Integrating Primary and Behavioral Health Services

Part 1

Content developed from materials provided by McSilver

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About the McSilver Institute

The McSilver Institute for Poverty Policy and Research at New York University Silver School of Social Work is committed to creating new knowledge about the root causes of poverty, developing evidence-based interventions to address its consequences, and rapidly translating research findings into action through policy and practice.

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About PCDC

Primary Care Development Corporation (PCDC) is a national nonprofit organization and a community development financial institution catalyzing excellence in primary care through strategic community investment, capacity building, and policy initiatives to achieve health equity.

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Integrating Primary and Behavioral Health: Part I

Today's Objectives:

- What is integrated care?
- Why is integration important?
- What is the impact of integration?

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The Current Healthcare System: Dis-Integrated

Mental Health, substance use and physical health care providers are typically

- In different locations
- Non-holistic: focus only on a narrowly defined set of problems (assessment, treatment and outcomes)
- Don't communicate/coordinate services for patients with multiple needs (hardly talk to each other)
- Spend their time with similarly trained practitioners
- Have their own set of regulatory, licensing and credentialing requirements
- Have little understanding of the interdependence of emotional functioning, physical health and substance use
- Unfamiliar with multi-disciplinary team work

What does "typical" care usually look like?

Medical Arena:

- Nurse takes vitals and initiates inquiry around the purpose of the visit (5 minutes)
- Individual medical practitioner diagnoses, prescribes further tests and provides treatment or refers to a specialist (10-15 minutes)
- Nurse may follow up with a call
- Focus on narrow complaints of the patient

Behavioral Health Arena: Mental Health

- Intake Interview with many life areas covered (60-90 minutes)
- Individual therapist assigned and sets up first meeting (45 minutes)
- Psychiatrist identified and sets up first mental status and psychiatric diagnosis and medication (15-30 minutes)
- Sets up follow-up meetings on a monthly, bi-monthly or quarterly basis
- Individual, group or more intensive treatments including full day services
- Focus primarily on mental health-related symptoms and functional problems

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What does “typical” care usually look like?

Behavioral Health Arena: Substance Abuse

- Intake Interview with many life areas covered with major focus on the details of substance abuse: types of substances, frequency of use, history of abuse, consequences associated with abuse (60-90 minutes)
- Substance use counselor assigned and sets up first meeting (45 minutes)
- Based on assessment, Medication Assisted Treatment options explored
- Individual, group or more intensive treatments including full day services
- Establish mental status and psychiatric diagnosis and medication (15-30 minutes)
- Follow-up meetings on a monthly, bi-monthly or quarterly basis
- Focus primarily on addiction behaviors and strategies to reduce cravings and eliminate substance abuse

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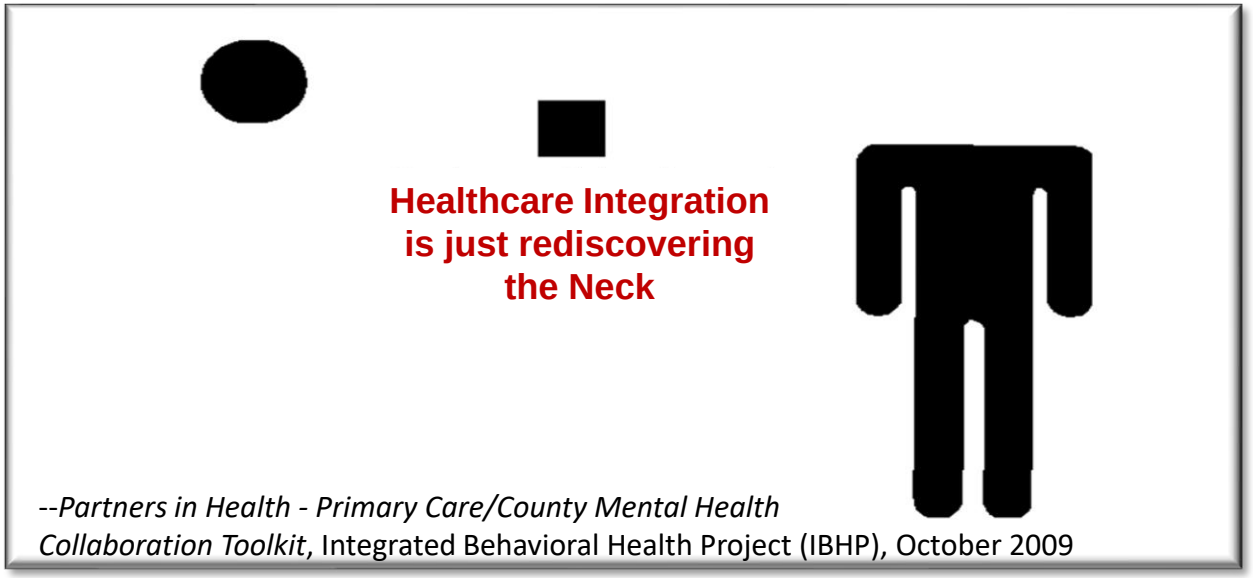
Integrated Care: Reconnection of the Head and the Body

Behavioral Health

Physical Health



--*Partners in Health - Primary Care/County Mental Health Collaboration Toolkit*, Integrated Behavioral Health Project (IBHP), October 2009

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Integration: A New Initiative?

The Body must be treated as a whole and not just a series of parts.

--Hippocrates 300 BC

What is Integrated Behavioral Health?

The care a patient experiences as a result of a team of PC & BH clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

C. J. Peek & The National Integration Academy Council's Lexicon for Behavioral Health and Primary Care Integration (2013)

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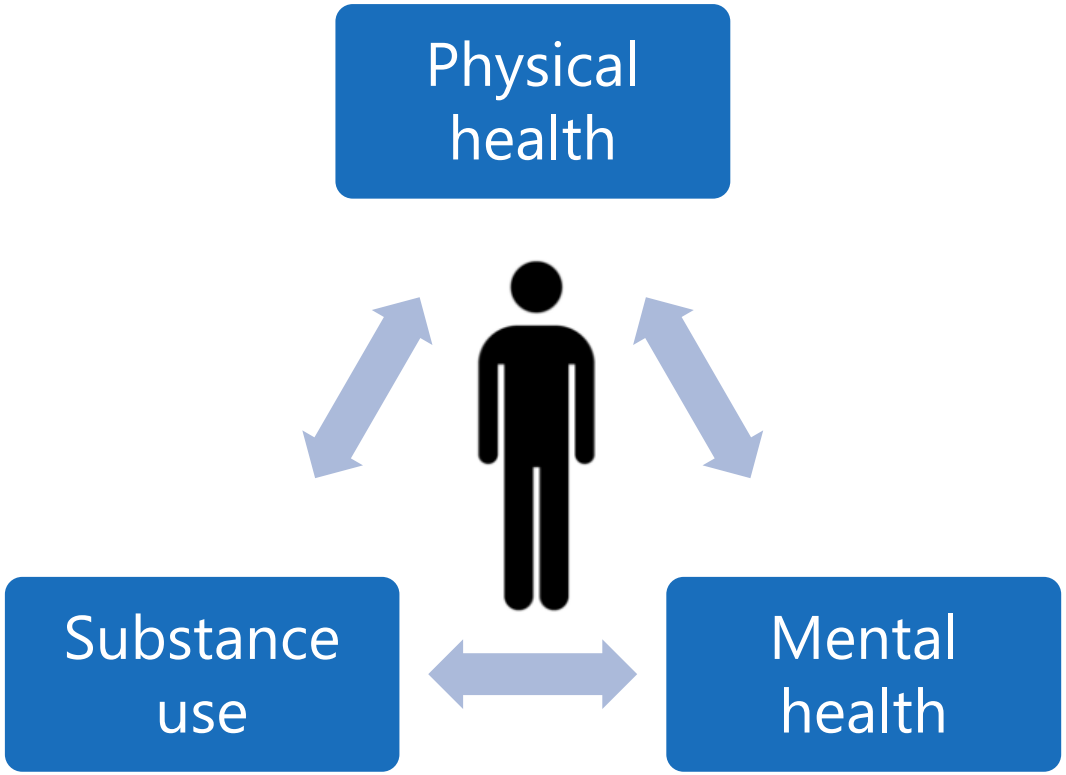
What is Integrated Behavioral Health?



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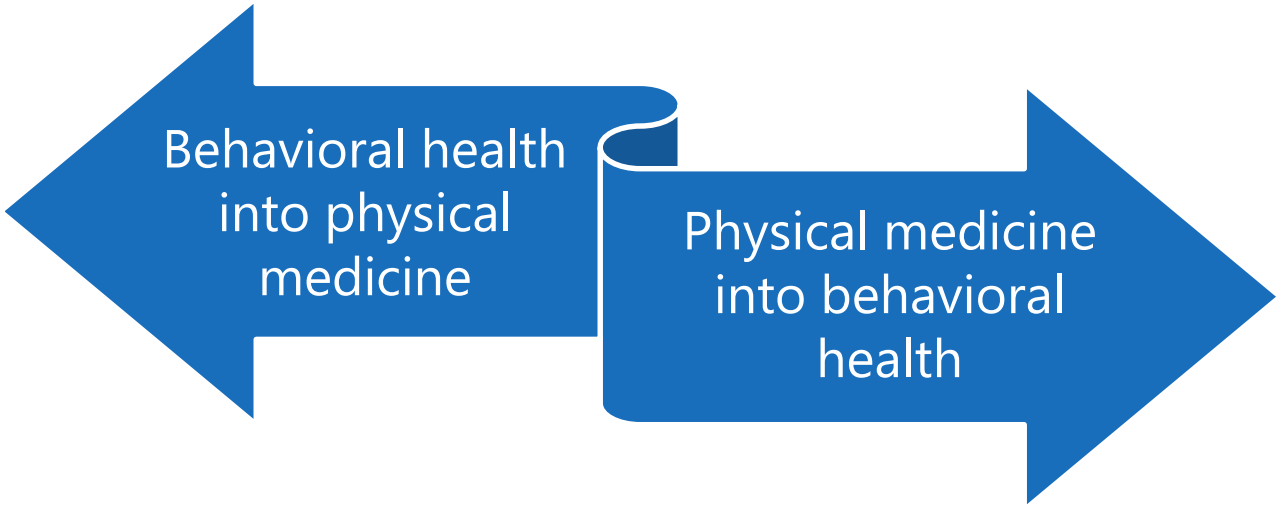
Bi-directional opportunities in an integrated system of care



Which direction is best?

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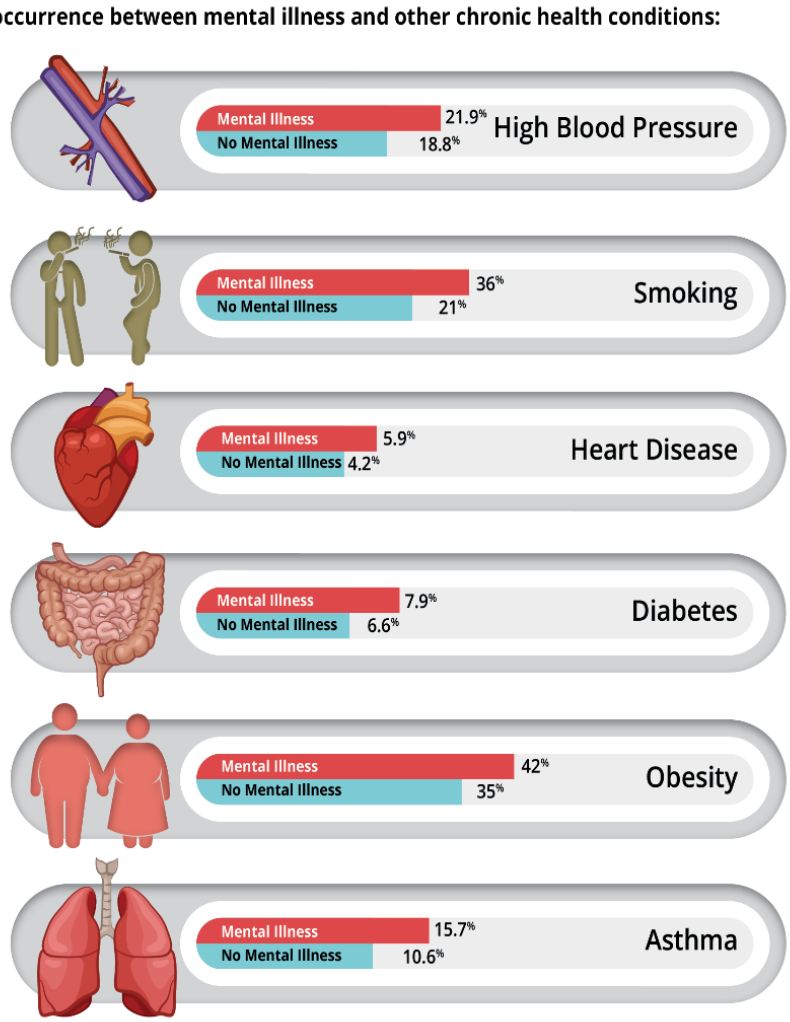
In the U.S., about:

- **1 in 5 adults experiences mental illness**
  - 18% experienced an anxiety disorder
  - 7% experienced one major depressive episode
- **1 in 25 adults experiences a serious mental illness**
  - 2.6% of adults live with bipolar disorder
  - 1.1% of adults live with schizophrenia
- **1 in 5 youth aged 13–18 experiences a severe mental disorder at some point during their life**
- **Among the 20.2 million adults who experienced a substance use disorder, 50.5% had a co-occurring mental illness**

(National Alliance on Mental Illness; NAMI)



(SAMHSA-HRSA Center for Integrated Health Solutions)

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Challenges Experienced by People with Serious Mental Illness

- Smoke more
- Eat less nutritious food
- Have higher BMI levels (obesity)
- Exercise less
- Use emergency rooms at a greater rate
- Higher rates of diabetes, arthritis, asthma, heart disease
- Persons with both chronic disease and mental illness have higher costs and poorer outcomes
- See physicians and other healthcare providers less
- Are more likely to underuse, overuse, or misuse medication
- Are prescribed antipsychotic drugs that have been linked to increased incidence of obesity, diabetes, and hyperlipidemia in patients with SMI
- Often live in neighborhoods that makes healthy lifestyle changes difficult

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Cost of Treating Patients with Chronic and Mental Health Conditions is High

- Costs for treating patients with chronic medical and comorbid mental health/substance use disorders can be **2-3 times higher**
- Additional costs incurred by people with behavioral comorbidities estimated to be **$293 billion** in 2012
- Estimated **$26 - $48 billion** can be potentially saved annually through effective **integration** of medical and behavioral services

Figure 5d - Impact of Behavioral Comorbidities, Medicaid Population – 2012 Total PMPM Costs

Body System (Condition)		No MH/SUD	MH/SUD
Benign/In Situ/Uncertain Neoplasm		$686	$1,580
Cardio-Respiratory Arrest		$4,798	$5,134
Cerebro-Vascular		$2,052	$3,299
Cognitive Disorders		$2,319	$3,552
Diabetes	>2x cost	$1,066	$2,368
Ears, Nose, and Throat		$488	$1,455
Eyes		$587	$1,625
Gastrointestinal		$843	$1,932
Genital System		$662	$1,538
Heart	>2x cost	$1,023	$2,134
Hematological		$1,419	$3,003
Liver		$1,328	$2,564
Lung		$737	$1,912
Malignant Neoplasm		$1,913	$3,185
Musculoskeletal and Connective Tissue		$693	$1,624
Neurological		$1,476	$2,365
Nutritional and Metabolic		$815	$1,923
Pregnancy-Related		$1,147	$1,669
Skin and Subcutaneous		$598	$1,771
Urinary System		$1,079	$2,395
Vascular		$1,808	$3,375
Total *(including those without any medical conditions)*		**$382**	**$1,301**

Source: Melek, et al (2014). Economic Impact of Integrated Medical-Behavioral Healthcare Implications for Psychiatry. https://integrationacademy.ahrq.gov/resources/new-and-notables/economic-impact-integrated-medical-behavioral-healthcare-implications

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People with serious mental illnesses (SMI) are at risk of premature death, largely due to cardiovascular and metabolic disorders associated with obesity, sedentary lifestyle, and smoking. Until very recently, mental health services have neglected prevention and health promotion as a core service need for people with SMI.

Steve Bartels, M.D., Dartmouth Medical Center

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What Do These Challenges Add Up To?

People living with a serious mental illness may die 25 years earlier unless we can do something different.

National Association of State Mental Health Program Directors report “Morbidity and Mortality in People with Serious Mental Illness”

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Behavioral Health Specialty Services are Not the Only Access Point

- Depression is the 3rd most common reason for a visit to a health center after diabetes and hypertension
- Opioid-related overdoses and misuse have reached epidemic proportions
- Prior to a suicide attempt, many people recently saw primary care
- Populations of color are even more likely to seek or receive care in primary care than in specialty behavioral health settings

- 70% of antidepressant prescriptions are written in primary care
- People with common medical problems are more likely to have behavioral health needs
  - Diabetes
  - Heart disease
  - Asthma with depression

(Worse outcomes and higher costs if <u>both</u> problems aren't addressed)

1. Ansseay M, et al. (2004). High prevalence of mental disorders in primary care. J. Affect Disorder; Jan;78(1): 49-55
2. The Business Case for Behavioral Health Care. SAMHSA-HRSA Center for Integrated Health Solutions. https://www.integration.samhsa.gov/financing/The_Business_Case_for_Behavioral_Health_Care_Monograph.pdf
3. Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. *Am J Psychiatry*. 2002;159:909-916

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The Triple Aim is…in Essence a Call for Care Integration

1. **Improving the Health of Populations of People**
2. **Bending the Cost Curve**
3. **Improving the Patient's Experience/Quality of Care**

Source: Berwick, Nolan, & Whittington (2008). The Triple Aim: Care, Health, And Cost. *Health Affairs*. vol. 27 no.3, 759-769.

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SAMHSA Levels of Integration

Level 1 *Minimal Collaboration*	Level 2 *Basic Collaboration at a Distance*	Level 3 *Basic Collaboration On-Site*
• Separate systems • Communicate about cases only rarely and under compelling circumstances • Communicate, driven by provider need • May never meet in person • Have limited understanding of each other's roles	• Separate systems • Communicate periodically about shared patients • Communicate, driven by specific patient issues • May meet as part of larger community • Appreciate each other' s roles as resources	• Separate systems • Communicate regularly about shared patients, by phone or e-mail • Collaborate, driven by need for each other' s services and more reliable referral • Meet occasionally to discuss cases due to close proximity • Feel part of a larger yet ill-defined team

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SAMHSA Levels of Integration

Level 4 *Close Collaboration On-Site with Some System Integration*	Level 5 *Close Collaboration Approaching an Integrated Practice*	Level 6 *Full Collaboration in a Transformed/ Merged Integrated Practice*
• Share some systems, like scheduling or medical records • Communicate in person as needed • Collaborate, driven by need for consultation and coordinated plans for difficult patients • Have regular face-to-face interactions about some patients • Have a basic understanding of roles and culture	• Actively seek system solutions together or develop work- a- rounds • Communicate frequently in person • Collaborate, driven by desire to be a member of the care team • Have regular team meetings to discuss overall patient care and specific patient issue • Have an in-depth understanding of roles and culture	• Have resolved most or all system issues, functioning as one integrated system • Communicate consistently at the system, team and individual levels • Collaborate, driven by shared concept of team care • Have formal and informal meetings to support integrated model of care • Have roles and cultures that blur or blend

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Core Components of Integrated Models

Patient-Centered Care Teams

- Team-based care: effective collaboration between PCPs and behavioral health providers.
- Nurses, social workers, psychologists, psychiatrists, licensed counselors, pharmacists, and medical assistants can all play an important role.

Population-Based Care

- Behavioral health patients tracked in a registry: no one "falls through the cracks."

Measurement-Based Treatment to Target

- Measurable treatment goals clearly defined and tracked for each patient.
- Treatments are actively changed until the clinical goals are achieved.

Evidence-Based Care

- Treatments are evidence-based.

Source: Beh Health Homes for People with MH & SA, 2012. http://www.integration.samhsa.gov/clinical-practice/CIHS_Health_Homes_Core_Clinical_Features.pdf

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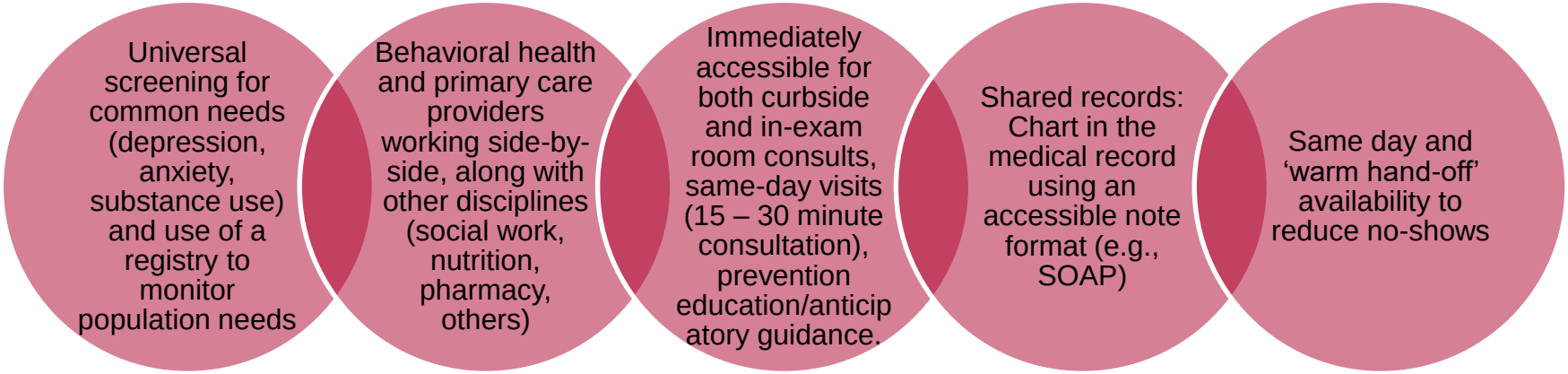
What can integration look like?



Partially adapted from Robinson, P.J. and Reiter, J.T. (2007). Behavioral Consultation and Primary Care (pp 1-16). N.Y.: Springer Science + Business Media.

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Common Intervention in Integrated Settings

- Brief treatments (versus traditional long-term therapies)
- Address a clear problem (depression, insomnia, pain)
- Help patients learn to manage the issues they live with (weight, chronic disease, tobacco use)
- Involve different types of professionals (doctors and nurses, social workers, psychologists, nutritionists, pharmacists) all addressing a related problem(s) in a single setting

Don't healthcare providers already know this stuff?

- Disconnect between training and the field
- Inconsistent standards between trade associations and accrediting bodies
- Integrated care is unique and distinct from traditional methods of thinking about patients' needs, delivering services, and organizing clinics

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What is the Impact of Integration

Integrated Care "can improve mental and physical outcomes for individuals with mental disorders across a wide variety of care settings, and they provide a robust clinical and policy framework for care integration."

Source: Comparative Effectiveness of Collaborative Chronic Care Models for Mental Health Conditions Across Primary, Specialty, & Behavioral Health Care Settings: Systematic Review and Meta-Analysis. *Am J Psychiatry 2012;169:790-804.*

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The Case for Integration: Improved Functioning in Primary Care Patients

- Patients treated in integrated care live better, are more functional, and less distressed
  - Studies examining integration of behavioral health into primary care find improvements in:
    - Anxiety
    - Depression
    - Trauma
    - Sleep
    - Tobacco

(Hunter, 2017; DOI: 10.1007/s10880-017-9512-0)

The Case for Integration: People with Severe Mental Illnesses

"…greater reductions in select indicators of risk for metabolic syndrome and several physical health conditions, including hypertension, dyslipidemia, diabetes, and cardiovascular ."

Source: RAND, 2013. Eval. SAMHSA Primary & Beh. Health Care (PBHCI) Grant Program: Final Report.

The Case for Integration: Satisfaction

- Patients in integrated primary care behavioral health settings have reported high levels (e.g., 97%) of satisfaction and increased functioning
- Team-based primary care-behavioral health care has also been shown to improve provider satisfaction and decrease provider burn-out

(Blount, 2003; https://doi.org/10.1037/1091-7527.21.2.121)
(Angantyr, 2015; https://doi.org/10.2224/sbp.2015.43.2.287;
Runyan, 2004; https://doi.org/10.1089/109350703322425527)

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The Case for Integration: Cost Savings

- Numerous studies have revealed cost savings with regard to decreased use of ED and admissions
  - 19% reduction in ED visits
- Overall reduction in number of primary care visits
- Individuals participating in primary care depression management experienced a reduction in workplace absenteeism by over 28%

(Lute & Manson, 2015; 10.1007/978-3-319-19036-5_2) (Institute for Healthcare Improvement, October 31, 2008) (Smith & Dickinson, 2004)

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Initial Estimated Cost Savings after 18 Months

Missouri Health Homes Total Saving

- 43,385 persons total served
- Cost Decreased by $51.75 PMPM
- Total Cost Reduction $23.1M

Source: Parks, J
See:http://www.integration.samhsa.gov/Joe_Parks,_Envisioning_the_Future_of_Primary_amd_Behavioral_Healthcare_Integration.pdf

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Integrated Care is Widely Supported

"Evidence has shown that mental disorders, especially depressive disorders, are strongly related to the occurrence, successful treatment, and course of many chronic diseases including diabetes, cancer, cardiovascular disease, asthma, and obesity."[1]

"People who receive primary care often may have multiple health issues... Integrating behavioral and primary care is especially important to meeting their needs. People with co-occurring disorders may seek primary care services first before seeking behavioral health services… primary care practitioners have unique opportunities to identify people with co-occurring disorders through screening."[2]

"By providing mental health services in primary healthcare, more people will be able to receive the mental healthcare they need." [3]

Sources:
1. https://www.cdc.gov/
2. https://www.samhsa.gov/disorders/co-occurring
3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2777553/

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Changes in NY and Nationally Promoting Integration

Federally-Qualified Health Centers expanding and partnering to provide behavioral health access

Medicare Psychiatric Collaborative Care Model (new Medicare billing codes)

NYS Delivery System Reform Incentive Payment Program billing and regulatory waivers

Expansion of Accountable Care Organizations designed to bring array of services under one roof

Health Homes address collaboration and coordination

Behavioral health programs expanding physical health services billable under their license

Certified Community Behavioral Health Centers (CCBHC)

Patient-Centered Medical Homes establishing multi-disciplinary teams

Community behavioral health organizations partnering with primary care organizations (including FQHCs)

(click the link in each box to learn more)

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End Goal: Whole Person Care

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Up Next: Part II

Applications of integrated care for children and youth

Further Reading/Resources

- Felt-Lisk, S. & Higgins, T. (2011). Exploring the Promise of Population Health Management Programs to Improve Health. Mathematica Policy Research Issue Brief. https://www.mathematica.org/our-publications-and-findings/publications/exploring-the-promise-of-population-health-management-programs-to-improve-health
- Parks, J., et al. (2014) Population Management in the Community Mental Health Center-based Health, Center for Integrated Health Solutions Homeshttp://www.integration.samhsa.gov/integrated-care-models/14_Population_Management_v3.pdf
- http://www.integration.samhsa.gov/ (Great resource on everything integration)
- http://www.integratedcareresourcecenter.com/ (Website detailing what is happening with health reform in each state)
- http://www.chcs.org/ (Website focused on publicly funded healthcare and the transformations underway)
- https://www.health2resources.com/ (Updates on the ACA for professions—great site to sign up for email notices)
- https://www.ahrq.gov/ (1.Framework for understanding measurement of integrated care; 2. A list of existing measures relevant to integrated behavioral health care; & 3.Organizes measures by the framework and by user goals to facilitate selection of measures).

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Further Reading/Resources

- Population Health Management: A Roadmap for Provider-Based Automation in a New Era of Healthcare; Institute for Health Technology Transformation http://www.exerciseismedicine.org/assets/page_documents/PHM%20Roadmap%20HL.pdf
- CREEPING AND LEAPING FROM PAYMENT FOR VOLUME TO PAYMENT FOR VALUE Webpage https://www.thenationalcouncil.org/capitol-connector/2014/09/creeping-leaping-payment-volume-payment-value/
- Guide https://www.thenationalcouncil.org/wp-content/uploads/2014/09/14_Creeping-and-leaping.pdf
- Workbook http://www.thenationalcouncil.org/wp-content/uploads/2013/10/National-Council-Case-Rate-Tool-Kit.pdf
- CMS Innovation Center: Health Care Payment Learning and Action Network http://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/

Further Reading/Resources

- Population Management in Community Mental Health Center Health Homes – The National Council for Behavioral Health http://www.integration.samhsa.gov/integrated-care-models/14_Population_Management_v3.pdf

- AIMS Center Dashboard Templates https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data

Thank you!

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