Evidence-based Integration: A Step-by-Step Guide to Integrating Behavioral Health into the Primary Care Setting

Speakers:
Lori Raney, MD, Principal, HMA
Nancy Jaeckels Kamp, Principal, HMA

Moderator:
Carl Mercurio, HMA Information Services

September 22, 2015
How are we doing?

“T’m afraid you’ve had a paradigm shift.”
How many of these people with behavioral health concerns will see a mental health provider?

No Treatment

Primary Care Provider

Mental Health Provider (psychiatric provider or therapist)

Wang P, et al., Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005
Mental Illness and Mortality

Mortality Risk:
2.2 times the general population

10 years of potential life lost

8 million deaths annually

# Annual Per Person Cost of Care

**Common Chronic Medical Illnesses with Comorbid Mental Condition**

**“Value Opportunities”**

<table>
<thead>
<tr>
<th>Patient Groups</th>
<th>Annual Cost of Care</th>
<th>Illness Prevalence</th>
<th>% with Comorbid Mental Condition*</th>
<th>Annual Cost with Mental Condition</th>
<th>% Increase with Mental Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Insured</td>
<td>$2,920</td>
<td></td>
<td>10%-15%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td>$5,220</td>
<td>6.6%</td>
<td>36%</td>
<td>$10,710</td>
<td>94%</td>
</tr>
<tr>
<td>Asthma</td>
<td>$3,730</td>
<td>5.9%</td>
<td>35%</td>
<td>$10,030</td>
<td>169%</td>
</tr>
<tr>
<td>Cancer</td>
<td>$11,650</td>
<td>4.3%</td>
<td>37%</td>
<td>$18,870</td>
<td>62%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$5,480</td>
<td>8.9%</td>
<td>30%</td>
<td>$12,280</td>
<td>124%</td>
</tr>
<tr>
<td>CHF</td>
<td>$9,770</td>
<td>1.3%</td>
<td>40%</td>
<td>$17,200</td>
<td>76%</td>
</tr>
<tr>
<td>Migraine</td>
<td>$4,340</td>
<td>8.2%</td>
<td>43%</td>
<td>$10,810</td>
<td>149%</td>
</tr>
<tr>
<td>COPD</td>
<td>$3,840</td>
<td>8.2%</td>
<td>38%</td>
<td>$10,980</td>
<td>186%</td>
</tr>
</tbody>
</table>

Cartesian Solutions, Inc.™--consolidated health plan claims data

**Melek S et al APA 2013**

[www.psych.org](http://www.psych.org)
# Integration Environmental Drivers

## ACA

- **Insurance Expansion**
- **Triple Aim Initiatives** – better outcomes, lower costs, better experience of care
  - Innovation Grants
    - Collaborative Care
  - Payment Structures
- **Behavioral Health Homes** – SPAs
- **Expand CHC**
- **Expand PBHCl**

## Other

- **IOM Report** - Crossing the Quality Chasm: There will be no quality health care unless mental health and substance use are integrated into primary care
- **6 of the required Medicare ACO quality measures are around behavioral health**
- **NCQA PCMH** – 2014 standards
- **HEDIS decision** to phase in new depression outcome measures
- **CMS – CCM fee** and proposed ruling for depression
- **Joint Commission** required quality measures as of 2011 on universal screening (tobacco, alcohol, and behavioral health)
NCQA PCMH Standards 2014  =  BH

NCQA 2011

PCMH Standard 1: Enhance Access and Continuity
• Comprehensive assessment includes depression screening for adolescents and adults

PCMH Standard 3: Plan and Manage Care
• One of three clinically important conditions identified by the practice must be a condition related to unhealthy behaviors (e.g., obesity) or a mental health or substance abuse condition.

PCMH Standard 5: Track and Coordinate Care
• Track referrals and coordinate care with mental health and substance abuse services

NCQA 2014

• Program Structure (QI 1)
  – Does the QI program specifically address behavioral health?
  – Is there a physician and behavioral health practitioner involved in the QI program?

• Accessibility of Services (QI 5)
  – Can members get behavioral health care when they need it?

• 7. Complex Case Management (QI 7)
  – Does the organization assess the characteristics and needs of its member population (including children/adolescents, individuals with disabilities and individuals with SPMI)?
  – Are the organization’s case management systems based on sound evidence?

• 9. Practice Guidelines (QI 9)
  – Does the organization adopt evidence-based practice guidelines for at least two medical conditions and at least two behavioral conditions with at least one behavioral guideline addressing children/adolescents?

• 11. Continuity and Coordination Between Medical and Behavioral Health Care (QI 11)
  – Does the organization annually collect data about opportunities for coordination between general medical care and behavioral health care?
  – Does the organization collaborate with behavioral health specialists to collect and analyze data and implement improvement of coordination of behavioral health and general medical care?

• 1. UM Structure (UM 1)
  – Is a behavioral health practitioner involved in the behavioral health aspects of the program?
Range of Opportunities for Collaborative Care

- Treat Behavioral Health in Primary Care Settings
- Treat General Medical Conditions in Behavioral Health Settings
- Medically Complex Patients
- ICU/Med/Surg
- Emergency Room
Clarify terms:

• **Integrated Care** – addressing physical and behavioral health conditions concurrently in various settings- primary care, community mental health centers, inpatient, ERs, etc. Many “models” – many not evidence-based but have merit

• **Collaborative Care** - often used interchangeably with the term integrated care. It’s how we interact with other disciplines. Sometimes used as shorthand for the Collaborative Care Model

• **THE Collaborative Care Model** – pioneered by Wayne Katon, has the most robust evidence base of any approach in primary care settings for addressing depression and other psychiatric disorders. Specific core features, psychiatric consultation needed to reach outcomes, allows accountability for outcomes and cost
Levels of Integration

<table>
<thead>
<tr>
<th>Coordinated</th>
<th>Co-located</th>
<th>Integrated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LEVEL 1</strong></td>
<td><strong>LEVEL 2</strong></td>
<td><strong>LEVEL 5</strong></td>
</tr>
<tr>
<td>Minimal Collaboration</td>
<td>Basic Collaboration at a Distance</td>
<td>Close Collaboration Approaching an Integrated Practice</td>
</tr>
<tr>
<td><strong>LEVEL 3</strong></td>
<td><strong>LEVEL 4</strong></td>
<td><strong>LEVEL 6</strong></td>
</tr>
<tr>
<td>Basic Collaboration Onsite</td>
<td>Close Collaboration Onsite with Some Systems Integration</td>
<td>Full Collaboration in a Transformed/Merged Integrated Practice</td>
</tr>
</tbody>
</table>

Definition of Collaborative Care

• Collaborative Care is a specific type of integrated care that operationalizes the principles of the chronic care model to improve access to evidence-based mental health treatments for primary care patients.

• Collaborative Care is:
  – **Team**-based collaboration and Patient-centered
  – **Evidence**-based and practice-tested care
  – **Measurement**-based treatment to target
  – **Population**-based care

  – **Accountable** care
The Chronic Care Model

Community
- Resources and Policies
  - Self-Management Support

Health Systems
- Organization of Health Care
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Improved Outcomes

Developed by The MacColl Institute
© ACP-ASIM Journals and Books
The Collaborative Care Model

**Effective Collaboration**

- Informed, Activated Patient
- PCP supported by Behavioral Health Care Manager

**PRACTICE SUPPORT**

- Measurement-based Treat to Target
- Psychiatric Consultation
- Caseload-focused Registry review
- Training
Doubles Effectiveness of Care for Depression

50% or greater improvement in depression at 12 months

Unützer et al., JAMA 2002
Building More Effective Models: Collaborative Care

Research Evidence Over 80 Randomized Controlled Trials


Collaborative care is consistently more effective than care as usual.
Collaborative Team Approach

- **Patient**
- **PCP**
- **BHP/Care Manager**
- **Consulting Psychiatric Provider**
- **Other Behavioral Health Clinicians**
- **Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources**

**Core Program**

**New Roles**

**Additional Clinic Resources**

**Outside Resources**
Components to a Collaborative Care Model

New processes, tools and roles:

1. Consistent method for assessment/monitoring (PHQ-9)
2. Presence of tracking system (registry)
3. Stepped care approach to intensify/modify treatment
4. Self-management skills and relapse prevention
5. Care manager for follow up, support, care planning and coordination
6. Consulting psychiatrist for caseload review and primary care team support

*Based on the Collaborative Care Model for depression by Wayne Katon, MD and the IMPACT study by Jurgen Unutzer, MD as well as numerous other controlled trials.
Tools for collaborative care

- Population health management
- Registries
- Care alerts and tracking systems
- Care plans used by integrated care team
- Protocols and treatment guidelines
- Self-management skills and tools
- Embedded in the PCMH model of team-based care, huddles, systematic case reviews, etc.
- Using measures to drive stepped care
Importance of Early Detection

• Issues with depression and substance abuse must be pre-empted, rather than treated once advanced.

• Goal is to detect early and apply early interventions to prevent from getting more severe
Screening Tools as “Vital Signs”

• Behavioral health screeners are like monitoring blood pressure!
  - Identify that there is a problem
  - Need further assessment to understand the cause of the “abnormality”
  - Help with ongoing monitoring to measure response to treatment
# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**NAME:** John Q. Sample  
**DATE:**

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use “✓” to indicate your answer)

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>Almost 1 day</th>
<th>More than 1 day</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>✓</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>✓</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>✓</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>✓</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>✓</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>✓</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>✓</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>✓</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself in some way</td>
<td>✓</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Total:** 15

*Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.*

**10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

<table>
<thead>
<tr>
<th>Difficulty</th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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## Registries to Track Progress

<table>
<thead>
<tr>
<th>Patient ID</th>
<th>Population</th>
<th>Date Enrolled</th>
<th>Status</th>
<th>Tools</th>
<th>Logout</th>
<th>Search Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>3400011</td>
<td>U</td>
<td>12/14/2010</td>
<td>L1</td>
<td>17 13 10 24</td>
<td>4/14/2011</td>
<td>0</td>
</tr>
<tr>
<td>3400016</td>
<td>U</td>
<td>1/20/2011</td>
<td>L1</td>
<td>10 5 16 4</td>
<td>4/21/2011</td>
<td>2</td>
</tr>
</tbody>
</table>

 AIMSCenter: [http://aims.uw.edu](http://aims.uw.edu)
Stepped Care Approach

1° Care

1° Care + BHP

Psychiatric consult (Face-to-face)

BH specialty short term tx

BH specialty long term tx

Psychiatric Consultation

Psychiatric Inpatient tx
“Warm Hand Off”
BHPs/Care Managers - Hire the Right Person

Who are the BHPs/CMs?
- Typically MSW, LCSW, MA, LPN, RN
- Variable clinical experience – need brief intervention skills

What makes a good BHP/CM?
- Organization
- Persistence - tenacity
- Creativity and flexibility
- Enthusiasm for learning
- Strong patient advocate
- Willingness to be interrupted
- Ability to work in a team

CAUTION:
Traditional Approach to therapy
Not willing to be interrupted
Timid, insecure about skills

PLEASE INTERRUPT ME!
Experts in Behavior Change
# Task Sharing Behavioral Health

<table>
<thead>
<tr>
<th>Behavioral Health Provider (BHP)</th>
<th>Function Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BHP 1. Paraprofessional Staff (Behavioral Health Aid, Community Health Worker, MA, etc).</strong></td>
<td>Behavioral health screening, entering and tracking data in registries, health promotion of diet, sleep hygiene, tobacco cessation, nutrition and weight control, etc.</td>
</tr>
<tr>
<td><strong>BHP 2. Paraprofessional with advanced training</strong></td>
<td>Brief interventions (motivational interviewing, solution focused intervention, etc.) for individuals with situational distress or with scores on PHQ-9 less than 15 or individuals who need for basic education on health changes (e.g., sleep, diet, tobacco, etc.)</td>
</tr>
<tr>
<td><strong>BHP 3. Licensed Provider with Behavioral Health Expertise (LCSW, PhD, RN, etc) (Can be engaged via telemedicine).</strong></td>
<td>Diagnostic clarification, brief intervention for higher need clinical cases (e.g., PHQ-9 above 15 or positive for suicidality, positive SBIRT screen, etc.) or high risk populations (youth, individuals with more complex mental health diagnoses).</td>
</tr>
</tbody>
</table>
## Psychiatric Providers: Caseload Consultant

### Availability to Consult Urgently

- Medication recommendations
- Diagnostic dilemmas
- Complex patients
- *Pattern recognition***
- *Education***
- *Build confidence and competence***

### Caseload Reviews

- Scheduled (weekly, etc)
- Prioritize patients that are not improving – *extend psychiatric expertise to more patients in need*
- Make recommendations that are relayed to PCP – may or may not implement depending on clinical situation and comfort level
### Prioritizing Cases in the Registry

<table>
<thead>
<tr>
<th>Patient</th>
<th>Caselead</th>
<th>Program</th>
<th>Tools</th>
<th>Logout</th>
</tr>
</thead>
<tbody>
<tr>
<td>#</td>
<td>#</td>
<td>#</td>
<td>#</td>
<td>#</td>
</tr>
<tr>
<td>MLITTS ID</td>
<td>POPULATION</td>
<td>DATE ENROLLED</td>
<td>STATUS</td>
<td>DATE</td>
</tr>
</tbody>
</table>

Population: 6 - GA-U, U - Uninsured, V - Veterans, F - Veteran Family Members, M - Moms, C - Children, B - Older Adults, 1 - CMH

- Red: Last recent score is below 10 and has not improved by 5 points from the initial assessment score.
- Yellow: Shows a 5 point improvement from the initial assessment score to the most recent score but most recent score is still below 10.
- Green: Most recent score is above 10.

AIMS Center 2011, [http://aims.uw.edu/](http://aims.uw.edu/)
## Sample Consultations ~ 30 min

<table>
<thead>
<tr>
<th>REASON FOR CONSULT</th>
<th>DIAGNOSIS</th>
<th>RECOMMENDATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Side effects from lithium</td>
<td>BP 1</td>
<td>Switch to valproic acid</td>
</tr>
<tr>
<td>SE from lisdexamfetamine</td>
<td>ADHD</td>
<td>Try another per protocol</td>
</tr>
<tr>
<td>Lithium level is 1.2</td>
<td>BP 1</td>
<td>Continue unless having side effects</td>
</tr>
<tr>
<td>Inc depression symptoms</td>
<td>MDNOS</td>
<td>TSH, if normal start lamotrigine</td>
</tr>
<tr>
<td>Poss SE from quetiapine</td>
<td>BP 1/PD</td>
<td>Decrease Seroquel to 100 mg</td>
</tr>
<tr>
<td>Paroxetine not effective</td>
<td>MDD</td>
<td>Add bupropion</td>
</tr>
<tr>
<td>Regular lamotrigine or XR?</td>
<td>BP 2</td>
<td>No difference</td>
</tr>
<tr>
<td>Side effects with citalopram</td>
<td>MDD</td>
<td>Switch to bupropion</td>
</tr>
<tr>
<td>Depression symptoms increase</td>
<td>BP 1</td>
<td>Check lithium level first, maximize if low, may need to add lamotrigine</td>
</tr>
<tr>
<td>Suicidal, acute distress</td>
<td>PD</td>
<td>Safety plan, DBT referral</td>
</tr>
<tr>
<td>High doses of meds, confused</td>
<td>MDD</td>
<td>Stop hydroxyzine, reduce lorazepam, call collateral</td>
</tr>
<tr>
<td>Anxious, wants alprazolam, nipple pain</td>
<td>GAD</td>
<td>No alprazolam, increase sertraline, coping skills</td>
</tr>
</tbody>
</table>
Experimenting with Delivery Telemedicine

Telemedicine-based team:
- Nurse care manager - phone
- Pharmacist – phone
- Psychologist – CBT - televideo
- Psychiatrist – televideo if did not respond to trial to 2 antidepressants
- Weekly – whole team met to make recommendations

How to Pay for This?

- Contained systems: Veteran’s Administration, Kaiser, Indian Health Service, Department of Defense
- Case rate payment: for care management and psychiatric consultation
- CMS – PFS – new CPT codes for physician services
- PMPM- DIAMOND
- Global Capitation
- Partially Capitated: PCP bills FFS and clinic gets paid for care management resources
  - Washington State Mental Health Integration Program – P4P incentive
## Business Case: Reduces Health Care Costs

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>4-year costs in $</th>
<th>Intervention group cost in $</th>
<th>Usual care group cost in $</th>
<th>Difference in $</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPACT program cost</td>
<td></td>
<td>522</td>
<td>0</td>
<td>522</td>
</tr>
<tr>
<td>Outpatient mental health costs</td>
<td>661</td>
<td>558</td>
<td>767</td>
<td>-210</td>
</tr>
<tr>
<td>Pharmacy costs</td>
<td>7,284</td>
<td>6,942</td>
<td>7,636</td>
<td>-694</td>
</tr>
<tr>
<td>Other outpatient costs</td>
<td>14,306</td>
<td>14,160</td>
<td>14,456</td>
<td>-296</td>
</tr>
<tr>
<td>Inpatient medical costs</td>
<td>8,452</td>
<td>7,179</td>
<td>9,757</td>
<td>-2578</td>
</tr>
<tr>
<td>Inpatient mental health / substance abuse costs</td>
<td>114</td>
<td>61</td>
<td>169</td>
<td>-108</td>
</tr>
<tr>
<td><strong>Total health care cost</strong></td>
<td><strong>31,082</strong></td>
<td><strong>29,422</strong></td>
<td><strong>32,785</strong></td>
<td><strong>-$3363</strong></td>
</tr>
</tbody>
</table>

### Savings

ROI

$6.50: $1

Performance Measures

• Percent of patients screened for depression
• Percent with care manager follow-up within 2 weeks
• Percent with 50% reduction PHQ-9
• Percent to remission (PHQ-9 < 5)
• Percent not improving that received case review and psychiatric recommendations
• Percent not improving referred to specialty BH
“Everyone Wants to do Integrated Care Until they Learn they have to Change Their Practice”
Two Cultures, One Patient

**PRIMARY CARE**
- Continuity is goal
- Empathy and compassion
- Data shared
- Large panels
- Flexible scheduling
- Fast Paced
- Time is independent
- Flexible Boundaries
- Treatment External (labs, x-ray, etc)
- Patient not responsible for illness
- 24 hour communication
- Saved lives
- Disease management

**BEHAVIORAL HEALTH**
- Termination is goal – “discharge”
- Professional distance
- Data private
- Small panels
- Fixed scheduling
- Slower pace
- Time is dependent – “50 min hour”
- Firm Boundaries
- Relationship with provider IS tx
- Patient responsible for participating
- Mutual accountability
- Meaningful lives
- Recovery model
Elements of High Functioning Integrated Care Teams

- Formal & Informal Team Development
- Shared Vision
- Team Values
- Effective Communication
- Outcome Based
Two Key Areas of Effectiveness

• **Patient Activation and Engagement:**
  - Strong leadership support and a strong physician champion are essential for patient activation into the program.
  - The more well defined and implemented the care manager role, the higher the rate of patient activation.

• **Patients Reaching Remission (PHQ-9 < 5):**
  - The more engaged a psychiatrist was and the more often in-person communication occurred, the more frequently patients experienced remission from their depression.
  - The less likely a group experienced operating costs as a barrier, the more likely their patients were to experience remission.

Resources

• APA Website: www.psych.org and list serve ksanders@psych.org
• AIMS Center: http://aims.uw.edu
• Center for Integrated Health Solutions: http://www.integration.samhsa.gov/
• ARHQ Integration Academy: http://integrationacademy.ahrq.gov/
• IBHP Partners in Care Toolkit 2013: www.ibhp.org
• Books/E-books:
  ▪ Integrated Care: Working at the Interface of Primary Care and Behavioral Health – edited by Lori Raney, MD
  ▪ Prevention in Psychiatry – Robert McCarron and colleagues
  ▪ Integrated Care and Psychiatry – Summergrad, Kathol