

Robert Lee Sutherland Seminar XV
Hogg Foundation for Mental Health

Integrated Health Care: What Do We Know?

Summary Notes

Integrated healthcare: What's in it for me?

A. Jurgen Unutzer

1. Core principles but not just one way to do integration
2. Tremendous amount of literature that says physical and behavioral health problems co-occur (co-morbidity)
 - a. High rates of common medical disorders co-exist with rates of depression and anxiety
 - b. Amplifies physical symptoms
3. Most mental health (MH) services are delivered in primary care
 - a. Co-morbidity survey-folks who have a need for mental health care have no significant care (59%)
 - b. 56% of mental health care is delivered in general medical settings
 - c. Vast majority of depression is treated in primary care. 70-80% of psychiatric medication is prescribed by primary care providers
 - d. In primary care setting, can enhance capacity to deal with common mental disorders
4. Path on moving towards integrated care. Worst case scenario is if primary care and behavioral health are competing with each other.
 - a. More common is where they co-exist, don't compete but not working together well, next step is to learn to consult with each other, co-locate in primary care setting
 - b. Ideal = collaborate effectively, shared set of goals, working together
e.g., depression-5-10% of primary care patients have major depression with chronic medical illnesses
 - c. Depression is #2 cause of disability globally
 - i. Increases total healthcare costs by 50-75%
 - ii. ½ of all depressed adults present to primary care are recognized and started on some sort of treatment
 - iii. High risk = older adults, very young patients, minority groups
 - iv. Only about 20-40% who are started in primary care for depression will have substantial improvement 12 months later
5. IMPACT Study-1999-2004-improving primary care depression treatment for depressed older adults
 - a. 60 and older patients with comorbid medical illness
 - b. Particularly hard to engage and treat
 - c. Wagner's chronic care model-work at a couple of diff things to do better
 - i. Identify staff member in every primary care practice and gave couple of days' training as care manager-keep track of caseload of depressed patients, not just start antidepressant but keep close tabs on patient

- ii. “Care management”-every practice had a staff member keeping track of patient, linking patient to other services like psychotherapy
 - iii. Support medication management but psychosocial treatment for client in office as well
 - iv. Every time patient comes into contact with provider, use rating scale PHQ-9 for depression
 - A. Measure it every single time, care manager will tell primary care
 - v. Designated psychiatrist to back up care team, make recommendations on patients not improving
 - d. Can get relatively more benefit with vulnerable population
 - e. Effect of doing this on total healthcare costs-the overall cost of this group, cost assigned to intervention/usual care and diff in costs
 - i. \$3k less in total health care costs that got intervention care
 - ii. Now 37 trials that says if this is done well more effective than usual care for depression
 - iii. Have to have active care management component, engage the patient, do this measurement stuff
 - iv. Support medication management that doctors are doing and provide access to psychiatry for those not getting better
 - f. New emerging literature that this can work for other disorders: anxiety, alcohol / substance abuse
6. Lots of other flavors of collaborative care
-diff practices, community health centers, VA clinics, HMO type clinics
7. Lessons
- a. Need all core components, primary care provider engaged, can keep patient engaged,
 - b. Care manager is key, need core role to make sure patients don’t fall through the cracks
 - c. Consulting psychiatrist is critical
 - d. Co-location is not enough
8. GA-U Mental Health Pilot (a pilot project administered by community Health Plan in King and Pierce Counties (Washington State) for the General Assistance-Unemployable (GA-U) segment of the Medicaid population)
- a. Co-morbidity is the norm-don’t just have medical/mental illness/substance problem, have all three
 - b. Expanded version of impact model
 - c. Shared tools to communicate, shared electronic medical record
9. Hogg Foundation Integrated Health Care Initiative
- a. Over 2500 patients seen by integrated care teams in 7 communities-people right here in state who have done the work
 - b. People’s Community Clinic in Austin has had wonderful outcome
 - c. Work to do on children, adolescents, no more research needed to know this works, have 37 trials, now need to think about how we get people to demand it

B. Benjamin Druss

1. Mental illness and early mortality in public mental health setting, people die earlier in public health sector than in other sectors
 - a. 28-29 years early mortality
 - b. Clients in public mental health sector are dying of same things as general population
 - c. Most common cause of death of clients with serious mental illness is cardiovascular disease
2. Risk Factors
 - a. Lifestyle/inactivity, poor diet, smoking
 - b. Medications-antipsychotic medications cause problems like obesity
 - c. Elevated weight, glucose, lipids, blood pressure
 - i. These are risk factors that if not caught early can lead to diabetes, etc and then mortality
 - d. Poor quality of care-detection and treatment
3. Public health approaches tend to think in terms of prevention
 - a. Primary prevention (wellness programs) means try to prevent problems from developing in the first place
 - b. Secondary prevention
 - i. Catch a problem and treat it before it becomes full-blown
 - c. Tertiary prevention (treatment)
4. Where should treatment happen? 4 Quadrant Model
 - a. If don't have a lot of problems, then primary care settings
 - b. Quadrant 2-people whose main problems are mental disorders, these people are commonly treated in community mental health centers, VA settings, other public health settings
 - i. How do you make sure they're screened for co-morbidity
 - c. Quadrant 4-co-morbid mental health and medical care
 - d. Providing secondary and tertiary prevention services onsite
 - i. Intervention associated with improved access quality and medical outcomes
 - ii. Real world: Cherokee Health Systems in Tennessee is a community mental health center (CMHC) that became a federally qualified health center (FQHC) and provides integrated, co-located medical and mental health care
5. How can you optimize care when client is receiving most of their care in pc setting?
 - a. PCARE (Primary Care Access, Referral, & Evaluation) Study-NIMH funded trial of medical care management at an Atlanta CMHC
 - b. Other strategies besides care management
 - i. Personal health records-web based record with all the information about your care
 - ii. In the forefront of where health system in general is moving
 - iii. For the most part, electronic tech is not going to solve whole problem but impt tools of solution

6. A lot of disease management programs are beginning to recognize that managing one illness at a time doesn't make sense if co-morbidities
 - a. In Georgia's Medicaid disease management program, manage diabetics, not just diabetes, manage all co-morbid problems of people with particular conditions (including schizophrenia)
7. Policy Initiatives: ways to fix health system in parallel to make it less convoluted
 - a. SAMHSA's 10 in 10 Campaign
 - b. In 10 years should be able to reduce mortality gap by 10 years
 - c. 2006 NASMHPD Medical Directors Morbidity and Mortality Report
 - d. Fed: CMHC Improvement Act would provide \$50 million each year to fund co-located primary services in the nation's CMHCs
8. Local Consideration in Choosing Care Models
 - a. Local sites need to take basic principles and feel empowered to make models that make sense, taking into account local needs and resources
 - b. What resources do you have already out there in community, what can you actually do onsite, what qualified staff do you already have
 - c. Reimbursement factors-can be different from state to state-need to figure out what services you can actually pay for and who will pay for them
 - d. Consumer preferences-figure out with local constituencies which setting makes the most sense, what their preference is
 - e. Local sites figure out what makes sense for them