
The Future of the Medical & Mental Health Collaboration

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Session Objectives

- At the close of the presentation, participants will understand how to:
 - Make the case to administration for the necessity of integrating behavioral health services into primary care.
 - Match a program of evidence based behavioral health services in primary care to local fiscal and organizational contingencies.
 - Add behavioral health services to an implementation of a Patient Centered Medical Home.

Primary Care is the future.

- **Primary care is our best venue for improving population health and for controlling medical cost.**
- **Primary Care is the only thing you can do MORE OF and get lower cost and better care**

The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation's Health Care:
A Report from the American College of Physicians January 30, 2006

EXHIBIT 9

Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000

Spending per beneficiary (dollars)

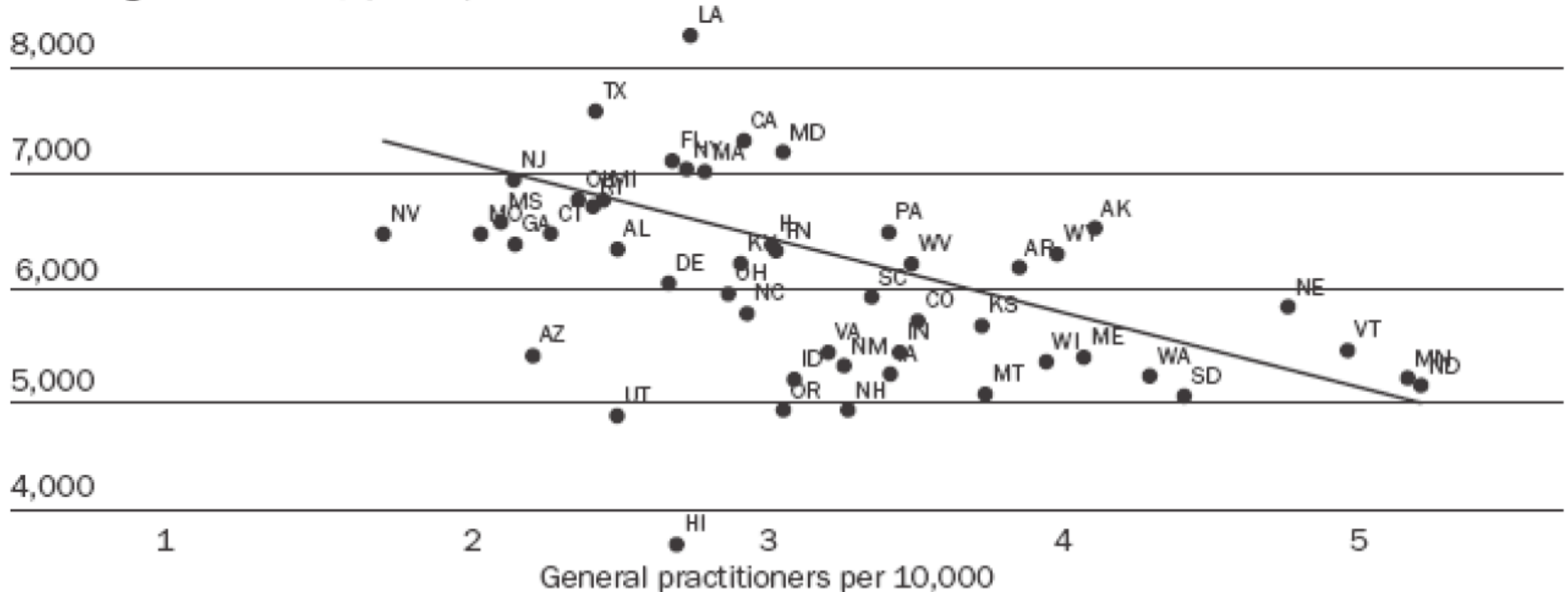
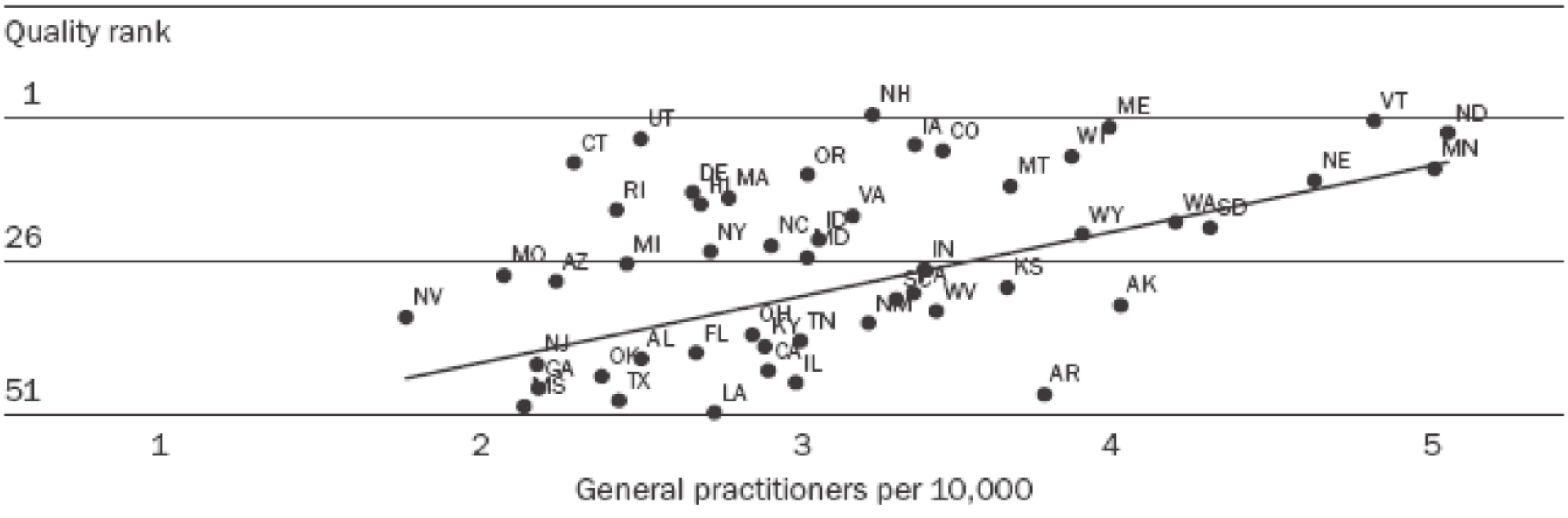


EXHIBIT 8

Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000



SOURCES: Medicare claims data; and Area Resource File, 2003.

NOTES: For quality ranking, smaller values equal higher quality. Total physicians held constant.

PCMH team is a chance to save PCPs from deserting just as their value is documented

Primary Care providers are the lowest paid medical specialties

-A PCP with a panel of 2500 patients would spend:

- 7.4 hours per day to deliver all recommended preventive care
 - [Yarnall et al. Am J Public Health 2003;93:635]
- 10.6 hours per day to deliver all recommended chronic care services
 - [Ostbye et al. Annals of Fam Med 2005;3:209]
- **Something has got to give! PCMH promotes payment reform and team-based care.**
 - Can fund services that increase value and outcome
 - Can take some of the burden from PCPs

PCMH is getting traction.

- Often mentioned and promoted in the Affordable Healthcare Act.
- Health plans offering enhanced payments for practices with certification by National Committee for Quality Assurance (NCQA).
- New 2011 Guidelines from NCQA require behavioral health services, including one of three care programs for chronic illness being a behavioral illness (level 3).

Behavioral Health Services in Primary Care and the Patient Centered Medical Home

Behavioral Health Needs Assessment in Primary Care

- Mental Health
- Substance Abuse
- Health Behavior Change
- “Ambiguous” Illnesses
- Chronic Illness
- Culturally Syntonic Approaches

Behavioral Health Needs Assessment in Primary Care

	PHQ-3000	Merillac 500
■ Major Depression	= 10%	24%
■ Panic Disorder	= 6%	16%
■ Other Anxiety Disorders	= 7%	21%
■ Alcohol Abuse	= 7%	17%
■ Any Mental Health Dx	= 28%	52%

Prevalence of Behavioral Health Problems in Primary Care

Unhealthy Behaviors

- Smoking = 20%
- Obesity = 30%
- Sedentary lifestyle = 50%
- Non-adherence = 20 - 50%

“Ambiguous Illness”

The vast majority of primary care complaints are related in some way to behavioral factors but not to diagnosed mental disorders.

Kroenke, K. & Mangelsdorff, A. D. (1989). Common symptoms in ambulatory care: Incidence, evaluation, therapy and outcome. *American Journal of Medicine*, 86, 262-266

10 most common complaints in adult primary care

15% x organic pathology found
(Kroenke & Mangelsdorff, 1989)

chest pain	back pain
fatigue	shortness of breath
dizziness	insomnia
headache	abdominal pain
swelling	numbness

Chronic conditions that require behavioral health component in standard of care protocols:

- Asthma
- Diabetes
- CVD
- Irritable Bowel Syndrome
- Obesity
- Substance Abuse

Depression with Chronic Illnesses:

- Increased rates of depression in patients with:
 - Congestive Heart Failure
 - Diabetes
 - COPD
- Patients with chronic illness and depression 2-5x the healthcare cost of patients with chronic illness alone
- Depression is the common factor in patients disabled (compared with pts equally sick but not disabled) by hypertension, asthma, arthritis, ulcers.

Bachman, J. http://www.wpic.pitt.edu/dppc/downloads/Depression_in_Disease_Management_Practices_for_Chronic_Conditions_FINAL.doc

Culture Impacts Depression

Culturally Syntonic Approaches

Signs of Depression found Cross-Culturally

- Appetite changes
- Sleep changes
- Psychomotor agitation or retardation
- Decreased energy
- Decreased libido
- Diminished ability to think or concentrate

Signs of Depression found in “Western” Cultures

- Self-deprecation
- Hopelessness
- Guilt
- Suicidality

Pfeiffer, W. (1968). The symptomatology of depression viewed transculturally. *Transcultural Psychiatry Research Review* 5: 121-123.

We use different words in different contexts.

Depression

= ?

Somatization

= ?

Anxiety

Correlates of Somatization in the United States

- lower socioeconomic class
- traditionally oriented ethnic groups
- blue collar workers
- rural living
- lower educational levels

Katon, W., Kleinman, A. & Rosen, G. (1982). Depression and somatization: a review, Parts I & II. *American Journal of Medicine* 72: 127-135, 241-247, page 131.

Underserved and Minority Populations are Particularly Affected

“...racial and ethnic minorities are less inclined than whites to seek treatment from mental health specialists. Instead, studies indicate that minorities turn more often to primary care.”

Surgeon General's Report on Mental Health, 1999. Supplement on Culture, Race and Ethnicity

Typical Morning in Practice*

- 56 yo diabetic with poor control
- 19 yo smoker for P.E.
- 33 yo with multiple somatic complaints
- 7 yo w/otitis media
- 67 yo w/insomnia
- 70 yo w/sinusitis
- 52 yo hypertensive patient
- 45 yo w/tinnitus
- 38 yo w/acute asthma
- 29 yo w/chest pain & SOB

* Thanks to Tom Campbell, MD

Typical Morning in the Office

MENTAL HEALTH DISORDERS

- 56 yo diabetic with poor control **OLD Dx BPD**
- 19 yo smoker for P.E.
- 33 yo with multiple somatic complaints **DEPRESSION**
- 7 yo w/otitis media
- 67 yo w/insomnia **ALCOHOL ABUSE**
- 70 yo w/sinusitis
- 52 yo hypertensive patient
- 45 yo w/tinnitus
- 38 yo w/acute asthma
- 29 yo w/chest pain & SOB **PANIC DISORDER**

Typical Morning in the Office

PSYCHOSOCIAL DISTRESS

- 56 yo diabetic with poor control ANXIETY
- 19 yo smoker for P.E.
- 33 yo with multiple somatic complaints
- 7 yo w/otitis media BED WETTING
- 67 yo w/insomnia
- 70 yo w/sinusitis FAMILY VIOLENCE
- 52 yo hypertensive patient
- 45 yo w/tinnitus HYPOCHONDRIASIS
- 38 yo w/acute asthma
- 29 yo w/chest pain & SOB

Typical Morning in the Office

BEHAVIORAL NEEDS

- 56 yo diabetic with poor control
- 19 yo smoker for P.E.
- 33 yo with multiple somatic complaints
- 7 yo w/otitis media
- 67 yo w/insomnia
- 70 yo w/sinusitis
- 52 yo hypertensive patient
- 45 yo w/tinnitus
- 38 yo w/acute asthma
- 29 yo w/chest pain & SOB

SMOKING/WEIGHT SMOKING CESSATION

CARDIAC RISK FACTORS

MED. COMPLIANCE

Typical Morning in the Office

FEASIBILITY OF REFERRAL

- 56 yo diabetic ANXIETY *“MEDICAL”*
- 19 yo smkr SMOKING CESS. *PRE-CONTEMPLATION*
- 33 yo somatic DEPRESSION *CULTURAL FACTORS*
- 7 yo w/otitis ENURESIS *PHYSICIAN EXP. PROVIDER*
- 67 yo insomnia ETOH *TELLS PHYS. FOR HEALTH*
- 70 yo sinusitis FAM. VIOL. *FEARS REVELATION*
- 52 yo hyperten. CARDIAC *NOT COVERED*
- 45 yo tinnitus HYPOCHND. *FEELS BLAMED*
- 38 yo asthma MED. COMPL *FAMILY ISSUES*
- 29 yo chest pain PANIC *POSSIBLE REFERRAL*

Interlude



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UMass Medical School

Categories of Relationship between Collaborating Medical and Behavioral Health Services

- **Coordinated** = Behavioral services by referral at separate location with formalized information exchange.
- **Co-Located** = By referral at medical care location
- **Integrated** = Part of the “medical” treatment at medical care location

Coordinated Care

- **Coordinated care elements:**
 - appointment arrival notification
 - clinical information exchange protocols
 - coordinated treatment planning
 - Example of eating disorder care.

- **Originally the model advocated for PCMH for behavioral health.**

- **Bartels et al. found “enhanced referral” still 50% less effective than co-location for access.** (Bartels, Coakley, Zubritsky, et al. Am J Psych, 2004)

- **Phone outreach programs (Wang, et al, JAMA, Sept 26, 2007, 14-1-1411.)**

- **Massachusetts Child Psychiatry Access Program**
 - **Built on a consultative model**

Co-located

BHP working in primary care seeing all referred.

Advantages:

Access

Patient Satisfaction

Provider Satisfaction

Cost Effectiveness

Clinical Outcome (in most studies)

Problems:

Referrals don't show

Case-loads fill up

Length of treatment in specialty mental health care vs. **Co- Located** behavioral health care:

- Specialty mental health care: 6.2 visits
- Co-Located behavioral hlth. care: 3.2 visits

Simpson, R. (1998). Developing a behavioral health system of care. In, Blount, A. (Ed.), *Integrated Primary Care: The Future of Medical and Mental Health Collaboration*. NY: WW Norton.

Making Co-Location Work

BHC in health center - 7 sessions/wk.

■ **Patients attending first visit w. BHP when scheduled by physician w/o introduction: 40%**

■ **Patients attending first visit w. BHP when scheduled after introduction by physician: 76%**

N=80, p= <.01

Apostoleris, N. & Blount, A. In preparation.

Information Exchange Between **Co-Located** Providers

- **Blanket information release with the goal of enhancing primary care**
- **Behavioral health clinician asks how PCP prefers to get info.**
- **Curbside consultations**
- **Forms for email**
- **Behavioral health rounds**

INTEGRATED

BHC working in primary care as part of a team delivering care through a single treatment plan.

- Expanded care management - **IMPACT**
- Behavioral Health Consultant model

Advantages:

Access
Patient Satisfaction
Provider Satisfaction
Fits MH. protocols **IMPACT**
Fits Med. protocols **BHC**
Cost Effectiveness and Offset
Clinical Outcome
Outcome Maintenance **IMPACT**

Problems:

Sometimes narrowly **IMPACT**
focused
May not provide much alt. to
individ. focus of medical approach



The IMPACT Treatment Model

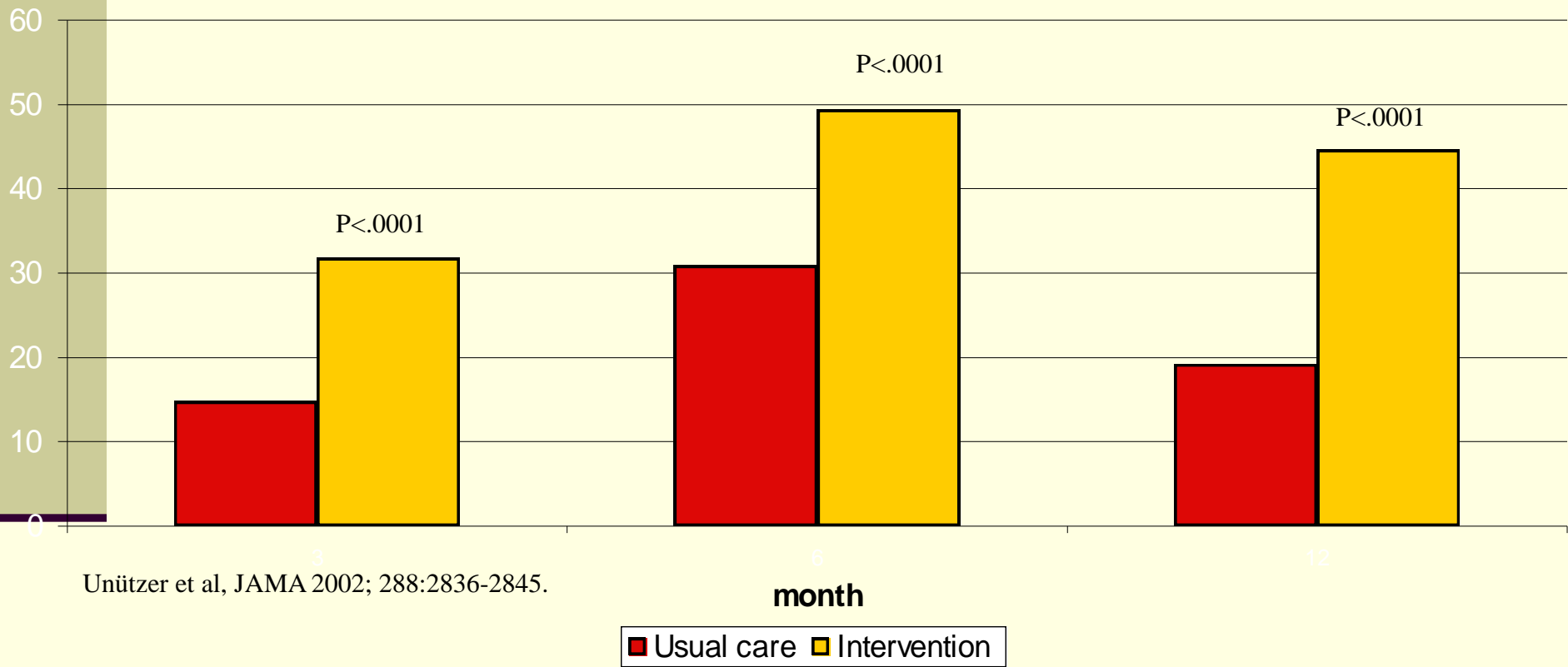
<http://uwaims.org/about.html>

- **Collaborative care model includes:**
 - **Care manager: Depression Clinical Specialist**
 - **Patient education**
 - **Symptom and Side effect tracking**
 - **Brief, structured psychotherapy: PST-PC**
 - **Consultation / weekly supervision meetings with**
 - **Primary care physician**
 - **Team psychiatrist**
- **Stepped protocol in primary care using antidepressant medications and / or 6-8 sessions of psychotherapy (PST-PC)**



Substantial Improvement in Depression ($\geq 50\%$ Drop on SCL-20 Depression Score from Baseline)

Response ($\geq 50\%$ drop on SCL-20 depression score from baseline)

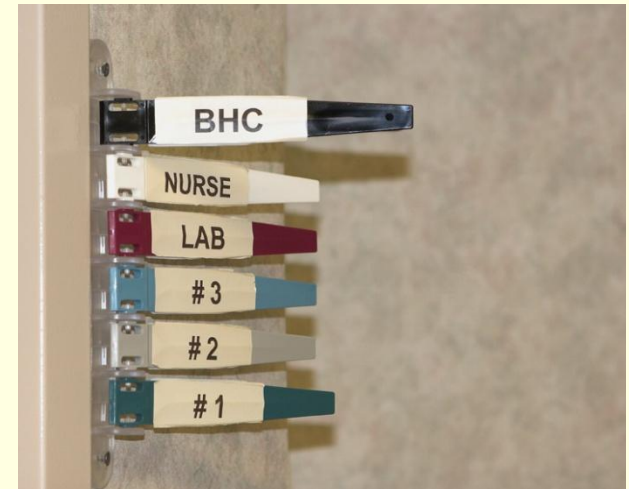


Unützer et al, JAMA 2002; 288:2836-2845.

Behavioral Health Consultant

- Management of psychosocial aspects of chronic and acute diseases

- Application of behavioral principles to address lifestyle and health risk issues



- Consultation and co-management in the treatment of mental disorders and psychosocial issues

■ Model developed by Kirk Strosahl, PhD

Details of Behavioral Health Consultation Model

Robinson outline:

- **Healthcare rather than psychotherapy mode**
- **Contacts a combination of unscheduled, scheduled with medical provider and scheduled with BHC**
- **Highly productive**
 - **7 ½ hr initial contacts /day**
 - **7 ¼ hr follow-up contacts /day**
 - **14 7.5 min consultations to MDs /day**

Robinson & Reiter, 2007. *Behavioral Health Consultation and Primary Care*

- **Very few programs are that organized, but more every day**
- **People should not imagine that anything else is “off model”**
- **With streamlined recordkeeping and billing processes, the MH billing and increased physician output, plus upcoding, and HB codes, it barely works financially in most states. Few are that organized.**

Integration: Beyond Co-Location

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Integrated Care

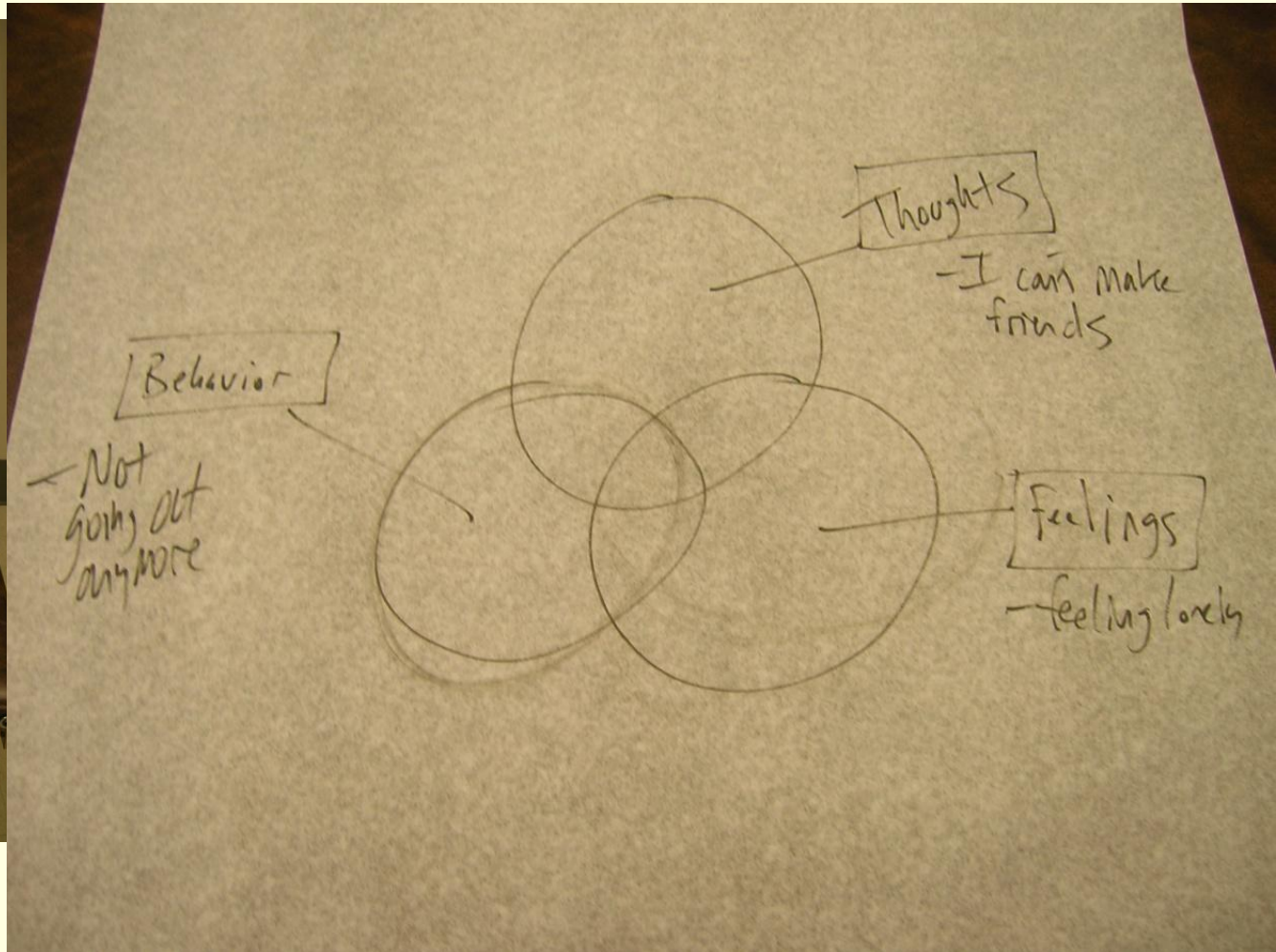
- Embedded member of primary care team
- Patient contact via hand off
- Verbal communication predominates
- Brief, aperiodic interventions
- Flexible schedule
- Generalist orientation
- Behavior medicine scope

Co-Located Mental Health

- Ancillary service provider
- Patient contact via referral
- Written communication predominates
- Regular schedule of sessions
- Fixed schedule
- Specialty orientation
- Psychiatric disorders scope

CBT in the Exam Room

- 1) CBT picture
- 2) Thought stopping or behavioral activation



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Cherokee Health Systems

A Federally Qualified Health Center and
Community Mental Health Center

Corporate Profile

Founded: 1960

Services:

Primary Care - Community Mental Health - Dental - Corporate Health Strategies

Locations:

21 clinical locations in 14 Tennessee Counties

Behavioral health outreach at numerous other sites including primary care clinics, schools and Head Start Centers

Number of Clients: 58,561 unduplicated individuals served - 24,958 Medicaid (TennCare)

New Patients: 19,829

Patient Services: 442,626

Number of Employees: 538

Provider Staff:

Psychologists - 40

Primary Care Physicians - 31

NP/PA (Primary Care) - 17

Master's level Clinicians - 59 Case Managers - 29

Psychiatrists - 13

NP (Psych) - 7

Pharmacists - 9

Dentists - 2

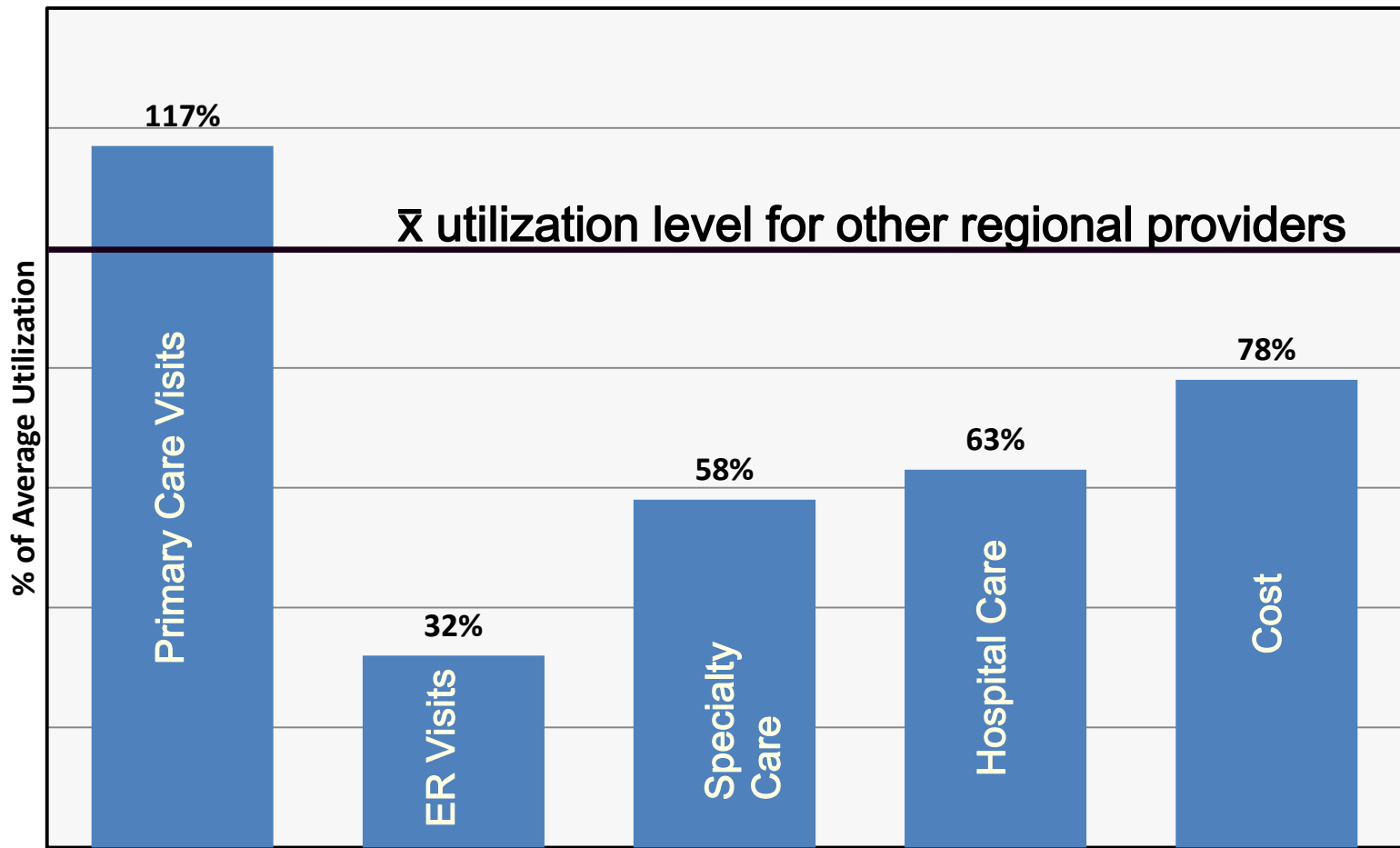


Figure 1: Comparison of CHS utilization with regional providers

Comparing the two “Integrated Models”

■ **IMPACT**

- Inductively derived by disease (first with depression, then some work with anxiety, now with diabetes and depression)
- Stronger clinical evidence because it was designed to be done in trials
- Developed and guided by psychiatrists
- Developed serving elderly population
- Some cost and satisfaction evidence as well

■ **Behavioral Health Consultant model**

- Deductively derived (what makes the best contribution to a primary care practice)
- Clinical evidence is promising but less well controlled
- Developed and guided by psychologists with other discipl.
- Developed to serve all ages
- Very strong cost and satisfaction evidence

Relationship with “Specialty Mental Health”

- **Still important for longer term care**
- **Makes referrals to SMH more likely to be successful**
- **Specialty MH able to better target high need populations**
- **Consultation backup to PCP**
- **In some systems SMH has developed specialized teams to support generalist PCBH clinician**

Role of Psychiatry in Primary Care

- Any practice offering psychotropic meds in primary care ideally should have psychiatric input and back-up.
 - Continuity of care problems crop up at the point the PCP feels s/he cannot go further with medication.
 - Reviews of PCP's prescribing patterns show less than half prescribing in evidence-based fashion.
 - We are starting to have protocols for prescribing patterns with PC depressed pts. (STAR*D)
- HMO systems that integrated (Kaiser and Group Health) had 1 BHP per 5-6 PCPs and one psychiatrist per 20-40.
- Programs like MCPAP are good examples of population based approaches to psychiatric back-up.
- NC Medicaid pays for psychiatric consult w/o pt.

Integrated Care Requires New Ideas About “Disciplines”

- Depression care managers – MSWs, nurses, psychologists, NPs and PAs
- Certificate Program at UMass has trained all of the above plus LMHCs, MFTs, psychiatrists, SA counselors
- Care Managers/Coordinators in the PCMH need both behavioral health skills and medical knowledge.
 - Medically trained people must be “behaviorally enhanced”
 - Behaviorally trained people must be “medically enhanced”
- Paraprofessional counselors – community health workers, promotoras, (tradition from MH adapted to PC)
- **Modular skill sets vs. disciplines**

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Generalist Behavioral Health Clinician

- **Care Management**
- **Brief Therapy**
 - **Cognitive-behavioral**
 - **Solution-focused**
- **Behavioral Medicine**
 - **Relaxation/biofeedback/hypnosis**
 - **Health behavior change**
- **Family Therapy**
- **Substance Abuse Counseling**
- **Child Development**
- **Psychotropic medication input**
- **Groups and Patient Education**
- **Community Outreach**
- **Organizational transformation agent**

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Why Primary Care behavioral health is difficult for clinicians trained only in specialty mental health

- **Treat somewhat different population than in Specialty Mental Health services.**
 - **Less disturbed and less diagnostically clear**
 - **Won't accept "mental health" definition of the problems they bring**
 - **Broader array of needs.**
 - **BHC must understand medical conditions and practice behavioral medicine and substance abuse care in addition to mental health**
- **Status as ancillary provider**
- **Different routines of time, confidentiality and instrumentality**
- **Can someone give us an example?**

Who trains Behavioral Health Clinicians?

- Certificate Program in Primary Care Behavioral Health is one formulation of this curriculum.

www.UMassmed.edu/FMCH/PCBH/welcome.aspx

- Other Certificate Programs:

- AIMS Center, University of Washington
- Farleigh Dickinson University

- Arizona State University offers a doctorate in Primary Care Behavioral Health

- Must already have a license to practice.

The Guilds are just getting engaged

- Psychology struggles with distinguishing Health Psychology (specialty) from Primary Care Psychology
 - For internships and post-docs, sort database at www.APPIC.org for “Primary Care”
- Social Work is “already doing that” though “medical social work” is not the background of most MSW BHCs I have met.
- Marriage and Family Therapy – MedFT tends toward a specialty treatment form
- Hybrid programs like Mental Health Counseling and Behavioral Medicine program at Boston University School of Medicine
 - <http://www.bumc.bu.edu/mhbm>
- Primary Care Psychiatry is a recognized entity (there is a journal) but not common in residency programs.
- The Collaborative Family Healthcare Association is leading multi-disciplinary organization committed to collaborative care.
www.CFHA.net
- *Families, Systems, & Health* is the journal of Collaborative Healthcare

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Who trains Primary Care Providers?

- Some Family Medicine Residencies are training providers in integrated practice sites
- I see more interest in Internal Medicine and Pediatric residencies
- Most BHC programs work on a model that the BHC should make most of the adaptations.
 - University of Mass Certificate Program adds PCPs on first workshop.
 - Program for PCPs is on the drawing board at the Center for Integrated Primary Care
 - The transition to team-based care in the PCMH is a perfect time to work on collaborative care routines.
- Free online webinars for PCPs

<http://www.cchealthnetwork.com/about/cchn-events-calendar/on-demand-webcasts-.aspx>

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At the very beginning physicians' perceptions are based on experience with specialty MH & SA

- Until they have worked with a BHP, physicians tend to think of mental health clinicians as uncommunicative.
- When they do communicate, mental health folks want to say too much.
- Mental health folks sometimes make confidentiality a way of protecting turf.
- Physicians not sure what happens in therapy, maybe some kind of catharsis or paid friendship
- Are they psychoanalyzing me?
- Others?

What does the PCP say to the patient and BHC about BHC's role?

- **S** – Situation
- **S** – Skill Set
- **R** – Relationship
- **I** – Indicators

Situation

What is the situation in the care of the patient that makes the PCP want to involve a Behavioral Health Clinician?

Skill Set

What is the skill set that the BHC brings that makes them able to be helpful in the patients care at this time?

BHP defined as the one with the right skill for patient's needs.

Case note:

“KB (15yo) F/u for depression.

Kathy reports still feeling depressed a lot of the time.

Suggested she might make use of counseling service here in the practice.

Says she would consider, but does not want someone who is ‘all nice and happy’

Refer to Dr. Blount who is neither nice nor happy.”

Relationship

What relationship will the patient's work with the BHC have to the overall treatment of the patient?

Indicators

What outcomes would indicate that the involvement of the BHC had been useful to the overall treatment of the patient?

Change your language to engage with and activate your patient

Negative/passive words

Suffers from

Refused to take

Didn't keep apt

Was non-compliant with

Arrived late

Positive/active words

Struggles with

Decided against

Was unable to be here

Had not seen value of

Was determined not to miss

Help me with the list.

Interlude



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Financial

- **Medical billing:**
 - **Increase number of patients seen by physicians. (1/sess.)**
 - **Up-code a visit: Level 3 to Level 4 or 5**
 - **Health and Behavior codes: 96150-96155**
 - **Medicare, many Blues, some Medicaid, some privates**
- **Mental Health billing:**
 - **Bill for small bits of time**
 - **If panels are a problem, primary care docs may help**
- **For medical people, Behavioral Health billing is a nightmare. This is why administrative staff need to feel some buy-in to integrated care.**
- **Expect to pay something for the increase in medical providers enjoyment of the practice.**
- **The PCMH is poised to flip the fee-for-service logic.**

Charting

- Unified charting means social Hx and previous medical Hx already done. Allows much briefer first visit.
- Unified charting may not need to be undifferentiated charting.
- Coming of EHR will make much of this moot.
- Health and Behavior codes charted in medical record as medical services.

Scheduling

- Medical scheduler keeps BHP's book
- Shorter time periods, 30, 20, 15 min.
- Consider an Open Clinic as a way of learning to work differently
- Schedule some free time for introductions and curbside consultations
- Schedule time for conjoint interviews
- On/off scheduling.
- Huddle instead of scheduling.

Advantages of Creating an Integrated Primary Care Program by Starting with Depression Care Management:

- Quick start up
 - Start up to model program in about 3 years
- Care management for MH problem treated as chronic illness. Easiest for PCPs to understand and accept
- BHPs get used to a high volume brief intervention service
- Buncombe County Health Center a good example

Implementing a Program

- Authority of evidence
- Medical champion
- Better patient care trumps all
- Involve all affected staff to the degree they are affected
- Train everyone before implementing
- Roll out date the people can see coming

Be Ready for Effects of Implementation

- **More people to assess**
- **More people to refer out**
 - **Have connections with referral destinations**
- **Lots more conversations about behavioral topics**
- **More consultations**
- **Fall off in screening and referral after 1-2 years**
 - **Opportunity to address other disorders**
- **What are some of your stories?**

Why Should Behavioral Health Be a Core Service of PCMH?

- Access – At least 50% better access to MH care if offered in primary care. (different from managing care across medical specialties) (Bartels, Coakley, Zubritsky, et al. Am J Psych, 2004)
- Complex patients with chronic illnesses needing behavioral health care are more likely to be designated for protocol level of care.
- Behavioral Care in medical setting is a better cultural fit for many patients.
- Behavioral Health Clinicians free up time for PCPs to spend with other patients, while enhancing patient satisfaction and self-efficacy.
- Care management is more effective when done by professionals with behavioral health skills. (Pincus, Pechura, Keyser, et al. Administration & Policy in Mental Health. 33(1):2-15, 2006)

PCMH Care Coordination

(per 2011 Standards)

- Develops written care plans for 75% of patients in the 3 population protocol programs (one behavioral) and for high risk complex patients.
- In many practices, the behavioral protocol is care management for depression.
- Arranges or provides treatment for MH and SA disorders.
- Supports patients and families in self-management, self-efficacy and behavior change.

So, what does all this mean?

- The PCMH model is going to be everywhere, even in mental health centers.
- Bits from all the heritages, case manager, care manager for depression, behavioral health consultant and care coordinator will probably be recognizable in the future version of the job.
- It is likely to be a role for which we will need thousands of properly trained people.

Questions?

- Today
- Future:
 - Alexander.Blount@umassmemorial.org

Certificate Program

www.Umassmed.edu/FMCH/PCBH/welcome.aspx

Further material:

www.IntegratedPrimaryCare.com