IHS Workgroup on Integrating Mental Health and Primary Care: Topic Brief

December 13, 2013

High-Level Research Question

What are the effects of different models of integrated mental health and primary care on outcomes that matter to patients?

Assignment for Workgroup Participants

- Based on your perspective (patient, clinician, payer, etc.), please state your top two or three research questions that—if answered over the next three to five years—could make the biggest impact on clinical practice and patient outcomes. Please phrase your choices as comparative effectiveness research questions: for example, "Which care model (A or B) is more effective in producing clinical outcomes that are important to patients (such as health, function, quality of life, etc.)?"
- Present and discuss your questions on the day of the workgroup meeting. Each presenter should take no longer than five minutes. Slides to accompany your questions will be prepared in advance of the meeting.

I. Introduction

"Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." (National Research Council 1994)

This definition of primary care seeks to align the provision of primary care services with patient needs and preferences rather than with primary care provider expertise. Mental illness is very common among patients. Currently, such issues are addressed either by a mental health provider or, more often, by a primary care provider (PCP). Integration of mental health care and primary care refers to the collaboration of care providers, co-management of care, and/or physical colocation of care. Recently, the need for enhanced access to high-quality mental health services has gained media attention and greater public awareness in response to the return home of US soldiers suffering from post-traumatic stress disorder as well as with the apparent increase in mass shootings and violence by people with mental illness. Some integration of mental health care and primary care is already occurring, but there is a lack of sustainable models that rely on evidence-based guidelines for treating common mental illnesses.

II. Conditions' Effects on Patients

Patients' self-management of any disease is made more difficult by comorbid conditions. Self-management of conditions includes behavior modification and taking medications as prescribed. Such mental conditions as depression and anxiety can hinder self-management, and they have been shown to decrease the likelihood of adherence to medical advice.

Medications routinely prescribed for one condition may worsen another. For example, a psychotropic medication very effective at treating depression may cause weight gain, which exacerbates co-occurring obesity or type 2 diabetes. Similarly, medications prescribed for physical ailments can cause psychological problems. For example, corticosteroids, which are used to treat a wide range of diseases, can induce mania and psychosis as side effects.

Persons with mental disorders are more likely to engage in behaviors that increase the risk of developing a chronic disease (Druss 2011):

- Patients with mental disorders are two to three times as likely to be cigarette smokers as those without a mental disorder.

- People suffering from schizophrenia or bipolar disorder are 12 to 20 percent more likely to be treated for alcohol abuse than members of the general population, and they are 35 to 42 percent more likely to be dependent on illegal drugs.
- People with severe mental illness are more likely than others to report sedentary lifestyles.

It is estimated that as many as 25 percent of US adults have a mental disorder (many of these are undiagnosed); 68 percent of them have a co-occurring physical medical condition (Druss 2011).

- Of disabled Medicaid-only claimants with a psychiatric diagnosis (Druss 2011):
  - 56 percent had diabetes;
  - 57 percent had cardiovascular disease; and
  - 55 percent had pulmonary disease.
- Unipolar depression affects 12 percent of US women and 6 percent of US men in their lifetimes; anxiety disorders affect 15 percent of the US population and are more prevalent in women; bipolar depression affects 4 percent of the US population, and it too is more prevalent among women (CDC 2013).
- Schizophrenia affects 0.5 to 1 percent of US adults; nearly one-third of persons with schizophrenia make at least one suicide attempt in their lifetimes, and 1 in 10 succeed (CDC 2013).

III. Current Practice

Mental health needs are commonly addressed in the primary care setting. In 1997, PCPs[1] saw 87 percent of patients seeking treatment for a major depressive disorder. More than 40 percent of antidepressant drugs are prescribed by PCPs. Yet the quality of care received by patients treated for mood disorders by PCPs is only better than "minimally adequate" 14 percent of the time; pharmacotherapy prescribed by PCPs only agrees with guidelines 11 percent of the time (Verughese 2012).

Quality deficits in the provision of mental health care by PCPs are compounded by poor access to specialists: in a large national survey, 66.8 percent of PCPs reported that they were unable to get high-quality mental health services for patients. A majority of surveyed physicians cited lack of adequate insurance coverage, health plan barriers, and provider

[1] Almost no studies addressed the backgrounds of PCPs who are typically general, internal, or family medicine physicians. These specialties have different levels of mental health training, in which may influence how these doctors treat patients with psychological conditions.

shortages as very important factors; 88.7 percent cited at least one of these elements, while 23.7 percent cited all three. In contrast, only 33.8 percent of these PCPs said they were unable to get high-quality specialist referrals in other fields (Cunningham 2009).

IV. Care Models

Many integrated care models show improved access to mental health care, increased detection of conditions, better patient management of chronic somatic diseases, and better mental health outcomes within limited settings and patient populations (e.g., depressive patients in an outpatient setting). However, literature reviews thus far have been unable to determine which aspects of these models make the difference (Miller 2013). Furthermore, little is known about physician reimbursement models that can support sustainable integrated care practices, although combined practice and reimbursement models employed by the Veterans Health Administration and the state of Minnesota have been shown to work (Benzer 2012; Chang 2013; O'Donnell 2013).

Some integrated care models address the needs of patients with severe mental illness whose main interaction with the healthcare system is through mental health providers and centers but who have other chronic medical conditions that require continuing care. This patient group tends to experience a high rate of preventable diseases that could be addressed by primary care. Outcomes for this population have improved dramatically under some models of integrated care (Weinstein 2013; Pirraglia 2012)—but not under others (Tosh 2011).

Measuring the true effects of integrated mental health and primary care is difficult because these programs often identify many previously undiagnosed problems. Increased screening efforts find more cases, which, in turn, increases the number of visits in the short run. However, patients who attend an integrated practice typically have lower downstream utilization of care, more symptom relief, and receive fewer prescriptions for psychotropic medications (Verughese 2012).

Care integration models have demonstrated increased provider satisfaction, with PCPs saying that their patients have received higher-quality care and that patients did not have to leave the practice to receive mental health treatment. Other reported advantages of care integration are a more defined process for treating patients with mental health needs and a broader team approach (Vickers 2013). Further, practice characteristics such as provider and clinic leadership buy-in have been identified as facilitators for adoption, reach, and fidelity for some models (Fortney 2012).

V. Innovations

The mental health parity movement has made significant progress in recent years, increasing awareness of the issue as well as improving policy. The most recent success has been the implementation (on November 8, 2013) of the Mental Health Parity and Addiction Equity Act, modified by the Affordable Care Act, which mandates that health plan features like copays, deductibles, and clinic visit limits for mental health and substance care must be equivalent to those for medical and surgical care. Other laws, such as the American Reinvestment and Recovery Act (2009), have funded research and programs across the federal government, including some at the Agency for Healthcare Research and Quality (AHRQ), Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), and the National Institute of Mental Health (NIMH).

The work done by AHRQ's Integration Academy is particularly useful in framing this discussion. Their lexicon[2] brings together a common language for this discussion. The Future Research Needs[3] report, literature reviews,[4] and library[5] set the stage for research; the Measures Atlas[6] provides a view of the specific measures available in this field. If you have time before the meeting, please take a look at these materials.

Researchers have already identified many promising practices in mental health and primary care integration, particularly within large health systems like the Veterans Health Administration and Kaiser Permanente. There is a tremendous interest among clinicians and researchers in this area: since 2010, more than 1,000 studies have been published. For future research, there are an increasing number of practice, clinic, and patient research networks that enhance the potential for larger, faster study implementation. To date, however, no model of integrated mental health and primary care has been shown to be effective and sustainable at a large scale.

[2] http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf
[3] http://www.effectivehealthcare.ahrq.gov/ehc/products/234/534/Future03--Abuse-09-23-2010.pdf
[4] http://www.ahrq.gov/research/findings/evidence-based-reports/mhsapc-evidence-report.pdf
[5] http://integrationacademy.ahrq.gov/literature/by_title
[6] http://integrationacademy.ahrq.gov/atlas

VI. Sample Questions that Could Be Answered by Comparative Effectiveness Research (CER)

- How do different elements of integrated care models affect outcomes that matter to patients?
- How does integrated care affect measures of outcomes that are important to patients and caregivers?
- What are the differences in the effects of integrated care on patients with different characteristics, such as age, sex, race, ethnicity, socioeconomic status, comorbid conditions, and health literacy?
- How does access to different mental health care services affect usage of these services in various populations?
- Which payment policies and incentives can promote and sustain integrated care strategies in real-world settings?
- How do models work in different settings, such as hospital clinics, community health settings, federally qualified health centers, and individual primary care practices? Which models work best where?
- Can a sustainable model of integrated care improve patient-centered outcomes for:
    - Patients who receive most of their care in primary care facilities?
    - Patients who receive most of their care in mental health facilities?

VII. Conclusion

There is a significant opportunity to conduct impactful new research on the comparative effectiveness of models of integration of mental health care and primary care improves outcomes that matter to patients and their caregivers. This research may address a range of models, settings of care, and payment policies that can facilitate adoption and long-term sustainability. Barriers to adoption must also be considered, including professional and organizational cultures; resistance to changes in the structure, organization, and processes of medical practice; local supply of primary care practitioners and mental health professionals; payment policies, education of professionals, and other resource limits.

VIII. References

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