UPDATE ON THE INTEGRATION OF BEHAVIORAL HEALTH AND PRIMARY CARE

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Professor of Family Medicine and Psychiatry
University of Massachusetts Medical School
Need for Change in Healthcare

- US healthcare is unsustainably expensive
  - It eats up about 18 cents of every dollar of wealth our economy generates (17.6% of GDP).
  - The average of European countries is 9.5%

- We have terrible healthcare for populations.
  - We have the best healthcare in the world for a few very sick individuals.
  - On all the population markers of health such as life span, we do not do well.

- In addition to the high cost of mediocre healthcare for the majority, unhealthy populations are very expensive and less productive throughout the lifespan.
EXHIBIT 9
Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000

Spending per beneficiary (dollars)

8,000

7,000

6,000

5,000

4,000

General practitioners per 10,000

SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTE: Total physicians held constant.
EXHIBIT 8
Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000

Quality rank

1

26

51

General practitioners per 10,000

SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTES: For quality ranking, smaller values equal higher quality. Total physicians held constant.
Understanding Primary Care: Two Approaches to Practice

<table>
<thead>
<tr>
<th>Specialist:</th>
<th>Generalist:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis-oriented</td>
<td>Problem-oriented</td>
</tr>
<tr>
<td>Time limited</td>
<td>Longitudinal</td>
</tr>
<tr>
<td>Focus on clarity and certainty</td>
<td>Tolerance for ambiguity, uncertainty</td>
</tr>
<tr>
<td>Reductionist</td>
<td>Holistic</td>
</tr>
<tr>
<td>Focus on technical expertise</td>
<td>Focus on the relationship</td>
</tr>
<tr>
<td>Uncommon events</td>
<td>Common events</td>
</tr>
<tr>
<td>Individual is the focus</td>
<td>Individuals, families and populations</td>
</tr>
</tbody>
</table>
Health reform is largely built around changing the role of primary care.

- If primary care is to be the hub of the healthcare wheel, instead of a feeder for the hospital and specialty system, it has to be enhanced.

- Concept of the Patient Centered Medical Home

- Then the PCMH has to be the center using the ACO as a total care, risk bearing organization.
The vast majority of services that make the US health system so expensive are related to behavioral disorders or behavioral factors

- The model of the Patient Centered Medical Home and the Accountable Care Organizations are being modified over time to require the integration of behavioral health services with medical services.
- Act.
The Prevalence and Cost of MHSA Comorbidities – Medicaid Adults*
Per 100k population - $535,680,000

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Prevalence</th>
<th>MHSA Comorbidity Prevalence</th>
<th>PMPM</th>
<th>No MHSA Comorbidity PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>04: Diabetes</td>
<td>9.6%</td>
<td>58.4%</td>
<td>$1,789.83</td>
<td>$801.03</td>
</tr>
<tr>
<td>05: Nutritional and Metabolic</td>
<td>29.4%</td>
<td>62.2%</td>
<td>$1,475.50</td>
<td>$633.19</td>
</tr>
<tr>
<td>06: Liver</td>
<td>7.4%</td>
<td>79.9%</td>
<td>$1,936.94</td>
<td>$952.81</td>
</tr>
<tr>
<td>07: Gastrointestinal</td>
<td>24.6%</td>
<td>66.9%</td>
<td>$1,511.39</td>
<td>$706.35</td>
</tr>
<tr>
<td>08: Musculoskeletal and Connective Tissue</td>
<td>39.9%</td>
<td>63.5%</td>
<td>$1,252.91</td>
<td>$553.33</td>
</tr>
<tr>
<td>09: Hematological</td>
<td>8.1%</td>
<td>67.4%</td>
<td>$2,319.20</td>
<td>$1,167.14</td>
</tr>
<tr>
<td>14: Neurological</td>
<td>12.3%</td>
<td>71.5%</td>
<td>$1,800.17</td>
<td>$1,012.52</td>
</tr>
<tr>
<td>16: Heart</td>
<td>24.3%</td>
<td>62.9%</td>
<td>$1,598.62</td>
<td>$694.46</td>
</tr>
<tr>
<td>19: Lung</td>
<td>18.9%</td>
<td>70.4%</td>
<td>$1,549.24</td>
<td>$740.96</td>
</tr>
<tr>
<td>24: Pregnancy-Related</td>
<td>4.4%</td>
<td>46.1%</td>
<td>$1,270.01</td>
<td>$863.24</td>
</tr>
</tbody>
</table>

Average medical conditions 2.16

Medicaid Population: 100,000
Annual Healthcare Cost of MHSA Comorbidity: $535,680,000

- Northeast state
Slide by Steven Melek, Consulting Actuary, Milliman & Co.
Relationship of Depression to Diabetic Symptoms

The Real Problem:

The Full Cost of Poor Employee Health

Medical & Pharmacy Costs
$3,376 PEY

Health-Related Productivity Costs
$10,128 PEY

Personal Health Costs
25%

Medical Care
Pharmacy

Productivity Costs
75%

Absenteeism
Short-term Disability
Long-term Disability

Presenteeism
Overtime
Turnover
Temporary Staffing
Administrative Costs
Replacement Training
Off-Site Travel for Care
Customer Dissatisfaction
Variable Product Quality

Total Costs =
$13,504 PEY

Total Medical, Pharma&Productivity Costs
-- per 1000/FTEs --

(HPBS – Phase 2 Employers)

- Depression
- Obesity
- Arthritis
- Back/Neck Pain
- Anxiety
- GERD
- Allergy
- Other Cancer (vs Skin)
- Other Chronic Pain
- Hypertension

Primary Care is the only setting for a population approach to behavioral health

- The vast majority of people will not accept a referral to specialty MH or SA offered by a PCP. It is care in primary care or none.

Regier DA, Narrow WE, Rae DS, Manderscheid RW, Locke BZ, Goodwin FK. The de facto US mental and addictive disorders service system Arch Gen Psychiatry. 1993 Feb;50(2):85-94.
Behavioral Health Needs Assessment in Primary Care

- Mental Health
- Substance Use
- “Ambiguous” Illnesses/Medically Unexplained Symptoms
- Chronic Illness/Health Behavior Change
- Culturally Influenced Presentations
Behavioral Health Needs Assessment in Primary Care

PHQ-3000  Merillac 500

- Major Depression = 10%  24%
- Panic Disorder = 6%  16%
- Other Anxiety Disorders = 7%  21%
- Alcohol Abuse = 7%  17%
- Any MH or SA Dx = 28%  52%
10 most common complaints in adult primary care
15% x organic pathology found
(Kroenke & Mangelsdorff, 1989)

<table>
<thead>
<tr>
<th>chest pain</th>
<th>back pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>fatigue</td>
<td>shortness of breath</td>
</tr>
<tr>
<td>dizziness</td>
<td>insomnia</td>
</tr>
<tr>
<td>headache</td>
<td>abdominal pain</td>
</tr>
<tr>
<td>swelling</td>
<td>numbness</td>
</tr>
</tbody>
</table>
Chronic Conditions with a BH Component

Chronic conditions with a Behavioral Health component in their standard of care protocols

- Arthritis
- Asthma
- Diabetes
- CVD
- Irritable Bowel Syndrome
- Obesity
- Substance Abuse
Prevalence of Behavioral Health Problems in Primary Care

Unhealthy Behaviors

- Smoking = 20%
- Obesity = 30%
- Sedentary lifestyle = 50%
- Non-adherence = 20 - 50%
**Culture Impacts Depression**

**Culturally Syntonic Approaches**

<table>
<thead>
<tr>
<th>Signs of Depression found Cross-Culturally</th>
<th>Signs of Depression found in “Western” Cultures</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Appetite changes</td>
<td>• Self-deprecation</td>
</tr>
<tr>
<td>• Sleep changes</td>
<td>• Hopelessness</td>
</tr>
<tr>
<td>• Psychomotor agitation or retardation</td>
<td>• Guilt</td>
</tr>
<tr>
<td>• Decreased energy</td>
<td>• Suicidality</td>
</tr>
<tr>
<td>• Decreased libido</td>
<td></td>
</tr>
<tr>
<td>• Diminished ability to think or concentrate</td>
<td></td>
</tr>
</tbody>
</table>

Underserved and Minority Populations are Particularly Affected

“...racial and ethnic minorities are less inclined than whites to seek treatment from mental health specialists. Instead, studies indicate that minorities turn more often to primary care.”

Categories of Relationship between Collaborating Medical and Behavioral Health Services

- **Coordinated** = Behavioral services by referral at separate location with formalized information exchange.

- **Co- Located** = By referral at medical care location. BH and medical treatment plans

- **Integrated** = Part of the “medical” treatment at medical care location

Coordinated Care

- Coordinated care elements:
  - **Appointment arrival notification**
  - **Clinical information exchange protocols**
    - Releases automatic (see handout)
    - Access to diagnoses/problem lists
    - Agreed communication methods (email, phone, EMR)
  - **Coordinated treatment planning and/or problem solving for complex patients or as needed**

- Originally the model advocated for PCMH for behavioral health and the model that physicians think of first.

- **Massachusetts Child Psychiatry Access Program**
  - **Built on a consultative model**
  - **Back up consultation needs to be part of the specialty/PC relationship**
Co-located

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>Referrals don’t show</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>Case-loads fill up</td>
</tr>
<tr>
<td>Provider Satisfaction</td>
<td>Slow PCP learning curve</td>
</tr>
<tr>
<td>Cost Effectiveness</td>
<td></td>
</tr>
<tr>
<td>Clinical Outcome</td>
<td></td>
</tr>
</tbody>
</table>
Making Co-Location work
Means moving toward Integration

- Patients attending first visit w. BHP when scheduled by physician w/o introduction: 40%
- Patients attending first visit w. BHP when scheduled after introduction by physician: 76%

N=80, p= .01
Apostoleris, N. & Blount, A. In preparation.
INTEGRATED CARE
The IMPACT Treatment Model
http://uwaims.org/about.html

- Collaborative care model includes:
  - Clinician/care manager called Depression Clinical Specialist
    - Patient education
    - Symptom and Side effect tracking
    - Brief, structured psychotherapy: PST-PC
  - Consultation/supervision between Depr Clin Spec and
    - Primary care physician
    - Team psychiatrist
  - Stepped protocol in primary care using antidepressant medications and / or 6-8 sessions of psychotherapy (PST-PC)
Substantial Improvement in Depression
(≥50% Drop on SCL-20 Depression Score from Baseline)

Behavioral Health Consultant

- Management of psychosocial aspects of chronic and acute diseases
- Application of behavioral principles to address lifestyle and health risk issues
- Consultation and co-management in the treatment of mental disorders and psychosocial issues

- Model developed by Kirk Strosahl, PhD
The architecture says it all, and makes it work.
<table>
<thead>
<tr>
<th>Service</th>
<th>Utilization Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Visits</td>
<td>117%</td>
</tr>
<tr>
<td>ER Visits</td>
<td>32%</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>58%</td>
</tr>
<tr>
<td>Hospital Care</td>
<td>63%</td>
</tr>
<tr>
<td>Cost</td>
<td>78%</td>
</tr>
</tbody>
</table>

Figure 1: Comparison of CHS utilization with regional providers
Whole System Integration

Primary Care Practice

Wellness

Universal Behavioral Health Screening

Mental Health

Substance Abuse

Primary Care Behavioral Health

Linked by proximity and protocol

Speciality Mental Health (Co-located?)

Consulting Psychiatry
Psychotherapy
DBT
Other services

Linked by referral and collaborative programs
What makes “Integration of behavioral health and primary care?”

“The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress related physical symptoms, and ineffective patterns of health care utilization.”

http://integrationacademy.ahrq.gov

“Bi-Directional” Integration

FQHC in partnership with CMHC to serve people with serious MH & SA disorders. (about 2%) of population.

FQHC in partnership with CMHC to serve people with serious MH & SA
Primary care from FQHC in CMHC and often BH from CMHC in FQHC.
Only a few examples of successful programs and the majority of those are grantees in the HRSA/SAMHSA integration project.

Takes a lot of money and/or mutual commitment to overcome cultural and business differences.
“Reverse” Integration for people with serious M.I.

Primary Care Practice

Medical Consults Lab?
Regular Primary Care for many patients with SMI

Linked by referral and collaborative programs

Full Service CMHC

Wellness

Universal Medical Screening

Primary Care Practice in CMHC

Full information system sharing

Health Teaching

Exercise
Primary Care Workforce Problems

- Primary physician/provider workforce is maxed out now.
  - Not enough new people coming in because of pay and level of demands.
- Graduate programs for non-medical disciplines are out of date in relation to workforce needs and the market.
  - Preparing people for the old roles in the old system.
- History of disciplinary competition doesn’t prepare new workers for collaborative team roles.
  - Efforts to protect standing and salaries distracts trainees from seeing the opportunities to be involved in exciting new approaches to patient care.
Why Primary Care behavioral health is difficult for clinicians trained only in specialty mental health

- Treat somewhat different population than in Specialty MH or SA services.
  - Less disturbed and less diagnostically clear
  - Won’t accept “mental health” or “substance use disorder” definition of the problems they bring
  - Broader array of needs.
    - BHC must understand medical conditions and practice behavioral medicine and substance abuse care in addition to mental health
- Status as ancillary provider
- Different routines of time, confidentiality and instrumentality
Generalist Behavioral Health Clinician
More training, not less

- Care Management
- Brief Therapy
  - Cognitive-behavioral
  - Solution-focused
- Behavioral Medicine
  - Relaxation/biofeedback/hypnosis
  - Health behavior change
- Family Therapy
- Substance Abuse Engagement and Counseling
- Child Development
- Psychotropic medication input
- Groups and Patient Education
- Community Outreach
- Organizational transformation agent
The Behavioral Shift

- Shift to medical and health issues
- Shift away from 45-50 minute, weekly approach
- Less rapport-building
- Problem solving mode; less assessment
- Evidenced-based approach (Behavioral Activation and Education)
The future of Primary Care will require new ideas about “disciplines.”

- Depression care managers – MSWs, nurses, psychologists, NPs and PAs
- Care Coordinators – Debate about nurses vs. social workers.
- Paraprofessional counselors – promotoras, health navigators
- UK developing Primary Care Counsellor program equivalent to a Master’s Degree
- Modular skill sets vs. disciplines, though the disciplines are working to be included explicitly
- Certificate Program is an example of modular training
Working in Primary Care is a Matter of Skill Set and Fit

- It takes training, or experienced support to get the orientation necessary to learn on the job.
- Good at making relationships with all of the roles in primary care. (Behavioral health clinicians and extra behavioral health needs of their patients are inconvenient to everyone from the old model.)
- They must do well in ambiguous situations, dive in rather than wait for an invitation.
- Handle new situations with assurance and confidence without misrepresenting knowledge.
Role of Psychiatry in Primary Care

- Any practice offering psychotropic meds in primary care ideally should have psychiatric input and back-up.
  - Continuity of care problems crop up at the point the PCP feels s/he cannot go further with medication.
  - Reviews of PCP’s prescribing patterns show only around half prescribing in evidence-based fashion. Psychiatrist as teacher as well as consultant.
  - PCPs and psychiatrists need help/collaboration with complex chronic illness and psychotropic medication regimens.
- HMO systems that integrated (Kaiser and Group Health) had 1 BHP per 5-6 PCPs and one psychiatrist per 20-40.
- Programs like MCPAP are good examples of population based approaches to psychiatric back-up.
- NC Medicaid pays for psychiatric consult w/o pt.
“Care Management” in IPC: crucial and confusing

- Core element in the PCMH
  - Maximize connection to services and adherence to tx.
    - Address social determinants of health and system holes
    - Default to “nurse care manager” limits possibilities for fit
    - Patient “complexity” often rests on behavioral factors

- “Depression care manager” needs to be a BH clinician.
  - Per Pincus et al and IMPACT

- Creates workforce dilemma
  - BH case managers don’t know health interventions
  - Nurse care managers often uncomfortable with BH

- Care management is a function, not just a job desc.
  - Consider Care Manager as resource to all
CBT in the Exam Room

1) CBT picture  2) Thought stopping or behavioral activation
How to describe the involvement of a BHP to the patient.

- **Situation**
- **Skill Set**
- **Relationship**
- **Indicators**
Situation

What is the situation in the patient’s care that makes the Primary Care Provider want to involve a Behavioral Health Provider?
Skill Set

What are the particular skills that the BHP brings that can be helpful in the overall treatment of the patient?
BHP is defined as the one with the right skill for patient’s needs.

Case note:

“KB (15yo) F/u for depression.
Kathy reports still feeling depressed a lot of the time.
Suggested she might make use of counseling service here in the practice.
Says she would consider, but does not want someone who is ‘all nice and happy’
Refer to Dr. Blount who is neither nice nor happy.”
Relationship

What relationship will the work of the BHP have to the overall treatment of the patient?
Indicators

What outcomes would indicate that the involvement of the BHP had been useful to the overall treatment of the patient?
Change your language to engage with and activate your patient.

<table>
<thead>
<tr>
<th>Negative/passive words</th>
<th>Positive/active words</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffers from</td>
<td>Struggles with</td>
</tr>
<tr>
<td>Refused to take</td>
<td>Decided against</td>
</tr>
<tr>
<td>Didn’t keep apt</td>
<td>Was unable to be</td>
</tr>
<tr>
<td></td>
<td>here</td>
</tr>
<tr>
<td>Was non-compliant with</td>
<td>Had not seen value</td>
</tr>
<tr>
<td>of</td>
<td></td>
</tr>
<tr>
<td>Arrived late</td>
<td>Was determined not</td>
</tr>
<tr>
<td></td>
<td>to miss</td>
</tr>
</tbody>
</table>
Warm Handoff Video

• How long was this meeting?

• What was the advantage of having both PCP and BHC present?

• What did each do that facilitated the meeting going smoothly?

• Might something have been lost if the conversation between professionals occurred in the hall?
Considerations in Adding a Behavioral Health Provider

- Provider skill set and fit
- Financial
- Information exchange between providers
- Charting
- Scheduling
- Space
Information Exchange Between Providers

- Medical and mental health cultures have very different approaches to confidentiality. The mental health approach is usually that the unit of confidentiality is the therapist/patient while the medical approach is that the unit of confidentiality is the team/patient.
- MH culture developed in a day when confidentiality was the only thing that made revelations possible.
- We are now in a day in which the patient can be at risk from failure to share information (e.g., changes in medication in one site unknown to the other)
- Reasonable sharing is possible if it is a goal.
- [http://www.integration.samhsa.gov/operations-administration/confidentiality](http://www.integration.samhsa.gov/operations-administration/confidentiality)
Integrated Care and Payment Models

• Integrated primary care does not flourish in fee-for-service environments.
  • The billing and documentation requirements of two systems (MH and medical) are too different to work easily as one service.

• The evidence for its effectiveness and cost savings comes from sites with some form of capitated or bundled payment for total (not just MH) care.
Payment Models for Behavioral Health Integration

- Fee for Service, + Health Behavior Codes
- Bundled payments
- Case rates
- Supplemental payments, eg, care management
- Pay for Performance
- Shared Savings
Mass Medicaid Primary Care Payment Reform Initiative

- In process right now. Full roll out – 3/1/14.
  - Capping 4 years of developing programming.
- First – “PCMH lite” – Chronic illness collaboratives
- Second – PCMH pilot
  - 48 practices, small financial incentives, care management only addition, training in integrated behavioral health
- Third and currently – PCPR
  - Small payments for quality
  - Some payments for savings (ACO model, shared risk)
  - Main Per Member Per Month decided by level of behavioral health offered
    - Tier 1 – BH screening, care management, and good linkages
    - Tier 2 – Tier 1 plus primary care BH, screening, brief intervention, referral to specialty care if necessary. BHC in the practice 40 hours a week.
    - Tier 3 – Tiers 1 & 2 plus specialty mental health, longer term tx and psychiatry
Look out for the Snowball!

“I use Sandy Blount's approach to behavioral integration. There are huge advantages to an integrated approach in terms of adherence outcomes and cost. Sandy has the data.”

State chief health officer

- Behavioral health clinicians need additional training in primary care BH or programs often fail.
- Practice transformation comes hard. It takes committed leadership.
- Exemplar programs have had time to mature
- Grant driven transformation only works if payment reform comes at the same time.
Workforce Crisis Alleviation

- Retrain the current BH workforce - examples
  - Certificate Program in Primary Care Behavioral Health – UMass Medical School
    - Behavioral Health Clinicians
  - Certificate Program in Integrated Care Management – UMass Medical School
    - Care Managers
  - Certificate of Intensive Training in Motivational Interviewing – UMass Medical School
    - Any member of the care team

- Support BH internships and residencies in primary care – at the level of primary care physician residencies
- Stipulate that BH trainees in approved training settings can be service providers in all future payment models.
Questions?

Contact Info:
Alexander.Blount@umassmemorial.org
Online Certificate Programs for Behavioral Health Professionals

- Primary Care Behavioral Health
- Integrated Care Management
- Intensive Training in Motivational Interviewing

www.umassmed.edu/cipc/
CIPC@UMassMed.edu