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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Chief Medical Officer
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

<table>
<thead>
<tr>
<th>Substance Use Type</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risky Drinking: Binge (≥5 drinks/sitting)</td>
<td>23%</td>
</tr>
<tr>
<td>Heavy (≥ 5 d/mo binge drinking)</td>
<td>6.5%</td>
</tr>
<tr>
<td>Illicit Drug Use</td>
<td>9.2%</td>
</tr>
<tr>
<td>Substance Abuse or Dependence</td>
<td>8.7%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>14.9 million</td>
</tr>
<tr>
<td>Illicit Drugs</td>
<td>4.5 million</td>
</tr>
<tr>
<td>Alcohol and Illicit Drugs</td>
<td>2.8 million</td>
</tr>
</tbody>
</table>

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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