Integrating Behavioral Health in Primary Care

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Disclosure

- No conflict of interest
- Will not be discussing off label use of medications

Objectives

- Participants will be able to discuss current evidence to support the integration of BH in primary care
- Participants will be able to discuss different processes for how to assess their organization’s readiness for integration
- Participants will be able to identify current models of integrated BH in primary care
- Participants will be able to discuss the use of depression and substance screening as an early step in BH integration
Current Health System

- **Silos of care in the US:**
  - Primary care or Urgent/Emergent Care for physical health related issues
  - Community Mental Health/ED’s for psychiatric related issues
  - Very limited substance treatment programs/detox/residential/ED’s for substance related issues

- The result: lack of access, long waiting lists, over-use of urgent and emergency care, premature death and chronic disability that could be preventable

Mind/Body Connection and co-morbidities

- Many physical conditions can have a psychiatric presentation (hyper/hypothyroidism)
- There are psychiatric complications of medical illnesses (cancer, diabetes, cardiovascular diseases)
- Significant association of depression and worsening of diabetes, cardiovascular diseases and other chronic illnesses such as HIV
- Can have psychiatric complications of treatments of medical illnesses (HIV treatment, Hep C tx, cancer tx)
- Co-morbidities of medical and psychiatric illnesses are more common than not

Primary Care

- Primary care is our best venue for improving population health and for controlling medical cost
- Primary Care is the only thing you can do MORE OF and get lower cost and better care
- Screening for preventable illnesses and early intervention for high risk individuals will results in lower health care costs in the long run
What is Integrated care?

- SAMHSA: Systematic coordination of general and behavioral health. Integrating mental health, substance abuse and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.
- AHRQ: Care resulting from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

7 Good Reasons for BH integration into Primary care

From the WHO:
1. The burden of mental disorders is great from social and economic perspective.
2. Mental and physical health problems are interwoven.
3. The treatment gap for mental disorders is enormous.
4. Primary care for mental health enhances access.
5. Primary care for mental health promotes respect of human rights.
6. Primary care for mental health is affordable and cost effective.
7. Primary care for mental health generates good health outcomes.

Integrated vs. Collaborative Care

- The American Academy of Family Physicians’ (AAFP) Collaborative Care Research Network (CCRN) has also defined the additional term “collaborative care” (CC).
- CC is one model of behavioral health integration in primary care.
- CC is also a comprehensive approach to health that sees no distinction between your mind and body, but rather focuses on your overall health. Integrating mental (behavioral) health services into primary care is one successful avenue for treating the health care of the whole person.
Collaborative Care Model

- Over the past 15 years, more than 70 randomized controlled trials have established a robust evidence-base for an approach called "collaborative care", especially for depression treatment in primary care.
- Collaborative Care Model more than doubled the effectiveness of depression treatment in primary care setting.
- CC yielded net savings in every category: health care costs examined, including pharmacy, inpatient and outpatient medical and mental health care.
- CC programs follow the principles of measurement-based care, treatment to target, and stepped care.
- Patient’s progress is closely tracked using validated clinical rating scales.
- Treatment is systematically adjusted – stepped up – if patients are not improving as expected, getting input from the psychiatric consultant.

IMPACT Model for Depression

- The largest trial of collaborative care is the IMPACT study, included 1,801 adults age 60 and older with depression, in 18 primary care settings in five states.
- IMPACT participants were more than twice likely as those in the usual care control group to experience a substantial improvement in their depression over 12 months.
- They also had less physical pain, better social and physical functioning.
- CC, which is used as a basis for IMPACT, has been recognized as evidence-based integrated care practice by SAMHSA and recommended as a best practice by the Surgeon General’s Report on Mental Health.

IMPACT Model for Depression treatment

The IMPACT Treatment Model Collaborative care model includes:

- Care manager (RN, behavioral health counselor): focus on care coordination, screening, education, symptom tracking, brief motivational session, providing coaching for managing illness.
- Consultation with behavioral health providers and psychiatric providers for management of symptoms.
- Team meetings to discuss more complex patients.
Substance issues in Primary Care

- Screening, brief intervention, and referral to treatment (SBIRT) is an evidence-based approach that health care providers can use to identify at-risk and high risk substance use for use in primary care.
- SBIRT has a level of evidence similar to that of colorectal cancer screening and exceeding that of cholesterol screening or obesity treatment.
- The U.S. Preventive Services Task Force also recently endorsed universal alcohol screening for patients age 18 and older in primary care.

SBIRT

SAMHSA defines a comprehensive SBIRT model:

- It is brief (e.g., typically about 5-10 minutes for brief interventions; about 5 to 12 sessions for brief treatments).
- The screening for substance use is universal.
- One or more specific behaviors related to risky alcohol and drug use are targeted.
- The services occur in a public health non-substance abuse treatment setting.
- Strong research or experiential evidence supports the model’s effectiveness.

SBIRT in primary care

- ASSIST
- CRAFFT
- AUDIT
- One Marijuana screening question
- Screening for opiate use
- Brief intervention uses motivational interviewing techniques to assist individual to cut down or stop risky substance use
- Referral to treatment has been found to work best in co-located or integrated settings
10 principles for Integrated BH Care into Primary Care

1. Policy and plans need to incorporate primary care for mental health.
2. Advocacy is required to shift attitudes and behavior.
3. Adequate education of primary care workers is required.
4. Primary care tasks must be limited and doable.
5. Mental health professionals and facilities must be available to support primary care.
6. Patients must have access to essential psychotropic medications in primary care.
7. Integration is a process, not an event.
8. A service coordinator is crucial.
9. Collaboration with other government non-health sectors, nongovernmental organizations, village and community health workers, and volunteers is required.
10. Financial and human resources are needed.

World Health Organization

Integrated care, is your organization ready?

- Organizational readiness?
- Do you have the capacity for tracking outcomes, collecting data?
- What are the populations you serve?
- Do you have the right staffing?
- Coordinated versus Co-located versus Integrated, what is right for you now and what is your plan for the future?

SAMHSA Levels of Integration

<table>
<thead>
<tr>
<th></th>
<th>Coordinated</th>
<th>Co-located</th>
<th>Integrated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some screening in place</td>
<td>Sharing of screening</td>
<td>Shared screening and warm hand-offs</td>
<td></td>
</tr>
<tr>
<td>All systems separate</td>
<td>systems may be separate</td>
<td>Shared information systems</td>
<td></td>
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<tr>
<td>Physical and BH separate</td>
<td>PH and BH share space</td>
<td>Frequent team meetings</td>
<td></td>
</tr>
<tr>
<td>ROI in place for communication</td>
<td>Systems in place for communication</td>
<td>Population-based practices with community</td>
<td></td>
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<tr>
<td>Information not easily shared</td>
<td>Collaborate on TX planning for specific pts</td>
<td>Collaborative TX planning</td>
<td></td>
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<tr>
<td>Billing separate</td>
<td>Billing separate</td>
<td>Billing system integrated</td>
<td></td>
</tr>
<tr>
<td>PH providers are separate</td>
<td>needs are treated separately</td>
<td>BH and PH of patients seen as one, treated as co-morbid</td>
<td></td>
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<tr>
<td>Referral network in place for BH</td>
<td>Referral are easier</td>
<td>Warm handoffs</td>
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<td>Providers see their traditional role</td>
<td>More understanding of roles of other disciplines</td>
<td>Provider flexibility, different role</td>
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How do you measure success?
Quality Improvement/Development of benchmarking to identify success:

• Define—Describe—Develop—Diligence
• What population, what screening? What is available in EHR to measure change? Can we develop this? Who is going to monitor for this and how often? How long are you going to measure this?
• Provider feedback individually or collectively?
• Administrative measures? No shows, admissions, discharges, transfers? Referrals and follow-up documented?
• Billing and charges?

Examples

• Clinic just began that hired primary care providers and behavioral health providers. See patients separately, share MAs. Some provider resistance to asking about BH issues
• PCP wants to hire BH provider due to all of the patients she/he has with depression but leadership convinced that productivity will suffer
• Other organizations?

References

• Unützer et al, JAMA 2002; 288:2836-2845
• http://www.samhsa.gov/sites/default/files/sbirtwhitepaper_0.pdf
• http://www.integration.samhsa.gov/clinical-practice/screening-tools
References
Care: A Report from the American College of Physicians January 30, 2006

http://www.integration.samhsa.gov/integrated-care-models/
Healthcare_Integration_In_the_Era_of_ACA.pdf

http://aims.uw.edu/impact-improving-mood-promoting-access-collaborative-treatment/