



## INTEGRATING PRIMARY CARE AND BEHAVIORAL HEALTH SERVICES

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A Program of the Foundation of Health Leadership and Innovation

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### WHO ARE WE?



- Center of Excellence for Integrated Care (COE): [www.coeintegratedcare.com](http://www.coeintegratedcare.com)
- A program of the Foundation for Health Leadership & Innovation (FLHI): [www.foundationhli.org](http://www.foundationhli.org)
- COE Team:
  - A team of experienced professionals with both clinical experience and technical assistance expertise.
  - Additional experts from the community related to billing and coding, psychotropic medications, chronic disease treatment, and others.

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### COE PROJECTS AND PROGRAMS

Federally Qualified Health Care Centers (FQHCs)	Free clinics
Privately-owned primary care and specialty mental health and substance abuse	State-funded Integrated Care management organizations
Pediatric practices	Hospital systems
School-based health centers	Rural health organizations
University-based health centers and residency programs	State Department of Health and Human Services
Academic programs	Other professional organizations
Managed Care Organizations (MCOs)	State, Federal and philanthropic Funded Projects
Area Health Education Centers (AHECs)	

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## OBJECTIVES

1. Define integrated care on the continuum and the different models of integrated care
2. Discuss outcomes of integrated care and the impact on population health
3. Discuss strengths, challenges, and next steps of implementing integrated care

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## THE STATE OF HEALTH

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## STATE OF HEALTH

- 1 in 5 youth suffers from diagnosable emotional, mental/behavioral disorder (Merikangas, He, Burstein, et al., 2011)
- 70% of children who receive mental health services get them at school (Rones & Hoagwood, 2000; Burns, Costello, Angold, Tweed, et al., 1995)
- **Less than half** of primary care patients with mental illness receive any treatment
- Among Medicaid population, behavioral health conditions are more than twice as prevalent as in the general population, plus they experience 3-5 times the average healthcare costs and 4 times the hospitalization rates.
- Life expectancy is **25 years less** for seriously mentally ill than general population

(Boyd, et al., 2010; Gatchel & Oordt, 2003; Kravitz, et al., 2009; National Association of State Mental Health Program Directors, 2006; US Department of Health and Human Services, 2000)

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## ANNUAL MEDICAL COSTS FOR ADULTS

### THE COST OF CARE

	Without MH	With MH
• All adults	\$1,913	\$3,545
• Heart Condition	\$4,697	\$6919
• High BP	\$3,481	\$5492
• Asthma	\$2,908	\$4,028
• Diabetes	\$4,172	\$5559

(Robert Graham Center for Policy Studies in Family Medicine and Primary Care, 2008)

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## INTEGRATION OF SERVICES

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## DEFINITION

Integrated care is "care that results from a practice team of [medical] care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care..."

(Peek, 2013)

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## WHOLE HEALTH CARE

"It is in our communities where we must end the distinct and separate histories and management of mental health from physical health; we need to change the dialogue to focus on whole and inclusive health for all people."

(Miller, Gilchrist, Ross, Wong, & Green, 2016)

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## Paradigm Shift



Behavioral Health Providers    All Clinic Staff  
Medical Providers    Administration    Patients & Families  
Root = Fundamental or essential part

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## TREATING THE WHOLE PERSON

Whole-person care requires a more comprehensive approach (biopsychosocial model of assessment)

- Biological
- Psychological
- Cognitive
- Social
- Interpersonal
- Developmental
- Spiritual
- Culture and other contextual factors

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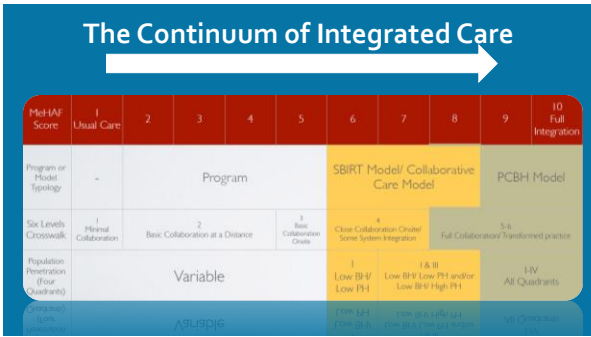
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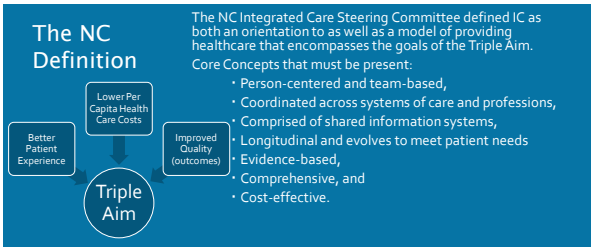
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### DEFINING IC IN NC




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### OUTCOMES FOR INTEGRATED CARE

- Decreases depression levels
- Improves quality of life
- Decreases stress
- Increases higher functioning
- Promotes greater adherence to medical recommendations and lifestyle change – prevention as well as treatment
- Lowers rates of hospitalization
- Reduces hospitalization readmissions
- Encourages movement toward value-based care for better overall health outcomes and wellness
- Lower cost to the system

(BHP, 2009; Kim, et al., 2012; O'Donnell, et al., 2013; Reiss-Brennan, et al., 2016)

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## POPULATION HEALTH

- Preventative approach to mental health
  - Increases access to mental health
  - Reduces stigma
  - Reduces unnecessary utilization of specialty mental health systems
- **Three different models**
    - PCBH - provides strategic contact between the mental health professional, PCP and patient across visits (e.g. more patients impacted per behavioral health professional than in caseload model)
    - SBIRT – substance use screening
    - IMPACT – registry driven approach to depression treatment

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## MODELS OF INTEGRATED CARE

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## PROGRAMS VS. MODELS

- Programs:
  - Are unique efforts to make improvements compared to "usual care" that are site specific
  - No evidence base is present specific to the effort, but there may be some general rationale for the effort that links to research
- Models
  - Have a clear definition of practice, personnel roles
  - Have an evidence base
  - Fidelity measures

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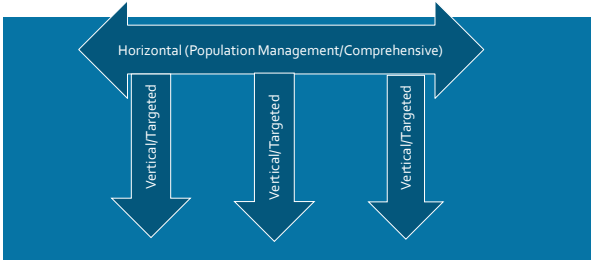
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### HORIZONTAL VS VERTICAL INTEGRATION




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### INTEGRATED CARE MODELS

- Differ in which populations they are applicable to
- Three exist: Collaborative Care (IMPACT), SBIRT & PCBH
  - Are not mutually exclusive and can run simultaneously in a practice setting given that two are vertical models (CC, SBIRT) and one is a horizontal model (PCBH)

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### PRIMARY CARE BEHAVIORAL HEALTH (PCBH)

#### WHAT

- Population Based – compared to vertical models – can see a wider range and more – In one year, 8 clinics = 8,000 patients with 19,000 visits (Reiter, 2015)
- Goal is to improve and promote overall health within a population.
- Clinical emphasis on function
- BHC operates as a consultant – not to create a case load of their own patients but are there to support the PCP.
- Team based with shared resources
- Can integrate care management and registries
- Often a core model of a practice – with possibly one of the other vertical models

(Robinson & Reiter, 2007)

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## PRIMARY CARE BEHAVIORAL HEALTH (PCBH)

### HOW -

- Generalist – applies to a broad range of issues, as many as PCP
- Be a teacher – helping PCP grow their behavioral health skill set
- Accessible – no formal schedule, but need structure for follow up that is strategically planned in the day. Access to patient as long as they continue to see PCP
- Minimal referrals to specialty mental health – mostly retaining up to 90%
- Involvement of family as support (e.g. hx gather/behavior mod)
- Interventions (Mountain View, 2013)
  - Assisting patients to replace maladaptive with adaptive traits
  - Skill training through psychoeducation
  - Developing specific behavior change plans to fit PC pace

(Robinson & Reiter, 2007)

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## PRIMARY CARE BEHAVIORAL HEALTH (PCBH)

### WHY -

- PCP is usually a patient's point of entry into the healthcare system
- If work life of PCP improves then they are more effective at patient care. They cannot do it alone and they are receptive (Reiter, 2013).
- Access to mental health/behavioral health services

### Notable outcomes

- Patients receiving just 2-3 visits showed broad improvement in functioning, well-being, with changes being robust and stable during 2-year follow-up (Bryan et al., 2009).
- Clinical gains two years post treatment of a brief behavioral health intervention in a primary care setting (Ray-Sannerud, Dolan, Morrow, Corso, Kanzler, Corso & Bryan, 2012)
- Improved frequency of screening tool use, reduction of referrals to specialty mental health, and reduce reliance on anti-depressant meds (Serano et al., 2011)

(Robinson & Reiter, 2007)

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## SCREENING, BRIEF INTERVENTION, & REFERRAL TO TREATMENT (SBIRT)

### Screening

- Assess patient for risky substance use behaviors (e.g. amount of consumption) using standardized screening tools
- Typically 1-3 questions – with follow up questions as needed



### Brief Intervention

- Engage in a short conversation including feedback and advice
- Time limited (5-30 minutes) and patient centered
- Increase insight, awareness, provide psychoeducation
- Encouraged to set goals



### Referral to Treatment

- Refer to brief treatment or additional treatment as needed (typically 5% or fewer)

(Babor et al., 2007)

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### SCREENING, BRIEF INTERVENTION, & REFERRAL TO TREATMENT (SBIRT)

#### WHY -

- Screening for substance use
- Helps those are not even looking for treatment (mild to moderate) in pre-contemplation stage
- Targets early intervention for non-dependent substance use
- Person trained in SBIRT to follow up with positive screens
- Substance use complicates healthcare conditions
- For every \$1 spent on screening – can save \$4 in healthcare costs
- Provides cost savings for employers as well

(Babor et al., 2007; Barbosa, Cowell, Bray, & Aldridge, 2015)

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### COLLABORATIVE CARE MODEL (IMPACT)

#### WHAT -

- Disease focused treatment model - depression
- Registry driven approach
- Collaboration between primary care, case manager & consulting psychiatrist
- Use of medication and visit algorithms
- Team based care
- Behavioral Activation and Problem Solving Treatment (PST)
- Improvement is defined by a reduction of the PHQ-9 score by 5 points or 50% within 10 weeks

(Unutzer et al., 2002)

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### COLLABORATIVE CARE MODEL (IMPACT)

#### WHY -

- At 12 months, about half of the patients receiving IMPACT care reported at least a 50 percent reduction in depressive symptoms (19% in usual care)
- Survey conducted one year after IMPACT shows that the benefits of the intervention persist after one year and last up to four years
- IMPACT patients experienced more than 100 additional depression-free days over a two-year period than those treated in usual care.

(Unutzer et al., 2002)

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## SERVICE DELIVERY COMPARISON

Traditional Primary Care	Traditional Behavioral Health	Integrated
PCP assesses for mental health issue	Intake done and patient sent to SU and/or MH counseling	PCP screens for behavioral health issues
Patient gets MH meds and maybe referred out to MH or SU system	MHSA develops separate Tx plan and refers to PCP for medical needs assessment	Behavioral Health Provider further assesses and makes Tx recommendations
1 out of 4 will show up to see counselor	Possible referral to psychiatrist if PCP uncomfortable with BH dx	Patient may get BH meds and/or BH services at PCP office.
50 min. counseling sessions	50 min. counseling sessions	20-30 min behavioral health sessions (time depends on level of integration)
Limited PCP/mental health provider communication	Limited PCP/SU/MH provider communication	Continuous PCP/behavioral health provider communication

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## EXAMPLES OF EVIDENCE-BASED INTERVENTIONS\* IN PRIMARY CARE

- For anxiety disorders:
    - Cognitive behavioral therapy (CBT), exposure, applied relaxation, exposure response prevention (for Obsessive Compulsive Disorder), and stress inoculation.
  - Substance misuse:
    - Community reinforcement, motivational interviewing, behavioral and marital therapy, and social skills training
  - Depression:
    - behavior therapy, brief psychodynamic therapy, IMPACT, CBT, and psychoeducation
  - Schizophrenia:
    - Behavioral family therapy, social-learning programs, and social-skills training
- \*These treatments assume that the patient will respond and has the primary and secondary supports for successful outcomes.

(Chambless & Ollendick, 2000)

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## SIDE-BY-SIDE COMPARISON

PCBH	SBIRT	IMPACT
<ul style="list-style-type: none"> <li>• Generalist</li> <li>• Warm handoff</li> <li>• PCP as first customer</li> <li>• Mirrors primary care</li> <li>• Horizontal model</li> </ul>	<ul style="list-style-type: none"> <li>• Universal screening</li> <li>• Brief intervention</li> <li>• Registry</li> <li>• Vertical model</li> </ul>	<ul style="list-style-type: none"> <li>• Registry driven</li> <li>• Medication and visit algorithm</li> <li>• Disease focused</li> <li>• Vertical model</li> </ul>

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## BIDIRECTIONAL INTEGRATION

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### BIDIRECTIONAL INTEGRATION

- Bidirectional Integrated Care involves placing primary health care providers into specialty mental health settings.
- Levels of bidirectional integration are also on a continuum.
- Primary Care services do not replace the need for more intensive, specialty care. The focus is on targeted medical issues for the population in the setting (Mauer & Jarvis, 2010).

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## IMPLEMENTATION

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## A COMMON UNDERSTANDING

- Begin with a clear description of integrated care
- Define the essential functions of what the practice wants for integrated care
- Operational definition

(Fixsen, Blasé, Metz, & Van Dyke, 2013)

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## EXPLORATION

- Critical step – often saves time and money (Romney, 2011)
- “During exploration, readiness is assessed by an Implementation Team.”  
<http://nim.fpg.unc.edu/learn-implementation/implementation-stages>
- Readiness Assessment – MeHAF (one example)
- Assessment should be conducted with full range of clinical, financial, operational/admin personnel and some or all (depending on availability and size of clinic) can form the implementation team for integrated care.

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## MEHAF PRACTICE ASSESSMENT

- The MeHAF is one tool that can be used to assess readiness
  - Best if done by a cross-cutting team of site personnel
  - Whenever possible pre and post administrations should be performed by the same individuals
  - Accuracy of interpretation of domains is key so team should be trained or self-train
  - Lowest reasonable score should be given for domains to allow for room for improvement
  - Focus on the process, not the score
  - At the end identify the domains that can be improved, celebrate the domains that are best

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## COSTS DURING IMPLEMENTATION

Cost Categories	Stages of Program Implementation			
	Planning	Training	Start up	Maintenance
Personnel	✓	✓	✓	✓
Supplies	✓	✓	✓	✓
Equipment			✓	✓
Training	✓	✓	✓	✓
Information systems			✓	✓
Outreach and communication			✓	✓
External consulting		✓	✓	✓

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## SUSTAINABILITY

### • Cost/sustainability

\* "processes for ensuring appropriate allocation of resources (utilizing community resources, leveraging less expensive personnel such as trainees); securing funding (fund-raising, grant writing, advocacy, and building partnerships with payers to adapt reimbursement strategies and change policy); ensuring receipt of payment for billable services; offering services for which patients are willing to pay out of pocket" (p. 70, Kwan & Nease Jr., 2013)




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## RECOMMENDATIONS FOR ECONOMIC EVALUATION OF BEHAVIORAL INTERVENTIONS

### Engage with the relevant stakeholders at the start of the program

- a. Identify provider(s) who might be champions of the program
- b. Identify the factors of primary interest to the organization

### Conduct a cost analysis to estimate the net cost of the intervention

- a. Prior to introduction of the program, identify current revenues and costs to delivering related services
- b. At the conclusion of the period of analysis, estimate the change in revenue and cost of delivering the service
- c. Estimate the net change in costs and revenues of delivering the service

### Estimate the value of the program/intervention to the patient (or payer)

- a. Estimate the patients' or payers' willingness to pay for the service using contingent valuation methods

### Identify the organization's return on investment

- a. Estimate the return on investment to each health care provider and organization involved with or influenced by the program

(Brown et al., 2014)

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## QUESTIONS?




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