Integrated Care for Older Adults with Serious Mental Illness and Medical Comorbidity

Evidence-Based Models and Future Research Directions

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The aging of the baby boomer population is resulting in an unprecedented growth in the number of middle-aged and older adults with serious mental illness (SMI) in the United States. People with SMIs (schizophrenia, schizoaffective disorder, bipolar disorder, and treatment refractory depression) make up to 4% to 6% of the population1 and experience high rates of comorbid chronic health conditions, with major consequences on life expectancy, functioning, community tenure, and health care costs.

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• Serious mental illness • Older adult • Elderly • Comorbidity • Integrated care
• Collaborative care • Illness self-management

KEY POINTS

• Older adults with serious mental illness have an increased risk of early mortality, medical comorbidity, early institutionalization, and high medical costs.
• Psychosocial skills training, integrated illness self-management, and collaborative care and behavioral health homes are current, evidence-based approaches to integrated care models for older adults with serious mental illness.
• Highly promising integrated care models of the future that incorporate novel uses of telehealth, mobile health technology and peer support, and strategies from developing economies are discussed.

The aging of the baby boomer population is resulting in an unprecedented growth in the number of middle-aged and older adults with serious mental illness (SMI) in the United States. People with SMIs (schizophrenia, schizoaffective disorder, bipolar disorder, and treatment refractory depression) make up to 4% to 6% of the population1 and experience high rates of comorbid chronic health conditions, with major consequences on life expectancy, functioning, community tenure, and health care costs.
Adults 55 to 64 years old with SMI are 4 times more likely to die compared with adults without mental illness and are faced with a reduced life expectancy of 11 years to 30 years compared with the general population. According to a national sample of Medicaid beneficiaries with schizophrenia (ages 20–64 years old), cardiovascular disease is the most common cause of early mortality. Additional major causes of this early mortality health disparity are largely due to high rates of diabetes, chronic obstructive pulmonary disease, obesity, and tobacco use as well as unrecognized medical disease. Furthermore, as persons with SMI age, they struggle to maintain community tenure and are 3.5-times more likely to reside in a nursing home compared with other Medicaid beneficiaries of the same age.

Middle-aged to older adults with SMI have special needs that potentially impede community tenure compared with similarly aged adults without SMI, including a greater likelihood of impaired independent living skills, inadequate social skills, minimal social support networks, and limited medical and psychiatric self-management skills. The adverse consequences of these needs result in excess medical hospitalizations and premature nursing home placement, despite a majority of older adults with SMI preferring to live in community-based settings. Greater use of acute hospital and nursing homes by older adults with SMI is largely responsible for healthcare costs that are 2-times to 3-times greater than those for dually eligible (Medicaid and Medicare) beneficiaries without a mental health condition.

Despite higher acute-care and long-term care costs, SMI are associated with inadequate, highly variable medical monitoring and treatment and numerous barriers to preventive and routine health care. Half of persons with a psychiatric disorder (59%) report at least 1 barrier to health care, compared with 19% of persons without a mental illness. The greater risk and incidence of adverse outcomes associated with SMI and medical comorbidity call for innovative models of integrated health care that address high rates of chronic health conditions in this high-risk group. The excess risk of early mortality, medical comorbidity, early institutionalization, and disproportionately high costs among persons with SMI make this group a major priority for developing and disseminating effective and sustainable integrated care models.

The purpose of this overview is to provide a summary of current evidence-based integrated models of care and to identify future promising approaches that address both the mental and physical health needs of older adults with SMI. Current evidence-based approaches include (1) psychosocial skills training, (2) illness self-management, and (3) collaborative care and behavioral health homes. Finally, a brief overview is provided of highly promising future models that build on these approaches by incorporating novel uses of telehealth and mobile health technology, peer support, and adapting models from developing economies to address under-resourced and unmet needs.

**PSYCHOSOCIAL SKILLS TRAINING**

This section provides a brief overview of 3 skills training programs specifically designed for older adults with SMI that proved effective in randomized clinical trials: Helping Older People Experience Success (HOPES); Functional Adaptation Skills Training (FAST); and Cognitive-Behavioral Social Skills Training (CBSST).

**Helping Older People Experience Success**

HOPES integrates psychosocial skills training and preventive health care management with the goal of enhancing independent functioning and community tenure in