Behavioral Health Integration: 
Clinical and Training Perspectives

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Learning Goals

- Participants will be able to:
  - Articulate the reason for special training to do behavioral health care in primary care settings.
  - Articulate clear reasons for not using past definitions of disciplinary roles in integrated primary care.
  - Explain the general role of Behavioral Health Consultant and Integrated Care Manager.
Need for Change in Healthcare

- US healthcare is unsustainably expensive
  - It eats up about 18 cents of every dollar of wealth our economy generates (17.6% of GDP).
  - The average of European countries is 9.5%
- We have the best healthcare in the world for a few very sick individuals.
- We have terrible healthcare for populations.
  - On all the population markers of health such as life span, we do not do well.
- In addition to the high cost of mediocre healthcare for the majority, unhealthy populations are very expensive and less productive.
The Current Transformation in Healthcare is “evidence-based”

- Evidence of the impact of primary care on cost and quality of medical care.
- Evidence of the role of behavioral health needs in driving up the cost of medical care, far beyond what is spent on behavioral health treatment.
- Evidence of the impact of treatable behavioral health needs on the productivity of America’s workforce, above and beyond the cost of medical care.
EXHIBIT 9
Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000

Spending per beneficiary (dollars)

8,000

7,000

6,000

5,000

4,000

1  2  3  4  5

General practitioners per 10,000

SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTE: Total physicians held constant.
EXHIBIT 8
Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000

Quality rank

1

26

51

General practitioners per 10,000

SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTES: For quality ranking, smaller values equal higher quality. Total physicians held constant.
### The Prevalence and Cost of MHSA Comorbidities – Medicaid Adults*

**Per 100k population - $535,680,000**

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Prevalence</th>
<th>MHSA Comorbidity Prevalence</th>
<th>MHSA Comorbidity PMPM</th>
<th>No MHSA Comorbidity PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>04: Diabetes</td>
<td>9.6%</td>
<td>58.4%</td>
<td>$1,789.83</td>
<td>$801.03</td>
</tr>
<tr>
<td>05: Nutritional and Metabolic</td>
<td>29.4%</td>
<td>62.2%</td>
<td>$1,475.50</td>
<td>$633.19</td>
</tr>
<tr>
<td>06: Liver</td>
<td>7.4%</td>
<td>79.9%</td>
<td>$1,936.94</td>
<td>$952.81</td>
</tr>
<tr>
<td>07: Gastrointestinal</td>
<td>24.6%</td>
<td>66.9%</td>
<td>$1,511.39</td>
<td>$706.35</td>
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<tr>
<td>08: Musculoskeletal and Connective Tissue</td>
<td>39.9%</td>
<td>63.5%</td>
<td>$1,252.91</td>
<td>$553.33</td>
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<tr>
<td>09: Hematological</td>
<td>8.1%</td>
<td>67.4%</td>
<td>$2,319.20</td>
<td>$1,167.14</td>
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<tr>
<td>14: Neurological</td>
<td>12.3%</td>
<td>71.5%</td>
<td>$1,800.17</td>
<td>$1,012.52</td>
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<tr>
<td>16: Heart</td>
<td>24.3%</td>
<td>62.9%</td>
<td>$1,598.62</td>
<td>$694.46</td>
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<tr>
<td>19: Lung</td>
<td>18.9%</td>
<td>70.4%</td>
<td>$1,549.24</td>
<td>$740.96</td>
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<tr>
<td>24: Pregnancy-Related</td>
<td>4.4%</td>
<td>46.1%</td>
<td>$1,270.01</td>
<td>$863.24</td>
</tr>
</tbody>
</table>

Average medical conditions: **2.16**

Medicaid Population: **100,000**

Annual Healthcare Cost of MHSA Comorbidity: **$535,680,000**

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* Northeast state  
Slide by Steven Melek, Consulting Actuary, Milliman & Co.
### The Prevalence and Cost of MHSA Comorbidities – Medicaid Children*

per 100k in population - $129,261,000

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Prevalence</th>
<th>MHSA Comorbidity Prevalence</th>
<th>MHSA Comorbidity PMPM</th>
<th>No MHSA Comorbidity PMPM</th>
</tr>
</thead>
<tbody>
<tr>
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<td>0.5%</td>
<td>44.2%</td>
<td>$1,888.97</td>
<td>$928.68</td>
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<tr>
<td>05: Nutritional and Metabolic</td>
<td>9.8%</td>
<td>30.7%</td>
<td>$1,264.12</td>
<td>$579.11</td>
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<tr>
<td>06: Liver</td>
<td>0.4%</td>
<td>47.1%</td>
<td>$2,131.14</td>
<td>$1,580.97</td>
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<tr>
<td>07: Gastrointestinal</td>
<td>16.1%</td>
<td>26.5%</td>
<td>$1,162.31</td>
<td>$567.49</td>
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<tr>
<td>08: Musculoskeletal and Connective Tissue</td>
<td>13.5%</td>
<td>31.9%</td>
<td>$1,007.48</td>
<td>$459.43</td>
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<td>3.0%</td>
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<tr>
<td>14: Neurological</td>
<td>3.8%</td>
<td>40.2%</td>
<td>$1,695.14</td>
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<td>16: Heart</td>
<td>2.7%</td>
<td>36.5%</td>
<td>$2,023.52</td>
<td>$1,414.53</td>
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<tr>
<td>19: Lung</td>
<td>18.9%</td>
<td>24.4%</td>
<td>$992.38</td>
<td>$456.09</td>
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<tr>
<td>24: Pregnancy-Related</td>
<td>2.0%</td>
<td>43.4%</td>
<td>$1,235.90</td>
<td>$882.71</td>
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Average medical conditions: 1.10

Medicaid Population: 100,000

Annual Healthcare Cost of MHSA Comorbidity: $129,261,000

* Northeast state

Slide by Steven Melek, Consulting Actuary, Milliman & Co.
Relationship of Depression to Diabetic Symptoms

The Real Problem:
The Full Cost of Poor Employee Health

Medical & Pharmacy Costs
$3,376 PEPLY

Personal Health Costs
25%
Medical Care Pharmacy

Health-Related Productivity Costs
$10,128 PEPLY

Productivity Costs
75%
Absenteeism
Short-term Disability
Long-term Disability

Presenteeism
Overtime
Turnover
Temporary Staffing
Administrative Costs
Replacement Training
Off-Site Travel for Care
Customer Dissatisfaction
Variable Product Quality

Total Costs = $13,504 PEPLY

Total Medical, Pharma & Productivity Costs
-- per 1000/FTEs --

(HPBS – Phase 2 Employers)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Medical</th>
<th>Drug</th>
<th>Absence</th>
<th>Presenteeism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>$100,000</td>
<td>$200,000</td>
<td>$300,000</td>
<td>$400,000</td>
</tr>
<tr>
<td>Obesity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back/Neck Pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GERD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Cancer (vs Skin)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Chronic Pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Primary Care is the only setting for a population approach to behavioral health

- The vast majority of people will not accept a referral to specialty MH offered by a PCP. It is care in primary care or none.


- Even if all of the difficulties with referral are addressed, at least 50% better access to MH care if offered in primary care.

Primary Care is full of behavioral health needs, many unrecognized.

- Mental Health
- Substance Abuse
- Health Behavior Change
- “Ambiguous” Illnesses
- Chronic Illness Behavioral Needs
- “Unfamiliar” Cultural Expressions of Problems
- Discovered and undiscovered trauma hx
- Serious mental illness, in and outside of MH tx
Behavioral Health Needs Assessment in Primary Care

PHQ-3000  Merillac 500

- Major Depression = 10%  24%
- Panic Disorder = 6%  16%
- Other Anxiety Disorders = 7%  21%
- Alcohol Abuse = 7%  17%
- Any Mental Health Dx = 28%  52%
Prevalence of Behavioral Health Problems in Primary Care

Unhealthy Behaviors

- Smoking = 20%
- Obesity = 30%
- Sedentary lifestyle = 50%
- Non-adherence = 20 - 50%
Depression with Chronic Illnesses:

- Increased rates of depression in patients with:
  - Congestive Heart Failure
  - Diabetes
  - COPD

- Patients with chronic illness and depression 2-5x the healthcare cost of patients with chronic illness alone

- Depression is the common factor in patients disabled (compared with pts equally sick but not disabled) by hypertension, asthma, arthritis, ulcers.

Culture Impacts Depression
Culturally Syntonic Approaches

Signs of Depression found Cross-Culturally
- Appetite changes
- Sleep changes
- Psychomotor agitation or retardation
- Decreased energy
- Decreased libido
- Diminished ability to think or concentrate

Signs of Depression found in “Western” Cultures
- Self-deprecation
- Hopelessness
- Guilt
- Suicidality

10 most common complaints in adult primary care
15% x organic pathology found
(Kroenke & Mangelsdorff, 1989)

<table>
<thead>
<tr>
<th>chest pain</th>
<th>back pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>fatigue</td>
<td>shortness of breath</td>
</tr>
<tr>
<td>dizziness</td>
<td>insomnia</td>
</tr>
<tr>
<td>headache</td>
<td>abdominal pain</td>
</tr>
<tr>
<td>swelling</td>
<td>numbness</td>
</tr>
</tbody>
</table>
CBT in the Exam Room

1) CBT picture  2) Thought stopping or behavioral activation
Categories of Relationship between Collaborating Medical and Behavioral Health Services

- **Coordinated** = Behavioral services by referral at separate location with formalized information exchange.
- **Co-Located** = By referral at medical care location
- **Integrated** = Part of the “medical” treatment at medical care location

Coordinated Care

Coordinated care elements:

- Appointment arrival notification
- Clinical information exchange protocols
- Coordinated treatment planning and/or problem solving for complex patients or as needed

- Expect communication to go both ways.
  - MH clinicians are healthcare professionals who should be knowledgeable about the patient’s health issues.

- Ask about the person’s health behavior goals and consider them in treatment planning.
Programs that link Specialty Mental Health as a consultant to Primary Care are best for populations and for coordination.

- Massachusetts Child Psychiatry Access Program
- For adults, in NC Medicaid pays for the time of the PCP and the psychiatrist, as patient visit rates, for consultation about a patient, whether the psychiatrist has met the patient or not.
- When behavioral health clinicians are working in primary care, the referrals to specialty care for patients needing longer term work is more likely to be successful.
Co-located
BH clinician working in primary care seeing all referred.

Evidence says:

Advantages: Problems:
Access Referrals don’t show
Patient Satisfaction Case-loads fill up
Provider Satisfaction
Cost Effectiveness
Clinical Outcome
Integrated Primary Care: The IMPACT Treatment Model
http://uwaims.org/about.html

- Collaborative care model includes:
  - Care manager: Depression Clinical Specialist
    - Patient education
    - Symptom and Side effect tracking
    - Brief, structured psychotherapy: PST-PC
  - Consultation / weekly supervision meetings with
    - Primary care physician
    - Team psychiatrist
  - Stepped protocol in primary care using antidepressant medications and/or 6-8 sessions of psychotherapy (PST-PC)
Substantial Improvement in Depression
(≥50% Drop on SCL-20 Depression Score from Baseline)


month

- Usual care
- Intervention
Integrated Primary Care: Behavioral Health Consultant

- Management of psychosocial aspects of chronic and acute diseases
- Application of behavioral principles to address lifestyle and health risk issues
- Consultation and co-management in the treatment of mental disorders and psychosocial issues
Cherokee Health Systems  
A Federally Qualified Health Center and Community Mental Health Center

## Corporate Profile

**Founded:** 1960

### Services:
- Primary Care
- Community Mental Health
- Dental
- Corporate Health Strategies

### Locations:
- 21 clinical locations in 14 Tennessee Counties
- Behavioral health outreach at numerous other sites including primary care clinics, schools and Head Start Centers

### Number of Clients:
- 58,561 unduplicated individuals served
- 24,958 Medicaid (TennCare)

### New Patients:
- 19,829

### Patient Services:
- 442,626

### Number of Employees:
- 538

#### Provider Staff:
- Psychologists - 40
- Primary Care Physicians - 31
- NP/PA (Primary Care) - 17
- Master’s level Clinicians - 59
- Psychiatrists - 13
- NP (Psych) - 7
- Case Managers - 29
- Pharmacists - 9
- Dentists - 2

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The architecture says it all, and makes it work.
Figure 1: Comparison of CHS utilization with regional providers

- Primary Care Visits: 117% x utilization level for other regional providers
- ER Visits: 32%
- Specialty Care: 58%
- Hospital Care: 63%
- Cost: 78%
Models of Integrated Behavioral Health

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

**IMPACT:**

Disease based
Research heritage
Patient outcome evidence
Care manager (SW or Psychologist)

**BHC:**

Program based
Clinical heritage
Cost and satisfaction evidence
Behavioral Health Consultant

Beginning to converge
Care manager does other behavioral health and chronic illness added
Array of services beyond disease prgms

BHC does some care mngment and Case Managers added
Beginning disease prgms
Patient Centered Medical (Health) Home Essence

What’s different in plain English?

- Team-Based care
- Proactive population management
- Continuous improvement (informed by data)
- Payment for health rather than only for service
Now behavioral health is becoming part of the core set of services.


- Complex patients with chronic illnesses needing behavioral health care are more likely to be designated for Medical Home level of care.

- Behavioral health care in medical setting is a better cultural fit for many patients.
Now behavioral health is becoming part of the core set of services.

- Behavioral Health Clinicians free up time for PCPs to spend with other patients, while enhancing patient satisfaction and self-efficacy.

- Care management for depression (part of many PCMHs) is more effective when done by professionals with behavioral health skills. (Pincus, Pechura, Keyser, et al. Administration & Policy in Mental Health. 33(1):2-15, 2006)
NCQA changed the game and will go farther next time.
Care Management-2011

- Develops written care plans for 75% of patients in 3 population protocol programs (one behavioral) and for high risk complex patients.
- Arranges or provides treatment for MH and SA disorders.
- Monitors and assures that patients and families receive offered (referred) resources.
- Supports patients and families in self-management, self-efficacy and behavior change with education, counseling for healthy behavior and goal setting.
The PCMH payment transformation is bringing health behavior change to center stage.

- Three of the following will probably be the chronic illnesses targeted for disease management:
  - Asthma
  - Diabetes
  - CVD
  - Depression
  - Obesity
  - Substance Abuse

- Each of these will require one or more of the following:
  - Improved healthy eating
  - Increased exercise
  - Smoking cessation
  - Weight loss
  - Improved medication compliance or substance reduction

- Practices will be paid extra based on their patients successful accomplishment of these changes.
Accountable Care Organizations

- Congress and CMS: an ACO would have at least one hospital, a minimum of 50 physicians (primary care and specialists), commit to be in business for at least 3-5 years, and serve at least 5,000 patients.
- ACOs would achieve this by addressing key barriers to improved value for healthcare:
  - Accountability for the continuum of patients’ care including outcomes, quality and costs
  - Focusing provider payments on improved health and outcomes, better quality, and reduced costs
  - Support patient choice by providing information on the risks and benefits of treatment options
Mass Medicaid PCMH/ACO Program Design:

- Care Manager in a PCMH/PC practice changed from nurse to any licensed clinician
- Care Coordinator does not need a license.
- Specifies that these are functions not job descriptions
- Three levels of risk available and three levels of incentive
- Three levels of BH services determine how big a PMPM a practice gets:
  1. Care management, emergency services, patient activation for healthy living, effective referrals
  2. The above and offer generalist care for depression, anxiety, adhd, marital and child behavior problems, substance abuse, insomnia, adherence and healthy living problems.
  3. The above and all psychiatry and psychotherapy needs of patients
OK, OK, It’s coming. Can’t we just reassign the workforce we have?

- Mental health and substance abuse professionals want to do specialty care in the generalist environment of Primary Care.
- Mental health case managers have little experience in working on issues of health.
- Medical care managers are mostly nurses and struggle if they have to deal continuously with depressed patients.
- Physicians, nurses and many MH professionals are used to giving advice and teaching, not to “activating” people and trying to help them reach their goals.
- Hardly anyone is used to thinking of the behavioral factors of chronic illness or the chronic illness factors in depression and anxiety.
Why Primary Care behavioral health is difficult for clinicians trained only in specialty mental health

- Treat somewhat different population than in Specialty Mental Health services.
  - Less disturbed and less diagnostically clear
  - Won’t accept “mental health” definition of the problems they bring
  - Broader array of needs.
    - BHC must understand medical conditions and practice behavioral medicine and substance abuse care in addition to mental health
- Status as ancillary provider
- Different routines of time, confidentiality and instrumentality
Generalist Behavioral Health Clinician

- Care Management
- Brief Therapy
  - Cognitive-behavioral
  - Solution-focused
- Behavioral Medicine
  - Relaxation/biofeedback/hypnosis
  - Health behavior change
- Family Therapy
- Substance Abuse Counseling
- Child Development
- Psychotropic medication input
- Groups and Patient Education
- Community Outreach
- Organizational transformation agent
Provider Skill Set and Fit
(Discipline is not a good guide to fit)

- It takes training, or experienced support to get the orientation necessary to learn on the job.
- Good at making relationships with all of the roles in primary care. (New behavioral health clinicians are inconvenient to everyone.)
- They must do well in ambiguous situations, dive in rather than wait for an invitation.
- Because the job integrates the separated worlds the disciplines train people for, ideas about what discipline is needed are often wrong.
Role of Psychiatry in Primary Care

- Any practice offering psychotropic meds in primary care ideally should have psychiatric input and back-up.
- HMO systems that integrated (Kaiser and Group Health) had 1 BHP per 5-6 PCPs and one psychiatrist per 20-40.
- Consultation models accept the reality of PCPs as the largest group of MH clinicians in the US and enhances their skill and effectiveness.
- Programs like MCPAP are good examples of population based approaches to psychiatric back-up.
- NC Medicaid pays for psychiatric consult w/o pt
Integrated Care will also have Care Management

- The active outreach to engage patients/clients, particularly in situations where the engagement between the person and the health system is likely to fail
  - transitions in care
  - barriers to access
  - poor fit between the patient and healthcare system
    - poor social skills (patient or provider)
    - lack of activation or empowerment
    - low health literacy or understanding of healthcare system
- Care managers (and care coordinators) access resources (medical, psychosocial, daily living) for patients
- Providing a monitor for the team on patients’ symptoms and responses to care
Integrated Care Requires New Ideas About “Disciplines”

- Depression care managers – MSWs, nurses, psychologists, NPs and PAs
- BHC’s – Masters and doctoral clinicians
- Care Managers/Coordinators in the PCMH need both behavioral health skills and medical knowledge.
  - Medically trained people must be “behaviorally enhanced”
  - Behaviorally trained people must be “medically enhanced”
- Paraprofessional counselors – community health workers, promotoras, (“peer” tradition from MH adapted to PC)

- Modular skill sets vs. disciplines
Who trains the Workforce for Integration?

Center for Integrated Primary Care – Univ. of Mass. Med. School

- **Certificate Program in Primary Care Behavioral Health**
  - Web Workshops – 36 hours

- **Certificate Program in Integrated Care Management**
  - Web Teaching – 20 hours

- **Certificate of Intensive Training in Motivational Interviewing**
  - Web Teaching – 20 hours, Live practice and coaching

Other Certificate Programs:
- AIMS Center, University of Washington – Training program aimed at psychiatrists.
- Farleigh Dickinson University
- Arizona State University offers a doctorate in Primary Care Behavioral Health
  - Must already have a license to practice

http://Umassmed.edu/CIPC/
How do roles interact on the team?

- BHCs tend to have a broader array of types involvements than care managers for complex patients.
- Care managers/coordinators often are directed to fewer and more complex patients who need more intensive contact.
- Letting the patient decide can be a necessary part of the “workflow”. (thanks Jeff Reiter)
- The idea that complex patients must have a nurse, supervised by a physician is not proving to stand up in practice.
- In some mature integrated settings, the care managers/care coordinators are supervised by the BHCs because their behavioral health skills are the “make or break” aspect of their work.
- As care management is broadened, it is crucial that it is understood as a role, not a job description. Any member of the team could be the care manager for some patients.
What should academic programs that want to prepare people for these roles do?

- Understand and embrace the new generalist roles
  - Teach the distinction between generalist and specialist medical services
  - Be aware of the tendency for specialists to see generalists as poorer quality versions of themselves. (Family physicians sometimes call specialists “partialists”.
- Teach the Triple Aim so that students can contribute in any area.
- Make primary care a track with appropriate site placements.
Let’s keep in contact

Center for Integrated Primary Care

http://UMassMed.edu/CIPC

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