Making the Case and Making It Work: Integrating Behavioral Health into Primary Care

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What we’ll cover today

• Why Integrated Behavioral Health
• Changing policy environment
• Where we are headed: Collective impact and Accountable Communities of Health
The Problem: Fragmentation

Clinical delivery

Payment/financing

Community expectation

Training/education

Fragmentation
The PROBLEM

People with mental illness die earlier than the general population and have more co-occurring health conditions.

68% of adults with a mental illness have one or more chronic physical conditions.

more than 1 in 5 adults with mental illness have a co-occurring substance use disorder.
Quick Review: Case for Integration

• 5% of the population use 50% of the health care resources (the 5/50 population)
• 1% use 20% of the health care resources
• Half of both groups have a behavioral health disorder
• Primary care is the sole source of MH treatment for 1/3 of patients receiving care for a MH condition
• Depressed patients are 3 times more likely than non-depressed patient to be non-compliant with treatment recommendations
Behavioral Health is a Key Concern for Health Care

• Disparities: Affects low-income populations
  - Nearly half (49%) of all Medicaid beneficiaries with disabilities have a psychiatric diagnosis
  - Among Dual eligibles (Medicare/Medicaid), 44 percent have at least one mental health diagnosis

• Cost driver
  - Behavioral health disorders are among the five most costly conditions in the U.S. with expenditures of $57 billion
  - Mood disorders such as depression are third most common cause of hospitalization in the U.S for both youth and adults
We only spend 5% of our health dollars to address what causes 60% of our avoidable deaths.

**Causes of avoidable death in the United States**

- Social factors: 15%
- Health care: 10%
- Genetics: 30%
- Behavior: 40%
- Environment: 5%

**United States health expenditures in 2013**

- Health care: 95%
- Population-wide approaches to health improvement: 5%

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1. McGinnis et al., The case for more active policy attention to health promotion. Health Affairs 2002; 21(2):78-93.
**Economic Impact of Integrated Behavioral Health**

- **CMSP**: reimbursing primary care clinics for up to 10 mental health visits and 20 substance abuse visits per year resulted in a dramatic 57% drop in psychiatric days by the treated group (vs. a 71% increase in the business-as-usual controls). However, this cost-savings was neutralized by an increase in outpatient expenses. Nonetheless, CMSP has elected to continue the program believing that there will be savings once the program is further underway. *Evaluation of the CMSP Behavioral Health Pilot Project, Draft Final Report*, prepared for CMSP by the Lewin Group, February, 2011.

- Depression management for depressed primary care patients resulted in a $980 cost decrease for those who complained of psychological symptoms, but there was a $1,137 cost increase for those who complained of physical symptoms only. Miriam Dickson et al., “RCT of a Care Manager Intervention for Major Depression in Primary Care: 2-Year Costs for Patients With Physical vs Psychological Complaints” Annals of Family Medicine, 2005, 3:15-22.

- “The impact of psychological interventions on the use of medical services was evaluated by examining the outcome of 91 studies published between 1967 and 1997 using meta-analytic techniques and percentage estimates. Results provide evidence for a medical cost-offset effect, specifically in the domain of behavioral medicine. Average savings resulting from implementing psychological interventions was estimated to be about 20%. About one third of the articles demonstrated that dollar savings continued to be substantial even when the cost of providing the psychological intervention was subtracted from the savings.” Jeremy A. Chiles et al. The Impact of Psychological Interventions on Medical Cost Offset: A Meta-analytic Review Clinical Psychology: Science and Practice, June 1999, Vol. 6.

- Collaborative care, implemented through brief cognitive-behavioral therapy and enhanced patient education in primary care, increased depression treatment costs, but improved the cost-effectiveness of treatment for patients with major depression. A cost offset in specialty mental health costs, but not medical care costs, was observed. Von Korff, “Treatment cost offsets and cost-effectiveness of collaborative management of depression”, Psychosomatic Medicine, 1998, 60.

- When clients with diabetes and depression received depression collaborative care (a depression care manager offered education, behavioral activation, and a choice of problem-solving treatment or antidepressant management), an increase in the cost of $1,129 was found over two years. The study concluded that this intervention is “a highvalue intervention for older adults with diabetes; it is associated with high clinical benefits at no greater cost than the usual care.” R. W. Katon et al., “Depression Management for Older Adults With Diabetes and Depression.” Diabetes Care 29:265-270, 2006.

- When family physicians worked collaboratively with mental health professionals to treat persons on short-term mental health disability leave, their patients returned to work at higher rates than those treated by physicians alone. The average cost savings to employers was $503 per patient. Carolyn Dewa et al, “Cost, Effectiveness and Cost-Effectiveness of a Collaborative Mental Health Care Program for People Receiving Short-Term Disability Benefits for Psychiatric Disorders”, Canadian Journal of Psychiatry, 54(6), 2009.

- Over 24 months, clients having both diabetes and depression who were assigned to a stepped-care depression/senior care program had outpatient health care costs that averaged $314 less compared to those who received care as usual. The authors conclude that “for adults with diabetes, systematic depression treatment appears to have significant economic benefits from the health plan perspective.” Gregory Simon et al., “Cost-effectiveness of Systematic Depression Treatment Among People With Diabetes Mellitus”, Archives of General Psychiatry, January, 2007, Vol. 64, No. 1. 15.

- A study of Medicaid recipients diagnosed as chemically dependent found that those not using mental health services increased their medical costs by 91% during the study period, compared to decreased costs for recipients of mental health treatment. In the first twelve months after treatment, some interventions produced net decreases of approximately $15 per person, N. Currie, et al., “The impact of psychological intervention on healthcare utilization and costs”. Biodynamics Institute, 1990.

- A collaborative care intervention for primary care clients with panic disorder, including systematic patient education and approximately two visits with an on-site consulting psychiatrist, resulted in no significant differences in total outpatient costs, and an analysis suggests a 70% probability that the intervention led to lower costs and greater effectiveness compared with usual care. Wayne J. Katon, “Cost-effectiveness and Cost Offset of a Collaborative Care Intervention for Primary Care Patients with Panic Disorder”, Arch Gen Psychiatry, 2002, 59.

- Comprehensive collaborative and structured mental health services provided to high utilisers of mental health services resulted in a 65% reduction in community hospital days. Nancy Anderson, “Medical Cost Offsets Associated with Mental Health Care” A Brief Review, Washington State Dept. of Social and Health Services, December, 2002.

- Use of managed care (structured, targeted, focused and brief treatment) for Medicaid enrollees reduced medical services costs and utilization by 33 to 40 percent relative to control groups. For enrollees with chronic medical diseases, managed treatment reduced medical costs by 28 to 47 percent. For enrollees without chronic medical diagnosis, traditional fee-for-service also reduced medical costs by about 20% but used times as many outpatient visits; Costs of managed care were recovered in 6 to 24 months. The managed mental health group spent fewer days in the hospital and used the emergency room less. M. S. Pallak et al., “Medical costs, Medicaid, and managed mental health treatment: the Hawaii study”, Managed Care Q, 1994 Spring: 2 (2).


- Primary care clients assigned to enhanced care for depression not only experienced significantly more depression-free days compared with usual care clients, but cost the health plan significantly less ($586 vs $12 in incremental costs; P <0.01). Katherine Katz, “Cost-Effectiveness of Enhancing Primary Care Depression Management on an Ongoing Basis”, 2005, Annals of Family Medicine 3: 2005.

- “Johns Hopkins HealthCare examined the first 12 months of claims histories of 603 adult Medicaid enrollees who frequently used mental health services and had a recent history of substance abuse. An intervention group of 400 was targeted for management by substance abuse coordinators and nurse care managers who received training in the integration of mental care management and substance abuse treatment. The training included mock interviews, lectures, and case conferences on substance abuse topics. A comparison group of 203 managed care clients managed in the usual manner with the same number of substance abuse care managers. Early results indicate that the intervention group reduced medical costs by $122 per member per month. Results of a comparison group’s cost reductions were realized through a decrease of 288 admissions per 1,000 members as well as a decrease in 92 days admitted per 1,000 members. The intervention group experienced increased enrollment in substance abuse treatment. Both groups were matched for severity of illness at the time of admission. In all, the PMPM cost reductions among intervention group members totaled $503,616 through the first year of the program based.” see “The Impact of Collaborative Health in the Worksite: Evaluation of a Model Incorporating Evidence Based Treatments for Substance Abuse”, update, 2005.

- Though the primary depression management intervention added the total care costs the first year of operation, these costs were offset by the health care savings during the second year. The intervention produced health and mental health improvements without a significant increase in costs. Wayne Katon et al., “Cost-effectiveness of Improving Primary Care Treatment of Late-Life Depression”, Archives of General Psychiatry, 2005, 62.


- “Patients who receive care for depression in primary care clinics with routine mental health integration teams and care processes were 54% less likely to use higher-order emergency department services.” Brenda Reiss-Brennan et al., “Cost and Quality Impact of Intermountain’s Mental Health Integration Program”, Journal of Healthcare Management, 55:2, 2010.

- Primary care patients with diabetes and major depression assigned to an intervention program including education about depression, behavioral activation and a choice between anti-depressant medication or problem-solving therapy had improved depression outcomes compared to the usual care group with no evidence of greater long-term costs. Wayne Katon et al., “Long-Term Effects on Medical Costs of Improving Depression Outcomes in Patients with Depression and Diabetes”, Diabetes Care, Vol. 31, 2008.

- When comparing clients with the highest risk scores enrolled in patient-centered health homes (PCHH) vs. those in the PCMH model was show to have a significant reduction in total costs in the first two years and significantly lower client admissions in the three years studied. Susannah Higgins et al., March, 2014. Published online.
The Solution

Primary Care

- Social Work
- Psychiatrist
- Psychologist
- Sub-specialty Service
- Physician
- MA, RN, NP, PA, RN, Etc.
Integrated Care Definition

- Integration of behavioral health and physical health care refers to the intentional, ongoing, and committed coordination and collaboration among all providers and the individual in treatment. Providers recognize and appreciate the interdependence they have with each other and the patient/client to positively impact healthcare outcomes. (Agency for Health Care Research and Quality (AHRQ))
Different types of models for integrated behavioral health have challenges.
Key Features of Successful Models

• **Communication:** Warm handoffs vs. referrals
• **Shift in scope and approach to practice:** e.g., Consulting psychiatrist vs. extended evaluation with case load
• **Coordination:** e.g., PCP prescribing vs. two prescribers
• **Engagement and Activation:** Recovery orientation and patient self management skills
• **Data driven care:** e.g., Data and documentation sharing; outcome tracking
Two Roles of BH Providers

**Behavioral Health in Primary Care**

- Embedded mental health and substance use services in a primary care clinic with the ability to address needs of persons with mild to moderate behavioral health disorders

**Behavioral Health Specialty Centers of Excellence**

- A partner with medical homes, providing high value, whole health-oriented, specialty care to individuals with complex behavioral health conditions
Integrated Care is Moving in the Right Direction, but has Challenges

- Lack of knowledge and experience with value based purchasing (rather than volume) and connection to outcomes
- Disconnect between belief in recovery philosophy and expectations for patient outcomes
- Perceived and real barriers to data sharing
- Stigma towards patients with mental illness and addiction persists among medical providers – creating barriers to access and treatment follow through
New Models of Care are Changing Faster than Work Force Supply & Preparedness

• Most providers receive limited training on working in teams; happens “on the job”

• MH provider shortages – CA rural counties (OSHPD, 2011)

• Demand for MH/SU social workers is projected to increase by 22.8 percent and 35.4 percent, respectively, from 2006 to 2016 (California Employment Development Department)

• Medical and BH fields have distinctly different training programs, professional cultures, and treatment approaches.

• BH providers lag behind medical providers in their capacity to track treatment outcomes and use data for clinical decision making
Consumers feel stigmatized by health providers

- Orientation of primary care is reactive – which deters clients reluctant or unable to seek help
- Physicians inexperienced in with mental health work may resist getting further involved with a client by not actively asking about symptoms (M. Phelan, 2001)
- Cramped schedules can limit time physicians have to discuss behavioral health issues with clients
- Subtle or not so subtle judgments and communication about patients’ mental health and substance use issues
Why stigma should matter to providers

• Issues with medication adherence
• Drop-outs and no shows
• Access
• Poor physical health outcomes
• Patient Experience: Key component and measure in the Triple Aim
IBH a Key Strategy for Improving Patient Experience

- Research evidence: IBH is an effective strategy to reduce stigma and improve access to behavioral health services, especially for vulnerable populations

- A 2005 IOM report concluded that the only way to achieve true *quality and equality* in the health care system is to integrated primary care with mental health and substance use services

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*Kautz C, Mauch D, and Smith S. Reimbursement of Mental health services in primary care settings. Rockville: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2008.*
Changing Policy Landscape
Los Angeles County Payer and Provider Relationships for Adult Medi-Cal Physical Health, Mental Health (MH) and Substance Use Disorder (SUD) Services

Funding Source
- Medi-Cal Capitation
- Short-Doyle Medi-Cal
- SAMHSA Grants
  For co-occurring services
- Mental Health Services Act (MHSA)
- SAMHSA Substance Abuse Prevention & Treatment (SAPT) Block Grant
- Drug Medi-Cal (DMC-ODS)

Payer Org.
- L.A. Care Health Plan
- L.A. County Dept. of Mental Health (DMH)
- L.A. County Dept. of Public Health (DPH) Substance Abuse Prevention and Control (SAPC)

Type of Service
- Physical Health
- Mild to Moderate Mental Health
- Specialty MH
- Co-Occurring MH/SUD Services
- Substance Use Disorder (SUD)

Delivery Location
- Hospitals
- Private IPAs
- L.A. County Dept. of Health Services (DH5)
- Federally Qualified Health Centers (FQHC's)

Created by: L.A. Care Health Plan
DRAFT: December 23, 2015
Health Reform is Pushing for System Realignment to Reduce Costs

Current Resource Allocation

- All things Inpatient and Institutional
- Prevention, Primary Care, BH
- Inpatient & Institutional
- Prevention, Early Intervention, Primary Care, and Behavioral Health

Needed Resource Allocation
Examples of Changing Integrated Behavioral Health Policy Landscape

• Medi-Cal Expansion: Expanded role of MCOs and expanded population
• ACA Section 2703 Health Home – Practice Transformation
• CA Medi-Cal 1115 Waiver
• Accountable Communities for Health
Medi-Cal Expansion and Expanded Benefit

- Started in 2014, but systems are still adjusting
- New relationships at the county level – County Behavioral Health, Health Plans, Managed Behavioral Health Organizations (e.g., Beacon), FQHCs and CHCs
- Emphasis placed on care transitions and maintaining continuity of care – e.g., hospital to community
- Acceleration of new integrated care delivery models, e.g. team-based care
ACA → Practice Transformation

• Integrated, Coordinated Care, e.g. Patient-Centered Medical Home (section 2703)
  o Growing awareness of the consequences of untreated mental health and SUD needs
  o Recognition of need for Integration/Person-Centered/Whole Person Care to achieve Triple Aim
  o Increased recognition of the role of housing; need to develop new partnerships with non-medical providers (Housing First)
  o Parity

• Implementation delayed in CA until 2018, but it’s still important to invest in capacity and infrastructure
Medi-Cal 1115 Waiver Components

• Shift from fee-for-service to Global Payment Program for services to the uninsured in designated public hospital systems

• Delivery system transformation and alignment incentive program for public and municipal hospitals

• Whole Person Care Pilots to target more integrated care for high-risk, vulnerable populations
Challenges in the New Practice Environment

• Significant **progress in practice and system transformation** in CA and nationally that provide strong evidence base, **BUT** there are issues with **sustainability and spread**

• Infrastructure and workforce (and practice culture) challenges in achieving:
  - Integrated, **team based care** with all members working to the top of their license, delegating activities to different team members, as appropriate
  - Improved **population management**
  - Better implementation and use of HIT, e.g., QI tracking of treatment outcomes
  - Payment reform (e.g., value based purchasing)
  - Shifting from data collection for compliance to using data for accountability
Key Reform Ingredient ➔ Outcomes Measurement

• US behavioral health system is moving from 50 states (50 sets of rules) to a national quality framework for BH

• BUT – there are currently many different quality measures relevant to BH (no clear consensus):
  o 116 in draft NBHQF
  o 64 in Meaningful Use set
  o 44 in the Physician Quality Reporting System
  o 37 in the SAMHSA State URS set
  o 28 in the FQHC UDS set
Changing the Frame: Collective Impact
The Collective Impact Foundation

• **Collective Impact** is the commitment of a group of actors from different sectors to a common agenda for solving a specific social problem, using a structured form of collaboration.

Isolated Impact: The Collective Impact Foundation

• What we know...

• Isolated Impact:
  o The prevailing model of health and human services in the US.
  o Historically promoted by payors and funders.
  o Has resulted in the development of over 1 million US nonprofit organizations devoted to isolated impact.

• Isolated Impact Definition: Efforts to effectively address a health or social problem by contracting with organizations that specialize in that particular problem.

• Problem: Complex Systems with many interconnected components do NOT respond well to isolated impact.

• Reality: The people, families, and communities you work with are the poster child of Complex Systems.
5 Collective Impact Components

- **Common Agenda**: All participants must have a shared vision for change.
- **Mutually Reinforcing Activities**: Each participant should undertake the activities at which it excels as part of a mutually reinforcing plan of action for CI to be successful.
- **Backbone Support Organization**: CI initiatives require a separate organization and staff to be successful because coordination takes time, and almost always none of the participating organizations has any time to spare.
- **Continuous Communication**: Participants need to meet regularly to appreciate the common motivation behind their efforts and to keep communication flowing among and within the network.
- **Shared Measurement Systems**: CI coalitions need to develop shared measurement systems.
Accountable Communities for Health

• Emerging strategy for improving population health
• ACHs integrate medical care, behavioral healthcare, and social service supports to improve the social determinants that shape health and wellbeing in a geographical area
• Collectively engage major healthcare providers across a geographic area to operate as partners rather than competitors
• Focuses on the health of all residents in a geographic area rather than just a patient panel
• New Initiative: The California Accountable Communities for Health Initiative (CACHI) will assess the feasibility, effectiveness, and potential value of a more expansive, connected and prevention-oriented health system
Snapshot of Interventions, Entry Points, & Population Health

**Clinical Interventions**
- **Screening**
  - ACES
  - SBIRT
  - PHQ-9
- **Wellness Interventions – Smoking, Food**
- **Asthma and Diabetes**
- **Community Programs (schools, CBOs)**

**Community Interventions**
- **Primary, Coordinated Care**
- **Primary and Secondary Prevention**
- **Chronic Health/High Utilizers**

**Upstream**
- Prevention
- Earlier Intervention

**Downstream**
- Moderate Conditions
- High Need/Chronic Conditions

**Population Health**
The Work You Do is Essential...

• All of this is new and nobody has the all the answers!
• The onus is on all of us to advance integrated primary care, mental health, substance use, and other person-centered services (e.g., dental, social services, and housing system of care).