Integrating Behavioral Health Services with Primary Care

Brenda J. Johnston, DNP, PMHNP-BC, PMHCNS-BC

This presenter has no conflict of interest to disclose

Objectives & Goals

Objectives

• Discuss the difficulties encountered providing care for patients with mental illness and co-morbid health conditions in a fragmented health care system.
• Define integrative care and discuss the benefits of collaborative care models.
• Describe integrative practice solutions for incorporating behavioral health services into the primary care setting.

Goals

• Improve Access
• Improve communication
• Facilitate shared-decision making
• Mentor
• Improved patient satisfaction
• Track outcome measures

Scope of the Problem

• Persons with mental illnesses die 14-32 years earlier than the general population

• Fragmented care contributes to poor mental health outcomes

Comorbidity

25% of US Adults have Mental Disorders

58% US Adults have a medical condition

64% of adults with mental illness have at least one medical condition

29% of adults with medical conditions have a mental health disorder


62% of US Adults have a medical condition

29% of adults with medical conditions have a mental health disorder

Primary Care is the ‘De Facto’ Mental Health System

Wang P. et al., Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005.

Only 12% see a psychiatrist

National Comorbidity Survey Replication
Prevalence of lifetime health care utilization

4% Primary Care

49% General Medical

50% No Treatment

66% Professional
The Gateway

- 75% of patients with depression see PCPs and 80% of antidepressants are prescribed by PCPs
- PCPs have limited psychiatric training and experience and most do not routinely screen for mental illnesses
- Depression goes undetected in >50% of primary care patients and is often undertreated
- Only 20-40% of patients improve substantially in 6 months without specialty assistance


The Free Medical Clinic (FMC)

- Opened in 1986
- Medical home for nearly 1300 patients.
- The mission is to provide the gift of health to those in need.
- The FMC is dedicated to the belief that everyone should have access to health care services.

The Free Medical Clinic

- The clinics unduplicated visits totaled 11,500 in 2012.
- Limited behavioral health (BH) services one night per month began in 2004,
- BH services comprise 7% of the total patient visits to the FMC.
Important Considerations

- There is an identified need to improve existing mental health care for established FMC patients
- The FMC is not a mental health facility
- It is a medical home for 1300 individuals, and many patients have co-morbid psychiatric illnesses
- There are no plans to expand services that include patients with mental illness as their primary diagnosis
- The program evaluation of existing BH services will be used only as a guide for making suggested revisions to current services

Top 4 Diagnosis at the FMC

- Hyperlipidemia
- Hypertension
- Diabetes
- Depression and Anxiety

Program Evaluation

Structure
- No established pt. flow
- PCPs express discomfort with BH treatments
- Limited screening & F/U
- No case management & limited counseling

Process
- 4 hour/mo. BH service
- No room for growth
- 3 mo. wait list for referrals
- No EHR
- No BH guidelines available for PCPs

Outcome
- No established pt. flow
- PCPs express discomfort with BH treatments
- Limited screening & F/U
- No case management & limited counseling

Outcome measures not routinely checked:
- Medication adherence
- Treatment progress
- Psychiatric medications filled

Mental Health Providers in the Primary Care Setting

- Able to use behavioral activation techniques with patients as an adjunct to other treatments
- Able to provide optional evidence-based, brief structured psychotherapy
- Able to establish quick raports to a wide range of individuals
- Ability to make patients feel that they are being listened to and supported
- Can bill utilizing therapy codes

A Pilot CCM

- Piloted CCM at the FMC each Thursday from 9am-1pm beginning August 2013 through April 2014
- Staff to include RN Care Manger and PMHNP
- Implement elements to determine feasibility and effectiveness
- Track outcome measures
  - Patient and provider satisfaction
  - Psychiatric vital signs
  - Number of patient visits
  - BH hospital admissions
  - Benefits of collaboration
  - Impact on BH monthly clinic
What is a PMHNP?

MSN or DNP prepared
Three separate, comprehensive graduate-level courses in:
• Advanced physiology/pathophysiology
• Advanced health assessment
• Advanced pharmacology
Content in:
• Health promotion and/or maintenance
• Differential diagnosis and disease management, including the use and prescription of pharmacologic and non-pharmacologic interventions
• Clinical training in at least two psychotherapeutic treatment modalities.
PMHNP-BC Credentialed through ANCC and licensed through the BON
Full prescriptive authority
Collaborative practice agreement with physician

Solutions

• Collaborative Care Models promote evidenced-based practices and significantly improve treatment outcomes;
  o Improved coordination of care
  o Shared treatment plans
  o Eliminating communication barriers
  o Facilitates patient-centered care
  o Emphasis is on evidenced-based practices with established methods of tracking patient outcomes
  o Prevents duplicative services
  o Cost effective

(Collaborative Care Models)
Collaborative Care Model (CCM)

- Comprehensive screening and assessment
- Shared development and communication of care plans
- Care coordination and management
- Increased patient-provider collaboration


Start in the Waiting Room

Comprehensive Screening and Assessment

- Utilize screening tools to identify mental health symptoms and monitor treatment progress
  - Generalized Anxiety Disorder Questionnaire (GAD 7)
  - Patient Depression Questionnaire (PHQ 9)
  - Mood Disorder Questionnaire
### GAD 7 Tools

- Simplified questionnaire developed to help in the diagnosis of Generalized Anxiety Disorder, or GAD.
- 7 item questionnaire
- Score of 10 or more on the GAD-7 represented a reasonable cut point for identifying cases of GAD
- Cut points of 5, 10, and 15 may be interpreted as representing mild, moderate, and severe levels of anxiety on the GAD-7.

### PHQ-9

- Patient completed, brief assessment tool with a diagnostic validity established in studies involving 8 primary care and 7 obstetrical clinics.
- PHQ scores ≥ 10 had a sensitivity of 88% and a specificity of 88% for major depression.
- PHQ-9 scores of 5, 10, 15, and 20 represents mild, moderate, moderately severe and severe depression

Mood Disorder Questionnaire

- Brief, self-report questionnaire
- Not as sensitive for bipolar II disorder
- Good sensitivity and specificity
- Can correctly identify 7 of 10 patients with bipolar disorder.
- The MDQ can provide primary care physicians with a quick and easy way to identify patients most likely to have bipolar disorder.
Shared Decision-Making

- Involves both provider and patient working together to balance clinician’s experience and expertise with patient preferences, values and experiences.

- Recommended for those patients with conditions, such as depression, for which more than one reasonable form of treatment exists.

(Hostetter & Klien, 2012).

Pre-evaluation Questionnaire

How am I doing?
- Sleep
- Appetite
- Mood
- Medication adherence
- Relationships
- Stressors
- Medication side-effects
- How are you helping yourself?
- What are your goals for the next two weeks?
- What would you like to talk about today?
Care Management

- Scheduling
- Appointment adherence
- Medications
- Awareness of issues that impact treatment
- Facilitate community connections
- Maintains the flow
- Keeper of the charts
- The bridge between providers

Care Coordination & Management

[Diagram showing care coordination and management with percentages for different health conditions, such as Terminal illness (27.7%), Asthma (49.1%), COPD (37.5%), Cancer (63.7%), Heart disease (66.8%), Diabetes (74.5%), and others.]
Collaboration

• Consolidated records
• Face to face connections
• Input regarding treatment needs/concerns
• Providers serve as an on-site resource
• When medical/psychiatric issues arise help is close by
• Can schedule back to back appointments to further enhance treatment adherence

Must have Mental Health Resources

• The National Alliance for the Mentally Ill: www.nami.org
• Substance Abuse and Mental Health Services Administration: www.samsha.gov
• National Institute of Mental Health: www.nimh.nih.gov
• Depression and Bipolar Support Alliance: www.dbsalliance.org

Must have Mental Health Resources

• American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Health Disorders 5th Edition
Results

- Improved access to mental health services
- Mentored 10 psychiatric nurse practitioner students from Shenandoah University
- Timely follow-up
- Only one patient hospitalized on the BH Unit during the CCM pilot
  - Patient received prompt f/u after the admission

Results

![Bar Chart: CCM Pilot 20% Better Show Rate]

- Improved patient and provider satisfaction
- Improved communication with PCPs
- Decreased burden on volunteer BH staff
- Decreased waiting times for new patient mental health evaluations
- Adopted psychiatric practice guidelines
- Utilized screening tools for tracking psychiatric vital signs
- Disseminated findings to PCPs in local community
Results and Future Directions

- Improved patient and provider satisfaction
  - Documented through verbal feedback, patient attendance & treatment adherence
- Improved communication with PCPs
  - More progression towards integration is needed
- Decreased burden on volunteer BH staff
  - Clinic is completed at 8pm most nights
- Decreased waiting times for new patient mental health evaluations
  - Eliminated new patient waiting list
- Adopted psychiatric practice guidelines
  - BH providers need more education on medical treatment protocols
- Utilized screening tools for tracking psychiatric vital signs
  - Progression toward an electronic medical record is needed
- Disseminated findings to PCPs in local community

Conclusions Regarding Integrated Care

- Better coordination of care
- Mind and body connection
- More likely to keep appointments where multiple issues are being addressed
- Greater comfort discussing mental health issues
- Established relationship with primary care provider
- Less stigma walking into primary care setting then mental health setting

Barriers to Integrated Care

- Policy Barriers
  - Physical health and Mental health funding streams
  - Difficulty of sharing information due to HIPAA regulations (progress notes)
- Organizational Barriers
  - Shortage of mental health professionals
  - Limited communication between medical and mental health providers
  - Lack of agreement between medical and mental health providers
**Barriers to Integrated Care**

- **Clinical Barriers**
  - Traditional separation of mental health issues from general medical issues
  - Lack of awareness of mental health screening tools in the primary care setting
  - Physicians' limited training in psychiatric disorders and their treatment

- **Financial Barriers**
  - Lack of insurance parity for psychiatric disorders
  - Medicaid's low payment rates
  - Billing restrictions

**Sustaining the CCM**

- **Funding Issues**
  - The clinic does not meet criteria as a federally qualified health center
  - The Medicaid issue in Virginia
  - Funding cuts from major contributors

- **Solutions**
  - The local university has agreed to continue the pilot because it is consistent with community outreach goals and is a valuable clinical site
  - Serves as a model to encourage local PCPs to consider developing CCMs

**Key Points**

- CCMs are an effective way to provide patient-centered care.
- Interpretation of the model can vary depending on the practice size and setting.
- Challenges to developing and sustaining CCMs can best be addressed by engaging key stakeholders and utilizing creative funding strategies.

**References**

References


