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

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

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