Integration

Primary Care & Behavioral Health
Delivers over 50% of all behavioral health (BH) care in West Virginia

Primary care (PC) is the largest prescriber of psychotropic medications

Psychiatry prescribes 18% of all psychotropic medications

Chronic diseases have co-morbid behavioral health components that complicate effective treatment & optimal outcomes

60% of pts. with chronic disease are non-complaint with treatment regimen

PCP’s have inadequate resources & time to effectively address BH components of care
BH patients have high levels of chronic disease: diabetes, cardiovascular, etc.

Mortality rates for seriously mentally ill (SMI) are higher vs. the general population (SMI die 25 yrs earlier)

Co-morbid diseases complicate BH disorders management

Co-morbid BH disorders complicate chronic disease management

Psychototropic medicines can complicate chronic disease – e.g. mood stabilizers & metabolic syndrome
The Relationship of Premature Death and Serious Mental Illness

People with severe and persistent mental illness (SMI) die, on average, 25 years earlier than the general population.

People with mental illness often have significant medical issues. A recent study found a chronic health condition in 74% of a population with SMI (Jones et al., 2004).
West Virginia - Percentage of Adults with Diabetes Having at Least One Day of Poor Mental Health in the Past 30 Days, 1994 - 2004

Prevalence of Smokers with Current Depressive Symptoms among those with and without Medicaid

<table>
<thead>
<tr>
<th>2006</th>
<th>Medicaid</th>
<th>No Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>percent</strong></td>
<td>57.6</td>
<td>34.8</td>
</tr>
</tbody>
</table>

Data Source: WV Health Statistics Center
Prevalence of Smokers by Severity of Depressive Symptoms

West Virginia Behavioral Risk Factor Surveillance System
Data Source: WV Health Statistics Center

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild Symptoms</td>
<td>33.7</td>
</tr>
<tr>
<td>Moderate Symptoms</td>
<td>42.3</td>
</tr>
<tr>
<td>Moderately Severe Symptoms</td>
<td>43.8</td>
</tr>
<tr>
<td>Severe Symptoms</td>
<td>56.1</td>
</tr>
</tbody>
</table>

2006
Prevalence of Smokers among those with Current Depressive Symptoms

- No Depression Diagnosis: 22.7%
- Currently Depressed: 44.4%

2006
Prevalence of Smokers among those with Current Depressive Symptoms

2006

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Depression Diagnosis</td>
<td>22.7</td>
</tr>
<tr>
<td>Currently Depressed</td>
<td>44.4</td>
</tr>
</tbody>
</table>

West Virginia Behavioral Risk Factor Surveillance System
Data Source: WV Health Statistics Center
For Persons with Mental Illness

- Prevalence = 75%
- Consume 44% of all cigarettes nationally
- Smoke heavier
- Smoke more efficiently

Full report available at http://www.nasmhpd.org/publications.cfm#techpap

NASMHPD Research Institute, Inc. © 2006
<table>
<thead>
<tr>
<th>DRUG</th>
<th>WEIGHT GAIN</th>
<th>RISK FOR DIABETES</th>
<th>WORSENING LIPID PROFILE</th>
</tr>
</thead>
<tbody>
<tr>
<td>clozapine (Clozaril)</td>
<td>+++</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>olanzapine (Zyprexa)</td>
<td>+++</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>risperidone (Risperdol)</td>
<td>++</td>
<td>±</td>
<td>±</td>
</tr>
<tr>
<td>quetiapine (Seroquel)</td>
<td>++</td>
<td>±</td>
<td>±</td>
</tr>
<tr>
<td>aripiprazole (Abilify)</td>
<td>±</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>ziprasidone (Geodon)</td>
<td>±</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
Collaborative vs. Integrated Care

Comparison
Collaborative = with
Integrated Care = within
## Collaborative vs. Integrated Care

<table>
<thead>
<tr>
<th></th>
<th>Collaborative</th>
<th>Integrated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mission</strong></td>
<td>Specialty BH care – PCP kept “informed”</td>
<td>PC service treats BH problem</td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td>Separate or co-located</td>
<td>Medical practice area</td>
</tr>
<tr>
<td><strong>Primary provider</strong></td>
<td>Therapist</td>
<td>Health care consultant</td>
</tr>
<tr>
<td><strong>Service modality</strong></td>
<td>Therapy sessions</td>
<td>Consultation session</td>
</tr>
<tr>
<td><strong>Team identification</strong></td>
<td>One of “them”</td>
<td>One of “us”</td>
</tr>
<tr>
<td><strong>Professional role</strong></td>
<td>BH specialist</td>
<td>BH consultant</td>
</tr>
<tr>
<td><strong>Philosophy of care</strong></td>
<td>“See a specialist I work with in the other wing.”</td>
<td>“Talk to one of our team consultants”</td>
</tr>
<tr>
<td><strong>Patient’s perception</strong></td>
<td>Separate services from collaborative specialist</td>
<td>Routine health care</td>
</tr>
</tbody>
</table>

Adapted from Strosahl in Blout (1998), p. 163
Four Quadrant Clinical Integration Model

- Identifies populations to be served
- Indicates service type mix
<table>
<thead>
<tr>
<th>Quadrant I</th>
<th>Quadrant II</th>
<th>Quadrant III</th>
<th>Quadrant IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral health: Low</td>
<td>Behavioral health: High</td>
<td>Behavioral health: Low</td>
<td>Behavioral health: High</td>
</tr>
<tr>
<td>Physical health: Low</td>
<td>Physical health: Low</td>
<td>Physical health: High</td>
<td>Physical health: High</td>
</tr>
<tr>
<td>Service setting: PC</td>
<td>Service setting: PC &amp; SBH</td>
<td>Service setting: PC</td>
<td>Service setting: PC &amp; SBH *</td>
</tr>
<tr>
<td>e.g. Fibromyalgia, moderate alcohol abuse</td>
<td>e.g. Bipolar disorder; chronic pain</td>
<td>e.g. Moderate depression; uncontrolled diabetes</td>
<td>e.g. Schizophrenia; metabolic syndrome; Hepatitis C</td>
</tr>
<tr>
<td>* Reverse model is an option</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Practice Models
by
Degree of Integration
Level I: Minimal Collaboration

Degrees of Integration
Level I: Minimal collaboration

PC & BH providers in separate facilities; separate systems; sporadic communication

- Improvement strategies:
  - Case manager
  - Telephone psychiatric consultation
  - Formal info sharing

- Barriers to improvement:
  - Referrals may be driven by provider need rather than pt. need due to limited screening options
    - Standardized assessment forms on all patients
  - Privacy laws: BH often defaults to the most restrictive state or federal law
    - State assistance on least restrictive acceptable policies
  - Costs: case manager; additional tracking
    - Reimbursed case mgmt.; enhanced per member, per month (medical home model)
Level II:
Basic Collaboration at a Distance

Degrees of Integration
Level II: Minimal collaboration
Basic Collaboration at a Distance

- PC & BH Providers in separate systems, separate sites. Engage in periodic communication (usually phone or letter) re shared patients
- Efficacy evidence: substance abuse; pain; smoking; panic; anxiety; depression
- PCP usually only direct provider
- Psychiatric consultant to doc – no co-management
- Screens for BH conditions: PHQ–9; Pediatric Symptom Checklist
- Follows BH brief intervention guidelines
Level II: Minimal collaboration
Basic Collaboration at a Distance

- Improvement strategies:
  - Co-education of PCP & psychiatrist and/or psychologist: CME’s; lunches presentations
  - Telephone psychiatric consultation
  - Formal info sharing

- Barriers to improvement:
  - PCP may be concerned of time burden of detailed assessments & multiple consultations
    - Payers reimburse for additional services; cost offset gains
  - Costs: case manager; additional tracking
    - Reimbursed case mgmt.; enhanced per member, per month (medical home model)
Level III:
Basic Collaboration On-site

Degrees of Integration
PC & BH Providers in separate systems, same facility. Improved communication. Separate professional cultures continue

Tradition BH model: 50 min. sessions, etc. Still specialty care model

BH provider’s schedule cannot pace PC referrals

Serious Mental Ill may not be as well served as in a specialty clinic

Efficacy evidence: better outcomes; improved diagnoses & treatment; greatest improvement in poorest health patients; cost offset may occur due to reduction in physical health care

PCP not only provider. BH practitioner co-management

BH brief intervention guidelines expanded to more varied intervention options

Group services possible
Level IV:
Close Collaboration –
Partly Integrated System

Degrees of Integration
Level IV: Close Collaboration – Partly Integrated System

- PC & BH Providers in separate systems, same facility. Improved communication. Merging of professional cultures.
- Unified Primary Care & Behavioral Health (UPCBH) Model: BH maintains specialty care, individual pt. model. BH model modified to serve primary care setting & culture.
- Tradition BH model: 50 min. sessions, etc. Still specialty care model.
- BH provider’s schedule cannot pace PC referrals
- Serious Mental Ill can be better served but still needs access to specialty clinic
- Efficacy evidence: clinically effective; cost effective w 20–40% cost offset for medical pts. Receiving BH services.
- Care managers are cross-trained for mgmt. of co-morbid conditions
- Registry database essential to monitor patients and progress
- New funding models by payers required
Level IV–R:
Reverse Co–Location Model

Degrees of Integration
Level IV–R: Reverse Co–Location Model

- Goal: to improve health care for SMI patients
- Primary care provider out–stationed in psychiatric specialty setting
- Could be psychiatrist with dual roles
Level V: Close Collaboration – Fully Integrated System

Degrees of Integration
Level V: Close Collaboration in a Fully Integrated System

- PC & BH Providers in same clinical, administrative & financial system: one team.
- BH care is an integrated primary care service.
- Integrated health record and single treatment plan.
- Primary Care Behavioral Health (PCB) Model: epidemiological, public health view of services delivery.
- Referring physician is primary customer.
- Entire primary care population is target.
- Efficacy evidence: clinically effective; cost effective w 20–40% cost offset for medical pts. receiving BH services.
- Care managers are cross–trained for mgmt. of co–morbid conditions.
- Registry database essential to monitor patients and progress.
- New funding models by payers required.
Level V: Close Collaboration in a Fully Integrated System

Sub-Models

- **Unified Primary Care & Behavioral Health Model:**
  - Specialty psychiatric care imbedded
  - BH provider part of specialty mental health
  - BH Services focus on individual
  - BH takes over responsibility for BH care
  - Implemented in FQHC & VA

- **Primary Care Behavioral Health Model**
  - Behavioral health is routine part of medical care
  - BH provider part of primary care team – temporarily co-manages patient with physician
  - Referring physician is principal “customer”
    - “Warm hand-offs”; “curb-side” consults
    - Multiple service delivery formats: education; case mgmt., telephone monitoring, skill coaching
  - Epidemiological, public health view of service delivery
    - Population-based care
    - At-risk are also targeted for intervention – “wide-net” approach
Collaborative System Care Model

- Core system integrated & imbedded in a collaborative (at a distance) system.
- Partners can add: housing, education, employment, legal advocacy, & welfare.
Innovation: Health Homes

- Under ACA 2703 a State Medicaid program may create a plan to provide care coordination to those with chronic health conditions.
- A program such as this qualifies for an enhanced match to cover the cost of care coordination for complicated patients.
- The program must meet the “triple aim”.
The first Health Home State Plan Amendment (SPA) in WV will focus on individuals with bipolar disorder and risk of/infected with, hepatitis B or C. This program will roll out in 6 counties.

Six coordination of care criteria must be met by providers who enroll as “health homes”.

Payment is based on a PMPM model with two tiers.
How was this population chosen?

- Bipolar disorder is common and costly
  - High cost meds
  - High frequency utilization
- Chronic viral hepatitis is on the rise
  - Risk is 15–fold higher in the bipolar population
  - Strong link to substance abuse
- Treatment of both conditions requires close coordination
- The health impact of both conditions is very significant
Health Homes

- The SPA will be submitted to CMS in early fall with implementation in 2014.
- Based on this model, future health home projects will focus on other chronic conditions (diabetes, asthma, serious mental illness, heart disease, etc.).
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Bureau of Medical Services