SECOND GENERATION INTEGRATION:
Blending the Community Mental Health Mission
into the
Patient Centered Medical Home

13th Annual Summer Institute
Center for Applied Behavioral Health Policy
Sedona, Arizona
July 17, 2012
Community Mental Health Centers: What were they? What are they? What happened?

- Historical roots – Action for Mental Health (1961), Community Mental Health Center Act (1963), 1960’s social activism
- Community Mental Health Centers -- the initial model
- Federal block grants gave the States authority over the program
- Psychosocial rehabilitation and “priority populations”
- Managed care and behavioral health carve-outs
- Advocacy/consumer groups, peer support and recovery models
- Federal, State and Medicaid cutbacks
The Mental Health System: Recent Reviews, Reports and Recommendations

- Surgeon General Satcher’s Report
- President’s New Freedom Commission
- IOM: Crossing the Quality Chasm
- NASMHPD Reports
- National Comorbidity Survey Replication
**National Comorbidity Survey Replication**

**Lifetime Prevalence of DSM-IV Disorders**

<table>
<thead>
<tr>
<th></th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any</td>
<td>46%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>29%</td>
</tr>
<tr>
<td>Impulse-Control</td>
<td>25%</td>
</tr>
<tr>
<td>Mood</td>
<td>21%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>15%</td>
</tr>
</tbody>
</table>

Any Anxiety Impulse-Control Mood Substance Abuse
Prevalence 26% 18% 9% 10% 4%

National Comorbidity Survey Replication
Twelve-Month Prevalence of DSM-IV Disorders

National Comorbidity Survey Replication
Provision of Behavioral Health Care: Setting of Service

SOURCE: Wang, Philip S., et al, Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005
National Comorbidity Survey Replication
Provision of Behavioral Health Care: Setting of Service

SOURCE: Wang, Philip S., et al, Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005
Access to Behavioral Health Intervention

Mental Health Treatment
41%
Access to Behavioral Health Intervention

80% of those with no mental health treatment had a primary care service

Mental Health Treatment 41%
Access to Behavioral Health Intervention

80% of those with no mental health treatment had a primary care service

Mental Health Treatment 41%

No Healthcare Visit 12%
Penetration into the General and Medicaid Populations

- 3 year (FY2007-2010) penetration into the general population ranged from 4% to 34%.
  
  Unduplicated patients: 94,213
  Total area population: 957,222
  Penetration: 9.8%

- 3 year (FY2007-2010) TennCare (Medicaid) penetration ranged from 8% to 59%.
  
  Unduplicated Medicaid patients: 44,593
  Total Medicaid enrollment: 173,027
  Penetration: 25.8%
### PREVALENCE OF PSYCHIATRIC DISORDERS IN PRIMARY CARE

<table>
<thead>
<tr>
<th>DISORDER</th>
<th>PREVALENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Mental Disorder</td>
<td>61.4%</td>
</tr>
<tr>
<td>Somatoform</td>
<td>14.6%</td>
</tr>
<tr>
<td>Major Depression</td>
<td>11.5%</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>7.8%</td>
</tr>
<tr>
<td>Minor Depression</td>
<td>6.4%</td>
</tr>
<tr>
<td>Major Depression (partial remission)</td>
<td>6.3%</td>
</tr>
<tr>
<td>Generalized Anxiety</td>
<td>7.0%</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>3.6%</td>
</tr>
<tr>
<td>Other Anxiety Disorder</td>
<td>9.0%</td>
</tr>
<tr>
<td>Alcohol Disorder</td>
<td>5.1%</td>
</tr>
<tr>
<td>Binge Eating</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

## PREVALENCE OF PSYCHIATRIC DISORDERS IN LOW-INCOME PRIMARY CARE PATIENTS

<table>
<thead>
<tr>
<th>Psychiatric Disorder</th>
<th>Low-Income Patients</th>
<th>General PC Population*</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Least One Psychiatric Dx</td>
<td>51%</td>
<td>28%</td>
</tr>
<tr>
<td>Mood Disorder</td>
<td>33%</td>
<td>16%</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>36%</td>
<td>11%</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>17%</td>
<td>7%</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>10%</td>
<td>7%</td>
</tr>
</tbody>
</table>

- 35% of low-income patients with a psychiatric diagnosis saw their PCP in the past 3 months
- 90% of patients preferred integrated care
- Based on findings authors argue for system change

Prevalence in Primary Care

Alcohol Use

- At Risk
- Abuse or Dependence
- Low Risk/Abstainers

The Georgia/Texas "Improving Brief Intervention" Project
Primary Care in the United States: The *de facto* Mental Healthcare System

• More mental health interventions occur in primary care than in specialty mental health settings. *(Wang, et. al., 2005)*

• Primary care providers prescribe 70% of all psychotropic medication, including 80% of anti-depressants. *(Strosahl, 2001)*

• Over one-third of the patients in most primary practices have a psychiatric disorder. *(Spitzer, et. al., 1994; Mauksch, et. al., 2001)*

• 50% of Cherokee medical patients reported complaints on the SF36 supporting a diagnosis of depression.
Primary Care IS Behavioral Healthcare

- Psychological distress drives primary care utilization.
- A variety of studies have concluded that 70% of all healthcare visits have primarily a psychosocial basis. (Strosahl, 1998; Fries, et. al., 1993; Shapiro, et. al., 1985)
- Every primary care presentation has a behavioral component.
- The highest utilizers of healthcare commonly have untreated/unresolved behavioral health needs. (Von Korff, et. al., 1992; Katon, et. al., 2003)
Factors Prompting Integration

- MH/SU services system can’t accommodate demand, let alone need
- More seek help for mental health problems in primary care
  - Failure of referral
  - Stigma endures
- Behavioral factors in chronic disease management
- Synergy with the concept of the Patient-Centered Healthcare Home
New Paradigms Sweeping Across the Safety Net

Paradigm Shift at the Systems Level

• Primary Care is a locus of mental health intervention
• Increased mental health service capacity at FQHCs
• FQHC/CMHC collaborations

Paradigm Shift at the Clinical Level

• Primary Care Provider focus on behavioral factors
• Mental Health Provider focus on general health status
• New service role for Behaviorists in primary care
The First Generation of Integration
Initial Forays

- Awakening interest in collaboration
- Preferential referral relationship
- Formalized screening procedures
- Specialty consultation
- Disease management
- Co-location
Second Generation Integration

- Blended care team
- Shared support staff and physical space
- Well orchestrated clinical flow
- One clinical record, unified treatment plan
- Communication is immediate
- Shared patient population
- Reimbursement mechanisms support the model
## Integration vs. Co-Location
### Role of Behaviorist

<table>
<thead>
<tr>
<th>Integrated Care</th>
<th>Co-Located Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Embedded member of primary care team</td>
<td>• Ancillary service provider</td>
</tr>
<tr>
<td>• Patient contact via hand off</td>
<td>• Patient contact via referral</td>
</tr>
<tr>
<td>• Verbal communication predominate</td>
<td>• Written communication predominate</td>
</tr>
<tr>
<td>• Brief, aperiodic interventions</td>
<td>• Regular schedule of sessions</td>
</tr>
<tr>
<td>• Flexible schedule</td>
<td>• Fixed schedule</td>
</tr>
<tr>
<td>• Generalist orientation</td>
<td>• Specialty orientation</td>
</tr>
<tr>
<td>• Behavior medicine scope</td>
<td>• Psychiatric disorders scope</td>
</tr>
</tbody>
</table>
Blending Behavioral Health into Primary Care

Cherokee Health Systems’ Clinical Model
Behaviorists on the Primary Team
The Behavioral Health Consultant (BHC) is an embedded, full-time member of the primary care team. The BHC is a licensed Health Service Provider in Psychology. Psychiatric consultation is available to PCPs and BHCs.

Service Description
The BHC provides brief, targeted, real-time assessments/interventions to address the psychosocial aspects of primary care.

Typical Service Scenario
The Primary Care Provider (PCP) determines that psychosocial factors underlie the patient’s presenting complaints or are adversely impacting the response to treatment. During the visit the PCP “hands off” the patient to the BHC for assessment or intervention.
The Behavioral Health Consultant (BHC) in Primary Care

- Management of psychosocial aspects of chronic and acute diseases
- Application of behavioral principles to address lifestyle and health risk issues
- Emphasis on prevention and self-help approaches, partnering with patients in a treatment approach that builds resiliency and encourages personal responsibility for health
- Consultation and co-management in the treatment of psychiatric and substance use disorders
Integrated Care targets...

- Psychological problems, such as anxiety and depression
- Problems that include both physical and psychological components, such as substance abuse
- Psychological components of physical illnesses, both acute and chronic
- Nonspecific factors related to acute/chronic illness states such as stress, noncompliance, coping styles, sleep/diet, social support, subclinical mood
Considerations for PCP “Hand-offs” for Behavioral Health Consultation Services

MENTAL HEALTH BEHAVIORAL ISSUES

• Diagnostic clarification and intervention planning
• Facilitate consultation with psychiatry regarding psychotropic medications
  • Behavior and mood management
  • Suicidal/homicidal risk assessment
• Substance abuse assessment and intervention
  • Panic/Anxiety management
• Interim check of psychotropic medication response
  • Co-management of somaticizing patients
  • Parenting skills
  • Stress and anger management
Considerations for PCP “Hand-offs” for Behavioral Health Consultation Services

HEALTH BEHAVIOR / DISEASE MANAGEMENT

• Medication Adherence
• Weight Management
• Chronic Pain Management
  • Smoking Cessation
  • Insomnia / Sleep Hygiene
• Psychosocial and Behavioral Aspects of Chronic Disease
  • Any Health Behavior Change
• Management of High Medical Utilization
The Integrated Care Psychiatrist

- Access and Population-Based Care
- Enhance the Skills of Primary Care Colleagues
  - Treatment Team Meetings
    - Telepsychiatry
- Stabilize Patients and Return to Primary Care
  - Co-Management of Care
Communication Model

Face to Face Verbal Feedback

Electronic Health Record

Treatment Team

Telehealth Consultation
Developing a Business Model for Integration
“Integration” from a CMHC Perspective...
Primary Care

Copyright 2004 Dean MacAdam
“Integration” from an FQHC Perspective...
“Reality”
What’s in YOUR Contract?
The Challenges of PC Practice

• Volume, Volume, Volume

• Can’t be a QB without a team
  • 24-7 coverage

• Specialist and hospital access

• Scarce workforce, competitive recruitment

• Complex, low-margin business
The Challenges of Making Integration Work in MH Setting

- Facility and equipment needs
- Administrative competence
- Accommodate the culture
- Define the population
- Financing/business model
Payment Policy Disincentives for the Integration Paradigm

- Mental health carve-outs
- Excessive documentation requirements
- Same day billing prohibition
- Encounter-based reimbursement
- Antiquated coding requirements
Financing Structure for Integration of BHCs into Healthcare Homes

- Health and Behavior Assessment/Intervention
  
  CPT Codes 96150-55

- Same day billing by PCP and BHC

- Valuing consultation and case coordination

- Global funding streams

- Value-based contracting
Integrated Care Standards

• Weekly multidisciplinary care team meeting
• Behavioral health provider embedded on primary care team
• Real-time psychiatric consultation available
• Behavioral health screening of primary care patient
• Integrated clinical record & treatment plan
• Teleconference capability to import providers, as needed
Funding Mechanisms

• Fee For Service
• Case Rate
• Care Management Rate
• Capitation
• Blended Capitation
• Incentive Pools / Shared Savings
• Percent-of-Premium
The Bottom Line...

Contracts MUST support Integrated Care
Placing a VALUE on Integrated Care
Distribution of Resources – TennCare Integrated RFP Databook

- Inpatient: 17%
- Other Services: 14%
- MH Inpatient: 5%
- Home Health: 4%
- Emergency Room: 9%
- Surgery: 16%
- Specialty Services: 17%
- MH Outpatient: 4%
- E & M Services: 16%
Placing a VALUE on Integrated Care

• Reduced ER Utilization
• Reduced Inpatient Admissions
• Reduced Specialty Referrals
• Increased Patient Satisfaction
• Increased Primary Care Utilization
• Improved Outcomes
Figure 1: Comparison of CHS utilization with regional providers

- Primary Care Visits: 117%
- ER Visits: 32%
- Specialty Care: 58%
- Hospital Care: 63%
- Cost: 78%
Cherokee’s Patient-Centered Healthcare Home

• Embedded Behavioral Health Consultant on the Primary Care Team
  • Real time behavioral and psychiatric consultation available to PCP
  • Focused behavioral intervention in primary care
    • Behavioral medicine scope of practice
  • Encourage patient responsibility for healthful living
    • A behaviorally enhanced Healthcare Home
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