

**Integration Policy Paper:
A Vision for Transforming the Mental Health System through Services Integration**

**Presented to the MHSOAC by the Services Committee
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Introduction and Background

In 2008 the Mental Health Services Oversight and Accountability Commission (MHSOAC) adopted its “Report on Co-Occurring Disorders, Transforming the Mental Health System through Integration.” Because a significant proportion of persons with mental illness have a co-occurring substance use condition, that report produced key findings and recommendations related to improving services and outcomes for persons with co-occurring disorders of mental illness and substance abuse by promoting the delivery of integrated services for persons with co-occurring conditions.

While that paper focused primarily on what it takes to best serve persons with the co-occurring conditions of mental illness and substance abuse, there were also specific recommendations related to the need to provide “behavioral health services” in primary health care settings. As used in this paper, behavioral healthcare is an umbrella term that refers to a continuum of services for persons with mental illness, substance use disorders, and/or co-occurring disorders.

With this policy paper the Commission wants to update its Report on Co-Occurring Disorders to emphasize that “behavioral healthcare” services should result in integrated or coordinated services for persons with co-occurring mental illness and substance use. Frequently it is assumed that if an agency is identified as a behavioral health entity that services are always integrated for persons with co-occurring mental illness and substance use. Because that is not always the case, continued attention to integrated behavioral health services is necessary. Additionally, this paper emphasizes the critical need for the bi-directional integration* of behavioral health services with physical healthcare services.

While the Commission’s role is to advise from the perspective of mental health, the Commission has a history of promoting integrated services as a best practice model for delivering effective and efficient services that result in positive life outcomes for individuals and families and cost effective services for healthcare systems. In fact, “integrated service experiences” is identified among other MHSA core values.

- **As defined in Mental Health Services Act regulations, (California Code of Regulations, Section 3200.190) “Integrated Service Experience” means the client, and when appropriate the client’s family, accesses a full range of services provided by multiple agencies, programs and funding sources in a comprehensive and coordinated manner.**

* See third paragraph on Page 7 for definition of bi-directional integration.

To date, requirements and incentives have not demanded or rewarded services integration. Now in the context of the Affordable Care Act (ACA), with shrinking local, state and federal budgets, there is an urgent need and opportunity in providing integrated services as a way to reduce costs and improve life outcomes for individuals and families. The Commission recognizes that given the implementation of the ACA and the increased interest among healthcare systems, this is a critical opportunity to focus on services integration, and collaborate with other state and local entities to further promote, review and measure the level of integration occurring between behavioral health and physical healthcare services in California.

A Vision for Integrated Services

As envisioned, in a transformed mental health system that provides integrated behavioral and physical healthcare services:

- There are clear definitions of what constitutes efficient and effectively integrated programs and services for persons of all ages.
- Systemic and programmatic integration strategies are understood and documented at the State and local level for persons across the lifespan and for persons from various racial, ethnic and cultural communities.
- Persons of all ages with co-occurring conditions are identified and served across healthcare and social service systems.
- Persons served will have an integrated service experience that serves the whole person.
- Local programs are able to report “system level outcomes” related to integration; including develop evaluation capacity to determine if access to care and outcomes are improved for persons with co-occurring conditions, including those who are part of un-served or underserved racial, ethnic or cultural populations
- Recovery itself is viewed from an integrated perspective which addresses the ability of persons with co-occurring conditions to access services that meet the needs of the whole person.

The stated emphasis for this paper is on integrating healthcare so that there is “no wrong door” to access services for persons with mental illness and co-occurring conditions, whether it be through a mental health, behavioral health, or primary healthcare clinic, child welfare, foster care, criminal or juvenile justice. In an integrated system, effective coordination of services and interventions result in improved outcomes for ‘whole persons’ and ‘whole systems.’

As such the Commission wants to reassert key findings contained in its Report on Co-Occurring Disorders that demonstrate persons with co-occurring conditions impact whole communities and public systems as follows:

- Individuals with co-occurring conditions touch every part of the mental health system and must be the expectation
- Persons with co-occurring conditions have more medical problems, poorer treatment outcomes, more negative social consequences and lower quality of life

- Persons with co-occurring conditions are disproportionately represented among arrestees, foster care placements, veterans, hospitalizations and the homeless

Accomplishing the vision for services integration among healthcare agencies will require: (1) state-level leadership, sponsorship and collaboration that encourages the integration of behavioral health and physical healthcare services for persons across the lifespan and evaluates levels of integration and the resultant outcomes; (2) local program and service integration that includes the collection and reporting of data necessary to measure integration and the resultant individual and system outcomes; (3) significant roles for clients, parents and family members in the planning and development of integrated services and any associated evaluation processes; (4) state and local collaboration with other non-mental health partners such as education, corrections, juvenile justice, social services, and foster care; and (5) state collaboration with private or public foundations to leverage funds and resources for enhanced evaluation of integration.

This report:

- 1) provides findings from various studies that identify the increased costs for care of persons with psychiatric illness and chronic health care conditions;
- 2) provides findings about the cost effectiveness of integrated services;
- 3) describes emerging models of integration in California; and
- 4) provides information, suggestions, and recommendations intended to guide the integration of all public healthcare services

Given that integrated services is a core value of the Mental Health Services Act, and consistent with the Commission's role to improve the care of all individuals with mental illness including those with behavioral health and medical needs, the Commission endorses the suggestions and recommendations contained in this report intended to guide the transformation of the mental health system through services integration.

Expanding the Focus of Behavioral Health Services Integration to Include Physical Healthcare

The deficiencies of mental health and substance abuse treatment integration were outlined in the 2008 MHSOAC Co-occurring Disorders Report. Although a comparable comprehensive survey of integrated medical and behavioral services is not available at this time, we do know about the costs and consequences of not providing coordinated medical care with behavioral health. Americans with mild, moderate, serious and severe mental health/substance use disorders have a substantially higher prevalence of chronic health conditions and higher total healthcare expenditures. For persons with serious mental illness, healthcare costs can be two to three times greater than for someone without serious mental illness.

Both implementation of the ACA and passage of the federal Mental Health Parity and Addition Equity Act¹ present opportunities to organize healthcare services that support

¹ Mandates that essential health insurance benefits that include mental health and substance abuse services be offered at comparable levels (parity) with benefits for medical disorders.

improved outcomes for persons being served by behavioral health systems. Implicit in implementation of the Affordable Care Act (2010) are service delivery reforms to our health care system that will be driven by “pay for performance” funding. For example, one element of the Affordable Care Act is the Pioneer Accountable Care Organization (ACO) Model, an initiative designed by the Center for Medicare and Medicaid (CMS) Innovation. CMS chose 32 healthcare organizations in the country with experience operating as accountable organizations providing more coordinated care to beneficiaries at a lower cost to Medicare. The Pioneer ACO Model will test the impact of different payment arrangements in helping these healthcare organizations achieve the goals of providing better care to patients, and reducing Medicare costs. Six of the 32 healthcare organizations participating are located in California.

The general move toward integrated services is supported by evidence that the majority of individuals with mental health or substance abuse disorders also suffer debilitating medical co-morbidities. Most alarming, individuals with chronic mental health or substance use disorders have a life expectancy that is 25 years less than average, mostly due to preventable medical conditions (diabetes, obesity, chronic obstructive pulmonary disorder, and cardiovascular disease). Commitments from federal and state health systems to integrate behavioral health (mental health and substance abuse treatment) into primary care services, both as part of the national standards for Federally Qualified Health Centers, and for non-qualifying medical clinics under the anticipated expansion of Medicaid under the Affordable Care Act, support the integrated services movement. Together these reforms will have a profound effect on California counties as more people obtain healthcare coverage that contains well defined benefits for mental health and substance use treatment. Implementation of the Affordable Care Act in this context, presents an opportunity for leadership in the development of an integrated healthcare system that can provide effective, accountable services and develop partnerships that leverage efforts toward systemic integration.

Currently, public services for behavioral health disorders in California and throughout the United States continue to be typically separate from those services provided for medical disorders. Like most other states, California lacks a system owner to provide collaborative leadership in improving and expanding integrated care for behavioral health and medical service delivery. Although the Commission acknowledges and supports previous efforts of California’s Co-Occurring Joint Action Council (COJAC) to promote best practice and the integration of local mental health and substance use programs and services, additional state leadership is critical. Given the recent restructuring of state departments that combined responsibility for mental health and alcohol and drug programs under the California Department of Health Care Services (DHCS), it would appear that DHCS is the logical system owner who may provide statewide, collaborative leadership focused on the integration of programs and services for persons with co-occurring mental illness, substance use, and medical conditions. The Commission is eager to work with DHCS and other community partners to develop an integrated healthcare system that is organized to provide effective and accountable services for California’s citizens, including those persons with co-occurring, mental illness, substance use, and medical conditions.

The Case for Integrated Services

Several statewide efforts to promote statewide integration of behavioral health and medical care, under the umbrella concept of “Primary Care Medical Home”, have been developed in collaborative grants by such agencies as the California Institute of Mental Health (CiMH) and the Integrated Behavioral Health Project. These collaborative efforts have been implementation oriented projects to develop service delivery models, standards, toolkits and trainings, which are designed to bridge the cultural gap between behavioral health and medical services, and to advance the integration of behavioral health into primary care settings.

What follows are findings provided by CiMH from multiple studies related to the outcomes and costs for persons with co-occurring disorders including chronic healthcare conditions.

- Adults with serious mental illness have a life expectancy about 25 years less than Americans overall with death primarily from natural or preventable diseases (average life span 53 years). Life expectancy is 5 years less with co-occurring substance use. (*NASMHPD 2006: Morbidity and Mortality in People w Serious Mental Illness*)
- Persons with serious mental illness have a higher prevalence of chronic health conditions and total healthcare expenditures that are 2 to 3 times greater than others. (*NASMHPD 2006: Morbidity and Mortality in People w Serious Mental Illness*)
- Those diagnosed with depression have twice the annual health care costs of those without depression. (*Unutzer J. Schoenbaum M. Katon WJ, et al., Healthcare Costs Associated With Depression in Medically Ill Fee-for-Service Medicare Participants, J Am Geriatric Society, 2009 Mar; 57 (3); 506-10.*)
- Depression is identified as the greatest cause of productivity loss among workers. (*Kessler RC, Greenberg PE, Mickelson KD, Meneades LM, Wang PS: The effects of chronic medical conditions on work loss and work cutback. J Occup Environ Med 2001; 43 (suppl 3); 218-255.*)
- Fewer than 5% of Medicaid beneficiaries account for more than 50% of overall Medicaid costs. (*October 2009 Center for Healthcare Strategies, Rick Kronick, PhD & Todd Gilmore, PhD*)
- 45% of Medicaid beneficiaries with disabilities have 3 or more chronic conditions. (*October 2009 Center for Healthcare Strategies, Rick Kronick, PhD & Todd Gilmore, PhD*)
- 49% of Medicaid beneficiaries with disabilities have psychiatric illness (*October 2009 Center for Healthcare Strategies, Rick Kronick, PhD & Todd Gilmore, PhD*)
- Not treating an employee with substance use issues results in more emergency room and inpatient utilization. (*Kaiser SU Study: Approach and Rationale*)
- Not treating an employee with substance use issues causes health problems and cost for family members. (*Kaiser SU Study: Approach and Rationale*)

- Medical costs drop by more than half after medical care is integrated for those with substance use conditions. (*Parthasarathy S. Mertens C. Weisner C. Utilization and cost impact of integrating substance abuse treatment and primary care. Med Care (Mar 2003, 41(3) 357-367.*)
- Pre-treatment, families of persons with substance use issues have higher medical costs than control families. (*G. Thomas Ray, MBA, Jennifer R. Mertens, PhD, & Constance Weisner, DrPH, MSW, The Excess Medical Cost and Health Problems of Family Members of Persons Diagnosed with Alcohol or Drug Problems*)
- A 10% reduction in excess healthcare costs of patients with comorbid psychiatric disorders via an effective integrated medical/behavioral healthcare program could result in \$5.4 million in healthcare savings for each group of 100,000 insured. (*Chronic conditions and comorbid psychological disorders, Milliman Research Report, July 2008*)
- The cost of doing nothing for persons with comorbid psychiatric disorders could exceed \$300 billion per year in the United States. (*Chronic conditions and comorbid psychological disorders, Milliman Research Report, July 2008*)

Summary of Emerging Models of Integration in California

CiMH recently conducted a survey of California counties inquiring about their various levels of integration. Based on CiMH definitions, there are five levels of integration as follows:

- 1) Minimal collaboration: Mental health providers and primary care providers work in separate facilities, have separate systems, and communicate sporadically.
- 2) Basic collaboration at a distance: Primary care and behavioral health providers have separate systems at separate sites, but engage in periodic communication about shared patients. Communication occurs by telephone or letter. Improved coordination is a step forward compared to completely disconnected systems.
- 3) Basic collaboration on site: Mental health and primary care professional have separate systems but share the same facility. Proximity allows for more communication, but each provider remains in his or her own professional culture.
- 4) Close collaboration in a partly integrated system: Mental health professional and primary care providers share the same facility; have some systems in common, such as scheduling appointment or medical records. Physical proximity allows for regular face-to-face communication among behavioral health and primary care providers. There is a larger team in which each professional appreciates his or her role in working together to treat a shared patient.
- 5) Close collaboration in a fully integrated system: The mental health provider and primary care provider are part of the same team. The patient experiences mental health treatment as part of his or her regular primary care.

With less than half of California's 58 counties reporting (as of March 2012), four counties report they have basic collaboration on site, three counties indicate close collaboration in a

partly integrated system, and three counties identify as being fully integrated with close collaboration in a fully integrated system.

While the close collaboration in a fully integrated system as described in No. 5 above involves persons receiving behavioral health treatment as part of their regular primary care, there are other appropriate versions of integration referred to as “bi-directional integration.” Bi-directional integration means that sometimes behavioral health is integrated into primary care settings and sometimes primary care is integrated into behavioral health settings. This type of integration could serve those with mild and moderate behavioral health risk in primary care settings and those with serious and severe behavioral health risk in behavioral health settings. It is expected that through the work of CiMH and the Integrated Behavioral Health Project we will learn more about the success and challenges associated with establishing these models for system and service integration.

Recommendations

In light of national and statewide trends demonstrating the urgent need to improve the care of all individuals, including those with behavioral health needs, the MHSOAC reasserts and updates the recommendations of its previous COD Report to emphasize those strategies that will be most productive in our currently changing environment.

The MHSOAC reasserts its commitment to improve the care for individuals’ behavioral health needs by endorsing strategies that will lead to transformation of the mental health system through services integration. As such, the Commission encourages the following activities for state level entities, county level entities, and the MHSOAC.

1. The MHSOAC would encourage that the Department of Healthcare Services (DHCS) be identified to work with SAMHSA to promote statewide integration of behavioral healthcare and physical healthcare services.

In this effort, the MHSOAC should work with DHCS on education that leads to a common understanding of (1) what are effective integrated services; (2) ways to measure various levels of integration and associated outcomes, and (3) the identification of persons with co-occurring conditions receiving services in mental health, physical healthcare, and alcohol and drug systems.

2. The MHSOAC recommends that the appropriate state entity develop a unified mental health care delivery framework that guides and promotes optimally integrated service delivery for co-occurring behavioral health and medical disorders. The MHSOAC would welcome the opportunity to collaborate with the identified state entity and suggests the following:
 - a. Form an Integrated Services Workgroup, led by the identified state entity and including other state and county entities, to study and consider ways to: (1) define and identify various levels of integration and associated outcomes; (2) collect and report data necessary to measure integration, access to integrated services, and other outcomes that may stem from integration; (3)

facilitate shared information among service agencies that takes into consideration the Health Insurance Portability and Accountability Act (HIPAA) procedures' and Federal confidentiality regulations found in Title 42, Part 2 of the Code of Federal Regulations (CFR) for persons receiving substance use services and (4) overcome service fragmentation that results from misaligned funding requirements arising from federal block grants, Medi-Care/Medi-Caid, and MHSA funding.

3. The MHSOAC encourages continued support of systemic integration programs and activities designed to promote integrated behavioral health and medical services, including those carried out by the Co-occurring Joint Action Council, the California Institute of Mental Health, and the Integrated Behavioral Health Project.
4. The MHSOAC recommends that, as part of the local MHSA community program planning process, community stakeholders (including clients, parents, family members and caregivers with lived experience with mental health, substance use, co-occurring disorders, and physical healthcare conditions) have an ongoing role in planning and development of strategies for programs that integrate behavioral and physical healthcare services.

The Commission also suggests that, as DHCS develops and expands the MHSA and Medi-Cal issue resolution processes, they address integrated services and involve stakeholders, including clients, family, parents and caregivers, in the ongoing review of these processes.

5. The MHSOAC recommends that statewide MHSA stakeholders involved in implementing Mental Health Services Act programs, seek opportunities to align MHSA services with program reforms mandated by the Mental Health Parity and Addiction Equity Act (2008) and Affordable Care Act (2010). Behavioral health programs that have services funded by the Mental Health Services Act should ensure that mental health, substance abuse, and medical services are integrated and available for all clients who need them. Medical necessity criteria for treatments for co-occurring disorders must be both explicit and designed to address the needs of individuals with co-occurring disorders. Individuals with behavioral health needs must not be improperly denied treatment based on their co-morbidities; rather, mental health disorders must be treated at parity with medical disorders.
6. The MHSOAC encourages the State to seek opportunities to enhance program and evaluation efforts through collaboration with private or public foundations serving un-served, underserved, or inappropriately served communities. Although it is expected that many outcomes relevant to or resulting from integration are measurable via data that is already being collected statewide, additional integration-specific outcomes may need to be incorporated into evaluations that look at the success of integration efforts, such as costs associated with integration. The MHSOAC will continue to look for opportunities to leverage funds and evaluation resources with the California Endowment and Health Care Foundation. Recognizing

that mental health affects both community health and physical health, the MHSOAC should seek to align with efforts focused on fostering healthy communities.

Conclusion

The Mental Health Services Act envisions a transformed mental health system. The Commission's vision is that 1) individuals receive comprehensively integrated services delivered in a culturally competent system of care, with identified strategies for integrated service access across the lifespan; 2) mental health services are delivered in collaboration with non-mental health partners; 3) the mental health system acknowledges the importance of input from peers and families and fosters "client-centered" and "family-centered" wellness and recovery and 4) as envisioned in the MHSA, individuals have an integrated service experience including services received through the Act's component programs. Achieving all of these goals will require the use of multiple tools to promote services integration and program development, ample technical assistance, appropriate identification of outcomes to measure progress, and incentives to encourage competency and transformation.

It is the Commission's intent that this policy paper, promoting comprehensively integrated care for individuals with co-occurring mental illness, substance use, and physical health disorders, will provide relevant suggestions and strategies for transforming the mental health system through services integration. Consistent with the Commission's November 2010 Policy Paper on "Accountability through Evaluative Efforts Focusing on Oversight, Accountability and Evaluation," and the May 2011 Policy Paper on "Client-driven, Family-focused Transformation of the Mental Health System Through the California Mental Health Services Act," this paper should guide Commission activities to promote greater system-wide mental health competency.

Towards this goal, the MHSOAC reasserts that services for co-occurring disorders at all levels must continue to be culturally competent, gender responsive, and trauma informed, as well as, focus on special populations including older adults, transition age youth, and individuals either currently in or recently released from the criminal justice system. It is also the intent of the Commission that the expertise of clients, parents, family members, and caregivers with lived experience of co-occurring disorders that include physical healthcare conditions, significantly inform the planning, design, implementation, and evaluation of integrated services and programs. Alongside the many systemic partners providing care for individuals with mental health, substance use, and physical health conditions, those with lived experience can assure that integrated care means that individuals receive a truly "integrated service experience".

In summary, mental health needs, substance abuse, and co-occurring disorders are pervasive. Successful recovery for persons requires a focus on the whole person. In other words, for individuals with behavioral health needs, there can be "no wrong door" to receive mental health, substance use treatment, or physical healthcare services. For providers of those services, there can be no adequate healthcare without integrating behavioral healthcare services with physical healthcare services. If we are to promote

wellness and recovery for both individuals and systems, we must leverage the power of services integration throughout California's entire mental health system.

Attachment 1²

The remaining nine (9) long-term recommendations from the MHSOAC Report on Co-Occurring Disorders listed below require review and reprioritization for action by the MHSOAC and its partners, in light of current state and local mental health and alcohol and drug realignment.

1. 1.2: The MHSOAC should work with the Department of Mental Health (DMH) and Alcohol and Drug Programs (ADP) to ensure that MHSA guidelines support flexible funding to allow development of integrated programs. Reporting requirements should not be a barrier to flexible funding for “whatever it takes” services.
2. 2.1: The MHSOAC should commission a work group on the Integrated Treatment of Youth.
3. 2.6: The MHSOAC should work with DMH’s Office of Multicultural Services, ADP, CMHDA’s Ethnic Services Manager and community-based organizations (CBOs) that primarily serve racial, ethnic and culturally diverse communities to identify culturally competent approaches and programs that show promise for individuals with COD.
4. 7.3: The MHSOAC should promote the use of MHSA Workforce Education and Training funds to train mental health and substance abuse providers to engage, collaborate, and support families as an essential resource. Training should include instruction to assess and refer families to collateral services when needed.
5. 7.4: The MHSOAC should include family members of individuals with COD as a priority population for PEI programs. In addition, mental health and ADP programs should provide referrals for family members to recovery services, including co-dependency and trauma services specifically for families.
6. 8.1: The MHSOAC should create a panel to educate the MHSOAC and the public about current public policy issues regarding trauma, including its impact on people with mental health and substance use disorders.
7. 8.2: The MHSOAC should establish a workgroup to inform and guide policy on the needs and perspectives of individuals who have experienced trauma, and create a plan to facilitate the implementation of core competency to recognize and address trauma.
8. 8.3: The MHSOAC should promote the use of MHSA Workforce Education and Training funds to educate and train mental health and substance abuse treatment

² At this time, 46, or 83.6 percent of the 55 recommendations are complete and marked as done or ongoing with long-term objectives. The MHSOAC Prevention and Early Intervention (PEI) program trends report shows that 86% percent of counties included co-occurring mental health and substance abuse issues as an element of at least one PEI program. The MHSOAC Services Committee believes it is important to maintain and continually improve upon these efforts as on-going system enhancements. The remaining nine (9) long term recommendations (see Attachment #1) require review and reprioritization for action by the MHSOAC and its partners in light of current state and local mental health and alcohol and drug realignment.

providers in the identification, assessment and treatment of individuals suffering from trauma and a substance-use and/or mental disorder.

9. 9.4: The MHSOAC should promote the use of MHSA Workforce Education and Training to train and educate mental health and alcohol and drug treatment staff to accuracy of screening, assessment, and diagnostic coding for COD and other serious mental illnesses.³
