The Clinical Paradigms in the “Journey” to Integration

- Psychosomatic
- Linear Thinking (Reductionistic Causal Connections)
- Biopsychosocial

Know who your patient is...

Integrated Collaborative Comorbid
What they have
Disorder
And Psychosocial
Medical/Psychiatric
COST is an Issue

The Focus is NOW Upon “Populations”

Screening for those “at risk”
The role of the Psychiatrist; Psychologist is changing?

Cost of Depression (in 2011)

- Absenteeism $11.8 Billion
- Low Productivity at Work $24.8 Billion
- Treatment Costs $26.1 Billion

Why are we changing now???
Table 1. Selected examples of impact of physical comorbidity on annual healthcare costs of adults with mental disorders.

<table>
<thead>
<tr>
<th>Study</th>
<th>Mental disorder</th>
<th>Comorbid physical disorder</th>
<th>Relative increase in costs of comorbidity (mental disorder alone)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chou et al. (9)</td>
<td>schizophrenia</td>
<td>obesity</td>
<td>1.81</td>
</tr>
<tr>
<td>McDonald et al. (9)</td>
<td>schizophrenia</td>
<td>diabetes</td>
<td>1.81</td>
</tr>
<tr>
<td>McDonald et al. (9)</td>
<td>schizophrenia</td>
<td>dyslipidemia</td>
<td>1.81</td>
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<tr>
<td>McDonald et al. (9)</td>
<td>schizophrenia</td>
<td>hypertension</td>
<td>2.11</td>
</tr>
<tr>
<td>Contorelli et al. (9)</td>
<td>bipolar disorder</td>
<td>metabolic disorders</td>
<td>2.11</td>
</tr>
<tr>
<td>Welsh et al. (10)</td>
<td>depression</td>
<td>congestive heart failure</td>
<td>2.01</td>
</tr>
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<td>Welsh et al. (10)</td>
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</tbody>
</table>

All of the studies were from the USA. *All differences statistically significant p < 0.05.

Change is Not Easy
From Biopsychosocial Perspectives
To Co-morbid Management
(an arguable dialectic)
London Times in 1834 re: Laennec's Stethoscope

That it will ever come into general use notwithstanding its value . . . [is] extremely doubtful; because its beneficial application requires much time and gives a good kit of trouble both to the patient and the practitioner, because its hue and character are foreign, and repose to all our habits and associations . . . There is something even ludicrous in the picture of a grave physician proudly listening through a long tube applied to the patient's thorax.

Disruptive Technologies
Products and services not as good as currently available but simpler, more convenient, and/or cheaper

Sustaining Services
Targets demanding, high-end Customers with better performance than was previously available

Before you dismiss this as an impossible fantasy or something no one will accept

Patients will never tolerate these formats!!!

Who would have guessed this???

Then  Timeline  Now
Problem of Cohorts and Generations


CHAPTER VII

THE PROBLEM OF GENERATIONS

1. HOW THE PROBLEM STANDS AT THE MOMENT

Empirical versus Romantic Views

Tools for Population Health/Collaborative Care

Is talking to a patient passé??

Electronic Medical Record

- Adds time to evaluation or follow up
- Loose narrative
- Bad data in keeps on in the record
- Templates often foster overload
- Doctor often talking while looking at computer—communication???

Telepsychiatry Not Just the Consulting Room
Case Registers:
Mandate not to let cases “fall through the cracks”

From Tools (EHR, Tele) to Models

Models: Location/Workflow/Payments?

- Hospital Settings
  - Higher risk settings
  - General wards
- Primary Care Settings
  - Co-location
  - Stepped care with case management (UW model)
    - Screen
    - Assess + PHQ Individuals
    - Case managers review
    - Case registry
    - Psychiatrist is consultant to those that don’t remit
    - Use of Problem Solving Therapy—short term
    - Pay for screening and referral (DIAMOND)
    - Hybrids of above
    - Other models to be developed

The Development of an “Active” Consultation Approach

- One psychiatrist rounding on a medical unit
  - Increased consults; How do the consultee’s react?
  - When reported Cost not a big factor for inpatient care on medical services (1990)
- Behavioral Intervention Team
  - New Cost is clearly an issue (LOS all understand)
  - Nurse screens all admissions then discusses them with social worker and psychiatrist—those in need have formal consultation (medical team must agree)

Torem, 1999; Sledge (in press); Desan, 2011
The Ambulatory Arena

- Most Primary Care Practices are in small groups
  - Can be part of a larger organization or independent
- Types of patients greatly differ:
  - Some high in Medicaid/medicare/rural vs. urban vs suburban
- Availability of specialists/hospitals varies
- Mental health services vary
  - Types of MH professionals
  - Number
  - Payment
- Patients are not in a confined setting (like a hospital) thus control far less
- Do physicians follow patients or group does so?
- Use of mid levels—NPs or PAs?
- EMR connects with who??

Examples of Integration of Psychiatry with Primary Care

- Common themes
  - Screening via inventories
  - Stepped care
  - Attempt to keep patient in primary care setting
  - Short term therapies if needed
    - Provided by nonMDs or PhDs

Integration with Primary Care - Challenge of Psychosomatic Approach in General Medicine

- What the Patient Not Who
  - Stepped Care (what it is)
  - PHQ-9 Screen
  - Integration in Developing Countries

Types of Therapy in Most of These Models

- Fee for Service
  - Cash
- Problem Solving Therapy
  - http://psnetwork.ucsf.edu/
- Seem to be the focus of current models of integration
- Psychoanalytic Treatment
- Psychodynamic Psychotherapy
- Pez Dispenser: Meds Primarily

Group Rx next to Primary Care Clinic in Rural India
Treat to Target: Key Concept

Q: What supports a measurement-based, treatment-to-target approach?
A: A care management tracking system. Care management tracking systems drive care by structuring encounters with patients, identifying those who aren’t improving, prompting changes in treatment, and tracking effectiveness across different providers and case loads—all while making the work of each team member more efficient and effective. They also track whether or not clinical targets are being met.

Symptom to be treated
Is it Remitting?

Co-Location: The Maine Project

Rural; Large Geography; Many Poor and Isolated

Co-Location (A Psychiatric SW or LPC)

- A contract model with staff fully accredited to the primary care sites with an IT access agreement in place
- Full time embedded behavioral health clinicians
- Training, supervision, consultation & resources provided by community mental health center
- Warm hand-offs and referrals seen within one to three days
- Physician/Psychiatrist consultation model
- Psychiatric consultation and brief treatment via telepsychiatry
- Brief, solution oriented treatment model
- Shared electronic health record
- Shared treatment planning & contiguous progress noting
- Active community engagement & education component

Length of Treatment

- 0-5 sessions: 19%
- 6-10 sessions: 34%
- 11-15 sessions: 38%
- 15+ sessions: 9%
- 20+ sessions: 3%
INOVa and IMG (INOVa MEDICAL GROUP)

- Multispecialty Group Practice
- 400 physicians including 29 Primary Care Offices
- Medical Home Requires Depression Screening
  - PHQ-9 in EPIC
- Large ambulatory campus plus 1000 bed hospital
- Still hospital-centric???

**Metrics**

*Proposed metrics for evaluation*

- **Phase 1**
  - Depression screening (PHQ)
  - HgbA1c, BP
  - Time to referral (by severity, chronicity)
  - Time to appointment
- **Phase 2**
  - Utilization
    - Pharmacy fills
    - RxP, ED, IP usage
    - Total cost per patient by depression severity
- **Phase 3**
  - Quality of life

**Depression Management in Primary Care**

*Strategy for Managing DEPRESSION*

**Phase 1**

- Refractory at need (Hospital)
  1. Patient Education
  2. Psychotherapy if needed
  3. FU 6 weeks - PHQ-9

**Phase 2**

- Antidepressant &/or Psychotherapy
  1. PHQ-9 at 1st visit
  2. FU 6 weeks - PHQ-9

**Phase 3**

- Antidepressant &/or Psychotherapy
  1. PHQ-9 at 1st visit
  2. FU 6 weeks - PHQ-9

**Where are We Going??**

*Indigent, Medicaid, Medicare, Insured, Self Pay*

*Will we (or are we now) Boutique Psychiatrists?*

*Where are We Going??*