Integration with Primary & Specialty Medical Care

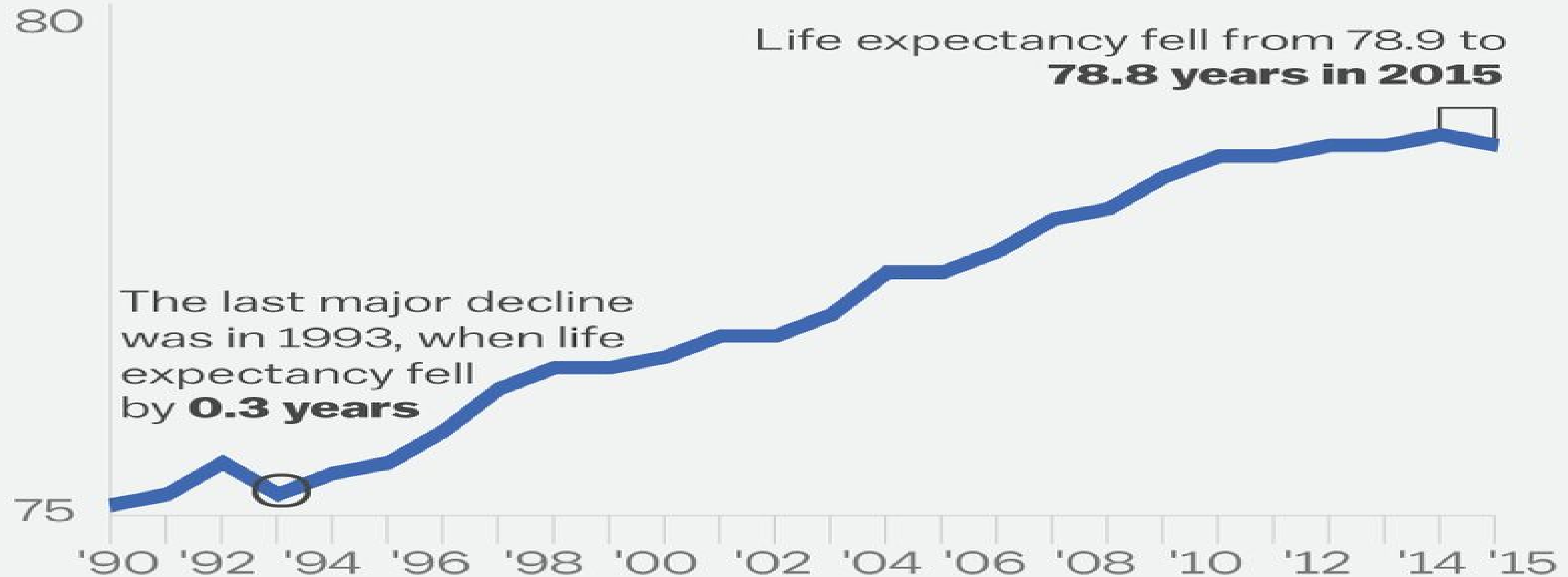
Opportunities and Challenges for Behavioral Health

NAADC-Denver, CO

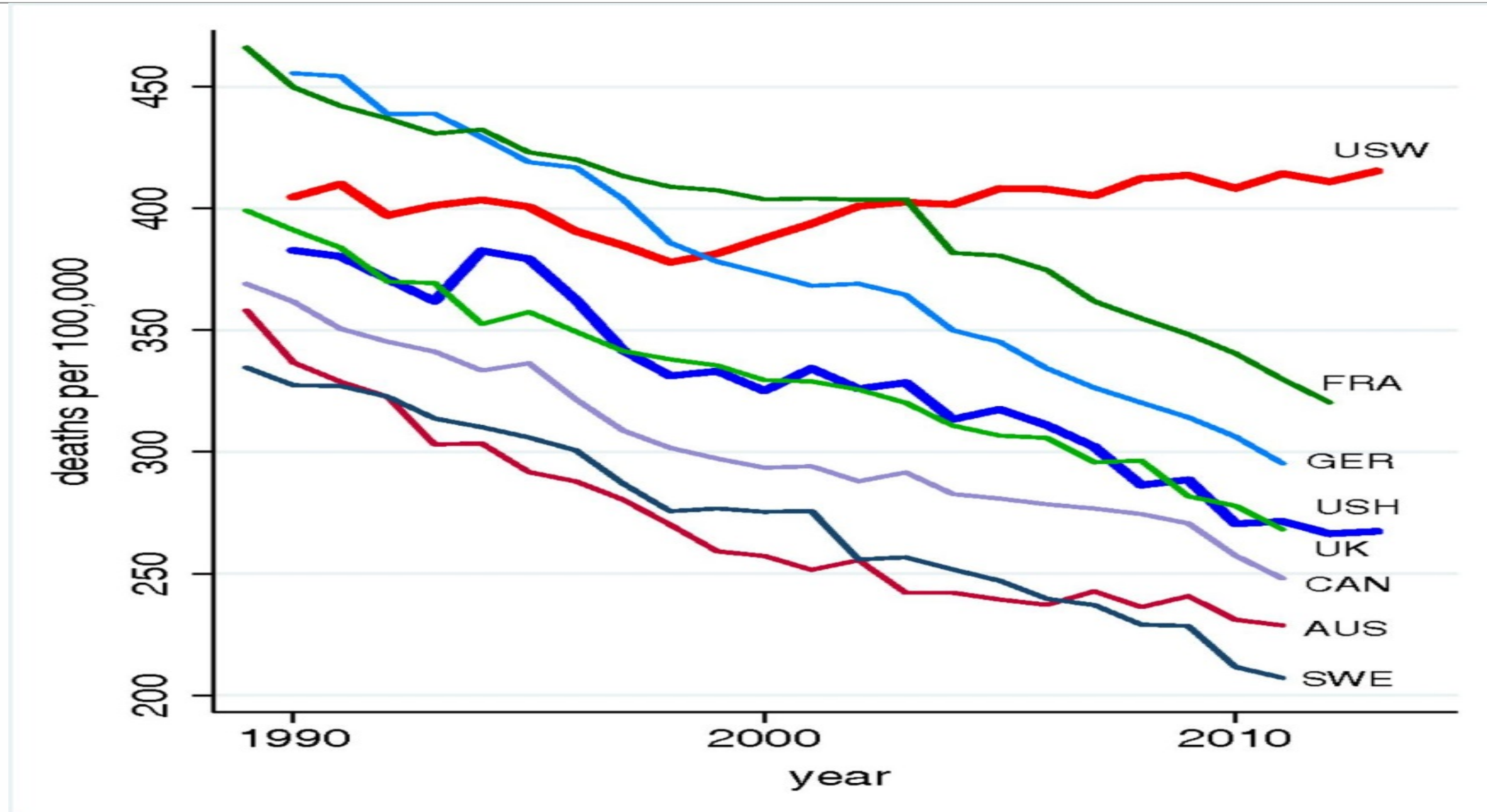
September 2017

What we Hope to Learn Today

- Why is Integration Important?
- Models or Phases of Integration/
- How is it Different?
- What Skills Do I Need?
- Barriers and Challenges

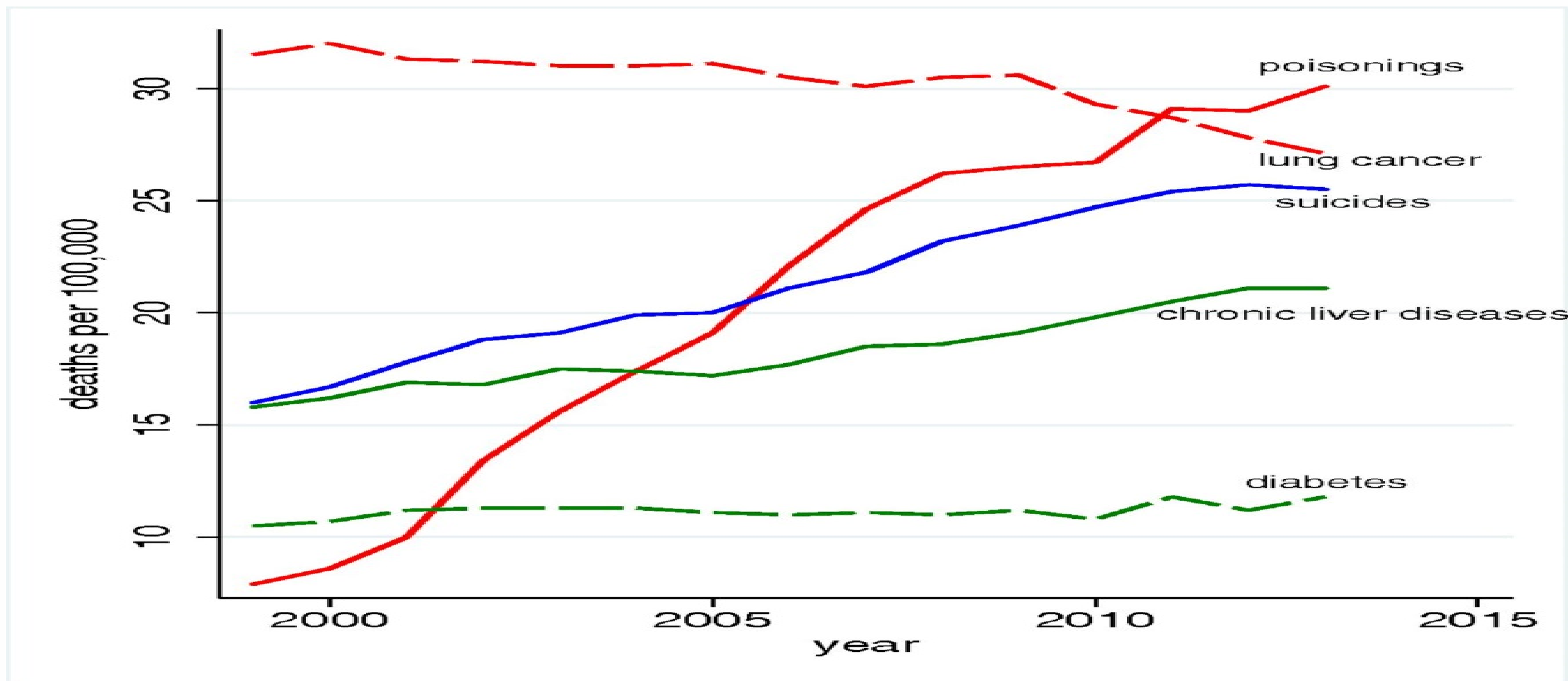

Life expectancy has improved in the US, but a 2015 dip shows that might be changing
80
75
Life expectancy fell from 78.9 to
78.8 years in 2015
The last major decline
was in 1993, when life
expectancy fell
by 0.3 years
'90 '92 '94 '96 '98 '00 '02 '04 '06 '08 '10 '12 '14 '15
Source: National Vital Statistics System
Credit: Sarah Frostenson
Vox

All-Cause Mortality, Ages 45–54



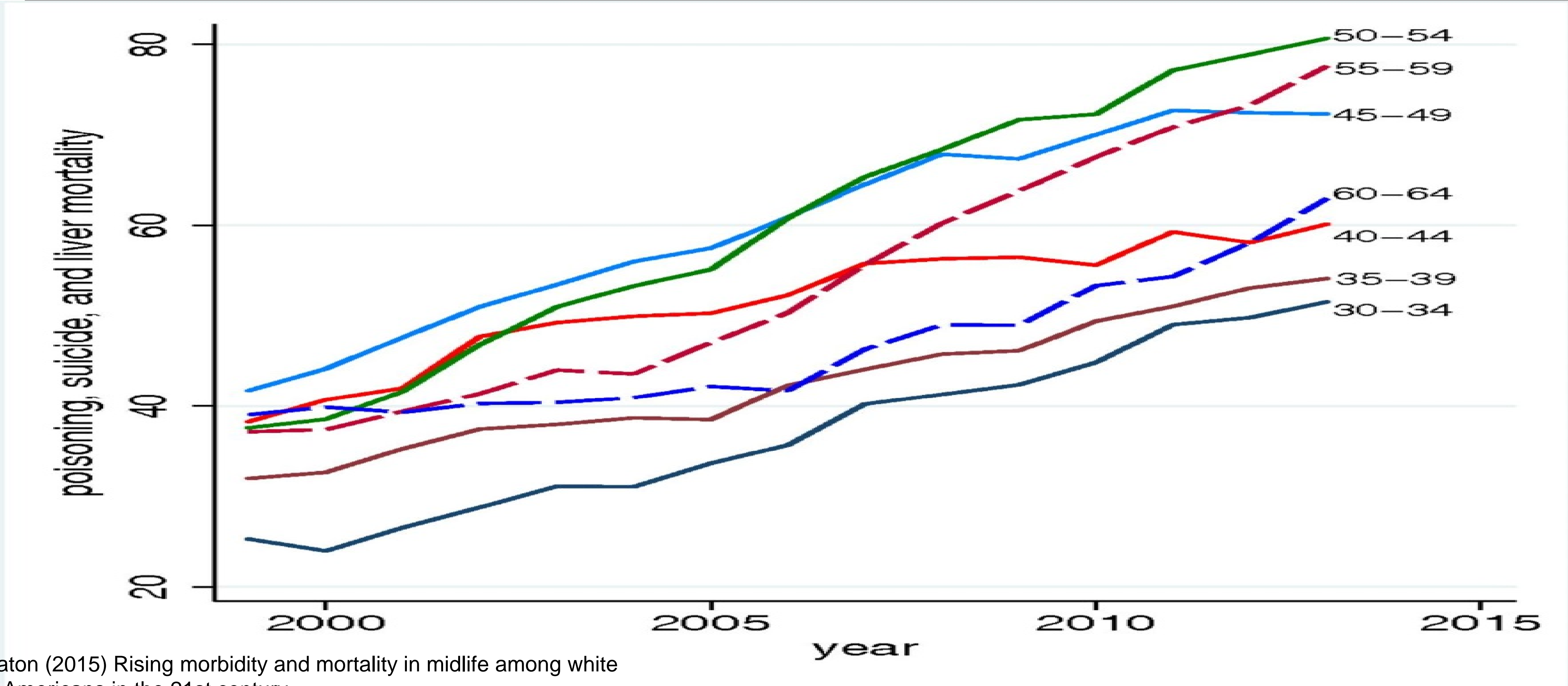
Case and Deaton (2015) US White non-Hispanics (USW), US Hispanics (USH), and six comparison countries: France (FRA), Germany (GER), the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE).

Mortality by Cause, White non-Hispanics ages 45–54



Case and Deaton (2015) Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century

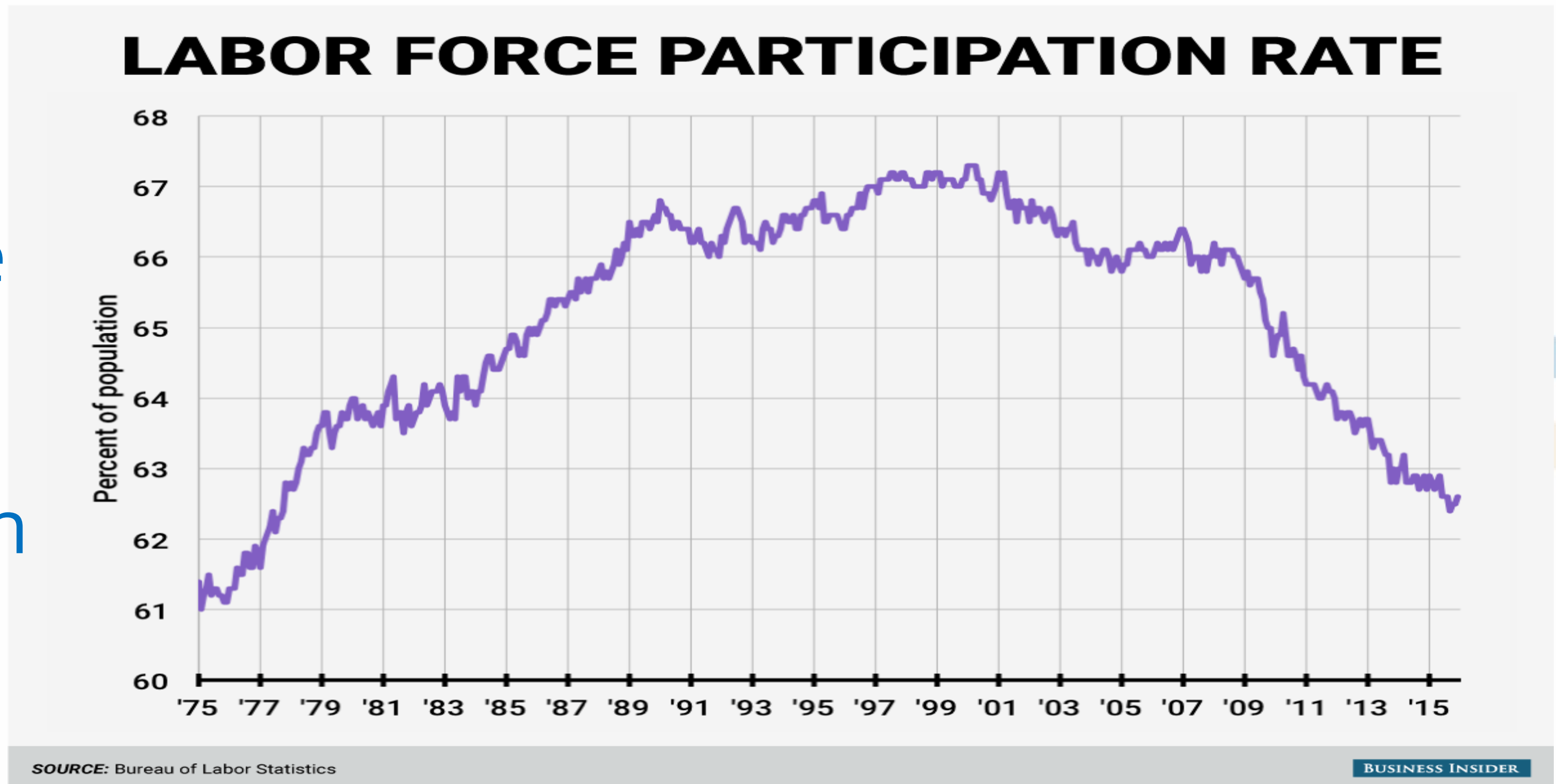
Mortality by Poisoning, Suicide, Chronic Liver Disease, and Cirrhosis, among White non-Hispanics



Case and Deaton (2015) Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century

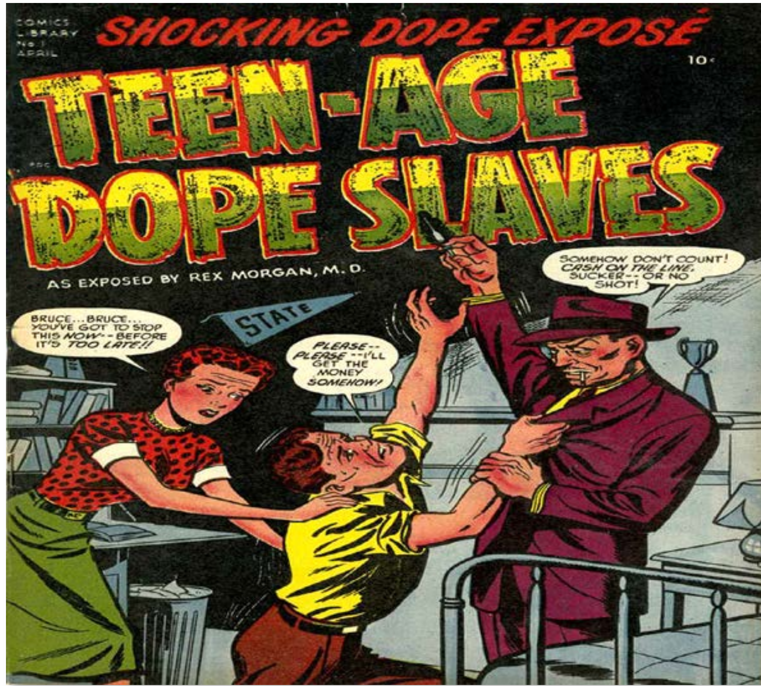
Economic Impact of Opioid Use

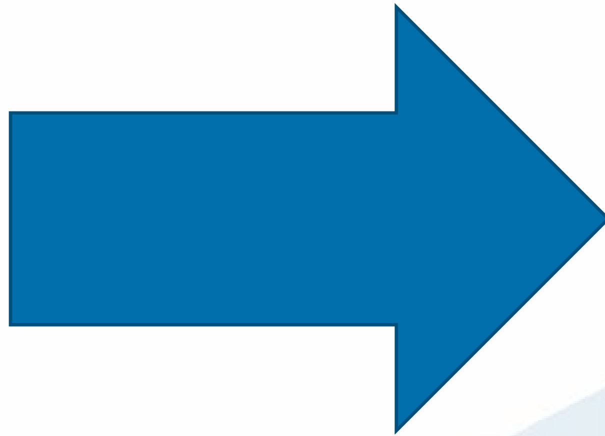
50% of prime age men who are **not** in the labor force take pain medication on a daily basis



Kreuger, A. 2016

We’ve Come a Long Way





Moral Model **Brain Disease**

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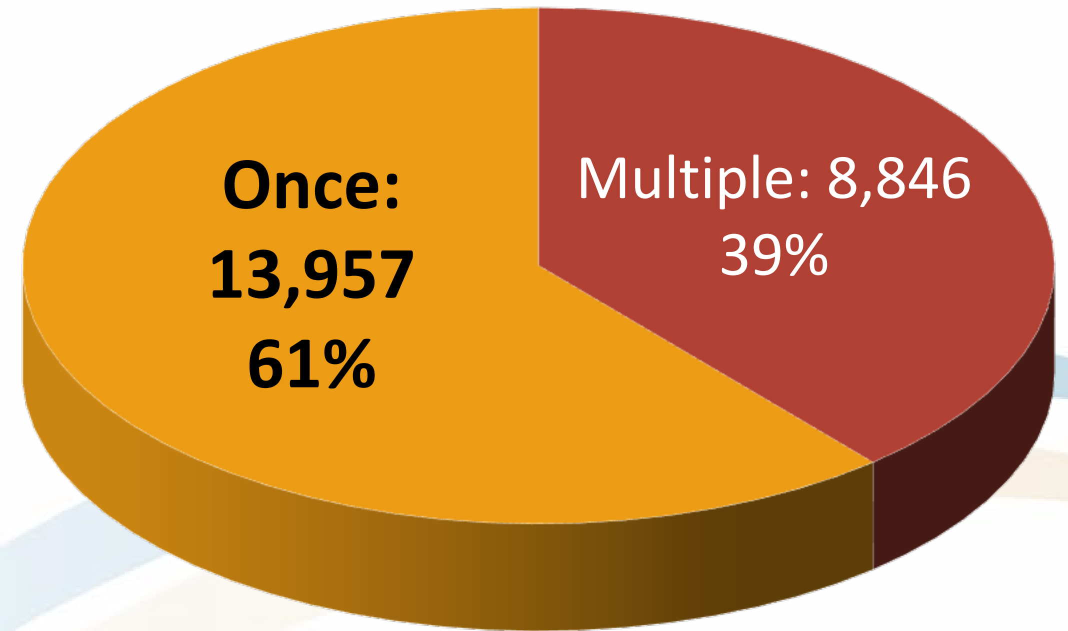
But Not From This…

Acute Care Model



2015 MA Detox Admits

IOM Quality Chasm 2003 Report

"Current care system can't do job"

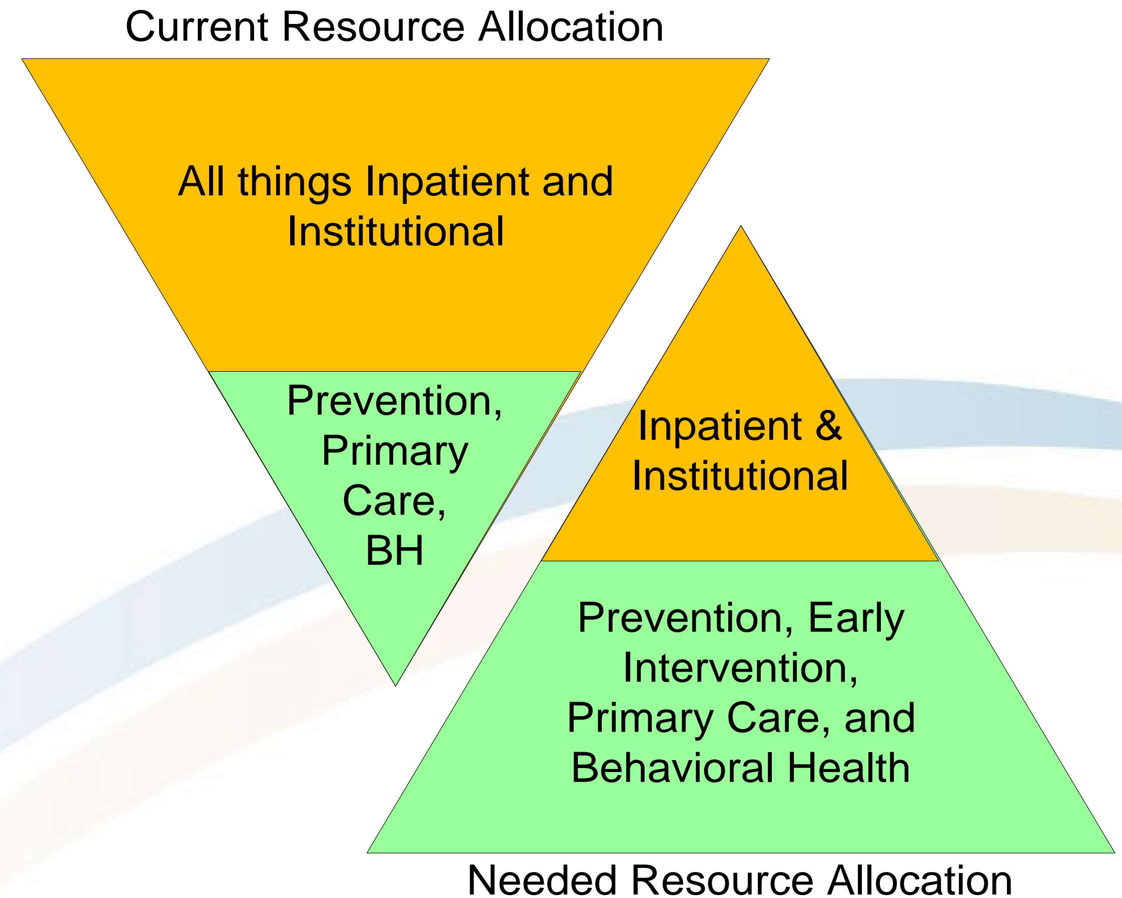
"Trying harder (doing same thing) will not work"

"Changing care systems will/might"

Healthcare Reform Task: Inverting the Triangle

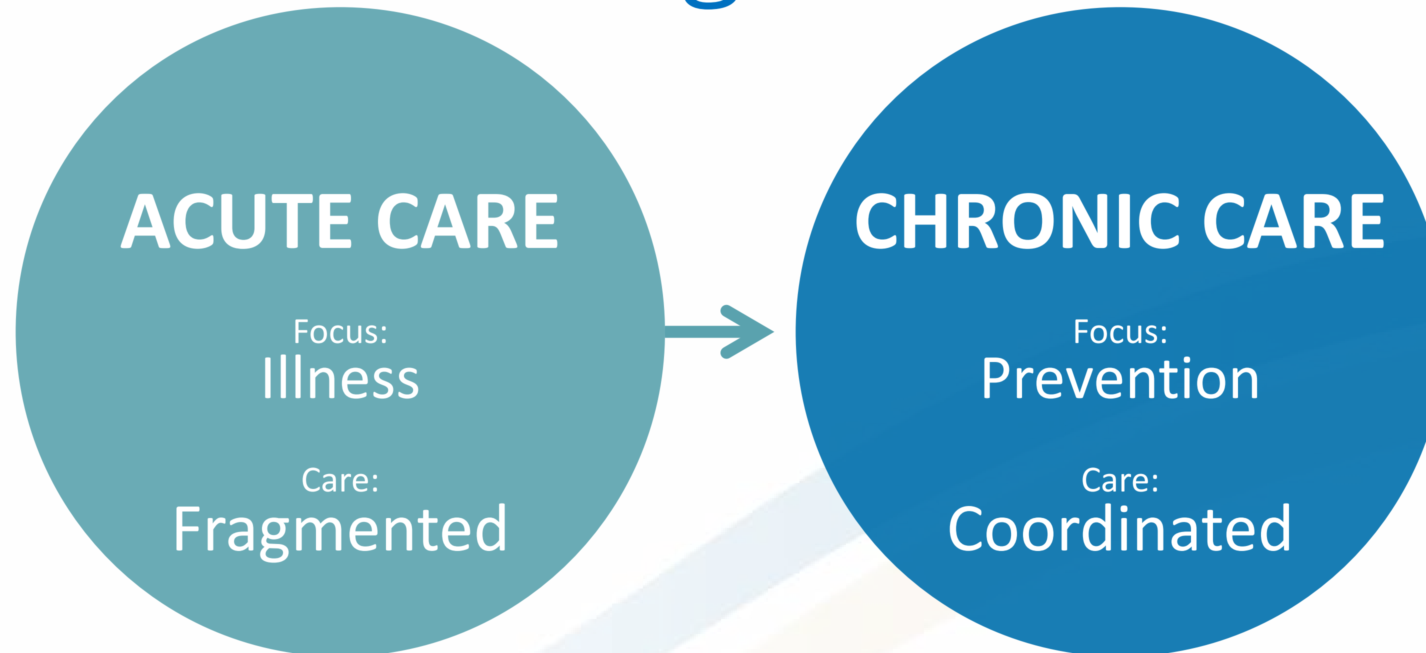
Realigning Resources

Inpatient and Institutional Care are limited; Chronic conditions are care coordinated; and spending is slowed



Transition in Health Care

Paradigm Shift



Factors Compelling Integration

- System can't accommodate demand or need
- More seek help in Primary Care
- SUD: 20% get care; Diabetes 84% get care
- Failure of Referral Conversions
- Stigma Endures
- Behavioral Factors in Chronic Management

National Supply and Demand, All Behavioral Health Practitioner Categories, 2013 and 2025

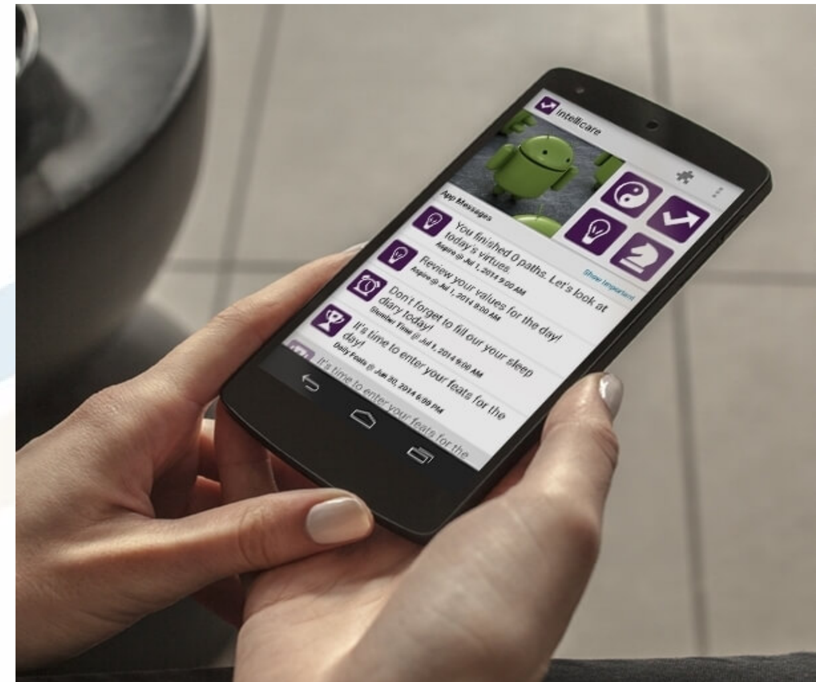
	2013 Estimates Scenario Two			2025 Projections Scenario Two		
Practitioner	**Supply**	**Demand**	**Difference**	**Supply**	**Demand**	**Difference**
Psychiatrists	45,580	56,980	-11,400	45,210	60,610	-15,400
Behavioral Health Nurse Practitioners	7,670	9,590	-1,920	12,960	10,160	2,800
Behavioral Health Physician Assistants	1,280	1,600	-320	1,800	1,690	110
Clinical, Counseling, and School Psychologists	186,710	233,390	-46,680	188,930	246,420	-57,490
Substance Abuse and Behavioral Disorder Counselors	85,120	106,380	-21,260	105,970	122,510	-16,540
Mental Health and Substance Abuse Social Workers	110,880	138,630	-27,750	109,220	157,760	-48,540
Mental Health Counselors	120,010	150,000	-29,990	145,700	172,630	-26,930
School Counselors	246,480	308,130	-61,650	243,450	321,500	-78,050
Marriage and Family Therapists	30,560	38,250	-7,690	29,780	40,250	-10,470

U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Workforce National Center for Health Workforce Analysis *National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025* November 2016

Self Management Tools

Can’t have a therapeutic relationship with a TV screen. Really?

Apps are for games, not for recovery. Oh yeah!



BH Screening in a Kiosk

Who's going to sit at a kiosk to get health services? That will never happen!

Attendant Call Light

Privacy Handset

Blood Pressure Cuff

Keyboard

Electronic Signature Pad

Handicapped Accessible Seat with Weight Scale

MAG Card Reader

Touch Screen

Thermometer

Breathalyzer

Thumbprint Verification Device

Emergency Call Light

MH/SUD Patients are High Cost

Patients with MH/SUD cost 2-3 times more ($1,000 PMPM compared to $400 PMPM)

Most of the added cost is facility-based costs (ER and inpatient) for medical care.

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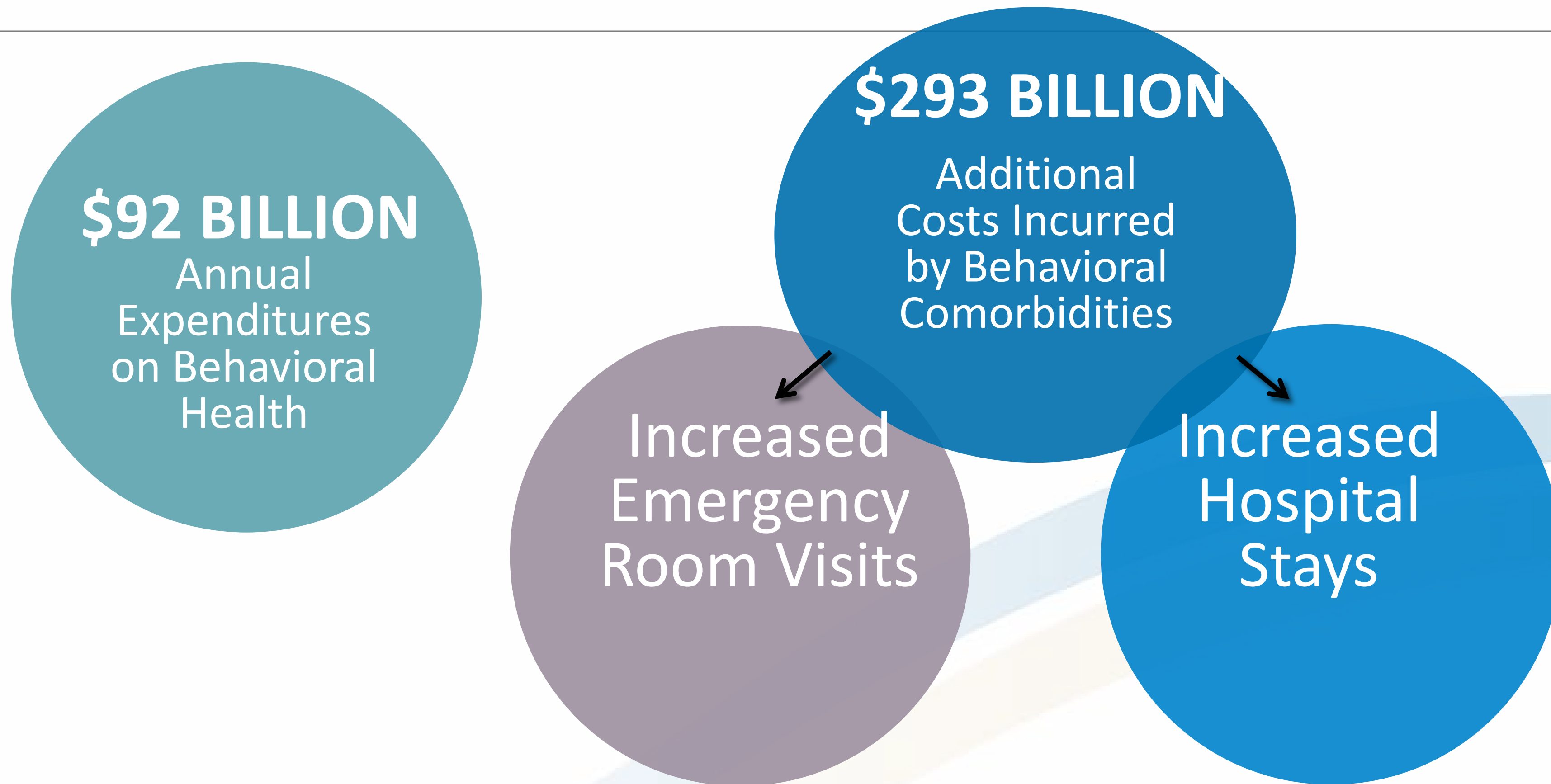
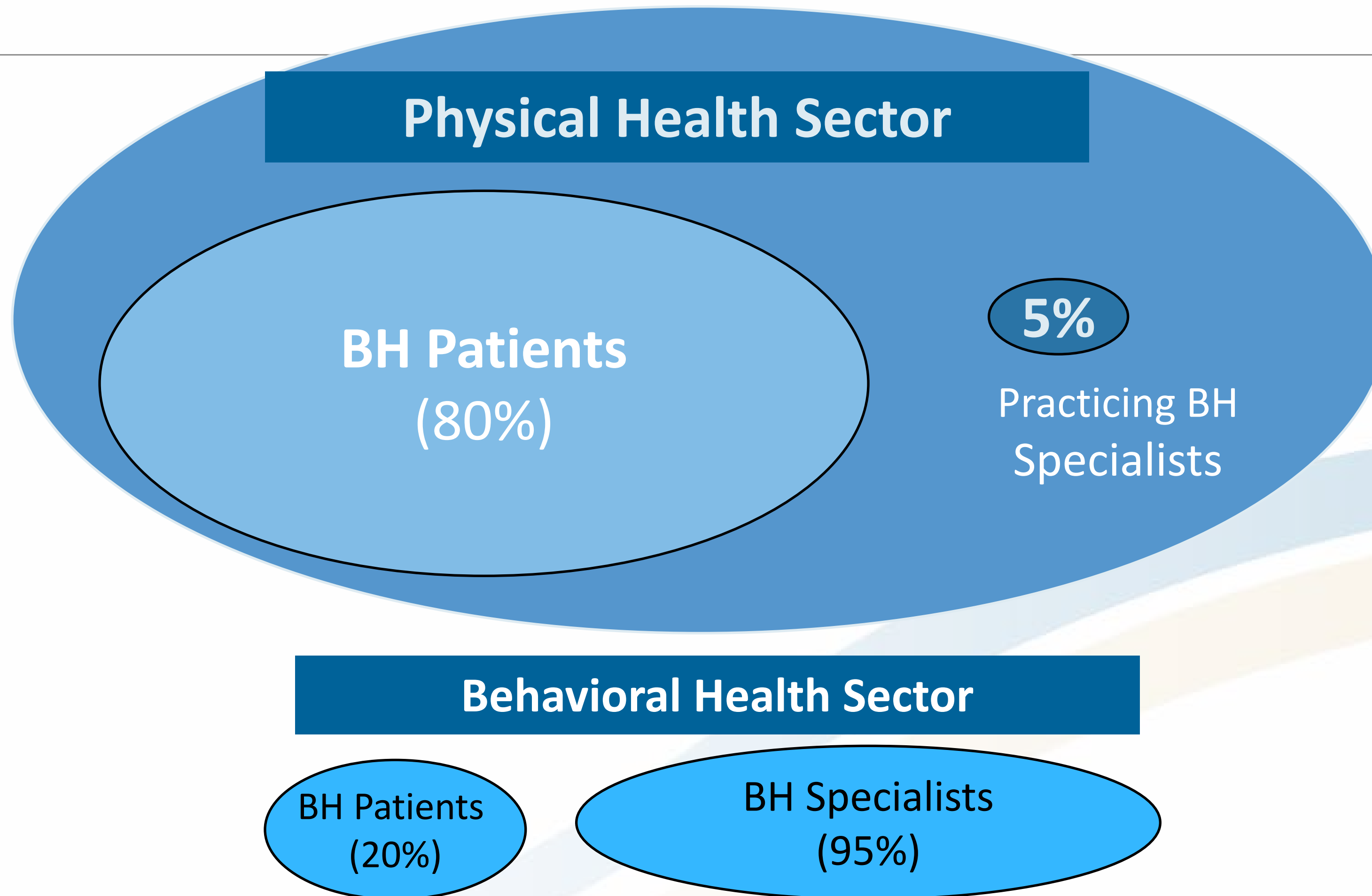
The BIG Numbers



Milliman Report 2014

BH Specialist-Patient Mismatch



Impact of BH Comorbidity in Patients with Chronic Medical Conditions

Patient Groups	Annual Cost of Care	Illness Prevalence	% with Comorbid Mental Condition*	Annual Cost with Mental Condition	% Increase with Mental Condition
Arthritis	$5,220	6.6%	36%	$10,710	94%
Asthma	$3,730	5.9%	35%	$10,030	169%
Cancer	$11,650	4.3%	37%	$18,870	62%
Diabetes	$5,480	8.9%	30%	$12,280	124%
CHF	$9,770	1.3%	40%	$17,200	76%
Migraine	$4,340	8.2%	43%	$10,810	149%
COPD	$3,840	8.2%	38%	$10,980	186%

*Approximately 10% receive evidence-based mental condition treatment

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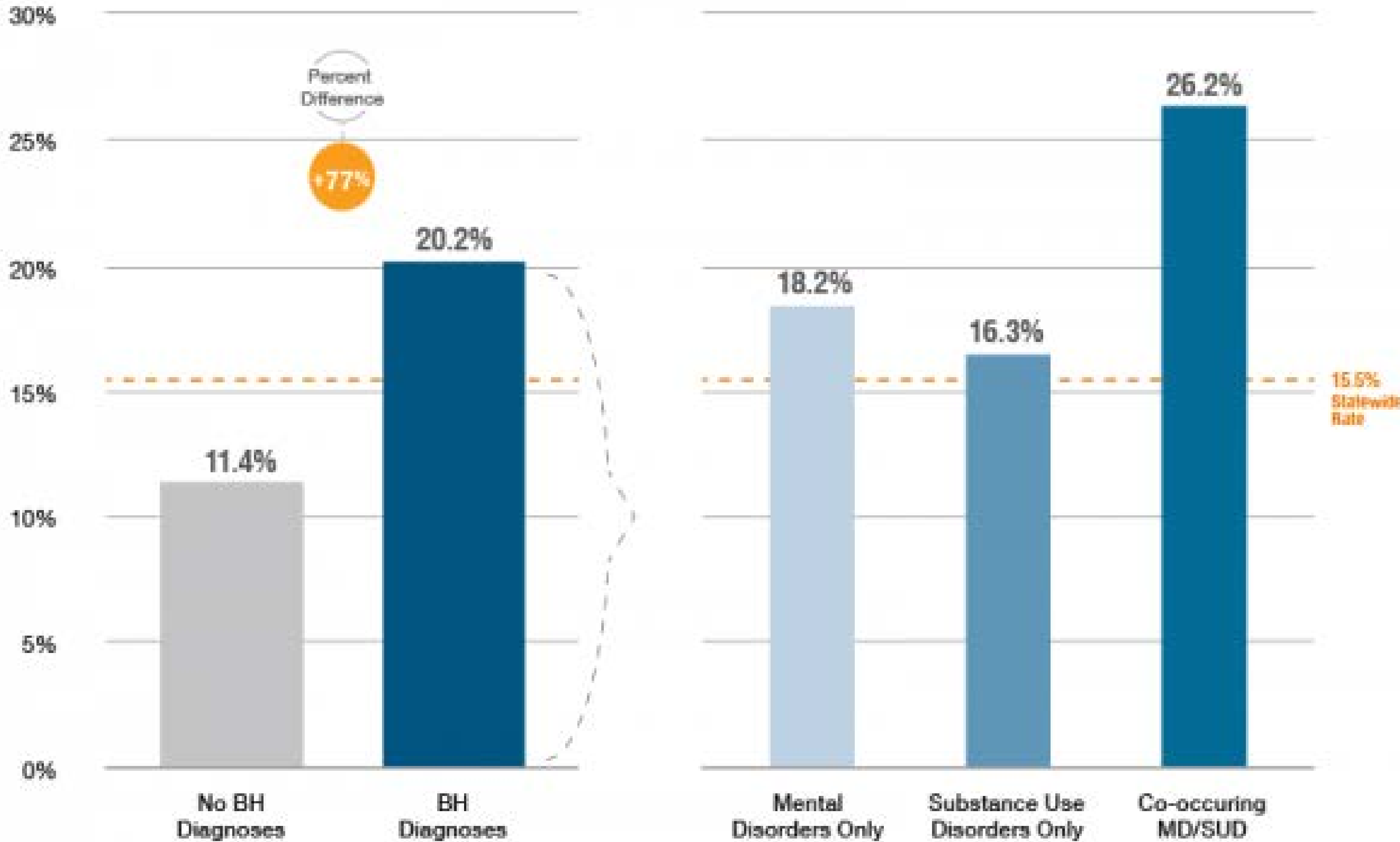
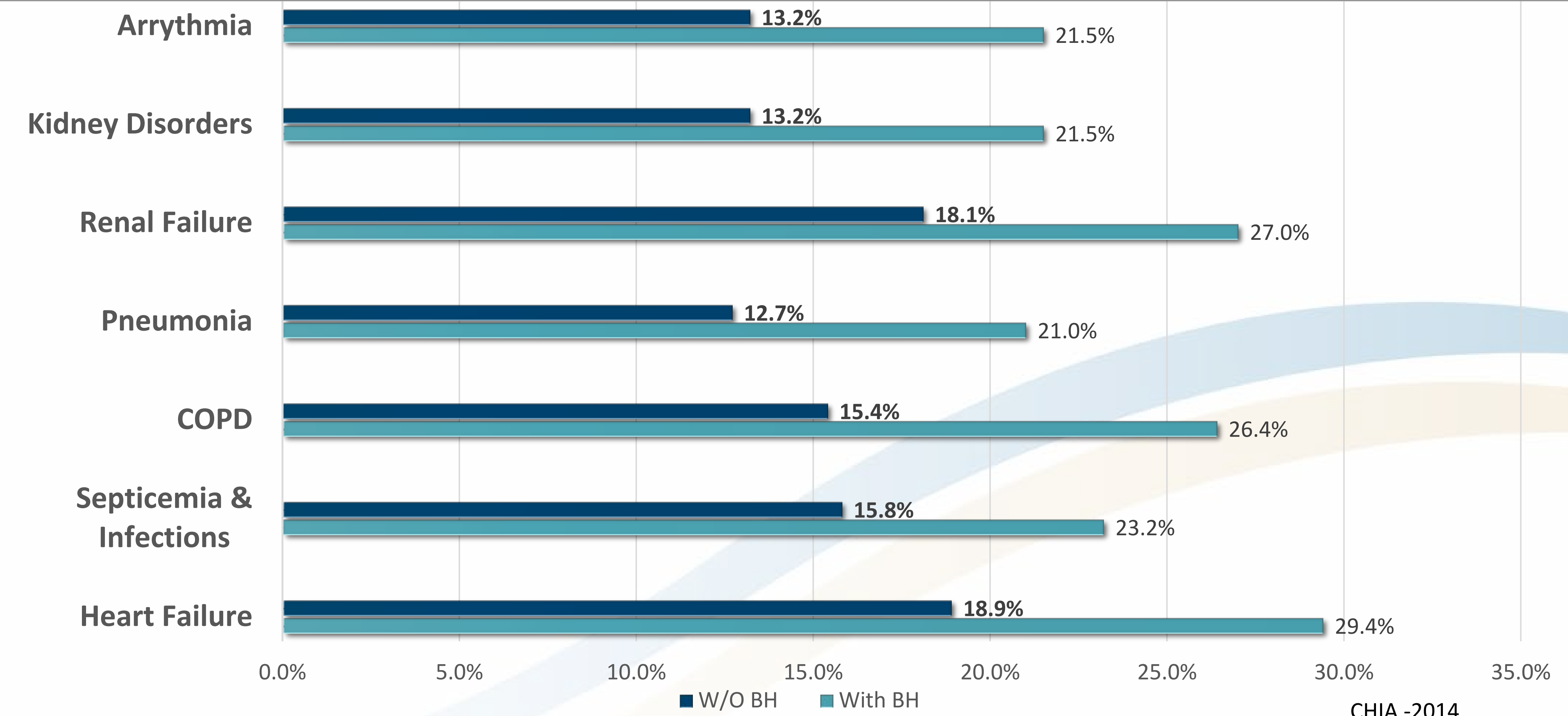
Statewide Readmission Rates with Behavioral Health Comorbidity

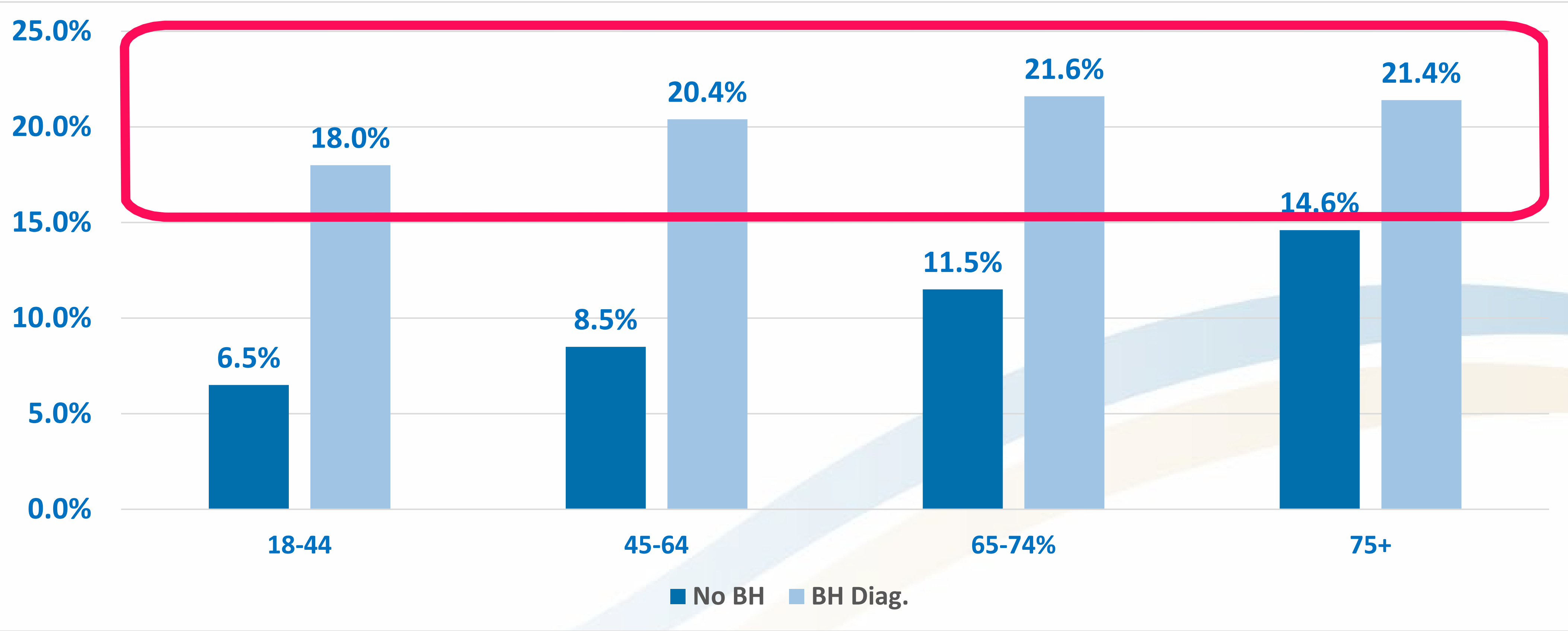


CHIA -2014

Readmission Rates & BH Comorbidity



Readmission Rates and Comorbidity (by Age)



Opportunity Abounds

Hospitals seek behavioral partners to reduce Medicare readmissions
Modern Healthcare Magazine

Medicare's Readmission Penalties Hit New High
U.S. News & World Report

Accountable Care & Behavioral Health

"Integrating behavioral health can lead to improved patient experience, improved provider satisfaction, improved medical and behavioral outcomes, and now the time is really right for ACOs." (S. Guterman, Commonwealth Fund)

"In order to get to the Triple Aim—better care, better health and lower per capita costs—ACOs are going to need to develop an integrated behavioral health strategy." (M. Laderman, IHI)

"If you don't address the underlying issues that drive their conditions, then you're facing a situation where people will just be repeat users of the healthcare system, which runs up a lot of costs that could be avoided with appropriate care for the underlying conditions." (D. Muhlstein, Leavitt Partners)

A New Paradigm

- Prevention, Identification and Early Intervention
- **Integration with General Medical Care & ERs**
- Extended Engagement (Recovery Management)
- Predictive Analytics and Precision Treatment
- Sustained and Comprehensive **<u>Prevention</u>**
- Technology Interventions and Tele-Health

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Levels of "Integration"

- Level 1: Minimal Collaboration--Separate Systems, little communication
- Level 2: Distance-Collaboration--Separate Systems, periodic communication
- Level 3: Onsite Collaboration--Co-location, still separate; infrequent communication
- Level 4: Partial Integration--Same site, common scheduling/charting, but BH and medical still seen as separate entities
- **Level 5: Full Integration--Same site, same vision, same team, a fully unified practice**

Services We Will Provide in Primary Care

- Triage/Rapid Assessment (SBIRT. PHQ-9)
- Consultation to Medical Team (on demand!)
- Patient Follow Up & Compliance
- Lifestyle Guidance & Management
- Specialty Care Referral % Tracking
- Subject Expert Training and Education

Integrated Model	Traditional Model
Population Management	Specialty Care
15-20 min. visits	45-60 min. visits
1-3 visits and done	5 or more visits
No limit # patients/day	5-7 patients/day
Open Access-Same Day Visit	Waiting Lists
Interruptible	Do Not Disturb
Instruct, Guide, Enhance	Diagnose and Treat

Integrated Model	Traditional Model
Therapeutic Relationship not Focus	Relationship Critical
Visit is Primarily Medical	Visit specific to BH Issue
Stigma Minimal	Stigma Usually Very High
Interventions Support Med Providers	Rarely involve Med Providers
Referrals from Med Providers	Referrals from Community
Patient “Ownership” is Shared	Clinician “Owns” the Patient
Provider Moves Rapidly	Clinician Focus on 1-1 Interaction

Integrated Model	Traditional Model
MI, CBT & Solution Focused	Based on Clinician Preference
Documentation in Unified Record	Documentation stands alone
PCP Always Involved	PCP Hardly Ever Involved

Best of All

NO CANCELLATIONS VS. 20-30% CANCELLATION RATE

Barriers and Challenges

- Primary & BH systems/practitioners cultures
- Lack of clinician training in a different service setting
- Clinicians Unable to Adapt to PCP Setting
- Information sharing/Electronic Health Record
- Issues of Confidentiality and Space
- Financing and Reimbursement--(Grants Will End!)

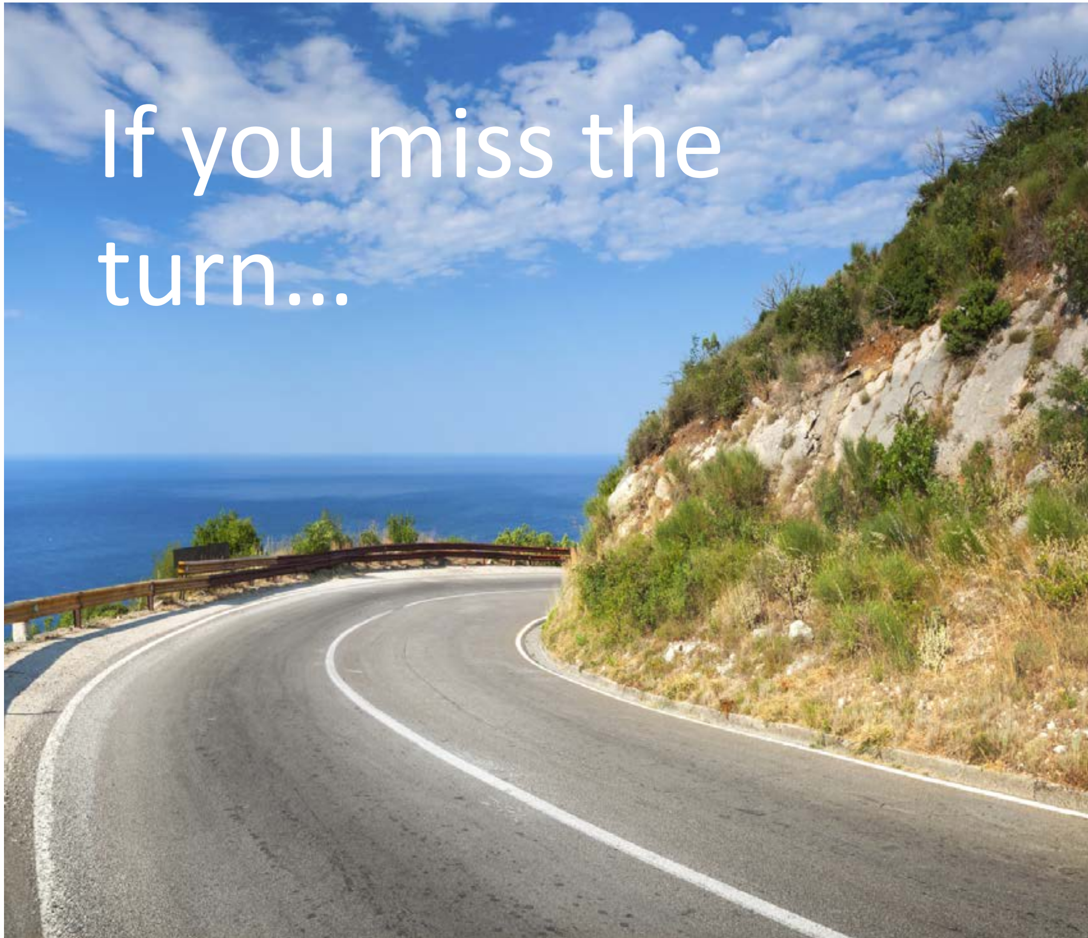
We Have What Health Care Systems Need

- Expertise in SUD & MH
- We Know How to Talk to Patients
- Knowledge of Community Resources
- Improve Compliance; Reduce Use of High Cost Resources
- Help Medical Practitioners Understand BH Links to Disease
- We Can HELP PATIENTS BEFORE THEY'RE IN CRISIS

How to Get Started

- **Educate** Yourself & Your Staff
- **Expand** Your Thinking--Challenge Old Beliefs
- **Change** the Language
- **Use Data** -BH Integration Lower Costs & Readmissions
- **Share** it with Hospitals & MDs (They Don't Know)
- Know and **BELIEVE** that you are **INDISPENSABLE** to Quality Care & Population Health Management

Making Decisions



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