2010 Military Health System Conference

Integration of Behavioral Health and Primary Care

Sharing Knowledge: Achieving Breakthrough Performance

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25 January, 2009

TRICARE Management Activity

Integration of Behavioral Health and Primary Care

- Overview
  - Define Integrated-Collaborative Behavioral Health (ICBH) in Primary Care (PC)
  - 6 Reasons ICBH must be an integral part of the Patient-Centered Medical Home (PCMH)
  - Current Service ICBH assets and focus
  - The Way Ahead

What is ICBH in PC?

- A form of care where behavioral health (BH) and PC providers interact systematically to meet the BH and health needs of their patients through collaborative development of treatment plans, provision of clinical services, and coordination of care.
- ICBH **is NOT** a specified model of care, but includes a range of models that fall under this umbrella term.

ICBH Models of Care in the DoD

– **<u>Care Management Model</u>** a population-based model of care typically focused on a discrete clinical problem (e.g., depression).

- It incorporates specific pathways to systematically address how BH problems are managed in PC.
- PC providers & care managers share information via direct communication, shared medical record, treatment plan, and standard of care.
- Typically, there is some form of systematic interface with the outpatient mental health clinic.

ICBH Models of Care in the DoD

– **Primary Care Behavioral Health Model** a population-based model of focused on all enrolled patients (e.g., depression, anxiety, substance use, stress, obesity, diabetes, insomnia, chronic pain)

ICBH Models of Care in the DoD

– **Primary Care Behavioral Health Model**

1. BHP is embedded with PC team serving as a team member in the assessment, intervention & health care of the patient
2. BHPs & PCMs share patient information, medical record & coordinate health care plans
3. Brings a team-based management approach to care
4. BHP helps PC team improve BH assessment & intervention
5. BHP sees patients in 15-30 minute appointments in PC clinic
6. Same day as well as scheduled appointment availability
7. BHP focuses on full range of BH & health behavior change

Why ICBH Must Be Part of the PCMH

- *Reason 1*: Prevalence of BH Problems in PC
- *Reason 2*: Unmet BH Needs in PC
- *Reason 3*: Cost of Unmet Needs
- *Reason 4:* Lower Cost When Needs are Met
- *Reason 5*: Better Health Outcomes
- *Reason 6:* Improved Satisfaction

Reason 1: Prevalence

- 84% of the time the 14 most common physical complaints have no identifiable organic etiology[1]
- 80% with BH disorder visit PC at least once a year[2]
- 50% of all BH disorders are treated in PC[3]
- 48% of the appointments for all psychotropic agents are with a non-psychiatric PC provider[4]

1. Kroenke & Mangelsdorf, Am J Med. 1989;86:262-266.
2. Narrow et al., Arch Gen Psychiatry. 1993;50:5-107.
3. Kessler et al., NEJM. 2006;353:2515-23.
4. Pincus et al., JAMA. 1998;279:526-531.

Reason 2: Unmet BH Need

- 67% with a BH disorder do not get BH treatment[1]
- Non-integrated PC treatment of BH disorders is suboptimal compared to outpatient BH treatment[2]
- 30-50% of referrals from PC to an outpatient BH clinic don't make 1st appt[3,4]
- 50% of PCMs, can only sometimes, rarely or never get high-quality behavioral health referrals for patients[5]

1. Kessler et al., NEJM. 2005;352:515-23.
2. Young et al., Arch Gen Psychiatry. 2001;58:55-61.
3. Fisher & Ransom, Arch Intern Med. 1997;6:324-333.
4. Hoge et al., JAMA. 2006;95:1023-1032.
5. Trude & Stoddard, J Gen Intern Med. 2003;18:442-449.

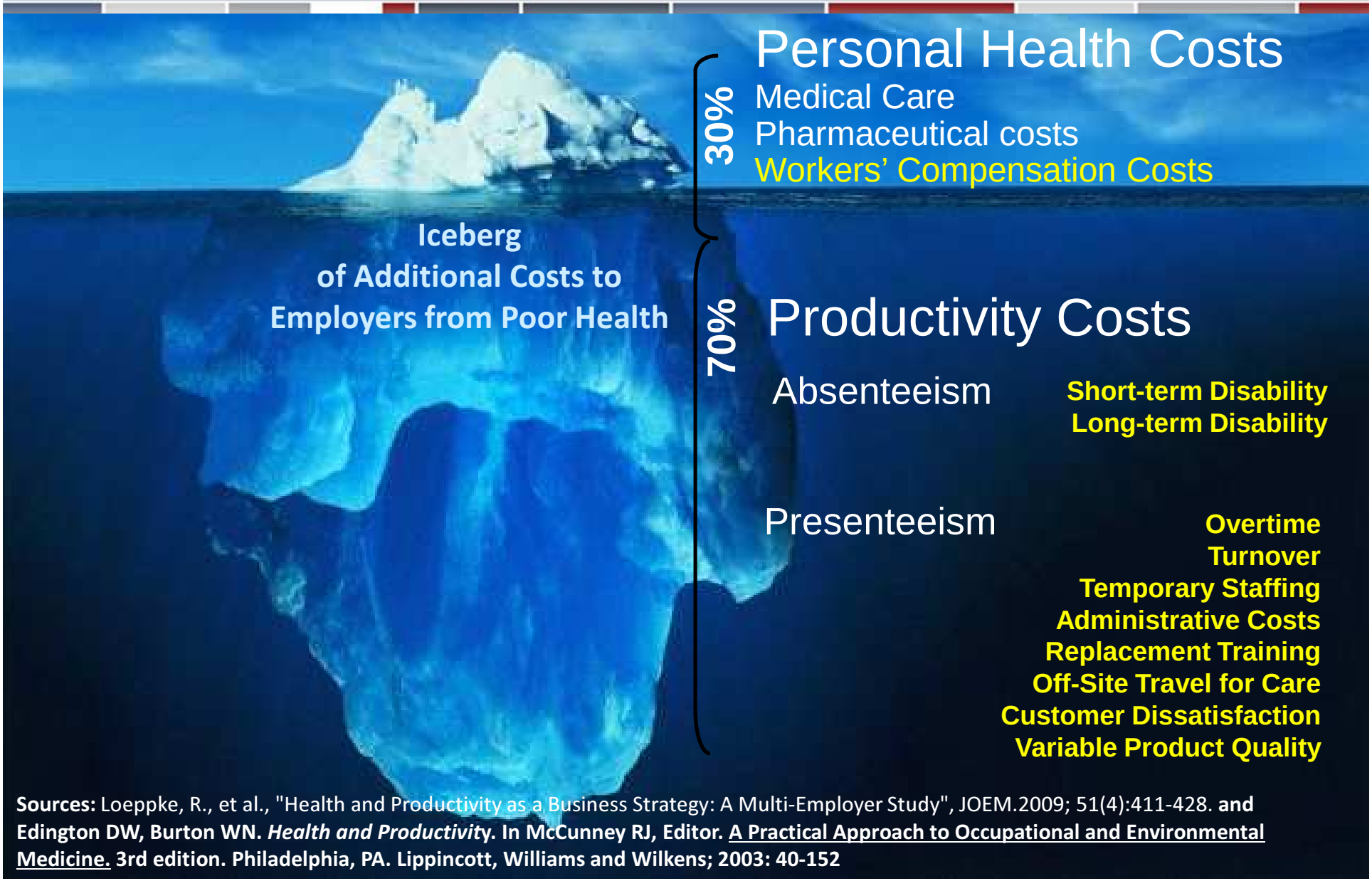
Reason 3: Cost of Unmet Need

- BH disorders account for ½ as many disability days as "all" physical conditions[1]
- Annual medical expenses--chronic medical & BH conditions combined cost
  - 46% more than those with only a chronic medical condition[2]
- Top 5 conditions driving overall health cost

  (work related productivity + medical + pharmacy cost)[3]
  - Depression
  - Obesity
  - Arthritis
  - Back/Neck Pain
  - Anxiety

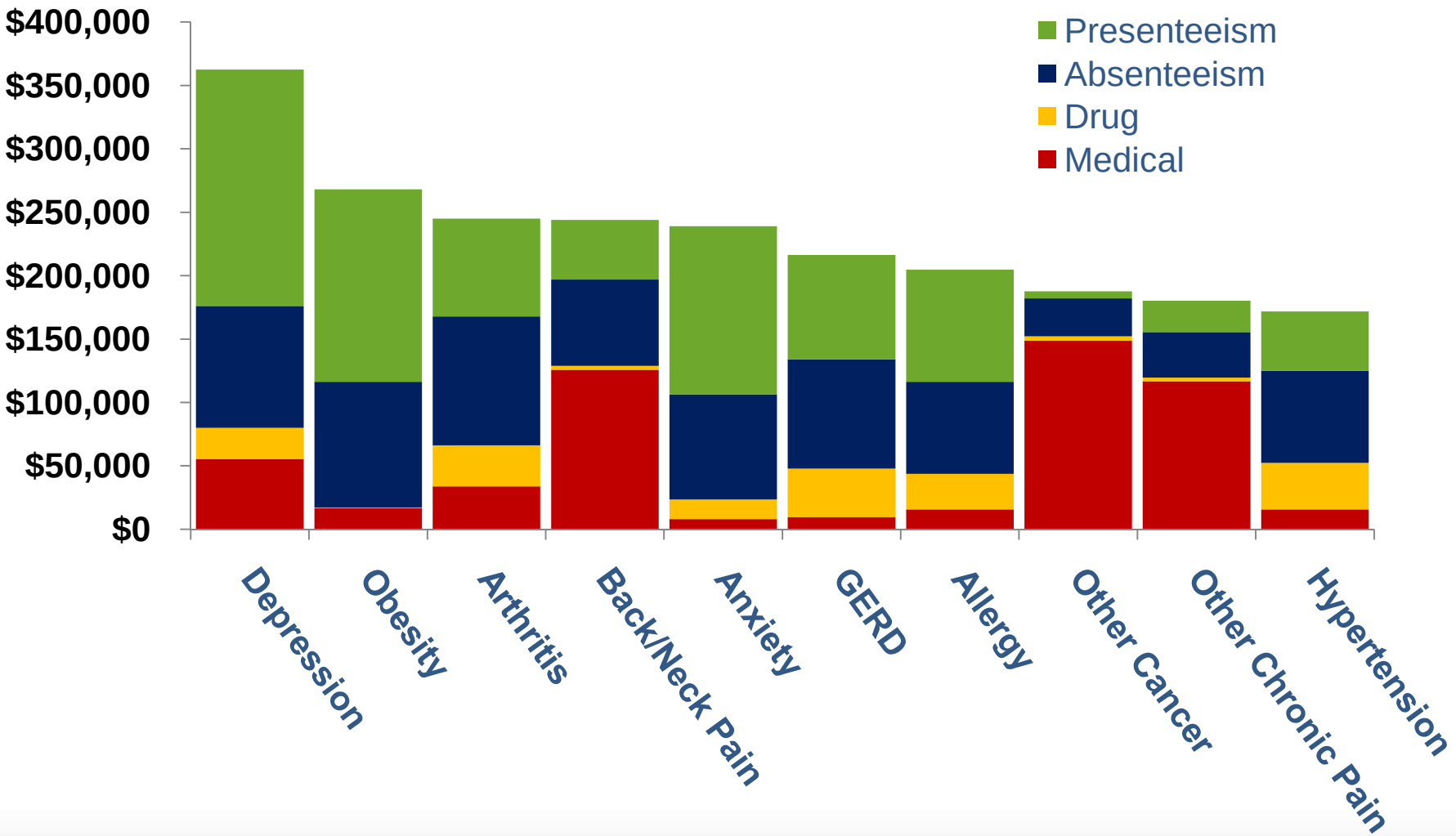
1. Merikangas et al., Arch Gen Psychiatry. 2007;64:1180-1188
2. Original source data is the U.S. Dept of HHS the 2002 and 2003 MEPS
3. Loeppke et al., J Occup Environ Med. 2009;51:411-428.

The Cost of Poor Health to Employers



Sources: Loeppke, R., et al., "Health and Productivity as a Business Strategy: A Multi-Employer Study", JOEM.2009; 51(4):411-428. **and Edington DW, Burton WN. *Health and Productivity*. In McCunney RJ, Editor. A Practical Approach to Occupational and Environmental Medicine. 3rd edition. Philadelphia, PA. Lippincott, Williams and Wilkens; 2003: 40-152**

Top 10 Driving Costs for Employers Per 1000 FTEs



Loeppke, et al., JOEM. 2009;51(4):411-428.

Reason 3: Cost of Unmet Need

– Health care use/costs--2X as high in diabetes & heart disease pts with depression*

	Annual Cost – those without MH condition	Annual Cost – those with MH condition
Heart Condition	$4,697	$6,919
High Blood Pressure	$3,481	$5,492
Asthma	$2,908	$4,028
Diabetes	$4,172	$5,559

*Original source data is the U.S. Dept of HHS the 2002 and 2003 MEPS. AHRQ as cited in Petterson et al. "Why there must be room for mental health in the medical home (Graham Center One-Pager)

Reason 4: Lower Cost When Treated

- Medical cost ↓17% for those receiving BH tx[1]
  - Controls who did not get BH tx cost ↑12.3%
- Depression tx in PC for those with diabetes[2]
  - $896 lower total health care cost over 24 months
- Depression treatment in PC[3]
  - $3,300 lower total health care cost over 48 months

1. Chiles et al., Clinical Psychology. 1999;6:204–220.
2. Katon et al., Diabetes Care. 2006;29:265-270.
3. Unützer et al., American Journal of Managed Care 2008;14:95-100.

Reason 4: Lower Cost When Treated

Examples of System Impact After Integration: Buncombe County Health Center

- Clinical Impact
  - Sig drop on depression measure 8 months after integration
  - Increase in functioning (SF-12) 8 months after integration
  - 41% drop in work or school missed for emotional reasons
  - 34% decrease in outpatient psychotherapy sessions
- Decrease in Health Care Costs
  - All types of health care-overall reduction---$66 PMPM
  - Mental health care reduction---$295 PMPM
  - In-patient cost reduction---$1455 PMPM
  - High users of health care decreased---$435 PMPM

Reason 4: Lower Cost When Treated

Examples of System Impact (Cont)
Cherokee Health System
After At Least 1 Primary Care Behavioral Health Visit

- 28% decrease in medical use for Medicaid patients
- 20% decrease in medical use for commercially insured patients
- 27% decrease in outpatient psychiatry visits
- 34% decrease in outpatient psychotherapy visits

Comparison: Cherokee Service Use Data vs. Other Regional Providers w/o integration

- Lower specialist utilization
- Lower ER utilization
- Lower hospital admissions
- Lower overall cost per enrollee

Recaptured Cost

Outpatient MTF BH services typically not available to AD family members, retirees & retiree family members.

Potential BH Service Dollars Recaptured

Air Force

FY 2007-9045 non-active duty PC BH appointments

Average cost for **1** network visit = $102.50

-Estimated **$927,112** of service recaptured by providing BH services in PC

Reason 5: Better Outcomes

- Quantitative & qualitative reviews[1-4]
  - Depression[1-4]
  - Panic Disorder[1,2]
- Other Studies[5]
  - Tobacco
  - Alcohol Misuse
  - Diabetes, IBS, Primary Insomnia
  - Chronic Pain, Somatic Complaints

1. Butler et al., AHRQ Publication No. 09- E003. Rockville, MD. AHRQ. 2008.
2. Craven et al., Canadian Journal of Psychiatry. 2006;51:1S-72S.
3. Gilbody et al., British Journal of Psychiatry, 2006;189:484-493.
4. Williams et al., General Hospital Psychiatry, 2007; 29:91-116.
5. Hunter et al., Integrated Behavioral Health in Primary Care: APA, 2009.

Reason 6: Improved Satisfaction With Health Care

Patient Satisfaction[1-5]

Provider Satisfaction[6,7]

1. Chen et al., American Journal of Geriatric Psychiatry. 2006; 14:371-379.
2. Unutzer et al., JAMA. 2002; 288:2836-2845.
3. Katon et al., JAMA. 1995; 273:1026-1031.
4. Katon et al., Archives of General Psychiatry. 1999; 56:1109-1115.
5. Katon et al., Archives of General Psychiatry. 1996; 53:924-932.
6. Gallo et al., Annals of Family Medicine. 2004; 2:305-309.
7. Levine et al., General Hospital Psychiatry. 2005; 27:383-391.

Service's Integration of BHPs and CMs in PC

Current Implementation Status

	Army	Navy	Air Force
Embedded BHPs	39	44	26^
Care Facilitator (CFs)	36 (R-Mil)	---	---
Positions open/slated for hire FY10	34 CFs (R-Mil)	9	---

^Plus 24 part time AD, average 7.4 hours in PC/week

Service's Integration of BHPs and CMs in PC

- Army
  - Re-Engineering Systems of Primary Care Treatment in the Military (RESPECT-Mil) Program Structure
    - Approach contained in "how to" guides
    - PC providers undergo 2 hours of Web-Based Training
    - Brief PC PTSD & depression screening
    - Positive screen followed by diagnosis & severity assessment
    - Patient education materials
    - PC-based psychosocial options
    - Care Facilitator assistance option
    - Web-based care management support system
    - Accountable, continuous follow-up to remission
    - Weekly BH Specialist staffing

Service's Integration of BHPs and CMs in PC

- Army RESPECT-Mil (Cont)
  - Care Facilitators are RNs who:
    - Monitor symptom severity, treatment adherence, and clinical risk using a State-Of-The-Science web-based care management technology ("FIRST-STEPS").
    - Assist patients with problem solving, goal setting, and active coping during regular scheduled phone contacts.
    - Strengthen and enhance specialist-patient-primary care contact, communication, and treatment planning.
- Army Embedded BHPs

Service's Integration of BHPs and CMs in PC

- Navy
  - –BHPs in Deployment Health Clinics
  - –BHPs in Primary Care

Service's Integration of BHPs and CMs in PC

- Air Force
  - –Behavioral Health Optimization Program (BHOP)
    - Increase access to BH care in AF MTFs
    - Offer effective and acceptable BH services along the entire continuum of health
    - Focus on prevention by identifying BH conditions early
    - Provide health care options to patients and encourage shared decision-making

Service's Integration of BHPs and CMs in PC

- Air Force
  - –BHOP Behavioral Health Consultants
    - Include psychologists and social workers
    - Members of the PC health team
    - See patients at the PCMs request
    - Focused assessments/intervention geared towards improving functioning, quality of life and symptoms
    - Provide immediate or same-day feedback to PCM
    - Appointments are 15-30 minutes
    - Number of appointments usually 1-4, but can be more
    - PCM remains responsible for health care plan

Integration of Behavioral Health and Primary Care

- Current Challenges
  - Variability Within and Between Services
    - Access to services
    - Different models of service
    - Fidelity to service model
    - Consistent provider availability

Way Ahead

– DoD Mental Health Integration Working Group
  - Tri-Service: psychology, psychiatry, social work, family medicine
  - Developed a set of recommendations for Integrated-Collaborative Care

Way Ahead

Recommendations

1. One full-time BHP & CM in PC clinics with 7500+ enrollees
2. One full-time BHP **or** a CM in PC clinics with 1500-7499 enrollees
3. BHP & CM billets owned by primary care
4. Evidence-based standardized screening, assessment & intervention protocols (e.g. for depression, anxiety)
5. Clinical, operational & administrative standards
6. Collaborative Service level oversight of BHP & CM programs

Integration of Behavioral Health and Primary Care

Questions

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