Session # C1

What it takes to turn the Queen Mary: or how a system supported psychiatry's partnership with primary care

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CFHA Annual Conference
October 17-19, 2019 • Denver, Colorado

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Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

2

Conference Resources

Slides and handouts shared by our conference presenters are available on the CFHA website at https://www.cfha.net/page/Resources_2019 and on the conference mobile app.

3

Learning Objectives

At the conclusion of this session, the participant will be able to:

- Identify the workforce and workplace characteristics related to psychiatry staff and service delivery that create barriers to change
- Describe the interventions that are useful in supporting systemic change focused on psychiatry partnering with primary care …
- Identify key action steps that one can take to create this change in other systems

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Bibliography / Reference

1. Raney, Lori E. Integrated Care: Working at the Interface of Primary Care and Behavioral Health. American Psychiatric Publishing. 2015
2. Robinson, Patricia J., Reiter, Jeffrey T. Behavioral Consultation and Primary Care: A Guide to Integrating Services. Second Edition. Springer International Publishing. 2016
3. Grimes, Katherine E. et al. Enhanced Child Psychiatry Access and Engagement via Integrated Care: A Collaborative Practice Model with Pediatrics
4. The Psychiatric Shortage: Causes and Solutions. National Council Medical Director Institute. National Council for Behavioral Health. March 28, 2017
5. Raney, Lori E. Integrating Primary Care and Behavioral Health: The Role of the Psychiatrist in the Collaborative Care Model. American Journal of Psychiatry. Vol 172. Issue 8, August 2015

5

Learning Assessment

- A learning assessment is required for CE credit.
- A question and answer period will be conducted at the end of this presentation.

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Behavioral Health Services in Maine

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MaineHealth - Who We are….

- A non-profit integrated healthcare system with
  - 11 general hospitals-serving 10 Maine counties and 1 NH county
  - Maine's largest behavioral health provider with a 100-bed psychiatric hospital and comprehensive array of outpatient services
- Providers of healthcare for over 250,000 individuals
- Largest integrated healthcare system in northern New England with 1,400 inpatient acute care beds
- ACO with over 1,200 independent and employed physicians and over 300 primary care physicians
- Network of home health care and rehabilitative service organizations linked tightly with acute care services

MaineHealth's Vision: Working Together so Our Communities are the Healthiest in America

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Maine Behavioral Healthcare

Our Vision:

Working together so our communities are the healthiest in America, Maine Behavioral Healthcare will provide the highest quality integrated and compassionate behavioral healthcare through a collaborative and engaging workplace.

Our Mission:

To provide a seamless and compassionate continuum of care through a community of providers collaborating to promote recovery and the overall mental and physical well-being of the people we serve.

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Maine Behavioral Healthcare Services

- Hospital and intensive treatment
- Community based (outpatient) treatment
- Assertive Community Treatment (ACT)
- Other hospital services
- Crisis services
- Partial Hospitalization/Intensive Outpatient Programs
- Behavioral Health Homes
- Outpatient Therapy
- Outpatient Psychiatry
- Substance Use Treatment
- Residential Services
- Peer Services
- Mutli-Systemic Therapy Services
- Center for Autism and Developmental Disorders
- Behavioral Health Integration

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Our Behavioral Health Integration (BHI) Program

- BHI in 100% of primary care practices across the system: Most LCSW's; some LCPC's or psychologists. (65+ clinicians working in 70+ practices)
- Primary care and specialty practices: including Family Med, Internal Med, Pediatrics, Ob/Gyn, Diabetes center, Virology, Neurology, Oncology, Bariatric center, Pain Clinics, Burn Unit, Cardiology, Weight and Wellness
- Focused and episodic treatment for: mental health, substance use, behavioral change around medical conditions

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Psychiatry and the connection to medical practices

Psychiatry programs: IP, IOP, Partial, OP Psychiatry

OP Psychiatry primarily delivers fee-for-service face-to-face services in 9 locations across the system

Psychiatry link to ambulatory medical practices:

- Coordinated through Consulting psychiatry: 6 primary care, 1 specialty medical practices, 1 women's health, 1 peds., 1 substance use treatment in ambulatory settings
- Co-located Psychiatry: 2 Psychiatrists and 2 Psych NP's in 2 locations
- Integrated psychiatrists: 1 in Family Med, 1 Psychiatrist and 1 Psych NP in Peds, 1 Psychiatrist in Ob/Gyn, 1 Psych NP in Internal Med practices

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Assumptions about psychiatry and primary care

- There aren't enough psychiatrists
- Primary care may not be viewed as a part of the mental health treatment continuum
- But, a large portion of behavioral health work is done in primary care
- PCP's could use more training and support in managing behavioral health issues
- Care teams now include more behavioral health clinicians and support
- Some psychiatrists are ready for a change
- And…..
- Stepped Care including primary care as part of the continuum of care is an answer
- We have to figure out how to pay for the changes

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Levels of Integration for Psychiatry and Primary Care

		Level	Attributes	Role of Psychiatry	Primary Care Facility Ramifications
Coordinated	Minimal Collaboration	I	Separate site & systems Minimal communication	· Fee-for-service model · Hand-off patients between PCP and Psychiatry · Separate record	None
	Basic Collaboration at a distance	II	Active referral linkages Some regular communication	· Fee-for-service model · Hand-off patients between PCP and Psychiatry · Phone contact to discuss shared patients as needed. · Some coordinated care planning · Access to PCP record, but separate records · Could allow Collaborative Care model	None
Co-Located	Basic Collaboration on site	III	Shared site; separate systems Regular communication	· Treat pts in fee -for-service model · Hand-off patients between PCP and Psychiatry · Phone and in person contact to discuss shared patients as needed. · Some coordinated care planning · Access to and communication in PCP record · Could allow Collaborative Care model	· Separate space in facility · Self-contained psych space · Could include group space
	Close Collaboration Onsite	IV	Shared site, some shared systems Routine communication and coordination	· Treat pts in fee-for-service model · "Share" patients between PCP and Psychiatry · Phone and in person contact to discuss shared patients. · Coordinated care planning · Access to and communication in PCP record · Could allow Collaborative Care model	· Separate space in facility · Self-contained psych space · Shared Consult space in PCP area · Shared waiting room in PCP area · Access to group room

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Integrated	Close Collaborative Approaching Integrated Practice	V	Shared site; shared systems Coordinated treatment plans Regular communication	· Fee for service within medical practice · Shared patients with PCP · In-person communication · Shared care planning · Shared record · Could allow Collaborative Care model	· Space within PCP practice · Same scheduling, wait space, EMR, medical supports as other providers · Access to group room
	Full Collaboration in a Transformed Integrated Practice	VI	Shared site, vision, systems Shared treatment plans Regular team meetings Population based behavioral health	· Fee for service within medical practice · Shared patients with PCP · In-person communication · Shared care planning · Shared record · Collaborative Care model · Included in med staff meetings	· Space within PCP practice · Same scheduling, wait space, EMR, medical supports as other providers · Access to group room

Adapted from: A
Standard Framework for Levels of Integrated Healthcare. National Council for Community Behavioral Healthcare

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Your psychiatry services? Now and in the future?

- Coordinated
- Co-located
- Integrated

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Access challenges in community psychiatry

- Low reimbursement:
  - 75% of the National Council for Behavioral Health members lose money and rate of loss is increasing.
  - Three year losses of $481,000 in 2013 to more than $550,000 in 2017.
- Shrinking workforce/recruitment difficulties
  - Practicing psychiatrists shrank by 10% from 2003 to 2013
  - 6.4% shortage of psychiatrists in 2013 reported by DHHS with anticipated 12-25% deficit by 2025.
  - Shortage is variable by geography:
    - » 77% of U.S. counties characterized as having a "severe shortage"
    - » 55% of counties not having any psychiatrist.
  - 40% of U.S. psychiatrists are in private practice and accept only cash reimbursement.
  - Shrinking workforce due to aging, burn out (vicious cycle with poor access), increased demand for services.
- Demand for outpatient behavioral health services expected to grow by 19% from 2017 to 2027 Sg2
  - 28% for SUD treatment
  - 20% for mood disorders
  - 16% for eating disorders
  - 27% for Cognitive disorders including dementia
  - 20% for psychotic disorders
  - 14% for anxiety and personality disorders

Sg2 Analysis, 2017 The Psychiatric Shortage: Causes and Solutions. National Council Medical Director Institute. National Council for Behavioral Health. March 28, 2017

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Access challenges experienced by MBH

- Low reimbursement
  - MBH runs >$3.5M/year deficit between outpatient therapy and psychiatry
  - MaineCare (Maine Medicaid Program) reimbursement rates not keeping pace with growing cost of providing care. Current rates cover 68% of costs to provide outpatient therapy and 70% of costs to provide outpatient psychiatry
  - Behavioral health funding deficits within context of more pervasive fiscal challenge, e.g. Maine's rural hospitals lost more than $20M between FY 2013 and 2017.
- Shrinking workforce/recruitment difficulties (MBH has one rural position that has been open > 2 years)
- In a partially-aligned system in which MBH bears the burden of providing behavioral health services to hospital systems throughout the MaineHealth, there are increasing requests for resources to fill unmet needs. This has led to frustration for all parties.
- Data regarding unmet need is unclear. Historically, waitlist length has been the primary proxy of need in a given community.

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Quality deficits in community psychiatry

- Extended wait times
- Patients treated at a higher level of care than required due to inadequate access at appropriate level.
- Brief and infrequent visits
- Inadequate evaluations that perpetuate a diagnostic mythology for some patients
- Inadequate collaboration with therapists, case managers, and other clinical providers resulting in limited evidence-based treatments
- Polypharmacy/excessive prescription of controlled substances
- Inadequate collaboration between behavioral healthcare and primary care
  - Medical needs not adequately addressed
  - Behavioral health issues that present in primary care clinics not adequately addressed

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Quality Deficits experienced by MBH

- Extended wait times and struggle to meet 5 day IP to OP expectation
- Patients being treated at a higher level of care than that required due to inadequate access at appropriate
- Brief and infrequent visits
  - Many patients seen only by provider and necessarily at frequency of < monthly
  - Perverse incentive to keep stable patients that may get by with infrequent visits
- Inadequate evaluations that perpetuate a diagnostic mythology surrounding any given patient exacerbated by different EHR's
- Inadequate collaboration with clinical team members resulting in lack of evidence-based treatments
- Polypharmacy/excessive prescription of controlled substances
- Inadequate collaboration between behavioral healthcare and primary care
  - Different EHR's
  - Lack of primary care for 25% of specialty behavioral health clients in one OP setting
  - PCP concerns about taking on increased behavioral health treatment without adequate training or support

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Challenges and Culture Shift

1. Community Mental Health →	1. Specialty Behavioral Health within Healthcare system
1. Psychiatry only care →	2. Team based care
2. Patients with no PCP →	3. Holistic care partnering with primary care
1. Long-term patients →	4. Patients transition to primary care with episodic psychiatry as needed
1. Serve the larger community →	5. Target a specific population

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Survey results – what did we hear from PCP's




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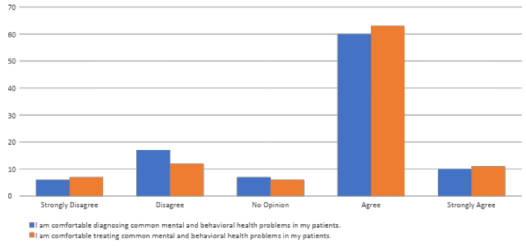
Comfort diagnosing and treating common behavioral health problems



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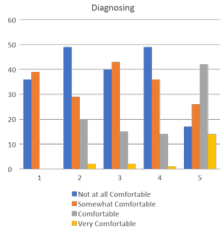
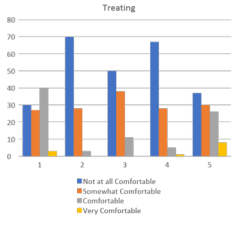
Question: What is your comfort with…





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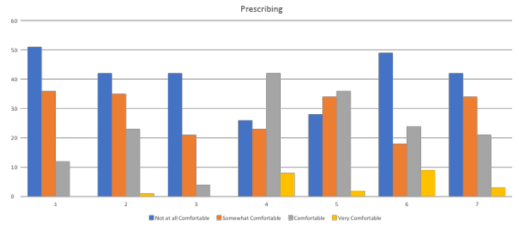
Question: How comfortable are you with prescribing…



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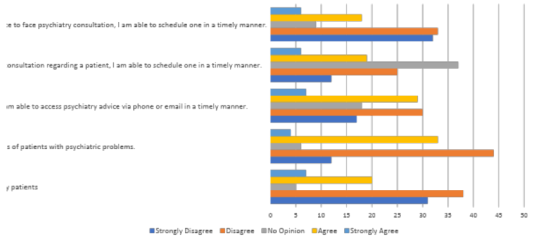
Access to psychiatry



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What have we done so far to begin the turn-around?

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Clinical interventions

- Linkage between psychiatry and BHC's in "consultation groups"
- Psychiatry and Primary Care Partnership (PPCP)
- Co-located OP Psychiatry within a primary care practice
- Billable consultation by psych provider in behavioral health clinics
- Embedded and integrated providers
- Efforts to facilitate stepped-level referral system
- Active facilitation for transitioning patients back to primary care

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Connection to BHC

- Group care consultation monthly for BHC's with consulting psychiatrist
- Ad hoc consultation and case discussion
- Triage patients for consult through coordination and assessment by BHC and psychiatrist
  - Save consult slots for complex patients
- Frequent communication in person, and via EHR
- BHC's assist in transitioning patient back to primary care

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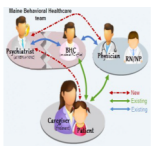
PPCP Program functions and intent

- Telephonic psychiatric consultation to primary care around specific clinical concerns
- Education through:
  - "Lunch and learns"
  - Informal discussion
  - Case based consultation
  - Webinars
  - Creation of enduring materials



- Streamlined access to the psychiatrist re: available community resources
- Coordination with integrated behavioral health clinician

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PPCP Background and Purpose

- Based on experience of Child Psychiatry Access Program (CPAP):
  - Relationships developed through educational programs
  - Fidelity of the model is maintained
  - Single/simple point of contact
- Funding: Grants from Behavioral Health Care Program at the PHO and MaineHealth – intention of sustaining partnership overtime
- Goal: Psychiatry will assist primary care providers in diagnosing and treating patients with behavioral health conditions in the primary care setting
- Additional aim – increase access to psychiatry and increase patient flow between systems
- Not just another initiative – but something that should provide value for PCP's and their patients

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The Model and Flow for PPCP

- Participating psychiatrists, primary care providers and supporting BHI clinicians are identified
- Relationships are established through:
  - Provider meetings
  - Case consultation
  - Lunch and Learn's
- PCP and/or BHI clinician can call psychiatrist during workday for advice/direction
- Call will be answered and psychiatrist will call back by end of day
- If needed patient may be seen by the psychiatrist for 1-3 sessions
- Rarely - patients may be transferred to ongoing psychiatry
- Patient remains a PCP patient, with psychiatry available for consultation at any time

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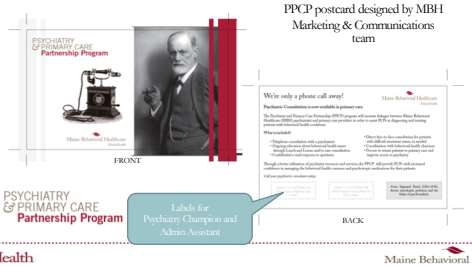
Preliminary PPCP activities

PPCP postcard designed by MBH Marketing & Communications team



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Expected outcomes of PPCP

- Utilization of service: Numbers of phone contacts. Numbers of patients directly affected
- PCP perceptions of:
  - Increased confidence in managing behavioral health concerns
  - Increased confidence in prescribing psychotropic medications
  - Increased knowledge of psychiatric conditions
- Positive patient experience
- Number of patients returning to primary care from specialty psychiatry
- Improved access to specialty psychiatry

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Co-located Psychiatry

- Intended to improve flow between primary care and psychiatry services
- Actual benefits: works well for patients, supports relationship building between psychiatry and primary care, some streamlined processes
- Actual barriers we have found:
  1. Failure to define the co-located services as different from OP Psych
  2. The work and flow doesn't really change – access problems remain
  3. Trouble narrowing the referral base, i.e. "community" vs. "health system patient"
  4. Separate records and glitches in coordination care
  5. Increased expectations by primary care, with no change in access

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Integrated Psychiatry

- Psychiatrist on site, visible
- Scheduled consults, but interruptible
- Warm hand-offs
- Flexible schedule to accommodate curbsides, warm hand-offs
- Shared EHR, schedules
- Attends team meetings
- Provides education via lunch and learns
- Teaches residents!

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Transitioning patients to primary care

- Relationship building between PCP's and psychiatry providers
- Facilitation by BHC's and BHI leadership
- Psych provider "registries" to better understand their patients and panel
- Review of "registry" with providers and psychiatry leadership
- Shared patient reviews between PCP's and psychiatry
- Creation of transition criteria
- Implementation of "transfer" document to gain buy-in
- Expectation that patients can easily return to psychiatry services for short time as needed and when needed
- Ongoing attention and commitment to this work

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At any level – aim for:

- Team approach to care
- Support for Psychiatry and PCP partnership
- Same medical record
- Meet at location (either co-located, integrated, tele-video, other?)
- Curbside within Epic or other EHR
- Consultation and re-consultation
- Facilitated referral to Psychiatry (by BHC)
- Ability for patients to flow smoothly between PCP and Psychiatry and back
- Support to PCP for difficult patients

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Systemic educational interventions through Residency program

- 3 residents at Family Medicine, 1 in IM, and 1 in Ob/Gyn clinic 1 ½ day per week during their 3rd year delivering:
  - Outpatient consultation,
  - Longitudinal care, and
  - Curbside consultation to their Family Medicine colleagues
- All third year Residents spend ½ day a week at the VA clinic - a multidisciplinary OP clinic
- All 4th year Residents spend ½ day a week at the PSLC (Preble Street Learning Collaborative) – a multi-disciplinary clinic serving the homeless population

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System and state level interventions

- Regional interventions
- Health system advocacy
  - Value oversight committees and beginning discussion of healthcare value of behavioral health
  - Clinical leadership – strengthening the voice of psychiatry within provider leadership
  - Administrative leadership – taking the value case to healthcare leadership, especially in relation to funding for behavioral health
- Hub and spoke model implementation for substance use services – link between specialty behavioral health and primary care
- State-wide advocacy
  - Beginning discussion about inclusion of Collaborative Care codes and other psychiatric consultation codes in the Maine Medicaid rate system

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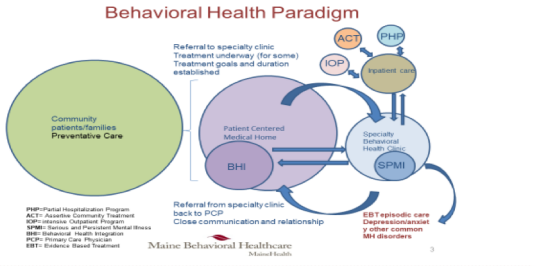
The Destination Postcard



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Next steps

- Clinical interventions
  - Collaborative Care model implementation
  - Other billing opportunities: virtual consults, record review codes
  - Treatment guidelines - focus on consistent treatment throughout the network. Tackling problems like:
    - Polypharmacy/controlled substances
    - Lack of CBT and other evidence-based treatments
    - Other areas identified by PCP's through survey

- Regional and central healthcare service interventions
  - "Delegation" to regional entities to collaborate re: "Destination Postcard"
  - Development of epidemiologic/population-based data re: unmet need/resource allocation
  - Focus on **VALUE** of behavioral health/psychiatry in relation to overall healthcare
- Educational interventions for both Residents, present psychiatry staff, and PCP's
- Legislative and state-wide interventions to support alternative funding, and improved fee-for-service rates

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What have you done to turn your system around?
What would you like to do?

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Questions and Contact Information

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Session Survey

Use the CFHA mobile app to complete the survey/evaluation for this session.

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

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Join us next year in Philadelphia, Pennsylvania! Thank you!

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