7 out of 10 in primary care waiting room have behavioral health-related needs
- 40% have mental health issues
- 68% of persons with MI have medical conditions
Meet people where they are

- 8 times as many would rather see PCP than MI
- 54% with psychiatric conditions treated by PCP alone
- 75% of all psychiatric prescriptions from PCPs
- 50% of mental health problems go un-identified
- Depression is risk factor for type 2 DM, post MI death


Charles Nemeroff, MD, PhD “Depression and Heart Disease: Link is Clear” JAMA 1993;270:1819-25
Maine Study: Comparison of Health Disorders Between SMI & Non-SMI Groups

<table>
<thead>
<tr>
<th>Disorder</th>
<th>SMI (N=9224)</th>
<th>Non-SMI (N=7352)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skeletal-Connective</td>
<td>59.4</td>
<td></td>
</tr>
<tr>
<td>Gastro-Intestinal</td>
<td>33.9</td>
<td></td>
</tr>
<tr>
<td>Obesity/Dyslipid</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td>28.6</td>
<td></td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>28.4</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>22.8</td>
<td></td>
</tr>
<tr>
<td>Dental Disorders</td>
<td>21.7</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>16.5</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>11.5</td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td>11.1</td>
<td></td>
</tr>
<tr>
<td>Pneumonia/Influenza</td>
<td>6.3</td>
<td></td>
</tr>
<tr>
<td>Liver Disease</td>
<td>5.9</td>
<td></td>
</tr>
</tbody>
</table>
Monthly Expenditures for Chronic Conditions With and Without Comorbid Mental Illnesses

From Melek and Norris (2005 Marketscan data)
10 Deadly Behaviors

- Tobacco use
- Lack of physical activity
- Avoidable infections/toxins
- Gun misuse
- Unsafe driving

- Poor diet
- Alcohol abuse
- Exposure to
  - Unsafe sex
  - Illicit drug use

Plus Nonadherence Behavior

More than half - smoking, being inactive and eating badly.

Actual causes of death in the United States.
McGinnis JM - JAMA - 10-NOV-1993; 270(18): 2207-12
What is Integrated Care?

- Integrated Care brings behavioral, mental, and physical health to people in a coordinated way. It creates a relationship between a patient and a team of health professionals to achieve improved health and cost effectiveness.

- *Desired Outcome*: People’s health, daily lives, and functioning improve as a result of engaging with a health care system that treats them as whole persons. The system integrates behavioral health and primary care and is cost effective.

- Backbone of care
# Levels of Collaboration

<table>
<thead>
<tr>
<th>Function</th>
<th>Minimal Collaboration</th>
<th>Basic Collaboration from a Distance</th>
<th>Basic Collaboration On-Site</th>
<th>Close Collaboration/Partly Integrated</th>
<th>Fully Integrated/Merged</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access</strong></td>
<td>Two front doors; consumers go to separate sites and organizations for services</td>
<td>Two front doors; cross system conversations on individual cases with signed releases of information</td>
<td>Separate reception, but accessible at same site; easier collaboration at time of service</td>
<td>Same reception; some joint service provided with two providers with some overlap</td>
<td>One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model</td>
</tr>
<tr>
<td><strong>Services</strong></td>
<td>Separate and distinct services and treatment plans; two physicians prescribing</td>
<td>Separate and distinct services with occasional sharing of treatment plans for Q4 consumers</td>
<td>Two physicians prescribing with consultation; two treatment plans but routine sharing on individual plans, probably in all quadrants;</td>
<td>Q1 and Q3 one physician prescribing, with consultation; Q2 &amp; 4 two physicians prescribing some treatment plan integration, but not consistently with all consumers</td>
<td>One treatment plan with all consumers, one site for all services; ongoing consultation and involvement in services; one physician prescribing for Q1, 2, 3, and some 4; two physicians for some Q4: one set of lab work</td>
</tr>
<tr>
<td><strong>Funding</strong></td>
<td>Separate systems and funding sources, no sharing of resources</td>
<td>Separate funding systems; both may contribute to one project</td>
<td>Separate funding, but sharing of some on-site expenses</td>
<td>Separate funding with shared on-site expenses, shared staffing costs and infrastructure</td>
<td>Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility</td>
</tr>
<tr>
<td><strong>Governance</strong></td>
<td>Separate systems with little of no collaboration; consumer is left to navigate the chasm</td>
<td>Two governing Boards; line staff work together on individual cases</td>
<td>Two governing Boards with Executive Director collaboration on services for groups of consumers, probably Q4</td>
<td>Two governing Boards that meet together periodically to discuss mutual issues</td>
<td>One Board with equal representation from each partner</td>
</tr>
<tr>
<td><strong>EBP</strong></td>
<td>Individual EBP’s implemented in each system;</td>
<td>Two providers, some sharing of information but responsibility for care cited in one clinic or the other</td>
<td>Some sharing of EBP’s around high utilizers (Q4) ; some sharing of knowledge across disciplines</td>
<td>Sharing of EBP’s across systems; joint monitoring of health conditions for more quadrants</td>
<td>EBP’s like PHQ9; IDDT, diabetes management; cardiac care provider across populations in all quadrants</td>
</tr>
<tr>
<td><strong>Data</strong></td>
<td>Separate systems, often paper based, little if any sharing of data</td>
<td>Separate data sets, some discussion with each other of what data shares</td>
<td>Separate data sets; some collaboration on individual cases</td>
<td>Separate data sets, some collaboration around some individual cases; maybe some aggregate data sharing on population groups</td>
<td>Fully integrated, (electronic) health record with information available to all practitioners on need to know basis; data collection from one source</td>
</tr>
</tbody>
</table>
MeHAF Investment

- $10 million
- 10 years
- Convening
- Grant Funding
- Research and Evaluation
- Policy Support for Sustainability
- Focus on Patient and Family-Centered Care
MeHAF Grantmaking, TA

- 3 rounds of funding
- 2007-2009
- Implementation 2008-2012
- Planning and Implementation
- Clinical Services and Systems Transformation
- Active Learning Community with quarterly meetings, Reimbursement and Coaching TA
Evaluation

- State-level
- Site Self Assessments
- Site Specific Evaluation and Outcome Measures
- Cross-Site Evaluation--JSI
Rapid Spread

- Maine Hospital Association efforts (with payment incentive legislated)
- SIM grant
- Patient Centered Medical Homes
- ACA Section 2703 Health Homes Stage A
- ACA Section 2703 Behavioral Health Homes (Stage B)
- MeHAF Behavioral Health Homes 5 planning grants
- BHHAC
Medical Home Movement

~ 540 Maine Primary Care Practices

82 NCQA PCMH Recognized Practices

~100 MaineCare Health Home Practices

26 Maine PCMH Pilot Practices

20 Pilot Phase 2 Practices

14 FQHCs CMS APC Demo

Payers:
- Medicare
- Medicaid
- Commercials (Anthem, Aetna, HPHC)

Payer: Medicare

Payer: Medicaid
State of Maine Initiatives (Including DHHS)

- Waivers
- Value-based Contracting
- SIMS
- Health Homes/PCMH
- ACO State Employees’ contracts
- Health InfoNet
- Recovery ME
- CDC
- Grants (AHRQ, MeHAF)
- Maine Health Management Coalition (Quality Indicators) Aligning Forces
What Have We Learned? (Adoption)

• Model evolution
• Leadership and PC provider buy-in
• BHP willingness to adapt to PC settings and to market services
• Perception that integration provides value added
• Patient and Family involvement in planning and decision making
What Have We Learned? (Clinical)

- Processes (screening, morning/hallway huddles, warm hand-offs, documentation)
- Changes in practice patterns (PCP and BHPs)
- Team approach (equal decision making)
- Articulated communication/collaboration processes
- Case/care management
- Patient-centered care
- Helpful: HIT
As soon as your dentist gets here, we’ll begin.
Patient Engagement/Involvement-4 Levels

- Broad Patient Community Involvement:
  - Patient advisory councils
  - Educational events
  - Surveys, Focus Groups (limited value)

- Direct Care Patient Engagement:
  - New patient education sessions
  - Precalls and call backs for no-shows
  - Waived fee for first behavioral health visit
  - Warm-handoffs
  - Scheduling BH and PCP appointments same day
  - Motivational interviewing
Policy Support for Sustainability

- Develop internal, external champions
- Identify barriers
- Convene Policy Committee
- Coaching for reimbursement codes; Regulatory support for sites
- Recruit public and private payer support
- Operationalize policies and procedures (PDSA)
- Integrated Care Training Academy
- Connect to national efforts
Policy Support for Key Issues

- Licensing, regulations, certification
- Work force development
- Relationship building
- Patient-centered care
  - Same Day co-pays
## Funding, Licensing and Regulation Grid

**Information for the state of Maine - Updated August 2009**

### Commercial and State Funders

<table>
<thead>
<tr>
<th>E&amp;M</th>
<th>Health &amp; Behavior</th>
<th>Health &amp; Behavior</th>
<th>Psychiatric Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201-99205</td>
<td>New Pt MD/NP/PA</td>
<td>96150 Assessment</td>
<td>Psych MD etc LCSW/PhD</td>
</tr>
<tr>
<td>99211-99215</td>
<td>Established Pt MD/NP/PA</td>
<td>96151 Re-assessment</td>
<td>Psych MD etc LCSW/PhD</td>
</tr>
<tr>
<td>99401-99404</td>
<td>Prev Med Ind Couns MD/NP/PA</td>
<td>96152 Ind Intervention</td>
<td>Psych MD etc LCSW/PhD</td>
</tr>
<tr>
<td>99411-99412</td>
<td>Prev Med Grp Couns MD/NP/PA</td>
<td>96153 Grp Intervention</td>
<td>Psych MD etc LCSW/PhD</td>
</tr>
</tbody>
</table>

### Administration and Interpretation of Health Risk Assessment Instrument

| 99242 Aetna - in Physician practice | 96110 Mental Health License |

<table>
<thead>
<tr>
<th>Telephone eval and management service</th>
<th>Physician practice and for Psychiatry</th>
</tr>
</thead>
</table>

### Phone Consults

| Physician, Medicaid only, Mass |

### Hospital License

| Hospital License |

### Primary Care Office - Physician Practice

| Primary Care Office - Physician Practice |

### Rural Health Clinic

| Rural Health Clinic |

### FQHC

| FQHC |

### FQHC Look-alike

| FQHC Look-alike |

### Developed by Mary Jean Mork, Neil Korsen, Girard Robinson and MaineHealth Funding and Licensing workgroup - based on information available. Contact morkm@mmc.org
Practice/Organization Level Learnings

• You think you’re wicked smart until you learn you aren’t.

• Go slow to go fast.
  – It takes time to change behavior (patients’, staff’s, organization’s).
  – Don’t expect results too fast.
  – Anticipate professional culture clash.
OK... ON THE COUNT OF THREE, WE EVOLVE INTO PIRANHA

STRATEGY VS. REALITY
Lessons: Administrative

- Top leadership support is essential.
- Develop clear expectations, vision.
- Lead personally.
- Develop partnerships outside your walls.
- Engage personnel, clients, families in meaningful ways. Listen.
Lessons: Administrative

• Develop business model.
• Develop clinical, operational models.
• Align policies and procedures.
• Establish systems of communication.
• Track data and give prompt feedback.
• Encourage shared decision making, innovation
Business Model: Staffing

- Determine level of staffing needed
  - What is realistic on # visits a day expected?
  - What reimbursements and other fees are needed to support that level of staffing?
  - What are the Scope of Practice leverages?
  - Identify potential savings (client flow on PC side; ED visits)

- Who you hire matters
  - Flexibility
  - Marketer
Business Model: Financial

- Put PMPM back into clinical supports and direct care.
- Support your partners financially when they provide services that are not reimbursable (peer navigation, for example).
- Track (what you bill; what is reimbursed, how PMPM is used; savings)
Communication Structures

• Steering Committee—partners, clients, providers, office management, administrators
• Administrative Team Meetings—Finance, operational, policy, clinical staffs
• Clinical Team Meetings, Morning Huddles
• Case/Care Reviews and Critical Incident Reviews
• Community Support/Payers Quarterly Trouble Shooting Meetings
EHR

• Communication and coordination tool
• Integrated client health record across partners
• Link to state HIN
• Develop registries
• Track and report data, giving timely feedback to providers and partners.
Resources: You’re Not Alone!

MeHAF Learning Community meetings, trainings, reimbursement guidelines, coaching

www.mehaf.org/integratedcarelearningcommunity.org

Integrated Care Resource Center:
www.integratedresourcecenter.com - joint initiative of the CMMS, Medicare-Medicaid Coordination Office and the Center for Medicaid and CHIP services

Toolkit
http://www.ibhp.org/
Resources/Technical Assistance Providers:

- **AHRQ’s Integration Academy Center:** [www.integrationacademy.ahrq.gov](http://www.integrationacademy.ahrq.gov) - a coordinating center and a national resource for people committed to delivering comprehensive, integrated healthcare.

- **Center for Health Care Strategies:** [www.chcs.org](http://www.chcs.org) – nonprofit health policy resource center dedicated to improving health care access and quality.

- **Center for Integrated Health Solutions:** [www.integration.samhsa.gov](http://www.integration.samhsa.gov) The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. CIHS is funded jointly by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA).
Complex Work: Worth The Effort!
Stay in Touch

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Integrated Primary Care
From Head to Toe

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Bangor, Maine
Outline

- Who is Penobscot Community Health Care (PCHC)?
- What does integrated care look like at PCHC?
- What is PCHC’s Psychiatry Integrated Primary Care?
Our Mission: We provide access to Patient-Centered, high quality, comprehensive, integrated, health care services regardless of ability to pay.
200 Clinicians
700 Employees
10 Integrated Clinics
PCHC by the Numbers

- 2/3 of patients under 200% federal poverty
- Target Population (70% of patients)
  - MaineCare, Medicare, Uninsured
- 70,000 Patients
- 350,000 visits/yr
- 5,000 New Medical/every year
- 5,000 New Dental/every year
- Joint Commission and NCQA PCMH accredited
- 1 of 10 sites reviewed by AHRQ grant for making of Guidebook to Integrated Care
- $3 Million Affordable Care Program (sliding fee scale)
- $60 Million budget, Federal grants less than 4% of budget
Care Management

- Medical Specialists
- HIV Services
- Pharmacy
- Dental
- MH/SA
- Homeless Services
- Audiology
- Geriatrics
- PT
- PCP
- Patient
What is integrated primary care?
## Different Levels of Integration

<table>
<thead>
<tr>
<th>Level of Integration</th>
<th>Attributes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal Collaboration</td>
<td>Separate site &amp; systems</td>
</tr>
<tr>
<td></td>
<td>Minimal communication</td>
</tr>
<tr>
<td>Basic Collaboration from a distance</td>
<td>Active referral linkages</td>
</tr>
<tr>
<td></td>
<td>Some regular communication</td>
</tr>
<tr>
<td>Basic Collaboration on site</td>
<td>Shared site; separate systems</td>
</tr>
<tr>
<td></td>
<td>Regular communication</td>
</tr>
<tr>
<td>Collaborative Care partly integrated</td>
<td>Shared site; some shared systems</td>
</tr>
<tr>
<td></td>
<td>Coordinated treatment plans</td>
</tr>
<tr>
<td></td>
<td>Regular communication</td>
</tr>
<tr>
<td>Fully Integrated System</td>
<td>Shared site, vision, systems</td>
</tr>
<tr>
<td></td>
<td>Shared treatment plans</td>
</tr>
<tr>
<td></td>
<td>Regular team meetings</td>
</tr>
</tbody>
</table>

*Modified from Doherty, McDaniels, and Baird - 1996*

De - Goals

- De-segregate
- De-fragment
- De-stigmatize

Design a model with enough real world financial viability to allow the model to transfer outside ourselves.
9 Years - >1000 % Growth

- September 2004 1 Psychiatrist, 1 MH/SA Counselor, 1 clinic
- September 2013 - 42 positions, 10 clinics
  - 16 LCPC/ LCSW (MH/SA counselors)
  - 11 Psychiatric Nurse Practitioners
  - 3 MD Psychiatrists – 1 Adult, 1 Geriatric, 1 Child
  - 2 Psychologists
  - 2 APRN– Clinical Nurse Specialists
  - 2 APRN– Clinical Nurse Specialists
  - 2 LADCs
  - 3 CADCs
  - 3 Targeted Case Managers for the Homeless

34,902 psychiatric encounters in 2010
41,890 psychiatric encounters in 2011
49,767 psychiatric encounters in 2012
Where Do We Start? Wherever the PCP suggests:

- Psychiatrist, psychiatric nurse practitioner or psychotherapist as dictated by the primary care practice’s own evaluation of their needs based on their strengths and patient population.

- 8 of 10 started with Psychiatric NP - can prescribe, do counseling, less salary than psychiatrists, trained in biopsychosocial medical model, culturally comfortable and: **FINANCIALLY VIABLE SOONER**

- Pattern has been to then add a Psychologist, LCSW or LCPC comfortable with MH and SA counseling within 1 year after the Psychiatric NP starts.
Comprehensive MH/SA Services

- Substance Abuse and other Mental Health Counseling
- Psychiatric Medication Management
- Psychosocial Evaluations
- Health and Behavior Coach
- Medication Assisted Treatment for Addictions
- MH/SA Groups
- Psychiatric Consultations
- Biofeedback for Pain
- Psychiatric Evaluation
Flexible Integrated Health Home

- Plan based on needs and strengths of the patient, not the practice.
- Different people may need different collaborators for the exact same goal.
- Multiple providers wrapping around the Family Practitioner with the patient as the centerpiece.
- The Family Practitioner manages the complexities utilizing the team members to assist.
- Together form a patient-centered care coordination team.
3 Keys

- RELATIONSHIP
- RELATIONSHIP
- RELATIONSHIP
Services Side by Side
Same Team
Same System
Same Site
Same Mission
Same Budget

Same Email List
Same Door
Same Name
Same Sign

Same Supervision
Same Record
Same Staff
Same Meetings
Same Office Manager
Same Waiting Room

Same
Same
Same
Same
Same
Same
### Intake Review
- Patient Bill of Rights reviewed and questions answered
- HIPAA reviewed and questions answered
- PCHC services reviewed and questions answered
- SF12 Health Profile completed and scored

### Depression
- Have you often been bothered by feeling down, depressed or hopeless? No
- Have you often been bothered by little interest or pleasure in doing things? No

### Alcohol Use Disorder
- When was the last time you had more than five drinks in one day?
  - Never
  - In the past three months
  - Over three months ago

### Intimate Partner Violence
- Have you been hit, kicked, punched, or otherwise hurt by someone in the past year? No
- Do you feel safe in your current relationship? No
- Is there a partner from a previous relationship who is making you feel unsafe now? No

### Social Anxiety Disorder
- Fear of embarrassment causes me to avoid doing things or speaking to people: Not at all
- I avoid activities in which I am the center of attention: Extremely
- Being embarrassed or looking stupid are among my worst fears: Not at all

### Generalized Anxiety Disorder
- Over the last 2 weeks, how often have you been bothered by the following problems?
  - Feeling nervous, anxious, or on edge: Not at all
  - Not being able to stop or control anything: Not at all

### PTSD
- In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:
  - Have had nightmares about it or thought about it when you did not want to? No
  - Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? No
  - Were constantly on guard, watchful, or easily startled? No
  - Felt numb or detached from others, activities, or your surroundings? No
Curbsides and Pop-Ins

- Helps immediately
- Reduces fear
- Cross-educates
- Multiplies the exchange
- Assimilates
- Interruptions are OK
EHR Cements Connections

- Easy collaboration
- Easy to extract information
- Same problem list
- Same medication list
- Same sequential record
- Same look
- Import data into HealthInfoNet

Allergies:
1) Penicillin G Sodium (Penicillin G Sodium)
2) Advil (Ibuprofen)
3) * Flu Vaccination
4) Asa (Aspirin)
5) * Peanuts

Complete Medication List (at conclusion of visit):
1) Ultramate 0.05 % Crea (Flurbiprofen) prn... Bid
Referral
Adaptable types, shorter times

- 30 min medication (illness) management
- 90 min psychiatric evaluation
- 60 min groups
- 30 – 90 min consultations
- 30 – 60 min counseling
- 30 min health and behavior screen
- 60 min psychosocial evals
- 30 min behavioral consults
Hiring the right person:

- Do you think the segregated mental health and substance abuse care system is producing the best possible outcome?
  - If they say yes they probably will not work out

- What would be your response if interrupted in the middle of a session by a colleague with a question?
  - If not ok, explore more

- What furnishings do you need in your office to serve patients?
  - If this makes a big difference, worry
Health Groups

- Obesity
- Diabetes
- Fibromyalgia
- Pain
- Educational
- Wellness
- Parenting
- CBT
- Stress Reduction
- Nutrition
- Substance Abuse
- Mindfulness
Expectations

- Psychiatric Nurse Practitioners 10/d
- MH/SA counselors 8/d
Boat! Land!
PERSPECTIVE
“To provide holistic care, we must always strive to meet patients where they are physically, emotionally and spiritually. The integration of primary medical and psychiatry services is a constant reminder to be conscious of all areas since no one area can be fully addressed in isolation of the others.”

“The communication between practitioners in our office normalizes psychiatric care and puts it back into the whole-person care everybody deserves”
“By having both services together and connected, it is far easier on the patient to get coordinated services which helps to get to the root of the problems, and more quickly!”

“Because they all get to know all aspects of your life. They all know what meds you are on and can ask and tell what is wrong, even when you don’t know what you might forget to ask”

“I know folks understand me and care about me”
Patient Leadership

- Patient Advisory Council at each clinic
- Majority of Penobscot Community Health Center Board made up of patients of the practices
“Thanks to yoga, I now gently stretch to conclusions instead of jumping to them”
Roadblocks

- Self interest ahead of patient
- Poor communication
- Thought distortions
- Compensation plans
- Separate Locations, Records, Admin
- Rules and Regs that segregate
- Failure to assimilate/integrate
- FQHC Medicare – no groups, LCPC, LADC
- bioPSYCHOSOCIAL vs BIOpsychosocial
Outcomes

BEFORE

AFTER
Thank you...

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