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Introduction to Effective Behavioral Health in Primary Care

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NATIONAL ASSOCIATION OF Community Health Centers

This session was coordinated by the National Association of Community Health Centers a Partner in the Center for Integrated Health Solutions

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Session Objectives

At the close of the presentation, participants will have gained:

- An increased understanding of what effective primary care and behavioral health integration looks like in practice
- An increased understanding of the evidence base and promising practices
- Knowledge of practical steps primary care teams can take to improve the identification of behavioral health problem in primary care setting
- Knowledge of practical steps primary care teams can take to improve the treatment of behavioral health problems in primary care setting

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Characteristics of Primary Care

First Contact – When you need to "go to the doctor", come see us.

Continuous – We are you over time. We can put today's concerns in the context of your life.

Comprehensive – We've got what you need

Coordinating – And if we don't have it, we'll help you find it.

Care for the "undifferentiated" patient – Whatever it is, you've come to the right place.

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Primary Care is the future.

Primary care is our best venue for improving population health and for controlling medical cost.

Primary Care is the only thing you can do MORE OF and get lower cost and better care

The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation's Health Care: *A Report from the American College of Physicians January 30, 2006*

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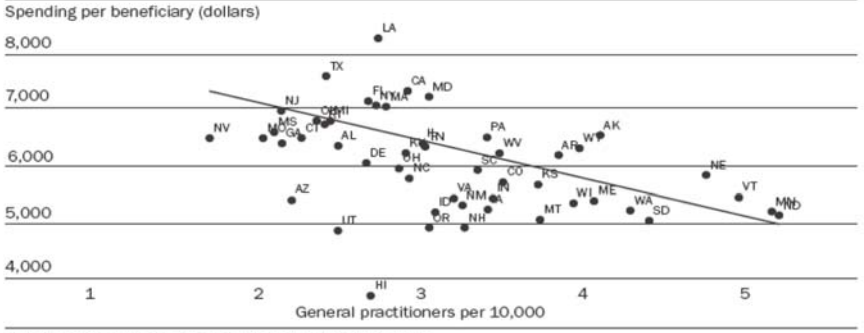
EXHIBIT 9
Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000



SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTE: Total physicians held constant.

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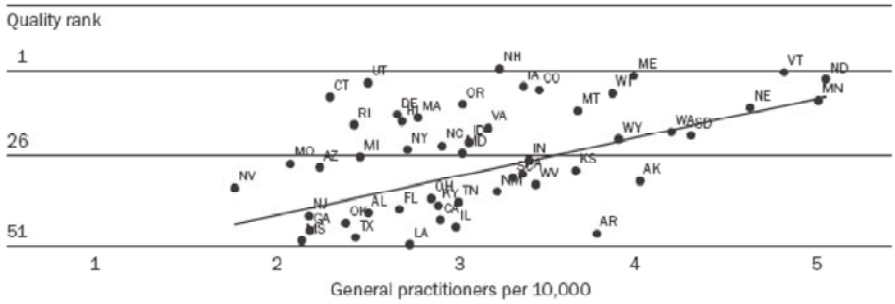
EXHIBIT 8
Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000



SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTES: For quality ranking, smaller values equal higher quality. Total physicians held constant.

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Mortality Outcomes

Primary care: 1 per 10,000 (20%) increase in primary care physicians results in 5% decrease in mortality or 40 fewer deaths per 100,000

- Family Physicians: 1 per 10,000 (33%) increase results in 9% decrease or 70 per 100,000 fewer deaths

- Specialists: 1 per 10,000 (8%) increase in specialist physicians results in 2% increase in mortality or 16 more deaths per 100,000 **Shi. J Am Board Fam Pract 2003;16:412-22.**

Certificate Program in Primary Care Behavioral Health

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Primary Care is rewarding to providers

Being THE doctor

"Driving the bus"

Mastery of a broad field

Caring for whole people (and families)

Connectedness

Making a difference

Preventive care

Other examples from physicians at the sites

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Primary Care is stressful for providers

Pace

Responsibility

- We all know the stories of a missed dx.
- Need to coordinate care in an uncoordinated system

Often up against the edge of their knowledge

Other examples from physicians at the sites

- Get the person at your site with the laptop to either "raise a hand" or type your answer on the chat.

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The New Math of the 15 Minute Primary Care Visit

- A primary care provider with a panel of 2500 average patients would spend:
- 7.4 hours per day to deliver all recommended preventive care
  - [Yarnall et al. Am J Public Health 2003;93:635]
- 10.6 hours per day to deliver all recommended chronic care services
  - [Ostbye et al. Annals of Fam Med 2005;3:209]

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What's Next?

The Patient Centered Medical Home

- http://www.pcpcc.net/
- Team takes some of the work
- Address patient problems in best way for the patient and the problem, not all by office visits
- New payment models to pay for health, not for visits

A central concept in Health Reform

First approach to get support from large employers, health plans, provider groups and consumer groups.

Currently pilots (most successful) in just about every state.

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Why Should Behavioral Health Be a Core Service of PCMH?

Access – At least 50% better access to MH care if offered in primary care. (different from managing care across medical specialties) (Bartels, Coakley, Zubritsky, et al. Am J Psych, 2004)

Complex patients with chronic illnesses needing behavioral health care are more likely to be designated for Medical Home level of care.

Care in medical setting is a better cultural fit for many patients.

Behavioral Health Clinicians free up time for PCPs to spend with other patients, while enhancing patient satisfaction and self-efficacy.

Care management is more effective when done by professionals with behavioral health skills. (Pincus, Pechura, Keyser, et al. Administration & Policy in Mental Health. 33(1):2-15, 2006

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Behavioral Health Needs Assessment in Primary Care

Mental Health (of every level of severity)
Substance Abuse
Health Behavior Change
"Ambiguous" Illnesses
Chronic Illness
Culturally Syntonic Approaches

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Prevalence of Behavioral Health Problems in Primary Care

	PHQ-3000	Merillac 500
Major Depression	= 10%	24%
Panic Disorder	= 6%	16%
Other Anxiety Disorders	= 7%	21%
Alcohol Abuse	= 7%	17%
Any Mental Health Dx	= 28%	52%

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Prevalence of Behavioral Health Problems in Primary Care

Unhealthy Behaviors

Smoking	= 25%
Obesity	= 30%
Sedentary lifestyle	= 50%
Non-adherence	= 20 - 50%

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"Ambiguous Illness"

The vast majority of primary care complaints are related in some way to behavioral factors but not to diagnosed mental disorders.

Kroenke, K. & Mangelsdorff, A. D. (1989). Common symptoms in ambulatory care: Incidence, evaluation, therapy and outcome. *American Journal of Medicine, 86*, 262-266

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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

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Chronic conditions that require behavioral health component in standard of care protocols:

- Asthma
- Diabetes
- CVD
- Irritable Bowel Syndrome
- Obesity
- Substance Abuse

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Depression with Chronic Illnesses:

Increased rates of depression in patients with:

- Congestive Heart Failure
- Diabetes
- COPD

Patients with chronic illness and depression 2-5x the healthcare cost of patients with chronic illness alone

Depression is the common factor in patients disabled (compared with pts equally sick but not disabled) by hypertension, asthma, arthritis, ulcers.

Bachman, J. http://www.wpic.pitt.edu/dppc/downloads/Depression_in_Disease_Management_Practices_for_Chronic_Conditions_FINAL.doc

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Culture Impacts "Depression"

Culturally Syntonic Approaches

Signs of Depression found Cross-Culturally	Signs of Depression found in "Western" Cultures
Appetite changes	Self-deprecation
Sleep changes	Hopelessness
Psychomotor agitation or retardation	Guilt
Decreased energy	Suicidality
Decreased libido	
Diminished ability to think or concentrate	

Pfeiffer, W. (1968). The symptomatology of depression viewed transculturally. *Transcultural Psychiatry Research Review 5*: 121-123.

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Underserved and Minority Populations are Particularly Affected

"…racial and ethnic minorities are less inclined than whites to seek treatment from mental health specialists. Instead, studies indicate that minorities turn more often to primary care."

Surgeon General's Report on Mental Health, 1999. Supplement on Culture, Race and Ethnicity

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Interlude

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Categories of Relationship between Collaborating Medical and Behavioral Health Services

- Coordinated = Behavioral services by referral at separate location with formalized information exchange.
- Co-Located = By referral at medical care location
- Integrated = Part of the "medical" treatment at medical care location

Blount, A. (2003). Integrated primary care: Organizing the evidence. *Families, Systems & Health: 21,* 121-134, 2003.

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Population Receiving Collaborative Care

Targeted = Defined by disease or problem

Non-targeted = Any patient requesting or referred for service

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Behavioral Health Service

Specified = received by all pts.

Unspecified = depends on clinician

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Coordinated Care

Coordinated care elements:

- **appointment arrival notification**
- **clinical information exchange protocols**
- **coordinated treatment planning**
- **Example of eating disorder care.**

Originally the model advocated for PCMH for behavioral health.

Bartels et al. found "enhanced referral" still 50% less effective than co-location for access. (Bartels, Coakley, Zubritsky, et al. Am J Psych, 2004)

Phone outreach programs (Wang, et al, JAMA, Sept 26, 2007, 14-1-1411.)

Massachusetts Child Psychiatry Access Program

- **Built on a consultative model**

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Moving along the continuum achieves improvement in:

Access
Patient Satisfaction
Provider Satisfaction
Patient Adherence
Cost Effectiveness
Cost Offset
Clinical Outcome Improvement
Clinical Outcome Maintenance

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Physicians Love I. P. C.

ANECDOTAL reports indicate:
Docs feel less isolated
Bolder in “can of worms” situations
Enjoy treating “complex” patients more
Better job satisfaction
Better provider retention

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The type of Behavioral Health service does make a difference.

HAWAII HEALTHCARE UTILIZATION STUDY is
Coordinated and Targeted
and compares the cost of
Specified and Unspecified
Behavioral Health care

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Chosen to be included in study:

1. Top 15% of health care users
2. Sufferers from chronic airway disease (COPD, asthma)
3. Sufferers from diabetes
4. Sufferers from hypertension
5. Sufferers from ischemic heart disease
6. Patients in mental health treatment
7. Patients with chemical dependency

HAWAII HEALTHCARE UTILIZATION STUDY

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For Medicaid study patients with chronic medical disease:

Unmanaged treatment lead to a slight increase in overall cost.

Targeted Focused Treatment saved 26% with an average of 7.5 outpatient visits

HAWAII HEALTHCARE UTILIZATION STUDY

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Studies of Collaborative Care

Co-Located

Non-targeted

Unspecified

Improved Access – 2
Patient Satisfaction – 9
Provider Satisfaction – 4
Improved Adherence – 1
Cost Effectiveness – 7
Cost Offset - 2
Clinical Improvement – 13
No Clinical Improvement – 12 (UK studies)

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At the very beginning: PCPs' perceptions

- Until they have worked with a BHP, physicians tend to think of mental health clinicians as uncommunicative.
- When they do communicate, mental health folks want to say too much.
- Mental health folks sometimes make confidentiality a way of protecting turf.
- Physicians not sure what happens in therapy, maybe some kind of catharsis or paid friendship
- Are they psychoanalyzing me?
- Others? PCPs please chime in.

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Making Co-Location Work

BHP in health center - 7 sessions/wk.

Patients attending first visit w. BHP when scheduled by physician w/o introduction:

40%

Patients attending first visit w. BHP when scheduled after introduction by physician:

76%

N=80, p= <.01
Apostoleris, N. & Blount, A. In preparation.

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Studies of Collaborative Care

Co-Located

Targeted

Specified

Access - 1
Improved Adherence – 2
Cost Effectiveness – 1
Clinical Improvement – 10
No Clinical Improvement – 1
Maintained Improvement - 2

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Studies of Collaborative Care

Integrated

Targeted

Specified

Improved Access – 1
Patient Satisfaction - 5
Provider Satisfaction - 3
Adherence – 6
Cost Effectiveness – 2
Cost Offset – 1
Clinical Improvement – 8
Maintained Improvement - 3

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Group Health Studies

Integrated Targeted Specified

Intervention + Patient education + alternating 4-6 visits with PCP and:

- a) psychiatrist to manage antidepressants (or)
- b) psychologist to provide C-B therapy

Results:

- 74% of depressed patients effectively treated
  - (40% in control group)
- No effect for minor depression

Average Cost / successfully treated case

- Collaborative Care - $1750
- Usual Care - $2000 (Katon et al, 1995, 1996)

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Depression Care Management Protocol

Depression in primary care, RWJ and MacArthur programs.

- **http://www.depression-primarycare.org/**
  - **Toolkit**
  - **Help in re-engineering practices**

Develop screening for depression in collaboration with providers (usually PHQ-9)

- **Who**
- **When**
- **What triggers**

Assure that assessment/diagnosis protocol is in place for positive screens and that all assessed positive are on a registry.

Protocol

- **Assures that patients know types of care offered**
- **Makes phone calls to assess medication effect and side effects**
- **Tracks visits**
- **Re-screening/outcome**

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Advantages of Creating an Integrated Primary Care Program by Starting with Care Management:

Quick start up
- Start up to model program in about 3 years

Care management for MH problem treated as chronic illness.

Easiest for PCPs to understand and accept

BHCs get used to a high volume brief intervention service

Buncombe County Health Center a good example

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The IMPACT Treatment Model

Collaborative care model includes:

- **Care manager: Depression Clinical Specialist**
  - **Patient education**
  - **Symptom and Side effect tracking**
  - **Brief, structured psychotherapy: PST-PC**
- **Consultation / weekly supervision** meetings with
  - **Primary care physician**
  - **Team psychiatrist (or psychologist)**

Stepped protocol in primary care using antidepressant medications and / or 6-8 sessions of psychotherapy (PST-PC)

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

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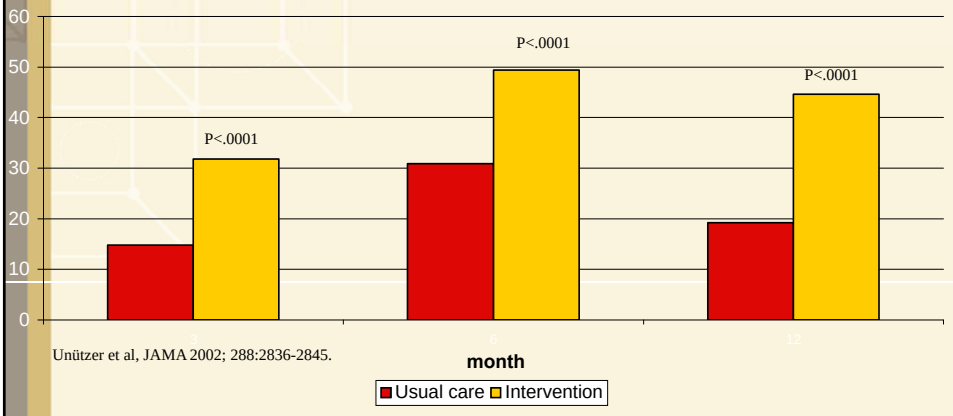
Substantial Improvement in Depression
(≥50% Drop on SCL-20 Depression Score from Baseline)



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

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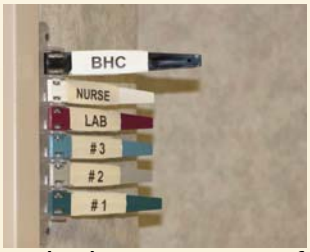
Behavioral Health Consultant

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

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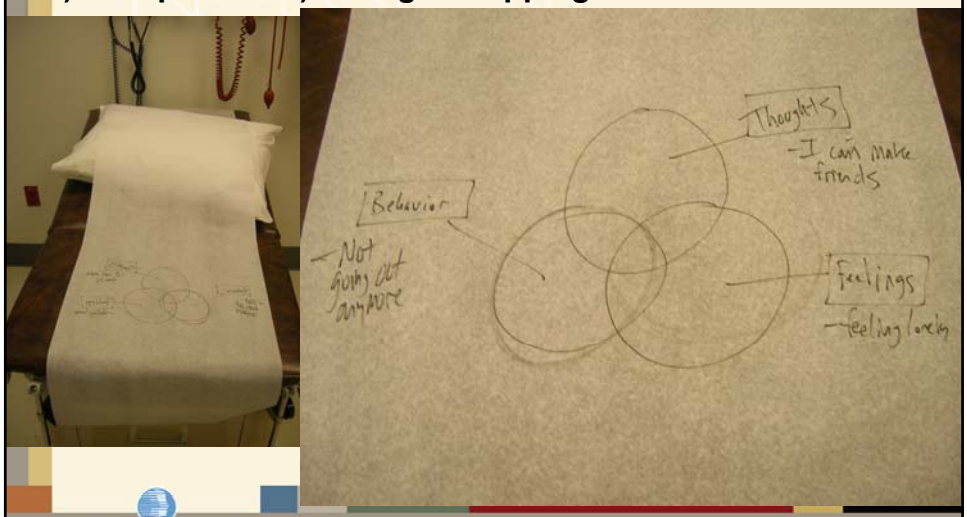
CBT in the Exam Room

1) CBT picture 2) Thought stopping or behavioral activation



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Integration: Beyond Co-Location

Integrated Care	Co-Located Mental Health
Embedded member of primary care team	Ancillary service provider
Patient contact via hand off	Patient contact via referral
Verbal communication predominates	Written communication predominates
Brief, aperiodic interventions	Regular schedule of sessions
Flexible schedule	Fixed schedule
Generalist orientation	Specialty orientation
Behavior medicine scope	Psychiatric disorders scope

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Cherokee Health Systems
A Federally Qualified Health Center and
Community Mental Health Center

Corporate Profile

Founded: 1960

Services:

Primary Care - Community Mental Health - Dental - Corporate Health Strategies

Locations:

21 clinical locations in 14 Tennessee Counties
Behavioral health outreach at numerous other sites including primary care clinics, schools and Head Start Centers

Number of Clients: 58,561 unduplicated individuals served - 24,958 Medicaid (TennCare)
New Patients: 19,829 **Patient Services:** 442,626
Number of Employees: 538

Provider Staff:

Psychologists - 40	Master's level Clinicians - 59	Case Managers - 29
Primary Care Physicians - 31	Psychiatrists - 13	Pharmacists - 9
NP/PA (Primary Care) - 17	NP (Psych) - 7	Dentists - 2

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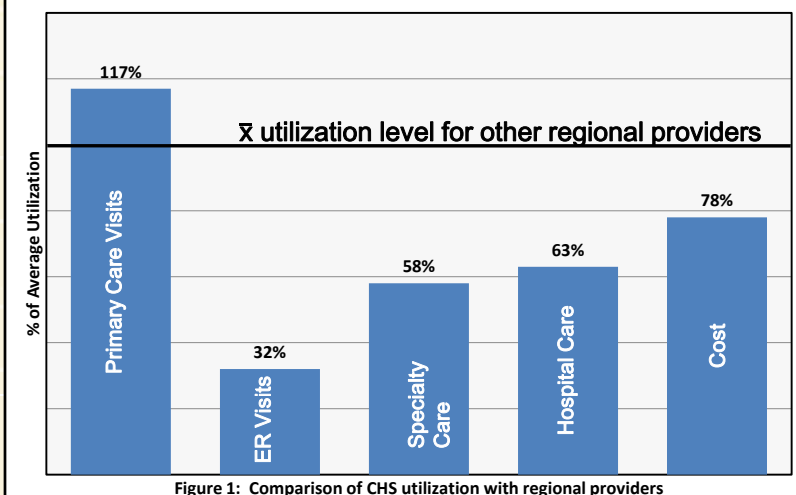

Figure 1: Comparison of CHS utilization with regional providers

Cherokee Health Systems
Together...Enhancing Life

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Relationship with "Specialty Mental Health"

- Still important for longer term care
- IPC makes referrals to SMH more likely to be successful
- Specialty MH able to better target high need populations
- Consultation backup to PCP
- In some systems SMH has developed specialized teams to support generalist PCBH clinician

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Designing a Program of Bi-Directional Integrated Primary Care

- PCP (NP or MD) is part of a primary care practice.
  - Sees some patients in the PC practice and some in CMHC
  - As patients become bonded to the PCP and team, they can move to Primary Care setting when ready
  - It is about passing relationships, face to face.
- Primary care in CMHC serves the purpose of fostering healthy behavior, initiating care and preparing consumers for how to succeed at "going to the doctor."

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How will the numbers break down?

Mature program in Maine

500 people categorized as SMI

35% get care in CMHC primary care

50% get care in CHC or other primary care site coordinated with CMHC.

15% get no care.

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Organizational Partnerships

Leadership buy-in at the top is crucial
- Continued administrative involvement in meetings is needed because each new innovation needs administrative support.

– Regular clinical case discussions teach everyone about the difference in cultures.
- Without regular discussions, the stresses of each group will be under recognized by the others and each will feel the others are not pulling their weight.
- Opportunities to help make each other's work easier will be missed.
  – Look for ways to help with "tough" patients/consumers for the other.
  – Each side will have a different experience of who is tough.

– Both partners will change substantially.
- FQHCs will need to move toward being very patient centered to serve SMI population effectively.
- CMHCs will need to move toward being true healthcare providers by delivering the full spectrum of care.

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Combined Model

A feature of the CIHS partnerships – Different consumers will have different services depending on needs.

Coordinated for consumers with specialty mental health, case management and health behavior change in CMHC and primary care in FQHC

-Regular routines of communication

Co-located for consumers getting MH and primary care in CMHC or FQHC

-Routine and unplanned communication opportunities

(MH and primary care in different parts of the building with separate intake, separate records, no regular communication is not Coordinated, Co-located or Integrated.)

Integrated for consumers getting all care in same place with one treatment plan, one team, one record, all "healthcare".

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So, do we have a "best" model defined for the future?

Was the Model T the "best" model car?

Experimentation at some point creates an innovation that fits the environment.

Innovation reshapes the environment and creates the context for new innovation.

Different populations have enough difference in needs that models should be different.

What does the FQHC population need?

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Considerations in Adding a Behavioral Health Provider

- Provider skill set and fit
- Financial
- Information exchange between providers
- Charting
- Scheduling
- Space

c. Certificate Program in Primary Care Behavioral Health

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Provider Skill Set and Fit

Someone who has taken our course should have the orientation necessary to learn on the job.

Good at making relationships with all of the roles in primary care

They must do well in ambiguous situations, dive in rather than wait for an invitation.

Handle new situations with assurance and confidence without misrepresentation knowledge.

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Financial

Medical billing:

- Increases number of patients seen by physicians. (1/sess.)
- Up-code a visit: Level 3 to Level 4 or 5
- Some integrated funding (SBIRT) can support broader engagement
- Health and Behavior codes: 96150-96155
  - Medicare, many Blues, some Medicaid, some privates

Mental Health billing:

- Bill for small bits of time
- If panels are a problem, primary care docs may help
- Some MH services (CSP) can support integrated case management

For medical people, Behavioral Health billing is a nightmare. This is why administrative staff need to feel some buy-in to integrated care. PCMH may turn all this around.

Expect to pay something for the increase in medical providers enjoyment of the practice and better outcomes.

c. Certificate Program in Primary Care Behavioral Health

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Information Exchange Between Providers

Medical and mental health cultures have very different approaches to confidentiality. The medical approach is the goal, in compliance with local regulations.

Blanket information release with the goal of enhancing primary care

Curbside consultations

Forms for email or EMR updating

Behavioral health or "troubling patient" rounds

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Charting

- Patient must give permission for unified charting
- Unified charting means social hx and previous medical hx already done for MH rules.
- Unified charting may not need to be undifferentiated charting
- Coming of EHR will make much of this moot.
- Check off notes for the brief interactions of PC
- Tracking BH values in EMR (eg PHQ-9 as vital)
- Health and Behavior codes charted in medical record as medical services.

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Scheduling

Medical scheduler keeps BHP's book
Shorter time periods, 30, 20, 15 min.
Consider an Open Clinic as a way of learning to work differently
Schedule some free time for introductions and curbside consultations
Schedule time for conjoint interviews

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Back to the Patient Centered Medical Home (Person Centered Healthcare Home)

- Care coordination/management is a piece of all of the versions.
- Important new role, though not new to everyone.
- Some people will be right in saying that they have been doing most of what is thought to be needed for years.
- Few have been doing it all.

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The impact of the 2011 standards

- New 2011 Guidelines from NCQA require behavioral health services, including one of three care programs for chronic illness being a behavioral illness (level 3).
- Each practice must arrange or provide for mental health care.
  - The difficulty with referral will create pressure for every practice to bring in behavioral health.
- Every practice must provide patient and family activation for healthy behavior.
- Every practice must provide care coordination, whether or not there is a care coordinator.

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So, what does all this mean?

- The PCMH model is going to be everywhere, even in mental health centers.
- Bits from all the heritages, case manager, care manager for depression, behavioral health consultant and care coordinator will probably be recognizable in the future version of the job.
- It is likely to be a role for which we will need thousands of properly trained people and no discipline seems to be preparing people for all the pieces of this work.
- Modular training, such as the Certificate Program in Primary Care Behavioral Health, is needed to get people ready to do the whole job. http://umassmed.edu/FMCH/PCBH/welcome.aspx

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Change like this is scary but it can be fun.

- While the grants and pilots look very good, the main stream system is not set up to support integration of behavioral health and primary care in most states.
- It is about administrative and fiscal change as much as clinical change.
- Currently it is a field of entrepreneurs and advocates which will soon give way to the systems builders and data producers.
- Specialty mental health will continue to be necessary, but it may have to become defined as a part of health care to survive.
- Anyone who produces good health outcomes with patient and family engagement at reasonable cost will always have a place at the table.

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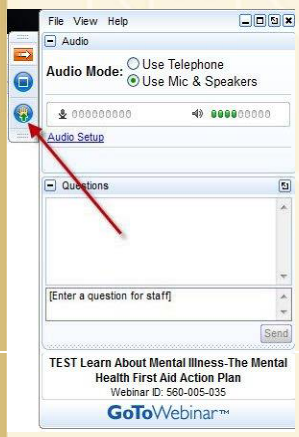

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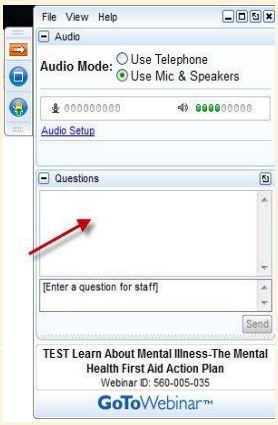

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