Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness

Presented by: Martha Gerrity MD, PhD
February 26, 2015
Introduction

Milbank Memorial Fund

• An endowed operating foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience

• Engages in non-partisan analysis of significant issues in health policy
Introduction

The Reforming States Group (RSG)

• A group of bipartisan state health policy leaders from both the executive and legislative branches supported by the Fund

• State leaders were looking for guidance as they develop and implement policies and programs that support the integration of primary care into behavioral health settings
Overview

• Background
  – Conceptual frameworks
• Methods
• Findings
  – Integration models
  – Model effectiveness
  – Implementation efforts, issues, resources
• Summary
Background
Rates of Serious Mental Illness (SMI) Across the US, 2011 - 2012

SMI Among Persons Aged 18 or Older, by State
Impact of Comorbid Medical Conditions

• $63 billion annually for schizophrenia

• People with SMI and/or substance use disorders (SUD)
  – Higher rates of acute and chronic medical conditions
  – Under-diagnosed and under-treated
  – More emergency and inpatient healthcare use
Conceptual Frameworks
Continuum of Behavioral Health Integration: Practice Structure and Level of Collaboration

* Adapted from Nardone (2014)
Unstructured vs. Coordinated Care Using Care or Case Management*

* Adapted from Oxman (2002) and Rubenstein (2009)
## Collaborative Care Management Interventions

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<tr>
<th>Components of Wagner’s Chronic Care Model</th>
<th>Specific Features of Care Management Interventions</th>
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<td>Delivery system redesign</td>
<td>- Care or case management</td>
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<td>- Enhancement of primary medical care (on-site or off-site)</td>
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<td>- Supervision and support for care managers</td>
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<td>- Direct patient care when needed</td>
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<td>- Education and consultation</td>
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<td>- Screening</td>
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<td>Patient self-management support (often delivered by care managers)</td>
<td>- Educational programs (e.g., Life Goals Program) &amp; materials</td>
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<td>- Motivational interviewing, goal setting</td>
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<td>- Systematic follow-up of symptoms &amp; treatment adherence</td>
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<td>- Links to community resources (e.g., travel, housing)</td>
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<td>Clinician decision support</td>
<td>- Treatment algorithms and guidelines</td>
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<td>- Expert advice from specialists</td>
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<td>Clinical information systems</td>
<td>- Patient registry</td>
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<td>- Refill monitoring through pharmacy databases</td>
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Methods
Key Questions

1. What models have been used to integrate primary medical care into mental health (MH) and chemical dependency (CD) treatment settings?

2. Do these models of enhanced coordination and collaborative care improve outcomes?

3. What are the key implementation issues and strategies?
Methods

• Searched evidence sources from 2004 – 2014 for systematic reviews (SRs)
• MEDLINE (OVID) search, reference lists, citations
• Focused on randomized controlled trials (RCTs)
  – SRs included studies not pertinent to this report
  – KQ1 required details of the interventions
• Included early RCTs of care management for bipolar disorder (BPD)
• Graded the overall quality of evidence
• Google search for evaluation studies
Findings
Search Results

- 5 SRs (2004 – present)
- 11 RCTs included in the SRs
  - 3 Bipolar Disorder (BPD)
  - 3 Serious mental illness (SMI)
  - 5 Chemical dependency (CD)
- 1 additional RCT identified in MEDLINE
- No studies of children or adolescents
  - Excluded RCT by Kolko published in 2014 because it was done in pediatric practices
Key Question 1: Integration Models
KQ1: Structure and Level of Collaboration

- **Co-located, Integrated**
  - Willenbring 1999 (CD)
  - Weisner 2001 (CD)
  - Druss 2001 (SMI)
  - Rubin 2005 (SMI, inpatient)

- **Co-located, Enhanced**
  - Samet 2002 (CD)*

- **Co-located, Not enhanced or unclear**
  - Umbrecht-Schneider 1994 (CD)
  - Saxon 2006 (CD)

- **Off-site, Enhanced**
  - Simon 2002 (BPD)*
  - Bauer 2006 (BPD)*
  - Kilbourne 2008 & 2013 (BPD)*
  - Druss 2010 (SMI)*

*Provided self-management support
Summary: KQ1 – BHI Models

- 3 models used to integrate care:
  - Fully integrated - joint treatment planning & care
  - Co-located care (without additional enhancement)
  - Enhanced coordination using care managers
- Additional staff, training, and oversight are needed to implement models
- Most studies occurred in integrated care systems with shared records
Key Question 2: Effectiveness of Integration Models by Condition
## Serious Mental Illness

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<tr>
<th>Study (sample size, quality)</th>
<th>Intervention</th>
<th>Outcomes</th>
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</table>
| Druss 2001 (n = 120, Fair)  | On-site, integration and care management | ↔ Mental symptoms/QoL  
↑ Physical QoL  
↑ Preventive services  
↓ ED use  
↑ Cost |
| Rubin 2005 (n = 139, Poor) | On-site integration, inpatient | ↑ Preventive services  
↔ Utilization/cost |
| Druss 2010 (n = 407, Good) | Off-site, care management | ↑ Mental symptoms/QoL  
↔ Physical health  
↑ Preventive services |

↑ improved  
↓ decreased  
↑ conflicting results  
↔ no significant difference
For BPD and SMI patients, care management* and integrated care *may improve*
- mental health symptoms (moderate QoE)
- physical HRQoL (moderate QoE)

Care management *improves* use of preventive services (high QoE)

For SUD, co-located PC alone *may not* improve outcomes (moderate QoE)

Unable to determine the impact on health care utilization and cost (very low QoE)
Limitations

• Variation in interventions, outcomes, and study quality limits conclusions
• Care managers were not explicitly trained to address medical conditions (e.g. HTN)
• 7 of the 12 interventions occurred in integrated health systems (e.g. VA, Kaiser)
• No studies included children with SMI
  – Kolko (2014) studied care management for children with serious emotional disorder in pediatric practices
Implementation Efforts
### Key Policy Considerations

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<th>Target Population</th>
<th>• Defining and enrolling target population</th>
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<td>Models &amp; Providers</td>
<td>• Fragmented care delivery systems</td>
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<td>• Fundamental practice change</td>
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<td>• Provider capacity and availability</td>
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<td>Information Sharing</td>
<td>• State and provider HIT infrastructure</td>
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<td>• Patient privacy laws</td>
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<td>Payment</td>
<td>• Lack of reimbursement for integration</td>
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<td>• Siloed payment, provider licensure</td>
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Technical Assistance and Tools

• SAMSHSA-HRSA Center for Integrated Health Solutions
• AHRQ Integration Academy
• Center for Health Care Strategies ROI calculator
• Toolkits
  – Advancing Integrated Mental Health Solutions (AIMS) Center, University of Washington
  – National Council for Behavioral Health
Questions?