

2011 Military Health System Conference

Behavioral Health in the Patient Centered Medical Home (PCMH)

An Important Part of Meeting the Quadruple Aim and Achieving Level II & III NCQA PCMH Recognition

The Quadruple Aim: Working Together, Achieving Success

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Behavioral Health in the PCMH



- Overview
 - Models of Care
 - Targeting the Quadruple Aim
 - Turning the MHS Strategic Imperative Dials
 - NCQA Level 2 & 3 Recognition
 - Funding & Current Status
 - The Way Ahead

Models of Care



– Care Management Model

Typically focused on a discrete clinical problem

- Specific pathways to systematically address how BH problems are managed in PCMH
- PC providers & care managers share information
- Systematic interface with the outpatient mental health clinic

Models of Care



– Primary Care Behavioral Health Model

Focused on all enrolled patients

- Embedded with PC team
- BHPs & PCMs share patient information
- Brings a team-based management approach
- Helps team improve BH assessment & intervention
- Sees patients in 15-30 minute appointments
- Same day as well as scheduled appointment availability
- Focuses on full range of BH & health behavior change

Models of Care



– Blended Model

Focused on all enrolled patients

- Care Manager and Embedded BHP
 - Continuity of Care
 - Stepped Care
 - Access to all enrollees to BHP in the PCMH
 - Clinical Feasibility and Efficiency
 - Implements DoD/VA guidelines

Targeting the Quadruple Aim



- ***Population Health***: Prevalence of BH Problems in PC
- ***Per Capita Cost***: Cost of Unmet Needs
- ***Experience of Care***: Better Outcomes/Satisfaction
- ***Readiness***: Delivering the Right Care at the Right Time

Population Health: Prevalence



- 80% with BH disorder visit PC at least once a year¹
- 50% of all BH disorders are treated in PC²
- 48% of the appointments for all psychotropic agents are with a non-psychiatric PC provider³

1. Narrow et al., Arch Gen Psychiatry. 1993;50:5-107.

2. Kessler et al., NEJM. 2006;353:2515-23.

3. Pincus et al., JAMA. 1998;279:526-531.

Population Health: Unmet BH Need



- 67% with a BH disorder do not get BH treatment¹
- 30-50% of referrals from PC to outpatient BH clinic don't make 1st appt^{2,3}
- 50% of PCMs, can only sometimes, rarely or never get high-quality behavioral health referrals for patients⁴

1. Kessler et al., NEJM. 2005;352:515-23.
2. Fisher & Ransom, Arch Intern Med. 1997;6:324-333.
3. Hoge et al., JAMA. 2006;95:1023-1032.
4. Trude & Stoddard, J Gen Intern Med. 2003;18:442-449.

Population Health: Unmet BH Need



- 20% of deployed Service members screen positive for symptoms indicative of a BH condition¹
- 78% report a need for help, but less than 1/4 receive it¹
- Health Care Survey of DoD Beneficiaries (2008):
 - ~40% of MHS beneficiaries report difficulties accessing BH care
 - ~70% of family members report challenges accessing urgent BH care

1. Hoge et al, NEJM. 2004; 351:13-22

Per Capita Cost: Cost of Unmet Need



- BH disorders account for ½ as many disability days as “all” physical conditions¹
- Top 5 conditions driving overall health cost (work related productivity + medical + pharmacy cost)²
 - Depression
 - Obesity
 - Arthritis
 - Back/Neck Pain
 - Anxiety

1. Merikangas et al., Arch Gen Psychiatry. 2007;64:1180-1188
2. Loeppke et al., J Occup Environ Med. 2009;51:411-428.

Per Capita Cost: Lower Cost When Treated



- Medical cost ↓17% for those receiving BH tx¹
 - Controls who did not get BH tx cost ↑ 12.3%
- Depression tx in PC for those with diabetes²
 - \$896 lower total health care cost over 24 months
- Depression treatment in PC³
 - \$3,300 lower total health care cost over 48 months

1. Chiles et al., *Clinical Psychology*. 1999;6:204–220.

2. Katon et al., *Diabetes Care*. 2006;29:265-270.

3. Unützer et al., *American Journal of Managed Care* 2008;14:95-100.

Per Capita Cost: Lower Cost When Treated



Examples of System Impact After Integration: Buncombe County Health Center

Decrease in Health Care Costs

- All health care-overall reduction---\$66 PMPM
- Mental health care reduction---\$295 PMPM
- In-patient cost reduction---\$1455 PMPM
- High users of health care decreased---\$435 PMPM

Per Capita Cost: Lower Cost When Treated



Examples of System Impact (Cont)

Cherokee Health System

After At Least 1 Primary Care Behavioral Health Visit

- 28% ↓ in medical use for Medicaid patients
- 20% ↓ in medical use for commercially-insured patients
- 27% ↓ in outpatient psychiatry visits
- 34% ↓ in out patient psychotherapy sessions

Cherokee Use Data vs. Other Regional Providers w/o Integration

- All Lower specialist utilization
- Lower ER utilization
- Lower hospital admissions
- Lower overall costs per enrollee

Experience of Care: Better Outcomes



- Quantitative & qualitative reviews¹⁻⁴
 - Depression¹⁻⁴
 - Panic Disorder^{1,2}
- Other Studies⁵
 - Tobacco
 - Alcohol Misuse
 - Diabetes, IBS, Primary Insomnia
 - Chronic Pain, Somatic Complaints

1. Butler et al., AHRQ Publication No. 09- E003. Rockville, MD. AHRQ. 2008.
2. Craven et al., Canadian Journal of Psychiatry. 2006;51:1S-72S.
3. Gilbody et al., British Journal of Psychiatry, 2006;189:484-493.
4. Williams et al., General Hospital Psychiatry, 2007; 29:91-116.
5. Hunter et al., Integrated Behavioral Health in Primary Care: APA, 2009.

Readiness: Identifying & Treating Problems Early



- 1) Screening for Depression and PTSD (R-Mil)
- 2) Engagement of AD/SM & Family in Care
- 3) Assistance with Health Behavior Change

Impacting Quadruple Aim & MHS Strategic Imperatives



- 1) Psychological health-screening referral and engagement
- 2) Evidence-based care-depression & anxiety consistent with CPGs
- 3) Engaging patients in healthy behaviors [% advised to quit smoking]
- 4) Annual cost per equivalent life (PMPM)
- 5) Enrollee use of emergency services
- 6) Patient satisfaction with and access to comprehensive health care
- 7) PCMH staff satisfaction
- 8) Efforts to identify and effectively manage those at risk for suicide
- 9) Recapture family member BH services from purchased care

PCMH Level 2 & 3 Recognition



- 1E Patient/Family Partnership
 - Practice is concerned about the entire range of a patient's health, patient self-management support
- 1G Practice Organization
 - Train and support patient/family in self-management, self-efficacy and behavior change (e.g., weight reduction, smoking cessation, stress reduction)
- 2C Comprehensive Health Assessment
 - Practice conducts and documents a comprehensive health assessment for all patients to understand their risks and needs:

PCMH Level 2 & 3 Recognition



- 3A Guidelines for Important Conditions
 - One of the conditions must be related to unhealthy behaviors (e.g., obesity) or a mental health or substance abuse condition
- 3B Care Management
 - Assesses and supports patients in adopting health behaviors
 - Assesses and arranges or provides treatment for mental health and substance abuse problems
- 5B Referral Tracking and Follow-up
 - Practice coordinates referrals designated as important (includes mental health and substance use)

Funding and Current Status



- FY12-17 POM
 - Services requested funding for 429 BH providers to work exclusively in PCMH
 - Funding for all PCMH FY12-17 requests being evaluated
- TriService Recommendations for BH in PCMH
 - MHS PCMH Guide
 - Army PCMH OPORD
 - Navy BUMED PCMH Instruction

Way Ahead



- Draft DoD Instruction/Manual
 - Tri-Service workgroup
 - Based on TriService concurred on recommendations
- Demonstration Project
 - Have off-the-shelf products and implementation role out best practices available for each Service as funds to hire new BHP in the PCMH comes available.

Take Home Message



- It is coming
 - Funding expected to be approved
- DoD Minimum Standards
 - Some already in place by Service specific instruction
- Quadruple Aim/MHS Strategic Imperatives
 - Enhance PCMH impact

Behavioral Health in the PCMH



Questions

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