Three World Concept of Behavioral Health and Primary Care Integration – Part 3 The Clinician Perspective

Colorado Behavioral Health Association
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Lexicon Part I:
A Family Tree of Related Terms in use in the field of Collaborative Care
C.J. Peck with the CCRN Research Conference Program Committee

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**Mental Health Care**
- A broad array of services & treatments to help people with mental illnesses & those at particular risk of developing them—to offer less emotional pain & disability & live healthier, longer, more productive lives. A variety of caregivers in diverse, independent, loosely coordinated facilities & services—public & private—often referred to collectively as the ‘de facto’ MH service system (Ragins et al., 1978; Ragins et al., 1993).
- **Specialty MHS units**: MHS professionals trained specifically to treat people with mental disorders in public or private practices, psychiatric units, mental hospitals, or as outpatients. **Primary mental health care** is provided by general medical providers (e.g., internists) in primary care practices. **Mental health centers** and **mental health clinics** are mental health facilities operated by public or private organizations and providing mental health services to individuals on a fee-for-service or sliding scale basis.
- **Shared Care** is a model of collaborative care for the treatment of chronic conditions. It involves the coordination of care among different health professionals, such as medical doctors, nurses, and specialists, to provide comprehensive care to patients with complex medical needs.
- **Integrated Care** is a model of healthcare that integrates mental health services into primary care settings, allowing for better coordination and management of patients' overall health needs.
- **Co-located Care** is a model of care where mental health services are provided in the same location as primary care services, allowing for easier access and coordination of care.
- **Consultation / Liaison** provides expertise and support to health care professionals in the care of patients with mental health needs. This can include providing consultation on diagnosis, treatment planning, and follow-up care.
- **Integrated Primary Care** combines primary care and mental health services to provide comprehensive care for patients with both physical and mental health needs.
- **Collaborative Care** is a model of care that uses a team approach to deliver mental health services in primary care settings, involving primary care providers and mental health specialists.
- **Behavioural Care** includes a variety of therapeutic approaches, such as cognitive-behavioral therapy, psychodynamic therapy, and family therapy, to help individuals manage their mental health challenges.
- **Chemical Dependency / SA Care** involves the treatment of addiction to substances such as alcohol, drugs, and other substances, as well as the management of the physical and social consequences of addiction.
- **Coordinated Care** provides a structured approach to delivering mental health services that is focused on the patients' needs and outcomes.
- **Primary Care Behavioral Health** is a recent term for new relationships emerging between specialty MH services and PC. **Primary behavioral healthcare** refers to at least three related activities: (1) behavioral healthcare delivered by PC clinicians, (2) specialty behavioral health care delivered in the PC setting, and (3) innovative programs that integrate elements of PC and specialty behavioral healthcare into new formats. (Saitz RJ & Burns JP, 2009. Changing Roles in Primary Behavioral Healthcare. Chap in “Textbook of administrative psychiatry: New concepts for a changing behavioral health system”; JA Talbot & RE Halas, Eds.)

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**Care Management**
- Specific type of service, often disease specific (e.g., depression, congestive heart failure) whereby a BH clinic, usually a nurse or other non-physician, provides assessment, intervention, care facilitation, and follow up. (e.g., Balk et al., 2006)

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**Patient-Centered Medical Home**
- An approach to comprehensive PC for children, youth and adults—a health care setting that facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient’s family.” (Joint Principles of PCMH, 2007)

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**Family-Centered Medical Home**

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**Perinatal Centered Health Care Home**

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**Patient-Centered Care**
- “Care that is respectful of and responsive to individual patient preferences, needs, and guide all clinical decisions” (Institute of Medicine, 2011)
C. J. Peek suggests that in order to impact healthcare, three worlds must be addressed simultaneously:

- Clinical – What do we do?
- Operational – How do we do it and support it?
- Financial – What is the return on investment and cost?
Clinical

Financial

Operational
How is care organized? Where is it provided?

- Patient Centered Health Care Home
- Levels of Collaboration
The Patient Centered Medical/Healthcare Home

- **American Academy of Family Physicians**
  
  **Definition:** “A place that integrates patients as active participants in their own health and well-being. Patients are cared for by a physician who leads the medical team that coordinates all aspects of preventive, acute and chronic needs of patients using the best available evidence and appropriate technology. These relationships offer patients comfort, convenience, and optimal health throughout their lifetimes”.
  

- **National Council Definition Adds:** use of the word “healthcare” home to insure that behavioral health is included
<table>
<thead>
<tr>
<th>Function</th>
<th>Minimal Collaboration</th>
<th>Basic Collaboration from a Distance</th>
<th>Basic Collaboration On-Site</th>
<th>Close Collaboration/Partly Integrated</th>
<th>Fully Integrated/Merged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>Two front doors; consumers go to separate sites and organizations for services</td>
<td>Two front doors; cross system conversations on individual cases with signed releases of information</td>
<td>Separate reception, but accessible at same site; easier collaboration at time of service</td>
<td>Same reception; some joint service provided with two providers with some overlap</td>
<td>One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model</td>
</tr>
<tr>
<td>Services</td>
<td>Separate and distinct services and treatment plans; two physicians prescribing</td>
<td>Separate and distinct services with occasional sharing of treatment plans for Q4 consumers</td>
<td>Two physicians prescribing with consultation; two treatment plans but routine sharing on individual plans, probably in all quadrants;</td>
<td>Q1 and Q3 one physician prescribing, with consultation; Q2 &amp; 4 two physicians prescribing some treatment plan integration, but not consistently with all consumers</td>
<td>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</td>
</tr>
<tr>
<td>Funding</td>
<td>Separate systems and funding sources, no sharing of resources</td>
<td>Separate funding systems; both may contribute to one project</td>
<td>Separate funding, but sharing of some on-site expenses</td>
<td>Separate funding with shared on-site expenses, shared staffing costs and infrastructure</td>
<td>Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility</td>
</tr>
<tr>
<td>Governance</td>
<td>Separate systems with little of no collaboration; consumer is left to navigate the chasm</td>
<td>Two governing Boards; line staff work together on individual cases</td>
<td>Two governing Boards with Executive Director collaboration on services for groups of consumers, probably Q4</td>
<td>Two governing Boards that meet together periodically to discuss mutual issues</td>
<td>One Board with equal representation from each partner</td>
</tr>
<tr>
<td>EBP</td>
<td>Individual EBP’s implemented in each system;</td>
<td>Two providers, some sharing of information but responsibility for care cited in one clinic or the other</td>
<td>Some sharing of EBP’s around high utilizers (Q4) ; some sharing of knowledge across disciplines</td>
<td>Sharing of EBP’s across systems; joint monitoring of health conditions for more quadrants</td>
<td>EBP’s like PHQ9; IDDT, diabetes management; cardiac care provider across populations in all quadrants</td>
</tr>
<tr>
<td>Data</td>
<td>Separate systems, often paper based, little if any sharing of data</td>
<td>Separate data sets, some discussion with each other of what data shares</td>
<td>Separate data sets; some collaboration on individual cases</td>
<td>Separate data sets, some collaboration around some individual cases; maybe some aggregate data sharing on population groups</td>
<td>Fully integrated, (electronic) health record with information available to all practitioners on need to know basis; data collection from one source</td>
</tr>
</tbody>
</table>
Collaboration

(Doherty, 1995; Doherty, McDaniel, & Baird, 1996)

1. Minimal collaboration – BH and MD work in separate facilities, systems, rarely communicate

2. Separate systems/sites (telephone, letters) – communication driven by patient issues

3. Regular communication about shared patients (occasionally face to face – mostly letters, phone)

4. Shared site; some systems in common (e.g. charting, scheduling)

5. “Seamless web of biopsychosocial services” providers and pt view team approach to care

www.thenationalcouncil.org
The Clinical World
Evidence Based Practices In Behavioral Health

- Care Management Case Management
  - More emphasis on physical health issues in our work
  - Health Navigator Role
    - Include health issues in treatment plan – shared care plan (diabetes, weight loss, smoking, obesity, blood pressure)
    - Assist with monitoring these health issues
    - Plan for health prevention activities (exercise, screenings)
    - Assist with getting and taking physical health care needs
    - Disease Management Protocols in Behavioral Health
    - Registries
Challenges for Case Managers/Care Managers

- Learning/training in health issues
- Adding this function into already full days
- Will electronic systems support this work?
- Will this work be paid for?
- How well do we take care of ourselves?
Why are we doing this?

- People are dying because we aren’t doing it – we need to improve **health outcomes**
  - Issues with referrals
  - Stigma
- Mental Health is Health – Whole Health focus in Colorado
- Patient Centered Health Care Home Concept Nationally
Integration as Core Part of Recovery

• Where do most individuals get help for mental issues?
• Public Mental Health System is specialty care
• Self Management is key in all healthcare – recovery is based on self management
• It's hard to recover from schizophrenia if you've died of a heart attack!
## Prevalence of Psychiatric Disorders in Primary Care

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>No mental disorder</td>
<td>61.4%</td>
</tr>
<tr>
<td>Somatoform</td>
<td>14.6%</td>
</tr>
<tr>
<td>Major Depression</td>
<td>11.5%</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>7.8%</td>
</tr>
<tr>
<td>Minor Depression</td>
<td>6.4%</td>
</tr>
<tr>
<td>Major Depression (partial remission)</td>
<td>7.0%</td>
</tr>
<tr>
<td>Generalized Anxiety</td>
<td>6.3%</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>3.6%</td>
</tr>
<tr>
<td>Other Anxiety Disorder</td>
<td>9.0%</td>
</tr>
<tr>
<td>Alcohol Disorder</td>
<td>5.1%</td>
</tr>
<tr>
<td>Binge Eating</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Low-Income Patients</th>
<th>General PC Population*</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Least One Psychiatric Dx</td>
<td>51%</td>
<td>28%</td>
</tr>
<tr>
<td>Mood Disorder</td>
<td>33%</td>
<td>16%</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>36%</td>
<td>11%</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>17%</td>
<td>7%</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>10%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Evidence Based Practices in Primary Care

• IMPACT Model for the Treatment of Depression in Primary Care
• Disease Management Programs for Diabetes (American Association of Diabetes), COPD, Cardiac Care
• Short Term Solution Focused Therapy
• Robinson/Stroshal Behavioral Health Consultation Model
Cultural Differences

Traditional Thinking

• The primary care provider is THE leader of the team

• Pace of work

• Documentation

• Long term approach to services

New Approach

• The patient is the leader of the team; non-medical staff can consult

• Behavioral health adjusts to the PC pace

• BH documentation in the PC record

• Short term solution focused therapy
Role of the Physicians

Primary Care Physician
- Shared responsibility for consumer care
- Prescribing for BH as comfort develops
- One treatment plan
- One record for documenting

Psychiatrist
- Consulting role
  - Curbside consults
  - Case conferences
  - Available all hours clinic is open
  - Some (fewer) evaluations
- Training
  - Support Primary Care Physician in prescribing behavioral health meds
  - Combined Grand Rounds/Training
Role of the Behavioral Health Consultant in Primary Care

Systems Services

- Primary customers are the primary care provider
- Most breakdowns originate from a systems problem
- Address systems thinking
- Easy access to public BH system

Individual Services

- Short term solution focused therapy
- 1-3 Sessions
- Always available
- Consultation to the primary care provider
- Dually trained in MH and SA EBP’s
Keys to Successful Integration

• Use of consulting psychiatrist
• Care Management/Case Management Role
• Prescribing by the primary care provider

What’s Financing Got to Do With It?
The State of Federal Financing

Current State of Federal Funding and Persons Served
(2007 OMB)

- Community Mental Health
- Community Primary Care

# of People Served (millions)
Federal/State Funding (billions)
Two Services in One Day and SBIRT

States Paying for Behavioral Health Visits On Same Day as Medical Visit

- States are marked according to whether they pay for behavioral health services on the same day as medical visits.
- Blue states indicate those where SBIRT (Substance Use Disorder Integrated Treatment) services are available.
- Yellow states indicate those with specific Medicaid programs for SBIRT.

Legend:
- **FQHCs not Eligible**
- SAMHSA Funded SBIRT Programs
- SBI = 11 States Medicaid pays for SBI codes

SBI = 11 States Medicaid pays for SBI codes *H=Hosp Only 9/14/09
<table>
<thead>
<tr>
<th>Insurance</th>
<th>Code</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>CPT 99408</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes</td>
<td>$33.41</td>
</tr>
<tr>
<td></td>
<td>CPT 99409</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes</td>
<td>$65.51</td>
</tr>
<tr>
<td>Medicare</td>
<td>G0396</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes</td>
<td>$29.42</td>
</tr>
<tr>
<td></td>
<td>G0397</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes</td>
<td>$57.69</td>
</tr>
<tr>
<td>Medicaid</td>
<td>H0049</td>
<td>Alcohol and/or drug screening</td>
<td>$24.00</td>
</tr>
<tr>
<td></td>
<td>H0050</td>
<td>Alcohol and/or drug service, brief intervention, per 15 minutes</td>
<td>$48.00</td>
</tr>
</tbody>
</table>
Health and Behavior Assessment Codes

States use of Medicaid’s Health and Behavior Assessment/Intervention (HBAI) codes (96150-96155 CPT Series)

Legend:
- Entire HBAI Series turned on*
- Part of HBAI Series turned on*
- HBAI Series not turned on
- No information
Health and Behavior Assessment/Intervention (96150-96155)

Health and Behavior Assessment procedures are used to identify the psychological, behavioral, emotional, cognitive and social factors important to the prevention, treatment or management of physical health problems.

96150 – Initial Health and Behavior Assessment – each 15 minutes face-to-face with patient
96151 – Re-assessment – 15 minutes
96152 – Health and Behavior Intervention – each 15 minutes face-to-face with patient
96153 – Group (2 or more patients)
96154 – Family (with patient present)
96155 – Family (without patient present)
Additional FQHC Billing Options

- Encounters – regardless of length of time
- Enhanced Medicaid rate – wrap around rate
- Billing for BH staff is at encounter rate
- Federal Tort Liability insurance
- Expansion Grants for BH services
- Change of Scope for bringing primary care into behavioral health
Additional Information

• Visit www.TheNationalCouncil.org/ResourceCenter for

  ➢ Practical resources including administrative, policy, and clinical documents
  ➢ News on the latest integration and collaboration research
  ➢ Strategies for community engagement and policymaking
  ➢ Information on available trainings and partner resources
  ➢ Opportunities for online dialogue with primary care and behavioral health providers who are also exploring integration and collaboration efforts.
Kathleen Reynolds
Vice President for Health Integration and Wellness
734.476.9879
kathyr@thenationalcouncil.org