Integrated Care 101

Tuesday, January 26, 2021
10:00-11:00 am EST

Presented by:
Jean Glossa, MD, MBA and Lori Raney, MD

The Integrated Care Technical Assistance Program (ICTA) is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,616,075.00 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, CMS/HHS, or the U.S. Government.

ICTA INTEGRATED CARE TECHNICAL ASSISTANCE

PRESENTERS

Jean Glossa, MD, MBA, FACP
Health Management Associates
Managing Director, Delivery System
ICTA Project Director
jglossa@healthmanagement.com

Lori Raney, MD
Health Management Associates
Physician Principal
ICTA Coach/SME
lraney@healthmanagement.com

Luizilda S. DeOliveira RN, BSN, MHA
La Clínica del Pueblo:
Director of Nursing and Care Management
My Health GPS Provider

DISCLOSURES

Faculty	Nature of Commercial Interest
Lori Raney, MD	Dr. Raney discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients. She has no relevant disclosures.
Jean Glossa, MD, MBA, FACP	Dr. Glossa discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients. She has no relevant disclosures.
Luizilda S. DeOliveira RN, BSN, MHA	Ms. DeOliveira is an employee of La Clínica del Pueblo, a non-profit Federally Qualified Health Center providing primary medical care with wraparound services, mental health and substance abuse counseling, language access services, and community health action programs to DC Latino residents. She has no relevant disclosures.
Elizabeth Wolff, MD, MPA	Dr. Wolff discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients. She has no relevant disclosures.

ICTA Technical Assistance

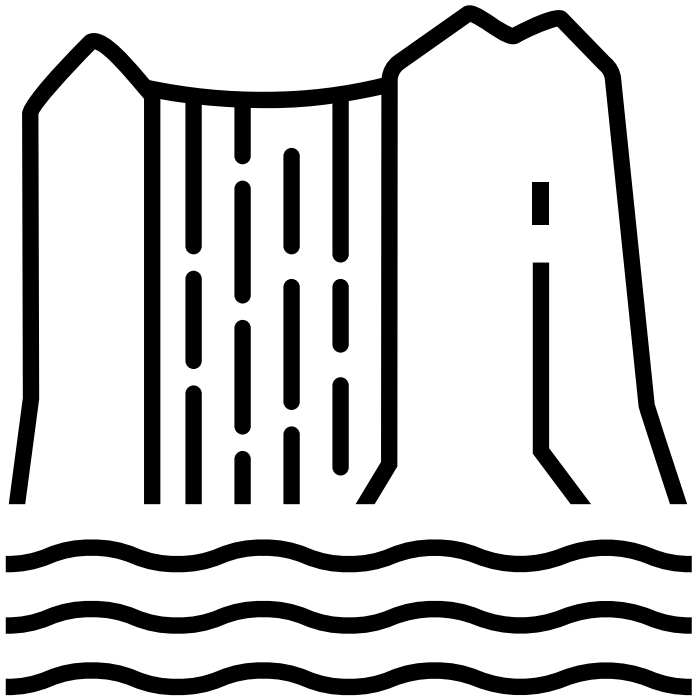
The program offers several components of coaching and training. Material is presented in various formats. The content is created and delivered by HMA subject matter experts with provider spotlights.

All material is available on the project website Integratedcaredc.com

Educational credit is offered at no cost to attendees for many of the components.

OBJECTIVES

1. Define integrated care as it relates to general physical and behavioral health conditions
2. Explain the core principles of effective integrated care
3. Outline the core team members and their roles in integrated care



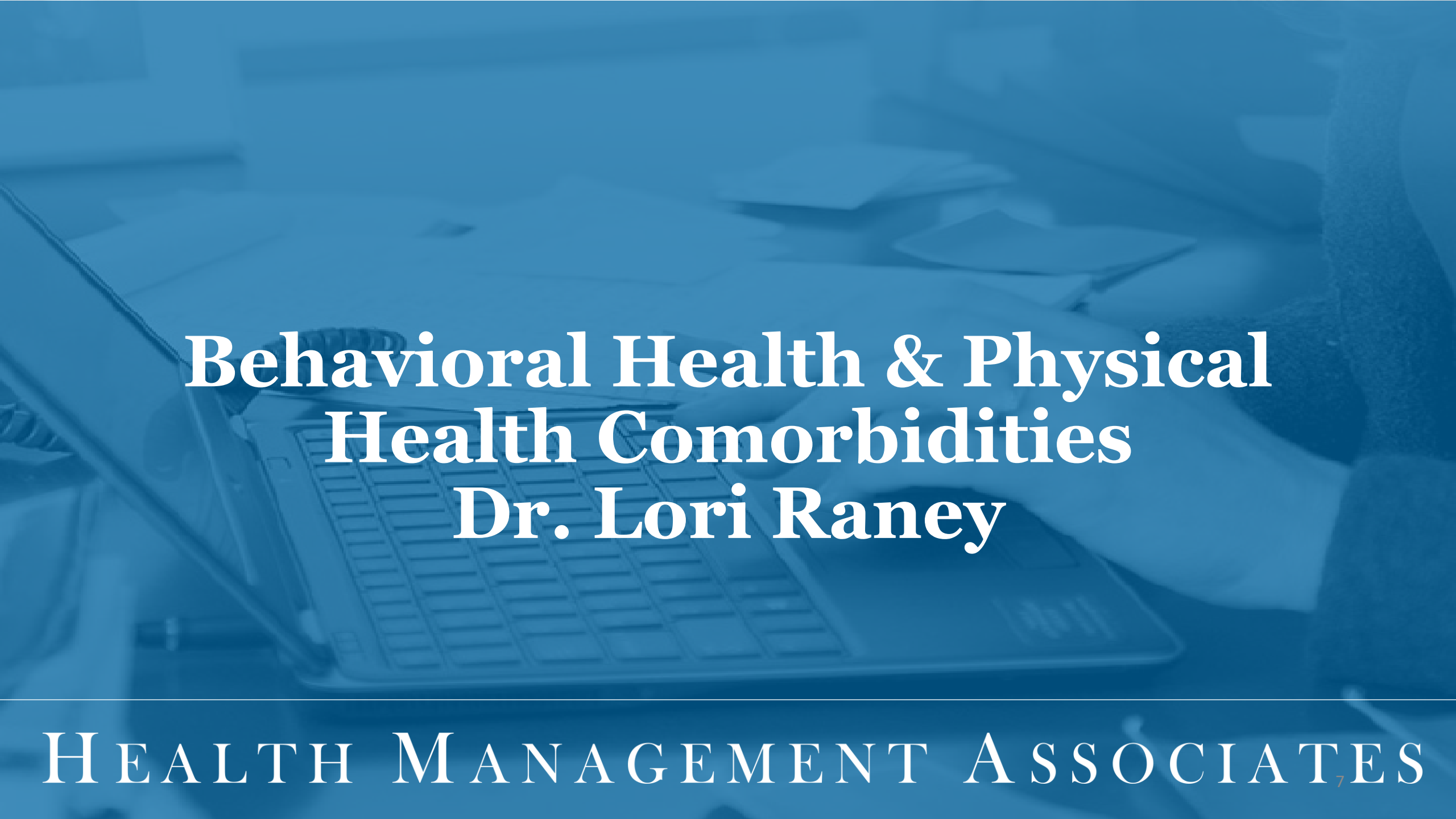
Chatterfall

1. How do you define “integrated care”?

    Use the chat box

2. How do you currently integrate care?

    Use the chat box



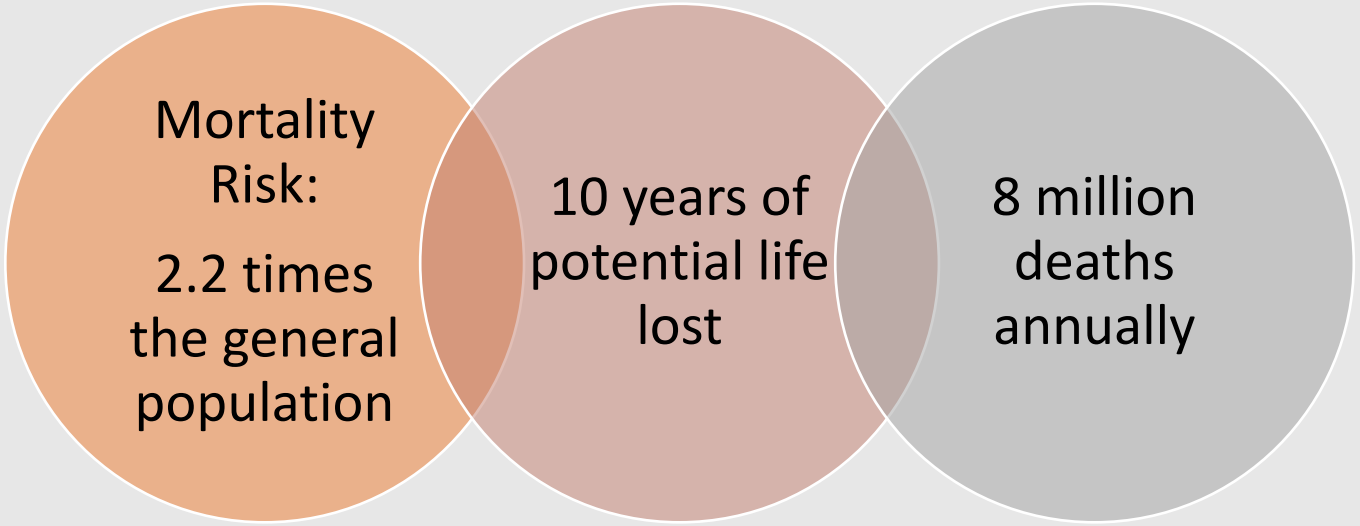
Behavioral Health & Physical Health Comorbidities
Dr. Lori Raney

HEALTH MANAGEMENT ASSOCIATES

The association between mental and physical health

- Poor mental health is a risk factor for chronic physical conditions
  - People with serious mental health conditions are at high risk of experiencing chronic physical conditions
- physical conditions are at risk of developing poor mental health such as depression

Mental Illness and Mortality



Source: Walker, E.R., McGee, R.E., Druss, B.G. *JAMA Psychiatry.* Epub, doi:10.1001/jamapsychiatry.2014.2502

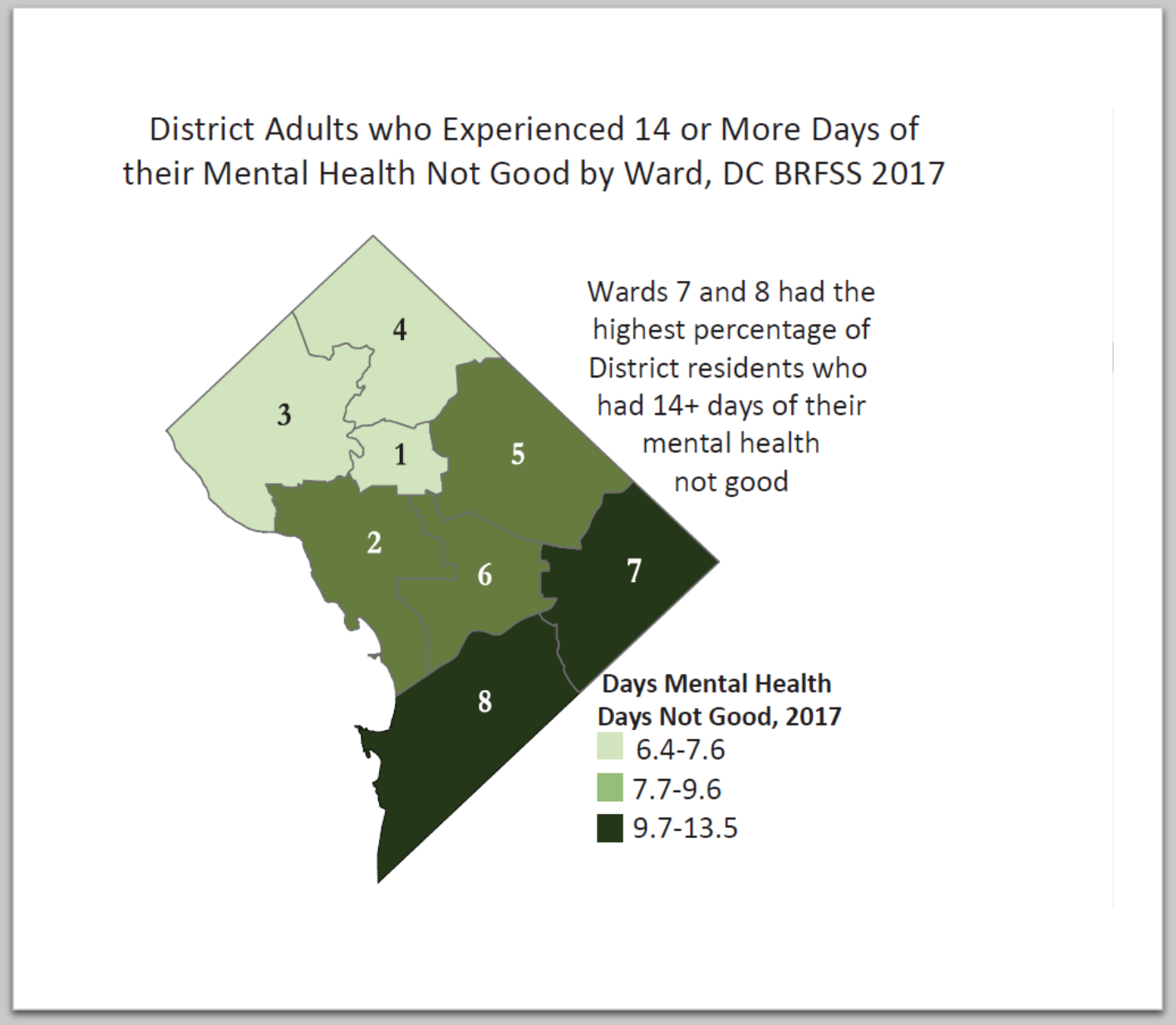
UNDERSTANDING BEHAVIORAL HEALTH

- Represents 25% of all disability worldwide
- 10% of Years Lived with Disability (YLD) from depression alone
- 20 million Americans have a Substance Use Disorder
- Among those, 15 million people in the United States have an alcohol use disorder
- In the US, one suicide every 14 minutes

HEALTH MANAGEMENT ASSOCIATES

2017 DC Resident Behavioral Risk Factor Data[1]

- Inpatient hospitalizations for mental health disorders ranked 3rd among all conditions
- 14.3% of DC adults have been diagnosed with a depressive disorder
- 25.6% of DC adults (18+) report binge drinking[2]
- 9.5% of District adults (18+) reported heavy drinking (males more than 14 drinks per week, females 7 or more drinks per week)
- 14.3% of district adults (18+) were current smokers

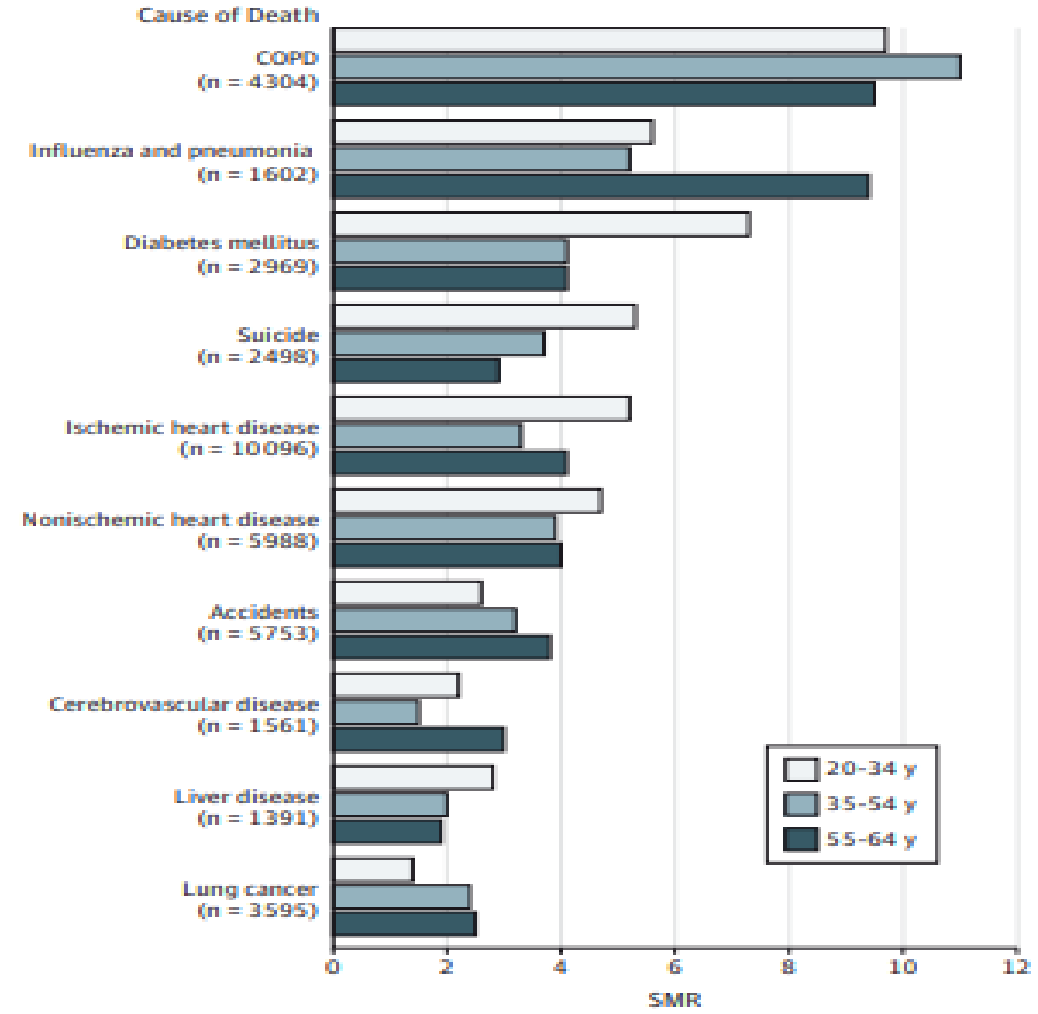


HEALTH MANAGEMENT ASSOCIATES

1 DC Behavioral Risk Factor Surveillance System (BRFSS)
https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/BRFSS%202017%20Annual%20Report%20Final.pdf
2 Males having five or more drinks on one occasion, females having four or more drinks on one occasion

PREMATURE MORTALITY IN ADULTS WITH SCHIZOPHRENIA IN THE US

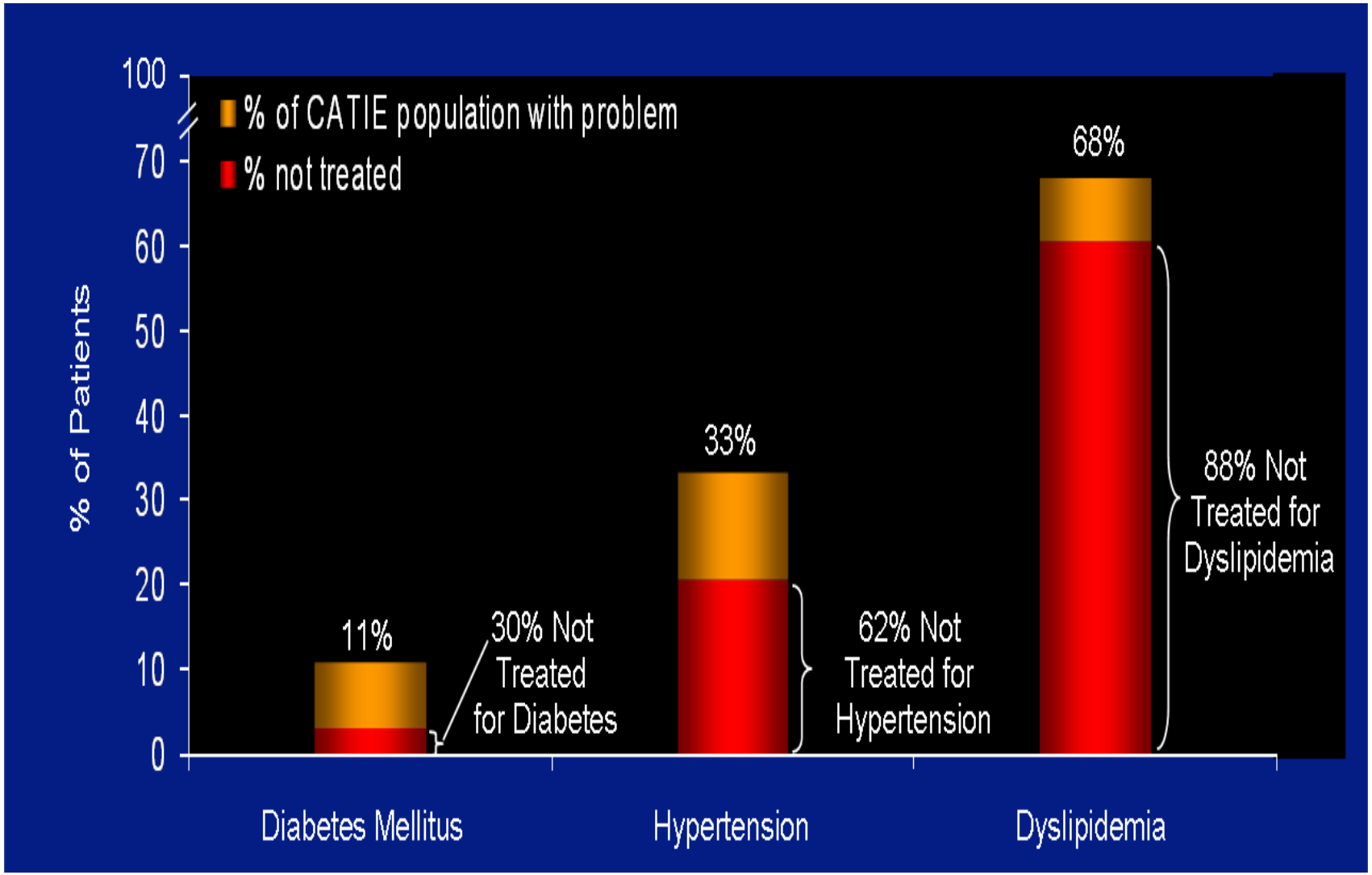
Figure. Standardized Mortality Ratios of Adult Medicaid Beneficiaries Diagnosed as Having Schizophrenia for 10 Common Causes of Death by Age Group (January 1, 2001, to December 31, 2007)



Schizophrenia mortality data are from the National Death Index of Medicaid beneficiaries. General population mortality data are from the Centers for Disease Control and Prevention WONDER data. COPD indicates chronic obstructive pulmonary disease; SMR, standardized mortality ratio (standardized for age, sex, race/ethnicity, and geographic region)

Source: *JAMA Psychiatry.* 2015;72(12):1172-1181. doi:10.1001/jamapsychiatry.2015.1737.

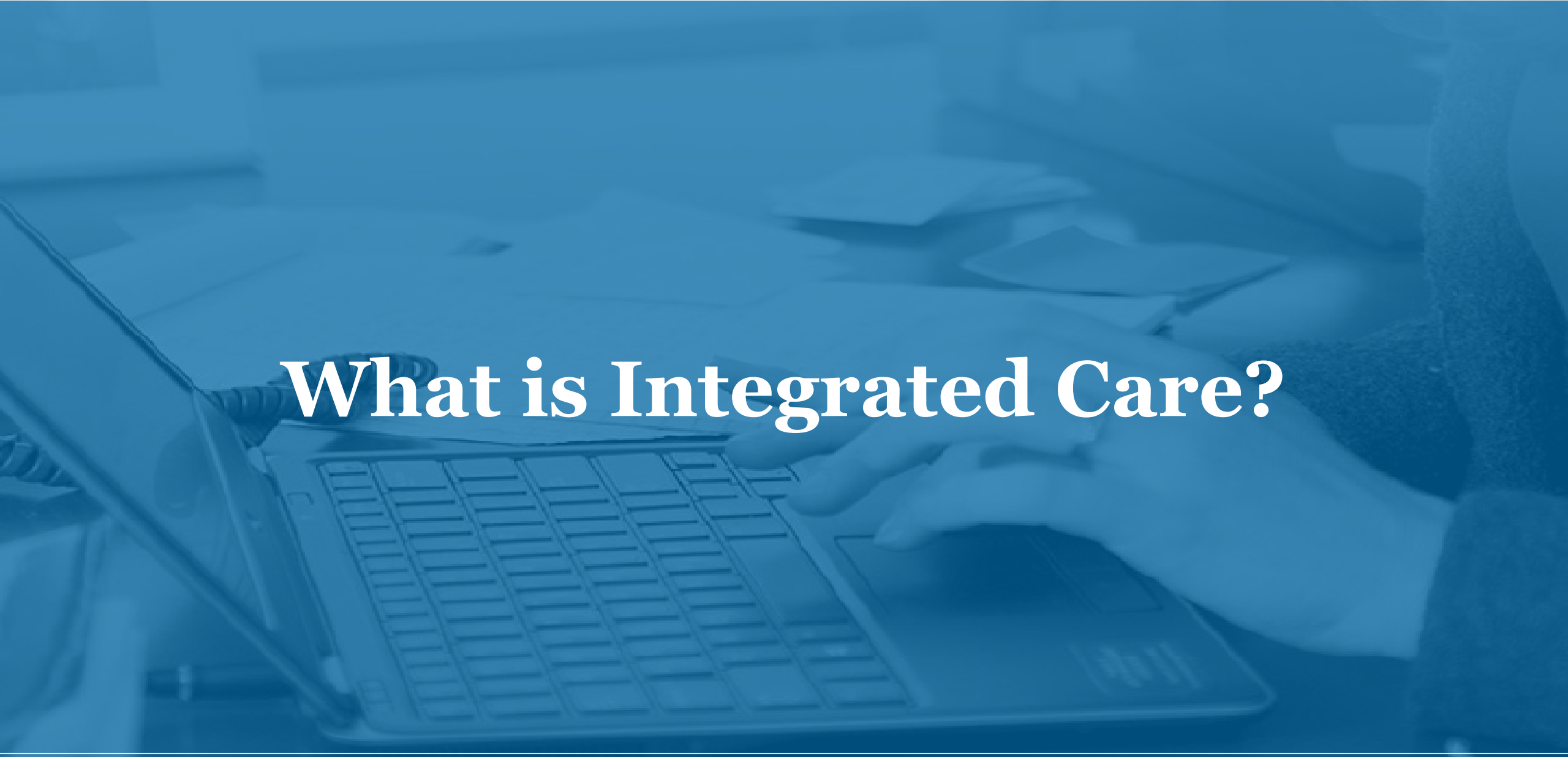
RATES OF NON-TREATMENT FOR PHYSICAL HEALTH CONDITION IN SERIOUS MENTAL ILLNESS



Source: NIMH- Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study

CHRONIC HEALTH CONDITIONS AND RISK OF BEHAVIORAL HEALTH DIAGNOSIS

- Although any illness can trigger depressed feelings, the risk of chronic illness and clinical depression increases with the severity of the illness and the level of life disruption it causes.
- The risk of getting depression is generally 10% to 25% for women and 5% to 12% for men.
- However, those with chronic illnesses face a much higher risk of developing a behavioral health condition-- between 25% and 33%.



What is Integrated Care?

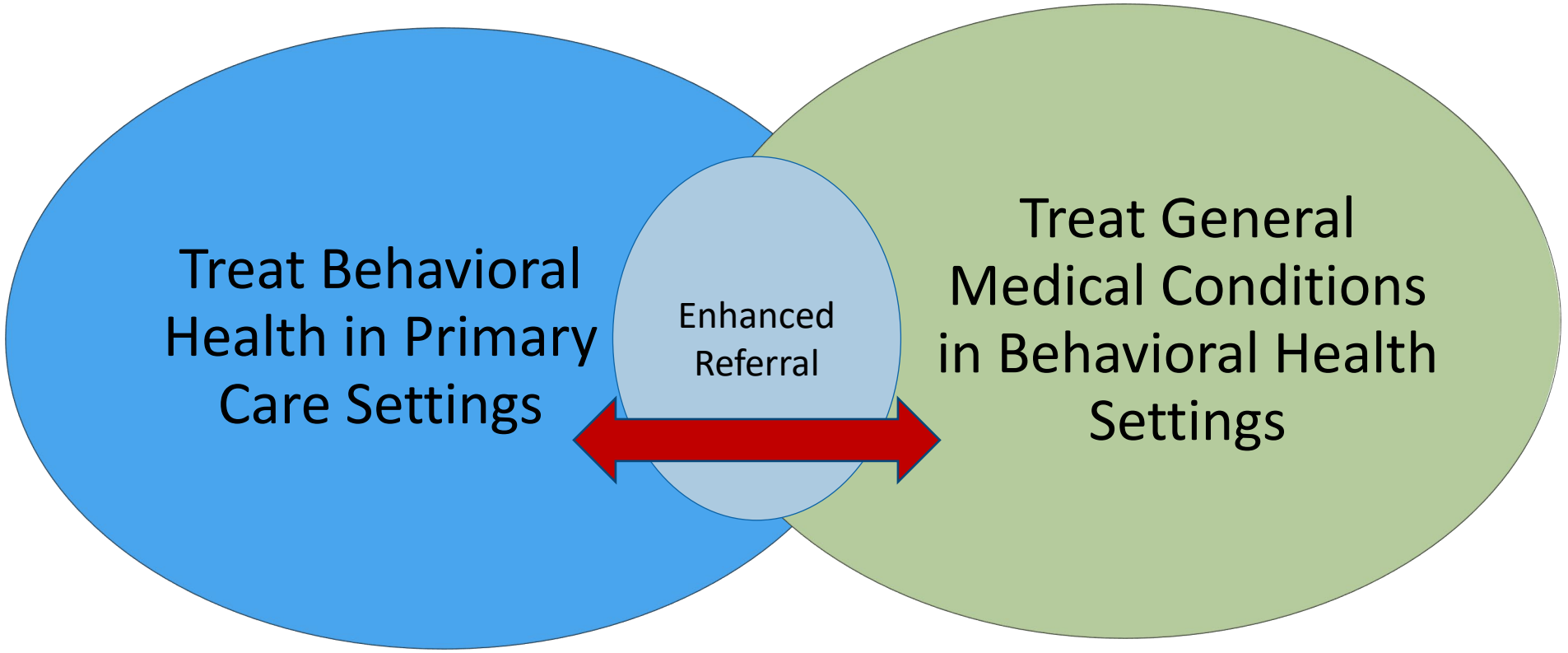
WHAT IS INTEGRATED CARE?

*The systemic approach to provide **person-centered care** for a defined population that coordinates through a team of **primary care and behavioral health practitioners**, **physical and behavioral healthcare** working with the **individuals served, families, and other natural and informal supports.***

*Integrated care models ensure that **mental health, substance use disorder, primary care, and specialty services** are coordinated and delivered in a manner that is most effective to caring for **individuals with multiple health care needs** and produces the best outcomes.*

Source: DC Department of Health Care Finance and Department of Behavioral Health working definition from Medicaid Health Transformation Request for Information.

BI-DIRECTIONAL INTEGRATED CARE



SECRET SAUCE—WHAT MAKES INTEGRATED CARE EFFECTIVE?

Recipe for Success

Ingredients TEMPA

Team that consists at a minimum of a PCP, BHP and psychiatric consultant
Evidence-based behavioral and pharmacologic interventions
Measuring care continuously to reach defined targets
Population is tracked in registry, reviewed, used for quality improvement
Accountability for outcomes on individual and population level

Process of Care Tasks

- ***2*** or more contacts per month by BHP
- Track with registry
- Measure response to treatment and adjust
- Caseload review with psychiatric consultant

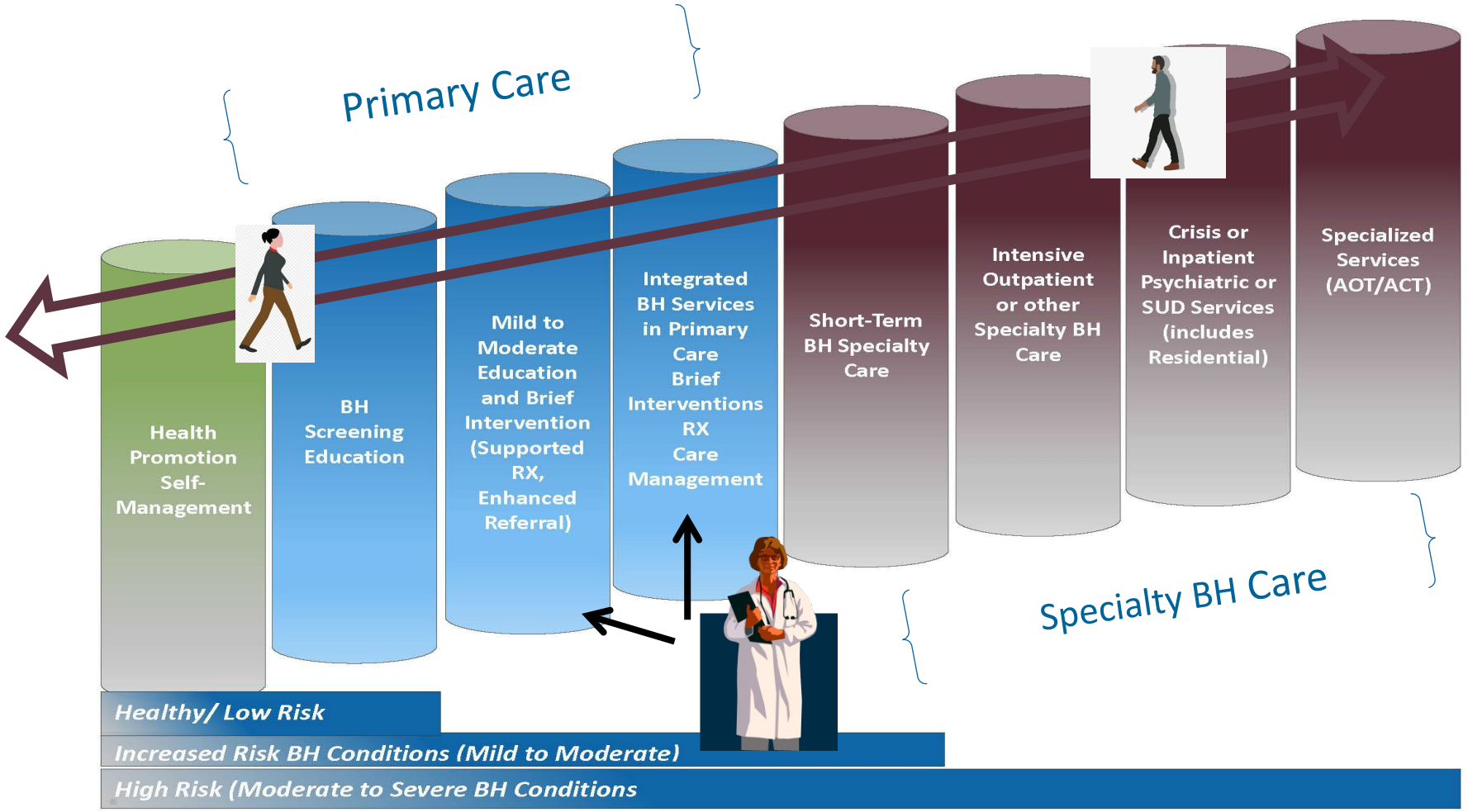
Secret Sauce *Whitebird Brand*

- Strong leadership support
- A strong PCP champion and PCP buy-in
- Well-defined and implemented BHP/Care manager role
- An engaged psychiatric provider
- Operating costs are not a barrier

Raney, Lasky, Scott: Integrated Care: A Guide for Effective Implementation APPI, 2017

DEVELOPMENT OF ROBUST CONTINUUM OF STEPPED CARE

- Uses limited resources to their greatest effect on a population basis
- Different people require *different levels of care*
- Finding the right level of care often depends on *monitoring outcomes*
- Increases effectiveness and *lowers costs overall*

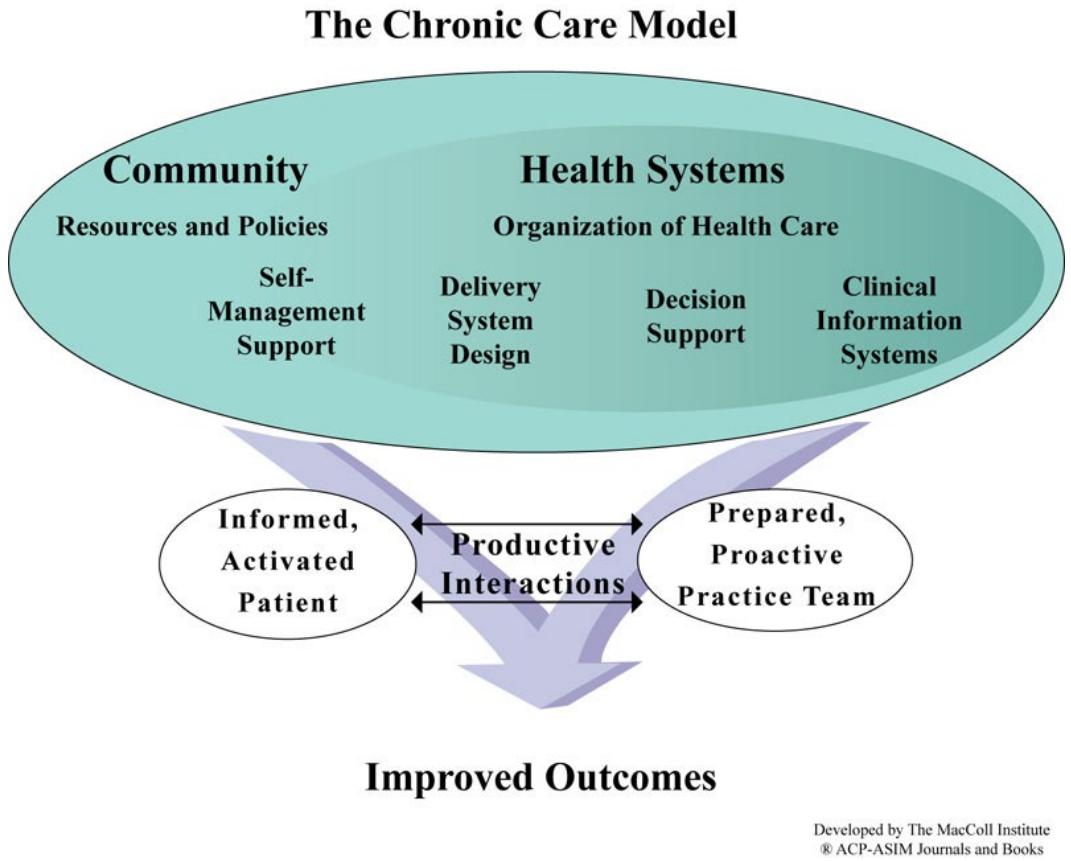


CORE PRINCIPLES OF EFFECTIVE INTEGRATED CARE

Operationalizes the principles of the chronic care model to improve access to evidence based mental health treatments for primary care patients

Integrated Care is:

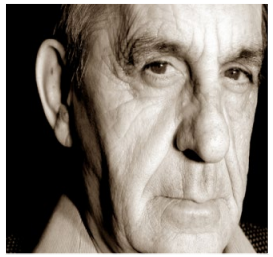
- **T**eam-based effective collaboration and Patient-centered
- **E**vidence-based and practice-tested care
- **M**easurement-based care, treat to target
- **P**opulation-based care – registry, systematic screen
- **A**ccountable care



CHALLENGE IS ACCESS TO BEHAVIORAL HEALTH CARE

How many of these people with behavioral health concerns will see a behavioral health provider?

No Treatment






Primary Care Provider


Mental Health Provider (psychiatric provider or therapist)

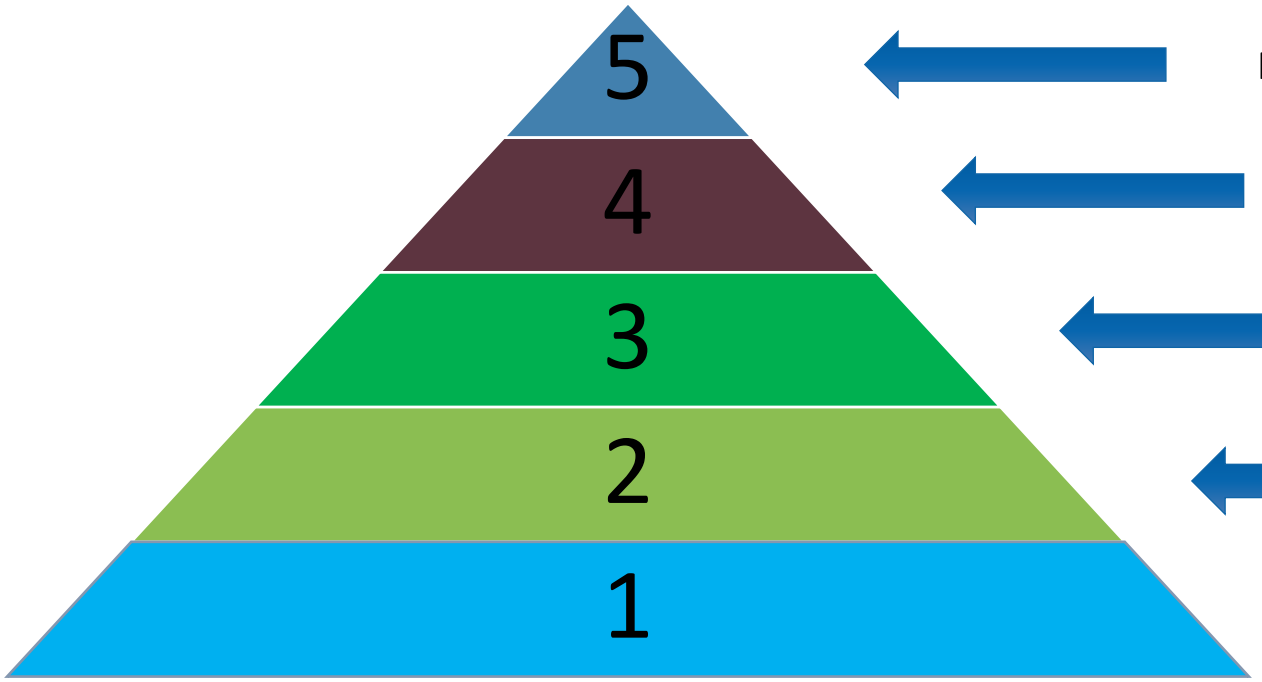

Only 20% receive "adequate" treatment

The study defined ''adequate treatment'' as a course of at least 30 days on an antidepressant or a mood stabilizer, along with four visits to a doctor or at least eight 30-minute psychotherapy sessions with a mental health professional

Wang P, et al., Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005

JAMA. 2003 Jun 18;289(23):3095-105.
The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R).
Kessler RC[1], Berglund P, Demler O, Jin R, Koretz D, Merikangas KR, Rush AJ, Walters EE, Wang PS; National Comorbidity Survey Replication.

ADVANCING LEVELS OF CARE IN THE PRIMARY CARE SETTING



Referral to mental health specialty care

PCP Supported by Collaborative Care Team

PCP supported by brief interventions from BHC

PCP receives ad hoc consultation

PCP provides first line treatment

Source: http://aims.uw.edu/

THE INTEGRATED CARE TEAM

Informed, Activated Patient

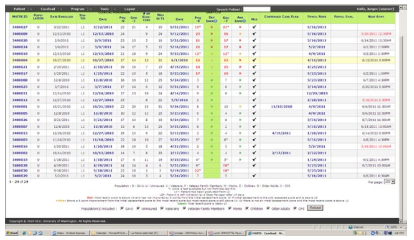
Effective Collaboration

PCP supported by Behavioral Health Care Manager/BHP

PRACTICE SUPPORT

Measurement-guided Treat to Target

Psychiatric Consultation



Caseload-focused Registry review

Training

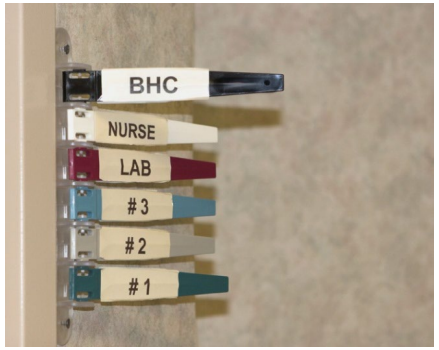
BHPS/CARE MANAGERS

Who are the BHPs/CMs?

- Typically MSW, LCSW, MA, RN, PhD, PsyD, paraprofessionals
- Brief intervention skills, generalists

What makes a good BHP/CM?

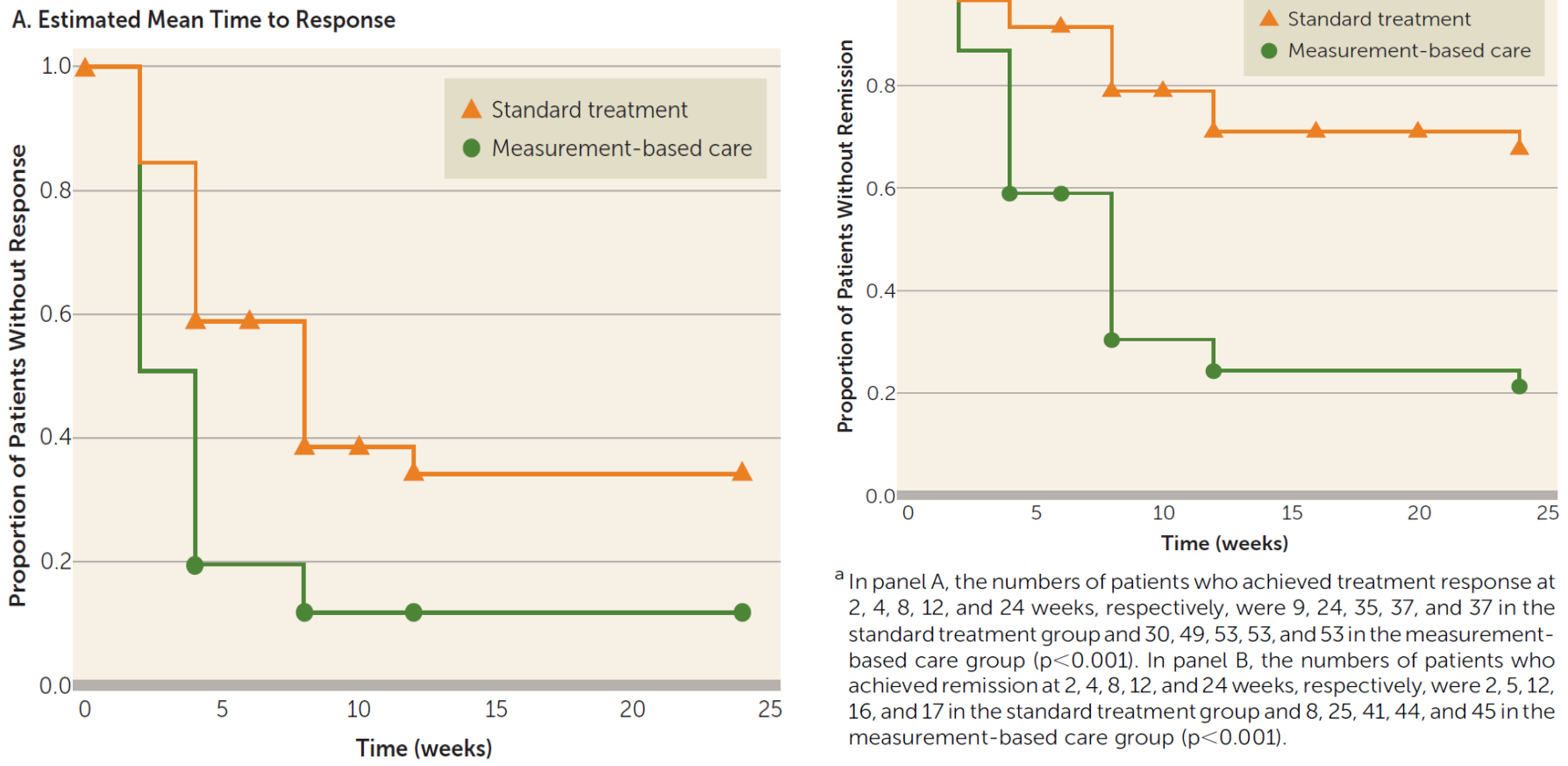
- Organization
- Persistence- tenacity
- Creativity and flexibility
- Enthusiasm for learning
- Strong patient advocate
- Willingness to be interrupted
- Ability to work in a team



CAUTION:
Traditional Approach to therapy
Not willing to be interrupted
Timid, insecure about skills

BEHAVIORAL HEALTH CARE THAT IS MEASURED GETS BETTER

FIGURE 1. Estimated Mean Time to Response and Remission, by Kaplan-Meier Analysis[a]



[a] In panel A, the numbers of patients who achieved treatment response at 2, 4, 8, 12, and 24 weeks, respectively, were 9, 24, 35, 37, and 37 in the standard treatment group and 30, 49, 53, 53, and 53 in the measurement-based care group ($p<0.001$). In panel B, the numbers of patients who achieved remission at 2, 4, 8, 12, and 24 weeks, respectively, were 2, 5, 12, 16, and 17 in the standard treatment group and 8, 25, 41, 44, and 45 in the measurement-based care group ($p<0.001$).

- HAMILTON DEPRESSION MEASUREMENT FOR DEPRESSION (HAM-D) 50% or <8
- Paroxetine and mirtazapine
- Greater response
- Shorter time to response
- More treatment adjustments (44 vs 23)
- Higher doses antidepressants
- Similar drop out, side effects

Source: Quo T, Correll, et al. American Journal of Psychiatry, 172 (10), Oct, 2015

A Tipping Point for Measurement-Based Care

John C. Fortney, Ph.D., Jürgen Unützer, M.D., M.P.H., Glenda Wrenn, M.D., M.S.H.P., Jeffrey M. Pyne, M.D., G. Richard Smith, M.D., Michael Schoenbaum, Ph.D., Henry T. Harbin, M.D.

Objective: Measurement-based care involves the systematic administration of symptom rating scales and use of the results to drive clinical decision making at the level of the individual patient. This literature review examined the theoretical and empirical support for measurement-based care.

Methods: Articles were identified through search strategies in PubMed and Google Scholar. Additional citations in the references of retrieved articles were identified, and experts assembled for a focus group conducted by the Kennedy Forum were consulted.

Results: Fifty-one relevant articles were reviewed. There are numerous brief structured symptom rating scales that have strong psychometric properties. Virtually all randomized controlled trials with frequent and timely feedback of patient-reported symptoms to the provider during the medication management and psychotherapy encounters significantly improved outcomes. Ineffective approaches included one-time screening, assessing symptoms infrequently, and feeding back outcomes to providers outside the context of the clinical encounter. In addition to the empirical evidence about efficacy, there is mounting evidence from large-scale pragmatic trials and clinical demonstration projects that measurement-based care is feasible to implement on a large scale and is highly acceptable to patients and providers.

Conclusions: In addition to the primary gains of measurement-based care for individual patients, there are also potential secondary and tertiary gains to be made when individual patient data are aggregated. Specifically, aggregated symptom rating scale data can be used for professional development at the provider level and for quality improvement at the clinic level and to inform payers about the value of mental health services delivered at the health care system level.

Psychiatric Services 2016; 00:1–10; doi: 10.1176/appi.ps.201500439

MEASUREMENT- BASED CARE CONCEPTS

Process:

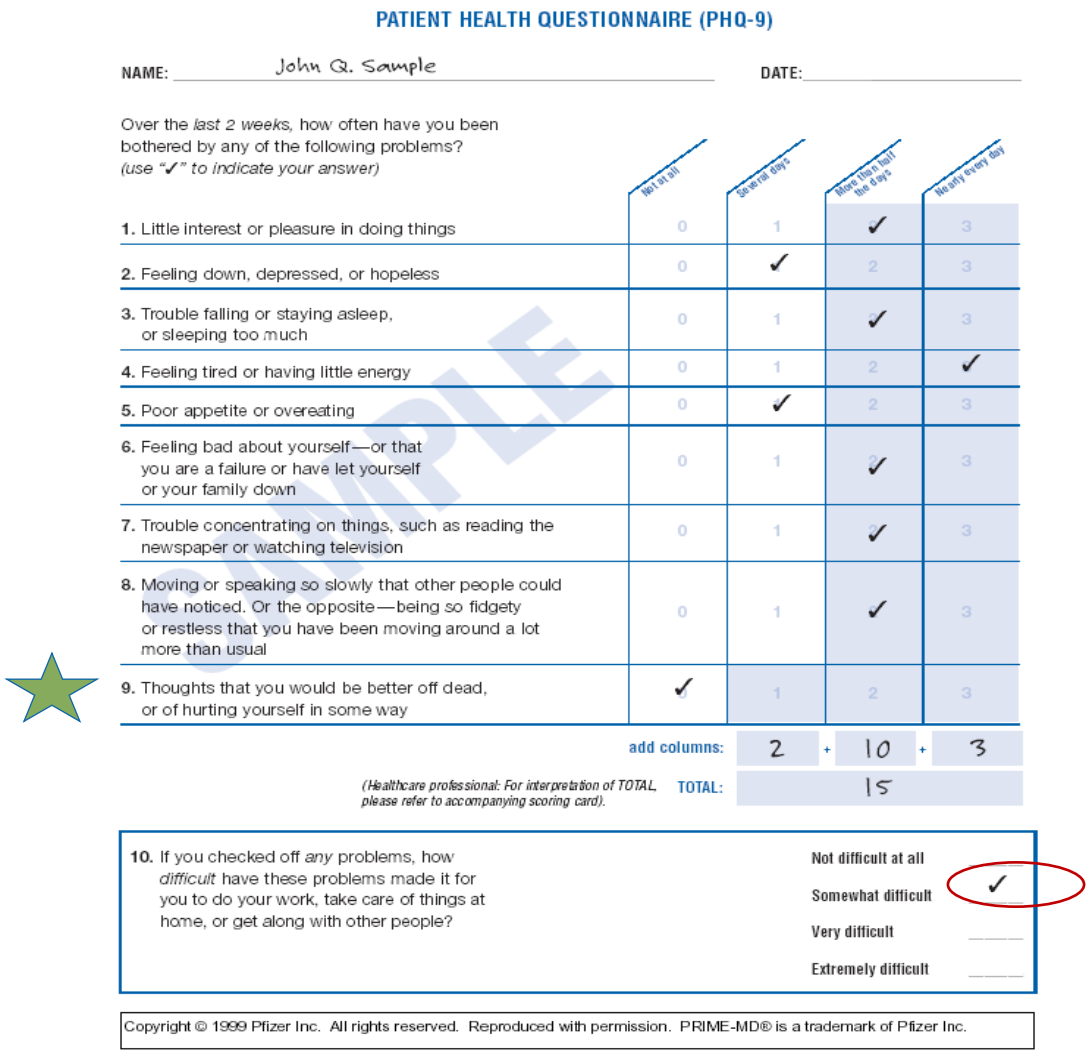
- Systematic administration of symptom rating scales – use huddle or registry
- NOT a substitute for clinical judgement
- Use of the results to drive clinical decision making at the patient level – overcome clinical inertia
- Patient rated scales are equivalent to clinician rated scales
- Aggregate data for
  - Professional development at the provider level – MACRA
  - Quality improvement at the clinic level
  - Inform reimbursement at the payer level

Ineffective Approaches:

- One-time screening
- Assessing symptoms infrequently
- Feeding back outcomes outside the context of the clinical encounter

Source: Fortney et al Psych Serv Sept 2016

VALIDATED SCREENING AND MEASUREMENT TOOLS



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: John Q. Sample DATE: _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	✓	3
2. Feeling down, depressed, or hopeless	0	✓	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	✓	3
4. Feeling tired or having little energy	0	1	2	✓
5. Poor appetite or overeating	0	✓	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	✓	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	✓	3
8. Moving or speaking *so* slowly that other people could have noticed. Or the opposite—being *so* fidgety or restless that you have been moving around a lot more than usual	0	1	✓	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	✓	1	2	3
add columns:	2	+ 10	+ 3	
TOTAL:	15			

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult ✓
- Very difficult
- Extremely difficult

PHQ 9 ≥ 10

- < 5 – remission
- 5 - mild
- 10 - moderate
- 15- moderate severe
- 20 - severe

POPULATION BASED CARE: REGISTRY TO TRACK, MEASURING CHANGE AND ADJUST TREATMENT

			Behavioral Heatlh											
			Treatment Status					PHQ-9				GAD-7			
MRN	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Average # Contacts per month	Initial PHQ-9 Score	Last Available PHQ-9 Sco	% Change in PHQ-9 Score	Date of Last PHQ-9	Initial GAD-7 Score	Last Available GAD-7 Sco	% Change in GAD-7 Score	Date of Last GAD-7
1234501	Active	Bryson Clay	2/28/2018	10/1/2018	9	30	1.20	21	9	-57.1%	10/1/2018	10	4	-60.0%	10/1/2018
1234502	Active	Kayla Ho	3/15/2018	9/30/2018	8	28	1.14	13	17	30.8%	9/30/2018	5	5	0.0%	9/30/2018
1234503	Active	Reed Snow	2/7/2018	9/3/2018	9	29	1.24	10	4	-60.0%	9/3/2018	18	14	-22.2%	9/3/2018
1234504	Active	Princess Hull	4/22/2018	9/17/2018	9	21	1.71	18	18	0.0%	9/17/2018	19	18	-5.3%	9/17/2018
1234505	Active	Ignacio Tanner	4/17/2018	10/1/2018	9	23	1.57	14	8	-42.9%	10/1/2018	16	14	-12.5%	10/1/2018
1234506	Active	Jan Jacobson	2/20/2018	10/2/2018	8	32	1.00	11	4	-63.6%	10/2/2018	19	18	-5.3%	10/2/2018
1234507	Active	Eddie Wu	2/19/2018	9/17/2018	8	30	1.07	16	8	-50.0%	9/17/2018	10	18	80.0%	9/17/2018
1234508	Active	Ulises Rosales	7/30/2018	9/15/2018	4	6	2.67	17	16	-5.9%	9/15/2018	4	3	-25.0%	9/15/2018
1234509	Active	Freddy Keith	7/21/2018	10/15/2018	13	12	4.33	22	18	-18.2%	10/15/2018	5	3	-40.0%	10/15/2018
1234510	Active	Grayson Mcgee	12/19/2017	10/15/2018	7	42	0.67	14	4	-71.4%	10/15/2018	7	17	142.9%	10/15/2018

Two crucial data points:
50% reduction PHQ-9
Remission (PHQ 9 < 5)

TEAM CARE REGISTRY

TeamCare Summary Report

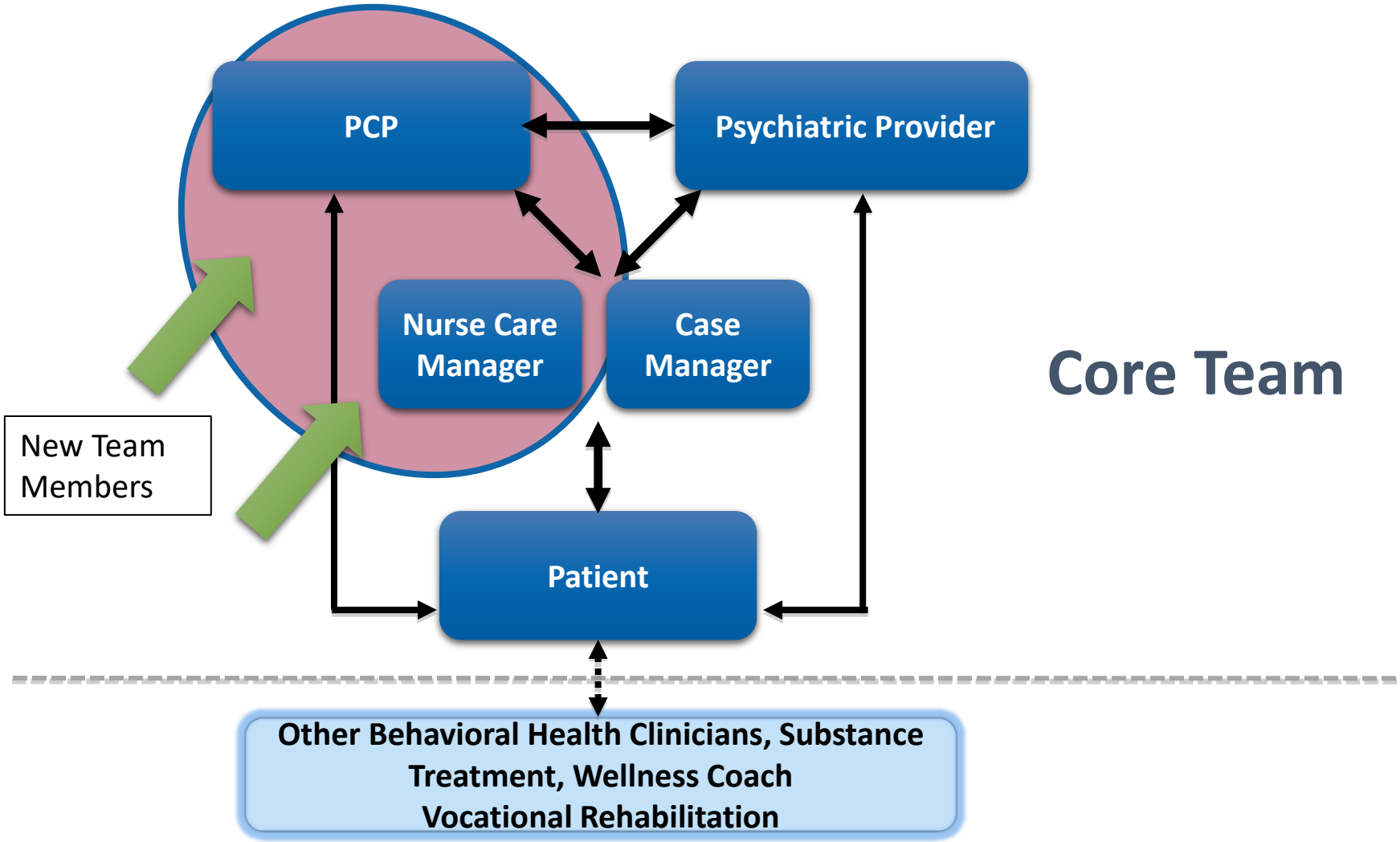
Initial	Clinic	Enroll Date	PHQ		BP		HbA_{1c}		LDL	
			BL	Now	BL	Now	BL	Now	BL	Now
	NSH	5/19/08	19	19	141/69	127/77	7.3	6.8	168	138
	NSH	1/9/08	15	2	118/80	130/80	9.2	8.3	138	124
	EVM	11/12/07	14	9	160/98	150/85	6.4	6.8	108	67
	EVM	10/30/07	13	2	209/119	126/76	7.3	7.7	119	103
	LYN	8/23/07	14	3	149/71	111/58	8.1	7.7	85	82

Source: http://www.teamcarehealth.org

3 MAJOR COMPONENTS FOR PRIMARY CARE IN BEHAVIORAL HEALTH

Source: Kern J in Integrated Care: Working at the Interface of Primary Care and Behavioral Health, L Raney editor, American Psychiatric Publishing, 2014

PRIMARY CARE ON-SITE



CARE MANAGEMENT AND CARE COORDINATION

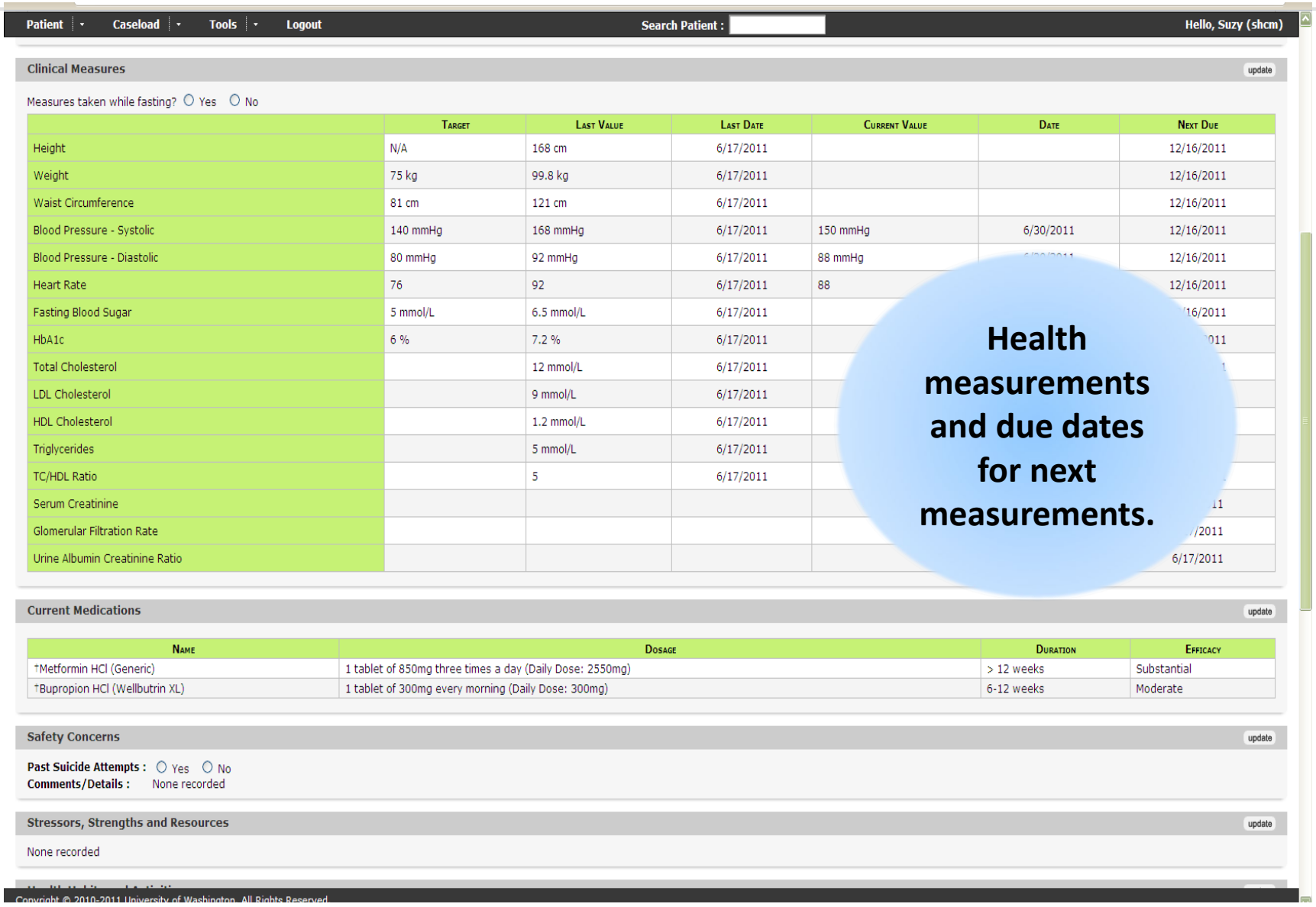
Care Manager

- Facilitates patient engagement and education for health behavior change
- Manages a caseload of patients and systematically tracks treatment response and transitions in registry
- Works closely with both primary care and psychiatric providers
- Supports medication management (both)
- Provides brief, evidence-based counseling or refers to other providers for counseling services
- Reviews challenging patients with appropriate provider (or together)
- Facilitates referrals to other services (e.g., substance abuse treatment, specialty care and community resources) as needed
- Support for case manager's/therapist's questions and education
- Manages care transitions

Care Coordination

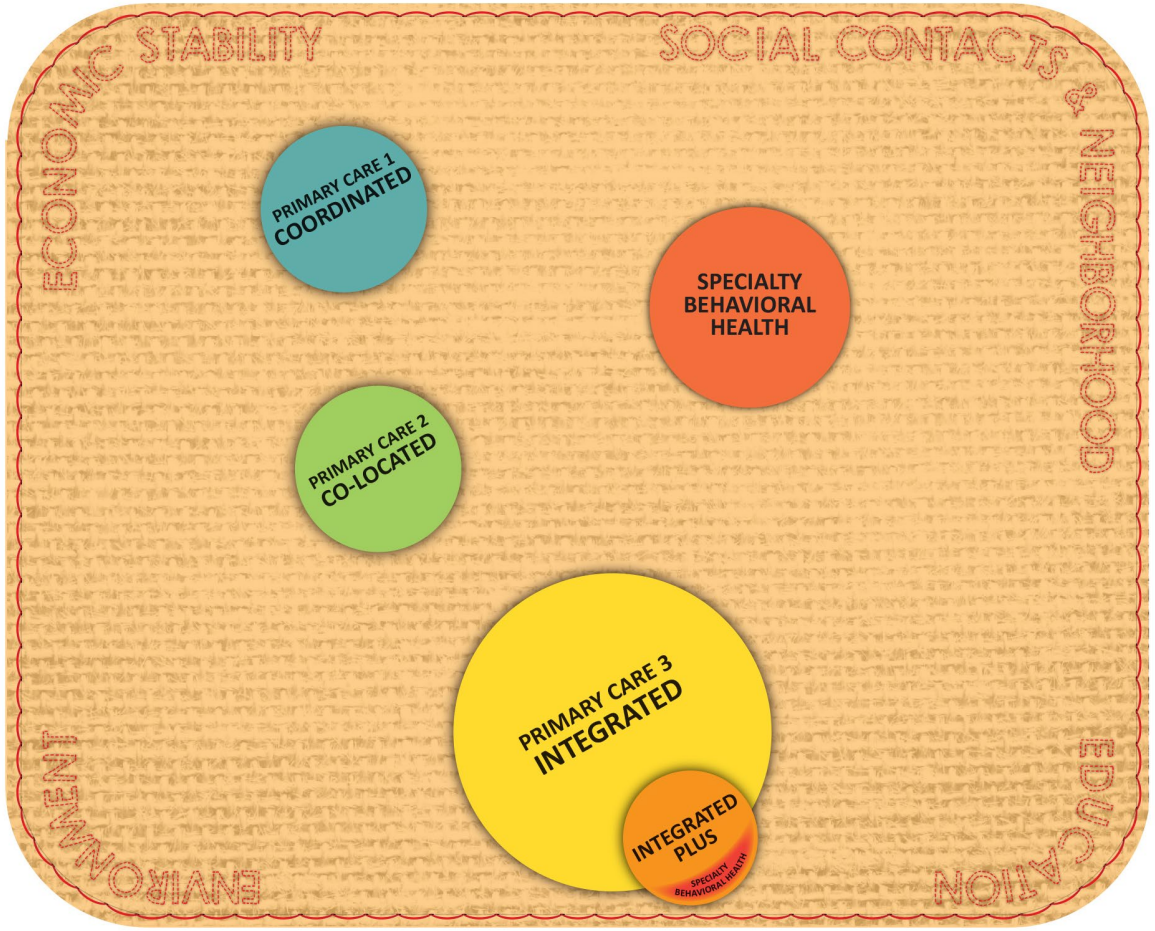
- Deliberately organizing consumer care activities
- *sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.
- *This means the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.

REGISTRIES TO TRACK AND MONITOR PROGRESS TOWARDS GOALS



SOCIAL DETERMINANTS OF HEALTH

PRIMARY CARE AND SPECIALTY BEHAVIORAL HEALTH



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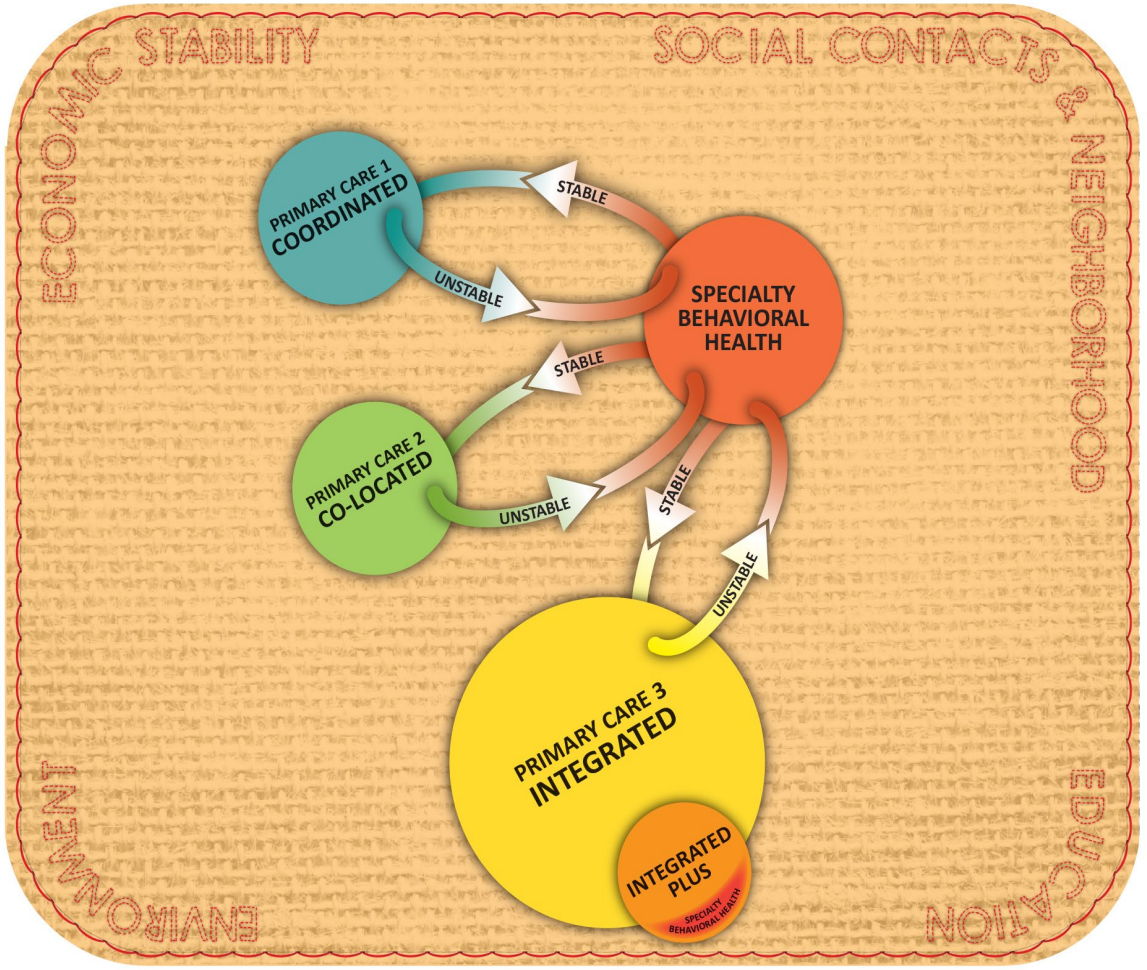
EPISODIC SPECIALTY CARE AS NEEDED



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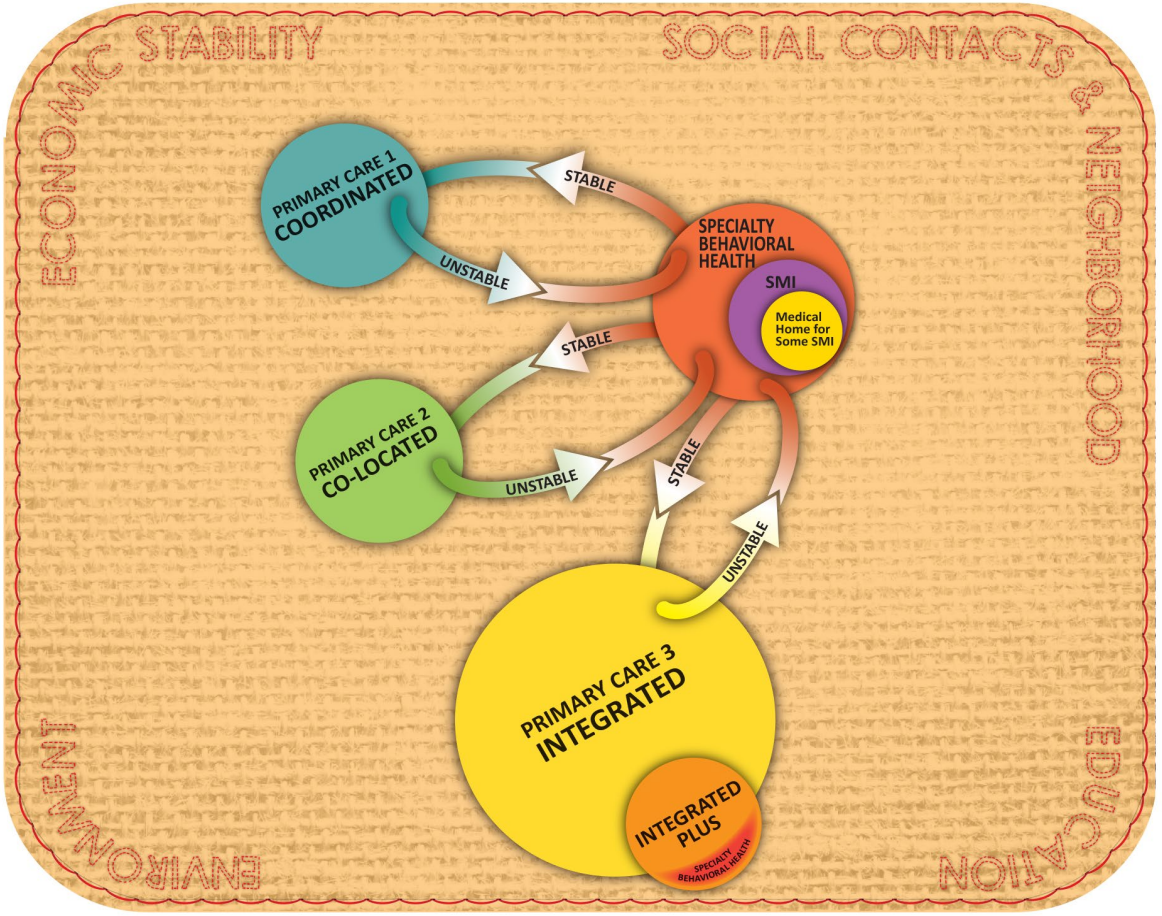
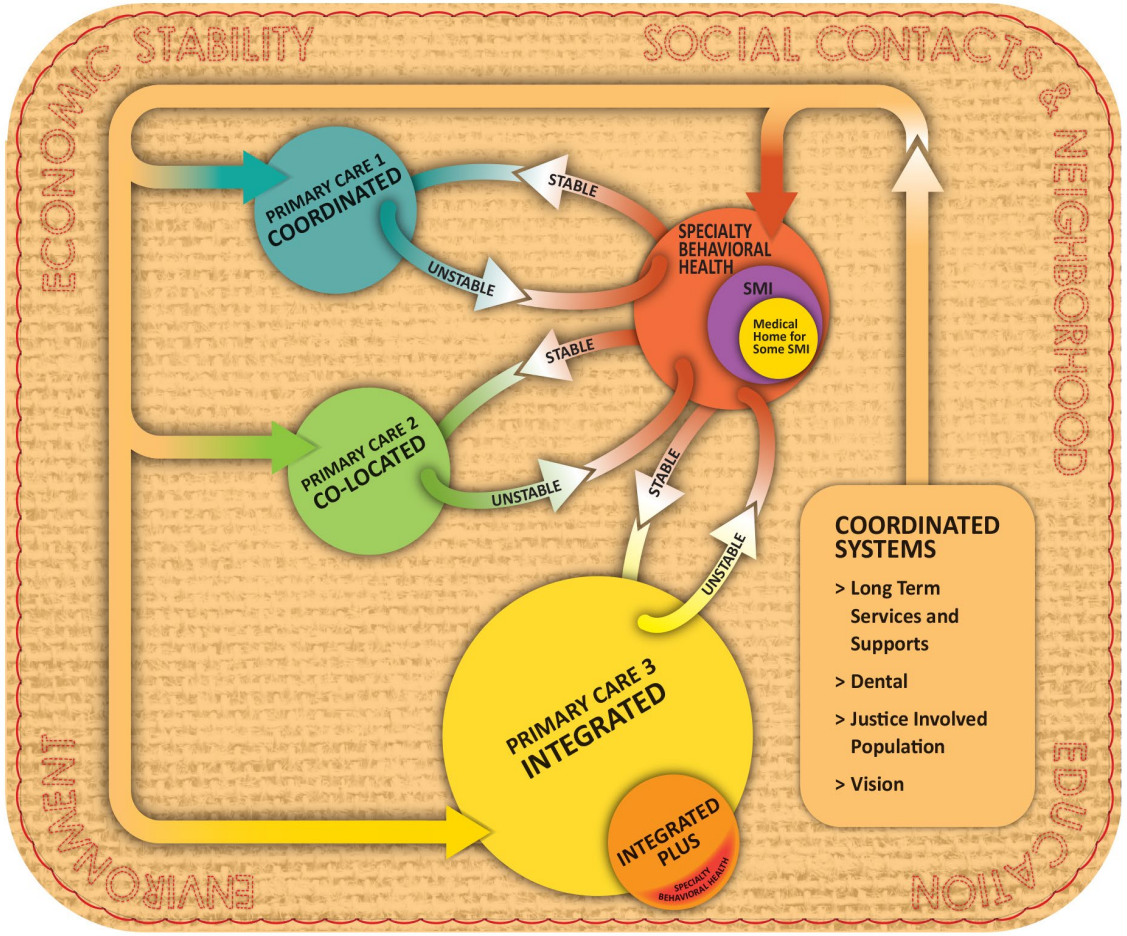
MEDICAL HOME FOR SMI



LTSS, CORRECTIONS, ETC.



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Provider TA Testimonial –

Luizilda S. DeOliveira, RN, BSN, MHA

Director of Nursing and Care Management

La Clínica del Pueblo

HEALTH MANAGEMENT ASSOCIATES

Q&A

HMA

HEALTH MANAGEMENT ASSOCIATES

TA OFFICE HOURS

Host: Dr. Lori Raney

Tuesday, February 2, 2021

1:00-2:00pm EST