

Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover



Integration of Behavioral Health and Primary Care: Sustainable Models

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Outline

- Integrated Care: Why do we need it?
 - Rates of co-occurring behavioral health and medical illnesses in people
- How do we provide it?
 - Primary care in BH programs
 - BH in primary care services
- What Services are needed regardless of setting?
- Sustainable models of integrated care: Approaches
 - Consultation and treatment of behavioral health disorders
 - Addressing complex co-occurring disorders
- Training primary care providers in behavioral health
 - SBIRT
 - Treatment of substance use and mental disorders: pharmacotherapy
 - Training methods

Epidemiology of physical and behavioral health problems: Rates of co-occurring disorders

- Rate of mental disorders in primary care populations: 29%
- Rate of physical illness in those with mental and substance use disorders: 68%
 - ***HIV: 8-20%***
 - ***Hepatitis: 20%***
 - ***Metabolic Syndromes: 40-50%***
- Complex co-occurring: mental/SUD with medical illness; e.g.: chronic pain, opioid misuse, depression: 25%

Services that should be available in all settings

- HIV testing
 - HIV Risk in people with BH disorders
 - Substance Users: Intoxication with high risk behaviors
 - Unsafe injection practices
 - Mental Disorders: Impulsive behavior, cognitive impairment, depression
 - USPSTF recommendation
 - Screening in adolescents and adults ages 15 to 65 years.
 - Younger adolescents and older adults who are at increased risk should also be screened

Services that should be available in all settings

- Hepatitis

- High rates: estimated 4.4 million Americans, most unaware

- Injection drug users:

- HBV: 17% of new cases HCV: up to 90%

- Alcohol users HCV: 14-36%

- SMI populations HCV: 19.6%

- USPSTF recommendations HCV: screening of the 1945-65 cohort; those at high risk

- Testing: HBV

- HCV: antibody test and nucleic acid confirmatory test; counseling

- Vaccinate for HAV and HBV

Services that should be available in all settings

- Screening for metabolic syndrome in those taking antipsychotic medications
- Obesity, Endocrine (diabetes) and CVD indices (hyperlipidemia)
- Rates are significant: 24% general population, 50% SMI
- Shortened lifespan
- Screening: abdominal girth, glucose, lipids

Services that should be available in all settings

- Screening for substance use disorders: SBIRT
- Screening, Brief Intervention, Referral to Treatment
 - Alcohol
 - Illicit drug use
 - Prescription opioid misuse
 - Tobacco
- Screening for depression (PHQ-2, PHQ-9)
- Basis of integrated care
- Vs.
- Bringing primary care into BH settings

How do we know integrated care is effective?

- Improvement in patient outcomes, treatment, costs (IMPACT study: depression treatment in primary care with depression care manager and consulting psychiatrist)
 - ***Facilitates information sharing between providers***
 - ***Patients retained in care***
 - ***Improvement in physical health with lower medical costs over time***
 - ***Cost effective: IMPACT patients had lower average costs for all their medical care – about \$3,300 less – than patients receiving usual care, even when the cost of IMPACT care is included***
- SBIRT for alcohol and illicit drug use
- When patients with lower severity mental health problems stay in primary care, more resources available for complex patients

Why Do We Need SBIRT?

Problem Substance Use is Prevalent in Americans

Risky Drinking: Binge (≥ 5 drinks/sitting)	23%
Heavy (≥ 5 d/mo binge drinking)	6.5%
Illicit Drug Use	9.2%
Substance Abuse or Dependence	8.7%
Alcohol	14.9 million
Illicit Drugs	4.5 million
Alcohol and Illicit Drugs	2.8 million

SAMHSA, National Survey on Drug Use and Health, 2012



SBIRT is Cost Effective

- Washington State Medicaid Cost Analysis of SBIRT in ED
- Working age (18-64 yr), disabled Medicaid patients
- Screened (AUDIT/DAST)
- SBI delivered by SA counselors
- SBIRT associated with significant reduction in Medicaid costs of \$366 per month per member (Estee et al. 2010)
- Similar results from study by Gentilello et al. 2005: SBIRT produced cost savings in reduced health expenditures/ improvement in workforce productivity of \$3.81 for every \$1.00 spent; possible savings of \$1.2 billion annually

Using SBIRT as a Means to Integration of Care

- SAMHSA General Medical Residency SBIRT Training Programs
- Training on assessment for substance misuse
- Incorporation of SBIRT into routine patient care
- Training on brief intervention/motivational interviewing
- Training on medication assisted treatment for substance use disorders

Challenges and Lessons Learned

- Just because you get a grant doesn't mean everyone is excited about it
- Data collection: patients are not the issue
- Classroom teaching is not enough

Just because you get a grant doesn't mean everyone is excited about it

- Resistance to new ideas/ways of doing things should be expected
- Not everyone is interested in substance abuse
- Have to get buy in from clinic leadership
- Identify champions and work closely with them
- Keep offering training (even if they say they don't want it)

Data collection: patients are not the issue

- Will patients object to being asked sensitive questions about their drug/alcohol use?
- Will staff address issues with their patients?
- EMR with reminders/ability to flag content for review by providers will help
- Cultural sensitivity is an important part of communication: eliciting information/understanding what the patient tells you

Classroom teaching is not enough

- Lectures/workshops introduce the ideas, but will not be enough to change practice
- Concept of screening for and possibly treating a substance use problem is outside of comfort zone for most primary care and mental health clinicians
- Other supports will be needed:
 - Standardized patient interactions with feedback
 - *Depression and alcohol abuse in an older woman*
 - *Alcohol abuse and atrial fibrillation in a young man*
 - *Prescription opioid abuse in a woman*
 - Case conferences; Project Echo
 - Consultant availability

Delivery of BH Services by Primary Care Physicians

- Primary care can deliver BH services:
 - Brief interventions
 - Alcohol pharmacotherapies (disulfiram, naltrexone, acamprosate)
 - Tobacco pharmacotherapies: nicotine replacement, bupropion, varenicline
 - Opioid pharmacotherapies (buprenorphine/naloxone, naltrexone)

Integration assures treatment of co-occurring disorders

- Care needs in terms of primary care, mental disorders and substance use disorders addressed
- Multiple disorders require a team approach
 - Psychiatry may consult and assist with treatment plan development or may provide the direct BH services needed
 - Psychology/social work/counseling/nursing provide for psychosocial needs/case management
- Complex, co-occurring disorders are easier to treat when a team approach is used
 - a more satisfying way of practicing medicine!
 - Sustainable in the evolving healthcare world
 - Medicaid health homes
 - Team approach for those with at least 2 chronic conditions, one chronic condition and be at risk for another, or one serious and persistent mental health condition
 - Same day billing restrictions are fewer

Consequences of not treating behavioral health problems

- Drug and alcohol use disorders affect approximately 10% of the American population; Mental disorders affect up to **25%**
- Substance use and mental disorders are chronic, relapsing diseases that are likely to recur
- Behavioral health disorders can negatively impact other illnesses present in the patient (e.g.: alcoholic cardiomyopathy, COPD, HIV/AIDS, HCV, other ID, chronic pain, CVD)
- SUDs may masquerade as an illness that the patient does not have (e.g.: HTN, seizure d/o, mental disorders)
- Can contribute to non-adherence, toxicities due to DDI
- Undetected illness
- More severe course
- Reduced quality of life
- Shortened life span

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