Models for Integrating Behavioral Health & Primary Care

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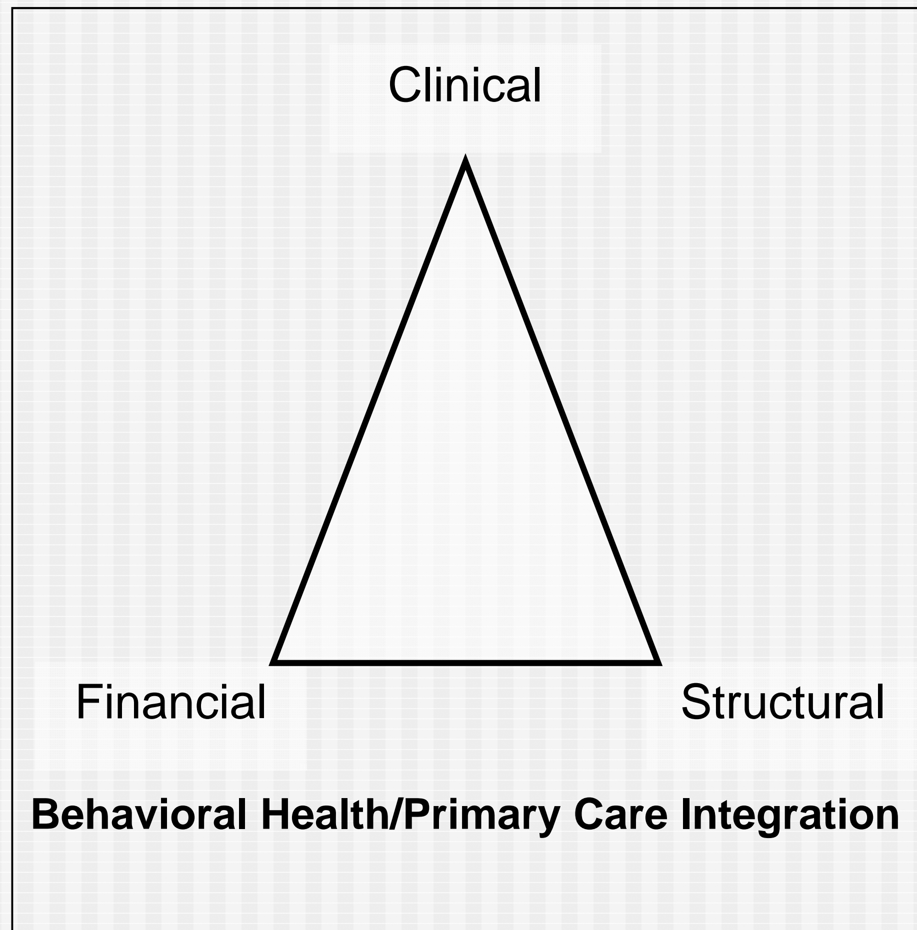
What Is Integration?

- Can be any/all elements of care system, but not meaningful without clinical integration
- Requires financial & structural support to be effective



Why Integrate BH & PC?

- BH disorder burden is great.
- BH and physical health problems are interwoven.
- Treatment gap for BH conditions is enormous.
- PC settings for BH services enhance access.

Why Integrate BH & PC?

- BH services in PC settings reduces stigma and discrimination.
- Treating common BH conditions in PC settings is cost-effective.
- Most people with BH conditions treated in collaborative PC have good outcomes.

Barriers to Integration

- BH & PC providers operate in separate silos
- Information sharing rare & difficult
- Economic crises lead to budget cutbacks; inertia mitigates against system reform.
- Workforce capacity and competency limitations
- Financial (revenue/billing) impediments
- Lack of parity for BH

LESSONS FROM THE
GREAT AMERICAN EXPERIMENT

HAVE WE SPAWNED AN ADDICTIVE SOCIETY?

PETER C WHYBROW

GEORGE SASLOW LECTURE
OREGON HEALTH & SCIENCE UNIVERSITY
Friday, May 9th, 2008

The Economist

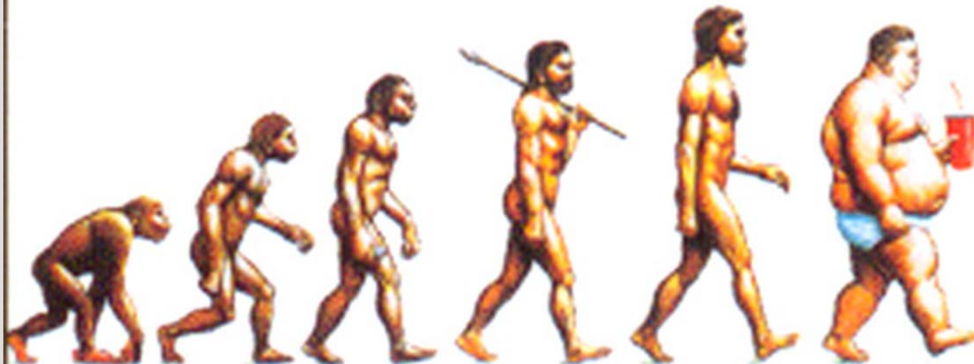
Gore anoints Dean

America's Taiwan test

The future of flight

A SURVEY OF FOOD

The shape of things to come



THE ECONOMIST DECEMBER 13, 2003

America is at the leading edge of an unusual human experiment

In 1975 Americans spent approximately 8% of GNP on health care and 15% on food.

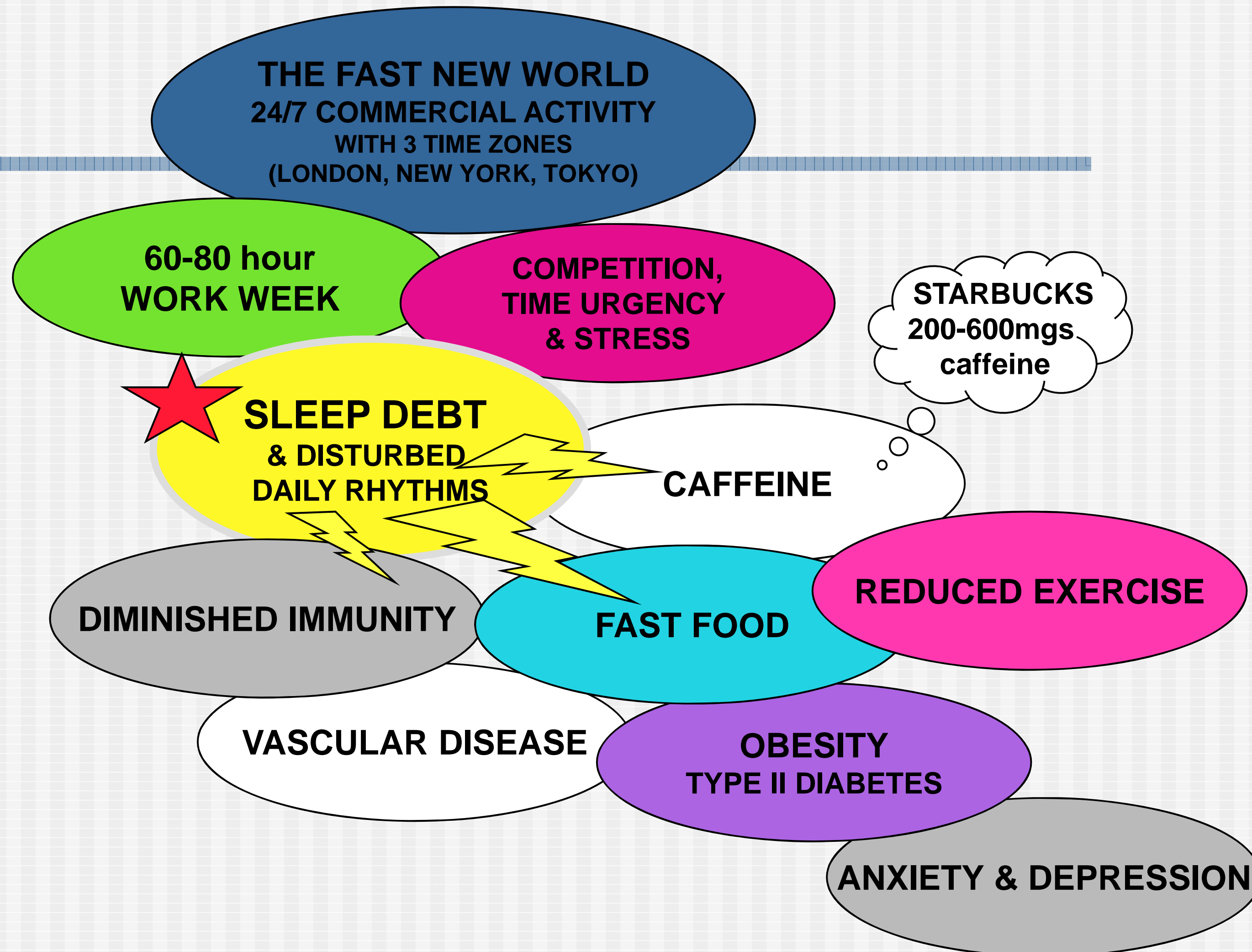
Today we spend 15% on health care and and 8% on food.

The twentieth century may yet be remembered as one of monstrous mass feeding.

M. F. K. Fisher

The Art of Eating, 1989.

TIME URGENCY & A CASCADE OF UNINTENDED HEALTH CONSEQUENCES



Social Organization and Health Pathology in the Fast New World

President’s New Freedom Commission Report

“Effective mental health treatments will be more readily available for most common mental disorders and will be better used in primary care settings. Primary care providers will have the necessary time, training, and resources to appropriately treat mental health problems.”

Governor's Mental Health Task Force

"Integration of care for mental illness, substance abuse, and physical health services is an essential part of a System of Care, particularly for those individuals who are uninsured or are covered by… public programs. Integration of services… will reduce the recycling of individuals through… the health system and the criminal justice system."

Governor's Health Care Safety Net Policy Team

"The Policy Team *recommends that the Governor's Office direct the Department of Human Services to better integrate primary care and behavioral health."*

Models for Integration

- **Critical concepts:**
  - **Patient-centered Primary Care Home**
  - **Health Care Team**
  - **Stepped Care**
- **Care Model**: redesign of care system for improved quality (How to organize these functions)
- **Four Quadrant Clinical Integration Model**: population/severity focused tool for identifying locus and intensity of care (Who does what, with whom, and where)

Patient-centered Primary Care Home

- **Access To Care**
- **Accountability**
- **Comprehensive Whole Person Care**
- **Continuity**
- **Coordination And Integration**
- **Person And Family Centered Care**

Health Care Team

- Doctor-patient relationship replaced with team-patient relationship
- Team members share responsibility for patient care
- Role definition and interoperability

Stepped Care Principles

- Least disruptive
- Least extensive for positive results
- Least intensive for positive results
- Least expensive for positive results
- Least expensive in terms of staff training required to obtain results

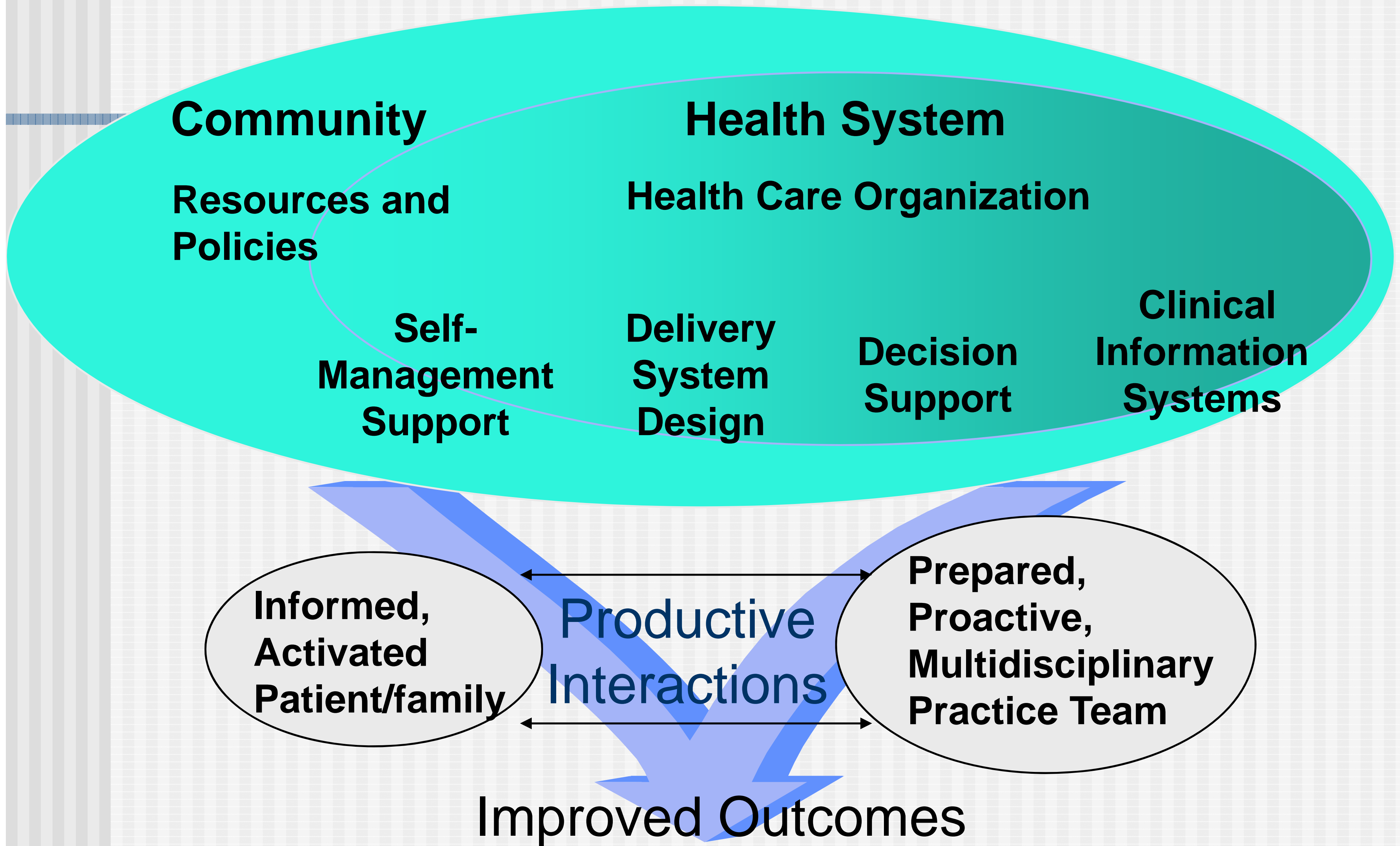
Stepped Care Levels

1. Basic education: info sharing & referral to self-help resources
2. Clinicians provide psycho-educational & motivational support
3. BH specialists use specific practice algorithms
4. Referral to external specialty or higher level BH providers

Care Model

- Good outcomes result of productive interactions btw/ informed, activated pt/family and prepared, proactive practice team
- Model developed by Wagner, et al, at Improving Chronic Illness Care

Care Model



Self-Management Support

- Emphasize the patient's central role
- Use effective self-management support strategies
- Organize resources to provide support

Delivery System Design

- Define roles and distribute tasks amongst team members
- Use planned interactions to support evidence-based care
- Provide clinical case management services
- Ensure regular follow-up
- Give care that patients understand and that fits their culture

Decision Support

- Embed evidence-based guidelines into daily clinical practice
- Integrate specialist expertise and primary care
- Use proven provider education methods
- Share guidelines and information with patients

Clinical Information System

- Provide reminders for providers and patients
- Identify relevant patient subpopulations for proactive care
- Facilitate individual patient care planning
- Share information with providers and patients
- Monitor performance of team and system

Health Care Organization

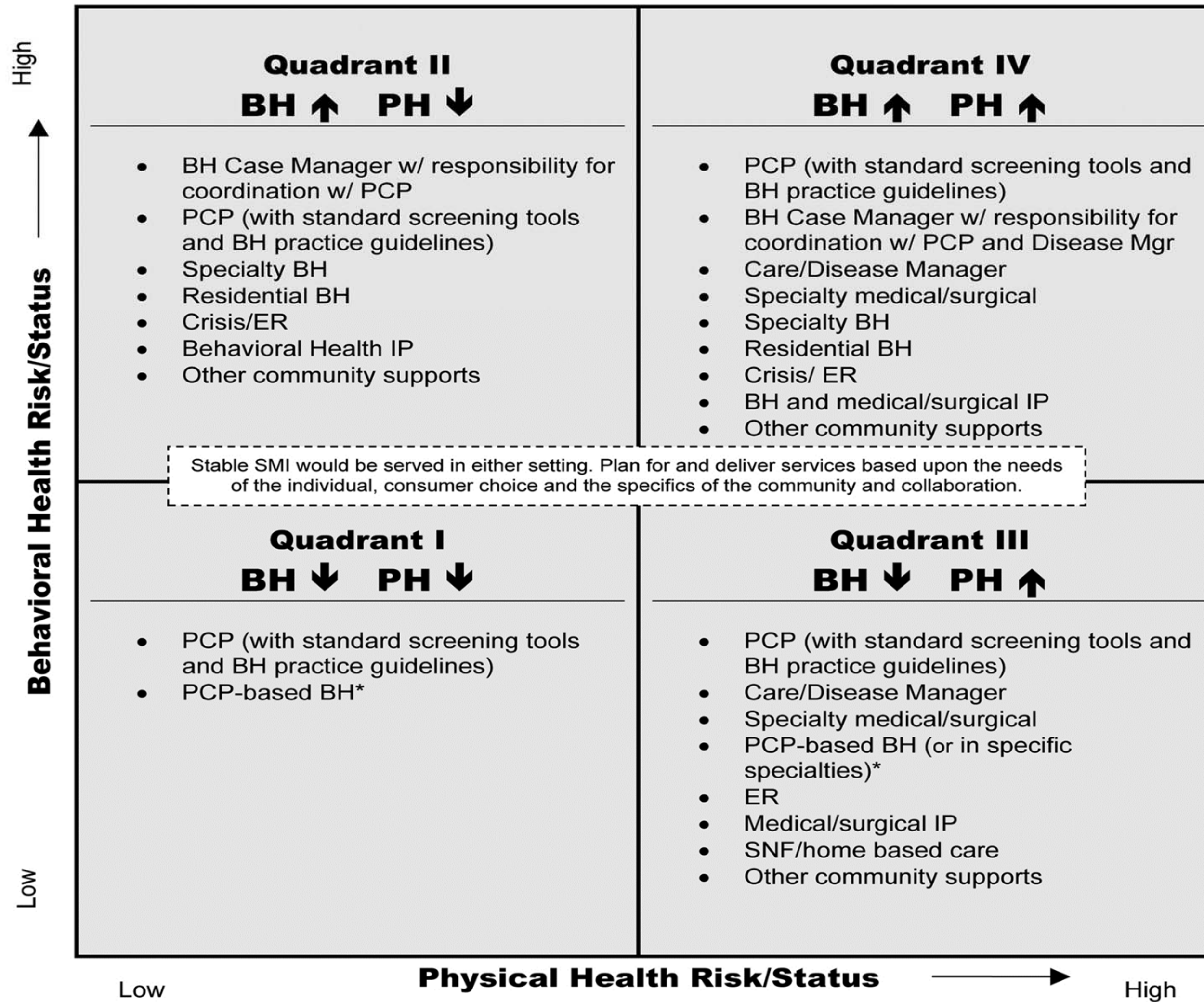
- Visibly support improvement at all levels, starting with senior leaders
- Promote effective improvement strategies aimed at comprehensive system change
- Encourage open and systematic handling of problems
- Provide incentives based on quality of care
- Develop agreements for care coordination

Community Resources/Policies

- Encourage patients to participate in effective programs
- Form partnerships with community organizations to support or develop programs
- Advocate for policies to improve care

The Four Quadrant Model

- Addresses the needs of the population and appropriate targeting of services
- Organizes our understanding of the potential approaches—there is no single method of integration
- Clarifies the respective roles and locus of PCP and BH providers, depending on levels of severity and co-morbidity
- Identifies system tools and clinician skill and knowledge sets needed and how they vary by subpopulation
- Developed by National Council for Community Behavioral Healthcare


The Four Quadrant Clinical Integration Model
Quadrant II
BH ↑ PH ↓
BH Case Manager w/ responsibility for coordination w/ PCP
PCP (with standard screening tools and BH practice guidelines)
Specialty BH
Residential BH
Crisis/ER
Behavioral Health IP
Other community supports
Quadrant IV
BH ↑ PH ↑
PCP (with standard screening tools and BH practice guidelines)
BH Case Manager w/ responsibility for coordination w/ PCP and Disease Mgr
Care/Disease Manager
Specialty medical/surgical
Specialty BH
Residential BH
Crisis/ ER
BH and medical/surgical IP
Other community supports
Stable SMI would be served in either setting. Plan for and deliver services based upon the needs of the individual, consumer choice and the specifics of the community and collaboration.
Quadrant I
BH ↓ PH ↓
PCP (with standard screening tools and BH practice guidelines)
PCP-based BH*
Quadrant III
BH ↓ PH ↑
PCP (with standard screening tools and BH practice guidelines)
Care/Disease Manager
Specialty medical/surgical
PCP-based BH (or in specific specialties)*
ER
Medical/surgical IP
SNF/home based care
Other community supports
High
Behavioral Health Risk/Status
Low
Low
Physical Health Risk/Status
High
*PCP-based BH provider might work for the PCP organization, a specialty BH provider, or as an individual practitioner, is competent in both MH and SA assessment and treatment

Quadrant I

- Low BH/low physical health complexity and risk
- BH services in primary care
- BH staff on site
  - Consultant to PCPs
  - Assessment and triage
  - Brief services
  - Referral to specialty BH
  - Referral to community resources
- BH staff competent in both MH and SA

Quadrant I

BH ↓ PH ↓

- PCP (with standard screening tools and BH practice guidelines)
- PCP-based BH*

Quadrant II

- High BH/low physical health complexity and risk
- BH services in PC & specialty BH settings
- BH/PC care manager assures access to primary care
- BH/PC care manager coordinates with PCP via established protocol
- BH staff competent in both MH and SA

Quadrant II

BH ↑ PH ↓

- BH Case Manager w/ responsibility for coordination w/ PCP
- PCP (with standard screening tools and BH practice guidelines)
- Specialty BH
- Residential BH
- Crisis/ER
- Behavioral Health IP
- Other community supports

Quadrant III

- Low BH/high physical health complexity and risk
- Served in primary/specialty healthcare system w/ BH staff on site
  - Consultant to PCPs
  - Assessment and triage
  - Brief services
  - Referral to specialty BH
  - Referral to community resources
- BH clinician as physician extender & health educator re: chronic health conditions
- BH staff competent in both MH and SA

Quadrant III

BH ↓ PH ↑

- PCP (with standard screening tools and BH practice guidelines)
- Care/Disease Manager
- Specialty medical/surgical
- PCP-based BH (or in specific specialties)*
- ER
- Medical/surgical IP
- SNF/home based care
- Other community supports

Quadrant IV

- High BH/high physical health complexity and risk
- Served in both specialty BH and primary care/specialty settings w/ appropriate coordination
- BH care manager works w/ other healthcare providers, esp. disease management care managers to assure coordination via established evidence-based protocols
- BH staff competent in both MH and SA

Quadrant IV

BH ↑ PH ↑

- PCP (with standard screening tools and BH practice guidelines)
- BH Case Manager w/ responsibility for coordination w/ PCP and Disease Mgr
- Care/Disease Manager
- Specialty medical/surgical
- Specialty BH
- Residential BH
- Crisis/ ER
- BH and medical/surgical IP
- Other community supports

Levels of Integration

Minimal	Basic at a Distance	Basic On-site	Close Partly Integrated	Close Fully Integrated

←--------- Collaboration Continuum ---------→

Model 1: Improving Collaboration btw/ Separate Providers

- Minimal
- BH & PC providers work in separate facilities, have separate systems, and communicate sporadically
- Private practices; settings w/ active referral linkages
- Q 1 & 3 (Low BH needs)

Model 2: Medical Provided BH Care

- Basic at a distance
- Providers in separate systems at separate sites, but engage in periodic communication about shared patients
- Private practices; settings w/ active referral linkages
- Q 1 & 3 (Low BH needs)

Model 3: Co-location

- Basic on-site
- Providers have separate systems but share same facility, allowing for more communication
- HMO settings; PC clinics that employ therapists or care managers
- Q 1, 2, & 3

Model 4: Disease Management

- Close, partly integrated
- Share same facility, have some systems in common, e.g., scheduling or records; physical proximity allows for regular face-to-face communication
- HMO settings; PC clinics that employ therapists or care managers
- Q 1, 2, & 3

Model 5: Reverse Co-location

- Close, partly integrated
- Share same facility, have some systems in common, e.g., scheduling or records; physical proximity allows for regular face-to-face communication
- HMO settings; PC clinics that employ therapists or care managers
- Q 2 & 4 (High BH needs)

Model 6: Unified PC & BH

- Close, fully integrated
- BH & PC providers part of same team
- Large practices and medical systems
- Q 1-4

Model 7: Primary Care Behavioral Health

- Close, fully integrated
- BH & PC providers part of same team
- Large practices and medical systems
- Q 1-4

Model 8: Collaborative System of Care

- Close, partly or fully integrated
- Specialty BH services integrated w/ PC services; may be partly or fully integrated depending on degree of collaboration
- HMO settings; PC clinics that employ therapists or care managers
- Q 2 & 4 (High BH needs)

Implementation Tasks

- Complete environmental scan
- Determine program's capacity and "filters"
- Establish administrative and clinical leadership "buy-in"
- Decide whether to rent or own BH staff
- Determine staffing pattern and BH tasks
- Define BH specialist skills

Clinical Tasks

- Triage
- Comprehensive assessment
- On-site treatment
- Referral
- Consultation
- Care monitoring & condition management
- **The key is balanced management of these tasks!**

Staffing the Model

- Behavioral health professional (Masters or higher)
- Psychiatric provider (for diagnostic and tx insights, not just for meds)
- Non-BH personnel trained to provide specific support functions

Clinician Characteristics

- Comfortable with primary care pace and treatment culture
- Respectful of cultural differences
- Bi-lingual language skills
- Flexible and adaptable
- Experience working in the public sector

Clinician Skills

- Adept with SPMI and addiction treatment issues
- Able to provide brief, creative, and effective treatment
- Evidence-based treatment experience
- Prevention & patient education skills
- Experience w/ triage, crisis interventions, & commitment process

Skills: continued

- Knowledge of Biopsychosocial and Care Models
- Curious & interested in medication and medical illness, labs etc.
- Computer competent and able to document clinical activities succinctly
- Understands the impact of stigma on client and providers

System Transformation Goals

- Through state and local leadership, create local safety net capacity and incentives to integrate behavioral health and primary care services.
- Provide adequate funding, administrative support and properly aligned risks.

System Transformation Goals

- Create an integrated health system that is accessible, continuous, comprehensive and available to all.
- System is adaptable and coordinated to each individual, setting, and specific community needs.
- System is evaluated and improved through outcome measures.

System Transformation Goals

- Co-locate services in all directions (PC/MH/SA).
- Patients are screened and provided the care they need in the setting of their choice
- Patients are served where they need and want to be served with culturally appropriate care.

Key Financing and Regulatory Questions

- How to get providers and payers together?
- What services can be provided and by whom?
- What individual credentialing and organizational certification issues must be addressed?

Key Financing and Regulatory Questions

- What services can/must be encountered and how to get credit/reimbursement for those that can't be encountered?
- Which ways can services be reimbursed, FFS, bundled services and/or global budget?
- Which enrollment and clinical record rules apply (MH or Medicaid) depending on where the patient is seen and who provides service?

Key Strategy I

Establish a cooperative partnership to identify:

- Preferred clinical models
- Dimensions of care (who does what with whom and where)
- Comprehensive screening tools, practice guidelines, & other decision supports
- Financial and administrative barriers

Key Strategy II

- Provide state level guidance and framework to support effective and flexible integration models.
- Guidance areas include: financing models, billing methods, program certification, QA/credentialing, documentation rules/regulations, Federal-State cooperation

Key Strategy III

- Implement regulatory changes to reduce paperwork and other administrative barriers to integration, especially clinical record and enrollment requirements.

Key Strategy IV

- Develop framework for full and partial integration pilots for the “low hanging fruit”, e.g., safety net system (FQHCs, RHCs, etc.), while working on setting policies that go beyond the safety net.

Key Strategy V

- Plan and implement strategies to develop core curricula and core competencies associated with behavioral health workforce development specific to the BH-PC interface.

Resources

- Chronic Care Model: www.improvingchroniccare.org
- NASMHPD Medical Directors Technical Report on BH-PC Integration: www.nasmhpd.org/general_files/publications/med_directors_pubs/Final%20Technical%20Report%20on%20Primary%20Care%20-%20Behavioral%20Health%20Integration.final.pdf

Resources

- EPC Effectiveness Report on Integration of BH & Primary Care: http://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf
- NASMHPD Medical Directors Technical Report on Excess Mortality for Persons with SPMI: http://www.nasmhpd.org/general_files/publications/med_directors_pubs/NASMHPD%20Medical%20Directors%20Health%20Indicators%20Report%2011-19-08.pdf

Resources

- Evolving Models of BH Integration in PC: http://www.milbank.org/reports/10430EvolvingCare/10430EvolvingCare.html
- BH-PC Integration & the Person-centered Healthcare Home: http://www.allhealth.org/BriefingMaterials/BehavioralHealthandPrimaryCareIntegrationandthePerson-CenteredHealthcareHome-1547.pdf
- Patient-Centered Primary Care Collaborative: http://www.pcpcc.net/behavioral-health

Psychiatrists and Integrated Care

- What roles can/should we play in these programs?
- How can we get/provide training & support?
- Is there a need for a caucus for psychiatrists involved in integrated/collaborative care?