THE STATE of ALASKA
GOVERNOR SEAN PARNELL

Department of Health and Social Services
DIVISION OF BEHAVIORAL HEALTH
Director's Office

3601 C Street, Suite 878
Anchorage, Alaska 99503-5924
Main: 907.269.3600
Toll Free: 800.770.3930
Fax: 907.269.3623

# Data Worksheet: *"BH & Primary Care Integration"*[1]

## What is the issue?

People with mental and substance abuse disorders experience untreated and preventable chronic illnesses like hypertension, diabetes, obesity, and cardiovascular disease that are aggravated by poor health habits such as inadequate physical activity, poor nutrition, smoking, and substance abuse. Barriers to primary care — coupled with challenges in navigating complex healthcare systems — have been a major obstacle to care.

At the same time, primary care settings have become the gateway to the behavioral health system, and primary care providers need support and resources to screen and treat individuals with behavioral and general healthcare needs. Conversely, behavioral health providers need ready access to primary care for their clients, many of whom have chronic health problems.

The solution lies in integrated care, the systematic coordination of general and behavioral healthcare. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.

## What are the Impacts on Health and Social Wellbeing?

When mental health, substance abuse and medical conditions co-occur, the combination is associated with elevated symptom burden, functional impairment, decreased length and quality of life, and increased costs.

When compared to other disabled populations, individuals with behavioral health illness differ significantly in that they:

- Are more likely to suffer from multi-systemic disorders with co-occurring chronic health and behavioral health conditions;
- Are generally frequent users of a wider, more costly range of services, including psychiatric and medical hospitalizations, and use of hospital emergency rooms;
- Have higher pharmacy costs due to co-occurring and chronic conditions and the need for specialty psychiatric medications;
- Are often unable to manage their health and nutrition without assistance;
- Are often unemployed or under-employed, with low income and unstable housing arrangements;
- Frequently face challenges accessing and receiving appropriate health care due to the primary care providers' uneasiness with trying to meet the unique needs of the SMI and SUD population, coupled with the providers' decreased expectations of behavioral health clients as partners in care.

[1] The data worksheet on BH & Primary Care draws heavily from the following resource: "Mental Disorders and Medical Comorbidity", the Synthesis Project, Policy Brief #21, February 2011, Robert Wood Johnson Foundation.

On average, SMI diagnosed individuals die at least 25 years earlier than the general population. A 2003 six-state study validates these early mortality rates and found that more than 80% of years lost was due to medical conditions, not suicide, accident or violence.

Other studies have shown that persons with SMI are less likely to receive recommended preventive monitoring and evidence-based treatments for their chronic medical conditions.[1]

## What is the Scope of the Problem?

Comorbidity between medical and mental conditions is the rule rather than the exception. In the 2001-2003 national comorbidity Survey Replication (NCS-R), a nationally representative epidemiological survey, more than 69 percent of adults with a mental disorder reported having at least one general medical disorder, and 29 percent of those with a medical disorder had a comorbid mental health condition[2]

## What Variables Contribute to Comorbid Behavioral Health and Medical Conditions?

- The pathways leading to comorbidity of mental and medical disorders are complex and bi-directional
- Exposure to early trauma and chronic stress may be a risk factor for both mental and medical disorders.
- Socioeconomic factors, such as low income and poor educational attainment, are associated with mental disorders and medical conditions.
- Four modifiable health risk behaviors – tobacco use, excessive alcohol and illicit drug consumption, lack of physical activity, and poor nutrition – are responsible for much of the high rates of comorbidity, burden of illness, and early death related to chronic diseases

## Does Integration of Primary Care and Behavioral Health Work?

SAMHSA reports that an integrated service delivery system works, improves lives, saves lives and reduces healthcare costs.[3] For example, one integration program enrolled 170 people with mental illness. After one year in the program, the following monthly benefits were identified:

- 86 recipients spent fewer nights homeless
- There were 50 fewer hospitalizations for behavioral health reasons
- 17 fewer nights in detox
- 17 fewer ER visits

This was calculated at a monthly savings of $213,000, for a total annual savings of $2,500,000.

[2] Alegria M, Jackson JS, Kessler RC, Takeuchi D. National Comorbidity Survey Replication (NCS-R), 2001-2003, Ann Arbor: Inter-university Consortium for political and Social Research, 2003.

[3] Access SAMHSA's "Integration Infographic" at www.integration.samhsa.gov

## Moving from Silos to Integration of BH & Primary Care

There have some been some positive and promising moves towards integration around our state particularly with those behavioral health agencies who have co-located with a Federally Qualified Health Center. We understand that not all agencies will be able to develop an on-site medical health capability but a number of agencies have developed strong working relationships with community health centers or primary care providers. In moving towards the goal of improving client health outcomes, it will be important that:

1) All behavioral health clients have a primary care provider.
2) Each grantee provider has a working relationship with a primary care provider that includes collaboration on individual client care.

In an effort to obtain a snapshot of "where we are now" in moving towards an integrated system of care, the DBH conducted an electronic survey i.e. a modification of the Doherty Levels of Integration Model (ending November 30, 2013.). Sixty-nine agencies responded:

- 24% indicated they were co-located with primary care,
- another 32% had a documented agreement and some level of coordination, and
- 43% indicated they had no or minimal collaboration.

Barriers cited to greater integration included a lack of funding for integrated services, clients lacking health insurance to access primary care, resistance from primary care providers to work with behavioral health clients, limited time to build partnerships, confidentiality issues particularly around 42 CFR Part 2, and significant obstacles to integrating electronic health records with primary care. Suggestions to enhance integration included technical assistance to agencies regarding available models, costs, and strategies for billing as well as dialogue and planning between DBH and the Alaska Primary Care Association.

## Looking Ahead

There is an increased expectation, fueled by Federal Health Care Reform legislation and includes increased integrated care between Primary Care and Behavioral Health. Recognizing the challenge of a single model of integration, there are concrete steps that behavioral health providers can take to increase sensitivity and responsiveness to the health care needs of their clientele. One step the division is taking to assist in this direction is to modify the CSR instrument (CSR 2013) to more specifically include "Health" related issues. The most common comorbid medical conditions for behavioral health clients include diabetes, pulmonary, and cardiovascular disease. Four modifiable health risk behaviors – tobacco use, excessive alcohol and illicit drug consumption, lack of physical activity, and poor nutrition – are responsible for much of the high rates of comorbidity, burden of illness, and early death

**Existing Integration activities in the State of Alaska**

Grant funded agencies with Community Health Center / Community Behavioral Health Ctr.

- Alaska Island Community
- Copper River Native Association
- Eastern Aleutian Tribes – King Cove
- Mat-Su Health Services – Wasilla
- Kenaitze Indian Community
- Ketchikan Indian Community
- Kodiak Area Native Association – Kodiak
- Peninsula Community Health Services – Soldotna
- South Central Foundation – Anchorage
- Tanana Chiefs Council – Fairbanks
- Yukon-Kuskokwim Health Corporation – Bethel area

Agencies funded by federal CMS Primary and Behavioral Health Care Integration (PBHCI) grants

- Alaska Island Community (Cohort III – 2010)
- South Central Foundation (Cohort IV – 2011)

Patient Centered Medical Homes (PCMH)

- South Central Foundation (Nuka)
- Anchorage Neighborhood Health Center
- Eastern Aleutian Tribes

related to chronic diseases.[4]

- The CSR includes questions targeting the "four modifiable health risk behaviors" of: – tobacco use, excessive alcohol and illicit drug consumption, lack of physical activity, and poor nutrition.
- For adults, children, youth, this will assist in preventive treatment planning
- For adults over 40, this will assist in preventive, mitigation and medical access.

| | Strategies | Actions | Partners |
|---|---|---|---|
| 1 | increase awareness of medical comorbidities and their impact on behavioral health and overall well-being | 1a. Collect and report Alaska-specific data on the relationship between medical comorbidities and health outcomes. | |
| 2 | Each grantee provider has a working relationship with a primary care provider that includes collaboration on individual client care. | 2a. Assist all behavioral health clients to obtain a primary care provider. | DBH Treatment Grantee Providers<br><br>HCS: Medicaid Data |
| 3 | increase assessment of and application of "Four Modifiable Risk Behaviors" into behavioral health treatment practice and settings, | 3a. Modify the CSR Instrument to include the "Four Modifiable Risk Behaviors"<br><br>2b. Develop capacity for provider and statewide monitoring of "Four Modifiable Risk Behaviors". | |
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[4] Centers for Disease Control and Prevention. Chronic Diseases and Health Promotion, 2010; www.cdc.gov/chronicdisease/overview/.