INTEGRATION AND COORDINATION OF BEHAVIORAL HEALTH SERVICES IN PRIMARY CARE

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A variety of similar terms in health care reform

- “Medical home” refers to a model of service delivery
- “Health home” refers to a model that combines service delivery and some form of managed care (roughly speaking)
- “Accountable care organization” refers to an organization that takes overall responsibility for the health care of a defined population.
“The Patient Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family.”

American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA)
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MEDICAL HOME PRINCIPLES

• Personal physician
• Physician directed medical practice
• Whole person orientation
• Care is coordinated and/or integrated
• Enhanced access to care
• Quality and safety
• Payment appropriately recognizes the added value
KEY ELEMENTS OF A PATIENT-CENTERED MEDICAL HOME

• Personal physician
• Range of services
• Evidence-based practices
• Integration of care
• “Meaningful use” of electronic medical records
2011 NCQA standards call for increased focus on integrating behavioral health and care management and require:

- Identification of behavioral health problems
- Identification of vulnerable populations
- Provide, or refer for, tracked coordinated behavioral health services
- Counseling to adopt healthy behaviors
- Organizational monitoring of at least one behavioral health condition

NO SPECIFICS
WHY INTEGRATE BEHAVIORAL AND PHYSICAL HEALTH CARE?

• 60% of people with diagnosable mental health conditions do not get treatment
  – Most get physical health care and could be identified and treated in primary care settings

• People with co-occurring chronic physical conditions and behavioral health conditions
  – High risk for disability and premature mortality
  – Much higher medical costs
WHY INTEGRATE BEHAVIORAL AND PHYSICAL HEALTH CARE?

• 2/3 of high cost Medicaid cases have co-occurring severe physical and behavioral disorders

• People with long-term psychiatric disabilities have low life-expectancy (10-25 years) in large part due to poor health and poor health care.

• Mental health is key to long-term care reform

• Prevention depends on changes of behavior and lifestyle
• Screening for anxiety, depression, substance abuse, dementia, co-morbidity
  – (PHQ-2 and 9, GAD7, AUDIT-C, etc.)

• Assessment and diagnosis

• Treatment using evidence-based approaches
  – Combined drug and psycho-therapies (CBT, PST)

• Disease/care management
  – IMPACT, PRISM-E, RESPECT-D, etc.
SERVICE ELEMENTS OF INTEGRATION OF PRIMARY AND BEHAVIORAL CARE

• Involve family and caregivers

• Communication, coordination, collaboration
  – Co-Location is not enough
  – Referral is not enough
  – **Linking** to behavioral health professionals
    • Within the medical home
    • Via referral to outside providers
  – Coordinating with social services

• Tele-health
SERVICE ELEMENTS OF INTEGRATION OF PRIMARY AND BEHAVIORAL CARE

• Prevention/mental health promotion (“wellness”)
  – Developmental and health determinants in children
  – Depression screening and treatment (Reduce disability and premature mortality)
  – Behavior/Lifestyle Change
  – Community education
• Psychiatrists
  – Role in medical home?
• Psychologists
• Clinical social workers
• Registered psychiatric nurses and nurse practitioners
• Other professionals
• Paraprofessionals, e.g. case management
• Peer care management (medical coaches)
MODELS OF INTEGRATION IN PRIMARY CARE

- Co-location
- Integrated treatment teams
- Care managers as adjuncts to pcp treatment
- Motivational interviewing
- The challenge of workforce shortages
- Tele-psychiatry
  - Consultation
  - Live diagnosis and/or treatment
- High tech-low touch approaches
IMPACT

• Screening (Usually PHQ-2 and/or PHQ-9)
• Diagnosis and prescribed treatment by PCP
• Collaborative care is the cornerstone of the IMPACT model and functions in two main ways:
  – The patient’s primary care physician works with a care manager to develop and implement a treatment plan
  – The care manager and primary care provider consult with a psychiatrist to change treatment plans if patients do not improve
• Depression Care Manager may be a nurse, social worker, or psychologist supported by a paraprofessional
  – Educates the patient
  – Supports anti-depressant therapy if prescribed
  – Coaches patients in behavioral activation and pleasant events scheduling
  – Offers brief counseling
  – Monitors depression symptoms
  – Competes a relapse prevention plan with each patient who has improved
  – Monitor depressive symptoms usually with PHQ-9

• Stepped Care

• Designated psychiatrist consults to the care manager and primary care physician regarding patients who do not respond to initial treatment
• Recruitment/standards/credentials
• Supervision and training
• Tracking and coordination (Required by NCQA)
• Quality assurance/improvement
  – Inclusion of behavioral health outcomes among outcome measures
  – Inclusion of satisfaction with behavioral health services in client satisfaction surveys
  – NCQA requires 1 of 3 “clinically important conditions to be related to unhealthy behaviors (e.g. obesity) or a mental health or substance abuse condition.”
ADMINISTRATIVE ELEMENTS

• Physical space
  – Confidentiality/Privacy
  – Opportunities for formal and informal interaction
  – Ambiance

• Compliance/risk management
  – NCQA: New in 2011 with “stronger focus on integrating behavioral health and care management”

• Community relations
  – Community Resources
  – Partnerships
  – Stakeholder relationships

• Funding
BUSINESS MODELS

- Staff Model
- Independent Practitioner Groups
- “Borrowed” Staff
- “Rented” Staff
- Joint project/program/venture
- Merger
• Community health center (esp. FQHCs)
• Hospital clinics and health centers
• Community behavioral health organizations
  – Clinics
  – Day programs?
• Private practices/medical groups
• Health plans and others can sponsor initiatives
• Health homes/ACOs
• Entitlement funding streams
  – Medicare
    • LEARN HOW TO USE IT, e.g. tele-health
  – Medicaid
    • FIGHT FOR ITS SURVIVAL AS AN ENTITLEMENT

• Increased funding for FQHCs, CMH programs, etc.
  – Grants
  – Medical home add-ons
  – “Meaningful use” add-on
    https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp#BOOKMARK1

• Will parity make a difference?