CENTER *for* INTEGRATIVE HEALTH

insight to innovation

Convene.
Strategize.
Activate.

Integrated Health and Behavioral Health and the Collaborative Care Model

Jerome Brown and Carolyn Mayo
Co-Consultants &

Minority Coalition (MCBHPC)
Integrated Care-Collaborative Care Model

Integrated Health and Behavioral Health & Collaborative Care Model(CoCM)

Objective

- Introductions
- Overview of Integrated Care/State & National Perspective
- Integrated Care-Collaborative Care Model(CoCM) for Behavioral Health Providers
- Share knowledge of operating principles
- Behavioral Health Providers-Best Practice Sharing(Clinical Workflow Process)
- Panel: Questions & Answers

Community Reinvestment Pilot

- CRP Sponsor: Cardinal Innovations Healthcare, MCO
- Minority Coalition- Co-Chairs: Diana Duncan/Flay Lee, Board Members
- Awardee Providers : Another Level Counseling, Community Specialized Services, Crandell's Enterprises, Genesis Project1, Universal Institute for Successful Aging of Carolinas (UISAC)
- Integrated Care Consultants: Jerome Brown and Carolyn Mayo

Integrated Care-Collaborative Care Model(CoCM)

Background

- Integration of Behavioral Health and General Medical Services(Primary/Physical Care) has been an intensive focus for at least a decade *(APA and APM, 2016 Integrated Care Report)*

- ADMINISTRATIVE STRUCTURES AND STRATEGIES: Administrative responsibility for physical and behavioral health services historically has been split among Medicaid and behavioral health agencies, with different leadership, missions, and staff expertise. (State Strategies-The Common Fund)*

*(STATE STRATEGIES FOR INTEGRATING PHYSICAL AND BEHAVIORAL HEALTH SERVICES IN A CHANGING MEDICAID ENVIRONMENT-Study Funded by The Commonwealth Fund)

Integrated Care-Collaborative Care Model(CoCM)

Background

- The administrative bifurcation of physical health services and behavioral health services.
- As payers consider ways to curb the cost of health care, the integration of medical and behavioral health care is emerging as an effective solution.
- According to a study by Milliman, an estimated $10 billion to $15 billion could be saved each year for Medicare and Medicaid and $16 billion to $32 billion for the commercially insured through effective integration of mental health care with other types of medical care. (Psychiatric News)

Why Collaborative Care?

- Collaborative Care is *population-focused*, using a registry to monitor treatment engagement and response to care.
- Mental illnesses such as depression, anxiety, and substance use disorders are responsible for 25 percent of all disabilities worldwide, with these disorders being a major driver of overall health care costs.
- There is growing acknowledgment by policymakers, payers, and providers that any solution to driving down the cost of health care must include treating mental health/substance use disorders with comorbid physical conditions.

(Psychiatric News)

Collaborative Care –How Does it work?

- **The CoCM** uses a team-based, interdisciplinary approach to deliver evidence-based diagnoses, treatment, and follow-up care.
- The model differs from other attempts to integrate behavioral health services because of the replicated evidence supporting its outcomes, its steady reliance on consistent principles of chronic care delivery, and attention to accountability and quality improvement.
- Collaborative care team is led by a **Primary Care Provider (PCP)** treating patients with mental health/substance abuse conditions. They are supported by a **Behavioral Health Care Manager** and a **Psychiatric Consultant.** The team implements a measurement-guided care plan based on evidence-based practice guidelines and focuses particular attention on patients not meeting their clinical goals.
- This model is flexible and can be implemented across varied geographic locations, practice sizes, and patient populations.

(Psychiatric News Online)

5 Key Principles of Collaborative Care

Population-Based Care

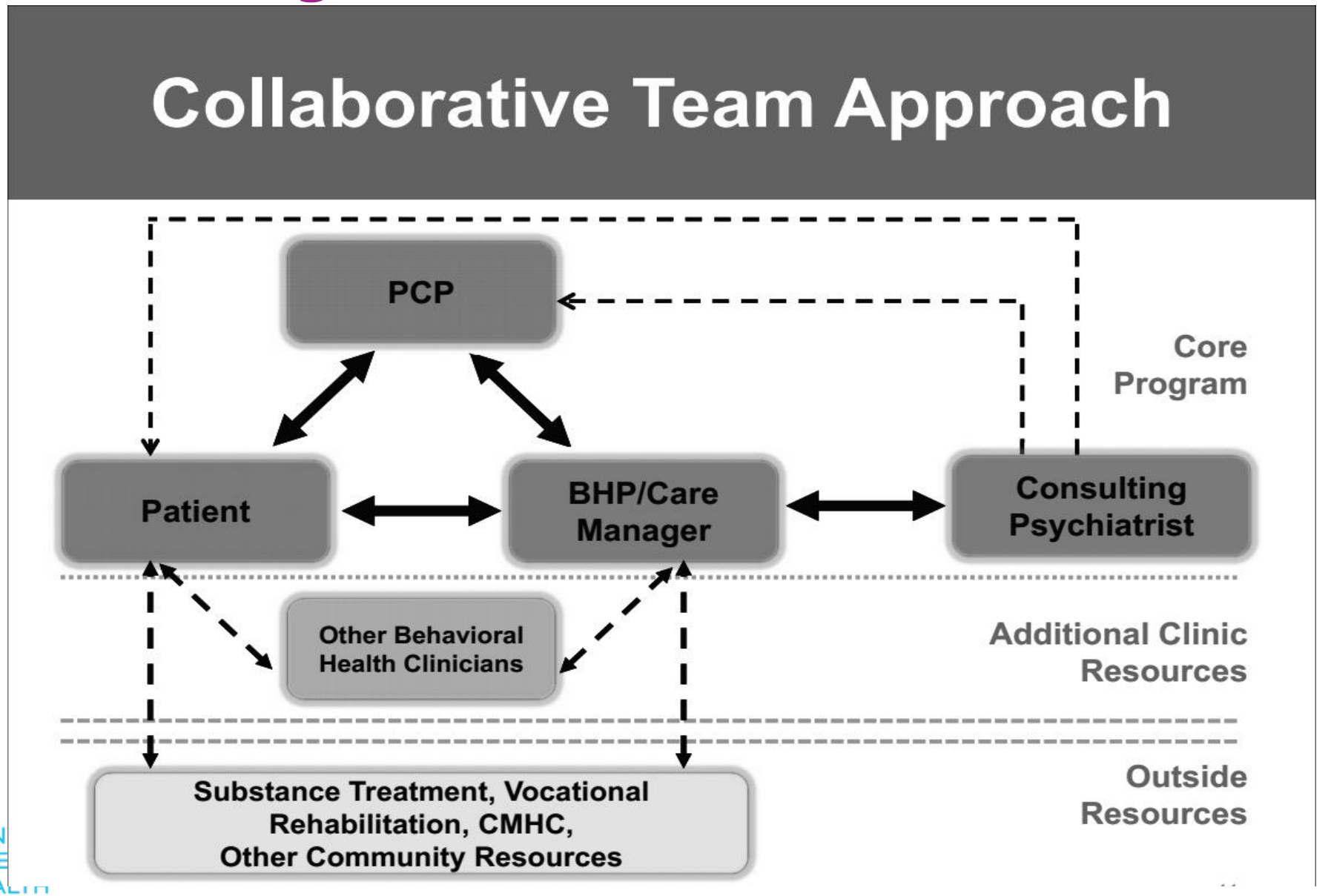
Measurement-Based Treatment to Target

Patient-Centered Collaboration

Evidence-Based Care

Accountable Care

Team Diagram of Collaborative Care Model



Genesis Project1

Mission

- Genesis Project is committed to the development of programs that address the factors that perpetuate poverty, addiction, oppression, disease, and abuse.
- Over 25 years in Mental and Behavioral Health
- Staff of licensed Medical Providers, Behavioral Health Clinicians, Qualified Professionals, and Certified Peer Support Specialists.
- Evidence Base Practices: Recovery-Oriented System of Care, Trauma Informed care (Trauma Focused CBT), EMDR

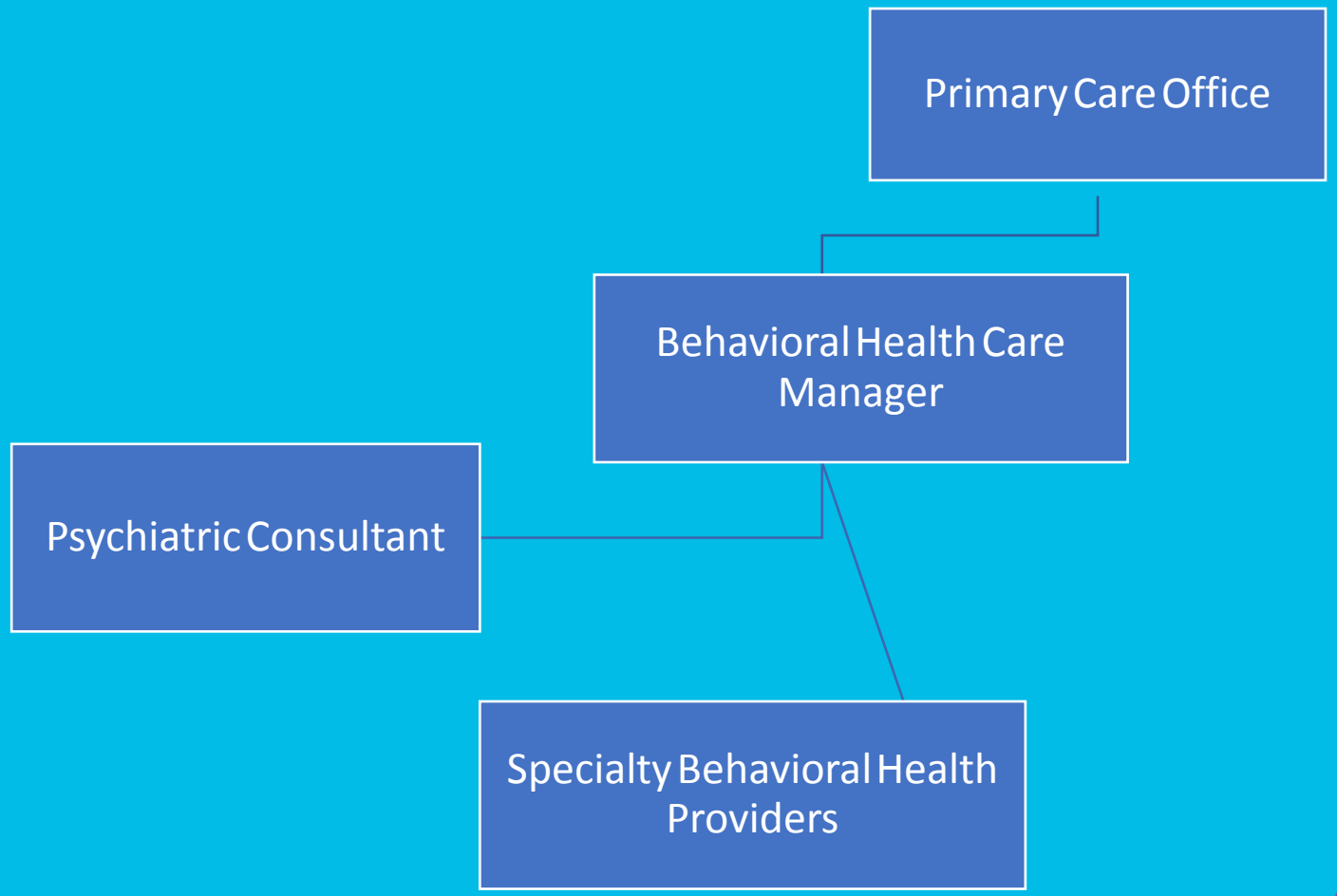
Genesis Project1

Who We Are

- Genesis Project is a family-system grounded, trauma informed, system of care focused, and recovery guided Integrated Care Organization. We provide a full array of mental health, substance abuse, fitness, and nutrition services for an array of consumers from infant/pediatric to geriatric .

- *Spanish, French, Sign Language*
- *Zero-Five Specialty*
- *Trauma Informed Care*

Genesis Project1-Integrated Care



Lessons Learned and Best Practice

Lessons Learned

The importance of care collaboration throughout the full cycle of Integrated Healthcare process. (Full Cycle Whole Health Care)

Best Practices

Most Important piece of Collaborative care is the helping/working relationship between : The Behavioral Care Manager, The General Medical Practitioner, and The Psychiatric Consultant/Practitioner
Medical Records
Outpatient or Substance Use Therapy
Medication Management

Contact Us

Dr. Trasha Black
Owner/CEO
Office: 5104 Reagan Drive Suite 5 Char NC
Email: tblack@genesisproject1.org

Tiona Washington
Behavioral Care Manager
Office Phone: 704.596-0505
Office: 5104 Reagan Drive Suite 5 Char NC
Email: twashington@genesisproject1.org

Mission

Community Specialized Services, Inc. is devoted to empowering individuals and families to improve their quality of life, and to promote community cooperation and support in responding to family needs.

Executive Team

Wendi Rice, MSW-Executive Director

Pasheena Days, MS- Director of Program Operations

Alisa Russell, MS, LPS- Director of Clinical Services

Community Specialized Services, Inc.

Our Objective

- To meet the mental, emotional, and social needs of children who have been diagnosed or are at risk of developing mental health and/or substance abuse problems.
- To promote continuity of care, community integration, and reduce symptoms through least restrictive treatment interventions.
- To provide therapeutic and behavioral intervention to children in a family environment to prepare them for family reunification or independent living.

Community Specialized Services, Inc.

Who We Are

- Community Specialized Services, Inc. is a non-profit human service organization licensed as a child-placing agency by the State of North Carolina Division of Social Services. Over 30 years experienced in Mental and Behavioral Health.
- Founded in March 2003, CSS, Inc. is committed to providing the best quality services to children and adolescents who are at risk of being displaced from their natural home and community environments due to emotional, behavioral, social, and developmental functional deficits.

Community Specialized Services, Inc.

- Our team is led by a **Primary Care Provider (PCP)** treating patients with mental health/substance abuse conditions. They are supported by a **Behavioral Health Care Manager** and a **Psychiatric Consultant.**

- After patients are assessed by Behavior Health Care Manager and found eligible based on their scores from PHQ-9 & GAD 7 they are entered on the Patient Registry and staffed with the PCP and Psychiatrist weekly on Thursdays

- Behavior Care Manager facilitates the development of the care plans for the patients with the support and consultation from the PCP and Psychiatrist

- Behavior Care Manager sets up an appointment for patients to be evaluated by the PCP after initial assessment by Care Manager. PCP completes initial assessment of patients for 70 minutes. The Primary Care Provider conducts assessments in the office on Tuesdays weekly as patients are assigned.

Community Specialized Services, Inc.

- Behavior Care Manager sets up an appointment for patients to be evaluated by the PCP after initial assessment by Care Manager. PCP completes initial assessment of patients for 70 minutes. The Primary Care Provider conducts assessments in the office on Tuesdays (weekly) as patients are assigned.

- Behavior Care Manager also links patients with other resources within the community that are deemed necessary

- Behavior Care Manager follows up with the patients within an identified timeline as indicated on the registry according to their PHQ-9 scores

Contact Us

Wendy Rice, MSW
Executive Director
Email: wrice-cssi@carolina.rr.com

Pasheena Days, MS
Director of Program Operations
Email: pdays-cssi@Carolina.rr.com

Alisa Russell, MS, LPA
Director of Clinical Services
Email: arussell-cssi@Carolina.rr.com
Office: 704-795-7600

CENTER *for* INTEGRATIVE HEALTH

insight to innovation

Convene.
Strategize.
Activate.

T.E.A.M. Healthcare

Integrated Care Program & Services

Who is Crandell's Enterprises, Inc.?

- Mary Crandell, CEO & Founder
- Deloris Chancey, Vice President
- Sandra Mayo, Chief Operations Officer
- Carolyn Mayo, Chief Information Officer

Crandell's Enterprises, Inc. – The Evolution

Ann's Family Care

2000

Crandell's Enterprises, Inc.

2004

T.E.A.M. Healthcare

2019

CENTER *for* INTEGRATIVE HEALTH

insight to innovation

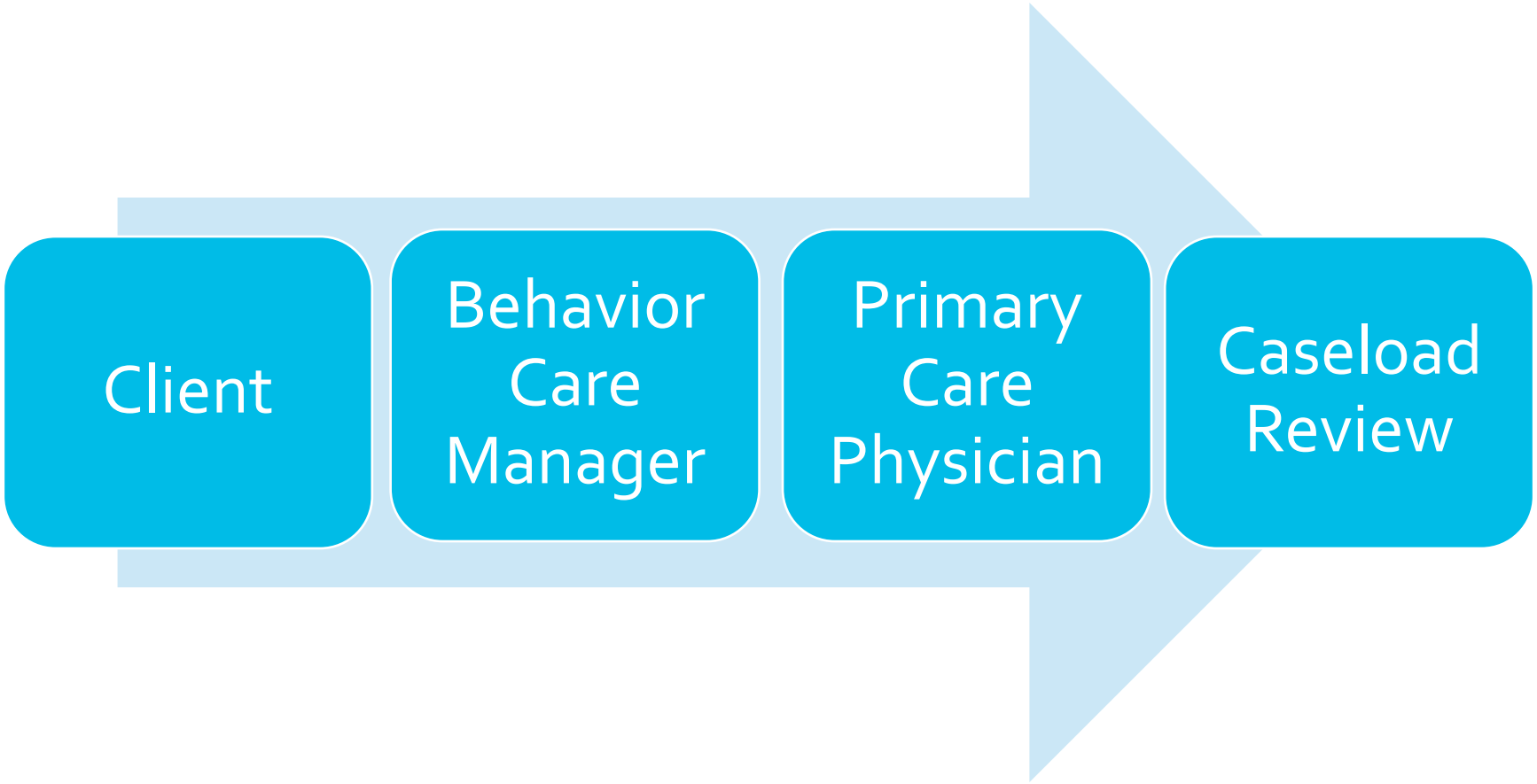
Why Integrated Care?

Crandell's Enterprises through T.E.A.M. Healthcare is able to provide services to meet the residential and healthcare needs for our clients

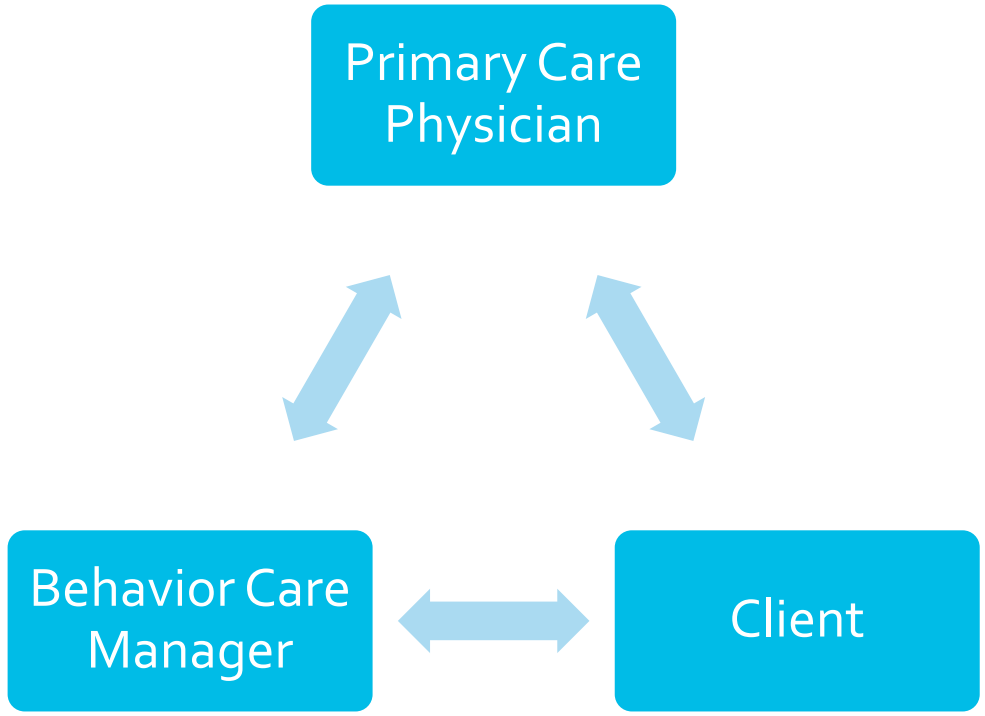
CRANDELL'S ENTERPRISES INC.

CENTER for INTEGRATIVE HEALTH
insight to innovation

Implementation



Bilateral Implementation



The model also works in the opposite direction where Primary Care Physicians are now referring their patients into our service model for medication management, psychiatric services, and therapy.

Scaling Up!

What we thought would happen

Actual Implementation

Primary Care Providers

- General Practitioner
- Pediatrician

Community-based Agencies

- Peer Support Agency
- Intensive Home Therapy

Unexpected

- Chiropractic Practitioner
- Pain Management Clinic

Contact Us

Visit us at www.CrandellsEnterprises.com

Treshell Herndon, therndon@crandellsenterprises.com

919.790.7663 x226

Findings/Conclusions

- There is little dispute that Medicaid patients fare best when their physical and behavioral health needs are addressed in tandem, coordinated by a single professional or team of professionals.
- EHR
- Training of staff for integration
- Work flow processes
- Define terminology among staff and Care Team

Findings/Conclusions

- Buy-in from Primary Care Physician & Psychiatric Consultant
- Monitor-Case Load Reviews(weekly)
- Management Process
- Billing requirements: Whether a provider can bill for both a behavioral health and primary health visit on the same day.
- Leadership- "Managing Change"

Contact Information

Jerome Brown
New Thought Leadership
Cell: 919-889-8214
Email: jbrown@newtleadership.com

Carolyn Mayo, CIO
Crandell's Enterprises, Inc.
Cell: 919-449-5818
Email: cmayo@crandellsenterprises.com

Diana Duncan
Minority Coalition, Co-Chair/Founder
Cell: 704-456-8389
Email: dduncan@minoritycoalitionbhp.org

Flay Lee
Minority Coalition, Co-Chair/Founder
Cell: 704-458-8225
Email: fjlee@minoritycoalitionbhp.org

Integrated Health and Behavioral Health and the Collaborative Care Model

Q & A