Behavioral Health and Primary Care Integration – Building a Model from the Ground Up (2014)

The Client:

The Region Ten Community Services Board in Charlottesville, VA released an RFP for development and implementation of an integrated care clinic partnering with the Sentara Martha Jefferson Health System primary care group.

The Challenge:

Throughout the behavioral health and medical community there has been a recognition that many primary care patients suffer from unrecognized and unaddressed behavioral health issues, just as behavioral health consumers suffer from chronic medical illnesses. However, few organizations have made substantial progress towards meaningful collaboration and integration. Established groups and programs have found the different locations, separate funding streams, dissimilar practice models, and distinct health care cultures of behavioral health and primary medical care have posed barriers that are too difficult to overcome. In addition, many behavioral health organizations are in the public sector, while most primary care is in the private sector, and each sector involves separate responsibilities and regulations.

The Approach:

Region Ten and Martha Jefferson realized the challenges that integration posed, but early on they had come to the conclusion that integration of behavioral health and primary care was important if they were to provide the best service for their patients, consumers, and community. They also recognized that the success and sustainability of their organizations were best served by collaborating to integrate their separate services. Region Ten was in a position of stagnant funding, and Martha Jefferson had recently evolved from being an independent community medical center to merging with a regional hospital and healthcare system. Region Ten at the time was renovating an existing building (the Peterson Building) and used this as an opportunity to design an integrated care clinic from the ground up. HMA created a multi-layer infrastructure to start organizing and attacking this work. HMA first began work by forming a leadership team that drew together key people from each organization to guide the overall integration project.

This leadership group accomplished the following work:

- Staff and leadership inclusion and buy-in from both organizations.
- Met monthly for 3-4 hours.
- Set a vision of an integrated care center designed, implemented and staffed through a collaborative team process.
- Realizing the vast differences between a mental health authority and an independent health system with a primary care group, a multi-disciplinary operations team was formed, and HMA facilitated a process of collaborative learning and growing of two distinct cultures into a new integrated culture and care delivery model.
- Developed and charged an operations team to work on the details of an action plan for pulling together this integrated care clinic.
- Developed an MOU (memorandum of understanding) between the two independent organizations as recognition of the commitment; it served as a guide for them on an agreement for working together, role distinctions, financial sharing and autonomy, operational tasks, and overall implementation responsibilities.
- Approved a collaborative organizational and oversight structure.

- Reviewed the different revenue streams of each other and emerging opportunities for funding in new state and federal programs for sustainability planning of the program.
- Heard progress from the operations group monthly, provided guidance, and worked through barriers to progress as they could.

The next layer of work was HMA facilitating and guide the newly created operations team. This work went on simultaneously with the leadership oversight group and provided the following milestones and accomplishments:

- Through a thorough review of current patient workflows in each setting, a shared understanding of each organization emerged. Each partner had very different patient populations but with identified needs that crossed both organizations scope of work. There were recognized differences in types of care delivered, approaches to those types of care, language differences, different workforce categories and staff responsibilities, and overall structure/model.
- Subsequently a new shared model was developed, a new workflow for a patient through the integrate clinic was formed, and work proceeded to move from a concept to a clinic.
- The operations team and its subgroups took on tasks such as defining the population of greatest need for this integrated clinic, creating new ways to market to this defined population, and determining size of practice and staffing.
- A sub-group was formed to specifically review each organization's policies and procedures that overlapped with the new shared work.
- Workforce competencies, cross-training, and orientation for new staff within the integrated care clinic were developed.
- Much attention was given to providing integrated care management and the coordination of that with behavioral health case management.
- New clinical and other necessary staff were hired or reassigned to the integrated clinic and were trained and oriented to its operation.
- Shared clinical information is a constant issue that comes up when designing and implementation an integrated care model. The two organizations were separate, independent organizations, coming together for a shared, integrated work product through an MOU. They needed to maintain their two separate electronic medical records, but they worked together to create administrative rights for the care team co-managing shared patients, to provide cross-training for staff on scheduling programs, and to set up Business Associate Agreements and Data Use Agreements for a clear policy for sharing data when needed for patient care and quality improvement purposes.
- Marketing materials and signage was developed within an outreach plan to draw patients to the integrated care clinic.
- Performance metrics were established, and goals for patient caseload within the integrated clinic were also developed as markers for progress and success.

The Results:

HMA completed the contractual work in December of 2014. In January of 2015, the HMA team attended the ribbon-cutting and grand opening for the integrated care clinic. The clinic had opened a few weeks prior (soft opening) and already had several integrated care clinic patients. They reported to us on how differently their team interacts with each other and their patients, and they noted that the response thus far from the patients has been very positive. HMA will be going back to them within the next few months to get an additional update on the progress towards their goals and overall feedback.

HMA Contact(s):

Nancy Jaeckels Kamp
Principal
nkamp@healthmanagement.com
(312)641-5007 x635

Terry Conway, MD
Managing Principal
tconway@healthmanagement.com
(312)641-5007 x612