PCMH in an FQHC: Primary Care and Behavioral Health Integration for Patients with Intellectual and Developmental Disabilities

ACU Conference

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Introductions

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Learning Objectives

- Describe best practices when integrating primary care (PC) and behavioral health (BH) for I/DD patient population
- List predominant medical and behavioral health conditions within the I/DD population
- Identify self-management strategies and workflows to improve service care delivery and care team roles
- Determine how Behavioral Health related PCMH criteria can be incorporated into the practice
Prevalence of Medical and Behavioral Health Needs

- Intellectual and developmental disability (I/DD) prevalence of individuals across the lifespan ranges from 1-2%

- Compared with the general public, those with I/DD are four times more likely to have a chronic disease and preventable mortality

- 31-40% of individuals with I/DD have co-occurring mental illness including impulse control/intermittent disorder (21%), anxiety (19%), depression (14%), and bipolar disorder (10%)

- Nearly 60% of the IDD population is prescribed psychotropic medications (primarily anti-depressants, mood stabilizers, and anti-anxiety medications)
# Predominant Conditions within I/DD Population

<table>
<thead>
<tr>
<th>Medical</th>
<th>Behavioral Health</th>
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<tbody>
<tr>
<td>Epilepsy</td>
<td>ADHD</td>
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<tr>
<td>Gastroesophageal reflux disease (GERD)</td>
<td>Anxiety</td>
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<td>Seizure Disorder</td>
<td>Bipolar Disorder</td>
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<td>Sleep disturbances</td>
<td>Depression</td>
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<td>Vision and hearing impairments</td>
<td>Obsessive Compulsive Disorder</td>
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<td>Oral health problems</td>
<td>Impulse Disorder/Intermittent Disorder</td>
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<td>Constipation</td>
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PCMH Integrated Care

Universal screenings for common needs (depression, anxiety, substance use) and use of a registry to monitor population needs

Providers accessible for consults, same-day visits (15–30 minute consultation), and prevention education/guidance

Same day and ‘warm hand-off’ availability to reduce no-shows and ensure connection to care

Behavioral health & primary care providers working side-by-side, along with other disciplines (social work, nutrition, pharmacy, others)

Shared health records and care plans: All providers and members of the care management team have access to and document the patient’s care in a single medical record

**A Spectrum of Integration**

**Coordinated care (off-site)**

- **Level 1: Minimal collaboration**
  - Patients are referred to a provider at another practice site, and providers have minimal communication

- **Level 2: Basic collaboration**
  - Providers at separate sites periodically communicate about shared patients

**Co-located care (on-site)**

- **Level 3: Basic collaboration**
  - Providers share the same facility but maintain separate cultures and develop separate treatment plans for patients

- **Level 4: Close collaboration**
  - Providers share records and some system integration

**Highly integrated care**

- **Level 5: Close collaboration**
  - Providers develop and implement collaborative treatment planning for shared patients but not for other patients

- **Level 6: Full collaboration**
  - Providers develop and implement collaborative treatment planning for all patients


Barriers to Integrated Care

- Create behavioral health related visit types
- Utilize appropriate billing codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Service Provided</th>
<th>Approx. Medicare Payment per 15-Minute Unit</th>
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<tbody>
<tr>
<td>96150</td>
<td>Assessment, initial</td>
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<td>96151</td>
<td>Reassessment</td>
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<td>Intervention, individual</td>
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<td>Intervention, group (per person)</td>
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<td>Intervention, family without patient</td>
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</table>

*Note. These CPT codes are for behavioral, social, and psychophysiological assessment and interventions for the prevention, treatment, or management of physical health problems.*

- Hire and/or train staff with time allocated to coordinate care internally
- Establish a staff supported culture of integrated care
Therapeutic Interventions

- Functional Behavioral Assessment (FBA)
- Applied Behavioral Analysis (ABA)
- Cognitive Behavioral Therapy (CBT)
Functional Behavioral Assessment (FBA) for I/DD

- Problem-solving strategy to help determine root cause of challenging behavior:
  - Compensation for pain, or
  - Associated with a behavioral health disorder

- Pain associated with health complications in patients with I/DD who are non-verbal or struggle to communicate often manifest as behavioral challenges
Functional Behavioral Assessment (FBA) for I/DD

- Behavioral therapists are not trained to diagnose physical health problems and medical providers are not trained to identify behavioral manifestations of pain
  - Solution: comprehensive cross-discipline collaboration on assessments

- Results from an FBA can build a behavioral intervention plan and identify health problems; directing certain medical and behavioral health treatments
Applied Behavioral Analysis (ABA)

- A method of therapy used to improve or change specific behaviors, can teach skills and improve attention, focus, social skills, memory and academics

- The process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement in behavior
ABA Approach

- Therapists who use ABA understand how human behaviors are learned and how they can be changed over time.

- The therapist evaluates a client’s behavior and develops treatment plans to help improve the communication and behavior skills necessary for success in their personal and professional lives.

- ABA therapists can also provide training to parents and teachers. For the greatest results, ABA requires heavy monitoring and continuous evaluation.

- Therapists and other health professionals work within settings such as schools, homes, and community centers to evaluate and modify treatment as it progresses.
ABA and Autism

- According to the Center for Autism, ABA helps the autistic client improve social interactions, learn new skills, and maintain positive behaviors.

- ABA also helps transfer skills and behavior from one situation to another, controlling situations where negative behaviors arise and minimizing negative behaviors.

- With autism, ABA is most successful when intensely applied for more than 20 hours a week and prior to the age of 4.
Focus of ABA

- Improving specific behaviors, such as social skills, communication, reading, and academics as well as adaptive learning skills, such as fine motor dexterity, hygiene, grooming, domestic capabilities, punctuality, and job competence

- ABA can also help aging adults cope with the losses that come with age, like memory, strength, and relationships

- For young and old, ABA can help individuals manage some of the lifestyle challenges that accompany many mental and physical health conditions
Cognitive Behavioral Therapy (CBT) for I/DD

- A form of psychotherapy that rests on the idea that thoughts and perceptions influence behavior

- Works to relieve negative emotions (i.e., anxiety and depression) by modifying behaviors and thoughts

- CBT focuses on solutions, encouraging patients to challenge distorted cognitions and change unhelpful patterns of behavior
Self-Management Tools

- Often when treating a patient with I/DD, therapists modify tools and educational material to fit the needs of the population.

- Using a slower pace to treatment, being more specific when sharing information, providing concrete examples, using pictures and adapted tools (i.e., anger thermometer, mood tracker and my thoughts worksheet).

- Strategies to cope with pain/discomfort (i.e., counting, breathing, listening to their favorite music during the visit).
Stress Thermometer

Emotions Thermometer

Exploding
Angry
Frustrated
Boiling
Warm
Annoyed
Cool
Fine
Calm

What can I do?

- listen to music
- relax in a quiet place
- I can take deep breath
- ask for help
### Mood Tracker 2019

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- Happy/joyful
- Normal
- Angry/grumpy
- Disgusted/annoyed
- Sad
- Nervous/anxious
- Productive/energetic
- Sick/tired
# My Thoughts Worksheet

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<tr>
<th>Situation</th>
<th>Upsetting thoughts</th>
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Case Example #1 - Jenny

Scenario
- Jenny is a 31 year old woman diagnosed with Autism Spectrum Disorder and Moderate ID
- She was referred to therapy to address “acting out at home”

Treatment
- Explored what exactly Jenny is afraid of (anxiety related to dental services)
- Validated her feelings and worked on strategies to cope with pain/discomfort (e.g. counting, breathing, listening to her favorite music during the visit)
- Virtual exposure technique - where the therapist spoke about what dental procedures entail and shared pictures of dental offices
  - Emphasis was on what control Jenny has during the visit
Case Example #1 – Jenny Continued

Treatment (continued)
- She saw the dental office on more than one occasion and met with the dental assistant who assured her that it was just a check-up and no dental work will be done during the first visit and Jenny agreed to schedule a dental visit.

Outcome
- On the day of her dental appointment the therapist walked Jenny to the dental office where she was greeted by the dental assistant and her dentist.
- Jenny completed the dental check-up and worked with her dentist from that day on without any further therapeutic involvement.
Case Example #2 - Allan

Scenario

- Allan is a 19 year old man with Autism, Mild Intellectual Disability, Intermittent-Explosive Disorder, and Morbid Obesity

- He sees a psychiatrist, but he has refused referrals for mental health services in the past

- The therapist met with Allan and his mother directly after his medical visit for a “warm handoff”

- Allan was reluctant, but the therapist asked him to attend five sessions and then decide if he wants to continue or not and he agreed
Case Example #2 – Allan Continued

Treatment
- After two sessions Allan started coming by himself and since then he has been attending therapy consistently
- Allan recently started discussing his frustrations, issues with racial identity, social skills and weight problems, but he is not ready to make changes in his eating habits yet

Outcome
- Having a warm handoff after his medical appointment helped Allan be more comfortable with the idea of seeing a therapist which resulted in him accepting this service
PCMH BH Related Criteria

- Behavioral Health Care Manager
- Depression Screening (PHQ2, PHQ9)
- Behavioral Health Screenings (Audit C, DAST, CAGE-AID)
- Controlled Substance Database Review
- Community Resource List
- Case Conferences
- Alternative Appointments (Telemedicine)
- Identifying and Monitoring Patients for Care Management
- Integrated Care Plans across settings of care
- Behavioral Health Referral Expectations
- Clinical Quality Measures (Depression screening and follow up)
Role of BH Manager

- What do they do?
- Tracking BH referrals - Facilitate patient engagement in follow up care
- Provide therapeutic interventions, patient education and information about treatment options
- Screen and assess patients for common mental health and substance use disorders
- Participate in regularly scheduled team meetings
- Facilitate referrals for community resources and support
BH Screening Tools

- PHQ2, PHQ9
- Audit-C
- DAST
- CAGE-AID
Community Resources

- Consider topic areas based on your patient population’s needs

- Develop better understanding of the social determinants of health that impact your patients

- These could be external support groups and services provided by community organizations or hospitals
Case Conferences

- When to have them, how often and what do they entail?
- These meetings could be held quarterly
- Include others outside the usual care team (i.e., community agency contacts and specialists)
- Opportunity to have both clinical and non-clinical professionals to share and discuss high risk patients to plan treatment for complex needs
Care Management

- Identify which BH conditions put your patients at higher risk and who would then benefit from additional support and care planning

- Consider how you integrate the care plan across settings of care
  - Do you share it between the BH and PC staff?
  - Do you attach it to external referrals?
  - Do you push it to your RHIO?
BH Referral Expectations

- Documented collaborative agreement between BH and PC providers about their roles
- Set expectations on what kind of reports, results, consults and patient information will be shared
- Identify timeframes for when appointments will be scheduled and consults received
- Review on an annual basis
- Track BH referrals to ensure that consults received were of good quality and provided in a timely manner
Clinical Quality Measures

- Depression screening and follow up
- Adherence to antipsychotic medications for individuals with schizophrenia
- Diabetes screening for people with schizophrenia or bipolar disorder
- Depression remission at twelve months
Lessons Learned

- Relationships impact the integration between Primary Care and Behavioral Health – agreements, handoffs, setting expectations – supporting both the care team and patient through care transitions and managing them more effectively.
- Evidence-based models and working at ways to standardize communication across multiple locations.
- Having enough staffing is essential as on-site support is imperative for caseload management and time allocated to perform integration activities.
- Participating in a PCMH ensures that attention is paid to the communication between primary care and behavioral health care team members.
Resources

Questions?
Presenters

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