Blending Behavioral Health and Primary Care to Improve Outcomes and Expand Access

Michigan Behavioral Health/Primary Care Integration Conference
East Lansing, Michigan
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Primary Care and Behavioral Health Integration
An Imperative for Safety Net Providers

- Widespread acceptance of the “concept” of integration
  - Tantalizing outcome studies
- Appreciation of behavioral factors in chronic disease management
- Diminished scope of Community Mental Health Centers
- Concept of the Patient-Centered Healthcare Home
Americans Suffering From a Diagnosable Behavioral Disorder

- 57% Treatment from Primary Care Provider
- 33% Treatment from Behavioral Specialists
- 10% Untreated

Source: Kathol and Gatteau – Healing Mind and Body, 2007
Access to Behavioral Health Intervention

Behavioral Intervention 43%
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80% of those with no mental health treatment had a primary care service

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Access to Behavioral Health Intervention

- 80% of those with no mental health treatment had a primary care service
- Behavioral Intervention: 43%
- No Healthcare Visit: 12%
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)
Blending Behavioral Health into Primary Care at Cherokee Health Systems  *National Register of Health Service Providers in Psychology, Fall 2007

Integrated Care Update
  * CareIntegra, Feb. 2007

Evolving Models of Behavioral Health Integration in Primary Care
  * Millbank Memorial Fund, 2010

Integrating Mental Health Treatment Into the Patient Centered Medical Home
  * AHRQ, June 2010

Integrating Behavioral & Primary Care
  * Community Health Forum, Sept/Oct. 2006

Integration of Mental Health/Substance Abuse and Primary Care
  * Evidence Report/Technology Assessment, No. 173, ARHQ, October 2008

How Healthcare Reform Can End the Stepchild Status of Primary Care and Behavioral Health
  * Dr. Ted Epperly, Behavioral Health Central, January 2010

Can Primary Care Docs and Behavioral Specialists Work Together?
  * Behavioral Healthcare Tomorrow, April 2004
The Emperor’s New Clothes

“Of course, we’re integrated.”
"As if we all knew where we're going."
A Few Nagging Questions About Integration

• What is it?
• What does it look like at the point-of-care?
• How does it modify provider roles and responsibilities?
• Does it broaden access?
• Does it improve outcomes?
Blending Behavioral Health into Primary Care

Cherokee Health Systems’ Clinical Model
Cherokee Health Systems

Number of Employees: 606

Provider Staff:

- Psychologists - 43
- Primary Care Physicians - 25
- NP/PA (Primary Care) - 25
- Master’s level Clinicians - 64
- Psychiatrists - 10
- NP (Psych) - 12
- Case Managers - 34
- Pharmacists - 9
- Dentists - 2
Cherokee Health Systems
FY 2012 Services

45 Clinical Locations in 14 East Tennessee Counties

Number of Patients: 63,800 unduplicated individuals

New Patients: 18,108

Patient Services: 493,490
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.
Behavioral Health Consultant (BHC) Intervention 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
Cherokee Health Systems
Penetration into the General and Medicaid Populations

• 3 year (FY2009-2012) penetration into the general population
  Unduplicated patients 99,485
  Total area population 1,014,058
  Penetration 9.8%

• 3 year (FY2009-2012) TennCare (Medicaid) penetration
  Unduplicated Medicaid patients 48,011
  Total Medicaid enrollment 174,665
  Penetration 27.5%
Clinical Outcome and Service Quality Benefits of Integration

- Greater improvement in anxiety, depression, and quality of care (Bradford, et al., 2011; Roy-Byrne, et al., 2010; Lang, 2003)
- Reduction of panic attacks in COPD patients (Livermore, Sharpe, & McKenzie, 2010)
- Improving treatment access for patients with PTSD (Possemato, 2011)
- Reduction in symptoms of insomnia (Buysse, et al., 2011)
- Improving treatment adherence for patients with comorbid diabetes and depression (Lamers, Jonkers, Bosma, Knottnerus, & van Eijk, 2011; Osborn, et al., 2010)
Clinical Outcome and Service Quality Benefits of Integration

- **Increased self-management skills** (Battersby, et al., 2010; Damush et al., 2008; Kroenke et al., 2009)

- **Improved quality of life for patients with chronic cardiopulmonary conditions** (Cully, et al., 2010)

- **Reduction of substance abuse** (Whitlock, et al., 2004)

- **Earlier of identification and intervention for pediatric behavior problems** (Berkovits, O’Brien, Carter, & Eyberg, 2010; Laukkanen et al., 2010)

- **Reduction of somatization** (Escobar, et al., 2007; Kroenke & Swindle, 2000)
Economic Benefits of Integration

• Early work, “medical cost offset” demonstrated (Cummings et. al., 1962)

• Meta-analysis of 57 controlled studies show a net 27% cost savings (Chiles et. al., 1999)

• Mental health interventions in primary care more cost effective (Van Korff et. al., 1998)

• In older populations, up to 70% savings in inpatient costs (Mumford et. al., 1984)

• 40% savings in Medicaid patients receiving targeted treatment (Cummings & Pallak, 1990)
Figure 1: Comparison of CHS utilization with regional providers
Key Values Compel Safety Net Providers to Integrate Care

• Increase Access
• Eliminate Disparities
• Ensure Patient-Centered Culture
  • Improve Population Health
  • Reduce Healthcare Costs
Exasperation to Collaboration

Integrating Corporate Cultures

Bob Franko
Cherokee Health Systems
Building a Foundation for Collaboration

• Identifying the value and purpose of the relationship
• Leveraging the relationship into a partnership
• Nurturing and supporting the partnership
• Training and continued education (and retraining, and retraining, and retraining...)

Cherokee Health Systems
Together...Enhancing Life
Value and Purpose

- Is this about doing the right things for the patients we serve?
- Is it about finding new revenue?
- Can it be both?
Leveraging the Relationship

- What are you good at?
- What talents, resources can you bring?
- Can we disagree, debate, interact and share – and move forward?
Supporting the Partnership

• Your relationship frames your agreement, not the other way around.
• Champions
• Meet, talk, socialize, publicize

Mike Smith ("Smith") is at the store ("store"). I'm not an idiot ("idiot").

If lawyers talked like they wrote.
Training, Education, Advocacy

- Providers
- Front desk staff
- Administrators
- Billers/coders
- Boards
- Patient advocates
- Payers
Serious Considerations

- Values/Mission
- Cultures/Purposes
- Involvements/affiliations
- Transparencies/Boards
- Finding champions/understanding the challenges
- Learning curve (simplicity to complexity)
Key Operational Differences Between Primary Care and Behavioral Health

Volume vs Flow
Divergence vs Evolution

- School-Based Services
- Corporate Wellness
- Bidirectional Care
- Telepsychiatry
- Telepharmacy
- Telemedicine
Cultural Differences
Language Differences for $200

U.D.S.

a. What is a Urine Drug Screen?
b. What is a Uniform Data System?
c. What is All of the Above?
Cultural Differences
Clinical Delivery Space
Behavioral Differences

Sanctity of the Session vs. Who’s in There Now?
Behavioral Differences
Styles of Communication
Operational Differences
Pace
Mental Health
Primary Care
A System to Integrated Care

- Mission
- Clinical
- Operations
- Financial
- Facility Plan
- Marketing
- Admin
- MIS

Project Coordinator
Administrative Team Meetings

- Meet Weekly, not Weakly
  - Transparency is Vital
- Shared Objectives – Work Toward Full Integration
- Creating a Process, Not a Destination – You’re in it for the Long Haul!
The Four Agreements

Be impeccable with your word

Don’t make assumptions

Don’t take anything personally

Always do your best

Miguel Angel Ruiz, 1997
Peanut Butter & Jelly...the perfect model for integration
• On their own, they’re fine, together they’re better
• You wouldn’t want to separate them once joined
• Just a matter of finding the “bread” to hold it together!
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