WHAT IS INTEGRATION? LESSONS LEARNED AROUND THE COUNTRY

"… the Patient Centered Medical Home will not reach its full potential without adequately addressing patients' mental health needs. Doing so, however, will likely shift responsibility for the delivery of much mental health care from the mental health sector into primary care… *a change that many stakeholders will likely oppose.*"

(italics added)

Croghan TW, Brown JD. Integrating Mental Health Treatment Into the Patient Centered Medical Home. AHRQ Publication No. 10-0084-EF. Rockville, MD: Agency for Healthcare Research and Quality. June 2010.

PRIMARY CARE AND MENTAL HEALTH: CURRENT REALITY

- Most mental and behavioral issues first present in primary care. When inadequately treated, mental health conditions and unhealthy behaviors lead to poor outcomes and higher cost of care.
- Most are either unrecognized, untreated or undertreated. Both primary care and mental health providers are already overburdened (and often underpaid and unappreciated).
- Most who are referred to mental health care do not engage in care, leading to progression of illness for many, with profound consequences for individuals, families and society as well as significantly increasing costs of overall healthcare. Non-engagement is typically "blamed" on the person.
- Moving existing mental health care into primary care is a good start but has not been effective. Integration requires a shift in how we understand and treat *most* people with MH conditions, while reserving our traditional specialized resources for those who cannot be managed in PC.
- Sometimes a few words from a trusted PCP carry more potential for change than a full course of therapy from a MH provider.
- Healthcare is evolving away from an exclusively disease-based approach to one emphasizing wellbeing. Typical healthcare has only a small impact on health and wellbeing.

TOUGH TO DO THIS ALONE

THIS IS ABOUT TRANSLATION OF EVIDENCE INTO PRACTICE

What does the evidence from systematic research (one pillar of evidence based care) tell us?

- Screening alone is (at best) inadequate to improve care. At worst it can be harmful
- Collaborative Care Model Improves outcomes with limited initial cost
- Health Psychology improves outcomes for many conditions
- Co-Location of MH/SA in primary care is necessary but not sufficient to improve care
  - Requires a change of our culture of care
- Measurement based care Improves clinical outcomes at same or reduced cost
- Peer support improves engagement in treatment and can be provided in primary care as well as mental health.
- The longer the wait for care, the less likely people will get it.

Caveat: Integrated care is still very early in its evolution

"Avoid premature orthodoxy" (AHRQ 2008)

TARGETING EVALUATION AND TREATMENT TO NEED: SHIFTING TO A STEPPED CARE APPROACH

- Primary: MH care can be delivered in the same setting as general Primary Care by primary care teams which includes clinicians with mental health expertise. Address the chief complaint with brief evaluation and treatment.
- Secondary: Those whose problems are more complex require more specialized care which may be more difficult to provide within primary care
- Tertiary: Many specific conditions require a more specialized team or residential setting

Does every patient with substance use disorder need referral to a program or are there other steps in between?

MANY MODELS AND TERMS: LIKE MOST MODELS, ALL ARE WRONG, BUT MANY ARE USEFUL

Models do not take reality into account but there are three prominent models of integration to talk about.

- Behavioral Health Consultant
- Collaborative Care Model
- Co-located collaborative care

An ideal system will include elements of all three. Disagreement about "which one is better" gets us nowhere.

WHAT DO THE MODELS HAVE IN COMMON?

- Co-location
  - necessary but not sufficient
  - Can be virtual
  - Without a change of approach, co-location alone will fail as access steadily deteriorates.
- Strive for open (or at least advanced) access
- Decision support
- 2-6 Brief, (15-30 minutes) problem focused appointments
- Team based care with clearly defined roles many disciplines.
- Population management, not caseload
- Measurement

TYPICAL OUTCOMES IN PEER REVIEWED LITERATURE

- Improved identification and treatment in the primary care population
- Improved engagement/continuation in care if referred to more intensive level
- Reduced demand for more specialized MH care
- High patient and provider satisfaction
- Increased likelihood of guideline concordant care
- Improved concordance with clinical practice guidelines by primary care providers when prescribing antidepressants
- Reduced no-shows

CHALLENGES

- Reimbursement, and understanding that PARITY is not just about money. Separate but equal doesn't get us there and adding more money to keep doing more of the same won't get us there either.
- Space: Quantity and Design (onstage/offstage model)
- Training, workforce development
- Maintaining open or advanced clinical access
- Expand the evidence base for brief treatments
- Cost effectiveness versus cost offset
- Improve integration with the rest of MH
  - Stepped care requires CULTURE CHANGE
  - Defining the limits of what can be done in primary care (moving toward increasing complexity)

BOTTOM LINE: MANY (MOST) PATIENTS CAN BE ADEQUATELY TREATED IN PRIMARY CARE IF WE DO A FEW THINGS DIFFERENTLY

- Accept that most mental health conditions are straightforward, and a stepped approach is efficient and saves the scarce specialty resources for those who need them
- Bring more MH/SA care into primary care (including Medication Assisted Treatment for SUD)
- Abandon requirements for "full" evaluations for any individual with a MH condition
- Embrace Patient Reported Outcome Measures (PROMs) to improve assessment/triage and guide treatment
- Build clinical pathways to follow-up positive screens
- Adopt shared decision making as the norm. Though individuals may have multiple problems that could be addressed, they are experts in their own lives and can prioritize
- Continue development of ultrabrief, problem focused interventions that can be used in primary care
- Maintain recent gains in reimbursement/credentialing for virtual care
- Eliminate the waiver requirement for buprenorphine prescribing
- Bundled payment systems
- Support "non medical" approaches that improve health and well-being, such as work, housing, spirituality, environment, social connection, etc.

A WORD (PICTURE) ABOUT SUICIDE PREVENTION

Population = 20,000,000
Rate = 40/100,000
Suicide Deaths = 8,000

"a large number of people at a small risk may give rise to more cases of disease than the small numbers who are at high risk" (Rose 1992).

At risk population = 10,000
Rate = 400/100,000
Suicide Deaths = 40

Start where you are

Use what you've got

Do what you can

Arthur Ashe