Putting New Hampshire on a Path to Primary Care and Behavioral Health Integration

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Learning Objectives

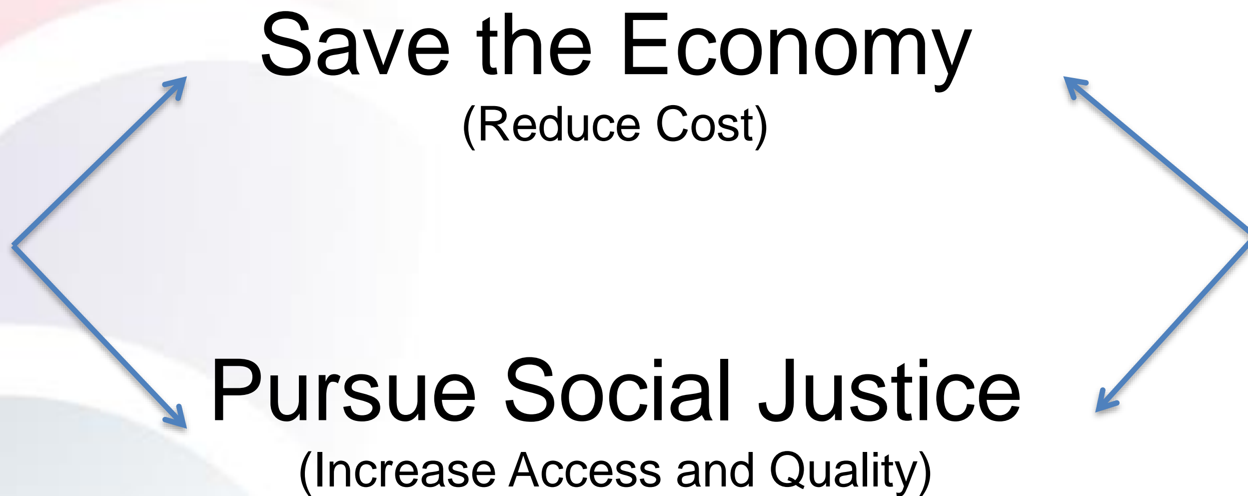
- List three categories of relationship between behavioral health and primary care clinicians
- Explain the difference between Collaborative Care and the Behavioral Health Consultant model of full integration
- Describe the role of leadership in the development of integrated behavioral health in primary care

The National Conversation About BH Integration has Moved from “Why” to “How”

- Integration of BH services in some form and to some degree is, or soon will be, required in most models of primary care, PCMH or otherwise.
- Strong evidence of overall cost reduction from mature integrated programs
- But for each new site considering integrating, “why” will have to addressed at the local level.
- “Integration” in itself is not a reason to do anything. It is about better and more efficient care for your patients. And that is the “why” to bring to your staff.
- When we talk about clinical outcomes, always translate what you see into changes in quality of life for patients (and providers).

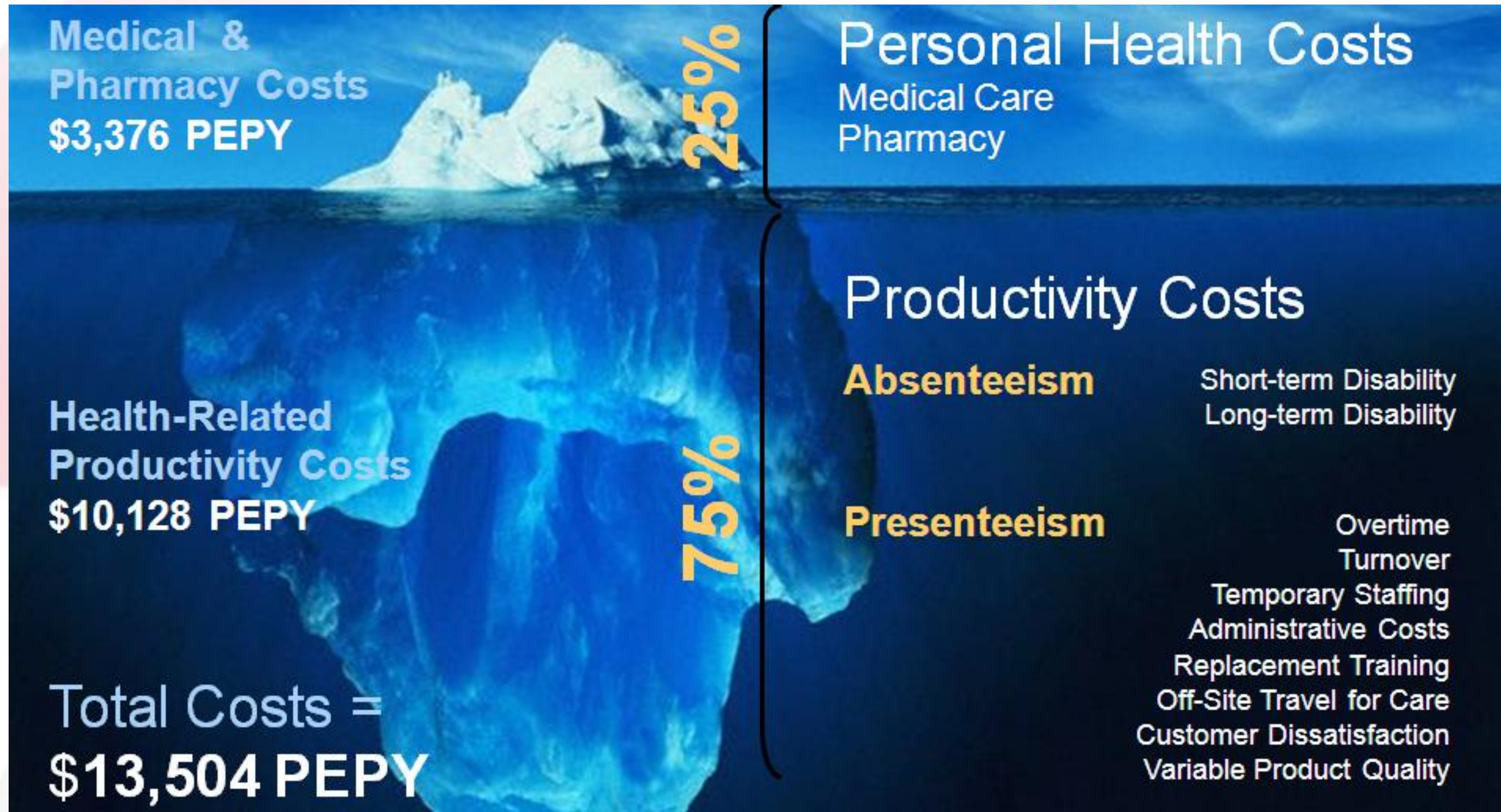
BH = behavioral health.

The Conversation is Driven by the Former Purpose of the ACA while Most of Us Work for the Latter



And Behavioral Health Integration is a central tool

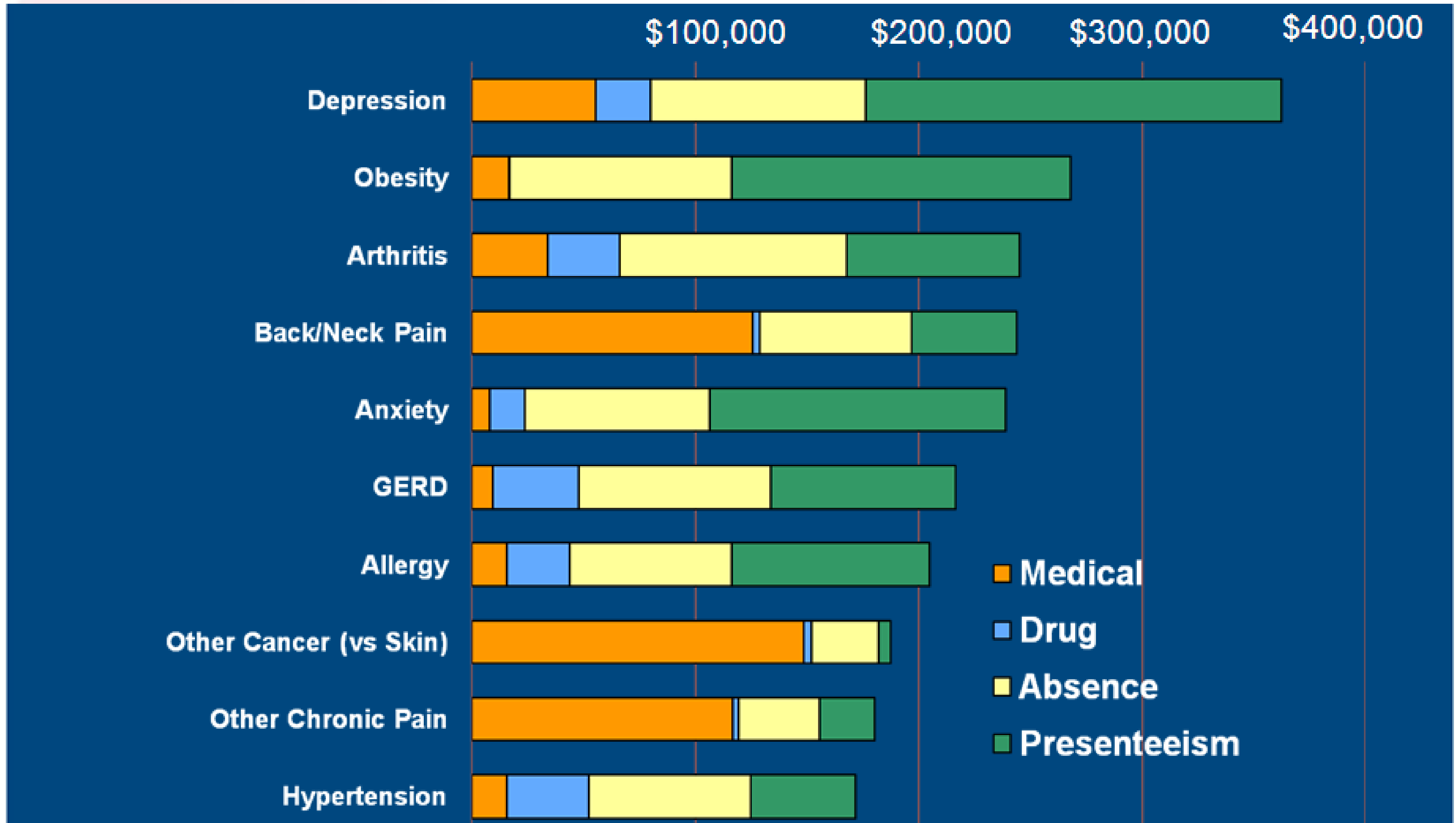
The Real Problem:
The Full Cost of Poor Employee Health



Edington DW, et al. *Health and Productivity.* In McCunney RJ, Editor. A Practical Approach to Occuplational and Environmental Medicine. 3rd edition. Philadelphia, PA. Lippincott, Williams and Wilkens; 2003:40-152. Loeppke R, et al. Health and Productivity as a Business Strategy. *Journal of Occupational and Envinromental Medicine.* 2007;49(7):712-721*. 2006 Mercer Annual Survey.*

Total Medical, Pharma & Productivity Costs

Per 1000/FTEs
HPBS – Phase 2 Employees



Health and Productivity as a Business Strategy. *JOEM.* 2009;51(4).

Primary Care is the Only Setting for a Population Approach to Mental Health and Substance Use Disorders

- The vast majority of people (+/- 80%) who meet criteria for a MH or SA diagnosis will not accept (act on) a referral to specialty MH or SA offered by a PCP. It is behavioral health care in primary care or none.

- Any planning for Behavioral Health needs of a region that does not treat primary care as the primary entry point and treatment setting for BH services is failing to address the illness burden of the population.

MH = mental health; SA = substance abuse; PCP = primary care physician.

Regier DA, et al. *Arch Gen Psychiatry*. 1993;50(2):85-94.

Primary Care is Full of BH Needs, Many Unrecognized

- Mental Health
- Substance Abuse
- Health Behavior Change/Chronic illness behavioral needs
- “Ambiguous” illnesses/Medically Undiagnosed Symptoms
- “Unfamiliar” cultural expressions of problems
- Discovered and undiscovered trauma history
- Serious mental illness, people in and outside of mental health treatment

Prevalence of Behavioral Health Problems in Primary Care

Condition	PHQ-3000	Merillac 500
Major Depression	10%	24%
Panic Disorder	6%	16%
OTH Anxiety Disorder	7%	21%
Alcohol Use Disorder	26%	50%
Any Mental Health Diagnosis	28%	52%

MAUKSCH, LARRY B., et al. "Mental Illness, Functional Impairment, and Patient Preferences for Collaborative Care in an Uninsured, Primary Care Population." *Journal of Family Practice* Jan. 2001: 41. *Academic OneFile*. Web. 12 Aug. 2016.

10 Most Common Complaints in Adult Primary Care

15% x organic pathology found

(Kroenke & Mangelsdorff, 1989)

Chest pain	Back pain
Fatigue	Shortness of breath
Dizziness	Insomnia
Headache	Abdominal pain
Swelling	Numbness

Behavioral Health is Not Just for MH And SA

- Medical problems benefitting from behavioral health intervention to improve their health, such as diet, exercise, stress reduction, and medication adherence
- Robust literature for redesigning primary care to better address health behavior change abounds
- First-line interventions include cognitive-behavioral treatments for insomnia and irritable bowel syndrome, and motivational interviewing is found to improve weight management, exercise, smoking cessation, medication adherence, and safer sex practices

Relationships Between Collaborating Medical and BH Services

Categories of collaborative relationships

- **Coordinated** = Behavioral services by referral at separate location with formalize arrangement for cooperation in delivering care.
- **Colocated** = By referral at medical care location. 2 treatments.
- **Integrated** = Part of the “medical” treatment at medical care location. 1 treatment with behavioral and medical aspects.
- This is not a hierarchy. Some practices have all three.

Blount, A. *Families, System, and Health.* 2003;21:121-134.

Coordinated Care

(Term used in 1115 Waiver for IDNs)

- Little evidence for coordinated care, but also little study of care across organizations
- Coordinated care elements:
  - Universal release at a 6th grade reading level and brochure for patients about health network.
  - Appointment arrival notification
  - Clinical information exchange protocols
    - Every record should have complete behavioral and medical problem list and med list
  - Coordinated treatment planning and/or problem solving meeting for complex patients or as needed

Programs That Link Specialty Mental Health As A Consultant To Primary Care Are Best For Populations And For Coordination

- Massachusetts Child Psychiatry Access Program
- For adults, in NC Medicaid pays for the time of the PCP and the psychiatrist, as patient visit rates, for consultation about a patient, whether the psychiatrist has met the patient or not
- Enhancing PC workforce with specialist consultation is essential workforce intervention.
  - We will never have enough psychiatrists

Co-located Behavioral Health

- BH in the same office space with primary care
- Involvement by referral
- Separate BH and medical treatment plans
- Practices that are co-located count themselves integrated

Advantages	Challenges
• Access greatly improved • Improved patient & provider satisfaction • Cost effective • Usually improved clinical outcomes	• Referrals don't show • Case-loads fill up • Slow PCP learning curve • Tends to still focus on MH/SA and ignore potential BH contribution to health • Communication often still difficult

Treatment Length Comparison

- Length of treatment in specialty mental health care vs. Co-Located behavioral health care:
- Specialty mental health care
- 6.2 visits
- Co-Located behavioral health care
- 3.2 visits

Simpson, R. Developing a behavioral health system of care. In, Blount, A. (Ed.), Integrated Primary Care: The Future of Medical and Mental Health Collaboration. 1998: NY: WW Norton.

Making Co-Location Work (beginning the “warm handoff”)

- Patients attending first visit w. behavioral health clinician (BHC) when scheduled by physician w/o introduction: **40%**
- Patients attending first visit with BHC when scheduled after introduction by physician: **76%**
- N=80, *P*<.01

Blount, McConnarty, Apostoleris, Reed & Combs, Impact of a Post-Doctoral Fellowship as a Training Intervention in a Family Practice Residency, Society of Teachers of Family Medicine, Mystic, CT. 2001

Integrated Care: The IMPACT study led to the Collaborative Care Model

- Developed out the Chronic Care model by Ed Wagner
  - Population approach to any chronic illness
  - Identify, diagnose, offer evidence based care, monitor for adherence, address barriers, stepped care for non-responders.
  - "Depression Clinical Specialist" (usually MSW or PhD/PsyD)
    - Patient education
    - Symptom and Side effect tracking
    - Brief, structured psychotherapy: PST-PC
  - As needed consultation and weekly meetings
    - Primary care physician, Depression clinical specialist
    - Team psychiatrist
- Stepped protocol in primary care using antidepressant medications and/or 6-8 sessions of psychotherapy (PST-PC)

Improvement in Depression

(≥50% drop on SCL-20 depression score from baseline)

60
50
40
Percent
0
P<.0001
P<.0001
P<.0001
3
Month
Usual care
Intervention

Unützer et al, *JAMA*. 2002;288:2836-2845.

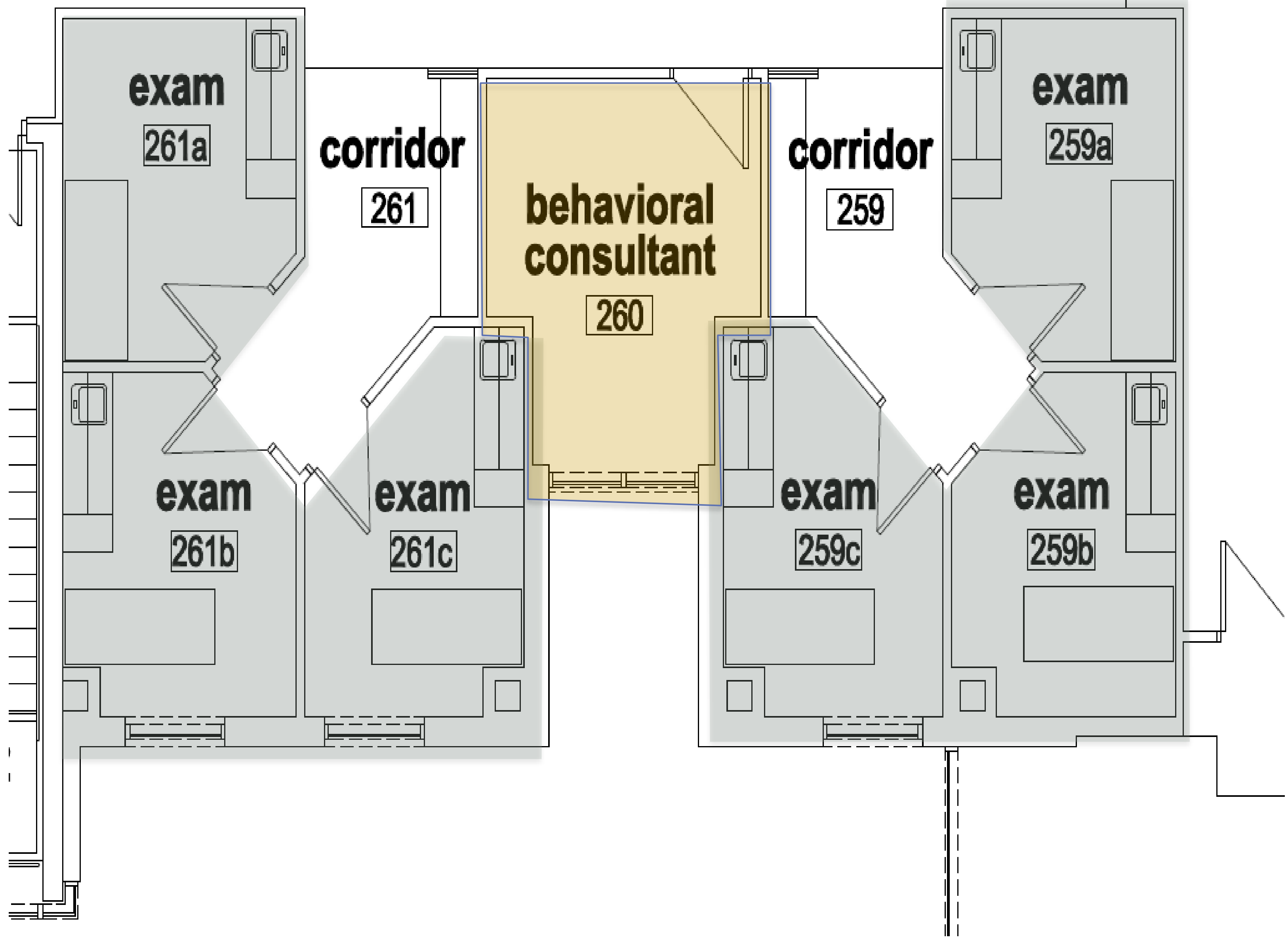
Behavioral Health Consultant

- 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.

Behavioral Health Consultant in Action

- Two equal "customers"
  - PCPs and patients
- Different conceptualization of meetings w. patients.
  - "Consults" and "follow-ups" (translated to billing codes when possible)
  - Scheduled to allow for both
  - Brief, active, goal oriented, solution focused visit with CBT and relaxation response interventions. Typically 15-30 min.
- Goal of returning patient to full care by PCP
  - Some will need expanded team for long term. May include Care Manager. Usually specialty MH (therapist and/or psychiatrist) accessed if longer term BH is necessary
  - Flexibility in patterns of response to patient needs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Mature integrated health system compared to other health systems in the same region.

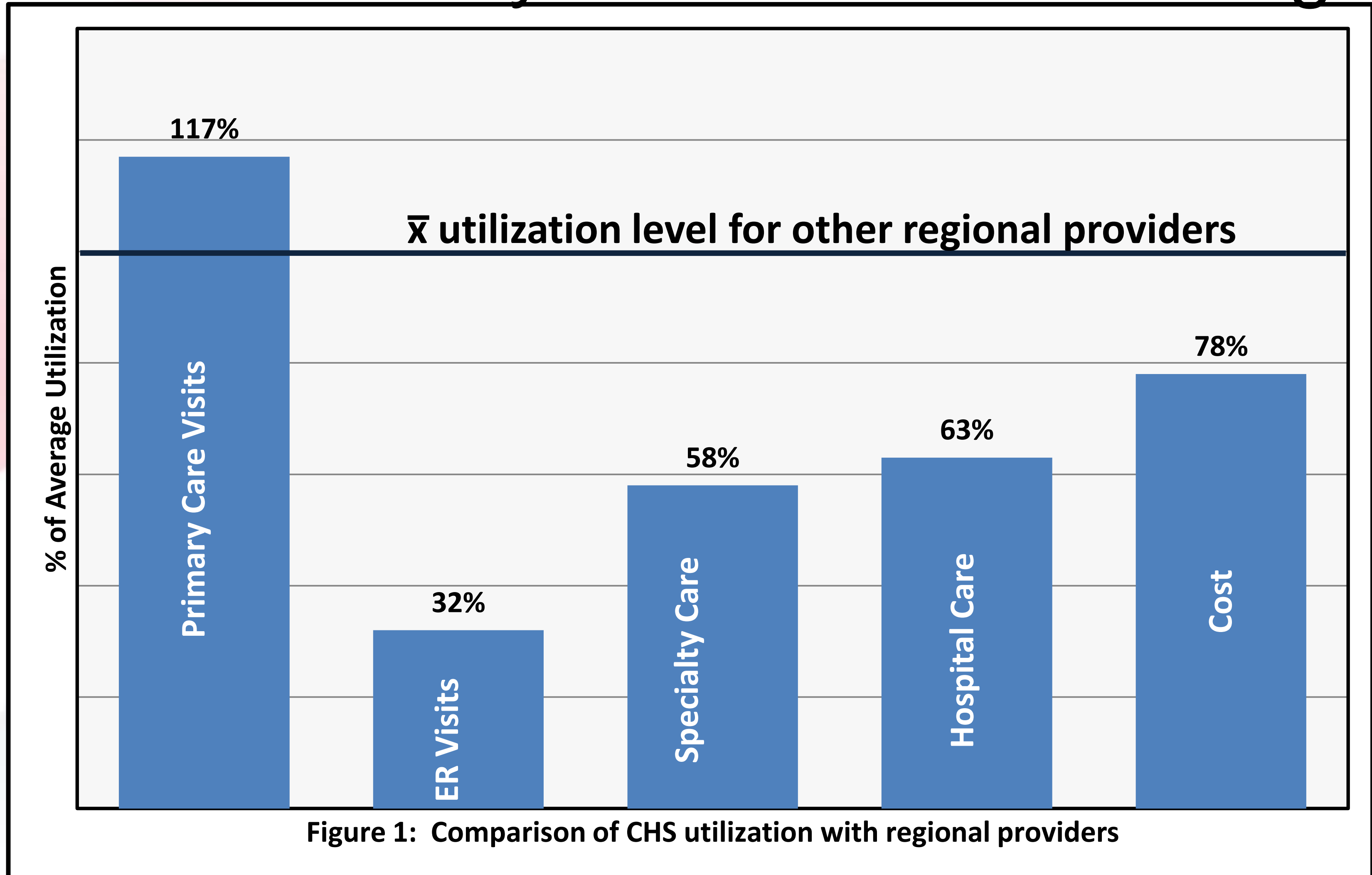

Figure 1: Comparison of CHS utilization with regional providers

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Models of Integrated Behavioral Health

Collaborative Care	**BHC plus PCMH**
Disease based	Program based
Research heritage	Clinical heritage
Strong disease outcome evidence	Evidence for most complex pts
Cost savings for treated patients	Cost savings for practice patients
Population focused	Behavioral health = infrastructure
Depression CM = SW or Psychol	B. H. consultant = Psychol or SW

Beginning to Converge

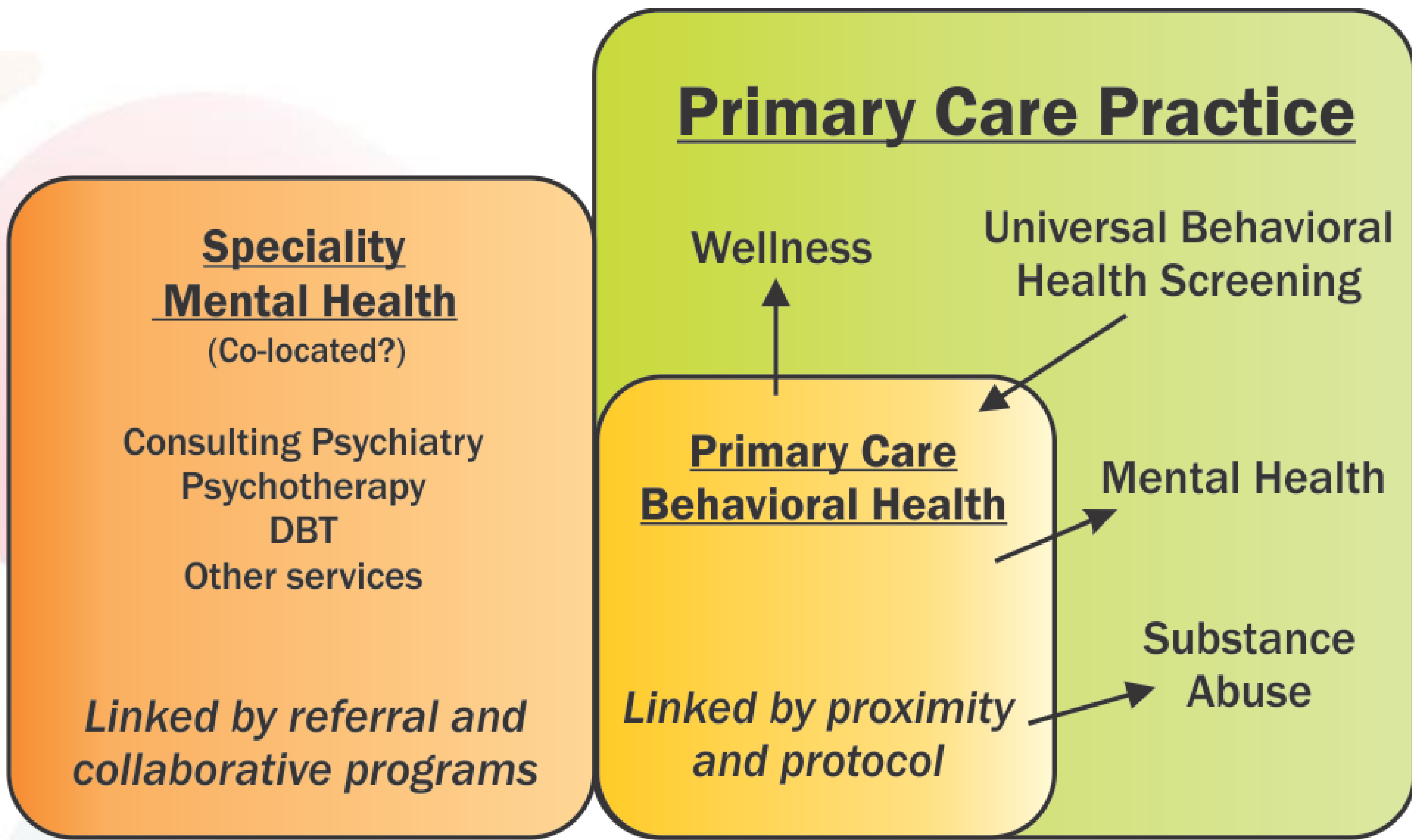
Depression specialist treats other BH	Targeted population protocols

Problems in Common

Highly variable implementations

Results in one study or implementation do not predict other implementations or same site at a later date.

All sites consider themselves "integrated" no matter what their data



University of Mass. Medical School.

BH Clinician Addresses Substance Abuse

- Patients are complex. We go in the door that is open.
  - Person with diabetes, HTN, depression and SUD might be willing to take a first step toward health in any of three areas. A step in any area has a positive impact in all. The clinician has to be able to work in all.
- Who can keep the engagement: SBI – one year - RT
- BH Clinicians central to opioid and pain programs.
  - Assessing and treating depression and life problems
  - Teaching CB and RR skills for pain management
  - Assessing risk of misuse.

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 he/she 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 when prescribing complex chronic illness and psychotropic medication regimens
- Programs like MCPAP are good examples of population based approaches to psychiatric back-up
- Psychiatrists need re-training to succeed in PC like other BH disciplines – re-understand risk, responsibility vs consultation

Role of “Care Enhancers”

Lots of roles being added: Care Manager, Care Coordinator, Navigator, Health Coach, Patient Advocate, Community Health Worker, Promotora, Patient Educators, (and on and on)

They tend to do some or all of the following:

1. Create and maintain patient engagement in care within and across health settings
2. Address issues of health literacy, adherence and healthy living
3. Address social and economic barriers patients face in caring for their health (“social determinants of health”) and obtaining healthcare
4. Keep information about the patient’s health flowing between the patient and the healthcare team.

- Each role has evidence for its individual contribution. No consistency across settings in duties paired with role names.
- Care enhancers add substantially when supported by best behavioral and medical expertise
- Core competencies needed for above duties tend to be behavioral, though for other duties, they may be medical.

Assessing the Workforce for the Integration of Behavioral Health and Primary Care in New Hampshire – released today

Endowment for Health

Center for Behavioral Health Innovation, Antioch University, Keene

- Surveyed the safety net clinics for workforce roles and needs
- Surveyed academic and certificate programs in NH about current and future commitment to training the primary care behavioral health workforce
- Assesses workforce and training needs for:
  - Behavioral Health Clinicians
  - Consulting Psychiatric Clinicians
  - Primary Care Clinicians
  - Care Enhancers
- Meeting for discussion involving clinics, academic programs and many other players in the state working on workforce.
- Leading to the development of an ongoing forum for PCBH workforce planning

Starting from scratch - What model shall we use?

- Start with a program for a population
  - What groups are most frustrating to PCPs?
  - What fits the PCMH requirements?
  - What group uses the most system resources? (partnership with payers?)
- Advantages of a program
  - Clear guidelines
  - Evidence base makes gaining acceptance easier with PCPs
  - Easier to predict workforce needs because population is defined.
  - Easer to assess results
- Be realistic about the level of training needed by BH clinicians, PCPs, administrators and staff.
- Design a program that takes pressure OFF PCPs.
- Be ready to expand toward practice-wide BH
  - Limiting access goes against providers' values
  - As they get used to collaborating, they want to expand

Why is Primary Care Difficult for BH Clinicians Trained Only in Specialty Mental Health?

- Treat somewhat different population than in Specialty Mental Health services
  - Less disturbed and less diagnostically clear
  - Won't accept "mental health" 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
- The shift from specialty mindset to generalist mindset
- People straight from specialty MH tend to struggle or fail

Generalist Behavioral Health Clinician

More training, not less. If they can't do it, they learn it

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

Role of Leadership in Successful Integration

- Articulating the centrality of integration to the mission of the organization
- Designating a core team to bring the change about
- Make the new model more appealing than the status quo
- Committing the time and resources to the process
- Monitoring staff reactions and changes in practice
- Keeping spirits up by articulating realistic first steps and time lines

Role of the Physician “Champion”

- Keep the needs and challenges of PCPs in the minds of the ILT
  - A reality check for what PCPs would actually do
- Be prepared to make the case for the new approach to the PCPs
  - Make sure that trials of workflow changes are explained as improving PCP support by the team and as better patient care.
- Identify best clinical opportunities for success/impact
- Facilitate creation of efficient workflows, especially re: accessing the BHC in a timely way and exchange of info

Sustainability

- Try to get past the “does it pay for itself with mental health billing” level of analysis and think “is the whole practice sustainable with BH services?”
    - You don’t ask if every new nurse covers her/his cost

Learn to Identify and Capture New Revenue Sources

- Medical side places to look for resources:
  - Increase number of patients seen by physicians. Average 1/session (Strosahl/Robinson/Reiter)
  - Many states offer SBIRT funds
  - "Incident to" billing done by team member, billed by physician
  - CMS about to promulgate new codes to pay for consulation
  - BH screening is an additional paid service for many payers
    - Sometimes only at times other than the annual physical
  - Health and Behavior codes: 96150-96155
    - Medicare, many Blues, some Medicaid, some privates
- Excellent tool for assessing cost and revenue in advance:
  - http://emrpl.us/CoachCostTool/Welcome.html

Space

- The next best to integrated archetecture is for exam rooms on a long hall to have a "consulting room" for each 5 or 6 exam rooms, used by BH or physicians for talking
- In that system, PCPs and BHCs do their charting and phone calling in a commons area, not in individual offices
- Constant contact and convenient access are keys
- Individual offices impede team based care.

Scheduling

- BHC is scheduled in same system as medical
- Shorter time periods, 30, 20, 15 minutes
- Consider an Open Clinic as a way of learning to work differently
- Schedule some free time for introductions and curbside consultations
- On/off scheduling, for follow-ups
- Huddle and “schedule mining” for BH clinician workflow

Charting

- Inform patients of unified charting at first visit
  - "Our behavioral health program – we work as a team" handout
- Unified charting means social history and medical history already done for MH rules
- Unified charting may not need to be undifferentiated charting
- Health and Behavior codes charted in medical record as medical services
- Help regulators and specialty MH in your system to understand that PCBH is PC and should be charted as such. MH charting conventions (eg, long intake and termination summaries) are not appropriate.
- Your charts will be available to patients at some point, start reading notes to patients now to "build the transparency muscle".

Foundational Practices of Patient-Centered Integrated Care Team

- Passing the relationship
- Speaking in front of the patient
- Basics of positive attribution
- Basics of solution talk
- Patient centered care plan for most complex patients
- Learning to do goal setting
- Shared decision making facilitated with all patients
- Systemic view – dangers of change

Passing the Relationship

How to describe the involvement of a BHC (or any new team member) to the patient so that the relationship with you is passed

Situation

Skill Set

Relationship

Indicators

Situation

What is the situation in the patient's care that makes the PCP (current team member) want to involve a BHP (new team member)?

Skill Set

What are the particular skills that the BHC (new team member) brings that can be helpful in the overall treatment of the patient?

BHC (new team member) defined as the one with the right skill for member's needs:

Actual case note:

"KB (15yo) F/u for depression.

Kathy would like to be in better control of her emotions.

She gets angry often when people are mean to her about her weight.

She can't talk to her mother.

She would agree to counseling as long as the counselor is not 'all nice and happy.'

Refer to Dr. Blount, who is neither nice nor happy."

Relationship

What relationship will the work of the BHC (next team member) have to the overall treatment of the patient?

Indicators

What outcomes would indicate that the involvement of the BHC had been useful to the overall treatment of the patient?

To Do All Your Work in the Presence of the Patient

Change your language to engage with and activate your patient

Negative/Passive Words	Positive/Active Words
Suffers from	Struggles with
Refused to take	Decided against
Didn’t keep appointment	Was unable to be here
Was noncompliant with	Has not seen value of
Arrived late	Was determined not to miss

- This takes practice, and you will laugh as you practice together

The statewide 1115 IDN transformation will be a frustrating time.
Only if we have a vision of where we are going
will the frustration ultimately be worth it
for patients and for the workforce

Questions?

Resources for Practice Transformation

- Center for Integrated Primary Care, University of Massachusetts Medical School. www.umassmed.edu/cipc

  Training for groups in your practice to succeed at integrated care:

  Behavioral health clinicians

  Care managers, care coordinators, navigators and health coaches

  Primary care clinicians (physicians, NPs, Pas)
- Psychiatrists can take a day of training at the annual meeting of the American Psychiatric Association
- Center for Behavioral Health Innovation, Antioch University New England http://www.antiochne.edu/community/center-for-behavioral-health-innovation-bhi/who-we-are/
  - Technical assistance and evaluation for integrated behavioral health programs
- The "*Playbook*" – soon on the Academy website, tells how to get from where you are to where you want to go in integrating behavioral health. http://integrationacademy.ahrq.gov
- *Guidebook of Professional Practices for Behavioral Health and Primary Care Integration.* What they do at the exemplar sites. http://integrationacademy.ahrq.gov/sites/default/filesAHRQ_AcademyGuidebook.pdf
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  - Email: ABlountEdD@gmail.com
  - Blog: www.integratedprimarycare.tumblr.com