Primary Care in Mental Health Settings

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The SAMHSA/HRSA Center for Integrated Health Solutions

Providing information, experts, and resources dedicated to behavioral health and primary care integration

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Phone: 202-684-7457
Email: Integration@thenationalcouncil.org

Why primary care service to mental health populations?

• High rates of physical illness in mentally ill
• Premature mortality
• Low quality of medical care to patients with mental illness
• High expense of physically ill with mental illness
• Access problems

Mental Disorders and Medical Comorbidity by Druss BG and Reisinger Walker E (http://www.rwjf.org/pr/product.jsp?id=71883)
Original data from National Comorbidity Survey Replication, 2001-2003

Monthly Expenditures for Chronic Conditions With and Without Comorbid Mental Illnesses

Mental Disorders and Medical Comorbidity by Druss BG and Reisinger Walker E (http://www.rwjf.org/pr/product.jsp?id=71883)
Original data from Adapted from Melek and Norris (2005 Marketscan data)

Mortality Burden of Mental Disorders

Mental Disorders and Medical Comorbidity by Druss BG and Reisinger Walker E (http://www.rwjf.org/pr/product.jsp?id=71883)
Original data from Adapted from Eaton et al., 2008 (literature review)
Increased Mortality

- It is well established that persons with mental illness experience excess mortality compared with the general population.
  - Compared to the general population, persons with major mental illness typically lose more than 25 years of normal life span. (Lutterman, 2003)
  - In Finland, differences in life expectancy of was 25 years less than that of compared with a person in the general population (32.5 years vs. 57.5 years, respectively. (Tiihonen, 2009)
  - Persons with mental disorder die on average of 8.2 years earlier than the rest of the population (Druss, 2011)

- While suicide and injury account for about 30-40% of excess mortality, 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases. (Parks, 2006)

Proposed Causes of Increased Mortality

| Modifiable Risk Factors: Smoking, Weight and Inactivity |
| Social isolation |
| Unemployment/ Poverty |
| Lack of access to care |
| Medications/ Polypharmacy |
| Separation of medical and mental health |

Non-Treatment of Medical Comorbidity: CATIE data

Rates of non-treatment

| 30.2% for diabetes, |
| 62.4% for hypertension |
| 88.0% for dyslipidemia. |

Nasrallah HA et al, 2006

Changing Approach to Medical Care:

everyone wants better. no one wants change.

Barriers to Providing Primary Health Care to Psychiatric Populations

| Cultural |
| Financial |
| Motivational |
| Organizational |
| Physical |

Primary Care in Mental Health Settings

Mental Disorders are Rarely the Only Health Problem

- Patient-centered care?
- Chronic Physical Pain: 25-50%
- Cancer: 10-20%
- Smoking, Obesity, Physical Inactivity: 40-70%
- Mental Health / Substance Abuse: 10-20%
- Neurologic Disorders: 10-20%
- Heart Disease: 10-30%
- Diabetes: 10-30%
- Diabetes: 10-30%
So, what do we do now?

Working Together: Many Possibilities!

- On-site primary care provider
- Primary care by psychiatrists
- Co-location
  - On-site primary care provider
  - Primary care by psychiatrists

How Care Delivered

- Facilitated referral from mental health center

Primary Care in Mental Health Settings

Working Together: A Team Approach

PCP
Psychiatrist

Care Manager
Case Manager

Patient

Core Team

Other Behavioral Health Clinicians
- Substance Treatment
- Vocational Rehabilitation

Other Resources

Roles for the Psychiatrist

Co-Management
- Each provider has their own caseload
- PCP manages all medical problems
- Psychiatrist manages all mental health problems
- Work together to reinforce treatment plans

Manage with Primary Care Consult
- Psychiatrist works with a care manager
- Manages a caseload of patients for BOTH mental health and basic medical health concerns using protocols from PCP
- PCP available for consultation and stepped care as needed

Comprehensive Management
- Typically dually trained psychiatrist
- Provider manages both medical and mental health problems
- Limited number of providers have this expertise

All psychiatrists are responsible for “not making people sicker”.

Experimenting: Some models developed so far

- PCARE study (Druss et al, 2010)
- Inpatient team with internist (Rubin et al, 2005)
- Facilitated referral to primary care (Griswold et al, 2010)
- Care Management - “Hot Spotters”
- TEAMcare (Katon et al, 2010)
- Missouri Medicaid Health Homes – PC and CMHC’s
- VA Programs - Three Efforts: enhanced care coordination, care manager to SMI patients and PC presence within SMI

Experimenting: Some models developed so far

- PCARE study Nurse care managers provided communication and advocacy to overcome barriers to primary medical care. (Druss, 2010)
  - Intervention group received more recommended preventive services, higher proportion of evidence-based services for cardiometabolic conditions, more likely to have a primary care provider (71.2% versus 51.9%).
- Inpatient program randomized patients to care with traditional psychiatric team vs team with internist (Rubin et al, 2005)
  - Inclusion of internist resulted in improved process and health maintenance care
- Facilitated referral to primary care randomly assigned patients to a navigator for referrals versus usual care (Griswold et al, 2010)
  - Intervention group was statistically more likely to access care, versus controls

...
Other Program Examples and Ideas

- **TEAMcare (Katon et al, 2010)**
  - A Program for Managing Depression, Diabetes and Coronary Heart Disease in Primary Care.
  - Covers SMI to the extent that they are seen in primary care setting.
- **Missouri Medicaid Health Homes – PC and CMHC’s**
  - Per member per month payment to support Nurse care manager, admin support, health home director, physician consultant, BHC.
  - PC’s required to use BHC model and SBIRT.
- **VA Programs: Three Efforts**
  - Assigning SMI patients to a general primary care team with enhanced coordination of care with MH.
  - Assigning a care manager to SMI patients to ensure that the patients receive appropriate services.
  - Creating a full service PC presence within SMI programs. VA is implementing the medical home now but tough to orchestrate all need services!

Primary Behavioral Health Care Initiative

- **Primary Behavioral Health Care Initiative**
  - SAMHSA grant – demonstration projects to improve physical health status in SMI; 64 grantees, beginning 2009.
  - Target audience Quadrant 4: Both high physical and high mental health risk.
  - Better coordinate and integrate primary and behavioral health care resulting in:
    - Improved access to primary care services
    - Improved prevention, early identification and intervention to reduce the incidence of serious physical illnesses, including chronic disease
    - Increased availability of integrated, holistic care for physical and behavioral disorders
    - Better overall health status of clients

PBHCI: Models developed so far

None of these more than 2 years old:
- **Doc on site**
- **Care management / coordination with primary care – like ACT.**
- **Use of registry [not widespread use of computerized registry]**
- **Wellness activities training**
- **Behavior change!**

Principles of Integrated Care for Seriously Mentally Ill

- **Find Patients:**
  - Screening, identification and determination of medical diagnoses
- **Track Patients:**
  - Systematic follow-up and use of registry
- **Treat Patients:**
  - Evidence based treatment of medical and mental health conditions
  - Health behavior change
  - Timely treatment adjustment
- **Program Oversight and Quality Improvement:**
  - Regularly review outcomes and make adjustments to program

Nuts and Bolts

Working Together: Floor plan of the future

![Floor plan image](Image)
Finding Patients

- Routine screening (Who?, Where?)
- Self referral
- Psychiatrist monitoring and referral in community mental health centers

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>4 wks</th>
<th>8 wks</th>
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<td>Blood Pressure</td>
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<tr>
<td>Fasting Lipid Profile</td>
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</table>


But remember… screening is just the start.

You cannot fatten a cow by weighing it.
~ Chinese Proverb

Who owns the information and what will you do with it?

Tracking Patients: Use of computerized registry

- This has been slow to evolve in PBHCI
- But here is an example of its use in a BHC program:
  - Track outcome data
  - Prevent falling through cracks
  - Treat to target

Case Load Statistics

<table>
<thead>
<tr>
<th>Case Number</th>
<th># of Phs</th>
<th># of Assessments</th>
<th>Max Pos</th>
<th>Max Skill</th>
<th>Max # of Phs</th>
<th>Max # of Assessments</th>
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</table>

Tracking measurements over time, snapshot of medications and can graph outcomes.

Another view of health measurements and due dates for next measurements.
**Treatments**

**Medical Treatments Targets**
- Glucose control
- Blood pressure
- Cardiac risk reduction

**Health Behavior Change Targets**
- Inactivity
- Smoking cessation
- Improving dietary habits

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**Care Manager**

- Facilitates patient engagement and education
- Manages a caseload of patients and systematically tracks treatment response
- Works closely with both primary care and mental health providers
- Supports medication management
- Provides brief, evidence-based counseling or refers to other providers for counseling services
- Reviews challenging patients with appropriate provider
- Facilitates referrals to other services (e.g., substance abuse treatment, specialty care and community resources) as needed

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**Working with Care Managers**

**Who are the care managers?**
- RN, MA, ARNP, Case Managers?

**What makes a good care manager?**
- Organization
- Persistence
- Creativity and flexibility
- Enthusiasm for learning
- Strong patient advocate
- Willingness to be interrupted
- Ability to work in a team

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**Sample Medical Treatment Protocol**

<table>
<thead>
<tr>
<th>Target</th>
<th>Goal</th>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucose Control</td>
<td>FBG 80-120 HbA1C &lt; 6.5</td>
<td>1) Metformin (250mg/day with dinner X 2 days, then 250mg BID for 2-3 days then 500mg BID) 2) Insulin as needed by protocol</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>BP &lt; 130/80 mmHg</td>
<td>1) Home blood pressure monitoring 2) Protocol for starting anti-hypertensive 1) Prinzide (10mg lisinopril/12.5 HCTZ) OR 2) Atentolol 25mg</td>
</tr>
<tr>
<td>Cardiac Risk Reduction</td>
<td>LDLc &lt; 100</td>
<td>1) Lisinopril 10mg X 2 days then 20mg Qday 2) Lovastatin as needed 3) ASA enteric coated 81 or 325 mg/day unless contraindicated</td>
</tr>
</tbody>
</table>

TEAMCare, Katon et al 2010

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**Health Behavior Change**

40% of deaths in US from behavioral causes.
Rates of smoking, obesity higher in poor, SMI.

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**Interventions**

<table>
<thead>
<tr>
<th>Target</th>
<th>Goal</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking Cessation</td>
<td>Quit</td>
<td>Behavioral activation and smoking cessation strategies OR smoking cessation program</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Maintain Weight or 5% Weight Loss</td>
<td>DASH diet, ADA, AHA Mediterranean diet, Weight Watchers or other “healthy plan”</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>Increase current activity as able to 30 min walking/day</td>
<td>Assess past activity and brainstorm options to increase physical activity</td>
</tr>
</tbody>
</table>

TEAMCare, Katon et al 2010
Inactivity

- IN SHAPE Health Promotion Program
  - Manualized Intervention with Multiple Replications
  - Individualized fitness and healthy lifestyle assessment
  - Individual Meetings with a “Health Mentor”
  - Membership Vouchers to Local Fitness Centers
  - Group Health Education/Motivational “Celebrations”
  - Nurse Evaluation and Consultation
- Participants spend time each week with personal mentors working out, taking walks, in classes or working on nutrition plans.
- Mentors help participants to track their progress, set goals and stay motivated.

Promoting Health and Functioning in Persons with SMI: CDC - R01 DD000140 (PI: Bartels)
Health Promotion and Fitness for Younger and Older Adults With SMI: R01 MH078052-01 (PI: Bartels)

In SHAPE Outcomes

- Benefits for participants:
  - Increased participation in regular exercise
  - Reduced waist circumference
  - Improved satisfaction with fitness
  - Improvement in mental health functioning and negative symptoms
- Role of Meds? Role of Dietary Component?


Smoking Cessation

- Interventions are worthwhile, don’t have to be complicated:
  - Unassisted quit attempt: 4-7% stop smoking. [2008 guideline]
  - Physician advice: 10.2% [2008 guideline]
  - >10 min counseling: 22% [Cochrane review]
- Nicotine Replacement Therapy increases chances of stopping smoking by 50-70% [Cochrane]
- Community interventions [smoke-free workplaces] - “limited evidence” for impact [Cochrane]
- Telephone support (e.g., 1-800-QUIT-NOW) effective as compared with no counseling.
- Counseling: Motivational Interviewing, CBT both effective.
- Self-help: weak effects [Cochrane and 2008 Guideline]


Smoking Cessation Brief Intervention

- Free online programs and information:
  - http://www.becomeanex.org/
  - http://www.smokefree.gov/
- Quit Line
  - 1-800-QUIT-NOW

Improving Dietary Habits

- An initial weight loss goal of 5 to 7 percent of body weight is realistic for most individuals.
- Many types of diets produce modest weight loss.
  - Options include: balanced low-calorie, low-fat low-calorie, moderate-fat low calorie, low-carbohydrate diets, and the Mediterranean diet.
- Encourage a diet that reduces energy intake below energy expenditure to individual patient preferences, rather than focusing on the macronutrient composition of the diet
- Explore community resources:
  - Example: Purdue Extension Service – absolutely free 6-8 sessions of in-home [or in, say, group home] instruction AND they cook with the patient!
Health Behavior Change

Many opportunities in mental health settings!

• A huge body of knowledge and expertise in behavior change is basically unknown to psychiatrists.
• A few examples of health behavior change models:
  • Health Belief/Health Action Model
  • Relapse Prevention Model
  • Health Action Process Approach
  • Motivational Interviewing

Simple Behavior Change Plan

STEP ONE:
Choose a tiny step.
(Walk one block.)

STEP TWO:
Find a spot.
(Every morning on my way to work.)

STEP THREE:
Train the cycle.
(Do it every day.)

STEP FOUR:
Assess Outcomes.
(Did it change? Any changes?)

Motivational Interviewing for Health Behavior Change

Definition
• “client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence” (Miller and Rollnick, 2002)

Evidence
• Demonstrated intervention for health behavior change:
  • Substance Use/Abuse
  • Dual Diagnosis
  • Eating Disorders/Obesity
  • Medical Co-morbidity (Cardiovascular health, Diabetes, Asthma, HIV treatment and more)
  • Health Promotion/Exercise Fitness
  • Medical Adherence
  • Depression and Anxiety
  • Smoking Cessation
  • Pain

Getting Started????
If you build it, they will not necessarily come…

North Shore put a nurse practitioner in place → Very little business!

Why not?
- Separate FQHC registration a significant barrier.
- It turns out staff are needed to shepherd the transition, even in the same office suite.
- All CMHC staff didn’t have message repeated and repeated and repeated...
- What seems like a lot of CMHC patients is a trickle for the FQHC!

Tasks Prior to Setting Up a Program

• Financial arrangements
• Agreements with primary care providers
  - If you don’t have pre-existing relationship, they may not be that interested
• Plan protocols and workflow
• Plan for evaluation
• Promotion, Promotion, Promotion!

Promoting the program

• PR, PR, PR
  - To Organizations
  - To Providers
  - To Patients
• Get your story straight!
  - Why should anyone care or want integration?
  - Why should anyone care about population health?
  - Need to develop tag line
    - “We need this to improve health outcomes!”

Regional Primary Care Initiative

- Persons with mental illness die up to 25 years too soon due to preventable health conditions.
- Regional Primary Care Initiative now offers a nationally recognized program to bring needed primary medical services to our clients, right in our Merrillville and East Chicago centers.
- General medical care at the Regional office.
- Assistance for medication management:
  - Healthy eating,
  - Stress management,
  - Healthy activities,
  - Stopping smoking,
  - Help negotiating the medical system.
Talk to your clients and peers about engaging in this program to live longer and healthier!

Sign up today by calling Olga at 219-9999

More PR

Improved Care for Comorbid Conditions Under Health Reform

• Financing and insurance
  - Ensure a core health benefits package that covers care management and other evidence-based services.
  - Use Accountable Care Organizations to allow vertical integration with other components of the health care system.
• Care delivery redesign
  - Ensure that mental health has a room in the medical home.
  - Help mental health providers develop IT infrastructure and participate in health exchanges.
• Fostering prevention and promotion
Until All This Happens…

Focus on principles of care!

Find Patients:
- Screening, identification and determination of medical diagnoses

Track Patients:
- Systematic follow-up and use of registry

Treat Patients:
- Evidence based treatment of medical and mental health conditions
- Health behavior change
- Timely treatment adjustment

Program Oversight and Quality Improvement:
- Regularly review outcomes and make adjustments to program

Get Creative!

- Find natural primary care partner
  - A local FQHC may be thrilled with your Medicaid population.
- Other solutions by PBHCI grantees:
  - Hire own doc
  - Partner with a provider, maybe by starting BHC program, offering other consultation / support services.
  - Academic partners may be looking for someone just like you!
  - State grants – e.g., Michigan Primary Care ACT.
- Capitalize on MH case management expertise.

Commit to Targets

<table>
<thead>
<tr>
<th>Goal</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve tracking of health outcomes</td>
<td>90% of eligible clients will have documented BMI, Hgb A1c, LDLc, and blood pressure in the last 6 months.</td>
</tr>
<tr>
<td>Improve health outcomes</td>
<td>Reduce by 25% the number and % of eligible clients with a Hgb A1c &gt; 7, a blood pressure &gt; 140/90, or LDLc &gt; 100.</td>
</tr>
<tr>
<td>Improve health behaviors</td>
<td>Reduce by 25% the number and % of clients who are smoking.</td>
</tr>
<tr>
<td>Increase by 25% the number and % of clients who are physically active (30 minutes or more of aerobic activity such as walking at least 4 times/week)</td>
<td></td>
</tr>
</tbody>
</table>

Spectrum of Patient Centered Collaborative Care

Mental Health in Primary Care Settings

Primary Care in Mental Health Settings

Resources

For consulting psychiatrists:

- AIMS Center: [http://uwaims.org](http://uwaims.org)
- Registry links

Resources to provide to your team:

- TEAMCare: [http://www.teamcarehealth.org/](http://www.teamcarehealth.org/)
- InSHAPE:

Primary Care in Mental Health Settings References -I


