INTEGRATED PRIMARY CARE FOR TEXAS ADULTS WITH SERIOUS MENTAL ILLNESS

FINDINGS FROM 10 TEXAS COMMUNITY MENTAL HEALTH CENTERS

SERIOUS MENTAL ILLNESS

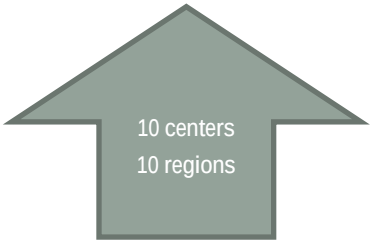
Centers addressed a challenging unmet need

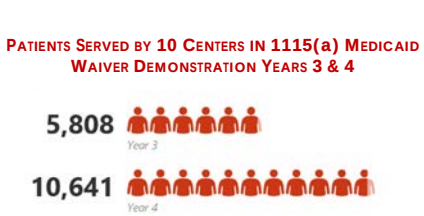
The Texas 1115(a) Medicaid Waiver provided Community Mental Health Centers a long-awaited opportunity to improve care for people with serious mental illness (SMI) and co-occurring physical health conditions. This summary provides information about 10 Community Mental Health Centers in Texas that used Medicaid Waiver funding to integrate primary care and mental health care.

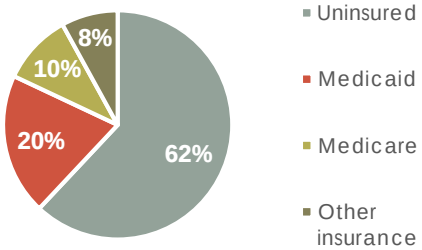
PREMATURE MORTALITY FOR PEOPLE WITH SERIOUS MENTAL ILLNESS IS ESTIMATED AT BETWEEN 8 AND 32 YEARS

About 1 in 25 people in the United States has an SMI that substantially impairs major life activities. Premature mortality associated with SMI has been estimated at between 8 and 32 years. This disparity is **related to lower levels of access to quality primary care**, higher rates of **smoking** and **unhealthy diets**, and the use of **antipsychotic drugs that are associated with health risks**.

This summary is based on analyses of data for Jan 2013 – Dec 2015 obtained from the 7 Centers that were able to compile and share data about the structure and functioning of their projects and the people who received that care. Information about individuals' hospital encounters, lengths of stay, and costs of care during the same period were obtained from the Texas Department of State Health Service's hospital discharge records.



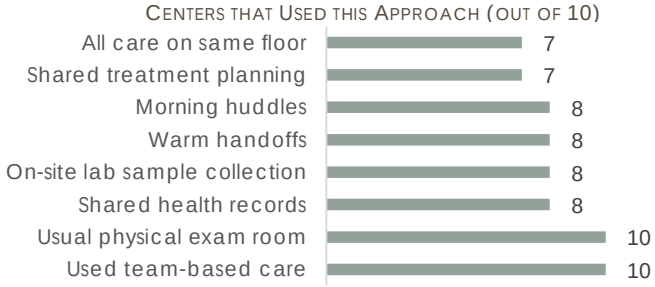




INTEGRATED PRIMARY CARE PROJECTS

Projects used teamwork, shared information, and warm-handoffs

All 10 Centers emphasized **team approaches** and **shared information** to meet patients' health needs holistically. Almost all Centers had a care coordinator who facilitated integration. Most Centers used **morning huddles**, **shared health records, physically escorting patients between physical and mental health care ("warm-handoffs")** and **integrated treatment plans.**



PATIENT HEALTH

Centers provided better care to more patients

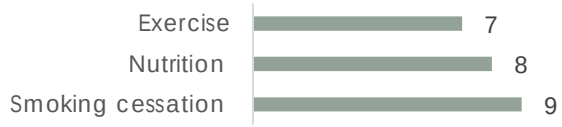
In one year, Centers almost **doubled the number of patients** who received integrated care, **from an average of 645 to 1,166 individuals per Center**. The Centers demonstrated the feasibility of providing integrated primary care for a patient population with complex disease conditions, medication plans with high risks of adverse drug interactions, and side effects.

Patients commented on access to care and high satisfaction

Having timely access to physical health care is particularly important to people with SMI, who often lack access, either because of stigma or difficulties with symptoms. Centers provided patients with **ready access to primary care**, mostly with appointments **within a week or same-day walk-in** care.

Patients expressed **high satisfaction with integrated care**, citing greater comfort receiving primary care in a familiar setting, improved ease of access, increased engagement in medication management and self-care, and more affordability.

Health coaching was a major feature

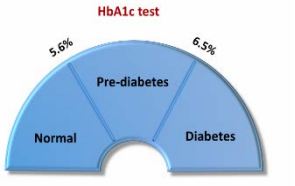


CENTERS THAT PROVIDED THIS TYPE OF COACHING (OUT OF 10)

Good nutrition and physical activity, both essential to health, are less common within the population with SMI than among the general population. In addition, the majority of individuals with SMI smoke, and **tobacco-related conditions account for approximately half of all deaths** in this population. The great majority of Centers provided coaching in smoking cessation, healthy nutritional habits, and exercise. Both patients and providers reported that individuals' **benefits extended beyond clinical indicators to quality of life** factors such as reduced stress about getting primary care, clearer thinking, and better sleep.

Screening for disease conditions and risk factors increased

Although people with SMI have a greater risk of developing chronic conditions such as diabetes, hypertension, and cardiovascular disease, research has found that patients with SMI have lower rates of preventive screening than other patients. Centers achieved **very substantial increases in screening rates** for body mass index, blood pressure, smoking, and diabetes for their patients during integrated care. Projects that directly employed primary care practitioners had higher screening rates for body mass index and blood pressure than did sites that contracted with independent primary care providers. This may reflect generally better access to patient information at these sites, or other aspects of fuller integration.

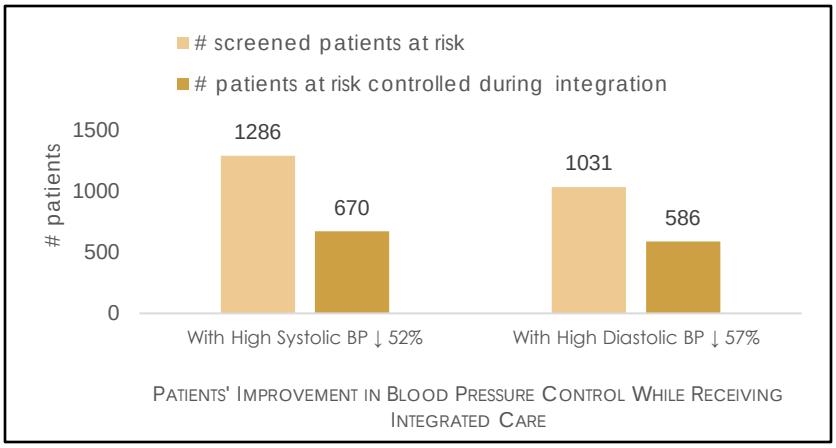


# Screened Increase in screening	3,700→16,000 BMI ↑ 4X	1,000→11,500 Smoking ↑ 10X	3,700→16,000 Hypertension ↑ 4X	20→1,500 Diabetes ↑ 78X

Patients had improved health

Among patients with initially **elevated blood pressure**, more than half had values demonstrating **controlled blood pressure within the first 90 days** of integrated care.

This is a major accomplishment, given that hypertension is predictive of serious cardiac and circulatory system conditions. Projects that directly employed primary care providers averaged better rates of blood pressure control than did Centers that contracted with independent primary care providers.



PATIENTS' IMPROVEMENT IN BLOOD PRESSURE CONTROL WHILE RECEIVING INTEGRATED CARE

Patients had fewer hospital encounters and shorter lengths of stay

Among patients who had at least one hospital encounter during the study period, in the first year of integrated care the **probability of hospital encounters decreased by 18 %**, after controlling for other factors such as patient severity, insurance status, and demographics (p< .001).

The **average length of stay was also almost a third shorter** during the first year of integrated services, compared to the prior year (p< .001). Overall, this study found significant decreases in hospital use for patients receiving integrated care as well as shorter lengths of stay; together the magnitude of the effects and their strong statistical significance suggest that integrated care significantly reduced hospital use.

HOSPITAL ENCOUNTERS

18 %

LENGTH OF STAY

32 %

Decreased hospital use meant substantial cost savings

For individuals with any hospitalizations during the study period, **less frequent hospital use** after receiving integrated care was associated with **cost savings that exceeded $1,000 per year per patient**.

In addition, the **1/3 reduction in length of stay** yielded **savings of more than $1,200 per hospitalization** from the accommodations portion of hospital costs alone.

LESS FREQUENT HOSPITAL USE WAS ASSOCIATED WITH COST SAVINGS OF MORE THAN $1,000/YEAR/PATIENT + SAVINGS FROM SHORTER LENGTH OF STAY

Fewer hospitalizations = $1000+ savings / year / patient

30% shorter stays = $1200+ savings / hospitalization

Next steps

The Centers participating in this study have a **wealth of raw data.** However, they currently have limited funding, through Medicaid Waiver Delivery System Reform Incentive Payments, to use the data for quality improvement and reporting. Given additional resources, for some Centers, the next step in analytic capacity development may be to store patient data in a digitally accessible manner. To facilitate analyses including patients from multiple sites, Centers may want to **identify common patient satisfaction, health, functioning, and cost measures**, as well as more consistent data on patient attributes and services. This may be particularly useful for smaller Centers that would not have sufficient sample sizes for some analyses on their own.

Future research should test the impact of integrated care through studies that include comparison groups, in order to further understand the causal relationships between integration and outcomes. A practical starting point may be for Centers providing integrated care to improve shared access to electronic records and to agree with other Centers on standardized record formats, so that future studies can more easily combine data bases from multiple sites for analyses. Results may be used for quality improvement, as well as to **demonstrate the value of integrated care to payers and other external stakeholders**.

Acknowledgements

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