Integrating Behavioral Health into OhioHealth Primary Care through the Collaborative Care Model

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Introduction to the Team and OhioHealth

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Today’s agenda

Goals for today:

• Describe Collaborative Care model of Behavioral Health Integration (BHI)
• Identify components of behavioral health screening, intervention and ongoing support within BHI
• Examine skills, competencies and readiness of staff and providers for BHI
• Understand outcome metrics associated with effective BHI programs
• Answer audience questions
Veronica’s Story
Collaborative Care is patient centered

All roles attend required 1-day training prior to implementation
Why Collaborative Care?

- More help for the PCPs
- More touchpoints for patients
- Better patient engagement
- All can lead to improved patient care
Behavioral Health conditions are prevalent and expensive

### Common Chronic Medical Illnesses with Comorbid Mental Condition “Value Opportunities”

<table>
<thead>
<tr>
<th>Patient Groups</th>
<th>Annual Cost of Care</th>
<th>Illness Prevalence</th>
<th>% with Comorbid Mental Condition*</th>
<th>Annual Cost with Mental Condition</th>
<th>% Increase with Mental Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Insured</td>
<td>$2,920</td>
<td></td>
<td>10%-15%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td>$5,220</td>
<td>6.6%</td>
<td>36%</td>
<td>$10,710</td>
<td>94%</td>
</tr>
<tr>
<td>Asthma</td>
<td>$3,730</td>
<td>5.9%</td>
<td>35%</td>
<td>$10,030</td>
<td>169%</td>
</tr>
<tr>
<td>Cancer</td>
<td>$11,650</td>
<td>4.3%</td>
<td>37%</td>
<td>$18,870</td>
<td>62%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$5,480</td>
<td>8.9%</td>
<td>30%</td>
<td>$12,280</td>
<td>124%</td>
</tr>
<tr>
<td>CHF</td>
<td>$9,770</td>
<td>1.3%</td>
<td>40%</td>
<td>$17,200</td>
<td>76%</td>
</tr>
<tr>
<td>Migraine</td>
<td>$4,340</td>
<td>8.2%</td>
<td>43%</td>
<td>$10,810</td>
<td>149%</td>
</tr>
<tr>
<td>COPD</td>
<td>$3,840</td>
<td>8.2%</td>
<td>38%</td>
<td>$10,980</td>
<td>186%</td>
</tr>
</tbody>
</table>

Source: Health Management Associates; Melek S et al APA 2013
BHI care model addresses depression and anxiety via early intervention

- Intervention\(^1\) integrates a behavioral health provider (BHP) into Primary Care

- OhioHealth utilized Health Management Associates as implementation consultants for first year of program

- Designed for population health management:
  - Universal screening (depression, anxiety, substance abuse)
  - “Treat to target” measurement based care
  - Patients with abnormal score referred for brief intervention/follow-up
  - Psychiatric consultant reviews patient progress weekly. Makes treatment recommendations to Primary Care Provider
  - Patients with severe mental illness referred to outpatient behavioral health or the community

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1. This model has been validated by 80+ randomized control trials and is linked to improved depression outcomes and medical outcomes for patients with diabetes and cardiovascular disease
2. Patients enrolled in Registry November 2017 - January 2019
3. Integrated Behavioral Health Implementation Toolkit, Advisory Board Company, 2015
4. Source: Health Management Associates

19 practices
70+ providers referring
1300+ Patients enrolled in care model\(^3\)
BHI is part of stepped care approach for behavioral health patients in Primary Care

- Uses limited resources to their greatest effect on a population basis
- Different people require different levels of care

Source: Health Management Associates; Van Korff et al 2000
Key elements of Collaborative Care

- Universal Screening with PHQ-9
- 2+ contacts per month by BHP
- Track with registry in CareConnect
- Measure response to treatment & adjust
- Caseload review with psychiatric consultant
Collaborative Care is NOT...

- A psychiatric consult for acutely ill patients
- A quick referral pathway to psychiatry
Psychiatric Consultant
(Physician or Nurse Practitioner)

Curbside Consults

- Diagnostic dilemmas
- Education about diagnosis or medications
- Complex patients, such as pregnant or medically complicated

Weekly Caseload Reviews

- Scheduled weekly for one hour
- Prioritize patients that are not improving
- Make recommendations to PCP (documented in CareConnect)—may or may not be implemented
- Answer PCP questions about medication recommendations

Source: Health Management Associates
Role of the Primary Care Provider

- “Captain of the ship” for patient treatment
- Identify individuals who are in “sweet spot” of BHI program and pitch program
- Make a warm handoff to BHP, either in-person or via telemedicine
- Collaborate & consult with BHP and psychiatric consultant – receive and implement psychiatric consultant recommendations if desired
- Utilize PHQ-9/ GAD-7 screening tools to track progress
- Submit CPT code charge each month for patients who meet billable minutes

Each practice designates a PCP Champion

- Attends day-long training and trains other providers in practice - ambassador for program
- Understands the integration & team approach to care
- Natural leadership skills & respect from peer physicians
Practice Manager

- Understand the care model
- Give guidance & feedback – coach each role
- Communicate to implementation team & leadership about physician/ team feedback
- Facilitate regular provider meetings and attend Practice Manager check-ins
- Give support
# Medical Assistant and Office Specialist

## Medical Assistant
- Enter PHQ-9 into CareConnect
- Alert the PCP and BHP of PHQ-9 scores or patient concerns if applicable
- Set up virtual technology if BHP is not physically present

## Office Specialist
- Administer the paper PHQ-9 screener
  - Paper screener... for now
  - Scripting to reinforce the “why” for depression screening
- Ensure that all patients are taking the screeners at the appropriate time
  - Tools available in CareConnect to determine whether patient needs a screener
**Behavioral Health Providers**

**Who are BHPs?**

- Typically independently licensed Social Workers/ Counselors or RNs
- BHP extenders are bachelors-level; assist with follow-up calls and community referrals

**What makes a good BHP?**

- Interruptible
- Organized
- Outgoing and assertive
- Ability to work in a team

**Role Description**

- Brief interventions
  - 15-20 minutes; not traditional counseling
  - Set goals and promote self-management
  - Phone calls to check in
- Monitor progress with PHQ-9 / GAD-7
  - Manage and update registry
  - Communicate with PCP and psych consult about progress of patients in case load
  - Patients stay on registry for 6-9 months
- Weekly caseload review with psychiatric consultant
- Coordinate referrals to community resources

Source: Health Management Associates
Overview of Brief Interventions: Diaphragmatic Breathing

Sit or stand in a comfortable position with your back straight and your feet flat on the floor

Place one hand on your chest and one on your stomach

Slowly inhale through your nose, counting slowly to 4

Slowly exhale through the mouth, counting slowly to 6

Source: Health Management Associates
Overview of Brief Interventions: Motivational Interviewing and goal setting

Believe in Yourself
Overview of Brief Interventions: Follow up on Goals

1) Praise and find success

2) Learn from goals not achieved
   a) Was the activity a poor choice?
   b) Did we expect too much?
   c) What were the obstacles?

3) Emphasize personal choice and control

4) Set new/next goal
Overview of Brief Interventions: Problem Solving Therapy

1) Define a problem
2) Select achievable goal
3) Generate multiple solutions
4) Pros and cons of each
5) Select a feasible solution
6) Implement solution
7) Evaluate outcome
## Relapse Prevention: ~6-12 months

<table>
<thead>
<tr>
<th>Team Member</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Participate in developing relapse prevention plan with the PCP and BHP, re-engages if symptoms return</td>
</tr>
<tr>
<td>PCP: convert to care as usual</td>
<td>Provides plan for ongoing medication management if needed, instructions for patient if symptoms return</td>
</tr>
<tr>
<td>BHP: 6-8 weeks before last visit</td>
<td>Reviews success and gains from treatment, discusses how to re-engage if needed</td>
</tr>
<tr>
<td>Psychiatric Consultant: final case review with recommendations for PCP</td>
<td>Clarifies goals around medication management, length of time to continue, contingency planning</td>
</tr>
</tbody>
</table>

Source: Health Management Associates
Process and Outcome Metrics

- # of BHPs
- # of practices live in program
- # of patients referred
- # of patients added to Registry per month (# who consent to program)
- Total # of patients on Registry
- Average PHQ-9 upon episode enrollment
- Average PHQ-9 upon episode closure

Outcome metrics

- % of patients on Registry with >=50% reduction of PHQ-9
- % of patients on Registry with last PHQ-9 <= 5
- Reduction in Emergency Department visits
- Change in per member per month spend
Significant treatment response achieved through BHI program

- 29% of patients enrolled in program for >6 months achieved significant treatment response (>50% reduction of PHQ-9)
- As program matures we aim to reach target of 50% 6-month treatment response
- Depression remission measures are reported for some Accountable Care Organizations

### Average PHQ-9 scores

<table>
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<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average PHQ-9 at start of episode</td>
<td>15.02</td>
</tr>
<tr>
<td>Average PHQ-9 score at last assessment</td>
<td>10.77</td>
</tr>
<tr>
<td>Average PHQ-9 score reduction</td>
<td>4.25</td>
</tr>
</tbody>
</table>

N=264 (Patients on Registry for 6+ months as of 10.1.18 with PHQ-9 scores entered in CareConnect)

Source: CareConnect Episode Report pulled 10.1.18
1. PHQ-9 score of 15-19 indicates moderately severe depression
Early data indicates decreased all-cause ED utilization among BHI patients

OhioHealth All Cause ED Utilization\(^1\) Rate\(^2\) Per BHI participants

<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>26.8%</td>
<td>22.3%</td>
</tr>
<tr>
<td>Change</td>
<td>-4.5%</td>
<td></td>
</tr>
</tbody>
</table>

OhioHealth All Cause ED Density\(^3\) Per 100 BHI participants

<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Density</td>
<td>41.29</td>
<td>40.91</td>
</tr>
</tbody>
</table>

\(^1\) includes patients whose ED visit had a final patient type of EMERGENCY, meaning they did not progress from the ED to OBS or to Inpatient
\(^2\) rate: % of unique patients with an ED visit per BHI population
\(^3\) density: # of unique Emergency Department encounters per BHI population

N=264 (# of patients enrolled in program for >6 months as of 10/2018)
Opportunities remain to serve Primary Care patients with severe mental illness

- Approximately 4% of patients have severe mental illness or SMI ¹ (i.e., schizophrenia, bipolar disorder), which is outside of the scope of BHI care model

- Patients with SMI referred to OP BH for transition / consult or community but long wait times persist
  - No longitudinal OP BH clinic currently

- PCP feedback indicates a significant need for support in addressing severe MI

Addressing SMI in primary care would fix a gap in care; Feasibility of virtual psychiatrist visits is being explored

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1. Integrated Behavioral Health Implementation Toolkit, Advisory Board Company, 2015.
Questions?

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