



Effective Clinical Integration of Behavioral Health and Primary Care

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Limits of our Current System

- Mental health / substance abuse problems
 - Common, disabling, and expensive
 - Few are effectively treated
 - ~ 25% are not recognized or effectively engaged in care
 - ~ 25 % drop out of treatment too early
 - ~ 25 % stay on ineffective treatments for too long
- Treatments for physical and behavioral health are poorly coordinated, resulting in many episodes of costly care that “don’t add up to much.”
 - Clients have to navigate poorly coordinated systems of care: primary care, mental health care, substance abuse care, vocational rehabilitation, social services, ...

Effective Integrated Care

General Principles

1. All clients have a **Person Centered Health Care Home (PCHCH)**.
2. All clients have **one problem list, one medication list, and one care plan** that is shared by all providers including behavioral health providers.

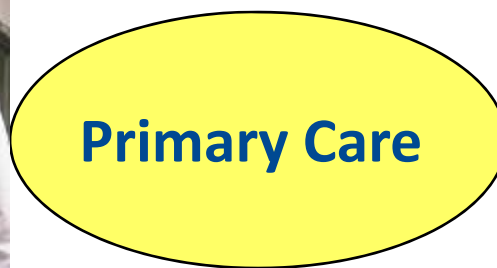
Specific Principles

1. **Population-Based Care:** Systematically identify need; help people get into care and prevent them from 'falling through the cracks'.
2. **Treatment to Target:** Track outcomes and provide care that works.
3. **Patient-Centered Integrated Care:** Coordinate primary and behavioral health care.
4. **Performance-Based Payment:** Pay for value, not volume.

Mental Health Integration Program (MHIP)



Primary Care Provider supported by Behavioral Health Care Manager



Practice Support



Informed, Active Patient



Outcome Measurement



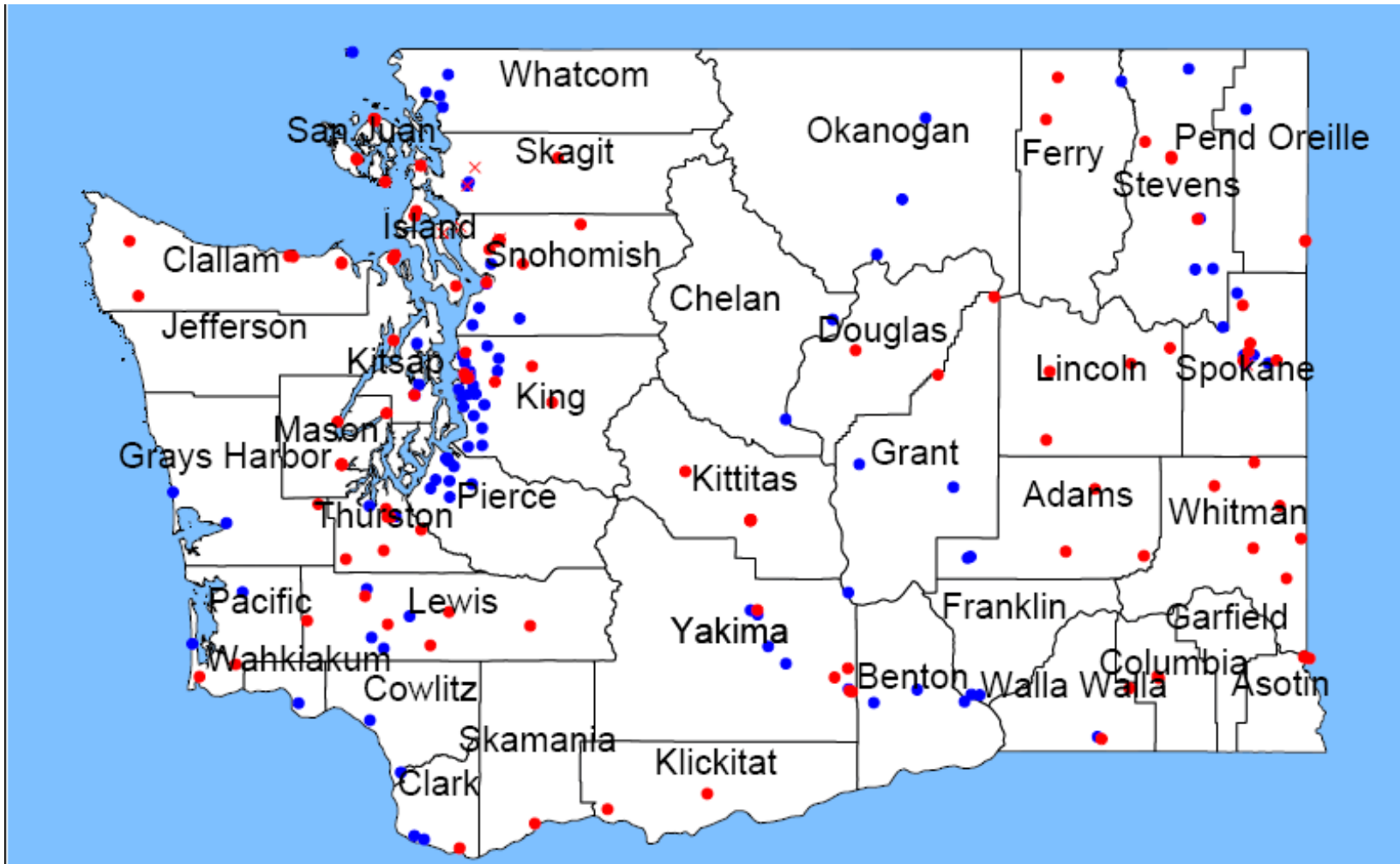
Caseload-focused psychiatric consultation. Referral to and coordination with specialty mental health care .



Provider Training and Support

Mental Health Integration Program (MHIP)

17,500 clients served across Washington State



Community Health Care

7 clinics; over 1,000 clients served

Population	Mean baseline PHQ-9 depression score	Engaged & followed-up (%)	Mean number of care coordinator contacts	Psych consultation (%)	% with significant clinical improvement
Disability Lifeline	19 / 27 = severe depression	90 %	9	78%	47 %*

Data from Mental Health Integrated Tracking System (MHITS)

*Compared to ~ 20 % in typical safety net populations.

Neighborcare Health

(6 clinics; over 2,000 clients served)

Population	Mean baseline PHQ-9 depression score	Follow-up (%)	Mean number of care coordinator contacts	% with psych consultation	% with significant clinical improvement
Disability Lifeline	16 / 27	92 %	8	69%	43 %
Uninsured	15 / 27	83 %	8	59%	50 %
Older Adults	15 / 27	92 %	8	55%	43 %
Vets & Family	15 / 27	92%	7	54%	53%
Mothers	15 / 27	81%	7	49 %	60%

Data from Mental Health Integrated Tracking System (MHITS)

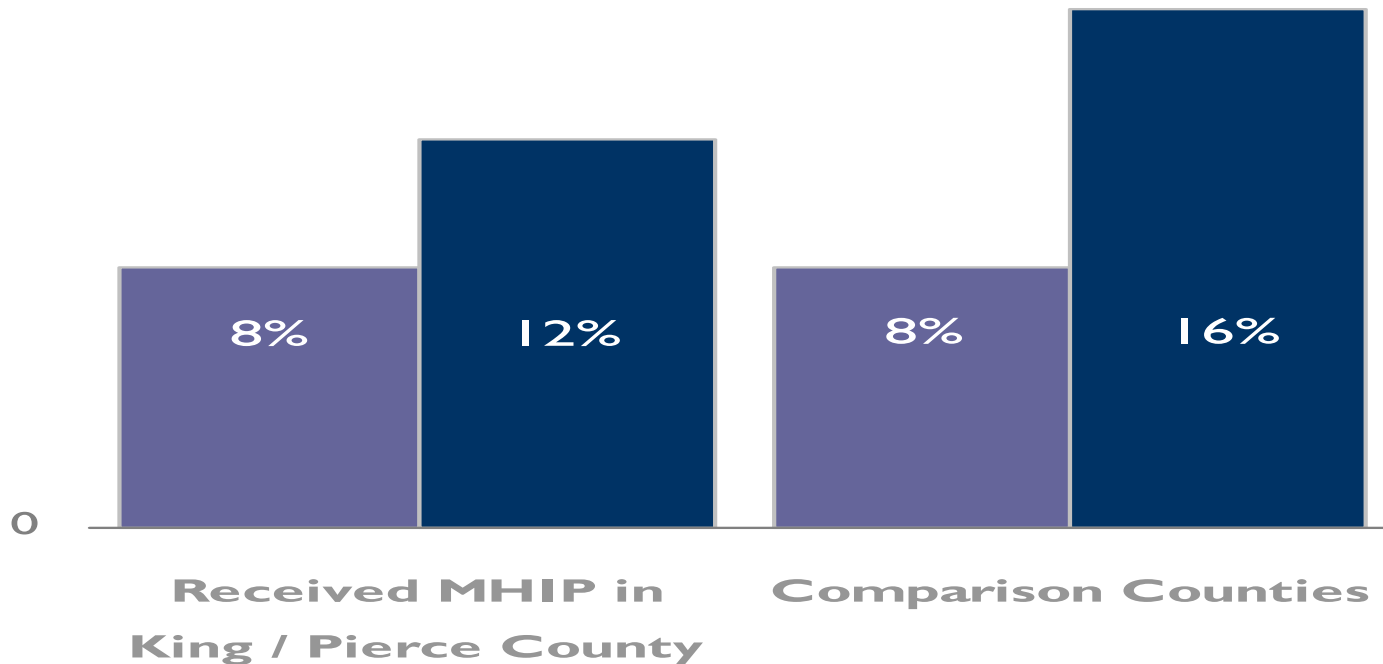
Changes in health care utilization?

- **Reduced inpatient medical admissions**
- **Smaller increase in inpatient psychiatric costs**

in DL clients with evidence of mental illness in MHIP pilot counties relative to similar GA-U clients in comparison counties.

- Research suggests that other cost savings may take longer to materialize.

Lower increases in Homelessness in Clients Receiving MHIP



Reduced Arrest Rates* in Clients Receiving MHIP



CHAMMP; Jan 27, 2011; <http://www.chammp.org/Program-Evaluation/Reports-and-Publications.asp>

* Arrests / 1,000 member months



- Over 17,500 Clients Served state-wide
 - Patient-centered, coordinated care
 - Improved Health Outcomes
 - Promising trends in health care costs
 - Safer Communities
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- A model for other safety net / Medicaid populations with a high burden of mental health / substance abuse problems.