



Improving Care for People with Severe Mental Illnesses

This is one of a series of issue briefs by the Bazelon Center on the integration of mental health in healthcare reform. They offer policy recommendations for:

- ◆integration of mental health in primary care;
- ◆medical homes;
- ◆chronic care management;
- ◆integration of mental health in the public health system;
- ◆the role of public insurance programs (Medicaid, SCHIP and Medicare); and
- ◆improving the quality of care.

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Healthcare reform must include policy to improve the management of chronic disorders. While individuals with long-term disorders represent a small proportion of those who use health services, they account for roughly 75-80 percent of healthcare spending. Yet much of this cost is thought to be avoidable. A 2007 study estimated that even modest improvements in prevention and treatment for the seven most common conditions, including mental illness, could reduce healthcare costs by 27 percent, or \$1.1 trillion annually.¹

To achieve better health outcomes and stem the rate of spending, both public and private health plans are investing in chronic care management strategies. National policy should support this trend.

Background

The needs of individuals with severe mental illnesses, such as schizophrenia, bipolar disorder or major depression, are not dissimilar to the needs of individuals with chronic illnesses, such as diabetes, cancer or cardiac disease. Caring for those struggling to manage long-term illnesses is complex. Good care requires case management and a range of individualized services. Rehabilitation, changes in behavior and provision of support services are all important contributors to good outcomes.

Approaches that target individuals with chronic illnesses such as disease management programs, medical homes, patient registries, etc. can be of great value to individuals with severe mental illnesses. These strategies have evolved from the recognition that standard care is insufficient. Helping a person manage his or her illness and cope with resulting life problems is crucial.

An important aspect of chronic disease programs is self-management. One self-management model that addresses all factors, including mental health, has shown savings between \$390 and \$520 per participant over a two-year period by reducing the use of health services. At the same time, the individuals involved reported significant satisfaction.²

Large private purchasers have recognized the value of mental health coverage in their insurance coverage and its impact on disability status and absenteeism. Examples of innovations that can result in healthcare savings over time include telephone care management and targeted outreach to providers to give them feedback about their care and increase their knowledge about best practices.

Recovery-focused systems of care used in the public sector have also shown good outcomes and, over time, lower costs than traditional medical care alone. For example, research has demonstrated the effectiveness of recovery-based Assertive Community Treatment (ACT)

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in leading to greater success in the community and reduced incidence of psychiatric hospitalizations, homelessness and criminal justice involvement. Treatment is only one aspect of this comprehensive approach, which includes interventions and support to help individuals re-build life skills, re-establish themselves in their families and communities and find meaningful work. A four-year study of a California ACT program found that its clients had only one seventh the number of institutional days compared to a control group. In the fourth year, the cost per client was \$11,035, versus \$25,682 for individuals in the comparison group.³

While proven helpful for people with chronic physical illnesses, disease management initiatives are much rarer for people with severe mental illnesses. Medical homes are now gaining support for management of complex disorders, but those with severe mental illnesses are not always included. Health plans can adopt models of care, like medical homes, that will facilitate better quality of care and link individuals with other entities to ensure that mental health and healthcare are coordinated with other social and community services and supports.

Some components of an effective and comprehensive program for people with severe mental illness are:

- ◆ early intervention;
- ◆ evidence-based community services (including medication, crisis services, counseling and rehabilitation);
- ◆ services that support the individual in managing an illness or disability;
- ◆ case management;
- ◆ acute inpatient care and other crisis residential options;
- ◆ primary care and other physical health treatment and a focus on overall wellness; and
- ◆ access and linkage to transportation, housing, child care, peer support, vocational and education services.

These components need to be supported by improved data systems that track performance and outcomes and allow payers or provider groups to intervene to improve quality.

Services covered should include rehabilitative services to assist people in managing their illnesses and disabilities and also to restore functioning across a range of life domains, including independent-living, social and cognitive skills. Other critical services are interventions to assist families and caregivers, especially families of children, to understand the illness and how to address the loved one's needs (known as psycho-education services, an evidence-based practice in mental health). Specialized placements, particularly crisis residential programs for adults and therapeutic foster care for children, should also be included.

This full range of services is rarely covered through an insurance program, but when it is available long-term outcomes and costs improve. Healthcare reform should encourage payers to reimburse providers for managing the total package of care for individuals with chronic disorders. More use should be made of capitation payments, case rates and other models where providers are charged with responsibility either for the whole person or at least for all of his or her mental health care. Mental health evidence-based practices are most effective when they combine interventions that can be furnished at the most critical

time, along with outreach and telephone follow-up. Assertive community treatment, multi-systemic therapy, therapeutic foster care and supported employment all meet the gold standard for evidence-based practice but are nearly impossible to furnish in an entirely fee-for-service system. Experience with these comprehensive approaches exists in public mental health.⁴ Another approach is to pay primary care providers for case management, and specialty providers for specific interventions.

Some of these services might be purchased from public-sector providers in the community, while others might be furnished by independent providers working as part of a team managed by a medical home. Public and private systems could find many advantages to collaborating around the care of people with long-term illnesses. For example, in Vermont a public-private initiative is focused on a patient registry and tracking system to improve chronic-care management.⁵

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Another key aspect of care for individuals with severe mental illnesses is attention to their various physical ailments. People with severe mental illnesses have significant difficulty in obtaining primary care and often encounter long delays before they receive a diagnosis and effective treatment. This is evidenced by the high rate of untreated or poorly treated physical disorders in this population (especially diabetes, cardiovascular, pulmonary and infectious diseases). The result is that members of this group die, on average, 25 years earlier than their age cohorts in the general population. Accordingly, integration of primary care within mental health provider agencies is a very important option.

Furthermore, individuals with other chronic illnesses are more likely than the general population to experience mental health problems. Those who have a co-occurring mental illness tend to do less well than others and their poorer health status correlates with higher healthcare costs. The effective treatment of the mental health problem (be it depression, anxiety, post-traumatic stress or some other disorder) will contribute to improving their health outcomes.⁶

Recommendations

Healthcare reform should encourage better management of chronic, long-term illnesses, including severe mental illnesses.

- Healthcare reform should include effective strategies for meeting the needs of people with all forms of long-term, chronic illnesses, including those with severe mental illnesses.
- These strategies should recognize that, in addition to typical medical services, individuals may need a mix of other supports to maximize the likelihood of recovery and to improve their ability to function and care for themselves in the community.
- Delivery-system innovations designed specifically to improve chronic-care management—including medical homes, electronic records, patient registries and other programs—should be encouraged through incentives.
- Behavioral health intervention should be available and incorporated into all programs for people with chronic physical illnesses.

The service needs of people with severe mental illnesses must be recognized and addressed:

- Benefit packages should include coverage of an appropriate array of evidence-based and best practices in mental healthcare, including rehabilitation for individuals with severe mental illnesses.
- Case management to link individuals to other support services (housing, transportation, etc.) should be the norm.
- Private and public plans should coordinate to ensure that there is one person or entity responsible for each individual's overall care.

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Financing policies should encourage improved management of long-term chronic illnesses:

- Payment mechanisms should enable flexibility in service delivery so as to encourage providers to accept responsibility for the total care of the individual; this might include case rates, capitation or other forms of bundled payment.
- Providers who treat people with more severe disorders should be compensated for the extra time it will take to serve a population with higher needs. Payment should reflect the intensity of care. For example, a system based on three levels would allow for a basic payment rate for those with mild or moderate disorders, a second level of rates for those with more complex needs (this might include people with, for example, significant limitations from bipolar disorder) and a third tier of rates for those with severe mental illnesses, including schizophrenia.

1 DeVol, R and Bedroussian, R. *An Unhealthy America: The Economic Burden of Chronic Disease. Charting a New Course to Save Lives and Increase Productivity and Economic Growth* (Oct 2007). Milliken Institute. Santa Monica, CA. Accessed online at: <http://www.milkeninstitute.org/publications/publications>
The report looks at the seven most common chronic conditions, including mental disorders and analyzes avoidable costs associated with these conditions.

2 <http://patienteducation.stanford.edu/programs/cdsmp.html>

3 Assertive Community Treatment: Promising Practices & Lessons Learned. *What Telecare Has Discovered About Barriers to Effectiveness and Overcoming Service Challenges*. Assertive Community Treatment: Promising Practices & Lessons Learned. *What Telecare Has Discovered About Barriers to Effectiveness and Overcoming Service Challenges*. Telecare Corporation. Accessed at: http://www.telecarecorp.com/images/medialibrary/BRO_ACT_Lessons_Learned_v8.pdf

4 One example is the Tucson, Arizona Medicaid Regional Behavioral Health Authority.

5 Silow-Carroll, Sharon, Moody, Greg, Health Management Associates for the Commonwealth Fund: *States in Action : Innovations in Health Policy*, August/September, 2008. Available at: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=700662#vermont

6 Esposito, Dominick, et al. (2007). *Evaluation of the Medicaid Value Program: Health Supports for Consumers with Chronic Conditions*. Washington, DC: Mathematica Policy Research, Inc. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=514988