INTEGRATING MENTAL HEALTHCARE AND PRIMARY CARE IN THE HOUSTON AREA

A Report of the Mental Health Policy Analysis Collaborative of UTHealth Houston July 2011

MEMBERS

William B. Schnapp, Ph.D.

University of Texas Medical School at Houston

(Director)

John W. Burruss, M.D.

Baylor College of Medicine

Scott Hickey, Ph.D.

University of Texas School of Public Health at Houston

Mental Health and Mental Retardation Authority

of Harris County

Karoline Mortensen, Ph.D.

University of Maryland

Paul R. Raffoul, Ph.D.

Graduate College of Social Work

University of Houston

The Mental Health Policy Analysis Collaborative is funded through a generous grant from Houston Endowment Inc.

TABLE OF CONTENTS

EXECUTIVE SUMMARY 4
I. INTRODUCTION 5
II. THE ARGUMENT FOR INTEGRATED CARE 6
III. THE HOUSTON SITUATION 8
IV. STEPS TOWARD INTEGRATION 10
V. CONCLUSION 12

INTEGRATING MENTAL HEALTHCARE AND PRIMARY CARE IN THE HOUSTON AREA

EXECUTIVE SUMMARY

Over the past two decades, a significant amount of work has been done to bring some rapprochement to the practices of primary care and mental healthcare. This is far from a simple matter as the style and emphasis of the two practices can be quite different. While primary care practice focuses on multiple medical issues, health maintenance, and structured diagnostic procedures, mental healthcare systems have employed multidisciplinary teams, group care, and case management. Forcing the issue of reintegration has been the growing "recognition of the central role played by primary care doctors in managing common mental health problems," (Gask, 2005) coupled to the awareness that mental disorders interact with other health conditions and, as stated in a pivotal article in The Lancet, there is "No health without mental health" (Prince, 2007).

A great deal of integration has already occurred within the public healthcare system in Houston, primarily through the realization of integration within the large Harris County Hospital District (HCHD) and Veterans Affairs (VA) public systems and more recently by placement of primary care clinicians within some of the Mental Health and Mental Retardation Authority (MHMRA) clinics. The greatest current opportunity lies in inter-institutional integration such that the specialty mental healthcare system and primary care systems are as indistinguishable as possible. Several achievable milestones will facilitate the desirable integration of Houston's public primary care and specialty mental healthcare systems. These include the following.

1. Comprehensive Eligibility
2. Shared Medical Information
3. Data Collection and Outcome Tracking
4. Co-localization
5. Case Management
6. Joint Educational Programs
7. Clear Protocols for Placement in the Proper Level of Care
8. Ongoing Interagency Collaboration

I. INTRODUCTION

Previous studies of the Mental Health Policy Analysis Collaborative (MHPAC) have analyzed various aspects of Houston's public mental health services. Reports have been published on the consequences of untreated mental illness, finance methodology, service rationing, veterans, and Medicaid. Among the major findings of these reports were:

- Untreated mental illness is costly in human and economic terms.
- While multiple federal, state and county sources fund mental health services in Houston, our services are insufficient to meet the needs of many people.
- Federal and State public mental health services are largely rationed to indigent people with serious, often chronic, mental illnesses.
- While humane, this policy results in insufficient early intervention services for those people who are moderately ill.
- The result of this practice is that many people cannot access services until their illnesses become more serious (and consequently more difficult and more expensive to treat).
- Medicaid improves access to healthcare and reduces crisis care utilization and criminal justice involvement.

This report will examine the benefits and challenges of integrated primary and mental healthcare and offer some potential steps that could be taken in the Houston area to realize a more integrated delivery system.

II. THE ARGUMENT FOR INTEGRATED CARE

There have been valid reasons in the past, and perhaps even continuing today, for segregating the funding for mental healthcare from that for primary and other forms of medical care. In many instances, this separation preserved the dollars that were dedicated to mental healthcare such that they were not consumed by other healthcare needs that were thought to be more pressing. As the validity and seriousness of mental illnesses has been better established and accepted, this segregation has become less necessary and will likely be unnecessary altogether in the foreseeable future.

Along with financial isolation tended to come geographic and professional isolation such that the providers of the great majority of the basic care for mental conditions, the primary care clinicians, and the specialty providers of mental healthcare were neither located together nor effectively conversant with each other. The resultant healthcare landscape included primary care clinics that housed general practitioners, family medicine doctors, general internists, and often obstetrician-gynecologists and mental health clinics that contained therapists, psychologists, psychiatrists and social workers. Though putatively useful to protect the funding for mental healthcare, this arrangement almost certainly accentuates the stereotypes that are inherent in the mental health professional and patient arena and heightens the stigma associated with seeking care for mental illness.

Over the past two decades, a significant amount of work has been done to bring some rapprochement to the two practices (Thielke, Vannoy et al. 2007). This is far from a simple matter as the style and emphasis of the two practices can be quite different. While primary care practice focuses on multiple medical issues, health maintenance, and structured diagnostic procedures, mental healthcare systems have employed multidisciplinary teams, group care, and case management (Thielke, Vannoy et al. 2007). Forcing the issue of reintegration has been the growing “recognition of the central role played by primary care doctors in managing common mental health problems,” (Gask, 2005) coupled to the awareness that mental disorders interact with other health conditions and, as stated in a pivotal article in The Lancet, there is “No health without mental health” (Prince, Patel et al. 2007).

A review of the work done in this area further illustrates the complexity of the task, showing that there are many types of attempted integration of care that have not been successful in improving mental health outcomes. For example, neither enhanced referral strategies nor simple co-location of mental healthcare providers alongside primary care clinicians have proven to improve mental health outcomes (Thielke, Vannoy et al. 2007; Williams, Shore and Foy, 2006). Programs that have shown to be successful build on ease of access and familiarity of co-location by including the following:

1) Integration of the strengths of primary care – systematic measurement of key health outcomes, stepped care approaches to treating chronic conditions;
2) Apply the strengths of specialty mental healthcare – multidisciplinary approach and implementation of psychosocial treatments in addition to medicine;
3) Employ evidence-based approaches to the management of chronic medical conditions, such as care managers (Thielke, Vannoy et al. 2007).

And the "essential elements" of effective collaborative care are as follows:

1) Support of medication management by primary care providers
2) Case Management
3) Supervision of care managers by consulting psychiatrists (Thielke, Vannoy et al. 2007; Williams, Shore and Foy, 2006).

When these criteria are met, there have been significant results to improve the treatment outcomes of mental illness with regard to functional status, patient satisfaction, and work outcomes (Williams, Gerrity, et al. 2007; Druss, B. G., vonEsenwein, S.A., et al., 2010). Better outcomes have also been proven in children (Williams, Shore and Foy, 2006), the elderly and particularly African-Americans (Unutzer, Katon, et al. 2002; Ayalon, Arean et al. 2007). Additionally, when fully implemented, programs to integrate care have proven to be cost-effective, though they have not been shown to reduce overall healthcare costs, (Katon, Schoenbaum et al. 2005; Thielke, Vannoy, et al. 2007). Finally, there is also data to support that treatment of substance abuse disorders in primary care settings results in improved outcomes (Ayalon, Arean et al. 2007).

III. THE SITUATION IN HOUSTON

Houston's public primary care delivery system consists of the Harris County Hospital District's Community Health Program (CHP) clinics, the Veteran's Affairs Community Based Outpatient Centers (C-BOCs) and the many free-standing and generally independent medical clinics that are often Federally Qualified Healthcare Centers (FQHCs) or "Look-Alikes." These can all be considered public as they receive portions of their operating funding directly from federal, state, and/or county tax revenues while they are also treated favorably within several areas of legislative cost relief such as the 340B Drug Pricing Program.

The Hospital District operates twelve community-based medical centers and nine school-based clinics that are spread throughout Harris County in addition to a pediatric specific clinic in Pasadena. Another facility, the Thomas Street Clinic, provides primary care for those infected with HIV. While there is some primary care delivered in the HCHD's three hospitals (Ben Taub General Hospital, Lyndon B. Johnson General Hospital (LBJ), and Quentin Mease Community Hospital), by far the majority is provided in these clinics. Of the twenty-three facilities, seventeen offer onsite, integrated mental healthcare. Those that do not, all of which are school-based clinics, are limited by their available space. The system as a whole delivers over a million annual patient contacts, and a recent study by one of the authors (Cully, Molinari et al. 2005) reported that between 20-25% of all visits were for a mental health diagnosis as either primary or secondary.

The VA's primary care system is based both in its main hospital, the Michael E. DeBakey Medical Center (MEDVAMC), and within the seven C-BOC's, most of which are outside of the Harris County boundaries. Almost one million primary care visits are provided throughout the system, the vast majority within the main campus of the MEDVAMC. As with the Hospital District, all of the VA facilities include onsite, integrated mental healthcare.

Harris County is also home to over 65 Primary Safety-Net Sites that offer predominately primary care for indigent and uninsured patient populations. Twenty-four of these clinics have achieved FQHC sites of services designation which brings with it a direct cash payment for operating support as well as enhanced Medicaid reimbursement, favorable malpractice treatment, and access to lowest cost drug procurement programs (the 340B program). One other is designated as a FQHC “Look-Alike” clinic which provides for enhanced Medicaid payments and 340B drug pricing, but does not provide the cash grant for operating costs nor the malpractice coverage advantages. Approximately 500,000 visits a year are provided to all Primary Care, Safety-Net sites. There is a loose organizational structure provided through the Harris County Healthcare Alliances’ Partners for Community Health, but these medical facilities remain for the large part independent. Less than 25 percent of these facilities provide onsite, integrated mental healthcare. Most have been constrained by the availability and cost of specialist mental health providers.

The primary component of Houston’s public mental healthcare system outside of the HCHD and VA is the Mental Health and Mental Retardation Authority of Harris County (MHMRA). This publically funded agency is comprised of four adult outpatient centers and three centers for children, all of which focus exclusively on mental healthcare. There were 619,261 outpatient encounters provided in 2010 throughout the organization.

Recently MHMRA partnered with EL Centro de Corazon, an FQHC, to deliver co-located integrated mental health and primary healthcare services. El Centro is now providing primary healthcare in MHMRA’s mental health outpatient service center at Ripley Clinic. This service benefits MHMRA’s patients and their family members.

IV. STEPS TOWARD INTEGRATION

A great deal of integration has already occurred within the public healthcare system in Houston, primarily through the realization of integration within the large HCHD and VA public systems and more recently by placement of primary care clinicians within some of the MHMRA clinics . The greatest current opportunity lies in inter-institutional integration such that the specialty mental healthcare system and primary care systems are as indistinguishable as possible. Several achievable milestones will facilitate the desirable integration of Houston's public primary care and specialty mental healthcare systems.

1. Comprehensive Eligibility wherein a patient's eligibility with one system assures eligibility within as many others as possible will greatly facilitate the achievement of integrated care across institutional borders. There has been an ongoing effort over many years by the "Quad Agencies" (HCHD, MHMRA, Harris County Health Department, and City of Houston Health Department) to implement joint eligibility across their institutions. As of this writing, however, this important milestone has yet to be reached.
2. Shared Medical Information is another important element of integrated care. Though the various public agencies utilize different electronic health record systems, there are many options to provide access to critical medical information between providers so that primary care clinicians are able to best manage and coordinate a patient's care. Attention must be paid to HIPAA compliance in any inter-agency health information solution but there have been successful systems who have addressed this critical need, paving the way for Houston to do likewise.
3. Data and Outcome Tracking across systems becomes possible when there is medical information sharing between agencies and allows systematic adjustment of healthcare strategies to achieve optimal recovery in all areas of healthcare.

4. Co-localization of primary care and specialty mental healthcare providers, while insufficient on its own to improve outcomes, is a necessary first step in achieving the necessary integration that will improve care. The many public providers of both primary and mental healthcare already operate a large number of clinics throughout the Houston area. It is questionable as to whether further “bricks and mortar” expenditures are warranted until all of the existing facilities offer a full array of integrated primary and mental healthcare options. In many cases, this will involve implementing primary care onsite within mental healthcare clinics. In other cases, it may involve provider cost offsets through rent/space arrangements so that a mental health team can co-locate within a free-standing primary care clinic.
5. Case Managers must be included within the integrated care model. In order to realize the improved outcomes and cost-effectiveness that is possible with this model, this type of professional is indispensible. These personnel should be supervised by psychiatrists and should teach and emphasize self-management to patients.
6. Joint Educational Programs to enhance the primary care physician’s comfort with mental health diagnosis and treatment and the mental healthcare provider’s familiarity with health maintenance and chronic disease management. Highly effective, evidence-based strategies should be introduced and reinforced with the outcomes data collected across systems.
7. Clear Protocols for implementing and “stepping down” higher levels of specialist care should be in place to maximize the availability of the scarcer providers and allow access for the greatest number of persons.
8. Ongoing Interagency Collaboration between MHMRA, HCHD, the VA and FQHC’s through joint planning, data sharing and interagency agreements will promote continuity of care and clinical and cost effective service delivery.

V. CONCLUSION

There is strong evidence that integration of primary care and specialty mental healthcare in the collaborative model leads to better outcomes for patients and enhanced provider satisfaction. Houston and Harris County face substantial challenges in healthcare delivery, but a great opportunity exists to implement this integration in a way that is cost effective while delivering higher quality care to those served within the public systems.

References

Ayalon, L., P. A. Arean, et al. (2007). “Integration of mental health services into primary care overcomes ethnic disparities in access to mental health services between black and white elderly.” Am J Geriatr Psychiatry 15(10): 906-12.

Cully, J. A., V. A. Molinari, et al. (2005). “Utilization of emergency center services by older adults with a psychiatric diagnosis.” Aging Ment Health 9(2): 172-6.

Druss, B. G., vonEsenwein, S.A., et al. (2010). “A randomized trial of medical care management for community mental health settings: The primary care access, referral, and evaluation (PCARE) study.” Am J Psychiatry 167: 151-159.

Gask, L. (2005). “Overt and covert barriers to the integration of primary and specialist mental health care.” Social Science & Medicine (1982) 61(8): 1785-94.

Katon, W. J., M. Schoenbaum, et al. (2005). “Cost-effectiveness of improving primary care treatment of late-life depression.” Archives of General Psychiatry 62(12): 1313-20.

Prince, M., V. Patel, et al. (2007). “No health without mental health.” Lancet 370(9590): 859-77.

Simon, G. E., W. J. Katon, et al. (2001). “Cost-effectiveness of a collaborative care program for primary care patients with persistent depression.” The American Journal of Psychiatry 158(10): 1638-44.

Thielke, S., S. Vannoy, et al. (2007). “Integrating mental health and primary care.” Prim Care 34(3): 571-92, vii.

Unutzer, J., Katon, W. et al. (2002). “Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. JAMA 288(22): 2836-2845.

Williams, J. S. Shore, S.E. and Foy, J.M. (2006). “Co-location of mental health professionals in primary care settings: Three North Carolina models.” Clinical Pediatrics 45: 537-543.

Williams, J.W., Gerrity, M. et al. (2007). “Systematic review of multifaceted interventions to improve depression care.” General Hospital Psychiatry 29: 91-116.