Behavioral Health Integration Best Practices and Challenges: *From Theory to Practice*

Linda Weinreb, MD
University of Massachusetts Medical School

Wayne Centrone
Center for Social Innovation (C4)

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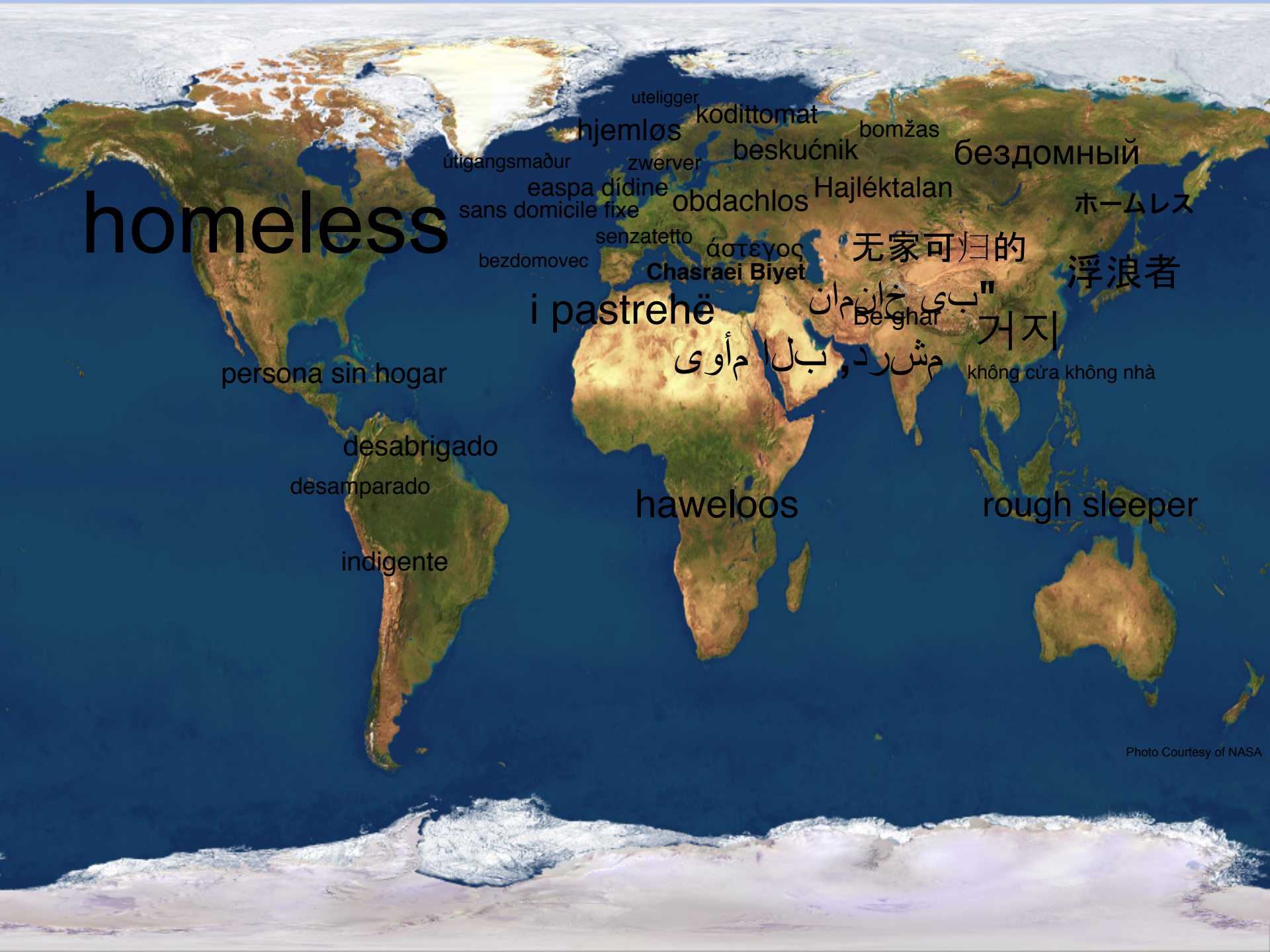
Putting the Pieces Together

- Make the argument for change
- Define “what” is Behavioral Health Integration
- Discuss the collaboration continuum
- Describe models and programmatic examples
- Discuss scaling and operationalization


homeless
uteligger
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бездомный
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obdachlos
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ホームレス
sans domicile fixe
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无家可归的
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Be ghar
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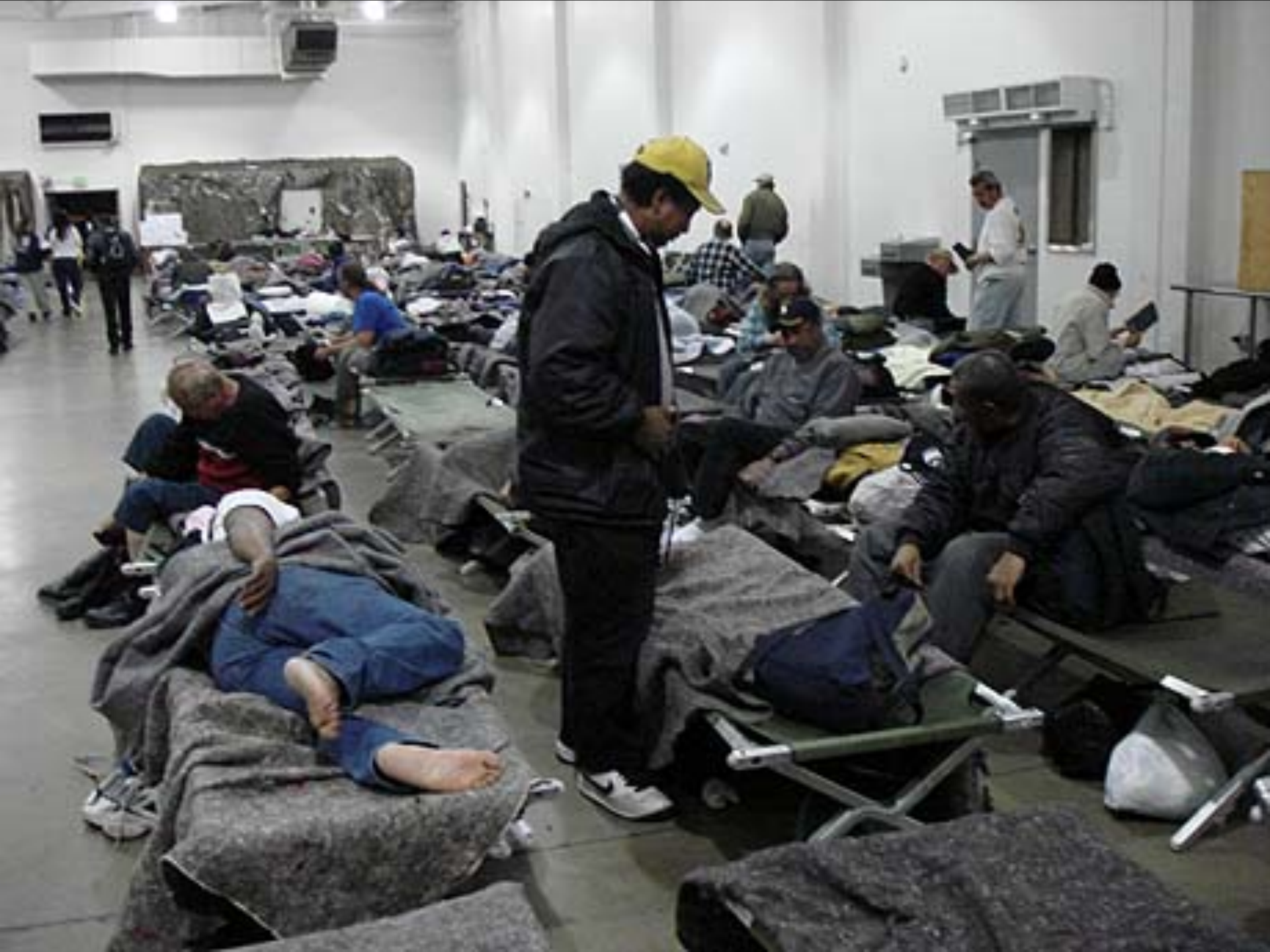
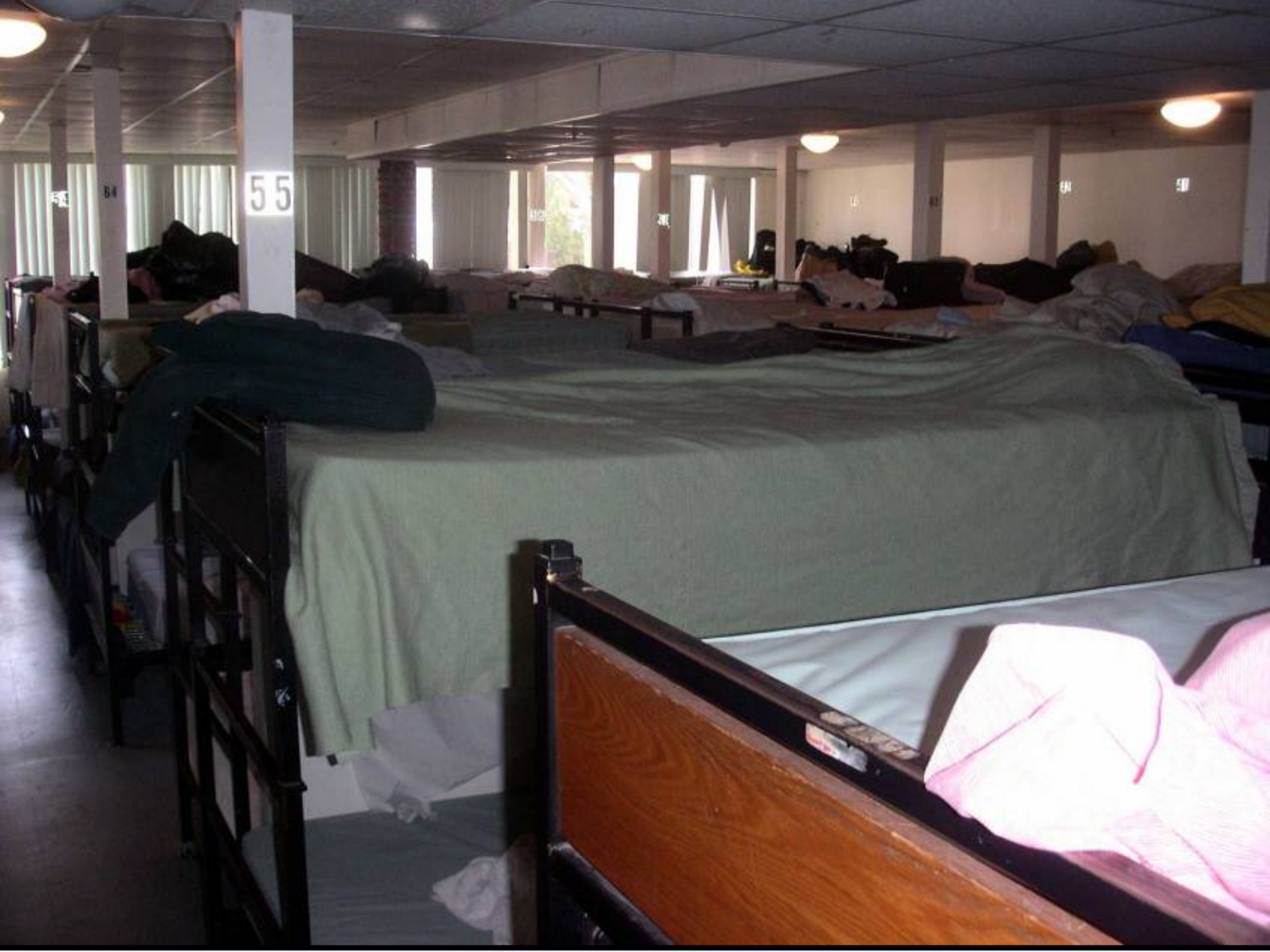
Photo Courtesy of NASA

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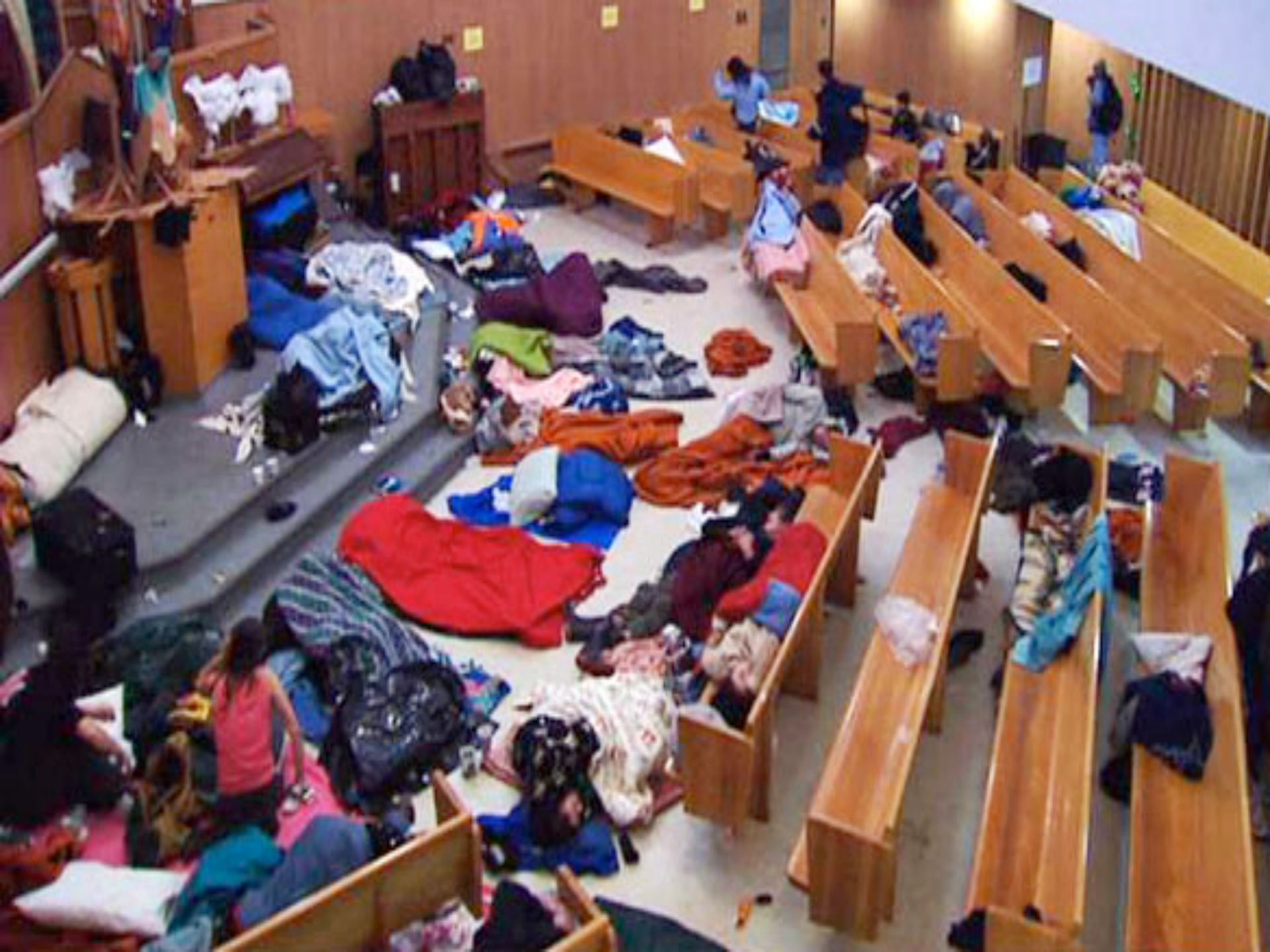
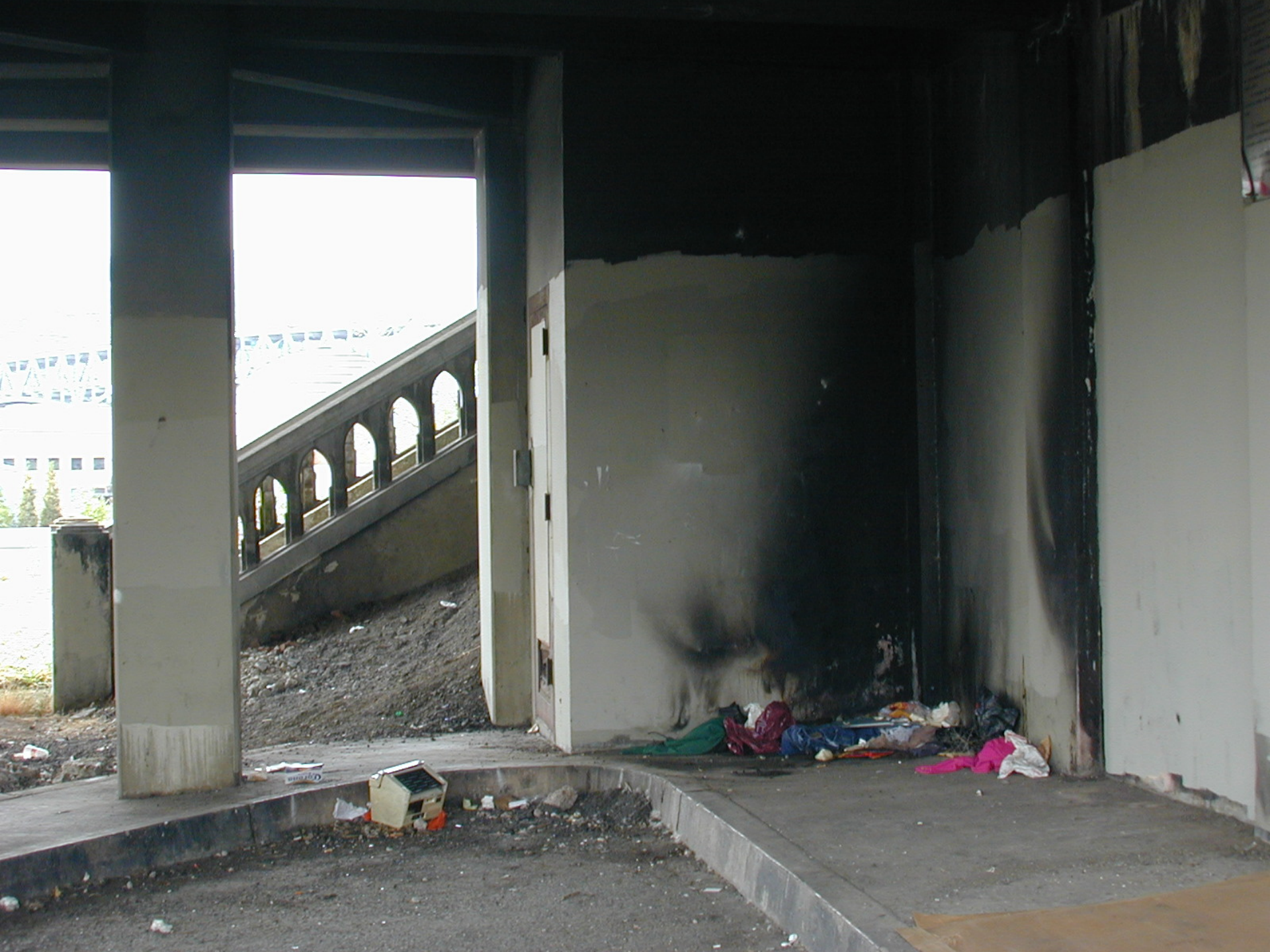
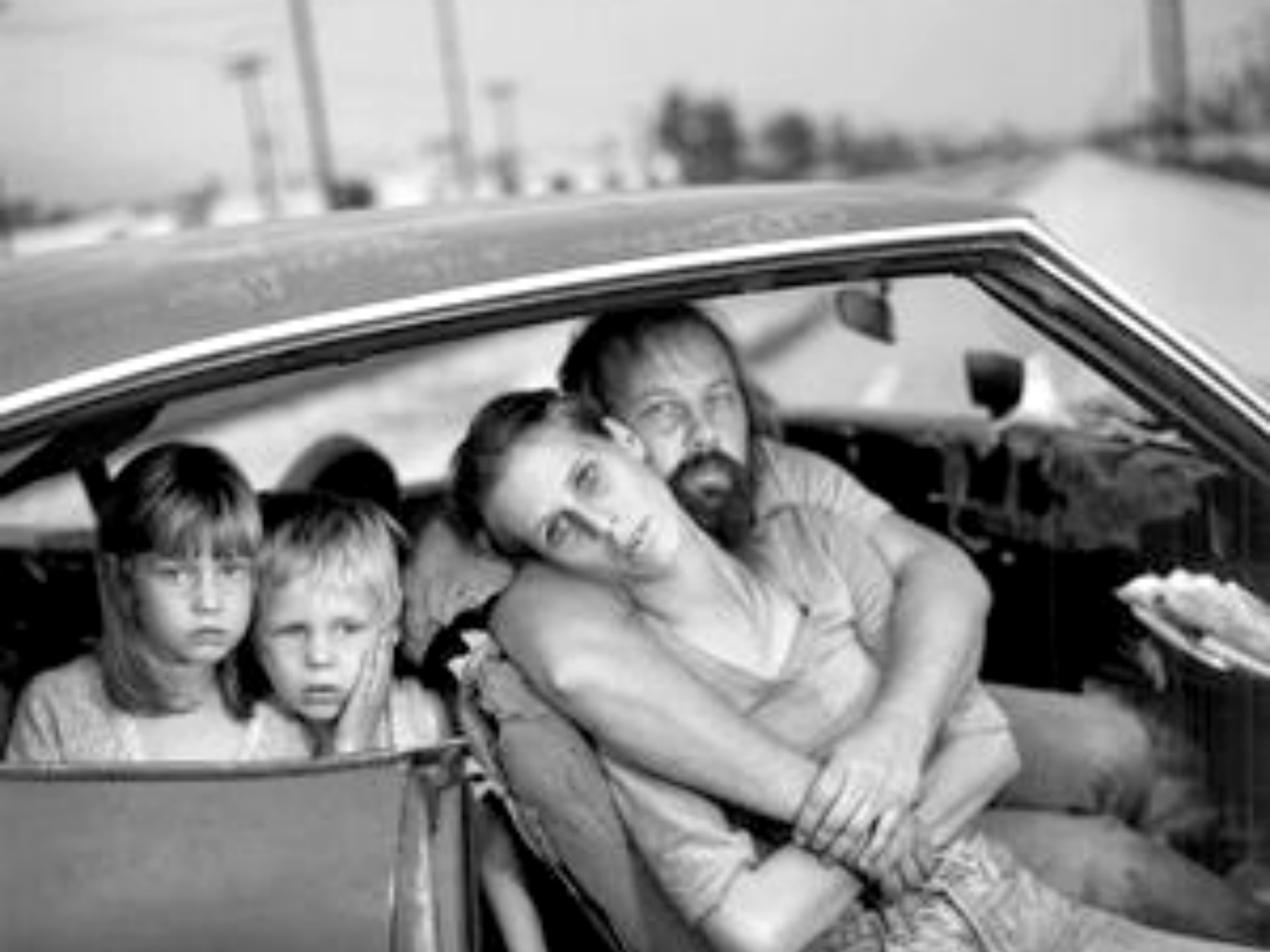
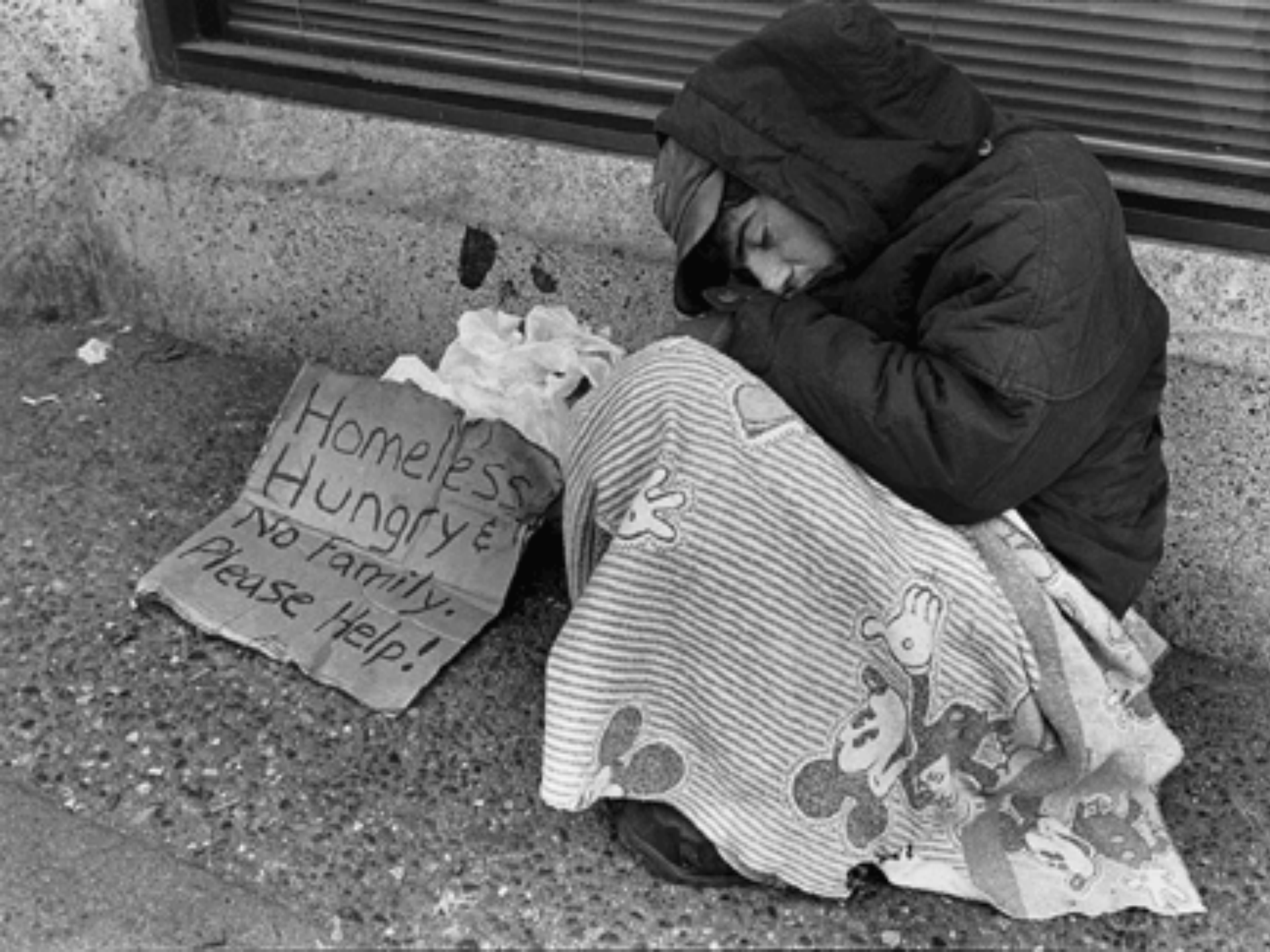
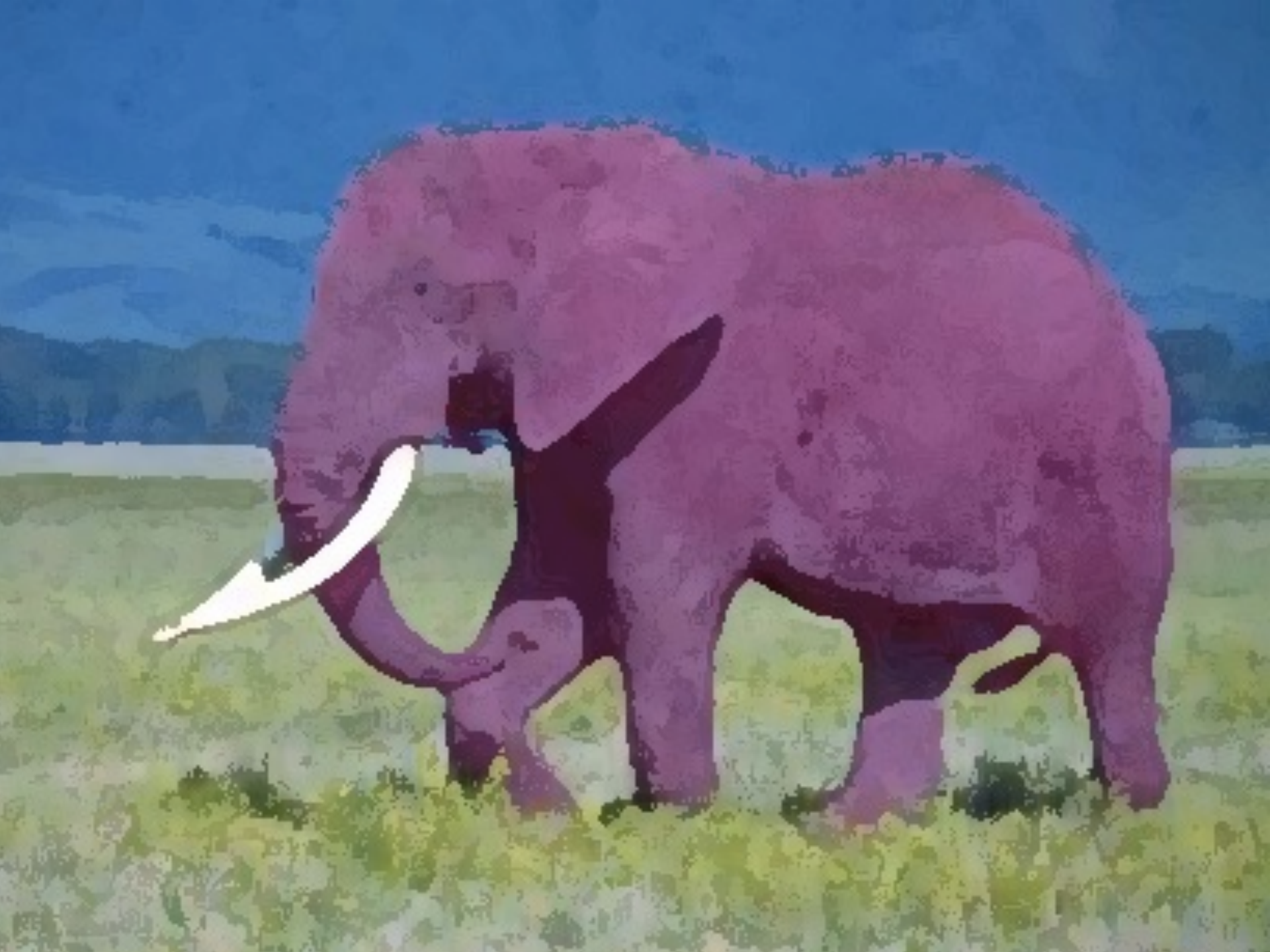







Homeless
Hungry &
No family.
Please Help!

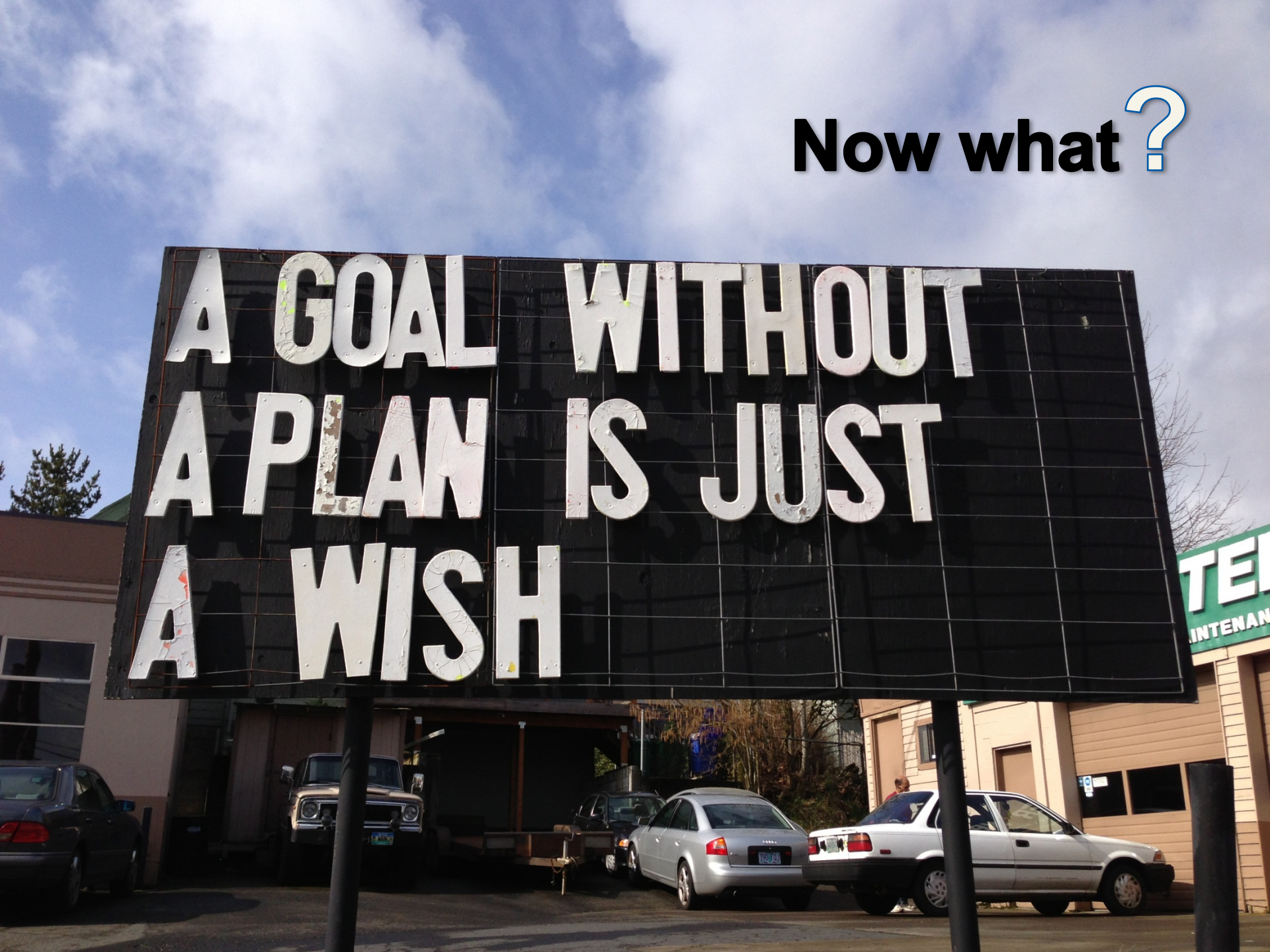


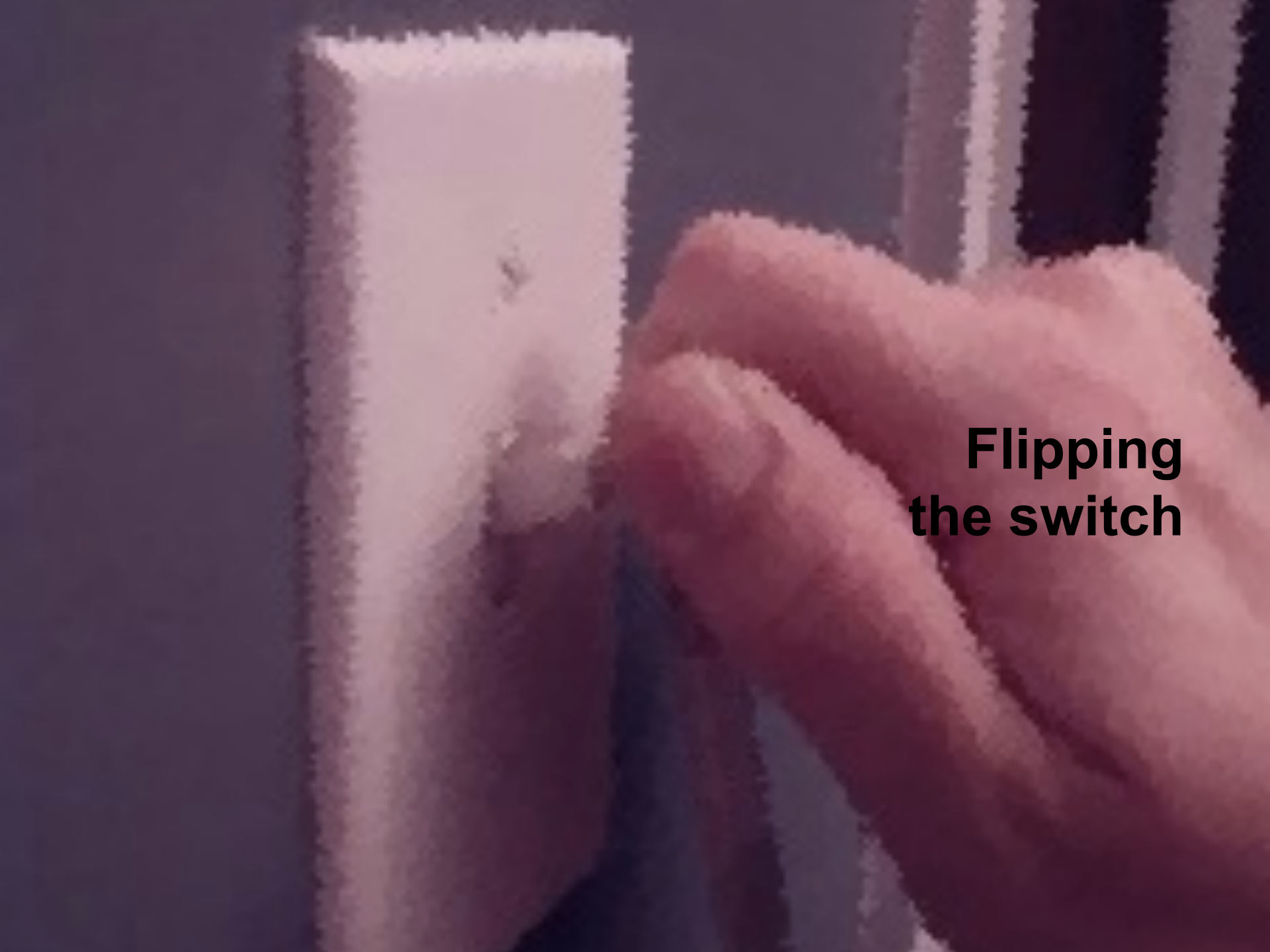

Recovery model

Recovery model

"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential"

(SAMHSA, 2010)


Now what?
A GOAL WITHOUT
A PLAN IS JUST
A WISH


Flipping
the switch

What does research and practice tell us?

That people are actually more *likely* to accept treatment once their basic needs have been met.

Why is Behavioral Health Integration Important?

- Homeless populations have multiple, overlapping needs (e.g., adult singles; families; youth; children)
- Relationship of behavioral health problems to housing stability
- Addresses health system fragmentation
- Growing evidence base supports integrated behavioral health and primary care
- Homeless subgroups may require adaptation and testing of models

Why the Primary Care Setting?

- Unmet physical and behavioral health needs
- Lack of access to mental health/substance abuse services
- Stigma of treatment in mental health/substance abuse setting
- Finding people where they "are," i.e., trauma survivors have physical health sequelae along with psychiatric problems and use health care
- Can build on strengths - *Engage when doing something right*

HCH Programs:
Next Steps to Better Integrate Services

- HCH programs have embraced rationale and integrated practice long before many others!
- No one way or right way to integrate services
- Many opportunities to adapt services to be better integrated
- Focus on implementation process and organizational contingencies is essential

Behavioral Health Integration: What Do We Mean?

- Inconsistent language describing interface of behavioral health and primary care can be confusing
- Are collaborative care and integrated care the same?
  - Overlapping principles and practices
  - Collaborative care: Behavioral health working *with* primary care*
  - Integrated care: Behavioral health working *within* and *as part of* primary care*
- Need for common language and metrics

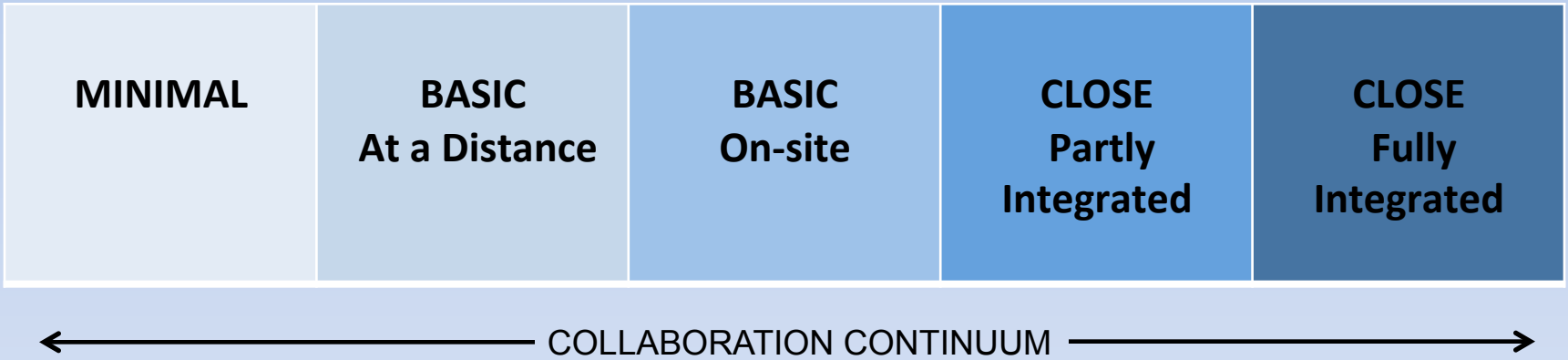
*Collins C et al, Evolving Models of Behavioral Health Integration in Primary Care. Milbank Memorial Fund Report, May 2010

What is Behavioral Health Integration?

- *A practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.**

*Peek CJ and the National Integration Academy Council, AHRQ Annual meeting, Sept 10, 2010; http://integrationacademy.ahrq.gov/

Collaboration Continuum*



*Collins, C, et al. Evolving Models of Behavioral Health Integration in Primary Care, Milbank Memorial Fund, 2010

Primary Care Behavioral Health Integration Models*

Coordinated

- Improving collaboration between separate providers
- Medical-provided behavioral health care

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Co-located

- Co-location
- Disease management
- Reverse co-location
- Unified primary care and behavioral health

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Primary Care Behavioral Health Integration Models*

COLLABORATION CONTINUUM

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- Medical-provided behavioral health care

Co-located

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Integrated

- Primary care behavioral health
- Collaborative system of care

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Primary Care Behavioral Health Integration Models - Coordinated*

- Improving collaboration between separate providers
  - BH providers and PCPs in separate facilities/systems
  - Sporadic communication
  - Referral linkages
  - When reimbursement does not support co-location
  - Barriers: access may be limited, referral follow through, fragmented services, separate records, coordination may not be funded

- Medical-provided behavioral health care
  - BH providers and PCPs in separate facilities/systems
  - Periodic communication about patients
  - Referral linkages
    - Behavioral health consultation support
  - Some evidence base (e.g., SBI, depression)
  - When reimbursement does not support co-location
  - Barriers: access may be limited, referral follow through, fragmented services, separate records, coordination may not be funded

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Primary Care Behavioral Health Integration Models – Co-Located*

- Co-location
- Disease management
- Reverse co-location
- Unified primary care and behavioral health

  - BH and PC share facility: separate → common systems
  - More communication possible; some integration
  - Patients may have better outcomes
  - Barriers: records may remain separate/fragmented services, follow up with referral, coordination may not be funded, benefits vary

*Collins, C, et al. Evolving Models of Behavioral Health Integration in Primary Care, Milbank Memorial Fund, 2010

Primary Care Behavioral Health Integration Models – Integrated*

- Primary Care Behavioral Health/Collaborative System of Care
  - BH and PC closely collaborate; part of the same team
  - Close collaboration → Fully integrated with primary care services
  - Large practices/medical systems
  - Patients may have better outcomes
  - When reimbursement is available
  - Barriers: staff training, coordination may not be funded, benefits vary, office system needs

*Collins, C, et al. Evolving Models of Behavioral Health Integration in Primary Care, Milbank Memorial Fund, 2010

Evidence-based Behavioral Health Primary Care Integration Models

- Collaborative Care Model
  - Depression
  - Anxiety and Substance abuse
- SBIRT (screening, brief intervention, referral to treatment): Alcohol/Drugs
- Specific interventions (selected)
  - Motivational interviewing
  - Seeking Safety/Trauma Recovery and Empowerment Model
  - Critical time intervention
  - Harm reduction (co-occurring mental health/SA disorders)
  - Others

Collaborative Care Model

- Recommended by USPSTF for depression care
- What does the evidence tell us?
  - Essential components
  - Dissemination challenges
- What adaptations are needed for homeless populations?

Integrating Primary Care into Specialty Behavioral Health Practice Settings

- Less known about effective practices compared to behavioral health integration in primary care
- Recognized knowledge/practice gap; growing attention and efforts
- Focus on preventive interventions and chronic disease management

*"Patient Engagement is the Blockbuster Drug of the Century"**

* Forbes 9/9/12; http://www.forbes.com/sites/davechase/2012/09/09/patient-engagement-is-the-blockbuster-drug-of-the-century/

Project Renewal: Research and Education in New Approaches to Alcohol Treatment for Homeless Women (NIAAA, 1R21 AA018311-01)

- Collaboration between UMass Medical School and Boston HCH Program
- Adaptation of CCM and PCP brief intervention
- Design: Intervention compared to usual care; 6 month follow-up
  - Outcomes: treatment initiation and engagement, health and mental health, functional (e.g., housing), provider attitudes/behavior
- Preliminary lessons learned
  - Strengthened linkages with SA agencies can improve service access
  - Systematic screening is challenging
  - Primary care focus on alcohol reduced women's alcohol use

Healthy Moms Project
(NIMH, 5R34 MH085881-01A1)

- Collaboration between UMass Medical School and Care for the Homeless NYC
- Adaptation of CCM: focus on engagement, co-morbidities, and delivering care within demands of context; modify advocate role
- Design: Intervention compared to usual care; 6 month follow-up
  - Outcomes: depression, health and mental health, substance use, functioning (e.g., meeting shelter requirements), parenting
- Preliminary lessons learned
  - Moving from reactive to proactive care management approach requires training, support, and organizational commitment
  - Focus on engagement at treatment initiation may be helpful
  - Understand treatment participation outcomes in context of women's lives is important

Healthy Moms Strong Moms
(MCH/HRSA 5 R40MC23633-01)

- Collaboration between UMass Medical School and Family Health Center Inc. and Edward M Kennedy CHC
- Adaptation of Seeking Safety intervention for pregnant women with PTSD: Modify advocate role to deliver intervention with routine prenatal care support; 6-8 brief sessions
- Design: Intervention compared to usual care; Follow-up @ 32 weeks and one month postpartum
  - Outcomes: PTSD symptoms, depression, substance use, pregnancy complications, birth outcomes, parenting
- Project status: Enrollment underway; 23% of women screened with PTSD or sub-threshold PTSD

Behavioral Health Integration: Challenges to Implementation

- Shifting the agency paradigm from:
  - Deficits and failure to strengths and goals for change
  - Reactive to proactive approach
- Strengthening responsiveness to trauma
- Integrating data collection/QI methods that provide meaningful information
- Developing effective coordination and communication approaches
- Financing and sustainability

Behavioral Health Integration: Many Opportunities and Possible Next Steps

- *What makes sense in our setting? Consider:*
  1. Array of services HCH program and community
  2. Workforce skills and needs
  3. Organizational support
  4. Reimbursement factors
  5. Target specific subgroup?
  6. Site in primary care? Behavioral health care? Both?
- *What are our current priorities and strengths?*
- *What are some feasible goals?*

Opportunities for Scaling

Scaling – what next?

- **Patient Centered Medical Home (PCMH) and Integration of BH services in HCH programs**
  - Changes in the ACA
    - » Health Home: Section 2703
    - » States will receive 90% FMAP for care coordination provided in conjunction with a health home
- **Models of staffing**
  - Recruitment
  - Training
  - Retention
- **Funding**
  - Models
  - Programs

Now what?

Operationalizing

- **Low hanging fruit**
  - Where are you already integrating services and supports?
- **Translational tools**
  - Motivational Interviewing
  - Critical Time Intervention
  - Strength-based approaches
  - Trauma-informed practices and principles
- **Partnerships**
  - Complementary
  - Aligned through shared philosophy, vision, values
  - "Gap" filling
- **Housing Focused**
  - Beyond the "three S's"
  - Housing First

Operationalizing

- **Colocation**
  - Integrated care delivery out of necessity
  - Uniting services and supports in one environment for ease of client engagement
  - E.g. Road Warrior Project
- **Recovery model**
  - "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (SAMHSA, 2010) (http://www.samhsa.gov/recovery/)
- **Consumer/client involvement**
  - Offer opportunities for decision making, transparency, and allowing client to define success
  - Celebrate success collaboratively
- **Support staff development**
  - Inventory current challenges, knowledge & success
  - Consider response in context of holistic HR

Next Steps

- Questions
- Support and TA/Training
- Materials
  - HCHC Website
  - SAMHSA
  - CMS
- Next up
  - Small Group Breakout Sessions