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

ACU Conference

July 29, 2019

PRIMARY CARE DEVELOPMENT CORPORATION

METRO COMMUNITY HEALTH CENTERS

Introductions

- Carolyn Driscoll, MSW
  - Director of Practice Innovation
  - Metro Community Health Centers, New York, NY
- Amy Goodman, LCSW, CPC-A, PCMH CCE
  - Senior Project Manager
  - Primary Care Development Corporation, New York, NY

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

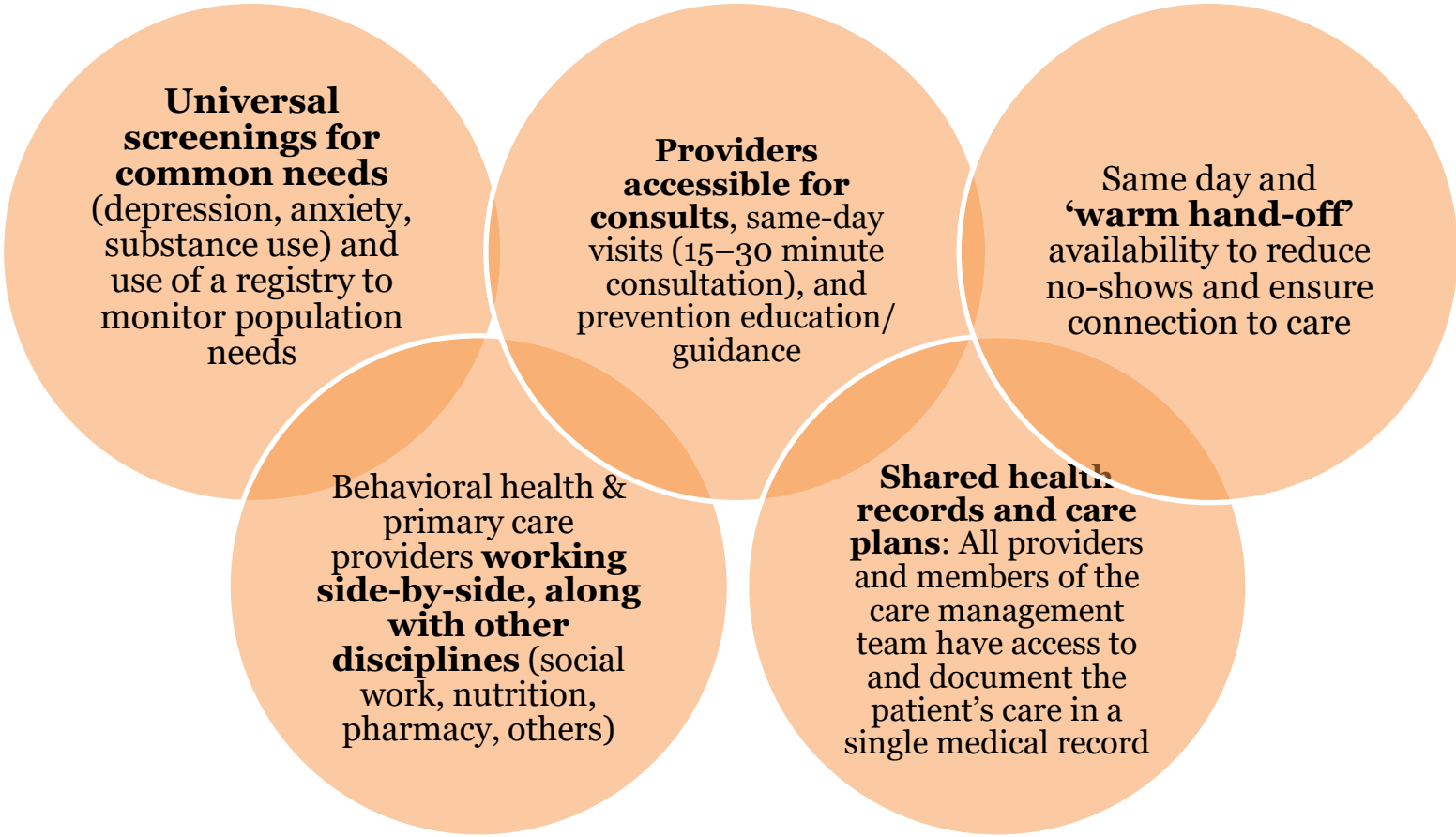
Prevalence of Medical and Behavioral Health Needs

- 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

Medical	Behavioral Health
Epilepsy	ADHD
Gastroesophageal reflux disease (GERD)	Anxiety
Seizure Disorder	Bipolar Disorder
Sleep disturbances	Depression
Vision and hearing impairments	Obsessive Compulsive Disorder
Oral health problems	Impulse Disorder/Intermittent Disorder
Constipation	

PCMH Integrated Care



Partially adapted from: Robinson, P.J. and Reiter, J.T. (2007). Behavioral Consultation and Primary Care (pp 1-16). N.Y.: Springer Science + Business Media.

A *Spectrum* of Integration

Coordinated care (off-site)

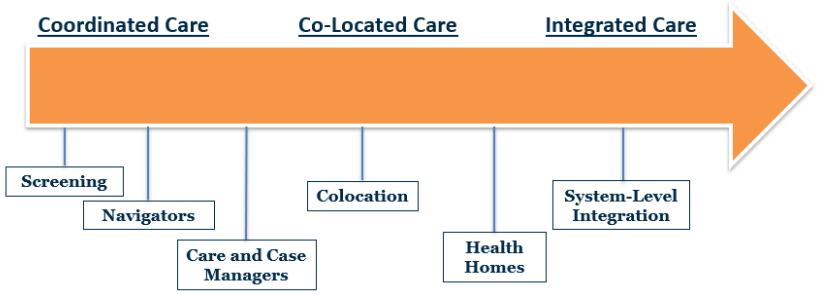
- Level 1: Minimal collaboration
  - Patients are referred to a provider at another practice site, and providers have minimal communication
- Level 2: Basic collaboration
  - Providers at separate sites periodically communicate about shared patients

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



Source: Gerrity, M., Zoller, E., Pinson, N., Pettinari, C., & King, V. (2014). Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness. New York, NY: Milbank Memorial Fund.

Adapted from: Gerrity, M., Zoller, E., Pinson, N., Pettinari, C., & King, V. (2014). Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness. New York, NY: Milbank Memorial Fund

Barriers to Integrated Care

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

New Current Procedural Terminology (CPT) Codes

CPT Code	Service Provided	Approx. Medicare Payment per 15-Minute Unit
96150	Assessment, initial	$26
96151	Reassessment	$26
96152	Intervention, individual	$25
96153	Intervention, group (per person)	$ 5
96154	Intervention, family with patient	$24
96155	Intervention, family without patient	$23

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

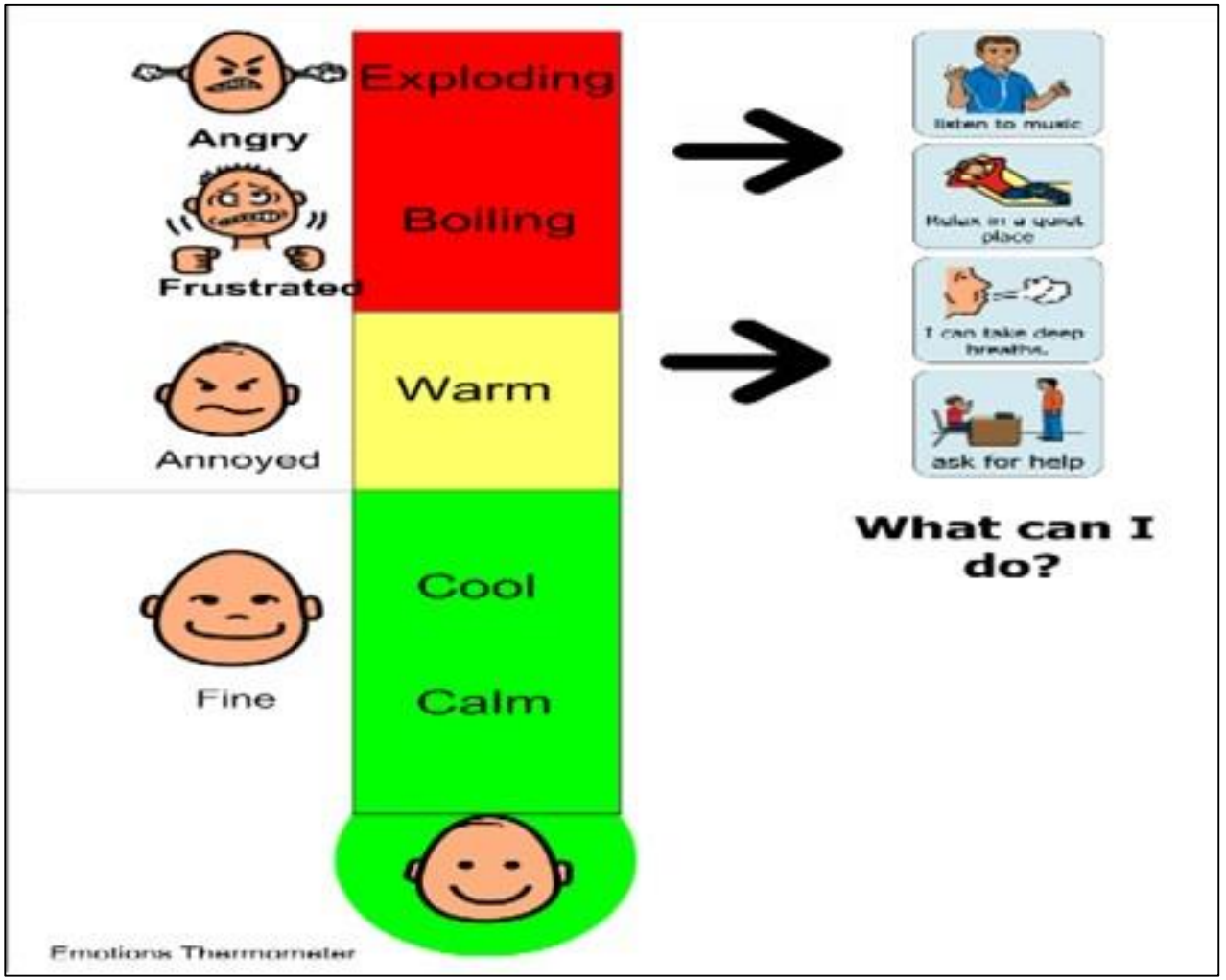
Cognitive Behavioral Therapy (CBT) for I/DD

- 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

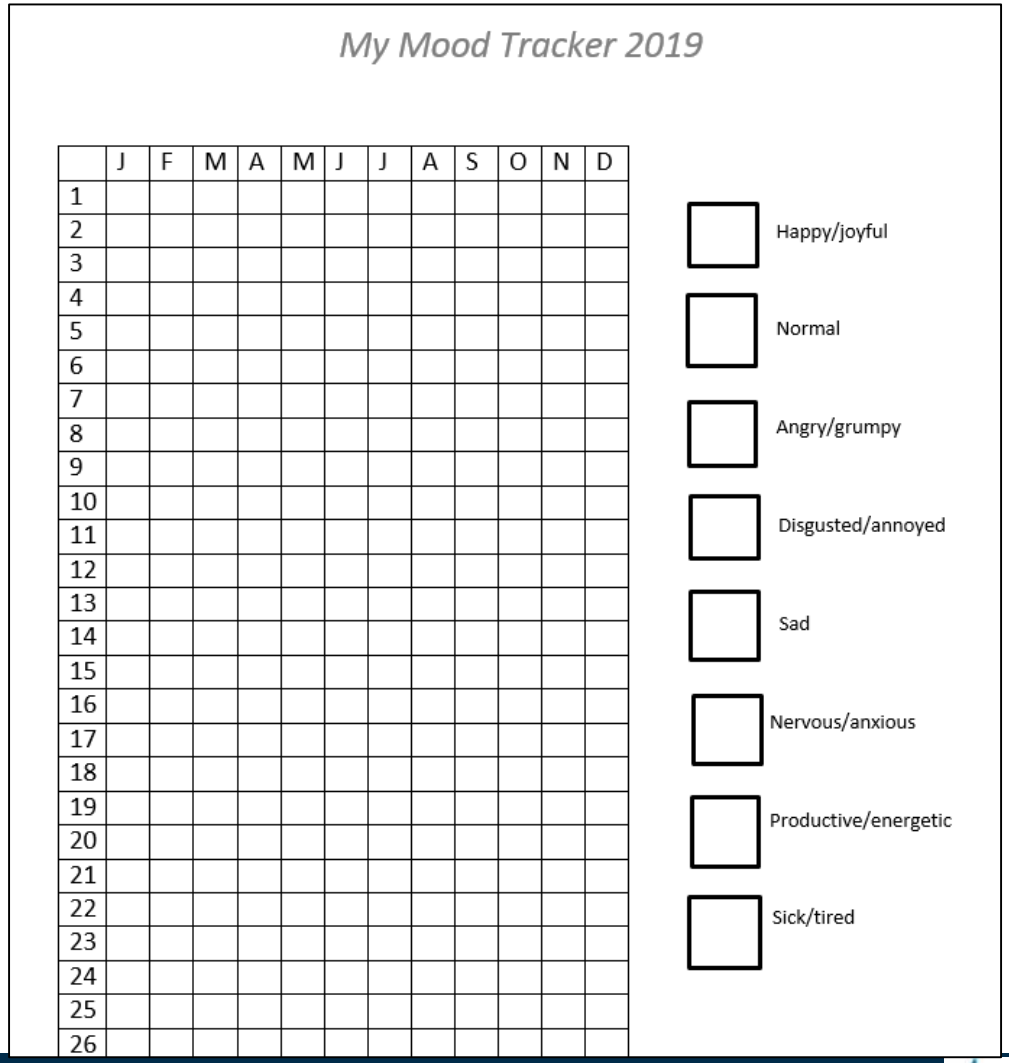
Self-Management Tools

- 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 there favorite music during the visit)

Stress Thermometer



Mood Tracker



My Thoughts Worksheet

My Thoughts

Situation	Upsetting thoughts	Feelings	Behavior	Calmer thoughts

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

- Applied Behavior Analysis (ABA). (n.d.). Retrieved from https://asatonline.org/for-parents/learn-more-about-specific-treatments/applied-behavior-analysis-aba/
- Applied Behavior Analysis. (n.d.). Retrieved from https://www.psychologytoday.com/us/therapy-types/applied-behavior-analysis
- Gerrity, M., Zoller, E., Pinson, N., Pettinari, C., & King, V. (2014). Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness. New York, NY: Milbank Memorial Fund.
- Horwitz, S. M., Kerker, B. D., Owens, P. L., & Zigler, E. (2000). The health status and needs of individuals with mental retardation. New Haven, CT: Yale University School of Medicine.
- Information on Dual Diagnosis: People with Developmental Disabilities. Retrieved at http://thenadd.org/resources/information-on-dual-diagnosis-2/.
- Krahn GL, Fox MH. Health disparities of adults with intellectual disabilities: what do we know? What do we do?. *J Appl Res Intellect Disabil*. 2014;27(5):431–446. doi:10.1111/jar.12067
- May, M. E., & Kennedy, C. H. (2010). Health and problem behavior among people with intellectual disabilities. *Behavior analysis in practice*, *3*(2), 4–12. doi:10.1007/BF03391759
- Robinson, P.J. and Reiter, J.T. (2007). Behavioral Consultation and Primary Care (pp 1-16). N.Y.: Springer Science + Business Media.
- Rush, K.S., Bowman, L.G., Eidman, S.L., Toole, T.M. & Mortenson, B.P. (2004). Assessing psychopathology in individuals with developmental disabilities. Behavioral Modification. 2004.Vol.28(5):621-37.
- Wilson, P. M., & Goodman, C. (2011). Evaluation of a modified chronic disease self-management programme for people with intellectual disabilities. Journal of Nursing and Healthcare of Chronic Illness, 3, 310–318. http://thenadd.org/resources/information-on-dual-diagnosis-2/

Questions?

Presenters

Carolyn Driscoll, LMSW

cdriscoll@ucpofnys.org

516.316.3957

Amy Goodman, LCSW, CPC-A, PCMH CCE

agoodman@pcdc.org

212.437.3964

PrimaryCareDevelopmentCorp

@PrimaryCareDev

PRIMARY CARE
DEVELOPMENT
CORPORATION