Integrated Primary and Behavioral Healthcare

Partners for Life: All Heart

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Review: What is a Mental Illness?

Mental illness/behavioral health disorder/mental disorder)

- is a health condition that is characterized by alterations in ***thinking, mood, or behavior*** (or combination)
  - that is mediated by the brain and associated with distress and/or impaired functioning.

Mental Disorders

Cause a host of problems that may include: personal distress, impaired functioning and disability, pain, or death.

- Serious emotional disturbance (SED)
- Serious mental illness (SMI)
- Serious & persistent mental illness (SPMI)

Behavioral Healthcare

is an umbrella term and refers to a continuum of services for individuals at risk of, or suffering from, **mental, behavioral**, or **addictive** disorders.

Center for Prevention and Health Services, 2005

Delivery of BHC is costly and complex

- The delivery of behavioral healthcare is relatively **complex** when compared to the delivery of general medical care.
- The industry annually generates **more than $104 billion** in direct care expenses and continues to experience rapid reorganization and realignment of services in response to purchaser demands.

Behavioral Health: as a discipline

Refers to mental health, psychiatric, marriage and family counseling, & addictions treatment

Includes services provided by social workers, counselors, psychiatrist, psychologists, neurologists, & physicians

Address mental health or substance abuse problems including services offered through the health plan, disability management programs, EAP, and health promotion or wellness programs.

Behavioral Health Integration

The care that results from a practice team of **primary care and behavioral health clinicians**, working with patients and families

- using a systematic and cost-effective approach,
- to provide patient-centered care
- for a defined population

AHRQ = Agency for Healthcare Research and Quality.

Lexicon Project. http://integrationacademy.ahrq.gov/lexicon. Accessed July 19, 2014.

Primary Healthcare (PHC)

- PHC became a core policy for WHO in 1978, with the adoption of the Declaration of Alma-Ata and the strategy of "Health for all by the year 2000".
- No uniform, universally applicable definition of PHC exists.
- The concept of PHC was discussed as both a level of care and an overall approach to health policy and service provision.
- In high-income and middle-income countries, PHC is mainly understood to be the first level of care.
- In low-income countries where significant challenges in access to health care persist, it is seen more as a system-wide strategy

PHC Core Principals

It is useful to understand **primary health care** as involving both core principles and a variable set of basic activities.

- universal access to care and coverage on the basis of need
- commitment to health equity as part of development oriented to social justice
- community participation in defining and implementing health agendas
- Inter-sectoral approaches to health.

PMC: Principles in a Systems Perspective

A health system based on primary health care will:

- build on the Alma-Ata principles of equity, universal access, community participation, and intersectoral approaches
- take account of broader population health issues, reflecting & reinforcing public health functions
- create the conditions for effective provision of services to poor & excluded groups
- organize integrated & seamless care, linking prevention, acute care * chronic care across all components of the health system
- continuously evaluate and strive to improve performance

The ~~Problem~~ Opportunities

- People with mental and substance abuse disorders may die decades earlier than the average person — mostly from untreated and preventable chronic illnesses like hypertension, diabetes, obesity, and cardiovascular disease that are aggravated by poor health habits such as inadequate physical activity, poor nutrition, smoking, and substance abuse.

- People with **SMI die an average of 25 years earlier**. And NOT getting better.

Problem (cont.)

- Individuals with serious physical health problems often have ***co-morbid mental health*** problems, and nearly half of those with any mental disorder meet the criteria for two or more disorders, with severity strongly linked to co-morbidity (Kessler et al. 2005).
- As many as ***70 percent*** of primary care visits stem from psychosocial issues (as cited in Robinson & Reiter, 2007).
- While patients typically present with a physical health complaint, data suggest that underlying ***mental health*** or ***substance abuse issues*** are often triggering these visits.

The Barriers: for Client/Patient

To PHC

- Lack of health insurance
- coupled with challenges in navigating complex healthcare systems

To BHC

- Stigma
- Lack of culturally & linguistically appropriate providers

Build it and they will come…..

Health disparities literature suggests certain cultures are less likely to present to a specialty mental health programs.

The Hispanic/Latino population is generally recognized as one of the least willing to seek services from mental health providers, and most underserved, due to the effect of negative stigma (American Psychiatric Association website - September 2007)

The Solution: Integrated Healthcare

- Define
- Why?
- How?
- Examples

According to the Canadian Collaborative Mental Health Initiative (CCMHI), "**there are almost as many ways of 'doing' collaborative mental health care as there are people writing about it**" (Macfarlane 2005, p. 11).

Primary care settings have become the gateway to the behavioral health system

Primary Care Providers: PCPs

Need Help!!!!

- The **Principal** providers
- PCPs provide 60% of the psychiatric care in the U.S.
- 13 – 15 min. visits to address 6-8 issues on average
- Up to 70% of the pts., seen in PMC have BH issues
- PCPs write 80% of the RXs for antidepressants

Help is on the Way: Practice Models of Integration

- Improved collaboration
- Medically provided behavioral health care
- ***Co-location***
- Disease management
- ***Reverse co-location***
- Unified primary care and behavioral health
- ***Primary care behavioral health***
- Collaborative system of care

The Milbank Group, 2013

Degree of Integration

Minimal	Basic at a Distance	Basic On-site	Close Partly Integrated	Close Fully Integrated

Collaborative Continuum

Models of Integration

- Behavioral health care may be **coordinated** with primary care, but the actual delivery of services may occur in different settings.
- treatment (or the delivery of services) can be **co-located** (where behavioral health and primary care are provided in the same location)
- or **integrated**, which means that behavioral health and medical services are provided in one treatment plan.

Integrated treatment plans can occur in co-location and/or in separate treatment locations aided by Web-based health information technology. Generally speaking, co-located care includes the elements of coordinated care, and integrated care includes the elements of both coordinated care and co-located care.

Source: Adapted from Blount 2003.

Integrative Care = Collaborative Care

Primary care settings have become the gateway to the behavioral health system

The triple aim of health care reform is to:

- Better health care outcomes for patients and populations of patients
- Improved patient and provider experience
- Lower health care costs

Enter Behavioral Health……..

Integrative Model (IM)

- BH is a routine part of care
- Pt. is as likely to see a BHC as a RN during routine visit
- BHC is part of the PC team
- BHC help co-manage the pt according to the PCP referral
  - Use of appropriate screening tool (i.e. PHQ9, GAD7)

The Answer: Behavior Activation

Convert evidence-based knowledge into condensed "bite-size" interventions with a psycho-educational format

- Emphasis on skill building
- Home-based practice

(Strosahl 2005)

The Assessment & Tools

- PHQ9 = 9 help identify depression
- GAD7 = 7 questions help identify anxiety
- SBIRT
  - evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.
  - AUDIT and AUDIT-C
  - AUDIT - Alcohol Use Disorders Identification Test; AUDIT-C - AUDIT-Consumption.

Screening Brief Intervention & Referral to Treatment (SBIRT)

- **Screening** — a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting
- **Brief Intervention** — a healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice
- **Referral to Treatment** — a healthcare professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services

Ex. of BI: evidence-based

SBIRT

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Used to identify, reduce, & prevent problematic use, abuse, & dependence on alcohol & illicit drugs.

The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.

SAMHSA-HRSA Center for Integrated Health Solutions, 2015

MI: Motivational Interviewing

The approach upholds four principles— expressing empathy and avoiding arguing, developing discrepancy, rolling with resistance, and supporting self-efficacy (client's belief s/he can successfully make a change)

Motivational Interviewing

1. Do I listen more than I talk?

   Or am I talking more than I listen?

2. Do I keep myself sensitive and open to this person's issues, whatever they may be?

   Or am I talking about what I think the problem?

3. Do I invite this person to talk about and explore his/her own ideas for change?

   Or am I jumping to conclusions and possible solutions

4. Do I encourage this person to talk about his/her reasons for not changing?

   Or am I forcing him/her to talk only about change?

5. Do I ask permission to give my feedback?

   Or am I presuming that my ideas are what he/she really needs to hear?

6. Do I reassure this person that ambivalence to change is normal?

   Or am I telling him/her to take action and push ahead for a solution?

7. Do I help this person identify successes and challenges from his/her past and relate them to present change efforts?

   Or am I encouraging him/her to ignore or get stuck on old stories?

8. Do I seek to understand this person?

   Or am I spending a lot of time trying to convince him/her to understand me and my ideas?

9. Do I summarize for this person what I am hearing?

   Or am I just summarizing what I think?

10. Do I value this person's opinion more than my own? Or am I giving more value to my viewpoint?

The Goal: Behavior Activation

- Educate patients about their condition
- Discuss different types of self-management strategies that patients can implement in their daily environments.
- The aim is to get patients doing something different.

A patient's problem is not causing the dysfunction, but rather the solutions being used to solve the problem cause the dysfunction.

(Strosahl, 2005)

The How

Solution Focused

focus on the exceptions to the client's problems.

- *Deliberate exceptions*
- *Random exceptions*

Pleasant Activity Scheduling

Shift the power back to clt

Relapse Prevention Plan

Brief Strategic

- Focusing on competence rather than pathology
- Finding a unique solution for each person
- Using exceptions to the problem to open the door to optimism
- Using past successes to foster confidence
- Looking to the client as the expert
- Using goal-setting to chart a path toward change
- Sharing the responsibility for change with the client

Brief Interventions: anyone can do

- BI also referred to as a brief conversation, consists of up to five counseling sessions.
- Efficacy and effectiveness has been found for brief interventions lasting 3-5 minutes. However, one needs to provide a minimum of 15 minutes for payment under CPT and HCPC rules.
- BI can take place in various settings, such as primary healthcare settings, and can be implemented by a variety of trained behavioral and primary healthcare providers.
- BI consist of feedback about personal risk, explicit advice to change, emphasis on patient's responsibility for change, and provides a variety of ways to effect change.
- BI techniques include an empathetic style and support for the patient's perception of self-efficacy or optimism that they can change.

Brief Therapy

- BT is a systematic & focused. Relies on assessment, client engagement, and immediate implementation of change strategies.
- BT in relation to traditional or specialist treatment, is generally of shorter duration, conducted in partnership with the client in 1-12 highly focused and structured clinical sessions.
- Each BT session is structured and conducted in anticipation that each session could be the last session.
- A high level of importance is placed on the work a client does outside of the therapy room
- Client progress does not begin and end in the therapy room.

Examples of Brief Therapy

- Solution Focused
- Brief Solutions
- CBT
- DBT

BI vs BT

- Are elements on a continuum of care
- Are distinguished from each other according to differences in outcome goals
- **Interventions** are generally aimed at motivating a client to perform a particular action (e.g., to enter treatment, change a behavior, think differently about a situation),
- **Therapies** are used to address larger concerns (such as altering personality, maintaining abstinence, or addressing long-standing problems that exacerbate substance abuse).
- BI are a way of improving client motivation for treatment.

Misconceptions

Warning:

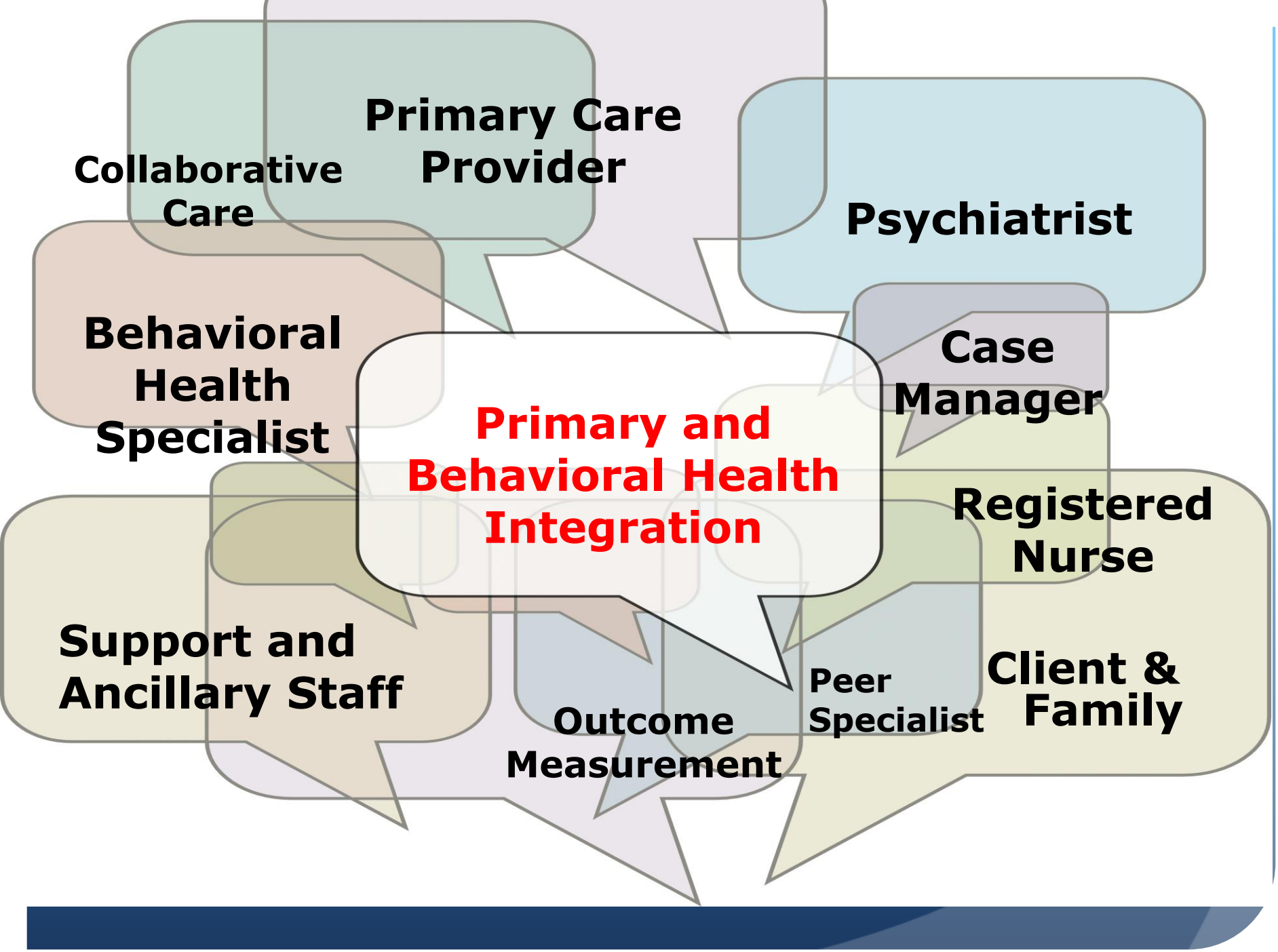
- Integrating BHC in the PC system cannot involve simply taking specialty mental health approaches and dropping them into PC.
- The sheer volume of BH needs would quickly outstrip the capacity of traditional MH approaches (Strosahl, 2001).

Know who your client is

- Who do you serve
- What do you need to help them meet their goals
- Where will you serve them
- When: begin at the initial visit
- How by beginning to identify who the team is

The Hallmark of PCBH Model

- Focus on an epidemiological, public health view of service delivery.
- In specialty behavioral health care, the focus is on the individual.
- In population-based care, the entire primary care population is the target.
- The goal is not just to address the needs of sick patients but also to target those who may be at risk or who are sick and do not seek care (Strosahl 1997).
- The primary care behavioral health model uses a “widenet” approach aimed at serving the entire primary care population with emphasis on brief, focused interventions. (Some unified programs, such as FQHCs, share this perspective.)


Collaborative Care
Primary Care Provider
Psychiatrist
Behavioral Health Specialist
Case Manager
Primary and Behavioral Health Integration
Registered Nurse
Support and Ancillary Staff
Peer Specialist
Client & Family
Outcome Measurement

It Works: ex. Reverse Co-location

SMI Community Mental Health Center

Juaquina 62 y/o female, suicide OD attempt (50 pills).

- Major Depression
- Non-insured
- Diabetic
- Waist Obesity
- Hypertension

Federally Qualified Health Center

FQHC staff @ CMH: PBHCI

- Connected to new PCP
- Identified and addressed health issue identified at PBHCI
- Wellness exams
  - Mammogram
  - PAP

Success: Stable, no meds, lost 50 lbs. and has became a Certified Peer Specialist employed FT at CMHC

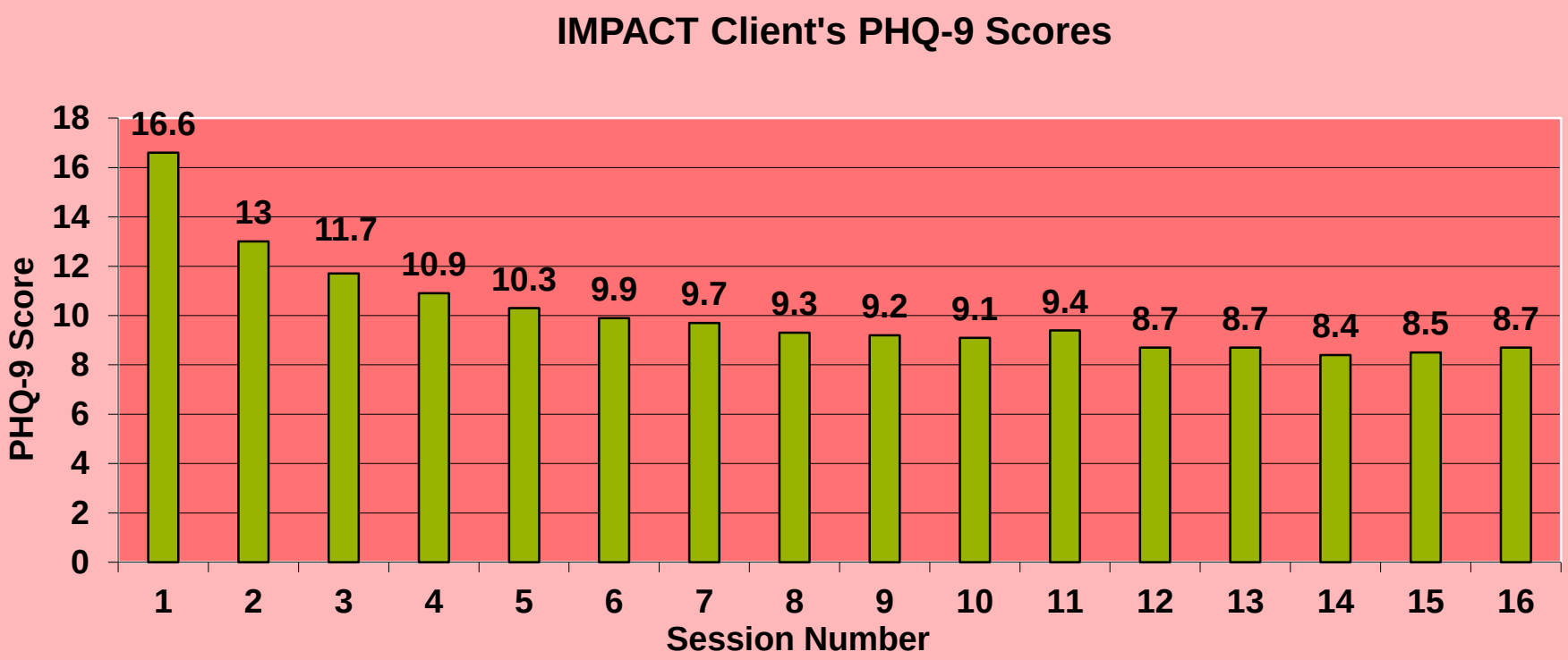
PBHCI Screening results

Age: 18-24 years (18); 25-44 years (163); **45-64 years (243);** 65+ (20)

Diabetes	92/357	25.7%
Hypertension	121/436	27.8%
High Cholesterol	177/353	50.1%
Obesity	233/436	53.4%
Smoking	153/433	35.3%

IMPACT

IMPACT clients complete PHQ-9 at each visit.
Graph represents PHQ-9 scores for 2,029 A & OA's seen
Between June 2007 and Dec 2013.



Ex1: Co-location/Integration (cont.)

PCMH and BH

- Called/Referred by Urgent Care
- Married 30 y/o Hispanic male, 2 bio children to adopt 4 family members. Construction worker.
- PHQ9 21 with 3 on # 9, GAD7 21, Audit and Audit-C positive
- Highly anxious self medicating with alcohol, binge drinking, blackout ED visits x 3 in 6 months for detox protocol

SBIRT, MI & Brief Interventions

- Strong familial Hx of Type ii diabetes
- Elevated liver enzymes
- A1c < 8
- Refused AA
- Blacked out/ Hospitalized

Ex2: Co-location/Integration (cont.)

PCMH and BH

15 y/o daughter is client

- Mother is a 37 y/o married Mexican female
- PHQ9 21 with 2 on # 9
- GAD7 21
- Non-insured, sole earner with major depression
- Husband deported in 2013
- 3 Children 15, 13 & 10

Community Resources & MI

Opportunities

- BT under Magdalena
- Connected to PCP
- Current medication to include antidepressant
- Referral to Legal Advocate

How are we doing?

Challenges:

Cross-discipline education & training needs are substantial

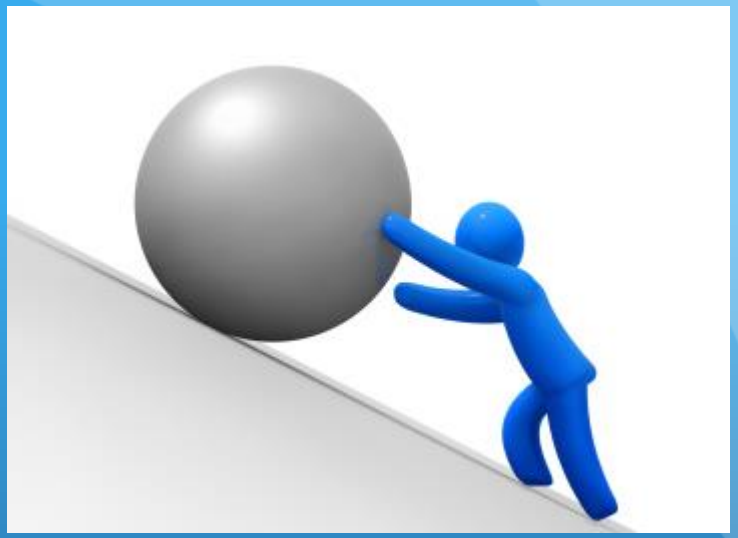
Office systems needs are substantial

Coordination of care among providers is generally not a funded activity

Same-day billing

Patients have different benefit packages for medical and mental health coverage

Lack of parity means that payment can be vastly different



If a new appointment is required, issues with no-show can increase

Sufficient funds to cover cost of employees needed

New codes for tobacco, substance, and behavior interventions may not be covered by various payers

Culture Shift: here or there?

Questions

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References & Resources

- Blount, A. 2003. Integrated Primary Care: Organizing the Evidence. Families, Systems, & Health 21(2):121–33. doi:10.1037/1091-7527.21.2.121. Available at http://dx.doi.org/doi:10.1037/1091-7527.21.2.121.

- Finch RA. Phillips K. Center for Prevention and Health Services. An Employer's Guide to Behavioral Health Services: A Roadmap and Recommendations for Evaluating, Designing, and Implementing Behavioral Health Services. Washington, DC: National Business Group on Health; 2005.

- Kessler, R., W. Chiu, O. Demler, and E. Walters. 2005. Prevalence, Severity, and Comorbidity of Twelve-Month DSM-IV Disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry 62(6):617–27. Available at http://archpsyc.ama-assn.org/cgi/reprint/62/6/617.

- Milbank Memorial Fund . (2010). Evolving models of behavioral health. Retrieved from http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf

- Robinson, P., and J. Reiter. 2007. Behavioral Consultation and Primary Care: A Guide to Integrating Services. New York: Springer. Available at http://www.amazon.com/Behavioral-Consultation- Primary-Care- ntegrating/dp/0387329714.

- Strosahl, K. 2001. The Integration of Primary Care and Behavioral Health: Type II Changes in the Era of Managed Care. In Integrated Behavioral Healthcare: Positioning Mental Health Practice with Medical/Surgical Practice , edited by N. Cummings, W. O'Donohue, S. Hayes, and V. Follette, pp. 45–70. San Diego: Academic Press. Available at http://www.amazon.com/Integrated-Behavioral- Healthcare-Positioning-Professional/dp/0121987612.

- Strosahl, K. 2005. Training Behavioral Health and Primary Care Providers for Integrated Care: A Core Competencies Approach. In Behavioral Integrative Care: Treatments That Work in the Primary Care Setting , edited by W. O'Donohue, M. Byrd, N. Cummings, and D. Henderson, pp. 15–52. New York: Brunner-Routledge. Available at http://www.amazon.com/Behavioral-Integrative-Care- Treatments-Primary/dp/0415949467.

References & Resources (cont.)

- SAMHSA-HRSA Center for Integrative Solutions. (2014). Brief Interventions. Retrieved from http://www.integration.samhsa.gov/clinical-practice/sbirt/brief-interventions

- Case Western Reserve. MI Cards. http://www.centerforebp.case.edu/client-files/pdf/miremindercard.pdf