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INTEGRATED CARE IS A DISRUPTIVE INNOVATION IN HEALTHCARE DELIVERY

"I'm afraid you've had a paradigm shift."

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WHY IS INTEGRATION A PRIORITY?

BEHAVIORAL HEALTH'S STAGE

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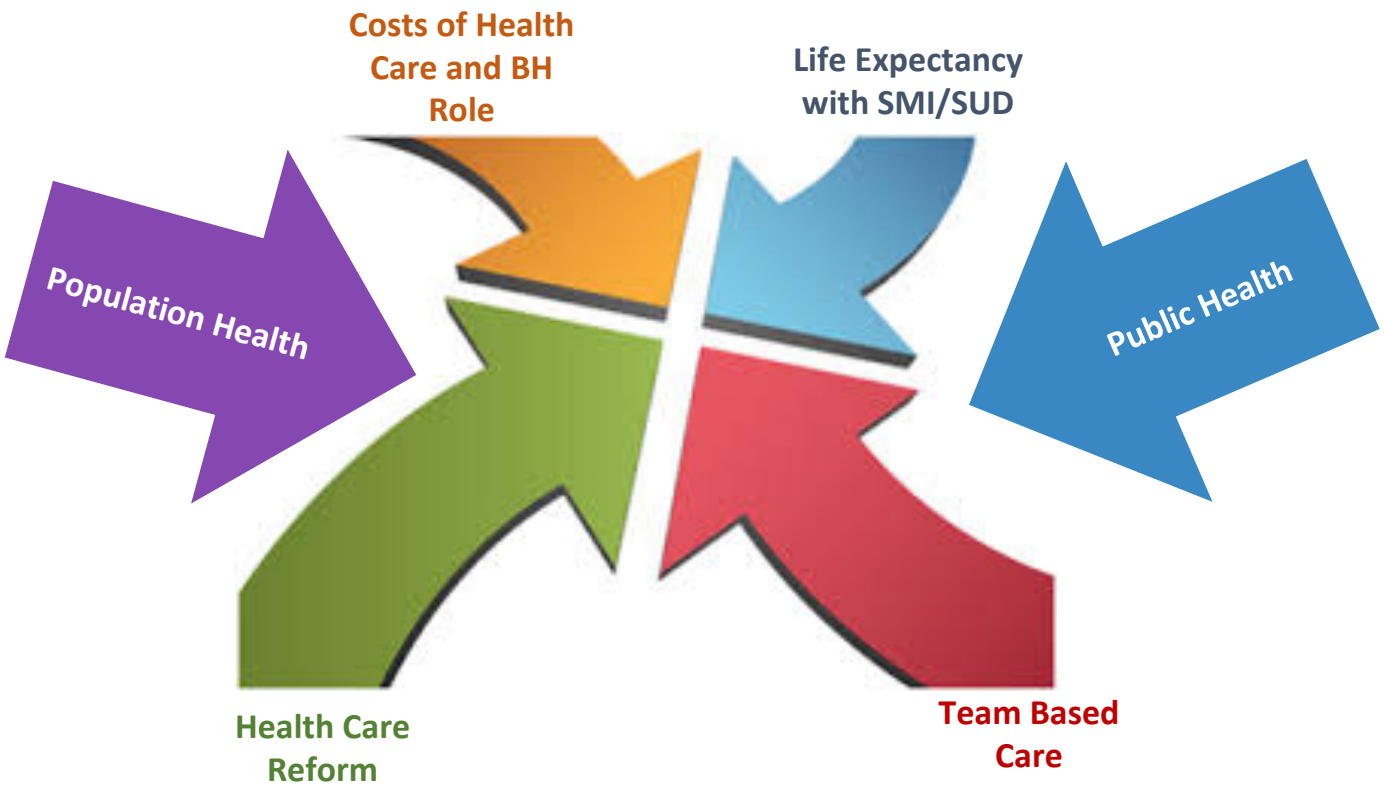
CONVERGING FACTORS DRIVING INTEGRATED CARE



ANNUAL COST OF CARE

Total Population
Common Chronic Medical Illnesses with Comorbid Mental Condition
"Value Opportunities"

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

Cartesian Solutions, Inc.™--consolidated health plan claims data

*Approximately 10% receive evidence-based mental condition treatment

BEHAVIORAL HEALTH DRIVING TOTAL COST OF CARE

Large claims data base Medicaid, Medicare, Commercial Insurers 2010 – no MH/SUD, non-SMI MH/SUD, SMI, SUD

Patients with treated MH/SUD cost 2-3 times more ($400 PMPM compared to $1,000 PMPM)

Most of the added cost is in facility-based costs (ER and inpatient) for medical care

Source: Milliman/APA Report
Melek, S.P., Norris, D.T., & Paulus, J. (2014) Economic impact of integrated medical-behavioral health care.: Implications for psychiatry.

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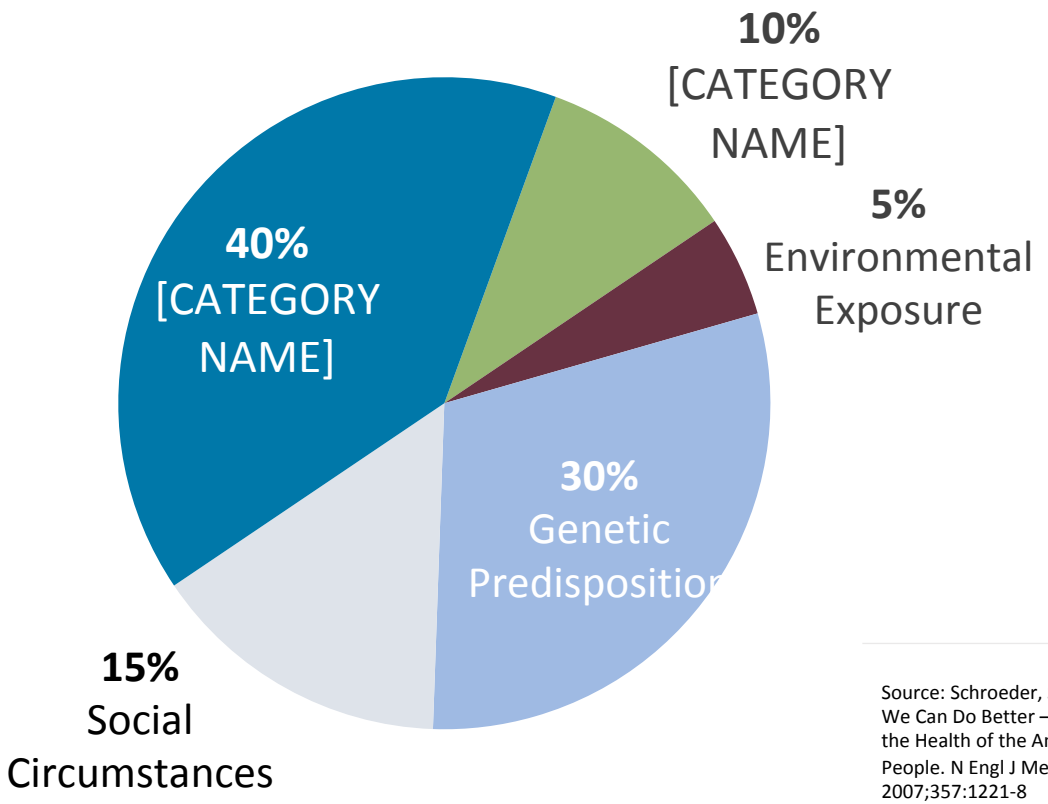
MORE THAN TRADITIONAL BEHAVIORAL HEALTH EXPERTISE IN BEHAVIOR CHANGE

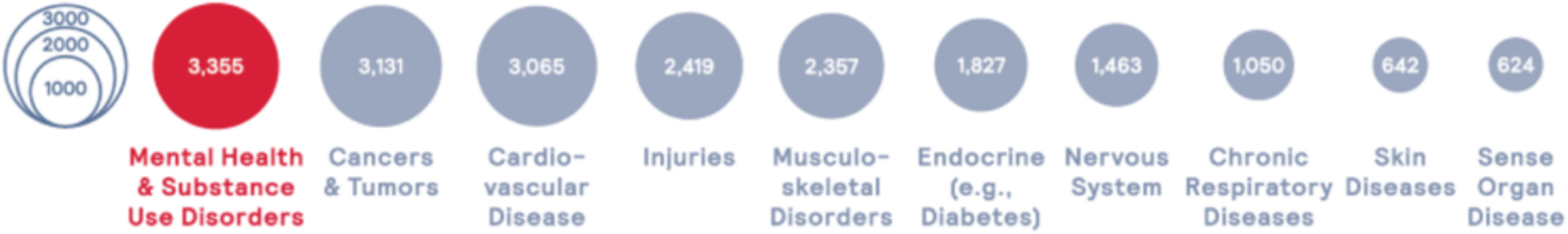


Source: Schroeder, Steven A. We Can Do Better – Improving the Health of the American People. N Engl J Med 2007;357:1221-8

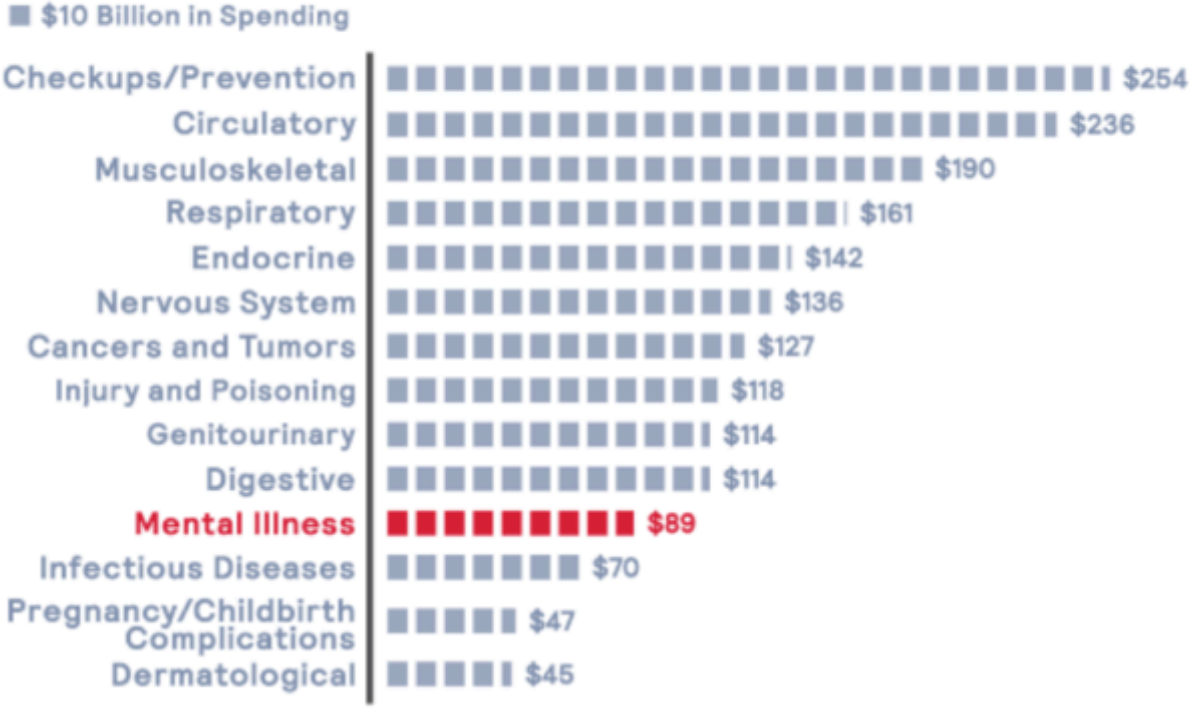
IMPACT OF MENTAL HEALTH AND SUBSTANCE USE

Mental Health and Substance Use Disorders Were the Leading Cause of Disease Burden in the US in 2015

Disability adjusted life years (DALYs) rate per 100,000 population

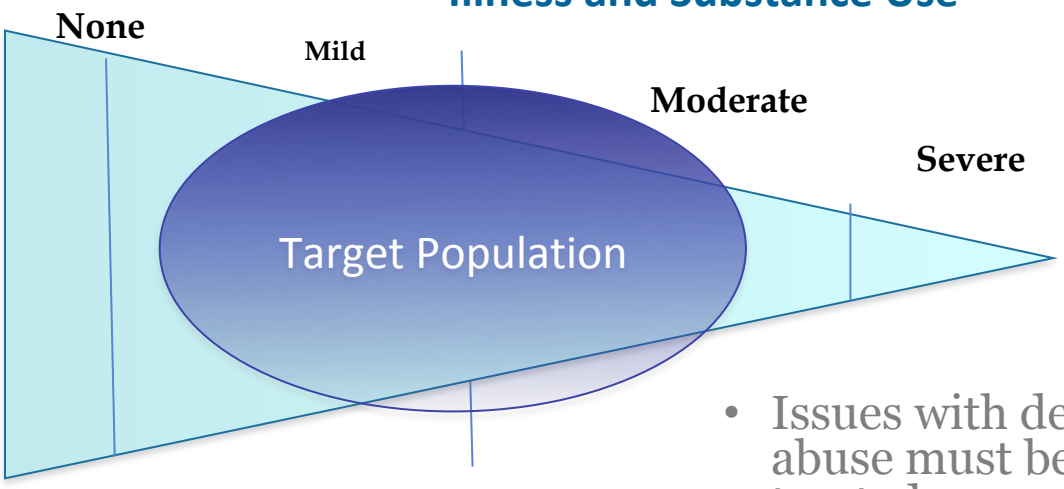


Mental Illness Treatment Accounted for $89 Billion (5%) of Total Medical Services Spending in the US in 2013



Source: Kaiser Family Foundation analysis. Original data and detailed source information are available at kff.org/JAMA_8-01-2017.
Please cite as: *JAMA*. 2017;318(5):415. 10.1001/jama.2017.8558

Primary Care Team Manages Mild to Moderate Mental Illness and Substance Use



- Issues with depression and substance abuse must be pre-empted, rather than treated once advanced
- Goal is to detect early and apply early interventions to prevent from getting more severe

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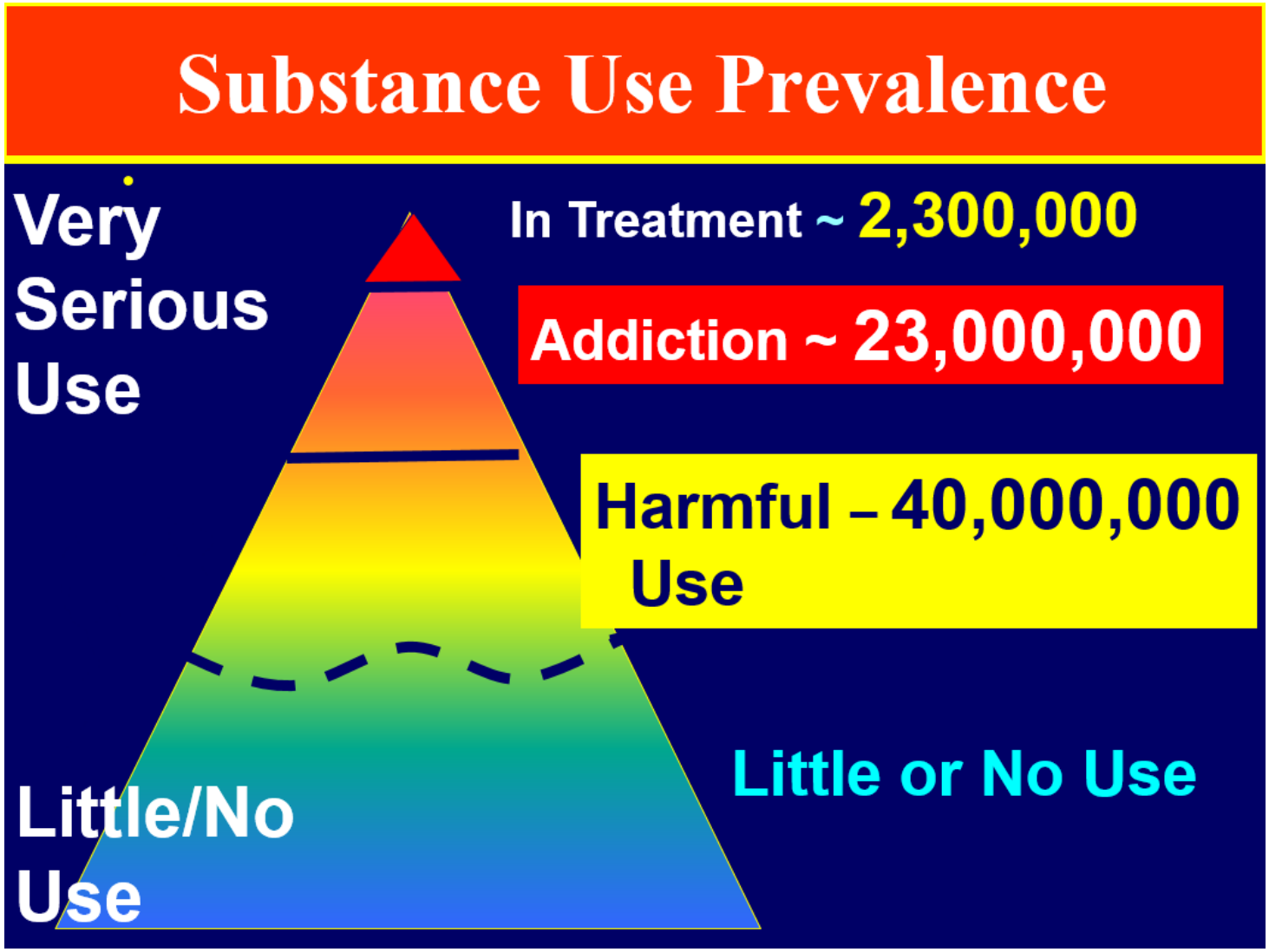
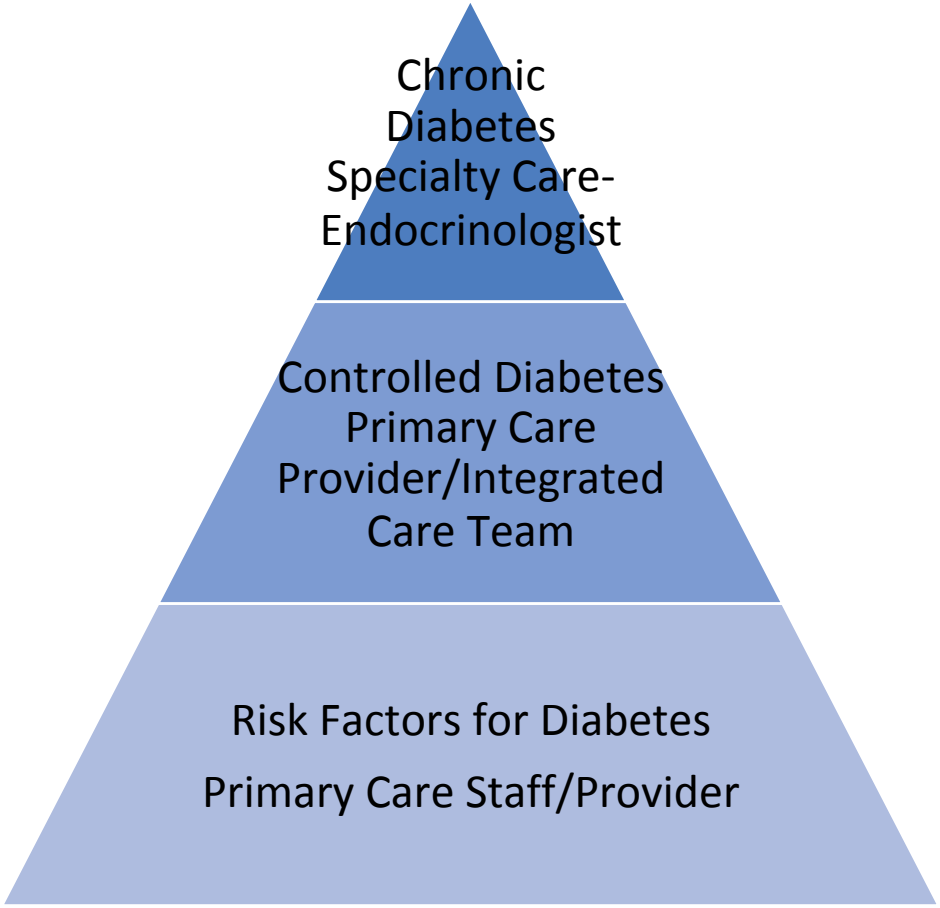
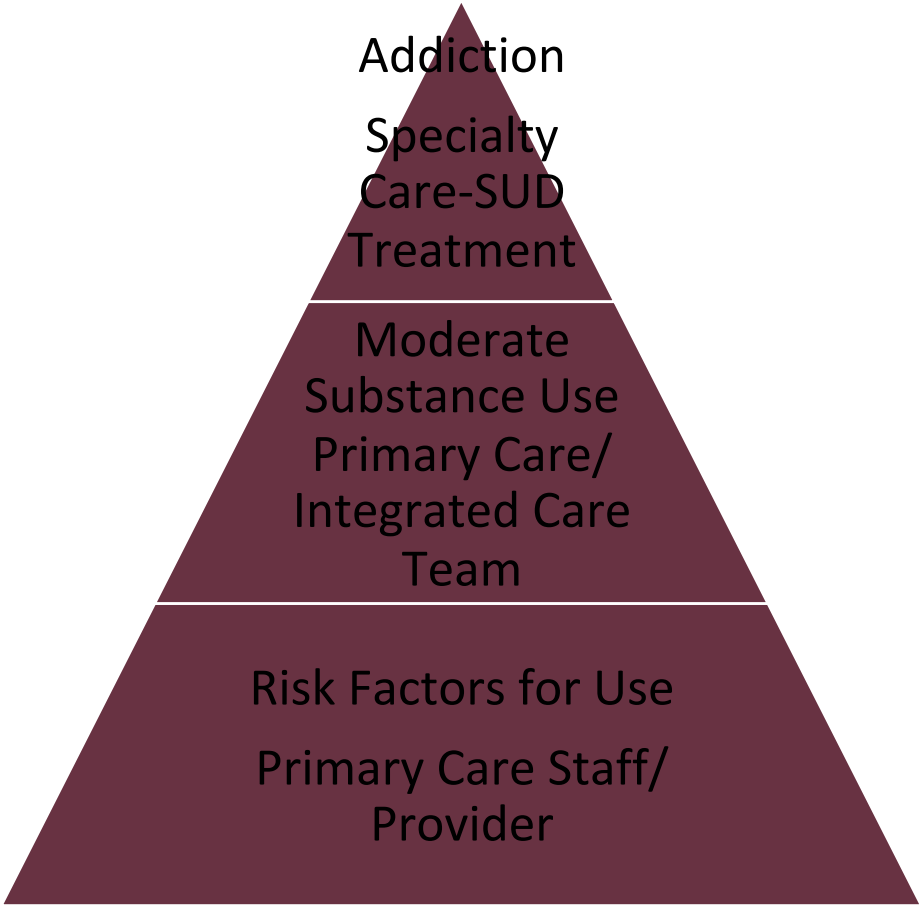
THE "SWEET SPOT" OF CARE



McLellan, (2014). The affordable care act and treatment for "substance use disorders:" Implications of ending segregated behavioral healthcare. *Journal of Substance Abuse Treatment, 46,* 541-545.

BEHAVIORAL HEALTH IS NOT DIFFERENT





CONTINUUM OF INTEGRATION

Evolving Models

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CENTER FOR INTEGRATED HEALTH SOLUTIONS LEVELS OF INTEGRATED CARE

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet ill-defined team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

COMMON APPROACHES TO INTEGRATED CARE

Traditional Consultation

- Limited access
- Limited feedback
- Expensive
- One Pass

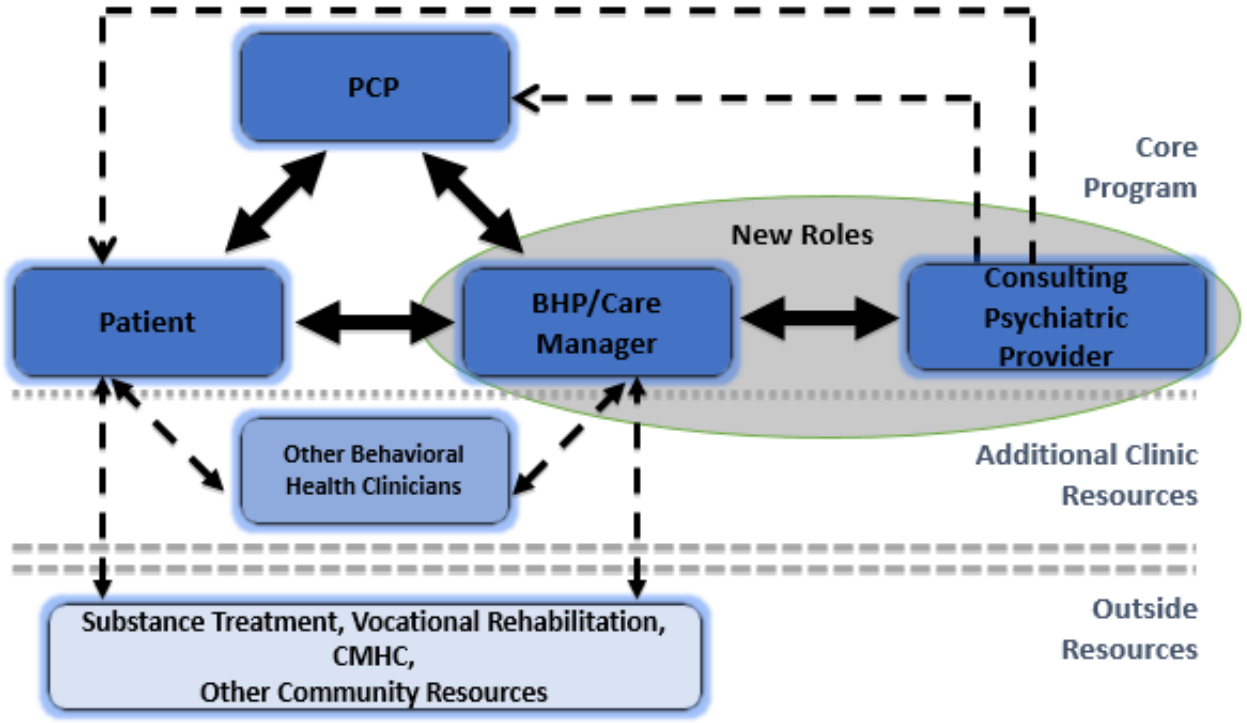
Co-Location

- Access and interaction
- Better communication
- Long waitlists and limited available providers
- Limited ability for follow through

Behavioral Health Consultant

- Solidly grounded in a clinical practice culture
- Generalist BHP
- Rapid access to brief behavioral interventions
- Limited evidence base

EVIDENCE BASED FULL INTEGRATION TEAM



http://aims.uw.edu

SECRET SAUCE

Recipe for Success

Ingredients TEMP

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*

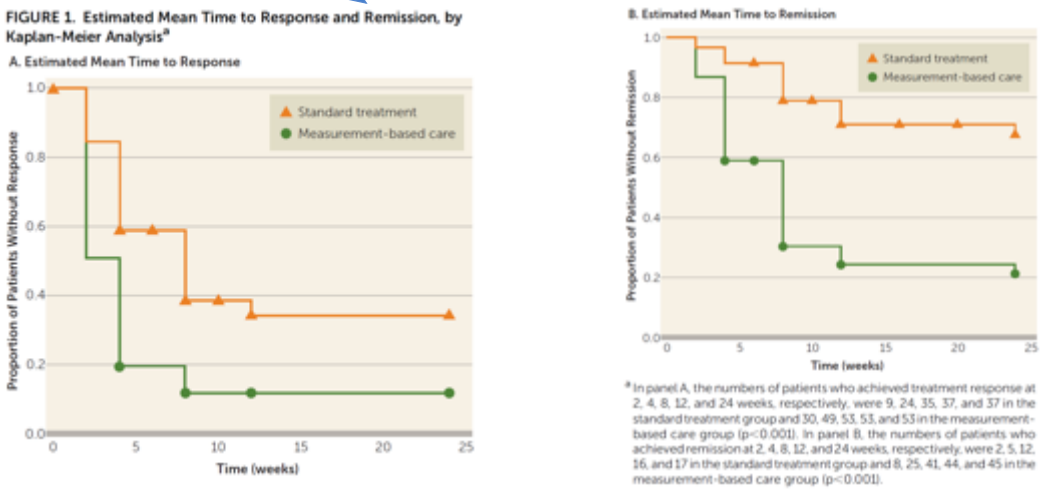
- Strong leadership support
- A strong PCP champion and PCP buy-in
- Well-defined and implemented BHP/Care manager role
- An engaged psychiatric provider
- Operating costs are not a barrier

INTEGRATED CARE IS DRIVING BEHAVIORAL HEALTH TO MEASUREMENT BASED CARE

TREAT TO TARGET

Response

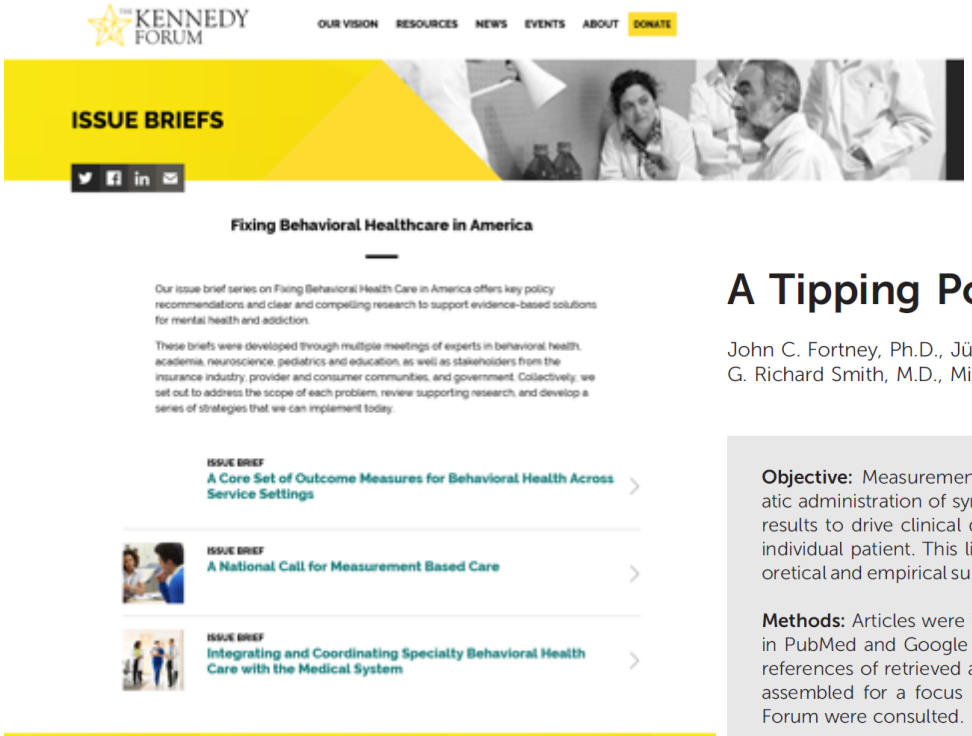
Remission



- 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

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

GROWING FOCUS ON MEASUREMENT BASED CARE



https://www.thekennedyforum.org/issuebriefs

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.

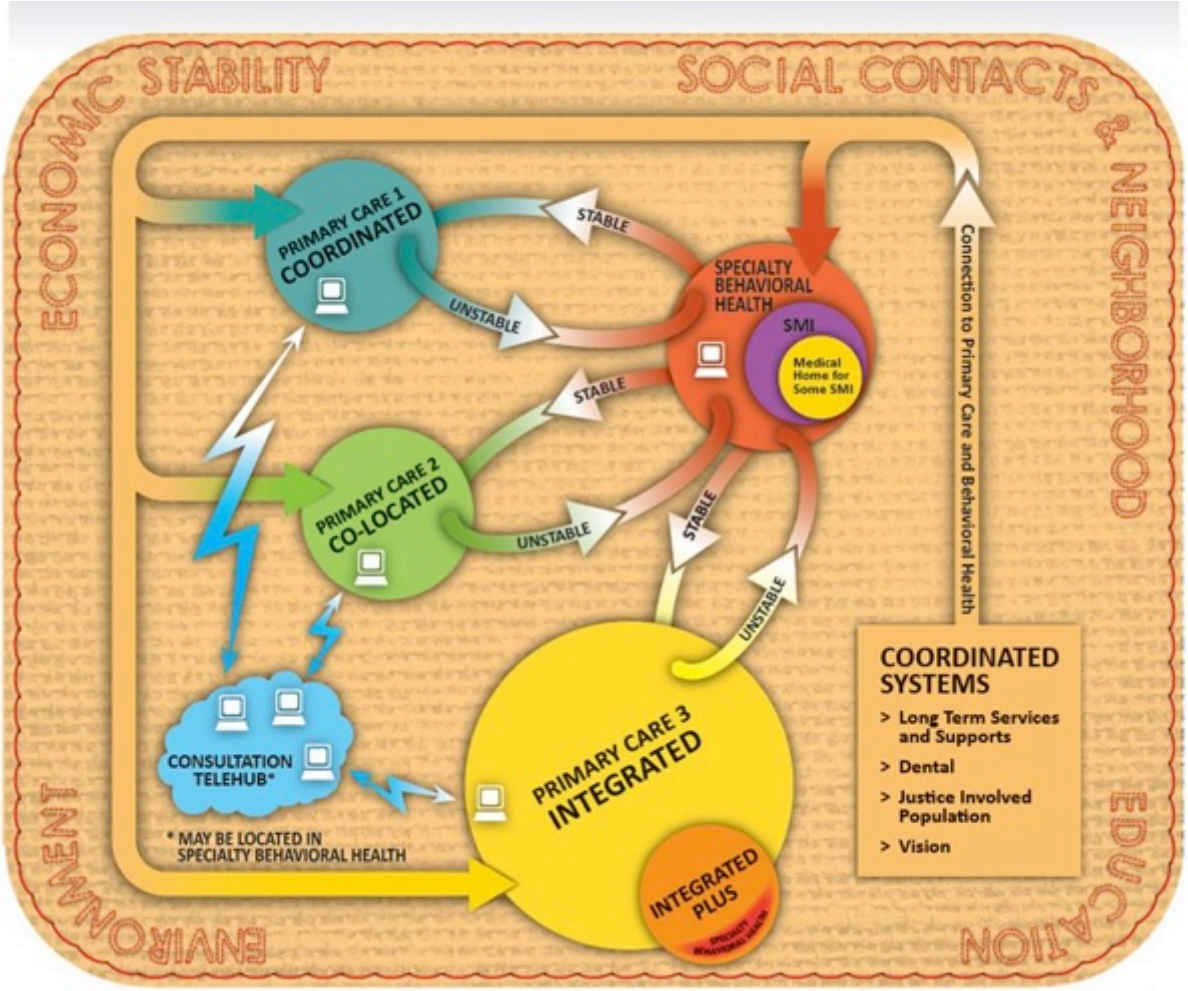
Results: Fifty-one relevant articles were reviewed. There are numerous brief structured symptom rating scales that have strong psychometric properties. Virtually all randomized controlled trials with frequent and timely feedback of patient-reported symptoms to the provider during the medication management 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

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

POPULATION WIDE INTEGRATED CARE



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SCALING, SUSTAINABILITY, AND IMPACT = LEADERSHIP

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SCALABILITY

NOW IS THE TIME
FOR BEHAVIORAL
HEALTH TO LEAD

- Normalizing mental health and substance use for the whole population
- Increasing access to behavioral health care
- Address behavior change and make early intervention a reality
- Shift the system from behavioral health to health

RISKS TO SUSTAINABILITY

POOR OUTCOMES

Integration approaches that fail to meet expected clinical, operational, or financial outcomes

PAYOR BYPASS MODEL

Integrated care is a provider/policy driven initiative and without robust outcomes, payors will move past it. We have to demonstrate the VALUE

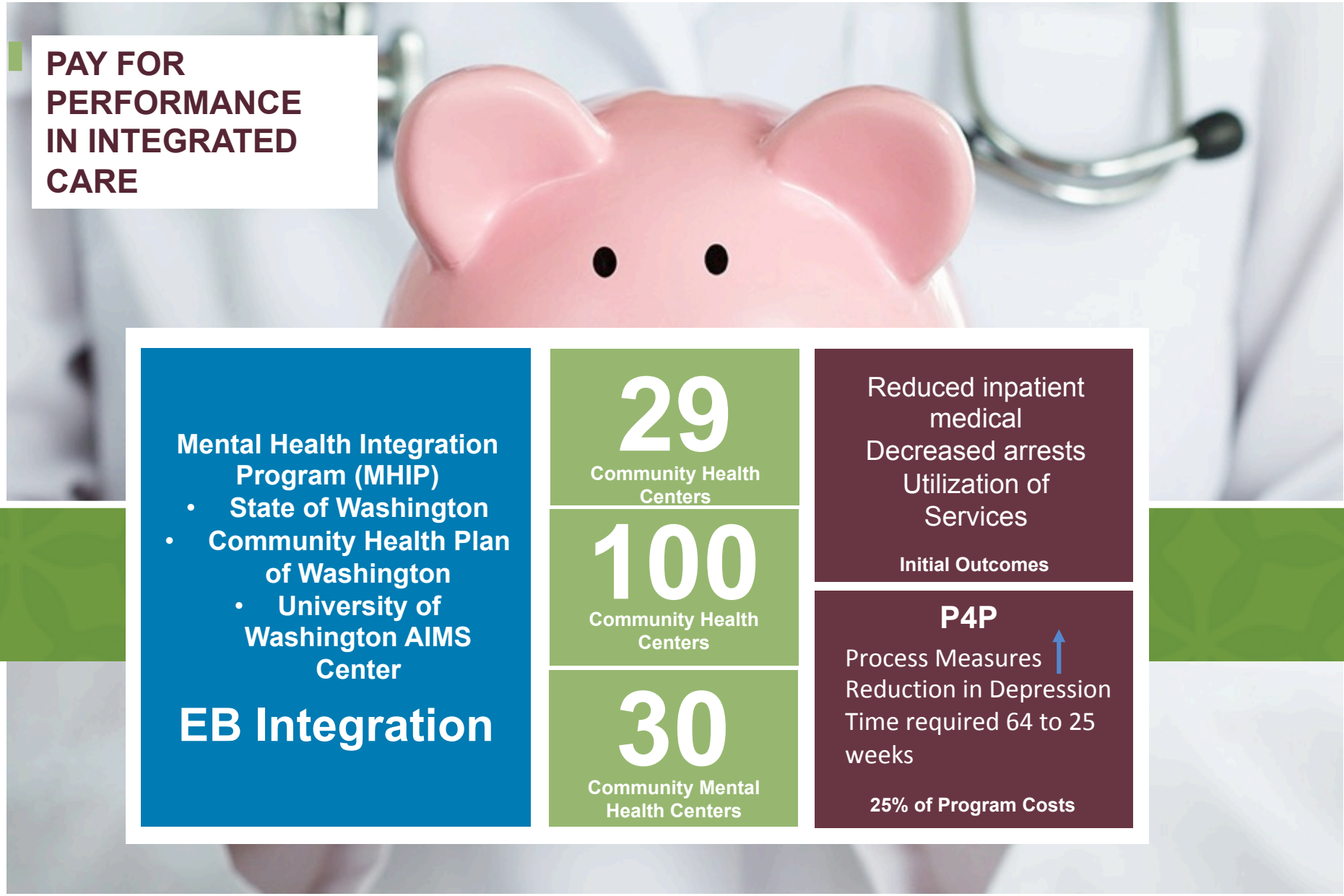
POLICY MAKERS

Move away from integration as a “failed experiment” while not understanding the challenges or implementation

LOSE MEDICAL BUY-IN

Steep change for medical providers and we need their buy-in and support

PAY FOR PERFORMANCE IN INTEGRATED CARE



Mental Health Integration Program (MHIP)

- State of Washington
- Community Health Plan of Washington
- University of Washington AIMS Center

EB Integration

29
Community Health Centers

100
Community Health Centers

30
Community Mental Health Centers

Reduced inpatient medical
Decreased arrests
Utilization of Services

Initial Outcomes

P4P

Process Measures ↑
Reduction in Depression
Time required 64 to 25 weeks

25% of Program Costs

Unützer, J., Chan, Y.F., Hafer, E. et al. (2012) American Journal of Public Health, 102(6).

RESEARCH ON THE ROLE OF LEADERSHIP

Leaders Create the Collective Value Base and Bring "Unity from Diversity"

8 COMMON ORGANIZATIONAL MYTHS IN IMPLEMENTATION

Many organizations miss the breath and depth of the change shifting to effective integrated care
and as a result fail in the set-up

Integrated Care is a Mechanical Change	If we Hire Them, they Will Team	We Need a Paradigm Shift but Don't Change Anything	Management is Sufficient
Clinical Integration is Enough	Like Kryptonite— Pulled to Silo	The Jump to False Negative	Rushing Through the Starting Gate to Miss the Finish Line

IMPORTANCE OF LEADERSHIP SUPPORT OF EFFECTIVE INTEGRATION

Integrated Care is ultimately about a change in culture.

It is an innovation in health care that requires both a *philosophical shift* as well as significant *changes in behavior*

- Leader behaviors
- Organizational attitudes and behaviors
- Provider staff behaviors
- Operational staff behaviors
- Patient behaviors

Beer & Nohria (2000). Cracking the Code of Change Harvard Business Review

70% of organizational change efforts fail to achieve desired results.

Most change efforts exert a heavy human and economic toll.

Understanding change in terms of goals, leadership focus, process, and rewards can improve the odds of success.

Everyone needs to be focused on this as a ***CHANGE EFFORT***

Integrated Care Requires Visionary Leadership

- Desire to reduce silos in care
- Shifting to quality based care (effective models) and away from volume based care (ineffective models)
- Commitment to health and wellness beyond sick care
- Patient and community centered rather than health care system centered

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