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.

“CAN WE TALK?”

“History repeats itself, opportunity doesn’t!”
A Community Well-Being Program Is Needed

"Don't blame yourself, Mom. It takes a village to raise a child."
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.
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

Outcomes (Quadruple Aim)
- Experience of Care
- Population Health
- Readiness
- Per Capita Cost

Specialist
Specialist Pain
Specialist BH
Specialist Nutrition
Specialist Pharmacist
Specialist Addiction

ACO
PCM
Patient Family
CCP In EMR
Care Centered on the Person and Their Identified Team(s)

ONE HEALTH PLAN!
(Managed by the Person and their Identified Team!)

The Person/ ‘Family’
Primary Care-Education Team
Specialty Teams
Administrative Support Teams
Support Services Teams

IMPORTANT!
Include "Family" as part of the team!
(Don’t ‘hide’ behind HIPAA!)

Information flows out from and back to Primary Care Team.

Requires Ownership, Knowledge, and Service Mentality!

CONSIDER: WHO ‘WORKS’ FOR WHO?
Patient-Centered ‘Service’ Approach
Inclusive and Integrated

Always ask…”who’s the patient?”
(with three fingers pointing back at us!)

The Patient (Family)
in “Med Home” Center

Military Practitioners

Primary Care Teams Continuity

Training/ GME Education

Specialty Care Services Acute-Crisis

Non-Military Practitioners

Timely Appointing/ Referral
Follow Up, Care Coordination, Case Management

A Medical Home Team!

Integrated ‘Virtual’ Team

A Collaborative Community Approach

Community-Network Education

COL-RET George D. Patrin, MD, Pediatrician, MHA, 210-833-9152, patrin.george@gmail.com
Savings will be derived from decreasing demand by improving the population’s health.

POPULATION HEALTH IMPROVEMENT (PHI)
Use every team member to improve health at every visit!

MANAGE COST  MANAGE HEALTH
The Health, Disease, Cost Continuum

y₁ = Population, millions

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

y₂ = Cost ($) in Dollars

20% GDP?

Primary Prevention  Secondary Prevention  Tertiary Prevention

Health  Risk  Signs  Symptoms  Illness  Disease

Population Health Management

PREVENTION  INTERVENTION

Manage Health  Manage Cost

™  2011, Patrin, MD, Pediatrician, MHA, 210-833-9152, patrin.george@gmail.com
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 (with 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%
Clinical Access To Care – “First Things First” Support Your Local Healthcare Team(s) (after all, they are the ones seeing the patients!)

1. **DEMAND** (Population)
   - Patient Family Team (Customer)

2. **SUPPLY** (Resources/Gaps)
   - Employee/Healthcare Team Ownership

   - Leadership Support
     - “Center of Gravity”

3. **BUSINESS PROCESSES** (Integration/Coordination)

   **HEALTHCARE PROCESS(ES)**
   - Cost-based or Value-based system?

4. **OUTCOMES** (Quality Results)
   - Health Patients & Families

**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)

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

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

Re-train ALL to work at the top of their respective license!
Providers VALIDATE!
(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
Re-Engineer (Optimize), via Focus Areas 3 & 4

**Patient Encounter Process**

- **RECEPTION:** Check In, Chief Complaint(s)
- **MED TECH:** Check Vitals, HPI, PMH
- **PROVIDER:** (V-HPI), (V-PMH), PE, Orders, Consults, (Education), (V-F/U Plan)
- **RN:** Education, Procedure(s), Follow-Up Plan
- **MED TECH/LPN:** Check Out (V-F/U Plan)

Remove the Provider:Patient ‘bottleneck.’
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
“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.”
“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

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<tr>
<th>Specialty</th>
<th>RN</th>
<th>LPN</th>
<th>NA</th>
<th>Med Clerk</th>
<th>Total Ratio</th>
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<td>0.6</td>
<td>0.9</td>
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<td>0.6</td>
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<td>0.9</td>
<td>0.5</td>
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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

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<tr>
<th>PCMs</th>
<th>Asgd/ Hired</th>
<th>FTEs</th>
<th>SUPPORT STAFF</th>
<th>Asgd/ Hired</th>
<th>FTEs</th>
<th>SPT Staff Ratio</th>
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<td>91W/LPN/LVN/NA</td>
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<td>NPs</td>
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<td>Med Clerk</td>
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<tr>
<td>Total</td>
<td>32</td>
<td>28.25</td>
<td>Total</td>
<td>80</td>
<td>71.4</td>
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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!")**

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<tr>
<th>Appointment Type</th>
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<th>Follow Up/Recurring/Routine</th>
<th>Established/Chronic/PE</th>
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<td>Head Trauma</td>
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<tr>
<td>(Loss of Consciousness)</td>
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**Emergency?** - Call 911 or Connect Caller to RN or Doctor On-Call if:

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

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**

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<th></th>
<th>10 - 30 Minutes</th>
<th>10-40 Minutes</th>
<th>30-50 Minutes</th>
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Managing Health...or Cost?
Know resourcing model = ‘Closed’ or ‘Open’ System?

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

Primary Care/ Prevention/ PCMH

Capitated per Patient:   *Maximize Enrollment       *Minimize # Visits

Achieve Health Care System Equilibrium!
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


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
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
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=CdCrPBgQALc)
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 Severely Affected Children
Veteran Humanitarian Clowning

PILOT TRIP TO GUATEMALA CITY
Day 5, Oct 15 – Gig #8 - Hillslide Refugee Camp
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.”
“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

**CLOWN VETS**

A DOCUMENTARY BY **ESTEBAN ROJAS**
Let’s begin with the end in mind – manage health and cost!
Provide Universal Integrated HEALTH Care!

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gpatrin@serendipityalliance.org
Cell 210-833-9152
References

- J. Foy. 2015. The Medical Home and Integrated Behavioral Health. Pediatrics 2015;135;930; Published Online
- Collaborative Family Healthcare Association, CFHA.net
# Staffing Ratios by Specialty

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<th>SPECIALITY</th>
<th>1 PROVIDER PER AOC</th>
<th>SUPPORT PER POP OF</th>
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<td>61U</td>
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<td>NUTRITION</td>
<td>65C</td>
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<td>ANESTHESIA</td>
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<td>PRIMARY CARE</td>
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COL-Ret George D. Patrin, MD, Pediatrician, MHA, 210-833-9152, patrin.george@gmail.com
# Access To Care BPR
## Provider Team Training

## Clinic Business Process Reengineering Teaching Plan

<table>
<thead>
<tr>
<th>Time</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
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<tr>
<td>800</td>
<td>CMD In-Brief</td>
<td>Clinic Visits</td>
<td>Clinic Visits</td>
<td>Mgmt Office Visits</td>
<td>IM/IT</td>
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<td>MTF Orientation</td>
<td>Process Review</td>
<td>Process Review</td>
<td>(Business Processes) and (Outcomes, Tools)</td>
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<td>TMC(s) Tour</td>
<td>(Employee Focus)</td>
<td>(Patient Focus)</td>
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<td>Process Follow-Up</td>
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<tr>
<td>1300</td>
<td>Teaching activities with Primary Care Staffs</td>
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<td>1330</td>
<td>Overview of Optimization</td>
<td>Clinic BPR: CSD</td>
<td>Access: CSD, QM</td>
<td>Quality Concepts/Tools: PAE/POP/PM/SM</td>
<td>Intro to Templates: (IM/IT)</td>
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<td>Pop Health Initiative</td>
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<td>Best Practices</td>
<td>CGPGs</td>
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<td>Your MTF's Performance</td>
<td>Brainstorming</td>
<td>Results/Outcomes</td>
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<td>ICDB/MEDBASE</td>
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<td>Avail. MEDCOM Support</td>
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<td>Patient Follow-Up</td>
<td>Final Brainstorming</td>
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<td>Satisfaction/QM</td>
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<td>Finalize Action Plan</td>
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