

Creating comprehensive systems of integrated Healthcare: the role of behavioral health

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What do you want your
mental health system to do?



EUGENE S. FARLEY, JR.
HEALTH POLICY CENTER
A Collaboration for Studies in Primary Care

A CASE FOR INTEGRATING

Behavioral Health and
Primary Care

PREVALENCE



of adults will experience
mental health illness or a
substance abuse disorder at
some point in their lifetime¹



of primary care
office visits are mental
health related²



of adolescents will experience mental health or a substance
abuse disorder with distress or severe impairment³

UNMET BEHAVIORAL HEALTH NEEDS

67%

of adults with a behavioral health disorder do not get behavioral health treatment⁴

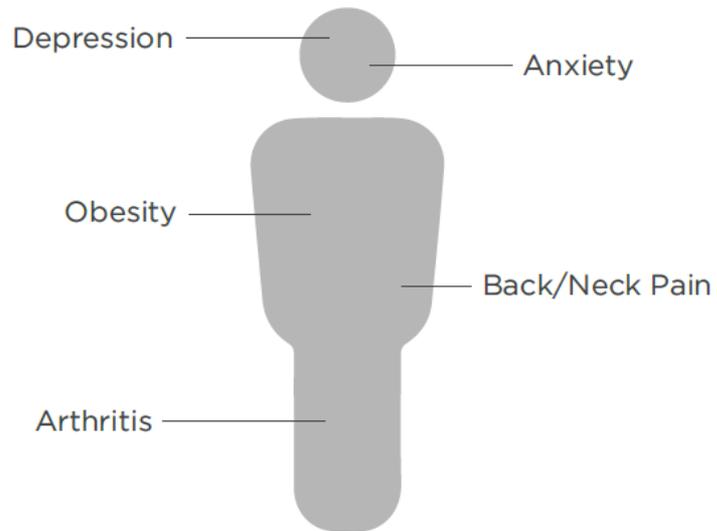
Depression goes undetected in >50% of primary care patients⁵

66%

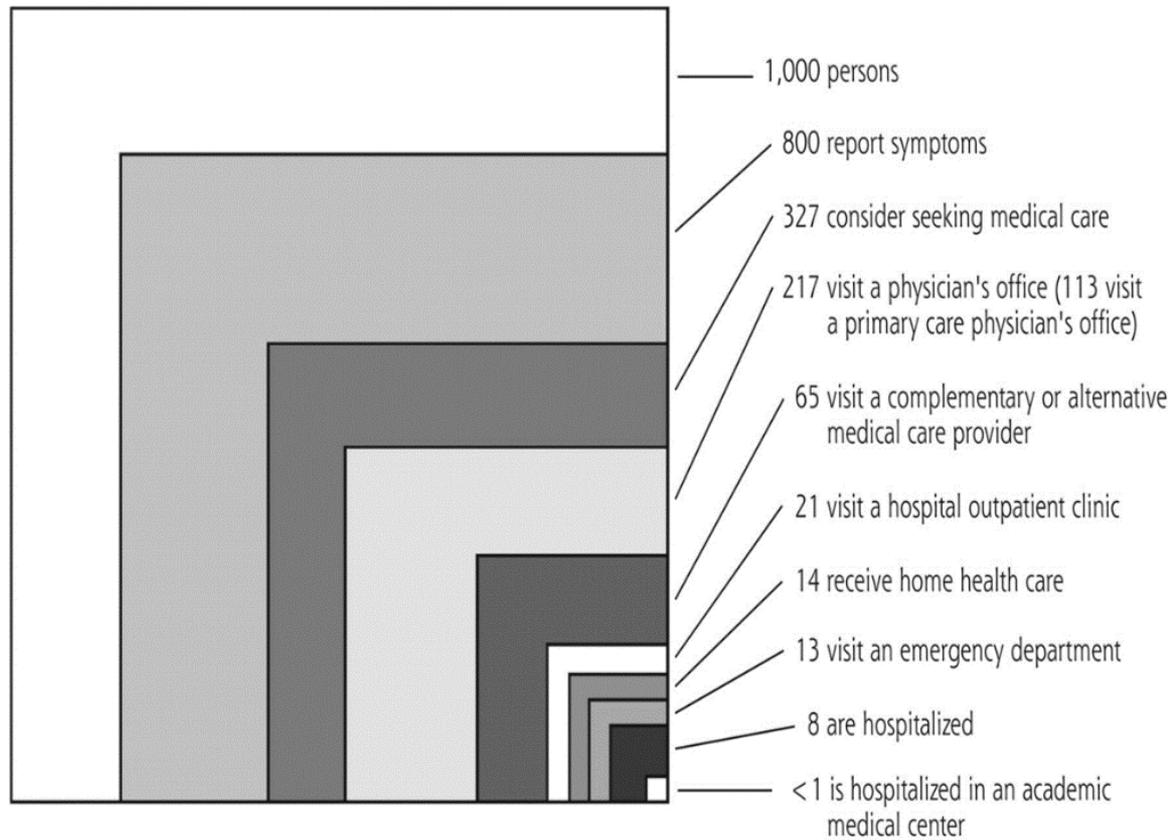


of primary care providers report they are unable to connect patients with outpatient behavioral health providers due to a shortage of mental health providers and health insurance barriers⁶

TOP 5 CONDITIONS DRIVING OVERALL HEALTH COST⁸



When treated in harmony with mental health, chronic physical health improves significantly, along with patient satisfaction.⁹



Green, L. A., Fryer, G. E., Jr., Yawn, B. P., Lanier, D., & Dovey, S. M. (2001). The ecology of medical care revisited. *N Engl J Med*, 344(26), 2021-2025.

Mental health and primary care are
inseparable; any attempts to separate
the two leads to inferior care

- IOM, 1996

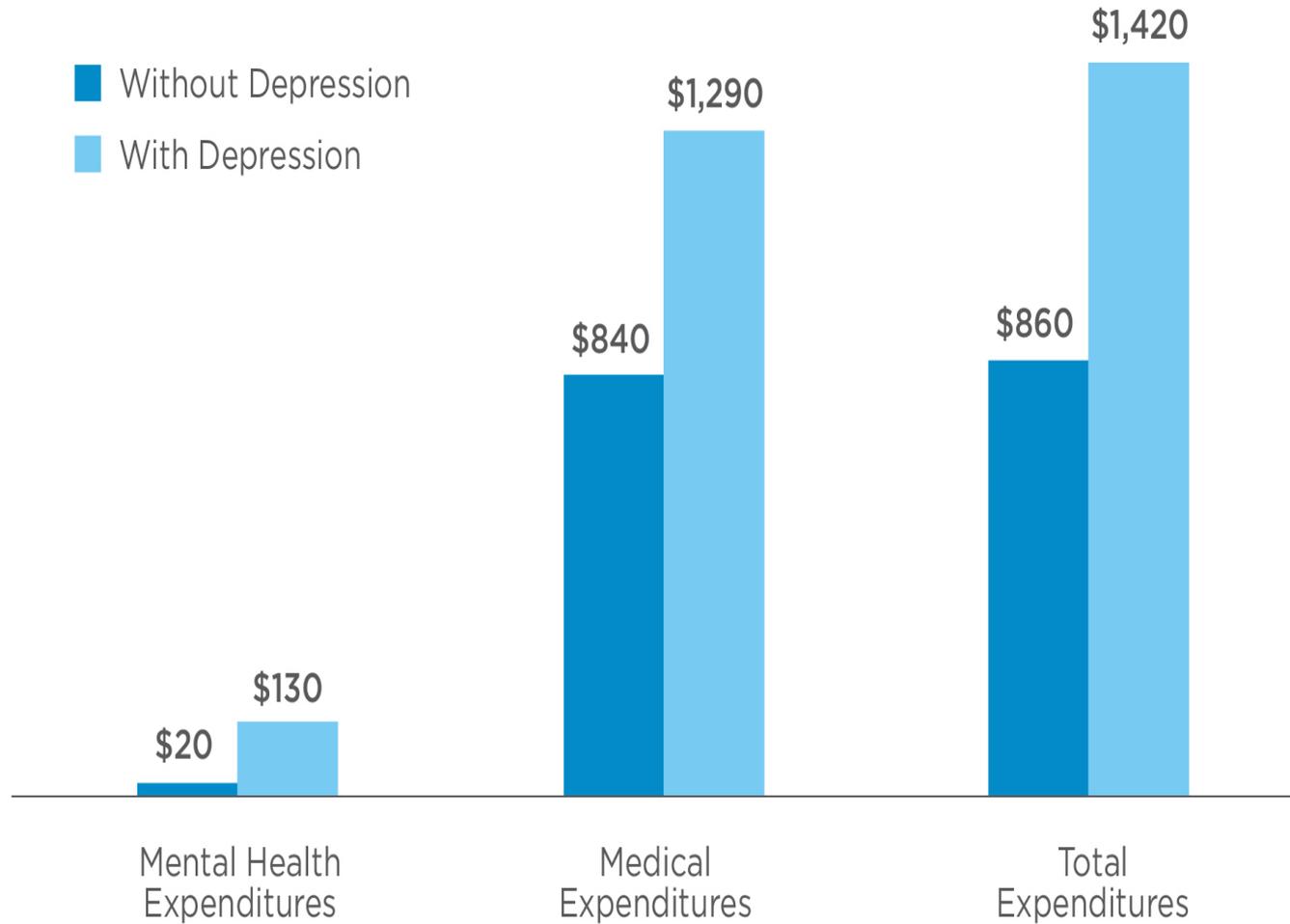
deGruy, F. (1996). Mental health care in the primary care setting. In M. S. Donaldson, K. D. Yordy, K. N. Lohr & N. A. Vanselow (Eds.), *Primary Care: America's Health in a New Era*. Washington, D.C.: Institute of Medicine.

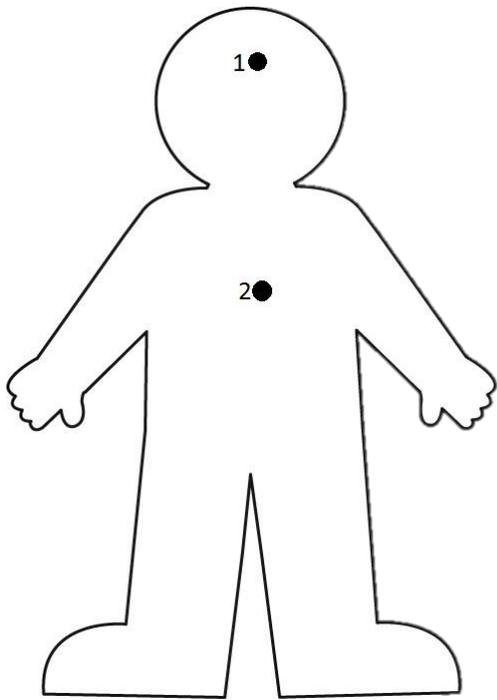
An Afternoon in Primary Care

Patient	Presenting Concern
<input type="checkbox"/> 12 yo male	<i>abdominal pain (new)</i>
<input type="checkbox"/> 40 yo male	<i>depression, diabetes, hypertension (f/u)</i>
<input type="checkbox"/> 50 yo female	<i>fibromyalgia, insomnia (new)</i>
<input type="checkbox"/> 44 yo female	<i>chronic pain, suicide attempt (f/u)</i>
<input type="checkbox"/> 50 yo male	<i>recent heart attack, substance abuse (f/u)</i>
<input type="checkbox"/> 59 yo female	<i>hypertension, diabetes, coronary artery disease, depression (new)</i>
<input type="checkbox"/> 54 yo male	<i>panic attacks, morbid obesity (f/u)</i>
<input type="checkbox"/> 46 yo female	<i>grief from death of child (new)</i>

h/t Dr. Khatri

The cost of care increases in the presence of comorbid behavioral health and physical health conditions. For example, the chart below depicts the monthly cost of care for chronic health conditions with and without comorbid depression.

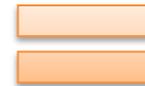




Payment /financing

Community expectation

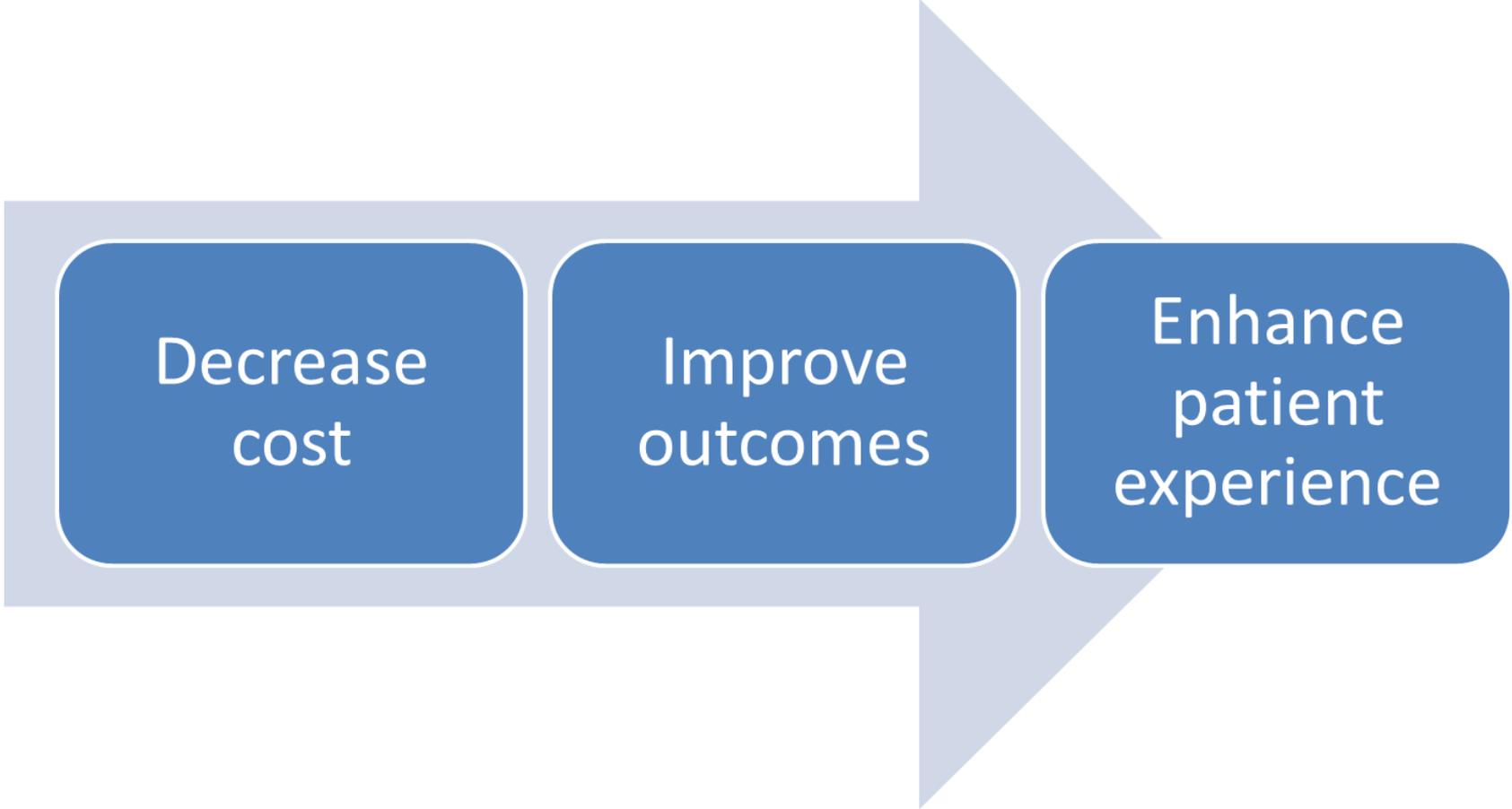
Training/education



Fragmentation

WIKI?

Our Rationale



Decrease
cost

Improve
outcomes

Enhance
patient
experience

Fragmentation keeps us from our goal



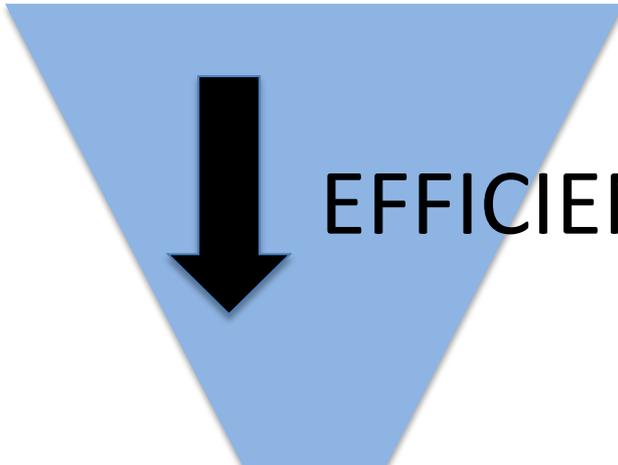
QUALITY

SEPARATE CLINICAL SYSTEMS

- Delayed/Limited Access
- Separate Records
- Minimal Coordination
- Training Silos

SEPARATE OPERATIONS

- Different administrative systems
- Different regulations and requirements
- Different processes and procedures
- Health Information Technology Barriers



EFFICIENCY



COST

SEPARATE FINANCIAL SYSTEMS

- Carve Outs
- Fee for Service model
- Incentivizes for fragmented care
- Regulatory barriers

Definition

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, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, ineffective patterns of health care utilization.

Value of Integration:

Physical/Behavioral Integration is **good health policy** and good for health.

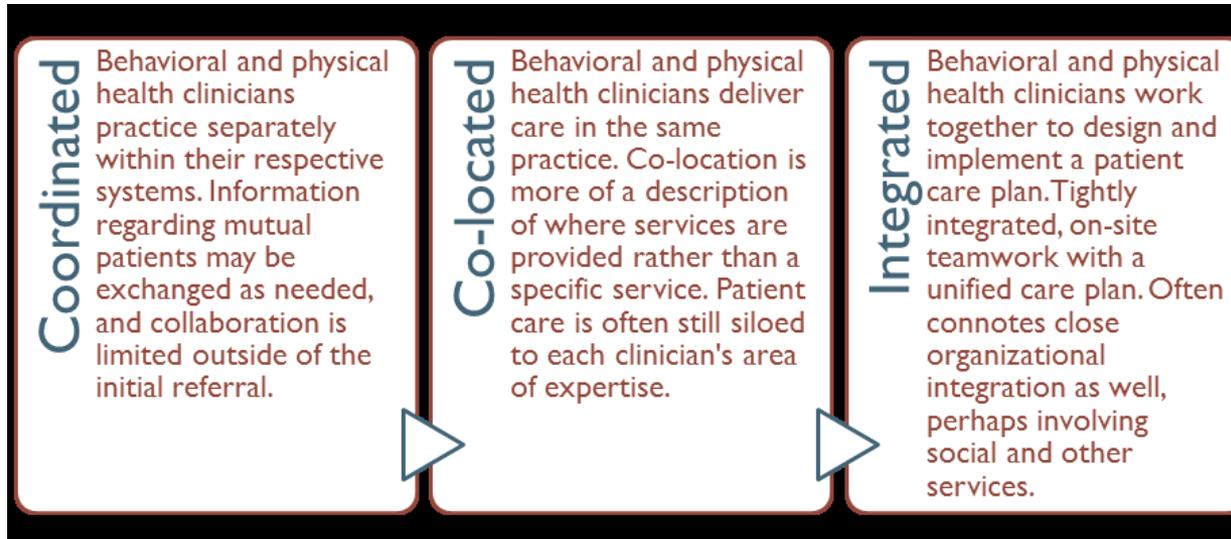
A Tale of Two Approaches

Component of Care	Traditional	Integrated
Access	Referral	Point of Primary Care
Scope of Service	Mental Health Diagnoses	Overall Health Function
Scheduling	Separate	Shared
Collaboration of Care	Individual Provider	Team Based
Health Record	Separate	Shared
Administrative Operations	Separate	Shared
Payment	Separate	Global
Communication	Minimal	Frequent & Timely
Focus of Care	Provider-Centric	Patient-Centric
Approach to Care	Case by Case	Population-Based
Efficiency of Delivery Structure	Fragmented & Inconsistent	Coordinated and Aligned

Head-to-Head Comparison

- Five year, federally funded study
- University of Pittsburgh
- 321 children
 - 160 received treatment at PCP's office
 - 161 received treatment at mental health provider
- Outcome:
 - PCP: 99.4% initiated care and 76.6% completed
 - MH: 54.2% initiated care and 11.6% complete

Overview – A “Path” Toward Integration



RISK STRATIFICATION AND BEHAVIORAL HEALTH INTEGRATION

Identification

- How do you identify and recognize individuals with behavioral health needs that might not currently be addressed?

Identification cont.

- In your practice is there someone responsible for screening/identifying BH?
 - Examples include:
 - Front desk administers a screener
 - Patient self identifies with symptoms and a screener is administered
 - Providers use screener to help assess possible underlying BH condition
 - Once a screener has been administered and it is positive, what next?
 - Who is responsible for following up with the patient?
 - Who stores the data from the assessment tool (and where)?
 - How is the screening tool used to monitor treatment?

Risk stratification

- Risk stratification is a systematic process for identifying and predicting patient risk levels relating to health care needs, services, and coordination
- Often, the goal is to identify those at the highest risk or likely to be at high-risk and focus intervention on these patients to prevent poor outcomes
- Often involves use of algorithms and registries, payer data, etc.

Why risk stratify?

- “Predict” potential patient health risks
- Prioritize resources and focus interventions
- Minimize negative outcomes

Start with the basics

- Create a process for collecting these data that is easily understood by all (not just data guy)
- For example:
 - Which patients are at highest risk?
 - Comorbid behavioral health?
 - Social status?
 - Consistent definitions for which patients meet what category
 - Criteria for different categories in stratification
 - Limitations of decisions (e.g. life event)

Risk stratification

- Look at the patients you are currently treating; what percent have a comorbid behavioral health diagnosis?
 - Examine if the patients you have identified are improving
 - Consider starting your behavioral health interventions with these cohort of patients
 - Patients who may also be in a high risk category who have complex chronic disease but no diagnosis of behavioral health may actually have one

**THERE IS NO ONE ONE-SIZE-
FITS ALL APPROACH – NEED TO
IDENTIFY WHAT
WILL WORK BEST IN YOUR
PRACTICE**

Workflow trumps technology

Designing workflows

Where

- Where are important events happening?
- Examples: clinic, patient's home, partner site, internet/web

What or How

- What is being done to help integrate care?
- How much time is being spent on this activity?
- Examples: ask questions, look at data, talk with someone, provide instructions, make a decision, connect to a resource

When

- When is the action performed or in what sequence?
- Examples: before, during or after a visit, three months from now, once a year.

Who

- Who is participating, receiving, or doing something?
- Examples: PCP, BH provider, staff, collaborator, patient, computer/Electronic Health Records

Workflows and risk stratification

- Once a risk stratification methodology has been established consider the following:
 - Who identifies?
 - Who intervenes?
 - Who records?
 - Who tracks?

Measures

Issue	Name of Measure	Number Items	Score for Positive Screen
Depression	PHQ-9	9	6-10 moderate 10-15 moderately severe 16+ severe
Alcohol Abuse	AUDIT	3	7 or more for women 8 or more for men
Generalized Anxiety	GAD-7	7	6-10 moderate 10-15 moderately severe 16+ severe
Bipolar Disorder	Mood Disorder Questionnaire	5	Yes to 7+ items in question 1 AND Yes to question 2 AND moderate to serious to question 3.
PTSD	PC-PTSD	4	Yes to one or more items
Montreal Cognitive Assessment Tool	MOCA	12	>26 (out of 30) Normal

Are patients improving?

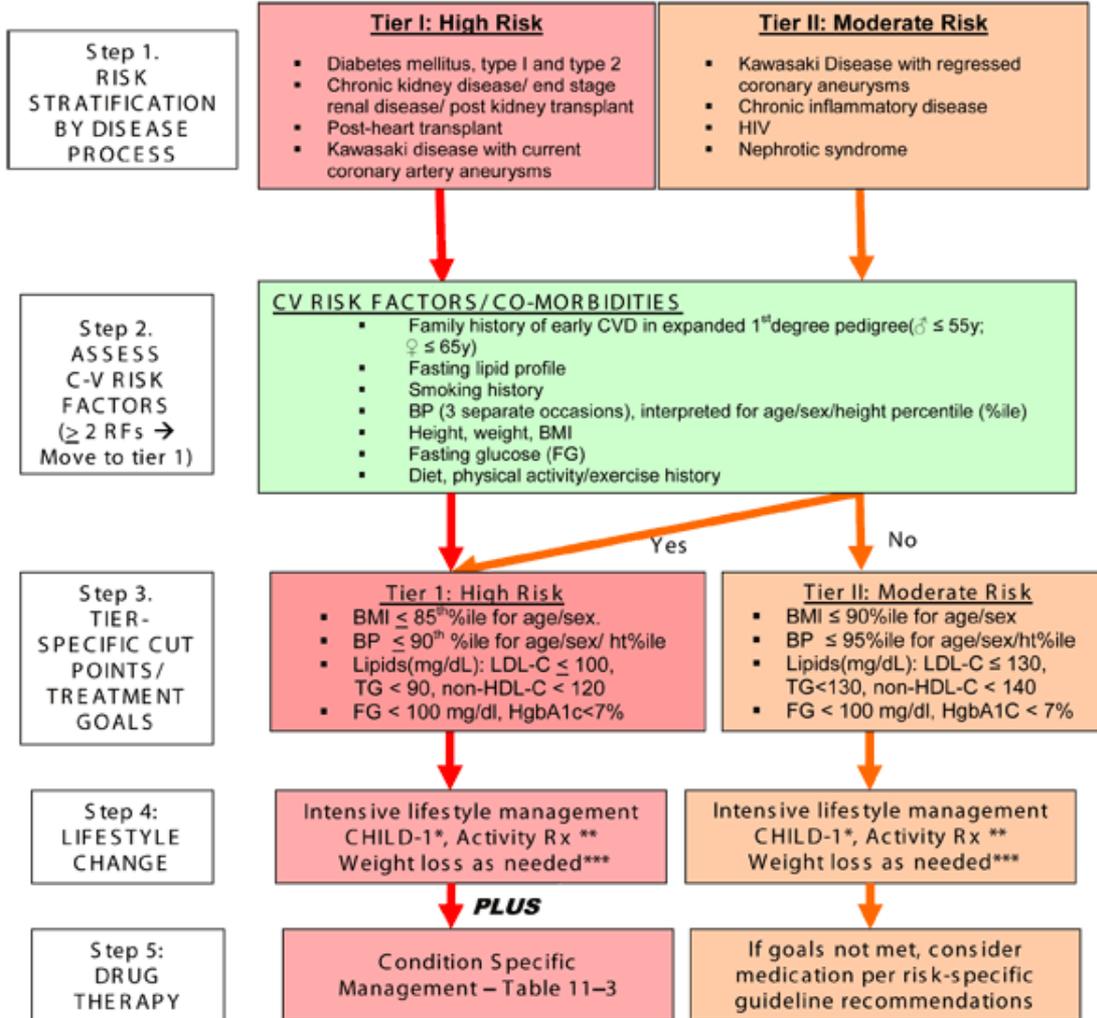
- Use standard screening tools for behavioral health conditions (e.g. PHQ-9 for depression, GAD-7 for anxiety)
 - Integrate these tools into the workflow
 - Use tools repeatedly to assess effectiveness of treatment (e.g. TREAT to TARGET, case review consultation)
 - Store these data in structured fields

Identify the disease(s)

Identify the risk factors

Set the goals for each "tier"

Intervene



Where are the behavioral health services?

- Which BH are part of the practice care team or staff resources your system provides you (for those practices that are part of systems), and which are available through established coordinated relationships in the medical neighborhood?
 - Factors to consider:
 - Finding the behavioral health providers in your community
 - The ability to track referrals or communicate with external partners
 - Availability of behavioral health provider to come onsite
 - Role behavioral health provider will play (e.g. brief interventions or more specialty mental health services)

Patients who need Integrated behavioral health

“Buckets”

Mental Health and Substance Abuse conditions commonly presenting in primary care
e.g. depression, anxiety, PTSD, or other depending on

Medical conditions with strong MH or SA contribution, even if pt doesn't see self as having MH or SA problem
e.g., diabetes, CV, asthma or

Straightforward situations: Typical protocols apply—usual care and decision-making with usual team arrangements

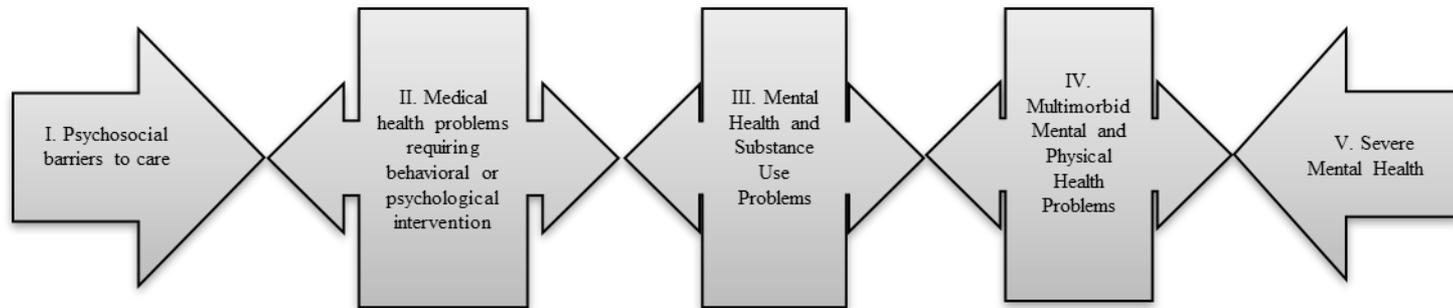
Complex situations: Interferences with usual care and decision-making that require unusual attention, non-standard care processes or team arrangements

“Zones”

Defining functions for both “buckets” and both “zones”:

1. Teams defined at the level of the patient “bucket” and “zone”
2. Shared care plans and targets that integrate behavioral health
3. Clinical systems to support Integrated treatment to target

What are the range of behavioral health services offered?



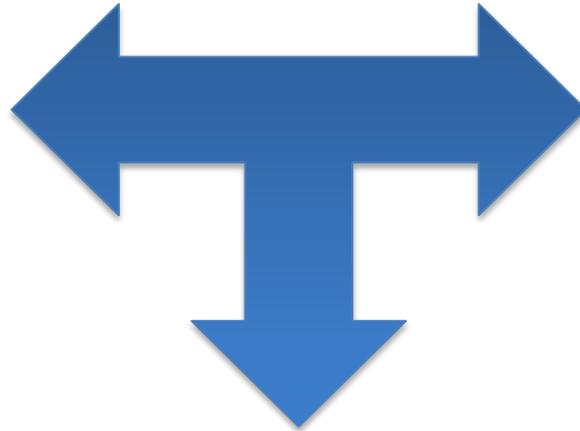
Building practice capacity

- Creating a team oriented practice
 - Offer internal practice team staff, training
 - Consultation/co-management relationships with behavioral health
 - Coordinate relationships within medical neighborhood
 - Share workflow to foster multidisciplinary teams



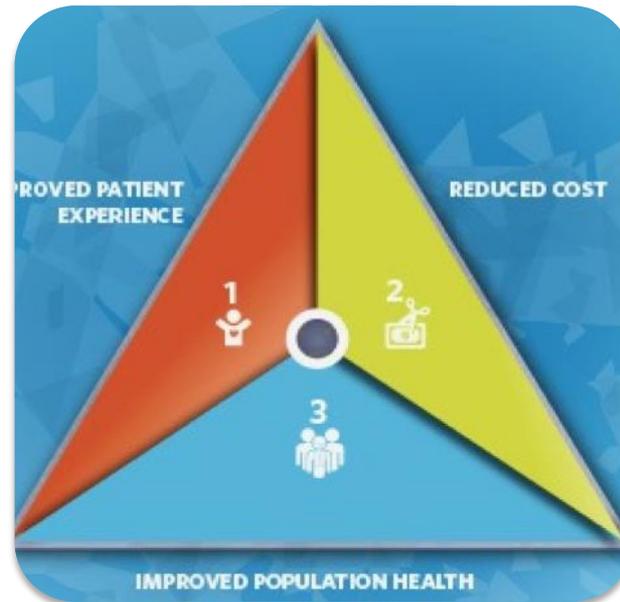
INTEGRATED PRIMARY CARE TEAM

- Access, Communication, Collaboration at Point of Care
- Shared Space, Workflow, Documentation, Support Staff
- Collaborative treatment planning
- Anchored in Patient Engagement



INTEGRATED POPULATION BASED CARE

- Integrated Operations
- Global Payment for Integrated Services
- Integrated Health Record
- Clinical Informatics to address population health needs
- Flexible Healthcare delivery to appropriately distribute resources
- Integrated Health Record for quality improvement and assurance
- Clinical informatics at population level



Resources

NCBH Day 1 PPT.pdf

<http://www.integration.samhsa.gov/>

<http://www.advancingcaretogether.org/>

<http://www.youtube.com/CUDFMPolicyChannel>

<http://coloradosim.org/>

[: http://www.cfha.net/](http://www.cfha.net/)

<http://www.pcpcc.org/behavioral-health>

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