Integrating Behavioral Health and Primary Care

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Disclosures

Employment: University of Washington
• Professor & Vice Chair, School of Medicine; Dept. of Psychiatry and Behavioral Sciences
  • Director, Division of Integrated Care and Public Health
  • Director, AIMS Center: Advancing Integrated Mental Health Solutions
• Adjunct Professor, School of Public Health: Depts. of Health Services and Global Health

Grant funding (current & recent)
• National Institute of Health (NIMH, NIDA, AHRQ, NLM)
• National Corporation for Community Service (Social Innovation Fund)
• Center for Medicare and Medicaid Innovation (CMMI)
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• American Federation for Aging Research (AFAR)
• John A. Hartford Foundation
• Alaska Mental Health Trust Authority
• George Foundation
• American Red Cross (RAND)
• California HealthCare Foundation
• Robert Wood Johnson Foundation
• Hogg Foundation for Mental Health

Contracts (current & recent)
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• Washington State Healthcare Authority
• California Institute of Mental Health
• Los Angeles County, Santa Clara County, Ventura County, Alameda County
• New York State Department of Health
• NAVOS
• Institute for Clinical Systems Improvement (ICSI)
• Mathematica / Center for Healthcare Strategies

Consultant (current)
• AARP Services Incorporated (ASI)
• National Council of Community Behavioral Health Care (NCCBH)
• Group Health Research Institute

Advisor (current & recent)
• Carter Center Mental Health Program
• World Health Organization
Division of Integrated Care and Public Health

AIMS CENTER
Advancing Integrated Mental Health Solutions

20 years of Research and Practice in Integrated Mental Health Care
2013 Affordable Care Act: opportunities and challenges

ACA & Medicaid expansion

- Up to 60 million Americans eligible for new or better MH coverage.
- High rates of unmet mental health need
- 15% of patients have mental health Dx => 30% of costs

- Accountable Care (ACOs)
  Those with comorbid medical and MH conditions have
  - 2-3 times higher health care costs
  - High rates of absenteeism & presenteeism

- Patient Centered Medical Homes (PCMH)
  NCQA: Integrated care for medical and mental health conditions
Mental health disorders account for 23% of Years Lived with Disability (YLD) worldwide.

Depression alone ~ 10% of YLDs

YLD from depression is
- 3x diabetes;
- 8x heart disease
- 40x cancer

US workforce: absenteeism, presenteeism
Depression kills - I

Worldwide: over 1 million suicides / year
In the US: one suicide every 17 minutes
More suicides than homicides.

Many are depressed but few are treated.
Depression kills - II

Major Depression

- Smoking
- Sedentary lifestyle
- Obesity
- Lack of adherence to medical regimens
- Psychophysiologic:
  - Insulin sensitivity ↓
  - Autonomic nervous system ↑
  - Inflammatory markers ↑
  - Cortisol ↑

- Diabetes and CHD at earlier age
- Poor symptom control
- ↑ Functional impairment
- ↑ Complications of medical illness
- ↑ Mortality

Katon et al. Biol Psychiatry 2003
Depression Is Expensive
Annual Health Costs

How good is current depression care?

Fewer than 2/10 see a psychiatrist or psychologist
5/10 receive treatment in primary care
The ‘2-minute mental health visit’ : Ming Tai-Seale; JAGS 2008.
20-30 million receive an antidepressant Rx, but only 25 % improve

“Of course you feel great. These things are loaded with antidepressants.”
2/3 of PCPs report poor access to mental health services for their patients.

Cunningham PJ, Health Affairs, 2009;28(3)490-501
Psychiatry Workforce

US: 40,000 psychiatrists (13/100,000)

- Most in urban areas
- Half of counties in US don’t have a single practicing MH professional
Available Psychiatrist Time / Week

Ideal: 50 minutes
United States: Urban: 6 minutes
United States: Rural: 1.5 minutes

Talk fast!
How do we close the gap?

Train more specialists?

Work harder?

Work smarter

Leverage mental health specialists more effectively

- partnerships (e.g., primary care)
- technology (e.g., telemedicine)
Building more effective care models.
IMPACT Study

1998 – 2003
1,801 depressed older adults in primary care
18 primary care clinics
8 health care organizations in 5 states
   – Diverse health care systems (FFS, HMO, VA)
   – 450 primary care providers
   – Urban and semi-rural settings

Funding

John A. Hartford Foundation, California HealthCare Foundation, Robert Wood Johnson Foundation, Hogg Foundation
IMPACT Team Care Model

Primary Care Practice with Mental Health Care Manager

Outcome Measures
Treatment Protocols
Population Registry
Psychiatric Consultation
IMPACT doubles effectiveness of care for depression

50 % or greater improvement in depression at 12 months

Unützer et al., JAMA 2002; Psych Clin NA 2004
IMPACT improves physical function

SF-12 Physical Function Component Summary Score (PCS-12)

Baseline 3 mos 6 mos 12 mos

Usual Care IMPACT

P=0.35 P<0.01 P<0.01 P<0.01

Callahan et al., JAGS 2005; 53:367-373
IMPACT reduces health care costs
ROI: $ 6.5 saved / $ 1 invested

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>4-year costs in $</th>
<th>Intervention group cost in $</th>
<th>Usual care group cost in $</th>
<th>Difference in $</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPACT program cost</td>
<td></td>
<td>522</td>
<td>0</td>
<td>522</td>
</tr>
<tr>
<td>Outpatient mental health costs</td>
<td>661</td>
<td>558</td>
<td>767</td>
<td>-210</td>
</tr>
<tr>
<td>Pharmacy costs</td>
<td>7,284</td>
<td>6,942</td>
<td>7,636</td>
<td>-694</td>
</tr>
<tr>
<td>Other outpatient costs</td>
<td>14,306</td>
<td>14,160</td>
<td>14,456</td>
<td>-296</td>
</tr>
<tr>
<td>Inpatient medical costs</td>
<td>8,452</td>
<td>7,179</td>
<td>9,757</td>
<td>-2578</td>
</tr>
<tr>
<td>Inpatient mental health / substance abuse costs</td>
<td>114</td>
<td>61</td>
<td>169</td>
<td>-108</td>
</tr>
<tr>
<td>Total health care cost</td>
<td>31,082</td>
<td>29,422</td>
<td>32,785</td>
<td>-$3363</td>
</tr>
</tbody>
</table>

IMPACT Study Summary

Less depression
IMPACT more than doubles effectiveness of usual care

- Less physical pain
- Better functioning
- Higher quality of life
- Greater patient and provider satisfaction

- More cost-effective

THE TRIPLE AIM

“I got my life back”
Replication studies show the model is ‘robust’

<table>
<thead>
<tr>
<th>Patient Population (Study Name)</th>
<th>Target Clinical Conditions</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult primary care patients (Pathways)</td>
<td>Diabetes and depression</td>
<td>Katon et al., 2004</td>
</tr>
<tr>
<td>Adult patients in safety net clinics (Project Dulce; Latinos)</td>
<td>Diabetes and depression</td>
<td>Gilmer et al., 2008</td>
</tr>
<tr>
<td>Adult patients in safety net clinics (Latino patients)</td>
<td>Diabetes and depression</td>
<td>Ell et al., 2010</td>
</tr>
<tr>
<td>Public sector oncology clinic (Latino patients)</td>
<td>Cancer and depression</td>
<td>Dwight-Johnson et al., 2005, Ell et al., 2008</td>
</tr>
<tr>
<td>Health Maintenance Organization</td>
<td>Depression in primary care</td>
<td>Grypma et al., 2006</td>
</tr>
<tr>
<td>Adolescents in primary care</td>
<td>Adolescent depression</td>
<td>Richardson et al., 2009</td>
</tr>
<tr>
<td>Older adults</td>
<td>Arthritis and depression</td>
<td>Unützer et al., 2008</td>
</tr>
<tr>
<td>Acute coronary syndrome patients (COPES)</td>
<td>Coronary events and depression</td>
<td>Davidson et al., 2010</td>
</tr>
</tbody>
</table>
Principles of Effective Integrated Behavioral Health Care

**Patient Centered Team Care / Collaborative Care**
- Colocation is not Collaboration. Team members have to learn new skills.

**Population-Based Care**
- Patients tracked in a registry: no one ‘falls through the cracks’.

**Measurement-Based Treatment to Target**
- Treatments are actively changed until the clinical goals are achieved.

**Evidence-Based Care**
- Treatments used are ‘evidence-based’.

**Accountable Care**
- Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.
Taking effective models from research to practice

everyone wants better.
no one wants change.
UW AIMS Center: Translating from Research to Practice

Clinicians Trained

5,000 providers trained in ~ 600 clinics
Collaborative Care
Team Building Process

- Based on experience (600+ implementations)
- Customizable
- Creates a functional workflow
- Results in better care

<table>
<thead>
<tr>
<th>Integrated Care Tasks</th>
<th>Key Areas to Focus On</th>
<th>Achieving Success</th>
<th>Resource Allocation</th>
<th>Workforce Preparation</th>
<th>Sustainability Strategies</th>
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## Program Staffing in Diverse Clinic Settings

<table>
<thead>
<tr>
<th>Clinic Population (mental health needs)</th>
<th>% of clinic population with need for care management</th>
<th>Typical caseload size for 1 FTE Care Manager</th>
<th># of unique primary care clinic patients to justify 1 FTE CM</th>
<th>Typical personnel requirement for 1,000 unique primary care patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low need (e.g., insured, employed)</td>
<td>2%</td>
<td>100</td>
<td>5000</td>
<td>0.2 FTE Care Manager, 0.05 FTE Psychiatrist (2 hrs / week)</td>
</tr>
<tr>
<td>Medium need (e.g., comorbid medical needs / chronic pain / substance abuse)</td>
<td>5%</td>
<td>75</td>
<td>1500</td>
<td>0.7 FTE Care Manager, 0.07 FTE Psychiatrist (3 hrs / week)</td>
</tr>
<tr>
<td>High need (e.g, safety-net population)*</td>
<td>15%</td>
<td>50</td>
<td>333</td>
<td>3 FTE Care Manager, 0.3 FTE Psychiatrist (12 hrs / week)</td>
</tr>
</tbody>
</table>
Collaborative Care Implementations

**Washington: Mental Health Integration Program**
- Managed Medicaid. 140 clinics; > 35,000 patients

**Minnesota: DIAMOND Program**
- 6 commercial health plans; > 80 clinics; > 400 PCPs; > 10,000 pts

**California:**
- KPSC; LA County DMH (>100 clinics), several other counties

**New York:**
- Department of Health Initiative; > 100 clinics.

**CMS / CMMI Compass**
- 8 organizations in 7 States

**Social Innovation Fund (SIF):**
- 5 health care organizations in 4 WWAMI States
Washington State: MHIP

- Funded by State of Washington and Public Health Seattle & King County (PHSKC)
- Administered by Community Health Plan of Washington and PHSKC in partnership with the UW AIMS Center
- Initiated in 2008 in King & Pierce Counties & expanded to over 100 CHCs and 30 CMHCs state-wide in 2009.
- [http://integratedcare-nw.org](http://integratedcare-nw.org)
Mental Health Integration Program
> 35,000 clients served ... 5 FTE psychiatrists
Collaborative Care effectively ‘leverages’ a psychiatrist to reach more people

<table>
<thead>
<tr>
<th></th>
<th>Office Based Private Practice</th>
<th>Mental health center</th>
<th>Collaborative Care (Psychiatrist Supports Primary Care based Team)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typical active caseload (unique patients) in any given month</td>
<td>35 – 150</td>
<td>100 – 300</td>
<td>500 – 1000</td>
</tr>
<tr>
<td>Typical caseload over 12 months*</td>
<td>50 – 300</td>
<td>100 – 500</td>
<td>1000 – 2000</td>
</tr>
<tr>
<td>Patient contacts / case reviews over 12 months**</td>
<td>1500</td>
<td>1500 – 2000</td>
<td>3000</td>
</tr>
<tr>
<td>Total population covered***</td>
<td>1,650 – 9,000</td>
<td>3,000 – 15,000</td>
<td>33,000 – 66,000</td>
</tr>
</tbody>
</table>

Assumptions:
* Typical caseload turns over once / year
** 1 FTE psychiatrist sees patients 30 hours / week
*** 3 % of population has need for mental health services in any given year
Care Management Tracking System (CMTS©)

- Access from anywhere.
- Population-based.
- Keeps track of ‘caseloads’.
- Structured workflow.
- Facilitates consultation.
- Allows research on highly representative populations

Caseload summaries help manage
- Clinical productivity
- Quality improvement

- Licensed by UW
  - 21 licenses
  - 14 US states (& Alberta)
- Supporting care of over 80,000.
## MHIP Common Client Diagnoses

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>Depression</td>
<td>71 %</td>
</tr>
<tr>
<td>Anxiety (GAD, Panic)</td>
<td>48 %</td>
</tr>
<tr>
<td>Posttraumatic Stress Disorder (PTSD)</td>
<td>17 %</td>
</tr>
<tr>
<td>Alcohol / Substance Abuse</td>
<td>17 %*</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>15 %</td>
</tr>
<tr>
<td>Thoughts of Suicide</td>
<td>45%</td>
</tr>
</tbody>
</table>

... plus acute and chronic medical problems, chronic pain, substance use, prescription narcotic misuse, homelessness, unemployment, poverty, ...
MHIP: P4P-based quality improvement cuts median time to depression treatment response in half.

Particularly effective in high risk mothers

Kaplan-Meier Survival Curve by Enrolled After 2009
Time to 50% PHQ improvement

Log-rank test for equality of survivor functions, p<0.001

Among Mom Population (African American, Asian, Latino & White) with baseline PHQ9>=10 (n=653)
Summary: The case for integrated care

• Improved access for and satisfaction for patients
• Improved job satisfaction and productivity of PCPs
  – Shorter, more productive primary care visits
• Position organization for future
  – Long-term cost savings attractive to programs that aim to achieve the triple aim: improve access, quality and outcomes while containing costs.
    » ROI: $ 6 saved for each $ 1 spent on the program (Unutzer et al 2008)
• Integrated Behavioral Health will be part of Patient Centered Medical Homes (NCQA level 3 criteria) and ACOs (mental health is essential health benefit)

Additional benefits:
• Psychiatric consultant provides support, education, and ‘capacity building’ through ongoing consultations to PCPs and Care Managers
• Reduced no show rates because of increased access, shorter wait times, and support from care coordinator
Mental-Health Care at the Doctor’s Office
Providers Take Integrated Approach, With Patient Numbers Set to Jump Under New Law and Psychiatrists in Short Supply

Body and Mind

- 25% of U.S. adults experience a mental health issue in a given year
- 60% of those never seek treatment
- 50% of adults with a mental health disorder use at least one mental health service
- 30% of those with a mental health problem have a mental health issue
- 50% of care for an adult with a mental illness is provided by primary care providers
- 20% of adults with a mental health issue never seek treatment

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Thank you.

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