

Current and Future Models of Integrated Care

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Objectives

• **After completing this session, the participant/learner will be able to...**

- 1) Understand the concept of integrated care
- 2) Identify current models of integrated care being utilized in the region
- 3) Identify models of integrated care that may be utilized in the region in the future.

Defining Behavioral Health

Behavioral Health is an umbrella term for care that addresses any behavioral problems impacting health, **including mental health and substance abuse conditions**, stress-linked physical symptoms, patient activation and health behaviors. The job of all kinds of care settings, and done by clinicians and health coaches of various disciplines or training.

Source: Peek, C. J., National Integration Academy Council. (2013). Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. In Agency for Healthcare Research and Quality (Ed.), *AHRQ Publication No. 13-00101-20E*.

Major Categories:

- Neurodevelopmental Disorders
- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive Compulsive and Related Disorders
- Personality Disorders
- Neurocognitive Disorders
- Addictions and Related Disorders
- Trauma and Stressor Related Disorders
- Dissociative Disorders
- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders
- Sleep-Wake Disorders
- Sexual Dysfunctions
- Gender Dysphoria
- Disruptive, Impulse Control, and Conduct Disorders
- Paraphilic Disorders



Why is this an issue?

- **67% of individuals with a behavioral health disorder do not get behavioral health treatment¹**
- **30-50% of referrals** to behavioral health from primary care don't make first appt^{2,3}
- Two-thirds of primary care physicians reported **not being able to access** outpatient behavioral health for their patients⁴ due to:
 - Shortages of mental health care providers
 - Health plan barriers
 - Lack of coverage or inadequate coverage
- **Depression goes undetected** in >50% of primary care patients⁵
- **Only 20-40% of patients improve** substantially in 6 months without specialty assistance⁶

Sources: ¹Kessler et al., NEJM. 2003;350:1141-23. ²Fisher & Ransom, Arch Intern Med. 1997;157:324-323. ³Hoge et al., JAMA. 2006;305:1023-1032. ⁴Cunningham, Health Affairs. 2009; 33:490-491. ⁵Mitchell et al. Lancet. 2009; 374:609-619. ⁶Schulberg et al. Arch Gen Psych. 1996; 53:913-919

Study reviewing Health Risk data and cardiac disease

- Tobacco use
- Hypertension
- Obesity
- Elevated cholesterol
- High blood glucose
- Sedentary lifestyle
- Stress
- Depression
- Excessive use of alcohol

• #1 ?

• #2 ?

J Occup Environ Med 2001 May;43(3):201.

Modifiable Health Risk Behaviors

- Low physical Activity
- Poor nutrition
- Excessive alcohol use
- Sleep
- Tobacco use



TABLE 6. STAGES-OF-CHANGE CHARACTERISTICS AND STRATEGIES

STAGE	CHARACTERISTICS	STRATEGIES
Precontemplation	The person is not even considering changing. They may be "in denial" about their health problem, or not consider it serious. They may have tried unsuccessfully to change so many times that they have given up.	Educate on risks versus benefits and positive outcomes related to change
Contemplation	The person is ambivalent about changing. During this stage, the person weighs benefits versus costs or barriers (e.g., time, expense, bother, fear).	Identify barriers and misconceptions Address concerns Identify support systems
Preparation	The person is prepared to experiment with small changes.	Develop realistic goals and timeline for change Provide positive reinforcement
Action	The person takes definitive action to change behavior.	Provide positive reinforcement
Maintenance and Relapse Prevention	The person strives to maintain the new behavior over the long term.	Provide encouragement and support

Source: Zimmerman et al., 2000; Tabor and Lopez, 2004

Assisting in health behavior change

- **MOTIVATIONAL INTERVIEWING:**
- It is based on 4 core principles:
 - Express empathy (i.e, lecturing/shame doesn't work...)
 - Develop discrepancy (between current and desired behavior-change takes time)
 - Roll with resistance (everyone is ambivalent)
 - Support self-efficacy (individual autonomy)

Variables re: behavioral health in primary care

- Emergent
- Urgent
- Routine/Chronic Disease Management*
- Illness/Behavior
- Severity
- Supports

Question:

- According to *Psychiatric Services* (2009), roughly _____% of psychotropic medications prescribed by physicians are prescribed by non-psychiatrists.
 - 35%
 - 50%
 - 65%
 - 80%

Ballpark....

of psychotropics frequently seen in primary care:

- Antidepressants: 15
- Mood stabilizers: 7
- Antipsychotics: 12
- ADHD meds: 10
- Alzheimer's meds: 4
- Sleep meds: 5
- Anti-anxiety meds: 7
- 60



So, what are our options?

- 1) Business as usual...
- 2) Screening
- 3) Consultation
- 4) Co-location
- 5) Collaboration

To Fractionate, or
Not to Fractionate: That is the Question



What is “Integrated Care?”

- “the systematic coordination of general and behavioral healthcare.”



Many of Integrated Care Models- However...

- Behavioral Health in Primary Care.
(By far far far the most common)
- Primary Care in Mental Health
- Primary Care in Behavioral Health

State Examples

- California: The Integrated Behavioral Health Project (IBHP)
- The Massachusetts Child Psychiatry Access Project (MCPAP)
- DIAMOND (Depression Improvement Across Minnesota Offering a New Direction)
- Missouri: Community Mental Health Case Management (CMHCM)
- ICARE Partnership North Carolina Project
- Tennessee: Cherokee Health Systems Model
- Vermont Blueprint for Health
- Washington IMPACT program

Integration: An Evolving Relationship

Consultative Model

- Psychiatrists sees patients in consultation in his/her office - away from primary care

Co-located Model

- Psychiatrist sees patients in primary care

Collaborative Model

- Psychiatrist provides caseload consultation about primary care patients; works closely with primary care providers (PCPs) and other primary care-based behavioral health providers (BHP)

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Source: <http://uwaims.org>

Patient-Centered Medical Home

A PCMH is not a PCMH without Behavioral Health

Core Principles of **Effective** Collaborative Care

Patient-Centered Care Teams

- Team-based care: effective collaboration between PCPs and Behavioral Health Providers.
- Nurses, social workers, psychologists, psychiatrists, licensed counselors, pharmacists, and medical assistants can all play an important role.

Population-Based Care

- Behavioral health patients tracked in a registry; no one 'falls through the cracks'.

Measurement-Based "Treat to Target"

- Measurable treatment goals clearly defined and tracked for each patient.
- Treatments are actively changed until the clinical goals are achieved – "treat to target".

Evidence-Based Care

- Treatments used are 'evidence-based'.
- Pharmacology, brief psychotherapeutic interventions, models.

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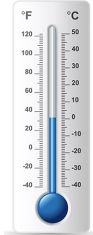
Source: <http://u.waimes.org>

Collaborative Care

- Collaborative Care is a specific type of integrated care that operationalizes the principles of the chronic care model to improve access to evidence based mental health treatments for primary care patients.

- Collaborative Care is:

- Team-driven collaboration and Patient-centered
- Evidence-based and practice-tested care
- Measurement-guided treatment to target
- Population-focused
- Accountable care

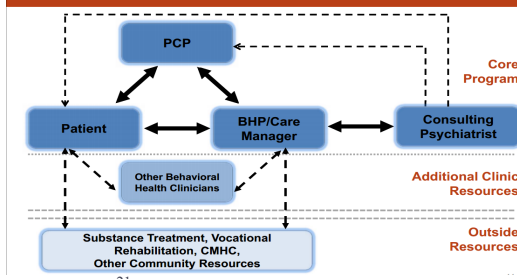


<http://u.waimes.org>

Collaborative Care

Collaborative care *optimizes* all behavioral health resources

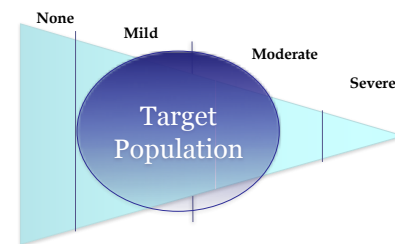
Collaborative Team Approach



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Source: <http://u.waimes.org>

"Sweet" Spot for the Collaborative Care Model



- Issues with depression and substance abuse must be pre-empted, rather than treated once advanced.
- Goal is to detect early and apply early interventions to prevent from getting more severe

Health Management Associates/L. Raney

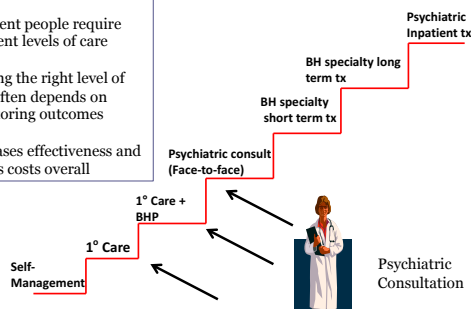
- Uses limited resources to their greatest effect on a population basis

- Different people require different levels of care

- Finding the right level of care often depends on monitoring outcomes

- Increases effectiveness and lowers costs overall

Stepped Care Approach



Van Korff et al 2000

Recent add for a "consulting psychiatrist"

Essential Duties and Responsibilities:


- Provide regularly scheduled consultation to participating primary care practices. Consultations will focus primarily on patients who are new to behavioral health treatment or who are not improving as expected.
- Provide phone consultation to primary care physicians (PCPs) as requested. Response time should be within 24 hours for low priority calls and 1-2 hours for urgent calls, if possible, within normal working hours.
- Work with participating practices to track and oversee patient outcomes using an integrated health model.
- Suggest treatment plan changes including medication recommendations for patients.
- Discuss patients who may need referral for additional behavioral health care and advise on treatment plans during the transition period to ensure continuity of care.
- Utilize electronic medical record (EMR) of the primary care practices to document patient information, referrals or other relevant information as required.
- Adhere to all compliance procedures relevant to protected health information (PHI) and HIPAA regulations.
- Communicate clearly to PCPs, care coordinators, or other designated contacts for the practices regarding limitations of consultation and treatment recommendations, if relevant.
- Maintain communication flow in relevant e-mail systems including a response time within 2 business days generally. Urgent e-mail should be responded to as soon as possible.
- Participate in weekly, monthly, or quarterly consult meetings as assigned.
- Provide on-site time at each participating practice at least monthly. On-site work may include meeting PCPs, care coordinators, or other designated staff, discussing procedures and coordinating services, provider education, case presentation, and in-person evaluation of patients.
- Participate in and/or provide training related to this position.

Caseload Review								
MRN	Name	Status	Date follow up due	Actual contact	PHQ-9	% change	GAD-7	% change
1236	Robert Sled	Active	2/1/17	2/4/17	15	0%	11	0%
			2/15/17	2/15/17	13	-13%	11	0%
			3/9/17	3/10/17	15	0	9	-18%
			3/23/17	3/23/17	13	-13%	6	-45%
			4/6/17	4/7/17	12	-20%	7	-36%
			4/20/17	4/20/17	11	-27%	7	-36%
			5/04/17	5/04/17	9	-40%	6	-45%

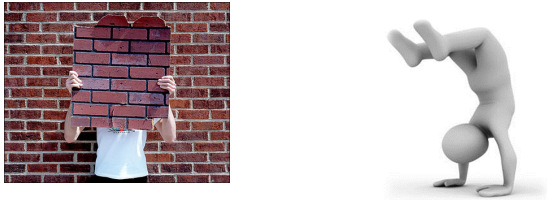
<https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data>

Disciplines-(examples)not all-inclusive...

- RNs
- LPNs
- APRNs
- Social Workers
- Therapists
- Psychologists
- LACs
- Physicians
- PA-Cs
- OTs
- PTs



What type of individual does it take for this type of model to be successful?



We couldn't possibly...

- Fill in the blank _____

So, all parties must be flexible

- Who is usually the Behavioral Health Care Manager?

MSW, LCSW, MA, RN

- If also a behavioral health provider, can be PhD, PsyD, LAC, etc..

SBIRT (screening, brief intervention, referral to treatment)

- **SBIRT CONSISTS OF THREE MAJOR COMPONENTS:**
- **Screening** — a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting
- **Brief Intervention** — a healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice
- **Referral to Treatment** — a healthcare professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services

• <http://www.integration.samhsa.gov/clinical-practice/SBIRT>

Screening Tools

Find one you are comfortable with, such as:

- (for substance use/SBIRT): AUDIT, MAST, CAGE-AID, ASSIST
- PHQ-2/9 Symptom Checklist
- GAD-7
- Mood Disorder Questionnaire
- AIMS

- Reporting and collaboration (NOMs/PQRS/NCQA)
- Many of the must-pass elements are behavioral health:
 - Practice Team (Team-Based Care)
 - Use Data for Population Mgt.
 - Care Planning and Self-Care Support
 - Referral Tracking and Follow-up
 - Implement Continuous Quality Improvement

Point of Care Guide

Screening Tests for Depression, Alcohol Problems, and Domestic Violence

Screening for depression:
During the past month:

Have you often been bothered by feeling down, depressed, or hopeless? ☐ Yes ☐ No

Have you often been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No

Screening for alcohol use disorder:
For men: When was the last time you had more than five drinks in one day?
☐ Never ☐ In the past three months ☐ Over three months ago

For women: When was the last time you had more than four drinks in one day?
☐ Never ☐ In the past three months ☐ Over three months ago

Screening for intimate partner violence:
Have you been hit, kicked, punched, or otherwise hurt by someone in the past year?
Do you feel safe in your current relationship?

☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No

Is there a partner from a previous relationship who is making you feel unsafe now?
Yes No

Interpretation*:
Positive screen for depression is answering "Yes" to either question.
Positive screen for alcohol use disorder is answering "In the past three months."
Positive screen for intimate partner violence is answering "Yes" to any of the three questions.

*~Interpretations should not be included on the screening form. They should be memorized by the physician.

Same Day Services:

- Mental health care services (which, under the Medicare Program, includes treatment for substance use disorder);
- Alcohol and/or substance (other than tobacco) abuse structured assessment, and intervention services (SBIRT services) billed under HCPCS codes G0396 and G0397; and
- Primary health care services.
- Medicare Part B pays for reasonable and necessary integrated health care services when they are furnished on the same day, to the same patient, by the same professional or a different professional. This is regardless of whether the professionals are in the same or different locations.

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Mental-Health-Services-Booklet-ICN903195.pdf>

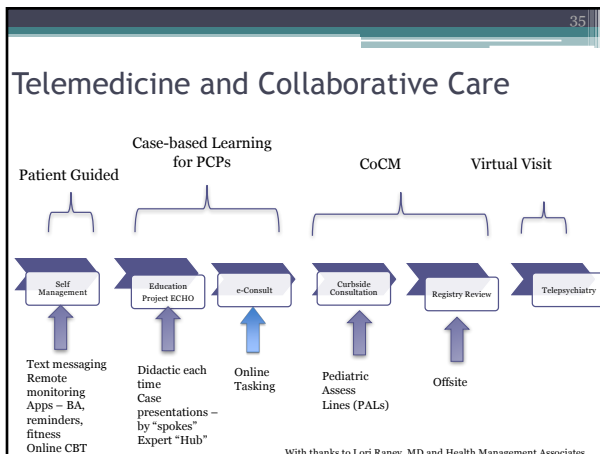
What is the Future Looking Like?




Telemedicine



- Setting
- Equipment
- Credentialing
- Services
- Payment




Popular Model



Project ECHO: A Revolution in Medical Education and Care Delivery

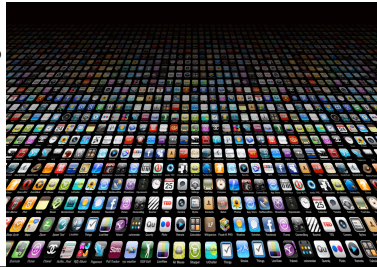
Project ECHO is a lifelong learning and guided practice model that revolutionizes medical education and exponentially increases workforce capacity to provide best-practice specialty care and reduce health disparities. The heart of the ECHO model is its hub-and-spoke knowledge-sharing networks, led by expert teams who use multi-point videoconferencing to conduct virtual clinics with community providers. In this way, primary care doctors, nurses, and other clinicians learn to provide excellent specialty care to patients in their own communities.



- People need access to specialty care for their complex health conditions.
- There aren't enough specialists to treat everyone who needs care, especially in rural and underserved communities.
- ECHO trains primary care clinicians to provide specialty care services. This means more people can get the care they need.
- Patients get the right care, in the right place, at the right time. This improves outcomes and reduces costs.

Mental Health Start-Up Companies

- Is there an app for that?
- 6 months ago: around 250
- As of this week, 353



Will this

- Increase demand in your office by increasing awareness?
- Reduce demand by allowing other access from other treatment providers?
- Complicate care due to lack of information sharing, or lack of evidence-based treatment?

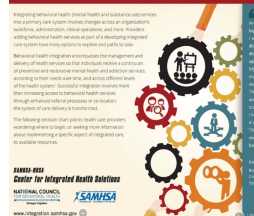
Data and communication

- HIPAA
- 42 CFR(2)



Resources

A QUICK START GUIDE TO BEHAVIORAL HEALTH INTEGRATION FOR SAFETY-NET PRIMARY CARE PROVIDERS



IMPACT Evidence-based depression care AIMS CENTER | UNIVERSITY OF WASHINGTON Psychiatry & Behavioral Sciences

Please visit the AIMS Center website for up to date information on other evidence-based Collaborative Care programs and new implementation resources

AIMS.UW.EDU

RSRHC specifically addresses the U.S. Surgeon General's 2003 National Strategy for Suicide Prevention's Objective 7 to identify and promote effective clinical and professional practices in primary care settings, and Objectives 1 and 2 to implement training for recognition of crisis, behavior and delivery of effective treatment by nurses, physician assistants, and medical residents.

The RSRHC was developed by the American Association of Suicideologists (AAS) with funding from the Irving and Barbara C. Cook Charitable Fund to provide physicians, nurses/nurse practitioners, and physician assistants with the knowledge they need in order to identify suicide risk assessment in routine office visits, to elicit risk when it exists, and work with patients to create treatment plans to reduce risk.

AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of research and programs, efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services.

For pricing information, please contact AAS.

AMERICAN ASSOCIATION OF SUICIDOLOGISTS
5221 Wisconsin Ave, NW 2nd Floor
Washington, DC 20015-2022
Phone (202) 237-2180
Fax (202) 237-2382
www.aasus.org
aas@suicidology.org

Recognizing and Responding to Suicide Risk in Primary Care
Information Brochure

25% of those who died by suicide visited their PCP within 24 hours prior to their death.

You could be the last medical professional seen by a patient on the brink of a life or death decision.

Sponsored by
Northeast Ohio Mental Healthcare

for RURAL PRIMARY CARE PRACTICES

<http://www.sprc.org/for-providers/primary-care-tool-kit>

Questions, thoughts?

