

Integration

Primary Care & Behavioral Health



Primary Care

- ▶ Delivers over 50% of all behavioral health (BH) care in West Virginia
- ▶ Primary care (PC) is the largest prescriber of psychotropic medications
- ▶ Psychiatry prescribes 18% of all psychotropic medications
- ▶ Chronic diseases have co-morbid behavioral health components that complicate effective treatment & optimal outcomes
- ▶ 60% of pts. with chronic disease are non-compliant with treatment regimen
- ▶ PCP's have inadequate resources & time to effectively address BH components of care

Behavioral Health

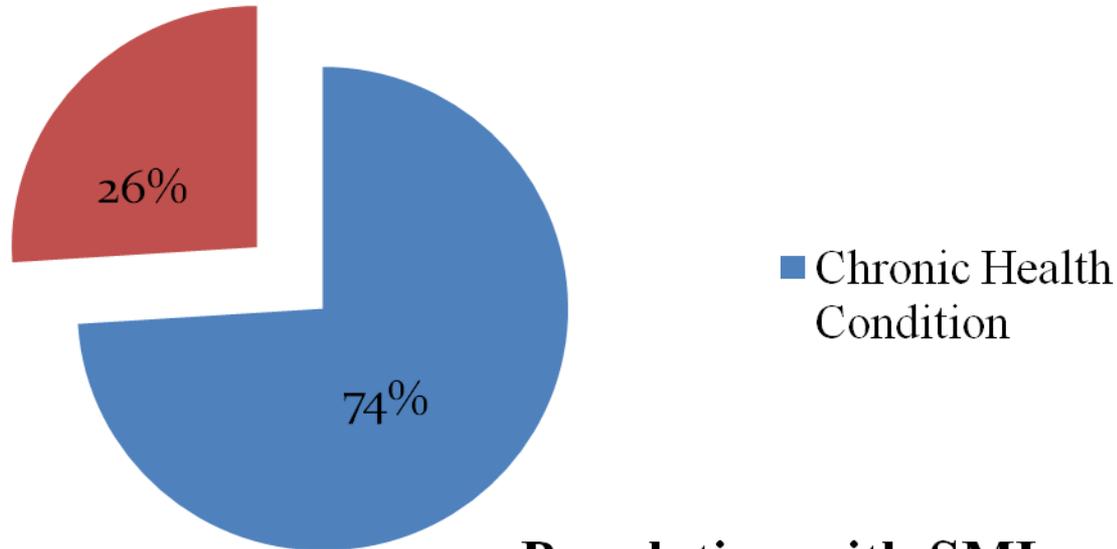
- ▶ BH patients have high levels of chronic disease: diabetes, cardiovascular, etc.
- ▶ Mortality rates for seriously mentally ill (SMI) are higher vs. the general population (SMI die 25 yrs earlier)
- ▶ Co-morbid diseases complicate BH disorders management
- ▶ Co-morbid BH disorders complicate chronic disease management
- ▶ Psychotropic medicines can complicate chronic disease – e.g. mood stabilizers & metabolic syndrome

The Relationship of Premature Death and Serious Mental Illness

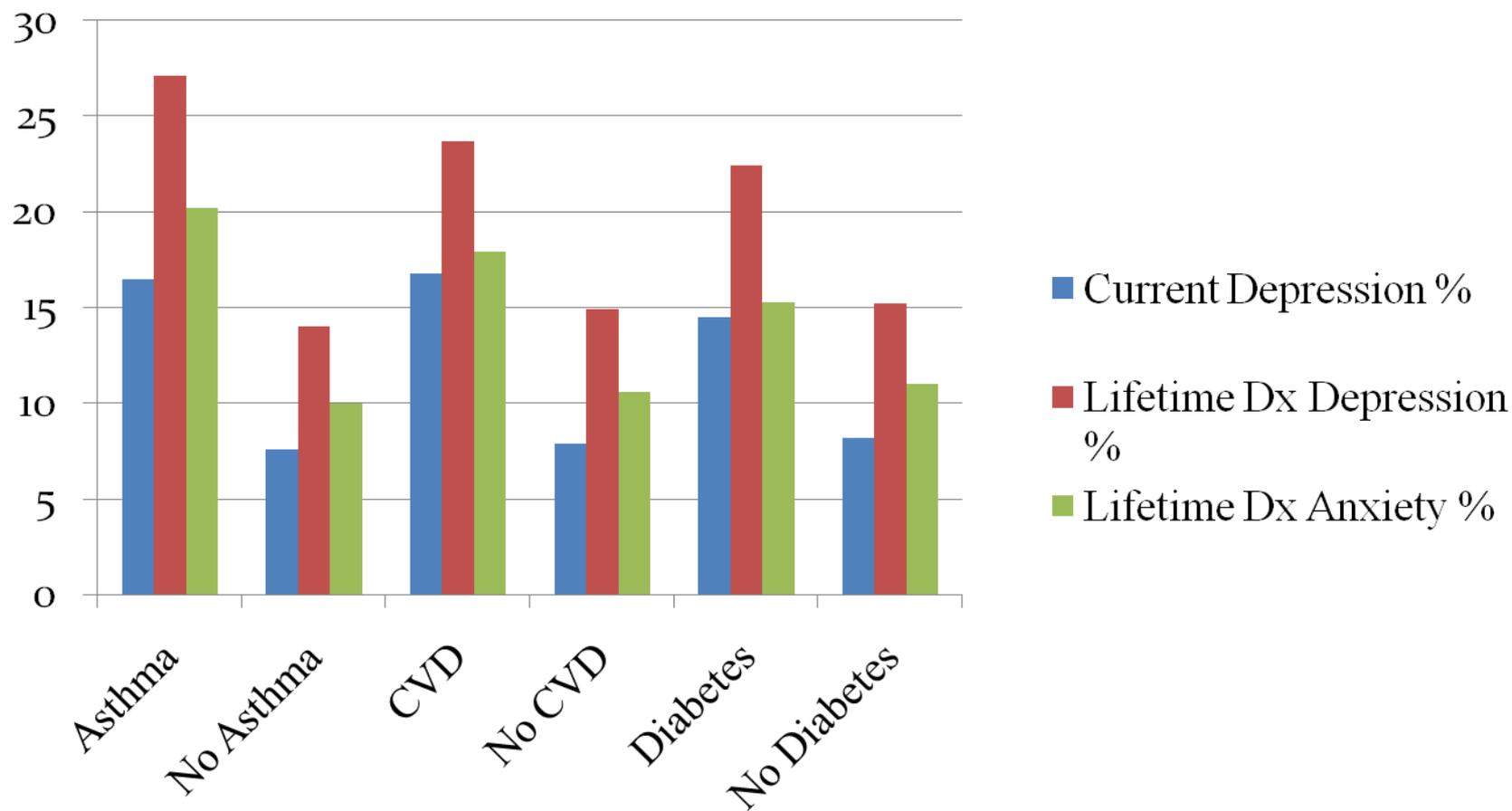
People with severe and persistent mental illness (SMI) **die**, on average, **25 years earlier** than the general population.

People with mental illness often have significant medical issues.

A recent study found a chronic health condition in 74% of a population with SMI (Jones et al., 2004).

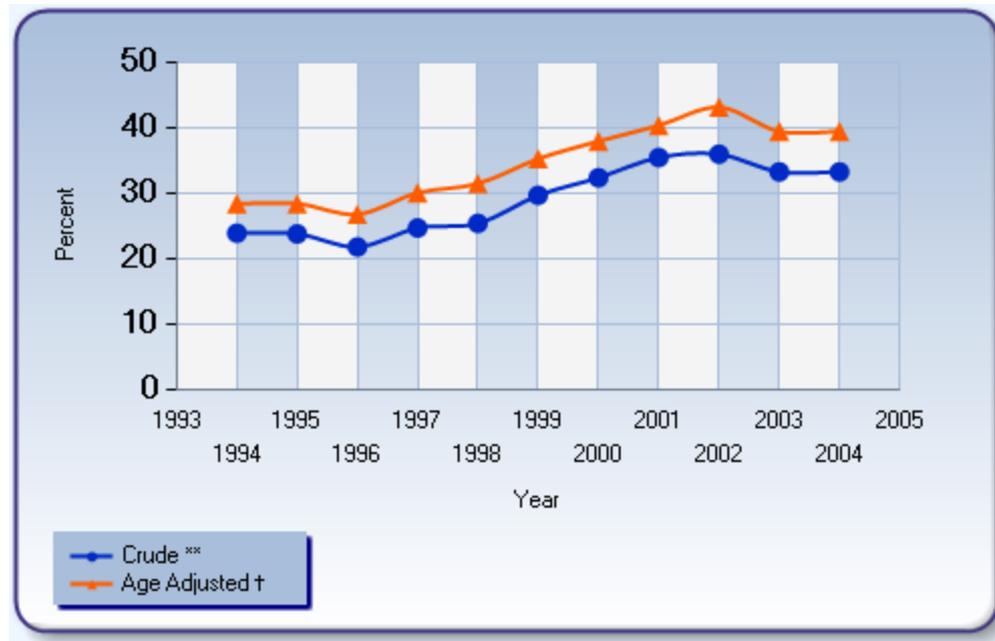


Population with SMI

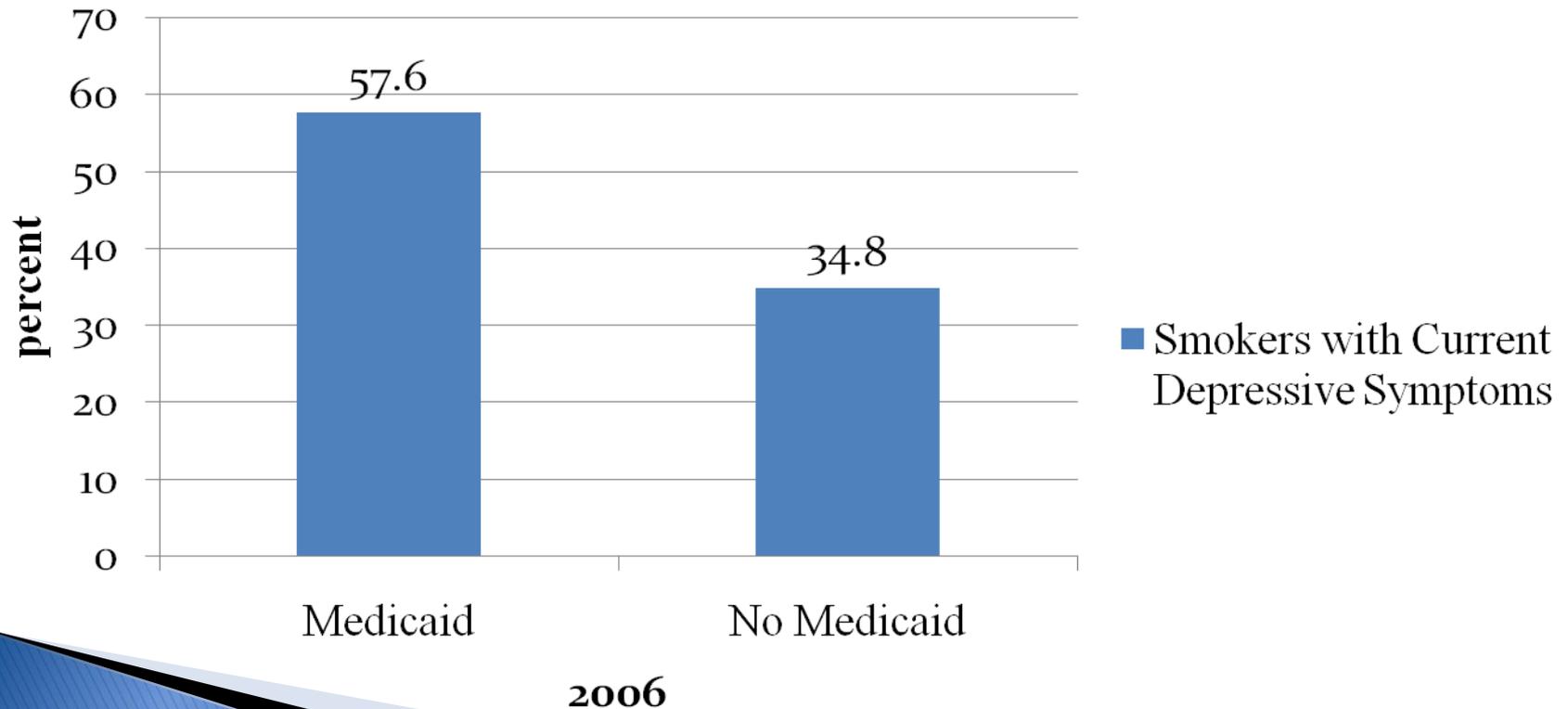


Lee, Lexa W. "Significant Associations Between Mental Illness and Chronic Physical Illness." Medscape Medical News. 17 August 2009. Online. Internet. 24 October 2007. Available <http://www.medscape.com/viewarticle/564778>

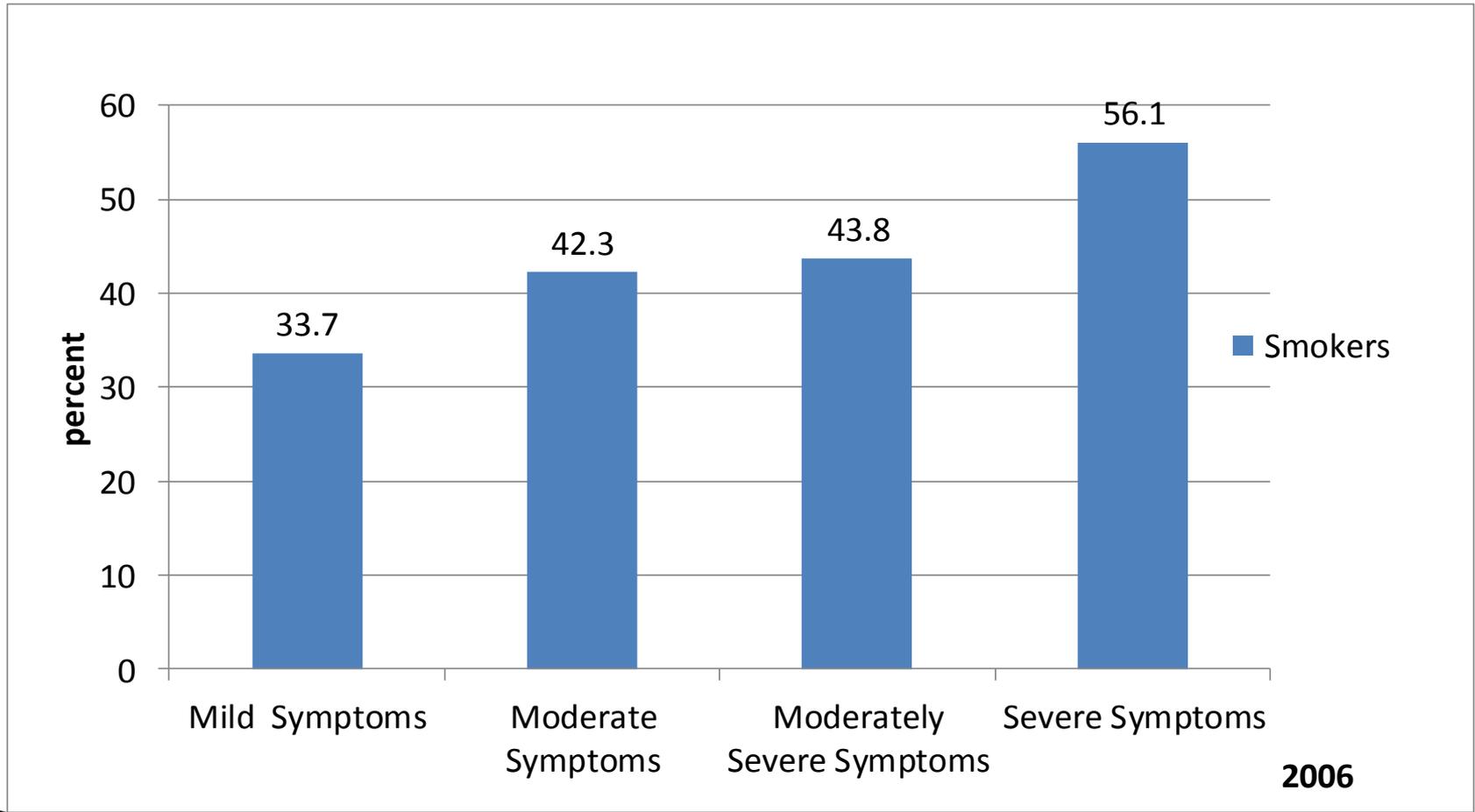
West Virginia - Percentage of Adults with Diabetes Having at Least One Day of Poor Mental Health in the Past 30 Days, 1994 - 2004



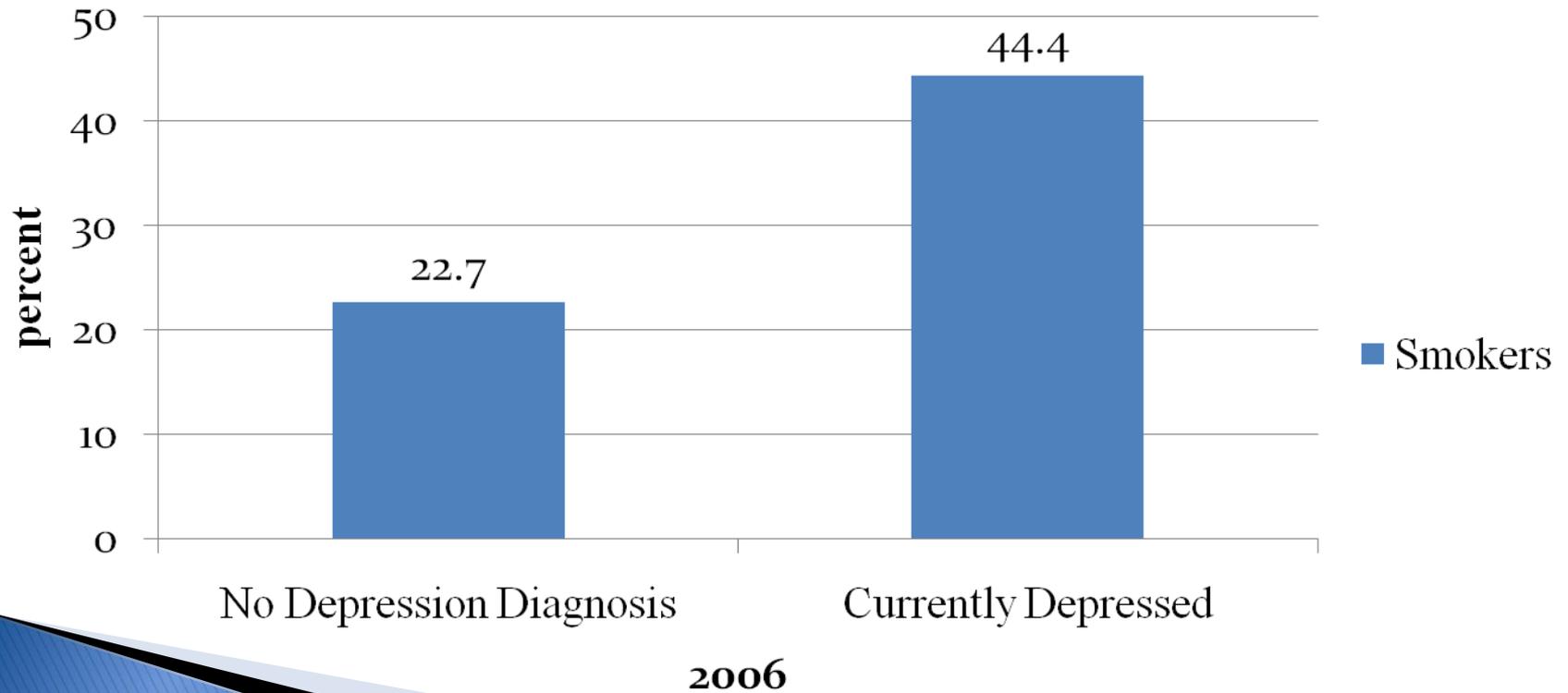
Prevalence of Smokers with Current Depressive Symptoms among those with and without Medicaid



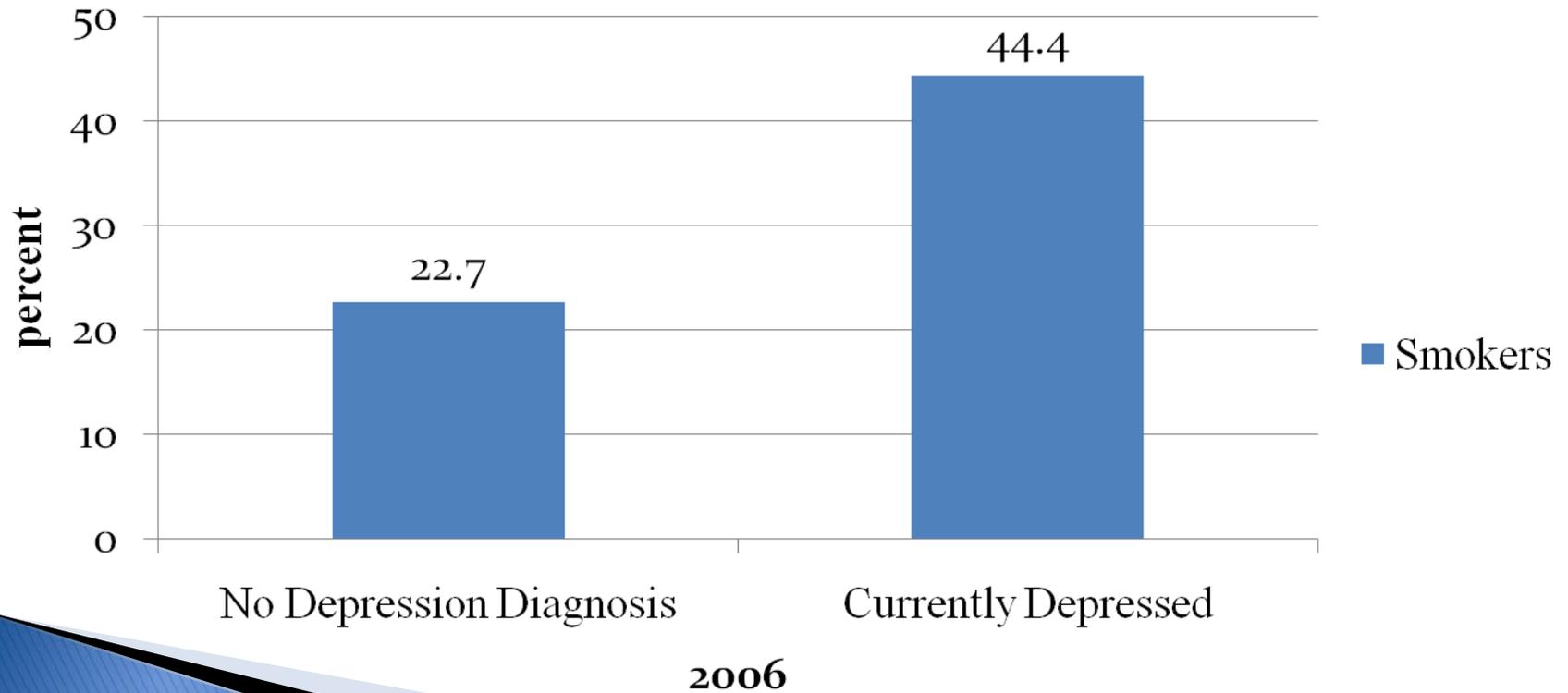
Prevalence of Smokers by Severity of Depressive Symptoms



Prevalence of Smokers among those with Current Depressive Symptoms



Prevalence of Smokers among those with Current Depressive Symptoms

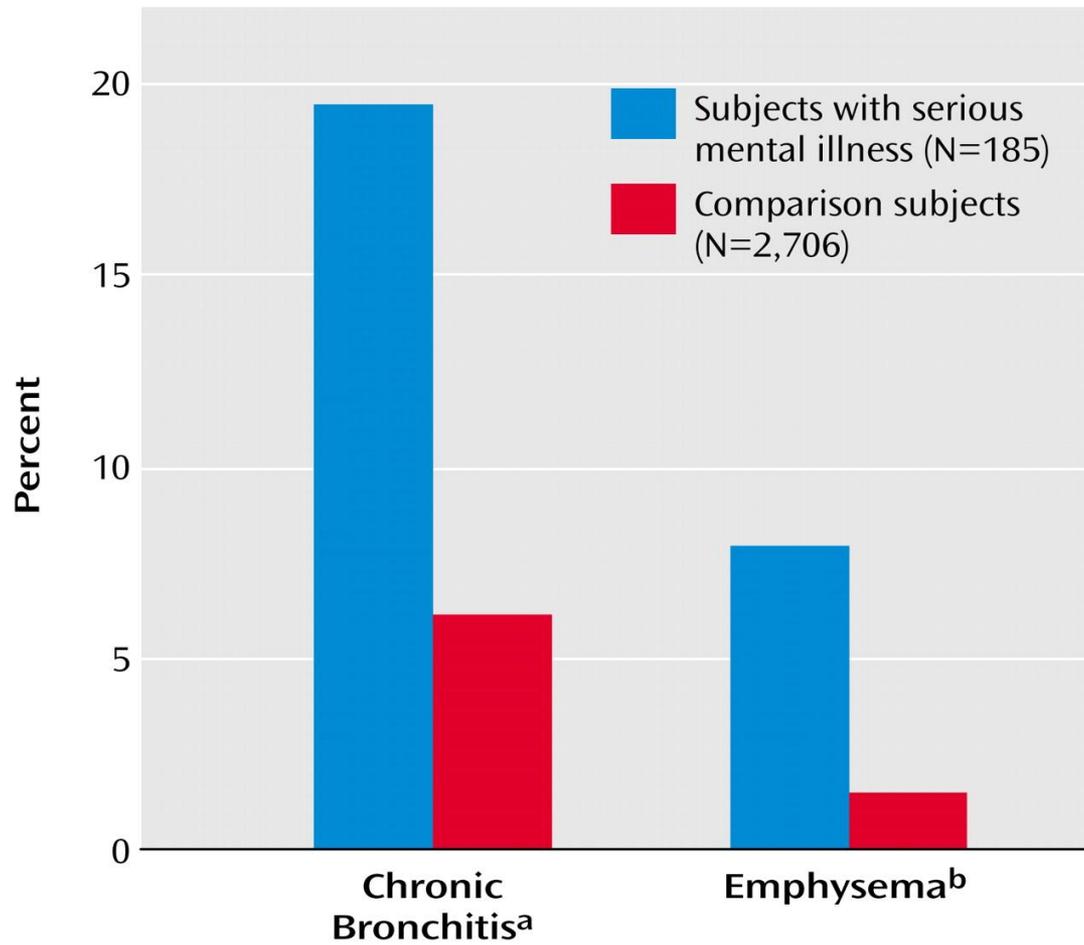


For Persons with Mental Illness

- ▶ Prevalence = 75%
- ▶ Consume 44% of all cigarettes nationally
- ▶ Smoke heavier
- ▶ Smoke more efficiently

Full report available at
<http://www.nasmhpd.org/publications.cfm#techpap>

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DRUG	WEIGHT GAIN	RISK FOR DIABETES	WORSENING LIPID PROFILE
clozapine (Clozaril)	+++	+	+
olanzapine (Zyprexa)	+++	+	+
risperidone (Risperdol)	++	±	±
quetiapine (Seroquel)	++	±	±
aripiprazole (Abilify)	±	-	-
ziprasidone (Geodon)	±	-	-

Collaborative vs. Integrated Care

Comparison

Collaborative = with

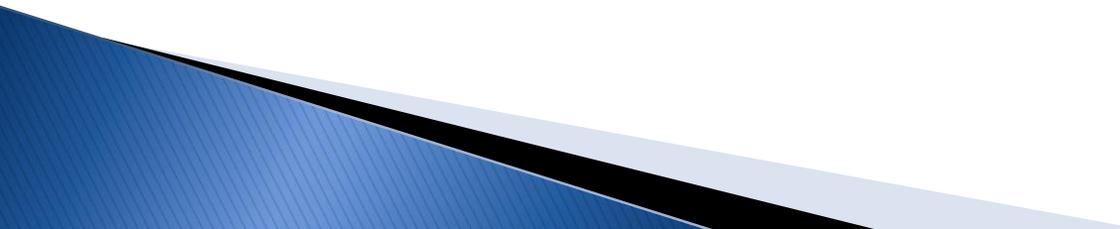
Integrated Care = within

Collaborative vs. Integrated Care

	Collaborative	Integrated
<i>Mission</i>	Specialty BH care – PCP kept “informed”	PC service treats BH problem
<i>Location</i>	Separate or co-located	Medical practice area
<i>Primary provider</i>	Therapist	Health care consultant
<i>Service modality</i>	Therapy sessions	Consultation session
<i>Team identification</i>	One of “them”	One of “us”
<i>Professional role</i>	BH specialist	BH consultant
<i>Philosophy of care</i>	“See a specialist I work with in the other wing.”	“Talk to one of our team consultants”
<i>Patient’s perception</i>	Separate services from collaborative specialist	Routine health care

Adapted from Strosahl in Blout (1998), p. 163

Four Quadrant Clinical Integration Model

- Identifies populations to be served
 - Indicates service type mix
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Four Quadrant Clinical Integration Model

Quadrant I	Quadrant IV
<p>Behavioral health: Low Physical health: Low Service setting: PC</p> <p>e.g. Fibromyalgia, moderate alcohol abuse</p>	<p>Behavioral health: High Physical health: High Service setting: PC & SBH *</p> <p>e.g. Schizophrenia; metabolic syndrome; Hepatitis C</p> <p>* Reverse model is an option</p>
Quadrant II	Quadrant III
<p>Behavioral health: High Physical health: Low Service setting: PC & SBH</p> <p>e.g. Bipolar disorder; chronic pain</p>	<p>Behavioral health: Low Physical health: High Service setting: PC</p> <p>e.g. Moderate depression; uncontrolled diabetes</p>

Practice Models
by
Degree of Integration



Level I: Minimal Collaboration

Degrees of Integration



Level I: Minimal collaboration

PC & BH providers in separate facilities; separate systems; sporadic communication

- ▶ Improvement strategies:
 - Case manager
 - Telephone psychiatric consultation
 - Formal info sharing
- ▶ Barriers to improvement:
 - Referrals may be driven by provider need rather than pt. need due to limited screening options
 - Standardized assessment forms on all patients
 - Privacy laws: BH often defaults to the most restrictive state or federal law
 - State assistance on least restrictive acceptable policies
 - Costs: case manager; additional tracking
 - Reimbursed case mgmt.; enhanced per member, per month (medical home model)

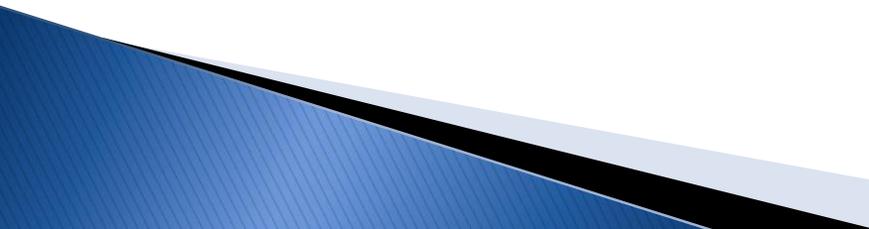
Level II: Basic Collaboration at a Distance

Degrees of Integration



Level II: Minimal collaboration

Basic Collaboration at a Distance

- ▶ PC & BH Providers in separate systems, separate sites. Engage in periodic communication (usually phone or letter) re shared patients
 - ▶ Efficacy evidence: substance abuse; pain; smoking; panic; anxiety; depression
 - ▶ PCP usually only direct provider
 - ▶ Psychiatric consultant to doc – no co-management
 - ▶ Screens for BH conditions: PHQ-9; Pediatric Symptom Checklist
 - ▶ Follows BH brief intervention guidelines
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Level II: Minimal collaboration

Basic Collaboration at a Distance

- ▶ **Improvement strategies:**
 - Co-education of PCP & psychiatrist and/or psychologist: CME's; lunches presentations
 - Telephone psychiatric consultation
 - Formal info sharing
- ▶ **Barriers to improvement:**
 - PCP may be concerned of time burden of detailed assessments & multiple consultations
 - Payers reimburse for additional services; cost offset gains
 - Costs: case manager; additional tracking
 - Reimbursed case mgmt.; enhanced per member, per month (medical home model)

Level III: Basic Collaboration On-site

Degrees of Integration



Level III: Basic Collaboration On-Site

- ▶ PC & BH Providers in separate systems, same facility. Improved communication. Separate professional cultures continue
- ▶ Tradition BH model: 50 min. sessions, etc. Still specialty care model
- ▶ BH provider's schedule cannot pace PC referrals
- ▶ Serious Mental Ill may not be as well served as in a specialty clinic
- ▶ Efficacy evidence: better outcomes; improved diagnoses & treatment; greatest improvement in poorest health patients; cost offset may occur due to reduction in physical health care
- ▶ PCP not only provider. BH practitioner co-management
- ▶ BH brief intervention guidelines expanded to more varied intervention options
- ▶ Group services possible

Level IV: Close Collaboration – Partly Integrated System

Degrees of Integration



Level IV: Close Collaboration – Partly Integrated System

- ▶ PC & BH Providers in separate systems, same facility. Improved communication. Merging of professional cultures.
- ▶ Unified Primary Care & Behavioral Health (UPCBH) Model: BH maintains specialty care, individual pt. model. BH model modified to serve primary care setting & culture.
- ▶ Tradition BH model: 50 min. sessions, etc. Still specialty care model.
- ▶ BH provider's schedule cannot pace PC referrals
- ▶ Serious Mental Ill can be better served but still needs access to specialty clinic
- ▶ Efficacy evidence: clinically effective; cost effective w 20–40% cost offset for medical pts. Receiving BH services.
- ▶ Care managers are cross-trained for mgmt. of co-morbid conditions
- ▶ Registry database essential to monitor patients and progress
- ▶ New funding models by payers required

Level IV–R: Reverse Co–Location Model

Degrees of Integration



Level IV–R: Reverse Co–Location Model

- ▶ Goal: to improve health care for SMI patients
 - ▶ Primary care provider out–stationed in psychiatric specialty setting
 - ▶ Could be psychiatrist with dual roles
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Level V: Close Collaboration – Fully Integrated System

Degrees of Integration



Level V: Close Collaboration in a Fully Integrated System

- ▶ PC & BH Providers in same clinical, administrative & financial system: one team.
- ▶ BH care is an integrated primary care service.
- ▶ Integrated health record and single treatment plan.
- ▶ Primary Care Behavioral Health (PCBH) Model: epidemiological, public health view of services delivery.
- ▶ Referring physician is primary customer.
- ▶ Entire primary care population is target.
- ▶ Efficacy evidence: clinically effective; cost effective w 20–40% cost offset for medical pts. receiving BH services.
- ▶ Care managers are cross-trained for mgmt. of co-morbid conditions.
- ▶ Registry database essential to monitor patients and progress.
- ▶ New funding models by payers required.

Level V: Close Collaboration in a Fully Integrated System

Sub-Models

- ▶ *Unified Primary Care & Behavioral Health Model:*
 - Specialty psychiatric care imbedded
 - BH provider part of specialty mental health
 - BH Services focus on individual
 - BH takes over responsibility for BH care
 - Implemented in FQHC & VA
- ▶ *Primary Care Behavioral Health Model*
 - Behavioral health is routine part of medical care
 - BH provider part of primary care team – temporarily co-manages patient with physician
 - Referring physician is principal “customer”
 - “Warm hand-offs”; “curb-side” consults
 - Multiple service delivery formats: education; case mgmt., telephone monitoring, skill coaching
 - Epidemiological, public health view of service delivery
 - Population-based care
 - At-risk are also targeted for intervention – “wide-net” approach

Collaborative System Care Model

- ▶ Core system integrated & imbedded in a collaborative (at a distance) system.
- ▶ Partners can add: housing, education, employment, legal advocacy, & welfare.

Innovation: Health Homes

- ▶ Under ACA 2703 a State Medicaid program may create a plan to provide care coordination to those with chronic health conditions.
 - ▶ A program such as this qualifies for an enhanced match to cover the cost of care coordination for complicated patients.
 - ▶ The program must meet the “triple aim”.
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Health Homes SPA

- ▶ The first Health Home State Plan Amendment (SPA) in WV will focus on individuals with bipolar disorder and risk of/infected with, hepatitis B or C. This program will roll out in 6 counties.
- ▶ Six coordination of care criteria must be met by providers who enroll as “health homes”.
- ▶ Payment is based on a PMPM model with two tiers.

How was this population chosen?

- ▶ Bipolar disorder is common and costly
 - High cost meds
 - High frequency utilization
- ▶ Chronic viral hepatitis is on the rise
 - Risk is 15-fold higher in the bipolar population
 - Strong link to substance abuse
- ▶ Treatment of both conditions requires close coordination
- ▶ The health impact of both conditions is very significant

Health Homes

- ▶ The SPA will be submitted to CMS in early fall with implementation in 2014.
- ▶ Based on this model, future health home projects will focus on other chronic conditions (diabetes, asthma, serious mental illness, heart disease, etc.).



WV DHHR Bureau for Medical Services



For more information contact:

James B. Becker, MD
Medical Director
james.b.becker@wv.gov

Kenneth J. Devlin, MA
Consulting Psychologist
ken.j.devlin@wv.gov

Bureau of Medical Services