Integrating Physical and Behavioral Health Care Services: The Next Generation

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Objectives

- Identify reasons for integrating physical and behavioral health services
- Define types of integration
- Review activities of an integrated delivery system
- Identify challenges to integration of physical and behavioral health
Vignette
Usual Care

- A fee-for-service environment in which a PCP can only make a “good living” by averaging 7-minute visits with patients, there is little choice but to rapidly figure out whether the presenting symptom is best addressed by a pill, test, or procedure.

Health Services

- Fee-for-service models reward service utilization without a focus on the long term.
- Managed Care has been viewed as a means to redirect services and to focus on health promotion.
- Additionally, carve-outs have been used to address specialty services.
Service Delivery Systems

- Health Maintenance Organization (HMO)
- Coordinated Care Organization (CCO)
- Community Care Organization (CCO)
- Accountable Care Organization (ACO)
- Physician Hospital Organization (PHO)
- Preferred Provider Organization (PPO)
- Managed Care Organization (MCO)
- Independent Provider Organization (IPO) (IPA)
- Managed Behavioral Health Organization (MBHO)
Value-based Purchasing


Triple Aim
- Improve healthcare
- Improve health
- Lower cost

\[ \text{Value} = \frac{\text{Quality}}{\text{Cost}} \]
Business of Integrated Health Services

- What is the product?
- Who are the customers?
- Who are the payers?
  - What is the financial model?
- Who are the providers?
  - What are the operational components?
Integrating Physical and Behavioral Health

Evolving the service delivery model...

- Mind and Body are connected
- Team Care is better care
Primary Care and Mental Health
Blending Cultures

Physician
Nurses

Patient

Behavioral
Health
Consultant
## Differences in Cultures

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Traditional Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient may not seek MH care</td>
<td>Patient seeking out MH care</td>
</tr>
<tr>
<td>Short-term, goal oriented</td>
<td>Short or long term, process oriented</td>
</tr>
<tr>
<td>Brief interactions</td>
<td>Longer sessions</td>
</tr>
<tr>
<td>Variable scheduling</td>
<td>Consistent scheduling</td>
</tr>
<tr>
<td>Rapid diagnoses and treatment plans</td>
<td>Comprehensive evaluation and treatment planning process</td>
</tr>
<tr>
<td>Exam room</td>
<td>Private office</td>
</tr>
<tr>
<td>Interruptions</td>
<td>Quiet, lack of interruptions</td>
</tr>
<tr>
<td>Unpredictable schedules</td>
<td>Predictable schedules</td>
</tr>
<tr>
<td>Focus of tx on overall health, may not have psychiatric dx</td>
<td>Focus more on MH issues, usually have psychiatric dx</td>
</tr>
<tr>
<td>Team-based care</td>
<td>Individual-based care</td>
</tr>
</tbody>
</table>
Why in Primary Care?

- It’s where the patients are…
  - Over half of patients seek treatment for behavioral health conditions from their primary care physicians
  - Non-psychiatrists write over three-fourths of antidepressant prescriptions (Mark, TL, et al, 2009)
    - 9.3% of patient’s visits to PCPs result in antidepressants being prescribed
    - 3.6% of visits to other providers, not psychiatrists (Mojtabai and Olfson, 2011).
Prevalence of Behavioral Health Conditions and Primary Care

- Prevalence estimates for psychiatric disorders of individuals seen in primary care range from 26 to 60 percent.
  - (Studies of patient populations based on the PRIME-MD)

- An estimated 20 percent of children in pediatric primary care have a clinically significant psychosocial problem/condition.

- An estimated 60 percent to 70 percent of physician visits are by patients with no medical illness.
Chronic Conditions and Depression

- Back or Joint Pain: 45%
- Cancer: 35%
- COPD: 25%
- Diabetes: 20%
- HIV/AIDS: 40%
- Hypertension: 35%
- General population: 5%
# Annual Per Capita Medicaid Costs: Implications of Behavioral Health Comorbidity

<table>
<thead>
<tr>
<th>Co-morbidity</th>
<th>Asthma and/or COPD</th>
<th>Congestive Health Failure</th>
<th>Coronary Heart Disease</th>
<th>Diabetes</th>
<th>Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Mental Illness &amp; No Drug/Alcohol</td>
<td>$ 8,000</td>
<td>$ 9,488</td>
<td>$ 8,788</td>
<td>$ 9,498</td>
<td>$ 15,691</td>
</tr>
<tr>
<td>Mental Illness and No Drug/Alcohol</td>
<td>$ 14,081</td>
<td>$ 15,257</td>
<td>$ 5,430</td>
<td>$ 16,267</td>
<td>$ 24,693</td>
</tr>
<tr>
<td>Drug/Alcohol and No Mental Illness</td>
<td>$ 15,862</td>
<td>$ 16,058</td>
<td>$ 15,634</td>
<td>$ 18,156</td>
<td>$ 24,281</td>
</tr>
<tr>
<td>Mental Illness and Drug/Alcohol</td>
<td>$ 24,598</td>
<td>$ 24,927</td>
<td>$ 24,443</td>
<td>$ 36,730</td>
<td>$ 35,840</td>
</tr>
</tbody>
</table>


Faces of Medicaid: Clarifying Multimorbidity Patterns of Improving Targeting and Delivery of Clinical Services for Medicaid Populations. Center for Health Care Strategies
December 2010
Why in Behavioral Health?

Compared with the general population, people with severe mental illness have:

- 4.1 times the overall risk of dying prematurely than the general population aged under 50
- 2 times the risk of diabetes [1]
- 2-3 times the risk of hypertension.
- 3 times the risk of dying from coronary heart disease. [2]
- Gastrointestinal disease is raised at least four times and most of that are liver issues to do with alcohol or other hepatitis illnesses.
- Cardiovascular disease is two and half times more.
- 10-fold increase in deaths from respiratory disease for people with schizophrenia.[3]

Why in Behavioral Health?

- Individuals with a severe and persistent mental illness die on average 25 years sooner than individuals without a severe and persistent mental illness.
- As many as 75% of individuals with schizophrenia have been found to have high rates of serious physical illnesses—diabetes, respiratory, heart and/or bowel problems and high blood pressure.
- High rates for vision (93%), hearing (78%), and dental problems (60%).
- 50% of a sample of community mental health service recipients reported not having a regular doctor.
- 61% indicated they would go to an emergency department or urgent care center if they felt sick.

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<tr>
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<tbody>
<tr>
<td>Percent individuals treated</td>
<td>.073%</td>
<td>2.37%</td>
<td>2.88%</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>71.1%</td>
<td>53.6%</td>
<td>43.1%</td>
</tr>
<tr>
<td>Pharmacotherapy (any)</td>
<td>44.6%</td>
<td>80.1%</td>
<td>81.9%</td>
</tr>
<tr>
<td>Psychotherapy and Pharmacotherapy</td>
<td>28.8%</td>
<td>48.1%</td>
<td>34.5%</td>
</tr>
<tr>
<td>Treatment by PCP</td>
<td>68.1%</td>
<td>87.3%</td>
<td>84.6%</td>
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Adherence and Antidepressant Medications

Premature Discontinuation Rates

- 29% to 42% at 4 weeks
- 63% to 76% at 6 months
- In one study of 147 patients only 19% of participants took antidepressants in accordance with clinical guidelines over 6-month period

Psychotherapy Adherence

- While it appears that most (54%) individuals seem to prefer psychotherapy, less than one in four who are referred to a mental health professional actually go to their first appointment \(^{(1)}\).

- However, there is evidence that psychotherapy combined with antidepressants is associated with enhanced adherence and response \(^{(2)}\).


Hogg Foundation Definition

**Integrated health care** – The systematic coordination of mental and physical health care to increase access, improve the quality of services, and to reduce the stigma of seeking mental health treatment
Types of Integration

- Usual Care—informal referral patterns
- Collaboration—structured and formalized referral to specialists; memorandums of agreement established
- Co-location—operate as separate programs, referrals are facilitated as the behavioral health specialists is onsite
- Integration—working together as a health care team in promoting the health of the individual from a holistic perspective
Models of Medical and BH Integration

Model 1: “Cross-Referral”

Medical Practice
(75% of BH Patients)

Referral

Behavioral Practice

Model 2: “Bidirectional”

Medical Practice
(75% of BH Patients)

Model 3 “Integrated”

Medical & Behavioral Practice
(90% of BH Patients)

Specialty BH Setting
(10% of BH Patients)
Implementing Integrated Physical and Behavioral Care

- BH professionals become part of total health team
- Makes medical possible in BH; BH possible in medical
- Sustainable payment for value-added integrated services (bidirectional--true parity)
- **Challenge**--requires change from status quo

Model 3 “Integrated”

Medical & Behavioral Practice  
(90% of BH Patients)

Specialty BH Setting  
(10% of BH Patients)
Core Activities in Integrated Care Models

- Screening and early detection
  - Depression, substance use, domestic violence, ADHD
- Patient engagement, activation, and self-management
  - Decision-aids
  - Health promotion
- Treatment
  - Health education
  - Psychotherapy—individual & group
  - Medical management, Adherence
- Coordination with specialists
  - Monitoring, follow-up
  - Medication reconciliation
Care Coordination

- Integrate patient’s clinical data
- Facilitate communication among health care providers, patient, and social network
- Provide support and coaching to assist patient in an understanding of health condition and care strategies
- Manage care transitions
- Establish linkages with community support and service providers
- Monitoring and tracking outcomes
Projected Healthcare cost savings through effective Integration (National, 2012)

<table>
<thead>
<tr>
<th></th>
<th>Cost Range</th>
</tr>
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<tbody>
<tr>
<td>Commercial</td>
<td>$15.8-$31.6 billion</td>
</tr>
<tr>
<td>Medicare</td>
<td>$3.3-$6.7 billion</td>
</tr>
<tr>
<td>Medicaid</td>
<td>$7.1-$9.9 billion</td>
</tr>
</tbody>
</table>

Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry

[www.psych.org/File%20Library/Practice/Professional%20Interests/...](http://www.psych.org/File%20Library/Practice/Professional%20Interests/...)

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Integrated care

- Co-location does not ensure integrated collaborative care
  - May only produce parallel practice
- Establish a culture and philosophy of care that considers physical and psychiatric needs, personal goals, and community issues
Evolving Integration: Next Generation
Summary Desired Outcomes of Integration

- Improved care
  - Increased availability of/access to care
  - Condition/disease management
- Improved health
  - Health condition
  - Quality of Life
- Improved patient satisfaction
- Improved cost management and cost savings
  - Reduced preventable hospitalizations and ED utilization