Seamless: Integrating behavioral health and primary care

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“The health care delivery system is incapable of meeting the present, let alone the future needs of the American public.” (IOM, 2002)

“We have developed a health care system that is unable to deal with the varied roles that mind and body play in so-called physical illness.” (Levant, May, & Smith, 2006)
But first...

A STORY
Primary care has become the “de facto” mental health system (Regier et al, 1993)


When asked “would you rather work for change, or just complain?” 81% of the respondents replied, “Do i have to pick? This is hard.”
INTEGRATION IS INEVITABLE

5 ways

#1 Recognize fragmentation has spread

Physical Health  Mental Health
Care Delivery
Payment
Training and Education
Public Perception

Primary Care
#2: Mental health needs are going unmet

- 84% of the time, the 14 most common physical complaints have no identifiable organic etiology.\(^1\)
- 80% with a behavioral health disorder will visit primary care at least 1 time in a calendar year.\(^2\)
- 50% of all behavioral health disorders are treated in primary care.\(^3\)
- 67% with a behavioral health disorder do not get behavioral health treatment.\(^1\)
- 30-50% of referrals from primary care to an outpatient behavioral health clinic don’t make first appointment.\(^2,3\)


Two-thirds of primary care physicians (N=6,660) reported not being able to access outpatient behavioral health for their patients.

Those Who Might Benefit From BH Services

Those receiving BH care

Those not receiving BH care

#3: The patient-centered medical home

Joint Principles of PCMH
- Personal Physician
- Physician Directed Practice
- Whole Person Orientation
- Care is Coordinated and/or Integrated
- Quality and Safety
- Enhanced Access to Care
- Payment to Support PCMH
#4 We must begin to address comprehensiveness in an entirely new way

#5 Fragmentation is Costly

<table>
<thead>
<tr>
<th>Condition</th>
<th>Annual Cost – those without MH condition</th>
<th>Annual Cost – those with MH condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Condition</td>
<td>$4,697</td>
<td>$6,919</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>$3,481</td>
<td>$5,492</td>
</tr>
<tr>
<td>Asthma</td>
<td>$2,908</td>
<td>$4,028</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$4,172</td>
<td>$5,559</td>
</tr>
</tbody>
</table>


Before we get to the solutions, let's consider the evidence

EMPIRICALLY SUPPORTING INTEGRATION

- Quantitative & qualitative reviews\(^1-4\)
  - Depression\(^1-4\)
  - Panic Disorder\(^1-2\)

- Other Studies\(^5\)
  - Tobacco
  - Alcohol Misuse
  - Diabetes
  - IBS
  - GAD
  - Chronic Pain
  - Primary Insomnia
  - Somatic Complaints

- Improved Patient Satisfaction \(^1-5\)
- Improved Primary Care Provider Satisfaction \(^6,7\)

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5. Hunter et al., Integrated Behavioral Health in Primary Care: American Psychological Association, 2009

1) Collaborative relationships between PCP’s and BH providers require preparation, time and supportive structures.
2) System-level integration requires preparation, reorganization & time to develop.
3) Co-location is important for both providers and patients.
4) Degree of integration does not in itself appear to predict clinical outcome.
5) Integrated care with treatment guidelines--better results for pts with depression.
6) Those with severe depression differentially impacted by integrated care.
7) Systematic follow-up for depression related to positive clinical outcomes.
8) Efforts to increase medication adherence through integrated care were a component of many successful studies. However analysis of the studies found no clear direct relation between medication adherence and clinical outcome.
9) Integration alone has not been shown to produce skill transfer or enduring changes in PCP knowledge or behaviors in the treatment of depression.
10) Enhanced pt education-a component of studies with good outcomes. However, the reviewers suggest that future research is needed to determine what if any contribution patient education makes to successful integrated care.
11) Patient choice about tx modality may be an important factor.

What’s Been Done?

Systematic Reviews

What is the impact of integrated care on outcomes?
Integrated care programs improve outcomes

Effects for symptom severity consistently favors integrated care for depression and anxiety, but not for somatization, at risk drinking, and ADHD

Treatment response and remission rate for depression and anxiety exhibit the same pattern of positive outcomes

Results for both depression and anxiety show a weakening effect within the first 6-12 months
A few ideas

ADVANCING INTEGRATION IN YOUR COMMUNITY
Fragmentation as a Parallel Process

- What we do (models)
- What data we collect (clinical)
- What we call ourselves (integrated)
- What we need for sustainability (money)
- Who we talk to (ourselves)
- What we want (change)

Advancing integration

RESEARCH
Lexicon (language critical)
First and second steps for the field in research
Metrics for evaluating integration
Unite the field and move it forward

Descriptive ↔ Evaluative

- Evaluative research
  - How would integrated mental health influence hypertension outcomes?
  - Collaboration between mental health and primary care providers

- Descriptive research
  - What components of integrated mental health care correspond to collaboration?
  - Can these components be measured at the provider level? At the practice level?
Descriptive

• Research questions
  – How do populations of patients with comorbid mental health and physical health presentations vary depending on method of detection of mental health?
  – What integrated care elements differentiate practices that exhibit high vs low levels of collaboration between mental health and primary care providers?

Evaluative (cause and effect)

• Research questions
  – For patients with comorbid hypertension and anxiety disorder, how do hypertension outcomes vary depending on level of collaboration between PCPs and BHPs?
  – Do practices characterized by elements of integrated care thought to facilitate collaboration have patients with better hypertension outcomes?
Oh yeah

**ELECTRONIC MEDICAL RECORDS**
One story

• Upon visiting a self-proclaimed “trail blazer” for integrated care, one question was asked to the HIT team that ruined their day:

  – “What percentage of the information in your EMR is “structured” and what percentage is “free text?”

  90
  “free text”

  10
  “structured”
In closing

TRANFORMATION

“Mental health and primary care are inseparable; any attempts to separate the two leads to inferior care” (IOM, 1996)
Take a deep breath

QUESTIONS?

Thank you

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