Mental Health in Primary Care: Models of Care that Work!

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Objectives

- Discuss the importance of mental health in primary care
- Acknowledge challenges
- Introduce concepts of integrated care
- Describe components of integrated care
- Look at 3 models of integration in action
WHY: Why is mental health important?

- 1 in 4 US adults suffer from mental illness in a given year
- 6% of adult US population suffering from serious mental illness
- 1996-2006 mental illness one of 5 most costly conditions
- 2006 medical expenditures on mental illness = $57,500,000,000
- Greatest cause of disability in US and Europe

http://www.ahrq.gov/research/mentalhth.htm
WHY: Current system not working

- National Comorbidity Survey 2001-2003 found 41% of those subsequently diagnosed with mental illness (anxiety, mood, impulsive control and substance abuse disorders) in face-to-face interview had received any treatment in the prior year.¹

- Mental health specialties have been cited as the most difficult specialty to access²

- Half of patients with 1 or more serious chronic illnesses have 3 or more different physicians³

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²) Trude, 2003
³) Gallup Serious Chronic Illness Survey 2002.
WHY: Why primary care?

- Primary care as the ‘de facto’ mental health care system
  - 43-60% psychological issues treated in primary care\(^1\)
  - 17-20% in specialty mental health care\(^1\)
  - Primary care is often the site of initial presentation with symptoms mental illness
  - Patients with medical illness often have co-existing mental illness and/or behavioral components of their medical illness

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\(^1\) Kessler, 2008.
WHY: Why primary care?

- Primary care setting ideal for treatment of mental health?
  - Interconnection b/w mental illness and other chronic illnesses.
    - Patients with diabetes and depression have higher HA1C, worse medication adherence, higher vascular complications and higher mortality rates than those without depression\(^1\)
  - Need for treatment of acute issues and to avoid delays in treatment
  - Cost effective at least for specific conditions such as depression\(^2,3\)

1) Lin, 2004
3) Rost, 2005
WHY? It’s trendy!

- Patient-Centered Medical Home (PCMH)
  - No clear articulation of treatment of mental health in the PCMH
  - However, core principles of PCMH apply to mental health
    - “The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients”
    - “Care is coordinated/integrated across all elements of the healthcare system.”
    - “Enhanced access to care is available”

http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home
Why Not? It’s hard!

- Lack of adequate training
  - Primary care providers often not trained in evidence-based intervention for mental illness
- Lack of adequate resources
  - Behavioral health generally costs more than compensation for services
- Lack of adequate time for behavior interventions in general and mental health treatment specifically
- Lack of clearly defined outcome measures - no HAIC for anxiety

What to do?

- **Levels of Integration of care**
  - Full segregation - close to what we have in many practices and many of our systems
  - Various forms of Integration/Coordination/Collaboration - Perhaps what you see at High Street Clinic, the VA, DH Geriatric and HIV Primary Care clinics
  - Full integration - a dream!
What to do?

Expanded screening and collaborative care models could save lives.

The Commission recommends that Medicare, Medicaid, the Department of Veterans Affairs, and other Federal and State-sponsored health insurance programs and private insurers identify and consider payment for core components of evidence-based collaborative care.
The Solution: the middle way

- Integration: the holy grail?
  - What does it mean?
  - What does it look like in practice?
  - What does it include?
  - Is there evidence that it works?
  - Is it do-able?
The Solution: the middle way

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Institute of Medicine on Integrated Care:

- **Integrated treatment**: “refers to interactions between clinicians to address the individual needs of the client/patient” and consists of “any mechanism by which treatment interventions for co-occurring disorders are combined within the context of a primary treatment relationship or service setting.”

Institute of Medicine, 2006.
What is Collaborative Care?

- Multimodal intervention
- Integration of a care manager into primary care
  - Works with both patient and PCP
  - Develop a shared definition of the problem
  - Providing patient education and support
  - Develop a shared focus on specific problems
  - Targeting goals and a specific action plan
  - Support and problem-solving to optimize self-management
  - Achieving closer monitoring of adherence and outcomes
  - Facilitating appointments to the PCP or specialist for patients with adverse outcomes or side-effects.

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  - **What does it look like in practice?**
  - What does it include?
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Levels of integration

- Consensus decisionmaking and onsite specialty mental health services.
- Coordinated decisionmaking and onsite specialty mental health services.
- Coordinated decisionmaking and separate service facilities OR PCP directed decisionmaking and on-site specialty mental health services.
- PCP directed decisionmaking and specialty mental health services not provided onsite.

Butler, 2008.
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RESULTS of AHRQ Comprehensive Systematic Review
Treatment Response by level of Provider Integration

<table>
<thead>
<tr>
<th>Level of Provider Integration</th>
<th>Project or Author, Year (time)</th>
<th>Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Level of Integration</strong></td>
<td>(Hedrick, 2003) (6 months)†</td>
<td>1.00 (1.00, 1.00)</td>
</tr>
<tr>
<td></td>
<td>(Katon, 1995, major depression) (6 months)‡</td>
<td>3.69 (1.53, 8.91)</td>
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<td>(Hedrick, 2003) (12 months)†</td>
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<tr>
<td><strong>Intermediate I Level of Integration</strong></td>
<td>(IMPACT) (6 months)†</td>
<td>2.21 (1.76, 2.76)</td>
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<td>(Pathways) (6 months)‡</td>
<td>1.62 (0.98, 2.67)</td>
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<td>3.65 (1.30, 10.22)</td>
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<td>3.66 (2.90, 4.64)</td>
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<td>(Pathways) (12 months)‡</td>
<td>1.48 (0.90, 2.39)</td>
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<td>(IMPACT) (18 months)‡</td>
<td>1.71 (1.35, 2.17)</td>
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<td><strong>Intermediate II Level of Integration</strong></td>
<td>(PROSPECT) (6 months)†</td>
<td>2.68 (1.50, 4.90)</td>
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<td>(Simon 1, 2004) (6 months)‡</td>
<td>1.37 (0.91, 2.08)</td>
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<td>(Simon 2, 2004) (6 months)‡</td>
<td>1.83 (1.19, 2.80)</td>
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<td>(Finley, 2003) (6 months)‡</td>
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<td>(PROSPECT) (12 months)†</td>
<td>1.99 (1.10, 3.50)</td>
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<td>*(Hilty, 2007) (12 months)‡</td>
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<td><strong>Low Level of Integration</strong></td>
<td>(Fortney, 2006) (6 months)†</td>
<td>1.93 (1.09, 3.45)</td>
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<td>(Tutty, 2000) (6 months)‡</td>
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<tr>
<td></td>
<td>(RESPECT-D) (6 months)‡</td>
<td>1.70 (1.10, 2.70)</td>
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<td>(Simon, 2000) (6 months)‡</td>
<td>2.22 (1.31, 3.75)</td>
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<td>2.33 (1.54, 3.54)</td>
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<td>(Datto, 2003) (6 months)‡</td>
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*Studies in grey indicate low quality
†Diagnosed patients—usual care
‡Patients initiating treatment—usual care
§Diagnosed—enhanced referral

Butler, 2008.
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<td>IMPACT (6 months)†</td>
<td>2.16 (1.69, 2.76)</td>
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<td>IMPACT (12 months)†</td>
<td>3.78 (2.78, 5.13)</td>
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<td>2.24 (1.63, 3.08)</td>
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<td>IMPACT (24 months)†</td>
<td>1.66 (1.20, 2.28)</td>
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<td>PROSPECT (6 months)†</td>
<td>2.00 (0.90, 4.10)</td>
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<td>Flintey, 2003 (6 months)‡</td>
<td>1.00 (1.00, 1.00)</td>
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<td>Partners in Care (6 months)†</td>
<td>1.46 (1.13, 1.88)</td>
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<td>1.00 (1.00, 1.00)</td>
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<td>Partners in Care (12 months)†</td>
<td>1.33 (1.03, 1.72)</td>
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Butler, 2008.
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Financial Barriers

- Mental Health often a “carve-out”
- Inter-provider consults not compensated
- Care manager not always compensated
- No re-imbursement for 2 encounters on same day with different professionals (in the same clinic)
- Telephone consults not compensated

Butler, 2008.
Potential Solutions

- Research funding (not viable)
- QI funding (a little more viable)
- Pay-for-performance funds
- RWJ Incentive Projects
  - CO Access and UCSF- looked at integration in carve-out setting with partnerships between primary care practices, medical plan, and carve-out behavioral services
  - U of Michigan partnered with Ford- developed new CPT codes to bill for services

Butler, 2008.
Organizational Barriers

- Resistance to change
- Staffing: mental health professionals
- Time: managing cases/ time for consultations, etc
- Training: Level of comfort in treating mental illness for primary care provider and all members of team
- Privacy Concerns: HIPPA

Butler, 2008.
Organizational Solutions

- Identify leaders/ champions
- Training of allied-professionals (physician extenders) to screen, provide case management and treatment for mental health
- Primary care provider training
- Telemedicine

Butler, 2008.
Example 1: TEAMCare

- Wayne Katon’s group at U of Washington
- NIMH funded RCT with 14 clinics, 150 PCP’s and 214 patients
- Inclusion Criteria: ICD-9 codes of DM and/or CAD with HA1C $\geq 8.5$, bp $> 140/90$ or LDL $> 130$, and PHQ-9 $\geq 10$
- Goals:
  - Improved depression care with behavioral activation and antidepressants
  - Improve medical disease control; HA1C, HTN, LDL
  - Improve self-care (diet, exercise, tob cessation, glucose testing)

Example 1: TEAMCare

Team Members

- 3 diabetes nurse educators
  - Motivational interviewing
  - Problem solving
  - Behavioral activation
  - Use of antidepressants,
  - “Treat-to-target” for blood glucose, HTN, and LDL

Physician supervisors

- 2 psychiatrists
- Nephrologist and family physician
- Email consultation with diabetologist

Example 2: DIAMOND MODEL*

- Depression Improvement Across Minnesota, Offering New Direction
- Based on Collaborative Care Model found to be successful in large RCTs (IMPACT by Unutzer and TeamCare by Katon)
- Worked with many stakeholders, including: primary care providers, behavioral health providers, health plans, state dept of human services
- MN unique in that none of health plans are national
- Worked on a bundled form of payment with the insurance plans
Example 2: DIAMOND MODEL*

- Depression Improvement Across Minnesota, Offering New Direction* based on Collaborative Care Model
  - Four processes
    - Assessment (PHQ-9)
    - Registry (tracking system across all clinics)
    - Stepped treatment (used to intensify treatment)
    - Relapse prevention
  - Two Roles
    - Care manager (education, supports self-management, care coordination, relapse prevention
      - MA’s, Nurses, Behavioral Health
    - Liaison/consultative relationship with psychiatry
      - Caseload review with care managers, new/ difficult cases
Example 3: The White River Junction VA

Addressing Mental Health Needs in Primary Care at White River Junction

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Pomerantz, 2010.
What does this mean for your practice?

- Different strokes for different folks
- Integration will have different requirements, challenges, and benefits in different settings
- Some degree of integration has been shown to improve care at least in depression
Questions?
Acknowledgements

- Toni, Mischa and Emma
- Ingrid Binswanger, MD
- UC Denver HRSA Primary Care Research Fellowship
- UC Denver GIM
References:


Gallup Serious Chronic Illness Survey 2002.


References Cont.

Philip S. Wang; Michael Lane; Mark Olfson; Harold A. Pincus; Kenneth B. Wells; Ronald C. Kessler. Twelve-Month Use of Mental Health Services in the United States: Results From the National Comorbidity Survey Replication. Arch Gen Psychiatry. 2005;62(6):629-640


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