NSRHN

Integrated Behavioral Health Care in Community Clinics "A Medical Provider's Perspective"

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Why Should Medical Providers even think about Mental Health Issues?

- For your diabetics–

More important to resolve issues around Zetia or Vytorin use OR screen for depression?

Need Primary Care Provider "Buy In"

- For Integrated Behavioral Health Program all the medical providers need to buy in.
- Convincing medical providers is the key to a successful IBHP program

Primary Care Issues

- Suicide rates highest in men over 65 with health problems
- Depression hard to spot in elderly
- Anxiety disorder 25%+, depression 25%+, bipolar about 10% in community clinics—most untreated
- Half of diabetics will suffer from depression
- Overall shortage of easy access to behavioral health providers and facilities—no one else to do it.

Primary Care Issues

- Stigma attached to patients seeking behavioral health treatment from specialty mental health
- Provider reaching for door handle concluding visit just as patient mentions mental health issues

Primary Care Issues

- Patients prefer to receive behavioral health care from their primary care provider—mental health issues are intimate
- Left untreated, mental illness related neuropsychiatric brain changes tend to worsen and become permanent

Primary Care Issues

- Real message to medical providers—don't create a chronic problem for the patient by not treating mental health issues now.
- Remember the brain is plastic and lack of treatment creates brain changes that can disable the patient.

Primary Care Provider Concerns

- Uncomfortable with multi-drug depression regimes (SSRI apathy common)
- Do not use mental health screening tools universally so miss most mental illness
- Make little use of any psychotherapy – most patients lack insurance coverage and patients are resistant to “head shrinker”

Primary Care Provider Concerns

- Think patients with mental illness are simply jerks, stupid, noncompliant, manipulative, drug addicts and the first patients to kick out of the practice or deny services to.
- Because there is no screening up front, patients raise mental health issues as provider reaches for the door handle. So the tendency is to reach for the prescription pad or sample bin rather than to talk to the patient.

Primary Care Provider Concerns

- Lack of access to psychiatrists for consultation
- Shortage of trained & licensed behavioral health workers for counseling services
- Insufficient referral knowledge of complimentary, community-based services
- Lack of coordination of care with specialty behavioral health systems

Why IBHP?

- Primary mental health conditions – depression, alcohol use, anxiety, sleep problems, chronic fatigue, and unexplained somatic symptoms – are prevalent AND respond to treatment in primary care, especially when they are identified early

Why IBHP?

- Studies show that 30% to 75% of patients waiting to see primary care physicians are also in need of mental health services
- Many patients are capable of behavior change if a clinician “problem solves” with them

Why IBHP?

- Every patient with serious mental illness needs a “medical home”. Psych meds are laden with medically significant side effects.

Patients "push back" about therapy what medical Providers deal with:

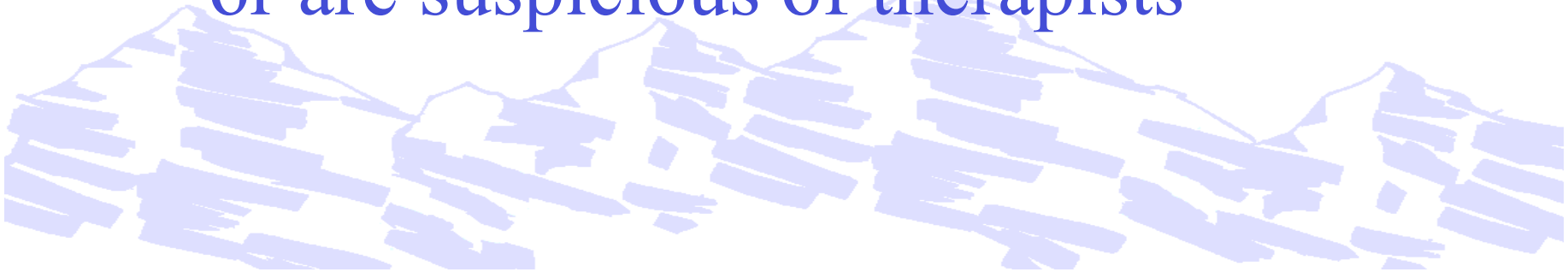
- Mental health is a taboo, or at least uncomfortable subject
- Don't want to be seen as "crazy" – will often park blocks away if going to mental health department
  - Concerned about consequences if insurance company, employer or the state finds out.

Patients "push back" about therapy

- Don't want to talk about their childhood or unhappiness in the distant past

– Don't have insurance coverage; therapy is expensive

– Often don't see the reason for therapy, or are suspicious of therapists



Why Universal Screening is Critical

- Evidence shows that many BH conditions go undetected in primary care
- Milder symptoms are more likely to be missed, so prevention is defeated
- Undetected mental health complaints elongate medical visits
- Dental clinicians can also learn to use screening tools and the services of behavioralist

Universal Screening

- Screening can increase visit efficiency
- PCP still has to determine what to treat, when and how
- Screening data will prepare the PCP and will explain many anomalies

Universal Screening

- Every patient receives MINI at least once a year (SAD, depression, GAD, panic disorder, alcohol use).
- Depressed patients followed with PHQ-9.
- Every depressed patient completes mood disorder questionnaire for bipolar screening before treatment and an ADD screen.

IBHP: Key Traits

- 3 key people for fully integrating BH into PC:
  - Primary Care Provider
  - Behavioral Health Consultant (BHC)
  - Consulting Psychiatrist
- On-site brief intervention therapy – co-located with primary care; rapidly available— “interruptable”.
- Concept of the “warm handoff”
- Access to psychiatrist on-site or by telepsych without long waits.

How to do a "Warm Handoff"

- Real time involvement of Behavioral Health Consultant during medical visit will double the number of patients who will complete their BH referral.
- Must explain why patient needs to see BHC and what will happen.
- Medical provider's attitude and behavior with the patient makes the key difference.

How to Introduce the BHC

- "Lifestyle Management" sign on door – makes it totally routine, like getting blood pressure.
- Directional psychology – offers a solution-oriented approach.
- Short, 15-20 minute visits with homework

How to Introduce the BHC

- 1-5 visits with BHC as a start – those needing more traditional psychotherapy referred.
- Uses SOAP note format in main body of chart so all providers can see what BHC is doing, and BHC can follow medical care.

Pain Management Program

- BHC teaches 4-class series that every patient on opiates must take to continue to receive controlled medications.
- Patient must meet with BHC every 60 days to update progress/monitor mental health.
- Patient sees PCP monthly for prescription.
- Helps patients put their pain in perspective.
- Weeds out drug seekers – “self select” out.

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