California Association of Public Hospitals and Health Systems
California Health Care Safety Net Institute

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LESSONS FOR TRANSFORMING CARE IN THE SAFETY NET

70 WASHINGTON STREET, SUITE 215 ▪ OAKLAND, CA 94607 ▪ PHONE: (510) 874.7100 ▪ FAX: (510) 874.7111 ▪ WWW.CAPH.ORG

Meeting Patients' Needs Through Physical and Behavioral Health Integration

Unmet behavioral health needs (mental health and substance abuse) can have dire consequences for individuals and their families, increasing a person's likelihood of developing chronic medical conditions or diseases, and resulting in death an average of 25 years earlier compared to other Americans.[1] Unmet needs also increase medical expense, as behavioral health-related visits to the emergency department (ED) can be longer and more costly than other types of visits.[2]

For low-income Medi-Cal and uninsured patients, the delivery of care for their physical and behavioral health needs has historically been siloed, with different types of providers and case managers often in different geographic locations. Recently, California's public health care systems (PHS) have made significant strides in addressing these issues. Through the Delivery System Reform Incentive Program (DSRIP), a federal pay-for-performance program tied to delivery system performance milestones (see sidebar), several PHS across the state are working to better integrate care for patients who have both physical and behavioral health needs. The DSRIP has catalyzed improvements in care coordination through stronger partnerships between PHS and county behavioral health agencies. These collaborations represent significant efforts to provide coordinated and seamless treatment of physical and behavioral ailments, leading to improved patient experiences and outcomes.

Seven California PHS included projects in their DSRIP plans to better integrate physical and behavioral health services. They are working

California's Delivery System Reform Incentive Program (DSRIP)

California's five-year Section 1115 Medicaid Waiver, which began in November 2010, provided California's 21 public health care systems an unprecedented opportunity to expand coverage and transform care. The waiver includes the DSRIP, a pay-for-performance initiative for public health care systems to achieve delivery system-based performance milestones and earn up to $3.3 billion in federal incentive payments. The DSRIP has provided an opportunity for these public health care systems to expand upon their existing quality improvement efforts and make them large-scale. In each of the DSRIP's five years, individual health care system's DSRIP plans include an average of 15 projects across the inpatient and outpatient setting in five major categories: developing and strengthening their infrastructures, implementing innovative models of care, advancing the health of the populations they serve, continuing to make improvements in quality and patient safety; and improving care coordination for patients with HIV/AIDS.

[1] Manderscheid R, Druss B, Freeman E. Data to Manage the Mortality Crisis. International Journal Of Mental Health [serial online]. Summer 2008 2008;37(2):49-68. Available from: Academic Search Complete.

[2] Salinsky, E., & Loftis, C. Shrinking Inpatient Psychiatric Capacity: Cause for Celebration or Concern? National Health Policy Forum, Issues Brief. George Washington University, Washington, DC. (2007) 823,1-21.

to co-locate services; use new tools to conduct comprehensive patient assessments; improve patient referral processes; and engage community stakeholders. With three years of experience behind them, these systems have gained some valuable insights that may be instructive to other teams seeking greater integration on behalf of their patients. Below is a sample of some of the lessons learned along the way.

Lesson #1: Successful Changes Are Rooted in Patients' Experiences.

Public health care system providers know that successful care improvements must start and end with the patient's perspective. At the San Francisco Department of Public Health (SFDPH), many mental health patients have psychiatric symptoms, such as disorganized or psychotic thinking, that can make it difficult for them to seek treatment in primary care settings, even though primary care is essential to their treatment. Understanding this, SFDPH began offering primary care services in their mental health clinics. Now, patients coming for mental health services are also screened for cancer and other physical risk factors (blood pressure, smoking status, cholesterol) and given appropriate immunizations.

Patient A's Success Story

Patient A is an HIV-positive, 58 year-old male who has a heart condition, hypertension, arthritis, Hepatitis C, asthma, and chronic obstructive pulmonary disease. In addition, he has a long history of co-occurring poly-substance use and mental health disorders that include depression and borderline personality disorder. He has relied completely on emergency and inpatient services for his medical care.

With SFDPH's co-location of physical and behavioral health services, Patient A now gets coordinated treatment from a team—primary care physician, psychiatrist, nurses, and case manager. Patient A's physical and mental health, and substance dependence issues have now substantially improved as a result of SFDPH's integrated care efforts. Patient A now adheres to a combined primary care and psychiatric medication regiment, and more importantly, he is now an active participant in his own recovery.

San Mateo Medical Center's Innovative Care Clinic (ICC) has piloted a project to improve care for patients with diabetes who were not taking their medications. Throughout the pilot, ICC staff closely monitored patients' medication compliance and made rapid changes as needs were identified. For example, ICC staff quickly learned that compliance rates increased if patients were screened for depression and received individual counseling during the same initial clinic visit rather than in a subsequent appointment. This screening was especially important for those patients with significant signs of depression.

In addition, the ICC pilot placed a mental health specialist directly in the ICC. For patients who came for their initial visits, this "warm hand-off" from a physical to mental health provider resulted in 81% of these patients continuing with their treatment post-intake, as compared to only 50% of patients who had received a standard referral.

Lesson #2: Eliminate Duplication and Inconsistencies.

Through their physical-behavioral health integration projects, PHS have come to appreciate the importance of creating a unified delivery and administrative system under which the two operate. Several public health care systems realized that in order to reach their DSRIP milestones, they would need to begin by streamlining screening tools and referral processes.

For instance, while working to implement screenings for depression, anxiety, and substance abuse, Kern Medical Center (KMC) discovered that there were more than 40 different behavioral health screenings in use within their health system. They reviewed the various tools, identified overlaps, and developed a standardized registration form. A universal screening tool is now being utilized by a number of their clinics, including family practice and inpatient services, which allows for a more streamlined patient experience and improved coordination of care.

In order to diminish the negative stigma associated with seeking mental health care, the Los Angeles Department of Health Services (LADHS) began co-locating mental health staff in physical health clinics as part of their DSRIP activities. However, they soon realized that the Department of Health Services (DHS) was using different referral processes than the Department of Mental Health (DMH). As a result, neither one was able to capture the information that the other needed. This led DHS to study the needs of each department and create a unified referral system. DHS incorporated DMH referral documentation into its referral system to provide the clinical information needed to make referral decisions. By incorporating DMH's referral documentation, the unified referral system is able to eliminate excessive and confusing paperwork and more appropriately refer patients to either co-located DMH staff or to an acute care provider or facility. These efforts to integrate behavioral health care into the primary care setting – along with their unified referral system – have resulted in an increase in the number of follow-up visits, demonstrating the enhanced coordination and access to services critical to improving the health of patients with complex needs.

A View of DSRIP from the Field

"DSRIP is a unique opportunity to invest in the processes and tools needed to take our organization to the next level. Integration of physical and behavioral health has historically been a long battle about when and how it should occur, and who should be involved. So, we got everyone together and listened to their thoughts, complaints and ideas about how to successfully integrate physical and behavioral health care. This is what we used to develop our implementation plan to accomplish our DSRIP milestone."

- Jacey Cooper, Executive Director of Managed Care, Kern Medical Center

Lesson #3: Create Buy-in Among Partners at All Levels.

In integrating physical and behavioral health, PHS quickly realized that silos can only be broken down if there is a commitment among partnering agencies to better serve their shared patient populations. Providers and administrators must be willing to work through the differences in terminology and philosophies used by each delivery system, and these understandings must be reinforced through regular and effective communication.

It is extremely important to foster trust, create a shared mission and goals, and develop a common language among clinicians and staff in each of the service areas.

Recognizing this lesson, the Santa Clara Valley Health & Hospital System created an entirely new entity within the Mental Health Department—the Division of Integrated Behavioral Health. The Division includes a new staff position dedicated to working with Ambulatory Care Services to solve issues related to the integration of behavioral health in primary care clinics and helping create a shared understanding between the ambulatory care and behavioral health services settings. Additionally, the Mental Health Department conducted educational trainings to engage stakeholders and ensure that they understood and embraced needed changes. These efforts laid the foundation for change and unified how the two agencies would better care for their shared patients.

At Kern Medical Center, an Integration Committee was formed to create system-wide support for their organization's physical and behavioral health integration efforts. The Committee held an initial meeting where stakeholders were able to voice concerns, thoughts, and ideas. The Committee then turned the collective ideas and concerns into an implementation plan. Leaders noted that the meeting was contentious at times, but the Committee's persistence in finding common ground and a common language resulted in their greatest skeptics becoming some of its fiercest supporters. KMC DSRIP leaders came to appreciate the value of actively engaging stakeholders, incorporating feedback, and creating a well-crafted strategic plan from the beginning to create the strong buy-in that can ultimately propel the organization's goals forward.

Building on Lessons Learned

As described, PHS are implementing tools that better identify and treat behavioral and physical health issues, streamline how patients receive their care, and create the buy-in necessary to build coordinated care systems across historically separate delivery systems. The lessons shared here are grounded in the patient experience, and demonstrate how PHS are working to not only become providers of choice, but also providers of high value care. The strong and lasting foundations of meaningful physical and behavioral health integration – which unify commitment among all stakeholders – help ensure that some of the most complex patients receive the right care at the right time and place.

A National View

"A truly integrated delivery system requires combining different kinds of services and supports, including behavioral and physical health care. With the Affordable Care Act (ACA) requiring parity between behavioral and physical health benefits in the new insurance exchanges, and the ACA's Medicaid expansions bringing coverage to a population with a range of behavioral and physical health needs, integration of the two has never been more important."

- Mike Stanek & Anne Gauthier, National Academy for State Health Policy