Integrated Behavioral Health Project

INTEGRATED BEHAVIORAL HEALTH: GETTING AHEAD….

BACK ON THE BODY

IBHP

a project of the Tides Center

WHY WE ARE HERE TODAY

- Provide you with an overview of:
  - -Where and why we started;
  - -What we've learned to date;
  - -Where we plan to go from here
- Look for your advice and feedback on our program development approach and strategies and the challenges we are facing
- Seek to "integrate our integration work" with yours

WHAT IS INTEGRATED BEHAVIORAL HEALTH CARE?

Simply put, it's a service delivery system that coordinates behavioral care with medical care — reattaching the head to the body.

In this team-based model, medical and mental health providers partner to facilitate the detection, treatment, and follow-up of psychiatric disorders in the primary care setting. It is an appropriate model for treating mild to moderate psychiatric disorders and for maintaining the treatment of severe psychiatric disorders (e.g., bipolar disorder, schizophrenia) that have been stabilized.

-Hogg Foundation

WHY INTEGRATED BEHAVIORAL HEALTH CARE?

- Primary care community clinics are often the "first line of defense," providing early intervention.

- Primary care community clinics are known for their emphasis on being culturally competent, responding to local community needs, and reflecting the changing demographics of California.

- Patient follow-through, satisfaction and convenience are improved:

  - Patients may be reluctant to seek out services in a mental health setting because of the associated stigma.
  - Patients like one-stop shopping.
  - Patients have often built up trusting relationships with their physicians.
  - Clinics are often easier to access than mental health facilities.

- Integration of services means a more cohesive service delivery system and better continuity of care.
- The presence of mental health professionals leads to increase recognition of behavioral needs and disorders in PC settings.
- Some studies indicate that integrated care leads to a reduction of inappropriate use of medical services and a cost-savings in big-ticket items like ER visits and hospitalization.
- Physician time is freed up to handle more medically-oriented problems.
- Physicians report increased satisfaction.

- The physicians' knowledge, skill-sets and comfort-zone is expanded as a result of collaboration with mental health professionals.
- Studies have shown increased patient compliance with medical regimens like diet and smoking cessation when behavioralists provide training and guidance.
- Management of the emotional/behavioral disorder may positively impact adherence to treatment of the physical disorder.
- There are better mental health outcomes when physical problems are managed.
- Both medical and behavioral professionals can get the "full picture" about the patients they're treating.

PREVALENCE OF PSYCHIATRIC DISORDERS IN LOW-INCOME PRIMARY CARE PATIENTS

- **35% of low-income patients with a psychiatric diagnosis saw their primary care physician in the past 3 months; 90% of patients preferred integrated care.**

  Mauksch LB, et. al. The Journal of Family Practice, 50(1): 41-47, 2001 as presented by Family Health Centers of San Diego

- **Studies show that 60% to 70% of patients waiting to see primary care physicians are also in need of mental health services.**

  Cummings, N. (1991). Arguments for the financial efficacy of psychological services in health care settings

- **"In the month prior to their suicide, 75% of elderly persons had visited their physician."**

  SAMHSA, National Mental health Information Center, Summary of national Strategy for Suicide Prevention Goals and Objectives for Action, 2004

- **50% of all mental health care is delivered by primary care providers.**

  Kessler et al., 1994; Narrow et al., 1993

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IN CALIFORNIA COMMUNITY CLINICS….

- There are 804 clinics with data in the OSHPD 2004 reports. Of these, 588 reported a total of 809,928 mental health encounters per year.
- 73% of the 804 reporting clinics billed for some mental health encounters.
- But only 27% (226) of clinics report employing mental health professionals (psychiatrist, psychologist, LCSW or MFT).

Source: California Primary Care Association based on 2004 OSHPD data

INTEGRATED CARE TAKES DIFFERENT SHAPES, OFTEN DEPENDING ON WHO "OWNS" THE BEHAVIORAL STAFF

- **Primary care clinics hire and train on-site behavioral staff** *(e.g., Family Healthcare Network of Visalia, Family Health Centers of San Diego and most other primary care clinics)*

- **Mental health clinics hire or contract for on-site primary care services** *(e.g., San Mateo County; Progress Foundation Residential Centers, in planning stages for LA County Dept. of Mental Health)*

- **Primary care clinics "purchase" behavioral services from mental health provider** *(e.g., Solano County, LA County Dept. of Mental Health is interested)*

- **Mental health agencies provide free or in-kind services to primary care clinics** *(e.g., San Mateo County, LA Child Guidance Clinic)*

- **College or university supplies student behavioral health staff as part of a training program** *(e.g., San Bernardino's Social Action Community Health Services and Loma Linda University; Glide Clinic of San Francisco and UCSF Nursing Program)*

INTEGRATED CARE ALSO VARIES BY TARGETED POPULATIONS

- **All or most persons with mental health problems** (*e.g., Shasta Community Health, San Ysidro Health Center*)
- **Persons with less severe mental health problems** (*e.g., Northeast Valley Health Corp., Venice Family Clinic*)
- **Specific age groups:** Minors (*e.g., LA Child Guidance; teen depression at Venice Family Clinic*) and Seniors (*e.g., Asian Health Services of Oakland*)

- **Persons with particular mental health disorders** *(e.g., depression - North Park Clinic of San Diego; Kaiser of San Diego; Neighborhood Healthcare in Temecula, Family Health Care of San Diego. Protocols like the MacArthur Depression Initiative, the Depression Collaborative, IMPACT and PRISM-E are implemented at some clinics visited.)*

- **Persons with co-morbid mental health and health problems** *(e.g., Project Dulce for depression and diabetes, instituted at San Diego's Family Care Mid City and Neighborhood Health Care)*

- **High Utilizers** *(e.g., Kaiser)*

AND CLINICS VARY IN THEIR INTEGRATED CARE OPERATIONS, MIXING AND MATCHING AMONG THESE CENTRAL COMPONENTS:

- Use of a screening tool to identify mental health problems
- "Warm hand-offs"
- Dispersement of behavioral health staff to work alongside medical staff
- Case conferencing between primary and behavioral staff
- Use of psychiatrist consultants
- Case management
- Short-term therapy
- Behaviorally and cognitively-oriented therapy

CENTRAL COMPONENTS …

- Involvement of primary care physicians in behavioral care
- Comprehensive feedback provided to the primary care physician
- Consolidation of patient's record
- Group or individual self-management sessions designed to help patients' compliance with medical treatment regimen
- Provision of cross-education: mental health training for primary care providers and medical training for behavioral staff
- Conjoint consultation
- Outcome measures

WHAT WE'VE DONE SO FAR

- Interviewed leaders in the mental health field about what's occurring and what's needed to promote integrated care
- Liaisoned with other foundations involved in this arena
- Attended workshops and professional conferences dealing with integrated care, have been invited to present at some

- Conducted a review of the literature and prepared a grid of published outcome studies
- Established linkages with local consortia, CPCA, CIMH, county mental health departments, universities and other involved agencies to identify issues and needs, exchange information and consider next steps
- Identified national experts to serve as consultants/trainers where needed
- Developed a survey instrument to facilitate the documentation, quantification and comparison of clinic practices and accumulated data

- Conducted comprehensive telephone interviews to 36 primary care clinics across the state to determine the extent of their integration

- Made on-site visits to 18 clinics across the State and teleconferenced with an additional three

- Monitored the Mental Health Services Act proceedings and interfaced with committee members to determine optimal ways to interface and provided material to them (ongoing activity)

- Identified potential evaluators to assess the initiative (ongoing activity)

- Determined potential Project Advisory Board members (ongoing activity)
- With the Tides Center, determined best methods for regranting (on-going activity)

LESSONS LEARNED AND ISSUES TO GRAPPLE WITH

"WHEN YOU'VE SEEN ONE PROGRAM, YOU'VE SEEN ONE PROGRAM."

All have different takes on integration and how to implement it.

IDENTIFYING MODEL PROVIDERS OF INTEGRATED SERVICES IS DIFFICULT BECAUSE THERE IS A PAUCITY OF OUTCOME INFORMATION AND NO CENTRAL REPOSITORY FOR THIS DATA.

WHILE HAVING STANDARDIZED ASSESSMENT TOOLS, DATA, POLICIES, METHODOLOGIES AND OPERATIONAL STRUCUTRE IS IMPORTANT AND MAY EASE IMPLEMENTATION, THE DIVERSITY OF POPULATIONS, FUNDING SOURCES, SKILL SETS, PHILOSOPHICAL ORIENTATIONS, ETC. ACROSS CLINICS MEANS *ONE SIZE DOES NOT FIT ALL*.

FINANCIAL CONTRAINTS ARE THE PRIMARY BARRIER TO INTEGRATION

- Lack of same-day service Medi-Cal reimbursement is the major deterrent to a central component of integration — the on-the-spot "warm-hand off" by the primary care physician to the behavioral health care worker.
- The primary care setting favors shorter office visits, thereby discouraging identification of issues beyond the primary presenting disorder.
- Reimbursement practices create far more financial incentives for medical procedures and diagnostic testing than for mental health screening, treatment and case management.

- Providers are not compensated for time communicating with colleagues which discourages phone and on-the-fly consultations by behavioral staff.

- Doctor-to-doctor consultation is not reimbursable and telepsychiatry is only reimbursable in rural clinics.

- Marriage and family therapists (MFT's) are usually a cheaper and more available alternative to social workers or psychologists, but their services aren't Medi-Cal reimbursable in California clinics, though they are in other states.

- Group therapy is a good fit for integrated behavioral health care delivery, but it's underutilized because of reimbursement issues and variability in patient receptivity.

- Case management is effective for engagement, follow-up, obtaining needed resources and continuity of care, but it's underutilized because it's not usually specifically funded.

- And, of course, there's little to no funding for mental health services for the uninsured.

COST-EFFECTIVENESS OF INTEGRATED CARE IS NOT CLEAR-CUT

- Any cost-savings generated may not be realized by the clinics themselves because the savings are often achieved via decreased ER visits and hospitalizations.

- Some studies have shown an initial spike in costs over the first year or so as the integration program is being implemented, followed by a slow but significant decrease.

- The most promising cost-saving successes seem to be treating major depression, especially when it accompanies a chronic disorder like diabetes or heart disease.

STUDIES REFLECTING IMPROVEMENT OF PRIMARY CARE PATIENTS COMPLETING TREATMENT SOMETIMES FAIL TO CONSIDER THOSE WHO WERE NOT ENGAGED.

- "No show" rates for behavioral health care patients were high at almost all the primary care clinics visited.
- Improvement rates, by reflecting only active participants, may be artificially high. Data on why participants don't return may provide insights into the integration model.

INTEGRATION PROGRAMS TARGETING DEPRESSION ARE WIDESPREAD AND REPORT POSITIVE RESULTS, BUT FOCUSING ON ONE DISORDER DOES NOT ACHIEVE COMPREHENSIVE INTEGRATED CARE.

MENTAL HEALTH PRACTITIONERS AND PRIMARY CARE PHYSICIANS OPERATE IN DIFFERENT CULTURES THAT MAY NOT MESH INITIALLY.

- Building working relationships and bridging these cultural differences is crucial to the success of the integration program.

- Cross-training of staff is important.

TRADITIONAL PSYCHOTHERAPY DOESN'T WORK WELL IN PRIMARY SETTINGS.

Behavioral health staff/mental health clinicians need to learn to practice in a new way.

PARTNERING WITH EDUCATIONAL INSTITUTIONS CAN ENHANCE THE SUSTAINABILITY OF INTEGRATED PROGRAMS WE HELP INITIATE.

INTEGRATION OF MEDICAL RECORDS IS AN IMPORTANT STEP TO ACHIEVING OVERALL INTEGRATED CARE.

RESOURCES ARE BEST APPLIED TO PROVIDERS WHO'VE EXPRESSED A STRONG INTEREST IN WORKING TOWARD INTEGRATION.

AGREEMENT ON THE SHARED VISION AND OPERATIONAL STRUCTURE SHOULD BE ATTAINED AT THE BEGINNING, BUT A "ROLLING START" IS OFTEN THE BEST WAY TO IMPLEMENT THE PROGRAM.

WITH INTEGRATED FUNDING NOW ON THE TABLE VIA THE MENTAL HEALTH SERVICES ACT, HRSA AND OTHER FOUNDATIONS, WE NEED TO BE MINDFUL OF THE BEST WAYS TO POSITION OUR EFFORTS AND FUNDING.

MOST POLICY MAKERS, MENTAL HEALTH PROFESSIONALS, PRIMARY CARE CLINICS AND PATIENTS FEEL THAT INTEGRATION IS A GOOD IDEA BUT, AS CAN BE SEEN, THERE ARE LOTS OF BARRIERS STREWN IN THE WAY.

WHAT WE PLAN TO DO NEXT

- Convening a Program Development/Focus Group Meeting with key experts in the field to advise us on:
  - Developing measurable outcomes; discussing piloting methods for documenting patient outcomes;
  - Validating readiness instruments for programs;
  - Taking advantage of opportunity to "mine" current data collection;
  - Developing a patient satisfaction instrument that measures stigma reduction;

- Developing descriptive narratives that:

  - document the developmental process of integrated programs
  - assess impact on "organizational culture" and catalog policy and advocacy implications
  - explore telemedicine and telepsychiatry opportunities
  - determine training and technical assistance needs
  - decide on other strategies

Identifying up to 6 sites to serve as "case studies"

- Sites to be selected will represent diversity:
  - volume diversity – size of patient load
  - geographic diversity – urban, suburban, rural
  - structural diversity – single or multiple sites

- Sites will:
  - demonstrate diversified methodologies in pursuing integration
  - facilitate analysis and generalizations to the larger clinic population
  - represent variations in the range and level of integration achieved
  - participate in local or regional clinic consortia

- Sites will have demonstrated some level of the "7 C's" of integration:
  - Communication
  - Collaboration
  - Comprehensiveness
  - Continuity of Care
  - Cultural Competence
  - Commitment
  - Copy Capacity

- Sites will have some common characteristics of the field:
  - Use of a mental health screening tool
  - Some type of "clinical case manager" as core support to the program
  - Some type of patient registry to track patients and potential outcomes
  - Some level of psychiatric supervision and consultation

- As part of grant activities, sites will participate with the IBHP team in the activities refined through the focus group process.

- Sites selected will receive grant for participation – amount will be determined by the number of sites selected but will be consistent across all sites.

- Grant activities will guide the development of the next phase of the initiative funding.

CHALLENGES

- "Standardizing" measurement outcomes to advance the argument for integration…or not?
- Strategically placing our resources within the rapidly growing and varied integration activities across the nation, within California and within TCE
- Identifying, extrapolating and channeling the relevant policy and advocacy issues that arise from our integration work