Care Coordination for Persons with Complex Mental Health, Substance Use and Medical Conditions: The Case for Health Plans and Other Payers

Why is Care Coordination Necessary?

Fragmented and poorly coordinated care is costly for patients, providers and payers. The poor health outcomes and dramatically decreased life expectancy of individuals with serious mental illness and/or substance use disorders are well documented. In addition to the high prevalence of co-occurring mental health, substance use disorders (MH/SUD) and medical conditions, having one condition is a risk factor for the other and common treatments for one condition may actually worsen the comorbid condition.[1]

- Persons with serious mental illnesses are 53% more likely to be hospitalized for diabetes, which was manageable in an outpatient setting.[2]
- Persons w/SUD have 9 times greater risk of congestive heart failure and 12 times the risk of liver cirrhosis and pneumonia[3]
- "Lack of care coordination leads to serious complications, including medication errors, preventable hospital readmissions, and unnecessary pain and suffering for patients. Higher costs are also a concern; the Institute of Medicine has estimated that care coordination efforts could result in $240 billion in annual healthcare savings."[4]
- "If a 10% reduction can be made in the excess healthcare costs of patients with comorbid psychiatric disorders via an effective integrated (coordinated) medical-behavioral healthcare program, $5.4 million of healthcare savings could be achieved for each group of 100,000 insured members…"[Commercially insured population analysis][5]
- In California, healthcare spending for individuals with SMI is 3.7 times greater than it is for all Medi-Cal fee-for-service enrollees. ($14,365 per person per year compared with $3,914).[6]

What is Care Coordination for Complex Conditions?

Care coordination involves providers across disciplines and organizations acting as a team, sharing clinical information, and coordinating treatment. Patients/clients (and their family/significant other) participate as the central member of the team. Individuals with co-occurring complex conditions require "high touch" active care coordination, including activities such as: outreach and engagement, support in transitioning among different providers, effective communication and clinical information sharing, sharing care plans, reconciliation of medications to reduce errors, and active engagement of the patient and family as team members. **Unfortunately, robust care coordination is not common practice—even for persons with the most complex and co-occurring behavioral health and medical conditions.**

What is the Evidence for the Cost Effectiveness of Care Coordination?

- Kaiser Northern California research found SUD treatment reduced by: 35% inpatient, 39% ER, and 26 % total medical, compared to the control group.[7]
- In a 4-year follow-up study, IMPACT—an evidence-based approach integrating depression treatment into primary care – was more than twice as effective as usual care for depression, improved physical and social functioning and reduced health care costs.[8]
- CA county partnerships tested and implemented care coordination functions during several CiMH Learning Collaboratives with early results trending toward improved outcomes.[9]
- America's Health Insurance Plans (AHIP) sponsored a 2011 study documenting federal savings in health care costs when care coordination is implemented.[10]

CiMH Helping You Make the Difference | IBHP Integrated Behavioral Health Project | CalMHSA California Mental Health Services Authority | Mental Health Services Act Proposition 63 California | Wellness · Recovery · Resilience

How can Health Plans and Other Payers Support Care Coordination?

The Affordable Care Act funds care coordination initiatives that include testing of payment and performance improvement incentives for Medicare and Dual Eligible populations. California has its share of these and other innovation grants, but few focus on coordination of specialty behavioral health services and primary care for the safety net population. The Medi-Cal carve-out for persons with serious mental illness and the Drug Medi-Cal carve-out for substance use disorders are often cited as barriers to funding and providing care coordination for complex medical and behavioral health problems. Provider systems including FQHCs have no source of ongoing funding for care coordination. Currently, health plans are not responsible for care coordination for individuals requiring specialty mental health and substance use services despite evidence for better outcomes and lower costs for **all** systems, including hospitals and emergency departments.

Despite the lack of a statewide initiative, Health Plans and other payers can, and are beginning to take leadership in collaborating with counties and local provider organizations to provide care coordination for high-risk populations. Plans are developing models and strategies for financing and re-investment of net savings as well as performance improvement incentives. Other opportunities to expand knowledge about and demonstrate the effectiveness of care coordination include:

- With Medi-Cal expansion, partner with MH/SU and PC providers to address network adequacy issues, and improve access, care coordination, and care management for members with complex health and behavioral health conditions.
- Partner with MH/SUD and PC learning collaboratives and other initiatives to test and implement strategies to finance and spread effective care coordination/care management interventions
- Convene/co-convene local or regional forums to plan and implement care coordination and integration
- Coordinate among safety net health plans to share best practices and coordinate initiatives
- Advocate with State DHCS and foundations to promote care coordination initiatives and modelsca that include specialty behavioral health care for persons with complex and costly conditions

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[1] Druss, MD, MPH, Benjamin G. and Elizabeth Reisinger Walker, MAT, MPH; Mental Disorders and Medical Comorbidity, Robert Wood Johnson Foundation, The Synthesis Project, February 2011.

[2] SAMHSA, 10by10 Campaign, http://www.promoteacceptance.samhsa.gov/10by10/PDF/PPT_CommunityActivationKit.pdf

[3] Mertens Jr, lu yw, Parthasarathy S, Moore C, Weisner cm. Medical and Psychiatric Conditions of Alcohol and Drug Treatment Patients in an HMO. 2003, Arch Int Med 163:2511-2517.

[4] National Quality Forum, Effective Communication and Care Coordination, (website-7/2013) https://www.qualityforum.org/Topics/Effective_Communication_and_Care_Coordination.aspx

[5] Chronic Conditions And Comorbid Psychological Disorders, Milliman Research Report. July 2008

[6] Jen Associates, "Beneficiary Risk Management: Prioritizing High Risk SMI Patients, report to the CA Department of Health Care Services 2010

[7] Parthasarathy, S., Mertens, J., Moore, C., & Weisner, C. (2003). Utilization And Cost Impact Of Integrating Substance Abuse Treatment And Primary Care. Medical Care, 41(3), 357-367.

[8] University of WA, IMPACT Implementation Center, http://uwaims.org/programs.html#researchpage

[9] CiMH Breakthrough Series Learning Collaboratives: Care Integration Collaborative (CIC) and Small Counties Care Integration Collaborative (SCCI),cimh.org, Integration Initiatives web page

[10] Thorpe, Kenneth E, PhD, Emory University, Estimated Federal Savings Associated With Care Coordination Models for Medicare/Medicaid Dual Eligibles, Study sponsored by the America's Health Insurance Plans (September 2011)