EXPANDING INTEGRATED CARE MODELS TO ADDRESS CULTURAL COMPETENCE AND PUBLIC HEALTH

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OVERVIEW

• Problems/Challenges
• Integrated Care Defined
• Cultural Competence and Integrated Care
• Public Health/Social Determinants of Health
• Future Directions
PROBLEMS/CHALLENGES

• The Rise of Chronic Disease
• Multiple Chronic Conditions
• Increasing Complexity
• Poor Access to Care
THE RISE OF CHRONIC DISEASE
WHAT IS CHRONIC DISEASE?

- Non-communicable illnesses that are prolonged in duration, do not resolve spontaneously, and are rarely cured completely (CDC)
- Diseases of long duration and generally slow progression (WHO)
- Those conditions that last a year or more and require ongoing medical attention and/or limit activities of daily living

EXAMPLES OF CHRONIC DISEASES

- Cardiovascular Disease
- Cancer
- Diabetes
- HIV/AIDS
- Hypertension
- Obesity
- Depression
- Schizophrenia
- Dementia
CHRONIC DISEASES

• **Leading cause of mortality in the world**
  • Represents 63% of all deaths

• **Causes 7 in 10 deaths each year** in the United States

• **133 million Americans** (almost 1 in 2 adults) live with at least one chronic illness

• More than **75% of health care costs** are due to chronic conditions

• Affect people of all ages throughout the lifespan

AN UNHEALTHY AMERICA: 
THE ECONOMIC IMPACT OF CHRONIC DISEASE

Number of Reported Cases

- Pulmonary
- Hypertension
- Mental Disorders
- Heart Disease
- Diabetes
- Cancer
- Stroke

Reported Cases in Millions

Milken Institute, 2003
MULTIPLE CHRONIC CONDITIONS
MULTIPLE CHRONIC CONDITIONS (MCC)

• Defined as more than one chronic condition
• Major public health and medical challenge
• The number of chronic conditions is directly related to risk of adverse outcomes:
  • Mortality
  • Poor functional status
  • Unnecessary hospitalizations
  • Adverse drug events
  • Duplicative tests
  • Conflicting medical advice
PREVALENCE OF MCCS

• 21% (63 million) of Americans had more than one chronic condition in 2005

• Risk of MCC increases with age:
  • 62% of Americans over 65 have MCC
  • Projected to reach 81 million Americans by 2020
  • 23% of Medicare beneficiaries have 5 or more chronic conditions

GENERAL ASSISTANCE - UNEMPLOYABLE (GA-U) PROGRAM IN WASHINGTON STATE

Co-occurring Diagnoses and the GA-U Population

52 percent had substance abuse or mental illness identified
31 percent had a chronic physical condition only

Chronic Physical Condition
- Chronic Physical Only 31%
- Chronic Physical + AOD 11%

Alcohol/Drug Problem
- AOD Only 5%
- AOD + MI 3%

Mental Illness
- MI Only 5%
- Physical + MI 14%

ALL THREE 13%

Disease Conditions
- Chronic Physical 69%
- Mental Illness 36%
- Substance Abuse 32%

Sources: MMIS claims, TARGET service encounters, and WSP arrest records, FY 2003-04. Chronic physical and mental illness diagnosis groups derived from CDPS grouper.
COMORBID PHYSICAL AND MENTAL HEALTH CONDITIONS

- Chronic Pain
- Asthma
- CAD
- Cancer
- Arthritis
- Diabetes
- HTN

2006 Milliman, Inc US Health Care Study
WHY ARE RATES OF COMORBIDITY SO HIGH?

• High prevalence of mental disorders and other chronic conditions
• Having a mental health disorder is a risk factor for developing another chronic condition (and vice versa)
• The pathways causing comorbidity are complex and bidirectional

MENTAL AND MEDICAL DISORDER INTERACTIONS – COMPLEX AND BIDIRECTIONAL

INCREASING COMPLEXITY
COMORBIDITY IS THE RULE

• Gone are the days of patients with one chronic condition
• Co-morbidity is the rule, not the exception
• Complexity involves unique challenges:
  • Prioritizing treatment
  • Polypharmacy
  • Coordinating care
THE ORIGINS OF COMPLEX PATIENTS

• Lack of emphasis on prevention
• People are living with one or more chronic conditions longer
• As our ability to treat disease improves, diseases that were previously acute and lethal have become chronic diseases
Remember the Red Ribbon?

**Put it back on**

**TAKE ACTION**

**AIDS IS NOT OVER!**

**Be Positively Aware!**
THE HYPOTHETICAL PATIENT

- 79 year old woman with COPD, diabetes, osteoporosis, HTN, and osteoarthritis
- Aggregated the evidence-based recommendations of clinical practice guidelines (CPGs)
  - Most CPGs did not discuss how their recommendations apply to older patients with multiple comorbidities
  - Most CPGs did not comment on short and long term goals of treatment
- If recommendations were followed, the hypothetical patient would be prescribed 12 medications ($406/month) and complicated non-pharmacological interventions
- Drug and disease interactions could occur
- Adhering to current CPGs could lead to poorer quality of care in complex patients

Boyd et al Clinical Practice Guidelines and Quality of Care for Older Patients with Multiple Comorbid Diseases. JAMA 2005.
POOR ACCESS TO CARE
CAUSES OF POOR ACCESS

• Lack of Insurance Coverage
• Inequalities in Coverage/Mental Health and Substance Abuse Parity
• Stigma and Treatment-Seeking Behaviors
~48 million people were without health insurance in 2012 (about 15% of the US population)

Among people with serious mental illness, 20% are uninsured.

McAlpine DD, Mechanic D: Utilization of specialty mental health care among persons with severe mental illness: The roles of demographics, need, insurance, and risk. Health Serv Res 35:277, 2000
The CBO estimates that **25 million** of the uninsured will gain coverage by 2023.
In states that do not expand Medicaid under the ACA, there will be large gaps in coverage available for adults.

NOTE: Applies to states that do not expand Medicaid. In most states not moving forward with the expansion, adults without children are ineligible for Medicaid.
“...a psychopathic, mass-murdering, schizophrenic clown with zero empathy”
“In this team-based model, medical and behavioral health providers partner to address both the physical and mental health needs of their patients.”
No Wrong Door
CONTINUUM OF INTEGRATION

Separate  Referral  Coordinated  Collaborative  Integrated

Separate  Co-Located  Common
WHY INTEGRATED CARE?

- Half of the care for common mental disorders is delivered in general medical setting
- Primary care providers prescribe the majority of psychotropic drugs for children and adults
- However, mental disorders often go undiagnosed, untreated, or under-treated in primary care
- When mental illness is recognized, it is not always adequately treated in the primary care setting, and referrals from primary care to specialty mental health care are often not completed
WHY INTEGRATED CARE?

• Mental health and substance use disorders can influence the onset, course, and outcomes of both physical and mental illnesses

• Poor physical health is 3 times more common among people who report significant emotional distress

• Promoting positive mental health is significant to overall health (for both physical and mental disorders)

• Among individuals with serious mental illnesses, nearly half have at least one chronic illness severe enough to limit daily functioning
WHY INTEGRATED CARE?

- Integrated Care Models have been proven effective
- Effective bi-directional integrated models exist
- Effective integration of substance use disorders in primary care settings exist
- Integrated Care models are highly supported by Health Care Reform
FOUR QUADRANT INTEGRATION MODEL

Quadrant II
- Behavioral Health Risk High, Primary Care Health Risk Low
- CMH or PCP Medical Home

Quadrant IV
- Behavioral Health Risk High, Primary Care Health Risk High
- CMH and PCP Co-managed Care

Quadrant I
- Behavioral Health Risk Low, Primary Care Health Risk Low
- PCP Medical Home

Quadrant III
- Behavioral Health Risk Low, Primary Care Health Risk High
- PCP Medical Home
Collaborative Care Team Structure

- Patient
- PCP
- BHP/Care Manager
- Consulting Psychiatrist
- Other Behavioral Health Clinicians

New Roles
Core Program
Additional Clinic Resources
Outside Resources

Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources

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“No matter how brilliant your mind or strategy, if you’re playing a solo game, you’ll always lose out to a team.”

- Reid Hoffman, co-founder, LinkedIn
One in ten older adults visiting a physician suffers from depression

IMPACT Team Care doubles the effectiveness of depression treatment

Quick Links

Get to the information you need by using the quick links below to some of the most popular pages.

Evidence base for IMPACT
IMPACT key components
Tools (manuals, videos, etc.)

Online training
IMPACT in the media
IMPACT patients’ stories featured in The John A. Hartford Foundation’s annual report

Success Stories from Across the Country

Read about how organizations across the US are having success with the IMPACT program. Click on the map to learn more.

Thank You

Most IMPACT materials, training, consultation and other assistance to adapt and implement IMPACT are offered FREE thanks to the generous support of the JOHN A. HARTFORD FOUNDATION, which is dedicated to improving health care for older Americans.

Site most recently updated: 6/6/2012

Tell us your story

Are you adapting or implementing IMPACT? We would like to hear your experiences with IMPACT.
“REVERSE” INTEGRATION

- Embedding primary care providers into behavioral health settings
- Less evidence that integrated care, but preliminary findings have shown an increase in overall health of patients
- SAMHSA PCBHI Grants – mixed outcomes
The Primary Care Access, Referral, and Evaluation Study

Medical Care Management Intervention

Increase in recommended preventive services (58.7% vs. 21.8%)

Higher proportion of evidence-based services for cardiometabolic conditions (34.9% vs. 27.7%)

Increased likelihood of having a primary care provider (71.2% vs. 51.9%)

Improved mental health-related quality of life

COORDINATED CARE

- Tracking & Confirmation of Referrals & Follow-up
- Sharing of Medical Records
- Sharing of Prescribing Changes & Medication Lists
- Inter-Operable Electronic Health Records
- Mutual Participation in Effective Health Information Exchange
COLLABORATIVE CARE

• All of the Above plus . . .
  • Team-Based Case Conferences
  • Frequent Interaction on Therapeutic Strategy
  • Patient-Centered, Shared Decision-Making
  • Shared Care Management
  • Joint Decision-Making on Medication Changes
  • Frequent, secure communication by phone, e-mail, & videoconferencing
BARRIERS TO EFFECTIVE IMPLEMENTATION
CULTURAL BARRIERS

Mental health and primary care delivery systems have, by virtue of their histories and the patients they treat, evolved to operate quite differently.
“Today’s mental health care system is a patchwork relic—the result of disjointed reforms and policies. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities...The time has long passed for yet another piecemeal approach to mental health reform.”

-New Freedom Commission on Mental Health, 2003
MOVING BEYOND DISEASE-SPECIFIC INTEGRATION MODELS

• Evidence for integrated treatment of depression and anxiety is very strong
• Evidence is slowly mounting for other behavioral health disorders
• Substance use disorders must be integrated more effectively into these models
WHAT IT WILL TAKE

• Implementation – Adopting evidence-based practices on a large scale
• Workforce Flexibility – in training, skills, and practice
• An ability to troubleshoot to solve systems-level challenges that will continue to evolve
• Shifting to a chronic care, recovery oriented approach
• A public health, population-based approach to health care
“Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender.”
MENTAL HEALTH DISPARITIES – BY RACE/ETHNICITY

Racial/Ethnic Minority Populations:
• Have **less access** to and availability of care
• Receive generally **poorer quality** mental health services
• Experience a **greater disability** burden from unmet mental health needs
DISPARITIES IN PERCENTAGE OF UNINSURED BY RACE/ETHNICITY
PERCENTAGE OF PEOPLE WITH NO ACCESS TO ALCOHOLISM, DRUG ABUSE, OR MENTAL HEALTH CARE AMONG THOSE WITH PERCEIVED NEED
Reasons for Not Receiving Mental Health Services in the Past Year among Adults Aged 18 or Older with an Unmet Need for Mental Health Care Who Did Not Receive Mental Health Services: 2010

- Could Not Afford Cost: 43.7%
- Could Handle Problem without Treatment: 32.2%
- Did Not Know Where to Go for Services: 20.5%
- Did Not Have Time: 14.6%
- Did Not Want Others to Find Out: 10.0%
- Might Cause Neighbors/Community to Have Negative Opinion: 9.9%
- Treatment Would Not Help: 9.8%
- Concerned about Confidentiality: 9.4%
- Health Insurance Did Not Cover Enough Treatment: 9.4%
- Did Not Feel Need for Treatment: 9.4%
- Might Have Negative Effect on Job: 8.3%
- Health Insurance Did Not Cover Any Treatment: 7.8%
- Fear of Being Committed/Having to Take Medicine: 7.6%
OUTPATIENT MENTAL HEALTH VISITS BY PROVIDER TYPE

Percentage

- PCP Visits
- Psychiatrist Visits
- Other Provider Visits

African American

White
PUBLIC HEALTH / THE SOCIAL DETERMINANTS OF HEALTH
THE PUBLIC HEALTH APPROACH TO MENTAL HEALTH

- Recognizes the interrelatedness of mental health and physical health
- Focuses on prevention and promotes mental health across the lifespan
- Identifies risk and protective factors
- Provides people with the knowledge and skills to maintain optimal health and wellbeing
- Brings together individuals, communities, and a variety of systems to work collaboratively towards better mental health for all
Individuals with serious mental illnesses die, on average, 25 years earlier than the general population.
AVERAGE LIFE EXPECTANCIES (WORLDWIDE)

- Japan
- Australia
- Canada
- United Kingdom
- United States
- Mexico
- Egypt
- Haiti
- Iraq
- Sudan
- South Africa
- Nigeria
- Mozambique
- Serious Mental Illness (US)

Legend:
- Overall
- Male
- Female
SOCIAL COMPLEXITY

• The psychological and social factors that contribute to poor health
• These factors tend to cluster together – syndemics
• The social determinants of health
SOCIAL DETERMINANTS OF HEALTH

• Those factors that impact upon health and well-being: the circumstances into which we are born, grow up, live, work and age, including the health system

• These circumstances are shaped by the distribution of money, power, and resources at global, national and local levels, which are themselves influenced by policy choices

• The social determinants of health are mostly responsible for health inequities
THE CAUSES OF THE CAUSES

“The Fundamental Causes of Disease”

If risk factors are the precursors of disease, then the environmental and contextual factors that precede or shape these risk factors are the causes of the causes.

Triple Aim

- Improve Population Health
- Improve Patient Satisfaction
- Reduce Costs of Care
G X E = Gene by Environment Interactions

Conceptualizing the Social Determinants of Mental Health
Doctors often act as though their professional responsibility does not go beyond the sick and the nearly sick (those at imminent risk), and politicians, who influence health more than the doctors, are rarely troubled by thoughts of the distant future.
THE INTEGRATED CARE WORKFORCE

• Health educators
• Primary care behavioral health specialists
• Expanded role care managers
• Consultation-liaison clinicians
INTEGRATED CARE
SYNERGIES
INTEGRATED CARE
SOCIAL
HEALTH
E-health
diagnosis
SMARTCARE
patient needs
management
savings
rehabilitation
regional systems
Response
Services
ICT
links
Active and Healthy Ageing
Electronic health record
closing the gap
Policymakers
accessing care
vulnerable groups
treatment
Wellbeing
delivery
EFFICIENCY
nurses
individuals
challenges
savings
region
PERCENTAGE OF US MENTAL HEALTH WORKFORCE ACCORDING TO RACE/ETHNICITY

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OPPORTUNITIES AND FUTURE DIRECTIONS
DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP)

• CMS section 1115 demonstration waiver authority
  • Permits and supports innovation in Medicaid and the Children’s Health Insurance Program (CHIP)
  • Innovations concern:
    • service delivery
    • coverage of expansion populations and new types of service
    • payment approaches designed to align financial incentives with program improvement goals
GOALS OF DSRIP

1. Transform the health care safety net at the system and state levels
2. Reduce avoidable hospital use and improve other health and public health measures at both the system and state levels
3. Ensure delivery system transformation continues beyond the waiver period by leveraging managed care payment reform
4. Near term financial support for vital safety net providers
5. Create a more cost efficient Medicaid program with improved outcomes
6. Assure access to quality care for Medicaid members and long-term delivery reform through managed care payment reform
SUCCESS IN ADDRESSING THE SOCIAL DETERMINANTS OF BEHAVIORAL HEALTH

- Nurse-Family Partnerships
- High/Scope Perry Preschool Program and Head Start
- Good Behavior Game
- Health Leads
- Medical-Legal Partnerships
“It always seems impossible until it’s done.”

~ Nelson Mandela