Working together to deliver physical-behavioral health integration for individuals experiencing chronic homelessness

Mark Sperber, MA
Behavioral Health Consultant, LPC-S, LMFT, LCDC
Healthcare for the Homeless – Houston

David S. Buck, MD, MPH
Professor
Baylor College of Medicine
Healthcare for the Homeless - Houston

Joseph Benson
Community Health Worker
Healthcare for the Homeless - Houston

Objectives

- *By the end of this session, participants will be able to:*
- 1): Name three strategies for tailoring the PCBH model to homeless population;
- 2): Discuss a clinical and a systems challenges to implementing the PCBH model in a homeless clinic;
- 3): Identify three brief screening tools that are helpful for integrated care.

The Story of Anna…

What is integration?

Terms and Description

Important Terms

PCP = Primary Care Provider

Retains ultimate responsibility for patient care

BHC = Behavioral Health Consultant

Member of the primary care team

Integrated Models

Referral		Co-Located		Integrated	
Key Element: Communication		**Key Element: Physical Proximity**		**Key Element: Practice Change**	
Level 1 *Minimal Collaboration*	**Level 2** *Basic Collaboration at a Distance*	**Level 3** *Basic Collaboration On-Site*	**Level 4** *Close Collaboration On-Site with Some System Integration*	**Level 5** *Close Collaboration Approaching an Integrated Practice*	**Level 6** *Full Collaboration in a Transformed/ Merged Integrated Practice*
Behavioral health, primary care and other healthcare providers work:					
In separate facilities	**In separate facilities**	**In same facility not necessarily same offices**	**In same space within the same facility**	**In same space within the same facility (some shared space)**	**In same space within the same facility, sharing all practice space**

Doherty, McDaniel, & Baird, 1996

What is the “Primary Care Behavioral Health” model?

The Primary Care Behavioral Health (PCBH) Model

- Behavioral Health Consultant (BHC) embedded within the primary care setting
- **Brief Interventions & Pathway Services**
  - One-on-One
    - PCP Prep
    - Conjoint Visit
    - Warm-handoff
  - Screening
  - Classes or workshops
  - Group visits

Behavioral Health Presence In PC – Why?

- **84%** of the time, the 14 most common physical complaints have no identifiable organic etiology[1]
- **80%** of individuals with a behavioral health disorder will visit primary care at least 1 time in a calendar year[2]
- **50%** of all behavioral health disorders are treated in primary care[3]
- **20-40%** of primary care patients have behavioral health needs[4]
- **48%** of the appointments for all psychotropic agents are with a non-psychiatric primary care provider[5]

Sources: [1]Kroenke & Mangelsdorf, Am J Med. 1989;86:262-266. [2]Narrow et al., Arch Gen Psychiatry. 1993;50:5-107.
[3]Kessler et al., NEJM. 2006;353:2515-23. [4]Martin et al., Lancet. 2007; 370:859-877. [5]Pincus et al., JAMA. 1998;279:526-531.

Why be brief?

- Primary care = fast-paced
- Lots of patients
- “On-Demand” services
- Population health focus (think horizontal versus vertical)
- Problem-focused
- Clear plan focused on patient’s strengths and abilities

What did we want to address by integrating?

- High no-show rates
- Poor referral success
- Treating the “difficult patient”
- Providing behavioral health in a less stigmatizing fashion

Background - SMI

- Individuals with severe mental illness (SMI):
  - Higher rates of mortality
  - Higher prevalence of chronic disease compared to the general population
- Health care status of homeless with SMI (Weinstein, et. al, 2014):
  - Individuals with experiences of homelessness and SMI also have serious medical/chronic illnesses
  - Integrated behavioral health care programs can improve access to care and offer regular health screenings

Background - SMI

- Miller, Brown-Levey, Payne-Murphy, & Kwan (2014) : Behavioral Health Consultants (BHCs) can address needs of persons with SMI by:
  - Behavioral interventions for physical health diagnoses
  - Monitoring medications and side effects
  - **Lower no-show rates in PC compared to specialty mental health**

What do you do in a brief, BH visit?

- Example interventions:
  - **Symptom/mood management**
    - Patient Education
    - Psychological skills (e.g. mindfulness, cognitive defusion)
    - Building Awareness/Options for behavior change
    - Problem Solving
    - Goal Setting
  - Behavioral Activation
  - Relapse Prevention Skills
  - Behavioral Medicine (e.g., self-mgmt for diabetes, sleep hygiene)
  - Learning to practice these consults are often a new skill for MH providers

Screening Tools

- PHQ-9: Depression screener
- GAD-7 – Anxiety screener
- PCL-5 – PTSD screener
- AUDIT – ETOH screener
- DAST – Drug Abuse Screener

- All these screening tools are in the EMR and each new patient in the clinic is administered PHQ-9, AUDIT, and DAST
- The use of screening tools can be tied to clinical pathways

PHQ9 Clinical Pathway

PHQ-9 completed at pt check-in for med appts (in new pt paperwork) – assist pt if needed

For PCC* or BHC*

PHQ-9 Administered **(New pts only)**

Score 5+ or question 9 ≥ 1? BHC follow-up (warm hand-off) or PCC assessment

*If BHC not present, schedule pt for BHC follow-up on same day as PCP appt for depression mgmt at later date

Score ≤ 4? No further action

*If BHC is not present, PCP should conduct suicide risk assessment if question 9 on PHQ-9 is ≥ 1 (before the pt leaves clinic visit)

MA enters PHQ-9 information in medical record (Problem List → enter "V79.0" in "search for new item" section and click "add." **Assess question 9: if "0," scan hard copy of PHQ-9 into chart. If greater than "0," alert pt's PCC or BHC before scanning into pt's chart.**

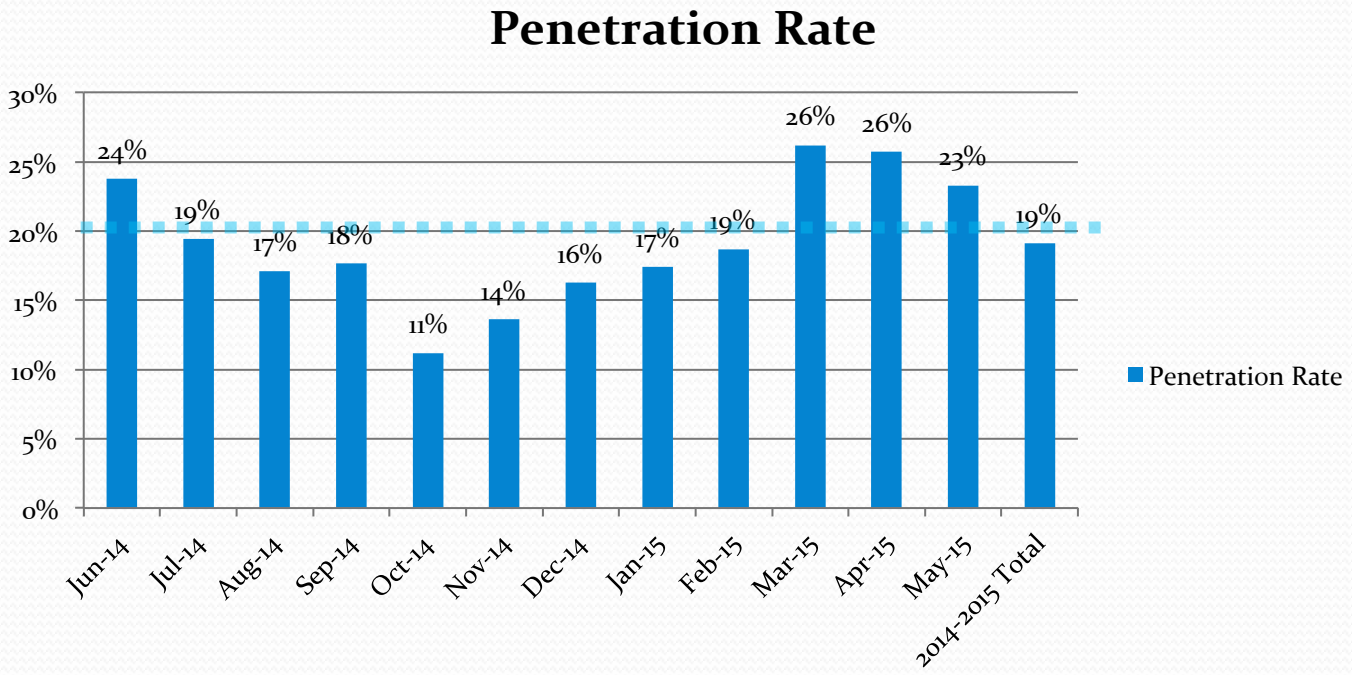
How does the PCBH model work?

- **System Integration and Operation Issues**
  - Clinical service delivery altered(e.g., cold consult, joint consult, warm-hand off).
  - EHR already in place - allowed for BHC to create a same-day encounter with a patient as well as create a note that can be viewed by the entire treatment team, as well as a note that can have additional signers (e.g., PCC and BHC, BHC and case manager).
  - Medical assistants: continued role as ancillary staff to the PCCs, but also provided additional assistance for the BHC such

So… how did it go?

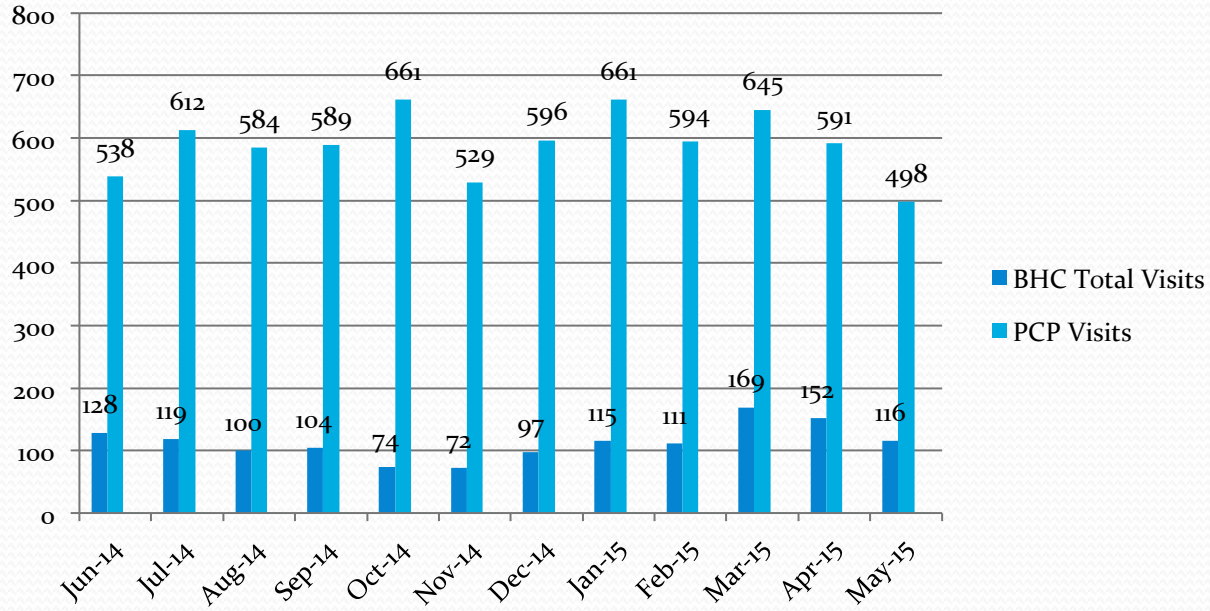
Reflections on the first year of PCBH practice at HHH

Data?



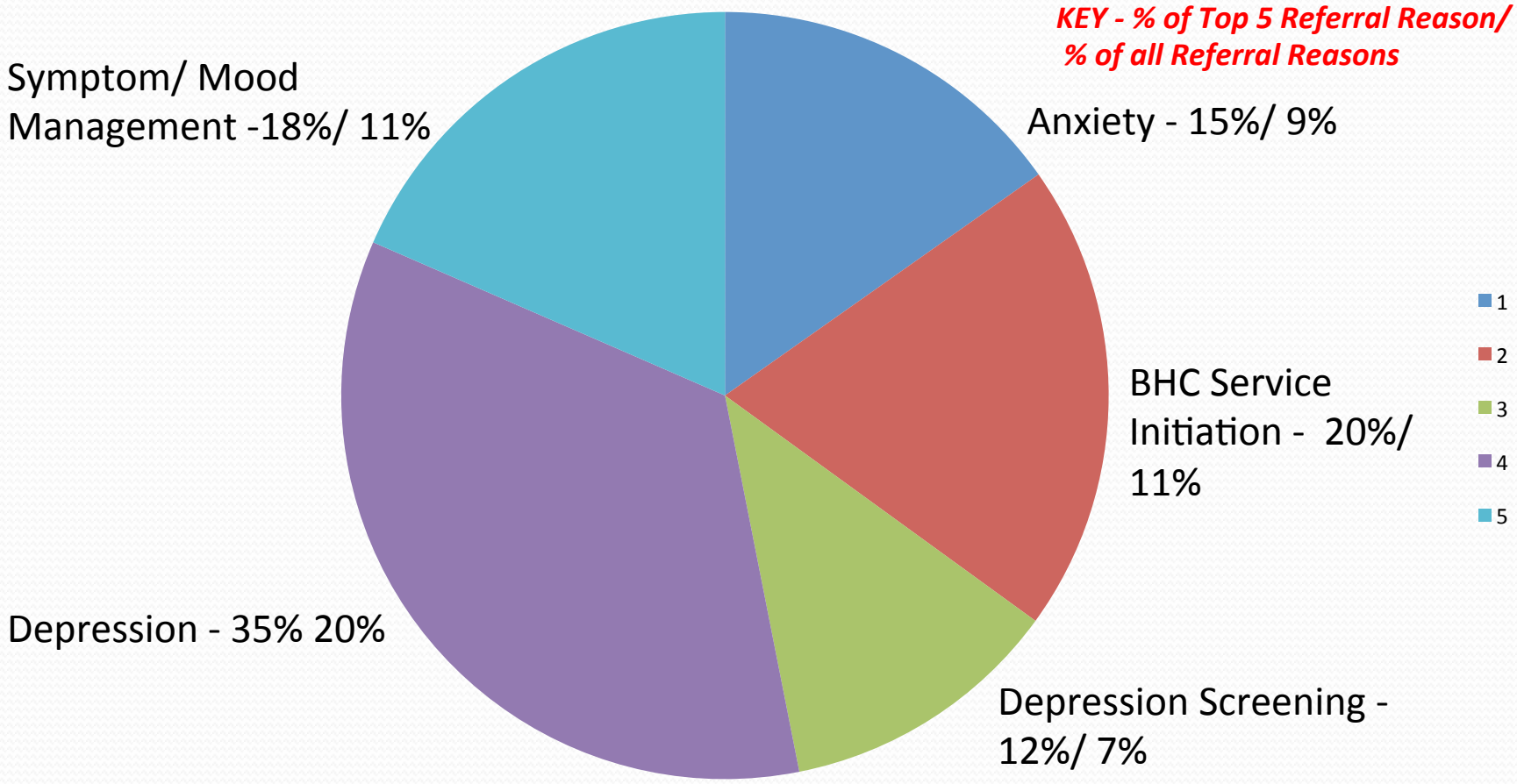
- **<u>Goal =</u>** *Penetration rate of at least 20% (BHC patient contact with at least 20% of the patient population seen by a primary care clinician with a BHC is present within the given clinic session.*

Data - Productivity



*From June 2014-Deecmber 2014, one (1) Behavioral Health Consultant (BHC) was employed at 1.0 FTE. An additional .9 FTE Behavioral Health Consultant was added in January 2015.

Top 5 BHC Referral Reasons – June 2014 – December 31, 2015



Psychologically Informed Environements (PIE)

- Crisis Providers and Crisis Patients
- Learning strategies for effectively working with Chronic Care
  1. Developing a Psychological Framework
  2. The Physical Environment and Social Spaces
  3. Staff training and support
  4. Managing Relationships
  5. Evaluation of outcomes

  Big Challenge – How do we deal with trauma (primary and secondary)

Obstacles and Opportunities

Learning, Tips, and Challenges

Learning…

- Robinson, P.J. & Reiter, J. T. (2016). *Behavioral consultation and primary care: A guide to Integrating Services* (2nd ed.). New York: Springer. doi: 10.1007/978-3-319-13954-8.
- Hunter, C. L., Goodie, J. L., Oordt, M. S., & Dobmeyer, A. (2009). *Integrated behavioral health in primary care: Step-by-step guidance for assessment and intervention.*Washington D. C.: American Psychological Association.
- Collaborative Family Healthcare Association http://www.cfha.net/

Tips…

- Organizational commitment… everyone is rowing in the same direction from leadership down
- Hiring a consultant with experience with PCBH to consult with the program as it was created
- Hiring key staff with experience working in PCBH and with training related to integrated care

Challenge - How do you pay for this?

- **Financial Sustainability**
  - Sustainability: BHC's ability to increase clinical revenue through Medicaid and Medicare over time
    - Difficult to sustain
  - Grant funding: Medicaid 1115 Waiver: Texas Healthcare Transformation and Quality Improvement Program
  - Increase # of PCP patients
  - Work in progress…
  - Need for reimbursement based incentives

for outcomes and team based care

Challenge – we have to change…

- BHC – getting accustomed to interruptions during visits
- Learning to identify patients to intervene
- BHC educating team that we can help beyond MH (e.g. HTN, DM, Weight)
- Learning the preferences for the PCP to help productivity
- Main goal is to be consultant for PCP to increase effectiveness of clinic and deliver more holistic care
- Improving and implementing clinical pathways
- Implementation is Hard!
- Behavior Change is Hard!

Challenge

- Figuring out how to effectively practice “housing first”
  - “Wet” housing in a “dry” housing model
  - Consumers and clinicians are bothered by this!
  - Consumers are telling us “When I get out of treatment, I don’t want to come back here!”

Thoughts from the road

Reflections from the team about what integration has been like for them.

Reflections

- MD
- BHC
- CHW

Are you ready for this???

- Please get in groups of 3-4
- How might the PCBH model of integrated care be helpful in our clinic?
- What about the PCBH model might not fit in our setting?
- If not using integration, what barriers would be most difficult to overcome?
- If using integration, what are some of your challenges?
- What is keeping us from moving forward?

Questions? Comments? Feedback?

Contact:
Mark Sperber: mark.sperber@bcm.edu
David Buck: dbuck@bcm.edu
Joseph Benson: JosephJr.Benson@bcm.edu

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