Optum Health Education™

1+1=3: The Value of Medical Behavioral Integration in Whole Person Health

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Disclosure

Dr. Tristan Gorrindo has no financial relationships to disclose.

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Learning Objectives

Describe the value of integrated physical and behavioral health treatment

Identify key components of evidence-based integrated behavioral health models

Describe barriers to adoption of integrated behavioral health models

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A Key Touchpoint for Behavioral Health: Primary Care

Of patients with behavioral health needs,

49% report receiving treatment

only through their primary care provider [1]

Up to

70% of all primary care visits

have a behavioral health component [2]

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Behavioral integration and the spectrum of care

Behavioral health care is not one size fits all. As severity of conditions vary, so do treatment options. Medical behavioral integration in the primary care setting is best for patients with mild to moderate conditions. Additional care in direct or longer-term outpatient settings may be needed for some patients.

	Low severity				High severity
Diagnosis	**Anna** *Stress*	**Sam** *Major depressive disorder*	**Julie** *Generalized anxiety disorder*	**Taryn** *Posttraumatic Stress Disorder (PTSD)*	**Daniel** *Schizophrenia*
Model of care	**Self-directed care**	**Primary care integration**		**Direct behavioral care**	**Subspecialty behavioral treatment**
Solutions	**Self Care and coaching apps**	**Collaborative Care Model (CoCM)**	**Integrated Behavioral Health (IBH)**	**Evidence-Based Therapy, Medication Management, Group, PHP, IOP, Residential and Interventional Treatments**	**Community-based wrap-around services**
Setting	Mobile phone/computer	Primary care office/clinic		In-person or virtual clinics	Specialized facilities

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Medical behavioral integration and patient experience

Patients benefit from their medical and behavioral health providers working together as a team, to provide effective whole-person care.

- Patients in integrated settings have **higher satisfaction** with their behavioral health and medical treatment [3]
- Patients engaged in the Collaborative Care Model (CoCM), a specific model of medical behavioral integration, get better faster compared to patients receiving care as usual in primary care [4]
- Integrated care reduces stigma by treating the patient as a whole person with one team, in a setting where they are already comfortable and familiar [5]

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Improve primary care provider wellbeing

Medical behavioral integration provides primary care providers with behavioral health specialist support - helping them navigate challenging cases, building team collaboration, and easing their workload.

- Behavioral health integration provides specialty resources and additional team members, which can improve patient care and help reduce provider burnout[6]
- PCPs are generally more satisfied working within an integrated behavioral health program[7]
- Engagement in medical behavioral integration can improve both behavioral health AND medical outcomes [8]

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Additional values of MBI

Decreases Costs

- Medical costs for treating patients with chronic medical and comorbid mental health/substance use disorder conditions are two to three times higher than patients without comorbid MH/SUD conditions[9]
- An estimated $38 to $68 billion can potentially be saved annually though effective integration of medical and behavioral services [9]
- A longitudinal study on the Collaborative Care Model (CoCM) found that for wvery $1 spent on collaborative care saves $6.50 in health care costs[3]

Increases Access

- Integrated care models are short term is short-term so patients are in care an average of 4-6 months
- Mild and moderate patients can be treated in the primary care setting, increasing access to specialty care for those who need it
- The Collaborative Care Model includes a consulting psychiatrist who oversees a caseload of patients, rather than seeing them directly. This increases access to psychiatry and can help address critical psychiatrist shortages.

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Levels of integrated healthcare

Pre-coordinated	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5	LEVEL 6
	Minimal collaboration	Basic collaboration at a distance	Basic collaboration onsite	Close collaboration onsite with some system integration	Close collaboration approaching an integrated practice	Full collaboration in a transformed/merged integrated practice

COORDINATED

Key element: Communication

- Separate systems
- Separate facilities
- Minimal **interactive** communication between behavioral health and medical providers driven by specific issues
    - If communication is not interactive, practice is considered “pre-coordinated”
- Behavioral Health viewed as specialty care

CO-LOCATED

Key element: Physical proximity

- Separate or some sharing of systems
- Shared physical or virtual facilities
- Regular interactive communication
- Increased understanding and appreciation of each other’s roles and cultures
- Medical and behavioral health providers beginning to see themselves as and function as a team

INTEGRATED

Key element: Practice change

- All barriers with separate systems or facilities have been addressed or ideally full sharing of all facilities and systems
- Medical and behavioral health providers equally involved in the approach to individual patient care and practice design
- Medical and behavioral health involved in a standard way across all providers and patients
- A single health system treating the whole person

Sources:
Heath B, Wise Romero P, and Reynolds K. A Standard Framework for Levels of Integrated Healthcare. Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions. March 2013.
Waxmonsky J, Auxier A, Heath B, Wise Romero P. IPAT Integrated Practice Assessment Tool. Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions. 2014.

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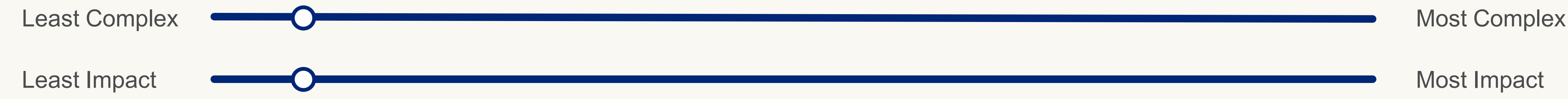
Levels 1-2: Referrals + Communication

Example	Pros and Cons	Best for:
A PCP develops a relationship with BH provider. The PCP sends referrals and the providers occasionally speak about specific patients. The BH provider may send progress notes or updated back to the PCP.	Pros: • Easiest to execute Cons: • Dependent on adequacy of referral network • Could have long wait times for patients to get into treatment	Systems that might not have time or resources to invest in higher levels of integration but want to start somewhere.



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Levels 3-4: Co-location

Example	Pros and Cons	Best for:
A PCP office decides to have a BH provider come and provide services from their office. The BH provider takes referrals and sees patients for traditional therapy appointments.	Pros: • Increases integration without a lot of system change Cons: • In providing care as usual, the BH provider could fill up quickly • Does not improve access overall	Systems with space to share, and that want to increase integration but may not be ready for total system change and shared treatment.

Least Complex — Most Complex

Least Impact — Most Impact

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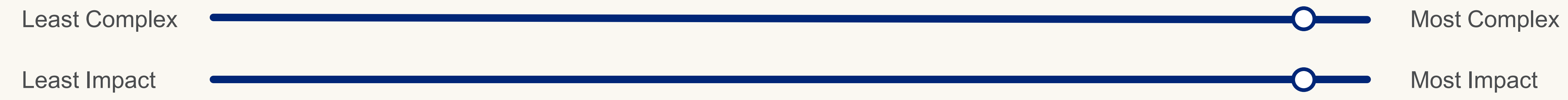
Levels 5-6: Full Integration

Example	Pros and Cons	Best for:
A PCP office has a BH provider as part of their care team. The BH provider engages in huddles and has a mix of prescheduled appointments and open time for warm handoffs. The BH provider provides brief, short-term treatment to maintain open access.	Pros: • Provides the most access • Reduces stigma Cons: • Requires full system change	Systems with a PCP champion who believes in full integration and can dedicate time and resources to system change.



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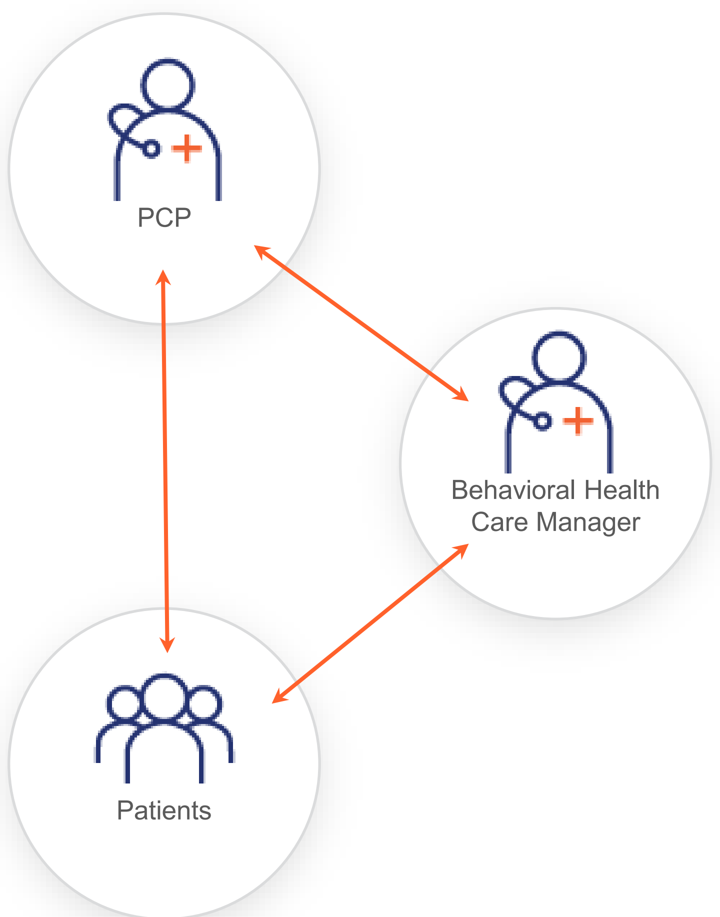
Levels 5-6: Primary Care Behavioral Health (PCBH)

Highlights	Pros and Cons
Target population: Generalist **Sessions**: 2-4 **Billing**: Behavioral health benefit **Entry point:** PCP or BHC **Highlights:** • Proactive • Can use to bridge to care • Preventative care in specialty populations (OB, peds)	**Pros:** • More flexible, not limited to registry **Cons:** • No support with medication management • BH and Medical payor overlap can be an issue • Higher copay for patient

Best for:

- FQHCs
- Systems with good payor overlap that are invested in shared treatment but do not want to manage medications



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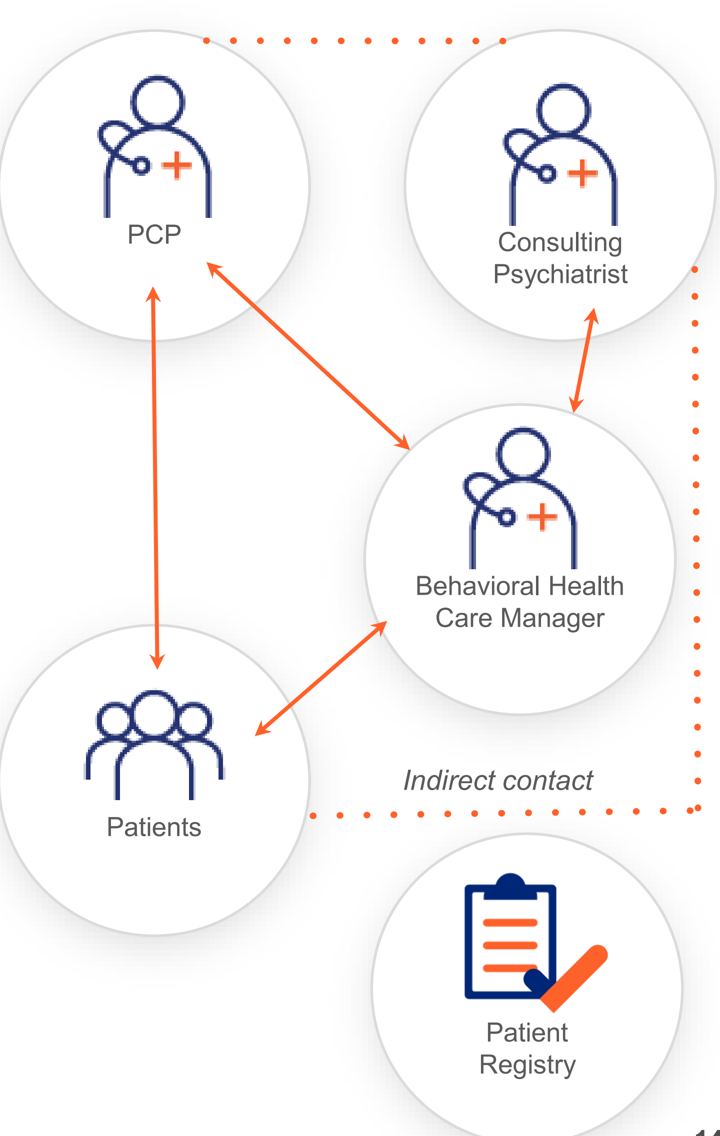
Levels 5-6: Collaborative Care Model (CoCM)

Highlights	Pros and Cons
Target population: Follows specific diagnoses (most often depression & anxiety) **Sessions**: 6-10 **Billing**: By PCP to the medical benefit **Entry point**: PCP **Highlights:** • Patients are tracked on a registry, more follow up • Psychiatric consultant	**Pros:** • Most research • Includes Psychiatric Consultant • Lower primary care copay for patient once a month **Cons:** • Requires PCP to lead care team and prescribe medications • Most complicated/most different from business as usual

Best for:

- Systems with providers who are comfortable prescribing with consultation support
- Systems ready for full system change



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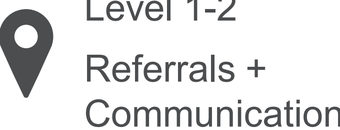
Optum Behavioral Care (OBC) Current IBH Integrations

“A behavioral health CDO”

MBI Implementations



Level 1-2

Referrals + Communication

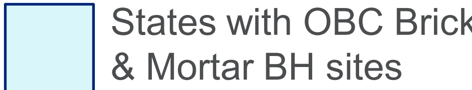
Level 3-4

Co-location

Level 5-6

Full integration/ CoCM

Traditional BH Services



States with OBC Brick & Mortar BH sites

OBC virtual capabilities in all states

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How well do you know your IBH?

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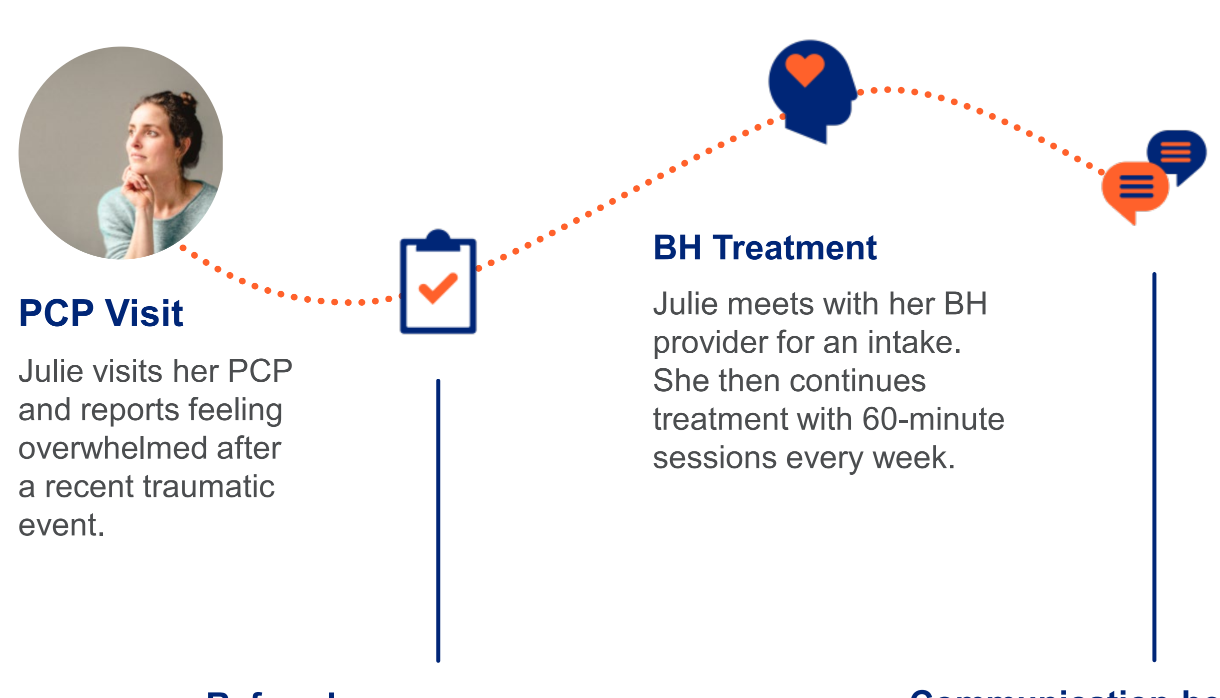
Julie's Journey: What level of integration does this describe?



ANSWER

Level 1-2

Referral + Communication

- ✗ PCP and BH not located in the same facility
- ✓ PCP and BH providers exchange patient information
- ✓ PCP and BH providers communicate to address specific patient treatment issues

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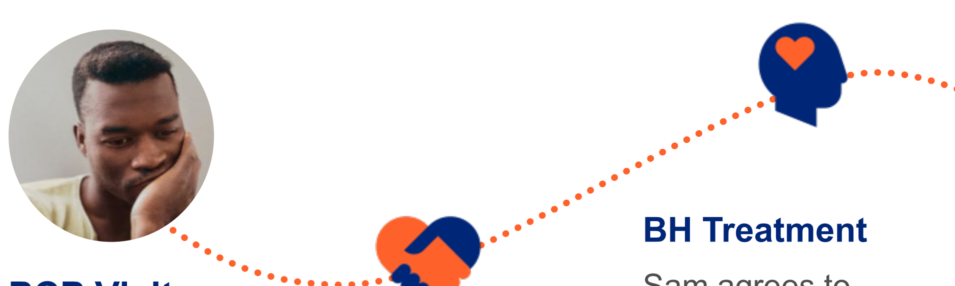
Sam's Journey: What level of integration does this describe?



PCP Visit

Sam visits his PCP and reports increase in anxiety and trouble sleeping.

Referral/Warm Handoff

Sam's PCP recommends he meet with the team's BH provider and introduces them through a warm-handoff.

BH Treatment

Sam agrees to treatment and record sharing by care team including PCP and BH provider. He continues with brief 30-minute visits focused on specific interventions for his anxiety.

Communication between PCP and BH provider

Sam's BH provider and PCP work together as a care team. They use a single EMR to seamlessly share notes and engage in joint treatment planning.

ANSWER

Level 5-6

Full Integration

- PCP and BH are located in the same facility
- PCP and BH providers share a single EMR and communicate regularly
- PCP and BH provider function as a single system treating the whole person

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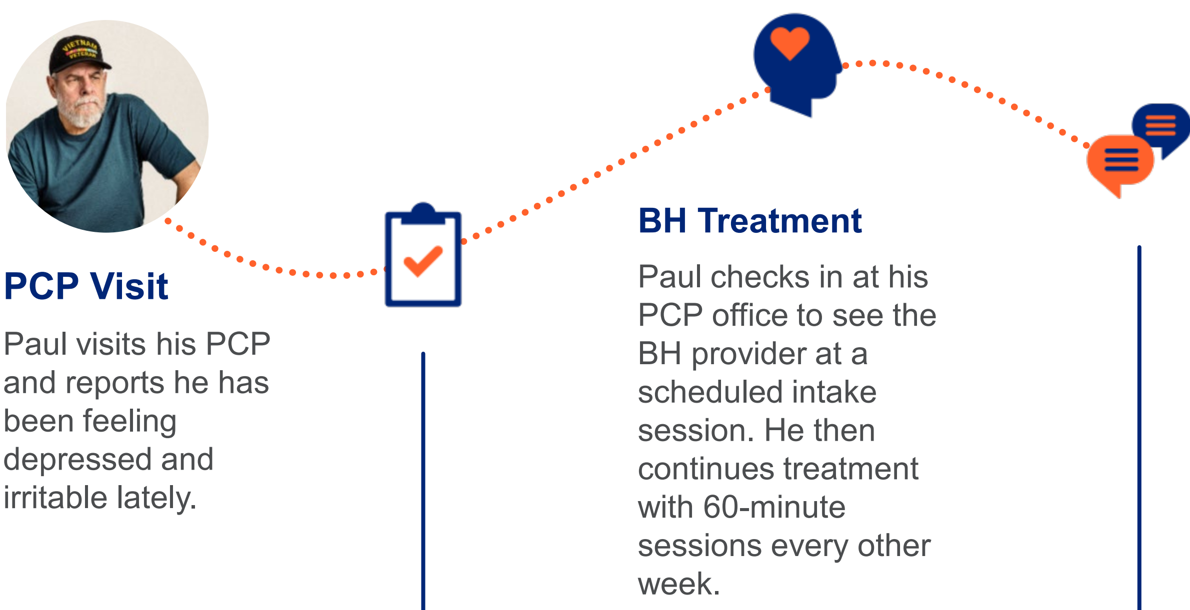
Paul’s Journey: What level of integration does this describe?



PCP Visit

Paul visits his PCP and reports he has been feeling depressed and irritable lately.

Referral

Paul’s PCP recommends that he be seen by the on-site BH provider and places a referral.

BH Treatment

Paul checks in at his PCP office to see the BH provider at a scheduled intake session. He then continues treatment with 60-minute sessions every other week.

Communication between PCP and BH provider

Paul’s PCP and BH clinician work in different EMR systems. Paul signs a release so his BH clinician can send notes to his PCP and so the providers can discuss his care in regular meetings.

ANSWER

Level 3-4

Co-location

- ✔ PCP and BH are located in the same facility
- ✘ PCP and BH providers do not share a single EMR
- ✔ PCP and BH providers engage in regular interactive conversation

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References

1. Petterson, S., Miller, B. F., Payne-Murphy, J. C., & Phillips, R. L., Jr. (2014, April 28). Mental Health Treatment in the Primary Care Setting: Patterns and Pathways. Families, Systems, & Health. Advance online publication. http://dx.doi.org/10.1037/fsh0000036

2. Segerstrom, S. C., & Miller, G. E. (2004). Psychological stress and the human immune system: A meta-analytic study of 30 years of inquiry. Psychological Bulletin, 130, 601-630.

3. Unutzer J etal. “The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes.” Health Home Information Resource Center Brief. Centers of Medicare and Medicaid Services May 2013

4. Garrison, G. M., Angstman, K. B., O'Connor, S. S., Williams, M. D., & Lineberry, T. W. (2016). Time to Remission for Depression with Collaborative Care Management (CCM) in Primary Care. Journal of the American Board of Family Medicine : JABFM, 29(1), 10–17. https://doi.org/10.3122/jabfm.2016.01.150128

5. Ruth Shim, George Rust, “Primary Care, Behavioral Health, and Public Health: Partners in Reducing Mental Health Stigma”, American Journal of Public Health 103, no. 5 (May 1, 2013): pp. 774-776.

6. Whitebird, et al. Clinician burnout and satisfaction with resources in caring for complex patients. General Hospital Psychiatry. 2017 Jan-Feb; 44: 91-95.

7. Bentham, W. D., Ratzliff, A., Harrison, D., Chan, Y.-F., Vannoy, S., & Unützer, J. (2015). The Experience of Primary Care Providers With an Integrated Mental Health Care Program in Safety-Net Clinics. *Family and Community Health*, *38*(2), 158–168. https://www.jstor.org/stable/48515398

8. Why Practice Collaborative Care. University of Washington, AIMS Center, 2019

9. Melek, S. P., Norris, D. T., Paulus, J., Matthews, K., Weaver, A., & Davenport, S. (2018). Potential economic impact of integrated medical-behavioral healthcare. Milliman.

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