2013

A Community Based System of Integrated Clinical Care: Primary Care, Mental Health and Substance Use Treatment

Terri Reuvers
Minnesota State University, Mankato

:
.

SOWK 665-675 Field Liaison:
Michelle Alvarez, MSW, PhD

Academic Advisor:
Nancy Fitzsimons, MSW, PhD

A Community Based System of Integrated Clinical Care
Primary Care, Mental Health and Substance Use Treatment

Offsite Field Instructor
Paul Force-Emery Mackie, MSW, PhD

Task Supervisor
Carolyn Wheeler L.I.C.S.W

Section 2703 of the Patient Protection and Affordable Care Act (Pub. L. 111-152) enacted March 2010, established the State Option to Provide Coordinated Care through a Health Home for individuals with Chronic Conditions

Statement of Purpose

Our segregated medical and mental health care system misses opportunities for early detection of physical disease.

Missed opportunities lead to increased costs.

Colorado's Medicaid health plan estimates that an integrated health program will reduce costs for patients with psychiatric disorders by 10%.

The cost of doing nothing may exceed $300 billion per year in the United States (NCCBH, 2010).

The purpose of this Capstone project is to critically examine existing models of Integrated Primary and Mental Health care. These models will then be evaluated to identify those most compatible with rural communities in Southern Minnesota.

Method

A systematic literature review of care models was conducted from April 1, 2013 through June 15, 2013. Electronic databases were searched for journal articles published between 2000 and April 2013. Search terms included: *integrated behavioral health care, collaborative care, coordinated care, and behavioral health homes serious and persistent mental illness, serious mental illness, mental illness, mental health, psychiatric disability, psychological disability and medical, primary, physical care, disease.* Case studies, case series, were excluded from the review.

Preliminary review of the research had uncovered inconsistent language pertaining to care models. Therefore, articles were studied for content and model types were defined based on the narrative explanation rather than linguistic description. Of the 250 articles considered, 48 were included in the review.

Unintended Consequences of Segregated Health Care Services

Individuals with serious mental illness need better access to primary care

Primary care patients need better access to mental health care

Milbank's 2010 conclusions indicate a third population of people who are not served at all.

People with Serious Mental Illness have higher rates of emergency service use for both mental health and medical care.(NAMHPA, 2012).

Individuals with Serious Mental Illness are likely to underuse important services such as preventative care (NAMHPA, 2012).

One-third of people with mental illness do not receive needed immunizations, or cancer screenings (NAMHPA, 2012).

As many as seventy percent of primary care visits stem from mental health or substance use concerns (Milbank, 2010).

Only 48% of patients referred to outside behavioral health providers actually followed through with an appointment (Bartels, Coakley, Zubritsky, & Ware, 2004).

Patients with medically unexplained symptoms do not easily access psychological therapies (Jackson & Kroenke 2006).

Practicum Agency & Location
South Central Human Relations Center
Owatonna, Minnesota

Terri Reuvers MSW
July 2013

Care Models- Key terms

Collaborative: Providers in separate locations

Co-located: Providers are in the same building, but this does not guarantee shared information

Integrated: Providers are in a shared space, work as a team on shared cases

Comparison of Models- Key Findings

Collaborative Care between separate MH and PC providers demonstrated little improvement in consumer outcome.

Co-located care - Findings reveal a relationship between provider's physical proximity, and patient outcomes

Integrated Care -Literature review determines that Integrated care is more effective than collaborated or co-located care.

Integrated care within Primary Care setting

Findings suggest a preference for integrated care within a PC setting for elderly patients (Bartels et al., 2004), as well as Latino populations (Manoleas, 2008).

Patients w/ chronic conditions seen four times more often (Belaszka-DuVernay, 2011). Patients were more likely to obtain MH services with integrated care than patients who were referred for services (Bartels et al., 2004; Belaszka-DuVernay, 2011).

Integrated MH care demonstrated a significant decrease in hospital admissions. Costs reduced by 21-22% (Belaszka-DuVernay, 2011). Decline in ED use by 31% resulting in related cost decrease by 36% (Belaszka-DuVernay,2011).

Better control of hypertension (Belaszka-DuVernay, 2011).

Reduced anxiety and panic attacks (Grames, 2006).

Significantly reduced depressive symptoms (Chan, Ming-Yu, & Unutzer, 2008; Grames, 2006; Vera & Perez, 2010).

Improved social functioning (Vera & Perez, 2010).

Integrated care within Mental health setting

Findings demonstrated reduced barriers to primary care (PC) for individuals with psychiatric disabilities (Mesldor, Gidugu, & Rogers, 2011).

PC Services for individuals with SPMI Increased access to primary care by 50-70%
- Reduced ED services 42%
- Increased healthcare screenings 44%
- 77% of previously unrecognized (medical) problems were found through routine physical examination and hematocrit determination (Boardman, 2006).

MH consumers experienced: Reduced depressive symptoms (Skrinar, Huxley, Hutchinson,& Menninger,2005).

Weight reduction (McKibbin et al., 2006; Skrinar et al., 2005).

Better management of diabetes related conditions (McKibbin et al., 2006).

Improved social functioning (Green, Poen, & Jamoff, 2008; Hodgson, McCullock, & Fox, 2011; Skrinar et al., 2005).

Recommendations based on Research may assist providers in assessing the feasibility of Services Community-Based System of Integrated Clinical Care Composed of three major branches of service.

Integrated Clinical Care within multiple Primary Care Settings (ICC-PC)

Primary Care Clinic
- Solution Focused Therapy
- Mind Body Stress hardiness
- Resiliency training

Hospital
Emergency Department
- High Utilization rates in collaboration with In-Reach
- Traumatic physical injury

Medical and Surgical Unit
- Depression, PTSD, and cognitive impairment
- Pre & Post Surgery Mind body techniques
- Pain reduction
- Promote healing

Based on work a the Penney George Institute at Abbott Northwestern Hospital

Community outreach

Mobile medical
- Follow up or screening as home or community based visits (Public Health Nursing)

Non-traditional

Community engagement points, & nontraditional public awareness approach.

Integrated Clinical Care within a mental health setting (ICC-MH)

Physical health screening
- Services Intake and Functional Assessments

Disease prevention

Rehabilitation Services
Whole person medicine
- Mind - Cognitive Remediation (evidence based models such as NEAR or CET)
- Body – Biopsychosocial-based psychoeducation (incorporates nutrition, smoking cessation diabetes)
- Soul – Promote social engagement and gratitude through volunteerism (Similar to Sage Club House model