

Integrating Primary Care & Mental Health/Substance Use

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**The Robert Graham Center: Policy Studies in
Family Medicine and Primary Care**

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Mental Health Balkanization

Of People with Poorer Mental Health in America:

50% --- Only see a Primary Care Physician

17% --- No visits

13% --- See both Primary Care and Mental Health

5% --- Only See a Mental Health Provider

Of those who see only primary care:

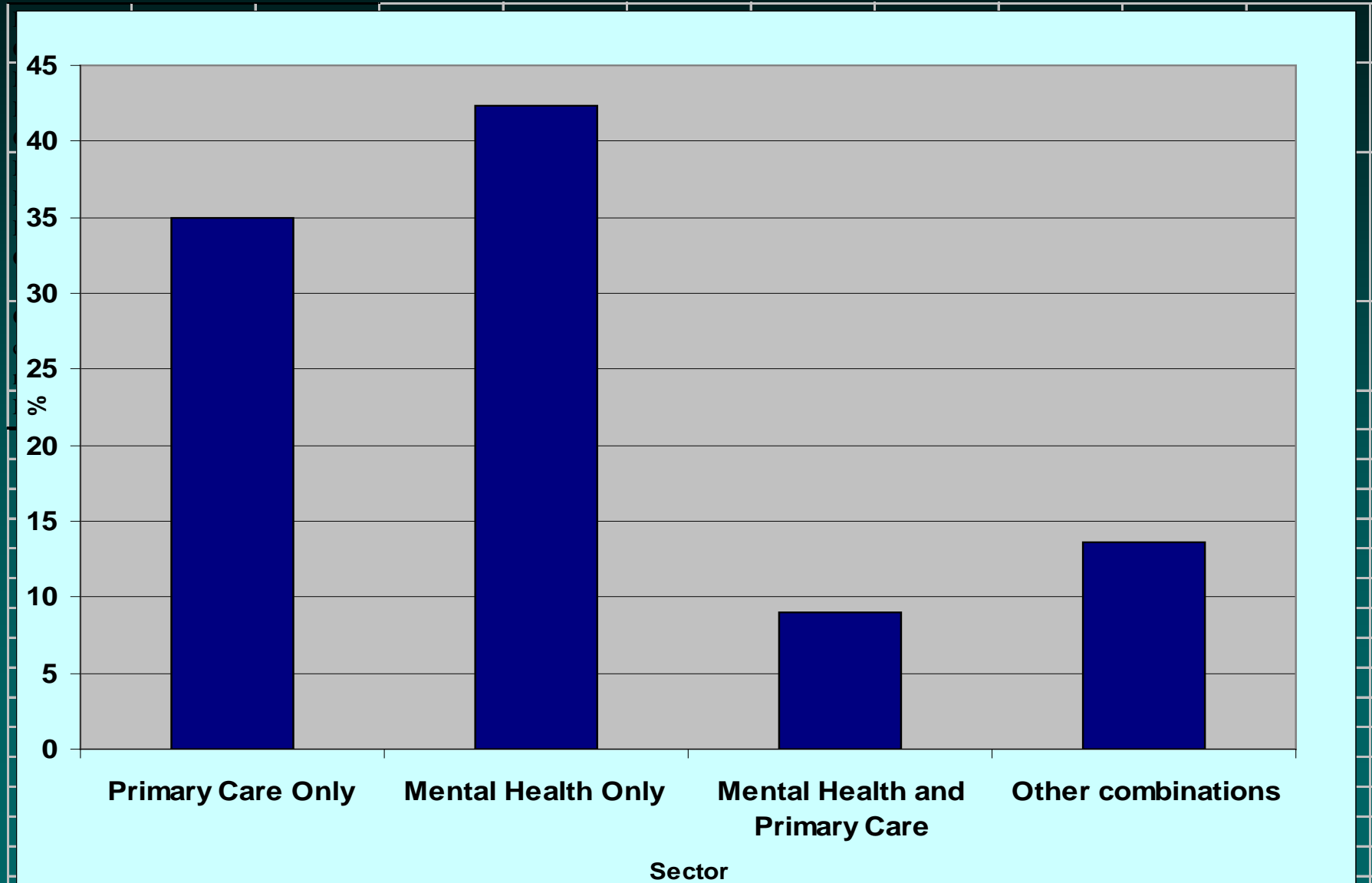
1/3rd will make only one visit

Mental Health Score is higher (better)

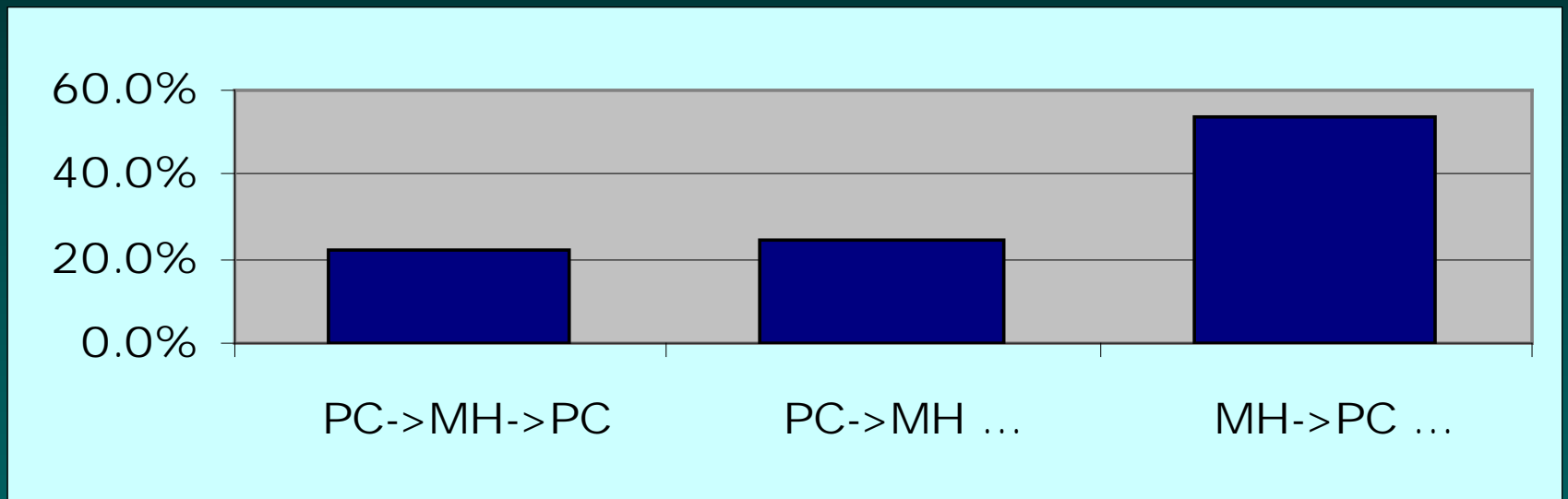
Are more likely to have other health conditions

Are older and less educated than those who see MH

For People with a Mental Health Diagnosis



Shared Care (9%)



Patient-Centered Medical Home

Continuous, healing relationship

Team of care-givers, jointly responsible

Whole-person care

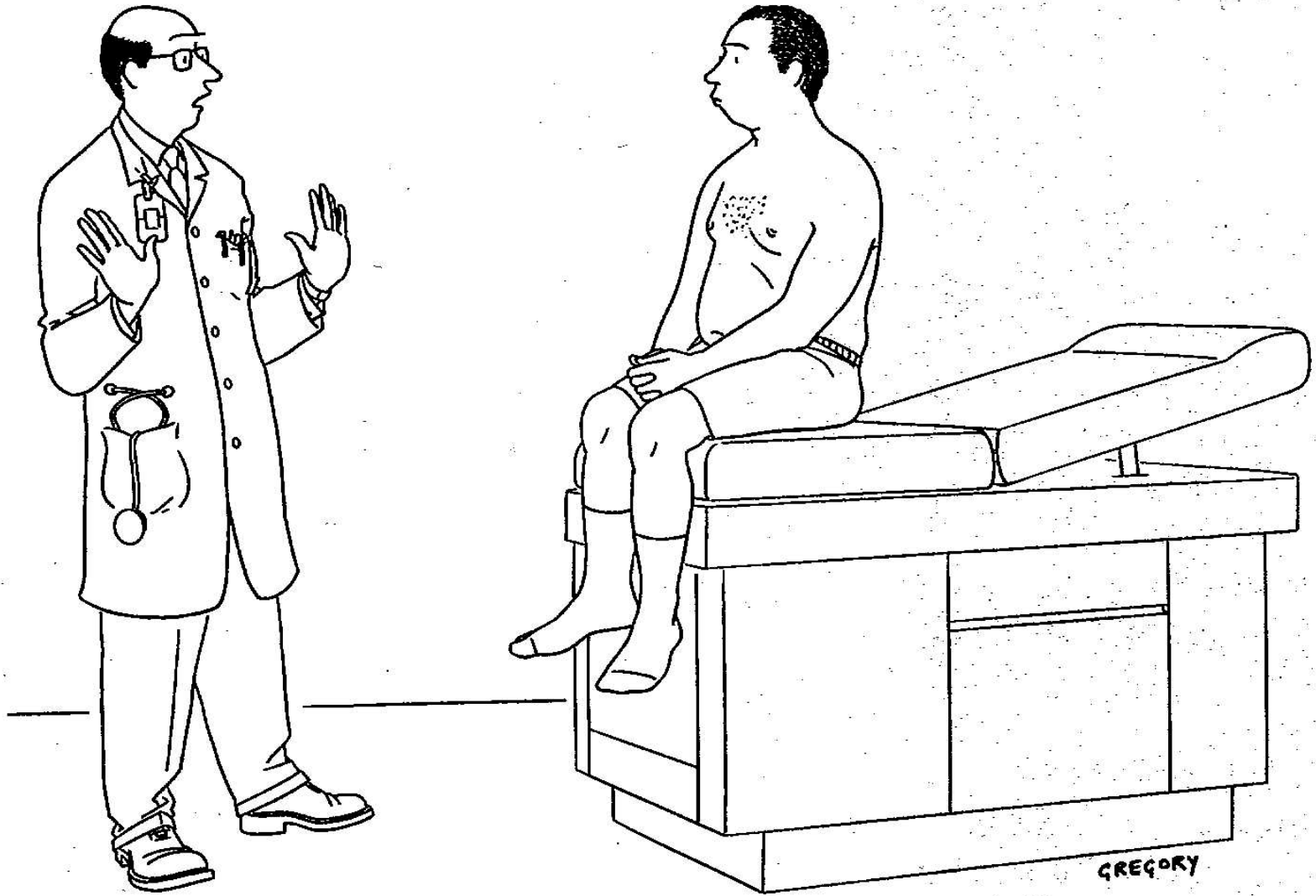
Care Integration

Focus on Quality & Safety

Enhanced Access

Making a Room for Mental Health and Substance Use in the Medical Home

- Patient-Centered without it?
- Must be *PURPOSEFUL*
- Reduces complications of other conditions
- Reduces costs
- Must remove barriers
- Need Active Experimentation & Demonstration



“Whoa—way too much information.”

Integrating Primary Care/ Mental Health/ Substance Use

**Mary Jane England, M.D.,
President, Regis College,**

Chair, IOM Committee

**on Improving the Quality of Health Care
for Mental and Substance-Use Conditions**

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The Crossing the Quality Chasm Series

To Err is Human (1999)

*Crossing the Quality Chasm - A New Health System for
the 21st Century* (2001)

Leadership by Example (2002)

Fostering Rapid Advances in Health Care (2002)

Priority Areas for National Action (2003)

Health Professions Education (2003)

*Keeping Patients Safe – Transforming the Work
Environment of Nurses* (2004)

*Patient Safety – Achieving a New Standard for Care
(2004)*

*Quality through Collaboration – the Future of Rural
Health* (2005)

*Improving the Quality of Health Care for Mental and
Substance-use Conditions* (2005)

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Applications of the IOM Report

- New joint project on integrating Mental Health and Substance Use care with primary care for general health
 - **Robert Graham Center, bringing a family medicine and primary care perspective to health policy deliberations from the local to international levels.**
 - **NAC (National Action Committee) / IOM**
- “Medical home” concept



Six Aims of Quality Health Care

- 1. Safe – avoids injuries from care**
- 2. Effective – provides care based on scientific knowledge and avoids services not likely to help**
- 3. Patient-centered – respects and responds to patient preferences, needs, and values**


Six Aims (cont.)

- 4. Timely – reduces waits and sometimes harmful delays for those receiving and giving care**
- 5. Efficient – avoids waste, including waste of equipment, supplies, ideas and energy**
- 6. Equitable – care does not vary in quality due to personal characteristics (gender, ethnicity, geographic location, or socio-economic status)**



Two Phenomena Central to the Committee's Work and Findings

- **Co-occurrence of mental, substance-use, and general health conditions**
- **The differences in M/SU health services delivery compared to general health care**



Mental, substance-use, & general health

CONCLUSION

Improving care delivery and outcomes for any one of the above depends upon improving care and outcomes for the other two.

OVERARCHING RECOMMENDATION

Health care for general, mental, and substance-use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body.



Evidence-based coordination– linkage mechanisms

- **Clinical integration of services**
- **Collocation of services**
- **Shared patient records**
- **Case (care) management**
- **Formal agreements with external providers**



Individual Clinicians

Recommendations:

- **Support consumer decision-making and treatment preferences;**
- **Use illness self-management practices;**
- **Have effective linkages with community resources;**
- **When coercion unavoidable, make the process transparent;**

Individual Clinicians

Recommendations, cont.:

- Screen for co-morbid conditions;
- Routinely assess treatment outcomes;
- Routinely share clinical information with other providers;
- Practice evidence-based care coordination; and
- Be involved in designing the National Health Information Infrastructure (NHII).



Organizations Providing Care

Recommendations:

- Have policies to enable and support all actions required of clinicians (on prior slide);
- Involve patients / families in design, administration, and delivery of services;
- If serving a high-risk population (e.g., child welfare, criminal and juvenile justice) screen all entrants for M/SU problems
- Involve leadership and staff in developing the National Health Information Infrastructure (NHII).



Other Stakeholders

- **Health Plans and Purchasers**
- **State Policy Makers**
- **Federal Government**
- **Institutions of Higher Education**
- **Funders of Research**



Institutions of Higher Education

Recommendations:

- **Increase interdisciplinary teaching and learning to facilitate core competencies across disciplines; and**
- **Facilitate the work of the Council on the Mental and Substance-Use Health Care Workforce.**

Recommendations for research

support:

- **Development and refinement of screening, diagnostic, and monitoring instruments to assess response to treatment;**
- **A set of M/SU “vital signs”: a brief set of indicators—for patient screening, early identification of problems and illnesses, and repeated use to monitor symptoms and functional status.**

Funders of Research

Recommendations, cont.:

- Research approaches that address treatment effectiveness and quality improvement in usual settings of care.
- Research designs in addition to randomized controlled trials, that involve partnerships between researchers and stakeholders, and create a “critical mass” of interdisciplinary research partnerships involving usual settings of care.