

# Dismantling Silos of Care: Implementation of an Integrated Care Practice

COLLEEN CLEMENCY CORDES, PH.D.

ASSISTANT DIRECTOR, NICHOLAS A CUMMINGS DOCTOR OF BEHAVIORAL HEALTH PROGRAM

WENDY DANTO ELLIS D.HED, MC, LPC

BEHAVIORAL SCIENCE DIRECTOR, SCOTTSDALE HEALTHCARE FAMILY PRACTICE RESIDENCY

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**“Clinicians know that the world of health care is really three simultaneous worlds including the clinical, operational, and financial. Unless daily practice is designed to incorporate the view of all three worlds tension results”**

**(Patterson et al. 2002 in Kessler 2008).**

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# COLLEEN



- ASU Counseling Psych
- VA Long Beach Healthcare
- Bedford VA
- UMass Medical School
- ASU DBH
  
- Chronic pain
- Disease management
- Sexual health
- Women's issues



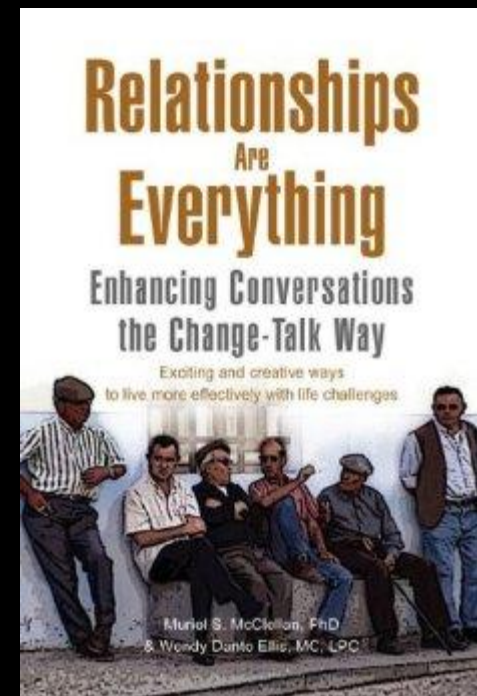
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# WENDY



- University of Massachusetts - Psychology
- ASU - Counseling Psychology
- A.T. Still University - School of Health Management
- Scottsdale Health Care – Graduate Medical Education & oversight and integration of outpatient behavioral health services
- Collaborative & Relationship Centered Care
- Electronic Medical Record Impact on Doctor – Patient Relationship
- Coping & Adjustment to Chronic & Critical Illness
- Change Management
- “Relationships Are Everything”

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# YOU



- How many behavioral health providers?
  - Physicians?
  - Allied Health?
  - Other?
- How many are working in behavioral health clinics?
  - Primary care?
- How many of your work sites are “integrated”
  - Behavioral w/ PC or PC w/ Behavioral?
  - Working towards integration?
  - What does that mean? How do you define integration?

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# Learning Objectives



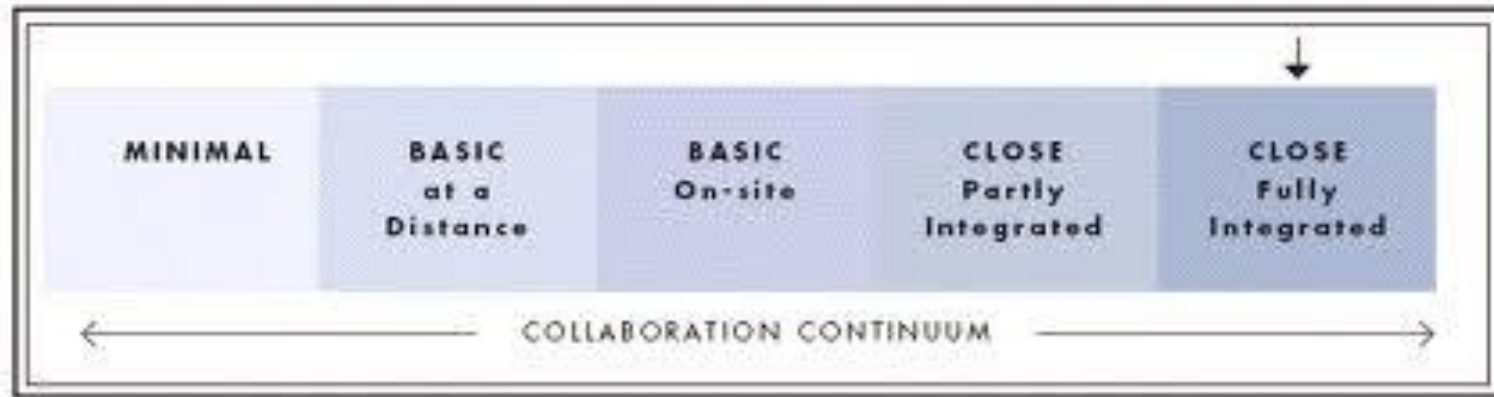
- 1) Identify strategies to lead and create systematic change in siloed healthcare systems
- 2) Describe the role of the behavioral health provider (e.g. DBH) in traditional and reverse integration systems
- 3) Describe a unique collaborative partnership between a behavioral health and medical residency training program and how this has led to increased provision of collaborative primary care and enhanced provider satisfaction

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# Integration: What is it?



- Limited consistency in use of terms across healthcare systems, states, etc.



Collins et al., 2011

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# Integration: It's happening



- SAMHSA awarded 94 community behavioral health organizations more than \$26.2 million
- In AZ:
  - CODAC Behavioral Health Services, Inc. (SAMHSA grant, 2009)
  - Cenpatico
  - Mountain Health & Wellness
  - Scottsdale Healthcare (Family Medicine Residency and NOAH FQHC-LA)
  - Mountain Park Health Center
  - Marana

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# Integration: Why is it important?



- In Primary Care:
  - 60-80% of PC visits are for behavioral health concerns (Gatchel & Oordt, 2003); 20% of patients consume 80% of available resources (Berk & Monheit, 2001)
  - PC lacks time to address BH issues appropriately (Collins et al., 2010)
  - By 2015 150 million Americans will have 1+ chronic condition (ACP, 2008)
  - Triple Aim (of US Healthcare Policy): decrease cost, improve outcomes, enhance the patient experience of care. (SHAPE Policy Brief, 2012)
- In Behavioral Health:
  - Cost per SMI in AZ is approximately \$11,560 (ADHS DBHS, 2013).
  - Persons with schizophrenia on average spend 3-4 times more than an other Medicaid enrollees (ADHS, 2011)
  - AZ has highest early mortality rate (31.8 years) in US (Nasrallah, 2007).
  - Invite patient ownership of health, wellness and chronic disease management

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# Integration: Applications



- Primary Care
  - Services provided in service of the primary MEDICAL diagnosis and in consultation with PCP
    - Health coaching/wellness, prevention
    - Self – management skill training, chronic disease management
    - MH screening & management
    - Referral to specialty care
    - Group medical visits
    - Psycho - educational groups (e.g. smoking cessation, weight loss)
    - Population Health/Community Health Initiatives

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# Integration: Potential Applications

- Behavioral Health

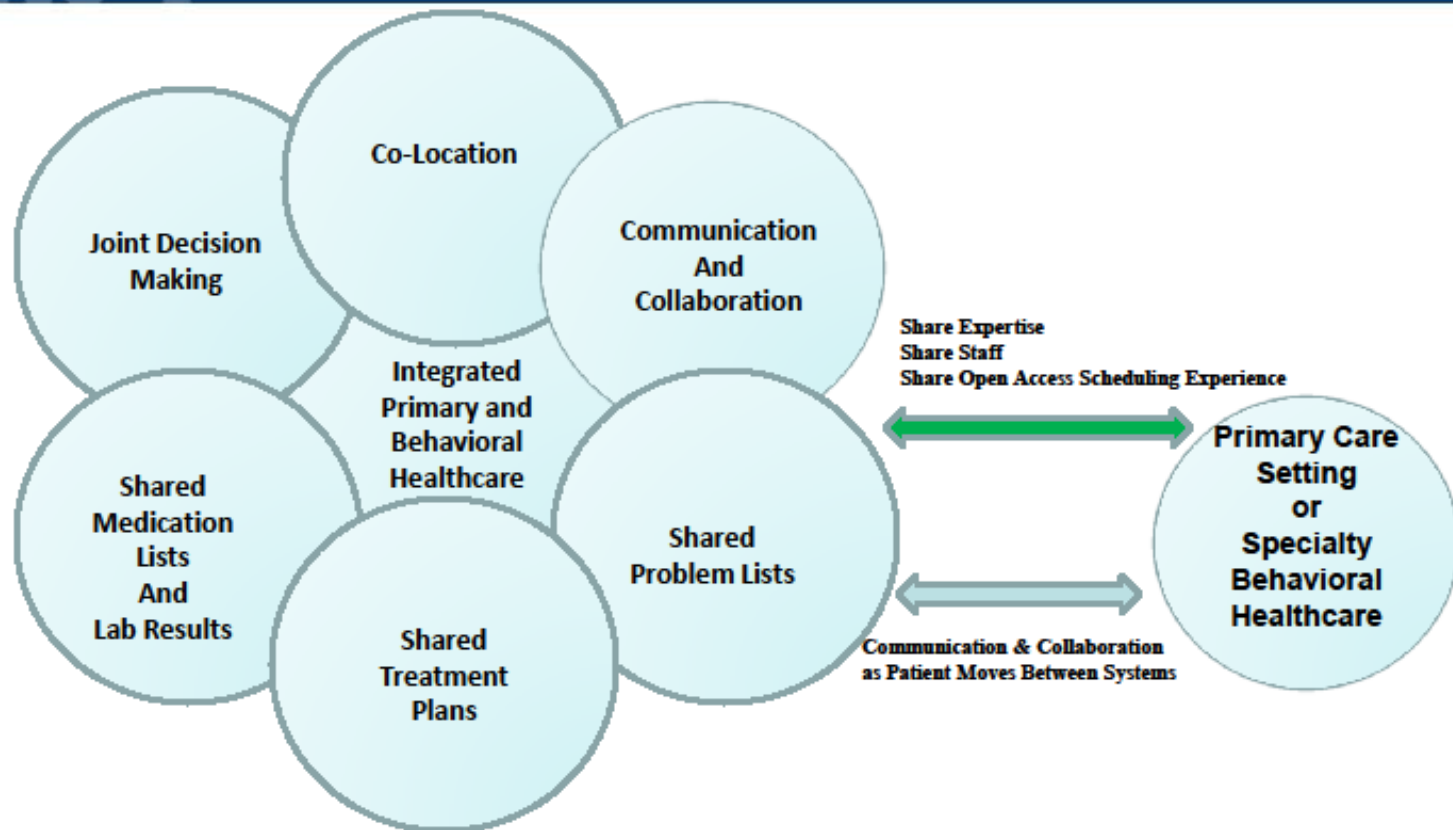
- “Whole-person” healthcare

- Health screening & vaccinations
    - Case management, behavioral interventions, psycho-therapy and psychiatry or other community referral
    - Coordinated referrals to medical specialists
    - Lab work & test result coordination
    - Possible on-site pharmacy or pharmacist consultation
    - Personalized wellness plan; disease prevention & disease management
    - Classes on topics like nutrition, physical activity, sleep & rest, and relaxation & stress management
    - Fitness classes, exercise equipment & training that you can either do at home or at a gym.
    - Group visits

<http://www.codac.org/programs-services/adult-treatment/integrated-care/>

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## Core Components of Successful Integrated Models

M. Lardiere – National Association of Community Health Centers 12/2008

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# Barriers to integration



- Workforce issues (the two way street):
  - Inadequate skill set for integrated practice
  - Reluctance to change current practice patterns
  - Negative attitudes towards persons with MH and SUD concerns
  - Lack of financial incentives; sustainable payment mechanisms
  - Reliance on grant funding which is unsustainable
  - Shortage of dedicated leaders who are committed to change
  - Conflicting accreditation and/or governing regulations (e.g. FQHC vs. particular state regulations vs. ACGME etc)
  - Dual and conflicting reporting lines (org chart)
  - Poor or ineffective organizational communication

SAMSHA-HRSA Center for Integrated Health Solutions; SHAPE Policy Brief

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# Barriers to integration



## Goals for workforce development (SAMSA-HRSA):

- Expand the role of consumers and their families to participate in, direct, or accept responsibility for their own care (*provide tools for doing so*)
- Expand the role and capacity of communities to identify local needs and promote health and wellness (*to meet local needs*)
- Implement systematic federal, state, and local recruitment and retention strategies
- Increase the relevance, effectiveness, and accessibility of (*Interprofessional*) training and education
- Actively foster leadership development among all segments of the workforce
- Enhance available infrastructure to support and coordinate workforce development effort
- Implement a national research and evaluation agenda on workforce development

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# Barriers to integration



- Reimbursement
  - Many programs currently grant funded (no sustainability planning)
  - Covering the uninsured patient
  - Medicaid does not always reimburse for services
  - Medicare discriminatory regulations (LCSW vs. LPC)
  - Restrictions on same-day services
  - Service pre-authorization needed by some insurance companies
  - Specific codes not being recognized or reimbursed
  - Denied for paneling due to too many providers

(Farrell, 2010)

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# Barriers to integration



- Reimbursement (continued)
  - Extensive paperwork for minimal reimbursement
  - Reimbursement rate a small portion of full rate of service
  - Lack of understanding of insurance and legal reimbursement requirements by agency administration
  - Primary care agencies reluctant to pursue reimbursement due to feared liability if it is not done the “correct” way
  - Local Medicaid system wants primary care to only use their specialty behavioral health services for eligible patients for all services
  - Lack of insurance benefits for IBHS in primary care
  - Difficulty communicating with payers (Farrell, 2010)
  - NEED for new payment mechanisms and global budget to support integrated services (SHAPE policy brief)
  - Healthcare billing departments unfamiliar with and uneducated about particulars of integrated care

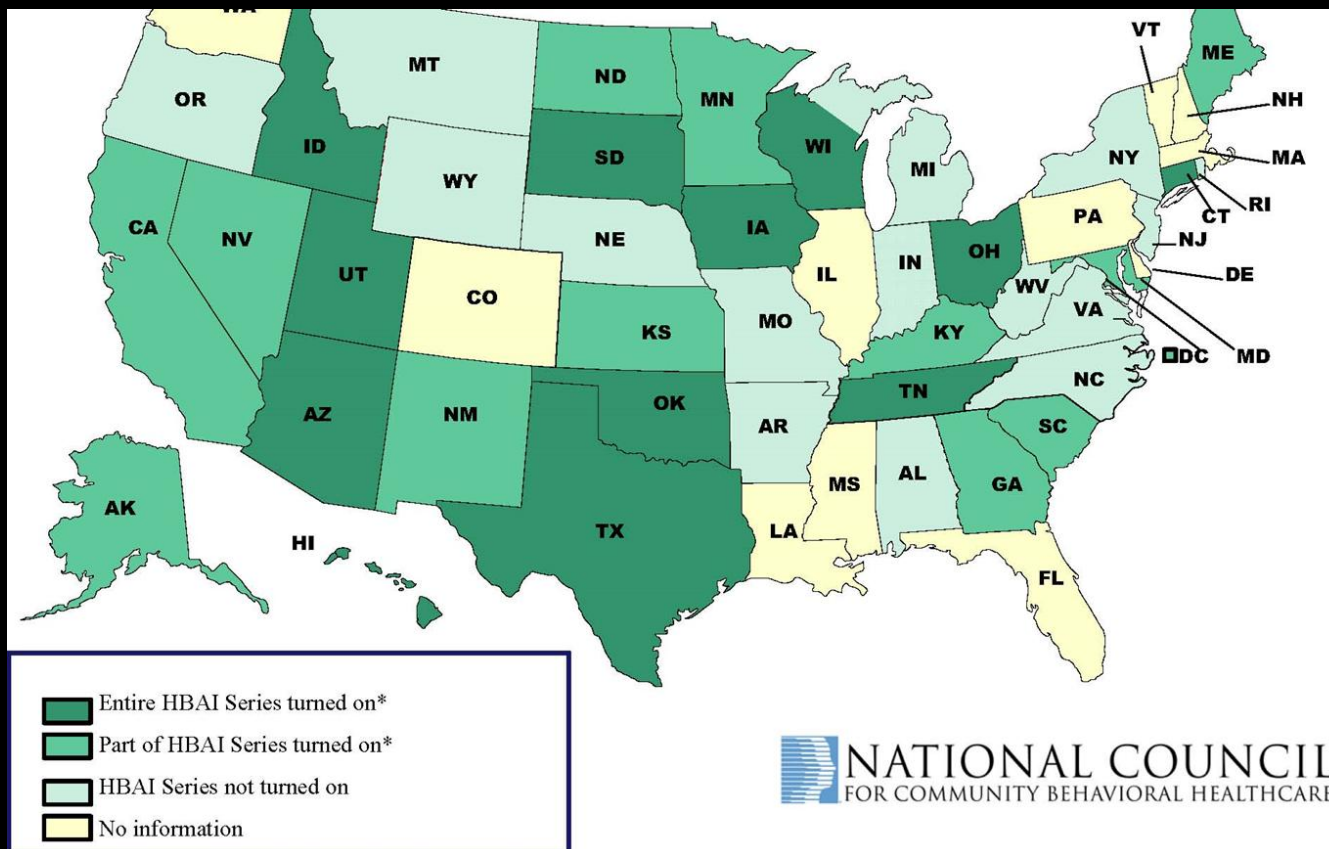
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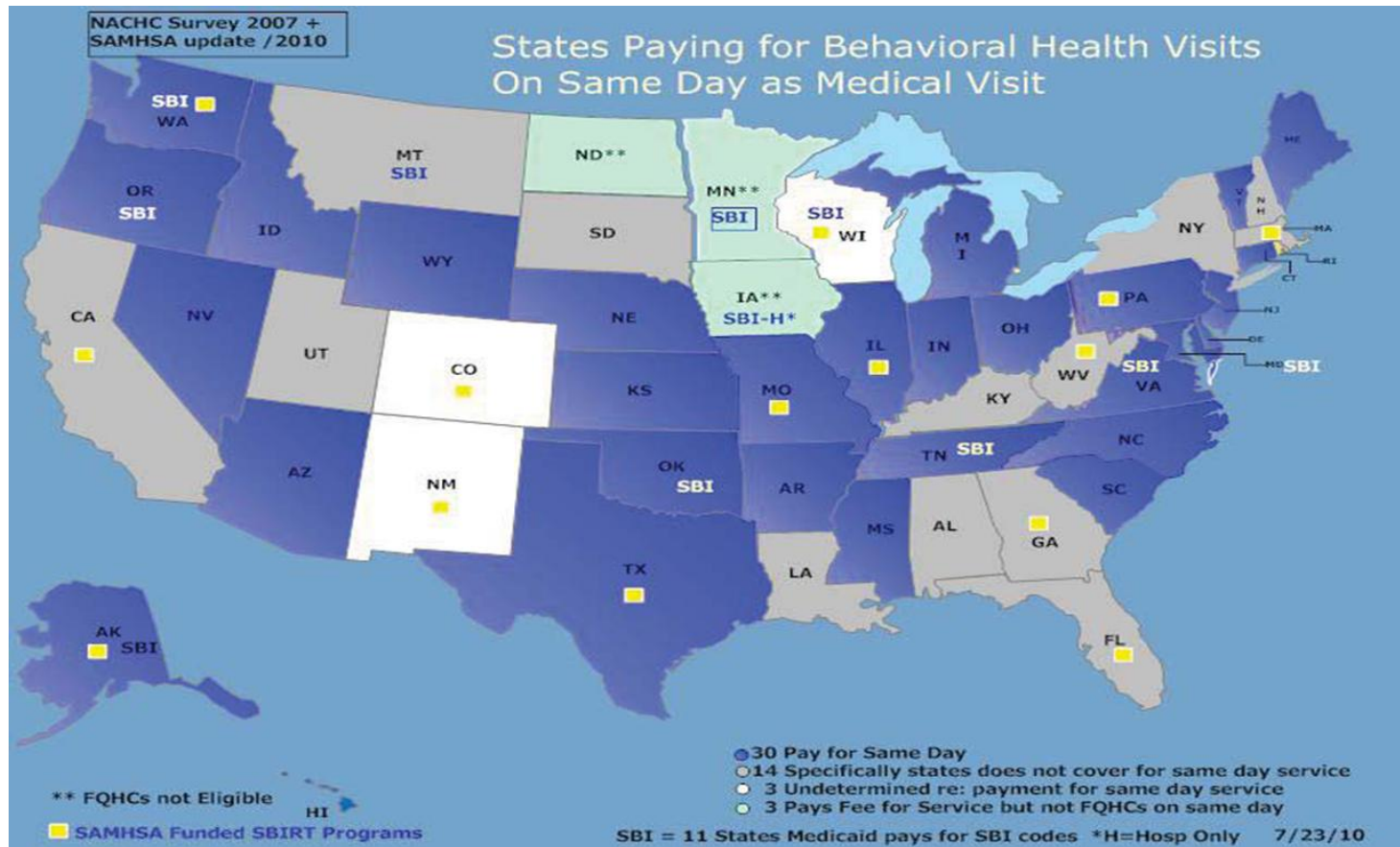


# Reimbursement: H&B Codes



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# Reimbursement: Same Day Billing



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# FQHCs Serving as Training Sites for Specialty Behavioral Health Staff, by Provider Type



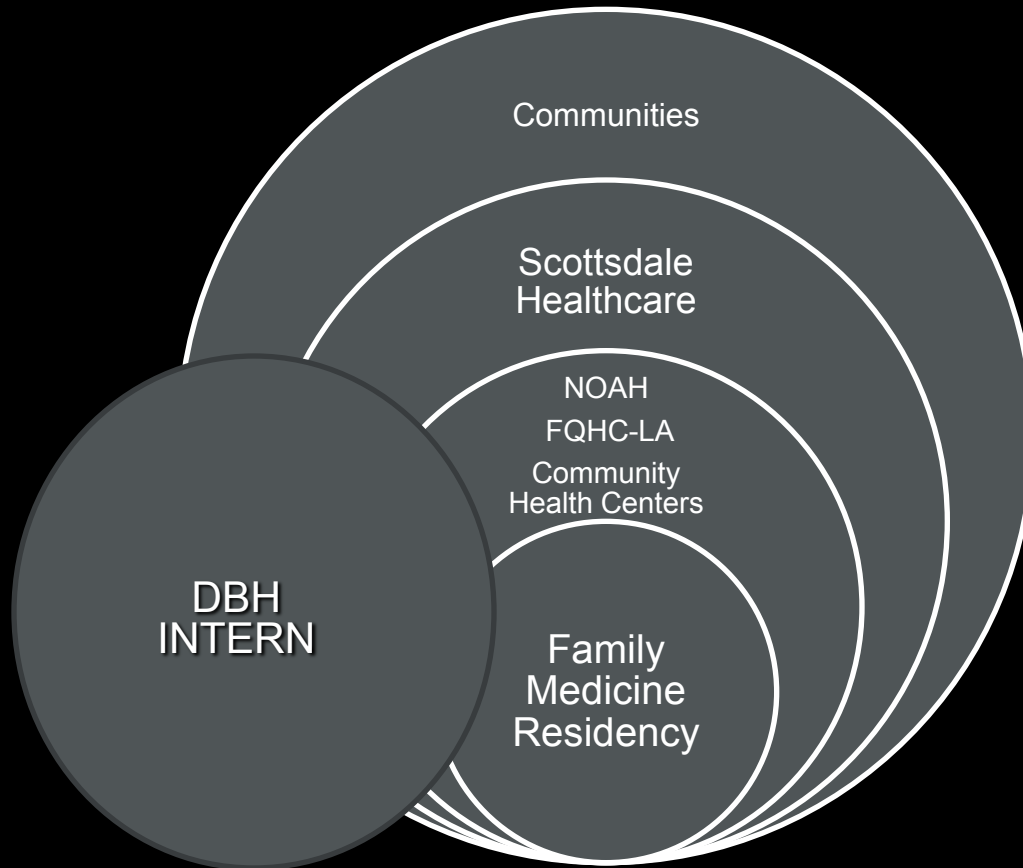
Provider Type	# FQHCs Serving as Training Sites	% FQHCs Serving as Training Sites
<b>Social Workers</b>	<b>120</b>	<b>34.5%</b>
<b>Prof. Counselors</b>	<b>47</b>	<b>13.5%</b>
<b>Psychologists</b>	<b>46</b>	<b>13.2%</b>
<b>Nurses</b>	<b>27</b>	<b>7.8%</b>
<b>Other</b>	<b>24</b>	<b>6.9%</b>
<b>Addiction Counselors</b>	<b>23</b>	<b>6.6%</b>
<b>Marriage/Family</b>	<b>23</b>	<b>6.6%</b>
<b>Psychiatrists</b>	<b>18</b>	<b>5.2%</b>

\* FROM: NACHC 2010 ASSESSMENT OF BEHAVIORAL HEALTH SERVICES IN FEDERALLY QUALIFIED HEALTH CENTERS

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# Multiple layers...



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# Strategies to promoting integration: A Look back at SHC partnership



- Creating stakeholder buy – in *before* implementing integrated delivery model
- Administrative/Executive support
- Team approach
- Punctuate provider satisfaction, improved time management, enhanced patient satisfaction
- EHR integration (Integrated Behavioral Health template)
- Education for providers on definition of Integrated Care (vs. traditional therapy)
- Evidence based medicine is not the same as evidence based behavioral health; BH considered “soft”

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# AND....



- Become an anthropologist – learn about the culture you are joining (norms, values, language, preferences etc.)
- Assume & accept total responsibility for work flow and practical details of implementation
- Design program to meet that particular practice culture and needs
- In case of Heuser & NOAH two distinct cultures and strategic goals = parallel cultures = challenges
- Assume future focused, relational and strength based stance in everything you do. Be appreciative!
- Don't assume everyone shares your perspective on the value of integration.

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# Blending Cultures



- **CULTURE OF MEDICINE**

1. Pathology based
2. Values certainty; dislikes ambiguity or change
3. Expert/ knowing stance
4. Goal is for doctor to diagnose and “fix” the problem
5. Functions with a system of assess, diagnose and treat
6. Evidence based
7. Outcome oriented
8. Training models are rooted in tradition and power differentials

- **CULTURE OF COUNSELING/BEHAVIOR CHANGE**

1. Resource, resiliency and strength based
2. Values change, differences and possibilities
3. Embraces “not knowing” stance
4. Goal is to connect with the “patient” and collaboratively define outcomes/objectives
5. Functions within a paradigm of conversation and collaboration
6. Values evidence based in addition to personal experiences
7. Multiple outcomes are acceptable/valued
8. Training models cross over disciplines and are evolving

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# Practical issues to address...



- Process for referring BH patients from provider
- Scheduling of BH patients; follow-up
- Fees for BH services; billing
- Record keeping; shared EHR or not
- Psych medications outside the practice scope of providers
- Referrals to ancillary services; community resources (process & follow-up)
- BHC communication with other center staff (front office, billing, nursing, providers, care managers etc)
- BHCs at different sites are isolated from each other; how to maintain esprit du corps
- Coverage for vacations/training/etc.
- Language/translation services
- Each site has its own “cast of characters”; different personalities, different team members (e.g. dental)

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# Accreditation Council for Graduate Medical Education (ACGME)



- Program and Institutional Guideline for Using a Community Health Center as outpatient clinic site include:
  1. Behavioral science education must be integrated into the residents' experiences in the CHC
  2. The appointment & assignment of faculty preceptors in the CHC must be under the control of the program director and in the presence of a qualified faculty ...
  3. The program director must have authority and responsibility for the educational program of the residents.

\*Example of conflicting regulations, cultures and barriers to integration.

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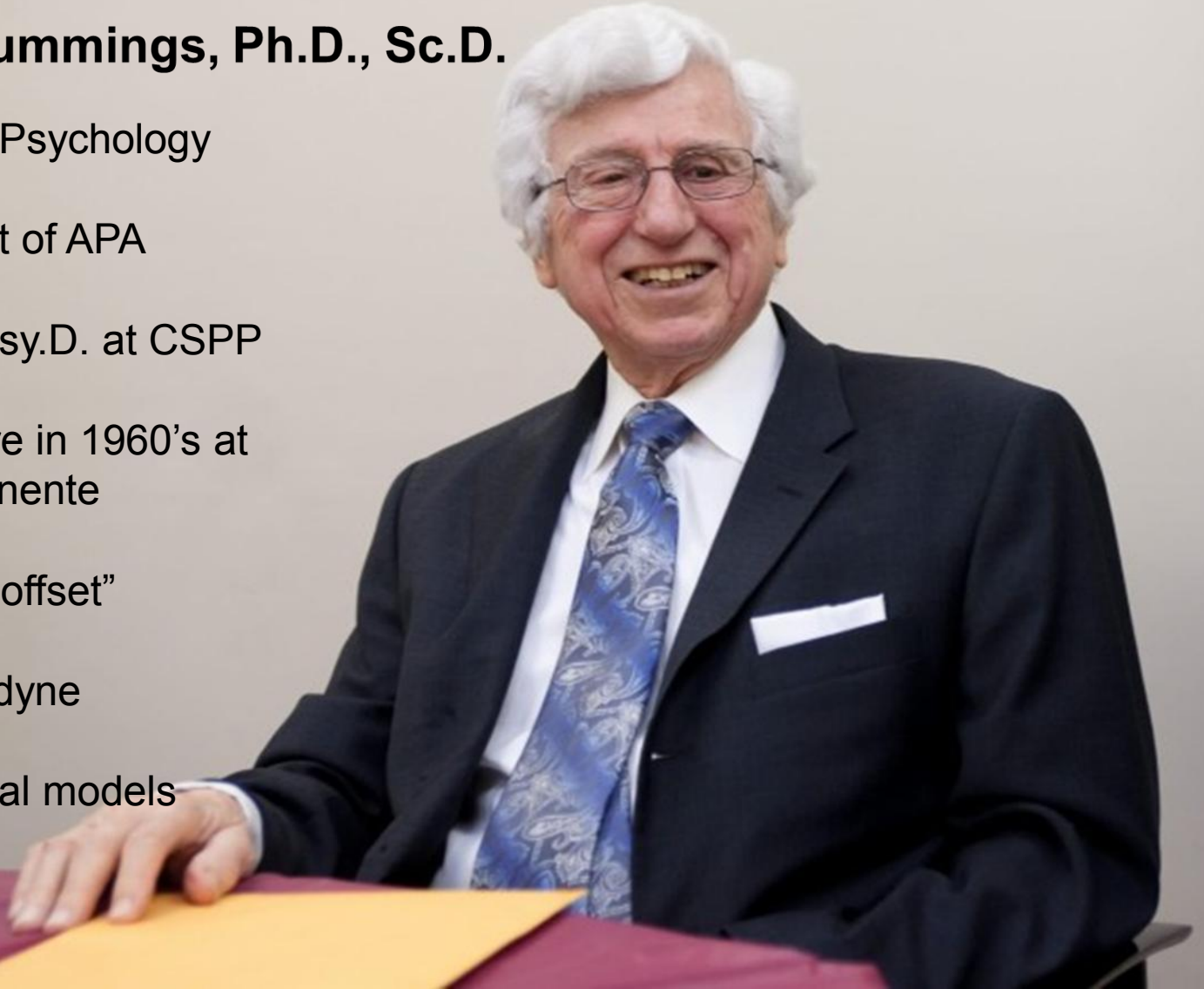


# Solutions: The DBH



## Nicholas A. Cummings, Ph.D., Sc.D.

- Leader in US Psychology
- Past president of APA
- Established Psy.D. at CSPP
- Integrated care in 1960's at Kaiser Permanente
- “medical cost offset”
- American Biodyne
- Biodyne clinical models



# ASU's Doctor of Behavioral Health Program



- **An *upgrade* for master's level clinicians or managers**
- **Online/Distance learning**
- **Primary care, hospital, or reverse integration internship program**
- **Replaces dissertation with culminating project**
- **Faculty practice topics they teach**

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# Curriculum: Clinical Track



## Core (Required) Courses (36 credits):

- IBC 604 - **Clinical Pathophysiology**
- IBC 608 - **Psychopharmacology for the Behavioral Care Provider**
- IBC 609 - **Clinical Neuropathophysiology**
- IBC 680 – **Internship (Also known as Practicum)**
- IBC 704 - **Individual Differences, Psychopathology and Personality (Also known as Evidence Based Interventions I)**
- IBC 706 - **Evidence-based Behavioral Assessment and Interventions II: Medical, Comorbid, and Specialty Behavioral Conditions**
- IBC 712 - **Population-based Health Management**
- IBC 714 - **Research Design in Health Care: Quality and Performance Measurement, Improvement and Incentives**
- IBC 718 - **Healthcare Systems: Organization, Delivery, and Economics**
- IBC 720 - **The Behavioral Health Business Entrepreneur**
- IBC 793 - **Culminating Project**

## Elective Course (Choose any 6 for a total of 18 credits):

- IBC 590 – **Professional Writing Skills** IBC 598 - **Chronic Pain & Opioid Misuse**
- IBC 602 - **Healthcare Statistics**
- IBC 610 - **Behavioral and Psychological Assessment in Primary Care**
- IBC 613 – **Cognitive and Affective Aspects of Health**
- IBC 624 – **Integrated Behavioral Health for Children and Adolescents**
- IBC 634 - **Behavior Change Strategies and Techniques in Primary Care**
- IBC 660 - **Legal, Ethical and Professional Issues in Health Care**
- IBC 690 – **Readings & Conference**
- IBC 691 - **Integrated Behavioral Interventions, Cost Savings, Medical Cost Offset and Return on Investment**
- IBC 708 - **Evidence-based Behavioral Interventions III**
- IBC 728 - **Cultural Diversity, Health and Illness**
- IBC 780 – **Integrated Care for Substance Use Disorders**
- IBC 780 – **Behavioral Health Management**
- IBC 780 – **Online Psychotherapy, Behavior Change, and Telemental Health**
- IBC 780 – **Introduction to Behavioral Interventions**
- IBC 780 – **Psychosomatic Illness: Diagnosis and Treatment**
- IBC 780 – **Integrative Medicine**

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# Curriculum: Management Track



## Management Core (Required) Courses (36 credit hours)

- IBC 724 - Behavioral Healthcare Management
- IBC 716 - Healthcare Information Management
- IBC 712 - Population-based Health Management
- IBC 714 - Research Design in Health Care: Quality and Performance Measurement, Improvement and Incentives
- IBC 718 - Healthcare Systems: Organization, Delivery, and Economics
- IBC 720 - The Behavioral Health Business Entrepreneur
- IBC 730 - Financial Management in Healthcare
- IBC 740 – Behavioral Health Cost Savings and Medical Cost Offset Programs
- IBC 793 - Culminating Project
- IBC 680 – Internship (Also known as Practicum)
- IBC 612 - Introduction to Behavioral Interventions
- MHI 538 - Healthcare Innovation and the Individual

## Management Elective Courses (18 credit hours)

- IBC 724 - Effective Consultation in Behavioral Health
- IBC 726 - Contract Negotiation in Healthcare
- 732 - Leadership in Healthcare
- HCSD 676 - Continuous Quality Improvement: Methods and Techniques
- MHI 542 - Systems Thinking in a Complex Environment
- MHI 540 - Understanding and Applying Principles of Evidence-Based Practice
- MHI 548 - Advanced Principles and Concepts of Innovation
- MHI 550 - Healthcare Policy and Innovation
- MHI 552 - Financing for Innovation
- MHI 554 - Outcomes Evaluation
- MHI 520 - Strategic Management of Technology

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# DBH Internship



- 400 hours (clinical)
  - Direct service provision
    - Disease management, groups, psychological screening and treatment, etc.
  - Consultation
  - Required project
- 200 hours (management)
  - Program development
  - Program evaluation
  - Consultation

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# DBH Program



## Student Admissions

Applicant Data	2009-2010 (Fall)	2010-2011 (Fall)	2011-2012 (Fall)	2012 (Spring)	2012 (Summer)	2012 (Fall)	2013 (Spring)
Applied to program	66	70	69	30	40	99	129
Number offered admission	63	59	52	24	26	59	68
Number enrolled (by cohort)	57	50	45	20	21	56	55
Head count *	57	96	107	111	83	162	187
Selectivity	95.5%	84.2%	75.3%	80%	65%	59.6%	52.7%
Yield	90.4%	86.7%	86.5%	83.3%	80.8%	94.9%	80.9%

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# Current DBH students



## Current Active Student Profile (\*Spring 2013)

% Woman		74.86% (140)
% Ethnicity	American Indian	2.67% (5)
	Asian	2.67% (5)
	Pacific Islander	1.07% (2)
	African American	25.67% (48)
	Hispanic	10.16% (19)
	White	53.48% (100)
	Unknown	4.28% (8)
% Minority		46.52% (87)
% International		0% (0)

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# DBH in action



- Do any of you have a DBH working on your site?
- How do you use them?
- What do you want to know to use them more effectively?

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# DBH Competencies



- Evidence-based interventions for mental health and chronic illness
- Medical literacy for enhanced collaboration
- Systems awareness and redesign
- Entrepreneurship

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# DBH Skills



- Health behavior change
- Mental health assessment & treatment
- Group medical visits & psychoeducational programs
- Program evaluation
- Physician consultation

*And much more!!*

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# DBH in action: Partnership with SHC



- Heuser NOAH – Non-medical pain intervention project – An excellent example of a successful integration and overcoming barriers of two cultures.
- Barriers overcome: different definitions of desired outcomes, VERY different attitudes toward chronic pain patients & change; office work flow challenges; provider awareness of and utilization of BHC
- Gains received: Increased patient satisfaction, increased provider satisfaction; still pending – lower PCP utilization for non-medical issues; education of providers, resident physicians and staff on non-medical interventions for chronic pain; revision of pain policy and pain contract; less need for patient referral to pain specialists = enhanced patient centered care within PCMH

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# NOAH IBH Mission Statement



The program's mission is to provide accessible, high quality, effective and efficient behavioral health services in partnership with patients/clients and in collaboration with all members of the healthcare and community team.

GOALS include:

- To improve the health and wellness of our patients
- To provide integrated, seamless, comprehensive behavioral health care in the context of the daily provision of primary health care
- To support and enhance self management skills
- To improve clinical outcomes
- To increase the use of prevention and wellness strategies to prevent the onset of a mental disorder or prevent its recurrence
- To serve as consultants to all members of the health care delivery team

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# QUESTIONS? COMMENTS?

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