The Case for Blending Behavior Health Consultants into the Healthcare Home

Tennessee Primary Care Association
August 18, 2010

Outline and Objectives

• Preparation without guidance; programming without grants
• Answer your questions
• Trends and emerging models of integrated care
• Common misconceptions & mistakes
• Dialogue with Mary Wakefield, HRSA Administrator
Primary Care and Behavioral Health Integration
An Imperative for Health Centers

- Widespread acceptance of the “concept” of integration
- Tantalizing outcome studies are beginning to appear
- Increased appreciation of behavioral factors in chronic disease management
  - Diminished scope of CMHC’s
  - Expansion of the FQHC system

New Paradigms Emerging Across the Safety Net

Paradigm Shift at the Systems Level
- Primary Care is a locus of mental health intervention
- Increased mental health service capacity at FQHCs
- FQHC/CMHC collaborations

Paradigm Shift at the Clinical Level
- Primary Care Provider focus on behavioral factors
- Mental Health Provider focus on general health status
- New service role for Behaviorists in primary care
Trends in Locus of Mental Health Services for Underserved Populations

- Restricted scope of CMHC’s has led to diminished access.
- Two-thirds of FQHCs provide behavioral health services; one-third provide service for substance use disorders.
- Four-fold increase in behavioral health at FQHCs 1998 to 2003.
  - Druss, American Journal of Public Health, 2006
- 758,000 patients received 3.8 million behavioral health services from 3,600 behavioral health professionals at FQHCs last year.
- Depression is the third most common condition at FQHCs.
- Are FQHC’s becoming the nation’s community mental health system?

National Comorbidity Survey Replication
Lifetime Prevalence of DSM-IV Disorders

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any</td>
<td>46%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>29%</td>
</tr>
<tr>
<td>Impulse-Control</td>
<td>25%</td>
</tr>
<tr>
<td>Mood</td>
<td>21%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>15%</td>
</tr>
</tbody>
</table>

National Comorbidity Survey Replication

Twelve-Month Prevalence of DSM-IV Disorders

<table>
<thead>
<tr>
<th>Prevalence</th>
<th>Any</th>
<th>Anxiety</th>
<th>Impulse-Control</th>
<th>Mood</th>
<th>Substance Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>26%</td>
<td>18%</td>
<td>9%</td>
<td>10%</td>
<td>4%</td>
</tr>
</tbody>
</table>


National Comorbidity Survey Replication

Provision of Behavioral Health Care: Setting of Service

SOURCE: Wang, Philip S., et al, Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005
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National Comorbidity Survey Replication
Provision of Behavioral Health Care: Setting of Service

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

Access to Behavioral Health Intervention

SOURCE: Wang, Philip S., et al, Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005
National Comorbidity Survey Replication
General Conclusions

• About half of US Population will meet criteria for a DSM-IV diagnosis in their lifetime; slightly over a quarter of the population in a year’s time.

• Half of all mental disorders begin by age 14 and three-fourths by age 24.

• Most people with mental disorders are untreated. For those in treatment, more than half receive less than adequate care.

• Over half of those who receive treatment for their disorders do so from a general medical provider.

• Only 12.7% who received care from a general medical provider received adequate care.
PREVALENCE OF PSYCHIATRIC DISORDERS IN PRIMARY CARE

<table>
<thead>
<tr>
<th>DISORDER</th>
<th>PREVALENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Mental Disorder</td>
<td>61.4%</td>
</tr>
<tr>
<td>Somatoform</td>
<td>14.6%</td>
</tr>
<tr>
<td>Major Depression</td>
<td>11.5%</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>7.8%</td>
</tr>
<tr>
<td>Minor Depression</td>
<td>6.4%</td>
</tr>
<tr>
<td>Major Depression (partial remission)</td>
<td>6.3%</td>
</tr>
<tr>
<td>Generalized Anxiety</td>
<td>7.0%</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>3.6%</td>
</tr>
<tr>
<td>Other Anxiety Disorder</td>
<td>9.0%</td>
</tr>
<tr>
<td>Alcohol Disorder</td>
<td>5.1%</td>
</tr>
<tr>
<td>Binge Eating</td>
<td>3.0%</td>
</tr>
</tbody>
</table>


PREVALENCE OF PSYCHIATRIC DISORDERS IN LOW-INCOME PRIMARY CARE PATIENTS

<table>
<thead>
<tr>
<th>Psychiatric Disorder</th>
<th>Low-Income Patients</th>
<th>General PC Population*</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Least One Psychiatric Dx</td>
<td>51%</td>
<td>28%</td>
</tr>
<tr>
<td>Mood Disorder</td>
<td>33%</td>
<td>16%</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>36%</td>
<td>11%</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>17%</td>
<td>7%</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>10%</td>
<td>7%</td>
</tr>
</tbody>
</table>

- 35% of low-income patients with a psychiatric diagnosis saw their PCP in the past 3 months
- 90% of patients preferred integrated care
- Based on findings authors argue for system change

“Mental Healthcare” in Primary Care Settings

- Psychological distress drives primary care utilization
- Most somatic complaints don’t have an identifiable cause (Kroenke & Mangelsdorf, 1984)
- Only 30% of primary care visits are for an identified medical condition (Strosahl, 1998)
- 50% of Cherokee medical patients reported complaints on the SF36 supporting a diagnosis of depression
- More mental health interventions occur in primary care than in specialty mental health settings
- Behavioral health problems inflate medical costs and impede outcomes
Integrated Care Business Development: Initial Considerations

- The Mission
- The Model
- The Manpower
- The Money
## Integration vs. Co-Location

### Integrated Care
- Embedded member of primary care team
- Patient contact via hand off
- Verbal communication predominate
- Brief, aperiodic interventions
- Flexible schedule
- Generalist orientation
- Behavior medicine scope

### Co-Located Mental Health
- Ancillary service provider
- Patient contact via referral
- Written communication predominate
- Regular schedule of sessions
- Fixed schedule
- Specialty orientation
- Psychiatric disorders scope

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## In Quest of Integration

**FQHC**
- Healthcare Home
- Primary Care
- Preventive Care
- Disease Management

**CMHC**
- Specialty Care
- Psychosocial Supports
- Psychiatric Consultation
- Case Management
In Quest of Integration

**FQHC**
- Healthcare Home
- Primary Care
- Preventive Care
- Disease Management

**Primary Behavioral Care**
- Real-Time Consultation
- Behavioral Medicine Scope
- Patient Self-Management
- Health/Wellness

**CMHC**
- Specialty Care
- Psychosocial Supports
- Psychiatric Consultation
- Case Management

“My physical therapist says this is the worst possible position you can lie in.”
Meshing Corporate Cultures

<table>
<thead>
<tr>
<th>FQHC</th>
<th>CMHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Program</td>
<td>State Program</td>
</tr>
<tr>
<td>“User” Board</td>
<td>Community Leader Board</td>
</tr>
<tr>
<td>Open Access</td>
<td>Eligibility-Based Access</td>
</tr>
<tr>
<td>Preventive-Oriented</td>
<td>Rehabilitation-Oriented</td>
</tr>
<tr>
<td>Clinically Focused</td>
<td>Community Focused</td>
</tr>
</tbody>
</table>

Blending Behavioral Health into Primary Care

Cherokee Health Systems’ Clinical Model

Behaviorists on the Primary Team
The Behavioral Health Consultant (BHC) is an embedded, full-time member of the primary care team. The BHC is a licensed Health Service Provider in Psychology. Psychiatric consultation is available to PCPs and BHCs.

Service Description
The BHC provides brief, targeted, real-time assessments/interventions to address the psychosocial aspects of primary care.

Typical Service Scenario
The Primary Care Provider (PCP) determines that psychosocial factors underlie the patient’s presenting complaints or are adversely impacting the response to treatment. During the visit the PCP “hands off” the patient to the BHC for assessment or intervention.
The Behavioral Health Consultant (BHC) in Primary Care

- Management of psychosocial aspects of chronic and acute diseases
- Application of behavioral principles to address lifestyle and health risk issues
- Emphasis on prevention and self-help approaches, partnering with patients in a treatment approach that builds resiliency and encourages personal responsibility for health
- Consultation and co-management in the treatment of mental disorders and psychosocial issues

“I think the dosage needs adjusting. I’m not nearly as happy as the people in the ads.”
The Behavioral Health Consultant (BHC) in Primary Care

• Psychological problems, such as anxiety and depression
• Substance use disorders and risk reduction
• Psychological components of physical illness, both acute and chronic
  • Factors impacting health status: stress, nonadherence, health behavior, social support

A Morning in the Life of a BHC

• 8:00 "Rounds" Check In
• 8:30 J.D. Chronic Pain/Depression
• 9:00 L.C. Trauma/Assessment
• 9:15 L.C. Compliance/Coping Skills
• 9:45 M.W. Transplant/Psychoeducation
• 10:00 A.K. Multiple ER Visits, Chest Pain
• 10:15 S.F. Domestic Abuse/Depression
• 10:30 M.A. Depression/Substance Abuse
• 10:45 M.B. Dx Clarification/Tx Plan
• 11:00 D.M. Bipolar/Diabetes/Asthma/Obesity
• 11:15 K.O’B Weight Management/Obesity
• 11:45 E.S. Anxiety Management
The Behavioral Health Consultant in Primary Care
Characteristics, Skills and Orientation to Practice

Characteristics
• Flexible, high energy level
• Team Player
• Interest in health and fitness

Skills
• Finely honed clinical assessment skills
• Behavioral medicine knowledge base
• Cognitive behavioral intervention skills

Orientation to Practice
• Action-oriented, directive, focus on patient functioning
• Emphasis on prevention and building resiliency
• Utilizes clinical protocols and pathways
• Invested in educating patients, health literacy

Considerations for PCP “Hand-offs” for Behavioral Health Consultation Services

HEALTH BEHAVIOR / DISEASE MANAGEMENT
• Medication Adherence
• Weight Management
• Chronic Pain Management
• Smoking Cessation
• Insomnia / Sleep Hygiene
• Psychosocial and Behavioral Aspects of Chronic Disease
• Any Health Behavior Change
• Management of High Medical Utilization
Considerations for PCP “Hand-offs” for Behavioral Health Consultation Services

MENTAL HEALTH BEHAVIORAL ISSUES

- Diagnostic clarification and intervention planning
- Facilitate consultation with psychiatry regarding psychotropic medications
  - Behavior and mood management
  - Suicidal/homicidal risk assessment
- Substance abuse assessment and intervention
  - Panic/Anxiety management
- Interim check of psychotropic medication response
  - Co-management of somaticizing patients
  - Parenting skills
  - Stress and anger management

Cherokee Health Systems

Job Description

**Job Title:** Behavioral Health Consultant

**Education/License:** Licensed Clinical Social Worker (Masters) or a Licensed Clinical Psychologist (Doctoral)

**Position Requirements:**
Excellent working knowledge of behavioral medicine and evidence-based treatments for medical and mental health conditions.

Ability to work through brief patient contacts as well as to make quick and accurate clinical assessments of mental and behavioral conditions.

Should be comfortable with the pace of primary care, working with an interdisciplinary team, and have strong communication skills.

Good knowledge of psycho-pharmacology

Ability to design and implement clinical pathways and protocols for treatment of selected chronic conditions.
Misconceptions and Mistakes

• Most any mental health provider will be effective in primary care
• Co-location is not integration; specialty mental health services are not primary behavioral healthcare
• Hiring unlicensed staff who will not be credentialed by payers
• Abiding the customary mental health schedule, i.e. the “50-minute hour”
• Contracting provider/organizations with incompatible mission

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