Behavioral Health Integration Within Properly Resourced Primary Care Clinics: What Does It Look Like to Effectively Promote Prevention?

Patient (Person)-Centered; Family-Driven

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- **Under Accreditation Council for Continuing Medical Education guidelines**
- **I have no relevant financial relationships or affiliations with commercial interests to disclose.**

Conference Mission

As national leaders in the prevention field
we are committed to improving behavioral and primary health outcomes
by integrating these with the science and practice of prevention
across public, private, and community sectors.

SERENDIPITY Alliance

"A voice for the voiceless — breaking the silence by listening to survivors"

"CAN WE TALK?"

"History repeats itself, opportunity doesn't!"

A Community Well-Being Program Is Needed

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Objectives

- **Objective 1.** Resourcing **Primary Care "Patient-Centered Medical Home**," to include **integrated Behavioral Health**, **to effectively promote prevention**.

- **Objective 2.** Integrated **Community Clinic procedures, person-centered, increase efficiency (NOT necessarily 'productivity')**.

- **Objective 3. Community-population-based resourcing;** address capacity gaps; **set integrated medical homes up for success to promote prevention**.

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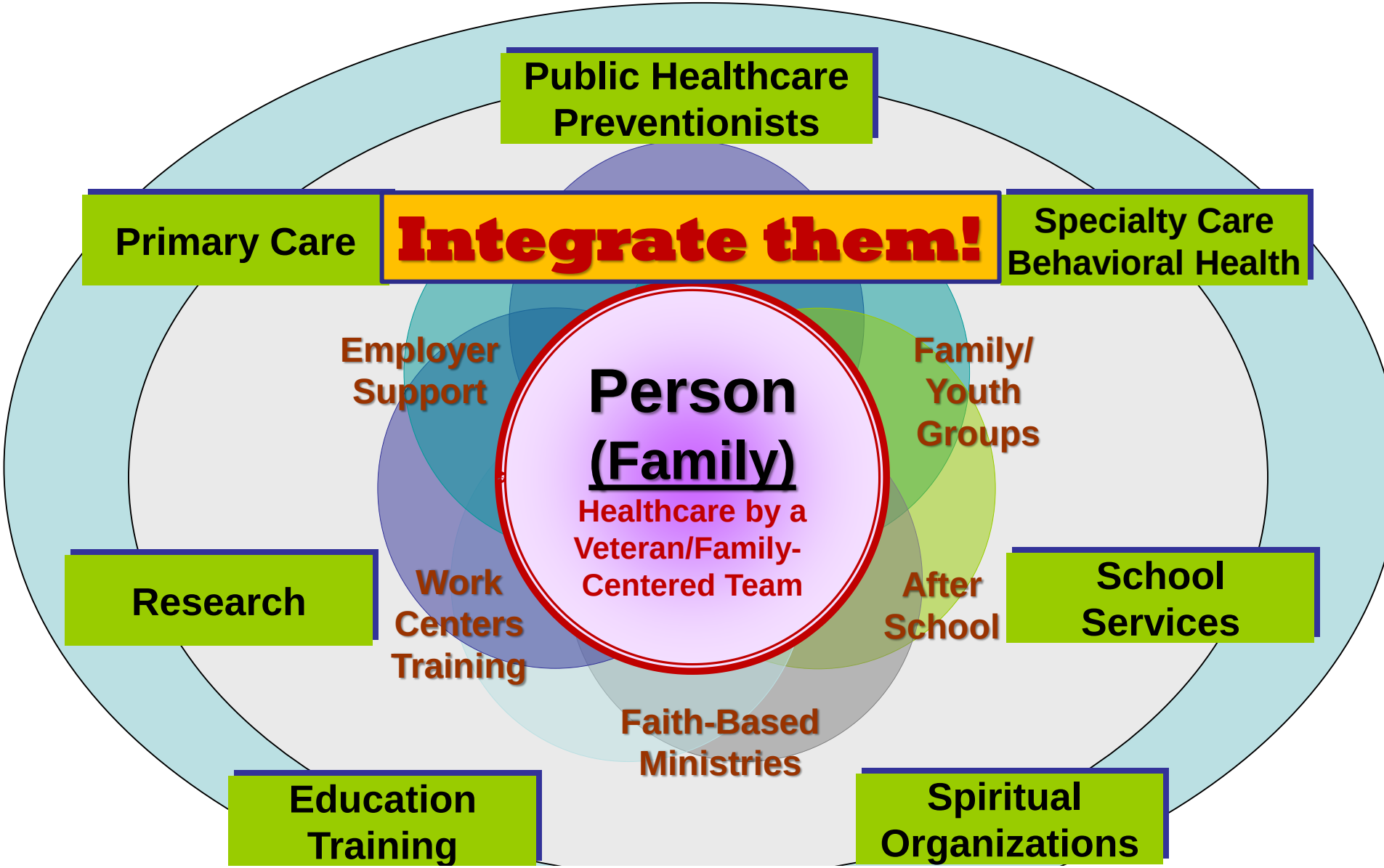
Community-Wide Cultural Change Required

Become an Accountable Care Organizations (ACO)

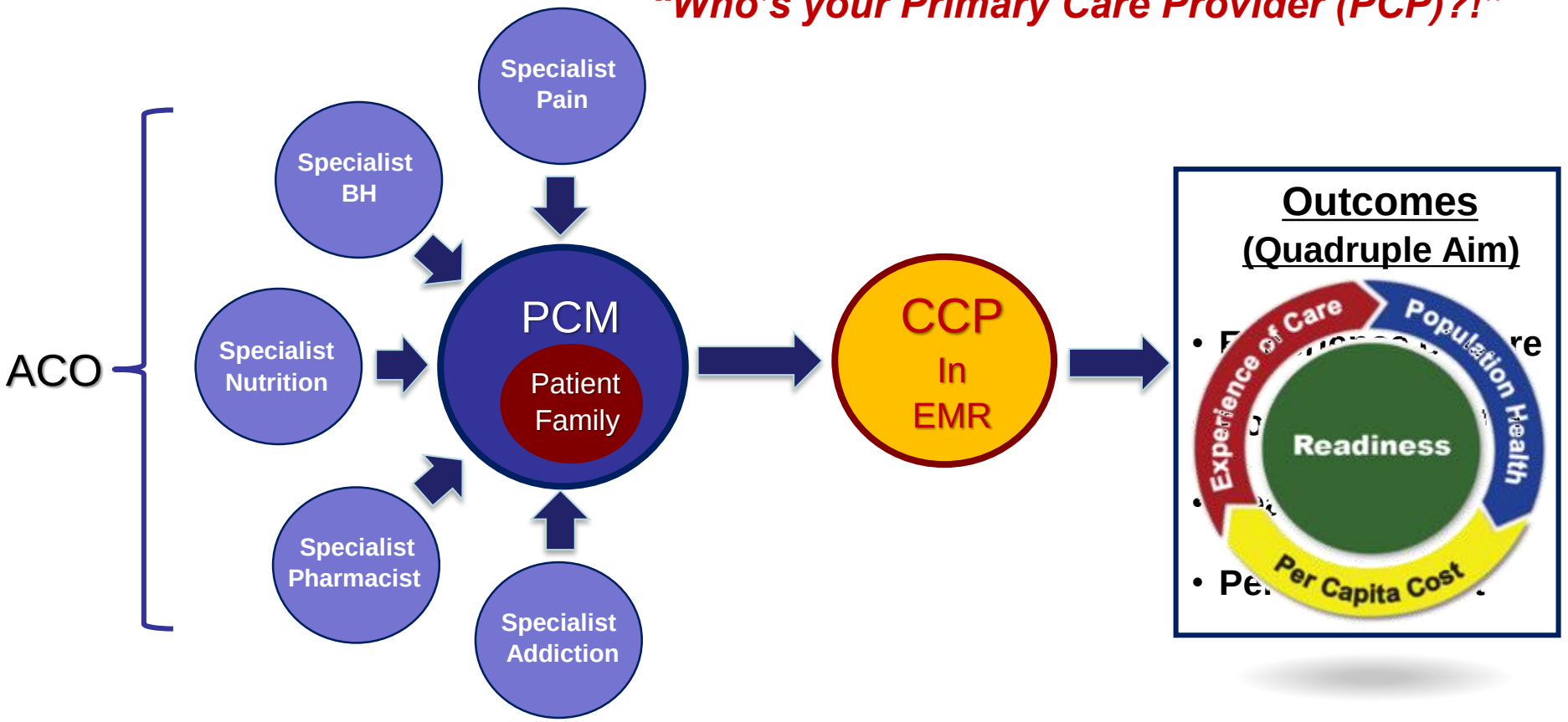


Tear down the (Communication) Silos!

The Accountable Care Organization (ACO)

The PCMH Primary Care Team integrates the Comprehensive Care Plan (CCP)

"Who's your Primary Care Provider (PCP)?!"



1) All provider teams have a "need to know" – share the CCP
2) The patient owns their plan and health status
3) A holistic approach

Care Centered on the Person and Their Identified Team(s)

IMPORTANT!

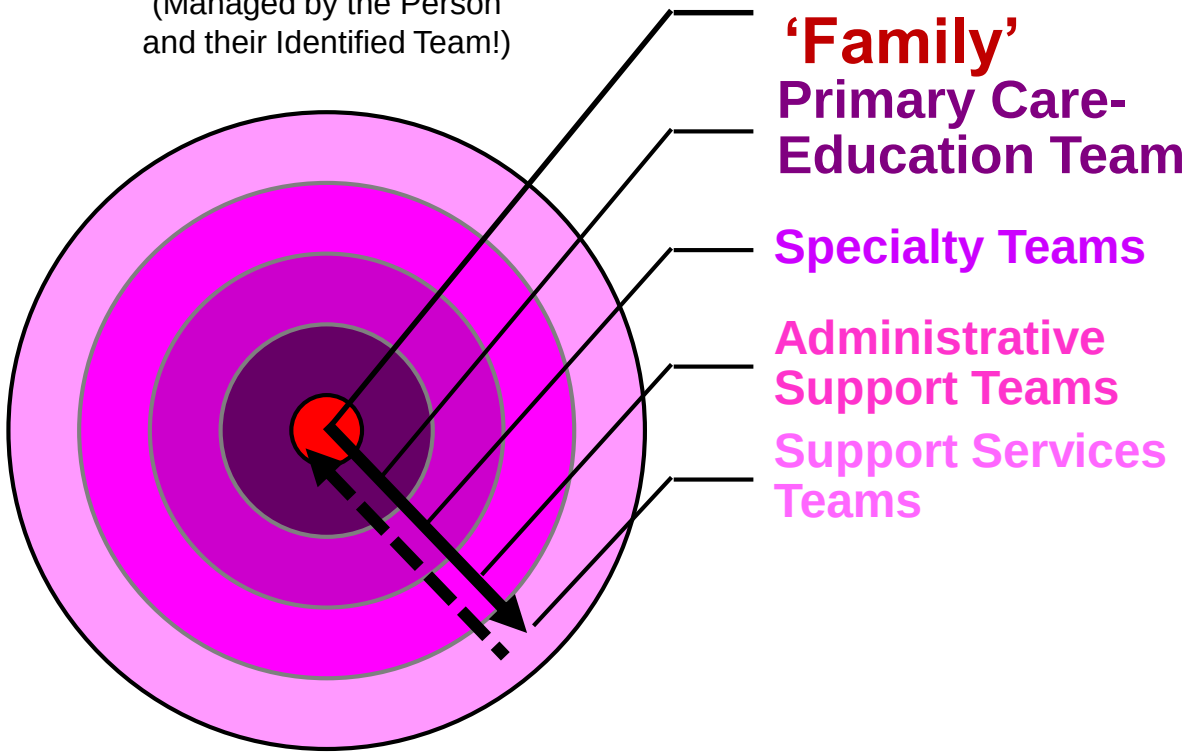
Include "Family" as part of the team!

(Don't 'hide' behind HIPAA!)

Information flows out from and back to Primary Care Team.

ONE HEALTH PLAN!

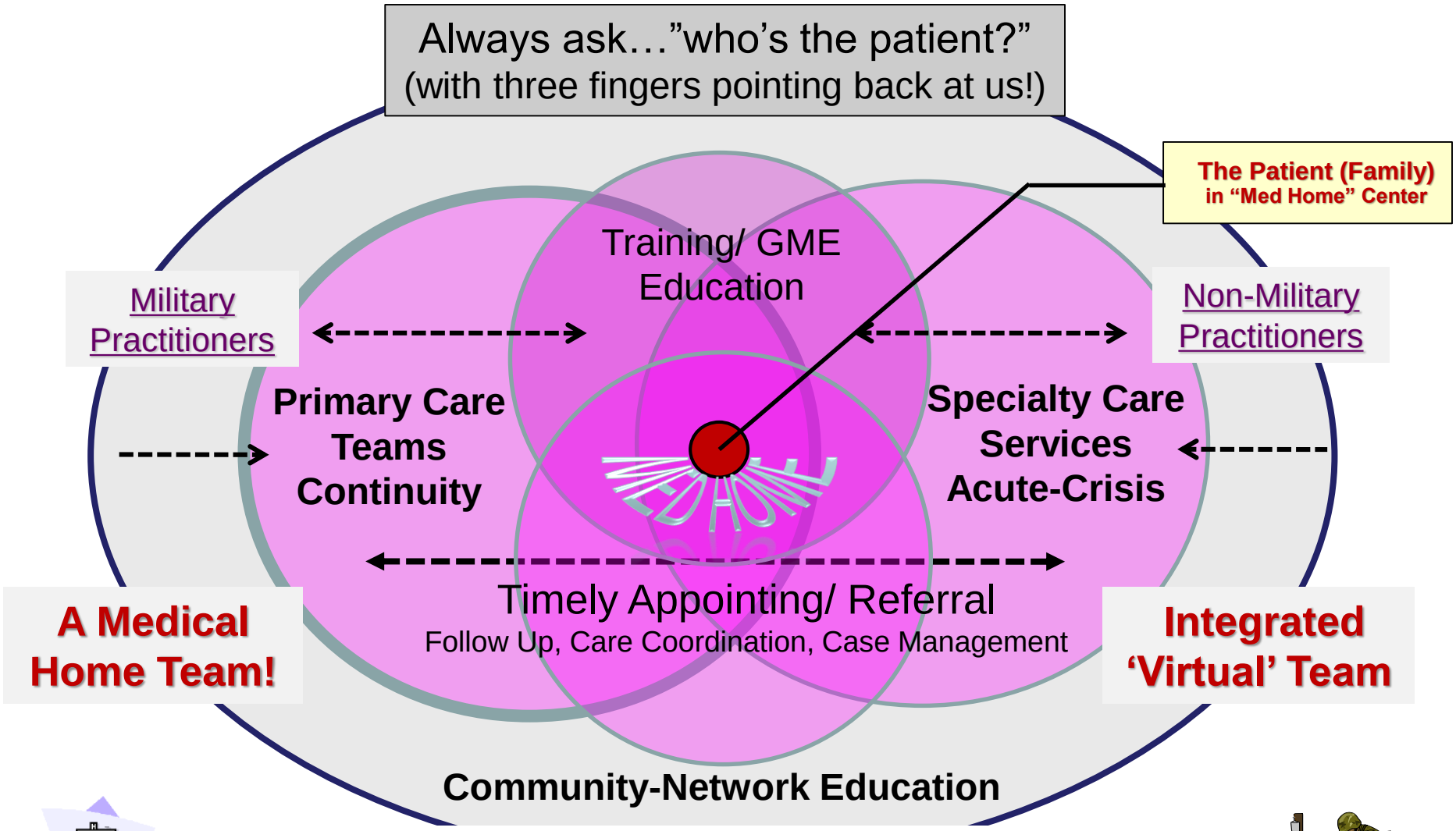
(Managed by the Person and their Identified Team!)



Requires Ownership, Knowledge, and Service Mentality!

CONSIDER: WHO 'WORKS' FOR WHO?

Patient-Centered 'Service' Approach
Inclusive and Integrated



A Collaborative Community Approach

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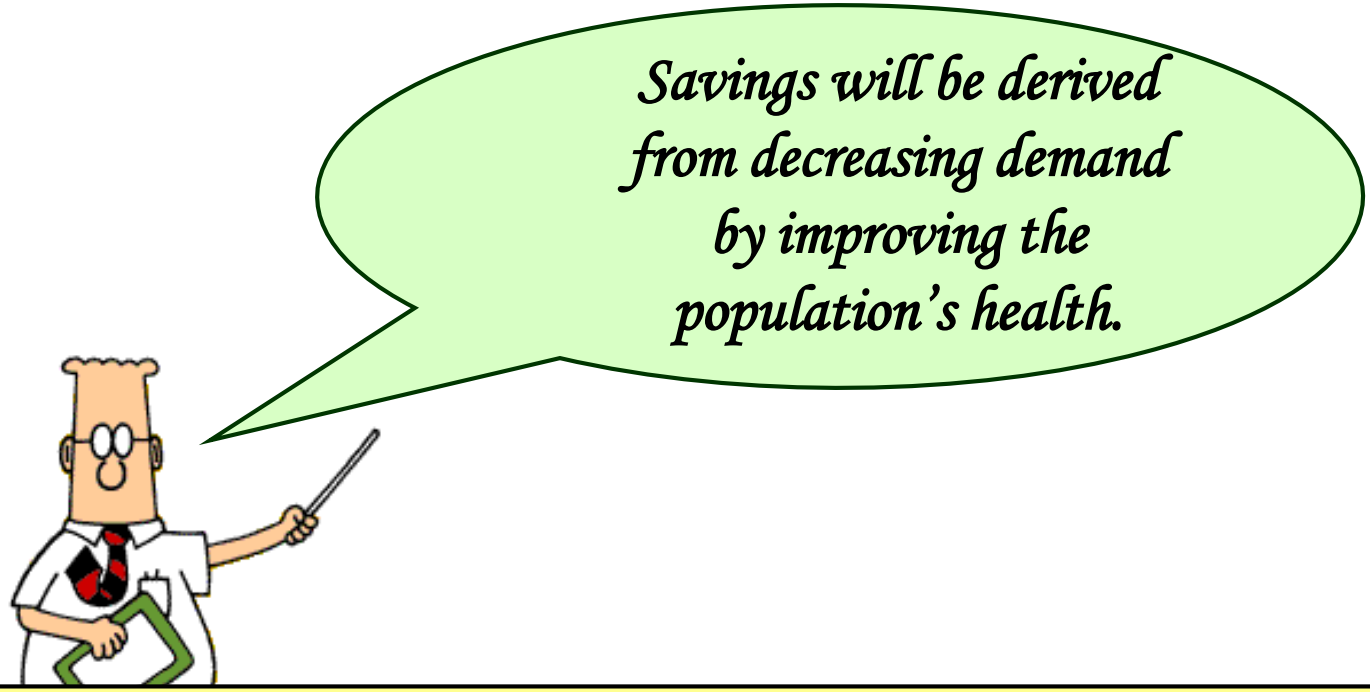

POPULATION HEALTH IMPROVEMENT (PHI)

Use every team member to improve health at every visit!

MANAGE COST → ***MANAGE HEALTH***

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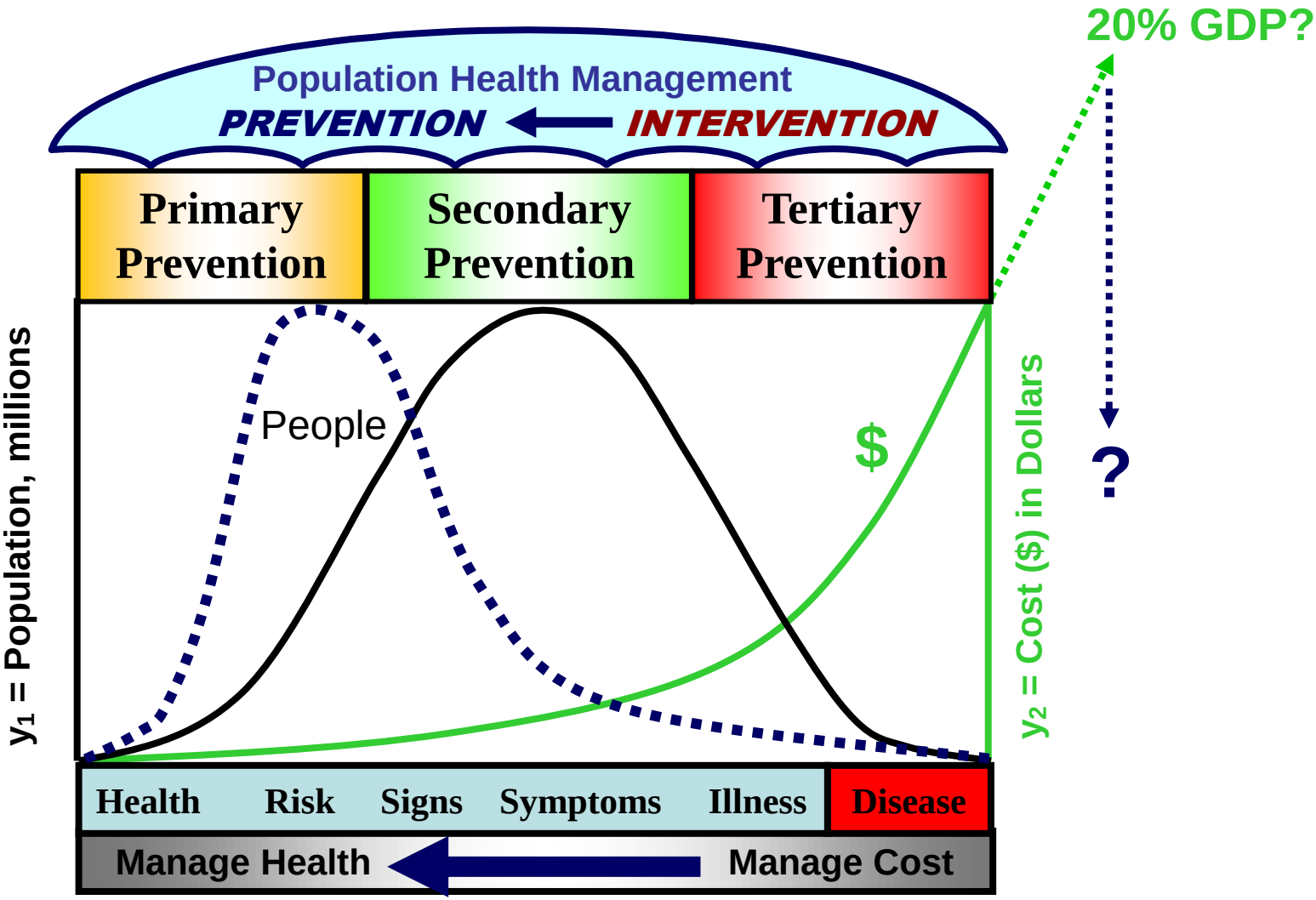
The Health, Disease, Cost Continuum



y (health and cost outcomes) is a function of x (use of primary Vs specialty care and severity of disease)

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Southcentral Foundation Outpatient Clinic

4501 Diplomacy Drive, Anchorage, AK 99508
Katherine Gottlieb, President/CEO

- Enrollment capacity from 15,000 to 40,000
- Visits per 1,000 Pts from 85 to 40 per month over a six year monitoring period
- ER visits from 30 to 18 per 1,000 Pts per month
- Visits to specialty clinics from 290 to 110!
- Visits to specialty clinics from 3,000 to 1,500 over 6 year period
- Admits from 7.5 per 1,000 to 4.3
- Asthma hospitalizations from 8% of asthmatics to 2.5%
- Immunization rate from 89% to 93%
- **Behavioral health services wait list from 1300 in 2004 to 0 now**
- Won the McArthur Fellowship award
- Website is http://www.southcentralfoundation.com/

Benefits Realized
in Civilian Best Practice PCMH Models

1. **Reduce wait time (I.e. 3rd available appointment) (waste)**
   - **for PE (<u>with</u> PCM) from 25 to 2 days**
   - **for PC Peds Clinic from 45 to 2 days (Mayo Clinic)**
2. **Increase appointments with PCM (supply w/continuity) from 59% to 80% (Sacramento, CA)**
3. **Decrease total visits (demand) from 8% - 25%**
4. **Reduce use of ER by 30%**
5. **Save 35% in healthcare costs per person/year**
6. **Improve prevention clinical outcomes (quality):**
   - **Lipids checked: from 59% to 88%**
   - **Tetanus given: from 50% to 97%**
   - **Pneumovax given: from 65% to 88%**

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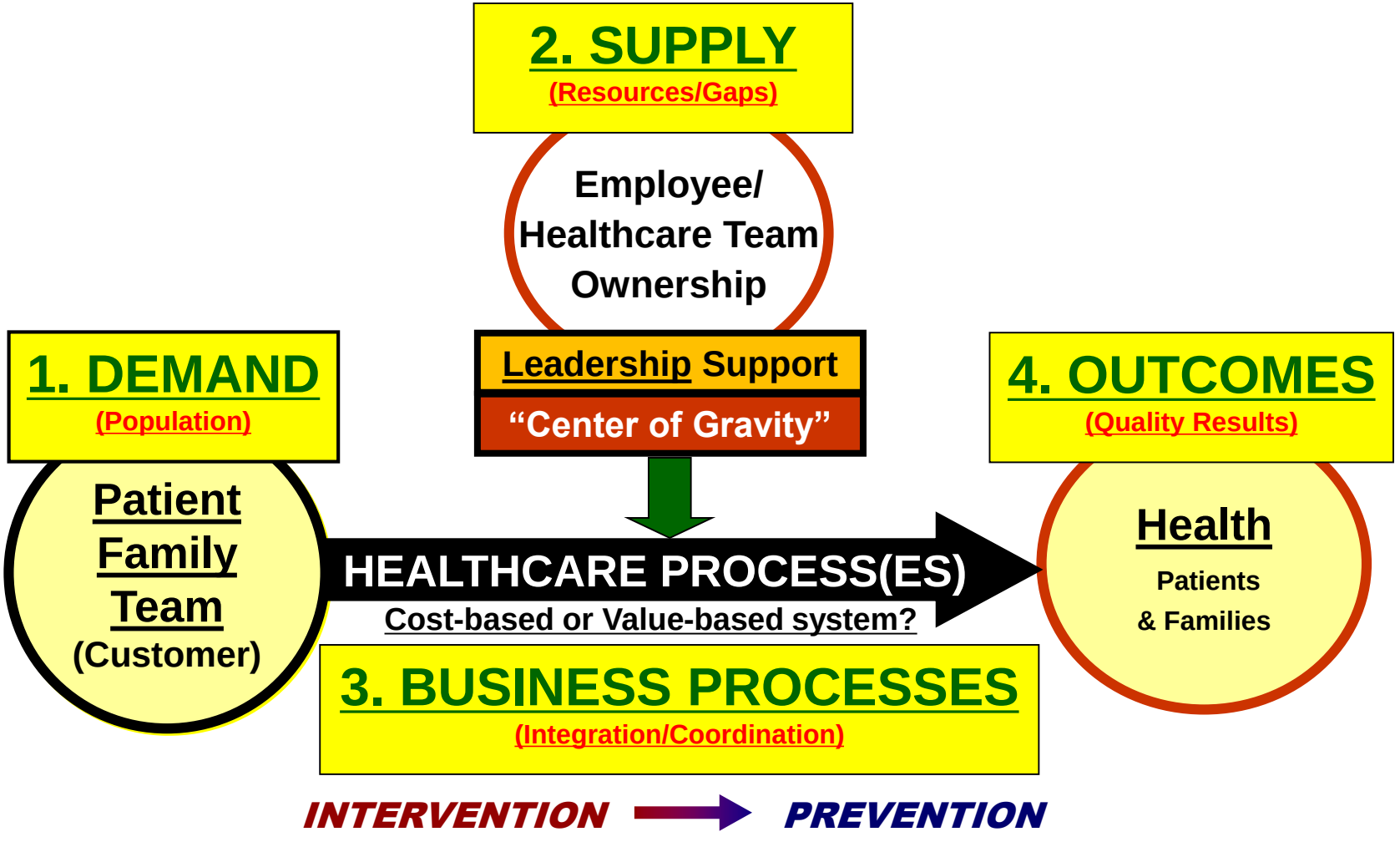
Clinical Access To Care – "First Things First"
Support Your Local Healthcare Team(s)
(after all, they are the ones seeing the patients!)



INTERVENTION → ***PREVENTION***

Four operational steps are required to achieve the desired end-state

Manage processes, support people!

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Enrollment (Healthcare) Capacity Gap (Reality Check – by location)

1. Provider FTEs
   - MD, NP, PA (and FP, Peds, IM)
2. Support Staff (Core Team) FTEs
   - RN (Clinical, Case Manager)
   - LPN/Medic/Corpsman/CNA
   - Medical Clerk/Reception
   - Group Practice Manager (GPM)
   - Admin Support/Coder
3. Space FTEs
   - Exam Room/ Treatment Room/ Team Office
4. Training – Stability
   - Hiring lag time
   - Inefficiency until operating at FTE

"FTE" = Full-Time Equivalent

What Is "Integrated Health Care" Centered on the Patient and PC Team?

- **Mental (or Behavioral) Health Care Providers (and their services) available in Primary Care settings, with a focus on Prevention.**

- Physically present and available on a same day basis in a "Community Clinic"
- Consider including Optometry, Physical Therapy/ Chiropractics, Occupational Therapy, Pharmacology, and OB-GYN as "Primary Care Specialties"
- Add Family/ Peer Health Coach Navigators

What is "Integrated Health Care" Centered on the Patient and PC Team?

Processes indicating a clinic is integrated

1. Enrollment to Primary Care Provider (Team) with shared NCM
2. Shared Comprehensive Health Plan (CHP)
3. Behavioral Health Specialists (Counselor, Social Worker, Psychologist, and/or Psychiatrist) on-site (or virtual)
4. Universal depression/suicidal ideation screening
5. Same day process for referring to Mental Health (BH)
6. Shared Release of Information (ROI) establishing "Family" the patient trusts (their safety net)

PCMH Integrated Health Care

Integrated Team Resourcing

(Population Based: 1500 to 3000 Reliant Beneficiaries)

Core Primary Care Team

1. Provider (MD, DO, NP, PA) (1.0)
2. RN (Treatment) (0.5)
3. LPN/ Medic/(CNA) (0.5)
4. Medical Clerk/ Admin Asst (0.5)
5. **Nurse Case Manager (N-CM) (0.5)**
6. **Practice Manager/ Admin (0.2)**

7. **Client/ Beneficiary (Patient/Person)**
8. Peer/ Family Navigators

Re-train ALL to work at the top of their respective license!
(Providers VALIDATE!)

Integrated Team - Consultants ("Primary Care Specialties")

- **Behavioral Health (0.2)**
- **Social Work (0.2)**
- Pharm D
- Nutrition
- Addiction/Pain Management
- Physical/Occupational Therapy (Exercise Physiology)
- Optometry

- Pathology (Lab)
- Radiology
- Central appointing, referral services
- Other specialty providers (based on population)

(Data available if interested in recommended ratios of employees to full-time Provider)

To “Optimize” Each Provider…

- **Focus on delivery of the highest quality care for each customer (patient)**
- **Balance customer service and cost (Best Value) with cost-competitive health care delivery**
- **Standardize all provider teams with a ‘proven’ model (make use of best practices with known “capacity gap”)**
- **Cross-level/ partner with other teams/ facilities/ services**
- **“Call it what it is” and then deal with reality**

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Re-Engineer (Optimize), via Focus Areas 3 & 4

Patient Encounter Process

Rethink Skill Sets!

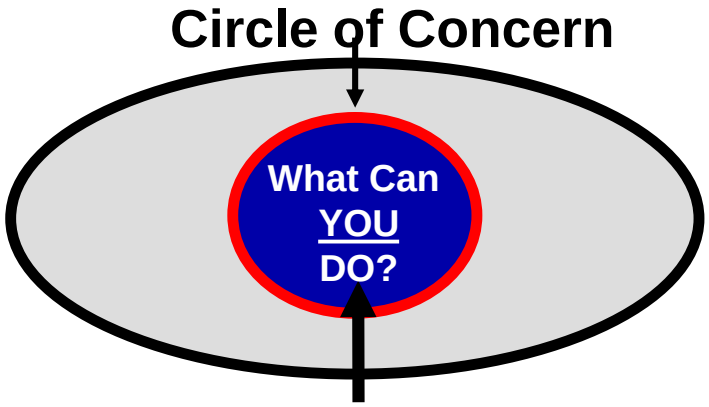
Access to Care

"…the ability to obtain needed, affordable, convenient, acceptable, and effective personal health services in a timely manner…"

Delivering Health Care in America: A systems approach, Shi and Singh, 2004

CONCERNS – UP FRONT

"If adequate resources are unable to meet demand consistently, significant disruption in the ability to offer same-day appts will confuse, irritate and dissatisfy both patients and staff."



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"Call It What It Is" Checklist

- **IDENTIFY the Population** (forecast demand)
- **IDENTIFY Capacity**/ capabilities/ resources and gap(s) (manage capacity)
- **INITIATE Business Process Reengineering** (evidence based interventions)
  - Align manpower, people, knowledge
  - Train team for maximum efficiency
- **SUBMIT Budget Request** (or suggest need to alter demand)

Avoid Enabling Dysfunction!

Support Staff to Provider Ratios

Specialty	RN	LPN	NA	Med Clerk	Total Ratio
Surgery	0.4	0.6	0.9	0.4	2.3
Cardiology	0.4	0.4	0.6	0.6	2.0
OB/GYN	0.5	0.9	0.9	0.7	3.0
Psychiatry/Psychology	0	0	1.0	0.2	1.2
Primary Care	**0.5**	**0.9**	**0.9**	**0.5**	**2.8**

Note:

RN = Registered Nurse

LPN = Licensed Practical Nurse

NA = Nurse Assistant

Capacity Gap
Provider Support Example

Population Factor earns the minimum number of provider FTEs needed.

1.0 aFTE of Primary Care Provider needs*:

0.5 RN

1.8 LPN/NA/91W

0.5 Med Clerk

*per Medical Group Management Association (MGMA) and HQ Consultants review

PRIMARY CARE CLINIC EXAMPLE							
PCMs	Asgd/ Hired	FTEs	SUPPORT STAFF	Asgd/ Hired	FTEs	SPT Staff Ratio	Gap
MD	19	16.75	RN	5	4.5	0.2	-9.6
PA	7	6.5	91W/LPN/ LVN/NA	64	57	2.0	6.2
NPs	6	5	Med Clerk	11	9.9	0.4	-4.2
Total	32	28.25	Total	80	71.4	2.5	-7.7

Staff Req'd: 28.25 x 2.8 = 79.1 FTEs (Need 10 RNs, 4 Med Clerks)

Advanced Open Access Booking Template *("Continuity Is King!")*

"Emergency?" - Call 911 or Connect Caller to RN or Doctor On-Call if:

Trouble Breathing | **Burn Victim** | **Chest Pains** | **Head Trauma (Loss of Consciousness)**

Appointment Type	*1st Time/Acute Same Day*	*Follow Up/Recurring/Routine*	*Established/Chronic/PE*
1. Start with:	**10 Minutes**	**10 Minutes**	**30 Minutes**
2. Then for each "positive response" below give an additional 10 minutes…			
A. Have you had this more than FIVE days already or called and followed phone advice (which hasn't worked)? If **"Yes"**-	**Add 10 Minutes**	**Not Applicable**	**Not Applicable**
B. Have you had this concern longer than a month, or if a follow-up, are you having complications? If **"Yes"**-	**(See above)**	**Add 10 Minutes**	**Not Applicable**
(Check provider availability at this point)			
C. Is the same provider, or your PCMBN, available? If **"No"**-	**Not Applicable**	**Add 10 Minutes**	**Add 10 Minutes**
D. Do you have any other issues to bring up today? If **"Yes"** (and appt available)	**Add 10 Minutes**	**Add 10 Minutes**	**Add 10 Minutes**
Minimum-Maximum Appointment Length	**10 - 30 Minutes**	**10-40 Minutes**	**30-50 Minutes**

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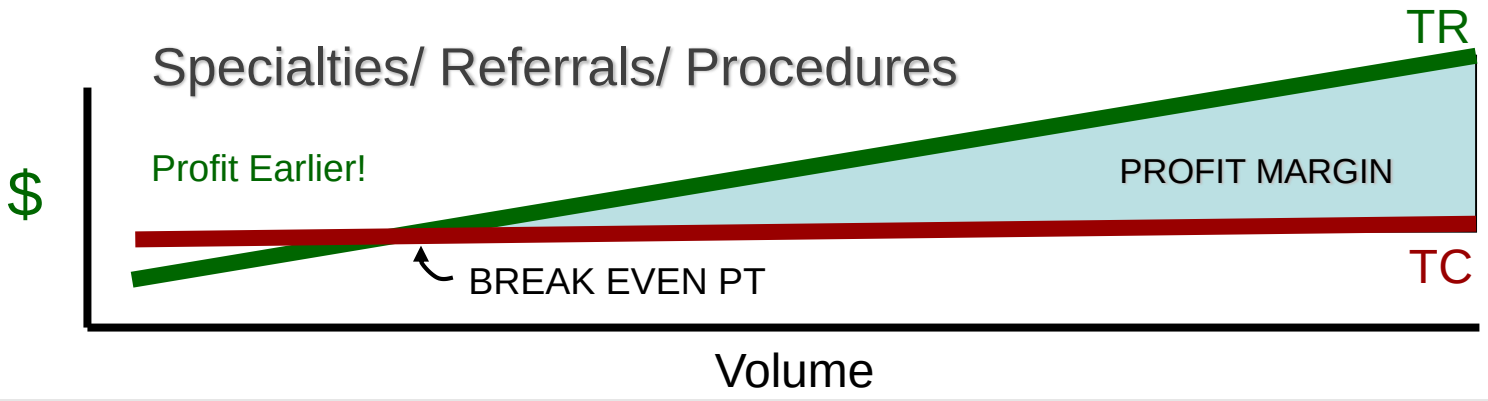
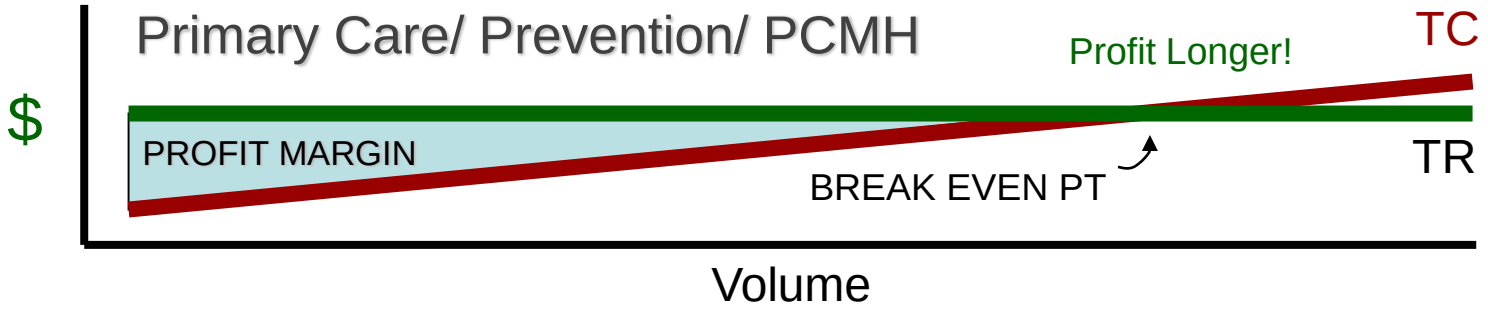
Managing Health…or Cost?

Know resourcing model = ‘Closed’ or ‘Open’ System?



Fee for Service: *Maximize # Visits *Minimize Cost/ Unit Service



Capitated per Patient: *Maximize Enrollment *Minimize # Visits

Achieve Health Care System Equilibrium!

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Five Take Home 'Must Do' Actions

(for next Monday)

1. Ask - "**Who's your PCM**?" (continuous relationship) (with **signed ROI** of 'trusted' family/friends)
2. **Universal Screen** Depression/ Suicidal Ideation
3. Establish **Integrated Primary Care Teams** with Behavioral Health and Case Management in PCMHs
4. **Same Day (BH) Access** (virtually if needed).
5. Implement **'Safety Net'** (Monitoring Plan) Process **Training**

Veteran Humanitarian Clowning:

A Viable Alternative Approach to Healing Military (Life) Trauma

PILOT TRIP TO GUATEMALA CITY

OCTOBER 10-18, 2015

Patch Adams, MD – Gesundheit! Institute

COL-Ret George Patrin, MD, MHA – Serendipity Alliance

PTSD Clinic - Chicago VA

Veteran Humanitarian Clowning

WHY?

- **Viable Alternative Approach to Healing Military (Life) Trauma**
- **Therapies often unsuccessful, re-traumatizing**
- **Need recovery approach (not labeling, non-stigmatizing)**
- **Unacceptable levels of Veteran suicide, homelessness, divorce, and unemployment**
- **Access pre-trauma spiritual center for long-lasting healing**
- **Brain neuro-plasticity**

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Veteran Humanitarian Clowning

Patch Adams

Challenged medical status quo utilizing laughter and love, compassionate clowning as 'serious' therapy.

International clowning "Nasal Diplomacy“ to raise awareness. Methods being researched for the first time to establish validity as a viable alternative to years of seeing a psychiatrist prescribing medications with unacceptable side effects.

(see https://en.wikipedia.org/wiki/Patch_Adams, https://www.youtube.com/watch?v=CdCrPBqQALc)

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Veteran Humanitarian Clowning

"Nasal Diplomacy"

Dr. Patrin traveled to Russia with Patch in 2012.

Noted remarkable change in trauma, grief symptoms.

'Immediate' transformation after two weeks.

Veteran Humanitarian Clowning

Integrated Team Resourcing

- **Investigators/Clown Staff**
  - PC (Peds/FP) Veteran (Me)
  - PC (FP) Military Dependent (Patch)
  - PC (FP)
  - PC (FP), Stress Technologies
  - Psychiatrist, C. Objector (IHB)
  - Psychologist, PhD, Vet Therapist
  - MSW, Crisis Line Manager (from Canada)
  - Vietnam Medic
  - Vietnam Spouse, Community Worker
  - Eco-Psychologist (Trip Coord)
  - Art Therapist (Trip Guide)
- **Veteran Clowns (20)**
  - Army
  - Navy
  - Air Force
  - Marines
  - Male (16)
  - Female (4)
  - USA (18)
  - Canada (2)
- **Film Crew**
  - Photography (Patch's Son)
  - Video (My Son)
  - Documentary Film Maker

Veteran Humanitarian Clowning

PILOT TRIP TO GUATEMALA CITY

Day 1, Oct 11 - Gig #1 - Anini Orphanage
Developmentally Severely Affected Children

Veteran Humanitarian Clowning

PILOT TRIP TO GUATEMALA CITY

Day 5, Oct 15 – Gig #8 - Hillslide Refugee Camp

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Veteran Humanitarian Clowning
Response of Veterans

- "One week worth years of VA therapy"
- "This was not a fluke"
- "I've found the child I was before I enlisted!"
- "This is the real thing"
- "The week has been amazing. Definitely, like, the best trip I've ever been on."

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“No one is exempt from suffering, yet we can thrive and flourish despite it—and, in some cases, because of it.”

Kalsey Killam of Harvard University, UnLoneliness Project

HUMANITARIAN CLOWNING WORKS!

Happily, trauma can, and will, drive positive change… and clowning can be a natural catalyst for that change with as little as a week of team clowning, the Gesundheit! way.


FROM WAR HEROES TO PEACE WARRIORS
PATCH ADAMS PRESENTS
CLOWNVETS
A DOCUMENTARY BY ESTEBAN ROJAS
THE GESUNDHEIT! INSTITUTE PRESENTS A CLOWNVETS LLC & ER FILMS PRODUCTION "CLOWNVETS"
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"A VOICE FOR THE VOICELESS"
BREAKING THE SILENCE BY LISTENING TO SURVIVORS

COMMENTS?

QUESTIONS?

Let's begin with the end in mind –
manage health and cost!
Provide Universal Integrated HEALTH Care!

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Staffing Ratios by Specialty

SPECIALITY	AOC	1 PROV PER POP OF	SUPPORT PER PROVIDER	ROUNDING FACTOR
PULMONARY DISEASE	60F	40000	2.40	0.75
GASTROENTEROLOGY	**60G**	**40000**	**2.40**	**0.75**
CARDIOLOGY	**60H**	**30000**	**2.00**	**0.75**
PEDIATRIC CARDIOLOGY	60Q	90000	2.30	0.75
DERMATOLOGY	60L	35000	2.30	0.75
ALLERGY	60M	60000	2.40	0.67
NEPHROLOGY	61A	60000	2.30	0.95
HEMATOLOGY-ONCOLOGY	61B	40000	2.30	0.90
ENDOCRINOLOGY	61C	60000	2.30	0.75
RHEUMATOLOGY	61D	50000	2.40	0.75
INFECTIOUS DISEASE	61G	50000	2.40	0.75
NEUROLOGY	60V	30000	2.40	0.80
CHILD NEUROLOGY	60R	90000	2.40	0.75
PSYCHIATRY	**60W**	**18000**	**1.20**	**0.75**
CHILD PSYCHIATRY	**60U**	**60000**	**1.20**	**0.75**
GENERAL SURGERY	61J	12500	2.30	0.50
THORACIC-CARDIAC	61K	50000	3.00	0.90
PLASTIC SURGERY	61L	60000	2.30	0.75
ORTHOPEADIC	61M	14285	2.30	0.50
PHYSICAL MEDICINE	61P	50000	2.30	0.90
PERIPHERAL VASCULAR	61W	60000	2.30	0.75
OPHTHALMOLOGY	60S	25000	2.30	0.75
OTOLARYNGOLOGY	60T	28000	2.30	0.75
UROLOGY	60K	30000	2.30	0.75
NEUROSURGERY	61Z	70000	2.30	0.66
OB/GYN	60J	11000	3.00	0.67
RADIATION THERAPY	61Q	75000	2.40	0.90
NUCLEAR MEDICINE	60B			
EMERGENCY MEDICINE	62A	12500	4.50	0.75
INTERNAL MEDICINE	**61F**	**20000**	**2.30**	**0.50**
PEDIATRICS	60P	25000	2.30	0.50
FAMILY PRACTICE	**61H**	**11000**		**0.50**
OPTOMETRY	67F	8100	2.00	0.75
PHYSICAL THERAPY	65B	7500	TABLE	0.67
OCCUPATIONAL THERAPY	65A	18000	TABLE	0.67
PODIATRY	67G			
AUDIOLOGY	72C	0	0.00	0.00
SPEECH	CIV			
PSYCHOLOGY	73B	9000	0.75	0.75
ALCOHOL & SUB ABUSE	CIV			
SOCIAL WORK	73A			
RADIOLOGY	61R			
PATHOLOGY	61U			
PHARMACY	67E			
NUTRITION	65C			
ANESTHESIA	60N / 66F			
PRIMARY CARE				
FP , IM, PEDS	61H,61F,60P	1178	2.80	0.500

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Access To Care BPR Provider Team Training

Clinic Business Process Reengineering Teaching Plan

Time	Mon	Tue	Wed	Thu	Fri
800	**MEDCOM Team Activities**				
	CMD In-Brief	**Clinic Visits**	**Clinic Visits**	**Mgmt Office Visits**	**IM/IT**
DIV.	**MTF Orientation**	**Process Review**	**Process Review**	**(Business Processes)**	and
THEME	**TMC(s) Tour**	**(Employee Focus)**	**(Patient Focus)**	**(Outcomes, Tools)**	**Process Follow-Up**
1130	LUNCH				
1300	**Teaching activities with Primary Care Staffs**				
POC FOCUS	**Overview of Optimization**	**Clinic BPR: CSD**	**Access: CSD, QM**	**Quality Concepts/Tools: PAE/POPM/QM**	**Intro to Templates: (IM/IT)**
	Pop Health Initiative	Skill Sets	Open/Adv. Access	Outcome Measures	The Future/CPR
	BSC Metrics/Outcomes	Room Utilization	Best Practices	CPGs	CHCS II
	Your MTF's Performance	Brainstorming	Results/Outcomes	Demand Mgmt	ICDB/MEDBASE
	Enrollment Capacity	Best Practices		Prev Med Interv's	**MTF Action Plan**
	Avail. MEDCOM Support	New Process Design		Patient Follow-Up	Final Brainstorming
1430	BREAK				
1500	**Developing Action Plan**	**Skill Sets Workshop**	**Satisfaction/QM**	**Business Tools: PAE**	Prioritization
			Groups	BCA/Funding	Finalize Action Plan
			Methods	Personnel Support	**CMD Outbrief**
			Strategy For Success	Coding & Superbills	
	Review Training				**END**
1600	**Questions**	(Develop Action Plan)	(Develop Action Plan)	(Develop Action Plan)	
1700	**END**	**END**	**END**	**END**	

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