Lakewood Health System: Rural, Integrated, Effective

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Purpose

• Compel you to investigate strategies to develop and implement integrated care in your healthcare facilities/systems.
Outline

1. Share data demonstrating need for integrated healthcare.

2. Discuss continuum of models for providing integrated care and review national and state examples.

3. Outline Lakewood Health System’s hybrid system for ensuring access to integrated healthcare in a rural setting while maintaining access to traditional MH services.

4. Discuss challenges when developing and integrating care.

5. Questions?
Abbreviations

PC = Primary Care
PCP = Primary Care Provider
MH = Mental Health
BH = Behavioral Health
MHP = Mental Health Provider
BHC = Behavioral Health Consultant
Epidemiology Data

• MDD #1 disability in U.S.
• Disease burden of MH disorders second only to all combined cardiovascular conditions and greater than all forms of cancer combined
• 70% all PCP visits psychosocial factors
• 80% PCP visits include pain, 33% PCP visits pain is primary complaint
• 10 most common complaints in PC: 85% no diagnosable organic etiology during 3 years of follow up.
Epidemiology Data

• U.S. Lifetime prevalence
  – 46% DSM-IV disorder
  – 21% Depressive mood disorder
  – 29% Anxiety disorder
  – 40-50% medical patients have Depression or Anxiety
BH Burden on Healthcare System

• Greater healthcare utilization: highest 20% pts use 88% of healthcare
• Increased medication use (and misuse): e.g., opioids 3-6x if MH co-morbidity
• Tx noncompliance, drop out, and relapse
• Only 40% of prescriptions taken
BH Burden on Healthcare System

- Poorer lifestyle management: inactivity, alcohol/drug use
- Increased pain complaints, severity, duration
- Greater functional impairment/disability
- Poorer rehab and surgery outcomes
- Delayed return to work
BH Burden on Healthcare System

- Other predictors of poor health outcomes:
  - Somatization
  - Anger
  - Catastrophizing
  - Unrealistic tx expectations
  - Coping styles
  - Personality factors
  - Stress mismanagement
  - Social support
  - Secondary gain
Treatment Data

• De facto BH tx system is Primary Care – e.g., 60-80% all psychotropic meds
• BH needs routinely not assessed
• When assessed, pts too often don’t follow-up
• PCP don’t have time, BHC/MHP not available
• BH disorder can be effectively tx
Other Factors

- 80% U.S. Population sees PCP yearly
- US Department of Health & Human Services: lifestyle factors prominent in majority of mortality and morbidity
- Chronic conditions fastest growing in PC
- PC job dissatisfaction due to BH issues in pts
- Medicaid/Medical Assistance greater BH needs
- Medication only tx insufficient/less effective
- Rural areas lack access to BH specialists
Societal Demands

• Healthcare Reform
  – Increased access expected
  – Bundled services
  – Prevention focus

• Outcome focus
  – NPI data
  – Pay for performance
  – Cost savings incentives

• Medical/Health Care Home
## The Continuum of Integration

<table>
<thead>
<tr>
<th>Model</th>
<th>Desirability</th>
<th>Attributes</th>
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</thead>
<tbody>
<tr>
<td>Separate Space &amp; Mission</td>
<td>- -</td>
<td>Traditional BH Specialty Model</td>
</tr>
<tr>
<td>1:1 Referral Relationship</td>
<td>+</td>
<td>Preferred provider/ Some information exchange</td>
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<tr>
<td>Co-location</td>
<td>++</td>
<td>On-site BH Unit/ Separate Team</td>
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<tr>
<td>Collaborative Care</td>
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<td>On site/shared cases w/ BH specialist</td>
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<tr>
<td>Integrated Care</td>
<td>+++++</td>
<td>PC Team Member</td>
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Integration Models

1. Co-located Clinics Model: BH as specialty service within PC setting
   - Some improved collaboration, but access issues remain
Integration Models

2. Primary Care Provider Model: BH provider a PC staff member, not specialty provider
   - Greater link between BH and general health care
   - Traditional BH visits still make access an issue
Integration Models

3. Staff Adviser Model: BH provider acts as consultant to PCP

- Helps train PCP, but limits BH provider helpfulness overall
Integration Models

4. Stepped-Care Approach: combination of 1-3 where BH care begins with lowest intensity and increases as needed
- Flexible, better integration, improved access
- Access can still quickly disappear
Integration Models

5. Primary Care Behavioral Health Model
   - Population focus
   - Side by side service with PCPs
   - BHC part of PC team
   - BHC assesses pt psychosocial needs
   - BHC works to develop tx plan for PCP to implement
   - Allows easy access to BH care
   - Not traditional BH care. Not therapy.
Benefits of Integrated Care

- Improvement in depression remission rates: from 42% to 71%
- Improved self management skills for patients with chronic conditions
- Improvement in MH, but also significant improvement in health outcomes for conditions such as diabetes and CHD
Benefits of Integrated Care

• Better clinical outcome than by treatment in either sector alone
• Improved consumer and provider satisfaction
• High level of patient adherence and retention in treatment
• Population health benefits
Benefits of Integrated Care

• Improved process of care
  – Improved recognition of MH and CD disorders
  – Improved PCP skills in medication prescription practices
  – Increased PCP use of behavioral interventions
  – Increased PCP confidence in managing behavioral health conditions
Benefits of Integration

• Increased Productive Capacity
  – Estimate of revenue ceiling of a health care system is closely tied to productive capacity of medical providers
  – Current capacity is overwhelmed with frequent management of behavioral health conditions (50% of medical practice time directed toward BH conditions)
  – Integrated behavioral health “leverages” BH patients out of PCP practice schedules
  – PCP’s are freed to see medical patients with higher RVU conditions
Economic Benefits of Integration

- Meta-analysis: 57 controlled studies show a net 27% cost savings
- 40% savings in Medicaid patients receiving targeted treatment
- In older populations, up to 70% savings in in-patient costs
- 20-30% overall cost savings overall average
  - Approaching $3 trillion health care costs annually
National and State Models

- IMPACT Model: Depression care in PC
- Intermountain HealthCare: Salt Lake City
- Virginia CHC Model
- Hawaii Medicaid Project
- US Military: Integrating PC in all branches
- DIAMOND Program: Bloomington, Minnesota- Depression care in PC
Minnesota

• DIAMOND Program: Bloomington based ~75 clinics throughout MN
  – PHQ-9 screen and dx by Physician
  – Care manager: medical assistant/nurse
  – Consulting psychiatrist
  – Evidence base tx and stepped care
  – Patient registry
  – Relapse prevention plan
  – 5-10x more effective than tx as usual
  – 3x more effective than tx in BH clinics
Lakewood Health System

- City of Staples, Todd County, MN
- Federally certified Rural Health Clinic
- High Medicare/Medicaid/Medical Assistance
- Developing a hybrid system
- Contains components of all 5 types of integrated care and similarities to DIAMOND
- Addressing all types of MH disorder as well as targeted medical populations, e.g., Pain, Women’s Health, Palliative Care, Dementia, FASD
- Improves access, satisfaction, and outcome
Interdisciplinary Team

– Providers
  • MD Psychiatrist (2)
  • PsyD, LP
  • APRN, CNS
  • MSW, LICSW
  • MA, NCC, LPCC, LAMFT
  • PhD, LP

– Key Staff
  • MSW, LICSW, Psychiatric Services Director
  • RN, MSN, Nurse Manager
  • PA-C, Physician’s Assistant
  • RN, Day Shift Supervisor
  • MS, LPCC, Counselor, Care Coordinator
Clinic OP Behavioral Health
Clinic OP Behavioral Health

- Child, Adolescent, Individual, Family, Couple Therapies—Traditional and BHC
- Psychiatric Consultation: Assessment, Tx Planning
- Psychiatric Medication Management
- Psychological Testing, Neuropsych Testing
- Behavioral Consultation To PCP, Pain Management, Palliative Care, And Women's Health Services
- Future Specialized Group Therapy—Dep/Anx, Pain, Peri/Post-Partum
How Does It Work

• PC Assessment and Screening: e.g., PHQ-9
• Stepped care approach
• Referrals from PC: PCP is gateway to BH specialty services
• Shared EMR
• Warm hand-offs
• Scheduling on spot
• Training front line LPNs in BH assessment and brief tx
Reflections Inpatient Program
Reflections
Inpatient Program

• Inpatient Acute Care Gero-psychiatric Program
• Critical Access Hospital
• Ten Bed Typical Stay = 10 To 12 Days
• Accept Most Major Insurance Plans
• 72 Hour Holds, Guardianship, Admit 24/7
• ER Medical Stability Clearance
Reflections
Structured Outpatient Program
Reflections
Structured Outpatient Program

- Gero-Pych Group Therapy
  - Individual And Family Therapy As Needed
- Typical Length Of Participation Is Six Months
- Sessions Available M-F 9am - Noon
- Transportation Available Up To 45 Mile Radius Of Staples
- Lunch Available On-site
- Accept Most Major Insurance Plans
Outpatient Electroconvulsive Therapy
On Site Psychiatric Services in Long Term Care
On Site Psychiatric Services in Long Term Care

Services Include:

• Psychiatric Assessment
• On-going Medication Management
• Psychological Testing
• Behavior Plan Development
Challenges

• Tradition: not like PC and not like therapy
• Cultural issues: PCP vs. MH providers
• Space
• Population health vs. Individual health
• Balancing traditional MH care and integrated care innovations
• Cost offset vs. Revenue
• Administrator buy in
• Payor buy in
• Bundled services
Summary

1. Shared data demonstrating need for integrated healthcare.
2. Discussed continuum of models for providing integrated care and reviewed national and state examples.
3. Outlined Lakewood Health System’s hybrid system for ensuring access to integrated healthcare in a rural setting while furthering access to traditional MH services.
4. Discuss challenges to effective integration
5. Questions?