

Integrating Primary and Behavioral HealthCare: Some Recommendations for Solutions and Success

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This is a time when we are undergoing tremendous change in needing to realign our system from one that has been in chaos to one that should be defined by stability and the achievement of the best possible health. And the world is moving to managed care models because health care is simply not sustainable under the fee for service structure that is so familiar to all of us. Economic concerns are primary drivers in this change process that we hope will result in healthier people with behavioral health diagnoses. The Mental Health Coalition offers the following recommendations for success in achieving integrated care.

Recommendation One – Pilot Case Management

NC deleted case management from our approved Medicaid services some time back, no doubt primarily because of cost problems. It has historically been difficult to contain case management. But we suggest it is a good time to look again at what we think is an essential service. Case management needs strict parameters: when people are stable, it should be phased out and when there are crises or life changes, case management should be introduced to assist that problem. It needs to be flexible, and it is especially needed to achieve the new challenges of integrating primary and behavioral healthcare. Our system has gotten incredibly complex, and perhaps this is the very argument to re-introduce case management- people need help finding the providers that they need to help them get well. We need to also think carefully about the training necessary for good case management- it needs to be pretty extensive for a case manager to be helpful. In some cases, peer navigators may be a cost effective alternative, even a step down from more traditional case management. We suggest this be piloted for effectiveness; comparing certain outcomes with those who get case management compared to the existing care coordination/care management/system of care approaches.

Recommendation Two – Ensuring people receive *only* the services/supports they need, and are discharged or stepped down as their recovery strengthens.

Too often, people are kept too long in group homes, in treatment of all kinds, when they could be moving towards more independence. The incentives do not exist for the providers to phase out the provision of services or to step people down to less restrictive services. Providers need specific training to help them understand recovery supports and to know when to let go. We need psycho education programs that train providers of all kinds, including doctors, to fade out paid supports as appropriate. We need to train providers to know how to really work with people to be active parts of their community. We talk about natural supports, but they are not well used or well supported. That needs to be our emphasis – the outcome, people living as independently as possible, with only the supports they need. And the system must be flexible enough to re enroll people

quickly if they have new episodes of their illness. In short, providers don't expect wellness on the part of those with severe mental illnesses- that attitude must change.

Recommendation Three: Expand low cost services that achieve effective health outcomes and wellness.

NC has made so many changes to the services offered- often they get pretty elaborate and expensive. We need to concentrate on things that are proven to work, that have evidence behind them. And we need to look at models that people with illnesses, and their families really say work for them and keep things stable. Too often the following models have not been adequately supported and nurtured:

- Psychosocial Rehabilitation
- Drop In Centers
- Wellness Centers
- Skill training
- Psychiatric rehabilitation
- Psycho education programs for families and for those with mental illnesses
- Helplines
- Outpatient providers
- On call support 24/7 by existing providers to interrupt the cycle of crises
- Recovery supports (peer support in a variety of ways, forensic, housing, etc.)

We think it bears looking at – to see how many PSRs we have lost, and why, and if rates play into it. All of these low cost services should be mapped – are they readily available, within 30 minutes, 30 miles of people in that catchment area? Interestingly, these models all have a basis in a belief and hope that wellness is possible, and recovery is the order of the day.

Recommendation Four – Change the Incentives

It is past time to start rewarding those who achieve certain outcomes in a substantial manner. The outcomes we all want are simple:

- Stable housing
- Symptom control
- Meaningful relationships
- Meaningful work, education, or daytime activities
- Avoidance of hospitalizations and criminalization
- Being a part of the community

LME/MCOs need to reward these outcomes through rate differentials. And we need to use common sense as well – don't just drop someone who is doing well. Make sure they get the amount of support they need to be stable, and to stay well.

Recommendation Five – Prevention and Health Integration

Integrating care means staying on top of the person's total health needs, and intervening as early as possible in any disease process – because that means it will almost always be more treatable and probably less serious. To do this well the following must be in place:

- Easy access to behavioral and medical services; and a complete service array
- Emphasis on prevention of criminalization (add more mental health courts, make jail diversion programs mandatory in all counties)
- Transitions are always tough- and often don't work well. Prevent these problem transitions through more of a case management approach
- Develop more MI/SA integrated care models, a SAMSHA EBP
- Shifting resources to the basics that stabilize everyone: housing and jobs are essential in achieving the best possible health outcomes.
- Develop regional behavioral urgent care models – they have thrived in primary care
- Common, integrated data systems- especially with integrated health care coming

In closing, in order to successfully integrate primary and behavioral healthcare, we believe it is necessary to look at methods that are more successful in tying together the right services for people in a very fragmented service delivery model that will only get more complicated with adding to the mix primary health care. We think case management is vital to its success. Also vital is having the right service array, and having the right attitudes of providers regarding the true hope and possibility of recovery. We very much want this to succeed for the population who lives with mental illness, and we hope these ideas will help in the current effort.

The Mental Health Coalition

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