HEALTH MANAGEMENT ASSOCIATES

Increasing Access to Effective Behavioral Health Integration Before, During, and After COVID

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DISCLOSURES

Dr. Raney receives royalties from American Psychiatric Publishing for textbooks in integrated care

Dr. Jacobs has no disclosures

LET'S GET TO KNOW OUR AUDIENCE

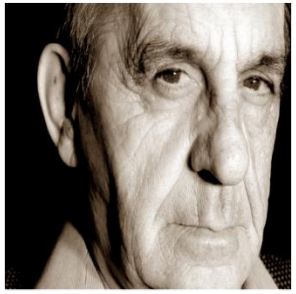
In the chat box let us know what type of organization you work for - behavioral health, primary care, substance use, pediatrics, health plan, etc

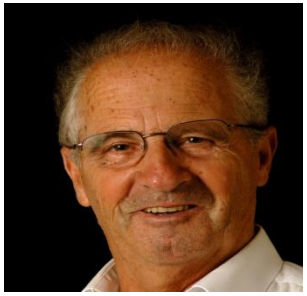
LEARNING OBJECTIVES

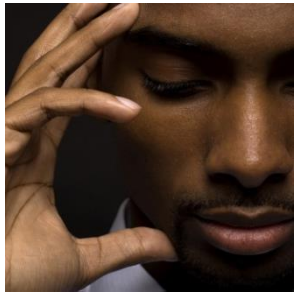
1. Describe at least 2 approaches to increasing access to behavioral health care
2. Define the core principles of effective integrated care
3. List key members of the integrated team and their duties, including paraprofessional staff
4. Recognize key culture change factors to successful integrated care

HOW MANY OF THESE PEOPLE WITH BEHAVIORAL HEALTH CONCERNS WILL SEE A BEHAVIORAL HEALTH PROVIDER?

No Treatment





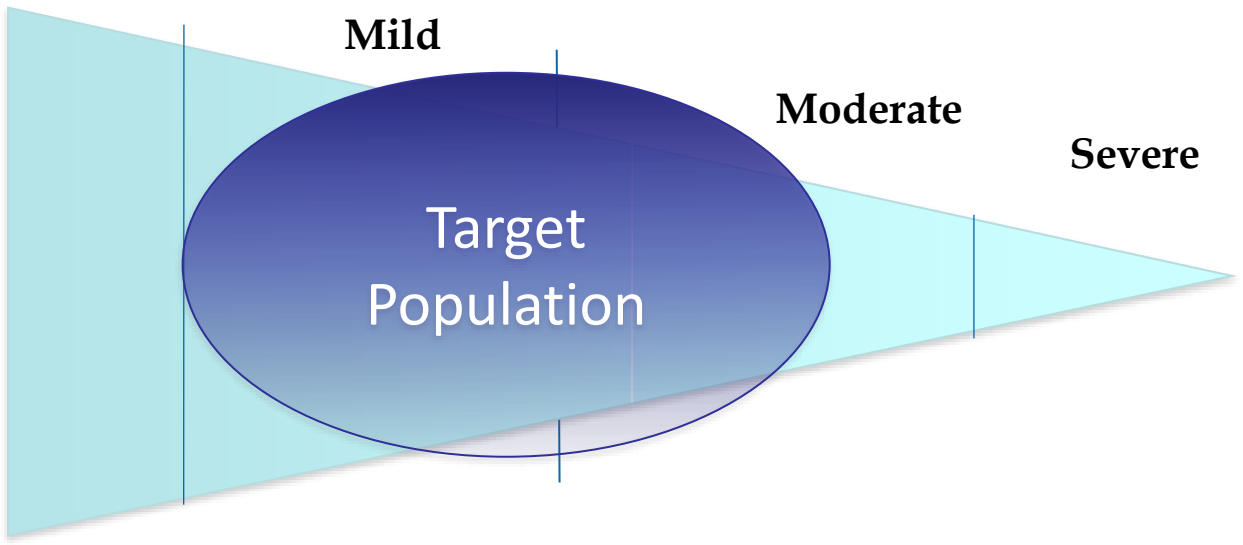
Primary Care Provider




Mental Health Provider (psychiatric provider or therapist)

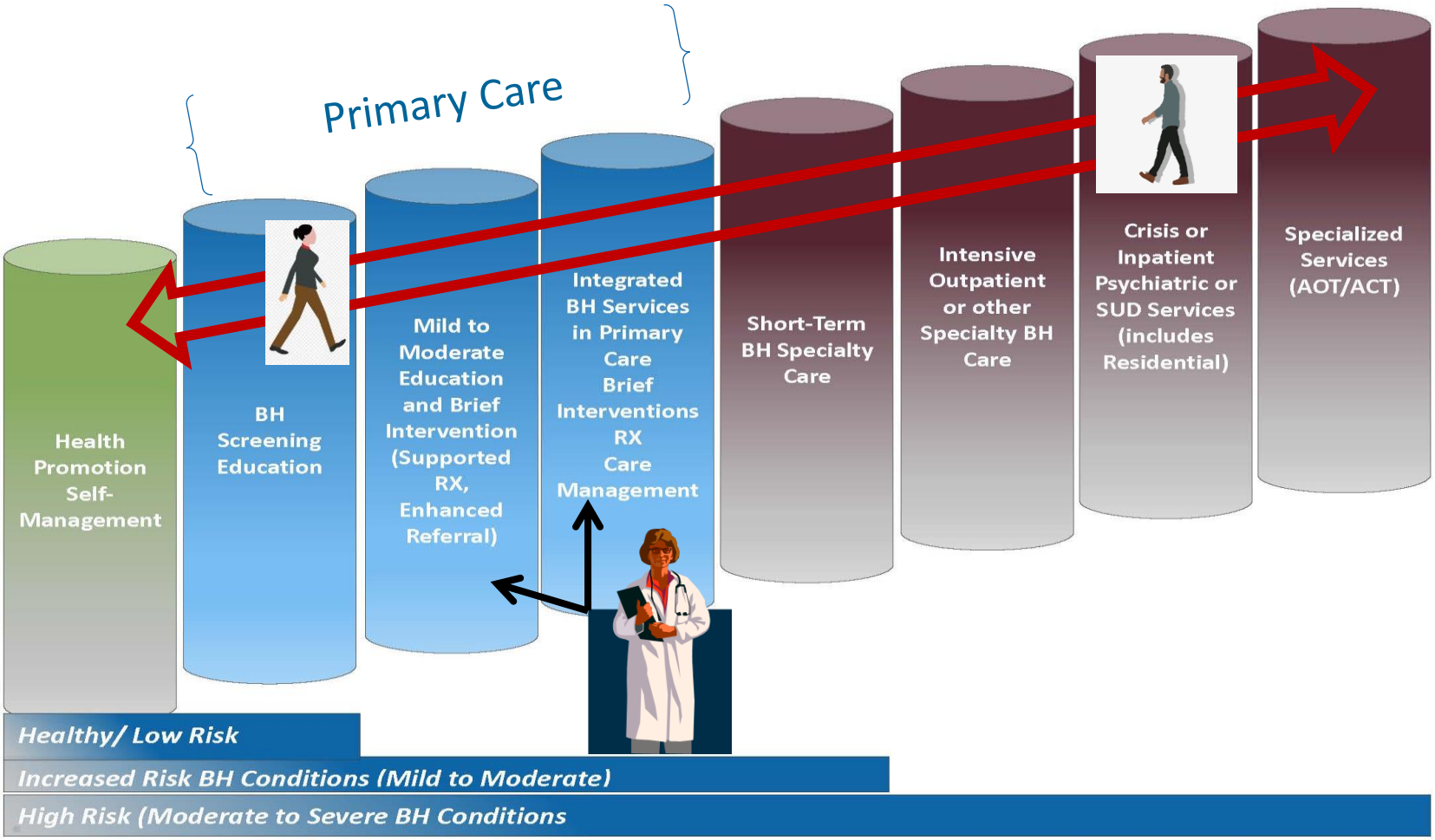
Wang P, et al., Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005

"SWEET" SPOT TO COMMONLY SEEN DIAGNOSIS IN PRIMARY CARE

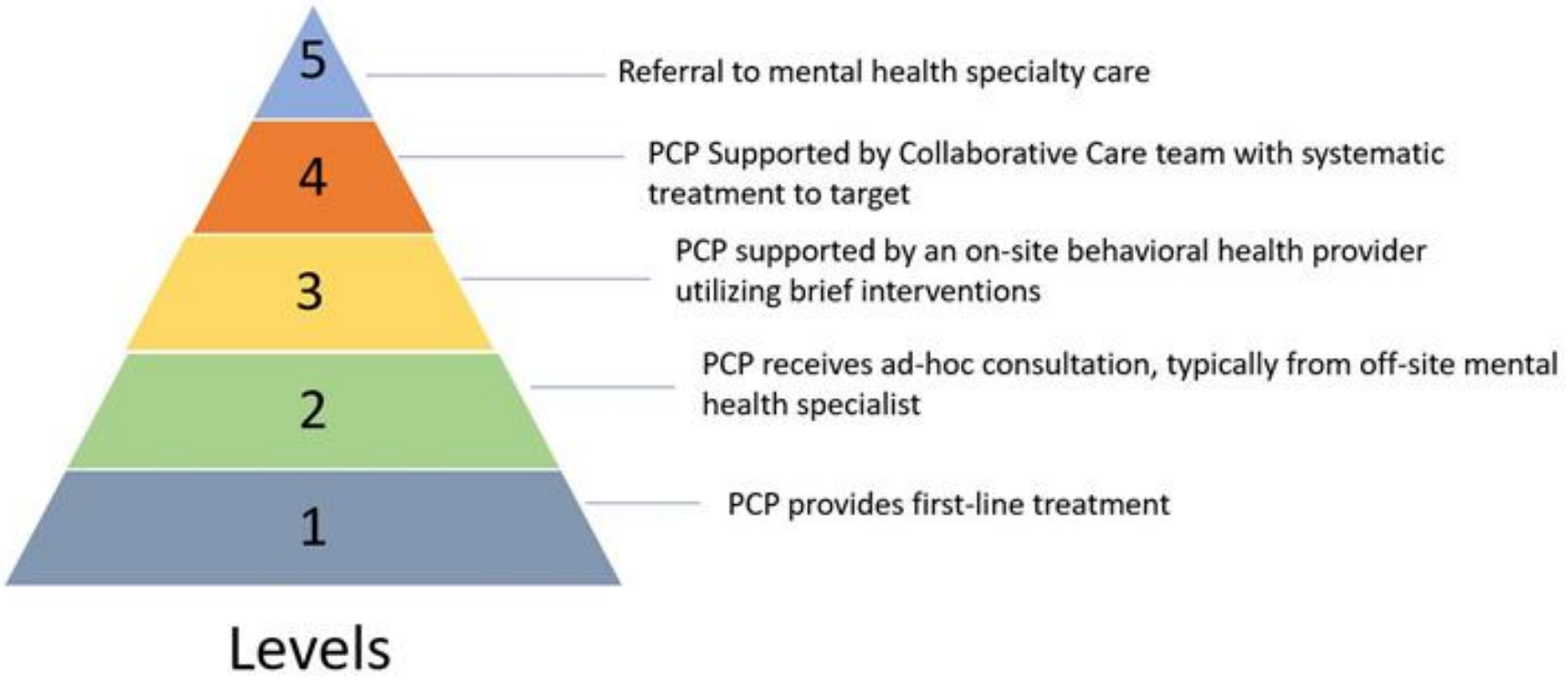


- Issues with depression and substance abuse can be pre-empted, rather than progressing to diagnosis
- Goal is to detect early and apply early interventions to prevent from getting more severe

DEVELOPMENT OF ROBUST CONTINUUM OF STEPPED CARE



Stepped Model of Integrated Behavioral Health Care



CHAT BOX RESPONSE

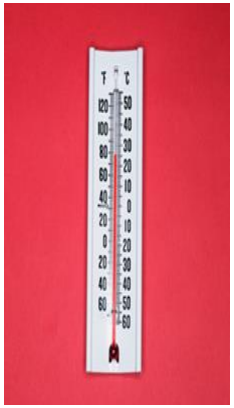
What type of integrated care is provided in your location based on the previous slide **number**?

EFFECTIVE INTEGRATED CARE

- Operationalizes the principles of the chronic care model to improve access to evidence based mental health treatments for primary care patients.

- Integrated Care is:
  - **T**eam-based effective collaboration and Patient-centered
  - **E**vidence-based and practice-tested care
  - **M**easurement-based care, treat to target
  - **P**opulation-based care – registry, systematic screen

  - **A**ccountable care



A Tipping Point for Measurement-Based Care

John C. Fortney, Ph.D., Jürgen Unützer, M.D., M.P.H., Glenda Wrenn, M.D., M.S.H.P., Jeffrey M. Pyne, M.D., G. Richard Smith, M.D., Michael Schoenbaum, Ph.D., Henry T. Harbin, M.D.

Objective: Measurement-based care involves the systematic administration of symptom rating scales and use of the results to drive clinical decision making at the level of the individual patient. This literature review examined the theoretical and empirical support for measurement-based care.

Methods: Articles were identified through search strategies in PubMed and Google Scholar. Additional citations in the references of retrieved articles were identified, and experts assembled for a focus group conducted by the Kennedy Forum were consulted.

Results: Fifty-one relevant articles were reviewed. There are numerous brief structured symptom rating scales that have strong psychometric properties. Virtually all randomized controlled trials with frequent and timely feedback of patient-reported symptoms to the provider during the medication management and psychotherapy encounters significantly improved outcomes. Ineffective approaches included one-time screening, assessing symptoms infrequently, and feeding back outcomes to providers outside the context of the clinical encounter. In addition to the empirical evidence about efficacy, there is mounting evidence from large-scale pragmatic trials and clinical demonstration projects that measurement-based care is feasible to implement on a large scale and is highly acceptable to patients and providers.

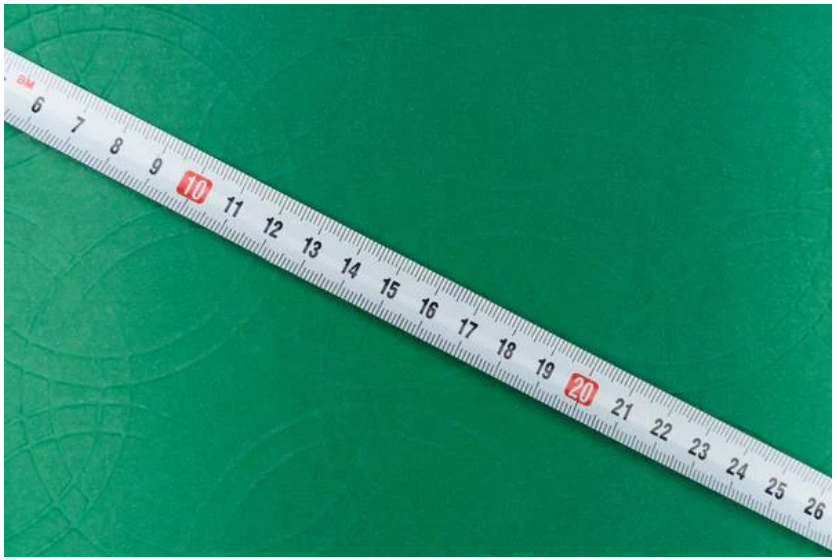
Conclusions: In addition to the primary gains of measurement-based care for individual patients, there are also potential secondary and tertiary gains to be made when individual patient data are aggregated. Specifically, aggregated symptom rating scale data can be used for professional development at the provider level and for quality improvement at the clinic level and to inform payers about the value of mental health services delivered at the health care system level.

Psychiatric Services 2016; 00:1–10; doi: 10.1176/appi.ps.201500439

MBC KEY CONCEPTS

Process:

- **M** Systematic administration of symptom rating scales – use huddle or registry
- NOT a substitute for clinical judgement
- **BC** Use of the results to drive clinical decision making at the patient level – overcome clinical inertia
- Patient rated scales are equivalent to clinician rated scales
- Aggregate data for
  - Professional development at the provider level – MACRA
  - Quality improvement at the clinic level
  - Inform reimbursement at the payer level



Ineffective Approaches:

- One-time screening
- Assessing symptoms infrequently
- Feeding back outcomes outside the context of the clinical encounter

Fortney et al Psych Serv Sept 2016

VALIDATED TOOLS FOR SCREENING AND MEASURING PROGRESS

Mood Disorders

- PHQ-2, PHQ-9: Depression
- CIDI 3.0: Bipolar disorder
- MDQ: Bipolar disorder

Anxiety and Trauma Disorders

- GAD- 7: Anxiety, GAD
- SCARED
- PCL-5: PTSD

Substance Use Disorders

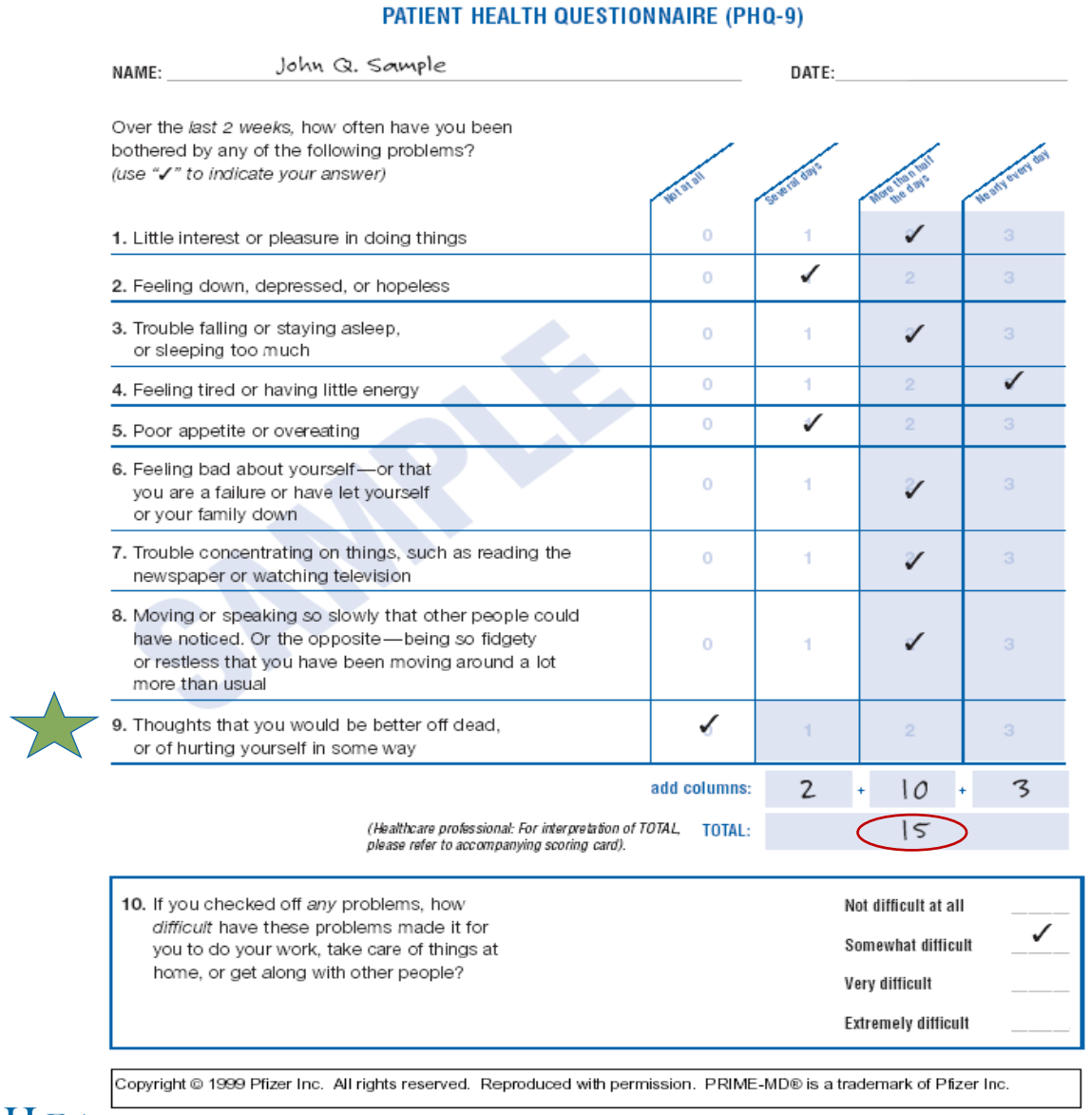
- BAM
- AUDIT-C
- DAST

PATIENT HEALTH QUESTIONNAIRE 2 ITEM

Over the last 2 weeks, how many days have you been bothered by any of the following problems?	Not at All	Several Days	More than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

- Ultra brief screening
- Commonly used in primary care
- Scoring:
  - 0-2: Negative
  - 3 or Higher: Positive and patient needs further assessment

PATIENT HEALTH QUESTIONNAIRE 9 ITEM



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)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	✓	3
2. Feeling down, depressed, or hopeless	0	✓	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	✓	3
4. Feeling tired or having little energy	0	1	2	✓
5. Poor appetite or overeating	0	✓	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	✓	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	✓	3
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	0	1	✓	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	✓	1	2	3
add columns:		2	+ 10	+ 3
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:			15	

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?

- Not difficult at all _____
- Somewhat difficult ✓
- Very difficult _____
- Extremely difficult _____

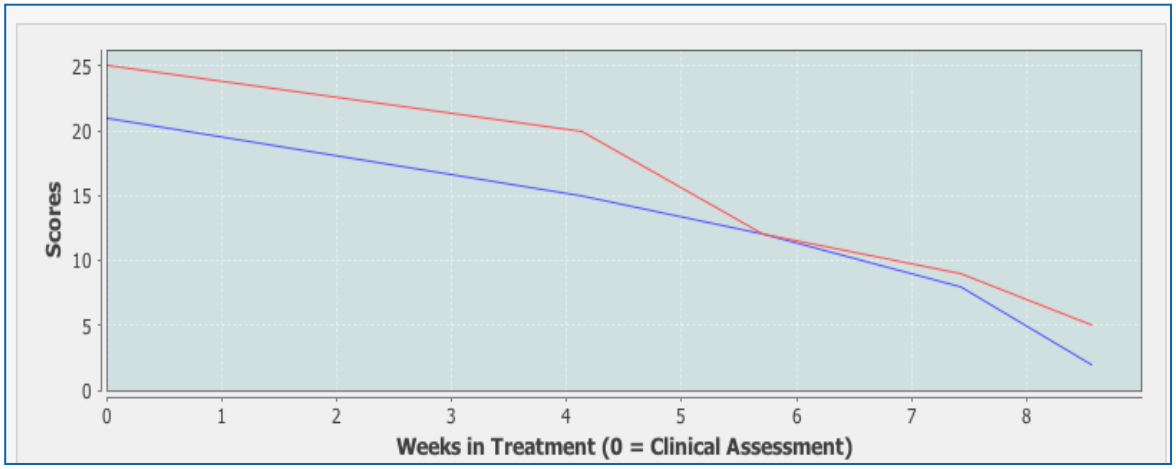
PHQ 9 > 9

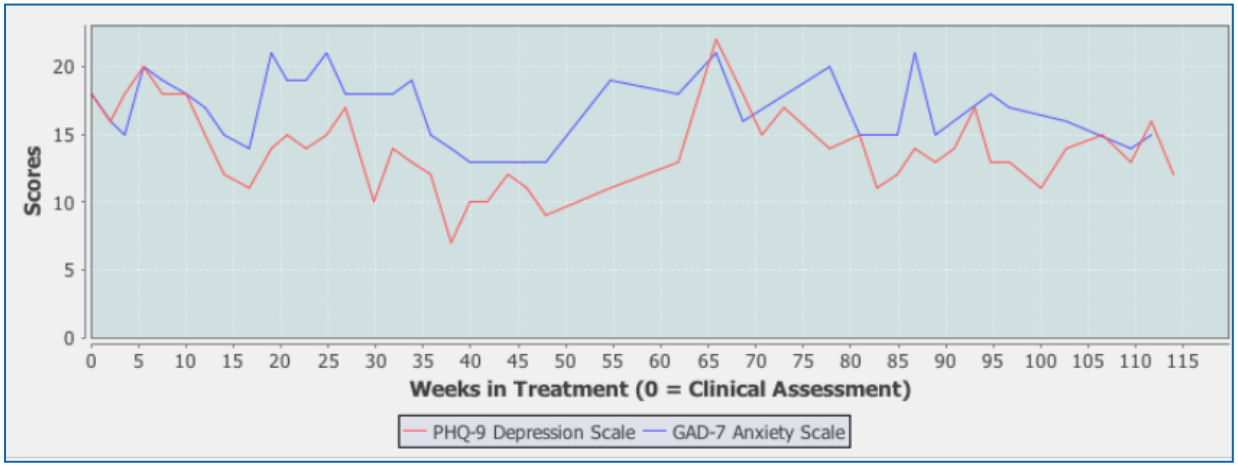
- < 5 - remission
- 5 - mild
- 10 - moderate
- 15- moderate severe
- 20 - severe

CHAT EXERCISE

What tools do you use to screen and do you use any to track progress/response to treatment?

MEASUREMENT BASED TREATMENT TO TARGET





HEALTH MANAGEMENT ASSOCIATES

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Population-based Care: Tracking, Care Gaps, Progress Toward Targets

			Behavioral Heatlh												
			Treatment Status					PHQ-9				GAD-7			
MRN	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Average # Contacts per month	Initial PHQ-9 Score	Last Available PHQ-9 Sco	% Change in PHQ-9 Score	Date of Last PHQ-9	Initial GAD-7 Score	Last Available GAD-7 Sco	% Change in GAD-7 Score	Date of Last GAD-7
1234501	Active	Bryson Clay	2/28/2018	10/1/2018	9	30	1.20	21	9	-57.1%	10/1/2018	10	4	-60.0%	10/1/2018
1234502	Active	Kayla Ho	3/15/2018	9/30/2018	8	28	1.14	13	17	30.8%	9/30/2018	5	5	0.0%	9/30/2018
1234503	Active	Reed Snow	2/7/2018	9/3/2018	9	29	1.24	10	4	-60.0%	9/3/2018	18	14	-22.2%	9/3/2018
1234504	Active	Princess Hull	4/22/2018	9/17/2018	9	21	1.71	18	18	0.0%	9/17/2018	19	18	-5.3%	9/17/2018
1234505	Active	Ignacio Tanner	4/17/2018	10/1/2018	9	23	1.57	14	8	-42.9%	10/1/2018	16	14	-12.5%	10/1/2018
1234506	Active	Jan Jacobson	2/20/2018	10/2/2018	8	32	1.00	11	4	-63.6%	10/2/2018	19	18	-5.3%	10/2/2018
1234507	Active	Eddie Wu	2/19/2018	9/17/2018	8	30	1.07	16	8	-50.0%	9/17/2018	10	18	80.0%	9/17/2018
1234508	Active	Ulises Rosales	7/30/2018	9/15/2018	4	6	2.67	17	16	-5.9%	9/15/2018	4	3	-25.0%	9/15/2018
1234509	Active	Freddy Keith	7/21/2018	10/15/2018	13	12	4.33	22	18	-18.2%	10/15/2018	5	3	-40.0%	10/15/2018
1234510	Active	Grayson Mcgee	12/19/2017	10/15/2018	7	42	0.67	14	4	-71.4%	10/15/2018	7	17	142.9%	10/15/2018

Two crucial data points:
50% reduction PHQ-9
Remission (PHQ 9 < 5)

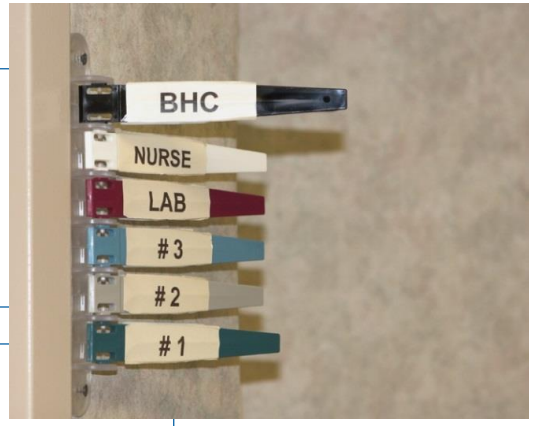
ROLES OF PRIMARY CARE PROVIDER

- ***IDENTIFY*** individuals who need BH support
- ***ENGAGE*** them in the treatment model – "pitch"
- **Utilize screening tools** to track progress (e.g., PHQ-9)
- Sufficient knowledge of **psychopharmacology for common behavioral health conditions**

** Need to have a PCP champion!

Who are the BHCs/CMs?

- Typically, MSW, LCSW, MA, RN, PhD, PsyD, paraprofessionals
- Brief intervention skills, generalists



What makes a good BHC/CM?

- Organization
- Persistence- tenacity
- Creativity and flexibility
- Enthusiasm for learning
- Strong patient advocate
- Willingness to be interrupted
- Ability to work in a team

Primary Care Behavioral Health (PCBH) Model

- No traditional psychotherapy
- Reflects pace and episodic nature of primary care
- Warm handoffs to “BHCs”
- All brief (10-15 min.) interventions
- Psychoeducation
- CBT, ACT, SBIRT

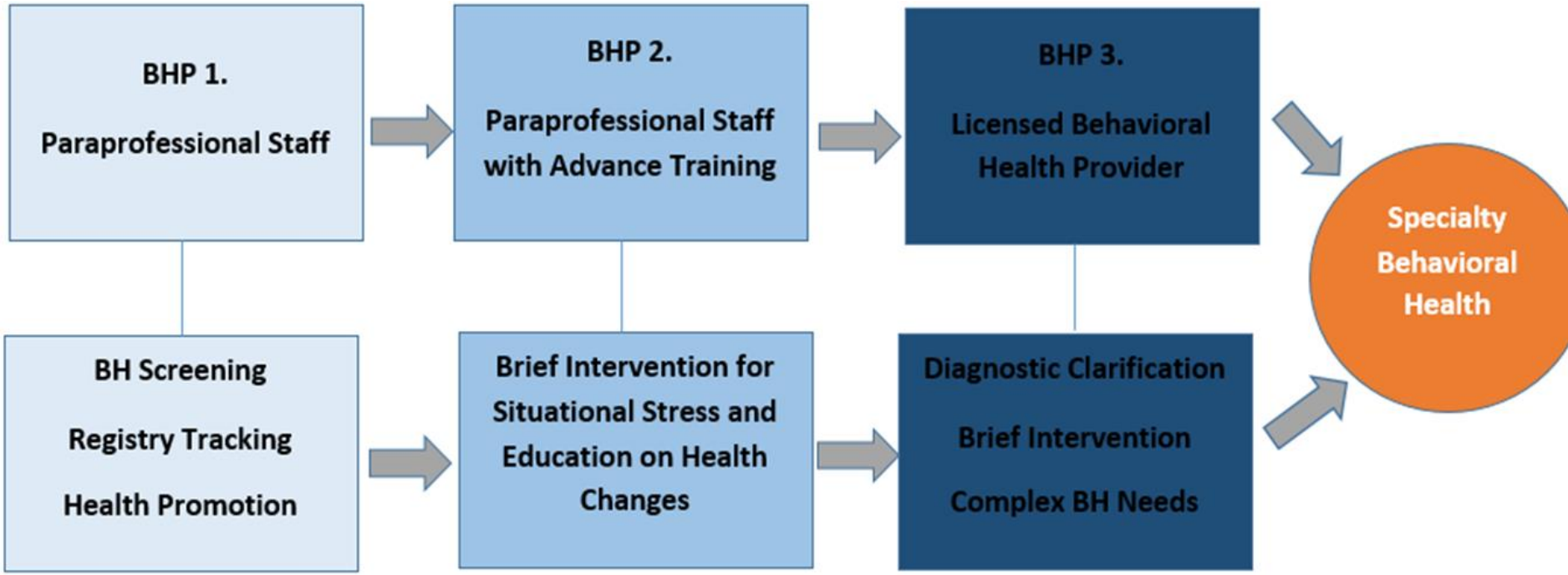
EVIDENCE-BASED BRIEF INTERVENTIONS

- Motivational Interviewing
- Distress Tolerance Skills
- Behavioral Activation
- Problem Solving Therapy

Typical BHC Morning

- Review appointment schedule to identify touches
- Team huddle
- Screen identified patients; confer with physicians in “flow”
- Pop into exam room for follow-up with parent and child with asthma seen previously
- Calls to specialty mental health provider re: referred patients

TASK SHARING – LARGER BEHAVIORAL HEALTH PROVIDER POOL



SHARED BHC TASKS

- Support and closely **coordinate mental health** care with the patient's PCP and, when appropriate, other mental health providers.
- **Screen and gather information** from patients regarding common mental health and substance abuse disorders.
- Provide the **patient with information** about common mental health and substance abuse disorders and available treatment options.
- Use **measurement-based tools** to track patients (in person or by telephone) for changes in clinical symptoms and gather information about treatment side effects or complications; cue other members of the treatment team as needed to address these issues.
- **Support psychotropic medication** management prescribed by PCPs by asking questions about treatment adherence, side effects and other complications, and effectiveness of treatment; cue other members of the treatment team if interventions are needed.

- Discuss with patients their current **activities,** discuss how being more active improves depression and plan additional activities with patients.
- Facilitate **in-clinic or outside referrals** to evidence-based psychosocial treatments (e.g, PST, CBT, IPT) as directed by other team members. Follow up that patient has connected and attended.
- Participate in **regularly scheduled case conferences with team**. Facilitate communication regarding treatment recommendations to the patient's PCP. Support patient engagement and follow-up in care.
- **Document patient follow-up and clinical outcomes** using a registry. Document in person and telephone encounters in the registry and use the system to identify and reengage patients

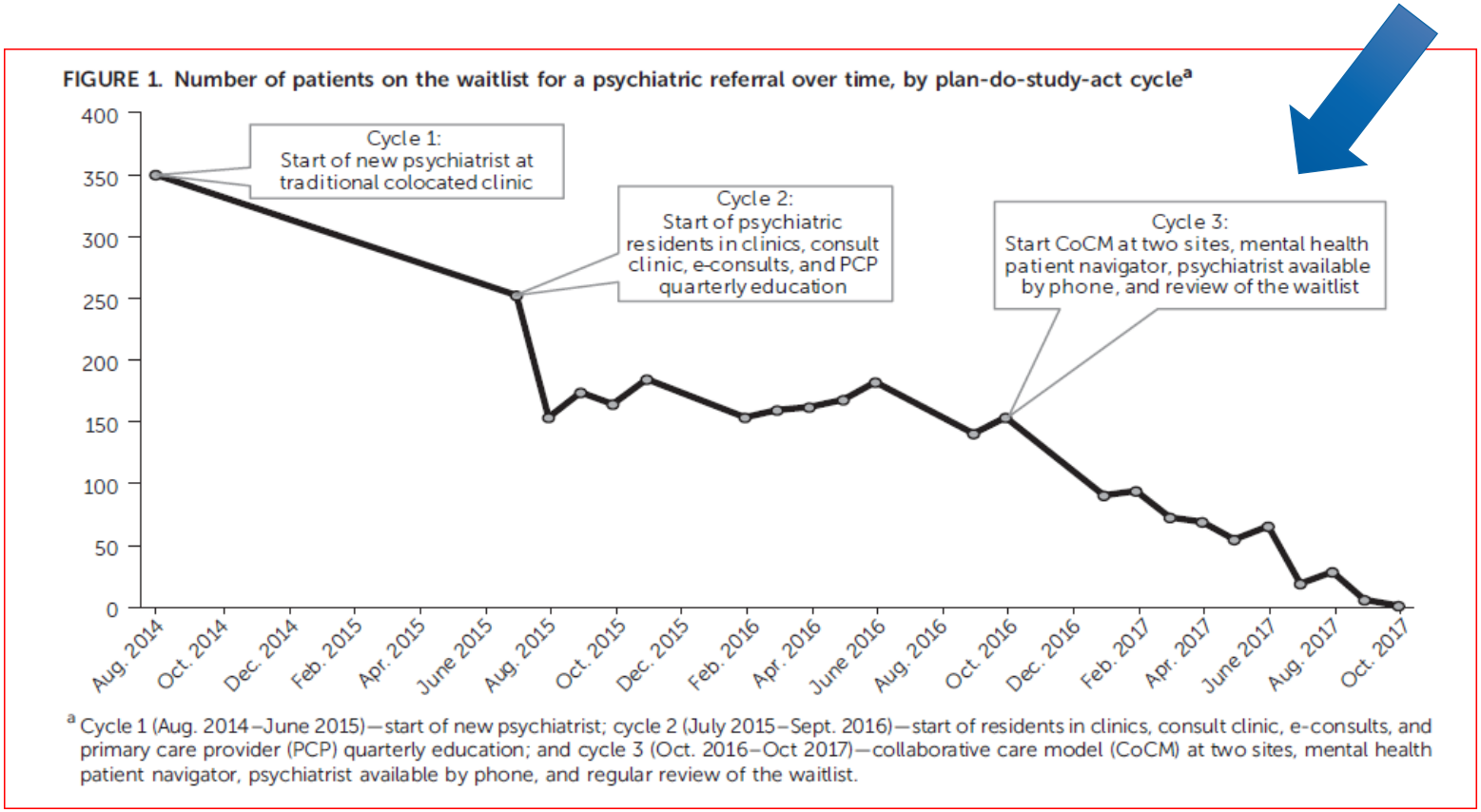
How have you engaged non-licensed providers to provide some behavioral health care in your organization?

LEVERAGE PSYCHIATRIC TIME

Approach	Who's Patient	Reduced Need Referral	Published effectiveness benchmarks	Insurance covers
Didactic presentations	PCP	maybe	No	no
Consults (one and done)	PCP	no	No	yes
eConsult/curbside	PCP	yes	No	Yes Medicare
Psychiatry access line	PCP	yes	No	No
Case Reviews with team	PCP	yes	No	No
Asynchronous consult	PCP	yes	No	No
Project ECHO	Some Sharing	yes	Yes	No
Collaborative Care management	Shared	yes	Yes	CoCM codes Medicare
Direct patient care and follow up	Psychiatrist	Temporarily	Yes	Yes

Consultative Approaches to Leveraging the Psychiatric Workforce for Larger Populations in Need of Psychiatric Expertise Lori Raney, M.D., Mark Williams, M.D., Patty Gibson, M.D., Tom Salter, M.D. Psych Serv in advance: 2020 doi: 10.1176/appi.ps.202000052

WAITLIST REDUCTION FOR PSYCHIATRIC SERVICES WITH COCM



Kinnan, Emerson et al. Psychiatric Services in Advance 2019 (doi: 10.1176/appi.ps.201900222)

EFFECTIVE INTEGRATED CARE: PUTTING THE PIECES TOGETHER

Informed, Activated Patient

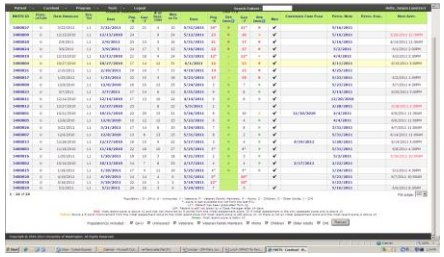
Effective Collaboration

PRACTICE SUPPORT

PCP supported by Behavioral Health Consultant

Measurement-based Treat to Target

Psychiatric Consultation



Caseload-focused Registry review

Training

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Virtual Integrated Care: COVID and Beyond

Medical Provider

Patient

Behavioral Health Provider

Psychiatric Consultant

	Behavioral Health																	
			Treatment Status					PHQ-9				GAD-7						
MRN	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Average # Contacts per month	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7
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Registry

HEALTH MANAGEMENT ASSOCIATES

CPT CODES FOR COCM

99492 – first 70 minutes

99493 – subsequent months

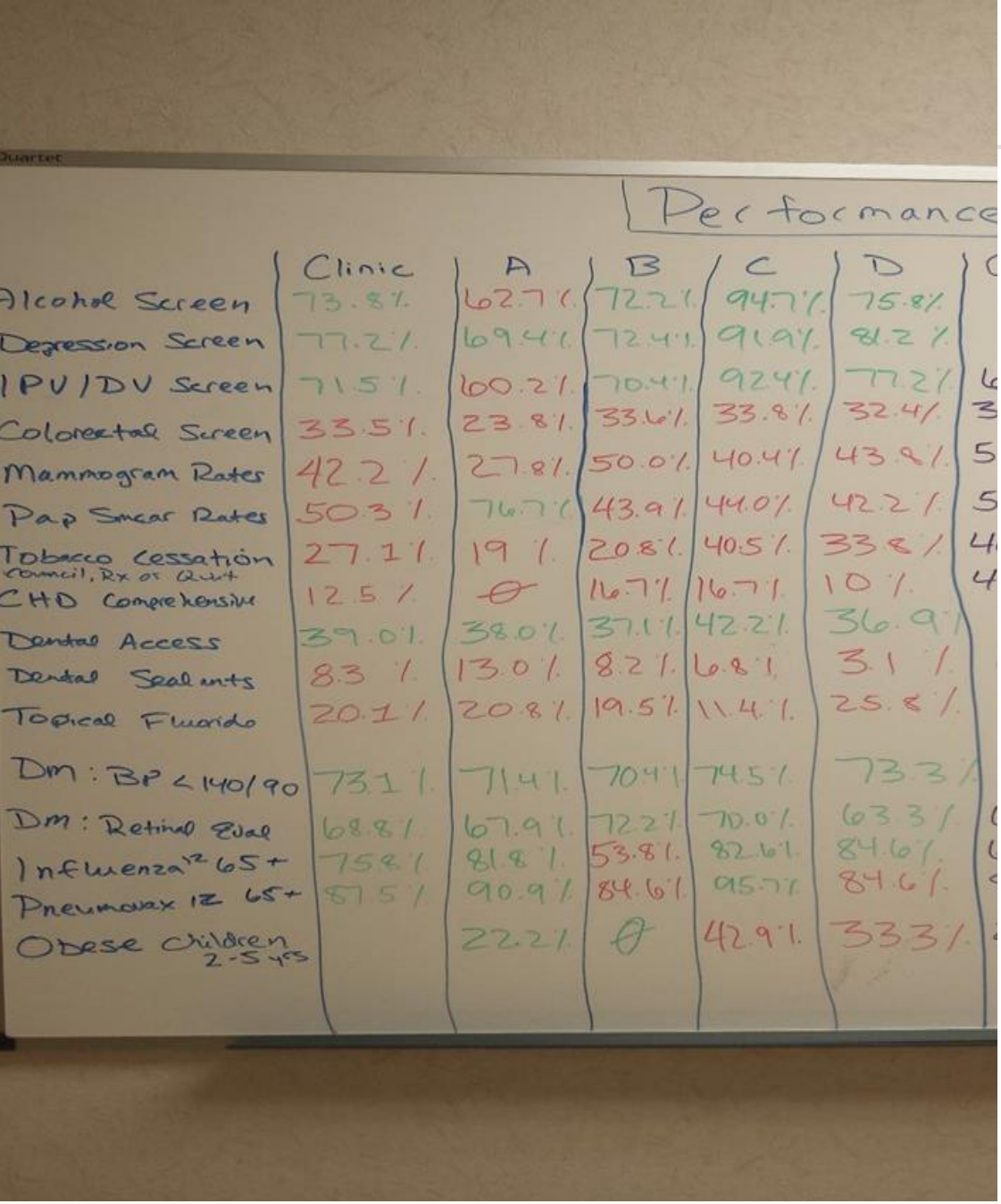
99494 – each additional 30 minutes

G2214 – 30 minutes of CoCM any month

G0512 -(FQHCs/RHCs only)

Billed once a month under PCP's NPI

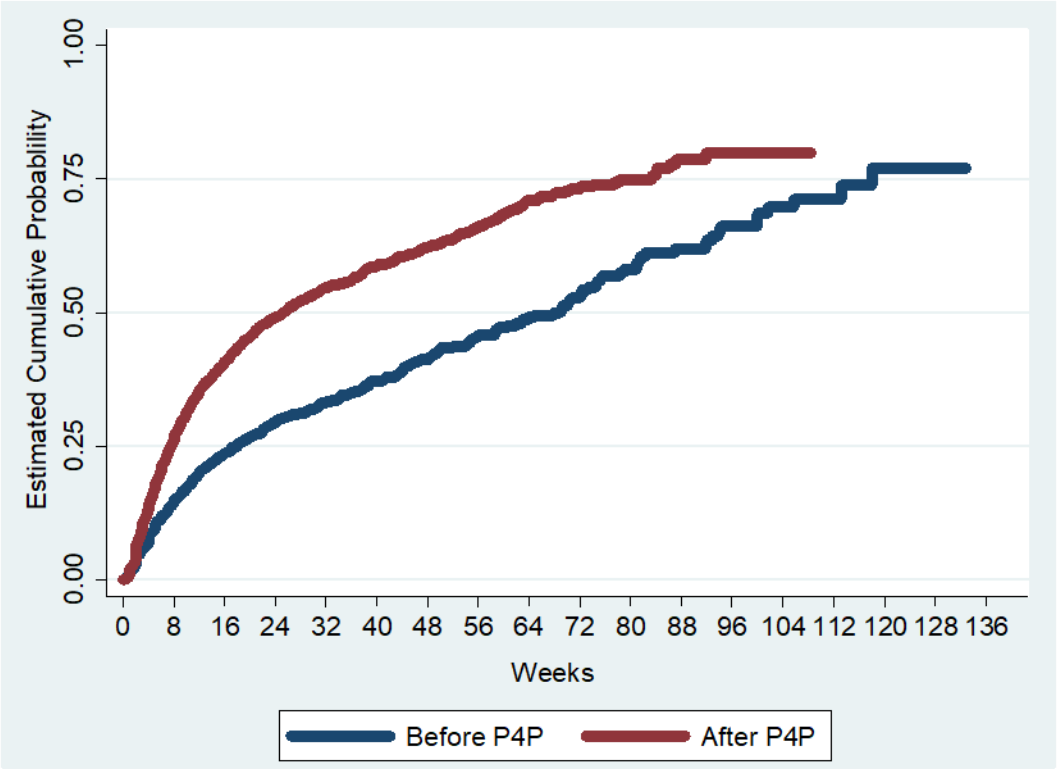
+ Outreach and engagement by BCM
+ Assessment of the patient, including administration of validated rating scales
+ Entering patient data in a registry and tracking patient follow-up and progress
+ Participation in weekly caseload review with the psychiatric consultant
+ Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.



QUALITY MEASURES FOR INTEGRATED CARE: VALUE

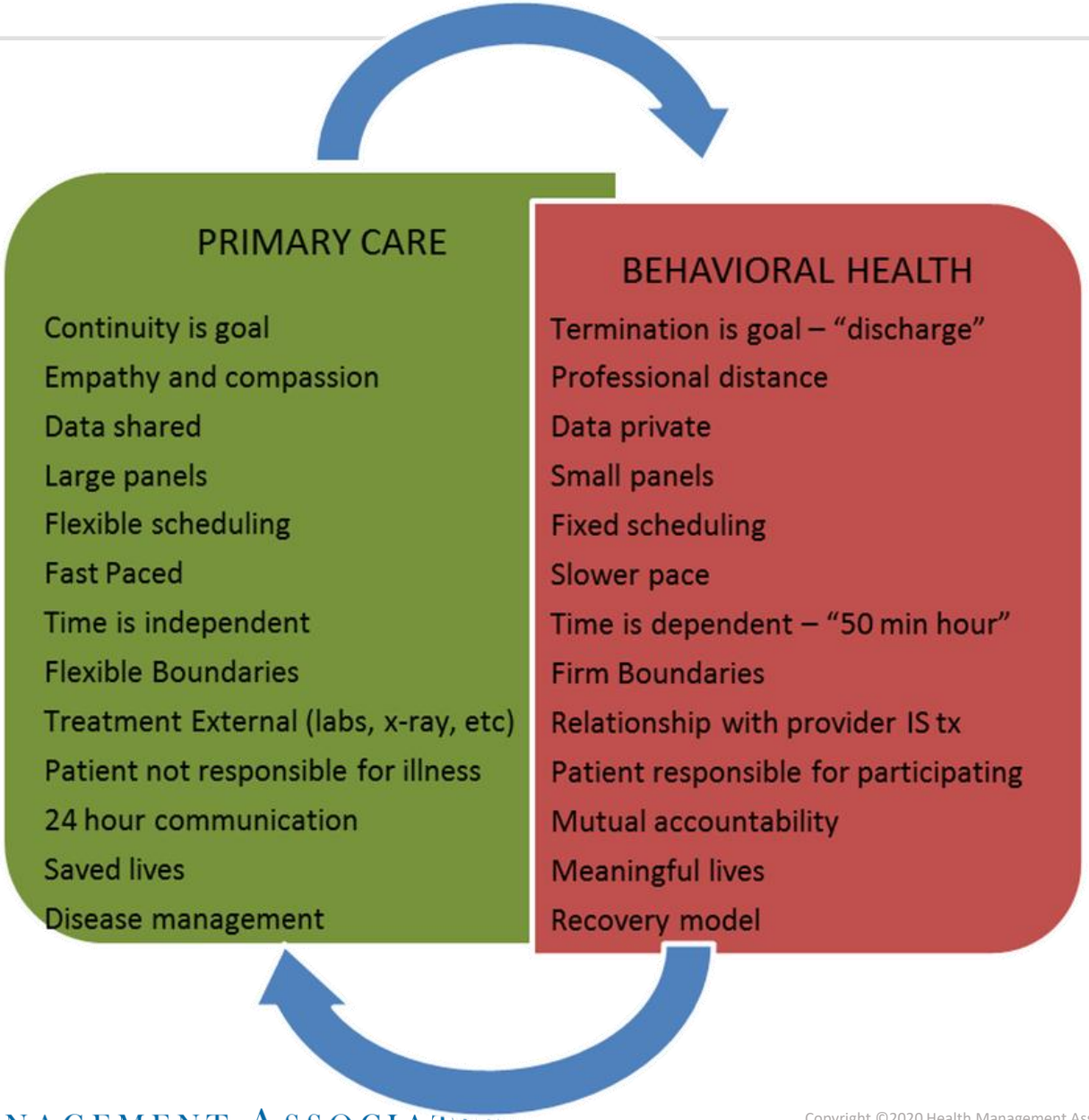
- Process Metrics:
  - Percent of patients screened for depression
  - Percent with follow-up with BHP/CM within 2 weeks
  - Percent not improving referred to specialty BH
- Outcome Metrics
  - Percent with 50% reduction PHQ-9 – Clinical Response
  - Percent reaching remission (PHQ-9 < 5) NQF 710 and 711
- Satisfaction – patient and provider
- Functional –work, school, homelessness, incarceration
- Utilization/Cost
  - ED visits, 30 day readmits, med/surg/ICU, overall cost

Pay-for-performance cuts median time to depression treatment response **in half**



Unützer et al., 2012

TWO CULTURES: ONE PATIENT



EFFECTIVE IMPLEMENTATION: 9 FACTORS

Table 1. Factors Considered Important for Implementation of DIAMOND

Ranking	Implementation Factor	Definition
1	Operating costs of DIAMOND not seen as a barrier	The clinic has adequate coverage or other financial resources for most patients to be able to afford the extra operational costs.
2	Engaged psychiatrist	The consulting psychiatrist is responsive to the care manager and to all patients, especially those not improving.
3	Primary care provider (PCP) "buy-in"	Most clinicians in the clinic support the program and refer patients to it.
4	Strong care manager	The care manager is seen as the right person for this job and works well in the clinic setting.
5	Warm handoff	Referrals from clinicians to the care manager are usually conducted face-to-face rather than through indirect means.
6	Strong top leadership support	Clinic and medical group leaders are committed and support the care model.
7	Strong PCP champion	There is a PCP in the clinic who actively promotes and supports the project.
8	Care manager role well defined and implemented	The care manager job description is well defined, with appropriate time, support, and a dedicated space.
9	Care manager on-site and accessible	The care manager is present and visible in the clinic and is available for referrals and patient care problems.

DIAMOND indicates Depression Improvement Across Minnesota—Offering a New Direction.

Whitebird, Jaeckels Kamp et al. Am J Manag Care. 2014;20(9):699-707

CHAT EXERCISE

What are some of the practice culture challenges you have experienced in your integrated primary and behavioral health care work?

LEARNING

What is one idea you might use at your site after participating in this webinar today?

QUESTIONS

?

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Photo form Unsplash

RESOURCES AND CITED ARTICLES

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- Quo T, Correll, et al. American Journal of Psychiatry, 172 (10), Oct, 2015
- Fortney et al Psych Serv Sept 2016
- Consultative Approaches to Leveraging the Psychiatric Workforce for Larger Populations in Need of Psychiatric Expertise Lori Raney, M.D., Mark Williams, M.D., Patty Gibson, M.D., Tom Salter, M.D. Psych Serv in advance: 2020 doi: 10.1176/appi.ps.202000052