Reclaiming Lost Decades:

The Role of State Behavioral Health Agencies in Accelerating the Integration of Behavioral Healthcare and Primary Care to Improve the Health of People with Serious Mental Illness

FIRST REPORT

in the

Cornerstones for Behavioral Healthcare Resource Series

Joel E. Miller
Senior Director of Policy and Healthcare Reform
National Association of State Mental Health Program Directors (NASMHPD)

&

Elizabeth Prewitt
Former Director of Public Policy
NASMHPD

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About NASMHPD

The National Association of State Mental Health Program Directors (NASMHPD) is home to the only member organization representing state executives responsible for the $37 billion public mental health service delivery system serving nearly 7 million people annually in all 50 states, 4 territories, and the District of Columbia. NASMHPD operates under a cooperative agreement with the National Governors Association.

About the Authors

Joel E. Miller, M.S.Ed., is Senior Director of Policy and Healthcare Reform for the National Association of State Mental Health Program Directors (NASMHPD). In his capacity, he leads the development and implementation of NASMHPD’s policy agenda and regulatory strategies designed to support state public behavioral health systems.

Mr. Miller served as Senior Vice President at the National Coalition on Health Care (NCHC), where he oversaw the evaluation, preparation and dissemination of innovative research and policy analysis on the nation’s health care system. At the National Alliance on Mental Illness (NAMI), Mr. Miller led NAMI’s State Policy Team, which is dedicated to improving the financing and delivery of mental health services at the state level, and addressing mental illness issues across the lifespan.

He has published over 50 articles and reports on behavioral health and healthcare delivery and financing issues, medical practice assessment and quality improvement, the healthcare workforce, Medicare, Medicaid, insurance exchanges, public/private health insurance programs, and state health care programs.

Elizabeth Prewitt, MA, is the former Director of Public Policy at NASMHPD. She has many years of working in health and mental health policy. Her professional background includes extensive experience with issues related to health care, including health care reform, Medicare, Medicaid, inner city health, and health professions education, and she has presented and written frequently on public policy issues affecting internal medicine, primary care and mental health. Ms. Prewitt has been especially interested in issues related to the link between primary health care and mental health.

Acknowledgements

The authors are indebted to Stephanie Sadowski, NASMHPD’s Administrative Program Associate, who developed the graphics you see in the report. She also assisted in the developing the overall design of document, and provided final reviews of the report.

Responsibility for the final content of the report rests entirely with the authors.
Preface.

This white paper on behavioral health services and primary care integration is the first in a series of 12 reports under the auspices of the NASMHPD Cornerstones for Behavioral Healthcare Resource Series initiative. The overarching role (Role 1) on integration is highlighted in the accompanying matrix below. The NASMHPD Cornerstones initiative has been developed to assist State Behavioral Health Agencies (SBHAs) to navigate the changing landscape of healthcare and behavioral healthcare, provide background on key issues, spotlight SBHA initiatives at the state level and focusing on key action steps.

The predicate for the development of the Cornerstones for Behavioral Healthcare Resource Series initiative flows from the NASMHPD report: CORNERSTONES FOR BEHAVIORAL HEALTHCARE TODAY AND TOMORROW: FORGING A FRAMEWORK TO POSITION STATE BEHAVIORAL HEALTH AGENCIES TO OPTIMIZE THEIR ROLE IN THE CHANGING LANDSCAPE OF HEALTHCARE. This “flagship” report broadly outlines 12 major roles that SBHAs can play in the rapidly changing healthcare environment and several individual actions that SBHAs can take to be sure that behavioral health concerns and interests are front and center at the state and federal levels.

The federal government, states, and communities have struggled for decades to develop programs that integrate critically important services for people with serious mental illnesses. We recognize that implementation of improved integrated initiatives and services, have been constrained due to a lack of funding, poorly designed payment approaches, and counterproductive regulations. We also recognize that people with serious mental illness are a challenging population at high risk for comorbid conditions such as substance abuse and suffer from serious physical diseases brought about from their behavioral health conditions, such as diabetes, hypertension, and asthma.

That is why it is incumbent that behavioral healthcare and primary care service are closely integrated. This report identified models and approaches for SBHAs to promote and initiate to address the needs of behavioral healthcare consumers on many levels, and highlights several strategic opportunities for state agencies to work with several stakeholders at the state and local to develop highly specialized services to improve the care for people with serious mental illnesses.

NASMHPD first identified that people with serious mental illnesses die decades earlier than those in the general population. If we fail to seize these opportunities to work to significantly integrate behavioral healthcare and primary care, we will have missed the greatest chance to address some of the largest disparities and gaps in the behavioral healthcare and the overall healthcare system in the last 40 years.
It is imperative that we – like the title of this report – reclaim those lost decades and remedy the many unfulfilled promises of caring for people with serious mental illness.

We believe the Cornerstones report and the individual white papers – like this document on integration – will identify opportunities for SBHAs to take advantage in a cost-efficient way, provide SBHAs with the necessary tools to oversee and implement key behavioral health aspects in the changing healthcare environment, and address your needs and help promote the interests of your agency in this challenging budget climate at the state and national levels.

We look forward to working with you to build a new framework to help position SBHAs to optimize opportunities to be a key player in the changing landscape of healthcare beginning with this white paper on integration.

Robert W. Glover, Ph.D.
Executive Director, NASMHPD
## Cornerstones for Behavioral Healthcare Today and Tomorrow

<table>
<thead>
<tr>
<th>Cornerstone I</th>
<th>ROLE 1</th>
<th>Accelerate the necessary linkages between physical health care and behavioral health services to promote and achieve recovery for people with mental illnesses and/or substance abuse who also have chronic physical diseases.</th>
</tr>
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<tbody>
<tr>
<td>Improve the Coordination of Behavioral Health Services with Primary Care and Supportive Services and Maximize the Use of Available Resources to Effectively Address Behavioral Healthcare Needs by Reducing Fragmentation and Ensuring a Full Spectrum of Care</td>
<td>ROLE 2</td>
<td>Provide content expertise in the development and implementation of behavioral health aspects of service delivery system reforms such as medical homes, health homes and accountable care organizations, and related payment initiatives such as bundling and capitation.</td>
</tr>
<tr>
<td>ROLE 3</td>
<td>Accelerate the necessary linkages between behavioral healthcare services and the array of supportive services (supported housing, employment, transportation, education and training, etc.) essential to promote and achieve recovery for persons with persistent mental illness and/or substance use.</td>
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<tr>
<td>Cornerstone II</td>
<td>ROLE 4</td>
<td>Develop and implement effective behavioral health promotion, wellness and prevention activities.</td>
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<tr>
<td>Leverage Mental Illness Prevention, Mental Health Promotion, and Public Health Resources — and Identify and Promote New Public Health Strategies and Practices to Reduce Risks for Behavioral Health Problems — with an Emphasis on Children and Youth</td>
<td>ROLE 5</td>
<td>Continue the development and expanded provision of services and supports, including safety-net services that are provided by or under the control of SBHAs, and ensure that proper linkages exist between these services and health and behavioral health services.</td>
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<tr>
<td>Cornerstone III</td>
<td>ROLE 6</td>
<td>Provide content expertise on the development of and inclusion of behavioral health quality measures in specifications for electronic health records, in the development of health information exchanges, and in public and private sector initiatives to improve the quality of behavioral healthcare.</td>
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<tr>
<td>Coordinate Measurement, Electronic Health Records’ and Health Information Technology Initiatives as Essential Prerequisites to</td>
<td>ROLE 7</td>
<td>Provide leadership to health providers, federal and state policymakers and officials, national medical societies, including primary care organizations, to ensure the adequacy of providers in the behavioral health workforce to deliver quality behavioral health care services.</td>
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<td></td>
<td>ROLE 8</td>
<td>Empower consumers to maximize control of their recovery through new and emerging ways to design, apply and organize existing treatments and by finding new platforms and avenues to deliver new treatments.</td>
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<tr>
<td>Role</td>
<td>Description</td>
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<tr>
<td>ROLE 9</td>
<td>Serve as the state authority for mental health/substance abuse benefits including, where possible, serving as the contractor for and payer of services on behalf of other state agencies (e.g., state Medicaid program), or by developing the scope and requirements for behavioral health services if contracted for or paid directly by the state Medicaid authority, as well as develop innovative payment systems that recognize and reward performance.</td>
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<tr>
<td>ROLE 10</td>
<td>Provide content expertise on benefits and scope and requirements for behavioral health services – in partnership with state insurance authorities – that are offered in public and private health insurance plans operating in the state.</td>
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<tr>
<td>ROLE 11</td>
<td>Actively ensure the outreach and enrollment of individuals with mental and substance use disorders so they may receive and maintain health coverage based on their eligibility and are able to easily access care.</td>
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<tr>
<td>ROLE 12</td>
<td>Educate providers, insurance carriers, federal and state policymakers and officials, health care providers, consumer organizations and the general public on behavioral health parity within public and private insurance and monitor its implementation.</td>
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Executive Summary

Persons in the U.S. public mental health system with serious mental illness are dying 25 years earlier than the general population. Consumers, who have co-occurring disorders – mental illness and a substance abuse condition, on average, die nearly 32 years earlier than their fellow citizens outside of the public mental health system. Increased morbidity and mortality are often due to treatable medical conditions such as hypertension and diabetes. Even individuals in the general population who self-identify as having a mental health disorder die nearly 9 years sooner than those without a mental health disorder.

Other studies have found that premature mortality for people with serious mental illness is roughly four (4) times that of otherwise similar individuals.

General medical conditions among adults with serious mental illness are frequently missed, and many of the published chronic condition rates are based on recorded diagnoses, therefore, *true* prevalence rates for these conditions are likely to be higher than reported.

There is a high personal toll on individuals who have multiple co-morbidities as well as a toll on society from the substantial impact on healthcare costs, productivity, economic growth, and public health.

We believe the problem of substantially shortened lifespans for people with serious mental illness is a major public health and health disparity issue. Although this issue has received more visibility by academia and mental health advocates and was spotlighted by NASMHPD initially 7 years ago in a groundbreaking report, it is the extent and degree to which premature death is the result of preventable medical conditions – and the rates appear to be accelerating – that lead us to conclude that this situation is a major public health crisis with consequences for the entire healthcare system. Over 60 percent of premature deaths are due to preventable chronic illness such as cardiovascular and pulmonary diseases.

There is also a compelling business case for addressing behavioral health conditions as part of delivering healthcare services. This conclusion is supported by research that shows behavioral health services can reduce healthcare spending and improve behavioral and healthcare outcomes. One study found a 10 percent reduction can be made in the excess healthcare costs of patients with comorbid psychiatric disorders via an effective integrated medical-behavioral healthcare program, or $5.4 million of healthcare savings could be achieved for each group of 100,000 insured member. The authors estimated that the cost of doing nothing may exceed $300 billion per year in the United States.

This report examines the roles that the State Behavioral Health Agencies (SBHAs)* can play in accelerating improvement in the health status of people with mental
illness in the public behavioral health system and provides several examples of innovative programs at the state level to integrate behavioral healthcare and primary care. Finally, the paper looks at the Medicaid options that are available to states to design and finance delivery system changes to advance integration and collaborative care.

**What Do We Mean by Integration?**

Integrated healthcare is the systematic coordination of physical and behavioral health care. Evidence demonstrates that physical and behavioral health problems often occur at the same time. Integrating services to treat both will yield improvement in clinical outcomes and quality of life and the best possible results, and the most acceptable and effective approach for those being served.

NASMHPD’s *Cornerstones for Behavioral Healthcare Today and Tomorrow* report identified integration as a key role for SBHAs by identifying the following overall objective:

(SBHAs should) accelerate the necessary linkages between physical health care and behavioral health services to promote and achieve recovery for people with mental illnesses and addictions who also have chronic physical diseases.

**Challenges to Integrating Behavioral Healthcare and Primary Care Services**

The primary reason there is a significant gap in mortality for people with serious mental illness is the difficulty that individuals in the public mental health system have in receiving care in a coordinated and comprehensive manner. The behavioral healthcare system—like the overall healthcare system—is riddled with problems of fragmentation and quality issues. The problems that plague the overall healthcare system are especially damaging for individuals with mental illness and addiction disorders. The lack of health insurance is a major but not exclusive factor in limiting access to healthcare that includes preventive services and treatment for both chronic and acute medical conditions.

The complex medical conditions of people in the public mental health system often require services in specialty mental health, primary and specialty medical care and in some cases, specialty substance abuse. However, as long as the delivery system consists of silos for behavioral healthcare and primary care, enormous barriers will remain for individuals seeking integrated cost-effective and quality services.

**The good news:** To address the mortality issue there is a growing body of research and initiatives that demonstrate the value of integrating mental health services, addiction services, and primary care services, as well as including mental health and addiction services as a component in improving quality of care and controlling overall
healthcare costs. An area of great promise for improving the health status of people with mental illness is in the reduction of risk factors for disease: lack of exercise, poor diet and smoking (Smoking prevalence is among the highest for people with mental illness with nearly 75 percent of individuals with serious mental illness tobacco-dependent, compared to approximately 22 percent of the general population.)

Because of their prevalence in individuals who have a mental illness, it is especially important to aggressively and strategically address these risk factors in a comprehensive and integrated fashion in this population.

The bad news: The reasons for the early mortality are a complex mix of socioeconomic, health system and clinical factors. The “chronicity” of these problems suggests – according to several experts – that it may take time for efforts to begin to narrow the mortality gap for persons with behavioral health disorders.

In response to this dynamic challenge and with a sense of urgency, SBHAs are implementing innovative programs to integrate behavioral health and primary care in order to accelerate improvement in the health status of people with mental illness in the public behavioral health system. However, there is a recognition that much more needs to be done – even in this difficult state budget climate – by SBHAs within their administrative purview, collaborating with other stakeholders, as well as capitalizing on Medicaid options that are available to states to design and finance delivery system changes to advance integration and collaborative care.

Integration on Two Levels: Behavioral Health and Primary Care and Mental Health and Substance Use Treatment

It is imperative that all states address how best to integrate behavioral health services and primary care recognizing each state’s unique healthcare resources and infrastructure. States are undertaking a variety of initiatives to accelerate the integration of behavioral health and primary care.

It is equally imperative that states address co-occurring mental health and substance use disorders because of the prevalence (with 40-70 percent co-occurrence) and the health impacts on people with mental illness. On a clinical level, the treatment of individuals with co-occurring disorders is moving toward integrated care but significant obstacles remain such as perceived and real barriers to sharing medical information and different cultures of treatment.

Development of a shared vision is a key element in successful integration efforts.
Role of the State Behavioral Health Agency in Accelerating Integration

Many SBHAs are playing a central leadership role in accelerating the integration of behavioral healthcare and primary care by creating and communicating a shared vision among several state stakeholders.

While there are innumerable ways to categorize models of integrated care, a useful concept to help think about organizational and clinical options is the notion of “bi-directional integration.” Simply stated, bi-directional integrated care can be achieved by bringing behavioral healthcare into the primary care setting or by bringing primary care into the behavioral health setting.

Demonstration projects conducted by the Pennsylvania SBHA have revealed valuable lessons on designing a system to improve outcomes and reduce costs by integrating physical and behavioral health. A “Collaborative Care” model is being used that is recovery-focused, team-based and includes several supports. Data from three Pennsylvania counties found reductions in emergency room visits (-2%), inpatient hospitalization days (-42%) and physical health specialist visits (-18%).

Another effort in Pennsylvania called the “Connected Care Pilot” is based on the “Patient-Centered Medical Home” model with an integrated team and care plan to address physical, behavioral health and social needs.

Lessons Learned from Initial SBHA Integration Efforts

Based on recent SBHA integration efforts and others cited in this report, we have identified key lessons learned to accelerate integration of behavioral healthcare and physical services. SBHAs need to:

- Increase public-private integration partnerships by involving major players in the development of a shared vision -- include governmental leadership, professional societies, public and private payers, educational institutions, consumers, and providers.
-
- Encourage health plans to run integrated financial data for the purpose of analysis with regard to clinical and financial outcomes. This review may identify common areas of concern and potential opportunities that can be the basis for shared objectives.
-
- Ensure that implementation tools are designed with input from primary care providers, specialty providers, and consumers.
-
- Reassure providers that integrated care is clinically beneficial and financially viable.
Roles for SBHAs

Specific actions that SBHAs can take to accelerate integration efforts include:

**Action.** SBHAs should work closely with Medicaid offices to ensure that behavioral health is included in health homes for all chronic conditions and to carefully evaluate the potential for health homes for individuals with serious mental health conditions.

**Action.** SBHAs should work with Medicaid officials and healthcare providers to provide the means and incentives necessary to integrate physical and behavioral health services to improve the overall quality of patient care.

**Action.** SBHAs should consider collaborating with behavioral health providers or other entities in designing and testing new service delivery models.

**Action.** SBHAs should strongly support the continued investment in co-location of primary care services in behavioral health settings and the robust evaluation of these programs and their ability to improve health status, especially those with serious mental illness.

*The term behavioral health refers to substance abuse and mental health. The number of combined mental health and addictions’ agencies has grown over the last decade to 31 such entities. The operational location in state government of these functions has a significant impact on the degree of coordination but is not the only factor. For purposes of this white paper, SBHAs are state substance abuse and mental health authorities.*
SECTION ONE
The Extent of the Problem and the Integration Imperative
“A refined view of integration calls for a commitment to patient-centered care for meeting people where they are.”

Richard Frank, Ph.D.
Harvard University

Introduction: Why Is Integration of Primary Care and Behavioral Health So Critically Important?

Behavioral health conditions are a major driver of increased expenses in healthcare delivery systems and poor to fair health outcomes as the following statistics highlight:

- Over 12 million visits to emergency departments on an annual basis are due to individuals with mental health and substance use disorders; many people are unable to make an appointment to see a primary care physician.¹

- Over 70 percent of primary care visits stem from psychosocial issues. Most primary care physicians are not equipped or lack the time to fully address the wide range of psychosocial issues that are presented by patients.²

- Americans with severe mental illness (SMI), on average, only have a 53-year lifespan – 25 years younger than the average lifespan for Americans without mental illness. And those Americans with co-occurring disorders (substance use) are dying, on average, according to one study, at age 45.³

- Nearly half of all cigarette consumption is by individuals with behavioral health disorders.⁴

- Healthcare expenditures of Americans with serious mental illness are two (2) to three (3) times higher than other patients.⁵

- Over 50 percent of all lifetime cases of substance use disorders begin at age 14 (essentially the same for mental health disorders) and three-fourths by age 24.⁶

- Nearly three in four individuals receiving Medicaid coverage with significant mental health and substance use disorders had at least one chronic health condition, nearly half had two (2) chronic diseases and almost one-third had three (3) or more conditions. When individuals have
three or more physicians, those physicians usually do not talk with another or share information.\textsuperscript{7}

- The annual total estimated societal cost of substance abuse in the United States is $510 billion.\textsuperscript{8}

Increased integration of behavioral health and physical healthcare services should be a priority at the national, state, local and person levels. Behavioral health conditions are under-diagnosed and under-treated in the U.S. despite their high prevalence in the population and solid research pointing to the fact that treatment works, prevention is possible, and recovery is achievable.\textsuperscript{9}

Behavioral health conditions commonly co-occur with other chronic health conditions in adults and yet services are rarely delivered in concert. These findings suggest the importance of having screening, evaluation and diagnostic services available at multiple access points in primary care and behavioral health care networks.

The acute shortage of both behavioral health and primary care providers in many areas makes the provision of care, particularly integrated services, difficult. This problem is compounded by the fact that both primary care and behavioral health providers often are not trained or educated about how to work in an integrated setting, resulting in a disconnect between the two cultures of care. In spite of these challenges and barriers, states have many opportunities to work with public and private healthcare stakeholders to help bridge the gaps in primary care and behavioral health delivery systems and promote integration.

**The Magnitude and Degree of the Problem**

It is well known that people with serious mental illness in the public system have shortened life spans but what is new is the extent to which premature death is the result of preventable conditions, and that the rates are accelerating.\textsuperscript{10} While the study found that suicide and injury accounted for 30-40 percent of excess mortality of people in the public system, 60 percent of premature deaths are due to preventable chronic illnesses.

The data compiled in the NASMHPD “Morbidity and Mortality” report on individuals in the public mental health system is being updated in individual state studies now being conducted in Missouri and Kansas.

In the 2001-2003 National Comorbidity Survey Replication (NCS-R), a nationally epidemiological survey, nearly 70 percent of adults with mental illness reported...
having at least one (1) general medical disorder, and nearly 30 percent of those with a medical condition had a comorbid mental health condition. (Exhibit 1)

Exhibit 1

Source: Adapted from the National Comorbidity Survey Replication, 2001-2003

A separate single-state study by the Oregon Department of Human Services and Addiction and Mental Health Division found that individuals in the public system with both addiction and mental health disorders die nearly 32 years younger than the general population.11

While these studies focus on a very disadvantaged population receiving services in the public system, they have implications for the broader population. There is a high personal toll on individuals who have multiple co-morbidities as well as a toll for society from the substantial impact on healthcare costs, productivity, economic growth, and public health.

A study by Dr. Benjamin Druss also describes the significant impact of mental illness and substance use on the general population.12 He found from a nationally representative sample using data from the National Health Interview Survey that individuals who self-identified as having a mental health disorder died nearly 9 years sooner than those without a mental health disorder. Among this general population with mental health disorders, the most common causes of mortality were also chronic
medical conditions such as cardiovascular disease and cancer (69%), and not suicides, accidents or homicide (5.4%).

Druss and his colleagues found that premature mortality for people with serious mental illness is roughly four (4) times that of otherwise similar individuals. The bottom line is that serious behavioral health conditions impose a substantial burden on individuals and society. These disorders are not only highly prevalent clinical conditions but they are also highly disabling. And this burden is predicted to grow over the next several decades.

Druss also found that the reasons for the early mortality are a complex mix of socioeconomic, health system and clinical factors. (Exhibit 2) The authors conclude that the “chronicity of these problems suggests that it may take time for efforts to narrow the mortality gap for persons with mental disorders.”

Exhibit 2

Proportional Contribution to Premature Death

- Genetic Predisposition, 30%
- Behavioral Patterns, 40%
- Health Care, 10%
- Social Circumstances, 15%
- Environmental Exposure, 5%


While acknowledging the significant impact of socioeconomic deprivation on mental illness, this paper focuses more on the health system (e.g., access to healthcare) and clinical factors (e.g., psychotropic medications) that contribute to excess mortality.
This report examines the roles that the State Behavioral Health Agencies (SBHAs) can play in accelerating improvement in the health status of people with mental illness in the public mental health system and provides several state examples of innovative programs to integrate behavioral healthcare and primary care. Finally, the paper looks at the Medicaid options that are available to states to design and finance delivery system changes to advance integration and collaborative care.

**Excess Mortality and Morbidity: Contributing Factors**

Contributing to increased mortality for people with serious mental illness are two broad categories: health system factors and clinical factors.

**Health System Factors**

The healthcare system is riddled with problems of fragmentation, duplication, quality issues and uncontrolled costs. Complex factors prevent individuals from receiving high-quality care, provided by an appropriately trained healthcare professional, in the right setting and at the right time. The lack of a strong primary care workforce that promotes care in a coordinated, continuous and comprehensive manner adds significantly to healthcare costs and negatively impacts quality. The problems that plague the overall healthcare system are especially damaging for individuals with mental illness and addiction disorders.

**Insurance and access to care:** There is a persistent view held by many Americans that people can always access care either in an emergency room or through charity care in a doctor’s office. The reality is that having good health insurance coverage remains a key determinant of an individual’s ability to access care. The best evidence of the importance of insurance is the recent study of the care received by Medicaid recipients in Oregon.15 Faced with severe budget constraints, Oregon had to limit the number of individuals who could receive coverage in its expanded Medicaid program. A lottery was held in 2008 to provide coverage to 10,000 out of a pool of 90,000 who sought coverage.

The Oregon lottery created an unprecedented opportunity to study the effects of access to public insurance in a randomized controlled trial. The study found that those selected in the lottery to receive Medicaid compared to the control group not selected “have substantial and statistically significantly higher healthcare utilization, lower out-of-pocket medical expenditures and medical debt, and better self-reported health…”16

The lack of health insurance is a major but not exclusive factor in limiting access to healthcare that includes preventive services and treatment for both chronic and acute medical conditions. Other factors that limit access to care include a shortage of
physicians, language and cultural barriers, and cost-sharing requirements. A recent study found that during the economic downturn even people with insurance postponed care due to the financial challenge of paying deductibles, coinsurance, and co-pays.17

**Fragmentation of Services:** It is often difficult for individuals in the public mental health system to receive care in a coordinated and comprehensive manner. The complex medical conditions of people in the public behavioral health system often require services in specialty mental health, primary and specialty medical care and in some cases, specialty substance abuse treatment. For the substantial number of individuals with co-occurring disorders, it is especially important for individuals to have a unified care plan and for healthcare providers to make treatment decisions based on the plan and in coordination with each other. As the Oregon morbidity and mortality study demonstrated, mortality is hastened dramatically when a person has both a mental illness and an addiction disorder.

The need to address integration has caught the attention of Medicaid officials. Average Medicaid spending on behavioral health for people with schizophrenia is nearly $12,000 plus another $5700 in other healthcare costs compared to $4000 for average adult beneficiary.18

As long as the delivery system consists of silos for mental health, addiction and primary care, there will be enormous barriers for individuals seeking cost-effective and quality services. Silos will continue to exist until both real and perceived differences in the other’s “culture” are addressed and progress is made to reduce fears of encroachment on the other’s clientele or funding sources. Concrete steps also must be taken to facilitate the sharing of electronic health records and the training of health professionals to work in teams.

**Clinical Factors**

The complexity of clinical factors is enormous for people in the public mental health system. As previously mentioned, 60 percent of premature deaths for people with serious mental illnesses served in the public system are due to preventable chronic illness such as cardiovascular and pulmonary diseases.

General medical conditions among adults with serious mental illness are frequently missed, and many of the published chronic condition rates are based on recorded diagnoses, therefore, true prevalence rates are likely to be higher than reported.

Among the risk factors contributing to these diseases are smoking, obesity, and lack of exercise. (Exhibit 3) The medications that treat the psychiatric illnesses are known to have a significant impact on factors that influence health status such as weight gain.
Psychotropic Medications: The medications that improve the psychiatric conditions for many have enormous side effects that result in diminished health status. The NASMHPD 25-year Morbidity and Mortality study reports that second generation antipsychotic medications (beginning with the introduction of clozapine in 1991) are highly associated with weight gain, diabetes, dyslipidemia, insulin resistance and the metabolic syndrome. In addition, first generation psychotropic medications such as lithium also may be associated with weight gain, especially when used in combination with second-generation antipsychotics. The report also highlighted that the superiority of clinical response of all second-generation medications with the exception of clozapine has been questioned.¹⁹

The NASMHPD report also describes the findings of the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) that show that CATIE subjects exceeded the general population prevalence for metabolic syndrome on every measure except one. Metabolic syndrome is diagnosed when three or more of the following risk factors are present: obesity; hypertension; insulin resistance (as demonstrated by elevated blood glucose level); and abnormal blood lipid (cholesterol and triglycerides) levels. It is associated with increased risk of heart attack and stroke.²⁰


Exhibit 3
Biomedical research must be accelerated and strategies pursued to mitigate the side effects of psychotropic medications. Until medications are developed with fewer harmful side effects, consumers must be made fully aware of the tradeoffs of medication options and informed about any measures that can be taken to reduce harmful impacts.

**Behaviors:** An area of great promise for improving the health status of people with mental illness is in the reduction of risk factors for disease: smoking, lack of exercise, and poor diet. These risk factors are common in the general population and many initiatives are underway to address them. Because of their prevalence in individuals who have a mental illness, it is especially important to aggressively and strategically address these risk factors in this population.

**Smoking:** As smoking prevalence falls, the remaining smokers will represent a ‘hard core’ group for which smoking cessation will be the most difficult. These individuals will have been smokers the longest and will have tried to quit multiple times. Many will have co-occurring mental and/or substance abuse disorders. By improving our knowledge and skills with respect to tobacco addiction and smoking cessation treatment, we can help individuals positively impact their health and wellness, contributing to their efforts toward recovery.

Smoking prevalence is among the highest for people with mental illness. About 75 percent of individuals with serious mental illness are tobacco-dependent compared to approximately 22 percent of the general population. In fact, about 44 percent of all the cigarettes consumed in the United States are by individuals with a mental illness and/or substance use disorder. Smoking prevalence is also high among those with addiction disorders. Approximately 60-95 percent of clients in drug abuse treatment programs smoke.

Excellent tools have been developed to help consumers stop smoking and to help providers develop tobacco cessation interventions and programs. The SAMHSA-HRSA Center for Integrated Solutions website lists several useful documents, including “Smoking Cessation for Persons with Mental Illnesses: A Toolkit for Mental Health Providers” by the University of Colorado Denver.

**Holistic Health Solutions:** Among the strategies that have proven to be effective in improving the lifestyle choices of people with mental illness is the use of “peer-based whole health services”. In addition to helping with smoking reduction, peer support also has been effective in promoting healthy habits regarding exercise, nutrition and...
stress reduction. The use of peer services in whole health is a natural evolution in the process of person-centered, self-directed care that has been emphasized in the mental health field for decades. The relatively new emphasis in the overall healthcare system on prevention and the inclusion of behavioral health also support a more holistic approach to health.

The third annual Pillars of Peer Support Services Summit held in 2011 highlighted several exemplary whole health programs that use peer specialists in key roles. For example, Dr. Benjamin Druss reported on the effectiveness of a peer-led medical illness self-management program for people with psychiatric disabilities titled “Health and Recovery Peer (HARP) Program.” Overall health behaviors improved in HARP participants.

At the federal level, SAMHSA provides a useful definition of “Relapse Prevention/Wellness Recovery Support Services” that delineates the activities or treatments to promote recovery and wellness. These include recovery planning, recovery management and adaptive skill training as well as the use of “Peer Recovery Coaches”, among others, to support recovery and promote wellness.

States have also used evidence-based practices such as Wellness Recovery Action Plan (WRAP) to promote wellness among consumers or developed their own initiatives with wellness as a focus such as the Institute for Wellness and Recovery at CSPNJ (Collaborative Support Programs on New Jersey). Other wellness programs that are not specifically targeted to individuals with mental illnesses can be used or adapted as part of an overall recovery program. Some states have developed partnership with the nation’s YMCAs and YWCAs to provide programs that can be very beneficial to consumers.
Physical Health Conditions among Adults with Serious Mental Illnesses

A major report released in April 2012 by the Substance Abuse and Mental Health Services Administration (SAMHSA), found that adults 18 and older who had any mental illness, serious mental illness, or major depressive episodes in the last year had substantially increased rates of high blood pressure, diabetes, heart disease, stroke and asthma. Data came from the 2008 and 2009 National Survey on Drug Use and Health (NSDUH).

For example, one in four adults experiencing serious mental illness or a major depressive disorder in the past year had high blood pressure, 17 percent of adults who had a major depressive disorder in the past year also had asthma while only 11 percent of those without mental illness had this condition. Adults with serious mental illness also evidenced significantly higher rates of heart disease, stroke and diabetes than individuals who did not have serious mental illness (see accompanying table). According to the study, adults with serious mental illnesses were substantially more likely to use an emergency department (48 percent vs. 30 percent) or to be hospitalized (21 percent vs. 11 percent) than adults without serious mental illnesses.

The results of the SAMHSA study point out the need to improve screening for and treating chronic physical conditions for individuals with serious mental illnesses as well as screening for and treating mental illnesses for persons with chronic illnesses. The report highlights a greater need for promoting current programs and new initiatives that integrate behavioral health screening, intervention, and treatment with primary care or primary care into specialty behavioral healthcare. This would increase the likelihood of providing optimal outcomes of care for adults with behavioral health conditions and serious medical conditions like diabetes.

<table>
<thead>
<tr>
<th>Mental Illness</th>
<th>High Blood Pressure</th>
<th>Asthma</th>
<th>Diabetes</th>
<th>Heart Disease</th>
<th>Stroke</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Mental Illness (AMI)</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Yes</td>
<td>21.9</td>
<td>15.7</td>
<td>7.9</td>
<td>5.9</td>
<td>2.3</td>
</tr>
<tr>
<td>No</td>
<td>18.8</td>
<td>10.6</td>
<td>6.6</td>
<td>4.2</td>
<td>0.9</td>
</tr>
<tr>
<td>Serious Mental Illness (SMI)</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Yes</td>
<td>21.6</td>
<td>19.1</td>
<td>7.7</td>
<td>5.2</td>
<td>2.6</td>
</tr>
<tr>
<td>No</td>
<td>17.7</td>
<td>12.1</td>
<td>6.6</td>
<td>4.2</td>
<td>1.1</td>
</tr>
<tr>
<td>Major Depressive Episode (MDE)</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Yes</td>
<td>24.1</td>
<td>17.0</td>
<td>8.9</td>
<td>6.5</td>
<td>2.5</td>
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<td>No</td>
<td>19.8</td>
<td>11.4</td>
<td>7.1</td>
<td>4.6</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Note: All percentages were adjusted for (a) age group, (b) gender, (c) race/ethnicity, (d) marital status, (f) current employment status, and (g) country type/metropolitan status. All associations between mental illnesses and chronic health conditions are statistically significant at the 0.05 level, except for marginally significant disease (significant at the 0.10 level) and SMI and heart disease (significant at the 0.10 level).

Integration on Two Levels: Behavioral Health and Primary Care and Mental Health and Substance Use Treatment

It is imperative that states address integrating behavioral health and primary care as well as integrating mental health and substance use. As can be seen in the section Models of Integrated Care in the States that follows, states are undertaking a variety of projects to accelerate the integration of behavioral health and primary care.

It is equally imperative that states address how best to address co-occurring mental health and substance use disorders because of the prevalence (with 40-70 percent co-occurrence) and the health impacts, as documented in the Oregon morbidity study as well as others. Many states have taken steps to integrate mental health and substance use treatment on an organizational as well as a clinical level. Over 30 states now have consolidated departments that include both mental health and substance use. On a clinical level, the treatment of individuals with co-occurring disorders is moving toward integrated care but obstacles remain such as perceived and real barriers to sharing medical information and different cultures of treatment. States that have consolidated mental health and substance use organizationally report positive results in terms of clinical integration of services. Other states that have retained separate departments are also making progress to integrate at a services level through the use of shared electronic health records, co-location of services, and other system improvements.

The case for integrating behavioral health and primary care was compellingly made by a report that examined 23,000 clients who received a GA-U cash grant. The report describes the prevalence of chronic health conditions in the GA-U population and how these conditions are related to outcomes including the frequency of emergency room (ER) visits, risk of arrest, and likelihood the GA-U client transitions to Medicaid. One in four clients in the study had at least one chronic condition along with a mental health or substance use disorder and 13 percent had all three disorders.

Most GA-U clients have chronic physical conditions, mental illness, and/or substance abuse problems. Among FY 2003 GA-U clients, 69 percent had at least one chronic physical condition, 36 percent had a mental illness diagnosis and 32 percent had a substance abuse problem identified in available administrative records. (Exhibit 4)
*THE GENERAL ASSISTANCE-UNEMPLOYABLE (GA-U) PROGRAM is a state-funded program providing cash and medical benefits for adults without dependents who are physically or mentally incapacitated and expected to be unemployable for more than 90 days. GA-U clients form a highly mobile population whose status changes frequently as they move into other benefit programs or cycle off and on public assistance.
The Cost of Doing Nothing: The Business Case for Integrating Behavioral Healthcare and Primary Care

In addition to the major reasons referenced above, there is a compelling business case for addressing behavioral health conditions as part of delivering healthcare services. This conclusion is supported by research that shows behavioral health services can reduce healthcare spending and improve behavioral and healthcare outcomes.

- Milliman Consulting conducted an analysis of the cost impact of “Comorbid Depression and Anxiety” on commercially-insured patients with chronic healthcare conditions. They found that many individuals with chronic healthcare conditions and co-occurring depression or anxiety are never diagnosed or treated for their behavioral health condition, and the treatment prevalence rate is significantly lower than the expected comorbidity rates.

  In their analysis, Milliman found that Comorbid Depression clearly results in elevated total healthcare costs, averaging $505 per-comorbid member per-month across all chronic healthcare condition. Comorbid Anxiety also clearly results in elevated total healthcare costs, averaging $651 per-comorbid member per-month (PMPM).

  According to the authors, if a 10 percent reduction can be made in the excess healthcare costs of patients with comorbid psychiatric disorders via an effective integrated medical-behavioral healthcare program, $5.4 million of healthcare savings could be achieved for each group of 100,000 insured member. The authors estimated that the cost of doing nothing may exceed $300 billion per year in the United States.\(^{28}\)

- A randomized trial that examined the effect of primary care depression management (the collaborative care model) on employer healthcare costs found that consistently-employed patients who participated in an enhanced depression management program, had 8.2 percent greater productivity and 28.4 percent less absenteeism over two years than did employees who received usual healthcare. The reduction in employee absenteeism and the increase in productivity had an estimated annual value of $2600 per full-time equivalent employee ($2000 for improved productivity and $600 for reduced absenteeism).\(^{29}\)

- In the Kaiser Permanente Northern California system, family members of patients with substance use disorders had greater healthcare costs and were more likely to be diagnosed with a number of healthcare conditions than family members of similar persons without a substance use condition, based on review of health insurer administrative data for cost and utilization in the two years prior to the consumer’s first service.\(^{30}\)
The Western New York State Care Coordination Program

The Western New York State Care Coordination Program is a collaborative initiative by six County governments, the New York State Office of Mental Health, providers and consumers to transform community services systems serving people diagnosed with serious mental illness. The goal of the program is to create integrated care systems that are responsive to the interests of consumers, ensure access to high quality services, and promote recovery.

In New York State (NYS), individuals with a dual diagnosis (mental illness and substance abuse – MI/SA) who had medical readmissions to the hospital, cost the state Medicaid program $400 million in 2007. Over 50 percent of all Medicaid-related readmissions in the state were for medical readmissions with a diagnosis of mental illness and substance abuse. Clients who had MI/SA who had a readmission due to their MI/SA diagnosis, cost the state Medicaid program $270 million in the same year.

Source: New York State Medicaid, 2007

With the Western NYS Care Coordination Program in place, the state saw through their “2009 Periodic Reporting Analysis” an immediate 46 percent decrease in emergency department visits per Medicaid enrollee, a 53 percent reduction in days spent in the hospital, and 92 percent lower costs for inpatient services in the integrated care coordination program compared to counties without this program in the rest of the state. Nearly 80 percent of clients reported “dealing more effectively with problems.”

The bottom line as a result of improved integration of services was—in a short period of time—better quality, better outcomes and lower costs.
Before we move to a discussion on models and strategies for accelerating integration, let’s recap the preceding discussion on the importance of integration, the extent of the problem, and the need for integration on many clinical and system-wide levels.

Each of the following elements should be considered in any effort to design or implement a collaborative approach, partial integration, or a fully integrated model.

1. *The burden of mental health disorders is great.* Mental health disorders are prevalent at all levels of society and create a substantial personal burden for affected individuals and their families. They produce significant economic and social hardships that affect society as a whole.

2. *Mental health and physical health problems are interwoven.* Many people suffer from both physical and mental health problems. Integrated primary care helps to ensure that people are treated in a holistic manner, meeting the mental health needs of people with physical disorders, as well as the physical health needs of people with mental disorders.

3. *The treatment gap for mental health disorders is enormous.* There is a significant gap between the prevalence of mental health disorders and the number of people receiving treatment and care. Coordinating primary care and mental health helps close this divide.

4. *Primary care settings for mental health services enhance access.* When mental health is integrated into primary care, people can access mental health services closer to their homes, thus keeping families together and allowing them to maintain daily activities. Integration also facilitates community outreach and mental health promotion, as well as long-term monitoring and management of affected individuals.

5. *Delivering mental health services in primary care settings reduces stigma and discrimination.*


7. *The majority of people with mental health disorders treated in collaborative primary care have good outcomes,* particularly when linked to a network of services at a specialty care level and in the community.
SECTION TWO
Accelerating Integration: Models, Lessons Learned, and Opportunities for State Behavioral Health Agencies
General Integration Models for Behavioral Health and Primary Care

Several reports have been issued that highlight models of integration to address the needs of patients with serious mental illness that require primary care services for their medical conditions.

The Milbank Memorial Fund has developed key models along a continuum – from minimal collaboration to full integration – and provides an implementation planning guide. (Exhibit 5) Rather than synthesizing the mass of information in the field, the report examines salient themes to identify practical implications for policymakers, planners and general practitioners and behavioral healthcare providers. The report describes eight (8) distinct models while acknowledging that most initiatives in real-world settings are hybrids that blend elements of these models.

Exhibit 5: Evolving Models of Behavioral Healthcare and Primary Care Integration

| Practice Model 1: Improving Collaboration between Separate Providers – minimal integration, separate systems |
| Practice Model 2: Medical-Provided Behavioral Health Care – basic collaboration, periodic communication |
| Practice Model 3: Co-location – basic collaboration on-site |
| Practice Model 4: Disease Management – close collaboration in partially integrated systems |
| Practice Model 5: Reverse Co-location – Similar to Model #4 |
| Practice Model 6: Unified Primary Care and Behavioral Health – close collaboration in fully integrated system |
| Practice Model 7: Primary Care Behavioral Health – BH and PCP providers are part of the same team |
| Practice Model 8: Collaborative System of Care – specialty providers are integrated with PC services. |

The “four-quadrant” framework identifies the setting in which patients should receive care based on their needs – from low to high physical health risk and complexity and low to high behavioral health risk and complexity. (Exhibit 6) For example, quadrant IV is for patients who have high needs in both areas, such as an individual with schizophrenia who has hepatitis C; these patients are served in both primary and specialty care settings.
If we expect to see reductions in morbidity and disability for people with serious mental illness, a bridging of the “treatment gap” must occur. The treatment gap represents the absolute difference between the true prevalence of a clinical condition.
and the treated proportion of individuals affected by the condition. New strategies are needed to enhance treatment initiation and quality.

Delivery systems have been evolving in behavioral health agencies for decades that embody the central concepts of integrated or collaborative care. Among the early adopters was the Cherokee Health Systems, establishing its integrated practice in 1984 and growing to include 42 clinical sites in 12 Tennessee counties today.

While Cherokee was the first community mental health center (CMHC) to become a Federally Qualified Community Health Center (FQHC), other CMHCs have become FQHCS in recent years including the highly lauded Crider Health Center in Missouri. Still others are developing a primary care capacity, including many that are grantees of the SAMHSA co-location program to assist behavioral health agencies integrate primary care into their services. Mergers between FQHCs and CMHCs have occurred and other restructuring within safety net organizations is anticipated.

While there are innumerable ways to categorize models of integrated care, a useful concept to help think about organizational and clinical options is the notion of “bi-directional integration.” Simply stated, integrated care can be achieved by bringing behavioral health care into the primary care setting or by bringing primary care into the behavioral health setting. Benjamin Druss and Elizabeth Walker describe three broad approaches to providing clinical care.32

A first approach is a “partnership model” in which primary care staff is embedded in a community mental health/substance use (MH/SU) organization and/or MH/SU staff are embedded in a primary care setting. A second approach is a “facilitated referral model” which does not include a physical presence of staff. A third approach is a fully integrated model such as a staff model HMO and Veterans Affairs (VA). The last has the least application to the public mental health system, even in state psychiatric hospitals that are required to do screening upon admission but provide limited primary healthcare.

State of Rhode Island

The two grants that have been awarded under the SAMHSA/HRSA co-location program in the state of Rhode Island provide examples of two of the three Druss/Walker models of clinical care. The grant-supported program at the Providence Center in Providence, Rhode Island represents the “partnership model.”

Beginning in 2011, the Providence Center, a community mental health center, provides primary care services on site to its clientele. The Kent County Community Mental Health Center illustrates the second model, “the facilitated referral model,” in that the Center has formed a partnership with a primary care practice that will provide a part-time physician who will oversee a full-time nurse practitioner, an additional
full-time physician and a nurse care manager. The nurse care manager will act as the link between primary care, behavioral healthcare and wellness programs.

In addition, Rhode Island’s Health Home application has been approved and will initially target individuals with serious mental illness meeting the State’s criteria for designation as a “community support client”. Enrollment in a health home will be mandatory for all eligible clients with payment for team activity being rolled into a single monthly “case rate” for each active client. While the implementation of Health Home required the restructuring of several other existing services, the increased attention to the physical healthcare end of the spectrum is seen as an overall upgrade in client care.  

State of North Carolina

Another example of the “partnership model” is Community Care of North Carolina (CCNC), a statewide public/private partnership between primary care physicians and the state’s Medicaid program with the medical home as its center. Built upon “Carolina Access,” a Medicaid primary care case management (PCCM) model created in 1991, CCNC was founded in 1998 as an enhanced medical home network. “Carolina Access” established a network of primary care physicians who provided basic services and referrals to specialty care when needed. CCNC enhanced these services to further address cost and quality issues, especially for individuals with complex chronic conditions. These enhancements include population management tools, case management and clinical support, and data and feedback.

The regulatory structure for the CCNC program as contained in the North Carolina Medicaid state plan is the “enhanced primary care case management model.” Practices designated as medical homes in the CCNC network receive fee-for-service payments and a PMPM (per member/per month) payment for enhanced services. The PMPM payment is higher for groups such as the disabled that require greater resources to provide the enhanced services.

As the need to address behavioral health issues in the primary care setting became clearer and more urgent, North Carolina undertook the “Mental Health Integration Pilot” program in 2005-2007 to develop a program model to address depression care in the primary care setting, implement the Four Quadrant Model and address communication and consultation between primary care and behavioral health providers.

Various initiatives continue in the collaboration of the NC Division of Mental Health, Developmental Disabilities & Substance Abuse, the Division of Medical Assistance, the Office of Rural Health, Research and Development, the NC Foundation for...
Advanced Health Programs, Inc., and CCNC. The Behavioral Health Integration Initiative (BHI) was approved in February 2010 to “support the integration of behavioral health services, including mental health and substance use, into the 1,400 primary care practices in the CCNC networks across North Carolina.” In anticipation of the Medicaid expansion in 2014, CCNC is making delivery system changes to more fully integrate physical and mental health.

Another initiative to improve access to high-quality, cost-effective behavioral health services by the NC Foundation for Advanced Health Programs, Inc. is the ICARE (Integrated, Collaborative, Accessible, Respectful, and Evidence-Based) Partnership. Building behavioral health capacity in primary care practices is one strategy supported by the partnership. In recognition of the variety of populations being served and workforce capacity, these initiatives do not promote one specific model of integrating primary care and behavioral health.

Another initiative, supported by the North Carolina Health and Wellness Trust Fund, has awarded funds to the state to form the North Carolina Center of Excellence for Integrated Care to promote the combined delivery of medical and mental health services in one location whether it be a hospital emergency department or community mental health center.

**Commonwealth of Pennsylvania**

Pilots conducted by the Commonwealth of Pennsylvania’s Department of Public Welfare reveal valuable lessons on designing a system to improve outcomes and reduce costs by integrating physical and behavioral health. Pennsylvania used a blending of the Milbank models, especially co-location and disease management. The goal of the two pilots conducted between July 2009 and June 2011 was to test innovative delivery systems that if successful could be replicated statewide.

The guiding principles of the program emphasized behavioral health as part of overall health; integration of good health habits; prevention; and that physical health interventions are best achieved through local collaborations and navigator systems.

The target population included people with serious mental illness, co-occurring drug and alcohol use and co-morbid medical conditions. Two regional demonstration sites were selected with different health plans and behavioral health carve-out plans: 1) Southeast Region (Philadelphia suburbs): Health Choices Health Connections (Keystone Mercy Health Plan and Magellan Behavioral Health Plan) and 2) Southwestern Region (Pittsburgh): Connected Care (UMPC for You and Community Care). In the Southeast HealthChoices Health Connections, physical health and

Representatives of both the physical and behavioral health plans as well as county officials played key roles, and stakeholders were significantly involved in the process in Pennsylvania.
behavioral healthcare are provided by different entities. In the Southwest, both are provided by the same entity.

The process for designing and implementing the demonstrations required a partnership among members of a leadership team led by the Secretary of Welfare and comprised of key staff from the department, the office of Medical Assistance (Medicaid), Office of Mental Health and Substance Abuse Services and medical directors who selected the sites and designed that framework for the demonstrations. The non-profit Center for Health Care Strategies provided technical assistance. Representatives of both the physical and behavioral health plans as well as county officials played key roles and the stakeholder community was involved early and in a significant way in the process.

**Health Choices, Health Connections Pilot (Southeast).** The target population for this pilot was stratified on the basis of physical and behavioral risk factors in order to target interventions based on need. The four-quadrant clinical integration model is being used. Member profiles are developed that include hospitalizations, pharmacy data and gaps in care. A multidisciplinary team, assigned to each member (after consent and engagement), does a complete evaluation of the individual and identifies and resolves gaps in care.\(^{42}\) A collaborative care model is being used that is recovery-focused, team-based and includes supports. Wellness Recovery Teams include a physical health professional (registered nurse), a behavioral health professional (Master degree in BH with co-occurring certification), an administrative navigator (approved certification in physical health/behavioral health).

Data from three counties in Pennsylvania show a small increase (4%) in behavioral health residential days and an increase in behavioral health outpatient days (22%) but reductions in ER visits (-2%), inpatient hospitalization days (-42%) and physical health specialists (-18%).\(^{43}\)

**Connected Care Pilot (Southwestern).** The Connected Care Pilot is based on the Patient-Centered Medical Home model with an integrated team and care plan to address physical, behavioral and social needs. The target population included members of the UPMC for You and Community Care who are 18 years old or older, live in Allegheny County and have a serious mental illness (defined as schizophrenic disorders, episodic mood disorders, or borderline personality disorder). High physical and high behavioral health needs were defined by specific criteria (e.g., three or more inpatient admissions for physical health and admission to a state mental hospital for behavioral health). High-need members were stratified into three intervention levels: Tier 1 (High BH/PH and High PH and Low BH); Tier 2 (High BH/Low PH); and Tier 3 (Low BH/PH).\(^{44}\)

Of the 5,828 eligible Medicaid members, 846 consents were obtained from July 2009 to July 2010. Behavioral health providers were used to help obtain consents along with an incentive of a $25 gift card to complete the consent and enroll in the program.
The program focused on Tier 1 members. Coordination between the physical health plan and behavioral health plan included: an integrated care plan, multi-disciplinary care teams, early identification of admissions and ED visits, concurrent case discussions, and 24-hour phone service to answer questions about the program. Consumer group input was used to design the program and develop materials. Providers were engaged early on in the program using mailings to explain Connected Care as well as visits to primary care offices and behavioral health providers.45

A rigorous evaluation of the project is underway and incentive funds for the counties and health and behavioral health plans will be awarded on the basis of their performance on a series of measures. A plan is also underway to provide 23 rural counties with an offering for behavioral health services while remaining in fee-for-service for physical health care, with a contract for disease management for certain chronic conditions. With the geographic, workforce and other challenges in rural areas, the plan is to build virtual teams around existing resources, according to Joan Erney, JD, Pennsylvania’s Mental Health Commissioner from 2003-2010.46

State of Missouri

The state of Missouri has initiated several programs to improve the health of people with serious mental illness through DMHNet, a partnership comprised of the Missouri Department of Mental Health (DMH), Missouri HealthNet (the Medicaid agency) and the Missouri Coalition of Community Health Centers.47 Since 2003, DMHNet has launched three programs focused on people with serious mental illness, many of whom are eligible for both Medicaid and Medicare: Improving Quality of Care for Persons with Schizophrenia; Chronic Care Improvement Program; and Disease Management 3700 Project.

In the first initiative, Improving Quality of Care for Persons with Schizophrenia, DMHNet identified a sub-cohort of over 6,000 people with a diagnosis of schizophrenia (out of a total of 19,000) who were continuously eligible for Medicaid between July 1, 2003 and June 30, 2004. A sub-analysis of this group revealed a high level of co-morbid medical conditions such as cardiovascular disease and obesity as well as fragmented and redundant care.

Missouri also used a blending of Milbank models to integrate services. DMHNet undertook a program to improve quality of care by retraining Community Mental Health Center (CMHC) case managers in chronic medical illnesses, training them to collaborate with primary care providers. As challenges arose such as difficulties in communicating with providers or individuals not having a medical home, DMHNet made attempts to address the issues and make improvements.
Several analyses were undertaken of the impact of the re-tooled case management services with one particularly significant finding that in a sub-group that received high doses of case management, there was a net cost reduction when increases in outpatient care and case management were offset by decreases in emergency room and inpatient services.

The second initiative involved providing enhanced management interventions through the Chronic Care Improvement Program (CCIP) for people receiving care in CMHCs. The CMHCs added primary care nurse liaisons on site at all CMHCs. Elements of the program included an independent tracking method, intervention “to do” lists, and performance outcomes with benchmark reports for ten Healthcare Effectiveness Data and Information Set (HEDIS) indicators and medication adherence for seven different medication classes. Preliminary results found that the program almost broke even after 18 months. A follow-up analysis showed a cost savings of 17% off expected trends.

The third initiative, the Disease Management 3,700 Project, identified 3,700 Medicaid beneficiaries with SMI who are not dual eligible but among the 25% highest in utilization and costs. CMHCs were given the names of the individuals for engagement of services at the same level being provided to SMI dual eligibles.

Finally, Missouri was the first state to receive approval for a Health Home state plan option on October 24, 2011. Services for people with chronic conditions will be provided in the state’s community mental health centers to improve quality of care and reduce costs. The initiative will be used to:

- Enhance the amount of primary care nurse liaison staffing available at the CMHCs;
- Add primary care physician consultation/support;
- Enhance the State’s ability to provide transitional care between institutions and the community; and
- Enable the state to provide incentive payments to the CMHCs for reducing ER visits and inpatient hospitalization.

The services became effective January 1, 2012.

In addition to the findings in Pennsylvania, Missouri and other states, several studies highlight several integration success stories:
• Behavioral health integration efforts in a cross-section of Inter-Mountain Health System’s primary care clinics increased outpatient use and medication adherence, reduced emergency department and inpatient use, lowered cost of care.

• Studies that have focused on individuals with serious mental illnesses have also shown positive outcomes, and offer collateral evidence of the utility of these program models of integration.

• Another study of Medicaid patients in a comprehensive HMO found substance abuse treatment was associated with a reduction of just under one-third of all medical costs per treatment member.

• Even more important, for patients who achieve abstinence after treatment, family members’ health care utilization and costs are similar to that of control families, five (5) years after treatment.

Many SBHAs over the last year have played a central leadership role in accelerating the integration of behavioral health and primary care by creating and communicating a shared vision. Several statewide initiatives have been important in a process to create a shared vision for each state:

• The Minnesota 10 by 10 Program to improve life expectancy by 10 years in 10 years is modeled on SAMHSA’s 10 by 10 Campaign to promote wellness and reduce early mortality. The Minnesota project is supported by SAMHSA through the Transformation Transfer Initiative (TTI) and has conducted activities throughout the state to highlight the problem of early morbidity and develop solutions.

• The June, 2011 Illinois conference titled “Beginning the Conversation: Statewide Policy Summit on Advancing Bidirectional Behavioral Health and Primary Care Integration,” with co-sponsors and partners: Department of Human Services (including Division of Mental Health Department {DMHD} and Division of Alcoholism and Substance Abuse), Department of Healthcare and Family Services and Department of Public Health, had a broad participation of behavioral healthcare stakeholders DMHD also has played a leadership role in the statewide collaboration with the Community Behavioral Healthcare Association of Illinois.

• The Behavioral Health Reform Work Group of the New York State Department of Health Medicaid Redesign Team (MRT) was co-chaired by NY State Office of Mental Health Commissioner Michael F. Hogan, Ph.D.
The MRT is part of NY Governor Andrew Cuomo’s effort to restructure Medicaid to improve outcomes and lower costs. The work group was asked to address integration of substance use and mental health services, examine opportunities for co-location of services, explore peer and managed addiction treatment services, and provide guidance about health homes and propose innovations that lead to improved care coordination between physical and mental health services. The work group issued its final recommendations on October 15, 2011.\textsuperscript{50}

Creating and refining the shared vision for integration should be an ongoing process that is informed by day-to-day implementation of policy and programs. In that context, NASMHPD has identified three broad areas of focus for SBHAs in redesigned healthcare systems: financing, workforce and health information technology.\textsuperscript{51} Financing strategies are integral to system change (providing seed money for planning, including contract provisions to pay for performance on health indicators; tying block grant funds to integration; etc.).

Most of these strategies to implement delivery system changes require a solid collaboration on financing options through the Medicaid program. Collaboration with Medicaid and other state agencies such as the Office of Primary Care is needed for workforce development. Health Information Technology (HIT) infrastructure must be built to facilitate the sharing of health information between behavioral health and primary care. Data systems that track the provision of services and outcomes must be in place to measure progress toward desired outcomes.

**Early Lessons Learned from Initial SBHA Integration Efforts**

Key lessons learned from SBHA initiatives are the need to:

- Increase public-private partnerships by involving major players in the development of a shared vision—include key governmental leadership, professional societies, major public and private payers, educational institutions, consumers, and provider representatives.

- Encourage payers to run integrated financial data for the purpose of analysis with regards to clinical and financial outcomes. This review may identify common areas of concern and potential opportunity that can be the basis for shared objectives.

- Develop a shared implementation plan that is driven by data, evidence-based guidelines, and consumer input. Includes strategic structure, process, and outcome measures. (\textbf{Exhibit 7})
• Use evidence-based guidelines and protocols that can improve detection and
treatment of mental illness in primary care settings and prevent relapse of
symptoms. But simply introducing treatment guidelines is not enough; more
complex interventions are needed to improve patient outcomes.

• Ensure that implementation tools are designed with input from primary care
providers, specialty providers, and consumers.

• Training during implementation will need to include clinical services, practice
redesign, cultural competency, reimbursement, and policy.

• Reassure providers that integrated care is clinically beneficial and financially
viable.

The following sections look at how states can accelerate integration through:

• Managed care strategies especially for dual eligible individuals,
• Quality measurement and improvement,
• Opportunities that exist due to the rapidly changing healthcare environment, and
• Medicaid and SBHA strategic collaboration.

Key Lesson: Develop a shared implementation plan that is driven by data, evidence-based guidelines, and consumer input.

Models for Integration in Managed Care Delivery Systems for “Dual Eligible” Beneficiaries

As states grapple with the ongoing budget constraints, many are looking to managed
care to reduce costs and improve outcomes. A recent report by The Integrated
Resource Center on “State Options for Integrating Physical and Behavioral Health Care,” takes a different look at potential models of integrating services within
managed care systems. Each description addressed specific considerations for
integrating physical and behavioral health services for beneficiaries who are “dually
eligible” for Medicare and Medicaid – considerations that are particularly relevant
since many people with serious mental illness are eligible for both programs.52

MODEL 1 - MANAGED CARE ORGANIZATION (MCO) AS INTEGRATED CARE ENTITY

One of the purest approaches to integrating behavioral and physical health is to
include both benefits in managed care contracts, rather than carving out behavioral
health care from MCO contracts and providing it separately. State experience with
such integration is more common for coverage of beneficiaries with limited
behavioral health needs than for those with serious mental illness (SMI).

**TennCare:** In 2009, Tennessee’s Medicaid program, known as TennCare, completed the integration of behavioral health services within its mainstream managed care system. More recently, the State has integrated long-term services within these contracts.

**Minnesota Preferred Integrated Network Program:** Through the Preferred Integrated Network (PIN), Minnesota is pilot testing a partnership between Medica, a Medicare SNP serving dual eligible beneficiaries with disabilities, and Dakota County to integrate Medicare and Medicaid physical health services with behavioral health services. Program goals are to improve the physical and mental health of dual eligible individuals with SMI by offering: access to the full continuum of services and a single point of contact for health care system navigation. States operating Primary Care Case Management (PCCM) programs may be interested in models of integration that do not require MCOs.

**Community Care of North Carolina:** In 2010, North Carolina added an enhanced per member per month (PMPM) payment to its existing PCCM program.

**MODEL 2 - PRIMARY CARE CASE MANAGEMENT PROGRAM AS INTEGRATED ENTITY**

Community Care of North Carolina (CCNC), to support integration of behavioral health services into the 1,400 primary care practices in CCNC networks across the State. The enhanced payment allowed each of the 14 CCNC networks to hire a psychiatrist and behavioral health coordinator to focus on integration at the local level.

**MODEL 3 - BEHAVIORAL HEALTH ORGANIZATION AS INTEGRATED ENTITY**

Behavioral health organizations (BHOs) have specialized capacity around managing behavioral health services, particularly for individuals with SMI. Thus an alternative to integrating care through MCOs, is to contract with BHOs to provide both physical and behavioral health services for individuals with SMI or other serious behavioral health needs.

**Behavioral Health and Physical Health:** Arizona is currently considering this model for a future re-procurement of its Regional Behavioral Health Authority (RBHA) contract in Maricopa County. Under the proposed model, one or more “specialty RBHAs” would manage all physical and behavioral health services for Medicaid beneficiaries with SMI in the county, under the single authority of the State’s behavioral health agency.
MODEL 4 - MCO/PCCM AND BHO PARTNERSHIP FACILITATED BY FINANCIAL ALIGNMENT

This option retains the existing separation in many states between medical and behavioral health care, but aims to better align payment in each program to enhance coordination. Specifically, many states carve out behavioral health services to a BHO, either for all beneficiaries or for the subset with SMI or other significant behavioral health needs.

A Word About Quality Measurement

Performance measures can be effective tools for improving quality of care for individuals with serious mental illness, but many measures primarily focus on treatment for one condition rather than the management of co-occurring disorders. Persons with chronic mental health conditions and co-occurring disorders are uniquely vulnerable to poor quality of care because many consider the behavioral health specialty setting their "home" site for care and many behavioral treatment settings lack the resources to manage co-occurring disorders.

There is a need to develop a comprehensive framework that refines quality measures for co-occurring disorders, validation of measures for integrated services and defining accountability. Practice guidelines and protocols, at the interface of behavioral health and primary care, must be developed if we expect to move the needle on improving the quality of care at the behavioral health/primary care intersection.\(^5\)
Exhibit 7
Common Structure-Process-Outcome Integration Model

**STRUCTURE OF CARE**

<table>
<thead>
<tr>
<th>Tools</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>• Registry/tracking system</td>
<td>(EMR)*</td>
<td></td>
</tr>
<tr>
<td>o Electronic medical records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Co-location of primary care services in the behavioral health center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o 1-2 supervising physicians (may be PC, family practitioner, psychiatrist, medical director)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o 1-2 NPs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 1-3 embedded care managers/coordinators</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o 10 sites have nurses as care managers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o 3 sites have non-RN care managers (e.g. social workers)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• ADA compliant facilities</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>• Primary care assessment and treatment services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Screening and referral services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Screenings for blood, glucose/diabetes, BMI/obesity, blood pressure, hypertension, lipid profile, tobacco use*, substance use*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Case management coordination services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Specialty Medical Care (at PH partner or outside PCBHI)</td>
<td></td>
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</tbody>
</table>

**SERVICES GUIDING PROCESSES OF CARE**

| Screening and referral services                                    |            |            |
| o Screenings for blood, glucose/diabetes, BMI/obesity, blood pressure, hypertension, lipid profile, tobacco use*, substance use* |            |            |

**OUTCOME OF CARE**

| Blood glucose/HbA1c diabetes                                      |            |            |
| Weight/height/BMI/obesity                                        |            |            |
| Blood pressure/hypertension                                      |            |            |
| Cardiovascular disease/cardiac risk factors                      |            |            |
| Lipid profile                                                    |            |            |
| Tobacco use                                                      |            |            |

**Wellness/prevention services**

| Individual wellness plans                                        |            |            |
| Wellness classes/groups                                          |            |            |
| o Topics vary by site                                            |            |            |
| o All sites include:                                             |            |            |
| o Nutrition education/counseling*                               |            |            |
| o Tobacco cessation*                                             |            |            |

* Unconfirmed for/not applicable to 1 site.

Source: Trina Dutta, MPP, MPH. “Primary and Behavioral Health Care Integration.” SAMHSA. October, 21 2010.
Will the Changing Healthcare Landscape Address and Facilitate New Integration Initiatives?

The changing healthcare landscape offers organizational and financing arrangements that can overcome many significant impediments to integration. Included among the measures that will accelerate integration efforts are the following:

- Eligibility expansion covering individuals who are at-risk for having behavioral health conditions, and who have been previously uninsured. The Kaiser Family Foundation estimates that up to 22.8 million more children and adults will enroll in Medicaid by 2019 depending on the success of state’s outreach and enrollment efforts.\textsuperscript{54}

- In a different study, researchers estimate that about 5.5 million uninsured (as much as 10 million people with MI will gain coverage) Americans with behavioral health disorders are expected to obtain health insurance coverage through the expansion of Medicaid, while many more will gain coverage through new health insurance pooling arrangements.\textsuperscript{55}

- The “Essential Health Benefits” package in Medicaid “Benchmark Benefit” plans will cover prevention, screening, treatment, habilitation, rehabilitation, and recovery support services at parity.

- Bi-directional integration of behavioral health services and primary care employ collaborative care and disease management for individuals with multiple chronic conditions.

- The Medicaid “Home and Community Based 1915(i) Option” covers a broad range of services to target populations, especially for people with serious mental illness.

- “Accountable Care Organizations (ACOs)” are composed of integrated provider networks operating with shared electronic health records, practice guidelines and protocols, quality measures, and performance standards.

As healthcare policymakers at the federal and state level seek to transform the cost-effectiveness and delivery of publicly-financed care, states are intensifying efforts to develop integrated care models for individuals with both physical and behavioral health conditions where there has been little care coordination across providers.
SBHAs and Partnerships with State Medicaid Officials

In response to the ongoing severe budget shortfall situation, many states have sought ways to reduce general revenue outlays while maximizing Medicaid revenues to pay for vital healthcare services. At the same time, pressure to reduce overall Medicaid spending continues at both the state and federal levels. The high prevalence of co-morbid conditions in the Medicaid population makes the existing silos of care for behavioral health and physical health unsustainable. In any given year, nearly half of all Medicaid beneficiaries will have a diagnosable mental health or substance use disorder.

Additionally, as we reported in Exhibit 1, 68 percent of adults in Medicaid with mental health disorder have medical conditions and 29 percent of adults with medical conditions have mental health disorders. Among individuals who are eligible for both Medicaid and Medicare, the prevalence of multi-chronic conditions is even higher. Approaches are now available to the states that hold the promise of reducing the cost of treating co-occurring conditions and improving outcomes for high-cost beneficiaries receiving care in the Medicaid program.

The changing healthcare landscape will pave the way for states to take more ownership and to be a catalyst for increased integration efforts. SBHAs must be more assertive in moving the system to more integrated care and reducing barriers as they forge the way for behavioral care that consumers require. But they alone will not overcome the barriers to improve integration of healthcare services. It will require a sea change in thinking about how healthcare is delivered in the U.S. and the participation of all key stakeholders – public and private purchasers, providers at all levels, consumers and educational institutions.

The changing healthcare landscape presents a unique set of opportunities to bring health coverage to more Americans. It also brings with it new challenges and opportunities as to how individuals with chronic diseases of persistent mental illness and/or substance use can best receive primary care and behavioral health services.

The needs of individuals with severe mental illnesses, such as schizophrenia, bipolar disorder or major depression, are not dissimilar to the needs of individuals with chronic illnesses, such as diabetes, cancer or cardiac disease. Caring for those struggling to manage long-term illnesses is complex.

The high prevalence of co-morbid conditions in Medicaid population makes existing silos of care for behavioral health and primary care unsustainable.

SBHAs, working with state Medicaid officials, can undertake specific measures and projects that address the need to link behavioral healthcare and primary care services are:
• A state plan option under Medicaid has been created to provide health homes for persons with multiple chronic conditions. Importantly, two of the six chronic conditions defined in the law are a serious mental health condition and a substance use disorder.

• Health Homes may be established in primary care settings or specialty care settings, depending on the resources available in those settings, the consumers’ needs, and established relationships with caregivers.

• One federal measure authorizes $50 million in grants to co-locate primary and specialty care in community-based behavioral health settings. The purpose of this program is to coordinate and integrate services for adults with mental illnesses who have co-occurring primary care conditions and chronic diseases. Primary and specialty care services in community-based mental health and behavioral health settings (such as community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs) will be co-located.

Initiatives that seek to prevent and reduce the incidence of chronic diseases also have the potential to improve the care and outcomes for people with behavioral health disorders.

• The Secretary of Health and Human Services is authorized to award grants to states to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles. These programs, which must be comprehensive and must have demonstrated success in helping individuals in areas such as lowering or controlling cholesterol and blood pressure, losing weight, quitting smoking, and managing or preventing diabetes, may also address co-morbidities, such as depression, associated with these conditions (see Role 4 in “Cornerstones” for additional information).

• The HHS Secretary may also award community transformation grants for programs to prevent and reduce the incidence of chronic diseases associated with overweight and obesity, tobacco use, or behavioral health disorders.

• SBHAs should work with Medicaid officials and healthcare providers to provide the means and incentives necessary to integrate medical and behavioral health services to improve the overall quality of patient care. For example, SBHAs could work with the state Medicaid plan to eliminate barriers to integrated behavioral health care, such as policies that prohibit billing multiple services on the same day.
In addition to developing partnerships with Medicaid officials, SBHAs can take these additional steps:

- SBHAs should consider collaborating with behavioral health providers or other entities in designing and testing new service delivery models. Services provided in Health Homes must be coordinated, including patient and family support, transition from the hospital, use of health information technology and provision of referral to community and social services. The full inclusion of behavioral health prevention and treatment services must be an essential part of all Health Homes.

- SBHAs should promote the adoption of innovative health care delivery models by developing new purchasing practices (e.g., purchasing practices that incentivize providers to deliver care for co-occurring mental health and substance use disorders) or using their funds to invest in infrastructure that would support these models. SBHAs could identify and promote value-added roles for behavioral health services in primary care and facilitate a dialogue between providers.

- SBHAs should strongly support the continued investment in co-location of primary care services in behavioral health settings and the robust evaluation of these programs and their ability to improve health status, especially those with serious mental illness.

- SBHAs could begin to promote connections between behavioral health specialists and primary care physicians who provide care within a Patient Centered Medical Home (PCMH). Once health teams are established, SBHAs could also consider ways to collaborate with health teams to foster integration of community-based behavioral health resources within disease prevention and disease management efforts.

- NASMHPD’s Medical Directors Council developed a technical paper titled “Consumer Involvement with Mental Health Authorities” that considered both population-based and person-centered approaches to care to guide SBHA efforts. The report can be accessed at: http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Consumer%20Involvement%20with%20Persons%20with%20SMI%20Final%20Part%201...rev.pdf
Members of the NASMHPD Medical Directors Council should engage medical leadership in their state public health agencies to promote integration of health and behavioral health issues in state level health policy, planning and reimbursement. Medical Directors could disseminate data at the state/local level on the association of behavioral health issues with health risk and chronic disease in the general population.

- In regard to strategies to support the integration of behavioral health into primary care, SMHAs could promote and help pediatric practices create a framework strategy for integration. Three broad categories of service models that primary care providers could adopt in order to provide behavioral health services to children are: consultation, co-location and collaboration.
Conclusion

State behavioral health authorities have a major role to play in accelerating the integration of primary care and behavioral health to improve the health outcomes of people with serious mental illness, thereby reducing the number of years of lost life and improving quality of life. The SBHAs also have a key role in improving the health outcomes for people with multiple chronic illnesses who would benefit from behavioral health interventions to reduce the symptoms of depression and anxiety that often accompany serious illnesses.

Targeting highly complex cases—the small percentage (5%) of individuals who account for about half of all health care spending—can result in reduced spending and improved outcomes.

Integration can be achieved in any healthcare delivery system but requires certain common elements: a well-trained and adequate provider network; health information technology; multidisciplinary care teams, providing services in a competent and coordinated manner; and financial and other incentives to improve care. The clinical and policy expertise that SBHAs provide are invaluable to other state agencies, especially the Medicaid authority, in developing financing and delivery innovations to improve the public’s health.

SBHAs also provide the leadership needed to bring other public agencies as well as private organizations together to develop and fund services that are vital individuals with serious mental illness. Supportive housing and employment are especially important for the health and inclusion of these individuals in their communities. While there are complex reasons for the shortened lifespan of individuals with serious mental illnesses, there are also promising strategies for making real progress in the near term, the first being a major state-by-state thrust to accelerate the integration of behavioral healthcare and primary care.
Endnotes


13 Druss B.G., et.al.

14 Druss, B.,G. et al; 603.


17 Lusardi A. et al, “Economic Crisis and Medical Care Usage.”


27 NASMHPD Research Institute, Inc., Profiles.


33 SMHSA/HRSA Integrated Care Center and Ron Tremper, Administrator, Office of Research, Data and Compliance, Division of Behavioral Healthcare, RI Department of Behavioral Healthcare, Developmental Disabilities & Hospitals, 2011.


35 Community Care of North Carolina, Mental Health Integration Pilot Program Summary, 2007.


37 Community Care website: http://commonwealth.communitycarenc.org/toolkit/14/Module_14.pdf


39 NASMHPD Research Inc., 2010 State Mental Health Agency (Health and MH Questions), Profiles.


44 Ibid.

45 Ibid.

46 Ibid.

47 Parks J., Summary of Missouri’s Efforts to Integrate Care for SMI Individuals, prepared in conjunction with a May 24 webinar on “Missouri’s Efforts to Integrate Care for Individuals with Serious Mental Illness: A Catalyst for Other States, ”http://www.nasmhpd.org/Webinar_MO_524211.cfm.


49 Parks J., Summary of Missouri’s Efforts to Integrate Care for SMI Individuals.

51 Financing and the Public Mental Health System – A Policy Brief; Health Information Technology and The Public Mental Health System – A Policy Brief; Workforce and the Public Mental Health System – A Policy Brief, NASMHPD Issue Briefs, 2011.

52 Hamblin A. et al., State Options for Integrating Physical and Behavioral Health Care, Center for Health Care Strategies (CHCS) and Mathematica Policy Research for the Integrated Care Resource Center, a national initiative of the Centers for Medicare & Medicaid Services (CMS). Technical Assistance Brief, October 2011.


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For more information about the report, please contact:
Joel E. Miller
Senior Director of Policy and Healthcare Reform
NASMHPD
joel.miller@nasmhpd.org or at 703-739-9333

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