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HEALTH SOLUTIONS

Back to the Basics:

What You Need to Know about Primary and Behavioral Health Care Integration

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Moderator:

Roara Michael, Associate, CIHS

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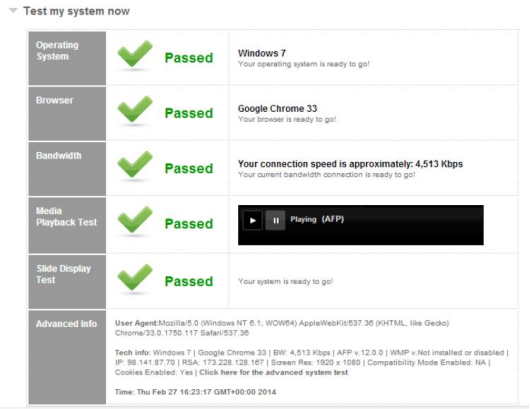

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Today's Speakers

Joe Parks, MD
Medical Advisor
The National Council for Behavioral Health and Medicaid Director for Missouri

Laura Galbreath, MPP
Director
SAMHSA–HRSA Center for Integrated Health Solutions

For Today – The Basics:

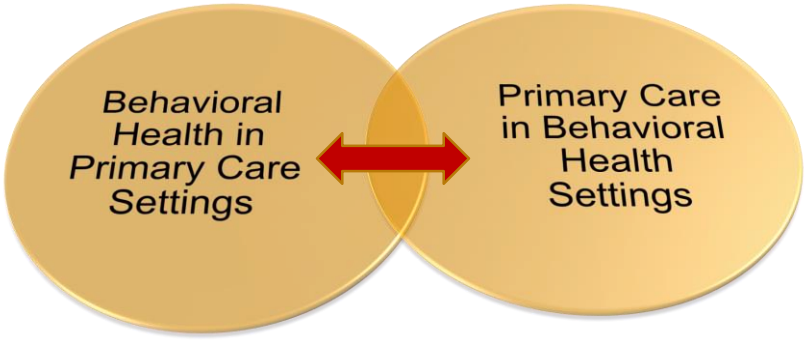
- What is integrated care?
- Why integrate primary and behavioral health care?
- Approaches to integrated care
- How you can get involved and learn more

What is Integrated Care?

Integrated Care Definition:

The care that results from a practice team of primary care and behavioral health clinicians working with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

Bidirectional Integration



What Is Integration?

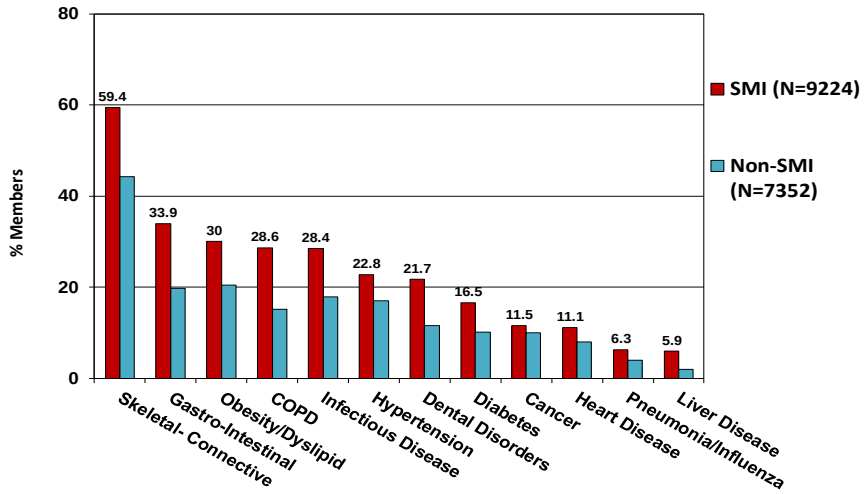
- Focus is on the integration of services
- This may or may not involve the merging of organizations

Why Integrate Physical and Behavioral Health Care?

Behavioral Health in Primary Care

- **Mild to moderate behavioral health problems are common in primary care settings**
  - Anxiety, depression, substance use in adults
  - Anxiety, ADHD, behavioral problems in children
    - **Prevention and early intervention opportunity**
- **People with common medical disorders have high rates of behavioral health concerns**
  - E.g., Diabetes, heart disease, asthma and depression
    - **Worse outcomes and higher costs if <u>both</u> problems aren't addressed**

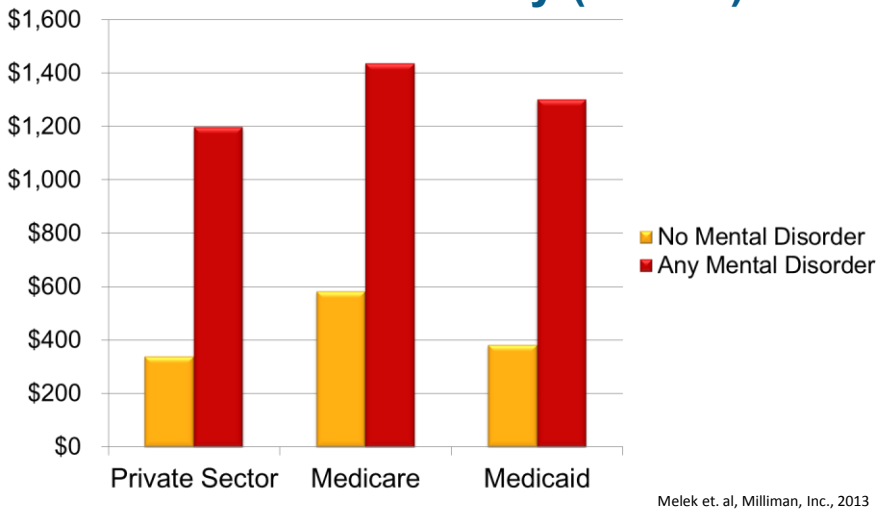
People with SMI have Higher Rates of Chronic Medical Illness



Seeking Behavioral Health Care in Primary Care

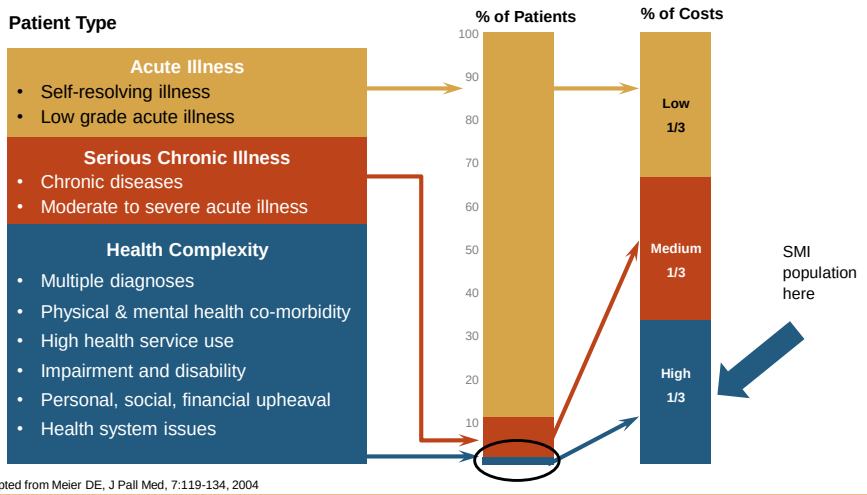
- ~1/2 of all care for common psychiatric disorders happens in primary care settings
- Populations of color are even more likely to seek or receive care in primary care than in specialty behavioral health settings

Care for Persons with Mental Disorders is More Costly (PMPM)



Melek et. al, Milliman, Inc., 2013

Cost of Health Complexity



Adapted from Meier DE, J Pall Med, 7:119-134, 2004

Why Do People Seek Behavioral Health Care in Primary Care Settings?

- Uninsured or underinsured
- Limited access to public mental health services
- Cultural beliefs and attitudes
- Low availability of mental health services, especially in rural areas

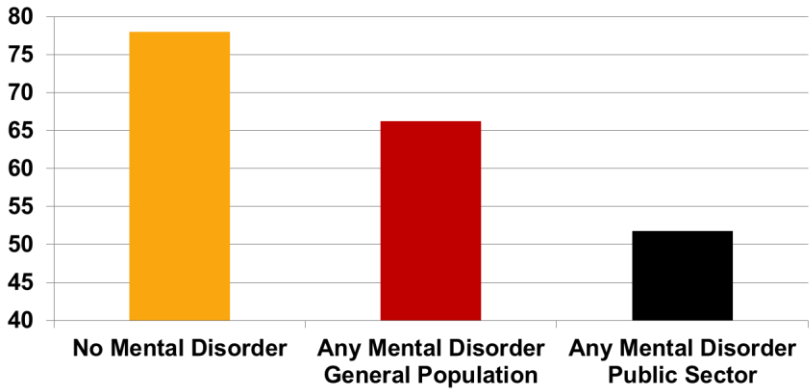
Without Integration:

- Mental illnesses go undetected and untreated
- When primary care providers detect mental illnesses, they tend to under-treat them
- Populations of color, children and adolescents, older adults, uninsured, and low-income patients more often receive inadequate care for mental health problems
- Substance use care involves same

Our Problem:

Early death from
physical illness prevents recovery
from serious mental illness.

Life Span With and Without Mental Disorder



Bar 1 & 2: Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 June;49(6):599-604

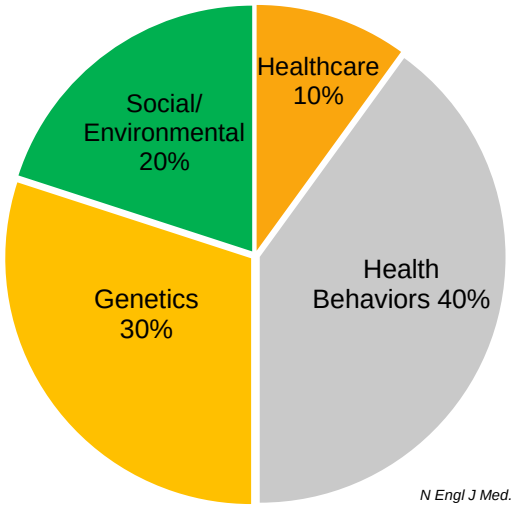
Bar 3; Daumit GL, Anthony CB, Ford DE, Fahey M, Skinner EA, Lehman AF, Hwang W, Steinwachs DM. Pattern of mortality in a sample of Maryland residents with severe mental illness. Psychiatry Res. 2010 Apr 30;176(2-3):242-5

Why Are They Dying Earlier?

88% of the deaths and 83% of premature years of life lost in persons with serious mental illness are due to “natural causes” like:

- Cardiovascular disease
- Diabetes
- Respiratory diseases
- Infectious diseases

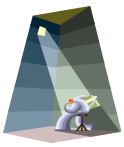
Preventable Causes of Death



N Engl J Med. 2007 Sep 20;357(12):1221-8.

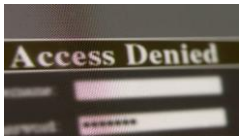
Cumulative Effect of Many Problems

Modifiable risk factors: smoking, weight and inactivity



Social isolation, vulnerability, and violence

Unemployment/ poverty



Lack of access to care

Medication/ polypharmacy

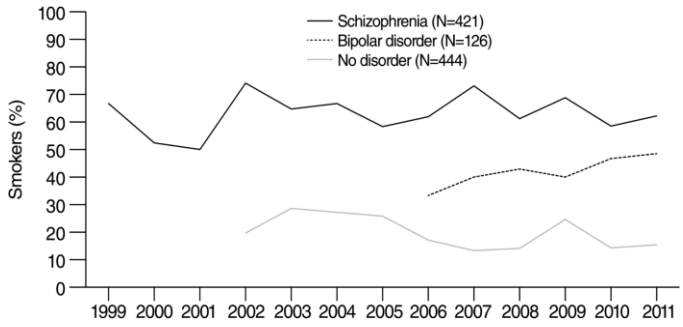
Separate silos of care

Cardiovascular Disease Risk Factors

Modifiable Risk Factors	Estimated Prevalence and Relative Risk (RR)	
	Schizophrenia	*Bipolar Disorder*
Obesity	45–55%, 1.5-2X RR[1]	26%[5]
Smoking	50–80%, 2-3X RR[2]	55%[6]
Diabetes	10–14%, 2X RR[3]	10%[7]
Hypertension	≥18%[4]	15%[5]
Dyslipidemia	Up to 5X RR[8]	42%
Metabolic syndrome	43%	37%

1. Davidson S, et al. *Aust N Z J Psychiatry*. 2001;35:196-202. 2. Allison DB, et al. *J Clin Psychiatry*. 1999; 60:215-220.
3. Dixon L, et al. *J Nerv Ment Dis*. 1999;187:496-502. 4. Herran A, et al. *Schizophr Res*. 2000;41:373-381.
5. MeElroy SL, et al. *J Clin Psychiatry*. 2002;63:207-213. 6. Ucok A, et al. Psychiatry Clin Neurosci. 2004;58:434-437.
7. Cassidy F, et al. *Am J Psychiatry*. 1999;156:1417-1420. 8. Allebeck. Schizophr Bull. 1999;15(1)81-89. 9. VanCampfort

Cigarette Smoking Among Persons With Schizophrenia or Bipolar Disorder



Psychiatric Services. 2013;64(1):44-50. doi:10.1176/appi.ps.201200143

44% of all cigarettes consumed nationally are smoked by people with SMI.

Comorbid Alcohol Use Disorders

Diagnosis	Lifetime Prevalence of Alcohol abuse or dependence
Bipolar I	46.2%
Bipolar II	39.2%
Schizophrenia	33.7%
Panic Disorder	28.7%
Unipolar Depression	16.5%
General Population	**13.8%**

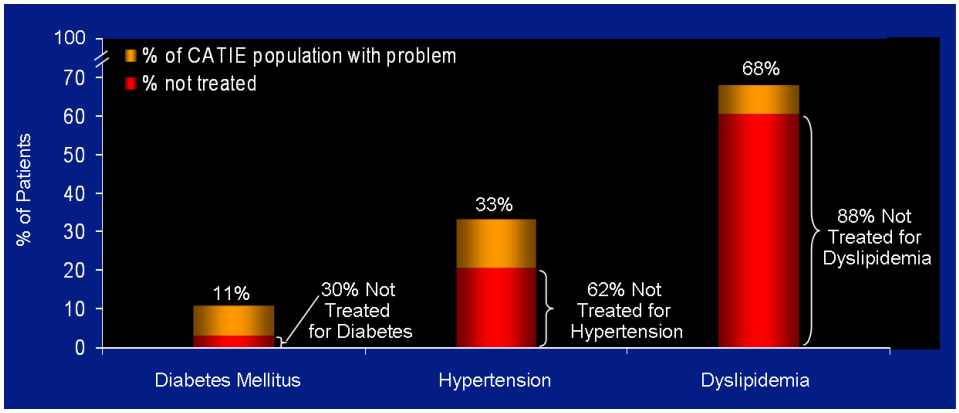
Regier DA et al. JAMA, 1990

In Primary Care Settings:

People with behavioral health concerns:

- Are less likely to receive effective medical care, including preventive services
- Report difficulties establishing relationships with primary care providers
  - Time limitations and stigma

Rates of Non-treatment



Nasralla, et al Schizophrenia Research 2006(86)

Why Primary Care Services in Mental Health?

- High rates of physical illness with mental illness
- Premature mortality
- People with mental illness receive a lower quality of care in primary care settings
- High cost of physical illness with mental illness
- *Access problems*

Our Mission:

Recovery.

SAMHSA HRSA Health Resources & Services Administration integration.samhsa.gov

Principles

- Physical health care is a core service for persons with serious mental illness
- Mental health systems have a primary responsibility to ensure:
  - Access to preventive health care
  - Management and integration of medical care

Key Opportunity

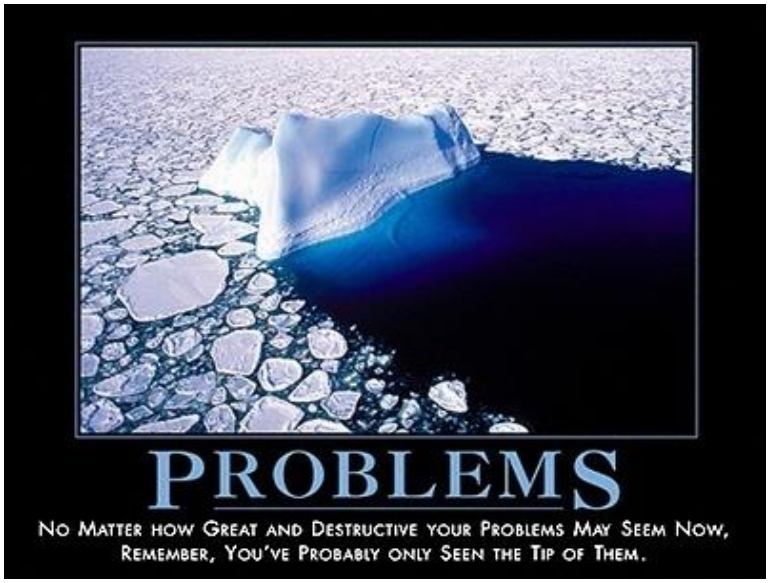
- Integrating care offers an important opportunity to reduce disparities:
  - Eliminate the early mortality gap
  - Reach people who cannot or will not access specialty behavioral health care
  - Intervene before issues develop or worsen

Drivers of Integration Demand

- ACA insurance reforms and coverage expansions provide new coverage many people need and want for behavioral health services
  - ACA requires newly covered populations meet the requirements of Wellstone-Domenici Parity Act
  - Multiple parts of ACA require or incentivize integration of behavioral health and general medical care
- Stigma of mental illness and addictions continues to decline
- Greater awareness of the need to increase access to mental health and addiction treatment

Benefits of Integration

- Patients prefer it
- Referral success rate rises from 15-20% to 40-60%
- Builds personal relationships – the foundation of any enduring arrangement
- Allows more accurate understanding of each other's incentives, methods and constraints
- Opportunities for informal consultation
- Single clinical record reduces errors



Barriers to Providing Primary Care to Psychiatric Populations

Cultural
- Mental health staff and patients not used to incorporating primary care as part of job
- Mental health staff feel time pressure to address screening, vital signs and may feel "out of scope of practice"

Financial
- Rarely funded
- Billing medical services challenging
- High no show rate, take extra time
- Psychiatric staff not provided resources to provide care (medical assistants to take vitals before appointments, blood pressure cuffs, scales)

Motivational
- Lack of perceived need for care
- Lack of motivation as part of negative symptoms of schizophrenia

Organizational
- Devoting space, time, and money
- Specialists do not cross boundaries
- Different languages
- Behavioral health EHRs may lack capacity to track physical health indicators
- Not perceived as part of the mission

Logistical
- Clinic location not always close proximity, which is crucial to success
- Not always in same building
- Space limitations

Patient-Level Factors

Lack of motivation, apathy

Cognitive impairment

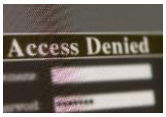
Lack of perceived need for health care

Poverty

Comorbidity

Fear and distrust

Poor social, communication skills



Lack of access to care

Provider-Level Factors

Lack of knowledge about specific disorders

Attribute physical symptoms to mental illness and miss the problems

Why bother? "Just treat the Schizophrenia and leave the rest."

Fear and Distrust

Discomfort

Take too long, high no-show, impacts bottom line

Lester HE. BMJ, doi.1136/bmj.38440.418426.8F 2005

What is Effective Integrated Care?

Principles of Effective Integrated Behavioral Healthcare

Person-Centered Team Care / Collaborative Care

- Co-location is not collaboration. Team members learn to work differently.

Population-Based Care

- All patients tracked in a registry. No one "falls through the cracks."

Measurement-Based Treatment to Target

- Treatments are actively changed until the clinical goals are achieved.

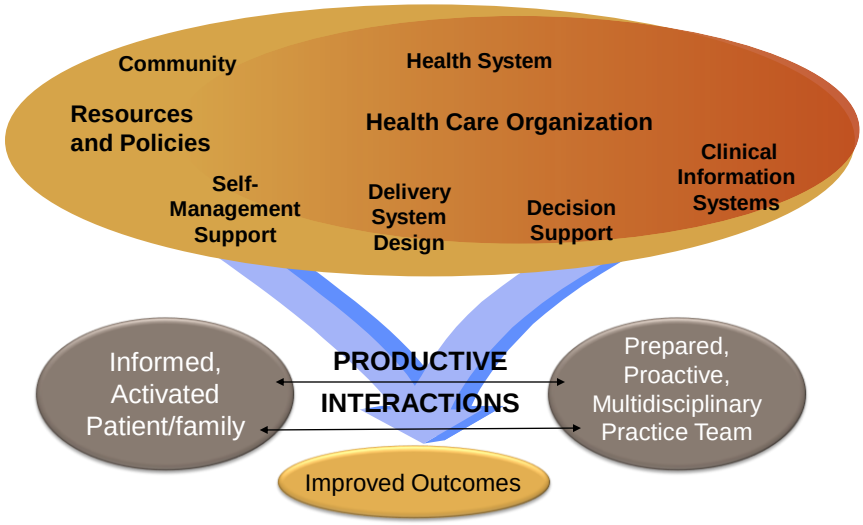
Evidence-Based Care

- Treatments used are evidence-based.

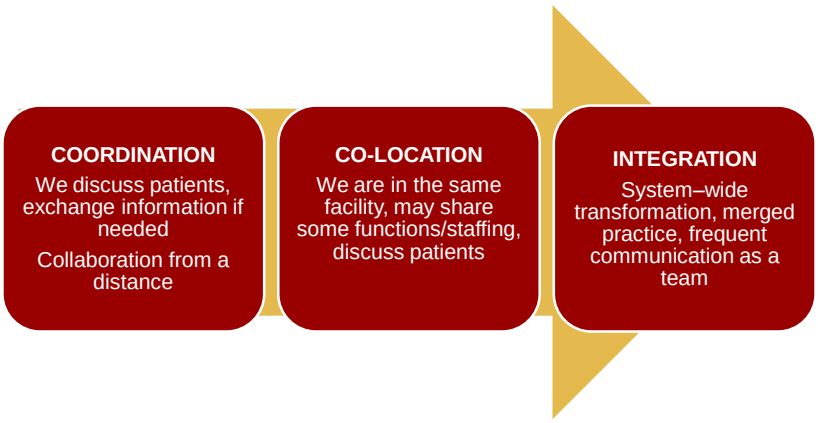
Accountable Care

- Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

The Wagner Chronic Care Model



Standard Framework of Integration



Doherty et al, 2013

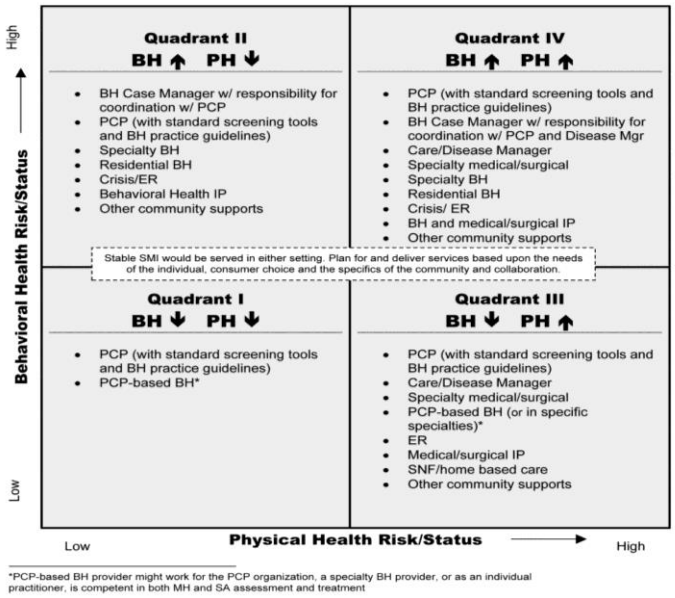
6 Levels of Collaboration/Integration

- **Coordinated Care - Key Element is Communication**
  - Level I - Minimal collaboration
  - Level II – Basic collaboration at a distance
- **Co-Located Care - Key Element is Physical Proximity**
  - Level III - Basic collaboration on site
  - Level IV - Close collaboration on site with some system integration
- **Integrated Care - Key Element is Practice Change**
  - Level V - Close collaboration approaching an integrated practice
  - Level VI - Full collaboration in a transformed merged integrated practice

Differences by Level of Integration

Level	Proximity	Systems	Communicate	Meet
I	Separate facilities	Separate	Rarely as provider needs	Maybe never
II	Separate facilities	Separate	Periodically as patient needs	As larger community
III	Same facility Separate space	Separate	Regularly by phone or email	Occasionally to discuss cases
IV	Same facility Share space	Some shared	Regularly in person as needed	Regular on some patients
V	Some shared space	Partially integrated	Frequently in person	Regular team meetings
VI	Share all space	Fully integrated	Consistently as individuals & team	Team meets on systems & patients

Four Quadrant Model



Developing Models

- Primary Care Access, Referral and Evaluation (PCARE)
- SAMHSA-HRSA Primary and Behavioral Health Care Integration (PBHCI) Grantees
- 2703 Medicaid State Plan Amendments (SPA)
  - Allow for enhanced Medicaid funding (usually case rate) for Health Home for patients with SMI
  - May be located in a community mental health center, sometimes called a “behavioral health home”

Integrating Behavioral Health into Primary Care

Helpful, but not sufficient:

- Physician training
- Screening
- Referrals
- Co-location of services

Behavioral Health Consultant

- Psychological problems, such as anxiety and depression
- Substance use disorders and risk reduction
- Psychological components of physical illness, both acute and chronic
- Psychological components of physical illness, both acute and chronic
- Factors impacting health status: stress, non-adherence, health behavior, social support

Strongest Evidence Base

Collaborative Care Model

- >25 years of research
- >38 randomized controlled trials, including IMPACT
- A population health management approach
- Adaptation of Wagner's chronic care model

www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2

IMPACT Study: J Unutzer, *JAMA*. 2002;288:2836-2845; and AIMS Center http://impact-uw.org/

Collaborative Care's Key Ingredients

- Care management – Patient education and empowerment, ongoing monitoring, care/provider coordination
- Evidence-based treatments – Effective medication management, psychotherapy
- Expert consultation for patients who are not improving
- Systematic diagnosis and outcome tracking
- Stepped care
- Technology support – registries

J. Unutzer, 2010, www.cimh.org/LinkClick.aspx?fileticket=84F6JQndwg8%3d&tabid=804
S. Gilbody et al, Arch Intern Med. 2006;166:2314-2321

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Identification of behavioral problems (alcohol, other drug, tobacco, depression, anxiety) and level of risk:

- **Low risk:** Raise awareness and motivate client to change
- **Moderate risk:** Provide brief treatment (cognitive behavioral, medications) with clients who acknowledge risks and are seeking help
- **High risk:** Refer those with more serious or complicated MH/SU conditions to specialty care

Used in primary care centers, hospital ERs, trauma centers, and other community settings

See http://sbirt.samhsa.gov/ for more information

Integrating Primary Care into Behavioral Health Settings

Same principles appear to apply

- Beginning Steps:
  - Screening and tracking of basic health indicators for everyone on psychotropic meds
    - Glucose, lipid levels, blood pressure, weight, BMI, etc.
  - Identification of and coordination with the primary care provider
- Wellness programs, including peer-led
- Collaborative care

The Medical Home

Patient-Centered Medical Home (PCMH)

- Ongoing relationship with a primary care provider
- Team with collective responsibility for ongoing care
- "Whole person" orientation

PCMHs need behavioral health capacity – mental health and substance use services need to be *integrated* into the medical home

Person-Centered Healthcare Home

- May be a primary care or behavioral health setting depending on a person's preference

- See www.thenationalcouncil.org for more info on person-centered healthcare homes and the role of behavioral health in medical homes.
- See www.pcpcc.net for more about medical homes.

How Do People Receiving Integrated Services Feel About Their Care?

People receiving integrated services report higher quality of life and greater satisfaction with:

- Access
- Attention to their treatment preferences
- Courtesy
- Coordination & continuity of care
- Overall care

Druss et al, Arch Gen Psychiatry. 2001; 58(9): 861-8.
Unutzer et al, JAMA. 2002; 288(22): 2836-2845.
Ell et al, Diabetes Care. 2010; 33(4): 706-713.

*"It is great having my two providers in the same building because **they talk with each other at the time of the problem** rather than me having to wait until I see my provider for psych meds and/or my therapist."*

– Jackie, Pathways Community Behavioral Healthcare, Clinton, MO

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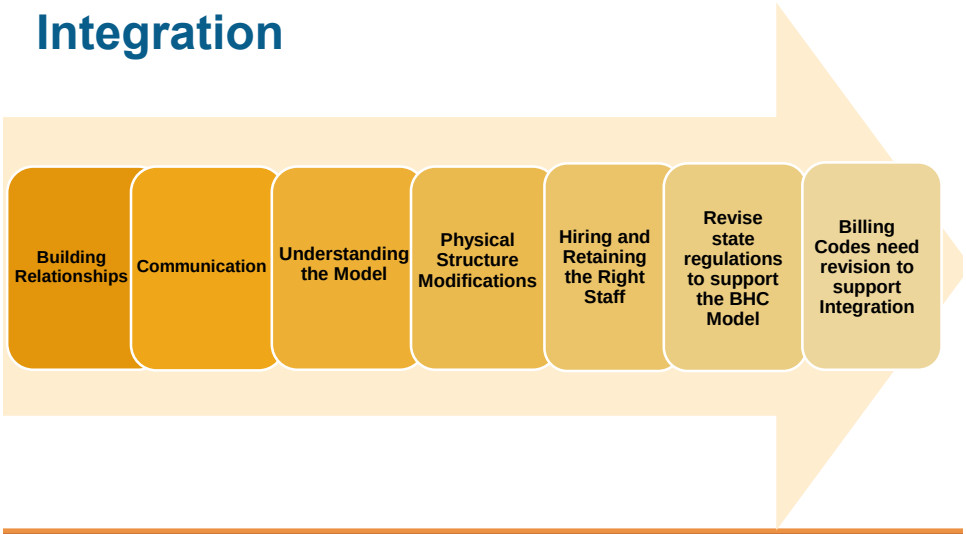
"Around the time that my bipolar condition was identified, I was diagnosed with kidney disease. Between the two disorders, it was a pretty upsetting time in my life… My doctors, dialysis clinic staff, and mental health case manager are well-connected. ***They take a team approach****, and they each check on the status of my health...* ***Today I have control over my health****; it doesn't have control of me. The coordinated care allows me to feel like I can go out and be a part of the community."*

– Cassandra McCallister, Board Member, Washtenaw Community Health Organization, Ypsilanti, MI

How You Can Get Involved and Learn More

Recurrent Themes on the Path to Integration



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What Makes Integration Possible?

- A relationship of basic trust between partners
- Transparent use of data instead of anecdotes to explore and discuss issues
- Principled negotiation and Motivational Interviewing
- Willingness of all partners to tolerate and share risk
- Willingness to change yourself first

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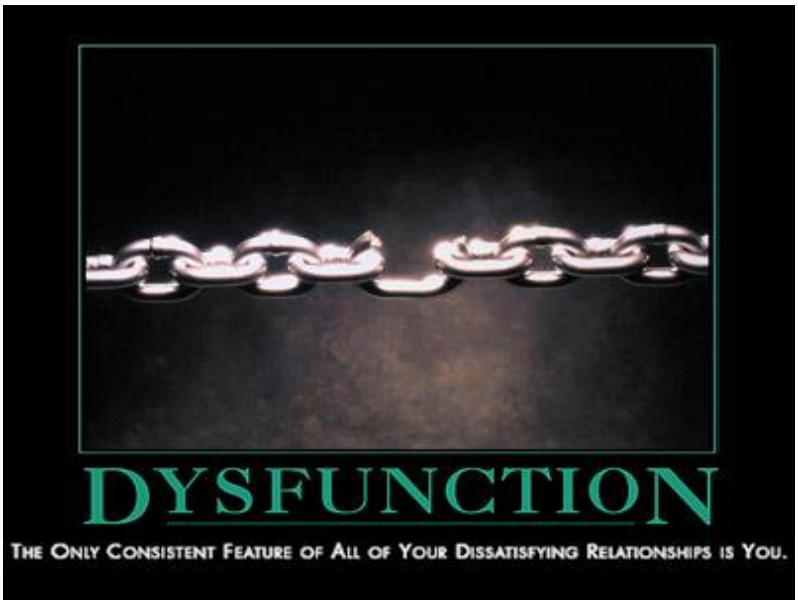


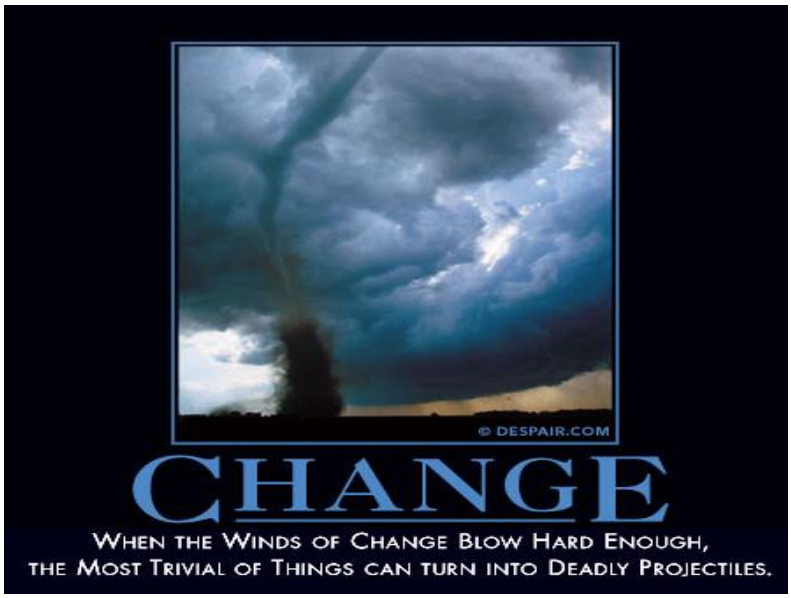
Partnership Principles

DO

- Ask about their needs first
- Give something
- Assist wherever you can
- Make it about the next 10
- Pursue common interest
- Reveal anything helpful
- Take one for the team

DON'T

- Talk about your need first
- Expect to get something
- Limit assistance to a specific project
- Make it about this deal
- Push a specific position
- Withhold information
- Let them take their lumps



CIHS Tools and Resources

Visit www.integration.samhsa.gov or
e-mail integration@thenationalcouncil.org

CIHS Tools and Resources

CIHS' Standard Framework for Levels of Integrated Healthcare helps primary and behavioral healthcare provider organizations improve outcomes by helping them understand where they are on the integration continuum. There are a number of assessment tools designed to help provider planning.

Lexicon for Behavioral Health and Primary Care Integration. Agency for Healthcare Research and Quality Integration Academy

Four Quadrant Model: This model describes levels of integration in terms of primary care complexity and risk and MH/SU complexity and risk.

CIHS Tools and Resources

Quick Start Guide to Behavioral Health Integration is an interactive flowchart to walk you through some of the questions to consider when integrating behavioral health care.

The Core Competencies for Integrated Behavioral Health and Primary Care provide organizations and individual professionals a "gold standard" for the skill set needed to deliver integrated care.

Customized Billing and Financial Worksheets for each state to help identify existing billing opportunities for services provided in integrated healthcare settings

Lessons Learned - Check out the eSolutions on Lessons Learned from Integration Pioneers or view the webinar to hear from SAMHSA Primary and Behavioral Health Care Integration (PBHCI) grantees who have taken on the task of integrating primary care into their services.

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Thank you for joining us today.

Please take a moment to provide your feedback by completing the survey at the end of today's webinar.

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