Bringing Behavioral Health Interventions to the Population in a Medical Home Model

SBM Symposium
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Statement on the PCMH: President Obama

“I support the concept of a patient-centered medical home, and as part of my health care plan, I will encourage and provide appropriate payment for providers who implement the medical home model, including physician-directed, interdisciplinary teams, care management and care coordination programs, quality assurance mechanisms, and health IT systems which collectively will help to improve care.”
Joint Principles of the Patient-Centered Medical Home
AAFP, AAP, ACP, AOA

- Ongoing relationship with personal physician
- Physician directed medical practice
- Whole person orientation
- Enhanced access to care
- Coordinated care across the health system
- Quality and safety
- Payment
Pillars of the Medical Home

Patient-Driven
- The primary care team is focused on the whole person
- Patient-prefereces guide the care provided to the patient

Team-Based
- Primary care is delivered by an interdisciplinary team led by a primary care provider using facilitative leadership skills

Efficient
- Patients receive the care they need at the time they need it from an interdisciplinary team functioning at the highest level of their competency

Comprehensive
- Primary care is point of first contact for a range of medical, behavioral and psychosocial needs, fully integrated with other health services and community resources

Continuous
- Every patient has an established and continuous relationship with a personal primary care provider

Communication
- The communication between the patient and other team members is honest, respectful, reliable, and culturally sensitive. “Patient Centered Communication”

Coordinated
- The PCMH team coordinates care for the patient across and between the health care system including the private sector.
Where Does Behavioral Health Fit In?

- Primary Care has been called “the de facto mental health system” (Regier et al., 1993)
- Patient-driven preferences most often include “one stop shopping” in the de-stigmatized medical clinic
- Comprehensive care requires holistic approach that does not support the artificial mind-body split
- Interdisciplinary teams are key to high quality care
- Efficient mental health services are designed for population-based delivery in the PC setting
- Communication that is patient-centered requires skill-development
- Coordinated care is maximized by embedded behavioral staff to support teams and patients
Training for Fully Functioning PCMH Addresses

- Needs of the medical providers
- Needs of the behavioral health providers
- Needs of the teams
The Prepared Medical Home Provider:
Using Professional Training Sequence to Teach Collaborative Attitudes and Behaviors

Mark E. Vogel, Ph.D., ABPP
Amy Collings, Ph.D.
Genesys Regional Medical Center

Consortium for Advanced Psychology Training
Patient Centered Medical Home

Well Prepared Patient

Collaboration

Well Prepared Provider
Training Sequence

Primary Care Physician
- Medical School
  - (4 years)
- Primary Care Residency
  - (3 years)
- Practice

Clinical Health Psychology
- Graduate School
  - (4-6 years)
- Internship
  - (1 year)
- Post-Doc Fellowship
  - (1-2 years)
- Practice

Collaborative work opportunities
Values Established in Training

- Follow what is modeled by Attendings/Faculty
- Practice what works

"Is There Hardening of the Heart During Medical School?" Academic Medicine, March 2008
Our Model of Collaborative Training

- Integrated Training & Learning
  - Clinical Health Psychology Training within Primary Care Residency Training Programs
    - Family Practice, Internal Medicine, Pediatrics, Ob/Gyn
  - Clinical Sites:
    - Ambulatory Care Center – IPC Model
    - Inpatient General Medicine

- Consortium Structure
  - Three hospitals, 9 Fellows,
    - Genesys: 3 Faculty, 3 Fellows, 70+ Residents

- Reciprocal Training
  - Resident and Fellow
Reciprocal Training

*Learning from each other & sharing of knowledge*

- **Physician Resident**
  - Structure of psychology
  - Improve clinical interviewing skills
  - Implement psychosocial interventions

- **Psychology Fellow**
  - Structure of medicine
  - Medical terminology
  - How to be helpful in medical setting
Educational Methods

- Shadow
- Modeling
- Shared Patient Care
- Didactic
Physician Behaviors/Skills in General

- Effective with Low Motivation
- Confident with Behavior Change
- Effective with MH/SA

n=70; * p<.05

Legend:
- OB/GYN
- IM
- FM

n=70; * p<.05
Physician Satisfaction with Practice

Impact of IPC

Impact of MH/SA focus

n=70
Physician Attitudes with IPC & BHC

BHC improved willingness to Tx BH

Would recommend BHC

Satisfaction with IPC

* p<.01

n=46 resident physicians with IPC experience
To Learn More

- Consortium for Advanced Psychology Training (CAPT) website
  - www.msufame.msu.edu/Psychology
  - www.genesyshealthpsych.info
The Prepared Medical Home
Behavioral Health Provider: Training Needs and Competencies for Success

Katherine M. Dollar, PhD
Acting Clinical Director & Clinical Coordinator
Center for Integrated Healthcare
Behavioral Health Providers in the Medical Home Model

Population-Based:

- Prevention
- Early Identification
- Access and acute care
- Effective Chronic disease management
- Engagement and adherence
- Clinical and functional outcomes
- Consultation
Models of Integrated Primary Care

- Psychologist as Primary Care Provider Model
- Staff Advisor Model
- Co-located Clinics Model
- Behavioral Health Consultant Model (Primary Care Behavioral Health, PCBH)
# BHP in Medical Home vs. Traditional MH

<table>
<thead>
<tr>
<th>Dimension</th>
<th>BHP in Medical Home</th>
<th>Mental Health Specialty Care</th>
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</thead>
<tbody>
<tr>
<td>Location</td>
<td>On Site</td>
<td>A different floor, bldg…</td>
</tr>
<tr>
<td>Population</td>
<td>Most are healthy, mild to moderate symptoms</td>
<td>Most have MH Diagnoses</td>
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<tr>
<td>Inter-Provider</td>
<td>Collaborative &amp; On-going Consultations via PCP’s Method</td>
<td>Consult reports</td>
</tr>
<tr>
<td>Communication</td>
<td>of Choice</td>
<td>Formal communications</td>
</tr>
<tr>
<td>Service Deliver</td>
<td>Brief appointments</td>
<td>50 - 90 minute psychotherapy sessions</td>
</tr>
<tr>
<td>Structure</td>
<td>Limited number of appointments</td>
<td>Longer treatment episodes</td>
</tr>
<tr>
<td>Approach</td>
<td>Problem-focused</td>
<td>Varies by therapy Diagnosis-focused</td>
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<tr>
<td></td>
<td>Solution Oriented</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient Centered</td>
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</tr>
<tr>
<td>Treatment Plan</td>
<td>PCP continues to be lead</td>
<td>MHP is lead</td>
</tr>
<tr>
<td>Leader</td>
<td></td>
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<tr>
<td>Primary Focus</td>
<td>Support the over-all health of the</td>
<td>Cure or Ameliorate Mental Health Symptoms</td>
</tr>
<tr>
<td></td>
<td>Focus on function</td>
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Preparing BHPs for Success in the Medical Home

- Undergraduate?
- Graduate Programs
  - Practica and Externships
- Internship
- Post-doctoral Fellowship
Behavioral Health Consultation: Domains of Competency for Skill-based Learning

- Domain 1: Clinical Practice
- Domain 2: Practice Management
- Domain 3: Consultation
- Domain 4: Documentation
- Domain 5: Teamwork
- Domain 6: Administrative Skills

Domain 1: Clinical Practice

Clinical Practice

- Define role accurately
  - Write out and practice brief description of role
    - (Sample scripts are available)
  - Introduction to patients and providers is key
- Identify problems rapidly
- Use appropriate assessment (e.g. not MMPI, Rorschach…)
- Limit problem definition
- Focus on functional outcomes
  - Less focus on specific diagnosis
  - Targeted interventions for improving behavior
Domain 2: Practice Management

Practice Management Skills

- Goal: to have brief visits, same day access, meet all referred pts.
- Use brief sessions effectively
  - Recommend 20-30 minutes initial sessions
  - Should include charting and contact with PCP
- Stay on time (track/practice!)
- Complete treatment in 4 sessions or less
  - Modal number of one contact
- Use an intermittent visit strategy
Domain 3: Consultation

- **Consultation Skills**
  - Focus on and respond to referral question
    - Keep narrow and clear focus in session and when giving feedback to PCPs
  - Tailor recommendations to the work pace of the medical unit
    - Keep notes brief
    - Use same language as PCP
  - Conduct effective curbside consultations
    - In hallways
    - Less than 5 minutes: 1-2 more like it
  - Willingness to follow-up assertively with physicians
    - Urgent v/s non-urgent
Domain 4: Documentation

• Documentation Skills
  • Use of same chart
  • Use same format as PCP
  • Brief, clear, concise (1/2-1 CPRS page max)
  • Templates when possible
  • Numbers when possible (e.g. PHQ 9 score)
  • Include brief Impressions/Plan/Recommendations
  • Include suggestions for PCP
Domain 5: Teamwork

Team performance skills~
be a team player, if not a leader

- Provide unscheduled services when needed
  - Consistent with PCP culture assist providers
  - Demonstrate willingness to work harder, longer
  - Be flexible on what needs to be done
- Be available for on-demand consultations
- Spend time/develop rapport with team (lunch, meetings etc)
Domain 6: Administrative Skills

- Administrative skills
  - Understand relevant polices and procedures
  - Market services (e.g., Brochures)
  - Review and refine linkages whenever possible
  - Minimize formal consults if possible
  - Ensure proper coding
  - Support Management in recruitment etc
Training Needs and Preparing for Success

- **Training Needs**
  - Purposeful Training Process
  - Skill-based learning
  - Population-based care
  - Team building
  - Assessment of skills
    - Self-assessment, supervisory-assessment tools, chart-reviews, performance plans

- **System Infrastructure**
Helpful Resources


Helpful IPC Resources

- http://www/integratedprimarycare.com
- http://www.cfha.net
- katherine.dollar@va.gov
Designing Collaborative Care Programs to Maximize the Public’s Health:
Training Providers to Assess and Treat as a Team

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Associate Clinical Professor
Research Director
Associate Program Director

Division of Family Medicine
University of California San Diego

Society of Behavioral Medicine Annual Conference
April 29, 2011  Washington, D.C.
UCSD Family Medicine

- Three clinics
- 35,000+ culturally diverse patients
- 30+ faculty MDs, ≈ 30 residents
- Two PhDs, ≈ 10 MFT/PhD interns
- Hybrid CC model: 50 minute hours, BHC, BFK, groups, integration
- EPIC

UCSD Division of Family Medicine
Matrix of Integrated Care Services and Program Goals

- **Three levels of service**
  - Primary (prevention)
  - Secondary (helping those at risk)
  - Tertiary (urgent need for assistance)

- **Program goals**
  - Assessment
  - Intervention
  - Training in teams/collaboration

- **Goal:** Create ‘prepared providers’ (MDs & BH)
## Opportunities for team learning

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<tr>
<th></th>
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<th>Secondary</th>
<th>Tertiary</th>
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<tbody>
<tr>
<td>Assessment</td>
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<tr>
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<tr>
<td>Training</td>
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Assessment (Practice-Based Population Health)

- Mine diagnostic and/or treatment data
- Survey subsample of patients
  - Patients at high risk (e.g., chronically ill)
  - Random sampling for population estimates
  - What issues/diagnoses to assess? (e.g., mood, relationships, lifestyle behaviors)
- Creation and on-going use of patient registries
Triarchic Model: Primary level

- Intervention

- Invite patients to view on-line video on relevant topic (depression, anxiety, diabetes)

- Encourage patients to discuss/get referral to collaborative care

- Offer groups, targeting patients with identified need:
  - Stress management, Parenting, Sleep hygiene
Triarchic Model: Primary level

- Training on teamwork
  - Roles
    - Assess individual learner’s strengths (technology, health behavior, depression)
    - Clarity: ability ≠ responsibility; different responses/roles @ different times (e.g., initiate registry versus response to patient mood v. lifestyle questions)
    - Cross-training of skills (skill to use as independent professional)
Triarchic Model: Primary level

Training on teamwork (cont.)

Communication
- Differs by individual provider
- Physician-patient, physician-behavioral health, behavioral health – patient
- Clarity of response times expected

Leadership
- How established?: by position/title, by interest, by skill
- Clarity of goals and expectations
- Trust
Triarchic Model: Secondary level

- Assessment
  - Physicians identify need of individual patient during clinic visit & refer individual for behavioral health care
  - Behavioral Health Consultant: reactive to MD and proactive in identifying patients in clinic
  - Behavioral Science clinic
Triarchic Model: Secondary level

• Intervention

- Referral of patients presenting in clinic to
  - Individual, marital, family therapy
  - Health coaching: use of SMGs by physicians
  - Group medical visits
  - Inclusion of Psychiatry, pain clinic, community resources

- BHC may screen appointment schedule and then initiate consult with physician prior to patient exam
Triarchic Model: Secondary level

- Training on teamwork
  - Roles
    - Assessment by physician in-visit
    - Medication management
    - Train physicians to: screen more effectively, manage patient issues during exam, and facilitate referral
    - Psychological testing for one MF patient
  - Communication
    - Bidirectional (recommending Rx, educating on Rx)
    - Flexible (cc: chart notes, EPIC email, phone, hallway)
  - Leadership
    - Develop team member’s weaknesses (CEU)
    - Service leadership
Triarchic Model: Tertiary level

- Assessment
  - Clinical:
    - Crisis intervention (acute stress disorder, suicidal)
    - Warm hand-offs
Triarchic Model: Tertiary level

- **Intervention**
  - Warm hand-offs versus ‘dump & run’
  - Crisis intervention
Triarchic Model: Tertiary level

- Training on teamwork
  - Roles
    - Clarify
  - Communication
    - Including debriefing
  - Leadership
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<td>Survey</td>
<td>Screen</td>
<td>On-call</td>
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<tr>
<td><strong>Intervention</strong></td>
<td>Invite</td>
<td>Referral</td>
<td>Warm hand-off</td>
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<tr>
<td><strong>Training</strong></td>
<td>Registry</td>
<td>Consult</td>
<td>Collaborate</td>
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UCSD Division of Family Medicine
Bringing Behavioral Heath to the Population in a Medical Home
What have we learned? Now what?

Jeffrey L. Goodie, Ph.D. ABPP
LCDR, USPHS
Assistant Professor, Dept of Family Medicine
Uniformed Services University
What do we know?

- The action is in primary care settings
- Primary care is changing
- We need to change
What needs to change?

- Our presentations have suggested:
  - We need to learn how to collaborate
  - We need to learn new practice skills
  - We need to learn new ways of thinking
What are the right ways to make these changes?

- What does experience tell us?
- What does the data tell us?
Do we know what we are talking about?

- Collaboration
- Integration
- Co-location
- Synergy
Now what?