

COLLABORATION BETWEEN
PRIMARY CARE AND
BEHAVIORAL HEALTH: WHAT,
WHO,
WHERE AND HOW

NIATx

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What, Who, Where and How

- What: What model of integration? Will you implement a variety of models based upon other factors? What services (billing codes) will be included? What skills are needed? What do staff know and not know?
- Who: Integration for whom, what population? Who will do what in the model chosen? Who will bill what? Who gets to be in charge? Will agencies remain separate or merge? Who else plays a role, payers, government? Who interviews staff and decides who to hire?
- Where: What is the location of service delivery? How does the population of focus influence that decision? How do answers to these questions influence the What and the Who?
- How: What are the considerations, operational and financial, in making this happen? How do we train staff? How will we problem solve and overcome the introductory and on-going issues that arise (including personnel issues)? How do we jointly advocate for change at the State and/or local level? How does this fit with ACA initiatives and medical home initiatives?

What is Integration?

- Provision of primary medical care and behavioral health treatment or intervention as unified treatment, blending of primary health care and behavioral health into a single service delivery process.
- This approach recognizes that nearly 70% of primary care medical visits are based upon psychosocial factors, that individuals with chronic health conditions also have co-morbid mental health problems and that individuals with a serious mental illness generally also have chronic health diagnoses.
- Generally integration has been interpreted as the addition of behavioral health to medical, not the reverse
- In all integration models implementation can vary along a continuum

What is Integration? Variations on a Theme

- Collaboration between separate providers: Each provider retains their own identity and usually the referral relationship is strengthened
- Behavioral health services provided by medical personnel: Often means screening for mental health and/or addictions issues with consultation with psychiatry and referral for specialty care
- Co-location: Medical and behavioral health clinicians are located in the same physical space

Variations Continued

- Reverse Co-location: Inclusion of primary care in the behavioral health setting. This is typically population specific and may mean either primary care doctors (or Nurse practitioners) in the behavioral health setting or psychiatrists providing some medical care
- In all of these models integration and/or collaboration can occur along a continuum.
- Fully integrated care means that the delivery of service is seamless, is within the same treatment plan and does not involve referral to specialty for routine services. Often there is a disease management structure to care and if referral is needed someone on the team is managing that referral and the specialty care provided

Introductory Questions

- What are your goals?
- Do your goals align with your potential partners, now and over time?
- Is there a specific population of interest?
- What might get in the way?
- What is my organization bringing that the other does not have? How can you add value?
- How can this be paid for?
- How will the day to day be managed?
- What will need to change to achieve integration?

What

- **What:** What model of integration? Will you implement a variety of models based upon other factors? What services (billing codes) will be included? What skills are needed? What do staff know and not know?
- To answer this question start with your **Goal(s)** and **Population(s)** of focus

Examples of Goals

- Improve identification and referral to treatment of mental health and addictions diagnoses in the medical setting
- Improve short term intervention for mental health and addictions diagnoses identified in the medical setting
- Improve access to behavioral health care for individuals treated in medical settings
- Decrease stigma of behavioral health by incorporating it into medical care and obscuring the difference between the two

More Goals

- Improve the ability of primary care to diagnose and treat behavioral health conditions including improvement in ability to prescribe effectively
- Expand the use of medication assisted treatment
- Improve the medical care of individuals treated in behavioral health settings
- Improve efficiency of care and decrease costs (ER diversion)
- Align the combined delivery of medical and behavioral health care services by location based on the population

Goal Alignment

- Good partnerships have shared goals
- Goals do not need to be shared 100% but there must be substantial overlap
- Goals can be prioritized, time framed and change as circumstances change
- Dream big but start small – pilots are a good idea

Population

- Good partnerships agree on the population of interest or focus
- Population together with the goals will determine training needs and what staff need to a part
- Population selected may determine location of most effective care
- You can't usually do it all at the beginning – the value of pragmatism

Who

- **Who:** Integration for whom, what population? Who will do what in the model chosen? Who will bill what? Who gets to be in charge? Will agencies remain separate or merge? Who else plays a role, payers, government? Who interviews staff and decides who to hire?
- Organizations need to flesh out roles by carefully outlining by goal and population the necessary services, staff credentials and billing codes that can be used along with reimbursement levels.

Services, Credentials, Skills and Codes

- Services needed : What are the translations to billing codes
- Codes have credential requirements. Know what they are.
- Skills: Integrated care takes specialized skills. Assume that training will be needed. Assume that there will be cultural shifts in operations to complement the training.
- Inventory codes: 96150 series, traditional mental health, psychiatry, Evaluation and Management Codes. Who gets paid for what? If there are FQHCs what codes can they bill? How much is the reimbursement?

Where

- Where: What is the location of service delivery?
How does the population of focus influence that decision? How do answers to these questions influence the What and the Who?

Where

- Determine location of service delivery based upon goals and population of focus.
- If partnering with an FQHC be aware of change of Scope applications and zip code assignments
- Look at other opportunities to leverage your skills and knowledge
- Determine how your organization can assist other health care providers in achieving their goals and in avoiding payment penalties

How

- **How:** What are the considerations, operational and financial, in making this happen? How do we train staff? How will we problem solve and overcome the introductory and on-going issues that arise (including personnel issues)? How do we jointly advocate for change at the State and/or local level? How does this fit with ACA initiatives and medical home initiatives?

Practical Considerations In How to Achieve Integration

- Start the conversation with the leadership. Their support is critical
- Keep talking to determine areas of mutual concern and interest
- Learn about the demands on the other organizations and your possible role, e.g. medical home accreditation
- Agree upon goals and population, location of care
- Establish a regular forum for discussion and problem solving
- Have an MOU or a contract before you begin
- Establish Business Associate Agreements and Qualified Service Organizations Agreements
- Which organization will do what and what is the contractual relationship (e.g. FQHC contracts for behavioral health staff from the behavioral health provider)

Practical (2)

- Establish procedures to support end goals, test your systems and make corrections (pilot)
- Determine skills needed and train staff for their new roles (e.g. Behavioral Health Consultant for use of the 96150 codes)
- Openly discuss and agree upon expectations for productivity, procedures, etc. Monitor performance
- Clearly assign staff roles (reimbursement will guide this but don't neglect the roles of staff that do not bill, e.g. Medical Assistants). Use flow charts
- Determine how to document care and how to exchange information

Practical (3)

- Select the right staff – know who can bill for what
- Change staff if they are unable to meet expectations or work within the model effectively
- Determine how to sustain the model financially and operationally.
- Perform financial projections – At some point, at minimum, organizations should break even; ideally both will see an increase in revenue. When will that occur?
- Meet cross organization often, make an agenda, keep minutes, assign responsibility for items

Practical (4)

- Determine what other organizational expectations are present and how to meet them, e.g. rapid access to one another's services
- Determine where the business operations between the organizations differ (e.g. confidentiality, 42CFR) and how to manage this.
- Include providers in decision making about clinical services and project evaluation
- Build outcomes into the project. Ideally select measures that have credibility beyond your project.
- Trust cannot occur with hidden agendas and trust is essential to an effective partnership

Conclusions

- You have to start someplace so make it as easy as possible
- Let the partnership evolve.