Community Care of North Carolina

North Carolina's Co location Project Overview

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What does the Research Say?

- Surgeon General Report says that 20% of the population has a mental health diagnosis
- Nearly 70% of all health care visits have primarily a psychosocial basis (Fries, et. Al 1993, Shapiro et al., 1985)
- 90% of the 10 most common complaints in primary care setting have no organic basis

MAHEC
Mountain Area Health Education Center

- 40-50% of people who get alcohol, drug or mental health treatment get it at primary care
- 67% of all psychopharmacological drugs are prescribed by primary care physicians
- 80% of clients prefer to get their behavioral health services from their regular medical provider
- National depression rate is 16%

- 6-10% of pts in primary practice have major depression
- Recent study (Simon, 1992) suggests that on average, primary care patients with even mild levels of depression use two times more health care services annually than their non-depressed counterparts
- Total economic cost of depression has been estimated at more than $83 billion/year in the USA

Why Integrate Care?

Because the vast majority of patients in primary care have either:

- a physical ailment that is affected by stress,
- problems maintaining healthy lifestyles,
- or a psychological disorder

it is clinically effective and cost effective to make behavioral health providers part of primary medical care.

Why Integrate Care?

- Improve treatment adherence
- More effective care
- More efficient care
- Decrease medical costs
- Increase patient functioning & productivity
- Improve patient satisfaction
- Improve staff satisfaction

- Co-location
  - Sharing the same space - necessary but not sufficient
- Collaboration
  - Specialty MH provided in close collaboration with primary care
- Integration
  - BH issues managed primarily by PCP with consultation from BH provider

Strosahl K, Behavioral Health Care Tomorrow, 1996

What is Integrated Care?

Integrated Primary Care combines medical and behavioral health services to more fully address the spectrum of problems that patients bring to primary medical care.

It is important to note that it is not a replacement for specialty mental health.

Key Program Components*

- Screening
- Treatment guidelines
- Patient education
- Physician education
- Tracking systems
- Treatment Coordination
- MH specialists

* Based on Chronic Care Model

Effectiveness Studies of Depression in Primary Care

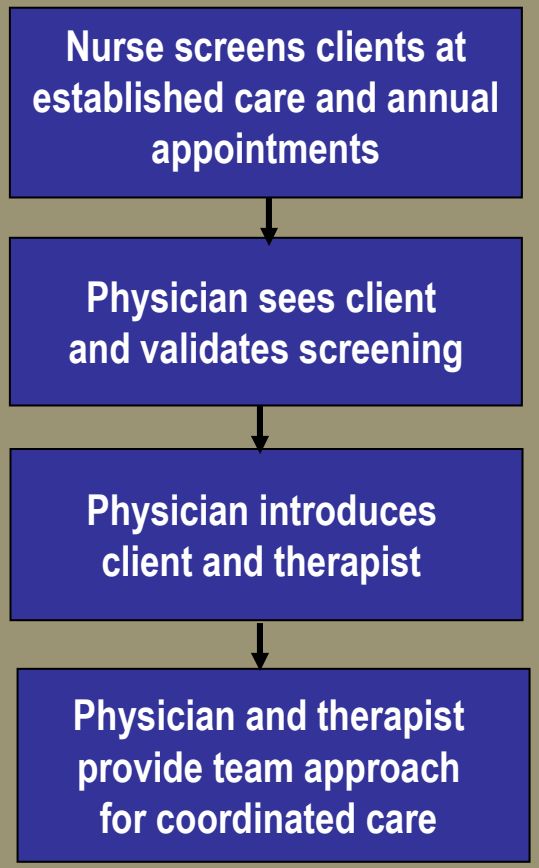
	Tx Guidelines	Case ID/ Screening	Patient Ed.	Physician Ed.	Tracking Systems	Tx Coord.	MH Spec.	Effective
Schulberg	+	+	+	+	+	+	++++	Yes
Mynors-Wallis	+	+	+	+	+	+	+++	Yes
Katon	+	+	+	+	+	+	++	Yes
Katzelnick	+	+	+	+	+	+	++	Yes
Rost	+	+	+	+	+	+	+/-	Yes
Hunkeler	+	+	+	+	+	+	+/-	Yes
Simon	+	+	+	+	+	+	-	Yes
Simon	+	+	+	+	+	-	-	No
Callahan	+	+	+	+	-	-	-	No
Goldberg	+	+	+	-	-	-	-	No
Dowrick	+	+	-	-	-	-	-	No

US Preventive Services Task Force:

Screening for Depression

- USPSTF found **good evidence** that screening improves the accurate identification of depressed patients in primary care settings and that treatment of depressed adults identified in primary care settings decreases clinical morbidity
- Small benefits observed in studies that simply feed back of screening results to clinicians
- Larger benefits observed in studies in which the communication of screening results is coordinated with effective follow-up and treatment

Integrated Care Model



Behavioral Health Services integrated with Primary Health Care:

- Screening
- Assessment
- Brief supportive counseling
- Therapy
- Case management
- Medication monitoring
- Coordinated team care

Evidenced Based Screenings

- Post Partum Depression
- Social Emotional (children)
- ADHD
- Depression
- Anxiety
- CAGE-AID alcohol and drug screen
- Bipolar
- Global rating of functional impairment

Behavioral Health Clinician Functions

Patient-focused support

- ✓ Address patient issues in their language
- ✓ Develop rapport
- ✓ Skill building, problem solving skills
- ✓ Self-management techniques

Behavioral Health Clinician Functions

Follow-up and communication

- ✓ Regular contact with patients to monitor progress
- ✓ Re-assess; follow-up on symptoms
- ✓ Remind patients of visits
- ✓ Frequent updates between providers
- ✓ Shared health records
- ✓ Coordinated follow-up care
- ✓ Track referrals

Behavioral Health Clinician Functions

- Patient Education
  - ✓ Disease specific
  - ✓ Lifestyle changes
- Therapy
  - ✓ Short-term psychosocial therapy
  - ✓ Intervene in crisis
- Medication management
  - ✓ Monitor medication adherence
  - ✓ Educate on side effects

Supervision/Education

- Clinical
  - ✓ Individual and group supervision
  - ✓ Present difficult patients
  - ✓ Educational updates
- Psychiatric back-up
  - ✓ Psychiatric evaluations/consultations
  - ✓ Medication issues
  - ✓ Review cases

Supervision/Education

- Education
  - ✓ Clinician PCP and BHP training with screening tools and clinical algorithms
  - ✓ PCP education on various mental health topics
  - ✓ BHP education on common medical and chronic conditions
  - ✓ BHP education on brief intervention and treatment
  - ✓ BHP language and operations of a primary care practice
  - ✓ PCP learning procedures and communication with BH providers
  - ✓ PCP and BHP need education on billing and coding
  - ✓ Mental Health Providers communication/HIPAA

Barriers to Integrated Care

- Organizational and professional culture differences between PC and BH providers
- Clinical and fiscal separation of physical and mental health care
- Legal barriers to open communication between providers
- Client cultural differences

ORHCC - Initial Request for proposals

The goal of co-location pilots in CCNC is to help improve mental health access in high Medicaid practices so that primary and behavioral health care can be better integrated.

The grant funds will be used as a development grant to build the co location infrastructure and provide a stipend to the practice until mental health provider billings can sustain the practitioner.

Grant funds would be primarily distributed through the CCNC Networks

12 of 14 CCNC Networks participating

- AccessCare
- Access II Care of Western NC
- Carolina Collaborative Community Care
- Carolina Community Health Partnership
- Community Health Partners
- Community Care of Eastern Carolina
- Community Care of Wake/Johnston
- Partnership for Health Management
- Northern Piedmont Community Care
- Northwest Community Care
- Sandhills Community Care
- Southern Piedmont Community Care

Demographic of the Primary Care Practices

- 44 PCP practices in 26 counties
- Include community health centers, rural health centers, health departments, family practice, internal medicine, adolescent medicine and pediatrics.
- 2 reverse co-location in 2 counties

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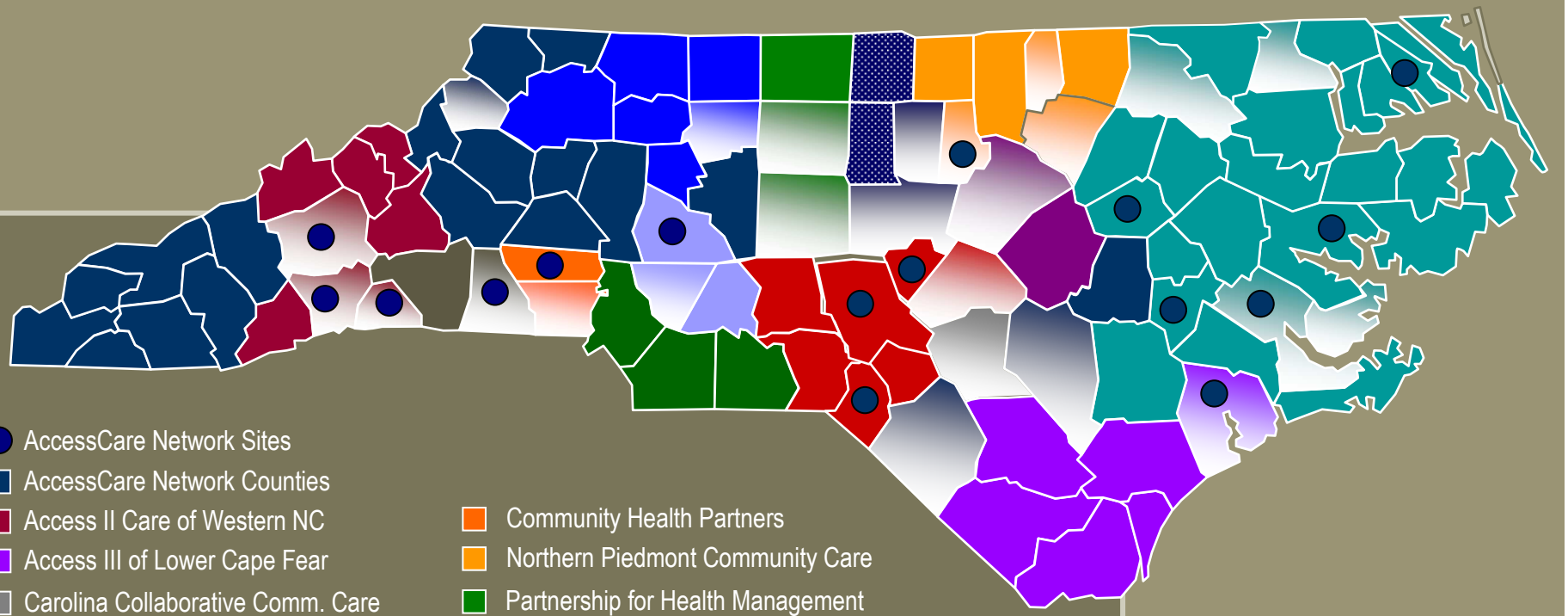
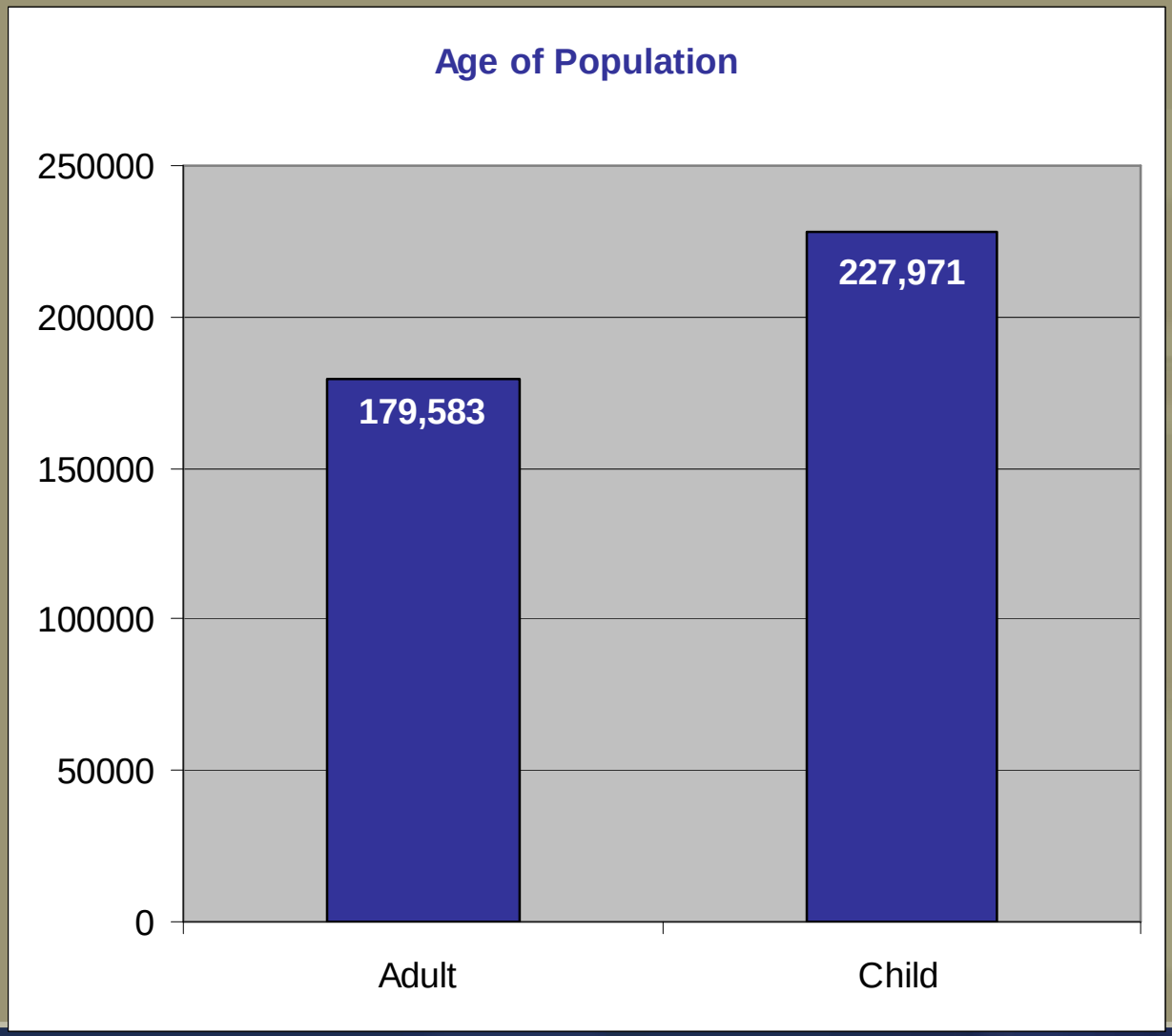
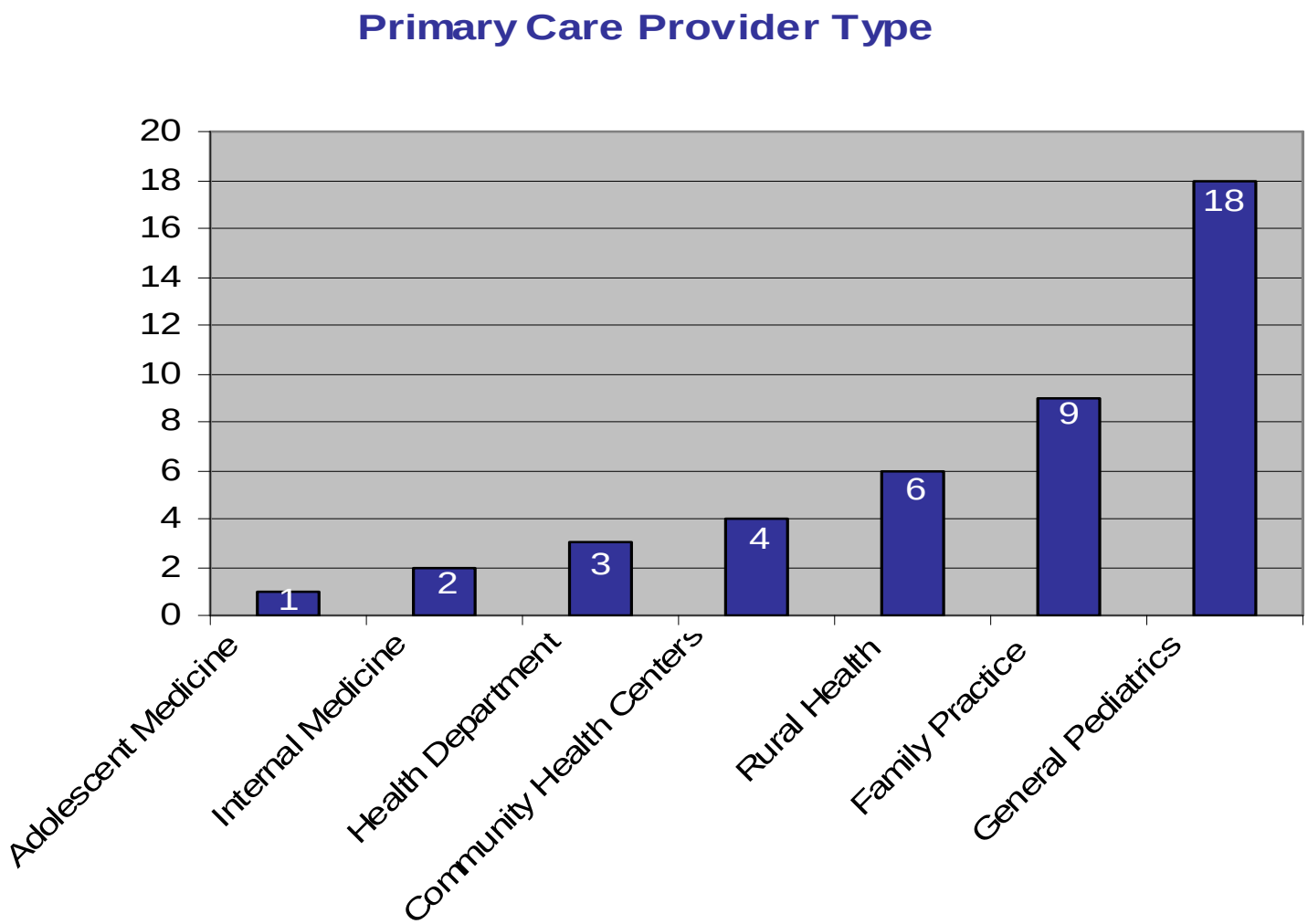
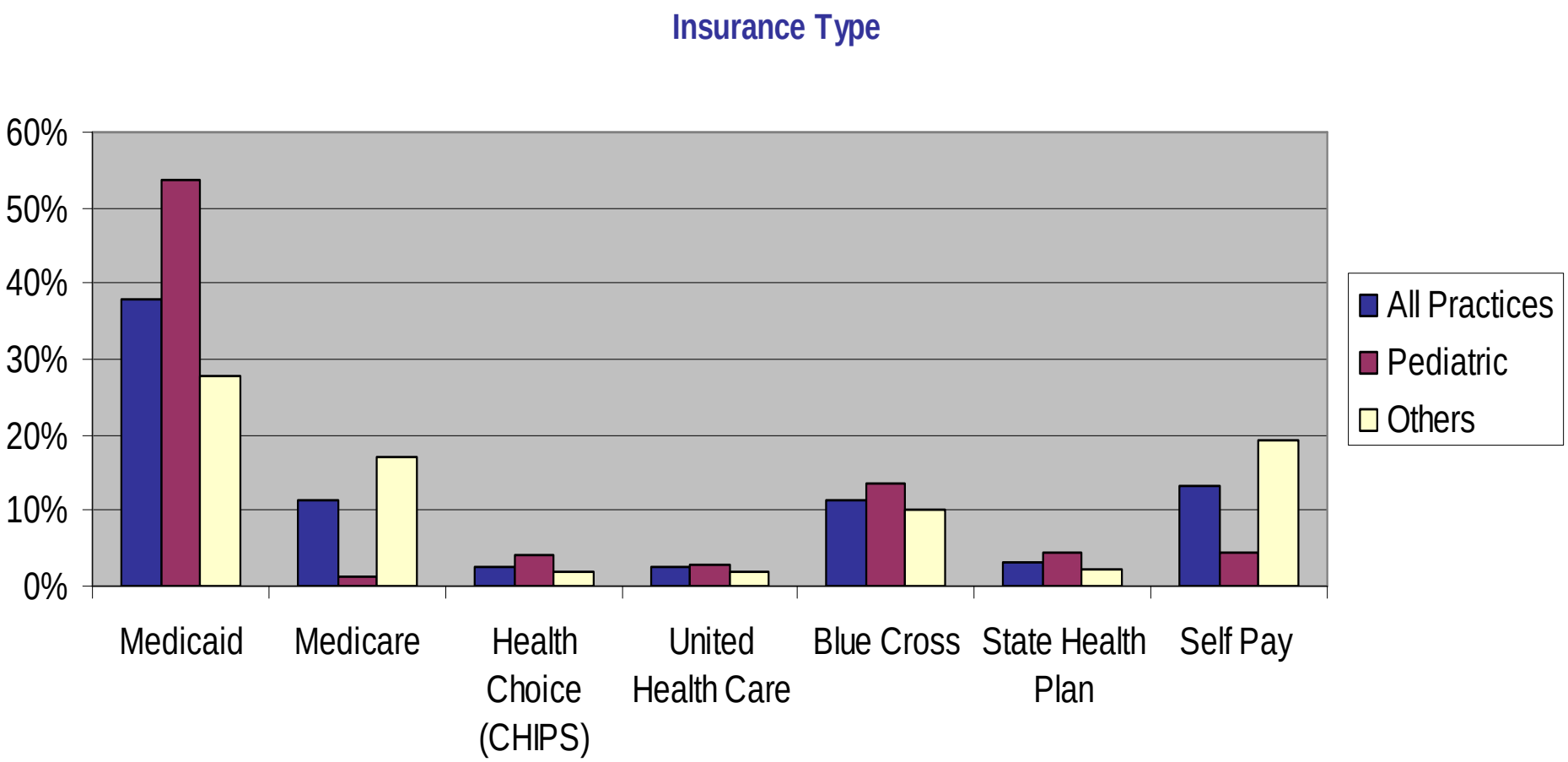
Participating CCNC Networks shaded in white



- AccessCare Network Sites
- AccessCare Network Counties
- Access II Care of Western NC
- Access III of Lower Cape Fear
- Carolina Collaborative Comm. Care
- Carolina Community Health Partnership
- Central Piedmont Access II
- Comm. Care Partners of Gtr. Mecklenburg
- Community Care Plan of Eastern NC
- Community Health Partners
- Northern Piedmont Community Care
- Partnership for Health Management
- Sandhills Community Care Network
- Southern Piedmont Community Care Plan
- Community Care of Wake and Johnston Counties
- Central Care Health Network


Age of Population
250000
200000
150000
100000
50000
0
179,583
227,971
Adult
Child


Primary Care Provider Type
20
18
16
14
12
10
8
6
4
2
0
1
2
3
4
6
9
18
Adolescent Medicine
Internal Medicine
Health Department
Community Health Centers
Rural Health
Family Practice
General Pediatrics


Insurance Type
60%
50%
40%
30%
20%
10%
0%
Medicaid
Medicare
Health Choice (CHIPS)
United Health Care
Blue Cross
State Health Plan
Self Pay
All Practices
Pediatric
Others

Key Components

- PCPs who use evidenced-based screening tools to identify patients
- PCPs who identify positive screenings to refer to the therapist
- Therapists who function in a brief model refer more traditional/complex to specialty mental health
- Practices and therapist to provide evidenced-based care
- Patients to show improvement
- Providers find value in the model
- Practice to be able to sustain the position
- Model is cost effective for payer

Key Components Reverse Co-location

- Increase the number of patients that have access to primary care services.
- Increase the number of patients that receive an annual exam.
- Demonstrate that patients receive the preventative care services in accordance with the US prevention Services Task force.
- Monitoring guidelines are adhered to for patient with Antipsychotic prescriptions.
- Mental Health Providers find value in the model.
- Model is cost effective for payer as evidenced by reduced cost and/or utilization.

Resources Provided

- .25 FTE Program Consultant
- CCNC Network liaison to the PCP
  - ✓ 44 PCP on average funded $25,000 (1 Million)
- DMA engaged in resolving billing/coding issues
- Supportive Division of MH/SA/DD

Partnership

- ICARE (www.icarenc.org)
  - Funding and posting of coding resources
  - Advisory board for reviewing, posting and training on evidenced-based tools
  - Training for PCP
  - Training for the BHP
  - Developing links to community resources
  - Job site to link practices with behavioral health providers

Considerations

- Internal Infrastructure
  - CCNC, DMA, Division MH/DD/SA, CCNC Networks
- Sustainability
  - Medicaid
    - Receiving payment (integrating billing systems)
  - Private Providers
  - Uninsured
- Model
  - Fiscal analysis of new codes that supports and incentives the model (Primary Care and Specialty Mental Health)

- Recruitment
  - At the practice level
- Education
  - At all levels (PCP, BHP, CCNC, MHP)
- Integration w/Specialty Mental Health
  - Consultations
  - Communication / HIPPA
  - Shared plans of care

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Thank You

HOME