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Challenges and successes in an integrated behavioral complex care clinic

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ABSTRACT

Background: Mental health and substance abuse disorders occur with other medical problems at a higher rate, resulting in increased costs and higher morbidity and mortality rates. Integrating behavioral health with primary care has shown success, but how this approach is experienced by patients and clinicians in a complex care clinic is not fully investigated.
Purpose: This study explored the benefits and challenges of a complex care clinic with an integrated behavioral health component.
Method: We used a conventional qualitative content analysis of semi-structured interviews with clinicians and patients, and team meeting observations.
Conclusions: Patients and clinicians perceive similar successes of an integrated behavioral health complex care clinic, such as decreased use of emergency room and improved health. Only clinicians found challenges, which were related to traditional medical care perceptions, time and space, and interprofessional teamwork. Patients did not identify challenges related to the integrated complex care clinic.

1. Introduction

Mental health and substance abuse disorders occur with other medical problems at a three to four times higher rate than those without concomitant medical conditions, resulting in fifty percent higher treatment costs and two to three times higher morbidity and mortality rates than the general population.[1–4] Mental illness is associated with a high rate of health risk behaviors. For instance, schizophrenia and bipolar disorder have an estimated smoking prevalence of fifty to eighty percent[5,6] compared to 16.8% in the adult population.[7] Obesity is increased in people with mental illness, though rates vary between diagnosis; people with schizophrenia have a 2.8–3.5 increased likelihood of obesity whereas depression or bipolar have a 1.2–1.5 increased likelihood.[5] High rates of chronic diseases (e.g., cardiovascular disease, diabetes, respiratory disease, and infectious disease) result in mortality rates two to three times higher and twenty-five years sooner for those with mental illness than the general population.[5,6] To compound matters, state studies have shown increases in the death rates of those with mental illness over the past years.[6] The increased mortality and morbidity rates for those with mental illness are complicated, as there is a tendency for healthcare providers to focus on either mental health symptoms or medical conditions, but not both.[5,6]

Integrating treatment and management of mental health and medical conditions is a challenge. Mental health conditions can mask medical symptoms, mental health symptoms can cause fear of medical care, and medication can result in health risk factors (e.g., weight gain, insulin resistance).[5,6] Patients with mental health disorders are more likely to be nonadherent with treatment.[2]

In response, integrated healthcare models have been presented as a means to provide needed integrated medical and mental health care services. These models are similar to team-based primary care models, which have shown positive outcomes related to reducing emergency room visits and hospital admissions, improving clinical outcomes, decreasing symptoms, improving adherence to treatment, improving provider satisfaction in care, and lowering cost of care.[8–13] A continuum of integrated healthcare models have been outlined, ranging from co-location of services, to staff from one service visiting the other service, case managers integrating care,

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and shared care (see Floyd[2] for a description of the continuum of approaches). While challenges still exist and barriers still need to be overcome, integrated behavioral care, at any level, produces better outcomes than no integration between medical care and mental health services.[14] An integrated model with co-located services has produced the most significant results in regards to increased quality and improved outcomes of medical care.[14]

While initial outcomes are promising,[3,15] understanding how an integrated behavioral health approach is experienced by patients and clinicians is not fully examined. This study explored the benefits and challenges of a complex care clinic with an integrated behavioral health component. Specifically, this research sought to answer the following question: What do clinicians and patients describe as challenges or successes in an integrated behavioral complex care clinic?

2. Methodology

We conducted a pilot observational study with clinicians and patients in an urban based complex care clinic from October 2014–May 2015. Qualitative data were collected during observations and interviews and analyzed using conventional content analysis. The interviews, along with clinic observations and other qualitative data, were collected as part of a separate study examining best practices in care coordination. The original study received approval from the Virginia Commonwealth University Institutional Review Board.

2.1. Setting

Research occurred at a large, urban research university-affiliated Complex Care Clinic (CCC) created in 2011 to address the needs of uninsured and Medicaid patients identified as having complex medical, behavioral, and social needs. Today, the CCC serves approximately seven hundred patients. Patients are generally referred to the clinic through their primary care practice or during a hospital admission. The clinic is designed to improve care and reduce costs for the most complex patients, which they define as patients who have at least six co-morbid conditions commonly including diabetes, hypertension, chronic obstructive pulmonary disorder, and mental, behavioral, or substance abuse issues.[16] The CCC uses a medical home model with an interprofessional team comprised of medical and behavioral health professionals to provide holistic care at a single location. The team strives to engage the patient, address patient barriers, and connect them to appropriate services and resources.[17]

2.2. Study participants

All full time CCC clinicians were interviewed ($N = 10$), excluding one physician who was on leave for the duration of the study (Table 1). While many team-based care approaches involve a coordinated approach with delegation of tasks, the CCC uses an interprofessional team-based approach with each contributing a specific aspect of care through direct interaction with the patient, often during the same visit. While each clinician manages a specific aspect of care (e.g., the physician diagnoses and prescribes medications, the psychologists addresses mental health issues, the social worker finds community resources, etc.), the team works collaboratively to address patient needs.

Table 1
Clinician sample.

Title	Number of Participants
Clinical Nurse	1
Clinical Psychologist	2
Nurse Practitioner	1
Pharmacist	1
Physician	2
Clinic Director	1
RN Case Manager	1
Social Worker	1

Patients were recruited from a sample provided by the clinic staff. Clinic staff were asked to identify both patients who were highly engaged and not struggling to effectively manage their health as well as patients who were not highly engaged and not managing their health. Inclusion criteria also included patients who had been attending the clinic for at least one year. The clinic identified a list of thirty-six patients, all of whom the research team attempted to contact via telephone. Over half were not able to be reached due to disconnected or changed phone numbers, or unreturned voice mail messages. Of those who were successfully reached, thirteen agreed to participate in the study (six from the list of highly engaged patients and seven from the list of less engaged patients) and two declined. Patient demographics were not provided though gender was identified via the interviews, resulting in a nearly even split of males (7) and females (6).

2.3. Data collection

Researchers attended and audio recorded twenty one-hour interprofessional team meetings across a four month time frame; a sample of ten were included in the analysis. Clinician and patient interviews were conducted one time, each from thirty to ninety minutes, across the next three months. Clinician interviews were conducted individually in private spaces in or near the clinic at times convenient to them and included questions about the clinic process and procedures, challenges and successes, patient engagement, and team based care (Appendix A). Patient interviews were conducted in locations convenient to the patient, such as the patient's home or the hospital library. In many cases, family was present during the interviews. The patient interviews included questions about their care and experience at the clinic, their perceived health changes, challenges to working with the clinic, and functional limitations (Appendix B).

The interviews were conducted by a PhD-trained qualitative researcher (male), a research associate in the Department of Family Medicine (female), or one of three occupational therapy students (female). All interviewers were trained on the interview process, though previous interview experience varied substantially from novice to expert. All interviewers were Caucasian with an age range of 24–40. Because all patients were known to be low-income, interviewers were instructed to dress neat, but casually so as to minimize potential appearance of power differentials. Interviewer field notes were made immediately following each interview. Field notes reported no apparent unease between the patient and interviewer, and patients appeared to be candid in their answers despite any race/age/income discordance.

2.4. Data management and analysis

The interviews were audio recorded and transcribed verbatim by professional transcriptionists. The accuracy of the transcription was verified by the second author during the deidentification process. The data was managed with Atlas.ti, v.7 and analyzed using a conventional content analysis. Conventional content analysis takes an inductive approach where codes and themes emerge from the data itself.[18] The three-member coding team read and coded together a subset of the transcripts (two each of patient interviews,