MENTAL HEALTH INTEGRATION: RETHINKING PRACTITIONER ROLES IN THE TREATMENT OF DEPRESSION: THE SPECIALIST, PRIMARY CARE PHYSICIANS, AND THE PRACTICE NURSE

Brenda Reiss-Brennan, MS, APRN, CS; Pascal Briot; Wayne Cannon; Brent James

Although primary care provides the majority of mental health care, lack of time and documented economic benefit make it difficult for healthcare delivery systems to proactively implement effective treatment strategies for the growing disability of depression.

Current care delivery models are inadequate and inefficient, leading to provider and consumer exhaustion, as well as significant gaps in care and poor outcomes. This publication describes a quality improvement pilot demonstration called ''mental health integration'' (MHI) that has been successful in realigning resources, enhancing clinical decision making, measuring the impact and building a business case to determine what actually is the value added for quality. Mental health integration (MHI) promotes the rethinking and retraining of traditional solo practitioner roles to new practitioner roles that facilitate partnership and effective communication as a means to help patients and families achieve a state of successful performance. Results describe the improvements in depression detection at a neutral or lower cost to the health plan. Recommendations are identified for building the business case for MHI quality in order to sustain improved outcomes and promote diffusion of the model outside of Intermountain Health Care (IHC) setting. (*Ethn Dis*. 2006;16[suppl 3]:S3-37–S3-43)

Key Words: Depression, Mental Health Integration, Primary Care, Quality Improvement, Team Roles

From Intermountain Health Care, Salt Lake City, Utah.

Address correspondence and reprint requests to Brenda Reiss-Brennan, MS, APRN, CS; Mental Health Integration Leader; Intermountain Health Care, Physician Division; 36 South State Street, Suite 2100; Salt Lake City, UT 84111; 801-442-3012 (ext 3206); 801-442-3026 (fax); cobreiss@ihc.com

INTRODUCTION

Health delivery in America today has become a wasteland of uncoordinated and fragmented care, which has exhausted both its providers and consumers. The purpose of this publication is to describe a quality improvement pilot demonstration called ''mental health integration'' (MHI) that has been successful in realigning resources, enhancing clinical decision making, measuring the impact and building a business case to determine what actually is the value added for quality.

Mental health integration (MHI) is a comprehensive approach to promoting the health of individuals, families and communities based upon communication and coordination of evidence based primary care and mental health services. The World Health Organization defines health as a complete state of physical and mental well-being.[1] The Surgeon General defines mental health as a state of successful performance of mental and physical function resulting in productive activities, fulfilling relationships with others and the ability to adapt and cope with adversity.[2] Mental health integration (MHI) is mental health care that is integrated into everyday primary care practice. The integration of mental health into primary care simply means to *treat* mental health as any other health condition from identification to recovery. This integration is one example of quality healthcare delivery redesign that is team based; outcomes oriented and follows a standardized quality process that facilitates communication and coordination based on consumer and family preferences and sound economics. Mental health integration (MHI) requires the rethinking and retraining of traditional solo practitioner roles to new practitioner roles that facilitate partnership and effective communication as a means to help patients and families achieve a state of successful performance.

Increasingly today, the responsibility for providing mental health care falls to primary care providers. Both consumer preference and economic disincentives are driving the need for this ''de facto'' delivery system. In the last decade, there has been a significant increase in the proportion of people with serious mental illness and substance abuse disorders who report receiving care from primary care providers and hospital emergency rooms.[3,4]

Depression and mental health disorders are increasingly associated with high disability, projected to rank second only to cardiovascular illness as the leading cause of disability worldwide by 2020.[5] Despite the availability of evidence-based treatment for mental health disorders, many patients and families do not receive effective treatment.[6–10] Ethnic minorities, older patients, children, and less-educated patients are more likely subject to treatment disparities and to receive lower quality of care than are other depressed patients.[2,7,11,12]

Although primary care provides the majority of mental health care, current care delivery models are inadequate and inefficient, leading to significant economic gaps in care and poor outcomes.

METHODS

The Institute of Medicine has outlined in its Quality Chasm series of

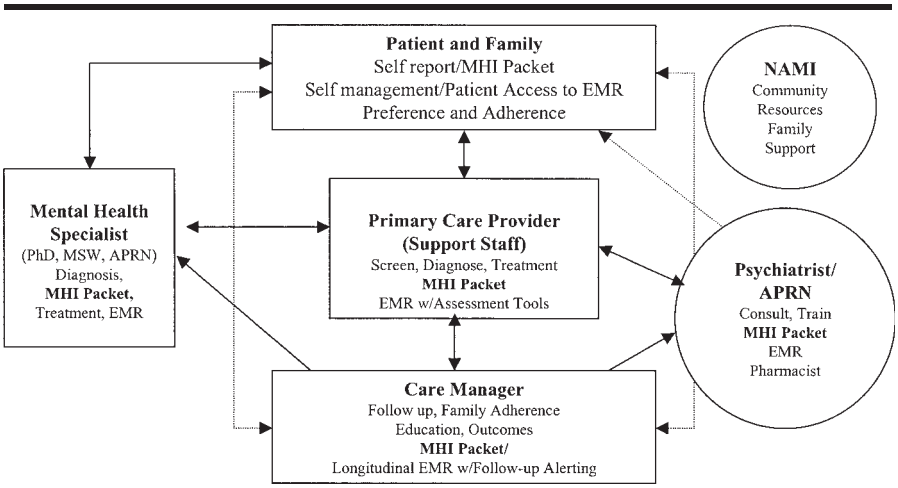

Fig 1. The clinical model. team roles

reports, a new conceptual framework for defining and operationalizing quality healthcare reform in our country.[13] Although not coordinated on a national level, multiple research and practice efforts across the country and abroad are actively testing and redesigning care to realign quality, performance and economic value. Many of the most effective models of care redesign combine several quality principles into "collaborative care" models, in an effort to improve the process and clinical outcomes of care for chronic illness.[14–16] These reorganized systems of collaborative care can improve health outcomes, lower overall costs and are more satisfying to consumers and providers. Ongoing evaluation of these efforts to measure the *value* of the impact of integrated models on satisfaction, clinical outcomes, and cost are needed and will require engaging diverse stakeholders who are influential in developing the business case for quality in their unique community.

As a nonprofit organization with no commercial investors, Intermountain Health Care (IHC) combines the financial, administrative and delivery aspects of health care into one integrated network committed to providing clinical excellence, quality and innovation rather than stockholder profit. In 1999 a key group of IHC leaders became increasingly concerned that primary care medical resources were not being used efficiently to treat patients with depression and other mental health conditions. These leaders were influential in establishing the Mental Health Integration (MHI) quality improvement program to address the practice burden of managing these conditions and to build a business case for integration. Consumers, providers, hospital and physician administrators, community partners and research staff worked together to enable this integration. To evaluate the value of mental health integration, IHC leaders utilize a strategy of measuring satisfaction, clinical and economic variables to determine if integration: 1) improves satisfaction for both patients and clinicians; 2) improves the health, functioning and productivity of the patients and their families; and 3) is cost neutral, in terms of both health plans claims and clinic operational expenses.

The MHI program has been tested at an urban primary care clinic in Salt Lake City, which houses a team of well-respected pediatricians and internists. This group of IHC physicians had already initiated collaborative care for conditions like diabetes and asthma and encouraged IHC leadership to redesign the clinic workflow in order to integrate mental health care as part of everyday practice.

A Mental Health Integration (MHI) leadership team was established in each region site to design, implement and evaluate the integrated care process model using standard quality improvement principles. Team membership included key stakeholders such as lead physicians, mental health practitioners, receptionists, clinic administrators, a quality researcher, consumers and onsite nursing care managers.

At the clinic site the roles of primary care providers (PCPs), consumers and families, mental health providers and care managers were redesigned and reorganized into a consultative and collaborative treatment team model to improve care for mental health conditions in the primary care setting (See Figure 1).

Members of the MHI team participate with primary care providers and their support staff in ongoing standardized MHI training and use the electronic medical record for documentation and communication with each other regarding treatment progress, poor response and/or recommended changes. The MHI training and role "rethinking" process focuses on family centered care and recovery. Families provide a significant proportion of support for the self-management of a chronic disease because they often navigate complex psychosocial and biological challenges. Family members may be a sustainable resource to the patient to promote ongoing adherence.[17,18] Therefore, educating the practitioner and support staff about engaging the patient and family in a health partnership is a critical foundation to the self-management component of the IHC MHI clinical model. Practitioners who are able to engage patients and their families in a positive helping relationship will have greater success promoting adherence and achieving improved health outcomes.[17,19–26] The real impact of self-management will be in the provider's ability to endorse the patient's and family's preferences while

instilling hope in recovery. Team members are acknowledged in and accountable for their role in promoting the identified recovery outcomes.

The patient and family are responsible for reporting their health needs and preferences. They also have a significant role in engaging with their PCP to establish a culturally congruent self-management plan. The PCP and their support staff are responsible for screening, diagnosis and treatment and most importantly preparing the family for the MHI team. The care manager is responsible for education and follow up and communication with the MHI team regarding the family's adherence preference and risk. They are specifically trained to help engage difficult families that may be either isolated from or have exhausted their natural support systems.

The MHI APRN/psychiatrist provides onsite and phone consultation to the integrated teams. The MHI licensed therapist provides brief solution focused psychotherapy. The IHC MHI team has also enlisted the support of NAMI (National Alliance of Mental Illness), which is a consumer advocacy community resource that is used to enhance the education and peer mentoring support needed by the family.

Further diffusion of the MHI program innovation has occurred whereby IHC has established MHI planning in all of its five regions and eight identified PCP MHI clinics with onsite MHI teams in various stages of implementation. The MHI program has further developed both clinical and computer tools to enhance the efficiency of practice operations. Through ongoing training and economic quality incentives, these tools have been adapted into physician practices and have helped organize the complex and burdensome impact of mental health conditions on the seven-minute visit and overwhelmed office staff. Mental health integration (MHI) has specifically targeted strategies that have improved the efficient management and outcomes of chronic diseases and co-morbid conditions. Early results demonstrated that collaborative primary and mental health care led to improved functional status in patients and improved satisfaction and confidence among physicians in managing mental health problems as part of routine care at a neutral cost.[27] These results allowed IHC's research team to advance its evaluation measures to test the impact of this intervention on IHC's resources. The MHI care process is designed to provide a ''treatment cascade'' for stratifying patients and families into three different treatment levels based on overall impairment and disease severity (mild, moderate, or severe). The treatment cascade and sorting process is activated by PCP's evaluation of a self-reported ''MHI packet'' assessment tool which helps them organize with the patient and family their presenting mental health concerns, existing risk factors, disease severity measures, global impairment and family support into an appropriate level of care plan. For example, when treating the disease of depression:

1. Routine Care is recommended for mild depression. This level of care involves only the primary care physician and support staff (with care management included only by PCP or patient preference). Family and social support are readily available and in use for these patients and their families.
2. Collaborative Care is recommended for moderate depression and/or co-morbid complex conditions. This level of care also involves the PCP and requires ongoing care management support. Brief onsite mental health team consultation is available as requested. Patients and families who are more isolated from needed support or who may have also exhausted their family or support resources will benefit from this level of MHI intervention. Care managers are specifically trained to help engage families and promote adherence and self-management.
3. Referral to a Mental Health Specialist(s), along with treatment from the primary care physician, care management, and onsite mental health team, is recommended for severe depression. Patients and families who have reached a level of danger risk as well as relational burden and co-morbid complexity require a consultation from the MHI specialist who will determine whether patient and family can continue with the PCP MHI team to achieve stabilization, or whether it is more appropriate to activate community secondary mental specialty services outside the clinic.

Current MHI analyses allows for evaluation of clinical improvement based on level of care provided for each severity classification. Future analyses will allow linkage between clinical outcomes, operational expenses, claims costs, workforce manpower and training. Measuring and reporting satisfaction, clinical, and cost outcomes that are meaningful to all stakeholders builds consensus and fosters continued support of MHI. The data generated from more robust evaluation will legitimize use of additional IHC and community resources for other population groups with unmet needs such as pediatrics and women's health and further diffusion of this model to rural clinics.

RESULTS

Providers/Staff satisfaction with the change in process was measured before and after intervention. It shows a marked improvement in a series of operational areas (see Figure 2). Similar studies were run to measure patient response to the new process. These also show marked improvement after intervention, as well as better results than for a control group (see Figure 3).

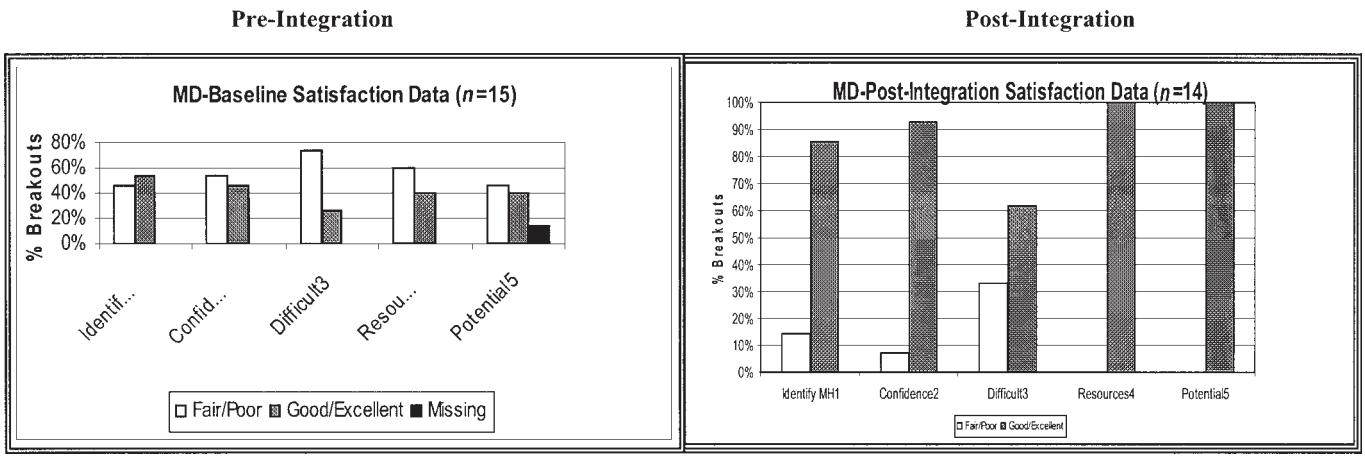

Fig 2. Staff satisfaction at Bryner Clinic

Areas of satisfaction:

- **Ability to identify mental health needs of your patients and their families.**
- **Confidence in working with patients and their families who have mental health needs.**
- **Ability to work with "difficult to treat" patients and their families.**
- **The resources and support from Intermountain Health Care (IHC) to help you meet/deal with the mental health needs of your patients.**
- **The potential to integrate collaborative primary mental health teams in your setting.**

A "cohort analysis" and "cost-trend analysis" were conducted to study the MHI impact on healthcare claims costs. A cohort analysis shows the evolution of a system over time and, hence, the impact of an intervention on that system. It allows separation of random variations (noise) from intervention variations and is therefore the analytical method of choice from a quality improvement point of view. However, cohort analysis describes a relatively small subset of a health plan's patient population and, therefore, is of limited inferential value. Cost-trend analysis, on the other hand, carries more validity from a health plan's perspective. Cost-trend analysis studies the whole patient population. Initial results of both types of cost analyses showed significant increases in depression detection rates,

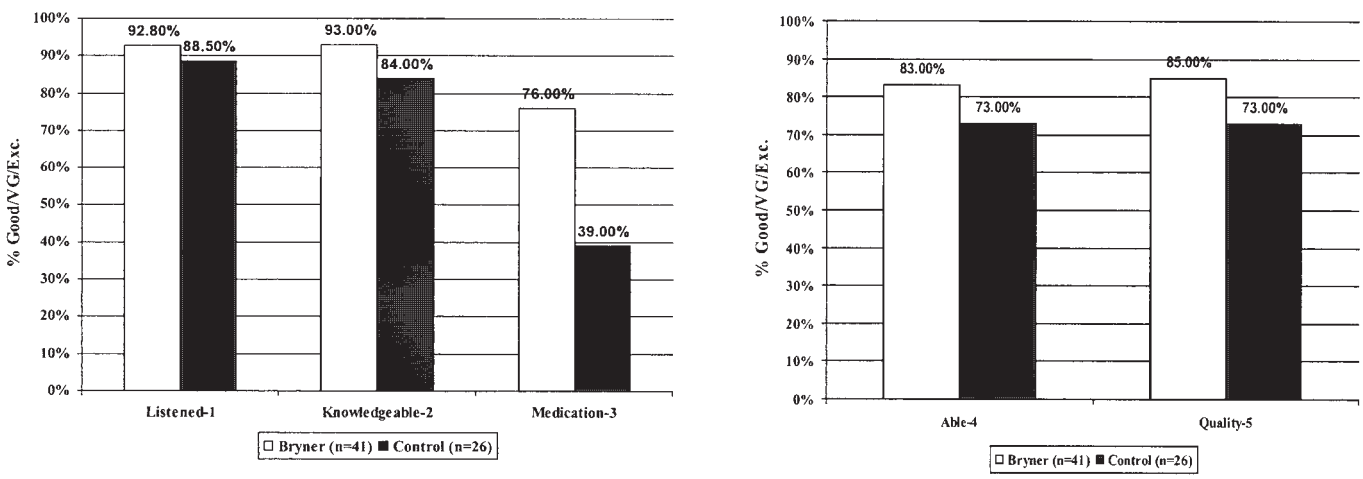

Fig 3. Satisfaction among patients who discussed a mental or emotional concern with their PCP within 6 months of PCP visit

without corresponding increases in healthcare claims costs. These results will be described in greater detail in a future publication.

These initial analyses, which show that mental health integration increased depression detection rates for adults and improved satisfaction, while not increasing healthcare claims costs, are an encouraging start. However, IHC is planning a more comprehensive evaluation of all the operational costs and clinical outcomes for the process to assure that quantitative processes are in place to account for all costs and outcomes.

DISCUSSION

Mental health integration (MHI) is only one of many examples of a quality driven integrated systems success in strategically using clinical quality and family centered care as drivers of sound economics. Intermountain Health Care (IHC) leadership considers MHI a success not only because it has not increased cost to Health Plans, but also because it has reduced the burden of PCPs in managing mental health by the use of MHI tools and teams. Mental health integration (MHI) has significantly contributed to primary care clinic operations by: mobilizing community resources; developing online diagnostic tools and patient and family education materials; providing onsite consultation that do not impact the clinic bottom line; and developing a data registry by which the clinic can measure its process and compare to overall regional benchmarks.

Despite this preliminary success at IHC, there remain barriers to sustaining a quality improvement such as MHI in the current healthcare market.

First, the lack of a well-coordinated national effort to improve the quality of mental health and substance abuse services in primary health care, or to improve the quality of primary healthcare services available in specialty mental healthcare services has emerged as a significant barrier to solo pilot integration efforts such as IHC. Lack of oversight and national leadership prevent the implementation of available research and practice findings into real world health delivery systems by enabling stigma, perverse economics and technological barriers to ensue.

Although stigma continues to be a leading barrier to mental health care, economic disincentives in our healthcare market have reinforced the low relative value of ''quality of life'' outcomes. Reimbursement for mental health care is impeded by the historical and prevailing disconnect between primary medical care and behavioral health. Mental health benefits continue to be subject to monetary restrictions, which are not imposed for other medical conditions. Many of the key elements of the proven collaborative care models such as MHI are not currently reimbursable through public and private insurers. Quality care provision without accompanying reimbursement for care managers for example, is impractical, detrimental to patient's health, and promotes adverse economic waste.

Shared communication between primary care and mental health in an integrated system is key to providing safe, person centered, efficient, effective, timely and equitable health care. Current technology language and interface barriers limit smooth information transfer and present ongoing challenges in confidentially and privacy interpretation of the regulations pertaining to the Health Insurance Portability and Accountability Act (HIPAA).

SUMMARY

The implementation of the MHI model has identified critical components of quality improvement that may be applied to other settings considering similar redesign.

The delivery of sustainable healthcare quality requires the identification of effective leadership. Establishing leaders to champion the MHI efforts at both the clinic and system level are critical in promoting the value of accountability.

Establishing community coalitions of consumers, providers, and payers is needed to negotiate disparate and competing interests. Intermountain Health Care (IHC)'s decision to treat all patient and families at each PCP clinic ''the same'' regardless of payor mix has developed sustainable community partnerships in implementing the MHI model beyond IHC.

Quality redesign includes providing consumers access to health information. To establish value for health partnerships consumers will need to have access to reporting information on service quality and community outcomes. This would then promote consumer demand and consumer choice, which should be supported by equitable healthcare policy mandating mental health parity with general medical benefits.[28] This would be a step forward in actualizing ''personalized'' consumer centered medicine. Consumers and families who have an active role in choosing their care and designing their treatment goals are more likely to engage in and achieve optimal health outcomes that match their cultural preference. Mental health integration (MHI) has a strong consumer and family health focus. Through IHC's partnership with NAMI, consumers have been engaged in evaluating the MHI process and online MHI tools and have endorsed a leadership role in designing primary care community resources.

Intermountain Health Care (IHC) has also learned that a vigorous but flexible clinical information system is needed to provide care coordination, generate proactive care reminders, maintain clinical registries, and create transparent communication between the consumer and their family, their prima-

ry care providers, and mental health resources. Technologically supported decision support at the point of care will increase provider's use of clinical practice guidelines as a baseline in their treatment decisions and hence improve mental health outcomes.[15,29,30] Intermountain Health Care (IHC) is planning partnerships to share its MHI model for sorting patients according to risk level and appropriate ''cascade treatment'' and tracking clinical and economic outcomes. Once effective information systems are in place, communities can share their methodologies and report their quality outcomes and compare these with other communities throughout the nation. To ensure and improve the quality of care delivered will require continual monitoring and sound measurement. National organizations, such as NCQA, that develop standard quality guidelines need to balance scientific inquiry with cost and practicality of administering them in real world health systems. Reimbursement can then be determined by achievement of selected process and outcome measures, rather than solely on consumption of healthcare resources.[31]

In summary, the most effective and sustainable healthcare delivery systems will be able to match healthcare resources to level of disease severity, thereby providing the communities they serve with the means to plan and allocate resources in a rational way. Measuring and reporting satisfaction, clinical, and cost outcomes that are meaningful to all stakeholders will build consensus and foster continued support of mental health integration.

Some might say that health care in the American free marketplace is all about the profit margin, no matter how altruistic a mission statement may sound. The quality reform leaders of IHC would say that health care in our community is all about using resources responsibly and building and maintaining quality relationships with all our stakeholders.

ACKNOWLEDGMENTS

The MHI efforts at IHC have been enhanced by the development of a strategic partnership between IHC and the Robert Wood Johnson Foundation's (RWJF) ''Depression in Primary Care'' program. This partnership has provided an opportunity to assess and alter economic barriers to sustaining the MHI program within the IHC community. An important component of this strategic process was to build consensus on the data required by organizational leaders and key stakeholders when faced with the decision to support the integrated mental health/depression program.

REFERENCES

1. World Health Organization. *The World Health Report 2001-Mental Health: New Understanding, New Hope*. Geneva: World Health Organization; 2002.
2. US Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, Md: US Department of Health and Human Services; 1999.
3. Kessler R, Demler O, et al. Prevalence and treatment of mental disorders, 1990 to 2003. *N Engl J Med*. 2005;352(24):2515–2523.
4. Reiger D, Narrow W, Rae D, et al. The de facto mental health and addictive disorders service system: epidemiological catchment area prospective 1-year prevalence rates of disorders and services. *Arch Gen Psychiatry*. 1993;50: 85–94.
5. Murray C, Lopez A. *The Global Burden of Disease. A Comprehensive Assessment of Mortality and Disability for Diseases, Injuries and Risk Factors in 1990 and Projected to 2020*. Cambridge, Mass: Harvard School of Public Health; 1996.
6. Hirschfeld RM, Keller MB, et al. The National Depressive and Manic-Depressive Association consensus statement on the undertreatment of depression. *JAMA*. 1997;277(4): 333–340.
7. Young AS, Klap R, et al. The quality of care for depressive and anxiety disorders in the United States. *Arch Gen Psychiatry*. 2001;58: 55–61.
8. Wang PS, Demler O, Kessler RC. Adequacy of treatment for serious mental illness in the United States. *Am J Public Health*. 2002;92:92–98.
9. Eisenberg L. Treating depression and anxiety in primary care. *N Engl J Med*. 1992;326: 1080–1084.
10. Whooley M, Simon G. Managing depression in medical outpatients. *N Engl J Med*. 2000;343(26):1942–1950.
11. Melfi CA, Croghan TW, et al. Racial variation in antidepressant treatment in a Medicaid population. *J Clin Psychiatry*. 2000;61:16–21.
12. Miranda J. Disparities in care for depression among primary care patients. *J Gen Intern Med*. 2004;19(2):120–126.
13. Quality of Health Care Committee, eds. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: Institute of Medicine; 2001.
14. Katon W, Von Korff M, et al. Collaborative care models for the treatment of depression. *Am J Manage Care*. 1999;5:794–800.
15. Simon G, VonKorff M, et al. Randomized trial of monitoring, feedback and management of care by telephone to improve treatment of depression in primary care. *BMJ*. 2000; 320(7234):550–554.
16. Wagner E, Austin B, VonKorff M. Organizing care for patients with chronic illness. *Millbank Q*. 1996;74:511–544.
17. VonKorff M, Gruman J, Schaefer J, et al. Collaborative management of chronic disease. *Ann Intern Med*. 1997;127:1097–1102.
18. Rost K, Nutting P, et al. Designing and implementing a primary care intervention trial to improve the quality and outcome of care for major depression. *Gen Hosp Psychiatry*. 2000;22:66–77.
19. Kroenke K, Mangeldorff A. Common symptoms in ambulatory care: incidence evaluation, therapy and outcomes. *Am J Med*. 1989; 86:262–265.
20. Bodenheimer T, Lorig K, et al. Patient self-management of chronic disease in primary care. *JAMA*. 2002;288(19):2469–2475.
21. Reiss-Brennan B, et al. Rebuilding family relationship competencies as a primary health intervention. *Prim Care Companion J Clin Psychiatry*. 2002;4(2):41–51.
22. Ciechanowski P, Katon W, et al. The patient provider relationship: attachment theory and adherence to treatment in diabetes. *Am J Psychiatry*. 2001;158(1):29–35.
23. Ciechanowski P, Hirsch I, Katon W. Interpersonal predictors of HbA1C in patients with type 1 diabetes. *Diabetes Care*. 2002; 25(4):731–736.
24. Roter D, Hall J. *Doctors Talking with Patients/ Patients Talking with Doctors: Improving Communication in Medical Visits*. Westport, Conn: Auburn House; 1992;203.
25. Kaplan S, Greenfield S, Ware J. Assessing the effects of physician-oriented interactions on outcomes of chronic disease. *Med Care*. 1989;27:679.
26. Sherborune C, Hays R, et al. Antecedents of adherence to medical recommendations: results from the Medical Outcomes Study. *J Behav Med*. 1992;15:447–468.
27. Quality of Health Care Communities, eds. *Report of the First Annual Crossing the Quality Chasm Summit: A Focus on Communities*. Washington, DC: Institute of Medicine, 2004;27–36.

28. Goldman HH. Perspectives: parity-prelude to a fifth cycle of reform. *J Ment Health Policy Econ*. 2002;5(3):109–113.
29. Wells K, Sherbourne C, Schoenbaum M, et al. Impact of disseminating quality improvement programs for depression in managed primary care: a randomized control trial. *JAMA*. 2000;283(24):212–220.
30. Hunkler E, Meresman J, et al. Effectiveness of nurse telehealth and peer support in augmenting SSRI treatment of depression in primary care. *Arch Fam Med*. 2000;9:100–105.
31. Leatherman S, Berwick D, et al. The business case for quality: case studies and an analysis. *Health Aff*. 2003;22(2):17–30.