
Primary Care Mental Health Integration (PCMHI)

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Three Models Most Widely Used

- **IMPACT (collaborative care)**
- **Behavioral health consultation (BHC)**
- **Co-location with focus on behavioral medicine**



The Rationale for PCMH

- Approximately half of all patients in primary care present with psychiatric co-morbidities, and 60% of psychiatric illnesses are treated in primary care
- There is no generalist level of care for MH/BH
- Patient behavior indicates that PC is a more acceptable context for services
- There are a variety of significant barriers to the existing MH system
 - Cost, access, stigma, fragmentation, poor service fit, etc.



The Spectrum of BH Conditions

Mild to moderate

- Large numbers
- Primary care providers
- “Sub-optimal” functioning
- Straightforward interventions
- Can manage in primary care

Severe

- Smaller numbers
- Specialty care providers
- Major impairment
- Complex interventions
- Require specialty care?



Primary Care Behavioral Health

- Population-based mental health clinical care that is:
 - Simultaneously co-located
 - Collaborative
 - Integrated within the primary care clinic



PCMHI

- Primary care mental health integration (PCMHI)
 - This is a *population* health approach
 - Acknowledges that health conditions do not fall neatly into “psychiatric” or “physical” categories
 - Refers to integration of screening, prevention, early intervention, and treatment of mental health conditions into the general medical care settings
 - Primary care provides the best opportunity to screen for previously undetected disorders



PCMHI Goals

- Improve access to evidence-based treatments
- Reduce symptom burden, improve quality of life, and functional status
- Reduced morbidity from psychiatric *and* non-psychiatric conditions
- Reduced health care costs
- For example, the “TRIPLE AIM”



BH Services

The majority of BH services should be delivered in the primary care context in a format acceptable to patients and PCPs



Project IMPACT

- Evidence of clinical efficacy and cost offset
- Improving mood-promoting access to collaborative treatment
- 1,801 depressed patients, age 60 or greater, enrolled from 18 primary care clinics
- Patients were randomized to either care as usual or assignment to collaborative care (CC) for up to 12 months
- CC consisted of nurse supervised by a psychiatrist and primary care provider
- CC nurse provided decision-support on evidence-based antidepressant prescribing guidelines or PST



IMPACT Results

- At 12 months: 45% of intervention patients had a significant reduction in depression vs. 19% in the usual care group
- Intervention patients endorsed more satisfaction with treatment, less functional impairment, and greater quality of life
- A full year after the study was completed: patients who had received the intervention fared significantly better than controls
- Modest impact on costs (\$500 to \$700 per year in older adults whose baseline costs averaged about \$8,000 per year) after the first year of the program
- Lesson learned:
 - Depression treatment with care managers can be effective, even in chronically ill elderly, and benefits can be lasting



How Care Is Delivered

1. PCP consults service *or* service automatically triggered by positive depression screen
2. Nurse clinical manager reviews chart, meets with patient for face-to-face, calls patient at home a day or two after the PCP visit
3. The initial evaluation includes some standardized assessments (PHQ9, GAD7, etc.)
4. Assessment results in a reasonable plan of action (e.g., no intervention, or brief therapy with or without antidepressant, etc.)
5. Nurse reviews cases with psychiatrist weekly or PRN
6. Nurse clinical manager works with patient and PCP to implement the care plan (PCP prescribes)

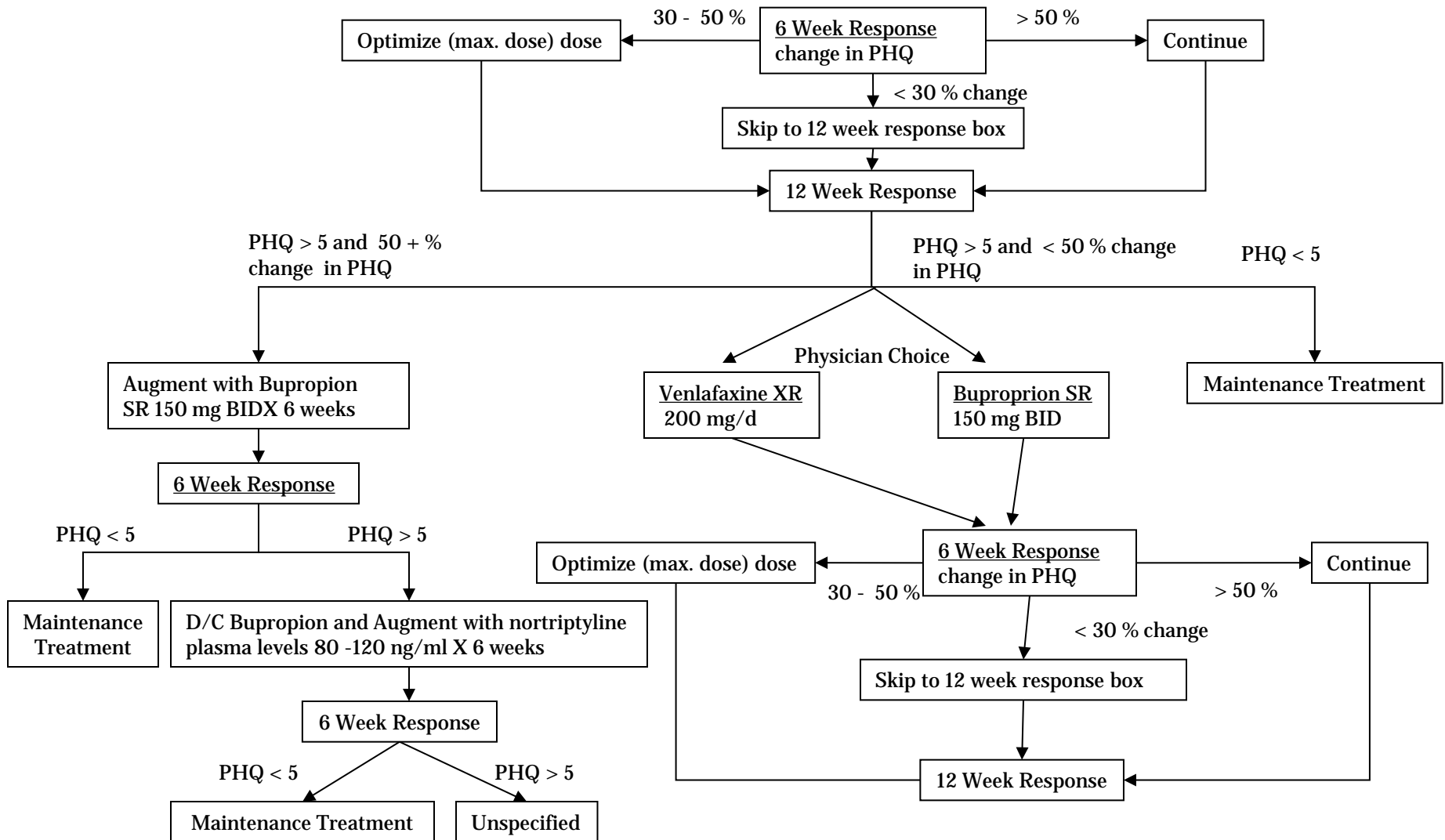


Collaborative Care is Structured

- Reliance on standardized assessments (e.g., PHQ9)
- Electronic patient registry
- Brief, evidence-based interventions
- Stepped care; algorithmic care
- Nurse care manager as “quarterback”
- Leverage psychiatric expertise
- Collaborative: PCPs prescribe all medications



Rational Pharmacotherapy Algorithm



Limitations

- Integrated care may be no better in managing *intrusive or dissatisfied patients* (though these are the cases that frustrate PCPs)
- Research published to date has not assessed effect on other disorders (e.g. anxiety, bipolar disorder, PTSD, and addictions)
- Not the appropriate response for actively suicidal patients in the clinic (though these are small in number)

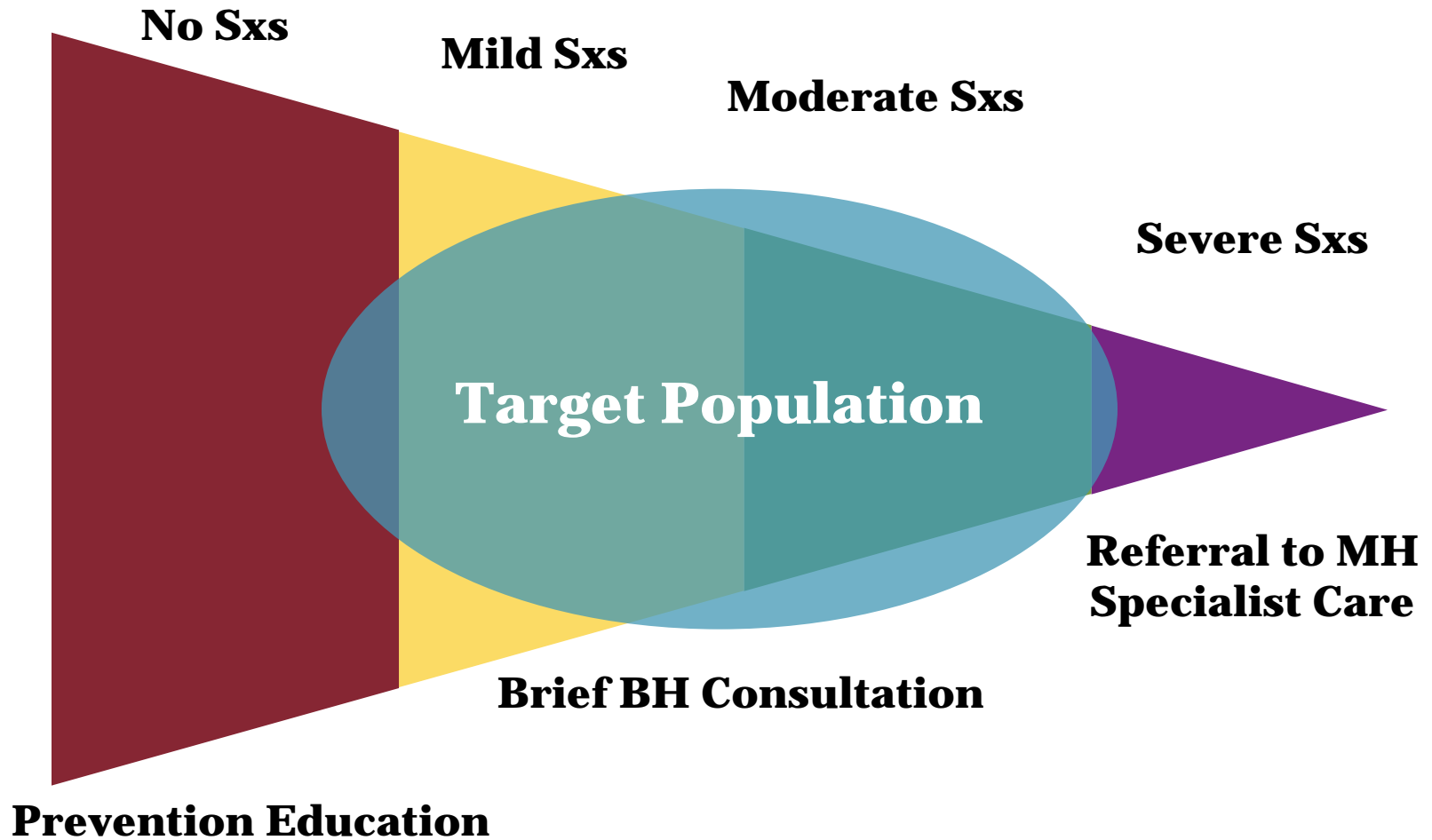


Behavioral Health Consultation

- Behavioral health consultants (BHCs) work alongside primary care provider as a consultant
 - PCP retains full responsibility for patient care decisions
- Immediately accessible for both curbside and in-exam room consults, same-day visits (15 – 30 minute consultation)
- Intervention typically 1 – 4 sessions with approximately 60% of patients seen once
- Shared records: Chart in the medical record using a SOAP note format
- Reimbursement by encounter – not by time
- No office, no caseload, no “no shows”



BHC Target Population



Behavioral Health Consultation

- Address a variety of issues common to primary care
 - Affective concerns: depression and anxiety
 - Response to physical illness, pain, and substance use and abuse
 - Health behavior change: obesity, smoking, sleep, medication adherence, self management of chronic conditions
 - Engage in prevention activities



Clinical Approach

- Problem-focused and functional-contextual approach to assessment and treatment of behavioral health conditions
- Use evidenced-based instruments to develop treatment plans, monitor patient progress, and provide care to meet patients' changing needs:
 - Motivational interviewing
 - Behavioral activation
 - Acceptance and commitment therapy
 - Screening, Brief Intervention, and Referral to Treatment (SBIRT) program



Population-Based Care

- Standardization of care across the population:
 - Algorithms
 - Protocols
 - Evidenced-based assessment tools
- Continuous improvement systems: PDSA cycles
- Implement disease registries
- BHCs proactively reach out to patients who do not follow up (or designate someone to reach out)
- Referrals to specialty care, social services, and community-based resources are seamlessly facilitated and tracked



Collaborative Approach

- PCPs systematically screen and do “warm hand-offs” according to patient needs
- PCPs and BHCs regularly review each other’s notes in the EMR
- Regularly consult about patient care and change or adjust treatments if patients do not meet treatment targets
- Co-monitor treatment response at each contact with valid outcome measures
- Patients who are not improving are identified and targeted for move to a higher level of care



Psychiatric Consultation

- PCPs prescribe and manage psychotropic medications as clinically indicated
- PCPs and BHCs collaborate to monitor treatment side effects and complications
- Psychiatric consultation is available for challenging patients in-person or via telemedicine



2009 Study

- How much of a “dose” of treatment is needed for patients to achieve adequate symptom and functional recovery?
 - 338 consecutive patients referred by PCP to BHC during a six-month period in an integrated large family medicine clinic at an Air Force base
 - At each BHC appointment patients completed the Behavior Health Measure-20 (BHM): assesses well-being, psychological symptoms, and life functioning
 - 66.57% met with the BHC only once; 23.7% kept two appointments; 7.40% kept three appointments; 2.37% kept four appointments



Results: 2009 Study

- Higher levels of distress at baseline were associated with more follow-up appointments (up to four)
- Patients demonstrated simultaneous, clinically meaningful improvement in well-being, symptoms, and functioning in as few as 2 – 3 BHC appointments
- Patterns of clinical improvement support the effectiveness of BHC interventions



2012 Follow-up Study

- Is the “dose” of the BHC intervention Insufficient for sustained improvements over time?
 - Behavior Health Measure-20 completed by patients at all appointments with the BHC.
 - BHM was then mailed to 664 patients 1.5 to 3 years after receipt of intervention from BHCs in primary care, of which 10.5% were completed and returned.



Results: 2012 Follow-up Study

- Approximately two years after their final appointment with a BHC, patients maintained the clinical improvements in global mental health functioning that were gained over the course of the BHC's intervention, regardless of subsequent mental health treatment of any kind



Increased PCP Satisfaction with Care

Clinicians Preferring Integrated Care to Enhanced Referral Care According to Aspects of Treatment of MH Problems

153 Clinicians surveyed, N=127 (83% responded)	Integrated Care Preferred* No. (%)	P Value†
Better communication	113 (92.6)	<.0001
More comprehensive services	74 (61.7)	.0106
Better management of depression	77 (64.2)	.0019
Better management of anxiety	91 (75.8)	<.0001
Better management of alcohol abuse	78 (65.5)	<.001
More convenient services for patients	106 (87.6)	<.0001
Less stigma for patients	111 (92.5)	<.0001
Better coordination of mental and physical care	109 (91.6)	<.0001
Quicker appointments for mental health	102 (85.7)	<.0001
Better health education	102 (88)	<.0001

* Some data missing due to item nonresponse. † P values represent the statistical test for whether the proportion preferring integrated care equaled 50%



BHC Model Implementation

- BHC model widely used by public and safety net providers
 - VA hospitals
 - US Air Force
 - FQHCs



Conclusion

- The BHC model is based on a view of change that respects the multifaceted nature and process of change, meeting the patient in the moment to catalyze the change process in the context of the patient's relationship to his or her PCP
- BHCs do not work only with “simple cases” referring out “difficult cases”
 - Referral is based on accessibility, patient motivation, and does not involve termination of work
- BHC is the equivalent of the family practice doctor who will maintain life-long relationships with patients



Summary

- Collaborative Care (CC) model has the most substantive evidence base, but is well studied only in relation to depression
- Behavioral health consultant (BHC) model is widely used with some positive findings
- Co-location seems ideal for individuals who pursue both services, but this number is limited



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