Strategies for Effective Behavioral Health Integration

Lori Raney, MD
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Denver, CO
Defining Integrated Care

“The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.”

SAMHSA Levels of Integrated Care

<table>
<thead>
<tr>
<th>COORDINATED KEY ELEMENT: COMMUNICATION</th>
<th>CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY</th>
<th>INTEGRATED KEY ELEMENT: PRACTICE CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEVEL 1 Minimal Collaboration</td>
<td>LEVEL 3 Close Collaboration Onsite</td>
<td>LEVEL 5 Close Collaboration Approaching an Integrated Practice</td>
</tr>
<tr>
<td>LEVEL 2 Basic Collaboration at a Distance</td>
<td>LEVEL 4 Close Collaboration Onsite with Some Systems Integration</td>
<td>LEVEL 6 Full Collaboration in a Transformed/Merged Integrated Practice</td>
</tr>
</tbody>
</table>

Stepped Model of Integrated Care

- Uses limited resources to their greatest effect on a population basis
- Different people require different levels of care
- Finding the right level of care often depends on monitoring outcomes
- Increases effectiveness and lowers costs overall (Van Korff et al 2000)

http://aims.uw.edu
Behavioral Health Presentations in PC

- **Distress**: 67yo man recently widowed
- **Social Anxiety Disorder**: 19yo man “horrible stomach pain” when starts college
- **Substance Use Disorder**: 43yo woman drinks “a couple of glasses” of wine daily
- **Major Depressive Disorder**: 32yo woman “can’t get up for work”
- **Diabetes Uncontrolled**
Behavioral Health Presentations in PC

- **Brief Intervention, Bill therapy code**
- **Registry – Track GAD7**
- **Distress**
  - 67yo man recently widowed
- **Social Anxiety Disorder**
  - 19yo man “horrible stomach pain” when starts college
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  - 43yo woman drinks “a couple of glasses” of wine daily
- **Major Depressive Disorder**
  - 32yo woman “can’t get up for work”
- **Diabetes Uncontrolled**
- **Brief Intervention – Track HgA1c**

**MI – several sessions. Could Track total weekly drinks/max drinks/day**

**Registry - track PHQ-9**
For those of you practicing IC what approach are you using?
Recipe for Success

Ingredients TEMP
- Team that consists at a minimum of a PCP, BHP and psychiatric consultant
- Evidence-based behavioral and pharmacologic interventions
- Measuring care continuously to reach defined targets
- Population is tracked in registry, reviewed, used for quality improvement
- Accountable for outcomes on individual and population level

Secret Sauce Whitebird Brand
- Strong leadership support
- A strong PCP champion and PCP buy-in
- Well-defined and implemented BHP/Care manager role
- An engaged psychiatric provider
- Operating costs are not a barrier

Process of Care Tasks
- 2 or more contacts per month by BHP
- Track with registry
- Measure response to treatment and adjust
- Caseload review with psychiatric consultant
Go Upstream: “Sweet” Spot in Primary Care

- Issues with depression and substance abuse can be pre-empted, rather than progressing to diagnosis
- Goal is to detect early and apply early interventions to prevent from getting more severe
Core Principles of Effective Integrated Care

- Effective integrated care operationalizes the principles of the chronic care model to improve access to evidence based mental health treatments for primary care patients.
- Care is:
  - Team-based effective collaboration and Patient-centered
  - Evidence-based and practice-tested care
  - Measurement-based care, treat to target
  - Population-based care – registry, systematic screen
  - Accountable care

http://aims.uw.edu
Collaborative Care

Effective Collaboration

Informed, Activated Patient

PCP supported by Behavioral Health Care Manager

PRACTICE SUPPORT

Measurement-based Treat to Target

Psychiatric Consultation

Caseload-focused Registry review

Training

Used with permission, AIMS Center
A Tipping Point for Measurement-Based Care

John C. Fortney, Ph.D., Jürgen Unützer, M.D., M.P.H., Glenda Wrenn, M.D., M.S.H.P., Jeffrey M. Pyne, M.D., G. Richard Smith, M.D., Michael Schoenbaum, Ph.D., Henry T. Harbin, M.D.

**Objective:** Measurement-based care involves the systematic administration of symptom rating scales and use of the results to drive clinical decision making at the level of the individual patient. This literature review examined the theoretical and empirical support for measurement-based care.

**Methods:** Articles were identified through search strategies in PubMed and Google Scholar. Additional citations in the references of retrieved articles were identified, and experts assembled for a focus group conducted by the Kennedy Forum were consulted.

**Results:** Fifty-one relevant articles were reviewed. There are numerous brief structured symptom rating scales that have strong psychometric properties. Virtually all randomized controlled trials with frequent and timely feedback of patient-reported symptoms to the provider during the medication management and psychotherapy encounters significantly improved outcomes. Ineffective approaches included one-time screening, assessing symptoms infrequently, and feeding back outcomes to providers outside the context of the clinical encounter. In addition to the empirical evidence about efficacy, there is mounting evidence from large-scale pragmatic trials and clinical demonstration projects that measurement-based care is feasible to implement on a large scale and is highly acceptable to patients and providers.

**Conclusions:** In addition to the primary gains of measurement-based care for individual patients, there are also potential secondary and tertiary gains to be made when individual patient data are aggregated. Specifically, aggregated symptom rating scale data can be used for professional development at the provider level and for quality improvement at the clinic level and to inform payers about the value of mental health services delivered at the health care system level.

*Psychiatric Services 2016: 00:1–10; doi: 10.1176/appi.ps.201500439*
Care That Is Measured Gets Better

- HAM-D 50% or <8
- Paroxetine and mirtazapine
- Greater response
- Shorter time to response
- More treatment adjustments (44 vs 23)
- Higher doses antidepressants
- Similar drop out, side effects

MBC Concepts

Process:
• Systematic administration of symptom rating scales – use huddle or registry
• NOT a substitute for clinical judgement
• Use of the results to drive clinical decision making at the patient level – overcome clinical inertia
• Patient rated scales are equivalent to clinician rated scales
• Aggregate data for
  – Professional development at the provider level – MACRA
  – Quality improvement at the clinic level
  – Inform reimbursement at the payer level

Ineffective Approaches:
• One-time screening
• Assessing symptoms infrequently
• Feeding back outcomes outside the context of the clinical encounter
Validated Tools

**Mood Disorders**
- PHQ-2, PHQ-9: Depression
- CIDI 3.0: Bipolar disorder
- MDQ: Bipolar disorder

**Anxiety and Trauma Disorders**
- GAD-7: Anxiety, GAD
- PCL-C: PTSD (with Criterion A)

**Substance Use Disorders**
- AUDIT-C Full AUDIT
- DAST
PHQ - 2

Over the last 2 weeks, how many days have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th></th>
<th>Not at All</th>
<th>Several Days</th>
<th>More than Half the Days</th>
<th>Nearly Every Day</th>
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<td>0</td>
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<td>2. Feeling down, depressed or hopeless</td>
<td>0</td>
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<td>2</td>
<td>3</td>
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- Ultra brief screening
- Commonly used in primary care
- Scoring:
  - 0-2: Negative
  - 3 or Higher: Positive and patient needs further assessment
# Validated Screening and Measurement Tools

## PHQ-9

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<th>Item</th>
<th>Score</th>
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<td>Little interest or pleasure in doing things</td>
<td>1</td>
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<tr>
<td>Feeling down, depressed, or hopeless</td>
<td>✓</td>
</tr>
<tr>
<td>Trouble falling or staying asleep, or sleeping too much</td>
<td>2</td>
</tr>
<tr>
<td>Feeling tired or having little energy</td>
<td>✓</td>
</tr>
<tr>
<td>Poor appetite or overeating</td>
<td>✓</td>
</tr>
<tr>
<td>Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>2</td>
</tr>
<tr>
<td>Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>✓</td>
</tr>
<tr>
<td>Moving or speaking so slowly that other people could have noticed; or the opposite—being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>✓</td>
</tr>
<tr>
<td>Thoughts that you would be better off dead, or of hurting yourself in some way</td>
<td>3</td>
</tr>
</tbody>
</table>

**Total:** 15

- **PHQ-9 > 9**
  - < 5 – remission
  - 5 - mild
  - 10 - moderate
  - 15 - moderate severe
  - 20 - severe

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## Generalized Anxiety Disorder 7-item (GAD-7) scale

<table>
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<th>Over the last 2 weeks, how often have you been bothered by the following problems?</th>
<th>Not at all sure</th>
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<th>Over half the days</th>
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<td>1. Feeling nervous, anxious, or on edge</td>
<td>0</td>
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<td>2</td>
<td>3</td>
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<td>2. Not being able to stop or control worrying</td>
<td>0</td>
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<td>2</td>
<td>3</td>
</tr>
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<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it's hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

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Add the score for each column:

|   | + | + | + |

Total Score (add your column scores) =

Score ≥ 10 indicates possible diagnosis
Readiness Quiz:
What screening and measurement tools are you currently using?
Using Data to Drive Response

**FREE UW AIMS Excel® Registry (**
https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data)
Measurement Based Treatment To Target

Used with permission UW AIMS Center
Applying the Core Principles in Your Clinic: Initial Analysis

Gap Analysis Effective Integrated Care Team Exercise

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<td><strong>2. Evidence-based care</strong></td>
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BHPs/Care Managers

Who are the BHPs/CMs?

- Typically MSW, LCSW, MA, RN, PhD, PsyD, paraprofessionals
- Brief intervention skills, generalists preferrable

What makes a good BHP/CM?

- Believes brief treatment works
- Organizational skills
- Persistence- tenacity
- Adaptable to change
- Comfortable with efficient and quick assessments
- Good triage skills
- Willingness to be interrupted
- Ability to work in a team

CAUTION:
Traditional Approach to therapy
Not willing to be interrupted
Timid, insecure about skills

PLEASE
INTERRUPT ME!
Evidence-based Brief Interventions

- Motivational Interviewing
- Distress Tolerance Skills
- Behavioral Activation
- Problem Solving Therapy
Frequent, Persistent Follow-up

FIGURE 1. Time to first clinically significant improvement in depression among patients in a collaborative care model, by follow-up contact in the first four weeks.

Bao et al: Psych Serv 2015
Task Sharing - Behavioral Health Provider

- **BHP 1.** Paraprofessional Staff
  - BH Screening
  - Registry Tracking
  - Health Promotion

- **BHP 2.** Paraprofessional Staff with Advance Training
  - Brief Intervention for Situational Stress and Education on Health Changes

- **BHP 3.** Licensed Behavioral Health Provider
  - Diagnostic Clarification
  - Brief Intervention
  - Complex BH Needs

Specialty Behavioral Health
## Registries to Track Progress, Change Treatment

<table>
<thead>
<tr>
<th>Patient</th>
<th>Caseload</th>
<th>Program</th>
<th>Tools</th>
<th>Logout</th>
<th>Search Patient:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHITS ID</td>
<td>Population</td>
<td>DATE ENROLLED</td>
<td>STATUS</td>
<td>DATE</td>
<td>PROG ID</td>
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<tr>
<td>3400016</td>
<td>U</td>
<td>1/20/2011</td>
<td>L</td>
<td>19</td>
<td>10</td>
</tr>
<tr>
<td>3400002</td>
<td>U</td>
<td>10/14/2010</td>
<td>L</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>3400029</td>
<td>U</td>
<td>5/2/2011</td>
<td>L</td>
<td>21</td>
<td>10</td>
</tr>
</tbody>
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**AIMS Center:** [http://aims.uw.edu](http://aims.uw.edu)
Psychiatric Consultant

Availability to Consult Promptly

- Diagnostic dilemmas
- Education about diagnosis or medications
- Complex patients, such as pregnant or medical complicated
  - Pattern recognition**
  - Education**
  - Build confidence and competence**

Caseload Reviews

- Scheduled (ideally weekly)
- Prioritize patients that are not improving – extends psychiatric expertise to more people in need
- Make recommendations – PCP may or may not implement
- NO RX
Psychiatric Providers Supporting Teams

Care Manager/BHP 1

Care Manager/BHP 2

Care Manager/BHP 3

Care Manager/BHP 4

50-80 patients/caseload
2-4 hrs psych/week/ care coordinator
= a lot of patients getting care
Roles of Primary Care Provider

- **IDENTIFY** individuals who need BH support and
- **ENGAGE** them in the treatment model
- Utilize screening tools to track progress (e.g., PHQ-9)
- Sufficient knowledge of psychopharmacology – prescribe meds
PCP “Buy-In”

Before Implementation

• This is going to slow me down
• I don’t have time to address one more problem
• I have liability concerns
• I already do a good job of treating mental illness

After Implementation

• This takes a load off my plate
• This speeds me up
• I always want to practice like this
• I am giving better care to my patients
• This gives me time to finish my note

“If you aren’t uncomfortable with your practice you aren’t practicing integrated care.”

PCP - Colorado
PCP “Champion”

- Someone that has *natural leadership skills*, respect from their peer physicians
- They may be in a formal leadership role or not – but they are seen as having a *respected opinion by their colleagues* and peers (formal or informal leader)
- Understand the integration and team approach to all care – respecting various roles and that while typically physicians are leading the team, the *other roles are vitally important and need to be respected*. They can lead other physicians to that approach and ability to “let go” of some of the work that they think they are the only ones that can do.
- *Committed to the work* and most ideal would be that they are given some time to truly lead the work and be the “champion” – *attending meetings, helping to aid in implementation, education to physicians and other team members, helping to recruit the consulting psychiatrist, etc.*

Pitch

- We have a new way we are providing health care at the clinic for patients experiencing stressors like yours.
- In this program, you will still have appointments with me to continue working with your medications, and
- You will be working with a behavioral care manager, whose job it is to help you improve your day to day function, while we work on your medications if you choose to take them.
- S/he and I will be in communication about your care and function. S/he will really be my “eyes and ears” between our appointments to let me know how you’re doing and if what we are doing is working to improve your function; so it is really important that you work closely with her/him so s/he can give me the clearest picture of what’s going on with you. S/he can also provide therapy.
- I want to set up an appointment/go get them now for you to meet her/him, so that s/he can meet you and assess your situation.
Audience Participation: Role Play

• PCP
• BHP
Two Cultures: One Patient

**PRIMARY CARE**
- Continuity is goal
- Empathy and compassion
- Data shared
- Large panels
- Flexible scheduling
- Fast Paced
- Time is independent
- Flexible Boundaries
- Treatment External (labs, x-ray, etc)
- Patient not responsible for illness
- 24 hour communication
- Saved lives
- Disease management

**BEHAVIORAL HEALTH**
- Termination is goal – “discharge”
- Professional distance
- Data private
- Small panels
- Fixed scheduling
- Slower pace
- Time is dependent – “50 min hour”
- Firm Boundaries
- Relationship with provider IS tx
- Patient responsible for participating
- Mutual accountability
- Meaningful lives
- Recovery model
Effective Implementation: 9 Factors

<table>
<thead>
<tr>
<th>Table 1. Factors Considered Important for Implementation of DIAMOND</th>
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<tbody>
<tr>
<td><strong>Ranking</strong></td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
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<td>8</td>
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DIAMOND indicates Depression Improvement Across Minnesota—Offering a New Direction.

“A shared belief that the team is safe for interpersonal risk taking. It can be defined as "being able to show and employ one's self without fear of negative consequences of self-image, status or career". In psychologically safe teams, team members feel accepted and respected. It is also the most studied enabling condition in group dynamics and team learning research.”

Source: Amy Edmondson, Novartis Professor of Leadership and Management at Harvard Business School.
Ted X on Psychological Safety in Teams 2014
WHAT HAPPENS ON TEAMS WITHOUT PSYCHOLOGICAL SAFETY?

Natural human tendency to use “impression management.”

No one wants to look:

- **Uninformed**
  - Don’t ask questions
  - Lack of cross training occurs & reduces collaboration

- **Incompetent**
  - Don’t admit weakness or mistake
  - Lack of trust developed between PCP & BHP

- **Intrusive**
  - Don’t offer ideas
  - Don’t benefit from diversity of disciplines & reduced warm handoffs

- **Negative**
  - Don’t critique the status quo
  - Missed opportunity to integrate

Source: Amy Edmondson Ted X on Psychological Safety in Teams
TEAMS WITH PSYCHOLOGICAL SAFETY

A SHARED BELIEF THAT THE TEAM IS SAFE FOR INTERPERSONAL RISK TAKING

+ Okay and even expected that team members will speak up with concerns, ideas, questions, mistakes, etc.
+ Team members take risk
+ Embrace and celebrate diversity of team members
+ Team members value and respect one another
+ Teams continuously improve processes
+ High communication and shared information
3 SIMPLE WAYS TO INCREASE PSYCHOLOGICAL SAFETY

LEADERS AND TEAM MEMBERS
Simple ways to increase psychological safety which is separate from motivating team members—creating safe spaces.

LEARNING PROBLEM
Frame change as a learning problem rather than an execution problem.

BE HUMBLE
Acknowledge your own fallibility.

MODEL CURIOUSITY
Ask questions and model exploration of new ideas.

Source: Amy Edmondson Ted X on Psychological Safety in Teams
Performance Measures: Accountability

• **Process Metrics:**
  – Percent of patients screened for depression
  – Percent with follow-up with behavioral care manager within 2 weeks
  – Percent not improving that received case review and psychiatric recommendations
  – Percent treatment plan changed based on advice
  – Percent not improving referred to specialty BH

• **Outcome Metrics**
  – Percent with 50% reduction PHQ-9 – Clinical Response
  – Percent reaching remission (PHQ-9 < 5) NQF 710 and 711

• **Satisfaction** – patient and provider

• **Functional** – work, school, homelessness

• **Utilization/Cost**
  – ED visits, 30 day readmits, med/surg/ICU, overall cost
CPT Codes for CoCM

99492 - $160
99493 - $130
99494 - $66
99484 - $48
G0512 -$134 (FQHCs only)

Billed once a month by the PCP

- Outreach and engagement by BHP
- Initial assessment of the patient, including administration of validated rating scales
- Entering patient data in a registry and tracking patient follow-up and progress
- Participation in weekly caseload review with the psychiatric consultant
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

*Plus can bill for traditional CPT codes
Applying the Core Principles in Your Clinic

Gap Analysis Effective Integrated Care Team Exercise

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What will you take back to your home team from this Learning Lab?
Who in this room could you connect with to help in your current stage of integrating primary care and behavioral health?

Swap business cards 😊