The presentation will begin shortly.

Creating a movement: Integrated healthcare

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A statement

Mental health and primary care are inseparable; any attempts to separate the two leads to inferior care

- IOM, 1996

FACTS

- Primary care has become the “de facto” mental health system (Regier et al, 1993)
- Two-thirds of primary care physicians (N=6,660) reported not being able to access outpatient behavioral health for their patients. (Cunningham, 2009)
- “We have developed a health care system that is unable to deal with the varied roles that mind and body play in so-called physical illness.” (Levant, May, & Smith, 2006)

“A new scientific truth does not triumph by convincing its opponents and making them see the light, but rather because its opponents eventually die, and a new generation grows up that is familiar with it.”

~ Max Planck

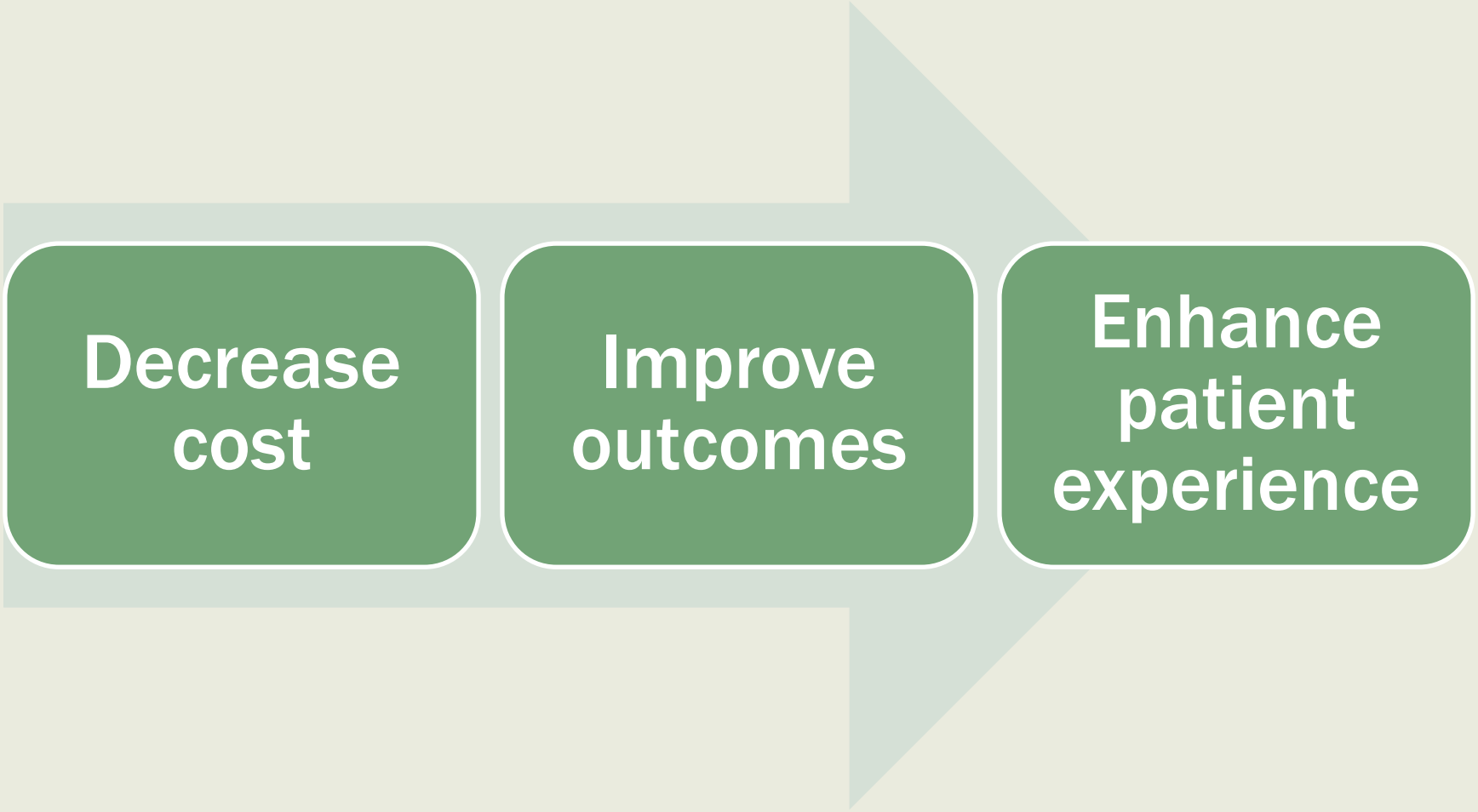
A definition

Primary care is the provision of ***integrated****, accessible health care services* by *clinicians* who are *accountable* for addressing a large *majority of personal health care needs,* developing a *sustained partnership* with *patients,* and practicing in the *context of family and community.*

Beginnings

THE QUESTION

Do you Triple Aim?
(more on this in a minute)



HOW DO YOU KNOW?

First

RATIONALE

Inseparable

- 84% of the time, the 14 most common physical complaints made to primary care have no identifiable organic etiology[1]
- 80% of people with a behavioral health disorder will visit primary care at least once in a calendar year[2]
- 50% of all behavioral health disorders are treated in primary care[3]
- 48% of the appointments for all psychotropic agents are with a non-psychiatric primary care provider[4]

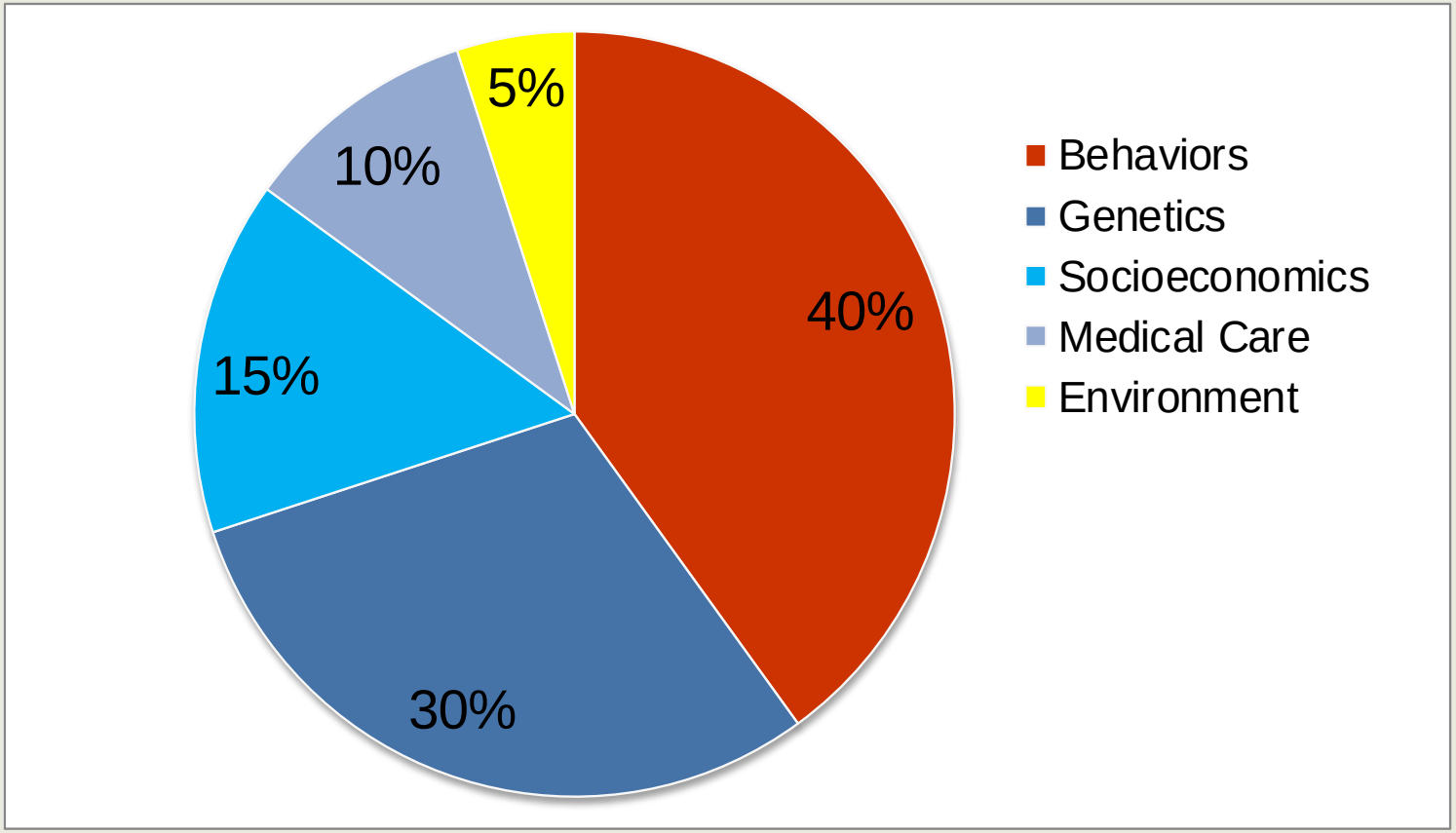
1. Kroenke & Mangelsdorf, Am J Med. 1989;86:262-266.
2. Narrow et al., Arch Gen Psychiatry. 1993;50:5-107.
3. Kessler et al., NEJM. 2006;353:2515-23.
4. Pincus et al., JAMA. 1998;279:526-531.

Access

- 67% with a behavioral health disorder do not get behavioral health treatment[1]
- 30-50% of referrals from primary care to an outpatient behavioral health clinic don’t make first appt[2,3]

1. Kessler et al., NEJM. 2005;352:515-23.
2. Fisher & Ransom, Arch Intern Med. 1997;6:324-333.
3. Hoge et al., JAMA. 2006;95:1023-1032.
4. Cunningham, Health Affairs. 2009; 3:w490-w501.

Behavior



1. McGinnis JM, Foege WH. Actual Causes of Death in the United States. JAMA 1993;270:2207-12.
2. Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual Causes of Death in the United States, 2000. JAMA 2004;291:1230-1245.

Cost

- Behavioral health disorders account for half as many disability days as “all” physical conditions[1]

- Annual medical expenses--chronic medical & behavioral health conditions combined cost 46% more than those with only a chronic medical condition[2]

- Top five 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. AHRQ as cited in Petterson et al. “why there must be room for mental health in the medical home Graham Center One-Pager)
3. Loeppke et al., J Occup Environ Med. 2009;51:411-428.

HOW DO YOU KNOW?

Language

Care Management	Specific type of service which is often disease specific (e.g. depression, congestive heart failure) whereby a behavioral health clinician, usually a nurse, provides assessment, intervention, care facilitation, and follow up (e.g., Belnap et al., 2006).
Co-located	Behavioral health providers and primary care providers delivering care in the same practice. Co-location is more of a description of where services are provided rather than a specific service; however, co-location maintains a referral process, which may begin as medical cases and are transferred to behavioral health (Blount, 2003).
Collaborative Care	An overarching term describing ongoing relationships between clinicians (e.g., behavioral health and primary care) over time (Doherty, McDaniel, & Baird, 1996). This is not a fixed model, but a larger construct consisting of various components which when combined create models of collaborative care (Craven & Bland, 2006; Peek, 2007).
Coordinated Care	Behavioral health and primary care providers practice separately within their respective systems. Information regarding mutual patients may be exchanged as-needed, and collaboration is limited outside of the initial referral (Blount, 2003).
Integrated Care	Tightly integrated, on-site teamwork with unified care plan. Often connotes close organizational integration as well, perhaps involving social and other services (Blount, 2003; Blount et al., 2007).

http://integrationacademy.ahrq.gov/lexicon

Lexicon for Behavioral Health and Primary Care Integration

Concepts and Definitions Developed by Expert Consensus

Components

	Referral-based		Consultant-based
Collaborative Care Models:	Co-located specialty behavioral health	Care Management	Integrated Care
Components:			
Screening	+++	++	+
Unified Treatment Plan	+	++	+++
Phone Follow Up Between Provider and Patient	++	+++	+
Primary Care Physician Follow Up	+	++	+++
Immediate Access	+	++	+++
Location of Behavioral Health “Note” in Medical Record	+	++	+++
Mental Health Billing	+++	++	+
Health Behavior Code Billing	+	++	+++
Shared Office Staff	+	++	+++

Metrics

Percent Detected

- Likelihood of detection
- All patients screened
- Periodic screening (i.e. annual)
- Actionable screening results
- Range of conditions detected
- PCP training side-effect

Percent Treated

- Likelihood of treatment
- Trust – PCP to MH/BHP
- Process integration
- Trust transfer for patient
- MH stigma – social
- MH stigma – education
- Overcoming denial
- Patient's logistics
- Patient's ability to pay
- Seamless with medical

Percent Improvement

- Overall Efficacy
- Protocol-based
- Treatments used
- Tailored to patient
- Continuity of care

Cost to the PC practice

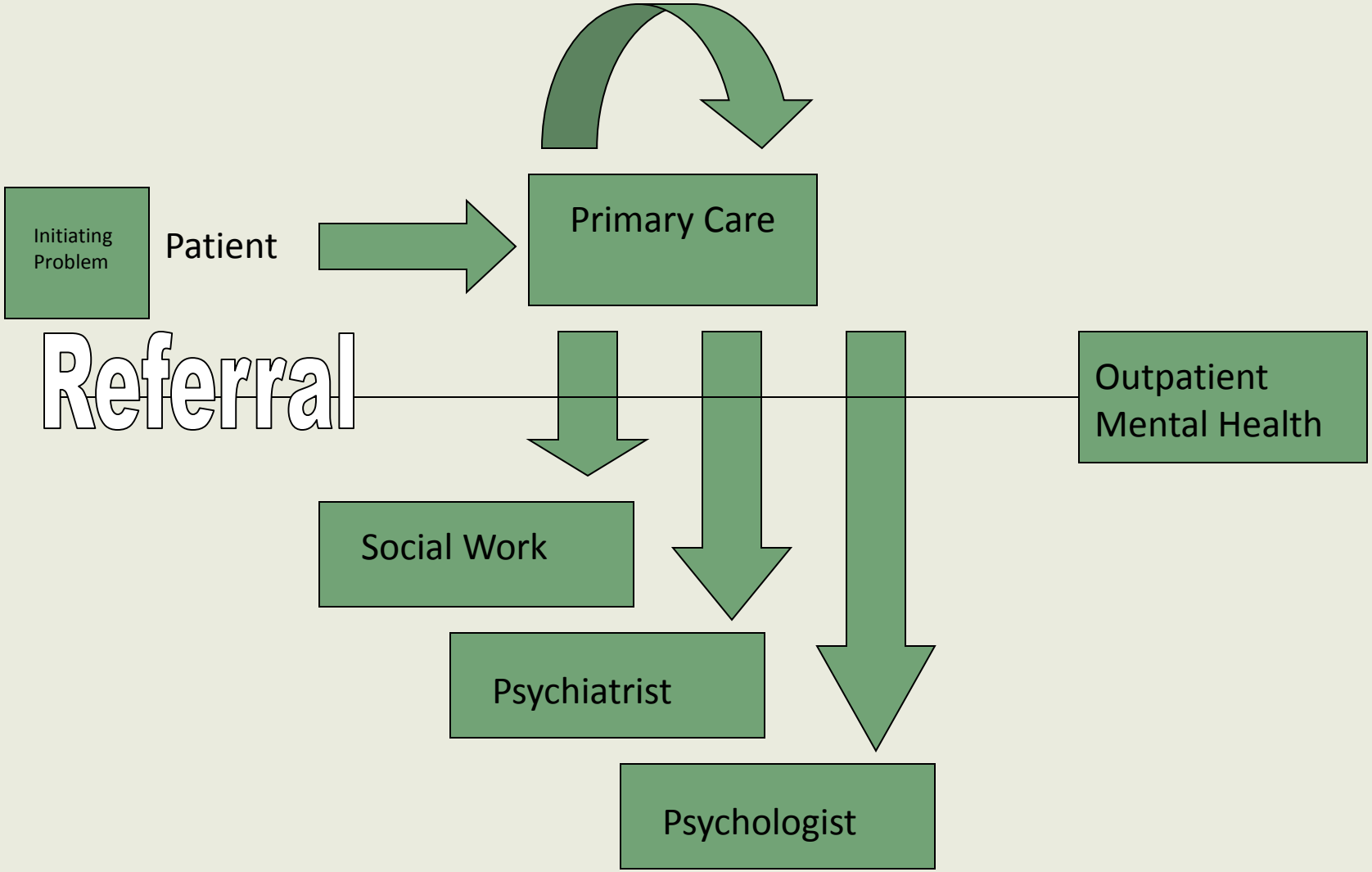
- Professional training/salary
- PCP involvement required
- PCP time saved
- Use of Brief Interventions
- Common Sched/Billing
- Common facilities
- Common EMR/IT
- PCP Coverage

Second

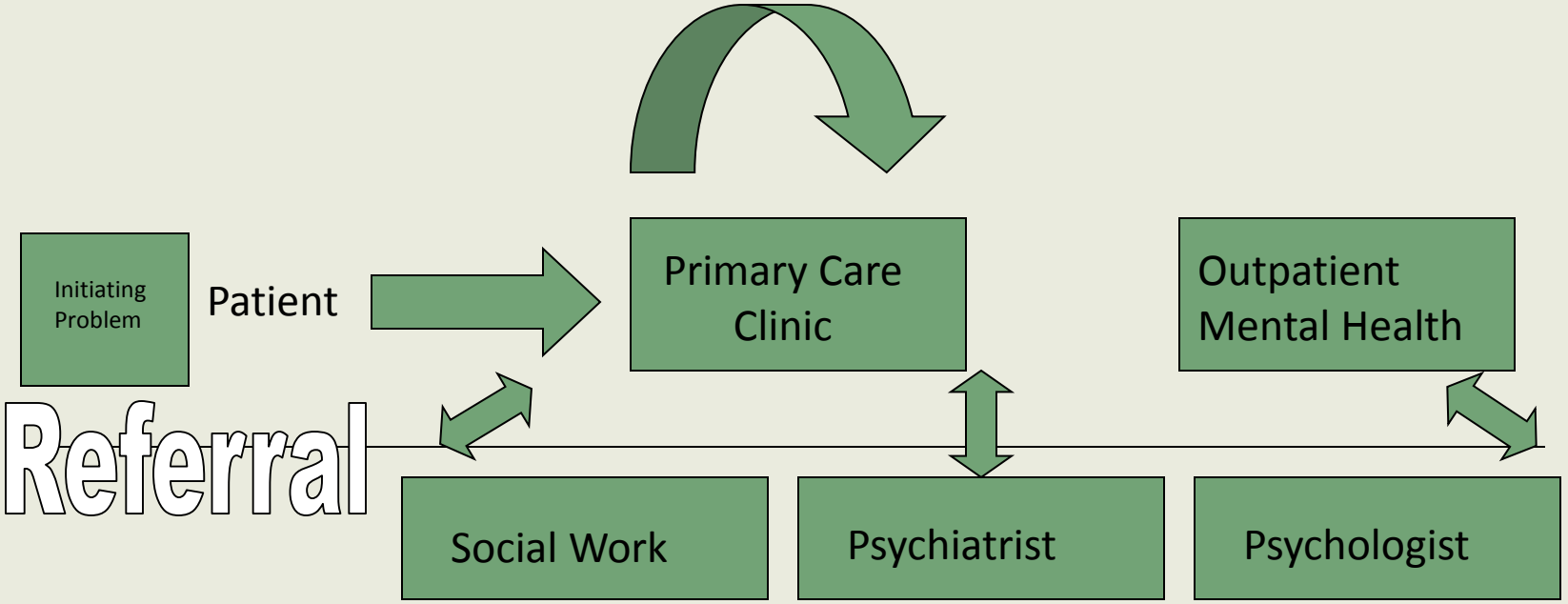
MODELS

HOW DO YOU KNOW?

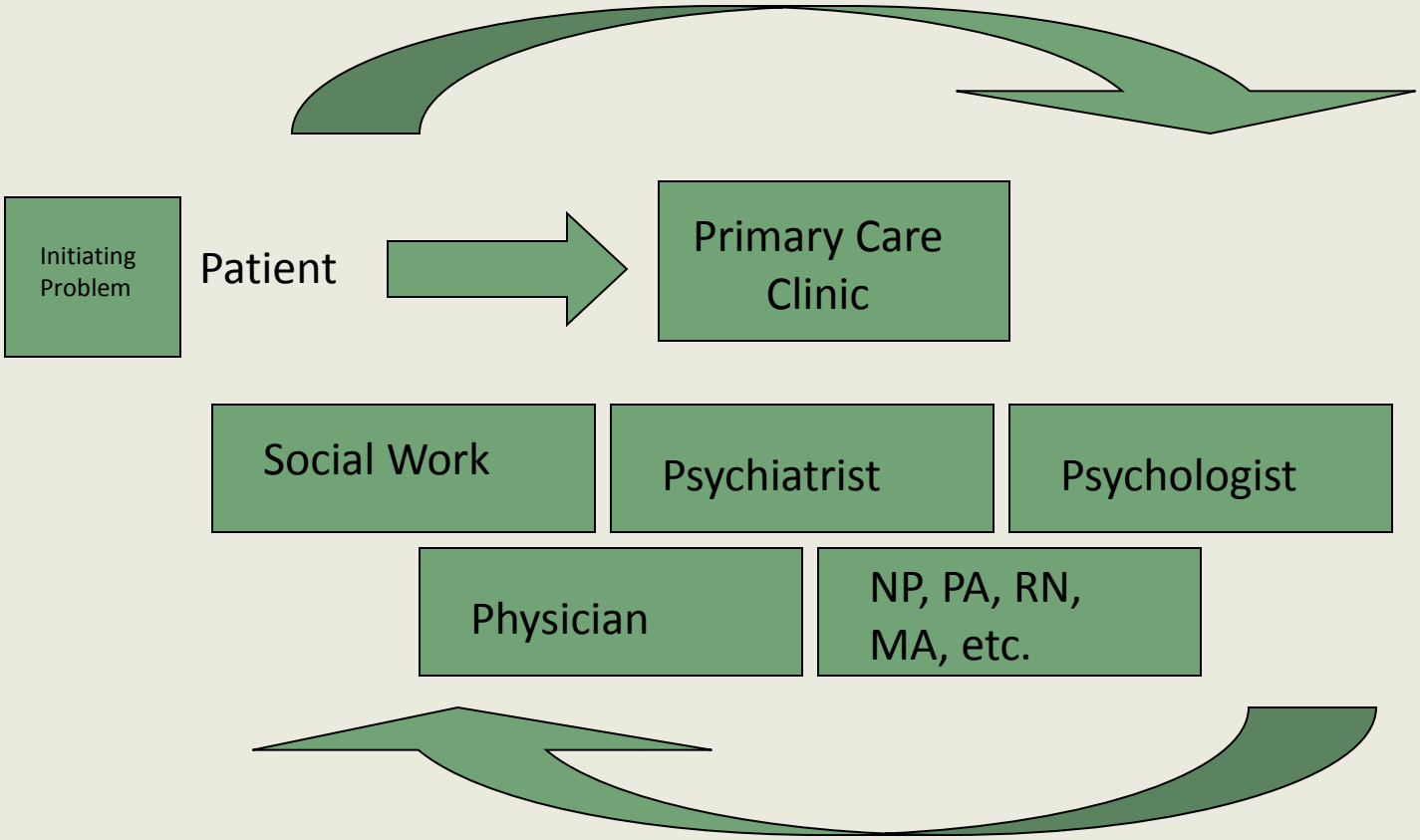
Traditional



Co-located


Initiating Problem
Patient
Primary Care Clinic
Outpatient Mental Health
Referral
Social Work
Psychiatrist
Psychologist

Integrated


Initiating Problem
Patient
Primary Care Clinic
Social Work
Psychiatrist
Psychologist
Physician
NP, PA, RN, MA, etc.

Third

COMMUNITIES OF SOLUTION

- COS concept arose from the recognition that complex political and administrative structures often hinder problem solving by creating barriers to communication and compromise.

EB Models

- Expanded care management – IMPACT/Diamond
- Behavioral Health Consultant model

IMPACT:	BHC:
Disease based	Program based
Research heritage	Clinical heritage
Patient outcome evidence	Cost and satisfaction evidence
Care manager (SW or Psychologist)	Behavioral Health Consultant

Beginning to converge

Care manager does other behavioral health and chronic illness added	BHC does some care management and Case Managers added
Array of services beyond disease programs	Beginning disease programs

U.S. Preventive Services Task Force

Screening for Depression in Adults

This topic page summarizes the U.S. Preventive Services Task Force (USPSTF) recommendations on screening for depression in adults.

Summary of Recommendations / Supporting Documents

This is an update to the May 2002 recommendations on screening for depression in adults. This recommendation was also updated in part for children and adolescents. Go to http://www.uspreventiveservicestaskforce.org/uspstf/uspschdepr.htm to view the new recommendation for children and adolescents, published in March 2009.

Summary of Recommendations

- The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.
  Grade: B recommendation.
- The USPTF recommends against routinely screening adults for depression when staff-assisted depression care supports are not in place. There may be considerations that support screening for depression in an individual patient.
  Grade: C recommendation.

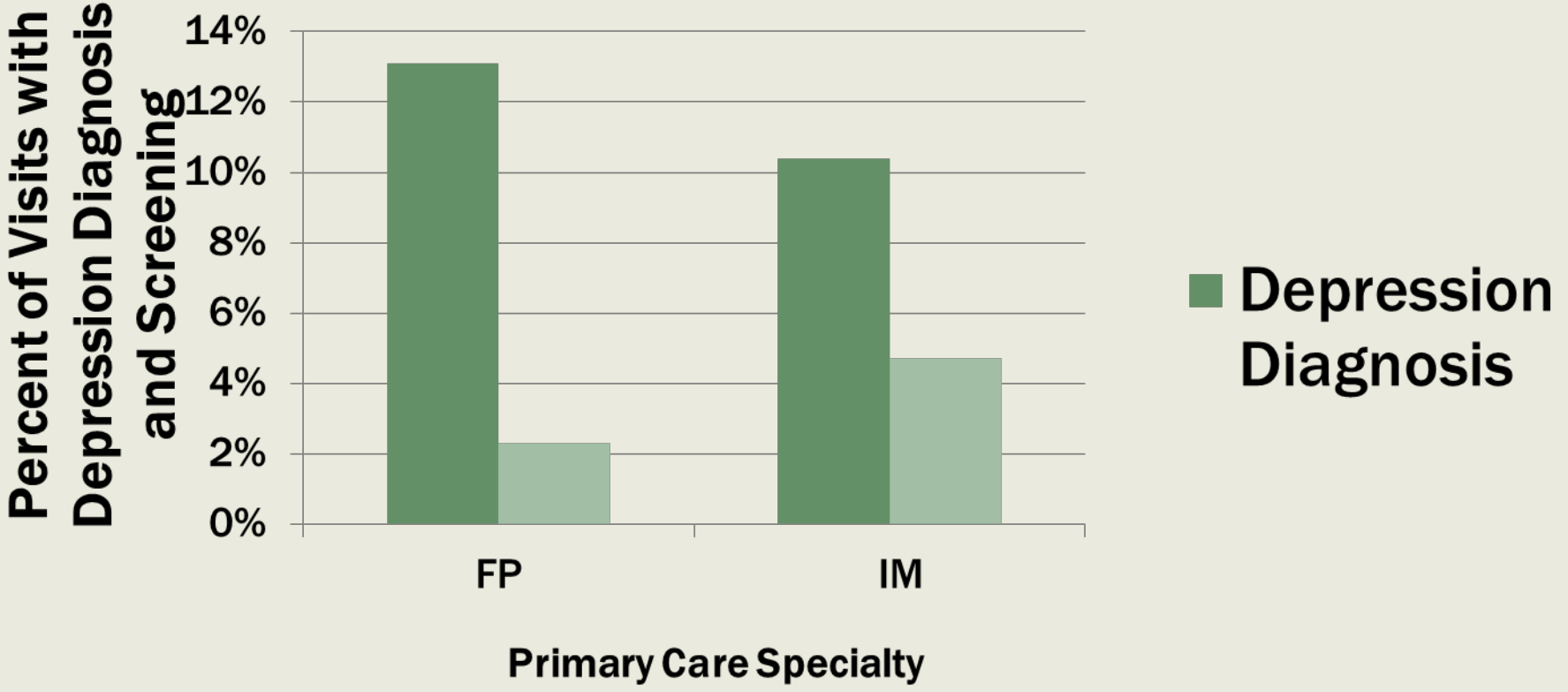
Screening

Necessary, but not sufficient first step in treating depression care (Gilbody et al., 2003; Gilbody et al., 2001)

USPTF grades depression screening as a B recommendation when staff-assisted depression care supports are in place (USPTF, 2009)

Screening with protocols or stepped care clinical procedures more likely to lead to improved outcomes (Gilbody et al., 2003; Unutzer et al., 2002)

What is being done?



Phillps, R. L., B. F. Miller, et al. (2011). "Better Integration of Mental Health Care Improves Depression Screening and Treatment in Primary Care." American Family Physician **84** (9): 980.
http://www.aafp.org/afp/2011/1101/p980.html

HOW DO YOU KNOW?

Alignment

Clinical

Operational

Financial

Context

OREGON

It’s coming

CHANGE

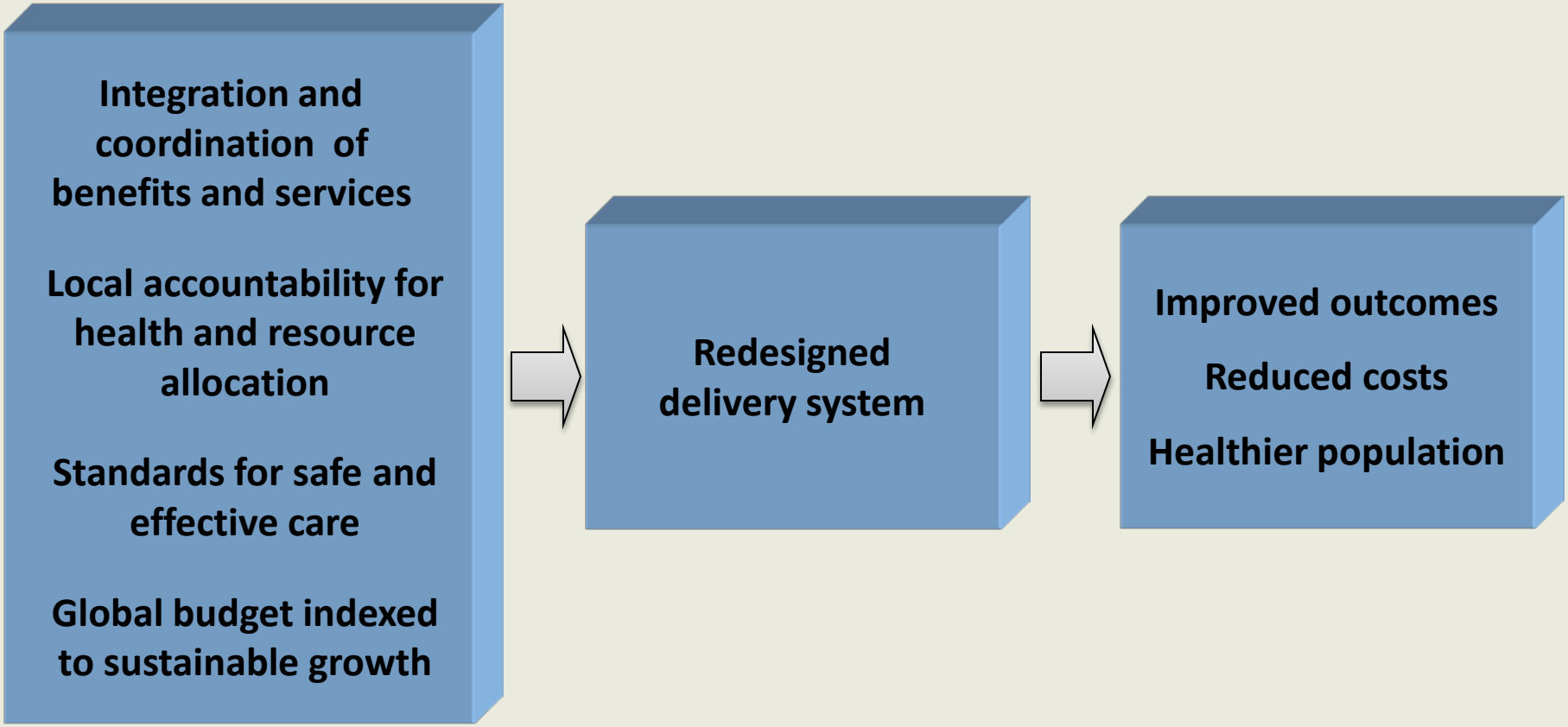
Oregon's Health Care Reform

- During 2011 and 2012 legislative session Governor Kitzhaber and bi-partisan lawmakers passed landmark legislation for healthcare reform
- 200 people met in Governor appointed work groups to help create the framework for CCOs
- More than 1,200 Oregonians provided input through eight community meetings that were held around the state

The Road to Health Care Reform

- SB 1580 became law in 2012, laying the foundation for CCO development with aggressive timelines
- $1.9 billion in Federal funds over 5 years to support healthcare transformation efforts
- Agreement with federal government to reduce projected state and federal Medicaid spending by $11 billion over 10 years
  - Oregon will lower the cost curve by two percent over the next two years or face stiff penalties

Vision of Coordinated Care



Oregon Health Plan

- 50% of babies born in Oregon
- 16% of Oregonians
- 85% of providers
- 11% percent of total state budget
- **Fastest growing** portion of state budget

Transforming Health in Central Oregon

Care Coordination

Regional Health Policy &Planning

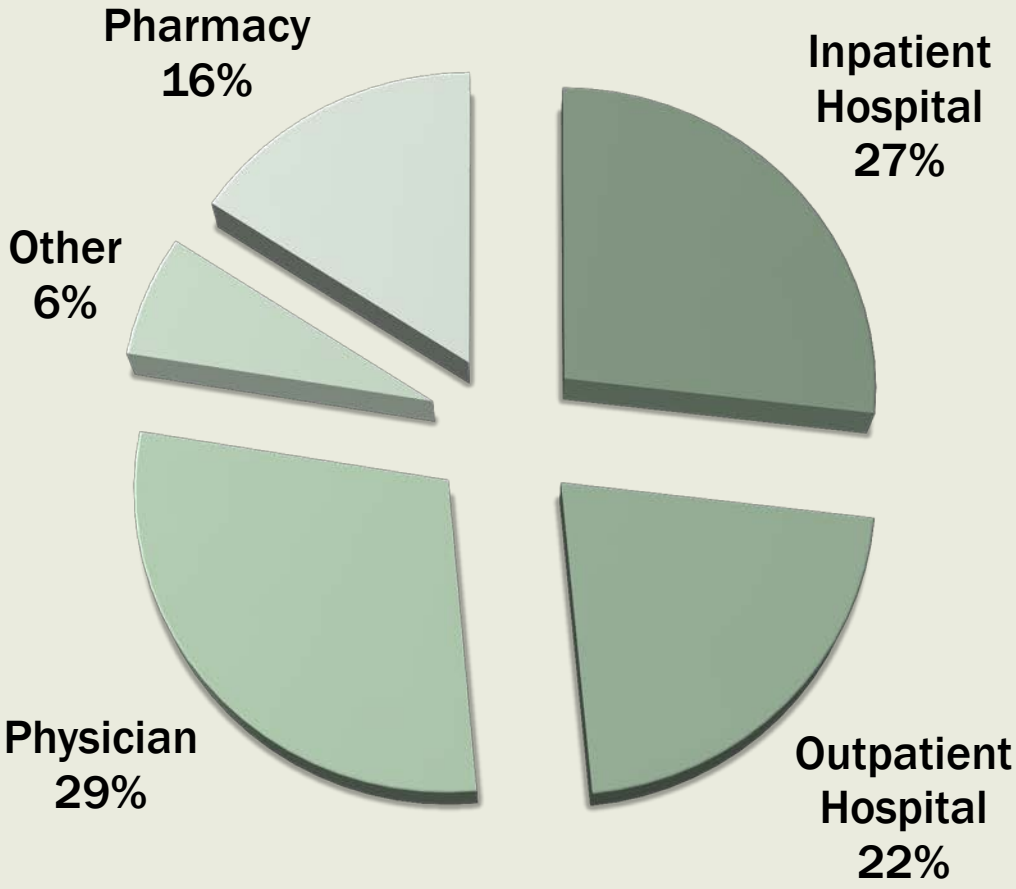
Resource Integration & Conservation

Better Health
Better Care
Better Cost

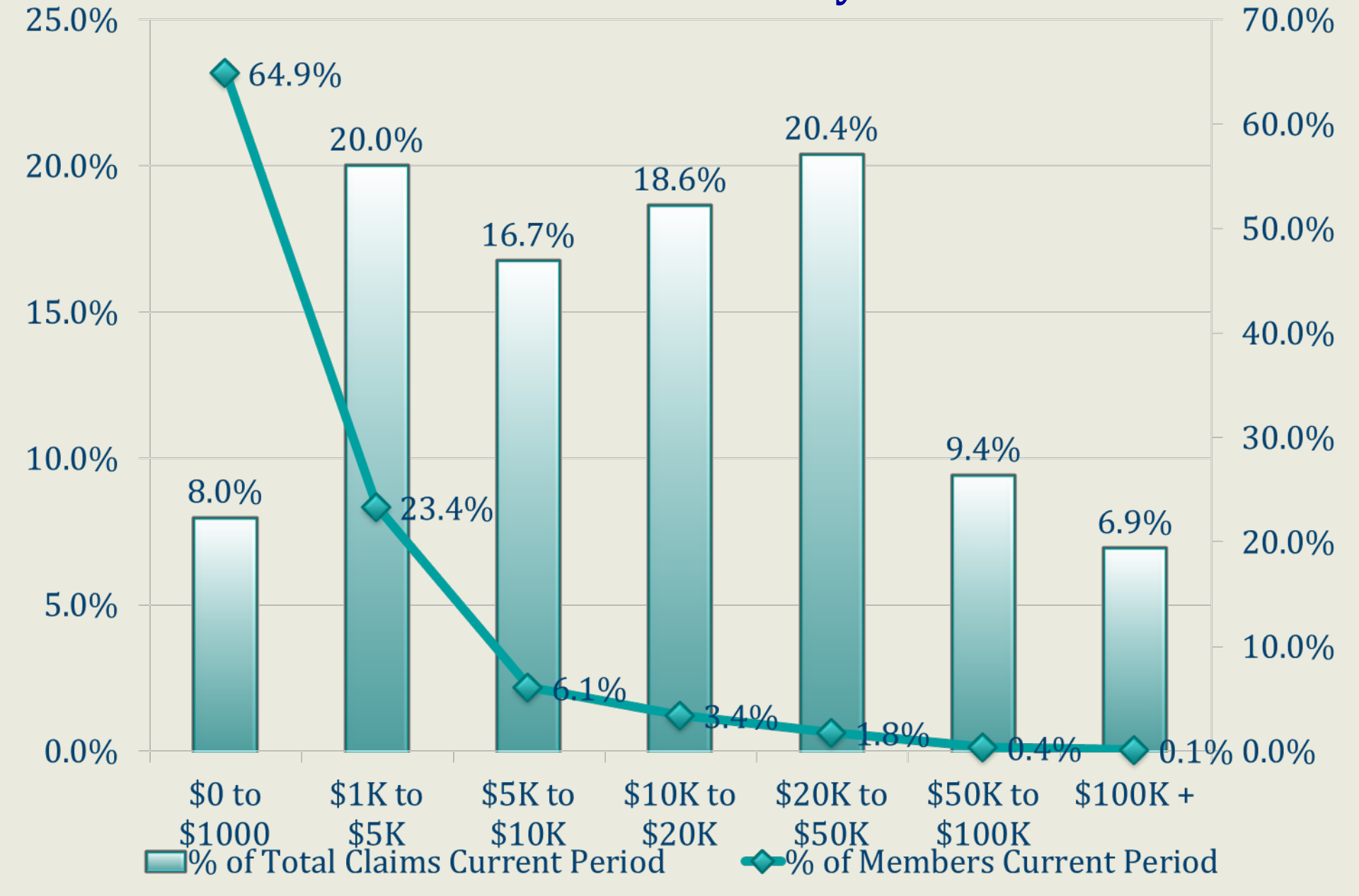
Accountability

- Governance
  - CCO Board—51% risk bearing
  - Community Advisory Council
  - Clinical Advisory Panel
  - Operations Council
- Global Budget
  - CCO Contract deliverables
  - Transformation Plan elements
  - 17 Incentive Measures
  - Regional Health Improvement Plan

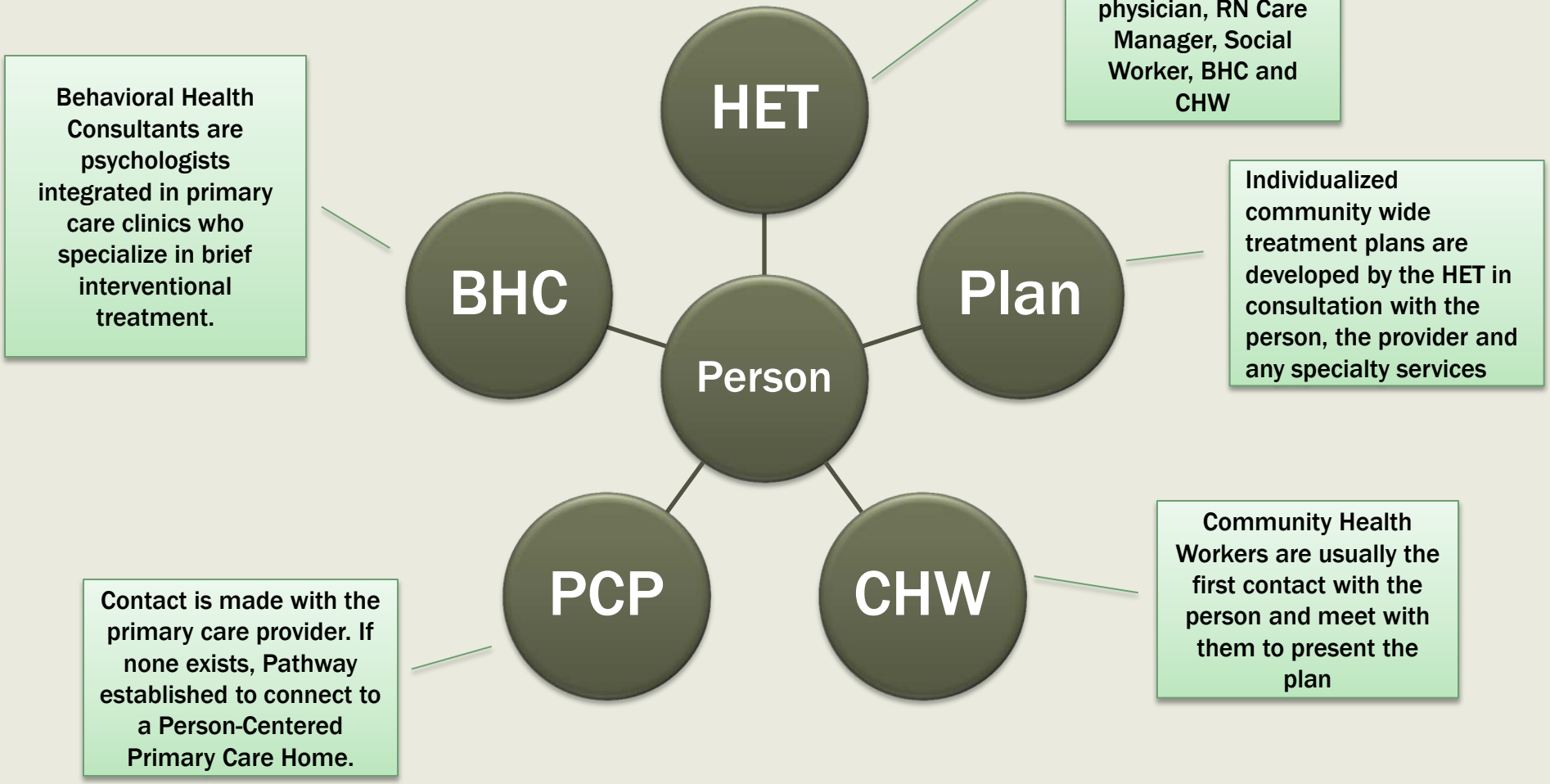
Distribution of non-MH Claims Paid



Claims Distribution by Member



Health Engagement Team



CCO Transformation Plan: 9 Elements

1. Integrated Behavioral Health in Primary Care Model
2. Advancing Patient-Centered Primary Care Home
3. Consistent Alternative Payment Methodologies
4. Community Health Assessment & Annual Health Improvement Plan
5. Electronic Health Records & Health Information Exchange
6. Tailoring Communications & Services to Cultural, Health Literacy & Linguistic Needs
7. Diversity and Cultural Competence
8. Quality Improvement Plan to Reduce Health Disparities
9. Primary Care & Public Health Partnership

Four Essential Elements

- Global Budget/Advanced Payment Methodology
- Data Analytics and Evaluation
- Workforce Development
- Health Information Exchange

Advanced Payment Methodology

- Accountable Care Neighborhood
- How will we be paid?
  - Pay for outcomes
  - Shared savings and gain-sharing agreements
  - Case Rate bundles
    - Do increased outpatient visits reduce hospitalizations?
- Traditional big dogs changing:
  - Hospitals become the cost centers rather than profit centers
  - Insurers become facilitators of care rather than barriers to care
- Goal: Value-Based Payment System

COHC Initiatives

- Maternal Child Health
- School Based Health Center
- Behavioral Health/Primary Care
  - Primary Care in Behavioral Health
- Chronic Pain
- Transitions of Care
- Complex Care Coordination
- Pediatric RN Care Coordination
- Integrating Care for Children with Special Healthcare Needs

Behavioral Health/Primary Care Integration

- Expand capacity for integrated Behavioral Health Consultants in primary care
  - Pediatrics
  - Obstetrics
  - Internal Medicine
- Development of consistent metrics to measure outcomes
  - Evaluate efficacy of integrated care models
- Global mechanism for payment

Primary Care: Mental Health Home of the (present) future

- Community Mental Health
  - Serves 5% of population
  - Primary focus is chronically mentally ill
  - Impact in the global budget: negligible
- Primary Care
  - 70% of all primary care visits involve health behaviors
  - Integrated behavioral health movement
    - The primary care provider for mental health
    - Referral mechanism to the specialty mental health

BH/PH Integration: Outcomes

- Outcomes currently being calculated for trials in St Charles Family Care clinics in Bend, Redmond and Prineville
- Partnership with University of Colorado's SHAPE project funded by Colorado Health Foundation
  - Study effects of global payment for care
  - Clinical outcomes of integrated care models
  - Provider utilization outcomes of fiscal and care models
  - Replication partners in two other CCOs

What can you do?

- Develop new friends
  - Payers, Health Systems, Legislators
- Engage in different conversations
  - Codes/CPT updates are second order change
  - Payment transformation is the future
  - How do you bridge the gap?
- Embrace your fear
- Release your creativity
  - Pilot your ideas

But wait!

OPPORTUNITY

Finally

RESOURCES

- http://integrationacademy.ahrq.gov/
- http://www.advancingcaretogether.org/
- http://www.apa.org/ed/resources/competencies-practice.pdf
- http://www.youtube.com/channel/UCGCWmd6TZpKZ6SCzR3zOcjA
- http://coloradosim.org/
- http://cohealthcouncil.org
- http://stcharleshealthcare.org

Questions and Comments