National Overview: Behavioral Health Primary Care Integration and the Person-Centered Healthcare Home

California Primary Care and Mental Health Integration Policy Initiative

Advisory Group Meeting
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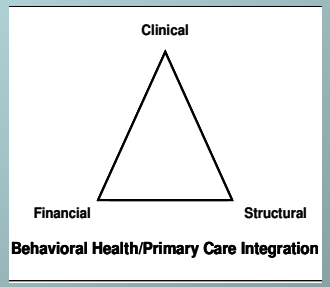
NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

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



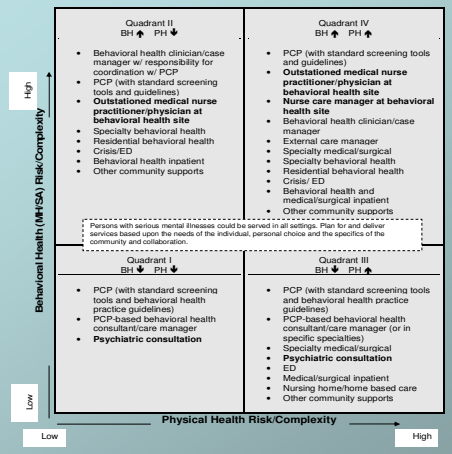
Where Should Care Be Delivered? The National Council Four Quadrant Integration Model

- 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

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

The Four Quadrant Clinical Integration Model



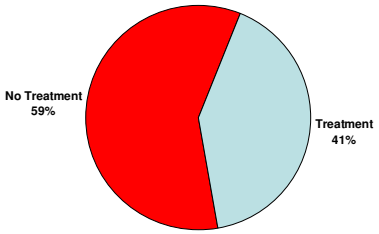
Quadrants I and III

National Comorbidity Survey Replication

- The National Comorbidity Survey Replication (NCS-R) is a household survey taken every 10 years
- Did not include homeless and institutionalized populations, or clinically complex disorders such as schizophrenia—likely that the prevalence rates are underestimates
- 26% of the general population reported symptoms sufficient for diagnosing a mental disorder in the past 12 months
- *Mental disorders gain the strongest foothold in youth: 50% of all cases start by age 14; 75% by age 24*
- Disorder severity: 22% of the 12-month cases were classified as serious, 37.3% moderate and 40.4% mild
- Thanks to Dennis Freeman of Cherokee, who prepared the following NCS graphic presentation slides

National Comorbity Survey Replication

Provision of Behavioral Health Care: Setting of Service



SOURCE: Wang, Philip S., et al, Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005

National Comorbidity Survey Replication

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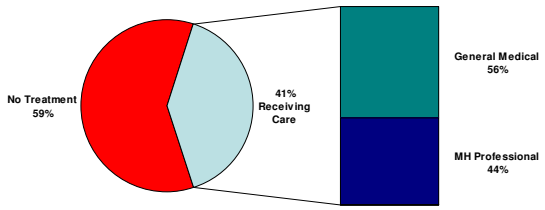

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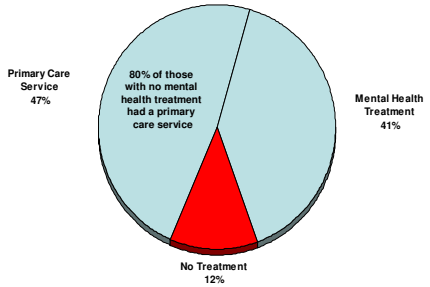
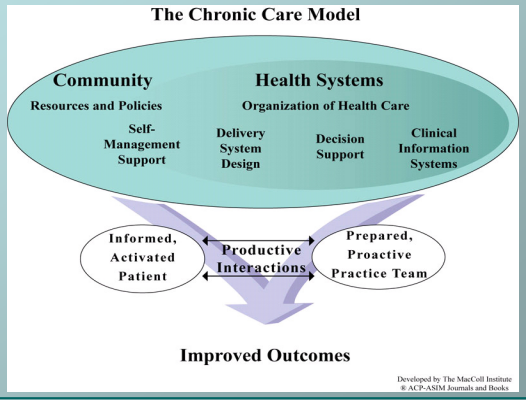
Access to Behavioral Health Intervention



Overall Model for Improving Primary Care



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
- 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"

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

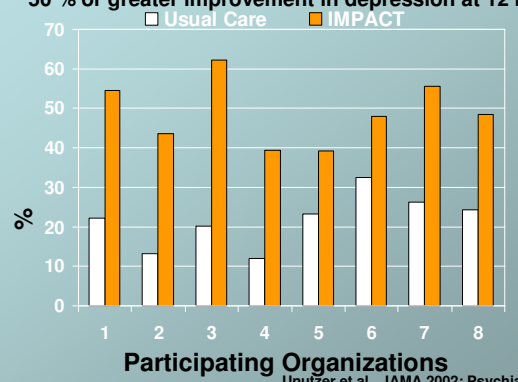
- Initial randomized controlled trial in 18 primary care clinics - 8 health care organizations in 5 states
- Model now being implemented in a broad range of settings, including the Minnesota DIAMOND project, which has initiated case rate payments to PC clinics (public and private payors)
- Systematic 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

Core Components of IMPACT Collaborative Care Program

TWO PROCESSES	TWO NEW 'TEAM MEMBERS'	
	Care Manager/BHC	Consulting Mental Health Expert
1. Systematic diagnosis and outcomes tracking e.g., PHQ-9 to facilitate diagnosis and track depression outcomes	- Patient education / self management support - Close follow-up to make sure pts don't 'fall through the cracks' - Support medication Rx by PCP - Brief counseling (behavioral activation, PST-PC, CBT, IPT) - Facilitate treatment change / referral to mental health - Relapse prevention	- Caseload consultation for care manager and PCP (population-based) - Diagnostic consultation on difficult cases - Consultation focused on patients not improving as expected - Recommendations for additional treatment / referral according to evidence-based guidelines
2. Stepped Care - Change treatment according to evidence-based algorithm if patient is not improving - Relapse prevention once patient is improved		

IMPACT: Doubles the Effectiveness of Usual Care for Depression

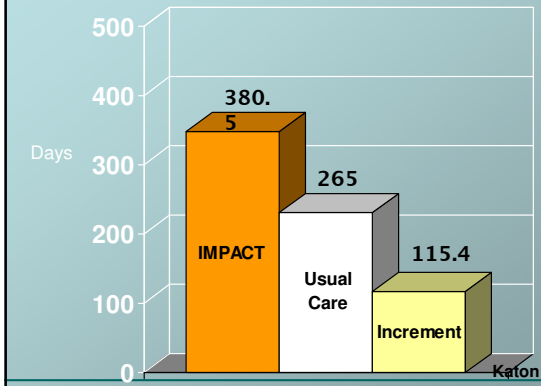
50 % or greater improvement in depression at 12 months



Unutzer et al., JAMA 2002; Psychiatr Clin N America 2005

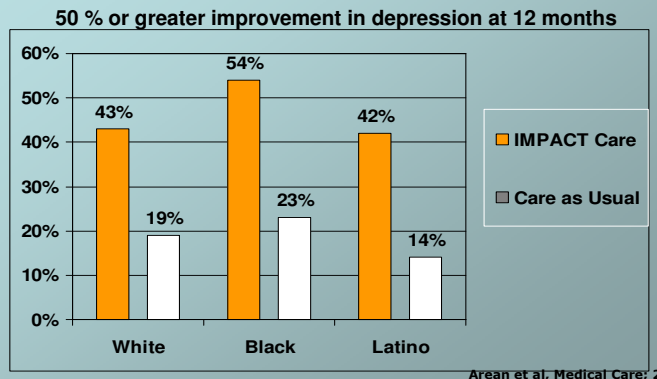
IMPACT: in Diabetes

115 more Depression Free Days over 2 Years



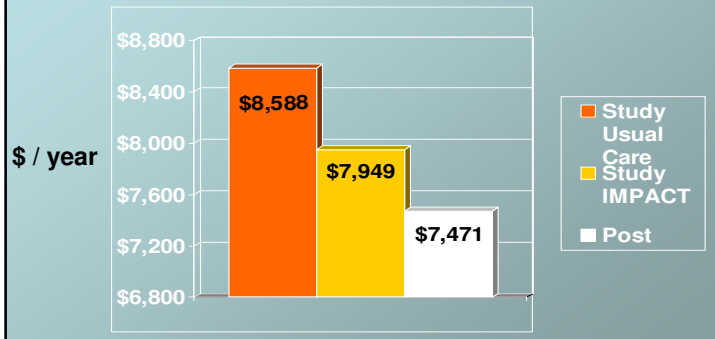
Katon et al, Diabetes Care; 2006

IMPACT: Benefits Ethnic Minority Populations



Arean et al, Medical Care, 2004

IMPACT: Lower Total Health Care Costs



Grypma, et al; *General Hospital Psychiatry*, 2006

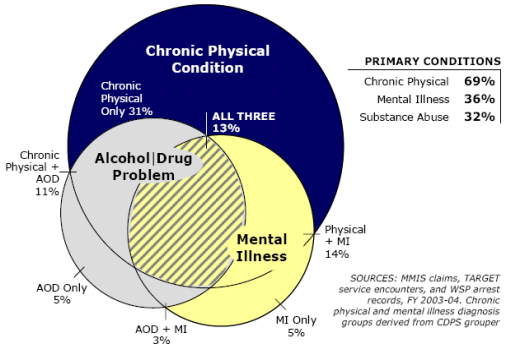
Washington State GA-U Project

(General Assistance Unemployable)

Co-occurring Diagnoses and the GA-U Population

52 percent had **substance abuse** or **mental illness** identified

31 percent had a **chronic physical condition** only

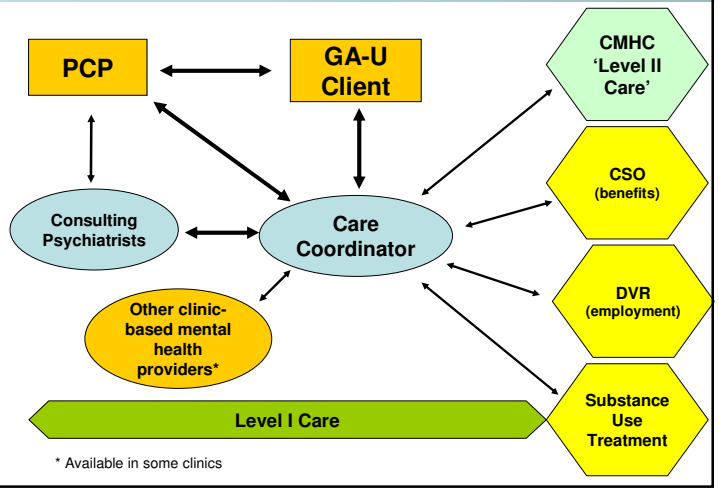


DSHS | GA-U Clients: Challenges and Opportunities August 2006

Washington State GA-U Project

- State-only funded program that provides cash grants ($339/mo) and medical coverage for adults who are physically or mentally disabled and unemployable for more than 90 days
- Mental Health Pilot adds MH benefit (in King [Seattle] and Pierce [Tacoma] counties) for an estimated 6500 eligibles (prior to pilot, GA-U eligibles were able to obtain crisis services only from the MH system)
- Goals of Mental Health Pilot
  - Build on success of GA-U medical pilot (managed care in King and Pierce CHCs)
  - Improve patient outcomes
  - Reduce costs
- Integrated physical health, mental health and substance abuse services to GA-U clients in their medical home (plus outreach)
- Structure of Mental Health Pilot
  - Level I: MH Treatment in Primary Care (IMPACT Collaborative Care model)
  - Level II: Community Mental Health Care for individuals needing more intensive services

Goal: Collaborative Care



Washington State GA-U Project

Data 1/1/08 through 11/30/08 (web-based registry is data source)

- 2073 clients enrolled
  - Level I: 1429 in open status at end of November
  - Level II: 364 in open status at end of November (44% were never known to the MH system previously)
- Most prevalent diagnoses
  - 82% screened for depression (PHQ-9), subsets also screened for anxiety (GAD-7), substance use (GAIN-SS), bipolar (MDQ), PTSD (PLC-C)
  - Level I: depression, anxiety, substance use, bipolar, PTSD
  - Level II: depression, bipolar, anxiety/PTSD, schizophrenia
- Clients with follow up within 4 weeks of initial assessment
  - Level I: 42% (range across clinics: 32%-64%)
  - Level II: 57% (range across clinics: 25%-70%)
- Clients with Psychiatrist Consultation
  - Level I: 31% (range across clinics: 20%-83%)
  - Level II: 28% (range across clinics: 15%-73%)

Washington State GA-U Project

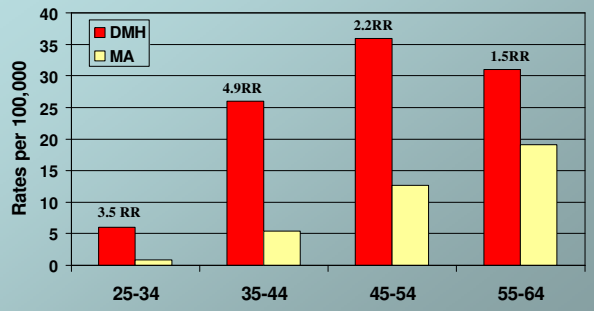
- Level I outcomes 12 weeks after initial assessment
  - Clients with PHQ-9 scored improved at least 50% over 12 weeks = 20% (range across clinics: 12%-28%)
  - Clients with GAD-7 score improved at least 50% over 12 weeks = 20% (range across clinics: 13%-26%)
- Observations
  - The collaboration involves 6 primary care clinic systems, 9 mental health agencies, the safety net health plan, the regional mental health authority and the University of Washington—everyone has learned a lot!
  - Removing the funding barrier did not remove the cultural differences, historic lack of trust, or the challenges of implementing evidence-based practices
  - There is significant variation in work processes across PC and MH clinics and in implementation of the care coordinator role across PC clinics
  - This creates variation in client follow up and use of psychiatric consultation which reduces ability to provide stepped care and lack of fidelity to stepped care model
  - Client outcomes are impacted by lack of fidelity to the model—the Hogg Foundation project shows that as fidelity increases, outcomes are improved

Quadrants II and IV

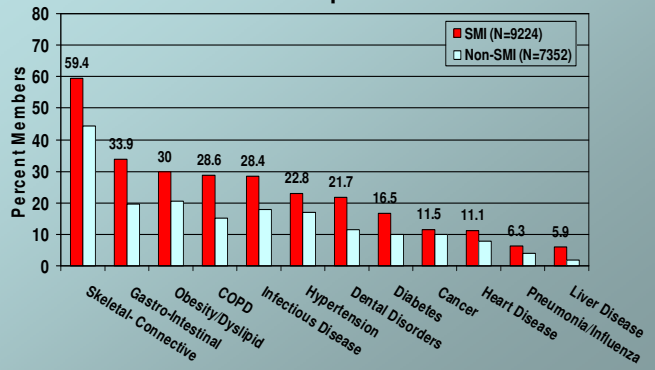
Morbidity and Mortality in People with Serious Mental Illness

- Persons with serious mental illness (SMI) are dying **25 years earlier than the general population**
- While suicide and injury account for about 30-40% of excess mortality, 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases (NASMHPD, 2006)

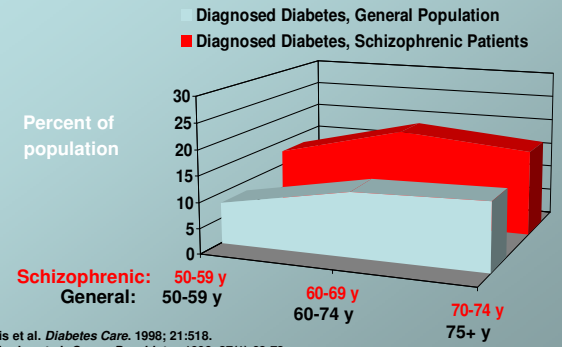
Massachusetts Study:
Deaths from Heart Disease by Age Group/DMH Enrollees with SMI Compared to Massachusetts 1998-2000



Maine Study: Comparison of Health Disorders Between SMI & Non-SMI Groups



Prevalence of Diagnosed Diabetes in General Population Versus Schizophrenic Population



Harris et al. *Diabetes Care.* 1998; 21:518.
Mukherjee et al. *Compr Psychiatry.* 1996; 37(1):68-73.

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