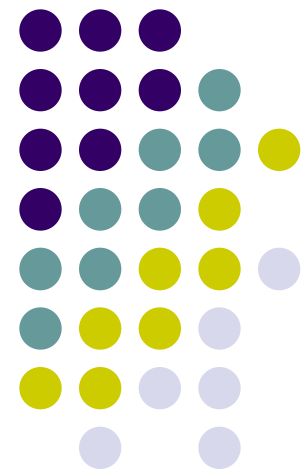
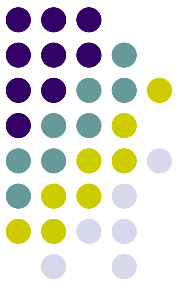
LifeLong Medical Care IBHP Phase III

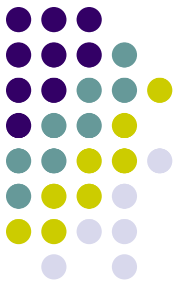


What We Are Testing



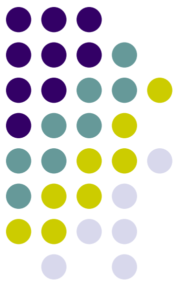
- Does universal behavioral health screening of adult diabetics in a community health center result in improved health outcomes
- How can behavioral health be integrated into a panel management model of chronic disease
- How can i2i tracks, a health management system, be utilized to maximize behavioral health/primary care integration
- Can clinical care assistants enhance behavioral health/primary care integration

Dimensions of a BEPCMH



- A well-defined assessment process and level of care system for identifying the level of need of the persons being served and ensuring that each individual is being treated in the right location with the right medical and behavioral health services at the right time.
- A full array of specialty behavioral health services provided inside the organization and/or through contract with specialty behavioral health partners.
- The ability to practice as a team to coordinate care within the BE/PCMH and across services in the behavioral health and medical service delivery system in order to ensure that the total healthcare of consumers is coordinated and properly managed.
- Measurement Systems and Tools that measure improvement in each consumer's behavioral health status and processes that use those data on a timely basis to adjust care as needed.
- Quality Improvement Processes and supporting Data Systems that allow organizations to run continuous experiments in improvement at every level of the organization in order to increase the effectiveness and efficiency of services and the infrastructure that supports service delivery

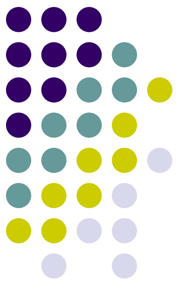
Project Description



- Population served
  - Adult diabetics at a large family practice

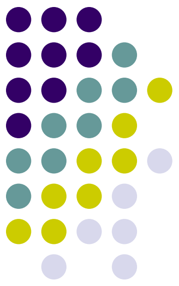
- Methods
  - Universal annual BH screening for all adult diabetics
  - Use of i2i to flag for screening, collect screening scores, track referrals for and receipt of BH services, track assessment scores over time, provide data for inclusion in panel management process
  - On call staff to assess/refer patients who screen positive
  - Use of i2i diabetes face sheet to improve communication between BH and PC staff
  - Development of clinical care assistants role to enhance integration
  - Training for psychosocial staff to increase knowledge about diabetes and develop their role in improving diabetes outcomes
  - Create model to be replicated at 5 other primary care sites

Project Description cont'd.



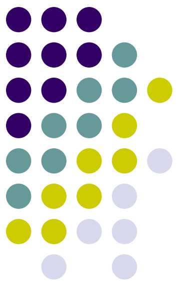
- Staffing
  - Chronic Care Program Manager (workflow, data collection, i2i)
  - Mid-level practitioner (program development and evaluation, training, on-site supervision)
  - LCSW (develop BH intervention protocols, supervise student interns doing assessments, facilitate interdisciplinary teams)
- Assessment Instruments:
  - Behavioral health screening tool for depression, anxiety, substance use, PTSD and educational needs
  - Full assessment tools for each area (PHQ9, GAD, CAGE-AID, PTSD screen)
  - Diabetes self management tool
  - Provider satisfaction survey
  - Diabetes knowledge test (for use with BH staff)
  - Patient satisfaction survey

Progress



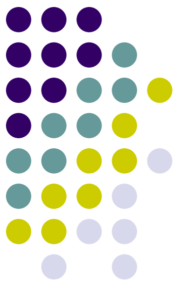
- Screening and assessment tools finalized
- Clinical care assistants, MAs, PCPs, and BH staff trained in process and pilot started three weeks ago
- Provider initial survey completed
- i2i adapted to flag for screening, collect data and track referrals and receipt of BH services
- Behavioral health diabetes training scheduled for 3/31

Deviations from plan



- Not yet, but still plenty of time!

Preliminary Findings/ Lessons Learned



- No findings yet – too early
- Need to anticipate and figure out how to work with the primary care providers who think they are the best at providing BH services
- Any change in clinic process takes a lot of time and patience
- Phasing in implementation has worked well and has helped us work out the kinks
- We’re going to have to be creative to deal with some BH staffing shortages in the summer