Integrating Primary and Behavioral Health Care for People with Serious Mental Illness and Substance Abuse Disorders

Andrea Cohen, JD
Office of the Mayor, New York City
Adam Karpati, MD MPH
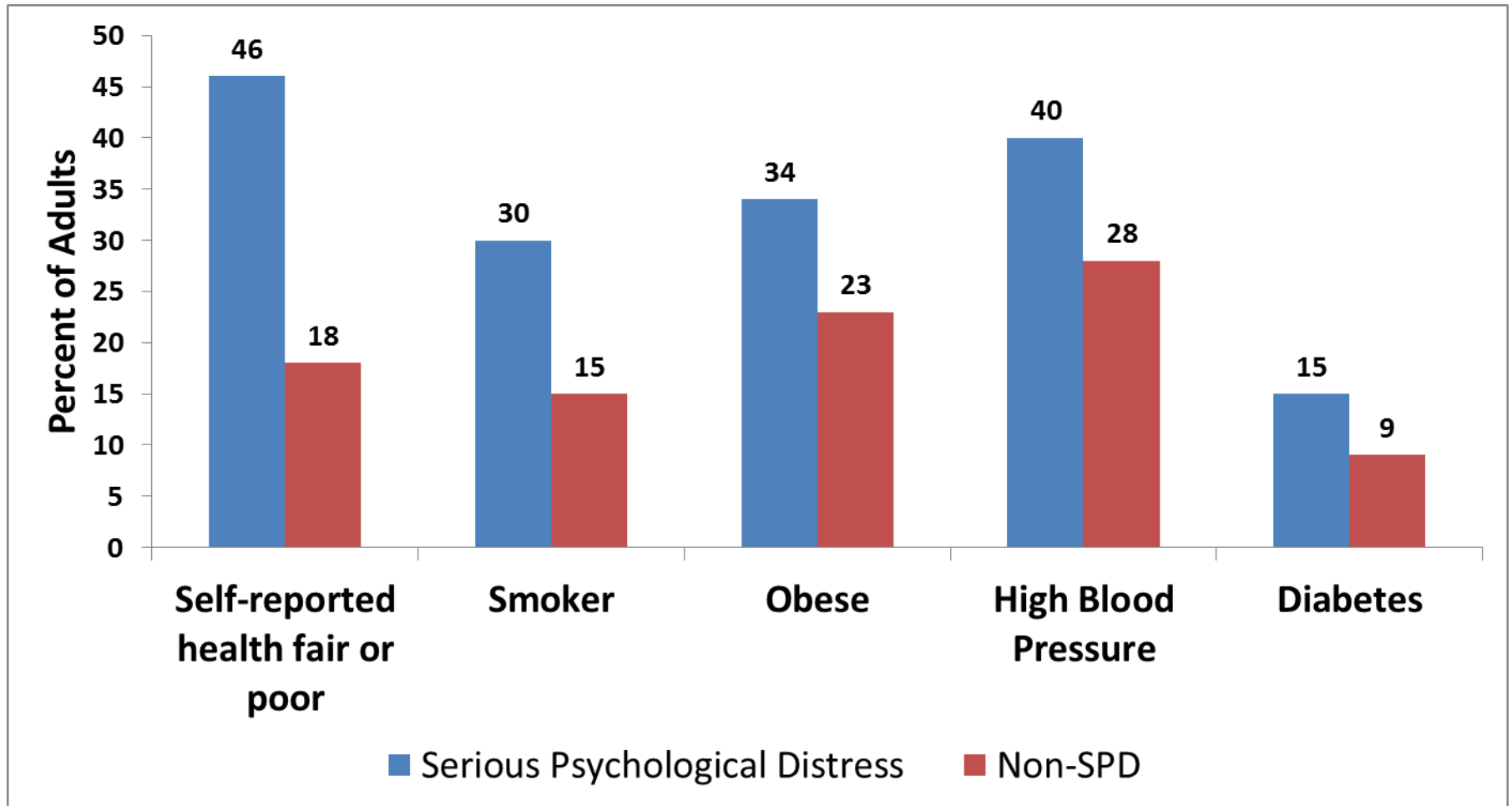New York City Department of Health and Mental Hygiene

Overview

- High mortality and disease burden among people with SMI

- Prevalence of chronic disease and other physical health issues

- Structural strategies for integrating care at the practice level

- Structural strategies for integrating care at the system level

Higher mortality among individuals with serious mental illnesses

Multistate study comparing mortality rates in general population to those with serious mental illnesses (2003)
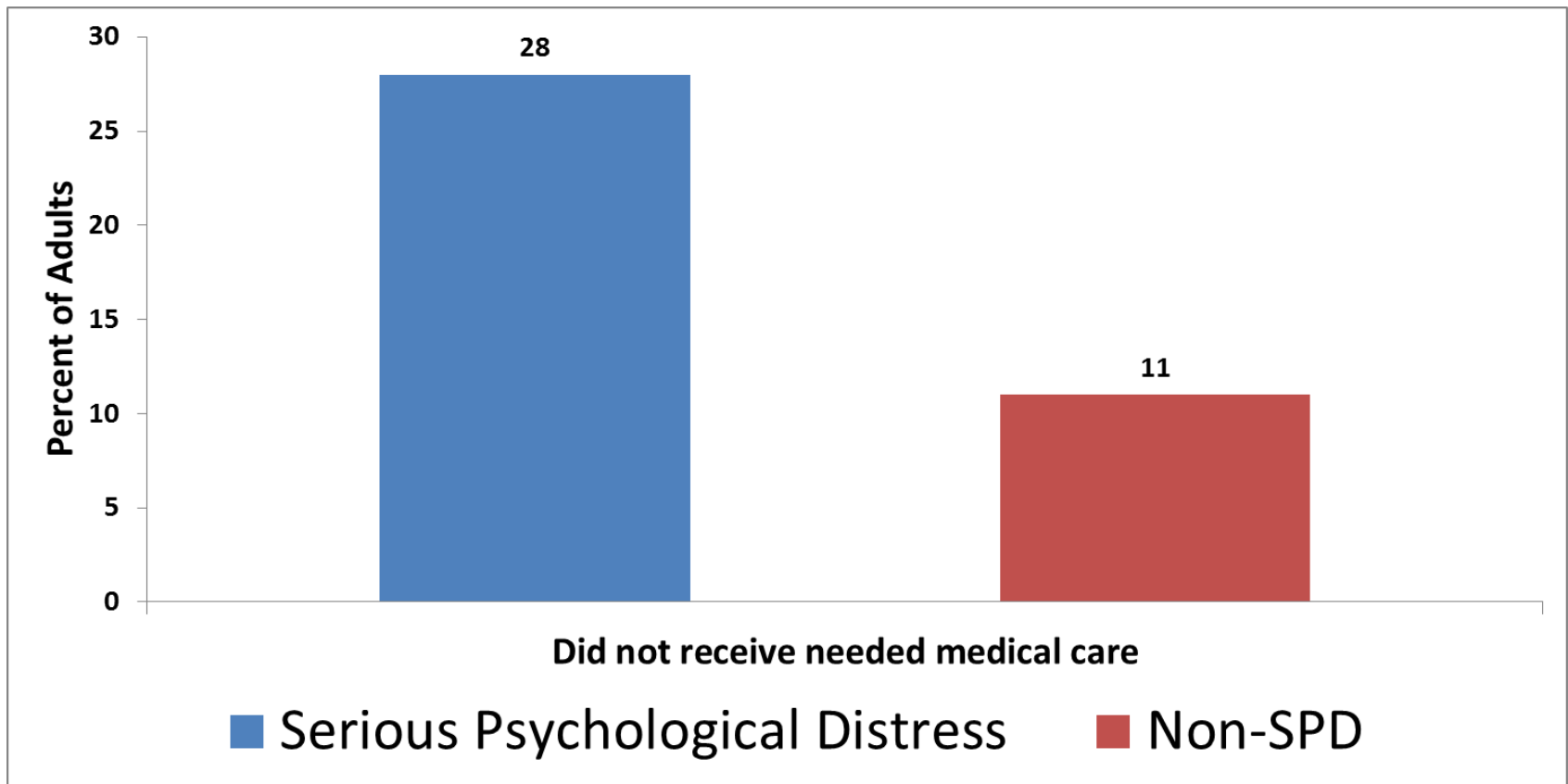
- – Deaths among those with SMI occurred ~25 years earlier than general population
- – Most deaths among SMI population were from cardiovascular disease, diabetes, respiratory diseases, and infectious disease

Source: Colton CW and Manderscheid RW. Preventing Chronic Disease, 2006.

Disproportionate burden of health conditions and risks among those with poor mental health

Percent of Adults

- Self-reported health fair or poor: Serious Psychological Distress 46, Non-SPD 18
- Smoker: Serious Psychological Distress 30, Non-SPD 15
- Obese: Serious Psychological Distress 34, Non-SPD 23
- High Blood Pressure: Serious Psychological Distress 40, Non-SPD 28
- Diabetes: Serious Psychological Distress 15, Non-SPD 9

■ Serious Psychological Distress   ■ Non-SPD

Source: NYC DOHMH Community Health Survey, 2009, http://nyc.gov/health/epiquery
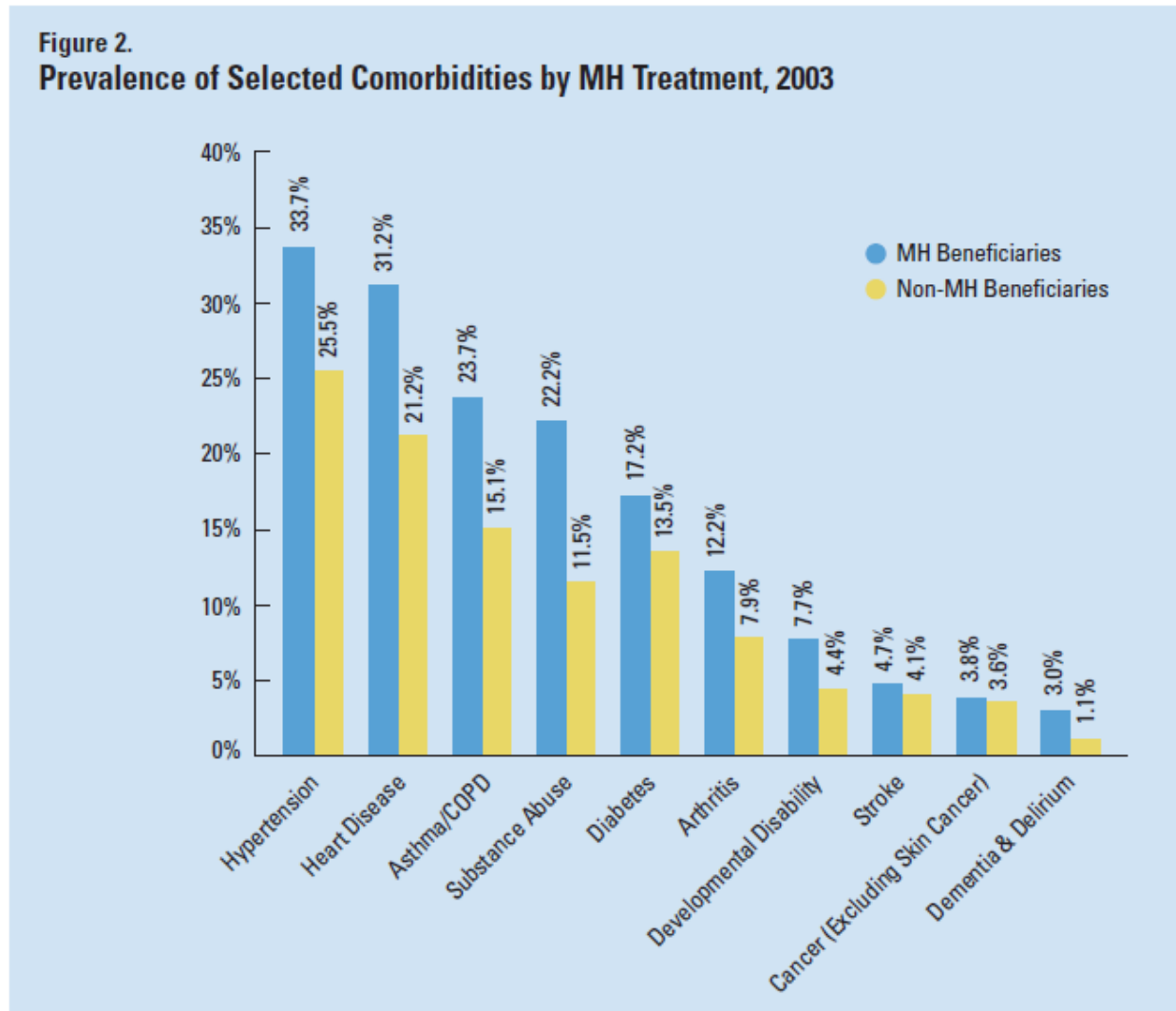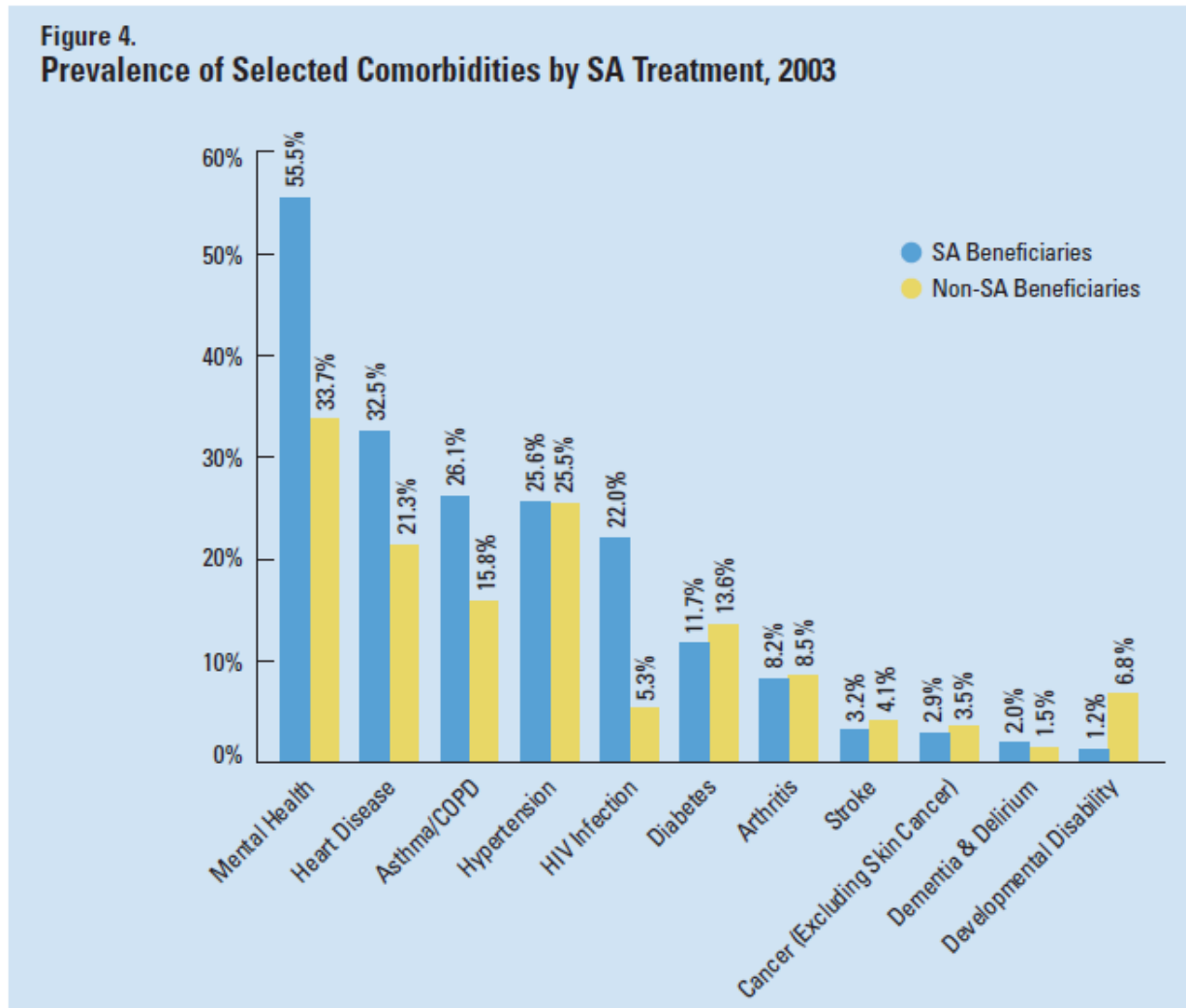
Low Rates of Accessing Medical Care

Was there a time in the past 12 months when you needed medical care but did NOT get it? Medical care includes doctor visits, tests, procedures, prescription medication and hospitalizations.

Co-occurring disorders among Medicaid beneficiaries with mental illnesses

Figure 2.
Prevalence of Selected Comorbidities by MH Treatment, 2003

Source: United Hospital Fund, New York Beneficiaries with Mental Health and Substance Use Conditions, 2011

Co-occurring disorders among Medicaid beneficiaries with substance use disorders

Figure 4.
Prevalence of Selected Comorbidities by SA Treatment, 2003

Source: United Hospital Fund, New York Beneficiaries with Mental Health and Substance Use Conditions, 2011

NYS Medicaid spending on hospital inpatient care

	All Inpatient Services	Related to primary diagnosis	Not Related to primary diagnosis
Primary Mental Health Diagnosis	7,017	2,282 (33%)	4,734 (67%)
Primary Substance Use Diagnosis	$11,738	$3,733 (32%)	$8,005 (68%)

City Health Information

IMPROVING THE HEALTH OF ADULTS WITH SERIOUS MENTAL ILLNESS

- Primary care providers and mental health professionals should collaborate to ensure that people with serious mental illness receive:
  - Care for illnesses that contribute to their increased morbidity and mortality.
  - Routine monitoring of medication side effects, weight, and blood pressure, and other regular preventive health screenings.
  - Attention to modifiable risk behaviors such as substance use, medication nonadherence, smoking, and poor nutrition.

People in the United States with serious mental illness (SMI)—including schizophrenia, bipolar disorder, and severe depression—die 15 to 25 years earlier than the general population.[1-3] While suicide accounts for 5% to 10% of deaths among patients with schizophrenia and bipolar disorder,[4] much of the increased mortality in this group is associated with preventable physical heath conditions. For example, one study showed that 60% of the increased mortality among people with schizophrenia is due to preventable conditions such as diabetes and cardiovascular, pulmonary, and infectious diseases.[5]

Many medications used to treat people diagnosed with SMI, particularly second-generation antipsychotics, can cause or worsen obesity, dyslipidemia, and diabetes.[6] Also, smoking, substance use, high-risk sexual behavior, and medication nonadherence are more common in people with SMI than in the general population.[7-10] Other contributors to morbidity and premature mortality in people with SMI include poverty, homelessness, and stigma, which can exacerbate SMI and affect access to care.[11-12]

When patients with SMI interact with the health care system, the quality of care may be compromised by literacy and communication issues or by difficulty navigating the poorly coordinated health care and mental health systems.[11] Medical conditions of people with SMI are often missed and health care concerns are often disregarded or not treated appropriately.[13]

Both mental health providers and primary care providers (PCPs) can improve the health of people with SMI.

City Health Information

IMPROVING THE HEALTH OF PEOPLE WHO USE DRUGS

- Ask all patients about substance use, including drugs, alcohol, and tobacco. Discuss health problems and risky behaviors that may be associated with drug use.
- Screen, vaccinate, and treat patients who use drugs for infectious diseases, physical health problems, and mental health issues commonly linked to drug use.
- Offer brief interventions for risky or harmful drug use and provide buprenorphine for treatment of opioid dependence.
- Refer patients to drug-treatment and harm-reduction programs when necessary.

Drug use is a serious public health problem that demands attention in primary care. In 2007, 9% of people aged 12 and older in the United States (US) were classified as having substance abuse or dependence.[1] In New York City (NYC), 10% reported illicit drug use in the past month, including 5% who used drugs other than marijuana.[2] Nonmedical use of opioids is a growing problem, with the number of new opioid users now exceeding the number of new marijuana users in the US.[1,3]

Drug use is associated with high morbidity and mortality (**Table 1**), including higher risk for overdose, injuries, HIV, hepatitis B and C, liver disease, hypertension, depression, insomnia, and violence.[7-10] Because of the pressures of addiction and fears of stigmatization, people who use drugs often seek medical care only in times of crisis, and they give low priority to routine care for chronic diseases, dental care, and other preventive health measures.[11-13] Still, people who use drugs are more often seen in physicians' offices and emergency departments than in drug treatment settings,[1] even if the drug use is not known to the clinician or stated as the reason for the visit.

TABLE 1. MORBIDITY AND MORTALITY AMONG DRUG USERS IN NYC—2007

- Emergency Department use[4]
  - 35,706 visits by cocaine users.
  - 28,435 visits by users of heroin or other opioids.
- Overdose[5]
  - 849 deaths.
  - Third-leading cause of death among adults aged 25 to 34 years.
  - Fourth-leading cause of death among adults aged 35 to 54 years.
- HIV/AIDS[6]
  - Up to 21% of people living with HIV/AIDS were infected through injection drug use.

Primary care providers and behavioral health professionals should collaborate to ensure that people with serious mental illnesses and substance use disorders receive:

- Care for illnesses that contribute to their increased morbidity and mortality.

- Routine monitoring of medication side effects, weight, and blood pressure, and other regular preventive health screenings.

- Attention to modifiable risk behaviors such as substance use, medication nonadherence, smoking, and poor nutrition.

Primary care practitioners should . . .

- Coordinate care with behavioral health providers.

- Provide regular physical exams and routine preventive health screenings, including weight, blood pressure, and cholesterol screenings, and immunizations for influenza and pneumonia

- Be alert to specific conditions, e.g., liver and neurologic disease related to chronic alcohol use; HIV and Hepatitis B and C related to injecting drug use

- Be alert to any significant changes in mental health symptoms, including suicidal ideation and risky behaviors, and promptly discuss any concerns about behavioral health needs with patients and their mental health providers.

- Be aware of potential side effects, drug interactions, and adherence issues in patients who are prescribed psychotropic medications.

- Advise and support patients to make healthy lifestyle choices and support their efforts to do so.

Behavioral health providers should . . .

- Coordinate care with the patient's PCP and other health care and social service providers.

- Discuss risks and benefits of various treatment options with patients.

- Routinely monitor psychotropic medications and their side effects with patients, and adjust medications as necessary.

- Ask about comorbid health conditions that are common. Encourage patients to see their PCPs as necessary.

- Work with patients to address modifiable behaviors.

"4 Quadrant" Model

NCCBH Four Quadrant Clinical Integration Model

	Quadrant II — BH ↑ PH ↓	Quadrant IV — BH ↑ PH ↑
High	• BH Case Manager w/ responsibility for coordination w/ PCP • PCP (with standard screening tools and BH practice guidelines) • Specialty BH • Residential BH • Crisis/ER • Behavioral Health IP • Other community supports	• PCP (with standard screening tools and BH practice guidelines) • BH Case Manager w/ responsibility for coordination w/ PCP and Disease Mgr • Care/Disease Manager • Specialty medical/surgical • Specialty BH • Residential BH • Crisis/ER • BH and medical/surgical IP • Other community supports

Stable SPMI would be served in either setting. Plan for and deliver services based upon the needs of the individual, consumer choice and the specifics of the community and collaboration.

	Quadrant I — BH ↓ PH ↓	Quadrant III — BH ↓ PH ↑
Low	• PCP (with standard screening tools and BH practice guidelines) • PCP-based BH*	• PCP (with standard screening tools and BH practice guidelines) • Care/Disease Manager • Specialty medical/surgical • PCP-based BH (or in specific specialties)* • ER • Medical/surgical IP • SNF/home based care • Other community supports

Behavioral Health Risk/Status (vertical axis: Low → High)

Physical Health Risk/Status (horizontal axis: Low → High)

Source: Mauer B. National Council for Community Behavioral Healthcare 2006.

Integration at the System Level

- Key Elements of System Integration
  - Care Coordination
  - Health Information Exchange
  - Aligned Incentives
  - Consumer Engagement

Adapted from United Hospital Fund, *Providing Behavioral Health Services to Medicaid Managed Care Enrollees: Options for Improving the Organization and Delivery of Services,* 2009

Care Coordination

- Provides an informed "Navigator" for individuals with care needs across systems
- Ideally connected to the "health home," which may be a mental health provider
- Clear designation of care coordinator
- Also can connect to critical social supports

Health Information Exchange

- Appropriate timely data must be available at clinical level across systems and providers

- Preferably electronic

- Requires guidance and standardized protocols on privacy and consent requirements

Aligned Incentives

- Alignment needed at payor and provider level
- Mechanisms for rewarding quality care
- Mechanisms for sharing savings from reductions in avoidable ER and hospitalizations across physical and behavioral care delivery systems
- Joint and standardized performance measures

Consumer Engagement

- Consumer participation in system and program design
- System design should leverage established provider relationships