Behavioral Health Integration Within Medical Settings: Promising Practices

9:45 AM – 10:45 AM
Steering Toward Success: Achieving Value in Whole Person Care
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The Healthier Washington Practice Transformation Support Hub

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Steering Toward Success:
Achieving Value in Whole Person Care

Behavioral Health Integration Within Medical Settings

AIMS CENTER | UNIVERSITY of WASHINGTON Psychiatry & Behavioral Sciences

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Learning Objectives

- Discuss the opportunities of a fully integrated model of care for primary care settings
- Identify the system barriers and challenges to developing fully integrated models of care in primary care medical settings
- Assess the role of the client/patient in a fully integrated model of care

Quality of Care

- ~ 30 million people receive a prescription for a psychotropic medication each year (most in primary care) but **only 1 in 4 improve**.
- Patients with serious mental illness **die 10 – 20 years earlier**, in large part due to poor medical care.

"Of course you feel great. These things are loaded with antidepressants."

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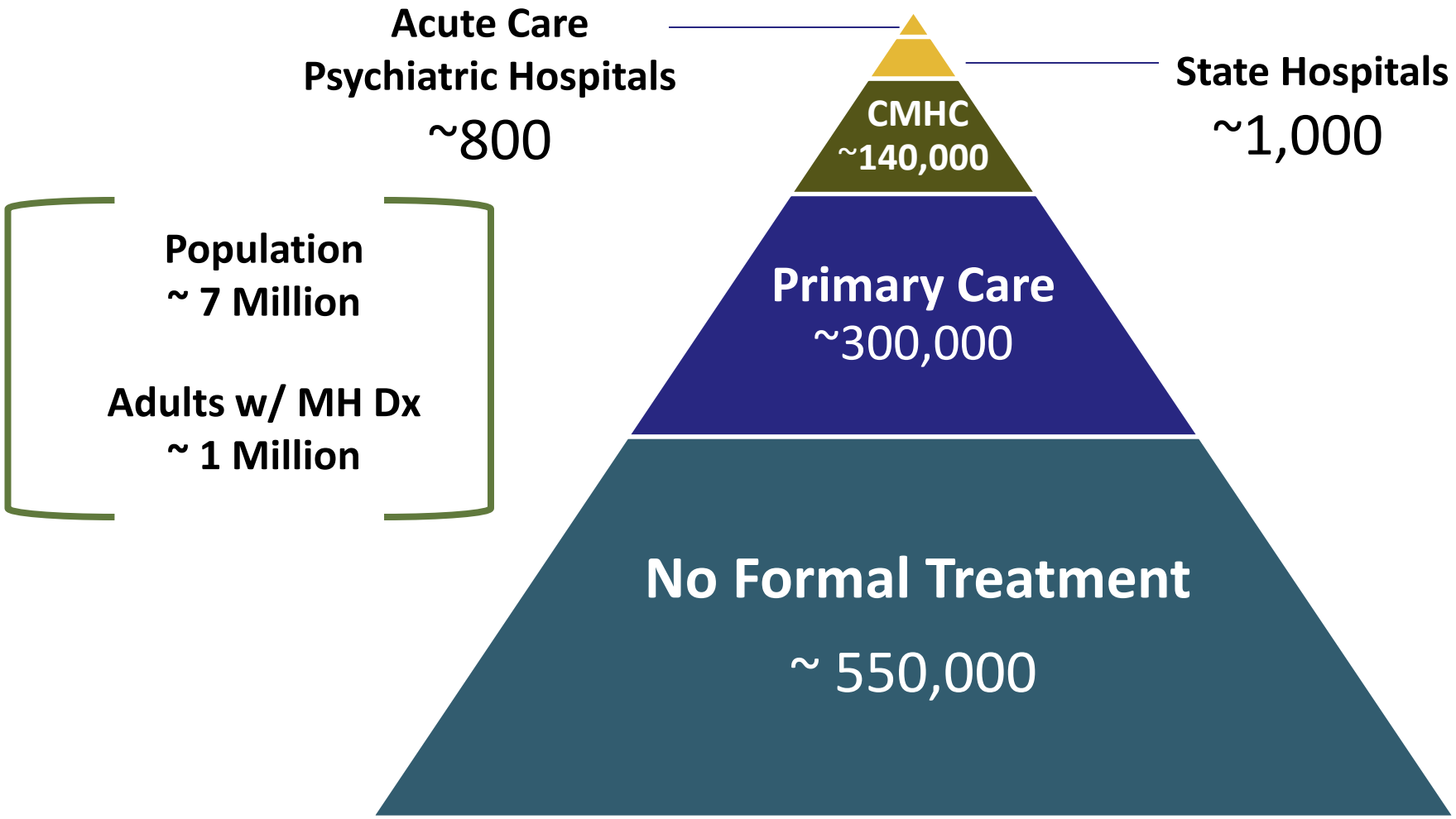
Behavioral Health Care in WA State



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Core Principles of Collaborative Care

Team-Based and Patient-Centered
Primary care and behavioral health providers collaborate effectively, using shared care plans.

Measurement-Based Treatment to Target
Measurable treatment goals clearly defined and tracked for every patient. Treatments are actively changed until clinical goals are achieved.

Population-Based Care
A defined group of clients is tracked in a registry so that no one "falls through the cracks."

Evidence-Based Care
Providers use treatments that have research evidence for effectiveness.

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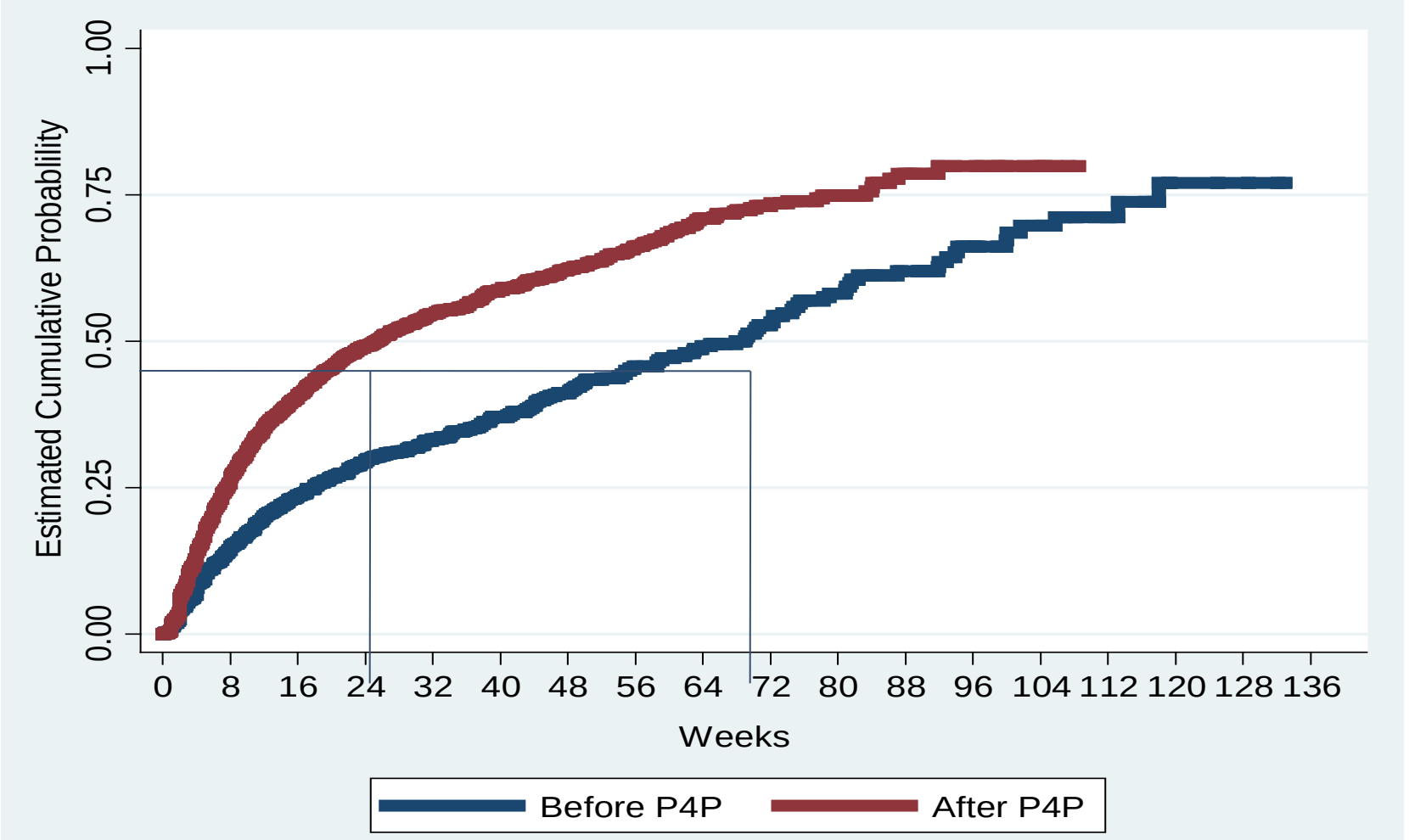
Accountability in Care:
Are We Providing Access to Effective Care?



Unutzer et al, *American Journal of Public Health* (2012)

Crosswalk for Project 2A - Integration

Same Elements in Bree Recs & Collaborative Care (CoCM)

- BH professional as part of primary care team
- Systematic BH screening
- Measurement-based BH services
- Population-based care
- Treatment to target
- Tracking patients and follow up
- Evidence-based treatments
- Access to psych (Bree) vs. psych case review (CoCM)

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Team-Based Care: Role of BH Team Members

BHC/PCBH Model

- Consultant on PCP team
- Aim for immediate access, minimal barriers
- Broad reach, serves significant portion of patient population
- Brief visits
- Limited follow up
  - Typically no more than 2-6 visits
- Focus on health prevention and behavior change

Collaborative Care Model

- Care manager on team
- Psych consultant on team
- Brief visits, more intensive management
- Follow up till specific clinical targets reached
- Average enrollment around six months
- Brief psychotherapies part of most successful programs

Further Reading: Psychiatryonline.org/All Hands on Deck

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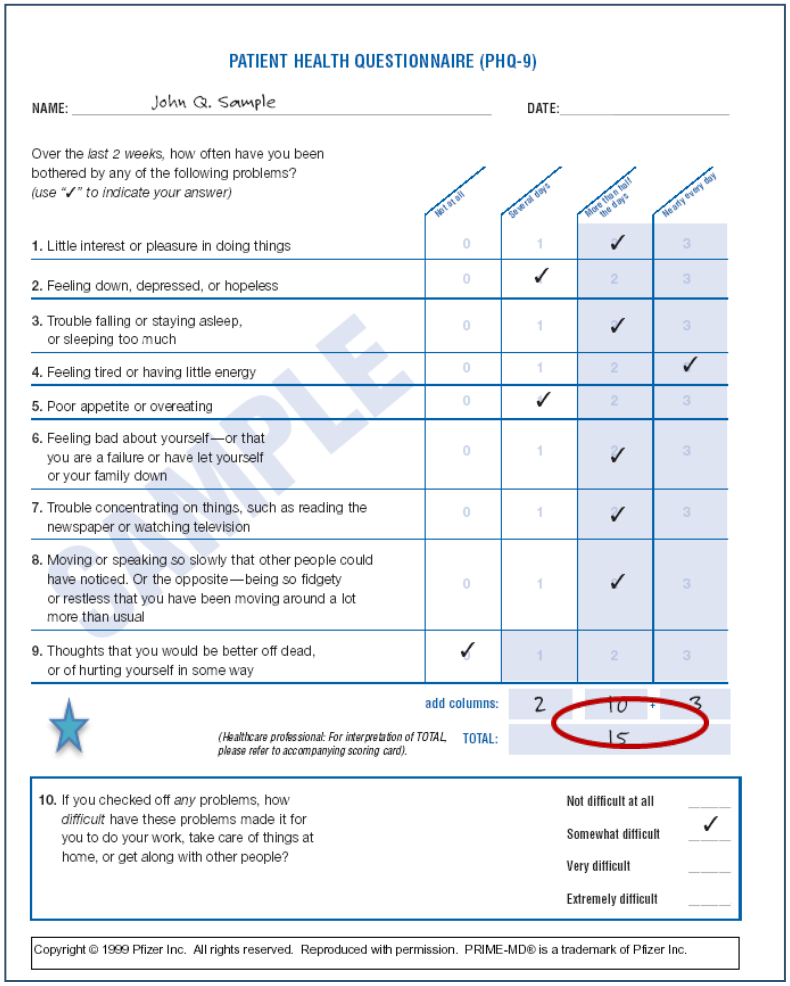
Validated Screening and Measurement Tools



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: John Q. Sample DATE:

Over the *last 2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	✓	3
2. Feeling down, depressed, or hopeless	0	✓	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	✓	3
4. Feeling tired or having little energy	0	1	2	✓
5. Poor appetite or overeating	0	✓	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	✓	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	✓	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	✓	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	✓	1	2	3
add columns:		2	10 +	3
TOTAL:			15	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult ✓
- Very difficult
- Extremely difficult

PHQ-9 > 9

- < 5 – none/ remission
- 5 - mild
- 10 - moderate
- 15- moderate severe
- 20 - severe

Registry Tracking

			Treatment Status				PHQ-9				GAD-7				Psychiatric Consultation	
			! indicates that the most recent contact was over 2 months (60 days) ago				✓ Indicates that the last available PHQ-9 score is at target (less than 5 or 50% decrease from initial score) ! Indicates that the last available PHQ-9 score is more than 30 days old				✓ Indicates that the last available GAD-7 score is at target (less than 10 or 50% decrease from initial score) ! Indicates that the last available GAD-7 score is more than 30 days old					
View Record	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Consultant Note
View	Active	Susan Test	9/5/2015	2/23/2016	10	26	22	14	-36%	2/23/2016	18	17	-6%	! 1/23/2016	Flag for discussion & safety risk	1/27/2016
View	Active	Albert Smith	8/13/2015	! 12/2/2015	7	29	18	17	-6%	! 12/2/2015	14	10	-29%	! 12/2/2015	Flag for discussion	
View	Active	Joe Smith	11/30/2015	2/28/2016	6	14	14	10	-29%	2/28/2016	10	✓ 6	-40%	2/28/2016	Flag for discussion	2/26/2016
View	Active	Bob Dolittle	1/5/2016	3/1/2016	3	9	21	19	-10%	3/1/2016	12	10	-17%	3/1/2016	Flag as safety risk	2/18/2016
View	Active	Nancy Fake	2/4/2016	2/4/2016	0	4	.	No Score			.	No Score				
View	RP	John Doe	9/15/2015	3/6/2016	10	25	20	✓ 2	✓ -90%	3/6/2016	14	✓ 3	✓ -79%	3/6/2016		2/20/2016

Downloadable University of Washington AIMS Center Registry Spreadsheet:
(https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data)

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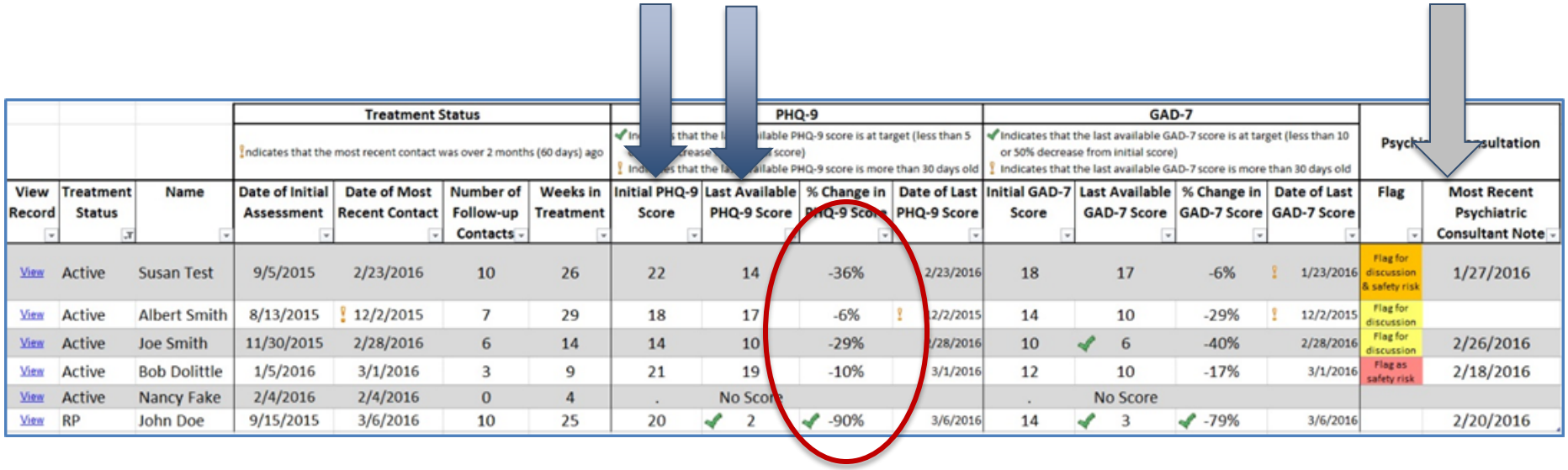
Registry Tracking and Treatment Intensification



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View Record	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Consultant Note
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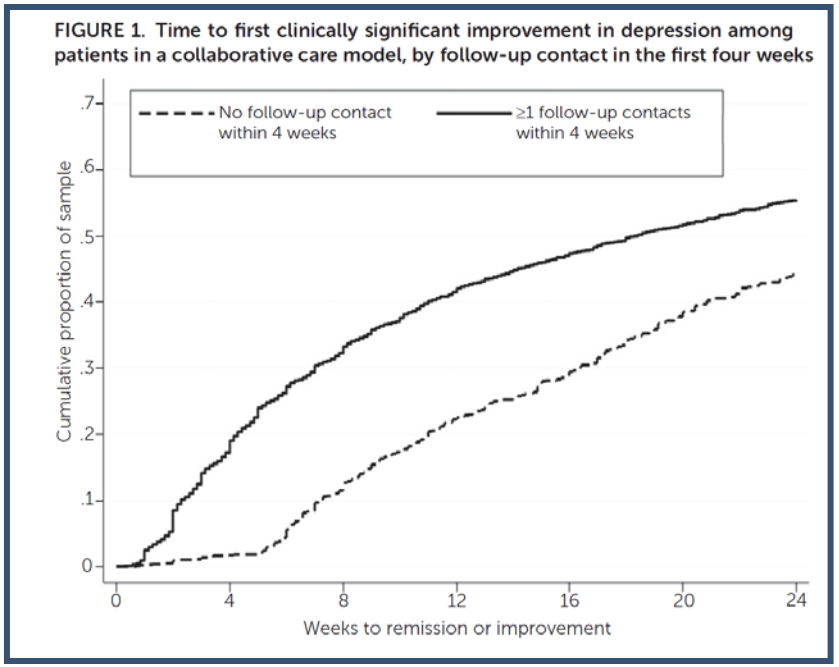
Evidence-Based Treatment

Evidence-based Brief Interventions

- Motivational Interviewing
- Distress Tolerance Skills
- Behavioral Activation
- Problem Solving Therapy

Frequent, Persistent Follow-up



Bao et al: Psych Serv 2015

Psychiatry and Primary Care:
An evolving relationship

Consultative model
- Psychiatrist sees patients in consultation in his/her office – away from primary care.

Co-located model
- Psychiatrist sees patients in primary care. Can use televideo.
- Better communication (often same chart) and coordination/ "transfers" back to primary care.

Collaborative model
- Psychiatrist takes responsibility for a caseload of primary care patients and works closely with PCPs and other primary care-based behavioral health providers.
- Can use televideo.

Key strategies to success:

→ System to track that referrals happen

→ Develop communication strategy to share information regularly and bi-directionally

→ Timely access (3 months is too long!)

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Integrated Care: Models vs Principles

- No one approach fits all
  - Focus on goal of access to effective mental health care.
- Evidence-based models have to be adapted to local settings in order to be successful.
- There are important principles that need to be followed in order to reach the Triple Aim.

Value = People Getting Better at a Reasonable Cost!

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Behavioral Health Integration Within Medical Settings

CHI Franciscan Health

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Background

- Primary care providers felt there was a wave of BH patients entering their clinics.
- Collaborative care was investigated for cost-effectiveness and direct collaboration with medical providers.
- After business plan development it was implemented as smaller pilot program.

Description of Integration Strategies

- Team
  - PCPs
  - Behavioral Health Consultants (LCSW & PsyD)
  - Psychiatrist
- Warm Handoffs
  - BHCs available during most clinic hours
- Registry
  - Currently use the provided AIMS registry
- Case conference
  - Weekly review for new and plateauing patients

Description of Integration Strategies

- Patient flow
- Psychiatric consults/education
- Patient Access
  - Reduced time to first appointment
- Active monitoring of registry
  - Tracking for progress and regular contact

Success Stories

- Patient success stories
- Therapy only successes
- PCPs more comfortable/knowledgeable
  - Diagnostically
  - Prescription choices

Challenges and Barriers

- Logistics of co-location
- Culture change
- Information sharing
- Creating and tracking registry
- Lack of community resources for referral for those patients that do not fully fit into model

Lessons Learned: Opportunities for Improvement

- Engagement of staff/providers
- Tracking registry and caseload review

Future Planning: Next Steps

- Ongoing value and role definitions
- Expansion of services to other clinics

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Behavioral Health Integration Within Medical Settings

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History of BH Integration

- History and commitment to the importance of the “patient voice” (patient majority Board of Directors)
- Honoring the patient perspective as we implement the “Patient Centered Medical Home”
- Involvement with mental health integration program around 2007

New Opportunities for BH Integration

- Social Innovation Fund Grant for Depression Care
  - BH grant received from the John A Hartford Foundation from the Corporation for National and Community Services in 2013

- Grant facilitated expansion of PCHS existing behavioral health integration program
  - Adding BH professionals at each clinical site
  - Hiring a consulting psychiatrist
  - Integrated collaborative care model (i.e IMPACT Model) to facilitate treatment of behavioral health issues specifically depression

Collaborative Care Model

- Team-based approach to care
- Care coordination and care management of BH issues
- Regular, proactive outcome monitoring and treatment to target using validated clinical rating scales like the PHQ-9 or SBIRT
- Regular, systematic caseload reviews utilizing a registry and psychiatric consultation for patients who do not show clinical improvement

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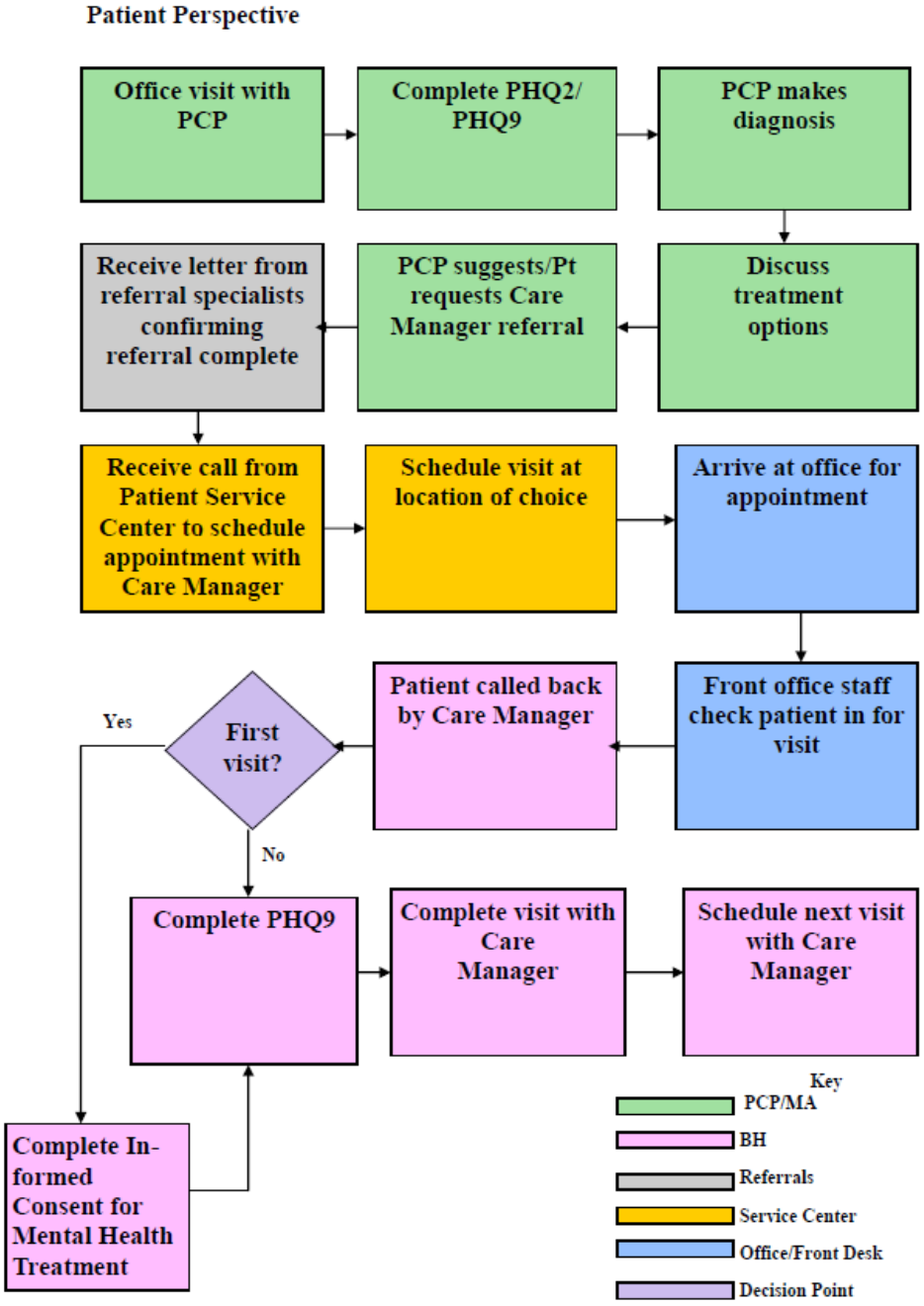
Description of Integration Strategies

- Identify patients through universal screening (Depression -PHQ-2/PHQ-9, GAD-7 –Anxiety, SBIRT – SUDs.)
- Engagement of patients for care coordination/ management and counseling as needed.
- Initiate and provide treatment through a primary care based team consisting of care managers, primary care providers, and psychiatric consultant.
- Track treatment adherence and outcomes utilizing population based registry (CMTS).
- Pro-actively adjust treatment to target by utilizing evidence based stepped care method with help of psychiatric consultant as needed.

PCHS Behavioral Health Program Workflow



Success Stories

- Implemented the collaborative care model in a way that its integrated into the clinical services
- Meeting established goals of patients served
- Maintaining good treatment outcomes
- Behavioral health team is an integral part of the clinical team
- New programs being implemented utilizing collaborative care model (Chemical Dependency Program- MAT)
- Bi-directional collaboration with specialty mental health programs underway

Success Stories

- 55% of active patients have noted 50% improvement of their depression based on PHQ-9 score after 10 weeks of treatment with IMPACT model (three more times than usual care)

- 53% of active patients have greater than a five point decrease on their PHQ-9

- 80% of active patients have received a psychiatric consultation (telephonic)

Challenges and Barriers

- Developing staff that fits the model
- Integrating the IMPACT (Depression Collaborative Care) model to all sites consistently
- Optimizing patient access and engagement
- Managing growing caseloads and complexity of patient population
- Transitioning patients to more appropriate settings
- Financial sustainability given current payment system

Lessons Learned: Opportunities for Improvement

- Integrated/collaborative model is complex and effective model of care.
- Implementation of collaborative care is a process that needs continual fine tuning.
- Education and training of staff are keys to successful collaborative care.
- Establishing resources/collaboration to transition patients needing a higher level of care is essential.

Future Planning: Next Steps

- **Sustaining Change Over Time**
  - ✓ Maintain staff engagement to model
  - ✓ Integrate BH team into clinical team through integrated team meetings and huddles
  - ✓ Continual education, training, and feedback

- **Financing Strategies**
  - ✓ Optimize documentation and coding
  - ✓ Optimize non-traditional BH schedules and group visits
  - ✓ Advocacy for improving reimbursement for collaborative care

Q & A

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