Behavioral Health and the Patient-Centered Medical Home (PCMH)

Six Reasons Behavioral Health Should be an Integral Part of the Patient-Centered Medical Home Practice
Six Reasons Behavioral Health Should be Part of the PCMH

Reason 1: Prevalence of Behavioral Health Problems in Primary Care
Reason 2: Unmet Behavioral Health Needs in Primary Care
Reason 3: Cost of Unmet Behavioral Health Needs
Reason 4: Lower Cost When Behavioral Health Needs are Met
Reason 5: Better Health Outcomes
Reason 6: Improved Satisfaction
Patient-Centered Medical Home
Reason One: Prevalence

Behavioral Health and Primary Care Are Inseparable

- 84% of the time, the 14 most common physical complaints have no identifiable organic etiology\(^1\)
- 80% with a behavioral health disorder will visit primary care at least 1 time in a calendar year\(^2\)
- 50% of all behavioral health disorders are treated in primary care\(^3\)
- 48% of the appointments for all psychotropic agents are with a non-psychiatric primary care provider\(^4\)

Patient-Centered Medical Home
Reason Two: Unmet Behavioral Health Needs

• 67% with a behavioral health disorder do not get behavioral health treatment\(^1\)

• 30-50% of referrals from primary care to an outpatient behavioral health clinic don’t make first appt\(^2,3\)

• Two-thirds of primary care physicians (N=6,660) reported not being able to access outpatient behavioral health for their patients. Shortages of mental health care providers, health plan barriers, and lack of coverage or inadequate coverage were all cited by PCPs as important barriers to mental health care access\(^4\)

Unmet Needs: Reasons People Die

Patient-Centered Medical Home
Reason Three: Cost of Unmet Needs

• BH disorders account for half as many disability days as “all” physical conditions\textsuperscript{1}

• Annual medical expenses--chronic medical & behavioral health conditions combined cost 46% more than those with only a chronic medical condition\textsuperscript{2}

• Top five conditions driving overall health cost (work related productivity + medical + pharmacy cost)\textsuperscript{3}
  - Depression
  - Obesity
  - Arthritis
  - Back/Neck Pain
  - Anxiety

\textsuperscript{1} Merikangas et al., Arch Gen Psychiatry. 2007;64:1180-1188
\textsuperscript{2} Original source data is the U.S. Dept of HHS the 2002 and 2003 MEPS. AHRQ as cited in Petterson et al. “why there must be room for mental health in the medical home Graham Center One-Pager)
\textsuperscript{3} Loepke et al., J Occup Environ Med. 2009;51:411-428.
The Cost of Poor Health to Employers

Iceberg of Additional Costs to Employers from Poor Health

Personal Health Costs
- Medical Care
- Pharmaceutical costs
- Workers’ Compensation Costs

Productivity Costs
- 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

Top 10 Health Conditions Driving Costs for Employers (Med + Rx + Absenteeism + Presenteeism)
Costs/1000 FTEs

Cost of Unmet Needs Continued

• Healthcare use/costs twice as high in diabetes and heart disease patients with depression\(^1\)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Annual Cost – those without MH condition</th>
<th>Annual Cost – those with MH condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Condition</td>
<td>$4,697</td>
<td>$6,919</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>$3,481</td>
<td>$5,492</td>
</tr>
<tr>
<td>Asthma</td>
<td>$2,908</td>
<td>$4,028</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$4,172</td>
<td>$5,559</td>
</tr>
</tbody>
</table>

• Untreated mental disorders in chronic illness is projected to cost commercial and Medicare purchasers between $130 and $350 billion annually\(^2\)

• Approximately 217 million days of work are lost annually to related mental illness and substance use disorders (costing employers $17 billion/year)\(^2\)

1. Original source data is the U.S. Dept of HHS the 2002 and 2003 MEPS. AHRQ as cited in Petterson et al. “Why there must be room for mental health in the medical home (Graham Center One-Pager)

Patient-Centered Medical Home
Reason Four: Lower Cost When Treated

Lower Cost

• Medical use decreased 15.7% for those receiving behavioral health treatment while controls who did not get behavioral health medical use increased 12.3%¹

• Depression treatment in primary care for those with diabetes $896 lower total health care cost over 24 months²

• Depression treatment in primary care $3,300 lower total health care cost over 48 months³

Patient-Centered Medical Home
Reason Five: Better Outcomes

• Quantitative & qualitative reviews\textsuperscript{1-4}
  • Depression\textsuperscript{1-4}
  • Panic Disorder\textsuperscript{1-2}

• Other Studies\textsuperscript{5}
  • Tobacco
  • Alcohol Misuse
  • Diabetes
  • IBS
  • GAD
  • Chronic Pain
  • Primary Insomnia
  • Somatic Complaints

2. Craven et al., Canadian Journal of Psychiatry. 2006;51:1S-72S.
5. Hunter et al., Integrated Behavioral Health in Primary Care: American Psychological Association, 2009
Patient Centered Medical Home
Reason Six: Improved Satisfaction

• Improved Patient Satisfaction\textsuperscript{1-5}

• Improved Primary Care Provider Satisfaction\textsuperscript{6,7}

Including Behavioral Health in the Patient Centered Medical Home Helps Meet Core Principles

A) Whole Person Orientation (majority of personal health care in primary care)

B) Coordinated Integrated Care
Personalized care across acute and chronic problems, to include prevention and focus on the physical, social, environmental, emotional, behavioral and cognitive aspects of health care.

C) Enhanced Access
Time to third available appointment and same day access to the range of health care needs the patient has to include addressing in primary care by the team mental/behavioral health and health behavior change.

D) Payment for Added Value
Enhance evidence-based screening, assessment and intervention for mental/behavioral health, substance misuse and abuse and health behavior change, that improves acute and long-term outcome, patient and provider satisfaction, decreases monthly cost for enrolled population, decreases ER visits, and prevents/decreases hospitalizations (i.e. medical and psychiatric).
### Patient Centered Medical Home

#### Integrating Behavioral Health into Primary Care Addresses Several Aspects of Health

<table>
<thead>
<tr>
<th>Range of Need for Collaboration in the Patient Centered Medical Home (Kessler &amp; Miller, 2009)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Functions</strong></td>
</tr>
<tr>
<td>Severe Mental Health/ Substance Abuse Management</td>
</tr>
<tr>
<td>Identify and Treatment of Mental Health and Substance Abuse</td>
</tr>
<tr>
<td>Comorbid Medical and Psychological Presentations</td>
</tr>
<tr>
<td>Medical Presentations Which Need Behavioral Treatment</td>
</tr>
<tr>
<td>Manage pharmacology; coordinate w/ community providers; crisis management</td>
</tr>
<tr>
<td>Identification; motivational interviewing; brief intervention; pharmacology, refer to mental health/substance abuse</td>
</tr>
<tr>
<td>Identification; patient education, co-treatment w/ mental health, monitor activation and adherence (e.g. chronic medical disorders, non-adherence)</td>
</tr>
<tr>
<td>Identification; education; referral for consultation and co-treatment (e.g., primary insomnia, Gastrointestinal, headache)</td>
</tr>
<tr>
<td><strong>Primary Care Mental Health Clinician</strong></td>
</tr>
<tr>
<td>Crisis intervention; communication w/ outside specialty care providers</td>
</tr>
<tr>
<td>Treatment of depression/anxiety; co-treatment w/ PCP; evidence based treatment; medication monitoring</td>
</tr>
<tr>
<td>Psychoeducation; motivational Interviewing; behavioral activation</td>
</tr>
<tr>
<td>Health behavior change; psychoeducation; evidence based treatment</td>
</tr>
</tbody>
</table>

Miller & Kessler, 2009
However,

CHANGES NEED TO OCCUR
Payment Reform Needed

Current System: Structured Around Reimbursement
- Payment and financing “carved out” - independent of medical care and expense
- Disincentivizes collaboration, communication and coordination among clinicians
- Payment is solely for psychiatric disorders and diagnosis
- Ignores behavioral needs of medical patients
- Focuses on individual siloed care delivery not on collaborative treatment
- No relationship to performance

Proposed System: Patient Centered
- Carve in to medical expense target (defragment payment system; blended payment systems)
- Payment related to collaborative medical psychological efforts
- Financing for broad spectrum of medical need for behavioral intervention including psychological treatments of medical problems
- Financing related to performance and quality

Kessler & Miller, 2009

16
PCPCC Payment Model
May 2007

Key physician and practice accountabilities/value added services and tools

- Proactively work to keep patients healthy and manage existing illness or conditions
- Coordinate patient care among an organized team of health care professionals
- Utilize systems at the practice level to achieve higher quality of care and better outcomes
- Focus on whole person care for their patients (including behavioral health)

Blended Hybrid Payment Model
(expanding upon the existing fee-for-service paradigm)

Care Coordination
Incentives

Office Visits
Incentives

Performance
Incentives
System Integration and Transformation Needed

Usual Care
Fragmented (siloed)
Not coordinated

Behavioral health care
- mental health
- substance abuse

Specialist care

Primary care
- Prevention
- Acute Care
- Chronic Care

Other care

Delivery System Transformation and Practice Redesign

PCMH Team

PC Physicians

BH Specialists

Specialists

Other licensed health care providers

Coordination
Collaboration
Communication

Care in PCMH
Integrated
Team-based
Matching Physical and Mental Health Services to Patient Location Needed

- Matching Physical and Mental Health Services to Patient Needs through:
  - Co-located and fully integrated physical & mental health personnel
  - Tightly coordinated mental & physical health services
- Common mental & physical health documentation system
- Unified outcomes analysis

Note: Stand alone mental health services could be paid for from the general medical budget, much as stand alone rehabilitation, eye, and cardiac services

Behavioral Health is an Inseparable Part of General Medical Health

Physical Illness

Mental Health & Substance Use Disorders

Kathol, 2009
Summary

- The patient centered medical home without behavioral health fails

- Research has shown:
  High Prevalence of Behavioral Health Problems in Primary Care
  High Unmet Behavioral Health Needs in Primary Care
  High Cost of Unmet Behavioral Health Needs
  Primary Care Behavioral Health
    - Improves Access
    - Reduces Costs
    - Improves Patient and PCP Satisfaction
    - Leads to Better Health Outcomes

- Healthcare systems change must occur to accomplish integration

- Now is the time to integrate behavioral health care into the PCMH
The Need for Integration and Transformation

A Patient who experienced integrating behavioral health into her medical home

"...the staff at Marillac Clinic actually cared about what I had to say - they were there to help when I needed it - not just medical help, but counseling - and the medications needed to get well. Marillac helped me learn how to care for myself - I understood how to accept myself from the kindness in their eyes.”

Past patient of Marillac Clinic, Grand Junction, Colorado

Primary Care Physician Perspective (3-physician practice)

“Thanks for your efforts toward integrating behavioral and mental health into the PCMH model. My personal belief is that we will fail unless this issue is addressed. The duration and quality of the physician-patient relationship within the PCMH can drive real changes to occur in the lifestyles and physical health status of our patients, but without mental health all will be lost.”

Dr. James Barr, Pleasant Run Family Physicians, New Jersey
<table>
<thead>
<tr>
<th><strong>TODAY’S CARE</strong></th>
<th><strong>PCMH</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>My patients are those who make appointments to see me</td>
<td>Our patients are those who are registered in our medical home</td>
</tr>
<tr>
<td>Patients’ chief complaints or reasons for visit determines care; BH may or may not be assessed</td>
<td>We systematically assess all our patients’ health needs, including BH and psychosocial factors necessary to plan care</td>
</tr>
<tr>
<td>Care is determined by today’s problem and time available today</td>
<td>Care is guided by patients goals</td>
</tr>
<tr>
<td>Care varies by scheduled time and memory or skill of the doctor</td>
<td>Care is standardized according to evidence-based guidelines</td>
</tr>
<tr>
<td>Patients are responsible for coordinating their own care</td>
<td>A team of professionals coordinates all patients’ care to ensure integrated care</td>
</tr>
<tr>
<td>I know I deliver high quality care because I’m well trained</td>
<td>We measure our quality and make rapid changes to improve it</td>
</tr>
<tr>
<td>Acute care is delivered in the next available appointment and walk-ins</td>
<td>Acute care is delivered by open access and non-visit contacts</td>
</tr>
<tr>
<td>It’s up to the patient to tell us what happened to them</td>
<td>We track tests &amp; consultations, and follow-up after ED &amp; hospital visits</td>
</tr>
<tr>
<td>Clinic operations center on meeting the doctor’s needs</td>
<td>A multidisciplinary team works at the top of our licenses to serve patients</td>
</tr>
</tbody>
</table>

Modified Slide from Daniel Duffy MD School of Community Medicine Tulsa Oklahoma
## System Redesign Needed

<table>
<thead>
<tr>
<th></th>
<th>Independent/Siloed</th>
<th>Integrated PCMH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>same</td>
<td>single identifier</td>
</tr>
<tr>
<td>Payment Pool</td>
<td>separate</td>
<td>single bucket</td>
</tr>
<tr>
<td>Network of Providers</td>
<td>separate</td>
<td>all in one</td>
</tr>
<tr>
<td>Practice Locations</td>
<td>separate</td>
<td>co-location (can be virtual)</td>
</tr>
<tr>
<td>Approval Process</td>
<td>separate</td>
<td>uniform</td>
</tr>
<tr>
<td>Information Systems</td>
<td>separate</td>
<td>unified</td>
</tr>
<tr>
<td>Collaboration &amp; Communication</td>
<td>rare</td>
<td>routine</td>
</tr>
<tr>
<td>Coding and Billing</td>
<td>separate</td>
<td>consistent process</td>
</tr>
<tr>
<td>Outcome Accountability</td>
<td>disciplinary</td>
<td>total health</td>
</tr>
<tr>
<td>Clinical/Cost Data Warehousing</td>
<td>separate</td>
<td>consolidated</td>
</tr>
<tr>
<td>Administrative Oversight</td>
<td>separate</td>
<td>coordinated workflows</td>
</tr>
</tbody>
</table>

Kathol, 2009
Resources Needed

• Training and education of both Primary Care Providers and Behavioral Health Providers to change the current paradigm/culture

• Tools for PCMH Team interested in integrating
  • Clinical Resources (What to do when integrated)
  • Operational Resources (How to make integration work)
  • Financial Resources (Information on payment reform)

• Information Technology

• Changes in Employer Benefit Designs

• Process of increasing providers encouragement of patient becoming actively participating in care plan
Selected Resources/Websites

• The Patient Centered Primary Care Collaborative: www.pcpcc.net

• The Collaborative Care Research Network (CCRN), a sub-network of the AAFP’s National Research Network (NRN), created so that clinicians from across the country can ask questions and investigate how to make collaborative care work more effectively. The objectives of the CCRN are to support, conduct, and disseminate practice-based primary care effectiveness research that examines the clinical, financial, and operational impact of behavioral health on primary care and health outcomes www.aafp.org/nrn/ccrn

• Collaborative Family Healthcare Association: www.CFHA.net

• National Council for Community Behavioral Health: www.thenationalcouncil.org


• “Purchaser’s Guide to Clinical Preventive Services” including services for alcohol misuse, tobacco use, and depression: www.businessgrouphealth.org/benefitstopics/topics/purchasers/fullguide.pdf
Acknowledgements

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