Collaborative Medicine Case Studies

Evidence in Practice
Collaborative Medicine
Case Studies

Evidence in Practice
To my father for influencing me in ways that I understand and don’t understand.
To my family for their influences.
To Danit, Essie, Amber, Soldie, Kadie and Solomon, you are, have been and always will be that which is cherished in my life.

Rodger Kessler

To my parents, for giving me their unconditional love and providing for my education.
To my wife, Mary Fran, for her love and support in all things.

Dale Stafford
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Part I
Background
Chapter 1
Introduction

Rodger Kessler and Dale Stafford

This book is intended to foster thinking and dialogue about behavioral health clinicians providing psychological treatments as part of medical practice. Since medical sites evaluate and treat more mental health and substance abuse problems than the specialty behavioral health system and because many acute and chronic medical presentations have significant psychological components, on-site collaboration between medicine and behavioral health is a logical, feasible, and important evolution of medical care. The majority of this book is the presentation of medical cases in which psychological dimensions are important components of the problem, or cases that are primarily mental health diagnoses that were treated in primary care or specialty medical settings. The feature common to each of the cases is that they represent some form of collaborative treatment between medicine and behavioral health.

Conversations about the issues raised in this volume will hopefully be held by those who participate in providing health care, who do not often think and talk about these issues together. The intended audience is physicians, psychologists, behavioral health providers, health care administrators, health care financers, and health care policy makers. Each has both a role and an impact on patient care and patient outcomes although each has a different perspective on achieving the goal. Because of new clinical advancements and administrative and cost pressures, the goals of medicine have shifted to achieving the right care for patients.

Right care has been defined as the set of clinical actions that have evidence-based probability of being effective in treating the medical and clinical problem with which a patient presents, that generates specified levels of outcome in specific dimensions of patient functioning. Such treatments would use the optimal clinical resources delivered in the fewest number of settings, in coordinated appropriate frequency, in a cost-effective fashion.1

We think that collaboration between medicine and behavioral health is an important dimension of right care. Currently we can comment on some aspects of right care as it relates to the need for collaborative medical-psychological approaches to the treatment of certain medical problems. Cowley et al.2 have noted that somatic complaints are the predominant reason for seeking general medical care. In their review of records of all patient visits in four 1-month intervals, 48% of all symptoms were evaluated to be psychiatric or idiopathic.2 In a 1-month chart review of patients...
attending a primary care clinic, Cowley et al.\textsuperscript{2} found that nearly half of presentations of physical problems were found to be idiopathic or psychiatric problems. Twenty-six percent of patients reported no improvement at follow-up.\textsuperscript{2} The most frequent presentations included back pain, limb pain, headache, dyspnea, cough, upper respiratory infection, abdominal problems, chest pain, swelling, dermatologic complaints, dizziness, sleep complaints, and fatigue.\textsuperscript{2}

Kroenke and Mangelsdorff\textsuperscript{3} suggested that of the most frequently presented medical problems, the majority often have significant psychological components. Treatments of these psychological issues are necessary to assist the achievement of successful medical outcomes. Abdominal and chest pain have been identified as two of the most frequent chief complaints of patients in primary care. It is significant, then, that in up to 60\% of those presenting with abdominal pain, and in approximately 80\% of those with chest pain, a nonorganic diagnosis is made.\textsuperscript{4} In England, it has been reported that 27\% of primary care patients have reported problems with widespread pain, orofacial pain, irritable bowel syndrome, or chronic fatigue. Each of these is a problem with high reported rates of medical-psychological comorbidities.\textsuperscript{5}

This book is important because it illustrates a response to these key issues in health care. Untreated, undertreated, or ineffective behavioral health treatment is a key driver of health care utilization and medical care costs. Collaborative care models are consistent with the contemporary focus on evidence-based practice and have a robust research literature to support their effectiveness. Integrating behavioral health services as part of medical care is consistent with contemporary ideas for the future of medical practice. This new model of primary care is endorsed by the American Academy of Family Medicine’s Future of Family Medicine initiative and is seen in recommendations from the US Preventative Services Task Force. There is demonstrated clinical, economic, and administrative viability of collaborative care models. Such efforts parallel the process-reengineering efforts inherent in contemporary chronic medical disease management. These findings will be elaborated upon in the next chapter.

The salient point is that it is now clear that a certain amount of specific psychological intervention is often necessary in any effort to generate effective and high-quality medical treatments. The premise of each of the chapters in this book is that collaborative care generates more effective, efficient, patient-involved, and cost-sensitive health care, as a result of behavioral health practice being part of medical treatment.

This is not a book that will make the argument about the need for medical-behavioral health collaboration. This has been done well by others over the course of the last 20 years. Many of those authors are contributors to this volume. Blount, Cummings and O’Donohue, McDaniel and Doherty, Peek, Patterson, Stroshahl and Robinson, James, and Gunn have all provided the conceptual and practical bases for the work described in this volume. Their books are compelling companions to this volume. As Katon and Unutzer\textsuperscript{6} have suggested, it is time to move from the time of more research to the time of implementation of what is known. Each case study is an example of the authors’ efforts to take the evidence generated from research and put it into practice.

This book is also not necessarily about what we traditionally think of patients with mental health or substance abuse diagnoses who need treatment for those disorders.
As Blount et al. have suggested, collaboration is about responding to behavioral health need, but frequently not about behavioral health diagnosis. This book is a series of chapters focused on aspects of life in primary care. Each chapter includes presentation of cases in which collaborative care was used to effect changes in functioning of patients who presented themselves for medical treatment and whose physicians identified the need for collaborative care with behavioral health to best respond to patient need. As a body of work, the chapters represent a shift from what John Reeves has identified as a culture of referral to the culture of collaboration (see Chap. 19 by Reeves and Merrill). Traditionally a physician who perceives the need for behavioral intervention either suggests that the patient seek such assistance or presents the patient with a series of names and, perhaps, phone numbers, with a suggestion that the patient choose someone to call. Occasionally, if the physician has had good reports from patients about a particular provider, the physician might suggest a particular clinician. Such is the “culture of referral.”

In the cases in this volume there exists the assumption between physician and behavioral health clinician that there is a mutual relationship in the treatment of their patient. It is understood that there will be communication and coordination of care, often provided within the same physical site. There is not so much a referral for services as a request for participation in the mutual care of the patient. This is the “culture of collaboration.”

Peek observed that models of physicians and behavioral health clinicians working together take a number of forms (Table 1.1). He proposes a continuum of collaboration, beginning with minimal collaboration on different sites, up to completely integrated systems. Doherty et al. have observed that where on this continuum a particular practice or set of collaborators fall depends on the complexity of the clinical presentation and the desired outcomes to be achieved. The greater the complexity of the case, the greater is the need for increased collaboration.

The relationship between the complexity of a patient problem and the levels of collaboration is present whether the presentations are primarily behavioral health or primarily medical. Stroshahl and Robinson observe in Chap. 8 that there are three types of patient presentation likely to be served in a collaborative model—primarily behavioral health, acute medical and/or psychological, and chronic medical issues. The cases in this volume present examples of a variety of models of collaboration in response all three clinical situations.

This book is certainly timely. It is probably apparent to the readers that what we have now does not work so well. In the larger health care system, the Institute of Medicine has called for a redesign of health care with a focus on six elements: safety; effectiveness; equity; timeliness; patient centeredness; and efficiency. Both the conceptualizations offered for collaborative care and the examples presented in this volume address what has clearly been thus far an unanswered question: Can behavioral health have a role in the new health care system? The new model of family medicine proposes that primary mental health treatment is an element of the core services delivered in family medicine practices.

Peek will propose that if there is to be an effective way for medical patients to receive appropriate services, then the Three Worlds of health care need to be aligned.
so there is clinical, administrative, and financial sense to health care planning, development, financing, and delivery. Mental health services in medicine have long been considered an impenetrable black hole—with no way to understand how to access services, no idea of what the content is, with little or no communication from its providers. The cases presented in this volume attempt to make sense of, and respond to, the varied views in the Three Worlds and display an alternative to the black hole.

When the authors set out to compile this volume, they were confronted with asking friends and colleagues for help. Individuals who were associated with collaboration and integration were contacted and asked to contribute. In some cases, interesting people who had interesting perspectives on collaboration, but no prior relationship with the authors, agreed to prepare chapters. In other cases, clinicians whose writings had been admired were contacted out of the blue with the idea for the volume and a request to contribute. The response was shocking and gratifying. Of those who were asked, almost all agreed and ultimately contributed. We are sure that there are many others who could have contributed, but through the fortunes of life we did not know about. Our sincere thanks go to the contributors for their interest and efforts.

The task that was outlined was formidable. We asked people to write about their work, selecting a case and writing about its various aspects. In addition, where possible, we encouraged teams of psychologists, physicians, behavioral health providers, and other providers to not only collaboratively practice but also to collaboratively write and provide both medical and psychological perspectives. In addition, one of R.K.’s colleagues, Alexander Blount, proposed that the cases be written through the lens of the Three World view proposed by Peek. Peek suggests that all health care and certainly behavioral health care has a clinical, administrative, and financial view that all clinical activity is viewed through. Aligning the different views is seen as an important component of health care practice and health care decision making. He elaborates those ideas in Chap. 3 of this volume. We asked case study authors to discuss Three Worlds elements of their cases when possible. A note about cases—all authors eliminated any information in the case that would easily identify individual patients. In addition, patient characteristics were altered to further blind the cases.

This volume begins with a chapter reviewing the data that provide the foundation for collaborative care. There is then a section of cases illustrating the organizational challenges of collaboration. The first case in that section is the chapter by Peek focusing on the Three Worlds of health care. The next section is a series of cases that illustrate issues that arise in the day-to-day life of primary care. This is followed by a section on women’s health and then a section on specialty medical care delivered to primary care patients. There is then a series of cases focused on chronic medical illness, psychiatric disorders in primary care and a last series of papers on pain.

The summary chapter by the editors outlines key ideas gleaned from the volume and summarizes observations about moving things forward. We hope that the efforts of the editors and all the contributing writers are helpful in assisting the movement of health care into a future characterized by collaborative, patient-centered care.
## Table 1.1: Peak stages of collaboration

<table>
<thead>
<tr>
<th>Model</th>
<th>Minimal collaboration</th>
<th>Basic collaboration</th>
<th>Basic collaboration</th>
<th>Close collaboration in a partly integrated system</th>
<th>Close collaboration in a fully integrated system</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>from a distance</td>
<td>on-site</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>● Separate systems</td>
<td>● Separate systems</td>
<td>● Separate systems</td>
<td>● Some shared systems</td>
<td>● Shared systems &amp; facilities in seamless biopsychosocial web</td>
</tr>
<tr>
<td></td>
<td>● Separate facilities</td>
<td>● Same facilities</td>
<td>● Regular communication mostly</td>
<td>● Same facilities</td>
<td>● PLs &amp; providers have same expectation of a team</td>
</tr>
<tr>
<td>Doherty, McDaniel, &amp; Baird (1995)</td>
<td>● Periodic focused communication mostly by letter, occ phone.</td>
<td>● Some appreciation of each other’s roles and general sense of larger picture, but not in depth</td>
<td>● Basic appreciation of each other’s role &amp; culture. Share biopsychosocial model.</td>
<td>● Everyone committed to biopsychosocial; in-depth appreciation of roles &amp; culture</td>
<td>● Collaborative routines are regular and smooth</td>
</tr>
<tr>
<td></td>
<td>● Little appreciation of each other’s culture; little influence sharing</td>
<td>● View each other as outside resources</td>
<td>● Medical side usually has more influence</td>
<td>● Collab, routines difficult—time &amp; operations barriers</td>
<td>● Conscious influence sharing based on situation &amp; expertise</td>
</tr>
<tr>
<td></td>
<td>● Little understanding of each other culture or sharing of influence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Handles adequately</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Routine, w little biopsychosocial interplay &amp; mgmt challenges</td>
<td>Moderate biopsychosocial interplay, e.g., diabetes &amp; depression with mgmt of each going reasonably well</td>
<td>Moderate biopsychosocial interplay requiring some face-to-face interaction &amp; coordination of tx. plans</td>
<td>Cases with significant biopsychosocial interplay &amp; mgmt complications</td>
<td>Most difficult and complex biopsychosocial cases with challenging mgmt problems</td>
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<td>Handles inadequately</td>
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<td>Cases refractory to tx or w significant biopsychosocial interplay</td>
<td>Significant biopsychosocial interplay, esp when mgmt is not satisfactory to either MH or medical providers</td>
<td>Signif. biopsychosocial interplay, esp those with ongoing &amp; challenging mgmt problems</td>
<td>Complex w multiple providers &amp; systems; esp with tension, competing agendas or triangulation</td>
<td>Team resources insufficient or breakdowns occur in the collaboration with larger service systems.</td>
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<td>Strosahl, Peek &amp; Heinrich, others</td>
<td>Informal consultation: MH professional helps physician deal with a clinical problem, but usually no contact with the patient</td>
<td>Formal consultation: MH professional has direct contact with pt. in typical relationship as a consulting specialist</td>
<td>Co-provision of care: Patient care is shared and the professionals may see the patient or family together</td>
<td>Collaborative networking: Provider team is extended to include family and other medical specialists, educators, community resources</td>
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<td>Traditional referral-between-specialities models</td>
<td>Co-location models</td>
<td>Organization integration or “primary care mental health” models</td>
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<td>Org. literature</td>
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References

Chapter 2
Primary Care Is the De Facto Mental Health System

Rodger Kessler and Dale Stafford

This chapter is a review of the research literature that suggests that primary care is the de facto behavioral health services and care system. It will summarize and reiterate the following points that have been made in the research literature for many years:

- Most patients with psychological problems are seen in nonpsychiatric medical settings.
- Many medical presentations contain significant psychological comorbidity. Strosahl and Robinson point out in Chap. 8 that presentations that are for specific psychological or substance abuse issues are infrequent. More often, psychological issues are found to be part of acute medical issues, such as sleeping problems, headache or gastrointestinal problems, as well as complex chronic medical conditions such as diabetes, cardiac conditions or pain.
- The costs of untreated or inadequately treated behavioral problems include lack of medical improvement, decreased compliance with medical treatment and overserved and underserved patients.¹
- There are multiple clinical, administrative and financial barriers to effective psychological care in medicine and medical settings.
- The most effective response to these issues is developing medical-psychological collaborative care models in primary care practices. There is ample reason to think that this will produce the holy grail of medicine—better care and higher levels of patient-centered involvement, resulting in better health status and reduced need and demand for medical resources.²

Patients with Behavioral Health Problems are Primarily Seen in Primary and Specialty Medical Care

For over 25 years there has been a robust literature suggesting that when patients have psychological or behavioral problems they will turn almost exclusively to the primary care medical office, not to traditional mental health and substance abuse services for care;³ hence the conclusion that primary care is the de facto mental health system.
Patients with psychological problems are most likely to receive medical services related to such problems solely in primary care medical settings.\(^4\)-\(^5\) It has been demonstrated that 43 to 60% of patients with psychological problems are solely treated in primary medicine, while 17 to 20% of patients with psychological problems are treated in the specialty mental health system.\(^6\)-\(^7\)

At any given time in primary care, there is a prevalence of psychiatric disorders of 21 to 26%.\(^8\)-\(^9\) For patients with chronic medical disorders the rates for hospitalized medical inpatients are triple the community rates of comorbidity.\(^8\)

Depression, anxiety, panic, somatization and substance abuse are the most frequently encountered diagnostic presentations.\(^10\)-\(^11\) Eighty percent of people who come to primary care because of psychological and social distress present with physical symptoms.\(^3\), \(^12\) Most often there is no identifiable organic cause for the somatic complaints that are presented and half of patients presenting to a primary care office will be found to have no medical illness, while almost a third will present with multiple unexplainable symptoms.\(^13\)-\(^15\)

In these settings psychological and behavioral problems are often undetected,\(^11\), \(^16\)-\(^17\) resulting in infrequent use of evidence-based treatments and suboptimal management.\(^16\), \(^18\) Treatment rates for the psychological diagnostic categories most frequently seen in primary care are generally poor.\(^19\) Among medical inpatients, formal diagnosis is made in only 11% of cases, depression was accurately diagnosed in 14 to 50% of cases and alcohol-related disorders were accurately diagnosed only in 5 to 50% of cases.\(^20\)

Pharmacology is the most common treatment intervention for psychological disorders. When pharmacologic treatment of behavioral disorders is initiated, less than half of all patients remain on the medication for a therapeutically indicated period of time.\(^21\)-\(^22\) Coyne et al.\(^23\) note that with focused efforts to detect comorbidities, a quarter to a third of primary care patients will screen positive and 18 to 30% of those positively screened will meet the criteria for diagnosis. For those patients diagnosed with psychological or behavioral comorbidity, treatment initiation is very low.\(^23\)-\(^24\)

Many Medical Presentations Have Psychological Dimensions

Psychological factors influence physiological functioning and in some situations appear to determine the course and utilization of medical care. Twenty percent to 50% of patients are not adherent to medical treatment recommendations.\(^25\) Patients who are treated for mental health related problems use significantly more medical services than patients who are not so treated\(^26\) and untreated psychological comorbidity is a predictor of decreased medication compliance.\(^27\)

The problem is particularly severe for patients with chronic medical disorders. Over 20 years ago, the Medical Outcome Study noted medical-behavioral comorbidity in any chronic medical condition of 65%. In 2002, United Health Care, as part of the Goal Focused Treatment and Outcome Study, observed that 40% of the
1,859 patients treated for depression also displayed at least one chronic medical condition. Recently, findings from the Star*D (sequenced treatment of alternatives to relieve depression) suggest that in both cohorts of over 4,000 patients, total depressive comorbidity with medical illness was about 50%.

Psychological distress increases with the number of medical comorbidities that are present. When there is a psychological comorbidity along with a chronic medical condition, significantly more impaired functioning and worse health status are reported. Heart disease, chronic lung disease, diabetes, cancer, chronic pain, sleep disorders, stroke and arthritis are the most frequently cited disorders associated with psychological comorbidity. The World Health Organization’s World Health Survey was recently completed by over 245,000 patients. The results suggested that depression causes the greatest decrement in health when compared with angina, arthritis, asthma or diabetes, and that the comorbid state of depression with any of the chronic diseases alone worsens health more than depression alone, or with any combination of the chronic diseases.

Major depression is a risk factor for the development of cardiac disease in healthy patients and for adverse cardiac outcomes in patients with heart disease. Depression is present in 20% of outpatients with cardiac disease and a third of patients with congestive heart failure. In patients with congestive heart failure, for example, there have been reports of comorbid depression rates from 11 to 25% in outpatients and from 35 to 70% in inpatients. Depressed patients who have a myocardial infarction or a stroke have higher mortality rates. Recently an analysis of 17 studies of cardiac disease depressive comorbidity found that depression after a cardiac event was associated with a threefold increase in cardiac mortality. The risks for depressive cardiac comorbidity are twice as high for women under 60 years of age as they are for women older than 60. In addition, there has been a recent finding that use of antidepressant medication in patients with heart failure was associated with increased likelihood of death or cardiovascular hospitalization, limiting pharmacologic treatment for depression as an option. So for such patients, nonpharmacologic psychological treatments are that much more important.

Patients with chronic obstructive pulmonary disease (COPD) have a comorbidity with depression that is almost 45% and is associated with longer hospital stays, increased symptoms and poorer functioning. There is a high prevalence of adults with arthritis and depression. When there is such a comorbidity, treatment compliance is worse, and there is poorer general health, greater disability and increased pain reports. There have also been reports suggesting that the presence of depression comorbid with sleep-related breathing disorders.

Considerable attention has been paid to psychological comorbidity with diabetes. Depression rates for patients with diabetes are twice as high as those for other primary care patients, with rates of 15 to 30% reported. Because depression is associated with hyperlipidemia and heart failure, there is increased risk of cardiac events among patients with diabetes. When there is behavioral comorbidity, there is a poorer illness course, particularly if there are multiple diabetic complications. The greater the level of measured depression, the worse the adherence to medical treatments. Panic is frequently comorbid with diabetes, and when panic
disorder is present, there is also a high frequency of comorbidity with depression. \[^{54}\]
Older adults with history of depressive symptoms were more likely to develop diabetes, and the association is not fully explained by risk factors for diabetes. \[^{55}\]
Depressive comorbidity is associated with higher A\(1c\) levels, \[^{56}\]\ and higher mortality. \[^{51},^{57}\]\ In addition, it appears that when women are diagnosed with type 2 diabetes, there is both a higher risk of their children developing diabetes \[^{58}\]\ and a higher incidence of depression in their offspring. \[^{59}\]\

**There Are Costs of Untreated or Inadequately Treated Psychological Problems**

It has long been established that patients with psychological comorbidities have more costly health care. This is only partially explained by their medical conditions. \[^{60}-^{61}\]\ The majority of these costs were for general medical services and medications, not behavioral health services. \[^{62}\]\ There is a large amount of research that suggests patients with behavioral and medical comorbidties have 30 to 100% higher non-mental-health utilization of health care resources. \[^{61},^{63}\]\

For example, in one investigation Simon et al. \[^{61}\]\ found that the annual health costs of depressed patients are $4,246 compared with $2,371 for nondepressed patients. Controlling for morbidity, depressed patients utilize three times the amount of health care services, incur twice the medical costs, and make seven times the number of visits to the emergency room. \[^{61}\]\ Depression associated with diabetes produces 50 to 75% increases in health care costs. \[^{64}\]\ Untreated psychological conditions result in poorer physical health, less effective medical treatment and higher mortality rates. This is in addition to the increased utilization of services and increased costs of medical services already discussed. \[^{65}-^{66}\]\ In some samples, almost 20% of primary care patients have been assessed with an anxiety disorder. \[^{61}\]\ When anxiety disorders are comorbid with asthma, there is triple the hospitalization rate. \[^{67}\]\ Such findings suggest a patient population that is overserviced and underserved. \[^{1}\]\

High utilizers of medical services have high frequencies of psychological distress. \[^{67}\]\ Conversely, patients with a chronic medical illness who are high utilizers of medical services have a high prevalence of comorbid psychological disorders. Affective, somatization and anxiety disorders are the most frequent comorbid conditions. \[^{68}\]\

The prevalence of psychiatric disorders amongst high utilizers of medical services reveals rates of somatization disorder and anxiety disorders over 20% and panic disorder over 10%. \[^{68}\]\ The top 10% of medical services utilizers account for 25% of all primary care visits, 52% of specialty visits, 40% of hospital days and 26% of all prescriptions written. \[^{67}\]\ High utilizers of health care had 3 times as many office visits, diagnoses and medications; and had 8 times as many hospital admissions. \[^{69}\]\ Katon et al. \[^{67}\]\ have further observed that the top 10% of primary care patients use more services than the lowest 50%.\
We are therefore left with a large patient population whose often unrecognized and untreated psychological comorbidities worsen health status and contribute to significantly greater utilization and cost of medical services.

There Are Multiple Clinical, Administrative and Financial Barriers to Effective Psychological Care in Medical Settings

There are multiple clinical and systems barriers that limit effective psychological and behavioral care for those patients that need it. It is still rare for psychologists and other behavioral health practitioners to practice within medical settings. One barrier is the lack of appropriately trained, on-site behavioral health clinicians. When referrals are made to clinicians outside of the medical office, patients rarely follow through and participate in off-site treatment. Studies show 50 to 90% of referrals made to out-of-the-office mental health practitioners result in no appointment being made.

Historically, it has been referral to specialty care off of the primary care site that has dealt with further evaluation and treatment of complex, chronic medical problems. Such a model has not been effective in dealing with psychological and psychiatric problems. It is also not the usual practice to have “specialty medical services” being provided as part of usual care. This has begun to change a bit. Within the last 15 years, the chronic care model has been the subject of substantial medical attention. Such a model identifies that chronic medical problems require ongoing, often interdisciplinary care. It also suggests that since psychosocial issues often interfere with optimal patient participation and compliance with medical care, there is a need to adopt behavior change as a focus of care. Unfortunately, such efforts have not often included assessing and treating the underlying psychological issues that limit effective adaptation and coping. Without that attention, behavior change has proved elusive. Even more recently, there has been a focus on applying the chronic disease model to depression. Unfortunately, the lack of focus on significant psychological involvement in the model reinforces mental health issues being carved out from other medical issues. This, then, limits the effectiveness of the intervention.

As any primary care physician trying to find psychological assistance for their patients knows too well, most psychological care has been carved out to managed care. Since managed care focuses on cost savings within given patient populations, it has focused on limiting access to and supply of services for short-term cost savings. There is no incentive to use behavioral health to assist in the reduction of the need and demand for medical services, even though untreated comorbidities are the demonstrable cost drivers. Managed care incursion into medicine adds to carve-out costs, so there is no motivation to assist patient behavioral health care in physicians’ practices. Neither is there motivation to develop procedures and funding streams to assist development of medical-behavioral collaboration.

This and other reasons have resulted in increased difficulty for physicians accessing already difficult to access psychological services and a natural reluctance
to take on yet another, time-consuming task. This is part of the reason why behavioral health services have consistently been identified by physicians as being more difficult to access than any other specialty.\(^78\) Mental health referral had the lowest percentage of specialty referral in a survey of family physicians’ referral decisions, with a rate of 4.2% of all referrals made in a sample of 2,534 referrals.\(^80\) Over half of primary care physicians sampled reported problems arranging outpatient behavioral health care.\(^78\)

On the behavioral health side, there has only been limited attention to working within nonpsychiatric medicine. Most psychologists and other providers are not on the staff of community and regional hospitals. They generally do not participate in the settings and tasks in which medical practitioners get to know each other and each other’s practice, or work together planning the delivery of health care. Because psychologists and behavioral health practitioners have functioned as autonomous practitioners, there is a limited knowledge of how primary care operates, the skills necessary to function in that setting and what is expected of them.\(^81\)--\(^82\)

This situation is compounded by behavioral health practitioners having a limited embracing of the empirically supported treatments whose applications have been demonstrated as effective in medicine. Despite lengthy evidence supporting guideline-based care for behavioral disorders in primary care, such treatments remain the exception, rather than the rule.\(^83\) The emerging culture of medicine includes a strong focus on evidence-based treatments. Until psychological and behavioral treatments address the importance of evidence-based support, there is a risk of their continuing to be viewed by primary care providers as a black hole, with no relation to medicine as practiced.\(^84\) Also, many physicians are uneducated as to the types of available behavioral health practitioners, their skill sets and the types of psychological treatments appropriate for a particular patient and problem.

On the other hand, there is ample reason to think that the most effective response to these issues is improving collaborative medical-psychological care delivered within primary care practices. There is consistent evidence that supports the efficacy of evidence-based psychological interventions as part of the treatment of medical issues.\(^12\), \(^85\)--\(^86\) Some studies have demonstrated the effectiveness of such interventions in the primary care office.\(^65\) Collaborative care models have been demonstrated to be more effective than consult-liaison models of care\(^87\) and have lowered costs while providing effective clinical outcomes.\(^65\), \(^88\)

Treating medical-psychological comorbidities has been the subject of a robust literature suggesting that specific behavioral health treatments are clinically, and potentially, cost-effective. Such psychological treatments of medical problems have demonstrated reduction of hospitalizations and rehospitalizations, physician visits, emergency room use, levels of pain, analgesic medication costs, disability claims, mortality and medical costs and enhanced quality of life.\(^89\)--\(^93\)

Kripilani et al.\(^25\) reviewed 37 controlled trials evaluating medication compliance and clinical outcomes in patients with chronic medical conditions from 1967 to 2004. The findings suggested that adherence increased most consistently with behavioral interventions. Such interventions have generally focused on enhancing self-management and self-efficacy, reducing psychophysiological arousal, altering
behavior patterns, stress management and enhancing social support. Chiles et al. found most dramatic treatment effects to be behavioral medicine interventions that provided psychoeducational interventions that assisted coping.

Evidence-supported programs to effectively treat behavioral health issues in primary care have been consistently demonstrated. Recently, Gilbody et al. reviewed 37 randomized studies of collaborative care for depression, including over 12,000 patients. The analysis suggested that depressive outcomes improved consistently, mostly owing to increased medication compliance. In 11 of the studies, gains were maintained up to 5 years. Availability of psychiatric supervision and increased level of training of behavioral health clinicians were also factors influencing better outcomes.

When depression is effectively treated there is a general decrease in use of medical services. This is also the case for the successful depression treatment of diabetic patients resulting in health care cost reductions between $379 and $952 per patient over the course of 2 years. Those who may benefit most from collaborative care of both diabetic and behavioral health comorbidities are those patients with multiple diabetic complications.

Cognitive and behavioral interventions have been demonstrated to be effective in treating behavioral comorbidities that include physical symptoms. In addition, the inclusion of cognitive behavioral therapy (CBT) as part of diabetic care is associated with improved hemoglobin A1c levels. When effective depression treatment is provided, COPD outcomes have improved. CBT has also been effective in treating high medical expense somatization disorder. Multidisciplinary assessment and intervention with frequent attendees at primary care clinics has demonstrated increased physician satisfaction and reduced the overall costs of medical care by almost 75% the year after the intervention. Patients who have substance abuse who are treated within the primary care office with collaborative medical and behavioral health care have both improvement in the substance abuse disorder and show per-member reductions in medical costs of between $431.12 and $200.03. Combined behavioral interventions for patients with alcohol dependence were demonstrated to have as good outcomes as that with naltrexone and better outcomes than that with acamprosate (Campral). Collaborative approaches involving both medical and behavioral practitioners have been generating more support. Colocation of behavioral health has been shown to improve collaboration. In one survey of 162 primary care physicians, there was cotreatment in some form about 30% of the time. Recent data show two beneficial outcomes from referring to psychological services within a primary care office. Appointments are kept at rates often over 90%, much higher rates than have been previously reported. Secondly, there is better compliance with prescribed medication.

Physicians appear to be ready to have active collaborative care relationships with behavioral health clinicians and in some cases prefer to have behavioral health services as part of their practice. Williams et al. have reported on a survey of primary care physicians showing that just over 60% of respondents would prefer to have behavioral health practitioners as part of their practice. If there is the opportunity for collaborative care, physicians select it as an intervention strategy more often than