

UNDER THE MICROSCOPE

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INTEGRATED CARE

Bringing Behavioral and Physical Care Together to Improve Personal & Community Health



TOPIC. The importance of bringing behavioral and physical health care together—establishing systems of integrated care—cannot be overstated from either human or economic perspectives, particularly as health reform moves forward through the Affordable Care Act. Integrated care can help save lives and dollars.

Millions of children and adults with mental illnesses, substance use disorders and intellectual/developmental disabilities experience high rates of morbidity and mortality, often due to concurrent chronic or acute physical disorders. Despite their complex array of needs and supports, many are left vulnerable, often untreated by today's fragmented, uncoordinated and separate health, behavioral, and social service systems. On average, for example, people with serious behavioral disorders die 20-25 years earlier than the general population. Most succumb to untreated, often preventable physical conditions, from heart disease and diabetes, to respiratory illness and HIV.

Integrated care also is important for people with physical illnesses. People with chronic ailments that impair the quality of life (e.g., cancer, arthritis, intractable pain, diabetes, heart disease, hip fracture) are at increased risk for depression, alcohol or drug use, and the misuse of prescription medications. Untreated, these behavioral disorders can slow healing, impair recovery, exacerbate the physical disorder or even lead to death, including by suicide. Yet, it is very well known that when a comorbid behavioral disorder is diagnosed and treated, overall health improves and hospital stays and costs are reduced.

The value of integrated care plays out in county, state and national health care costs. The vast majority of people with behavioral disorders or intellectual/developmental disabilities are served by public care systems through Medicaid and Medicare. Over half of all Medicaid beneficiaries with disabilities and over 40% of dual eligibles have a diagnosis of a mental disorder. Medicaid costs for beneficiaries with both physical and mental disorders are as much as 75% higher than for individuals with a physical ailment alone. Integrated care systems would yield better coordination of care. They also will result in greater diagnostic and treatment precision, enhanced opportunities for preventive interventions and overall improved health. Integrated care can lower health care costs by reducing duplication and overlap, creating shared infrastructures, and preventing or delaying hospitalizations or long-term care through early intervention and concurrent treatment of co-occurring disorders.

ANALYSIS. The good news is that, even before health reform was implemented, the behavioral health field was talking about integrated care. With the recognition that co-occurring mental and substance disorders are the expectation, not the exception, the early emphasis was on bringing the disparate behavioral health service systems together, not on integration behavioral and physical health. Rather than integrate *care*, the effort sought to integrate *financing*. Since treatment for mental disorders is largely covered by Medicaid, Medicare, and private insurers, while substance use treatment is largely supported through SAMHSA's block grant, not public or private insurers, the effort ultimately foundered. The chasm between the disparate public funding levels for mental and substance use disorders was simply too broad to bridge.

That said, it is very important to distinguish between *integrated care* and *integrated financing*. They are not the same. Financing for behavioral health care can be—

- (1) *Carved out*, in which behavioral care and primary care have separate funding pools;
- (2) *Carved in*, in which a percentage of a pool's total care dollars are set aside for behavioral care; or
- (3) *Integrated*, in which no distinction is made between dollars for behavioral and primary care.

When it comes to distinguishing between integrated care and integrated financing, the key point is whatever financing method chosen, care itself can be integrated across behavioral and physical disorders. Thus, contrary to some thinking, *integrated care can be undertaken even when financing for behavioral health services is carved out.*

With today's ACA impetus, dwindling public funding, a growing body of best practices in coordination, and broadened emphasis on prevention of and early intervention, the behavioral health field at the county, state and federal levels has been reaching out to primary care practitioners to advance integrated care. Thus, SAMHSA has reached out to HRSA to advance integrated behavioral and primary care whether through health homes or other ways of organizing personal care. It has collaborated with CDC on integrating preventive interventions. In all cases, the goal has been to put the behavioral head back on the primary care body and consider the whole person across the spectrum from health to illness to recovery.

We all know the usual practice of "collaborate and refer" doesn't work. The fragmented health care systems leave too many gaps through which too many people with behavioral disorders and intellectual/developmental disabilities fall. The beauty of integrated care is that, structured right, it can seal the holes in the public health care safety net.

So what does integrated care look like? It comes in two very distinct flavors:

(a) *Integrate behavioral health into primary care.* That's the classic way community health centers operate. In such a center, a primary care provider may call a behavioral health colleague in to assess, diagnose and treat a primary care patient for a possible behavioral disorder. This means of integrating care can help overcome the stigma that still surrounds behavioral disorders and intellectual/developmental disabilities in the mind of the general public.

(b) *Integrate primary care into behavioral health care.* This relatively rare model opens the doors to primary care for people with behavioral disorders or intellectual/developmental disabilities who rarely seek care for physical ailments. The result is longer lives and reduced health care costs. Each model obviously has different consequences that must be considered and evaluated carefully and fully up front.

Under the ACA, health care will be organized through Accountable Care Organizations (ACOs). ACOs consist of physicians, hospitals, and other providers in various combinations that coordinate patient care with the goal of improving its quality while reducing costs. Successful ACOs would share in any savings they produce, over and above their usual fee-for-service reimbursements. Under just-released final regulations for Medicare, ACOs can be sponsored by primary care and other physicians in group practice arrangements; networks of individual practitioners; and hospitals that partner with or employ eligible physicians, nurse practitioners, physician assistants and specialists. Under the regulations, while not eligible as ACO sponsors, behavioral health entities can be part of an ACO. Community health centers and rural health clinics will be allowed to lead ACOs—a distinct opportunity for integrated behavioral health care.

ACTION STEPS. The integrated care movement is growing. It's about bringing together the services, the providers, the facilities across practices and specialties, to serve the whole person. It's not about integrating the dollars, but it will result in saving dollars. What will *you* do to help make it happen to benefit the people you serve in the behavioral health and intellectual/developmental disability fields? We suggest you *begin planning now*. Here are just a few suggestions to get you thinking *and* acting:

- Begin to identify how you will prepare to meet the increased demand for behavioral health care within an integrated care system, given the ACA's expansion of Medicaid in 2014. Remember, 1/3 of the newly eligibles likely will have a behavioral health problem!
- Talk, talk, talk with your colleagues in primary care and also those in other behavioral health areas.
- Get together with groups, with whom you've rarely worked— other specialty care organizations, long-term care organizations, primary care groups, among others, pharmacists, private practice groups, among others.
- Identify the role your county behavioral health and public health authorities can and should play in ACOs. How can you help build a viable ACO in your area?
- Work with your local Federally Qualified Health Center (FQHC), if you have one. FQHCs, as well as you, need to be part of any county effort to create an ACO. If you don't have a local FQHC, take action to help establish one.
- Start designing and testing new models of how behavioral care will be delivered as part of a new integrated system of care. Get the models in place *before* ACA implementation in 2014.

The integrated care movement won't wait for you; it is just about to leave the station. Get on board and stay on board. Educate and engage county and state policymakers about the human and economic value of integrated care for people of all ages across the continuum of health and illness. Demonstrate the economic and human value of integrated care. Examine how best to move integrated care forward in your community and get buy-in from all involved. Together, we *can* put behavioral health and physical health together again. They've been separated for far too long.

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