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This Evidence-based Research Brief was prepared by Lydia Chwastiak, MD, MPH

Integrated Care for Older Adults with Serious Mental Illness and Medical Comorbidity: Evidence-based Models and Future Research Directions

Stephen J. Bartels; Peter R. DiMilia; Karen L. Fortuna; John A. Naslund *The Psychiatric Clinics of North America*, 41(1), 153–164, 2018.

Statement of the Problem

Older adults with serious mental illnesses (SMI), such as schizophrenia, schizoaffective disorder, and bipolar disorder, have more hospitalizations and 4 times greater risk of death at any given age than those without SMI. They are also 3.5 times more likely to live in a nursing home. Despite higher acute and long-term healthcare costs, adults with SMI experience greater barriers to preventive and routine health care, and often receive care that is fragmented and inadequate. These disparities highlight a need for effective and sustainable integrated care models designed specifically to support the special health care needs among older adults with SMI.

The Goal

This paper provides a summary of evidence-based integrated models of care that address the mental and physical health needs of older adults with SMI.

What the Researchers Did

This paper provided brief overviews of the following evidence-based approaches to integrate care for older adults with SMI: (1) psychosocial skills training, (2) illness self-management, and (3)

Key Points

- Social skills training interventions are associated with improved social functioning and independent community living among older adults with serious mental illness.
- Illness self-management programs can improve management of either psychiatric or medical disorder among older adults with serious mental illness—but integrated interventions that address both are scarce.
- Integrated health homes have the potential to increase access to preventive care and improve the quality of care for chronic medical conditions, but inconsistently achieve clinically significant results.

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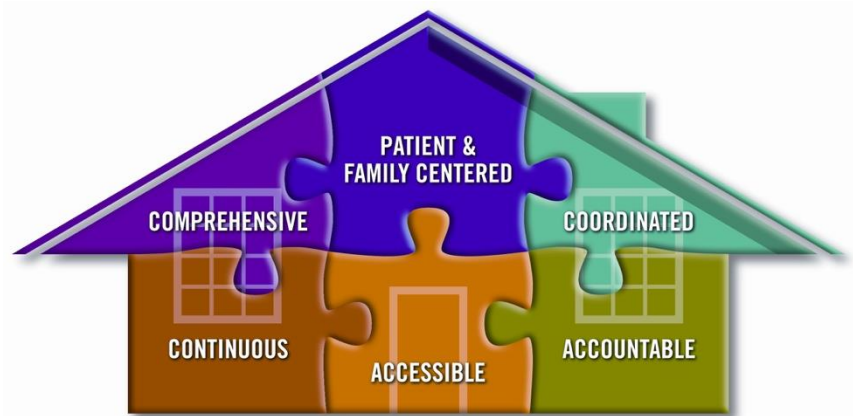
behavioral health homes. For each approach, the authors summarize the components and duration of the programs, and their impact as demonstrated through randomized controlled trials (RCT).

What the Researchers Found

Psychosocial Skills Training: Three group-based programs have research evidence of effectiveness in improving psychosocial skills among older adults with SMI: (1) Helping Older People Experience Success (HOPES) program, (2) Functional Adaptation Skills Training (FAST) program, and (3) Cognitive-Behavioral Social Skills Training (CBSST) program. These programs range from 12 weeks (CBSST) to 12 months (HOPES); an integrated health management component of HOPES is delivered by a registered nurse. Common features of all three are that they are group-based, provide accommodations for people with physical or cognitive disabilities, and use age-appropriate cognitive behavioral principles and skills training techniques to meet the specific needs of older adults with SMI.

Integrated Illness Management and Recovery: Three interventions have been shown to be effective in improving chronic disease self-management among adults with SMI: (1) Health and Recovery Peer (HARP) program, (2) Targeted Training in Illness Management (TTIM), and (3) Integrated Illness Management and Recovery (I-IMR). The HARP program consists of 6 peer specialist-led sessions and was adapted from the widely-disseminated Chronic Disease Self-Management Program. TTIM is also group-based and is led by a peer and a nurse educator. This 12-week program blends social support with diabetes and mental health psychoeducation and goal setting. I-IMR combines four evidence-based psychosocial interventions: psychoeducation, which improves knowledge about mental illness management; behavioral tailoring which improves medication adherence; coping skills training, which reduces distress related to symptoms; and relapse prevention training.

Behavioral Health Homes: In contrast to the extensive research on integrating mental health care in primary care settings, little research has studied co-locating primary care within mental health settings. Three RCTs that assessed the impact of behavioral health homes on adults with SMI and medical comorbidity were identified. A 2001 study evaluated the effectiveness of co-locating primary care services in Veterans Affairs hospital's mental health clinics. After 12 months, veterans who received care in this co-located clinic received, on average, more preventive services and self-reported better physical health functioning. The Primary Care Access, Referral and Evaluation (PCARE) intervention involved a nurse care manager, located at a community mental health center, who coordinated care with medical providers and used motivational interviewing to enhance patient activation, promote self-management and health advocacy skills. In an RCT, after 12 months, patients who received



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PCARE had more primary care visits and greater reduction in 10-year risk of cardiovascular disease, compared to those receiving usual care. The 2017 Health Outcomes Management and Evaluation (HOME) study compared outcomes among patients receiving primary care through a Behavioral Health Home to those who received usual care, and found that Behavioral Health Home patients had higher preventive service uptake and better quality of cardiometabolic care, but showed no clinically significant difference in blood pressure, cholesterol, blood glucose, or 10-year cardiovascular risk.

Why the Research Matters

There is an unprecedented growth in the number of middle-aged and older adults with serious mental illnesses, and these individuals have high rates of comorbid chronic medical illness. In contrast to a large number of evidence-based practices for older adults with depression and comorbid medical illnesses, there are only a limited number of interventions aimed at addressing the needs of adults with comorbid physical and serious mental illness. The existing interventions have shown promise in improving illness management, increasing access to primary care and preventive services, and improving the quality of care for some medical conditions—but these models have not improved clinically significant outcomes.

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