

Improving Access and Outcomes: Collaborative Care Implementation in the Primary Care Setting

Lorin M. Scher, M.D.
Professor and Vice-Chair
Director, Integrated Behavioral Health Services

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Disclosures UC DAVIS HEALTH

- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC)
- UC Davis Practice Management Board
- Archstone Foundation
- California Health Care Foundation (CHCF)
- Center for Care Innovation (CCI)

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Agenda UC DAVIS HEALTH

- Rationale for behavioral health integration within primary care
- Tiered Integrated Programs at UC Davis
 - Screening initiatives
 - Electronic Consultations
 - Ambulatory Case Management Team
 - Collaborative Care Model (CoCM)
 - Tele psychiatry Implementation
 - Embedded Psychiatric Consultants
- Training / Research / CQI Initiatives

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The Problem UC DAVIS HEALTH

Psychiatric disorders:

- 25% of all disability worldwide
- 10% of Years Lived with Disability (YLD) – depression alone
- In U.S., one suicide every 14 minutes
- Increase risk: diabetes, heart disease, cancer

Health Behaviors

- Behavior determines = 50% of all mortality / morbidity
- Unhealthy behaviors are major drivers of health care costs
- 40-50% struggle with treatment adherence
- Employers struggle with absenteeism and presenteeism

C. Murray, Global Burden of Disease Study, Lancet 2012 4

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Background: the youth mental health crisis

- 20% of youth have a MH condition
 - 50% of MH conditions onset <14 yo
 - 75% of MH conditions onset by age 24
- Only 20-30% of patients receive treatment
 - Average of 8-10 year delay to getting care
- Untreated youth MH conditions have long-lasting effects
 - Falling off trajectories: social, academic
 - Leading causes of death: accidental death and suicide*

```

            graph TD
            A[Prevalent] --> C[Disease Burden]
            B[High Morbidity/Mortality] --> C
            C --> D[Treatment gap]
            
```

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Background: the youth mental health crisis

- Gap between **need** for and **availability** of youth MH services
- AAP and AACAP have called for:
 - Partnership between CAPs and pediatricians / family medicine
 - Integration of MH services in pediatrics
 - Increased training for pediatricians to increase MH competency
 - Emphasis on training for pediatrics residents

County Map
Mostly Sufficient Supply (n=47) | High Shortage (14-46) | Severe Shortage (1-17) | No CAPs

https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx

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WHO GETS TREATMENT?



Source: American Psychiatric Association 2018; Wang et al., 2005

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WHO GETS TREATMENT?

No Treatment			Primary Care Provider		
					
					
			Mental Health Provider		


Source: American Psychiatric Association 2018; Wang et al., 2005

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Background and Situation

- 25-30% of primary care patients have a mental health diagnosis
- Only 50% of patients referred to specialty mental health actually followed through with making an appointment



- Cunningham, Health Affairs

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Background and Situation UC DAVIS HEALTH

- Stigma
- Lack of access to behavioral health for many primary care patients
 - Shortage of specialists and behavioral health providers
 - Increased social needs/barriers
- Patients with behavioral health conditions
 - High rates of medical complexity
 - Poor cardiovascular outcomes

EQUITY
requires action

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Mental Health Rarely Occurs in Isolation UC DAVIS HEALTH

Mental Health Disorders

Percentage with comorbid condition

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Collaborative Care Model (CoCM) UC DAVIS HEALTH

- The CoCM is a specific model of integrated care
- Developed to treat common and persistent mental health conditions (i.e., depression / anxiety) in the primary care setting
- Provides MH / SUD treatment in primary care settings through consultation between a PCP working collaboratively with a psychiatric consultant and a behavioral health clinician (LCSW, MFT, psychologist)
- An evidence-based model with over 90 validated studies to show efficacy
- Recognized by CMS with specific billing codes

- Patient-Centered
- Population-Based
- Treat to Target
- Evidence-Based
- Accountable

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Collaborative Care Model (CoCM) UC DAVIS HEALTH

- **Strong evidence base:**
 - Improves health outcomes
 - Improves access to care
 - Reduces healthcare costs
- **90+ randomized control trials (RCTs) demonstrating clinical efficacy in a variety of common conditions**
 - depression, anxiety and trauma disorders, chronic pain, ADHD, and substance use disorders including alcohol and AUD

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History of Collaborative Care UC DAVIS HEALTH

The diagram shows three stages of collaborative care development:

- 1980-1990s:** Recognition of need to address depression in primary care
- 2000-2010s:** Over 80 RCTs demonstrating effectiveness of collaborative care
- 2010-Present:** Focus on implementation, sustainability and reach

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IMPACT Trial (JAMA, 2002) UC DAVIS HEALTH

- **RCT:** 1801 older adults with depression at 18 primary care clinics in 5 states
- **Usual care:** medications (70%) and/or behavioral health referral
- **Collaborative care:** tracked clinical outcomes, adjusted treatment.
- **Results:**
 - Improved satisfaction
 - Doubled effectiveness with 50% reduction of symptoms at 12 months vs 19% with usual care
 - Better functioning (PCS-12)
 - Lower healthcare costs
 - Benefits persisted at 1 year follow-up

Participating Organization	Usual care (%)	Collaborative care (%)
1	19	50
2	15	45
3	20	55
4	18	40
5	22	42
6	30	48
7	25	52
8	20	45

As part of usual care patients at organization #7 were offered psychotherapy from Master's level clinicians co-located within the primary care clinic.

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Improving Depression Care for Older Patients in Primary Care (Medical Care, 2005)

- IMPACT trial data
- Compared depression severity, quality of life, and mental health service use at 0, 3, 6, and 12 months.
- Treatment effects were of similar magnitude in all sub-groups included in the trial.

	N = 1801
Mean age (SD)	71.2 (7.5)
Male	35%
Female	65%
Non-Hispanic White	77%
Black	12%
Latinx	8%
All Others	3%

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Effectiveness of Collaborative Care for Depression (Psychiatric Services, 2017)

- RCT:** 400 patients with depression in 3 LA primary care clinics serving predominantly Latinx individuals (included FM/IM resident clinics)
- Enhanced usual care (N = 204):** Regular care from PCP, depression pamphlet, a letter from PCP about positive depression screen, and a list of local mental health resources
- Collaborative Care (N = 196):** Social Workers and PCP's: CBT and/or antidepressant medication
- Results:** By 16 weeks, Collaborative Care had two-fold increase in patients experiencing >50% reduction in depressive symptom severity
- Outcome:** Significantly improved quality-of-care indicators, including the proportion of patients receiving either psychotherapy or antidepressant medication (77% versus 21%, $p < .001$)

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- Sacramento, CA

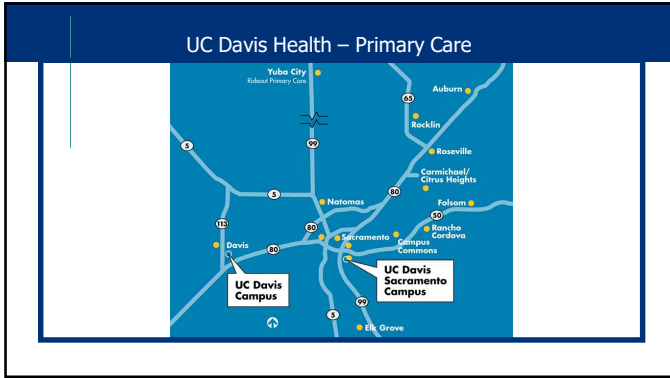
Medical Center

- 690 Bed Hospital
- Level 1 Adult and Pediatric Trauma Center

Primary and Specialty Care

- 18 ambulatory sites across multiple counties

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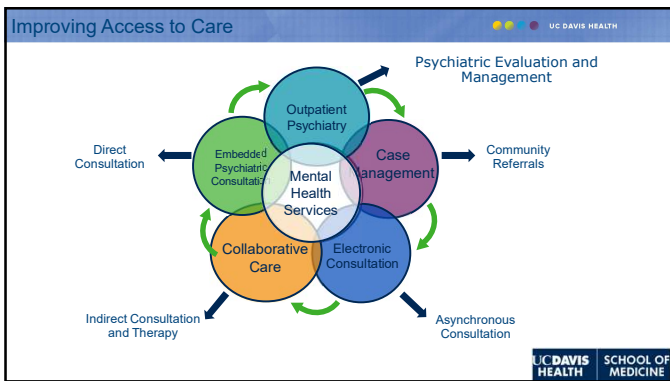
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A Phased Approach to Integration



- Screening
- Psychiatry E-consults
- Case Management
- Collaborative Care Model (CoCM)
- Psychiatry Consultation

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Screening

Front

Back

UC Davis Primary Care Sites

Now screening 2500+ patients per week

Available in MyChart

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Alcohol and Substance Use -- Screening

Low Screening Practices Despite USPSTF Recommendation

Population	Recommendation	Grade
Adults 18 years or older, including pregnant women	The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.	B
Adults age 18 years or older	The USPSTF recommends screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatments, and appropriate care can be offered or referred. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens.)	B

Alcohol Screening During US Primary Care Visits, 2014-2016

Brittany Chatterton, MD, Alicia Agosti, MD, MPH, MHS, [] and Joshua J. Fenton, MD, MPH

Higher risk of being missed by appropriate screening based on race, ethnicity and insurance class.

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AUDIT and DAST

Annual Brief Screen

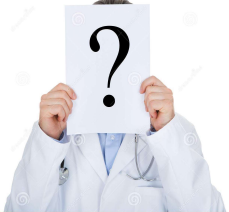
AUDIT

DAST

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Psychiatry E-consults







- PCPs ask questions to specialists
- An effective and efficient way to connect psychiatrists to PCPs
- Straight forward questions that don't need a psychiatry referral
- Cost effective and PCP satisfaction

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E-consult structure


- 
Shared EMR inbox covered by a team
 - 5 adult psychiatrists, rotating coverage by day of the week
 - 2 child consultants, one women's mental health consultant
- 
Recommendations are provided after brief chart review
- 
Common questions include:
 - Medication recommendations, particularly anxiety and depression
 - Safety of treatments in setting of comorbid medical issue or concerns for drug interactions
- 
Consider direct consultation if provider would like diagnostic clarification or more in-depth assessment is needed

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Ambulatory Case Management



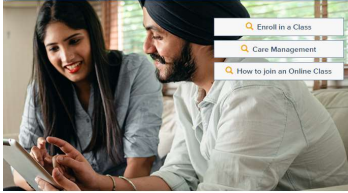
- Care Transitions
- Education
- Social Resources
- Transportation
- Linking patients to therapy

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Health Management and Education

- Nurses
- Social Workers
- Pharmacists
- Health Educators
- Dieticians
- Health Psychologists
- Hospital Discharge Call Program

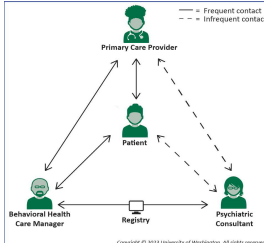


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CoCM Achieves Quintuple Aim

- **Population Health Outcomes**
 - Increases access
 - Improves clinical outcomes
- **Reduces Total Cost of Care**
- **Provider Satisfaction and Productivity**
 - Compared to UC
- **Patient Satisfaction**
 - Increased 25%
- **Reduces Health Disparities & Stigma**
 - Equivalent or better outcomes



Unutzer 2002; Levine 2005; Arian 2005; Unutzer 2008; Bowen 2020; Hu 2020

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Supervising Psychiatrist:
Kate Richards, M.D.

- Consults with PCPs and BHC regarding diagnostic and medication questions.
- Meets with patients directly or via video visit if needed (one to three visits) to discuss specific medication options.




Behavioral Health Clinician:
Jorge Hernandez, LCSW:

Will provide short-term counseling services (usually eight visits) that include:

- Talk therapy
- CBT
- Mindfulness
- Problem-solving therapy
- Motivational interviewing
- Behavioral activation techniques

Will conduct periodic case review with psychiatry.



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Role of consultant psychiatrist



- **Consultative model**
 - Collaborative
 - Recommendations to PCP
- **Weekly team systematic caseload reviews (SCR)**
 - EPIC Registry review
 - Treat-to-target (time-limited)

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UCD Collaborative Care Model: 2023 Data

- **39%** of patients are in **remission** within 12 weeks
- **60%** of the above patients have achieved a **response** to treatment within 12 weeks
 - Usual care is **19-25%**
- **Access to Care:** 2-3 weeks

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Psychiatry Referrals

- UC Davis Psychiatry (Psychiatry Behavioral Health Referral)
- MIND Institute (children with ADHD or autism)
- UC Davis EDAPT (early psychosis program ages 12-40)
- Medicare (EMR list)/Medi-Cal (ACCESS referral)
- Therapy: Psychologytoday.com or back of insurance card
- Cognitive Disorders: Health Aging Clinic, TBI clinic, Neurology, or Neuropsychological testing
- Panic Disorder, OCD, Agoraphobia: The Anxiety Treatment Center
- Eating Disorders: Eating Recovery Center

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Who should be referred?

Current patients who are:

- Age 50 and older.
- Suffering from depression or grief symptoms.
- Have a current (within 90 days) PHQ-9 score of 10 or above.

Patients who are acutely suicidal, have psychotic disorders, significant neurocognitive disorders, and/or substance use disorders **do not** qualify for the Collaborative Care Program at this time.

All payors qualify!

Referral Process

1. Select Network Behavioral Health referral.
2. Under Available Behavioral Health Resources, select Collaborative Care (for LCSW/short term psychotherapy) **or** select Psych Consult 1-3 visits (for psychiatrist).
3. Document the clinical indication.

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Tracking Performance Improvement

Depression Screening Summary

Referral ID	Referral Date	Referral Type	Referral Status	Referral Priority	Referral Class	Referral Reason	Referral Comment	Referral Link
10000001	10/1/2023	Internal Referral	Normal	Routine	Internal Referral	Psych Consult (1-3 consult visits with a Psych MD for diagnostic clarification and treatment recommendations to PCP (Patients ...		
10000002	10/1/2023	Internal Referral	Normal	Routine	Internal Referral	Addiction Psych Evaluation and Treatment (please see referral guidelines link above)		
10000003	10/1/2023	Internal Referral	Normal	Routine	Internal Referral	Child Psychiatry Consult		
10000004	10/1/2023	Internal Referral	Normal	Routine	Internal Referral	Psych Consult (1-3 consult visits with a Psych MD for diagnostic clarification and treatment recommendations to PCP (Patients ...		
10000005	10/1/2023	Internal Referral	Normal	Routine	Internal Referral	Psych Consult (1-3 consult visits with a Psych MD for diagnostic clarification and treatment recommendations to PCP (Patients ...		
10000006	10/1/2023	Internal Referral	Normal	Routine	Internal Referral	Psych Consult (1-3 consult visits with a Psych MD for diagnostic clarification and treatment recommendations to PCP (Patients ...		
10000007	10/1/2023	Internal Referral	Normal	Routine	Internal Referral	Psych Consult (1-3 consult visits with a Psych MD for diagnostic clarification and treatment recommendations to PCP (Patients ...		
10000008	10/1/2023	Internal Referral	Normal	Routine	Internal Referral	Psych Consult (1-3 consult visits with a Psych MD for diagnostic clarification and treatment recommendations to PCP (Patients ...		
10000009	10/1/2023	Internal Referral	Normal	Routine	Internal Referral	Psych Consult (1-3 consult visits with a Psych MD for diagnostic clarification and treatment recommendations to PCP (Patients ...		
10000010	10/1/2023	Internal Referral	Normal	Routine	Internal Referral	Psych Consult (1-3 consult visits with a Psych MD for diagnostic clarification and treatment recommendations to PCP (Patients ...		
10000011	10/1/2023	Internal Referral	Normal	Routine	Internal Referral	Psych Consult (1-3 consult visits with a Psych MD for diagnostic clarification and treatment recommendations to PCP (Patients ...		
10000012	10/1/2023	Internal Referral	Normal	Routine	Internal Referral	Psych Consult (1-3 consult visits with a Psych MD for diagnostic clarification and treatment recommendations to PCP (Patients ...		
10000013	10/1/2023	Internal Referral	Normal	Routine	Internal Referral	Psych Consult (1-3 consult visits with a Psych MD for diagnostic clarification and treatment recommendations to PCP (Patients ...		
10000014	10/1/2023	Internal Referral	Normal	Routine	Internal Referral	Psych Consult (1-3 consult visits with a Psych MD for diagnostic clarification and treatment recommendations to PCP (Patients ...		
10000015	10/1/2023	Internal Referral	Normal	Routine	Internal Referral	Psych Consult (1-3 consult visits with a Psych MD for diagnostic clarification and treatment recommendations to PCP (Patients ...		
10000016	10/1/2023	Internal Referral	Normal	Routine	Internal Referral	Psych Consult (1-3 consult visits with a Psych MD for diagnostic clarification and treatment recommendations to PCP (Patients ...		
10000017	10/1/2023	Internal Referral	Normal	Routine	Internal Referral	Psych Consult (1-3 consult visits with a Psych MD for diagnostic clarification and treatment recommendations to PCP (Patients ...		
10000018	10/1/2023	Internal Referral	Normal	Routine	Internal Referral	Psych Consult (1-3 consult visits with a Psych MD for diagnostic clarification and treatment recommendations to PCP (Patients ...		
10000019	10/1/2023	Internal Referral	Normal	Routine	Internal Referral	Psych Consult (1-3 consult visits with a Psych MD for diagnostic clarification and treatment recommendations to PCP (Patients ...		
10000020	10/1/2023	Internal Referral	Normal	Routine	Internal Referral	Psych Consult (1-3 consult visits with a Psych MD for diagnostic clarification and treatment recommendations to PCP (Patients ...		

- Hemoglobin A1c
- Blood pressure
- BMI
- PHQ-9 (depression)
- GAD-7 (anxiety)
- Substance Use Screenings

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NETWORK BEHAVIORAL HEALTH REFERRAL [accept] [Cancel]

Reference Links: 1. Referral Guidelines

Class: Internal Referral [Internal Referral] External Referral

Status: Normal [Normal] Standing Future

Priority: Routine [Routine] Urgent

Available Behavioral Health Resources (select clinics):

- Psych Consult (1-3 consult visits with a Psych MD for diagnostic clarification and treatment recommendations to PCP (Patients ...
- Addiction Psych Evaluation and Treatment (please see referral guidelines link above)
- Child Psychiatry Consult
- Collaborative Care**

RefType: Consultation [Consultation Only] Consultation and Visits

Referral Reason: Evaluate and [Care and Tx Recommendations] Evaluate and Treat

Comments: Clinical Indication and behavioral health goals for Patient: ***

Age 50 or over with depression/grief and recent PHQ-9 score of 10 or above

Next Required [accept] [Cancel]

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Short-Term Psychiatry Consults

- Short-term (1-3 visits total) coordinated with PCP regarding specific diagnostic questions or refractory symptoms.
- Not already established with a UCD/external psychiatrist.
- Open to medication management.
- Consider CMP, CBC, TSH/Free T4.

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Teaching Builds Relationships

- **Integrated Teaching**
 - Every consultation is an opportunity to teach!
 - PCP / BHC
- **Structured Teaching**
 - "Lunch & Learns" on topics in Primary Care Psychiatry
 - CME
- **Formal educational content**
 - Journal articles / handouts / protocols



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Building Relationships with PCPs

- Maximize facetime with providers
- Consider brief meetings for additional 1:1 psychopharm education
- Lunch and Learns
- Offer accessibility and drop-in discussion of cases
- Communicate recommendations clearly

- Route your notes
- Clarify preferred pharmacy
- Discuss risks and benefits of treatment recommendations
- Include titration/tapering instructions, monitoring guidelines

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Resident feedback

- ACLP 10-year follow up survey showed only 19.4% of responding programs had a required outpatient CL component (*Beach et al, 2023*)
- A 2020 systematic review in JACLP looked at interventions to train psychiatry residents in integrated care
 - Most surveyed residents found these experiences to be positive experience
 - Rotations were relevant in preparing them for their future careers
 - CoCM rotations enhanced learning on how to assess and manage complex medical-psychiatric patients

Zimbrea et al., 2020

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Resident feedback UC DAVIS HEALTH

A summary of **5 psychiatry training programs** that provided **integrated care training for residents** found that the **success of such programs** depended on:


- Supervising psychiatrist with experience in integrated care
- Funding for faculty time
- Time to do the rotation within the residency program
- Office space accommodations within the clinical site
- PCP clinic "champion" who supports integrated care

Zimbren et al., 2020 43

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Educating The Workforce UC DAVIS HEALTH

- Training PCPs
- Training Psychiatrists
 - C-L Fellows
 - PGY-5 Combined Residents
 - PGY-4 General Residents
- Medical Student rotations



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Program Development UC DAVIS HEALTH




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Program Development (cont.)

- Clinical Quality Improvement
- Education
 - PCP education
 - Trainees
- Research
 - Telepsychiatry
 - Population health



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A program built from CQI projects

- 2011 – Depression Care Management – Pay for Performance Initiative
 - 2 clinics – improved depression outcomes
 - Highly rated by patients and PCPs
- 2012 – Depression Care Management – expanded
 - 3 clinics – replicated 2011 results
- 2013 – Care Coordination Program
 - Now Ambulatory Care Management (ACM)

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Brief History -- Program Development

THIS IS A BUSY SLIDE ON PURPOSE!!! ☺

- 2015: Asynchronous Telepsychiatry for Depression in Primary Care
- 2016: PRIME – Public Hospital Redesign and Incentives in Medi-Cal
- 2016: Universal screening
- 2017: E-Consult launch
- 2018: Collaborative Care Model implementation
- 2019: Care Partners Grant for Late-Life Depression (Archstone Foundation)
- 2021: Expansion to Academic Clinics
- 2022: CHCF-CCI: Behavioral Health Equity in Primary Care
- 2023: WITH Study; Expand Inclusion Criteria for CoCM

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Pediatric Integrated Care UC DAVIS HEALTH

- Pediatric integrated care models can be based on adult models (with modifications) but there are unique challenges that face these pediatric programs
- Successful programs take into consideration key differences like lower volume, longer visits, more complexity, importance of care coordination
- Pediatric integrated care models are excellent training sites and can help expand the mental health workforce
- It is possible to use a population health framework to shape a large system of care and improve access to mental health treatment

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Mental Health and COVID UC DAVIS HEALTH

CDC report

Centers for Disease Control and Prevention

MMWR Morbidity and Mortality Weekly Report
Weekly / Vol. 69 / No. 32 August 14, 2020

Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020

Mark E. Cougle^{1,2}, Rachel L. Lane MA³, Emilio Petrosky MD³, Joshua F. Wiley PhD¹, Alex Christensen MPP¹, Rashid Niaz PhD³, Matthew D. Weaver PhD^{4,5}, Rebecca Robbins PhD⁶, Eric S. Thorpe PhD⁷, Laura K. Biegel PhD^{8,9}, Charles A. Czeisler MD PhD^{10,11}, Mark E. Howard MBS PhD^{12,13}, Shantia M.W. Rajaratnam PhD^{14,5}

The coronavirus disease 2019 (COVID-19) pandemic has been associated with mental health challenges related to the morbidity and mortality caused by the disease and to mitigation activities, including the impact of physical distancing and stay-at-home orders.¹ Symptoms of anxiety disorder and depressive disorder increased considerably in the United States during April–June of 2020, compared with the same period in 2019 (1,2). To assess mental health, substance use, and suicidal ideation during the pandemic, representative panel surveys were conducted among adults aged ≥18 years across the United States during June 24–30, 2020. Overall, 40.9% of respondents reported at least one adverse mental or behavioral health condition, including symptoms of anxiety disorder or depressive disorder (3,4,5).


INSIDE

- 1058 Characteristics of Marijuana Use During Pregnancy — Eight States, 2017
- 1064 Top Food Category Contributors to Sodium and Potassium Intake — United States, 2015–2016
- 1070 Serious Adverse Health Events, Including Death, Associated with Ingesting Alcohol-Based Hand Sanitizers Containing Methanol — Arizona and New Mexico, May–June 2020
- 1074 COVID-19-Associated Multisystem Inflammatory Syndrome in Children — United States, March–July 2020
- 1081 Hospitalization Rates and Characteristics of

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Suicidal Ideation during Pandemic UC DAVIS HEALTH

- Symptoms of **depression** and **anxiety** increased significantly during pandemic, compared with same period in 2019
 - CDC August 2020
- 41% report at least one mental health condition, including substance use disorder
- **11% reported seriously considering suicide in 30 days prior to survey**



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COVID-Era Disparities UC DAVIS HEALTH

- **COVID impact: Mental health conditions disproportionately impact specific populations**
 - Young Adults
 - Black, Latinx and Indigenous communities
 - Essential workers
 - Unpaid caregivers for adults
 - Patients with pre-existing mental health conditions

Structural Racism in medicine impacts outcomes

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CHCF-CCI Learning Collaborative: Advancing Behavioral Health Equity in Primary Care UC DAVIS HEALTH

- Aligning behavioral health and social needs
- Reducing Barriers to Care
 - Racism, discrimination, trauma
- Social determinants of health
 - Screening, tracking, and referral
 - Housing insecurity, food insecurity, legal support

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The American Journal of **Psychiatry** REVIEWS AND OVERVIEWS
History of Psychiatry

175th Year of Publication

Integrating Health and Mental Health Services: A Past and Future History

Benjamin G. Druss, M.D., M.P.H., Howard H. Goldman, M.D., Ph.D.

The authors trace the modern history, current landscape, and future prospects for integration between mental health and general medical care in the United States. Research and new treatment models developed in the 1980s and early 1990s helped inform federal legislation, including the 2008 Mental Health Parity and Addiction Equity Act and the 2010 Affordable Care Act, which in turn are creating new opportunities to further integrate services. Future efforts should build on this foundation to develop clinical, service-level, and public health approaches that more fully integrate mental, medical, substance use, and social services.

Am J Psychiatry 2018; 175:1199–1204. doi: 10.1176/appi.ajp.2018.18020169 54

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Making the "business case" for integrated care

- Improved patient outcomes
- Savings in total health care costs
- Improved patient / provider satisfaction
- Improved provider productivity
- In safety net populations
 - Reduced homelessness / arrest rates

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Sustainability Plan

- Alternative Payment Models
 - Pay-for-Performance / Outcomes
 - PRIME
 - Health Homes
 - CaAIM
- Billing codes for Collaborative Care

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Improved Access – Value-based care

- Mental Health Parity and Addiction Equity Act
- ACA insurance expansion
- Accountable Care Organizations
- **Key Talking Points with Leadership**
 - Better outcomes
 - Lower costs
 - Better experience of care for patients and providers

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Integrated Care – Next Steps

- Further align with population health team
- Expansion into Pediatrics settings (Dr. Hopkins)
 - Psychology Faculty and Trainees
- Expand workforce
 - Psych NPs / FNPs / Clinical Pharmacy
- Expand inclusion criteria
- Financial sustainability
 - CoCM billing codes
 - Alternative payment models

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A team approach to care




Interprofessional and Patient-centered

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▪ Mike Hooper, MD	▪ David Lubarsky, MD

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