Utilizing Integrated Behavioral Health To Improve Chronic Health Conditions

Laurie Smith, LMSW, CDE
Behavioral Health Care Manager
Medical Network One Health Solutions
lsmith@mednetone.net

Michigan Readmissions, Care Coordination & Behavioral Health Summit
June 1, 2017
Objectives

❖ Define how behavioral health factors and social determinants of health impede or enhance chronic disease health outcomes

❖ Explore how an embedded behavioral health care specialist, cross trained in disease management, can optimize health outcomes, improve patient and provider satisfaction, and drive quality scores

❖ Identify strategies to make this work in your practice
Cost Savings of Treatment of Medically Unexplained Symptoms Using Intensive Short-term Dynamic Psychotherapy (ISTDP) by a Hospital Emergency Department, Abbass, et al.

In the year following treatment, there was a 69% reduction in ED visits by these patients at an average cost reduction of $910 per patient. ISTDP interventions averaged 3.8 sessions averaging $406 per patient.

https://www.youtube.com/watch?v=c8ueviWMN1A
Quadruple Aim

- Better care
- More satisfied patients
- Lower total medical costs
- More satisfied providers
Leading Determinants of Overall Health are Behavioral\textsuperscript{1,2}

- Behavioral: 40% (dark blue)
- Genetic: 30% (light blue)
- Socioeconomic: 15% (green)
- Environment: 10% (yellow)
- Health Care: 5% (brown)

## Social Determinants of Health

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
</tr>
<tr>
<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
<td></td>
</tr>
<tr>
<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
<td>Social integration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
<td>Support systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td>Community engagement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td>Walkability</td>
<td></td>
<td>Discrimination</td>
<td>Provider availability</td>
<td></td>
</tr>
</tbody>
</table>

### Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations
Psychological Factors

❖ Health Behaviors
❖ Health Beliefs
❖ Self-Efficacy
❖ Trust/Mistrust of the Health System
❖ Stress
Prevalence

Behavioral Health is **Highly Prevalent** in Primary Care

- **84%** of the time, the 14 most common physical complaints have no identifiable organic etiology\(^1\)
- **80%** of individuals 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\(^3\) (92% with elderly)
- **20-40%** of primary care patients have behavioral health needs\(^4\)
- **48%** of the appointments for all psychotropic agents are with a non-psychiatric primary care provider\(^5\) (up to 80% of antidepressants)

Sources:  
Unmet Behavioral Health Needs

• **67% of individuals with a behavioral health disorder** do not get behavioral health treatment\(^1\)
• **30-50% of referrals** to behavioral health from primary care don’t make first appt\(^2,3\)
• Two-thirds of primary care physicians reported **not being able to access** outpatient behavioral health for their patients\(^4\) due to:
  • Shortages of mental health care providers
  • Health plan barriers
  • Lack of coverage or inadequate coverage
• **Depression goes undetected** in >50% of primary care patients\(^5\)
• **Only 20-40% of patients improve** substantially in 6 months without specialty assistance\(^6\)

# Prevalence of Mental Health Conditions in Primary Care

<table>
<thead>
<tr>
<th>Psychiatric disorders</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depression</td>
<td>10 to 24%</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>6 to 16%</td>
</tr>
<tr>
<td>Other Anxiety Disorders</td>
<td>7 to 21%</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>7 to 17%</td>
</tr>
<tr>
<td>Any Psychiatric Diagnosis</td>
<td>28 to 52%</td>
</tr>
</tbody>
</table>

Depression is 2\(^{nd}\) most common illness after hypertension.
10 Most Common Complaints in Adult Primary Care

- Chest Pain
- Fatigue
- Dizziness
- Headache
- Back Pain

- Swelling
- Insomnia
- Abdominal Pain
- Numbness
- Shortness of Breath

10 to 15% had identifiable organic basis

Kroenke & Mangelsdorf (1989) Am J Med; Strosahl et al. (1998); Kaiser; APA
Comorbidities:
Chronic Conditions and Depression

- Alzheimer’s 11%
- Asthma 45%
- HIV 12%
- CAD 17%
- Stroke 23-40%
- MI 25-40%
- Diabetes 27%
- COPD 40%
- Cancer 42%
- Parkinson’s Disease 51%
- Chronic Pain 52%

Common Chronic Medical Conditions that Have Significant Behavioral Health Components

- Pain
- Hypertension
- Asthma
- Diabetes
- Sleep disorders
- HIV
- Cardiovascular Disease
- Irritable Bowel Syndrome
- Obesity
- Sexual Dysfunction
Depression and Diabetes

- 80% of increased cost are medical, not behavioral
- More than doubled: excessive hunger, abnormal thirst, shakiness, blurred vision. Feeling faint and daytime sleepiness nearly five fold (Malek, Norris, 2008)
- Poor self-care increases acute healthcare episodes
- Depressed and anxious patients consume up to 4 times more medical resources
- Depression is more predictive of negative outcome for most other chronic diseases than the severity of the other diseases themselves
Increased Costs

**COMORBID ANXIETY**

67% increase in monthly health care expenditures for those with chronic conditions and comorbid anxiety.

- Without Anxiety: $870/mo
- With Anxiety: $1460/mo

**COMORBID DEPRESSION**

54% increase in monthly health care expenditures for those with chronic conditions and comorbid depression.

- Without Depression: $840/mo
- With Depression: $1290/mo

## Annual Medical Expenditures for Adults with and without a MH Condition

<table>
<thead>
<tr>
<th>Condition</th>
<th>Cost without mental health condition</th>
<th>Cost with mental health condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>All adults *</td>
<td>$1,913</td>
<td>$3,545</td>
</tr>
<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>

*Refers to all adults with and without chronic conditions.

Improved Outcomes and Lower Costs With BH Integration

- **Medical use decreased 15.7%** for those receiving behavioral health treatment while medical use increased 12.3%\(^1\) for controls who did not receive behavioral health treatment

- Depression treatment in primary care for those with diabetes resulted in **$896 lower** total health care cost over 24 months\(^2\)

- Depression treatment in primary care resulted in **$3,300 lower** total health care cost over 48 months\(^3\)
  - Resulting in a **return of $6.50 for every $1 spent**

- **Multi-condition collaborative care for depression and diabetes** saved **$594 per patient** over 24 months.\(^4\)

Sources:  
The addition of psychological interventions for Kaiser clients with serious medical disorders resulted in:

- 77.9% reduction in their average length of hospitalization
- 66.7% reduction in hospitalization frequency
- 48.6% decrease in number of prescriptions written
- 48.6% decrease in physician office visits
- 45.3% decrease in emergency room visits
- 31.2% decrease in telephone contacts.

Meeting Patients Where They Are: Reducing stigma against seeking mental health care

Integrated Care for Mental Health Conditions
- Depression/Anxiety
- Substance Abuse
- ADHD
- Other

Integrated Care for Medical Conditions
- Diabetes/BP/Obesity
- Heart Disease
- Childhood Chronic Illness
- Stress-linked Physical Symptoms

Integrated Care for Persons: Social and Care Complexity
- Functional impairments or diagnostic uncertainty
- Distress, distraction & readiness to engage in care
- Social safety, support & participation
- Organization of care / relationships in health system
- Shared language with providers / sufficient insurance

Source: CJ Peek & Mac Baird, 2010
How do we do this? Integrated Care Models

**Consultative Model/PCMH-N**
- Psychiatrists/Therapist sees patients in consultation in his/her office – away from primary care

**Co-located Model**
- Psychiatrist/Therapist sees patients in primary care

**Collaborative Model**
- Psychiatrist/Therapist provides caseload consultation about primary care patients; works closely with primary care providers (PCPs) and other primary care-based behavioral health providers (BHP)

Source: http://uwaims.org
Patient Centered Care – whole person care

- Integrated
- Meeting the person where they are
- Impossible to separate behavioral component from health component
  - Jim: Type 1 hypoglycemia, prevention of ER visits
  - Kathy: Obese, CHF, DM2, heart valve replacement, depression
  - Insulin starts/restarts
Psychological Factors

❖ Health Behaviors
❖ Health Beliefs
❖ Self-Efficacy
❖ Trust/Mistrust of the Health System
❖ Stress
Team-based care

- PCP able to focus on what they do best
- Physician consultation
  - Mental Health support
  - Engagement with patients and family members
- Office In-services (anxiety, depression, medications, etc.)
Population-Health Management

- close gaps in care, routine screenings, preventative maintenance (mental and health), patient handouts, etc. move towards proactive vs. reactive care

ADT’s/Transitions of Care
Enhanced Access

- On-site brief intervention. Most patients referred to mental health services don’t go. “The grey area”
- 2-way coordination with community resources, schools, specialty mental health (Suicidal patient, APS)
- Development of Community Resource book/Relationships – PCMH-N
Payment for Added Value

• Assessment and Intervention for mental/behavioral health, substance abuse and misuse/abuse and health behavior change. PHQ-2’s, etc.

• Improve acute and long-term outcomes, patient and provider satisfaction, decrease monthly costs for enrolled population, decrease ER visits and prevent/decrease hospitalizations (both medical and psychiatric) – 15% reduction in ER visits this year
PCMH Behavioral Health Care Management

- Care Management and Support – value and risk based (what the patient needs and when). Address population and individual health behaviors. Offer self management support.
  - Diabetes Prevention/Group Visits
  - ADHD medication follow-ups
  - Asthma flare-ups, anxiety, high/low BG, food insecurities, etc.
Care coordination and Transitions of Care – Assessing social determinants of health, health literacy, medication management, etc. and action planning to reduce readmission.

• ER pain medications
• Pharmacies, Specialists, Community Resources, etc.
• Reducing Barriers (transportation, costs, support, SUD, etc.)
Performance Measurement and Quality Improvement Strategies

- Program development, evaluation, treatment and follow-up protocols (PDSA’s, practice education, staff support/education, corrective action plans, etc.)
  - CAPHS, MIPCT/SIMS, HEDIS, etc.
- A1c’s <7 from 23% to 40% improvement
Examples

❖ Group Visits

• Improve quality of care and clinical outcomes
• Provide another option for patient access
• Raise patient and provider satisfaction
• Improve efficiencies and control costs
• Peer support
• Increase patient understanding of disease/condition
• Address medical and psychosocial issues
Examples

❖ Diabetes Prevention Program
  • 5-7% weight loss over 12 months
  • Increased physical activity to 150 minutes/week
  •Pt engagement leads to prevention of diabetes, reduced medical costs

❖ Chronic Disease Self Management Programs: Diabetes, Chronic Pain, etc.

❖ Anxiety, Depression, Stress Management, etc.
Susan

- CVD, DM for 15+years, obese, lower leg edema, neuropathy, possible skin cancer. Areas addressed: medication adherence (using insulin adequately), nutrition, physical activity, obtaining preventative exams and addressing skin lesion (addressing fears), utilizing specialists when needed to avoid hospitalization (foot care, cardiologist) using Motivational Interviewing, Brief Action Planning, Cognitive Behavioral Therapy, Strengths-Based Interventions and utilizing patient’s spiritual beliefs and family support. A1c from 9.1 to 7.9
Case Example

❖ Derek

- 34 Bipolar Disorder other mental health impairments, Diabetes, Asthma. Low health literacy. Excessive ER visits (5 in 3 mths) due to transportation. Result: Self-advocacy, new PCP. Brief Action Planning, Problem-solving, Motivational Interviewing. A1c = 7, hospitalizations in past 6mths: 0
Case Example

❖ ‘Dwayne’ – 56yr, CHF, previous hospitalizations, new onset DM, morbid obesity, cellulitis of lower limbs, hypertension, cholesterol, suicidal. BG 100’s-600 pp. Results: decreased suicality, medication adherance, cellulitis improved, no further hospitalizations.
Case Example

❖ Chronic pain symptoms
  • Howard Schubiner – Unlearn Your Pain
  • Alan Gordon – Pain Psychology Center
  • Allan Abbass – www.reachingthroughtheresistance.com
Considerations

- What’s your goal? What do you want to accomplish?
- Who is your target population?
  - How will they be identified?
- Perform a needs analysis
- Determine available financial mechanisms
Funding

• Multiple avenues for compensation!

• Healthcare delivery is moving towards team-based care – ie. Care Management which practices will be compensated for

• Multiple codes exist for this care delivery

• How much is YOUR time worth to deliver person-centered care in order to reduce costs, improve health outcomes, improve patient satisfaction and improve YOUR job satisfaction?

• We can help reduce your burden while improving care!
How do you get one?

- ACO
- PO
- Health System
- Build the case: it’s all about the downstream cost savings
Moving Forward…

• What does this look like for you?
• What are your next steps?
• What will you do this week towards improving your behavioral health outcomes?
  • SMART Goals
References

• Melek et al., Economic Impact of Integrated Medical-Behavioral Healthcare, Milliman 2014

• Klein and Hostetter, In Focus: Integrating Behavioral Health and Primary Care, Quality Matters Archive, The Commonwealth Fund Sep 2014