Behavioral Health Integration

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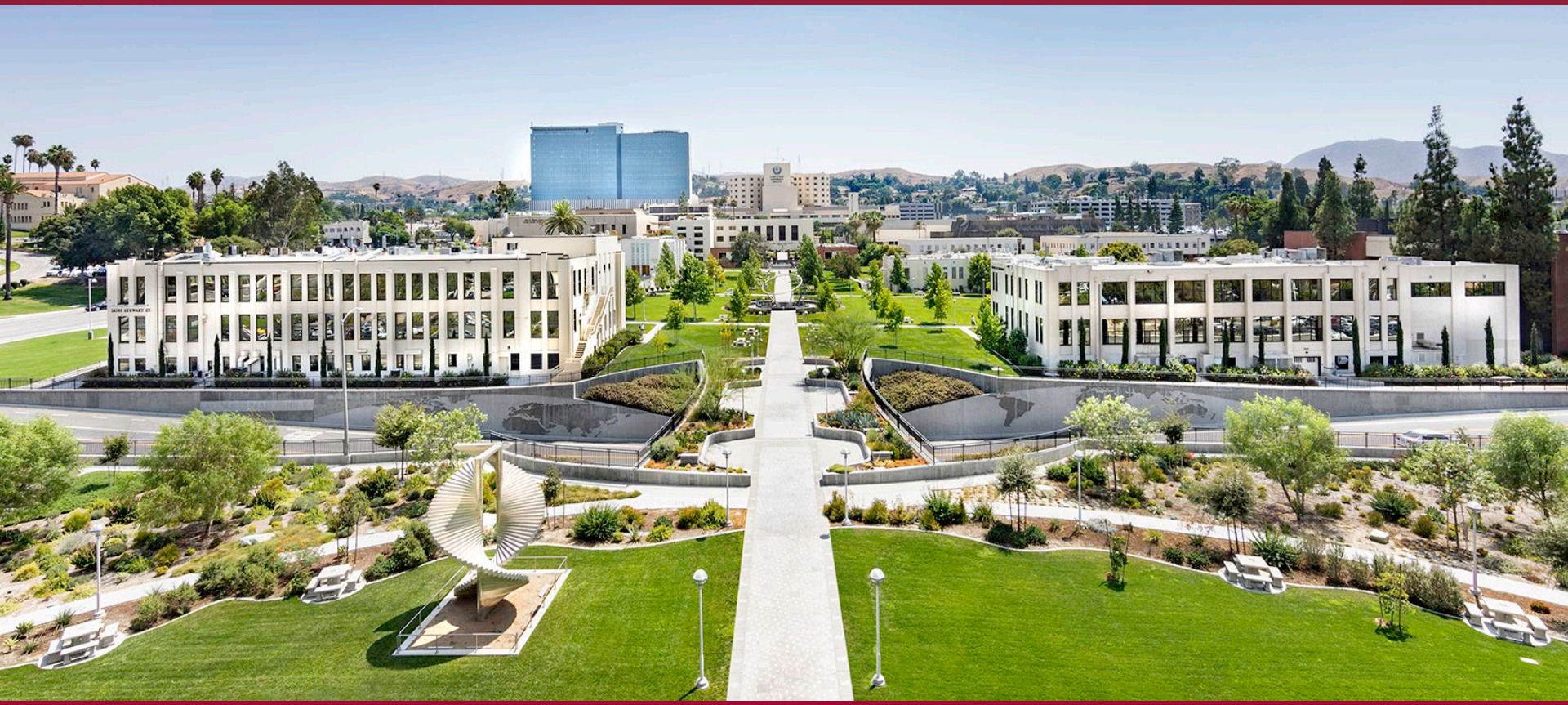
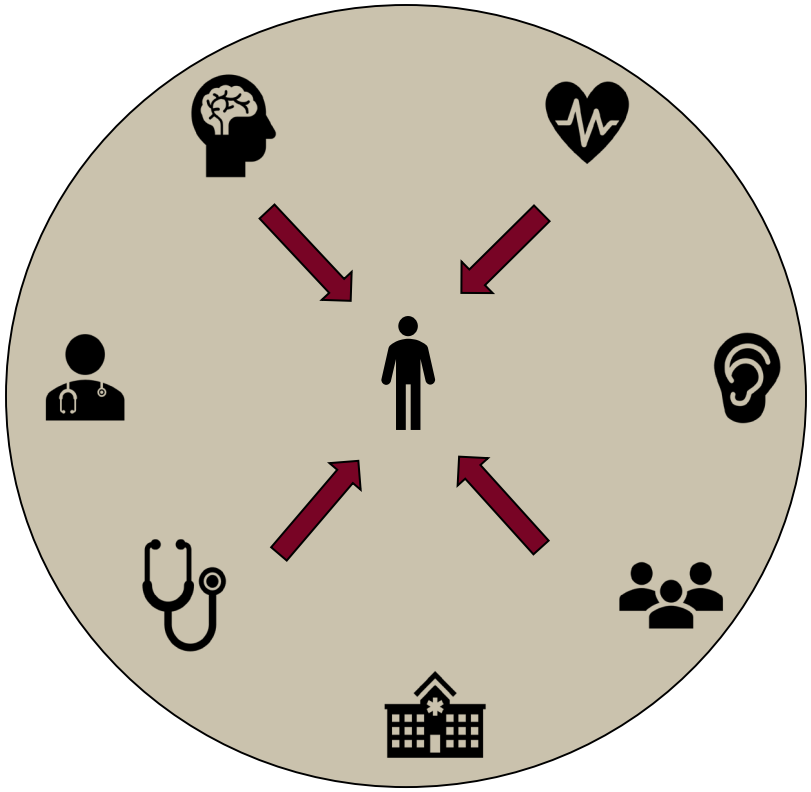


LOMA LINDA UNIVERSITY HEALTH

Many Strengths. One Mission.

What is Behavioral Health Integration?



Behavioral health is an umbrella term that includes mental health and substance abuse conditions, life stressors and crises, stress-related physical symptoms, and health behaviors. Behavioral health conditions often affect medical illnesses.

Integrated behavioral health care blends care in one setting for medical conditions and related behavioral health factors that affect health and well-being. Integrated behavioral health care, a part of "whole-person care," is a rapidly emerging shift in the practice of high-quality health care. It is a core function of the "advanced patient-centered medical home."

Integrated behavioral health care is sometimes called "behavioral health integration," "integrated care," "collaborative care," or "primary care behavioral health." No matter what one calls it, the goal is the same: better care and health for the whole person.

Agency for Healthcare Research and Quality: https://integrationacademy.ahrq.gov/about/integrated-behavioral-health#:~:text=Integrated%20behavioral%20health%20care%20blends,of%20high%2Dquality%20health%20care.

Background on Behavioral Health

1. Medicaid Expansion (ACA)

2. Medicaid Managed Care Plans (MMCPs)

3. FQHCs and Rural Health Clinics

4. Micro projects, studies and outcomes
   - Reduced costs
   - Preventing higher level system engagements (e.g. ED and Urgent Care)
   - Improved Health Related Quality of Life
   - Highest benefits for patients with co-occurring behavioral and physical health chronic conditions (e.g. these patients cost 2-3X for systems)

Current Practice

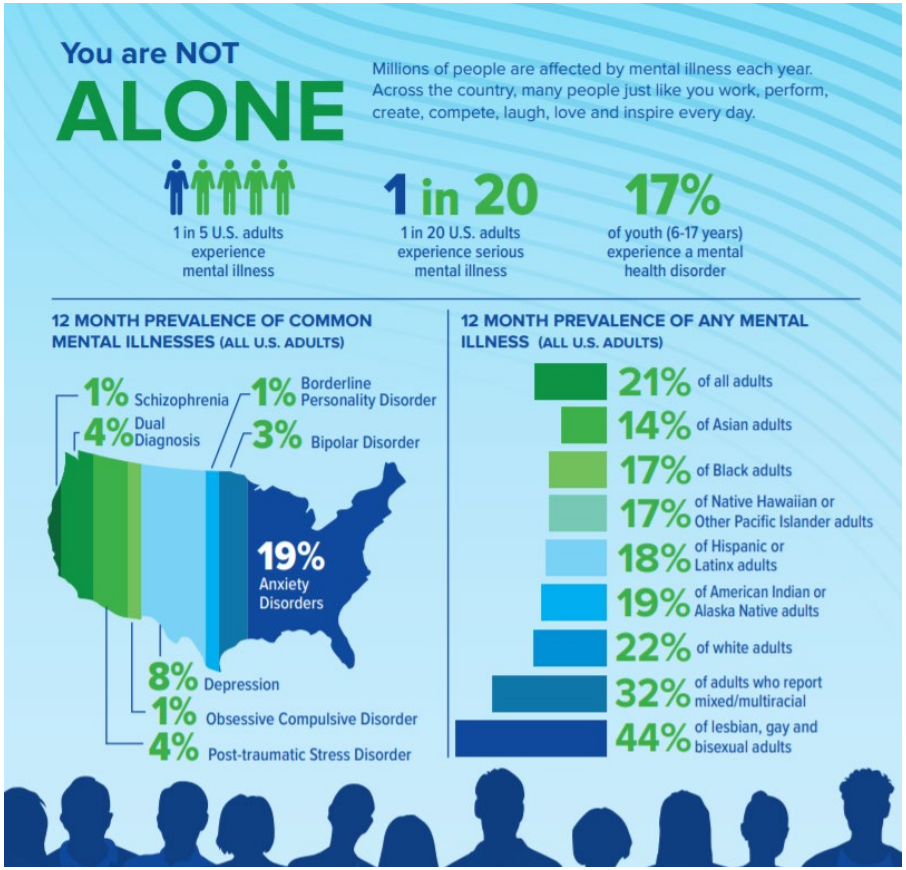
Behavioral Health Continuum

Physical Health
ED/ Hospital Based Care
Ambulatory Care
Primary care

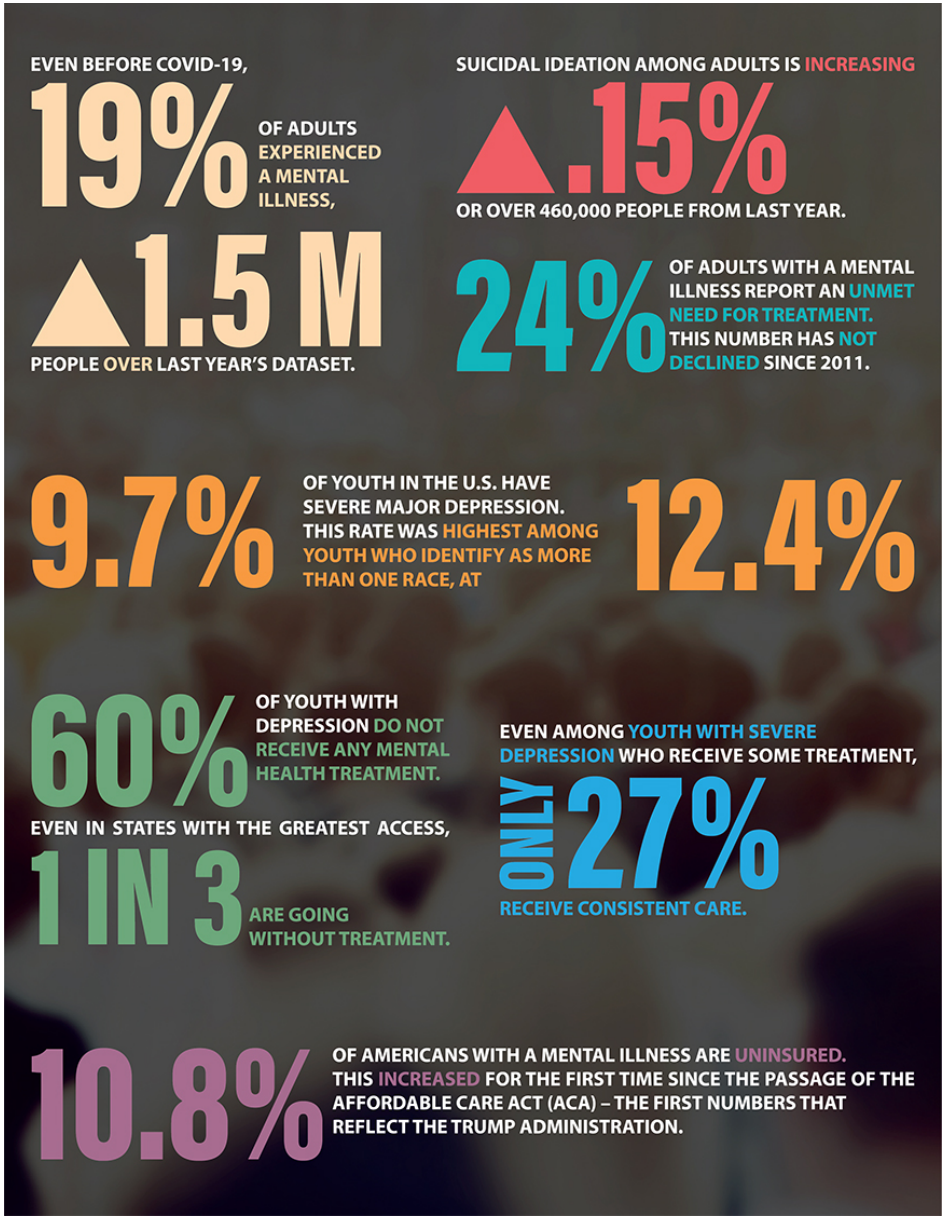
High Acuity
ED
Inpatient Care
Detox

Moderate Acuity
Hospital Based
Partial Hospitalization
Intensive Outpatient

Low Acuity
Outpatient
MAT
Therapist
Evaluations/Assessments

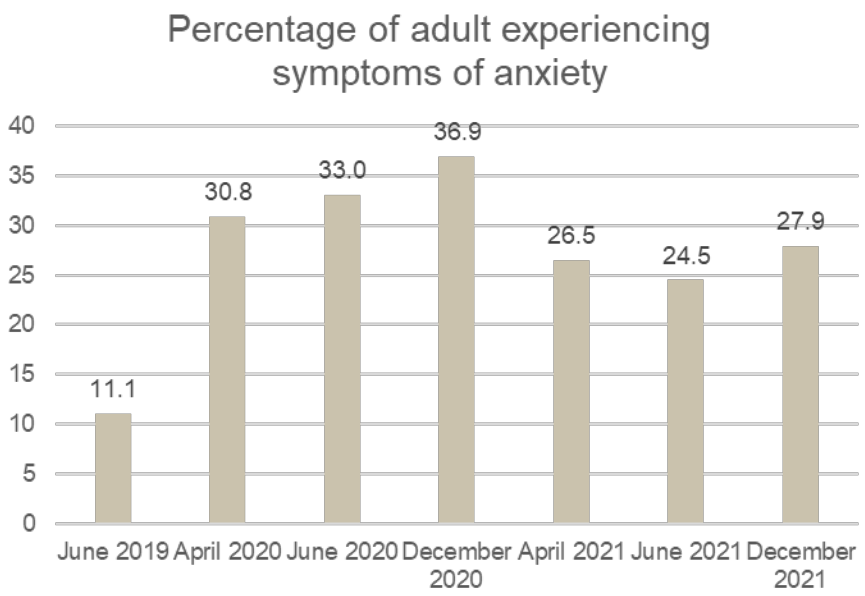


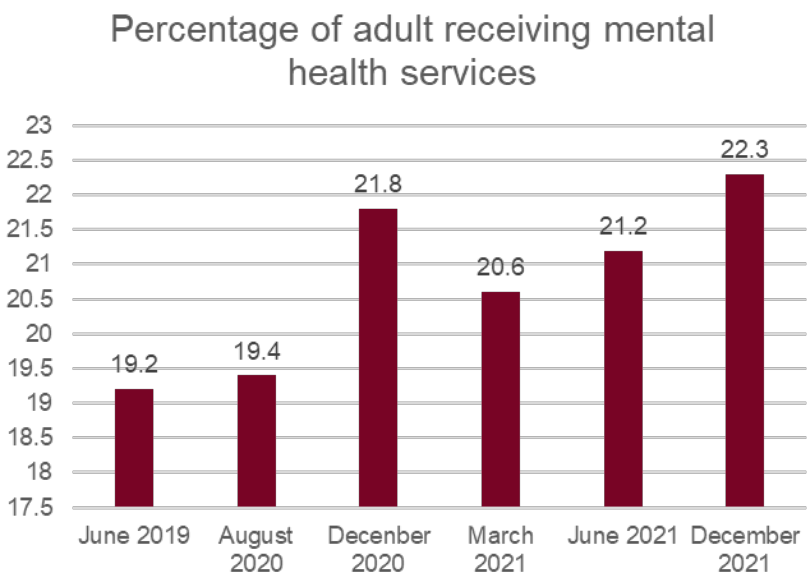
NAMI (2022): https://www.nami.org/NAMI/media/NAMI-Media/Infographics/NAMI_YouAreNotAlone_2020_FINAL.pdf



Mental Health America. The State of Mental Health in America, 2020: https://mhanational.org/issues/state-mental-health-america

Changes Due to COVID-19





Household Pulse Survey data (retrieved 2022), https://www.cdc.gov/nchs/covid19/pulse/mental-health-care.htm

45-60% increase in ED visits for BH needs

California

- 9.2% of adults have a SUD
- 4.5% of adults have SMI
- The rate of SMI has increased 50% from 2008-2019
- 7.6% of youth have a Severe Emotional Disorder (SED)

Figure 2. **Number of Suicides in California per 100,000 Youth Ages 15-24**[13]

Period	2012 - 2014	2013 – 2015	2014 - 2016	2015 - 2017	2016 - 2018	2017 - 2019
Suicide rate per 100,000	7.3	7.6	7.7	8.3	8.6	8.9

- 24% increase in youth SI/SU between 2012-2019
- A possible 31% during COVID

DHCS 2022: Assessing the Continuum of Care for Behavioral Health Services in California. Data, Stakeholders Perspective, and Implications. https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf

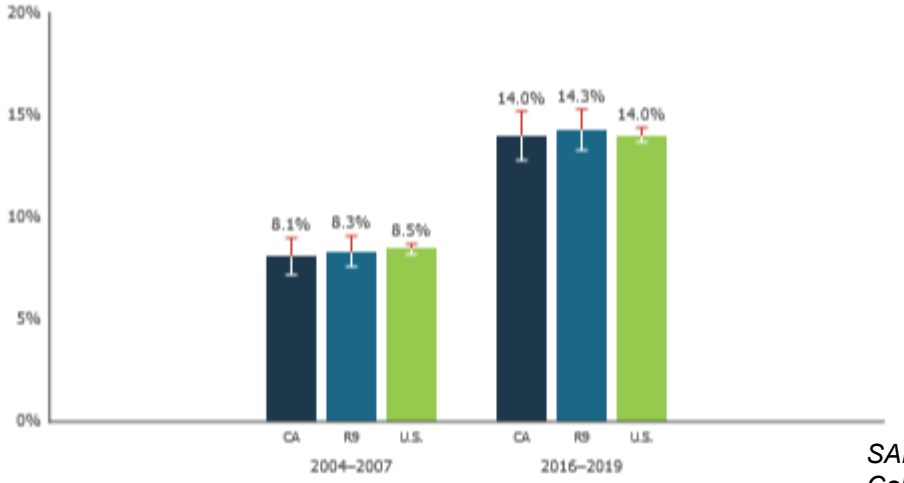
Youth Mental Health and Service Use

Depression

Changes in Past-Year Major Depressive Episode (MDE) among Youth Aged 12–17 in California, Region 9, and the United States (Annual Averages, 2004–2007 and 2016–2019)[1,2]

Among youth aged 12–17 in California, the annual average percentage with an MDE in the past year increased between 2004–2007 and 2016–2019.

During 2016–2019, the annual average prevalence of past-year MDE in California was **14.0%** (or **410,000**), similar to both the regional average (**14.3%**) and the national average (**14.0%**).



Error bars indicate 95% confidence interval of the estimate.
CA = California; R9 = Region 9 (Arizona, California, Hawaii, and Nevada); U.S. = United States.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2004–2007 and 2016–2019.

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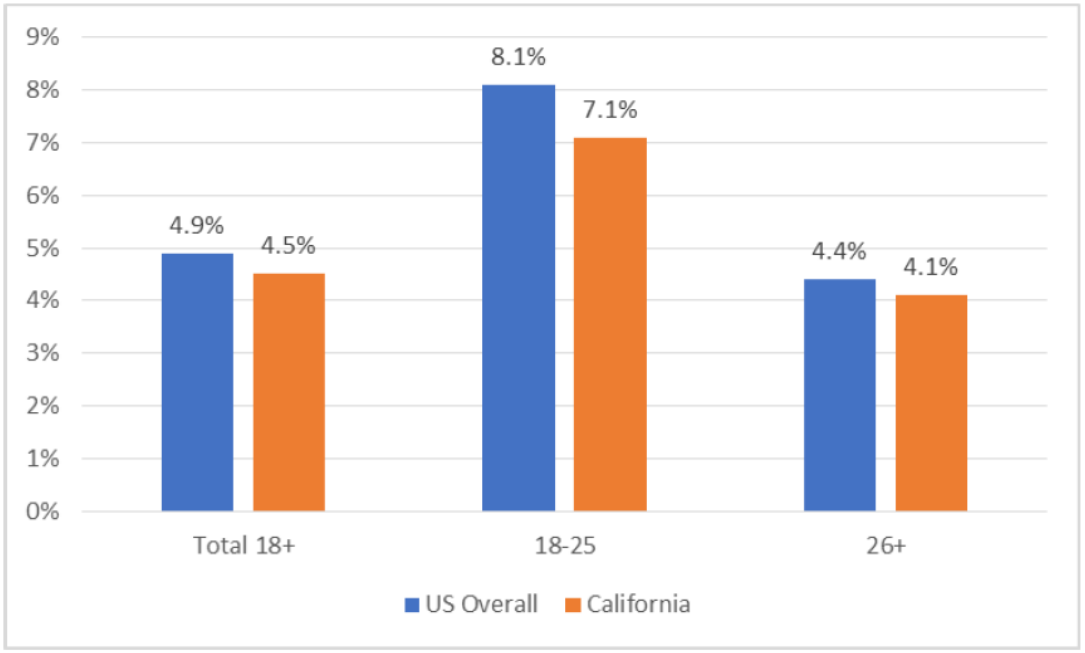
SAMHSA (2019): Behavioral Health Barometer. California, Volume 6
https://www.samhsa.gov/data/sites/default/files/reports/rpt32821/California-BH-Barometer_Volume6.pdf

California

Figure 3. **Percentage of Individuals Aged 18+ Living with Serious Mental Illness in California Relative to United States Overall[56]**



31% increase in youth ED visits due to COVID-19

DHCS 2022: Assessing the Continuum of Care for Behavioral Health Services in California. Data, Stakeholders Perspective, and Implications. https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf

California

- 43% of Californians say it is difficult to access BH resources
- 90% of individuals with SUD do not receive services
- 21 million Californians receive BH resource via commercial insurance, 14 million via Medi-Cal

DHCS 2022: Assessing the Continuum of Care for Behavioral Health Services in California. Data, Stakeholders Perspective, and Implications. https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf

Access and Utilization

- 8-16% of all ED visits have a primary/secondary behavioral health Diagnosis *(Strover, Brett, Michaels & Petrini, 2021)*

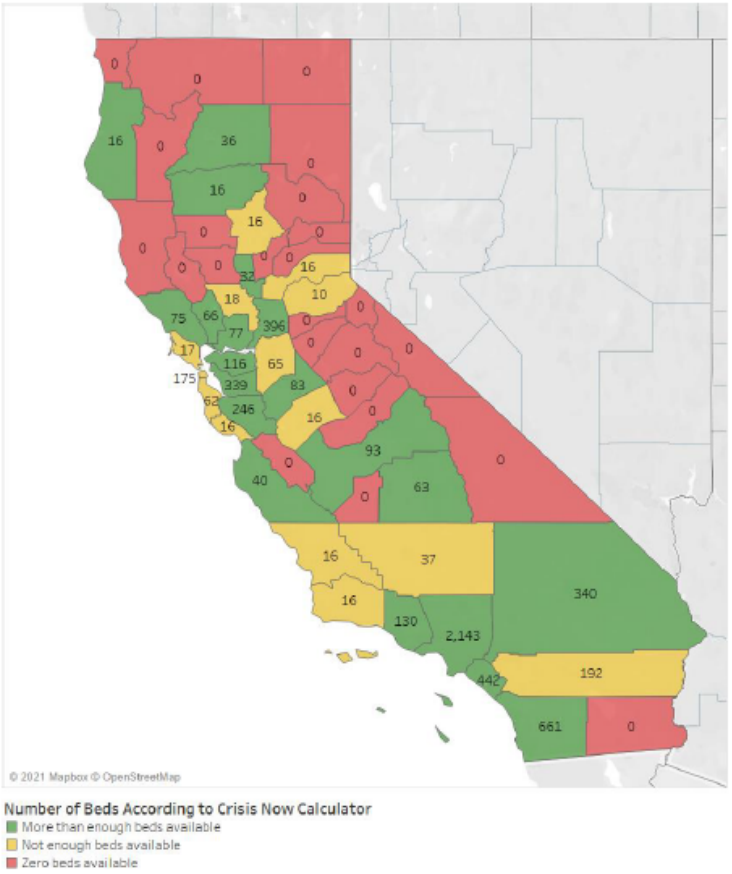
- Since COVID the utilization rate has increased by 45-60% with the highest increase in lower income and older populations.

- Less than 20% of individuals with a mental health needs receive care from a behavioral health specialty professional/clinic *(CDC, 2022)*

California

Figure 14. **Number of Acute Mental Health Inpatient Treatment Beds and Estimates of Need for Additional Capacity**[139]

Counties shaded in green have more than enough beds according to the Crisis Resource Need Calculator. Counties shaded in yellow have beds available but do not have enough beds according to the calculator. Counties shaded in red do not have any beds available. Labels on counties reflect the current number of acute inpatient beds licensed by the state. Note that some counties may have suspended beds that are not actively available—temporarily due to staffing, or permanently—so this map may overestimate capacity.



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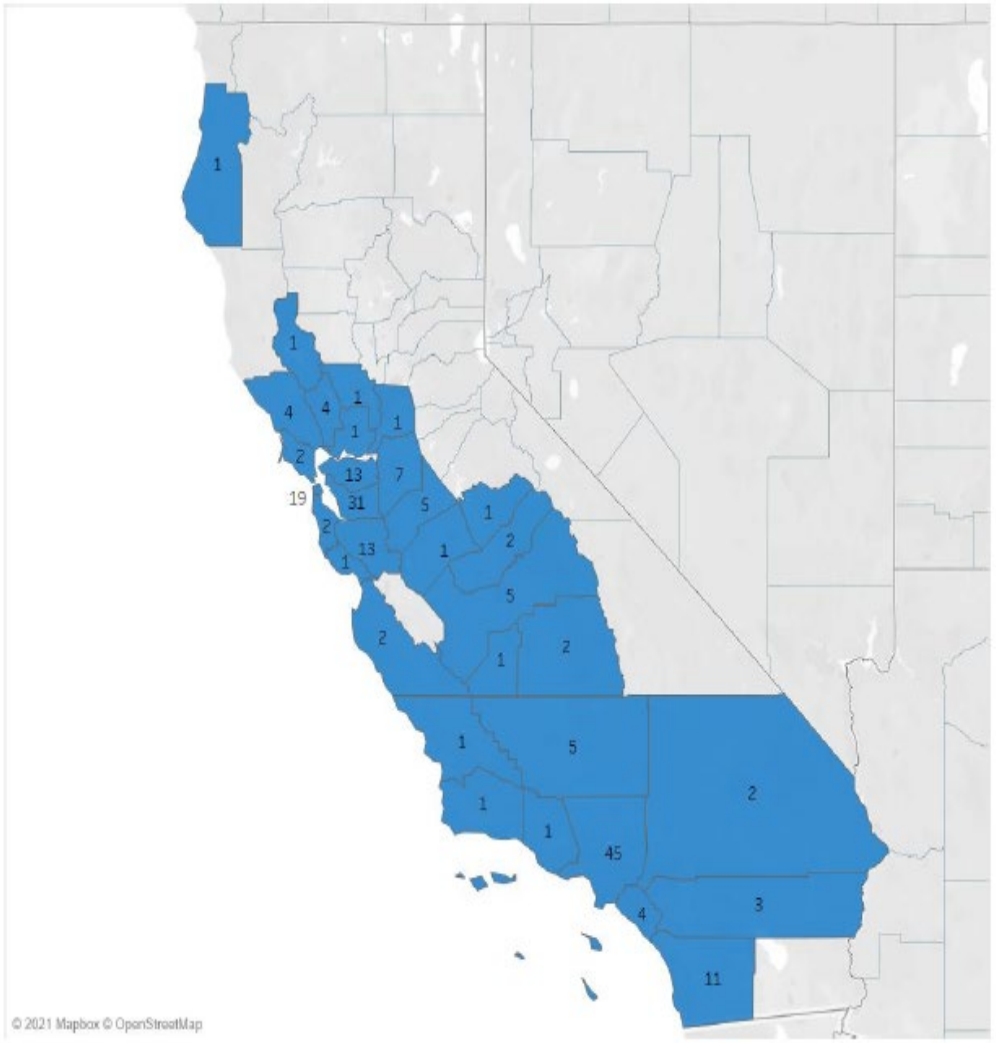
California

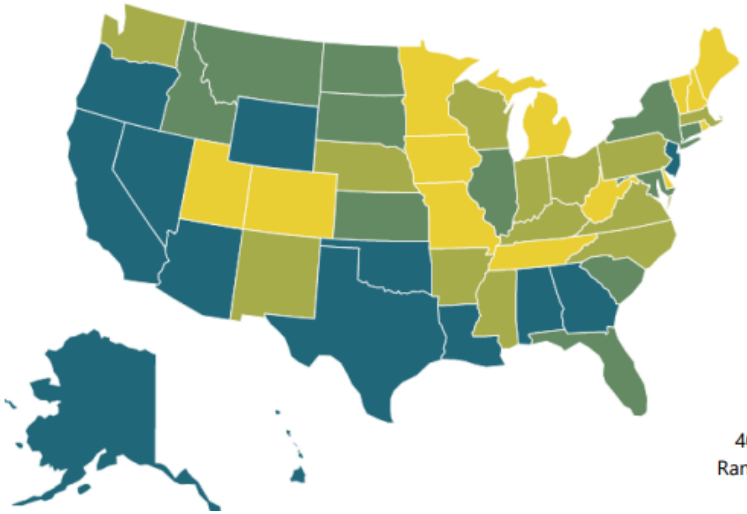
Figure 15. **Counties with School-Linked Health Programs That Provide Mental Health Treatment Services**[150]



DHCS 2022: Assessing the Continuum of Care for Behavioral Health Services in California. Data, Stakeholders Perspective, and Implications.
https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf

Adult Access to Care

Adults with AMI who Did Not Receive Treatment



57.2 percent of adults with a mental illness receive no treatment.

Over 26 million individuals experiencing a mental illness are going untreated.

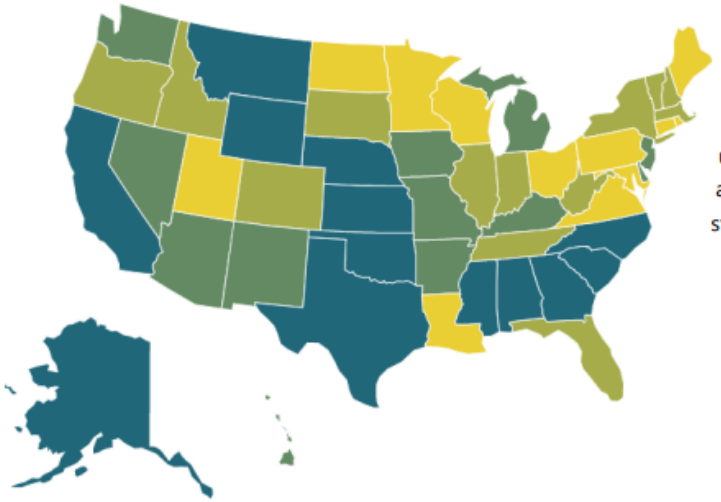
The state prevalence of untreated adults with mental illness ranges from:

40.7% (VT) Ranked 1-13

64.8% (CA) Ranked 39-51

Youth Access to Care

Youth with MDE who Did Not Receive Mental Health Services



59 percent of youth with major depression do not receive any mental health treatment.

Youth experiencing MDE continue to go untreated. Even among the states with greatest access for youth, almost 50 percent of youth are still not receiving the mental health services they need.

The state prevalence of untreated youth with depression ranges from:

39.5% (RI) Ranked 1-13

74.3% (NC) Ranked 39-51

Mental Health America. (2020). *The State of Mental health in America 2020.* https://mhanational.org/sites/default/files/State%20of%20Mental%20Health%20in%20America%20-%202020_0.pdf

Chronic Illness And Mental Health: What We Know

1. Individuals with a physical/chronic condition are 2-3 times more likely to develop an Axis I mental health condition

2. Mental health needs are 60% more likely to be missed or underdiagnosed in individual's with a chronic physical health condition

3. Individuals with a physical health condition have the greatest barriers to accessing services/resources

Summary

PROBLEM/CHALLENGES:

1. All levels of behavioral health are on the rise in California.
2. While California has sufficient resources for BH in comparison to the rest of the country we aren't reducing the upward trend.
   - We have a significant shortage of upstream resources
   - Limited workforce capacity
3. There are few sustainable models and most rely on Medicaid/care focus versus commercial plans

Initiatives:

1. $6.2 Billion in funding for Behavioral Health
2. A focus on down stream activities
3. A focus on prevention and behavioral health integration

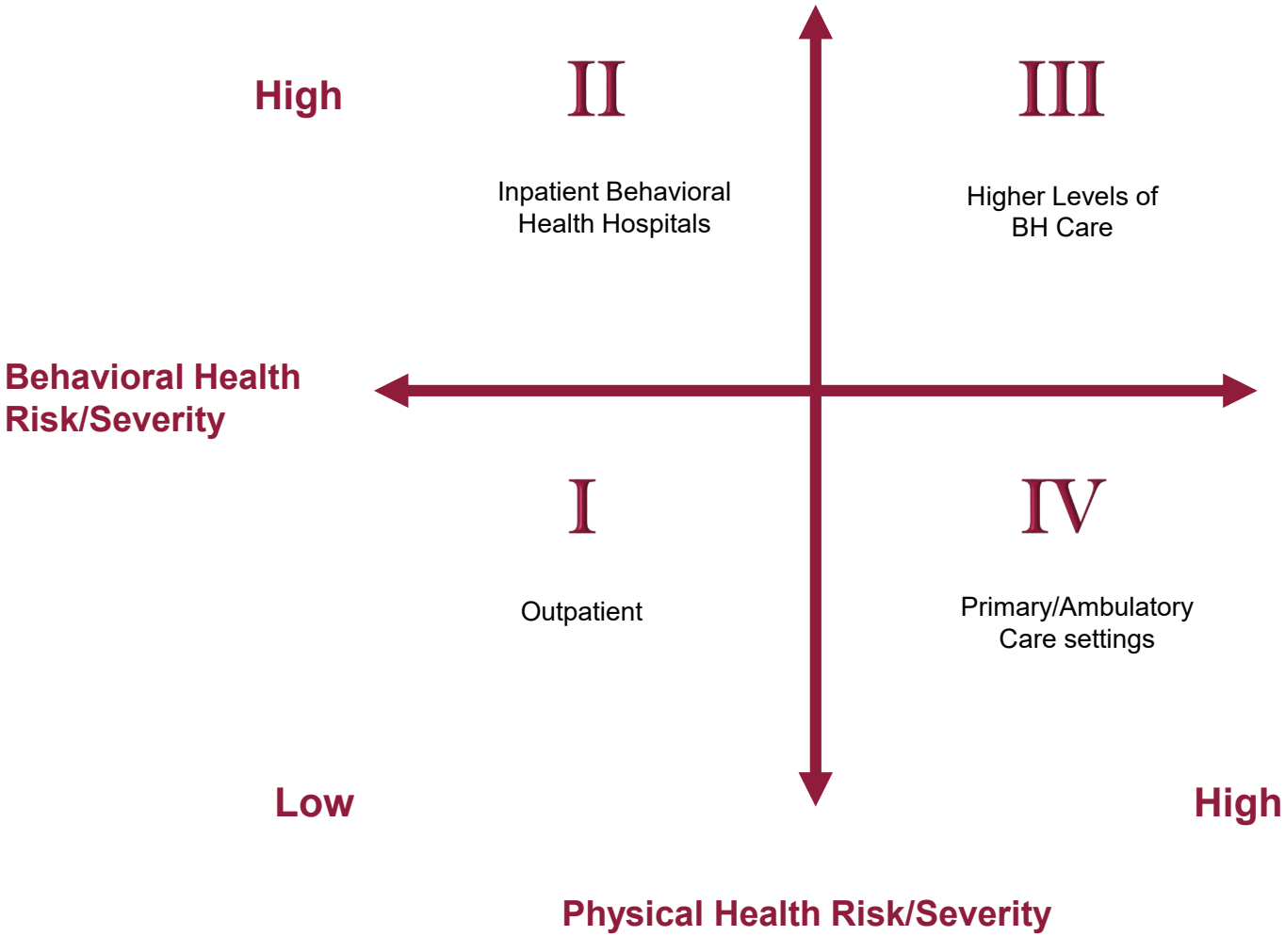
Models

A. Two major questions to consider

B. Models in use and evidence based

C. Models in pilot

D. Models locally



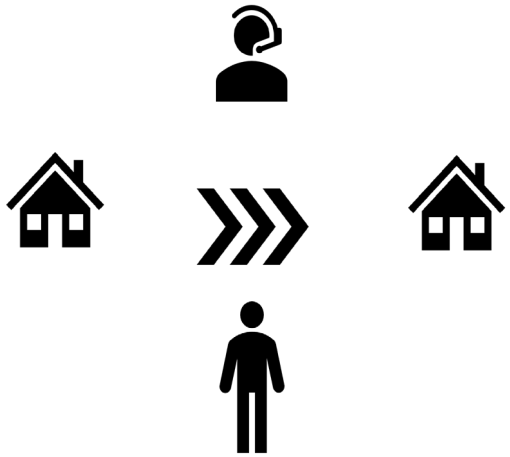
Adapted from: Mauer, Barbara J.. "Behavioral Health/Primary Care Integration and the Person Centered Healthcare Home". April 2009. The National Council for Behavioral Health Care.

Coordinated

KEY ELEMENT: COMMUNICATION

Level 1: Minimal Collaboration. Patient referred to other practice.

Level 2: Basic Collaboration. Periodic bi-directional communication

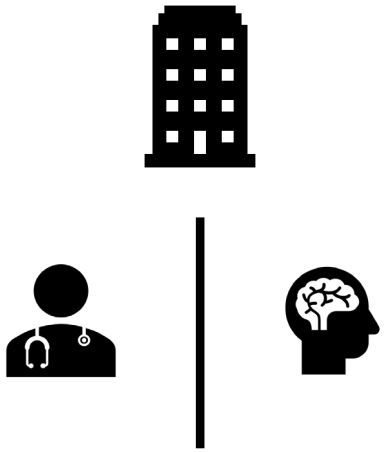


Co-Located

KEY ELEMENT: PHYSICAL PROXIMITY

Level 3: Basic collaboration onsite. Separate practice but located together

Level 4: Close Collaboration onsite with some system integration. Separate practice but shared EMR and some face to face interaction

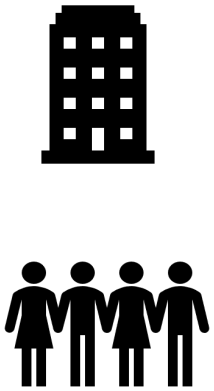


Integrated

KEY ELEMENT: PRACTICE CHANGE

Level 5: Close collaboration approaching an integrated practice. Collaborative TX planning, but separate TX plans

Level 6: Full collaboration in a merged integrated practice for all patients. Team of providers jointly develops one TX plan. Patients experience a single system/team



Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

Evidenced Based Models in Use

A. Screening, Brief Intervention, Referral to Treatment (SBIRT)
   - A few RCTs. Most of the studies show moderate evidence of substance use remission
   - Trained behavioral health professionals administer a screening protocol
   - Trained professionals provide recommendations and support in accessing additional care
   - Can be executed by B.S. level/trained professionals
   - Mostly executed in primary care
   - Medi-Cal reimbursement available for these services currently

Ramanuj, Ferenchik, Docherty, Spaeth-Rublee & Pincus. (2019). Evolving models of integrated behavioral health and primary care. Current Psychiatry Reports. 21: https://doi.org/10.1007/s11920-019-0985-4

Evidence Based Models

B. Collaborative Care Model

- Generally done in Levels 2-3
- Targeting depression, anxiety and other BH needs (usually less severe populations)
- Often applied in primary care settings
- Usually include onsite case/care managers. Their primary role is for screening and access to the BH resources
- Includes systemic TX supervision and follow-up (e.g. usually 12-16 weeks)
- Richest evidence base. Shows strong support for patient outcomes (over 135 studies, 35 RCTs)

Evidence Based Models

C. **Behavioral Health Integration Program**

- Levels 3-4
- Few studies
- Only in pediatric primary care
- Screening, care management and onsite BH care provided
- Teams
  - 1 PCP/NP
  - Psychiatry Consult when needed
  - BH clinician (Social Workers, psychologists, counselors)
  - Care Coordinator
- Outcomes noted:
  - Increased PH and BH visits
  - Increased TX congruence
  - Reduction in ED costs by 19%

Evidence Based Models

D. CoCM and IMPACT

- Level 3-4
- Lead by a primary care practice site
- Screening for needs (e.g. IMPACT is focused on depression and older populations
- Very focused on fidelity to specific screening tools and formulaic TX plans
- Multiple psychoeducation components
- Coordinated/shared TX plan
- Long term follow-up (e.g. 12 months)
- Team
  - PCP
  - Care managers (nurses or psychologists trained in the model)
  - Psychiatry consult when needed

Summary from the current data

1. Integration models seem to result in:
   - Improved patient and provider satisfaction
   - Improve patient heath outcomes
   - Provide a cost benefit for payers
   - Improve TX adherence

2. Common Practices:
   - Coordinated teams, lead by PCP inclusive of a care managers, behavioral health provider and access to psychiatry consults.
   - The vast majority of models exist in PCP practices
   - Screening and TX tools
   - Access to higher level resources

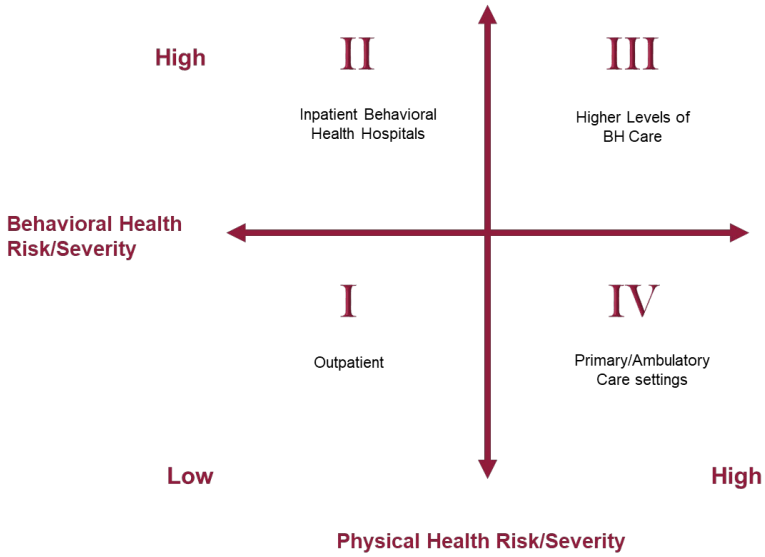
Limitations in Current Evidence

1. Limited research on higher levels of integration (levels 5-6)

2. Limited research on models located outside of primary care

3. No results showing differences in outcomes by integration level or model

4. Almost all of the research is focused on mental health outcomes or SUD populations. Little to no research has addressed co-occurring populations or populations with PH primary needs.



Local Models

1. ED
2. OB/GYN
3. Teams Center/ Specialty Peds
4. Diabetes Coordinated Care

Improving Follow-Up after Emergency Department Visit for Behavioral Health Diagnosis

- Addition of BMC-ED The Therapists are in the Emergency Department Monday through Friday 8:00a-4:30p.
- Patient Navigators: Navigators are trained community health workers with access to the LLU ED and BMC. When an aftercare plan is ordered through the C&L process the navigator begins working with the patient at the bed side and facilitates a smooth and warm hand off to the next stage of care.
- Psychiatrists/Residents through the C&L team

Improving Follow-Up after Emergency Department Visit for Behavioral Health Diagnosis

- The LLUH Emergency department is the primary ED for the Inland Empire. This ED serves the counties of San Bernardino and Riverside.
- In Fiscal Year 2019 the LLUH ED saw a total of 37,140 visits were from adult patients.
- 1,200 patients were admitted and a behavioral health diagnosis or need was identified during their ED visit and 563 were adult patients.

3.2% of patients identified with BH needs before implementation

Improving Follow-Up after Emergency Department Visit for Behavioral Health Diagnosis

- Grew our Screening Capacity from 709 patients screened with PHQ2/PHQ9 in the Summer to 4,496 patients screened in the winter.
- We attribute this growth to the partnerships with the ED leadership and nursing staff.
- 19.7% of ED patients require some level of BH resources
- 61.1% of patients identified for BH resources received those resources within 7 days of ED discharge

19.7% of patients identified with BH needs after implementation

Specialty Teams Center

- Teams of Peds Physicians, RNs, Therapists, Case Workers
- Full integration model with access to specialty BH resources
- 5.6% of youth in the specialty teams center screen high for behavioral health resources
- 62.5% have been engaged in behavioral health services

OB/GYN Teams

- Teams of Physicians, RNs, Therapists, Case Workers
- Full integration model with access to specialty Behavioral Health resources
- Screening all new mothers and post partum appointments
- 21.9% of mothers screen high for depression
- 73.8% of mothers in need of resources received BH resources within 30 days of screening

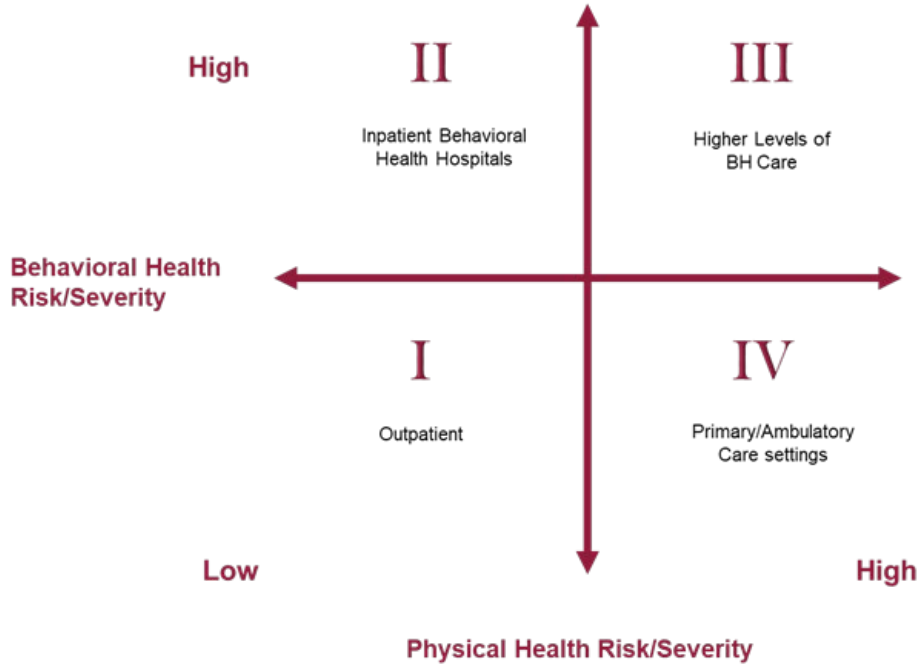
Diabetes Teams

- Teams of DTC RNs, and BMC multidisciplinary team
- Full integration model with access to specialty Behavioral Health resources
- Screening all adults admitted to the BMC (Inpatient)
- 5-10% screen high on A1C (e.g. > 9.0)
- Beginning CDC efforts while inpatient and extending these resources post discharge

Keys to BH Integration

1. Determine the type of integration needed, and the feasibility

COORDINATED	CO-LOCATED	INTEGRATED
KEY ELEMENT: COMMUNICATION	KEY ELEMENT: PHYSICAL PROXIMITY	KEY ELEMENT: PRACTICE CHANGE



Keys to BH Integration

2. Determine the outcome/objective
   - Access
   - Improved HRQL
   - Improved patient satisfaction
   - Enhanced screening

Keys to BH Integration

3. Determine the appropriate team structure
   - Level of Psychiatry involvement
   - Level of primary care physician involvement
   - Care managers and level of training/skill set
   - Location and engagement of behavioral health clinicians (e.g. Therapists, Social Workers, Psychologists etc)
   - Need and embeddedness of RNs
   - Additional of patient navigators

Keys to BH Integration

4. Leadership and Champions
5. Initial investments versus ROI
6. Change the culture and change the hierarchy
7. EMR changes and barriers
8. Communication issues due to setting and legal requirements
9. Plan for sustainability (system sustainability and financial sustainability)

Questions