Behavioral Health and Primary Care:
Drowning in the Mainstream or Left on the Banks

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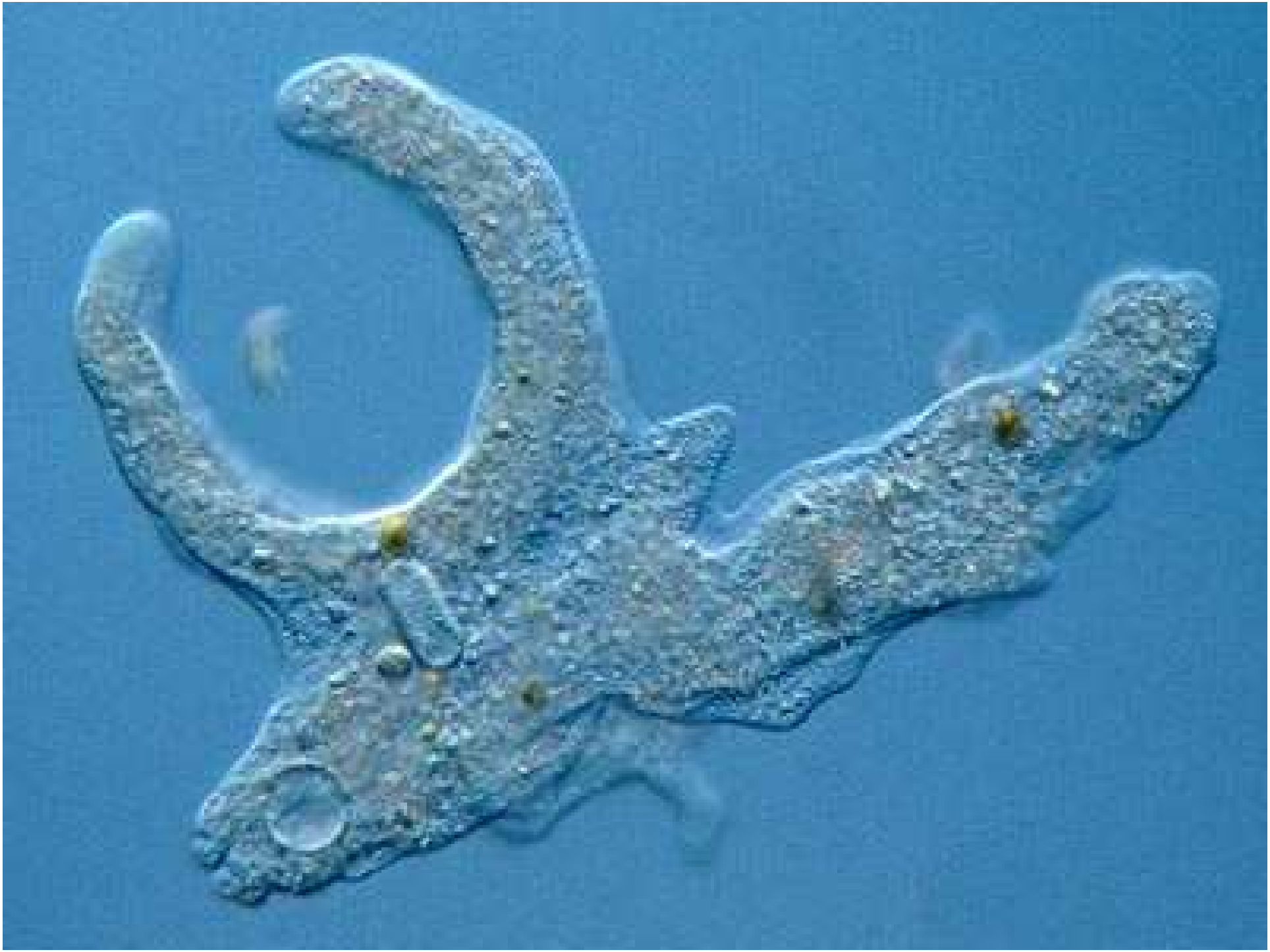
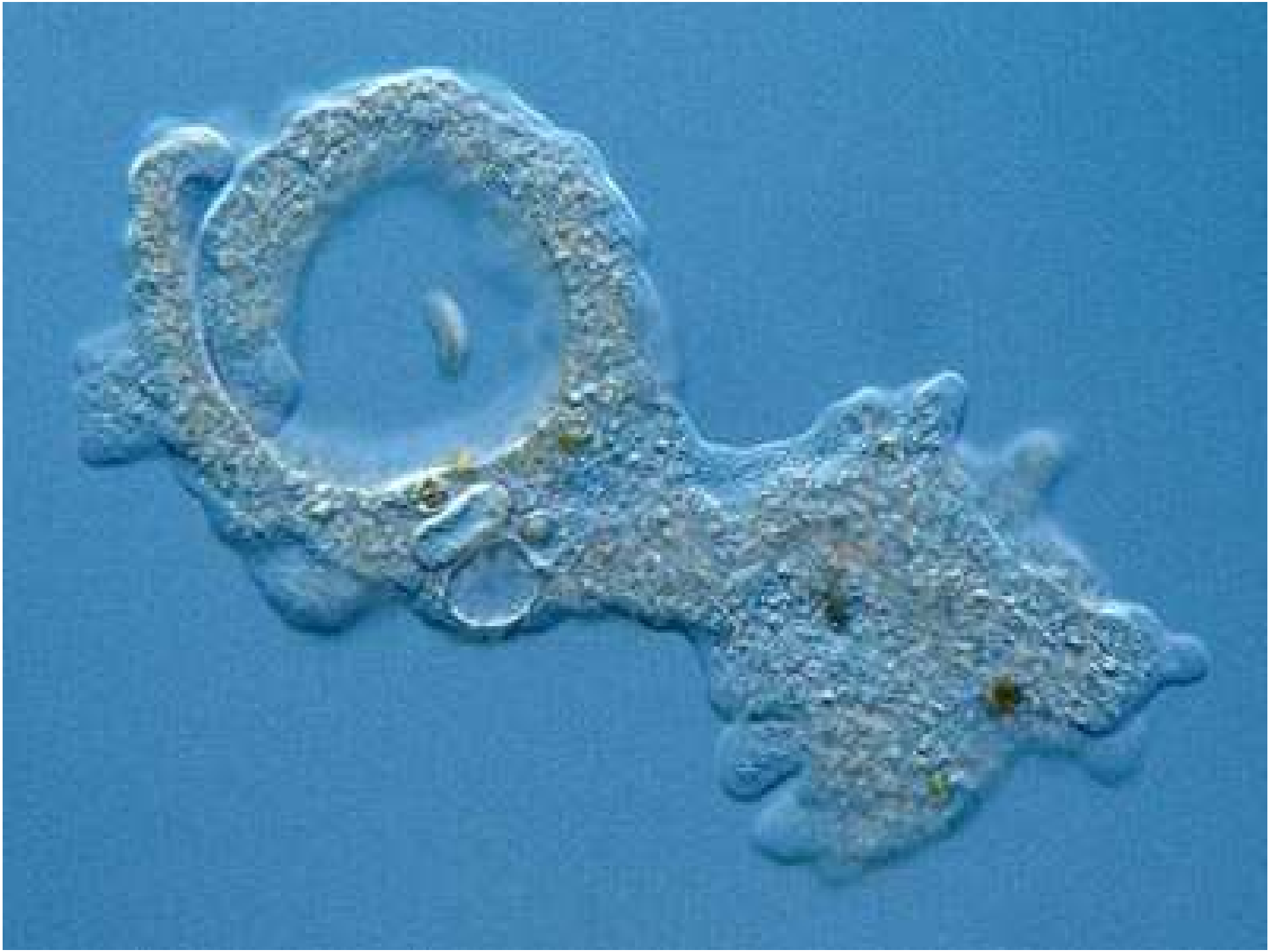




Questions

- How should behavioral disorders / psychosocial problems in primary care be defined?
- What are the expectations for screening / identification/follow-up?
- What are the expectations for PCP/MHS roles in treatment?
- What are the optimal practice organizations for meeting these expectations?
- What financing mechanisms need to be put in place?

Overview

- Why – Prevalence and Impact
- What – Definitions
- Why Not – Problems and Barriers
- How – Systems Innovations
- When – Crossing the Quality Chasm

Why Now?

- High prevalence/Pharma (NCHS)
- Surgeon General's Report
- President's New Freedom Commission
- Disaster Response (9/11, Katrina)
- FDA activities
- Media (suicide/antipsychotics)
- IOM *Crossing the Quality Chasm* – Behavioral Health Adaptation (more on this later)

Why Behavioral Health and General Health Care?

- Depression
- Preventive / chronic illness care for people with Severe Mental Illness
- Disaster response

Why Depression?

- Prevalent
- Significant personal, social and economic impact
- Strong clinical science base
- Strong evidence on care improvement interventions
- Depression as a chronic disease
- Large gap between evidence and action

2020 World Health Organization Burden of Disease (DALYs)

1. Ischaemic heart disease
2. Unipolar major depression
3. Road traffic injuries
4. Cerebrovascular disease
5. Chronic obstructive pulmonary disease
6. Lower respiratory infections
7. Tuberculosis
8. War
9. Diarrhoeal diseases
10. HIV

DALY = Disability-adjusted life year

Source: WHO, Evidence, Information and Policy, 2000

Leading Causes of Years of Life Lived with Disability (YLD) in 15- to 44-Year-Olds

(WHO, Mental Health: New Understanding, New Hope, 2001)

		% total
1	Unipolar depressive disorders	16.4
2	Alcohol use disorders	5.5
3	Schizophrenia	4.9
4	Iron-deficiency anemia	4.9
5	Bipolar affective disorder	4.7

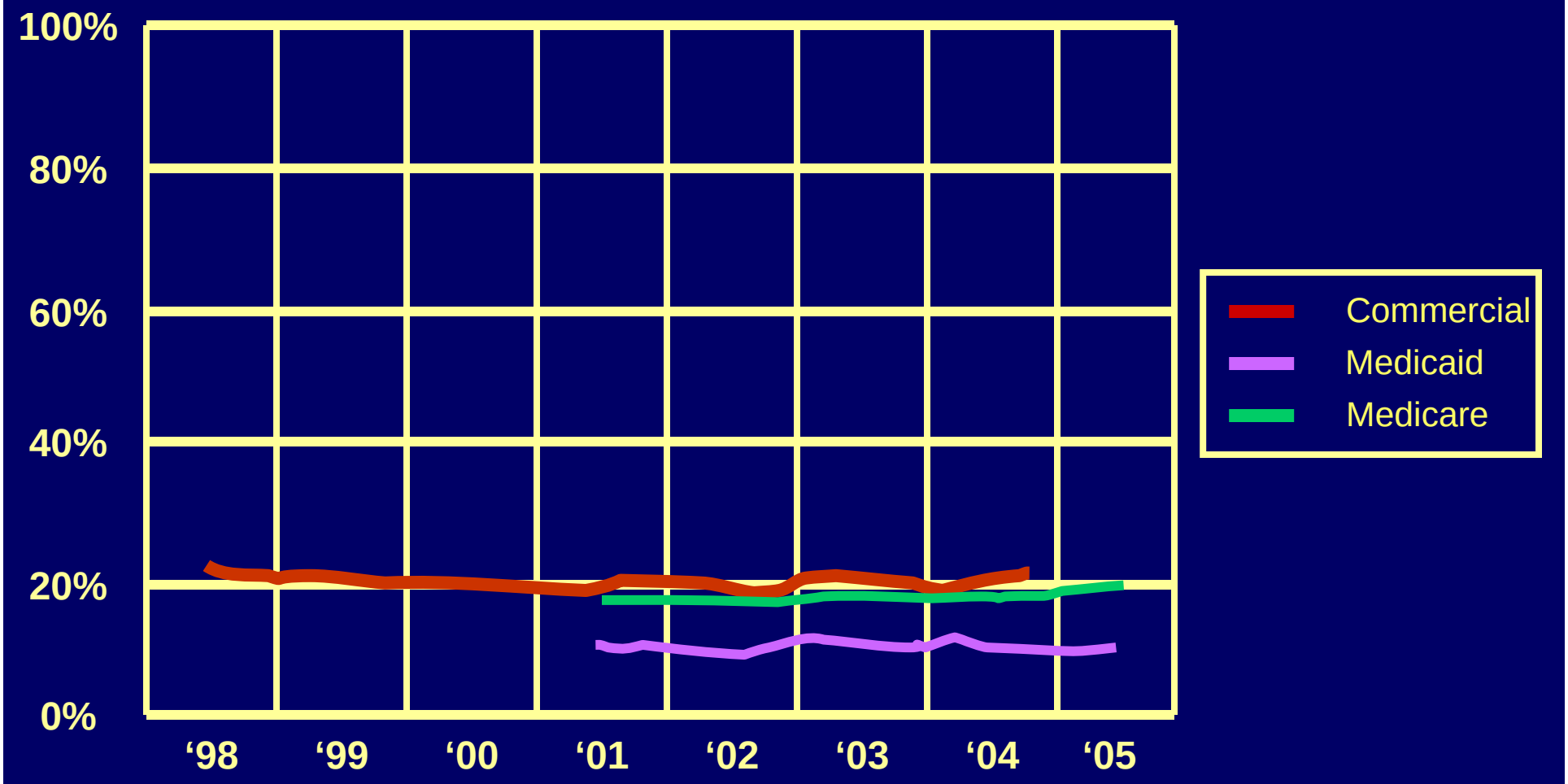
The State of Health Care Quality 2006, NCQA

There are, however, disturbing exceptions to this pattern of [overall health care quality] improvement. The quality of care for Americans with mental health problems remains as poor today as it was several years ago. Patients on antidepressant medication are about as likely to receive appropriate care today as they were in 1999.

www.ncqa.org

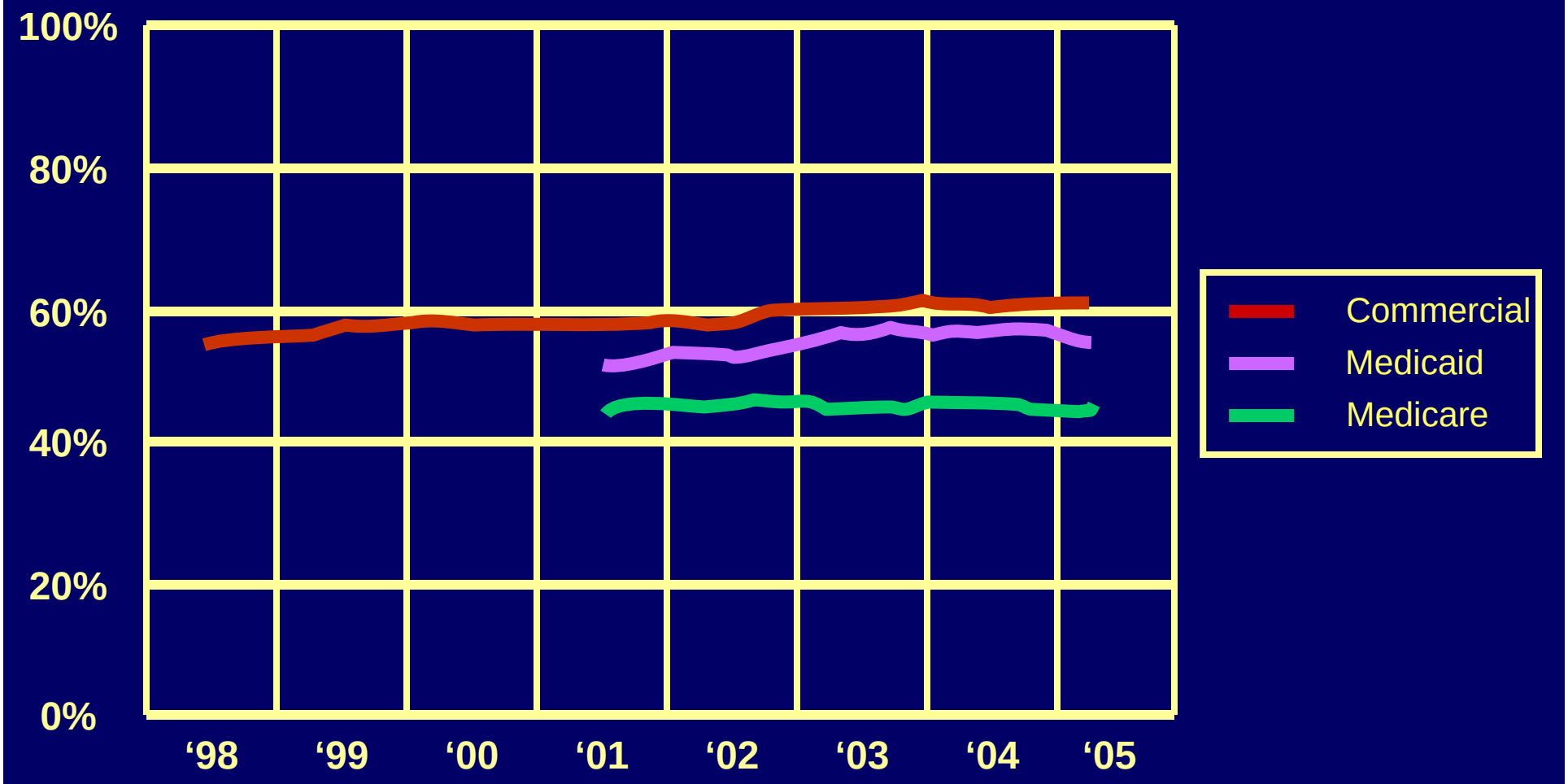
Antidepressant Medication Management:

Optimal Practitioner Contacts Trends, 1998-2005



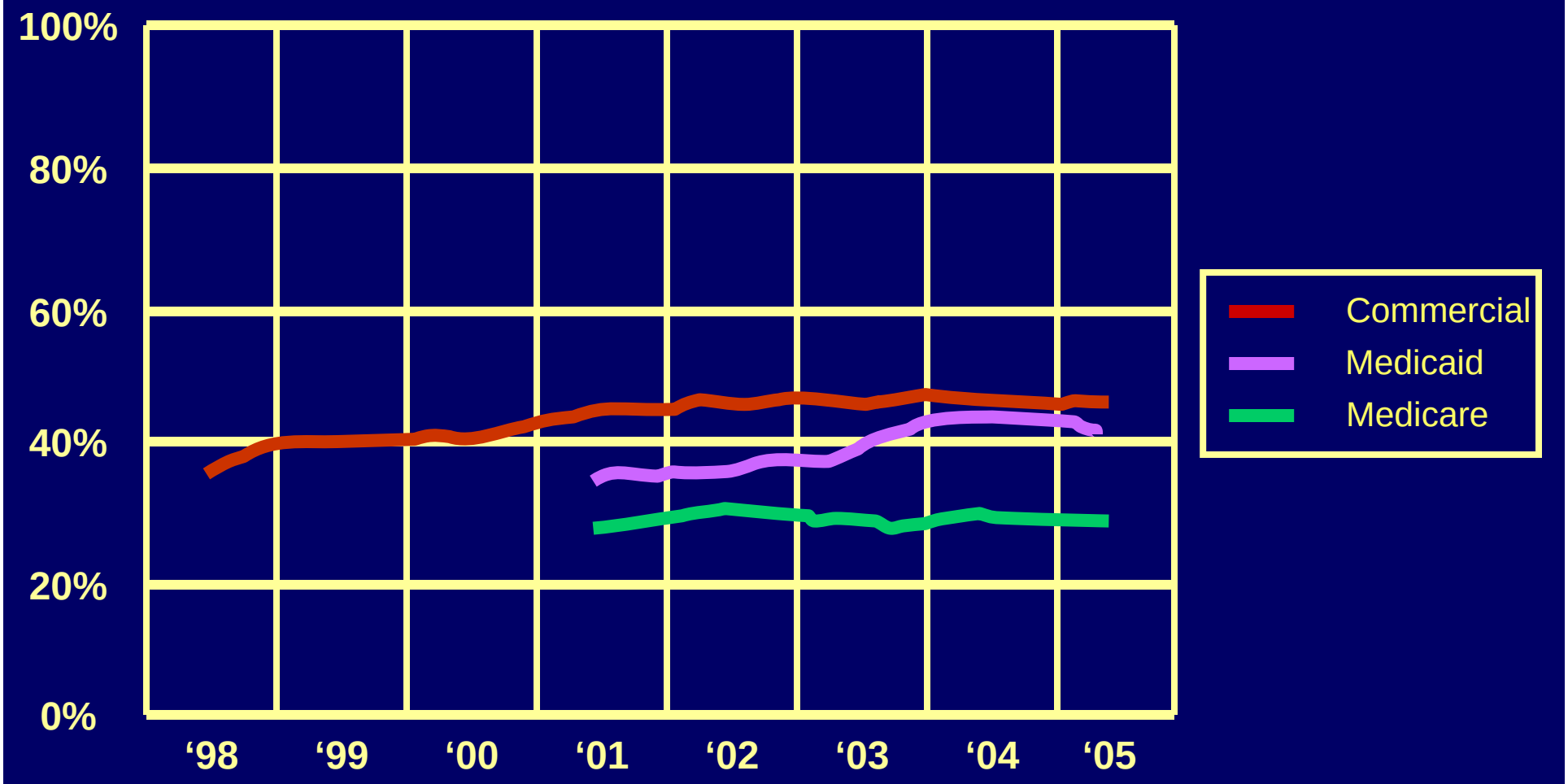
Antidepressant Medication Management:

Effective Acute Phase Treatment Trends, 1998-2005

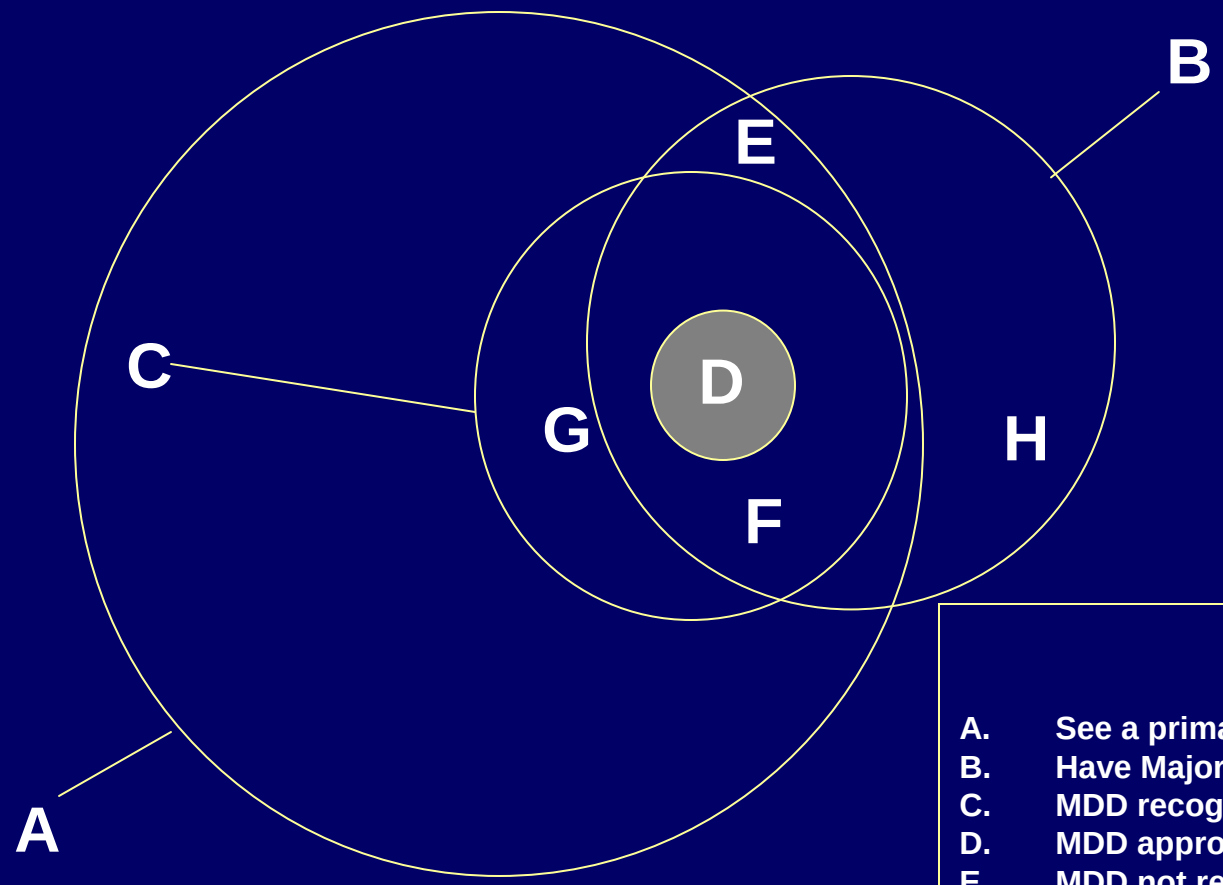


Antidepressant Medication Management:

Effective Continuation Phase Treatment Trends, 1998-2005



Scope of the Problem: Recognition and Treatment of Depression in Primary Care Settings*

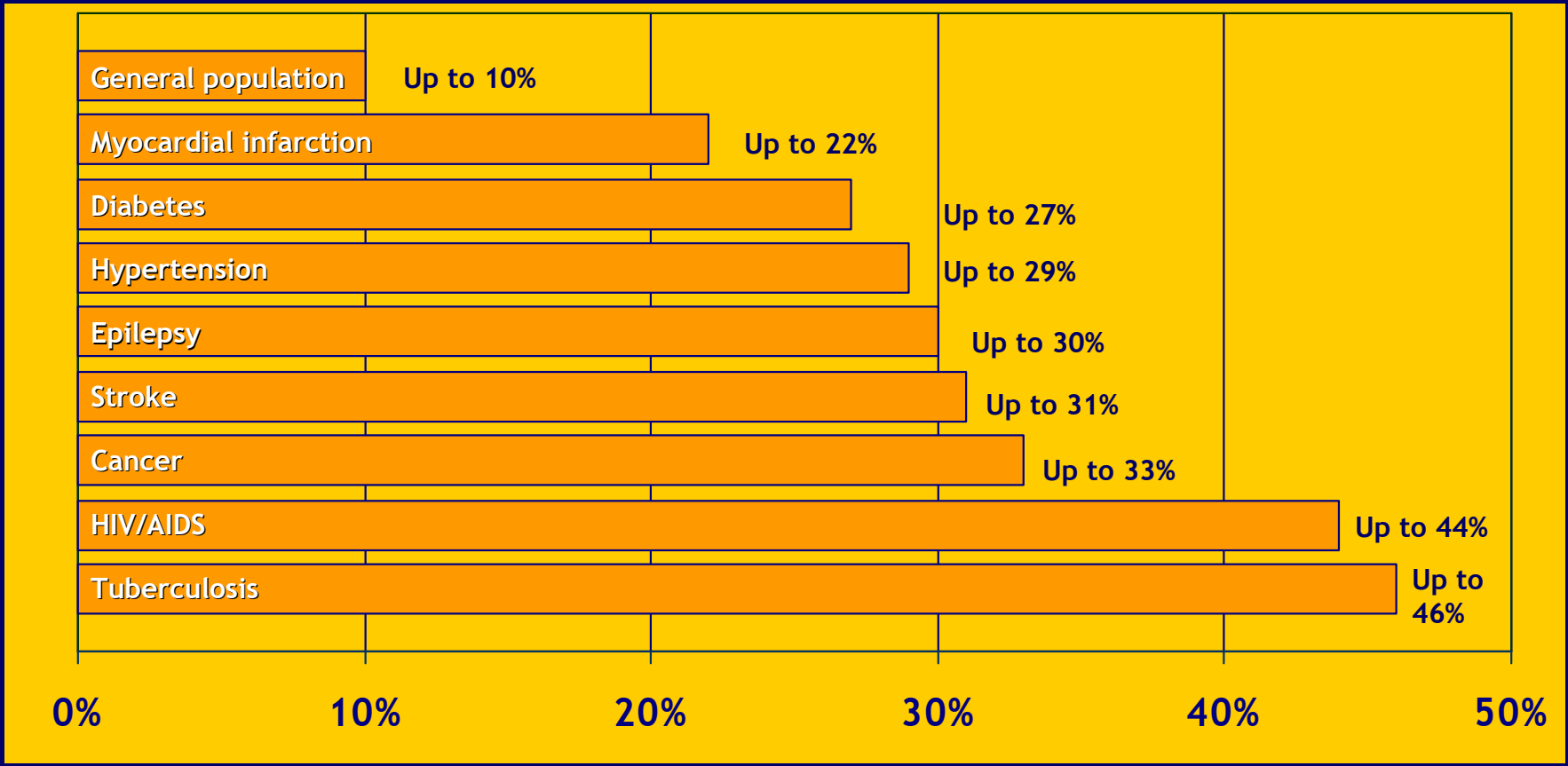


Legend

A. See a primary care physician
B. Have Major Depressive Disorder (MDD)
C. MDD recognized
D. MDD appropriately recognized and treated
E. MDD not recognized, not treated
F. MDD recognized, not appropriately treated
G. "Recognized" but not MDD (false positive)
H. Have MDD but do not see a primary care physician

* Adapted from Goldberg & Huxley, 1980.

Prevalence of Major Depression in Patients with Physical Illnesses



Comorbidities Among Depressed Patients

Comorbidity	% of Depressed Patients with Comorbidity
Arthritis	48.1%
Heartburn / Acid Reflux	42.1%
Hypertension	34.7%
High Cholesterol	29.7%
Migraines	23.5%
Bowel Problems	20.1%
Asthma	15.2%
Diabetes	14.9%
Skin Problems	13.7%
Menstrual Problems	9.3%

Source: http://www.medstat.com/healthcare/depression4.asp

General Medical Comorbidity in Patients with Severe Mental Illness

- Diabetes: 20% in VA sample with bipolar disorder (Kilbourne et al. *Bipolar Disorder*, 2004)
- Cardiovascular disease: HBP 34%, Heart 15.6%
- Weight gain and obesity (2x)
- Smoking (2x)
- Other: breast cancer (9.5x), HIV (8x), Hepatitis B (5x) and C (10x)

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Mental-Health Challenge Emerges As Victims Face Multiple Traumas

BATON ROUGE, La. –

"…Post-traumatic stress disorder, depression and anxiety are common after major disasters, mental-health experts say, because disasters frighten people and disrupt their lives. But Hurricane Katrina poses special challenges…"

"…The hurricane's upheaval also has exacerbated the symptoms of some people who suffer from developmental disabilities and mental illnesses such as schizophrenia…"

What?

Selected Terms Used to Describe the Subject of this Presentation

Adjectives	Nouns
Mental	Diseases
Behavioral	Illnesses
Emotional	Disorders
Social	Conditions
Psychological	Problems
Psychosocial	Factors
Biopsychosocial	Issues
Addictive/substance-related	Treatments
Cognitive	Interventions
Stress-related	Health
Maladaptive	Variation
Brain	Morbidity
Nervous	
Developmental	
“New”	

“Non-Behavioral” Conditions

- Medical Disorders
- Organic Diseases
- Physical Illnesses
- General Medical Conditions
- Other Medical Conditions

Conceptual Issues:
Primary Care vs. Mental Health Specialties

- Different perspectives
  - Definitions / clinical measures (i.e., no lab tests)
  - Majority of literature comes from specialty (and often tertiary) care settings
  - Diagnostic systems such as DSM-IV often seen as too complex and specialty-focused
  - But DSM PC unsuccessful?
- Linkages between and among various systems (SUD, social services, schools, consumer, directed, etc.)

PCP vs. DSM Frameworks

Psychiatry/DSM Identified Mental Disorder	Primary Care Identified Mental Health Condition: +	Primary Care Identified Mental Health Condition: –
+	1	2
–	4	3

What's Unique about Behavioral Health?

- Mind-body dualism
- Stigma
- Role of the state
- Legal / regulatory distinctions (e.g., privacy, competency)
- Multiple complex systems intrinsically involved (e.g., social services, criminal justice, education, consumer-directed, etc.)
- Different diagnostic systems

What's Unique about Behavioral Health? (continued)

- Separate delivery systems
- More heterogeneous work force / greater solo practice
- Few procedures
- Separate financing systems / different market structure
- Less developed quality improvement / performance measures
- Less linkage to IT innovations

Why Not? (Barriers)

- Historical
- Conceptual
- Patients / Consumers
- Providers
- Practices / Delivery Systems
- Plans – Managed Care Organizations (MCO)/ Managed Behavioral Health Organizations (MBHO)
- Purchasers – Public / Private
- Population / Community

Provider Barriers

- Time
- Interest
- Tools: DSM-PC, PHQ-9
- Training

Mapping Training to Roles

Interventions	Depressive Disorders	Substance Use Problems	Panic Disorder	Somatization	Social, Specific Phobias / Other - Anxiety Disorders e.g.	Substance Abuse	Bipolar Disorder	Substance Dependence	Severe Personality Disorder	Schizophrenia
Longitudinal f/u and monitoring										
Extended B/P/S interventions										
2nd level or higher meds										
Brief B/P/S interventions										
Initial Medications										
Diagnosis/Comprehensive P/S assessment										
Counseling/Psychoeducation										
Recognition/Limited P/S assessment										
Primary Care For GMC										

Note - did not include child (e.g. ADHD)
geriatric (e.g.. dementia)

Conditions / Populations

Interventions	Depressive Disorders	Substance Use Problems	Panic Disorder	Somatization	Other - Anxiety Disorders e.g. Social, Specific Phobias	Substance Abuse	Bipolar Disorder	Substance Dependence	Severe Personality Disorder	Schizophrenia
Longitudinal f/u and monitoring	Pr	Pr	Pr	Pr	Pr/Ps	Pr/B/Ps	Pr/Ps	Pr/B/Ps	B2/Ps	Ps/B2
Extended B/P/S interventions	B1	B1	B	B	B	B	B2	B2	B2	B2
2nd level or higher meds	Pr	Ps	Ps	Ps	Ps	Ps	Ps	Ps	Ps	Ps
Brief B/P/S interventions	Pr/B1	Pr/B1	Pr/B1	Pr/B1	B1/Pr	B/Pr	B/Ps	B/Ps	B/Ps	B/Ps
Initial Medications	Pr	Pr	Pr	Pr/Ps	Pr/Ps	Ps/Pr	Ps	Ps/Pr	Ps	Ps
Diagnosis/Comprehensive P/S assessment	Pr	Pr	Pr	Pr/B1	B1/Pr	B1//Pr	B/Ps	B/Ps	B/Ps	Ps
Counseling/Psychoeducation	Pr	Pr	Pr	Pr/B1	B1//Pr	B1/Pr	B/Ps	B	B	B
Recognition/Limited P/S assessment	Pr	Pr	Pr	Pr	Pr	Pr	Pr	Pr	Pr	Pr
Primary Care For GMC	Pr	Pr	Pr	Pr	Pr	Pr	Pr*	Pr*	Pr*	Pr*

Pr - Primary Care Provider
* = in specialty setting
B - B1 - Behavioral health Specialist in PCP setting
B2 - Behavioral Health specialist in specialty setting
Ps - Psychiatrist

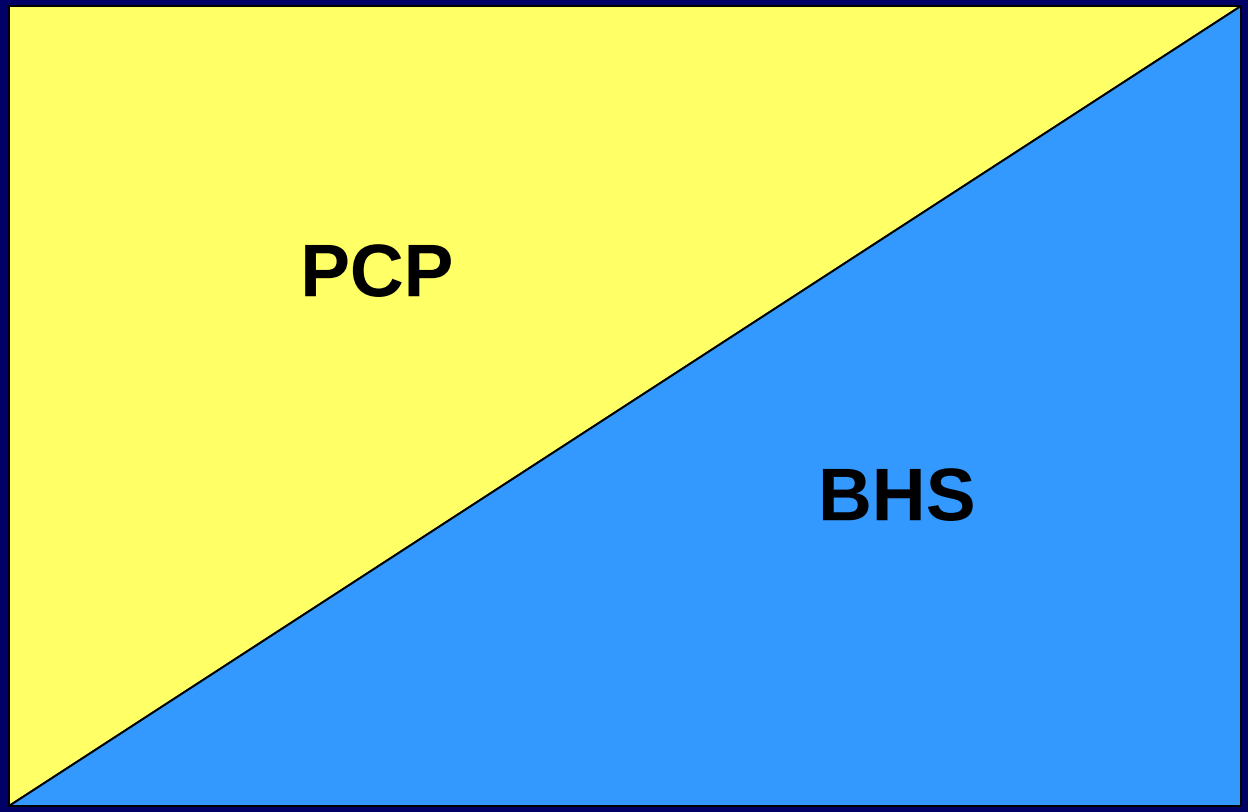
Note - did not include child (e.g. ADHD) geriatric (eg. dementia)

Conditions / Populations

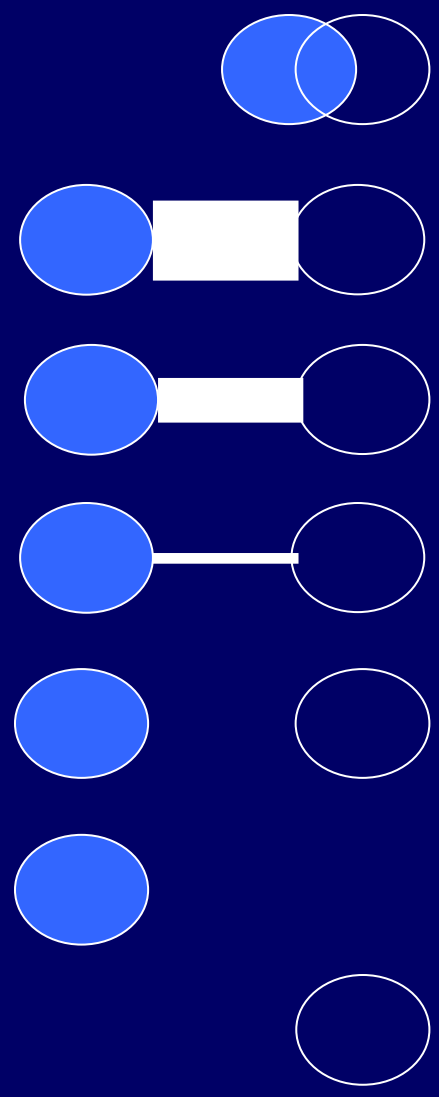
Practices / Delivery System Issues

- **Organization does not enhance patient-provider interactions & promote successful outcomes**
- ***Who* is responsible for care?**
  - Limited communication and teamwork between primary care and mental health specialties
- ***How* should care be provided?**
  - Consultative? Collaborative? Integrated?
- ***When* should care be provided?**
  - Lack of longitudinal focus

Who? Responsibility for Care



How?



Integrated Team

Collaborative Care

Consultative Care

Referral

Independent

Autonomous (PCP)

Autonomous (MHS)

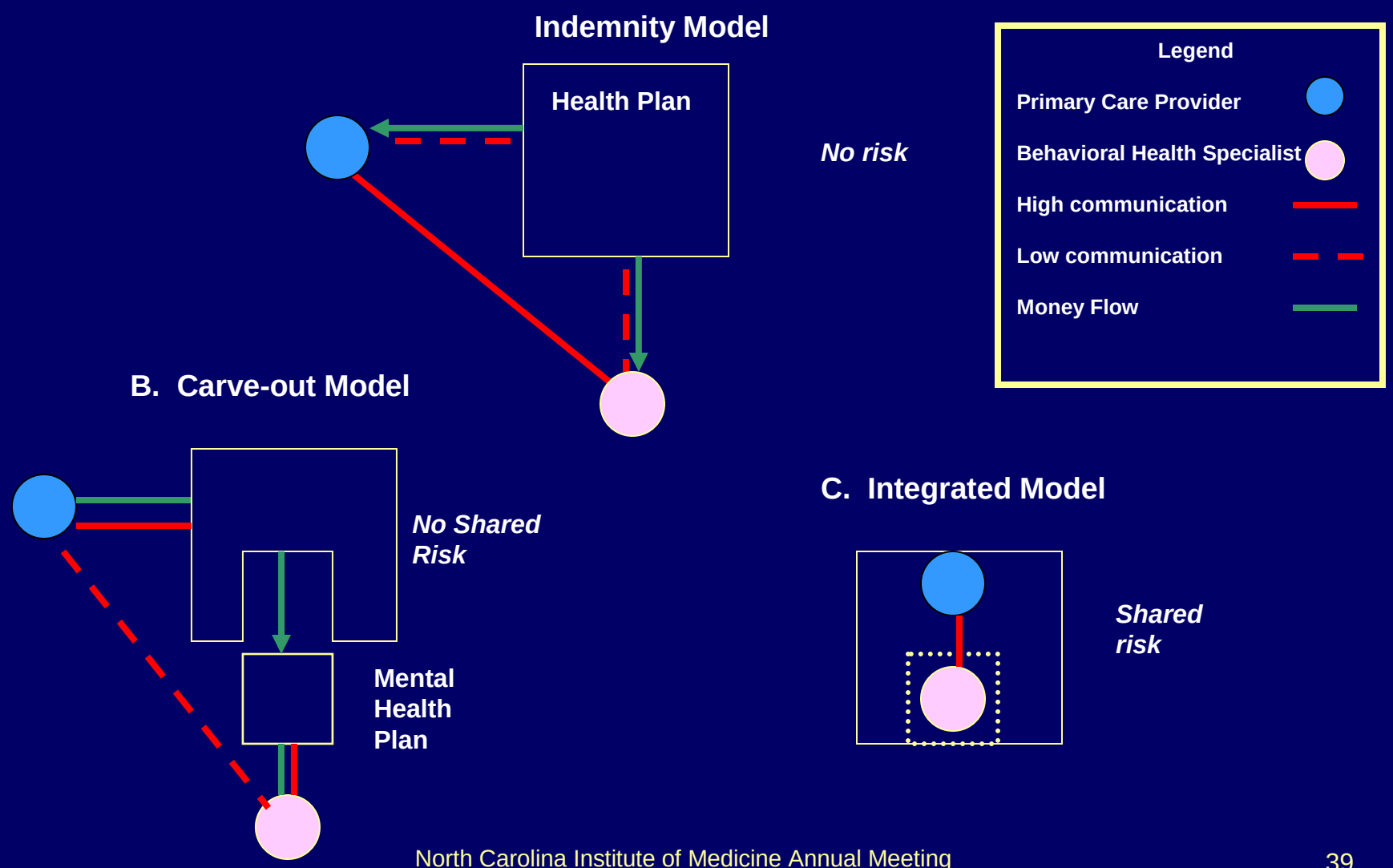
When?

Risk Factor Identification/ Prevention	Diagnosis/ Assessment	Short-term Management	Continuing Care

Health Plan Issues

- Traditional / indemnity models rare
- Managed care and behavioral carve-outs for over 80% of Americans
- Shifts in incentive structures
- Impact on coordination and communication
- Growth of disease management industry

Health Plans Money Flow, Risk and Communication

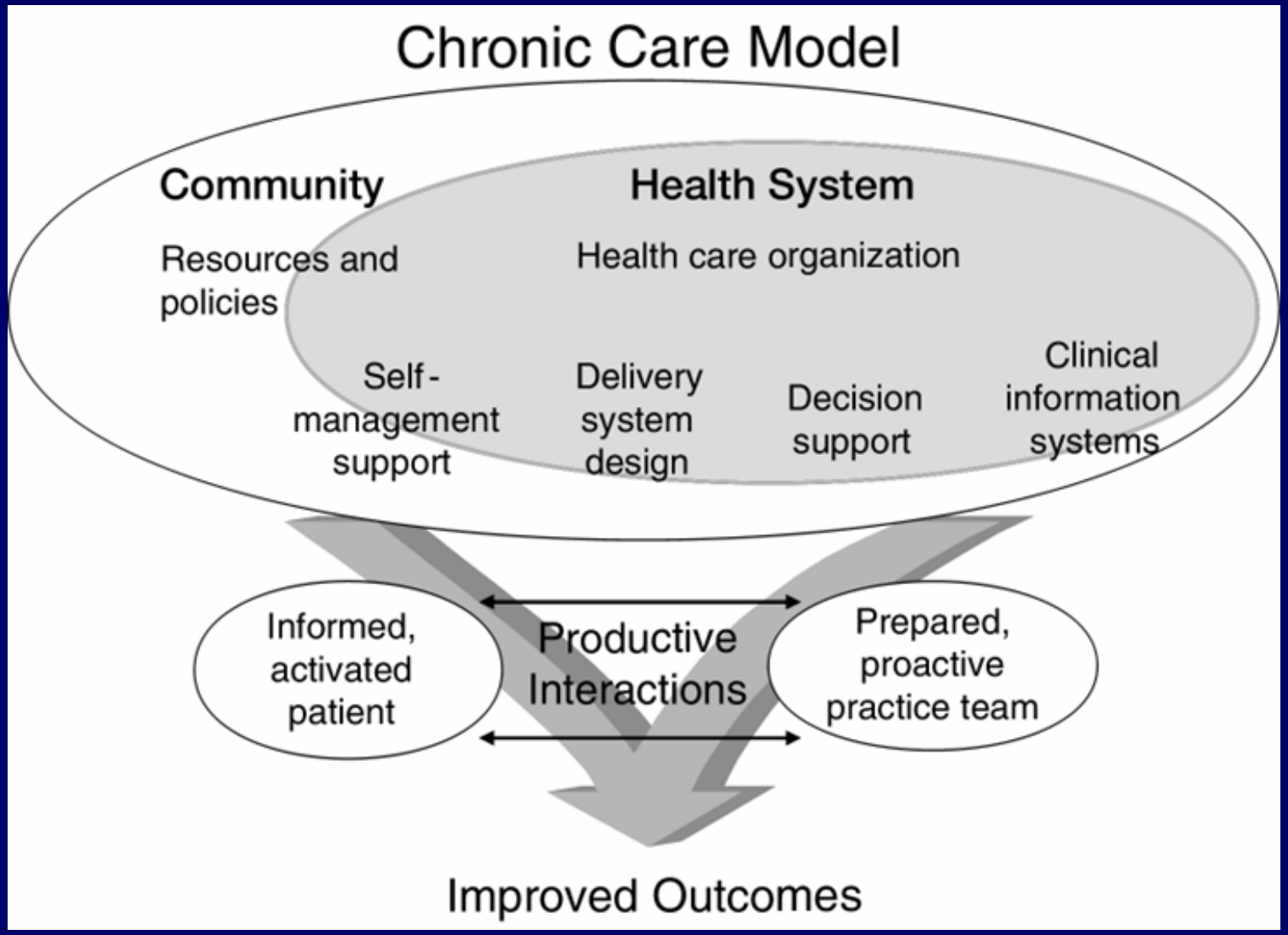


Purchaser Issues

- Depression not on radar
- Stigma, bias, misinformation related to value of mental health care
  - e.g., uninformed regarding indirect costs, i.e., productivity and disability
- Do not use (mental health) quality measures in purchasing decisions
- Inattention to growing complexity / “siloism”
- No clue as to perverse incentives
- National Business Group on Health tool kit

How? Strategies

- Chronic (Planned) Care Model
- The Robert Wood Johnson Foundation's national program on Depression in Primary Care: Linking Clinical Systems and Strategies
- Models of linkage/integration
- Institute of Medicine / Crossing the Quality Chasm



Wagner, Improving Chronic Illness Care, 2002

Chronic Disease Clinical Models

- Hypertension
- Congestive heart failure (CHF) / Coronary artery disease (CAD)
- Stroke
- COPD (Chronic Obstructive Pulmonary Disease)
- DM (Disease Management)
- Asthma
- Multiple comorbidities
- Transitional care management

Depression Clinical Models

- Chronic (planned) care model – Wagner
- Collaborative care – Katon
- Partners in Care (AHRQ) – Wells
- PROSPECT – Alexopoulous, Katz, Reynolds
- Telephone care management – Simon, Hunkeler
- IMPACT (Hartford) – Unutzer
- RESPECT (MacArthur) – Dietrich
- Quality Improvement for Depression (NIMH) – Rost, Ford, Rubenstein
- Child models – Campo, Asarnow, GLAD-PC

Depression in Primary Care

LINKING CLINICAL & SYSTEM STRATEGIES

A national program supported by The Robert Wood Johnson Foundation

www.depressioninprimarycare.org

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"6 P" Conceptual Framework

Patient / Consumer

- *Enhance self-management / participation*
- *Link with community resources*
- *Evaluate preferences and change behaviors*

Providers

- *Improve knowledge / skills*
- *Provide decision support*
- *Link to specialty expertise and change behaviors*

Practice / Delivery Systems

- *Establish chronic care model and reorganize practice*
- *Link with improved information systems*
- *Adapt to varying organizational contexts*

Plans

- *Enhance monitoring capacity for quality / outliers*
- *Develop provider / system incentives*
- *Link with improved information systems*

Purchasers (Public / Private)

- *Educate regarding importance / impact of depression*
- *Develop plan incentives / monitoring capacity*
- *Use quality / value measures in purchasing decisions*

Populations and Policies

- *Engage community stakeholders; adapt models to local needs*
- *Develop community capacities*
- *Increase demand for quality care enhance policy advocacy*

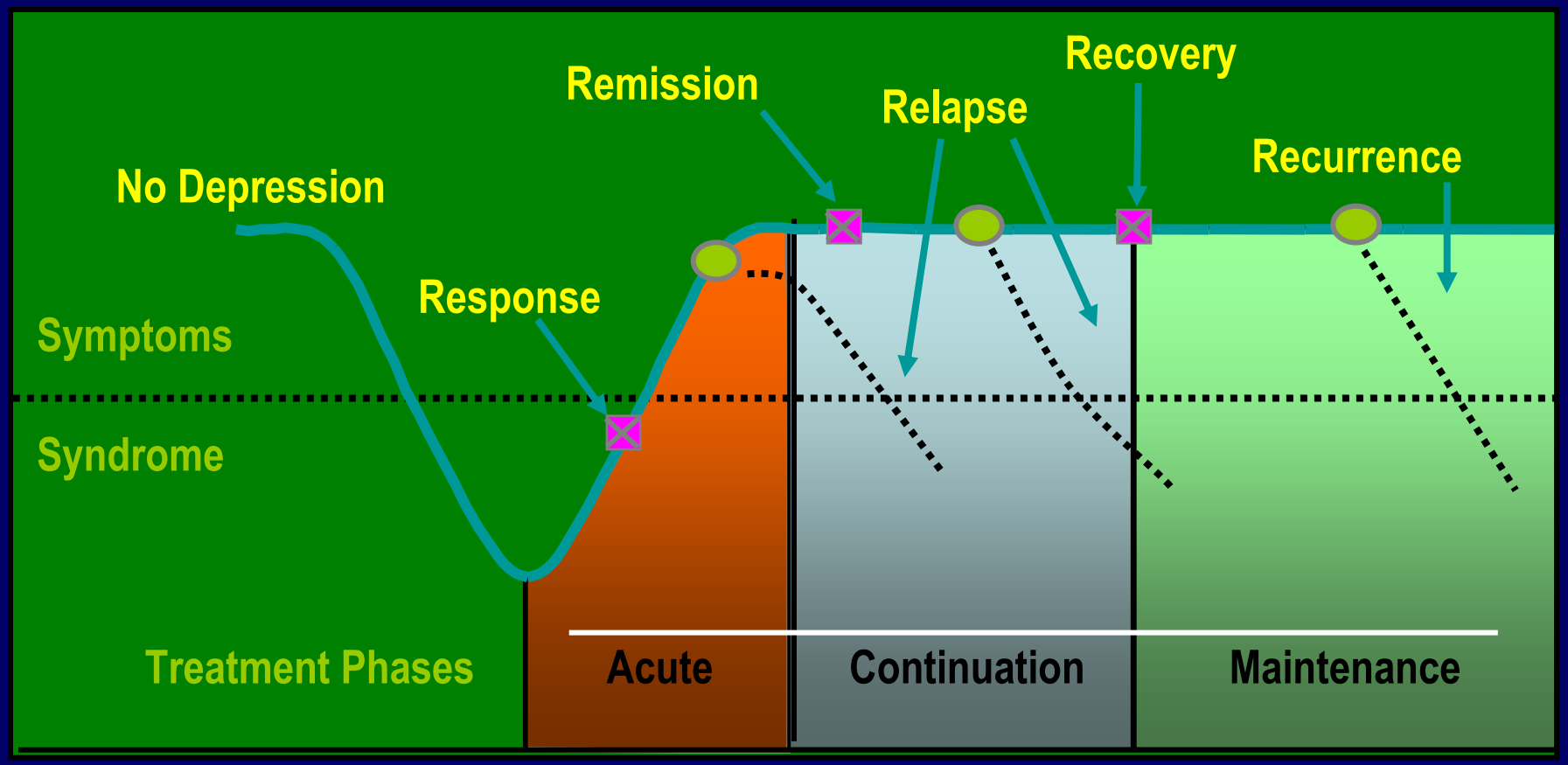
Incentives Demonstration

- Partnerships of health plans (Health Management Organizations [HMO] and Managed Behavioral Health [MBHOs]) and practice groups (and purchasers)
- 8 sites
- Commercial, Medicaid
- Implementation of:
  - Clinical Model
  - Economic Model

Clinical Model: Major Components

Leadership	Accountability Vision Resources
Practice design	Patient registry Protocols Depression care manager
Clinical information systems	Red flags Feedback to provider on clinical progress Support depression care manager
Decision support	Guidelines Provider training Expert / specialist consultation Referral pathways
Self management support	Patient preferences/WRAP Information on depression, medications
Community resources	Information on and for consumer groups and other services Access to non-provider sources of care

Phases of Depression Treatment

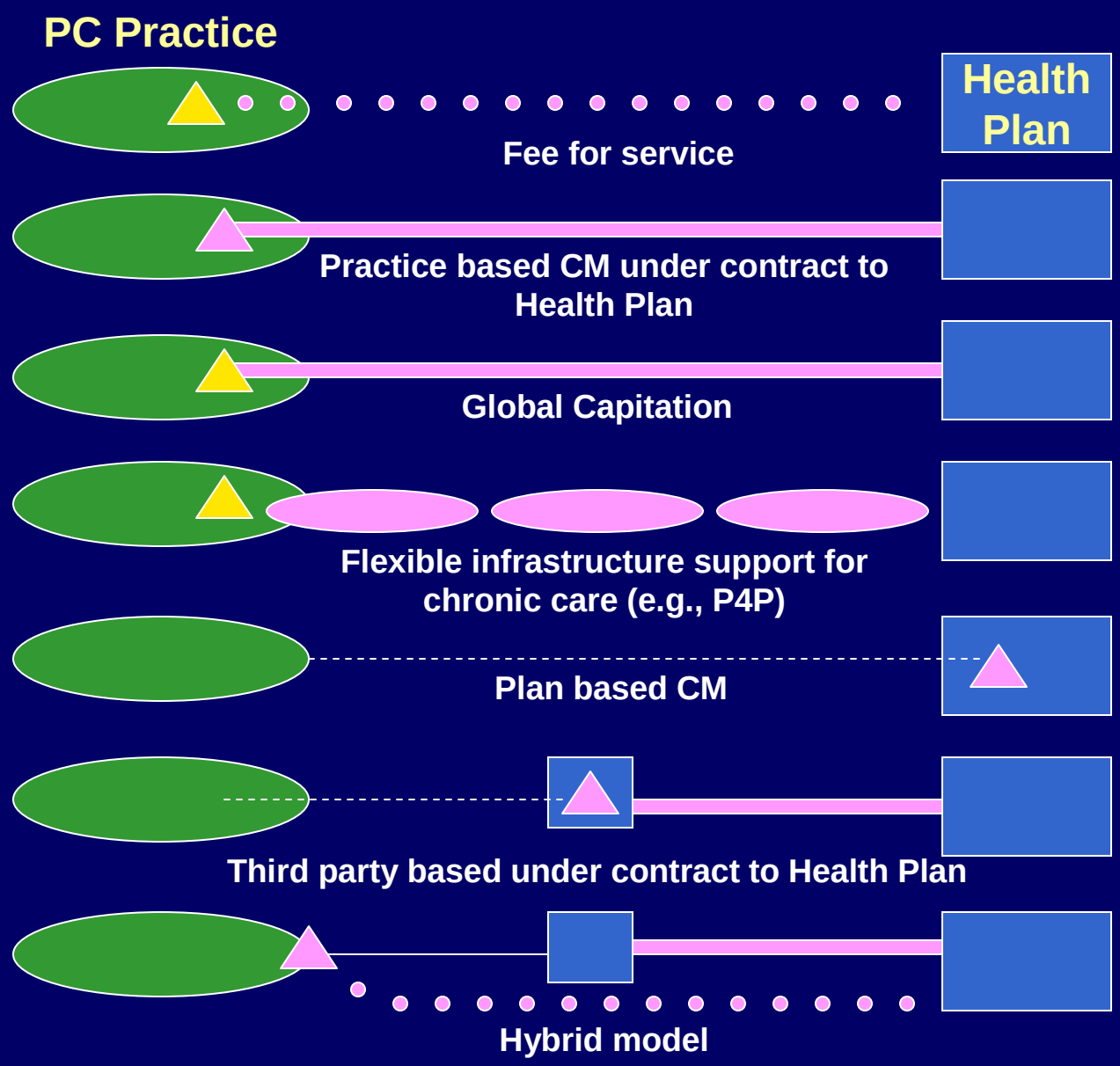


Kupfer DJ. J Clin Psychiatry. 52(5s):28-34,1991.

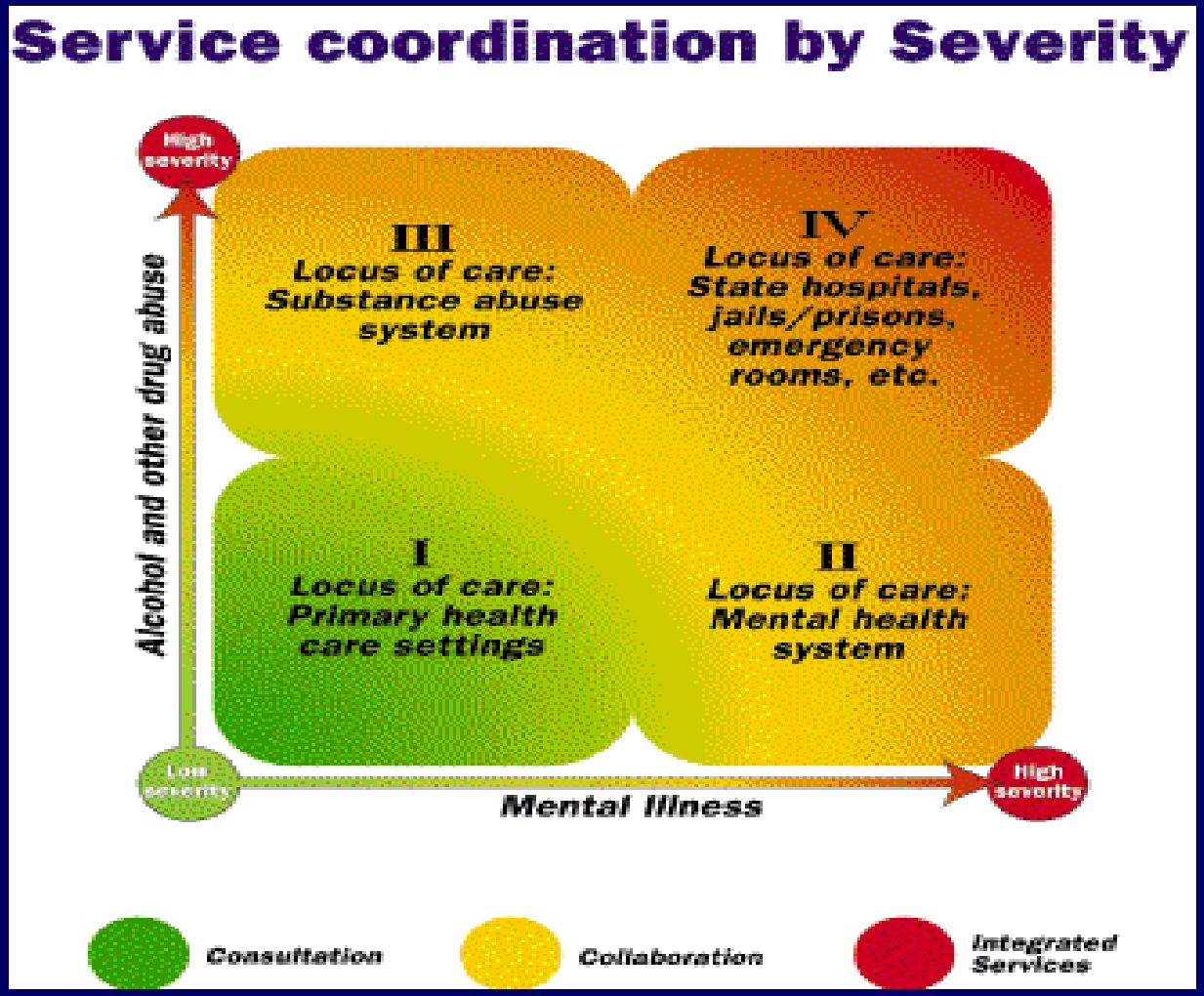
RWJF/DPC Economic Model

- Reinforce clinical model
- Realign financial and non-financial incentives
- Alter contractual / organizational arrangements
- Pay for:
  - PCP depression care
  - MHS consultation
  - Care management
  - Distinguished performance
- Unique issues in local context

Methods of Paying for Care Management



The Four Quadrant Model



SAMHSA Report to Congress on the Prevention and Treatment Co-Occurring Substance Abuse Disorders and Mental Health Disorders (2002)

The Four Quadrant Clinical Integration Model

Behavioral Health Risk/Status (High ↑ / Low)

Quadrant II
BH ↑ PH ↓

- Behavioral Health (BH) Case Manager w/ responsibility for coordination w/ Primary Care Provider (PCP)
- PCP (with standard screening tools and BH practice guidelines)
- Specialty BH
- Residential BH
- Crisis/ER
- Behavioral Health IP
- Other community supports

Quadrant IV
BH ↑ PH ↑

- PCP (with standard screening tools and BH practice guidelines)
- BH Case Manager w/ responsibility for coordination w/ PCP and Disease Mgr
- Care/Disease Manager
- Specialty medical/surgical
- Specialty BH
- Residential BH
- Crisis/ ER
- BH and medical/surgical IP
- Other community supports

Stable SPMI would be served in either setting. Plan for and deliver services based upon the needs of the individual, consumer choice and the specifics of the community and collaboration.

Quadrant I
BH ↓ PH ↓

- PCP (with standard screening tools and BH practice guidelines)
- PCP-based BH*

Quadrant III
BH ↓ PH ↑

- PCP (with standard screening tools and BH practice guidelines)
- Care/Disease Manager
- Specialty medical/surgical
- PCP-based BH (or in specific specialties)*
- ER
- Medical/surgical IP
- SNF/home based care
- Other community supports

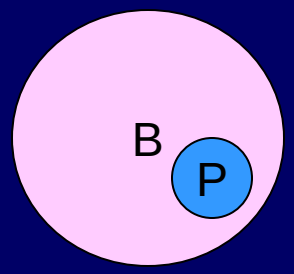
Physical Health Risk/Status (Low → High)

*PCP-based BH provider might work for the PCP organization, a specialty BH provider, or as an individual practitioner, is competent in both MH and SA assessment and treatment

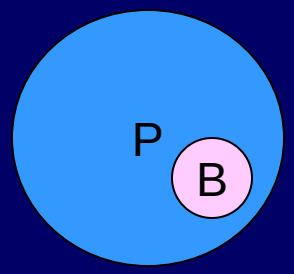
National Council for Community Behavioral Health (Winter, 2004)

Models of Linkage / Integration

Embedded PCP in BHS



Co-location of BHS in PCP



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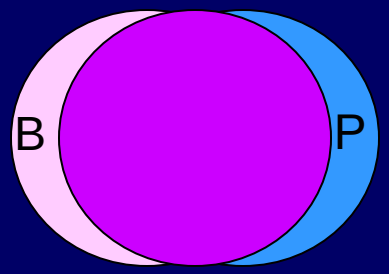
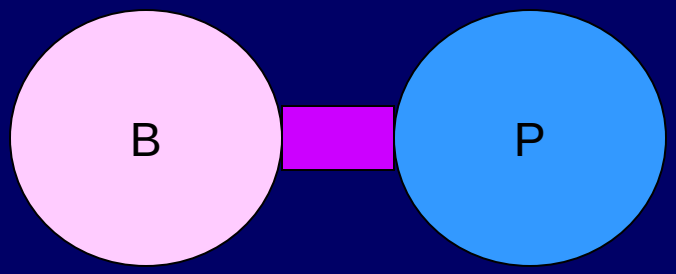


Coordination / Collaboration



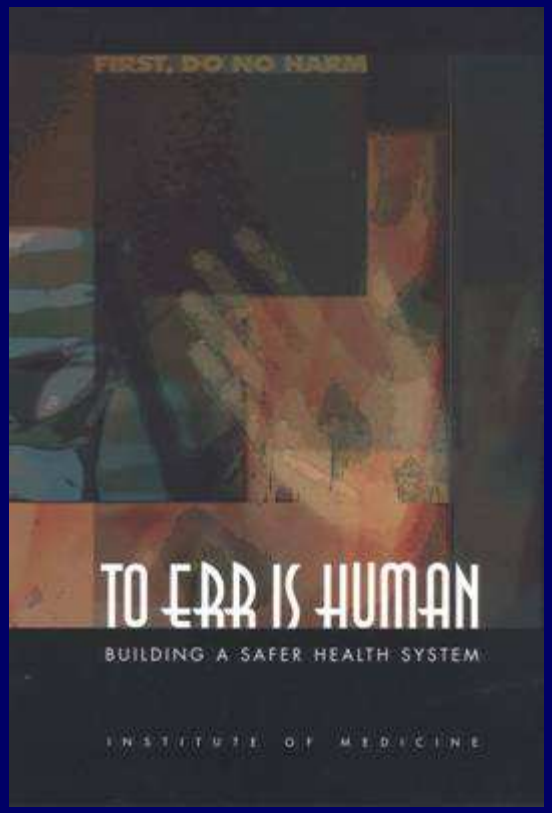
“Crossing the Quality Chasm”

Studies Documenting the "Quality Gap"

- Literature reviews conducted by RAND
  - Over 70 studies documenting quality shortcomings
- Large gaps between the care people should receive and the care they do receive
  - true for preventive, acute and chronic
  - across all health care settings
  - all age groups and geographic areas
- Only 50% chance of getting appropriate care

(Schuster et al, MMFQ,1998; updated 2000; McGlynn et al, NEJM 2003)

To Err Is Human: Building A Safer Health System

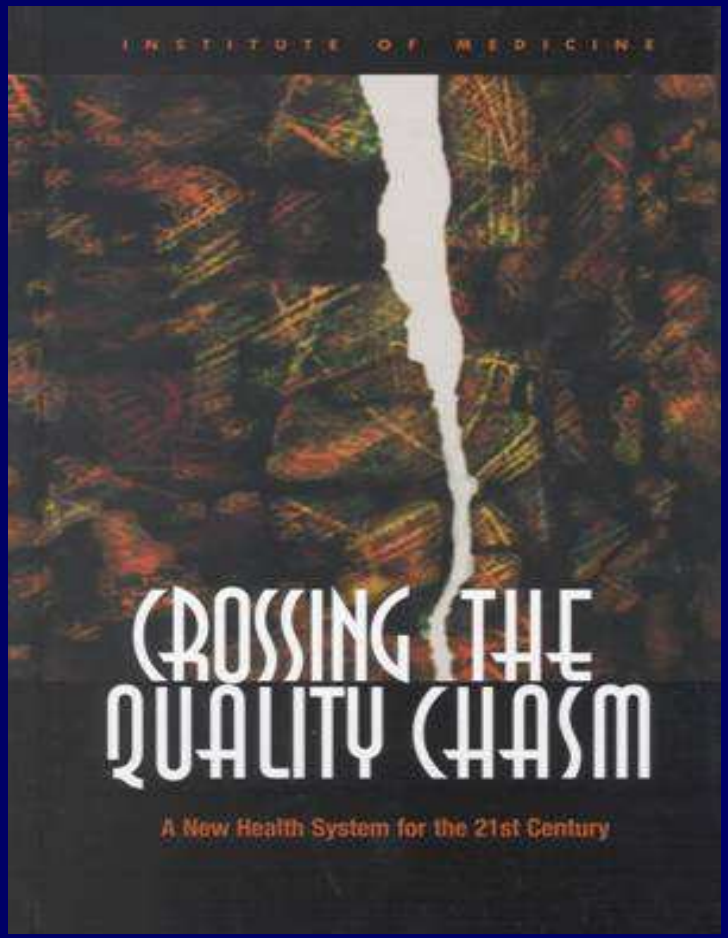


- First Report

- Committee on
- Quality of Health Care
- in America

- To order: www.nap.edu

Crossing the Quality Chasm



- Second Report
- Committee on Quality of Health Care in America
- To order: www.nap.edu

Committee's Conclusion

The American health care delivery system is in need of fundamental change. The current care systems cannot do the job. Trying harder will not work. Changing systems of care will.

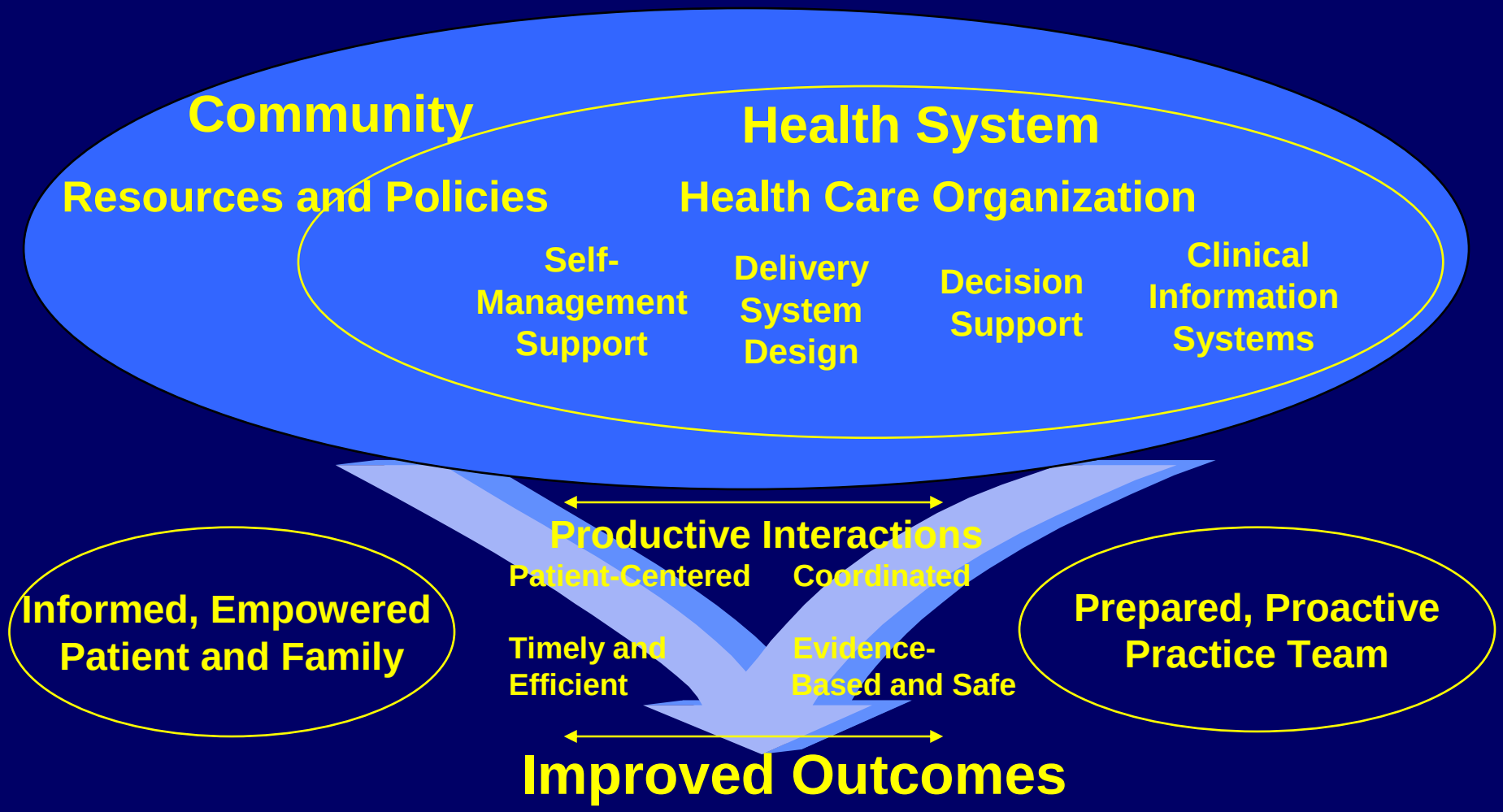
Six Aims For Improvement

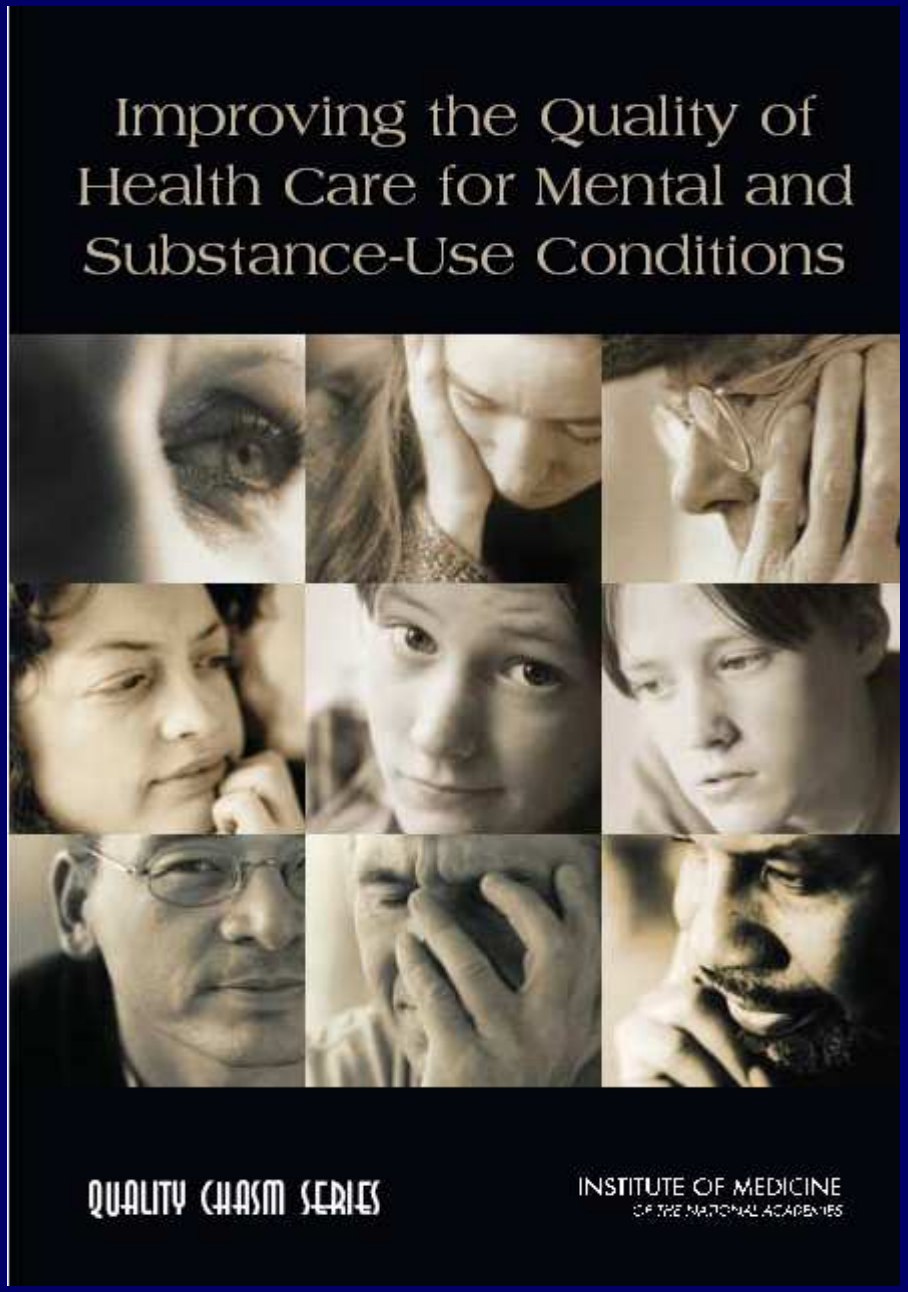
- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable

What People Should Expect from the Health Care System (10 rules)

- Continuous healing relationships
- Safety
- Cooperation
- Science
- Individualization
- Control
- Information
- Anticipation
- Transparency
- Value

Evidence-Based Chronic (Planned) Care Approaches for Treating Depression Are Effective




Improving the Quality of Health Care for Mental and Substance-Use Conditions
QUALITY CHASM SERIES
INSTITUTE OF MEDICINE

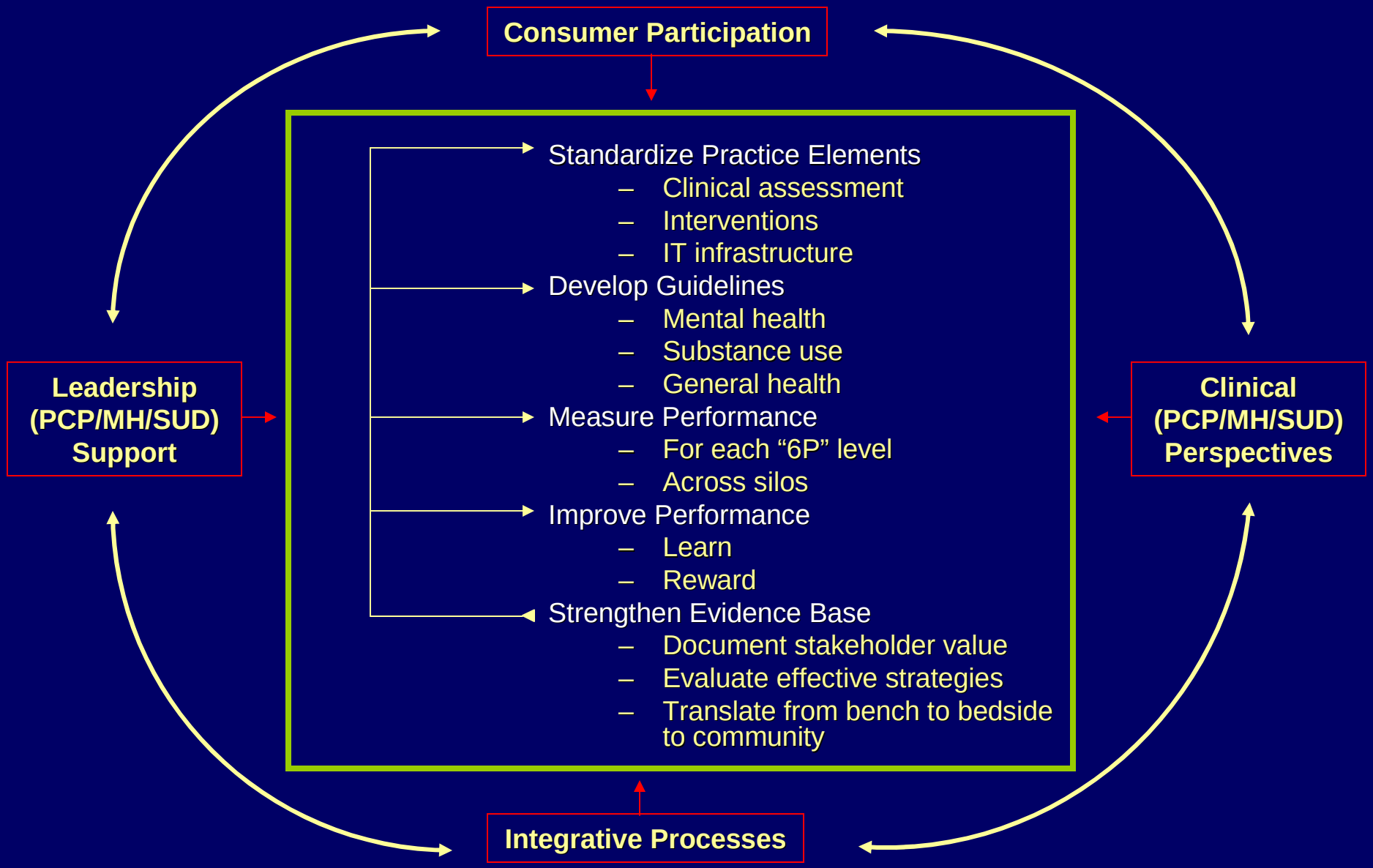
Six Problems in the Quality of M/SU Health Care

- Problem 1: Obstacles to patient-centered care
- Problem 2: Weak measurement and improvement infrastructure
- Problem 3: Poor linkages across MH/SU/GH
- Problem 4: Lack of involvement in National Health Information Infrastructure (NHII)
- Problem 5: Insufficient workforce capacity for QI
- Problem 6: Differently structured marketplace

Overarching Recommendation 1

The aims, rules, and strategies for redesign set forth in *Crossing the Quality Chasm* should be applied throughout M/SU health care on a day-to-day operational basis but tailored to reflect the characteristics that distinguish care for these problems and illnesses from general health care.

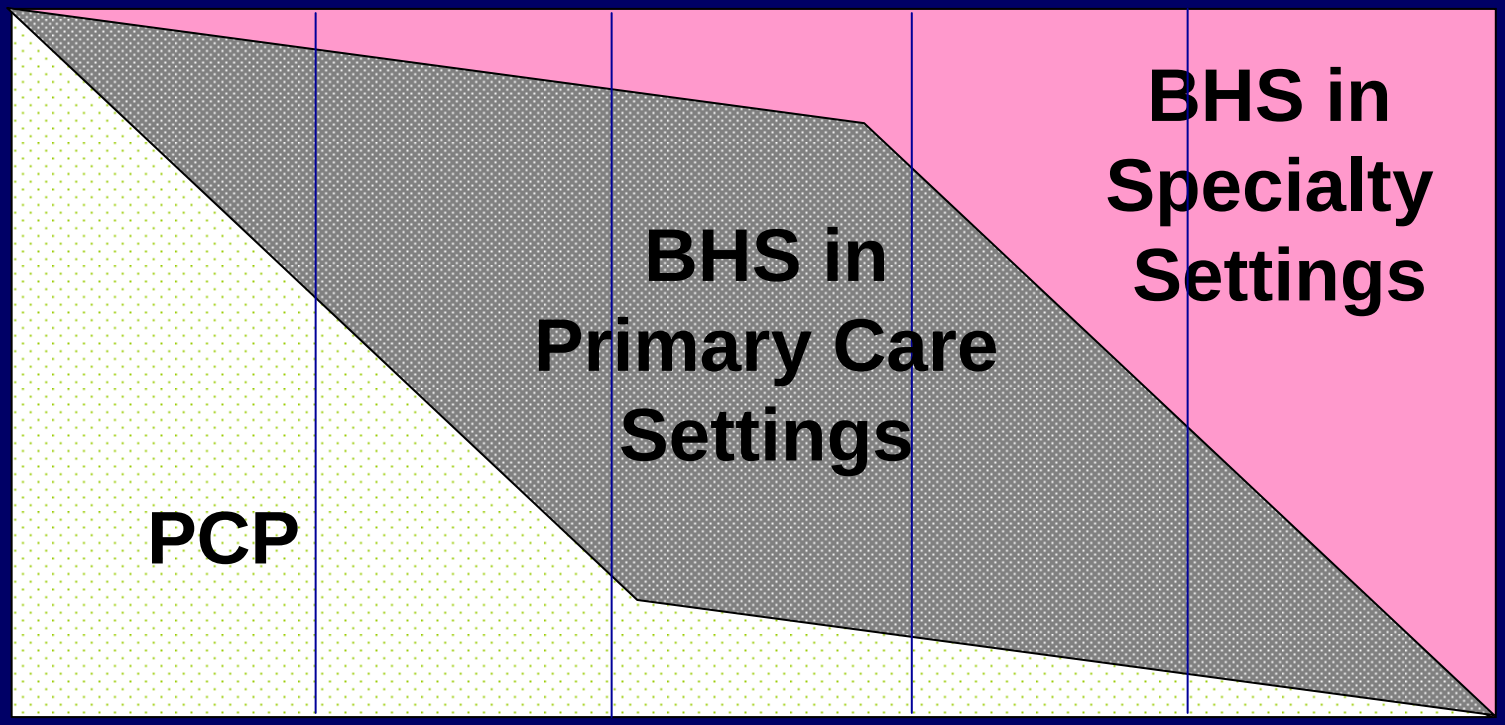
Preparing for the Future



Overarching Recommendation 2

Health care for general, mental, and substance-use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind / brain and the rest of the body.

Relative Degree of Involvement of PCPs and Behavioral Health Specialists (BHS)



None Subthreshold Simple Complex Severe

Type of Problem / Disorder

“10 P” Framework

- Patients / Consumers
- Providers
- Practices / Delivery Systems
- Plans – MCO / MBHO
- Purchasers – Public / Private
- Populations / Community
- Professors (Educators, Researchers)
- Policy Makers (Regulators, Funders)
- Politicians
- Purveyors (“experts”, consultants)

René Descartes

Don’t Split Mind and Body

Questions

- How should behavioral disorders / psychosocial problems in primary care be defined?
- What are the expectations for screening / identification/follow-up?
- What are the expectations for PCP/MHS roles in treatment?
- What are the optimal practice organizations for meeting these expectations?
- What financing mechanisms need to be put in place?