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Behavioral Health Integration: Exploring Its Effect on Clinical Practice

Announcer:
You're listening to ReachMD, and this is a special edition of Reaching the Potential of Value-Based Care, entitled: "Behavioral Health Integration: Exploring Its Effect on Clinical Practice", brought to you by the American Medical Association.

Here's your host, Dr. Matt Birnholz.

Dr. Birnholz:
Welcome to Reaching the Potential of Value-Based Care on ReachMD. I'm Dr. Matt Birnholz, and joining me to discuss the benefits and challenges of behavioral health integration services are Drs. Donald Meyer and Travis Mickelson. Dr. Meyer is Assistant Professor of Psychiatry at Harvard Medical School, with Staff Appointment at the Beth Israel Deaconess Medical Center, and the Mount Auburn Cambridge Independent Practice Association. Dr. Meyer, great to have you with us.

Dr. Meyer:
My pleasure to be here.

Dr. Birnholz:
And Dr. Mickelson is Assistant Professor in the Division of Child Psychiatry at the University of Utah School of Medicine, where he also serves as Medical Director of Mental Health Integration at Intermountain Healthcare and Adjunct Professor of Psychiatry at University of Utah. Dr. Mickelson, welcome to you.

Dr. Mickelson:
Thank you. Happy to be here.

Dr. Birnholz:
So, doctors, to kick things off, Dr. Meyer over on the east coast, why did your organization decide to pursue behavioral health integration, or BHI services as it's often called? What was your team looking to achieve?

Dr. Meyer:
First, our societies are awash in either untreated or undertreated mental illness, 20% of the population will at some time have a mood disorder, 29% will have an anxiety disorder, 17% or greater will have a substance use disorder, and 2% have psychosis. Our PCP waiting rooms are awash in untreated and undertreated mental illness. Many of them will never see a mental health professional. Second, increasingly, physicians are tasked with managing populations. The mission of behavioral care integration was two-fold; to identify these two different groups that have significant overlaps, and then identify avenues of intervention.

Dr. Birnholz:
Dr. Meyer, those are obviously some sobering statistics that help propel the mission of your program. How did you take the first steps in this direction?

Dr. Meyer:
Well, our first step was taken with the aid of a grant we had won from an organization that had funding to study cost savings and healthcare outcomes by using a collaborative care model, or what's been called an iIMPACT model. Our group is an IPA, independent practice association, and we have 75 PCPs, 400 specialists. The PCPs are grouped into pods, and the IPA identified a metabolic specialist in each pod of PCPs. We hired healthcare coaches who were post-Bachelor degree individuals interested in medicine and

psychology, and train them in motivational interviewing in formulating small steps a patient could take to improve their health. And we had psychiatrists deployed to each of the pods to meet with metabolic specialists and a pods healthcare coach to share information and make plans.

Dr. Birnholz:
That's excellent, Dr. Meyer, thank you very much. Dr. Mickelson, let me turn to you for your story out to the west. How did Intermountain Healthcare get started in this initiative, and why?

Dr. Mickelson:
Dr. Meyer mentioned that the majority of patients' mental health needs were not being addressed, and they actually felt more comfortable being able to have these mental health concerns addressed within their primary care practice with their primary care clinician who really knew them well and they didn't have to deal with the stigma and added burden of having to go outside of their primary care clinic; however, these primary care providers weren't necessarily well trained in managing mental health issues, and so it was quite clear that the only way to address that concern would be to integrate mental health professionals into primary care. And so our mental health integration program started in 2001, by an APRN, Brenda Reiss-Brennan and a couple of her pediatrician friends. As a team, they were able to get positive outcomes that allowed their patients and families to have their needs met within their primary care setting, which improved patient satisfaction, and reduced the need for more expensive services.

Dr. Birnholz:
That's great. And I'm curious about compared to Dr. Meyer's model how your mental health integration model works, whether it compares or contrasts with those delivery mechanisms that Dr. Meyer spoke to?

Dr. Mickelson:
Well, one of the things I really noticed in listening to his model is one of the similarities is having someone on that team within that primary care clinic that plays a role of the health advocate or care manager. Because one of the important aspects of any successful behavioral health or mental health integration model is we need some added support to help that primary care provider and the psychiatrist. This is not something that only a psychiatrist or primary care provider is going to be able to adequately manage on our own.

Dr. Birnholz:
And Dr. Meyer, let me come back to you then. Any thoughts from your vantage point on these respective models, as you hear Dr. Mickelson's take on mental health integration or behavioral health integration services?

Dr. Meyer:
Well, Dr. Mickelson's system has in place an administrative structure that can decide that this program is going to be deployed, and it's a significant advantage in getting it done. We in my group perceived by consensus, and so it was one thing to develop the program, but then we had to persuade the consumer that is the PCPs, that this was something that they would want. And I'm sure you all know, PCPs are in the position these days of having one more task and one more program added to their plate, and their experience often is that it increases the workload rather than increasing treatment efficacy, and so our mission was to try to show the PCPs that we were offering them something of value. So the hope was that we would build some feeling that we're all in this together, trying to fix the problem.

Dr. Birnholz:
So, doctors, you've given me a good sense of how your peers initially reacted and then started to adopt these models in practice. What about the responses that you both received from patients as these initiatives got under way? Dr. Meyer, let me start with you. How were the early goings on your end?

Dr. Meyer:
The acceptance of patients was greatly facilitated if the treating doctor, that is the PCP, had bought into the value of the program. The patients had to be educated about what a health coach was going to do and that they were not psychotherapists in the field, but they were advocates for the patient's health and well-being. Many of the patients, especially those who were more isolated, welcomed the ongoing interest of the healthcare coaches, and that they were – the coaches were conveying clinical information, both to the PCP and to the psychiatrist. There were other people who were more private, didn't want to talk to someone, wouldn't answer the phone. So we had a range of responses, though by and large, most of them were pretty good.

Dr. Birnholz:
Dr. Mickelson, was your experience with patients similar to that of Dr. Meyer's when you were helping to launch this integrative model?

Dr. Mickelson:
When I first started working in this large pediatrics clinic, the pediatricians that had been working in this clinic had been dealing with mental health concerns from their patients on their own without much support for several years. And it felt almost as if I was a rock star

walking onto the stage. I was so appreciated for what I was able to bring to the team. And again it's very clear that patients and families would much rather have all of their healthcare needs met within that safe, comfortable space within their primary care clinic, than having to go outside of that. And so I've just had overwhelming success and appreciation, both from patients and primary care providers.

Dr. Birnholz:
For those just tuning in, you're listening to Reaching the Potential of Value-Based Care on ReachMD. I'm Dr. Matt Birnholz, and today I'm speaking with Drs. Donald Meyer and Travis Mickelson about their experiences implementing behavioral health integration models into practice.

So doctors, we've gotten a good sense of the origins, the early developments, and some of the patient and peer responses to these initiatives from your respective vantage points; I'd like to now cover some of the challenges you've encountered along the way. So, Dr. Mickelson, what barriers have you come across? And how have you addressed them to date?

Dr. Mickelson:
One of the big challenges we have in developing these mental health or behavioral health integration programs is to really change the culture of that practice. We sometimes run into providers who will tell us, "I don't do depression," or "This is something that a psychiatrist needs to manage," and so it's important for us to be able to show them why this work matters and why working in an integrated way does improve the health and well-being of our patients. And if we do this right, and do this well, we can actually decrease the primary care stress and burden that they're under. And also if we can do this in a way that really measures outcomes, we can show that we are improving quality and decreasing the high cost of care

Dr. Birnholz:
And Dr. Meyer, are there any additional issues expected or unexpected that you're dealing with over on the east coast?

Dr. Meyer:
Yes, one of the issues when we first conceived of this program was to facilitate PCPs treating various types of depression and anxiety. As we examined the patient pools we had, both from our registry and from the electronic health record and the PCP referrals, we also identified patients who were in the community who were undertreated or untreated, but who had substantial mental illness that I felt was outside the wheelhouse of your average PCP. And so we were able to offload that clinical responsibility to an appropriate specialist. And I think everybody was better served by that determination. We also faced monetary issues because the grant ran out. And the IPA decided they wanted to continue something, but they didn't have the financial wherewithal to replace what the grant had been giving. And so we had to form a second iteration to try to address these two patient populations.

Dr. Birnholz:
So clearly there are some overlapping issues from your respective practices. But since implementing BHI services, I'd love to know from both of you what kinds of changes and outlooks from that culture change you both spoke to that was needed, to responses, to outcomes, most importantly, that you've seen since that time. Dr. Meyer, can you speak to the impact that these programs have had?

Dr. Meyer:
Yes, well one of the most satisfying things about these programs is that we saw the hoped-for differences. So if you look at the aggregate scores on PHQ-9s, they improved dramatically because of these programs. And if you look at hemoglobin A1c's or blood pressure control, those improved as well. And the experience really of the team was also very positive.

Dr. Birnholz:
Well, it certainly sounds so. How about for you, Dr. Mickelson.

Dr. Mickelson:
Likewise. I also found that in our program, that overwhelmingly, our primary care providers really appreciate that this mental health integration program is just a critical component of our value-based healthcare strategy, and that value is felt both by the physician and patients alike. We are receiving measurable improved outcomes, lower cost, and that's an excellent thing to be able to see. And also just in that time today where we're really dealing with large amounts of physicians disengagement and the increased risk of suicide and suicide rates, just having that immediate and accessible health for that distressed patient has just really been invaluable.

Dr. Birnholz:
Doctors, my last question to you both then. Considering our audience, what advice would you give those who are considering implementing behavioral health integration models into their practices? Dr. Mickelson, let me start with you.

Dr. Mickelson:
Yeah, so number one, I just feel that this is the most meaningful work that I can imagine doing as a psychiatrist. Number two, it's critical

to have that leadership support and have the adequate resources that are really needed for our primary care medical homes to be successful. And we can't forget that important role of the healthcare manager. They're so valuable to our integrated model. And then number three is that it's really important to make sure that you have a very clearly-defined process that will allow you to identify the complexity of the patient's needs in a very patient-centered manner that will help you identify the appropriate level of engagement required from the behavioral health integrated team, and what that level of care that would be needed.

Dr. Birnholz:
Thank you, Dr. Mickelson, that was really informative. Dr. Meyer, you have the last word.

Dr. Meyer:
I think it's important whether you are big or small, that you attempt to address these questions we've talked about because they're major determinates of health and illness with your patients. There are various forms of behavioral health integration that can be scaled to a single practice, to a group practice, or to a major system. And each of them in their own ways provides access for intervention for these patients, and I would just say it's enormously satisfying kind of work to do.

Dr. Birnholz:
Well, those are great takeaways from both of my guests. I want to thank Dr. Meyer and Dr. Mickelson for joining me to discuss the current realities, challenges, and opportunities for physicians considering behavioral health integration models in practice. Doctors, it was great having you both on the program.

Dr. Meyer:
It was my pleasure to be here.

Dr. Mickelson:
It was a real pleasure, thank you.

Announcer:
This was Reaching the Potential of Value-Based Care, sponsored by the American Medical Association. To access other episodes of this series, visit ReachMD.com/ValueBasedCare, where you can be part of the knowledge.