

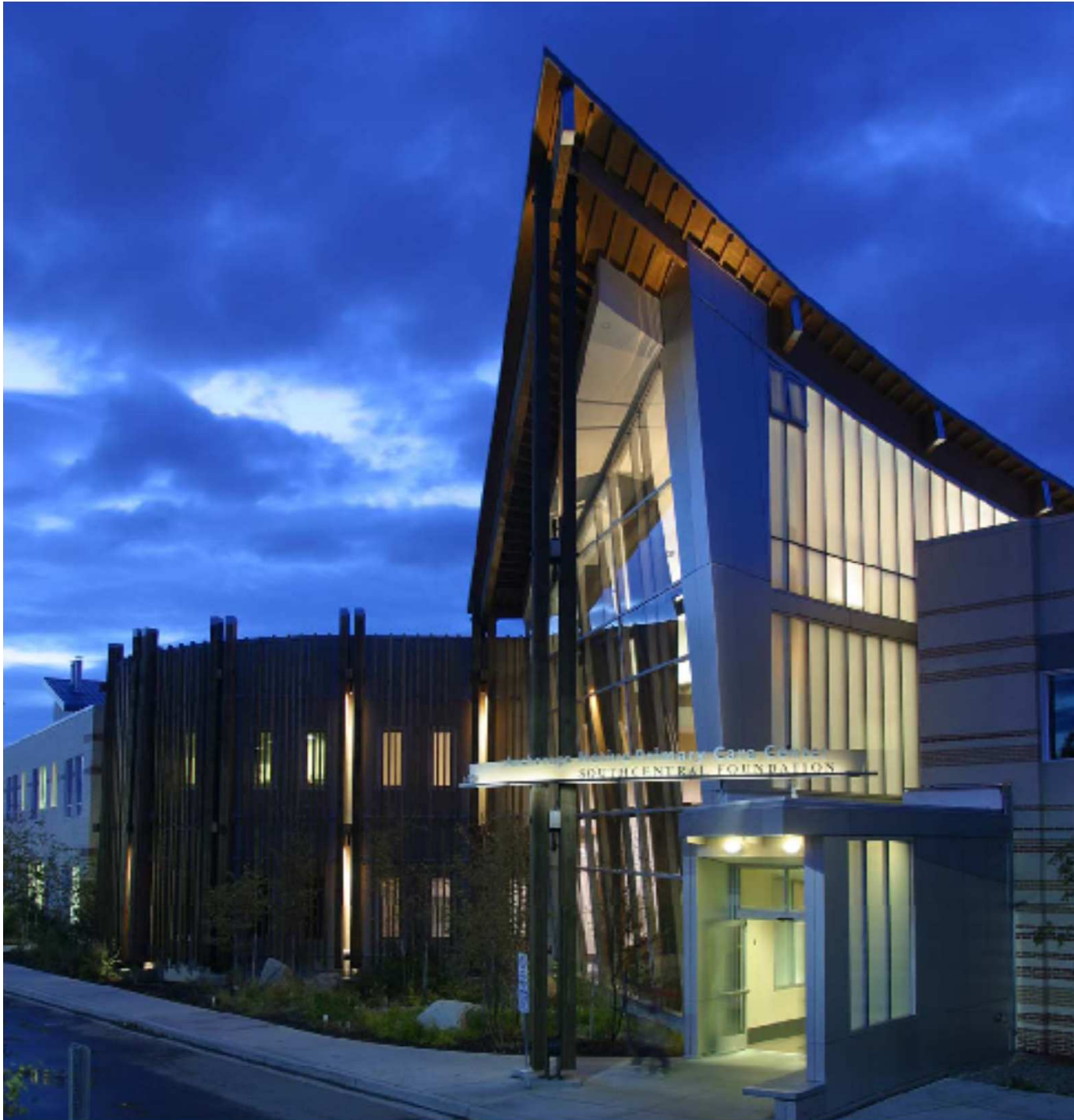
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# Behavioral Health Integration

## Southcentral Foundation

- Wendy Bradley LPC, CDC
- Christopher Campbell MPAS PA-C





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# Mission and Vision



Katherine Gottlieb, MBA  
President and CEO

## *Mission:*

Working together with the Native Community to achieve wellness through health and related services.

## *Vision:*

A Native Community that enjoys physical, mental, emotional and spiritual wellness.

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# Key Points

## *S*hared

### **Responsibility**

We value working together with the individual, the family, and the community.

We strive to honor the dignity of every individual.

We see the journey to wellness being traveled in shared responsibility and partnership with those for whom we provide services.

## *C*ommitment to **Quality**

We strive to provide the best services for the Native community.

We employ fully qualified staff in all positions and we commit ourselves to recruiting and training Native staff to meet this need.

We structure our organization to optimize the skills and contributions of our staff.

## *F*amily Wellness

We value the family as the heart of the Native community.

We work to promote wellness that goes beyond absence of illness and prevention of disease.

We encourage physical, mental, social, spiritual, and economic wellness in the individual, the family, the community, and the world in which we live.



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# Objectives

- Examine How We Integrate Behavioral Health Consultants into Primary Care
- Define the Key Elements of the Behavioral Health Integrated Model at SCF
- Review Outcomes for the Integrated Behavioral Health Program

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# Operational Principles

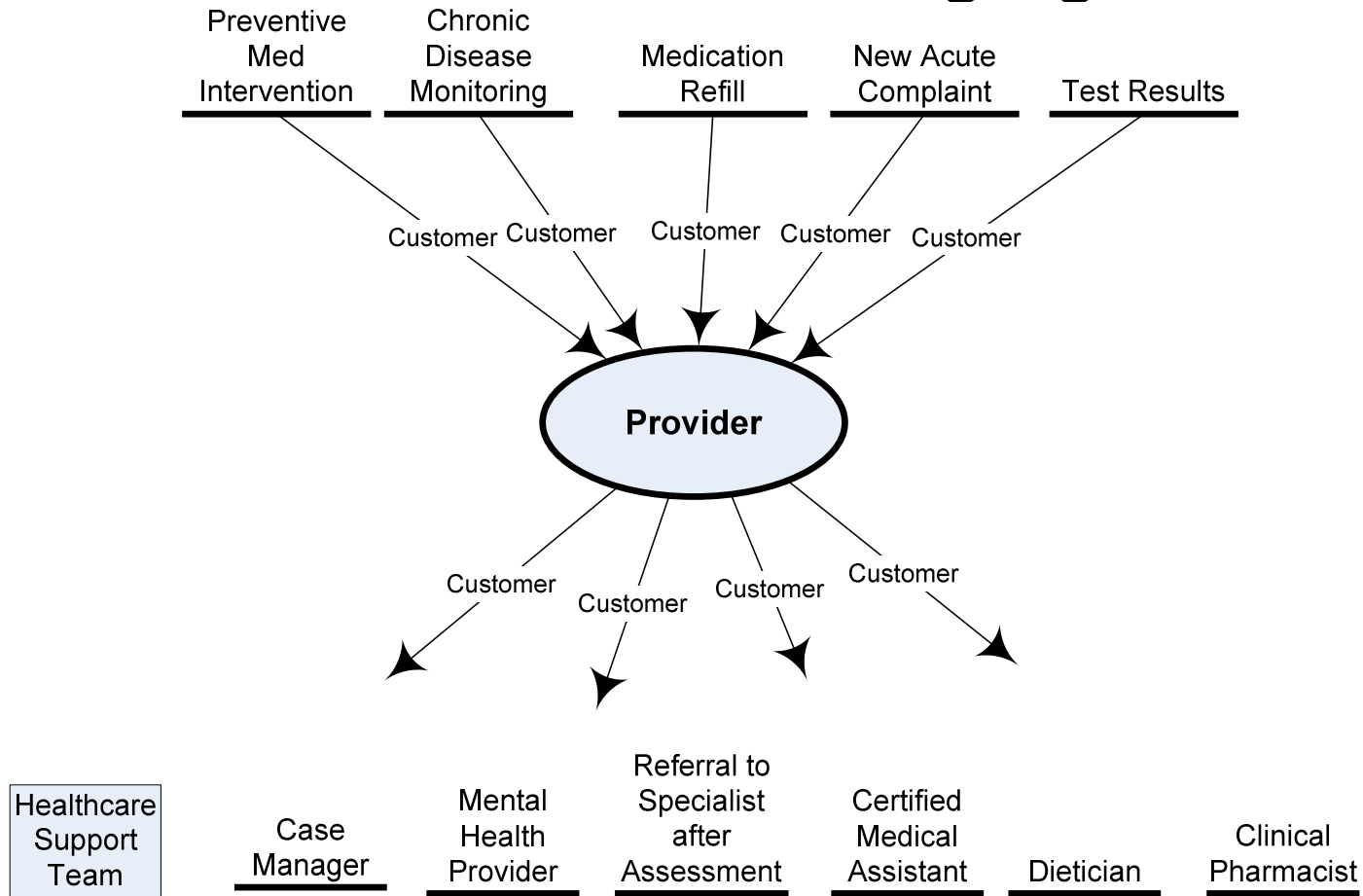
## *RELATIONSHIPS*



*At 591,000 square miles, Alaska is as wide as the lower 48 states and larger than Texas, California and Montana combined.*



# Traditional Methods of Managing Work Flow



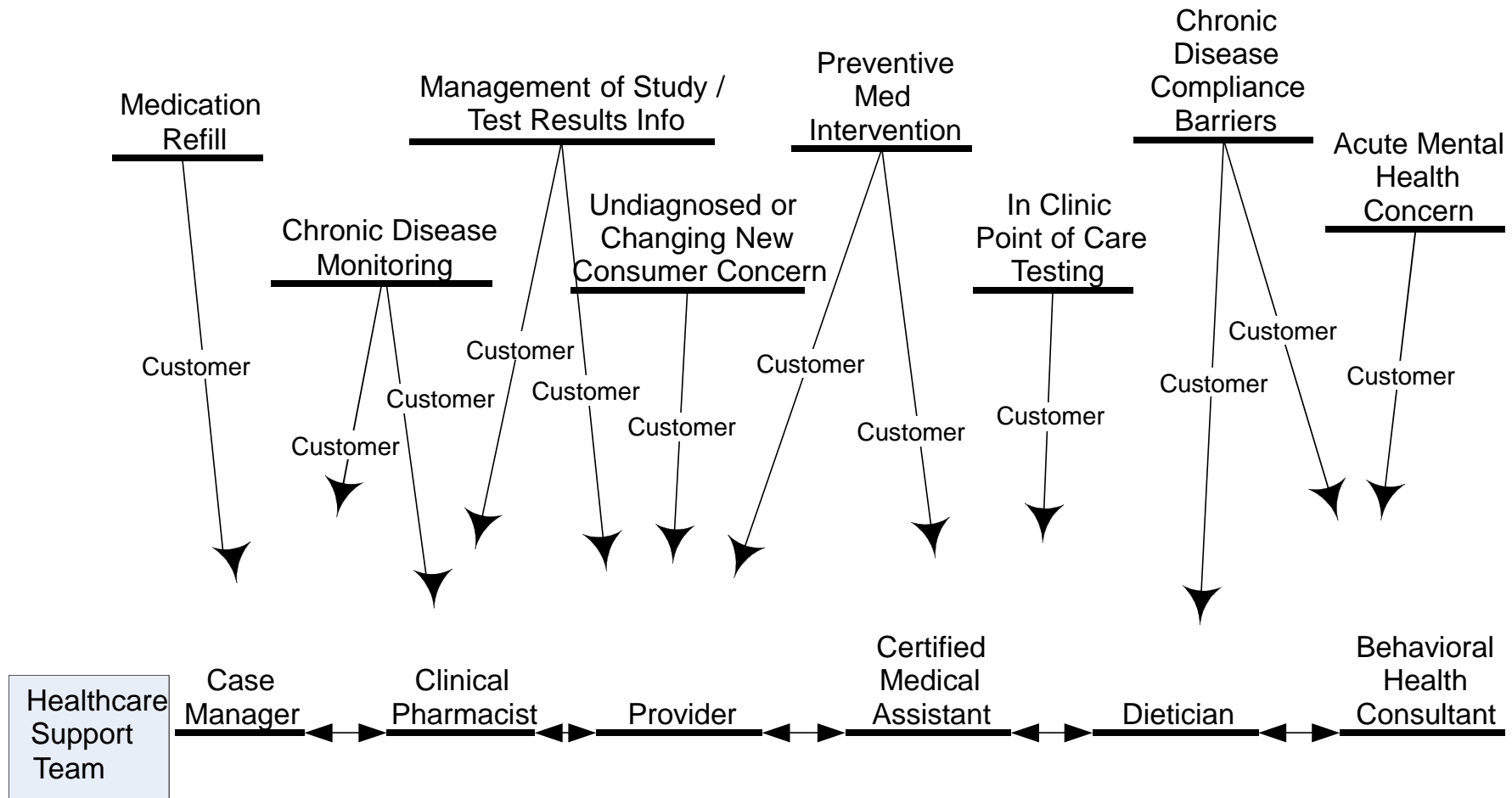
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# Redefine Work

- Move from episodic, reactive care to long-term relationship
- Move from only one-to-one visits to use of groups, phone, email, fax, home visitors
- Move from doctor-centric to team based approach in relationship
- Move to team based meetings, problem solving



# Parallel Work Flow Redesign



# Scope

- Customers with CMI die 20 years earlier
- 70% of all health care visits due to psychosocial factors
- 75% of customers with depression present with an initial physical complaint
- Most mental health and addiction is treated in primary care
- Targeting medical and socially complex Medicaid customers with psychosocial intervention reduced medical costs by 21% compared to a rise of 22 % not receiving services

- *Integration of Mental Health/Substance Abuse and Primary care (Evidence Report Number 173, page 10*
- *Fries et al., 1993; Shapiro et al., 1985*
- *Unutzer et al., 2006*
- *Unutzer et al., 2006*



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# Why We Integrated Behavioral Health in FMC and Peds

- As we developed “relationships” with our customers, we became aware of deeper struggles that impacted their overall health.
- We found that much of what we saw physically had a behavioral component.
- We wanted to improve access to behavioral health (1200 person wait list).

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# Continued...

- We wanted to meet customers on their time, not ours.
- We thought we could reduce costs by being preventative, instead of reactive.
- We wanted to provide services that addressed the whole person.
- We wanted to allow professionals to work to the top of their license and acknowledge that medical and behavioral professionals come with different skill sets.

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# Models of Integration

- Diversification – BHC is a active member of the Integrated Care Team
- Co-location – Behavioral Health Professional located on site providing traditional behavioral health services
- Referral – Behavioral health services provided by contracted agency
- Enhancement – train primary care providers to provide behavioral health services



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# Background

- Our first attempt at integration failed
  - One behaviorist in Pediatrics only
  - We were co-located, not integrated
  - We needed to identify the best fit for staffing the BHC position
  
- Benchmarking best practices (which were limited)

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# Background

- Treated the BHC integration as an improvement project
  - Annual plan with measurement and due dates
  - Completed a needs assessment
  - Multi-disciplinary team
  - Began under SBIRT SAMSHA grant
  - Used outside consultant

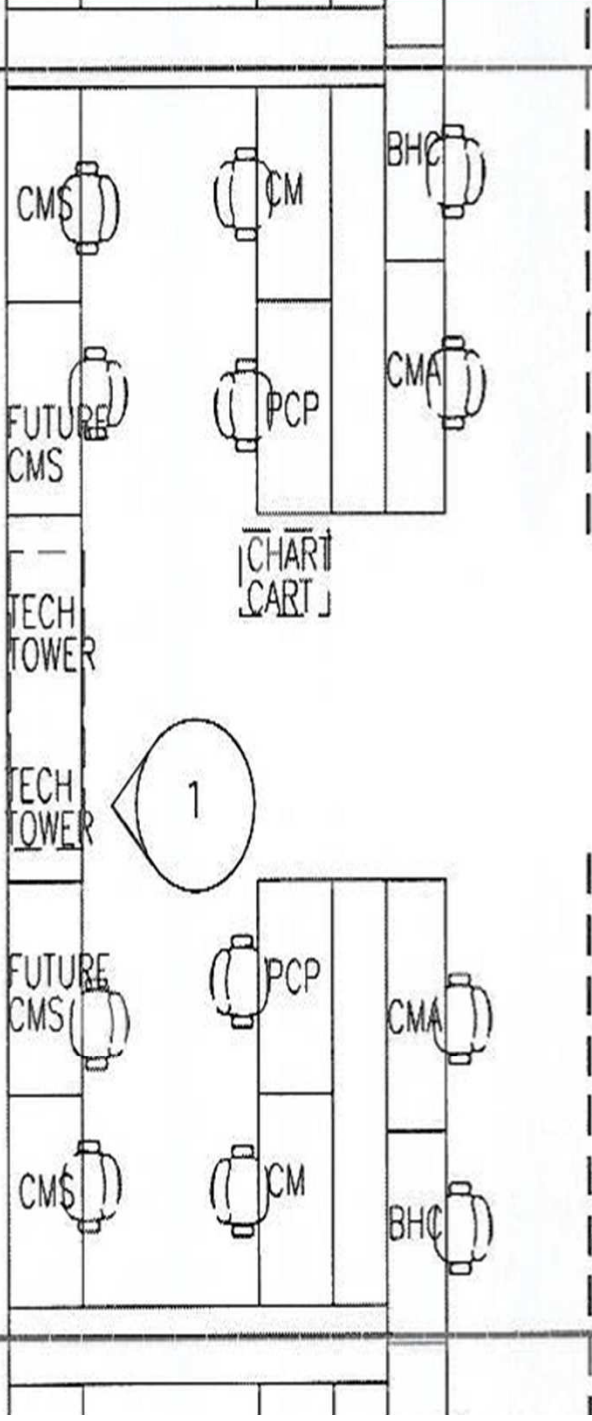
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# A Framework to Integrated Care

- Behavioral Health is ROUTINE component of medical care (charts are integrated)
- Shifting Boundaries of Care
  - Location
  - Staffing
- Scope of Integration
  - Horizontal
  - Vertical

GRID

1'-10"



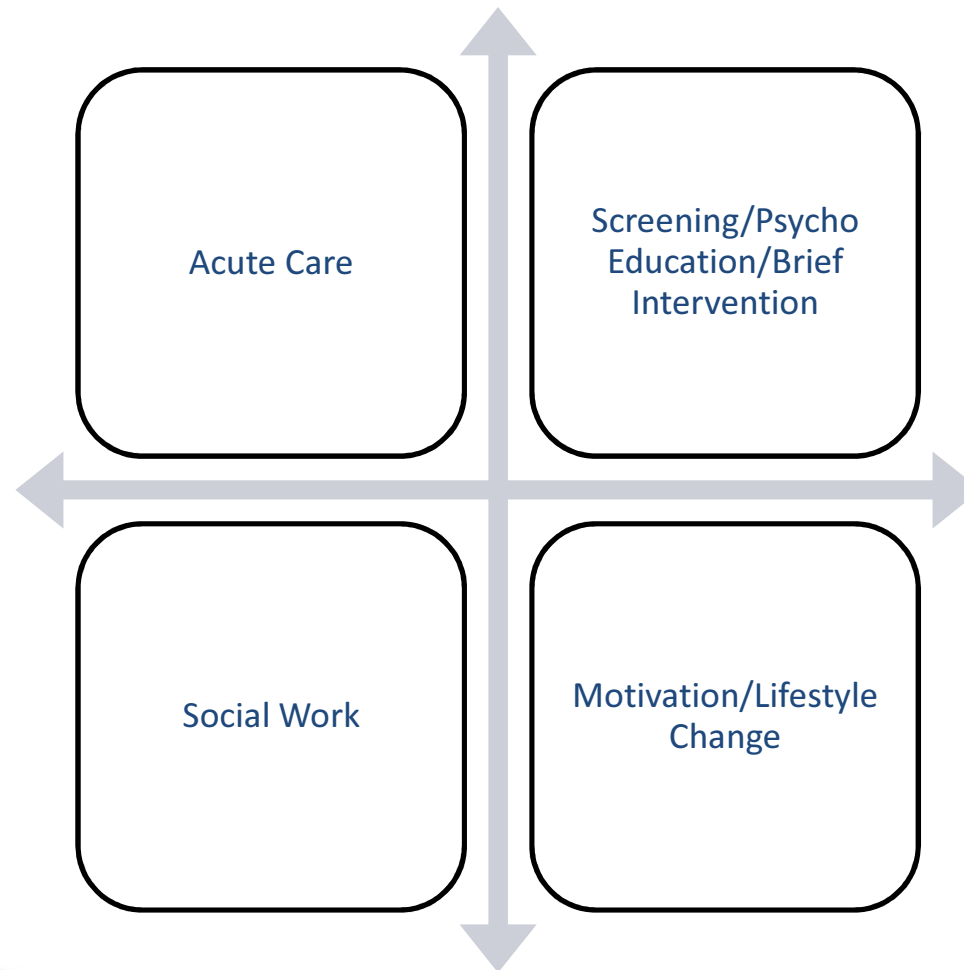
FLEX ROOM

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FLEX ROOM

GRID

# What We Do



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# What We Assess

- Depression using the Prime MD
- Substance abuse using the AUDIT & CRAFFT
- Cognitive function using the MMSE
- Child development using the ASQ and M/CHAT, SDQ
- Behavioral functioning for chronic pain using the MBMD/SCL 90



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# Current Initiatives

- Chronic Pain Collaboration
- Preconception to Age 5
- Wellness plan program
- Internships with local universities
- Specialty clinic collaboration
- YES program for adolescents

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# Key Elements

- Maintaining strong connection to Behavioral Health
- Orientation and Training of Primary Care Providers
- Flexible Communication
- Recruiting/training
- Funding
- Outcome Measures

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# Flexible Communication

## Who

- Primary care team (PCP, Case Manager, CMA, CMS)
- Customer / Owners
- Behavioral Health Consultants
- Behavioral Health
- Additional departments

## How

- Being visible
- Reachable via pager
- Open to quick consults
- Concise feedback
- Technology Assisted



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# Recruiting BHC's

- Fit is everything
  - Let a prospective applicant see the clinic and give an example of a typical day
- Not every Behavioral Health professional is cut out to be a BHC
  - The “process oriented” clinician will struggle
  - Able to provide good “customer service”



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# Clinician Training

- Orientation Process
- Motivational Interviewing / Brief Interventions
- Formal training/Practice advisories
- Peer shadowing and chart reviews
- Mentor program



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# Primary Care Provider Orientation & Training

- Needs assessment
- Formal training
- Regular, informal one on one training
- BHC in primary care provider interviews
- Motivational Interviewing Training



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# Behavioral Health Connection

- Education (Therapeutic vs. Therapy)
- Continuum of Care
- Continuity of Care

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# Co-location

- Suboxone/ Naltrexone Clinic
- TBI collaboration
- Case Management
- BSD Screeners
- Co-located traditional therapists and psychiatrists

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# What We Found...

- Redirects behavioral health related office visits and provides access to appropriate services
- Frees providers time and resources to allow for more efficient use of limited appointment time
- Provides customers with a more comprehensive evaluation of symptoms and issues

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## What We Found....

- Offers providers an in-clinic specialty resource for challenging cases
- Customers have immediate access to BHC and follow up same day access
- Team approach to care
- Improved BHC and provider satisfaction and retention



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# Success Data

- # customers with > 6 Visit utilization in 6 months has decreased since BHC Integration:
  - ER 19%, UC 25%, FMC 15%, Peds 39%
- 77% Primary Care Clinic staff reported increased efficiency
- 88% Primary Care Clinic staff are more satisfied with their job since BHC Integration
- 91% increase in access to Behavioral Health Service
- 23,778 customer visits to BHCs in 2010
- Reduction in anti-depressants and narcotic medication and lab orders

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# Next Steps

- Develop BHC track in local university
- Working with state on Medicaid billing
- Increasing local programs for developmental delays
- Expanded training and model consistency



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# Getting Started

Quyana  
Maasee'  
Ba-see  
Quyanaq  
Gunalche'esh  
Ha'w'aa  
Qagaasakung

(Central Yupik)

(Gwich'in Athabaskan)

(Koyukon Athabaskan)

(Inupiaq)

(Tlingit)

(Haida)

(Aleut)

*...Thank You!*

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# Questions?

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