Best Practices in Collaborative Healthcare

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by

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To Cover this Morning

- Defining Collaborative Care
- Behavioral Health Needs in PC
- Types of Collaborative Programs
- Patterns of Practice
- How to Get Started.
What’s in a Word?

- Collaborative Care
- Integrated Primary Care
- Team care
- Integrated Healthcare
- Integrative Healthcare
“SPMI” patients in an urban C.M.H. program:

- 81% - at least one significant medical illness
- 51% - at least one previously undiagnosed illness
- 53% - judged to need medical attention

“Integrated” Primary Care Seems to be Coming

- Primary care mental health services part of the Model Health Center promulgated by the Bureau of Primary Health Care
- Federal Partner's Senior Working Group-Mental Health and Primary Care Integration (DoD, HRSA, SAMSHA, OMH, OPHS, AoA, NIMH, AHRQ, ACF & VA)
- Primary care mental health services part of the “Basket of Services” advocated by the Future of Family Medicine Report
- Called for in IOM Crossing the Quality Chasm follow-up report.
Primary care is our best venue for improving population health and for controlling medical cost.

The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation’s Health Care: 
A Report from the American College of Physicians 
January 30, 2006
EXHIBIT 9
Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000

<table>
<thead>
<tr>
<th>Spending per beneficiary (dollars)</th>
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<tbody>
<tr>
<td>8,000</td>
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<td>7,000</td>
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<td>6,000</td>
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<td>5,000</td>
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General practitioners per 10,000

SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTE: Total physicians held constant.
EXHIBIT 8
Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000

<table>
<thead>
<tr>
<th>Quality rank</th>
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<tr>
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<tr>
<td>26</td>
</tr>
<tr>
<td>51</td>
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</table>

General practitioners per 10,000

SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTES: For quality ranking, smaller values equal higher quality. Total physicians held constant.
Behavioral Health Needs Assessment in Primary Care

Mental Health/Substance Abuse
Health Behavior Change
“Ambiguous” and Chronic Illness
Culturally Syntonic Approaches
Prevalence of Behavioral Health Problems in Primary Care

Mental Health/Substance Abuse

PHQ-3000  Merrilac 500

- Major Depression  = 10%  24%
- Panic Disorder  = 6%  16%
- Other Anxiety Disorders  = 7%  21%
- Alcohol Abuse  = 7%  17%
- Any Mental Health Dx  = 28%  52%
Prevalence of Behavioral Health Problems in Primary Care

Health Behavior Change

- Smoking = 25%
- Obesity = 30%
- Sedentary lifestyle = 50%
- Non-adherence = 20 - 50%
“Ambiguous” and Chronic Illness

The vast majority of primary care visits are related to behavioral health needs but not to identified mental health disorders.

"Ambiguous" and Chronic Illness

10 most common complaints in adult primary care. 15% x organic pathology found (Kroenke & Mangelsdorff, 1989)

<table>
<thead>
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<th>chest pain</th>
<th>back pain</th>
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<tbody>
<tr>
<td>fatigue</td>
<td>shortness of breath</td>
</tr>
<tr>
<td>dizziness</td>
<td>insomnia</td>
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<tr>
<td>headache</td>
<td>abdominal pain</td>
</tr>
<tr>
<td>swelling</td>
<td>numbness</td>
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Depression with Chronic Illnesses:

- Increased rates of depression in patients with:
  - Congestive Heart Failure and CAD
  - Diabetes
  - COPD

And increased morbidity and mortality if depressed.

- Patients with chronic illness and depression 2-5x the healthcare cost of patients with chronic illness alone.

- Depression is the common factor in patients disabled (compared with pts equally sick but not disabled) by hypertension, asthma, arthritis, ulcers.

Culture Impacts Depression

Culturally Syntonic Approaches

Signs of Depression found Cross-Culturally

- Appetite changes
- Sleep changes
- Psychomotor agitation or retardation
- Decreased energy
- Decreased libido
- Diminished ability to think or concentrate

Signs of Depression found in “Western” Cultures

- Self-deprecation
- Hopelessness
- Guilt
- Suicidality

Underserved and Minority Populations are Particularly Affected

“...racial and ethnic minorities are less inclined than whites to seek treatment from mental health specialists. Instead, studies indicate that minorities turn more often to primary care.”

Therefore:

Reducing waiting time at specialty mental health services is not necessarily an indicator of improved access to mental health services for underserved and minority populations.
Typical Morning in Practice*

- 56 yo diabetic with poor control
- 19 yo smoker for P.E.
- 33 yo with multiple somatic complaints
- 10 yo w/otitis media
- 67 yo w/insomnia
- 70 yo w/sinusitis
- 52 yo hypertensive patient
- 45 yo w/tinnitus
- 38 yo w/acute asthma
- 29 yo w/chest pain & SOB
Typical Morning in the Office
MENTAL HEALTH DISORDERS

- 56 yo diabetic with poor control
- 19 yo smoker for P.E.
- 33 yo with multiple somatic complaints
- 10 yo w/otitis media
- 67 yo w/insomnia
- 70 yo w/sinusitis
- 52 yo hypertensive patient
- 45 yo w/tinnitus
- 38 yo w/acute asthma
- 29 yo w/chest pain & SOB

DEPRESSION
ALCOHOL ABUSE
PANIC DISORDER
Typical Morning in the Office

PSYCHOSOCIAL DISTRESS

- 56 yo diabetic with poor control
- 19 yo smoker for P.E.
- 33 yo with multiple somatic complaints
- 10 yo w/otitis media
- 67 yo w/insomnia
- 70 yo w/sinusitis
- 52 yo hypertensive patient
- 45 yo w/tinnitus
- 38 yo w/acute asthma
- 29 yo w/chest pain & SOB

ANXIETY

FAMILY VIOLENCE

HYPOCHONDRIASIS
Typical Morning in the Office

BEHAVIORAL NEEDS

- 56 yo diabetic with poor control
- 19 yo smoker for P.E.
- 33 yo with multiple somatic complaints
- 10 yo w/otitis media
- 67 yo w/insomnia
- 70 yo w/sinusitis
- 52 yo hypertensive patient
- 45 yo w/tinnitus
- 38 yo w/acute asthma
- 29 yo w/chest pain & SOB

SMOKING CESSATION

CARDIAC RISK FACTORS

MED. COMPLIANCE
**Typical Morning in the Office**

**FEASIBILITY OF REFERRAL**

- 56 yo diabetic, ANXIETY, "MEDICAL"
- 19 yo smkr, SMOKING CESS., PRE-CONTEMPLATION
- 33 yo somatic, DEPRESSION, CULTURAL FACTORS
- 10 yo w/otitis media
- 67 yo insomnia, ETOH, ONLY TRUSTS PHYSICIAN
- 70 yo sinusitis, FAM. VIOL., FEARS REVELATION
- 52 yo hyperten., CARDIAC, NOT COVERED
- 45 yo tinnitus, HYPOCHND., FEELS BLAMED
- 38 yo asthma, MED. COMPL, FAMILY ISSUES
- 29 yo chest pain, PANIC, POSSIBLE REFERRAL
Patients in Integrated Care compared to patients in specialty mental health care:

- More likely to be first mental health contact
- Less psychologically “sick”
- Less likely to define themselves as impaired
- Require fewer visits
- Often coping with chronic illnesses
- Often needing health behavior change
Categories of Relationship between Collaborating Medical and Behavioral Health Services

- Coordinated
- Co-Located
- Integrated
<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tbody>
<tr>
<td>Coordinated</td>
<td>Behavioral services by referral at separate location</td>
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<tr>
<td>Co-Located</td>
<td>By referral at medical care location</td>
</tr>
<tr>
<td>Integrated</td>
<td>Part of the “medical” treatment at medical care location</td>
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Programs of Collaborative Care

- Coordinated

Mass. Child Psychiatry Access Project
Some telephone care management programs
Eating disorder outpatient programs
Co-located

BHP working in primary care seeing all referred.

Advantages:                               Problems:
Access                                        Referrals don’t show
Patient Satisfaction                    Case-loads fill up
Provider Satisfaction
Cost Effectiveness
Clinical Outcome (in most studies)
Physicians Love I. P. C.

ANECDOTAL reports indicate:
Docs feel less isolated
Bolder in “can of worms” situations
Enjoy treating “complex” patients more
Better job satisfaction
Better provider retention
Length of treatment in specialty mental health care vs. Co-Located Non-targeted Unspecified behavioral health care:

- Specialty mental health care: 6.2 visits
- Co-Located behavioral health care: 3.2 visits

Making **Co-Location Work**

BHP in health center - 7 sessions/wk.

- Patients attending first visit w. BHP when scheduled by physician w/o introduction: 40%
- Patients attending first visit w. BHP when scheduled after introduction by physician: 76%

N=80, p= <.01

Apostoleris, N. & Blount, A. In preparation.
Group Health Studies
Integrating Targeted Specified

- Intervention + Patient education + alternating 4-6 visits with PCP and:
  - a) psychiatrist to manage antidepressants (or)
  - b) psychologist to provide C-B therapy

- Results:
  - 74% of depressed patients effectively treated
    - (40% in control group)
  - No effect for minor depression

- Average Cost / successfully treated case
  - Collaborative Care - $1750
The IMPACT Treatment Model

- Collaborative care model includes:
  - Care manager: Depression Clinical Specialist
    - Patient education
    - Symptom and Side effect tracking
    - Brief, structured psychotherapy: PST-PC
  - Consultation / weekly supervision meetings with
    - Primary care physician
    - Team psychiatrist
  - Stepped protocol in primary care using antidepressant medications and / or 6-8 sessions of psychotherapy (PST-PC)
Substantial Improvement in Depression
(≥50% Drop on SCL-20 Depression Score from Baseline)

Response (≥50% drop on SCL-20 depression score from baseline)

Advantages of Creating an Integrated Primary Care Program by Starting with Care Management:

- Quick start up
  - Start up to model program in about 3 years
- Care management easiest for PCPs to understand and accept
- BHPs get used to a high volume brief intervention service
- First set of results presented 2/2005 at Families and Health Conference
Behavioral Health Consultant

- Management of psychosocial aspects of chronic and acute diseases
- Application of behavioral principles to address lifestyle and health risk issues
- Consultation and co-management in the treatment of mental disorders and psychosocial issues

Model developed by Kirk Strosahl, PhD
Integrated Care Requires New Ideas About “Disciplines”

- Depression care managers – MSWs, nurses, psychologists, NPs and PAs
- Paraprofessional counselors - promotoras
- Modular skill sets vs. disciplines
Generalist BHP

- Care Management
- Brief Therapy
  - Cognitive-behavioral
  - Solution-focused
- Behavioral Medicine
  - Relaxation/biofeedback/hypnosis
  - Health behavior change
- Substance Abuse interventions
- Family Therapy
- Child Development
- Psychotropic medication input
- Groups and Patient Education
- Community Outreach
Why Primary Care is difficult for BHPs trained in specialty mental health

- Treat different population than in Specialty Mental Health services.
  - Less disturbed and less diagnostically clear
  - Won’t accept “mental health” definition of the problems they bring
  - BHP must understand medical conditions as well
  - Return to functioning rather than work through Status as ancillary provider

- Different routines of time, instrumentality & confidentiality
Implementing Integrated Primary Care
Integrating Biomedical and Mental Health Services

- Change the Language of care
- Change the Sequence of care
- Change the Relationship of providers
Working in the Middle:
Getting Beyond “Either/Or”

- Sequence of Care
- Relationship of Providers
- Language of Care
Sequence of Care

- Modify the “rule-out train”
- Assess psychosocial factors at the same time as medical systems
- Multi-faceted treatment plan
- A “trial” of behavioral health care
Language of Care

- Use words that do not require a physical or psychosocial definition of the problem.
- We can work to help with “pain, discomfort, inability to function, can’t enjoy your grandchildren, can’t serve your church, etc.”
- Use of scripts to introduce care.
Relationship of Providers

- The structure of the team should mirror the experience of the patient and family of the cause of the illness
  - Medical – Physician led
  - Separate problems – Collaborative
  - Psychosocial – BHP led

- Story of Crossroads
Describing the Involvement of a BHP to the Patient

- Situation
- Skill Set
- Relationship
- Indicators
Situation

What is the situation in the patient’s care that makes the Primary Care Provider want to involve a Behavioral Health Provider?
Skill Set

What are the particular skills that the BHP brings that can be helpful in the overall treatment of the patient?
Relationship

What relationship will the work of the BHP have to the overall treatment of the patient?
Indicators

What outcomes would indicate that the involvement of the BHP had been useful to the overall treatment of the patient?
BHP defined as the one with the right skill for patient’s needs.

Case note:
“KB (15yo) F/u for depression. Kathy reports still feeling depressed a lot of the time. Suggested she might make use of counseling service here in the practice. Says she would consider, but does not want someone who is ‘all nice and happy.’ Refer to Dr. Blount who is neither nice nor happy.”
When PCP should consider involving the BHP

- Patient presents symptoms w/o findings
- Problem involves family members
- Noncompliance
- PCP feels over his/her head
When PCP should consider involving the BHP (cont.)

- PCP is chronically in conflict w. patient
- Patient is diagnosed with chronic or potentially terminal condition
- Emotional difficulties presented by patient


- Any condition or symptom in which “stress” (broadly defined) can affect course or outcome.
Considerations in Adding a Behavioral Health Provider

- Provider skill set and fit
- Financial
- Information exchange between providers
- Charting
- Scheduling
- Space
Provider Skill Set and Fit

- Generally, you want a generalist.
- Someone you like to talk to.
- They must do well in ambiguous situations.
Financial

- Targeted, Specified, Integrated programs save the most money for payers.
- Panels, Panels, Panels
- For medical people, Behavioral Health billing is a nightmare. This is why administrative staff need to feel some buy-in to integrated care.
- Expect to pay something for the increase in medical providers enjoyment of the practice.
Health and Behavior Codes

- For behavioral health services that are not directed at alleviating a psychiatric condition
  - Eg. smoking cessation, addressing non-compliance, addressing psychosocial problems that impact medical illness.
- Medicaid mandated by HRSA to pay for them at FQHCs
- Where they have been funded reasonably, they have proved to be the change that launched truly integrated care.
Information Exchange Between Providers

- Behavioral health rounds

- Curbside consultations

- Blanket information release with the goal of enhancing primary care
Charting

- Patient must give permission for unified charting
- Mental health professionals usually hold confidentiality in much higher regard than primary care patients do
- Unified charting may not need to be undifferentiated charting
- Coming of EHR will make much of this moot.
- Health and Behavior codes charted in medical record as medical services.
Scheduling

- Practice scheduler keeps BHP’s book
- Shorter time periods than 50 min. hour
- Consider an Open Clinic as a way of learning to work differently
- Schedule some free time for introductions and curbside consultations
- Schedule time for conjoint interviews
Space: The Final Frontier

- Least important of the administrative issues
- BHP can “squeeze in”
- PCP’s tend to move toward more space for BHP to show they value BHP function
In the future, “manpower” needs will be acute.

- Programs that brought mental health clinicians straight from specialty mental health settings into primary care have often failed.
- We cannot hope to train enough people to meet the need through current limited primary care behavioral health training opportunities.
- We will need a reasonable, efficient way for licensed mental health clinicians to become primary care behavioral health clinicians.
- UMass Department of Family Medicine and Community Health has a Certificate Program in Primary Care Behavioral Health.
Some conclusions from the Economic Evidence
Better identification of behavioral health needs (screening) and better targeting of care, particularly using multi-disciplinary collaborative care, leads to lowered overall medical cost in some cases and more cost-effective care in most cases.
Programs that achieve “cost offset”

- Collaborative protocols for panic disorder
- Programs that teach patients what level of care they need and how to manage their own illness
- “Relaxation response” methods taught to patients for stress mediated illnesses like hypertension
- Health behavior change programs, both intensive targeted programs and less intensive population-based ones
- Screening and treatment for mental health disorders in high-utilizers of care
- Targeted programs for people who express their life pain somatically
- Programs for patients with chronic pain
The better targeted the behavioral health intervention is to the needs of a specific population using behavioral medicine, care management, primary care behavioral health consultation and psychiatric consultation, the more the cost savings.

The more generic the behavioral health intervention (outpatient psychotherapy), the less medical cost savings.
Substance abuse services should be part of any plan to bring behavioral health into medical settings, both because of the level of need and because of the overlap of substance abuse problems with physical and mental illnesses.
The more broadly we account for the impact of behavioral health services in primary care, the greater the identified savings, but the more difficult it is to document these savings rigorously.
Employment functioning data in the medical literature:

- When a person is depressed or anxious, vocational functioning is one of the first activities to be impaired and one of the first to return with treatment.
  

- Under-functioning ("presenteeism") due to depression can equal the same loss in productivity as 2.3 days absent per month.
  

- Successful treatment of depression lowers disability days:
  
  - severe depression treated – down 36%
  - moderate depression treated - down 72%
  
Primary care behavioral health treatment outcomes and cost results tend to be reported in a different literature from EAP treatment and cost outcomes where savings of $4 per $1 spent on EAP care are common. Full spectrum programs operating in the workplace, specialty mental health settings and primary care are rare and little combined cost data is available.
The separation of funding streams into two separate worlds of medical and mental health services greatly impedes innovation in the development and implementation of targeted behavioral health programs in medical settings.
For further information:

Collaborative Family Healthcare Association Conference
DENVER Nov. 6-8, 2008
www.CFHA.net

www.IntegratedPrimaryCare.com
blounta@ummhc.org