

**“Integrated Primary Care &
Behavioral Health Programs”
California Mental
Health Planning Council
Presentation**

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Presentation Overview

- ✔ What is Integrated Behavioral Health?
- ✔ General Overview of IBHP and Findings
- ✔ The Case for Integration
- ✔ Models and Key Components of Integration
- ✔ New Developments in the Field
- ✔ California Statewide Integration Policy Project

What is Integrated Behavioral Health?



IBHP
Integrated Behavioral Health Project

What is IBH?

- ✔ “Integrated primary care is a service that combines medical and behavioral health services to more fully address the spectrum of problems that patients bring to their primary medical care providers.”
- ✔ “It allows patients to feel that, for almost any problem, they have come to the right place.”

Alexander Blount

- ✔ “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 that have been stabilized.”

The Hogg Foundation for Mental Health

“ Re-attaching the head to the body.”





General Overview of IBHP and Findings

About IBHP....

- 🕒 Launched in March 2006 as a project of



to accelerate integration of behavioral health services into primary care settings

- 🕒 Focus is on services in California Community Health Clinics (CHCs)
- 🕒 Beginning to design a new phase which will include a “merger” with Community Clinics Initiative of the Tides Center

Our goals ...

- ✔ Increase access to behavioral health services
- ✔ Reduce stigma associated with seeking treatment
- ✔ Improve treatment outcomes
- ✔ Strengthen linkages between mental health and primary care

By...

✔ Grantmaking:

- Identify, study and disseminate emerging promising practices, special projects and data outcomes

✔ Establishing a learning community:

- Sponsor training opportunities
- Design a resource website

✔ Advocating for needed policy and system changes

PHASE I

- ✔ Conducted developmental and initiative-specific design activities
- ✔ Selected seven primary care clinics and two clinic consortia to receive grants and serve as demonstration sites in order to:
 - Build capacity
 - Study operations
 - Evaluate approaches
- ✔ Identified policy and system barriers to integration

Phase I Demonstration Sites

Open Door Community Health Centers, Arcata

Mendocino Community Health Clinic, Ukiah

Sierra Family Medical Clinic, Nevada City

Golden Valley Health Center, Merced

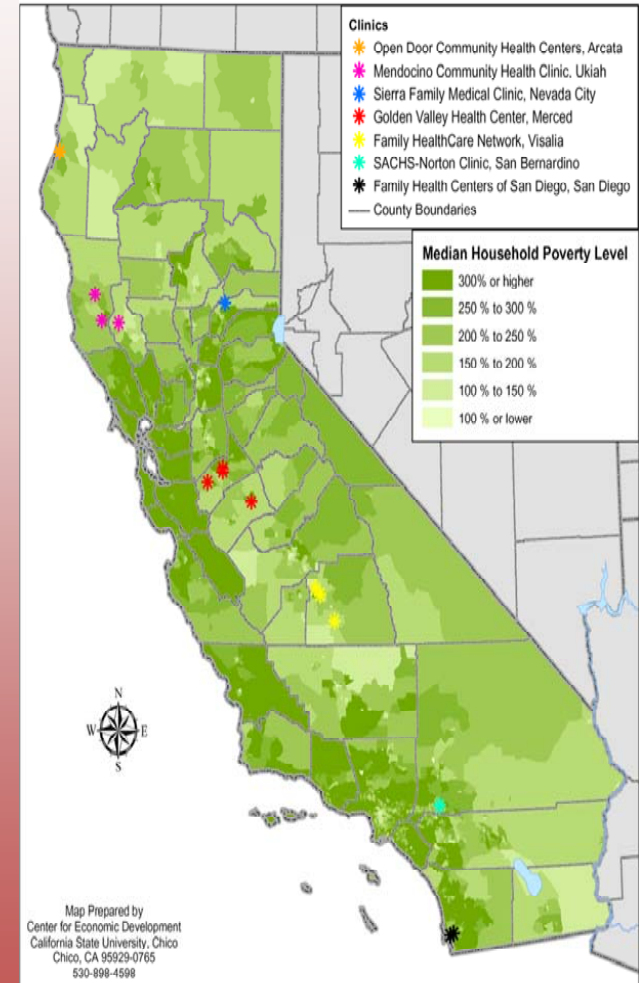
Family Healthcare Network, Visalia

SACHS-Norton Clinic, San Bernardino

Family Health Centers of San Diego

Northern Sierra Rural Health Network, Nevada City

Council of Community Clinics, San Diego



PHASE I LEARNINGS

Data from IBHP Phase 1 Suggests:

- Learning Communities are important “tools” in the spread of innovations...help to “connect the dots”
- High Patient Satisfaction
 - Comfortable receiving services in clinic setting
 - More engaged and feel like their well-being is important to providers
 - More likely to follow through with an outside referral for mental health services after engagement in the behavioral health program

PHASE I LEARNINGS

✔ BH Care in PC Setting is Effective

- Repeated PHQ-9 results indicate a decrease in depression among IBH patients (across gender, race, and patients with diabetes)
- Improvements in repeated DUKE measures were statistically significant for physical health, mental health, general health, depression, and anxiety; though improvements still below normative scores.

PHASE I LEARNINGS

- ✔ PCPs & BH staff like the model; it increases job satisfaction
- ✔ Challenges: standardized screening, tracking outcomes, case management, co-occurring disorders, client f/up, psychiatric consultation
- ✔ Varying models are used and none is the gold standard
- ✔ Transformation is hard; BH and PCPs have to learn to work differently & as a team

Phase II Sites

- ✓ Council of Community Clinics, San Diego
- ✓ CommuniCare Health Centers, Davis
- ✓ Community Health Clinic Ole, Napa
- ✓ Family Health Centers of San Diego
- ✓ Glide Foundation, San Francisco
- ✓ Golden Valley Health Center, Merced
- ✓ La Clinica de La Raza, Oakland
- ✓ LifeLong Medical Care, Berkeley
- ✓ Long Valley Health Center, Laytonville
- ✓ Mendocino Community Health Clinic, Ukiah
- ✓ Open Door Community Health Centers, Arcata
- ✓ Petaluma Health Center, Petaluma
- ✓ Sierra Family Medical Clinic, Nevada City
- ✓ South Bay Family Healthcare Center, Torrance
- ✓ All for Health, Health for All, Glendale
- ✓ Asian Health Services, Oakland
- ✓ Asian Pacific Health Care Venture, Los Angeles
- ✓ Avenal Community Health Center
- ✓ Central City Community Health Center, Los Angeles
- ✓ Chapa-De Indian Health Program, Grass Valley
- ✓ East Valley Community Health Center, West Covina
- ✓ Eisner Pediatric & Family Medical Center, Los Angeles
- ✓ North Coast Clinics Network, Eureka
- ✓ Ravenswood Family Health Center, East Palo Alto
- ✓ San Francisco Community Clinic Consortium
- ✓ Share Our Selves, Costa Mesa
- ✓ St. John's Well Child and Family Center, Los Angeles
- ✓ Bill Moore Community Health Clinic (URDC/Pacific Clinics), Pasadena

PHASE II

- ✔ Launched summer of 2008
- ✔ Provides one-year grants to 24 CHCs and three (3) consortia to support IBH development opportunities and to foster innovative projects
 - Grants range from \$10,000 to \$75,000

PHASE II Goals

- ✔ Continue advocacy for policy and system changes targeting:
 - Barriers that inhibit integration efforts
 - Attainment of support for basic tenets of integrated care
- ✔ Expand Learning Community to include new providers through educational activities, trainings, and sharing of information (www.ibhp.org)
- ✔ Establish a “mentor”/ T.A. consultation component involving Phase I grantees as “experts” to introduce best practices to new grantees

The Case for Integration



IBHP

Integrated Behavioral Health Project

Why Integrate?

- ✔ Health care visits often have psychosocial drivers.
- ✔ Addressing psychosocial aspects often results in lower overall health costs.
- ✔ Primary care is often the first-line intervention and only access for many.
- ✔ Reduces “stigma” associated with seeking mental health services.

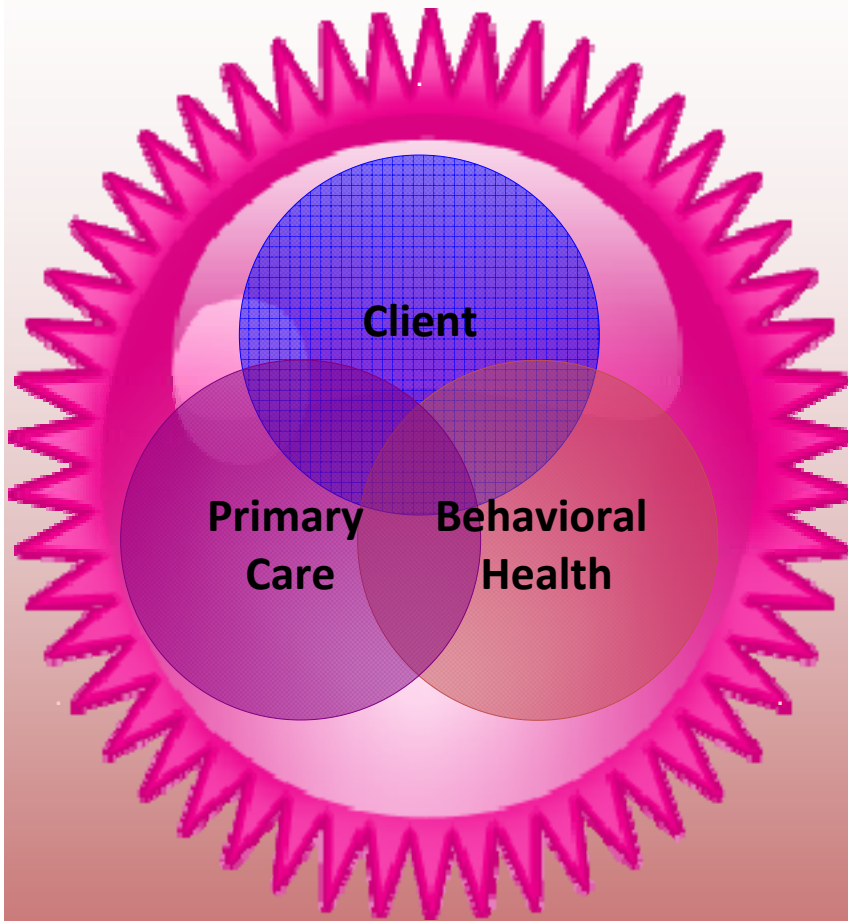
Why Integrate?

- ✔ Presents an important opportunity
 - Intervene early and prevent more disabling disorders
 - Reach people who cannot or will not access specialty behavioral health care
- ✔ Leads to improved process of care
 - Recognition of MH and CD disorders
 - Improve PCP skills in medication prescription practices
 - Increase PCP use of behavioral interventions
 - Increase PCP confidence in managing behavioral health issues

Why Integrate?

- ✔ People with serious mental illness die on average 25 years earlier than the general population.
 - Average age: 51 vs. 76
 - 3.4 times more likely to die of heart disease
 - 6.6 times more likely to die of pneumonia and influenza
 - 5 times more likely to die of respiratory ailments

Models and Key Components of Integration



IBHP

Integrated Behavioral Health Project

The Framework for Integration

Population-Based Care

- ✔ 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

Population-Based Care (continued)

- ✔ 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

Dimensions of Integration

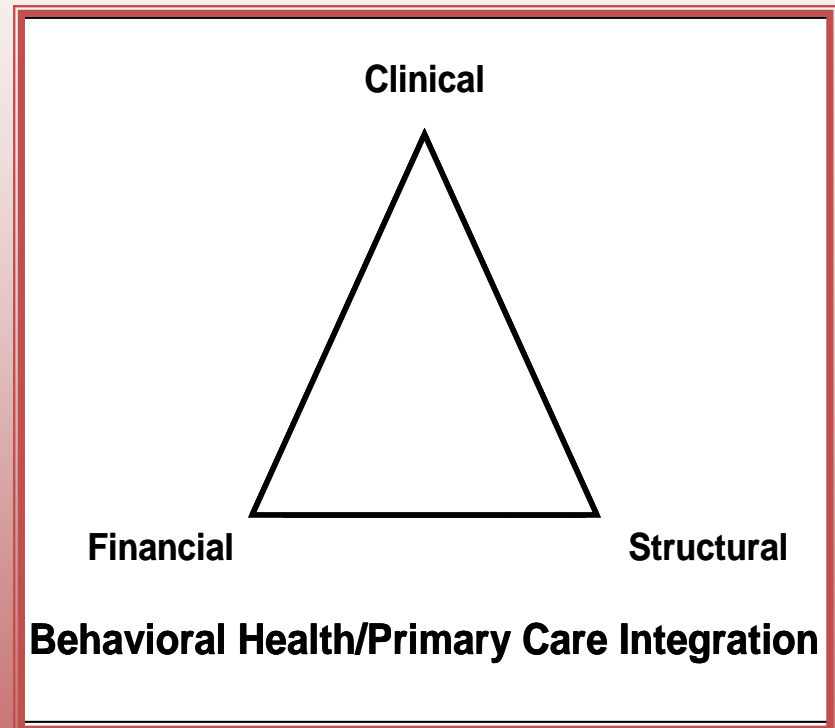
- ✔ Integration is best understood along a “continuum”
- ✔ No agreement on the definition of “integration” or even proposed terms that should be used to set the framework within that continuum
- ✔ Consider both the function, components and the “metrics” of levels or models

Dimensions of Integration (IBHP)

- ✔ Communication
- ✔ Physical Proximity of PC and BH Care
- ✔ Temporal Proximity of PC and BH Care
- ✔ Integration of BH Expertise/Services
- ✔ Integration with Respect to the Degree of Stigma

Elements of BH/PC Integration

- ✓ Financial or structural integration does not assure clinical integration
- ✓ Clinical integration helps us focus on what people need
- ✓ Public sector efforts focused on financial integration (carve-ins) have had limited success
- ✓ BUT clinical integration requires financial and structural supports in order to be successful

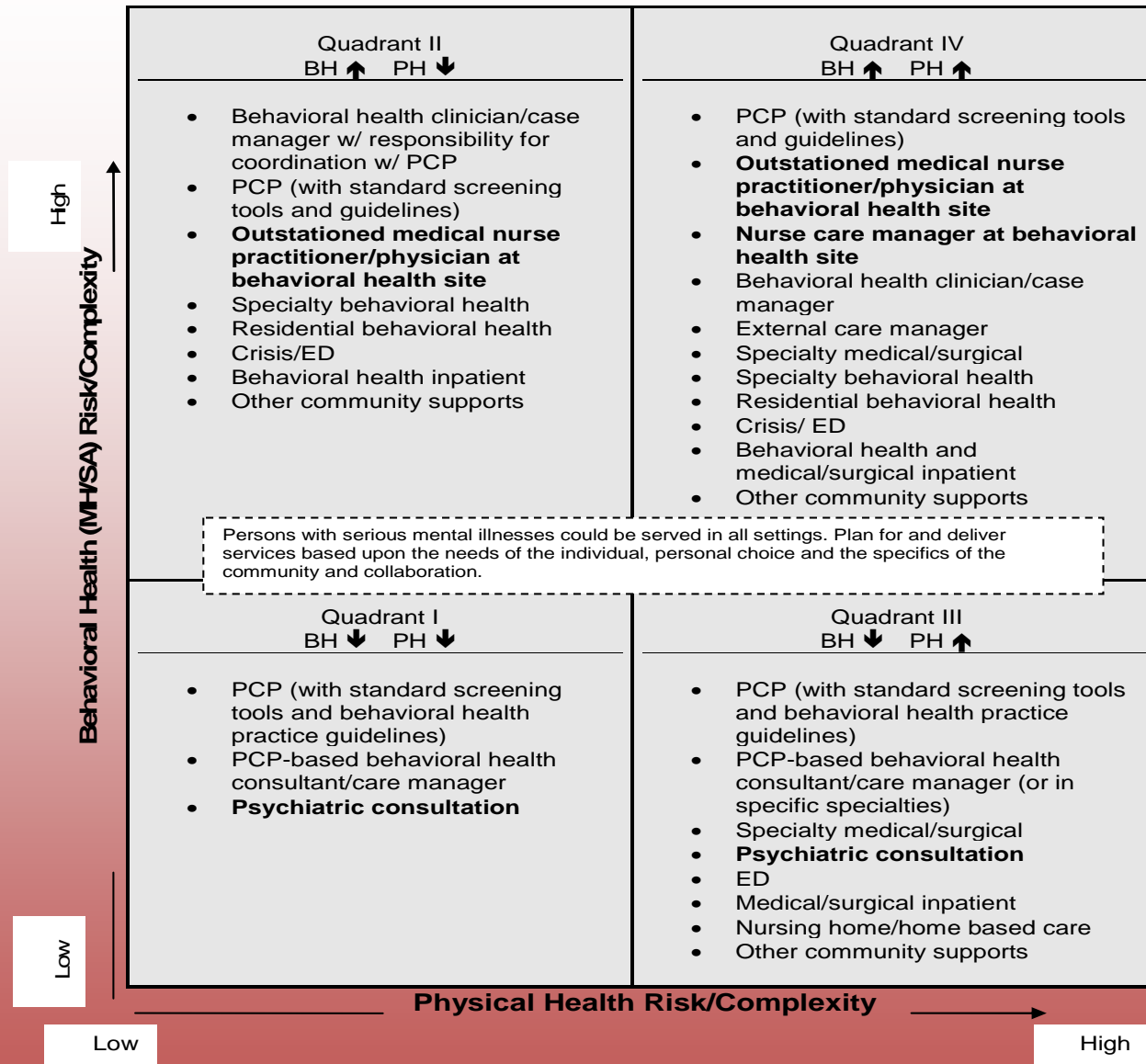


Where Should Care Be Delivered?

The National Council Four Quadrant Integration Model

- ✔ Organize our understanding of the many differing approaches—there is no single method of integration
- ✔ Think about the needs of the population and appropriate targeting of services
- ✔ Clarify the respective roles of PCP and BH providers, depending on the needs of the person being served
- ✔ Identify the system tools and clinician skill and knowledge sets needed and how they vary by subpopulation
- ✔ Population based for system planning, services should be person-centered

The Four Quadrant Clinical Integration Model



Where Should Care Be Delivered?

Stepped Care

- ✔ There is always a boundary between primary care and specialty care
- ✔ There will always be tradeoffs between the benefits of specialty expertise and of integration
- ✔ *Stepped care* is a clinical approach to assure that the need for a changing level of care is addressed appropriately for each person—IMPACT research demonstrates the effectiveness of a stepped care model and is the basis for the National Council Collaborative Care Project
- ✔ We need to implement this model bi-directionally—to identify people in primary care with MH conditions and serve them there unless they need specialty care, and to identify people in MH care that need basic primary care and step them to a full scope medical home for more complex care

Hogg Foundation: The Models

🕒 Co-location

- House BH specialists and primary care providers in same facility, supporting “warm hand-off”
- Does not ensure that providers collaborate in treatment; this may vary greatly across clinics
- Research is somewhat limited—“simply placing a BH specialist in PC is unlikely to improve patients’ outcomes unless care is coordinated and based in evidence-based approaches”

🕒 Primary Care Behavioral Health Model

- BH consultant serves as consultant to PCP, focusing on optimizing the PCP’s quality of BH care for patients
- Targets behavioral issues related to medical diagnoses instead of traditional BH problems like depression and anxiety
- Has not yet been systematically evaluated—“although likely beneficial, the effectiveness of the model is not yet known”

Hogg Foundation: The Models

🕒 Collaborative Care

- Adaptation of the chronic care model for psychiatric disorders, used stepped care to treat depression, anxiety disorders, bipolar disorder
- Integration of BH care manager and consulting psychiatrist into PC setting, with registry to track and monitor response to treatment
- Numerous studies of clinical and cost effectiveness, with adolescents, adults, and older adults, with and without co-morbid medical illnesses and from different ethnic groups—“significant research evidence demonstrates that collaborative care improves outcomes for a wide range of patients”
- This is the model the Hogg Foundation has been implementing in a number of Texas PC clinics

IMPACT Collaborative Care Model

- ✓ Initial randomized controlled trial in 18 primary care clinics - 8 health care organizations in 5 states
- ✓ Model now being implemented in a broad range of settings, including the Minnesota DIAMOND project, which has initiated case rate payments to PC clinics (public and private payors)
- ✓ Systematic outcomes tracking and stepped care
 - e.g., PHQ-9 for depression, GAD-7 for anxiety
- ✓ Treatment adjustment as needed
 - based on clinical outcomes
 - according to evidence-based algorithm
 - in consultation with team psychiatrist
- ✓ Relapse prevention



New Developments in the Field

Recent Reports on Integrated Care

✓ World Health Organization

- *Integrating Mental Health Into Primary Care: A Global Perspective (Fall 2008)*
- http://www.who.int/mental_health/resources/mentalhealth_PHC_2008.pdf

✓ Agency for Healthcare Research and Quality

- *Integration of Mental Health/Substance Abuse and Primary Care (Fall 2008)*
- <http://www.ahrq.gov/clinic/tp/mhsapctp.htm>

✓ Hogg Foundation for Mental Health

- *Connecting Body and Mind: A Resource Guide to Integrated Health Care in Texas and the United States (Fall 2008)*
- http://www.hogg.utexas.edu/programs_RLS15.html

WHO: The Key Messages

- 1. Mental disorders affect hundreds of millions of people and, if left untreated, create an enormous toll of suffering, disability and economic loss.**
- 2. Despite the potential to successfully treat mental disorders, only a small minority of those in need receive even the most basic treatment.**
- 3. Integrating mental health services into primary care is the most viable way of closing the treatment gap and ensuring that people get the mental health care they need.**
- 4. Primary care for mental health is affordable, and investments can bring important benefits.**
- 5. Certain skills and competencies are required to effectively assess, diagnose, treat, support and refer people with mental disorders; it is essential that primary care workers are adequately prepared and supported in their mental health work.**
- 6. There is no single best practice model that can be followed by all countries. Rather, successes have been achieved through sensible local application of broad principles**
- 7. Integration is most successful when mental health is incorporated into health policy and legislative frameworks and supported by senior leadership, adequate resources, and ongoing governance.**
- 8. To be fully effective and efficient, primary care for mental health must be coordinated with a network of services at different levels of care and complemented by broader health system development.**
- 9. Numerous low- and middle-income countries have successfully made the transition to integrated primary care for mental health.**
- 10. Mental health is central to the values and principles of the Alma Ata Declaration; holistic care will never be achieved until mental health is integrated into primary care.”**

AHRQ: The Research

- 📌 Quantitative and qualitative analysis of 33 trials that examined the impact of integrating MH specialists into primary care
 - Studies tended to show positive results for symptom severity, treatment response and remission when compared to usual care
 - Wide variation in levels of provider integration and integrated processes of care
 - No clear patterns that suggest that outcomes improve as levels of provider integration or integrated process of care increase
 - IMPACT has strongest results for adults and older adults; limited studies exist for children

AHRQ: The Research

- 📌 More work is needed on understanding what elements of integration are vital to producing desired goals—“research aimed at efficiently matching clinical and organizational processes and resources to different levels of care for varying levels of severity, and patients stratified by risk and complexity, would build on the...IMPACT trials and Intermountain Healthcare’s examples”

The Patient-Centered Medical Home

Principles of the Patient-Centered Medical Home

- Personal physician
- Physician directed medical practice (team care that collectively takes responsibility for the ongoing care of patients)
- Whole person orientation
- Care that is coordinated and/or integrated
- Quality and safety (including evidence based care, use of information technology and performance measurement/quality improvement)
- Enhanced access to care
- Payment structure that reflects these characteristics beyond the current encounter-based reimbursement mechanisms

*The American Academy of Family Physicians, American Academy of Pediatrics,
American College of Physicians, and American Osteopathic Association*

<http://www.pcpcc.net/>

The Person-Centered Healthcare Home for People with SMI

- ✔ Note the proposed renaming of the concept from patient-centered medical home
- ✔ See *Behavioral Health/Primary Care Integration and The Person-Centered Healthcare Home*, recently prepared by the National Council

The Person-Centered Healthcare Home for People with SMI

- ✔ For BH providers envisioning a future role as person-centered healthcare homes, there are two pathways to follow:
 - Providers who want to become full scope person-centered healthcare homes for people with SMI should ***look to the Cherokee model*** and seek to become full scope providers of primary care services, for a broad community population as well as for those receiving BH services
 - Providers who want to ***partner with full scope primary care*** organizations to create person-centered healthcare homes for individuals with SMI should ***organize a parallel to the IMPACT primary care model***, with collaborative care, care management, a designated PCP consultant, outcome measurement, and stepped care for primary care needs in BH settings

The Person-Centered Healthcare Home for People with SMI: Partnership

- ✔ Assure regular screening and registry tracking/outcome measurement at the time of psychiatric visits for all BH consumers receiving psychotropic medications
- ✔ Locate medical nurse practitioners/PCPs in BH clinics—provide routine primary care services in the BH setting via staff out-stationed under the auspices of a full scope person-centered healthcare home
 - BH organization hiring a nurse practitioner directly, without the backup of a skilled PCP and a full scope healthcare home cannot be described as providing a healthcare home, and is not a recommended pathway

The Person-Centered Healthcare Home for People with SMI: Partnership

- ✔ Identify a primary care supervising physician within the full scope healthcare home to provide consultation on complex health issues
- ✔ Assign nurse care managers to support individuals with elevated levels of glucose, lipids, blood pressure, and/or weight/BMI
- ✔ Use evidence based practices developed to improve the health status of all individuals with chronic health conditions, adapting these practices for use in the BH system.
- ✔ Create wellness programs

California Statewide Integration Policy Project

The California Mental Health, Primary Care, and Substance Use Services Integration Policy Initiative “IPI”



IPI's Goals

- 🕒 Developed to address the pressing need for improved linkages between the primary and behavioral healthcare systems serving California's Safety Net Populations, its goals are to:
 - ✓ Develop a set of policy recommendations enhancing the interface between primary and behavioral healthcare.
 - ✓ Advance these recommendations through a report to local and state policy makers identifying changes in law, regulation and practice to support integration of mental health, primary care and substance use services.
 - ✓ Accelerate the systems integration needed to enhance the health outcomes of underserved populations and to promote efficiencies across the safety net systems.

IPI's Vision

“Overall health and wellness is embraced as a shared community responsibility.”

IPI – Current Activities

- 🕒 Convening a statewide Project Advisory Group, comprised of leaders with expertise from each of the systems, to participate in an extensive planning process. The Project Advisory Group has now launched two working groups:
 - ✓ *A Delivery System Design Work Group*: identifying universal measurements for the system design including potential process, capacity and outcome measures; and
 - ✓ *A Finance Work Group*: identifying and prioritizing policy barriers that impact financing of an integrated delivery system and advancing recommendations for change.

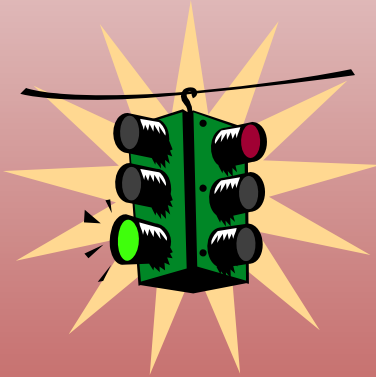
IPI – Current Activities

- ④ Meeting with key constituents, community based organizations, academia, and state and national leaders on the IPI and the opportunity for IPI recommendations/findings to be included in health reform discussion, including the renewal of California's Hospital Financing Waiver.
- ④ Collaborative Family Healthcare Association (CHFA) Policy Summit October 22, 2009 in San Diego

IPI – Long-Term Activities

2009

- ✓ Obtain approval to pay for same day MH and PC services
- ✓ Obtain approval to pay for expanded definition of qualified staff (e.g., MFTs)



2010

- ✓ Develop systematic approaches to improve system performance
 - ✓ Develop strategies to reduce stigma regarding SU
- ✓ Leverage/align what each system currently has in resources and incentives
- ✓ Gather Certified Public Expense (CPE) and maximize federal match

IPI – Long-Term Activities

2011

- ✓ Implement systematic approaches on a pilot basis
- ✓ Implement strategies on a pilot basis
 - ✓ Submit Medicaid MH waiver that
 - ✓ incorporates the integration Vision
 - ✓ Develop revised regulations based upon approved waiver

2012

- ✓ Spread systematic approaches throughout the system
- ✓ Spread strategies throughout the system
 - ✓ Begin to implement revised regulations and waiver

2013-2014

- ✓ Complete implementation of revised system (continue and refine)



Questions or Comments?

Thanks!



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