Integration of Behavioral Health and General Medical Services for Youth

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Duke University Health System
May 12, 2016
Disclosures

• No disclosures of potential conflicts of interests or honoraria to report.
Objectives

• Gain a working understanding of “integration” and “collaborative care” in child psychiatry.

• Introduce evidence-based models for integrating behavioral health and primary care services.

• Identify financial models supporting integrated care for youth.

• Consider integrated care in the broader scope of population health.
Objectives

• Gain a working understanding of “integration” and “collaborative care” in child psychiatry.
• Introduce evidence-based models for integrating behavioral health and primary care services.
• Identify opportunities for financial support for integrated care for youth.
• Consider integrated care in the broader scope of population health.
Why integrate?
Why integrate?

• Adults:
  – Adults with serious and persistent mental illness (SPMI) have significantly lower life expectancy, often due to chronic physical conditions.
  – Adults with high utilization of healthcare services often have comorbid behavioral health (BH) problems.
  – Adults are unlikely/unwilling to receive care in the specialty BH arena.

Why integrate?

• Youth:
  – Of those who do receive care, most have less than 3 visits in the specialty BH sector.
  – For youth with BH problems, possibly decreased receipt of preventive medical care?

Integration continuum

Four quadrant model
The Four Quadrant Clinical Integration Model (MH/SU)

Quadrant II
MH/SU ↑ PH ↓
- Outstationed medical nurse practitioner/physician at MH/SU site (with standard screening tools and guidelines) or community PCP
- MH/SU clinician/case manager w/ responsibility for coordination w/ PCP
- Specialty outpatient MH/SU treatment including medication-assisted therapy
- Residential MH/SU treatment
- Crisis/ED based MH/SU interventions
- Detox/sobering
- Wellness programming
- Other community supports

Quadrant IV
MH/SU ↑ PH ↑
- Outstationed medical nurse practitioner/physician at MH/SU site (with standard screening tools and guidelines) or community PCP
- Nurse care manager at MH/SU site
- MH/SU clinician/case manager
- External care manager
- Specialty medical/surgical
- Specialty outpatient MH/SU treatment including medication-assisted therapy
- Residential MH/SU treatment
- Crisis/ED based MH/SU interventions
- Detox/sobering
- Medical/surgical inpatient
- Nursing home/home based care
- Wellness programming
- Other community supports

Quadrant I
MH/SU ↓ PH ↓
- PCP (with standard screening tools and MH/SU practice guidelines for psychotropic medications and medication-assisted therapy)
- PCP-based BHC/care manager (competent in MH/SU)
- Specialty prescribing consultation
- Wellness programming
- Crisis or ED based MH/SU interventions
- Other community supports

Quadrant III
MH/SU ↓ PH ↑
- PCP (with standard screening tools and MH/SU practice guidelines for psychotropic medications and medication-assisted therapy)
- PCP-based BHC/care manager (competent in MH/SU)
- Specialty medical/surgical-based BHC/care manager
- Specialty prescribing consultation
- Crisis or ED based MH/SU interventions
- Medical/surgical inpatient
- Nursing home/home based care
- Wellness programming
- Other community supports

Persons with serious MH/SU conditions could be served in all settings. Plan for and deliver services based upon the needs of the individual, personal choice and the specifics of the community and collaboration.

Integrated care

• Four components common to integrated care models:
  – Patient health (or medical) home.
  – Team-based care.
  – Stepped care.
  – Four quadrant model for clinical integration.

Integrated care: SAMHSA

- Family and youth-guided teams with care coordination capability.
- Individualized and coordinated care plans.
- Use of evidence-based guidelines.
- Established and accountable relationships with other entities.
- Data-informed planning.

<table>
<thead>
<tr>
<th>Components of the Chronic Care Model</th>
<th>Specific Features of the Interventions</th>
</tr>
</thead>
</table>
| Delivery System Redesign            | • Care/case management* or integrated practices  
• Medical care, mental health, or CD enhancement (on-site or off-site by appropriate specialists) to provide  
  – Supervision of care managers  
  – Direct patient care when needed  
  – Education and consultation  
• Screening |
| Patient Self-Management Support (often delivered by care managers) | • Educational programs (e.g., Life Goals Program) and materials  
• Goal setting  
• Motivational interviewing  
• Systematic follow-up of symptoms and adherence to treatment  
• Links to community resources (e.g., travel, housing) |
| Decision Support                    | • Treatment algorithms and guidelines  
• Expert advice from specialists |
| Clinical Information Systems        | • Patient registry  
• Refill monitoring through pharmacy databases to assure adherence |

*Care manager functions include coordination and communication among health care providers, systematic follow-up with structured monitoring of symptoms and treatment adherence, patient education and self-management support including motivational interviewing.
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Evidence for pediatric collaborative care
Evidence for pediatric collaborative care

Four selected randomized trials


<table>
<thead>
<tr>
<th>Study location, year</th>
<th>Study sample</th>
<th>Personnel</th>
<th>Study type, Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors’ Office Collaborative Care (DOCC), Children’s Hospital of Pittsburgh, 7 community &amp; 1 academic pediatrics practices, published 2014</td>
<td>321 randomized, 292 completed&lt;br&gt;Age 5-12 yrs&lt;br&gt;Diagnoses: ADHD, externalizing behaviors, anxiety</td>
<td>Case Managers (Master’s level Social Workers)</td>
<td>Cluster randomized control trial&lt;br&gt;Intervention: Case manager delivered/coordinated CBT (6-12 sessions over 6 months), psychoeducation&lt;br&gt;Control: Case manager provided psychoeducation and facilitated referral to outside mental health provider</td>
</tr>
<tr>
<td>Reaching out to Adolescents with Depression (ROAD) study, University of Washington Seattle, 9 urban pediatric &amp; FM clinics, 2010-11</td>
<td>101 randomized, 94 completed&lt;br&gt;Age 13-17 yrs.&lt;br&gt;Diagnosis: Depression</td>
<td>Depression Care Managers (Master’s level Social Workers)</td>
<td>Randomized control trial&lt;br&gt;Intervention: Depression care manager delivered psychoeducation, treatment planning, CBT (two 4-session modules), check-in every 1-2 wks regarding psychiatric medications, stepped care based on PHQ-9 score&lt;br&gt;Control: Usual care with primary care provider</td>
</tr>
<tr>
<td>Youth Partners in Care (YPIC), University of California at Los Angeles, 2 public sector sites, 2 managed care sites, 2 academic sites, 1999-2003</td>
<td>418 randomized, 344 completed&lt;br&gt;Age 13-21 yrs.&lt;br&gt;Diagnosis: Depression</td>
<td>Care Managers (psychotherapists with a Masters Degree or PhD in mental health or nursing)</td>
<td>Randomized comparative effectiveness trial&lt;br&gt;Intervention: Care managers delivered psychoeducation, CBT (three 4-session modules), stepped care&lt;br&gt;Control: Primary care clinicians trained on depression evaluation and treatment</td>
</tr>
<tr>
<td>Boston Medical Center, one urban CHC and one urban academic pediatrics practice, 2010-13</td>
<td>156 randomized, 148 completed&lt;br&gt;Age 6-12 yrs&lt;br&gt;ADHD diagnosis being considered</td>
<td>Lay Case Managers (Bachelor’s or Master’s Degree level without formal mental health training), Case Managers received training in motivational interviewing and Triple P parenting program for the study</td>
<td>Randomized comparative effectiveness trial&lt;br&gt;Intervention: Control conditions + Case Managers delivered motivational interviewing to address ambivalence toward treatment and parental mental health problems, and Triple P parenting program&lt;br&gt;Control: Case managers coordinated completion of ADHD scales, obtained clinical information on child symptoms, were liaisons between child psychiatrist or developmental pediatrician and PCP regarding diagnosis &amp; treatment</td>
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### Selected outcomes

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<tr>
<th></th>
<th>Clinical improvement</th>
<th>Quality of life improvement</th>
<th>Increased MH service use</th>
<th>Satisfaction with care</th>
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<td><strong>DOCC, Children’s Hospital of Pittsburgh</strong></td>
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<td>✔️</td>
<td>✔️</td>
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<td><strong>ROAD, University of Washington, Seattle</strong></td>
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MH = Mental Health; ✔️ = Statistically significant (p<0.05); NA = Not assessed
Evidence for pediatric collaborative care

Original Investigation

Integrated Medical-Behavioral Care Compared With Usual Primary Care for Child and Adolescent Behavioral Health: A Meta-analysis

Joan Rosenbaum Asarnow, PhD; Michelle Rozenman, PhD; Jessica Wiblin, BA; Lonnie Zeltzer, MD

**From: Integrated Medical-Behavioral Care Compared With Usual Primary Care for Child and Adolescent Behavioral Health: A Meta-analysis**


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**Figure Legend:**

Overall and Individual Study Effects Error bars indicate 95% CI. CBT indicates cognitive-behavioral therapy; TBI, traumatic brain injury. Because this figure breaks studies into finer categories than those in the overall moderator analyses, summary effect sizes may differ slightly.
Child psychiatry telephone consultation for primary care clinicians
Design of telephone consultation programs

– Regional hubs at academic centers with a Child Psychiatry consultation team:
  • 1 FTE Child Psychiatrist
  • 1 FTE mental health therapist
  • 1 FTE care coordinator

– Each hub enrolls the primary care practices in its surrounding geographic region
Design of telephone consultation programs

- Regional hubs provide
  - Telephone consultation within 1 hour of request by pediatricians during business hours.
  - Face-to-face evaluation with a specialist within 2 weeks when indicated.
  - Referral back to primary care or to the specialty mental health system depending on complexity.
  - Care coordination
  - Ongoing pediatrician education
Clinicians’ Utilization of Child Mental Health Telephone Consultation in Primary Care: Findings From Massachusetts

Katherine Hobbs Knutson, M.D.
Bruce Masek, Ph.D.
Jeffrey Q. Bostic, M.D.
John H. Straus, M.D.
Bradley D. Stein, M.D., Ph.D.

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Improved pediatrician education

- Pediatricians report improved knowledge, skills, and attitudes following involvement in a telephone consultation program.
- Mental health specialists providing telephone consultation note improved sophistication of consultation questions.
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Potential funding for integrated programs for youth
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- Health Homes option for states through an amendment to the Social Security Act added through the ACA section 2703

Health Homes

• Services:
  – Comprehensive care management
  – Care coordination
  – Transitional care between healthcare settings
  – Individual & family support
  – Referral to community & social support services
  – Use of Health IT

Health Homes

• Provider types
  – Designated providers – example community mental health providers
  – Team of behavioral healthcare professionals
  – Multidisciplinary health team

Potential funding for integrated programs for youth

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• Patient Centered Medical Home capitated rates

Potential funding for integrated programs for youth

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• Patient Centered Medical Home capitated rates
• Medicaid Targeted Case Management
Potential funding for integrated programs for youth

- Health Homes option for states through an amendment to the Social Security Act added through the ACA section 2703
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- Medicaid waiver programs
  - 1915A voluntary managed care waivers
  - 1115 waivers for innovative approaches to service delivery
Potential funding for integrated programs for youth

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- Blending Medicaid with other funding streams
  - Child protective services, Department of Education, Department of Justice, among others
  - SAMHSA System of Care and mental and behavioral health state block grants
  - HRSA Division of Services for Children with Special Healthcare Needs grants

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The transition from volume- to value-based care

Fee-for-service care—or, volume, encounter-based care—is transitioning to value-based medicine. New care delivery models, such as Accountable Care Organizations (ACOs) and patient centered medical homes (PCMH), are taking center stage. At the core of value-based medicine is the goal of collaborative, coordinated care and population health management. Are you equipped for change?
Population health

Severe

Moderate

Mild

No Behavioral Health problems

Specialty behavioral health services

Integrated behavioral health services in primary care
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