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# **The Imperative for Integrating Primary Care and Behavioral Health**

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Kathleen M. Reynolds, LMSW, ACSW

[kathyr@thenationalcouncil.org](mailto:kathyr@thenationalcouncil.org)

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





Texas Incubator Project

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# Making the Policy Case for Integration

- Consumer/Personal Based Reasons
    - Family and Consumer demand
    - Consumer Impact
  - State Wide Reasons
    - Status of Integrated Health in Texas
  - National Reports
    - New Freedom Commission Report
    - National Council for Community Behavioral Healthcare (NCCBH)
    - Institute of Medicine Report(s) (IOM)
    - Bureau of Primary Healthcare/HRSA
    - National Morbidity and Mortality Report
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## Prevalence of Psychiatric Disorders in Primary Care

Disorder	Prevalence	
No mental disorder	61.4%	
Somatoform	14.6%	
Major Depression	11.5%	
Dysthymia	7.8%	
Minor Depression	6.4%	
Major Depression (partial remission)	7.0%	
Generalized Anxiety	6.3%	
Panic Disorder	3.6%	
Other Anxiety Disorder	9.0%	
Alcohol Disorder	5.1%	
Binge Eating	3.0%	

Source: Spitzer RL, Williams JBW, Kroenke K, *et al.* Utility of a New Procedure for Diagnosing Mental Disorders in Primary Care: The PRIME-MD 1000 Study. *Journal of the American Medical Association*, 272:1749, 1994.

## Prevalence of Psychiatric Disorders in Low-income Primary Care Patients

- › 35% of low-income patients with a psychiatric diagnosis saw their PCP in the past 3 months
- › 90% of patients preferred integrated care
- › Based on findings, authors argue for system change

Disorder	Low-Income Patients	General PC Population*
At Least One Psychiatric Dx	51%	28%
Mood Disorder	33%	16%
Anxiety Disorder	36%	11%
Alcohol Abuse	17%	7%
Eating Disorder	10%	7%

Source: Mauksch LB, et. Al. Mental Illness, Functional Impairment, and Patient Preferences for Collaborative Care in an Uninsured, Primary Care Population. *The Journal of Family Practice*, 50(1):41-47, 2001.

# Local/Consumer Rationale

	<b>Washington State</b>	<b>Colorado Access</b>	<b>Marrilac Clinic, Grand Junction CO</b>
<b>Population</b>	Medicaid Adults: Aged, Blind, Disabled	Medicaid Adults	Uninsured
<b>Number</b>	100,171	6,500	500
<b>Any MH/SA Diagnosis</b>	47% (claims)	40% (claims)	51% (PHQ9)
<b>Percent w/ Dx Seen by MH/SA system</b>	52%	33%	n/a

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# Morbidity and Mortality for Persons with Serious Mental Illness

- According to a 2006 report from the National Association of State Mental Health Program Directors (NASMHPD), persons with serious mental illness (SMI) are now dying **25 years earlier** than the general population
  - While suicide and injury account for about 30-40% of excess mortality, 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases
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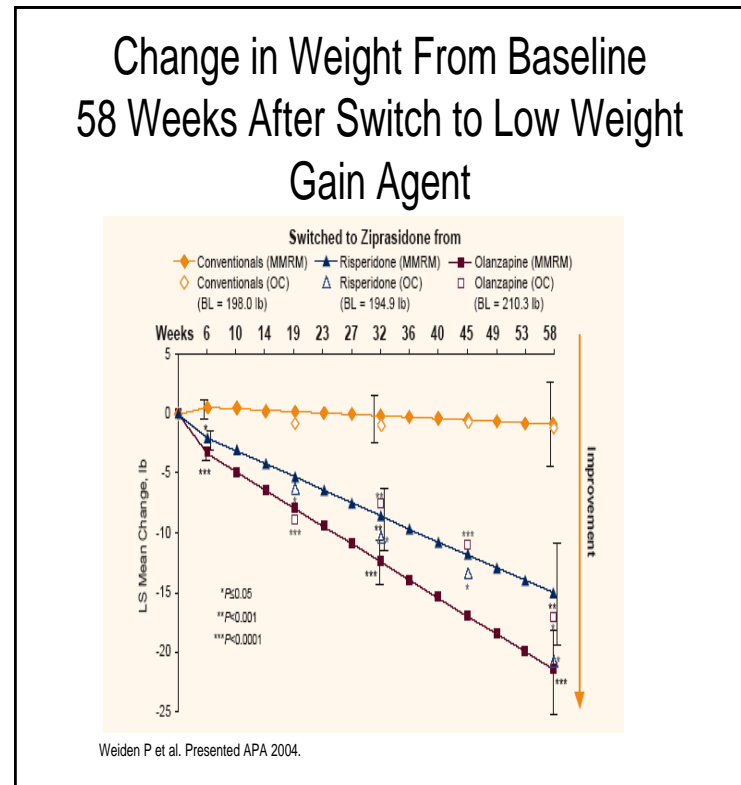
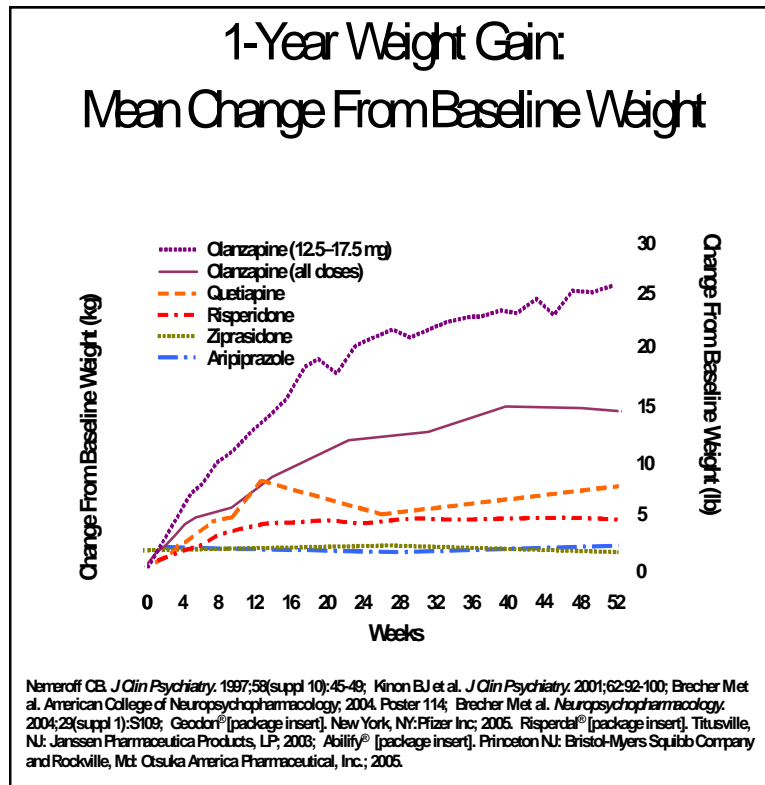
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# Modifiable Risk Factors

- Higher rates of modifiable risk factors:
    - Smoking
    - Alcohol consumption
    - Poor nutrition / obesity
    - Lack of exercise
    - “Unsafe” sexual behavior
    - IV drug use
    - Residence in group care facilities and homeless shelters
  - Vulnerability due to higher rates of:
    - Homelessness
    - Victimization / trauma
    - Unemployment
    - Poverty
    - Incarceration
    - Social isolation
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# Morbidity and Mortality-SMI

## The Impact of Medications



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# PRISM-E Study

- According to the PRISM-E Study
    - 11 sites, 50 primary care clinics and referral MH specialty clinics across the nation
    - 24,863 patients, 65 or older, screened, evaluated and randomized to integrated care or referral care
    - 20% scored positive for psychological distress, 8% for at risk drinking, 5% had suicidal thoughts
    - The “best referral process ever”
    - Engagement rate for depression—integrated model 76%, referral model 55%
    - Engagement rate for alcohol—integrated model 72%, referral model 29%
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# Texas Specific Initiatives

- Integration of Health and Behavioral Health Workgroup
    - Legislation requiring a report
    - Currently holding meetings for recommendations
  - Hogg Foundation Integrated Health Learning Community
    - Currently 12 sites across the state
  - Texas Transformation Project Emphasis
  - Incubator Grants for CHC and CMHC coordination and planning for HRSA Grants
    - 6 sites
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# The National Council Goals for Integration

- Every provider of public BH services assures assessment of health status as well as mental status and has specific protocols in place for medically monitoring all consumers receiving second generation antipsychotic medications. An integral part of their service for consumers is to assure that each person is connected to a primary care medical home, and there are specific mechanisms between the BH and primary care providers for coordination of services.
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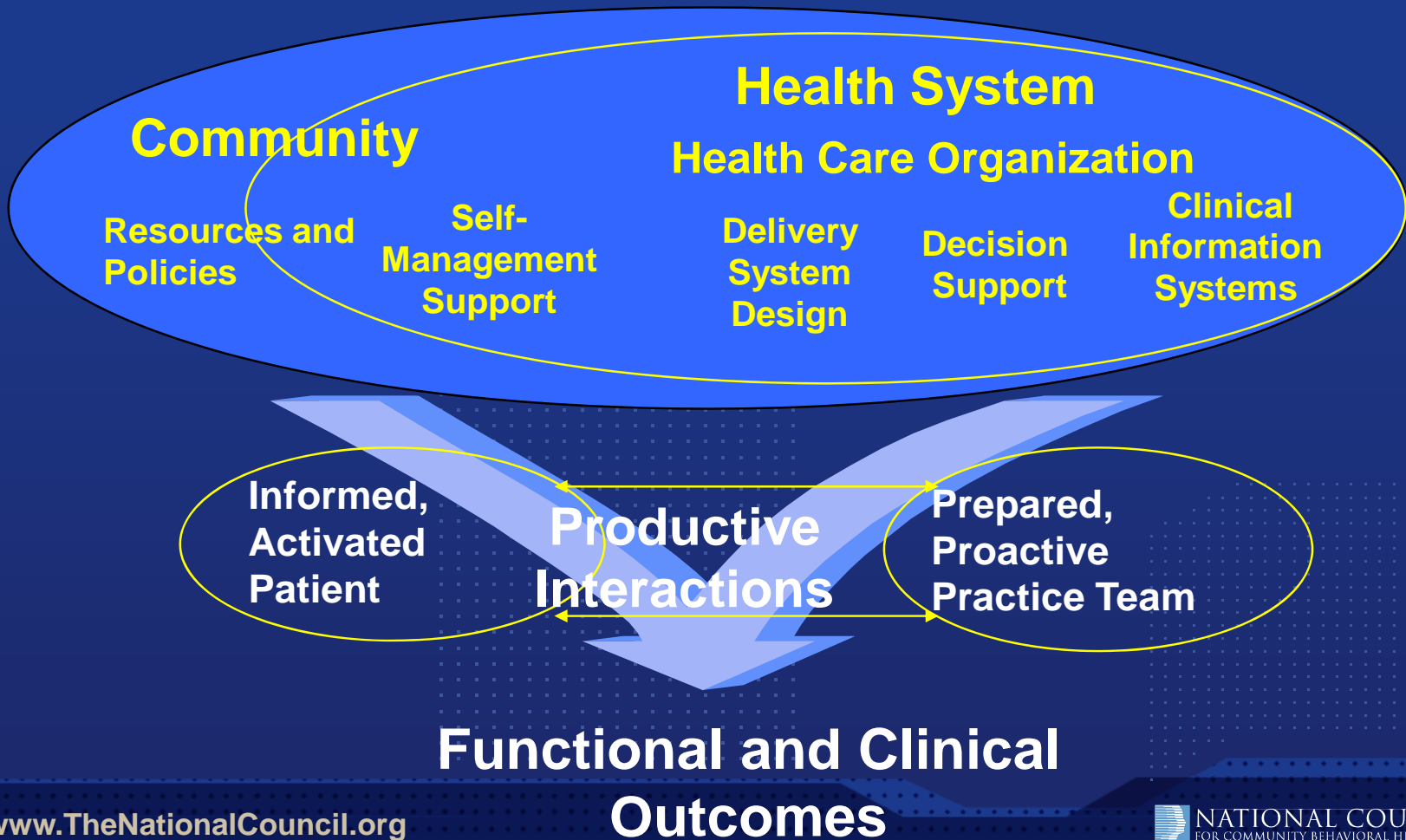
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# Current Federal Financing Initiatives

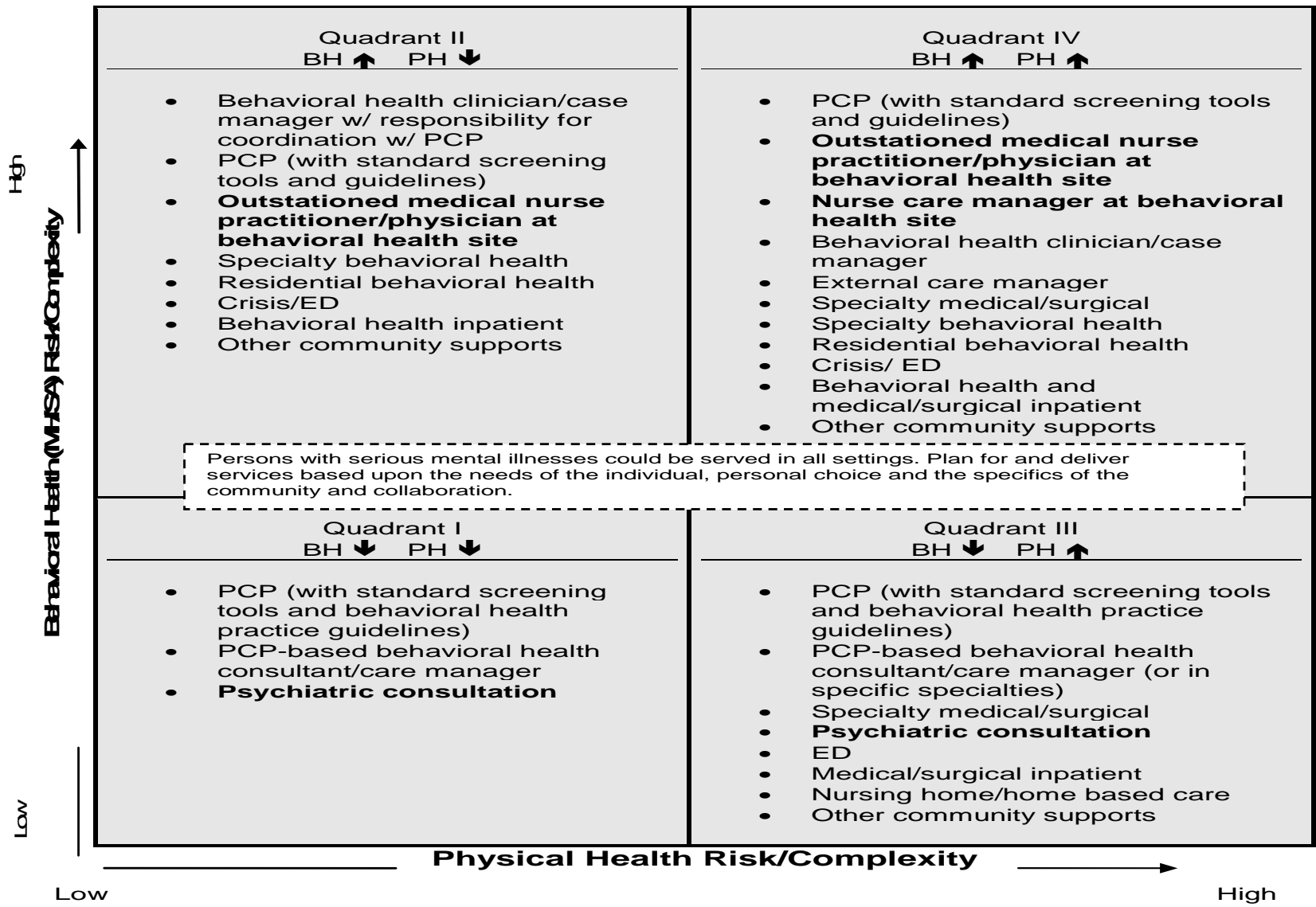
- HRSA Expansion Grants Available for adding behavioral health into FQHC settings
  - Strong emphasis on adding behavioral health: all new FQHC applications must include behavioral health services
  - Medicare/Medicaid Medical Home Pilot Projects
  - ARRA
  - Healthcare Reform
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Function	Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration On-Site	Close Collaboration/Partly Integrated	Fully Integrated/Merged
<b>THE CONSUMER and STAFF PERSPECTIVE/EXPERIENCE</b>					
Access	Two front doors; consumers go to separate sites and organizations for services	Two front doors; cross system conversations on individual cases with signed releases of information	Separate reception, but accessible at same site; easier collaboration at time of service	Same reception; some joint service provided with two providers with some overlap	One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model
Services	Separate and distinct services and treatment plans; two physicians prescribing	Separate and distinct services with occasional sharing of treatment plans for Q4 consumers	Two physicians prescribing with consultation; two treatment plans but routine sharing on individual plans, probably in all quadrants;	Q1 and Q3 one physician prescribing, with consultation; Q2 & 4 two physicians prescribing some treatment plan integration, but not consistently with all consumers	One treatment plan with all consumers, one site for all services; ongoing consultation and involvement in services; one physician prescribing for Q1, 2, 3, and some 4; two physicians for some Q4: one set of lab work
Funding	Separate systems and funding sources, no sharing of resources	Separate funding systems; both may contribute to one project	Separate funding, but sharing of some on-site expenses	Separate funding with shared on-site expenses, shared staffing costs and infrastructure	Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility
Governance	Separate systems with little of no collaboration; consumer is left to navigate the chasm	Two governing Boards; line staff work together on individual cases	Two governing Boards with Executive Director collaboration on services for groups of consumers, probably Q4	Two governing Boards that meet together periodically to discuss mutual issues	One Board with equal representation from each partner
EBP	Individual EBP's implemented in each system;	Two providers, some sharing of information but responsibility for care cited in one clinic or the other	Some sharing of EBP's around high utilizers (Q4) ; some sharing of knowledge across disciplines	Sharing of EBP's across systems; joint monitoring of health conditions for more quadrants	EBP's like PHQ9; IDDT, diabetes management; cardiac care provider across populations in all quadrants
Data	Separate systems, often paper based, little if any sharing of data	Separate data sets, some discussion with each other of what data shares	Separate data sets; some collaboration on individual cases	Separate data sets, some collaboration around some individual cases; maybe some aggregate data sharing on population groups	Fully integrated, (electronic) health record with information available to all practitioners on need to know basis; data collection from one source

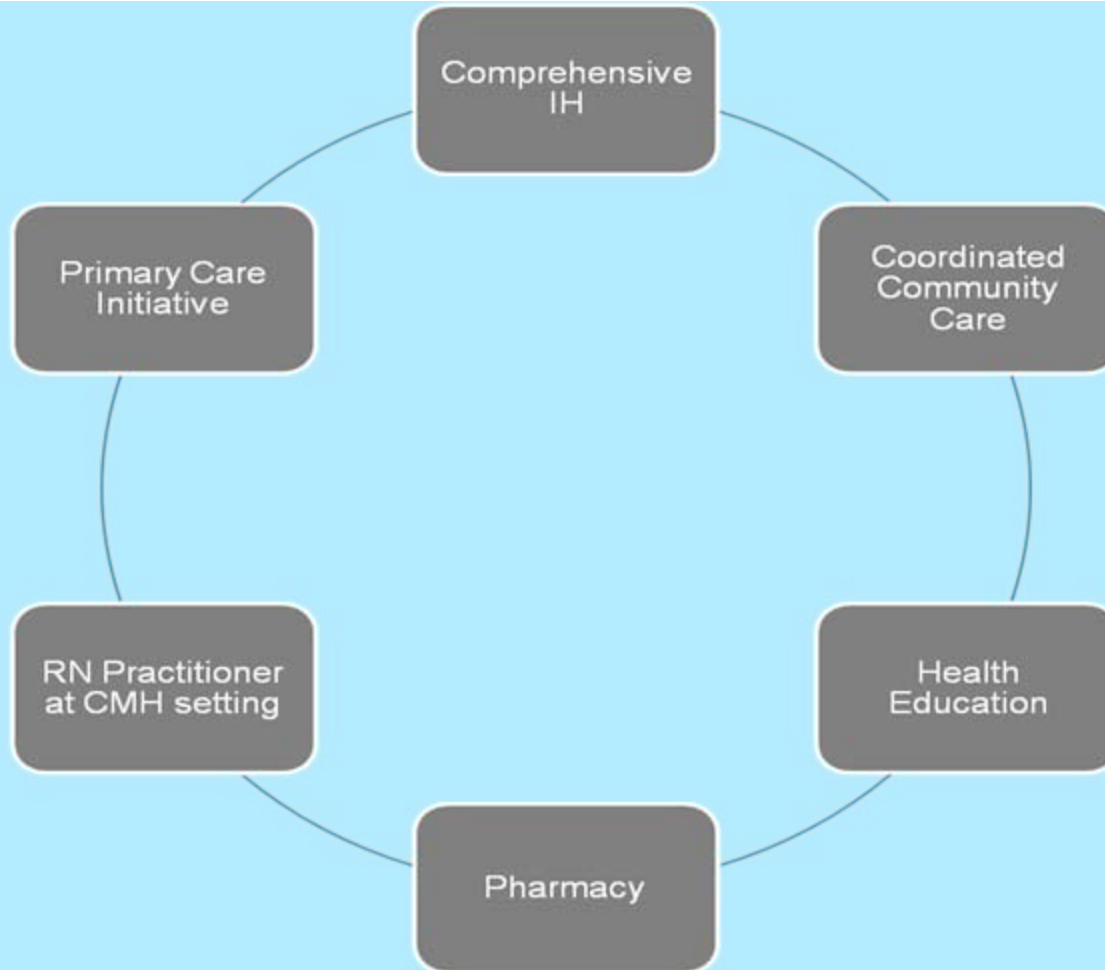
# Wagner Chronic Care Model



# The Four Quadrant Clinical Integration Model

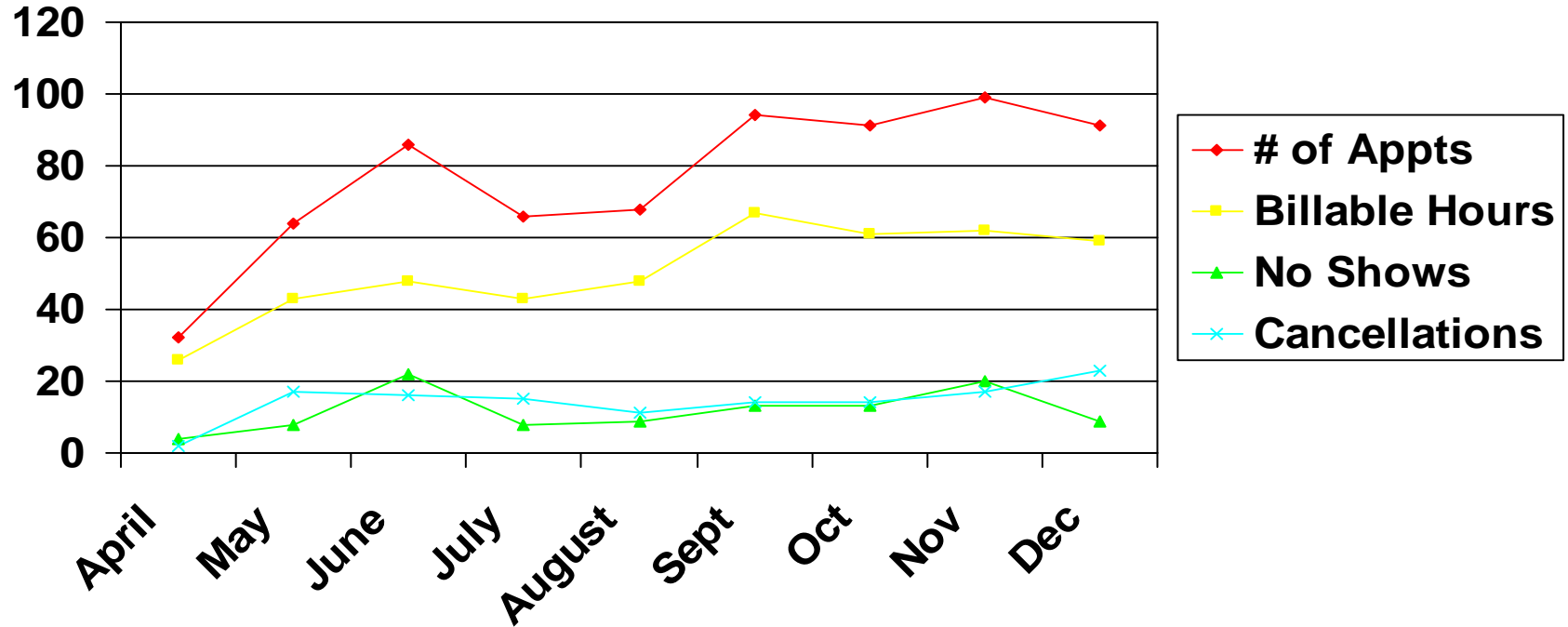


# Washtenaw County, MI Model



# Washtenaw County, MI - Primary Care Clinic Statistics

## Scheduled Appointments - 2004



# Financial Costs & Offsets

Primary Care Clinic	Return on Investment - Financial Costs and Offsets				
All are not-for-profit clinics that serve safety net patients	Behavioral Health Providers	FY 2006-07 full year mental health staff cost	FY 2006- 07 full year budgeted cost off-sets*	Variance	FY 2006-07 Projected Savings for CMH **
Clinic #1:	1. FTE MSW .10 FTE Psychiatrist .10 FTE Admin 3 <sup>rd</sup> year operation	\$97,040	\$98,967	\$1,927	\$48,608
Clinic #2:	.30 FTE Psychiatrist .10 FTE admin 3 <sup>rd</sup> year operation	\$78,608	\$52,576	(\$26,032)	None; expect 33% shortfall in this program
Clinic #3:	.10 FTE Psychiatrist .10 FTE Admin (FTE MSW planned in 2007) 2 <sup>nd</sup> year operation	\$35,459	\$25,770	(\$9,689)	\$48,608
Clinic #4:	1. FTE MSW .10 FTE University Psychiatrist*** .10 FTE Admin 7 months operation	\$71,516	\$24,806	(\$46,710)	\$30,380
Clinic #5:	1. FTE MSW .10 FTE Psychiatrist .10 FTE Admin 5 months operation	\$88,218	\$44,627	(\$43,591)	\$60,760

# Washtenaw County, MI - Return on Investment for Integrated Health

## Impact on Costs

