

## NEW PERSPECTIVES

**Behavioral Health in Primary Care: From Solo to Collaborative Care**

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**A** 70-year-old man presents with new onset depression to an academic medical center primary care clinic. He is not suicidal. He has Medicare and a limited fixed income from Social Security. He is not disabled or on Medicaid. The academic psychiatry consultation clinic offers one-time consultation visits. The local community psychiatrists often do not accept new Medicare patients, and he does not think he can afford a private practice psychologist for therapy. What are his options?

Behavioral health problems are routinely treated by primary care providers. Many providers would treat this patient with an antidepressant medication and arrange short-term follow-up for medication adherence, clinical reassessment, and dose titration. Clinicians who have received additional training may provide short-term counseling using techniques such as cognitive behavioral therapy (CBT). In the teaching clinic, we may discuss with residents the pharmacology and practical aspects of using medications such as selective serotonin reuptake inhibitors (SSRIs) in primary care.

**Scenario 1:**

*The patient is seen by a resident and an attending physician and started on fluoxetine. He is seen in close follow-up, and his dose is uptitrated. He wishes he could engage in other treatments in addition to pharmacotherapy. He is given a list of community psychologists and therapists but does not establish with any, citing geography and lack of coverage. Nevertheless, his depression improves slowly over the next six months.*

In our academic internal medicine primary care clinic, the above scenario has been commonplace. The patient gets better, and the treatment—entirely encompassed within physician-patient encounters—is considered a success. Our trainees often find their practice most gratifying when they can address the clinical problem “on their own” without referral to a specialist.

But what does the evidence show regarding optimal outcomes for patients with common mental health disorders in primary care? Multiple studies have shown both short- and long-term benefit to a collaborative care model within primary care.<sup>1</sup> Care models include a team comprising a primary care provider, case manager, and mental health specialist and have been shown to be effective at modest cost among older adults in primary care settings.<sup>2,3</sup>

Would referral of patients with mental health disorders to a separate specialty clinic be as effective? Possibly. At least one study has shown that enhanced referral was comparable to integrated care for six-month outcomes in depressed patients. However, most practices do not have enhanced referral services, which would include facilitation of the referral and availability of mental health providers. Additionally, Medicare participants have traditionally paid higher out-of-pocket outpatient costs for mental health care. While Medicare reforms are reducing these costs from approximately 50% to 20% to match other Medicare part B services, access to psychiatrists may be limited because providers often do not accept new Medicare patients.<sup>4</sup>

**Scenario 2:**

*The patient is referred to the Behavioral Health Integration Program and meets with a care coordinator located in the primary care clinic. He participates in therapy sessions, and his case is reviewed by a psychiatrist within the primary care clinic. The psychiatrist and primary care provider coordinate care, with the primary care provider adjusting medication therapy and tracking his PHQ-9 scores. The patient improves and is grateful for not having to go somewhere else for his care. He feels that he has developed long-term skills for managing his depression.*

Because of the efforts of our psychiatry department, our clinic has been fortunate to have moved from the first scenario to the second in the past year. What has been our experience?

1. *Most patients prefer coming to the same clinic for their care, especially patients who already suffer from multiple chronic medical conditions. Finding a mental health provider without a referral and encumbered by insurance restrictions is prohibitively difficult. For some patients, there is less stigma associated with making a dedicated trip to see a mental health provider in a familiar setting.*
2. *Coordination with the behavioral health team is seamless compared to working with external providers. When patients are seen by an external psychologist or other mental*

continued on page 2

## NEW PERSPECTIVES

continued from page 1

health provider, documentation may not be transmitted to primary care. The electronic medical record, coupled with standardized assessment/recommendation templates and tracking with the PHQ-9 and GAD-7, facilitates coordination.

3. *Patient selection remains important.* Resources remain limited, and over time, we realized that the elderly patient who is accustomed to coming to the primary care clinic but who would have difficulty finding and paying for external mental health care is the ideal candidate for our services. For other patients, the behavioral health team can still assist with coordination with other resources such as facilitating progression to long-term psychiatric care and accessing the community mental health system when appropriate.
4. *Personal knowledge is very effective in starting the treatment program.* When we refer patients, we can state with confidence, "I am referring you to \_\_\_ and Dr. \_\_\_ in our Behavioral Health Program. I

know them both, and we've been working together for over a year now with great results for most of my patients." In the era of ever-increasing size of health care organizations, patients may value this personal knowledge.

5. *There is a positive spillover effect.* There was use of instruments such as the PHQ-9 and GAD-7 questionnaires prior to the program, but their use has now become more routine. Many of us have become more adept at screening for bipolar disorder and choosing different medications through consultation with the psychiatrist on the team.

These positive impressions do not mean that the program has worked for every patient. However, it does serve as an anchor for both patient and provider in the unsteady waters of our current mental health system by using a chronic disease management model housed within primary care. As the country moves toward Accountable Care Organizations and as more primary care clinics transform to the patient-centered medical home, attention

to behavioral health will be essential to maintaining the good health of our patient populations. Funding for integrated, coordinated behavioral health will continue to be a challenge in many locations, as will finding appropriate mental health providers, especially in underserved locations.

### References

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