Integrating Behavioral Health and Primary Care

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Presentation Goals

• Provide evidence-based rationale for behavior health – primary care integration in the medical neighborhood

• Identify some challenges and approaches for evaluating care integration
Top 10 reasons why behavioral health should be part of the medical neighborhood (overheard at the PCPCC Annual Summit)

7. Prevalence of Behavioral Health Problems in Primary Care
6. Unmet Behavioral Health Needs in Primary Care
5. Cost of Unmet Behavioral Health Needs
4. Lower Cost When Behavioral Health Needs are Met
3. Better Health Outcomes
2. Improved Patient Experience
1. Helps meet core principles of PCMH
7. Prevalence of Behavioral Health Problems in Primary Care

Behavioral Health and Primary Care Are Inseparable

• 84% of the time, the 14 most common physical complaints have no identifiable organic etiology\(^1\)

• 80% of people 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\(^3\)

• 48% of the appointments for all psychotropcic agents are with a non-psychiatric primary care provider\(^4\)

6. Unmet Behavioral Health Needs

- 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 appt\(^2,3\)
- Two-thirds of primary care physicians (N=6,660) reported not being able to access outpatient behavioral health for their patients.

- PCPs cite important barriers to mental health care access\(^4\)
  - Shortages of mental health care providers
  - Health plan barriers
  - Lack of coverage or inadequate coverage

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Unmet Needs: Reasons People Die

5. Cost of Unmet Needs

• BH disorders account for half as many disability days as “all” physical conditions\textsuperscript{1}

• Annual medical expenses--chronic medical & behavioral health conditions combined cost 46% more than those with only a chronic medical condition\textsuperscript{2}

• Top five conditions driving overall health cost (work related productivity + medical + pharmacy cost)\textsuperscript{3}

  Depression  Arthritis  
  Obesity  Back/Neck Pain  Anxiety

\textsuperscript{1} Merikangas et al., Arch Gen Psychiatry. 2007;64:1180-1188
\textsuperscript{2} Original source data is the U.S. Dept of HHS the 2002 and 2003 MEPS. AHRQ as cited in Petterson et al. “why there must be room for mental health in the medical home Graham Center One-Pager)
\textsuperscript{3} Loeppke et al., J Occup Environ Med. 2009;51:411-428.
The Cost of Poor Health to Employers

Personal Health Costs
- Medical Care
- Pharmaceutical costs
- Workers' Compensation Costs

Productivity Costs
- Absenteeism
  - Short-term Disability
  - Long-term Disability
- Presenteeism
  - Overtime
  - Turnover
  - Temporary Staffing
  - Administrative Costs
  - Replacement Training
  - Off-Site Travel for Care
  - Customer Dissatisfaction
  - Variable Product Quality

Iceberg of Additional Costs to Employers from Poor Health

30% 70%

Top 10 Health Conditions Driving Costs for Employers (Med + Rx + Absenteeism + Presenteeism)

Costs/1000 FTEs

5. Cost of Unmet Needs - Continued

Healthcare use/costs twice as high in diabetes and heart disease patients with depression¹

<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>

1. Original source data is the U.S. Dept of HHS the 2002 and 2003 MEPS. AHRQ as cited in Petterson et al. "Why there must be room for mental health in the medical home (Graham Center One-Pager)
5. Cost of Unmet Needs - Continued

- Untreated mental disorders in chronic illness is projected to cost commercial and Medicare purchasers between $130 and $350 billion annually\(^2\)

- Approximately 217 million days of work are lost annually to related mental illness and substance use disorders (costing employers $17 billion/year)\(^2\)

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4. Lower Cost When Treated

Medical use decreased 15.7% for those receiving behavioral health treatment, while controls who did not get behavioral health medical use increased 12.3%.

Depression treatment in primary care for those with diabetes had a $896 lower total health care cost over 24 months as compared to those who did not receive treatment for depression.

Depression treatment in primary care $3,300 lower total health care cost over 48 months.

3. Better Outcomes

Systematic reviews and other rigorous, peer-revised studies show that integrated care leads to better patient outcomes\(^1\)\(^-\)\(^5\) for:

- Depression
- Panic Disorder
- Tobacco cessation
- Alcohol Misuse
- Diabetes
- IBS
- GAD
- Chronic Pain
- Primary Insomnia
- Somatic Complaints

2. Craven et al., Canadian Journal of Psychiatry. 2006;51:1S-72S.
5. Hunter et al., Integrated Behavioral Health in Primary Care: American Psychological Association, 2009
2. Improved Patient and Provider Experience

- With a shift to integrated delivery models, *patient experience* with healthcare delivery improves\(^1\)\(^{-5}\)
- With a shift to integrated delivery models, *primary care provider* experience improves too\(^6\)\(^,7\)

1. Including Behavioral Health in the Patient Centered Medical Home Helps Meet Core Principles

A) **Whole Person Orientation** - (majority of personal health care in primary care)

B) **Coordinated Integrated Care** - Personalized care across acute and chronic problems, to include prevention, focus on physical, social, environmental, emotional, behavioral and cognitive aspects of healthcare

C) **Enhanced Access** – Improved access to a range services to meet healthcare needs must include addressing behavioral health issues in primary care

D) **Payment for Added Value** - Enhance evidence-based screening, assessment and intervention for mental/behavioral health, substance misuse and abuse and health behavior change, that improves acute and long-term outcome, patient and provider satisfaction, decreases monthly cost for enrolled population, decreases ER visits, and prevents/decreases hospitalizations (i.e. medical and psychiatric)
What does a successful model of behavioral health – primary care integration look like?

Prescription for Health

• In-practice health risk assessment (HRA) and brief counseling, coupled with referral and outreach to a valued and known counseling resource, emerged as the best way to consistently coordinate and encourage follow-through for health behavior counseling.

• Automated prompts and decision support tools for HRA, brief counseling and referral, training in brief counseling strategies, and co-location of referral with outreach facilitated implementation.

What does a successful model of behavioral health – primary care integration look like?

Prescription for Health

• Interventions that attempted to minimize practice or clinician burden through telephone and Web-based counseling systems or by expanding the medical assistant role in coordination of health behavior counseling experienced difficulties in implementation and require more study to determine how to optimize integration in practices.

  – Brief descriptions of the P4H Intervention
  – Results
Cutting-edge Integration Programs

• Advancing Care Together (TCHF)

• Academy for Integration (AHRQ)
  – National Integration Academy Council (NIAC)
  – Survey Work
  – Workforce Assessment
Advancing Care Together

ACT program goals:

To unite frontline clinicians and leaders working in the areas of mental health, substance use, health behavior change and primary care to work together to identify, test and compare practical strategies that can accomplish the delivery of comprehensive, whole-person care for people with emotional and behavioral problems...
Just a few of the complexities...

• Behavioral health staff part-time
  – Implications for workflow
• How clinicians communicate about behavioral health services
• How billing is done
• Who helps and how are services paid for in crisis situation
• Additional effort or coordination and collaboration work
Implications for Research Design

• Dissemination or quality improvement research rests on the experiences and behaviors of frontline innovators
• Methods are needed to bridge frontline expertise and systematic inquiry
• There is a need to move the experience-based knowledge of those implementing quality improvement interventions from the realm of anecdote to the realm of science
What are the current challenges

• Dissemination of evidence-based approaches
  – Strengths and weakness of the RCT
    • Scientific rigor and sustainable reality
    • Key elements of integration – process pieces; not meds and therapy
    • Effort, motivation and ‘real’ costs
    • Systematizing integration – the realities...

• Measurement of integration in everyday practice
  – What are we measuring?
  – There is no gold standard “tool”
  – Consistent documentation and relevant tracking

• Financial sustainability
ACT Evaluation Design

• Mixed-methods evaluation
  – Qualitative cross-project comparative analysis to examine the process of implementing ACT interventions
  – Quasi-experimental study
    • Longitudinal pre-post cohort study to examine the effectiveness of ACT interventions on improving patient outcomes
ACT Evaluation Design
Design enhancement

• Process evaluation changes – we’re working directly with practices
  – Diagramming / specifying interventions at baseline
  – Inclusion of additional voices
    • Practice members (additional site visits and interviews)
    • Patients (interviews)

• Examine overall system utilization

• Patient Outcomes
  – Collaborative approach that is reasonable
  – Establish common elements
    • Variables / Measures – PHQ9, GAD 7, AUDIT
    • Selection criteria – all patients eligible for the intervention
    • Patient Tracking – detailed tracking of Reach, treatment and demographic information, as well as patient ID. -- FINITE
    • Data collection time points – pre and post
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