Integration of Psychiatric and Primary Care

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Psychiatric conditions in the Primary Care Setting

- 1 in 5 patients at a primary care clinic have a diagnosable psychiatric condition (according to DSM IV)
- 50% of primary care visits are for stress related symptoms such as poor sleep, fatigue or headache
- 80% of patients with anxiety and depression present initially with physical complaints; primary care providers often do not recognize that these physical symptoms are signs of psychiatric disorders until after costly medical testing has been done

Increased Primary Care Utilization

- Stressful life events and psychiatric disorders lead to increased utilization of primary care services
- Increased utilization occurs in every component:
  - ER visits
  - Primary care visits
  - Medical specialty visits
  - Pharmacy
  - Inpatient days
  - Lab and X-Ray
  - Mental health costs

Increased Medical Costs

- Increased utilization leads to higher medical costs
- Patients with major depression have 50%-100% higher TOTAL MEDICAL COSTS over a one-year period (after controlling for sociodemographic factors and chronic medical illness)

Additive Impairment and Progressive Decline

- Psychiatric intervention reverses impairment and declining physical performance
  - Anxiety and depressive disorders are associated with as much or more functional impairment as chronic medical disorders such as diabetes, heart disease, COPD
  - When anxiety and depression occur with these chronic medical issues, there is additive functional impairment
  - Depression is associated with progressive decline in physical functioning in the aged population
- Major depression is the leading cause of disability in America. (Not cancer; not heart disease)

- Collaborative care
- Access to psychiatric care in the medical setting
- Better medical care in the psychiatric setting

Collaborative Care

- Randomized trials demonstrated improved depression quality of care and outcomes (Diamond Project)
- Two components:
  - Allied Health Professional
    - Increases frequency of patient contact
    - Enhances patient education
    - Activates the patient to become a partner in care
    - Tracks outcomes with a depression rating tool (PHQ-9)
    - Facilitates return to primary care or makes referral to mental health professional
  - Psychiatrist
    - Provides back up for urgent situations
    - Provides caseload supervision and decision support
    - Provides consultation for patients who do not respond to initial treatment

Need for Better Medical Care in the Psychiatric Setting

- Chronic psychiatric illness patients have a higher prevalence of diabetes and heart disease
  - Dysregulation of stress response system
  - Poor diet and smoking
  - Medication that increase risk of obesity and diabetes
- Early deaths
  - Bipolar patients: 10-15 years younger
  - Schizophrenic patients: 20-25 years younger

Problems

- 80%+ of patients with mental health and chemical dependency disorders have little or no access to psychiatric services
- Patients are treated in the general medical sector where payment mechanisms discourage psychiatrists from delivering care
- Untreated or poorly treated mental health disorders:
  - Increase psychiatric treatment resistance
  - Increase functional impairment
  - Increase physical health service use
  - Creates up to $300 BILLION in additional health care costs nationwide

Access to Psychiatric Services

- Psychiatrists
  - Care for only 10% of patients with psychiatric difficulties
  - Practice in segregated settings with a separate health record
  - Are paid by an independent reimbursement system
  - Rarely interact with non-psychiatrist medical colleagues about patients in common.

Managed Behavioral Health Care (carve outs)

- As long as carve outs drive the system, mental health care and general health care will continue to be segregated
- Carve outs create a competing budget for mental health
  - Viewed as an EXTRA expense rather than PART OF HEALTH
- Psychiatry has lost 4 times greater value in dollars spent for mental health services than the medical sector lost for medical services.
- Although depression is the leading cause of disability in America, only 3.3% of the healthcare budget is spent on treating it.

Policy Statement on Systems/Services for the Integration of Psychiatry into Primary Care

- The preceding information was taken from an APA draft white paper produced by Roger Kathol, MD, et al

Change is Needed

- Reform must address the fragmentation that makes our system not only too expensive but also ineffective relative to other modern nations

- "*Seattle…spends at least 1.8 billion a year directly and indirectly dealing with mental illness, or its aftermath. Of that money, 530 million is spent directly dealing with mental illness. The rest…7 out of every 10 dollars goes toward prisons, police, homeless shelters and other social services that deal with the consequences of lack of treatment and preventative care*." — NAMI Newsletter, Winter 2009

- Ignoring the treatment needs of the mentally ill does not save society money. It costs more, and shifts costs.

A Striking Example of Cost Shifting

- PHARMACY BENEFITS
  - Limited number of “preferred” medications
  - Each “preferred” drug list is different
  - Prior authorization process discourages use of medications
  - Costs, time, frustration passed to patient
  - Costs, time, frustration passed to pharmacy staff
  - Patients delay treatment, experience prolonged symptoms, may need additional medical care

The Car Factory Metaphor

"Health care reimbursement needs to integrate across the lifespan and across clinical concerns (inpatient, outpatient, medications, and devices). As long as it is fragmented, the parts will compete against each other at great cost to society.

Imagine a car factory where the frame division tried to make ends meet by doing things with the chassis that wrecked engines...or that the drive train division was making ends meet in a way that made brakes fail after 1000 miles. If the focus is on the financial success of the division (pharmaceutical benefits, outpatient benefits, etc...) the system will fail.

Health care has to be seen and managed as a whole".

John Van Loon, MD
President, MPS

Characteristics of Integrated Systems

- Co-located mental health resources within medical settings
- Pay mental health and medical benefits out of same fund
- Share medical records
- Uniform coding and billing
- Mental health provider teams
- Educate entire health care team about psychiatric care
- Educate entire team about medical care relevant to mental health

Does Prior Authorization of Medications Save Money? No

In New Hampshire, use of a three-prescription monthly payment limit (cap) increased overall care costs for those with schizophrenia by 17-fold and patients experienced increased pain and suffering.

Soumerai SB, McLaughlin TJ, Ross-Degnan D, and others. "Effects of limiting Medicaid drug-reimbursement benefits on the use of psychoptropic agents and acute mental health services by patients with schizophrenia." N Engl J Med 1994;331:650-655.

Project Patient Care, in conjunction with Harris Interactive, has estimated that more than a million older Americans have experienced negative health outcomes resulting from formulary restrictions, reducing their quality of health care.

Drug plan formularies and restrictions can have a negative impact on the health of many older Americans. Project Patient Care. July 2002. Available at http://www.projectpatientcare.org. Accessed May 10, 2005

In a prospective study that followed nearly 8,000 individuals over three years, University of Michigan researchers found that older adults who cut back on their prescription drugs because of cost were 76 percent more likely to manifest a significant decline in their overall health, including worse cardiovascular outcomes and increased rates of depression.

Heisler M, Langa KM, Eby EL, and others. "The health effects of restricting prescription medication use because of cost." Med Care 2004; 42:626-634.

Similar outcomes occurred in members of a California Medicare HMO upon implementation of a generic-only pharmacy benefit. In this study, based on claims data, lack of access to certain brand-name medication was associated with increased overall hospital admissions and a negative impact on selected measures of adherence to treatment guidelines, implying there were potential quality-of-care concerns.

Christian-Herman J, Emons M, George D. "Effects of generic-only drug coverage in a Medicare HMO." Health Affairs (Web Exclusive), 10.1377/hlthaff.w4.455. Available at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.455. Accessed May 10, 2005

A prior authorization program for Michigan Medicaid recipients led to exacerbations of medical and mental health disorders, increased difficulty in performing daily activities and medication-related side effects after patients were switched to a different type of medication.

Miller JE. "Restricting access to medications hurts patients, their families, and their communities." Drug Benefit Trends 2003; 15(suppl 1):30-35.

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