Hello. The topic today is Integrated Care Models: Choosing the Right One for Your Patients in Your Practice. And now, without further ado, I would like to turn things over to your host, Matthew Prentice, Behavioral Health Lead for Alliant Quality. Sir, the floor is yours.

Hello and welcome to Alliant Quality's Learning and Action Network for Improving Identification of Depression and Alcohol Use Disorder in Primary Care. As Alliant Quality's Behavioral Health Task Lead, I would like to extend my appreciation to you for participating in today's event and your commitment to improving the behavioral health outcomes of the patients you serve. Before we begin with today's presentation, I would like to remind you that in addition to our free monthly Quickinars, we also provide free evidence-based tools, resources and technical assistance to help you enhance your service delivery and operational efficiency. I encourage you to take advantage of these opportunities and to frequently engage with us to share your thoughts, experiences and best practices. And now it's my honor to introduce our guest speaker Dr. Cathy Hudgins.

Joining the Center for Excellence of integrated care as executive director in May 2013. In her role, she is part of a team that works across the state and nation to promote successful sustainable integrated care. As the integrated care professional she is not only a generalist but also specializes in integrated care ethics, policy, and program development. Prior to joining the Center of Excellence Dr. Hudgins gained experience in integrated care management and development, behavioral health consulting, crisis assessment, prevention, community based and [inaudible] based outpatient counseling, in patient assessment and intervention, and community mental health consulting. As cofounder and prior director of Bradford University Center for Integrated Care and Training and Research, she has also trained and developed integrated care systems and participated in research and grant writing initiatives. Welcome Dr. Hudgins.

Thank you so much Matthew. Quickly I don't want to take up too much time on our objectives but today we are going to look at the two main evidence-based integrated care models, identify the basic core concepts of these integrated care models and then we are going to discuss how each model addresses specific patient care needs and primary care. I do want to say as you are listening to this presentation it would be really helpful for you to think about the needs that you have in the questions that you have about which model to choose for your program, or if you are currently using a model, how it aligns with one of these evidence-based practices.

I'm going to start with leveling everyone with the definition of integrated care that we use at the Center of Excellence and the one that we have been sharing across the United States with our partners. We use the CJ Peek definition that came out in the ark which says, "Integrated care is care that results from a practice team of medical care and behavioral health clinicians working together with patients and families using a systematic and cost-effective approach to provide patient centered care," and I think the key parts to this to highlight is the fact that you are a care team, a team of professionals working together, sharing the patient responsibilities and focusing on systematic and cost-effective patient centered care.

So why do we integrate? Quickly if this is not a question you have contemplated or maybe this is where you are thinking right now, the majority of people have comorbid mental health and medical problems that do not receive any care consistent with established practice guidelines. This was found at the Institute of Medicine. Now we - and effectively treating medical and behavioral health comorbidities requires a team-based care approach. Not the traditional siloed style of care which is something we have been using for a very long time which means that providers are working within their own practice areas in their scope of practice but they are not collaborating and sharing the patient responsibilities. As we are really focusing on putting these behavioral health providers together with primary care, one of the questions we get quite often is how does it work because to be very honest if you just put two types of providers who have been traditionally trained together in

one setting they are going to probably do traditional care side-by-side. The other thing is that they will come up with some processes that they will have to test and it takes a very long time to refine these. The great news is through these models we have come up with evidence-based processes and practice protocols that really do make this a very streamlined, systematic way of putting these providers together in a team-based care environment. If you look at the concepts underneath the team-based care it assumes that that health is a shared community responsibility, and that mental health and medical care providers do need to work together. This is very important, to coordinate the detection which is that screening to identify the patient, the treatment part of it and then the follow-up. All three of those areas are very important in team-based care because if you only have one part of that then you really are not working toward a total health, whole person care approach. You are basically doing some part of traditional care and then hoping that someone else will pick up the other part. It is very strategic. We really want to look at the person's health needs and goals and we do this on a continuum, so integrated care starting from what we really do in traditional care which is working very far apart, siloed, all the way to working side-by-side in the room, in real-time working with the patient as a team.

There are core concepts that we have developed over time that are reflected in the 12 domains of the integrated care lexicon. I just want to highlight those because (we will not have time to go over this today) but most of them really do break down the individual domain when you are building a practice. Everything from where the providers are located within proximity to each other all the way to administrative buy-in and processes within your own policies and procedures. So if we look at what happens in the practice on the ground, on the patient contact level all the way to the policy and implementation side.

Moving on to the model that we're going to talk about and I know I am moving through this very fast and again these are quick little webinars but if you are interested in any of these aspects that I'm referring to that we are just touching on, the literature and all references will be included and I would encourage you to peruse those if you are interested in that systematic development through the core domains.

The two evidence-based integrated care models that we are going to talk about today, there are actually a couple more but these are the ones that you were assigned in primary care or some type of specialty medical care setting. The first one is the primary care behavioral health model and that is the PCBH - which is what we call it in the field. In this model the behavioralist is a generalist, so the behavioral health provider that is on-site sees all patients that come through. It is not targeted to one specific population. It is in untargeted model that really does look at all of the healthcare needs that have a behavioral health component to it. It is the behavioral health provider is in proximity to the medical provider and can be introduced and then work with the patient in real time so that is called a warm handoff. The PCP, or primary care provider, is the first customer. You really are there in the behavioral health provider is there to support the primary care team and the primary care provider. That is the behavioral health, health behavior sort of support. It is not you do your traditional care and you are only serving the patient. You are working with the PCP team. It mirrors primary care style in terms of pace and the number of patients seen, the brief interventions. It really matches the expectations that patients have of primary care knowing that the providers who are working in the practice are talking to each other exchanging information, working together to work with their patient. Just as we have in traditional care with PCPs working with their nursing staff and the lab staff and the front desk and the billing, the expectation is that the information will also be shared with the provider working with the primary care provider. We call this the horizontal model because it is across all populations and not targeted to a specific population or disease state. It is very much a population health approach.

The collaborative care model which had been actually coined and had been called the IMPACT model but they have rebranded that model to be more inclusive so that is a collaborative care model. It is registry driven meaning that you identify specific complexity of patients that would have comorbidities for medical and

behavioral health problems. You set the thresholds for that so that as patients are identified with those conditions of comorbidities that are put on the registry and are followed through medication and algorithms. In other words there are clear protocols that would trigger through the registry follow-ups by a care manager or possibly a behavioral health person or nurse manager who would be calling that patient to follow up. It is very disease focused so for depression and diabetes for instance those comorbidities would be very common and actually it has been validated for depression in older adults with comorbidities that there are current trials just to expand that validation to other disease states, and it is a vertical integration model meaning that it is very targeted, it has a clear glide path to outcomes - they are measuring outcomes, and it is not that whatever comes in the door we will take care of it kind of approach. It also requires a consulting psychiatrist.

Again, the PCBH model we've already talked about this a little bit, it's population based if you look at this you can see that in one year with 8 clinics you can see 8000 patients with about 19,000 visits so you are really getting a lot of impact into your patient population. It is based on a brief intervention lifelong relationships with patients and not really looking at what we would consider long-term treatment, it is focused on functioning so we are looking at helping patients function. We are not necessarily doing traditional mental health that would require long-term consistent weekly visits of 50 minutes, these are visits that can be 15 or 20 minutes long. Again we talked about this, the behavioral health consultant is operating as a consultant.

Why would we want the PCBH model? We understand that folks are going into healthcare looking for their total health needs and we know that healthcare or total health includes behavioral health. It improves the work life of the PCP. When we have a behavioral health provider in there we can really get some traction in terms of reducing the amount of time a PCP is with a patient, especially if they have needs that a behavioral health provider can help with in the moment. It does increase the access because a lot of times when a behavioral health issue or a substance use issue is identified the patient is given a referral and one out of four will go to that referral and the other three will not. You get that in real time. This is very brief, it is not looking at someone long-term - doing, having a patient panel where you would end up with a waitlist. The clinical gains are high because we are looking at health interventions that actually prevent many of the healthcare issues to exacerbate or deepen and also behavioral health issues are reduced as well. And then it does reduce the referrals to specialty care which allows specialty care to be freed up for the folks who need that more intensive special mental health.

The collaborative care model is disease focused, registry driven – so, registry meaning not like a legal pad with people's names on it that you have to remind yourself, we're talking about something that you would actually build into your EHR so you would get some type of consistent follow-up that you could track and then use that data for outcome measures. It is a collaboration between primary care. It says case manager, and in this case this is how it is written in their protocol but you could also use another type of behavioralist and then a consulting psychiatrist. Use medications, and again this is for folks who really do need medication. For PCBH, you really are working with people that might not need medication. They do not necessarily need that much of an intensity of treatment where they would be monitored in their symptomology. Then you are looking at behavioral health activation and problem-solving treatment as the key follow-up strategies and then looking at your improvement by using the PHQ-9, which is a depression screening score, and then tracking that over time. When you're thinking about the model that works for your system you might want to be thinking Do I have access to a psychiatrist? Do we have more people who could benefit by more of that prevention and health behavior and really looking across the population approach, as opposed to a more targeted approach.

So the collaborative care model, again we have some great outcomes with this. If you're looking at patients who do need medication there is a 50% reduction in depressive symptoms at 12 months, and if you look at usual care where people are coming in for their diabetes, they are not getting that depression medication and follow-up. It

is only about 19%. And then again, looking at how the interventions that are used with IMPACT really do reduce over time the recurrence of major depressive disorder or other types of severe persistent mental illnesses. And then looking again at the experience that those 100 additional depression free days because we do know that there are many folks who will have depressive episodes that are recurrent and we are able to reduce that.

This is a diagram to look at what we mean by the population horizontal approach as opposed to a very vertical targeted.

You can combine these. We worked with quite a few sites that it is a stepped approach where if they do have the capacity to put both models in, they can have a PCBH model running for their general population and a targeted collaborative care model for their folks who really do need more intensive treatment, and it really does work very nicely together.

So thinking about your practice and the decisions you are making about your model what questions do you have?

We have a first question. What if we do not have access to a psychiatrist? What would be the best [inaudible] for us?

That is something to really consider because the protocol for collaborative care does require a consulting psychiatrist. If you really do feel like that integrated care is something that your patients would benefit by and you do have access to specialty mental health referral once that patient may need to receive some type of more intensive treatment, I would go with the PCBH model. There are some folks who would use tele-psychiatry in their collaborative care if you do have some access to that. I know they are doing some research on the efficacy of that. Again, you do get a whole lot more if you have that behavioralist on site, and then allowing the medical provider to potentially increase their capacity and comfort with maybe prescribing if the patient does need prescribing since the behavioralist is there and can monitor symptomology and work with the patient.

Dr. Hudgins, what type of behavioral health provider would we want to hire?

Depending on your state, we try not to build our services especially for the PCBH model based on what you can be reimbursed for, but the basic bottom line is that you have to pay for these services. In most states for Medicare, and as matter of fact this is a federal guideline, LCSWs and psychologists can bill Medicare and they are wonderful to have on-site because they can work with the older adults as well as any of the other populations or anyone who is a Medicare recipient. LPCs or whatever your state may call that, at your licensed counselors and then your licensed marriage and family therapists are great. Medical family therapists, so LMFTs that are med FTs, are trained in medical family therapy which is integrated care essentially, so they are wonderful to have. That is where the PCBH model - for the collaborative care model you can get a psychiatric nurse or a nurse care manager, someone who really does understand how to run the protocols and do screenings for the PHQ-9 follow-up, so that is another one that would be really good. And then if you have some associates, those are called aids in North Carolina but if you have some folks who are working through their licensure and they are under supervision sometimes you can use those as care managers and they are great because they are learning and they do have that extra level of supervision.

Dr. Hudgins, what would be the top two pieces of advice you would have for practices in selecting their model?

A lot of people would start with billing, what can we bill for? I would say don't do that. I would say, if anything, go back up a whole lot farther and look at the capacity and goals that you have from your providers and your

administrators because one of the things that we lose when we start adding new standards of care is the reason the providers got into this business in the first place. Ask your providers, what are you struggling with the most in helping your patients be well and healthy. As they are talking about the behavioral health issues, thinking about what are those issues that they can't help them with and what is taking up their most time. Are you working with patients who really do have those behavioral health needs and need that extra support? That is when you start building your program. I would also say - I would look at the patient health needs through your data. If you have an EHR, start looking at your comorbidities. What are the most – the top five comorbidities that you all are identifying or that you are aware of, and what would be the best way to address those through the capacity that you have in your practice but also in your community? That question about your psychiatrist, do you have access and what else, how else can you address the medication needs? That would be what I would say. I know people want me to be more build an EHR that looks like this or use this EHR instead of that EHR, that is Electronic Health Record, I'm so sorry if I'm using all my acronyms but I really think it needs to back up even further as you are planning.

Dr. Hudgins, thank you for that excellent presentation and thank you all for participating as well. Before you go I would like to remind you to fill out the post presentation evaluation. Once that is completed you will be able to download your CE certificate. If at any time you have questions or concerns, please do feel free to reach out to me at the contact information you see before you. I look forward to our continued engagements and your attendance at our next Quickinar on January 19th. More information about this will be sent out to you shortly. Until then, take good care.