Integrated Care Supports Improved Outcomes for Individuals With Chronic Illnesses and Behavioral Comorbidities in Health Home Settings

By Sandra L. Forquer, PhD
Senior Vice President, State Government Programs, Optum

The prevalence of comorbid chronic physical and behavioral health conditions is high. Treatment for mental health and substance use conditions have historically been provided in systems of care that are separate from primary care and physical health. Optum recognizes that these fragmented approaches are not as effective. Integrated care promotes a person-centered approach with a whole-health focus. This also fosters the inclusion of social and community resources in the development of systems of care that promote well-being and resiliency.

The Affordable Care Act and other health reform initiatives to improve the quality and outcome of care have also promoted new service delivery models. These include Accountable Care Organizations (ACOs), Health Homes/Patient-Centered Medical Homes (PCMHs), Federally Qualified Health Centers (FQHCs), and Federally Qualified Behavioral Health Centers (FQBHCs), among others. Each of these systems of care have built their own solutions for providing services for physical and behavioral health conditions. The Health Home model of care has been endorsed by the Centers for Medicare and Medicaid Services (CMS) as an approach that fosters integrated care for chronic physical and behavioral health conditions.

Historically, models of collaboration between primary care and behavioral health providers have been in use for many years. For instance, five levels of collaboration have been described by Doherty, McDaniel, and Baird (1996). These include: 1) Minimal collaboration; 2) Basic collaboration from a distance; 3) Basic collaboration on site; 4) Close collaboration in a partly integrated system; 5) close collaboration in a fully integrated system. Druss (2011) has described three models of behavioral health and primary care integration. These include a *fully integrated* medical and behavioral health staff model where providers equally participate within a single organization; a *partnership model* in which primary care and behavioral health providers are embedded within a medical or behavioral health clinic or organization; and a *facilitated referral* model where staff are not physically present, but formal arrangements support information sharing and referrals.

Most evidence-based approaches for addressing comorbid chronic physical illnesses and behavioral health conditions have been built from the framework developed in the Chronic Care Model (Druss, 2011). Six core elements of this approach include self-management support; decision support; delivery system design; clinical information systems; health care organization; and community resources. Optum recognizes the importance of health homes in comprehensive systems of care and has also identified several similar keys for the integration of care in health homes and other organized systems of care. These include; cross-training primary care and behavioral health clinicians on common medical comorbidities; emphasizing wellness and preventative care across provider systems; sharing medical and behavioral health information through electronic health records; increased measurement and monitoring of treatment pathways and outcomes; and sharing decision-making with consumers. Treating patients from a combined behavioral and medical perspective is respectful of their choices and empowers them to take an expanded role in directing their own care.

Optum provides a range of services through a Network Administrator model to support Health Homes in their coordination of care. This scalable approach provides newly emerging groups of providers with the necessary infrastructure resources to begin to aggregate service and coordinate care. For more mature health home organizations, the Health Home Network Administrator (HHNA) framework can be tailored to meet the specific requirements of states and other payer systems to assume responsibility for population health management and outcomes.

Optum has implemented the HHNA framework in Washington. Some of the core components of the model include support for shared information and clinical responsibilities. The Optum Washington Health Home System provides a common platform for this shared information. A single web-enabled management information system supports these health homes. This is used to communicate, document, monitor and track, and support administrative functions across provider systems. Utilizing this portal, interdisciplinary treatment teams are able to support beneficiaries and their families. The access to and sharing of information is controlled by appropriate release of information documentation. Care planning and documentation are provided through paper copy, fax, secure e-mail, and electronically on the web portal.

Shared care coordination responsibilities are also promoted through the HHNA model. Services are provided by a combination of licensed clinicians and wellness coaches. Care coordinators have primary responsibilities for assisting beneficiaries

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with developing treatment goals and care plans, and overseeing and tracking their progress. They also provide oversight of the wellness coaches. Trained to support beneficiaries and their families, the wellness coaches provide outreach and engagement, and are active in the development and support of treatment goals. These coaches are individuals who have lived with chronic conditions themselves, and they are trained in peer support and chronic illness self-management.

Through a network administrator approach Optum is able to provide the resources and services necessary to support the custom development and design of integrated clinical systems of care. Using integrated data, Optum is able to help identify individuals with chronic physical and behavioral health conditions. Working with states, provider systems, and community stakeholders, Optum's approach helps identify which individuals are at highest risk for poor health outcomes and helps coordinate resources to support their care. Implementing chronic care management programs for payers and providers helps high-need/high-risk members receive the care they require. This can also coordinate care across multiple systems and community resources to foster improved outcomes.

Developing networks of providers who have demonstrated outcomes of evidence-based care and chronic illness management are facilitated within Optum's network administration model. Technical assistance is also provided to emerging health home organizations and other integrated systems of care. This approach promotes integrated care for physical and behavioral health needs. It also provides necessary population health management tools to support existing clinical operations and resources.

As integrated systems of care evolve and health homes play an increasingly larger role in delivery systems, new payment models are also being developed. The Optum network administrator program has the capacity to support a variety of reimbursement models. Case rates, capitation, and population based outcome models of reimbursement are supported through claims tracking and adjudication, and contract monitoring and compliance. As providers join in organized systems of care like health homes, the capacity to monitor services and adjudicate a comprehensive range of services is necessary.

As a network administrator, Optum is also able to help establish quality monitoring and improvement programs. These can be based on standardized national and state indicators, as well as custom designed resources that meet the specific needs of individual providers and systems of care. Quality management can also support outcomes management and clinical and contract reporting requirements.

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References

Doherty, W. J., McDaniel, S. H., & Baird, M. A. (1996). Five levels of primary care/ behavioral health collaboration. *Behavioral Healthcare Tomorrow, 5,* 25–27.

Druss, B. G., Walker, E. R. (2011). Mental Disorders and medical comorbidities. Research Synthesis Report No. 21 Robert Wood Johnson Foundation.

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medicine experts, neurologists, pulmonologists, and pain management specialists may be involved to help rule out medical problems. If a medical disorder is identified, such as sleep apnea, restless leg syndrome, or a circadian rhythm disorder, it should be treated by the medical team, keeping the behavioral health providers apprised and involved. Similarly, if the cause is psychiatric, substance use, or other behaviorally derived issues, these should be addressed by the behavioral health team, keeping the medical providers in the loop.

One of the first responses to sleep issues, whether the problem is medical or behavioral, is sleep hygiene education, a preventive tool and treatment strategy. Sleep hygiene (or habits) refers to a set of practices that contribute to a restful night's sleep. At their most basic, these "healthy" sleep habits are common knowledge: establish and follow a regular bedtime routine, minimize use of drugs and alcohol, maintain a healthy diet and exercise regularly. Other practices are less intuitive such as ensuring adequate exposure to natural light to help balance the sleep-wake cycle, isolating the sleep environment to ensure it's primarily associated with sleep, and establishing a pleasant and relaxing sleep environment.

A more involved behavioral response to sleep is Cognitive Behavioral Therapy for Insomnia, or CBT-I. CBT-I focuses on helping people avoid anxiety about not falling asleep by building confidence that a good night's sleep is possible. CBT-I participants maintain sleep diaries, and may be placed on sleep restriction (where they are not allowed to go to bed earlier initially to recover from exhaustion). The practice involves sleep hygiene education and incorporating cognitive changes such as identifying and challenging irrational thoughts that cause or worsen sleep problems. It also stresses providing education to reframe or replace problematic thoughts and/or feelings related to sleep. Many people report that initially, CBT-I participants get even less sleep than before starting, but after several weeks, they are able to resume normal sleep habits. ("Cognitive-Behavioral Treatment of Insomnia" *Penn Sleep Centers Newsletter* (Winter 2006): Web 5 March 2014.)

For some people, resolving sleep issues requires medication. There are a number of medications that prescribers may use to promote sleep. These include zolpidem, eszopiclone, ramelteon, zaleplon, doxepine, quetiapine, trazadone, mirtazapine, and benzodiazepines such as

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