BIDIRECTIONAL INTEGRATED CARE

THE WALL STREET JOURNAL.

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U.S. NEWS

Mental-Health Care at the Doctor's Office

Providers Take Integrated Approach, With Patient Numbers Set to Jump Under New Law and Psychiatrists in Short Supply

By Melinda Beck

Seattle psychiatrist Anna Ratzliff oversees mental-health care for nearly 500 patients—most of whom she will never meet.

As the consulting psychiatrist for four primary-care practices, Dr. Ratzliff confers weekly with 10 care managers who follow the patients closely, provide counseling and chart their progress in electronic registries. She helps devise treatment plans and suggests changes for those who aren't improving.

"I get to touch so many more lives than I would if I were seeing these patients in person," she said.

Dr. Ratzliff's practice is part of a burgeoning effort to integrate psychiatric care into pri-

The New State Of Health Care

Body and Mind

Who needs, gets, gives care

25% of U.S. adults experience a mental-health issue in a given year

60% of them receive no treatment

68% of adults with a mental-health disorder have at least one medical condition

29% of those with a medical condition have a mental-health issue

50% of care for mental-health disorders is delivered by primary-care providers

66% of visits to family physicians involve stress-related symptoms

Sources: National Alliance on Mental Illness; National Comorbidity Survey

Dr. Thomas Goforth with patient Magali King, who

WSJ Sept 25, 2013

JOHN S. KERN MD
REGIONAL MENTAL HEALTH CENTER
MERRILLVILLE, IN

GREETINGS FROM BEAUTIFUL NW INDIANA

WHY THIS WILL BE THE MENTAL HEALTH SERVICE OF FUTURE AND YOU WANT TO GET GOOD AT IT…

- **Dwindling of dedicated MH funding.**
- **Expansion of primary care funding**
- **Potential to impact the cost curve for primary care opens funding opportunities: ACO's…**
- **Scarcity of psychiatrists.**
- **Fun [!]**

"Of course you feel great. These things are loaded with antidepressants."

• •

EVOLVING A MORE USEFUL PARTNERSHIP:

1. **CONSULTATIVE MODEL – Psychiatrist sees patients one by one, in separate location.**
2. **CO-LOCATED MODEL – Psychiatrist sees patients one by one, on-site in primary care, but in traditional model.**
3. **COLLABORATIVE MODEL - Psychiatrist takes responsibility for a caseload of primary care patients and works closely with PCPs and other primary care-based behavioral health providers.**

CORE PRINCIPLES OF EFFECTIVE INTEGRATED CARE

Patient Centered Care

- Team-based care: effective collaboration between PCPs and Behavioral Health Providers.

Population-Based Care

- Behavioral health patients tracked in a registry: no one ‘falls through the cracks’.

Measurement-Based Treatment to Target

- Measurable treatment goals and outcomes defined and tracked for each patient.
- Treatments are actively changed until the clinical goals are achieved.

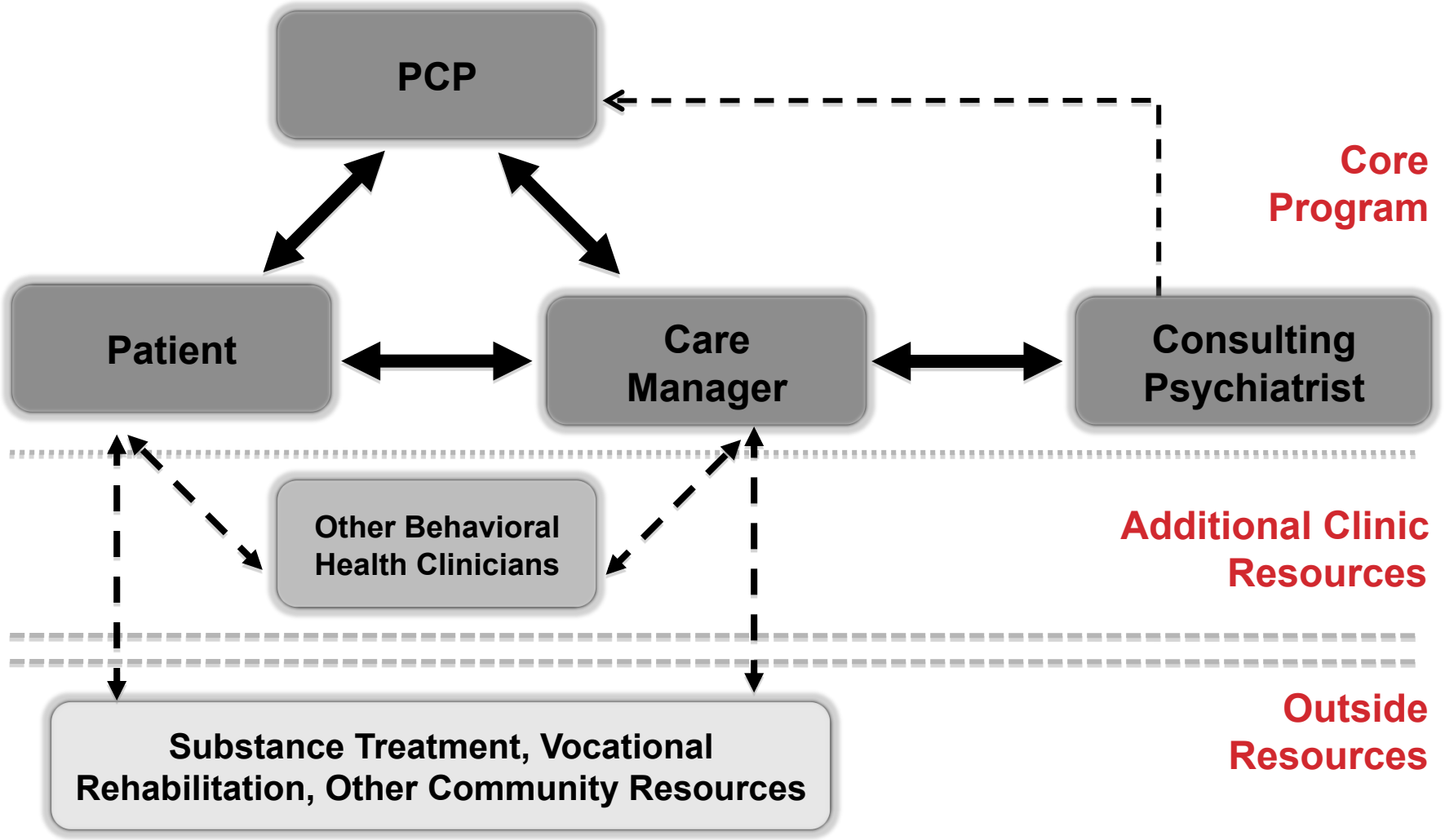
Evidence-Based Care

- Treatments used are ‘evidence-based’.

Accountable Care

- Providers are accountable and reimbursed for quality of care, clinical outcomes, and patient satisfaction, not just the volume of care provided.

COLLABORATIVE TEAM APPROACH – HOW DOES IT LOOK?



How does it look from 5 feet?
Collaborative Care: The Graphic Novel


Enter care in any part of clinic – no wrong door
NorthShore Health Centers
Family Practice & Urgent Care
NorthShore Health Centers
Pediatrics & Obstetrics New Entrance

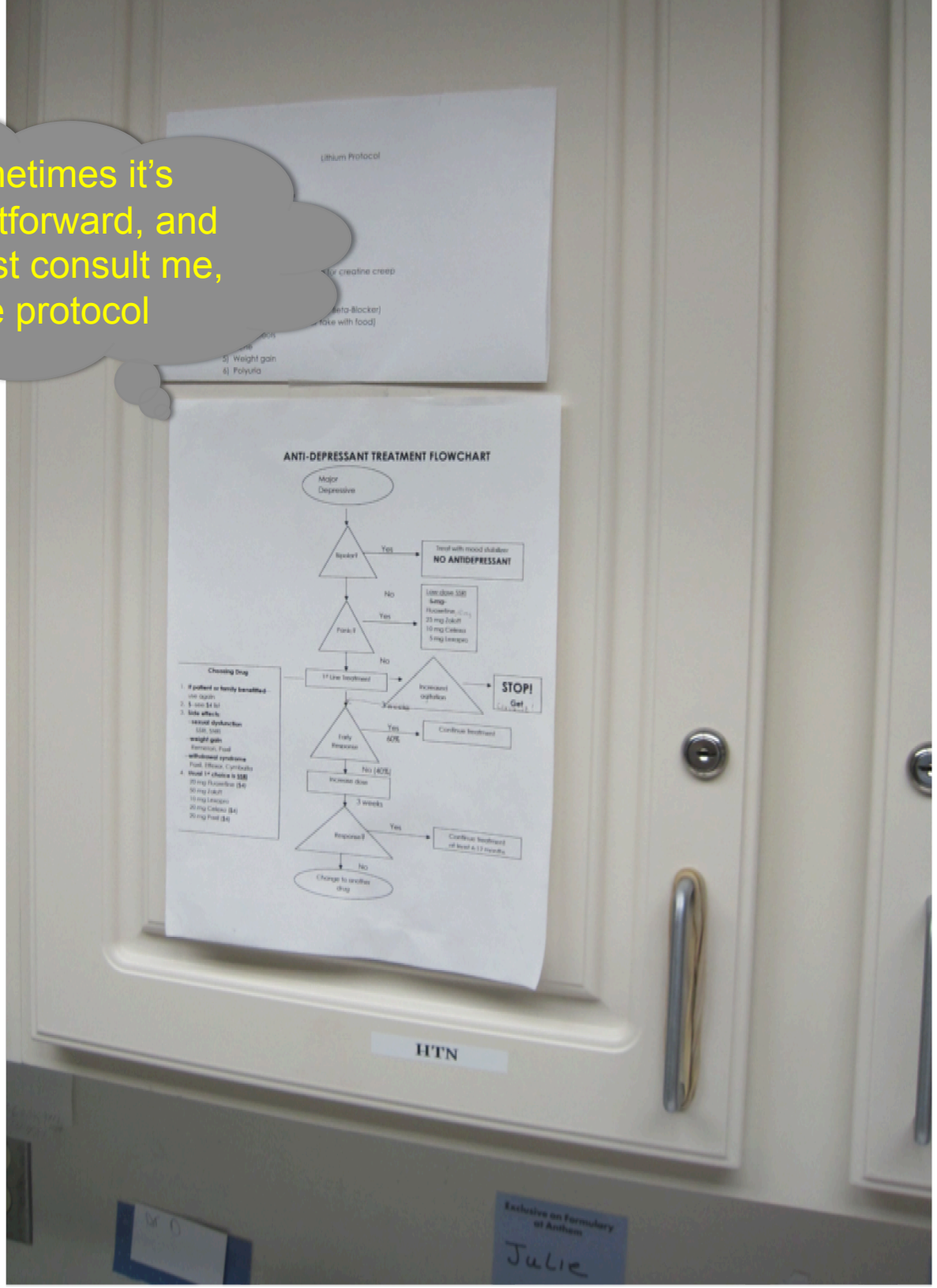

Welcome to NorthShore – a few screening documents…
Breast and Cervical Cancer Program
Are you eligible? ☑ into it and give us a call:
Age


Latex Exam Gloves
Select
Small
STRONG BODIES.
STRONG MINDS.
Sometimes the primary care doc identifies the need for care.

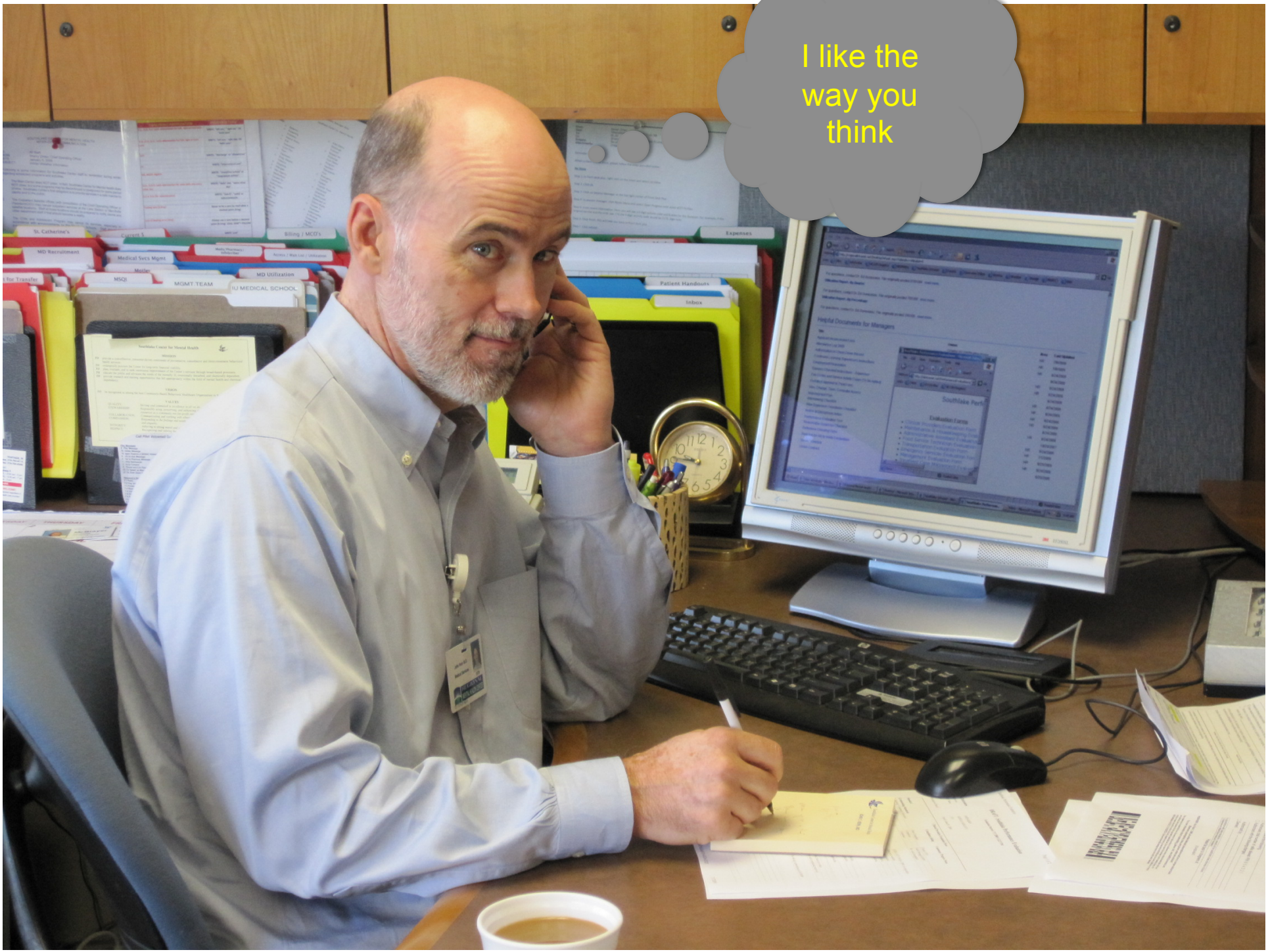

Warm handoff to Behavioral Health Consultant for immediate consultation.

Lots of resources in the toolkit: screenings, educational info, brief behavioral interventions…

Sometimes it's straightforward, and they just consult me, the protocol



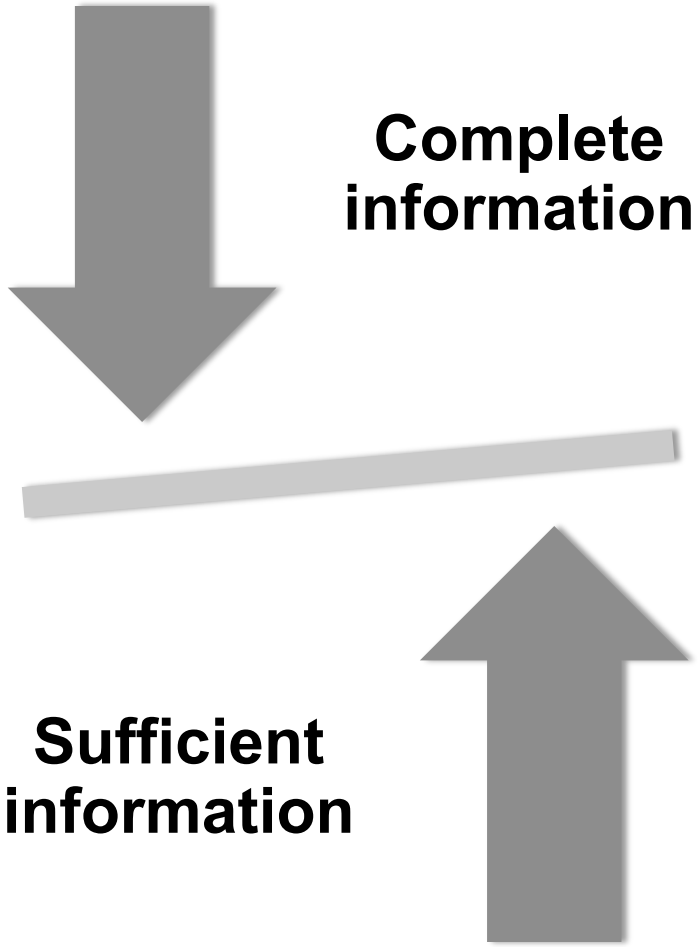

Hmm,, this one bipolar? – let's call for consult.


I like the way you think


Brief, focused consult to doc, with treatment recommendations.


Why didn't we think of this sooner?
Diagnosis and Treatment of Streptococcal Pharyngitis

UNCERTAINTY: REQUESTS FOR MORE INFORMATION

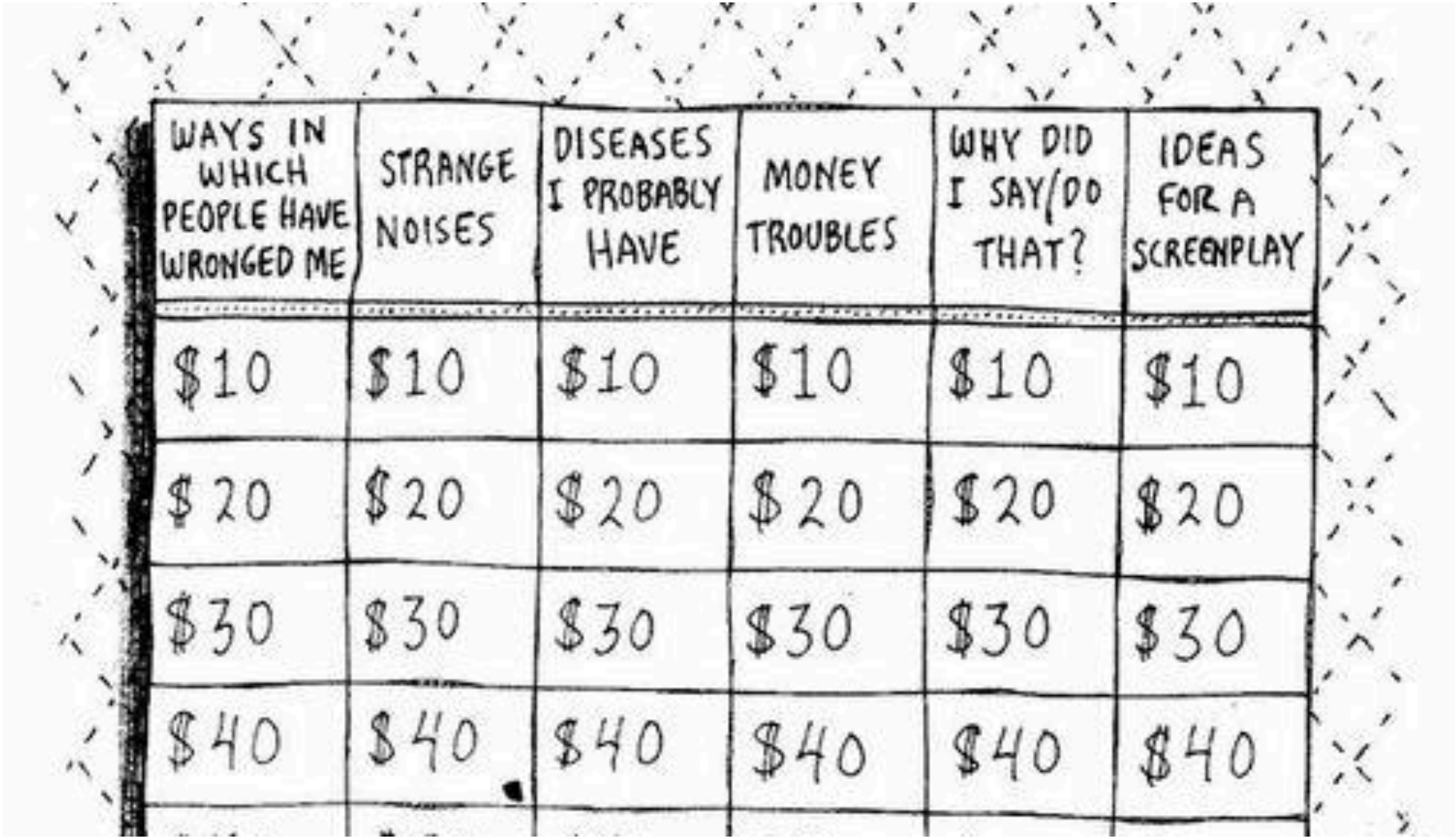


- Tension between complete and sufficient information to make a recommendation
- Often use risk benefit analysis of the intervention you are proposing

TOP 10 CONSULTATION QUESTIONS

10. Everyone else has Vicodin…
9. How can I be better by tomorrow?
8. If I tell you the truth, will you lock me up?
7. Am I going crazy?
6. My girlfriend says I am SO bipolar.
5. I need MORE antidepressant.
4. What does “trauma” have to do with anything?
3. Why do you need to know about the weed?
2. What are you going to give me for this?

NOBODY SLEEPS, REALLY



WAYS IN WHICH PEOPLE HAVE WRONGED ME	STRANGE NOISES	DISEASES I PROBABLY HAVE	MONEY TROUBLES	WHY DID I SAY/DO THAT?	IDEAS FOR A SCREENPLAY
$10	$10	$10	$10	$10	$10
$20	$20	$20	$20	$20	$20
$30	$30	$30	$30	$30	$30
$40	$40	$40	$40	$40	$40

TOP CONSULTATION QUESTION:

Where's my Xanax?

BENZO GUIDELINES FOR CLINIC

Use of benzodiazepines

Basic principles:

- Benzodiazepines have limited role in mgmt of anxiety disorders.
  - SSRI's & behavioral measures first line.
  - Often anxiety is presenting symptom of other mental health condition.
- Risk of substance abuse significant in our population.
  - The angrier the patient, the more likely the substance abuse problem.
- Increased risk of fall and of dementia.
- We have obligation to change culture in our organization re addressing psych issues:
  - Risk of controlled substances
  - Role of non-medication treatment.
  - Identifying substance abuse in our patients
  - Limiting waste of provider time - as our organization is believed in community to be easy source of controlled substances, we will see more patients with this in mind.

Recommendations:

- Avoid use of benzos as first line treatment of anxiety, agitation, insomnia.
- Become familiar with and encourage use of sleep hygiene education and techniques. A good sleep history can be done in a few minutes.
- Consider tapering clients who present with benzo use - even if they have been on for many years, this does not necessarily make it a good idea.
  - If tapering, set a schedule and do not permit "early fills" of meds. Some patients will attempt to manipulate by taking more meds than prescribed and daring you to let them withdraw.
- Use INSPECT to limit clinic-shopping.
- Use BHC as resource if needed.
- Use treatment contract for everyone, not just when problems arise.

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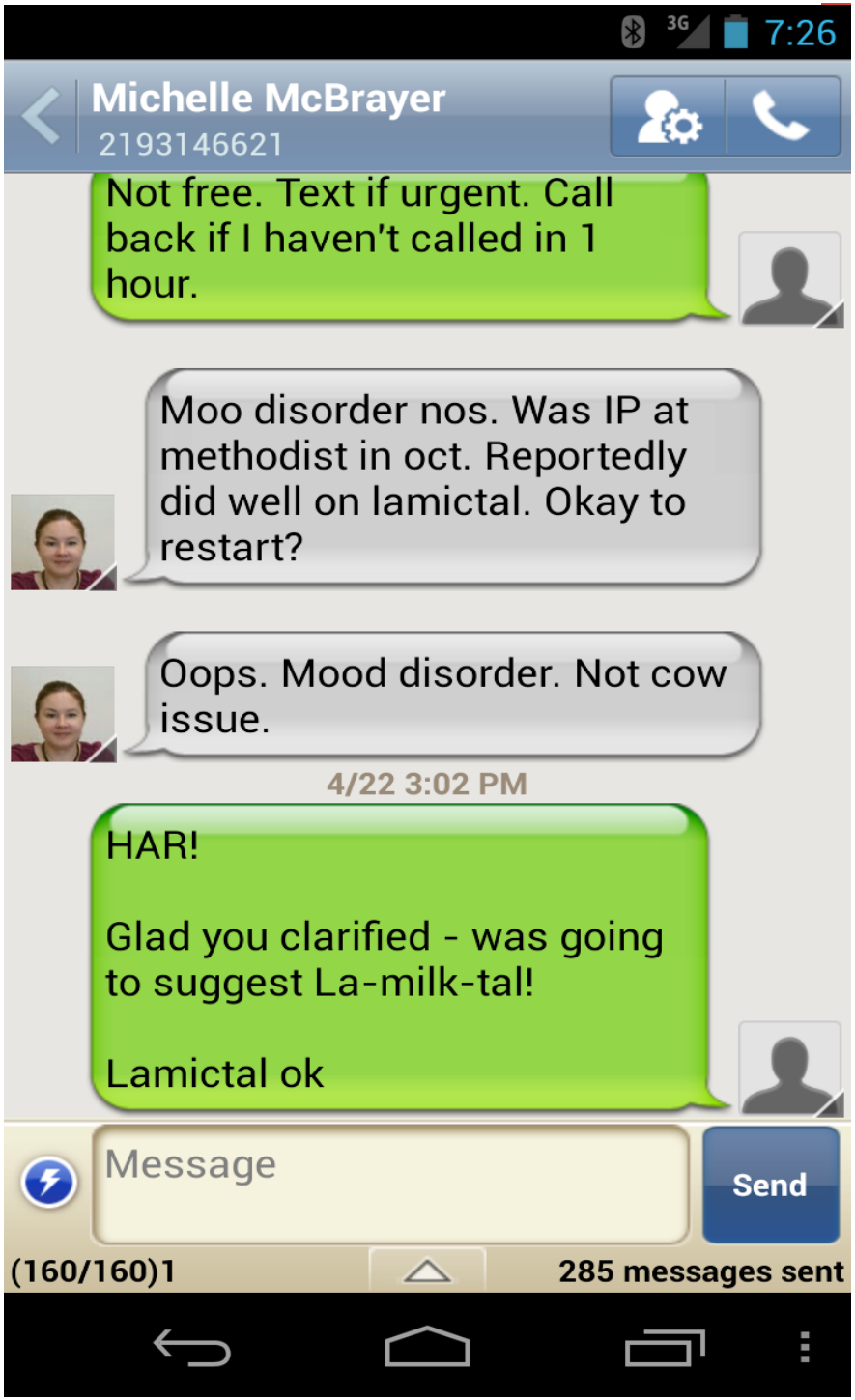
THE BEHAVIORAL HEALTH CONSULTANT

Priorities:

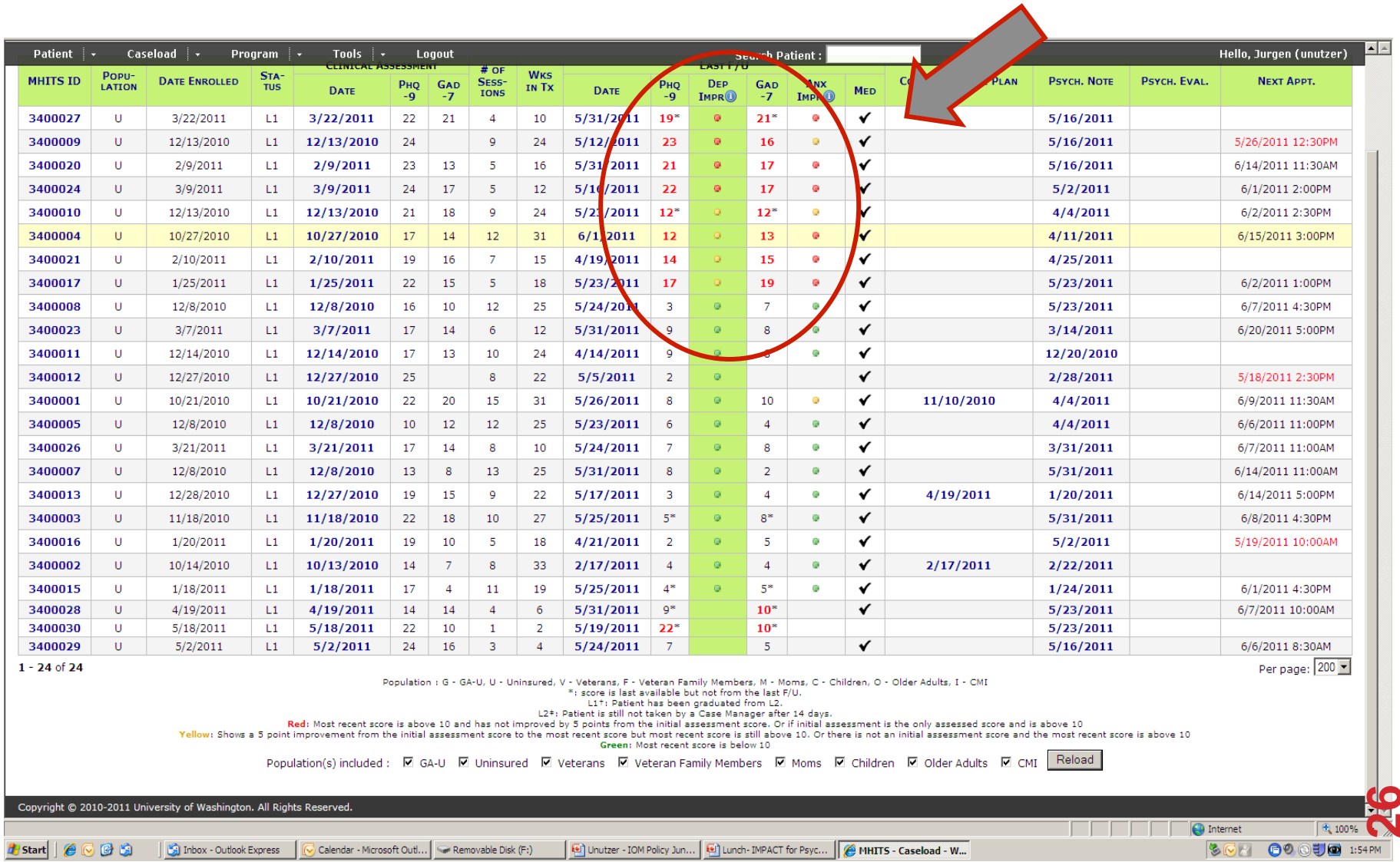
Availability for immediate consult

Population Management

TEXTING CAN WORK



PRIORITIZING CASES IN THE REGISTRY TO REVIEW



Patient | Caseload | Program | Tools | Logout — Search Patient : — Hello, Jurgen (unutzer)

MHITS ID	Popu-lation	Date Enrolled	Sta-tus	Clinical Assessment Date	PHQ -9	GAD -7	# of Sess-ions	Wks in Tx	Last F/U Date	PHQ -9	Dep Impr	GAD -7	Anx Impr	Med	Co	Plan	Psych. Note	Psych. Eval.	Next Appt.
3400027	U	3/22/2011	L1	3/22/2011	22	21	4	10	5/31/2011	19*		21*		✓			5/16/2011		
3400009	U	12/13/2010	L1	12/13/2010	24		9	24	5/12/2011	23		16		✓			5/16/2011		5/26/2011 12:30PM
3400020	U	2/9/2011	L1	2/9/2011	23	13	5	16	5/31/2011	21		17		✓			5/16/2011		6/14/2011 11:30AM
3400024	U	3/9/2011	L1	3/9/2011	24	17	5	12	5/10/2011	22		17		✓			5/2/2011		6/1/2011 2:00PM
3400010	U	12/13/2010	L1	12/13/2010	21	18	9	24	5/23/2011	12*		12*		✓			4/4/2011		6/2/2011 2:30PM
3400004	U	10/27/2010	L1	10/27/2010	17	14	12	31	6/1/2011	12		13		✓			4/11/2011		6/15/2011 3:00PM
3400021	U	2/10/2011	L1	2/10/2011	19	16	7	15	4/19/2011	14		15		✓			4/25/2011		
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3400008	U	12/8/2010	L1	12/8/2010	16	10	12	25	5/24/2011	3		7		✓			5/23/2011		6/7/2011 4:30PM
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3400011	U	12/14/2010	L1	12/14/2010	17	13	10	24	4/14/2011	9		8		✓			12/20/2010		
3400012	U	12/27/2010	L1	12/27/2010	25		8	22	5/5/2011	2				✓			2/28/2011		5/18/2011 2:30PM
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3400007	U	12/8/2010	L1	12/8/2010	13	8	13	25	5/31/2011	8		2		✓			5/31/2011		6/14/2011 11:00AM
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3400029	U	5/2/2011	L1	5/2/2011	24	16	3	4	5/24/2011	7		5		✓			5/16/2011		6/6/2011 8:30AM

1 - 24 of 24 — Per page: 200

Population : G - GA-U, U - Uninsured, V - Veterans, F - Veteran Family Members, M - Moms, C - Children, O - Older Adults, I - CMI
*: score is last available but not from the last F/U.
L1†: Patient has been graduated from L2.
L2‡: Patient is still not taken by a Case Manager after 14 days.
Red: Most recent score is above 10 and has not improved by 5 points from the initial assessment score. Or if initial assessment is the only assessed score and is above 10
Yellow: Shows a 5 point improvement from the initial assessment score to the most recent score but most recent score is still above 10. Or there is not an initial assessment score and the most recent score is above 10
Green: Most recent score is below 10

Population(s) included : ☑ GA-U ☑ Uninsured ☑ Veterans ☑ Veteran Family Members ☑ Moms ☑ Children ☑ Older Adults ☑ CMI Reload

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Start | Inbox - Outlook Express | Calendar - Microsoft Outl... | Removable Disk (F:) | Unutzer - IOM Policy Jun... | Lunch- IMPACT for Psyc... | MHITS - Caseload - W... | Internet | 100% | 1:54 PM

SELLING BHC MODEL TO BURNED-OUT PCP'S:

"Today is interpret-your-own-test-results day"

WHO'S ON THE TEAM?: WHAT PCP'S ARE LIKE

Primary Care is stressful for providers

- Pace
- Responsibility
- Up against the edge of their knowledge

SELLING THE BHC MODEL TO PROVIDERS

Mental health and addiction issues are already presenting.

INSPECT reports

Creating structure for patients with drug-seeking behavior

BHC's have time to allow the patient to "tell their story" – PCP can move on.

Make yourself invaluable– what do providers need?


Hell

WHO'S ON THE TEAM?

THE CONSULTANT PSYCHIATRIST

- Immediate phone consult
- Population review
- Teaching
- Contact with PCP's
- Protocol development
- Policy-setting

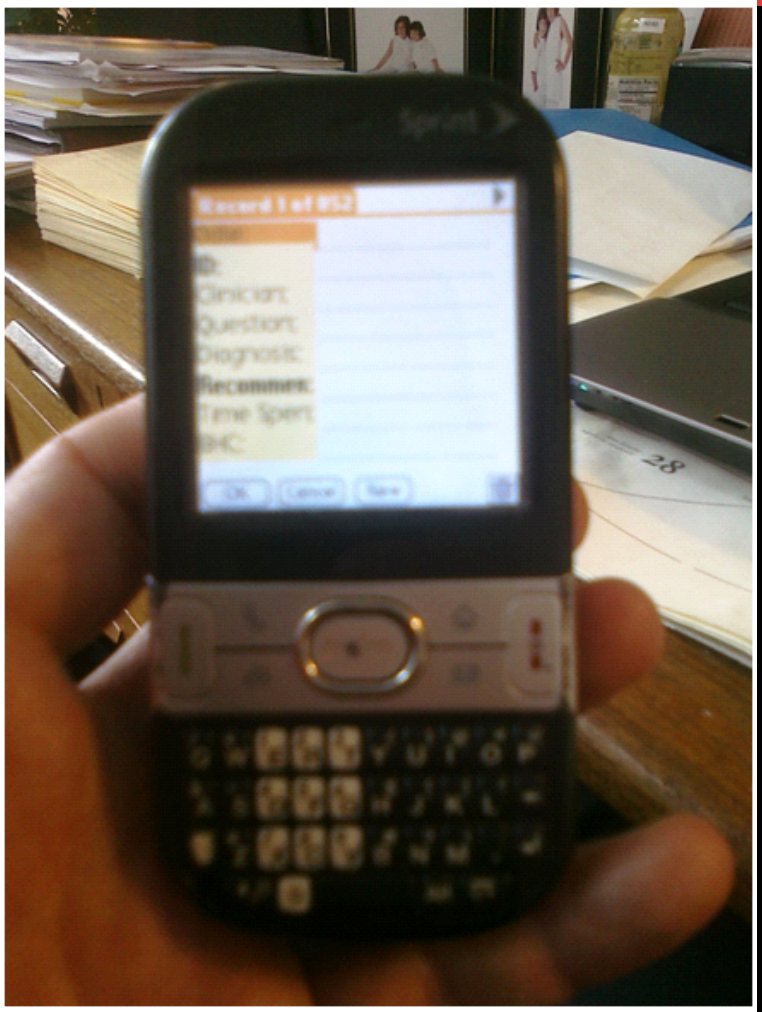
"CURBSIDE" BY PHONE

70 per month or about 3.5 per day

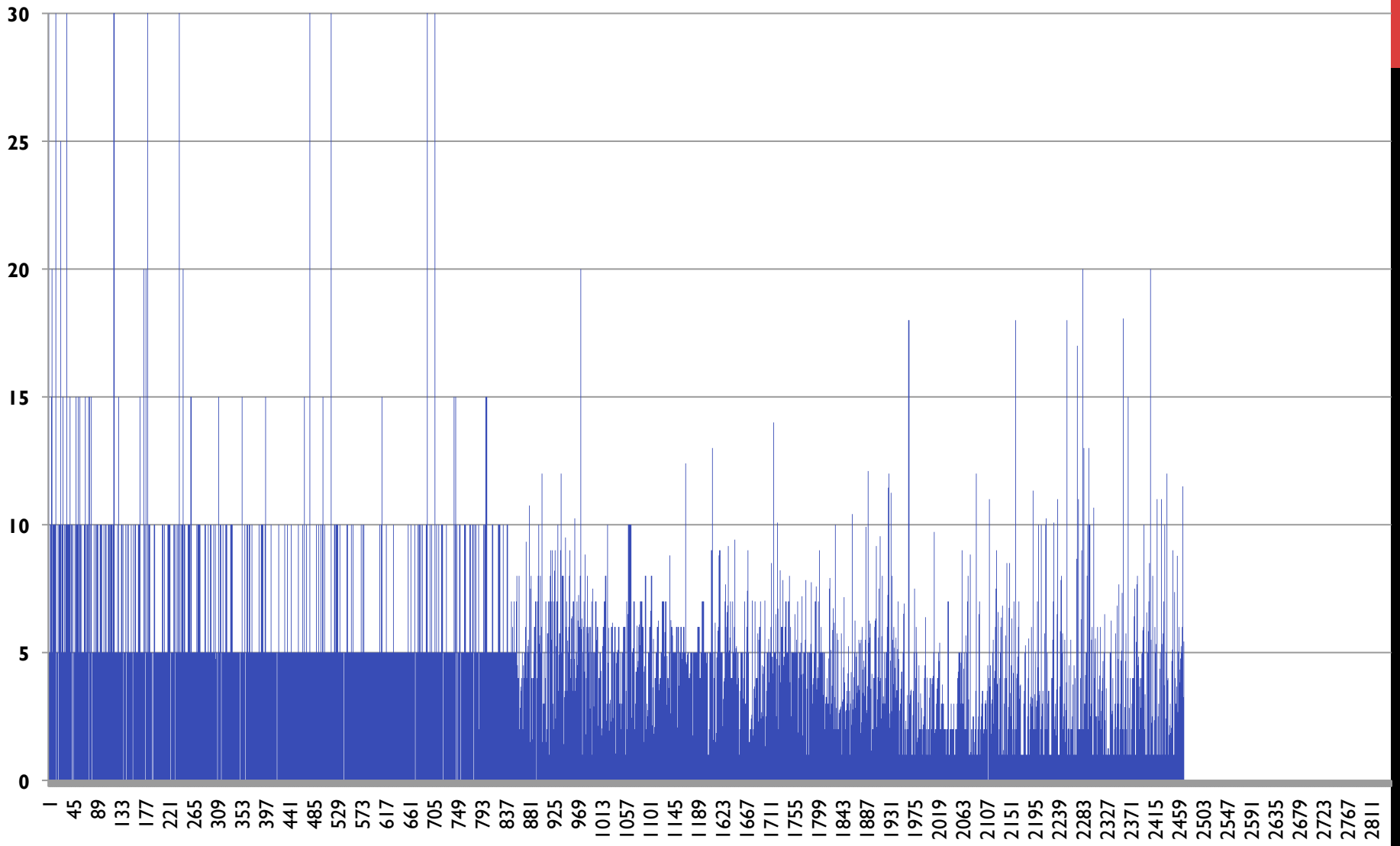
- **5.1 minutes per consult: about 15 mins per day.**

Subject – almost all diagnosis, disposition or psychopharm.

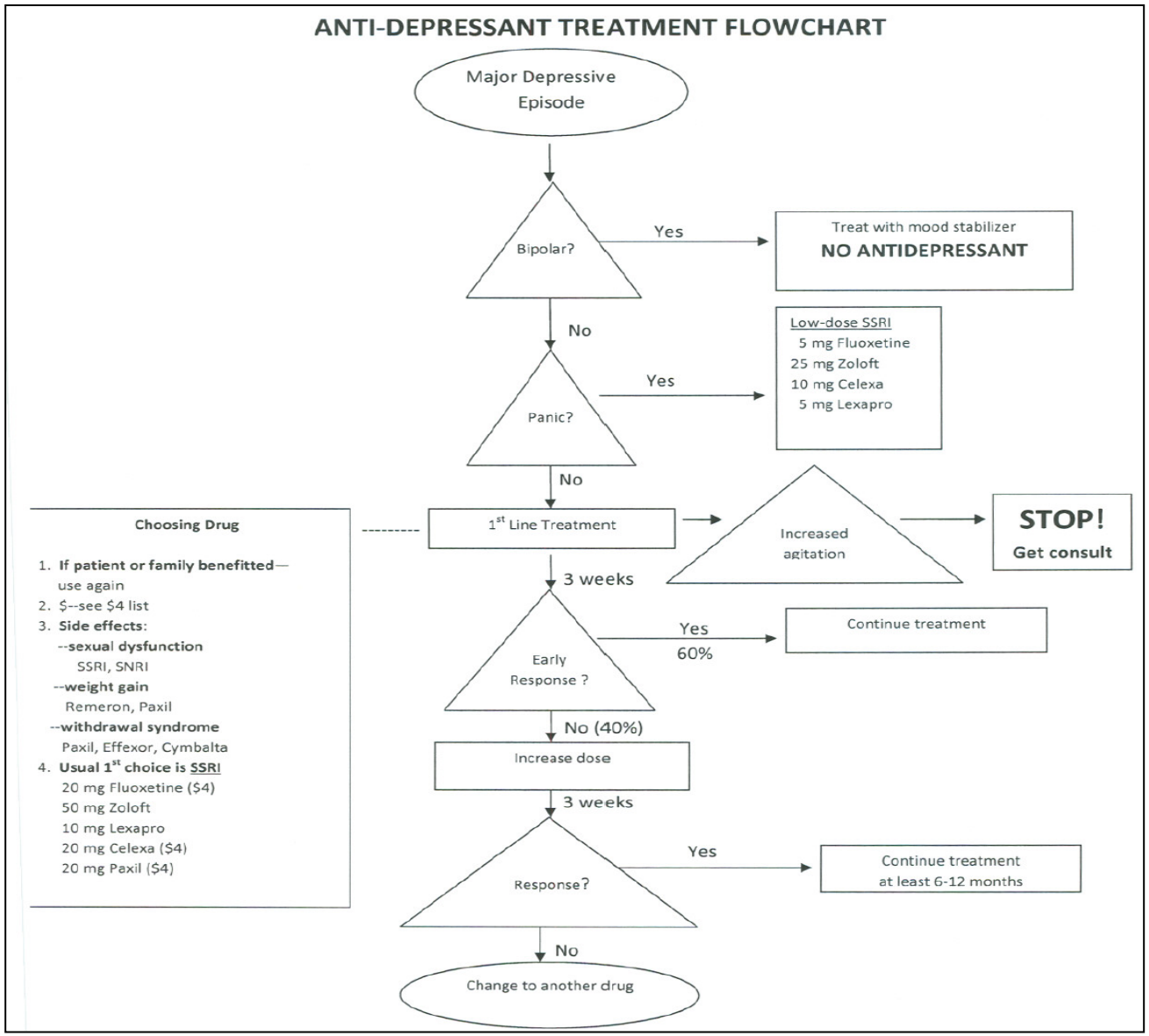
About 20% of cases lead to phone consult.



Minutes per psychiatric phone consult 2008-2012: mean 5.6 mins



Provide PCPs with Algorithms



ADHD PROTOCOL

ADHD Protocol

Diagnosis

Inattentive sx: often fails to give close attention to details or makes careless mistakes in schoolwork,work, or other activities; · often has difficulty sustaining attention in tasks or play activities; · often does not seem to listen when spoken to directly; · often does not follow through on instructions and fails to finish school work, chores, or duties in the work place (this failure is not due deliberately refusing to do it or not understanding instructions); · often has difficulty organizing tasks or activities; · often avoids or is reluctant to engage in tasks that require sustained mental effort; · often loses things necessary for tasks or activities; · is often easily distracted by extraneous stimuli; · often forgetful in daily activities	Hyperactive sx: · often fidgets with hands or squirms in seat; · often leaves seat in classroom or in other situations in which remaining seated is expected; · often runs about or climbs excessively in which it is inappropriate (in adolescents and adults, may be limited to subjective feelings of restlessness; · often has difficulty playing or engaging in leisure activities quietly; · is often "on the go" or often acts as if "driven by a motor" · often talks excessively; · often blurts out answers before questions have been completed; · often has difficulty awaiting turn; · often interrupts or intrudes on others (e.g. butts into conversations or games)

Use rating scales: adult [adult ADHD screen] / child [Vanderbilt]

- 6/9 inattentive and/or hyperactive symptoms
- Onset before age 7
- Impairment in at least two settings [like home and school]
- Chronic course [not intermittent - at least 6 months]

Treatment

Long-acting stimulants the first line of treatment for ADHD, particularly when no comorbidity is present. 1) Stimulant effects nearly immediate. 2) Try all types of med if not responding 3) PM dose of short-acting may help with homework, evening. 4) Risks of **diversion**: less with long-acting, don't give stimulant in pt with substance abuse, **don't refill "lost" scripts or if missing appointments.**

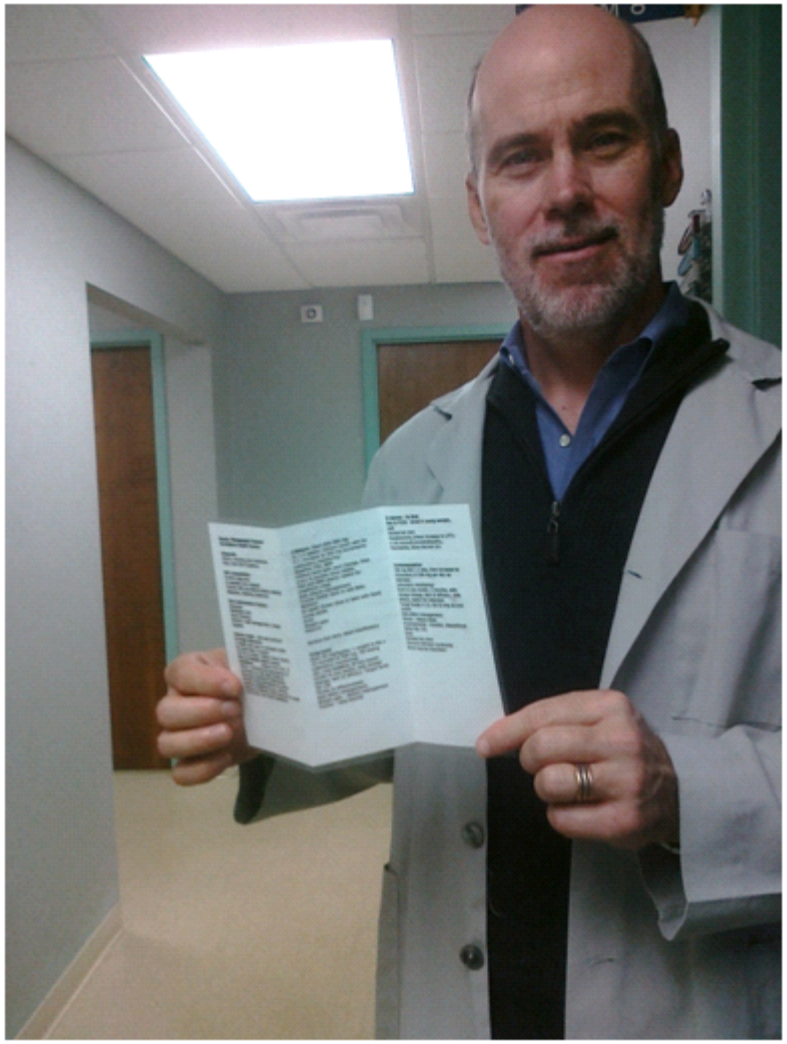
Followup: Titrate upward every 1-3 wks until: Max dose for stimulant reached, Symptoms of ADHD remit or Side effects prevent further titration Obtain teacher & parent rating scales after 1 wk. Office visit in at most 1 month, then at least several x/ yr. Review the child's behavioral & academic functioning; periodically assess height, weight,BP{blood pressure, and pulse; and assess for the emergence of comorbid disorders and medical conditions.

Non-stimulant meds: Strattera [atomoxetine] with active substance abuse problem, comorbid anxiety, tics or mood lability **Antidepressants** [Wellbutrin] especially useful if comorbid depression. **Alpha-2 meds** good for end-of-day agitation, not so much for attention

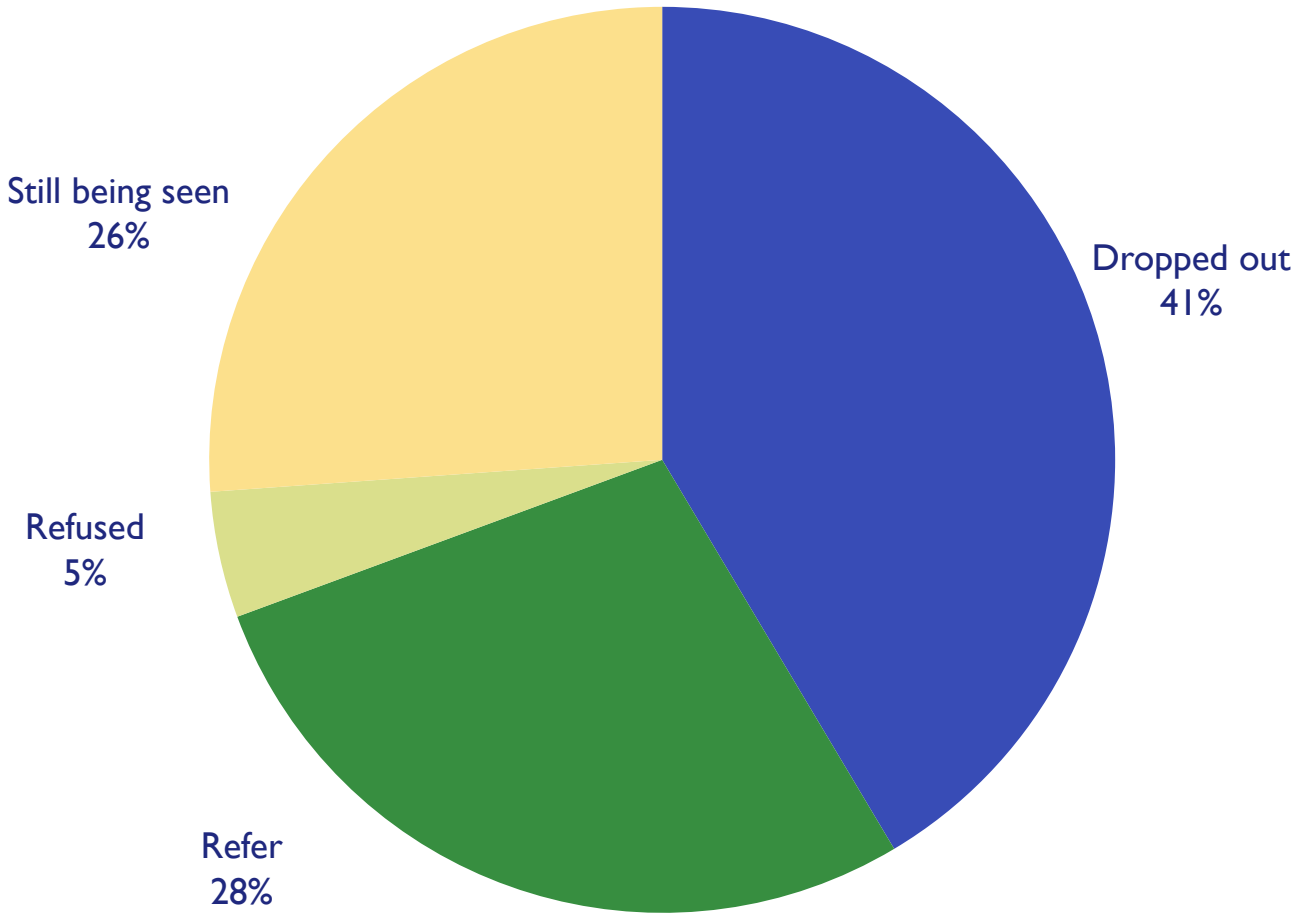
When to use non-medication treatment: 1)Family wishes 2) Symptoms mild 3) Diagnosis uncertain 4) Partial response to meds.

Behavior therapy principles: !) Identify specific target behaviors [e.g., compliance with adult directives, completion of classwork and homework, on-task behavior, etc.] 2) Develop menu of specific rewards & punishments 3) "Currency system" [e.g., points, tokens, stickers] to track degree of success in meeting target behaviors and signaling the dispensing of rewards & punishments. 4) Treat parents with ADHD and address family dysfunction.

BIPOLAR PROTOCOL – BITE-SIZE!

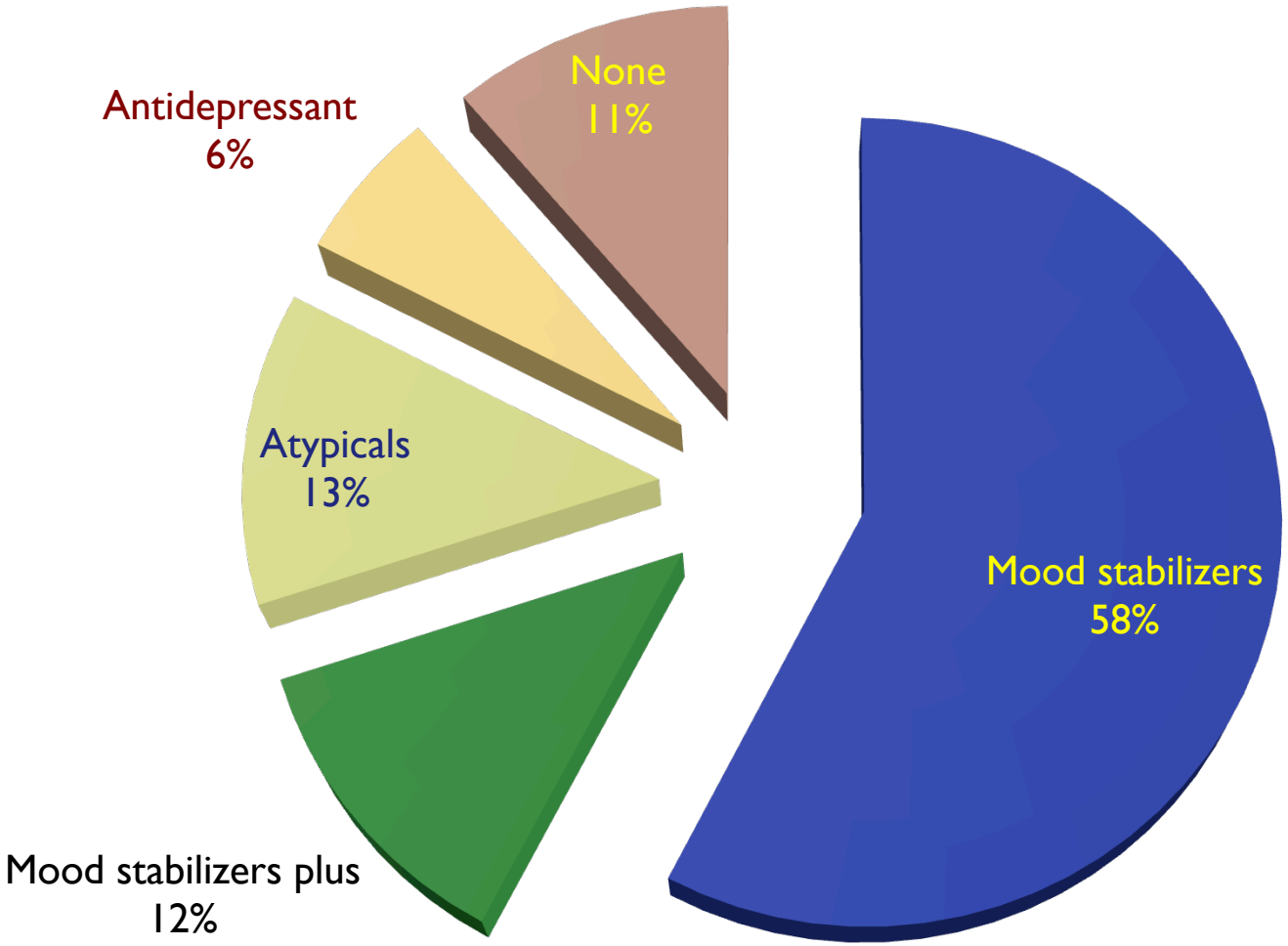


NorthShore Bipolar outcome 2008-2011

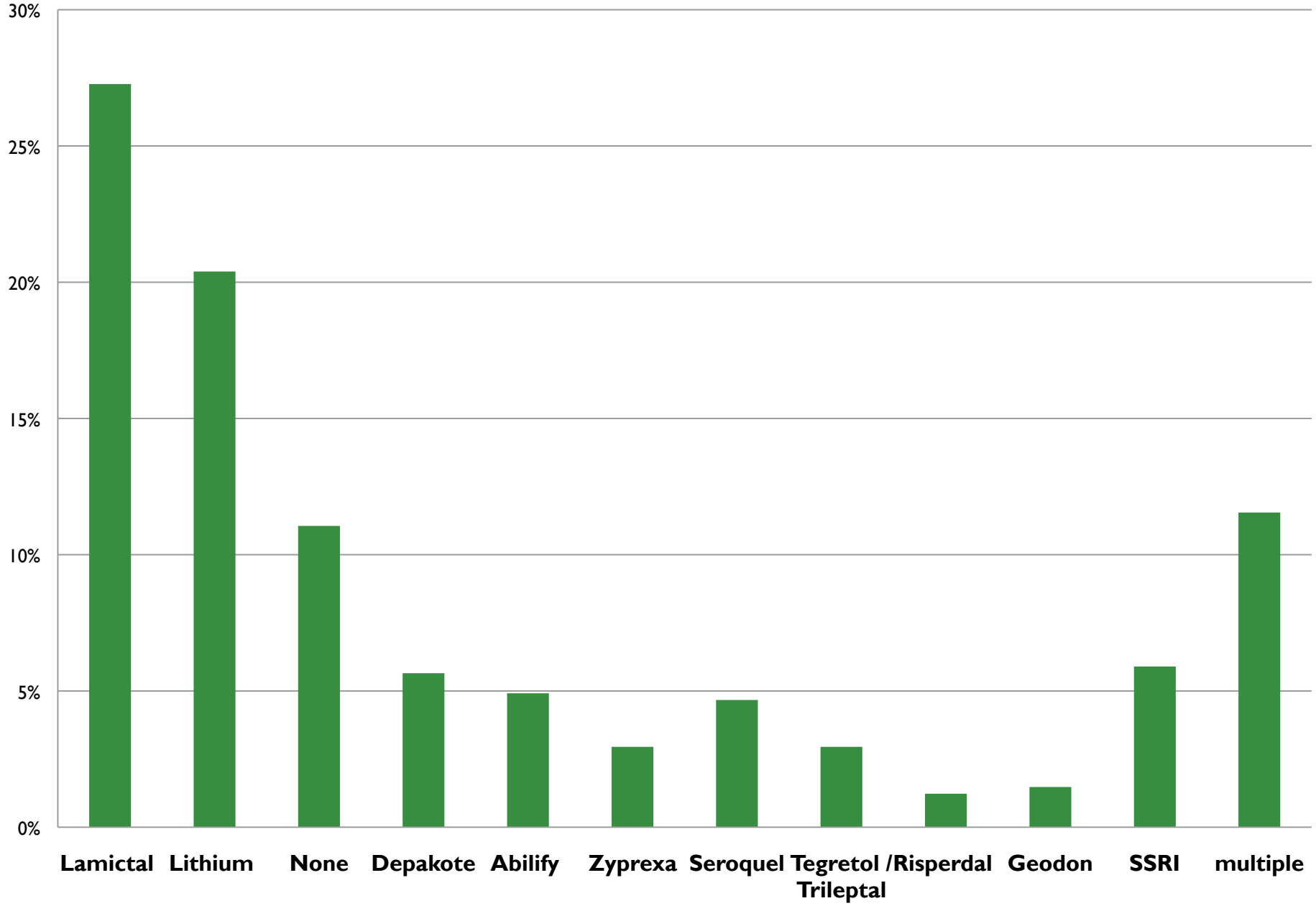


700 BIPOLAR PTS SEEN AS OF 2014

NorthShore Bipolar Meds by type QTR 2 2011



NorthShore Meds for Bipolar QTR 2 2011



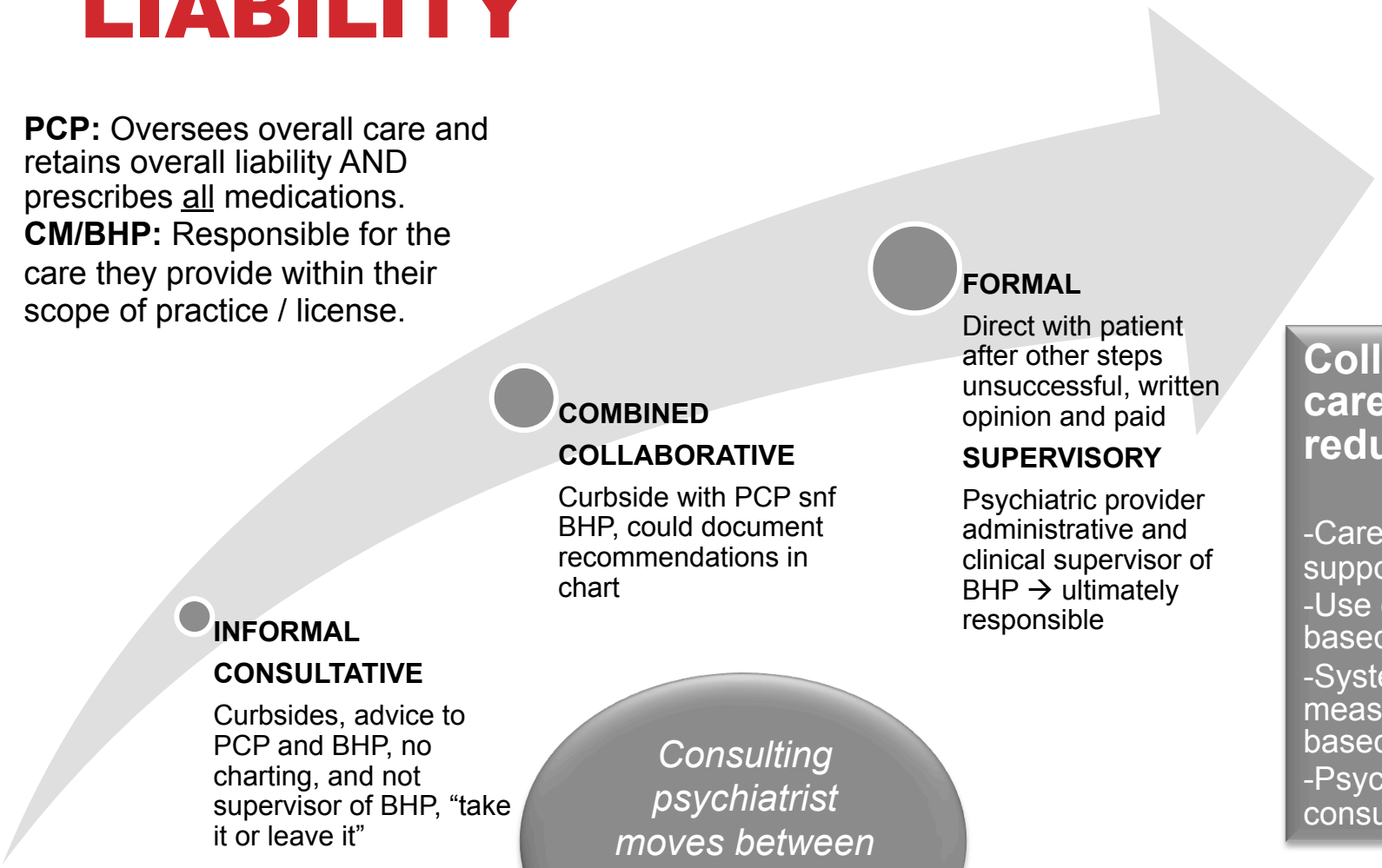
BIPOLAR AFTERTHOUGHTS

- PCP's haven't decided to do it alone.
- Diagnosis – the "mucky mood disorder."
- Can adequate bipolar mgmt be done - info, monitoring, psychosocial support, lifestyle change?
- Institute for Psychiatric Services 2014: "Bipolar Disorder Treated in Primary Care – Steps Toward a Standard of Care."
- Bipolar in Primary Care Affinity Group.

"They have no military, sire—no one's ever made it past their receptionist."

LIABILITY

PCP: Oversees overall care and retains overall liability AND prescribes all medications.
CM/BHP: Responsible for the care they provide within their scope of practice / license.



Collaborative care should reduce risk:

-Care manager supports the PCP
-Use of evidence-based tools
-Systematic, measurement-based follow-up
-Psychiatric consultant

•Olick et al, Fam Med 2003
•Sederer, et al, 1998
•Sterling v Johns Hopkins Hospital., 145 Md. App. 161, 169 (Md Ct. Spec. App. 2002

THE 'BUSINESS CASE' FOR INTEGRATED BEHAVIORAL HEALTH CARE OUTCOMES

- **Savings in total health care costs**
  - Demonstrated in research (IMPACT, Pathways)
  - Demonstrated in real world evaluations (Kaiser Permanente, Intermountain)
- **Improved patient and provider satisfaction**
- **Improved provider productivity**
  - PCPs have shorter, more productive primary care visits = more visits
  - Mental health consultants in primary care have lower no-show rates
- **Improved productivity**
  - Reduced absenteeism and presenteeism
  - Higher incomes / net worth
- **In safety net populations**
  - Reduced homelessness and arrest rates

BILLING BEHAVIORAL HEALTH SERVICES IN PRIMARY CARE SETTING.

Psychiatric codes can be billed in primary care site.

LCSW cannot bill 90791 [Psychiatric diagnostic] in primary care, CAN bill psychotherapy codes or H&B [or telemedicine! >20 miles apart]

PhD or PsyD can bill 90791 in Primary Care

MD can bill any psych codes in Primary Care. E/M only MD, NP, PA.

Raises all the requirements for MH documentation, pre-cert, etc.

Health and Behavior codes: 96150 family:

Underlying physical illness or injury, and

For whom the purpose of the assessment is not for the diagnosis or treatment of mental illness, and

For whom there is reason to believe that a biopsychosocial factor may be significantly affecting the treatment, or medical management of an illness or an injury,

HOW MANY PROVIDERS CAN BE SUPPORTED BY 4-HR PSYCHIATRIC CONSULTANT?

- **NorthShore Health Centers: 4 primary care sites**

- **In last 12 months:**
- **32,449 patients**
- **100,893 overall visits**
- **24 medical providers**

SCALABILITY!

PROGRAM STAFFING IN DIVERSE SETTINGS

Clinic Population (mental health needs)	% of clinic population with need for care management	Typical caseload size for 1 FTE Care Manager	# of unique primary care clinic patients to justify 1 FTE CM	Typical personnel requirement for 1,000 unique primary care patients	
				FTE Care Manager	FTE Psychiatrist**
Low need (e.g., insured, employed)	2%	100	5000	0.2	0.05 (2 hrs / week)
Medium need (e.g., comorbid medical needs / chronic pain / substance abuse)	5%	75	1500	0.7	0.07 (3 hrs / week)
High need (e.g, safety-net population)*	15%	50	333	3	0.3 (12 hrs / week)

PRIMARY CARE IN BEHAVIORAL HEALTH SETTINGS

WHY PROVIDE PRIMARY CARE TO MENTAL HEALTH POPULATIONS?

- High rates of physical illness in severely mentally ill
- Premature mortality
- Low quality of medical care to patients with mental illness
- High expense of physically ill with mental illness
- Access problems

CHRONIC CARE MODEL (CCM) CORE ELEMENTS

Patient Self-Management

- Coaching, Problem solving skills and psychoeducation to support self-management.

Clinical information systems use

- Facilitation of information flow from clinical sources such as a registry.

Delivery system redesign

- Redefining provider roles for more proactive care.

Community resource linkage

- Support for needs from resources outside the health care organization.

Health care organization support

- Organizational leadership and resources to support these goals and practices.

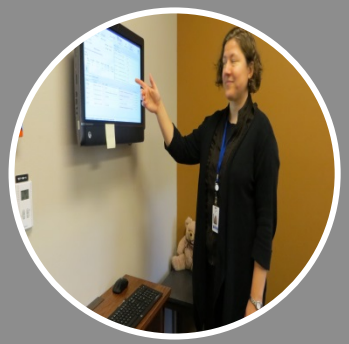
EXPERIMENTING: SOME DEVELOPING MODELS

- PCARE study (Druss et al, 2010)
- PBHCI Grantees
- Missouri Medicaid Health Homes – Primary Care and Community Mental Health Centers

PROGRAMS GENERALLY CONTAIN THREE MAJOR COMPONENTS:

Primary Care Service

Care Management and Tracking



Health Behavior Change

PCARE
PRIMARY CARE ACCESS, REFERRAL AND EVALUATION

- **PCARE study: Nurse care managers provided communication and advocacy to overcome barriers to primary medical care. (Druss, 2010)**
  - Intervention group received more
    - recommended preventive services,
    - higher proportion of evidence-based services for cardiometabolic conditions,
    - more likely to have a primary care provider (71.2% versus 51.9%).
- *Reduction in Framingham Cardiovascular Risk Index score in intervention group:*
- *6.9% compared to usual care 9.8%*

PRIMARY BEHAVIORAL HEALTH CARE INITIATIVE (PBHCI)

- **Primary Behavioral Health Care Initiative (PBHCI)**
  - SAMHSA grant – demonstration projects to improve physical health status in SMI
  - 100 grantees, beginning 2009
  - Target audience: high physical and high mental health risk.
- **Better coordinate and integrate primary and behavioral health care resulting in:**
  - Improved access to primary care services
  - Improved prevention, early identification and
- **Intervention to reduce the incidence of serious physical illnesses, including chronic disease**
  - Increased availability of integrated, holistic care for physical and behavioral disorders
  - Better overall health status of clients

HEALTH BEHAVIOR CHANGE: WHAT WORKS BARTELS ET AL. REVIEW

5% weight loss is worthwhile: cardiorespiratory fitness has substantial health benefits independent of weight loss

3 months or longer

Measurement and monitoring

Nutritional component with active weight management (i.e., participant and program monitoring of weight and food diaries), as opposed to nutrition education alone.

Physical fitness: intensive exercise and measurement

Bartels S, Desilets R. Health Promotion Programs for People with Serious Mental Illness (Prepared by the Dartmouth Health Promotion Research Team). Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions. January 2012.

BENEFICIAL EFFECTS OF INTERVENTIONS TO REDUCE RISKS OF CVD – "SMALL STEPS, BIG REWARDS"

Blood cholesterol

- 10% ↓ = 30% ↓ in CHD (200-180)

High blood pressure (> 140 SBP or 90 DBP)

- ~ 6 mm Hg ↓ = 16% ↓ in CHD; 42% ↓ in stroke

Diabetes (HbA1c > 7)

- 1% point ↓ HbA1c = 21% dec in DM related deaths, 14% decrease in MI, 37% dec in microvascular complications

Cigarette smoking cessation

- ~ 50% ↓ in CHD

Maintenance of ideal body weight (BMI = 18.5-25)

- 5-10 % loss is clinically significant,
- 35%-55% ↓ in CHD

Maintenance of active lifestyle (~30-min walk daily)

- 35%-55% ↓ in CHD

Stratton, et al, BMJ 2000

Hennekens CH. *Circulation* 1998;97:1095-1102.

Rich-Edwards JW, et al. *N Engl J Med* 1995;332:1758-1766.

Bassuk SS, Manson JE. *J Appl Physiol* 2005;99:1193-1204

RAND EVALUATION – DECEMBER 2013

Integrated systems of various kinds created.

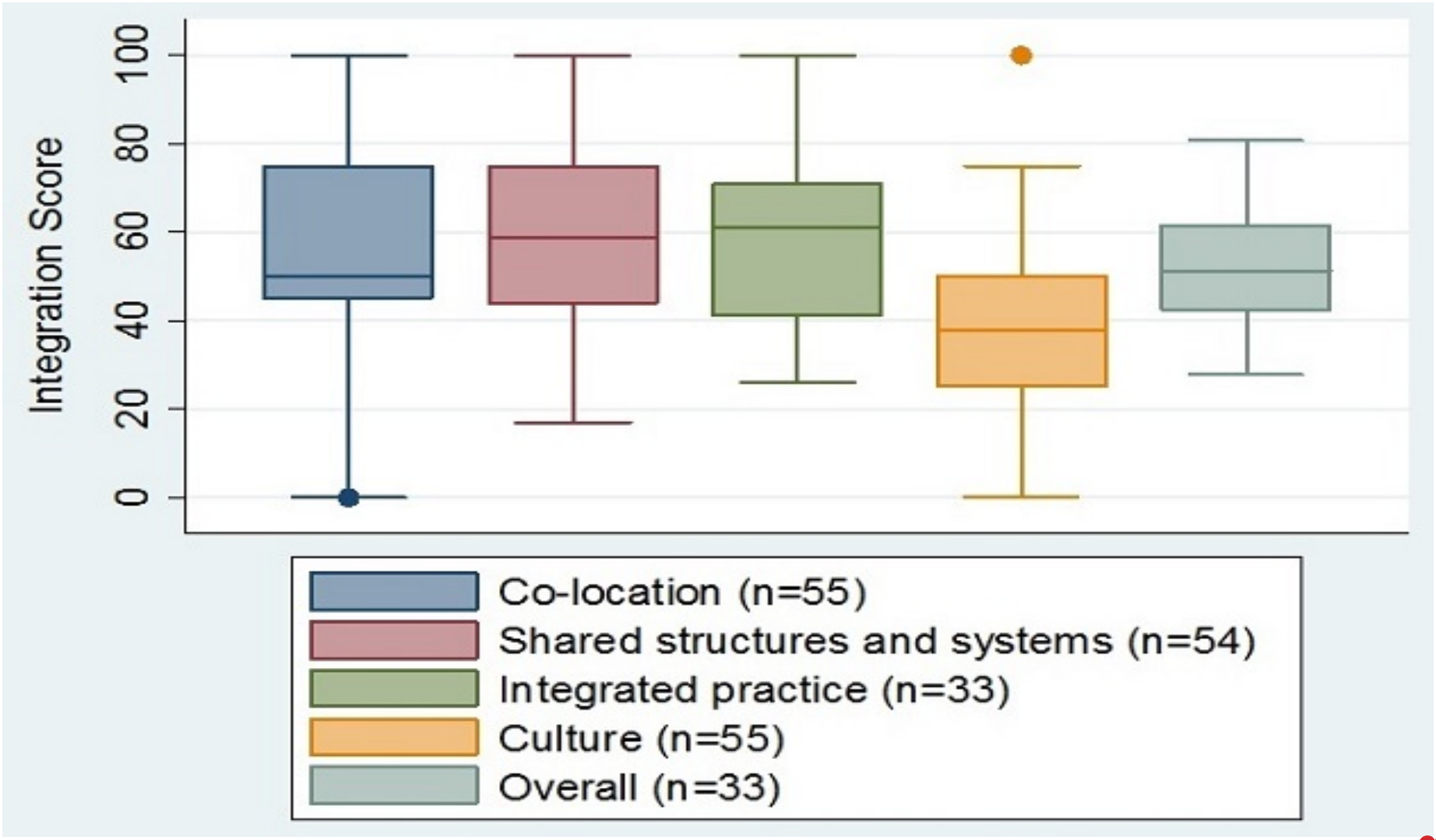
Limited use of EBP's for smoking, obesity.

Not able to identify centers which functioned best.

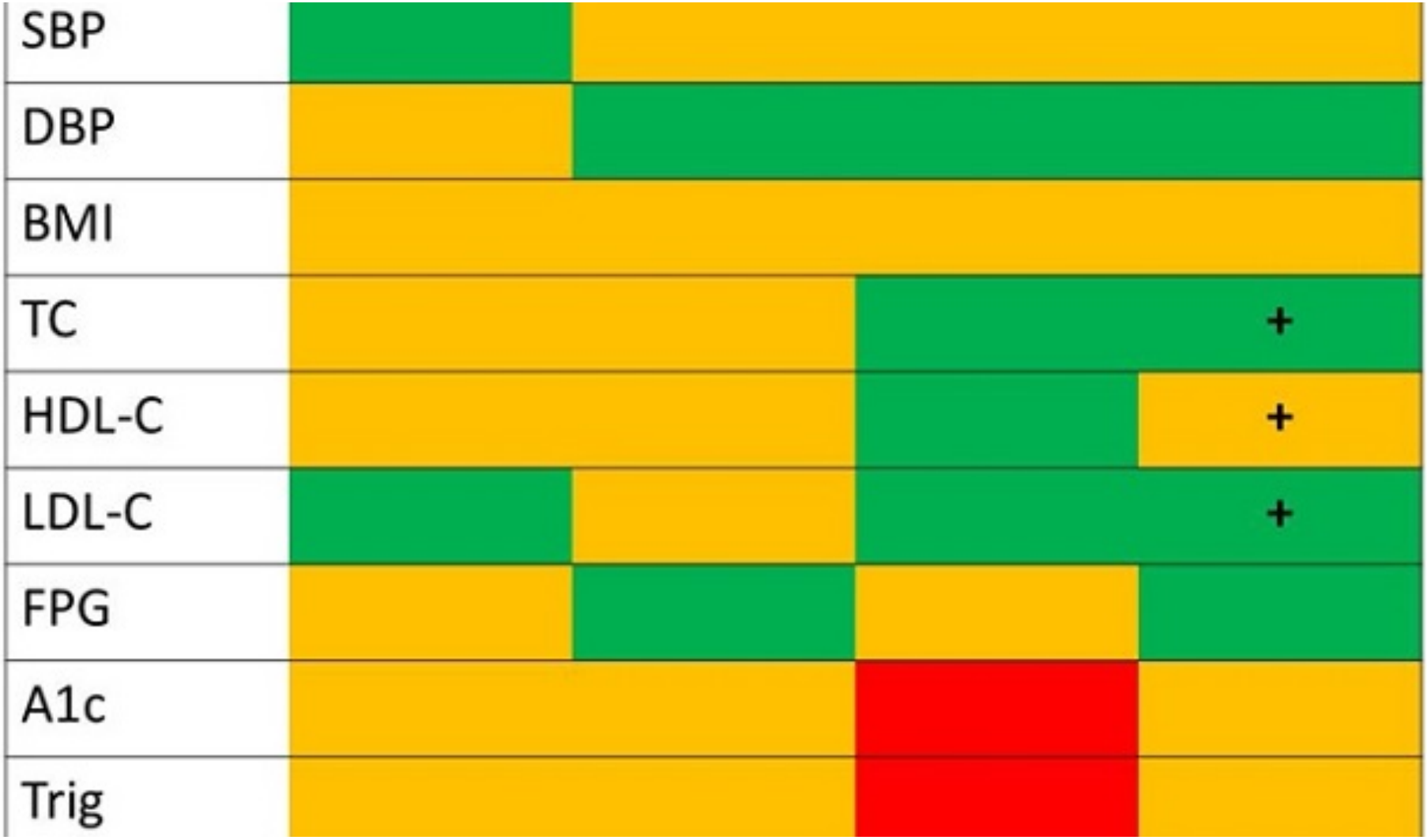
Small clinical eval did not show significant effect on physical health.

Scharf, et al 2013

INTEGRATION SCORES FOR PBHCI GRANTEES



PBHCI CLINICAL OUTCOMES – N OF 3, 12 MONTHS.



COMMENTS ON PBHCI

Administrative Burden.

High-intensity work with select group of patients vs whole-population.

Why do health homes seem to work better?

Who were the best PBHCI sites, and what did they do?

HOME (HEALTH OUTCOMES MANAGEMENT AND EVALUATION) STUDY

300 patients with SMI and at least one chronic condition: DM, HTN, Dyslipidemia, Heart Disease

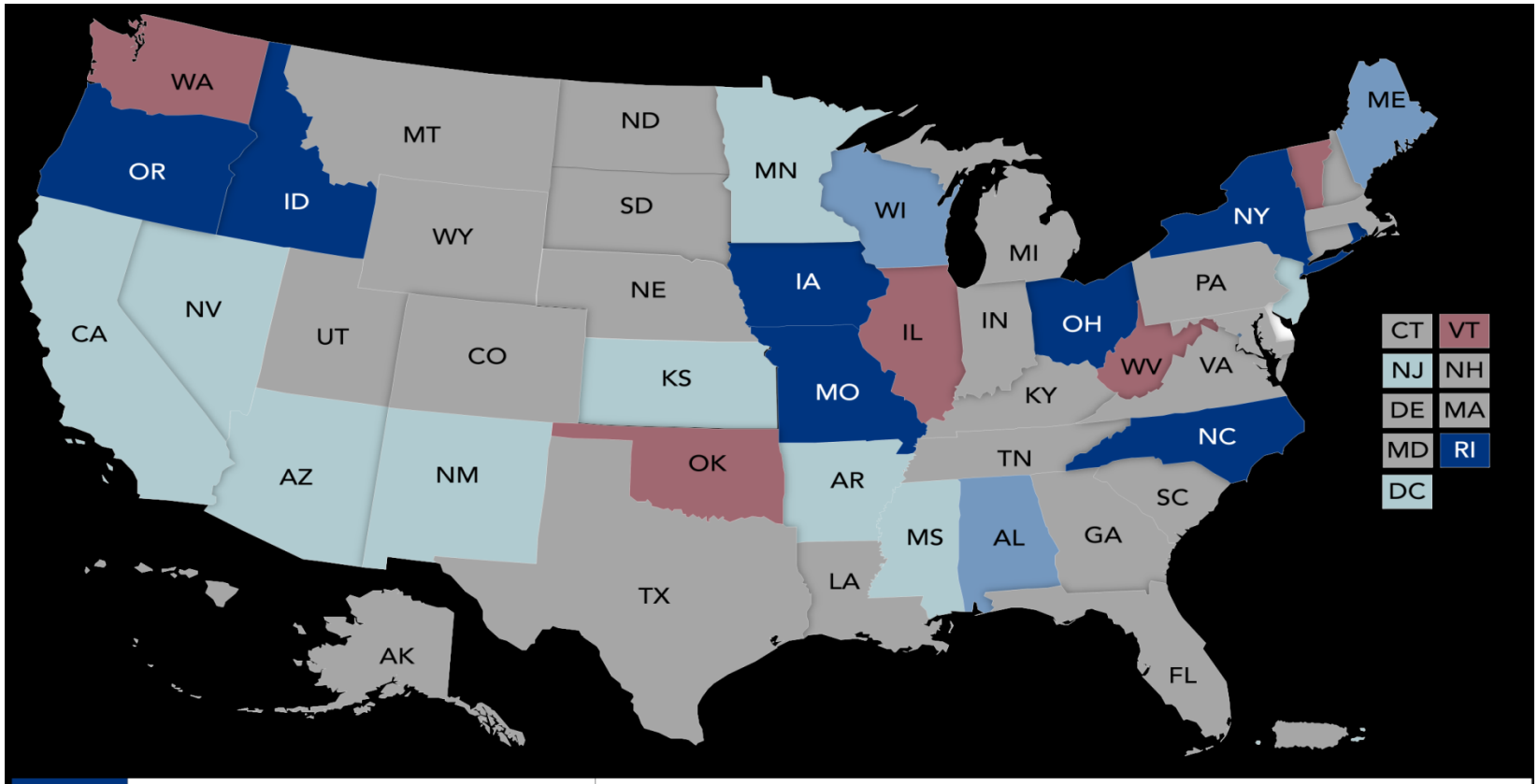
Randomized 150/150 usual care or intervention

Partner with FQHC on site

ICC: Integrated Community Care

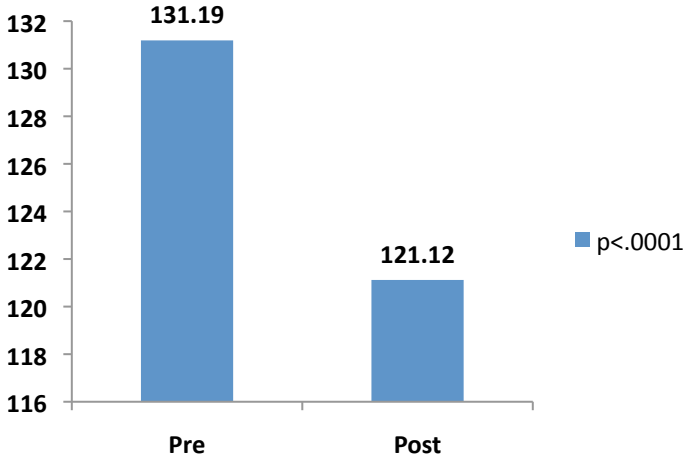
- Medical outcomes and budget analysis

2703 STATE MEDICAID HEALTH HOME AMENDMENTS

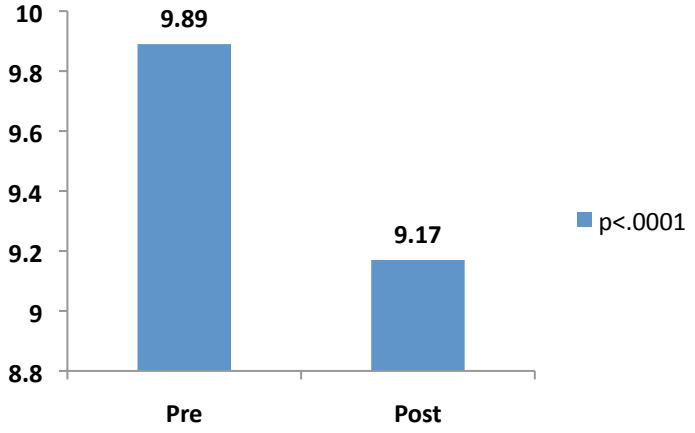


	Approved Health Home State Plan Amendment (SPA)	Idaho, Iowa, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island
	Health Home SPA "On the Clock" (officially submitted to CMS)	Alabama, Maine, New York (phase II), Wisconsin
	Draft Health Home SPA Under CMS Review	Illinois, Oklahoma, West Virginia
	Approved Health Home Planning Request	Alabama, Arizona, Arkansas, California, District of Columbia, Idaho, Kansas, Maine, Minnesota, Mississippi, Nevada, New Jersey, New Mexico, North Carolina, Washington, West Virginia, Wisconsin
	No Activity	Alaska, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Montana, Nebraska, New Hampshire, North Dakota, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Wyoming

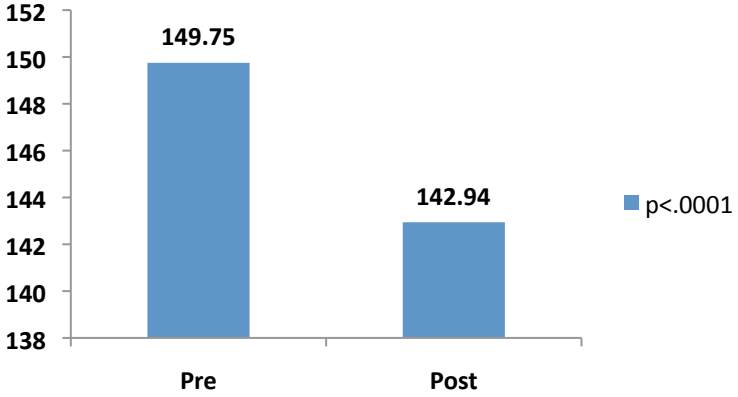
LDL Changes in PCHH Patients with Initially High Levels



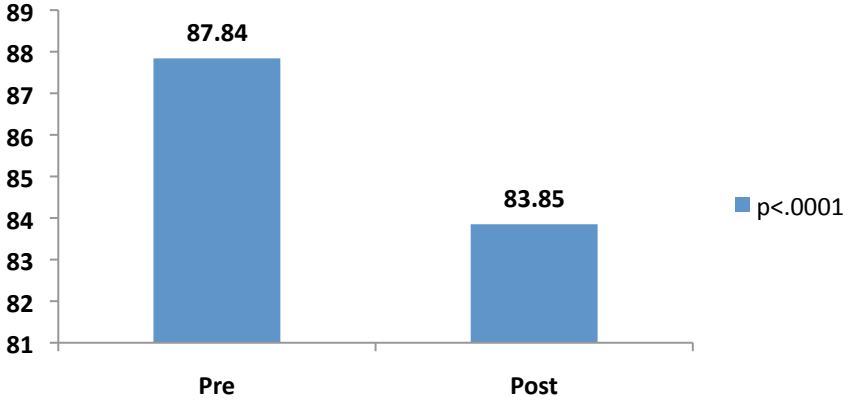
HA1c Changes in PCHH Patients with Initially High Levels



Systolic Blood Pressure Changes in PCHH Patients with Initially High Values



Diastolic Blood Pressure Changes in PCHH Patients with Initially High Values



WHAT'S NEXT?

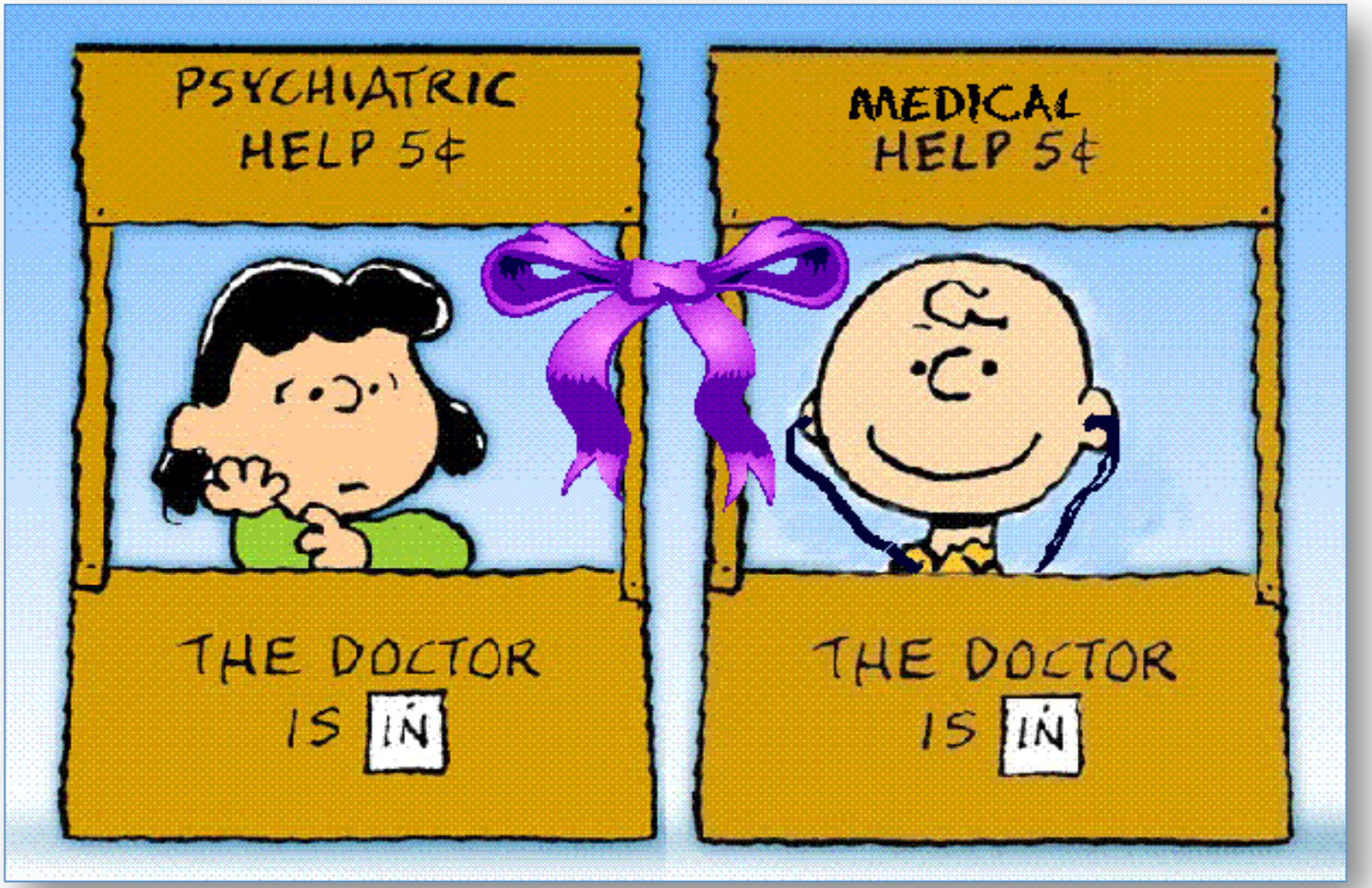
Certified Community Behavioral Health Clinics

More Health Homes

Completely integrated system – CMHC + FQHC

REGIONAL HEALTH CLINIC

Healthy Bodies. Healthy Minds. Healthy Communities.



Partners in Health - Primary Care/County Mental Health Collaboration Toolkit, Integrated Behavioral Health Project (IBHP), October 2009

INTEGRATED CARE ELEVATOR SPEECH

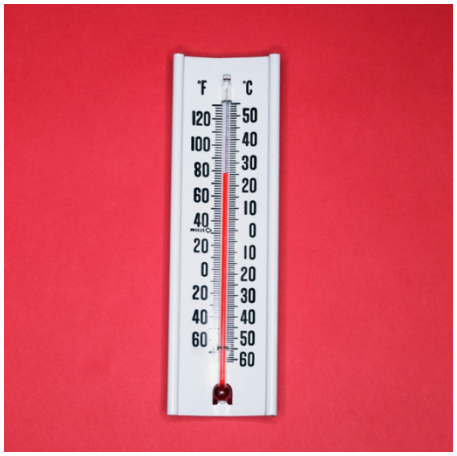
Integrated Care is a structured approach to healthcare delivery where physical and behavioral health conditions are treated concurrently to improve outcomes, contain costs and increase patient and provider satisfaction (the Triple Aim).

T – Team-based

E – Evidence-based

M –Measurement-based

P – Population-based



OUR FUTURE LIES IN COLLABORATIVE CARE:

Behavioral health issues impact all triple aim outcomes.

Collaborative care in health systems improves them.

Incentivizing outcome, rather than events, demands collaborative approaches.


Why didn't we think of this sooner?
Diagnosis and Treatment of Streptococcal Pharyngitis

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