



Integrated Behavioral Health in Primary Care

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GIM Grand Rounds

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What do you do?

32 y/o healthy female with resolved Graves' disease s/p workup for breast lump. Seen twice in 2 weeks prior to US; had US done and received phone call with normal result within 2 days of US. Returns for 3rd week in a row to discuss concerns about lump and workup. Is undocumented and only has coverage for primary care services. She is obviously anxious during the initial interview.

What do you do?

46 y/o female with closed head injury from MVA, memory loss, chronic pain, chronic headaches, OSA, s/p gastroplasty for obesity, B12 deficiency, asthma, knee osteoarthritis, GERD, & hypoglycemia with worsening depression because of partner's diagnosis of breast cancer. On celexa 40 mg 3 tablets daily, ritalin 20 mg, topamax 150 mg daily, plus 8 others. Is on the 'discount program' which doesn't cover mental health services.



Outline/Objectives

- Problem of mental health disorders in primary care
- Models for delivery of mental health care
- Integrated Care
 - Define
 - Describe the evidence base
 - Discuss barriers



Mental health problem in primary care: Depression

- 6-10% of primary care pts meet dx criteria for Major Depressive Disorder
 - ~ 50% are accurately diagnosed
- DM + depression: how well do we capture and treat?
 - Universal screening done with mailed PHQ-9
 - 51% were diagnosed prior to that screening
 - 33% received adequate pharmacotherapy
 - 6.7% received adequate psychotherapy

Katon et al. Prim Care Companion CNS Disorder. 2011; 13(1): PC10r01019blu.
Katon et al. Med Care 2004(12): 1222-1229

Why mental health is important: Depression

- Impairs of psychosocial functioning if untreated/undertreated
 - As bad or worse than impairment from DM, HTN, arthritis
- Occurs with co-morbid illness
 - Increases the risk of poor management of these co-morbid conditions
 - Mancuso et al, Chest 2008
 - Poor asthma control and increased asthma severity associated depressive symptoms in patients

Katon et al. Prim Care Companion CNS Disorder. 2011; 13(1): PC10r01019blu.
Mancuso et al. Chest 2008; 133(5):1142-1148.

Challenges in treating : Depression

- **Implementation of clinical guidelines difficult**
 - 52% received any treatment
 - 42% received adequate treatment
- **Adherence poor**
 - 49% stop antidepressants early
 - 50-75% don't take meds for the recommended length of time
- **Medical system barriers to depression care**
 - Time, training, knowledge
 - Lack of registries
- **Legal barriers**
 - HIPAA – limits communication and information sharing
- **Financial**
 - Reimbursement for mental health a mess!

Mental health in primary care



Models for mental health care

1. Traditional “specialty” model
2. Special referral relationship
3. Co-location
 - On-site behavioral health unit or team
4. Collaborative care
 - Same site and same cases
5. Integrated care
 - The BH specialist is a member of the primary care team



Minimal Collaboration (traditional model)

- Separate facilities at separate systems
- Rare communication
- Works for...
 - Cases with routine medical or psychosocial problems that have little biopsychosocial interplay and few management difficulties

Basic Collaboration at a Distance (special referral relationship)

- Separate systems at separate sites
- Periodic communication driven by specific issues
- Little sharing of power & responsibility
- Works for...
 - Cases with moderate biopsychosocial interplay, for example, a patient with diabetes and depression where the management of both problems proceeds reasonably well

Basic Collaboration On-Site (co-location)

- On-site behavioral health
- Separate systems but same facility
- Regular communication
- Works for...
 - Cases with moderate biopsychosocial interplay that require occasional face-to-face interactions between providers to coordinate complex treatment plans



Close Collaboration in a Partly Integrated System (collaborative care)

- Same site and same cases, some common systems
- Regular face to face interactions
- Works for...
 - Cases with significant biopsychosocial interplay and management complications



Close Collaboration in a Fully Integrated System (integrated care)

- The behavioral health specialist is a member of the primary care team
- Same sites, same vision, and same systems

- Works for...
 - The most difficult and complex biopsychosocial cases with challenging management problems



Coordinated vs. Co-located

- Coordinated
 - Information exchange on a routine basis
 - Success is dependent on providers' efforts
- Co-location
 - Usually has a referral system in place
 - Cases begin as medical and then are later referred for behavioral health
 - Physical closeness fosters communication
 - Medical providers enjoy providing behavioral health services to pts with (because of) the support
 - Encourages conversations about psychosocial issues (help is readily available if it gets beyond their expertise)
 - Improves show rates

Integrated Care

- One treatment plan with team delivering care
 - “Warm hand-off” during PCP visit
 - Open/frequent communication among team members
- Chronic disease management approach
 - Regular screening
 - Protocols for addressing the illness
 - Database/registry
 - Staff to manage the care
- Can work in either direction
 - mental health care → primary care
 - primary health → mental health care

TABLE 1: FOUR QUADRANTS OF CLINICAL INTEGRATION BASED ON PATIENT NEEDS

	QUADRANT II	QUADRANT IV
HIGH ↑ BEHAVIORAL HEALTH RISK/COMPLEXITY ↓ LOW	Patients with high behavioral health and low physical health needs Served in primary care and specialty mental health settings (Example: patients with bipolar disorder and chronic pain) Note: when mental health needs are stable, often mental health care can be transitioned back to primary care.	Patients with high behavioral health and high physical health needs Served in primary care and specialty mental health settings (Example: patients with schizophrenia and metabolic syndrome or hepatitis C)
	QUADRANT I	QUADRANT III
	Patients with low behavioral health and low physical health needs Served in primary care setting (Example: patients with moderate alcohol abuse and fibromyalgia)	Patients with low behavioral health and high physical health needs Served in primary care setting (Example: patients with moderate depression and uncontrolled diabetes)
	LOW ←————— PHYSICAL HEALTH RISK/COMPLEXITY —————→ HIGH	

Source: Adapted from Mauer 2006.



Why integrate mental health into the primary care setting?

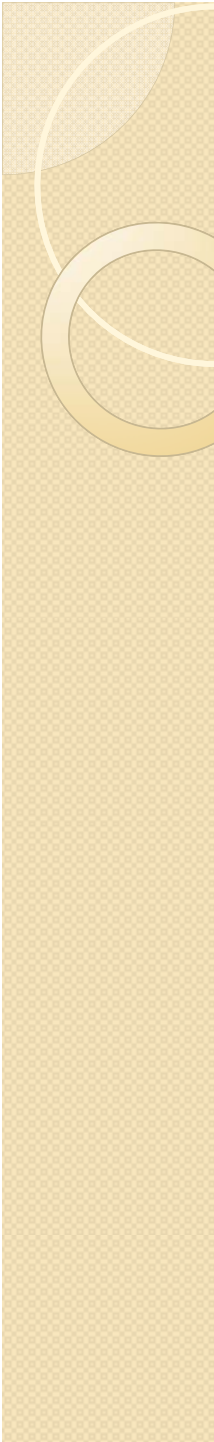
1. Mental health problems often don't get treated
2. Patients with mental health problems are seen as frequently in PC as in mental health care settings
3. Patients are more likely to see a PCP each year than a mental health specialist
 - PCPs may be in the best position to recognize and improve rates of appropriate treatment
4. Co-morbid physical health problems are common in those with mental health problems.
5. Common mental health problem treatment can be effectively delivered in primary care

From Integration of Mental Health/Substance Abuse and Primary Care Agency for Healthcare Research and Quality Publication No. 09-E003 October 2008



What is happening at DH clinics

- Integrated care in 2 clinics
- Colorado Health Foundation Grant
 - Full-time BHCs at Eastside and Westside (Lowry and FIM already have BHCs)
 - Psychologists or social workers
 - Part-time psychiatrist
 - Measurement of outcomes in the clinics with integrated care model



What is the evidence base for integrated care?

- Is there improvement in the...
 - Quality of mental health care?
 - Control of chronic medical conditions?
- Studies
 - Multiple meta-analyses
 - Large RCTs
 - IMPACT, PROSPECT, RESPECT, Pathways
 - Implementation studies
 - TIDES, DIAMOND



Improved outcomes: depression

- Improved adherence (meta-analyses, IMPACT)
- Improved pt satisfaction with treatment (meta-analyses, Pathways)
- More depression free days (meta-analyses)
- Lower depression severity (IMPACT, PROSPECT, Pathways)
- Higher rates of treatment response (IMPACT)
- Higher rates of complete remission (IMPACT)
- Less functional impairment (IMPACT)
- Better quality of life (IMPACT, PROSPECT)
- Reduced suicidal ideation (PROSPECT)
- Improved adequacy of dosing of antidepressants (Pathways)



Improved outcomes: other

- Mental health disorders studied
 - Anxiety (4 studies)
 - Somatizing disorders (one study)
 - Attention Deficit and Hyperactivity Disorder (one study)
 - At-risk alcohol disorders (one study)
- Results
 - Worked for anxiety
 - No change in somatization, ADHD, & at risk-alcohol use

From Integration of Mental Health/Substance Abuse and Primary Care Agency for Healthcare Research and Quality Publication No. 09-E003 October 2008



Is there improvement in the control of chronic medical conditions?

- What has been studied
 - IMPACT
 - Depression & arthritis in elderly adults
 - Pathways
 - Depression & diabetes control
 - A pilot trial
 - Depression & hypertension adherence/control
 - In all, depression care & outcomes improved

IMPACT: depression & arthritis

- Does collaborative care for depression improve pain and functional outcomes in older adults with depression and arthritis?
- RCT of 1001 depressed older adults with arthritis
- Depression care managers vs. usual care
- Outcome Measures (interviews)
 - Depression, pain intensity, interference with daily activities due to arthritis, general health status, and overall quality-of-life
- Results at 12 months (intervention vs. control)
 - Lower pain intensity
 - Lower interference with daily activities
 - Higher overall health and quality of life

IMPACT: depression & arthritis

- Does collaborative care for depression decrease arthritis pain and disability among older adults at different levels of pain?
- RCT -1001 elderly with depression & arthritis
- Depression care managers vs. usual care
- Outcome Measures (interviews)
 - arthritis pain severity, activity interference, depression, analgesic use, overall functional impairment, and coexisting medical conditions
- Results (intervention vs. usual care)
 - Pts with lower initial pain severity had decreases in pain
 - Pts with higher initial pain severity did not have decreases in pain

Pathways: DM & depression

- Does enhancing the quality of care for depression improve both depression and diabetes outcomes?
- RCT of 329 patients with DM & major depression +/- dysthymia.
- Pathways case management intervention vs. usual care
 - Enhanced education/support OR problem-solving therapy
 - Stepped approach for failures
- Outcome Measures
 - surveys: depression assessment, global improvement, & satisfaction with care
 - automated clinical data: adherence to antidepressant regimens, % receiving specialty mental health visits, and HgbA1c levels
- Results (intervention vs. usual care)
 - no differences in HgbA1c
- Conclusion: improved depression care alone did not result in improved glycemic control

Katon et al. Archives of General Psychiatry 2004; 61(10):1042-9.



Hypertension & depression

- Does integrated depression care improve hypertension adherence & control?
- RCT of 64 pt prescribed meds for HTN & depression
- integrated care vs. usual care

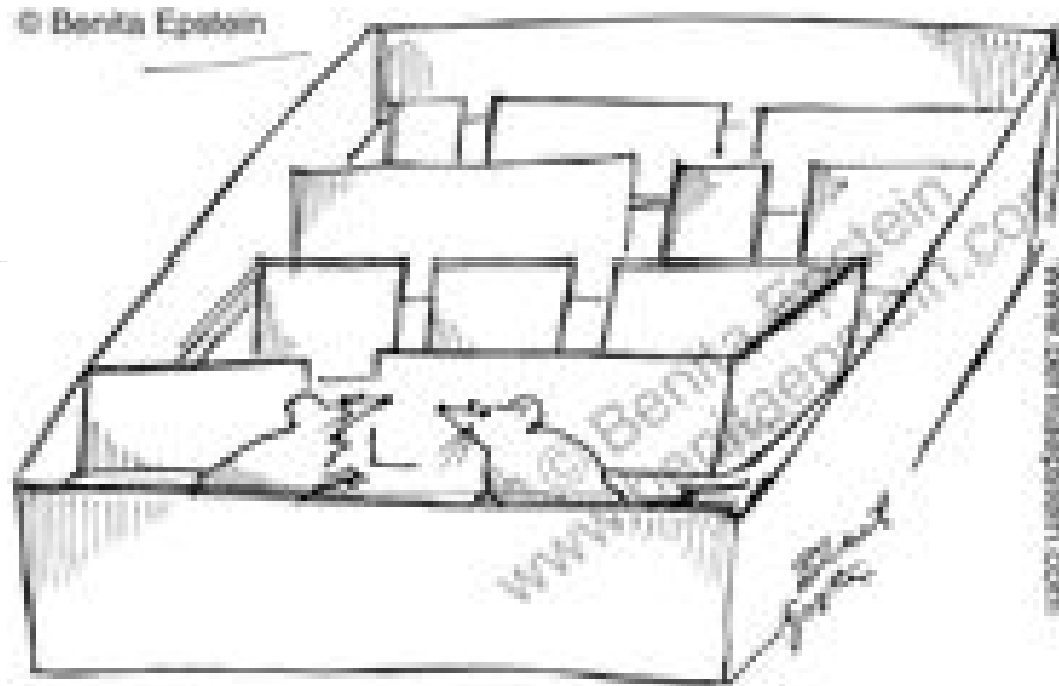
- Outcome Measures
 - Depression scale via interview
 - Electronic record for BP control & medication adherence
- Results (intervention vs. control)
 - Lower systolic BP
 - Greater adherence to BP medication
- Conclusion: integration of depression care improves patient outcomes in hypertension

Is Integrated Care Cost Effective?

- Systematic review (2010)
 - 8 'good' studies found
- Inconsistent measure between studies
- All studies found collaborative care more effective but more expensive
 - 6 studies – depression free days
 - \$20 - \$24/depression free day in direct costs
 - 4 studies - QALY
 - \$21,478 – \$49,500
 - direct & indirect costs of all health care services
 - One study - direct costs over 4 yrs
 - Intervention: \$29,422
 - Control: \$32,785

Van Steenberg-Weijenburg et al. BMC Health Services Research 2010, 10(19).

If it is so good, what's the problem?



"This is easier than navigating through Medicare."



Barriers: financial

- Carved out of behavioral health services from primary care
- Benefit designs often prohibit reimbursement for mental health services by primary care physicians (except usually the initial visit)
- Often can't bill for a therapy visit the same day as an evaluation & management visit (state/insurance dependent)
- No reimbursement for consultation between providers, team meetings, or telephone calls
- No reimbursement for care management
- No reimbursement for telephone care



HRSA/SAMHSA/CMS report on reimbursement

1. State Medicaid restrictions on payments for same-day billing
2. Lack of reimbursement for collaborative care and case management related to mental health services
3. Lack of reimbursement of services provided by non-physicians, alternative practitioners, & contract practitioners
4. Medicaid disallowance of reimbursement when primary care providers submit bills listing only a mental health diagnosis and corresponding treatment
5. Reimbursement rates in rural and urban settings
6. Difficulties in getting reimbursement for mental health services in school-based health center settings
7. Lack of reimbursement incentives for screening and providing preventive mental health services

<http://store.samhsa.gov/shin/content//SMA08-4324/SMA08-4324.pdf>



What is happening in CO

- Examples of successes in primary care
 - Mirallac clinic in Grand Junction, CO
 - Clinica Campesina in NW Denver suburbs
- Legislative action (?)
 - CO HOUSE BILL 11-1242
 - Seeking input from stakeholders about the barriers to integrated care and what regulations can be changed to remove those barriers
 - Seeking input about how to incentivize integrated behavioral health

Conclusions

- Integration is a promising model
 - Needs more medical outcome research
 - Needs reform of payment systems
- Patient follow-up: both doing well!



"Ever notice the medical programs never show the dashing young doctors doing paperwork?"