



American Mental Health Counselors Association White Paper Series

Integration of Mental Health and Primary Care Services

Introduction

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 a dual diagnosis of mental illness and substance abuse, on average, die nearly 32 years earlier than their fellow citizens. In the general population, individuals with a mental illness die nearly 9 years sooner than those without a mental health disorder. The leading solution to address this problem is to integrate behavioral healthcare and primary healthcare services.

The problem of substantially shortened lifespans for people with serious mental illnesses is a major public health and health disparity issue. This issue was initially spotlighted by the National Association of State Mental Health Program Directors (NASMHPD) nine years ago. The magnitude and degree to which premature death is the result of preventable medical conditions has become a major public health crisis with consequences for the entire healthcare delivery and financing system.

A lack of coordinated care is the major reason for severe mortality and morbidity problems for behavioral health consumers.

In essence, we are witnessing epidemics within epidemics, that is, an epidemic of growing morbidity and mortality among those with mental illness within a broader epidemic of obesity, diabetes, and related health conditions. Specifically, persons with schizophrenia have more than three times the mortality rate for respiratory diseases and diabetes than the general population. Major depression is strongly linked with other chronic conditions like diabetes and asthma, and individuals with these conditions make twice as many visits to primary care doctors as the general population. From a system-wide perspective, this problem is costing the nation billions of dollars. People with major depression who have diabetes have four times the health expenditures as the general population.

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To address this alarming national public health and cost issue, with other mental health organizations, AMHCA is working to address these issues through leadership and technical assistance. AMHCA is sponsoring several forums under its ASCENT initiative and has issued numerous materials on how CMHCs can better position their practices by integrating their services with health care providers.

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What Do We Mean by Integration?

Integrated health care is the *systematic coordination of behavioral healthcare and primary care*. Evidence demonstrates that physical and behavioral health problems often occur at the same time for people with serious mental illness. Episodic, point-of-service treatment is ineffective and inefficient for chronic behavioral and medical illnesses. Integrating services will yield improvement in clinical outcomes and quality of life and the best possible results.

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The quality improvement movement in health care—which contains the goal that consumers should always receive the right care, at the right time, by the right caregivers—supports the idea of integrative, comprehensive health care services for people with serious mental illness. Clinical mental health counselors (CMHCs) should participate in state and local public and private sector programs that accelerate the necessary linkages between physical health care and behavioral health services to promote and achieve recovery for people with mental illnesses and addictions.

Various groups define integrated care differently, but the field agrees that integrated care is patient centered, accountable, based on evidence and measurement, and delivered by a care team that shares a defined group of patients tracked in a registry.

- Five major models of care have emerged including collaborative care, care management, co-location, medical homes, and Accountable Care Organizations (ACOs).
- Although evidence for some integrated care models is robust, more research is needed on the number of CMHCs currently involved with new care models, how new care models address behavioral health disparities and these models' effect on children and adolescents.
- Developing integrated care models that can be sustained will require financial changes, since traditional reimbursement models will not work.
- The role of the CMHCs and other behavioral providers within these new models of care must be defined, along with appropriate training and education of core competencies in integrated care models.

Early Integration Results

There are several new models that have recently been developed to redesign and align financial incentives to advance integration and collaborative care. 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. More than 50 percent of all Medicaid-related readmissions in the state were for medical readmissions with a diagnosis of mental illness and substance abuse.

Clients with MI/SA who had a readmission due specifically to their MI/SA diagnosis cost the state Medicaid program \$270 million in the same year. With a new integration program in place—the Western NYS Care Coordination Program—the state saw 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. 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.

Challenges to Integrating Behavioral Healthcare and Primary Care Services

The primary reason for the significant gap in mortality for people with mental illness compared to the rest of the population is the difficulty these individuals have in receiving care in a coordinated and comprehensive manner. The behavioral health care system—much like our overall health care system—has fragmentation and quality problems such as misuse of services.

The complex conditions of people with a mental health issue—especially people with a severe mental illness—often require services in specialty mental health, primary and specialty medical care, and in many cases, specialty substance abuse care. About 60 percent of premature deaths in persons with schizophrenia are due to chronic conditions such as heart disease, diabetes, respiratory diseases, and infectious diseases. The “chronicity” of these problems suggests to some observers that it may take additional time for efforts to begin to narrow the mortality gap for persons with behavioral health disorders.

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

It is imperative that mental health providers learn how to best integrate behavioral health services and primary care, recognizing each state’s and locality’s unique health care resources, financing of services and programs, and infrastructure.

It is imperative that states address co-occurring behavioral health and substance use disorders because of the prevalence (anywhere from a 40 to 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 still remain, such as real and perceived barriers to sharing medical information and different cultures of treatment.

Lessons Learned in Efforts to Accelerate Integration

The primary care sector needs to work together with CMHCs to deliver good behavioral health care. Otherwise, mental illness will go undiagnosed and untreated.

Key overall lessons to accelerate integration of behavioral health care and primary care services include:

- Integrate care everywhere! The research is clear: With a behavioral health specialist on the care team (not in another agency or across town physically), good care can be delivered in a dependable way to clients. We must integrate health care into behavioral health specialty settings because without it, clients will never receive good health care, and the rates of premature death for people with mental illnesses will not improve.

- Increase public-private integration partnerships by involving major players in the development of a shared vision, including governmental leadership, professional societies, and payers.
- Ensure that implementation tools are designed with input from CMHCs, primary care providers, specialty providers, and consumers.
- Reassure providers that integrated care is clinically beneficial and financially viable.
- Social factors such as stigma and discrimination must also be addressed.

Health Homes and ACOs as Pioneer Integration Efforts

Under the Affordable Care Act (ACA), the Centers for Medicare and Medicaid Services' (CMS) Innovation Center was created, and is currently implementing "Health Homes" under Medicaid, and "Accountable Care Organizations (ACOs)" under Medicare, in order to improve quality of care and reduce healthcare costs.

Behavioral health service providers such as clinical mental health counselors have the expertise in integrated care, care coordination, and service delivery, and should play an important role in the implementation of these two new models of care and other emerging strategies as they play out both in the public and private sectors.

Health Homes and Accountable Care Organizations have the potential to unleash powerful incentives to better coordinate and integrate behavioral health and primary care services, thus can be labeled "Taking Integration to the Next Level," since they contain several new elements to improve care.

A new model called the "Coordination Care Organization," which the state of Oregon is introducing on a system-wide basis, is a further example of enhanced integration that encompasses large insurance companies and accountable care organizations.

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Role of the CMHCs in Accelerating Integration

CMHCs need to ready their practices and the agencies where they work for the changes ahead.

- Do you have a plan for integrated or coordinated care?
- Will you be a health home? Part of a person-centered medical home (PCMH)?
- Managed by an Accountable Care Organization (ACA)?
- Will your practice/agency be merged with a bigger behavioral health organization or taken over by a hospital organization?

What can you as a CMHC do now?

1. Begin using a certified electronic health record (EHR).
2. Know the cost of services by program.
3. Know current access to care.
4. Know current productivity.

5. Use evidence-based practices and measure outcomes objectively—improve quality!
6. Measure change over time often—adjust to increase quality!
7. Provide preventative services—follow through.
8. Build relationships with other providers—share and coordinate care!
9. Create data-based evidence to demonstrate quality and efficiency (cost saving) service delivery.
10. Develop sample outcomes with objective data to demonstrate quality and efficiency.
11. Engage patients with patient portals.
12. Help patients self-manage their health, wellness and recovery.
13. Use concurrent documentation and involve patients in decisions.

It is critically important to meet with health plans and insurance companies ASAP!

- Form relationships yesterday!
- Give them your business cards
- Offer them tours of your facility and describe your treatment methods and services
- Use the state association to provide an education day and offer resources
- ENGAGE!

AMHCA Policy Actions

On a wider policy front, AMHCA is:

- Helping pass legislation to co-locate primary health care services within community behavioral health treatment provider agencies and vice versa. Basic physical and behavioral health care should both be available in virtually all clinical settings.
- Supporting the continued investment in co-location of primary care services in behavioral health settings—and vice versa—and the robust evaluation of these programs and their ability to improve health status, especially for individuals who have complex mental illnesses.
- CMHCs should contact their elected officials to help promote legislation that addresses these areas raised above, including payment for services under Medicare and Medicaid.

CMHCs should:

- Play a major role in formulating integrated care solutions by defining their role and benefit to patients. NIH, CMS, and other federal agencies should continue their ongoing research and evaluation of these models.
- Work closely with other care professionals to monitor and ensure that agreed-upon policies and standards result in the best care for patients and families. Special emphasis should be placed on working with CMS and other federal agencies in developing quality metrics for integrated care to be implemented through the patient registries.

- Inventory current models should be developed with data on best practices for CMHCs, physicians, health care leaders, and policy makers.

Integrated Care: A Health Care Reform Imperative

With or without the Affordable Care Act, health care reform through new delivery and financing models is moving forward. In other words, health care reform is not simply about what is codified in the ACA. There are market forces—as well as other state and federal initiatives—that predate the ACA, and will persist going forward. Integration of mental health and primary care services is part of those marketplace and regulatory imperatives.

Integrated care models hold promise in addressing many of the challenges facing our health care system. The clinical and policy expertise that CMHCs possess and can provide will be invaluable to other primary care physicians in developing innovations in integration to improve the nation's public's health, with the goal of dramatically reducing the unacceptable high morbidity and mortality rates experienced by Americans with mental illness.

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The Advancement of Clinical Practice Committee of the American Mental Health Counselors Association (AMHCA) is responsible for developing, coordinating, and producing the white papers, which give a brief orientation to clinical mental health counselors about topics relevant to current practice. Existing AMHCA white papers include technology in counseling, trauma-informed practices, and responding to suicide risk. The Committee has a protocol for interested authors and contributors; please contact the chair of the Committee.

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