

*Integrated Physical and  
Behavioral Healthcare: Case  
Study and Policy  
Perspectives*

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- Reasons to be Optimistic

# *Overview of Presentation*

- Can integration improve the quality of care?
- Why is improvement difficult?
- Where can we look for improvement?
- Barriers to adopting evidence based treatment in primary care
- Some practical steps to consider
- Policy implications

# *Principles of the Medical Home*

- Doctor-patient relationship
- Physician team leader
- Considering the whole patient
- Commitment to care coordination
- Safe, high quality care
- Access and communication

# *Can it Work for People with Mental Illness?*

- PCP medical homes hold promise for people with conditions of mild to moderate severity
- The evidence has been examined for the treatment of depression and anxiety
- Cautionary notes about the PCP model for people with SPMI

# *Improving Treatment for Depression in the U.S.*

- Focus on primary care
- Why?
  - Growth in treated prevalence has come from primary care
  - Share of primary care in mental health care has grown to 53% of cases
  - Technical change in drugs and manualized therapies especially significant for PCPs
  - PCP historically weak in recognizing and treating depression

# *Elements of Evidence Based Treatment of Depression for PCPs*

- Physician time
- Care manager services
- Specialty consultation
- Registry-decision support

# *Learning About Impacts of Evidence Based Care*

- Effectiveness: Meta Analysis (Gilbody et al Arch Int Med 2006)
  - Six month gains ~ 0.25
  - Five year gains ~ 0.15
- Key elements of treatment
  - Medication adherence
  - Credentials and supervision of care managers

# *Cost-Effectiveness*

Evidence based treatment increases treatment costs and improves outcomes

- Estimates of incremental costs per QALY \$11,270 to \$19,510 when Canadian cut offs were \$20,000 to \$30,000 (Lave et al 1998)
- Little evidence of general medical offsets
- Results in improved work outcomes; probability of working; hours of work (Timbie et al, 2006)
- Finding replicated in several different settings

## *Usual Care for Depression Differs from EBT*

- PCPs still frequently fail to recognize depression
- PCPs visit duration increases by 1.8 minutes with cases of depression/anxiety (Frank and Zeckhauser, 2007)
- High percentages of usual care patients do not have follow-up contact
- Typical PCP treating depression adjusts treatment according to *level* of symptoms not *change* in symptoms (Henke et al, 2007)

# *What Stands In The Way Of Adoption Of Evidence Based Treatment?*

- PCP attitudes and habits
- Organization of PCP practices
- Implementation of quality improvement efforts
- Payment policies
- Use of decision supports

# *Attitudes and Habits*

- Physicians do not devote extra time
  - Average visit 17 minutes; depression cases get less than 19 minutes on average
  - When mental health problems are raised with PCP; video tape evidence suggests subject is changed in about 1 minute (Tai-Seale et al, 2007)
- Cases of depression less likely to have return visits than other chronic conditions

# *Organization of Physician Practice*

- Approximately 30% of PCPs are in solo practice and 20% to 30% more are in small groups (<5)
- The costs of a care manager are typically higher in small groups and solo practices
  - Difficult to spread quasi fixed cost of care manager
- Small groups less likely to use electronic records

# *Payment Policies*

- Carve-outs can be an impediment to evidence based treatment in primary care
  - Some plans that carve-out behavioral health do not pay PCPs for treatment of mental disorders
  - Referral networks between PCP and carve-out may not overlap (although this is a declining problem)
- Medicare and other payers do not pay for care management or some types of consults

# *Plan Quality Improvement Programs*

- Results from a national survey of health plans
- Surveyed 242 individual plans
- Sixty six percent for-profit
- Distributed across all regions of U.S.
- Fifty three percent had over 50,000 lives

# Data Collection and QI Activities

	Anti-depressant medication	Cholesterol Management	Asthma Medication
Plan level Data			
Collects Data	91.3%	92.1%	95%
Target Measures	84.3%	83.1%	87.6%
Demonstrate Improvement	47.5%	73.1%	81.4%
Physician/Group Data			
Collects Data	53.7%	68.2%	79.8%
Feedback	38.4%	58.3%	68.6%
Uses in P4P	17.4%	28.9%	33.1%
Uses in Report Cards	13.6%	19.0%	21.5%

# *Observations*

- Plans consistently devote less QI effort to depression performance
- Plan-physician interactions on depression QI are low relative to other chronic conditions
- Fewer financial and non-financial incentives tied to performance on treatment of depression
- Incentive effects: a) less of a positive effect; and b) multi-tasking impact (diversion of effort away from unpaid outcomes or “teaching to the test”)

# *Towards Renewed Improvement: Care Management*

- Spreading costs/ training are key
- Generic chronic disease care managers
- Experiences in 6 major demonstrations suggest case loads of 40-80 patients per care manager
- Use of carve-outs for virtual/telephonic care management
- Only virtual model compatible with solo/small group practices

# *Physician Time*

- Altering scheduling is very difficult
- UCSF experimented with adjustment to productivity formula to give PCP more time for depression care
  - Adjustment allowed 30 minute depression visit to count as two visits
- Few PCPs availed themselves of extra time
  - Suspect that since only a share of patients were eligible for adjustment habits did not change (Feldman et al 2006)

# *Carve-Outs*

- Can be structured to promote EBT
  - Credential and pay PCPs FFS for EBT
  - Serve as care manager
  - Aid in constructing referral network

# *Plan QI Programs*

- Plans can help motivate effort aimed at improved performance
- Consistent Measurement (HEDIS)
- Feed Back to PCPs
- Use in Report Cards
- Include in incentive schemes

# *Bottom Line*

- Path to improving depression care is clear
  - Improved care management
  - Longitudinal tracking of symptoms by PCP
- Plans have key role to play in motivating performance
- Improving depression care will improve health
- Likely raises costs modestly
- Results in some productivity improvements (captured by partly employers mostly by households)
- Few medical offsets should be expected

# *Policy Implications*

- Medicare
- Medicaid
- Integrated Primary and Specialty Care
- Parity
- Reform Activities
- Repeat: reasons to be optimistic