Behavioral Health Integration Within Medical Settings: Promising Practices

9:45 AM – 10:45 AM
Steering Toward Success: Achieving Value in Whole Person Care
October 26, 2017

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

- Define the principles for behavioral health integration in a medical setting
- Describe the opportunities in a fully-integrated model of care and give examples
- Articulate the challenges and system barriers that make integration work hard to do
- Identify opportunities for improvement amongst the promising practice sites

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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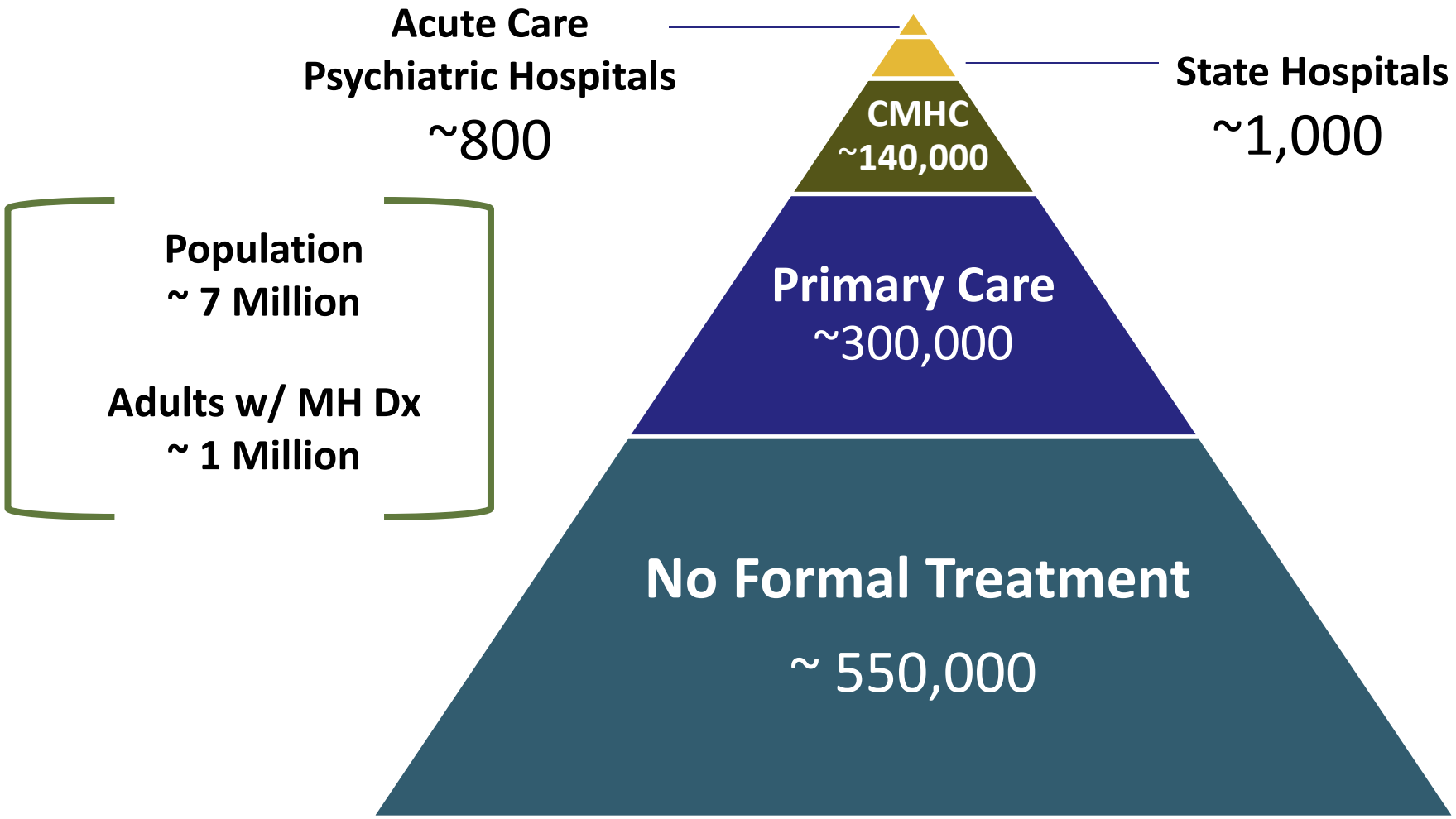
Behavioral Health Care in WA State



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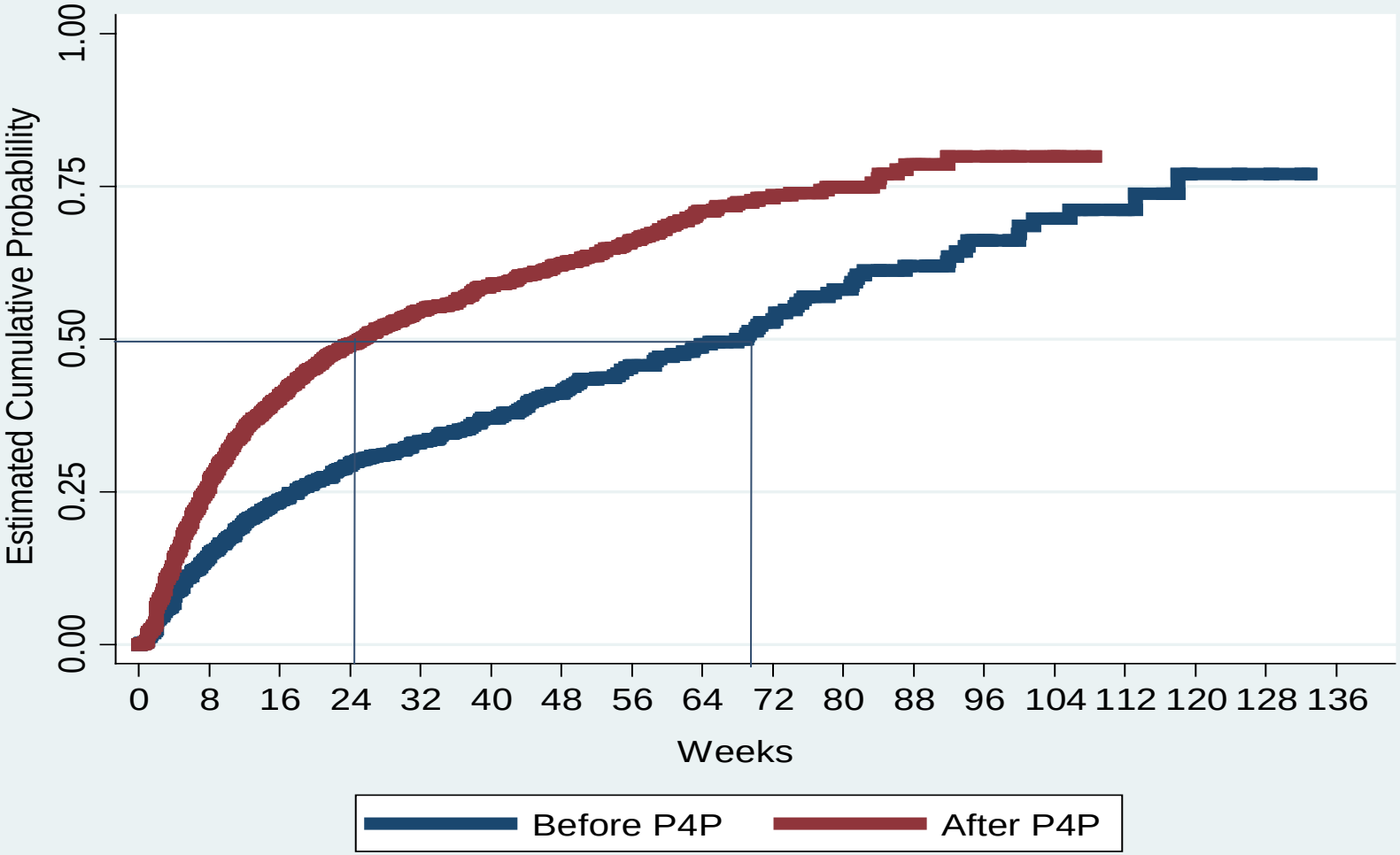
Accountability in Care:
Are We Providing Access to Effective Care?



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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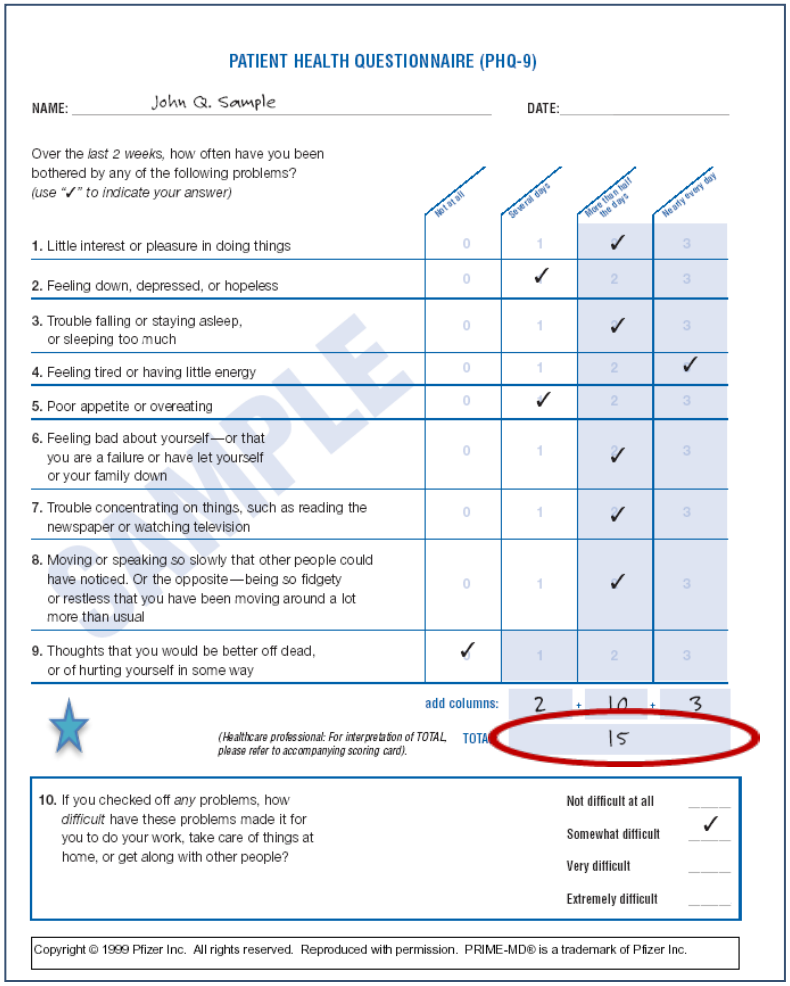
Validated Screening and Measurement Tools



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

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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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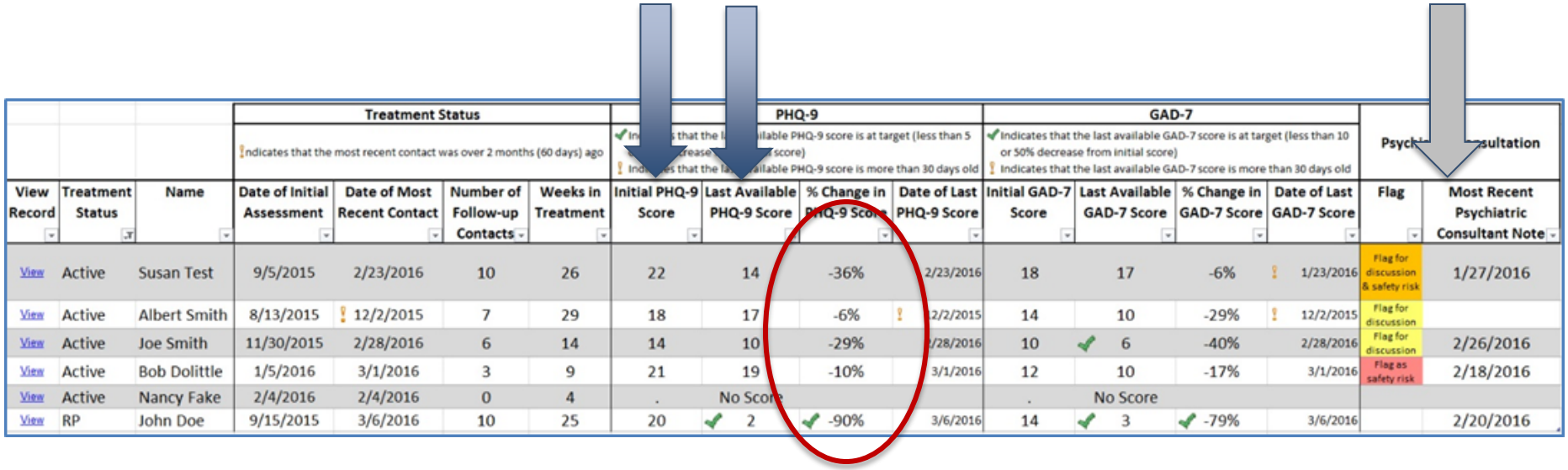
Registry Tracking and Treatment Intensification



			Treatment Status				PHQ-9				GAD-7					
			! 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				Psychiatric Consultation	
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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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

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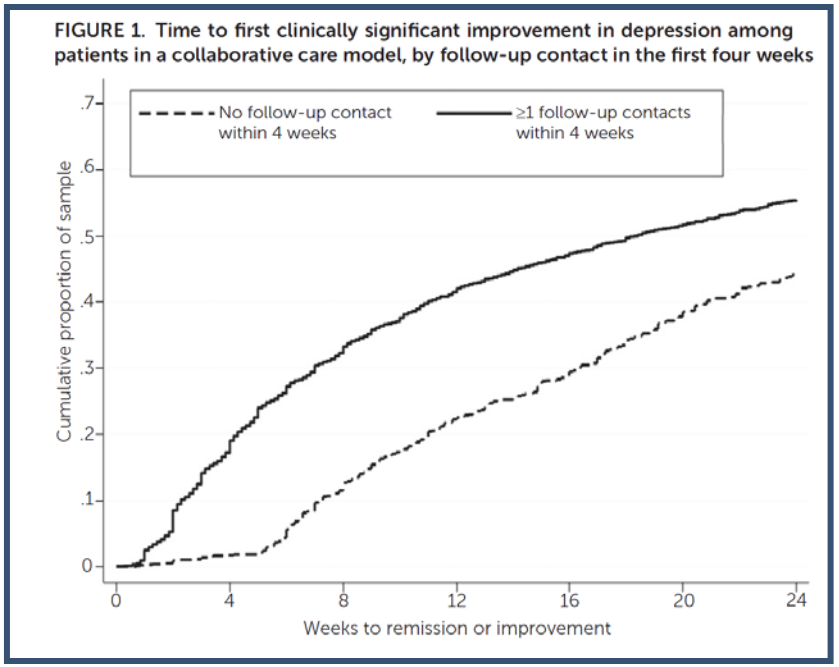
Evidence-Based Treatment

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

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Lead WA State Behavioral Health Consultant
Yakima Valley Farm Workers Clinic

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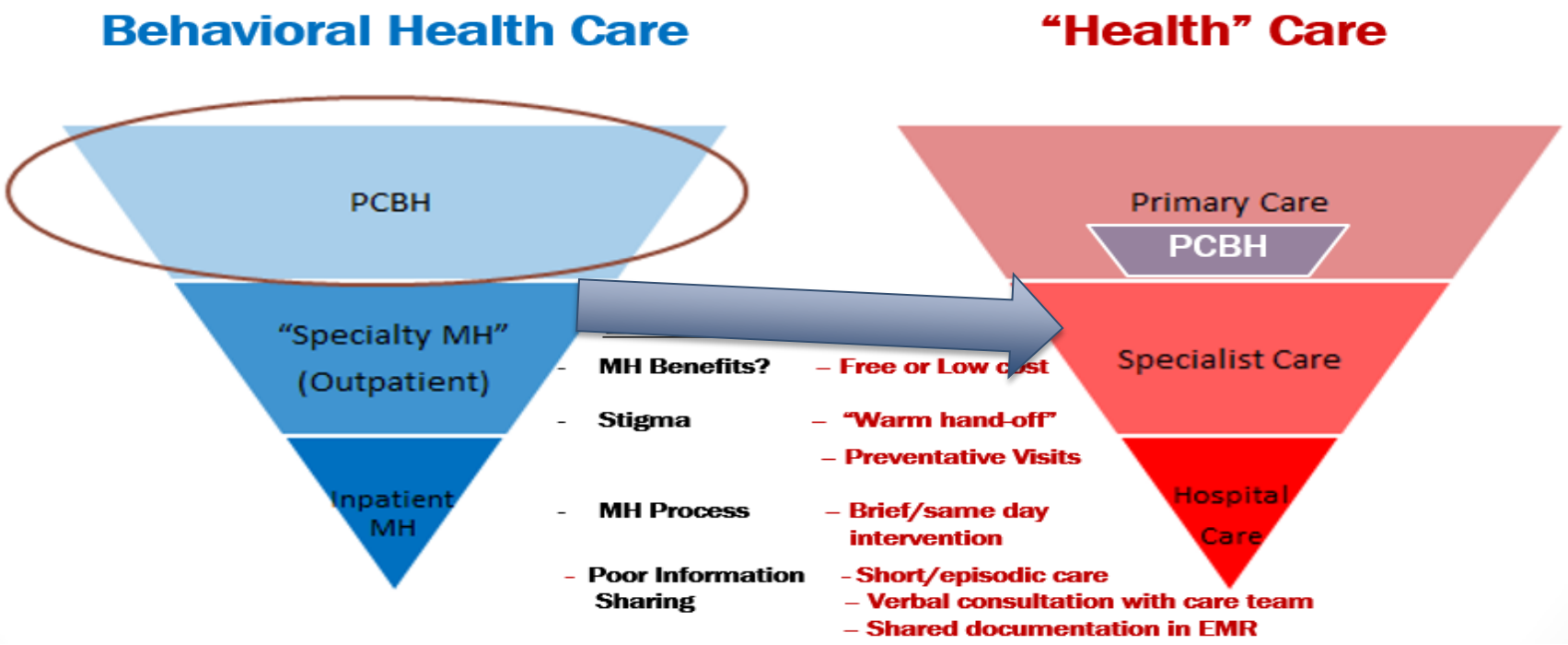
Background

- Yakima Valley Farm Workers Clinic integration began with Dr. Patti Robinson in the early 2000s.
- Currently 15 BHCs across 11 clinics in WA/OR with over **13,000** unique patients served in 2016.

Description of Integration Strategies

PCBH meets patients **where they are**



Description of Integration Strategies

Beyond our PCBH model, BHCs have demonstrated flexibility in how they meet the needs of their patient populations. This has included:

- Increased communication with specialty behavioral health from within our own organization and with other local behavioral health organizations

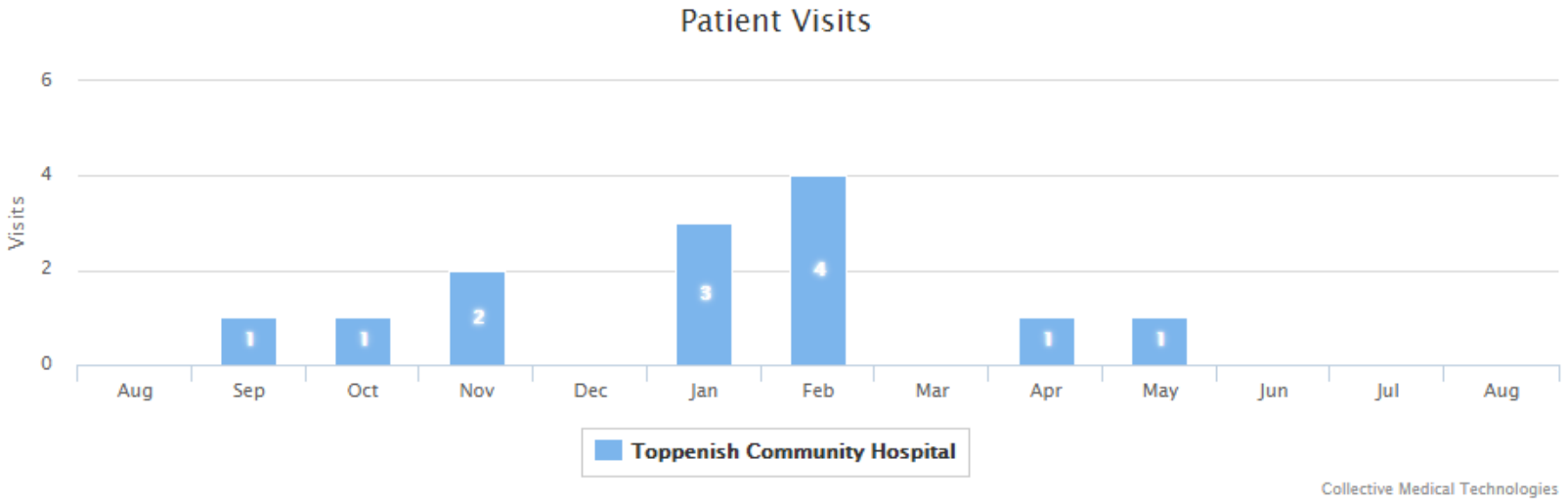
- Increased coordination with local educational systems

Description of Integration Strategies

- Training and education for medical professionals, staff, and residents
- Support organizational initiatives to meet quality metrics such as SBIRT yearly depression/substance use screening
- Expanding integrated efforts through partnerships with payers to include collaborative care approaches

Success Stories

30 y.o. female with severe health-related anxiety. BHC was able to meet with her at her PCP appointments and continue to discuss anxiety and positive coping strategies. Patient has been very reluctant to begin any medication or therapy as she viewed the issue as a “medical” concern and we have been able to provide non-pharmaceutical options which have resulted in an increased insight into her anxiety, learning healthy ways to cope, and patient has had a dramatic reduction in her ED utilization since she began to meet with BHC at her medical appointments at the beginning of 2017.



Success Stories

- Courtney Valentine, Ph.D., Toppenish BHC, has worked with local school districts to eliminate barriers in communication providing the educational system a better way to coordinate with health care providers.

- Spokane highlighted in Qualis Health Strategies for Success video on YouTube:

www.youtube.com/watch?v=dexm1FRhQi0

Courtney Valentine, PhD
Behavioral Health Consultant

Nicholas Wiarda, PsyD
Behavioral Health Consultant

Kirsten Hallstrom, PsyD
Behavioral Health Consultant

Challenges and Barriers

- Stigma and access to specialty services for those in need
- Data collection and measuring improvement
- Growing demand needed to address substance use, depression, and severe mental illness
- Sustainability (working with payers to improve understanding of integration and preparing for alternative payment models)

Lessons Learned: Opportunities for Improvement

- There is no “one size fits all approach.”
- Improved EMR and data collection can allow for better tracking of patient’s care over time and improved reporting to demonstrate success and identify areas of growth.
- Utilization of staff and working at the top of their license is essential to a program that has a broad reach with high quality patient impact.

Future Planning: Next Steps

- Tele-BHC: Growing access to patients
- Improved tracking using registry techniques to proactively reach out to patients
- Further advancement in communication with other organizations and resources

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Behavioral Health Integration Within Medical Settings

PROVIDENCE Medical Group

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Care Navigator, Providence Internal Medicine

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Background

- Launched Collaborative Care in March of 2017 in primary medical practice with 6390 patients
- Development/Implementation began approximately a year prior with support of UW AIMS (Advancing Integrated Mental Health Solutions) program
- Over 70 referrals to date, 31 active patients with nine of those patients having graduated
- Our care manager supports 15 providers and sees only patients on Medicare

Description of Integration Strategies

- We began accepting patients through Medicare Wellness visits which already required screening for depression.
- A physician team leader was established to begin taking patients and communicate with the implementation group as we launched.
- Workflows were developed for each employee in the practice in addition to training opportunities to support patients as the program was launched.

Description of Integration Strategies

- The implementation team met on a monthly basis to address progress before and after launch so processes could be adjusted if needed.
- Provider and staff meetings were also scheduled to provide updates, training, admission criteria, and receive feedback.
- A provider survey was given within a week of launch. We plan to provide an updated survey every six months.

Success Stories

- Following four sessions that included medication change and brief psychotherapy, one patient states “I feel like a new person,” and “I can’t remember feeling this good in a long time.” The patient’s PHQ-9 decreased by 100% and the GAD-7 by 75%.
- After four months of the program the average decrease in depression for patients was over 30%. Average decrease in anxiety was over 50%.
- Most patients report they enjoy the treatment because it focuses on lifestyle changes and they enrolled secondary to their trust of providers.
- There is nearly a 60% enrollment rate for those patients who have been referred to the program in the first five months.

Challenges and Barriers

- Limited to Medicare for the first seven months (expanded to full BHI Program Oct. 22).
- Billing has always been a challenge; the collaborative care codes are new as of January 2017 and many health care entities (including insurance companies) are not familiar with them.
- In looking at expanding the program to other clinics, it has been difficult to find applicants who are licensed social workers.
- The patient registry is very helpful in tracking outcomes, but has had some technical difficulties and takes additional time.

Lessons Learned: Opportunities for Improvement

- Adding additional staff support as the care managers' panel size grows (MA's, RN's care navigators)
- Improving workflows between internal medicine clinic and psych residency program to better integrate and collaborate our programs
- Assuring all providers have access to community mental health resources for patients not meeting criteria for collaborative care.

Future Planning: Next Steps

- The program expanded October 22 to offer collaborative care for all patients, regardless of insurance, utilizing psych billing codes. (Full BHI Program).
- Develop a training program to roll out more seamlessly to other clinics.
- In 2018, we plan to add four additional LICSWs to primary care clinics in Spokane.
- Work toward the recommended case load of 90-150 patients.
- Further integration with psych residency clinic to provide face-to-face appointments, additional referrals, and suboxone treatment.

Q & A

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