Integrating Primary Care and Behavioral Health Services: A Compass and A Horizon

A curriculum for community health centers
Developed for the

Bureau of Primary Health Care
Managed Care Technical Assistance Program

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Workshop Objectives

- Understand managed care influences in the movement toward service integration
- Evaluate process of care, outcome and cost factors that support change to an integrated services approach
- Apply population care concepts to the design of integrated behavioral health programs
- Consider possible approaches to integrating PC and BH services
- Anticipate ways to apply the primary behavioral health model to your practice or clinic
Managed Care Drivers of Primary Care Behavioral Health Integration

- Adverse effects of the “carve out” model
  - Problems with access to basic BH services for CHC populations with high levels of risk
  - Burden of behavioral healthcare complicates process of healthcare and drives up costs
  - Major reimbursement barriers for primary care systems
  - CHC system carries a disproportionate share of service and financial risk in carve out model
    - Health care spending for BH services equal to BH spending in specialty sector
Managed Care Drivers of Primary Care Behavioral Health Integration

- Adverse impacts of the “carve out” model
  - Utilization review and gatekeeper roles located in MBHO, not primary care
  - Poor to non-existent coordination of care
  - Bewildering variety/quality of MBHO systems in both public and private sectors
  - Referral process complicated and difficult to navigate
  - Service entry criteria favor SMI population, denying access for treatable episodic & recurrent conditions
  - Collapse of CMHC system due to excessive cost restraints over last 5 years
Managed Care Drivers of Primary Care Behavioral Health Integration

- Positive impacts of managed care
  - Financial incentives favor efficiency, rather than waste (e.g. at risk contracting)
  - Emphasis on population based care and health care team model
  - Conversion to primary care gate-keeper model
  - Consumer-centered “one stop” shopping
  - Emphasis on functional, cost and health outcomes (e.g. disability, productivity)
Provision of Behavioral Health Care in the US: Setting of Services
Why Integrate Primary Care and Behavioral Health Care?

- **Cost and utilization factors**
  - 50% of all MH care delivered by PCP
  - 70% of community health patients have MH or CD disorders
  - 92% of all elderly patients receive MH care from PCP
  - Top 10% of healthcare utilizers consume 33% of outpatient services & 50% of inpatient services
  - 50% of high utilizers have MH or CD disorders
  - Distressed patients use 2X the health care yearly
Why Integrate Behavioral Health and Primary Care?

- **Process of care factors**
  - Only 25% of medical decision making based on disease severity
  - 70% of all PC visits have psychosocial drivers
  - 90% of most common complaints have no organic basis
  - 67% of psychoactive agents prescribed by PCP
  - 80% of antidepressants prescribed by PCP
  - Work pace hinders management of mild MH or CD problems; better with severe conditions
Why Integrate Primary Care and Behavioral Health?

- Health outcome factors
  - Medical and functional impairments of MH & CD conditions on a par with major medical illnesses
  - Psychosocial distress corresponds with morbidity and mortality risk
  - MH outcomes in primary care patients only slightly better than spontaneous recovery
  - 50-60% non-adherence to psychoactive medications within first 4 weeks
  - Only 1 in 4 patients referred to specialty MH or CD make the first appointment
Benefits of Integrating Primary Care and Behavioral Health

- Improved process of care
  - Improved recognition of MH and CD disorders (Katon et. al., 1990)
  - Improved PCP skills in medication prescription practices (Katon et. al., 1995)
  - Increased PCP use of behavioral interventions (Mynors-Wallace, et. al. 1998)
  - Increased PCP confidence in managing behavioral health conditions (Robinson et. al., 2000)
Clinical Outcome and Service Quality Benefits of Integration

- Improvement in depression remission rates: from 42% to 71% (Katon et al., 1996)
- Improved self management skills for patients with chronic conditions (Kent & Gordon, 1998)
- Better clinical outcome than by treatment in either sector alone (McGruder et al., 1988)
- Improved consumer and provider satisfaction (Robinson et al., 2000)
- High level of patient adherence and retention in treatment (Mynors-Wallace et al., 2000)
Economic Benefits of Integration

Cost Effectiveness of Treatment

– Measure of impact of adding additional dollars to a medical procedure for value received (e.g. better diagnostic accuracy, clinical effectiveness)
– Integrating behavioral health service adds $264 per case of depression treated in primary care
– Treatment success rates nearly double with this expenditure
– Result is a positive cost effectiveness index of $491 per case of depression treated (Von Korff et. al., 1998)
Economic Benefits of Integration

- Increased Productive Capacity
  - Estimate of revenue ceiling of a health care system is closely tied to productive capacity of medical providers
  - Current capacity is shackled due to frequent management of behavioral health conditions (50% of medical practice time directed toward BH conditions)
  - Integrated behavioral health “leverages” BH patients out of PCP practice schedules
  - PCP’s are freed to see medical patients with higher RVU conditions
Economic Benefits of Integration

- Medical cost savings
  - Meta-analysis: 57 controlled studies show a net 27% cost savings (Chiles et. al., 1999)
  - 40% savings in Medicaid patients receiving targeted treatment (Cummings & Pallak, 1990)
  - In older populations, up to 70% savings in in-patient costs (Mumford et. al., 1984)
  - 20-30% overall cost savings is the average of studies reviewed (Strosahl & Sobel, 1996)
Population-based Care: The Framework for Integration

- Based in public health & epidemiology
  - Focus on raising health of population
  - Emphasis on early identification & prevention
  - Designed to serve high percentage of population
  - Provide triage and clinical services in stepped care fashion
  - Uses “panel” instead of “clinical case” model
  - Balanced emphasis on who is and is not accessing service
Population-based Care: The Framework for Integration

- Employs evidence based medicine model
  - Interventions based in research
  - Goal is to employ the most simple, effective, diagnosis-specific treatment
  - Practice guidelines used to support consistent decision making and process of care
  - Critical pathways designed to support best practices
  - Goal is to maximize initial response, reduce acuity, prevent relapse
Analysis of Behavioral Health Needs in a Primary Care Population

Vertical Integration Program
(Critical Pathways)

- Panic Disorder
- Generalized Anxiety
- Somatoform Disorders
- Major Depression
- Alcohol Abuse/Dependence

35%
(8,750 Patients)

Depressive & Anxiety Symptoms
Life stress

35%
(8,750 Patients)

No Behavioral Health Need

30%
(7,500 Patients)

Hypothetical Cohort of 25,000 patients
## The Continuum of Integration

<table>
<thead>
<tr>
<th>Model</th>
<th>Desirability</th>
<th>Attributes</th>
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</thead>
<tbody>
<tr>
<td>Separate Space &amp; Mission</td>
<td>- -</td>
<td>Traditional BH Specialty Model</td>
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<tr>
<td>1:1 Referral Relationship</td>
<td>+</td>
<td>Preferred provider/Some information exchange</td>
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<tr>
<td>Co-location</td>
<td>++</td>
<td>On-site BH Unit/Separate Team</td>
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<tr>
<td>Collaborative Care</td>
<td>+++</td>
<td>On site/shared cases w/ BH specialist</td>
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<tr>
<td>Integrated Care</td>
<td>+++++</td>
<td>PC Team Member</td>
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Two Perspectives On Population-Based Care

### Horizontal Integration
- Panel Population
- Specialty Consultation
- Integrated Programs
- General Behavioral Health Consultation

### Vertical Integration
- Depression Clinical Pathway
- Chronic Depression
- Major Depression
- Dysthymia & Minor Depression
- Adjustment & stress reactions with depressive symptoms
Vertical Integration: Chronic Conditions Management

- Implement integrated care programs if they . . .
  - Produce better outcomes
  - Reduce costs or are “cost neutral”
  - Are acceptable to providers
  - Are liked by consumers
  - Can be implemented without damaging the delivery system in other areas
Common Vertical Integration Targets

- Depression
- Anxiety and panic
- Chronic pain
- Somatization
- Alcohol and drug abuse
- Frail elderly
- Post M.I.
- Diabetes
Integrated Care: Is It a Rose by Any Other Name?

- The dilemma:
  - Integrated care has different meanings for different people.
  - Different models of integrated care lead to different costs and outcomes.
  - How do we pick an approach?
Consider:

- The program must be able to address tremendous unmet demand among PC patients.
- Additional staffing resources are likely to be scarce; BH providers must have high population impact.
- The service should be consistent with the mission and objectives of primary care.
Consider:

- By definition, the less separation of services, providers and infrastructure, the better.
- Service needs to be patient centered and organized to be culturally competent.
Primary Behavioral Health: Primary Goals

- Act as consultant and member of health care team.
- Support PCP decision making.
- Build on PCP interventions.
- Teach PCP “core” behavioral health skills.
- Educate patient in self management skills through training.
- Improve PCP-patient working relationship.
- Monitor, with PCP, “at risk” patients.
Primary Behavioral Health: Primary Goals

- Manage chronic patients with PCP in primary provider role
- Assist in team building
- Simultaneous focus on health and behavioral health issues
- Effective triage of patients in need of specialty behavioral health
- Make PBH services available to large percentage of eligible population
Primary Behavioral Health: Referral Structure

- Patient referred by PCP only; self-referral rare
- May accept “warm handoff” on same day basis
- BH provider may screen PCP appointment schedule to “leverage” medical visits
Primary Behavioral Health: Session Structure

- Limited to 1-3 visits in typical case
- 15-30 minute visits
- Critical pathway programs may involve 4-8 appointments
- May use classes and group care clinics
- Multi-problem patients seen regularly but infrequently over time
Primary Behavioral Health: Intervention Structure

- Informal, revolves around PCP assessment and goals
- Low intensity, between session interval longer
- Relationship generally not primary focus
- Visits timed around PCP visits
- Long term follow up rare; reserved for high risk patients
Primary Behavioral Health: Intervention Methods

- Limited face to face contact
- Uses patient education model
- Consultant is a technical resource to patient
- Emphasis on home-based practice to promote change
- May involve PCP in visits with patient
Primary Behavioral Health: Cultural Competency

- Program design recognizes cultural competence requirement
- Symptoms evaluated using culturally appropriate methods
- Interventions tailored to cultural practice
- Use of community resources supportive of culture
- Services available for mono-lingual patients
Primary Behavioral Health: Termination and Follow-up

- Responsibility returned to PCP “in toto”
- PCP provides relapse prevention or maintenance treatment
- BHC may provide planned booster sessions for at risk patients (telephone)
Primary Behavioral Health: Primary Information Products

- Consultation report to PCP
- Part of medical record
- “Curbside consultation”
- Written relapse prevention plans
Qualities of A Successful Integrated Behavioral Care Service

- Provides timely access for PCP
- Service is integrated within primary care setting
- Service is viewed as a form of primary care
- Service is provided in collaboration with the PCP
- Service is provided as part of the health care process
Qualities of a Successful Integrated Behavioral Health Care Service

• Goal is to increase impact of PCP team interventions
• Goal is to consult with and train the PCP to produce better outcomes
• Improved clinical outcomes, satisfied patients and health care providers, and managing productivity and financial risk are key targets
A Study of Integrated Care

Study Design

Physician Referral
n = 217

Baseline & Randomization
n = 153

Intervention
n = 77

Control
n = 76
Integrated Program for Depression

- PCP & Psychologist Team
  - 1-3 15-minute PCP contacts over 4-6 weeks
  - 4 to 6 20+ minute BHC contacts over 4-6 week period
  - 4 phone follow-ups by BHC 2, 4, 12 & 24 wks post acute TX (to support relapse prevention)

- Major process of care targets
  - Medication compliance
  - Home-based practice of coping skills
  - Relapse prevention planning
  - PC and BH co-management model
50% Improvement in Depression Symptoms at 4-Months

- 70% Improvement in Major Intervention
- 42% Improvement in Control
- 68% Improvement in Minor Intervention
- 53% Improvement in Control
Coping

Baseline 1-Month 4-Month 7-Month
CC/Major CC/Minor UC/Major UC/Minor

The graph shows the coping scores over time for different categories: CC/Major, CC/Minor, UC/Major, and UC/Minor. The x-axis represents the time points: Baseline, 1-Month, 4-Month, and 7-Month. The y-axis represents the coping scores ranging from 0.00 to 20.00. The coping scores at each time point are marked with specific values for each category.
Major Depression:
Taking Medication for 25 of past 30 days

- 85% at 1 month
- 89% at 4 months
- 79% at 7 months
Following RP Plan at 4-months

- Major: 74%
- Minor: 90%

Intervention: 27%
Control: 33%
Rated TX for Depression as Good or Excellent

- Major Intervention: 88%
- Major Control: 56%
- Minor Intervention: 97%
- Minor Control: 71%