Integrating Primary Care and Behavioral Health

Bob Moser, M.D. F.A.A.F.P.
Secretary/State Health Officer
Kansas Dept. of Health and Environment
My Experience with Integrated Care

• Assessed population health issues
  – Co-Morbid Conditions
  – Follow-up to Referral Rates
• Co-located BH within Clinic as Colleague
  – Warm handoffs
  – Adoption of processes to recognize BH issues
• Difficulty transitioning to PC Model
• Learning HER and HIPAA requirements
• Reimbursement to sustain model
Problems with Current System

• Primary Care Physicians
  Unsatisfying work
  Poorly paid
  Unable to spend time with patients
  Dealing with co-morbid conditions and behavioral health components
  HIPAA preventing exchange of information

• Patients
  Access
  Relationships
  Fragmentation

• Purchasers/Payers
  Costs (esp. chronically-ill, wrong place for service)
  Quality
  Experience
Problems with Current System

• The dramatic rise in health care costs and failures of current fragmented system – no improvement in population health status
  – Payers not paying for certain outcomes
  – Many stakeholders embracing innovative ideas on new models of care and payment

• Health research continues to clarify the importance of social and environmental determinants of health and the impact of primary prevention

• An unprecedented wealth of health data is providing new opportunities to understand and address community-level health concerns
Resource Limitations

• Since 2006, employer costs for health care have risen **40%**
  – while **employee** costs (out-of-paycheck and out-of-pocket) have risen **82%**.

• Funding has been stagnant or decreased and now more focused on effectiveness/outcomes
Problems with Current System

- Mental health diagnosis often go unrecognized in primary care
- Primary care providers often under treat mental health diagnosis
  - Also end up managing medications prescribed by other providers
- Screening alone does not improve outcomes for primary care
  - Increases recognition, may broaden community capacity and capability but not considered integrated care
Comorbidity

- Chronic Pain: 20-40%
- Multi-condition Seniors: 23%
- Heart Disease: 15-20%
- Diabetes: 11-15%
- Stroke: 30-50%

Major Depression
Morbidity and Mortality in People with Serious Mental Illness

• Persons with serious mental illness (SMI) are dying 25 years earlier than the general population

• While suicide and injury account for about 30-40% of excess mortality, 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases (National Association of State Mental Health Program Directors, 2006)
Expectations

• Population Health Management
• Team-based care
• Improved communication
• Improved data flow & access
• Right patient at the right time and right place
• Patient-centered aligned incentives – outcomes, quality, cost
• Accountability – outcomes, quality, cost
Why Integrate Behavioral Health In Primary Care?

- Focus is NOT on mental health but bio-psychosocial factors relating physical health
- Address improving patients health and well being
- Focus on reduction of disease related problems
- Focus on treatment adherence and better medication management across providers
Déjà Vu Again

- **Historical Perspective**
  - *Folsom Report* 1967
    - Community Health Centers
  - *Community Oriented Primary Care*
    - 1950 South Africa to Current Models (Explanatory Model)
  - *Medicine and Public Health - the power of collaboration*
    - AMA and APHA effort 1997
  - *Primary Care and Public Health: Exploring Integration to Improve Population Health*
    - IOM March 2012 Report
Health Outcomes

- Length of Life (50%)
- Quality of Life (50%)

Health Factors

- Health Behaviors (30%)
  - Tobacco Use
  - Diet & Exercise
  - Alcohol & Drug Use
  - Sexual Activity

- Clinical Care (20%)
  - Access to Care
  - Quality of Care

- Social & Economic Factors (40%)
  - Education
  - Employment
  - Income
  - Family & Social Support
  - Community Safety

- Physical Environment (10%)
  - Air & Water Quality
  - Housing & Transit

Policies & Programs

County Health Rankings model © 2014 UWPHI
Impact of Chronic Disease

Source: 2010 World Economic Forum

8 risks and behaviors:
1. Diabetes
2. Coronary Artery Disease
3. Hypertension
4. Back Pain
5. Obesity
6. Cancer
7. Asthma
8. Arthritis

15 chronic conditions:
9. Allergies
10. Sinusitis
11. Depression
12. Congestive Heart Failure
13. Lung Disease (COPD)
14. Kidney Disease
15. High Cholesterol

accounting for 80% of total costs for all chronic illnesses worldwide
Clinical Prevention and Public Health: Actual Causes of Death

**Leading Causes of Death**
United States, 2000

- Heart Disease
- Cancer
- Stroke
- Chronic lower respiratory disease
- Unintentional injuries
- Diabetes
- Pneumonia/influenza
- Alzheimer's disease
- Kidney disease

**Actual Causes of Death**
United States, 2000

- Tobacco
- Poor diet/Physical inactivity
- Alcohol consumption
- Microbial agents (e.g., influenza, pneumonia)
- Toxic agents (e.g., pollutants, asbestos)
- Motor vehicles
- Firearms
- Sexual behavior
- Illicit drug use

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What are Determinants of Health?

- Income and social status
- Social support networks
- Education
- Employment/working conditions
- Social and physical environments
- Culture
- Personal health practices and coping skills
- Healthy child development
- Biology and genetic endowment
- Health services
- Gender
## Chronic Disease in Kansas

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Current Prevalence</th>
<th>Estimated Number of Adults</th>
<th>Trend over Last Nine Years</th>
<th>Comparison with National Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>28.7%</td>
<td>600,000</td>
<td>Increasing (by 24%)</td>
<td>Similar</td>
</tr>
<tr>
<td>High Cholesterol among those who were tested</td>
<td>38.6%</td>
<td>640,000</td>
<td>Increasing (by 32%)</td>
<td>Similar</td>
</tr>
<tr>
<td>Smoking</td>
<td>17.8%</td>
<td>376,000</td>
<td>Declined in last 4 years and now stable</td>
<td>Similar</td>
</tr>
<tr>
<td>Diabetes</td>
<td>*8.4%</td>
<td>*179,000</td>
<td>Increasing (by 42%)</td>
<td>Similar</td>
</tr>
<tr>
<td>Overweight or Obesity</td>
<td>64.6%</td>
<td>1.4 million</td>
<td>OW – stable; OB - increasing (by 33%)</td>
<td>Similar</td>
</tr>
<tr>
<td>Less than 5 times F/V Consumption</td>
<td>81.4%</td>
<td>1.7 million</td>
<td>Stable</td>
<td>Similar</td>
</tr>
<tr>
<td>No physical Activity</td>
<td>23.2%</td>
<td>490,000</td>
<td>Declining (by 13%)</td>
<td>Similar</td>
</tr>
</tbody>
</table>

Source: 2001-2009 Kansas BRFSS. Bureau of Health Promotion, KDHE. *2010 KS BRFSS.
Lifestyle Behaviors

• A large proportion of deaths each year in Kansas results from modifiable lifestyle behaviors

• Tobacco use, poor diet and physical inactivity contribute to the largest number of deaths in Kansas.

Recommendations

• Address lifestyle behaviors in a coordinated and systematic fashion

• Implement interventions across multiple sectors

• Implement proven and promising issue-specific interventions
The Solution?

• Integration
  – Learn from previous attempts and ongoing models

• Utilize Population Health Management
  – Define the “Population”
  – Identify Stakeholders
  – Determine “Status” and Gap Analysis
  – Determine Strategies and Tactics to Address
  – Bring the right players to the table - community
Why Integrated Models - for the provider?

• Improve the quality of care
• Lower the cost of care to the healthcare system
• Reduce unnecessary and duplicated care
• Focus on populations of patients
• Improve provider compensation
• Improve work/life balance
• Allowing physicians to do “doctor things” and other providers to contribute to the collaborative effort
• Other Funding Opportunities
Why Integrated Models - for the hospital?

- Reduced length of stay
- Lower cost per case
- Decreased adverse events
- Reduced operating costs
- Higher employee retention rates
- Decreased malpractice claims
- Increased market share
Why Integrated Models – for the patient?

• Established relationship with primary care provider
  – More comfortable discussing mental/behavioral health issues
• Less stigma walking into primary care setting then mental health setting
• More likely to keep appointments where multiple issues are being addressed
Why Integrated Models – for the Community Mental Health System?

• Behavioral Health is Essential to Health
• To better address the needs of individuals with mental health and substance use conditions
• Effective use of resources
• Less stigma walking into primary care setting then mental health setting
Barriers to Integrated Care

• Clinical Barriers
  – Traditional separation of mental health issues from general medical issues
  – Lack of awareness of mental health screening tools in the primary care setting
  – Physicians' limited training in psychiatric disorders and their treatment

• Financial Barriers
  – Medicaid's low payment rates
  – Billing restrictions
Barriers to Integrated Care

• Policy Barriers
  – Physical health and Mental health funding streams
  – Difficulty of sharing information due to HIPAA regulations (progress notes)

• Organizational Barriers
  – Shortage of mental health professionals
  – Limited communication between medical and mental health providers
  – Lack of agreement between medical and mental health providers
HIPAA Regulations in Summary

- The HIPPA regulations permit broad sharing of treatment information without consent.
  - However, the HIPPA regulations only permit sharing of psychotherapy notes with authorization.
  - Moreover, the substance abuse confidentiality law does not permit sharing of records relating to substance abuse treatment or rehabilitation organizations conducted, regulated, or funded by the federal government, without consent, except within a program or with an entity with administrative control over a program.
  - Whenever a state law is more protective of privacy than either the federal HIPAA regulations or the federal substance abuse confidentiality statute and regulations, the state law governs. KANSAS ISSUE
Principles for Successful Integration

A shared goal of population health improvement;

• **Community engagement**
  – defining and addressing population health needs;

• **Aligned leadership that**
  – bridges disciplines, programs, and jurisdictions to reduce fragmentation and foster continuity,
  – clarifies roles and ensures accountability,
  – develops and supports appropriate incentives, and
  – has the capacity to manage change;

• **Sustainability**, key to which is the establishment of a shared infrastructure and building for enduring value and impact;

• The sharing and collaborative use of data and analysis.
Principles for Successful Integration

• Use of multidisciplinary care teams;
  – coordination across care settings;
  – enhanced access to primary care;
  – continuous care, both in and outside of office visits;
  – patient self-management education;
  – a focus on health behavior and lifestyle changes;
  – use of health information technology
    • data access and reporting for communication among providers and between providers and patients

• Select Right Focus
Recommended Readings

• Evolving Models of Behavioral Health Integration in Primary Care. Milbank Memorial Fund. C Collins, D Levis Hewson, R Munger, and T Wade

• Integrating Behavioral Health into Primary Care. SAMHSA-HRSA Center for Integrated Health Solutions [http://www.integration.samhsa.gov/](http://www.integration.samhsa.gov/)
  – Primary Care Provider Curriculum – Learn how to be successful in integrated behavioral health settings

• Community Oriented Primary Care. The Robert Graham Center. Curriculum and Resources
Recommended Readings

• Primary Care and Public Health: Exploring Integration to Improve Population Health; IOM Report March 2012

• Communities of Solution: The Folsom Report Revisited; Griswold, KS; Ann Fam Med May/June 2012 vol. 10 no. 3 250-260
  – http://www.annfammed.org/content/10/3/250.full

• A Healthier America 2013: Strategies to Move from Sick Care to Health Care in Four Years; Trust For America’s Health Report, January 2013
  – http://healthyamericans.org/report/104/
Recommended Readings

• POPULATION MANAGEMENT IN COMMUNITY MENTAL HEALTH CENTER–BASED HEALTH HOMES
  SAMSHA-HRSA Center for Integrated Health Solutions. September 2014
Recommended Readings

• Making a Powerful Connection: The Health of the Public and the National Information Infrastructure
  – Report of the U.S. Public Health Service Public Health Data Policy Coordinating Committee (July 6, 1995); Lasker R, Humphreys B, and Braithwaite W.

• Medicine and Public Health, the power of collaboration
Health Homes in KanCare
Must be eligible for Medicaid, and have at least:

• Two chronic conditions;
• One chronic condition and is at risk for another chronic condition; or
• One serious and persistent mental illness
CHRONIC CONDITIONS

- Mental health conditions
- Substance use disorder
- Asthma
- Diabetes
- Heart disease
- Being overweight
- Expanded list
SIX CORE SERVICES

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care
- Individual and family support
- Referral to community and social support services, if relevant
ROLE OF HIT

- To link services
- Quality reporting
- Provider supports/requirements
- Facilitate communication and feedback
THREE APPROACHES TO INTEGRATED CARE

• **Facilitated referral** - develop formal and informal relationships

• **Co-locate** - behavioral health clinician in a physical health setting or vice versa

• **In-house** - provision of primary care and behavioral health care together
KANCARE HEALTH HOME MODEL

MCO staff + health home partner = a Health Home

Medicaid Agency

MCO

MCO

MCO

CIL
CMHC
PCP
Safety Net Clinic
SUD
CDDO
Other

Recipient
Recipient
Recipient
Recipient
Recipient
Recipient
Recipient
Recipient

Kancare
SERVICE STRUCTURE

Individual and Family Supports

- Health Promotion
- Referral to community and social supports
- MCO
- HH Partner (HHP)
- Comprehensive transitional care

Member with designated condition
IMPROVING HEALTH

- Critical information is shared
- Patient has tools needed to help manage his/her chronic condition
- Necessary screenings and tests occur timely
- Unnecessary emergency room visits and hospital stays are avoided
- Community and social supports are in place
HEALTH HOMES GOALS

- Reduce utilization associated with avoidable (preventable) inpatient stays
- Improve management of chronic conditions
- Improve care coordination
- Improve transitions of care between primary care providers and inpatient facilities
TARGET POPULATIONS

• First target population is people with serious mental illness (SMI)
• Second target population will include people with asthma or diabetes who are also at risk for another chronic condition
• Can’t exclude dual eligibles or limit to a particular age group
• All HH members must be in KanCare and must select a HHP within the MCO network
ENROLLMENT

• Passive enrollment with “opt out” feature
• Enrollee will receive a letter and may choose to opt out
• Must have a choice of health home provider, but may be limited to certain number of times in a year
• Grievance and appeal rights
MEET EARLEEN

Earleen is unemployed but interested in employment

Earleen is 41 years old

Earleen has diabetes

Earleen has bipolar disorder

Earleen has COPD

Earleen has been admitted to the hospital 4 times in the past year.
KANCARE Health Home: Scenario – How will KanCare help Earleen?

**MCO**
- Care Management
  - Assists in locating primary care physician and schedules initial appointment and follow-up appointment
  - Assists in scheduling appointments with specialists and physical therapist
  - Communicates and collaborates with PCP, Specialists, and Care Coordinator
  - Assists in setting up NEMT
  - Refers for diabetes education

**CMHC**
- Case Coordinator
  - Works with Earleen to help her ask her PCP and specialists questions, and to understand information provided
  - Refers Earleen to CMHC Psychiatrist and private therapist
  - Helps Earleen understand medications and diabetes education information.
  - Connects Earleen and her family to support group for people with bipolar and other conditions.
  - Assist Earleen to complete a subsidized housing application
  - Refers Earleen to Vocational Rehabilitation

**Communication between Care Coordinator and Case Management**
- Assists in scheduling appointments with specialists and physical therapist
- Assists in setting up NEMT

**Earleen**

**HIT**
- Connects Earleen and her family to support group for people with bipolar and other conditions.
KANCARE Health Home: Scenario – Meet Bobby

- Bobby has Asthma
- Bobby’s Asthma is not controlled
- Bobby is 8 years old
- Bobby has gone to the ER several times this year for Asthma related issues
- Bobby is in Foster Care and has moved to several different families in the past several years
- Bobby possibly has Fetal Alcohol Syndrome
KANCARE Health Home: Scenario – How will KanCare help Bobby?

**MCO**
- Care Coordination
- Arrange for environmental assessment to remove Asthma triggers
- Provide information to foster parents about proper use of Asthma controller and rescue medications
- Set up family and Bobby with support group for child with complex conditions
- Assist in transition from one foster home to another

**Pediatrician**
- Makes sure the foster family understands condition
- Referral to determine if Bobby has Fetal Alcohol Syndrome
- Make sure Bobby has all immunizations and that he has regular check ups
- Develop an Asthma action plan that can move with Bobby when he moves to a different foster family and for school nurse
- Medication monitoring and management

**Communication between Care Coordinator and Case Management**
PAYMENT STRUCTURE

State pays MCO for each HH member

MCO shares HH payment with HH Partner (HHP) through contractual arrangement, taking into account the division of 6 HH core services

MCO and HHP jointly provide HH core services as specified in their contract

MCO pays for all KanCare services

- Physician
- Specialist
- Safety Net Clinic
- Behavioral Health Services
- Home and Community Based Services

HH Partner may be one of these; providers will still provide other services beyond HH
STAYING INFORMED

• Web page:  
  www.kancare.ks.gov/health_home
• Monthly newsletter: *Health Homes Herald*
• E-mail questions/comments:  
  healthhomes@kdheks.gov