Integrated Mental Health Care

Closing the gap between what we know and what we do.

Jürgen Unützer, MD, MPH, MA

Questions

Due to the large number of participants, it is not practical to take questions over the phone line.

If you have a question, please contact us at the AIMS Center at http://uwaims.org
Why Behavioral Health Care in Primary Care?

1. Access to care and reach:
   Serve patients where they are

2. Patient-centered care:
   Treat the ‘whole patient’

3. Effectiveness of care:
   Help patients get better.
Primary Care is where the patients are

National Comorbidity Survey Replication
Provision of Behavioral Health Care: Setting of Service

No Treatment 59%
41% Receiving Care

General Medical 56%
MH Professional 44%

Wang P et al., Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005

Patient Centered Care

Chronic Physical Pain 25-50%
Smoking, Obesity, Physical Inactivity 40-70%
Heart Disease 10-30%
Cancer 10-20%
Diabetes 10-30%
Mental Health / Substance Abuse 10-20%
Neurologic Disorders 10-20%
Services are Poorly Coordinated

“Don’t you guys talk to each other?”

Limits of our Current System

Few clients with behavioral health problems receive effective treatment.

| ~25% Not recognized or effectively engaged in care | ~25% Drop out of treatment too early | ~25% Stay on ineffective treatments for too long |
Health Care Reform may dramatically expand Medicaid coverage

- Beginning January 2014, Medicaid coverage will be available to low-income adults without regard to pregnancy, disability status or the presence of children in the household.
- The low-income expansion is likely to more than double the population of working-age adults receiving Medicaid.
- 20 – 50% of Medicaid clients need mental health/substance abuse services.

=> need for access to effective behavioral health care will increase substantially.

Health Care Reform: Moving Towards Better Integrated Care

Un-managed
- Fee For Service
  - Inpatient focus
  - O/P clinic care
  - Low Reimbursement
  - Poor Access and Quality
  - Little oversight
- No organized networks
- Focus on paying claims
- Little Medical Management

Coordinated Care
- Accountable Care
  - Organized care delivery
    - Aligned incentives
    - Linked by HIT
  - Integrated Provider Networks
  - Focus on cost avoidance and quality performance
    - PC Medical Home
    - Care management
    - Transparent Performance Management

Patient Centered
- Integrated Health
  - Patient Care Centered
    - Personalized Health Care
    - Productive and informed interactions between Patient and Provider
    - Cost and Quality Transparency
    - Accessible Health Care Choices
    - Aligned Incentives for wellness
  - Multiple integrated network and community resources
  - Aligned reimbursement/care management outcomes
  - Rapid deployment of best practices
  - Patient and provider interaction
    - Information focus
    - Aligned self care management
    - E-health capable

Paul McGann, MD. Acting CMO; CMS. 2/25/2011
• Patient Centered Medical Homes
• Accountable Care Organizations
• Meaningful use of Health IT

• New opportunities for integrated behavioral health care.

Research Evidence for Collaborative Care

Systematic collaboration of primary care providers and mental health providers to improve care for depression and other common mental disorders

Over 40 RCTs for depression
  – Gilbody S. et al., Arch Int Medicine; Dec 2006

Several RCTs for anxiety disorders
  – CALM Study (Roy Byrne et al); PTSD (Zatzick et al)
The IMPACT Study
http://impact-uw.org

Funded by
John A. Hartford Foundation
California Healthcare Foundation

IMPACT Team Care Model

Effective Collaboration

Prepared, Pro-active
Practice Team

Informed, Activated
Patient

Practice Support
IMPACT Doubles Effectiveness of Care for Depression

50 % or greater improvement in depression at 12 months

Unützer et al., Psych Clin NA 2004

Better Physical Function

SF-12 Physical Function Component Summary Score (PCS-12)

Callahan et al., JAGS 2005; 53:367-373
### Long-Term Cost Savings

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>Intervention group cost in $</th>
<th>Usual care group cost in $</th>
<th>Difference in $</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPACT program cost</td>
<td>522</td>
<td>0</td>
<td>522</td>
</tr>
<tr>
<td>Outpatient mental health costs</td>
<td>661</td>
<td>767</td>
<td>-210</td>
</tr>
<tr>
<td>Pharmacy costs</td>
<td>7,284</td>
<td>7,636</td>
<td>-694</td>
</tr>
<tr>
<td>Other outpatient costs</td>
<td>14,306</td>
<td>14,456</td>
<td>-296</td>
</tr>
<tr>
<td>Inpatient medical costs</td>
<td>8,452</td>
<td>9,757</td>
<td>-2578</td>
</tr>
<tr>
<td>Inpatient mental health / substance abuse costs</td>
<td>114</td>
<td>169</td>
<td>-108</td>
</tr>
<tr>
<td>Total health care cost</td>
<td>31,082</td>
<td>32,785</td>
<td>-$3363</td>
</tr>
</tbody>
</table>


### IMPACT Summary

- Less depression (IMPACT doubles effectiveness of usual care)
- Less physical pain
- Better functioning
- Higher quality of life
- Greater patient and provider satisfaction
- Effective with minorities
- Cost effective

“*I got my life back*”

Photo credit: J. Lott, Seattle Times
## IMPACT Replication Studies

<table>
<thead>
<tr>
<th>Patient Population (Study Name)</th>
<th>Target Clinical Conditions</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult primary care patients (Pathways)</td>
<td>Diabetes and depression</td>
<td>Katon et al., 2004</td>
</tr>
<tr>
<td>Adult patients in safety net clinics (Project Dulce; Latinos)</td>
<td>Diabetes and depression</td>
<td>Gilmer et al., 2008</td>
</tr>
<tr>
<td>Adult patients in safety net clinics (Latino patients)</td>
<td>Diabetes and depression</td>
<td>Ell et al., 2010</td>
</tr>
<tr>
<td>Public sector oncology clinic (Latino patients)</td>
<td>Cancer and depression</td>
<td>Dwight-Johnson et al., 2005 Ell et al., 2008</td>
</tr>
<tr>
<td>HMO patients</td>
<td>Depression in primary care</td>
<td>Grypma et al., 2006</td>
</tr>
<tr>
<td>Adolescents in primary care</td>
<td>Adolescent depression</td>
<td>Richardson et al., 2009</td>
</tr>
<tr>
<td>Older adults</td>
<td>Arthritis and depression</td>
<td>Unützer et al., 2008</td>
</tr>
<tr>
<td>Acute coronary syndrome patients (COPES)</td>
<td>Coronary events and depression</td>
<td>Davidson et al., 2010</td>
</tr>
</tbody>
</table>

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## From Research to Practice

**Building and implementing effective collaborative care teams**
Over 5,000 Providers Trained

Principles of Effective Integrated Behavioral Health Care

Patient Centered Team Care
- Collaboration is not a natural state.
- Team members have to learn new skills.

Population-Based Care
- Patients tracked in a registry: no one ‘falls through the cracks’.

Measurement-Based Treatment to Target
- Treatments are actively changed until the clinical goals are achieved.

Evidence-Based Care
- Treatments used are ‘evidence-based’.

Accountable Care
- Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.
Collaborative Team Approach

- PCP
- Patient
- BHP/Care Manager
- Consulting Psychiatrist
- Other Behavioral Health Clinicians
- Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources

New Roles

Core Program

Additional Clinic Resources

Outside Resources

Integrated Care Team Building Process

1. Define Scope and Tasks of integrated care team.
2. Assess current resources and workflow.
3. Define team member responsibilities and new collaborative workflows.
4. Assess hiring and training needs.
Workflow: Core Components and Tasks

1. Patient identification and diagnosis
2. Engagement in integrated care
3. Evidence Based Treatment
4. Systematic Follow-up/Treatment Adjustment
5. Communication, Care coordination and Referrals
6. Systematic Psychiatric Case Review
7. Program oversight and Quality Improvement

Primary Care Provider

- PCP
- Patient
- BHP/Care Manager
- Consulting Psychiatrist
- Other Behavioral Health Clinicians
- Additional Clinic Resources
- Outside Resources
- Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources
Primary Care Provider

- Oversees all aspects of patient’s care
- Diagnoses common mental disorders
- Starts & prescribes pharmacotherapy
- Introduces collaborative care team
- Makes treatment adjustments
  - in consultation with care manager, team psychiatrists, and other behavioral health providers.

BHP/ Care Manager

Core Program

Additional Clinic Resources

Outside Resources

Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources

Consulting Psychiatrist

Other Behavioral Health Clinicians

Patient

BHP/Care Manager

PCP
Staffing: BHPs/Care Manager

Who are the BHPs/CMs?
• Typically MSW, LCSW, RN, MA, PhD or PsyD

What makes a good BHP/CM?
• Organization
• Persistence
• Creativity and flexibility
• Willingness to learn
• Strong patient advocate

Behavioral Health Professional (BHP) / Care Manager - I

• Facilitates patient engagement and education
• Works closely with PCP and helps manage a caseload of patients in primary care
• Performs systematic initial and follow-up assessments.
• Systematically tracks treatment response
• Supports medication management by PCPs
BHP/Care Manager – II

• Provides brief, evidence-based counseling or refers to other providers for counseling services
• Reviews challenging patients with the consulting psychiatrist weekly
• Facilitates referrals to other services (e.g., substance abuse treatment, specialty care and community resources) as needed
• Prepares client for relapse prevention

Consulting Psychiatrist
Consulting Psychiatrist

Supports BHPs/care managers and PCPs

- Provides regular (weekly) and as needed consultation on a caseload of patients followed in primary care
  - Focus on patients who are not improving clinically → intensification of treatment
- In person or telemedicine consultation or referral for complex patients
- Education and training for primary care-based providers

Other Behavioral Health Clinicians
Incorporate Other Behavioral Health Clinicians

Can provide valuable services such as:

- Comprehensive assessment
- Evidence-based counseling / psychotherapy
  - Individual or Group
- Behavioral health interventions focused on health behaviors
- Chemical dependency counseling / treatment
- Social work services

‘Silent’ Partners

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‘Silent’ Partners

- Administrators
  - CEO, CFO, COO, Clinic Manager
- Receptionists/Front Desk Staff
- Medical Assistants
- IT Staff

Program Staffing in Diverse Clinic Settings

<table>
<thead>
<tr>
<th>Population (severity of mental health needs)</th>
<th>% of clinic population with need for mental health care management</th>
<th>Typical caseload size for 1 FTE Care Manager</th>
<th># of unique primary care clinic patients to justify 1 FTE CM</th>
<th>Typical Personnel Requirement for 1,000 unique primary care patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low need (e.g., insured, employed)</td>
<td>2%</td>
<td>100</td>
<td>5000</td>
<td>0.2 (2 hrs / week)</td>
</tr>
<tr>
<td>Medium need (e.g., medically ill, elderly, some comorbid chronic pain / substance abuse)</td>
<td>5%</td>
<td>75</td>
<td>1500</td>
<td>0.7 (3 hrs / week)</td>
</tr>
<tr>
<td>High need (e.g., safety-net population with high mental health, substance abuse, and social service needs)*</td>
<td>15%</td>
<td>50</td>
<td>333</td>
<td>3 (12 hrs / week)</td>
</tr>
</tbody>
</table>

* Needs can be approximated by # and % of clinic population with ICD diagnoses of mental disorders and / or prescription of psychotropic medications.

** Usually, 0.1 FTE psychiatric consultant time is required for 1 FTE care manager. If clinics or populations covered are small, a minimum of 2 hours / week is needed.
More than 23,000 patients served in over 100 Community Health Centers in WA.

**MHIP for Behavioral Health**

**Mental Health Integration Program**

Primary Care Provider supported by Behavioral Health Care Coordinator

Collaborative Care

Practice Support

Informed, Active Patient

Outcome Measurement

Referral to and coordination with specialty behavioral health care

Provider Training and Support
## Clinical Diagnoses

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>71%</td>
</tr>
<tr>
<td>Anxiety (GAD, Panic)</td>
<td>48%</td>
</tr>
<tr>
<td>Posttraumatic Stress Disorder (PTSD)</td>
<td>17%</td>
</tr>
<tr>
<td>Alcohol / Substance Abuse</td>
<td>17%*</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>15%</td>
</tr>
<tr>
<td>Thoughts of Suicide</td>
<td>45%</td>
</tr>
</tbody>
</table>

... plus acute and chronic medical problems, chronic pain, substance use, prescription narcotic misuse, homelessness, unemployment, poverty, ....

### MHIP for Behavioral Health

**Mental Health Integration Program**

**DISEASE CONDITIONS**
- Chronic Physical: 71%
- Mental Illness: 66%
- Substance Abuse: 38%

**72 percent had substance abuse or mental illness identified**

**15 percent had a chronic physical condition only**

**Co-occurring diagnosis among DL-U clients**

**Sources:** MMS claims, TARGET service encounters, and WSP arrest records, FY 2006-07. Chronic physical and mental illness diagnosis groups derived from CDPS grouper. Mental illness also indicated by receipt of mental health medications.
## Sample Community Health Center
(6 clinics; over 2,000 clients served)

<table>
<thead>
<tr>
<th>Population</th>
<th>Mean baseline PHQ-9 depression score (0-27)</th>
<th>Follow-up (%)</th>
<th>Mean number of care coordinator contacts</th>
<th>% with psych consultation</th>
<th>% with significant clinical improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability Lifeline</td>
<td>16.7</td>
<td>92 %</td>
<td>8</td>
<td>69%</td>
<td>43 %</td>
</tr>
<tr>
<td>Uninsured</td>
<td>15.8</td>
<td>83 %</td>
<td>8</td>
<td>59%</td>
<td>50 %</td>
</tr>
<tr>
<td>Older Adults</td>
<td>15.3</td>
<td>92 %</td>
<td>8</td>
<td>55%</td>
<td>43 %</td>
</tr>
<tr>
<td>Vets &amp; Family</td>
<td>15.5</td>
<td>92%</td>
<td>7</td>
<td>54%</td>
<td>53%</td>
</tr>
<tr>
<td>High risk Mothers</td>
<td>15.4</td>
<td>81%</td>
<td>7</td>
<td>50 %</td>
<td>60%</td>
</tr>
</tbody>
</table>

Data from Care Management Tracking System (CMTS); [http://uwaims.org](http://uwaims.org).

## Training Options

**Online IMPACT Training**

**UW Certificate Program in Integrated Behavioral Health Care**

**In-person Training**
Online IMPACT Training

13 modules
(~ 17 hours of content)

Sample modules
• Behavioral Activation (BA)
• Antidepressant Medications
• Challenging Cases
• Chronic Medical Illness & Depression

CEU available

UW Academic Certificate Program

3 Courses in 6 Months
– Online format
– In-depth training (90 contact hours)
– Results in an academic certificate from UW
– First cohort starts in January 2012
UW Academic Certificate Program

Three Courses

1. It Takes a Team
   • How to Plan and implement an effective, evidence-based integrated care program

2. Clinical Skills for Integrated Care
   • Learn the clinical tools that make the biggest difference in clinical outcomes

3. Specific Populations & Co-Occurring Behavioral and Medical Conditions
   • Application of integrated care for diverse conditions and populations

In-person Training

We can provide on-site in-person training as part of a package of implementation technical assistance
MHIP Website: http://integratedcare-nw.org/

MHIP for Behavioral Health
Mental Health Integration Program

A Partnership to Promote Patient-Centered Collaboration

Community  Collaboration  Compassion  Care  Cost-effective

What is MHIP?

Integration & Collaboration

The Mental Health Integration Program is a state-wide, patient-centered, integrated program serving clients with medical, mental health, and substance abuse needs. The program provides:

- High quality mental health screening and treatment
- An evidence- and outcome-based model of collaborative stepped care to treat common mental disorders

Results-oriented

Since the start of the program in January of

MHIP Website – Training Resources for Care Managers / Care Coordinators

MHIP for Behavioral Health
Mental Health Integration Program

Care Coordinator Training and Support

Care coordinators participating in MHIP are offered three types of training and support: comprehensive training sessions, training sessions focused on specific topics of interest to care coordinators and roundtable support and discussion sessions.

Comprehensive Training

Once or twice per year (depending on need) comprehensive training sessions are offered for new care coordinators or those who want a refresher in integrated care. Comprehensive training sessions provide a detailed description of the integrated care approach, including the evidence supporting this type of approach. Specific skills and techniques care coordinators can use to implement integrated care are covered in these training sessions which typically last for one or two days.

Training on Specific Topics

Based on feedback and requests from care coordinators and others involved in MHIP, training in specific topic areas relevant to integrated care is offered 6-12 times per year. These training sessions are offered as webinars or in-person. Past topics include:

- Supporting medication therapy (for non-prescribers)
- Motivational interviewing
- Referring patients for vocational rehabilitation, chemical dependency treatment, GAI or SBI, and other services
- Problem-solving treatment
- Managing psychiatric emergencies
- Challenging patients and dialectical behavioral therapy
- Managing patients with chronic pain

Roundtable Support and Discussion

Periodically roundtable discussions are held with care coordinators and/or case managers. The purpose of these sessions is to offer a forum for peer discussion and support and an opportunity for care coordinators to give feedback to program managers about challenges and best practices.

Schedules and Information

Information about upcoming trainings and materials from past trainings can be found in the Clinical section (password protected).
**Want to Learn More?**

Visit the AIMS Center website

http://uwaims.org

AIMS Academy
AIMS Center Webinars – Live!

Launching quarterly webinar series
– Implementation Examples
– Integrated Care Topics

Next webinar:
January 25, 2012
9-10AM Pacific Time

Mental Health Integration Program (MHIP): Lessons learned from over 100 community health clinics and over 35 mental health clinics providing integrated care to a variety of low-income populations.

Registration will open by November 18

http://uwaims.org
unutzer@uw.edu