



Executive Summary

Talking Points

Behavioral health is critical to overall health and wellness. Health care reform must include the coordination and integration of primary care and behavioral health care and take into consideration the following:

- There are severe economic, health and quality of life consequences when behavioral health is not adequately addressed.
- Poor access to coordinated and integrated primary care and behavioral health care is resulting in premature deaths that are preventable.
- Healthcare reform policies, funding and incentives should encourage, not discourage, the coordination and integration of primary care and behavioral healthcare.

Behavioral healthcare providers must be able to serve as medical homes either in a single provider model or through coordination with primary care.

These four core operational elements of medical home recognize that the medical home must incorporate behavioral health services and providers:

- Patients must have access to a full scope of primary care and behavioral healthcare.
- Healthcare should be coordinated across providers and specialties.
- Care management services are essential to ensure maximum benefit from clinical services.
- All patients and their caregivers should have access to effective education, training and services that support prevention, wellness, self care and management.

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Health Care Reform

The Integration of Primary Care and Mental Health Care

Behavioral health is critical to overall health and wellness. Health care reform must include the integration of primary care and behavioral health care and take into consideration the following:

- There are severe economic, health and quality of life consequences when mental health is not adequately addressed.
- Poor access to integrated primary care and mental health care is resulting in premature deaths that are preventable.
- Healthcare reform policies, funding, and incentives should encourage, not discourage, the integration of primary care and mental healthcare.

There are severe economic, health and quality of life consequences when mental health is not adequately addressed.

Depression is the leading cause of disability in the U.S., accounting for over 10% of all disability. It is projected that by 2020 the leading cause of disability will be major depressive illness.¹ Mental health issues account for four of the ten leading causes of disability in the United States according to the World Health Organization. The devastating economic impact of poor mental health care is estimated to be \$79 billion annually in the U.S.; while in Ohio, The Ohio Business Roundtable estimates that depression leads to somewhere between \$2 and \$3 billion per year in lost productivity within Ohio's workforce.² These costs are primarily due to the lost productivity of those with mental health disabilities and those who must care for them.³

Poor access to integrated primary care and mental health care is resulting in premature deaths that are preventable.

Statistics from the National Institute of Mental Health show that one in four adults, or approximately 60 million people, in the United States have a mental health disorder in a given year. Unfortunately, only 1 out of 2 people with severe mental illness seek treatment even though the treatment success rate for mental illness is between 60 – 80%. This is comparable to the treatment success rate for asthma and diabetes and is better than the success rate for heart disease.⁴ Individuals with serious mental illness are dying on average 25 years earlier than the general population. This high morbidity and mortality is

¹ World Health Organization. (2002) *The World Health Report 2001- Mental Health: New Understanding, New Hope*. Geneva: World Health Organization.

² Ohio Business Roundtable. (2009) *Improving Ohio's Health System*: Ohio Business Roundtable

³ Rice, D.P. & Miller, L. S. (1996) The economic burden of schizophrenia: Conceptual and methodological issues and cost estimates. In M. Moscarelli, A Rupp, & N. Sartorius (Eds.), *Schizophrenia* (pp. 321-334). Chichester, UK: Wiley.

⁴ Policymakers Fact Sheet on the Mental Health System, <http://www.bazelon.org/takeaction/legislationcampaign2000factsheet.pdf>.

primarily caused by preventable medical conditions that are caused by modifiable risk factors such as obesity, smoking, substance abuse, and poor access to healthcare.⁵

Health care reform policies, funding, and incentives should encourage, not discourage, the integration of primary care and mental health care.

Most primary care and mental health care systems in the U.S. are fragmented. Current funding systems often discourage collaboration because it usually costs the provider billable time. There are some exciting concepts that could promote integrated care and truly reform the system. The reformed healthcare system should focus on improving the overall wellness and functioning of the citizens that it serves. The system should facilitate prevention and early intervention whenever possible. The integration of primary care and mental health can improve quality, efficiency and value. The use of effective, privacy-protected health information technology systems can promote coordination and better outcomes.

Currently, many individuals with severe mental illness are using emergency rooms when they need primary care services. Not only does this increase costs, but it also does not promote coordinated primary care and mental health care. Individuals with severe mental illness should be served by a Medical Home that coordinates primary care, mental health care and other specialty services. The Health Resources and Services Administration (HRSA) states that a Medical Home is "care that is accessible, family-centered, comprehensive, continuous, coordinated, culturally competent, and compassionate." According to HRSA, a Medical Home is geographically and financially accessible, ensures continuity of care, and identifies linkages to comprehensive services based on the needs of the individual.⁶

The integration of primary care and behavioral health, including the Person-Centered Healthcare Home, is a good investment because it decreases overall health and societal costs and enables people to be healthy, productive, contributing members of society.

The Medical Home model should be expanded to include Community Behavioral Health Providers both as "Specialty-Care" providers, as well as Medical Homes for persons with severe mental illnesses. The National Council for Community Behavioral Healthcare is promoting the Person-Centered Healthcare Home model, which includes Community Behavioral Health Providers in both these roles. Technical assistance is available through National Council for Community Behavioral Healthcare⁷ and the Ohio Coordinating Center for Integrating Care.⁸

Person-Centered Healthcare Homes should be used to utilize resources more effectively and improve overall outcomes for U.S citizens with severe mental illness. Improving access to integrated care will reduce premature death rates, improve quality of life, and save tax dollars.

⁵ National Association of State Mental Health Program Directors (2006). *Morbidity and Mortality in People with Serious Mental Illness*.

⁶ Sia, C., *Partnership for Change: The Role of the Medical Home for CSHCN*, Human Resources and Services Administration; <http://www.hrsa.gov/reimbursement/disability/ppt6/default.htm>.

⁷ National Council for Community Behavioral Healthcare: http://www.thenationalcouncil.org/cs/new_at_the_resource_center

⁸ Ohio Coordinating Center for Integrating Care: <http://www.occic.org/>

Suggested Principles for Ohio Health Care Coverage and Quality Council Task Force: Patient Centered Medical Home

Patient Centered Medical Homes are a mechanism for coordinating healthcare in order to:

- Improve health
- Increase patient satisfaction
- Enhance access
- Ensure the delivery of efficient and effective health care

The Patient Centered Medical Home will vary based on the patient's needs and the healthcare resources in a community. Often, the primary care provider will be the most appropriate medical home. However, for patients with one or more chronic illnesses, a specialty provider may be the most effective medical home. For individuals with severe mental illness, behavioral healthcare providers should be funded to act as a medical home and deliver all needed services when appropriate. There are four unifying Patient Centered Medical Home service elements that should be considered as health care policies, regulation and funding strategies are developed. These operational elements include:

- **Patients must have access to a full scope of primary care and behavioral healthcare.** People with serious mental illnesses do not utilize primary and other specialty healthcare, with the exception of behavioral healthcare. Therefore **behavioral healthcare providers that include primary care must be included as a designated medical home provider.** In some instances this will be a “one-stop shop”, with both a full-range of behavioral healthcare and primary care services. In other instances, this will be a behavioral healthcare provider as a specialty care provider (see below).
- **Healthcare should be coordinated across providers and specialties.** Continuity of care is critical to improving outcomes and efficiencies. If a service is not available within the Patient Centered Medical Home, then the patient should be referred to the service efficiently and effectively. The majority of Ohioans will receive their behavioral healthcare services at a “specialty” medical provider. The health services delivered at the specialty behavioral healthcare provider must be coordinated with their primary care medical home. **Coordination of care, including collaboration and consultation across providers (both specialty and medical home) must include behavioral healthcare providers and services.**
- **Care management services ensure maximum benefit from clinical services.** Care Managers work with patients in a variety of settings such as primary care, behavioral healthcare, pharmacy, hospitals, nursing homes, and home health. Care management services such as education, access, and follow-along support, particularly for those with chronic health conditions, are critical when a patient has multiple serious health conditions or when the patient is not able to coordinate care on their own. **Behavioral healthcare providers have the infrastructure and proven experience to improve outcomes through the provision of care management services for persons with severe mental illnesses.**
- **All patients should have access to prevention and wellness services.** Patient Centered Medical Homes should focus on proactive and not just reactive healthcare. Prevention and wellness services need to be available for clinicians who focus on keeping their patients healthy and productive. **Behavioral healthcare and Consumer-Operated service providers have been providing effective recovery-oriented prevention and wellness services for decades. These effective services and providers must be included in Ohio's medical home continuum of services.**

Suggested Principles for Ohio Health Care Coverage and Quality Council Task Force: “Informed and Activated Patients”

Patient Centered Medical Homes are a mechanism for coordinating healthcare in order to:

- Improve health
- Increase patient satisfaction
- Enhance access
- Ensure the delivery of efficient and effective health care

Patient Centered Medical Homes coordinate primary care and specialty healthcare, and are based on the chronic care model which recognizes the critical services of education and support which facilitate wellness. As service elements for informed and activated patients within medical homes are developed, consider these operational elements:

- **Patients must have access to a full scope of primary care and behavioral healthcare, including prevention and wellness services.**
People with serious mental illnesses do not consistently utilize primary and other specialty healthcare, with the exception of behavioral healthcare, including Consumer-Operated services. **Including prevention and wellness services of behavioral healthcare and Consumer-Operated providers acknowledges the importance and efficacy of prevention and wellness services for all people, including those with chronic health conditions such as mental illnesses.**
- **Healthcare should be coordinated across providers and specialties.**
Continuity of care is critical to improving outcomes and efficiencies. If a service is not available within the Patient Centered Medical Home, then the patient should be referred to the service efficiently and effectively. The majority of Ohioans will receive their behavioral healthcare services at a specialty medical provider. The health services delivered at this behavioral healthcare provider must be coordinated with their primary care medical home. All providers (medical home and specialty care) should receive payments for coordination of care services. . **Coordination of care service design including collaboration and consultation across providers (both specialty and medical home) must include prevention and wellness services.**
- **Care management services ensure maximum benefit from clinical services.**
Care Managers work with patients in a variety of settings such as primary care, behavioral healthcare, pharmacy, specialists, hospitals, nursing homes, and home health. Care management services such as education, access, and follow-along support, particularly for those with chronic health conditions, are critical when a patient has multiple serious health conditions or when the patient is not able to coordinate care on their own. **Behavioral healthcare providers and Consumer-Operated service providers operate from a wellness framework and have the infrastructure and proven experience to provide care management services for persons with severe mental illnesses.**
- **All patients should have access to effective prevention and wellness services.**
Patient Centered Medical Homes should focus on proactive and not just reactive healthcare. Payments for prevention and wellness services need to be available for health service providers who focus on keeping their patients healthy and productive. **Behavioral healthcare and consumer operated service providers have been providing effective recovery-oriented prevention and wellness services to people with serious mental illnesses for decades. These effective services and providers must be included in Ohio’s medical home continuum of services.**

Suggested Principles for Ohio Health Care Coverage and Quality Council Task Force: “Health IT”

Patient Centered Medical Homes are a mechanism for coordinating healthcare in order to:

- Improve health
- Increase patient satisfaction
- Enhance access
- Ensure the delivery of efficient and effective health care

Patient Centered Medical Homes coordinate primary care and specialty healthcare, and are based on the chronic care model which recognizes the critical services of education, and support which facilitate wellness. As Health Information Technology policy elements for medical homes are developed, consider these operational elements:

- **Patients must have access to a full scope of primary care and behavioral healthcare care**
People with serious mental illnesses do not consistently utilize primary and other specialty healthcare, with the exception of behavioral healthcare providers. **Behavioral healthcare providers and the people they serve must be included in Health Information Technology funding opportunities, infrastructure development and demonstration projects.**
- **Healthcare should be coordinated across providers and specialties.**
Continuity of care is critical to improving outcomes and efficiencies. Electronic Health Records are at the heart of a coordinated efficient health care system. **Behavioral health providers and the people they serve must be included in Ohio’s Electronic Health Record opportunities and policy development.**
- **Care management services ensure maximum benefit from clinical services.**
Care Managers work with patients in a variety of settings such as primary care, behavioral healthcare, pharmacy, specialists, hospitals, nursing homes, and home health. Care management services such as education, access, and follow-along support, particularly for those with chronic health conditions, are critical when a patient has multiple serious health conditions or when the patient is not able to coordinate care on their own. **Electronic Health Records must capture and disseminate care manager services.**
- **All patients should have access to effective prevention and wellness services.**
Patient Centered Medical Homes should focus on proactive and not just reactive healthcare. **Electronic Health Records must capture and offer information regarding a person’s utilization and outcomes of prevention and wellness services.**

Suggested Principles for Ohio Health Care Coverage and Quality Council Task Force: “Payment Reform”

Patient Centered Medical Homes are a mechanism for coordinating healthcare in order to:

- Improve health
- Increase patient satisfaction
- Enhance access
- Ensure the delivery of efficient and effective health care

Patient Centered Medical Homes coordinate primary care and specialty healthcare, and are based on the chronic care model which recognizes the critical services of education, and support which facilitate wellness. As payment and service elements for medical homes are developed, consider these operational elements:

- **Patients must have access to a full scope of primary care and behavioral healthcare.** People with serious mental illnesses do not consistently utilize primary and other specialty healthcare, with the exception of behavioral healthcare providers. **As Ohio’s funding sources, structures and services for Patient Centered Medical Homes are developed, behavioral healthcare services and providers must be fully included.**
- **Healthcare should be coordinated across providers and specialties.** Continuity of care is critical to improving outcomes and efficiencies. If a service is not available within the Patient Centered Medical Home, then the patient should be referred to the service efficiently and effectively. The majority of Ohioans will receive their behavioral healthcare services at a specialty medical provider. The health services delivered at behavioral healthcare providers must be coordinated with their primary care medical home. **Behavioral healthcare providers (medical home and specialty care) should receive payments for coordination of care, consultation and collaboration services.**
- **Care management services ensure maximum benefit from clinical services.** Care Managers work with patients in a variety of settings such as primary care, behavioral healthcare, pharmacy, specialists, hospitals, nursing homes, and home health. Behavioral healthcare providers have the expertise to provide Care management services to persons with severe mental illnesses. Care management services such as collaboration, education, access, and follow-along support, particularly for those with chronic health conditions, are critical when a patient has multiple serious health conditions or when the patient is not able to coordinate care on their own. **Care management services must be seen as essential elements of medical home, and behavioral healthcare providers should be reimbursed for them.**
- **All patients should have access to effective prevention and wellness services.** Patient Centered Medical Homes should focus on proactive and not just reactive healthcare. **Prevention and wellness services for persons with mental illness, delivered by behavioral healthcare providers must included as eligible reimbursable services.**