

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



A curriculum for community health centers

Developed for the

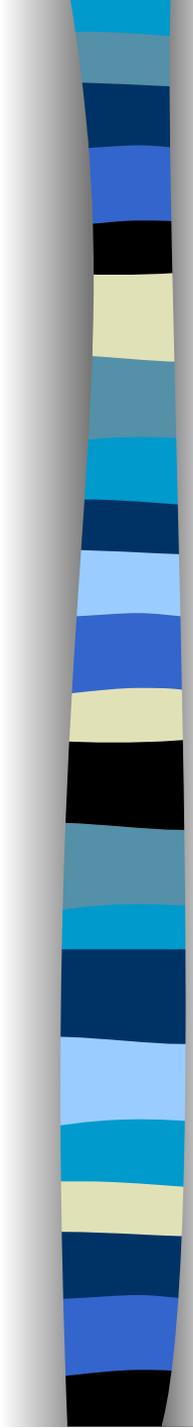
**Bureau of Primary Health Care**

Managed Care Technical Assistance Program

By

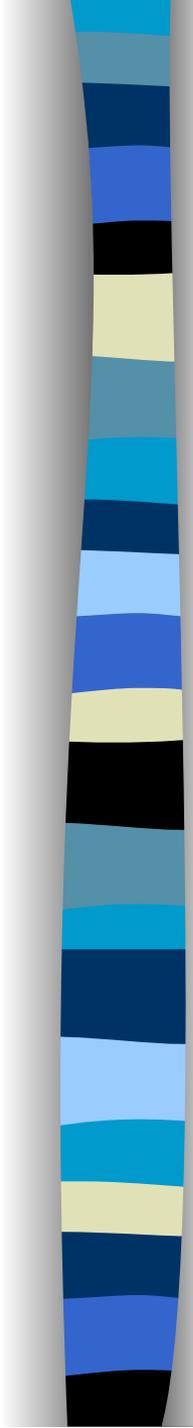
Mountainview Consulting Group, Inc.

E-mail: [mconsult@televar.com](mailto:mconsult@televar.com); (509) 249-1546



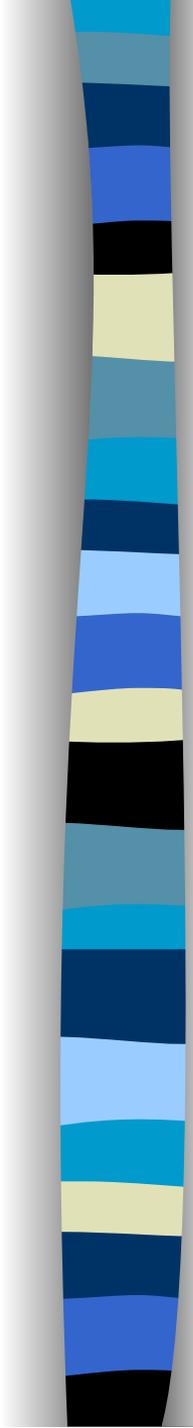
# Workshop Objectives

- 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



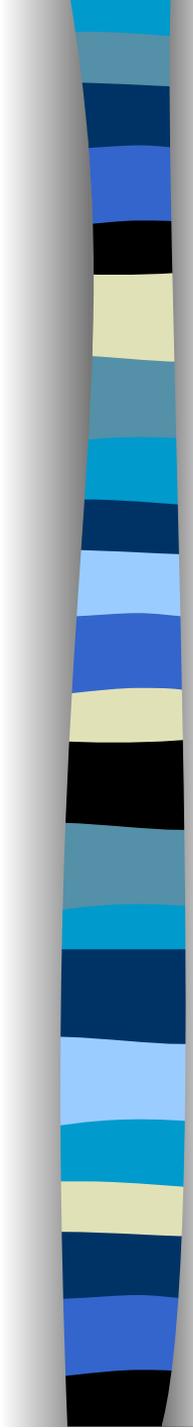
# Managed Care Drivers of Primary Care Behavioral Health Integration

- 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

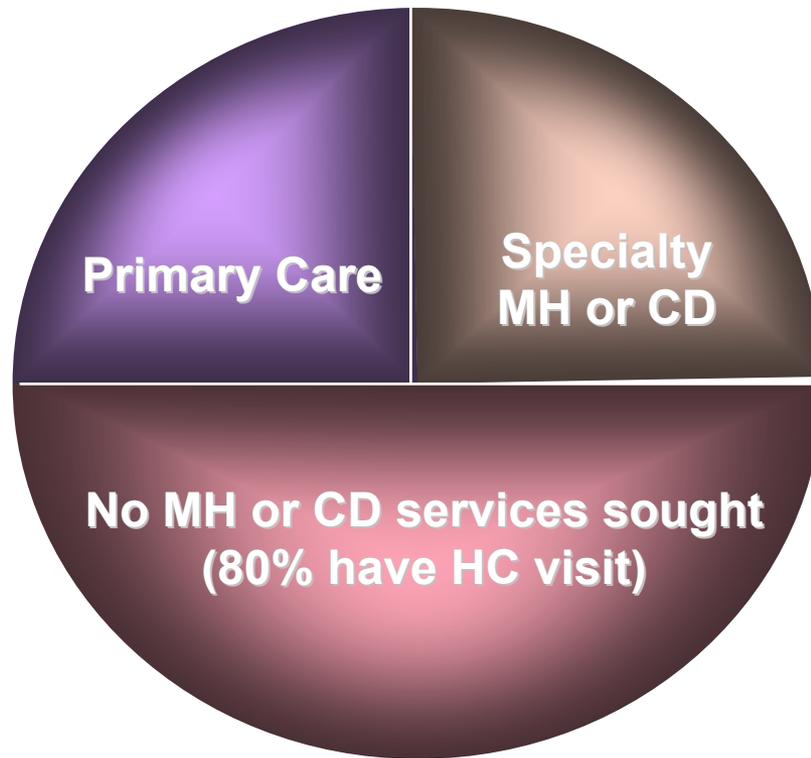
- Adverse impacts of the “carve out” model
  - Utilization review and gatekeeper roles located in MBHO, not primary care
  - Poor to non-existent coordination of care
  - Bewildering variety/quality of MBHO systems in both public and private sectors
  - Referral process complicated and difficult to navigate
  - 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)

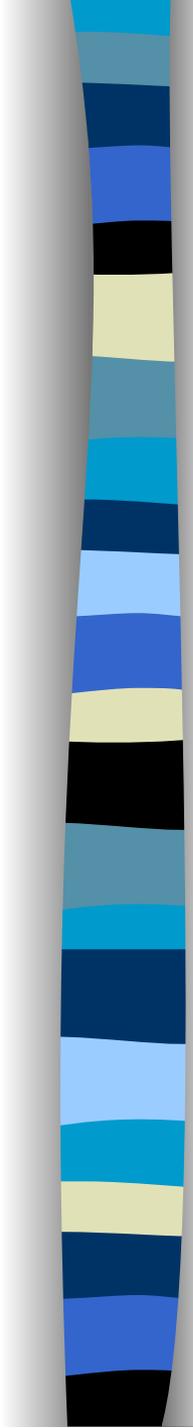
# Provision of Behavioral Health Care in the US: Setting of Services





# Why Integrate Primary Care and Behavioral Health Care?

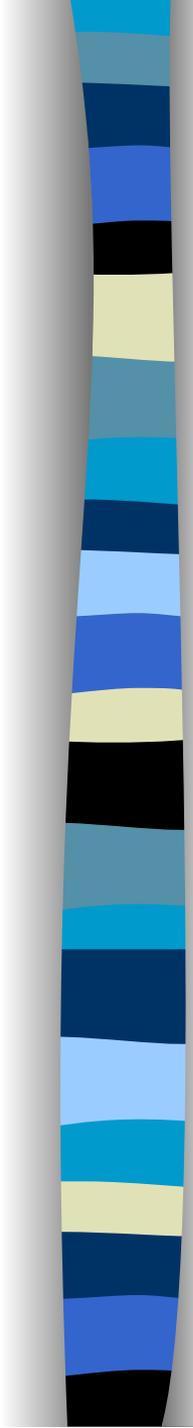
- Cost and utilization factors
  - 50% of all MH care delivered by PCP
  - 70% of community health patients have MH or CD disorders
  - 92% of all elderly patients receive MH care from PCP
  - Top 10% of healthcare utilizers consume 33% of outpatient services & 50% of inpatient services
  - 50% of high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



# Why Integrate Behavioral Health and Primary Care?

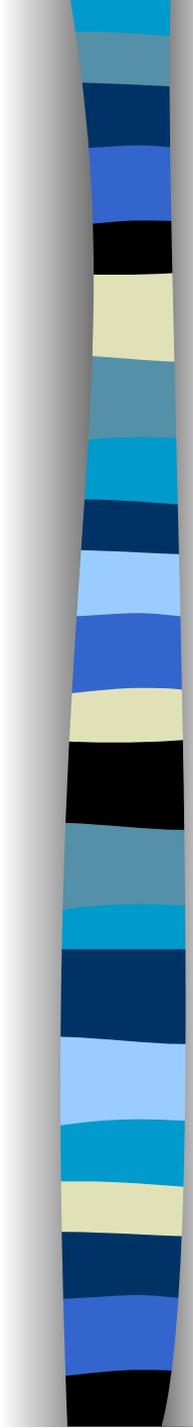
## ■ Process of care factors

- 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



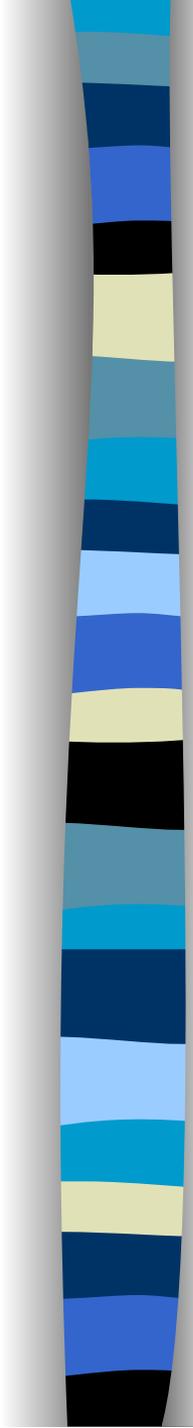
# Benefits of Integrating Primary Care and Behavioral Health

- 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)



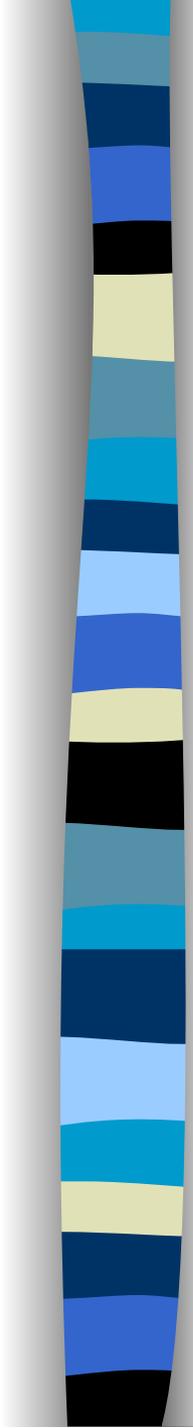
# Clinical Outcome and Service Quality Benefits of Integration

- 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

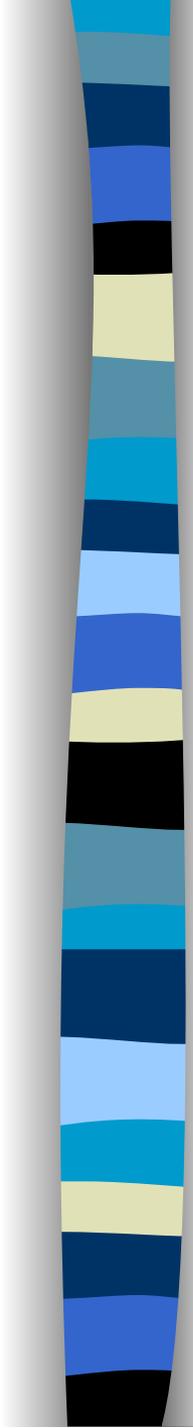
## ■ Medical cost savings

- 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



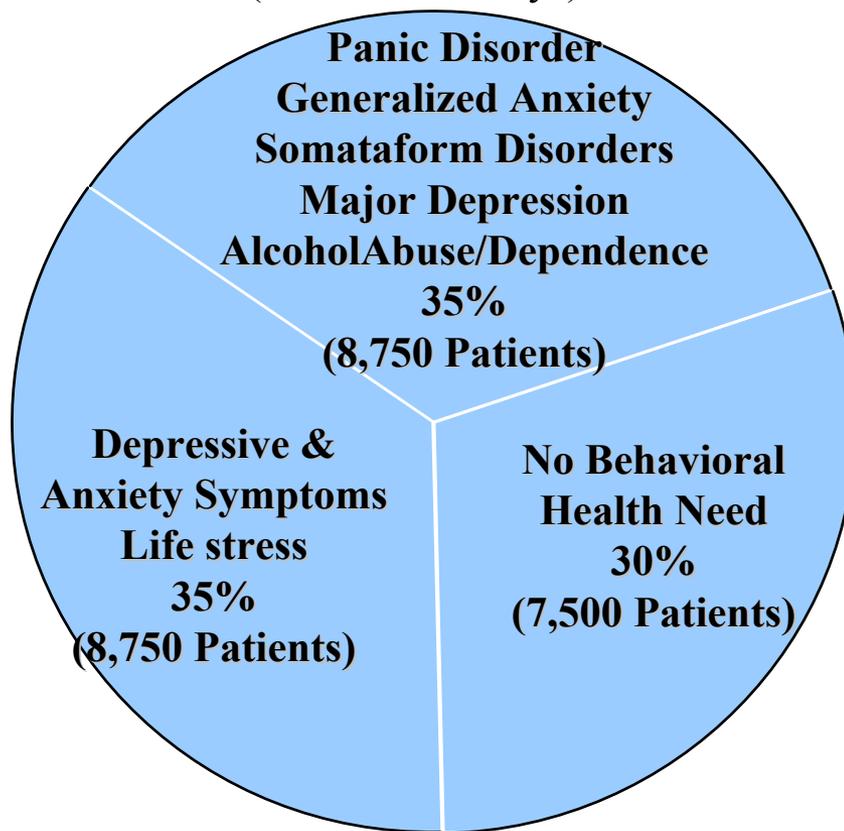
# Population-based Care: The Framework for Integration

- 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

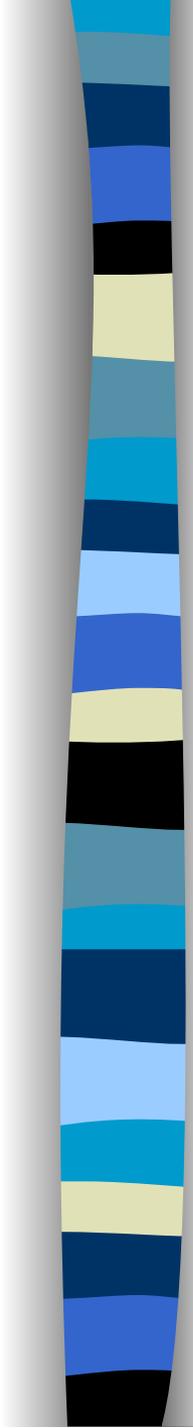
# Analysis of Behavioral Health Needs in a Primary Care Population

Vertical Integration Program  
(Critical Pathways)

Horizontal Integration Program



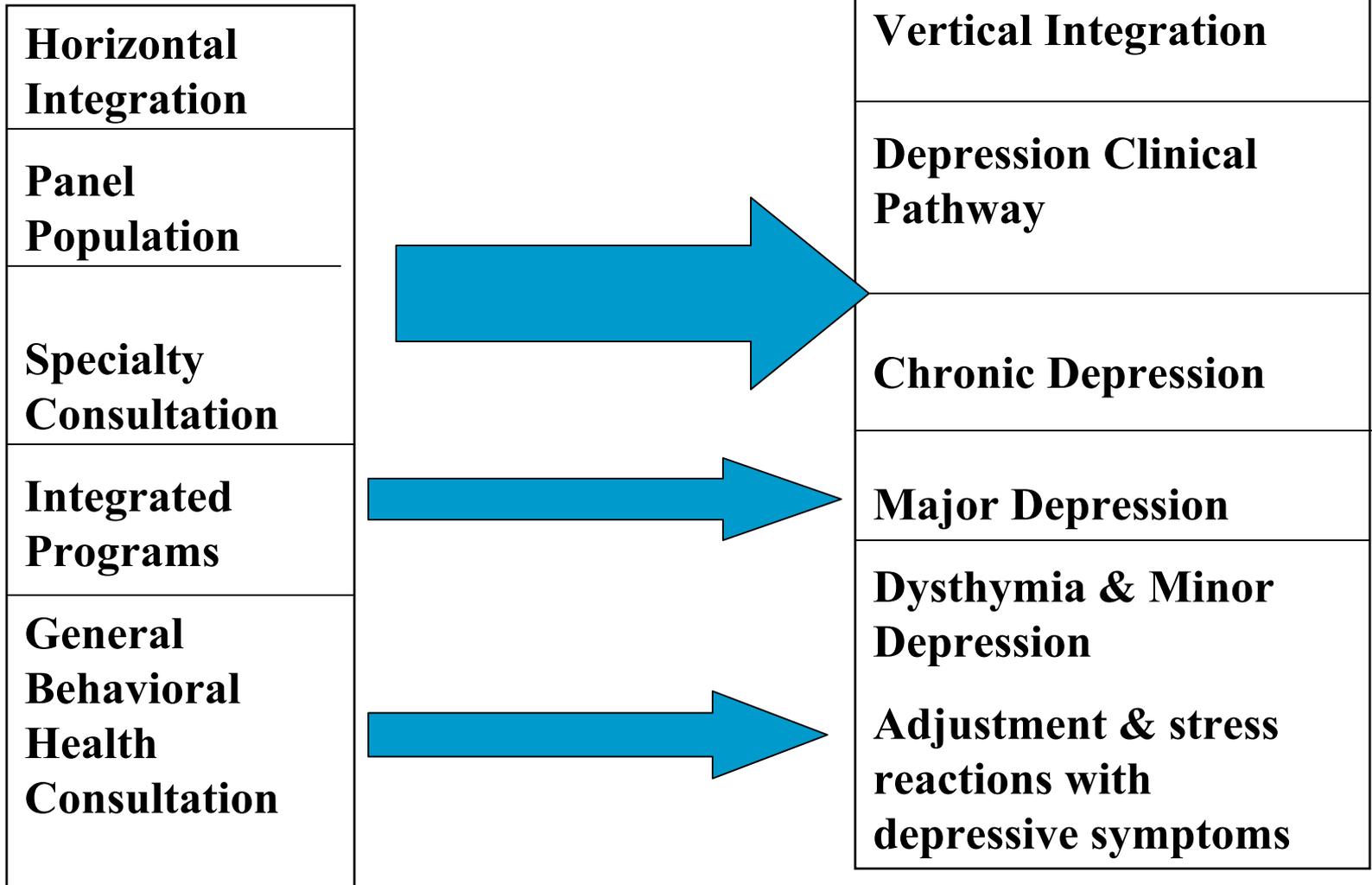
Hypothetical Cohort of 25,000 patients

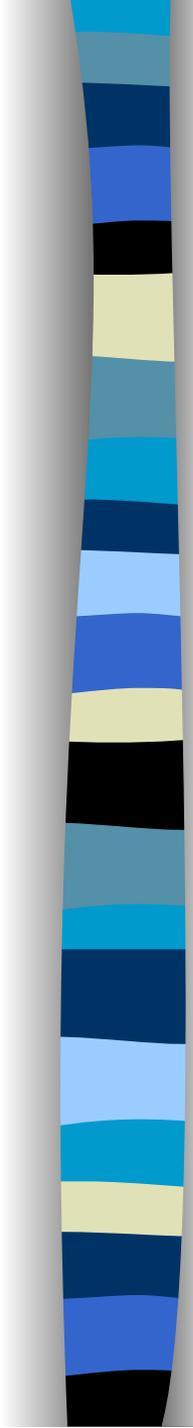


# The Continuum of Integration

| Model                     | Desirability | Attributes                                       |
|---------------------------|--------------|--|
| Separate Space & Mission  | - -          | Traditional BH Specialty Model                   |
| 1:1 Referral Relationship | +            | Preferred provider/<br>Some information exchange |
| Co-location               | ++           | On-site BH Unit/<br>Separate Team                |
| Collaborative Care        | +++          | On site/shared cases w/ BH specialist            |
| Integrated Care           | +++++        | PC Team Member                                   |

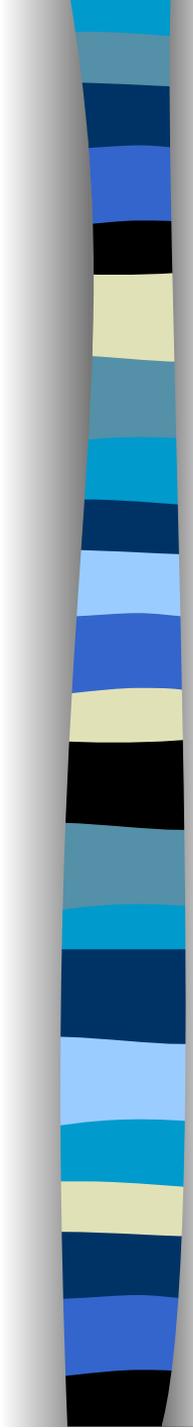
# Two Perspectives On Population-Based Care





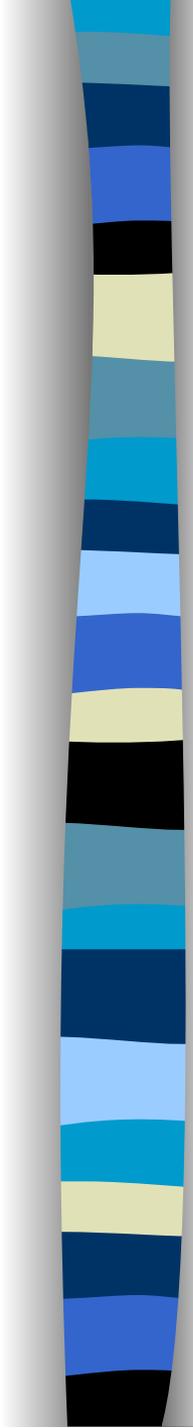
# Vertical Integration: Chronic Conditions Management

- 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



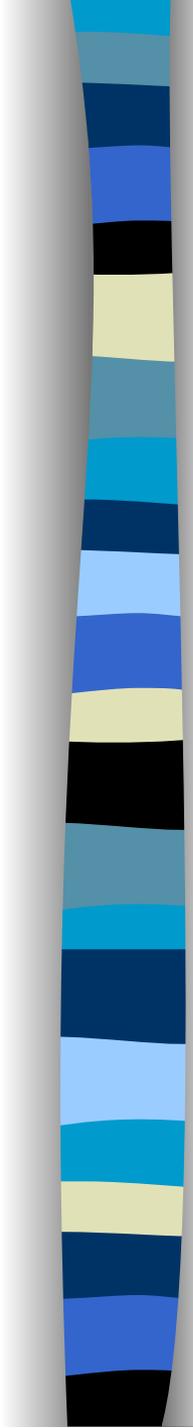
# Common Vertical Integration Targets

- Depression
- Anxiety and panic
- Chronic pain
- Somatization
- Alcohol and drug abuse
- Frail elderly
- Post M.I.
- Diabetes



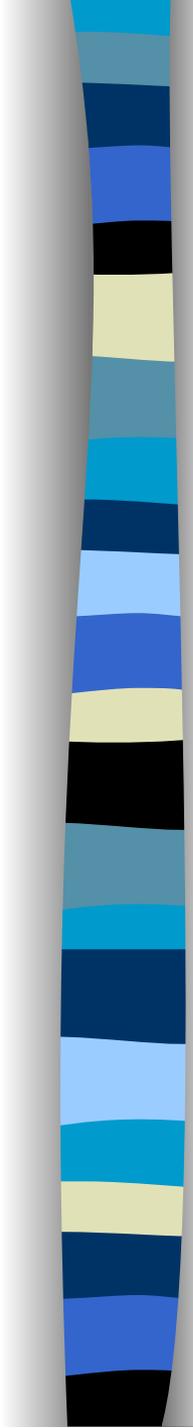
# Integrated Care: Is It a Rose by Any Other Name?

- 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?



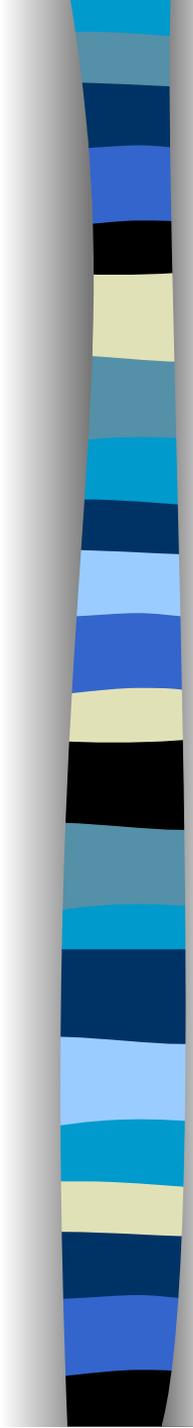
## Consider:

- 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.



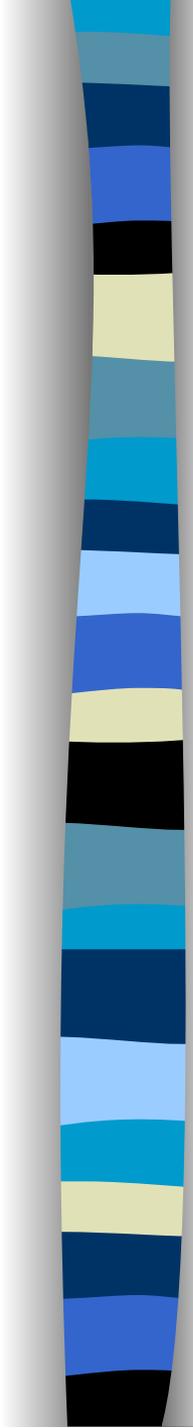
# Primary Behavioral Health: Primary Goals

- 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.



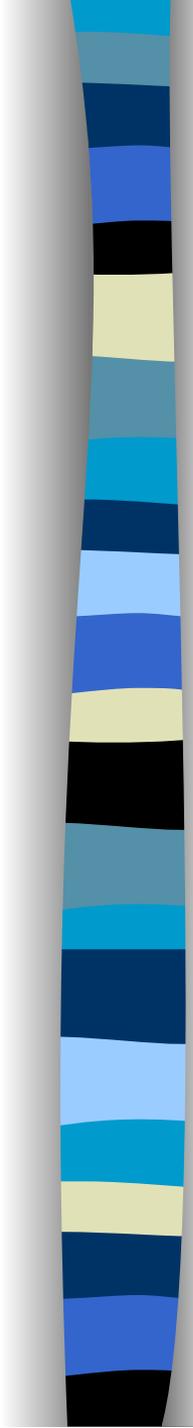
# Primary Behavioral Health: Primary Goals

- 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



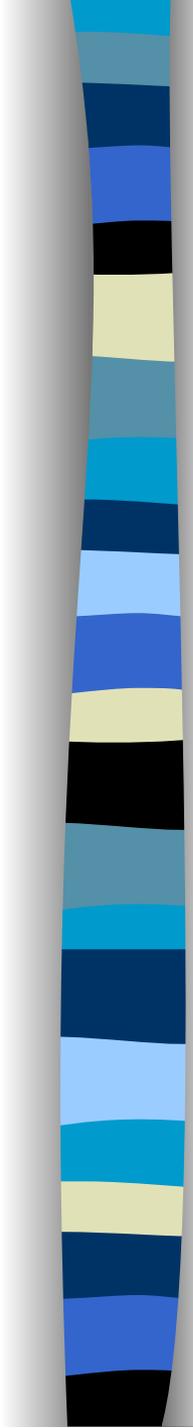
# Primary Behavioral Health: Referral Structure

- 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



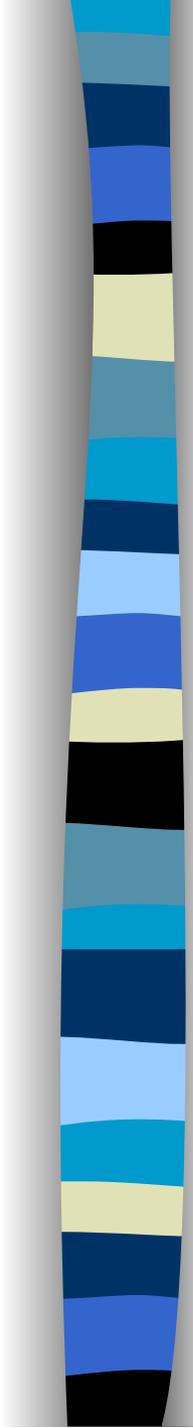
# Primary Behavioral Health: Session Structure

- 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



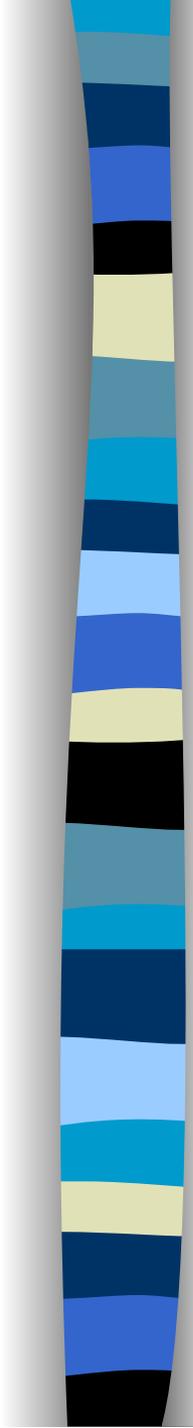
# Primary Behavioral Health: Intervention Structure

- 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



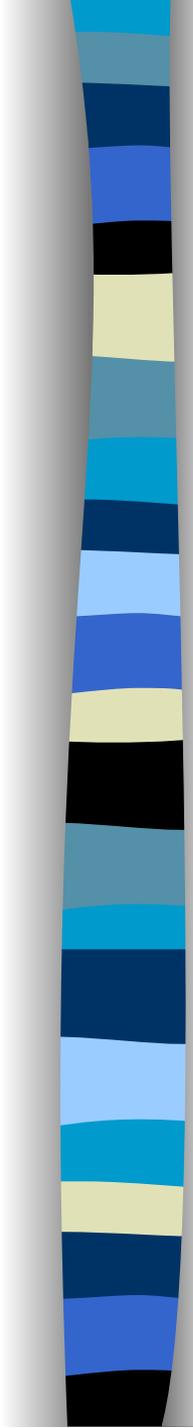
# Primary Behavioral Health: Intervention Methods

- 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



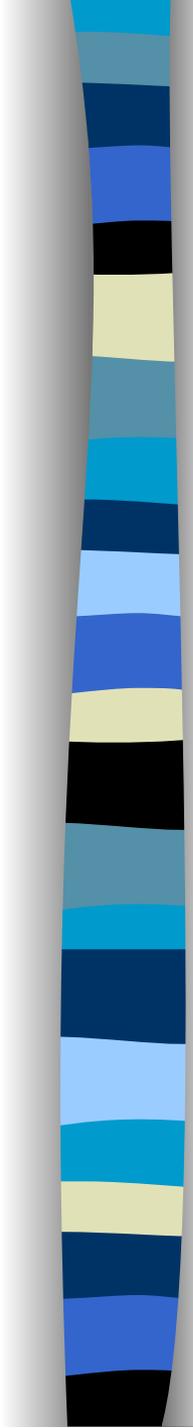
# Primary Behavioral Health: Cultural Competency

- 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



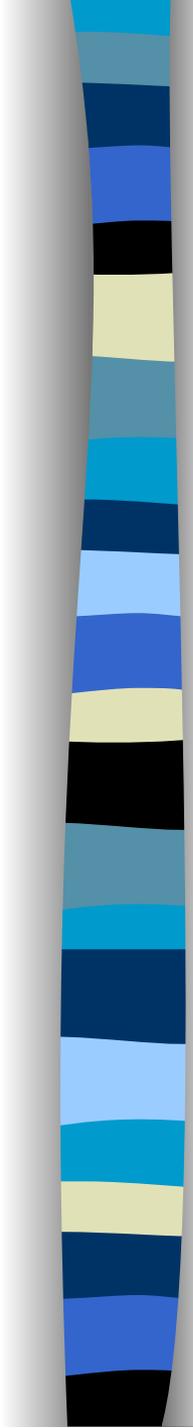
# Primary Behavioral Health: Termination and Follow-up

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



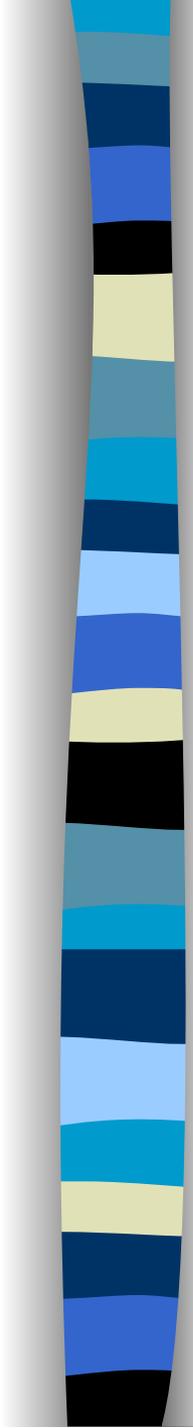
# Primary Behavioral Health: Primary Information Products

- 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

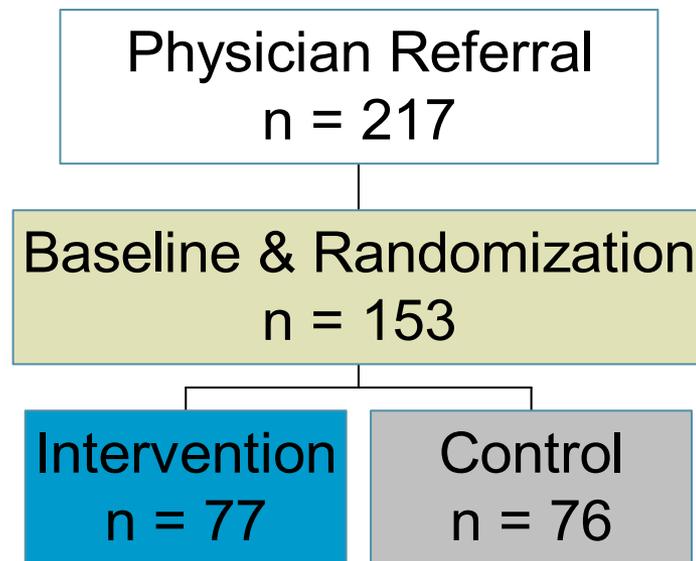


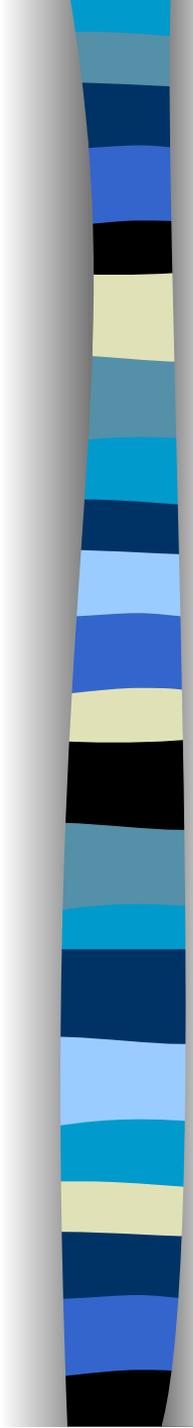
# Qualities of a Successful Integrated Behavioral Health Care Service

- 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

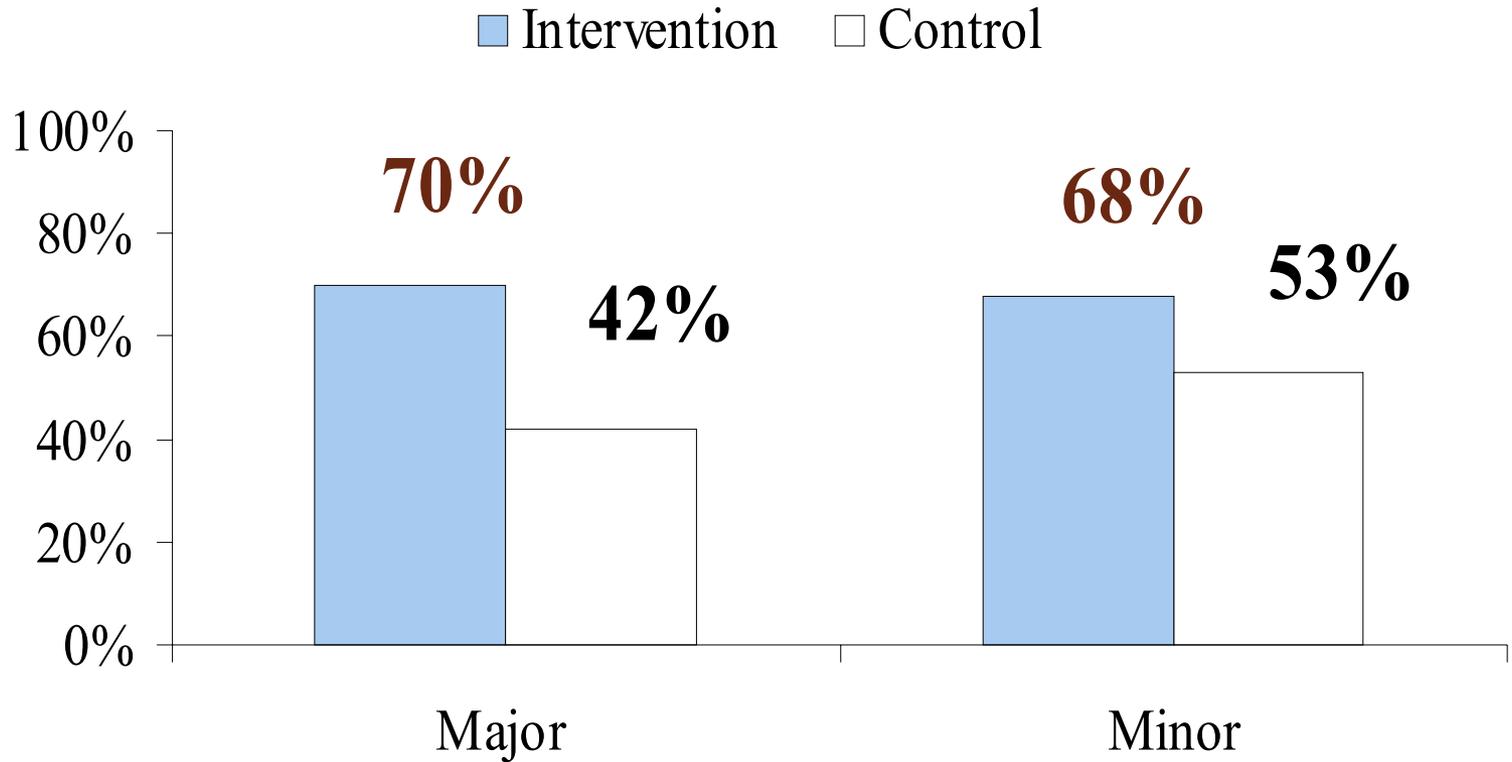




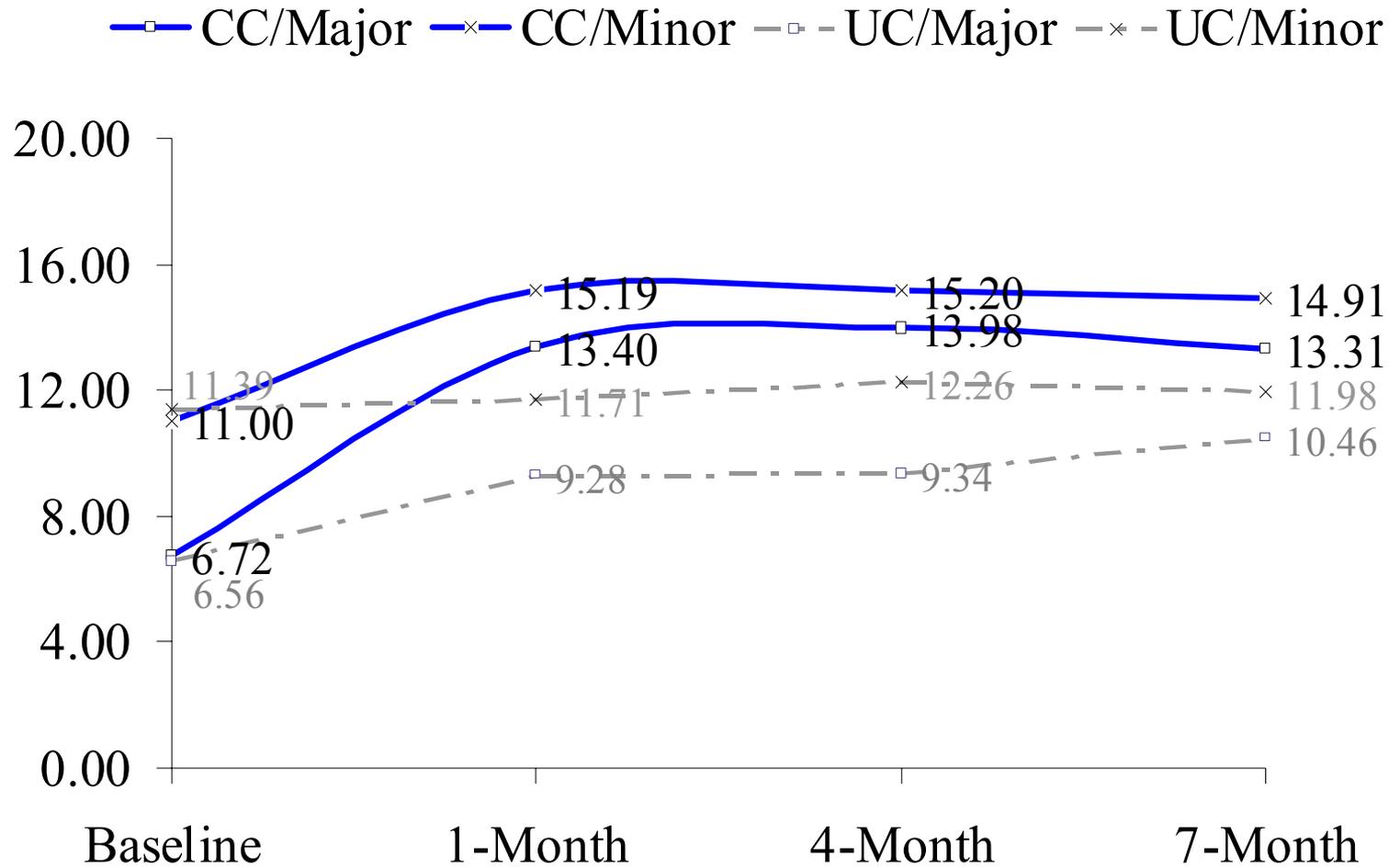
# Integrated Program for Depression

- 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

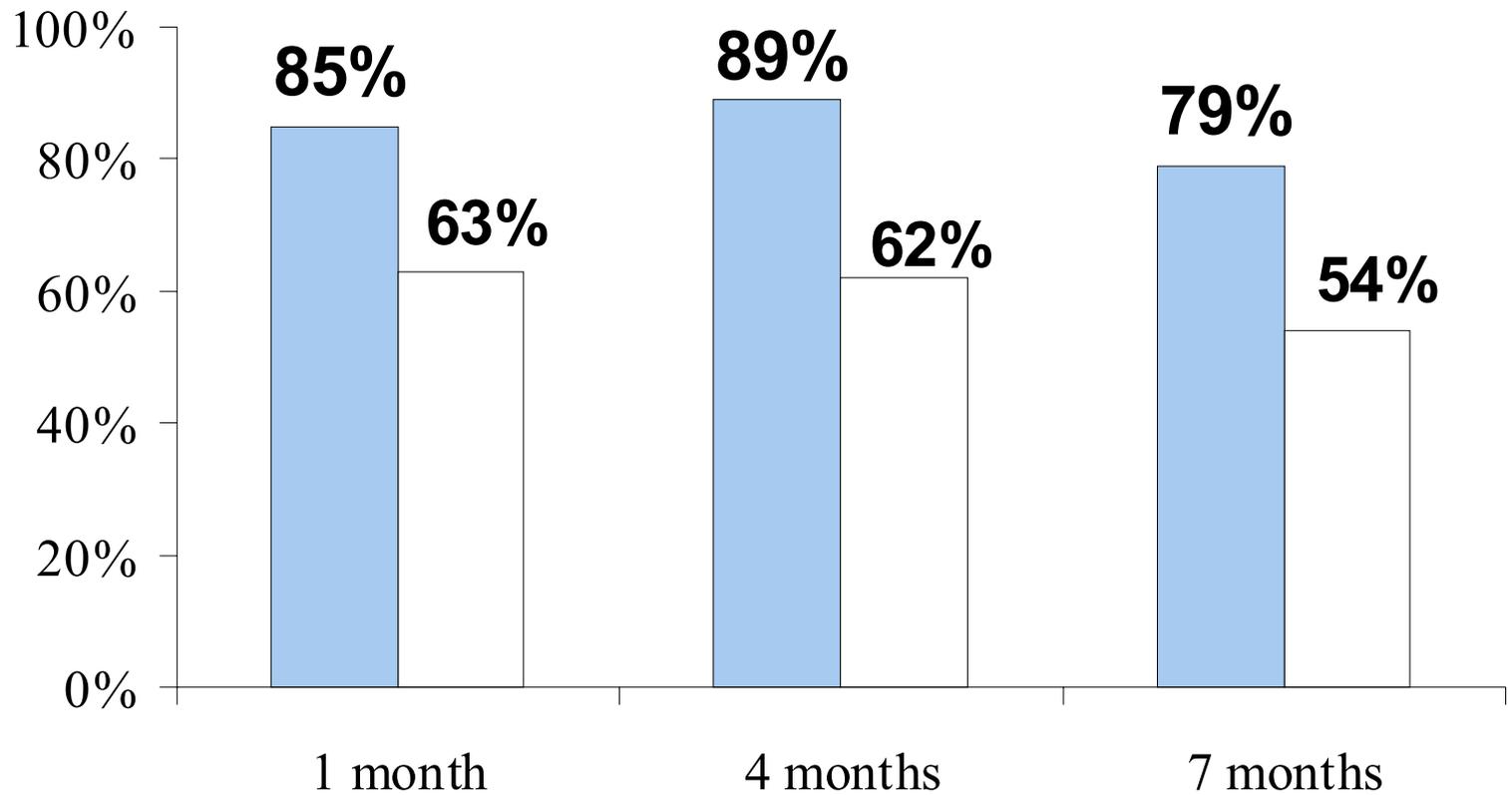


# Coping

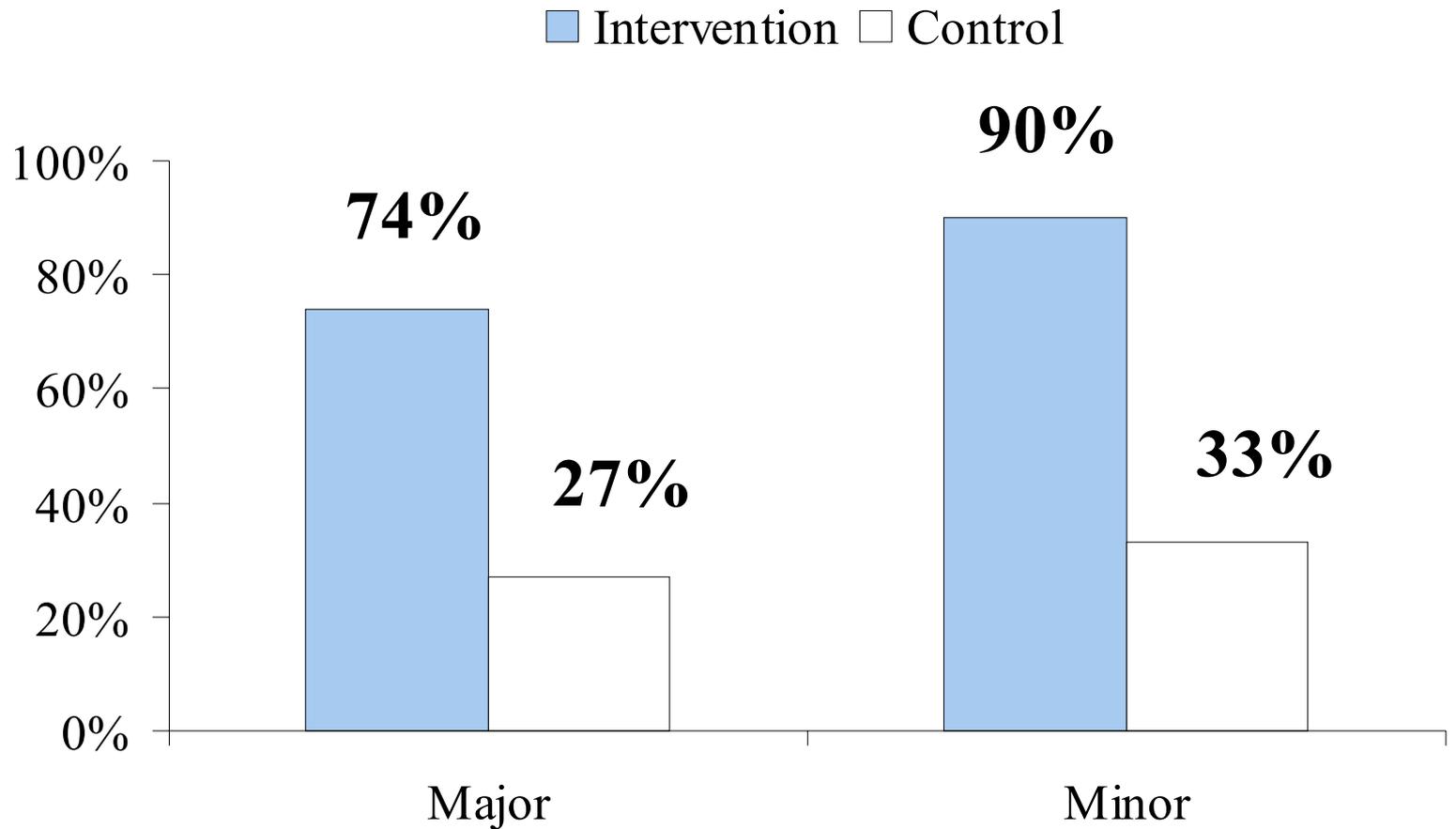


# Major Depression: Taking Medication for 25 of past 30 days

■ Intervention    □ Control



# Following RP Plan at 4-months



# Rated TX for Depression as Good or Excellent

■ Intervention □ Control

