Behavioral Health Aspects of Integrated Care

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Oregon Health & Science University
International Comparison: 10,000’ View

- National health system models (*The Healing of America*, T.R. Reid)
- US compares poorly with OECD countries (*Gapminder.org*)
- Impact of income inequality (*Spirit Level*, Richard Wilkinson)
Goal: Triple Aim
A New Vision For Health

1 Better health.
Can We Shift Focus To Population Health?

- Human Biology: 30%
- Environmental: 5%
- Social: 15%
- Lifestyle & Behavior: 40%
- Focus: Medical Care 10%
Time Urgency & a Cascade Of Unintended Health Consequences

THE FAST NEW WORLD
24/7 COMMERCIAL ACTIVITY
WITH 3 TIME ZONES
(LONDON, NEW YORK, TOKYO)

60-80 hour WORK WEEK

COMPETITION,
TIME URGENCY & STRESS

SLEEP DEBT & DISTURBED DAILY RHYTHMS

DIMINISHED IMMUNITY

VASCULAR DISEASE

CAFFEINE

FAST FOOD

REDUCED EXERCISE

OBESITY TYPE II DIABETES

ANXIETY & DEPRESSION

STARBUCKS 200-600mgs caffeine

Social Organization and Health Pathology in the Fast New World

Do not cite or reproduce content without appropriate citation.
America is at the leading edge of an unusual human experiment.

In 1975 Americans spent approximately 8% of GNP on health care and 15% on food. Today we spend 15% on health care and 8% on food.

But, in 5-8-12 NYT: “Bans on School Junk Food Pay Off in California”

The twentieth century may yet be remembered as one of monstrous mass feeding.

M. F. K. Fisher
Goal: Triple Aim
A New Vision For Health

2. Better care.
Better Care Elusive: Can We Get It Together?
Goal: Triple Aim
A New Vision For Health

2. Better care.
3. Lower costs.
Costs Shifting:
Still Crazy After All These Years

Change Eligibility

Those who do not fit into a category (Uninsured)

Employers and/or employees drop coverage

Public

Private

Pressure on State/Federal budgets

ED (uncompensated, expensive care)

Increase in premiums, co-pays, coinsurance

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Models for Integration

- Critical concepts:
  - Patient-centered Primary Care Home
  - Health Care Team
  - Stepped Care

- Care Model: redesign of care system for improved quality (How to organize these functions)

- Four Quadrant Clinical Integration Model: population/severity focused tool for identifying locus and intensity of care (Who does what, with whom, and where)
Patient-centered Primary Care Home

- Access To Care
- Accountability
- Comprehensive Whole Person Care
- Continuity
- Coordination And Integration
- Person And Family Centered Care
Patient-Centered
Primary Care Home (PCPCH) Attributes

ACCESS TO CARE
“Be there when we need you.”

ACCOUNTABILITY
“Take responsibility for making sure we receive the best possible health care.”

COMPREHENSIVE WHOLE PERSON CARE
“Provide or help us get the health care, information, and services we need.”

CONTINUITY
“Be our partner over time in caring for us.”

COORDINATION AND INTEGRATION
“Help us navigate the health care system to get the care we need in a safe and timely way.”

PERSON AND FAMILY CENTERED CARE
“Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness.”
## PCPCH Measures

<table>
<thead>
<tr>
<th>Access To Care</th>
<th>Continuity</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Person Access</td>
<td>Provider Continuity</td>
</tr>
<tr>
<td>Telephone and Electronic Access</td>
<td>Information Continuity</td>
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<tr>
<td>Administrative Access</td>
<td>Geographic Continuity</td>
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<td></td>
<td></td>
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<tr>
<td>Accountability</td>
<td>Coordination And Integration</td>
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<tr>
<td>Performance Improvement</td>
<td>Data Management</td>
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<tr>
<td>Cost and Utilization</td>
<td>Care Coordination</td>
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<tr>
<td></td>
<td>Care Planning</td>
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<td></td>
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<tr>
<td>Comprehensive Whole Person Care</td>
<td>Person And Family Centered Care</td>
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<tr>
<td>Scope of Services</td>
<td>Communication</td>
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<tr>
<td></td>
<td>Education and Self-Management Support</td>
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<td></td>
<td>Experience of Care</td>
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</tbody>
</table>

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Advanced Primary Care Home

- Mature performance improvement capacity and ability to manage populations of patients
- Accountable for quality, utilization and cost of care
- Meets most Tier 2 and Tier 3 measures and many “additional” measures

Intermediate Primary Care Home

- Demonstrates performance improvement
- Additional structure and process improvements
- Meets many Tier 2 or Tier 3 measures
- Meets some “additional” measures

Basic Primary Care Home

- “Foundational” structures and processes in place
- Meets all Tier 1 measures
Health Care Team

- Doctor-patient relationship replaced with team-patient relationship
- Team members share responsibility for patient care
- Role definition and interoperability
Stepped Care Principles

- Least disruptive
- Least extensive for positive results
- Least intensive for positive results
- Least expensive for positive results
- Least expensive in terms of staff training required to obtain results
Stepped Care Levels

1. Basic education: info sharing & referral to self-help resources
2. Clinicians provide psycho-educational & motivational support
3. BH specialists use specific practice algorithms
4. Referral to external specialty or higher level BH providers
Care Model

- Good outcomes result of productive interactions btw/informed, activated pt/family and prepared, proactive practice team
- Model developed by Wagner, et al, at Improving Chronic Illness Care
Informed, Activated Patient/family

Productive Interactions

Improved Outcomes

Community

Resources and Policies

Self-Management Support

Health System

Health Care Organization

Delivery System Design

Decision Support

Clinical Information Systems

Improved Outcomes

Do not cite or reproduce content without appropriate citation.
The Four Quadrant Clinical Integration Model

Quadrant II

BH \uparrow PH \downarrow

- BH Case Manager w/ responsibility for coordination w/ PCP
- PCP (with standard screening tools and BH practice guidelines)
- Specialty BH
- Residential BH
- Crisis/ER
- Behavioral Health IP
- Other community supports

Quadrant IV

BH \uparrow PH \uparrow

- PCP (with standard screening tools and BH practice guidelines)
- BH Case Manager w/ responsibility for coordination w/ PCP and Disease Mgr
- Care/Disease Manager
- Specialty medical/surgical
- Specialty BH
- Residential BH
- Crisis/ER
- BH and medical/surgical IP
- Other community supports

Quadrant I

BH \downarrow PH \downarrow

- PCP (with standard screening tools and BH practice guidelines)
- PCP-based BH*

Quadrant III

BH \downarrow PH \uparrow

- PCP (with standard screening tools and BH practice guidelines)
- Care/Disease Manager
- Specialty medical/surgical
- PCP-based BH (or in specific specialties)*
- ER
- Medical/surgical IP
- SNF/home based care
- Other community supports

Stable SMI would be served in either setting. Plan for and deliver services based upon the needs of the individual, consumer choice and the specifics of the community and collaboration.

*PCP-based BH provider might work for the PCP organization, a specialty BH provider, or as an individual practitioner, is competent in both MH and SA assessment and treatment.
Implementation Tasks

- Complete environmental scan
- Determine program’s capacity and “filters”
- Establish administrative and clinical leadership “buy-in”
- Decide whether to rent or own BH staff
- Determine staffing pattern and BH tasks
- Define BH specialist skills
Clinical Tasks

- Triage
- Comprehensive assessment
- On-site treatment
- Referral
- Consultation
- Care monitoring & condition management
- Treatment/medication optimization
- The key is balanced management of these tasks!
Staffing the Model

- Behavioral health professional (Masters or higher)
- Psychiatric provider (for diagnostic and tx insights, not just for meds)
- Non-BH personnel trained to provide specific support functions
Utilization of Non-Traditional Health Workers: Community Health Workers, Peer Wellness Specialists, Personal Health Navigators

<table>
<thead>
<tr>
<th>Role</th>
<th>Supplemental Training Elements</th>
<th>CHW</th>
<th>PWS</th>
<th>PH Nav.</th>
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</thead>
<tbody>
<tr>
<td>1. Outreach and Mobilization</td>
<td>Self-Efficacy</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>1.</td>
<td>Community Organizing</td>
<td></td>
<td>X</td>
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<tr>
<td>1.</td>
<td>Group Facilitation Skills</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>1. Community and Cultural Liaising</td>
<td>Conducting Community Needs Assessments</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Case Management, Care Coordination and System Navigation</td>
<td>No training elements recommended beyond core that applies to all three worker types</td>
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</tr>
<tr>
<td>1. Health Promotion and Coaching</td>
<td>Popular Education Methods (Community Health Workers)</td>
<td></td>
<td>X</td>
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<tr>
<td>1.</td>
<td>Cultivating Individual Resilience (Peer Wellness Specialists)</td>
<td></td>
<td></td>
<td>X</td>
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<tr>
<td>1.</td>
<td>Recovery Model (Peer Wellness Specialists)</td>
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<td>X</td>
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<tr>
<td>1.</td>
<td>Healthcare Best Practices (specific to fields of practice)</td>
<td></td>
<td>X (specific to field of practice)</td>
<td>X (specific to field of practice)</td>
</tr>
<tr>
<td>1.</td>
<td>Wellness within a specific disease (Personal Health Navigator)</td>
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<td>X</td>
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<tr>
<td>1.</td>
<td>Basic health screenings (e.g. blood pressure measurement)</td>
<td></td>
<td>X (specific to job role)</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Motivational interviewing</td>
<td>X</td>
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Psychiatric Providers in Integrated Care

- Integrated care will be an increasingly more prominent component of the care system.
- Roles for psychiatric providers in integrated care:
  - Complex case assessment
  - Limited direct patient care
  - Curbside and case-specific consultation with PCPs, BH providers, and care teams
  - Guidance re when and how to utilize meds: treatment optimization
  - Clinical supervision and training
  - Team and systems level administrative, policy, and service coordination functions
- Workforce training implications: We must train psychiatrists to be competent, creative, collaborative, and adaptive members of integrated care systems!
Motivational Interviewing and Stages of Change

- Applicable to a wide range of chronic illnesses
- Focused on activating patients to develop their own goals
- Tied to recognizing a patient’s level of engagement and readiness to acknowledge existence and impact of health care condition, but also to identify other barriers to change.
Impact of Trauma

- Interdependence btw/ accumulated traumatic experiences and manifestations of physical, mental, and substance use symptoms.
- High prevalence of trauma-related experiences in high utilizing (hot-spotter) populations
- High incidence of dismissive stigma → denial of appropriate care
- Need for trauma-informed and trauma-sensitive care throughout the care system
Treatment Optimization

- Recovery-oriented method that supports judicious use or non-use of psychotropic meds.
- Balanced with other effective, recovery-based services and supports.
- Primary goal is to improve/maximize self-determination, functioning, & quality/meaning of life.
- May include postponing/avoiding use of meds, sensitive & collaborative initiation of meds, timely med tapering/withdrawal, and regular reassessment to guide shared decisions re med adjustments.
Guiding Principle
(stolen from the feminist wo-manifesto)

The psychiatrist who most needs liberating is the psychiatrist in every primary care provider.

The primary care provider who most needs liberating is the primary care provider in every psychiatrist.
The Grand Finale: Better Health, Better Care, Lower Cost
How to Cite this Presentation:


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