

# EXECUTIVE SUMMARY

May 2011

## INTEGRATING PHYSICAL AND BEHAVIORAL HEALTH

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PRHI'S Center for Perfecting Patient Care<sup>SM</sup> has been approved by the Pennsylvania State Nurses Association as a provider of continuing education.

In last year's federal health reform legislation, Congress established primary care as the focal point for improving Americans' health and containing rapidly increasing costs. The Pittsburgh Regional Health Initiative (PRHI) came to the same conclusion – *three years earlier*.

PRHI and several partners have been working with hundreds of the Pittsburgh region's primary care providers, helping them to implement and use electronic health records, develop medical home capabilities, and coordinate care and manage patients' chronic illnesses.

[www.prhi.org/docs/PrimaryCareintheSpotlight.pdf](http://www.prhi.org/docs/PrimaryCareintheSpotlight.pdf)

One of PRHI's earliest undertakings was Integrating Treatment in Primary Care (ITPC). ITPC was conceived to help primary care practices and their patients with chronic physical conditions and co-occurring depression and/or unhealthy substance use. The project was suggested by PRHI research that showed high rates of hospital readmissions and emergency care among individuals affected by both physical and behavioral health conditions.

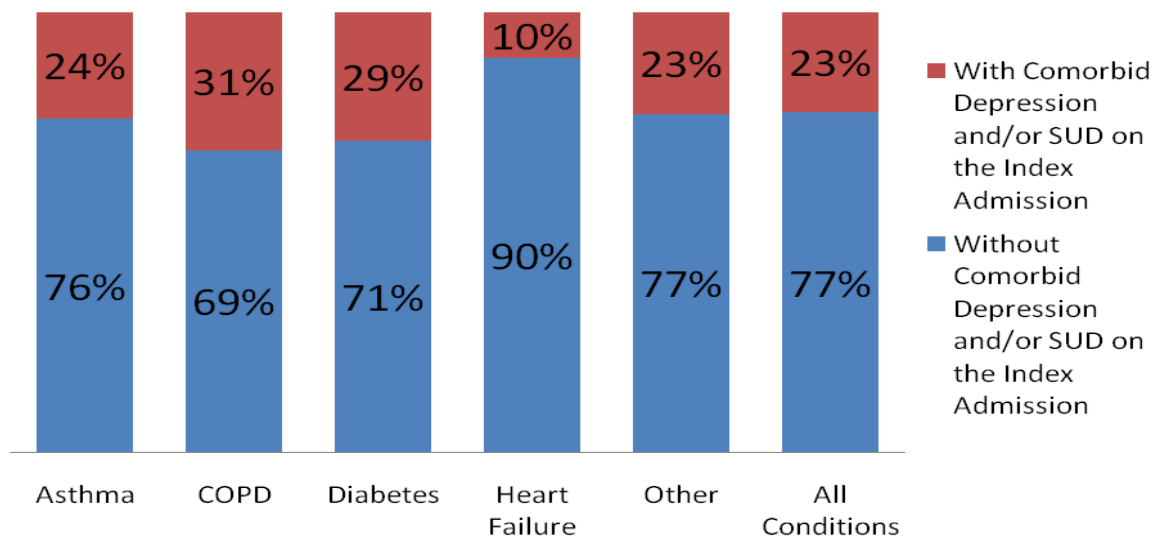
With support from three local foundations (Jewish Healthcare Foundation, The Fine Foundation and Staunton Farm Foundation), PRHI recruited three primary care centers to participate in an 18-month test of the feasibility of a hybrid model — ITPC — for early screening and early intervention for depression and unhealthy substance use. The recently completed project was successful in reducing symptoms of depression. But it did not identify



ITPC Regional Kickoff, March 2009

as many patients as expected who used alcohol and/or drugs in an unhealthy manner, nor did the duration of the project allow for initiating a sustainable reimbursement model. Valuable information and insights helped PRHI and partners from two other states win a competitive grant from the federal government to develop the ITPC model for national dissemination (commencing in 2011).

### 30-day Hospital Readmissions Comorbid Depression and/or SUD



PA Health Care Cost Containment Council - hospital discharges 10/1/2007 to 9/30/2009

#### THE PROBLEM

A number of studies connect behavioral health problems and exacerbations of physical health issues. Using the unique all-payer database of the Pennsylvania Health Care Cost Containment Council ([www.phc4.org](http://www.phc4.org)), PRHI research quantified this connection: approximately one-fourth of patients readmitted to the hospital for a chronic physical health condition also had co-occurring substance use disorder and/or depression.

The association of these co-morbid conditions with frequent hospital readmissions is part of an enormous over-burden of healthcare costs from depression and substance use problems. Depression alone costs employers \$350,000 per 1,000 FTEs in annual presenteeism, absenteeism, drug and medical costs. In regard to substance use disorders and mental illness, approximately 217 million days of absence or at-work productivity are estimated to be lost annually.

#### ITPC PROJECT DESIGN

ITPC is designed to identify and initiate treatment in primary care settings for behavioral health problems among patients with chronic physical conditions. ITPC begins with screening for unhealthy substance use and depression. The model relies on an integrated, team-driven approach to provide brief, evidence-based interventions for patients who manifest these behavioral issues.

Integrating behavioral health services into primary care settings is not new; however, the combination of three evidence-based models to address more than one behavioral health condition is unique.

## IMPACT for Depression

(Improving Mood-Promoting Access to Collaborative Treatment – [www.nrepp.samhsa.gov/ViewIntervention](http://www.nrepp.samhsa.gov/ViewIntervention))

Originally developed as an intervention for patients 60 years or older who have major depression or dysthymic disorder, the IMPACT intervention has been adapted for adults of all ages. The intervention is a one-year, stepped collaborative care approach in which a nurse, social worker, or psychologist works with the patient's regular primary care provider to develop a course of treatment. A psychiatrist consults with the team on new patients or those who are not progressing as expected. IMPACT has been found to be clinically and cost effective, and the U.S. Preventive Services Task Force (USPSTF) recommends screening for depression when staff-assisted supports are in place to ensure effective treatment. One study found that IMPACT patients had a four-year cost-savings of \$3,363 per patient, compared to patients who were not randomly assigned to the IMPACT intervention.

**SBIRT for Unhealthy Substance Use** (*Screening, Brief Intervention, and Referral to Treatment* -- [www.samhsa.gov/SAMHSA\\_News/VolumeXVI\\_2/article2.htm](http://www.samhsa.gov/SAMHSA_News/VolumeXVI_2/article2.htm))

Brief screening questionnaires administered at patient intake identifies alcohol or substance use problems, and provides a general determination of severity. Moderate to high risk triggers brief education and motivational interventions. Patients with screens indicating severe problems may be referred for substance abuse treatment. Several studies found that each dollar spent saves \$3.20 — \$4.30 in future healthcare costs.

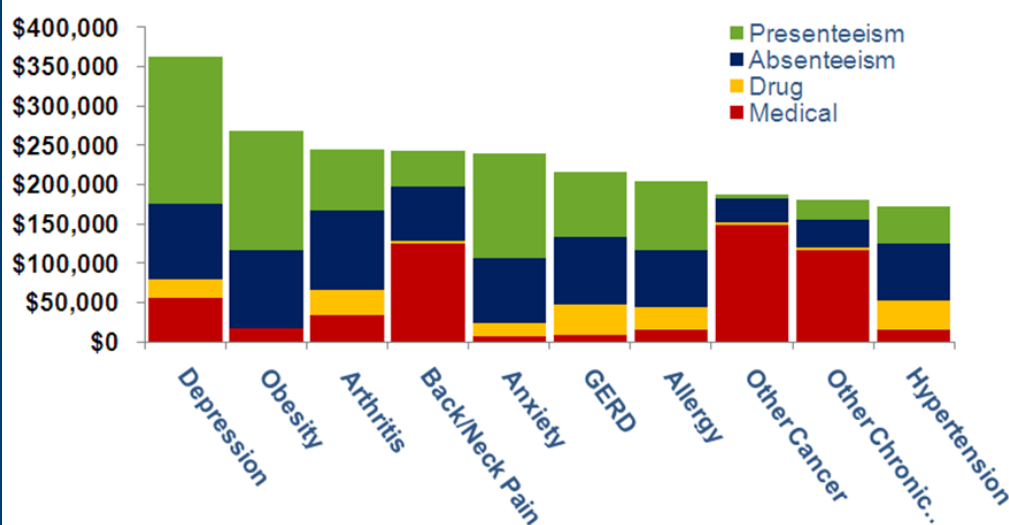
## CHRONIC CARE MODEL

([www.improvingchroniccare.org/The\\_Chronic\\_Care\\_Model](http://www.improvingchroniccare.org/The_Chronic_Care_Model))

Developed by Dr. Ed Wagner and colleagues at the MacColl Institute for Healthcare Innovation, the Chronic Care Model (CCM) focuses on the essential elements of a healthcare system that encourage high-quality chronic disease care: the community, the health system, self-management

support, delivery system design, decision support and clinical information systems. In combination, evidence-based changes in each element of care foster productive interactions between informed patients, who take an active part in their care, and providers with resources and expertise.

## Top 10 Health Conditions Driving Costs for Employers (Med + Rx + Absenteeism + Presenteeism) Costs/1000 FTEs



Loeppke, et al., JOEM. 2009;51(4):411-428.

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## DEMONSTRATION TRAINING AND SUPPORT

PRHI-provided program management, training, and practice coaching consisted of:

1. Training members of primary care teams to identify and manage co-occurring depression and/or unhealthy substance use among patients with chronic physical health problems.
2. Developing a Collaborative Care Team for each primary care center: a consulting Psychiatrist, consulting Pharmacist, and an on-site licensed Clinical Specialist or trained Behavioral Health Care Manager.
3. Developing a patient registry to track appointments, follow-up care and progress.
4. Guiding the development of a sustainable reimbursement model at each participating practice.
5. Developing an implementation toolkit to facilitate dissemination of ITPC to other primary health centers.

Initial group training for the Clinical Specialists, supervisors, ancillary medical providers, and administrators from the three primary care organizations began in March 2009. The training included team-building exercises, lectures, facilitated discussions, case studies, and role-playing activities.



ITPC Regional Kickoff, March 2009

— Breakout Session Debriefing

## DEMONSTRATION PARTICIPANTS

PRHI recruited three primary care centers:

1. Federally Qualified Health Center (FQHC) “look-alike:”  
Southwestern Pennsylvania Human Services, Inc., Mon Valley Community Health Centers, Monessen, PA
2. Family Practice Residency Program:  
UPMC St. Margaret, New Kensington Family Health Center, New Kensington, PA
3. FQHC:  
Cornerstone Care, Inc., Community Medical and Dental Plaza, Burgettstown, PA

At the time of the demonstration, each health center had an annual patient volume of about 3,000, 50% of whom were covered by Medical Assistance, and staff complements that included both physicians and ancillary providers: nurses, physician assistants, and medical assistants – but not full-time behavioral health specialists.

The PRHI practice coach (previously a project coordinator for the Allegheny County (PA) SBIRT initiative) held weekly implementation team meetings at each health center, and worked with the Clinical Specialists and Behavioral Health Care Managers on performing brief, effective interventions in primary care settings. Clinical Specialists were also given certified training and case supervision support from the IMPACT Implementation Center at the University of Washington (via audiotapes submitted by the Clinical Specialists). This was complemented by a telephone Learning Collaborative that was facilitated by the PRHI practice coach and the certified IMPACT trainer.

Primary care physicians and consulting psychiatrists were unable to attend the didactic training, but on-line ITPC training and on-site training for the patient registry were built into the implementation strategy. On-line training included an accredited SBIRT course and webinars on IMPACT, SBIRT, and anti-depressant medication. The consulting pharmacists were not

required to complete the training; however, the PRHI practice coach oriented them to the ITPC model.

Lastly, PRHI, with support from the IMPACT Implementation Center, provided the health centers with guidance on creating a reimbursement model to sustain ITPC. PRHI staff held reimbursement meetings with the practices’ administrators and billing managers to work through challenges and discuss potential strategies. Providers also attended a webinar on billing for behavioral health services in the primary care setting. The consultant from the IMPACT Implementation Center also held calls with two of the three practices to provide site-specific guidance.

**IMPLEMENTATION OF THE ITPC MODEL**

Patients with targeted chronic conditions were screened for depression and unhealthy substance use when they attended their routine physical healthcare appointment. Pre-screens were generally given out at the front desk or by the rooming staff (e.g. medical assistants). For those who were positive on the pre-screen, full screens were generally administered by the primary care provider.

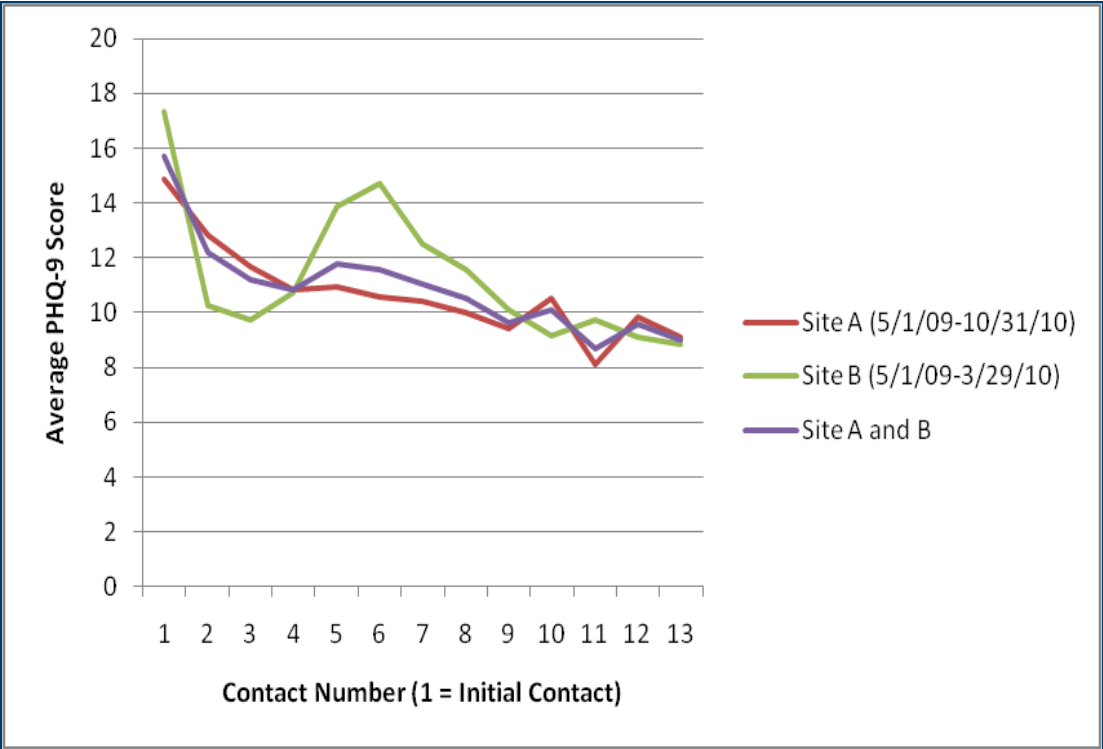
If a patient screened positive on the full screen, the primary care provider engaged the on-site Clinical Specialist or Behavioral Health Care Manager. Follow-up contacts between the Clinical Specialist or Behavioral Health Care Manager and the patient occurred over the phone and at the primary care center.

The Clinical Specialists were trained and coached to use Motivational Interviewing to facilitate patient change, Behavioral Activation to

re-engage the patients in pleasant activities, and Problem Solving Treatment in Primary Care (PST-PC) to improve the patients’ problem-solving abilities. The Behavioral Health Care Manager was also trained and coached in these techniques; however, he or she was not trained in PST-PC, since a licensed clinical social worker was available on an as-needed basis.

The Clinical Specialists and Behavioral Health Care Managers also served as the “facilitating presence” between the Collaborative Care Team and the primary care practice. The consulting psychiatrist consulted with the Clinical Specialist or Behavioral Healthcare Manager for about one hour per week, and the consulting pharmacist performed initial pharmacy reviews. Based on the Collaborative Care Team’s recommendations and the patient’s progression according to evidence-based guidelines, the primary care provider determined whether to augment the patient’s care.

Treatment was supported by a web-based registry for patient tracking, documentation, and generating real-time data reports. The registry also alerted Collaborative Care Teams to overdue follow-ups and aided internal team communications.





## ITPC RESULTS AND EVALUATION

Among patients enrolled through at least 6 *contacts* in the ITPC demonstration:

- 24%** reported ER visits in past 6 months at intake
- 18%** reported ER visits through enrollment
- 11%** reported hospitalization in past 6 months at intake
- 11%** reported hospitalization through enrollment

Among patients enrolled for at least 6 *months* in the ITPC demonstration:

- 23%** reported ER visits in past 6 months at intake
- 14%** reported ER visits through 6 months in ITPC
- 16%** reported hospitalization in past 6 months at intake
- 14%** reported hospitalization through 6 months in ITPC

At the end of the grant-funded demonstration, two of the three participating primary care centers were planning to sustain the Clinical Specialist with possible program funding and reimbursement or by budgeting for the costs.

## INDEPENDENT EVALUATION

The University of Pittsburgh's Evaluation Institute conducted a program evaluation of ITPC between March 2009 and October 2010. Analysis of data from the project's patient registry disclosed the following:

- ◆ Among 1,559 patients pre-screened at the practices, 23% screened positive for depression, and 5% screened positive for unhealthy drug and/or alcohol use.
  - Based on previous studies in primary care settings, positive screening rates for depression should be around 20%, and positive screening rates for substance use should be between 8% and 23%.
- ◆ 62% of patients who screened positive for depression or unhealthy drug and/or alcohol use completed at least one follow-up contact with the

Clinical Specialist/Behavioral Health Care Manager.

- ◆ Each enrolled patient completed an average of six follow-up contacts.
- ◆ 49% of enrollees achieved at least a 50% reduction in symptoms of depression at six months.
- ◆ On average, patients who were discharged early from ITPC (five follow-up contacts or less) achieved a clinically significant improvement of depression symptoms.
- ◆ Self-reported emergency room utilization declined, but the decrease in self-reported hospital utilization was negligible. This may have been due to the relatively short time period of the ITPC demonstration.
- ◆ ITPC did not have a negative impact on the job satisfaction of practice staff.
- ◆ Each health center cited the Clinical Specialist or Behavioral Health Care Manager as a major contributing factor to high scores in certain areas of the Assessment of Chronic Illness Care survey, such as "community linkages."
- ◆ Small- to medium-sized health centers cannot generate enough short-term cost savings to offset the cost of integrated care activities in the current reimbursement system.
- ◆ Analysis at one of the three practices found that frequent patient-visitors averaged 2.42 fewer PCP visits after initial meetings the Clinical Specialist. Less frequent visitors averaged 0.5 fewer primary care provider visits. Evaluators concluded that affected patients received timely services, support, and resources from the Clinical Specialist that supplemented and enhanced their ability to manage their diseases (and lessened the need for frequent PCP visits).

## LESSONS LEARNED

Based on the program evaluation, weekly project and evaluation team meetings to guide the project team and problem-solve challenges, and anecdotal reports from the adopting organizations, PRHI's ITPC project team formulated the following lessons:

## **Leadership**

**ITPC implementation requires a significant commitment of professional resources** at all levels of medical office administration, staff, and providers. This commitment is needed to ensure resources (e.g. internet access for Clinical Specialist or Behavioral Health Care Manager) and develop appropriate methods of accountability, supportive supervision, strong communication and reciprocal learning relationships between the Collaborative Care Team and medical staff, and an ongoing approach for quality improvement and problem-solving.

**Practice culture change must occur among all levels of the practice staff.** If any member along the chain does not accept or support integrated care components of screening, patient activation, structured follow-ups, and stepped care, the sequence can be broken. It is known that physician buy-in is critical; however, there must be strong evidence of the physician buy-in before implementation.

**Engaging stakeholders and community resources is essential.** Patients, families, providers, health insurers, state agencies, county agencies, community-based organizations, and employers are all critical stakeholders to engage before and during implementation.

## **Collaborative Care Team**

**It is essential to have a provider/mid-level champion and a flexible Clinical Specialist or Behavioral Health Care Manager who has strong interpersonal skills.** A Clinical Specialist or Behavioral Health Care Manager must nurture an existing primary care culture to support new requirements, while still becoming a part of that culture. This requires phenomenal interpersonal skills. For example, when referring to the medical staff, the Clinical Specialist remarked light heartedly, “I just knew them as those people in primary care across the hall. They started to include me and I felt I included them even more, but it took 60 to 90 days to have that kind of rapport.” Later on, the Clinical Specialist was told that a doctor expressed that he/she had “really learned a lot from [him/her].”

**Recruiting, training, and retaining mental health therapists as Clinical Specialists can be a challenge.** Although the Clinical Specialists reported that a background in therapeutic interventions helped them in their roles,

many behavioral health professionals are unfamiliar with brief intervention strategies and struggle to adapt to time-limited, structured, solution-focused work in primary care. For example, the Clinical Specialists were not certified in PST-PC, even though they received training and case supervision. The Clinical Specialists reported, “It was very easy to step back into that full-time Therapist mode.” If the health center decides to use a behavioral health practitioner to fulfill the role of the Clinical Specialist, then the health center should be careful not to have the practitioner manage dual roles of a Therapist and Clinical Specialist, even if it makes sense financially.

## **Reimbursement Models**

**The current system of reimbursement in southwestern Pennsylvania cannot sustain ITPC.** New billing paradigms that do not thwart the evidence-based components of ITPC must be created in collaboration with insurers to sustain Clinical Specialists and Behavioral Health Care Managers in Pennsylvania’s safety net setting. Providing guidance on billing during webinars, telephone calls and meetings, in addition to funding were not sufficient to initiate routine billing for unfamiliar services due to the complexity and limitations of using billing codes to sustain ITPC’s services.

## **Unhealthy Substance Use**

**There were several challenges with identifying unhealthy drug and/or alcohol use in the demonstration sites.** Medical providers and even some Clinical Specialists perceived SBIRT to be a method to detect substance dependence and abuse as opposed to *unhealthy* substance use, despite strong training and coaching efforts. In addition, the practices reported that patients and providers were concerned and uncertain about confidentiality for substance use in primary care settings and how to properly document substance use in the medical record. Stigma around substance use, especially in small towns, was reported as a major barrier, as well.

## MAJOR FEDERAL GRANT

### *REFINING AND SPREADING THROUGH COLLABORATION*

Organizations from across the country are providing resources to support integrated care, but dissemination is not being addressed across and within regions and states. Last year, three regional health improvement collaboratives (RHICs) and an SBIRT-funded program at the University of Wisconsin came together to submit a joint application to the (federal) Agency for Healthcare Research and Quality (AHRQ) to implement unhealthy substance use and depression services in up to 90 primary care sites in the three states and develop resources for national dissemination.

PRHI was subsequently awarded \$3.5 million from AHRQ to lead this multi-state consortium to disseminate and implement a combined model of IMPACT and SBIRT. The consortium consists of PRHI, the Institute for Clinical Systems Improvement (ICSI) in Minnesota, the Wisconsin Collaborative for Healthcare Quality (WCHQ), the Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL), and the Network for Regional Healthcare Improvement (NRHI). ICSI is nationally renowned for implementing IMPACT in 84 practices with Depression Care Managers, and WIPHL is nationally renowned for implementing SBIRT in 18 sites with Health Educators.

This grant aims to merge PRHI's, ICSI's, and WIPHL's best practices and lessons learned to strengthen the integrated care initiatives in WI, PA, and MN, and to develop an Implementation Toolkit and a Communication Plan that can be applied to multiple regions. The theory is that RHICs are effective dissemination vehicles for IMPACT and SBIRT, because most RHICs have existing quality measurement systems, strong relationships with primary care practices in their region, a broad geographic reach, a long-term mission and community support, and involvement of stakeholders from all sectors of the economy.



#### In Memoriam

On April 22, Anne Mullaney, a beloved friend and PRHI Board Member passed away. She was an extraordinary person and we are so lucky to have known her.

Anne was a partner at Thorp Reed & Armstrong, and in addition to our board, she also served on the board of directors of the Jefferson Regional Medical Center, the Duquesne University School of Law Alumni Association and Leadership Pittsburgh, and was a past president of Pittsburgh Habitat for Humanity and the Health Executive Forum. She was also secretary to the board of Family Hospice & Palliative Care.

Our thoughts and prayers are with Anne's family.