Integrated Care

Comorbidity, the co-occurrence of mental and physical disorders in the same person, is a well-established clinical and public health fact. The National Comorbidity Survey Replication for 2001–2003 indicated that more than 68% of persons with mental disorders reported having one or more general medical disorders, and 29% of those with medical disorders had a comorbid mental disorder (1). Diabetes, cardiovascular disease, and pulmonary disease are the most common illnesses among persons with psychiatric disorders.

From a population perspective, individuals with mental disorders have a twofold to fourfold elevated risk of premature mortality. These deaths are due to "natural causes" (such as cardiovascular disease) rather than suicide. In a multistate study of mortality data from 1997 to 2000, public-sector patients were found to die 25 years earlier on average than the general population (2).

Despite these facts, systems of care that treat individuals with serious mental illness are separate from general medical systems of care. From the mid-19th to the mid-20th century, psychiatric care took place in institutions, primarily state hospitals. Since the 1960s, most care has occurred in community settings, such as community mental health centers, day programs, nursing homes, and homeless shelters. These are separate mental health specialty programs; physical health care takes place elsewhere or not at all. Federal and state financing have reinforced two separate systems of care—one for mental health, one for physical health.

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In this issue of the *Journal*, Druss et al. (3) report on a single-site randomized controlled trial of medical care management for individuals with serious mental illness treated in a community mental health center. This intervention consisted of registered nurses educating and coaching patients and assisting with visits to comprehensive primary care services. A usual care comparison group was given a list of primary care programs in the community and referred to these programs. Individuals who received medical care management had sustained improvements in their quality of life as a result of improved quality of medical care relative to the comparison group. The authors also compared the clinical as well as the financial sustainability of the intervention after 2 years. From the broad perspective of the health system, the intervention was cost-effective—that is, positive outcomes were complemented by decreased costs during the study period. From the perspective of the clinic itself (that is, the managers who must cope with budget realities and financial losses), it was not sustainable. After the 2-year project and the lapse of the grant, the program was abandoned.

The population studied was primarily African American and poor. There was 40% coverage by Medicaid, so nearly 60% were uninsured. This lack of insurance coverage was the primary reason for the lack of financial sustainability.

There are a number of models for integrating medical, mental health, and substance use services: models within a single organization that provides all services; a partnership model in which primary care staff are embedded in a community mental health or-

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ganization, or the opposite, where mental health staff are embedded in a primary care setting; and the model described in the Druss et al. article, a facilitated referral model that coordinates referrals to primary care, shares information with primary care, and helps educate patients about their health needs.

It is no surprise that the facilitated referral model Druss et al. describe failed to sustain itself beyond the grant period despite evidence of its cost-effectiveness. The large numbers of uninsured patients receiving care in this community mental health center destroyed its prospects for sustainability. The primary goal of the Affordable Care Act passed and signed by President Obama in 2010 is to decrease the number of uninsured Americans. The expansion of Medicaid to 133% of the poverty level and the creation of health insurance exchanges for uninsured middle-class Americans with subsidies should accomplish that goal. Political opposition may undermine the funding of the Affordable Care Act and its ability to decrease the number of uninsured. Even if this opposition is overcome, increased numbers of insured is a necessary but not sufficient reform to increase opportunities for integrated mental and physical health care. Programs and concepts contained within the Affordable Care Act (such as the primary care medical home and the accountable care organization [ACO]) have the potential to bring together both mental health and physical health services. Medical homes and ACOs could focus on the seriously mentally ill as fee-for-service migrates to bundled payments. These entities have clearly developed objectives and quality goals with rewards for certain outcomes, and they could move the delivery system substantially toward integration of physical and mental health. Bringing primary health care services into the community mental health center and bringing mental health services into primary care are needed changes as part of health care system reform. But they are also hostage to the issue of whether there will be enough funds to implement these service delivery innovations.

Our science tells us that it makes it little sense to split the mind and the body. Serious mental disorders are brain (body and mind) disorders requiring multiple pharmacologic and nonpharmacologic interventions. We also know that compromised brain function leads to compromises in other parts of the body, and there is the added factor that psychopharmacology can create metabolic and cardiovascular risks. Health system reform can make a difference in the lives and lifespans of patients with serious mental illness by bringing together their psychiatric and general medical care. Access to such integrated care saves lives.

References

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