

**Robert Lee Sutherland Seminar XV
Hogg Foundation for Mental Health**

National Integrated Health Care Initiatives – Part II
Summary Notes

I. Tina Runyan

A. Choosing a model of integration: Consider population and consider current resources as well

- this particular model was geared towards active duty military and their dependents
- a lot of care facilities were outsourcing dependents
- when seen at the military treatment facility, could see lots of providers, but when go outside of treatment facility, individual hospitals cost a lot of money
- early identification and prevention
- huge issue of stigma with active duty military personnel in seeking mental health help
- financing was less of an issue

B. Not until people got to point of being identified did they seek or get care for identified conditions - disease burden prior to getting into disease state was getting missed

1. Predictable, measureable events along the way - need to catch problem along the way before PHQ-9 score of 10 or a significant event in their life
2. Don't have to deliver services as intensely if catch people earlier on continuum which means a lot less personal suffering
3. Earlier you catch people, just need a little bit of treatment (as Ms. Darden said)
4. If you believe we're all susceptible, if you can catch those events that lead them to spiral down can prevent them from getting to that disease state

C. Behavioral Health Consultant (BHC) - role for clinical psychologist in this along with nurses/social workers – provider that has received specialized training to work in consultative model of behavioral healthcare - Addresses depression, anxiety, substance misuse, chronic pain patients

D. Key Elements: behavioral health consultant becomes part of primary care (PC) healthcare team

1. Patients seen at primary care provider (PCP) or nurse's request
2. BHC is a consultant, PC remains responsible for patient's overall healthcare
3. No written informed consent, no separate mental health (MH) record
4. Capitalizing on relationship with PCP, a lot of trust in them

E. Key elements: brief, focused assessment and intervention, target functioning and quality of life, shared decision-making with patient, same day feedback to PCP

1. Patient education, self-management, strategies and skill building techniques
2. Short appointments (30 mins); limited number of visits

F. Key Aspects of Consultative Model

1. Using the full PHQ for screening-addresses panic disorders, eating disorders, helps to know what you're dealing with
2. Services provided by consultant: diagnosis and problem definition-recommendations for psychopharmacology to PCP

3. Provide behavioral health (BH) treatment - establishing self management/behavioral activation plans
 - providing feasible new strategies for managing physical, emotional and behavioral aspects of health
- G. Implementation - establishing model of care, getting key stakeholders involved, comprehensive manual as part of training program, selectively picked sites to train
 1. Distance learning, brought expert on site for clinical training, evaluation of training
 2. 40 medical facilities in Air Force that have integrated healthcare provider, 30 predoctoral psychology students being trained
 3. Fiscal Years 2003-05 integrated care was estimated to have saved \$1.7 million

II. Sally Smith

- A. Statewide initiative: ICARE
 1. Integrated Collaborative Accessible Respectful Evidence-based
- B. Collaborative group of agencies dedicated to medical and mental health well being of North Carolinians
 - many partners, over \$3 million committed to date: the Duke Endowment, pharmaceutical companies, Kate B. Reynolds Charitable Trust
- C. Practices-4 pilots involving 19 practices - idea to determine in own region what would work
 - partnered with NC Medicaid Co-Location Project - \$1 million into integrated care: behavioral health and chronic disease
 - they put in \$25,000 per clinic - 60 practices have those start-up funds, usually used to hire on behavioral health provider
- D. Process and Policy Change - state leaders meet monthly to establish list of barriers and develop strategies to reduce or eliminate barriers, eliminate one by one
 - lack of communication, lack of coding, reimbursement/billing issues
 - 6 things that insurers can do - insurance providers and payers willing to allow same day billing, reimburse behavioral health costs
- E. Training and Technical Assistance - education and training across the state, onsite technical assistance, regional training of all kinds, other collaborations with state organizations
 1. Developed curriculum with eye on PCPs providing behavioral health within their clinic, and training BH professionals that understand how to do their work within clinics
 2. Technical Assistance: onsite training - every clinic is different, if you're private/pediatric/rural/latino population - all look different
 - part of money is spent on training people to travel and give technical assistance
- F. Clinical Use of Psychiatry - real role for psychiatrists
 - on site consultation, phone consultation, working on telepsychiatry
 - Rapid Evaluation and Stabilization - comes from therapists - sometimes they need to see patients, need face to face work (small percentage) - if they can be seen soon then don't need to go to specialty mental health