Implementing Mental Health and Substance Abuse Integration: Drivers and Considerations

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Vision:
Mental health is universally perceived as essential to overall health and well-being with services that are available, accessible, and of high quality.

Mission:
NASMHPD serves as the national representative and advocate for state mental health agencies and their directors and supports effective stewardship of state mental health systems. NASMHPD informs its members on current and emerging public policy issues, educates on research findings and best practices, provides consultation and technical assistance, collaborates with key stakeholders, and facilitates state to state sharing.

Guiding Values:
Recovery and resiliency are the overall goals and certain fundamental values guide NASMHPD in its mission:
- Person- and family-centered
- Integration of health and mental health services
- Attention to prevention and early intervention
- Community integration
- Emphasis on diversity

2007-2009 PRIORITIES
Transforming Mental Health

Workforce

Financing

Consumers

Changing/ evolving role of SMHA

Integration of health and mental health

Recovery & Resilience
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Rates for Mental Health and Substance Use Disorders

- Half of all lifetime cases of mental and substance use disorders begin by age 14 and three-fourths by age 24 (Kessler et al, 2005)

- 72 million people (15 million children and 57 million adults) – 23% of US population – affected by MH/SUD yearly (SAMHSA, 2011)

- In 2009, an estimated 23.5 million persons (8.9% of the population aged 12 or older) were classified with substance dependence or abuse based on criteria specified in the DSM-IV (SAMSHA, 2010a)

- The National Institute of Mental Health (NIMH) estimates that 26.2% of Americans – or roughly 57.7 million people – are affected by mental illness in any given year (NIMH, 2010)
Approximately half of individuals (50.9%) with a lifetime history of a mental disorder also have a lifetime history of at least one addictive disorder, while 41% to 65.5% of those with a lifetime history of an addictive disorder also have a history of a mental disorder (Kessler, 1996).

Swendensen and colleagues (2010) found that mental disorders were prospectively associated with the transition to substance use, abuse, and dependence with abuse over a ten year period. Behavioral disorders and pre-existing substance use conditions were most strongly and consistently associated with these transitions, suggesting potential targets for prevention efforts.

In 2002, rates of serious mental illness were relatively low among adults who did not have a substance use disorder (7%). In contrast, the rate was much higher among those with alcohol dependence or abuse (19.0 percent) or illicit drug dependence or abuse (29.1 percent), and was highest among those with drug and alcohol dependence or abuse (30.1 %) (Epstein et al, 2004).

In 2000 and 2001, adults who had received substance abuse treatment had 2 to 5 times higher rates of past year mental health treatment than adults who never had substance abuse treatment (Barker et al, 2004).
Mental Health and Substance Use Disorders are Growing as a Source of Disease Burden

- By 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability worldwide (WHO, 2004)
- The annual total estimated societal cost of substance abuse in the United States is $510.8 billion (Miller and Hendrie, 2009)
- One estimate puts the total economic costs of mental, emotional, and behavioral disorders among youth in the United States at approximately $247 billion (IOM, 2009)
- Societal costs associated with untreated depression and substance use conditions include lost wages, reduced productivity, and overall medical costs
Treatment Seeking

- In 2000 and 2001
  - about 1.3 million adults received only treatment for a substance abuse problems
  - 1 million received treatment for both mental health and substance abuse problems
  - 20 million were treated only for a mental health problem in the past year (Barker et al, 2004)

- Those admitted to treatment reporting psychiatric problems in addition to substance abuse problems more than doubled between 1992 and 2006 (SAMSHA, OAS, 2011*; SAMHSA, 2011- Leading Change)
Mental Health and Substance Use Disorders are a Significant Source of High Cost Emergency and Inpatient Utilization

- 12 M Emergency Department (ED) visits due to MH and/or SU disorders in 2007; 12.5% of all visits (AHRQ, 2010)
- Persons with co-occurring BH conditions at highest risk of frequent ED use (Curran et al, 2003)
- Represent substantial portion of “super users” (DeLia and Cantor, 2009)
- 98% increase in SU driving ED visits from 2004 to 2009 (DAWN, 2009)
- MH and/or SU disorders in ED 2.5 times more likely to result in hospitalization (AHRQ, 2010)
- Complex conditions not well treated in ED, continuing pattern of poor care at high cost (Alakeson et al, 2010)
Environmental Drivers of Integration: Behavioral Health and Primary Care Integration

Untreated Comorbidities are Costly

- Untreated cardiac, diabetes, other physical health conditions driving preventable morbidity and mortality in persons with serious mental illness; 25 fewer years of life (Parks et al, 2006)

- Presence of behavioral condition with cardiac or diabetes drives morbidity, mortality and cost (Katon et al, 2010)
Integrated Treatment Gets Results

- Mental health integration efforts in a cross section of Intermountain Health system’s primary care clinics increased outpatient use and medication adherence, reduced emergency department and inpatient use, lowered cost of care (Reiss-Brennan et al, 2010)

- 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 (Druss et al, 2011)

- 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 (Walter, Ackerson and Allen, 2005)

- Even more important, for patients who achieve abstinence after treatment, family members’ health care utilization and costs are similar to that of control families, 5 years after treatment (Weisner, Parthasarathy, Moore and Mertens, 2010)
Environmental Drivers of Integration: Impact of Behavioral Managed Care on Provider Base

- MBHOs disrupted exclusive and bifurcated lines from State Mental Health and State Substance Abuse Authorities to providers
- Imposed standard rules for credentials, contracts, payment, quality reporting
- Drove reimbursement to levels that demanded economies of scale from providers
- Drove consolidation among provider agencies, including across Mental Health and Substance Abuse
Environmental Drivers of Integration: Behavioral Health and Primary Care Integration

- Focus on prevention, early identification and treatment
- Reduce acute episodes, associated disability and care costs (ER and inpatient readmissions)
- Manage multiple chronic conditions (MCC) and limit associated morbidity and mortality
- Integrate care to improve clinical results, delivery system and cost efficiency
- Orient practices and delivery to promote recovery
- Address shortages of behavioral and primary care practitioners
Eligibility Expansion covering individuals who are at-risk for or having behavioral health conditions, and who have been previously uninsured; Kaiser Family Foundation (KFF) estimates that 15.9 to 22.8 million more children and adults will enroll in Medicaid by 2019, depending on the success of states’ outreach efforts (KFF, 2010).

In a different study, researchers estimate that approximately 5.4 million uninsured persons with MH/SUD will obtain coverage through the expansion of Medicaid, while many more will gain coverage through the health insurance exchanges (Donahue et al, 2010).

Essential Health Benefits in Benchmark Benefit plans will cover prevention, screening, treatment, habilitation, rehabilitation, and recovery support services at parity.

Bi-directional integration of primary and behavioral health.

Health homes employing collaborative care and disease management for individuals with multiple chronic conditions.

HCBS 1915 (i) Option to cover a broad range of services to target populations.

Accountable Care Organizations composed of integrated provider networks operating with shared EHRs, practice protocols and performance incentives.

Financial reforms (e.g., pay for performance, global payments, DSH payments, episode payments, cost offsets and cost effectiveness, return on investment, actuarial implications of benefit packages,
Environmental Drivers of Integration

- Consumer Needs: inexcusable morbidity and mortality tied to complex co-occurring conditions
- Economic Climate: pressure for effective use of limited public resources and alternative to service cuts
- Eligibility and Payment: 2014 expansion will secure Medicaid’s dominance and standards, drive demand and exacerbate professional supply shortages
- Political/Administrative Structures: 30 States integrated and created State Behavioral Health Authorities or Umbrella HHS Agencies
“Integration refers to those activities at the level of any behavioral health organization (state system, mental health system, county, agency, program) that organize both the structure of the organization and the functional processes of the organization so that mental health and substance abuse “components” are interwoven in a coherent manner in order to accomplish the organization’s mission for its total population of individuals and families with mental health and/or substance disorders” (Cline, 2005)

Not, parallel, co-located or blended

“Integration does not mean that the independent identity and value of each component is lost; rather each type of component or service is a valuable element in the interwoven fabric of care” (Minkoff, 2007)
Implications and Benefits: Define Organizational Function

Address Historical Mental Health and Substance Abuse Silos

- Complex needs of consumers do not align with the silos in entitlements and agency mandates creating resource gaps, fragmentation, and inflexibility

- Fade historical focus on differences between discrete mental health and substance use conditions

- Integrate administrative, financial, regulatory and program structures

- Unify divided eligibility rules, payment practices, professional standards, service models and delivery systems

- Tackle view that efficiencies will only accrue to other agencies (Justice, Health, Social Services) as reason for delay
Implications and Benefits: Individual and Clinical Dimension

- No wrong door for users and families improves access
- Reduced fragmentation makes experience more manageable and focuses therapeutic alliance
- Capture advantages from multidisciplinary care and leverage value of cross-seeding of staff expertise
- Research cited in earlier slides confirms better clinical, cost and satisfaction results from integration of care
Implications and Benefits: Practitioner and Provider Dimension

- Capitalize on convergence of previously disparate models
  - Recovery model – mental health field now embraces recovery as achievable, even in the context of persistent, chronic conditions
  - Chronic disease model – substance abuse field now recognizes substance use disorders and chronic conditions to be managed, rather than acute and episodic conditions

- Borrow lessons from colleagues working in underserved areas and with disparities populations, where care integration has long been a survival and delivery strategy

- Recognize experience working with integrated care networks for Medicaid and other payors’ managed care networks

- Improve results by implementing integrated treatment models that arose in response to earlier failures in parallel and sequential treatment approaches to serving individuals with dual disorders (ACT, IDDT, MTC)
Implications and Benefits: Practitioner and Provider Dimension

- Leverage and cross-seed expertise to strengthen service offerings and reduce impact of professional staff shortages

- Focus on facilitating work with complex client populations without loss at the boundaries of components

- Secure fairer reimbursement with shared standards and increased clout

- Manage risk in new global payment structures
Implications and Benefits: System of Care Dimension

- Eliminate redundancies to stretch funds to cover other priorities and services
- Provide more robust and effective response to consumer and family needs, preferences and recovery goals
- Reap rewards of an integrated economic model, producing better care management efficiencies
- Retain resources and strengthen position as ACOs roll out
- Measure impact of efficiencies that accrue to other health, welfare, social services and justice agencies
Implications and Benefits:
Supporting Effective and Efficient Care

- Cohesive benefit package that includes prevention and early intervention services, evidence-based and best practice treatments and supports to promote recovery and preserve resilience.

- Public Health approach using epidemiological data to guide prevention and early intervention and utilization data to target treatment and recovery support interventions.

- Unified program standards, service definitions and utilization, quality, performance and outcome measures.

- Integrated workforce with cross-cutting credentials and professional competencies.

- Aligned health systems providing bi-directional care delivered by multidisciplinary teams with shared roles for behavioral health and primary care practitioners.

- Funding strategies that support team based care, flexible and sufficient resources to achieve results rather than utilization.
Steps in Promoting System Integration: Leadership

- Balanced and fair leadership is essential to guiding efforts to merge, without submerging one party or the other

- Change benefits from a “respected, persistent champion” (Gelber)

- Acknowledge shifting of professional roles and identities at all levels of care system and government agencies
Steps in Promoting System Integration: Engage Stakeholders

- Convene joint planning and advisory councils to craft vision and mission
- Confirm shared vision and mission
- Strengthen common ground and mutual understanding of history, culture and roles
- Devise shared solutions
- Build trust and frame expectations
- Report on outcomes
Steps in Promoting System Integration: Engage Stakeholders

- Establish common and distinct priorities in a transparent manner
- Reaffirm rights protection and advocacy functions for all individuals served
- Account for resource allocation plans and decisions
- Preserve visibility with governor, legislature, advocates for behavioral health, and mental health and substance use conditions within that, to provide advocates a platform for preservation of rights and resources
Steps in Promoting Integration: Structural Opportunities

- Strengthen linkages to and resource commitments from courts, justice, social welfare and public health
- Align legal, regulatory and administrative structures to free resources for the care mission
- Capitalize on 2014 Medicaid expansion and harmonize fragmented financing
Steps in Promoting Integration: Tackle Structural Barriers

- Data
- Quality Assurance and Oversight
- Contract and Grants Administration
- Workforce Recruitment, Credentials, Training
- Facilities and Services
- Financing and Reimbursement
Tackle Structural Barriers: Financing and Reimbursement

Fragmented Behavioral Health Funding Sources

Private Dollars
- Commercial Insurance
- Grants

State Dollars*
- DMH
- DSS
- DYS
- DPH
- DOE
- DOC
- Facilities
- Community
- Purchase of Service

State and Federal Dollars
- Medicaid FFS
- Medicaid PCC
- Medicaid MCOs
- Medicaid Other
- Medicaid Plans
- Fee for Service Plan (EPSDT, SCHIP)
- Primary Care Clinician Plans
- Managed Care Organizations
- Specialty Plans (Disabled, Aged)

Federal Dollars
- Medicare Block Grants
- Title IVE
- State Dollars* (as indicated in State and Federal Dollars)
- Private Dollars (as indicated in Private Dollars)
- Medicaid Plans (as indicated in State and Federal Dollars)
- Federal Dollars (as indicated in Federal Dollars)
Shared Aspirations for Results

- Access expanded, particularly for persons with substance use conditions, comorbid conditions, and disparities populations
- Effectiveness increased through use of sound prevention, screening, treatment and recovery supports
- Efficiency improved to support impact
- Innovation and care advances supported
- Recovery achieved for all
References

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