The Opportunity with Primary Care Integration

By Ian Chuang, M.D. and Dennis Morrison, Ph.D.
The goal of integrating primary care and behavioral health is more than breaking down a long-standing gap between two core disciplines of medicine. It is really about addressing the mind/body health needs that unite to positively impact health and well-being on a large scale. Done correctly, integration will take advantage of what each discipline does well, improve care coordination and leverage each discipline’s unique expertise to improve the total well-being of the individual. In doing so, it establishes a care process and experience for the individual that is more holistic and person-centric. For physicians, this model challenges long-held beliefs that began in medical school.

There are many models currently being tested that attempt to provide clearer clinical and financial accountability for the health of an individual across time and space. These models are not just targeting those times when the patient feels ill and makes an appointment with her provider. Whether a patient-centered medical home (PCMH) or accountable care organization (ACO), each model of care has its advantages, but all are currently heavily anchored and focused on physical ailments. Primary care integration and delivery models such as Health Homes recognize that high risk groups need better and more cost effective care coordination and management of physical and behavioral health conditions.

Primary and behavioral health care integration is ideally a better connection between caring for the whole person. There are different degrees of integration but, at its conceived pinnacle, the mind/body connection is well appreciated by all providers and factored into the clinical decision and care approach.

Here is what we know:

- 68% of adults with mental health conditions also have medical conditions
- 29% of adults with medical conditions also have mental health conditions
- 50% of the top 5% of the population consuming 50% of the healthcare resources have a behavioral health condition
- 21% of patients seen by primary care physicians are depressed; only 1.2% self-report depression
- Primary care physicians write 67% of all psychotropic prescriptions; psychiatrists wrote less than 18%
- 70% of all primary care physician visits are for psychosocial problems

Based on these stats, a few conclusions can be drawn:

1. For people who have both physical and mental health conditions, both have to be addressed in order to impact their total health and health care cost.
2. Many individuals with mental health conditions cared for by mental health professionals have concurrent physical illnesses that often are not well managed.
3. For those with physical illness struggling with mental health conditions, the mental health conditions themselves make the illness worse and/or harder to treat and recover.
4. Much of the effectiveness in treatment of physical conditions requires individuals to engage in their own healthcare, be adherent and even change their behavior and lifestyle choices. Psychosocial interventions don’t exist in the primary care practices; they are part of the programs and services available through behavioral health providers and provider organizations.
5. Primary care physicians prescribe medications as their most frequent treatment intervention. They are often not familiar with nor do they know about alternative, and often more effective, treatment options such as cognitive behavioral therapy (CBT). Those who are familiar with the efficacy of these non-pharmacological interventions are not able to provide them.
6. Consumers are more familiar with accessing and navigating the physical medicine system compared to accessing behavioral health services. A care coordinator or care manager that is monitoring and prompting the necessary care across physical and mental health needs will be necessary.
The Reality of Primary Care

Primary care clinicians in an ambulatory care setting are trained to do three core functions:

1. **Assess**: Determine if the patient is sick and how they are sick
2. **Diagnose**: Categorize sick patients with a label that describes the pathophysiology
3. **Prescribe**: Order the treatment (often prescriptions), diagnostic tests or procedures

The reality is that primary care clinicians’ most frequent treatment intervention is to prescribe medications for mental health conditions, and most other conditions for that matter. The main treatment modalities in the physical medicine world are procedures, including surgery, or chemicals, in the form of medications in various forms and delivery methods. Often, pharmacotherapies are not necessary, are not the best treatment options or do not achieve any meaningful results.

In fairness, this is not just due to the biases of the providers. The mindset of the consumer is to expect a medication for any ailment and for every physician visit. They’ve come to rely on medications as the “silver bullet” answer of medical care assuming, “There must be a medication to fix that.” For those providers who are disinclined to prescribe a medication, this expectation creates tension between physicians and patients around treatment decisions.

Lastly, outside of an inpatient facility, it is very difficult to ensure that medications are actually taken. Ensuring that the drugs that are prescribed are actually taken is out of the physician’s control. If a prescription is electronically delivered to a pharmacy, the primary care physician can remove one level of uncertainty – that the prescription actually made it to the pharmacy. But he or she has no guarantee that, i) the patient filled and picked up the medication, ii) the patient is taking the medication, or iii) the patient is taking the medication as prescribed. By comparison, in the hospital, the patient relinquishes all control and responsibility of these activities to the clinical care team. This provides the consumer and the treatment team high confidence in knowing what medication or treatment was taken/provided and when. Despite their best intentions, primary care physicians don’t have the skills to be coaches and advocates to help patients with their psychosocial struggles, including medication adherence, or address other practical barriers, such as finance, transportation, etc.

What We Know about Depression Pharmacotherapy

Based on scientific studies, pharmacotherapy isn’t always necessary, nor the most effective treatment options for depression.

External drivers that lean towards pharmacotherapy rather than psychotherapies (besides the physician and consumer bias noted above) include managed care insurance programs and the pharmaceutical industry. Managed care companies are in the business of providing care for the least cost, and medications appear to be more cost effective than other interventions like CBT. This is most likely an erroneous assumption. Pharmaceutical companies have invested heavily in the development of antidepressants and have aggressively marketed these products to primary care physicians and the general public.

A drug such as an antidepressant may be technically efficacious in the pharmacological sense, but the magnitude of the effect may not be sufficient to be clinically meaningful. What physicians frequently see is over-prescribing and over-utilization for long periods of time, without clearly knowing if the results are clinically meaningful nor whether an alternative approach would be better. There have been studies that show limited efficacy for antidepressant for mild to moderate cases of depression.

Another issue with antidepressants is the large placebo response quantified in the research. The reality is, for conditions related to the mind and mood, people are suggestible, and even placebo treatment is bound to
have some subjective impact. A large placebo response makes it difficult to determine the actual cause of the treatment response to antidepressants. Interestingly, for reasons not entirely clear, the placebo response has gotten larger over the past few decades.\(^6\)

Despite the merits of antidepressants, many patients do not respond sufficiently to pharmacological therapies to warrant continued treatment. This can be because the degree of their illness isn’t at a level that medications are the best treatment. There are also manifestations of depression that are treatment-resistant, which requires rethinking a treatment course that isn’t helpful. Approaches combining medication and psychotherapy can enhance clinical outcomes. For milder forms of depression, initial treatment with non-pharmacological therapies may be a more effective option.

The New Paradigm Opportunity

The integration of primary care with mental health providers has potential value in many aspects. One key area will be an improved multi-disciplinary approach to treating mental health conditions in the best way, based on sound practice, tapping the respective skills and expertise between physical and mental health clinicians.

Consumers have easier and more familiar access to primary care physicians, but they don’t always readily admit that their presenting problems are related to their mental health. Sometimes this is due to a lack of awareness and sometimes they are in denial. Consequently, primary care providers have to increase their sensitivity and be tuned into the possibilities of mental health conditions. In addition, a care manager can coordinate care more optimally between multiple disciplines. In the primary care workflow, assessments must include common screening tools for mental health risk or conditions, and diagnostic workups also must include mental health conditions. Treatments must also include services and programs available through behavioral health caregivers, and not just pharmacotherapy.

The Stages of Primary Care Integration

What is primary care integration? It would be nice if there were a single model that demonstrated best practice for integration. Instead, there are multiple models and examples across the U.S., sponsored by various national, state and regional programs. Each model represents an implementation of a stage and a degree of integration of four stages of primary integration: Data Integration, Collaboration, Process Integration and Holistic Care. Each stage is a prerequisite for the next level. Achieving the full potential of integration requires a care experience that is holistic (i.e. addressing the entire person), that recognizes not just both physical and mental health conditions, but also the mind/body connection. It must also recognize that the right care is sensitive to the individual’s preference and circumstances. The four stages are described in more detail on the following page.

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4 Silberman, S., Placebos Are Getting More Effective. Drugmakers Are Desperate to Know Why. Wired; Aug. 24, 2009
Stage 1: Data Integration

The first step to breaking down the care silo is to break down the data silo. The separation of the clinical information regarding physical conditions and behavioral care must be breached. Data integration is just as important as physically placing clinicians of both disciplines in close proximity or restructuring an organization for integration. Having better information doesn’t automatically change the care process or how clinicians from two different disciplines work together and think about the benefit of tapping into their expertise. However, it is a prerequisite for the care process to start to integrate and coordinate.

The insights gained from the shared information and reducing the chance of missing key information are just the start of the positive benefit. Information can also be leveraged by the Clinical Decision Support (CDS) system to safeguard against adverse drug reactions and other quality and safety parameters. The integration of care process and outcomes data will support new knowledge discovery. These are prerequisites for a knowledge-driven care model.
Stage 2: Collaboration between Primary Care and Mental Health Clinicians

The next stage of integration occurs when physical health clinicians and mental health clinicians coordinate care for common patients. Some demonstration projects have been initiated that promote this initial level of collaboration as their first step. Organizational affiliation and having a defined process for patients to access care between the two organizations is integral to this stage. It starts with proactively referring patients to a specialist for conditions that fall into their respective areas of expertise. Coordination includes awareness of the care being provided by each specialty, follow-ups, and sharing of findings and treatment. At the most rudimentary level, this level of integration can even take place in paper-based systems. There is one important caveat to this approach: It will be difficult to implement successfully if an inefficient and unreliable process for referrals exists. This is mainly because a manual system is reliant on human recall and human-initiated steps to be successful. An automated infrastructure mitigates this risk.

Stage 3: Care Process Integration

At this stage, care is no longer in independent silos, based on hand-offs between clinicians. The distinction between medical care and mental health care has diminished. Either through physical or organizational integration, the care process has become better aligned and better coordinated. Proactive planning and managing the client’s care ensures optimal and timely delivery of care without things “falling through the cracks.” This model will likely require the need for a care coordinator or care manager who helps ensure that both clinical specialties work together and engages the client with his or her care. In this model, the care providers are truly a team, proactively planning and acting in the interest of the individual’s health and well-being, not just when they are sick and long before they schedule an appointment to address an ailment.

Stage 4: Holistic Care

Care can and does extend beyond the walls of a clinic or medical office. Traditional models about where care “should” be rendered are abandoned. Care is delivered where it makes sense, including at work, at home and in the community. Technology such as telehealth (telephonic or video conferencing) becomes part of the care interaction. Mobile and web technology are also ways for caregivers to stay connected with clients. Care no longer has to be confined to the formality of an office appointment. In this holistic model of care, the borders differentiating “care” and “life” disappear. The goal is to fully engage and understand the determinants of health and work within the individual’s reality of home, workplace and community. The opportunity to connect in real-time, when care guidance can be most effective, and leverage different communication modalities truly provides the necessary just-in-time care that can alter the course of disease escalation or access issues that lead to over-utilization of the emergency room. Understanding where and when individuals feel unwell or struggle with their condition or their treatment allows the care team to refine and personalize the treatment, tackle some of the social service barriers, and align treatment with what matters to the individual’s reality of home, workplace and community. The opportunity to engage and understand the determinants of health and work within the healthcare system becomes part of the care interaction. Mobile and web technology are also ways for caregivers to stay connected with clients. Care no longer has to be confined to the formality of an office appointment. In this holistic model of care, the borders differentiating “care” and “life” disappear. The goal is to fully engage and understand the determinants of health and work within the individual’s reality of home, workplace and community. The opportunity to connect in real-time, when care guidance can be most effective, and leverage different communication modalities truly provides the necessary just-in-time care that can alter the course of disease escalation or access issues that lead to over-utilization of the emergency room. Understanding where and when individuals feel unwell or struggle with their condition or their treatment allows the care team to refine and personalize the treatment, tackle some of the social service barriers, and align treatment with what matters to the individual’s reality of home, workplace and community.
individual’s total health and well-being. The focus of attention shifts from a clinician-centric view to one that is consumer-centric. Care has evolved from population based services to personalized health.

Future Opportunities

After we gain experience with primary care integration, we will quickly address other health system needs to reduce the fragmented, silo-based care delivery that currently takes place. Self-insured employer groups have been willing to purchase additional services such as disease management, health coaches, or Employee Assistance Programs (EAPs) because they realize having healthy and productive employees does not occur under a disease-based medical care model. These employers believe the added up-front cost of these initiatives will be justified if they lead to improved compliance with care and improved lifestyle and behavior that slows the progression of illness. That translates to lower medical costs.

Thus far, the experience has been very mixed. Adding more third-party caregivers who have no relationship to the employees, on top of an already fragmented care model, has had limited positive impact. The time may be right to shift away from third-party health coaches and EAP call centers. All the necessary care coordination, social and psychological services necessary to intervene early and guide individuals to achieve optimal care and health status can be delivered through a structured care model, such as the primary care and behavior health integration model described in this paper. In addition to improving efficiency of care and reducing cost of care due to disease progression, there is also cost savings for employers and payer organizations that have previously pre-paid for stand-alone services outside of the healthcare system, producing limited impact. Most importantly though, health is improved for individuals and communities via their community-based clinical professionals working as a team.

About Netsmart

Through innovative and interactive solutions and services, Netsmart leads the health and human services industry in transforming the way care is delivered. Our expertise in helping organizations navigate their way through Meaningful Use and Accountable Care shows our commitment to partnering with organizations of all sizes to ensure they have the technology and know-how they need to deliver the highest level of care to those they serve. Healthcare today is an ever-changing, rapidly-evolving world. Organizations must seek technology partners who understand their current needs and have their pulse on the industry to envision how needs can be met in the future. Our obligation is to guide our clients through this rapidly changing environment by providing them with solutions and services that help improve outcomes and reduce costs. We help our clients adapt to these changes so that they can reach their goals and improve the health of the populations they serve.

Netsmart is committed to helping health and human services providers deliver effective, recovery-based care with Netsmart CareFabric™, a tightly woven framework of innovative clinical and business solutions and services that supports integrated, coordinated delivery of health services across the spectrum of care. Moving forward at the speed of thought, we are at the forefront of healthcare innovation and we continue to evolve our services and solutions to meet the needs of our clients today and in the future. Our goal is ensuring that our clients in behavioral health, public health, substance abuse and addiction services emerge from the healthcare reform era as leaders in their respective fields of specialization.

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Dr. Morrison has worked in the behavioral health field since 1969. Academically, he holds two Masters degrees in Psychology and Exercise Physiology from Ball State University. His doctorate is in Counseling Psychology also from Ball State University. He is co-inventor on a patent for a behavioral healthcare outcomes software product.

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