PRIMARY CARE INTEGRATION

Presented By:
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DHCF
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INTEGRATION IMPROVES LIVES, REDUCES COSTS

RETURN ON INVESTMENT

ROI of $6.50 for every $1 spend

CONTROLLED TRIALS DEMONSTRATE IT IS MORE EFFECTIVE AND EFFICIENT

70+ randomized controlled trials demonstrate it is both more effective and more cost-effective

+ Across practice settings
+ Across patient populations
+ For a wide range of the most common BH disorders

BETTER OUTCOMES

Better outcomes for common chronic medical diseases.

GREATER PROVIDER SATISFACTION

Sources: Unützer J et al. “The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes.” Health Home Information Resource Center Brief. Centers for Medicare and Medicaid Services. May 2013. https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf. See also reference list at end of slide deck.

FOUR CORE PRINCIPLES OF INTEGRATED CARE

Based on a summit held at UW in 2011, four principles were identified that should be incorporated into workflows

- Team-based care
- Evidence-based care
- Measurement-based care
- Population-based care

Source: aims.uw.edu

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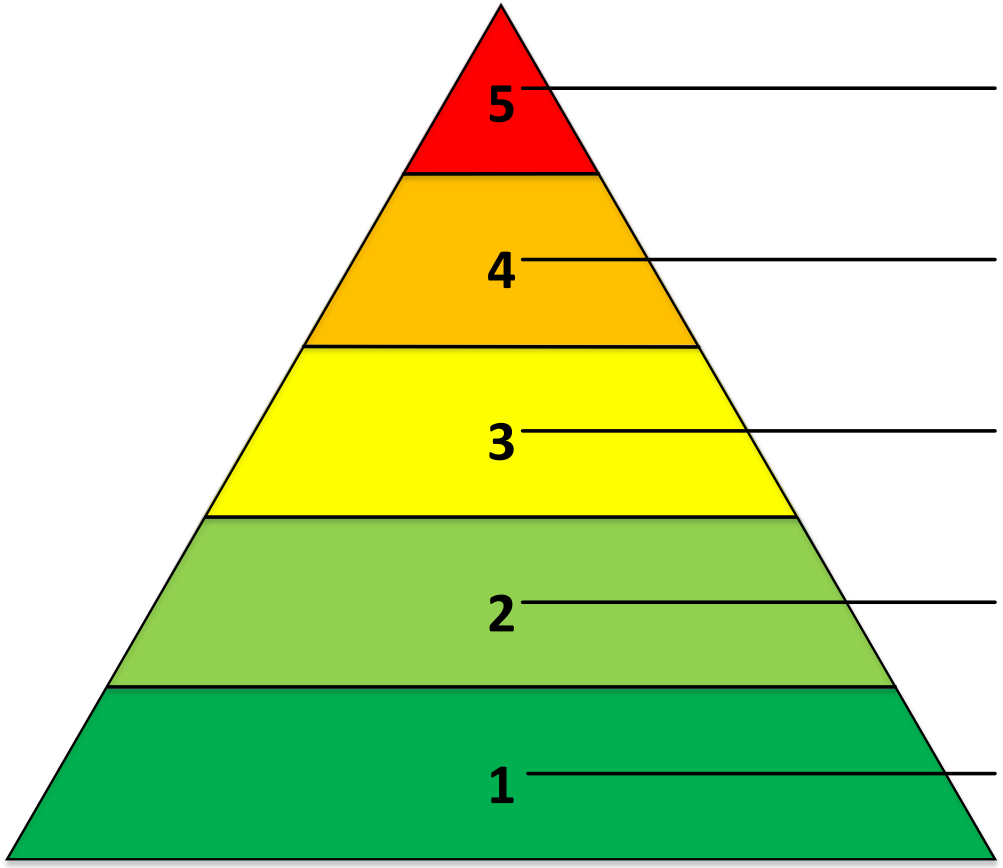
STEPPED MODEL OF INTEGRATED BEHAVIORAL HEALTHCARE



Referral to BH specialty care

PCP supported by collaborative care team with systematic treatment to target

PCP is supported by brief intervention from on-site BH consultant

PCP receives ad-hoc consultation, usually from off-site specialist

PCP Provides first-line treatment

Source: aims.uw.edu

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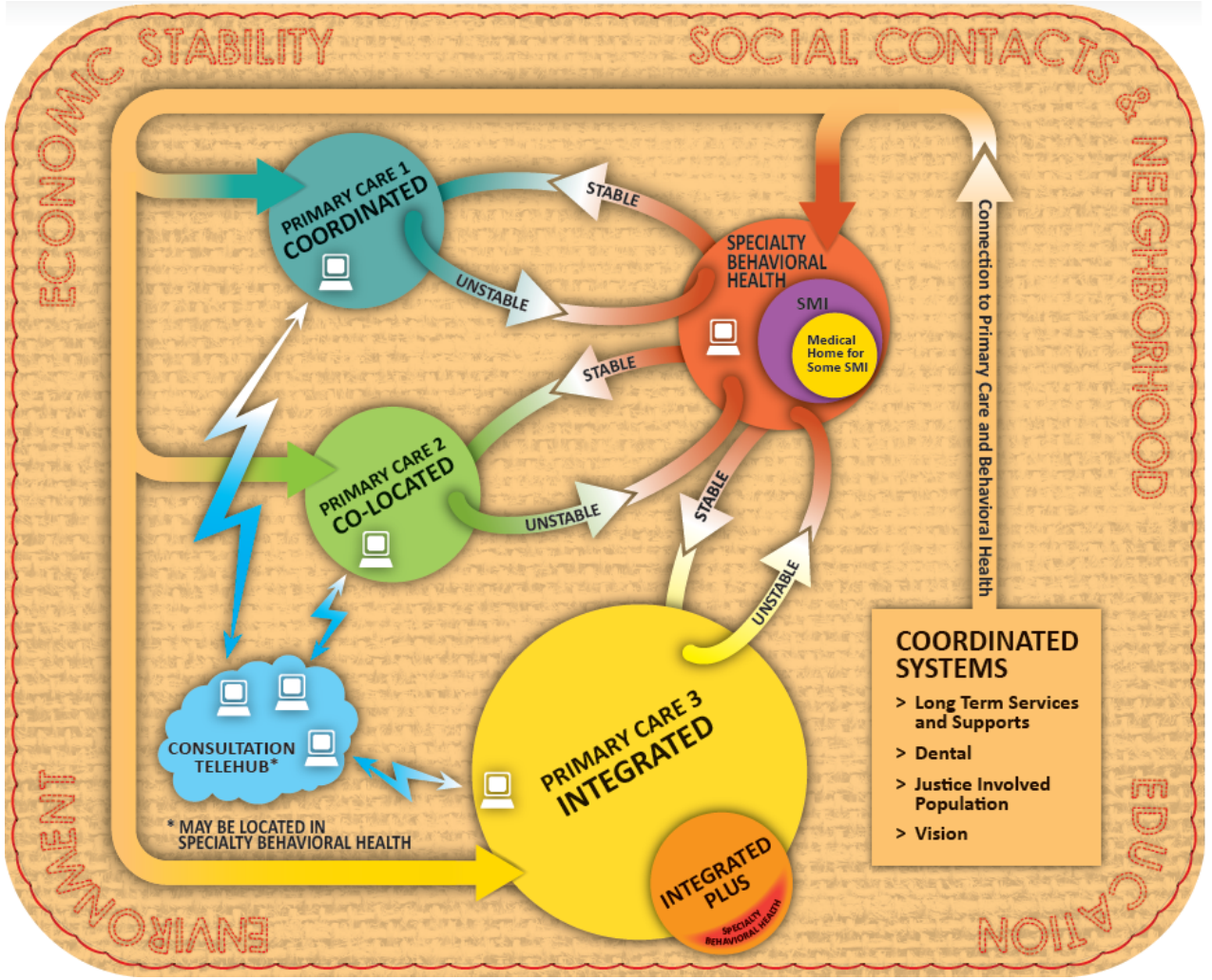
BH IS NOT YOUR AVERAGE SPECIALTY, BUT NEEDS TO ACT MORE LIKE ONE



Source: Raney, Lasky, and Scott (2017). *Integrated Care: A guide to effective implementation.*

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PROBLEMS WE NEED TO ADDRESS TO MAKE PC-BH INTEGRATION WORK

FUNDAMENTAL PROBLEMS

- Demand for BH services far exceeds the supply of BH services
- Siloed services
- BH is both a typical specialty service and a highly atypical specialty service
- Differential metrics, roles, histories, languages
- BH spending leads to medical savings, not BH savings
- Power dynamics

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TWO CULTURES: ONE PATIENT/CLIENT/CONSUMER

Primary Care:

- Continuity is the goal
- Empathy and compassion
- Data are shared
- Large panels
- Flexible scheduling
- Fast-paced
- Time is independent
- Flexible boundaries
- Treatment is external (labs, x-ray, etc.)
- Patient not responsible for illness
- 24-hour communication
- Saved lives
- Disease management

Behavioral Health:

- Termination is the goal – “discharge”
- Professional distance
- Data are private
- Small panels
- Fixed scheduling
- Slower pace
- Time is dependent – “Fifty minute hour”
- Firm boundaries
- Relationship with provider is treatment
- Patient is responsible for participating
- Mutual accountability
- Meaningful lives
- Recovery model

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REALITY CHECK

We cannot ignore the historical realities that have shaped the system of today

- Stigma of behavioral health disorders
- Historical underfunding of behavioral healthcare
- Historical underfunding of social services
- Silos impeding integration
- Power dynamics impacting our conversations
- Cultural impediments to health equity

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SOURCES

- Source: Unützer J, Harbin H, Schoenbaum M, Druss B. The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes, Health Home Information Resource Center Brief, May 2013.
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