# Behavioral Health and General Health Integration:

## Drowning in the Mainstream or Left on the Banks?

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# Disclosure

- No relevant commercial interests

# Top 10 Questions/Issues

1. Why? Importance of the MH/GH interface
2. Balance: Assessing both sides of the interface
3. Siloism (and Fear of Phagocytosis)
4. Barriers: What? Who? How? Why?
5. Building models that work
6. “Measurement-Based Care” as clinical core
7. Key strategies at organizational levels: Continuums
8. Key strategies at policy levels
9. “Shared Accountability” as a core concept
10. Building a quality measurement infrastructure

# 1.Importance of the interface

## Global Burden of Disease 2020 (DALYs)

1. Ischaemic heart disease
2. Unipolar major depression
3. Road traffic injuries
4. Cerebrovascular disease
5. Chronic obstructive pulmonary disease
6. Lower respiratory infections
7. Tuberculosis
8. War
9. Diarrhoeal diseases
10. HIV

**DALY = Disability-adjusted life year**

Source: WHO

# Leading Causes of Years of Life Lived with Disability (YLD) in 15- to 44-Year-Olds (WHO)

| | | % total |
|---|---|---|
| 1 | Unipolar depressive disorders | 16.4 |
| 2 | Alcohol use disorders | 5.5 |
| 3 | Schizophrenia | 4.9 |
| 4 | Iron-deficiency anemia | 4.9 |
| 5 | Bipolar affective disorder | 4.7 |

# Costs

Faces of Medicaid” White Paper:

“Mental illness is nearly universal among the highest cost, most frequently hospitalized Medicaid beneficiaries”

Center for Healthcare Strategies (2010)

# Waste

- 30 million receive a prescription for a psychiatric medication in primary care
- Only 1 / 4 improve.

# BH/GMC Clinical Examples

- 25 year old HIV+ female IV drug user with PTSD
  - Frequent ED visits, non adherence to meds, increased medical costs
- 60 year old female with diabetes, CHF and depression
  - Frequent (re-) hospitalizations, poor self management and adherence, early candidate for LTC
- 35 year old male with schizophrenia, diabetes, and tobacco dependence
  - Can expect up to 25 year shortened life span, increased medical costs

# 2. Assessing both sides of the interface

- Patients primarily in contact with the general medical sector with co-morbid BH conditions (e.g., depression, substance abuse)
  - Not identified or treated as acute problems with little follow-up
- Patients with severe and persistent BH conditions (e.g., schizophrenia, bipolar disorder) and treated in BH specialty settings
  - Poor self-care, medications worsen general medical conditions
  - Limited provider capacity and incentives for
    - Accessing treatment of co-morbid medical conditions
    - Preventive and wellness care
- Medical and BH providers operate in silos

# 3.a. Siloism and….


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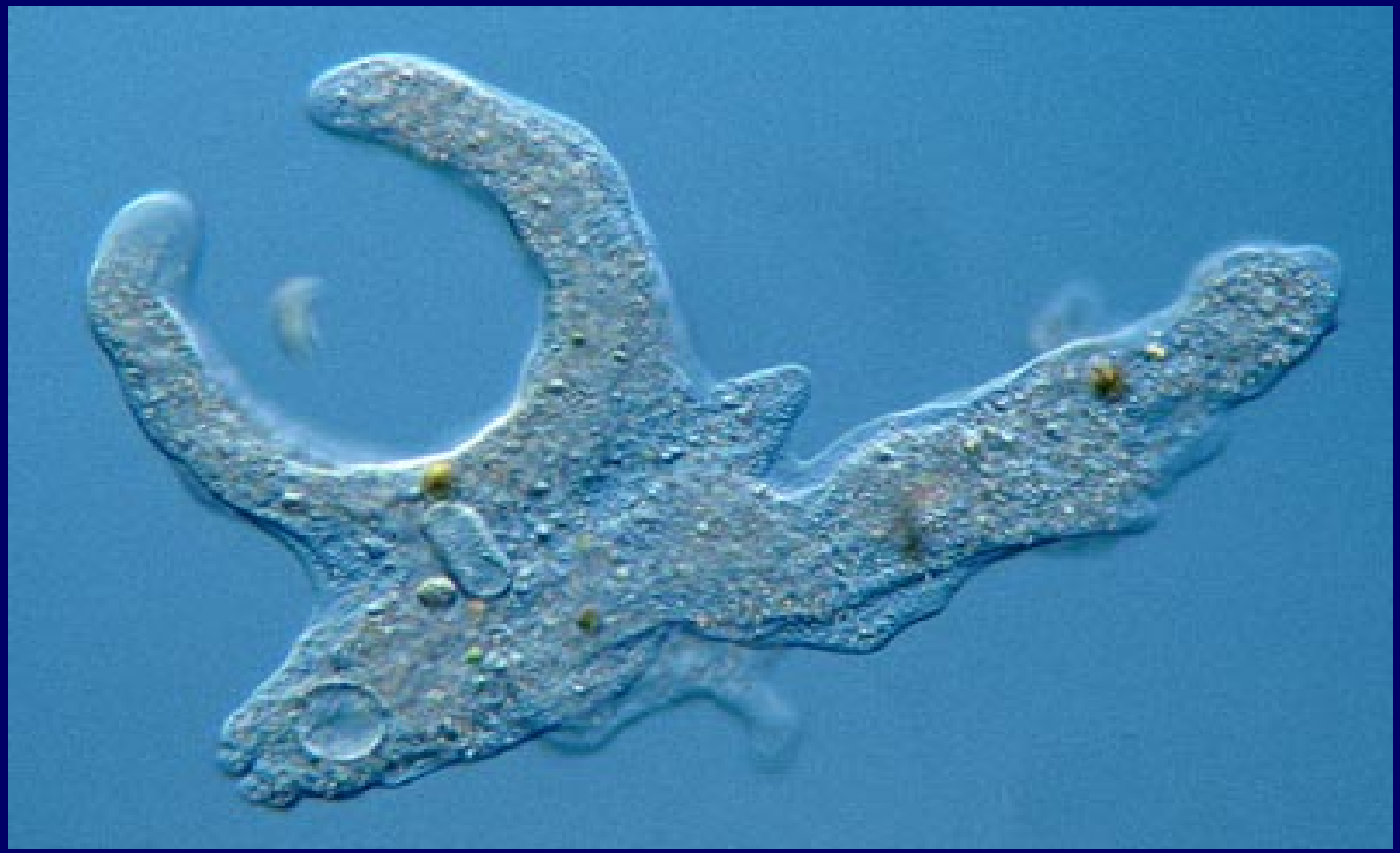
# 3.b….and Fear of Phagocytosis



# 4. Barriers: Key Conceptual Questions

- What?
- Who?
- How?
- When?
- Why not?
  - History, Stigma, Dualism, Culture, Policy
- Why?

# What do we call these things?

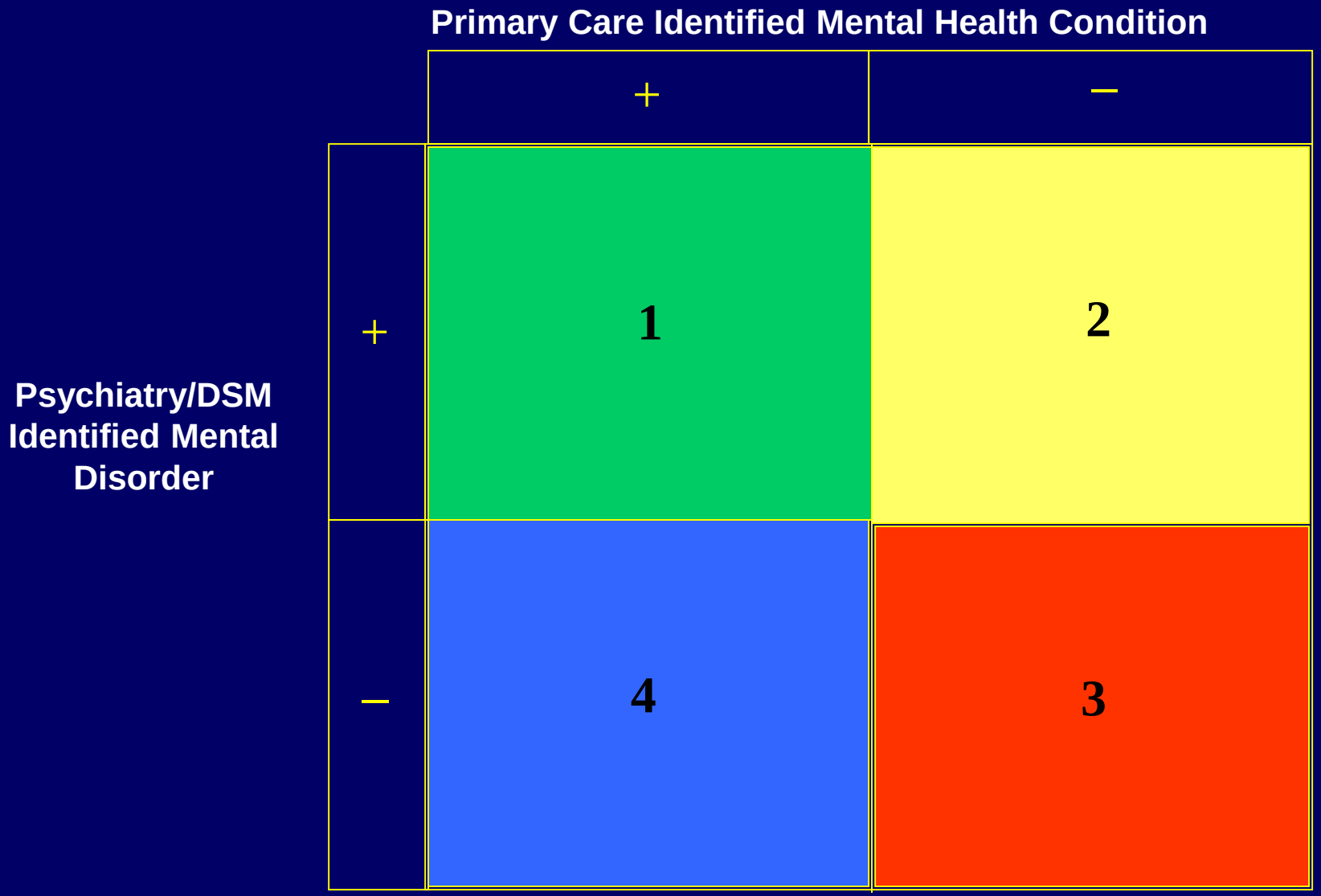
## Selected Terms Describing the "Subject of this Presentation"

| Adjectives | Nouns |
| --- | --- |
| Mental | Disorders |
| Behavioral | Illnesses |
| Emotional | Diseases |
| Social | Conditions |
| Psychological | Problems |
| Psychosocial | Factors |
| Biopsychosocial | Issues |
| Addictive/substance-related | Treatments |
| Cognitive | Interventions |
| Stress-related | Health |
| Maladaptive | Variation |
| Brain | Morbidity |
| Nervous | |
| Developmental | |

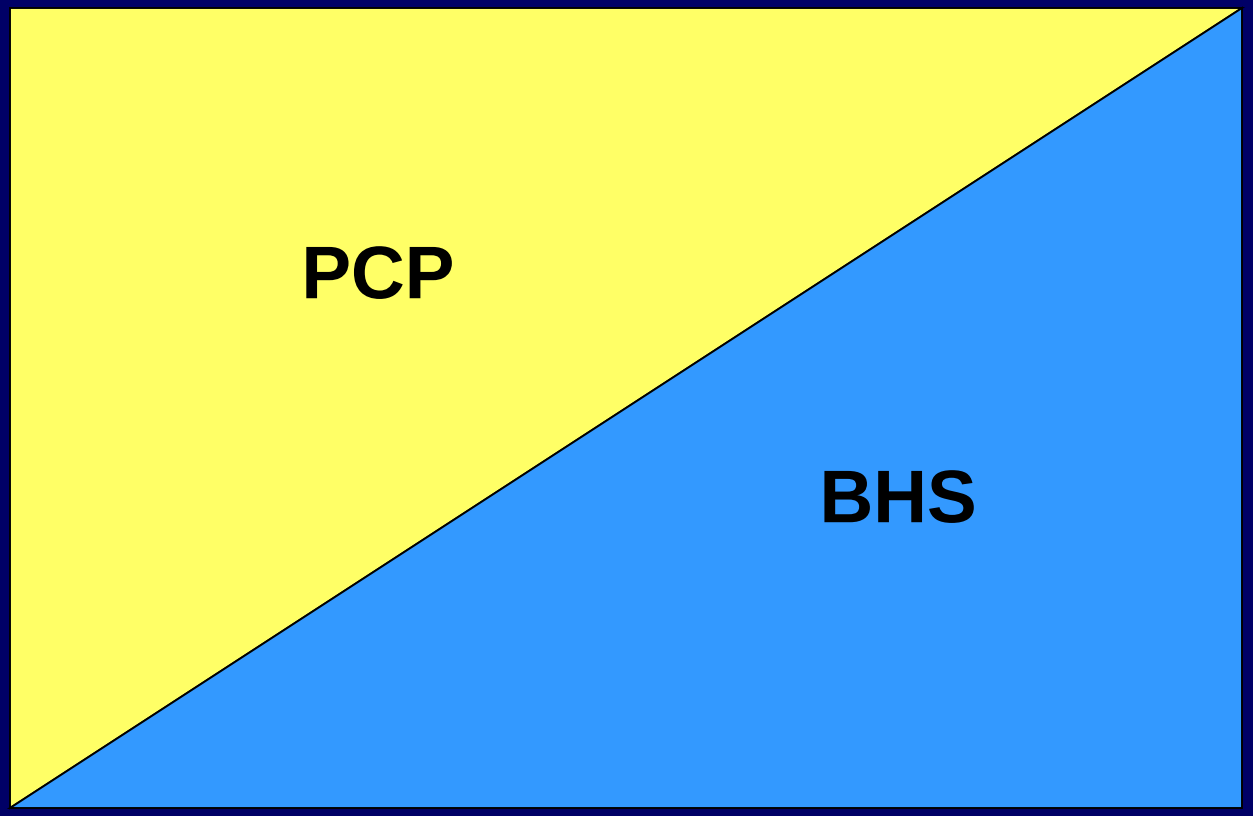
# What do we call "Non-Behavioral" Conditions?

- Organic Diseases
- Physical Illnesses
- Medical Disorders
- General Medical Conditions
- Other Medical Conditions

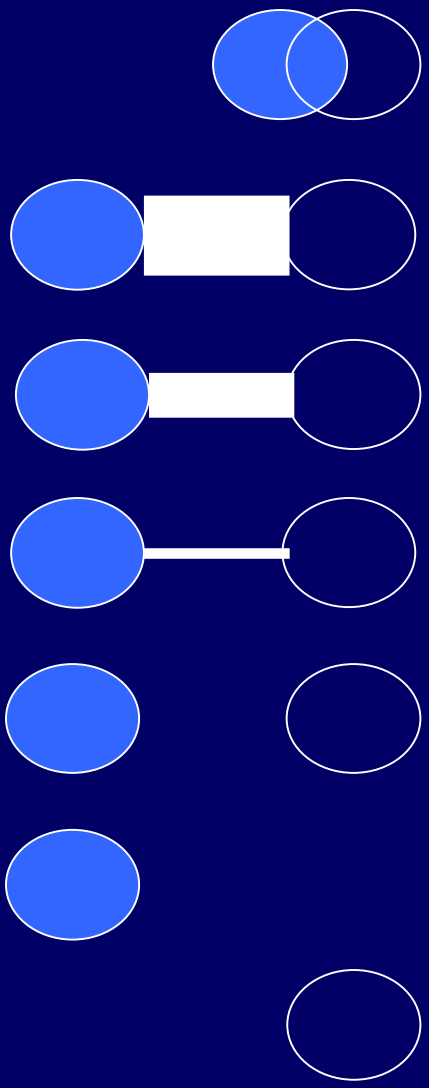
# PCP vs. DSM Frameworks



# Who Is responsible for care?



# How are providers connected?



- Integrated Team
- Collaborative Care
- Consultative Care
- Referral
- Independent
- Autonomous (PCP)
- Autonomous (MHS)

# When is care provided?

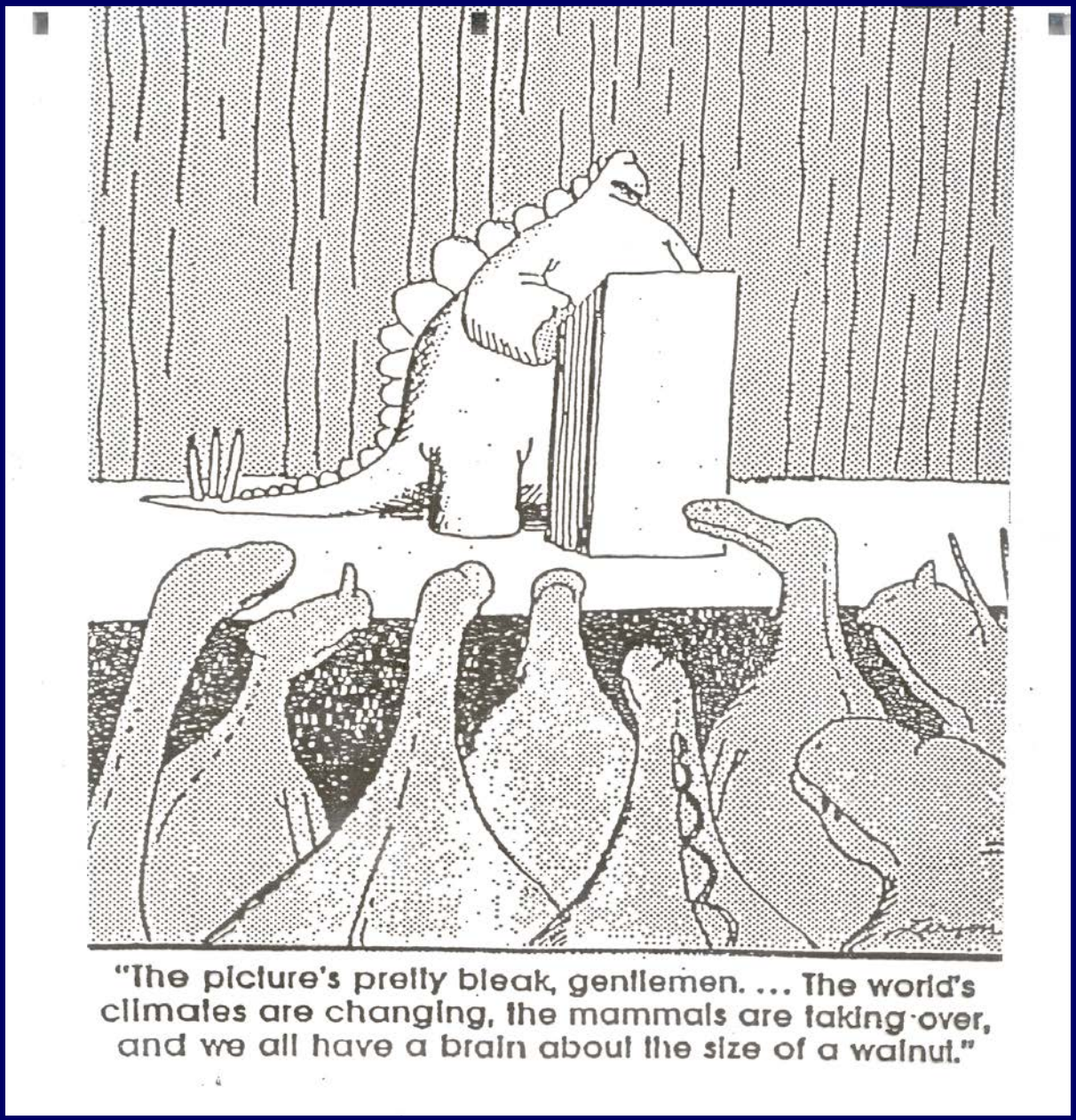
| Risk Factor Identification/ Prevention | Diagnosis/ Assessment | Short-term Management | Continuing Care |
|---|---|---|---|

# Why Not?

- Mind-body dualism
- Stigma
- No lab tests/Few procedures
- Legal/regulatory distinctions (e.g., privacy/coercion)
- Separate delivery systems (FQHC v. CMHC)
- Different diagnostic systems (ICD v. DSM)
- Different financing systems (MCO v. MBHO)
- Costs are hidden (Direct BH costs 5-7%)
- Effective clinical, organizational and policy solutions exist

# Why?

- It’s the patient, stupid!



"The picture's pretty bleak, gentlemen. ... The world's climates are changing, the mammals are taking over, and we all have a brain about the size of a walnut."

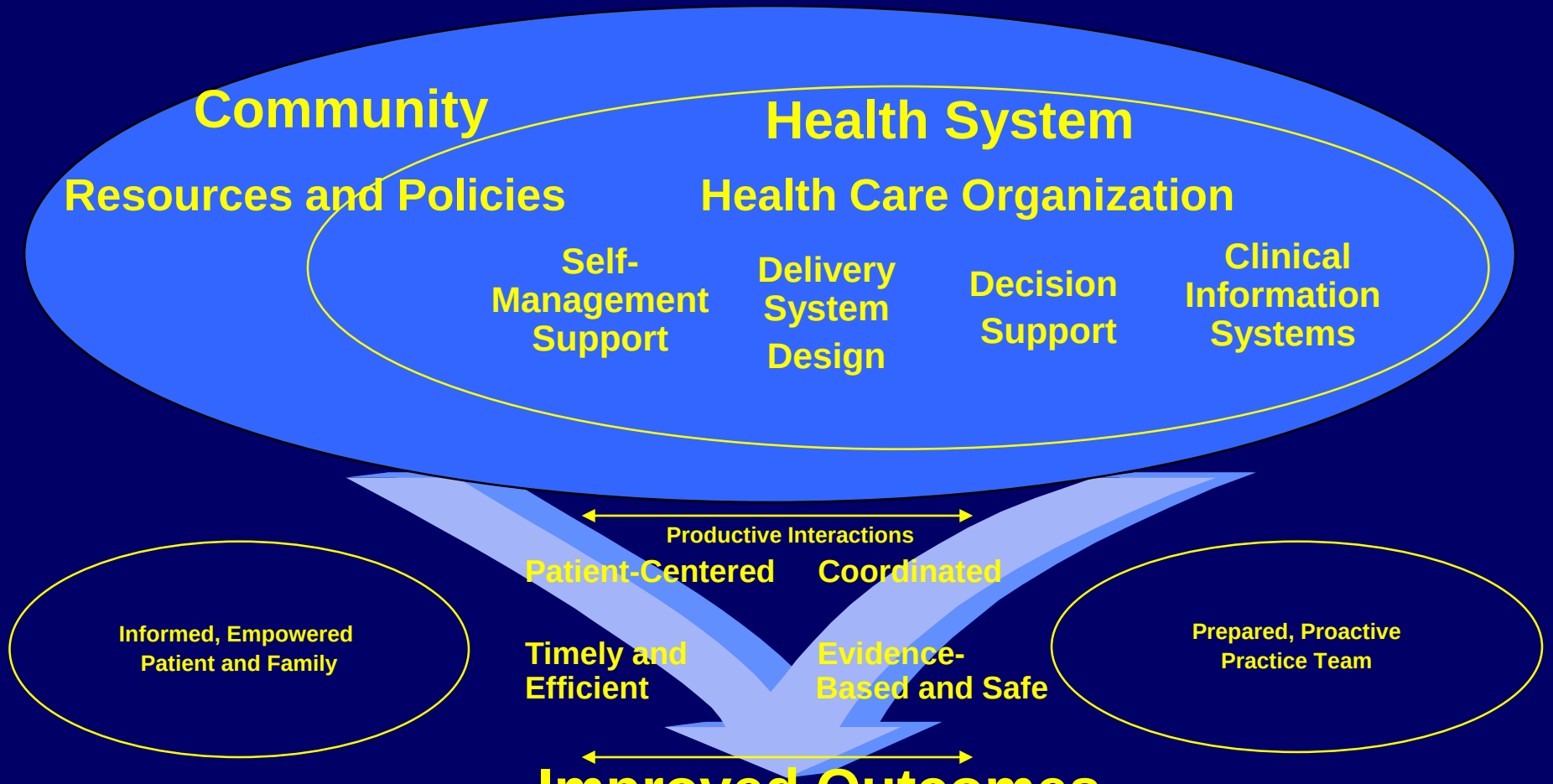
# How do we evolve into mammals?

Or

Can we implement effective “integrated care”?

# 5. Building models that work

## The Chronic Care Model



# Selected Tested BH/GH Models

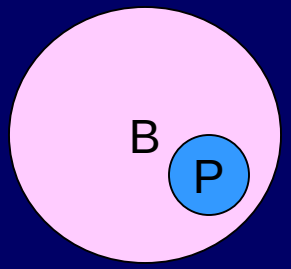
- Collaborative care – Katon
- Partners in Care (AHRQ) – Wells
- PROSPECT – Alexopoulous, Katz, Reynolds
- Telephone care management – Simon, Hunkeler
- IMPACT (Hartford) – Unutzer
- RESPECT (MacArthur) – Dietrich
- Quality Improvement for Depression (NIMH) – Rost, Ford, Rubenstein
- RWJF National Program/Clinical & Economic– Pincus
- Child models – Campo, Asarnow, GLAD-PC
- PCARE – Druss
- CALM – Roy-Byrne
- RESPECT-Mil/STEPS-UP – Engel
- SUMMIT- Watkins

# 5. Building models that work: Key Questions

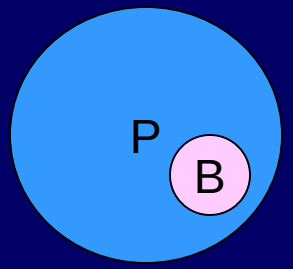
- For Whom?
  - Specify the population
- Do What?
  - Specify the services provided
- Where?
  - Which professionals are in which settings
- How?
  - Clinical, Organizational, Policy Strategies

# Key Question 3: WHERE?

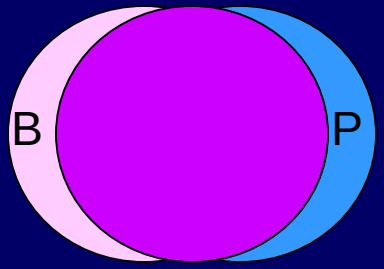
**Embedded PCP in BHS**



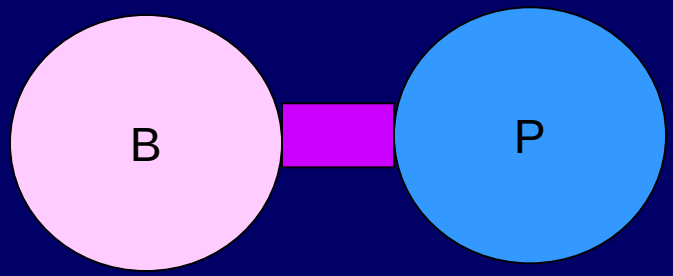

**Co-location of BHS in PC**




**Unified**




**Coordination / Collaboration**



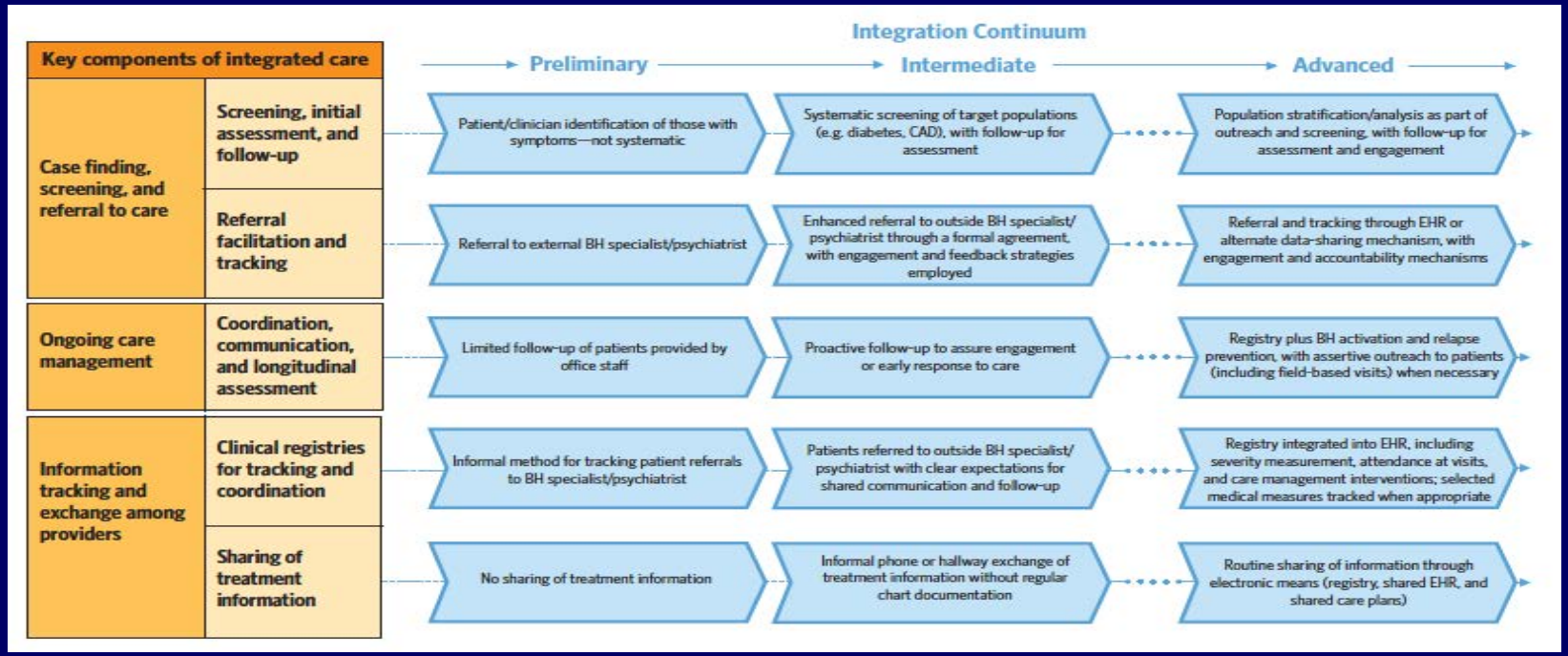
# In the “Cloud”?

# 6. How: Measurement-Based Care (Clinical Level)

- Systematically apply appropriate clinical measures
  - e.g. HA1c, PHQ-9, Vanderbilt Assessment Scales
  - Create a measurement tool kit
- Assure consistent, longitudinal assessment
  - “Ruthless” Follow-Up/Care Management
- Use action-oriented menu of evidence-based options
  - Treatment intensification/“Stepped Care”
- Establish practice-based infrastructure
  - Build IT/Registry Capacity
- Enhance Clinical Connectivity among Systems
  - MH/PC/SUD/Social Services/Education

# 7. How: Key Strategies at Organizational Levels

## Continuum-Based Framework
(Chung, Rostanski, Glassberg, Pincus: UHF, 2016)



# 8. How: Key Strategies at Policy Levels

- Disseminate best practices
  - D&I science/learning health systems
- Support Infrastructures that produce outcomes
  - PCMH+, PBHCI, CCBH
    - Flexible funding
  - Develop HIT infrastructure
    - For effective communication and measurement
  - Build bridges to “non-health” services
    - Transportation, Housing, SUD, Dental, CJ, SS
- Establish “Shared Accountability”
  - Implement integrated care measures
  - At multiple levels
- Realign financial and non-financial incentives
  - Alter contractual/organizational arrangements between/among Providers and Payers

# “6 P” Conceptual Framework

| | |
|---|---|
| **Patient/ Consumer** | • *Link with community resources*<br>• *Enhance self-management/participation*<br>• *Evaluate preferences and change behaviors* |
| **Providers** | • *Improve knowledge/skills*<br>• *Provide decision support*<br>• *Link to specialty expertise and change behaviors* |
| **Practice/ Delivery Systems** | • *Establish chronic care model and reorganize practice*<br>• *Link with improved information systems*<br>• *Adapt to varying organizational contexts* |
| **Plans/Payers** | • *Enhance monitoring capacity for quality/outliers*<br>• *Develop provider/system incentives*<br>• *Link with improved information systems* |
| **Purchasers (Public/Private)** | • *Educate regarding importance/impact of depression*<br>• *Develop plan incentives/monitoring capacity*<br>• *Use quality/value measures in purchasing decisions* |
| **Populations and Policies** | • *Engage community stakeholders; adapt models to local needs*<br>• *Develop community capacities*<br>• *Increase demand for quality care enhance policy advocacy* |

# 9. Shared Accountability
## Breaking Down Silos

- Relatively simple concept
- Applies to all participants caring for a patient
- For example, PCP is jointly responsible for assuring quality for both GH and BH care
- BHS is jointly responsible for assuring quality for both BH and GH care
- The same applies to Med/Surg Health Plan and BH Carveout
  - (GP Commissioners and MH Commissioners)
- Instantiated in training, practice, contracts, performance incentives……

……..And, ultimately, culture

# 10: Building a Quality Measurement Infrastructure:
## Engaging the Quality Measurement Industrial Complex

# A Reality Check

- How do YOU choose a doctor for yourself, your children, your parents?
- How do YOU choose a mental health provider for your children or suggest one for a friend or a family member?
- How do YOU determine whether your children are receiving high quality medical care?
- High quality mental health care?
- What DATA do you examine to answer these questions? What data do you WISH you had?

# It's all about BH/ GM Care Integration

## Commonwealth Fund Project

ISQua®

*International Journal for Quality in Health Care*, 2017, 1–7
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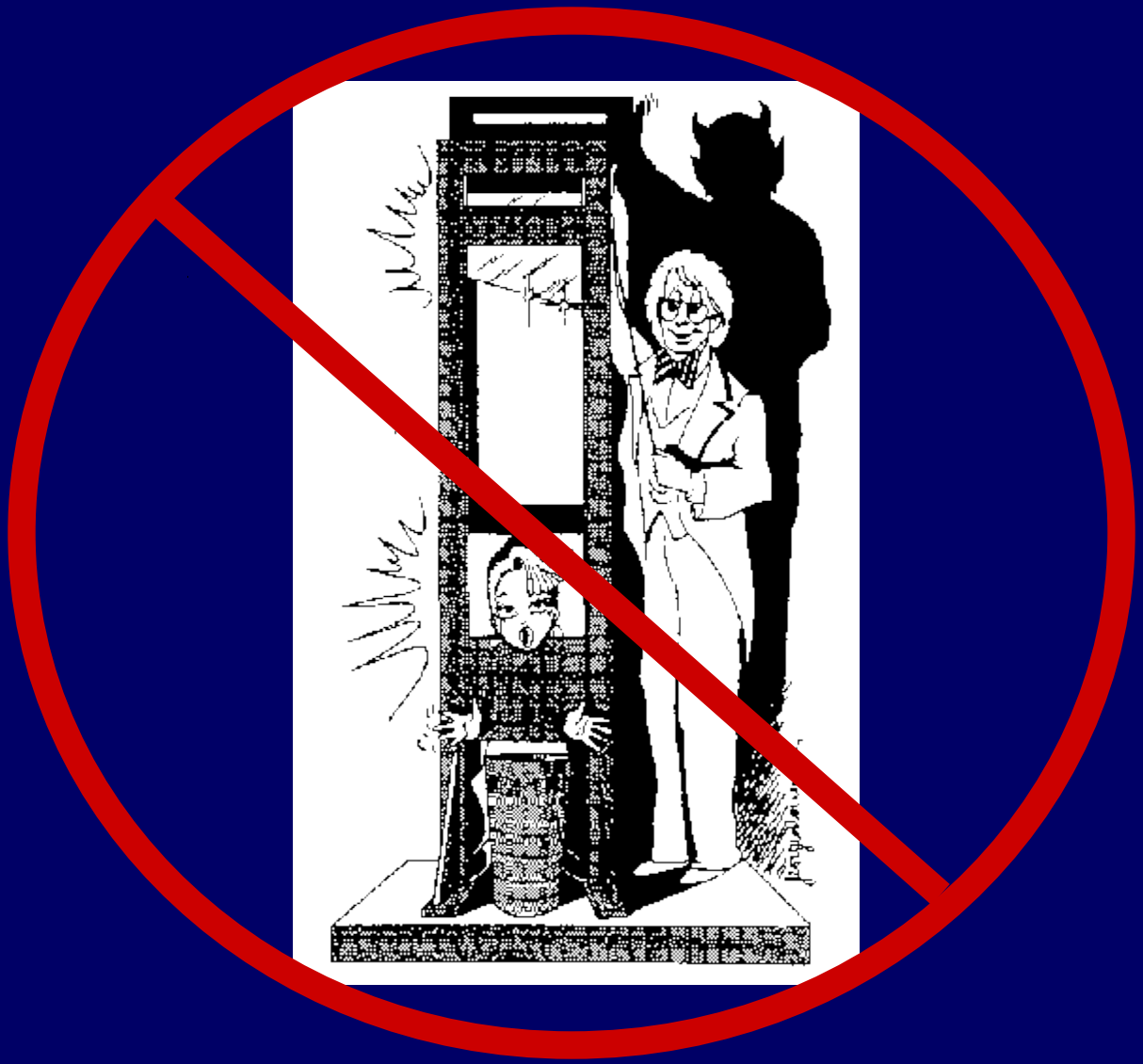
Article

Article

### Prioritizing quality measure concepts at the interface of behavioral and physical healthcare

HAROLD ALAN PINCUS[1,2], MINGJIE LI[3], DEBORAH M. SCHARF[4], BRIGITTA SPAETH-RUBLEE[3], MATTHEW L. GOLDMAN[3,5], PARASHAR P. RAMANUJ[6], and ERIN K. FERENCHICK[7]



# Don’t Split Mind and Body

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# Back-up Slides