Making Integration Work:
Theoretical and Practical Essentials

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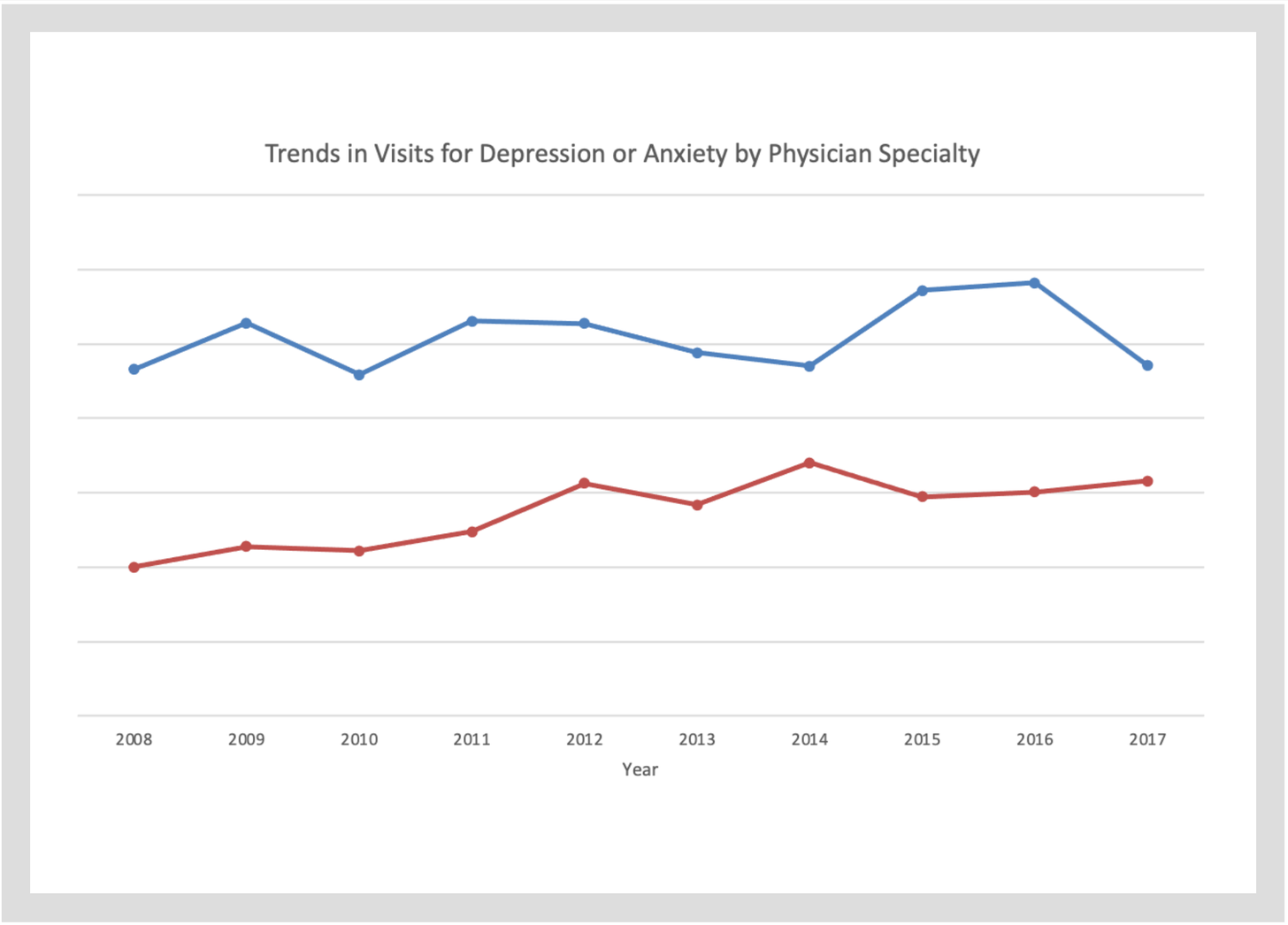
LET'S START WITH… THE "WHY"?

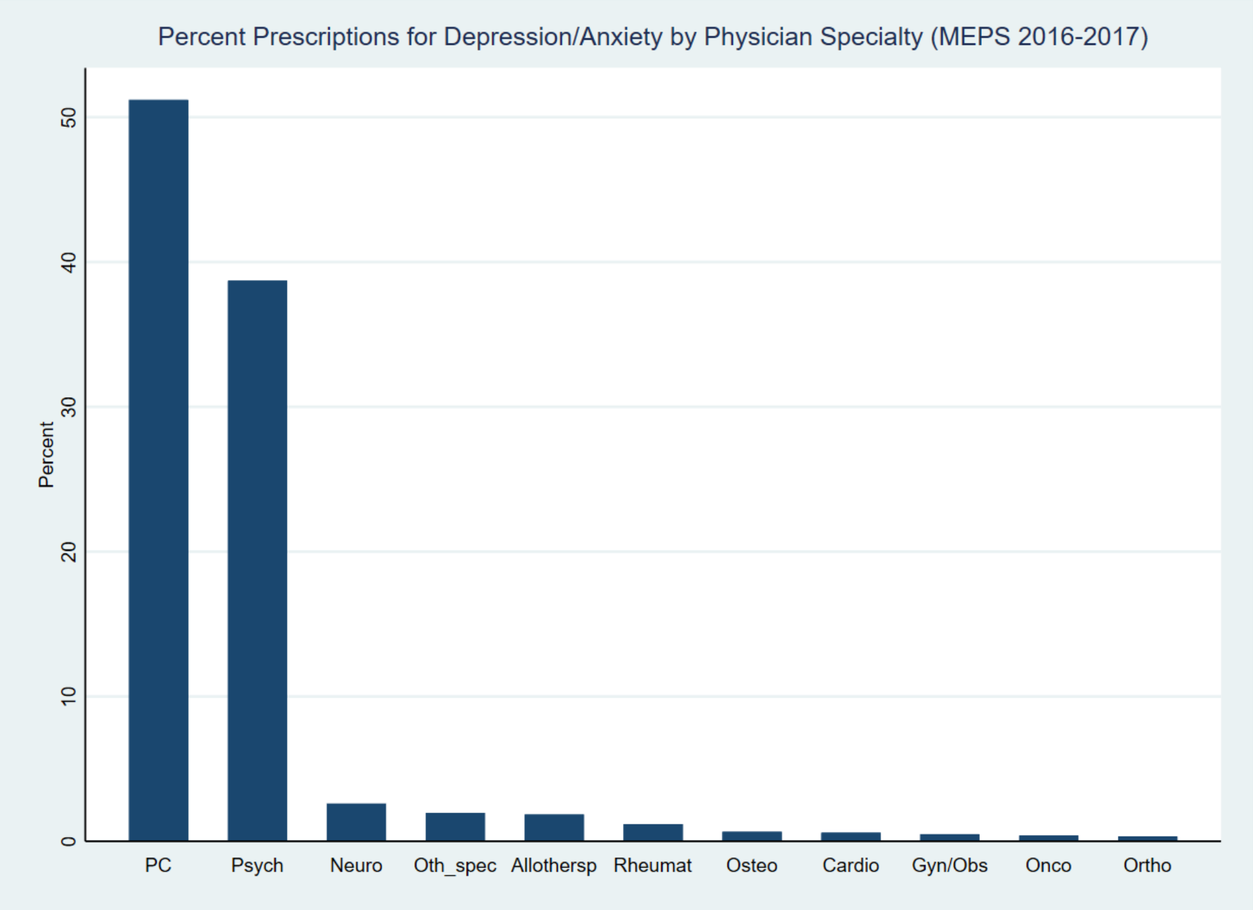
The Rationale for Integrated Care

PRIMARY CARE: THE DE FACTO MENTAL HEALTH SYSTEM

Primary care is the "de facto" mental health care system of the country



PRIMARY CARE: THE DE FACTO MENTAL HEALTH SYSTEM



PRIMARY CARE: THE DE FACTO MENTAL HEALTH SYSTEM

76% of all mental health care treatment is done in primary care only [1]

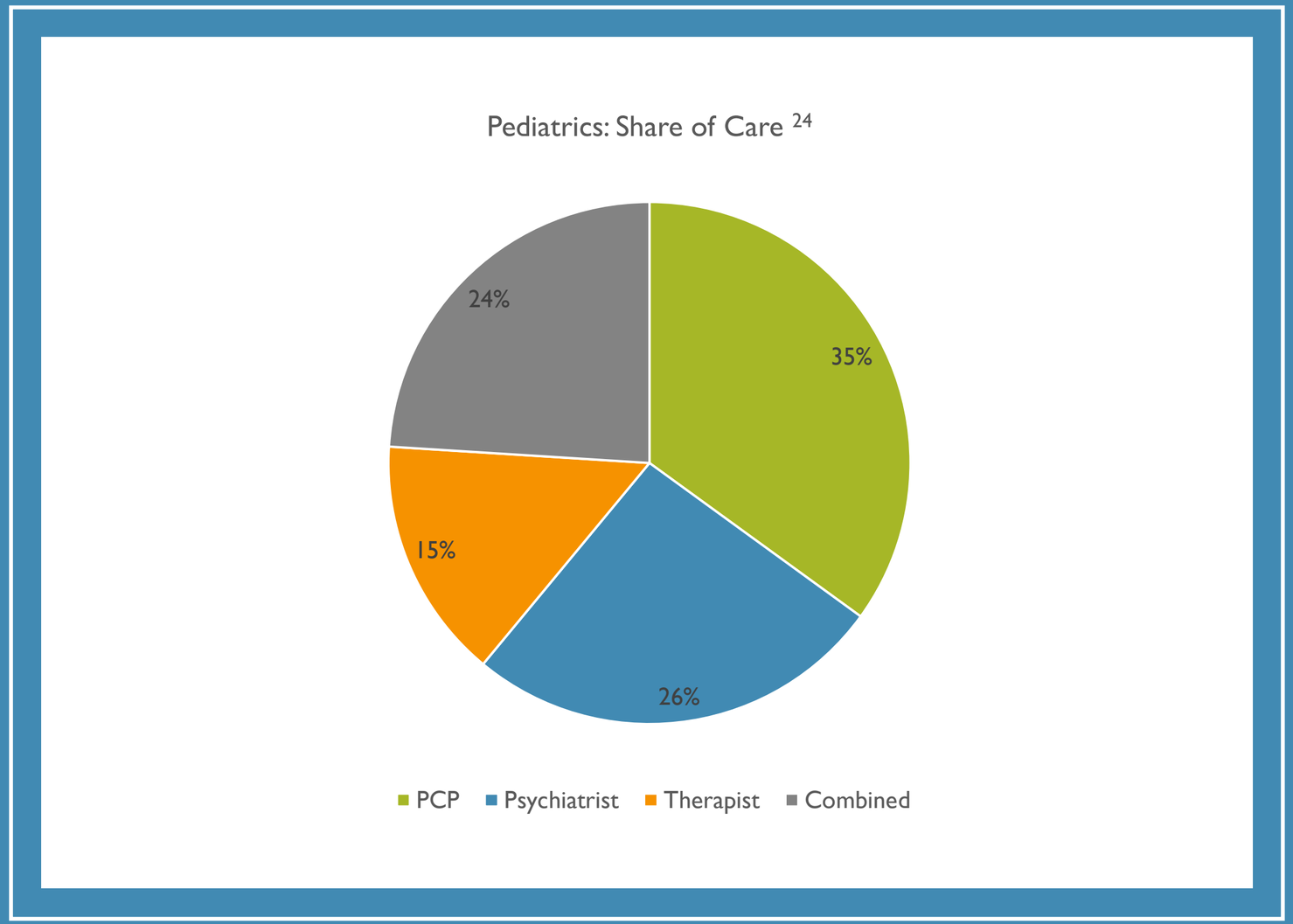
PCPs prescribe more medication for serious mental illness (including antipsychotics) than psychiatrists [2]

Visits to PCPs for mental health concerns increased 50% (16% of all visits) from 2006-2018 [3]

25% of pediatric primary care and ~ 50% of pediatric visits involve behavioral, developmental, emotional, educational and/or psychosocial concerns [3]

Takeaways: Primary care is the main source of mental health care, and integration must assist with the full range of ages and psychiatric conditions

YES, IT'S TRUE FOR KIDS, TOO



SPECIALTY MENTAL HEALTH (SMH): THE ACCESS PROBLEM

66% of PCPs report having no access to SMH [9]

25% of US population has a MH disorder [5], but only 6% visit SMH [5]

Only 20% of children with a MH problem see a MH provider [6]

- But 75% visit a pediatrician [6]

Only 34% of adults with a MH problem see a MH provider [7]

- But 86% talk with a health care provider of some sort (e.g., a PCP) [7]

SPECIALTY MENTAL HEALTH (SMH): THE ACCESS PROBLEM

Question:

What are the barriers to patients accessing SMH?

OBSTACLES TO SMH ACCESS: SYSTEMS AND PATIENT FACTORS [9,10]

Long waitlists, due at least in part to:

- Lengthy visits (typically one hour)
- Extended follow-up

Limits on MH provider's scope of practice

- Restrictions on ages seen
- Restrictions on type of problem seen

Patient's lack of resources

- Insurance/Financial limitations (e.g., many MHPs are cash-only)
- Patient lacks time for ongoing, frequent visits
- Lacks accommodations for visits (e.g., childcare, transportation)

Lack of diversity in the MHP workforce

Stigma

OBSTACLES TO SMH ACCESS: SYSTEMS AND PATIENT FACTORS [9,10]

Less familiarity, comfort with SMH

- Primary care in general is familiar to most people (MH is not)
- Patients may also be familiar with a specific clinic, staff

Patient views problem as "physical"

- Stress often produces physical symptoms (e.g., fatigue) that prompt a PCP (rather than MH) visit
- Patients may resist MH referral for perceived physical problem

Uneven geographic distribution of MHPs (mostly urban, coastal)

Takeaway: minimizing these barriers is key to the success of integration

THE FREQUENT INTERSECTION OF HEALTH AND BEHAVIOR (1/2)

- Aside from DSM conditions, PCPs manage behavior in many other ways:
  - Chronic disease management
    - Diabetes, hypertension, COPD, heart disease, etc.
    - PCPs assist patients with lifestyle changes
  - Physical symptoms with lifestyle/stress component
    - Chronic pain, obesity, chronic fatigue, headaches, etc.
    - PCPs assist with lifestyle change and counseling for stress
  - Psychosocial problems
    - Marital problems, IPV, child behavior problems, grief, etc.
    - PCPs counsel patients, connect them with resources

THE FREQUENT INTERSECTION OF HEALTH AND BEHAVIOR (2/2)

- Aside from DSM conditions, PCPs manage behaviors in many other ways:
  - Preventive health
    - Tobacco cessation, diet/exercise change, safe sex practices, etc.
    - PCPs educate, assist patients regarding preventive lifestyle change
  - Treatment non-adherence
    - Incorrect use of medications, lack of follow-through on referrals, etc.
    - PCPs educate, problem-solve with patients to improve adherence

Takeaway: Integrated care must help with more than psychiatric conditions

THE FINANCIAL COST OF MENTAL HEALTH PROBLEMS

MH conditions can be costly to the system [11]

- Among patients with co-morbid physical and mental health conditions:
  - Total healthcare cost x 2-3 higher than those with only a physical condition (next slide)
  - The most costly 6% of these account for 44% of <u>all</u> healthcare costs
  - Yet only a small percentage of healthcare costs in these patients is MH care – almost all costs are medical care

Integrated primary care may reduce costs by 9-17% [11]

Takeaway: Improving identification, treatment of MH problems may reduce costs

Diagnosis	Annual Cost w/o Psych	Annual Cost w/ Psych	Cost Increase
Asthma	$ 6,828	$ 16,668	+ 244%
Back Pain	$ 19,488	$ 24,740	+ 147%
Cancer	$ 16,320	$ 28,056	+ 172%
CHF	$ 15,288	$ 23,940	+ 157%
COPD	$ 11,904	$ 25,056	+ 210%
DM (uncomp)	$ 9,732	$ 16,236	+ 167%
DM (w/ comp)	$ 21,852	$ 32,172	+ 147%
HTN	$ 8,256	$ 13,884	+ 168%

THE FINANCIAL COST OF PSYCHIATRIC CO-MORBIDITY [11]

PRIMARY CARE TAKES A TEAM

The work of a provider in primary care has become too involved for one person

PCP visits last about 18 minutes, on average [12]	Complex patients and multiple complaints per visit are common [13]	PCPs spend more time on administrative tasks than in patient visits [14]	No clear organic etiology to many presenting complaints [15]

The stressful work environment, low pay relative to other medical specialties [16] and other issues have led to a shortage of primary care providers nationally [17]

Takeaway: Integrated care must subtract from the PCP workload

PRIMARY CARE TAKES A TEAM

The quality of care for MH problems in usual primary care is often lower than it should be [18]

- MH problems are often not detected in primary care [19]
- Medications are heavily relied upon, even when patients prefer therapy [20]
- Medications are often stopped earlier than recommended, and used longer than recommended [21]

Most PCPs report insufficient training in treating MH problems and helping patients make healthy lifestyle changes [22]

Takeaway: Integrated care must improve the team's behavior change skills

TAKEAWAYS & IMPLICATIONS FOR US

Takeaway	Implication: To Succeed, Integrated Care Should…
Primary care provides the most mental health care of any specialty	Be prepared for a high volume of care
Primary care treats all ages and all types of psychiatric conditions	Utilize a generalist approach
Behavior factors into PCP visits in myriad ways	Help with more than the DSM disorders
Long waitlists are a barrier to SMH	Avoid waitlists
Therapist scope limits are a barrier to SMH	Avoid scope limits
Lack of resources is a barrier to SMH	Minimize resource demands on patients
Stigma is a barrier to SMH	Destigmatize care/Look like routine healthcare
Less familiarity/comfort with SMH is a barrier to SMH	Integrate into the routine operations of the clinic (scheduling, etc.)
Viewing a problem as physical is a barrier to SMH	Be highly accessible for patients who are wary or skeptical
Improving identification and treatment of MH problems may lower costs	Help primary care improve identification and treatment
Primary care is a high-demand environment for PCPs, team	Subtract from the PCP/team workload
Most primary care team members have insufficient training in bx change	Bolster the entire team's skills for behavior change

THE HOW?

The Structure of Integrated Care

THE *HOW*? DIFFERENT FLAVORS OF INTEGRATION

- Co-Located Therapy
- Primary Care Behavioral Health (PCBH) Model [23]
- Population-specific approaches:
  - Screening, Brief Intervention and Referral to Treatment (SBIRT)
  - Medication-Assisted Therapy (MAT)
  - Collaborative Care Model (CoCM)
- Others

Which Approach?
It Depends On Your Goals

Do You Wish To...	Or...
Be more accessible *	Spend more time with each patient
Focus on the population *	Focus on the individual
Share care *	Own the care
Improve primary care (for all) *	Improve mental health outcomes
Be a generalist *	Be a specialist

* Recommended

WHY FOCUS ON IMPROVING PRIMARY CARE FOR ALL?

- Primary care has high value if done well
  - Better health outcomes
  - Fewer healthcare disparities
  - Lower healthcare costs
- But…behavioral issues of patients hinder primary care
  - Longer visits
  - High stress
  - This negatively affects care for all

Thus, improving management of behavioral issues in primary care is key to helping primary care realize it's potential – for all

WHAT IT LOOKS LIKE

Integration in the PCBH Model [23]

SAMPLE CLINIC DAY: WHAT TO LOOK FOR

Timing of BHC visit *

- Before, after and with PCP
- Mix of scheduled and same-day visits

Variety of problems and ages

- Clinical ("mental" and "physical" conditions, all ages)
- Care management/coordination

Variety in the goals of visits

- Helping manage the patient
- Helping treat the patient

* Note the flexible visit length and start/stop times for visits

SAMPLE CLINIC DAY

9:00 (8:55-9:25)

PCP wants diagnostic guidance for medication selection

- 52 y/o homeless, ? ADHD vs. bipolar

9:30 (9:30-9:50)

Question re disability expiring

- 64 y/o Russian-speaker, depression

10:00 (9:55-10:30)

PCP says "I don't know her problem"

- 62 y/o, psychiatrist d/c'd, on 3 meds from 3 Drs

10:30 (10:45-11:00)

Open→Same-day w/ PCP in exam room

- 12 y/o autism, ADHD, recently showing tics, hallucinations

SAMPLE CLINIC DAY (CONT'D)

N/S → Same-day to prep for PCP visit

6 y/o ADHD, insomnia, enuresis

11:00 (11:15-11:35)

Cx → Same-day visit with BHC instead of PCP

- 65 y/o for smoking cessation/NRT refill

2:00 (2:05-2:25)

11:30 (11:40-12:10)

Planned f/u from 1 week earlier

- 20 y/o Spanish-speaker, depressed w/ SI

2:30 (2:50-3:10)

Open → warm-handoff to complete medication agreement

- 60 y/o severe etoh, chronic arm pain

- 12:00 Lunch
- 1:00 Team meeting (15-min talk on pain, 5-min on tobacco cessation)

SAMPLE CLINIC DAY (CONT'D)

3:00 (3:15-3:40)

Planned f/u after 2 weeks

- 47 y/o homeless, MDD w/ psychosis, acute SI due to meds

3:30 (3:40-3:55)

Planned f/u after 1 month

- 45 y/o homeless, MDD, trying to get disability

4:00 (4:10-4:40)

Cx → Warm-handoff to assist with PCP visit

- 16 y/o expelled from school, needs risk assessmt

4:30 (4:45-5:10)

Open → Same-day f/u after 4 mos

- 20 y/o seeking disability for PTSD, dep

TOP 10 SINKHOLES AND TRAMPOLINES

REITER'S TOP 10 SINKHOLES AND TRAMPOLINES

Sinkholes

1. Isolated location
2. Passive approach
3. Triage and refer
4. Meet-and-greets
5. Inefficient warm-handoffs

Trampolines

1. Be central and visible
2. Do today's work today
3. Believe in primary care
4. Be flexible with visit length
5. Efficient warm-handoffs

REITER'S TOP 10 SINKHOLES AND TRAMPOLINES

Sinkholes

6. Over-emphasize BHC interventions
7. Limit problem scope
8. Emphasize time (more = better)
9. Treat "diseases"
10. Have low expectations for BHC ("nicety")

Trampolines

6. Emphasize ways to help the PCP/team
7. Be a generalist (learn)
8. Emphasize access
9. Teach skills
10. Have high expectations for BHC ("necessity")

MOST IMPORTANT….KEEP THE FOCUS

Optimize access

Make primary care better

QUESTIONS? THANK YOU FOR INVITING ME!

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RECOMMENDED READINGS

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- (NOTE: This is part of a special edition)

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