Integrating Physical and Behavioral Health Care Services: The Next Generation

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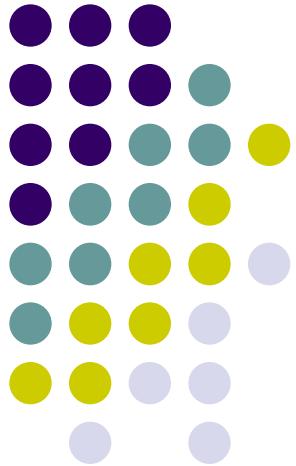


Objectives

- Identify reasons for integrating physical and behavioral health services
- Define types of integration
- Review activities of an integrated delivery system
- Identify challenges to integration of physical and behavioral health

Vignette

Usual Care

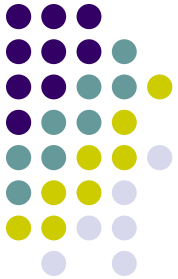
- A fee-for-service environment in which a PCP can only make a “good living” by averaging 7-minute visits with patients, there is little choice but to rapidly figure out whether the presenting symptom is best addressed by a pill, test, or procedure.

http://www.forbes.com/sites/davechase/2013/04/30/the-hot-spotters-sequel-population-health-heroes/2/

Health Services

- Fee-for-service models reward service utilization without a focus on the long term.
- Managed Care has been viewed as a means to redirect services and to focus on health promotion.
- Additionally, carve-outs have been used to address specialty services.

Service Delivery Systems



- Health Maintenance Organization (HMO)
- Coordinated Care Organization (CCO)
- Community Care Organization (CCO)
- Accountable Care Organization (ACO)
- Physician Hospital Organization (PHO)
- Preferred Provider Organization (PPO)
- Managed Care Organization (MCO)
- Independent Provider Organization (IPO) (IPA)
- Managed Behavioral Health Organization (MBHO)

Value-based Purchasing

- ***"Can Integrated Care Save American HealthCare?*** ***(Washington Post January 18, 2013)***

- Triple Aim
  - Improve healthcare
  - Improve health
  - Lower cost

$$\text{Value} = \frac{\text{Quality}}{\text{Cost}}$$

Business of Integrated Health Services

- What is the product?
- Who are the customers?
- Who are the payers?
  - What is the financial model?
- Who are the providers?
  - What are the operational components?

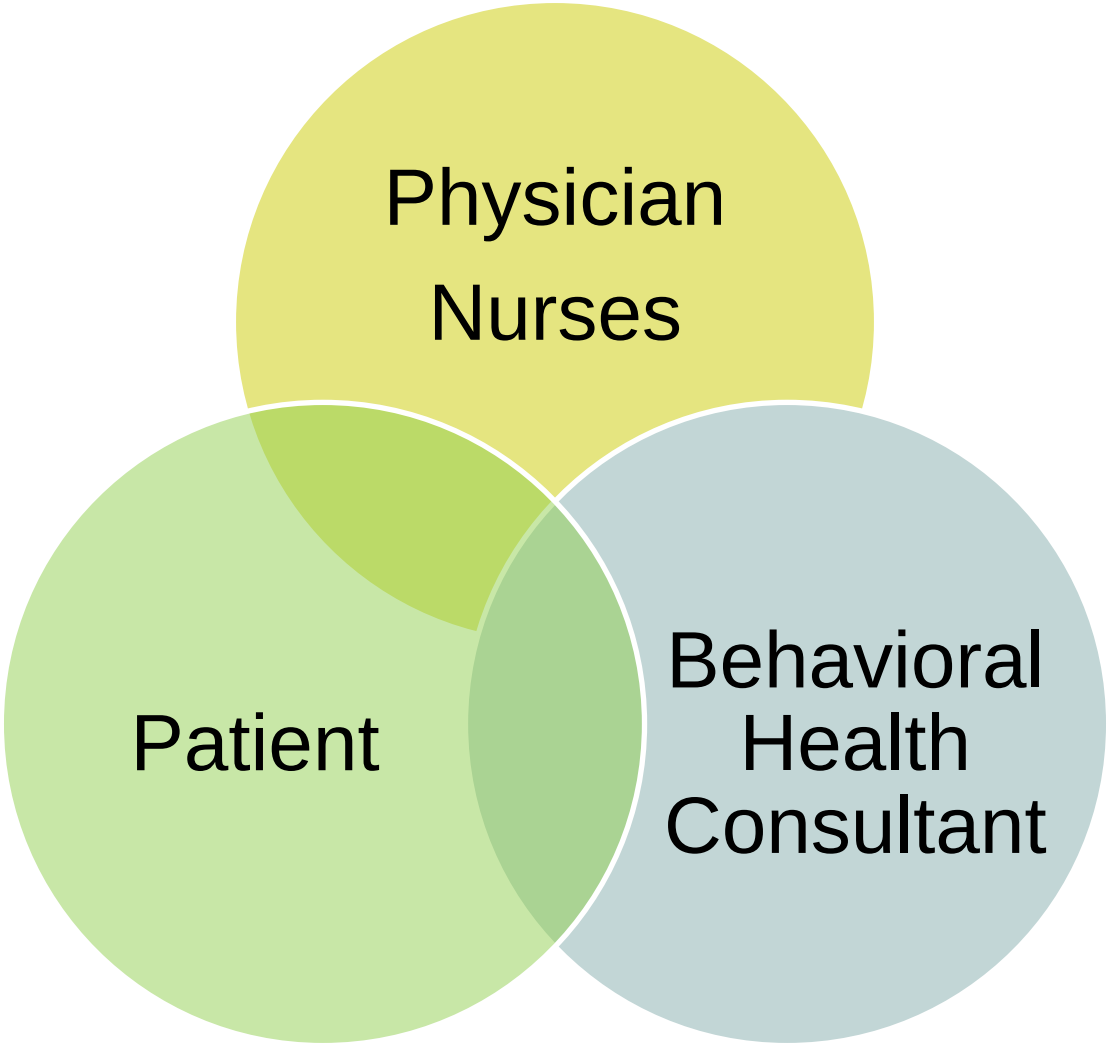
Integrating Physical and Behavioral Health

Evolving the service delivery model…

- Mind and Body are connected
- Team Care is better care

Primary Care and Mental Health

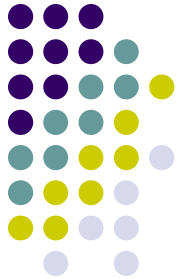
Blending Cultures



Differences in Cultures

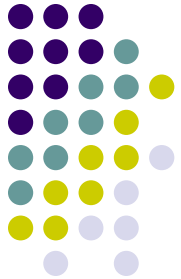
Primary Care	Traditional Mental Health
Patient may not seek MH care	Patient seeking out MH care
Short-term, goal oriented	Short or long term, process oriented
Brief interactions	Longer sessions
Variable scheduling	Consistent scheduling
Rapid diagnoses and treatment plans	Comprehensive evaluation and treatment planning process
Exam room	Private office
Interruptions	Quiet, lack of interruptions
Unpredictable schedules	Predictable schedules
Focus of tx on overall health, may not have psychiatric dx	Focus more on MH issues, usually have psychiatric dx
Team-based care	Individual-based care

Why in Primary Care?



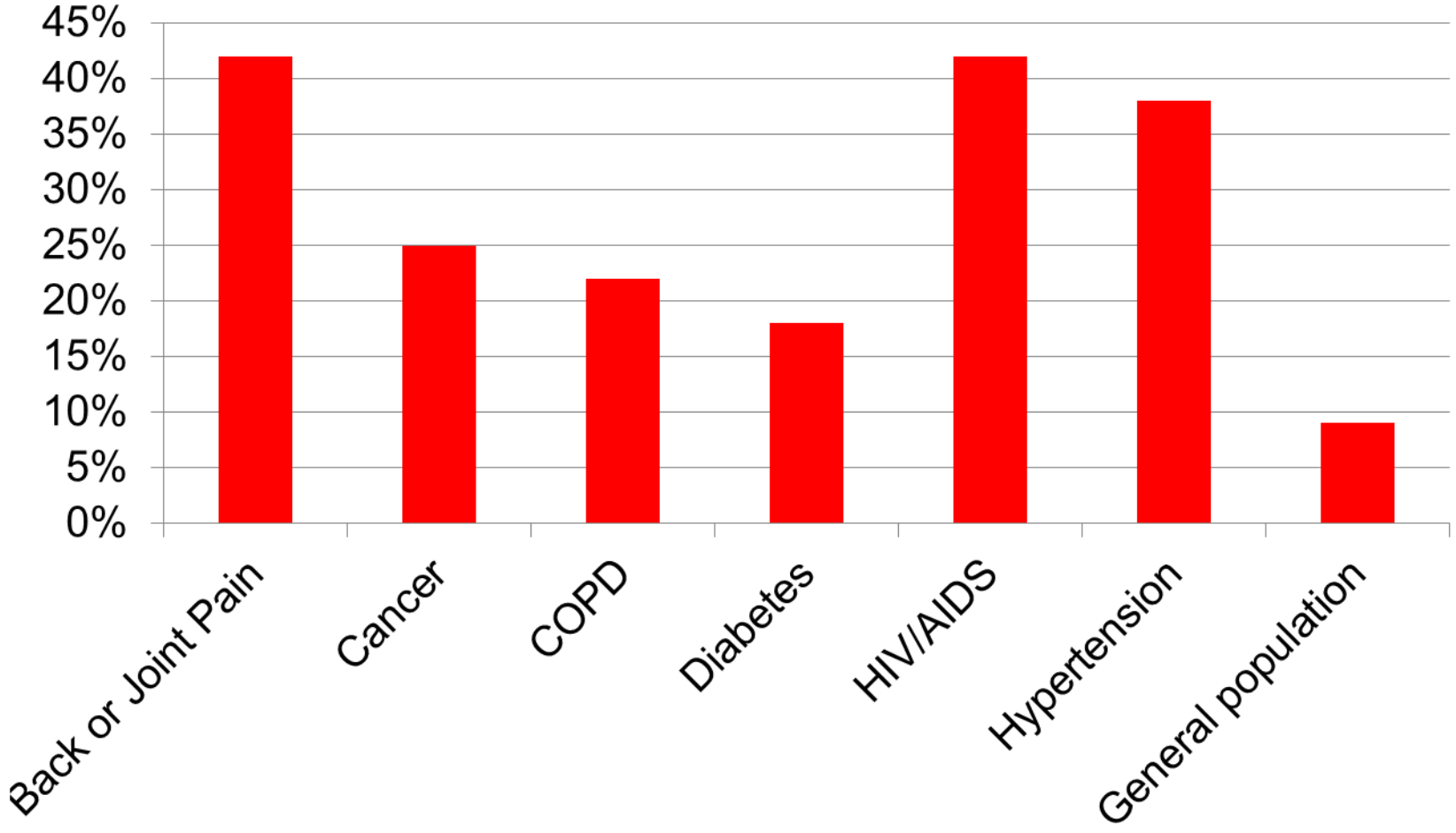
- It's where the patients are…
  - Over half of patients seek treatment for behavioral health conditions from their primary care physicians
  - Non-psychiatrists write over three-fourths of antidepressant prescriptions (Mark, TL, et al, 2009)
    - 9.3% of patient's visits to PCPs result in antidepressants being prescribed
    - 3.6% of visits to other providers, not psychiatrists (Mojtabai and Olfson, 2011).

Prevalence of Behavioral Health Conditions and Primary Care

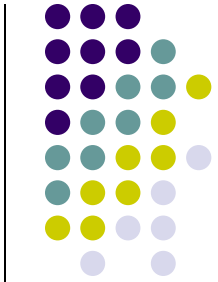


- Prevalence estimates for psychiatric disorders of individuals seen in primary care range from 26 to 60 percent.
  - (Studies of patient populations based on the PRIME-MD)
- An estimated 20 percent of children in pediatric primary care have a clinically significant psychosocial problem/condition.
- An estimated 60 percent to 70 percent of physician visits are by patients with **no medical** illness.

Chronic Conditions and Depression



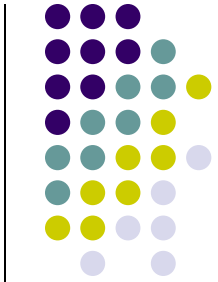
Annual Per Capita Medicaid Costs: Implications of Behavioral Health Comorbidity



Co-morbidity	Asthma and/or COPD	Congestive Health Failure	Coronary Heart Disease	Diabetes	Hypertension
No Mental Illness & No Drug/Alcohol	$ 8,000	$ 9,488	$ 8,788	$ 9,498	$ 15,691
Mental Illness and No Drug/Alcohol	$ 14,081	$ 15,257	$ 5,430	$ 16,267	$ 24,693
Drug/Alcohol and No Mental Illness	$ 15,862	$ 16,058	$ 15,634	$ 18,156	$ 24,281
Mental Illness and Drug/Alcohol	$ 24,598	$ 24,927	$ 24,443	$ 36,730	$ 35,840

Source: C. Boyd, B. Leff, C. Weiss, J. Wolff, A Hamblin, and L. Martin.
Faces of Medicaid: Clarifying Multimorbidity Patterns of Improving Targeting and Delivery of Clinical Services for Medicaid Populations. Center for Health Care Strategies December 2010

Why in Behavioral Health?



Compared with the general population, people with severe mental illness have:

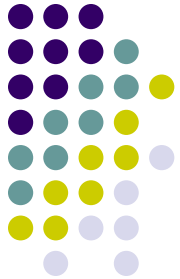
- 4.1 times the overall risk of dying prematurely than the general population aged under 50
- 2 times the risk of diabetes [1]
- 2-3 times the risk of hypertension.
- 3 times the risk of dying from coronary heart disease. [2]
- Gastrointestinal disease is raised at least four times and most of that are liver issues to do with alcohol or other hepatitis illnesses.
- Cardiovascular disease is two and half times more.
- 10-fold increase in deaths from respiratory disease for people with schizophrenia.[3]

[1] Royal College of Psychiatrists (2013) *Whole person care: from rhetoric to reality. Achieving parity between mental and physical health*. London: Royal College of Psychiatrists. https://www.rcpsych.ac.uk/files/pdfversion/OP88xx.pdf

[2] Osborn DP, Nazareth I, King MB. (2007) Physical activity, dietary habits and Coronary Heart Disease risk factor knowledge amongst people with severe mental illness: a cross sectional comparative study in primary care. *Social Psychiatry and Psychiatric Epidemiology*. 2007; 42(10): 787-93.

[3] Faculty of Public Health (2008) *Mental health and smoking: a position statement*. London: Faculty of Public Health. http://www.fph.org.uk/uploads/ps_mental_health_and_smoking.pdf

Why in Behavioral Health?



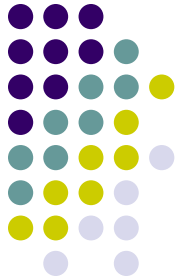
- Individuals with a severe and persistent mental illness die on average 25 years sooner than individuals without a severe and persistent mental illness
- As many as 75% of individuals with schizophrenia have been found to have high rates of serious physical illnesses—diabetes, respiratory, heart and/or bowel problems and high blood pressure
- High rates for vision (93%), hearing (78%), and dental problems (60%)
- 50% of a sample of community mental health service recipients reported not having a regular doctor
- 61% indicated they would go to an emergency department or urgent care center if they felt sick

Outpatient Treatment of Depression 1987, 1998, and 2007

Treatment	1987	1998	2007
Percent individuals treated	.073%	2.37%	2.88%
Psychotherapy	71.1%	53.6%	43.1%
Pharmacotherapy (any)	44.6%	80.1%	81.9%
Psychotherapy and Pharmacotherapy	28.8%	48.1%	34.5%
Treatment by PCP	68.1%	87.3%	84.6%

Source: Source: Marcus, S.C .and Olfson, M.O. (2010) National Trends in the Treatment for Depression from 1998 to 2007. Arch General Psychiatry: 67;12, 126-1273.
And
Olfson, M.O., Marcus, SC, Druss, B., et al (2002) National Trends in the Outpatient Treatment of Depression. JAMA: 287;2, 203-209.

Adherence and Antidepressant Medications



Premature Discontinuation Rates

- 29% to 42% at 4 weeks
- 63% to 76% at 6 months
- In one study of 147 patients only 19% of participants took antidepressants in accordance with clinical guidelines over 6-month period

Source: Hunot, V.M., et al (2007) A Cohort Study of Adherence to Antidepressants in Primary Care: The Influence of Antidepressant Concerns and Treatment Preferences. Primary Care Companion J Clin Psychiatry. 9:91-99.

Psychotherapy Adherence

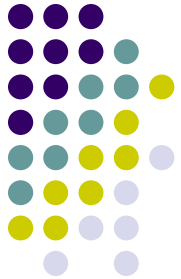
- While it appears that most (54%) individuals seem to prefer psychotherapy, less than one in four who are referred to a mental health professional actually go to their first appointment (1)
- However, there is evidence that psychotherapy combined with antidepressants is associated with enhanced adherence and response (2)

1) Rafeyan, R. (2010) Depression: The Physical and Fiscal Impact of Patient, Society and Payers. Journal of Managed Care Medicine, 13:4; 22-27.
2) Pampallona, S, et al (2004) Combined Pharmacotherapy and Psychological Treatment for Depression, Arch Gen Psychiatry, 61; 714-719.

Hogg Foundation Definition

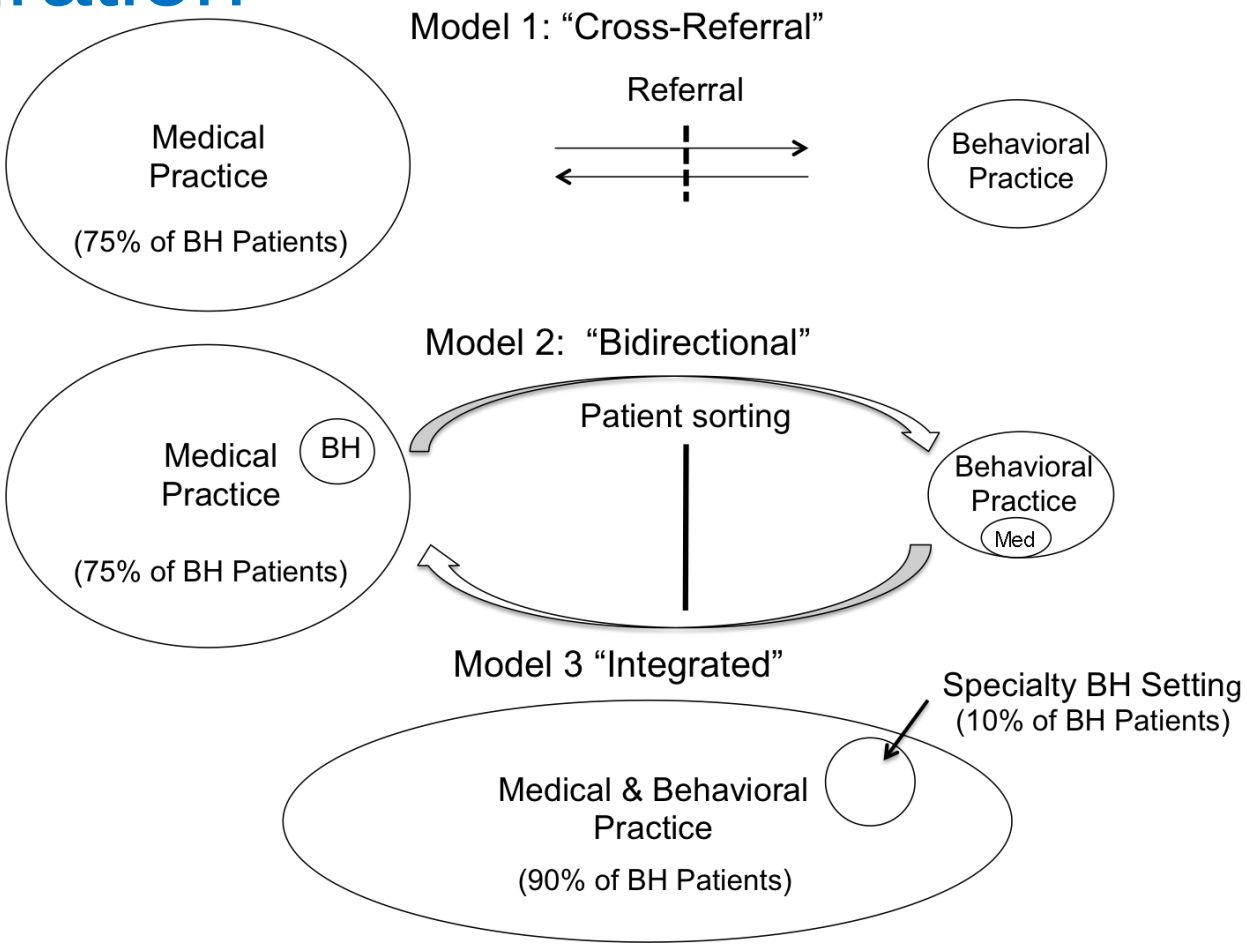
Integrated health care – The systematic coordination of mental and physical health care to increase access, improve the quality of services, and to reduce the stigma of seeking mental health treatment

Types of Integration



- Usual Care—informal referral patterns
- Collaboration—structured and formalized referral to specialists; memorandums of agreement established
- Co-location—operate as separate programs, referrals are facilitated as the behavioral health specialists is onsite
- Integration—working together as a health care team in promoting the health of the individual from a holistic perspective

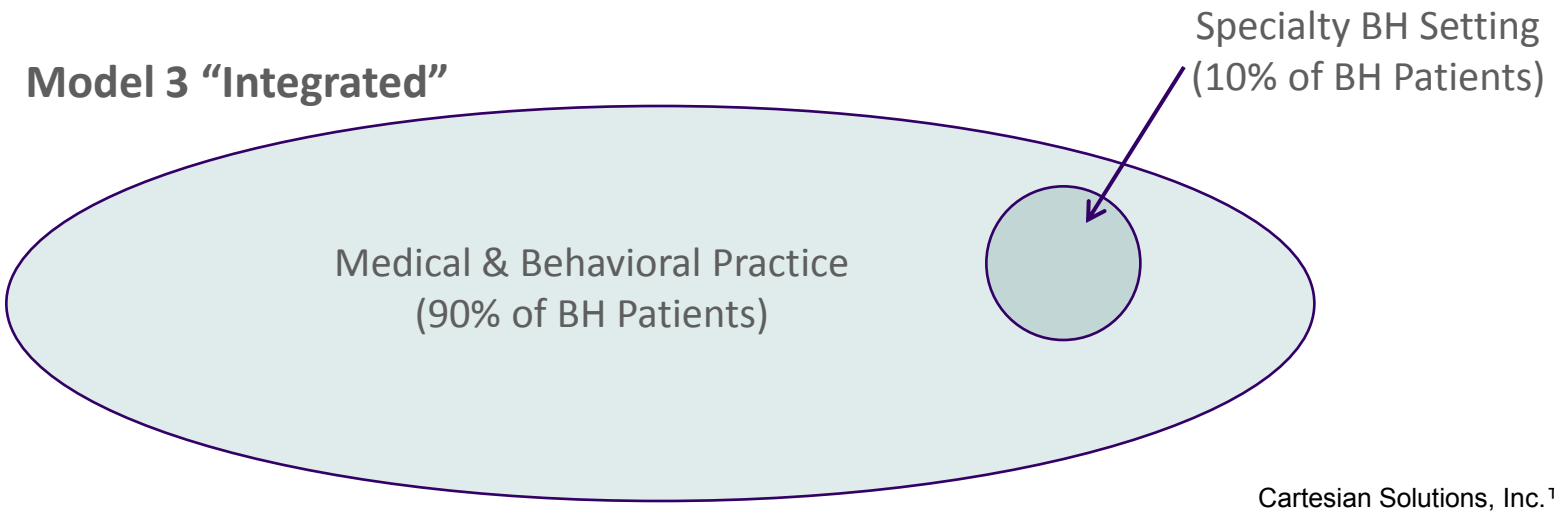
Models of Medical and BH Integration



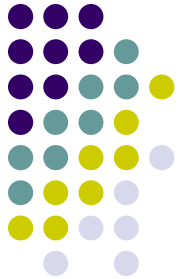
Manderscheid & Kathol, AIM, 2014

Implementing Integrated Physical and Behavioral Care

- BH professionals become part of total health team
- Makes medical possible in BH; BH possible in medical
- Sustainable payment for value-added integrated services (bidirectional--true parity)
- **Challenge--requires change from status quo**



Core Activities in Integrated Care Models



- Screening and early detection
  - Depression, substance use, domestic violence, ADHD
- Patient engagement, activation, and self-management
  - Decision-aids
  - Health promotion
- Treatment
  - Health education
  - Psychotherapy—individual & group
  - Medical management, Adherence
- Coordination with specialists
  - Monitoring, follow-up
  - Medication reconciliation

Care Coordination

- Integrate patient's clinical data
- Facilitate communication among health care providers, patient, and social network
- Provide support and coaching to assist patient in an understanding of health condition and care strategies
- Manage care transitions
- Establish linkages with community support and service providers
- Monitoring and tracking outcomes

Projected Healthcare cost savings through effective Integration (National, 2012)

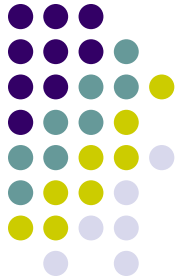
Commercial	$15.8-$31.6 billion
Medicare	$3.3-$6.7 billion
Medicaid	$7.1-$9.9 billion

Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry

Melek, Stephen P., Norris, Douglas T., Paulus, Jordan. Milliman (April 2014)

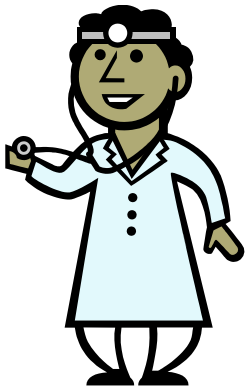
www.psych.org/File%20Library/Practice/Professional%20Interests/...

Integrated care



- Co-location does not ensure integrated collaborative care
  - May only produce parallel practice
- Establish a culture and philosophy of care that considers physical and psychiatric needs, personal goals, and community issues

Evolving Integration: Next Generation



Summary Desired Outcomes of Integration

- Improved care
  - Increased availability of/access to care
  - Condition/disease management
- Improved health
  - Health condition
  - Quality of Life
- Improved patient satisfaction
- Improved cost management and cost savings
  - Reduced preventable hospitalizations and ED utilization