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]

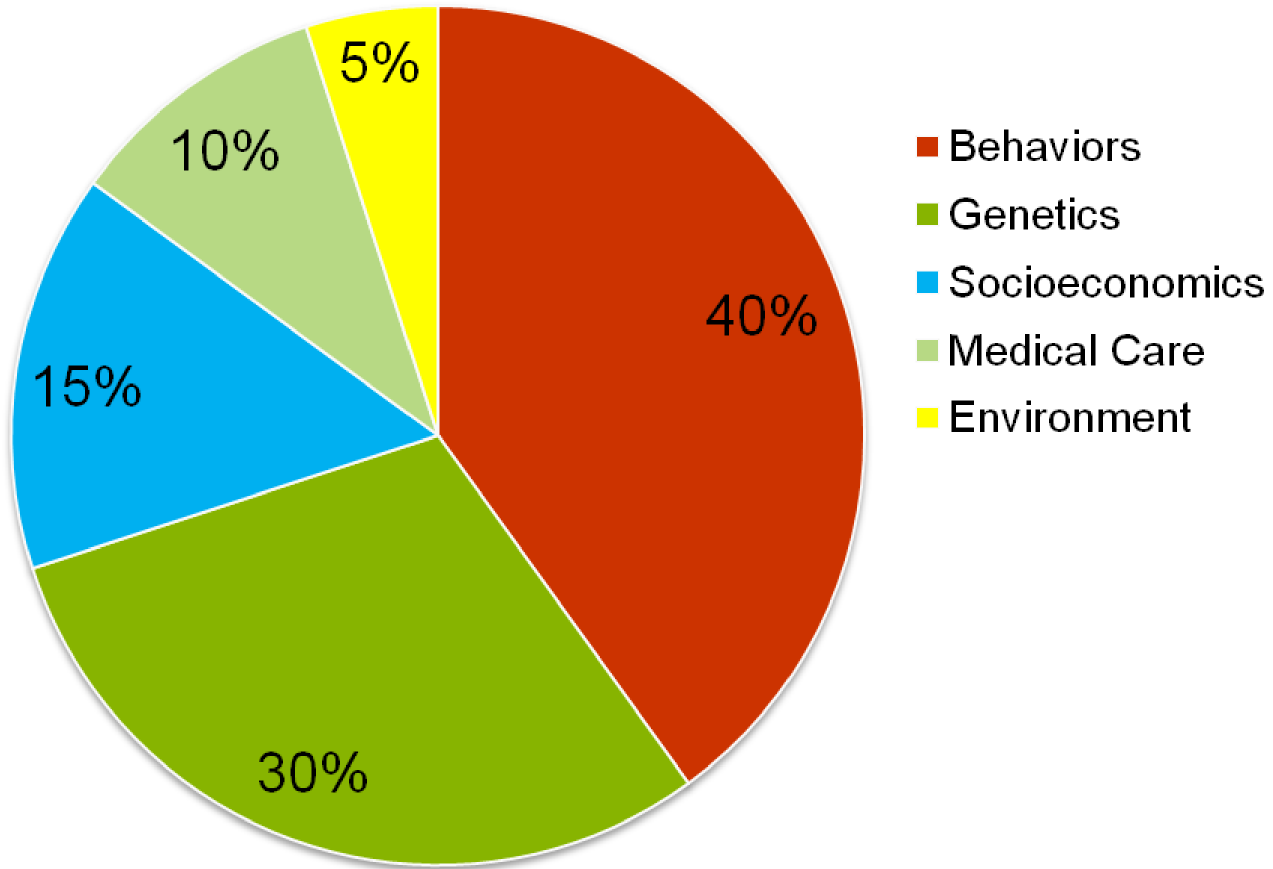
1. Kroenke & Mangelsdorf, Am J Med. 1989;86:262-266.
2. Narrow et al., Arch Gen Psychiatry. 1993;50:5-107.
3. Kessler et al., NEJM. 2006;353:2515-23.
4. Pincus et al., JAMA. 1998;279:526-531.

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]

1. Kessler et al., NEJM. 2005;352:515-23.
2. Fisher & Ransom, Arch Intern Med. 1997;6:324-333.
3. Hoge et al., JAMA. 2006;95:1023-1032.
4. Cunningham, Health Affairs. 2009; 3:w490-w501.

Unmet Needs: Reasons People Die



1. McGinnis JM, Foege WH. Actual Causes of Death in the United States. JAMA 1993;270:2207-12.
2. Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual Causes of Death in the United States, 2000. JAMA 2004;291:1230-1245.

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

- BH disorders account for half as many disability days as “all” physical conditions[1]

- Annual medical expenses--chronic medical & behavioral health conditions combined cost 46% more than those with only a chronic medical condition[2]

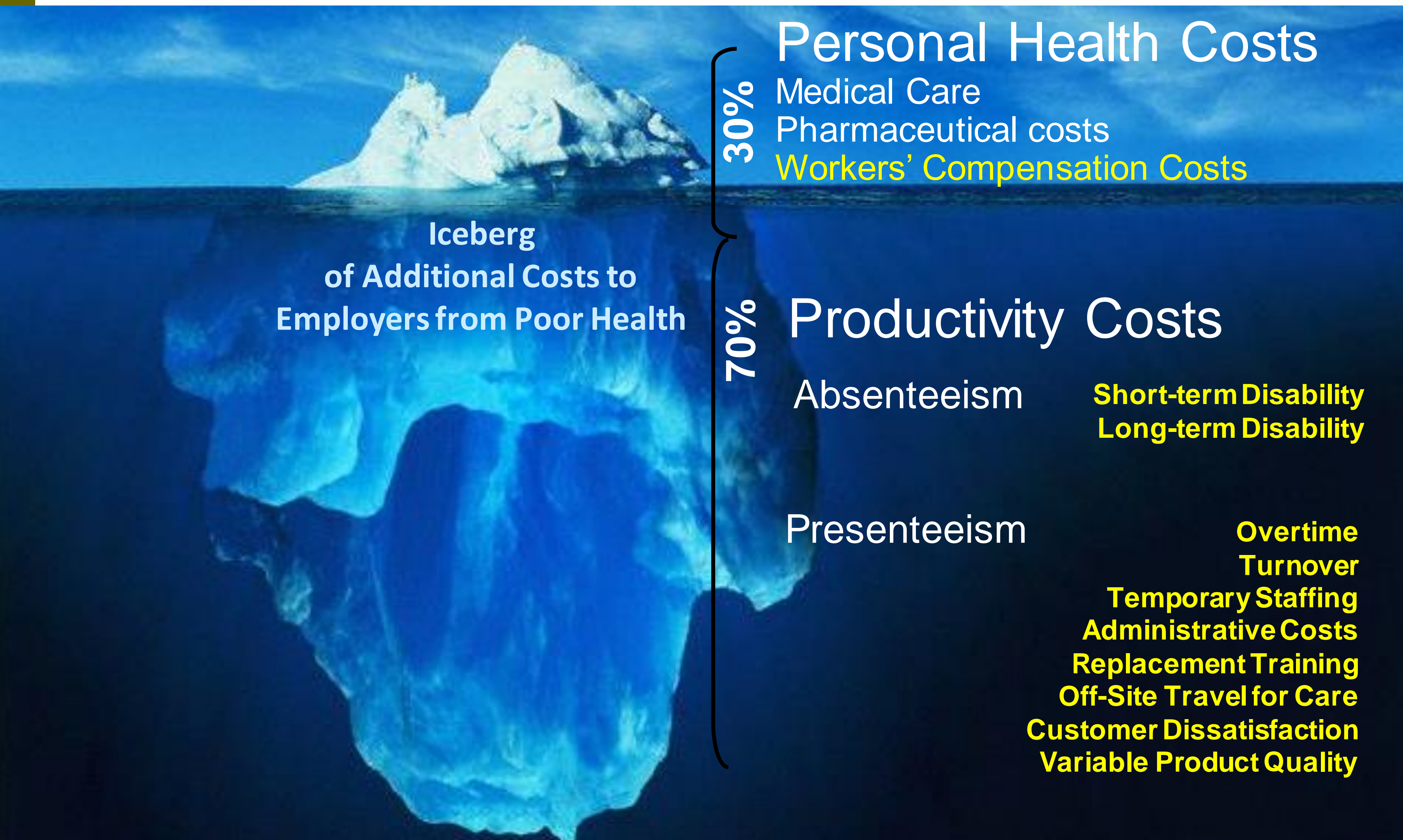
- Top five conditions driving overall health cost

(work related productivity + medical + pharmacy cost)[3]

  - Depression
  - Obesity
  - Arthritis
  - Back/Neck Pain
  - Anxiety

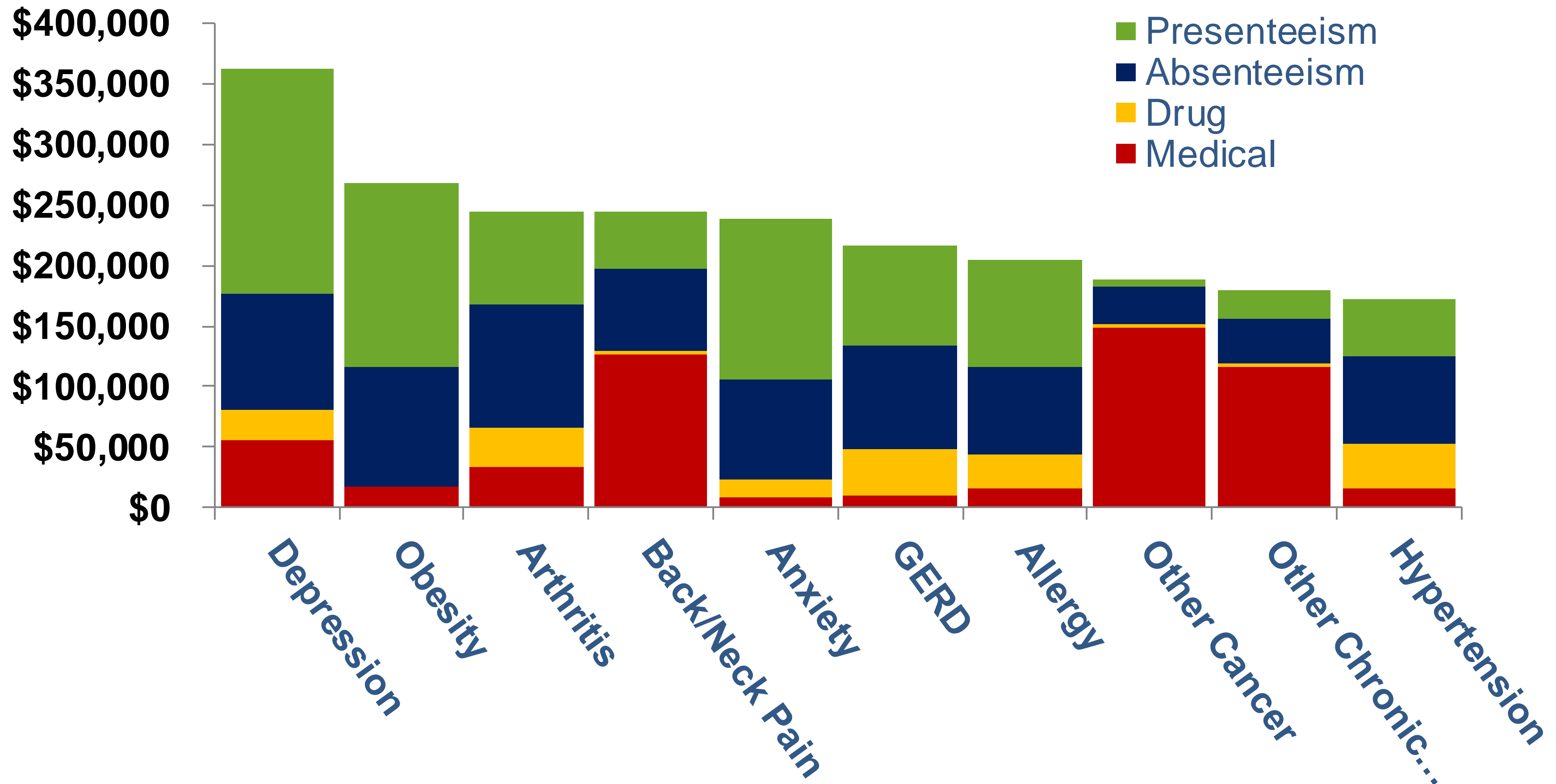
1. Merikangas et al., Arch Gen Psychiatry. 2007;64:1180-1188
2. Original source data is the U.S. Dept of HHS the 2002 and 2003 MEPS. AHRQ as cited in Petterson et al. “why there must be room for mental health in the medical home Graham Center One-Pager)
3. Loeppke et al., J Occup Environ Med. 2009;51:411-428.

The Cost of Poor Health to Employers



Sources: Loeppke, R., et al., "Health and Productivity as a Business Strategy: A Multi-Employer Study", JOEM.2009; 51(4):411-428. **and Edington DW, Burton WN.** ***Health and Productivity*****. In McCunney RJ, Editor.** **A Practical Approach to Occupational and Environmental Medicine.** **3rd edition. Philadelphia, PA. Lippincott, Williams and Wilkens; 2003: 40-152**

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



Loeppke, et al., JOEM. 2009;51(4):411-428.

Cost of Unmet Needs Continued

- Healthcare use/costs twice as high in diabetes and heart disease patients with depression[1]

	Annual Cost – those without MH condition	Annual Cost – those with MH condition
Heart Condition	$4,697	$6,919
High Blood Pressure	$3,481	$5,492
Asthma	$2,908	$4,028
Diabetes	$4,172	$5,559

- 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)

2. Hertz RP, Baker CL. The impact of mental disorders on work. *Pfizer Outcomes Research*. Publication No P0002981. Pfizer; 2002.

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 months[2]
- Depression treatment in primary care $3,300 lower total health care cost over 48 months[3]

1. Chiles et al., Clinical Psychology. 1999;6:204–220.
2. Katon et al., Diabetes Care. 2006;29:265-270.
3. Unützer et al., American Journal of Managed Care 2008;14:95-100.

Patient-Centered Medical Home
Reason Five: Better Outcomes

- Quantitative & qualitative reviews[1-4]
  - Depression[1-4]
  - Panic Disorder[1-2]

- Other Studies[5]
  - Tobacco
  - Alcohol Misuse
  - Diabetes
  - IBS
  - GAD
  - Chronic Pain
  - Primary Insomnia
  - Somatic Complaints

1. Butler et al., AHRQ Publication No. 09- E003. Rockville, MD. AHRQ. 2008.
2. Craven et al., Canadian Journal of Psychiatry. 2006;51:1S-72S.
3. Gilbody et al., British Journal of Psychiatry, 2006;189:484-493.
4. Williams et al., General Hospital Psychiatry, 2007; 29:91-116.
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 [1-5]
- Improved Primary Care Provider Satisfaction [6,7]

1. Chen et al., American Journal of Geriatric Psychiatry. 2006; 14:371-379.
2. Unutzer et al., JAMA. 2002; 288:2836-2845.
3. Katon et al., JAMA. 1995; 273:1026-1031.
4. Katon et al., Archives of General Psychiatry. 1999; 56:1109-1115.
5. Katon et al., Archives of General Psychiatry. 1996; 53:924-932.
6. Gallo et al., Annals of Family Medicine. 2004; 2:305-309.
7. Levine et al., General Hospital Psychiatry. 2005; 27:383-391.

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

Range of Need for Collaboration in the Patient Centered Medical Home (Kessler & Miller, 2009)

	Severe Mental Health/ Substance Abuse Management	Identification and Treatment of Mental Health and Substance Abuse	Comorbid Medical and Psychological Presentations	Medical Presentations Which Need Behavioral Treatment
Primary Care Functions	Manage pharmacology; coordinate w/ community providers; crisis management	Identification; motivational interviewing; brief intervention; pharmacology, refer to mental health/substance abuse	Identification; patient education, co-treatment w/ mental health, monitor activation and adherence (e.g. chronic medical disorders, non-adherence)	Identification; education; referral for consultation and co-treatment (e.g., primary insomnia, Gastrointestinal, headache)
Primary Care Mental Health Clinician	Crisis intervention; communication w/ outside specialty care providers	Treatment of depression/anxiety; co-treatment w/ PCP; evidence based treatment; medication monitoring	Psychoeducation; motivational Interviewing; behavioral activation	Health behavior change; psychoeducation; evidence based treatment

Miller & Kessler, 2009

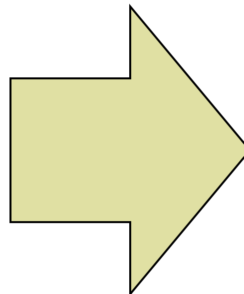
However,

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

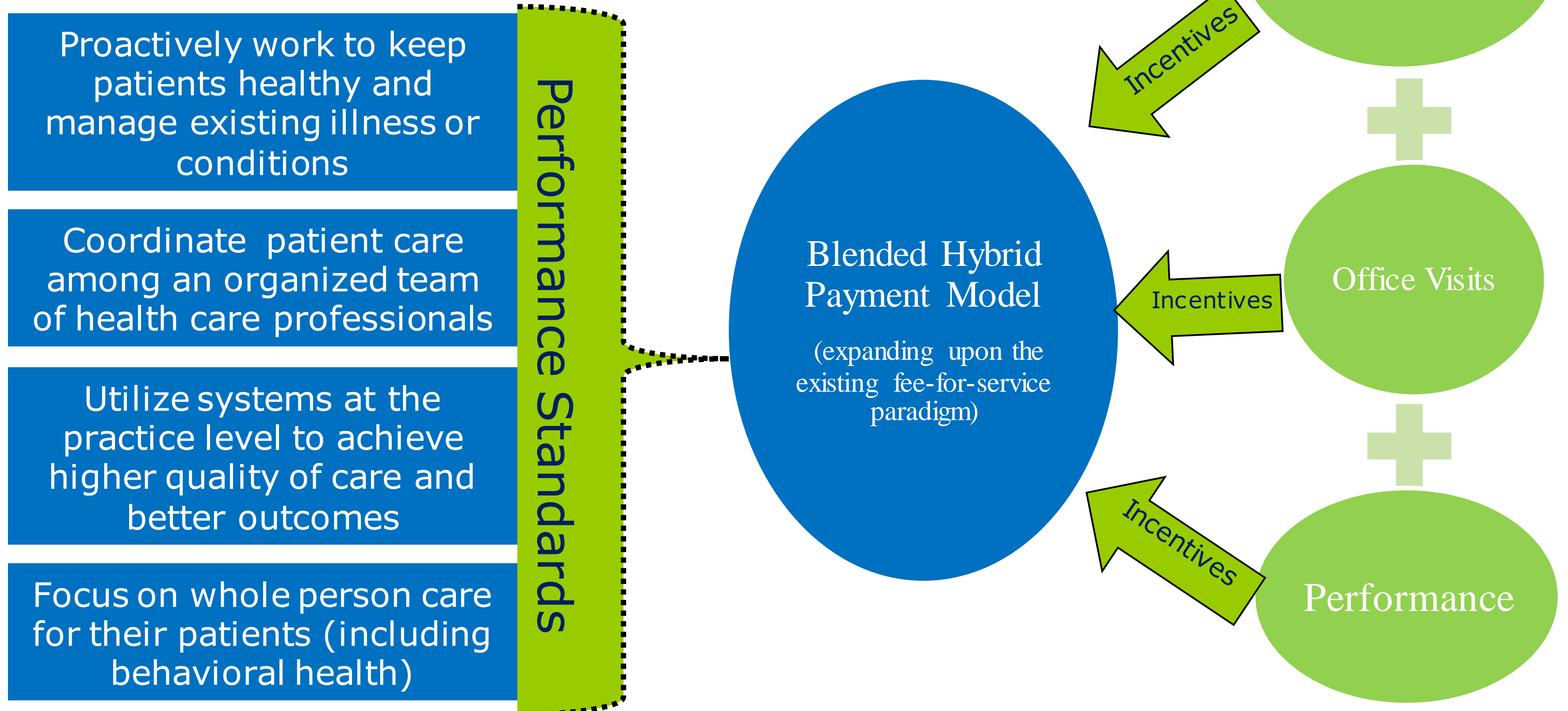


Proposed System: Patient Centered

- 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

PCPCC Payment Model
May 2007



System Integration and Transformation Needed

Usual Care

Fragmented (siloed)
Not coordinated

Behavioral health care
- mental health
- substance abuse

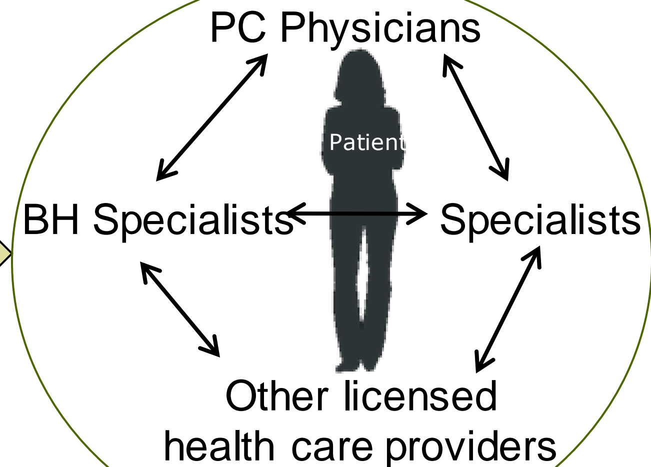
Specialist care

Other care

Primary care
- Prevention
- Acute Care
- Chronic Care

Delivery System Transformation and Practice Redesign

PCMH Team



Coordination
Collaboration
Communication

Care in PCMH

Integrated
Team-based

Matching Physical and Mental Health Services to Patient Location Needed

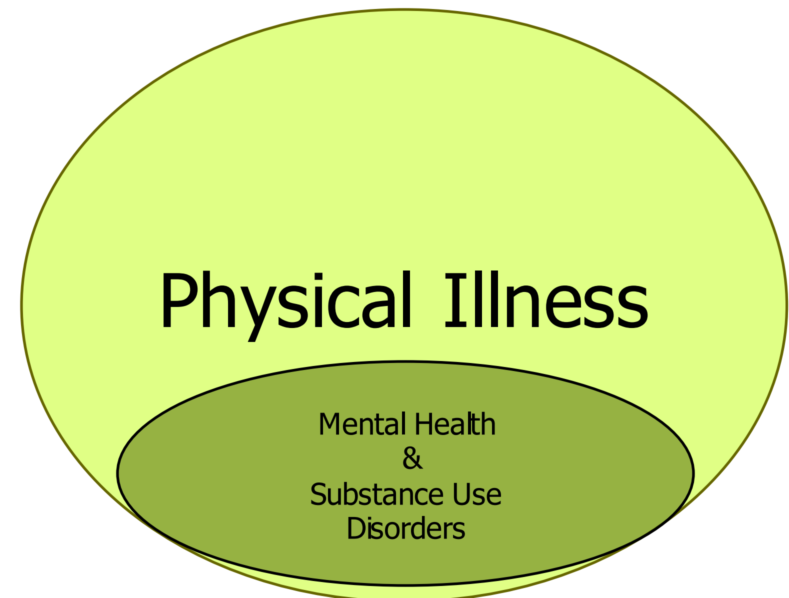
- Matching Physical and Mental Health Services to Patient Needs through:
  - Co-located and fully integrated physical & mental health personnel

    OR

  - 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



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

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

Modified Slide from Daniel Duffy MD School of Community Medicine Tulsa Oklahoma

System Redesign Needed

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

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

- *"An Employer's Guide to Behavioral Health Services"*: www.businessgrouphealth.org/pdfs/fullreport_behavioralHealthservices.pdf

- "*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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