



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

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## Objectives

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- ▶ 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?

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- ▶ 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

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▶ <http://www.ahrq.gov/research/mentalhth.htm>

<http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf>

## WHY: Current system not working

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- ▶ 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.<sup>1</sup>
- ▶ Mental health specialties have been cited as the most difficult specialty to access<sup>2</sup>
- ▶ Half of patients with 1 or more serious chronic illnesses have 3 or more different physicians<sup>3</sup>

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1) Wang, 2005.

▶ 2) Trude, 2003

3) Gallup Serious Chronic Illness Survey 2002.

## WHY: Why primary care?

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- ▶ **Primary care as the ‘de facto’ mental health care system**
  - ▶ 43-60 % psychological issues treated in primary care<sup>1</sup>
  - ▶ 17-20% in specialty mental health care<sup>1</sup>
  - ▶ 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?

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- ▶ 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 HAI C, worse medication adherence, higher vascular complications and higher mortality rates than those without depression<sup>1</sup>
  - ▶ Need for treatment of acute issues and to avoid delays in treatment
  - ▶ Cost effective at least for specific conditions such as depression<sup>2,3</sup>

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1) *Lin, 2004*

▶ 2) *Wang, 2008.*

3) *Rost, 2005*

## WHY? It's trendy!

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- ▶ 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”

# Why Not? It's hard!

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- ▶ **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?

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## ▶ 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?

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PRESIDENT'S NEW FREEDOM

COMMISSION ON MENTAL HEALTH

[www.MentalHealthCommission.gov](http://www.MentalHealthCommission.gov)



***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.

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# The Solution: the middle way

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- ▶ **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?



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## Institute of Medicine on Integrated Care:

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- ▶ **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.”

# What is Collaborative Care?

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- ▶ 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.

# The Solution: the middle way

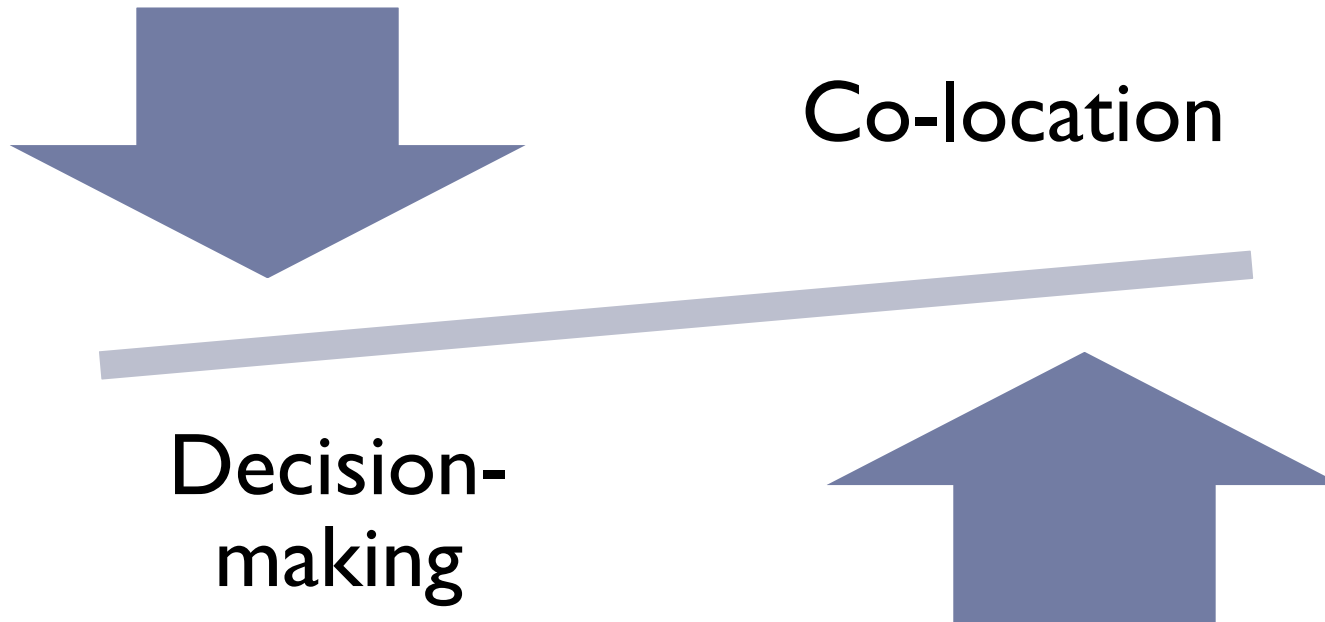
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# Levels of integration

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- 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.

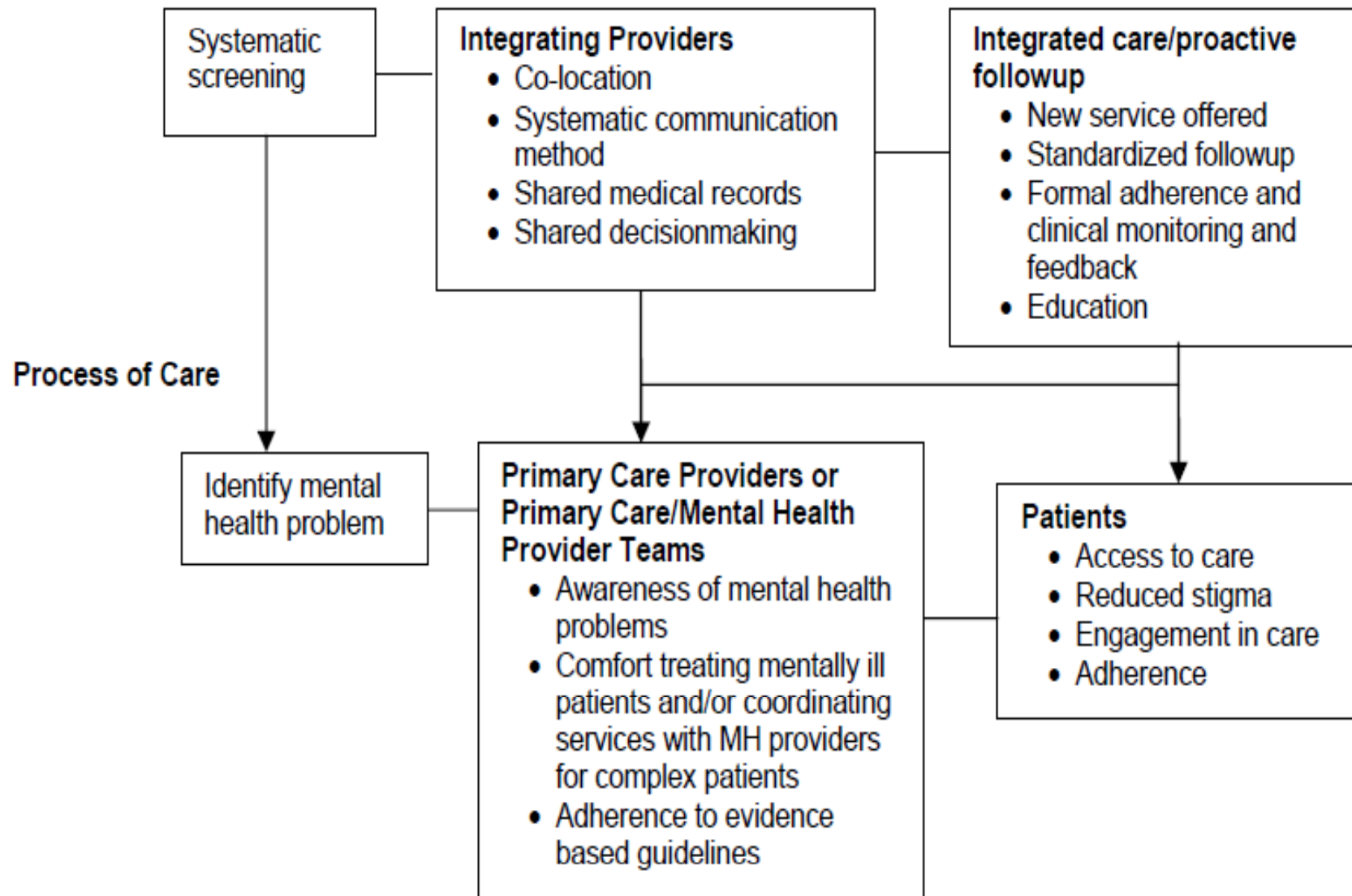
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## Characteristics of Integrated Models



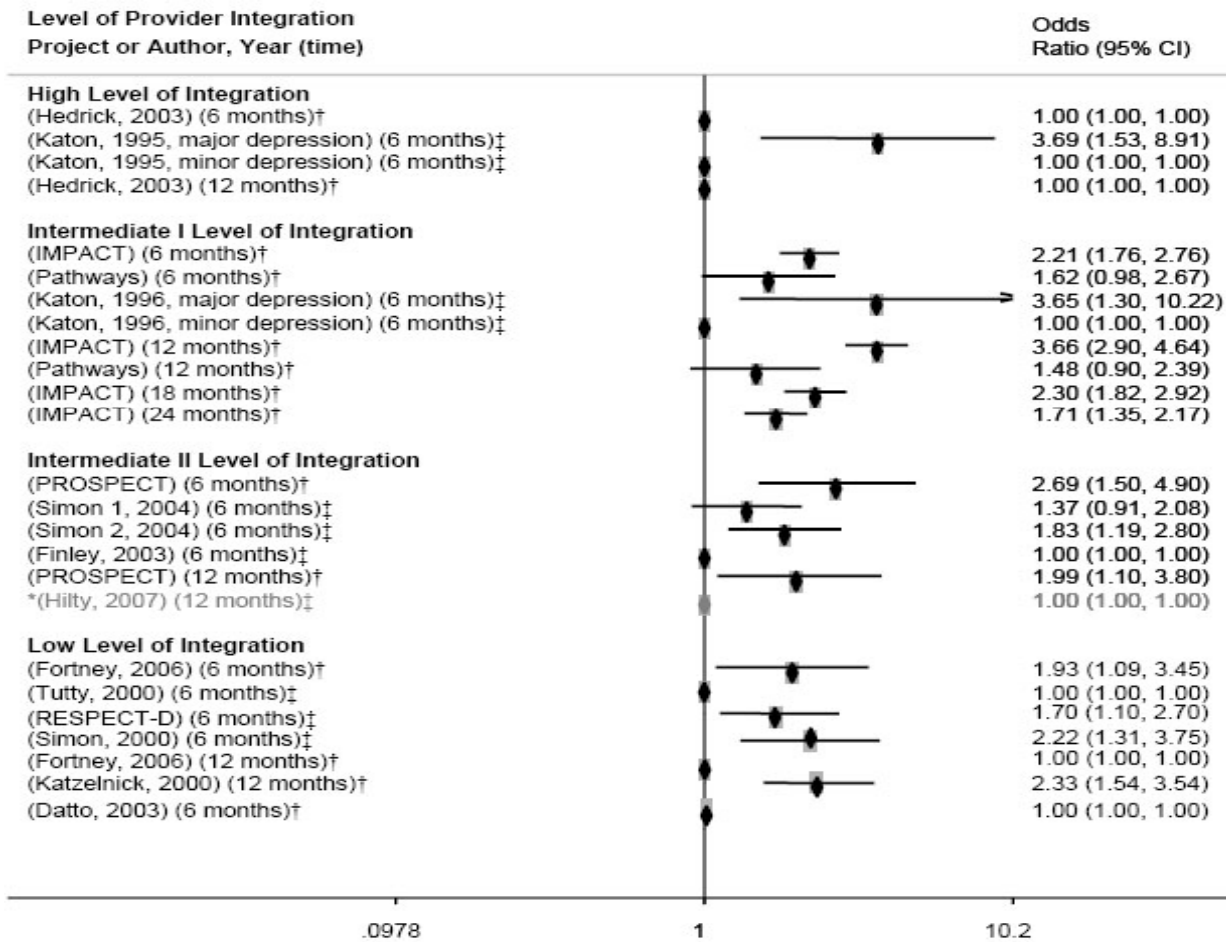
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  - ▶ Is it do-able?

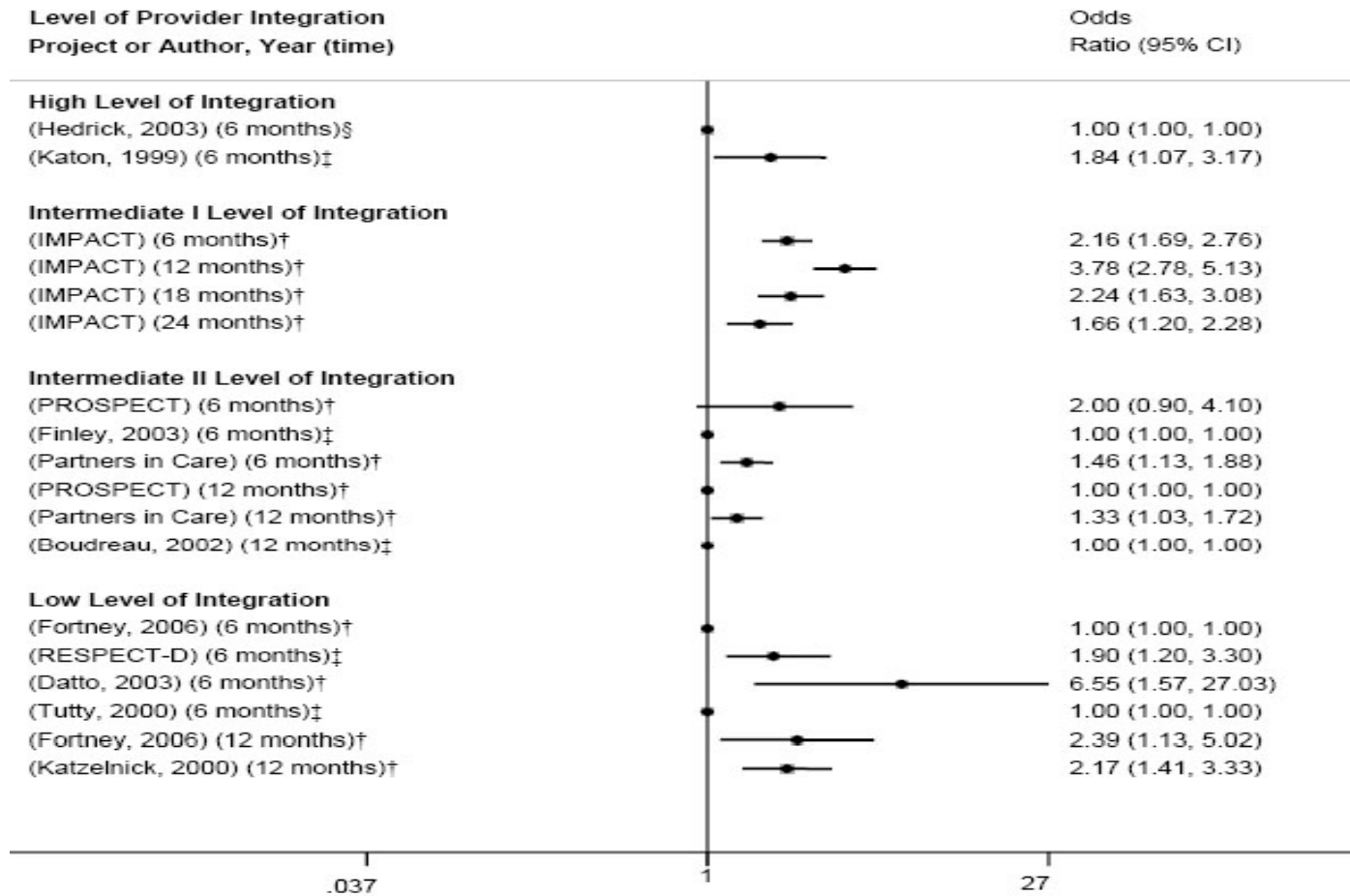


# RESULTS of AHRQ Comprehensive Systematic Review Treatment Response by level of Provider Integration



\*Studies in grey indicate low quality  
 †Diagnosed patients—usual care  
 ‡Patients initiating treatment—usual care  
 §Diagnosed—enhanced referral

# RESULTS of AHRQ Comprehensive Systematic Review Remission Rate by level of Provider Integration



†Diagnosed patients—usual care  
‡Patients initiating treatment—usual care  
§Diagnosed—enhanced referral

# The Solution: the middle way

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  - ▶ Is there evidence that it works?
  - ▶ **Is it do-able?**



## Financial Barriers

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

# Potential Solutions

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- ▶ 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

# Organizational Barriers

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- ▶ 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

## Organizational Solutions

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

## Example 1: TEAMCare

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- ▶ 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 HAIC  $\geq 8.5$ , bp  $> 140/90$  or LDL  $> 130$ , and PHQ-9  $\geq 10$
- ▶ Goals:
  - ▶ Improved depression care with behavioral activation and antidepressants
  - ▶ Improve medical disease control; HAIC, HTN, LDL
  - ▶ Improve self-care (diet, exercise, tob cessation, glucose testing)

# Example 1: TEAMCare

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## ▶ 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\*

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- ▶ 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



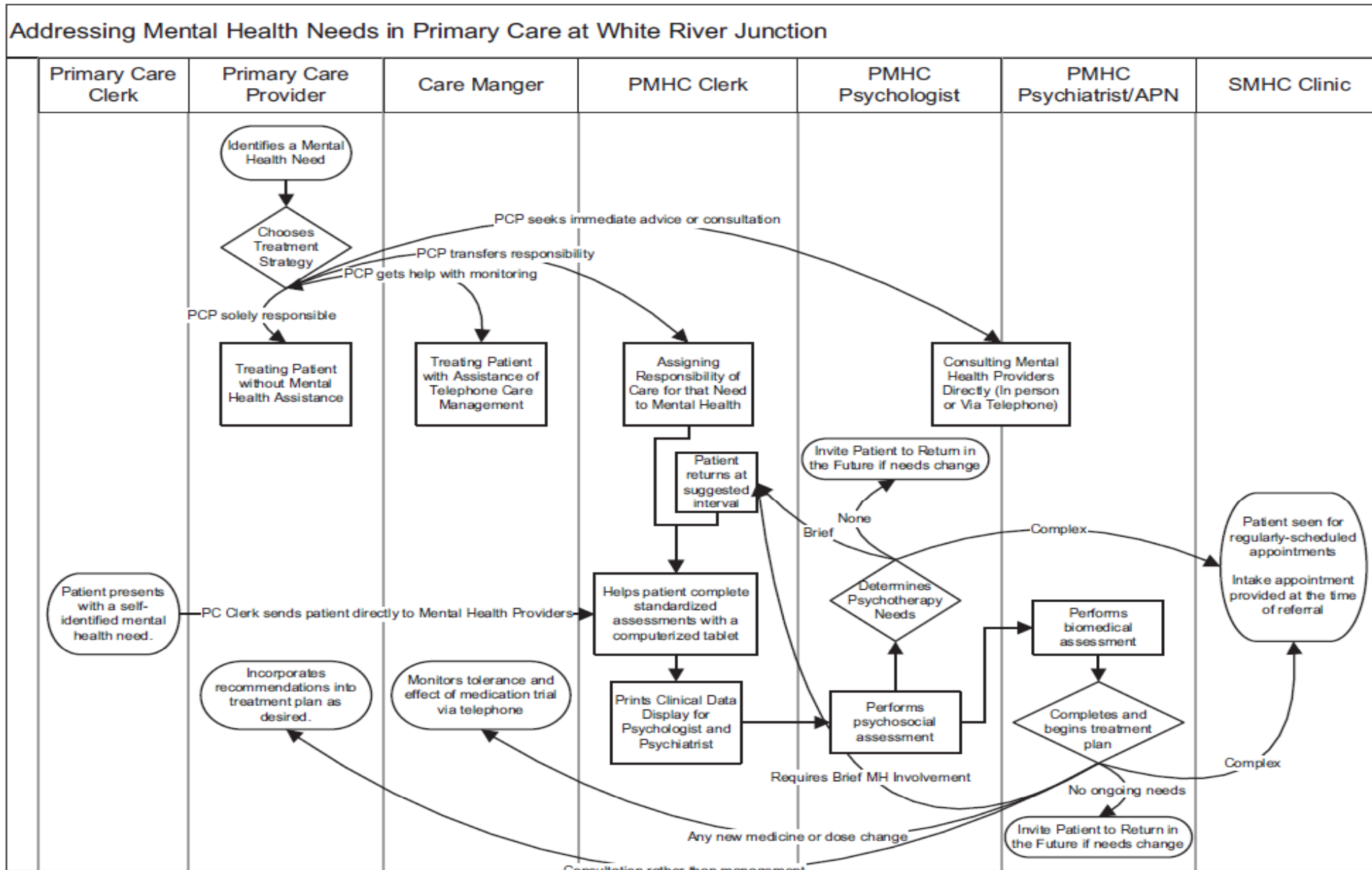
## Example 2: DIAMOND MODEL\*

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- ▶ 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



# What does this mean for your practice?

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- ▶ 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



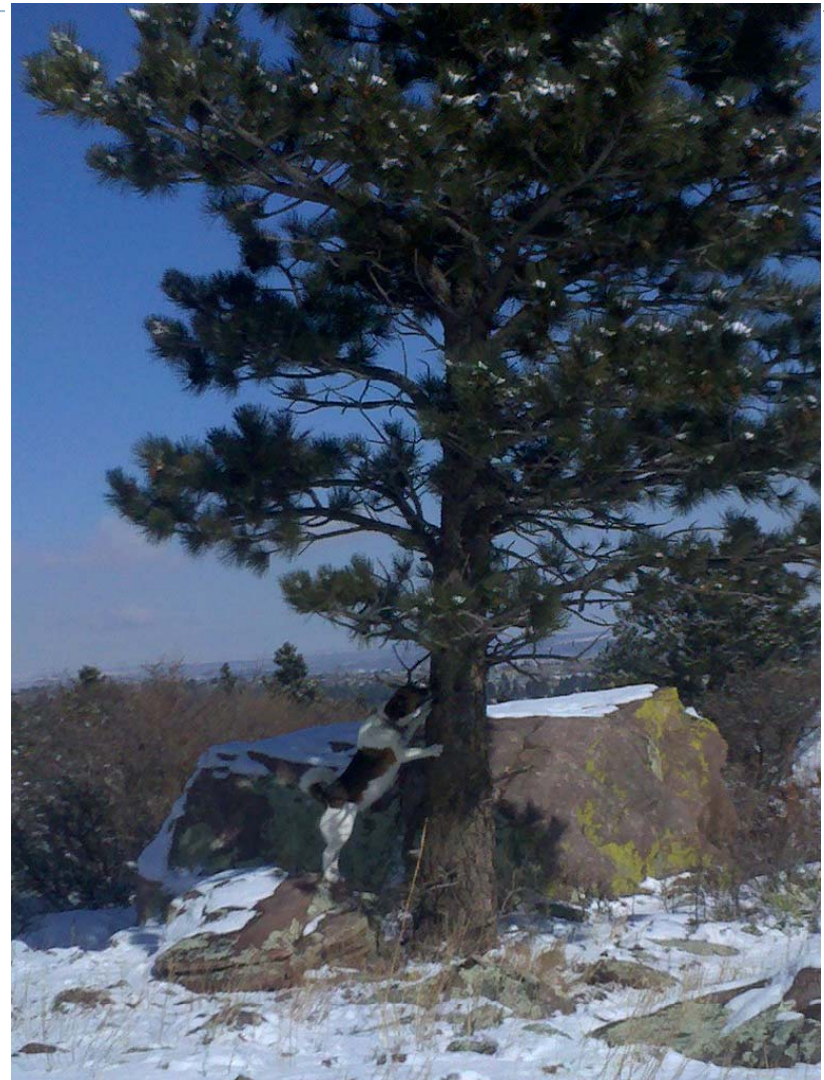
# Questions?



# Acknowledgements

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