2018 Fall Forum - *Integrating Physical Health and Behavioral Health Services*

CAHA's Fall Forum drew 123 people to learn about Integrating Physical Health and Behavioral Health Services. Held on September 19, 2018 at the Eagle Eye Conference Center, the forum offered overviews of models of integration and insights into the experiences of providers working in integrated settings.

The program opened with a patient perspective by Lansing resident Jonathan Thurston. Mr. Thurston shared his experiences at the Forest Health Clinic in Lansing, where on his first visit a Behavioral Health Consultant (BHC) described available behavioral health services and asked if he would be interested in utilizing those services. Thurston saw the consultant for about six months, sometimes coordinating the appointments with regular doctor visits, and "saw the solutions (the BHC) offered affecting both my behavioral and physical health over time."

The program next focused on the conceptual basis, models, and drivers of integrated care; the Primary Care Behavioral Health Model; and integrated care initiatives in the Capital Area. Presentations by Robert Sheehan, CEO of the Community Mental Health Association of Michigan and Matt Wojack, Supervisor of Health Care Integration at the Community Mental Health Authority of Clinton, Eaton and Ingham Counties (CMHA-CEI) provided this important context.

Data shared by Mr. Sheehan and Mr. Wojack underscored the potential effectiveness of integrated services. Both discussed changes in healthcare financing and delivery that are driving a movement toward integration. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides a framework for the levels of integrated care, from coordinated care (minimal or basic collaboration), to co-located care (physical proximity, some shared systems, elements of working as a team), to integrated care (approaching or achieving shared systems, consistent communication, and team-driven collaboration). Visit https://www.samhsa.gov/children/educational-resources/behavioral-health-care-integration for more information.

A study by the Center for Healthcare Research and Innovation, examining the work of Michigan's public mental health system, identified 570 initiatives in 2017 involving coordination, co-location or integration methods. In the Capital Area Region, CMHA-CEI has worked with Ingham County Health Centers, McLaren Greater Lansing, Michigan State University and Sparrow Health System to implement the Primary Care Behavioral Health Model (PCBH). The PCBH model utilizes Behavioral Health Consultants to work with the primary care team to address behavioral health conditions, such as anxiety, depression and substance use issues. They can also work with patients on health behaviors that impact their care plans, such as patient activation, medication compliance, smoking cessation and positive health screenings.

Panel One: Experience of Providers in Integrated Settings
Panelists: *Jennifer Edgar,* NP-C, Ingham Community Health Centers • *Tressa Gardner,* DO, FACOEP, FACOP, Medical Director, McLaren Greater Lansing Emergency Dept. • *Amy Odom,* DO, Medical Director, Sparrow Family Health Center Mason • *Jane Turner*, MD, FAAP, Pediatrician and Professor of Pediatrics and Human Development, MSU •*Luis Valle,* MD, Birch Community Health Center

The first of two panels explored the experience of providers working in integrated settings. Primary care providers offered several examples of how integration has helped their patients. Patients with chronic conditions benefit from working with a BHC who can help them to recognize care plan compliance issues and barriers early and help them to identify needed supports. The consultants are important to screening for risks of Adverse Childhood Experiences (ACEs) and working with parents during a critical time for newborns. Patients screening positive for behavioral health issues during their visit have immediate access to a BHC for follow up. Benefits are also realized for patients with chronic conditions seeking care in an Emergency Department, where behavioral health screening is becoming routine. By providing access to a BHC, the department can do more for those patients. Panelists believed that patients are more receptive to receive behavioral health services in a primary care environment that they view as familiar, and that they are becoming accustomed to the availability of the BHC.

Panelists identified challenges in implementing the PCBH model. It takes time to integrate the BHC with the existing team, and there are many logistic and administrative issues to address, including billing and reimbursement, space for BHCs to work, and integrating electronic medical records to keep pace with clinical integration. Language issues were also identified as needing attention. But for the providers, staff and residents working in integrated clinics, use of behavioral health screenings and consultants is becoming the norm, and is inherent in their workflow.

PANEL Two: System and Organizational Readiness for Integrative Care
Panelists: *Linda Keilman,* DNP, GNP-BC, FAANP, Adult Gerontology Nurse Practitioner Program Director, MSU • *Anne Suess,* MDiv, MD, MPH, Owner and Pediatrician, Mason Pediatrics • *Lori Ryland,* PhD, LP, CAADC, BCBA-D Director, Skywood Recovery

The second panel focused on implementing integrative, whole-person care in an organization. While the three panelists came from organizations of different size and mission, common themes emerged about how integrative, whole-person care is practiced in their settings. For instance, each of the three organizations approaches their work as providing a "home" for each patient, one that considers patient needs related to mind, body and spirit. Also, each has implemented whole-person care approaches that address the needs of the patient and the patient's family.

The two inpatient facilities represented on the panel were a facility working with substance users who have a mental health diagnosis and a sub-acute rehabilitation facility. Both began with the objective of providing whole-person care and designing their facilities and programs to support that objective. Key elements were use of multi-disciplinary teams, identifying measures across multiple dimensions, and providing every team member access to training.

Implementation of whole-person, integrative care was very different in a small, ambulatory pediatric practice than for either of the two inpatient facilities. The implementation at the pediatric practice involved a decision by the entire clinical and administrative staff that they wanted to do more for their patients. They identified resources to support their whole-person care philosophy, such as the Child Collaborative Care program at the University of Michigan (MC3), which provides primary care providers with access to psychiatric resources. The clinical and administrative staff work as a team to identify and address physical, behavioral and basic human needs of their pediatric patients and their parents.

In all three settings, both clinical and non-clinical team members are important to implementation of integrative care. As with the first panel, all the panelists identified billing and reimbursement as a challenge to their implementation. All stressed the importance of a champion for whole-person care in the organization's administration, and all stressed that integration is a difficult thing to do. As one panelist shared, administrators need to "make a decision to care," because good things to do aren't always the most efficient thing to do.

Before closing, the forum participants were engaged to share their ideas for strategies that would expand the availability of integrated care in the region. They recorded their thoughts on cards that were collected at the end of the program for compilation and use in identifying next steps. As a convener of collaborative efforts, CAHA plans to engage people representing the disciplines and organizations participating in the forum to further explore expanding integrative care in the Capital Area Region.