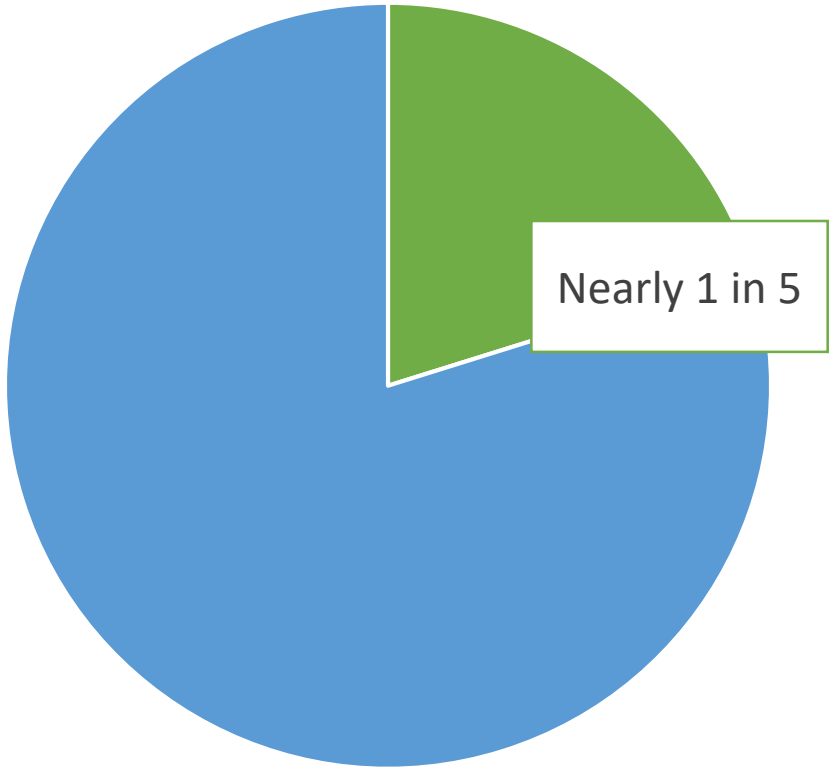
AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

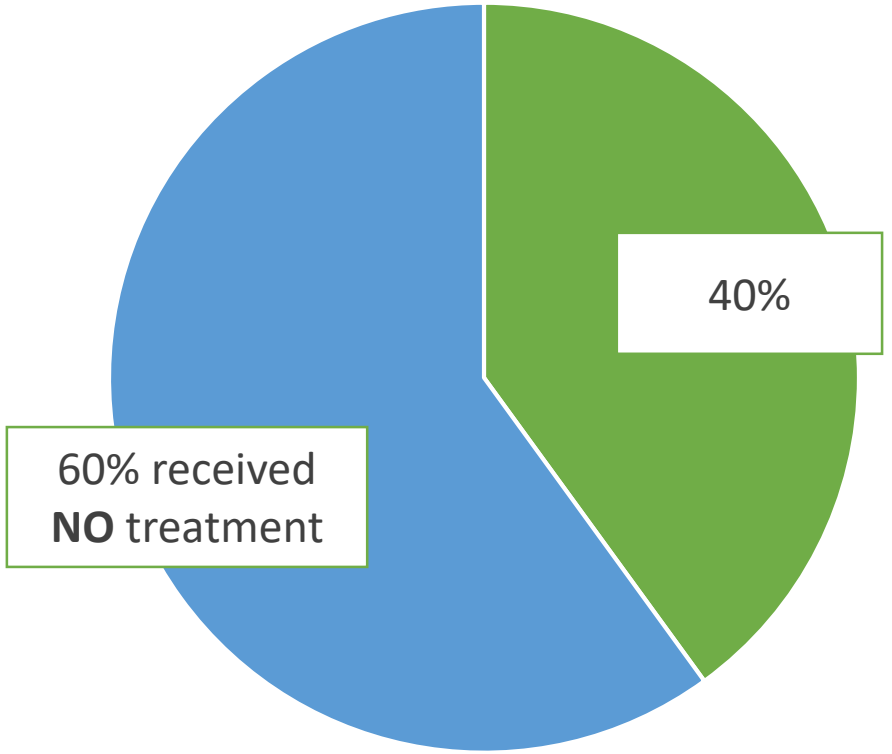
Integrating Behavioral Health and Primary Care

Anne Shields
Associate Director, AIMS Center, University of Washington
Jeff Thomas
Chief Executive Officer, Frontier Behavioral Health
Caitlin Safford
Director of Governmental Relations, Amerigroup Washington

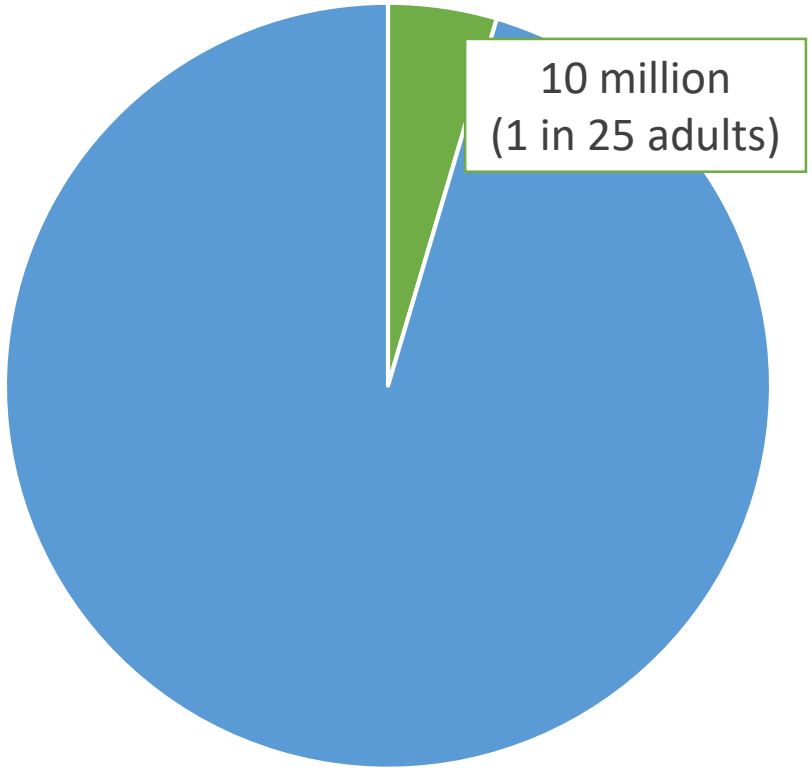
Mental Illness Prevalence Rate in U.S.



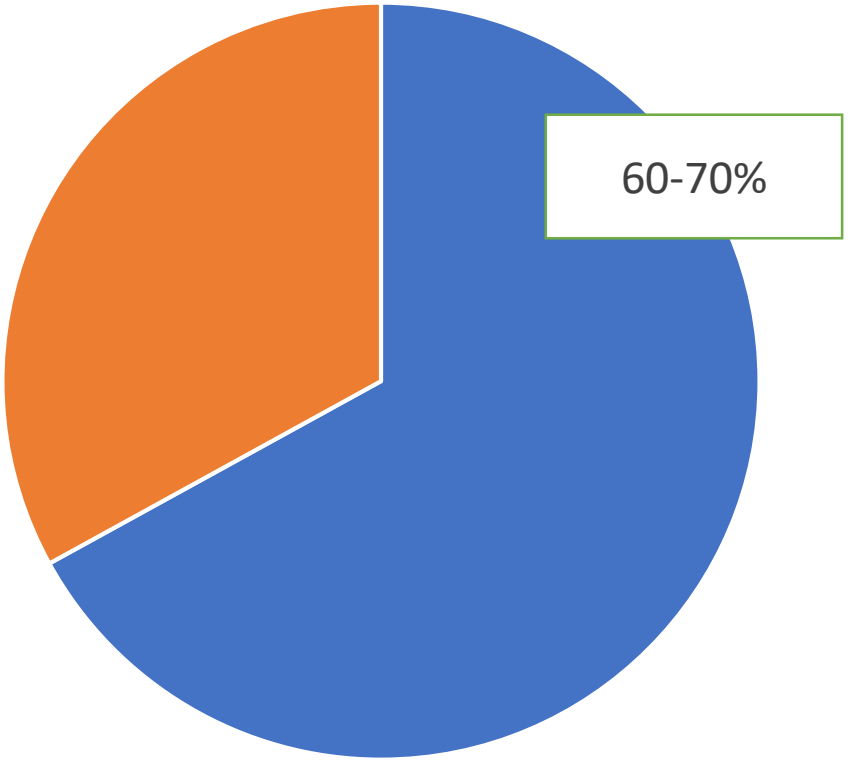
Individuals with mental illness who received treatment within past year



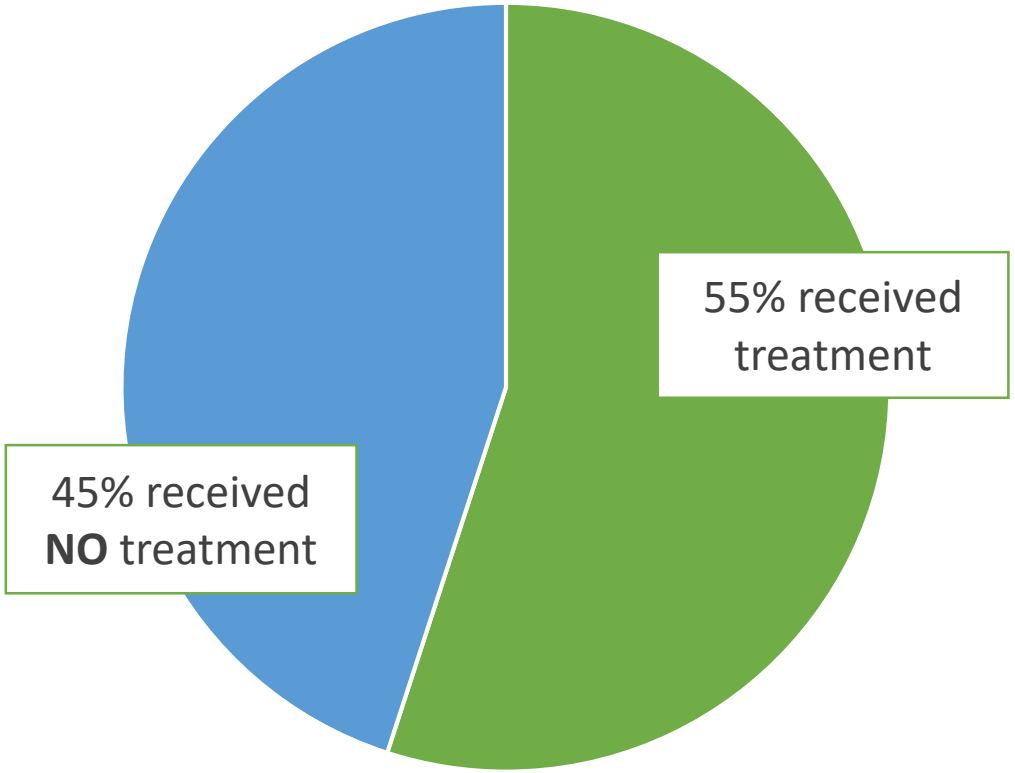
Adults with Serious Mental Illness



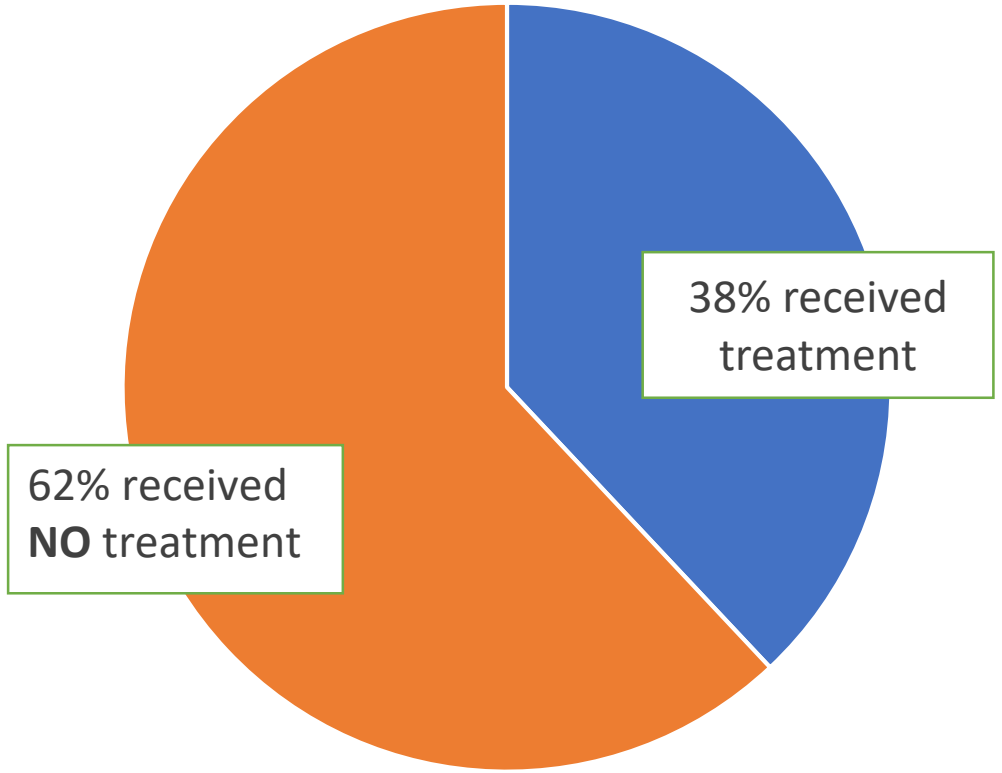
Co-morbidity of serious mental illness and 1+ chronic health condition

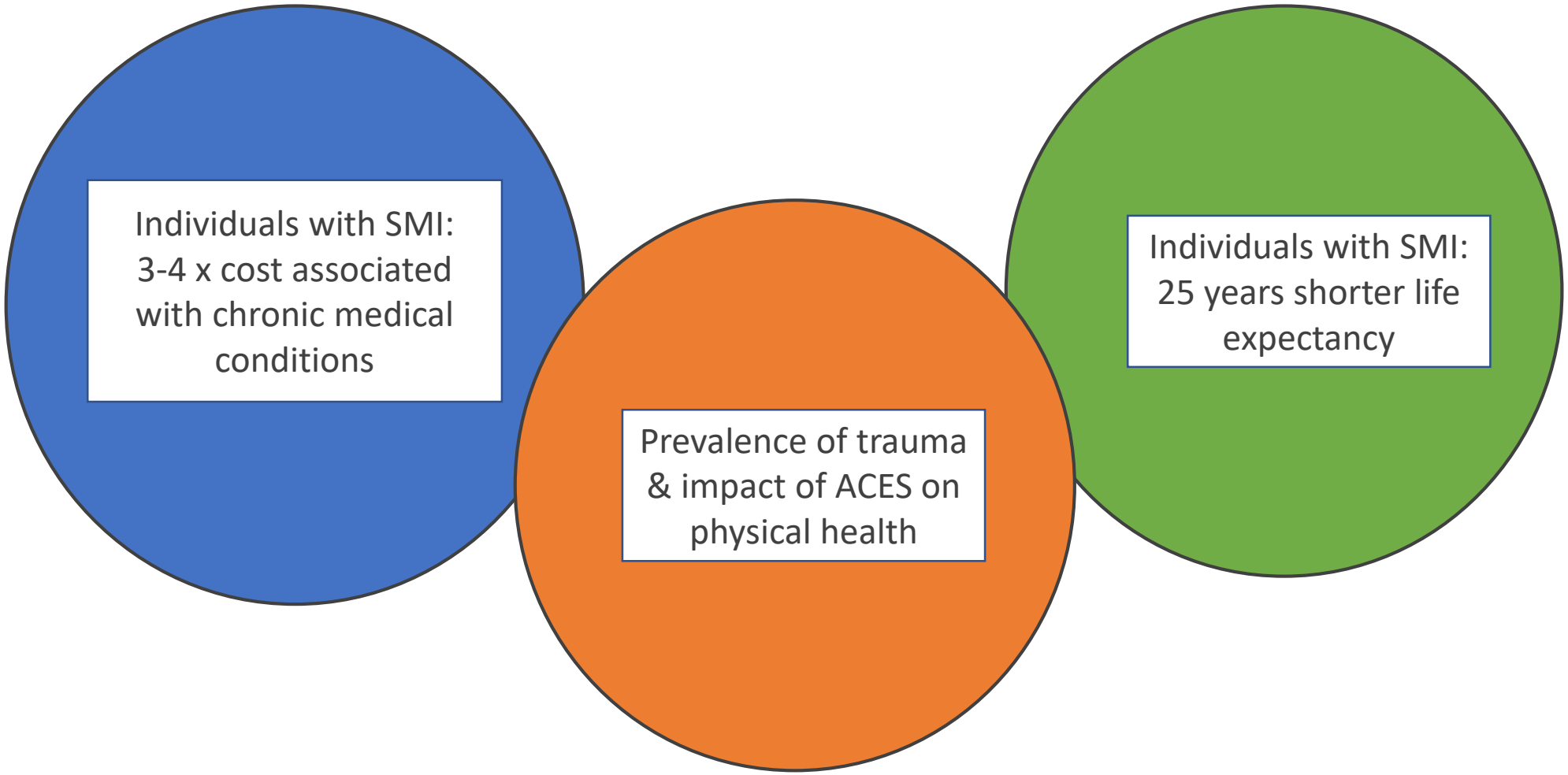


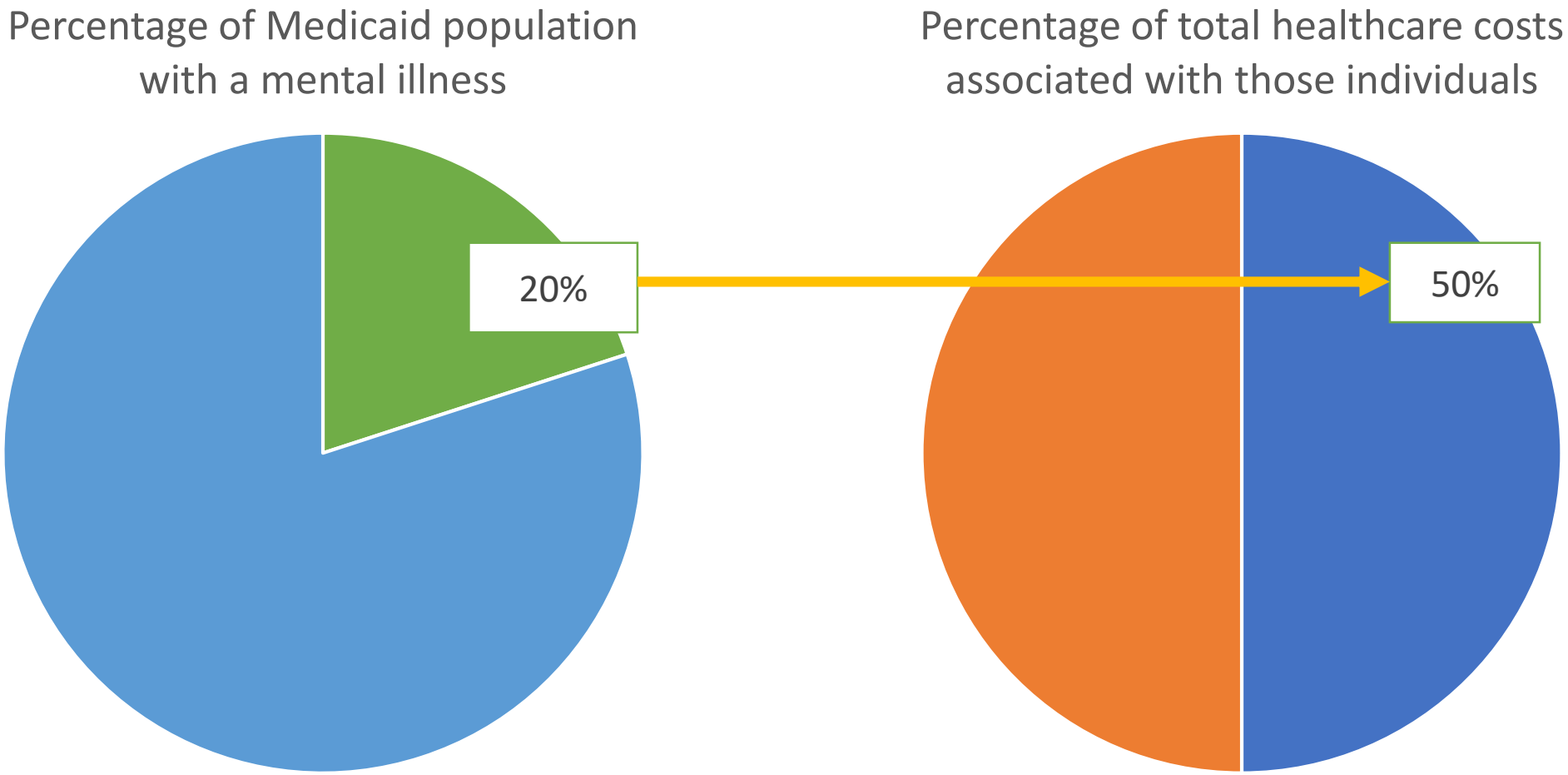
Treatment rate for individuals with Schizophrenia and Type 2 Diabetes



Treatment rate for individuals with Schizophrenia and Hypertension




Individuals with SMI: 3-4 x cost associated with chronic medical conditions
Prevalence of trauma & impact of ACES on physical health
Individuals with SMI: 25 years shorter life expectancy


Percentage of Medicaid population with a mental illness
20%
Percentage of total healthcare costs associated with those individuals
50%

Pilot projects and lessons learned

Care Connector

Lessons Learned:

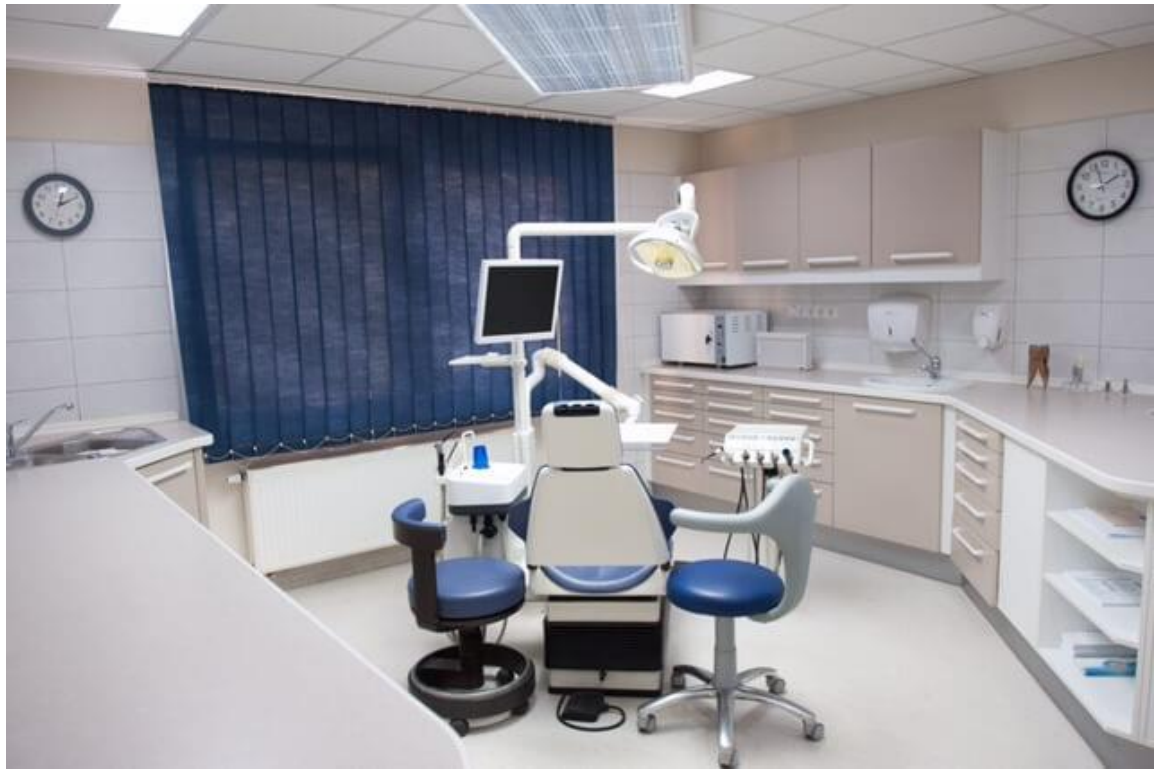
- Provider first-hand knowledge of resource and value
- Make it easy
- Engagement skills are critical

Brick House

Lessons learned:

- It’s not just about proximity
- Every extra step creates a potential barrier
- Must be someone’s top priority

Oral Health Local Impact Network



Lessons learned:

- Convergence of funding, technology, capacity
- Importance of making process “seamless” to the client

TCPi

Lessons learned:

- Brought together physical and behavioral health providers
- Being in the same room helped identify gaps and opportunities

Opportunity:
Referrals from primary care to behavioral health treatment

Historical Process

(how it's "supposed" to work)

- Primary care provider (PCP) identifies potential BH issue
- PCP knows where to refer/process
- PCP verbally informs; possibly provides name and number
- Patient calls BH provider for appointment
- Patient gets an appointment
- Patient attends appointment
- Patient informs provider who referred them
- Information provided back to PCP

Potential Failure Points:

- PCP may/may not know how to screen or what to look for
- PCP may not know of resource/process
- Patient is responsible for following through; BH provider unaware of referral
- Maybe
- Maybe
- Maybe
- Maybe
- Minimal, if any

Opportunity:
Referrals from primary care to behavioral health treatment

Historical Process

(how it's "supposed" to work)

- Primary care provider (PCP) identifies potential BH issue
- PCP knows where to refer/process
- PCP verbally informs; possibly provides name and number
- Patient calls BH provider for appointment
- Patient gets an appointment
- Patient attends appointment
- Patient informs provider who referred them
- Information provided back to PCP

Enhanced Process:

- PCP trained in screening and identification of BH issues
- Referral process parallels other specialties
- BH provider receives auto-notification that patient has been referred
- BH provider reaches out to patient
- Open access (already available at FBH)
- Provider follows up if necessary
- Provider knows who referred patient
- PCP notified via secure portal; key info shared

Opportunity:
BH provider role in management of chronic physical health conditions

Key elements:	**Current process:**
• BH provider awareness of patient's chronic health condition(s)	• Based on patient report; historical records obtained
• BH provider awareness of patient engagement with physical health provider	• Based on patient report
• BH provider awareness of ongoing physical health services received & medications	• Based on patient report
• BH provider awareness of physical health related hospitalizations/ED visits	• No awareness unless psychiatric
• BH provider awareness of current status of chronic health condition	• Only aware if symptoms detected
• BH provider ability to intercede	• **Negligible**

Opportunity:
BH provider role in management of chronic physical health conditions

Current/historical practice:

- BH provider awareness of patient's chronic health condition(s)
- BH provider awareness of patient engagement with physical health provider
- BH provider awareness of ongoing physical health services received & medications
- BH provider awareness of physical health related hospitalizations/ED visits
- BH provider awareness of current status of chronic health condition
- BH provider ability to intercede

Enhanced Process:

- Obtained from MCO and in BH patient registry
- Physical healthcare provider identified in EMR
- Information in BH patient registry
- Auto-notifications received
- Indicators, lab/test results in patient registry
- Prescriber; clinician; care navigator, based on actionable information

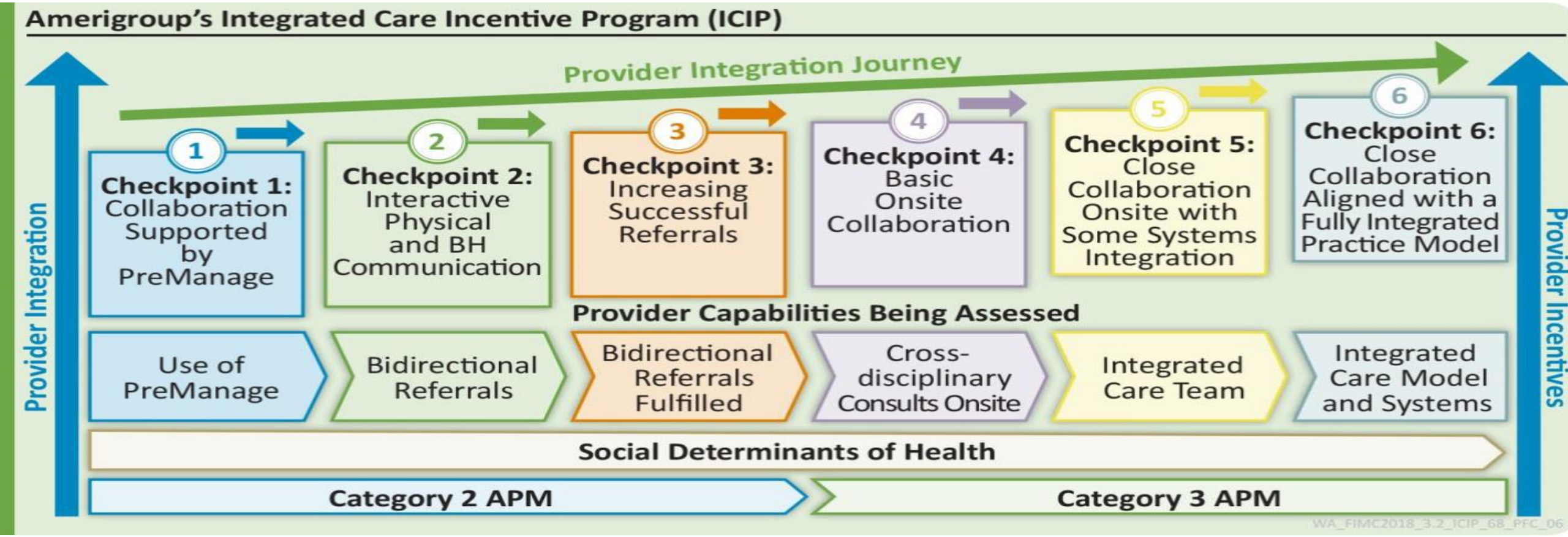
Takeaways and future opportunities

1. Co-location isn’t the only answer
2. A shared EMR isn’t requisite for integration to occur
3. Need to attend to fourth element of “quadruple aim”
4. Mutual commitment between organizations is critical
5. One or more “champions” is essential
6. Be flexible; willing to try new things and learn from mistakes
7. Improving care transitions is another opportunity
8. Partnerships with law enforcement, EMTs, housing providers
9. Engagement, customer service and a “seamless” experience for client
10. Opportunities related to patient registries, risk stratification, population health approach, use of analytics

State of Reform

Lani Spencer, BSN, MHA Regional VP of Health Care Management

AMERIGROUP'S INTEGRATED CARE INCENTIVE PROGRAM (ICIP)



Implementation Activities

- **Define success for implementation** with providers, community stakeholders, and our fellow MCOs
- **Collectively understand** the potential gaps in the continuum of care and determine how they will be filled
- **Finalize contracts with providers** and enroll them in the Amerigroup systems, including billing and training modules
- **Identify provider education and training needs** to effectively work with managed care health plans
- **Align processes** with our fellow MCOs in partnership with providers and their needs
- **Additional hiring** for operational and provider support
- **Configure provider IT systems** to bill health plans for services

Our Approach to Integration

- Three pillars to our approach
  - Trauma-informed
  - Strengths-based
  - Person-Centered
- Accomplished through:
  - Integrated, multi-disciplinary teams at the health plan
  - Community-based case management and care coordination
  - Supporting our providers in clinical integration and whole-person, population health management

Questions?

AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Thank you!