



The Center for Policy, Advocacy, and Education of The Mental Health Association of New York City

INTEGRATE PHYSICAL AND BEHAVIORAL HEALTH SERVICES AN ADVOCACY AGENDA

Preamble

The fragmentation of physical and behavioral health services in the United States contributes to widespread failure to identify and effectively treat people of all ages with diagnosable mental, substance use, and physical disorders as well as to missed opportunities to promote physical and mental health. The problems are significant.

- Each year over 25% of Americans have a diagnosable mental and/or substance use disorder. Only 40% get treatment.
- People with serious mental illness have vastly lower life expectancy than the general population in large part because of poor physical health and poor health care.
- People with chronic physical illnesses such as diabetes, cardiac conditions, or neuromuscular disorders who have untreated, co-occurring mental disorders are at elevated risk of disability and premature mortality, and their medical costs are double or more those of people with the same chronic illnesses without mental illness.
- People with co-occurring serious behavioral and physical health conditions are generally the highest cost Medicaid cases, largely because their conditions go untreated until they are in severe crises resulting in frequent visits to emergency rooms and long inpatient stays for physical and/or behavioral disorders.
- Failure to address behavioral health problems of people with long-term disabilities and their family caregivers is among the major reasons for over-utilization of nursing homes.
- There is growing evidence that preventive interventions could reduce the prevalence mental and physical disorders, but for the most part the American physical and mental health systems are not oriented to pursue opportunities for prevention.

In response to these disturbing facts, The Mental Health Association of New York City (MHA) has made integration of physical and behavioral health services a priority for advocacy so as to:

- Promote mental and physical health for children, adults, and older adults
- Improve identification of people of all ages with mental or substance use disorders
- Improve access to behavioral and physical health services
- Improve quality of care in the community physical and behavioral health settings and in institutions
- Reduce morbidity and mortality of people with co-occurring chronic physical and mental disorders
- Increase life expectancy of people with long-term psychiatric disabilities
- Reduce unnecessary utilization of institutions, such as adult homes and nursing homes
- Provide more effective, and less costly care, to high cost cases.

Integration in Multiple Settings

To help achieve these goals, MHA will advocate for integration of services in many different service settings including those operated by state and local government, voluntary and proprietary providers, the VA and the military, private practitioners, and employers.

Primary Health Care

MHA supports integration of primary physical health care and behavioral health services on two fronts--in primary physical health care settings and in behavioral health care settings. Integration in behavioral health care settings is especially important for those with long-term psychiatric disabilities and/or substance abuse disorders who are connected with mental health or substance abuse programs.

Primary health care providers who should be encouraged to integrate physical and behavioral health services include:

- Clinics and community health centers
- "Patient centered medical homes", "accountable care organizations", and the like
- Private practitioners.

Mental health programs that should be encouraged to integrate mental and primary physical health services include:

- Information and referral programs
- Clinics
- Private practitioners
- Psychiatric rehabilitation programs including Personalized Recovery Oriented Services (PROS)
- Housing programs
- Day treatment programs including partial hospitalization
- Inpatient psychiatry.

Substance abuse programs that should be encouraged to integrate behavioral and primary health services include:

- Information and referral

- Methadone maintenance
- Inpatient and outpatient detoxification programs
- Inpatient and outpatient rehab
- Self-help and mutual aid groups.

Specialty Health Care

MHA is also committed to improving attention to mental health and/or substance use disorders by medical specialists, especially those who provide treatment for people with chronic, physical health conditions such as diabetes, heart disease, neuromuscular disorders, pulmonary conditions, and HIV/AIDS. This includes:

- Chronic disease specialists in clinics and in private practice
- Inpatient physical health care
- Residential programs
- Physical rehabilitation programs.

Long-term Care Programs

Long-term care programs are regulated by the physical health system because they are generally regarded as serving people with physical health problems. In fact, however, a substantial portion of the people who receive long-term care services have mental disorders, most often dementia, but also mood, anxiety, and psychotic disorders, which often co-occur with physical disorders and with dementia. MHA is committed to vastly enhanced attention to behavioral disorders in the long-term care system in:

- Information and referral services such as NY Connects
- Home health care
- Adult day services
- Assisted living
- Adult homes
- Nursing homes.

Normative Community Settings

Normative community settings offer many opportunities to promote mental and physical health, to provide behavioral health education, to identify people with mental and/or substance use problems, to link people to needed interventions, and to provide interventions on-site. This includes:

- Early childhood programs
- Schools
 - Health education
 - School-based clinics
- Child welfare programs
 - "Preventive" services programs
 - Foster care
 - Residential programs

- The Workplace
 - Employee assistance programs (EAPs)
 - Disability management programs
 - In house physical and mental health clinics
- Aging services settings
 - Senior housing
 - Naturally occurring retirement communities (NORCs) especially those with supportive service programs on-site
 - Senior centers
 - Food service
 - In-home case management
 - Adult protective services
- Houses of worship
- Neighborhood and community organizations

"On The Streets": The Challenge of Reaching Those Who Are Unaffiliated

Many of the people who have the greatest need for both physical and behavioral health services are not regularly connected with service programs. Sometimes they drop in and out of programs to get what they need at the moment, but mostly they choose to manage for better or for worse on their own.

In order to help this population effectively (and also to potentially bring down Medicaid costs) reaching them is a critical challenge. The most common suggestion regarding how to reach them is some form of managed care. It is not clear, however, that this will be effective. There are other forms of assertive outreach to unaffiliated people, such as intensive case management, assertive community treatment, and more.

MHA supports the use of demonstration programs with careful evaluation components to determine what programs are most effective with what populations.

Elements of Integrated Physical and Behavioral Health Services

MHA will also advocate for a comprehensive range of integrated behavioral and physical health services. The following is a list of critical elements of integrated physical and behavioral health care.

- Public education regarding mental and/or substance use disorders and about the promotion of physical and mental health.
- "Wellness" initiatives
- Information and referral services
- Screening
- Access to appropriate assessments and interventions
- Ongoing communication and coordination of care between physical and behavioral health providers including but not limited to:
 - Successful linkage of patients to appropriate care. Co-location can be useful, but co-location is not integration.
 - Collaborative treatment planning

- Electronic medical records that include capabilities to support coordination, such as allowing for inter-office data exchange
- In-home care
- Support for family and formal in-home caregivers
- Residential programs with the capacity to serve people with co-occurring physical and behavioral disabilities
- Services in normative settings
- Tele-medicine, tele-psychiatry, and other high-tech interventions.

Quality of Care

MHA will also advocate for improved quality of care both generally and specifically with regard to integration of physical and behavioral health services.

In general, quality of care is a major problem in the American physical and behavioral health care systems. For example, the NCS-R revealed that primary health care physicians are the most frequent starting point for the treatment of mental disorders but that they provide "minimally adequate" care less than 15% of the time. Mental health professionals do better, but they provide minimally adequate care less than 50% of the time.

In addition, there is a well-documented shortage of clinically and culturally competent behavioral health providers.

Beyond these general problems of quality, there is considerable danger that efforts to integrate care will founder on structural requirements that are not substantive.

For example, there is currently tremendous enthusiasm about establishing "patient-centered medical homes", and Medicaid and Medicare will pay higher rates for providers who win "recognition" as medical homes from NCQA. Unfortunately, the standards so far promulgated by NCQA have very little substance with regard to integrating behavioral health services in medical homes.

The failure to establish meaningful standards is also a problem in New York State, where progressive regulatory changes over the past few years have encouraged primary health care programs to provide behavioral health services and vice versa. But these changes did not establish even rudimentary standards with regard to types of services, competence and credentials, expectations regarding coordination, or structures of oversight.

Regulation to Enhance Quality

In order to address issues of quality, MHA will advocate for the development of meaningful, minimum standards of integrated care that will include types of services, professional qualifications, communication and coordination of physical and behavioral care, and adequate oversight of service delivery.

MHA will also advocate to keep these standards limited so as to avoid the bureaucratic nightmares that result from excessive regulation. This will include advocating against dual licensure and for a "no wrong door" policy according to which people seeking help can get the

range of physical, mental, and substance abuse services they need in a single setting licensed by one and only one state agency.

Workforce Development

MHA will also advocate for workforce development initiatives designed to increase the number of clinically and culturally competent professionals and to make better use of paraprofessionals, including peers, to provide services for which professional education is not essential.

Research

MHA will also advocate for services research projects that explore the impact and effectiveness of various models of integration such as the eight models recently reviewed in "Evolving Models of Behavioral of Behavioral Health Integration in Primary Care," a recent publication of the Milbank Memorial Fund. MHA will particularly encourage services research that goes beyond integration in primary care and explores integration in specialty health care and long-term care as well.

Public Policy

A number of major public policy issues will need to be addressed in 2011. These include:

- Possible mergers of state agencies
- Expanded use of managed care by Medicaid
- Financing problems.
- Implementation of recent regulatory changes
- Social work licensing requirements.

Mergers

MHA will oppose rumored mergers of OMH and OASAS and of these two agencies into DOH. There is no reason to believe that mergers of state agencies will result in improved integration of physical and behavioral services at the level of service delivery, where it is needed. A "no-wrong-door" approach is far more promising as the basic way to achieve integrated services.

Medicaid Managed Care

Particularly because of the concern about high cost Medicaid cases, NYS officials have pressed for managed care initiatives that integrate oversight and treatment of people with complex needs. In the 2011-12 budget, NYS approved the development of regional interim behavioral health organizations (BHOs) to manage carved-out behavioral health services for people with serious mental illness and children with serious emotional disturbance. Under this structure, behavioral health services will remain in fee-for-service for two years, while BHOs provide administrative and management oversight designed to produce savings and improve care by reducing avoidable inpatient and ER visits and improving post discharge follow up care. After two years, integrated managed behavioral health plans or behavioral health special needs plan will be developed.

MHA will develop positions as specific proposals emerge, but will advocate that whatever approach is adopted will have to be credible for people with serious mental illness, which is far easier said than done.

Finance Problems

In addition to the financing problems inherent in the apparent decision of the new administration to cut funding rather than to increase revenues, there are a number of financial barriers to integrating physical and behavioral health services. The fundamental problem is that various types of integrated services are not reimbursable. For example, follow up care management is a major strategy when treatment for mental illness is provided in a primary care setting. This type of service is not reimbursable.

MHA will advocate for the removal of financing rules that interfere with integration of physical and behavioral health and advocate for the development of financing mechanisms that support integrated care and treatment.

In general, MHA will advocate for the maintenance and expansion of funding for community-based mental and physical health services. It will support credible proposals for re-investment strategies, but will oppose efforts that amount to nothing more than robbing Peter to pay Paul.

Implementation of Regulatory Changes

Major regulatory changes that could enhance integration of physical and behavioral health services have been made in NYS but not fully implemented. These include the decision to allow DOH licensed health clinics to provide a substantial amount of mental health service without dual licensure and for OMH licensed mental health clinics to be able to provide some primary health care. Apparently, some physical health clinics have been able to move ahead. Others are holding off, claiming there are barriers. OMH licensed clinics have not been permitted to move ahead at all. All of these implementation glitches need to be resolved, and MHA will advocate for them to be addressed once and for all.

In addition, OMH and DOH have made proposed changes in Medicaid reimbursement in the outpatient programs that they license. Some of these changes such as payment for multiple same day services would help to bring about service integration. MHA will continue to advocate for implementation of the commitments that were originally made during the process of planning the new reimbursement system.