

Integrated Primary Care: Lessons Learned

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“SPMI” patients in an urban C.M.H. program:

- 81% - at least one significant medical illness
- 51% - at least one previously undiagnosed illness
- 53% - judged to need medical attention

Maricle, R., Hoffman, W. & Bloom, J. “The Prevalence and Significance of Medical Illness Among Chronically Mentally Ill Outpatients.” *Community Mental Health Journal* 23:81-90, 1987.



Behavioral Health Needs Assessment in Primary Care

Mental Health/Substance Abuse
Health Behavior Change
“Ambiguous” and Chronic Illness



Prevalence of Behavioral Health Problems in Primary Care

Mental Health/Substance Abuse

PHQ-3000 Merrilac 500

■ Major Depression	= 10%	24%
■ Panic Disorder	= 6%	16%
■ Other Anxiety Disorders	= 7%	21%
■ Alcohol Abuse	= 7%	17%
■ Any Mental Health Dx	= 28%	52%



“Ambiguous” and Chronic Illness

The vast majority of primary care visits are related to behavioral health needs but not to identified mental health disorders.

Kroenke, K. & Mangelsdorff, A. D. (1989). Common symptoms in ambulatory care: Incidence, evaluation, therapy and outcome. *American Journal of Medicine*, 86, 262-266.



“Ambiguous” and Chronic Illness

10 most common complaints in adult primary care. 15% x organic pathology found

(Kroenke & Mangelsdorff, 1989)

chest pain	back pain
fatigue	shortness of breath
dizziness	insomnia
headache	abdominal pain
swelling	numbness



Culture Impacts Depression

Culturally Syntonic Approaches

Signs of Depression found Cross-Culturally

- Appetite changes
- Sleep changes
- Psychomotor agitation or retardation
- Decreased energy
- Decreased libido
- Diminished ability to think or concentrate

Signs of Depression found in “Western” Cultures

- Self-deprecation
- Hopelessness
- Guilt
- Suicidality

Pfeiffer, W. (1968). The symptomatology of depression viewed transculturally. *Transcultural Psychiatry Research Review* 5: 121-123.



Underserved and Minority Populations are Particularly Affected

“...racial and ethnic minorities are less inclined than whites to seek treatment from mental health specialists. Instead, studies indicate that minorities turn more often to primary care.”

Surgeon General's Report on Mental Health, 1999.
Supplement on Culture, Race and Ethnicity



Categories of Relationship between Collaborating Medical and Behavioral Health Services

□ Coordinated

□ Co-Located

□ Integrated



Coordinated = Behavioral services by referral at separate location

Co-Located = By referral at medical care location

Integrated = Part of the “medical” treatment at medical care location



Programs of Collaborative Care

- Coordinated
- Targeted
- Specified

Massachusetts Child Psychiatry
Access Project



CO-LOCATED

BHP working in primary care seeing all referred.

Advantages:

Access

Patient Satisfaction

Provider Satisfaction

Cost Effectiveness

Clinical Outcome (in most studies)

Problems:

Referrals don't show

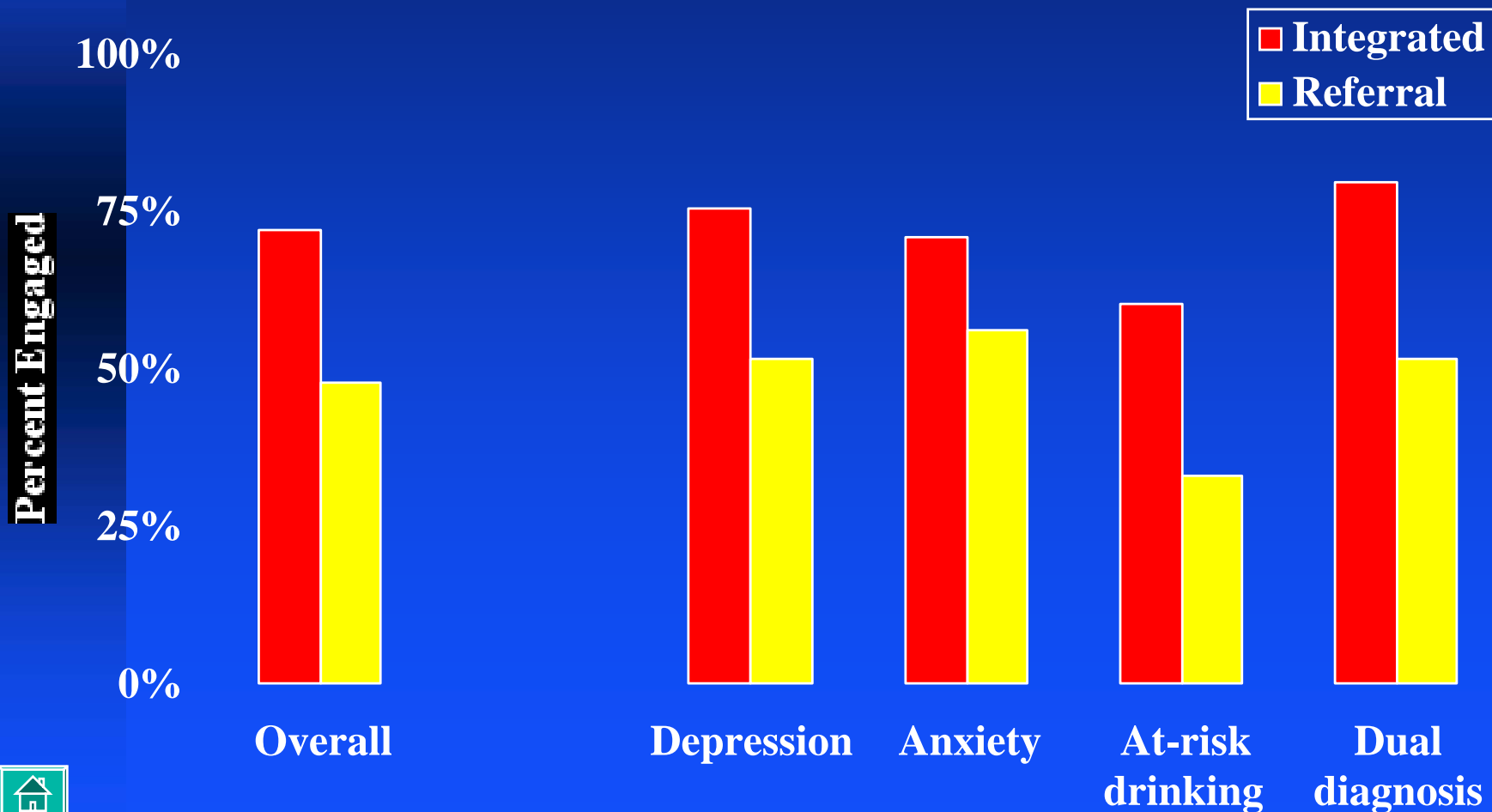
Case-loads fill up



It is crucial to ACCESS

Rates of Engagement in MHSA Care: By Diagnosis/Condition

Stephen Bartels, MD, MS – Dartmouth Medical School



INTEGRATED

BHP working in primary care as part of a team delivering care through a single treatment plan.

Advantages:

Access

Patient Satisfaction

Provider Satisfaction

Fits protocols

Cost Effectiveness and Offset

Clinical Outcome

Outcome Maintenance

Problems:

Sometimes narrowly
focused



Summary of 1st & 2nd Generation Studies

Stephen Bartels, MD, MS – Dartmouth Medical School

- Multiple component interventions
- Lectures &/or distributing guidelines do not change behavior nor outcomes
- Adding patient tracking with a care manager significantly improves outcomes
- Including a mental health specialist in an integrated treating or consulting role improves outcomes the most



Relationship with “Specialty Mental Health”

- Still important for longer term care
- Makes referrals to SMH more likely to be successful
- Specialty MH able to better target high need populations
- Consultation backup to PCP
- In some systems SMH has developed specialized teams to support generalist PCBH clinician



Won't the increased attention to primary care eat up most of the resources for Specialty Mental Health?

- Not if it is done right.
- Care for the “Over-Serviced and Under-Served”



Examples of the Impact of a Team Approach to “Complex” Pts

- **CareOregon** – risk stratify most costly 12% (60%)

	<u>2004</u>	<u>2005</u>	<u>Change</u>
High-risk/high-cost	\$8296	\$3285	- 60%
Low-risk/high-cost	\$1624	\$ 847	- 48%

- **Permanente No. Cal.** – Asthma, CAD, CHF, DM

Improved quality indicators, slower rise in admissions, lower rise in costs (12% vs 25% over 4 years), when contrasted against control group



Won't the increased attention to primary care eat up most of the resources for Specialty Mental Health?

- Not if it is done right.
- NC is an example of what is possible.
 - ◆ Voluntary Community Care networks by county paid by Medicaid
 - ◆ Coordinated by local non-profit
 - ◆ PM/PM for medical home for all
 - ◆ Care managers provided to support PCPs
 - ◆ Evidence based initiatives for chronic illnesses
 - ◆ Co-location of MH providers



Results in NC

- In FY 2004 investment in Community Care Networks – \$10.2 million
- Savings over FY 2003 - \$124 million
- FY 2005 and 2006 final results - \$231mil.

“We were able to pay for overruns in the Mental Health budget (helping to preserve those services).” Allen Dobson, MD Former Head of NC Medicaid



Primary care is our best venue
for improving population health
and for controlling medical cost.

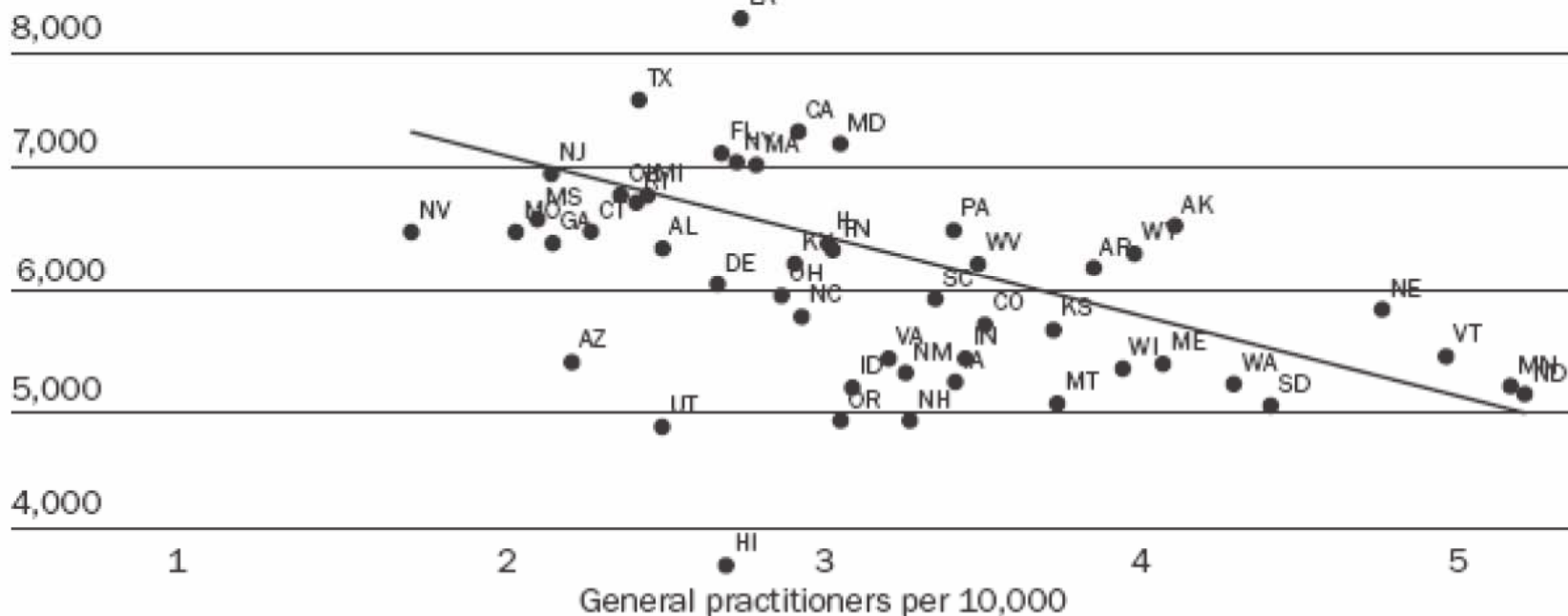
**The Impending Collapse of Primary Care Medicine and Its
Implications for the State of the Nation's Health Care:
A Report from the American College of Physicians
January 30, 2006**



EXHIBIT 9

Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000

Spending per beneficiary (dollars)



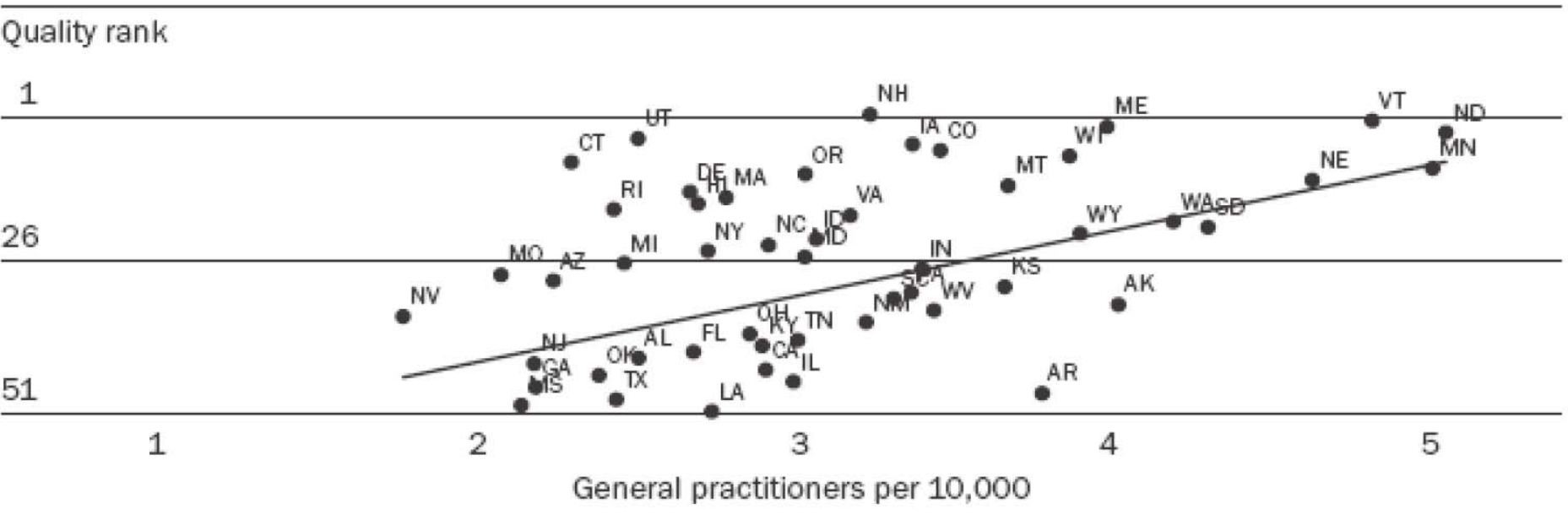
SOURCES: Medicare claims data; and Area Resource File, 2003.

NOTE: Total physicians held constant.



EXHIBIT 8

Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000



SOURCES: Medicare claims data; and Area Resource File, 2003.

NOTES: For quality ranking, smaller values equal higher quality. Total physicians held constant.



Mortality Outcomes

- Primary care: 1 per 10,000 (20%) increase in primary care physicians results in 5% decrease in mortality or 40 fewer deaths per 100,000
 - ◆ Family Physicians: 1 per 10,000 (33%) increase results in 9% decrease or 70 per 100,000 fewer deaths
- Specialists: 1 per 10,000 (8%) increase in specialist physicians results in 2% increase in mortality or 16 more deaths per 100,000



For further information:

Collaborative Family Healthcare Association

www.CFHA.net

www.IntegratedPrimaryCare.com

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