Medical Home Telephone Conference
March 28, 2006

Lisa Samson-Fang, MD and Brenda Reiss-Brennan IHC Mental Health Integration Project.

Brenda Reiss-Brennan is a nurse practitioner by training and has been integrating mental health into primary care practices since 1998 for Intermountain Health Care. She has been integrating since 1984 and integrated her family therapy practice into a medical family practice out in West Jordan. Some great lessons have been learned and some great successes to share with us.

Even though this model started with intermountain health care it is really a community model and we have designed a process by which any patient and family that is coming into a primary care practice gets the same treatment process. Only about 30% of the patients that come into any one clinic have IHC health plan. There are Medicaid patients. There are uninsured patients. We've just started up in one neighborhood clinic where we have families that speak about 20 different languages, We're also working with the department of health in terms of really organizing as a community how do we reach as many families as possible, and then how do we deal with the barriers of lack of resources and how do you afford to do this.

The clinical model begins with the primary care provider, their support staff, the patient and the family; they are at the center. If you were looking at diagram you'd see them in the focus. What we've been able to do is wrap around them through our mental health integration team, a care manager; you have care coordination. We have nurses available by phone or on site that provide care management follow-ups. In our neighborhood clinic, this is actually the receptionist that does this, because she does most of the follow-ups in that practice anyway. Also on the team we have an APRN or a psychiatrist, an APRN is a nurse practitioner like myself, that prescribes medication or gives medication consults as well as diagnostic clarification on mental health issues. Then on the team we also have a talking therapist, that can either be a PhD, a social worker, a licensed professional counselor. We also have on the team our consumer advocacy groups, (NAMI National Alliance for the Mentally Ill, CHAD the advocacy group for adults and children with ADHS), these community teams actually provide family mentors that are linked up to our clinics that can help families that come in if they choose not to do medication or therapy or they can't afford that then we fill that gap in with already existing services and link them through. So that describes everybody that is on the team.

The way the process works is that families come into the clinic and the primary care provider identifies the mental health issue. We train the primary care doctors and their support staff, the receptionist, the MA's, everybody that works with the

families, how to screen and how to be culturally sensitive to mental health issues walking in the clinics. Even though they are already dealing with them it doesn't mean they are comfortable dealing with them. We do training and help them get set up for that. As the patients come through they say something simple like "You know, I think there is something more going on here" or "This isn't getting better, let's fill out this mental health packet and see if we can really get to the bottom of this". I must say in our pediatric practices it is a rare occasion for parents not to fill out the mental health packets that are available for them. They will sit in the office, they are usually in dire need to find out what is going on with their family or their child and they want help. The mental health packet is on the website under primary care clinical programs and mental health integration. There is both an adult and child packet.

The way this process works is then the doctor and the family go over the details of what is in the packet so the families responsibility is to give us as good a self report as they possibly can, and it's basically a mental health x-ray It covers biological risk, environmental risk, and then specific measures for ADHD, depression, anxiety etc… Then the physician and the family look at it together and the physician says oh I think I know what's going on here, I'm going to treat this myself and use the training and the tools that I have. Or if it's a moderate risk then they involve the care coordinator or care manager to help assist, that is the minimum standard and then if it is something that has a more severe level of need that is when they call in the mental health specialist to take a look. It kind of flows in a cascade and the care manager and the mental health specialist are there to support the primary care doctor and the team.

Q: What practices are you integrated in right now?
A: There will be a map given at the retreat on Friday. There are six stages, so some clinics are in mature phases and some clinics are just starting but there are over 20 practices. We have a mission to do it in all the primary care practices, our intermountain medical group is committed to having this available to all of practices. The way we can do this, we've been able to build an economic model while we are building this great treatment cascade and I've just explained the treatment cascade.

Q: In the practices that have this, does the patient have to be IHC?
A: No

Q: Is there anyone on the call that is part of this model?
A: All of the IHC practices: IHC Sandy (beginning), IHC MCKay-Dee (Advanced), and Budge Clinic (beginning).

Q: How can I become involved?
A: Some of our IHC practices are out in the cold. They don't have any care managers or mental health people so what they are doing are Use the tools and come to our primary care learning days, there is one coming up on May 04,

2006, Brenda will be presenting mental health integration, they also do up-to-dates on diabetes and asthma and others. The physicians that come to these are offered, if they would like to use the tools and try them in their practice they can fax the packets up to our central office and Brenda will review them and do a 5-10 minute consult on the phone with them about the patient they are evaluating. Anyone can call Brenda for a consult you do not have to be an IHC practice. It's best to access the tools through the primary care learning days and you do not have to be an IHC practice.

Q: If we decide to go to the learning days and use these tools and called you about a patient, what can we expect that you might help us with?
A: Typically, I would walk you through what the scores mean in the packets, and then I would coach you on the next step that you should take.

Q: So you would coach on us whether we could go ahead a treat this in our primary care setting with certain medicines or whether we should refer this patient and help out where to refer this patient?
A: Yes, this helps get our thoughts organized and figure out what we should do, but this is really just a bandaid, the better solution is to continue talking to the Utah Department of Health and actually build a collaborative pilot so that we can help you all get the teams you need set up in your setting so that we can teach them how to do it.

Q: So in the long run you would like to see teams who come out to practices who can then evaluate these patients?
A: Right, and if we do get our grant funded we'll be helping Barbara and Dr. Delavan really look at the medical home clinics and take a couple of those clinics and say ok, if we were to expand the mental health integration to the medical home model, what would that look like, and how would we do that and we would actually set up a measurement system.

What is there already to support us, it sounds like the use of the packets to have families fill out to be able to assess the issues that are going on and then input from a consult to help us understand that and decide where to go with that information, is what is available to a majority of us that are on the phone.

Q: How often do you have the learning days?
A: Dr. Canon is in charge of those. They are about 6 times a year, all over the state, and we've got one coming on May 04, 2006, and one coming up in Logan and we just completed one in St. George.

Q: When is the one in Logan?
A: Not sure but you can find out by contacting Dr. Cannon's secretary Cami Kreuger at 801-442-2990.

Q: I'm looking at the website and I see that you have some stuff on evaluating depression and then you have your ADHD care process model, which I don't know if other people have used but I have used it a lot and found it very helpful, particularly the Vanderbilt being readily accessible, are there other specific mental health issues that you have in addition?
A: Yes, there is a tab for mental health integration.
Click the primary care guide and this explains the packet and what every score means. Like lab values, so if the patient put down five somatic complaints what does that mean.

I see a tab on adolescent baseline packet that looks like it has a cover letter, a paper to record your history and physical, a Vanderbilt, a home and home and care scale, a developmental disorder rating scale (used to screen for aspergers and autism), depression rating scale, a mood regulation scale (used for bi-polar), anxiety post-traumatic stress rating scale, a parent screen and family rating scale (used to screen for paternal and maternal depression). The family rating scale helps the family self-report their natural style in engaging in helping and what's the likelihood they are actually going to be able to follow through in self-management on the things we ask them to do to manage their disease.

Then I see a baseline school packet which is primarily the Vanderbilt with a cover letter, and then there are some follow-up scales to use with any of those, so if evaluated anxiety or depression and you had certain rating and you treated it you can use the follow-up scales. Then we've repeated some of the baseline information like on chronic pain and sleep and then there's a checklist for medication side effects.

In summary for people on the line, I see sort of a global packet that will let you look at depression, bi-polar, anxiety, post-traumatic stress, ADHD, family factors that are contributing to all that. Turn to the primary care guide on the very last page, you will see all possible summary scores and based on the response of all those you either have mild, moderate or severe level of need. Mild/moderate is being scored for somatic problems, chronic pain, sleep problems, environmental stressors, anxiety, depression, ADHD, all those things and then you come up with the actual diagnoses. At the bottom are the different buckets of what should I do. Should I use the care manager, should I do the patient ed material, do I get a consult, should I screen for suicide risk and danger, should I send them to the ER.

To me these are the tools to allow a primary care doctor to efficiently do a thorough an initial evaluation. Something will you probably want to do in a couple visits is meet with the family, give them the information to fill out, have them get it back to you, score it, meet back with them to decide where to go. There are varying ways in the implementation part of it.

Q: Are these available in Spanish on the website?

A: They are being translated into Spanish, I'm not sure if the packets done yet, but I think the patient education material is done. You can order these directly. There are 5 different patient handouts you can use right now even if you don't use the tools.

Q: There is a link to pediatric psychiatrists, are these primarily IHC?
A: Yes, and that's not part of our mental health integration, that's part of what IHC does.

There are good tools that will be helpful to our practices, there are some good education materials as well. We have the opportunity to go to the education days We also have access to Brenda.

Q: How are you going about trying to measure the effectiveness of these interventions?
A: We have four different areas of outcomes. One is detection, we are tracking on all of the practices, we also built a mental health integration registry. The MHI registry is different because it is not just IHC health plans it is a clinical program registry. Just built one for depression and will break that down into anxiety, ADHD, bipolar and anxiety for both kids and adults.

Q: What do you track with that registry?
A: They way you get into the registry is you have to have a diagnoses that has been billed, the doctor has had to put that diagnoses on their medical records, then they also have to have filled a script for that diagnosis, and then we've also added a clinical outcome so for adults it's the PHQ9 and for ADHD it will be the Vanderbilt and all of this is building as we move forward.

Q: What is the goal of the registry?
A: The goal of the registry is to follow the patients over time, to link the mild, moderate risk clinical care process cost data to that. Did patients in the mild/moderate bucket really get better and what did that cost. Are you identifying the right level of resource needed to get those patients and families better? And then for us to be able to assess as a community, well it looks like these care managers and care coordinators are really worth it, they follow up with patients, they get them to where they want to go. Whose going to pay for those and how are we going to pay for those as a community? Right now, IHC's medical group has decided they are part of their clinic budget. But that's not available to the one and two man physicians that are out there. The other is satisfaction. Both physician and patient satisfaction. And then the clinical outcome (are patients getting better? are kids going back to school? etc…).

Are there any mental health topics for future conference calls?
Bi-polar
Medications
First lines of treatment in primary care

Anxiety
Relationship between anxiety and OCD

Attendees: Lisa Samson-Fang, Barbara Ward, Brenda Reiss-Brennan, Lisa Lee, Wendy Hobson, Robert Terashima, Val Jones, Kendra Tortalita, Gladina Yanito, Donna, Fred, Lois.

Next conference call: April 25, 2006